AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

October 3, 2018

Paul Beahm
SVP, Health and Wellness Operations
Walmart, Inc.
702 SW 8th St.
Bentonville, AR 72716

Dear Mr. Beahm:

On behalf of the American Medical Association (AMA) and our physician and medical student members, thank you for the response to my letter expressing concerns regarding the new Walmart corporate policy to restrict initial opioid prescriptions for acute pain to no more than seven days and 50 morphine milligram equivalents (MME). We agree that there are no simple solutions, which is why we remain concerned by the one-size-fits-all corporate policy you have implemented rather than a patient-centered understanding of the complexities surrounding pain. We also remain concerned that—based on the information you provided—the new policy is based on a fundamental misunderstanding of the *Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain*. Nowhere in the *Guideline* does it support a hard and fast threshold whereby prescriptions under the limit are acceptable, and prescriptions above prohibited.

The effects of the new Walmart corporate policy have led to patients reporting that "[I] felt very embarrassed of the questions they asked [me] in front of everyone." Physicians have reported being asked for extensive medical documentation before dispensing a prescription for a controlled substance, including visit notes, tried/failed modalities and other information that goes far beyond a pharmacist's corresponding responsibility. We also have reports that a Walmart pharmacy has refused to fill prescriptions for buprenorphine for the treatment of an opioid use disorder because Walmart's corporate policy apparently did not account for the fact that calculating MME for buprenorphine for the treatment of opioid use disorder is inappropriate—according to the CDC.[1] Finally, there have been reports that Walmart pharmacists have refused to fill prescriptions until the treating physician referred the patient to a pain specialist. These are but a few examples where patient harm has likely occurred.

We are further concerned by the strain being put on the physician-pharmacist-patient relationship. What real choice do the 18,000 pharmacists employed by Walmart have when faced with dispensing a prescription outside the boundaries of the corporate policy? A pharmacist's professional and ethical obligations—similar to a physician's—are guided by his or her training and obligations under state and federal law. Having the corporate entity determine what is—and is not—acceptable clinical practice is deeply troubling.

[1] See January 4, 2018 letter from Debra Houry, MD, MPH, Director, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, to the American Society of Addiction Medicine. Available at https://www.asam.org/docs/default-source/advocacy/letters-and-comments/2018-1-4-letter-on-buprenorphine-and-cdcs-guideline-(002).pdf?sfvrsn=7fa840c2_2

Furthermore, we are surprised that you point to a 101-patient review of opioids prescribed as evidence for a 50 MME/7-day limit governing the actions of your pharmacists given that the 300-word review did not look at MME, and the *average* days that opioids were needed was seven days—meaning some patients required additional pain relief that would be interrupted by a seven-day hard threshold.

At the same time, we agree and have supported more judicious prescribing from physicians—and there has been a 22 percent decrease in opioid prescriptions since 2013. Furthermore, the prevailing research highlights the need for individual tailoring, the importance of evaluating patient outcomes rather than blind implementation of impenetrable thresholds, and to tailor prescribing by specialty and patient rather than a one-size-fits-all paradigm. Some of those studies include:

- The lack of evidence informing prescribing interventions. "This summary highlights the paucity of high-quality studies that provide clear evidence on the most effective intervention at reducing postoperative opioid prescribing."[2]
- While policy efforts are underway, study quality remains low. "While important efforts are underway to affect prescriber and patient behavior, data on state policy and systems-level interventions are limited and inconsistent. Improving the evidence base is a critical need so states, regulatory agencies, and organizations can make informed choices about policies and practices that will improve prescribing and use, while protecting patient health."[3]
- The need for patient-centered decisions. "The optimal length of opioid prescriptions lies between … 4 to 9 days for general surgery procedures, 4 to 13 days for women's health procedures, and 6 to 15 days for musculoskeletal procedures."[4]
- Large health systems emphasize education and training to change clinical practice. "A comprehensive system-level strategy has the ability to positively affect inappropriate opioid prescribing. Kaiser Permanente Southern California's approach focused on multiple levers to create prescribing and dispensing policies, monitor processes, organizational and clinical coordination that included information technology integration."[5]
- Patients have been adversely affected by arbitrary prescription limits. "Pain medicine specialists report that many patients, who were effectively managing their pain on a well-established opioid regimen, have been forced to taper their medications, as a result, of policies that limit the duration of opioid prescriptions or set maximum dose of morphine milligram equivalents (MME) per day. Eighty-three percent of pain medicine specialists surveyed said that they, or their patients, have been required to reduce the quantity or dose of medication they have prescribed. As a result, these patients are going into withdrawal, experiencing anxiety and depression and suffering with increased pain, as a result, of these restrictions. [6]

---

[2] Wetzel, MSPH, et al, "Interventions for Postsurgical Opioid Prescribing: A Systematic Review." JAMA Surgery. August 15, 2018.

[3] Haegerich, Tamara M., et al, "What we know, and don't know, about the impact of state policy and systems-level interventions on prescription drug overdose." Journal of Drug and Alcohol Dependence. September 15, 2014.

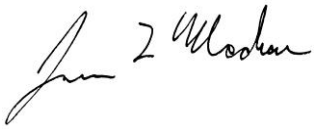
[4] Scully, MD, Rebecca E., et al, "Defining Optimal Length of Opioid Pain Medication Prescription After Common Surgical Procedures." JAMA Surgery. September 27, 2017.

[5] Losby, Ph.D., MSW, Jan L., et al, "Safer and more appropriate opioid prescribing: a large healthcare system's comprehensive approach." Journal of Evaluation in Clinical Practice. March 10, 2017.

[6] American Board of Pain Medicine. "2018 ABPM Barriers to Pain Care Pain Medicine Specialists Survey." Available at http://abpm.org/uploads/files/abpm%20survey%20results.pdf

Given the research, prevailing trends, and importance of ensuring patient-centered care, we once again urge you to revisit your new policy and allow for the therapeutic triad to guide clinical decision-making rather than imposing a hard threshold that cannot distinguish clinical or patient needs. If this is something you will consider, please contact the AMA's Daniel Blaney-Koen, JD, Senior Legislative Attorney, Advocacy Resource Center at daniel.blaney-koen@ama-assn.org or (312) 464-4954 to continue this important discussion.

Sincerely,



James L. Madara, MD

cc: AMA Opioid Task Force