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The Honorable John D. Rockefeller IV
United States Senate
531 Hart Senate Office Building
Washington, DC 20510

Dear Senator Rockefeller:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate your leadership and efforts to draw attention to prescription drug abuse and diversion. Thank you for providing the AMA with the opportunity to outline our efforts to address this crisis, as well as the chance to identify additional solutions that we could work with you to implement. The AMA has worked with federal and state policymakers to address this growing public health crisis for many years. We remain committed to continuing our collaboration with other stakeholders to implement effective solutions to rapidly reverse the trends and successfully treat addiction, overdose, and death.

Physicians work hard to balance their ethical obligation to treat patients with legitimate pain management needs against the need to identify drug seekers and prevent abuse, overdose, and death from prescription drugs. Physicians must confront numerous challenges in their efforts to maintain that balance. I have outlined below what the AMA has done to date, and has planned for the short-term to try to help physicians meet those challenges. I would welcome the opportunity to work with you and other policymakers to determine next steps.

The AMA agrees with the Obama Administration that the solution to the prescription drug abuse and diversion problem requires a multipronged, coordinated strategy. We support rapid implementation of a combination of federal and state policies to address both the supply and demand side of this epidemic. Equally important, the AMA and its partners in the medical community have committed resources to promote physician education and awareness, as well as strategies to treat addiction and reduce the incidence of overdose and death. With concerted coordination and team work, this comprehensive approach should substantially improve our ability to stop abuse and diversion and avoid pushing those with opioid addiction to the use of illicit drugs, such as heroin.[1]

Key components of the AMA's recommended comprehensive approach include:

[1] News accounts have emerged indicating that individuals addicted to prescription drug opioids are likely to use heroin if they are unable to obtain prescription drugs. It is our goal to work with others to stop addiction before it starts, but we must also implement strategies to support treatment and recovery as well. See, for example, http://www.kobi5.com/component/zoo/item/prescription-drug-abuse-down-heroin-abuse-up.html.

- full funding and staffing for up-to-date, interoperable, at the point-of-care prescription drug monitoring programs (PMP) that are integrated into a physician's workflow;[2]

- state-based tools and resources that support identification and assessment of state-based addiction treatment gaps and appropriate targeting of funding and resources to expand access in concert with efforts to decrease the supply of diverted prescription drugs;

- federal funding for a national framework to support accessible state-level take-back locations to remove unneeded prescription drugs including controlled substances from medicine cabinets;

- positive incentives to promote physician education that provides current best prescribing practices and is tailored to meet a physician's practice/patient population needs;

- enforcement actions to halt "pill mill" activities and rogue online pharmacies that are coordinated with public health efforts to expand access to addiction treatment and recovery in order to ensure that those suffering from addictions do not resort to illicit drug use, such as heroin; and

- a public health approach that places a premium on treatment and includes promoting widespread adoption of drug courts.

Barriers

Are you aware of any barriers that restrict your members' abilities to effectively prevent, identify, and treat prescription drug abuse—including misuse, addiction, overdose, and death—throughout the lifespan?

We are aware of a number of barriers that undermine the ability of physicians to identify drug seekers and those who engage in diversion.

First and foremost, physicians do not have access to reliable, real-time information about prescriptions, patients have obtained (and filled) from other prescribers, particularly controlled substances. As a result of years of concerted advocacy by the AMA and other national medical specialty societies, the National All Schedules Prescription Electronic Reporting Act of 2005 (NASPER) was signed into law. Although $52 million was authorized over a five-year period, it was not until 2009 that federal funds were appropriated to support the state adoption of PMPs. In theory, PMPs were to provide reliable and actionable information. It has been only in the past couple of years that most states have finally passed state legislation establishing PMPs, but the majority of PMPs are not real-time, interoperable, or available at the point of care as part of physician's workflow. In the rare instances when PMPs are available at the point-of-care, with up-to-date

[2] In far too many states, PMPs remain underfunded and understaffed and are far from achieving a state of technological optimization. For example, we have learned of one state where the PMP has one staff person assigned to reconcile potentially overlapping patient records in the PMP. This can cause significant delay in a physician's access to up-to-date and accurate information.

information, and integrated into physician workflow, the efficacy of PMPs is remarkable. As a pilot, Ohio placed PMPs in emergency departments and found that 41 percent of prescribers given PMP data altered their prescribing for patients receiving multiple simultaneous narcotic prescriptions. Of these providers, 63 percent prescribed no narcotics or fewer narcotics than originally planned. This indicates that PMP data can help inform sound clinical decision-making to ensure prescriptions are medically-necessary, reducing illicit use of controlled substances.

Many policymakers have not acknowledged or are unaware that the majority of state PMPs provide data that cannot be reasonably relied upon by a physician when making prescribing decisions. Providing physicians with database information that is out-of-date and unreliable cannot enhance or improve their ability to make informed prescribing decisions. **The AMA has expressed strong support for the reauthorization and full appropriations for H.R. 866, National All Schedules Prescription Electronic Reporting Reauthorization Act of 2011 (NASPER 2011), which would provide some of the needed funding and support to modernize existing state-based PMPs that have a public health focus and provide physicians with a basic tool to make treatment determinations based on patient-specific needs.** Until up-to-date PMP data are provided to physicians as part of the normal flow of information in their practices, patients who are intent on abusing or diverting prescription drugs and who are proficient "doctor shoppers" will still be able to evade detection. **Congress should reauthorize NASPER and provide substantial new funding to upgrade and modernize all PMPs so that states have resources to ensure interstate interoperability and prescriber real-time access at the point-of-care.**

In addition to supporting H.R. 866, the AMA has participated in and supports the Obama Administration's efforts to identify technical solutions to improve interoperability, enhance communication among state PMPs, and facilitate integration of PMP data into physicians' normal work flow. The AMA also has:

- Expressed strong support for the Administration and Congress' efforts to ensure that the Veterans Administration (VA) shares prescribing information with relevant state PMPs and that VA-based prescribers are authorized to consult the state PMP.

- Urged CMS to require Medicare Advantage and Medicare Prescription Drug plan sponsors to work with state PMPs to coordinate and share prescribing information.

- Supported implementation of the National Association of Boards of Pharmacy software program "InterConnect" that provides Health Information Portability and Accountability Act-compliant interoperability for state PMPs.

Second, physicians face challenges when advising patients on proper disposal of unused prescription drugs that sit in their patients' medicine cabinets at home. It is well understood that youth in particular are able to access leftover medications in their home and this is where diversion and substance misuse may begin. Currently, we do not have the national infrastructure to safely and efficiently dispose of unused prescription drugs. This has not only contributed to the prescription drug diversion crisis, but raised very serious public health concerns as increasingly our drinking water has become contaminated with prescription drugs. In 2008, an investigation found that at least 46 million Americans were exposed to prescription drugs through their drinking water**. The AMA**

supports H.R. 2939, Pharmaceutical Stewardship Act of 2011, which would address the lack of capacity and infrastructure to facilitate the safe and convenient destruction of unused prescription drugs. Drugs should not be disposed of in the trash or through the sewer. Currently, the Drug Enforcement Administration (DEA) hosts regional unused prescription drug take-back events. However, neither the resources nor the capacity exist to establish an entity or location where unused drugs may be safely and legally returned all year round. It has been reported that the DEA would issue "take-back" regulations earlier this year, but regulations would provide that states would have to find the funds to establish an infrastructure that facilitates take-back programs.

Physicians have also been impacted by the lack of coordination and communication among federal agencies and state governments, until relatively recently. In April 2011, the Obama Administration's Office of National Drug Control Policy (ONDCP) offered the Prescription Drug Abuse Prevention Plan. The AMA welcomed the Administration's effort to not only recommend and implement a set of comprehensive strategies that cut-across federal agencies, but to include components to engage a cross-section of external stakeholders. **In addition to discussions between AMA leaders and ONDCP to identify elements of the plan where we could offer assistance, we also offered additional recommendations, as well as activities, we could initiate or sponsor in order to promote the national plan.** As discussed more fully below in response to question number 3, the AMA has now been able to work with others to expand our efforts to promote physician education and awareness of prescription drug abuse and diversion.

More recently, we supported passage of the Food and Drug Administration Safety and Innovation Act of 2012 (FDASIA) including the provision that directs the U.S. Department of Health & Human Services (HHS) in coordination with other federal agencies to review current federal initiatives and identify gaps and opportunities to ensure the safe use of prescription drugs with the potential for abuse and the treatment of prescription drug dependence. This coordination is essential to ensure that we are able to work collaboratively to expand the reach of the various activities of these federal agencies, and translate it into tools that our membership or Federation members are able to use to combat prescription drug abuse and diversion.

In May, the AMA participated in the **National Governors Association (NGA) Experts' Roundtable on Reducing Prescription Drug Abuse**. The meeting was held to bring together key stakeholders on the prescription drug abuse/diversion issue. Along with identifying challenges, potential solutions, and resources available to states, the meeting was held to start the process for **NGA to establish a policy academy on this topic**. The NGA policy academy will focus on seven states, including Alabama and Colorado, which participated in this meeting, and will attempt to implement best practices in those states. Further, after meeting with various stakeholders, NGA authored an issue brief entitled "Reducing Prescription Drug Abuse." The AMA was proud to assist in the development of this issue brief. **Just as we have supported the efforts initiated by ONDCP and the Administration, we welcome and support this NGA initiative**.

We believe that additional national and state focus should be placed on strategies that go beyond combating diversion and misuse, and includes policies that help physicians and other stakeholders to stop overdose and death. **To that end, we have supported and joined efforts led by other stakeholders to draw greater attention to the barriers to the use of naloxone, a safe and effective FDA-approved medication that prevents opioid overdose.** Since the mid-1990s, community-based programs began offering naloxone and other opioid overdose prevention services to persons who use

drugs, their families and friends, and service providers (e.g., health-care providers, homeless shelters, and substance abuse treatment programs). These services include education regarding overdose risk factors, recognition of signs of opioid overdose, appropriate responses to an overdose, and administration of naloxone. A February 2012 report in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report summarized the findings from 48 such programs (representing 188 local sites). These programs reported training and distributing naloxone to 53,032 persons and receiving reports of 10,171 overdose reversals. Earlier this year, the FDA held a public workshop regarding access to naloxone, during which the agency heard compelling testimony from individuals, parents, researchers, public health professionals and medical providers about the need to increase access to—and awareness and utilization of—naloxone in the battle against overdose deaths. We joined a letter sent to the HHS Secretary urging action on this front. We support continued efforts to identify a host of strategies to ensure an adequate supply of naloxone along with access as a means to reduce overdose and death.

The AMA also met with representatives of the CDC to identify joint opportunities to facilitate physician education and resources that the CDC is able to offer states to assist them in developing data-driven strategies to address the core problem of abuse and addiction without driving drug seekers to illicit drug abuse. We will continue this collaboration.

Physicians are constrained by the lack of options to address, manage, and treat pain with medication that is not subject to tampering or that has the potential to lead to addiction. **The AMA supports FDASIA provisions directing the FDA to promulgate guidance on the development of abuse-deterrent drug products. Further, we support prioritizing publicly funded research and consideration of additional incentives to promote discovery and innovation in this arena.**

Prescribers

What percentage of your membership has an active license to prescribe controlled substances? Of that group, what percentage has received training on evidence-based clinical guidelines and/or best practices for prescribing opioids for chronic pain and identifying people at risk of addiction?

Nearly all physicians have DEA numbers and the ability to prescribe controlled substances, but only a subset of DEA-registered practitioners prescribe opioid analgesics. According to the FDA, there are about 320,000 prescribers of extended release and long-acting opioids in the United States. The AMA developed and maintains free continuing medical education (CME) to promote appropriate prescribing for pain management and to combat drug diversion. The AMA developed a free 12 credit Pain Management CME Program online in 2004, revised in 2007 and again in 2010. To date, approximately 155,000 CME certificates have been issued for the online version of this program, and 65,000 for the print version, with an additional 26,000 certificates issued to non-physicians, primarily physician assistants. This course has recently undergone substantial revision to reflect contemporary concerns about responsible opioid prescribing and will be offered again for credit in November.

As part of the FDA's Risk Evaluation and Mitigation Strategy (REMS) for extended release and long-acting opioids, the FDA expects companies to train 25 percent of the 320,000 prescribers of these drugs by the end of the first year following implementation of the REMS program, 50 percent after two years, and 60 percent within four years of the start of training. As part of our commitment

to be part of the solution, the AMA intends to submit a grant proposal to the REMS Program Companies to develop Opioid REMS compliant training in conjunction with other educational partners.

The AMA also has suggested legislation and advocated for Administration rule-making that would waive all or a portion of DEA fees for prescribers who take relevant CME or have qualifying specialized training. Currently, the DEA diversion control program must be funded by registration fees. The DEA has authority to reweight these fees in order to waive or reduce DEA fees for physicians who complete the relevant CME and increase the fees to manufacturers and others in a fashion that more accurately reflects their equitable portion of costs related to the program. Thus far, the DEA has declined to reduce physician registration fees and continues to assert that it does not have the statutory authority.

The AMA has also expressed support for legislation and grants that support development and deployment of voluntary CME that promotes appropriate prescribing for pain management and to combat diversion. As discussed in greater detail below, we strongly believe that the diversity of education and awareness activities will reach the vast majority of physician prescribers through existing and new educational tools and materials.

Education

In what ways, if any, do you seek to educate your membership on best practices for reducing the risk of prescription drug abuse, while ensuring access to prescriptions for people with legitimate medical need? If so, how do you distribute this information to your members and encourage its use?

The AMA has utilized a broad array of vehicles to educate physicians on best practices for managing pain while reducing the risk of prescription drug abuse. In addition, the AMA has also worked in a concerted fashion to raise awareness among physicians of the crisis and the steps that can be taken to address it. The AMA educational and awareness programs and efforts have been available to physicians at the AMA's two national meetings, our state meetings, our website, as well as widely accessible and consulted publications including the *AMNews*, and AMA journals.

As noted above, the AMA has offered a free online CME program since 2004 that underwent a revision this year and will be launched shortly. In addition, from October 2012 through June 2014, the AMA is scheduled to develop and release 12 free webinars on topics related to responsible opioid prescribing as part of the collaborative for the Prescriber Clinical Support System for Opioid Therapies led by the American Academy of Addiction Psychiatry and joined by the American Dental Association, American Osteopathic Academy of Addiction Medicine, American Psychiatric Association, American Society for Pain Management Nursing, the International Nurses Society on Addictions, and the AMA. The first such free webinar is scheduled for November 1, 2012, featuring "Eight Principles for Safe Opioid Prescribing." A second free webinar tentatively scheduled for December 2012 in conjunction with the CDC's National Center for Injury Prevention and Control will educate prescribers on the known demographics and patient risk factors associated with unintentional opioid overdose.

Available on the AMA's website is a free educational video vignette[3] that provides an overview on prescription drug abuse and offers tips for physicians on how to educate and counsel patients. This activity is part of AMA's Educating Physicians on Controversies and Challenges in Health (EPoCH) program.[4] The AMA supported the launch of NIDAMED,[5] which is devoted to educating physicians on issues surrounding substance abuse. As part of NIDAMED, AMA partnered with NIDA Centers of Excellence[6] via AMA's Innovative Strategies for Transforming the Education of Physicians program. These Centers of Excellence for Physician Information are charged with the task of developing innovative drug abuse and addiction curriculum resources with the goal of helping to fill the gaps in current medical students/resident physician curricula.

Last year, in Washington D.C., the AMA hosted a meeting for representatives of national medical specialty societies with the FDA and ONDCP representatives to identify strategies to combat prescription drug abuse and diversion and to offer concrete recommendations. In addition, it was an opportunity to highlight the contents of the Administration's Plan among specialty societies. Last Fall, the AMA offered an education session at our AMA Interim Meeting that included the ONDCP Director and other experts speaking on a widely-attended panel on "Addressing the National Epidemic of Prescription Drug Abuse." Subsequently, the AMA offered another educational session that included the ONDCP Director and a panel of additional experts at our January 2012 State Legislative Strategy Conference (SLSC). In attendance at the SLSC were representatives from over 30 state medical associations and 25 national medical specialty societies, as well as representatives from the Federation of State Medical Boards. The AMA offered another briefing on measures to combat prescription drug abuse and diversion to senior leadership of 35 state medical associations and 20 national medical specialty societies this Summer. Public policy efforts to combat prescription drug abuse and diversion will be highlighted at a leadership briefing at the AMA's forthcoming Interim Meeting and will also be highlighted at the AMA's 2013 SLSC. Finally, the AMA has made available to state medical associations, on the AMA's website, an issue brief on prescription drug monitoring programs outlining the AMA's efforts to combat prescription drug abuse and diversion.

Member Communication

Do you regularly communicate with your membership to determine the challenges they face when seeking to appropriately prescribe controlled substances and seek their recommendations for health system improvements in this area?

In addition to the AMA-convened meetings that we outlined above, the AMA has provided regular briefings to the AMA's physician leadership Councils and the Board of Trustees on the prescription drug abuse and diversion barriers, challenges, and educational opportunities. The AMA's President and Board Chair have highlighted this crisis in their communications to physicians. In addition, the AMA has received significant feedback on a regular basis for the past couple of years from physicians who are members of the Federation through the AMA's House of Delegates (HOD), where

[3] http://ama-cmeonline.com/prevention_drug_misuse_diversion/
[4] http://www.ama-assn.org/ama/pub/physician-resources/public-health/general-resources-health-care-professionals/educating-physicians-controversies-challenges-health/epoch-prescription-drug-misuse.page
[5] http://www.drugabuse.gov/nidamed-medical-health-professionals
[6] http://www.drugabuse.gov/nidamed/centers-excellence

these issues have been debated and discussed by physicians representing a cross-section of state medical associations and national medical specialty societies.

Insurance Companies

In what ways can third-party payers—both public and private—help provide information resources and tools that providers need to make decisions regarding controlled substances? How do you suggest we use and build on existing systems within Medicare, Medicaid, and the private sectors to identify inappropriate drug use and provide feedback to doctors and patients to ensure better coordinated care?

The AMA has already actively engaged in a constructive conversation with the Centers for Medicare & Medicaid Services (CMS) on the role that Medicare Advantage (MA) and stand alone Medicare prescription drug plan sponsors can play to provide information to prescribers to support informed clinical decision-making. CMS is in the process of working with these Medicare Part D prescription drug plans to implement a series of strategies and processes that the AMA had a role in modifying and developing to protect beneficiaries with legitimate medical need for prescribed medication regimens.

CMS had proposed that Medicare Part D prescription drug plans should conduct utilization reviews of all drugs. If the plans determined that prescribed drugs were not medically necessary, they would have been authorized to deny payment at the point of sale. This would have meant that patients would find out at the pharmacy counter that Medicare is not paying for their medications. We agreed that combating potential prescription drug abuse and/or diversion is a pressing national priority, but outlined our serious concerns with the application of policies and programs that did not involve engagement of a patient's physician. This was especially troubling when the population of patients impacted would have been elderly, more likely to be medically-fragile, and less likely to be equipped to navigate an appeals process.

We recommended as an alternative that CMS design, a process whereby the plans had to first communicate directly with all of the prescribers to determine medical necessity. CMS agreed and has adopted additional safeguards suggested by the AMA. The ultimate takeaway is that physicians are best equipped to evaluate the medication needs of their patients, and third-party payers should not promote the adoption of policies that substitute physician clinical judgment with that of a plan's without a process for engaging physicians and understanding a patient's underlying medical needs.

Treatment and Recovery

With regard to the daily practice challenges faced by your membership, how does prescription drug abuse fit into the larger context of barriers to appropriate mental health, substance abuse, and addiction treatment?

We are deeply concerned by the barriers faced by physicians in finding and placing patients in addiction treatment and recovery programs. Emergency room physicians are on the frontlines of this dilemma because there is inadequate capacity to refer patients for detoxification and treatment and recovery programs. A profound need exists to address the workforce limitations and the lack of accessible and affordable treatment programs. Our thoughts on the particular implications for

prescription drug abuse and diversion have been informed, in part, by the AMA's participation in the 2010 Methadone Mortality Reassessment and the Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT) Open Dialogue Meeting IV on Prescription Drug Misuse and Diversion.

Making certain prescription drugs less accessible does not stop prescription drug abuse, diversion, overdose, and death. In fact, simply making these drugs less accessible without policies and strategies to provide treatment and recovery simply changes the drug of choice from legal prescription drugs to illegal drugs that have no legitimate medical use. **If the ultimate goal is to stop addiction, overdose, and death, a far greater effort is needed to focus on the treatment and recovery side of this crisis.**

For example, the AMA strongly supports increased access to treatment for drug addiction and physician office-based treatment of opioid addiction. The Drug Addiction Treatment Act of 2000 provided for an office-based option for opiate treatment utilizing buprenorphine. However, there remain limits on the number of patients a physician may treat utilizing buprenorphine, a drug that can be used to facilitate recovery from opiate addiction. There is broad consensus in the medical community that buprenorphine is a major tool to fight addiction, and does not have a high potential for misuse or fatal overdose. Lifting the cap would enable physicians to treat more patients with this highly-effective drug.

In addition, suboxone, a combination of buprenorphine (a potent synthetic compound that acts on the same opiate receptors as morphine and methadone) and naloxone (an inhibitor of the opiate receptor), is very safe to be administered on an outpatient basis and is available to be prescribed by any licensed practitioner after completing a CME course that focuses on the pathophysiology of opiate addiction, screening of patients, symptom identification and management, and prescribing of the medication.[7] Becoming a prescriber for suboxone requires a fee for completion of the course, registration with governmental entities, and after a waiting period, the ability to prescribe suboxone to 30 patients for the first year. The prescriber may submit a waiver request to treat up to 100 patients after the first year.[8]

There are two distinct advantages of suboxone treatment over methadone: (a) suboxone is safe for treating patients on an outpatient basis since the presence of the opiate inhibitor naloxone in the product makes suboxone extremely safe in the cases of overdose and diversion due to the co-presence of naloxone in the product; and (b) suboxone is extremely effective in the treatment of opiate addiction. The clear benefit of suboxone treatment is the fact that treatment can be offered as an outpatient, thereby reducing the stigma associated with participation in methadone clinic and being readily available to more patients.

The regulatory process for becoming a prescriber and the patient limits serve as barriers to increase capacity to treat opiate addiction and the availability of suboxone to opiate-addicted patients, particularly those patients in jurisdictions that have adopted a law enforcement approach (as opposed to a public safety approach) to combat prescription drug abuse. The advantages of reducing the regulatory burdens to prescribing suboxone would not only increase the availability of suboxone

[7] http://buprenorphine.samhsa.gov/about.html
[8] http://buprenorphine.samhsa.gov/titlexxxv.html

treatment for patients with opiate addiction, but would also increase clinical identification, awareness, and acceptance of opiate addiction as a disease and reduce the stigma associated with opiate addiction.

There are several options to expand the current capacity to treat opiate addiction. First, suboxone training could be offered free-of-charge to prescribers with either renewal or initial application of a prescriber's DEA number. Second, the initial patient cap could be increased with a waiver option after 6 months instead of one year. In addition, Medicare reimbursement rates for suboxone treatment and counseling could be increased as an incentive for prescribers to treat opiate-addicted patients.

Finally, we continue to urge national and state policymakers to pursue a public health approach to combating addiction. To that end, the AMA HOD, this past June, adopted policy in support of drug courts. Specifically, the AMA encourages the establishment of drug courts at the state and local level as an alternative to incarceration and as a means of overcoming addiction for individuals with addictive disease convicted of nonviolent crimes. According to the National Association of Drug Court Professionals, drug courts are an alternative to individuals with addictive disease, providing them with intensive treatment and regular drug testing. A 2009 study of the National Institute of Justice found that drug court participants had significantly fewer positive drug tests and reported better improvements in their family relationships. As noted by AMA's leadership, individuals with an addictive disease require treatment, and when they are convicted of a nonviolent crime, drug courts can provide the medical attention, support, and accountability needed to help them conquer their addiction and turn their lives around. In support of that policy, the AMA has reached out to every state medical association, as well as all national medical specialty societies, to communicate that the AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; and, (2) is interested in working with them to encourage legislators to establish drug courts at the state and local levels. Additional activities will be set-up to followup on this initial effort by early next year.

Conclusion

Since 2005, the AMA has offered support for legislation that would support appropriate efforts to ensure access to appropriate pain management and support treatment for substance abuse and addiction in addition to legislation to combat prescription drug abuse and diversion. We look forward to working with you, the Administration, state leaders, and other stakeholders to reverse the disturbing trends of prescription drug abuse, diversion, addiction, overdose, and death.

Sincerely,

James L. Madara, MD