Congressman Earl L. 'Buddy' Carter
Member Testimony – Energy & Commerce Hearing on the Opioid Epidemic

Chairman Burgess and Ranking Member Green, I want to start my testimony by thanking you for holding today's hearing and for soliciting input from Members on how to continue to combat this growing epidemic.

As a pharmacist, I have always made it a priority to advise and assist my patients with the medications they are prescribed. As a community pharmacist, I developed close bonds with people who were often my friends and neighbors. That bond pushes pharmacists to always act proactively in helping their patients.

One of the largest concerns I have seen is the increased prescribing of opioids for pain relief. We need to look at other options and other outlets for the treatment of pain and find a good medium. I believe we can work with the FDA to prioritize non-opioid treatments for patients and create a channel for the approval of those therapies.

In addition, as it currently stands, prescribers are able to write up to three 30-day prescriptions for schedule two drugs for patients. I believe it would be pertinent to reexamine that prescribing structure and look at the effectiveness of allowing fewer initial prescriptions and a limited number of refills rather than 3 months of prescriptions.

Similar to that notion, allowing pharmacists to have a greater say in limiting the number of pills filled in a prescription could help to address the transition to addiction. For instance, limiting the fill for acute pain needs, such as a dental procedure, could help prevent an individual from getting hooked on opioids.

Under CARA, a pharmacist is only able to partially fill a prescription with the consent of the patient or prescriber or in the instance it doesn't have enough stock to fully fill a prescription. A simple, seven-day fill could cover their pain needs and keep more pills out of potential use or circulation.

Prescription drug monitoring programs (PDMPs) are a great resource in combating the prescription drug abuse, but they can be strengthened to better curb this epidemic. One way to do so is to better align the data included in those PDMPs so that states can collaborate to create a more comprehensive picture of people's drug use. Further linking state PDMPs and including data and work flows could allow for more accuracy in how states monitor and respond to potential abuses.

Drug take back programs continue to expand across the country. Currently, at least 19 states have some form of drug take back programs and 23 states have programs allowing pharmacies to accept unused and unwanted drugs. One of the most common ways in which adolescents access prescription drugs is through the drug cabinets of their parents and grandparents. Too often, these unused pills can act as a gateway to further abuse by young adults. Expanding these programs through law

enforcement, pharmacies, or a paid-for mail programs can take some of these prescriptions drugs off the street.

The creation of a middle ground of therapies will provide the alternatives that are missing in today's market. By facilitating research and development, we can help drive the expensive and time-consuming efforts needed to make those treatments a reality. Currently, there are few options left between Tylenol, Tramadol and opioids and that void is driving prescribing decisions across the country. We have an opportunity to support the efforts of NIH through public-private partnerships to address this and other issues.

Finally, as a lifelong pharmacist, I am never short of amazed at how my colleagues in our profession continue to evolve and excel in their roles advising patients. We now have an opportunity to capitalize on existing progress and to work with the Administration, the FDA, and outside groups to right the ship on opioid abuses. I thank the committee for the opportunity to provide testimony and I look forward to working with everyone to tackle this issue.