UT Health San Antonio

29 November 2019

RE: SOFA Act (S. 3148)

I am Professor of Pharmacology and Psychiatry and the *Robert A Welch Distinguished University Chair in Chemistry* at the University of Texas Health Science Center in San Antonio Texas. For the past 40 years, my laboratory has studied drug addiction while supported predominantly by research grants from the National Institute on Drug Abuse, National Institutes of Health (NIH), and in collaboration with numerous pharmaceutical and biotechnology companies. We have contributed to the development of FDA-approved medications and we have terminated the development of compounds that displayed adverse effects in laboratory studies. I am also the President Elect of the *American Society for Pharmacology and Experimental Therapeutics*, a nearly 5,000-member scientific organization dedicated to the study of drugs and the discovery of new therapeutics.

I am writing to express my concerns regarding congressional efforts to legislatively add compounds to Schedule I of the Controlled Substance Act, in the absence of direct scientific evidence for potential harmful effects of those compounds. The third wave of the ongoing opioid crisis (first prescription opioids, then inexpensive heroin, and now synthetic opioids) is especially challenging because fentanyl and related analogs are exceptionally potent, inexpensive, and easy to synthesize. Small modifications in these molecules can have profound effects of their activity, changing an inactive compound to an exceptionally potent opioid with high abuse potential. On the other hand, this chemical class includes compounds that are or could be useful for treating pain, inflammation, gastrointestinal diseases, and addiction, among others. Putting all fentanyl-related molecules into DEA Schedule I will undoubtedly decrease the likelihood of researchers being able to identify and exploit the therapeutic potential of compounds in this chemical class This situation poses a formidable challenge to Congress and the Drug Enforcement Administration (DEA) since there are literally thousands of (existing or potential) fentanyl analogs, some of which have high abuse and dependence potential. In the face of the opioid crisis, it is tempting to globally put all compounds that are chemically similar to fentanyl in Schedule I; however, I believe that such an action would have little impact on the manufacture, distribution, and abuse of fentanyl-related compounds, while severely limiting biomedical research and, in the long term, adversely impacting public health. The opioid crisis is a very challenging public health issue and, arguably, we are not winning that battle despite our current research efforts. To further restrict research by limiting access to potentially important compounds, based solely on chemical structure, is not likely to facilitate progress in this arena.

Because I have had a DEA Schedule I license for nearly 30 years, I know first-hand the hurdles that researchers encounter when working with compounds in this scheduling category. Getting a Schedule I registration is complicated, burdensome, and can take a long time (e.g., more than a year), disincentivizing researchers in general and particularly young researchers (e.g., graduate students and postdoctoral fellows) who often need to complete their studies on strict academic schedules. Moreover, the additional security that is necessary for handling Schedule I substances can be prohibitively expensive, particularly for young investigators in the current climate when securing NIH funding is very challenging. Specialized safes, locking refrigerators and freezers, video surveillance, and renovations can be expensive, and institutions often are not willing to pay these costs. Each additional Schedule I compound that I want to study needs a protocol review that can take many months. Even for someone like me who has been conducting research in this area for many years and has an efficient, well-funded laboratory, the delay in obtaining Schedule I compounds for experiments it prohibitively long and significantly impedes progress. Moreover, despite having a DEA Schedule I registration, importation from outside the US of a Schedule I compound that proved to have significant therapeutic value and no abuse liability, required

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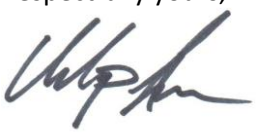
nearly two years. In fact, the conditions that apply to Schedule II substances, including very potent fentanyl analogs such as carfentanil, are comprehensive, appear adequate to protect public health, and are considerably less burdensome compared with Schedule I.

Investigators like me have dedicated our careers to research in this area because we want to make a difference in protecting individuals from the devastation caused by drug abuse. But we believe that more information, not less, is the most likely way we can achieve that goal. I encourage you and your colleagues to consider alternative approaches so that the potential benefits and risks of new chemical entities can be characterized before decisions are rendered regarding DEA scheduling.

Respectfully yours,



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