Maine Medical Association

Karen Saylor, MD, President | Jeffrey S. Barkin, MD, President-Elect | Erik N. Steele, DO, FAAFP, Chair, Board of Directors
Andrew B. MacLean, JD, CEO | Dan Morin, Director of Communications & Government Affairs

TO: The Honorable Heather Sanborn, Chair
The Honorable Denise Tepler, Chair
Members, Joint Standing Health Coverage, Insurance and Financial Services

FM: Dan Morin, Director of Communications and Government Affairs

DATE: February 11, 2021

RE: **Opposed**
LD 178—An Act To Reduce Waste of Prescription Medications

The Maine Medical Association is the state's largest professional physician organization representing more than 4300 physicians, residents, and medical students in Maine whose mission is to support Maine physicians, advance the quality of medicine in Maine and promote the health of all Maine residents.

The bill summary outlines the intent for registered nurses, providers of osteopathic medicine, providers of allopathic medicine, podiatrists and dentists may not prescribe to a patient more than a 30-day supply of a prescription drug that the provider has not previously prescribed to that patient. It also would prohibit a pharmacist from dispensing more than a 30-day supply of a new prescription drug order to a patient who does not have a previous prescription drug order for that drug.

The Maine Medical Association opposes the bill for the reasons listed below based on direct feedback from numerous physician members.

First, our concern in general in pediatrics we are working with a patient population that does not always have an advocate for them in the home. This may be a difficult thing to discuss at the state policy level, but it is common at the ground level. Our specialty clinics have many children in them who have a disease that is not difficult to treat from a medical/physiologic level but can be extremely difficult to treat from a social/resource/medical level. The ability to provide more than 30

days of medication in the home does provide "convenience" for the family, but it is more about increasing adherence to treatment for the patient who is unable to advocate for themselves or do the work of getting the medication themselves.

The Maine Medical Association is also more focused than ever on health care disparities that exists throughout the state—be they racial, ethnic, socioeconomic, demographic, or geographic. Some medicines require additional medical appointments. Hidden disparities arise when considering many patients do not live close to provider, do not have access to transportation, or if they do have their own vehicle may struggle paying for fuel.

One example provided from an MMA member had to do with Levothyroxine. The drug is used to treat an underactive thyroid gland (hypothyroidism). It replaces or provides more thyroid hormone, which is normally produced by the thyroid gland. The prescriber assesses whether the dosage is efficacious until lab results are received. Those results are best reviewed after six to eight weeks. This would require a second—and more expensive out-of-pocket cost—for those patients.

Every medical diagnosis and medical treatment are different. Pediatricians across our membership were very vocal in response to requests for comments on the bill.

A group of pediatric gastroenterologists that cares for 250+ children with inflammatory bowel disease passed along instances requiring lifelong immune suppression to keep symptoms at bay. They start these medications at the time of diagnosis and always send the initial prescription for these medications (methotrexate, mercaptopurine, mesalamine) for >30 days because they do not want to risk a break in medication with return of symptoms and potential complications from those symptoms.

Medical formulas for inborn errors of metabolism are needed for life from the moment of diagnosis. Inborn errors of metabolism: rare genetic (inherited) disorders in which the body cannot properly turn food into energy. All individuals with inborn errors of metabolism, particularly those identified on Newborn Screening, require dietary management with specific medical formulas. There are very limited options, especially for babies, and having to re-do the prior authorization process

for commercial insurances would cause significant barriers.

In Maine there are 100 individuals with these disorders all of whom have medical formula prescriptions. They live in all counties in Maine and range in age from infants (current youngest patient is 5 weeks old, oldest is > 60 years). These formulas comprise 25-80% of daily nutrition requirements. If they do not have them, they cannot eat other thing, and many will become seriously ill (hospitalized) or risk neurodevelopmental decline (i.e., develop ID/MR). It takes on average multiple telephone calls, paperwork, and time (up to 10 months) to get these approved. One physician member relayed that if she had to tell her dietitians that they have to do this repeatedly, they would revolt. Children often change formulas due to taste preference, volume etc and again, redoing a prescription on one month time frames would be completely overwhelming to staff.

Another issue would be if the prescription has to change based on growth (same medication different dose) would we have to redo all the PA process? and if we had to do this an additional time (i.e., after 1 month) this would hinder the ability to maintain proper dosing (adding more time before the patient can get the appropriate dose). This would also apply to patients on long term enzyme replacement therapy, for whom they often need to discuss treatment with the medical insurance medical directors (usually denied as it is expensive).

One medical practice relayed a concern from an advanced registered nurse practitioner (APRN) colleague. It is common for patients to have many medications. This practice has recently experienced an extremely high turnover rate of primary care providers in southern Maine. If a number of patients are stable on current medications for diabetes, hypertension, or depression it is less expensive to get 90 days vs. 30 days per their insurance. It shouldn't be a barrier to mandate return to a 30-day prescription simply because of a switch to a new provider. It should be up to the new prescriber's preference and physician-patient relationship on their comfort level if they feel the patient should have 90 days vs. 30 days.

We also oppose the restriction on pharmacists dispensing more than a 30-day supply. There are many instances where patients receive prescriptions from multiple pharmacies—whether through various shopping preferences, pharmacies near work and another near their home, or due to

vacationing. Restricting another pharmacist from dispensing only a 30-day supply after using a particular treatment method for many months, or even years could very much be an inconvenience for patients.

Finally, there are many built in out-of-pocket cost savings for patients through receiving a 90-day prescription versus a 30-day supply.

Thank you for your attention to our comments.

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