THE DOCTOR PATIENT FORUM
Proud supporter of the Don't Punish Pain Rally Organization

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Re: Joint Meeting of the Drug Safety and Risk Management Advisory Committee and the Anesthetic and Analgesic Drug Products Advisory Committee Meeting Announcement

Introduction

As an advocacy organization dedicated to protecting the rights and safety of patients with complex, chronic pain conditions, The Doctor Patient Forum respectfully submits this comment on the upcoming May 5, 2025, joint advisory committee meeting evaluating PMRs 3033-1 and 3033-2. We urge the FDA to ensure transparency, evidence-based review, and balanced representation of all stakeholders.

The Doctor Patient Forum is an independent 501(c)(3) nonprofit that does not receive any government grants, industry sponsorships, or institutional funding. Our organization is funded by individual donors, enabling us to represent the interests of patients experiencing pain and those affected by current opioid policies without financial conflicts.

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1. Primary Request: Transparency and Public Access to PMR Results

We respectfully request that the FDA release the full study data, methodology, and disclosures of conflicts of interest (COIs) for PMRs 3033-1 and 3033-2 at least two weeks prior to the May 5 advisory committee meeting. The current policy of providing background materials only two business days in advance is insufficient for meaningful analysis, public engagement, or professional comment.

With an estimated 8 to 10 million Americans on daily opioid therapy for pain, including a subset on extended-release/long-acting (ER/LA) formulations, often for serious or life-limiting conditions, it is essential that patient advocates, clinicians, researchers, and the public have adequate time to evaluate and respond to the data. The consequences of policy change are far-reaching, and the stakes for patients could not be higher.

FDA Commissioner Dr. Marty Makary, upon being sworn in stated: “As Commissioner, I hope to ensure that the FDA holds to the gold standard of trusted science, transparency, and common sense so that we can Make America Healthy Again.” That commitment must include transparency surrounding these two pivotal studies, both in the form of public access and sufficient time for meaningful stakeholder participation.

2. Background: The Creation of PMRs 3033-1 and 3033-2

In 2012, Physicians for Responsible Opioid Prescribing (PROP) submitted a citizen petition to the FDA urging the agency to modify the approved labeling for all opioid analgesics [1]. PROP requested that the FDA:

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- Strike the term "moderate" from the indication for non-cancer pain.
- Add a maximum daily dose, equivalent to 100 milligrams of morphine (MME) for non-cancer pain
- Add a maximum duration of 90-days for continuous (daily) use for non-cancer pain.

The FDA responded in 2013 with a partial grant of the petition [2]. The agency agreed to revise labeling for extended-release/long-acting (ER/LA) opioid only. These changes narrowed the indicated use to severe pain requiring daily, around-the-clock, long-term opioid treatment, where alternative options are inadequate. Importantly, the FDA declined to impose dose or duration limits, stating: “Creating a maximum dose of 100 mg MED, or another dose ceiling, could imply a superior opioid safety profile under that set threshold, when there are no data to support such a conclusion.” Instead of imposing label-based limitations, the FDA invoked its authority under Section 505(o)(3) of the Federal Food, Drug, and Cosmetic Act (FDCA) to initiate a comprehensive research program. Between 2013 and 2014, it required 11 postmarketing studies (PMRs), designated 3033-1 through 3033-11, to evaluate the long-term risks associated with ER/LA opioids [3]. These included studies of:

- Misuse, abuse, and addiction
- Overdose and death
- Opioid-induced hyperalgesia
- Doctor shopping and transition to illicit opioids

The FDA limited these studies to ER/LA opioid products only, stating that these medications posed disproportionate safety concerns compared to immediate-release (IR) opioids.

3. PROP’s Comment

The upcoming meeting's original agenda included only PROP’s submission as a comment. Instead of addressing the design or execution of the studies under review, PROP took this opportunity to reintroduce proposals from their 2012 petition for labeling changes that had previously been denied. [4].

PROP argued the PMRs are flawed because they would not detect patients who take opioids as prescribed but still meet DSM-5 criteria for OUD, stating “These individuals would not be detected by PMRs designed to identify misuse and abuse.” This suggests these patients should still be flagged and redirected to treatment. [5]. This reveals PROP’s goal is not solely safety, but reclassification. Contrary to the DSM’s own language, they seek to pathologize patients taking opioids as prescribed.

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If this perspective shapes policy:

- Stable, compliant patients may be relabeled with Opioid Use Disorder (OUD) even in the absence of misuse. As Kolodny writes, *"Although some of these patients appear to function well using long-term opioids, the new findings suggest that a large group of patients who are taking opioids as prescribed may nevertheless have OUD."* [6].
- These patients may also be forcibly tapered and offered buprenorphine (Suboxone), a drug not FDA-approved for pain. Kolodny argues that switching to buprenorphine *"often improves outcomes,"* implying it should replace traditional opioid therapy regardless of patient preference or diagnosis.
- Many will lose access to individualized care altogether, as pain management is reframed as addiction treatment for anyone physically dependent on opioids, blurring the line between dependence and a use disorder.

The FDA itself recently warned of serious dental complications associated with transmucosal buprenorphine, including tooth decay and oral infections [7]. While buprenorphine can be life-saving for individuals with Opioid Use Disorder (OUD), offering it as the only option to stable pain patients raises significant ethical concerns. Critics often claim there's insufficient evidence that opioids work for long-term non-cancer pain, a claim we will refute later in this comment, yet there is less evidence that Suboxone is effective for long term pain. Now, with unmistakable evidence of severe dental harm as a side effect, that risk must be considered before recommending Suboxone to pain patients who have been stable on their current opioid regimen.

Patients already face intense monitoring, including urine drug tests, pill counts, and pharmacy lock-ins. Adding a misapplied psychiatric diagnosis could permanently sever their access to care, flag them in Prescription Drug Monitoring Programs (PDMPs), and harm their health for life. This approach ignores the lived reality of chronic pain. The goal should be safe, individualized care, not punitive, one-size-fits-all solutions.

4. Conflicts of Interest and Lack of Transparency

This issue cannot be separated from the lack of transparency surrounding the very systems and stakeholders driving these changes:

- PROP members have repeatedly served as paid expert witnesses in opioid litigation, often receiving substantial compensation for testimony aligned with their public policy positions. For instance, Dr. Andrew Kolodny, PROP's founder, was compensated at a rate of $725 per hour, earning more than $500,000 for his testimony in Oklahoma's lawsuit against Johnson & Johnson. Similarly, PROP President Dr. Jane Ballantyne worked as a paid consultant for the law firm Motley Rice, as an expert in opioid litigation. Notably, these financial relationships were not

disclosed in PROP's comment to the FDA docket, reflecting a pattern of nondisclosure regarding conflicts of interest. These financial conflicts must be disclosed and weighed in any regulatory process [8].

- DSM-5 criteria for OUD were shaped by workgroup members with over $12 million in undisclosed industry funding, including direct ties to Indivior, the maker of Suboxone. This raises critical questions about the integrity of the OUD diagnosis being used to justify reclassification [9].

- Suboxone, the only brand-name buprenorphine product specifically listed on the NSDUH survey, was added to the "pain reliever" category starting in 2015, despite not being FDA-approved for pain. Since 2021, all users of "pain relievers," including those taking Suboxone, are screened for OUD. Naturally, many people taking Suboxone as prescribed will screen positive for OUD, because that's the very condition for which the medication is typically prescribed in the first place. These survey design choices artificially inflate misuse and OUD rates while ignoring the context of medical compliance. All statistics derived from this methodology must be reevaluated. This is not, as Dr. Kolodny suggests, a case of widespread underdiagnosis, it is a case of industry-influenced overdiagnosis, strategically structured to expand the market for one medication. Full transparency should include the NSDUH survey. [10]. Patients deserve to know why these decisions were made, and by whom, since it may greatly affect their treatment plans.

5. The Changing Landscape: What PROP Ignores

The PROP petition was submitted in 2012. Since then, the opioid landscape has undergone sweeping transformation. Opioid prescribing in the U.S. has fallen by over 60% since its peak in 2011 and is now at the lowest level in over three decades. There is broad consensus, outside of groups like PROP, that opioid prescribing is no longer a primary driver of the overdose crisis. While medications like OxyContin played a role in the past, today's epidemic is overwhelmingly fueled by illicit opioids, particularly fentanyl.

Far from being "overprescribed," ER/LA opioids are now difficult to obtain even by patients with advanced illness or intractable pain. According to Dr. Chad Kollas in a 2023 study on prescribing trends at a major U.S. cancer center: "Among patients referred by oncologists to outpatient palliative care, the prescribed doses of opioids for cancer pain declined five-fold from 2016 to 2021… This steep decline occurred even in patients receiving end-of-life care." [11]

Despite this reality, PROP writes in its 2025 docket comment: "Sponsors of extended-release opioids have been permitted to promote use of their products for conditions where evidence of safety and efficacy is lacking." This claim is not only outdated, it is factually inaccurate.

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As part of the Multidistrict Litigation opioid settlement, manufacturers of prescription opioids agreed to strict marketing prohibitions, including:

- No promotion of opioids to prescribers
- No use of sales representatives or paid speaker programs
- No targeting of high-volume prescribers or provision of financial incentives

These restrictions are legally binding and enforced by court order. The idea that ER/LA opioids are actively promoted today is false, and there is no need to change drug labeling to prevent such promotion, because it is already prohibited under the settlement agreement [12].

PROP's narrative is stuck in the pre-2012 era. Today's crisis is not one of liberal prescribing, but of medical abandonment and non-consensual opioid tapers. Patients who were once stable on long-term opioids now struggle to find any provider at all. Many are "legacy patients," left behind by policy shifts, and are now facing rapid tapers, treatment refusal, or dismissal from care.

6. Evidence of Benefit in Pain Populations

While the risks of opioids are often emphasized, very little attention is given to the patients who benefit, especially those on stable, low-to-moderate doses for chronic or cancer-related pain. Studies by Farrar et al. (2000) and Kollas et al. (2023) demonstrate that a carefully selected subset of patients can achieve long-term improvements in pain and function through sustained opioid therapy [13][11].

As Dr. Chad Kollas and colleagues wrote, *"Long-acting opioids are important for managing chronic cancer pain,"* yet their study found that access to these medications has sharply declined—even among patients receiving end-of-life care. They warn this trend is *"potentially dangerous and may adversely impact outcomes."* The authors also emphasize that *"the suggestion that short-acting opioids are safer or more appropriate... is not supported by evidence."*

These findings highlight the need to preserve individualized care. Many patients rely on stable, low-dose ER/LA opioids not to eliminate pain, but to remain functional and engaged in daily life. If labeling changes further restrict prescribing or prompt insurers to deny coverage, the consequences could be severe for patients already safely maintained on these therapies.

7. The Harm of Involuntary Tapers and Care Abandonment

A growing body of research, at least 16 studies, has linked non-consensual opioid tapering, both rapid and abrupt, to serious harms, including:

- Increased emergency department visits and hospitalizations
- Higher rates of suicide and overdose

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- Functional decline and new disability
- Increased mental health crises

These findings reflect the real-world consequences of destabilizing patients who were previously well-managed. [14].

When the CDC issued its 2016 prescribing guideline, many believed that reducing access to prescription opioids would lead to a drop in addiction and overdose deaths. But the opposite occurred: overdose deaths rose sharply, driven by illicit fentanyl and increasingly desperate patients turned away from care. We are only now seeing early signs that overdose rates may be stabilizing, and repeating the same restrictive approach could reverse that progress.

We are not advocating for unfettered access to opioids. However, we respectfully urge the agency to take a more balanced approach. If the risks of opioid use justify years of federally mandated research, then the risks of removing treatment must also be studied, particularly when they affect millions of patients and carry life-threatening consequences.

8. Data Misuse and the Risk of Unintended Harm

As we previously stated, many of the arguments in PROP's comment rest on inflated statistics produced by recent changes to the National Survey on Drug Use and Health (NSDUH). These numbers are already being misused to justify policy shifts that target stable pain patients, pushing them toward discontinuation or onto Suboxone, even when neither is appropriate. Yet, as we have seen over the past decade, well-intentioned efforts to reduce opioid use have not lowered overdose deaths, and in many cases, there have been worsening outcomes.

We respectfully urge the FDA to approach these findings with caution. Diagnostic inflation, data opacity, and one-size-fits-all solutions will not solve the crisis, and may have created a new one.

9. Recommendations

In light of the issues raised throughout this comment, The Doctor Patient Forum respectfully offers the following recommendations:

a. Ensure Transparency of PMR Results

Release the full data, methodology, authorship, and conflict of interest disclosures for PMRs 3033-1 and 3033-2 at least two weeks prior to the May 5, 2025, advisory committee meeting. Stakeholder, including clinicians, researchers, patients, and advocates, deserve time to analyze the findings and provide meaningful feedback.

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b. Reject PROP's Recycled Proposals

PROP's 2025 comment echoes elements of its 2012 petition that the FDA already evaluated and declined to fully adopt. The agency should maintain its position that such changes require strong supporting evidence, not assumption or ideology.

c. Do Not Expand Diagnostic Criteria Without Safeguards

Calls to flag patients taking opioids as prescribed, without misuse, as having OUD risk mislabeling millions of Americans. The FDA should resist using NSDUH data in ways that promote inappropriate diagnoses or diminish access to individualized care. The FDA should also resist the weaponization of the DSM OUD criteria.

d. Require Transparency in the Systems That Shape Policy

This includes:

- Disclosures of litigation payments to expert witnesses involved in policymaking
- Full publication of DSM workgroup funding sources and committee meeting notes
- Public explanation of NSDUH survey revisions and classification decisions (e.g., Suboxone listed as a pain reliever)

e. Fund Research on the Consequences of Involuntary Tapering and Abandonment

The harms of opioid prescribing have been studied extensively. The harms of deprescribing and care discontinuation remain largely unexamined, despite robust evidence of risk. The FDA is well-positioned to lead this urgently needed research.

f. Protect Access for Stable Patients

Any further regulatory action must account for the realities of patients on stable opioid regimens. These individuals are not seeking "unfettered access," but rather the ability to maintain function, dignity, and quality of life with care that works. If label changes increase prescriber fear, insurance denials, or pharmacy refusals, the human toll will be severe.

10. Conclusion

The upcoming advisory committee meeting presents an important opportunity, not just to review postmarketing data, but to restore trust in the regulatory process.

We respectfully ask the FDA to uphold its commitment to transparency, scientific integrity, and patient-centered care. That begins with releasing the full results of PMRs 3033-1 and 3033-2 well in advance of the May 5 meeting, allowing the public and professional stakeholders adequate time for review].

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It also requires rejecting proposals rooted in ideology rather than evidence, particularly those that would pathologize compliant patients, expand diagnostic labels without transparency, and limit access to care for individuals who rely on these medications to function.

Millions of patients remain on long-term opioid therapy. Many are stable, working, and living meaningful lives, yet face the constant threat of dismissal, mislabeling, or being forced onto treatments that may not be appropriate. Their experiences, and the risks of abandoning them, must not be ignored.

As Commissioner Marty Makary recently stated, the FDA must be a model of "trusted science, transparency, and common sense." Those principles should extend to every part of this process, from postmarketing study review, to diagnostic standards, to how we treat the most vulnerable patients.

We urge the agency to take balanced, evidence-informed action that protects patient safety without contributing further to stigma, suffering, or silence.

Sincerely,

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