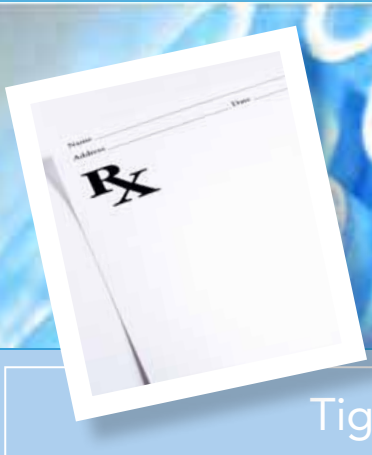

CLINICAL CORNER

Tighter Controls On Hydrocodone Drugs Endorsed By FDA Advisory Panel

{ Promise or Pessimism? }

by Michael Nguyen, PharmD, Director of Clinical Pharmacy

The Drug Enforcement Administration (DEA) is one of several government and private groups working to fight the epidemic use of prescription pain killers in America. Recently in this battle the DEA proposed changes to current prescription laws regarding hydrocodone drugs (i.e. Vicodin, Lortab, Norco, etc). After a two-day meeting the Drug Safety and Risk Management Advisory Committee voted 19 to 10 to move hydrocodone combination drugs from Schedule III to Schedule II on January 25.

Under federal Schedule III regulations physicians can prescribe a 30 day supply of Vicodin with five refills that expire in six months. Prescriptions can be faxed or phoned into the pharmacist and the pharmacy can also fax refill authorizations to be signed by the prescriber. Now as a Schedule II drug, patients will only be able to obtain hydrocodone with a hard copy prescription and refills are prohibited. However, there is still debate over the necessity and value of this change.

Proponents of the change do not appear entirely optimistic that this will solve the problem but view the misclassification of hydrocodone as a contributing factor. Studies have shown that a 10 mg tablet of hydrocodone is equal in effect to a 10 mg dose of morphine sulfate, a Schedule II drug. Some critics point to this factor as evidence that hydrocodone has been historically misclassified as a Schedule III drug. This could have created the perception that hydrocodone is less dangerous and may also be a contributing factor to the statistic that Americans are currently using 99% of the world supply of hydrocodone.

Opponents of the change have one main voiced concern; that people who really need hydrocodone drugs will not be able to get them. The unvoiced concerns may have something to do with money considering the opponents are largely represented by drug companies, pharmacists, and pain specialists. Perhaps the concern is not that patients will lose access but that the change will actually drive down the amount of prescriptions written for these drugs. Whether this will happen or not remains to be seen.

We view this change with guarded optimism. We are hopeful that our job to bring attention to inappropriate opioid prescribing will be slightly easier because of this change, but we have a long road ahead us. What we can look forward to is related to the proponent's argument that hydrocodone is a gateway drug to higher potency narcotics.

We are therefore hopeful that changing hydrocodone to a Schedule II drug will eventually change the perception that hydrocodone is safe and can be tried on any patient as a first-line option; that hydrocodone is less addictive. The statistics show this is not the case and for now this change can be viewed as a win in the battle against opioids.