April 1, 2019

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Health
200 Independence Avenue, S.W., Room 736E,
Attn: Alicia Richmond Scott, Task Force Designated Federal Officer
Washington, DC 20201


Dear Members of the Pain Management Best Practices Inter-Agency Task Force,


ASH represents approximately 17,000 physicians, scientists, and medical trainees committed to the study of blood and treatment of blood-related diseases. ASH members include clinicians who specialize in treating children and adults with hematologic disorders and researchers who investigate the causes of disease and potential new treatments and therapies. Many of ASH’s members care for individuals with hematologic conditions that are associated with severe acute and chronic pain complications, such as sickle cell disease (SCD), blood cancers, and other bleeding disorders. Additionally, ASH members also include researchers who investigate the causes and potential treatments of pain associated with hematologic conditions.

The Society recognizes that the opioid epidemic in the United States is a public health emergency that requires immediate attention. As our nation continues to address this crisis, ASH wants to promote cautious, thoughtful consideration in order to avoid unintended consequences for patients with chronic diseases. In 2018, ASH released a Statement on Opioid Use in Patients with Hematologic Diseases and Disorders. The Society is concerned about potential adverse effects that policy changes could have on the administration of necessary and appropriate pain medicine for patients with hematologic conditions, such as SCD, blood cancers, and other bleeding disorders. The Society supports a public health approach that improves the way opioids are prescribed and reduces misuse and overdose, yet safeguards access to these drugs for acute and chronic pain treatment for individuals with certain clinical conditions. Patients, including those with the hematologic diseases, who rely on opioids to treat their debilitating pain, should have opioids prescribed safely with proper follow-up.

ASH commends the Task Force for releasing a comprehensive draft Report that is reflective of the current state of the science, practice and challenges associated with pain management. The Society supports the overall provisions outlined in the draft guidance, but wanted to request that the Task Force consider some recommended changes to help strengthen this Report.
Comment re: Section 2.7.5 – Chronic Relapsing Pain Conditions

➢ **Comment 1**: ASH recommends adding hemophilia to the Task Force’s recommendation in section 2.7.5 regarding examples of Chronic Relapsing Pain Conditions. Joint bleeding is the major clinical manifestation of hemophilia. While patients of all ages can suffer painful joint bleeds requiring opioids, a third of adults with hemophilia have chronic pain often requiring opioid use due to chronic disease of the joints.

**Comments re: Section 2.7.6 – Sickle Cell Disease**

Adequate management of acute and chronic pain associated with SCD is an ongoing challenge both for patients and clinicians responsible for their care. ASH is pleased that the Task Force invited patients with SCD to share their perspective on the unique challenges they encounter managing pain and that the Report reflects this by including a dedicated section on SCD (2.7.6) in the Special Populations portion of the Report.

The clinical complexities associated with pain management for people living with SCD have been a focus of ASH’s own multifaceted SCD initiative. The Society’s effort seeks to ensure that all patients are able to access quality care for SCD, especially in areas of the country that lack providers with the comprehensive knowledge and expertise to care for this population. With a goal of increasing the use of evidence in practice, ASH is developing education and training modules for hematologists and other health care providers to ensure proper care. The Society is also drafting new evidence-based clinical practice guidelines to better inform the management of the patients we serve who experience acute and chronic pain. To that end, ASH believes that the SCD provisions in the Report will help address the obstacles associated with the management of pain in individuals with SCD. The Society also encourages the Task Force to make the following modifications to help strengthen these provisions:

➢ **Comment 1**: Pain in SCD is multifactorial and multiple mechanisms may be contributing to pain and thus may need different therapeutic options. To manage pain adequately, it is important to also understand the underlying mechanisms of pain. To address these issues, ASH recommends modifying Recommendation 1b with the highlighted text below to better reflect the high priority research needs for pain in SCD.

**Recommendation 1b**: Conduct research to understand underlying mechanisms of acute and chronic pain and develop mechanistic targeted at nonopioid pharmacologic therapies and nonpharmacologic approaches for SCD pain management.

➢ **Comment 2**: Individuals with SCD often present with acute pain in the emergency department and they either do not have an individualized pain plan or a primary physician managing their care. To address this issue, ASH recommends expanding Recommendation 2c with the highlighted text below when an individualized pain plan or a patient’s primary physician is not available. This addition to the recommendation will help ensure appropriate management of these individuals.

**Recommendation 2c**: Develop an individualized approach to pain management that includes consideration of opioid and nonopioid therapies, such as behavioral health strategies and multimodal approaches and/or weight-based approach if individualized plan or patient’s primary physician is not available.

➢ **Comment 3**: Individuals with SCD and their medical providers have reported that opioid prescribing policies regarding duration and dosage have prevented patients from obtaining access to appropriate medications. To address this issue, ASH recommends adding the following text to Gap 2 to more accurately address the barriers that many individuals currently encounter when trying to get the appropriate dosage of their medication. This change to Gap 2 would help address all aspects of this challenge.

**Gap 2**: Unpredictable, episodic exacerbations of acute pain pose a challenge for SCD pain management, and the majority of patients have failed nonopioid pain drugs prior to presentation for acute care. Constraints on opioid treatment duration and dosage can be restrictive for individualization of pain management. Further,
limited access to oral opioids at home for the treatment of unplanned acute pain events can result in increased use of health care services that could have been avoided.

➢ **Comment 4**: Revise Gap 3 to more accurately reflect the actual data showing that perceived racial bias has been associated with greater pain burden in individuals with SCD. This change is important to recognize that stigma and negative provider bias does indeed exist.

**Gap 3**: The SCD patient population faces significant health care disparities that affect access to and delivery of comprehensive pain care and mental health services. Further, stigma, negative provider attitudes, and perceived racial bias may possibly be associated with SCD pain, and which may compromise care, thus leading to increased suffering from pain and pain care delivery.

➢ **Comment 5**: It is important to consider a reimbursement mechanism for the Task Force’s Recommendations 3a and 3b below to ensure participation and sustainability of the proposed delivery models. ASH encourages the Task Force to explicitly note the importance of building these payment components in the actual recommendations to increase provider and hospital participation and ensure sustainability of the programs.

**Recommendation 3a**: Develop comprehensive care delivery models for SCD pain management, including collaborative partnerships between pain medicine and hematology.

**Recommendation 3b**: Develop outpatient infusion clinics/day hospitals for SCD pain.

➢ **Comment 6**: The time of transition from pediatric to adult care is an especially vulnerable period for individuals with SCD as both their disease and insurance status is changing, and the population often sees an increase in emergency department utilization and mortality during this time. ASH is pleased to see that the pediatric to adult transition of care is highlighted in Section 2.7.1 Unique Issues Related to Pediatric Pain Management as this is a particularly challenging time for many individuals. To address this incredibly challenging time for individuals with SCD, ASH encourages the Task Force to also include Recommendation 2a from this section in the SCD section.

**Add 2.7.1/Recommendation 2a to section 2.7.6**: Develop models of care for appropriate transition for pediatric patients with acute or chronic pain conditions to ensure seamless care delivery as well as decreased morbidity and mortality.

**General re: Section 3.3.2 – Insurance Coverage for Complex Management Situations**

ASH is pleased to see that there is a dedicated section in the Report that addresses Insurance Coverage for Complex Management Situations (3.3.2) and does not have any recommended changes to this section. A major issue for many individuals managing both acute and chronic pain is that non-pharmacologic pain interventions are often not covered by Medicare and other payors. ASH is extremely supportive of the recommendations in the Report that encourage CMS and other payors to expand reimbursement for evidence-based non-opioid and non-pharmacologic pain therapies (i.e., psychological, complementary and alternative medicine, physical therapy, etc.), as well as evidence-based holistic, integrated, multimodal pain management, including complementary and integrative health approaches.

**Comments re: Section 4 – Review of the CDC Guideline**

ASH is pleased to see that the Task Force addresses the challenges and unintended consequences related to the *Centers for Disease Control and Prevention’s (CDC) Guideline for Prescribing Opioids for Chronic Pain*. The Society continues to receive

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feedback about the access issues that individuals with hematologic conditions are having as a result of the confusion the CDC’s guideline has caused.

An ASH representative participated in a meeting with representatives from CDC, the U.S. Food and Drug Administration, American Society of Clinical Oncology (ASCO), National Comprehensive Cancer Network (NCCN) and other stakeholder groups to explore areas where multiple guideline recommendations for prescribing opioids were inadvertently causing confusion and variation in both clinical practice and in reimbursement patterns. The group agreed that there was an immediate need to clarify the intended audience for the CDC Guideline to address unintended implementation and reimbursement consequences that have been occurring in practice. As a follow-up, on February 13, 2019, ASH, ASCO and NCCN sent a letter to CDC (attachment 1) underscoring these issues. The groups also requested that CDC clarify for the public that for selected patient populations, such as those who have been affected by cancer or SCD, clinical practice guidelines specifically addressing pain control for those target populations be used to guide treatment and reimbursement practices. On February 28, 2019, the CDC sent the groups a response letter (attachment 2) noting that “the Guideline is not intended to deny any patient who suffers from chronic pain from opioid therapy as an option for pain management. Rather, the Guideline is intended to ensure that clinicians and patients consider all safe and effective treatment for patients. Clinical decision making should be based on the relationship between the clinician and patient, with an understanding of the patient’s clinical situation…” ASH encourages the Task Force to highlight this information in Section 4 of the Report and/or encourage the CDC to work with key stakeholders to disseminate the key information from the Agency’s letter more widely.

Thank you for the opportunity to provide these comments. We welcome any discussion on this issue. If you have any questions or require further clarification, please contact Stephanie Kaplan, ASH Senior Manager, Government Relations and Public Health at skaplan@hematology.org or 202-292-0263.

Sincerely,

Roy L. Silverstein, MD
President

Attachments
February 13, 2019

Deborah Dowell, MD, MPH
Chief Medical Officer
Opioid Response Coordinating Unit, CDC - National Center for Injury Prevention and Control
4770 Buford Highway, NE; Mail Stop F63
Atlanta, GA 30341

Dear Dr. Dowell,

We are writing in follow up to our November 8, 2018 meeting of stakeholders to discuss issues related to the harmonization of clinical practice guidelines for pain control as developed by ASCO, NCCN and the Centers for Disease Control and Prevention (CDC). As we discussed, these issues were recently highlighted in a JAMA Oncology article “Bridging the Critical Divide in Pain Management Guidelines from the CDC, NCCN, and ASCO for Cancer Survivors”.

The intent of our meeting was to explore areas where multiple guideline recommendations for prescribing opioids were inadvertently causing confusion and variation in both clinical practice and in reimbursement patterns. A variety of harmonization issues were discussed and will be the focus of further investigation among the stakeholders. However, the group agreed that one pressing issue should be addressed immediately: clarifying the intended audience for CDC guidelines to address unintended implementation and reimbursement consequences that have been occurring in practice.

As the JAMA Oncology article authors point out, the CDC guideline recommendations on pain management, especially concerning use of opioids, are intended to apply to cancer survivors. However, as we discussed, for select groups of cancer survivors—even when there is no evidence of disease—the relationship of benefits to risk in the use of opioids is unique and distinct from the needs of other patients with chronic pain. These survivors may have persistent pain due either to past cancer or past cancer treatment. For example, patients with lingering neuropathic pain from treatments such as vincristine or bortezomib often need long-term opioid medications to help relieve chronic pain in addition to other medications. Another example is patients with post-thoracotomy or post-mastectomy syndrome where occasionally intractable pain requires opioids when other modalities fail. In addition, as heard at the November 8th meeting, other patient populations such as those with sickle cell disease often suffer from recurrent severe painful crisis and chronic daily pain from a variety of causes including avascular necrosis, leg ulcers, and other neuropathic pain.

Also discussed at the meeting was the pressing issue of the misapplication of the guidelines for use with patients during active cancer treatment. Although the CDC Guideline clearly states that the guideline is not intended to apply to this population, many payers are still inaccurately applying the CDC guidelines to patients in active cancer treatment for coverage determinations relating to opioids. While this is not the CDC’s intention for the guideline, the resulting actions by payers are extremely likely to cause unnecessary pain and suffering to
patients with cancer. A clarifying communication from the CDC on which patient populations are excluded from the guideline would be extremely helpful to both payers and prescribers.

To ensure clarity and appropriate implementation of the CDC guideline, we are writing to ask that the CDC clarify for the public that for selected patient populations, such as who have been affected by cancer or sickle cell disease, clinical practice guidelines specifically addressing pain control for those target populations be used to guide treatment and reimbursement practices. We suggest CDC communicate the following

"It is acknowledged that there are select populations of patients, including those with sickle cell disease, patients in active cancer treatment, and some survivors of cancer with no evidence of active disease, for whom unique considerations would change the balance of benefits and risks for the use of opioids in pain management. In these select patient populations, clinical practice guidelines addressing use of opioids as part of pain control for those specific conditions should be used to guide treatment and reimbursement decisions."

Thank you again for your participation at our November 8th meeting and for all the work you do to ensure appropriate prescribing of opioids in America. We appreciate your time and consideration and would be happy to answer any questions you may have.

Sincerely,

[Signatures]

Robert W. Carlson, MD
Chief Executive Officer
National Comprehensive Cancer Network

Clifford A. Hudis, MD
Chief Executive Officer
American Society of Clinical Oncology

Martha Liggett, Esq.
Executive Director
American Society of Hematology
February 28, 2019

Robert W. Carlson, MD
National Comprehensive Cancer Network

Clifford A. Hudis, MD
American Society of Clinical Oncology

Martha Liggett, Esq.
American Society of Hematology

Dear Dr. Carlson, Dr. Hudis, and Ms. Liggett,

Thank you for your letter regarding CDC’s Guideline for Prescribing Opioids for Chronic Pain. CDC greatly appreciates your feedback regarding the interpretation of the Guideline, particularly with regard to patients undergoing cancer treatment, cancer survivors who have chronic pain, and individuals with sickle cell disease.

The Guideline was developed to provide recommendations for primary care clinicians who prescribe opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Because of the unique therapeutic goals, and balance of risks and benefits with opioid therapy in such care, clinical practice guidelines specific to cancer treatment, palliative care, and end of life care should be used to guide treatment and reimbursement decisions regarding use of opioids as part of pain control in these circumstances.

The Guideline may apply to cancer survivors in specific conditions, namely, when these patients experience chronic pain after completion of cancer treatment, are in clinical remission, and are under cancer surveillance only. As you note, for select groups of cancer survivors with persistent pain due to past cancer or past cancer treatment, the relationship of benefits to risks in use of opioids for chronic pain is unique. Clinical practice guidelines addressing pain control for cancer survivors, such as the 2016 American Society of Clinical Oncology Clinical Practice Guideline on Management of Chronic Pain in Survivors of Adult Cancers and the 2018 National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology: Adult Cancer Pain, have been published subsequent to release of CDC’s Guideline for Prescribing Opioids for Chronic Pain. Such guidelines provide useful guidance on unique considerations for use of opioids for pain control in cancer survivors.

As you additionally note, unique considerations in sickle cell disease can change the balance of benefits and risks for the use of opioids in pain management. Given the challenges of managing the painful complications of sickle cell disease, clinical practice guidelines addressing use of opioids as part of pain control in patients with sickle cell disease should be used to guide treatment and reimbursement decisions. The CDC Guideline refers readers to NIH’s National Heart, Lung, and Blood Institute’s Evidence Based Management of Sickle Cell Disease Expert Panel Report for guidance for management of sickle cell disease. This resource can be found at https://www.nhlbi.nih.gov/health-topics/evidence-based-management-sickle-cell-disease.
The Guideline is not intended to deny any patients who suffer with chronic pain from opioid therapy as an option for pain management. Rather, the Guideline is intended to ensure that clinicians and patients consider all safe and effective treatment options for patients. Clinical decision-making should be based on the relationship between the clinician and patient, with an understanding of the patient’s clinical situation, functioning, and life context, as well as a careful consideration of the benefits and risk of all treatment options, including opioid therapy. CDC encourages physicians to continue to use their clinical judgment and base treatment on what they know about their patients, including the use of opioids if determined to be the best course of treatment. Providers should communicate frequently with their patients to discuss both the benefits and risks of opioid therapy and revisit treatment plans for pain regularly to achieve the most positive outcomes for patients.

CDC has developed translational materials and trainings for providers to continue to emphasize that the Guideline is intended for primary care physicians for the treatment of chronic pain. Some of these resources include:

- **Assessing Benefits and Harms of Opioid Therapy:**

- **CDC Training Series Applying CDC’s Guideline for Prescribing Opioids,** a web-based training to help providers gain a deeper understanding of the Guideline. Trainings address a variety of topics, including provider-patient communication and decision-making on initiating opioids for chronic pain. [https://www.cdc.gov/drugoverdose/training/online-training.html](https://www.cdc.gov/drugoverdose/training/online-training.html)

Chronic pain is common and multidimensional, and patients deserve safe and effective pain management. Collaborative relationships between patients and providers are critical to provide optimal pain management. CDC will continue to emphasize what the Guideline and associated materials say about communication, patient engagement in decision-making, and maintenance of the patient-provider relationship.

CDC will revisit the Guideline as new evidence and recommendations become available to determine when gaps have been sufficiently closed to warrant an update. We value stakeholder input to assist with such an update.

Sincerely,

[Signature]

Deborah Dowell, MD, MPH
Chief Medical Officer
The National Center for Injury Prevention and Control
Centers for Disease Control and Prevention