ACPA©
American Chronic Pain Association

March 22, 2026

Oregon P&T Committee

Subject: P&T Committee OHA Analgesics Drug Class Update Comments

Dear P&T Committee:

On behalf of The American Chronic Pain Association (ACPA), we appreciate the opportunity to provide comments on the OHA Analgesics Drug Class Update. The ACPA is a non-profit, 501(c)(3) organization dedicated to facilitating peer support, education, hope, and motivation for individuals living with pain and for the clinicians who treat pain conditions. A central component of our mission is to raise awareness among the health care community, policymakers, and the public about the complex challenges of living with pain and the importance of evidence-based, patient-centered treatment options.

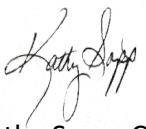
According to the document, the purpose of this review is to evaluate new comparative literature related to pain management and to assess evidence for pain conditions that are currently unfunded. We commend the Committee for undertaking this important work. However, we are concerned that the update does not meaningfully address the role of newly approved non-opioid medications for moderate to severe acute pain, despite including a section devoted to acute pain management.

There appears to be a significant omission regarding recently approved non-opioid therapies that offer clinically appropriate alternatives for moderate to severe acute pain. As policymakers and payers continue to emphasize multimodal and opioid-sparing strategies, it is essential that coverage policies reflect current science and regulatory approvals. Failure to incorporate these options may inadvertently limit access to innovative, evidence-based treatments and constrain clinicians' ability to tailor care to individual patient needs.

We respectfully request that the Committee revise the recommendations to explicitly evaluate and allow access to newly approved non-opioid medications for moderate to severe acute pain. Doing so would demonstrate a commitment to comprehensive, patient-centered pain management and ensure that Oregonians living with acute pain are not disadvantaged by outdated or incomplete coverage policies.

Thank you for your consideration of our comments and for your continued efforts to improve pain management policy. We would welcome the opportunity to provide additional information or to serve as a resource as you finalize this review.

Respectfully,



Kathy Sapp, CEO

On January 30, 2025, the FDA approved *JOURNAVX*®, the first new class of therapy for moderate-to-severe acute pain in more than 20 years.[1-4] Prior to *JOURNAVX* approval, opioids were the only oral monotherapy indicated for the initial treatment of moderate-to-severe acute pain.[5-8] The full safety information for *JOURNAVX* has been previously shared and can be found in the *JOURNAVX* prescribing information.[4] *JOURNAVX* has a highly selective mechanism of action (Nav1.8 voltage-gated sodium channel blocker); nonclinical and clinical safety assessments with *JOURNAVX* demonstrate no adverse cardiovascular, CNS or behavioral effects and no evidence of addictive potential or dependence.[9] *JOURNAVX* does not carry a Boxed Warning.[4] As of January 6th, 2026, Vertex confirmed durable unrestricted access policies of *JOURNAVX* (defined as no prior authorization, step therapy, or quantity limits ≥14 days) in 21 states, representing approximately 38% of total Medicaid lives.

The American Pain Society (APS) and American Society of Anesthesiologists (ASA), CDC and FDA recommend multi-modal analgesia and maximizing non-opioid pharmacologic therapies for acute pain.[10-12] However, all available opioids[13] and NSAIDS, including COX-2 inhibitors[14-16], carry Boxed Warnings, underscoring the need for effective non-opioid options that reduce risks and downstream associated costs. *JOURNAVX* was developed and studied to address this gap.

Despite these recommendations, a critical unmet need remains for Medicaid beneficiaries given the risks associated with current opioid treatments. A new Vertex analysis of over 1.5 million patients (n= 392,544 Medicaid-insured, n = 1,099,729 commercially-insured) receiving oral opioids following major surgeries, emergency room, or urgent care visits found 11.4% of Medicaid patients experienced an opioid-related adverse event (ORADE) within 30 days, compared to 6.5% of commercially-insured patients.[17] Risk increased over time, with approximately 1 in 5 Medicaid patients experiencing an ORADE by Day 90 after their initial opioid prescription.[17] The most frequently observed types of ORADEs in the Medicaid population were gastrointestinal issues (e.g., nausea and vomiting) (10.6%), followed by respiratory (e.g., bradypnea and respiratory failure) (4.5%), and central nervous system symptoms (e.g., delirium/altered cognition, dizziness/vertigo) (4.0%).[17]

In addition, all prescription NSAIDs have Boxed Warnings for serious cardiovascular (CV) thrombotic events, myocardial infarction (MI), and stroke, and serious gastrointestinal (GI) bleeding, ulceration and perforation.[14-16] Although the FDA warnings focus on long-term use, studies show increased risk for CV-, GI-, and renal-related complications even with short-term NSAID use.[15,18-20] This risk is amplified in older adults and patients with underlying conditions.[21] NSAIDs more than double the risk of acute kidney injury within 30 days in adults over 65, and multiple comorbidities and polypharmacy further increase the risks of CVD and bleeding events.[19,22] The American Geriatric Society (AGS) Beers Criteria identify NSAIDs as potentially inappropriate for older adults.[23]

According to a Kaiser Family Foundation analysis, overall 2.9% of all Medicaid beneficiaries[24] have a diagnosis of opioid use disorder (OUD), defined as a problematic pattern of opioid use that causes significant impairment or distress.[25] Furthermore, compared to commercially insured beneficiaries, previously opioid-naïve Medicaid beneficiaries are 3.8 times more likely to experience an overdose after being prescribed an opioid.[26] For Medicaid patients, even short-duration (≤7 days) opioid prescriptions[27] carry substantial risk of new persistent opioid use (NPOU, defined as continued opioid use between 90 and 180 days after initially using opioids to manage postsurgical acute pain[28]) and OUD. Based on a new Vertex analysis of longitudinal CMS State Medicaid data, in the state of **Oregon**, the incidence of NPOU and OUD in the first year following an initial opioid prescription in opioid-naïve adult enrollees is 9.3% and 1.3%, respectively, with a mean time to diagnosis of OUD of 166 days.[29]

As previously shared, across the two largest Phase 3 randomized, double-blind controlled trials in established models of acute pain, *JOURNAVX,* compared to placebo, demonstrated statistically significant reduction in moderate-to-severe acute pain and a faster time to clinically meaningful onset; JOURNAVX was generally safe and well-tolerated.[30] A third Phase 3 study of single-arm, open-label use demonstrated that *JOURNAVX* was generally well-tolerated in 256 participants with moderate-to-severe acute pain following a broad range of surgical procedures and non-surgical conditions, and treated up to 14 days.[31] Across all pivotal studies, *JOURNAVX* had low rates of discontinuation and no serious AEs related to *JOURNAVX.*[30,31]

New evidence from two single-arm Phase 4 studies further supports the pivotal trial findings. *JOURNAVX* was examined as part of multimodal therapy (MMT) treated up to 14 days across a broad range of aesthetic and reconstructive surgeries that would typically be treated with opioid therapy for at least 72 hours postoperatively (Study VX24-548-113, N=99)[32] and laparoscopic procedures of the intraperitoneal or retroperitoneal cavities or arthroscopic orthopedic procedures (Study VX24-548-108, N=47).[33] Nearly all participants (90.7% and 90.9% from studies VX24-548-113 and VX24-548-108, respectively) rated the effectiveness of *JOURNAVX* as part of MMT for treating post-surgical pain on a patient global assessment as good, very good, or excellent.[32,33]

In recently presented results of Study VX24-548-113, 90.9% of participants were rescue opioid-free through the end of treatment. Among the 9 subjects who used rescue opioids, the mean number of tablets used was 2.4, the mean number of days of opioid rescue medication usage was 2.0 days, and the mean total opioid rescue medication usage per person was 20.4 MME.[32] In contrast, in the published historical literature, <10% of participants who underwent similar procedures were rescue opioid–free.[34,35] In Study VX24-548-108, 76.1% were rescue opioid-free (81.5% in the orthopedic surgery sub-group, n=27), and among the 11 subjects who

used rescue opioids, the mean number of tablets used was 2.2 and the mean number of days of opioid rescue medication usage was 1.7 days, and the mean total opioid rescue medication usage per person was 16.7 MME.[33] The safety profile of *JOURNAVX* in both Phase 4 studies was generally similar to the Phase 3 studies.[32,33]

Newly published real-world claims data analysis of *JOURNAVX* utilization examining prescribing patterns across payer types within 9 months of FDA approval demonstrate that *JOURNAVX* is being used in a diverse population of patients across an age range of 17 to 100 years old, with a median days' supply of the initial prescription of 15 days.[36] More than 30% of patients receiving *JOURNAVX* underwent surgery across a broad range of surgical specialties, including orthopedic, plastic, and general surgeries, in both inpatient and outpatient settings. Approximately 70% percent of patients were prescribed *JOURNAVX* for non-surgical procedures.[36] Almost all (98.9%) of initial *JOURNAVX* prescriptions were for ≤30 days and 74.6% were for ≤15 days. *JOURNAVX* was the only analgesic prescribed on the day of the initial prescription for 82.8% of patients.[36]

Of note, *JOURNAVX* has shown controlled uptake following inclusion on formularies, consistent with Vertex expectations. In an analysis of 8 State Medicaid Plans, each with >1M lives, at 7 months after addition to formulary, utilization of *JOURNAVX* was approximately 0.26%.[37] Percent market share of *JOURNAVX* was calculated as the monthly *JOURNAVX* treatment days divided by the total monthly acute pain treatment days for each plan.[37]

Newly published societal modeling methodology projects that the economic burden of the opioid epidemic in Oregon will reach $88B annually over the next 15 years, and a nonopioid acute pain medication has the potential to substantially reduce this burden.[38,39] Opioid misuse in Oregon is projected to lead to 101,000 new OUD cases, 24,000overdose deaths, and $3.7B in total costs over the next 15 years without intervention.[39] A substantial share of this burden is directly tied to opioid use for acute pain, creating a clear opportunity for upstream prevention. Replacing 10–25% of opioid use for acute pain with a nonopioid alternative is projected to reduce statewide opioid epidemic costs by $24M–$61M annually in Oregon.[39] This substitution could avoid 1,400-3,500 new OUD cases and 50-120 overdose deaths over the same period.[39] Societal model costs (2025 USD$) included both direct costs (healthcare expenses related to non-medical opioid use, OUD treatment, and opioid-related mortality) and indirect costs encompassing lost productivity (e.g. due to premature mortality) along with broader societal costs such as criminal justice, homelessness, and family impacts.[38] Of note, a study from the CDC, which included the value of reduced quality of life and the value of statistical life lost, estimated the national annual cost of the opioid epidemic to be $1.02 T in 2017; the Joint Economic Committee adapted this approach to estimate the burden to be nearly $1.5 T in 2020.[40,41] We therefore consider our economic projections to be conservative as they do not include these elements of economic burden.[42,43]

Medicaid bears a disproportionate share of the opioid epidemic burden, with significantly higher OUD incidence and costs among Medicaid beneficiaries compared with commercially insured populations. The opioid epidemic is estimated to cost Oregon Medicaid $367M annually and replacing 10–25% of opioids for acute pain with a nonopioid alternative could generate $39M–$97M in Medicaid savings over the next 15 years.[39]

Of note, in the Institute for Clinical and Economic Review (ICER)'s cost-effectiveness analysis, *JOURNAVX* was found to be less costly and more effective (i.e. dominant result) compared to HB/APAP from the healthcare sector perspective. Vertex is encouraged that ICER recognizes the lifetime costs and harms of OUD and concluded that treatment with *JOURNAVX* would be slightly cost-saving relative to opioid therapy while producing greater health benefits.[44]

The Vertex budget impact model results suggest that *JOURNAVX* will be cost saving for Medicaid programs in the first two years on formulary given projected reductions in OUD/opioid abuse and AEs for patients with moderate-to-severe acute pain.[45] Treatment with *JOURNAVX* in Oregon's Medicaid population of 1,083,000 is estimated to result in cost savings, with a budget impact of $0.04 per member per month over the first 2 years.[45] Its use is estimated to prevent 318 nausea or vomiting AEs and 78 opioid-related events, yielding around $1.2 million in cost savings—offsetting approximately 56% of the incremental drug treatment costs.[45]

Limited access of *JOURNAVX* in the Oregon Medicaid program, despite having FDA approval for moderate-to-severe acute pain, risks unnecessary exposure of state recipients to opioids and threatens serious complications of NSAIDs, which are not indicated for moderate-to-severe acute pain. The status quo critically limits therapeutic options for Medicaid patients with moderate-to-severe acute pain. We respectfully request your consideration for a re-review of *JOURNAVX* to allow unrestricted Medicaid access for *JOURNAVX* in Oregon.

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EKTERLY® (sebetralstat) tablet 300 mg

Executive Summary

EKTERLY® (sebetralstat) is a plasma kallikrein inhibitor indicated for the treatment of acute attacks of hereditary angioedema (HAE) in adult and pediatric patients aged 12 years and older. The recommended dosage of EKTERLY is one dose of 600 mg (two tablets) orally at the earliest recognition of an acute HAE attack. A second dose of 600 mg (two tablets) may be taken 3 hours after the first dose if response is inadequate, or if symptoms worsen or recur. The maximum recommended dosage is 1,200 mg (four tablets) in any 24-hour period. There are no contraindications.[1]

EKTERLY® is the first orally administered on-demand treatment for HAE attacks and the first new on-demand treatment in more than a decade.[2-6] Although early treatment of HAE attacks is recommended according to treatment guidelines, observational studies have shown that treatment delays remain common.[7-14] Without timely treatment, HAE attack duration can be prolonged, increase in severity, and require hospitalization as well as longer hospital stay.[15] Oral sebetralstat enables compliance with treatment guidelines as demonstrated by early treatment upon attack recognition resulting in reduced attack severity.[14]

The approval of EKTERLY was based on the results of the phase 3 KONFIDENT trial (N=110) that evaluated the efficacy and safety of sebetralstat in patients living with HAE.[1]

Efficacy

KONFIDENT Trial

KONFIDENT trial (NCT05259917) was a phase 3, randomized, double-blind, placebo-controlled, three-way crossover trial evaluating the efficacy and safety of sebetralstat in patients ≥12 years of age with HAE Type I or Type II including patients on long-term prophylaxis. A total of 136 patients were randomized in a 1:1:1:1:1:1 ratio to self-administer up to two doses of sebetralstat 300 mg, sebetralstat 600 mg, or placebo for the treatment of on-demand HAE attacks.[14,16]

In KONFIDENT, all endpoints were met. The primary endpoint, median time to beginning of symptom relief, was achieved with sebetralstat 300 mg and sebetralstat 600 mg dose, both were significantly faster than with placebo (1.61 hours and 1.79 hours vs 6.72 hours, respectively). The time to reduction in attack severity and time to complete resolution was also significantly faster with both sebetralstat doses compared to placebo. Efficacy results were consistent across various subgroups by age, attack location and severity, regardless of background long-term prophylaxis therapy use.[14]

Primary Endpoint[14]

	Sebetralstat 300 mg (N=87)	Sebetralstat 600 mg (N=93)	Placebo (N=84)
Time to beginning of symptom relief within 12 hours[b] Median (IQR)	1.6 (0.78 to 7.04)	1.79 (1.02 to 3.79)[a]	6.72 (1.34 to >12)
P-value versus Placebo	*0.001*	0.001	

[a]Attacks with missing check-ins were excluded from this published analysis. The US prescribing information reported the median time to beginning of symptom relief with EKETERLY 600 mg as 2.0 hours based on an FDA-agreed method that included these attacks in the analysis. In that method, attacks with incomplete data were censored at 12 hours, reflecting a more conservative approach.
[b]Defined as a rating of at least "A Little Better" on the PGI-C scale for two or more consecutive time points.

Safety

The safety of EKTERLY is based on a double-blind, randomized, placebo-controlled, three-way crossover KONFIDENT trial. In the KONFIDENT trial, a total of 110 patients aged 12 years and older with HAE treated 264 attacks. In the safety population, 93 patients received EKTERLY 600 mg, 86 patients received 300 mg, and 83 patients received placebo. While EKTERLY 300 mg was included in KONFIDENT, the safety data is based on the recommended dosage of EKTERLY 600 mg.[1]

Adverse Reaction with incidence ≥2% and More Common than Placebo in Patients with HAE[1]

n (%)	EKTERLY 600 mg (N=93)	Placebo (N=83)[a]
Headache	3 (3.2)	1 (1.2)

[a]One patient assigned to administer placebo actually received EKTERLY 600 mg. Safety results are presented by actual treatment received.

In addition to KONFIDENT trial, the ongoing KONFIDENT-S (NCT05505916) open-label extension trial is evaluating the long-term safety and effectiveness of sebetralstat 600 mg in adult and adolescent patients ≥12 years of age for the treatment of HAE-C1INH.[17] Efficacy and safety remain consistent in the KONFIDENT and KONFIDENT-S trials.

Administration of a Second Dose

KONFIDENT Trial

Median time from attack recognition to treatment for all attacks was 41 minutes (IQR, 6.0 to 140.0).[14]

Administration of Second Dose[14]

	Sebetralstat 300 mg (N=87)	Sebetralstat 600 mg (N=93)	Placebo (N=84)
Time from onset of an attack to first sebetralstat administration, minutes Median (IQR)	35 (6 to 130)	41 (5 to 142)	51 (6 to 166)
Administration of second sebetralstat dose within 12 hours, n (%)	34 (39.1)	37 (39.8)	47 (56.0)

Note: n/N represents the number of attacks treated with trial agent.
Patients were instructed to administer the optional second dose of trial agent ≥3 hours after the administration of the first dose.

KONFIDENT-S Trial

Median time from the onset of an attack to first administration of sebetralstat was 9 minutes (1.0 to 69.0) and 10 minutes (1.0 to 69.0) in the January 31, 2024 and September 14, 2024 data cutoff, respectively.[18]

Administration of Second Dose (Interim analysis)[18]

	Sebetralstat 600 mg All Treated Attacks (N=640)	Sebetralstat 600 mg All Treated Attacks (N=1706)
	DCO: Jan 31, 2024	DCO: Sep 14, 2024
Time from onset of an attack to first sebetralstat administration, minutes Median (IQR)	9.0 (1.0 to 69.0)	10.0 (1.0 to 69.0)
Administration of second sebetralstat dose within 12 hours, n (%)	127 (19.8)	323 (18.9)

Note: n/N represents the number of attacks treated with trial agent.
DCO: data cutoff

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Date: March 23, 2026

Oregon Drug Use Review / Pharmacy & Therapeutics Committee
c/o Drug Use Research & Management Program
Oregon State University College of Pharmacy
500 Summer Street NE, E35
Salem, OR 97301-1079

Re: Written Public Comment in Support of Patient-Centered Recommendations – Analgesics Class Update

Dear Members of the Oregon Pharmacy & Therapeutics Committee,

I hope this letter finds you well. My name is Barby Ingle, and I am writing in my capacity as Vice-President and Founder of the International Pain Foundation (iPain), a 501(c)(3) nonprofit dedicated to improving the lives of people living with chronic pain. I am also a chronic pain patient myself, living with Complex Regional Pain Syndrome (CRPS/RSD) for over 25 years. As a nationally recognized patient advocate, author, and speaker who has testified before legislative bodies and served on multiple pain-related advisory panels, I appreciate the opportunity to submit these comments for the April 2, 2026 P&T meeting.

I am writing specifically to offer my strong support for the Analgesics Class Update and the thoughtful, evidence-based direction the committee is taking. The update correctly emphasizes multimodal, patient-centered pain management that prioritizes non-opioid therapies (including antidepressants such as duloxetine, gabapentinoids for neuropathic pain, NSAIDs where appropriate, and non-pharmacologic interventions) while reserving opioids for individualized care cases. This approach reflects the real-world needs of Oregonians living with chronic pain.

I particularly support the following elements in the draft recommendations:

- Promotion of multimodal care that combines pharmacologic and non-pharmacologic therapies to improve function and quality of life.
- Continued access to options such as suzetrigine for acute pain.
- Requirements for shared decision-making, documented functional improvement, PDMP checks, and naloxone co-prescribing.
- Recognition that pain management must be individualized—especially for complex conditions like neuropathic pain, cancer-related pain, sickle cell disease, and end-of-life care.

As someone who has experienced both the benefits and risks of various pain treatments, I know firsthand how critical it is to avoid one-size-fits-all policies. Blanket restrictions that limit access

to effective therapies can lead to unnecessary suffering, loss of function, increased healthcare utilization, and, in some tragic cases, loss of life. The committee's balanced approach—preserving clinical flexibility for patients — represents responsible stewardship of the Oregon Health Plan.

I respectfully urge the Committee to adopt the proposed updates to the prior authorization criteria and to continue monitoring real-world outcomes so that Oregonians with chronic pain continue to have timely, individualized access to the full range of safe and effective treatment options. Patients like me rely on the P&T Committee to protect both safety and access.

Thank you for your service and for considering the patient voice in these important decisions. I am happy to provide additional information or answer any questions the Committee may have.

Sincerely,

Barby Ingle, BSc
Board of Directors, International Pain Foundation 2006-2027
Global Genes Leadership Council 2025-2027
Board of Directors, Arizona Chronic Care Coalition 2017- Present
AZ RDAC – BioPharma Representative 2026-2027
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March 27, 2026

Oregon P&T Committee

Subject: P&T Committee OHA Analgesics Drug Class Update Comments

Dear Pharmacy & Therapeutics Committee Members,

I am writing today, as a resident of Oregon, to request an update on the implementation of SB 598 and availability of non-opioid pain medications. The opioid epidemic continues to devastate Oregon, and overdose deaths continue throughout the. United States. 133 Americans died every day from an opioid-related drug overdose between April 2024 and April 2025. While public attention often focuses on illicit drug use, a key driver of this crisis remains the routine prescribing of opioids for pain. For many patients, addiction begins not on the street, but with a prescription after surgery or injury.

As a rare disease and two-time kidney transplant recipient, I know pain management is not optional, it is essential to healing. Transplant patients CANNOT take NSAIDs and often require individualized pain plans. Yet when patients seek safer, non-opioid options, they face insurance barriers, prior authorization requirements, step therapy, and higher out-of-pocket costs, while opioids remain the easiest and most accessible choice. That imbalance puts patients at risk.

In 2025 alone, more than 400 transplants were performed in Oregon. Each of those patients deserves the opportunity to learn about and access non-opioid pain management options without unnecessary financial or administrative hurdles.

Oregon's pain parity law, SB 598, addresses this directly by requiring insurers to apply the same coverage standards to non-opioid pain treatments as they do to opioids, eliminating policies that inadvertently steer patients toward more addictive medications.

Millions of Americans become persistent opioid users each year following surgery, often because safer alternatives were unavailable or unaffordable. Expanding equitable access to effective, non-opioid pain treatments is a practical, upstream solution to reduce misuse, prevent addiction, and save lives.

The opioid crisis is a public health emergency, but in many cases, it is preventable. Patients deserve real choices when it comes to pain care. Transplant recipients, in particular, should have access to safer options that support the long-term success of their lifesaving gift while honoring the extraordinary generosity of donors. Implementing SB 598 and ensuring true pain care parity can help save lives in Oregon.

Aimee Adelmann
Portland, OR Resident
Patient Advocate

March 23, 2026

To Whom It May Concern,

I am writing to share a patient and family perspective on the current limitations placed on access to non-opioid analgesics—specifically the 48-hour restriction and prior authorization requirement for suzetrigine—and to respectfully request clarification and revision of these criteria.

My family has firsthand experience with the challenges of managing acute pain while avoiding opioid medications. In 2021, after my elbow surgery, my medical record clearly stated that I did not want opioids. Despite this, I was still offered them repeatedly, and I had to advocate for myself at a time when I was in significant pain and not in a position to debate treatment options. More recently, my wife—who is in long-term recovery—was in a serious car accident. She declined opioids, yet the only alternative offered to her in the emergency department was over-the-counter medication, which was inadequate for the level of pain she was experiencing. These experiences highlight a systemic problem: when patients choose non-opioid options, the system often makes that path harder, not easier.

This is why access to medications like suzetrigine matters. The Oregon Drug Class Update confirms that:

- Suzetrigine is safe and effective for up to 48 hours, and while evidence beyond that timeframe is limited, there is no indication of increased harm in the available data.
- It performs similarly to low-dose hydrocodone/acetaminophen for acute post-surgical pain.
- Importantly, use of an opioid is not required for authorization.

Despite this, the current policy requires patients to obtain a new prescription and prior authorization after 48 hours. For someone recovering from surgery or an injury, this is not a minor inconvenience — it is a barrier that interrupts pain control, delays treatment, and forces patients to navigate administrative hurdles at the worst possible time.

Meanwhile, a 7-day opioid prescription can be obtained without prior authorization.

This imbalance contradicts the intent of Oregon Senate Bill 598, which requires that non-opioid medications not be subject to more restrictive utilization controls than opioids. When a patient is trying to avoid opioids — whether because of recovery status, personal preference, or past adverse experiences — the system should support that choice, not make it more difficult.

From a patient perspective, the current structure creates several harms:

Young People in Recovery
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- Interrupted pain management during the most acute phase of recovery
- Administrative burden on both patients and prescribers
- Unintentional steering toward opioids, simply because they are easier to access
- Reduced adherence to multimodal, non-opioid pain plans
- Increased risk of complications or emergency care when pain becomes uncontrolled

For families like mine, who have repeatedly had to advocate for non-opioid options in moments of crisis, these barriers are not theoretical. They are lived realities that undermine safety, dignity, and patient choice.

I respectfully request:

1. Removal of the prior authorization requirement for suzetrigine beyond 48 hours, or
2. Clear, patient-centered criteria allowing prescribers to continue therapy for up to 14 days without interruption, consistent with available evidence, and
3. Alignment of non-opioid access with opioid access, ensuring that non-opioid options are not subject to more restrictive controls.

Patients who choose safer alternatives should not face greater obstacles. When a non-opioid medication is clinically appropriate, evidence-supported, and preferred by the patient, access should be straightforward and uninterrupted.

Thank you for your consideration and for your commitment to improving pain management policy in Oregon. I would welcome the opportunity to provide additional testimony or patient-experience context as needed.

Sincerely,

Billy O'Bryan

Kentucky Program Director, Young People in Recovery

Billy O'Bryan

KY Program Director

Young People In Recovery

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