

Steve Miller: Litigation Won't Solve the Opioid Crisis

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Patients suffering from the effects of abuse need real help, not scapegoats.

In my 40-year career helping companies navigate crises, including stints as vice chairman of a near-bankrupt Chrysler in the 1980s and chairman of AIG after the federal bailout a decade ago, I'd never encountered a situation as challenging or important to society than the one I now face as chairman of Purdue Pharma.

At issue is the opioid crisis. States, cities and towns have turned to the courts and are suing Purdue and other manufacturers, distributors and pharmacy chains, claiming they are responsible for damage to communities across the country.

The litigation raises important questions. Can America address the crisis without abandoning pain patients who rely on opioid medications to lead productive lives? What is the liability of companies that make, distribute and sell legal products that provide medical benefits and are regulated by the federal government? More specifically, can Purdue be held responsible for the societal costs of the opioid crisis when it warned of the risks of addiction and is far from the only seller of prescription opioid pills?

Earlier this month, a North Dakota court provided some answers. In dismissing all of the state's claims against Purdue, the court said the state's theory depended on an "extremely attenuated, multi-step and remote causal chain," and that the state "completely fails" to show how Purdue's marketing caused the financial damage claimed by the state. The court noted that "holding Purdue solely responsible for the entire opioid epidemic in North Dakota is difficult to comprehend, especially given Purdue's small share of the overall market for lawful opioids." Even at OxyContin's peak in 2003, the Purdue-made drug accounted for only 4% of all opioid prescriptions in the U.S. That share had dropped to 1.3% by 2018.

While Purdue is prepared to defend these cases vigorously, it sees little good coming from years of litigation and appeals. The people and communities affected by the opioid crisis need help now. Purdue understands that each day consumed by litigation is another in which critical resources don't make it to the people who need them.

That's why Purdue agreed in March to a creative resolution offered by Oklahoma Attorney General Mike Hunter to establish a National Center for Addiction Studies and Treatment at Oklahoma State University in Tulsa. This settlement ensures that money will directly help those affected by the crisis and also advance understanding of the causes of addiction.

Some other states are also opting to settle instead of drawing out litigation. Earlier this month, West Virginia announced it reached a settlement with McKesson, a drug distributor, that will immediately channel tens of millions of dollars to the state, one of the hardest hit by the crisis.

These resolutions are a good start, but nearly 2,000 cases are still pending and more are added daily. Plaintiffs are doubling down on opioid litigation, along with a campaign of public vilification. It's designed to damage the defendants before the true facts emerge in the legal cases.

The demonization of Purdue is inaccurate and unfair. Purdue is a good company, founded and still run by doctors. Since becoming chairman 10 months ago, I've come to know many of the company's 500 employees. They are dedicated to making a legal medicine—approved and regulated—that is prescribed to millions of Americans suffering from debilitating pain.

Purdue has been an industry leader in preventing and solving problems caused by opioid abuse. Most notable was our creation of the first opioids with abuse-deterrent properties approved by the Food and Drug Administration. This innovation has been used in all OxyContin sold in the U.S. since 2010. Purdue also financially supported the development of the prescription-drug monitoring programs used in 49 U.S. states to prevent patients from receiving duplicate prescriptions from different doctors.

Litigation may satisfy the public's desire for a scapegoat, but real long-term solutions are needed. The first step should be a constructive global resolution to the opioid litigation that helps suffering people and strained communities. There's no time to waste.

Mr. Miller is chairman of Purdue Pharma.

IMPORTANT SAFETY INFORMATION

WARNING: ADDICTION, ABUSE AND MISUSE; RISK EVALUATION AND MITIGATION STRATEGY (REMS); LIFE-THREATENING RESPIRATORY DEPRESSION; ACCIDENTAL INGESTION; NEONATAL OPIOID WITHDRAWAL SYNDROME; CYTOCHROME P450 3A4 INTERACTION; and RISKS FROM CONCOMITANT USE WITH BENZODIAZEPINES OR OTHER CNS DEPRESSANTS

Addiction, Abuse, and Misuse

OXYCONTIN® exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient's risk prior to prescribing OXYCONTIN and monitor all patients regularly for the development of these behaviors and conditions [see *Warnings and Precautions (5.1)*].

Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS)

To ensure that the benefits of opioid analgesics outweigh the risks of addiction, abuse, and misuse, the Food and Drug Administration (FDA) has required a Risk Evaluation and Mitigation Strategy (REMS) for these products [see *Warnings and Precautions (5.2)*].

Life-Threatening Respiratory Depression

Serious, life-threatening, or fatal respiratory depression may occur with use of OXYCONTIN. Monitor for respiratory depression, especially during initiation of OXYCONTIN or following a dose increase. Instruct patients to swallow OXYCONTIN tablets whole; crushing, chewing, or dissolving OXYCONTIN tablets can cause rapid release and absorption of a potentially fatal dose of oxycodone [see *Warnings and Precautions (5.3)*].

Accidental Ingestion

Accidental ingestion of even one dose of OXYCONTIN, especially by children, can result in a fatal overdose of oxycodone [see *Warnings and Precautions (5.3)*].

Neonatal Opioid Withdrawal Syndrome

Prolonged use of OXYCONTIN during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated, and requires management according to protocols developed by neonatology experts. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available [see *Warnings and Precautions (5.4)*].

Cytochrome P450 3A4 Interaction

The concomitant use of OXYCONTIN with all cytochrome P450 3A4 inhibitors may result in an increase in oxycodone plasma concentrations, which could increase or prolong adverse drug effects and may cause potentially fatal respiratory depression. In addition, discontinuation of a concomitantly used cytochrome P450 3A4 inducer may result in an increase in oxycodone plasma concentration. Monitor patients receiving OXYCONTIN and any CYP3A4 inhibitor or inducer [see *Warnings and Precautions (5.5), Drug Interactions (7), Clinical Pharmacology (12.3)*].

Risks From Concomitant Use With Benzodiazepines Or Other CNS Depressants

Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death [see *Warnings and Precautions (5.6), Drug Interactions (7)*].

- Reserve concomitant prescribing of OXYCONTIN and benzodiazepines or other CNS depressants for use in patients for whom alternative treatment options are inadequate.
- Limit dosages and durations to the minimum required.
- Follow patients for signs and symptoms of respiratory depression and sedation.

CONTRAINDICATIONS

OxyContin is contraindicated in patients with:

- Significant respiratory depression
- Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment
- Known or suspected gastrointestinal obstruction, including paralytic ileus
- Hypersensitivity (e.g., anaphylaxis) to oxycodone.

WARNINGS AND PRECAUTIONS

Addiction, Abuse, and Misuse

- OxyContin contains oxycodone, a Schedule II controlled substance. OxyContin exposes users to the risks of opioid addiction, abuse, and misuse. Because extended-release products such as OxyContin deliver the opioid over an extended period of time, there is a greater risk for overdose and death due to the larger amount of oxycodone present.
- Although the risk of addiction in any individual is unknown, it can occur in patients appropriately prescribed OxyContin. Addiction can occur at recommended doses and if the drug is misused or abused.
- Assess each patient's risk for opioid addiction, abuse, or misuse prior to prescribing OxyContin, and monitor all patients receiving OxyContin for the development of these behaviors and conditions. Risks are increased in patients with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depression). The potential for these risks should not, however, prevent the proper management of pain in any given patient. Patients at increased risk may be prescribed opioids such as OxyContin, but use in such patients necessitates intensive counseling about the risks and proper use of OxyContin along with intensive monitoring for signs of addiction, abuse, and misuse.

- Abuse or misuse of OxyContin by crushing, chewing, snorting, or injecting the dissolved product will result in the uncontrolled delivery of oxycodone and can result in overdose and death.
- Opioids are sought by drug abusers and people with addiction disorders and are subject to criminal diversion. Consider these risks when prescribing or dispensing OxyContin. Strategies to reduce these risks include prescribing the drug in the smallest appropriate quantity and advising the patient on the proper disposal of unused drug.

Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS)

- To ensure that the benefits of opioid analgesics outweigh the risks of addiction, abuse, and misuse, the Food and Drug Administration (FDA) has required a Risk Evaluation and Mitigation Strategy (REMS) for these products. Under the requirements of the REMS, drug companies with approved opioid analgesic products must make REMS-compliant education programs available to healthcare providers. Healthcare providers are strongly encouraged to do all of the following:
 - complete a REMS-compliant education program,
 - counsel patients and/or their caregivers, with every prescription, on safe use, serious risks, storage, and disposal of these products,
 - emphasize to patients and their caregivers the importance of reading the Medication Guide every time it is provided by their pharmacist, and
 - consider other tools to improve patient, household, and community safety.
- To obtain further information on the opioid analgesic REMS and for a list of accredited REMS CME/CE, call 1-800-503-0784, or log on to www.opioidanalgesicrems.com. The FDA Blueprint can be found at www.fda.gov/OpioidAnalgesicREMSBlueprint

Life-Threatening Respiratory Depression

- Serious, life-threatening, or fatal respiratory depression has been reported with the use of opioids, even when used as recommended, and if not immediately recognized and treated, may lead to respiratory arrest and death.
- While serious, life-threatening, or fatal respiratory depression can occur at any time during the use of OxyContin, the risk is greatest during the initiation of therapy or following a dosage increase. Closely monitor patients for respiratory depression, especially within the first 24-72 hours of initiating therapy with and following dosage increases of OxyContin.
- To reduce the risk of respiratory depression, proper dosing and titration of OxyContin are essential. Overestimating the OxyContin dosage when converting patients from another opioid product can result in a fatal overdose with the first dose.
- Accidental ingestion of even one dose of OxyContin, especially by children, can result in respiratory depression and death due to an overdose of oxycodone.

Neonatal Opioid Withdrawal Syndrome

- Prolonged use of OxyContin during pregnancy can result in withdrawal in the neonate. Neonatal opioid withdrawal syndrome, unlike opioid withdrawal syndrome in adults, may be life-threatening if not recognized and treated, and requires management according to protocols developed by neonatology experts. Observe newborns for signs of neonatal opioid withdrawal syndrome and manage accordingly. Advise pregnant women using opioids for a prolonged period of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.

Risks of Concomitant Use or Discontinuation of Cytochrome P450 3A4 Inhibitors and Inducers

- Concomitant use with a CYP3A4 inhibitor, such as macrolide antibiotics, azole-antifungal agents, and protease inhibitors, particularly when an inhibitor is added after a stable dose of OxyContin is achieved, and discontinuation of a CYP3A4 inducer, such as rifampin, carbamazepine, and phenytoin, may increase plasma concentrations of oxycodone and prolong opioid adverse reactions, which may cause potentially fatal respiratory depression. Monitor patients closely at frequent intervals and consider dosage reduction of OxyContin until stable drug effects are achieved. Concomitant use of OxyContin with CYP3A4 inducers or discontinuation of a CYP3A4 inhibitor could decrease oxycodone plasma concentrations, decrease opioid efficacy or, possibly, lead to a withdrawal syndrome in a patient who had developed physical dependence to oxycodone. Monitor patients closely at frequent intervals and consider increasing the opioid dosage if needed to maintain adequate analgesia or if symptoms of opioid withdrawal occur.

Risks from Concomitant Use with Benzodiazepines or Other CNS Depressants

- Profound sedation, respiratory depression, coma, and death may result from the concomitant use of OxyContin with benzodiazepines or CNS depressants (e.g., non-benzodiazepines sedatives/hypnotics, anxiolytics, tranquilizers, muscle relaxants, general anesthetics, antipsychotics, other opioids, alcohol). Because of these risks, reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate.
- If the decision is made to prescribe a benzodiazepine or other CNS depressant concomitantly with an opioid analgesic, prescribe the lowest effective dosages and minimum durations of concomitant use. In patients already receiving an opioid analgesic, prescribe a lower initial dose of the benzodiazepine or other CNS depressant than indicated in the absence of an opioid, and titrate based on clinical response. If an opioid analgesic is initiated in a patient already taking a benzodiazepine or other CNS depressant, prescribe a lower initial dose of the opioid analgesic, and titrate based on clinical response. Follow patients closely for signs and symptoms of respiratory depression and sedation.

- Advise both patients and caregivers about the risks of respiratory depression and sedation when OxyContin is used with benzodiazepines or other CNS depressants (including alcohol and illicit drugs). Advise patients not to drive or operate heavy machinery until the effects of concomitant use of the benzodiazepine or other CNS depressant have been determined. Screen patients for risk of substance use disorders, including opioid abuse and misuse, and warn them of the risk for overdose and death associated with the use of additional CNS depressants including alcohol and illicit drugs.
- The use of OxyContin in patients with acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment is contraindicated. OxyContin-treated patients with significant chronic obstructive pulmonary disease or cor pulmonale, and those with a substantially decreased respiratory reserve, hypoxia, hypercapnia, or pre-existing respiratory depression are at increased risk of decreased respiratory drive including apnea, even at recommended dosages of OxyContin.

Life-Threatening Respiratory Depression in Patients with Chronic Pulmonary Disease or in Elderly, Cachectic, or Debilitated Patients

- Life-threatening respiratory depression is more likely to occur in elderly, cachectic, or debilitated patients because they may have altered pharmacokinetics or altered clearance compared to younger, healthier patients.
- Monitor such patients closely, particularly when initiating and titrating OxyContin and when OxyContin is given concomitantly with other drugs that depress respiration. Alternatively, consider the use of non-opioid analgesics in these patients.

Adrenal Insufficiency

- Cases of adrenal insufficiency have been reported with opioid use, more often following greater than one month of use. If adrenal insufficiency is suspected, confirm the diagnosis with diagnostic testing as soon as possible. If adrenal insufficiency is diagnosed, treat with physiologic replacement doses of corticosteroids. Wean the patient off of the opioid to allow adrenal function to recover and continue corticosteroid treatment until adrenal function recovers.

Severe Hypotension

- OxyContin may cause severe hypotension including orthostatic hypotension and syncope in ambulatory patients. There is an increased risk in patients whose ability to maintain blood pressure has already been compromised by a reduced blood volume or after concurrent administration of certain CNS depressant drugs (e.g., phenothiazines or general anesthetics). Monitor these patients for signs of hypotension after initiating or titrating the dosage of OxyContin. In patients with circulatory shock, OxyContin may cause vasodilation that can further reduce cardiac output and blood pressure. Avoid the use of OxyContin in patients with circulatory shock.

Risks of Use in Patients with Increased Intracranial Pressure, Brain Tumors, Head Injury, or Impaired Consciousness

- In patients who may be susceptible to the intracranial effects of CO₂ retention (e.g., those with evidence of increased intracranial pressure or brain tumors), OxyContin may reduce respiratory drive, and the resultant CO₂ retention can further increase intracranial pressure. Monitor those patients for signs of sedation and respiratory depression, particularly when initiating therapy with OxyContin. Opioids may obscure the clinical course in a patient with a head injury. Avoid the use of OxyContin in patients with impaired consciousness or coma.

Difficulty in Swallowing and Risk for Obstruction in Patients at Risk for a Small Gastrointestinal Lumen

- There have been post-marketing reports of difficulty swallowing OxyContin tablets. These reports include choking, gagging, regurgitation, and tablets stuck in the throat. Instruct patients not to pre-soak, lick or otherwise wet OxyContin tablets prior to placing in the mouth, and to take one tablet at a time with enough water to ensure complete swallowing immediately after placing in the mouth.
- There have been rare post-marketing reports of cases of intestinal obstruction, and exacerbations of diverticulitis, some of which have required medical intervention to remove the tablet. Patients with underlying GI disorders such as esophageal cancer or colon cancer with a small gastrointestinal lumen are at greater risk of developing these complications. Consider use of an alternative analgesic in patients who have difficulty swallowing and patients at risk for underlying GI disorders resulting in a small gastrointestinal lumen.

Risks of Use in Patients with Gastrointestinal Conditions

- OxyContin is contraindicated in patients with known or suspected gastrointestinal obstruction, including paralytic ileus. The oxycodone in OxyContin may cause spasm of the sphincter of Oddi. Opioids may cause increases in the serum amylase. Monitor patients with biliary tract disease, including acute pancreatitis.

Increased Risk of Seizures in Patients with Seizure Disorders

- The oxycodone in OxyContin may increase the frequency of seizures in patients with seizure disorders, and may increase the risk of seizures occurring in other clinical settings associated with seizures. Monitor patients with a history of seizure disorders for worsened seizure control during OxyContin therapy.

Withdrawal

- Avoid the use of mixed agonist/antagonist (e.g., pentazocine, nalbuphine, and butorphanol) or partial agonist (e.g., buprenorphine) analgesics in patients who are receiving a full opioid agonist analgesic, including OxyContin. In these patients, mixed agonist/antagonist and partial agonist analgesics may reduce the analgesic effect and/or may precipitate withdrawal symptoms. When discontinuing OxyContin, gradually taper the dosage. Do not abruptly discontinue OxyContin.

Risks of Driving and Operating Machinery

- OxyContin may impair the mental or physical abilities needed to perform potentially hazardous activities such as driving a car or operating machinery. Warn patients not to drive or operate dangerous machinery unless they are tolerant to the effects of OxyContin and know how they will react to the medication.

Laboratory Monitoring

- Not every urine drug test for “opioids” or “opiates” detects oxycodone reliably, especially those designed for in-office use. Further, many laboratories will report urine drug concentrations below a specified “cut-off” value as “negative.” Therefore, if urine testing for oxycodone is considered in the clinical management of an individual patient, ensure that the sensitivity and specificity of the assay is appropriate, and consider the limitations of the testing used when interpreting results.

ADVERSE REACTIONS

- OxyContin may increase the risk of serious adverse reactions such as those observed with other opioid analgesics, including respiratory depression, apnea, respiratory arrest, circulatory depression, hypotension, or shock.
- The most common adverse reactions (> 5%) reported by adult patients in clinical trials comparing OxyContin with placebo are constipation, nausea, somnolence, dizziness, pruritus, vomiting, headache, dry mouth, asthenia, and sweating.

Please read [Full Prescribing Information](#), including **Boxed Warning**.