AmericansFor SafeAccess
Advancing Legal Medical Marijuana Therapeutics and Research

Americans for Safe Access Supports Senator Madsen's SB 73 because it Provides the Best Therapeutic Options for Physicians and Their Patients

Americans for Safe Access thanks the Utah State Legislature for its consideration of legislation that would help the many residents of Utah that could benefit from medical cannabis therapy. As the nation's largest organization focusing exclusively on advancing safe and legal access to medical cannabis for patients and researchers, we are pleased to see a number of bills and resolutions that have been offered that show a genuine concern for the patients of Utah.

Summary of position on SB 73 and SB 89

ASA has been working on state, local, and federal legislation since 2002 and experience has shown that the most successful programs are the ones that generate the greatest amount of wellness by enabling physicians to use this as another tool in their toolbox to use when appropriate in their sound medical judgement. While we appreciate the intent of each of these pieces of legislation, only Senator Madsen's SB 73 would create the type of system that would help the greatest number of Utahans. It is the most comprehensive and pro-patient medical cannabis bill before the legislature, which is why strongly urge passage of SB 73.

We appreciate the compassionate impetus behind Senator Vickers SB 89, as it shows a desire to help people gain in state access to medicine that is currently not legal to be produced or obtained in regulated stores within the state. However, the bill simply leaves out too many patients, and by restricting forms of medical cannabis as well as the cannabinoid profiles, even patients that qualify under the SB 89 program might not be able to acquire the type of medical cannabis they need to truly treat their condition. Beyond these most significant limitations (qualifying conditions, forms of medicine, and access to the full cannabinoid profile), other issues exist, such as the lack of discrimination protections on for child custody and employment, and limitations on the number of dispensing locations that will create unnecessary hardships for even those limited number of patients eligible under SB 89. While ASA does not oppose legislation this sort of limited legislation, SB 73 would create a significantly better program for patients in Utah.

Restrictions on Qualifying Conditions

While it is common for states to impose restrictions on what types of conditions a physician may recommend medical cannabis as a treatment option, this is not ideal. Lists of qualifying conditions by definition impede a physician's ability to treat their

physicians with the full array of treatment options. Allowing a physician to recommend any treatment option when the potential benefits outweigh the risks should be the gold standard. All treatment options have potential risks and benefits. Surgery and prescription drugs both run the risk of worsening a patient's condition or even causing death (notably, there no confirmed overdose deaths from cannabis use). If a physician feels those potential risks are worth taking to receive the benefit, they are allow to treat their patients with those options. Cannabis therapy should be no different. If a physician feels that the potential risks of using cannabis is worth the potential benefits, a physician should be able to recommend that option to their patients, just as we trust physicians to exercise sound judgement in recommending surgery or prescription drug options.

While neither of these bills fully meets ASA's model language for empowering physicians, only SB 73 comes close. The ability under SB 73 that allows physicians to recommend cannabis to treat chronic pain, as well as the mechanism to allow Compassionate Use Board to approve unlisted conditions on a case-by-case basis makes it the superior bill for patients and physicians alike.

Inhaled cannabis has been shown in several reports to safely and effectively treat various kinds of pain.[123] Additionally, a 2014 study published in the Journal of the American Medical Association cannabis states experienced nearly 25% fewer opioid overdoses from 1999 to the conclusion of the study in 2010.[4] ASA would prefer that SB 73 not have any restrictions on the type of pain that cannabis can treat. However, SB 73 essentially says your physician can recommend cannabis if your pain cannot be treated effectively with ibuprofen, aspirin, or acetaminophen. We feel that this reasonable under the circumstances, as would it lessen the harms of opioid dependency to those with chronic pain.

The limitation on the types of pain that can be treated under SB 89 harms all patients with other types of pain. Even when using available studies as a guidepost, it is essentially arbitrary to impose the condition-specific requirement to pain, as physicians

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[1] "Average pain improvement on a 0–10 pain scale was 5.0 (from 7.8 to 2.8), which translates to a 64% relative decrease in average pain. Half of all respondents also noted relief from stress/anxiety, and nearly half (45%) reported relief from insomnia. Most patients (71%) reported no adverse effects, while 6% reported a cough or throat irritation…No serious adverse effects were reported." Webb, Charles, and Webb, Sandra, *Therapeutic Benefits of Cannabis: A Patient Survey*, Hawaii J Med Public Health. 2014 Apr; 73(4): 109–111, abstract available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3998228/.

[2] Ware, MA, et al., *Smoked cannabis for chronic neuropathic pain: a randomized controlled trial*, CMAJ. 2010 Oct 5;182(14):E694-701, abstract available at: http://www.ncbi.nlm.nih.gov/pubmed/20805210.

[3] Demonstrating safety of 12.5% THC cannabis to treat pain is *Cannabis for the Management of Pain: Assessment of Safety Study (COMPASS),* by Ware, M., et al, published in e Journal of Pain, Vol 16, No 12 (December), 2015: pp 1233-1242, available at: http://www.jpain.org/article/S1526-5900(15)00837-8/pdf.

[4] Bachhuber, A., et al. Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010, JAMA Intern Med. 2014;174(10):1668-1673, abstract available at: http://archinte.jamanetwork.com/article.aspx?articleid=1898878.

can prescribe opioids to treat any condition regardless of whether there is a study that has confirmed its effectiveness.

The flexibility that SB 73 allows the Compassionate Use Board to add conditions on a case-by-case basis a reasonable compromise on allows access for those not included in the set of qualifying conditions if both their physician and the Board agree the potential benefits outweigh the risks. This type of patient approval process is not optimal because it could cause harmful delays and other medications do not require such approval process. Yet this is better than no alternative, and SB 73 provides a basic failsafe that patients deserve. For example, patients with a veteran with traumatic brain injuries may be approved by the board. A study found that traumatic brain injury patients who used THC had significantly lower incidences of mortality than those who did not use THC (2.4% compared with 11.5%, about a five-fold increase in chances of survival).[5] That means that SB 73 potentially gives traumatic brain injury patients a nearly five-fold increase in their chances of survival. While SB 89 would allow a veteran suffering an amputation from combat explosion to have access to CBD to treat phantom limb pain, yet that same veteran would be denied by SB 89 to treat their traumatic brain injury with THC.

Full Cannabinoid Profile and Forms of Medicine

The restrictions the cannabinoid profile imposed by SB 89 harm its ability to treat the limited conditions in the bill. By requiring at minimum of 10 parts of CBD to THC and not allowing cannabis to be accessed in its dried flower form, patients will be denied access to the forms of cannabis that have been used in studies that have demonstrated the substance's therapeutic effect. In other words, SB 89 limits the types of cannabis available to forms and cannabinoid profiles that we have less knowledge regarding their effectiveness.

For example, the study *Smoked medicinal cannabis for neuropathic pain in HIV: a randomized, crossover clinical trial* involved patients using dried flowers.[6] The cannabis inhaled by patients in this study almost certainly did not have a 10:1 CBD ratio, as CBD is only mentioned once in passing during the article. The patients in the study achieved a 30% reduction in their neuropathic pain, but under SB 89 HIV patients in Utah might not receive the same type of benefit. The study looked at varying THC levels up to 8%, meaning that patients in Utah would have to hope that there was a product available that could deliver an 88% CBD product in order to have 8% THC, and existing examples of such products are very difficult to find. It would take vast amounts of raw cannabis to produce small amounts of extract oil that would meet this cannabinoid profile, which makes it more difficult and costly to obtain. Difficulty is important because SB 89 limits the number of retail access locations for medical cannabis products in the state. Cost is

[5] Nguyen BM, et al., Effect of marijuana use on outcomes in traumatic brain injury, Am Surg. 2014 Oct;80(10):979-83, abstract available at: http://www.ncbi.nlm.nih.gov/pubmed/25264643.
[6] Ellis, RJ, et al., Neuropsychopharmacology. 2009 Feb;34(3):672-80, available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3066045/.

important because medical cannabis expenses are not covered by health insurance. However, it would take significantly less raw cannabis to produce this much THC if patients could access it in the dried flower form, which is the form that was show to be effective in the study. For an HIV patient in severe pain on a fixed income, SB 89 provides fewer and less proven medicine options with additional cost and travel hurdles compared to SB 73.

For epilepsy patients, many will not find relief with the maximum 10:1 threshold. The type of cannabinoid profile involvement with successful treatment of epilepsy through the use of cannabis seems to vary greatly from patient to patient. Some patients do well with a 30:1 extract, while others with the same symptoms will only see benefit at a 2:1 ratio. Other patients will have their needs change of the course of their therapy, sometimes need to increase or lower the amounts of THC and CBD in order to find the most effective relief. The only way to allow epilepsy patients to consistently find relief is to not impose restrictions on an inherently restrictive cannabinoid profile.

Positions on Resolutions HCR 3 and SCR 11

With respect to the resolutions the have been introduced by Representative Daw (HCR 3) and Senator Shiozawa (SCR 11), ASA sees value in their passage in both resolutions. ASA is working to pass the federal Compassionate Access, Research Expansion, and Respect States (CARERS) Act in Congress (H.R. 1538/S. 683), which would help facilitate the type of research sought by both resolutions. The bill would also fully protect Utah under either the SB 73 or SB 89 program, the current restrictions on the federal Department of Justice from interfering with state legal medical cannabis programs, known as the Rohrabacher-Farr Amendment, must be renewed by Congress each year. The CARERS Act would also move cannabis to Schedule II of the Controlled Substances Act. ASA would prefer cannabis be listed in Schedule III or less restrictive, but acknowledges that Schedule II would help remove certain bureaucratic hurdles that prevent research.[7] Regardless of what type of medical cannabis legislation a given state senator or representative supports, they can further help protect the patients of their state by urging members of Utah Congressional Delegation to support the CARERS Act.

[7] See *Ending the U.S. government's war on medical marijuana research*, John Hudak and Grace Wallack, Brookings Institution, Oct. 2015, available at: http://www.brookings.edu/~/media/research/files/papers/2015/10/20-war-on-marijuana-research-hudak-wallack/ending-the-us-governments-war-on-medical-marijuana-research.pdf.