ACP policy originating from ACP sponsored resolution introduced to the AMA House of Delegates

DRUGS

Medicare Prescription Drug Coverage

1. Medicare Part D should be financed in such a way as to bring in sufficient revenue to support the costs of the program, both short and long-term, without further threatening the solvency of the Medicare program or requiring cuts in payments for other services or reduced benefits in other areas. Given the anticipated high cost of a prescription drug benefit, Congress must assure that revenues for financing the benefit do not depend on overly optimistic assumptions about tax revenues resulting from growth in the economy or under-estimates of the costs of the benefit. A predictable and stable source of financing, which will assure that revenues keep pace with the costs of the benefit without requiring cuts in other benefits, should be identified. If it turns out that costs in future years exceed anticipated revenues, Congress will need to consider making adjustments in the benefit and/or financing mechanism to assure that prescription drug coverage can be sustained without requiring cuts in other benefits.

2. ACP believes that the highest priority should go toward providing prescription drug benefits for those most in need: low income beneficiaries who do not have access to drug coverage under other plans. Funding of programs to assist low-income Medicare beneficiaries in paying their Part D costs, such as the low-income subsidy, should be provided and adjusted as needed. The federal government should improve its efforts to alert qualified beneficiaries of their eligibility to receive financial assistance related to Part D cost-sharing.

3. While ACP strongly prefers that the Government not require the use of formularies for covered prescription drugs, existing Medicare Part D-formularies should operate in a way consistent with ACP policies on drug formularies.

4. A method of pricing Medicare payments for prescription drugs should be included that will balance the need to restrain the cost of the benefit with the need to create financial incentives for manufacturers to continue to develop new products. Rigid price controls that will discourage innovation should be rejected.

5. Physicians should continue to be able to prescribe covered drugs for accepted off-label uses.

6. The prescription drug benefit should not require an expansion of prescribing privileges for non-physician health professionals beyond what can be supported based on their level of training.

7. Issues of generic and therapeutic substitution under the Medicare program should be addressed in a way that is consistent with existing ACP policies on those issues. (BoR7-99, revised BoR 10)

Honoring of Primary Care Physicians’ Prescriptions by the VA Medical System

ACP advocates for legislative and regulatory changes that allow non-VA physicians’ prescriptions for eligible patients to be filled by pharmacy services within the Department of Veterans’ Affairs facilities.
Methadone Regulation
The American College of Physicians (ACP), recommends that Methadone be considered no differently than any other DEA Schedule II agent. (BoR 4-99, reaffirmed BoR 10)

Improving FDA Regulation of Prescription Drugs
1. Improve the FDA’s ability to approve and monitor prescription drugs through increased funding.
2. Increase the FDA’s capacity to regulate drugs manufactured outside the U.S. through both appropriations and user fees.
3. The FDA’s regulatory authority should be expanded and more clearly exercised in the design of preapproval trials and studies. Design of preapproval trials should include at least the following:
   • A sample size large enough to reflect an appropriate distribution of age and comorbidity among subjects.
   • Similar priority given to evaluating both drug safety and efficacy
   • Use of scientific and technological tools (such as pharmacogenetics and computer simulations) to provide earlier warnings about drug toxicities and potential harm.
   • Mandatory registration and public reporting of all clinical trial results.
4. Bundling of drugs to limit marketability and availability should be prohibited.
5. Improve the adverse events reporting system.
6. Grant the FDA the authority to require that newly approved drugs have a special symbol on their labels to help increase public awareness that they are new, and limit direct-to-consumer (DTC) advertising for the first 2 years after approval. (BoR 10)

FDA Regulation of Drugs and Medical Devices
ACP opposes any efforts to weaken FDA authority to demand rigorous evaluations of drugs and medical devices for both safety and effectiveness based on sound scientific and medical evidence and opposes legislative attempts to curtail FDA authority to establish and maintain standards of safety and effectiveness for approval of drugs and medical devices. (ACP AMA Del A-95; reaffirmed BoR 08)

Removal of Drugs by the Food and Drug Administration (FDA)*
ACP recommends that the FDA inform the medical profession of the evidence for the need to withdraw drugs of long standing use prior to implementation of such an order and there shall be opportunity and time for a response by the medical profession except in instances of immediate threat to life and well being. Consideration should be given to the experiences, views and opinions of physicians in the clinical practice of medicine before condemning or removing drugs from the market. (HoD 71; revised HoD 73; reaffirmed HoD 87; reaffirmed BoR 04)

Statement of the American Pharmaceutical Association (APA) and ASIM on Prescriptions*

Introduction
Historically, the pharmaceutical and medical professions have devoted considerable time and effort to the development and rational utilization of safe and effective drugs for the treatment and prevention of illness. Today, that successful effort continues, helping to achieve the highest standards of health in the world for the American people. But in order to gain maximum benefit from the use of drugs while minimizing their adverse side effects, prescribers and pharmacists must maintain effective communications
not only among themselves, but with their patients as well. The directions for drug use and other information which prescribers indicate on prescription orders and which pharmacists transfer to prescription labels are critical to safe and effective drug therapy. In order to assure that this information is conveyed clearly and effectively to patients, the following guidelines have been developed by the APA and ASIM.

Guidelines for Prescribers

The following guidelines are recommended for prescribers when writing directions for drug use on their prescription orders: The name and strength of the drug dispensed will be recorded on the prescription label by the pharmacist unless otherwise directed by the prescriber. Whenever possible, specific times of the day for drug administration should be indicated. (For example, "Take one capsule at 8:00 am, 12:00 noon, and 8:00 pm" is preferable to "Take one capsule three times daily." Likewise, "Take one tablet two hours after meals" is preferable to, "Take one tablet after meals.") The use of potentially confusing abbreviations, i.e., qid, qod, qd, etc., is discouraged. Vague instructions such as, "Take as necessary," or, "Take as directed," which may be confusing to the patient, are to be avoided. If dosing at specific intervals around-the-clock is therapeutically important, this should specifically be stated on the prescription by indicating appropriate times for drug administration. The symptom, indication or intended effect for which the drug is being used should be included in the instructions whenever possible. (For example, "Take one tablet at 8:00 am and 8:00 pm for high blood pressure," or, "Take one teaspoonful at 8:00 am, 3:00 pm and 6:00 pm for cough.") The metric system of weights and measures should be used. The prescription order should indicate whether or not the prescription should be renewed and, if so, the number of times or the period of time such renewal is authorized. Statements such as "Refill prn" or "Refill ad lib" are discouraged. Either single or multi-drug prescription forms may be used when appropriately designed, and pursuant to the desires of local medical and pharmaceutical societies. (reaffirmed HoD 87; reaffirmed BoR 04) When institutional prescription blanks are used, the prescriber should print his or her name, telephone number, and registration number on the prescription blank.

Guidelines for Pharmacists

Pharmacists should include the following information on the prescription label: name, address and telephone number of pharmacy; name of prescriber; name, strength and quantity of drug dispensed (unless otherwise directed by the prescriber); directions for use; prescription number; date on which prescription is dispensed; full name of patient; any other information required by law. Instructions to the patient regarding directions for use of medication should be concise and precise, but readily understandable to the patient. Where the pharmacist feels that the prescription order does not meet these criteria, he or she should attempt to clarify the order with the prescriber in order to prevent confusion. Verbal reinforcement and/or clarification on instructions should be given to the patient by the pharmacist when appropriate. For those dosage forms where confusion may develop as to how the medication is to be administered (for example, oral drops which may be mistakenly instilled in the ear, or suppositories which may be mistakenly administered orally), the pharmacist should clearly indicate the intended route of administration on the prescription label. The pharmacist should include an expiration date on the prescription label when appropriate. Where special storage conditions are required, the pharmacist should indicate appropriate instructions for storage on the prescription label.

Conclusions

Communicating effective dosage instructions to patients clearly and succinctly is a responsibility of both the medical and pharmaceutical professions. Recent studies documenting the low order of compliance with prescription instructions indicate that inadequate communication between the medical and pharmaceutical professions and poor comprehension by the public may be causative factors. The APA and ASIM believe that the guidelines as stated above will serve as an initial step toward patients achieving a better understanding of their medication and dosage instructions. The two organizations urge state and local societies representing pharmacists and prescribers to appoint joint committees for the purpose of refining these guidelines further as local desires and conditions warrant. Cooperative efforts
between the professions are essential to good patient care and significant progress can be made in other areas by initiating discussions between the two professions concerning common interests and goals. (HoD 74; reaffirmed HoD 87; reaffirmed BoR 04)

**DRUGS: ADVERTISING**

**Direct-to-Consumer Prescription Drug Advertising**

Position 1: ACP believes that direct-to-consumer advertising of prescription drugs is an inappropriate practice that undermines the patient-physician relationship and often leaves patients confused and misinformed about medications.

Position 2: In the absence of legislation or regulation to ban DTC advertising, the FDA should play a stronger role in ensuring that complete, valid, and clear information is provided to the public and in making determinations about whether the commercial information in a DTC ad actually will educate and enhance the health of the public. ACP calls on the federal government to expeditiously strengthen regulations governing DTC ads in the following ways:

- Congress should give the FDA the authority to issue regulations that require review and approval of the content of any DTC advertisement prior to it being released to the public.
- Congress should provide additional resources for the FDA to carry out enhanced oversight and enforcement duties and to study the effectiveness of DTC advertising.
- Congress should give the FDA the authority to regulate “reminder” and “help-seeking” ads.
- The FDA should require at least a two-year moratorium on DTC advertising for newly launched prescription drugs to allow for appropriate monitoring and regulation of drug safety and efficacy.
- Federal regulations should require manufacturers to run corrective ads after receiving both “untitled” and “warning” letters.
- The FDA should take steps toward regulating image selection in ads.
- The FDA should require that information about a drug’s effectiveness, side effects, and contraindications, as well as references to where more comprehensive information can be obtained, be prominently displayed in ads and on labeling and be in a language that is clear and understandable to the general public.
- The FDA should require that ads provide key information to consumers on alternative treatments, such as lifestyle changes.
- DTC ads should be required to contain a statement directing patients to report all adverse reactions to a physician and the FDA at MedWatch, and give the toll-free telephone number and Web address of MedWatch.
- The FDA should require that ads for those drugs approved on the condition of further studies publicly identify that safety concerns have been identified and are being investigated.
- The federal government should sponsor public service ads that do not mention particular treatments, but instead are aimed at increasing the public’s awareness of various under-treated diseases.
- Federal regulations should prohibit the use of DTC ads to promote controlled substances.

Position 3: ACP recognizes the value of patient education and supports public and private efforts to make patients—particularly older patients—aware of diseases/conditions, treatment options, indications, and contraindications. The FDA, in cooperation with the medical profession, the pharmaceutical industry, and the pharmacy industry, must further evaluate, define, and measure the impact of DTC ads on patients and
physicians and identify ways to ensure that patients and physicians are provided with complete, truthful, and non-confusing health information. (BoR 04-06)

**DRUGS: IMPORTATION**

**Reimportation**
ACP supports legislative and/or regulatory measures to develop a process to ascertain and certify the safety of reimported prescription drugs. (revised BoR 05)

Recommendation 1: Action is needed, including consideration of drug importation, to reduce the high cost of prescription drugs in the United States. However, assuring high quality and patient safety must remain the top priority of any cost control program.

Recommendation 2: Before legalizing the importation of prescription drugs, Congress should:

- Permit state pilot programs to test the safe implementation of prescription drug importation programs. Trials could initially be aimed at individuals without drug coverage. The results of such pilots should serve as a model for the federal government and individual states.
- Create an independent FDA oversight board to handle drug safety issues, including those related to prescription drug importation, and to communicate more effectively with patients and physicians about the risks and benefits of such medications.
- Study and report on the effectiveness of promising new and emerging anti-counterfeiting technologies, such as radio frequency chips to track drug shipments. Nevertheless, it should be recognized that widespread adoption of authentication technologies is a daunting task that could raise the cost of imported drugs, thereby reducing any expected savings from importation.
- Urge the expansion of accreditation programs. In particular, ACP urges the NABP to consider applying its Internet pharmacy accreditation program on an international level to help consumers identify legitimate Internet pharmacies.
- Enhance resources of the FDA to inspect facilities manufacturing prescription drugs for export to the U.S. and enhance resources of the FDA, the U.S. Customs Service, law enforcement agencies, and other federal agencies involved in assuring that products that are illegal, are counterfeit, or do not meet U.S. safety and quality standards are not allowed into the U.S.

Recommendation 3: ACP believes that any drug importation system that Congress approves should:

- Be a closed system, in which participating pharmacies and Internet sites must meet FDA standards;
- Have a tightly controlled and documented supply chain;
- Not include controlled substances, biologics, or products that are infused/injected or products that are photo reactive or have strict temperature requirements;
- Be limited to countries that meet U.S. standards to assure high quality and patient safety of imported drugs;
- Include adequate resources for inspections of facilities and enforcement of U.S. requirements; and
- Require that only prescriptions written by a U.S.-licensed physician with an established professional relationship with the patient be accepted for importation.

Recommendation 4: Prescription drug importation is not a long-term solution to the high cost of prescription drugs, which is having a detrimental effect on Americans’ access to life-saving therapies. ACP urges the federal government to take immediate action to improve access to pharmaceuticals by:
● Assuring there are sufficient incentives for pharmaceutical research and development;
● Encouraging increased competition among brand-name manufacturers;
● Speeding the approval and encouraging the use of generic drugs;
● Negotiating volume discounts on prescription drug prices and pursuing prescription drug bulk purchasing agreements under the Medicare program;
● Expanding the availability of public and private sector health insurance that includes coverage for prescription drugs;
● Encouraging pharmaceutical manufacturers to expand their patient assistance and drug discount programs and increase patient education for these programs;
● Protecting state pharmaceutical programs that may be impacted by the new Medicare law;
● Reviewing recent increases in the cost of pharmaceuticals;
● Studying the effectiveness of prescription drug substitutes, such as lower-cost, therapeutically equivalent medications;
● Encouraging and helping to implement disease management programs;
● Encouraging the use of evidence-based medicine; and
● Considering limits on direct-to-consumer drug advertising. (BoR 05)

Controlling Health Care Costs: Ensure Accurate Pricing of Services

1. The Federal government should take action to reduce the high cost of prescription drugs in the United States by using its purchasing power to obtain the best prices from pharmaceutical manufacturers covered by publically funded plans, including Medicare, similar to the prescription drug purchasing process used by the Veterans Administration. However, ensuring high quality and patient safety and support for continued innovation and research on drugs that can advance medical care must remain the top priority of any program to address the price of prescription drugs. Prescription drug importation is not a long-term solution to the high cost of prescription drugs. Efforts to reduce prescription drug prices should include:
   a. Encouraging increased competition among brand-name manufacturers
   b. Studying the effectiveness of prescription drug substitutes, such as lower-cost, therapeutically equivalent medications and expediting approval of generic drugs and encouraging their use
   c. Negotiating volume discounts on prescription drug prices and pursuing prescription drug bulk purchasing agreements under the Medicare program
   d. Encouraging pharmaceutical manufacturers to expand their patient assistance and drug discount programs and increase patient education for these programs.

Drugs: Labeling and Packaging

Pharmacy Labeling*
In order to reduce patient confusion and the potential for therapeutic errors, ACP calls upon pharmacy organizations, mail-order pharmacies, national pharmacies to label prescriptions with both the generic drug name and brand name substituted for. (HoD 93; reaffirmed BoR 04)

Quality Assurance and Labeling*
ACP believes that appropriate action should be taken to ensure that, through federal regulations or laws,
all pharmaceutical manufacturers be required to perform effective and meaningful ongoing quality assurance studies of the biologic efficacy and purity of prescription medications they are marketing. (HoD 89; reaffirmed BoR 04)

**DRUGS: PRESCRIBING AND DISPENSING**

**Drug Formularies and Pharmacy Benefit Management**

**Formularies**

1. ACP opposes any formulary that may operate to the detriment of patient care, such as those developed primarily to control costs.

2. Decisions about which drugs are chosen for formulary inclusion should be based upon the drug’s effectiveness, safety, and ease of administration rather than solely based on cost.

3. Evaluation of physician prescribing patterns (i.e., drug utilization review) should give priority to the effectiveness, and safety and ease of administration of the drugs prescribed rather than solely based on costs.

4. ACP recommends that financial incentive arrangements should be linked to cost-effective practices rather than formulary compliance.

5. ACP opposes financial arrangements that place the physician’s financial interest in conflict with his or her patient’s well-being.

6. ACP recommends that formularies should be constructed so that physicians have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically indicated cause) without cumbersome prior authorization requirements.

7. ACP recommends that a patient information program be instituted by Managed care plans to make patients aware of formulary utilization and any associated costs such as co-pays.

8. Patient formulary education should include how the formulary functions, and a discussion of how co-payment and/or deductible requirements may affect their pharmacy benefit.

9. ACP supports prompt prior notification to patients and physicians when formularies are changed or discontinued.

10. ACP recommends such notification be given within a specified time period, not fewer than ninety (90) days prior to change implementation.

11. Formularies should be approved on a regional basis by a professionally qualified body which includes practicing physicians using that formulary.

12. ACP recommends that Pharmacy &Therapeutic (P&T) Committees be representative of, and have the support of, the medical staffs that will utilize the formulary.

13. ACP supports industry moves to develop technology to make formularies more accessible and easier to utilize. ACP recommends physician input in designing, and pre-testing of, these technologies.

14. ACP supports continued government and industry studies of the impact of formularies on patient care. ACP recommends that CMS and states develop annual report-cards on the impact of formularies on beneficiaries enrolled in Medicare managed care plans.

15. Prescribing patterns should be influenced primarily through educating physicians on safety and efficacy. Cost should be a determinant only when safety and efficacy are equal among specific drug choices.

**Pharmacy Benefit Management**
1. ACP supports government regulation and industry self-regulation of Pharmacy Benefit Managers (PBMs). ACP particularly supports close government oversight of mergers between PBMs and pharmaceutical manufacturers.

2. ACP supports the disclosure to patients, physicians, and insurers of the financial relationships between PBM companies, pharmacists, and pharmaceutical manufacturers.

3. ACP supports requiring that PBM organizations’ requests to alter medication regimes should occur only when such requests are based on objective data supported by peer reviewed medical literature and which undergo review and approval of associated Managed care plans’/MBHOs’ P & T Committees.

4. ACP supports requiring that, with a patient’s consent, PBM organizations be required to provide treating physicians with all available information about the patient’s medication history. (BoR 00, reaffirmed 11)

**Internet Prescribing**
The ACP advocates that a direct physician patient relationship remain inviolate and that the use of the Internet for prescribing should facilitate, not circumvent that relationship, and that Internet prescribing should be used only in the context of an established physician-patient relationship. (BoR 10-99, reaffirmed BoR 10)

**Misuse of DEA Numbers***
ACP, in order to protect confidentiality and minimize administrative burdens on physicians, supports the AMA policy to eliminate requirements by pharmacies, prescription services and insurance plans to include physicians’ DEA numbers on prescriptions written for non-controlled drugs. (HoD 95, reaffirmed BoR 10)

**Mail Order Pharmacy Confidentiality***
ACP opposes the use of confidential prescribing data by third parties to directly contact patients for any purposes. (HoD 93; reaffirmed BoR 04)

**Negative Formularies**
Resolved, that the Board of Regents encourage the deletion of drugs from Negative Drug Formularies for which there exist FDA A-rated generic substitutes. (BoR 00)

**Proper Use of Accepted Drugs***
ACP believes that physicians in clinical practice are best suited to determine the proper usage of accepted drugs, and professional judgment should not be restricted by legislative or administrative fiat. Physicians should be permitted to use already approved drugs in any manner consistent with prudent medical judgment. (HoD 78; revised HoD 89; reaffirmed BoR 04)

**Physician Drug Dispensing***
ACP believes that patients should be informed that they have the right to have their prescription filled at a pharmacy of their choice. However, physicians should have the option to dispense medication in their offices, especially when it is to the medical or economic advantage of their patients. Under no circumstances should physicians who dispense medication place their own financial interest above the welfare of their patients. (HoD 87; reaffirmed BoR 04)

**Behind the Counter Drugs**
The College’s believes that the current two-drug category system of prescription-only and over-the-counter (O-T-C) drugs formalized by Congress under the Durham-Humphrey’s Amendment to the Food, Drug and Cosmetic Act is effective in ensuring safe and accessible medications to the population. The current system allows for the general availability within the O-T-C market of those drugs suitable for self-medication that also require no medical monitoring and have a low potential for significant adverse side-
effects, overdose or abuse. Furthermore, it appropriately requires the intervention of a physician, specifically trained in the diagnosis and treatment of medical conditions, to serve as the intermediary prior to having access to medications that don’t meet the O-T-C conditions.

The College believes that the B-T-C drug category under consideration offers little evidence of improving the current two-category system and poses increased patient-safety concerns. More specifically, the College opposes the implementation of a B-T-C drug category for the following reasons:

- The pharmacist does not have the necessary training to serve as the intermediary to drugs that fall outside the current O-T-C requirements—Many of the medications being considered for potential inclusion in this B-T-C category (e.g. cholesterol-lowering drugs, drugs for the treatment of asthma) relate to conditions that require the taking of a skilled medical history, a physical exam, and the use of laboratory results to ensure that an accurate diagnosis is made and the most appropriate medication is used. The pharmacist, while skilled in areas of drug effects and interactions, does not have the adequate training to provide these diagnostic and treatment considerations.

- The pharmacist may not have time in their current schedule of activities to even perform limited counseling or educational expectations—The experience of many of our members is that most pharmacists are already having difficulties meeting their current drug dispensing demands. These increased demands are fueled by current demographics and the implementation of the Medicare Part D benefit. It is unclear whether the typical pharmacist would be able to adequately meet even minimal additional intervention requirements.

- The consideration of a B-T-C drug category raises a number of questions that must be addressed prior to any consideration of implementation—The FDA Notice of Comment includes a large number of questions that currently have no suitable answer regarding the potential implementation of a B-T-C drug category. These include questions pertaining to the criteria for a drug to be treated as a B-T-C, the appropriate role of the pharmacist and the training required, and the type of documentation that would be required. Additional issues not included in the Notice that need to be considered include the process by which the patient’s personal physician would be notified regarding this medication intervention to ensure appropriate subsequent care, the pharmacist’s responsibility to provide follow-up consistent with their intervention, and the extent the pharmacist would be legally liable for their actions during this encounter.

- There is no currently available data supporting the contention that a B-T-C drug category would safely increase access, lower cost, or generally effect improvement to our current two-category system—As you are aware, the most comprehensive study of this issue was a 1995 Government Accounting Office (now the Government Accountability Office) study 1 that examined international (and the limited national) experience with a B-T-C drug category. The results reflected that there was no clear pattern of increased or decreased access, that the counseling conducted by pharmacists was infrequent and incomplete and that any safeguards provided to deter drug abuse were easily circumvented. The study concluded that “the evidence that is available tends to undermine the contention that major benefits are obtained in countries that have such a class.” The College is aware of no evidence in the current literature to refute this conclusion.

The College is not opposed to the FDA’s expanding of the limited number of drug exceptions to the two-category system that were recently implemented for non-medical reasons and require only an administrative intervention on the part of the pharmacist. Examples of this include the recent implementation of a proof-of-age requirement prior to the dispensing of a Plan B emergency
contraceptive, which was motivated by social/legislative concerns and the signature requirement and quantity limitations coupled to the dispensing of drug products with pseudoephedrine, which was motivated by concerns related to its use as a key ingredient to the production of methamphetamine.

**DRUGS: SUBSTITUTION**

**Use of "A" Rated Generic Drugs**
ACP will petition the FDA or other appropriate agency to develop a national system that would allow physicians who permit generic substitution to designate substitution by only "A" rated generic drugs; require any prescription medication crossing state lines, such as those as part of a prescription filled by an out-of-state pharmacy, to use only "A" rated generic drugs if brand name is not required by the prescribing physician; and require a national uniform policy regarding a phrase that can be used to denote the need for a brand name drug. (HoD 94; reaffirmed BoR 04)

**Drug Product Selection and/or Substitution**
ACP opposes therapeutic substitution in an outpatient setting without the prescribing physician's consent. ACP physicians should prescribe generically when therapeutic equivalency, therapeutic safety and bioavailability are established. Physicians should carefully consider the advice of the pharmacist and use his or her knowledge and experience regarding selection of drug product alternatives that could result in cost savings to the patient. When therapeutic equivalency and bioavailability of alternative generic drug products are assured, then the privilege of drug product selection may be delegated to the pharmacist. Any generic drug product selected by the pharmacist must be therapeutically equivalent and bioavailable and should result in cost savings to the patient. The physician, at his or her discretion, must at all times have the authority to specify in some simple manner the source of the drug product to be dispensed. (HoD 79; HoD 88; revised HoD 93; reaffirmed BoR 04)

**Generic Drug Prescriptions**
ACP believes that the Food and Drug Administration and other state regulatory agencies should require that generic drugs be held to the same standards as the trade name drug. (HoD 90; reaffirmed BoR 04)