CUT OFF…. Paying out-of-pocket not using their insurance those are being paid out-of-pocket, and the oxycodone specifically are paying out-of-pocket or i know we might see a higher proportion of a patient out-of-pocket for well, yeah, I allow patients to pay my visits with credit cards or debit cards I don't accept cash pay, but I do accept credit cards and because I have many patients who have no insurance so I think that's it.

Other doctors refer patients to me because they don't accept any form of non-insured payments so I have a higher percentage of patients who don't have insurance and as far as I know, they all use their insurance if they can there might be some exceptions, but I don't know how I don't ask. I don't really I don't track how they pay for them, but we do.

I have a full-time person getting prior authorizations and we're constantly busy getting prior authorization so that would be my only explanation as I'm fairly certain I have a higher percentage of non-insured patience one of my patients not too long ago said she called like 20 pain Doctors and none of them would allow her to come and without insurance so that that's not uncommon, but I have no way uninsured oh gosh, I don't track that. It's not it's not a low number, but I mean it's not rare, but yeah, there's a fair number of people who who can't get insurance and so I couldn't really maybe 10 to 15% 10% probably more likely I honestly I just don't know ok,

So you know there are a number of patients on like higher quantity and so you know when hydrocodone are being written as the Norco for 115% of the oxycodone is the Percocet for quantity of 180 well, I gave that some thought last night and I did write up a response that I will be emailing you and better detail than perhaps what I can tell you now, but as I thought about it,

and I realized that first of all, the patient population that I have should not be compared to other pain specialist and this is the reason why: most of the other pain specialist who write prescription opioids are interventionalists that is by far the majority and it's a completely different set of variables and like I said, I've written it up I will get it to you.

I also prefer, especially in older populations, I prefer to maintain immediate release as opposed to adding extended release. There's all kinds of issues surrounding extended release opioids in elderly and i so i prefer that when it comes to hydrocodone, I told you yesterday that I have a lot of problems almost impossible for me to get a long acting hydrocodone so if I get somebody on 120 and they're not doing well, i either have to add a long acting you know, oxycodone — or morphine, sometimes I do that but they often don't tolerate that well. Then again it's simpler, less room for confusion

when I keep them on the one drug that they're familiar with. With all of my patients if I hit the 120 mark, I will almost always try to introduced Butrans or Belbuca and I assume you're familiar with those, is that correct? so that is my first go-to when adding a long acting, and whenever I get to the mark of four/day, I explained to my patients that 24 hour pain is being demonstrated by needing more than four tablets a day. Clearly the pharmokinetics of immediate releas always does not allow for four to always measure up for 24 hour pain and I think you should know that, right?

So sometimes you just need six/day they don't last a full six hours, but nevertheless, my first step to answer your question I go to Butrans or Belbuca, when that doesn't work I'm more likely to go to higher immediate release than I am to add another molecule.

If I can get Hysingla ER, I will, but I've almost given up even trying now because I can't seem to get it. Pharmacies don't get it. I don't know. And Percocet, you know again it's kind of the same thing. Yeah, I could take six Percocet 10's tabs per day and give somebody 4 per day of 15's. Why don't I like doing that? Because first of all, when I do that I give them a higher dose and if I give a higher dose I'm going to get more of a secondary bit of that "feel good" with it. if I give them the 15mg, that's going to be more enhanced than using the 10's. They're used to the 10's and they probably have built significant tolerance to that effect and I'd rather avoid that effect, so instead of giving them 4 15's. i'd rather keep them on 6 Percocet 10's.

The other thing about 15's, I'm sure you understand, 15's have no abuse deterrence whatsoever. Percocets do - they are not considered abuse deterrent but if you ever ask anybody who's tried to snort one or shoot one up, they'll only do it once because it's not tolerated, so people do not tend to do that. So giving them 6 Percocets is safer to them if there's an abuse problem.

So again, it'll be much more preferred pharmacokinetically, number one, safety number two. I'd be happy to write them all out, but that is my immediate response, I don't want to keep your time.

Your patient visits, are they always in person or for telemedicine? No instances - all my visits are in-person the only exception to that is during a government emergency such as hurricane or Covid. That is the only time. It is illegal for me to do it on the phone. I just want to remind you. It's not legal to do that.

I've done some TeleMed for Suboxone addiction patients but even then it's usually only once since i see everybody every 30 days. I think I mentioned that, so give or take I mean it can't be every 30 exactly but I see somebody every month and even when I

have to do a TeleMed with an addiction, patient that would generally only be once and then the next two visits would be in person. Telemed is allowed for Suboxone for addiction.

 and then we talked a little bit about greater than 50 miles and then from other pharmacies, you know i guess that you help us quantities are the main reason that they're not filling. Or are there any pharmacies that are refusing to fill your prescriptions?
No pharmacy that I'm aware of refuses prescriptions from me no.

So that is the only reason they prefer small family pharmacies, because they in general feel like they get better service from them. So everybody who's been moved to CVS from those pharmacies it's because of distance limitations and quantity limitations.

So, some pharmacies just refuse to give more than 120 - it doesn't matter if I write 180, they refuse to do it - so I say, well go to CVS. They are reasonable. 50 miles was put in place many times, so I'm glad you brought that up again.

 I won't keep you but yesterday I had my IT guy go through and scan all the documents I told you when I did a survey a few months back because when I encountered this 50 mile policy — which again, I emphasize is illegal — I decided well. I'm just going to show it to the pharmacist why people come to 50 miles to try to dissuade them from enforcing a 50 mile policy. I just hadn't been able to get around to actually collating them and all of that. I got my IT guy to work on that I should be able to provide you with full results of that probably in the next day or two, and you can see exactly all the reasons why people select coming here, but that…. CUT OFF