Dear Committee Members,

My name is Dale Rappaneau and I am both a resident of Maine and a practicing attorney specializing in privacy and data regulation laws. Earlier in my life, I also worked as a pharmacy technician, during which I witnessed firsthand the heavy restrictions and monitoring imposed upon individuals prescribed controlled substances such as oxycontin and methadone.

Today, in my personal capacity, I am writing to give my full support for LD 1277.

The core idea of the Prescription Monitoring Program (PMP) makes sense: we want to track high-risk medications that lead to addiction or overdose. We want to keep people safe from substances that pose a high risk to the public at large, and we want to improve clinical practice regarding these controlled drugs.

But for the PMP to continue making sense, the list of drugs monitored by the program must also make sense.

Opioids, stimulants, morphine, sedatives, benzodiazepines—the common characteristic shared between these substances is their extreme potential for addictive abuse. And given this shared characteristic, it makes sense to monitor them: to amass information on the patient to ensure both the patient and the public are kept safe from the high risk of addiction.

However, included among this list of controlled and monitored substances is an odd outlier: testosterone. If the goal of the PMP is to keep the public safe from high-risk medications that are ripe for substance abuse, why is a commonly prescribed hormone included? What is the justification for so thoroughly monitoring patients taking this hormone, as if they or those around them are at risk of addiction, when it poses little to no risk of overdose or dependency?

It does not make sense.

And yet, we treat this hormone and those prescribed it as if they may at any point become patient zero for an overdose epidemic akin to opioids. The PMP monitors them. It collects their name, their identifying information, their protected health information—all while not directly covered by HIPAA's restrictions and protections, mind you—and creates a trove of information that poses more risk of abuse than the hormone itself.

We have already seen state regulators target PMP data for weaponized and politically-motivated investigations and actions. We know people will forgo medical treatment because of fear and uncertainty about misuse of health data. Still, we continue monitoring people prescribed this

hormone as if these risks from hostile governments or to healthcare access are somehow outweighed by the benefits of monitoring the hormone.

I say again: it does not make sense.

Therefore, the PMP must be amended. To ensure our drug surveillance program follows a common-sense approach to monitoring Mainers, I strongly support LD 1277.

Best Regards,
Dale Rappaneau

Dale Rappaneau
Bowdoinham, ME
LD 1277

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