United States Department of Transportation
FEDERAL MOTOR CARRIER SAFETY ADMINISTRATION

Meeting Summary

The U.S. Department of Transportation's (DOT) Federal Motor Carrier Safety Administration (FMCSA or the Agency) Medical Review Board (MRB) convened on September 11, 2013, in Alexandria, Virginia. The meeting was open to the public.

Attendees

Board Members:
Christine Cisneros, M.D.
Benjamin H. Hoffman, M.D.
Brian T. Morris, M.D.
Albert J. Osbahr III, M.D.
Gina C. Pervall, M.D., Committee Chairperson

FMCSA Staff:
Charles Horan, Director; Office of Carrier, Driver and Vehicle Standards
Larry W. Minor, Associate Administrator for Policy, Designated Federal Officer
Eileen Gregory Nolan
Angela Ward, R.N., Nurse Consultant

Members of the Public:
Megan Benfatti, National School Transportation Association
Stephen Owings, Road Safe America, Member, FMCSA Motor Carrier Safety Advisory Committee

Call to Order, Official Remarks, and Agenda Review

Gina C. Pervall, M.D., FMCSA MRB Committee Chairperson,[1] explained the meeting's purpose to discuss Schedule II licit medications.[2] Meeting attendees received an agenda and Dr. Pervall introduced Dr. Albert Osbahr, M.D.

[1] Dr. Pervall, Medical Director for Johns Hopkins University's Applied Physics Laboratory in Laurel, Maryland.

[2] Other MRB members included Dr. Cisneros, M.D., with U.S. Health Works; Benjamin H. Hoffman, M.D., Medical Director at General Electric; Brian T. Morris, M.D., with AllOne Health; and Albert J. Osbahr III, M.D., occupational physician from Hickory, North Carolina.

Overview of 2006 Evidence Report, Medical Expert Panel Report and 2007 MRB Recommendations on Schedule II Licit Medications

Dr. Osbahr introduced the 2006 Evidence Report on Licit Schedule II Drug Use and Commercial Motor Vehicle (CMV) Driver Safety, including summarizing expert panel commentary from a December 9, 2006 meeting.[3] He noted first that the evidence report focused largely on Schedule II opioids and stimulants (but not oral cannabinoids). With that context, he explained that the principal evidentiary inquiries were whether the licit use of Schedule II drugs leads to motor vehicle crashes, and whether the licit use of these drugs affects mood, behavior, and driving ability as measured on the road or with a driving simulator.

Dr. Osbahr acknowledged that the Evidence Report frequently refers to a paucity of strong evidence-based studies to address the principal inquiries, and said that the panel found this troubling. He said the expert panel observed that several smaller studies and indirect information indicated a disconcerting trend regarding the relationship between licit Schedule II drug use and motor vehicle crashes.

With this context, he began a summary of the findings of a systematic review examining the eight key questions formulated by FMCSA concerning the licit use of Schedule II drugs by CMV drivers.

Key Question #1: Does the licit use of a prescribed Schedule II drug increase the risk for a motor vehicle crash?

Dr. Osbahr said the systematic evidence review produced no strong studies meeting the inclusion criteria for Key Question #1.[4] The Evidence Report review uncovered no studies showing a relationship between the licit use of a Schedule II drug, driving, and motor vehicle crash risk.

Key Question #2: Does the licit use of a prescribed Schedule II drug negatively impact indirect measures of driving ability?

Dr. Osbahr said that several smaller studies provided indirect evidence (i.e., simulator, cognitive, or psychomotor) of a relationship between licit use of Schedule II drugs and indirect measures of driving ability. He said he would later discuss a 2013 Canadian study relevant to opioid use and driver function. Next, he described one study in which performance measured in a driving simulator showed the deleterious effects of a single 50-mg. dose of codeine on driving ability, and other studies showing indirect performance effects from a single intravenous dose of Schedule II opioids. He described two studies supporting the contention that the long-term use (>7 days) of two Schedule II opioids (transdermal fentanyl and morphine) may have a deleterious impact on cognitive and psychomotor function. He said there were no studies evaluating the effects of opioids on mood or behavior.

[3] The following five people served on the 2006 Expert Panel: Dr. Osbahr; Natalie Hartenbaum, M.D., M.P.H., F.A.C.O.E.M. President and Chief Medical Officer OccuMedix, Inc., Dresher, Pennsylvania; Michael Holland, M.D. Director of Occupational Medicine at the Glens Falls Hospital Center for Occupational Health, and Clinical Associate Professor at SUNY Upstate Medical University; Michelle Riba, M.D., M.S., University of Michigan, Department of Psychiatry; Robert Swotinsky, M.D., M.P.H., M.R.O. board-certified in occupational medicine, Reliant Medical Group in Worcester, Massachusetts.

[4] The Evidence Report: Licit Schedule II Drug Use and Commercial Motor Vehicle Safety (Evidence Report) states that the systematic review produced 49 potentially relevant articles, none of which met the inclusion criteria for key questions 1 and 3.

Key Question #3: What is the correlation between the serum level of a Schedule II drug and the risk for a motor vehicle crash?

Dr. Osbahr said the systematic evidence review produced no studies meeting the inclusion criteria for Key Question #3. The Evidence Report review uncovered no studies showing a correlation between a user's serum level of a Schedule II drug, driving, and motor vehicle crash risk. However, he noted that the Expert Panel questioned whether urine studies could have been used to provide evidence on this question.

Key Question #4: What is the correlation between the serum level of a Schedule II drug and indirect measures of driving ability?

Dr. Osbahr said the systematic evidence review produced no studies meeting the inclusion criteria for Key Question #4. The Evidence Report review uncovered no studies showing a correlation between a user's serum level of a Schedule II drug and indirect measures of driving ability. He noted further that there were no studies investigating the relationship between a user's serum level of a Schedule II opioid and driving ability, mood, or behavior. He described several studies showing the effects of a single dose of certain opioids or stimulants on "higher cognitive function," including two low-quality studies revealing significant correlations between serum levels of the Schedule II opioids fentanyl and morphine and assessments of high-level cognitive or psychomotor function.

Key Question #5: Is there a relationship between the pharmacokinetics of a Schedule II drug and the risk for a motor vehicle crash?

Dr. Osbahr said the systematic evidence review produced no studies meeting the inclusion criteria for Key Question #5. The Evidence Report review uncovered no studies showing a relationship between the pharmacokinetics of a Schedule II drug, driving, and motor vehicle crash risk.

Key Question #6: Is there a relationship between the pharmacokinetics of a Schedule II drug and indirect measures of driving ability?

Dr. Osbahr noted a lack of evidence made it impossible to draw evidence-based conclusions about the relationship between the pharmacokinetics of Schedule II drugs and driving ability (as measured by a simulator or on a pre-specified driving course). However, Dr. Osbahr explained that there is strong indirect evidence supporting the conclusion that the pharmacokinetics of the Schedule II opioids morphine, fentanyl, and meperidine are closely correlated with temporal changes in cognitive and psychomotor function in healthy, opioid-naïve individuals. These changes are important, he said, because they affect central nervous system function, which must be clear to drive. He noted further that in 2006, a lack of data made it impossible to draw indirect evidence-based conclusions about this subject for chronic licit users of these drugs, including users of Schedule II depressants. Dr. Osbahr said chronic licit users of amphetamines (e.g., individuals treating Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder) displayed better focus and concentration.

Key Question #7: Are there common drug interactions with any prescribed Schedule II drug that increase the risk for a motor vehicle crash?

Dr. Osbahr said the systematic evidence review produced no studies meeting the inclusion criteria for Key Question #7. The Evidence Report review uncovered no studies showing that common drug interactions with prescribed Schedule II drugs increased motor vehicle crash risk.[5]

[5] The Evidence Report states that the systematic review produced 14 potentially relevant studies, none of which met the inclusion criteria for this key question.

Key Question #8: Are there common drug interactions with any prescribed Schedule II drug that affect indirect measures of driving ability?

Dr. Osbahr said that because of a paucity of data, it was impossible to draw evidence-based conclusions concerning common drug interactions with Schedule II drugs and indirect measures of driving ability.

Dr. Osbahr's Summary of Expert Panel Commentary and Recommendations

Dr. Osbahr began his summary by describing a 2013 population-based study of Canadian-based drivers where the study broke down morphine-equivalent opioid doses for high-, moderate-, low-, and very low-range users.[6] He said the study found that drivers – a cohort somewhat representative of truck drivers – showed more road trauma (i.e., emergency room visits after a crash) if they were chronic moderate-category opioid users. He described this research as being "of some quality."

Dr. Osbahr continued, summarizing several of the Expert Panel's findings and recommendations. He noted frequent comments in the Evidence Report and Panel commentary to a "paucity" of data. However, he stated that an absence of acceptable evidence-based research to answer most of the key questions concerning licit Schedule II drug use and CMV driver safety, did not mean an absence of data concerning patient effects or risk effects and driving ability. He noted several smaller studies in which the Panel found indirect measures of driving ability (high-level cognitive and psychomotor functions and simulated driving ability) suggested that using Schedule II opioids or depressants might impair the driving ability of opioid- or depressant-naïve healthy individuals. He noted the importance of a finding to share crash data for the purposes of evaluating the factors contributing to trauma or crashes and evaluating and applying lessons learned.

Dr. Osbahr next addressed the Panel's recommendation that FMCSA consider separately whether the underlying or impairing medical condition for which a driver licitly used Schedule II drugs was itself a condition that should disqualify a commercial driver. He said that medical examiners (MEs) should consider whether a commercial driver could be medically qualified when that driver is not taking the prescribed medication for an underlying condition that could be debilitating without the prescription. He noted the Panel's recommendation to "standardize (attending) physician attestations" so that there is consistency and accountability for applying the regulatory exception through which a driver may qualify to use a substance otherwise banned under 49 CFR 391.41(b)(12)(ii). He stated that the Panel also recommended expanding drug testing to include synthetic medicines (e.g., hydrocodone, oxycodone).

In concluding his summary remarks, Dr. Osbahr noted that since publication of the 2006 Evidence Report, there has been increased interest in chronic-pain medicines and chronic opioid use. He said that since 2006, the American College of Occupational and Environmental Medicine, the American Academy of Pain Medicine, and the American Pain Society have provided guidelines concerning chronic pain management and medications. Dr. Osbahr noted further that individual states educate physicians, physician assistants, and nurse practitioners about the risks and problems of prescribing opioids, and the appropriate process for prescribing these medications. He said that irrespective of the quality of medical evidence relating to commercial driving and opioid use, each physician on the Expert Panel felt "very concerned" about commercial drivers' chronic use of opioids and performance behind the wheel. Finally, he noted the Panel's lack of opportunity to study the effects of licit use of barbiturates and oral cannabinoids on driving; and the lack of studies concerning the licit use of cannabinoids, the underlying conditions for which they are prescribed (e.g., cancer to maintain appetite), and effects on driving.

[6] Gomes, T. et.al. "*Opioid dose and risk of road trauma in Canada: a population-based study.*" Journal of Internal Medicine, 2013 (available at: http://www.ncbi.nlm.nih.gov/pubed/23318919).

MRB Deliberations on Licit Schedule II Drug Use and CMV Driver Safety

General Discussion

Dr. Osbahr opened the proceedings for questions from the MRB, and the discussion began with a question concerning the 2013 Canadian study. Citing the Leveille study of 1994,[7] which examined the crash rate among older drivers in Seattle, Washington; Dr. Morris asked whether the Leveille and Canadian studies together provide compelling evidence that using Schedule II drugs impairs cognitive and motor function, in turn leading to an increased crash risk for commercial drivers (who are mostly an older population). Dr. Osbahr responded that because it involved a small number of study participants none of whom where truck drivers, the Leveille study was "not powerful enough" to constitute compelling evidence for systematic review for the licit Schedule II key questions. He noted, however, that there were no data to prove licit use of these drugs is *not* a crash risk for commercial drivers. Dr. Hoffman commented that in these studies, the absolute risk is an issue, because the absolute increase in crashes is not high.

Commenting that drug effects should not vary depending upon whether the subject is a commercial driver, Mr. Owings asked why it is necessary to have truck drivers involved in studies relating to Schedule II drugs. Dr. Osbahr responded that a continuing issue for epidemiological studies is whether the study population differs from the group under review. He noted that when the study population sample is small (e.g., a study of commercial drivers only), the power and quality of the research is compromised, and the data may be insufficient to support a change in treatment or policy.

Acknowledging the paucity of data Dr. Osbahr described in his summary, Dr. Cisneros suggested that the MRB consider how to create a practical system in which healthcare providers have tools to make reliable decisions concerning whether an individual using Schedule II drugs can safely operate a CMV. In response, Dr. Hoffman asked FMCSA to state its expectations for this MRB meeting, and Dr. Pervall read from the task statement for MRB Task 13-01.[8]

Agreeing with Dr. Cisneros and observing that the third subtask in Task 13-01 was most important, Dr. Morris said the use of Schedule II drugs is among the most difficult issues in occupational health. He gave the following as factors making it difficult or impossible to develop data concerning these medications.

- Schedule II drugs are a heterogeneous group of medications.
- The study populations are "extremely complex" given acute, chronic, sub-acute, and intermittent user effects; and the pharmacological variations among individuals. (i.e., any two people may respond differently to the same dose of a medication.) The user population varies, consisting of healthy, responsible users; users with co-morbidities; and individuals using many drugs, including Schedule II drugs.

[7] "*Psychoactive medications and injurious motor vehicle collisions involving older drivers,*" (available at: http://www.ncbi.nlm.nih.gov/pubmed/7841240).

[8] Under Task 13-01, the MRB's five tasks are as follows: (1) review the 2006 evidence; (2) re-examine the key questions found in the 2006 reports; (3) consider medical certification requirements of CMV drivers and issues relevant to Schedule II medication use; (4) determine existing gaps between the previous evidence and present day medical certification concerns faced by MEs in motor carriers; and (5) propose relevant key questions that the Agency may consider in order to update the 2006 reports concerning Schedule II medication and CMV driving crash risk.

- Use of these drugs is highly variable with a population consisting of stable, long-term users; licit users; and illicit users. [9]

Dr. Morris said that these drugs unquestionably present a public safety risk. Given the complexities stated and the boundaries of FMCSA authority, it would not be "palatable" to pursue a strategy of risk elimination as the Federal Aviation Administration (FAA) does. He said risk reduction should be FMCSA's goal for CMV drivers. Mr. Owings disagreed, noting that many more people die daily in truck crashes than die yearly in aircraft crashes. Mr. Minor said that in a regulatory context, it would be difficult to justify adversely affecting large numbers of truck drivers who are licit users of Schedule II medications when there are no data showing that applying such a strategy would substantially reduce crashes or fatalities. Dr. Cisneros said the MRB should focus on obtainable goals that work in the political context, and provide tool sets for MEs that help them affect outcomes and mitigate risks when making medical certificate decisions. As such a goal, she suggested prohibiting driving for methadone users and users of medications with a Federal Drug Administration black-box warning of possible loss of consciousness. She said giving clear guidance to MEs would help them make better, supportable decisions. Dr. Morris said that this recommendation was similar to the Expert Panel's recommendation of medically disqualifying Schedule II drug users, but carving out exceptions according to data (e.g., amphetamines).

In response to Mr. Minor's question concerning the advisory criteria mentioning methadone as a drug that would disqualify a user from driving, Dr. Morris explained that whereas using methadone once was a sign of an underlying heroin addiction, doctors later began prescribing it as a chronic-pain medication. He said some people have a legitimate use for certain pain medications that are commonly abused, and Dr. Hoffman asked what the MRB's role should be regarding medications used to treat chronic pain.

Dr. Pervall suggested the MRB consider medical certification requirements for drivers relevant to use of Schedule II medications. A Board member said the MRB should focus on providing help to MEs making medical certification decisions. The MRB agreed to recommend that FMCSA rules medically disqualify drivers using Schedule II medications, subject to exceptions granted through a rigorous process managed by MEs. Mr. Minor and Dr. Morris discussed the feasibility of providing driver exceptions from Schedule II drug use only through MEs who are medical doctors. Mr. Minor said the National Transportation Safety Board would support this proposition. Mr. Minor said FMCSA would be in a better position to assess the feasibility of such a practice once the Agency launches the National Registry of Certified Medical Examiners (National Registry) in May 2014 and identifies how many MEs also are medical doctors.

Dr. Hoffman expressed concern that restrictions on Schedule II drug use would impel drivers to ask for Schedule III medications instead. He suggested that the MRB recommend restricting the use of any "impairing" drug irrespective of the Drug Enforcement Administration Schedule, and that the Agency present guidelines for implementation. Dr. Cisneros proposed convening a body of physicians who would regularly consider licit medication use exceptions, creating a tool kit, or developing a physical assessment to test psychomotor functions related to driving. In response to a question from an MRB member concerning quickly launching a program to help implement MRB recommendations for Schedule II medications, Mr. Minor said the fastest way to disseminate information concerning Schedule II drugs was through developing educational materials about the subject. He said these materials should be distributed to MEs on the National Registry. He said further that mandatory ME training and testing is the best way to promote uniform and consistent application of medical qualification standards. Dr. Morris stated that educational initiatives should focus on certified MEs rather than overloading candidates in training. He said that whatever tools the MRB recommends must be simple (e.g., a listing of disqualifying medications

[9] Note that medical advice on long-term use is changing. See new guidelines from State Medical Boards http://www.fsmb.org/pdf/pain_policy_july2013.pdf.

or a short medical information questionnaire) so that the process of evaluating licit users is not unduly burdensome to MEs. Dr. Cisneros reiterated her suggestion that the MRB recommend a prohibition on medications with a black-box warning about possible loss of consciousness or control, and suggested that MRB focus on creating a model tool that MEs can use to make medical decisions concerning licit medication user.

In response to Mr. Minor's question about whether an authoritative source (other than pharmaceutical firms) could be cited for black-box warnings, MRB members said that the U.S. Food and Drug Administration (FDA) requires warnings for certain medications with serious side effects irrespective of whether the manufacturer wants the warning on its product. Mr. Minor said that if another Federal agency has data to support loss of consciousness as a possible side effect of using certain medications, FMCSA conceivably could rely on that data to disqualify CMV drivers using those medications. Dr. Hoffman said the MRB should be aware of the possible economic consequences of a rulemaking disqualifying large numbers of drivers using licit medications. A Board member said that prohibiting the use of certain medications for commercial drivers might not bar these drivers from the profession because drivers have treatment options other than these medications for various conditions (e.g., implanted stimulators for chronic pain). Dr. Hoffman replied that the medications under discussion were cheaper options. The Board discussed whether to recommend that FMCSA also consider prohibiting medications with a black-box warning of syncope, psychotic break, or suicidal thoughts. One MRB member expressed concern with relying on black-box warnings to prohibit medications for drivers and suggested focusing on medications and effects that should provide triggers for further investigation.

Dr. Pervall asked whether the Board was suggesting a recommendation to add medications with certain black-box warnings and chronic use to the classes of disqualifying medications and conditions in the current regulation. Dr. Morris expressed concern with the current regulation permitting an exception from the Schedule II medication ban if a licensed practitioner familiar with the driver's assigned duties has advised the driver that the medication will not affect the ability to operate a CMV safely. He said that prescribing clinicians might be unfamiliar with a driver's assigned duties and have no access to job descriptions. He also stated that drivers have incentives to mislead treating clinicians, and that practitioners cannot assure drivers that using a given medication will not impair safe driving. Dr. Hoffman described a process for granting exceptions putting the responsibility for obtaining exceptions into the driver's hands.

Medication Questionnaire

After further discussion among Board members concerning the complexities of the exception process, Dr. Pervall said that the Board agreed on the necessity of having the prescribing physician weigh in on medication decisions. The best way to do this, she said, is with a web-accessible, standardized form. The Board then discussed what the form should include. It based the form on a template of eight questions Dr. Osbahr uses in his practice. The principal issues were whether the form should include the applicable regulation; how comprehensive the medical information should be (e.g., list of medications and doses, underlying condition requiring treatment, side effects); the burden on clinicians to complete the form; duplicating information on the long form; and the driver's responsibility for obtaining a sign-off from the prescribing physician.

Dr. Morris expressed concern about keeping the physician's responsibility as simple as possible to encourage physicians to fill out the form. He suggested limiting the physician response to whether the driver is fit to drive, irrespective of what other information is on the form. Dr. Hoffman engendered extensive Board discussion by suggesting that the form include a final statement that in the physician's opinion, the driver can operate a CMV safely while taking the prescribed medications. Board members also discussed whether the form should describe the CMV driver's duties and state that a motor carrier may add to these duties.

In response to a question from a Board member, Mr. Minor said that the context for using the form would be facilitating written communication between a prescribing physician and the ME who will issue a driver's medical certificate. He said the information obtained on the form might help the ME decide whether to issue a medical certificate at all, whether to issue the certificate for the full 2-year period, or whether to issue it for some lesser period. The Board agreed that the form should cover all medications referenced in 49 CFR 391.41(b)(12), not just Schedule II medications, especially because pharmaceutical firms are working to remove medications from Schedule II.

After extensive discussion of the form and content, the MRB agreed unanimously to recommend that FMCSA develop a Medication Questionnaire protocol for use by clinicians prescribing medications for CMV drivers and who must attest that the driver meets the requirement for exception from the ban on medications listed in 49 CFR 391.41(b)(12). Four of the five Board members also agreed to recommend and present a form and content (see Attachment) developed through deliberations at the meeting.

Medical Disqualification of Drivers for Licit Use of Certain Medications

Dr. Pervall reopened an earlier discussion concerning whether the MRB would recommend medical disqualification of drivers for the licit use of drugs with certain black-box warnings. Dr. Cisneros restated her suggestion to declare CMV drivers medically unqualified if the driver uses medications with a black-box warning of loss of consciousness or syncope episodes. Dr. Pervall asked whether the Board should include medications with psychiatric side effects such as suicidal ideation. Dr. Osbahr said the MRB already had developed guidance on psychiatric disorders. Mr. Minor asked whether the MRB guidance on psychiatric disorders addressed the disorder itself, not medications that might trigger psychiatric episodes. Dr. Osbahr replied that the guidance asks MEs for more attention to drivers who are taking anti-psychotic medications.

The primary issues were whether medications with other black-box conditions (e.g., seizure-inducing, arrhythmias) or with impairing conditions should cause medical disqualification; clarity on what constitutes a black-box warning;[10] the number of drugs that might subject a driver to disqualification; FDA's process for requiring black-box labels; using sources other than the black-box label to choose which medications should disqualify a driver (e.g., the International Council on Alcohol and Drugs); and listing specific medications without a black-box warning (e.g., methadone and medications prescribed for hypersombulance). MRB also discussed whether for certain medications, the disqualification period should turn on the dose and period of release in the system. Ultimately, the Board decided to recommend having FMCSA advise MEs to "give particular attention" to specific medications and classes of medications (based on a list from the FAA) that might impair a driver's ability to operate a CMV safely. The Board decided that recommending a best practice in evaluating drivers using licit medications would give the Agency a strategy that it could implement quickly. The MRB might later address whether to recommend creating a list of medications or classes of medications the licit use of which would medically disqualify a CMV driver.

Refreshing the 2006 Evidence Report and Developing a List of Disqualifying Medications

The Board discussed whether to recommend refreshing the 2006 Evidence Report to address the questions "left on the table" in 2006, and agreed that it should make such a recommendation. The principle issues for which the Board needed more evidence were drug interactions (opiates with other medications), the effects of chronic use of stimulants and opioids, and the viability of using indirect measures (simulator performance, impaired cognitive and psychomotor function) to show whether using certain medications

[10] Reading from a Web site, Dr. Cisneros offered the following description of a black-box warning: "A black-box warning appears on the label of a prescription medication to alert consumers and health care providers about safety concerns such as serious side effects or life threatening risks. A black-box warning is the most serious medication warning required by the U.S. Food and Drug Administration."

might impair driver performance. The Board agreed that there was no evidence to address questions concerning serum interactions.

The Board also discussed whether to recommend that the Agency convene a new board or panel to develop a recommended list of medications the use of which would disqualify a driver from receiving a medical certificate. The Board agreed to recommend that FMCSA convene an expert panel to discuss medications that could impair driver performance on the road, beginning with medications with an FDA black-box label and medications listed by other reputable sources such as FAA's list of prohibited medications.

MRB Recommendations

Following Board deliberations, Dr. Pervall presented a summary of the Board's recommendations concerning licit Schedule II medication use.

Standardized Medication Questionnaire

The MRB unanimously agreed to recommend that FMCSA develop a standardized Medication Questionnaire to promote consistency and accountability among MEs in applying medical certification criteria, and among prescribing clinicians (medical doctors, physician assistants, and nurse practitioners) who provide input to MEs in making medical certification decisions. Although there was not unanimous agreement concerning all elements of the document, the MRB developed a questionnaire during the meeting; four members of the board recommended adoption.

Promote ME Awareness of Particular Classes and Side Effects of Medications

The MRB unanimously recommended that FMCSA advise MEs that when considering whether to issue a CMV driver medical certificate, the ME should give particular attention to the following classes of medications, the use of which can impair an individual's ability to operate a CMV safely.

Anticoagulants
Antivirals
Anxiolytics
Barbiturates
Chemotherapeutic Agents
Experimental
Hypoglycemic
Investigational
Mood-ameliorating
Motion Sickness
Narcotic
Sedating Antihistaminic
Sedative
Steroid drugs
Tranquilizers

The MRB further recommended that FMCSA's advice include promoting ME awareness of medications with an FDA black-box warning of side effects that include syncope, loss of consciousness, seizures, arrhythmia, hypoglycemia, and psychosis.

Updated Evidence Report

The MRB unanimously recommended that FMCSA request an update of the 2006 Evidence Report on licit Schedule II drug use and CMV driver safety to address certain questions requiring more evidentiary study. The Board also recommended that FMCSA reemphasize including synthetic opioids in the panel of medications for which tests are performed.

Convene a Panel of Experts to Review Medications

The MRB unanimously recommended that FMCSA convene a panel of experts to review medications and categories of medications with the objective of listing permissible and disqualifying medications for CMV drivers based on potential adverse side effects.

Dr. Pervall concluded the deliberation on Licit Schedule II Drug Use and Commercial Motor Vehicle Driver Safety.

Public Comment Period

There were no public comments.

Call to Adjourn

Dr. Pervall adjourned the meeting.

Attachment

Certification

The minutes were approved by the Medical Review Board on 10/29/13.
(Date)

We hereby certify that, to the best of our knowledge, the foregoing minutes are accurate and complete.

Gina C. Pervall, M.D.
Chairperson
Medical Review Board

Larry W. Minor
Designated Federal Officer
Medical Review Board