

N.J. Law Allows Limited Medical Marijuana Use

BY MARY ELLEN SCHNEIDER

New Jersey has become the 14th state in the nation to allow the medical use of marijuana, although its program will be the country's most restrictive.

Outgoing Gov. Jon S. Corzine (D) signed the "Compassionate Use Medical Marijuana Act" into law on Jan. 18, shortly before leaving office; the law will take effect in 6 months. The new law will remove legal penalties for the possession and use of marijuana for medical purposes. Under the law, the drug must be recommended by a licensed state physician for a qualifying medical condition such as cancer, HIV/AIDS, multiple sclerosis, amyotrophic lateral sclerosis, or Crohn's disease.

The program is expected to be tightly regulated by the state Department of Health, and patients who wish to obtain medical marijuana will be issued identification cards. Marijuana for medical use will be dispensed at Alternative Treatment Centers around the state, which will also be regulated by the state. Unlike other state medical marijuana laws, the New Jersey bill prohibits the cultivation of marijuana at home.

The enactment of the New Jersey law was applauded by advocates of medical marijuana. Ken Wolski, R.N., executive director of the Coalition for Medical Marijuana—New Jersey, said it was a significant step forward for patients in the state.

But he said the new law is too restrictive. For example, the group had urged legislators to allow at-home cultivation of marijuana, but such a provision was stripped from the bill. Mr. Wolski said the list of qualifying medical conditions also is too narrow, leaving marijuana available to only a fraction of the patients who could potentially benefit.

But he praised the new system of alternative treatment centers that will be set up to dispense marijuana under the bill. Mr. Wolski said these dispensaries will be tightly regulated and should mimic the pharmaceutical distribution system.

"This may very well be a model for the rest of the country or for the nation moving forward," he said.

Dr. Nathan Wei, a rheumatologist in Frederick, Md., agreed that the restrictive nature of the New Jersey law might be exactly what makes it appealing as a model for other states.

"People don't want to become another California," Dr. Wei said. New Jersey's legislature has "created a legalization model that I think most people could live with."

The developments in New Jersey come as the use of marijuana as a medicine seems to be gaining some legal and political traction.

Since 1996, 13 other states have enacted laws that allow for some type of medical use of marijuana. In November 2009, the American Medical Association approved a new policy recommending that the federal government review its classi-

fication of marijuana with the goal of making research into cannabinoid-based medicines easier.

Also last fall, the Justice Department weighed in on medical marijuana in a memo to federal prosecutors. The memo effectively told federal prosecutors in states with laws authorizing the medical use of marijuana not to waste time enforcing the federal prohibition on marijuana.

The prosecution of cancer patients who use marijuana as part of a recommended treatment regimen is "unlikely to be an efficient use of limited federal resources," the memo said.

In a February 2009 position paper, the American College of Physicians backed "rigorous scientific evaluation of the potential therapeutic benefits of medical marijuana" and stated that physicians who prescribe or dispense medical

marijuana and patients who use it in accordance with state law should be shielded from federal criminal prosecution.

The ACP also urged review of marijuana's status as a schedule I controlled substance "and its reclassification into a more appropriate schedule, given the scientific evidence regarding marijuana's safety and efficacy in some clinical conditions." ■



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ONGLYZA has not been studied in combination with insulin.

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- **Use with Medications Known to Cause Hypoglycemia:** Insulin secretagogues, such as sulfonylureas, cause hypoglycemia. Therefore, a lower dose of the insulin secretagogue may be required to reduce the risk of hypoglycemia when used in combination with ONGLYZA
- **Macrovascular Outcomes:** There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with ONGLYZA or any other antidiabetic drug

Most common adverse reactions (regardless of investigator assessment of causality) reported in $\geq 5\%$ of patients treated with ONGLYZA and more commonly than in patients treated with control were upper respiratory tract infection (7.7%, 7.6%), headache (7.5%, 5.2%), nasopharyngitis (6.9%, 4.0%) and urinary tract infection (6.8%, 6.1%). When used as add-on combination therapy with a thiazolidinedione, the incidence of peripheral edema for ONGLYZA 2.5 mg, 5 mg, and placebo was 3.1%, 8.1% and 4.3%, respectively.