The Pharmacist Activist

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The Sleeping Giant

What are the names and party affiliations of your senators and representatives at the state and national levels?

Have you ever personally spoken with your legislators regarding issues that are important to the profession of pharmacy?

Have you ever written a letter to your legislators regarding issues that are important to the profession of pharmacy?

Have you contacted your legislators regarding changes in the prescription drug program in Medicare and the changes that are being considered in the prescription drug program in Medicaid? If not, why not?

I am not aware of a previous time in which the future of our profession can be so dramatically influenced by changes in legislation as what we are experiencing now. At this time, there continue to be more questions than answers with respect to the impact the changes in the Medicare program will have on pharmacists and the patients served in this program. However, there are some things that we do know. One is that the interests of one group—the pharmaceutical companies—were very well protected in the Medicare legislation by the inclusion of a provision that prevents the government from negotiating with the companies to obtain the best prices for their medications.

The Medicare legislation authorized a drug discount card program as a first step that would be followed by more comprehensive changes in the program. The discount card program was very poorly planned, and the understanding of the program on the part of the "beneficiaries" was even worse. "Chaos" is probably an understatement in characterizing this program.

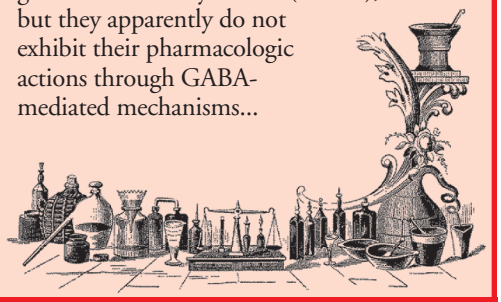
Local pharmacies (independent and chain) face important decisions in determining which of the numerous Medicare prescription plans they will participate in. Are the dispensing fees provided equitable? What opportunities and compensation will be available to local pharmacists to provide Medication Therapy Management (MTM) services, or will the insurance companies and pharmacy benefit managers attempt to provide these services from a distant location without the benefit of face-to-face interaction with patients?

(Continued on Page 2)

Contents

Discussion

Pregabalin (Lyrica-Pfizer) is structurally related to gabapentin (eg, Neurontin) and has many properties that are similar to those of the older drug. Both agents are structurally related to the neurotransmitter, gamma-aminobutyric acid (GABA), but they apparently do not exhibit their pharmacologic actions through GABA-mediated mechanisms...



The Pharmacist Activist

Editor's Note

The profession of pharmacy is facing many threatening issues. We need many more activists to address these issues and it is this recognition that has motivated me to develop this publication, *The Pharmacist Activist*. Each monthly issue will include an editorial on a topic that is important for our profession and/or our other responsibilities. The opinions provided are intended to be thought-provoking and a stimulus for action. Some will disagree with certain of the opinions expressed, and that is fine. I continue to learn from those who hold opinions that differ from my own.

The second regular feature in each issue is a New Drug Review. The format in which information is provided for a new drug is intended to enable pharmacists to recognize the relative importance of the drug and effectively use the information in their interactions with patients and other health professionals. A primary focus is to compare the new drug, where possible, with older drugs that are used for the same indications for which the new one has been approved. Several years ago, I developed the New Drug Comparison Rating (NDCR) system using a numerical scale from 1 to 5, with 5 being the highest rating. The NDCR is provided for each new drug considered, along with the advantages and disadvantages for the drug that were considered in the determination of the rating.

The Pharmacist Activist is being provided to interested pharmacists free of charge. It is anticipated that support for financing the publication will be available from sources who have an interest in the provision of objective and unbiased information regarding new drugs and the provision of opinions about important issues facing the profession. Support will not be accepted from individuals or organizations who might be perceived as wishing to have influence on the content of the publication.

My service as author/editor of *The Pharmacist Activist* is a part-time responsibility, and I continue in my full-time position on the faculty at the Philadelphia College of Pharmacy at University of the Sciences in Philadelphia. Although I would hope that every reader agrees with the information and opinions I provide, experience has taught me not to expect that. The opinions I provide do not necessarily represent those of my full-time employer or the publisher.

- Daniel A. Hussar

(The Sleeping Giant cont.)

Changes being considered in the Medicaid prescription program could also have an extremely negative impact on both pharmacists and the patients served in this program. Other matters that demand our attention are efforts to 1) remove the antitrust restrictions that currently prevent pharmacists from working together to negotiate with the organizations administering these programs regarding the terms of the programs including dispensing fees; 2) prevent the mandated participation of patients in mail-order pharmacy programs; and 3) remove the inequitable provisions of current plans such as the restriction that local pharmacies may dispense no more than a 30-day supply of a maintenance medication while there are financial incentives for patients to obtain a 90-day supply at a mail-order pharmacy.

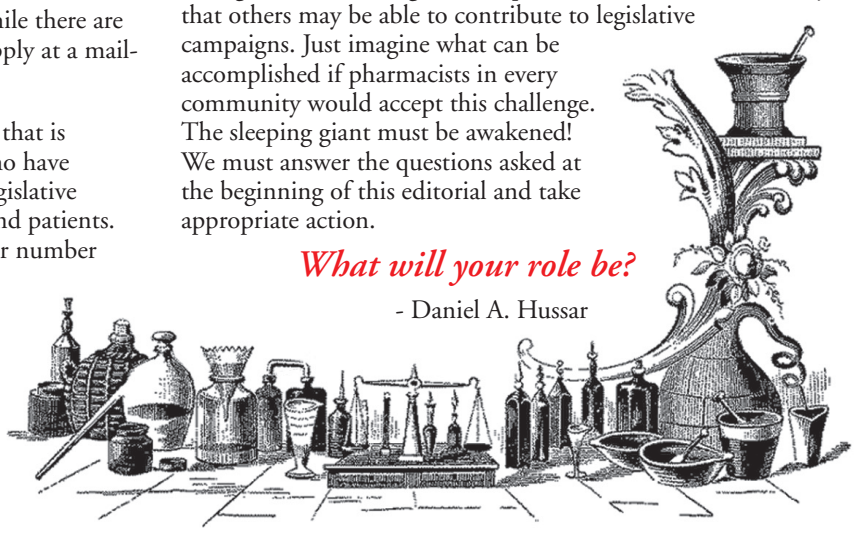
What all of these issues have in common is legislation that is enabling or restrictive. There are some pharmacists who have committed considerable time, effort, and money to legislative efforts that will have positive results for pharmacists and patients. Their efforts are to be applauded. However, a far larger number of pharmacists have done little or nothing in this direction! Our profession has been a sleeping giant!

Some who will agree with the "sleeping" part of this characterization will question how our profession can be viewed as a "giant." They note that pharmacists and our professional associations have only a very small fraction of the money and professional lobbyists that the pharmaceutical and insurance companies have. We may not have money but we have the potential to have far greater influence than we have demonstrated to date.

Every pharmacist can be an "unofficial" lobbyist. We can also have a very persuasive influence on how our patients, family members, and other members of our community vote. If there is something that legislators give a higher priority than anything else, it is securing enough votes to be elected. Our collective ability to influence voting results is of far greater importance than all of the money that others may be able to contribute to legislative campaigns. Just imagine what can be accomplished if pharmacists in every community would accept this challenge. The sleeping giant must be awakened! We must answer the questions asked at the beginning of this editorial and take appropriate action.

What will your role be?

- Daniel A. Hussar



New Drug Review

Pregabalin (Lyrica)

Indications:

Management of neuropathic pain associated with diabetic peripheral neuropathy; management of postherpetic neuralgia; adjunctive therapy for adult patients with partial seizures.

Comparative drugs:

Gabapentin (eg, Neurontin)

Advantages:

- Has a labeled indication for neuropathic pain associated with diabetic peripheral neuropathy
- May be administered two (or three) times a day (compared to three times a day with gabapentin for the indications the two agents share)
- Dosage adjustment may be easier

Disadvantages:

- Is a controlled substance (Schedule V)
- May be more likely to cause creatine kinase (CK) elevations and musculoskeletal adverse events
- May reduce platelet counts and cause prolongation of the PR interval
- Has not been evaluated in pediatric patients
- Is more expensive

New drug comparison rating (NDCR) = 3
(no or minor advantage/disadvantage)
in a scale of 1 to 5, with 5 being the highest rating

Conclusions:

Neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia is often difficult to manage, and pregabalin is a welcomed addition to the small group of drugs that have been useful in this type of pain. However, pregabalin has not been demonstrated to be more effective or safer than gabapentin, and it may cause certain problems that have not been associated with the older agent. Although gabapentin does not have a labeled indication for neuropathic pain associated with diabetic peripheral neuropathy, it has been widely prescribed for this purpose. If one of these agents is to be selected for the management of neuropathic pain, gabapentin is the best choice. In addition to the extensive experience with its use, gabapentin is available generically and is less expensive. In situations in which gabapentin does not provide adequate management of neuropathic pain, pregabalin may provide benefit although its effectiveness in this context has not been demonstrated.

Discussion

Pregabalin (Lyrica-Pfizer) is structurally related to gabapentin (eg, Neurontin) and has many properties that are similar to those of the older drug. Both agents are structurally related to the neurotransmitter, gamma-aminobutyric acid (GABA), but they apparently do not exhibit their pharmacologic actions through GABA-mediated mechanisms. Their mechanism(s) of action may involve modulation of calcium channel function that results in the reduction of calcium-dependent release of several neurotransmitters.

Pregabalin was initially approved in late 2004 for the management of postherpetic neuralgia and neuropathic pain associated with diabetic peripheral neuropathy, and in mid-2005 for the adjunctive treatment of partial seizures in adult patients with epilepsy. It is the first prescription medication to be approved for the management of neuropathic pain associated with both postherpetic neuralgia and diabetic peripheral neuropathy.

Gabapentin is indicated for postherpetic neuralgia and for the adjunctive treatment of partial seizures. Although it does not have a labeled indication for neuropathic pain associated with diabetic peripheral neuropathy, it has been widely prescribed for this condition.

The effectiveness of pregabalin was demonstrated in placebo-controlled studies. There are insufficient data to conclude that pregabalin is more effective, or even as effective, as gabapentin. Similarly, it has not been demonstrated that the new drug is effective in patients in whom the use of gabapentin has not provided an adequate response; however, this is the situation in which pregabalin may be of the greatest value.

Pregabalin is being evaluated for the treatment of generalized anxiety disorder, fibromyalgia syndrome, and pain associated with conditions such as trigeminal neuralgia. However, these are not labeled indications at the present time.

As with gabapentin, the most frequently experienced adverse events with the use of pregabalin are dizziness and somnolence that occurred in 26% and 16% of patients, respectively, in the studies of the drug for the management of postherpetic neuralgia.

(Continued on Page 4)

(Discussion cont.)

Patients should be advised not to drive or operate other potentially hazardous machinery until they have determined that the drug does not adversely affect mental and/or motor performance. They must also be cautioned regarding the concurrent use of other central nervous system depressants, including alcoholic beverages.

In the controlled studies with pregabalin, 4% of patients reported euphoria as an adverse event (compared with 1% of those receiving placebo) and, in a study of the drug in recreational users of sedative/hypnotic drugs, the response (eg, a "high") was considered similar to that with diazepam (eg, Valium). When treatment with pregabalin is abruptly or rapidly discontinued, some patients have experienced symptoms such as insomnia, nausea, headache, or diarrhea that are suggestive of physical dependence. The Drug Enforcement Administration has classified pregabalin as a controlled substance in Schedule V, the least restrictive of the classifications. Gabapentin is not classified as a controlled substance; however, when treatment with either drug is to be discontinued, the dosage should be reduced gradually over a period of at least one week.

Other adverse events that have been commonly experienced by patients treated with pregabalin include peripheral edema (12%), dry mouth (8%), headache (7%), ataxia (5%), blurred vision (5%), and weight gain (4%). The occurrence of edema and/or weight gain has important implications for patients with heart failure and certain other cardiovascular disorders. The thiazolidinedione class of antidiabetic drugs (pioglitazone [Actos], rosiglitazone [Avandia]) may also cause fluid retention and/or weight gain, and the concurrent use of pregabalin has been reported to increase the frequency of these events.

The use of pregabalin in the clinical studies was associated with creatine kinase (CK) elevations, and rhabdomyolysis was reported in several patients. A causal relationship has not been established but patients should be instructed to promptly report unexplained muscle pain, tenderness, or weakness.

The labeling for pregabalin also contains precautions regarding a decrease in platelet counts and prolongation in the PR interval of the electrocardiogram although it has not yet been determined whether these changes are of clinical importance. In animal studies with the new drug, male animals were less fertile and birth defects were reported in the offspring of male animals that were treated with the drug (male-mediated teratogenicity). It is recommended that male patients for whom treatment with pregabalin is being considered should inform their physician if they plan to father a child.

Pregabalin is not appreciably metabolized and is primarily eliminated in the urine in unchanged form. The dosage should be reduced in patients with impaired renal function (ie, creatinine clearance less than 60 mL/minute).

Pregabalin may be administered without regard to food. The recommended initial dosage for postherpetic neuralgia and adjunctive treatment of partial seizures is 75 mg 2 times a day or 50 mg 3 times a day, and for neuropathic pain associated with diabetic peripheral neuropathy is 50 mg 3 times a day. The dosage may be increased to 300 mg a day in divided doses in the management of the pain disorders, and to a maximum of 600 mg a day in divided doses in the treatment of partial seizures. Gabapentin is administered 3 times a day.

Pregabalin is supplied in capsules in 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg, 225 mg, and 300 mg potencies. Gabapentin is supplied in an oral solution formulation in addition to capsule/tablet formulations. Certain of its formulations are available generically and at a lower cost than pregabalin.

- Daniel A. Hussar

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