The Pharmacist Activist

Volume 5, No. 3 • March 2010

Editorial

Tobacco sales in Pharmacies – A Historic Decision by APhA Delegates

The title for my editorial in the October 2008 issue of *The Pharmacist Activist* was, "January 1, 2010 – Make This Date the Goal to Get Cigarettes Out of All Pharmacies!" Well, January 1, 2010 has come and gone and cigarettes are still sold in thousands of pharmacies, primarily in chain stores. Although I am disappointed that there has been so little progress in discontinuing the sale of tobacco products in pharmacies, I am now all the more determined to persevere with this effort.

The good news

As with so many issues, there is some good news and some bad news. We will start with the good news. In the last two years, there have been elections, legislative actions, and other events that have been described as being of "historic" significance. The House of Delegates of the American Pharmacists Association (APhA) adopted a policy on Monday, March 15, 2010 that should have historic implications for the profession of pharmacy. The title of the policy is "Discontinuation of the sale of tobacco products in pharmacies and facilities that include pharmacies." The background for the policy is stated very briefly but the components of the policy are far-reaching:

Background:

Tobacco products are addictive and carcinogenic. More than 400,000 Americans die each year as a result of illnesses in which the use of tobacco products has been a major contributing factor. The sale of products that can cause illness and death is contradictory to the mission and role of pharmacists/pharmacies to protect, promote, and improve the health of those whom they serve.

Motion:

APhA

1. Urges the pharmacies, and the facilities that include pharmacies, that sell tobacco products to discontinue doing so;

2. Urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products;

3. Urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products;

4. Urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students;

5. Urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs only use pharmacies that do not sell tobacco products, and;

6. Urges pharmacists and pharmacy students who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.

Following discussion, the motion was approved by the House of Delegates and is now policy of the American Pharmacists Association. It is important

Contents

to note that none of the individuals, organizations, or agencies that APhA will be urging to take these actions has an obligation to do so. However, the scope of this policy and the boldness of the stand of the APhA delegates on this matter is unprecedented, and the policy provides a strong foundation from which the profession can move forward in accomplishing its goals.

The good news also includes the recognition of the large majority of independent pharmacies, Target stores, and certain regional chains such as Wegmans that do not sell tobacco products. The good news might also include the decisions of city officials in San Francisco and Boston that recognize the contradiction of selling tobacco products in pharmacies to the point that they have taken action to ban the sales of these products in pharmacies. However, this should be an embarrassment for the executives of the chain pharmacies who want to benefit from an image of promoting good health at the same time they persist in selling products that have such devastating health consequences.

The bad news

There are thousands of pharmacists working for the chain pharmacies that sell tobacco products who do not agree with this decision of their employers. However, concerns that they voice are ignored and, sadly, some even feel that making a recommendation to stop the sale of tobacco products will be held against them. I have spoken with many chain pharmacists about this matter and the typical response is that they agree with my concern but they have no authority or influence with respect to this decision. When I ask who does have the authority to make a decision to discontinue the sale of tobacco products, the unanimous response is that it is the CEO of the company. Therefore, during the last two years, I have attempted to arrange personal meetings with the CEOs of four of the largest chains that sell tobacco products – CVS, Rite Aid, Walgreens, and Wal-Mart. I would quickly acknowledge that these CEOs have no obligation to meet with me — and they wouldn't – although I did meet with other executives of CVS and Rite Aid, and spoke by phone with an executive at Walgreens. However, notwithstanding the conclusion that these were exercises in futility, the manner in which these companies rejected my recommendation carries a message of its own.

I endeavored to convey my recommendation in as positive a manner as possible by encouraging the particular chain pharmacy to be a leader among the chain pharmacies in discontinuing the sale of tobacco products, and that this action would be in its own best interest as an organization. When I was able to meet personally with an executive of a chain, I provided the following reasons for which I thought it would be advantageous for their company to discontinue the sale of tobacco products. The list of reasons was personalized for the company but the list below uses the general designation of "Chain."

1. It would provide a clear statement of Chain's commitment to promote the public health in the communities it serves.

2. It would be a source of encouragement to the pharmacist employees by removing a product line in their work environment that is contradictory to their role as health professionals.

3. It would be of value in recruiting pharmacists and pharmacy students.

4. Chain would receive very positive and extensive publicity in its communities, and in the national lay press and pharmacy publications.

5. Chain would be a leader among chain pharmacies and provide an example that would be emulated by others.

6. The challenge of verifying the age of purchasers would be eliminated.

7. The challenge of internal theft of tobacco products would be eliminated.

8. Peace of mind (clear conscience) from knowing that products that can cause illness and death are not being obtained from Chain pharmacies.

9. Contributing back to the profession of pharmacy that has been good to the Chain organization and its employees by taking a stand that enhances the recognition of the professional role and services of pharmacists and the role of the profession of pharmacy in promoting public health.

I initiated my communication with the four large chains by sending personalized letters to the CEOs. I wrote these letters as an individual pharmacist and not as one who was representing my employer or any other organization or group. In describing the following experiences, I have specifically identified only the individuals to whom my letters were sent and who were unwilling to meet with me or speak with me by phone.

CVS

My letter was sent to Mr. Tom Ryan, Chairman of the CVS Corporation. I was contacted by a Vice President of CVS who came to Philadelphia with a CVS regional manager to meet with me. At one point, the Vice President made the comment that, although CVS sold cigarettes, they did not promote them. I removed from my file a recently taken photo of a CVS pharmacy with a large sign in its front window promoting "Lower Cigarette Prices." She said that she would look into it but I have heard nothing further about it. The meeting was cordial but they acknowledged that they did not have the authority to make the decision I was requesting. They noted, however, that the individual I should be contacting is Mr. Larry Merlo, President of CVS/pharmacy. I wrote to Mr. Merlo and followed up with a telephone message requesting an opportunity to meet with him. When I did not hear anything for approximately a month, I called again and left a second message. Soon thereafter, I received a letter from Mr. Merlo that concluded with the following statements:

"Thank you for the opportunity to explain our policies around tobacco sales. As we have no plans currently to change these policies, I must respectfully decline your request for a meeting to discuss this issue."

Rite Aid

My letter was sent to Ms. Mary Sammons who, at the time, was Chairman, President, and Chief Executive Officer of Rite Aid. I was contacted by a Vice President of Rite Aid who arranged for me to meet with the COO whom I was told had the authority

for decisions including tobacco sales. We had a cordial meeting at Rite Aid headquarters and they agreed to consider my request. A number of months went by and then I learned from another source that the COO with whom I met was no longer with the company.

In the meantime other changes were occurring at Rite Aid, and Mr. John Standley was appointed President and COO. I wrote to him on May 22, 2009 and followed up with a telephone message. I wrote to him again on July 29, 2009 but have received no response.

Walgreens

My letter was sent to Mr. Jeffrey Rein who, at the time, was Chairman and CEO of Walgreens. I soon received a letter from Mr. Rein that was very thoughtfully written but did not address my request for a meeting. I followed up with a telephone call and left a message. I was contacted by a Vice President of Walgreens and we had several cordial telephone conversations. He acknowledged that he did not have the authority to make a decision to discontinue the sale of tobacco products and I requested that he convey to Mr. Rein my request to meet personally with him. The Vice President responded that he would do that but that he would not be able to get back to me until the following week because Mr. Rein would be involved in Board meetings. Later that week it was announced that Mr. Rein was leaving Walgreens.

When Mr. Gregory Wasson was subsequently appointed President and CEO of Walgreens, I wrote to him requesting a meeting. He responded with an explanation of their business decision to continue to sell tobacco products that included the observation that they do not promote tobacco products in their advertising. His letter did not address my request for a meeting so I wrote again to request a meeting and also called attention to a photograph I had of a Walgreens pharmacy with a large sign that promotes, "Best Cigarette Prices Around." I have not received a response.

Walgreens is taking steps to sell beer and wine in their stores in states in which this is permitted. It was not that many years ago when they discontinued the sale of alcoholic beverages.

Wal-Mart

My letter was sent to Mr. Lee Scott, the President and CEO of Wal-Mart. When a number of months went by without a response, I tried to call his office, only to learn that calls will not be transferred to his office or offices of other executives. My call arrived on what was designated as the "priority assistance line," and the individual with whom I spoke was able to confirm that my letter had been received and had been referred "to the appropriate level of management." When I asked to be transferred to Mr. Scott's office, I was informed that they could not do that and that the only individual who could make that request on my behalf was the district manager in my area. I was provided with the name and telephone number for the district manager.

On my third attempt I was able to speak on the phone with the district manager. He responded that it is "the buyers" who make the decisions regarding tobacco sales and that he would forward my request to them. I noted that my request was to meet with Mr. Scott, and not with the buyers, and that I had been informed that I needed to pursue this request through him. He was interested in seeing my letter and I sent a copy to him. When I did not receive any response from him during the next 10 months, I called the Wal-Mart corporate offices again. They indicated that I must work through the same individual, only this time they identified him as a "market manager." I called and spoke with his assistant who said he was on vacation and she would give him my message when he returned. When I did not hear from him in almost four weeks, I called and left a message on his voicemail. That was on August 10, 2009 and I am still waiting for a return call.

In the meantime, Mr. Scott retired and was succeeded as President and CEO by Mr. Mike Duke. I wrote to him on May 22, 2009. There has been no response.

Next steps

I had initially thought that I could persuade the CEO of at least one of these companies to stop the sale of tobacco products. If one of these companies took this action and received extensive positive publicity, the others might follow rather than run the risk of being embarrassed by negative comparisons. But I was wrong. I tried to take the high road in addressing this issue through polite discussion, but I failed. Although some of the individuals in these experiences were responsive and courteous, others were unresponsive and/or arrogant. However, the one message that came through very clearly from all four companies is that the only thing the leaders of these companies care about is the money that customers will spend in their stores. They do not care about their health and it is blatant hypocrisy for them to suggest they do.

I have not given up; indeed, I am all the more determined. The bold action of the APhA delegates provides new momentum and strategies that position APhA to provide strong leadership in getting tobacco products out of pharmacies and facilities that include pharmacies. We need to provide strong support.

Daniel A. Hussar

Author/Editor
Daniel A. Hussar, Ph.D.
Philadelphia College of Pharmacy
University of the Sciences in Philadelphia

Publishers
Christopher J. Polli • G. Patrick Polli II

Assistant Editor - John Buck

Publications Director - Jeff Zajac

Graphic Artist/Designer - Joe Monte

The opinions and recommendations are those of the author and do not necessarily represent those of his full-time employer or the publisher.

The Pharmacist Activist
661 Moore Rd., Ste. 100, King of Prussia, PA 19406
610-337-1050 • Fax: 610-337-1049
E-mail: pharmacistactivist@news-line.com

News, Information and Career Opportunities
NEWS - Line PUBLISHING

New Drug Review

Ustekinumab

(Stelara – Centocor Ortho Biotech)

Agent for Psoriasis

New Drug Comparison Rating (NDCR) = 4

(significant advantages) in a scale of 1 to 5, with 5 being the highest rating

Indication:

Administered subcutaneously for the treatment of adult patients with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

Comparable drug:

Etanercept (Enbrel).

Advantages:

- Unique mechanism of action (interleukin-12 and -23 antagonist);
- More effective that etanercept in a comparative study;
- Less frequent administration (every 12 weeks for maintenance treatment compared with once weekly maintenance treatment with etanercept);
- May be associated with a lesser risk of infection (compared with a boxed warning regarding this risk in the labeling for etanercept).

Disadvantages:

- Labeled indications are more limited (etanercept also has labeled indications for rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, ankylosing spondylitis, and psoriatic arthritis);
- Should only be administered by a healthcare provider (whereas etanercept may be self-administered).

Most important risks/adverse events:

Risk of infections (should not be used in patients with clinically important active infections; patients should be evaluated for tuberculosis prior to initiating treatment); risk of malignancies (as a result of immunosuppressant action); reversible posterior leukoencephalopathy syndrome (one case report in clinical studies); patients should not receive live vaccines during period of treatment (all immunizations appropriate for age should be administered prior to initiating therapy).

Most common adverse events:

Nasopharyngitis (7%), headache (5%), upper respiratory tract infection (4%), fatigue (3%).

Usual dosage:

Administered subcutaneously; in patients weighing 100 kg or less, the recommended dosage is 45 mg initially and four weeks later, followed by 45 mg every 12 weeks; in patients weighing more than 100 kg, the recommended dosage is 90 mg initially and four weeks later, followed by 90 mg every 12 weeks.

Products:

Single-use vials and prefilled syringes – 45 mg/0.5 mL, 90 mg/1 mL (should be stored in a refrigerator).

Comments:

Advances in the treatment of moderate to severe plaque psoriasis have included the use of tumor necrosis factor (TNF) inhibitors (etanercept, adalimumab [Humira], infliximab [Remicade]), and alefacept (Amevive) that interferes with T-cell activation. Interleukin-12 (IL-12) and interleukin-23 (IL-23) are naturally-occurring proteins that are also thought to have a role in the occurrence and worsening of psoriasis. Ustekinumab is a human monoclonal antibody that is the first drug to selectively target and bind these cytokines. In two placebo-controlled clinical studies, approximately 70% of patients treated with the new drug achieved at least a 75% reduction in psoriasis after two doses, compared with less than 5% of those receiving placebo. Patients were evaluated through one year and approximately 90% of those having at least a 75% reduction in psoriasis maintained this response through one year of treatment. In a study in which ustekinumab was compared with etanercept, 68% and 74% of patients treated with 45 mg and 90 mg dosages of ustekinumab, respectively, experienced at least a 75% reduction in psoriasis, compared with 57% of the patients treated with etanercept.

Ustekinumab has a long duration of action and following the first two doses at weeks 0 and four, subsequent doses are administered every 12 weeks. In the maintenance treatment of plaque psoriasis, etanercept is administered once a week, adalimumab once every two weeks, infliximab (intravenously) once every eight weeks, and alefacept (intramuscularly) once a week.

Daniel A. Hussar