The Pharmacist Activist

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Editorial

Prescription Benefit Programs – Pharmacy Needs Greater Strength and New Strategies!

It has happened again! For the third consecutive Pennsylvania legislative session, each of which is two years in length, proposed legislation that addresses the inequities of many prescription benefit programs has died in committee. The proposed legislation would have prevented insurance companies and pharmacy benefit managers (PBMs) from requiring patients to obtain certain prescriptions from a mail-order pharmacy and would prevent the use of financial incentives for patients to use a mail-order pharmacy. The proposed legislation was approved by a large margin in the House of Representatives and, following considerable delay, was approved by the Senate Banking and Insurance Committee. It was then referred to the Senate Appropriations Committee and discussions with the individual senators on this Committee indicated that there were enough votes for approval. However, the Chairman of the Committee refused to place this proposed legislation on the agenda and, as a consequence, it died in his committee and the full Senate was denied the opportunity to consider it before the conclusion of the legislative session.

Throughout the legislative session, the insurance companies, PBMs, and the legislators who opposed the proposal insisted that the legislation would increase the cost of prescription programs, and that the required or incentivized use of mail-order programs reduced costs. However, when requested to provide the studies and other information that supports their position, they either did not have it or claimed that it was proprietary information and could not be released. None of the legislators or their aides with whom I met had actually personally seen any studies or data. However, some of them were willing to accept these claims from companies who are in a position to present financial information in a manner that supports their own interests and plans to drive more patients and prescriptions to the mail-order pharmacies they own.

The word "frustration" is an understatement in describing the experience of the pharmacists who committed extensive time and effort in support of the legislative proposal. We consider our position to be so valid and important that it is difficult to accept rejection, even though it is temporary, when it is seemingly based on politics, secrecy, and deception. But we must learn from these experiences and further strengthen our support for the legislators who are willing to address our concerns, and challenge those who do not. It has also become very clear that the profession

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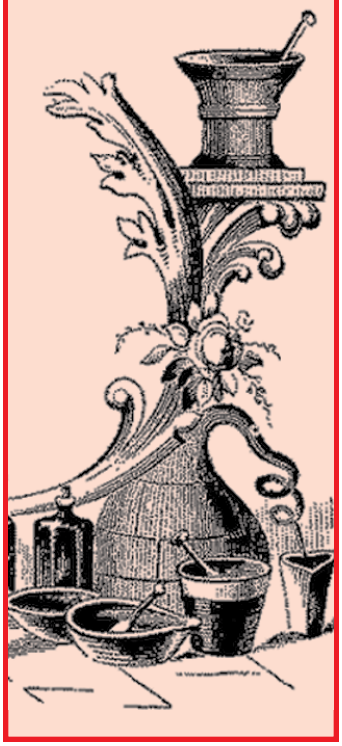

of pharmacy in general, and community pharmacists in particular, need much greater financial and political strength, as well as new strategies for attaining greater effectiveness in addressing our concerns. The following recommendations are proposed for evaluation and action.

Pharmacy networks

Many independent pharmacists are participants in buying groups or networks that increase their purchasing power and efficiency. This has proven to be an effective model on a local or regional basis but we must work toward the development of a national network of independent pharmacies. A critical question that must be addressed is whether the numerous local and regional groups/networks view each other as competitors or as colleagues who can work together in constructing a national network that has the potential for synergies in attaining greater purchasing and political strength. A network of 10,000 independent pharmacies would be considerably larger than even CVS and Walgreens.

It will take considerable planning and time to establish this national network of pharmacies. Therefore, we should concurrently identify one or more states that have the greatest potential to establish a statewide network of independent pharmacies. The development of such a network would provide a model that could be subsequently extended to the national level.

Negotiating

Antitrust is the word that is screamed as a warning to pharmacists who might consider working together as individuals or within a professional organization to insist on a higher rate of compensation for dispensing prescriptions and better terms of participation in the current "take it or leave it" prescription benefit programs. As a result, independent pharmacists are not able to effectively "negotiate" as individuals when dealing with a huge insurance company or PBM.

In stark contrast is the charade in which Walgreens and CVS Caremark were engaged earlier this year. Walgreens announced that it would be discontinuing its participation in prescription programs administered by CVS Caremark, but that it was receptive to further discussions. CVS Caremark responded by announcing that it would be dropping Walgreens from the programs it administers. The next announcement followed quickly–an agreement had been reached although the terms would not be disclosed. Clearly, Walgreens received a better deal, and it is just as clear that its deal is better than the ones available to independent pharmacists. This situation illustrates the power of numbers when the negotiator is a single corporate entity.

The profession of pharmacy must continue to pursue changes in the antitrust laws that would exempt individual pharmacists and permit them to work together and through our organizations to resolve the inequities of current prescription benefit programs. However, progress in this direction has been very limited and other alternatives must also be considered. As with the benefits identified earlier in the purchase of medications using the size and influence of networks, the concept of a large network of independent pharmacies requires active exploration with respect to having legal authority to negotiate on behalf of its members. The structure of such a network would have to include financial arrangements that would permit negotiating authority without violating antitrust laws. Would a parent "company" that would own a small fraction of each independent pharmacy in its network have the legal authority to negotiate for its members? Would 1% of the ownership be sufficient to have such authority and, if not, what percentage of ownership would provide such authority?

This is also a situation in which the implementation of such a network within a state might be accomplished much more quickly than on a national basis. Although each of the issues being considered is deserving of high-priority attention, the challenges of the prescription benefit programs must be considered urgent. Some PBMs are already moving in the direction of using preferred pharmacies or networks of pharmacies in programs that could prevent the involvement of independent pharmacies that wish to participate.

Pharmacist services

Community pharmacists must greatly expand the comprehensiveness and quality of the professional services provided to patients. Medication therapy management (MTM) services are extensively discussed but most pharmacists do not currently provide such services. The widespread provision of MTM services will go a long way towards demonstrating and documenting the value of the services we claim we are capable of providing. I recognize the difficulty encountered by community pharmacists in finding the time to participate in educational programs that will provide the competence and skills to provide such services, and then finding the time in a busy practice setting to provide these services on a timely basis. Some pharmacists will conclude that it is not possible to expand their professional services, particularly at a time when the compensation for dispensing prescriptions is inadequate and it is not known

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New Drug Review

Polidocanol (Asclera – BioForm Medical)

Sclerosing Agent

New Drug Comparison Rating (NDCR) = 4

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

Indications:

For intravenous administration to sclerose uncomplicated spider veins (varicose veins 1 mm or less in diameter) and uncomplicated reticular veins (varicose veins 1 to 3 mm in diameter) in the lower extremity.

Comparable drug:

Sodium tetradecyl sulfate (Sotradecol).

Advantages:

- Satisfaction with treatment reported by a higher percentage of patients;
- Lower incidence of adverse events;
- Fewer contraindications (e.g., sodium tetradecyl sulfate is contraindicated in patients with uncontrolled systemic diseases such as diabetes and asthma).

Disadvantages:

- None.

Most important risks/adverse events:

Contraindicated in patients with acute thromboembolic diseases and in patients with known allergy (anaphylaxis) to the drug; severe allergic reactions, including fatal anaphylactic reactions (risk is greater with the use of volumes greater than 3 mL of the injection; following injection, patients should be under supervision for at least 20 minutes); accidental intra-arterial injection; inadvertent perivascular injection.

Most common adverse events:

Injection site reactions (usually mild in severity) – hematoma (42%), irritation (41%), discoloration (38%), pain (24%), pruritus (19%), warmth (16%).

Usual dosage:

For intravenous administration-the 0.5% solution should be used for the treatment of spider veins, and the 1% solution for reticular veins; a syringe with a fine needle (26- or 30-gauge) should be used and the solution should be injected slowly; a volume of 0.1 to 0.3 mL should be used for each injection, and no more than 10 mL should be injected per session; repeat treatments may be needed if the extent of the varicose veins requires more than 10 mL of solution; treatments should be separated by one to two weeks; following injection, compression in the form of a stocking or bandage should be applied and the patients should be encouraged to walk for 15-20 minutes; compression should be maintained for two to three days following treatment of spider veins, and for five to seven days for reticular veins.

Product:

Ampules – 5 mg (0.5%) and 10 mg (1%) in water for injection with 5% (v/v) ethanol.

Comments:

Varicose veins most commonly occur in the legs and are characterized by weak or damaged valves that result in pooling of blood and swelling. Although symptoms may not occur, some individuals experience mild to moderate pain, blood clots, and/or skin ulcers. Spider veins involve the capillaries and have the appearance of a spider web, and reticular veins are flat blue veins that are usually seen behind the knees. Sclerosing agents have been used in the treatment of smaller varicose veins. Following injection, they cause irritation and scarring inside the vein, resulting in the vein closing off and fading away.

Polidocanol is a non-ionic detergent that consists of two components – a polar hydrophilic (dodecyl alcohol) chain and an apolar hydrophobic (polyethylene oxide) chain. Its properties and use are most similar to those of sodium tetradecyl sulfate, an anionic surface active agent. The effectiveness of polidocanol was demonstrated in a study in which it was compared with sodium tetradecyl sulfate and placebo. Treatment was determined to be successful at both 12 and 24 weeks in more than 90% of the patients treated with polidocanol or sodium tetradecyl sulfate, but in less than 10% of those receiving placebo. Patient satisfaction was evaluated and approximately 85%, 64%, and 15% were satisfied or very satisfied with their treatment with polidocanol, sodium tetradecyl sulfate, and placebo, respectively. The incidence of injection site reactions was considerably lower in patients receiving polidocanol compared with their incidence in patients treated with sodium tetradecyl sulfate.

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whether there will be compensation for additional services. However, it will be the pharmacists who do find a way to extend their services whose practices will have the best opportunity to not only survive, but thrive. The services these pharmacists provide should also result in higher levels of compensation (please see the editorial, "Prescription Benefit Programs – Classes of Pharmacies Should be Established," in the September 2009 issue of *The Pharmacist Activist*, www.pharmacistactivist.com).

Prescription benefit programs

The traditional terms and policies of many prescription benefit programs need to be reconsidered. Many of the components of these programs are coercive, restrictive, and inequitable for both patients and pharmacists. Some policies place patients at greater risk and extensive revisions are warranted (please see the editorial, "Prescription Benefit Programs – A New Model is Needed," in the June 2009 issue of *The Pharmacist Activist*, www.pharmacistactivist.com).

Medication packaging and distribution

In many countries prescription medications are dispensed in the packaging in which they are supplied by the manufacturer. This has not usually been the situation in the United States although there are an increasing number of examples in which commonly prescribed quantities of tablet and capsule formulations are prepackaged. There are many advantages of utilizing unit-of-use packaging including the elimination of the need and cost for a second container to be supplied by the pharmacy, the reduction in the amount of staff time utilized in the preparation of the prescription to be dispensed, and the decreased likelihood of a counterfeit product and/or contamination when the medication is dispensed in the sealed container supplied by the manufacturer. The opportunity to have a patient information leaflet directly affixed to the container by the manufacturer has also been suggested by some as an advantage; however, others have identified potential problems and questions as disadvantages.

Unit-of-use packaging can be both practical and efficient for the dispensing and use of many, but not all, medications. One example of how such a system would work advantageously for many medications would be to package them in containers containing 7-day and 30-day supplies that are consistent with the usual dosage recommendations. Some would also add a 90-day supply but I would contend that there is value in having patients obtain medications for chronic conditions at not more than 30-day intervals. This will permit closer monitoring of patient compliance in using the medication, an opportunity to discuss possible adverse events and for the patient to ask questions, and less wastage if the drug is discontinued or the dosage is changed.

Prepackaged quantities of commonly prescribed medications are already in widespread use in selected situations such as the discount generic prescription programs in certain chain pharmacies and in the offices of physicians who dispense medications. This approach to the packaging and dispensing of medications should be adopted on a much wider basis. Companies that market a large number of generic medications are best positioned to implement this strategy quickly although all companies should participate.

The topics considered in this commentary are diverse and challenging. However, they also include opportunities that we must not ignore and which offer exciting possibilities for pharmacists to extend the value of their services to patients.

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