The Pharmacist Activist

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Editorial

Some Pharmacies Still Sell Cigarettes – Such as Walgreens at the Congested Corner of Smokey and Sickly!

Initiated many decades ago by Pharmacist Fred Mayer of California, the annual Great American Smokeout that was observed on November 16 is an opportunity to reflect on progress that has been made in discouraging the use of tobacco products, but also to recognize the importance of doing much more to greatly reduce the extent of this deadliest of all risks.

Many pharmacists have done their part, and more, in addressing this challenge. Most independent pharmacists have never sold or have discontinued the sale of cigarettes. Some large retailers such as Target, CVS, and Wegmans have stopped selling cigarettes. Elected and civic leaders in large cities like San Francisco, Boston, and New York have recognized the contradiction of selling toxic products (i.e., cigarettes) in pharmacies that are supposed to be protecting and improving the health of their customers, and have prohibited their sale in pharmacies. Yet cigarettes continue to be sold in many pharmacies and facilities that include pharmacies (please see my editorial in the March issue of *The Pharmacist Activist*, "Many Walmart Customers Will Stop Smoking Today! Their Funerals Will be Held Sometime in the Next Three or Four Days").

Every several years I send letters to the CEOs of the largest pharmacy retailers and encourage them to be a leader in discontinuing the sale of cigarettes, and asking for the opportunity to personally meet with them to discuss this request. There is rather rapid turnover in these CEO positions and I cling to the hope that the newest CEO will have the clarity of conscience to take this action in the interest of the health of their customers and community.

Walgreens

On October 25th, I sent the following letter to Mr. Alex Gourlay, the Co-Chief Operating Officer of Walgreens Boots Alliance, Inc.

> Dear Mr. Gourlay:
>
> I urge you to become a leader among chain pharmacies and discontinue the sale of tobacco products in your pharmacies. It is my understanding that Walgreens has considered this matter on previous occasions but has declined to take this action. Indeed, I have contacted several previous Walgreens executives regarding this matter but have

not been provided the opportunity to personally meet with them.

I wish to request the opportunity to meet with you to discuss what I am confident will be the positive outcomes of an action by Walgreens to discontinue the sale of tobacco products in your pharmacies. I will contact your office soon for the purpose of requesting a meeting with you.

Thank you for your consideration of this matter.

On November 2nd, I received the following email response from the Divisional Vice President of Corporate Communications of Walgreens:

Hi, Dr. Hussar,

Alex Gourlay asked that I respond for him to the letter you sent regarding discontinuing the sale of tobacco products at pharmacies. You're right that we do review these products, along with all of our product categories, on a regular basis. We believe that the most effective step we can take to help smokers quit is to address the root causes of smoking, which go far beyond the small percentage of smokers who access this product at pharmacies.

Walgreens is well positioned and committed to offering customers alternatives and a growing set of solutions to help them change behavior and quit smoking. For example, we offer individual consultations regarding smoking cessation, whether with our pharmacists in store, our other health care professionals in our clinics or online through our telemedicine initiatives. In addition, our Balance Rewards for healthy choices program offers smoking cessation content on Walgreens.com and tools to enable participants to track their progress toward smoking cessation while earning Balance Rewards points as an incentive. And we have made an active decision to reduce space and visibility of tobacco products in certain of our stores as we focus on helping customers who want to stop smoking.

We continue to review this issue and how we can enhance our efforts to help lower the smoking rate in our country. In the meantime, I'm sorry that we won't be able to set up an in-person meeting regarding this.

My response is as follows:

Although I am very disappointed that Mr. Gourlay will not meet with me to discuss this matter, I appreciate how promptly you have responded. I have to think that you and Walgreens know "…how we can enhance our efforts to help lower the smoking rate in our country," but it is unfortunate you are not willing to make that decision.

It is noteworthy that I was provided a response so quickly, in less than a week from the time my letter was received at Walgreens and even before I followed up to attempt to schedule a meeting. But maybe they felt that a prompt written response would spare my feelings as compared with having to reject my request in a more personal telephone conversation.

The response I received reminded me of my visit in a Walgreens store while traveling, not long after CVS had implemented its decision to discontinue the sale of cigarettes. I mentioned to the cashier that I was "shocked" that cigarettes were being sold in a pharmacy and she suggested that I speak with the store manager who was close by. When I did that, the manager immediately boasted that their cigarette prices were the lowest in their area and that some people who previously purchased their cigarettes at CVS were now purchasing them at their store.

New strategies needed

Cigarettes are legally available and, as much as I would prefer that no one smoked, I am not attempting to ban their sale. However, I hold the very strong opinion that the sale of cigarettes in pharmacies is a blatant contradiction to the protection and improvement of health that our profession and individual pharmacists claim as our mission. I recognize that the CEO of a chain pharmacy or other retailer has no obligation to meet with me or even respond to my communication. However, much more needs to be done to expose the hypocrisy of promoting

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New Drug Review

Voxilaprevir/Sofosbuvir/Velpatasvir
(Vosevi – Gilead) *Antiviral Agents*

New Drug Comparison Rating (NDCR) = 4
(significant advantages)
in a scale of 1 to 5 with 5 being the highest rating

Indications:
Treatment of adult patients with chronic hepatitis C virus (HCV) infection without cirrhosis or with compensated cirrhosis who have 1) genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor, and 2) genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor.

Comparable drugs:
Sofosbuvir/velpatasvir (Epclusa).

Advantages:
- Is effective in patients who have failed certain previous HCV regimens.

Disadvantages:
- Interacts with more medications;
- Is not recommended in patients with moderate or severe hepatic impairment.

Most important risks/adverse events:
Risk of hepatitis B virus (HBV) infection reactivation in patients coinfected with HCV and HBV who are not receiving HBV antiviral therapy (boxed warning; patients should be tested for evidence of current or prior HBV infection before initiating treatment); bradycardia in patients also being treated with amiodarone (concurrent use is not recommended; risk is greater in patients also receiving beta-blockers or those with underlying cardiac comorbidities and/or advanced liver disease); use in patients with moderate or severe hepatic impairment is not recommended because of significantly higher exposures of voxilaprevir; concentrations and activity are reduced by CYP450 and drug transporter (e.g., P-glycoprotein) inducers (concurrent use of rifampin is contraindicated and the use of other inducers such as rifabutin, carbamazepine, efavirenz, phenytoin, and St. John's wort is not recommended); activity is also reduced by tipranavir/ritonavir and concurrent use is not recommended; action of voxilaprevir may be increased by cyclosporine, atazanavir, and lopinavir, and concurrent use is not recommended; action of velpatasvir may be reduced by gastric acid-reducing agents (e.g., antacids, proton pump inhibitors) and recommended dosages and dosing intervals should be observed); may increase the action of digoxin, tenofovir disoproxil fumarate, dabigatran (Pradaxa), and the statins, and concurrent use should be closely monitored (concomitant use of rosuvastatin or pitavastatin is not recommended; pravastatin may be used in a daily dosage that does not exceed 40 mg; atorvastatin, fluvastatin, lovastatin, and simvastatin should be used in the lowest approved dosages).

Most common adverse events:
Headache (21%), fatigue (17%), diarrhea (13%), nausea (13%).

Usual dosage:
One tablet once a day with food for 12 weeks.

Products:
Tablets – 100 mg voxilaprevir, 400 mg sofosbuvir, and 100 mg velpatasvir (should be dispensed in the original container).

Comments:
The development of direct-acting antiviral agents has resulted in cure rates of chronic HCV infection exceeding 90%. These agents inhibit enzymes/proteins that are essential for HCV replication: daclatasvir, elbasvir, ledipasvir, ombitasvir, and velpatasvir are HCV NS5A inhibitors; grazoprevir, paritaprevir, simeprevir, and voxilaprevir are HCV NS3/4A protease inhibitors; sofosbuvir is a nucleotide analog NS5B inhibitor and dasabuvir is a nonnucleoside NS5B palm polymerase inhibitor. A sofosbuvir/velpatasvir combination formulation was marketed in 2016 as the first product to be approved for treating all 6 major HCV genotype infections. The new antiviral agent voxilaprevir has been added to these agents and the 3-drug combination formulation is the first to be approved for patients whose previous treatment with certain other antiviral regimens has not been successful. The new combination was evaluated in two studies in which the primary endpoint was sustained virologic response 12 weeks following completion of treatment (SVR12). The first study was placebo-controlled and a SVR12 response was experienced by 96% of the patients across all 6 HCV genotypes, and no placebo patients achieved SVR12. In the second study patients were treated with the new combination or sofosbuvir/velpatasvir. Treatment with the new product resulted in higher SVR12 rates in patients with genotypes 1a (97% vs. 82%) and 3 (96% vs. 85%) infection.

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and benefiting from an image of "health," while at the same time selling products that damage it. More money/profit is the single factor that motivates retail pharmacy executives to continue selling products that they know will damage the health of their customers. It is well known that smokers have a shorter life expectancy than nonsmokers and one would expect that a pharmacy retailer would want its customers to live and shop at their store for the longest possible time. But it should also be expected that large retailers would have evaluated business and marketing strategies for both short-term and long-term success. Is it possible that they have studies that enable them to conclude that the revenue from cigarette sales and the prescriptions for the medical problems resulting from smoking over the shorter life span of their customers who smoke, is greater than the revenue they could anticipate from nonsmoking customers who have a longer life (and purchasing) expectancy? Bolder and better strategies are needed to expose the hypocrisy that exists.

1. We must increase the awareness of the strength of the commitment to the good health of their patients and communities on the part of pharmacies that do not sell cigarettes. Several years ago an independent pharmacist in my community made the decision to stop selling cigarettes. There is a Walgreens less than a block away from his pharmacy and I encouraged him to prominently communicate his decision. I proposed that his announcement include a message such as the following: "We value the opportunity to provide you with needed medications, counseling, and other healthcare services. Cigarettes and other toxins may be purchased at Walgreens." He did not use the second part of my suggested statement but his decision to stop selling cigarettes was very positively received.

   Another way in which the consequences of the sale of cigarettes by a pharmacy retailer such as Walgreens might be communicated would be to identify the approximate percentage of cigarette sales (e.g., cartons of cigarettes) in a particular state for which it is responsible. This data could then be linked with the corresponding percentage of deaths in the state during the same period of time that are attributable to smoking-related causes. This information, coupled with a recommendation to use a pharmacy that does not sell cigarettes, could be communicated in media advertisements, highway billboards, etc. The cost of communicating such information is an important consideration but I anticipate that there would be public health advocacy and other organizations that have a commitment to smoking cessation initiatives that would share the cost for such messages.

2. State boards of pharmacy should not issue licenses or renew licenses for pharmacies or stores that include pharmacies that sell tobacco products. The most important responsibility of a board of pharmacy is to protect the health and interests of the public with respect to the practices and operations of the individuals and facilities for which it issues licenses. The sale of cigarettes and the resultant harm to the purchasers severely compromises the fulfillment of that responsibility.

3. Pharmacists and the public should support the efforts of public health organizations and elected and civic leaders in efforts to prohibit the sale of cigarettes in pharmacies and facilities that include pharmacies. One would hope that such regulations/policies would not be necessary and that retail organizations with pharmacies would recognize their responsibility to not sell products that are so harmful to health. Very regrettably, this is not occurring!

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