The Pharmacist Activist

Volume 4, No. 9 • September 2009

Editorial

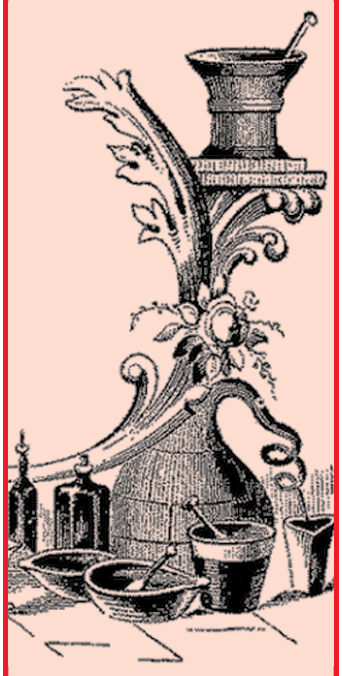
PRESCRIPTION BENEFIT PROGRAMS - Classes of Pharmacies Should be Established

My editorial in the June issue of *The Pharmacist Activist* (available at www.pharmacistactivist.com) identified concepts that I recommended for inclusion in a model prescription benefit program. In this editorial I wish to more specifically address several of the components I suggest for such a program.

I recommended that a professional fee of $15.00 be provided for dispensing a prescription, and that this fee be reviewed on an annual basis and adjusted by an amount that is at least equivalent to the cost of living. This fee is linked to the provision of comprehensive services by the pharmacist/pharmacy. In addition, I recommended that separate compensation based on an hourly rate be provided for services such as medication therapy management (MTM) that require a longer period of time, as well as the necessary expertise.

Ideally, every pharmacy would provide comprehensive services. The reality is that many pharmacies do not and, in some, there is no direct communication between pharmacists and patients. When these latter pharmacies are provided with the same professional fee as the pharmacies that provide comprehensive services (and incur the added costs of doing so), a very inequitable situation exists that acts as a disincentive to provide comprehensive services. This situation brings us to the challenge of determining a variable fee structure that corresponds to varying levels of service. This concept is not new and has been used previously in some prescription benefit programs. However, at a time when the attention of the nation is riveted on health care reform, the reformation of prescription programs also deserves high priority attention. The place to start is to provide equitable compensation as an incentive for pharmacists to provide comprehensive services, which I am convinced will provide a net reduction in overall health care costs because such services will reduce drug-related problems that require expensive interventions such as hospitalization. Compensation must also be based on the level of services provided.

Contents



Classes of pharmacies

To provide a starting point for discussion and revision, I propose the establishment of a prescription program that would include five classes of pharmacies that would receive different fees based on the type and scope of services provided and the image/commitment to promote health care that is communicated to patients and the community. Specific requirements to be met by pharmacies in each of the five classes are proposed below:

Class 1 pharmacies – Professional fee - $15.00

Requirements include:

1. Medication record review;
2. Personal (i.e., face-to-face) counseling with each patient for whom a new prescription is dispensed;
3. Provision of medications on an emergency basis (i.e., 24 hours a day; after closing);
4. Compliance monitoring;
5. Delivery of medications to homebound patients;
6. Dispensing of prescriptions that require compounding;
7. Uncompromised health care image/commitment (e.g., no tobacco sales).

Plus at least three of the following:

a. Medication therapy management (MTM) program;
b. Wellness program (e.g., immunization services);
c. Communication of medication records for patients being admitted to and discharged from a hospital;
d. Medical equipment/supplies/services;
e. Health educator role in the community.

Class 2 pharmacies – Professional fee - $12.00

Requirements include:

1. Medication record review;
2. Personal (i.e., face-to-face) counseling with each patient for whom a new prescription is dispensed;
3. Provision of medications on an emergency basis (i.e., 24 hours a day; after closing);
4. Compliance monitoring;
5. Delivery of medications to homebound patients;
6. Dispensing of prescriptions that require compounding;
7. Uncompromised health care image/commitment (e.g., no tobacco sales).

Plus one or two of the following:

a. Medication therapy management (MTM) program;
b. Wellness program (e.g., immunization services);
c. Communication of medication records for patients being admitted to and discharged from a hospital;
d. Medical equipment/supplies/services;
e. Health educator role in the community.

Class 3 pharmacies – Professional fee - $9.00

Requirements include:

1. Medication record review;
2. Personal (i.e., face-to-face) counseling with each patient for whom a new prescription is dispensed;
3. Provision of medications on an emergency basis (i.e., 24 hours a day; after closing);
4. Compliance monitoring;
5. Dispensing of prescriptions that require compounding.

Class 4 pharmacies – Professional fee - $7.00

Requirements include:

1. Medication record review;
2. Personal (i.e., face-to-face) counseling with each patient for whom a new prescription is dispensed;
3. Provision of medications on an emergency basis (i.e., 24 hours a day; after closing).

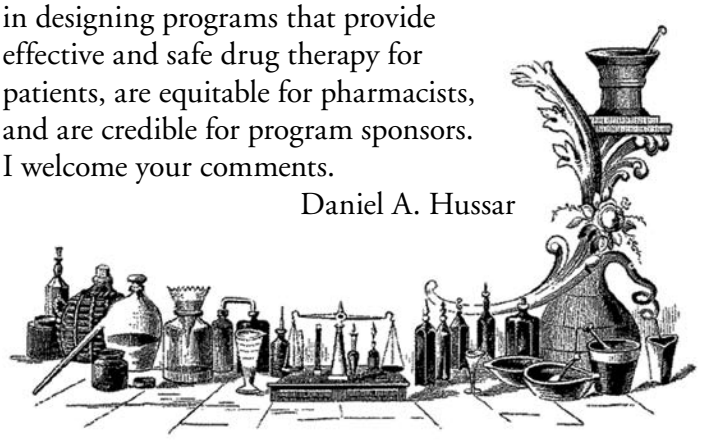
Class 5 pharmacies – Professional fee - $4.00

Requirements include:

1. Medication record review.

Reform of our current prescription benefit programs is essential. Our profession should seize the initiative in designing programs that provide effective and safe drug therapy for patients, are equitable for pharmacists, and are credible for program sponsors. I welcome your comments.

Daniel A. Hussar



New Drug Review

Prasugrel hydrochloride (Effient – Daiichi Sankyo; Lilly)

Antiplatelet Agent

New Drug Comparison Rating (NDCR) = 4

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

Indication:

To reduce the rate of thrombotic cardiovascular events (including stent thrombosis) in patients with acute coronary syndrome (ACS) who are to be managed with percutaneous coronary intervention (PCI), including patients with unstable angina or non-ST-elevation myocardial infarction (NSTEMI), and patients with ST-elevation myocardial infarction (STEMI) when managed with primary or delayed PCI.

Comparable drugs:

Clopidogrel (Plavix).

Advantages:

- Is more effective in reducing nonfatal myocardial infarction and stent thrombosis;
- Action is not likely to be changed by genetic influences that reduce CYP2C19 activity;
- Action is not likely to be reduced by the concurrent use of CYP2C19 inhibitors (e.g., omeprazole);
- May be less likely to cause thrombotic thrombocytopenic purpura.

Disadvantages:

- Is more likely to cause bleeding (boxed warning);
- Is contraindicated in patients with a history of prior transient ischemic attack (TIA) or stroke;
- Labeled indications are more limited (indications for clopidogrel also include use in patients with NSTEMI who are to be managed medically or with coronary artery bypass graft (CABG) surgery, and for the reduction of atherothrombotic events in patients with a history of recent myocardial infarction, recent stroke, or established peripheral arterial disease);
- Use should generally be avoided in patients 75 years of age and older because of an increased risk of bleeding (except in high-risk situations such as in patients with diabetes).

Most important risks/adverse events:

Contraindicated in patients with active pathological bleeding (e.g., peptic ulcer, intracranial hemorrhage), and in patients with a history of prior (TIA) or stroke; bleeding risk (boxed warning) with risk factors for bleeding including bodyweight less than 60 kg, propensity to bleed (e.g., recent trauma), concomitant use of medications that increase the risk of bleeding (e.g., warfarin, heparin, chronic use of nonsteroidal anti-inflammatory drugs), and age of 75 years and older; treatment should not be started in patients likely to undergo urgent CABG surgery; where possible, treatment should be discontinued at least 7 days prior to any surgery; if bleeding occurs, efforts should be made to manage it without discontinuing treatment as this may increase the risk of subsequent cardiovascular events.

Most common adverse events:

Non-CABG-related major or minor bleeding (5%), hypertension (8%), hypercholesterolemia/hyperlipidemia (7%), headache (6%), back pain (5%), dyspnea (5%), nausea (5%).

Usual dosage:

A single loading dose of 60 mg, followed with a maintenance dosage of 10 mg once a day; patients should also be treated with aspirin in a dosage of 75 mg to 325 mg daily; in patients weighing less than 60 kg, decreasing the maintenance dosage to 5 mg once a day should be considered.

Products:

Tablets – 5 mg, 10 mg.

(Continued on Page 4)

New Drug Review (cont.)

Comments:

Prasugrel is a thienopyridine derivative that is structurally and pharmacologically related to clopidogrel and ticlopidine (e.g., Ticlid). Like these other agents, prasugrel is a prodrug that is converted to an active metabolite that inhibits platelet activation and aggregation by binding to the P2Y12 class of adenosine 5' diphosphate (ADP) receptors on platelets. Whereas the conversion of clopidogrel to its active metabolite primarily involves the CYP2C19 pathway, the involvement of this pathway in the conversion of prasugrel to its active metabolite is limited, and the action of prasugrel is not likely to be influenced by genetic variations in CYP2C19 activity or the concurrent use of a CYP2C19 inhibitor such as omeprazole.

The effectiveness of prasugrel was demonstrated in studies in which it was used in conjunction with aspirin and compared with a regimen of clopidogrel and aspirin. The prasugrel/aspirin regimen provided a 19% relative risk reduction with the greater effectiveness almost entirely attributable to a reduction in nonfatal myocardial infarction. There were also fewer stent-related clots (i.e., stent thrombosis) in patients treated with prasugrel/aspirin, with a relative risk reduction of approximately 50%. The greater effectiveness of prasugrel in the treatment of patients with ACS who are to be managed with PCI should be considered in the context of a greater risk of bleeding that necessitates stronger warnings and restrictions for the new drug, as well as much more limited labeled indications when compared with clopidogrel.

Opinions differ regarding the results of the clinical studies and some have proposed that, if a lower dosage of prasugrel had been used, there might be little or no difference in the efficacy of prasugrel and clopidogrel, as well as the risk of bleeding. The labeling for prasugrel also includes an "alternative explanation" for the differences reported in the comparison of the two drugs, that being the lack of an evaluation of the possibility that the action of clopidogrel may have been reduced in some patients because of genetic influences that reduced the activity of the CYP2C19 metabolic pathway, or the concurrent use of a CYP2C19 inhibitor such as omeprazole.

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