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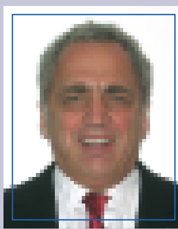
PRESIDENT'S MESSAGE



Change is not always welcome, but it continues to be a fact of life for everyone in pharmacy. As of October 1st, New York State Medicaid program has started its move to managed care, meaning that the PBMs are now in control of about 2/3 of the pharmacy program, determining its network panels, formularies, payments, and just about everything else. The state plans to complete moving the rest of the pharmacy portion of Medicaid to managed care within three years. That is an enormous change; one to which we must adapt. It is our adaptability which allows us to endure in this industry. I keep reminding everyone that there are about 1,000 independent pharmacies in New York City……. we must be REALLY good at adapting for there to be so many of us in one place!

The changes in Medicaid were announced well in advance, and both our board chairman Charles Catalano, and I have tried our best to keep NYCPS members informed. We have participated in each one of the "stakeholders' conference calls" throughout the summer, reporting to you all at our monthly CE programs and in our newsletters. We have also fielded many phone calls from pharmacy owners about the Medicaid changes and other issues. However, it is each pharmacy owner's responsibility to keep informed individually, by checking with the DoH, PSSNY and NYCPS websites for the latest information.

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Guest Editorial

NHPI AND HIEs

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At the recent ASAP midyear conference in June, I heard two interesting presentations. One was on the national health plan ID (NHPI), a new identifier that was written into the HIPAA regulations for health plans. CMS will be issuing a proposed rule shortly on who will be required to obtain and use the NHPI. Suffice it to say, many of the players in healthcare, including the health plans, are not happy about this new identifier. It's another change that will cost money to implement. Pharmacy, in particular, has made known its feelings that the BIN and PCN should still be allowed for routing pharmacy claims, rather than the NHPI. Another recommendation from pharmacy is that prescription benefit

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Chairman's Report

A LOOK AT MEDICARE PART D FOR 2012

CMS has announced the Medicare Part D Plans for New York State, which includes 12 benchmarks plans. There are 2 new benchmark plans Aetna CVS/pharmacy Prescription Drug Plan and First United American. The 10 prescription drug plans that were benchmarks in 2011 and will remain benchmarks for 2012 are: AARP Medicare Rx Preferred, Bravo Rx, Cigna Medicare Rx Plan One, Community CCRx Basic, CVS Caremark Value, Envision Rx Plus Silver, Health Spring Prescription Drug Plan-Reg 3, Humana Wal-Mart-Preferred Rx Plan,
Medco Medicare Prescription Plan, and WellCare Classic.. There is one plan that was a benchmark in 2011 and will not be a benchmark in 2012 is RX America. Medicaid beneficiaries which were assigned to RX America will be moved to one of the twelve benchmark plans listed above, however if a Medicaid Beneficiaries intentionally moved to RX America from another benchmark plan they will have to choose a plan or they will be without coverage in January.

The are a total of 29 Medicare Part D Plans in New York State for beneficiaries to choose. This year the open enrollment period is earlier then previous years. For new enrollees and beneficiaries that wish to change their plans the open enrollment period is October 15th, 2011 to December 7th, 2011.

The deductible for 2012 is $320. No deductible is being charged by 13 plans
And 16 plans have the maximum deductible of $320.

The co pays for non-dual eligible will be $2.50 for generics and $6.50 for brands.

It is important that you confer with all beneficiaries that have EPIC, since EPIC is undergoing dramatic changes for 2012. A Medicare beneficiary that is eligible for EPIC should be enrolled in a Part D plan that has no deductible since EPIC will not fund any prescription costs toward the deductible for 2012. EPIC participants will be given until December 31st, 2011 to enroll in a Medicare Part D plan. EPIC will pay for the medications during the donut hole.

GAP coverage for 2012 (Doughnut Hole) will be $3727.50. The Healthcare Reform Act will be enforced as follows: 50% discount for brands and 14% discount for generics during the doughnut hole period.

As always I encourage all NYCPS Pharmacist to become familiar with the Medicare Part D 2012 changes which can be an asset to your community, ℞

Charles R. Catalano
Chairman NYCPS

PRESIDENT'S REPORT

from page 1

Over the past year, I have spent an enormous amount of time dealing with Operation AMMO, our Anti-Mandatory-Mail-Order project. As of this writing (October 2nd) the bill has yet to reach the governor's desk for his signature. You all have received via fax, computer, e-mail and wholesalers' invoices, directions as to contacting your legislators, asking them to call the governor on our behalf. We need everyone to follow up with this. If our AMMO legislation becomes law, each and every pharmacy owner will benefit.

We have just learned that the governor has vetoed the OMIG-reform legislation. However, in his veto message he state that he was "..directing the Medicaid Inspector General to conduct a thorough review of OMIG's policies and methods…", and also assigning a group to address the concerns raised in the bill by providers. Evidently the passage of the bill by both houses of the legislature alerted the governor to the over-reaching done by OMIG. We hope he's serious.

At the last NYCPS CE program, I mentioned the necessity for pharmacy owners to contribute to RxPAC of NY, which is the political action arm of the state society. Funds are dangerously low, and need to be replenished. Contributing to the political campaign chests of state legislators is probably the most effective way to get their attention. I repeat my suggestion that pharmacy owners should contribute $50 per month, per pharmacy to the PAC. That's not a lot, when you consider how many decisions are made by state legislators. Our PAC gives us the visibility that we sorely need.

There has been considerable talk about next June's PSSNY annual convention and trade show being held in NYC, for the first time in my memory. This will be an opportunity for pharmacy owners to more easily participate in PSSNY business meetings than previously, when the summer convention was always held at an upstate venue. At the same time, if it is moved to NYC, there will be no excuses for poor participation by NYC independent pharmacy owners, especially the members of the ethnic affiliates. Over the years, there have been a lot of people with much to say regarding the way the state society is run. Those people may now have the opportunity to "speak their minds" if we get the convention held here. This will also be an opportunity for us to exchange ideas. A change in venue for the convention will enable communication among us, to weather the many changes in our business.℞

Treasurer's Corner

Well the summer is over, September is here, and as we all get back into our normal routines. School starts and vacations are distant memories. We find the daily routine gets back to normal. Every September I also see come across my desk my renewal for NCPA and PSSNY membership. This is a reminder that we are all part of a bigger community, not isolated to the four walls that comprise our daily world.

As the treasurer of the New York City affiliate of PSSNY I get the figures of people who renew. The numbers remain consistent, but not anywhere near the total number of practicing pharmacists in New York City. What brought that out clearly was the attendance at our September 14th seminar. We ran the program with McKesson and McKesson customers were allowed to attend and get credit even if they were not NYCPS/PSSNY members. I was at the registration table and was amazed at the number of pharmacy owners, who were not members of our societies. I mean we are the only game in town, there is no other pharmacy society with the interests of community pharmacy in New York. There is no one else who will champion our issues.

I have been involved for the past 17 years out of self interest, the self interest of preserving my business and my livelihood. What got me involved was an organization that actually believed it represented its members. The society took on a megalithic provider and filed a class action law suit that actually succeeded in getting its members monies due them. The society has consistently worked to try and better the lot of the corner drug store. All of this for self interest ,not just for individual members, but for all the membership. This is most recently capped by the incredible drive by your President and Chairman, Ray Macioci and Charles Catalano to fight our biggest enemy, mandatory mail order. They have worked ceaselessly against what was considered insurmountable odds to get this bill to the governor's desk. What is even more amazing is they did it on their own time, as volunteers. If it is signed into law it will be the first such law in existence in any state.

So what has this got to do with membership? Only because we have support from a portion of the community pharmacists were we able to get this far. Although the society is an all volunteer organization, and its board works without compensation, we do have costs to get our issues heard above the voices of the opposition. The society hired its own lobbyist to bring our concerns to the legislature. We have been involved in all the discussions that impact your livelihood.

I have always said membership is the cost of a cup of coffee per day, now with the current cost of coffee, we are about the cost of 1/2 a cup of that same coffee per day. The cost of membership is minimal, the effect of your support is incalculable. We need to get more of those owners I saw two weeks ago to add their voice to those who have already realized the value to their own selfish interests. Everyday those membership dollars are working to keep you abreast issues that can make you more profitable. Again I am asking you to reach out to those you know who don't belong to join, allow the society to continue to work on your behalf.

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As we approach the month of October there is plenty of important changes taking place with New York Medicaid. By the time this edition of the newsletter reaches you, New York State will have moved 75% of their Medicaid population to the hands of managed care pharmacy benefit managers. At press time, we are uncertain as to how this transition will take place. To those of you who can remember back almost 6 years ago, the move to Medicare Part D is a distant and UGLY memory. We wonder if the move to NY Medicaid managed care will be of a similar vein.

There has been ongoing communications with the NYS Department of Health Office of Health Insurance programs (who manages the NYS Medicaid program) and your NYCPS and PSSNY leaders over these changes over the past several months. Additionally there was a meeting of the NYSDOH Pharmacy Advisory Committee (PAC) held on September 15, 2011 in Albany with the Medicaid officials and members of the pharmacy community to address recent issues, including audit practices, pharmacy swiping level concerns, poor reimbursement on state mandated generic rates of reimbursement for many multi source drugs, eligibility problems and other issues which affect the day to day pharmacy operations. As I reported in our last edition, Mr. Sheehan has been replaced as the New York Medicaid Inspector General by a former Health & Human Services Inspector General employee, James Cox. Will changes come to the OMIG under a new leader, we certainly hope so. Especially after learning that Governor Cuomo has officially vetoed widely supported OMIG REFORM legislation which had passed both the NYS Assembly and the NYS Senate without much of a fight.

Providers from all areas of health care were behind this reform legislation, with endorsement from over 600 various organizations and health care provider groups. We do hope that in spite of the veto of this legislation, many of the initiatives listed in the reform legislation can be promulgated by executive mandate and can still be enacted. Of course we need to see how Governor Cuomo and OMIG James Cox will work out the reforms that have been described in various circles of government.

Getting back to the discussions of the September 15, 2011 PAC Meeting we learned that the various New York Medicaid Managed Care health insurers(NYMMCHI) will have the right to declare a particular medication as a "specialty" medication. As a designated specialty drug, these NYMMCHI will have the ability to mandate that the patient receives these specialty medications exclusively from a designated specialty pharmacy provider. There is a one time only override permitted on this mandatory use of a specialty pharmacy provider. Interestingly, the statute which authorized the transition to NYMMCHI also has language that provides for use of mail order pharmacy delivery of maintenance medications. The legislative language written into law allows for a community pharmacy to demand a contract to handle the maintenance drugs designated for mail order so long as the community pharmacy accepts the reimbursement that the mail order pharmacy is paid. The curve ball that I see coming the way of community pharmacies is the following: I expect that the various PBM's will call all the maintenance drugs as "Specialty Drugs" as there is no written definition of a specialty drugs and only a handful if any will be considered maintenance drugs. This "play on words" appears to be a ploy pulled off by those PBM lobbyists that influenced the governor a short time before the passage of the State budget which included this move to managed care, was approved.

These changes coming about in October are huge and very significant. Access to durable medical equipment, over the counter supplies and brand named medications will all be thrown upside down with restrictive formularies and one time only non formulary dispensings. If you have any problems with theNYMMCHI, please call both the NYCPS hotline at 212 616 7086, and also please call the PSSNY office at 800 632 8822. We need to be vigilant and care for the Medicaid patients in their dispensing needs.

Jim Schiffer

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Contemplating these activities?

- Sale of your pharmacy to a key employee?
- Transfer of pharmacy ownership to a family member?
- Sale of your prescription files/inventory to a chain?
- Sale of your pharmacy to an unnamed outside buyer?

If you answered "Yes" to any of these questions, you owe it to yourself to have a confidential, no obligation conversation with one of our associates. In order to proceed effectively with any of these activities, ask yourself:

- Do you know the fair market value of your pharmacy to any or all of the parties mentioned above?
- Are you aware that your pharmacy has different values, depending upon who the prospective purchaser might be?
- Do you understand all the issues, legal, financial and operational, that must be dealt with in order to transfer the ownership of your pharmacy to any of these entities?
- Do you know what kind of documentation is required to satisfy prospective buyers as regards the value of your pharmacy?

Planning on selling your pharmacy?

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New Survey Reveals Pharmacists Are Struggling With PBM Audits and Reimbursement Practices

We recently surveyed our members about their pharmacy benefit manager (PBM) audits and Maximum Allowable Cost (MAC) reimbursement experiences. We have heard that PBM audits, rather than concentrating on fraud, severely punish pharmacies for trivial issues. Moreover, pharmacies lose money because PBMs arbitrarily lower and belatedly raise the MAC pricing in response to generic drug cost increases.

The survey must have struck a nerve. While a similar survey last year generated about 100 responses; this year the number of responses swelled to 1,850. The answers paint a stark picture of independent community pharmacists enduring time-consuming and unfair tactics by PBMs.

So what did the survey results reveal? Compliance with excessive audits is an enormous challenge. Some 62 percent considered the requirements to be inconsistent from one health plan to another; 48 percent report auditors asking them to justify claims that are two years old or older; 81 percent describe the audit process as burdensome and unsatisfactory; and 98 percent say PBM recordkeeping requirements go beyond state and federal law and that even minor instances of noncompliance are harshly penalized by commission-driven auditors.

There is an utter lack of transparency and timeliness with MAC pricing. About 91 percent report receiving little or no information justifying how PBMs arrive at reimbursement rates for generic drugs and how often the prices will be updated to reflect a pharmacy's cost; 71 percent of pharmacists tried to use the PBM's appeals process when they believed that the reimbursements did not reflect the pharmacy's costs; and many complained about the one-sided nature of the appeals process and noted that MAC-based reimbursement can take months to increase after drug costs spike (and is never done retroactively), but is reduced immediately when prices go down.

But the most sobering statistics for independent community pharmacists is that when asked how PBM reimbursement and auditing practices affect their ability to provide patient care and remain in business, 97 percent said it was a significant or very significant factor.

The survey also included first-hand accounts, such as these:

During a post-audit conversation with the auditor, I was told that there were only 4 claims with which he had found any problems and being of such a minor nature, they could be easily addressed so as not to be penalized. When the summary of the audit arrived weeks later, there were multiple claims that were not initially flagged as being part of the audit, nor discussed post-audit, which were listed as being in violation of some obscure PBM policy. Payment for those claims would be reversed, and there was no recourse on our part to even appeal the ruling. Upon examining the prescriptions in question, there was NO apparent reason for the PBM's ruling. They simply stole money from my pharmacy.

MAC prices on generics that triple in price overnight are not updated for several months. That means we lose dollars on each Rx for several months. The PBM will NEVER go back to the date the generic actually increased in price and reimburse the difference. We are just expected to absorb the cost.

With this system run amok, now is the time to urge the U.S. Congress to pass the companion bills S.1058 and H.R. 1971, The Pharmacy Competition and Consumer Choice Act. This legislation would help ensure PBM auditing practices focus on the rare cases of true problems rather than administrative and technical errors. It also would require that PBMs reveal their sources for MACs. Often members of Congress and their staff, before taking legislative action, ask for evidence justifying a group's concerns. This survey is validation for our arguments. Let's keep the pressure up.

By B. Douglas Hoey, PD, MBA,
NCPA Executive Vice President and CEO

WHERE HAVE YOU GONE, PERRY?

This series, Pharmacy and the Law, is presented by Pharmacists Mutual Insurance Company and the New York City Pharmacists Society through Pharmacy Marketing Group, Inc., a company dedicated to providing quality products and services to the pharmacy community.

Do you remember Perry Mason? How about Matlock? OK then, Denny Crane? Depending on your age, you should be familiar with at least one of these famous TV attorneys and their courtroom performances. This makes for entertaining TV, but in real life, the story is a little bit different. In most jurisdictions, the number of civil cases filed has been steady or increasing, but the number of trials has been decreasing. Why is this so?

The first reason is the discovery process. Discovery is the phase of the litigation process where the opponents share or exchange information and evidence. This includes documents, oral testimony (depositions), and written questions & answers (interrogatories). This exchange is mandated by the court rules. When discovery is complete, both parties should have all of the information that they need to evaluate the case and evaluate their chances of prevailing at trial. This typically makes at least one party reluctant to take the case to trial because they know what their chances are. No more surprise piece of evidence or last minute, surprise witness. These Perry Mason staples are virtually unheard of today. There are still some surprises at trial, but they tend to be smaller issues rather than earth-shattering ones.

The second reason is alternative dispute resolution (ADR). This ADR is different from the acronym that pharmacists are familiar with. ADR in the legal sense is a process of resolving cases without a trial. The most common forms are arbitration and mediation. In arbitration, the issues are presented to a neutral arbitrator who issues a ruling on the case. The process is greatly streamlined from that of a trial. For instance, in most cases, arbitration will not have live witness testimony. It is quicker and less expensive than a trial. The ruling can be binding or non-binding. In the non-binding situation, the parties can evaluate the ruling and compare it to their own predictions, but are not forced to accept it. Binding arbitration is considered a final ruling.

Mediation has no third party decision maker. A neutral mediator

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ANATOMY OF A STOCK CHART PART 2

Did you know it was Thomas Edison who invented the ticker tape in 1869? The ticker tape made chart analysis possible as we know it today. The pioneers of the stock charts took stock prices off the ticker tape to record them on a graph. The different art forms of stock charts have changed over the years, but the basic data used has not. Price, Volume and time are the most important components of the data available. There are many different ways of charting the data and the most popular form of charting data is the candlestick as show below.

The chart above represents a daily chart. Each candle shows the open, high, low and close, for one day. In one glance you study the action of a particular stock in one day. Put the daily chart in a three, six or one year span and you can see the stock's progression. It's like a symphony. The open, high, low, and close are also shown on the top of the chart. Other criteria, such as volume, price change, and % of the price change also are show on the top in most stock charts. The price change in the stock price is based on the prior day's close. The time of the chart is also a big and important factor; the same stock can be shown in a weekly, monthly and intraday. Intraday means data reflecting the movement of a stock price anywhere from a one minute chart to a four hour chart during the day. Many day traders use intraday charts. By studying the chart above you will get a good perspective on how the stock is doing now in relation to the previous time and what the possible future prices will be in a short term, intermediate term and long term. Volume plays a very important factor in chart analysis of a stock. A good chartist can determine the price direction by looking at the volume on a particular day or week, or even intraday.

It's the combination of price, volume and time that forms an important picture by a graph that a chartist can use to determine the future of the stock price, by analyzing the trend and the strength behind the trend. He can also compare this strength to the market index such as the Dow Jones Average. This is called Relative strength which I discussed in a previous article.

There is a way of forming a relationship between the data of price, volume and time into a formula by using indicators. It gives the chartist a perspective of what is really happening to the price of a stock. Is the trend up, down or sideways? Is the momentum of the stock up or down? Indicators reflect any changes in trend or momentum of a stock. However, be aware that they are only tools that you should use in the general perspective of the market in the USA and the entire world. Do I need to tell you the world economy and particularly Greece and Spain has an effect on our country's stock prices?

The most common and popular indicator is the moving average. A moving average smoothes out the price of a stock over time. An example is the 50 day moving average which many professional traders follow. It's the average of the price of the stock over the last 50 days. When the 51st day is reached the first price is dropped and the latest close price is added on. Then the 50 days of pricing is added up and subtracted by 50 which results in the average price over the last 50 days. Most computer programs compute this automatically.

Analysis is performed from different variations of the moving averages and the way they correspond to each other. As an example- if the 10 day moving average crosses and above the 30 day moving average that is considered bullish, and of course when the 10 day moving average crosses below the 30 moving average that is considered bearish. Remember 2008? The 50 day moving average crossed below the 200 day moving average when the index was about 1500 and the index dropped all the way down to 666 in March of 2009. Usually you would use the 50 and 200 day MA for long term trading when you are a long term investor, and the 20 and 30 day MA when you are a short term investor. Many analysts sell a stock when it falls below the 50 day or 200 day MA.

Another favorite indicator is the MACD which stands for "Moving Average Convergence Divergence" which is a mouth full. It's really simple. It uses the 12 day MA and 26 day MA, and the MACD line is the difference between the two. Then the 9 day moving average of the difference or the MACD line is plotted. This is called the signal line. It is bullish when the MACD line crosses above the Signal line. It's more important to understand and interpret the graph itself than remembering the definitions.

A good site to really learn about this popular technical indicator is: http://stockcharts.com. Click on CHARTSCHOOL and type MACD in Site Search. I will continue with other technical indicators in the next newsletter.

Happy Investing

James A. De Franco, R.Ph.
Executive Director NYCPS
Organizer
Long Island Stock Traders Meetup Group

The NCPA Report

Ensuring Proper Use of Medications is the Right Prescription for Better Health

Medication adherence, or ensuring the proper use of medication, is a serious and growing problem, particularly with older Americans. It not only has serious health consequences, it's also a major contributor to rising health-care costs. Ten years ago, the costs of non-adherence – such as hospitalizations and other costly medical treatments – was estimated to be $177 billion annually, according to researchers Ernst and Grizzle of the University of Arizona's College of Pharmacy. In 2009, the research group NEHI released a study estimating the potential costs to be as high as a staggering $290 billion each year.

That's roughly 13% of all U.S. health care costs – about the same amount that Americans spend on prescription drugs. Put another way, for every dollar spent on prescription drugs, we pay another dollar treating the problems resulting from their improper use.

Community pharmacists play a vital role in maximizing both the health and economic benefits of adhering to prescribed medication regimens and reining in the soaring costs of non-adherence. Recognizing this, U.S. Senators Kay Hagan (D-N.C.), Sherrod Brown (D-Ohio), Al Franken (D-Minn.) and Tim Johnson (D-S.D.) and Representatives Cathy McMorris Rodgers (R-Wash.) and Mike Ross (D-Ark.) have introduced critical legislation that would help to reduce health care costs and improve patient outcomes by making more patients eligible for Medication Therapy Management, or MTM, in the Medicare Part D prescription drug benefit. Presently, eligibility for MTM services is restricted to a subset of Medicare beneficiaries suffering from multiple chronic conditions, such as diabetes, high blood pressure or heart disease. This legislation wisely expands Medicare coverage to any beneficiary battling a chronic condition.

Through MTM, a pharmacist works directly with a patient to personally review their complete medication regimen. These sessions allow patients to get the most out of their medications, ensure they fully utilize cost-saving generic drugs where appropriate, and head off any interactions or other problems that can cause unnecessary health concerns and lead to expensive medical interventions. That's why this legislation has the strong support of the National Community Pharmacists Association as well as the National Association of Chain Drug Stores.

There is growing body of evidence demonstrates both the money-saving power of Medication Therapy Management as well as the real need for these services. In Minnesota, patients enrolled in an MTM program experienced a reduction in health care costs from $11,965 to $8,197 – a return on investment of 12:1 – according to the American Pharmacists Association. In Senator Hagan's home state of North Carolina, Kerr Drug found that MTM programs helping seniors with Medicare can save upwards of eight dollars for every one dollar invested. As Kerr Drug has noted, a state initiative known as ChecKmeds, that predated Medicare MTM, enlists 500 community and retail pharmacists. Through the end of June 2010, they served 31,191 patients and achieved an estimated, cumulative cost savings of $34 million – well in excess of program outlays.

Moreover, a study published in the Journal of the American Pharmacists Association concluded that pharmacist-provided MTM services are more effective than mass mailings and other forms of MTM. And a new analysis released by the National Pharmaceutical Council argues that better health outcomes, whether through face-to-face MTM or other means, produce additional savings in other areas including workforce productivity, limited absences due to health and enhanced quality of life for employees and their families.

Community pharmacists are among America's most accessible and most trusted health care providers. We're able to work directly with patients to help them stay healthy through effective use of their medicines while also avoiding costly medical complications. This bipartisan legislation to expand Medicare's coverage of Medication Therapy Management services is the right prescription for reducing care costs and improving health outcomes.

Executive Vice President and CEO National Community Pharmacists Association

NEW MAILING ADDRESS

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Jim Schiffer reporting...

News from Around The Pharmacy World

SEPTEMBER 2011 EDITION

PBMs Update

The entire pharmacy world is watching to see if the Federal Trade Commission (FTC) will block the proposed merger of Express Scripts and Medco Health. If this merger is allowed to go through as planned, it will certainly stifle the ability of community pharmacies to serve their patient population. The FTC has taken a tough look at another merger that of the cell phone industry, between ATT and T-Mobile. While many experts in the telecommunications industry felt that the merger between ATT and T-Mobile was a certainty, we have seen otherwise. The folks at FTC are looking closely at documents provided by the attorneys for both sides which are supposedly favoring the merger. However it seems that someone from ATT gave false or misleading information regarding the cost of expanding the ATT cell tower strength and network which shook up the FTC folks because the numbers quoted in this report were significantly different and lower than the costs which were attached to the merger of ATT and T-Mobile. The reason that ATT allegedly wanted to merge with T-Mobile was to save money on expanding their cell network. So if a report exists regarding the lower costs of expansion if the companies do not merge then why two companies would merge except to decrease competition?

Looking at the lessons of the ATT/T-Mobile merger request, we need to take a lesson from this and then make the same argument with Express Scripts and Medco. The two PBM's will not save money to the consumers of pharmacy benefits, but will extract more profits to line their pockets.

Walgreens War with Express Scripts

While Express Scripts and Medco are trying to tie the knot, Walgreens is attempting to divorce themselves from Express Scripts. It appears that Walgreens is, at least for now talking the talk that they will discontinue filling Express Scripts prescriptions effective January 1, 2012. This is a very real gutsy move by Walgreens but, as all parties have noticed in past threatened action of this nature, that the PBM gorillas are getting bigger and meaner. This also means that if Walgreen's with over 7,000 retail outlets (and related buying power) cannot make money on Express Scripts prescriptions how can you in your mom and pop operation? Walgreens is now a defendant in a suit brought by none other than Express Scripts alleging false advertising by the national pharmacy chain. Express Scripts asked a federal court judge to grant an injunction to stop Walgreen from making what is considered false and misleading statements that are intended to persuade Express Scripts members (actually sponsoring groups) to switch over to health plans that include Walgreens in their networks. As part of the Walgreens offense, Walgreens has launched a website identified as www.ichoosewalgreens.com. When an individual goes to the website, the individual selects what particular form of Rx Coverage through Express Scripts they have and then the patient is encouraged to drop out of health plans that are clients of Express Scripts. There is also a spot on the site for members of the TriCare Plan, which is the Department of Defense employees health plan, to sign an electronic petition to support Walgreens continued participation in the TriCare program. This is getting dirty, and getting interesting. Some industry analysts predict a last minute settlement around 11 30 PM on December 31, 2011 between the parties. Time will tell. Also what happens if Walgreens does drop Express Scripts, and Express Scripts does complete their intended merger with Medco? What a mess that will mean. Stay tuned for the continued fireworks.

PHARMACEUTICAL DATA MINING ALLOWED BY US SUPREME COURT

Over the summer the United States Supreme Court handed down

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AROUND THE PHARMACY

FROM PAGE 12

a very controversial ruling having to do with the pharmaceutical industry detailing of doctors and other health care practitioners and the marketing data that goes along with such marketing. What was a victory this was for the big Pharma and the folks like IMS and other data mining companies. The United States Supreme Court struck down a Vermont statute which attempted to curb the practice of pharmacies selling the prescription sales activity data to data mining companies containing specific information on the Vermont medical community's breakdown of what drugs were prescribed by which doctor. In this case it focused on commercial free speech, a variation of the traditional freedom of speech found in our United States Constitution. The struck down Vermont law would have greatly restricted the way data mining would be conducted in Vermont medical practices, but the US Supreme Court in a 6-3 vote held such a law would be unconstitutional. The main reason for the decision was a fear that a restriction of this nature would severely hamper free speech, especially the commercial type. In spite of what many folks traditionally believe which is that most doctors find annoying the manner in which pharmaceutical representatives promote products and track dispensing habits. The purpose of the now struck down law was to prevent the pharmaceutical industry from convincing doctors to prescribe more expensive products for their respective patients to use. Justice Anthony Kennedy wrote that, "While Vermont's goals of lowering the costs of medical services and promoting public health may be proper, (the contested law) does not advance them in a permissible way." It seems that throughout the United States, pharmacies (especially the chain operations) sell their prescription data which identifies the prescriber and drugs dispensed at the request of specific prescribers to drug companies, who then use the work of data-mining companies to review the data for the names of prescribers whom the pharmaceutical manufacturers should target for direct sales pitches.

Vermont's law was a simple solution to this problem. The Vermont law sought to prohibit pharmacies from selling the information to drug companies for marketing purposes and to prevent data reviewers or "detailers" from using the data obtained from the pharmacies to sell more drugs. There was an exemption in the now struck down law to let healthcare researchers buy the information for research purposes.

The majority of justices on the US Supreme Court held that limiting the sale of the data on prescribers and the use of such data by marketers and drug firms inappropriately limited free-speech rights on the grounds that Vermont's lawmakers disagreed with the content of the speech. "If pharmaceutical marketing affects treatment decisions, it can do so only because it is persuasive," the majority opinion says. "Fear that speech might persuade provides no lawful basis for quieting it." The Vermont law had support from three editors of the New England Journal of Medicine. "As medical journal editors committed to the open communication of medical knowledge, we are strong proponents of First Amendment protection for speakers who attempt to communicate important evidence-based health information or advocate for patients' and physicians' rights," these editors are quoted they continued, "This undesirable practice is nothing more than commercial conduct—not speech—and it is not in the best interest of the health of the American people." Nevertheless, I was not surprised by this decision and I expected this law to be struck down as the issue of free speech is a major one and if we want to ban such commercial use of free speech, we would probably need a congressional law to so direct. By trying to do something at the state level, I believe this law was bound to fail.

Direct to Consumer Advertising

Another sensitive issue is the constant flow of advertising we see all the time about various prescription products, from Nexium for your stomach to Viagra for your sex life. How many times do you hear about the purple pill or ED? I remember "ET" was the name of a mild mannered science fiction movie nearly 30

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MEDICATION SAFETY • PREVENTING ERRORS

By the Institute for Safe Medication Practices
Have you experienced a medication error or close call? Report such incidents in confidence to the USP—ISMP Medication Errors Reporting (MER) Program at 1-800-fail-safe to activate an alert system that reaches manufacturers, the medical community, and FDA. Your information may also be published anonymously to alert professional colleagues.

WHOSE PATCH? WHAT PATCH?

Daytrana–not a "special Band-Aid." Even when affixed properly, children may remove medication patches and possibly share them with others. In fact, ISMP learned of such an event. A kindergarten student who had been prescribed DAYTRANA (methylphenidate transdermal system), used to treat attention deficit hyperactivity disorder (ADHD), removed his patch and asked a friend at school "Would you like to wear my special Band-Aid?" When the friend said yes, the student applied the patch to his friend's skin. The patch remained on the second student for several hours until a teacher became aware of the event. Thankfully, no harm occurred to either child. We may not think of school students commonly taking medications for chronic conditions. However, ongoing medication use to treat conditions such as ADHD and asthma is not rare. It is critical that healthcare practitioners teach parents to share information about their child's medications with the child and school staff. Parents should instruct their child that a medication patch is not to be removed or shared. Parents should never refer to medications as Band-Aids or candy because representing medicines as other products promotes misuse and sharing. Remind children that they should never take a medicine unless an authorized adult gives it to them.

Anonymous patches. Nurses and pharmacists have reported that CATAPRES (clonidine) patches present problems because the manufacturer does not print the name or strength of the drug on the patch itself. The patches are available in a variety of strengths and are worn for a week at a time. Problems are often reported, especially if the dose of a drug delivered via patch is changed, or if the patient requires multiple patches. Long-term care settings seem to be particularly vulnerable to problems using this product. Because the

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NEWS AROUND THE WORLD:

FROM PAGE 13

years ago when erectile dysfunction was not even a medical condition. I read an article in the Wall Street Journal about the effect of marketing on prescription decision making. According to a study prepared by UCLA Medical Center along with other medical centers (the "UCLA Study") back in 2007, the average American TV viewer sees over 1,000 prescription drug ads over the course of a year. The study continued to analyze such advertising. The UCLA Study also found that the large majority of these television ads fail to fulfill the education purpose. Additionally, the UCLA Study found that the average American is inundated with 16 hours of drugs ads over that one year period, and it is stated that the average American does not even spend nearly as much time with their health care professionals over the course of a year. Nevertheless, these ads clearly are effective in selling drugs. Then the United States House Energy and Commerce Committee (the "House") analyzed another aspect of direct to consumer advertising, that was the return on the dollar for such ads. The House found that for every $1,000 spent by the drug industry for direct to consumer advertising, that investment of $1,000 translated into 24 new prescriptions. Dartmouth Institute for Health Policy and Clinical Practice (the "Dartmouth Study") did another study, this one directed at impact on print drugs ads on patient preferences. The subjects of this study had one of two possible ads, the original drug ads run by the drug industry or a altered ad which clarified the drug brief summary which appears at the end of the ad and instead of the traditional information, this group was given a "Drug Facts Box" which was intended to draw the actual drug value in a clear and accessible fashion. The Dartmouth Study found that two thirds of the individuals that saw the original ads overestimated the real benefit of the proposed therapy was ten times more effective that it actually was. In the meantime, 75% of those individuals who received the altered ad which contained the drugs facts box correctly assed the actual benefit of the drug therapy. What do these three studies tell you about Direct to Consumer Ads? My explanation of these ads are that they are confusing, they are somewhat misleading and they are driving up the costs of health care by having patients demand particular drugs (with a high price tag) over other generic or more economically valued medications. For instance generic Ciprofloxin is a decent quinolone antibiotic as compared to a newer generation quinolone product.

Obama Health Care Reform

It appears that the massive health care reform package is headed to the United States Supreme Court for a review from head to toe. We are uncertain whether or not the law as we see it today will remain on the books. My prediction is that most if not all of the law will be upheld. It seems that the White House staff made a decision not to have the various appellate courts maneuver around the particular regional challenges to this massive re-write of health care legislation. The President and his staff would rather have a spring 2012 decision by the US Supreme Court finally determine if this law is legal pursuant to our United States Constitution. A new wrinkle in this review process is the report that Supreme Court Justice Clarence Thomas has failed to disclose for nearly 6 years that his wife is the beneficiary of consulting work for the insurance industry lobby. Additionally, Justice Thomas had taken an all expenses paid trip in 2008 to Palm Springs for four days to make a speech with money that he says came from a conservative legal group but that may have actually come from the controversial company Koch Industries. What is the big deal about Koch Industries? Back in 2010 the Supreme Court overturned limitations on corporate political spending in a controversial case known as Citizens United v. FEC. The Koches —happen to be staunch fiscal conservatives who own an energy conglomerate — since the 5-4 decision in their favor, have run wild with that new freedom, so the group known as Common Cause argues that if it had been disclosed about the travel arrangements for Thomas, then Thomas should have disqualified himself from ruling in Citizens United. (Had Thomas recused himself the 5-4 decision would have been a 4-4 tie and the lower court decision against corporate political donations would have remained intact.) Should Justice Thomas recuse himself regarding the Health Care reform? From what we see he probably should. Will he? Who knows??

The biggest risk of the health care reform being overturned is the aspect of the reform which is known as the individual mandate. That part of the reform requires all Americans to obtain health insurance. There is a penalty which is associated with failure to obtain such insurance. There are many republicans, and tea party individuals who protest the concept of a mandatory insurance requirement. What I did not know is that the concept of an individual mandate first surfaced some time ago during the push for health care reform and the concept of mandating health care insurance has been the brainchild of a republican idea. Now, not one republican wants to own up to it. The President firmly believes that the constitution provides for such individual mandate as a regulation from his advisors interpretation of the Commerce Clause where the federal government has broad powers over interstate commerce. Hopefully we will see where this national debate ends up in a few months.

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NHPI and HIEs:

from page 1

cards show the NHPI instead of the current issuer identification, and that the BIN and PCN continue to be shown as well.

Where it may become a little complicated is with coordination of benefits and the information that is transmitted to the pharmacy from the primary payer. If there is a secondary payer involved and the primary knows this, will the primary be required to send the NHPI rather than the BIN and PCN for routing of the secondary claim? If this is the case, the pharmacy will need a way of getting the BIN and PCN for that plan, assuming CMS will recognize the BIN and PCN for routing pharmacy claims. We will just have to wait for the proposed rule to see where CMS goes with all this.

The other presentation was on health information exchanges (HIEs). The speaker was responsible for formation and implementation of the Delaware Health Information Network, the first operational statewide clinical health information exchange in the country. While the concept of an HIE might seem pretty straightforward, getting one started is not as easy as it sounds. Selling the stakeholders on the benefits is the first hurdle. There are issues with patient matching when data is being shared. There are interoperability issues when different standards and codes are used. Then there is the cost associated with participation in order to provide operating revenue for the exchange.

What I found interesting is that community pharmacy is not represented in this HIE. One reason is the developers of the HIE didn't want to build point-to-point interfaces with each pharmacy. Moreover, the HIE is gaining access to prescriptions from a third-party aggregator, which includes prescriptions being fed to it from Surescripts.

Getting prescription information from other sources certainly lessens the motivation to press for pharmacy participation. However, pharmacy would benefit from having access to lab test results and diagnoses, two missing ingredients to round out medication therapy management.

But the cost to participate may be a barrier for pharmacy. There will have to be an equitable compensation model in place before pharmacy embraces clinical services in a big way and can justify the cost of participating in an HIE. Even though our survey for this issue's cover story found that chains are actively involved with MTM, I doubt this activity can be considered a profit center at this point in time. Bottom line: Until pharmacy sees solid revenue potential from MTM, I think we are going to see more lip service than action when it comes to participation in an HIE. CT℞

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Credit Card Processing Corner: How to call in a Code 10

If during a credit card processing transaction you ever have doubts about the validity of the credit card presented to you for payment, a signature or even a customer's behavior – you can call in a Code 10. A Code 10 is a unique term that allows the merchant to inform the authorization center of a possible fraudulent transaction without alerting the cardholder.

Here are the steps you will take when calling in a Code 10:

Dial the Voice Authorization Center with the credit card in hand, if possible. The Voice Authorization Center's number can be obtained from your processor. For members in the Retail Council's program, Global Payment Direct, Inc.'s authorization center number should be on a sticker attached to your terminal.

Inform the operator of a Code 10.

The operator will put you through to the correct person who will ask a series of "yes" or "no" questions. Answer these questions in a calm, normal tone of voice.

If the operator decides something is amiss, he or she will deny authorization.

The operator may request to speak with the cardholder to ask account information questions that only the true owner of the card would know.

If the operator asks you to retain the card, do so only if you feel safe.

A Code 10 can be used any time a merchant feels a transaction may not be legitimate, even if the transaction is approved or the customer already left the premises.

When to call in a Code 10:

When embossing on the card is illegible.

When the last few numbers are not embossed on the hologram, or if these numbers do not match the account number on the sales draft or at the POS device.

When there is no Bank Identification Number (BIN) above or below the first four digits.

When the name on the card does not match the signature or there is a misspelling.

When holograms are not clear or the picture in the hologram does not move.

When the card does not have an expiration date.

When the card does not start with the correct numeric digit – all Visa cards should start with the number four, all MasterCard cards with the number five, all Discover cards with the number six and American Express cards with the number three.

Be aware of cards that don't swipe – check these cards for other security features.

If a card does swipe, make sure the card number and the number that appears on the POS device match.

If the message is other than "approved" or "declined."

If you haven't considered joining the Retail Council's processing program, why not allow us to do a free, no-obligation savings analysis? We're typically able to save businesses money on this expense and we offer the added protection of a periodic review of statements through our Watchdog Program.

For a nominal dues payment, your membership in the Retail Council is a great complement to the continuing education and other services you receive through NYCPS and PSSNY. In addition to our competitive credit card processing service, the Council also has a great workers' compensation program, which can save pharmacies 50 percent or more on this mandatory insurance. More than 170 independent pharmacies in New York State are already participants because the savings is difficult to beat! ℞

You can learn more about the Retail Council and its verious programs by visiting www.retailcouncilnys.com or by contacting us at (800) 442-3589 or PSSNY@retailcouncilnys.com.

NOTICE TO MEMBERSHIP

OUR JOINT NYCPS/ PSSNY DUES WILL BE RAISED AS A RESULT OF PSSNY RAISING THEIR SHARE OF THE DUES STRUCTURE WHICH WILL BE EFFECTIVE JANUARY 1, 2012

THE FOLLOWING SCHEDULE WILL APPLY AND WILL BE EFFECTIVE WITH ALL RENEWALS TAKING EFFECTIVE JANUARY 1, 2012 OR LATER:

PHARMACIST OWNERS $400
PHARMACIST NON OWNERS $325
RETIRED PHARMACISTS $250
NON PHARMACISTS ASSOCIATE MEMBERS $275

2011 LEGAL WAR CHEST UPDATE

For the past six years, The New York City Pharmacists Society has had a Legal War Chest to fund the local battles that we as community pharmacists fight by ourselves day after day. We have fought various battles including some with our elected officials, the OMIG, PBM's, and other foes of community pharmacy. Back in 2008 we were successful in convincing HIP of New York that they should not recover payments made to pharmacies based on allegations of overpayments that went back to 2006. That effort took time and resources of NYCPS. Additionally we have educated elected officials in Albany and New York City about the shortcomings that are affecting both patients and pharmacies the way PBM's make payments to pharmacies. We are fighting for our survival. This fund is separate from the existing PSSNY Legal Defense Fund which is being utilized to fund the ongoing PSSNY Medicaid dispute over their audit practices.

By supporting the NYCPS Legal War Chest, we will be enabled to fight the fight for survival in this dog eat dog health care environment. Thanks to the generosity of our members this fund continues to grow. We ask for your support during these difficult times for our profession.

As we see the outrageous tactics and actions of the PBM in their contracts, their administration of Medicare Part D and also we see the erosion of our patients due to mandatory mail order contracts and the reduction of our levels of reimbursement due to the newly formed Medicare Part D Contracts. At this time more than ever, we truly need a strong professional voice to fight for our concerns. Please join us in these necessary struggles.

Enclosed we are sharing the Final List for 2010 as well as for 2009 and 2008. See if your name and pharmacy are posted. As we start this New Year 2011 we have plenty of problems to deal with, and we need your help. We will continue to publish past years donations as space permits.—the list is done alphabetically, not in order of receipt or donation amount. (All new contributions will have an asterisk *).

Final List of Donations for 2009

Rao Alturi, Atluri/Laconia Pharmacy Inc .... *$500.*
Khalid Amin, Audobon Pharmacy *$300*
Robert Annicharico, Delco Drugs & Specialty Pharmacy *$250*
Chris Aprile, Thriftway 10th Ave. Drug Corp. *$350*
Samsul Bakar, Kings Bronx Inc *$200*
Robert J. Baker, SBC RX/Thriftway Pharmacy *$350*
Robert J. Baker, Thriftway-Kings Highway Pharmacy *$350*
Charles Catalano, C&D Drug Corp. *$2,500*
Joseph M. Ciol, J&C Pharmacy *$350*
James Detura, Melrose Pharmacy *$5,000*
Ray & Dana Eisner, The Charles Pharmacy *$300*
John Kranjac, Marama Pharmacy *$1,000*
Steven Gelwan, Hosp Rx, Thriftway Pharmacy *$350*
Jagdeesh Gummella, Loisaida Rx Inc. *$500*
Martin Katz, Scarpa Pharmacy *$250*
Dominic Lettieri, Drug Mart Pharmacy Corp. *$500*
Joseph Locastro, Clinton Apothecary *$200*
Long Island Pharmacists Society (LIPS) *$3,000*
Suni Mandalapu, New Amsterdam Drug Mart *$300*
Murugan Naidu, Rite Choice Pharmacy *$500*
The Paganelli Family, Mt. Carmel Pharmacy *$1,500*
Alex Perchuk, STM RX/Thriftway Pharmacy *$350*
Alex Perchuk, STJ RX/Thriftway Pharmacy *$350*
Wendy & John Rossi, Rossi Pharmacy *$200*
Adam Siegel, Parkway Pharmacy *$500*
Bill Scheer, Scheer Drugs *$500*
James Schiffer, Jim & Phil's Family Pharmacy *$100*
*Russell Sherman, Esco Drug Co,** *$1000*
Nadira Singh, Thriftway Church Ave. Drug Corp *$350*
Michael Somma, Artis Drugs *$300*
Robert Spivack, employee of Pathmark Pharmacy *$100*
Lesly Thelemaque, Vanderveer/Thriftway Pharmacy *$350*
Yan Vilensky, Thriftway Flatbush Ave. Drug Corp *$350*
Alex Zatsepilo, Thriftway Foster Ave. Drug Corp. *$350*
Gilbert Zuckerman, Kenby Pharmacy *$300*
Our war chest total for 2009* *$23,650

Final Donations as of December 31, 2010

Mike Agovino, Sedgwick Pharmacy *$250*
Khalid Amin, Audobon Pharmacy *$350*
Narsinh Desai, Leroy Pharmacy *$500*
Jim Detura, Melrose Pharmacy *$5,000*
Roy and Dana Eisner, The Charles Pharmacy and Surgical *$300*
Keith Diamond, Dermer Pharmacy and Surgical *$525*
Michael Ferri, Kings HealthMart Pharmacy *$350*
Jagdeesh Gummella, Loisaida Rx Inc *$500*
Dominick Letteri, Drug Mart Pharmacy *$1,500*
Vincent Mazzamuto, Sedgwick Pharmacy *$250*
Syed Muzaffar, Prospect Ave. Pharmacy Inc. *$300*
Thomas Pelizza, Kinray *$500*
*Peter Patel, Mott Pharmacy & Surgical** *$500*
Stewart Rahr, Kinray *$5,000*
James Schiffer, Jim & Phil's Family Pharmacy *$200*
William Scheer, Scheer Drugs *$200*
Hasmukh Shah, Marin Pharmacy *$250*
Jeffrey Smith, Kinray .... *$500.*
Frank Wong, Rx Center *$2,000*
Final Total as of December 31, 2010* *$18,975

List of Donations as of September 2011

Dominick Amendola- Salzman Chemists *$100*
Jim Detura, Melrose Pharmacy *$5,000*
Jack Eaton, S Bros Pharmacy *$125*
Ray & Dava Eisner, The Charles Pharmacy *$300*
Anton Fallah, Best Care Pharmacy *$300*
Michael Ferri, Kings Health Mart Manhattan *$300*
Gerald Gold S Bros Pharmacy *$125*
Peter Lau, Confucius Pharmacy *$300*
Dominick Lettieri, Drug Mart Pharmacy *$1,500*
William Mantell, Variety/ Brothers Drug Corp *$125*
Michael Morelli, Arrow Pharmacy *$1,000*
*Naveen Parupalli Green Van Pharmacy ** *$100*
*Bill Scheer, Scheer Drugs ** *$1,000*
Jim Schiffer (formerly Jim & Phil's Family Pharmacy) *$200*
Russell Sherman, Esco Drug Co *$300*
Sam Scwhartz, Variety/ Brothers Drug Corp *$125*
Total for 2011 as of September 25, 2011* *$10,750

2011 Legal War Chest Coupon

The NYCPS Board of Directors appreciates the vote of confidence from our colleagues who have been making these contributions. Thanks you for this support! Can we count on you to join us in this fight to survive in 2011? If you have not already done so, please send in your contribution with the coupon below.

Yes, count me in; I want to contribute to the New York City Legal War Chest!

Name ______________________________

Pharmacy ______________________________ Donation Amount ____________

Address ______________________________

City, State ______________________________

Please send to: NYCPS Legal War Chest c\o Mr. William Scheer • 77 Louis Drive • Farmingdale, NY 11735

NEWS AROUND THE WORLD:

FROM PAGE 16

Drug Abuse Growing

I do not have to tell you that the abuse of controlled substances is growing by leaps and bounds. Now a new report has come out which describes the numbers in graphic detail.

Statistics from 2009, the latest year for which data are available, show that 37,485 people died of drug overdose that year, compared with 33,808 who were killed in traffic accidents, according to the Los Angeles Times. This data is from statistics from the Centers for Disease Control and Prevention and the National Highway Traffic Safety Administration. Analysts believe that there are two factors which have contributed to the trend. The first is about general traffic safety; people are driving more but dying less. The number of deaths per 100,000 automobile occupants fell nearly 23% between 1975 and 1992, and then dropped another 8.5% between 1992 and 2007. Between 2005 and 2009 alone, the overall number of deaths due to vehicle accidents fell by nearly 10,000.

Meanwhile, overdoses are constantly increasing. The death rate for drug overdoses rose 63% between 1999 and 2004, and then another it rose another 27% between 2007 and 2009. Most overdoses are related to using prescription painkillers like OxyContin and Vicodin, which users typically combined with alcohol or anti-anxiety drugs like Xanax. Deaths involving painkillers have increased more than 300% for the time between 1999 and 2006.

This trend appears to have its origin in the late 1990s and 2000s, when prescribers, pharmaceutical manufacturers and patient advocates pressed for increased access to pain-relieving drugs for patients with cancer and chronic pain, who were being severely undertreated. Analysts have found that this campaign did increase patients' access; for example, opioid prescriptions for Medicaid patients rose three-fold from 1996 to 2002.

It seems that the greater availability of these potent pain killing medications has had serious unintended side effects: first has been the increase in overdose deaths of adults, but also there has been an increase in the accidental poisonings of children. A recent study on child poisoning examined data on 544,133 children aged 5 or younger, who had been taken to the Emergency Room between 2001 and 2008 for swallowing drugs. In 95% of cases, the children had taken the drugs themselves. More than half of the cases involved prescription drugs rather than over-the-counter medications, and the most serious problems were associated with prescription opioids, sedatives and heart medications. Poisonings among children in this age group increased by 22%. A dangerous trend indeed. Bottom line, know your prescribers and know your patients.

Boeing's Philadelphia area Chinock Helicopter manufacturing facility was the location of a DEA raid in late September. Almost 40 individuals were arrested in this facility for the possession, with intent to sell and related distribution charges for sale of OxyContin, Alprazolam, Fentanyl and Actiq. There is a growing concern that the prescribers of this country need to be re-educated in the appropriate use of potent pain killing medication. The numbers of individuals who are hooked on mediations is a growing concern. We need to educate the prescribers so that we can eradicate the drug addicts from society.℞

Until next month,

Jim Schiffer
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RX AND THE LAW:

from page 9

works to get both sides to agree to a mutually acceptable settlement of the case. The mediator does that by moving between the parties, sharing information where necessary, and listening to the strengths and weaknesses of each side. If no agreement is reached, the parties move on in the litigation process. Nothing that is said or offered at a mediation is admissible at trial, so parties are motivated to be as open and honest as possible with the mediator. In many jurisdictions, at least one round of ADR is required before any case can go to trial. It is not uncommon for a judge to order the parties to a second, or even a third, mediation.

In today's legal environment, the possibility, or desirability, of trial is quite different from TV lawyers. They try a case almost every week. Non-TV lawyers might have as few as two or three civil trials per year. Some commentators have actually expressed concern that we don't have enough trials. Case law is built on appellate decisions and with fewer trials, there are fewer appeals. But with all of our cards on the table and court rules that favor ADR, we shouldn't be surprised that there are more settlements and fewer trials. Maybe that is a good thing because it puts the parties in control of the ultimate resolution of their case and reduces the emotional toll on the parties. It won't be as entertaining to watch Matlock take more depositions.℞

By Don. R. McGuire Jr., R.Ph., J.D.

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This article discusses general principles of law and risk management. It is not intended as legal advice. Pharmacists should consult their own attorneys and insurance companies for specific advice. Pharmacists should be familiar with the policies and procedures of their employers and insurance companies, and act accordingly.

WHOSE PATCH? WHAT PATCH?:

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Catapres patch does not contain the name of the drug, caregivers cannot determine the drug, the dose, or, in some cases, even distinguish it from adhesive bandages and specialty dressings. This can lead to errors. For example, a nurse could receive a new order for a clonidine patch or an oral dose of clonidine, and proceed to administer additional medication not realizing that the patient already has a clonidine patch affixed. Or, if the patient has a clonidine patch along with another unlabeled drug patch, the wrong patch can be removed and replaced with the same patch that remains on the patient. Another error-prone feature is the ability of Catapres' cover to be mistaken for the actual drug patch and applied to the skin. We contacted the manufacturer, Boehringer Ingelheim, and learned that they have no immediate plans to print the drug name and dose on the patch. We were also advised that the patch should not be written on because it is not known if volatile chemicals contained in ink might affect delivery of the drug. However, the manufacturer did note that the patch cover could be labeled and placed over the drug patch to protect it. There's also a code on each patch (see figure 1) that can be used to identify the strength: BI 33 designates a 0.3 mg patch, BI 32 is 0.2 mg, and BI 31 is a 0.1 mg patch. Share these codes when dispensing these patches. Educate patients about this issue. Inform them of the need to keep an accurate, up-to-date list of their medications, including the date each patch was applied. Long-term care pharmacies and facilities should consider attaching a notation about the code designation along with the inventory item so that dosing information appears on computer-generated medication administration records.

The danger with cutting medication patches

A physician instructed staff from a hospice healthcare agency to cut a 50 mcg/hour fentaNYL transdermal system patch and apply it to a patient to deliver a 25 mcg/hour dose. Soon thereafter, a visiting nurse discovered the cut patch, immediately removed it, and called the agency to notify the physician about the risk of an overdose with this practice, and to request a supply of 25 mcg/hour patches. Fortunately, the patient suffered no adverse effects; however, serious harm, including fatalities, has been reported under similar circumstances in which patients cut and applied a reservoir membrane fentaNYL patch to their skin, intending to reduce the dose but instead delivering an overdose.

In the US, several transdermal drug delivery systems exist:1

Reservoir membrane-modulated systems: The drug is contained in a reservoir between an impermeable backing layer and a rate-controlling microporous membrane. Drug release is controlled by the membrane. Cutting the patch makes the entire dose available immediately. An example of this type of system is DURAGESIC (fentaNYL).

Microreservoir systems: The drug is contained in multiple, smaller drug reservoirs. Cutting the patch destroys some of the reservoirs, although most remain intact. However, the number of reservoirs that remain may not be proportionate to the surface area of the patch. So, cutting a patch in half does not guarantee that the amount of drug in each half is equal. CATAPRES-TTS (cloNIDine) is an example of this system.

Drug-in-adhesive layer systems: The drug is homogeneously mixed with a polymer-based adhesive, which is applied to an impermeable backing. The amount of drug delivered is diffusion controlled and directly proportional to the surface area of the patch. Cutting the patch will decrease the amount of drug delivered without presenting a hazard. LIDODERM (lidocaine) patches fall into this category and can be safely cut to the desired size to deliver a smaller dose than the full patch.

Matrix systems: The drug is evenly distributed throughout a drug-in-adhesive matrix similar to that of the drug-in-adhesive layer system. Again, the amount of available drug is directly proportional to the surface area of the patch. Cutting the patch may be possible but may decrease the efficacy of the adhesive. An example of this type of system is VIVELLE-DOT (estradiol).

Most fentaNYL patches are available in a reservoir membrane-modulated system. Product labeling clearly notes that these patches should never be cut or altered prior to application. A fentaNYL transdermal matrix system patch is also available (Mylan); however, labeling for this product specifically warns users not to divide, cut, or damage the patch before application. No formal studies have been done to determine the clinical effectiveness of cut fentaNYL matrix patches. Thus, all types of fentaNYL transdermal patches should never be cut to titrate doses. Instead, prescribers should provide patients with a new prescription for a reduced strength of the patch. Patients should be warned about the risks associated with cutting patches, and instructed to properly dispose of higher-strength patches if a lower strength patch has been prescribed. For other products offered via a transdermal system, always refer to the package insert and follow the manufacturer's recommendations regarding the safety and efficacy of cutting patches.

References: 1) Ball AM, Smith KM. Optimizing transdermal drug therapy. Am J Health-Syst Pharm. July 15, 2008;65:1337-46.

Tapering or Increasing Doses

Many times pharmacies receive a prescription where the doctor is tapering or increasing the dose for the patient. These types of claims can be an easy recoupment for Third-Parties. Examples of this are:

Effexor XR 75mg #60 1 qd x7d, then 1 bid thereafter with 3 refills. If you dispense #60 for a 30 day supply in the first month, a Third-Party would recoup 7 capsules in an audit.

Vagifem 10mcg, #18, 1 qd x 2 weeks, then 1 biw with 3 refills. If you dispense #18 for a 28 day supply for the associated refills, a Third-Party would recoup 10 tablets in an audit.

PAAS recommends having two separate prescriptions in these situations. One Rx for the first month with the appropriate amount to dispense, and the second Rx for dispensing the proper quantity on the associated refills.

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DUES AUTOMATICALLY INCLUDES MEMBERSHIP IN THE PHARMACISTS SOCIETY OF THE STATE OF NEW YORK

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