

Rx Montana Pharmacy TODAY

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PO Box 1569 • Helena, MT 59624 • www.rxmt.org

MPA Member Get A Member Campaign

Winners can receive discounts, iPod touch

You chose MPA as your professional association—now help your colleagues do the same by participating in our **Member-Get-A-Member Campaign**. This campaign is the new MPA membership recruitment and rewards program running from December 20, 2010 to January 31, 2011. With great new incentives members are driven to recruit colleagues by sharing the value of their association membership! The MPA Member-Get-A-Member Campaign is intended to drive networking, drive professional development and drive participation in the association.

Reasons for getting others to participate in MPA:

- Great way to develop your professional network.
- Increasing your knowledge of pending pharmacy issues.
- Varied Leadership Opportunities.
- Influence the direction of the pharmacy profession
- Reduce the cost of receiving CE.

How the campaign works:

1. Sponsors should use the enclosed membership application to sign-up new members. You can also retrieve Member-Get-A-Member application by visiting the MPA website at www.rxmt.org or click on

the JOIN button. Eligible sponsors are current members who have paid their 2011 MPA dues.

2. Tell your peers and co-workers about MPA. Simply encourage them to fill out MPA's membership application or complete the application online. Be sure to include your name in the sponsor's name category on the enclosed application or in the cover e-mail when joining on-line.
3. Sponsors will be eligible to receive a \$25 dues credit on your 2012 membership renewal for each new member you join. After five referrals that join (prior to January 31, 2011) you earn free dues during the 2012 membership year. **If you join more than 5 members you will be eligible for 1 new 8 GB iPod touch.**
4. **This campaign only applies the three membership categories:** pharmacists, pharmacies and pharmacy technicians. Individuals and businesses that have never been an MPA member or in the last two fiscal years are eligible as non-members. To learn if someone is a member just e-mail us at info@rxmt.org.
5. The MPA Member-Get-A-Member Campaign will end on January 31, 2011. The grand prize winner will be announced shortly thereafter.

Attend the MPA Winter CE & Ski

January 14-16 at Fairmont Hot Springs

Registration material for the 2011 MPA Winter CE & Ski is available and we invite all pharmacy professionals to attend. **See back cover for more details.**



Pharmacists are people too

by Oriana Pawlyk,
2010 APhA Intern in Political Journalism

As January 1, 2014, approaches, pharmacists will be thinking about how to care for the 30 million Americans who will gain access to health insurance under provisions of the Affordable Care Act (ACA). But that is not all that will be on their minds; members of the profession will also be watching to see just how health care reform will affect their own health plans.

Most pharmacists are now employees of either big companies such as large chain pharmacies and hospitals, small businesses such as independent pharmacies, or their own companies. As such, many pharmacists must address the requirements of ACA from a professional perspective and determine what the requirements mean for them personally.

“At this time, it's too early to say or speculate how this legislation will benefit pharmacists as employees,” said Jim Cohn, Media Relations Manager at Walgreens. “However, we do believe that it will be good for patients and also good for pharmacy. We certainly support the guiding principles of the legislation—those being greater access, greater affordability, and higher quality of health care services.”

Changes: What and when?

The promises of ACA, as specified in the patient's bill of rights trumpeted by President Barack Obama when he signed health care reform into law, are that preexisting conditions and other limitations on health insurance will be removed, patients can keep their insurance and health care providers if they choose, and the “hidden” tax on insured Americans will be reduced.

But what the law and those promises mean for the individual is the source of considerable

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Short-Cycle Dispensing Defined

At the end of November, 2010 CMS released the proposed regulations to implement Section 3310 of the Affordable Care Act, which states that the Secretary shall require Part D sponsors to utilize specific, uniform dispensing techniques, as determined by the Secretary in consultation with relevant stakeholders, such as weekly, daily, or automated dose dispensing when dispensing covered Part D drugs to enrollees who reside in LTC facilities in order to reduce waste associated with 30-day fills. Below, you will find a brief outline of the proposed rules:

7-Day Dispensing for Brands: CMS will require all pharmacies servicing LTC facilities, including not only closed-door LTC pharmacies, but also retail pharmacies and mail order pharmacies that dispense to LTC facilities (this provision does not apply to settings such as group homes, assisted living facilities, ICFMRDDs, and IMDs), to dispense brand-name medications to patients in 7-day-or-less increments. CMS stated that they believe the more prudent course is to proceed with a partial versus a full implementation, and have chosen to simply encourage shortened dispensing intervals for generic drugs at present.

Exclusions: Drugs that are difficult to dispense in a 7-day-or-less supply and drugs that are dispensed for acute illnesses are exempted from the short-cycle requirement. Examples include: eye drops, ear drops, inhalers and inhalation drugs, nasal sprays, reconstituted antibiotics, parenterals, drugs that must remain in their original container, and topical medications.

Drug Disposal: CMS is requiring that your contracts with Part D plans include terms that require any unused drugs originally dispensed to Part D patients be returned to your pharmacy (not necessarily for

reuse) and reported to the Part D plan. Your contracts with the Part D plans must also address contractual obligations for disposal in accordance with Federal and State regulations, as well as whether return for credit and reuse is authorized where permitted under State law.

Dispensing Technique: Part D plans must permit your pharmacy to implement uniform dispensing techniques selected by each LTC facility, and may not require you to use a different packaging system or technology than that selected by you in collaboration with the facility.

Deliveries: CMS recognizes that for some of your pharmacies there will be changes in the way deliveries are made and not all of you will be able to justify hiring additional delivery drivers and purchasing additional delivery vehicles. In accordance with Chapter 5 of the Medicare Prescription Drug Benefit Manual and subject to any state law restrictions, your pharmacy may develop an agreement with a LTC facility to use a common carrier for some deliveries. CMS clarified that it does not consider a pharmacy making some but not all deliveries by common carrier to be a mail order pharmacy.

Reporting Waste: CMS believes that it is critical to obtain data to evaluate the relative efficiencies of different dispensing methodologies in the effort to reduce waste. To that end, CMS is establishing a new requirement in which Part D plans must collect and report to CMS the dispensing methodology used for each dispensing event. NCPDP is considering the adoption and transmission of specific codes on billing transactions that would facilitate the collection of this information by Part D plans.

Co-payments: Co-payment methodologies may vary depending on the types of billing

and dispensing methodologies used; however, copayments for LIS beneficiaries should be billed with the first or last dispensing event of the month.

Dispensing Fees: CMS also clarified the definition of “dispensing fees” by including the salaries of pharmacists and other pharmacy workers as reasonable costs for any pharmacy. Though CMS believes they are prohibited from intervening in negotiations between pharmacies and Part D plans, they state that it is reasonable to expect that dispensing fees be adjusted based on the newly proposed requirements. Dispensing fees should take into consideration the number of dispensing events in a billing cycle, the acquisition and maintenance costs associated with the type of dispensing methodology utilized, and with respect to Part D drugs dispensed in LTC facilities, the techniques to minimize the dispensing of drugs that go unused. Dispensing fees may also take into account restocking fees associated with return for credit and reuse in LTC pharmacies, when return for credit and reuse is permitted under State law and is allowed under the contract between the Part D sponsor and the pharmacy.

Timeline: Pursuant to the statute, these changes will take effect on January 1, 2012. However, a limited extension has been granted to independent community pharmacies (not closed door) that are the primary providers to a small LTC facility (less than 80 beds) in rural communities, as defined by the Bureau of the Census, where the pharmacy is not already dispensing a 7-day supply to any patient population in the LTC facility. These pharmacies may supply drugs in a 14-day-or-less supply until full compliance is required on January 1, 2013.

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Pharmacists are people too (continued from page 1)

consternation across America after the midterm elections in November. Most people assume that large employers—defined in the law as having more than 50 employees—are already offering health benefits and will continue to do so.

The red-letter date under ACA is January 1, 2014, by which large employers will need to provide health insurance or pay \$2,000 per full-time employee. But several important provisions kick in earlier—beginning next month. As companies reach their enrollment periods and new plan years begin on or after September 23, employers providing group health coverage must amend their benefits to add these provisions:

- No exclusion for preexisting conditions
- No revocation of coverage when an individual files a claim unless there is fraudulent activity and/or intentional falsification of facts
- Dependent coverage for adult children of employees until age 26
- Notification of employees beforehand if coverage is to be canceled
- Provision of 60 days' notice prior to any changes in employees' health coverage plans

In addition, employers offering new group health plans must include these provisions:

- Plans cannot discriminate in favor of highly compensated individuals.
- If a plan requires an employee to choose a primary care provider, it must permit employees to freely choose any participating primary care provider.
- Both in-network and out-of-network emergency care must be covered.

Employers will also be required to report the cost of health benefits on W-2 forms of employees for the first taxable year starting after December 31 of this year. Those amounts will be critical in 2018, when penalties begin on so-called “Cadillac plans.”

Nursing mothers

One little-noticed provision of ACA that has already taken effect requires employers to provide reasonable unpaid breaks for nursing mothers who need to express breast milk. Employees must be provided with access to a private break area shielded from intrusion by the public and coworkers during these breaks. In pharmacies with limited space and with limited pharmacist staffing, implementing these breaks may be challenging.

Under the federal law, employers are not required to compensate nursing mothers for these breaks, although about half the states have similar laws, and some of these require compensation. Businesses with fewer than 50 employees can be exempt from requiring these breaks if they cause difficulty in the workplace or are unduly expensive relative to the employer's resources.

'Even pharmacists have spending limits!'

For pharmacists who own or are working for small businesses, the effects of health care reform are much less certain. Because there is no penalty for the first 30 employees over the 50-employee threshold at which coverage is mandatory, companies with fewer than 80 workers don't really have to offer health benefits. Will they offer health benefits as the purchasing exchanges begin providing reasonably priced plans? Will competition with other employers prod them to provide health benefits? Or will they let employees get policies on their own?

“We anticipate that many plans and employers will progressively cost-shift the difference to employees, resulting in broader coverage but a net increased out-of-pocket cost for consumers,” said Dan Buffington, PharmD, MBA, who owns a pharmacology practice in Tampa that employs about 20 people. “We have always offered health benefits to our employees, but we are worried about the potential rise in base cost for benefits. In addition, as a small business employer, we are very concerned that the proposed tiered ‘tax credits’ for businesses employing either 50 and fewer or 25 and fewer will not sufficiently compensate or offset the escalating overhead associated

with ACA and with the future adjusted costs of providing health benefits.”

The Small Business Health Care Tax Credit Buffington referred to takes effect this year. It provides tax credits for small businesses if they cover at least half of health care costs and have low payrolls. A tax credit is money that comes straight off the tax obligation of the business. Because pharmacies typically have high average payrolls, many do not qualify for the tax credits.

Small businesses have also been at a disadvantage in procuring lower premiums for health plans. Brian Fulcher, BPharm, Manager of Realo Discount Drug in Greenville, NC, experienced that firsthand when he moved from one of the national chains to his current position.

“It's a shame that my true risk to the insurer did not change, but my rate doubled because my group buying power was lowered,” Fulcher told Today. “With higher deductibles and copayments, my family is more reluctant to pursue care. There is no question that this leads to a decrease in preventive care. Even pharmacists have spending limits! If our company could pool our buying power with other similar companies, then overall cost to the consumer could be reduced.”

Whether such “pooling” will happen under ACA and its insurance exchanges remains to be seen.

But more than the cost of insurance, Fulcher is worried about the effects of health care reform on pharmacy in general. “We should be careful not to allow payers alone to define the role of pharmacy or to decide how and when a service is provided,” he said. “Reducing the role of community pharmacists to [just a] commodity will cause outcomes to decline and long-term cost to increase. Studies such as the Asheville Project in diabetes certainly proved that better health and reduced cost occur with increased pharmacy services.”

Clearly, pharmacists have a lot to think about, both personally and professionally, as ACA moves forward.



Opioid-Dependence Treatment and Withdrawal

Abuse of opioid drugs is a widely occurring problem and ranges from injectable heroin use among addicts to prescription pain medication abuse among teenagers. A list of some abused opioid analgesics is provided in Table 1. Helping physically dependent patients withdraw from opioids can be difficult because of euphoria, cravings

Generic name	Example Brand Name
Morphine	MS Contin®
Codeine	Tylenol #3®
Heroin	
Hydromorphone	Dilaudid®
Oxymorphone	Opana®
Oxycodone	OxyContin®
Hydrocodone	Vicodin®
Dextromethorphan	Delsym®
Pentazocine	Talwin®
Meperidine	Demerol®
Fentanyl	Duragesic®
Methadone	Dolophine®
Propoxyphene	Darvon®
Buprenorphine	Subutex®
Butorphanol	Stadol®
Tramadol	Ultram®

and withdrawal symptoms commonly experienced by users of opioid medications. Tolerance to opioids is a consequence of repeated administration and can lead to physical dependence because users require larger doses or more potent formulations to experience the same euphoria, or “high”, initially felt with these drugs. Withdrawal symptoms result from acute or chronic opioid use and include influenza-like symptoms (i.e., fever, diaphoresis, etc.), piloerection, mydriasis, insomnia, nausea, vomiting, diarrhea, yawning, and rhinorrhea.

Treatment of opioid withdrawal can be initiated when patients have an acute opioid intoxication, withdrawal

symptoms, concomitant disease complications, a desire to stop using opioids, behavioral problems, or a history of relapse. The American Psychiatric Association suggests psychosocial therapy with positive reinforcement from family, friends, and the community in addition to medications indicated for withdrawal or dependence (see Table 2).

For acute opioid intoxication, opioid antagonists (i.e., naltrexone) and clonidine are useful. Opioid withdrawal can cause an excessive sympathetic nervous system response, which can lead to arrhythmias and pulmonary edema. Clonidine can help prevent these adverse responses and does not produce tolerance or dependence. Additionally, if an opioid antagonist is used, adjunctive clonidine helps to relieve rapid withdrawal symptoms and the aforementioned adrenergic responses.

Methadone, an opioid agonist, has been used in patients with a history of opioid dependence lasting greater than one year. It has been shown to decrease mortality, bloodborne infections, and opioid use during withdrawal. Methadone has a good analgesic effect, extended duration ($t_{1/2}$ =15-40 hours), and persistent effects with repeated administration. Tolerance to methadone develops more slowly than with morphine. Unfortunately, the analgesic effect of methadone is typically shorter than

its half-life, which consequently requires dosing every eight hours. Moreover, methadone use can put patients at risk of respiratory depression and QT prolongation. Some patients require chronic methadone therapy if they are unable to withdraw or habitually return to drug use. Usually, detoxification occurs gradually over 30 to 180 days.

Buprenorphine is a high affinity partial mu-receptor agonist that slowly dissociates from the receptor and blocks the effect of other opioids. Additionally, its analgesic activity has a ceiling effect. Buprenorphine is available alone (Subutex®) or in combination with naltrexone (Suboxone®). The addition of naltrexone prevents the opioid effects of buprenorphine if the tablet is crushed or injected. Subutex® is used during induction of opioid withdrawal, and Suboxone® is for long-term maintenance or withdrawal. Buprenorphine has a better safety profile than methadone and can be given every 2-3 days instead of daily, but is more expensive. Additionally, according to the Drug Addiction Treatment Act of 2000, physicians must qualify to use buprenorphine for the treatment or maintenance of opioid withdrawal.

A randomized, double-blind, double-dummy trial compared the efficacy of buprenorphine to methadone in opioid

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Medication	Mechanism of Action	Indication	Dosing	Adverse Drug Reactions
Buprenorphine	Partial opioid agonist	Withdrawal/maintenance	2-32 mg sublingual daily or 3 x weekly	Respiratory depression, headache, constipation
Clonidine	2-agonist	Withdrawal	0.1-0.3 mg orally every 6 hours	Bradycardia, hypotension, dry mouth, drowsiness
Methadone	Opioid agonist	Withdrawal/maintenance	20-100 mg orally daily	Constipation, respiratory depression, QT prolongation, hypotension,
Naltrexone	Opioid antagonist	Withdrawal/maintenance	50-100 mg orally daily or 3 x weekly	Anxiety, nausea, myalgia

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Opioid-Dependence (continued from page 4)

dependence therapy. Four hundred and five patients, 18 years of age or older, who met DSM-IV criteria for opioid dependence were randomized to receive one active medication (methadone in syrup or buprenorphine as sublingual tablets) and one placebo, so that patients received both a tablet and a syrup. Medications were dosed to effect up to 150 mg of methadone and 32 mg of buprenorphine over 13 weeks. The primary endpoint was retention in treatment and the absence of morphine in urine samples. The retention in the buprenorphine group was significantly less than in the methadone group ($p=0.037$). The mean number of morphine positive urine samples was 3.14 (standard deviation [SD]= 2.49) with buprenorphine and 3.62 (SD= 2.38) with methadone, which were not significantly different ($p=0.262$). Both drugs improved behavior by decreasing alcohol consumption and illicit drug use. Adverse events of buprenorphine and methadone included pain, flu-like symptoms, nausea, constipation, and insomnia. The authors concluded that buprenorphine and methadone were both effective, statistically and clinically, in reducing illicit opioid use, while improving behavior and wellness. Moreover, they hypothesized that the difference in retention may be due to slow induction of buprenorphine. Limitations were that physicians were not required to follow a treatment protocol, and patients reported to the clinic from an outpatient setting.

Opioid withdrawal and dependence should be approached by positive psychosocial interaction and appropriate medications. For acute opioid intoxication, clonidine can be used to suppress withdrawal and is helpful in combination with naltrexone to counter the adrenergic response. For chronic opioid users, methadone and buprenorphine are both effective for withdrawal and maintenance. Buprenorphine may be preferred due to fewer side effects and a more flexible dosing regimen, but it is more expensive.

Dean's Column

by David Forbes

Dean, Skaggs School of Pharmacy, University of Montana, College of Health Professions and Biomedical Sciences



I am pleased to report that Royce Engstrom has been selected as the next President of The University of Montana effective on October 15. President Engstrom has served as The University Provost and Vice-President for Academic Affairs for a bit over three years. He earned his doctorate in chemistry from the University of Wisconsin and has previously served the University of South Dakota in a number of important academic positions. We look forward to working with President Engstrom and we wish George Dennison well in his retirement.

I also thought this would be a good time to share some information with the MPA membership on the Skaggs School of Pharmacy's first year (P1) class.

Total Students	65
In-State	52
Out-of-State	13
(3 were pre-pharmacy UM students)	
Female	38
Male	27
Avg. Age	24
Avg. CUM-GPA	3.59
Avg. PREQ-GPA	3.62
Avg. PCAT Composite	61 percentile

We have used personal interviews as part of the student selection process now for three years. I was skeptical at first but I have come to

believe that personal interviews (while far from perfect) have been a positive addition to our process.

As stated above, the vast majority of students in the Fall 2010 class are Montana residents and here are few states and/or countries our non-residents have come from, those being: Alaska (3), Idaho (2), Hawaii, North Dakota, New Mexico, Ohio, Oregon, Texas, Washington, Pakistan, Nigeria, and Kuwait.

I get a boost (because I only speak English!) knowing about the impressive number of languages spoken in the Skaggs Building and here are the ones I know of: Arabic, Russian, French, Swahili, Portuguese, Spanish, German, Italian, Pashto, Nepalese, Chinese, Polish, and Korean. So, even Missoula, Montana is becoming more international!

Again, the welcome mat is always out for campus visitors and we enjoy a great deal providing visitors a tour of our outstanding facility.

David Forbes, Dean



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Calendar of Events

January 3, 2011: Montana State
Legislature Convenes

January 14-16, 2011: MPA Winter CE &
Ski, Fairmont Hot Springs Resort

January 14, 2011: Montana Board of
Pharmacy, Fairmont Hot Springs

April 12, 2011: Montana Board of
Pharmacy, Helena

June 2-5, 2011: Northwest Convention,
Coeur d'Alene, Idaho

July 19, 2011: Montana Board of
Pharmacy, Helena

October 25, 2011: Montana Board of
Pharmacy, Helena

Winter CE & Ski: Jan. 15-17

The Winter CE will include 14.5 hours
of continuing education plus attendees
receive discounted ski rates at Discovery
Basin. **Registration is available on-line at,**
www.rxmt.org.



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