

Rx Montana Pharmacy TODAY

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State and University System Roll Out New Pharmacy Benefit

The State of Montana (SOM) and the Montana University System (MUS) employee benefits divisions, through their contracting entity -- the Montana Association of Health Care Purchasers (MAHCP), are introducing URx, a new pharmacy benefit plan that will cover 50,000 Montanans. The State of Montana will replace its current employee prescription drug program with URx on January 1, 2010; the Montana University System will implement URx on July 1, 2010. The URx pharmacy benefit has been under development for over 18 months and separates the typical all-inclusive pharmacy benefit manager (PBM) offering into 6 individual components – pharmacy benefits administrator or PBA (claims processor), pharmacy network management, evidence based formulary development, rebate contracting, mail service, and specialty pharmacy management. By separating these components, the URx program maintains local control over management decisions and benefit design. One of the goals of URx is to remove the misaligned incentives that are typical in most employer sponsored pharmacy programs.

URx will strive to improve clinical outcomes and control costs through the use of a sophisticated evidence-based formulary that allows members and their doctors to select

medications based upon outcome and value. This formulary was developed by URx's own Montana based Pharmacy Technical Advisory Committee (PTAC), using a unique affiliation with an industry leading clinical pharmacy services program founded by a world class medical school. The PTAC consists of three Montana pharmacists, three Montana physicians, a nurse case manager, an employee/union representative from the State, and a University system retiree/faculty representative.

The URx formulary utilizes well-designed comparative analyses of drugs within existing drug classes that are based upon up-to-date peer-reviewed clinical data, national/international consensus guidelines/recommendations, systematic reviews of the scientific literature, and access to input from key researchers and specialists. In addition to this clinical evaluation, the formulary uses "on the ground" critical thinking by the Montana based PTAC as further application of this evidence. This formulary will evaluate drugs based on their proven clinical results and overall value to the member. Each drug will be assigned to a co-pay level using a unique benefit design. This benefit design is based on a value base of evidence, outcome

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Join MPA: Application Enclosed!

The Montana Pharmacy Association (MPA) appreciates the support of pharmacy professionals across the state. But in order for us to continue fighting for the interest of the pharmacy profession we need your participation. That is why we are asking non-members and on-going members to become a member at this time. To join MPA for 2010 just fill out the enclosed invoice and return with your check OR visit the MPA website at www.rxmt.org and click on the "Join" button to pay by credit card.

Reasons to support MPA:

Montana Legislative Success: During the 2009 Montana Legislative Session MPA safeguarded the practice of pharmacy in Montana. Our efforts included passing two bills to enhance the profession such as the new Advanced Pharmacist Practitioner Act and a bill to add a pharmacist to the Board of Pharmacy. We also defeated several bills, including a dispensing related bill that would have immediate, negative impacts on the practice of pharmacy.

Continuing Education: We co-sponsored the Northwest Pharmacy Convention last May and we are currently planning for a Winter ski/swim CE Conference at Fairmont Hot Springs January 15-17, 2010.

Federal Legislation: Working with national pharmacy leaders and our own powerful Congressional Delegation MPA was again active in working on federal legislation to delay AMP, provide passage of Prompt Pay, and clarify DME Competitive Bidding. By working closely with Montana's Congressional Delegation, we will continue to fight for your interest as the national health care debate continues.

For all these reasons and more we ask you to JOIN MPA by completing and returning the enclosed application.

Attend the MPA Winter CE & Ski January 15-17 at Fairmont Hot Springs

Registration material for the 2010 MPA Winter CE & Ski is available and we invite all pharmacy professionals to attend.

See back cover for more details.





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potential, and overall net cost. Five “class” levels will be employed using a report card theme. URx will assign member co-pays into “Classes” of “A” through “F”. This unique design requires very little prior authorization or provider intervention to process a prescription at the point of sale - by empowering the member and their physician/provider to make value decisions about medications within the URx formulary. The local control over the pharmacy benefit also allows for “plan exceptions” to be handled by State of Montana (SOM) and Montana University System (MUS) benefits staff for those members who have special prescribing circumstances.

There are several significant benefit design features of the URx plan that providers and members should be aware of. For the upcoming plan year, URx members will NOT be required to meet a deductible before cashing in on the benefit plan. In addition, medications that fall under the “D” or “F” classifications do not contribute to MOOP, or maximum out of pocket levels.

The URx benefit design is member centric and encourages members to review their medications with their provider and pharmacist. Medications in Classes A, B, and C offer members clinical advantage, clinical

alternatives, and lower overall cost than medications in Class D or F. There are also numerous benefit design options that allow for members to receive D or F medications at a lower class level if they are enrolled in a care management program, meet clinical requirements, or are grandfathered.

Members who are currently taking drugs that fall into Class D or Class F—the least of the overall value categories—will be notified by the SOM/MUS benefits division and advised to discuss alternatives with their prescribing clinician. Benefits staff will work directly with members and their doctors/providers in situations where an exception may be justified. As a value added benefit to members, URx and MAHCP have collaborated with the Skaggs School of Pharmacy at the University of Montana to develop a member help desk called “Ask-a-Pharmacist”. Members may call or email this help desk to request a “consult” with pharmacy students that have been trained on the URx pharmacy benefit and are under faculty supervision relative to providing information on the five “Classes” and possible alternatives to D or F medications. This is a unique opportunity for pharmacy students to learn about

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URx’s Evidence and Value Based Drug Formulary	No Deductible for URx members	Retail 30- day Supply
Value Base (Evidence, Outcome potential, Overall net cost)		
Excellent level of value based on graded evidence, best overall net cost, or opportunity to provide highest available treatment outcomes focusing on disease management.	Class A	\$0 Co-pay
High level of value based on lower overall net cost savings for generic drugs compared to their brand counterparts.	Class B	\$15 Co-pay
Good level of value based on evidence grading, but displaying higher overall net costs relative to generic counterparts or less expensive clinical alternatives.	Class C	\$40 Co-pay
Lower level of value based on outcome relative to other clinical alternatives and also much higher overall net cost.	Class D	50% Co-insurance
Lowest level of value based on evidence for outcome or highest overall net cost in relation to generic or other brand alternatives. Class F drugs may include drugs that were previously not covered by the plan, allowing members to participate in pharmacy network discounts.	Class F	100% Co-insurance

The Effectiveness of ACEi/ARB Therapy in Diabetes Complications and Chronic Hypertension

Mark Gottlieb, PhD, Epidemiologist, Mountain-Pa
Dwight Hiesterman, MD, Clinical Lead, Mountain-Pa

Introduction

Major medical standards and guidelines for care uniformly agree with the 2009 American Diabetes Association Standards of Care, which state: “Pharmacologic therapy for patients with diabetes and hypertension should be with a regimen that includes either an ACE inhibitor or an angiotensin receptor blocker (ARB).” The standards also recommend that if one class of these agents is not tolerated, the other should be substituted, and that if needed to control hypertension, other antihypertensive agents should be added.

These recommendations are supported by clinical trials demonstrating that ACEi or ARB therapy is generally protective against a variety of microvascular and macrovascular conditions. In patients with diabetes the use of these medications appears to reduce the occurrence of retinopathy and of major cardiovascular events. In patients with diabetes and chronic kidney disease, ACEi/ARB therapy has been shown to reduce levels of proteinuria and slow progression toward kidney failure, and in these trials the benefits of ACEi/ARBs appear to extend beyond their hypertension reduction effects. It has been suggested that the agonistic impact of these medications on the inflammatory effects of the rennin-angiotensin system (RAS) may underlie these results.

Methods

Recent studies have attempted to clarify how best to employ these medications, particularly with regard to minimizing renal complications in diabetic patients. Addressing the question of whether combined ACEi and ARB therapy might be more protective than either,

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ODAY

Therapy in Slowing the Progression of Chronic Kidney Disease

Specific
-Pacific

The ONTARGET study reported in 2008 that this combination therapy led to more complications, with no benefit over separate treatment with either agent. A series of trials addressing ACEi or ARB therapy for renal protection confirmed the ability of ACEi or ARBs to slow the progression of CKD once kidney disease was present but found no differences in the proportions of diabetic patients without kidney disease who went on to develop nephropathy regardless of treatment with an ACEi or an ARB.

Conclusion

While research continues on how best to modulate RAS and minimize kidney disease progression in patients with diabetes, an expert panel report from the Centers for Disease Control (CDC) proposes American medicine adopt a conceptual model of a public health approach to minimizing the impact of CKD. It proposes steps to enhance prevention of CKD (primary prevention), prevention of CKD progression and complications (secondary prevention), and more effective treatment of kidney failure (tertiary prevention). The use of ACEi or ARBs is a predominant public health therapeutic strategy for both the primary and secondary prevention approaches of this panel. Until medical knowledge advances and we develop better agents and strategies for addressing CKD, the use of ACEi or ARBs continues to provide physicians with the best chance of controlling kidney disease in their patients with diabetes. Pharmacists are well positioned to assist physicians in improving the care of diabetic patients by recommending ACEi or ARB use in diabetic patients, particularly if those patients are also receiving antihypertensive medications.

Dean's Column

by David Forbes

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



As I mentioned in my last two articles, change is in the wind. As of this writing, 60 Democrats in the U.S. Congress have voted to bring the health care debate to the floor of the Senate (a real novel idea for sure!) and again, as I predicted in the last two issues, congeniality is dead and it is possible that our elected officials are mostly "rearranging the deck chairs on the Titanic"! I still am highly pessimistic that any real meaningful health care reform will take place.

But, where there is chaos and confusion, there could be opportunity! While I am very pessimistic about our society's willingness to pay for health care, I believe that part and parcel of health care reform is society's desire for more services. That is a simple thought for sure and it appears that many health professional groups are lining up to provide those services.

Pharmacy needs to do the same as I suggest above and I am not implying the standard practice of pharmacy as has been understood over the years of most of our careers. No, I mean patient

care at the patient level – interacting with patients such that patients will have their pharmaceutical care needs met. A lot has changed since I was a student in a pharmacy school (over forty years ago!) and a lot has changed since I became

Dean of UM's Pharmacy Program over 20 years ago!

We must embrace technology (a slide rule was a big deal when I was a student) and supportive personnel so that we can provide pharmaceutical care to our patients. Patients are going to find pharmaceutical care information somewhere, somehow – often on a web site, which may or may not be either accurate or understood by the individual patient.

Finally, I do not know what form health care reform will take in its initial phase or what health care reform will morph into over time but I do believe that patients want more personal attention and more health care information. Pharmacists can and should be available and willing to be that provider.

I hope everyone has a safe and rewarding holiday season and a Happy New Year.

David Forbes, Dean

Pharmacy Benefit (continued from page 2)

benefit design principles and utilize their knowledge and skills to provide education to SOM/MUS members.

URx has contracted with MedImpact for claims adjudication and network services and they will be URx's PBA, or pharmacy benefits administrator. MedMetrics, founded originally as an affiliate of a world class medical school, provides the research and

literature components for the evidence based decision process that URx employs through its Pharmacy Technical Advisory Committee.

The URx formulary and additional information can be viewed by logging on to www.urx.mt.gov (scroll half way down the page and click on the "formulary list"). For more information, contact Paul Bogumill, Director of Benefits for the Montana University System at (406) 444-0329.

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Calendar of Events

January 15-17, 2010: MPA Winter CE & Ski, Fairmont Hot Springs Resort

January 15, 2010: Montana Board of Pharmacy, Fairmont Hot Springs

April 13, 2010: Montana Board of Pharmacy, Helena

June 3-6, 2010: Northwest Convention, Coeur d’Alene, Idaho

Winter CE & Ski: Jan. 15-17

The Winter CE will include 14.5 hours of continuing education and participants will learn about current clinical and drug therapy issues in cardiology, diabetes, osteoporosis, oncology, prescription drug abuse as well as relevant policy information. You will also have the chance to complete the live portion of the Immunization Certification Program through the UM School of Pharmacy. Plus, attendees receive discounted ski rates at Discovery Basin. **Registration is available on-line at, www.rxmt.org.**



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