NYCPS New York City Pharmacists Society
An Affiliate of the Pharmacists Society of the State of New York

NEW YORK CITY PHARMACISTS SOCIETY

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The Voice of Pharmacy in the Big Apple www.NYCPS.org

President's Message

Fair Audit Reforms Bill: Real Progress & Our Next Step!

After many discussions at our conventions and board meetings of the pharmacy issues we all face, it was clear that audit reforms legislation was long past due. We heard a parade of horror stories about pharmacists being subjected to unrealistic and excessive demands and order practices – sometimes downright abusive and totally unfair.

I, myself, was just one of those stories: a PBM contract was terminated. Why? For a simple clerical error. Poof! The contract was gone … with no recourse, no option, no appeal.

All of us knew it was time to act. New York State was behind! After all, 34 states had passed legislation already to protect their pharmacists. What about us?

But how to get a bill on the books? In June of last year, PSSNY formed a legislative sub-committee to research and draft one. And let me tell you: that is not an easy process!

We held countless conference calls and meetings. We also reached out to the NCPA and other state organizations that had successfully past legislation. Armed with what we had learned, we worked to create our

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HOW TO SURVIVE A DEA INSPECTION SERIES: The Pharmacy and Its Prescribers

As you know, DEA has been leading a charge on the prescribing of opioids for pain and clearly saying that the abuse of opioids is leading to the high usage of heroin. DEA and law enforcement has been focusing on the prescribing of Oxycodone and Morphine Sulfate as the leading cause of death in patients. It is a fact that statistics are being provided to the public showing the abuse of pharmaceutical opioids as the leading cause of death.

What this means to you as a pharmacist is clear that when such a death occurs, DEA and law enforcement will focus on the prescriber of the opioid and the pharmacy that filled such prescription. In many cases, criminal

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Chairman's Report

Greetings friends,

I write to you right after the NYS Budget has been passed. This year's budget was just a little bit late for the 1st time in 5 years and broke Governor Cuomo's streak of on time budgets passing on April 1st. We pharmacy owners dodged this year's budget cuts due to resistance once again of the PSSNY/ NYCPS organized lobbying and strong presence on Lobby Day. We were in Albany and we showed our support of the pharmacy profession. This year's budget comes with a major disappointment, as NYS passed a minimum wage bill of $15 per hour to be paid to all employees starting in 2018. This, my friends will be a huge hit to all of our pharmacy owners, especially when you consider that the pharmacy technician registration/certification issue is being discussed as being made part of the state education law by the NYS Board of Pharmacy. I don't see how all of our independent pharmacies can afford such an increase in payroll, where our reimbursement is being slashed on an ongoing daily basis. Day in and day out we are faced with difficulties of running our businesses and we are told that this state administration will be brining on many investigators to will help to enforce and investigate any salary or related employment wrongdoing by employers.

As we all know that the NYS Electronic Prescribing regulations went into effect on March 27th, 2016.Many of us were confused with the exceptions by the DOH. We all received letters with Questions and Answers to explain that pharmacists are NOT required to verify that a practitioner has a waiver from the requirement to electronically prescribe, or if that prescriber properly falls under one of the other exceptions from the requirement to electronically prescribe Pharmacists may continue to dispense medications from otherwise valid written oral or fax prescriptions that are consistent with current laws and regulations.

On other pharmacy news we may benefit on our bottom line as Medicaid FULs are finally rectified after many years of being frozen in place. CMS has issued the Federal Upper Limits(FULs) used to determine reimbursement for generic drugs covered by fee-for-service Medicaid programs, as required under the recently released Average Manufacturer Price final rule. FULs are calculated when there are at least three pharmaceutically and therapeutically equivalent multiple source drug products. States will have up to 30 days from April 1st, 2016 effective date to implement the FULs. Thereafter, the FULs will be updated monthly. Thank heaven New York State updated the prices right on time on April 1, 2016. You should notice a difference in some of your generic drugs which had previously been grossly underpaid.

In other news from NCPA word on the street is that PBMs are not complying with Medicare MAC price update rule. NCPA has outlined community pharmacy's concern regarding the non-compliance of multiple Medicare Part D plans and PBMs on the usage of generic drug pricing standards to reimburse pharmacies that clearly do not reflect the market price of acquiring the drug, in direct violation of the federal law. NCPA has been consistently alerting CMS since January that many pharmacies are experiencing underwater MACs and of general noncompliance with the new MAC requirements. Unfortunately, many of the problems have not been addressed during the first quarter of the year and continue to worsen.

The next lobby day for general pharmacy issues was held on April 12th in Albany. See the remainder of this newsletter for details of the event. Please don't forget to register for our annual PSSNY convention on June 24-26, all of the details are on website check out the details at www.pssny.org.

Stay tuned and stay involved. The profession you protect is your own!

~ Alex Perchuk
Chairman, NYCPS

Two Important Late Breaking and Timely Updates

NY Medicaid has announced in their February 2016 Medicaid Update that pharmacists/pharmacies are not permitted to get involved in the Prior Approval/Prior Authorization process particularly the patients involved in Medicaid Managed Care Plans. Shortly after the Medicaid announcement was made in the Medicaid Update, CVS Caremark issued a related memorandum referencing this NYS Medicaid Policy.

Next important issue relates to refill requests via fax which is commonly referred to as "Fax Backs". With the shift to Electronic Prescribing becoming the standard of practice in New York State, the Board of Pharmacy and the Department of Health have issued Question and Answer documents to help inform the pharmacists understand what can and cannot be accepted as a valid prescription. The most recent opinion issued by state officials is that "Fax Back" responses from prescribers can no longer serve as a substitute for an electronic, or written or telephone authorization for a prescription order. It is suggested that you would discontinue the use of Fax Back documents as a substitute for valid prescriptions.

~Submitted by Jim Schiffer

Treasurer's Corner

CHAINS FEEL THE PAIN TOO

Most recently with former CEO of Turing Pharmaceuticals Martin Shkreli in the news for pharmaceutical pricing abuses, we are seeing a lot more interest in the pricing of prescription drugs. Actually a long term care pharmacy coalition has issued a white paper on the PBM pricing practices. It brought to light the anti competitive PBM pricing practices and the false claims by these benefit managers that they are truly market based prices. It brought out the discrepancies in Maximum Allowable Cost (MAC), It revealed payments for the same drugs from different PBMs on the same day to vary widely.

Recently when testifying before Congress the executives from CVS Health and Express Scripts admitted they keep multiple MAC lists for the same drugs. This on the heels of the PBMs assertion that the marketplace is highly competitive and transparent, even though the facts show that three firms own about 80 percent of the marketplace. Those three firms are CVS Health – Caremark, Express Scripts/Medco Health and Optum Rx/Catamaran Rx (divisions of United Healthcare). This is a fact we have long asserted was a problem in the industry.

Well CVS has brought suit against Prime Therapeutics (PBM) for underwater MAC prices. One would think that CVS with its number of stores and buying power would not be affected by below cost MAC pricing, unlike what the small independent pharmacy experiences at the hands of these one sided contracts. CVS contends the last half of 2015 saw a cost of over $50 million dollars in losses to this pharmacy giant. Prime Therapeutics even admitted to CVS, as documented in the lawsuit, that the MAC pricing wasn't in response to changes in the market, but to gain a competitive edge in bidding out contracts to plan sponsors.

Martin Shkreli may have been ethically challenged in the unheard of price gouging by his firm, but I really think that he cannot even hold a candle for the unbridled greed of the middlemen we deal with on a daily basis. The recent ad campaign by the PBMs cites their lowering costs to consumers and sponsors, a claim which we all know not to ring true, with higher copayments to consumers and higher costs for

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A MESSAGE & GREETINGS FROM PSSNY EXECUTIVE DIRECTOR

WHITE COATS RULE!

Pharmacy Lobby Day on April 12 was a sea of white coats in the Capitol and Legislative Office Buildings in Albany.

Nearly 500 students were led by dozens of pharmacists through the halls of government where more than 100 meetings took place with Senate and Assembly members. The topics of discussion were our post-budget legislative priorities:

- Allow pharmacy interns to immunize adults (A9312-A McDonald/S7242 Funke);
- Remove sunsets and authorize Certified Immunizers to administer all CDC-recommended vaccines for adults (A9529 Paulin);
- Set standards in law for fair pharmacy audits (A9424-A Lavine/S7201 Hannon); and
- Recognize and regulate pharmacy technicians (A4841 Englebright/S1883 Griffo).

Allow Pharmacy Interns to Immunize (A9312-A McDonald/S7242 Funke)

This bill authorizes pharmacy interns to administer vaccines to adults when they are directly supervised by a licensed pharmacist who has a current, valid Immunization Certification issued by the State Education Department (SED). New York is one of only seven states that restrict interns from this growing area of professional practice and training that is required for the Doctor of Pharmacy degree.

We asked legislators to not short-change New York pharmacy students from this real-life, comprehensive practice experience by co-sponsoring this bill and supporting passage in the Higher Education Committees and in both houses.

Remove Sunsets and Authorize Certified Immunizers to Administer all CDC-recommended Vaccines (A9529 Paulin)

This one-house bill makes permanent pharmacists' authority to administer vaccines to adults, removes county restrictions in non-patient-specific orders, and allows pharmacists to administer all CDC-recommended vaccines for adults adding varicella, HPV, MMR and Hepatitis A&B vaccines to the approved list.

Since implementation of the original law in 2008 authorizing SED to grant immunization certificates to qualified pharmacists, members of the public as well as medical professionals have accepted immunization by pharmacists as routine. SED reports that over 12,000 pharmacists are certified. The law has been highly successful in increasing vaccine rates in the State and it is time to make New York's pharmacist immunizer law permanent.

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A MESSAGE FROM PSSNY PRESIDENT ROGER PAGANELLI

As I begin my message to my colleagues, I'm reminded of yet another successful owner's lobby day in Albany with a successful outcome in the New York State budget with respect to pharmacy reimbursement in the Medicaid program. The governor's original budget proposed that DOH develop a list of drugs they considered "specialty" and the ability to manipulate reimbursement as to what they considered fair and equitable, without considering the sustainability of the community pharmacy business model, ever included in their plan. The proposal was a prescription for disaster which I testified in front of Chairs of the Assembly Health Committee, using exactly those words.

The lobby day program and the victory didn't happen by accident. You should know the Herculean efforts, both paid and volunteer, that went into the entire process. This included, but was not limited to, countless lobbyist meetings, testimonials, the staff's phone & email efforts with continuous follow-up and follow-through in order to schedule the 100's of meetings, the rented space, the food for both breakfast and lunch, etc... and the list goes on. Many of you reading this actually played a role in lobby day and everything that went into it but more of you did not in fact had anything to do with it. Time and again we answer questions from our members regarding what are we doing about certain forces against our business. Well, these events are what we do. We mounted a campaign against the DOH and their budget proposals, we strategized a lobby day and we executed that day. The result, as stated above, was a PSSNY victory. My message to you all is simple; if you cannot partake in any of our lobby day functions, than at the very least, please support our efforts by contributing to the RXPAC OF NY with a monthly recurring credit card contribution. That will give us the access we need to the legislators that will hopefully help us be victorious.

With the two remaining months of my presidential term, I will be focusing on some very important issues. The first being our top priority of the legislative session; The Fair Audit Bill. Our assembly sponsor Lavine, and Senate sponsor Hannon will be the focus of our lobby efforts. Please keep an eye out for in-district lobby day dates in May. We did this last year for the first time and we achieved success. You will be asked to visit your state senators and assembly persons, both where you live and work, with specific talking points as to what our ask is. The importance of these in-district days are multifold. You will get to have time at the district office where you're not competing with other special interest groups for their time like in Albany, when they are typically inundated. The legislators respond very positively to their constituents who visit in district and will most likely remember WHO you are when you visit there vs. Albany. And most effectively for our campaign, our opposition's lobbyist will most likely NEVER lobby a legislator in-district, putting us in a much more strategic advantage. Please mark your calendars once you see the in-district dates and help to make a difference for your own businesses.

Another priority of mine will be a successful June convention from the 24-26 at the Westchester Hilton in Rye Brook. If you haven't registered, please log onto pssny.org today and do so. Take advantage of the early bird and be a part of the celebration in honoring Russell Gellis, NYCPS past president, being installed as PSSNY's next President. We have a robust program including two keynote speakers and poolside, bikini jeopardy! Don't miss it!

A new addition to PSSNY is the Hercules buying group- see our member benefit page for details and consider purchasing generics with Hercules to help benefit your bottom line and PSSNY's as well. Hercules has been a proud sponsor of PSSNY for two years and we welcome them to our list of preferred vendors.

Thank you,

~ Roger Paganelli , PSSNY President

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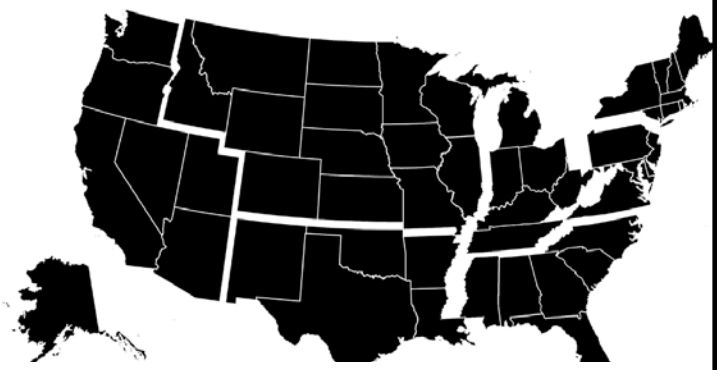

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Secretary's Report

Another April 1st Budge has been passed by the New York State Legislature and pharmacy cuts appear to have been avoided once again. Credit MUST be given to the strength of your PSSNY leadership and your local leaders of the New York City Pharmacist Society. And once again, a thank you to all of the members of our NYCPS group that traveled up to Albany on April 1st to let our state officials know that we cannot tolerate any more cuts.

I have a quote which appeared in the Wall Street Journal on Wednesday March 30th. See if you can figure out who said it. "There was always waste and abuse in the Medicaid Program…my instinct is it's only gotten worse". Who said that? It was none other than our beloved Governor Andrew Cuomo. It seems that Governor Cuomo has no affection for providers of the New York Medicaid program. That quote appeared when the Governor was questioned about the budget discussions two days before the budget was due) Governor Cuomo was searching for a way to squeeze $250 million from the budget and he was looking for a way to justify squeezing another $250 million from the current spending plan for New York Medicaid. To those of you who have been around this profession back in the early 1990's the late Governor Mario Cuomo was even more aggressive about squeezing pharmacy providers. A little history, back in the winter of 1992, Governor Mario Cuomo instructed the Department of Social Services (which was the governing agency for Medicaid back then) to reduce reimbursement by 10% to pharmacies in spite of a federal moratorium on any states attempt to cut reimbursement as a result of the commencement of the famous federal OBRA 90 (passed in October 1990) legislation which gave all state Medicaid programs a new source of revenue in the form of rebates off of the net price paid for medications dispensed to Medicaid recipients and had required a moratorium on any state cuts to Medicaid payments for pharmacies for a 5 year period expiring in January 1996. (Eventually the federal courts imposed a retroactive repayment of the cuts which were found to be illegal). This OBRA 90 rebate concept has been a windfall to all state Medicaid programs but has also served as a way for the pharmaceutical industry to create artificial price markups based on the back end rebates. Anyway the point I am trying to make is that neither the late Governor Mario Cuomo nor his son Governor Andrew Cuomo have any idea of what the average pharmacist does to help keep their patients healthy. Governor Andrew Cuomo was rebuffed by the state assembly and senate in his efforts to once again reduce reimbursement to pharmacies for specialty drugs dispensed in the Medicaid program. Thank your PSSNY/NYCPS leaders for helping stop the bleeding once again with their prompt and effective lobbying efforts. And a big Thank You to all of our NYCPS members that participated in the Pharmacy Day trip to Albany on April 1st. We need to stay united and in touch with our state officials to let them all understand our predicaments of financial hardship in dealing with the pharmacy benefit for our patients.

Now that the state budget has been passed, our attention will turn to the efforts to have passed in Albany our fair audit legislation to make the PBMs and health insurers treat us fairly when they audit our pharmacies. More details on this new legislative initiative are located in this newsletter.

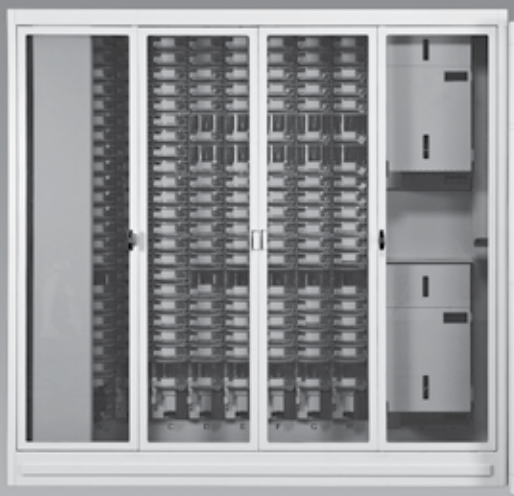
One thing is abundantly clear to me as I look back on my nearly 43 years of practicing pharmacy. The challenges we as a health care professional face in our day to day activity are overwhelming to the average pharmacy owner and "bench" pharmacist. Since the PSSNY Mid Winter Convention, I- along with my colleague Carlos Aquino - - have been asked to conduct professional pharmacy CE programs in various venues, from New York City, to Westchester to various locations in New Jersey. The feedback from most of the attendees is somewhat shocking as to the enforcement and recovery efforts being undertaken by the various pharmacy benefit managers and government oversight agencies. A word to the wise, take advantage of your PSSNY/NYCPS membership and stay involved. The pharmacist license you are protecting is priceless and you don't want to jeopardize it in any way.

Mark your calendar now, for the annual PSSNY Convention. It is being held on June 24-26, 2016 and will be at the Hilton Westchester in Rye Brook New York. For more information see www.pssny.org

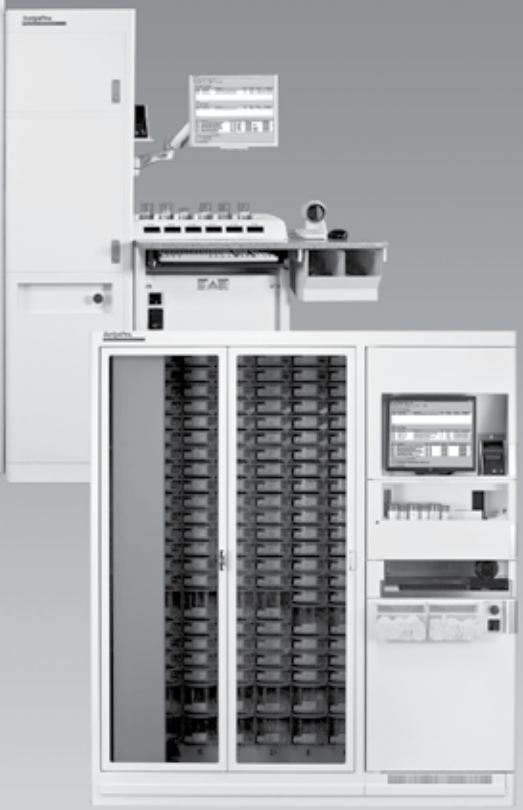
Stay well and stay informed.

- Jim Schiffer,
Secretary NYCPS

It's time to...



SP 200 CCC Robotic Prescription Dispensing System



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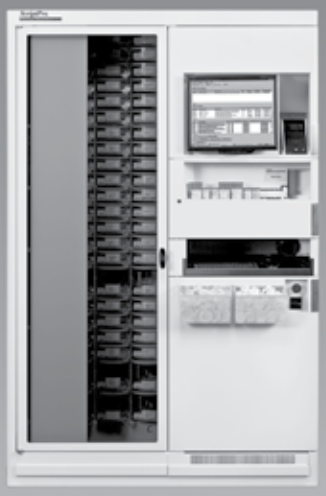

Compact Robotic System

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MEDICAID CAN FUL PEOPLE ALL THE TIME

In late February more than 200 pharmacy owners and industry leaders dialed in to the NCPA Member Forum, "**Changes Coming to Medicaid Pharmacy Reimbursement—What You Need to Know**." We hosted the forum because of the impact on prescription reimbursement that will result from the Centers for Medicare and Medicaid Services' (CMS) recent release of the final rule on Average Manufacturer Price (AMP)-based FULs, or federal upper limits. Not only will it have an impact on fee-for-service Medicaid prescriptions (17% of the average community pharmacy's prescriptions according to the *2015 NCPA Digest, sponsored by Cardinal Health*), but there is a decent chance that other payers will use this model as a point of reference for their payments.

You are likely already aware of the checkered history of the AMP-based FULs. As originally released by CMS in 2007, the list of drug prices was fatally flawed. Pharmacy payments would have been slashed and patients would likely have lost access to thousands of pharmacies.

NCPA and the National Association of Chain Drug Stores (NACDS) filed a federal lawsuit seeking a temporary restraining order. We were granted that request and were able to halt implementation. That legal win avoided cuts of more than $5 billion to community and chain pharmacies and maintained patient access to thousands of pharmacies that would have been in jeopardy of closing their doors.

The Director of CMS' Medicaid Pharmacy Division, John Coster, PhD, RPh, was the special guest this week at the Member Forum. Coster knows this issue well having worked in the early '90s on the staff of Sen. David Pryor (D-Ark.), who led changes to prescription drug pricing, and then for NCPA years later. John gave an overview of the final rule and then answered dozens of questions submitted from NCPA members. If you missed the call, you can listen to the audio file.

It's heady stuff and there are enough acronyms to fill a barrel of alphabet soup. One of the key acronyms is NADAC, National Average Drug Acquisition Cost, which has a function that is self-explanatory. NADAC is calculated by averaging prescription drug invoices from community and chain pharmacies. If you live in one of the 13 states that currently or will soon use either a state Actual Acquisition Cost (AAC) or NADAC as the basis for paying for Medicaid prescriptions, then you're already familiar with it.

Thirteen states have turned their Medicaid program over to Managed Care Organizations (MCOs). Their pricing is not directly affected by the new final rule, but approximately two dozen states are trying to decide whether to go with an MCO or use NADAC as the basis for Medicaid prescription reimbursement.

One of the questions that John responded to that I thought was particularly important to prescription pharmacy payments was about the dispensing fee: "Has there been a range for the professional service fee?"

"For the states that have gone to a NADAC or AAC (payment model), their dispensing fees have generally been in the $10-$11 area. What I will say is that states have flexibility to set pharmacy reimbursement within reason," Coster said. "So, some states may want to pay independents more than chains; they may want to pay more for generics than brands. We're open to different methodologies that states might want to use. At the end of the day, we (CMS) kind of know where we want to land. If a state comes in with a fee of $8 for all pharmacies we would probably say that was too low. If they came in at $14 we'd probably say that was too high. We kind of know the range we're looking for but if a state wanted to, for example, pay pharmacies more for dispensing generics or preferred brands and less for non-preferred brands, that's something that we would look at and entertain."

The changes to Medicaid pharmacy payments are one more example of pharmacy payment reform that is moving pharmacy toward a value-based payment system. Individual state advocacy efforts regarding Medicaid reimbursement will be more important than ever. Understanding pharmacy payment changes, starting with Medicaid, will keep your business FULproof.

- B. Douglas Hoey, RPh, MBA
National Community Pharmacists Association CEO

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 ISMP National Medication Errors Reporting Program (ISMP MERP) at 1-800-FAIL-SAF(E) or online at www.ismp.org to activate an alert system that reaches manufacturers, the medical community, and FDA. ISMP guarantees confidentiality of information received and respects reporters' wishes as to the level of detail included in publications."

Preventing wrong-patient errors at the point-of-sale

Problem: A woman who was six weeks pregnant received the high-alert medication methotrexate instead of the prescribed antibiotic from her community pharmacy. According to reports, she took one dose of methotrexate before she discovered the error and was sent to an Emergency Department (ED) by her physician. One of the factors contributing to the error was the similarity of patient names. The methotrexate was intended for a woman with the same last name and similar first name. The patient told news media that the pharmacist did not ask for her address or date of birth to confirm her identity at the point-of-sale, a process which was part of the pharmacy's standard procedure.

In another event, a patient requested a refill for zolpidem 10 mg tablets, which she takes at bedtime as needed for sleep. She was unable to pick up the medication herself so asked her father to do so. When he approached the pharmacy counter he told the cashier the patient's last name. The cashier recognized him and asked if he was picking up medications for his daughter. He said yes and the cashier obtained the medication and completed the transaction. Two days later the patient called the pharmacy to inform them that she had received the tricyclic antidepressant desipramine which was intended for another patient, one with a similar yet different last name.

Safe Practice Recommendations: High-leverage safeguards should be incorporated whenever possible. Standardized systems and processes are essential to ensure that everyone follows an established process. Consider the following strategies to help standardize processes and reduce the risk of wrong patient errors at the point-of-sale.

Use a second patient identifier. Ask for the patient's date of birth in addition to the patient's name. Compare their answer to the information on the prescription receipt. Never ask a "Yes" or "No" question by reading

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HHS-OIG REPORT SHOWS GLUCOSE TEST STRIP SUPPLIES WERE NOT NEARLY EXHAUSTED

On November 23, 2015 the Office of the Inspector General (OIG) released a report about the audit they conducted to review potential overpayments of Diabetic Testing Supplies (DTS) made by National Government Services (NGS). NGS is the current DME MAC for Jurisdiction B that includes Minnesota, Wisconsin, Michigan, Illinois, Indiana, Ohio and Kentucky. The report claims that NGS may have paid for claims to multiple suppliers when the supplies provided by the first supplier were not nearly exhausted.

The report specifically looked at overlapping dates of service that were provided by different suppliers during 2013. The current Local Coverage Determination (LCD) states that for DTS provided on a recurring basis, the supplier must contact the beneficiary prior to dispensing the refill to ensure 1) the item remains reasonable and necessary; 2) confirm any changes or modifications; and 3) existing supplies are approaching exhaustion. Medicare guidelines also state that the patient may not order supplies if they have more than 14 days remaining and the supplier may not dispense or delivery supplies if there is more than 10 days remaining.

Typically a full Refill Request would need to contain:

- Patient or representative's name (relationship if other than patient);
- Description of the items requested;
- Date of refill request;
- Remaining supply (quantity or days remaining);

A signed Proof of Delivery for in-person or retail store pickup is sufficient to document request for refill. It may not be sufficient to meet the requirement for assessing exhaustion of previous supplies. PAAS National® has seen changes to the Medical Review notices for DTS in regards to refill request documentation beginning with notices issued in November 2015 in all jurisdictions based on the results of this report. **PAAS recommends that for all DMEPOS supplies, that you obtain proof of being nearly exhausted regardless of delivery method. If you are a PAAS member we do have a couple of templates available to document this information. *If you have any questions email PAAS National® at info@paasnational.com or call 888-870-7227.***

Jim Schiffer Reporting… News from Around The Pharmacy World

APRIL 2016 EDITION

Pharmaceutical Industry News

You probably already heard that the marriage between Pfizer from the good old USA and Allergan the pharmaceutical manufacturer from Ireland is now officially dead. Reason being, the US Treasury Department finally created a rule to kill the concept known as "inversion" which would take a US company and move it overseas to a foreign country in order to save tax dollars. Pfizer has to pay a deal breakup penalty to Allergan in the sum of $150 million. That is chump change to Pfizer and remarkably the day the announcement that the deal was dead, Pfizer stock went up by about 5%. Crazy times we have. It seems that Pfizer may split off their company in the same way Abbott did a few years ago, one company will have the new and innovative drugs while the second company will be left with the Pfizer staple and generically available products. You may recall that Pfizer has already spun off their animal health division under the Zoetis name. Back in early 2013 Pfizer had decided to spin off its majority stake in animal health business which had been operating as a company owned subsidiary under the name, Zoetis Inc., to Pfizer shareholders by granting authority for Pfizer shareholders to swap Pfizer stock for Zoetis shares at a 7 percent discount. Pfizer, sold Zoetis shares in an initial public offering (IPO) in February 2013 that raised $2.2 billion. Pfizer also retained an 80 percent stake in Zoetis after the IPO and Pfizer intends to gradually unwind that, starting with the initial offer to current shareholders. The bottom line in this entire process it that Pfizer wants to divest from its non-pharmaceuticals products to instead focus on its core prescription drugs business, which has far higher profit margins. Now that the Allergan deal is dead, Pfizer is back to the drawing board. There are several options that exist for the largest drug manufacturer in the world. Even before the Allergan deal, Pfizer was talking about splitting up the company to separate the part that develops new products from the part that owns older, but still profitable, drugs.

Speculation in the drug industry exists that Pfizer may do a split of their pharmaceuticals now that the Allergan deal is dead. When the death of the Allergan deal was announced, Pfizer suggested that they'd announce a course of action "by no later than the end of 2016, consistent with Pfizer's original timeframe." This approach basically puts the carrot back in front of the stock again – splitting up the drugs side of the business would be unique and unprecedented, and basically something Pfizer has been considering for the past five years. If this ever does happen, it will be rather interesting to see how it does shake out. Other large pharmaceutical companies with both established and innovative parts of the business have split along these same lines in the recent past, specifically Abbott Laboratories spun off AbbVie, and Baxter spun off Baxalta.

Allergan wasted no time to make another deal, something that Allergan must have had up their sleeve for some time as a backup in the event the Pfizer wedding fell through. Allergan completed a licensing deal to develop drugs for Alzheimer's and other neurological conditions shortly after the collapse of its $150 billion tie-up with Pfizer Inc., confirming Allergan's drive to move on as a stand-alone company.

Under this new deal, Allergan will spend $125 million cash to Heptares Therapeutics, a British-based biotechnology company which is wholly owned by Japan's Sosei Group Corp., plus additional payments of $665 million after the successful conclusion of clinical research trials. Additionally another $2.5 billion in milestone payments, plus royalties, will be made if there is eventual commercial success of the drugs under this agreement. Allergan has also thrown in $50 million in a joint research-and-development program to advance several drugs to mid-stage human testing. After all, Allergan just got $150 million in a wedding cancellation fee from Pfizer. Easy come, easy go.

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Around the Pharmacy

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Drug Price Issues

The U.S. Department of Health and Human Services (HHS) issues a report this past month claiming that the rising cost of prescriptions is straining both government budgets and family budgets. According to HHS, there was about $457 billion spent in the U.S. on prescription drugs last year, or about 17 percent of the overall $2.7 trillion spend in total on health care, according to the HHS report, which says that pharmaceutical price hikes have the largest effect on the increase in spending than the growth in volume of prescriptions medication has. In 2014, drug spending rose 12.6 percent and is projected to hit $535 billion in the year 2018, it is reported by HHS. Also alarming is the increase in spending on what is known in the industry as specialty drugs. Spending on specialty drugs grew from $14.5 billion in 2009 to $27.1 billion in 2015, an average annual growth of 11 percent, according to the HHS report. "The number of prescriptions is rising, but the majority of the growth in retail drug spending appears to be related to rising prices and changes in the composition of drugs prescribed — e.g., a general shift toward more expensive prescriptions — rather than changes in the total quantity of prescriptions," the HHS report concluded. To combat that finding the pharmaceutical industry trade group known as the Pharmaceutical Research and Manufacturers of America, (aka PHARMA), says many factors contribute to prices, including the number of new medicines approved and how many lose patent protection. Between 2009 and 2013, for example, more than $105 billion in brand name drugs faced generic competition. PHARMA also claims that overall drug prices are reasonable given their value to society and the cost to research and develop them. "New medicines are transforming care for patients fighting debilitating diseases like cancer, hepatitis C, high cholesterol and more," PHARMA spokeswoman Holly Campbell stated. "With that said, we recognize that too often patients struggle with access to their medicines at the pharmacy," she added. "There also needs to be a greater focus on the critical challenge facing patients: increasingly high cost sharing and additional restrictions on access as a result of their health insurance coverage."

Specialty drugs comprised 37 percent of drug expenditures in 2015 and are projected to reach 50 percent by 2018, according to pharmacy benefits manager Express Scripts. Brand name drugs increased 164 percent between 2008 and 2015, the Express Scripts report also noted. The price of older drugs is going up too, not as dramatically, but frequently, which compounds over time, according to the report.

For example, as I reported in an earlier newsletter, "pharma bro" Martin Shkreli, the indicted former head of Turing Pharmaceuticals, bought Daraprim, a toxoplasmosis treatment used by AIDS patients, which is an important but little-used drug (with no generic competition) and hiked its price by 5,000% (from $13.50 to $750 per pill) overnight. Then Mr. Shkreli became more hated when he plead the Fifth at a recent

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Congressional hearing held over his outrageous price increases. "He is such a perfect villain," said John Rother of the National Coalition on Health Care, a nonpartisan research group. But there are other companies buying up drugs with expired patent protections and jacking up costs, including Valeant, which was also called before Congress to justify its actions, Rother said. According to Rother, "When you get to where only one manufacturer is left, they feel they can jump the price with no competition," he said. "And these increases are not 5- or 6-percent. They're often double or triple overnight. That's price gouging." We pharmacists all see this on a daily basis. While we are on the subject of HHS, we owe that agency a big belated thank you. You may not have yet realized it but Federal Upper Limit prices finally have been updated. It seems that the last time the Federal Upper Limit prices were updated was in September 2007, nearly nine years ago. So we finally have relief as many of the generic drugs have gone up in price tremendously and we have not had any reflective compensation for such when such products are dispensed under Medicaid fee for service covered patients.

Back to Pharma Issues

For example, according to the analysts, the price of Humulin R U-500 insulin jumped more than 350 percent from $12.01 to $54.48 per milliliter between 2007 and 2014. AARP investigated price increases and examined 622 commonly used drugs by older Americans and AARP reported that the retail prescription prices for this market basket of 622 drugs grew at a rate six times faster than inflation. According to the report, the average annual increase in retail prices was 9.7 percent compared with an inflation rate of 1.5 percent in 2013, while the average annual increase for brand name drugs was 12.9 percent and the increase for specialty drugs was 10.6 percent. "High and growing prescription drug prices are making it increasingly difficult — if not impossible — for older Americans to access the drugs that they need to get and stay healthy," said Leigh Purvis, director of health services research with AARP's Public Policy Institute.

On Thursday April 14, IMS Health (a company who tracks pharmacy and health care data) released their calculations on drug spending for the 2015 calendar year. For the first time, IMS Health included a new version of their spending report. They released the value of drug spending based on billing prices and then they issued a second value, based on the "NET" cost of such drugs estimating the true out of pocket expense for such drugs after that dirty little word "REBATES TO INSURANCE COMPANIES".

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Around the Pharmacy

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PBM Updates

I make a habit of reviewing annual corporate statements of health care related companies. I try to pay particular attention to pharmaceutical manufacturers, health insurance companies and pharmacy benefit managers. The most recent statement to hit the streets is that of Express Scripts Incorporated (ESI). Did you know Express Scripts is now 30 years old? Here are some statistics I gathered from my review of the ESI Annual Report. ESI currently covers about 85 million lives with prescription drug benefits. During 2015, ESI estimates that they provided curative treatment for 50,000 Hepatitis C patients. ESI reported that they were able to keep the increase in drug costs down to a measly 5.2% in 2015, less than half of the overall increase in 2014. They also bragged how they cut down on compounded prescription costs by a whopping 97%, and finally they fought back on the Turing Pharmaceutical price increase for Daraprim by having a specialty pharmacy compound a similar compound (but with Folic Acid added) for less than $1 per compounded tablet. What ESI did not say—maybe because it was after they printed their annual report—that health insurer, Anthem, has sued ESI, claiming that ESI is holding back on billions of dollars in potential savings from ESI's discounted negotiated drug prices through their buying power. As a result, Anthem is asking the court for $15 billion in damages and is also seeking a termination of their PBM contract with ESI. An Anthem spokeswoman said the damages reflect drug price overpayments Anthem allegedly has made. It also factors in the remainder of Anthem's 10-year contract with Express Scripts, which runs through 2019. The amount also covers an unspecified transition period.

That's not all there is with the suit, you see Anthem is also seeking $150 million for "compensation related to operational breaches," the spokeswoman said. Anthem has not yet decided whether it will immediately end its contract with Express Scripts, but the company has been contemplating a major change for the past several months. Anthem sold their in house PBM to ESI several years ago. You may remember that Anthem through their Well Point corporate name, sold their in house PBM known as NextRx to ESI back in December 2009, some six years ago. The transaction included a 10-year agreement under which ESI would provide pharmacy benefits management services, including home delivery and specialty pharmacy services, to members of the various Well Point various health plans operated under their umbrella. Express Scripts acquired the NextRx subsidiaries for $4.675 billion, which

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Around the Pharmacy

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includes consideration for the value of a future tax benefit for Express Scripts based on the structure of the transaction. Stay tuned as this case develops.

MEDICARE PART D PROPOSED CHANGES FOR 2017

Every year around this time the Centers for Medicare and Medicaid Services (CMS) releases proposed changes to the Medicaid Part D Rx program. It is referred to as the 2017 Final Call Letter for Medicare Advantage and Part D plans. NCPA has reviewed the proposed changes which I am summarizing below. First issue is that CMS plans on establishing mail order protocols for urgent need fills to prevent gaps in therapy: CMS has received beneficiary complaints about mail order pharmacies indicating that they will rush ship an urgently needed order, but the order does not arrive when promised or at all, potentially resulting in gaps in medication therapy. In order to better protect Medicare beneficiaries from inconsistent or unreliable practices that may jeopardize timely access to medications, CMS expects sponsors to establish and have protocols in place to address how to handle urgently needed medication requests from beneficiaries by Calendar Year 2017 if not sooner and to be able to clearly communicate this to their beneficiaries. CMS will continue to monitor complaints for issues related to mail order or access to urgently needed medications. The next issue being tackled is an effort to reduce the use of Opioid medications. CMS intends to introduce an Opioid overutilization edit which when in place will be a requirement of all Medicare Advantage and Prescription Drug Plans. In 2017, CMS expects sponsors to implement either a soft edit or a hard edit, or they may use both soft and hard edits as originally proposed in the draft Call Letter, and work toward a hard edit at a minimum in 2018 using reasonable controls to limit false positives. CMS will review 2016 and 2017 experience with these edits to inform content in the 2018 Call Letter. Finally, regarding Specialty drug patient cost sharing, CMS plans on increasing the threshold of determining what exactly is a specialty drug (by monthly cost). Since the Medicare Part D program inception back in 2006, CMS has used a cost threshold of $600 per month to identify "specialty" drugs. CMS will increase the threshold to $670 per month for 2017. CMS may or may not increase the threshold on an annual basis moving forward. These proposed changes to the Medicare Rx program are much more conservative than CMS had been accustomed to planning a few years ago. However once Congress jumped all over CMS two years ago as CMS attempted to reign in the abuses brought by the powerful insurance and PBM industry, CMS has been much more conservative in their handling of annual changes. It will be up to a new Congress and a new President of this country to shape the direction of Medicare Part D going forward. As things look currently, I would say that, "The tail is wagging the dog", as CMS is tolerating many unfair tactics of the health insurance and PBM groups. It is up to an informed Congress to straighten things out. This problem encompasses both sides of the aisle. Republicans and Democrats alike lack the understanding of the abuses of patient rights and their comprised freedom of choice in selecting a pharmacy of their choice. Realize that the abundance of "Preferred Pharmacies" is just one aspect of this unfair practice. When I travel to the Annual National Community Pharmacists Association Legislative meeting held in Washington next month, I hope to get an idea of what the leadership of NCPA feels we can accomplish in our election cycle this fall.

Folks enough for April. "They say April showers bring May flowers", then I say, let it RAIN..

Stay well,

- Jim Schiffer

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Rx AND THE LAW

NEW ADVANCES

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.

We are entering another period of change in the pharmacy profession. We experienced such a period during the 1990's when collaborative practice and pharmacist-administered immunizations were new topics of conversation. Now we are seeing an enhancement of pharmacist-provided, patient-centered services. And these changes are dovetailing with the drive for provider status for pharmacists. I remember performing kinetic dosing for aminoglycosides at our hospital in the 1990's. We were very proud of how progressive and advanced we were. Our results were improving our patients' outcomes. It was only later that we discovered that collaborative practice wasn't yet authorized by our state practice act.

At the opposite end of the spectrum from those who blindly race ahead are those who resist such changes. These are pharmacists who are comfortable in their existing practices and are worried about the extra liability when exposure performing new patient care services. These extra liability concerns have been discussed in previous articles. Change and progress are necessary to stay relevant and useful in the modern world. The key to managing change is preparation.

Ohio enacted a law at the end of 2015 that enhanced the ability of pharmacists and physicians to enter into collaborative practice agreements. Among the authorities granted to pharmacists are; ordering blood and urine tests, analyzing those results, modifying drug regimens (including ordering new drugs), and authorizing a refill of critical medications. Oregon has a new law going into effect in 2016 which authorizes pharmacists to prescribe self-administered oral or transdermal birth control. California has also passed a law similar to Oregon's. Typically these statutes authorize pharmacists to expand their practices, but they do not require them to do so. So how do you prepare to expand your (and your patients') horizons?

Examine the new practices open to you in your state. Which of them are you currently competent to perform? Which can you obtain addition training relatively quickly and become competent? Which ones best serve the needs of your patients? Once you know that, you can assess your liability exposure in performing those services. This is done by reviewing your legal duties to your patients. What duties are required for you to provide the service? What possible ways could those duties be breached? What possible injuries that could result from that breach? In this way, you can evaluate your exposure for providing any new service.

Once you have decided to move ahead, the next step in preparation is to examine your insurance coverage. You can't just assume that new practices are covered. Individual insurance companies can determine what they do and do not want to cover in a policy, regardless of what constitutes the scope of practice in your state. It is never safe to assume that you have coverage for something without first asking and validating that with your insurance carrier. For example, there are policies available in the marketplace that exclude damages resulting from patient counseling – whether or not the counseling is required by law. While we are talking about optional activities and services here, your insurance policy should certainly cover the activities that you are required to perform. To avoid problems later, it is a good practice to read your insurance policy to make sure that it provides the coverage that you need.

Once you have assessed your possible exposure and verified your insurance coverage, you are ready to begin providing advanced services like those authorized in Oregon, Ohio, California and other states. You are part of the next wave of change in pharmacy practice. The profession of pharmacy has come a long way in a relatively short period of time. In the 1950's, it was unethical to tell a patient the name of their prescribed medication. Now pharmacist are engaging in extensive collaborative practices, providing MTM and immunizations; even prescribing medications whose names they weren't allowed to disclose a few years ago. It is an exciting time to be a pharmacist!

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1. Tug Valley Pharmacy, LLC, et al. v. All Plaintiffs below in Mingo County Cases, No 14-0144 (Supreme Court of Appeals of West Virginia, May 13, 2015.)
2. Orzel v. Scott Drug Co., 537 N.W.2d 208, 213 (Mich. 1995.)

© Don R. McGuire Jr., R.Ph., J.D., is General Counsel, Senior Vice President, Risk Management & Compliance at Pharmacists Mutual Insurance Company.

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 policies and procedures of their employers and insurance companies, and act accordingly.

NEW PROCEDURES FOR ACCEPTING CHIP CREDIT CARDS AT YOUR POINT OF SALE

Merchants are getting new equipment, cardholders are getting new cards. And with all that new hardware comes a new procedure for processing transactions at your point of sale.

Accepting EMV cards isn't difficult, but it's different enough that it might cause some initial confusion among your staff and clients. In the interest of eliminating such confusion and ensuring smooth transactions at your point of sale, we offer the following guide.

1. Select your transaction and card type, then enter the amount of the transaction. Even if your client presents an older magnetic stripe card, you cannot skip this step; simply swiping the card to initiate a sale no longer works.
2. If the client is using an EMV card, they need to "dip the chip," or insert their card into the terminal. Hand your terminal to the client or turn it to face them, then instruct them to insert their card into the smart card slot chip side first and face up until they feel it click. Tell them to leave the card in the slot. Clients using magnetic stripe cards do not need to do this.
3. The terminal may prompt the cardholder for a card PIN.
4. Make sure they press Enter after they've entered their PIN.
5. Your terminal will now process the transaction.
6. The client should remove their card from the smart card slot when the terminal indicates.
7. If you have swiped an EMV card, you may need to hit the red "X" key and start the transaction over then insert the card.
8. If the client was using a magnetic stripe card or their smart card does not require a PIN, have them sign the printed receipt. Be sure to check the back of the card to verify the signature and hand the card back to the client.

And that's it. Review these procedures with your sales staff and you'll be experts in no time!

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.

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 has a great workers' compensation program.*

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

**Must be a Retail Council member to participate in the workers' comp program.*

President's Message

From page 1

own first draft for audit reforms. Then—MORE calls and still MORE meetings.

Finally—after five distinct versions—we achieved a final draft that all of us believed in. We owe a big debt of thanks to Elizabeth Lasky, our Lobbyist, and our Legislative Committee for the many, many hours and the unwavering dedication they devoted to the entire process. Without their commitment and hard work, we would never have achieved what we did.

Next it was time to get sponsors from the State Senate and State Assembly to endorse our bill. First we had to figure out what aspect of the law needed to be amended. After deliberation, we concluded that amending Public Health legislation was the wisest approach to take. We went directly to the Chair of the Health committee and met with Senator Hannon. He was wonderfully helpful and agreed to be our spokesman in the Senate.

Then … on to the Assembly! We had meetings with Assemblyman Charles Lavine from Long Island who also agreed to be our sponsor. Getting bills numbered is another process of its own. But finally—lo and behold: our 7201 HANNON /A9427-ALAVINE Fair reform bill was born.

We're getting closer, folks! Now it's YOUR turn to help. This is the one-on-one work that will make all the difference in obtaining our approval. We need YOU!

The point is this: we must all work actively together to urge full support from our legislators. That means getting them to sign onto our Bill… getting it onto the floor for a vote, in BOTH Senate and Assembly.

How? We're organizing and something important—IN-DISTRICT LOBBY DAY. We need—each of us!—to visit our legislators' offices and let them know how much we will value and appreciate their support.

We can do to this, my friends. We can—and we WILL—turn all the hard work that's been accomplished thus far… transforming a sponsored bill into actual, official New York State Law. JOIN IN… your participation will matter, absolutely.

P.S. I look forward to seeing all of you at our annual PSSNY convention June 24th - 26th at the Westchester Hilton. Please register ASAP and join us for an exciting, educational and fun weekend to keep us advancing.

Thank you,
~ Ron Del Gaudio, R.Ph.
NYCPS President

DEA

From page 1

and civil cases have been brought by federal and state prosecutors on prescribers and dispensers of those opioids that led to the death.

Reality is that practitioners and pharmacist have been charged with manslaughter due to the death of a patient being prescribed an opioid but developed a high dependency on not only the pharmaceutical opioids prescribed but other illicit drugs use such as heroin. How do you as a pharmacist keep yourself from being prosecuted for what a prosecutor will call a "wrongful" death? It starts with the prescriber.

As a pharmacist, there are many tools you can use to evaluate a prescriber of opioid for pain. In New York, you have the website www.nydoctorprofile.com which will provide you with the doctor's personal information. You want to look at their formal education, their field of medicine, their board certification and if the prescriber has ever had a complaint file against them. All this information is in that New York State website.

Another thing that you as a pharmacist needs to look at is the prescribing of controlled substances. Some doctors only learned two numbers (30 and 180) in medical school. Meaning **180** dosage units of Oxycodone 30mg tablets. If this type of "bad" doctor only writes for this type of prescription for every patient, the action is a "red flag" in the eyes of DEA and state and local law enforcement.

Accepting such prescription and the patient wanting to pay cash is the second "red flag" for such prescription. I find it ironic that a pharmacist will fill such prescription especially if the patient is a New Jersey resident and wants to pay cash.

Look, no patient travels 100 miles because of your service. The typical arrest of a New York pharmacist has been caused by a New Jersey patient seeing a New York doctor who has no pain management experience and receiving an Oxycodone 30mg prescription for 180 tablets. In many cases, the New Jersey patient is getting the same prescription from a New Jersey doctor and paying cash at a New Jersey pharmacy. DEA and law enforcement will make a case on the patient and use that patient in the prosecution of the prescriber and the pharmacist.

One recommendation is for a pharmacy to only accept insurance payments for Oxycodone and Morphine Sulfate prescriptions. Also it is a good rule of thumb that the patient must be a resident of New York with a valid New York State driver's license. An **I-Stop** profile should be done for every opioid prescription after you verified the prescription with the prescriber even if the prescription is an electronic prescription.

As a pharmacist or the owner of a pharmacy, you need to have in place an internal policy pertaining to Oxycodone and Morphine Sulfate prescriptions. All pharmacy staff will need to adhere to such policy. In doing so, you will prevent yourself from being a target of a DEA and law enforcement investigation the costs of which can be a serious problem for you emotionally and financially.

- Carlos Aquino, ©2016 Carlos Aquino

Treasurer's Corner

From page 4

sponsors by using no transparency for sponsors. They claim their "specialty" pharmacies are increasing saftey, safety from what –competition? They state they help patients make informed decisions, they mandate compliance with their formularies, blocking as best they can any deviation from their choice drugs, which garner them the best reimbursement from the manufacturers. They also claim to increase adherence for chronic care patients, when they do not have the face to face effect local pharmacists can have on a patient's compliance with their long term medication. They tout that they have created a network of select pharmacies, when we all know they are making an effort to limit the network participation of our pharmacies.

This is why the new MAC pricing Bill passed last year is going to have an effect on your bottom line; the state now mandates that there is a set appeals process available for those underwater MAC prices. March 10, 2016 was the date it became law. You need to file the appeal process for an adjustment to any MAC price below your cost, the PBM must respond within 7 days, and if the appeal is rejected must inform you of a New York wholesaler selling the drug at their MAC price. This needs our input to be effective; we have to submit our disputed prices to the PBMs if we want to make the PBMs accountable for correcting the discrepancies.

This was a hard won battle for our industry in New York State, one of many we have been able to implement to help pharmacy in the past few years. The battle continues on a national level this May as NCPA holds its political action meeting in Washington, and we take the message to Congress that this unregulated middleman has got to be made to be accountable for its actions in raising the costs of healthcare in America. We need to keep the pressure on in this battle. Nobody wants price controls on any free marketplace operation as this country was founded on a capitalistic free enterprise approach, but the drug industry better start doing a better job of self policing themselves on prices before one of the presidential candidates starts the chant to do exactly that, regulate drug prices.

- Bill Scheer, R.Ph.

PSSNY Executive Director

From page 4

We asked Assembly members to become a co-sponsor of A9529 Paulin and Senate members to introduce a matching bill.

Set Standards for Fair Pharmacy Audits (A9424-A Lavine/S7201 Hannon)

This legislation, which now has Senator Hannon as a sponsor, would establish reasonable and fair business practices for any entity conducting a pharmacy audit including a pharmacy benefit manager, health plan, third party administrator or other entity.

The three tenets of this legislation are:

- Fair notification of impending audits,
- Fair documentation, and
- Fair results.

We asked legislators to stop taking pharmacists away from critical time spent with patients to address unreasonable audit requests by becoming co-sponsors of these bills and supporting passage in the Senate/Assembly Health Committees.

Recognize and Regulate Pharmacy Technicians (A4841 Englebright/ S1883 Griffo)

New York is one of only four states lacking jurisdiction over unlicensed personnel employed in pharmacies. For the first time in nearly a decade, the many pharmacy groups with a stake in this legislation have come to agreement on the definition, details and qualifications that would be required of pharmacy technicians.

The current bills need to be amended to reflect this common ground and we expect that to be completed in the coming weeks. We explained to legislators that pharmacy technicians are individuals assisting in the dispensing process under the direct supervision of licensed pharmacists. Forty-five other states regulate technicians and we anticipate that if New York does so as well, there will be an increase in medication safety, pharmacists will be able to spend more time on patient care services, and the risk of drug diversion will be reduced.

We asked them to sign on as co-sponsors once the bills have been amended.

PSSNY members will need to continue to advocate for these issues in the coming months. Mark your calendars for in-district lobby days on May 12-13. More information will be released shortly to assist you in meeting with your local legislator.

Respectfully submitted,

- Kathy Febraio, CAP

PSSNY Executive Director

The future of the profession: A glimpse of the nearly 300 LIU students on Pharmacy Advocacy Day in Albany.

ISMP

From page 11

aloud the patient's date of birth.

Employ technology. Consider linking the register with the pharmacy computer system so that when the barcode on the prescription receipt is scanned a blind prompt requires the pharmacy staff member to ask the customer for the birth date, then key punch it into the register. If the date of birth does not match the patient's profile or is not entered, the transaction cannot be completed.

Open the bag. The opportunity for a final accuracy check is lost when a prescription is handed over without the bag being opened before the patient leaves the pharmacy. Have the patient look at the prescription vials and the medications they contain to verify what was ordered and expected. This may not be appropriate when a friend or neighbor is picking up the prescription. In these cases, patient's should be told to open the package at home, check the contents before taking any of the medication, and call the pharmacist with any concerns or questions.

Flag patients with similar names. Include electronic notes in computer systems to warn about patients with similar names. Alerts should appear when these patients are selected during prescription data entry. These flags should also be visible at the point-of-sale.

Educate patients. Patient education sessions should include a discussion of the medication's purpose to help ensure the correct medication is being dispensed to the correct patient. Teach patients how to actively participate in patient and medication identification. This may not be possible if someone other than the patient is obtaining the medication(s), so important information must be conveyed to the patient via telephone.

Quality processes. Pharmacy managers should periodically perform quality control checks by observing the processes at the point-of-sale to ensure adherence to the standardized work practices.

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