On April 1, 2008 Mary Walker will be the new Executive Director of the Wyoming Board of Pharmacy. Mary is part of a long-time Wyoming pharmacy family who owned Newcastle Drug and Jewelry from 1910 to 1990. Being born in Newcastle, growing up near the drug store, and having an interest for biology and chemistry, Mary naturally developed a great passion for pharmacy. With the help of a strong female pharmacist mentor, Mary was driven to not only pursue a career in pharmacy but also become heavily involved in Wyoming's pharmacy practice.

Mary graduated from the University of Wyoming School of Pharmacy in 1974 and worked in various retail and hospital pharmacies in Cheyenne, Thermopolis, and New Castle. Since 1987, Mary has been the Director of Pharmacy at Cheyenne Regional Medical Center. She has earned several honorable awards and designations throughout her career as a Wyoming pharmacist. Mary received the UW Preceptor of the Year in 1995, the Wyoming Hospital Pharmacist of the year in 1995, and the Wyoming Bowl of Hygeia Award in 2005. She was also president of the Wyoming Pharmacy Association (WPhA), Zonta International Club of Cheyenne, and Wyoming Society of Health-System Pharmacy (WSHP).

Mary originally had the vision of starting a pharmacy residency program at Cheyenne Regional Medical Center, which is now up and running. She advocated and worked with the Board of Medicine to allow pharmacists the opportunity to administer immunizations. Mary eventually wants to start an education program for technicians and make it possible for pharmacy interns to administer immunizations themselves.

Mary enjoys being a leader and setting examples for others to follow. Through her leadership experiences, Mary hopes to reach out to pharmacists across Wyoming and encourage them to voice their opinion and be active members of WPhA. Mary maintains that the pharmacy community must be able to stay united, have strong voices, and learn from each other.

Mary feels the Board of Pharmacy does not need to travel in a new direction. Instead, Mary is ready to take on the Board’s current agenda. Mary plans to help revise Chapter 8 of the Controlled Substance Act Rules and Regulations and have technician license renewal accessible through the Board of Pharmacy’s Website. She plans to support other associations’ endeavors and keep current with all of the issues affecting the pharmacy community.
Plan on attending the Wyoming Pharmacy Association 91st Annual Convention in Casper June 26-28, 2008. The event will include ACPE accredited education sessions, Golf Tournament, University of Wyoming School of Pharmacy Benefit Auction, WPhA/WSHP Awards Presentations, and social times to interact with colleagues, friends, vendors and family.

The educational sessions will include topics such as National Pharmacy Update, Collaborative Practice, HIV Update, E-Prescribing, New Drug Update, Board of Pharmacy Law Update and How to Utilize Your Technician. Pharmacists will receive ACPE education credits and technicians will receive WPhA continuing education credits.

Some of the vendors this year will include AmerisourceBergen, Daiichi Sankyo, McKesson, Novo Nordisk, NuAire, Inc., Pharmacists Mutual Companies, Rx-Plus Pharmacies, Wal-Mart, Walgreens, Wyoming Immunization Program, and the Wyoming Professional Assistance Program, Inc. Our Brown and Gold Sponsors for this convention already include AmerisourceBergen, McKesson and Rx-Plus Pharmacies. The WPhA Board appreciates all of the support received from these vendors.

There is still time to nominate a colleague for the Wyoming Pharmacist of the Year, Wyoming Technician of the Year, Bowl of Hygeia, Distinguished Young Pharmacist, and Innovative Pharmacy Practice. These awards will be presented on Saturday, June 28, 2008. Please use the form below to nominate a colleague for an award.

**2008 WPhA Awards Nomination Form**

Send completed form to: WPhA, Attention: Awards, P.O. Box 228 Byron, WY 82412 or e-mail to: director@wpha.net by May 1, 2008

Name of Award: __________________________________________________________

Nominee Information: ______________________________________________________

Name: _________________________________________

Home Address: ____________________________________________________________

Work Address: ____________________________________________________________

Home Phone: _________________________ Work Phone: _________________________

Supporting Information, contributions to the profession of pharmacy:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Nomination Submitted By: __________________________________________________

Name: _________________________________________

Home Address: ____________________________________________________________

Work Address: ____________________________________________________________

Home Phone: _________________________ Work Phone: _________________________

E-mail: ________________________________________________________________
New Anti-Hypertensive Treatment Option

Jessica Meyer, PharmD Candidate, University of Wyoming

Hypertension affects more than 26% of adults in the United States and is a major risk factor for heart failure, congestive heart disease, and other debilitating conditions. On March 6, 2007, Tekturna (aliskiren) became the first oral direct renin inhibitor (DRI) approved by the Food and Drug Administration for the treatment of hypertension. Aliskiren targets the first rate-limiting step of the renin-angiotensin-angiotensin-adosterone system. It blocks the conversion of angiotensinogen to angiotensin I. This then decreases the formation of angiotensin II, a very strong blood pressure elevating peptide. Historically, similar medications target the system further down the pathway at the angiotensin converting enzyme (ACEI) and angiotensin receptor level (ARB).

Aliskiren is poorly absorbed with about 2.5% of the medication bioavailable. When taken with high fatty meals, the absorption is decreased even more by 71%. A majority of the aliskiren dose is hepatically metabolized by the CYP 3A4 pathway. In patients with hepatic or renal dysfunction, clinical studies found no significant pharmacokinetic changes. Therefore, no dosage adjustment is required for hepatic or renal failure. Lipitor (atorvastatin) and ketoconazole may increase the levels of aliskiren. When taken in conjunction with other medications, the aliskiren dosage may need to be adjusted.

Studies have found that aliskiren is well tolerated and has a side effect profile similar to placebo and ARBs. Side effects associated with aliskiren treatment include dizziness, diarrhea, rash, hyperkalemia, hypotension, and cough (1-2%). Aliskiren, unlike ACEIs, does not increase the bradykinin levels that lead to cough and angioedema. In clinical trials, angioedema with aliskiren occurred 0.06%. If angioedema of the head and neck does occur, aliskiren should be immediately discontinued. Aliskiren can potentially cause injury and death to a developing fetus in the second and third trimesters of pregnancy. For this reason, aliskiren has a black box warning prompting the discontinuation of its use as soon as possible once pregnancy has been detected.

Aliskiren can be taken alone or with other antihypertensive agents and is available as brand only in both 150 mg and 300 mg unscored tablets. The recommended starting dosage of aliskiren is 150 mg once daily. In those patients with uncontrolled blood pressure, doses may be increased to 300 mg once daily after two weeks. Daily doses greater than 300 mg increase the incidence of diarrhea without improving blood pressure control. The monthly cost of a 150 mg and 300 mg supply is about $74 and $93 respectively, while the monthly cost of lisinopril, an ACEI, is about $10 to $20.

In clinical studies, once daily dosing aliskiren as monotherapy and in combination with a thiazide diuretic, a CCB, an ACEI, or an ARB has proven to maintain 24-hour blood pressure control. Aliskiren was found to be as effective as the other anti-hypertensive classes and is comparable to lisinopril in the treatment of severe hypertensive patients. However, as described earlier aliskiren is not equivalent to lisinopril in price. Future studies will evaluate the use of aliskiren in the treatment of congestive heart failure, diabetic nephropathy, renoprotection, and cardioprotection.

References:
5) Pool J. Direct Renin Inhibition: Focus on Aliskiren. Journal of Managed Care Pharmacy. 2007; 13 (8); S-b.
CMS Amends AMP Rule, Implementation Still Blocked

The federal government has tweaked its final interim rule on average manufacturer price that would severely cut Medicaid pharmacy reimbursement, but the change leaves unresolved several other issues that led community pharmacy to successfully sue to block the rule.

The proposed change is to redefine “multiple source” drugs. In a joint statement, the National Association of Chain Drug Stores (NACDS) President & CEO, Steven C. Anderson, IOM, CAE, and NCPA Executive Vice President & CEO Bruce T. Roberts, RPh, said:

“NACDS and NCPA are pleased that the Centers for Medicare & Medicaid Services (CMS) have acknowledged serious legal concerns about the agency’s definition of ‘multiple source drug’. CMS acknowledges that it revised the definition in response to our lawsuit, which challenged the definition of multiple source drugs contained in the original rule. We are reviewing the revised rule to ensure that CMS will in fact comply with the statute. If we determine that the revised rule does not comply with the statute we may need to raise the issue with the federal court that has jurisdiction over our ongoing lawsuit.

“It is important to note that this revised rule does not eliminate the lawsuit filed by NACDS and NCPA in November of 2007 to block the average manufacturers price (AMP) rule, which would drastically cut reimbursement payments to community pharmacies that serve disadvantaged Americans in the Medicaid program. The injunction against the AMP rule remains in place.

“This rule does not address two other major arguments in the lawsuit: 1) the AMP rule does not comply with the Social Security Act’s definition of AMP; and 2) the AMP rule improperly applies federal upper limits on reimbursement to non-equivalent drug products.

“While we are hopeful for continued success in court, NACDS and NCPA will continue to encourage Congress to work with pharmacy to find more appropriate models for reimbursement under Medicaid.”

Schedule of Events

- April 15, 2008—USP797 Conference Call
- April 16-17, 2008—Wyoming Board of Pharmacy Meeting in Casper
- April 21-22, 2008—Wyoming Business Coalition on Health “Improving Quality to Lower Costs” stakeholders meeting
- June 25-26, 2008—Wyoming Board of Pharmacy Meeting in Casper
- June 26-28, 2008—91st Annual WPhA Convention-Parkway Plaza, Casper
- June 29, 2008—University of Wyoming Preceptor Workshop, Parkway Plaza, Casper
- September 2008—Technician Conference-date and place to be determined.
Wyoming Legislative Update

SF78

During the Legislative Session this February, the Wyoming Pharmacy Association worked with Senator Jane Mockler and the National Community Pharmacists Association (NCPA) to support and pass Senate Bill 78 (SF78) which required Pharmacy Benefit Manager (PBM) transparency. President, Whitney Buckley, Pharm D, spoke before the Senate Health Committee regarding this legislation. This committee approved this legislation to be sent to the Senate Floor for vote.

Unfortunately, the legislation failed by not even being introduced. There was great opposition from the PBM companies. This will be legislation that we will support again in the future. This legislation is still important for community pharmacies, employers, and other health care providers. Here are just some of the ways PBMs wreak havoc in the marketplace:

- Spread Pricing: PBMs bill employers at a higher rate than they reimburse pharmacies, pocketing the difference, or “spread.”
- Rebates: PBMs receive rebates from drug manufacturers and, in turn, alter their formularies depending on those rebates.
- Mail-Order: PBMs often have coercive co-payments or mandatory mail-order in their plans, even though they own their own mail order facilities, an obvious conflict of interest.

SF78 would have fixed this problem in Wyoming by requiring disclosure by PBMs of their business dealings, allowing private insurers and patients a better understanding of their prescription drug benefits. It would require PBMs to act, not in their best interest, but the best interest of the covered entities and patients. SF78 will save Wyoming money, resulting in a savings for taxpayers as well.

HB0127

WPhA also worked on changing the language of House Bill HB0127 on Prescription Drugs—Physician Shopping. This legislation was introduced by Representatives Simpson, Gingery, and Lubnau, and Senator Fecht. The way the legislation was originally worded, it would have been considered an “unlawful act” for a pharmacist to dispense a controlled substance to a person who is knowingly trying to obtain it by misrepresentation. While the intent of the legislation is good, “knowingly” is a very broad term. The legislation was changed to not include that language.

MISSION STATEMENT:
The mission of the Wyoming Pharmacy Association is to advance the practice and profession of pharmacy through education, understanding, and promotion.

VISION STATEMENT:
Wyoming pharmacists and technicians are recognized for their significant contributions to the health care field. They are caring and competent individuals who improve the use of medications, assure the safety of drug therapy, and enhance health-related quality of life.
WPhA’s Pledge to the University of Wyoming

The Association believes in the University of Wyoming's vision to provide the opportunity for its students to seek and achieve a better life through its mission of teaching, research and service. At the 90th Annual Convention the Board, from direction of the membership, committed to a $50,000.00 pledge agreement. To date, the Association has raised $4,375.00 towards this pledge. We need your help to make this commitment happen. To assist us in this pledge please send your pledge to WPhA, UW Pledge, PO Box 228, Byron, WY 82412.

Thank you to those who have already contributed!

Shatto’s Frontier Drug  Robert Nelson  Ronald Yoxe
Medical Center Pharmacy  Dave & Karen Burk  Matthew Titchener  Art Zube
Powell Drug  Joan Anderson  Bruce Hoffman  Elizabeth Cantrell  Norleen Julian

MEDICARE ACTS TO REDUCE THE NUMBER OF YEARLY DRUG PLAN REASSIGNMENTS AMONG LOW-INCOME BENEFICIARIES

Today, the Centers for Medicare & Medicaid Services (CMS) issued a final regulation that could allow nearly one million Medicare beneficiaries with limited income and resources to remain in the Medicare prescription drug plan in which they are enrolled without having to pay a premium.

The new rules apply to people with Medicare who are eligible for Medicare’s extra help program, the low-income subsidy (LIS) provided under the Part D prescription drug program. Currently, LIS beneficiaries who are enrolled in prescription drug plans that no longer offer a zero-premium plan, and who have not made an affirmative choice to change plans, are reassigned by Medicare to a different prescription drug plan in their region that offers coverage with no premium.

The final rule changes the way that Medicare will calculate the regional low-income subsidy benchmarks, based on comments received on the proposed rule issued in January. The LIS benchmarks reflect the amount of a plan’s premium that will be paid by the Federal government through the low-income subsidy. For example, the Federal government pays up to 100 percent of the Part D premium for LIS beneficiaries who are in plans with premiums below the regional LIS benchmark. Lower low-income subsidy benchmarks mean that there are fewer plans that offer low or zero-premiums for low-income subsidy beneficiaries. That results in more beneficiaries being reassigned to other plans.

Under the final rule, these benchmarks will be weighted based on each plan’s share of enrollees receiving the low-income subsidy, rather than their share of total Part D enrollment. This means plans with a greater number of low-income subsidy enrollees will be a larger factor when CMS calculates the benchmark. This will help to ensure that the premium subsidy amount better reflects the plans that low-income subsidy beneficiaries are enrolled in. This will result in fewer LIS beneficiaries seeing their drug coverage disrupted by having to change prescription drug plans in order to avoid paying a premium. For example, if the regulation issued today had been in place for 2008, the number of reassignments would have been reduced by 850,000.

The final rule is effective May 31, 2008. The rule can be read online and will be available at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/CMS4133F.pdf
Pharmacy Groups Unveil Findings, Future of “Project Destiny”

Next phase begins in effort to enhance pharmacy’s role in patient-centric healthcare

WASHINGTON, DC – According to initial results of the landmark “Project Destiny” initiative, community pharmacy can ensure its healthcare services beyond dispensing medication are embraced broadly, if it acts decisively and cooperatively with healthcare industry stakeholders. The three pharmacy groups advancing the initiative now are developing a strategic plan to advance the concepts identified in the first phase, which hold promise for healthcare quality, access and affordability.

Project Destiny is a joint initiative of the American Pharmacists Association (APhA), the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association (NCPA). Pharmaceutical companies supporting the project financially include sanofi-aventis, GlaxoSmithKline, Boehringer Ingelheim Pharmaceuticals, Pfizer U.S. Pharmaceuticals and Wyeth.

The stated objective of Project Destiny is to develop a replicable, scalable, measurable, and economically viable future model for community pharmacy. The project seeks to identify ways that patients and the healthcare system can benefit from community pharmacy’s medication expertise, in a way that is economically viable for all parties.

To that end, the groups hired BearingPoint, which conducted extensive research and interviews with patient and provider groups, and private and public payers. BearingPoint also led the intensive analysis of the interview results, as well as the development of potential next steps for community pharmacy.

One key concept that emerged from the first phase of the project is that of a “primary care pharmacist,” who would work collaboratively with the healthcare delivery and financing systems and focus on managing medications, positively impacting health outcomes, reducing overall healthcare system costs and empowering consumers to actively manage their health. Putting this concept into practice would require the development of pharmacy-based Patient Care Management Services that are consistent nationwide while maintaining the autonomy of individual pharmacies.

“We will not succeed in our efforts to improve health and save money without innovative new steps to coordinate care,” said Mark B. McClellan, M.D., Ph.D. Director, Engelberg Center for Health Care Reform; Senior Fellow, Economic Studies; Leonard D. Schaeffer Director's Chair in Health Policy; Brookings Institution. “Helping pharmacists work together with physicians, payers, and other stakeholders is critical to achieving the goal of affordable, accessible, quality health care.” Dr. McClellan is also the former administrator for the Centers for Medicare and Medicaid Services (CMS) and former commissioner of the Food and Drug Administration (FDA) in the U.S. Department of Health and Human Services.

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