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— Jake Olson, Pharm.D.
Skywalk Pharmacy
Milwaukee, WI
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Tell Us What You Really Think

This issue includes the second of two articles on the impact DIR (direct and indirect remuneration) fees are having on retail pharmacy. The author, Bruce A. Semingson, former chief operating officer of American Associated Pharmacies and former CEO of United Drugs, estimates that PBMs may reap as much as $2.16 billion in DIRs from their Medicare Part D pharmacies in 2016. Perhaps just as bad as the costs of DIRs is their unpredictability, which can make hiring and capital investment decisions a challenge.

These DIR fees represent the breaking of the PBMs’ “adjudication promise” (our term, not theirs!). For example, one month the PBM adjudicates a claim payment of $25 for that prescription you just filled. Several months later, they may come back with a $7 retroactive payment clawback. That’s not right.

I hope you read this month’s article on pharmacy performance measures and the one in the November America’s Pharmacist. They are worth investing your time and underscore the importance of maxing out your pharmacy’s quality measures. Please channel that motivation through your voice in Washington. At NCPA’s Annual Convention this past October, keynote speaker Greg Bell reminded us that we’ve moved from the agricultural age to the industrial age to the technology age and now we are in the relationship age. Like it or not, Uncle Sam is pharmacy’s biggest customer. We will be reaching out to you with specific actions you can take as the Nov. 8 results continue to sink in and the new president and Congress assume office next month, but I can tell you that No. 1 on the list is to position yourself to have a relationship with your representatives in Congress.

DIRs, of course, are not the only issue confronting pharmacy owners and managers today. We know that in part because of our annual Member Priority Survey, which will help further inform the NCPA board, officers, and staff in 2017. We hope you take a few minutes to fill out the survey, and we have been providing a link to it regularly in eNews. The survey deadline is Jan. 6.

Many of you already have told us that the need for MAC transparency and timely price updates remain a top issue. What about any willing pharmacy having access to Medicare Part D preferred networks? How Medicaid calculates its payments to pharmacies? Pharmacist provider status under Medicare Part B?

Along with legislative and regulatory priorities, we’d like to hear from you about our programs and services intended to strengthen business practices and the profession of community pharmacy:

- Assisting in creating community pharmacy pay for performance networks?
- Developing programs that help pharmacies start new revenue-generating niche services?
- Creating programs on quality measures and Star Ratings and their effect on pharmacies?
- Spurring innovation by sharing information about other innovative pharmacy owners?

The Member Priority Survey helps us be sure we are meeting your expectations. It is intended for owner/managers, should take less than 10 minutes, and can be completed on any electronic device. Take a few minutes today to give us your input on what NCPA can do for you during the 2017 calendar year.

Best,

B. Douglas Hoey, Pharmacist, MBA
NCPA Chief Executive Officer
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This is the traditional month to make New Year’s resolutions. Here are some advocacy-oriented ones to consider:

- Set up a regular monthly contribution plan to the NCPA Political Action Committee (personal funds only) and the NCPA Legislative/Legal Defense Fund (corporate contributions OK).
- Get off on the right foot with your just-elected members of Congress and invite them to visit your pharmacy.
- There’s strength in numbers. Renew your NCPA membership and recruit a new member.
Explaining OptumRx’s VAWD Requirement for Pharmacies

Q: We received a notice from OptumRx that our wholesalers must be VAWD with the NABP. What does that mean?

A: Effective Oct. 1, 2016, OptumRx added changes to its provider manual that all of a pharmacy’s wholesalers must be “Verified Accredited Wholesale Distributors” (VAWD) with the National Association of Boards of Pharmacy (NABP). As a network provider in OptumRx’s network, all pharmacies are being required to comply with the terms and conditions of their agreement and provider manual. The OptumRx Provider Manual is available online at http://bit.ly/paas-optum.

OptumRx explains how non-VAWD can apply for this accreditation through NABP in a recent memo. OptumRx states that it reserves the right to allow unique or limited distribution-type medications to be purchased from non-VAWD in extenuating circumstances with written and approved consent only.

By Mark Jacobs, RPh, PAAS National, the Pharmacy Audit Assistance Service. For more information, call 888-870-7227 toll-free, or visit www.paasnational.com.
Pharmacist’s Persistence, Compassion, Sets Positive Example

While using the original prescription to verify a refill for the antidepressant Effexor XR (venlafaxine extended release), a pharmacist discovered that the prescription had incorrectly been filled on the previous refill with 75 mg capsules instead of 150 mg capsules. Two months prior, the patient was started on Effexor XR 37.5 mg daily with instructions to titrate up to 75 mg daily over the first month. The patient was then to receive 150 mg daily after the first month. We have previously written about errors caught when dispensing refills and recommended to always verify against the original prescription.

What stood out in this recent event is the pharmacist’s persistence in following up with the prescriber and the patient as well as his advocacy on behalf of the patient with the prescriber. After discovering the error, the pharmacist contacted the prescriber and was directed to move forward with the 150 mg strength as originally prescribed. The pharmacist then called the patient to inform her of the error. When assessing how the patient was feeling given the error, he discovered that she in fact was feeling very well and was planning to be away from home for a couple of weeks. Given the patient’s current condition and travel plans, the pharmacist reached back out to the prescriber to recommend that the patient be kept on Effexor XR 75 mg.

After further discussion with the pharmacist and patient, the prescriber agreed with the pharmacist’s recommendation. We would like to highlight this pharmacist’s effective and compassionate response to the error. We hope others follow his example.

LABEL CHARACTERISTIC CONTRIBUTES TO ERRORS

The way the manufacturer’s strength is oriented on a product container label is an important safety consideration, especially for pharmacists, pharmacy purchasers, and medication safety officers. The Apotex brand of ARIPiprazole tablets is a case in point. Take a look at the bottles at left. The bottle size, shape, label, and container colors are all similar. Still, you would certainly be able to identify what the medication is. It is the way the product strength appears that is troubling. Since most drug containers are round, when strengths appear to the far right of the label, they may easily be missed if the container is turned just slightly. The drug name may be readily visible, but not the strength. Confirmation bias could lead to a mix-up. In this case, the font size used to express the strength is also much smaller than the font size used for the drug name, which may add to the confusion. A pharmacist told us that he recently picked up the wrong bottle and nearly dispensed the wrong strength.

Sometimes graphic designers and reviewers view sample label print-outs on a flat surface, without considering how the label will look when applied to a round container, or how the product will be stored and later used. When we checked label graphics from other U.S. ARIPiprazole generic manufacturers, they all had the strength either immediately following the drug name on the same line or had the strength centered immediately beneath the drug name, as it should be. When there’s a choice of brands for specific products, avoid labels that separate the dose/strength from the product name.

A good reference to check for container label appearance is DailyMed, a service provided by the U.S. National Library of Medicine (http://bit.ly/DailyMedlink). Whenever possible, use barcode scanning when selecting products. Also, make sure labels are facing forward when bottles are stored on a shelf.

This article is from the Institute for Safe Medication Practices (ISMP). The reports described were received through the USP–ISMP Medication Errors Reporting Program. Errors, near misses, or hazardous conditions may be reported at www.ismp.org. ISMP can be reached at 215-947-7797, or ismpinfo@ismp.org.
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— Jill and Fred S., Hamilton, AL

“I have never seen merchandising put together in such an easy-to-understand model.”
— Jason Callicoat, Paris Apothecary, Paris, TX
In last month’s column in America’s Pharmacist, we talked about the kind of message we should be sending out in our marketing materials when targeting the patient with diabetes. Not surprisingly, patients are not as motivated by words like “adherence” and “compliance” as they are by words like “proactive” and “remembering for you” when it comes to taking their medications.

Can we use these same concepts when we speak with physicians? Absolutely. It is, after all, about best practices for patient care.

The best marketing plays to solving pain points for people. When you work hard to keep patients adherent, it becomes a win-win for both them and their physician. Remember, you have a better idea than their physician about whether they are taking their medications correctly. That’s the piece that should become a central core for your physician detailing. “We are a proactive pharmacy that remembers for your patients and will not make your patient wait 24 hours to fill a prescription. Refill requests are made to your office sooner than same day. When it comes to working with the patient with diabetes, we stay involved and anticipate their needs.”

How often do you go out on physician visits? Once a week? Once a month? Never? I am here to tell you that physician detailing is an amazingly effective way to build your business. If you are uncomfortable doing it yourself, hire someone to do it for you. You don’t have to be a pharmacist to deliver the message about innovative practices your pharmacy engages in that have better patient outcomes.

I have interviewed physicians about how they feel about pharmacy sales calls. Interestingly, very few have pharmacies stopping in. I also learned that their preferences are that:

1. You set an appointment. Before the clinic opens or lunch times are best. And of course, bring food!
2. Each meeting has a purpose. Physicians know that you fill prescriptions. They may even know that you have great customer service and you are nice. What they don’t know is that you have 38 percent of your patients enrolled in a synchronization program and it has resulted in an 85 percent adherence rate. They may also be interested to learn that you take care of all prior-authorizations. See, these are things that make their lives easier and their patients healthier and sets you apart from other pharmacies.
3. Follow up. A nice note as well as some well-designed marketing piece will help keep you front of mind. Also, schedule a time on your calendar to go back with another interesting offering.

Recently I spoke with a pharmacy that does an amazing job with physician detailing. The pharmacist told me that after only three months of sales efforts, it has one provider that will likely account for 15 percent of the pharmacy’s current volume alone by the first quarter of 2017. Whether you are demonstrating patient adherence through your synchronization plan, educational components for your patients with diabetes, or one-on-one coaching, you can prove to physicians that you will make a difference in their patient’s overall health. The results speak for themselves. Now get busy and set up your doctor detailing plan for 2017.

Liz Tiefenthaler is the president of Pharm Fresh Media, a full-service marketing company focused on helping independent pharmacies gain new customers and build loyalty with their current customers. She can be reached at liz@pharmfreshmedia.com.
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Community pharmacy research fellowships play a pivotal role in expanding community practice

by Taylor James

Every day independent community pharmacy owners, their pharmacists, and the pharmacy staff make life-changing interventions on behalf of their patients. More often than not, these interventions are not reimbursable through the traditional pharmacy dispensing model in which payment is tied to a product. However, many of those in the profession have sought to change community pharmacy practice through advocacy, education, and research. One way this is being done is by colleges and schools of pharmacy employing faculty with expertise in community pharmacy practice. This allows pharmacy students to be given opportunities to learn more about practicing in a community-based setting during the didactic curriculum from the experts themselves. It gives students an understanding about the various practice opportunities in the community setting along with their experiential experiences. By expanding practice, community pharmacists are solidifying their role as health care providers who can offer more clinically based services beyond drug dispensing.
In 2007, the University of Pittsburgh established the first community pharmacy research fellowship after a mutual interest between the school of pharmacy and its current PGY-1 community pharmacy resident. Since then, programs have emerged at Purdue University in 2010, East Tennessee State University (ETSU) in 2014, the University of North Carolina (UNC) in 2014, and the Ohio State University (OSU) in 2015. The programs created so far, with the exception of the fellowship at ETSU, require community pharmacy residency training or equivalent experience.

GROWING OPPORTUNITIES
Additionally, opportunities for community pharmacy residency training have also grown. Community pharmacy residencies, which have expanded since their inception in 1986, provide residents with a one-year opportunity to advocate, teach, and complete research, along with gaining clinical practice experience. Through completion of a residency program, the goal was to establish community pharmacy experts as demand for pharmacy faculty and preceptors experienced in both practice and research continues to grow. However, a previous evaluation of newer pharmacy practice faculty showed that of those with only post-graduate training from a one-year community pharmacy residency, many believed they were unprepared to take on faculty roles, mostly due to lack of in-depth research experience. To help fill this gap, community pharmacy research fellowships have emerged nationally over the last decade. These research fellowships were created with the goal being to create highly skilled faculty in the area of community pharmacy practice.
FELLOWSHIP OVERVIEW
In simplest terms, a community pharmacy research fellowship is a program designed to focus on unique research opportunities involving community pharmacist-delivered patient care, and develop community pharmacy academic faculty. Typically, a fellowship program lasts two years. Unlike community pharmacy residencies, which are accredited by the American Pharmacists Association and the American Society of Health-System Pharmacists, community pharmacy fellowships have no accreditation body. However, those meeting specific standards can be successfully peer reviewed by the American College of Clinical Pharmacy Fellowship Review Committee, which is an indication of an “excellent training program.”

At each program, fellows have the opportunity to further their education and hone their research skills by completing graduate coursework individualized based on interest. Purdue University and OSU both offer the completion of a Master of Science degree. At the University of Pittsburgh, the fellow completes a Master of Public Health (MPH) degree. Fellows at ETSU are given the option to complete an MPH as well, or they have the ability to receive a graduate certificate in biostatistics, epidemiology, and health care management if they decide not to pursue an MPH degree. At UNC, the fellow enrolls in courses through the Translational and Clinical Research Curriculum, focusing on biostatistics, epidemiology, and career development. All of the fellowship programs offer teaching opportunities and certification. Each program is highly individualized, yet they share similar core features such as a mentorship approach, prerequisites, length of program, and overall structure. For more details about the structure and early program outcomes, please see “Fellowships in Community Pharmacy Research: Experiences of Five School and Colleges of Pharmacy,” published in JAPhA.

OPENING DOORS
Expanding clinical pharmacy experience and improving research development skills can open more doors for the world of community pharmacy. By further enhancing assets you can bring to the table, these particular fellowships can make you stand out and allow you to keep up with the ever-changing pharmaceutical field. As

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As of today, from the five established programs, there have been a total of seven graduates, with other fellows in various stages of their fellowship training. Following fellowship, all graduates accepted either tenure-track or clinical practice faculty positions with colleges and schools of pharmacy throughout the United States. Their participation in a community pharmacy research fellowship program has allowed them to advance their individual careers. Beyond just the participating fellow, community pharmacy practice has been able to prosper due to the work of these fellows and the program. The following are comments from the seven graduates.

“Initially, I was drawn in by the opportunity to conduct meaningful research to help advance community practice. I realized almost immediately that community pharmacy is an area that has potential to make an impact on patients, but is widely underappreciated. It was and is still my hope to advance this area of our profession through showing outcomes via sound research, thereby drawing me to a community pharmacy research fellowship.”

– Brianne Porter, PharmD, RPh, is a community practice advancement fellow at the Ohio State University College of Pharmacy, to be completed in 2017.

“My fellowship, first and foremost, allowed me to obtain a strong foundation in research through numerous opportunities for mentored research within many different practice settings and pharmacy organizations, as well as completion of my Masters in Public Health. I also highly value how the fellowship has enabled me to seamlessly transition into the next phase of my career as a junior faculty member.”

– Jennifer Bacci, PharmD, MPH, BCACP, is an assistant professor and Kelley-Ross Faculty Fellow at the University of Washington School of Pharmacy. She was previously a fellow in the University of Pittsburgh Community Pharmacy Research Fellowship from 2013 to 2015.

“I would not be in the position I am today without [my] fellowship. I developed skills in research, teaching, and practice that are all critical to my current work and made me more competitive in my search for a faculty position.”

– Caity Frail, PharmD, MS, BCACP, is an assistant professor at the University of Minnesota College of Pharmacy and previous Purdue University Community Pharmacy Practice Research Fellow, which she completed in 2013. She was the NCPA executive resident from 2009-2010.

“The fellowship program helped me further develop the skills I needed to become an independent researcher. It also provided me with additional teaching experience while broadening my area of expertise through the MPH program. This experience allows me to become a more well-rounded pharmacist with a lot more to offer as a faculty member to future student pharmacists.”

– Daniel Ventricelli, PharmD, MPH, is current assistant professor of clinical pharmacy in the Department of Pharmacy Practice at the University of the Sciences in Philadelphia College of Pharmacy, and was previously community pharmacy practice research fellow at ETSU Gatton College of Pharmacy, which he completed in June 2016.

the health care system focuses more on patient outcomes and value-based care, the skills that are developed during a fellowship have become even more essential.

“I believe completing a pharmacy research fellowship will set me apart from many of my colleagues also completing post-graduate training,” says Brianne Porter, PharmD, currently a community practice advancement fellow at the Ohio State University College of Pharmacy. “I have had and will continue to have many unique training experiences that will certainly prepare me for a career in academia, which is my ultimate goal. Additionally, I do believe as our profession considers to examine and evaluate what the ideal role of the community pharmacist is, those with training specific to advancing this area of our profession will serve as leaders in this process.”

Not only can completion of a community pharmacy research fellowship benefit the fellow by advancing his or her skill set, the community pharmacies benefit as well. Specifically in an independent community pharmacy setting, there are many opportunities for the pharmacy staff to collaborate with the ongoing research and utilize results to better their practice. Ultimately, these fellowship programs are proving to others something many of us already know—how vital pharmacists are at the community level, which will help establish future growth of the profession and reimbursement opportunities.

“Some of the pharmacists I have worked with chose to participate in research to help demonstrate their value so they could communicate this to their patients, prescribers, and payers,” says Caity Frail, PharmD, MS, BCACP, assistant professor at the University of Minnesota College of Pharmacy and previous Purdue University Community Pharmacy
Practice Research Fellow. “Creating new knowledge helps us better tell the story of what pharmacists can do, and helps us find better ways to serve our patients.”

**GAINING INFLUENCE**

One of the primary reasons to become a community pharmacist is the tremendous opportunity to become one of the most influential and accessible health care professionals in our patients’ everyday lives. With the help of independent community pharmacies, fellows can participate in research at these sites in areas such as medication therapy management (MTM), transitions of care, and medication synchronization, to name a few. Community pharmacy research fellowships provide fellows with many opportunities to make an impact at the patient level, and these fellows have been able to use their experiences to strengthen community pharmacy entirely.

“Training pharmacy students and residents in community pharmacy innovation, implementation, and evaluation is the greatest impact I have had or have on community pharmacy practice as a fellow, and now, as a faculty member,” says Jennifer Bacci, PharmD, MPH, BCACP, current assistant professor and Kelley-Ross Faculty Fellow at the University of Washington School of Pharmacy, and a previous fellow in the University of Pittsburgh Community Pharmacy Research Fellowship from 2013 to 2015. “I use the training I received during my fellowship to help teach and mentor others who are passionate about community practice. During my fellowship, I mentored 12 community pharmacy residents across the Commonwealth of Pennsylvania and more than 20 Pitt pharmacy students in performing community pharmacy-based research, all of whom have gone on to make a difference for their patients and their practice. It’s creating a ripple effect.”

**ADVICE FOR STUDENTS**

As a student interested in community pharmacy or academia, start looking into community pharmacy residencies and fellowships now. Attending conferences such as the NCPA Annual Convention is a great way to network with community pharmacy leaders. Talk with your school’s faculty and see what opportunities they are aware of and what connections they can help you make.

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Feedback from Fellows (Continued from page 42)

“Community pharmacy research is itself a small niche and only a handful of faculty are continuously contributing to this area. The fellowships are a great way to increase the number of researchers contributing to the field. The reason we need this work is to shape health policy to support community pharmacists’ role in health care and inform health insurers, pharmacy corporations, and individual pharmacists in how to actually implement changes to the profession. Then, as changes are taking place, community pharmacy research can measure the impact on humanistic, economic, and health outcomes.”

– Megan Smith, PharmD, is current assistant professor in the Department of Pharmacy Practice at the University of Arkansas for Medical Sciences College of Pharmacy, and previously a Community Pharmacy Research Fellow at UNC Eshelman School of Pharmacy, Division of Practice Advancement and Clinical Education, which she completed in June 2016.

“Get to know the people who are pioneers in the field that interest you. How do you do that? Read, read, READ! Take the time to read those journals your pharmacy school subscribes to! Once you’ve found what interests you, look up the people that wrote those articles and see what they’ve done. You can find great mentors and opportunities that way.”

– Stephanie Gernant, PharmD, MS, is an assistant professor of Pharmacy Practice at Nova Southeastern University College of Pharmacy. She completed her fellowship in 2015 at Purdue University.

“During pharmacy school, try to find ways to become involved in community pharmacy practice based research….Being able to have that experience during pharmacy school helped ignite a passion for pharmacy practice based research and solidify my decision to complete a community pharmacy academic fellowship.”

– Chelsea Phillips Renfro, PharmD, is a Community Pharmacy Academic Fellow at UNC Eshelman School of Pharmacy, to be completed in June 2018.

With the constant evolution in health care practices, it is increasingly important for pharmacy to continue advancing and evolving as well. Particularly in community pharmacy, we have the opportunity to reach out to many lives and further improve pharmacist-delivered patient care. Fellowship programs can be utilized by the participating pharmacies to advance their practice as health care providers. The capacity for growth within the profession itself, as well as with research, teaching, and practice skills, provide a strong foundation for the continuing success of community pharmacy research fellowships.

The ability to conduct practice-based research in a community setting is invaluable to the growth of the pharmacists in those positions and can better prepare them to take on roles as university faculty to further educate others about community pharmacy. As a result, the development of future experts will help take the practice to the next level and further strengthen the role it plays in pharmacist-delivered patient care.

“Any profession needs to consistently reinvent itself; otherwise, it suffers from becoming outdated,” says Stephanie Gernant, PharmD, MS, who became an assistant professor of Pharmacy Practice at Nova Southeastern University College of Pharmacy after completing her fellowship in 2015 at Purdue University. “Pharmacy fellowships and community research keep innovation flowing into the profession and set it up for future success.”

Taylor James is a 2017 PharmD candidate at the Purdue University College of Pharmacy.
In fact, you could argue that we are the largest investor in community pharmacies, lending close to $750 Million to the industry since 2010. Contact your lending experts today.
USP <800>: How Your Pharmacy Can Prepare

One compounding pharmacy shares its story and the importance of homework and preparation

by Jennifer L. Bruckart, CPhT
Photography by Jennifer L. Bruckart

When it comes to compounding, federal regulation is increasing by the day. Whether it’s the Drug Quality and Security Act potentially eliminating office use for 503A pharmacies, or the Food and Drug Administration issuing new draft guidance for industry relating to compounding for veterinary use, it’s more important than ever for compounding pharmacies to stay ahead of the regulations and be prepared to make changes to their business.

Perhaps the greatest challenge ahead lies in preparing for the implementation of United States Pharmacopeial Convention (USP) General Chapter <800>, a set of guidelines that sets new standards for the handling of hazardous drugs in health care settings, including pharmacies.

The requirements are significant and impact nearly every pharmacy that performs compounding services. The current implementation date has been set for July 1, 2018, and barring a delay at the individual state level, pharmacies will need to take a serious look at what is needed to comply with the new regulations.

HAZARDOUS DRUGS: A FOCUS ON SAFETY
USP <800> specifically looks at the handling of hazardous chemicals in the practice of compounding. It details a series of processes that will be required to minimize exposure to hazardous drugs (or potentially hazardous drugs) in health care settings. Its purpose is to protect the employees and patients who routinely come in contact with these drugs.

The chapter was officially published on Feb. 1, 2016, after two years of comments from the industry. Its scope is not limited to pharmacies. The chapter also applies to hospitals, clinics, physician offices, and veterinary clinics—essentially any facility where hazardous drugs are stored, prepared, or administered.
It’s a common misconception that USP <800> only applies to sterile compounding. However, it’s important to note that USP <800> applies to all forms of compounding, even non-sterile. Any pharmacy that performs any manipulation (such as crushing or mixing) to any drug identified as hazardous must follow the requirements of the new chapter.

**WHAT’S A HAZARDOUS DRUG?**

As mentioned, USP <800> deals with a specific subset of drugs—those identified as hazardous or potentially hazardous by the National Institute for Occupational Safety and Health (NIOSH). NIOSH makes the determination based on a drug having at least one of the following six characteristics: carcinogenicity, teratogenicity, reproductive risk, organ toxicity, genotoxicity, or new drugs that mimic existing hazardous drugs in structure or toxicity.

NIOSH maintains and publishes the list of hazardous drugs. The most recent update came out in September 2016, and it added 34 new drugs to the list. The list contains the usual suspects—chemotherapy drugs and others that pose significant toxicity concerns. Visit [http://www.cdc.gov/niosh/topics/hazdrug/](http://www.cdc.gov/niosh/topics/hazdrug/) for more information.

However, it also contains some drugs that compounding pharmacies use on a daily basis, including hormones like testosterone, progesterone, and estrogen, along with drugs such as apomorphine, fluconazole, misoprostol, and tretinoin. As a result, nearly every compounding pharmacy will be affected by USP <800>.

**GETTING A HEAD START**

As I’m writing this article, I’m preparing to head to PCCA’s International meeting in Houston. I’m hoping to talk to other pharmacies that have read USP <800> and find out what they’re doing to prepare.

In the meantime, I thought I would share what our pharmacy is doing to get ready. Although the 2018 deadline seems like far away, as we’ve already discovered, there is plenty pharmacies can (and should) be doing now to prepare.

**Buy and Read USP <800>**. I recommend every compounding pharmacy owner read USP <800> to get the best understanding of the new guidelines. It’s a relatively quick read at 18 pages, but it contains very explicit guidelines for everything from lab design to pharmacy operations.

As you read, pay particular attention to the use of the words “must” versus “should.” The chapter contains a lot of general recommendations and best practices noted with the use of the word “should.” These are helpful, but it’s imperative that pharmacies pay attention to the requirements that start with “must.” A few of these are noted below.

**Pharmacies must:**

- Maintain a list of hazardous drugs that includes the NIOSH list and review it annually.
- Implement facility and engineering controls. *(This one’s a real doozy...more on this later.)*
- Ensure employees don appropriate personal protective equipment (PPE) during any potential exposure to hazardous drugs.

The only way to access the full text of USP <800> is to buy it directly from USP. Pharmacies can purchase the chapter through a 12-month subscription to the USP Compounding Compendium ($150). The compendium also includes more than 40 general chapters relevant to compounding, including the full text of USP <795> and <797>. It is available to NCPA members at the online bookstore (www.ncpanet.org/bookstore).

**Make Business Decisions.** With the new guidelines, it’s almost impossible for a pharmacy to do “a little” compounding. Some pharmacies may look at the requirements for the lab design alone and make the decision to get out of compounding altogether. If you read the online message boards, that’s certainly been the decision of some pharmacies.

But for young compounding pharmacies like ours, we saw the new guidelines as a chance to improve our business and even expand our services. Either way, it comes down...
Under USP <800>, pharmacies must maintain a list of hazardous drugs located in the pharmacy. The list must be reviewed and updated.

to a business decision that many pharmacies will need to make in the months ahead.

Find USP <800> Experts. Fortunately, a number of organizations are working diligently to develop resources to help compounding pharmacies prepare for USP <800>. In the past six months, industry groups such as NCPA, IACP, PCCA and others have hosted webinars and developed helpful FAQs to help pharmacies understand the new guidelines and make a plan. If you haven’t done so already, visit these organizations’ websites and access recordings of past webinars and other resources to help in your preparations.

Additionally, given the chapter’s new guidelines for lab design, PPE, and cleaning, find vendors who specialize in these areas and have experience helping compounding pharmacies and are familiar with USP <800>. The last thing you want to do is invest in an overhaul of your lab to find out it doesn’t comply with the requirements.

Review Your Policies and Procedures. For our pharmacy (less than two years old) with a small staff of 1-2 compounders, we had not yet developed any substantial standard operating procedures (SOPs). Once we saw the extent of USP <800> guidelines that detailed everything from cleaning procedures to processes for opening hazardous drug shipments to requirements for PPE, we got to work on our policies and procedures.

We started by purchasing pre-written SOPs from PCCA (Compounding Today also can be a great resource for SOPs) and spent a full six months of 16-18 hours a week customizing the policies to fit our practice and our workflow. We also conducted a series of four one-hour trainings for all of our staff. In the end, we had a 200-plus page document, plus two dozen forms, checklists, and logs to standardize our pharmacy operations. It was not an easy task, but it was definitely worthwhile and helped elevate our business. Plus, it puts us in a better position to apply for accreditation, something else we are considering.

Budget for Facility and Engineering Control Upgrades. As I mentioned, this one is the real sticking point. USP <800> lays out very specific requirements for facility and engineering controls to help limit employee and patient exposure to hazardous drugs.
Our Footprints

Bone Marrow Donor Drive: Since 2009, more than 2,800 individuals have been added to the National Bone Marrow Registry from donor drives conducted at independent pharmacies. This health initiative is coordinated by the NCPA Foundation and DKMS Americas.

Business Plan Competition: Established in 2004, the Good Neighbor Pharmacy NCPA Pruitt-Schutte Student Business Plan Competition challenges NCPA student members to devise a viable proposal for buying an existing independent community pharmacy or developing a new pharmacy endeavor. With more than 1,000 participants since its inception, this annual contest has provided many young pharmacists with the confidence and business savvy needed to embrace ownership.

Disaster Relief Fund: To date, the NCPA Foundation has distributed more than $200,000 to independent pharmacy owners trying to pick up the pieces after calamity.

Dispose My Meds*: More than 1,400 independent pharmacies are participating in Dispose My Meds, a prescription drug disposal program that offers NCPA members a low-cost way to help consumers safely dispose of unused medications—while offering eco-friendly disposal options.

Scholarships: The NCPA Foundation continues to support pharmacist education. In the past few years alone, more than $380,000 has been awarded in educational aid to high-achieving NCPA student members with a demonstrated interest in ownership.

All of this is made possible by the generosity of our donors.

NCPA Foundation: Donation Form

TODAY’S DATE

NAME

PHARMACY/COMPANY NAME

ADDRESS

CITY \ STATE \ ZIP

Donation

☐ $1,000 ☐ $500 ☐ $250 ☐ $150 ☐ Other $

Payment

☐ Check

Enclosed is my check payable to the NCPA Foundation for $

☐ Credit Card

☐ AMERICAN EXPRESS ☐ DISCOVER ☐ MASTERCARD ☐ VISA

CARD NUMBER \ EXP. DATE (MM/YY) \ SEC. CODE

NAME ON CARD (PRINT)

SIGNATURE \ TODAY’S DATE

RETURN THIS FORM by fax to 703-995-0344, mail to NCPA Foundation, 100 Daingerfield Road, Alexandria, VA 22314, or visit www.ncpafoundation.org to make a donation. Thank you!

Why give?

The only way the NCPA Foundation stays relevant, proactively serves the needs of the profession, and continues leaving footprints to lead others is through the generosity of individual and corporate supporters. The NCPA Foundation is a non-profit 501(c)(3) organization established in 1953 (tax ID 90-0633086).

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USP <800> mandates the use of a vented or double-HEPA-filtered powder containment hood, biological safety cabinet, or negative-pressure glove box for all particle-generating activities (such as crushing, stirring, and mixing).

It further states that the hood must be located within a room that:
- Is separate from other compounding areas
- Is externally vented via HEPA filtration
- Maintains at least 12 air changes per hour (ACPH)
- Has a negative pressure between 0.01 and 0.03 inches of water column.

My guess is that most community pharmacies that provide non-sterile compounding do not have a room that meets these stringent requirements. Ours didn’t, so we began the daunting task of researching the costs to build such a room.

We ended up looking at modular labs. We liked the flexibility that this type of construction offered, not to mention the fact that it could grow with us. It also offers some financial benefits, including depreciation considerations for tax purposes.

After finding two vendors that came highly recommended and specialize in building pharmacy cleanrooms, we discovered the cost just to add the modular lab and the necessary HVAC upgrades would run in excess of $50,000-$75,000. Definitely not chump change.

Additionally, as we discovered, many of the vendors are still learning the ins and outs and real-world applications of USP <800>. It’s important to ask a lot of questions and look for partners who have actual experience and working knowledge of these new guidelines. Knowing USP <800> helps you spot the vendors who know their stuff. It’s also very important to pay close attention to what your state determines to be the best course of action regarding uptake and enforcement of USP <800>. States are likely to have a variety of approaches, which may include incorporating only portions of the Chapter, delaying enforcement, or potentially not requiring compliance with the Chapter. (NCPA is tracking this closely. This is a huge, unnecessary, expensive burden for its members. NCPA is fighting and will continue to fight for fair guidelines and implementation.) Whatever your pharmacy decides in regard to USP <800>, it’s important to do your homework. With a little planning and a lot of research, your pharmacy can be ready to meet the new requirements for USP <800> when it takes effect in 2018.

Jennifer L. Bruckart, CPhT, is a former NCPA staff member and currently the director of outreach and education for WeCare Pharmacy, a compounding pharmacy and wellness center in Warrenton, Va.
Pharmacy Performance Measures

Significant upside, but proceed with caution

by Bruce A. Semingson, Pharmacist
Since the advent of the Medicare Part D prescription drug program in 2006, the Centers for Medicare & Medicaid Services (CMS) has implemented many patient care programs. Its objective is improving patient treatment outcomes, controlling prescription costs, and reducing medical costs by limited excessive physician and emergency room visits and unnecessary hospitalizations. Medication therapy management (MTM) programs and quality measurement programs for Part D Prescription Drug Plans (PDPs) and Part C Medicare Advantage prescription drug plans (MA-PDs) are two components of these initiatives. Since the passage of the Affordable Care Act in 2010, these programs are evolving into Medicare value-driven health care instead of the tradi-
To date, retail pharmacy performance programs are utilized to calculate a plan’s Star Rating for 2019. For example, 2017 measures are used in future years. Plan performance measures are used to determine a plan’s Star Rating two years after the measures are performed. For example, 2017 measures are used to calculate a plan’s Star Rating for 2019.

Star Ratings can yield payment bonuses for Medicare plans as well as financial penalties for poor performers. Additionally, CMS has implemented other performance programs for hospitals, physicians, nursing homes, dialysis facilities, and home health agencies. This article will review pharmacy performance or quality measures, some of which are in standard networks or in preferred networks. The most common performance measures are MTM measures, which are components of the Star Rating system for plans. However, generic dispensing rates, generic equivalency rates, 90-days supply dispensing rates for maintenance medications, and other measures may be utilized by plans which are not current components of the Star Ratings. Pharmacies participating in quality measure programs pay per claim participation fees which are often tied to performance levels or thresholds.

**PLANS AND NETWORKS**

CMS has documented a favorable return on investment when MTM programs are implemented. PDP and MA-PD plan sponsors may utilize pharmacies or other providers to perform these activities. The plans’ MTM programs are described in the sponsor’s annual bid to CMS and must comply with CMS’ minimum requirements. Commonly, plan sponsors that offer performance or quality measure programs to pharmacies use a preferred or narrow network. Preferred networks have different contractual terms than a standard network, including lower reimbursement rates and per claim access, often referred to as direct and indirect renumeration (DIR) fees. At least one PDP’s performance measure program charges per claim access fees to participate in its standard network.

This article references 2017 PDPs performance measures. CMS has indicated that measures will change and expand in future years. Plan performance measures are used to determine a plan’s Star Ratings two years after the measures are performed. For example, 2017 measures are used to calculate a plan’s Star Rating for 2019.

To date, retail pharmacy performance programs are utilizing a complex system of performance measures which are described in the network agreements between retail pharmacies, and the plan sponsor or PBM administrator. Many pharmacies are members of pharmacy services administration organizations (PSAOs) that negotiate and administer these agreements. The performance criteria are defined in these plan agreements.

Pharmacies can utilize outside services such as EQuIPP, iMedicare, PrescribeWellness, Ateb, Mevesi, Rx30, PioneerRx, QS/1’s eNGAGE and others to measure and track their performance. MTM platforms such as Mirixa and OutcomesMTM are utilized by pharmacists to manage this component of patient services. Performance programs may include pharmacy paid access and/or DIR fees, preferred networks participation, quality measure benchmarks, and/or the potential for a performance bonus (or reduced access fee). Fees are calculated and charged in arrears months after the close of the measurement period.

**MEASURING PERFORMANCE**

In one example, Humana’s PDP offers retail pharmacies the option to participate in its performance network, which also requires the pharmacy to pay a per-prescription fee for prescriptions the pharmacy dispenses to PDP patients. Apparently the prescription fee funds the performance program. The following is a hypothetical example utilizing publicly available information. Assume that the PDP’s average member utilizes six prescriptions per month. The plan’s performance program has four performance measures and will pay the top performing pharmacies a bonus of $5.50 per dispensed prescription and nothing to pharmacies who do not reach the required performance threshold. (Note: A partial bonus to pharmacies that perform at a level below the highest threshold may be available.) In this example, A, B, C, D represents performance measures specified by the PDP. (See Table 1 for a list of performance measures that determine the 2017 plan ratings.) Assume that the pharmacy has 100 patients enrolled in the PDP, which is the basis for the prescription fee calculation of $5 per prescription. The annual cost or investment for participation in this plan’s performance program is $36,000 (100 patients times six prescriptions per month times 12 months times $5 per prescription).

<table>
<thead>
<tr>
<th>Table 1: Quality Measures for 2017 Plan Year</th>
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<tbody>
<tr>
<td>High Risk Medication</td>
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<tr>
<td>Medication Adherence for Diabetes Medications</td>
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<tr>
<td>Medication Adherence for Hypertension (RAS Antagonists)</td>
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<tr>
<td>Medication Adherence for Cholesterol (Statins)</td>
</tr>
<tr>
<td>MTM Program Completion Rate for CMR</td>
</tr>
</tbody>
</table>

Note: CMS requires Part D to offer CMRs to all eligible patients annually and TMRs (targeted medical reviews) quarterly. TMRs aka: “medical alerts”
One plausible method for calculating performance bonuses would be to measure the pharmacy’s performance based on a weighted calculation, which measures the components of the performance program and the methodology for calculating a bonus. Assuming the performance threshold is 80 percent, Table 2 demonstrates the pharmacy meets the threshold for measurements A and B, but is below the threshold in C and D. The overall weighted performance level is 76.40 percent, which is inadequate for a performance bonus. Table 3 demonstrates an overall performance of 86.86 percent, which would yield an annual performance bonus of $39,600.

In addition, pharmacies may be measured against other performance network pharmacies. Some primary business questions include the following:

### Table 2: Hypothetical Performance Calculation

<table>
<thead>
<tr>
<th>Measure</th>
<th>Weighting for Performance Calculation</th>
<th>Number of Patients</th>
<th>Number of Adherent Patients</th>
<th>Completion Rate Percentage</th>
<th>Weighted Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>25%</td>
<td>100</td>
<td>80</td>
<td>80%</td>
<td>20.00%</td>
</tr>
<tr>
<td>B</td>
<td>25%</td>
<td>80</td>
<td>68</td>
<td>85%</td>
<td>21.25%</td>
</tr>
<tr>
<td>C</td>
<td>35%</td>
<td>70</td>
<td>55</td>
<td>79%</td>
<td>27.65%</td>
</tr>
<tr>
<td>D</td>
<td>15%</td>
<td>40</td>
<td>20</td>
<td>50%</td>
<td>7.50%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100%</strong></td>
<td><strong>76.40%</strong></td>
<td></td>
<td></td>
<td>76.40%</td>
</tr>
</tbody>
</table>
Table 3: Hypothetical Performance Calculation

<table>
<thead>
<tr>
<th>Measure</th>
<th>Weighting for Performance Calculation</th>
<th>Number of Patients</th>
<th>Number of Adherent Patients</th>
<th>Completion Rate Percentage</th>
<th>Weighted Calculation</th>
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</thead>
<tbody>
<tr>
<td>A</td>
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<td>100</td>
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<td>80%</td>
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<td>85%</td>
<td>21.25%</td>
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<tr>
<td>C</td>
<td>35%</td>
<td>70</td>
<td>65</td>
<td>92.80%</td>
<td>32.48%</td>
</tr>
<tr>
<td>D</td>
<td>15%</td>
<td>40</td>
<td>35</td>
<td>87.50%</td>
<td>13.13%</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>100%</td>
<td></td>
<td></td>
<td>86.86%</td>
<td></td>
</tr>
</tbody>
</table>

1. Are the pharmacy measures calculated individually or as a network such as a chain or PSAO?
2. What is the potential return on investment for participating in such a performance program

PHARMACY MUST ADAPT

Implementation of pharmacy-based performance programs will expand during the next decade as the health care industry transitions to a value-based payment system. At the same time, community pharmacy will bifurcate into two primary business functions: dispensing and patient care services. Many pharmacies will be able to incorporate both into their practice setting, while some will not. Patient care services will include MTM, adherence intervention, disease management, and wellness counseling, and will be coordinated with other health care providers via electronic health records.

In the meantime, the industry must adapt to operating in a health care system that is increasingly focused on quality and outcomes. CMS and other private sector payers need to recognize that dispensing prescriptions is a product-based service with extremely small margins. The current approach to product reimbursement may not be adequate to fund pharmacy-based patient care services, and the costs of participating in performance networks may further reduce the ability of retail pharmacies to provide quality performance results. Physicians and hospitals are serviced-based providers, and their revenue is derived from a myriad of diagnostic, service, and billing codes.

Pharmaceuticals are invoiced separately from their service fees. Performance programs for physicians, hospitals, and others incentivize them to modify their practice settings and procedures, thereby becoming more efficient and reducing care costs.

There are other concerns with current pharmacy performance programs. Among them:

- How are cash prescriptions added to dispensing data that is utilized to calculate performance metrics?
- If a patient utilizes multiple pharmacies, how is the data incorporated into each pharmacy’s performance calculation?
- If a physician will not approve a medication that is required for a performance metric, then what is the process for adjusting the measurement?
- Do plans with performance programs have a transparent system calculating, reporting, and appealing performance metric scores?
- What is the mechanism for counting plan enrollees assigned to a particular pharmacy? Is it daily, monthly, quarterly? This number is critical for the calculation of the performance metric.

PHARMACISTS WELL POSITIONED

Pharmacists are well positioned to provide patient care services such as ensuring and increasing adherence levels for selected maintenance drugs, encouraging and performing comprehensive medication reviews (CMRs), reducing the use of high risk medications (HRM) in elderly or otherwise compromised patients, and working to reduce the misuse of opioids, to name a few. They have the expertise, patient skills, patient relationships, and accessibility. However, pharmacists and pharmacy owners must be extremely cautious when evaluating current performance proposals. As described in this article, it is imperative that we separate the reimbursement methodologies for the dispensing of pharmaceuticals from the provision of patient care services. Under these circumstances, pharmacists will be able to demonstrate their unique ability to improve patient outcomes and help transform health care to a value-driven program.

Bruce A. Semingson, Pharmacist, is president of Pharmacy Perspectives, LLC, Cave Creek, Ariz. He can be reached at bruce.semingson@gmail.com.
"I felt the urge to light up a cigarette leaving me. It was amazing... it was amazing."

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**What is CHANTIX?**
CHANTIX is a prescription medication that, along with support, helps adults 18 and over stop smoking.

**Important Safety Information**
Some people have had changes in behavior, hostility, agitation, depressed mood, suicidal thoughts or actions while using CHANTIX to help them quit smoking. Some people had these symptoms when they began taking CHANTIX, and others developed them after several weeks of treatment or after stopping CHANTIX. If you, your family or caregiver notice agitation, hostility, depression or changes in behavior, thinking, or mood that are not typical for you, or you develop suicidal thoughts or actions, anxiety, panic, aggression, anger, mania, abnormal sensations, hallucinations, paranoia or confusion, stop taking CHANTIX and call your doctor right away. Also tell your doctor about any history of depression or other mental health problems before taking CHANTIX, as these symptoms may worsen while taking CHANTIX.

Some people had seizures during treatment with CHANTIX. Most cases happened during the first month of treatment. Tell your doctor if you have a history of seizures. If you have a seizure during treatment with CHANTIX, stop taking CHANTIX and contact your healthcare provider right away. Decrease the amount of alcohol you drink while taking CHANTIX until you know if CHANTIX affects your ability to tolerate alcohol. Some people experienced increased drunkenness, unusual or sometimes aggressive behavior, or memory loss of events while consuming alcohol during treatment with CHANTIX.

Sleepwalking can happen with CHANTIX, and can sometimes lead to behavior that is harmful to you or other people, or to property. Stop taking CHANTIX and tell your doctor if you start sleepwalking.

Do not take CHANTIX if you have had a serious allergic or skin reaction to CHANTIX. Some people can have serious skin reactions while taking CHANTIX, some of which can become life-threatening. These can include rash, swelling, redness, and peeling of the skin. Some people can have allergic reactions to CHANTIX, some of which can be life-threatening and include: swelling of the face, mouth, and throat that can cause trouble breathing. If you have these symptoms or have a rash with peeling skin or blisters in your mouth, stop taking CHANTIX and get medical attention right away.

Before starting CHANTIX, tell your doctor if you have a history of heart or blood vessel problems. If you have new or worse heart or blood vessel symptoms during treatment, tell your doctor. Get emergency medical help right away if you have any symptoms of a heart attack or stroke.

The most common side effects of CHANTIX are nausea, sleep problems, constipation, gas and vomiting. If you have side effects that bother you or don’t go away, tell your doctor. Patients also reported trouble sleeping, vivid, unusual or strange dreams. Use caution driving or operating machinery until you know how CHANTIX may affect you. You may need a lower dose of CHANTIX if you have kidney problems or get dialysis. Before starting CHANTIX, tell your doctor if you are pregnant, plan to become pregnant, or if you take insulin, asthma medicines or blood thinners. Medicines like these may work differently when you quit smoking. CHANTIX should not be taken with other quit-smoking medicines. Should you slip up and smoke, keep trying to quit.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

Please see Important Risk Information on the next page.

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- New or worse mental health problems, such as changes in behavior, hostility, agitation, depressed mood, and suicidal thoughts or actions. Some people have had these symptoms when they began taking CHANTIX, and others developed them after several weeks of treatment, or after stopping CHANTIX.

**Before taking CHANTIX**, tell your doctor if you have ever had depression or other mental health problems. You should also tell your doctor about any symptoms you had during other times you tried to quit smoking, with or without CHANTIX.

**Stop taking CHANTIX and call your doctor right away** if you, your family, or caregiver notice agitation, hostility, depression or changes in your behavior or thinking that are not typical for you, or you develop any of the following symptoms:

- thoughts about suicide or dying, or attempts to commit suicide
- new or worse depression, anxiety, or panic attacks
- feeling very agitation or restless
- acting aggressive, being angry, or violent
- acting on dangerous impulses

When you try to quit smoking, with or without CHANTIX, you may have symptoms that may be due to nicotine withdrawal, including urge to smoke, depressed mood, trouble sleeping, irritability, frustration, anger, feeling anxious, difficulty concentrating, restlessness, decreased heart rate, and increased appetite or weight gain. Some people have even experienced suicidal thoughts when trying to quit smoking without medication. Sometimes quitting smoking can lead to worsening of mental health problems that you already have, such as depression. See “WHAT ARE THE POSSIBLE SIDE EFFECTS OF CHANTIX?” for more information about other side effects.

### WHAT SHOULD I TELL MY DOCTOR BEFORE TAKING CHANTIX? (continued)

- have kidney problems or get kidney dialysis. Your doctor may prescribe a lower dose of CHANTIX for you.
- have a history of seizures
- drink alcohol
- have heart or blood vessel problems
- have any other medical conditions
- are pregnant or plan to become pregnant. It is not known if CHANTIX will harm your unborn baby.

Tell your doctor about all the medicines you take, including prescription and over-the-counter medicines, vitamins and herbal supplements. Your doctor may need to change the dose of some of your medicines when you stop smoking.

### WHAT SHOULD I AVOID WHILE TAKING CHANTIX?

- Use caution when driving or operating machinery until you know how CHANTIX affects you. CHANTIX may make you feel sleepy, dizzy, or have trouble concentrating, making it hard to drive or perform other activities safely.
- Decrease the amount of alcoholic beverages that you drink during treatment with CHANTIX until you know if CHANTIX affects your ability to tolerate alcohol.

### WHAT ARE THE POSSIBLE SIDE EFFECTS OF CHANTIX?

**Serious side effects of CHANTIX may include:**

- See “WHAT IS THE MOST IMPORTANT INFORMATION I SHOULD KNOW ABOUT CHANTIX?”
- Seizures
- New or worse heart or blood vessel (cardiovascular) problems
  - Get emergency medical help right away if you have symptoms of a heart attack
- Sleepwalking which can sometimes lead to behavior that is harmful to you or other people, or to property.
- Allergic or serious skin reactions. See “WHO SHOULD NOT TAKE CHANTIX?”

If you experience any of the above side effects, stop taking CHANTIX and get medical help right away.

The most common side effects of CHANTIX include:

- nausea
- sleep problems (trouble sleeping or vivid, unusual, or strange dreams)
- decreased appetite
- constipation
- gas
- vomiting
- rash, with peeling skin
- blisters in your mouth
- headache, dizziness, upset stomach, and tiredness to happen more often than if you just use a nicotine patch alone.

### WHAT SHOULD I TELL MY DOCTOR BEFORE TAKING CHANTIX?

See “WHAT IS THE MOST IMPORTANT INFORMATION I SHOULD KNOW ABOUT CHANTIX?”

**Before you take CHANTIX**, tell your doctor if you:

- use other treatments to quit smoking. You should not use CHANTIX while using other medicines to quit smoking. Using CHANTIX with a nicotine patch may cause nausea, vomiting, headache, dizziness, upset stomach, and tiredness to happen more often than if you just use a nicotine patch alone.

### WHAT IS CHANTIX?

CHANTIX is a prescription medicine to help adults stop smoking.

### WHO SHOULD NOT TAKE CHANTIX?

Do not take CHANTIX if you have had a serious allergic or skin reaction to CHANTIX. Symptoms may include:

- swelling of the face, mouth (tongue, lips, gums), throat or neck
- trouble breathing
- rash, with peeling skin
- blisters in your mouth

Some of these reactions can become life-threatening.

### WHAT SHOULD I TELL MY DOCTOR BEFORE TAKING CHANTIX? (continued)

- have kidney problems or get kidney dialysis. Your doctor may prescribe a lower dose of CHANTIX for you.
- have a history of seizures
- drink alcohol
- have heart or blood vessel problems
- have any other medical conditions
- are pregnant or plan to become pregnant. It is not known if CHANTIX will harm your unborn baby.

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The Pharmacist’s Role in Coronary Artery Bypass Graft

by Corey Marin, PharmD

BACKGROUND
According to the American Heart Association, one in three deaths each year is related to cardiovascular disease (CVD). CVD may lead patients into elective or non-elective surgeries to decrease mortality and improve quality of life. In 2017, the Centers for Medicare & Medicaid Services (CMS) will add the initial diagnosis of coronary bypass artery graft (CABG) surgery to the Hospital Readmission Reduction Program (HRRP).

CABG surgery is performed due to worsening coronary artery disease (CAD), where the buildup of plaque in the arteries has put the patient at an increased risk of myocardial ischemia and myocardial infarction. As the stenosis worsens, a patient’s risk continues to rise. Therefore, CABG is completed to reduce these risks and increase oxygenated blood flow to the heart muscle tissues. Reducing myocardial ischemia and myocardial infarction risk, relieving angina, and improving one’s ability to perform physical activity are benefits of CABG, if surgery is necessary.

Though the types of CABG surgery may vary by institution or patient specifics, the medications during the preoperative, perioperative, and postoperative times differ little. This is where you, the community pharmacist, can help decrease the chances of readmission following a CABG procedure and improve patient outcomes.

HOW DID CMS GET TO THIS?
In 2012, the Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation (YNHHSC/CORE) created a CABG Measure Methodology Report for CMS. The document’s goal was to develop risk-adjusted CABG...
outcome measures that reflect the quality of care patients receive when undergoing CABG surgery for the upcoming addition to HRRP.

Data from Medicare Fee-for-Service (FFS) was used to show that readmission rates following CABG surgery varied across hospitals. From January 2009 – September 2011, the median readmission rate for all hospitals after CABG was 16.8 percent (range 11.2 percent - 22.2 percent). This is similar to data published in a 30 day all cause readmission in New York state where the median readmission rate was 16.5 percent. Of the patients readmitted in New York, 87.3 percent were related to the initial CABG surgery, 14.4 percent were related to complications of CABG surgery, and these patients had an overall three-fold higher 30-day mortality rate.

The costs of readmission can be detrimental to overall health care costs. In 2007, the Medicare Payment Advisory Committee (MedPAC) produced a report showing CABG to be the most costly in potentially preventable readmission cases following discharge, and second highest for average Medicare Payment per readmission at $8,136. Overall, preventing readmission of CABG patients could save Medicare at least $151 million a year.

THE PHARMACISTS’ ROLE
Upon discharge following a CABG, patients will have prescriptions for an antiplatelet therapy (aspirin or clopidogrel), a beta blocker, a nitrate, a renin-angiotensin system antagonist, a lipid lowering agent (statin preferred), and other short-term medications. Whether these are old or new medications, patients will most likely be overwhelmed and confused with their changes. Pharmacists who want to partner with a cardiology practice to reduce readmissions could propose medication reconciliation, bedside delivery of discharge medications, and planned follow-up calls to ask about side effects, taking medications on time, and facilitating medication refills. In exchange, a pharmacist might propose a defined role in discharge planning, receiving a copy of discharge orders, receiving prescriptions for discharge medications, and compensation for services. For now, as the business model evolves, compensation might be funded by grants, by the hospital, and partly by realized savings if the collaboration helps the hospital reduce or avoid an HRRP penalty. Absent a formal partnership, having the patient, family member, or caregiver bring the discharge summary to the pharmacy is the first step in ensuring appropriate therapy. Often these discharge summaries will discontinue, hold, or add medications. Without obtaining this information, the pharmacy may be unaware of any changes, which could result in suboptimal care. Knowing and discussing medication changes with the patient is the first step in ensuring a decreased readmission risk.

ADHERENCE
The American College of Cardiology states that between 31-58 percent of all cardiovascular patients are non-adherent. This is a major gap in the care for these patients because adherence is a simple way to improve outcomes. Types of non-adherence include not taking the medication, not taking the right medication, and taking the medication incorrectly. As community pharmacists, adherence is at the heart of our competencies.
A recent study from Oregon State University has shown that utilizing the Indian Health Service Model for counseling directly improves a patient’s understanding and adherence to his or her medication. The Indian Health Service method is an interactive method that is based on open-ended questions that refer to the name and purpose of the medication, its use and storage, and potential side effects. These questions often begin with words such as: what, why, how, or describe. (See sidebar.) They successfully create a dialogue between the pharmacist and patient by allowing the pharmacist to identify gaps in the patient’s understanding of the medication.

Along with appropriate counseling, these patients are excellent candidates for medication synchronization. This type of program allows a patient to pick up all of their medications at the same time each month. In this way, patients can have an easier time managing their medications without accidentally forgetting one. It is critical to increase patient adherence and outcomes along with saving health care system spending by reducing the need for hospitalization. Counseling and synchronization are just two methods to aid in improvement.

**MODIFIABLE RISK FACTORS**

Many CVD patients will have a history of smoking, elevated stress, poor diet and exercise habits, uncontrolled hypertension, and diabetes. Implementation of active programs, such as patient outreach, smoking cessation, and diabetes self-management education are a few examples of how pharmacies could reduce a patient’s risk of complications. For example, an estimated 40 percent of patients will develop depression after CABG surgery. These patients would normally go untreated until they were readmitted to the hospital, but a patient outreach program could identify this development and aid the patient before potential readmission.

**MAIN REASONS FOR READMISSION**

In Hannan et al., the top three causes of readmission after CABG surgery were post-operative infections, heart failure, and surgical complications. These readmissions may be furthered assessed by knowing a patient’s risk factors that increase their overall risk of readmission. (See Table 1.) While these are all potential outside the realm of at-home treatment, there are ways to improve outcomes. For example, preventing infection is important following CABG, so patients will have to care for their chest and/or leg surgical wounds. To decrease readmissions, test studies created post-discharge care networks between hospitals and pharmacies to improve medication reconciliation, patient education about medication changes, patient access to medications, and patient follow-up with outpatient care providers. Reports have shown that collaboration between the two have reduced hospital readmission rates.

The State Action on Avoidable Rehospitalization (STAAR) initiative reported data from 2010-2013 in which high-risk patients were identified as those taking 10 or more medications with at least one condition: heart failure, pneumonia, acute renal failure, atrial fibrillation, cancer pain, dehydration, urinary tract infection, or change in mental status. It was determined that 52 percent of patients had medication-related issues because they were unable to follow instructions. The most common issue was the patient’s inability to follow proper dosing instructions. Screening for poor health literacy or simple misunderstanding is just one example of the ways a pharmacist can bring improved patient outcomes to post-discharge transitions of care.

**CONCLUSION**

The opportunity for community pharmacies to intervene with patients after CABG surgery is feasible through a variety of services. Using a pharmacist’s pharmacotherapy knowledge and appropriate counseling methods, adherence can improve, which can reduce the need for revascularization later in life. Pharmacists can be instrumental in improving patient quality of life after CABG surgery and decreasing the chances of readmission.

Corey Marin, PharmD, is a 2016 graduate of the University of Iowa and was a winter 2016 APPE rotation student at NCPA.
Compound Your Way to Lower Taxes
Do you own a compounding pharmacy or compound a few medications in your store each day? If so, you already likely have good margins from this revenue stream, but you may also have a valuable tax deduction to utilize. That tax deduction is the domestic production activities deduction (DPAD), or Internal Revenue Service Code Section 199.

Section 199 gives a tax break to taxpayers who manufacture products for resale and who pay employees to assist in that manufacturing. Under current tax law, pharmacies that compound are considered manufacturers and are eligible for this deduction. Thankfully, there are no Food and Drug Administration or other technical compounding requirements or definitions that impact this area of the tax law. If you are a compounder, you qualify for DPAD if you meet the IRS limitations described in the following.

The deduction for 2010 and thereafter is 9 percent of whichever of these numbers is lower: taxable income or qualified production activity net income (QPANI). The deduction is also limited to 50 percent of the wages that are attributable to the manufacturing/compounding process. Let’s look at these factors and examples of how much this could save you in taxes.

**TAXABLE INCOME**

Taxable income is simply your taxable income from the business as a whole. It includes all sales departments and expenses, including compounding. QPANI is your net income directly allocable to compounding. To calculate your QPANI, take your compounding revenue minus compounding cost of goods sold, minus compounding expenses (direct and indirect). Your net bottom line from this calculation is your qualified production activity net income from compounding. Revenues, cost of goods, and expenses attributable to other revenue streams such as prescription fills, durable medical equipment (DME), and over-the-counter (OTC) are not taken into consideration when calculating QPANI.

Once you’ve calculated your taxable income and QPANI, you must take into consideration the employee wage limitations. The deduction cannot exceed 50 percent of Form W-2 Medicare wages you paid allocable to compounding. Keep in mind that these are wages you paid directly allocable to employee(s) involved in compounding. In most instances, pharmacy owners do not track this information as some employees work in many areas of the pharmacy. As a result, many pharmacy owners use a reasonable method—which varies from pharmacy to pharmacy—to determine the allocation between compounding wages and other departments. Ideally, you want to track this wage category separately, and many payroll companies can easily assist you with this.

Let’s look at an example. If you have QPANI of $100,000, taxable income of $310,000, and you paid your employees Form W-2 Medicare wages of $10,000 for compounding, your deduction is limited to $5,000 (or 50 percent) of $10,000. If wages were $20,000, the deduction would be $9,000, or 9 percent of QPANI ($100,000). A $9,000 deduction at a 35 percent tax rate can save you $3,150 in taxes.

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Special deductions may help pharmacies save money

by Scott W. Sykes, CPA
Suppose you are a compounding-only pharmacy and you have QPANI of $300,000 and—since it is compounding-only—your taxable income is $300,000. You paid your employees Form W-2 wages of $250,000. As QPANI and taxable income are the same, 9 percent of this number would be $27,000. Taking 50 percent of your wages would be $125,000. Clearly, the $27,000 (or 9 percent of QPANI) does not exceed 50 percent of your wages. Therefore, your deduction is $27,000, and your tax savings at 35 percent is $9,450.

FACTORS TO CONSIDER
Before you jump ahead, there are some important considerations to review. The rules and calculations can be complex and time consuming, so the deduction may not be worth the effort and cost to compile and calculate if compounding is a small percentage of your overall revenue. Your tax advisor can assist you with making this determination. Other items to consider are net operating losses, multiple pharmacy entities that claim DPAD, and Section 481(a) adjustments. These should all be taken into consideration during the tax preparation process.

As is the case with most tax break opportunities, and especially this one, it’s imperative that the proper accounting structure and fundamentals be in place to simplify this process at the end of the year. You must be able to track compounding revenues, cost of goods, and expenses separately. Pharmacies should be able to easily track and capture this compounding information daily in their accounting system. Tracking on a daily basis and coding the revenues and expenses to a separate compounding class makes year-end processing seamless and saves you time, costs, and headaches.

All eligible taxpayers are allowed to claim the deduction regardless of their tax entity status. S corporations, sole proprietors, single-member limited liability companies (LLCs), and partnership taxpayers all use adjusted gross income (AGI) to calculate the lesser of QPANI or AGI, and IRS Form 8903 is used to calculate the deduction. The deduction is reported on line 35 of IRS Form 1040. C corporations use taxable income on Page 1 of the tax return. C corporations report the deduction on line 25 of IRS Form 1120.

PROS AND CONS OF SEEKING PRIOR YEAR DEDUCTIONS
If you find out that you have been missing this deduction, you do have an option to ease your frustration. The IRS allows you to go back and amend your prior two-year tax returns to claim the deduction. However, keep in mind that amending prior year tax returns may increase your audit risk, so be careful when considering this option. Even if your tax returns are perfect, an audit is not a fun process, so the drawbacks may outweigh the benefits. Additionally, if you have been missing this deduction and are eligible for it, you may want to consult with a tax advisor who understands this deduction and how it applies to pharmacies.

As with any tax strategy, it is important to perform your due diligence and review with your advisors before moving forward. If proper accounting is in place and compounding revenues make the calculations worthwhile, it shouldn’t be too complex, stressful, or difficult for a pharmacy to calculate and take advantage of this valuable deduction.

Scott Sykes, CPA, of Sykes & Company, P.A., works directly with pharmacy owners, assisting with day-to-day accounting and tax compliance issues. He is also active in year-end payroll preparation, tax planning, individual tax preparation, and corporate tax preparation for pharmacy owners and businesses. He can be reached at scott@sykes-cpa.com.
There’s a reason we created an innovative base that dramatically improves the appearance of scarred skin.

His name is Matt.

PracaSil®-Plus features a unique, proprietary blend of silicone and Pracaxi oil to help patients with all kinds of scarring.

To learn more about PracaSil®-Plus or PCCA membership, call PCCA Customer Service at 800.331.2498
Palliative Care
Compounding can support and improve quality of life

by Nat Jones, RPh, FIACP

If you think about it, we’re all dying. Most of us prefer later rather than sooner and to enjoy life as much as possible between now and then, but as the end draws near everyone appreciates gentle care when the going gets tough. That’s when pharmacists can play a special role in delivering relief to those who need palliative care.

Confusion exists about the meaning of palliative care. Many organizations have defined it, including the American Cancer Society, Center to Advance Palliative Care, and the Joint Commission, to name several, but there is no consensus. Like many medical terms, it has a Latin root; in this case, palliatus, meaning to cloak or conceal pain and other suffering. Palliative care is frequently confused with hospice, and when most people hear hospice they think of death and dying. Palliative care can begin years before hospice is needed, dealing with a myriad of problems faced by the patient and the family.

In the United States, hospice is a Medicare benefit defining a special way of caring for people in the late stage of terminal illness, where curative therapies are no longer used. In contrast, palliative care is an approach that improves the quality of life for patients and their families facing serious illness that can be life-threatening, though not necessarily terminal. Palliative care is most effective through the prevention and relief of suffering by means of early treatment of pain and other physical, psychosocial, and spiritual problems. It may be delivered in conjunction with disease state management and life-prolonging and often curative therapies. It can also be a transition toward hospice.

Because of the confusion between the terms ‘palliative care’ and ‘hospice care,’ patients often experience late referrals and late acceptance of palliative care for themselves and/or their families, thus depriving them of the numerous benefits of palliative care because serious illness can affect everyone in the family in various ways. Many providers of palliative care prefer the term “supportive care” to take away the “end of life” connotations associated with hospice, so that patients will potentially seek help sooner. The current components of palliative care service are supportive care and hospice care.

SUPPORTIVE CARE
Supportive care includes treatment of many medical conditions, including almost every aspect of adult medicine. Compounded medications can be...
helpful for many of these conditions, potentially encompassing thousands of formulations. Compounding pharmacists can offer knowledge and expertise in preparing medications that are not commercially available, yet needed. By educating practitioners about the myriad of compounded medication options, compounders can provide drug therapies from which patients can benefit. Quite often, compounds can improve compliance and outcomes by utilizing drug combinations and/or unique formulations to individualize treatment.

Supportive care compounds include a wide variety of dosage forms for potential treatments that may be of benefit in a large number of disease states and for symptomatic relief. (See Table 1.)

Cancer patients undergoing chemotherapy and/or radiation commonly develop mucositis or suffer radiation damage to the oral cavity. Many of the familiar compounded formulations (such as Miracle Mouthwash and Stanford Mouth Rinse) can now be reformulated following the development of a mucoadhesive suspension (MucoLox™), a base that potentially prolongs contact time of the active ingredients with the oral mucosa, which would lead to decreasing dosage volume (less than half that of traditional rinse formulas) and frequency, yet still improve outcomes. Formulas for oral use even include popsicles for a cryotherapy component. (See formulation examples in Table 2.) Treating mucositis, radiation damage, and mouth pain will make it easier for the patient to maintain intake of nutritious food. Poor nutrition and wasting are detrimental to the survival of seriously ill patients.

Xerostomia is another common problem that palliative care patients face. Compounding formulas treating xerostomia are in demand because there is a lack of efficacious products commercially available. Data suggest that the daily use of topical dry mouth products containing olive oil, betaine, and xylitol is safe and effective in relieving symptoms of dry mouth in a population with polypharmacy-induced xerostomia. Additionally, mouth pain is a widely seen symptom in head and neck cancer patients and is often difficult to treat. Doxepin rinse has shown to be beneficial in treating mouth pain in these patients. (See formulation examples in Table 2.)

Complications from radiation therapy can be dermatitis or burns. Radiation damage is in part mediated by oxidative free radicals. Melatonin is a unique potent anti-oxidant. A melatonin emulsion significantly reduced skin toxicity from radiation therapy for breast cancer, according to results of a small randomized trial. One example of a topical formulation is melatonin 2.5%/beta glucan 0.5% topical cream (XemaTop™). XemaTop is a ceramide-containing barrier cream base, designed for compounding pharmacists to incorporate additional ingredients when needed. Ceramide containing barrier creams have shown to help reduce transepidermal water loss.

Wound care is also needed for many palliative care patients. Choosing the proper therapy for the type of wound is a key to successful treatment. Wound care compounding bases have evolved in recent years. The choice of active pharmaceutical ingredients (APIs) and

<table>
<thead>
<tr>
<th>Table 1: Supportive Care Compounding Dosage Forms</th>
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<tbody>
<tr>
<td><strong>Oral</strong></td>
</tr>
<tr>
<td>- Capsule: prompt and slow release</td>
</tr>
<tr>
<td>- Mucoadhesive rinses, paste, and gels</td>
</tr>
<tr>
<td>- Ready dissolve tablets and tablet triturates</td>
</tr>
<tr>
<td>- Solutions or suspensions</td>
</tr>
<tr>
<td>- Popsicles and lollipops</td>
</tr>
<tr>
<td><strong>Rectal</strong></td>
</tr>
<tr>
<td>Suppositories, enemas, and Rectal Rockets</td>
</tr>
<tr>
<td>(including mucoadhesive formulas)</td>
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<tr>
<td><strong>Vaginal</strong></td>
</tr>
<tr>
<td>Suppositories, inserts, gels, and creams</td>
</tr>
<tr>
<td>(including mucoadhesive formulas)</td>
</tr>
<tr>
<td><strong>Topical</strong></td>
</tr>
<tr>
<td>Creams, ointments, gels, solutions, and foams</td>
</tr>
<tr>
<td>(including otic and nasal dosage forms)</td>
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<tr>
<td><strong>Transdermal</strong></td>
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<tr>
<td>Creams and gels</td>
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<tr>
<td><strong>Sterile</strong></td>
</tr>
<tr>
<td>Injectables, ophthalmics, and irrigations</td>
</tr>
<tr>
<td>(bladder, wound, and nasal)</td>
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<table>
<thead>
<tr>
<th>Table 2: Oral Supportive Care Compound Formulations</th>
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<tbody>
<tr>
<td>Tetracycline Hydrochloride USP 1.25% / Nystatin USP 12,000u/ml / Hydrocortisone USP 0.125% / Preserved Water / MucoLox Mouthwash</td>
</tr>
<tr>
<td>Lidocaine HCL 1% / Beta Glucan 0.5% / Dexamethasone 1% / Vitamin E Acetate 2% / Glutamine 2% Popsicle (MucoLox)</td>
</tr>
<tr>
<td>Xylitol 7% / Betaine 4% / Olive Oil 2% / Calcium Pantothenate 0.1% Oral Rinse (MucoLox)</td>
</tr>
<tr>
<td>Doxepin HCL 0.5% Mouthwash (MucoLox)</td>
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</tbody>
</table>

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an appropriate compounding base for the wound are essential for a positive outcome. Older formulas used simple emollient cream bases that proved difficult to debride with bandage changes. Polyox 301 bandage is a dry powder useful in exudative wounds (such as venous stasis ulcers) when cream or gel bases may simply run off. Spira-Wash™ is a soft, opaque polyethylene glycol (PEG) water-washable ointment base, thus making it an ideal vehicle choice for a variety of wound conditions such as decubitus ulcers (including debridement), pressure ulcers, burns, sores, and cuts. Topical phenytoin, misoprostol, and nifedipine have been studied and shown to improve wound healing. Innovative formulations such as phenytoin 5%/misoprostol 0.0024%/nifedipine 2% Spira-Wash Gel are being prescribed by physicians for wound care.

**TREATING POST-SURGICAL SCARS**

A lot of patients survive cancer and are left with scars inside and out. While compounders can’t do much for the psychological scars, they can help improve the appearance of many of those on the outside. A unique compounding base called PracaSil-Plus™, made with a proprietary blend of ingredients, including silicones in a semipermeable polymer network and Pracaxi oil (which is rich in skin-friendly fatty acids and lipids), has been helping to make a huge difference for patients with scars, including post-surgical cancer scars. Silicone gel has been studied for years and has shown to be an adjunct for various scar treatments. PracaSil-Plus is ideal for the incorporation of appropriate APIs to treat various aspects of scars. Proper selection of APIs depends on the type and location of scar and is essential for a good outcome.

**SCAR TREATMENT CASE STUDY**

In 2015, PCCA Science published a case study of the management of a post-surgical scar using PracaSil-Plus in a 41-year-old white male patient with basal cell carcinoma as a solitary patch at the tip of his nose. Basal cell carcinoma is a type of skin cancer that often leads to surgical excision of the affected area, which results in destruction of the tissues and skin scarring. Graft skin was taken from the patient’s forehead to patch the
Compound medications helped in treating scars from a patient with skin cancer on his nose. Skin was taken from his forehead to cover the tip of his nose. He is shown (clockwise from below) immediately following his surgical procedure, 60 days post-op, 11 months post-op, and at present.
tip of his nose. Following five days of bacitracin ointment application immediately post-op, the patient began applying PracaSil-Plus twice daily starting after wound closure. There were no actives added for this patient. However, several actives can be added depending on the type of scar and the patient’s scarring tendencies (such as atrophic, hypertrophic, and keloid).

The patient’s evaluation parameter scores all decreased, including pain, itching, color, stiffness, thickness, and irregularity. His overall appearance demonstrates a successful recovery process and a considerable improvement in the patient’s quality of life.

**TREATING RADIATION PROCTITIS**

Patients undergoing radiation therapy of the cervix, prostate, and colon often experience radiation proctitis (RP). Radiation therapy causes production of matrix metalloproteases (MMPs) and reactive oxygen species (ROS) that cause tissue degradation and damage to the endothelial lining of the rectum, leading to symptoms that include inflammation, pain, bleeding, and diarrhea. The diarrhea from RP is commonly treated with oral opioid receptor agonists. Loperamide and diphenoxylate are opioid-receptor agonists that interfere with peristalsis by a direct action on the circular and longitudinal muscles of the intestinal wall to slow motility. Both may directly inhibit fluid and electrolyte secretion and/or increase water absorption.

Researchers have found that the recto-anal inhibitory reflex is most pronounced when stimulated in regions close to the anal canal and that distention stimuli are also perceived best in that region. Both effects are counteracted by loperamide, and since stimulation of the inhibitory reflex is a pronounced local phenomenon, then local treatment seems logical. This possibly implies that a formula of loperamide HCl 1 mg/Gm rectal gel (MucoLox/VersaBase®) may be an alternative to oral opioid therapy, potentially providing symptomatic relief without the systemic side effects.

Repairing the damage caused by ROS to the rectal lining will benefit patients with radiation proctitis. Studies have shown that β-(1-3)-D-glucan has the ability to activate macrophages to aid in the removal of cellular debris resulting from oxidative damage, thus allowing for faster tissue recovery. A formula containing lidocaine HCl 1%/beta glucan 0.5%/dexpanthenol 1%/glutamine 2% rectal suspension enema in MucoLox contains several ingredients that may potentially help with recovery. Glutamine has been used orally for healing of the GI tract after radiation treatment, and dexamethasone helps improve hydration of epithelial tissue, so both ingredients are included along with lidocaine for pain.

**HOSPICE CARE COMPOUNDS**

Hospice care compounds are treatments for end of life to ease...
suffering in any way needed. Those needs would include treatment of pain, nausea and vomiting, anxiety, agitation, wound odor, and excessive secretions (sialorrhea). (See formulation examples in Table 3.) Because many hospice patients can’t swallow medications or receive IV therapies, transdermal or rectal dosage forms are often needed. Lipoderm®, a transdermal delivery system, was developed to facilitate delivery of single or multiple APIs through the skin.

Another aspect of hospice care, with few commercially available options, is for patients with persistent cough that are struggling with dyspnea. For decades, morphine inhalation therapy has been used as an option for these patients, as this commonly occurs in end-stage chronic lung, cardiac disease, and cancer patients. Formulations such as sterile preservative-free morphine sulfate 0.25% inhalation solution (or higher concentrations) compounded from bulk Morphine Sulfate USP powder, have been used in cases for titration of symptom control.

If your pharmacy currently compounds and isn’t presently involved in palliative care, find the medical providers in your area that are and educate them about the services you offer. Contact the hospitals in your area and become involved with their supportive and palliative care team. Let them know you are available for their outpatients and home hospice patients with all of these valuable/innovative things that can help bring individualized patient care and improved quality of life.

Pharmacies that don’t currently compound and are interested in doing so can find out what it takes to properly perform compounding in their state and start the process of becoming a compounding. Supportive care and hospice care are two of the many rewarding and needed segments of compounding.

Nat Jones, RPh, FIACP, is a pharmacy consultant at PCCA.

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A few years back when I was playing a slot machine, the gentleman sitting next to me slid a large bill into the machine and then turned to me and said, “I hope I break even, I could use the money.”

I got to thinking about how many times I have put myself or watched others put themselves in that same position while gambling with the revenue of a store. Here are common gambles some community pharmacy owners take with inventory, advertising budgets, and revenue, and how you can avoid making the same poor bets.

GET RID OF SLOW-MOVING PRODUCT
Liquidating slow-moving product is best done quickly and with a proven system. First, reposition the item(s) and discount by 20 percent for two weeks, and then increase the discount to 50 percent for two more weeks. After four weeks at a discount, if the item has not sold, get rid of it.

PREPARE FOR DONATION REQUESTS
Don’t get caught off-guard when asked to donate to a particular cause. Use this as a barometer for what to give when your store is asked to make a donation: for a great nonprofit, health-related request, write a check. For a local sports team or club-affiliated group, offer merchandise, a store gift card, or, at last resort, a check. For an unrecognizable contact that you have never seen in your store and the request is not for something well known, give them that Russ Berrie vintage 30th wedding anniversary photo frame that is celebrating 25 years of being in your gift section (okay, I’m guilty of doing that).

MAP OUT YOUR ADVERTISING STRATEGY
Gambling with a spur-of-the-moment decision to run an ad is a break-even proposition at best. You know how it goes—someone representing the local newspaper with a clipboard and a smile is standing in front of the pharmacy bench, waiting to ask you what you want to do for an ad for the upcoming homecoming issue. You end up saying, “What did we do last year? Okay, let’s just do that again.” Or, “Here, just print our business card.” Sigh. I’m guilty of doing this, too. You know this is going to happen every year, so take a minute when you have a minute and prepare a few good ads in advance for just this type of situation.

KEEP YOUR SHELVES STOCKED
Perhaps you’ve heard of the “let’s just keep one item on the shelf; we can always get another tomorrow” gamble.

Why is this a gamble? Think of how poorly the shelves look with just one of each item. With this type of inventory management, you won’t come close to breaking even. Keep your shelves adequately stocked.

RUN SALES FOR ONLY 10 DAYS
Finally, there is the equivalent of hitting the maximum bet button by using the same in-store sales circular for a month. What happens when you do not end sales in a timely manner? You end up selling best-selling OTC items, sometimes high-demand seasonal cold remedies, at a deep discount for the entire month. Additionally, there is no sense of urgency for your customers and nothing to get excited about when a sale runs the same lunar phase of a full moon. Try running your sales for 10 days; start on a Wednesday and end on the second Saturday from the starting date. If you are closed on Sundays, that schedule works out to 10 days.

By following these inventory, advertising, and revenue tips, you won’t need luck on your side to find success and profits in your pharmacy.

Gabe Trahan is NCPA’s senior director of store operations and marketing. Gabe uses 40 years of front-end merchandising experience to help NCPA members increase store traffic and improve profits. Visit www.ncpanet.org/feo to watch videos, read the tips, and view two galleries of photo examples by Gabe. Follow him on Twitter @NCPAGabe for additional tips.
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