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January 2016

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+ ***Convention Recap***
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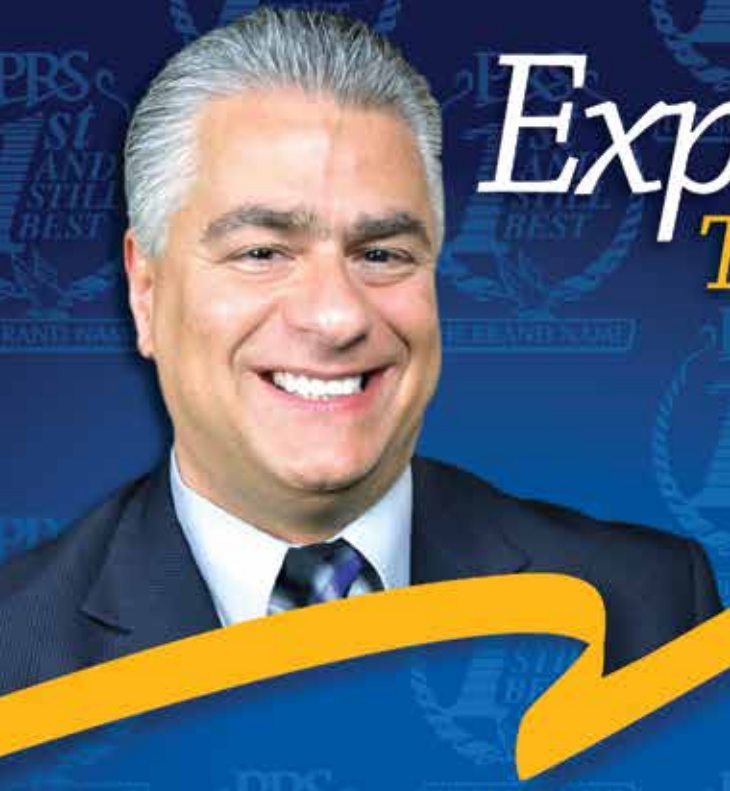

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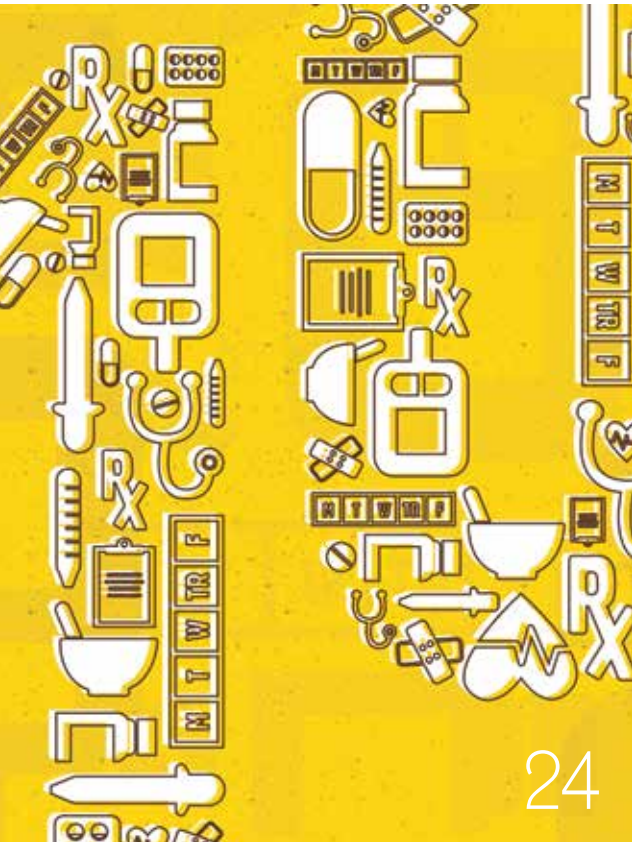

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NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

The National Community Pharmacists Association (NCPA®) represents the interests of America's community pharmacists, including the owners of more than 22,000 independent community pharmacies. Together they represent an $81.4 billion health care marketplace and employ more than 314,000 individuals on a full or part-time basis. To learn more, go to www.ncpanet.org, visit facebook.com/commpharmacy, or follow NCPA on Twitter @Commpharmacy.

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What's Around the Corner?

January is a good time to really look ahead, and not just make the usual, soon-broken resolutions. NCPA's vision of the future sees patients being connected with their local community pharmacy, their physician, and the health system.

Those patients will go seamlessly from one provider to another—not like the disjointed system we have today. Pharmacists will use their unique medication expertise to make sure patients are receiving the most effective medication at the best value to the health system. Market pressures will continue to try to commoditize the product.

NCPA will continue to fight for fair payments for the invaluable service of dispensing medications—a primary tool of our profession.

Revenue streams will come from a number of sources. Opportunities for pharmacists will be prevalent in our changing health care system for those willing to help shape the system.

Independent community pharmacies offer what payers need. We can have the most impact with the sickest and most costly patients. We are missing one key ingredient right now. Independents must aggregate in a way different than today. They must be able to contract with a payer or a hospital system as a group to provide products and services. They especially must be able to do this in geographic regions where that hospital or health plan has a lot of patients. In this model, payers can skip the middleman.

Who needs them in the middle adding costs anyway?

Of course, the future is largely reliant on the successes in the present—the here and now. I've said it before and I'll say it again: NCPA's strength is in its membership—the men and women touching patients' lives every day. Working in your community. Giving back to your community.

We recently measured that community contribution.

It's probably not surprising to know that 63 percent of community pharmacies support five or more community-based organizations. That's data from the *2015 NCPA Digest,* sponsored by Cardinal Health.

We dug even deeper to find out that the typical financial contribution independent pharmacies make to their communities is $3,000 per pharmacy!

That amounts to more than $65 million, or 2.6 percent of your pre-tax profit. As a point of reference, Walmart gives over $300 million back to charities, but that represents 1.3 percent of its pre-tax profit.

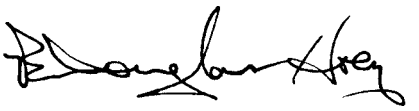
If independents were a corporation, not only would it be in the Fortune 50 ahead of household names like Disney, Google, and McDonalds, it would be one of the most generous charitable givers in all of corporate America!

> ***NCPA exists… so that you can continue to take care of your patients and your communities.***

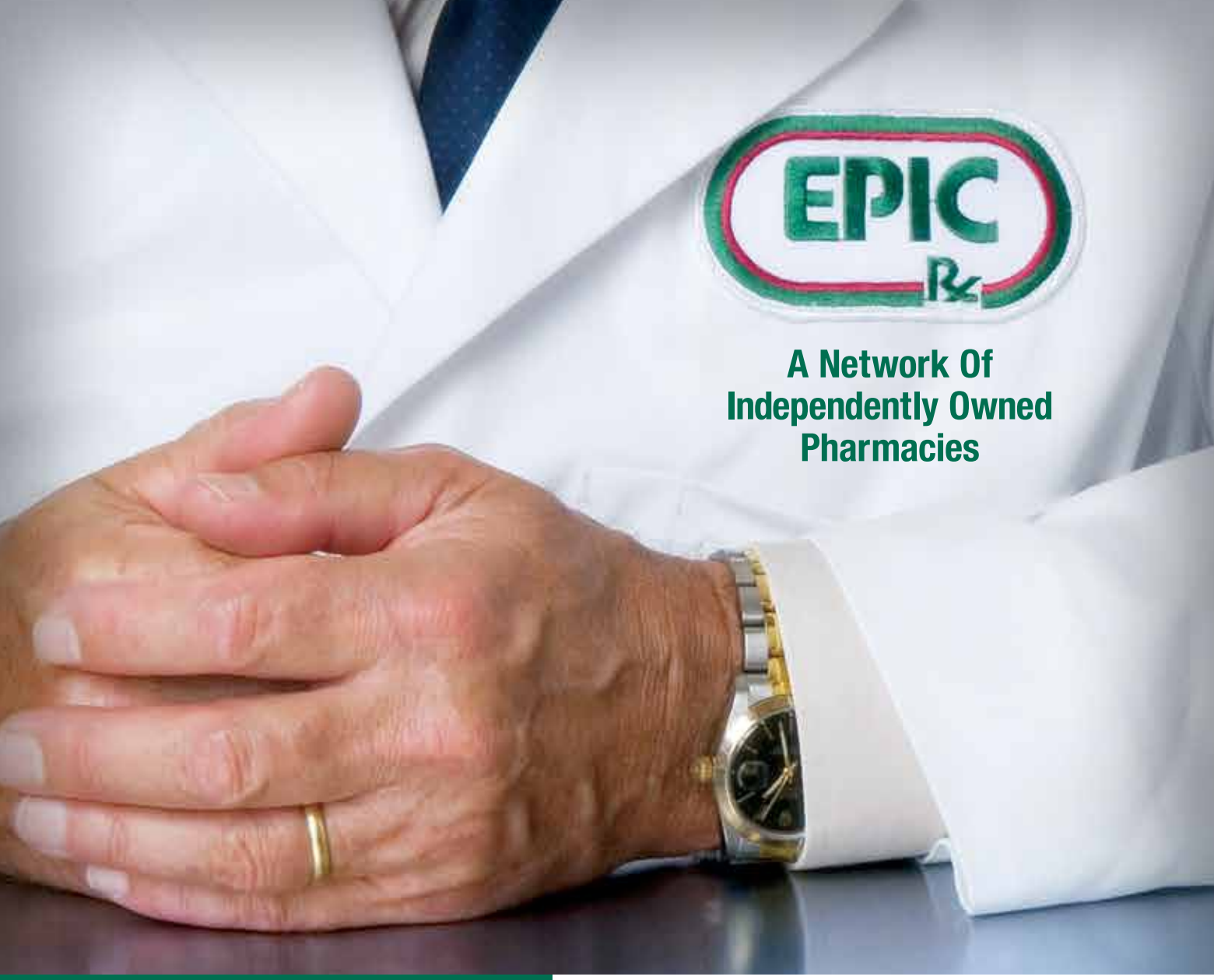
Of course, your connection to the community goes deeper than financial contributions. Many times, not only are independent pharmacies the sponsor, but the owners and their staff are often the coach, the mayor, the chairman, the president, or are behind the scenes making sure the fields get mowed, the vans get driven, or the food gets served.

NCPA exists because of you, and it is our priority to protect you so that you can continue to take care of your patients and your communities. ■

Best,



B. Douglas Hoey, Pharmacist, MBA
NCPA Chief Executive Officer



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ADVOCACY ALERT

- NCPA President Bradley J. Arthur testified before the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law, and he told the lawmakers that the concentrated PBM marketplace is detrimental to both government payers and community pharmacies.
- NCPA participated in the invitation-only HHS summit on prescription drug pricing.
- NCPA's state government affairs team recently went on the road to support independent community pharmacy at the local level: attended the Lieutenant Governors Association Policy Conference in **New York** and met personally with lieutenant governors of **Arkansas, Florida,** and **Kansas**; testified on the PBM industry's impact on community pharmacy before a joint select committee of the **Washington** State legislature; participated in a **Virginia** Board of Pharmacy meeting on PBMs; and attended the national meeting of the National Association of Insurance Commissioners in **Maryland**.

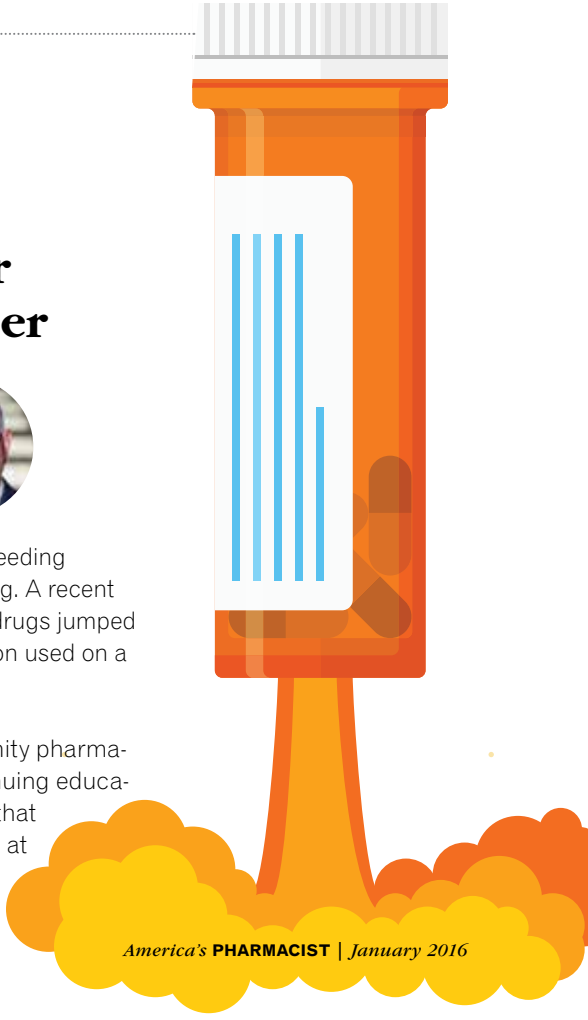
NCPA Q&A

Why is the percentage of mail order prescriptions decreasing, but cost per prescription skyrocketing?

David M. Smith, chairman, Board of Directors
Indiana, Pa.

Part of that reason is due to PBMs incentivizing/directing/steering patients needing specialty medications into their mail order pharmacies. Another part is pricing. A recent AARP study found that retail prices for more than 100 widely used specialty drugs jumped by nearly 11 percent in 2013. The average annual cost of a specialty medication used on a chronic basis exceeded $53,000.

NCPA has undertaken a number of initiatives to help independent community pharmacies understand and explore specialty drug issues. To name a few: a continuing education article in the March 2015 issue of *America's Pharmacist,* a June forum that brought together stakeholders from across the industry, and a CE program at the NCPA Annual Convention that attracted some 160 pharmacists. ■



THE AUDIT ADVISOR

Near 100 Percent Denial Rate for Medical Reviews of Diabetic Test Strips

Q: Our pharmacy continues to receive denials on diabetic test strips. What can we do to avoid this in the future?

A: First quarter audit results for test strips from January through April of 2015 have come down from the National Government Services medical review department with a denial rate of 98.9 percent. The top denial reasons cited by NGS were:

- No medical records submitted
- Incorrect use of modifier
- No documentation to support the specific reason for overutilization
- Proof of delivery (POD) did not include beneficiary signature
- POD did not include the delivery address

Eleven percent of the claims were denied due to documentation not being received by NGS in a timely manner.

NGS has a Policy Education Section, which includes "Dear Physician" letters, a Quick Reference guide, and other documents that may be helpful for many pharmacies struggling with getting paid for diabetic testing supplies. You can find this section about diabetic testing supplies at http://bit.ly/paas-dts.

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.

Independent Pharmacy Today

81%

52%

28%

7%

5%

Source: 2015 *NCPA Digest*, sponsored by Cardinal Health

Transdermal Medications and Heat Sources Are a Bad Match

Figure 1. Embossed print is nearly impossible to decipher. (Image provided courtesy of the Institute for Safe Medication Practices.)

While hospitalized, a woman with multiple myeloma was placed on transdermal fentaNYL (DURAGESIC) 25 mcg per hour for back pain management. The patient had previously suffered two vertebral compression fractures. During the first two weeks at home, things went well. But soon thereafter, a family member noticed that the patient seemed disoriented, was losing her balance, and had nausea and vomiting. A thorough investigation was conducted, and it was discovered that the fentaNYL patch was being applied to the patient's back. At the same time, the patient routinely sat in her favorite recliner which vibrates and has a heating component which was activated.

As mentioned in product labeling, it's important to remind patients and caregivers to avoid exposing transdermal fentaNYL and other transdermal medication patches to heat from heating pads, electric blankets, heat or tanning lamps, sun bathing, hot baths, saunas, hot tubs, heat wraps, and heated water beds, as this could increase the rate of drug delivery. Also, avoid tight coverings over the patch and strenuous exercise, which can heat the body. The person who reported this wanted us to remind others that heated loungers and even vehicles with heated seats can affect absorption of medication when exposed to these heat sources for more than a short time. Encourage patients to apply the patch to appropriate body areas that won't come into contact with these heat sources.

ANOTHER EXPIRATION DATE SITUATION

Add yet another problem with the way expiration dates appear on drug products. The NITRO-DUR (nitroglycerin) patch from Key Pharmaceuticals (Figure 1) embosses the lot number and expiration date over a corrugated area that seals the protective paper outerwrap. Unfortunately, this makes the date nearly impossible to read and the numbers 3 and 5 difficult to distinguish. An illegible expiration date on a nitroglycerin patch can result in negative outcomes for patients.

The Institute for Safe Medication Practices has asked the Food and Drug Administration and the US Pharmacopeia Convention to assure that manufacturers use specific expiration date formats that express dates in a uniform sequence to clearly communicate the date in a consistent and unambiguous manner. Manufacturers should also avoid packaging features that might interfere with legibility (such as printing on shiny foil or corrugated areas).

A POINT ABOUT LEVOTHYROXINE

After reviewing transfer orders from a hospital, a nursing care facility physician ordered SYNTHROID (levothyroxine) 0.25 mg for a patient. The long-term care pharmacy confused mg and mcg and dispensed levothyroxine 25 mcg—a 10-fold underdose. This is not the first time we have heard about errors confusing mg and mcg with these products. In our May 2003 newsletter we reported that errors had become so common with levothyroxine that one pharmacist told us that he had set up his computers to signal an alert whenever a 0.25 mg dose was entered. When the warning appeared, the correct dose almost always was 0.025 mg or 25 mcg. Clinicians need to be alerted to the risks associated with dosing this product and have pharmacists or nurses at community, ambulatory, or long-term care sites provide feedback directly to prescribers if a dosing error, especially an overdose, is suspected. To avoid decimal points and dose conversions, health care practitioners should express the dose of levothyroxine in the same way most manufacturers express the dose—in mcg, not mg. ■

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 on the ISMP website at www.ismp.org. ISMP can be reached at 215-947-7797 or ismpinfo@ismp.org.

Making a difference.

Mike Collins, RPh, FIACP

PCCA's 2015 M. George Webber, PhD Compounding Pharmacist of the Year

"Mike is one of those special people who inspires everyone around him to be the best they can be in all areas of life, not just professionally," Lizzie Dragon, Vice President of Marketing, Education and Member Relations at PCCA, says of Mike Collins. "Whenever you spend time with him, you leave feeling as if you've become a better person. It's an honor to call him both a friend and a colleague."

Collins has been compounding for more than 30 years. It all began in 1985 when he opened Healthway Pharmacy in St. Charles, Michigan. Quickly, he saw the need for personalized medications with his patients and their pets, so he added a compounding laboratory to the facility. The practice grew dramatically, and in 1994, he built a new state of-the-art compounding laboratory.

To accommodate a growing base of patients and prescribers, he opened a second compounding-only pharmacy in 2001 in Saginaw, Michigan, and in 2007, Healthway Pharmacy was accredited by the Pharmacy Compounding Accreditation Board (PCAB). In accepting the award, Collins said, "So many people in this room have been mentors to me and many others. All of them share in this award."

Serving compounding pharmacists since 1981, PCCA helps pharmacists and prescribers create personalized medicine that makes a difference in patients' lives. We are the complete resource for the independent compounding pharmacist, providing the highest-quality products, education and support.

Real World Fraud Lessons for the Pharmacy Arena

by Jeffrey S. Baird, Esq.

In fraud and abuse land, there are several wise sayings that pharmacies need to follow. One is, "If your brain tells you one thing, and if your stomach tells you something else, ignore your brain and trust your stomach." Another is "If it looks like a duck, walks like a duck, and sounds like a duck … then it is a duck."

Now let's switch gears and talk about human nature. If you leave $10,000 in a brown paper sack on the side of the road, someone will pick it up. A tendency for some pharmacies is to promote products that are easy to provide and have high reimbursement. Doing so invites scrutiny. Third party payers will see that a particular code is being heavily billed and will clamp down on it.

Recently, the *Wall Street Journal* ran a front page article entitled "Probes Target Fraud in Military Health Plan." The article says, in part:

"Federal prosecutors in at least four states are mounting investigations into what they describe as widespread fraud by compounding pharmacies in claims to the health-insurance program that covers 9.5 million U.S. military members and their families. … [F]our Florida pharmacies last month agreed to pay $12.8 million combined to settle civil allegations that they falsely billed the insurance program [TRICARE] for expensive pharmaceutical creams and gels to treat pain, scars and other ailments. … Two of the compounding pharmacies… employed salespeople who paid doctors to write prescriptions to [TRICARE] beneficiaries. …. In some cases, doctors would conduct telephone consultations with beneficiaries and then write them prescriptions, despite having not met with the beneficiaries in person. …. Those prescriptions were illegitimate because they weren't based on genuine doctor-patient relationships, a violation of the federal False Claims Act, the prosecutors said. One of the pharmacies had paid commissions of up to 58 percent of the amount paid by [TRICARE] to marketers who promoted their drugs to physicians, prosecutors alleged …. The commissions amounted to improper kickbacks in exchange for referring business to a government agency. … In many cases, pharmacies charged [TRICARE] between $10,000 and $40,000 for a one-month supply of compounded medication. …. [TRICARE] paid $1.75 billion for compounded drugs during its 2015 fiscal year that ended in September—18 times the amount paid in 2012. ... Compounded drugs represented 19 percent of [TRICARE'S] estimated $9.14 billion prescription drug budget in 2015, up

Probes Target Fraud In Military Health Plan

By Joseph Walker

Federal prosecutors in at least four states are mounting investigations into what they describe as widespread fraud by compounding pharmacies in claims to the health-insurance program that covers 9.5 million U.S. military members and their families.

In the latest move, four Florida pharmacies last month agreed to pay $12.8 million combined to settle civil allegations that they falsely billed the insurance program Tricare for expensive pharmaceutical creams and gels to treat pain, scars and other ailments, according to A. Lee Bentley III, the U.S. attorney for the Middle District of Florida.

Two of the compounding pharmacies, which make customized medicines by mixing pharmaceutical ingredients, employed salespeople who paid doctors to write prescriptions to Tricare beneficiaries, prosecu- said. In some cases, doctors would conduct telephone consultations with beneficiaries and then write them prescriptions, despite having not met with the beneficiaries in person, prosecutors said. Those prescriptions were illegitimate because they weren't based on genuine doctor-patient relationships, a violation of the federal False Claims Act, the prosecutors said.

One of the pharmacies had paid commissions of up to 58% of the amount paid by Tricare to marketers who promoted their drugs to physicians, prosecutors alleged in settlement agreements. The commissions amounted to improper kickbacks in exchange for referring business to a government agency, the prosecutors said.

The pharmacies aren't admitting civil liability in the settlement agreements, according to copies of the agreements re-

Please see DRUGS page A6

Continued on page 55 ▶

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Is Tomorrow's ***Health*** System Here *Already?*

Annual convention connects present to future

by Michael F. Conlan

Photography by Michael DeFilippo

Recharge. Reimagine. Reinvent.

#NCPA2015

On the banks of the Potomac River, some 3,000 pharmacists, students, educators, and vendors convened at the NCPA Annual Convention to "recharge, reimagine, and reinvent" the business of independent community pharmacy. The Oct. 10–14, 2015 assembly was held at the Gaylord Resort in National Harbor, Md., just a few miles from the nation's capital where, as NCPA President John T. Sherrer observed, "so much of NCPA's identity has been forged."

Sherrer's farewell address at the First General Session was delivered in an emotional multi-media video necessitated by his ongoing recovery from a major stroke. "Six years ago, I began a journey I never expected and never asked

Editor's Note: *To view a gallery of convention photos, visit NCPA's Facebook page at www.facebook.com/commpharmacy.*

NCPA 2015 Annual Convention

for…My entire life changed in the blink or an eye," he said. Evoking the spirit of Franklin Delano Roosevelt, whose "Little White House" in Warms Springs, Ga., is just 88 miles from Sherrer's home and pharmacy in Marietta, he continued, "Remember President Roosevelt's life after he was stricken with polio? His goals were the same, but his methodology was different. He worked more readily with others to complete his tasks and to work toward his goals. And that is something that I can definitely relate to, as I am personally inspired by his 'infinite patience and never-ending persistence' in my own life."

At the Second General Session, NCPA CEO B. Douglas Hoey, Pharmacist, MBA, delivered the state of the association address. Looking ahead to a value-based pharmacy reimbursement model, Hoey said, "Independent community pharmacies offer what payers need. We can have the most impact with the sickest and most costly patients. We are missing one key ingredient. Independents must aggregate in different ways. They must be able to contract with a payer or a hospital system as a group to provide products and services. They especially must be able to do this in geographic regions where that hospital or health plan has a lot of patients. In this model, payers can skip the middleman. Who needs them in the middle adding costs anyway?"

As part of the convention, the House of Delegates elected officers and board members for 2015-16 (see page 18) and approved new policy positions. Bradley Arthur, RPh, was named president of the 117-year-old organization. Arthur co-owns two full-line pharmacies in Buffalo, N.Y., and is the son of the late NCPA President Donald J. Arthur, who served in that role in 1988-89. (See page 22.) New to the leadership team is Justin Wilson, PharmD, who was named fifth vice president. Wilson is co-owner/manager of Valu-Med Pharmacy in Midwest City, Okla. He serves as chairman of NCPA's committees on state legislation and state regulatory affairs.

The delegates also ratified policy resolutions supporting value-based care with community pharmacies serving as outpatient health care centers and reaffirmed support for collaborative practice agreements with prescribers, while expressing opposition to PBM inflation of patient copays and PBM imposition of direct and indirect remuneration fees (DIRs) that make it difficult and sometimes impossible for pharmacies to determine their true reimbursement rates.

"These resolutions address two areas that are vitally important to independent community pharmacists," Hoey said. "Tomorrow's health system will put more emphasis

on quality of care and patient outcomes. Independent community pharmacists are well positioned to lead that transformation, at times through physician-pharmacist collaborative practice agreements, and should be appropriately reimbursed for their services. In addition, the claw back tactics of PBM corporations are out of control. As our country demands more transparency in health care pricing, requiring more disclosure from PBM corporations is a great place to start."

Other convention highlights included (see what you missed?):

- The three-day, 11-hour trade show featuring more than 235 exhibitors and 310 booths.
- Educational programming comprised of 21 hours of CE, 17 hours of non-CE sessions, and 87 speakers.
- Keynote speaker and economist Steven D. Levitt, co-author of the best-sellers *Freakonomics* and *Think Like a Freak,* describing how asking simple questions can reach startling and far-reaching conclusions, including the example of an IRS employee whose suggestion saved taxpayers $2 billion in its first year alone.
- White House "Drug Czar" Michael Botticelli calling on community pharmacists to help fight opioid prescription drug abuse.
- Award-winning TV journalist and former CNN anchor Candy Crowley moderating a panel at the Second General Session titled, "Community Pharmacy's Future in the Rapidly Changing Health Care System." The panel consisted of now NCPA President Bradley J. Arthur; Edmund J. Pezalla, MD, a vice president at Aetna; Charlene Frizzera, former acting administrator of the Centers for Medicare and Medicaid Services; and Albert Thigpen, RPh, a former PBM executive.
- In a separate speech, Crowley predicted that the Democratic and Republican presidential nominees, respectively, would be Hillary Clinton and Jeb Bush or Marco Rubio.
- Eight major awards presented (see page 20).
- Pharmacy students from the University of Arkansas for Medical Sciences College of Pharmacy winning the 2015 Good Neighbor Pharmacy NCPA Pruitt-Schutte Student Business Plan Competition (see page 21).
- The bring-down-the-house closing night entertainment of Tony Award-winning singer and TV sitcom icon Jason Alexander (George Costanza of "Seinfeld").

The NCPA 2016 Annual Convention will be held at the Ernest N. Morial Convention Center in New Orleans Oct. 15-19. Registration information will be available in the spring. ■

Michael F. Conlan is editor of *America's Pharmacist.*

MEET YOUR ASSOCIATION LEADERS: NCPA'S BOARD OF DIRECTORS AND OFFICERS

Operating a small business is demanding enough. Add to it volunteering to serve in a leadership role in a professional association that requires passion and commitment—traits that NCPA's 2015–16 leaders demonstrate daily. The board of directors and officers devote countless hours of their personal time to advancing NCPA's founding mission: continuing the growth and prosperity of independent community pharmacy by representing its professional and proprietary interests before Congress, the courts, and regulatory agencies in Washington, D.C., and in state capitals across the country.

The new leadership team (pictured above), ratified by the House of Delegates Oct. 13, 2015, personify the spirit, determination, creativity, and dedication of independent community pharmacy today, and they passionately share a vision for its future.

All are small business health care providers. They know that independent community pharmacists must constantly innovate and take full advantage of their education, expertise, and technology to deliver the highest quality care, service, and outcomes to their patients. They know that independent community pharmacists must use their business, management, and clinical skills not just to survive, but to thrive, in a constantly changing and challenging health care landscape. And they know NCPA must be there to help.

BOARD OF DIRECTORS

Bradley J. Arthur, president, co-owns two full-line independent pharmacies in Buffalo, N.Y. He graduated from the University of Florida College of Pharmacy. For more on the new president, see page 22.

DeAnn Mullins, president-elect, is a certified diabetes educator and owns Mullins Pharmacy, WeCare Wellness, and the WeCare Diabetes Education Program in Lynn Haven, Fla. She is a former member of the Florida Board of Pharmacy and graduated from Samford University's McWhorter School of Pharmacy.

David M. Smith, chairman, is former owner of four pharmacies. He graduated from the University of Pittsburgh School of Pharmacy in 1976.

Bill Osborn is president of Osborn Drugs, Inc., in Miami, Okla. He graduated from the University of Oklahoma College of Pharmacy and received his PharmD from Oklahoma University.

Brian Caswell is president of Wolkar Drug in Baxter Springs and co-owner of Four States Pharmacy in Gelena and Cherryvale Pharmacy in Cherryvale, all in Kansas. He graduated from the University of Kansas School of Pharmacy.

Michele Belcher co-owns Grants Pass Pharmacy, Inc., in Grants Pass, Ore., which offers compounding, hospice care, and compliance packaging for long-term care. She graduated from the Oregon State University College of Pharmacy.

Hugh Chancy co-owns five Chancy Drug locations in south Georgia, including four retail and one closed-door pharmacy. He graduated from the University of Georgia College of Pharmacy.

Jeff Carson, is part owner of Oakdell Pharmacy, which has five locations in San Antonio. He graduated from the University of Texas.

John T. Sherrer, immediate past president, co-owns Poole's Pharmacy in Marietta, Ga., and is a partner in three more Georgia pharmacies. Sherrer also owns First Aid of America, an industrial first aid and safety supply company. He graduated from the Mercer University Southern School of Pharmacy.

OFFICERS

Lea Wolsoncroft, first vice president, co-owns, with her husband Tom, two pharmacies in Birmingham, Ala.: KidsMeds Pharmacy, specializing in pediatrics, and Freeman's Compounding Pharmacy. She graduated from Samford University's McWhorter School of Pharmacy.

Jeff Harrell, second vice president, is co-owner of six independent pharmacies in Washington state. He graduated from Washington State University.

Kristen Riddle, third vice president, is president, director of clinical services for U.S. Compounding Pharmacy, a PCAB™-accredited, compounding-only pharmacy located in Conway, Ark. She is also partner/owner in a community pharmacy—American Home Pharmacy.

Christian Tadrus, fourth vice president, owns a pharmacy in Moberly, Mo. A graduate of Boston University and the St. Louis College of Pharmacy, he is vice president of the Missouri Board of Pharmacy, past president of the Missouri Pharmacy Association, and lead developer of the Missouri Pharmacists Care Network.

Justin Wilson, fifth vice president, currently co-owns Valu-Med Pharmacy in Midwest City, Bestyet Pharmacy in Harrah, and Valu-Med Pharmacy in Ft. Gibson, all in Oklahoma. He is a member of the Oklahoma State Board of Pharmacy, a past president of the Oklahoma Pharmacists Association, and adjunct clinical professor at the University of Oklahoma College of Pharmacy, his alma mater.

AWARD WINNERS

Eight major awards for outstanding contributions to independent pharmacy were presented at the NCPA 2015 Annual Convention at National Harbor, Md.

1. CORPORATE RECOGNITION AWARD—UPSHER-SMITH
DeAnn Mullins (left), NCPA president-elect, presented Upsher-Smith Laboratories, Inc. with the Corporate Recognition Award. Accepting on behalf of Upsher-Smith is JoAnn Gaio and Mike McBride.

2. JOHN W. DARGAVEL MEDAL—CARSON
John Carson (center), was honored with the John W. Dargavel Medal. He was presented with the award by Sharlea Leatherwood, NCPA Foundation president and past NCPA president, and Rex Catton of McKesson.

3. JOHN W. DARGAVEL MEDAL—VINCENT
The late James Vincent was also named the recipient of the John W. Dargavel Medal. Presenting the award to Vincent's son Matt Vincent (center) were Sharlea Leatherwood, NCPA Foundation president and past NCPA president, and Rex Catton of McKesson.

4. NATIONAL PRECEPTOR OF THE YEAR AWARD—SCHWARTZWALD
Laura Schwartzwald (right) was presented with the National Preceptor of the Year Award by Sharlea Leatherwood, NCPA Foundation president and past NCPA president.

5. PRESCRIPTION DRUG SAFETY AWARD—BEACH
Brian Beach (center) was the recipient of the Prescription Drug Safety Award. With him are (left to right) NCPA President-elect DeAnn Mullins, White House "Drug Czar" Michael Botticelli, and Tim Gallagher and Tom Jackson of Smart-Fill.

6. WILLARD B. SIMMONS INDEPENDENT PHARMACIST OF THE YEAR—MOOSE
Joseph Moose (center) received the Willard B. Simmons Independent Pharmacist of the Year Award from NCPA President-elect DeAnn Mullins (left), and JoAnn Gaio of Upsher-Smith Laboratories Inc.

7. OUTSTANDING ADHERENCE PRACTITIONER—SYKORA
John Sykora (left) received the NCPA Outstanding Adherence Practitioner Award from Marvin Richardson, Mirixa CEO.

8. NARD OWNERSHIP AWARD—COHENOUR
Frances Cohenour (right) was presented the NARD Ownership Award from Sharlea Leatherwood, NCPA Foundation president and past NCPA president.

THE UNIVERSITY OF ARKANSAS WINS STUDENT BUSINESS PLAN COMPETITION

A team of pharmacy students from the University of Arkansas for Medical Sciences College of Pharmacy was named the winner of the 12th annual 2015 Good Neighbor Pharmacy NCPA Pruitt-Schutte Student Business Plan Competition. A team from the South Carolina College of Pharmacy-USC was runner-up, and a team representing the University of Minnesota College of Pharmacy finished as the second-runner up.

The three finalist teams made live presentations of their business plans before the competition judges at the NCPA 2015 Annual Convention held Oct. 10-14 in National Harbor, Md.

The 2015 competition drew participants from 43 schools and colleges of pharmacy across the Unites States. This is the first national competition of its kind in the pharmacy profession and started in 2004. The contest is named in honor of two great champions of independent community pharmacy, the late Neil Pruitt, Sr., and the late H. Joseph Schutte. The competition's goal is to motivate pharmacy students to create a business model for buying an existing independent community pharmacy or developing a new one. The competition is supported by Good Neighbor Pharmacy, Pharmacists Mutual Companies, and the NCPA Foundation.

The University of Arkansas for Medical Sciences College of Pharmacy was comprised of team captain Luke Morrison and members Kristen Belew, Brooklyn Pruett, and Christina Watkins. Team advisors were Seth Heldenbrand and Schwanda Flowers, and the dean is Keith Olsen. Their NCPA chapter received $3,000, and $3,000 was contributed to the school in the dean's name to promote independent community pharmacy. The team members, team advisor, and the dean will also receive complimentary registration, travel, and lodging to NCPA's 2016 Multiple Locations Conference next month in Fort Myers, Fla.

The South Carolina College of Pharmacy chapter received $2,000, and $2,000 was contributed to the school in the dean's name to promote independent pharmacy.

The University of Minnesota College of Pharmacy chapter received $1,000, and $1,000 was contributed to the school in the dean's name to promote independent pharmacy.

1) The University of Texas was named the 2015 NCPA Student Chapter of the Year.

2) Robert Maher (right), NCPA Chapter advisor at Duquesne University, received a Catalyst Research Grant Award for Innovative Practice in Pain Management during the NCPA Foundation Awards Ceremony. Presenting the award is Joseph Mosso (far left) and Charles M. West from the NCPA Foundation.

3) Peter Tyczkowski (right), coordinator of Educational Outreach at the University of Connecticut School of Pharmacy, is shown with the Faculty Liaison of the Year award, presented by NCPA 2015-16 President Bradley J. Arthur on behalf of the NCPA Foundation.

4) Jan Kavookjian, a professor at the Auburn University Harrison School of Pharmacy, received the NCPA Outstanding Adherence Educator Award. With her is NCPA 2015-16 President Bradley J. Arthur.

MEET NCPA'S NEW PRESIDENT BRADLEY J. ARTHUR

by Michael F. Conlan

Unlike most people who grew up in a pharmacy family, Brad Arthur's first job wasn't at one of his father's eight stores. "I didn't want my buddies to think that the only reason I got a job in a pharmacy is because my father owned one," Arthur recalled recently. "So when I turned 16, I went to work in a gas station. After three months my father said, 'OK. You've made your point. You start in the pharmacy Monday.'"

And pharmacy has been a family affair ever since. Brad works with his sister at Black Rock Pharmacy, one of the two pharmacies he and his brother, Donald J. Arthur Jr., co-own in Buffalo, N.Y. His brother served as his preceptor. Their father, Donald J. Arthur Sr., was NCPA president in 1988-89 and introduced Brad when he was elected NCPA 5th vice president in 2001. Brad is the first son to succeed his father as NCPA president.

In his acceptance speech to the House of Delegates in October, Brad repeated his father's words from the 1989 Annual Convention when he said independent community pharmacy "must work closely with those in industry and in medicine who support us and confront those that hurt pharmacy…these sentiments still hold true today and I pledge to work and fight each and every day to ensure that our friends appreciate us, and our adversaries respect us.

> ***I pledge to work and fight each and every day to ensure that our friends appreciate us, and our adversaries respect us.***

"NCPA is the loudest, most credible voice for independent community pharmacy, and I assure that our commitment to advocacy efforts will not go away; they will not go unnoticed; and we will not relent until there is meaningful change for independent community pharmacy and the patients we serve."

Arthur is a 1987 graduate of the University of Florida College of Pharmacy. He is past president and board chair of the Pharmacists Society of the State of New York.

At the NCPA 2015 Annual Convention, Arthur was the pharmacy representative on a panel asked to look at the role of pharmacists in the future. He said that about 10 years ago various stakeholders in pharmacy came together to address how best to help move the profession forward.

"We got started in the colleges of pharmacy," Arthur said. "We have to ensure that pharmacists are participants such that they are going to be able to deliver value-based services, which we know are going to be a fundamental part of health care moving forward; [that] pharmacy students and the recent graduates have the skill sets to be able to provide these services. It is incumbent upon us to repurpose those skills for the betterment of patients. I'm convinced we're headed in the right direction."

Michael F. Conlan is editor of *America's Pharmacist.*

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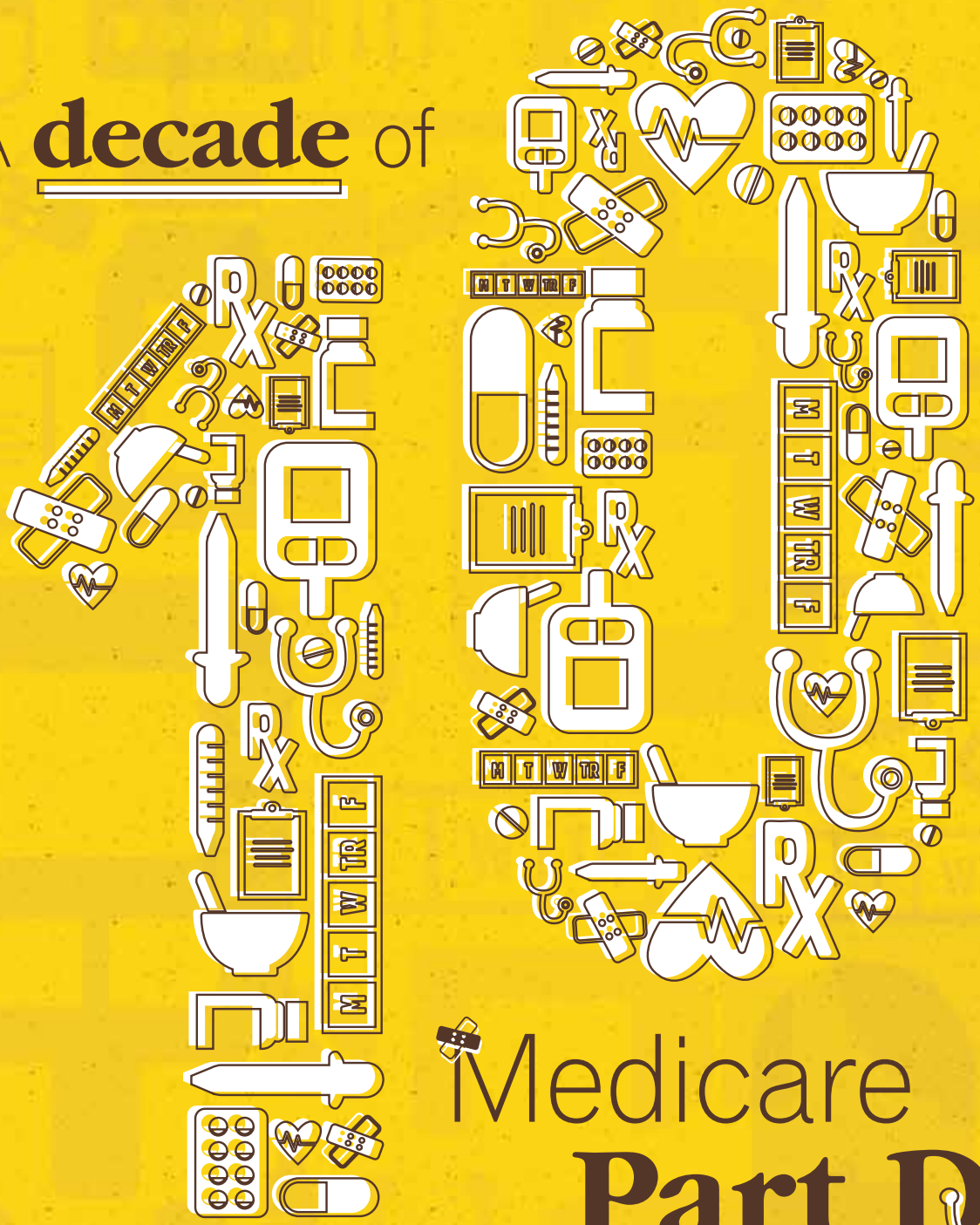

Medicare
Part D

Ten years in, the landmark law continues to bring challenges and opportunities

by Jennifer L. Bruckart

It's not an understatement to say the creation of the Medicare Part D program forever changed community pharmacy. For millions of elderly and disabled Americans, Part D meant access to lower-cost prescription medications. However, for community pharmacy, it meant the beginning of declining reimbursements, unprecedented oversight, and a virtual stranglehold by the pharmacy benefit managers (PBMs) that operate the Part D plans.

HOW PART D CAME TO BE

The Medicare Prescription Drug, Improvement, and Modernization Act (otherwise known as the Medicare Modernization Act) was introduced in the summer of 2003 and hotly debated for nearly six months in Congress before passing the House and eventually the Senate. The bill was signed into law by President George W. Bush on Dec. 8, 2003 and the program launched on Jan. 1, 2006.

The law amended the Social Security Act to create the first-ever voluntary prescription drug benefit under the Medicare program, and it represented the largest overhaul in the program's 38-year history.

Prior to the creation of Part D, community pharmacists saw firsthand the challenges seniors faced in paying for prescription medications. Many pharmacists, such as Drew Miller, RPh, owner of Wynn's Pharmacy in Griffin, Ga., supported the program's goals of making medications more affordable for seniors.

"Before Medicare Part D, there were many seniors who had to decide whether to pay their gas bill, buy groceries, or get their medicines," recalls Miller. "I'm sure the focus of this program was to make it easier for these individuals not to have to make such a critical choice about whether or not to stay well and take their medicines. I think that was the original purpose of Part D."

PHARMACISTS TAKE THE LEAD

And so with access and affordability as its goal, the Medicare Part D program was scheduled to launch Jan. 1, 2006. For the two years leading up to its debut, the Centers for Medicare & Medicaid Services (CMS), the agency tasked with implementing the Part D program, began writing the regulations for the new program.

As a more immediate measure, CMS also rolled out a drug discount card program. In this program, the government contracted with private companies to provide eligible individuals with prescription drug discounts and other subsidies. Many of the early participants in the discount card program would become eventual players in the full Part D program.

Organizations such as NCPA could see a major change was ahead. Instead of sitting on the sidelines, NCPA, along with wholesalers, buying groups, and state associations, joined together in an unprecedented fashion to educate pharmacists about the new prescription drug benefit.

Pharmacists by the thousands flocked to 27 town halls nationwide to learn the ins and outs of the Medicare Part D program. In total, some 7,000 community pharmacists attended these free events, which took place across the country from July to September 2005.

"It was a completely new program, and pharmacists were looking for education and guidance about how it would affect them and their patients," says Ed Heckman, then-CEO of Compliant Pharmacy Alliance buying group, who served as one of the town hall speakers.

> ***It's not an understatement to say the creation of the Medicare Part D program forever changed community pharmacy.***

Pharmacists came with a lot of questions, many of which centered on the enrollment process and what type of assistance they and their staff could provide to patients during the enrollment period. In 2005, many seniors did not know how to use a computer or understand what factors to consider when choosing a prescription drug plan (PDP).

Pharmacists headed home from these town halls to find patients deluged with marketing materials from the plans. In many cases, patients brought these brochures and fliers to the professional they trusted most with decisions about their prescription medications—their community pharmacist.

"Patients really relied on us to help them find the best plan for them," explains Miller, recalling how patients would literally come in with grocery bags full of marketing information from the plans. "I can remember sifting through those bags and just being shocked at the amount of money these companies were spending to get patients to join their plan."

Community pharmacies, including Barney's Pharmacy in Georgia, dedicated significant resources to helping patients understand this new program. Owner Barry Bryant, RPh, tasked multiple pharmacists who did nothing but meet with patients and walk them through the process.

"I can remember the pharmacy consistently having a room full of people waiting to have a personal discussion about the new plans," says David Pope, a staff pharmacist at the Barney's location in Augusta, Ga. Pope recalls the challenges of explaining the Medicare Part D structure to patients. "Many patients didn't even know what a deductible was, so we had to explain that to them," he says. "Then, we had to explain how their coverage would essentially go away when they entered the coverage gap. That was difficult for a lot of patients to understand."

Despite the overwhelming confusion, pharmacists were limited in what they could do to help their patients choose a plan.

"As pharmacists, we were only allowed to give out certain information. We couldn't steer patients toward a particular plan," Miller explains. "It was always funny to me because as pharmacists, we understood more about the dispensing and pricing of prescription medication than the people who were out there selling these plans."

And while pharmacists couldn't direct patients toward any particular plan, there was one plan pharmacists enthusiastically supported—Community CCRx®.

Community CCRx grew out of a desire to create a Medicare Part D plan that emphasized the relationship between patients and their community pharmacist. Creating a new Part D Plan was resource and expertise intensive, so NCPA collaborated with MemberHealth, a small PBM, to develop the core principles that would define Community CCRx. This included a commitment to 90 days at retail (no mail order) and aligned incentives that rewarded pharmacists for encouraging the use of cost-saving generics and reimbursing pharmacists for providing face-to-face patient care services to improve patient outcomes.

First launched as a Medicare drug discount card, Community CCRx became one of the first 10 national PDPs approved by CMS. As a direct result of pharmacists' efforts to educate their patients about Community CCRx and its unique benefits, the plan was a major success and became one of the largest plans out of the gate behind PDPs offered by insurance giants UnitedHealthcare, Humana, and WellPoint (now Anthem).

Community CCRx's success also made it a target, and the plan transitioned to Universal American in 2007 before eventually being acquired by CVS Caremark in 2011.

"That was so unfortunate, because it was such a good model, and it surprises me that no one has tried to replicate it," Miller laments. "It was such a great working model, and it's because it had community pharmacists as part of the mix."

MEDICARE D DAY

The start of the Part D program on Sunday, Jan. 1, 2006, was anything but smooth. Claims couldn't be transmitted to many of the plans. Pharmacists frequently couldn't verify patients' eligibility. Many patients had not yet received their identification

Responding to the Call

"We sat down with patients during 20-minute slots and used the Medicare.gov site to enter their medications, show them their best plan options, and explain to them the premium, deductible, donut hole, and total out-of-pocket costs for each plan. Even if I couldn't do them all at the store, I would call the patients at night."

Jack Dunn, RPh
Owner, Jasper Drug Store
Jasper, Ga.

"We started by hosting town hall meetings to educate our patients and our community about the Part D program. Our pharmacies became the places our disabled and seniors went for help with the Part D program—navigating formularies, narrowing down the best plans. We met not just with seniors, but their entire families."

Tripp Logan, PharmD
Vice President, Logan & Seiler Inc.
Charleston, Mo.

"We had to make so many phone calls early on. I can remember vividly one of our longtime patients signed up for a plan that was based in California. I had to stay one night until almost 7:30 p.m. on hold to try to get into that plan's network so I could serve that patient."

Drew Miller, RPh
Owner, Wynn's Pharmacy
Griffin, Ga.

"[Due to eligibility issues and claims processing challenges], pharmacies gave away medications for the first 3-6 months of the program without knowing if they'd ever be paid for them. Community pharmacists really deserve a medal of honor for what they did to make the program work."

Edward Heckman, RPh
Founder/President, PAAS National
Stoughton, Wis.

"If there's one thing I would put my money on, it's that independent pharmacists know quality. Because at the end of the day, they care about their community. They live in their community, and the same people they serve are sitting beside them in church on Sunday. Ultimately, their ability to put food on the table is dependent on quality."

David Pope, PharmD
Staff Pharmacist, Barney's Pharmacy
Augusta, Ga.

cards from their plans. Even patients who did have identification cards didn't always show up in the system.

"January's always a tricky time in the pharmacy anyway [because of coverage and benefit changes]," explains Miller. "But when you have a third of your patients experiencing that, it was almost overwhelming."

Pharmacists would receive vague, non-descriptive errors when they tried to submit claims and had no option other than to call the plan's help desk. The calls flooded the call centers at a record rate, and few plans could keep up. Many pharmacists recall numerous instances of being on hold for more than an hour trying to get through to the help desk.

But with their patients relying on them, pharmacists did what they do best. "We knew we had to get in there and make it work for them," Miller says.

In cases where coverage could not be verified, pharmacists gave away medicines with the hope they would be paid. When the payments eventually came, it was at a much slower pace than pharmacies had been accustomed. Many Part D patients had previously been covered by state Medicaid programs, which often paid on a weekly schedule. Now, pharmacies were looking at payments from the Part D plans that averaged 4-6 weeks during the first six months of the program.

Some pharmacies were forced to take out loans to pay their wholesalers. NCPA worked feverishly with Congress to implement legislation that required prompt payment. In 2008, despite extensive opposition lobbying and a veto by President Bush that had to be overridden, a prompt payment provision was passed as part of the Medicare Improvements for Patients and Providers Act, and pharmacies began to receive payments in a more reasonable timeframe (14 days for clean claims submitted electronically).

Fortunately, pharmacists' efforts in those early days did not go unnoticed. Then-CMS Administrator Mark McClellan, MD, acknowledged the tremendous efforts of community pharmacists at NCPA's Legislative Conference in May 2006, saying, "…pharmacists were central to making the program work…. pharmacists were doing what it took to get beneficiaries the prescriptions they needed—even when you had to cope with gaps in billing information for certain beneficiaries, and with unacceptably long wait times on pharmacy help lines."

PBMS PUSH THE ENVELOPE; CMS RESPONDS

When Medicare Part D was enacted, it was the first time a government program had been created and essentially turned over to private companies. The plans received payments from the government to provide Medicare-subsidized drug coverage to enrolled beneficiaries.

Despite provisions in the MMA that prohibited mandatory mail order, these for-profit plans began aggressively marketing their mail order services, including misleading robo-calls and confusing letters sent to beneficiaries' homes. When groups such as NCPA stepped in to oppose these efforts, CMS responded with more regulation to protect beneficiaries.

In another move to influence patients' choice of pharmacy, plans began co-branding with large retail pharmacy chains. It started in 2011 when Humana debuted its co-branded Humana Walmart-Preferred Rx plan and was followed by the Aetna-CVS/Pharmacy plan in 2012.

Continued on page 30 ▶

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▶ *Continued from page 28*

NCPA had previously successfully fought to remove large chain drugstore logos from beneficiary cards. These new preferred networks once again led to confusion among beneficiaries about where they could obtain their prescriptions.

"Patients were (and still are) confused many times about where they must fill their prescriptions and at what cost," says Tripp Logan of Logan & Seiler Inc., which operates three pharmacies in southeast Missouri. "Unfortunately, independents are often left out in the cold when Part D patients are pushed to chains and mail order, not realizing they can still fill their prescriptions at their community pharmacy."

This confusion has only increased with the growth of tiered pharmacy networks. In these tiered models, beneficiaries are incentivized with lower co-pays to fill their prescriptions at preferred cost-sharing pharmacies. To participate in these preferred cost-sharing networks, pharmacies must accept lower reimbursement and often pay a fee to the plan (known as a Direct/Indirect Remuneration or DIR fee).

A recent report by the Kaiser Family Foundation, entitled "Medicare Part D at Ten Years: The 2015 Marketplace and Key Trends, 2006-2015," found that an astounding 87 percent of all PDPs (representing 81 percent of all enrollees) now have a preferred pharmacy network. NCPA membership has cited this as one of their top advocacy priorities. NCPA has coordinated work with other industry proponents and as a result, community pharmacies have more choices of pharmacy networks. Still, the association continues to advocate that any pharmacy willing to accept the same contract terms and conditions should be allowed to participate in the taxpayer-funded Part D program.

NEW OPPORTUNITIES FOR PHARMACIST-DELIVERED SERVICES

For all its challenges on the reimbursement side, Medicare has created new opportunities for pharmacists to get involved in clinical services.

Pope, who also consults for independent pharmacies across the country, points to medication therapy management (MTM) and diabetes education, a Medicare Part B benefit, as two opportunities for pharmacists to get involved in reimbursable clinical services.

"MTM is a good start, but pharmacists have proven they can do much more," Pope explains. He points to the program's restrictive criteria and says more could be done to help patients before their health declines. "When you look at MTM, in order to qualify (for Part D coverage), you pretty much have to be a diabetic, hypertensive train wreck," he says, referring to CMS' MTM eligibility criteria, which requires a beneficiary to have multiple chronic diseases, be taking multiple Part D drugs, and likely to incur annual Part D drug costs that meet or exceed $3,507 for 2016.

In September, CMS announced it will be piloting an enhanced MTM program in 2017 in 11 states. The pilot would allow community pharmacists to refer patients into a Part D plan's MTM program instead of waiting for patients to qualify based on their projected drug spend and diagnosis codes.

Pope and others would like Medicare Part D to lead the way in other areas too, including chronic care management, which would allow pharmacists to be paid for the non-face-to-face activities they do to help patients achieve better outcomes.

MORE OVERSIGHT, MORE REGULATIONS

As soon as CMS got through the initial hurdles of the program's implementation, the agency and plan sponsors quickly shifted their focus to oversight to protect the program's integrity and ensure its financial solvency.

"The Medicare Part D program was designed from the beginning for sponsors to have compliance programs, including policies to detect, correct, and prevent fraud, waste, and abuse," explains Heckman, who is also the founder and president of PAAS National, which specializes in helping community pharmacies defend themselves against unfair audit practices.

"The audits started very early in the game and have grown over time and have become an even greater focal point as a result of Office of Inspector General reports and Government Accountability Office studies that have brought to light much of the rampant abuse in the Medicare program," Heckman says.

Heckman also attributes much of the recent enforcement activities to plan sponsors' and CMS' data-mining capabilities.

"The standardization of Prescription Drug Event (PDE) data in the Part D program gives organizations like CMS, OIG, GAO, and the plan sponsors unparalleled abilities to electronically cultivate it and get all sorts of data," he says. "It allows them to look for outliers, basically anything that falls outside normal ranges."

Pharmacies with numbers that fall outside the norm have an uphill battle ahead of them, according to Heckman. "Even if the pharmacy is judged to be okay, it's likely to be a tough fight involving extensive audits, intense scrutiny, and potentially involvement of the [Drug Enforcement Administration], especially for opioid-related activities, which are a huge focus."

A NEW EMPHASIS ON QUALITY

A key feature of the Medicare Modernization Act was its emphasis on quality. To fiscally sustain such a large program, a fundamental change needed to take place—shifting the program from one that paid based on the quantity of services provided to one that paid based on quality.

CMS began measuring plans' performance in 2006 and formally introduced the now-familiar five-star ratings scale in 2008. Initial criteria included factors such as call center performance. Over time, these process-oriented measures shifted toward more quality-based measures, including the adherence measures for statins and oral diabetes medications seen today.

This emphasis on quality has changed how pharmacies look at these services. Logan, who also helps pharmacies build and implement adherence services, explains that before Part D, most pharmacies weren't looking at things like medication adherence and medication safety in a formal way.

> ***When Medicare Part D was enacted, it was the first time a government program had been created and essentially turned over to private companies.***

"Community pharmacies now have to focus on 'measurable quality' to ensure they are seen by health plans as positive outcomes-producing, quality-driving health care partners," Logan explains. "Prior to Part D, this was not a common focus in community pharmacies, but now it is."

However, quality also has the potential to be a game-changer when it comes to independent pharmacy's participation in preferred pharmacy networks, according to Pope. Current preferred network contracts, he says, are a "race to the bottom" in terms of who will accept the lowest reimbursement. However, the emphasis on quality gives independents an advantage.

"Ultimately, the goal with these quality measures is to go from 'Are your patients taking their medications?' to 'Are your patients having better outcomes?'" Pope says. "If we're able to aggregate our results and show that we go beyond adherence to better outcomes, we can challenge our insurance companies and have the upper hand when it comes to creating preferred pharmacy networks based on quality."

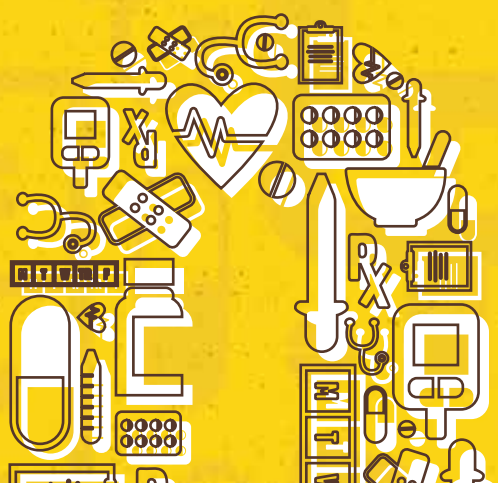
PART D CONTINUES TO EVOLVE

What the future holds for Medicare Part D is hard to say. The total number of PDPs in 2016 represents less than half the number offered at the peak level in 2007 of 1,875 plans. Several high-profile mergers in the marketplace have led to a consolidation of Part D plans. The Kaiser report found nearly half of all Part D beneficiaries are currently in a plan operated by three plan sponsors: UnitedHealth, Humana, and CVS Health.

New, high-cost biologics and specialty medications may pose significant financial challenges to the government-subsidized program. Pending MAC transparency legislation, which will require more frequent (and transparent) pricing, may help to ease some of the reimbursement challenges on the pharmacy side.

However, regardless of what happens, you can believe community pharmacy will be a valuable part of the Medicare Part D program for many years to come. ■

Jennifer L. Bruckart served as NCPA's director of Medicare outreach/education from 2007-2012. She currently is the director of outreach and education for WeCare Pharmacy in Warrenton, Va.



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An FAQ on the Risks of Inappropriate Opioid Prescribing

by Brian Bowman

WHERE DOES THIS "MEASURE TRIO" FIT INTO THE OVERALL MEDICARE PART D STAR RATINGS?

The Pharmacy Quality Alliance (PQA) endorsed high dose and/or multiple provider opioid use in persons without cancer or receiving hospice care as measures of interest in 2015. This three measure set is not included in the current Medicare Part D Star Ratings, but could be included in the future.

WHAT DOES THIS MEASURE ANALYZE?

This measure looks at the patients who have filled prescriptions for opioids on two or more separate days for a total of 15 or more days' supply in one year, and calculates the percentage of this patient population who meet one or both of the criteria that may indicate inappropriate use, overuse, or abuse. This qualification applies to all three of the individual opioid measures and excludes patients being treated for cancer or receiving hospice care.

WHAT IMPACT CAN THIS HAVE ON MY PHARMACY?

The West Virginia Supreme Court of Appeals ruled in May 2015 that prescribers and pharmacies can be sued for causing or contributing to a patient's addiction to controlled substances. To help reduce liability, pharmacists should carefully document the procedures taken to screen for addiction and substance abuse behavior. This set of opioid misuse/abuse quality measures are

Types of Potentially Inappropriate Opioid Prescribing		
Measure	Identifies proportion of individuals that are receiving opioid prescriptions*:	This could indicate:
1: High Dose	> 120mg MED** for ≥ 90 consecutive days	Inappropriate dosing and possible adverse events
2: Multiple Providers	Prescriptions from ≥ 4 prescribers AND ≥ 4 pharmacies***	Uncoordinated care and/or doctor/ pharmacy shopping
3: High Dose and Multiple Providers	From ≥ 4 prescribers AND ≥ 4 pharmacies AND daily dose > 120mg MED for ≥ 90 consecutive days	Misuse, abuse, or inappropriate and/or fragmented care

**Measurement period is one year*
***MED = Morphine Equivalents per Day*
***When days' supply is greater than 15*

an important tool for health plans to use to identify problem prescribers and to screen for patients who may be abusing or diverting opioids and who are at risk for injury from opioid overdose. Pharmacies can use data in a prescription drug monitoring program (PDMP) database to identify individual patients who would be counted in the numerator.

WHAT IMPACT DOES THIS HAVE ON PATIENT SAFETY?

Abuse and overdose of prescription opioids is a major public health issue. Patients who take opioids at high doses for prolonged periods are at higher risk of substance abuse and psychiatric disorders. It has been determined that patients using multiple prescribers or multiple pharmacies are more likely to die of drug overdoses. Although not as severe as opioid overdose risk, there is also a risk of acetaminophen toxicity when patients are taking multiple opioid-acetaminophen combination products from different prescribers and pharmacies. A hospitalization from an opioid overdose is a severe consequence that pharmacists should take all measures to help prevent.

WHAT CAN I DO TO IMPROVE PERFORMANCE IN MY PHARMACY?

Reducing the number of patients who meet these criteria is the primary goal. A quick reference of opioid MED doses (www.globalrph.com/narcoticonv.htm) may be helpful at prescription order entry stations. Health plans or providers of pharmacy data analytics may be able to generate reports of patients who meet the criteria. If your state is one of the 49 that has a prescription drug monitoring program (PDMP), assess a patient's fill history before dispensing a prescription. The Substance Abuse and Mental Health Services Administration (SAMHSA, www.samhsa.gov/find-help/national-helpline) national helpline can help patients find treatment. Pharmacists may notify the prescriber when they decline to fill a prescription and state whether they also provided the SAMHSA helpline info. Pharmacists with concern for prescriber practices should contact the board of pharmacy or medical licensing board for guidance.

Appropriate medication use lowers the risk patterns of abuse and addiction even though physical dependence may exist. Counsel on the potential for addiction if these drugs are not taken as prescribed and answer questions to help ease some of their concerns about addiction. Pharmacists have an important role in appropriate medication use with opioid therapy. Together with patients and prescribers, pharmacists can lower the number of patients who are at risk for harm from opioid overdose. ■

Brian Bowman is a 2016 PharmD candidate at the University at Buffalo School of Pharmacy and Pharmaceutical Sciences.

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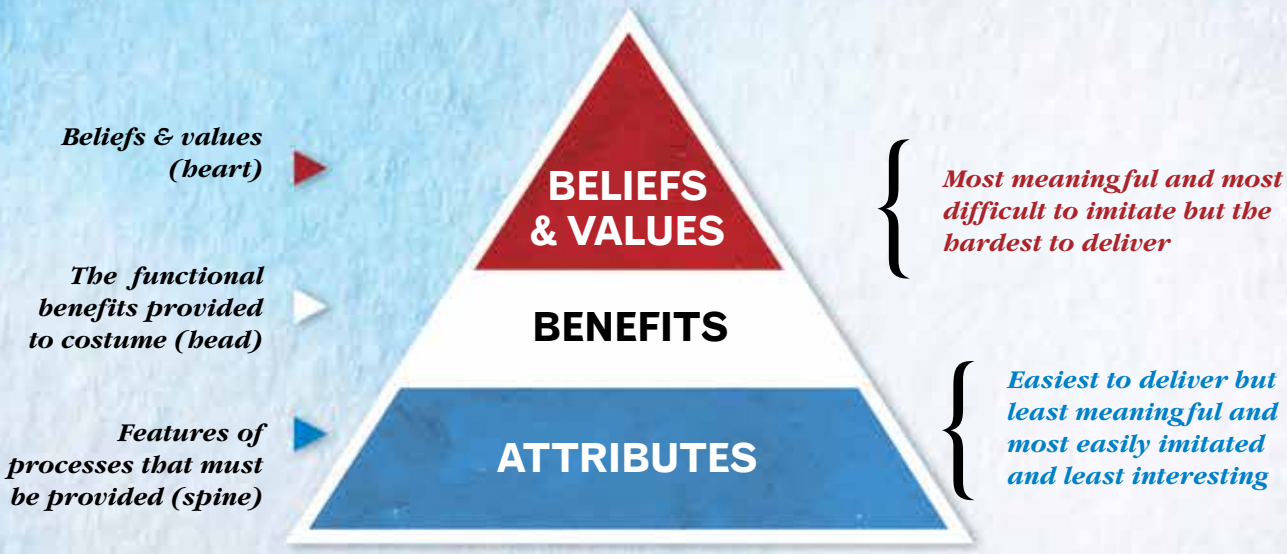
Telling YOUR *brand* story

Create a message from the heart that connects with patients

by Chris Linville

photography by Michael De Filippo

Levels of Brand Association



In the January issue of *America's Pharmacist*, we get an expert's view on methods to help understand and manage your most important asset: your pharmacy's brand. In upcoming issues we will look at ways to help build collaborative relationships between pharmacists and physicians, and turning stories about your pharmacy into an executable marketing strategy.

In a post-convention program entitled "Creating, Telling, and Selling Your Value Story" at the NCPA Annual Convention last fall, Kurt Proctor, NCPA senior vice president for strategic initiatives, moderator for the event, offered this anecdote summing up the goals for the session:

"If you got on an elevator with a potential new patient, can you tell him about you and your pharmacy in a way that entices him to transfer to you before the doors open?" he asked. "What about a doctor? Or a local employer? Why don't you run an immunization program for them, or smoking cessation, or something else? We want to make sure you have a crisp elevator speech and message about your pharmacy to those you run into."

BRAND ASSETS

So, what are the key elements of a pharmacy branding campaign? How do you create a compelling message for your community pharmacy? For pharmacies, the most important asset is their brand, says Wayne Glowac, chief marketing officer for Pharm Fresh, Waunakee, Wis., a company that, among other things, assists pharmacies in doing just that—marketing the brand. Glowac says a brand is "the promises and perceptions about your pharmacy." Brand management is "understanding and impacting those promises and perceptions for maximum loyalty and profitability."

In Glowac's opinion, getting independent pharmacists to tell their tale is vitally important. "Your brand story summarizes and communicates the heart and soul of your business and emotionally connects your brand with the consumer," he says.

Why do pharmacists often struggle with marketing their business? Glowac thinks it's the "soft and fuzzy side of it" that trips them up.

"My experience with health care professionals is that they are first and foremost scientists who happen to care about people, but don't understand that there is an unscientific art to marketing," he says. "We all have a responsibility to better tell the story of locally owned independent community pharmacy and how important it is. Stories connect people. We forget that in marketing. In marketing we want to have the clever slogan or shout from the rooftop, but really the most effective form of communication is stories."

So, why should pharmacists be concerned about telling their story effectively? For one, Glowac says that we are in "an amazingly over-communicated society."

"I can remember not that long ago hearing that we received 1,000 advertis-

Be Prepared for Your Elevator Opportunity

Are you prepared to make your pitch if you meet a potential patient on an elevator? A video on NCPA's YouTube channel gives an example of an opportunity lost and a pitch that could pay off: http://bit.ly/NCPAelevatorpitch.

ing messages per day," he says. "Then it went to 2,000. Now there isn't even data to accurately say how many messages we are bombarded with in a day. People are flooded with these messages. So it's even more important that you create a message from the heart that resonates with people, because there is less time for people to get and hear and understand your message."

Glowac says that in 1964, a Procter & Gamble product manager could reach 80 percent of women ages 18-49 with three TV commercials (during a time with only three channels). This was during the "Mad Men" era, and 80 percent of women in that age group were watching TV.

"You could buy your way into people's minds with just three TV commercials," he says. "Those days are gone. It's more important than ever to craft a succinct elevator speech, and use that elevator speech consistently in your marketing."

Glowac says that although word of mouth is still an impactful form of advertising, there has been a shift in recent years. An October 2009 study by Harris Interactive indicated that for the first time, more people were going on the Internet for information instead of asking family or friends. When word of mouth was replaced by word of mouse, the No. 1 source became search engines. This should serve as a wake-up call, Glowac says.

"I am hearing a disturbing fact that a lot of independent pharmacies don't have a website," he says. "You have to have a website, because people will perceive the value of your business based upon your site. It doesn't have to be elaborate or expensive, but you have to have one. Because people get that local pharmacies are about caring, but they have to feel that you are amazingly competent at what you do. People will judge you by your lack of a website, and it won't be positive." Even the most basic website with the name, logo, address, phone number and hours of operation establishes the online presence for patients and other health care professionals who may be looking for the pharmacy.

LEVELS OF BRAND ASSOCIATION

For Glowac, levels of brand association speak more to the art than the science of marketing. He breaks it into a pyramid with three tiers. At the bottom are the attributes. They are the easiest to deliver, are easily imitated, are the least meaningful, and the least interesting. Yet they are also what's talked about the most. Attributes might be basic offerings and OTC products that just about every pharmacy has.

The middle tier is comprised of the functional benefits provided to customers. If the pharmacy has a drive-thru service, that's a feature as it's more convenient. It's not as easily imitated.

At the top of the pyramid are beliefs and values. They are the most meaningful and most difficult to imitate, but the hardest to deliver. Pharmacies that can reach this level are stepping up their game.

As an example of beliefs and values Glowac says that if pharmacists asked their best patients what they most appreciated about their pharmacy, he suspects it wouldn't be their highly efficient service, or their private conference rooms (though they certainly do like those aspects). No, he thinks it's simply a case of being there to answer their questions, and being their advocate to find the best solutions for their health care concerns.

"They would say, 'I had a sick kid and they stepped up for me.' Or, 'I had a conflict with some prescriptions, and they made me feel like they really cared for me because they gave me some amazing advice. It certainly made me healthier and could have saved my

Continued on page 41 ▶

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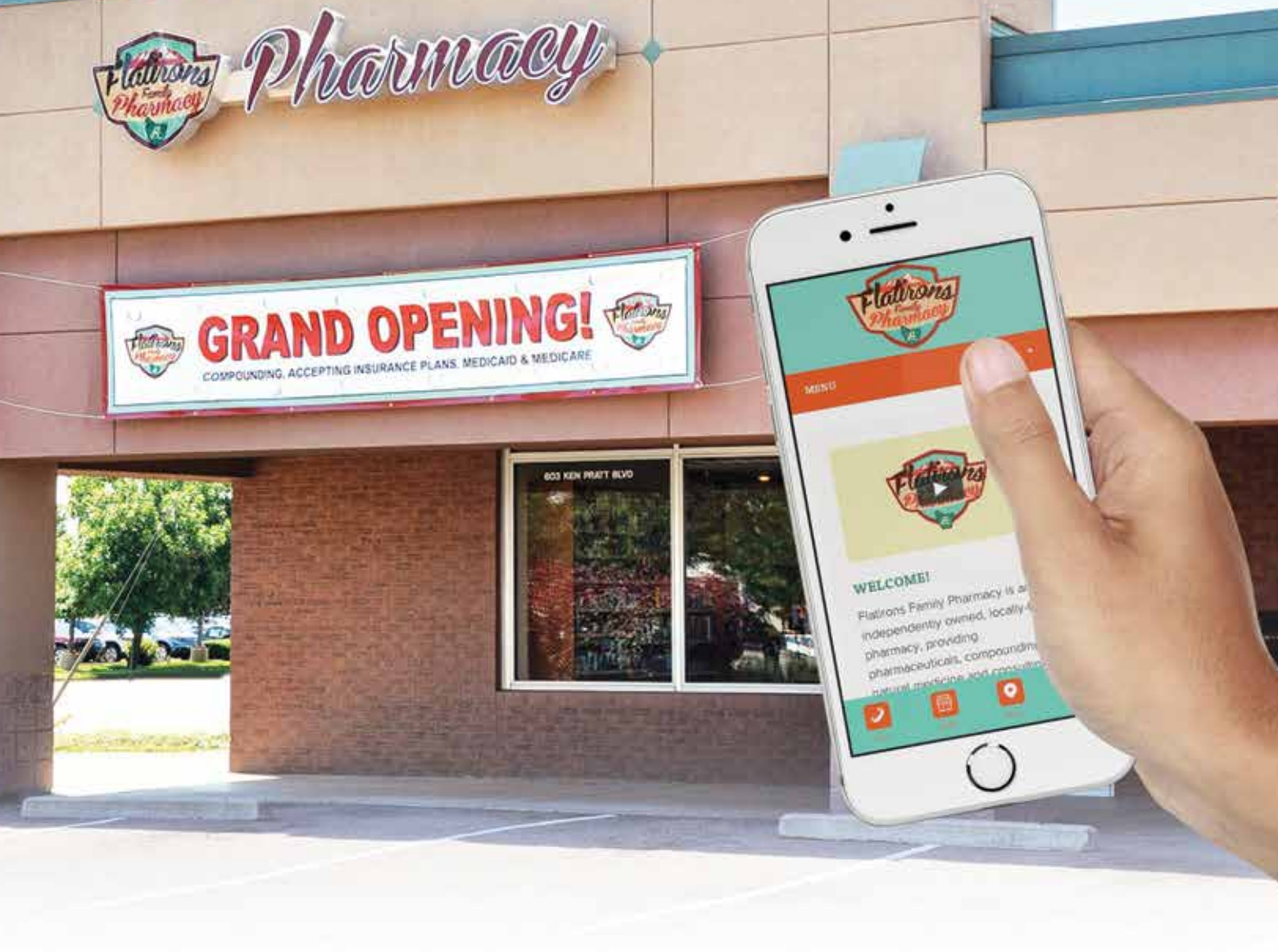

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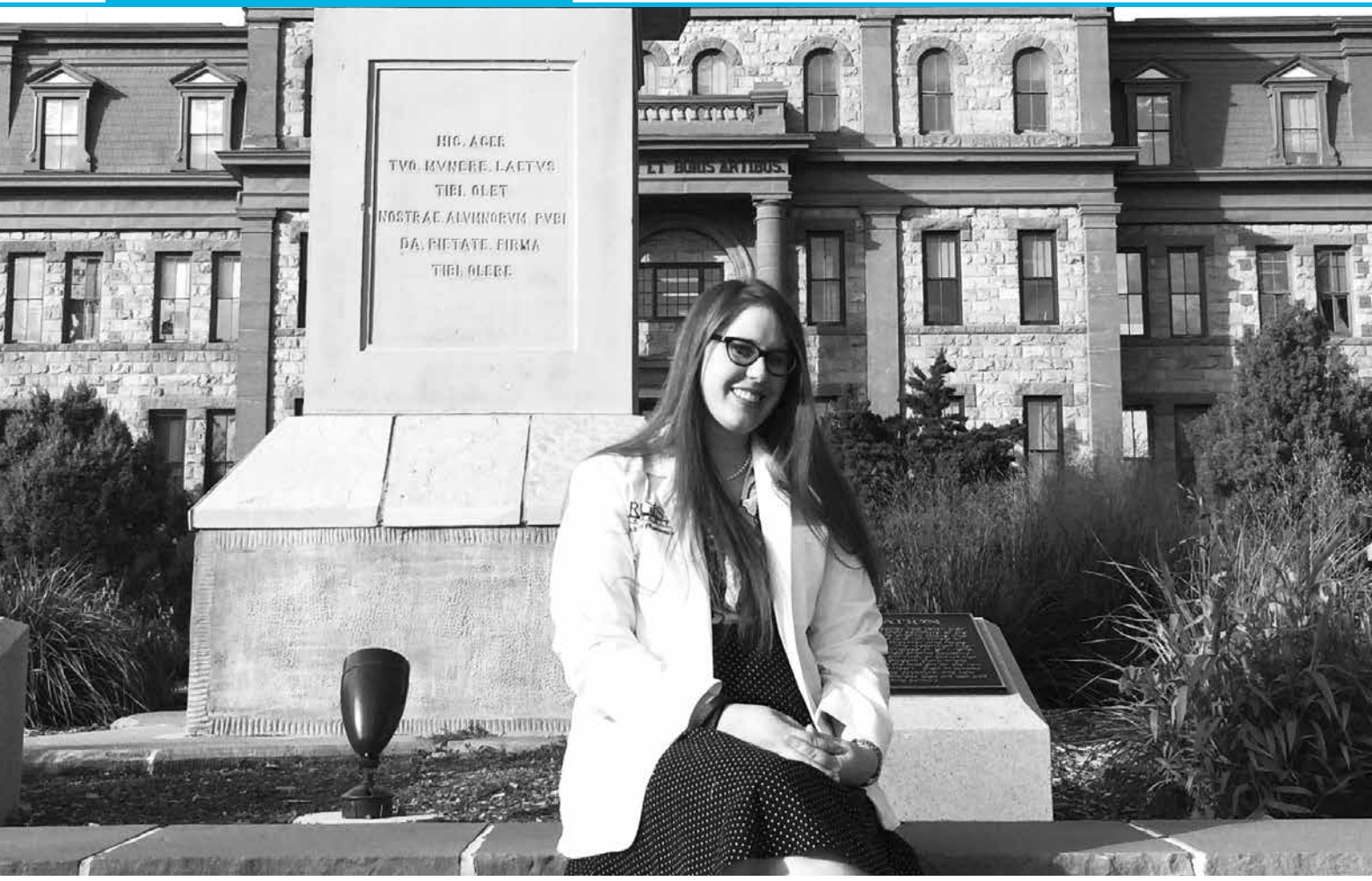

Megan Willis
PharmD Candidate 2017
Regis University

"Growing up in a small town that had an independent pharmacy, I was inspired by the impact our pharmacist made on her patients and the community. I am so grateful to the NCPA Foundation for helping me with my education; I know its continuous support of students like me will keep independent pharmacy alive and thriving so that we can continue to make an impact."

The National Community Pharmacists Association Foundation preserves the legacy of independent pharmacy through scholarships to NCPA student members, programs that encourage independent pharmacy ownership, research that enhances patient care, community health awareness programs, and disaster aid to community pharmacy owners. The Foundation was established in 1953 and is a non-profit 501(c)(3) organization. The ***McKesson Foundation*** *supports the NCPA Foundation's scholarship program.*

The NCPA Foundation
Established in 1953 in honor of John W. Dargavel

▶ *Continued from page 38*

life,'" Glowac says. "People talk about the upper levels of beliefs and values, and that's where the brand lives, that's where the heart is, and that's where the power of your story is."

Glowac says it costs about $80 to acquire a patient through advertising and marketing. To help keep those patients, he suggests that pharmacy owners do an exercise with key staff. First, he says, draw a pyramid and on the bottom list all of the attributes of the business (hours of operation, drive-thru, generic offerings, OTC, and everything else associated with the pharmacy). After that, start thinking from a customer standpoint – what benefit does this provide patients, the community, and the marketplace?

"Eventually you'll start talking in more emotional terms," Glowac says. "And then you should start thinking about some of the comments that have stuck in your heart over the years that you have heard from people. Those can become the beliefs and the values that you live in your organization. That's why you come to work every day. People need to feel cared for. You can help your staff understand why you got into the business, and what your mission and values are. They can make people feel welcome when they come into the store and amazing things can happen."

Sometimes the story needs a rewrite if the pitch is ineffective. Glowac mentioned a health care service provider in Wisconsin as an example. The company wanted to market to businesses to buy into their insurance plan, but a lot of the businesses said the organization was uncaring, didn't listen, and was uncooperative.

"The organization was humbled by what it learned," Glowac says. "Its position statement was, 'To be a better leader in health care, we're following your lead.' But saying it isn't enough, you have to live the brand. So what they did was take their upper management executives to business meetings with local business leaders throughout their service area (15 counties) and had meetings every quarter. The business leaders got the crap beaten out of each other because they hadn't listened."

However, the company got the message. "They realized they had to make a change," Glowac says. "So the executives would go and listen to the challenges they had, and they made significant strides. Because they understood their story, they needed to change their story, and they lived their story."

Glowac says the growing interest in "buying local" fits perfectly for independent community pharmacies. Some of that interest comes from a demographic that may at first surprise you: Millennials. While Baby Boomers may drive much of the prescription business now, this group of young adults and parents are looking for trustworthy products and services. They just have a tendency to go online and research the options before taking action. Millennials are interested in quality over quantity and appreciate custom or unique offerings—something they may not ever know the local independent pharmacy provides if they can't find a website. In a world where interpersonal communication seems to be a dying art, a local pharmacy provides a tangible and comforting sense of place.

"We're so busy being wired and digital that we want some personal connection," he says. "People are yearning for that. Mind share leads to market share. Create a message from the heart that connects with people. Stories have power. Stories connect people." ■

Chris Linville is managing editor of *America's Pharmacist.*

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A Review of New Guidelines and Treatment Options for Obesity

by Kylee Funk, PharmD

Jan. 4, 2016 (expires Jan. 4, 2019)
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Upon successful completion of this article, the pharmacist should be able to:

1. Explain the key pharmacologic considerations for each Food and Drug Administration-approved chronic obesity medications.
2. Describe recent guidelines on pharmacologic and nonpharmacologic management of obesity.
3. Recommend clinically appropriate obesity medications on a patient by patient basis.

Upon successful completion of this article, the pharmacy technician should be able to:

1. List the prescription drugs that are approved by FDA for treatment of chronic obesity.
2. Describe recent guidelines on pharmacologic and nonpharmacologic management of obesity.
3. Choose an appropriate course of action if a patient taking a prescription medication for the treatment of obesity appears to be experiencing an adverse event.

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INTRODUCTION

Obesity is a common diagnosis in the United States and affects more than one-third of adults. As we learn more about obesity, there is an increasing interest in developing programs and treatments to both help prevent its development and lessen its negative effects.

BMI Calculation
BMI kg/m2 = Weight (kilograms) / Height (meters) squared

Obesity is defined by the World Health Organization as "abnormal or excessive fat accumulation that may impair health." Adults are commonly classified as being obese based on their body mass index (BMI). A BMI of greater than or equal to 25 kg/m2 is considered overweight and a BMI of greater than or equal to 30 kg/m2 is considered obese. As a point of reference, someone who is 5 feet 6 inches tall would be obese if they are 186 pounds or greater and someone who is 6 feet tall would be obese if they are 221 pounds or more.

Obesity is described as a national public health threat and is directly tied with an increased risk of morbidity and mortality. Obesity causes cardiovascular morbidity as well as morbidity from the respiratory system, some cancers, and other diseases as described in Table 1. The broad range of organ systems affected by these morbidities leads to increased health care expenditures treating acute illness and trying to lower long-term risk and symptoms. When compared to non-obese counterparts, obese patients experience 46 percent greater inpatient costs and 80 percent greater costs on prescription medications.

Table 1: Obesity Increases the Risk of the Following Disease States
• Hypertension
• Dyslipidemia
• Type 2 diabetes
• Coronary heart disease
• Stroke
• Gallbladder disease
• Osteoarthritis
• Sleep apnea and other respiratory diseases
• Certain cancers

**Adapted from the American Heart Association, American College of Cardiology, and the Obesity Society guidelines*

OBESITY AS AN "ESSENTIAL HEALTH BENEFIT" WITHIN THE AFFORDABLE CARE ACT

Preventive care is gaining traction with payers, providers and patients in United States health care and this is likely in part influenced by the Affordable Care Act. Certain preventative services are outlined that need to be a part of health plans available on the individual market or for small groups as a result of the ACA. One of the services payers are required to cover is preventative care and chronic disease management. Each state defines how the essential health benefits will be covered, which results in specific services included varying from state to state. Recent analysis found that services with respect to obesity treatment vary greatly at the state level; 23 states cover bariatric surgery, 12 states include nutrition counseling, and only three states include weight loss programs as essential health benefits. However, treatment and prevention of obesity is a growing area, and so it is likely that more services for obesity will be covered in the future.

NONPHARMACOLOGIC TREATMENT OF OBESITY

The American Heart Association, American College of Cardiology, and the Obesity Society (AHA/ACC/TOS) published "2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults" (http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee) regarding management of obesity. The full text of this guideline is available online from *Circulation,* the journal of the American Heart Association. This guideline covers topics surrounding obesity that do not relate to medications and certain key concepts are summarized here.

Identification

The first step to treatment is to identify patients who could benefit from weight loss. Patients who are either obese or overweight with comorbidities related to obesity or certain cardiovascular risks (such as prediabetes or waist circumference greater than 40 inches for men and 35 inches for non-pregnant women) are candidates for weight loss. Both BMI and waist circumference should be monitored and documented at least annually. Patients who are overweight or obese should be informed that as their BMI or waist circumference increases, their risk for diabetes, cardiovascular disease, and all-cause mortality becomes greater.

Communication of Benefits

The concept of weight loss is often overwhelming for many patients and this can be compounded by the daunting task of losing enough weight to achieve a normal weight (BMI 18.5 - 25 kg/m2). However, it is important to note that benefits can be obtained without reaching a normal weight. For instance, a sustained weight loss of only 3-5 percent can lead to important clinical benefits such as improved triglycerides and decreased risk of developing diabetes. That obese, 6-foot tall patient weighing 221 pounds referenced earlier in the article could see clinical benefit from losing 6-8 pounds, whereas it would require losing 37 pounds to have a healthy

BMI. Weight loss beyond 5 percent can lead to decreased need for medications to treat blood pressure and diabetes. An overall goal of 5-10 percent weight loss within six months is recommended through the AHA/ACC/TOS guideline.

Recommendations for Diets

The AHA/ACC/TOS guideline focuses on prescribing several different types of diets and three options are outlined: 1,200-1,500 kcal/day diet for women, or a 1,500-1,800 kcal/day diet for men; a diet that is 500-750 kcal/day less than the patient's usual diet; or a diet that restricts certain food types and is evidenced-based. The guideline lists more than a dozen diets that have high strength of evidence for achieving weight loss.

Recommendations for Lifestyle Changes

Patients who would benefit from weight loss should be enrolled in a "comprehensive lifestyle program." This sort of program is defined as one that provides at least 14 sessions over the course of six months and is administered by a professional trained for this work. It includes prescriptions for dieting, exercise, and also behavioral techniques to help patients adhere to these changes.

Surgical Treatment for Obesity

Patients are indicated for bariatric surgery if they are committed to losing weight, have failed lifestyle changes, and have a BMI greater than or equal to 40 kg/m2, or greater than or equal to 35 kg/m2 with certain comorbidities.

Medication Monitoring

When patients lose weight, their requirements for medications for blood pressure, diabetes, and other conditions related to obesity generally decrease. It is important for the clinician to monitor these medications closely and make adjustments as appropriate.

MEDICATIONS THAT LEAD TO WEIGHT GAIN

Many different medications can lead to weight gain and it is important for pharmacists to have an understanding of these medications in order to advise patients.

Medications Used to Treat Diabetes

Diabetes is a common comorbidity with obesity and several medications used to treat diabetes lead to weight gain. Medications such as insulin and sulfonylureas (such as a glyburide and glipizide) often lead to weight gain because their mechanism of action results in increased cellular uptake of glucose.

Experts suggest preferential use of diabetes medications that lead to weight loss. These medications include metformin, glucagon-like-peptide-1 (GLP-1) agonists (such as albiglutide, exenatide, and liraglutide), or sodium-glucose-linked transporter 2 (SGLT-2) inhibitors (such as canagliflozin, dapagliflozin, and empagliflozin). In an obese patient, the second two classes of medications should be added to metformin, which is still considered the first-line therapy for diabetes. For patients who need insulin, it is recommended that metformin, pramlintide, or GLP-1 agonists are also used to combat the weight-gain effects of insulin. Further, it is recommended that basal insulin be used preferentially over a mixed basal-bolus regimen. There are clearly many considerations surrounding the best medication regimens for concomitant diabetes and obesity, and key points to remember are that metformin remains first line and that diabetes medications that lead to weight loss are generally preferred as a first line addition to metformin, especially in cases where insulin is used.

Medications Used to Treat Depression

Depression is also a concomitant diagnosis to patients with diabetes and other chronic diseases, and medications used for depression have differing effects on weight. Antidepressants that are commonly associated with weight gain include tricyclic antidepressants (such as amitriptyline and nortriptyline) and mirtazapine. Bupropion can be considered as an antidepressant in an obese patient since it is the antidepressant often associated with weight loss.

Medications Used to Treat Schizophrenia

Schizophrenia medications can lead to changes in appetite that lead to weight gain. The side effects profile of atypical antipsychotics means they are preferred for many patients, but they often lead to weight gain. Clozapine, olanzapine, quetiapine, and risperidone are all associated with weight gain. Ziprasidone is commonly found to cause significantly less weight gain when compared with other atypical antipsychotics. The Endocrine Society recommends "using weight neutral antipsychotics when clinically indicated rather than those that cause weight gain, and the use of a shared decision making…"

Medications to Treat Epilepsy

Antiepileptic medications can lead to either weight gain or weight loss. For example, gabapentin, pregabalin, carbamazepine, and valproate have been found to cause weight gain, whereas topiramate and zonisamide may lead to weight loss. Similar to recommendations for antidepressant and antipsychotic agents, the Endocrine Society recommends employing a shared-decision model when choosing the most appropriate antiepileptic with a patient.

Other medications to consider when assessing an obese patient include depot-medroxyprogesterone and corticosteroids. Studies evaluating weight gain and use of contracep-

tives report greater weight gain with depot-medroxyprogesterone than oral contraceptives, and little or no difference between women taking oral contraceptives and the control group. The other issue to consider is the estrogen dose in oral contraceptives. There is data that oral contraceptives with lower doses of estrogen may not be as effective in obese women as compared to non-obese women; however, it should be noted that often times the benefit outweighs the risk. If oral contraceptives containing estrogen are prescribed for obese women. Intrauterine devices are another option for effective contraception in women of normal and obese weight. When utilizing these medications in an obese patient for benefits other than contraception, other options for contraception (if desired), such as barrier methods, should be recommended. Corticosteroids may cause weight gain and may raise blood glucose, so consider other options for inflammation such as nonsteroidal anti-inflammatory drugs, if appropriate.

BRIEF HISTORY OF OBESITY MEDICATIONS

When considering the current medications approved by the FDA, an understanding of the history of obesity medications is important. Several medications have been removed from the market due to adverse cardiovascular side effects. This has undoubtedly led to increased hesitancy among prescribers when considering newly approved products.

Fenfluramine was approved in 1973 and increased satiety by increasing levels of 5-hydroxytriptamine (5-HT, serotonin). Several decades later, in 1996, the dexfenfluramine enantiomer was approved because it was thought to lead to fewer adverse effects. Due to cardiovascular adverse effects, both fenfluramine and dexfenfluramine were withdrawn from the market in 1997.

In the same year that fenfluramine and dexfenfluramine were withdrawn from the market, sibutramine was approved for treatment of obesity. Sibutramine works by inhibiting the reuptake of norepinephrine and serotonin. After cardiovascular adverse effects were reported, the SCOUT trial was initiated to further investigate cardiovascular effects of sibutramine. The composite outcome of non-fatal myocardial infarction (MI), nonfatal stroke, and resuscitation after cardiac arrest or CV death as well as the incidence of non-fatal MIs and non-fatal stroke were all found to be elevated when compared to placebo. The FDA requested the withdrawal of sibutramine from the market in 2010 after the results of this study were published. When sibutramine was withdrawn, the only remaining FDA-approved product for chronic management of obesity was orlistat.

Given the history of obesity medications leading to adverse cardiovascular side effects, many clinicians are more cautious in prescribing these medications. A discussion of the current approved medications for obesity is outlined below.

GENERAL RECOMMENDATIONS ABOUT MEDICATIONS RECENTLY APPROVED FOR OBESITY

Since 2012, four medications have been approved for the chronic treatment of obesity. Table 2 outlines all five FDA-approved medications for chronic treatment of obesity. There are some commonalities among all of the approved obesity medications. The indication is nearly identical for each of the medications and can be paraphrased as: weight loss & management in combination with low-calorie diet for adults with initial BMI ≥ 30 kg/m2, or BMI ≥ 27 kg/m2 with other weight-related comorbidities such as diabetes, hypertension, or dyslipidemia. The indications for some of the medications also include recommendations for an increase in physical activity. Providers should stress to patients the importance of combining both diet and exercise interventions with these medications. The practitioner should be aware that the clinical trials which led to approval for these medications included robust programs to assist participants in behavioral changes. If obesity medications are taken without the addition of behavioral changes, it is likely the weight loss that the patient achieves will be significantly less than what was demonstrated in the clinical trials.

Table 2: FDA Approved Medications for Chronic Treatment of Obesity

Generic Name	Brand Name	Year of FDA Approval
Orlistat	Xenical (prescription) Alli (over the counter)	1999 2007
Lorcaserin	Belviq	2012
Phentermine/topiramate ER	Qsymia	2012
Naltrexone/bupropion ER	Contrave	2014
Liraglutide	Saxenda	2014

Table 3: Recommendations Within Package Labeling for Discontinuation of Chronic Obesity Medications	
Medication	**Discontinuation Recommendations**
Orlistat	None listed
Lorcaserin and Naltrexone/Bupropion ER	Discontinue at 12 weeks if weight loss is <5%
Phentermine/Topiramate ER	At 12 weeks of treatment on the 7.5 mg/46 mg dose if weight loss is <3%, consider stopping or increasing the dose. If the 15 mg/92 mg dose is used, discontinue after 12 weeks of this highest dosage if weight loss is <5%.
Liraglutide	Discontinue at 16 weeks if weight loss is <4%

Pregnancy is a contraindication that is consistent across all of the medications for chronic treatment of obesity because of risk for fetal harm.

With the exception of orlistat, all of the medications for chronic treatment of obesity were approved with guidance from the manufacturer for discontinuation if predetermined efficacy measures are not achieved. The recommendations are outlined in Table 3. Although orlistat does not have product labeling that discusses discontinuation, it is reasonable to discuss a general plan with a patient of re-evaluating the use of orlistat at 12 weeks if weight loss is less than 5 percent.

DETAILS ABOUT INDIVIDUAL OBESITY MEDICATIONS

Orlistat (Xenical/Alli)

Orlistat is unique among the current obesity medications in that it does not act systemically. It works through inhibiting gastrointestinal lipases that hydrolyze triglycerides into free fatty acids and monoglycerols. This action restricts the ability of the intestine to absorb triglycerides and they are excreted by the fecal route instead. This mechanism leads directly to several considerations including side effect profile and proper absorption of vitamins.

Gastrointestinal complaints are by far the most common type of side effects reported by patients taking orlistat. Gastrointestinal side effects that occur in more than 10 percent of patients taking orlistat include oily spotting, flatus with discharge, fecal urgency, fatty/oily stool, oily evacuation, and increased defecation. Of note, fecal incontinence was also reported to occur in 7.7 percent of patients. Patients describe the gastrointestinal effects as "mild to moderate" and also note that they improve over time. In clinical trials, all GI effects that occurred in more than 10 percent of patients in the first year only occurred in approximately 2-5 percent of patients during year two. In fact, the resolution of side effects may be much quicker than one year; participants in clinical trials noted that most side effects subsided after the initial four weeks of treatment with orlistat.

Certain fat-soluble vitamins have demonstrated decreased absorption in patients taking orlistat. This occurs because orlistat inhibits the lipase that breaks down fat-soluble vitamins into absorbable components. Multivitamins have been shown to reverse the abnormal vitamin concentrations that were identified in clinical trials. The manufacturer of orlistat recommends administration of a multivitamin at least two hours before or after a dose of orlistat.

Orlistat has several known drug interactions—which are most often related to orlistat's effect on decreasing absorption of other medications. Both the concentrations of levothyroxine and cyclosporine were decreased when administered with orlistat. It is recommended to separate doses of orlistat from cyclosporine by three hours and from levothyroxine by four hours. Concentrations of warfarin and antiepileptic medications may also be affected, and patients taking these medications should be monitored more closely if orlistat is initiated. Additionally, amiodarone may be affected, and due to the potential for sub-therapeutic levels, patients should be monitored.

Dosing of orlistat occurs in conjunction with meals. The prescription strength dose is 120 mg and the over-the-counter dose is 60 mg and is taken up to three times daily with each meal. Patients should be instructed to take orlistat at the same time as—or up to one hour after—their meals. Patients should only take orlistat with meals and should skip a dose if they are skipping a meal. Additionally, if a meal is eaten that does not contain fat, orlistat can be skipped.

Lorcaserin (Belviq)

Lorcaserin activates the 5-HT_{2c} receptors subtype. This mechanism is similar to that of fenfluramine in that it

increases serotonin levels, but the molecule is more selective. Because lorcaserin is selective for the 2C receptor subtype, it has not caused the adverse cardiac effects fenfluramine does. It is thought that activation of receptor subtypes other than the 2C subtype is what led to fenfluramine's adverse cardiac effects.

Due to lorcaserin's serotonergic effect, there are certain drug-drug interactions and side effects to monitor. (See Table 4.) Perhaps the most clear drug-drug interaction is the possibility of serotonin syndrome when lorcaserin is used concomitantly with other serotonin modulating medications. This includes medications that are traditionally known to increase serotonin levels such as selective serotonin reuptake inhibitors (SSRI) and selective norepinephrine reuptake inhibitors (SNRI), but also includes medications such as dextromethorphan, monoamine oxidase inhibitors (MAOI), lithium, triptans, and tramadol, as well as the herbal preparation St. John's Wort. Additionally, lorcaserin is a CYP2D6 inhibitor and as a result, may increase the concentration of medications that are metabolized by CYP2D6, which includes many medications that modulate serotonin (such as fluoxetine, paroxetine, and venlafaxine). The combination of lorcaserin's own action on serotonin with the potential for increased concentration of other serotonin modulating medications can put patients at greater risk for serotonin syndrome. Serotonin syndrome is often characterized by mental status changes, tachycardia, variable blood pressures, and/or neuromuscular abnormalities. Counsel patients taking these medications to immediately report these symptoms.

Among the available medications for chronic obesity, lorcaserin is well tolerated. Side effects that occurred in more than 10 percent of patients include upper respiratory tract infections, nasopharyngitis, and headache. Caution should be taken when lorcaserin is used in patients with diabetes as hypoglycemia is more frequent.

Table 4: Select Interactions to Screen When Initiating Lorcaserin

Increased risk of serotonin syndrome	Drugs with metabolism inhibited* by lorcaserin
SSRIs	TCAs
SNRIs	SSRIs
MAOIs	SNRIs
TCAs	Mirtazapine
mirtazapine	Opioid analgesics
Lithium	Antipsychotics
Triptans	Beta Blockers
Dextromethorphan	Class 1 antiarrhythmics
Tramadol	Promethazine
St. John's Wort	Metoclopramide

**Not all drugs within a class may be affected. Refer to package insert of drug in question.*

Lorcaserin is dosed as a 10 mg tablet taken twice daily. Of note, in clinical trials a dose of 10 mg once daily was studied and found to have almost as much weight loss at the twice-daily dose. Therefore, if this medication appears appropriate for a person, the twice-daily dosing scheme should not be a barrier since it may be possible to have similar efficacy if the second dose is occasionally missed. Specific dosage adjustments for renal and hepatic impairment are not provided, but the manufacturer does recommend avoiding use of lorcaserin in patients with severe renal or hepatic disease.

Phentermine/Topiramate ER (Qsymia)

Phentermine is known as an anoretic, which is a type of medication that works in the hypothalamus to increase satiety. Topiramate's exact mechanism to promote weight loss is unclear, but it is thought to work to both decrease appetite and increase satiety through action at multiple receptors.

Side effects are varied and are more prevalent with increased dosages. Side effects that occurred in more than 10 percent of patients at the highest dosage of phentermine/topiramate ER include: paresthesia, headache, constipation, dry mouth, and upper respiratory tract infections. Other side effects that occurred frequently include insomnia and dysgeusia (which most often lead to a metallic taste in the mouth).

The FDA has required a risk evaluation and mitigation strategy (REMS) due to the risk that phentermine/topiramate ER poses to a fetus. Topiramate is a known teratogen and there is increased risk for cleft palate formation if topiramate is used during a pregnancy. The REMS program requires prescribers of phentermine/topiramate ER to complete training that reviews the need to counsel females of reproductive age on the risks of birth defects, appropriate pregnancy testing, and the recommended contraceptive options. Pregnancy testing should be completed prior to initiating treatment and monthly during use. Additionally, pharmacies must become certified to dispense phentermine/topiramate ER by completing an online program and registering with the manufacturer. Information for dispensing pharmacists is available at http://qsymiarems.com/information-for-pharmacists.htm.

Many drug interactions have been identified that are associated with the use of phentermine/topiramate ER. It is important to investigate these interactions prior to

prescribing or dispensing this medication. One of the more common interactions that might be encountered during clinical practice is with metformin. When the highest dose of phentermine/topiramate ER is used in combination with metformin 500 mg BID, a 23 percent increase in area under the curve for metformin is observed. The clinical effects of this interaction are unclear, but dosage adjustments for metformin may be considered if side effects or safety concerns for high-dose metformin are a concern.

The dosing for phentermine/topiramate ER is detailed and somewhat complicated. There are a total of four different dosing steps for this medication and two instances where evaluation will help influence dosing changes. An initial dose of 3.75 mg/23 mg should be used for the first 14 days of therapy, and after this time, the patient should be transitioned to the 7.5 mg/46 mg dose. After 12 weeks of this increased dose, the patient's weight should be evaluated. If at this time weight loss is 3 percent or greater, the patient may continue at the current dose. If weight loss is less than 3 percent, a decision should be made to either discontinue treatment or to increase the dosage. If the dosage is increased, a two-week dosage of 11.25 mg/69 mg should be prescribed and followed by a 12-week prescription for 15 mg/92 mg dose. If after 12-weeks of treatment at the highest dose (15 mg/92 mg) the patient has not lost 5 percent body weight, phentermine/topiramate ER should be discontinued. Of note, when phentermine/topiramate ER is discontinued from the highest dose, a taper of one dose every other day for one week should be used to decrease the risk of seizure.

Naltrexone/Bupropion ER (Contrave)

Naltrexone/bupropion is thought to work through two complementary mechanisms. One site of action is the hypothalamus, which helps to regulate the appetite, and the other action is through the mesolimbic dopamine circuit, which can be referred to as the "reward center."

Adverse reactions that occurred in more than 10 percent of patients in clinical trials included nausea, constipation, headache, and vomiting. It is also important to be aware of less common, but more concerning adverse reactions. Many antidepressants come with labeling for increased risk of suicidal ideation and the inclusion of bupropion in this medication means that naltrexone/bupropion ER also carries this risk; appropriate monitoring should be conducted. Additionally, bupropion is known to lower the seizure threshold and so this medication should not be used in people with pre-existing seizure disorders. Care should be taken not to exceed the recommended dosages or titrate more quickly than recommended so as to not further increase risk for seizures.

Several drug interactions exist for patients taking naltrexone/bupropion ER. Because naltrexone is an opioid antagonist, this medication should not be taken concomitantly with opioids. Naltrexone/bupropion ER administration can be temporarily held if a short-term treatment of opioids is needed, but if chronic opioid treatment is initiated, naltrexone/bupropion ER should be discontinued. Of note, a patient's sensitivity to opioids may be increased after taking naltrexone/bupropion ER, so lower doses of opioids should be initiated. Additionally, bupropion use concomitantly with monoamine oxidase inhibitors (MAOI) is contraindicated, and administration of these two medications should be separated by at least 14 days to avoid the risk of hypertensive reactions.

Each pill contains 8 mg naltrexone and 90 mg bupropion ER. The dose of naltrexone/bupropion ER is increased each week for the first month of therapy; patients initiate the medication by taking one pill daily for the first week, increase to one pill twice daily during week two, and then during week three add another pill in the morning, and complete the titration at week four when they are taking two pills twice daily. For patients with moderate-severe renal impairment, the maximum dose is one tablet BID, and for those with hepatic impairment, the maximum dose is one tablet daily. Patients should be advised to not take naltrexone/bupropion ER with a high fat meal as the concentrations of both naltrexone and bupropion increased significantly when patients took these medications with high fat meals.

Liraglutide (Saxenda)

Liraglutide is a glucagon-like peptide-1 (GLP-1) receptor agonist. GLP-1 helps to control appetite and is degraded by endogenous enzymes within minutes of production. Liraglutide is formulated to be more stable and not break down as quickly as GLP-1. It was originally developed and is still used as a medication for diabetes (Victoza at a dose of 1.2 or 1.8 mg daily), but has been approved by the FDA for use at higher doses (3 mg daily) for weight loss.

The most common side effects associated with liraglutide are gastrointestinal in nature. Nausea, diarrhea, constipation, and vomiting all occurred in more than 10 percent of patients in clinical trials. In general, patients described these adverse effects as mild-moderate and noted that they improved with time. A total of 6.2 percent of patients discontinued liraglutide in clinical trials as a result of gastrointestinal adverse events (versus 0.8 percent of patients treated with placebo). The liraglutide label has a boxed warning describing the risk of thyroid c-cell tumors based on studies in rats and mice, though it is unknown if it causes this cancer in humans. Other adverse events to monitor for include injection site reactions and hypoglyce-

mia (which is most commonly seen in patients with type 2 diabetes on insulin or sulfonylurea therapy).

There are relatively few known drug interactions with liraglutide. Dosage adjustments in insulin secretagogues (such as glipizide, glyburide) are recommended. When initiating liraglutide, the manufacturer suggests initially decreasing the dose of the secretagogue in half and monitoring blood sugars closely.

Liraglutide for weight loss is supplied in a pre-filled pen that can deliver five different dosage forms. The first week of therapy should consist of the lowest dosage (0.6 mg). The patient should be instructed to increase the dosage by 0.6 mg weekly until he or she reaches the full dose of 3 mg. The full dose should be initiated at the start of week five. The dose is escalated slowly simply to decrease the gastrointestinal side effects associated with liraglutide. If the patient is having trouble tolerating the dose increase, consideration should be given to waiting an additional week prior to increasing the dose further. If the patient misses three doses in a row, they should be instructed to start back at 0.6 mg as if they were re-initiating the medication and once again increase the weekly dose.

Liraglutide is injected subcutaneously and can be administered in the abdomen, thigh, or upper arm. It can be given without respect to meals. Pens should be stored in the refrigerator until the expiration date on the package, but once they are started they can be stored at room temperature for up to 30 days.

COMPARISON OF OBESITY MEDICATIONS

When considering weight loss medications for patients, it is important to review variations that exist between medications. One of the first potential differences that may come to mind is the efficacy of the medication. Since these medications are relatively new, the main outcome that is available to judge efficacy is weight loss (for many medications, there are ongoing cardiovascular outcomes trials). Table 6 outlines the percentage of patients who were able to achieve clinically meaningful weight loss (often defined as 5 percent weight loss in three months) during clinical trials. When interpreting these numbers, it is important to keep in mind that these were not generated from head-to-head trials. The different clinical trials from which these data were generated enrolled patients of different backgrounds and also provided patients with different levels of support to make lifestyle changes. Therefore, this efficacy data should not be viewed as a definitive comparison among the medications, but instead as a guideline about general weight loss that can be achieved for individual medications when combined with lifestyle interventions.

Administration of medications is another important consideration when choosing an obesity medication. Liraglutide is unique from the other obesity medications in that it is an injectable. However, it is administered once daily, which is

Table 5: Suggested "Patient Friendly" Counseling

Medication	Description	Patient Pearls
Orlistat	"Doesn't allow your body to absorb fat"	• Take a multivitamin at least 2 hours before or after administration. • Take during each meal (can take up to one hour after meal). • Skip if skipping a meal or eating a no fat meal.
Lorcaserin	"Makes you feel full"	• This medication interacts with other medications (especially those used for depression), so let us know when you start new medications.
Phentermine/topiramate ER	"Makes you feel full and also decreases your appetite"	• Take in the morning so the medication won't keep you up at night. • This medication shouldn't be suddenly stopped. We can help you with a plan to discontinue the medication, if needed.
Naltrexone/bupropion ER	"Decreases your appetite"	• Do not take with a high fat meal. • This medication interacts with several medications (especially those used for pain), so let us know when you start new medications.
Liraglutide	"Decreases your appetite"	• Inject in your abdomen, thigh, or upper arm. • If you miss more than 3 doses in a row, start your dosing back at week 1 and increase the dose in the same way you did when you started the medication.

a benefit for many patients. Lorcaserin and phentermine/topiramate ER are the other once daily medications and of them, lorcaserin allows for the most flexible dosing times as it can be administered at any time. Phentermine/topiramate ER should be administered in the morning because phentermine is a stimulant. Lastly, naltrexone/bupropion ER is administered twice daily and orlistat is administered up to three times daily; these two medications may not be ideal for someone who is not accustomed to taking a medication several times daily.

Another consideration when comparing the various obesity medications is any concomitant diseases the patient may have. Diabetes is one of the more common diseases that coexists with obesity, and when considering weight loss medications, liraglutide is the only option that is approved to treat both diseases. The Endocrine Society guidelines recommend preferentially considering liraglutide—after metformin has been maximized—for treatment of diabetes in patients who are obese. As was highlighted in the details for each individual medication, there are certain disease states and drug interactions that would cause the practitioner to avoid a particular obesity medication in specific populations. In brief, orlistat should not be used in patients that have irritable bowel disease or other conditions that might make the gastrointestinal side effects of the medication particularly uncomfortable. Patients who are taking serotonin modulating medications may not be the best candidates for lorcaserin, and if lorcaserin is used in these instances, extreme caution should be taken to identify serotonin syndrome. Naltrexone/bupropion ER should be avoided in patients who are taking chronic opioids and also for those who have seizure disorders. Although there are many other disease-specific considerations, the ones highlighted above are likely some of the more common issues that will arise.

ENDOCRINE SOCIETY RECOMMENDATIONS AND CONCLUSION

The Endocrine Society published guidelines in January 2015 about the use of pharmacologic agents for the treatment of obesity. Key concepts from these guidelines are summarized as follows.

In discussing medications, the Endocrine Society recommends that when pharmacologic treatment is used, it should be in addition to lifestyle changes. Further, these guidelines recommend that pharmacologic treatment should be used—when indicated—to decrease effects from comorbidities and to help enhance a person's ability to adhere to lifestyle changes.

Monitoring parameters outlined by the manufacturers for these medications are reinforced by the guidelines. Namely, the recommendations to discontinue these medications if not effective in the first three months (see Table 3) are supported. Additional medication monitoring parameters include assessing efficacy and safety every month for the first three months of therapy and then every three months thereafter.

Table 6: Patients Who Achieved Clinically Meaningful Weight Loss

Orlistat	35-73%
Lorcaserin	37-47%
Phentermine/topiramate ER	67-70%
Naltrexone/bupropion ER	44-62%
Liraglutide	36-57%

These guidelines also discuss medication selection for people with certain disease states. For instance, it is recommended that patients with type 2 diabetes who are overweight or obese should preferentially use diabetic medications that help to decrease weight (such as GLP-1 agonists or SGLT-2 inhibitors) in addition to metformin. Additionally, for those patients with a cardiovascular disease and an indication for a chronic obesity medication, it is recommended to avoid sympathomimetics, and instead choose medications such as orlistat or lorcaserin. ■

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Editor's Note: For the list of references used in this article, please contact *America's Pharmacist* Managing Editor Chris Linville at 703-838-2680, or at chris.linville@ncpanet.org.

Continuing Education Quiz

Select the correct answer.

1. Which of the following patients is considered obese?
a. A female who is 5 feet 5 inches (1.65 meters) and 170 pounds (77 kilograms).
b. A male who is 5 feet 7 inches (1.70 meters) and 195 pounds (88 kilograms).
c. A female who is 5 feet 2 inches (1.57 meters) and 150 pounds (68 kilograms).
d. A male who is 6 feet 2 inches (1.88 meters) and 225 pounds (102 kilograms).

2. Obese patients experience how much more in increased prescription costs compared to their non-obese counterparts?
a. 20 percent more
b. 50 percent more
c. 80 percent more
d. 150 percent more

3. A patient asks you how his waist size relates to his health. What is a correct answer?
a. You should be monitoring your BMI and not your waist size because a BMI that indicates obesity is tied with increased risk of death.
b. If you are overweight or obese, as your waist size increases, your risk for heart disease and death increases.
c. Waist size is important and we recommend monitoring it every five years.
d. Waist size is not important to your health.

4. In an adult patient who is 260 pounds (BMI 32 kg/m2), what is the smallest amount of sustained weight loss that can lead to clinically meaningful results?
a. 3-5 pounds
b. 8-13 pounds
c. 13-26 pounds
d. 26-52 pounds

5. Which of the following patients do the AHA/ACC/TOS guidelines recommend as a candidate for bariatric surgery?
a. Any obese patient (BMI ≥ 30 kg/m2)
b. BMI ≥ 25 kg/m2 or ≥ 30 kg/m2 with comorbidities
c. BMI ≥ 30 kg/m2 or ≥ 35 kg/m2 with comorbidities
d. BMI ≥ 40 kg/m2 or ≥ 35 kg/m2 with comorbidities

6. Which medication for diabetes can lead to weight loss?
a. Glipizide
b. Insulin glargine
c. Canagliflozin
d. Pioglitazone

7. Which antidepressant is associated with weight loss?
a. Amitriptyline
b. Bupropion
c. Mirtazapine
d. Paroxetine

8. One of your patients has questions about medications for chronic weight management. He wonders if he is a candidate for a medication. He is 42 years old and tells you he is 6 feet tall and weighs 210 pounds. He tells you he has depression and seasonal allergies. Is this patient a candidate for one of the chronic weight loss medications presented in this article?
a. Yes
b. No, because weight loss pharmacotherapy is contraindicated in patients with depression.
c. No, because the patient does not meet the criteria for initiation of pharmacotherapy.

9. A patient presents for her fourth prescription of lorcaserin; she has filled the medication consistently for three full months. She tells you that she has lost six pounds since she started lorcaserin (at that time she weighed 180 pounds) and is wondering if she should keep taking lorcaserin. What should you tell her?
a. We generally give the medication four full months before we evaluate its effect.
b. You have lost over 3 percent of your body weight, which means you should continue the medication.
c. You haven't lost 5 percent of your body weight so at this point, we think the medication likely isn't effective.
d. This is a medication that is used chronically so you shouldn't stop the medication.

10. What advice is NOT recommended per the package labeling for orlistat?
a. Skip the dose if you are eating a meal that doesn't contain fat.
b. If you only eat two meals per day, take orlistat twice – once with each meal.
c. Take half your dose with each snack.
d. Add a multivitamin to your medication regimen if you're on orlistat.

11. Which medication is contraindicated in pregnancy?
a. Lorcaserin
b. Phentermine/Topiramate
c. Naltrexone/Bupropion
d. All of the above

12. A 28-year-old female with a BMI of 32 kg/m2 is interested in starting a medication for obesity. She notes that she has anxiety and insomnia. She has been consistently taking escitalopram 20 mg daily and melatonin 3 mg daily. Which medication would you avoid in this patient due to drug-drug interactions?
a. Orlistat
b. Lorcaserin
c. Phentermine/Topiramate
d. Liraglutide

13. Which medication is contraindicated in someone with seizure disorders?
a. Lorcaserin
b. Phentermine/Topiramate
c. Naltrexone/Bupropion
d. Liraglutide

14. One of the providers you work with wants to start an obesity medication for a patient, but wants the titration schedule to be as simple as possible. If she based the decision solely on a simple titration schedule, which medication should she select?
a. Lorcaserin
b. Phentermine/Topiramate
c. Naltrexone/Bupropion
d. Liraglutide

15. A local prescriber calls you to discuss a patient. The patient is taking liraglutide for weight loss and has just completed week three of the titration schedule (1.8 mg), but believes he has not adapted to the nausea that started at the beginning of week three. The prescriber wonders what should be done to help. What is the best response?
a. The patient can continue for another week taking the week three (1.8 mg daily) dose before titrating up to the week four dose (2.4 mg daily).
b. The patient can start back at the week one (0.6 mg daily) dose and then continue the recommended titration schedule.
c. The patient should be initiated on ondansetron and escalate the dose to the week four dose (2.4 mg daily) today.
d. The patient should discontinue this medication and try another medication for obesity.

16. What is the risk of discontinuing phentermine/ topiramate ER without a taper?
a. Extreme nausea
b. Hypoglycemia
c. Seizure
d. Serotonin syndrome

17. Which of the following is true about the efficacy of the medications for weight loss presented in this article?
a. Data regarding mortality effects as a result of these medications is not available.
b. When phentermine/topiramate ER and lorcaserin are compared head-to-head, more weight loss is achieved with phentermine/topiramate.
c. Because the medications are for long-term use, no efficacy measures can be evaluated until a patient has completed one year of therapy.
d. All of the above

18. Why do the Endocrine Society guidelines recommend use of obesity medications?
a. To decrease mortality and increase adherence to lifestyle changes
b. To decrease mortality and decrease effects from comorbidities
c. To decrease effects from comorbidities and increase adherence to lifestyle changes
d. None of the above

19. You receive a prescription for a 26-year-old female for phentermine/ topiramate ER 11.25 mg/69 mg take one by mouth at night QHS #30; 0 refills. She is taking no other medications. What question(s) may you have for the provider?
a. This dose is only approved to be used as a titration step for two weeks. Do you want to change the days supply to 14?
b. This medication should be taken in the morning. Would you like me to change the directions?
c. What did you and the patient discuss for contraception options?
d. All of the above

20. A patient tells you she started taking orlistat two weeks ago for weight loss. She asks you for more information about flatus and oily spotting since she is experiencing these side effects with orlistat. What can you tell her?
a. Attempt to eat lower fat meals since the side effects from orlistat are more pronounced with high fat meals.
b. Those side effects are known to improve over time.
c. Unfortunately, there are no tricks to decreasing these side effects.
d. A and B

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▶ *Continued from page 16*

from 1.3 percent in 2012. … "I believe that the increase is due almost entirely to fraud," [U.S. Attorney for the Middle District of Florida A. Lee] Bentley said. …. [TRICARE] spending on compounded pain medicines began to skyrocket around 2012 as pharmacies, often working with independent marketing companies, aggressively marketed the drugs to doctors and patients.

There are several lessons that pharmacies can learn from the *Wall Street Journal* article. Pharmacies cannot pay commissions to 1099 independent contractor marketing reps that generate patients covered by a government health care program. Doing so violates the Medicare anti-kickback statute. On the other hand, the pharmacy can pay commissions to bona fide full-time or part-time W2 employees. Why? Because there is an exception to the anti-kickback statute that says that a pharmacy can do so.

If a pharmacy is billing the heck out of particular code (such as compounded pain cream), then the pharmacy will have a bullseye painted on it. A third party payer or a governmental agency (such as the OIG) will likely look at the pharmacy. And so if the pharmacy is billing the heck out of a code, its operations need to be pristine.

Health care is moving rapidly into telemedicine. This is a good thing. However, the pharmacy needs to be aware of state telemedicine laws. Most state telemedicine laws say that for a proper physician-patient encounter to take place, the physician and patient must have both an audio and a visual encounter. Visual can include Skype and Facetime.

Our law firm has the privilege of representing many pharmacies throughout the country. We saw pharmacies become intoxicated with the easy money resulting from billing for compounded pain creams. It was "funny money." We warned pharmacies about the dangers of what they were doing. But money—particularly easy money—is intoxicating. The lessons discussed in the *Wall Street Journal* article are critical for pharmacies to understand. ■

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The Best Cure for an Ailing Front End Is to Know Its Value

by Gabe Trahan

Sales reports and profit and loss data offer important numbers for any business owner, but numbers can deceive. Data that points a finger at OTC and front-end sales as a perceived value of 5 percent or less of total store sales will cause a few to ponder whether they should give it up or step it up. More extreme: those who do not recognize the value of a front end may say "board it up."

Before you make a decision, let's look at some other numbers: the Centers for Disease Control and Prevention (CDC) reports that 5-20 percent of the U.S. population comes down with the flu. Even more try desperately never to get it. The CDC also tells us adults have an average of 2-3 colds per year and children have even more. The American College of Allergy, Asthma, and Immunology estimates that nasal allergies affect approximately 50 million people in the U.S. The American Academy of Pain Medicine states that every year, millions suffer from acute or chronic pain. A recent Healthline.com report found that in a 12-month period, 60 percent of the adult population will experience some type of gastroesophageal reflux disease, and 20-30 percent will experience weekly symptoms. You get the idea.

All of this data tells us that an undeniable large number of customers suffer from the flu, colds, allergies, stomach ailments, pain, and bumps and bruises. They will turn to their pharmacy and the pharmacy's OTC section for relief. Customers forced to go elsewhere to finish purchasing their needs will go to the competition to do it; there, the competition waits with open arms. A well-managed front end will keep customers out of your competitor's aisles and away from its pharmacy counter. There is some value to that.

A healthy-looking front end will add value to the perceived operation of your pharmacy. A properly stocked (not to be confused with overstocked), well-managed front end will shine a bright and positive light on the pharmacy area. There is some value to that as well.

Step it up! Position the OTC categories neatly into two sections: health-related products and personal care products. Ensure your health care departments are an ample size to meet customers' needs. Going too small will disappoint customers; going too large will discourage revenue. Identify and stock no fewer than four each of the 10-15 best-sellers in each category, with no fewer than two each of the remaining inventory. Have a balanced offering of brand name and private label products.

If your front end accounts for less than 5 percent of gross sales, it's time to reassess your method of inventory control and your pricing strategy. Review your retail zone pricing and ensure you are competitive. When pricing product, either go stickerless or place the price tag on the back or bottom of the package. Place an OTC order every day.

Giving up means boarding up. Stepping up means staying alive. I hope you choose the latter. ■

Gabe Trahan is NCPA's senior director of store operations and marketing. Gabe uses 30+ 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 tips, and view galleries of photo examples by Gabe. Follow him on Twitter @NCPAGabe for additional tips.

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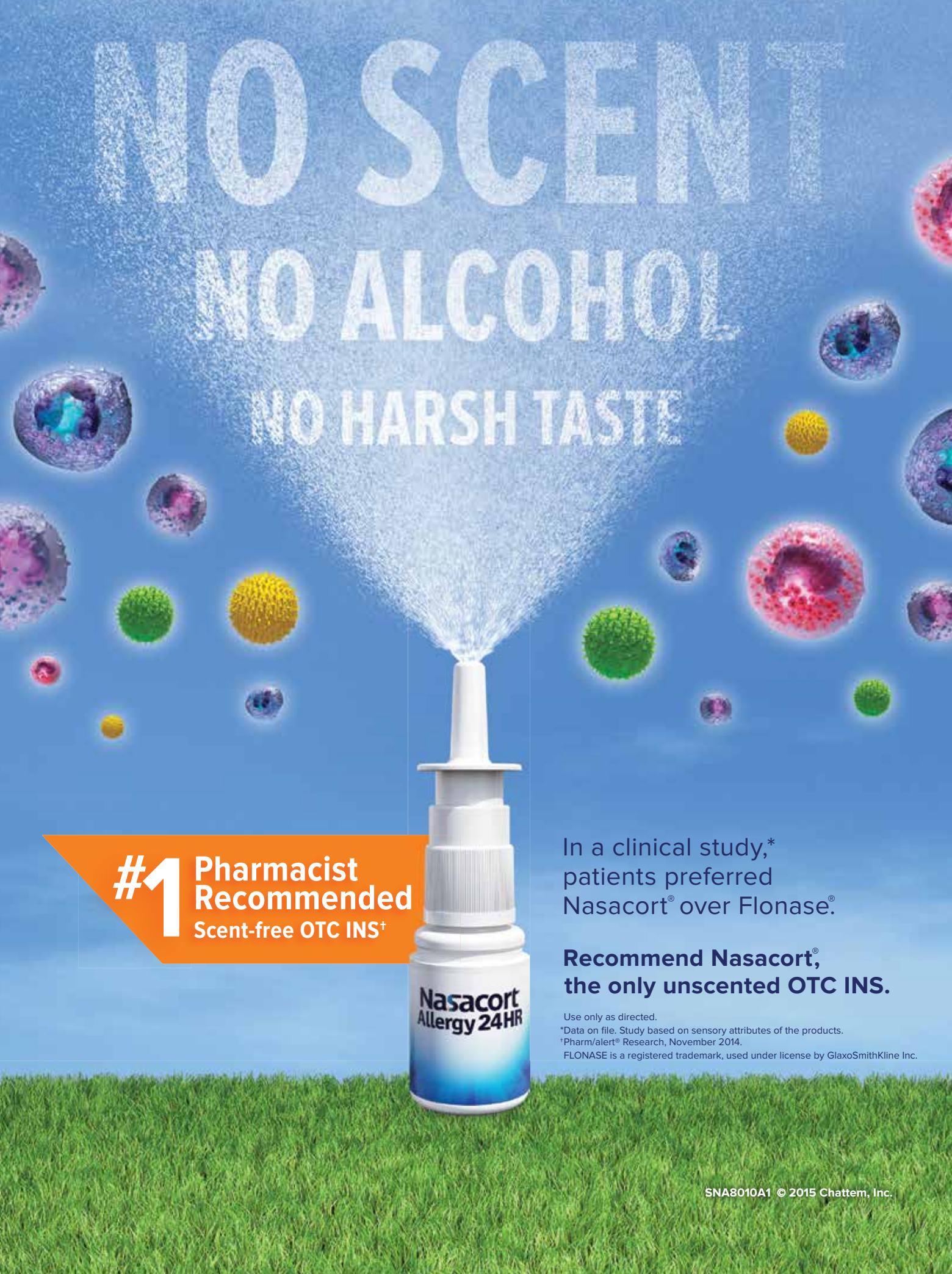
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