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america's PHARMACIST

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National Community
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THE VOICE OF THE COMMUNITY PHARMACIST

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america's PHARMACIST

Visit NCPA's Web site for the latest industry news, continuing education programs, pharmacy management software, convention information, and more.

Web Site
www.ncpanet.org

NCPA® represents the nation's community pharmacists, including the owners of more than 24,000 pharmacies. The nation's independent pharmacies, independent pharmacy franchises, and independent chains represent a $84 billion marketplace, dispensing nearly half of the nation's retail prescription medicines.

Part D Day

By now most of you should have had your first Medicare Part D patients in your pharmacies. I hope things are going smoothly, but seniors are clearly confused about the program, and glitches are inevitable in a program of this size and complexity.

Although this is not the Medicare drug benefit we would have designed, we are committed to making it work for our senior and disabled patients, and to turning the program into an opportunity for community pharmacy. Medicare beneficiaries are looking to their pharmacist to make sense of this complex new program, and I'm proud that NCPA members across the nation have answered the call. For more than two years, NCPA and its partners have been preparing for this month.

Along with MemberHealth and Computer Sciences Corp., we established Community Care Rx℠—a viable alternative to the traditional PBM model and part of our vision of pharmacy's future. Playing the hand we were dealt, CCRx offered a Medicare discount card and you racked up an impressive stream of achievements. You enrolled nearly 400,000 beneficiaries and filled almost 9 million prescriptions—and none of them were lost to mail order.

Our ability to build an impressive network and to deliver an effective pharmacy benefit for the card plan was essential to demonstrating that community pharmacy—through CCRx will deliver an equally effective, competitive network for the full Part D program.

Last summer, we undertook one of the most extensive and important outreach efforts in our history, the Medicare Rx Forums. Crisscrossing the country, our dedicated speakers and hard-working staff held 27 town halls sessions to explain the ins-and-outs of Part D to community pharmacists. Initially, we would have been ecstatic to have an average audience of 100. Instead, we averaged better than 250—some 7,000 pharmacists in total attendance. We also created the Web-based NCPA Medicare Resource Center. We could not have done all of this without our sponsors, who are cited on page 16.

Last September, the Centers for Medicare & Medicaid Services approved CCRx as one of just 10 national providers for the actual Medicare Part D benefit. To augment that, we created a new and distinct company to demonstrate through research that a pharmacist-centered approach to medication therapy management services is the way to go. Community MTM (CMTM), we expect, will usher in a new era where clinical and financial services represent the primary value-added service of community pharmacists.

It is critical that we all work to make this a success. CCRx and CMTM are crucial steps in bringing about meaningful change in our industry. I truly believe that CMTM is the future of our industry. Getting pharmacists paid for their non-dispensing services is a battle that has been raging for at least 30 years. Now is the time for all of pharmacy to step up to the plate.

Bruce Roberts, PD
NCPA Vice President & CEO

Pharmacies Required to Register To Dispense Isotretinoin

Pharmacies must be registered to continue dispensing isotretinoin products. The Food and Drug Administration (FDA) has approved iPLEDGE, an enhanced risk management program designed to minimize fetal exposure to isotretinoin. To further the public health goal to eliminate fetal exposure to isotretinoin. iPLEDGE requires mandatory registration of prescribers, patients, wholesalers, and pharmacies.

As of Dec. 30, 2005, unregistered and unactivated pharmacies are not able to legally dispense Accutane (isotretinoin), Amnesteem, Claravis, or Sotret to patients with severe acne without enrolling in the iPLEDGE program through a physician who is enrolled.

Pharmacy owners have two steps in preparing their pharmacies to dispense isotretinon prescriptions under iPledge—"registration" and "activation." After a pharmacy registers for iPledge on www.ipledgeprogram.com or by calling 866-495-0654, the "Responsible Site Pharmacist" is sent a follow-up mailing, which contains instructions on how to activate its pharmacy.

Pharmacies that did not register and activate by Dec. 30 are not eligible to order isotretinoin from wholesalers and must return all unused product to the manufacturer. Wholesalers that did not register by Dec. 30 are not eligible to order isotretinoin from the manufacturers, and must return all unused product to them. Patient registration began Dec. 30. Patients currently being treated with isotretinoin may register in the iPledge program or continue in their current program until Feb. 28, 2006.

Starting on March 1, 2006, all patients taking isotretinoin must be registered in iPledge. Prescribers who have not registered and activated by March 1, 2006 will not be eligible to prescribe isotretinoin for patients. Be sure to let dermatologists in your area know when your pharmacy is authorized to dispense isotretinoin. To register and activate your pharmacy, go to www.ipledgeprogram.com or call 866-495-0654.

DEA Warns Consumers On No Rx Web Sites

The Drug Enforcement Administration (DEA) has issued a new consumer warning against ordering prescription drugs without a doctor's prescription, especially controlled substances, from Internet pharmacies.

The agency estimated there may be almost 5 million Web sites offering drugs to consumers without a prescription. Many of these sites are not pharmacies at all and are not affiliated with doctors. They are a means for drug dealers to illegally sell and distribute controlled substances and other drugs to consumers electronically, DEA said.

"Many of these sites—and the sources of the drugs---are controlled by individuals operating overseas---e-traffickers in white coats, masquerading as doctors and pharmacists," DEA continued. "You have no idea where the drugs you order originate, if they contain safe ingredients, and if they are what you think they are."

Consumers may think they are dealing with a legitimate "doctor" as they order drugs on the Internet. In some cases, consumers are asked to fill out a questionnaire that is approved by a "doctor."

"These forms do not constitute a medical exam, and they do not represent a valid doctor/patient relationship," DEA said. "Any doctor who enables you to buy products online without a valid prescription is breaking the law. He or she can be arrested and lose the ability to practice medicine."

Consumers too are breaking the law by ordering without a valid prescription from a doctor. DEA also noted:

- The site should have a physical address for the pharmacy, in addition to its phone number—if it does not, it's probably suspect.
- Real pharmacies don't send spam to advertise to consumers.
- Suspect sites don't participate in insurance plans and demand that purchases be made by credit card or money orders.
- Illegitimate sites sell only a limited number of drugs.
- If you suspect an illegal online pharmacy, report it on DEA's Web site www.dea.gov or call DEA's toll free number, 877-792-2873.

PSTAC Releases Pharmacy Companion Guide—2nd Edition

The Pharmacist Services Technical Advisory Coalition (PSTAC) has released the second edition of the Health Care Claim: Pharmacy Professional Services Companion Guide

NCPA Exclusive

Discount on Redesign Services

Stay ahead of the competition with the new Pharmacist e-link. Pharmacies often increase their sales by 25 percent or more after a redesign or remodeling. A fresh look not only increases revenues but it can increase patient loyalty and employee morale.

NCPA has contracted with Gladson Design Group to provide NCPA members with professional on-site design services at a reduced price. NCPA members will receive $1,000 off Gladson on-site design services regular price of $3,750.

The $1,000 discount is for NCPA members only. Go to www.ncpanet.org for details.

X12N 837 (Pharmacy Companion Guide). The Pharmacy Companion Guide is based on the "parent" May 2000 X12N 837 Professional Electronic Data Interchange (EDI) Implementation Guide (IG) 4010, and the October 2002 X12N 837 Professional EDI Addenda (4010A1)—the standard for the entire health care industry under the Health Insurance Portability and Accountability Act of 1996 to transact electronic health care claims for professional services.

The Pharmacy Companion Guide may be ordered online from Washington Publishing Company at www.wpc-edi.com for: $225—bound document; $205—portable document (PDF) on CD-ROM; and $190—downloadable PDF.

NCPA Medicare Rx Forum Online

Did you miss attending any of NCPA's Medicare Rx Forums? Want to refresh your memory? NCPA has posted an online version of one of the briefing and town hall discussions on the Medicare Part D prescription drug benefit. The program provides 2 contact hours (0.2 CEUs) of continuing pharmacy education credit. Go to www.ncpanet.org □

Inside Third Party

Eye on PBMs

Every month, *America's Pharmacist* highlights an example of PBM abuse of the nation's independent community pharmacies. These transgressions not only hurt our business and our profession, they negatively affect our patients, their employers, and our local economies. E-mail a recent example of a problem you've had with a PBM to mike.conlan@ncpanet.org, or fax it to (703) 683-3619. We may edit it for length and clarity.

Blues in the Night

"Here I am at 12:32 a.m., still working, in my pharmacy since 9 a.m. I am trying to catch up, which is totally impossible—just gets worse every day …. Why can we not all refuse to 'play' by their rules? Guess I am just sick and tired of the insurance companies (and their partners, drug companies and some politicians) continually insulting our intelligence by offering us insulting reimbursement rates and requiring everything from us except our first-born (which will probably be discussed next year).

"Sorry—just tired of working 18-hour days just to make ends meet and be in the only profession that I can think of that gets walked on by everybody in the system. We do the insurance companies' work for them and have to pay them for it. We are accountants, psychologists, computer/software experts; the one who catches Rx mistakes, and everything else, except the ones getting paid.

"I can't even fill Rxs because of insurance rejects. I had four in a row this morning. I am the only pharmacist in a small family owned and operated pharmacy and I am worried. Not so much for myself (because I can run to Wal-Mart and be a pharmacist behind glass and make twice the money and work half the hours with none of the worries), but more for my customers.

"They rely on me and trust me. They will be lost if they have to go to a pharmacy where they are just a number and the pharmacist does not know or care if their pet just died, or won't look at their baby pictures, or listen to their stories about their grandchildren, or just listen to them about anything-worries, good times, and bad.

"Things just seem really, really, really bad for independent pharmacies now.

"Thanks for your time to listen to my worries."

Big PBMs Try to Tweak NCPA

The Pharmaceutical Care Management Association, the trade group for the "Big 7" PBMs and their mail-order arms, has launched an advertising campaign that includes the statement, "PBM tools are so effective that even the independent pharmacy lobby has hired a pharmacy benefit management organization to help their members better complete in Medicare."

That is a reference to MemberHealth, the Ohio-based PBM that is a partner of NCPA and Computer Sciences Corp. in Community Care Rx℠, one of the 10 national prescription drug plans approved for Medicare Part D.

A couple of points are in order. First of all, PCMA represents only the seven largest PBMs: Caremark, Express Scripts, Medco, Wellpoint, Cigna Pharmacy Management, Prescription Solutions, and MC-21 Corp. MemberHealth is not a member of PCMA. Second, MemberHealth is not lobbying Congress to overturn the current ban against mandatory mail order in Medicare Part D as PCMA is. Third, MemberHealth has not spent millions of dollars in lobbying and legal fees to fight PBM transparency legislation and lawsuits as PCMA has and continues to do. We could go on, but you get the picture.

THE AUDIT ADVISER

Documentation for Oral Rx Orders

***Q:* Are there special precautions to take on oral or telephone prescriptions that are billed to third parties?**

***A:* Taking oral prescription orders can present special audit problems and challenges. All verbal prescription orders must contain at least the minimum information as is legally required on any prescription, including:**

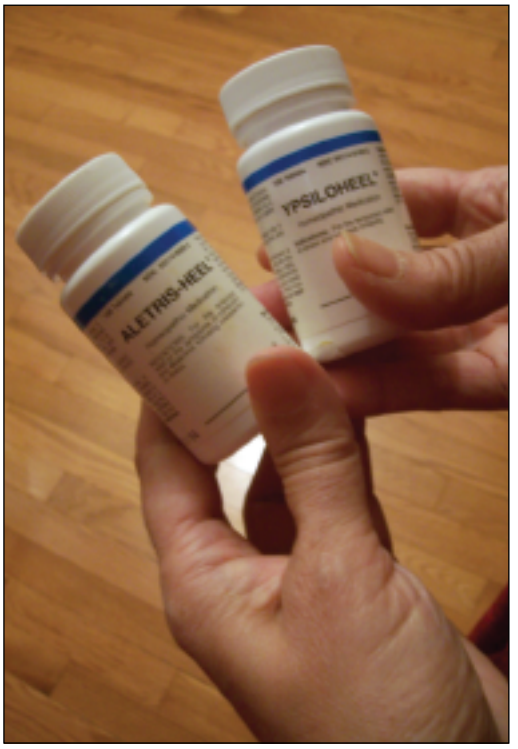
- **Patient's first and last name**
- **Drug name, strength, dosage unit, and quantity**
- **Dosing directions (avoid U.D.) and refill authorizations**
- **Prescriber's name and DEA number (when applicable)**
- **Prescriber's substitution preference (DAW or BMN mandate), if applicable**

If someone other than the doctor phones in the prescription, it is a good idea to note the name and title of the person calling. Third parties, in an audit situation, are penalizing pharmacies for oral prescription orders failing to contain the requisite information. For instance, many pharmacies neglect to properly indicate or check DAW/BMN on verbal prescriptions that physicians specify brand product only. When a telephone prescription does not contain the correct dispense-as-written information, auditors view such prescriptions as eligible for generic substitution. Some auditors are targeting variances in the date written versus the actual date dispensed. Other auditors are challenging the use of computer-generated stickers as documentation of new prescriptions.

Many third parties do not want to allow any subsequent documentation after the fact to reverse their findings. Avoid problems by making sure procedures are in place to sufficiently document all required information and actions concerning any verbal prescription orders.

By H. Edward Heckman, RPh, PAAS National, the Pharmacy Audit Assistance Service. For more information call toll free to 888-870-7227.

Look-Alike Packaging Causes Errors, Near Misses



PHOTOGRAPHY: ????????? ????????

The Institute for Safe Medication Practices has received several reports of errors and near misses involving **Norvasc** (amlodipine) 10 mg and **Zyrtec** (cetirizine) 10 mg. According to reporters, the primary reason for these mix-ups has been similar packaging. The 10 mg strength of each product is packaged in similar bottles with nearly identical labeling and use of color. One report described an incident where a patient was to receive 90 tablets of Norvasc 10 mg. Because the product is packaged in a 90-tablet bottle, the pharmacy applied the computer-generated label directly to the manufacturer's bottle. However, the label was incorrectly applied to a Zyrtec 10 mg bottle. Fortunately, the pharmacy label did not cover the manufacturer's label and the pharmacist caught the error during verification.

When the near miss was investigated, an additional Zyrtec 10 mg bottle was found where the Norvasc 10 mg was stored. In this pharmacy, because medications were stored alphabetically by generic name, the medications were in the same vicinity. It was determined that similarities in packaging caused the person who stocked the pharmacy to place the products on the shelves incorrectly.

In another report, a government facility dispensed a 90-day supply of Norvasc 10 mg instead of Zyrtec 10 mg. After taking several doses of the medication, the patient recognized the change in tablet appearance and called to verify that he had received the correct medication. To prevent drug selection errors with these products, consider adding auxiliary labels to drug containers or using some other mechanism to differentiate the two products. Warnings on pharmacy shelves could also help.

Although it would seem that these products should already be adequately separated, keep in mind that if medications are stored by generic name or in "fast-mover" sections, they could be in close proximity to one another.

Although it would seem that these products should already be adequately separated, keep in mind that if medications are stored by generic name or in "fast mover" sections, they could be in close proximity to one another.

Pharmacies that use bar coding or match the NDC number that appears on the manufacturer's product to the one that appears in the computer database (and subsequently printed along with the pharmacy label) are less likely to select the wrong product. During the verification process, pharmacists should open prescription bottles to confirm the appearance of the medication. Also, when a medication is dispensed in a manufacturer's bottle, the pharmacy label should never completely cover the manufacturer's label.

Inventing Drug Suffixes Adds to Confusion

Drug name suffixes are confusing enough without coining our own. A physician assistant recently wrote a prescription for a patient that was misread by a pharmacy technician as **Vicodin ES** (hydrocodone 7.5 mg, acetaminophen 750 mg). Upon closer examination, the pharmacist thought that the suffix looked more like RS. The pharmacist called the prescriber's office and learned that the physician assistant had used "RS" to indicate "regular strength." Vicodin (hydrocodone 5 mg, acetaminophen 500 mg) was subsequently dispensed.

Because numerous brand and generic combinations of hydrocodone and acetaminophen products are available, there is a large potential for confusion. To minimize confusion, prescribers could include the strength of each ingredient on prescriptions for brand name products, as is done for prescriptions written using the generic drug names. □

This article has been provided by the Institute for Safe Medication Practices (ISMP) and has previously appeared in the ISMP Medication Safety Alert! *Community/ambulatory Care Edition. This e-newsletter is a monthly compilation of medication-related incidents and error-prevention recommendations designed to inform and alert community pharmacy practitioners to potentially hazardous situations that may affect patient safety. Individual subscription prices are $45 per year for 12 monthly issues. Discounts are available for organizations with multiple pharmacy sites. For more information contact ISMP at 215-947-7797 or e-mail to community@ismp.org.*

Four E-Prescribing Benefits Worth Sharing

By Ken Whittemore, RPh

Pharmacists who participate in electronic prescribing with software that is connected to the SureScripts Electronic Prescribing Network are finding there are many advantages for them in the areas of efficiency and accuracy. However, what about the effect of electronic prescribing on the pharmacist's patients? What advantages do patients experience because their pharmacist's computer can receive new prescriptions and refill authorizations from, and can send refill requests directly to the physician's computer? In fact, many of the advantages that affect pharmacists also improve the patient's experiences, as well.

Patient Safety

Patient safety, with all its ramifications, is one of the leading advantages of electronic prescribing for pharmacy patients. Electronic prescriptions offer more security and a greater opportunity for authentication than traditional paper prescriptions. The information passes directly from the physician's computer to the pharmacist's computer, ensuring more protection against prying eyes or fraud. Furthermore, electronic prescribing data is often more accurate and is certainly legible. The pharmacist doesn't have to struggle with the physician's handwriting on either a paper prescription or a fax, where the physician's already difficult to read handwritten prescription can be made more difficult to interpret by faulty transmissions or inadequate toner supply.

Also, many medications have names that look or sound similar, which contributes to confusion and errors, whether the pharmacist receives information by hand, fax, or voice mail. Finally, the pharmacist doesn't have to play telephone or fax tag with the physician's office to find out what the physician actually wrote or said, which increases clarity and saves time (which leads us to the next advantage).

Time Savings

What's efficient for the pharmacist is also efficient for the patient. Because a new prescription transmits directly from the physician's computer to the pharmacist's, often before the patient has even left the examining room, there's a strong chance that the filled prescription may be ready sooner. Certainly, there's less chance for the prescription to be misplaced or lost during transmission because the fax paper tray is empty or the fax is jammed.

When a patient calls a pharmacist to refill a medication that has no refills remaining on it, the pharmacist can transmit a request for refill authorization directly to the physician's computer. All indications are that physician offices respond more quickly to these requests, even during the evening or a weekend, because physicians tell us they often check their prescription software while they're at home.

Electronic prescribing can even save time for patients (and pharmacists) when a physician prescribes a medication that requires a prior approval from the insurance carrier. The physician can seek prior approval from the patient's health insurer before writing and transmitting the prescription, so the pharmacist will not attempt to fill it and the patient won't be waiting for it, only to find that a prior approval is required. Consequently, the patient won't be confronted with a filled prescription that might cost hundreds of dollars as originally prescribed.

Cost Savings

Electronic prescribing can save patients dollars as well as time. That's because physician e-prescribing software usually provides access to a patient's formulary information. The physician can see right on the screen if the patient's health insurance will cover the particular medication the physician is prescribing, or if there is a generic or alternative that will work just as well. This is a real time-saver for the pharmacist and the patient, for every pharmacist has seen that shocked look on a patient's face when, instead of the expected $10 or $20 co-pay, they're charged $100 or $200 or more. Then, either they leave without buying the medication, which is dangerous as well as a waste of time for everyone involved, or the pharmacist and patient spend time contacting the physician's office to attempt to identify an alternative that meets the patient's insurance requirements.

More Pharmacist Attention

The same efficiencies that create patient safety, time savings, and cost savings from electronic prescribing allow the pharmacist to spend more time on patient care, instead of administrative tasks. Pharmacists will have more opportunity to review a patient's overall medication regimen to better identify the potential for duplication or adverse drug interactions. Pharmacists will have more time to offer medication therapy management (MTM) services to patients, providing patients, especially those with chronic conditions, with better and more attentive care. If the patient meets the MTM criteria in the Medicare Modernization Act, then pharmacists will have more time to perform not only as the true professionals they are, but also find a new source of income from Medicare at the same time. Finally, and perhaps most important, the extra time that pharmacists will have to spend on their professional activities will enrich their patients' experience. □

Ken Whittemore, RPh, MBA, is vice president of Professional and Regulatory Affairs for SureScripts For questions about electronic prescribing and how you can ensure that your pharmacy is taking advantage of this technology, please contact the SureScripts Electronic Prescribing Resource Center at 1-866-RxReady. More information about SureScripts is available by e-mail at info@surescripts.com, or at its Web site (www.surescripts.com).

OUTREACH CAMPAIGN PRECEDED MEDICARE PART D DEBUT

To help prepare community pharmacists for this month's launch of the Medicare drug benefit, NCPA last year undertook one of the most intensive and successful outreach campaigns in its history.

With support from AmerisourceBergen, Cardinal Health, McKesson, and Community Care Rx, along with regional wholesalers in select cities, NCPA hit the road with 24 Medicare Rx Forums on the Part D benefit. From July through September, the live town hall sessions with their free CE ranged from Anaheim to New York and Seattle to Miami, with plenty of stops in between. Due to popular demand, three more sessions were added in November. Two of them were sponsored by H.D. Smith and one by Pfizer.

All told, some 7,000 community pharmacists attended the 27 forums. "When we started planning this last spring, we hoped to attract 2,000 pharmacists, and we weren't sure we could even do that," recalled Bruce Roberts, RPh, NCPA executive vice president and CEO. "That well more than three times as many pharmacists as expected attended is a

PHOTOGRAPHY: SARAH S. DIAB

Medicare Rx Benefit Timeline

Jan. 1, 2006	• Part D coverage begins for all beneficiaries enrolled in a plan • Dual eligibles' auto-enrollment takes effect • Low-income subsidies for Part D coverage begin • Medigap insurers prohibited from selling new policies with drug coverage
Jan. 1, 2006–December 2007	Moratorium on formation of new local Medicare PPOs
Jan. 1 – June 30, 2006	• Open enrollment period for MA-eligible individuals (during which they can change plans once) • CMS launches "urgency" phase of message campaign
Feb. 25, 2005	States begin making monthly "clawback" payments to federal government for dual eligibles
Feb. 28, 2006	Retiree drug subsidy payments begin
March 2006	CMS identifies all beneficiaries not enrolled in a Medicare prescription drug plan
April 2006	CMS mails spring enrollment reminder to beneficiaries
April – May 2006	CMS facilitates enrollment in a prescription drug plan for those determined to be eligible for low-income subsidies but have not yet enrolled in a plan
May 15, 2006	Open enrollment period for 2006 Part D enrollment beneficiaries ends
June 1, 2006	Coverage begins for low-income subsidy eligible beneficiaries who were assigned to a prescription drug plan by CMS
Oct. 15, 2006	Deadline for Secretary to notify states of their annual per capita drug payment amounts ("clawback") for 2007
Nov. 15, 2006	States and entities offering drug coverage provide written disclosures to Part D eligible individuals regarding actuarial equivalence
Nov. 15 –Dec. 31, 2006	Annual coordinated election period for 2007 Part D enrollment for all beneficiaries

tribute to our generous sponsors, our dedicated speakers, and our hard working staff. It also showed the hunger for knowledge and the commitment of community pharmacists to making the Medicare drug benefit work."

Speakers, who took time from their busy schedules and who accepted no compensation for their assignments, are listed in the box on page 32.

NCPA has posted an online version of one of the briefing and town hall discussions on the Medicare Part D prescription drug benefit. The program provides two contact hours (0.2 CEUs) of continuing pharmacy education credit. Go to the NCPA Web site: www.ncpanet.org.

The town hall meetings may not have answered all of the complex questions surrounding Part D, but several attendees expressed gratitude for NCPA's efforts.

"I accomplished my goals that I had before I came," said Mimi Hill Shanahan, RPh, owner of Hill's Drug Store in Easton, Maryland, who attended the Baltimore area town hall. "It was an excellent meeting. The question and answer session was helpful, and the handout content was good. I had a two-hour drive to get here and it was worth it."

Gail Rosenberg, RPh, of Leisure World Pharmacy in Silver Spring, Maryland, said, "My expectations were not high coming in, but I was very impressed. It gave me a better insight. They didn't hide behind 'I don't know' when we asked questions. It was very up to date."

Tom Bolton, RPh, owner of Taneytown Pharmacy in Taneytown, Maryland, said the meeting "enlightened me to help ask more productive questions," adding half-jokingly, "At least now I know what I don't know."

Along with the forums, NCPA established the Medicare Resource Center. This online tool posted the latest information on the Medicare Part D prescription drug benefit for both pharmacists and beneficiaries; continuing education; forum registration forms; contract information; marketing material; and links to other Web sites, including that of Community Care Rx, NCPA's wholly owned subsidiary. The center is sponsored by AstraZeneca, Boehringer Ingelheim, and CCRx.

Another project designed to help community pharma-

cists was *Medicare 2006: A Pharmacist's Reference Guide*. Even after the launch of Part D, the guide is essential for community pharmacies. It includes an extensive review of Medicare Part D and its implications for pharmacy practice. It also highlights areas of professional and business opportunities to make the best of the new Medicare benefit throughout 2006 and beyond. It is available through the NCPA bookstore at www.ncpanet.org. The price is $149 for NCPA members and $449 for non-members.

Last month NCPA mailed all independents two copies of *The 1-Minute Medicare Consult Guide*, handy, quick reference booklets for pharmacists and their staff that provide information to answer some of the most common beneficiary questions. The booklets are pocket-sized and can be kept at the counter so they are readily available when patients have questions about Medicare Part D. This Medicare educational tool is supported by AstraZeneca.

"The Medicare drug benefit brings many challenges and opportunities for community pharmacists," said Roberts. "We are going to build on what we accomplished last year and to continue to provide them with the resources they need in 2006 and beyond."

Medicare Rx Bytes: Late Enrollment Penalty

The new Medicare Part D prescription drug benefit is optional, but there are strong incentives for Medicare patients to enroll in this program. Some people with Medicare may be subjected to a late enrollment penalty if they do not sign up for Part D when first eligible. Here's when your Medicare patients will be subjected to this penalty in 2006:

For patients who were eligible for Medicare before January 2006—if they do not sign up for Part D by May 15, 2006, they will have to pay a higher monthly premium. (Some members of Congress want the May 15 deadline extended, but the Bush administration is opposed.)

Or, for patients who are eligible for Medicare after January 2006—if they do not sign up for Part D for 63 days or longer after the end of their initial enrollment period, they will have to pay a higher premium. If your patients do not sign up for Medicare Part D, the premium will increase at least 1 percent of the base premium of $32.20 per month for every month that they waited to enroll. In 2006, this rate will be 32 cents per month. So, if your patient delays enrolling for seven months, then the increase in premium is seven times 32 cents, or $2.24 per month on top of their base premium. The individual will have to pay this higher premium for their entire lifetime. This percentage may increase each year.

It is important that your Medicare patients know that they do not have to pay this late enrollment penalty if they are currently receiving retiree coverage at least as good as Medicare Part D (also known as creditable coverage). Your patients should have received notification from their retiree benefits coordinator last fall to indicate whether their current coverage is creditable. If they did not receive or cannot find this notice, Medicare patients should call their retiree benefits coordinator to make this determination.

Compounded Drugs Covered

Compounded medications are covered under Medicare Part D. However, there are some restrictions that pharmacists need to be familiar with when billing a Part D plan for a compounded prescription drug.

The Centers for Medicare & Medicaid Services (CMS), the agency that runs Medicare, prohibits a pharmacist for billing a compounded product using a catch-all NDC code such as 99999999999 or 99999999992. So, in 2006, a pharmacist will typically need to bill the Part D plan for the most expensive component mixed in the compound, provided that medication is covered on the plan's formulary. Labor costs associated with mixing a compound are included in dispensing fees.

It is important to note that a pharmacist cannot bill a prescription drug plan (PDP) for an OTC ingredient or a non-covered prescription drug product. However, the costs of those compounded products can be charged to the Medicare patient. ■

The above Medicare Rx Bytes were excerpted from Medicare 2006: A Pharmacist's Reference Guide. *Check www.ncpanet.org for more information.*

Town Hall Speakers

Bruce Semingson—United Drugs
Lonny Wilson—Pharmacy Providers of Oklahoma
Ed Heckman—PAAS National
Pam Bufe—Cardinal Health
Cheryl Hoffer—Medicine Shoppe International
Brandi Booze—McKesson/Access Health
Maggie Essman—McKesson
Stefan Linn—McKesson
Aileen Gould—AmeriSource Bergen Corp.

Special thanks to the Centers for Medicare & Medicaid Services and the Social Security Administration for supplying speakers for all the sessions.

MIKE DEFILLIPO

Meet NCPA's 108th President:

JIM RANKIN

Elvis Presley and Jim Rankin never crossed paths in Tupelo, Mississippi, where both were born and raised. They probably would have met in high school, but by the time Rankin started Presley and his parents had left for Memphis and his date with destiny. If young Elvis and Jim had met, who knows what the affect on music—and pharmacy—might have been.

Serendipity also played a role in Rankin's purchase of his first pharmacy. After graduating from the University of Arkansas pharmacy school in 1962 and working in Little Rock for several years, Rankin was ready to head out on his own. While at a conference in New Orleans, he met a pharmacist from Illinois who was ready to sell his pharmacy.

"It was a freakish thing," Rankin remembers. "I was looking for a pharmacy to buy. If I hadn't attended the conference, we would have never met."

Rankin now is the president and principal owner of Family Care Pharmacy, Family Care Properties, and Rankin Cards and Gifts in Highland, a town of about 9,000 some 30 miles east of St. Louis, as well as Family Care Pharmacy locations in nearby Breese and Trenton. He and his brother Tom, also a pharmacist, were partners in the Trenton pharmacy for more than 30 years until illness forced his retirement. Tom's wife Brenda still manages the pharmacy. Jim also is co-owner of Family Care Medical Equipment.

A 40-year-veteran of NCPA, Rankin has climbed the officer and executive committee ladder and is ready to lead the association into the uncertainties of the Medicare Part D drug benefit. "It's going to end up being a boon for pharmacies because of prescription volume," he said in an interview. "It could double within five years."

"There will be problems at first," he continued. "But it will be a success and we will be successful with it. The value of the pharmacist is going to be even more identified, especially with medication therapy management services and the emphasis on people going to their pharmacist for information." He plans an aggressive campaign to support both Community Care Rx℠ and Community MTM Services.

Pharmacist information also is a the key to a major initiative Rankin announced in his acceptance speech to the House of Delegates after the 107th Annual NCPA Convention and Trade Exposition. At the convention, keynote speaker Newt Gingrich, the former speaker of the House of Representatives, suggested that the federal government should take advantage of the 55,000 U.S. pharmacies and their trained health care professionals in times of local or national emergencies. Rankin said he would establish an NCPA task force to explore "the role this nation's community pharmacists should play as the front line of defense in times of natural disasters, terrorist attacks, or pandemics." He plans to select six to eight NCPA members, perhaps including a past president or two, for the task force.

Also high on his agenda is building on the momentum and success NCPA has had recently with getting pharmacy students interested in independent community pharmacy again through its student chapters at 67 universities. He would like his colleagues to take the time and share the message of independent community pharmacy with the students, who represent the future of the profession.

Rankin is on the advisory board for the new pharmacy school at Southern Illinois University Edwardsville, which opened last August, as well as on the board of the university's foundation. As a brand new pharmacy school, Southern Illinois it has no pharmacist alumni base to support it, of course, so Rankin wants nearby pharmacists to "adopt" the school—a model that should be followed for well-established schools, too. "We should continue to support our school of graduation," he said, "but we should 'adopt' another school closer to where we practice."

This year Rankin also will be urging his colleagues to take every possible opportunity to build on their relationship with prescribers, and discourage efforts by PBMs to insert themselves inappropriately into the physician, patient, pharmacist relationship. One way NCPA already has protected that relationship was the establishment of the SureScripts e-prescribing network. Unfortunately, relatively few independents are taking advantage of SureScripts, and Rankin and NCPA will be working toward gaining 100 percent participation.

Another agenda item is continued expansion of NCPA's government affairs activities in Congress, the states, the courts, and government agencies. "We all budget two or three percent for advertising," he said in his remarks to the House of Delegates. "A better investment? Budget just one percent every year to political action—whether it's a corporate contribution to the Legislative Defense Fund, or our personal contribution to our PAC."

In 2003, Rankin was named Highland Business Person of the Year and is a past chairman of the Highland Economic Development Commission. In 2005 he was honored with the Bowl of Hygeia. He is a member of the Illinois Pharmacists Association, the National Home Infusion Association (a past board member), the Metro East Pharmacists Association, and the Gateway East Pharmacists Association (a past president), as well as the Illinois Association of Medical Equipment Suppliers. He is a fellow of the American College of Apothecaries and the American Society of Consultant Pharmacists.

In addition, he is a member of the advisory board to Pharmacists Mutual Insurance Company and has served on the board of several civic associations in the Highland area.

Jim and his wife Darrell have two children, five grandchildren, and two great grandchildren.

NCPA's New Leadership Team:

MEET THE OFFICERS AND EXECUTIVE COMMITTEE

NCPA's leaders are dedicated to the 108-year-old association's enduring mission: continuing the growth and prosperity of independent community pharmacy by representing its professional and proprietary interests. Foremost this year is making sure that independent pharmacists and their senior citizen and disabled patients survive this month's start up of the Medicare Part D prescription drug benefit and thrive in the days ahead.

Once again, the officers and executive committee members are marked by multistore owners with a strong sense of civic involvement. The NCPA leaders whose pictures appear above exemplify the spirit and determination of independent community pharmacy today. (See NCPA President Jim Rankin's profile on preceding page.)

NCPA OFFICERS

John E. Tilley, PD :: Downey, California

President-Elect

After graduating from the Idaho State College of Pharmacy in 1977, John Tilley went to work for Zweber Apothecary in Downey, California. Seven years later, he bought all three Zweber pharmacies.

From 1990 to 1997, Tilley was a member of the California Pharmacists Association (CPhA) Board of Trustees, serving as its president in 1997. During that time, he chaired numerous committees, including the Academy of Pharmacy Owners and the political action committee. In 1994, Tilley was honored by CPhA with the Bowl of Hygeia Award and again in 2001 when CPhA selected him as Pharmacist of the Year.

The Idaho State College of Pharmacy named Tilley as its alumnus of the year in 1997, and he was appointed to the dean's advisory board, on which he still serves. From 1992 to 2005, Tilley served as a regional director for the American College of Apothecaries.

In January, 2001, Tilley opened his first Super Rx pharmacy inside a Stater Bros. food market. He was appointed to the California State Board of Pharmacy that same year.

In 2002, Tilley was honored with the Small Business Award

for California. He also served that year as president of the Downey Chamber of Commerce and was inducted into the Downey High School Hall of Fame in 2004.

By the time Tilley sold the Super Rx pharmacies to Stater Bros. in August, 2005, he owned 16 pharmacies inside the markets, for a total of 20. Tilley currently owns four pharmacies, and plans on further expansion.

Donnie Calhoun, PD :: Anniston, Alabama

Secretary-Treasurer

Donnie Calhoun, a 1987 graduate of Samford University's McWhorter School of Pharmacy, owns two Alabama pharmacies—Golden Springs Pharmacy and Quick Meds Express Pharmacy. He was a founder of the Alabama Independent Drugstore Association in 1994 and served as the group's president through 1996. He is a member of the adjunct faculty of Auburn and Samford universities.

Calhoun served as vice speaker and speaker for the House of Delegates of the Alabama Pharmacy Association from 1989 to 1991, and in 2005 the association honored him as Pharmacist of the Year. He is active in his community, serving as a deputy sheriff and member of the Calhoun County Drug Task Force and as president of the Northeast Alabama Tennis Association.

He is the recipient of the Pfizer Community Pharmacy Internship Award and the 1991 Distinguished Young Pharmacist Award presented by Marion Merrell Dow and the Alabama Pharmacy Association.

In 2005, Calhoun was named a member of the Pharmacists Mutual Insurance Co. National Board of Directors. He currently is a member of the pharmacy and therapeutics committee for MemberHealth, Inc.

Gerard A. Herpel, PD :: Accident, Maryland

First Vice President

Jerry Herpel is a 1982 graduate of the University of Maryland School of Pharmacy and owns two pharmacies in Maryland's Garrett County—Deep Creek Pharmacy in McHenry and Tri-Towns Pharmacy in Westernport. He has served as a member of the board of directors for EPIC Pharmacies since 1999 and is currently secretary of the board; is a past president of the Maryland Pharmacists Association (MPhA); and served on the association's board of trustees from 1991 to 1999. In addition, he serves as chairman of both the Maryland EPIC PharmPAC and EPIC's Maryland Legislative Committee; is past chair of MPhA's legislative committee; and past president of the Garrett County Pharmacists Association.

Herpel is active in his community, serving as a member of the Garrett County Health Advisory Committee since 1996 and as a member of the board of directors for Big Brothers/Big Sisters from 1998 to 2004. He previously served as a member of the board of directors for the Garrett County Chapter of Day of Hope for Prostate Cancer Research. He coaches youth league soccer, basketball, and baseball in his community. Herpel is also an official observer for the Mid-Atlantic Collegiate Basketball Officials Associations, where he observes and evaluates Division II and junior college officials.

Bradley Arthur, PD :: Buffalo, New York

Second Vice President

A 1987 graduate of the University of Florida College of Pharmacy, Brad Arthur is co-owner of two full line independent pharmacies in the Buffalo, New York area that were started by his father (NARD Past President Donald Arthur) some 40 years ago.

Arthur is active in his community with the local businessmen's association, one of the oldest in the country, and has served both as president and chairman of the board of the Pharmacists Society of the State of New York. He has received the Bristol-Myers Squibb Pharmacy Leadership Award as well as the McKesson Outstanding Achievement in Pharmacy Award. In 2001, he was the Pharmacists Association of Western New York Pharmacist of the Year.

John T. Sherrer, PD :: Marietta, Georgia

Third Vice President

John Sherrer, a 1977 graduate of Mercer University, Southern School of Pharmacy, is co-owner of Kenmar Pharmacy in Marietta and is a partner in nine other pharmacies in Georgia. Sherrer also owns and operates First Aid of America, an industrial first aid and safety supply company.

Sherrer is past president of the Georgia Pharmacy Association and currently serves as a member of the board of directors. He is vice chairman of the GPhA Insurance Trust and also serves on the Georgia Pharmacy Foundation board of directors.

He served on the Georgia State Board of Pharmacy for 10 years, including two terms as president. He is founder and past president of the Cobb County Pharmaceutical Association, where he was named Pharmacist of the Year, and has served as treasurer of the Metro Marietta Kiwanis Club for some 25 years.

Sherrer is past president of the Mercer University, Southern School of Pharmacy, Alumni Association, is an adjunct assistant professor, and currently serves on the dean's advisory board. He is a recipient of the University of Georgia Alumni Association Service Award, the Mercer University Meritorious Alumni Award, and the Southern School of Pharmacy Dean's Award. He received the Bowl of Hygeia in 1998 and NCPA's Drug Abuse Education Award in 1997.

Mark Riley, PD :: Little Rock, Arkansas

Fourth Vice President

Mark Riley became executive vice-president of the Arkansas Pharmacists Association (APA) in July 2003. Prior to taking this position, he was pharmacist-in-charge at East End Pharmacy near Little Rock for 20 years, which he and his wife, Brenda, still own.

Riley, who completed his pre-pharmacy requirements at the University of Arkansas at Little Rock, earned his bachelor of science in pharmacy from the University of Arkansas for Medical Sciences (UAMS) College of Pharmacy in 1977. Twenty years later he received his doctor of pharmacy degree from UAMS.

Riley has been an active participant in APA since joining in 1976. He served as president of the association from 1984-1985, the youngest president in the organization's history. In 1999 he was elected to the Arkansas State Board of Pharmacy. He has been an active member of NCPA since 1979, and in 2004 he received the Charles M. West Distinguished American Award

Keith Hodges, PD :: Urbanna, Virginia

Fifth Vice President

A 1989 graduate of the Medical College of Virginia School of Pharmacy, Keith Hodges is the owner of Gloucester Pharmacy in Virginia's historic Tidewater region. He also is vice president of Poquoson Pharmacy.

Hodges is an assistant clinical professor in the department of pharmacy at Virginia Commonwealth University and also teaches a pharmacy design, layout, and merchandising course there. He has served as an officer in a number of associations, including terms as president of the Virginia Pharmacists Association (VPA), the Chesapeake Pharmaceutical Association, the West Point Area Chamber of Commerce, and also is on the board of directors of EPIC Pharmacies. In 2002 he was honored with the NCPA Leadership Award, the VPA President's Award, and the Merck Pharmacists Achievement Award.

EXECUTIVE COMMITTEE

Stephen L. Giroux, PD :: Middleport, New York

Chairman

Steve Giroux, a 1981 graduate of the State University of New York (SUNY) at Buffalo School of Pharmacy, owns the Middleport Family Health Center, Transit Hill Pharmacy, Thee Barker Store, and Lockport Home Medical, and is co-owner of Rosenkrans Pharmacy, Oakfield Family Pharmacy, and Summit Park Pharmacy, all in western New York.

Giroux has held a number of positions for the Pharmacists Society of the State of New York, including president and chairman of the board. He is a past president of the Pharmacists Association of Western New York, past president and member of the Middleport Rotary Club, and a member of Kappa Psi.

He also is past president of the Medina Memorial Hospital Board and a board member, as well as past president and member of the board of the Rochester Drug Co-Op, a wholesaler owned solely by pharmacists. Giroux is past president and current member of the Rotary Club of Middleport. In addition, he serves on an advisory committee for the New York Department of Social Services.

Giroux's awards include the Gregory Award from SUNY at Buffalo School of Pharmacy Alumni, the McKesson Leadership Award in 1993, the NCPA Leadership Award in 1992, the 1988 Marion Outstanding Young Pharmacist Award, and the A.B. Lemmon Award from SUNY at Buffalo in 1981.

Holly Whitcomb Henry, PD :: Seattle

Holly Henry is co-owner of Rxtra Care, Inc., which operates four pharmacies in the Seattle area. She sold her interests in Medicine Ladies, which operated four pharmacies, in October 2003, retaining only one traditional neighborhood pharmacy in Rxtra Care. Since then, she has opened a start-up neighborhood location emphasizing compounding and services to adult family homes and a long-term care pharmacy located within a skilled nursing facility. In April 2004, she acquired another community pharmacy with a strong home medical department.

A board certified pharmacotherapy specialist, Henry also holds a specialty certificate in geriatric pharmacy practice from the University of Washington (UW) School of Pharmacy. She earned her degree in pharmacy from Washington State University (WSU), and holds clinical affiliate faculty appointments at both the UW and WSU schools of pharmacy. In addition, she is a member of the board of trustees for the WSU Foundation.

Henry is a past president of the Washington State Pharmacists Association and of United Drugs, a cooperative of independent pharmacies. She is an active member of University Sunrise Rotary Club, where she serves on the board of directors. She and her former business partner received the Innovative Practice Award in 1995 and Henry was chosen one of the "Top Fifty Most Influential Pharmacists" in 1999 by *American Druggist* magazine. She received the WSU Preceptor of the Year Award and was named its Outstanding Pharmacy Alumnus in 1999.

Henry represents NCPA on the steering committee of the Pharmacists Professional Services Coalition (formerly the X-12 Advisory Panel), serving as its chair.

Joseph H. Harmison, PD :: Arlington, Texas

Joe Harmison, a 1970 graduate of the University of Oklahoma College of Pharmacy, is owner of Harmison Pharmacies and The Dispensory Corp., both surgical center pharmacies, and DFW Prescriptions, an apothecary pharmacy.

Harmison is a past president of the Texas Pharmacy Association (TPA), past chair of its political action committee, and a past member of the Texas Pharmacy Practice Coalition.

He has served on a number of NCPA committees, including stints as vice chair of the national legislation and government affairs committee, vice chair of the third-party payment programs committee, and a member of the executive committee of the political action committee.

Harmison has received numerous awards, including the TPA Pharmacist of the Year and Tarrant County Pharmacy Association Pharmacist of the Year, both granted in 1999, and the

Merck Outstanding Achievement in Pharmacy Award. He is also the recipient of the University of Oklahoma Distinguished Alumni Award.

Robert Greenwood, PD :: Waterloo, Iowa

Bob Greenwood, a 1977 graduate of Creighton University School of Pharmacy in Omaha, Nebraska, began his pharmacy career in Waterloo, Iowa, where he purchased Hurdle Drug Company in 1987. He bought a second pharmacy in Denver, Iowa, in 2000, and two years later opened the Professional Compounding Center of Iowa in Waterloo.

He was elected to the Waterloo City Council in 2001 and re-elected to a four-year term last year with 63 percent of the vote. He chairs the Waterloo Housing Authority and the City of Waterloo Finance Committee.

Greenwood has served as a director of Waterloo's chapter of the American Diabetes Association, a past board member of the local Salvation Army Board of Directors, and as past board member and president of the board of governors of Sunnyside Country Club. He also is a member of the Waterloo Chamber of Commerce.

Greenwood is presently serving on the Black Hawk County Visiting Nurses Advisory Board and as a preceptor and adjunct instructor for the University of Iowa College of Pharmacy. He serves on the Black Hawk County Compensation Committee, is a member of the Black Hawk County Pharmacy Association, and the Iowa Pharmacy Association, where he serves on its legislative committee.

Joseph P. Lech, PD :: Tunkhannock, Pennsylvania

A 1981 graduate of the Philadelphia College of Pharmacy and Science, Joe Lech is the owner of five community pharmacies in Northeastern Pennsylvania—Lech's Pharmacy in Laceyville and Nicholson, Dushore Pharmacy in Dushore, and MedFast/Lech's Pharmacy in Tunkhannock, and a closed-door pharmacy in Nicholson.

Lech has held a number of offices in the Pennsylvania Pharmacists Association (PPA), including service as vice-speaker and speaker of its House of Delegates, as well as president of the organization. He currently serves on PPA's third-party and legislative committees.

Lech organized and established the Endless Mountain Pharmacists Association—representing Bradford, Sullivan, and Wyoming counties—as an affiliate of PPA. He currently serves as its president.

He is past president of the Wyoming County Chamber of Commerce and past chair of the Wyoming County Chapter of the American Red Cross. He is a member of the Wyoming County Rural Health Task Force, where he is a member of the steering committee. He also serves on the board for the State Health Insurance Plan. As a Kiwanian, he chairs the pediatric outreach program, which raises funds to support the local hospital's pediatric/obstetric programs. He is a member of the Phi Delta Chi Alumni, Epsilon chapter.

Lonny Wilson, PD :: Oklahoma City, Oklahoma

Lonny Wilson, a graduate of Southwestern Oklahoma State University School of Pharmacy, has 30 years of experience in retail community pharmacy and currently owns and operates two pharmacies in eastern Oklahoma County. One of the original organizers of Pharmacy Providers of Oklahoma (PPOk), Wilson has served as CEO since 1989. He also is president and CEO of RxLinc, a national claims transmission network. Wilson serves as a clinical instructor for the pharmacy schools at Southwestern Oklahoma State University and the University of Oklahoma. He is on the boards of the Independent Pharmacy Marketplace Alliance, the National Independent Pharmacy Network, and the Independent Pharmacy Cooperative. Additionally, he is a member of the board of directors of Federated Pharmacy Network and is a member of the SureScripts Independent Pharmacy Advisory Council.

Wilson is one of the organizers of Community Care Rx, and currently serves on its executive board. He is past president of the Oklahoma Pharmaceutical Association, a past board member of Pharmacy Providers of Oklahoma, and a past member of Glaxo Wellcome's pharmacy director advisory committee.

Bruce Roberts, PD :: Alexandria, Virginia

Executive Vice President

Shortly after graduating from the West Virginia University School of Pharmacy in 1976, Bruce Roberts opened Leesburg Pharmacy in Leesburg, Virginia. The pharmacy has since become a leader in providing innovative services such as compounding, nutritional counseling, health screenings, hospice care, and various disease state management services.

Roberts previously owned two other pharmacies in Loudon County, Virginia, and Espirit Homecare, a provider of home infusion, nursing, physical therapy, occupational therapy, and respiratory care services to both adult and pediatric clients, as well as durable medical sales and rentals.

Roberts was named NCPA executive vice president and CEO in January 2002. He is a member of the board of directors of Community Care Rx, established in 2003 by NCPA to provide a Medicare prescription drug plan. He also is a member of the board of directors of SureScripts, the electronic prescribing platform established by NCPA and the National Association of Chain Drug Stores in 2001.

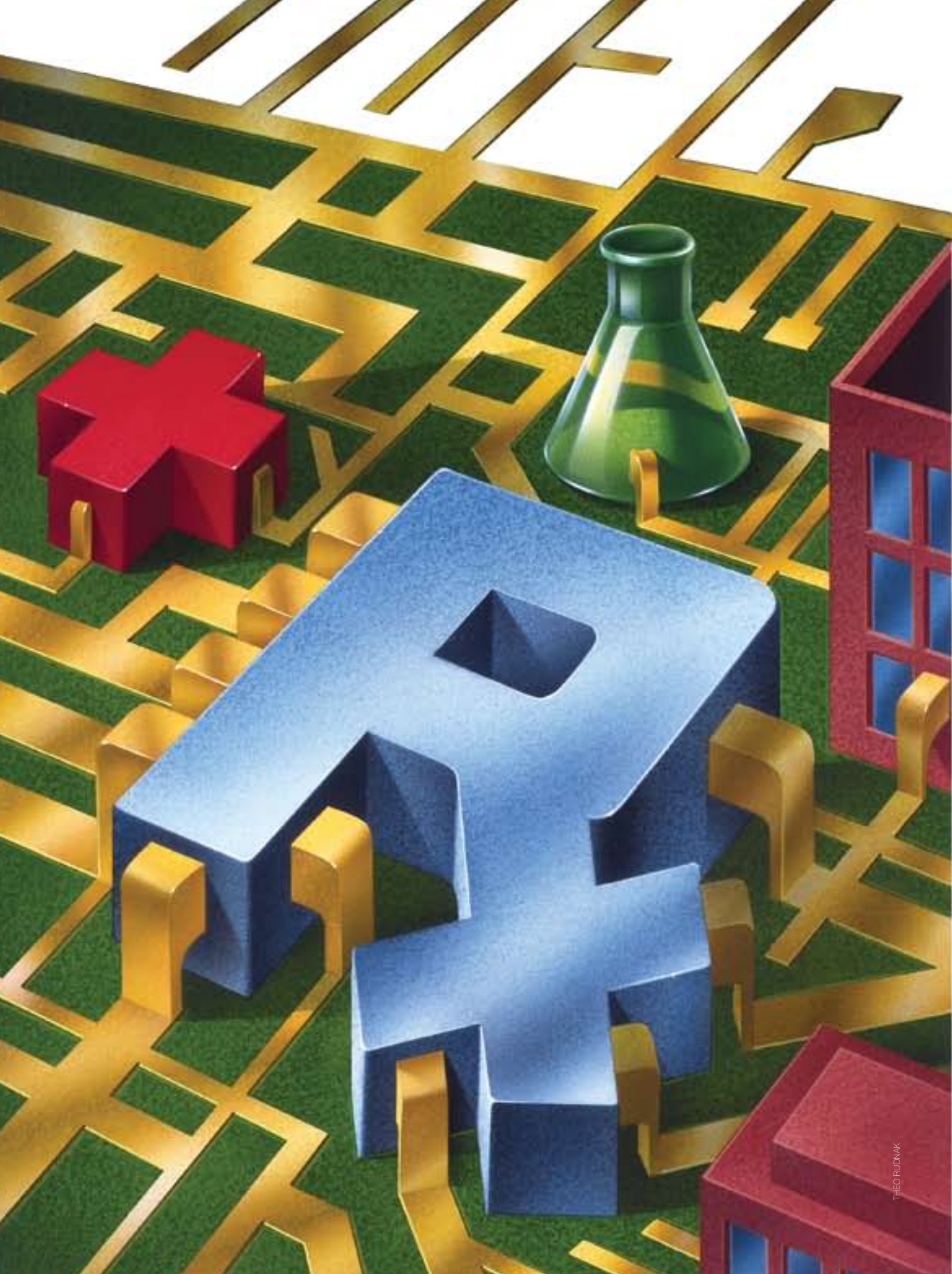
Roberts is a past board member of the International Academy of Compounding Pharmacists and the American Society for Automation in Pharmacy. He also served on the Expert Advisory Panel on Compounding for the United States Pharmacopoeia. He serves on the board trustees for Shenandoah University as well as the university's pharmacy advisory board.

Roberts has been long recognized by his peers both for his innovation and excellence in community pharmacy practice. He is the recipient of the 1998 Innovative Pharmacist of Virginia, NCPA's 1998 Willard B. Simmons Independent Pharmacist of the Year, and the 2000 American Pharmacists Association's Community Practitioner of the Year awards. ■

State Pharmacy Association Meetings

Mark your 2006 calendars and support your state pharmacy association by attending its annual meeting. The information is the best available in early December. Please contact the organizations directly for details.

Name of Pharmacy Association	Date	Location
Alabama Pharmacy Association	June 5–9	Orange Beach, AL
Alaska Pharmacists Association	Feb. 10–12	Anchorage
Arizona Pharmacy Alliance	July 28–30	Tucson, AZ
Arkansas Pharmacists Association	June 14–17	Little Rock, AR
California Pharmacists Association	Feb. 16–19	Palm Springs, CA
Colorado Pharmacists Society—Annual Winter Meeting	Jan. 8–11	Snowmass, CO
Colorado Pharmacists Society—Annual Summer Meeting	June 8–10	Copper Mountain, CO
Connecticut—New England Pharmacists Convention	Sept. 28–29	Ledyard, CT
Delaware Pharmacists Society	May 18–19	Rehoboth Beach, DE
Florida Pharmacy Association	June 14–18	Boca Raton, FL
Georgia Pharmacy Association	June 10–14	Sandestin, FL
Hawaii Pharmacists Association	April 8–9	Honolulu
Idaho State Pharmacy Association—Tri-State Convention	June 8–11	Coeur d'Alene, ID
Illinois Pharmacists Association	Sept 15–17	Moline, IL
Indiana Pharmacists Alliance	Oct. 29–30	French Lick Springs, IN
Iowa Pharmacy Association	June 9–11	Cedar Rapids, IA
Kansas Pharmacists Association	Sept. 28–Oct 1	Topeka, KS
Kentucky Pharmacists Association	June 22–25	Bowling Green, KY
Louisiana Pharmacists Association	July 15–17	Baton Rouge, LA
Maine Pharmacy Association	March 31–April 2	South Portland, ME
Maryland Pharmacists Association	June 10–13	Ocean City, MD
Massachusetts—New England Pharmacists Convention	Sept. 28, 29	Ledyard, CT
Michigan Pharmacists Association	Feb. 17–19	Dearborn, MI
Minnesota Pharmacists Association	June 23–26	Alexandria, MN
Mississippi Pharmacists Association	June 11–14	Sandestin, FL
Missouri Pharmacy Association	June 8–11	Kansas City, MO
Montana Pharmacy Association—Tri-State Convention	June 8 –11	Coeur d'Alene, ID
Nebraska Pharmacists Association	July 27–30	Lincoln, NE
New Jersey Pharmacists Association	June 28–30	Atlantic City, NJ
New Mexico Pharmacists Association	June 23–25	Albuquerque, NM
Pharmacists Society of the State of New York	June 21–24	Lake George, NY
North Carolina Association of Pharmacists	Oct. 22–24	Triangle Park, NC
North Dakota Pharmacists Association	April 20–23	Dickinson, ND
Ohio Pharmacists Association	April 21–23	Columbus, OH
Oklahoma Pharmacists Association	June 22–25	Branson, MO
Oregon State Pharmacists Association	Sept. 15–17	Salem, OR
Pennsylvania Pharmacists Association	Aug. 10 –13	King of Prussia, PA
South Carolina Pharmacy Association	June 22–25	Hilton Head Island, SC
South Dakota Pharmacists Association	June 2–4	Chamberlain, SD
Tennessee Pharmacists Association	July 23–26	Knoxville, TN
Texas Pharmacy Association	July 20–23	Woodlands, TX
Utah Pharmaceutical Association	April 20–22	St. George, UT
Virginia Pharmacists Association	July 23–26	Virginia Beach, VA
Washington State Pharmacists Association—Tri-state Convention	June 8 –11	Coeur d'Alene, ID
West Virginia Pharmacists Association	Oct. 6–8	Roanoke, WV
Pharmacy Society of Wisconsin	Sept. 14–16	Milwaukee
Wyoming Pharmacy Association	June 21–25	Cody, WY



THEO RUDNAK

NOT MY FATHER'S PHARMACY

A new generation of pharmacists turns to technology to redefine their family businesses.

By Tom Bowen

Ian Ginsberg, RPh, was planning on a career in music when his parents convinced him to continue the family legacy and attend pharmacy school. "I knew if I was going to enter this family business, handed from my grandfather to my father, that I would have to do things differently. I never envisioned myself counting pills. The question I asked then and continue to ask today is 'What can we do here that can't be duplicated?'"

One of many of the innovative answers Ginsberg has identified for New York city's C.O. Bigelow is to implement robotic technology to "free staff to do what we do best, which is to take care of people."

"We've been around 167 years. We try to keep the old apothecary experience while being at the edge of technology," he adds.

Ginsberg is not alone as an heir of his father's pharmacy seeking to redefine his future by changing the nature of the pharmacy itself.

Technology Offers "Old-Fashioned" Edge

John McElmoyl PharmD, owner of Greenfield Pharmacy in Firebaugh, California, gave up a career teaching biochemistry 14 years ago to help his father fend off chain competition and save the pharmacy he founded in 1959.

"We did it by reintroducing the personal touch of an old-fashioned pharmacy," McElmoyl says. "I made a point of sending cards to customers, using direct mail, doing automatic refills. Our customers starting spreading the word that we made time for them, and people started flocking back."

In 2004, McElmoyl discovered a robotic dispensing system at a trade show to which he had brought both of his parents. "My dad is 'old and skeptical," McElmoyl says, laughing. "He doesn't like computers, but he thought (the robotic dispensing system) was way too cool."

According to McElmoyl, he decided to implement robotic technology as a way to reduce errors with the store's growing prescription volume and give him more time with patients. "We handle a large elderly population. They remember the way pharmacy used to be. They really like the old-fashioned pharmacy where you as the pharmacist greet them and talk to them. Now I can do that again. It's that personal touch that this technology has given back to me."

Entrepreneurship Motivates Young Owners

"It's so much more complicated now in pharmacy," says John Pavis, RPh, who co-owns Northampton, Pennsylvania-based Newhard Pharmacy. "When my dad started out there were typewriters and few insurance carriers. Now you really

have to be on top of things. These are things – the business side—that they don't teach you in pharmacy.

"My role has really changed. I'm not on the counter as much any more. I'm looking for ways to do things more efficiently. We're ahead of the game with our computers, our programs, our technology; doing things more effectively and efficiently to save money. I want to make our environment better for our employees. I look at things less like a pharmacist today and more like a business owner."

Pavis indicated that he started looking at technology to help the pharmacy improve efficiency without adding more people. "There are so many more things with which you have to be involved, and so many more pills now too. There is a much greater need for patient counseling because there are so many more drugs. Technology gives us more time to be customer-oriented in terms of drug information and counseling."

"John was instrumental in helping us get started with robotic technology," says Jack Pavis, RPh, John's father. "You really have to stay one step ahead of everything today. With third-parties and insurance companies, price is no longer relevant. Now it's service and personal contact, which we offer uniquely with our family of pharmacists: me, my son, John, my wife, Charlotte, and the support of our dedicated staff.

"Responding to these challenges with John keeps me going. I want to make sure Newhard survives for him and future generations."

Looking to the Future

At L&S Pharmacy in Charleston, Missouri, the Logan family is full of technophiles. "My son Tripp and I both look to the future and what it will take to get there. His future is just a longer future than mine," Richard Logan, PharmD., says.

"We're a technology family," Tripp, PharmD, adds. "We had palm pilots when they first came out. When automation came on the front burner we did some shopping around together. We were pretty much on the same page. I'm a little more aggressive, but we both saw the need. Right now script volume is up and up. A couple sick employees can make or break your Monday."

According to Richard, "Tripp has a pretty clear vision of what the future is going to be with things like integrated workflow and telephony, and how they will integrate with what we do, with the computer and the Internet. Part of the reason we've implemented robotics now is so we'll have the tools we need to take the next steps."

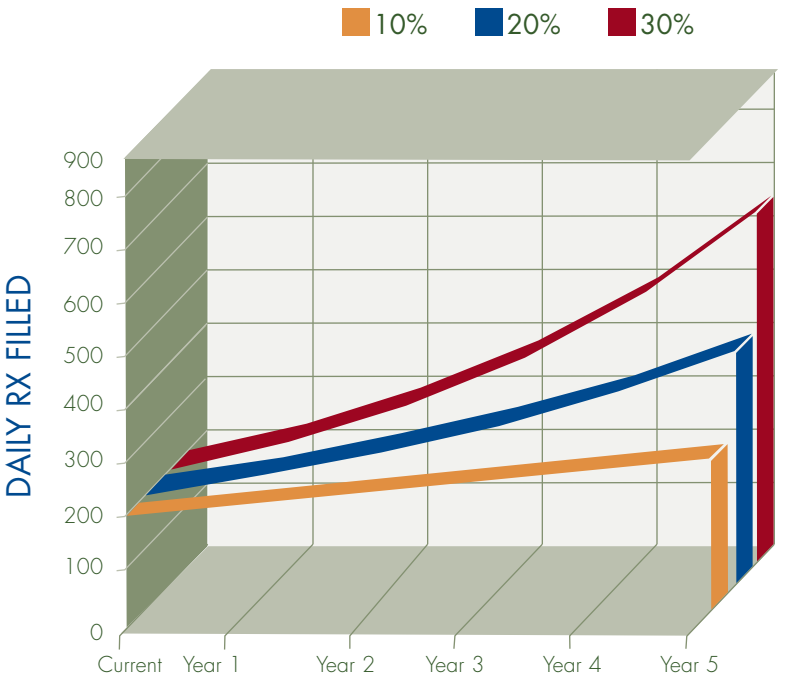
Richard says that as much as his family loves technology, his son immediately understood that in the pharmacy there was no room for technology for its own sake. "He knew it really had to enhance productivity and the bottom line."

Tripp agrees, saying, "Technology is making it easier for me to manage all aspects of our pharmacy with less effort. I can sit at my desk and tell exactly what patient came in when, what they received, even what size bottle, all with less paperwork.

"I like the one-on-one with patients. That's what I like to do. That's a perk of automation. Now that I have automation, I can fill the script, talk to patients, get a grasp of what's going on with them. I have time to counsel them on their prescription. When I'm done with my patient, the script is ready. That's the best part of this job now."

Richard says, "Technology has to help us be more efficient, more accurate and more available to patients. Both of us understand our patients are coming in the front door to talk to us, not a machine. Technology should be in the background and run the way it is supposed to so we can talk to patients, interact with doctors. Taking care of folks is what we do." ■

Tom Bowen is director of customer satisfaction for Parata Systems, LLC. For more information on Parata, visit www.parata.com



PRESCRIPTION GROWTH IMPACTS SATISFACTION

With 10-15 percent annual growth rates, pharmacists find it increasingly challenging to keep pace and do the things they trained to do, which impacts job satisfaction. The chart above right shows the significant impact on prescription growth over a five-year period. (Calculate growth rates specific to your pharmacy using Parata's pharmacy growth calculator at www.parata.com.)

Source: Parata Systems, LLC

PHARMACY TECHNOLOGY: EMERGING TRENDS

SARAH S. DIAB

Tech expert Bill Felkey wants to help you find solutions to your practice problems.

By Chris Linville

In the early 1800s, a social movement of English workers known as the Luddites protested against the changes produced by the Industrial Revolution that they felt threatened their jobs. Since then, the term Luddite has been used to describe someone opposed to technological progress and technological change.

Where the Luddites feared technology, Bill Felkey sees it as a liberating force. As a professor of pharmacy care systems at Auburn University, Felkey keeps a close tab on technology's pulse. If you have a question about technology, he can answer it. If there's a new toy that can make his work and life easier and more fun, he more than likely has it. In fact, his love affair with technology is such that he is affectionately known as "Professor Gadget."

These days, more people seem to be taking advantage of an ever-expanding array of technology applications. Yet, in Felkey's view they are not realizing its full potential.

"Most individuals get about 10 percent of the tech capability that they use," he says. "So if you have a computer or PDA, you are only getting about 10 percent out of it."

So, Felkey's goal is help others take advantage of technology as he has. Felkey says he isn't a futurist who focuses on what might come down the pike five or 10 years from now. He's more interested in what's available now and what purpose it might serve.

"I'm kind of like the Underwriter's Laboratory, where I go out and evaluate technology and try to see which of those things are ready to be used," Felkey says. "I've wrapped my arms around everything involving technology, and if somebody says, 'I have this problem,' then chances are, I have a technology solution that will address that problem. If you give me a problem, I'll tell you about the technology to address it."

Felkey has always had an affinity for technology. Growing up, he was a ham radio operator, and worked with his father, who was heavily involved with electronics and built transceivers. From there, he went into production technology, and taught television production as an undergraduate student at the University of Maine.

Felkey, who came to Auburn in 1977, says that in the early 1980s, after the PC had come out, he wanted to show what it could do in practice. He conducted a national meeting with state pharmacy association executives, demonstrating six programs available for pharmacy. The response was enthusiastic. "Everybody went nuts about it," he says. In the years since, he has served as a technology guru, through his classes, in more than 700 published papers, and in presentations such as the one he gave at NCPA's 107th Annual Convention and Trade Exposition last October in Fort Lauderdale, Florida.

TECHNOLOGY SOLUTIONS

Felkey says that the opportunities for pharmacists to use technology are vast, and, if you have a reasonable amount of tech savvy, are easy to accomplish. For example, he says that his PDA (personal data assistant) contains "literally a library shelf of information." Felkey says that pharmacists can do the same with information about drugs, diseases, and anything else that a patient may ask about, as opposed to reaching for a shelf and pulling down a 35-pound reference book.

"Pharmacists can open up a PDA, and in matter of seconds, have precise knowledge to answer the question even if they don't have it on the top of their heads," Felkey says. "And it can be updated on a daily basis."

Speech recognition is another evolving technology. "If you have to document your MTM (medication therapy management), you can do it on the keyboard or you can do it with your voice," Felkey says. "I can speak at 160 words a minute, and 99 percent accuracy will occur when documenting my patient care."

When Felkey discusses technology, he frames it in terms of what he describes as "total digital convergence." "It's a global network," he says. "The new definition of the Internet is that every cell phone, medical device, PDA, pager, and computer in the world talks to every other one."

An increasingly utilized technology is RFID (radio frequency identification), which uses radio waves to automatically identify people or objects. Various types of RFID are being used throughout the economy. Chips are being installed on products at the manufacturing stage, which allows the product to be tracked almost anywhere, even from 30,000 feet in the air. In stores, self-checkout with RFID has become increasingly common.

"It's sort of like when the UPC bar codes came out," Felkey says. "It took awhile to work out some of the kinks, but it quickly became accepted. Stores can do a lot of cashier work without paying a person to stand there and push things across the bar code. The vision in the retail environment is that you go in and shop, you walk out, it debits your account, and then it sends an e-mail receipt."

According to Felkey, RFID can play a key role in helping independent pharmacies. He says that if he has a health card with RFID, as he comes into a pharmacy and approaches the counter, "It (RFID) automatically opens up my computer

profile, and if I've made an appointment for service it tells the receptionist what I'm there for. The RFID can be mixed in at several different levels in this scenario. "

Felkey also points to situations where pharmacists have to bill for their cognitive services on a time-based current procedural terminology code; thus for auditing purposes, they need to be able to document and have proof that they have actually provided services.

"Say I have a patient sitting in an exam-like room in the pharmacy," Felkey says. "The moment I walk in the door (which has an RFID reader), or if any of my personnel walk in and spend time with that patient, it's actually clocking the amount of time they are spending with patients, and when they leave it can create a combination of the time and what they did when they were in that room, which is also digitally recorded because their name badge has an RFID on it. It can create and submit the bill, and before the pharmacist starts talking to the next patient, he or she has already been reimbursed for their services."

TELEPHARMACY

The concept of working from a site removed from a central location—known as telecommuting or remote work, to name a few terms, has become fairly routine. In the health care world, those concepts are being used for a number of applications. Felkey says it is estimated that there are some 160,000 individuals with varying levels of health care practitioner skills actively working in the United States. But there may be 50,000 others who are out of the workplace for any number of reasons—they may be home raising children, they may be disabled, or they have simply left the field—yet whose knowledge base is still intact, and who could be put back to work quickly if needed. In the aftermath of the Gulf Coast hurricanes, a major chain did just that.

The chain set up homes with the necessary technology to do remote verifications. During Katrina, this chain had hundreds of pharmacists available to assist any of their stores still operating in the affected areas, and they processed untold numbers of prescriptions with the support of thousands of telepharmacy connected practitioners.

Felkey says, "When you look at ability to digitize the prescription, where you have a high quality image of it, and are able to use barcodes on the actual doses, and even have a camera view on the physical inspection of what's being dispensed, it's not necessary to have an individual pharmacist on site handling and holding the drugs in his or her own hands to assist in the dispensing process. So now we're seeing different states around the country making it easier for telepharmacy to take place in the community setting."

Perhaps the "final frontier" in telepharmacy, says Felkey, is reaching into a patient's home and providing remote health care. At a certain level, remote patient monitoring is nothing new. Bracelets or necklaces with emergency call buttons are fairly common. But through a wide variety of RFID devices, such as wireless chips, implants, bandages, and wristwatches, to name just a few, pharmacists and others can focus on preventive care, as opposed to reacting after a health crisis occurs.

Felkey presents a hypothetical scenario of a patient with congestive heart failure who is equipped with an RFID device. If the patient steps on a digital scale in his bathroom and notices he has gained five pounds in a single day, a health care provider—from a remote location—can determine that the patient gained that weight because of edema from their heart failure.

"We would be able to take out and connect that information into a monitoring care environment where people could react before that person has to be hospitalized," Felkey says. "We would save system costs; we would increase the patient's quality of life; and we would use the appropriate team member—a doctor, nurse, or pharmacist—to do the intervention for that patient. So when you think about telepharmacy, you're also thinking about having all kinds of connectivity with the patient that you are assigned to, and you are able to keep them healthier and engage them in their own self-care management."

Another example is a patient with diabetes. Felkey says that a patient can do a finger stick, and as soon as the reading is taken, it's logged into a patient continuity of care record (CCR). "You are able to see how their blood sugar control is over time," Felkey says. "And also, the team that's taking care of the patient is prompted to go ahead and record a hemoglobin A1C as an overall indication of the patient's glycemic control."

Additionally, Felkey says, "If somebody's on a complex regimen, I am tracking more than 160 technologies that will inform the patient when he needs to do a health behavior, such as taking a medicine. It will record that they have done it, and let them know if they have forgot that they have done it, and that they don't need to do it again.

"It will reduce the complexity of their medicine by actually showing them what it is that they are supposed to take at any given time during the day for doses, and it will communicate with the pharmacy to make sure that they get their refills and don't have a lapse in taking their medicine."

Telepharmacy is simply another part of Felkey's theme of total digital convergence, where universal interconnectivity is becoming an increasingly common part of health care.

"We live in a knowledge-based society," he says. "I believe that every pharmacist needs to stop and say, 'OK, how can I use technology in this process; how can I use the Internet to keep connected with my prescribers and my collaborating physicians, and also my patients when they go home.'"

Felkey points out that in the Medicare Part D era, as pharmacists get more patient responsibilities, it's conceivable that they will have a higher level of on-call type situations.

"A pharmacist, while he is out dining somewhere, might

be interrupted and asked to make a decision regarding a proper drug therapy for someone who's in an emergency room," Felkey says. "Normally, he would have to leave the restaurant and go to the physical location, such as the emergency room. But with the connectivity that we have now, we can draw down the complete medical record, do the PDA smart phone at the restaurant, and the pharmacist can provide the input as part of the multi-disciplinary care team, and then finish the entrée and order dessert."

MEDICARE PART D AND TECHNOLOGY

The size and complexity of the new Medicare D drug benefit, which took effect Jan. 1, promises to present numerous challenges to pharmacists. However, technology may help make the process a bit easier.

Clearly, pharmacists will be expected to process vast amounts of information. They will need to know what plan a patient is using, along with formulary coverage, reimbursement levels, whether patients have copays, and if so, how much, among other responsibilities.

Felkey says that the NCPDP (National Council on Prescription Drug Programs) has come up with a connection to the TRooP (true-out-of pocket cost) facilitator database, allowing pharmacists to query and find out if patients are enrolled, and if they are, what type of plan it is.

However, as Felkey points out, "If you look at the ability to process claims, and to do all the things that a pharmacy management system is able to do, it's also possible to look at the drug spend of an individual patient and to see if that patient is eligible for MTM services.

"Once you've identified that, because of the nature of the patient's illness, and the patient's at risk status, and total spend in health care, then the person can be engaged in MTM services, and pharmacists can also coordinate with disease management companies who are doing something called CCIP (chronic care improvement programs), and the technology does what it does best." This includes utilizing products by companies that, whenever a patient's blood pressure is taken, automatically records the blood pressure numbers and puts it into the pharmacy system, saving time and effort.

Felkey adds that "there are literally hundreds of technologies available to help the pharmacist doing these services, and some of these will actually assist in providing education to a patient." Felkey says he uses movies from a leading pharmaceutical manufacturer's Web site that features three-dimensional graphics, to explain the various attributes and actions of diseases and other health issues.

"It does so in a way that turns the pharmacy into an 'Epcot pharmacy,'" he says. "It repackages what the pharmacist previously did, and maybe gave away for free, and repackages it using the technology service provision so it can be done more efficiently and more effectively, and the patient is going to be fully engaged in the care."

Bill Felkey, a professor of pharmacy care systems at Auburn University, displays some of his tech toys.

CHOICES, CHOICES

With all the available technology, how do you choose? There are a number of factors to consider, Felkey says. Obviously, you don't want to purchase something that breaks your budget and doesn't provide a return on investment. Fortunately, Felkey says, many technology solutions are becoming more affordable.

Basically, he says, it comes down to figuring out what type of technology best fits a pharmacy's goals.

"I get 100 e-mails per day from people who want to take the next step," Felkey says. "You start from where you are, and you find one thing that addresses the problem you have today, and you go through the learning curve of how to integrate that into your practice, and when that's working well for you, you keep it, and if it doesn't, you discard it. But then you look for the next thing.

"And that's where we are right now. People graduate from pharmacy school, and practice for 40 years, but nobody comes into their practice every Tuesday saying, 'Here's the next thing you should do to make your practice better.'"

Finally, Felkey says, "There's no question now that technology exists to be able to support any direction a practice wants to take. It's then a question of figuring out where you want your practice to go, and finding out the technology that will help you get to where you are going with that practice." ■

Chris Linville is managing editor of America's Pharmacist.

Diet Pills Need Boost From Exercise

There's no free lunch with diet pills, new research concludes: They work much better accompanied by the hard work of dieting and exercise.

The study backed by the National Institutes of Health is the biggest and best yet to demonstrate why obese people should adopt healthy habits, even if they take weight-loss drugs, researchers said.

"If you pit this medication against your favorite all-you-can-eat buffet, the ... buffet is going to win nine out of 10 times. So it's important you try to modify eating habits," advised University of Pennsylvania psychologist Thomas Wadden, who led the study published in *The New England Journal of Medicine*.

Medical guidelines have recommended that obese patients also change eating and exercise habits since doctors first began prescribing today's long-term weight-loss medicines in the late 1990s. Still, many patients fail or ignore the advice.

Yet in the one-year study, the most successful patients took the weight-loss drug Meridia along with 30 sessions of group counseling that promoted a 1,500-calorie daily diet and half-hour walks on most days. It was especially effective when patients recorded how much they ate each day.

Obese people who took pills alone typically lost 11 pounds in the study. When they added the full program promoting lifestyle changes, they lost 27 pounds—more than twice as much.

A third group took the drug with brief doctor's counseling, and a fourth underwent only group counseling. Within five months, those two groups lost a bit more weight than the group that only took the drug, but all three of these groups were roughly equal after a year.

It is unclear how well the study patients will keep off their lost weight in future years. Researchers also hope that future studies will clarify whether doctors can offer better counseling to approximate the results of extended group sessions. Such in-office sessions would be faster and cheaper.

Arthritis Drug May Ease Another Joint Disease

The drug adalimumab (Humira)—commonly used to treat rheumatoid arthritis—may also help reduce the signs of symptoms of ankylosing spondilitis (AS), a painful and disfiguring autoimmune disease, according to an international study presented at the American College of Rheumatology.

AS, which affects about one in 2,000 people in the United States, occurs when a protein called tumor necrosis factor (TNF) attacks certain spinal joints and causes inflammation those joints. Adalimumab is an anti-TNF agent.

This study included 315 AS patients in the United States and Europe who had no success with at least one other form of therapy. Patients were randomly assigned to receive either 40 milligrams of adalimumab or a placebo for 24 weeks.

Researchers used five assessment methods to measure the patients' clinical responses treatment. The goal was a 20 percent improvement in AS signs and symptoms.

At 12 and 24 weeks, more than twice as many patients taking adalimumab had achieved the 20 percent improvement goal, compared to those taking the placebo. Some of the patients showed improvement as early as two weeks into the study.

Statins May Delay Alzheimer's Effects

Cholesterol-lowering drugs may help to delay the progression of Alzheimer's disease.

In a three-year study involving 342 Alzheimer's patients, they found that the illness did not develop as quickly in sufferers with high cholesterol levels who were given statins as in patients not taking the drugs.

Florence Pasquier, a professor at the University Hospital in Lille, France, said the drugs "may slow cognitive decline in Alzheimer's disease and have a neuroprotective effect."

Nearly 130 patients in the study had high cholesterol levels. About half were given statins while the remainder did not receive any treatment.

The findings, which are reported in the *Journal of Neurology Neurosurgery and Psychiatry*, support the results of other human and animal studies which have suggested that high cholesterol levels may play a role in the progression of Alzheimer's.

Most of the patients in the study were women. Their average age was 73. The progression of the disease was rated at 1.5 points a year for the women taking the drugs, compared to 2.4 for those who were not treated with statins and 2.6 for patients with normal cholesterol levels.

In an editorial in the journal, Frank-Erik de Leeuw, a doctor with the University Medical Center in Nijmegen in the Netherlands, said more work needs to be done before any conclusions can be drawn.

Alzheimer's affects an estimated 12 million people around the world. There is no cure for the progressive illness that robs people of their memory and mental ability but drug treatments may slow its early progression. □

February Health Events

AMD/Low Vision Awareness Month
Prevent Blindness America
www.preventblindness.org

American Heart Month
American Heart Association
www.americanheart.org

Congenital Heart Defect Awareness Week—Feb. 7–14
Congenital Heart Information Network
www.tchin.org

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Diagnosis and Treatment For Restless Leg Syndrome

By Dondel C. Moorman, PharmD

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

1. Discuss the criteria for a definitive diagnosis of restless leg syndrome (RLS).
2. Recognize the clinical features associated with RLS.
3. Understand the rationale for the proposed pathophysiology of RLS.
4. Distinguish between the classifications of RLS.
5. Recommend the appropriate pharmacological treatment for RLS depending upon its presentation.

Introduction

First characterized by the Swedish neurologist Karl-Axel Ekbom in 1945, restless leg syndrome (RLS) is observed between 2–15 percent of the population. Symptoms of RLS can be observed at almost any age. Although approximately 45 percent of patients have onset of RLS symptoms at 20 or under, this movement disorder's prevalence is thought to increase with age. It is most notably observed in people of European decent as opposed to those of African or Asian ethnic background, and occurs more often in women than men.

Diagnosis

RLS is often described as a sleep disorder; however, sleep disturbances are not required to make a definitive diagnosis. In 1995, the International Restless Leg Syndrome Study Group (IRLSSG) developed criteria to aid in RLS diagnosis. While attending the National Institute of Health (NIH) conference in May 2002, the IRLSSG, in collaboration with experts in epidemiology and scale design, revised these criteria. The final recommendations regarding the criteria for diagnosis were published in 2003 and include essential criteria, supportive criteria and associated features of RLS (see Table 1, page 39). As determined by this NIH consensus, the essential features listed in Table 1 are the only clinical attributes necessary for diagnosis.

Essential Clinical Features

The key feature of RLS is the irresistible urge to move the legs. This urge to shift the position of the legs is a *voluntary* action to relieve the uncomfortable sensations associated with periods of extended rest. The associated feelings have been described in various ways, including "burning," "creeping," "tingling," and "tugging," and may or may not be accompanied by pain. Although the symptoms can occur during the day, symptoms are usually worse during the evening hours or occur only at night.

Supporting Clinical Features

RLS is often characterized as a sleep disorder, however it is important to observe that sleep disturbance is not considered essential for appropriate diagnosis. The insomnia resulting from RLS is frequently due to period limb movements of sleep (PLMS). These *involuntary* movements of the legs occur during hours of slumber and are usually first noticed by a significant other rather than the afflicted person. PLMS are defined as an involuntary movement of legs that is at least 25 percent more in intensity than voluntary leg movements. This distinction is achieved by measuring the surface electromyography of the legs. Prior to sleep, the patient is instructed to voluntarily move the legs. This documented movement is then compared to observed involuntary movements during sleep, which occur at intervals of five to 90 seconds and lasts anywhere from a half-second to five seconds. While PLMS occur in as many as 80 percent of patients with RLS, they are also associated with several other conditions, including sleep apnea, spinal cord lesions, narcolepsy and the use of certain antidepressant and neuroleptic medications. During periods of wakefulness, approximately 25 percent of patients may experience PLM.

Another supporting factor for RLS diagnosis is the role of dopaminergic agents in preventing the symptomatology. The observed improvement after dopamine agonists initiation, such as levodopa and ropinirole, further establishes the proposed mechanism of RLS pathophysiology.

Although predominantly considered a

Useful Web Sites

www.rls.org
The Restless Legs Syndrome Foundation provides information for patients, friends and families regarding support groups, treatment options, as well as information about specialists.

www.wemove.org/rls/
The Worldwide Education and Awareness for Movement Disorders (WE MOVE) provides patient-friendly information about restless leg syndrome and other movement disorders.

www.ninds.nih.gov/disorders/restless_legs/restless_legs.htm
The National Institute of Neurological Disorders provides patients and caregivers facts about restless leg syndrome and the organizations designated for further information.

www.mayoclinic.com/health/restless-legs-syndrome/DS00191
The Mayo Clinic offers information to patients and other interested parties including an overview of restless leg syndrome, the available treatment options as well as a Q&A section.

www.restlesslegs.com.
This is a useful site for patient-oriented information. It includes several links for patients and a link to a site established for health care professionals.

movement disorder involving the legs, up to 48 percent of patients report RLS-related symptoms in the upper extremities. Other associated features of RLS are provided in Table 1.

RLS Classification

RLS presentation may vary depending upon the underlying etiology of the disease process. This syndrome can be deemed primary (familial), secondary or idiopathic.

Primary (Familial) RLS

As previously stated, RLS may occur at any age. Onset in childhood is usually indicative of a familial link to the development of RLS. RLS symptoms have been described in patients as young as 10, but this group is usually misdiagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD) or "growing pains."

In 1945, Ekbom first described the familial link of RLS. Since that time, several attempts of genetic mapping have been undertaken. By examining the hereditary aspects of several large families from the United States, Germany, Italy and Canada, three major susceptibility loci have been identified for this autosomal dominant syndrome. The first locus, discovered in 2001, was found on chromosome 12q in the investigated Canadian families. The chromosome 12q locus was not confirmed after examining three European families shortly after. The subsequently discovered loci were a region of chromosome 14q13-21 in an Italian family and chromosome 9p24-22 in two large U.S. families. Due to this variability in identification, further analysis is needed to determine any other markers.

Secondary RLS

RLS development may be due to metabolic abnormalities such as iron deficiency, pregnancy or end-stage renal disease (ESRD). RLS presence is usually observed when the serum ferritin level is less than 50 mcg/L, or the iron saturation is less than 16 percent. Although iron stores are diminished, the iron deficiency noted in RLS is usually not associated with anemia. Some patients with RLS associated with iron deficiency have also reported a worsening of symptoms during blood transfusions. RLS occurs in approximately 20 percent of women during pregnancy. While these symptoms may be solely associated with pregnancy, manifestations of RLS may continue for several weeks postpartum.

There is no identifiable difference between the development of RLS and the mode of dialysis (peritoneal dialysis versus hemodialysis). The risk factors for developing symptoms of uremic RLS include hypoparathyroidism, iron deficiency, and vitamin deficiencies, along with subtherapeutic dialysis. Due to these predisposing factors, RLS in ESRD may occur in up to 62 percent of dialysis patients. Patients with ESRD who experience RLS are believed to have a higher mortality risk. Although lack of sufficient dialysis may lead to RLS, these symptoms cannot be improved by appropriate dialysis. However, recovery has been observed after transplantation.

One study exhibited a direct link to the number of dialysis sessions per week and the development of RLS. The theory behind this direct causal relationship is the loss of essential nutritional elements in the dialysate.

An additional cause of secondary RLS may be related to a patient's medication regimen. Several medication classes have been associated with the development of extrapyramidal symptoms similar to those observed in RLS. These include tricyclic antidepressants, dopamine antagonists, caffeine and certain over-the-counter (OTC) medications, to name a few. Table 2 (page 39) lists the most common agents, but is not an all-inclusive list of the medications associated with RLS development.

Differential Diagnoses

When examining the secondary causes of RLS, it is essential to consider the possible differential diagnoses that may have similar presentations. As stated previously, PLMS occur in approximately 80 percent of patients with RLS and may be associated with other underlying neurological disorders. PLMS is not the only disease process that can be mistaken for RLS. Others include peripheral neuropathy, radiculopathy, neuroleptic akathisia, positional discomfort, leg cramps, paresthesias, and vascular disease. Although similar sensations of the extremities may lead one to make a diagnosis of RLS, the criteria for appropriately diagnosing RLS may prove to be beneficial in differentiating the possible origins.

Proposed Pathophysiology

While an exact RLS action mechanism is yet to be determined, several factors have played a large role in the proposed mechanism for its disease process. Most believe dopamine dysfunction is the key to developing RLS. This is supported by the observed exacerbation of symptoms with the use of dopamine antagonists in patients with RLS, the marked improvement with use of dopamine agonists, and the increased prevalence of RLS among patients with Parkinson's Disease (PD). These observations have guided clinical trials as well as the pharmacological management of this condition.

RLS Rating Scales

RLS Rating Scale

Developed by the IRLSSG, this subjective rating scale is comprised of 10 questions that relate to RLS symptoms occurring in the past week. To use this scale, the patient must first meet the essential criteria developed by IRLSSG in association with the NIH panel (see Table 1). Scoring for this scale is determined by obtaining the sum of the established rating for each question, which ranges from very severe (four) to none (zero) in most cases. Interpretation of the scores ranges from mild (score one to 10) to very severe (score 31 to 40). For assessment of the complete scale, please visit this Web site: http://www.jr2.ox.ac.uk/bandolier/booth/RLS/RLSratingscale.pdf. This is a useful tool for assessing not only the severity of RLS symptoms, but also the impact these symptoms have on sleep and quality of life.

The Johns Hopkins RLS Rating Scale

This one question rating scale focuses on confirming the severity of RLS by the time of day in which the onset of symptoms occurs. The earlier in the day the symptoms begin, the more severe the disease progression.

Suggested Immobilization Test (SIT)

A recently utilized tool for evaluating RLS, the suggested immobilization test

(SIT) examines the actual period of time it takes for RLS symptoms to occur while observing a patient during a period of rest. This assessment tool has not been validated for the sensitivity or specificity in RLS.

Treatment

General Treatment Considerations

The first step in the management of almost any disease state is to treat an underlying cause if one exists. RLS is no different. By obtaining a thorough family history and simple laboratory data, RLS may be distinguished as primary or secondary. No matter which form of RLS a patient has, the implementation of non-pharmacological methods may prove to be beneficial. These techniques include avoiding alcohol, caffeine, or nicotine consumption; incorporating moderate exercise into daily activities; and improving sleep hygiene through the use of relaxation techniques and other methods. Recently, the use of pneumatic compression devices has also shown some benefit as a non-pharmacological treatment modality.

Secondary RLS

Usually the cause of some metabolic or medication-related imbalance, secondary RLS is treated most effectively by correcting the underlying cause. Useful tools in managing a patient with secondary RLS include a complete medication and past medical history, as well as iron studies. Examination of the patient's medication regimen is imperative. If the patient truly has drug-induced RLS, simple removal of the causative agent provides symptom relief.

The other considerable issue related to secondary RLS is iron deficiency. As previously stated, RLS symptoms typically occur with serum ferritin levels less than 50 mcg/L or iron saturation less than 16 percent. Use of ferrous sulfate 325 mg with 100 to 200 mg of vitamin C in a patient-specific regimen will correct the deficiency and relieve the symptoms. The goals for iron therapy are to increase serum ferritin to greater than 50 mcg/L, or increase iron saturation to greater than 20 percent. While fairly benign when used appropriately, iron therapy does have its complications. The common patient complaints include constipation and gastrointestinal discomfort, but the serious concerns with iron supplementation is the potential development of hemochromatosis.

Table 1. NIH Panel's Criteria for Diagnosing RLS

Essential criteria	• Overwhelming urge to move the legs, which is often done to relieve an unusual feeling in legs. • Unusual or unpleasant sensation in the legs often relieved or lessened by movement. • Symptoms occur or worsen during periods of rest or inactivity. • Symptoms only occur at night or are worse at night than during the day.
Supporting criteria	• Presence of periodic limb movements of sleep • Positive family history • Positive response to dopaminergic therapy
Associated features	• Normal clinical progression: - Appropriate diagnosis is often made in patients who are middle-aged, but symptoms can begin at any age. - Periods of waxing and waning of symptoms have been reported, but the disease process is usually progressive. - Symptom free periods are described to exceed one month or more. - Up to 48% of patients present with involvement of the upper extremities. • The unpleasant sensations and the desire to move the legs to alleviate these feelings may result in sleep disturbances. • Clinical examination: - In the idiopathic and familial forms, neurological examination is often within normal limits. - In the non-familial form of RLS, peripheral neuropathy or radiculopathy are occasionally present. Low serum ferritin (less than 50 mcg/L).

Primary or Idiopathic RLS

Several medication classes have been used to treat RLS, including dopaminergic agents, anti-epileptic agents, opioid analgesics and benzodiazepines. The main considerations when selecting an agent are the time at which symptoms occur, severity of symptoms and particular patient factors.

Dopaminergic Agents

This class of drugs is the most established in the treatment of RLS and con-

Table 2. Medications Associated With Drug-Induced RLS

Tricyclic antidepressants	Metoclopramide
Selective serotonin reuptake inhibitors (SSRIs)	Prochlorperazine
Serotonin norepinephrine reuptake inhibitors (SNRIs)	Phenytoin
Lithium	Droperidol
Dopamine antagonists	Haloperidol
Caffeine	Phenothiazine derivatives
Nicotine	OTC cold and allergy medications
Alcohol	

tains the only current Food and Drug Administration (FDA)-approved entity. These first-line agents, which include levodopa and other dopamine agonists, reduce the symptoms of RLS and PLMS. Even though these agents are very effective in treating RLS, two major drawbacks of their use have been identified: augmentation and rebound.

Augmentation is characterized by several signs involving early onset of symptoms during the day, and an increase in the severity of symptoms and/or involvement of additional body parts after the initiation of dopaminergic therapy. This phenomenon is not completely understood, but one theory links the development of augmentation to a shift in the circadian rhythm of RLS symptoms. Most often observed with the use of levodopa, two methods have been utilized to alleviate this shift. Adding an extra dose earlier in the day has been used to treat augmentation secondary to dopaminergic agents, but this method may lead to an increase in augmentation severity. Cessation of the contributing agent is also effective.

Rebound, or the appearance of symptoms at a time that correlates with the half-life of the drug, may also occur with the use of dopamine agonists. This occurrence has been compared to withdrawal, and is only observed with levodopa use.

Levodopa

Levodopa, a short-acting dopamine agonist, is most often utilized in patients with mild, intermittent RLS. Limiting this agent's use to mild, intermittent disease decreases the possibility of patients developing augmentation and rebound with therapy.

While using a controlled release formulation may also decrease the incidence of rebound, immediate release preparations typically allow for a more predictable onset. While rebound frequently occurs three to four hours after immediate-release dosing, the observed delay in rebound with use of sustained-release formulations is approximately seven hours. Rarely used as a single agent, levodopa is administered with carbidopa to prevent the peripheral metabolism of the active entity. This combination is also available as an orally disintegrating tablet. Major drug interactions include isoniazid, MAOIs, antipsychotics, general anesthetics, iron salts, and linezolid.

Dosing and other information about levodopa and further dopamine agonists is provided in Table 3 (below left). There are no recommendations regarding renal or hepatic dosage adjustments for this agent.

Non-ergot Dopamine Agonists

A non-ergot dopamine agonist, ropinirole is the only FDA-approved agent for the treatment of moderate to severe primary RLS. This agent is longer acting than levodopa, and therefore is less associated with augmentation. If augmentation develops with ropinirole use, a dose given earlier in the day may relieve these symptoms. If the patient has hepatic insufficiency, ropinirole must be used with caution. Major drug interactions include antipsychotics, cimetidine, droperidol, metoclopramide, rifampin, and zileuton. Pramipexole, another non-ergot dopamine agonist, is similar to ropinirole. However, this agent is primarily excreted through the kidneys and thus requires caution in renal insufficiency.

Another promising agent currently in development, rotigotine, is a once-a-day transdermal patch. It exhibited a dose-dependent improvement of RLS symptoms in a 2002 study. This transdermal system was tested in doses of 1.13 mg, 2.25 mg, and 4.5 mg. Clinical trials are still ongoing.

Ergot Dopamine Agonists

Bromocriptine, pergolide, and cabergolide are the ergot dopamine agonists that have been evaluated for use in RLS. The first direct dopamine agonist ever studied for RLS was bromocriptine. Limited data exist for its use in RLS, but studies suggest that this agent provides partial subjective improvement in restlessness and paresthesias. Also, a 57 percent reduction in PLMS has been observed. This agent should be used with caution in hepatic insufficiency and possesses multiple drug interactions, including several HIV medications.

Pergolide, a semi-synthetic ergot alkaloid, has a longer half-life than bromocriptine. The major concern with its use is the development of pulmonary fibrosis or vascular fibrosis of the heart,

Table 3. Dopaminergic Agents

Agent	Starting Dose*	Maximum Dose*	Disadvantages
Levodopa	50 mg	200 mg	augmentation, rebound, tachyphylaxis, nausea, vomiting, orthostatic hypotension, insomnia
Ropinirole	0.25 mg	4 mg divided bid to tid	augmentation, nausea, vomiting, orthostatic hypotension, nasal congestion, fluid retention, insomnia
Pramipexole	0.125 mg	1.5 mg divided bid to tid	same as ropinirole
Bromocriptine	7.5 mg	N/A	augmentation, nausea, vomiting, GI bleeding, MI, chest pain
Pergolide	0.025 mg	0.5 mg divided bid to tid	same as ropinirole, pulmonary fibrosis
Cabergoline	0.5 mg	4 mg	augmentation, nausea, fatigue, dizziness, headache, vertigo, diarrhea

* Agents usually given as one single dose at bedtime unless otherwise specified.

which is normally observed at doses greater than 4 mg. Caution must be used in renal impairment and with concomitant use of antipsychotics, droperidol, metoclopramide and memantine.

Although not currently packaged for use in the United States, cabergoline is more widely used to treat RLS in Europe. It is the longest acting dopamine agonist with a half-life of more than 65 hours. Like bromocriptine, this agent interacts with several HIV medications as well as haloperidol, metoclopramide, and phenothiazines. Its primary mode of elimination is hepatic and therefore caution should be used in liver disease.

Anti-Epileptic Agents

Anti-epileptic agents, considered second-line therapy for RLS, are most often used to decrease the unpleasant sensations. Gabapentin, which was well tolerated at mean doses of 800 mg, reduced the sensimotor symptoms and PLMS in idiopathic RLS. If used in patients with ESRD, a supplemental dose of 200–300 mg is necessary. Other anticonvulsants, such as carbamazepine and divalproex sodium, have limited data supporting their use.

Opioid Analgesics

Also considered a second-line treatment option by some, opioid analgesics are also used to relieve the pain associated with RLS symptoms. These agents, used in smaller doses than for chronic pain, have a limited risk of dependence when utilized. Out of this class, propoxyphene and oxycodone have been studied.

Benzodiazepines

The preferred benzodiazepine agent for RLS treatment is clonazepam, which is usually initiated at doses of 0.25 mg at bedtime and titrated to 2 mg. Other agents studied within this class included temazepam and triazolam.

Miscellaneous Agents

Two additional agents have also shown some efficacy in treating RLS symptoms. Clonidine, an alpha-2 agonist, has been effective for patients with delayed sleep onset due to leg discomfort. Furthermore, the reduction in the force of PLMS has been observed with baclofen; however, PLMS' frequency was not affected.

Table 4. Drug Recommendations for Pregnancy And Breastfeeding

Agent	Pregnancy Category	Breastfeeding Recommendations
Dopamine Agonists		
Levodopa	C	Contraindicated; inhibits lactation by preventing the release of prolactin
Ropinirole	C	Use caution
Pramipexole	C	Not recommended
Bromocriptine	B	Contraindicated; inhibits lactation; risk of stroke, hypertension and seizures
Pergolide	B	Contraindicated
Cabergoline	B	Contraindicated
Anticonvulsants		
Gabapentin	C	Use only if benefits to mother clearly outweigh risks to baby
Carbamazepine	D	Cease use of breastfeeding or drug
Divalproex sodium	D	Not recommended
Opioid Analgesics		
Oxycodone	B	Do not use chronically
Propoxyphene	C/D*	Use with caution
Benzodiazepines		
Clonazepam	D	Contraindicated
Temazepam	X	Contraindicated
Triazolam	X	Contraindicated
Additional Agents		
Clonidine	C	Contraindicated
Baclofen	C	Avoid use

*Risk increase with prolonged use

Pregnancy and Breastfeeding Considerations

Since as many as 20 percent of women experience RLS when pregnant, the implications of the previously mentioned agents on fetal development must be considered. In Table 4 (above), there is a list of most of the agents utilized in RLS along with their pregnancy category and breastfeeding recommendations.

Overall Treatment Recommendations

When treating RLS, non-pharmacological intervention is first-line. These include the use of relaxation techniques and moderate exercise as well as elimination of alcohol, nicotine, caffeine or medications that may increase the severity of RLS symptoms. The American Academy of Sleep Medicine guidelines recommends:

- Using dopaminergic agents as first-line therapy
- Using opioids, gabapentin, or clonazepam as second-line treatment options
- Initiating therapy as a single nighttime dose □

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CONTINUING EDUCATION QUIZ

Select the correct answer.

1. Which of the following is not included in the IRLSSG criteria to make a positive diagnosis of RLS?
a. An irresistible urge to move the legs
b. Symptoms are lessened by movement
c. Sleep disturbance
d. Symptoms are worse during the evening or at night

2. What percentage of patients experience the PLMS associated with RLS?
a. 40 percent
b. 10 percent
c. 60 percent
d. 80 percent

3. What percentage of patients report PLMS while awake?
a. 10 percent
b. 50 percent
c. 25 percent
d. 70 percent

4. Which of the following agents, used as therapy in RLS, is not contraindicated in breastfeeding?
a. Levodopa
b. Clonidine
c. Clonazepam
d. Propoxyphene

5. Doses of greater than _____ increase a patient's risk of developing vascular fibrosis with pergolide.
a. 4 mg
b. 0.5 mg
c. 2 mg
d. 1 mg

6. In what year was RLS discovered to have a familial link?
a. 1952
b. 1975
c. 1920
d. 1945

7. What percentage of patients report the involvement of arm sensations in RLS?
a. Up to 30 percent
b. Up to 48 percent
c. Less than 1 percent
d. 100 percent

8. Which of the following disease states is not associated with secondary RLS?
a. Pregnancy
b. Iron deficiency
c. Pancreatitis
d. End-stage renal disease

9. What is the earliest age of onset reported for symptoms of RLS?
a. 10 years
b. 50 years
c. 7 years
d. 27 years

10. Restless Leg Syndrome:
a. Decreases with age
b. Is higher in women than in men
c. Occurs more frequently in African and Asian ethnic groups
d. Is always associated with sleep disturbances

11. At what ferritin level is RLS usually associated with iron deficiency?
a. Less than 50 mcg/L
b. Less than 30 mcg/L
c. Less than 18 mcg/L
d. Less than 70 mcg/L

12. What is the goal for iron saturation with iron supplementation?
a. Greater than 16 percent
b. Less than 16 percent
c. Greater than 50 percent
d. Greater than 20 percent

13. What percentage of patients with ESRD has been reported to develop RLS?
a. Up to 25 percent
b. Up to 62 percent
c. Up to 10 percent
d. Up to 75 percent

14. Which of the following is not a risk factor for developing symptoms of RLS in ESRD?
a. Hypoparathyroidism
b. Iron deficiency
c. Vitamin supplementation
d. Subtherapeutic dialysis

15. Which of the following agents requires a dosage adjustment for renal insufficiency?
a. Pramipexole
b. Ropinirole
c. Levodopa
d. Cabergoline

16. Elimination of which of the following commonly consumed substances will most likely not result in a reduction in RLS symptom severity?
a. Alcohol
b. Nicotine
c. Water
d. Caffeine

17. Which of the following does not support the mechanism for the proposed pathophysiology of RLS?
a. Worsening of symptoms with the use of dopamine antagonists
b. Improvement of symptoms with the use of dopamine agonists
c. Increased frequency of RLS in PD patients
d. Dysfunction of acetylcholine observed through imaging

18. What is the first step in treating secondary RLS?
a. Dopaminergic agents
b. Benzodiazepines
c. Opioid analgesics
d. Correcting any underlying causes

19. Which of the following agents is currently the only FDA approved drug for RLS?
a. Rotigotine
b. Ropinirole
c. Pramipexole
d. Levodopa

20. Which is the most common reason for altering dopaminergic therapy?
a. Headache
b. Nausea
c. Augmentation
d. Somnolence

Diagnosis and Treatment For Restless Leg Syndrome

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Quiz: Shade in your choice

	a	b	c	d	e		a	b	c	d	e
1.	❑	❑	❑	❑	❑	11.	❑	❑	❑	❑	❑
2.	❑	❑	❑	❑	❑	12.	❑	❑	❑	❑	❑
3.	❑	❑	❑	❑	❑	13.	❑	❑	❑	❑	❑
4.	❑	❑	❑	❑	❑	14.	❑	❑	❑	❑	❑
5.	❑	❑	❑	❑	❑	15.	❑	❑	❑	❑	❑
6.	❑	❑	❑	❑	❑	16.	❑	❑	❑	❑	❑
7.	❑	❑	❑	❑	❑	17.	❑	❑	❑	❑	❑
8.	❑	❑	❑	❑	❑	18.	❑	❑	❑	❑	❑
9.	❑	❑	❑	❑	❑	19.	❑	❑	❑	❑	❑
10.	❑	❑	❑	❑	❑	20.	❑	❑	❑	❑	❑

Quiz: Circle your choice

21. Is this program used to meet your mandatory C.E. requirements? **a**. yes **b**. no

22. Type of pharmacist: **a**. owner **b**. manager **c**. employee

23. Age group: **a**. 21–30 **b**. 31–40 **c**. 41–50 **d**. 51–60 **e**. Over 60

24. Did this article achieve its stated objectives? **a**. yes **b**. no

25. How much of this program can you apply in practice?
a. all **b**. some **c**. very little **d**. none

How long did it take you to complete both the reading and the quiz? ____ minutes

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A 15-Minute Marketing Plan

By Bob Owens

Ah, the first of the year. Time for getting organized, making better deals on purchasing, and putting that fantastic marketing plan into action, right?

Oops, wait…that last part (about the fantastic marketing plan)…*what* marketing plan?

Okay, so you've been busy, what with the holiday season and all. But now it's 2006 and you've got to do *something* to promote your store.

While it would be great to have a well-thought out marketing plan with the promise of sure-fire results, it's also important to simply get the word out to your community.

Basic Steps

Goodness knows I would like to give you a plan for the whole year, as this is what works best for our pharmacy clients and other small business owners. But in the absence of a plan, I'd like for you to take at least these three basic steps:

1. Promotional Geography

The best choice at first: the area four to six blocks surrounding your store. Get a paper map of your community and highlight your ITA (immediate trading area). Contact the post office or a mailing service to determine the location of postal carrier routes in this area.

2. Create an "Offer" Of Something Valuable

- Don't have vague coupon offers such as "10–20 percent off on anything in the store."
- Don't have a prescription offer unless it is a whole lot better than anyone else for 25 miles around.
- Don't offer something vague like "personal service."
- Do offer (or invite) the community to a free event of some kind, hopefully health oriented. Make sure that the times, place, and benefits of the event are clear on your print materials.
- Do offer free booklets, pamphlets, or videos on health information topics. (The programs we produce feature this type of offer, and it has proven successful.)

Print Material Considerations

Some words of caution: make sure that your materials are designed by a professional. Good design is worth it, and remember, your materials are competing with all the other print advertising that your customers see, and your pharmacy will be judged on the image your materials project.

…your materials are competing with all the other print advertising that your customers see, and your pharmacy will be judged on the image your materials project.

Remember, that whoever does the work or however your print materials are produced, that the "offer" should be the main feature.

Doorhangers

Try this. Make sure the doorhangers are printed on both sides. Make sure the distribution group (boy scouts, church group, family "volunteers," or distribution company) actually do the work. Drive around and check up on them.

Postcards

If you have a mailing list of your customers, use this, and suggest your customers bring a friend when they visit.

Flyers (Or Newspaper Inserts)

A full color flyer inserted in the newspaper can bring good results, especially if geared to seniors and women 45 and older, and if the "offer" will be seen as meaningful. Avoid wasted circulation, though. Check with your newspaper to see if your ITA can be covered efficiently. Don't just substitute a newspaper ad.

Bag Clippers

Use bag clippers stapled to the outside of the prescription bag. Try putting an offer that will involve your customer bringing a friend to visit.

Newsletters

A good newsletter can be welcomed into the homes of customers and prospects. However, newsletters can be very time consuming to regularly produce, and most "do-it-yourself" newsletters don't do justice to the professional image of your pharmacy. (Professional design and writing is especially important here.)

3. Just Do It

The most important thing is to get the word out to your community about your store and project what makes you different and better than your competition. Do try to be consistent by "getting the word out" at least every quarter.

The points I've covered here are barely just a few of the basics and are no substitute for a well-rounded marketing plan, but it's better than spinning your wheels or putting off your local marketing efforts altogether. If you already have a marketing plan ready for the year, that's great. I hope some of these basic points will help. □

Bob Owens is a regular contributor to America's Pharmacist and actively participates in NCPA events. Owens is owner of his own marketing consulting and publishing firm and has recently launched the "Marketing In A Box" program for pharmacies to help make the marketing process easier and more affordable. Owens can be contacted at robert@robertowens.net, by calling 360-318-9485 between 9 a.m. and 6 p.m. PST.

2005: What a Year It Was for Pharmacists

"Pharmacy Technology" contains occasional articles from pharmacy technology expert William A. Lockwood, Jr.

By William A. Lockwood, Jr.

It's amazing how quickly 2005 went by. But this is always the case when there is so much going on, and in pharmacy there is no rest for the weary. As I write this, all eyes are on the impending launch of the Medicare prescription drug benefit under Part D. I have been following this with interest because of the complexity of the TrOOP (true-out-of-pocket) component. I sure hope all this works as planned because if it doesn't, there is going to be a tremendous consumer backlash.

The other component of the Part D program that is garnering a lot of attention is medication therapy management (MTM) services. Will this, in fact, be something the Part D plans give pharmacists a shot at? So far, the only plan that I know of that is committed to pharmacists is Community Care Rx—one reason I favor this plan.

MTM Billing

This takes me to billing for these services. Here I have to applaud the work of the Pharmacist Services Technical Advisory Coalition (PSTAC). Kathryn Kuhn, senior vice president of pharmacy programs with NCPA, is the acting executive director of this coalition and has done an outstanding job in keeping things moving forward.

Also, the long-sought-after CPT (current procedural terminology) codes specific to pharmacy services finally became a reality in 2005. Not to be overlooked were the Pharmacist Services Technical Advisory Coalition (PSTAC) efforts to also ensure that the billing transaction, namely the 837 pharmacy companion guide, was updated to comply with version 4010A1 of this X12 standard. To bill out professional services, whether for Medicare Part D MTMS or commercial plans, the 837 is the required billing standard under HIPAA (Health Insurance Portability and Accountability Act)—the Centers for Medicare & Medicaid Services (CMS) recently reconfirmed this.

This companion guide can serve another useful purpose. It can provide software developers with what needs to be captured during a patient encounter in order to populate the transaction with the required information. Keep in mind, the CPT codes are not an end-all. There is also the need for the billing transaction to carry these codes.

CMI Must Be Addressed

On another topic, something has to be done about the consumer medication information (CMI) being handed out. The industry doesn't appear to be taking the Food and Drug Administration (FDA) seriously on the need to improve the readability and legibility of patient education leaflets. This must be fixed quickly, because time is running out—the FDA will be taking another look at the CMI being distributed in 2006. Fixing it means more than just increasing the point size of the text. If the FDA has to step in and regulate CMI, pharmacists could find themselves printing out a lot more paper, adding extra cost to filling a prescription.

E-Prescribing Still Lagging

Then there is e-prescribing. Why independent pharmacies are lagging behind the chains in getting connected to SureScripts is a mystery to me. My good friend at SureScripts, Ken Whittemore, just wrote a letter to independents urging them to get connected. I agree with all the points he made. With monetary incentives being made available to physicians to get into e-prescribing, we should start seeing more volume here. But I can't help but wonder why the government is willing to subsidize physicians but not pharmacies when they too are part of the equation. Electronic prescriptions figure into the bigger picture of the e-health record, and the Department of Health and Human Services is opening its checkbook here too, to move this along.

2006 certainly looks as if it will be another interesting year. □

This article was originally printed in ComputerTalk for the Pharmacist*, and has been reprinted with permission from William A. Lockwood, Jr., founder and publisher. Lockwood also serves as the executive director of the American Society for Automation in Pharmacy (ASAP).* ComputerTalk *and ASAP are located in Blue Bell, Pa. The author can be reached at wal@computertalk.com.*
Information about SureScripts is available at its Web site www.surescripts.com or by calling 866-RxReady.

PHOTO-ILLUSTRATION: SARAH S. DIAB

New Product News

New From Sicor: Octreotide Acetate Injection

Sicor Pharmaceuticals Sales, Inc., introduces octreotide acetate injection. This product is AP rated to Sandostatin injection. Octreotide is available in 50 mcg/mL, 100 mcg/mL, and 500 mcg/mL concentrations, and in 1 mL single dose amber glass vials. For more information call 800-729-9991, or visit www.sicor.com.

Critical Therapeutics' Zyflo Provides Asthma Aid

Critical Therapeutics, Inc., has launched Zyflo (zileuton tablets), indicated for the prevention and chronic treatment of asthma in patients 12 and older. For full prescribing information, visit www.crtx.com/pat_pi.html or call 866-835-8216.

Novartis Gets OK for Exjade Iron Overload Medicine

The Food and Drug Administration has approved Novartis' Exjade (deferasirox)—he once-daily oral iron chelator. Exjade has been approved for treating chromic iron overload due to blood transfusions in adults and children 2 and older. Exjade iron chelator is administered as a drink (the tablets are dispersed in a glass of orange juice, apple juice, or water). For further information visit www.novartis.com.

Teva Unveils Azithromycin Tablets

Teva Pharmaceuticals USA, has introduced Azithromycin tablets. This product is AB rated and bioequivalent to Zithromax tablets. Azithromycin tablets come in 250 mg, 500 mg and 600 mg. For more information contact Teva at 888-TEVA-USA, or visit www.tevausa.com.

Baxter's Ceftriaxone Infection Injection Product Approved

Baxter Healthcare has received approval from Food and Drug Administration for ceftriaxone injection, USP 1g/50 mL and 2g/50mL packaged in single-dose plastic containers. Ceftriaxone is the generic version of Roche Pharmaceuticals' Rocephin, used to treat a wide range of acute infections. For more information, visit www.baxter.com.

Procter & Gamble Launches New Children's Pepto

Procter & Gamble Co. has launched the new Children's Pepto antacid. It is a 400 mg calcium carbonate chewable tablet (161 mg of calcium) not formulated with salicylates, with children's dosing by age (between 2 and 12) and weight. For more information, visit www.childrenspepto.com.

Gate Introduces Lipid Disorder Treatment

Gate Pharmaceuticals, a division of Teva Pharmaceuticals, USA, has introduced a tablet formulation for Lofibra (fenofibrate). Lofibra is indicated as an addition to diet for treating lipid disorders such as elevated cholesterol and triglycerides. Lofibra tablets are available in 54 mg and 160 mg tablets for once-daily oral administration. For more information, please contact Gate Pharmaceuticals at 800-292-4283.

FDA Approves Valent's Diastat Seizure Treatment

Valent Pharmaceuticals International said the Food and Drug Administration has approved Diastat AcuDial (diazepam rectal gel) for at home treatment of emergency seizures. Diastat is a proprietary drug delivery system that gives physicians and pharmacists greater ability to adapt dosage based on individual patient needs. For more information visit www.caleant.com.

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FACULTY POSITION

Social Administrative Sciences
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The Department of Pharmacy Practice & Science in the College of Pharmacy at the University of Kentucky invites applications for a position with an emerging group of faculty in the social administrative sciences. Currently there are faculty in behavioral science, economics, econometrics, epidemiology and jurisprudence. We are seeking an individual who is complementary to this group and has an interest in assisting in developing plans and business models for innovative models of pharmacy practice, and in the Pharmaceutical Policy PhD program being developed. The College has a significant history in the development of innovative clinical programs. In relation to this the College has new innovative practice models, the PharmacistCARE (http://www.mc.uky.edu/pharmacy/news_archive.asp?id=45) and DATIS (http://www.datisusa.org/overview.asp) programs.

The Pharmaceutical Policy PhD program is being developed in junction with the nationally ranked Martin School of Public Policy and Administration. This PhD program is a natural extension of a long standing joint PharmD/Masters in Public Administration offered by these two academic units. Additional joint programs include the PharmD/MBA and the PharmD/Masters in Economics. The University also has all six health science colleges providing significant opportunities for collaboration and multidisciplinary research.

The successful candidate will be expected to teach in the professional and graduate programs of the Department, and develop an extramurally funded research program. The applicants should have a PhD degree or equivalent with a minimum of two years of postdoctoral training/experience in the person's area of expertise. A professional pharmacy degree will be a strong asset. The level of this tenure track appointment will be commensurate with experience.

Please send a curriculum vitae, a one-page statement of research interests, and the names and addresses of three references to: **Don Perrier, Chair, Department of Pharmacy Practice & Science, College of Pharmacy, University of Kentucky, Lexington, KY 40536-0082.** Or, send this information by e-mail to **dgperr2@email.uky.edu.** Applications will be considered until the position is filled.

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Special Service To Our Readers

A Bull's-Eye Letter on Medicaid

Daniel Hussar, a Philadelphia College of Pharmacy professor, told Rep. Curt Weldon (R-Pa.) the following about the wrong-headed Medicaid pharmacy cuts approved by the House of Representatives on Nov. 18, 2005:

"On Friday morning (Nov. 18), I learned that the House of Representatives had approved H.R. 4241 by a vote of 217 to 215 and that you had voted in support of the bill. I called your office again to record my objection to your vote and, in the course of conversation, the individual with whom I was speaking noted that the bill would not enact 'cuts' but reduces the extent to which increases might otherwise have been provided. I responded that this was absolutely not true with regard to the drug product cost reimbursement or total compensation that local pharmacies would receive to dispense prescriptions to patients in the Medicaid program. It became clear to me that neither he, nor presumably you, recognize the devastating implications that H.R. 4241 has for the local pharmacies in your district and nationally, even though I and other pharmacists have attempted to reach you with this message.

"I recognize that the House and Senate versions of the legislation proposed are different and that these differences must be reconciled. I urge you to be a leader in revising the proposed legislation in a direction that will provide fair compensation to participating pharmacies."

Who Said Pharmacists Were Overpaid?

Many of our members have inquired about the origin of the wrong-headed provisions in H.R.4241 (Deficit Reduction Act of 2005). The answer is clear. In the president's 2006 budget submitted on Feb. 11, 2005, the following proposal was made:

"The budget proposes to require states to reimburse the average sales price (ASP) of a drug to pharmacies for Medicaid drugs, plus a 6 percent fee for storage, dispensing, and counseling. ASP is the weighted average of all non-federal sales from manufacturers, and is therefore a sound proxy for pharmacy acquisition cost. This reimbursement scenario aligns pharmacy reimbursement with pharmacy acquisition cost and will create a more suitable system. Reimbursing ASP + 6 percent is consistent with Medicare reimbursement for Part B-covered drugs as established by the Medicare Modernization Act. (Page 189)"

This approach reflected similar objectives set out by House Energy and Commerce Committee Chairman Joe Barton (R-Texas) following his Dec. 7, 2004 hearing entitled "Medicaid Prescription Drug Reimbursement: Why the Government Pays Too Much." In an Oct. 31, 2005, editorial by Barton in the *Washington Times*, he stated in part:

"Medicaid is a study in contradiction. Thanks to it, America's neediest get health care paid for by taxpayers. Often they get better health care than taxpayers can afford for themselves. The program is both 'free' and break-the-bank expensive. It lets poor people look rich and rich people look poor, and it rewards lawyers and druggists with real wealth."

'Creative' Debate On H.R. 4241

Although not much was specifically stated about the pharmacy issues in the debate on H.R.4241, community pharmacists were specifically targeted in the one hour presentation on Nov. 18 by the designees of House Majority Leader Roy Blunt (R-Mo.): Reps. Jeb Hensarling (R-Texas) and Phil Gingrey (R-Ga.). Their creative exchange included the following grossly misleading comments:

Gingrey: "But pharmaceutical spending is out of control, as it certainly is. Listen to this: Medicaid once paid $5,336 for a prescription that only cost the pharmacist $88 to obtain. The Department of Health and Human Services inspector general found, this was back in 2002, that Medicaid reimbursements exceeded pharmacists' true costs during that year, 2002, exceeded the actual cost by $1.5 billion.

"Every dollar wasted on overpayment is a dollar that does not go to the patients who truly need that benefit."

Hensarling: "Mr. Speaker, if the gentleman will yield for just one point, and I think I heard the gentleman correctly that the government paid over $1,000 for a prescription that should have cost approximately how much?"

Gingrey: "Well, let me repeat that, because I know it sounds unbelievable. It is even more unbelievable than the gentleman from Texas just stated. Medicaid once paid $5,000, not $1,000, but $5,336 for a prescription that only cost the pharmacist $88 to obtain. Now, was that a mistake on the part of the pharmacist? Possibly. We are not trying to single out any individual.

"But the point is that there is so much waste, fraud and abuse; and this oversight is needed. We absolutely need it." □

BY JOHN RECTOR, ESQ., Sr. Vice President for Government Affairs and General Counsel for NCPA.