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A Look Ahead at What to Expect

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A Look Ahead at What to Expect

PLUS

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Gestational Diabetes Counseling

Autoimmune
Psoriasis Treatments

Vaccines
Vaccination Authority Update

Pain
Addressing the Opioid Crisis

Respiratory
Rapid Diagnostic Technologies

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PREPARING FOR A NEW DECADE

Pharmacy Trends in 2020 and Beyond

As we head into a new year, Drug Topics® is exploring some of the latest pharmacy trends and how they will shape the industry in the next decade.

An article from Jennifer Gershman, PharmD, explored upcoming drug pipeline approvals and provides a look at some of the most valuable and exciting drugs expected to be approved by the FDA in the months ahead. She also explores some of these medications’ potential financial impacts.

As Gershman notes, “Vizient, a health care performance improvement company, released its 2019 Drug Price Forecast for health systems, with an expected 4.57% increase for pharmaceutical purchases made from January 1, 2020 to December 31, 2020.” The pipeline looks strong for migraine and oncology medications, as well as some exciting new vaccines, including Merck’s Ebola vaccine.

This issue also features an article focused on upcoming 2020 trends for the industry. How will the role of technology change? What policy changes are slated to impact pharmacy? As the pharmacy profession moves into 2020, pharmacists will need to find new ways to diversify their practice to match the ever-changing landscape.

To help keep you up to date with vaccination policy changes, this issue also offers an article providing an update on state vaccination laws for pharmacists. In this article, pharmacy associations discuss the current status of vaccination regulations and how pharmacists’ can help expand their authority and immunization offerings.

With the new year comes new resolutions, and in this issue you will find recommendations for how to enhance your pharmacy services and get creative with your business offerings. A column in this issue offers advice on how to build on your pharmacy career in the new year with 4 potential new year’s resolutions.

Last but certainly not least, contained within this issue, and of course on DrugTopics.com, readers will find our conference coverage from the American Society of Health System Midyear Clinical Meeting & Exposition held in Las Vegas last month. Thanks for reading and Happy New Year!

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Most Valuable Drugs in the 2020 Pipeline

Here are the top drugs expected to be approved this year

By Jennifer Gershman, PharmD, CPh

According to the FDA, 48 drugs have been approved in 2019, bringing more treatment options to the market for patients.1 Vizient, a health care performance improvement company, released its 2019 Drug Price Forecast for health systems, with an expected 4.57% increase for pharmaceutical purchases made from January 1, 2020 to December 31, 2020.2

Here are drugs in the pipeline expected to be approved in 2020 and their financial impact.

Pipeline drugs for 2020

It can sometimes be difficult to predict which medications will be approved, as there can be drug safety issues that the FDA needs more clarification on and further studies may be warranted, according to Erin Fox, PharmD, BCPS, FASHP, senior director, Drug Information and Support Services, University of Utah Health, Salt Lake City. Fox, who provides budget forecasting in her clinical practice setting, discussed how the budget is generally set after drugs receive FDA approval.

According to Fox, the pharmacy and therapeutics committee reviews the medications, and drug monographs are created to determine whether the new drugs will be added to the hospital formulary.

The FDA approved Eli Lilly’s Reyvow (lasmiditan) for acute treatment of migraine with or without aura, and it is expected to be available in January 2020. Reyvow is unique in that it is the first FDA-approved medication in a new class of acute migraine treatments known as serotonin (5-HT)1F receptor agonists.3

Adakveo (crizanlizumab-tmca) received FDA approval on November 15, 2019, which is 2 months ahead of schedule. Adakveo is manufactured by Novartis and is the first targeted therapy to treat patients with sickle cell pain. Additionally, Adakveo received orphan drug designation, which provides incentives to the manufacturer.4 Alder Biopharmaceuticals submitted the Biologics License Application (BLA) for eptinezumab for migraine prevention, and the expected approval date is February 21, 2020. Eptinezumab is a monoclonal antibody that has demonstrated positive results for migraine prevention in the PROMISE 1 and PROMISE 2 phase 3 studies.5

Seattle Genetics and Astellas have submitted the BLA for enfortumab vedotin for advanced or metastatic bladder cancer, and the target approval date is March 15, 2020. Enfortumab vedotin is considered a novel investigational antibody-drug conjugate that targets Nectin-4, which is a protein that is prevalent in bladder cancer. The BLA submission was based on positive results from the first cohort of patients in the EV-201 pivotal phase 2 clinical trial.6

Merck submitted the BLA for the Ebola vaccine (V920), which was granted priority review with an expected approval date of March 14, 2020.7 Biohaven Pharmaceuticals is studying rimegepant for acute treatment and prevention of migraine. Rimegepant is a calcitonin gene-related peptide receptor antagonist with a long half-life and good oral bioavailability, and the New Drug Application (NDA) has been submitted to the FDA with an expected approval of early 2020. Data presented at the International Headache Conference demonstrated that rimegepant decreased disability by about 41% and reduced lost productivity time by approximately 50% over a 1-year treatment period.8

Alnylam Pharmaceutical’s Givlaari (givosiran) was approved November 20, 2019, earlier than the expected date of February 4, 2020, for the treatment of acute hepatic porphyria, a rare genetic disease that can resemble other conditions and affect quality of life. Givlaari is the first drug approved for this rare disease, and it comes with a high wholesale price of $575,000. Alnylam plans to offer patient assistance and work with insurance companies to help provide coverage.
Drugs In Pipeline

2019-2020 Drug Approval Status Update

<table>
<thead>
<tr>
<th>Drug</th>
<th>Indication</th>
<th>Approval Status</th>
</tr>
</thead>
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<tr>
<td>Lasmiditan (Reyov, Eli Lilly)</td>
<td>Acute treatment of migraine with or without aura</td>
<td>Approved October 11, 2019</td>
</tr>
<tr>
<td>Crizanlizumab-tmca (Adacyjo, Novartis)</td>
<td>Reduction of frequency of vaso-occlusive crises for patients ages 16 years and older with sickle cell disease</td>
<td>Approved November 15, 2019</td>
</tr>
<tr>
<td>Eptinezumab (Alder BioPharmaceuticals)</td>
<td>Migraine prevention</td>
<td>BLA submitted; expected approval date of February 21, 2020</td>
</tr>
<tr>
<td>Enfortumab vedotin (Seattle Genetics and Asettlas)</td>
<td>Locally advanced or metastatic urothelial cancer</td>
<td>BLA submitted; target approval date of March 15, 2020</td>
</tr>
<tr>
<td>Ebola vaccine (V920, Merck)</td>
<td>Prevention of Ebola virus</td>
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<tr>
<td>Rimegepant (Biohaven Pharmaceuticals)</td>
<td>Acute treatment and prevention of migraine</td>
<td>Expected approval of early 2020</td>
</tr>
<tr>
<td>Givosiran (Givlaari, Alnylam Pharmaceutical)</td>
<td>Treatment of acute hepatic porphyria</td>
<td>Approved November 20, 2019</td>
</tr>
<tr>
<td>Tazemetostat (Epizyme)</td>
<td>Epithelioid sarcoma</td>
<td>Approval expected January 2020</td>
</tr>
<tr>
<td>Obeticholic acid (Intercept)</td>
<td>Fibrosis due to nonalcoholic steatohepatitis</td>
<td>Approved expected in 2020</td>
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REFERENCES

The ENVISION phase 3 study demonstrated that Givlaari improved quality of life measures compared with placebo. Epizyme’s tazemetostat was granted priority review for patients with epithelioid sarcoma who cannot receive curative surgery, and approval is expected January 2020. Intercept has submitted an NDA for obeticholic acid for patients with fibrosis due to nonalcoholic steatohepatitis (NASH). Approval is expected in 2020 based on positive results from the REGENERATE phase 3 study showing obeticholic acid improved liver fibrosis without worsening NASH at 18 months. Jennifer Gershman, PharmD, CPh, is a pharmacist and medical writer residing in South Florida.
Optimism is strong around the pharmacy industry as we head into a new decade, and many believe that 2020 is going to be a pivotal year for the industry.

**Top Trends**

Raj Jhala, PharmD, Pharmacist in Charge of Saint Peters Community Pharmacy, located in Saint Peters, Missouri, said that in 2020, more and more pharmacies will be offering delivery.

"From my perspective, with Amazon entering the prescription market with PillPack, and Walmart, Costco, and CVS offering delivery, brick and mortar shops will have to move in this direction," he said. "Every year from here on out will see a greater trend toward delivery."

Brian Nightengale, RPh, president of Good Neighbor Pharmacy, a cooperative network of more than 4500 independently owned and operated pharmacies, said the reimbursement environment has continued to intensify and its impact on the pharmacy segment is going to become more visible in the year ahead.

"Across retail chains and independent community pharmacies, we've already seen poor reimbursement impact bottom lines and ultimately lead to store closures," he explained. "2020 will be a defining year for pharmacies that have stayed complacent and those who have pushed to diversify their businesses. And this year, those who have worked to develop new solutions beyond dispensing will benefit from that decision and see opportunities for more growth."

Ramzi Yacoub, PharmD, chief pharmacy officer at Boston-based RxSense, said as insurance plans and patients continue to try to find ways to help reduce their medical and pharmacy spend in 2020, he foresees increased enrollment in high-deductible health plans (HDHPs).

"As a result, patients will continue to look for lower cost options when purchasing prescription medications," he said. "Patients are increasingly comparison shopping for their medications and taking advantage of prescription savings services like SingleCare to save money on their medications."

In 2020, he also expects the continuation of health care services expanding in retail pharmacy settings as pharmacies try to increase offerings for more convenient services.

"I predict that there will be continued consolidation in the retail pharmacy segment," Nightengale said.
landscape as chains, grocers, and others adjust their footprints to the right size,” Yacoub said. “We’ve already seen 2 of the largest chains announce strategic store closings. Grocers like Raley’s have closed some of their pharmacies and HealthPartners is preparing to close 30 local pharmacies. We also expect to see disruptors in the pharmaceutical industry, such as Roman, Simple Health, Hims and Capsule, continue to focus on the consumer experience.”

Benjamin McNabb, PharmD, owner at Love Oak Pharmacy in Eastland, Texas, believes more pharmacies will enter into new care management and community health worker roles in 2020.

“These are exciting new opportunities because health plans typically spend far more on care management than prescription drugs and industry leaders believe pharmacies can do it much more efficiently,” he said. “To provide these enhanced services, I encourage pharmacies to join an enhanced services network like CPESN(R) and leverage a Pharmacist eCare Plan platform.”

McNabb said Love Oak Pharmacy has used FDS ENGAGE and FDS MYDATAMART to improve patient medication adherence and increase revenue by nearly $500,000.

With things getting tighter with reimbursement, Jhala believes there will be a consolidation of the various branches of pharmacies.

“New hub-style pharmacies will emerge—where there’s 1 large pharmacy that caters to more of the patient population with different offerings and features,” he said. “With more and more prescriptions moving online, we’ll see the growth of these large pharmacy offerings.”

Brian Roberts, CEO of PipelineRx, which offers telepharmacy services and a technology platform designed to optimize clinical pharmacy, said in 2020, he expects the transition to thinking and deploying pharmacists in a more strategic way to continue.

“Specifically, the regulations and focus on antimicrobial management will require greater pharmacist engagement and augmentation,” he says. “We also expect 2020 will see an increasing awareness and use of personalized or genetic screening to inform the management of complex drug protocols.”

As the Centers for Medicare and Medicaid Services (CMS) continue to encourage bundled care and other forms of value-based care, Roberts believes the effective pharmacist-led medication review and verification will be increasingly important to enable health systems to reduce medication variability.

Tech Time

Cathy Kuhn, director of strategy consulting with Updox, president of American Pharmacists Association (APhA) Academy of Pharmacy Practice Management and board trustee with APhA, discussed 2 emerging technologies that will become increasingly important in 2020 (and the rest of the decade): secure text messaging and video chat.

Innovative pharmacists are already using these to offer medication therapy management and inform patients about immunizations and point-of-care testing, in addition to medication follow-ups.

“These tools can help pharmacists engage existing patients by meeting them where they are—on their phones,” she said. “In addition, patients of all ages greatly appreciate the flexibility and convenience of text messaging and video conferencing.”

For example, patients enjoy receiving personalized text and email reminders about refills. Likewise, patients with chronic conditions appreciate the ability to connect with their pharmacist via their smartphone if they have a question about a new medication or need to leave a message.

In the past, a significant pain point for pharmacists has been the ease of transferring patient data from various health care settings to the pharmacy. In 2020, Nightengale thinks the industry will see some big plays in supporting data connectivity between care team members.

“In addition to data sharing, there is a push for independents to meet patients where they are, specifically online.

“Technology, such as social media and mobile apps, has aided in the pharmacist’s role and expanded their reach,” he says. “It has allowed the pharmacist’s knowledge to extend from the pharmacy directly to the hands of their patients, no matter where they are, to create a better patient experience and improve adherence. We expect technology to impact the overall customer experience model and increase the importance of connecting the pharmacy’s physical and digital presence.”

On the pharmacy side, Jhala said it’s going to be easier for independent pharmacy owners to compete against big chains as they innovate and develop new tech. On the patient side, he said it’s going to make it easier for the millennial generation as they age to order and receive their medications.

Yacoub said as telehealth adoption continues to increase, patients are becoming increasingly more accustomed to using these services.

“The continued movement to meet the customers where they are and engage with them according to their preferences will drive retailers to evolve and improve their technology,” he said. “From CVS launching CarePass nationwide to provide delivery of medications, to Costco and Instacart’s pilot to provide local delivery of medications, you will also see more movement from old mainframe legacy systems to the cloud. This
New Policies

Ken Whittemore Jr., vice president of professional & regulatory affairs for Arlington, Virginia-based Surescripts, an information technology company that supports e-prescriptions between health care organizations and pharmacies, said NCPDP SCRIPT v2017071 is the topic that leads all of its conversations, as the industry prepares for CMS’ upcoming deadline.

Beginning January 1, 2020, all electronically transmitted prescriptions must be sent using the new SCRIPT Standard version 2017071, replacing SCRIPT Standard 10.6.

“The transition to the new standard is complex, the benefits are clear: it will modernize electronic prescribing and medication history, improve patient safety and prescription accuracy, and create workflow efficiencies for clinicians and pharmacists,” he said. “NCPDP’s SCRIPT v2017071 will improve the e-prescribing process in hundreds of ways, many of which are game changers for pharmacy staff.”

Whittemore shared that enhancements to the SCRIPT standard fall into 2 categories: 1) the incorporation of new and/or enhanced data segments, elements, and codes to existing message types, such as new prescriptions; and 2) the addition of new message types, such as the ability to transfer electronic prescription information between pharmacies (RxTransfer), or for physicians to proactively set messages that tell pharmacy staff who to call for refill or for a follow-up appointment (FollowUp Prescriber).

An expected new policy to look out for is the potential for pharmacists to be considered health care providers. Yacoub noted this would be a significant win for the pharmacy community, improving patient care and increasing access to much-needed services.

“After the last few years of vertical integrations—with retail pharmacy deals such as Walgreens and Rite Aid—I expect hospital mergers to see smaller scale deals occurring in 2020, primarily focusing on adding capabilities to improve the customer experience and enhancing their specialty pharmacy offerings,” he said.

A policy about opioid management may also come into play in 2020. Roberts noted that although CMS has not mandated opioid management in an inpatient setting or tied reimbursement penalties to this, it is a likely outcome of the current opioid challenge the United States faces.

“Fortunately, health plans and employers are very focused on this, as are state governments creating an important opportunity to support the proper use of these medications through an integrated technology and service platform,” he said. “This allows hospitals to maintain opioid stewardship programs without having to hire additional in-house staff to manage these programs.”

Michael Schneider, a principal at Avalere Health, a health care consulting firm said the Medicare Part D benefit redesign is potentially the biggest change as Medicare Part D members could have a maximum out-of-pocket cost.

“Congress aimed to make drugs more affordable to those in Part D plans, and it will affect drug pricing directly,” he said. “The interpretation and understanding of new laws will have a significant impact on PBMs and their clients. I expect that in 2020 we will see how pharmaceutical manufacturers and Medicare Part D plan sponsors respond to increased liability expected the following year as the pharmacy industry likely won’t see changes for business until 2021.”

A Peek into the 2020’s

By 2030, the industry is expected to undergo even more dramatic changes, with technology playing a bigger role than ever before.

McNabb expects the future of pharmacy to be in value-based payment (VBP) models and addressing social determinants of health.

“New VBP models are incentivizing pharmacies to approach patient care much more comprehensively and require pharmacies to move beyond dispensing,” he said.

Nightengale said the reimbursement environment is failing community pharmacies, and that should change in the next 10 years.

Still, the biggest change is expected to come about with more reliance on machine learning and artificial intelligence, according to Roberts.

“These systems should not only replace routine tasks such as patient reminders, physician communications, and direct intervention when required, but also proactively identify high-risk patients for more targeted review and interventions,” he said.
Get A New Certification

According to the American College of Clinical Pharmacy (ACCP), a board certification indicates an extra level of skill and expertise and can lead to personal satisfaction, financial reward, and career advancement. Not to mention, in this competitive job market, a certification will surely make one stand out from the crowd.

Patty Taddiei-Allen, PharmD, MBA, BCACP, BCGP, Senior Director of Clinical Analytics at WellDyneRx, advises pharmacists to perform self-reflection to “assess where you are in your career and what you hope to achieve in the short term (within 1 year) and long term (in the next 3 to 5 years).”

Once you identify your goals, Taddiei-Allen recommended assessing what skills are necessary to achieve these goals. For example, when she knew she wanted to design and deliver clinical programs, she realized that a Board Certification in Ambulatory Care Pharmacy would be a great certification to achieve, giving her a broad focus on chronic disease management. From there, she went on to obtain her BCGP, knowing that the elderly population was rapidly growing and would need clinical services.

Taddiei-Allen credits her certifications with helping her to develop clinical programs and analytics as well as formulary management. A bonus: “The ongoing board certification education requirements, which are intense and...”

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require focus and true understanding of clinical principles, also keep me on my toes and up to date with relevant clinical care.”

**Go Green**

According to an article in PBA health, customers prefer shopping from companies committed to the environment.

“We believe it is our responsibility to maintain this planet for future generations,” Courtney McQuade, PharmD, owner of McQuade’s Marketplace pharmacies, said. “We are always looking to improve our environmental impact. As grocery store pharmacies, we always strive to provide the best service while helping to maintain the environment for future generations.”

McQuade’s deliveries, both prescriptions and groceries, go out in diesel vans that have been retrofitted to use vegetable oil that is a waste product of their kitchens and cafe. They boast a large solar array, converting natural sunlight into energy and have also eliminated plastic bags at the checkouts, using recycled paper bags instead.

Additionally, McQuade is replacing a large percentage of health and beauty care products with sustainable lines that use minimal packaging. The stores carry many other items that are reef safe and packaged in metal tins. Dr Bronner’s soaps and washes are a hot seller due to the company’s commitment to the environment.

**Get Out From Behind The Counter**

According to ASHP Guidelines on Pharmacist-Conducted Patient Education and Counseling, “pharmacists can contribute to positive outcomes by educating and counseling patients to prepare and motivate them to follow their pharmacotherapeutic regimens and monitoring plans.”

A major cause of nonadherence is that patients do not understand their conditions and medications and the importance of adherence to therapy. However, in the daily chaos of being overworked and understaffed while trying to add in dozens of immunizations, how do we find time to fulfill our duty to help patients?

Trisha Winroth, PharmD, is the pharmacy manager at Walgreens in Lowell, MA. She acknowledged, “Counseling patients in a busy retail setting is an
ongoing challenge as the demands grow to do more with less.” Winroth prioritizes patient-centered tasks and delegates other tasks to her qualified technicians. “Training and engaging technician staff to work at their top capacity frees up valuable minutes for pharmacists to engage with patients.” For example, with vaccinations, her technicians perform data entry, go over paperwork with the patient, and ring up the sale, so that the pharmacist can spend time speaking to the patient while administering the vaccine.

“A successful pharmacy team will quickly develop methods to ensure the patients who need the pharmacist’s time get it.”

Bhavana Mutha, RPh, BCMAS, reminded us that “counseling patients is one of the most important aspects of pharmacy.” Mutha recalled a time when, on just another routine, hectic day at the pharmacy, she noticed a patient who seemed out of sorts. “I immediately stepped out of the pharmacy. This woman was 7 months pregnant, dizzy, and about to fall. I had her sit down and checked her blood pressure. The number was very low. I directed the technician to maintain the pharmacy workflow and had another member of the team grab Gatorade while keeping her in sight.”

Mutha and her pharmacy team helped the patient, staying with her until she felt better, reached out to her family, and made sure she made it home safe. Feeling gratification from helping this patient out of a risky situation, Mutha proudly said, “We are the face of health care, with so much knowledge, and should abide by counseling in our role.”

**Get Reimbursed For Services**

We hear a lot about provider status and pharmacists being reimbursed for clinical services.

Ambulatory care pharmacists are already being reimbursed for services such as anticoagulation, behavioral health, and oncology. Some pharmacists are billing for office visits. Often, getting reimbursed involves getting creative, forming collaborative practice agreements with physician offices, offering enhanced services such as medication consultations or managing prior authorizations.

After completing his community pharmacy rotation, Michael Higbee, PharmD, pharmacy manager and clinical specialist at Buhl Drug in Buhl, Idaho, saw the potential in providing reimbursable clinical services to the community.

Soon after he graduated pharmacy school, Higbee opened Buhl Drug. “From the start, I focused on MTM services, employer health programs, and physician outreach.” Over the last 9 years, Higbee has built a fee-for-service patient care pharmacy.

Through marketing his MTM services, he receives patient referrals from local providers who pay cash for clinical services. Higbee goes out into the community to provide on-site flu shot clinics for various clubs, businesses, schools, and municipalities, billing directly for those services.

Building on those relationships, he offers smoking cessation treatment and weight loss clinics, charging the employer $40 per employee who enrolls.

Several years ago, Higbee wrote a collaborative practice agreement with a local physician so he could prescribe smoking cessation therapies. Since then, laws have changed in Idaho and pharmacists are allowed to prescribe for a host of conditions. Because they cannot currently bill insurance for these services, they charge a competitive cash price in line with insurance copays.

“Patients are usually happy to pay the small service fee because they can get quick service instead of waiting days to get into an available doctor,” Higbee said.

Higbee, who has been recognized for outstanding outcomes and was a regional McKesson Healthmart Pharmacy of the Year winner, also regularly prescribes naloxone (Narcan) to patients on opioids, without charging for that service.

“I personally feel so much more fulfilled with my career when I am an active participant in my patient’s health care team. Pharmacists learn and train to provide these services, but all too often are stuck just trying to keep their head above water in understaffed pharmacies. There is nothing better than making a real difference for my patients.”

**REFERENCES**

Patients with diabetes now have access to more technology than ever before to help them manage the chronic disease, but the devices can be complicated for patients to use.

“The diabetes technology space is growing very quickly. No one really has ownership of this space, there’s a lot to learn and so this is really a great opportunity for pharmacists,” said Diana Isaacs, PharmD, BCPS, BCACP, BC-ADM, CDE, a clinical pharmacy specialist at the Cleveland Clinic Endocrinology & Metabolism Institute Diabetes Center in Cleveland, Ohio.

Isaacs believes pharmacists can be particularly valuable in helping patients master the use of continuous glucose monitoring (CGM) devices now that 2 of the devices—the Freestyle Libre and Dexcom G6—are available for purchase at local community pharmacies.

“I think with CGM especially there’s a huge opportunity because now CGM can help patients learn about different adhesive options to get the devices—which have to be worn in the Libre for 14 days and the Dexcom for 10 days—to stick. Two of the 3 insulin pumps on the market can now be integrated with CGMs and an increasing number of patients are relying on mobile apps and glucose meters that can be directly connected to Bluetooth through various platforms.

Norman Tomaka, BS, Pharm.MS, FAPhA, a media spokesperson for the American Pharmacists Association, said pharmacists are the ideal providers to partner with patients on learning how to use this complex technology because of their long history with patient counseling.

“Pharmacists are used to working with patients at every level and helping to tap into what resources the patient needs for a successful outcome so what better medical professional at the point of care access than a pharmacist to help with this evolving technology in diabetes and other disease states,” said Tomaka, who works as a health system pharmacist and has almost 30 years of experience in community pharmacy.

By helping patients manage the technology associated with treating diabetics, pharmacists can demonstrate their value to payers and other care providers as well as solidify their position with the patients they serve, Tomaka added.

But for pharmacists to seize the opportunity in the market, they will have to stay current on the latest diabetes technology.

Isaacs recommends free diabetes technology resources available free to members of the American Association of Diabetes Educators or the website diaTribe.

“Read up as much as you can,” Tomaka said. “Don’t be afraid of it.”

He recommends trying to meet patients where they are instead of forcing patients to use certain technology.

“You have to be able to manage the patient and match the technology to the level of the patient’s desires and abilities. Not everybody is willing to do that.”
Implementing rapid diagnostic technologies (RDTs) into a health system can improve outcomes for patients and may be helpful in reducing unnecessary antibiotic use, according to data presented at the 2019 Annual American Society of Health-System Pharmacists Midyear Clinical Meeting & Exposition.

Katie Lusardi, PharmD and Clinical Pharmacist of Infectious Disease and Antimicrobial Stewardship at the University of Arkansas for Medical Sciences and Brandon Hill, PharmD and Clinical Pharmacist of Infectious Diseases at University of Virginia Health reviewed the multitude of RDT platforms available to practitioners and noted the role these technologies can play in collaborating with antimicrobial stewardship programs (ASPs).

There are a wide variety of blood and respiratory RDT platforms available, Dr Lusardi said, but RDT are only impactful when the data are available quickly, in conjunction with active interventions to help guide antibiotic decisions.

Making the Case for RDT Implementation
Dr Hill noted that high rates of hospital-acquired infections can lead to a lack of reimbursement from the Centers for Medicare and Medicaid Services (CMS), but showing how RDTs can impact patient care and the use of antimicrobials may convince the hospital “C suite” staff to invest in more of these technologies.

He suggested using publicly reported data available to patients via Medicare.gov to demonstrate to hospital administrators that RDTs can improve facility standings. Effective and timely care can improve sepsis recognition and management, he said.

As of March, hospitals are being asked by CMS to establish ASPs, and RDTs can help facilities gain traction in reducing unnecessary antibiotic use.

Dr Hill connected how using RDT can play a role in helping to fulfill some of the CDC’s Core Elements of an ASP:

- **Pharmacy Expertise:** RDT helps clinical pharmacists streamline the process for identifying appropriate treatment options and ensuring those medications are administered in a timely manner.
- **Actions:** RDT helps with prospective audit and feedback and offers measurable outcomes.
- **Tracking:** RDT results can be used to monitor compliance with ASP recommendations and can provide a tangible outcome to be tracked following implementation.
- **Reporting:** ASPs can use RDT to facilitate communication with key stakeholders on outcomes, and results can show pharmacy activities and their impact.
- **Education:** Educating administrators and clinicians on RDT can improve acceptance when beginning a new initiative; providing RDT data to raise confidence in ASP and new technology.

To persuade hospital leadership to embrace purchasing more RDT technologies, Dr Hill suggested enlisting an interdisciplinary group, incorporating goals and a vision for the health system, and highlighting previously published studies that show patient and institution specific benefits of RDT.

Dr Hill urged attendees to prepare a detailed RDT proposal that predicts changes in outcomes of interest such as potential clinical and financial benefits. Implementation also should have regular updates on the impact of RDT in collaboration with an ASP based on pre-determined tracking and reporting methods. Finally, Dr Hill said that development of a structured algorithm for implementing RDT and ASP interventions are key in successfully implementing these strategies.
As the most accessible health care providers, pharmacists are in a unique position to counsel patients with gestational diabetes about the importance of taking their medications and lifestyle interventions.

In a poster presentation at the 2019 Annual American Society of Health-System Pharmacists Midyear Clinical Meeting & Exposition, Taylor McGhee, who is a PharmD candidate at High Point University Fred Wilson School of Pharmacy, and her colleagues noted that “a prospective pharmacist intervention to be made in these patients is proper initiation therapy with oral diabetes agent or injectable insulin as well as strict insulin control and titration during weeks 26 to 36.”

In an interview with Drug Topics® at the meeting, McGhee said that although the study was in a health system setting, retail pharmacists have a role to play in counseling patients with gestational diabetes as well.

The study researchers included 30 patients with gestational diabetes who had a mean hemoglobin A1c of 5.28 and a mean body mass index (BMI) of 32.05.

Although the patients’ treatments were managed by nurse and nurse practitioners, McGhee said their findings, which noted 3 patients who were given a rapid acting insulin either didn’t pick them up or didn’t use them, clearly demonstrated where a pharmacist’s intervention could have helped.

McGhee said that in this sample, no pharmacists were involved in patient management, but if they had been involved, it’s possible that the patients’ adherence to their recommended regimens would have been better. The researchers also noted that since about 67% of the patients with high AC ratios had babies with hypoglycemia less than 45 mg/dl at birth, the potential clinical implications of a pharmacy-led intervention become even more clear, she explained.

In their poster, the researchers noted that “medication adjustments by a clinical pharmacist can be made based on A1c percentages and self-reported blood glucose readings. Having clinical pharmacists available to gestational diabetes patients within ambulatory care settings could help lead to improved gestational diabetes care and better outcomes for both mother and baby.”

In the retail setting, McGhee noted that pharmacists can be another important health care provider for patients. Discussing the importance of adherence to recommended diabetes treatments, counseling about interventions and “just being another person to talk to about all this,” are key, she said.

2% to 10% of pregnancies in the United States are affected by gestational diabetes, and approximately 50% of women with gestational diabetes go on to develop type 2 diabetes.

Source: CDC
When it comes to state vaccination laws, pharmacists are gaining increasing authority to administer immunizations, but association experts say there’s still work that needs to be done.

“Pharmacy differs from other health professions like medicine in that our authority is state dependent,” Mitchel C. Rothholz, RPh, MBA, Chief Strategy Officer for the American Pharmacists Association, said. “Our vision for pharmacists’ authority is that pharmacists will be authorized to administer all (Advisory Committee on Immunization Practices) recommended vaccines as valued members of the immunization neighborhood.”

Although pharmacists in all 50 states have been given the authority to administer influenza vaccines to adult patients, pharmacists in some states are still limited by which vaccines outside of influenza they are able to administer, the age of patients they are able to administer to, and whether a patient needs a prescription before getting a vaccine at the pharmacy.

**Current Landscape**
According to a January 2019 report released by the National Alliance of State Pharmacy Associations, pharmacists in 48 states—including Puerto Rico and the District of Columbia—are authorized to administer all vaccines to adult patients. However, 9 of those states require prescriptions for at least some of the vaccinations.

Four states still do not have the authority to administer all vaccines, the report found.

Many states also continue to limit pharmacists’ vaccination authority by age restrictions for the patients they are able to immunize, with just 27 states allowing pharmacists to administer to any age—for at least for some of the vaccinations, according to the report.

“With respect to pharmacists’ authority to be able to administer vaccines, there’s just a patchwork of laws across the country,” Michelle Cope, director of federal and state public policy for the National Association of Chain Drug Stores (NACDS), said.

Some states have made recent progress to expand pharmacists’ authority. In Wisconsin, a bill was recently passed that expands a pharmacists’ ability to administer vaccines for any age, as long as a prescription is obtained for certain vaccines. It also gives authority for pharmacy students to administer vaccines if they are under the direct supervision of a pharmacist.

Legislators in South Carolina are also expected to consider a bill in the upcoming legislative session that would lower the age for pharmacist-administered vaccines. What makes this bill unique, according to Allie Jo Shipman, PharmD, MBA, director of state policy for the National Alliance of State Pharmacy Associations, is that it was brought up by parents who wanted to see the changes made.

“You are seeing now that it’s not just pharmacists, but the public, I feel like the patients are really starting to see the pharmacy as the place that they go for that public health care,” Shipman said.

**Goals Of Pharmacy Associations**
Although there has been advances at the
state level, pharmacy association leaders say there is still progress to be made.

“Our broadest policy goal is for pharmacists to have autonomous authority to provide immunizations for all FDA-approved vaccines that are available and that have been approved by the FDA in the same manner as all other vaccine providers,” Mary Ellen Kleiman, senior vice president of state government affairs/deputy general counsel for NACDS said.

Cope said NACDS is now looking to “standardize” the vaccine types that can be administered while also eliminating the administrative barriers that still exist in some states that make delivery more challenging.

John Beckner, RPh, senior director of strategic initiatives for the National Community Pharmacists Association (NCPA) echoed those sentiments, saying the NCPA believes pharmacists should be able to administer any approved vaccine to any patient.

“I think NCPA as an association really believes that immunization services really need to be a core competency of the pharmacy profession,” he said. “It’s such an important service that we offer and we began offering it in the mid-to late ’90s, so obviously something that we feel is very important.”

In addition to expanding authority for pharmacists, Beckner believes that it’s also important to give pharmacy students the authority to administer vaccines under the supervision of a trained pharmacist as part of their training.

“Certainly, it makes sense that these students and interns need to be trained to provide immunizations if it is going to become a core competency and service offered by all pharmacies,” he said.

**Tackling the Under-17 Market**

One of the largest challenges remains expanding pharmacists’ authority to administer vaccines to those patients 17 years of age and younger.

Pediatricians and legislators have historically been more cautious in allowing these vaccines to take place outside the physicians’ office, but Cope said she believes pharmacists’ success in adult immunizations has helped to quell possible concerns.

“It’s just getting policy makers to get comfortable with the idea, but the evidence now has grown that pharmacists are great providers for vaccines, that they are convenient to access, that they can help improve overall vaccine rates, so I think with that growing evidence that’s really kind of put policy makers minds at ease around this,” she said.

Although the rate of adolescents who are receiving the recommended vaccines continues to rise, the population group continues to lag behind younger children, according to the US Department of Health and Human Services.

Cope believes if pharmacists in more states are given the authority to administer vaccines to adolescents, they could help close this gap and improve adolescent vaccination rates.

“If we’re opening pharmacists’ vaccines up to that age group in particular, given that pharmacists have historically improved vaccine rates, I think that that can really help to address that,” she said.

**What Pharmacists Can Do To Help**

Pharmacists can help expand pharmacists’ authority on an individual level by continuing to demonstrate their capabilities and value as an immunization provider.

“When others outside our profession advocate for our increased inclusion then we are doing things right—and there are folks doing this,” Rothholz said.

Shipman said pharmacists also need to make sure “they are doing everything in their practice to provide the vaccines that people need,” whether that’s expanding the current offerings, keeping vaccines fully stocked, or taking a proactive approach to determining which vaccines a patient may need.

Although the industry has “made incredible progress,” Shipman said there is still “a long way to go.”

Advances can still be made both within state legislatures and in individual pharmacies themselves as they continue to offer more vaccine options for patients.

“I think that’s the area where we as an association are encouraging our members to expand is their vaccine portfolio because it’s such an opportunity for them to diversify their revenue, but it’s also an opportunity for them to have an impact on the public health arena,” Beckner said.

Pharmacists can also support the efforts of their state pharmacy associations by inviting state legislators into their practices to show the value of the services they provide or take a more active role in advocacy efforts at the state level themselves.

“Certainly, pharmacists on the state and local level can become actively involved with their legislature, they can continue to forge relationships in the medical community and really market and advertise their services to let people know that they are an immunizer and what vaccines they are able to offer,” Beckner said. “The more people that know about it, the more likely that it’s going to be an accepted practice.”

For references, visit drugtopics.com.
Pharmacists can play an integral role in managing patients with psoriasis through medication therapies and lifestyle modifications.

Psoriasis is a common chronic autoimmune disease that affects the skin, causing raised, red, scaly patches. Complications may include psoriatic arthritis, metabolic disorders, and cardiovascular disease.

Psoriasis Treatment Options and Counseling Pearls

Treatment for psoriasis can be broken down into 3 categories: topical, phototherapy, and systemic medications. Phototherapy is a prescription treatment usually performed by a dermatologist that involves exposing the skin to controlled amounts of ultraviolet light. Most patients with mild-to-moderate psoriasis can have their symptoms controlled with topical medications or phototherapy, while biologics should be reserved for individuals with moderate-to-severe psoriasis. Topical corticosteroids are the most common treatment option for mild-to-moderate psoriasis and may be combined with phototherapy for more severe cases. It is important for patients to apply a small amount on the affected areas. Pharmacists should recommend short-term use of corticosteroids since they can cause thinning of the skin and may stop working over-time. Systemic medications are used to treat moderate-to-severe psoriasis and are an option for patients that do not respond to topical drugs or phototherapy. Acitretin (Soriatane) is an oral retinoid taken once per day with food. Acitretin can cause severe birth defects so it’s important to counsel that women of childbearing potential must have 2 negative pregnancy tests before starting the medication, and use 2 effective forms of birth control at least 1 month before beginning therapy, while on the drug, and for 3 years after stopping. Cyclosporine is taken orally daily for up to 2 years and may increase the risk of developing infections, kidney problems, hypertension, and skin cancer. Methotrexate is available orally and as a subcutaneous injection and may cause stomach pain, appetite loss, and fatigue as well as serious adverse effects including liver damage and low blood counts. Apremilast (Otezla) is taken orally twice per day, and adverse effects include diarrhea, nausea, and vomiting. Tofacitinib (Xeljanz) is taken orally once or twice daily, and adverse effects include upper respiratory infections, headache, diarrhea, and an increased risk of serious infections.

Biologics target specific parts of the immune system and are taken by injection or intravenous infusion. Medications include certolizumab pegol (Cimzia), secukinumab (Cosentyx), etanercept (Enbrel), adalimumab (Humira), infliximab (Remicade), and brodalumab (Siliq), among others. Biologics can increase the risk of infection and tuberculosis screening is required prior to starting therapy. All inactivated vaccines can be given with biologics; however, biologics may need to be stopped prior to and after administering live vaccines.

For references, visit drugtopics.com
The opioid crisis continues to be one of the worst public health crises that the United States has ever seen. Opioids—mainly synthetic opioids (other than methadone)—are currently the main driver of drug overdose deaths. According to the CDC, opioids were involved in 47,600 overdose deaths in 2017 or 67.8% of all drug overdose deaths. Approximately 2.1 million Americans live with opioid use disorder.1

Some small signs of improvement have come to light. Opioid prescribing has declined since 2012, and July 2019 data from the CDC demonstrated a 5.1% decline in overdose deaths for the first time since 1990.1 “These numbers are provisional and positive, but improvement is minimal and slow,” Jim Lichauer, PharmD, BCPS, FASHP, program director for Pharmacy Performance Improvement Collaboratives at Vizient, a health care performance improvement company, said. “Increased awareness, appropriate education regarding opioid risks and benefits, and education on non-pharmacologic and non-opioid alternatives have improved prescribing practices.”

The federal government continues to address the crisis with new regulations, said Katharine Van Tassel, JD, MPH, visiting professor of law, Case Western Reserve University School of Law. In the summer of 2019, the FDA issued new draft guidance, “Opioid Analgesic Drugs: Considerations for Benefit-Risk Assessment Framework,” which describes the application of the benefit-risk assessment framework that the agency uses in evaluating applications for opioid analgesic drugs.

“Normally, when deciding whether to approve a new drug, the FDA only looks at the risks and benefits to patients who take it as directed, not risks to everyone else,” Van Tassel explained. “Under its new proposal, the FDA will consider whether a new opioid works better than other painkillers—opioid and non-opioid—that are already on the market. Officials will also analyze a new drug’s potential impact on public health.” For example, does it have characteristics that might tempt people to misuse it, such as it being very potent, or easy to crush, dissolve, and inject.

On another front, the Drug Enforcement Administration (DEA), which is responsible for keeping controlled substances from being diverted for abuse and sets a quota for how many opioid pills drug makers are allowed to produce in the United States along with input from the FDA and drug manufacturers, is proposing that appropriate quota reductions be made only after estimating the potential for pills to be sold illegally. Under the proposal, the diversion potential would be based on rates of overdose deaths and abuse, as well as the overall public health impact related to specific controlled substances.

Furthermore, the FDA is using its authority under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018 to mandate short-duration packaging for outpatient dispensing of certain solid, oral dosage forms of immediate-release opioid analgesics to treat acute pain and require manufacturers to develop technologies such as mail-back pouches to dispose of unused opioid medications, Van Tassel reported.

The FDA also plans to announce changes to strengthen the Risk Evaluation and Mitigation Strategy for transmucosal immediate-release fentanyl medicines, and issue updated guidance to promote the development of non-opioid drugs to treat pain, Van Tassel added.

Finally, the FDA is focused on securing the legitimate supply chain and doing more to hold distributors responsible. Under the Drug Supply Chain
Security Act (DSCSA), manufacturers, re-packagers, wholesale distributors, and dispensers—which are all mainly pharmacies—are all required to have systems and processes in place to quarantine and investigate suspect and illegitimate medications, Van Tassel said. “The FDA plans to ensure that entities responsible for maintaining the supply chain take measurable steps under the law to appropriately track and trace opioid medications as these products move through the supply chain, and to respond to incidents involving illegal or illegitimate products to protect the public health,” Van Tassel said.

States also issue their own laws regarding drugs, which generally address limiting initial prescription quantities, requiring prescribers to query the state’s prescription drug monitoring program prior to prescribing, requiring provider education or training as well as patient education, and requiring co-prescribing of naloxone, the opioid reversal agent, Lichauer said.

The Pharmacist’s Role
Regarding states’ rules, Lichauer said that limiting initial prescription quantities will reduce the potential for leftover pills, which can fall into the wrong hands and be misused, and can lower the risk of long-term opioid dependency. A CDC study correlated higher initial prescription quantities with a greater risk of continued use at 1 and 3 years. The same study also demonstrated an increase in continued use at 1 and 3 years for patients who received a third prescription refill of their initial opioid pain medication.

Upon dispensing in most states, pharmacists are required to query a patient’s history in the prescription drug monitoring program (PDMP) database. “Pharmacists need to know their state regulations on prescription quantities and refills as well as requirements for patient education,” Lichauer said.

Pharmacists should be sure that their entire staff is registered for their state’s PDMP and that they check it every time a controlled substance medication is dispensed, said Andrew Smith, PharmD, BCPS, BCCCP, assistant professor and PGY-2 emergency medicine residency program director, Touro College of Pharmacy. Furthermore, since pharmacies are required to send data to the state for this reporting program, finding ways to streamline the reporting process will help decrease their perceived workload burden.

Pharmacists need to review their state laws and figure out what their roles can be to help their communities. “If naloxone is available as a standing order under state law, pharmacies should be sure to have an adequate supply and they should train their pharmacists and interns to counsel patients and be candid about the risks of even a short course of opioids for patients,” Smith said. Furthermore, pharmacies should become more familiar with medication-assisted treatment (MAT) as more emergency physicians begin initiating treatment in the emergency department as a bridge to long-term treatment with an addiction medicine specialist. MAT will grow over time as more patients get the help they need.

Van Tassel said that pharmacists are stepping up to address the opioid crisis by playing an active role in stewardship programs to prevent opioid misuse. These programs are designed to promote appropriate use of opioids, improve patient outcomes, and reduce the misuse of opioids.

Pharmacists are also participating in opioid stewardship programs through clinical education and guideline generation, and by using PDMP database searches to track prescribing practices and patient behavior that can drive opioid abuse, Van Tassel said. Pharmacists are monitoring prescribing practices to identify outliers among providers, to assess the appropriate use of clinical decision support, to impose restrictions on specific opioids and doses, and to provide daily feedback to prescribers.

Most hospitals assign pharmacists to play pivotal roles in drug therapy management. Pharmacists do so by assessing therapeutic drug levels, patient outcomes, laboratory results, and adverse drug events to track potential opioid abuse, Van Tassel concluded.

For references, visit drugtopics.com.

Karen Appold is a medical writer in Lehigh Valley, Pennsylvania.
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NEW DRUG REVIEW

Lefamulin (Xenleta) for Community Acquired Bacterial Pneumonia

By Allissa M. Long, PharmD and Kevin W. Chamberlin, PharmD, FASCP

Community acquired bacterial pneumonia (CABP) can result in hospitalizations, morbidity, and mortality. Streptococcus pneumoniae is one of the most common bacterial pathogens and has shown increased resistance to typical antibacterial therapies. Lefamulin, a novel pleuromutilin antibiotic that inhibits the 50S ribosomal subunit at the peptidyl transferase center, with known activity against typical CABP organisms, was approved by the FDA in August 2019 for the treatment of CABP.1,2

Efficacy
In the LEAP 1 trial, lefamulin was shown to be noninferior to moxifloxacin ± linezolid (if MRSA coverage necessary) in the treatment of CABP in hospitalized adults. In a randomized controlled trial, IV to PO lefamulin was as successful as IV to PO moxifloxacin ± linezolid at improving at least 2 CABP symptoms without worsening of CABP or the need to receive a non-study antibiotic for treatment.2

In the LEAP 2 trial, oral lefamulin demonstrated noninferiority to oral moxifloxacin for CABP. PO lefamulin was as successful as PO moxifloxacin at achieving resolution of CABP symptoms without worsening of CABP or the need to receive a non-study antibiotic for treatment.3

Although in the LEAP 1 trial lefamulin was used to treat CABP caused by MRSA, the product package insert does not endorse that use due to only treating a small number of patients in the study and the need for additional antibiotics for treatment.4

Spectrum of Activity

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<th>Gram-Positive Bacteria</th>
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<td>Streptococcus pneumoniae</td>
<td>Haemophilus influenzae</td>
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<td>Staphylococcus aureus (MSSA)</td>
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<td>Legionella pneumophila</td>
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Safety
Commonly reported adverse events related to lefamulin in LEAP 1 and LEAP 2 include administration site reactions, elevation of hepatic enzymes, nausea/vomiting/diarrhea, headache, insomnia, and hypokalemia. Serious adverse events include QTc prolongation and the risk of Clostridium difficile-associated diarrhea. No C. difficile infections were observed in either treatment arm of LEAP 1 and 1 incidence of C. difficile was associated with lefamulin treatment in LEAP.2,3,4

Dosage and Administration
Lefamulin IV is dosed at 150 mg every 12 hours over 60 minutes for 5-7 days. It can be switched to oral therapy once the patient is clinically stable. Lefamulin IV is available as a 15 mL vial that will be further diluted by addition into a supplied diluent bag that contains 250 mL of 10 mM citrate buffered 0.9% sodium chloride. Lefamulin PO is dosed at 600 mg every 12 hours for 5 days. Take the tablets at least 1 hour before or 2 hours after a meal. The tablets cannot be crushed or split.4

In patients with severe hepatic impairment (Child-Pugh Class C), lefamulin IV should be heparically dose-adjusted to 150 mg IV every 24 hours over 60 minutes. Lefamulin PO has not been studied in patients with hepatic impairment. Both lefamulin formulations do not need to be renally dose adjusted.

References
Sunosi for Excessive Sleepiness in Adults with Narcolepsy or Obstructive Sleep Apnea

By Andrew J. Fratoni, PharmD and Kevin W. Chamberlin, PharmD

Narcolepsy and obstructive sleep apnea (OSA) are associated with excessive sleepiness. Several monoamines such as norepinephrine and dopamine impact wake-promotion and have been popular drug targets.

Solriamfetol (Sunosi, Jazz Pharmaceuticals) to treat excessive sleepiness in adult patients with narcolepsy or obstructive sleep apnea was approved on March 20, 2019. Solriamfetol is a dopamine and norepinephrine reuptake inhibitor (DNRI) and is categorized as a schedule IV controlled substance (low potential for abuse and low risk of dependence).

DOSING
Solriamfetol is available in 75 and 150 mg tablets. The 75 mg tablet is scored and may be split for 37.5 mg doses. Initial dosing for narcolepsy is 75 mg by mouth upon awakening; dose may be doubled 3 days later based on efficacy and tolerability to a max of 150 mg/day. Initial dosing for OSA is 37.5 mg by mouth upon awakening; dose may be doubled at intervals of at least 3 days based on efficacy and tolerability to a max of 150 mg/day. Avoid use within 9 hours of planned bedtime. Solriamfetol may be taken with or without food.

Efficacy

For each indication (Narcolepsy and OSA), separate 12-week, multi-center, randomized, double-blind, placebo-controlled studies were conducted. Primary Endpoints were the change from baseline in the Maintenance of Wakefulness Test (MWT) and the Epworth Sleepiness Scale (ESS). The MWT measures an individual’s ability to remain awake during the daytime in a darkened, quiet environment. The ESS is an 8-item questionnaire by which patients rate their perceived likelihood of falling asleep during usual daily life activities.

In the narcolepsy study, NCT02348593, patients randomized to receive 150 mg of solriamfetol (received 75 mg for the first 3 days) showed statistically significant improvement in both MWT (+7.7 mins) and ESS (-3.8 points) compared to placebo. The study arm randomized to receive 75 mg did not achieve statistical significance.

The OSA study, NCT02348606, compared placebo to solriamfetol doses of 37.5, 75, and 150 mg (75 mg for the first 3 days) for 12 weeks. Patients in all three treatment arms showed statistically significant improvements on the MWT (+4.5, 8.9, and 10.7 mins, respectively) and ESS (-1.9, 1.7, and 4.5 points respectively) compared to the placebo group.

Safety

Solriamfetol comes to market with warnings and precautions for its use. This drug can increase systolic blood pressure, diastolic blood pressure, and heart rate in a dose-dependent fashion. Patients with risk factors for major adverse cardiovascular events are at increased risk and should be monitored. In clinical trials, patients have also experienced psychiatric adverse effects like anxiety, irritability, and insomnia. Use caution in patients with history of psychosis or bipolar disorders. Other less serious, but common (>5% incidence) side effects include nausea, vomiting, headache and decrease in appetite.

Concurrent treatment with a monoamine oxidase inhibitor (MAOI) or use of an MAOI within the preceding 14 days is contraindicated with solriamfetol.

References
Social media posts show that pharmacists are more overworked and stressed out than ever. Let’s take a look at some of the most common issues pharmacists are facing, as seen recently on Facebook.

**Stress**
Pharmacists are reporting enormous stress due to a hectic daily workload combined with demanding flu shot quotas. On top of filling hundreds of prescriptions daily, pharmacists are constantly being pulled from behind the counter to administer flu shots or other immunizations.

“The stress is unbelievable. I’m actually going to go in today and speak with my PIC. Turns out my suspicions have been correct. Although my cough is instigated by an illness, it is magnified by stress. The biggest culprit is work. There’s just an unbelievable workload. MTM, vaccines, constant training of new staff. High turnover. Good techs don’t stick around because of the low pay and high stress.”

“We get weekly threats on … vaccinations (we have a contract quota to uphold or ‘we’ll lose a million dollars’ lol)”

“I wish everyone was competent, but that’s not the case anymore. Those of us that are, we’re burning out. The lack of help. The tight job market that makes it hard to get out. All of it. It’s hard to have high expectations when others just don’t get it, so workflow is always different depending on who’s working.”

“I personally don’t understand how some are doing 400 prescriptions plus 40+ vaccines in 1 day. I struggle with breaking 200 with what I have and I’m working every queue. A lot of people turn queues off, but I never feel like I can do that because my techs are usually stuck up front and that’s the only way I can get things moving forward.”

It’s not all bad news though: Some pharmacists seem relatively satisfied with their job.

**Job Security**
Stress isn’t the only thing pharmacists are worried about. Pharmacists are worried about job security. The prevailing worry is, “Will I be forced out and replaced with someone younger that will work for less money?” Many pharmacists are seeing this happen in the workplace, and fear for their jobs.

“It seems like a cycle. Increased pay rate with sign on bonuses, pharmacy schools turn out students, the market saturates, they lower the pay rate, less people enter the profession due to pay, time goes by, people retire, competitors open, there’s a demand for pharmacists, they increase the rate, market saturates, then repeat.”

“I got pushed out after 20 years at (my chain) and replaced by a new grad making $18 less an hour.”

“We need provider status, a desk, 1:4 pharmacist to tech ratio, mandatory lunch breaks, and absolutely no more opening of pharmacy schools!”

Given decreased technician hours at a time when they are needed the most, pharmacists are torn between going home at closing time or staying and working off the clock. It’s a catch-22: those who work off the clock may be helping their team open up to a smooth morning the next day; however, many argue that working off the clock for free shows the companies that they can keep decreasing support staff hours because they see that everything is getting done.
The ‘Unattainable Triangle’ of Community Pharmacy

Quality, speed, and price has been referred to as the “Unattainable Triangle”. Fast, good, cheap—pick 2. Every business faces this question every time the doors are open for business. You can’t possibly have all 3. When you try to improve 1 side of the triangle, the other 2 sides will be impacted.

**PRICE:** Price seems to get the most attention. The monetary aspects of our profession seem to govern most of its workings. The insurance companies and government have put the squeeze on the community pharmacies for the last 4 decades—they want lower and lower prices; our patients want lower and lower prices. It comes at a price. Most pharmacies are always cutting staffing to satisfy the demand for the price side.

Many patients are forced to go to one of the preferred chains in their insurance company’s “preferred network”. They get a 90-day supply for the same price as they would pay for a 60-day supply at my pharmacy, if I’m not in their network. It comes at a price. Most pharmacies are always cutting staffing to satisfy the demand for the price side.

**SPEED:** In the store I have staffed for the past 11 years, we have a huge Medicaid population. It never ceases to amaze me that the first question a patient asks is “how long is it going to be?” I smile and tell them “10 minutes, it is always 10 minutes” I tell my student pharmacists that you only have to know 3 answers to staff the pharmacy: 10 minutes (how long); we won’t know until we run it through your insurance (how much); no we don’t (have a public bathroom!). Price doesn’t matter to our Medicaid population, speed does.

**QUALITY:** This is the aspect of the Unattainable Triangle that appeals to me the most as a pharmacist. I frequently hear pharmacists describe how they can “bust out” 400 prescriptions in an 8-hour shift. It scares me. Today at the pharmacy I had a bag flagged for consultation. It was a 15-year-old who was put on Flovent 110, who was new to my store. Her mom was in to pick up the prescription. She informed me that her daughter was on this medication and this was a dosage increase. In my usual fashion, I continued with my speech about mechanism, adherence, and rinsing and spitting after each dose.

The mom said, “We’ve never been told that before, I’ll have her come in.” I described how inhaled corticosteroid therapy worked and the importance of adherence, as well as rinsing and spitting. The daughter agreed to use her Flovent in the morning before school and at bedtime before brushing her teeth. I went further and gave her a free peak flow meter from my stash. I set her peak flow meter and instructed her on its appropriate use and handed her an asthma action plan. We both sacrificed speed for a quality engagement.

Our owners struggle with the triangle, but think about our individual struggle with the triangle. How many of us are in low quality, high stressed jobs because of our “price” (salary)? In a fulfilling pharmacist career, the focus is always on quality.

By Pete Kreckel, RPh

In My View

Dispensed as Written

"Quality, speed, and price has been referred to as the 'Unattainable triangle'. Fast, good, cheap—pick 2."

Pete Kreckel, RPh, practices community pharmacy in Altoona, PA.
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