Optimizing Outcomes for High-Risk Patients

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Pharmacists:
Trusted Professionals On the Frontlines of Patient Care

Once again, national survey results recently released by Gallup have placed pharmacists as one of the most trusted professions, surpassed only by nurses, engineers, and medical doctors. This is not surprising; patients continually turn to pharmacists for advice and rely on their accessibility.

The consistency of this ranking, which places the profession in the top 5 spots for the most highly rated for honesty and ethics, underscores the value that you bring to the patients that come through your pharmacy. Whether it’s offering a recommendation about an OTC product or ensuring that a patient remains adherent to a complex medication regimen, the expertise you offer has a ripple effect on optimizing outcomes.

In this issue’s cover story, Tzipora Lieder, RPh discusses managing high-risk patients with comorbidities. As Lieder notes, “Community pharmacists are ideally placed to manage these patients in a way that can positively impact their health outcomes.” In this article, you’ll find effective strategies for doing so, including the use of med sync, collaborative care, and best practices to get paid for the important services you provide.

As winter trudges on, more and more patients are likely seeking relief from cold-related symptoms. A column in this issue offers a guide to best practices for recommending OTC cold medications. Pharmacists often have an arsenal of “go-to” drugs they recommend, but by performing your own detective work, you can help patients refine their options and choose the most appropriate medication for their symptoms.

This issue also features an article focusing on the pivotal role that pharmacists play in a diabetes care team. The article discusses how hospital pharmacists can guide treatment decisions and help contain costs for patients. Not only that, but they can also work collaboratively with pharmacists in other settings—acting as a bridge to those in the community and ambulatory systems to assist in “warm handoff” transitions of care.

Despite an upswing in the number of pharmacists from minority backgrounds in the field, the overall numbers are still low. In a series of interviews in this issue, pharmacists from underrepresented racial and ethnic groups discuss ways that diversity can be improved throughout the industry.

You will also find an overview of managing patients with inflammatory bowel disease, tips for becoming a better pharmacy manager, and a look at oncology pain management.

Thank you for reading and continue to follow us on DrugTopics.com for more insights.

Mike Hennessy, Sr.,
Chairman and Founder
of MJH Life Sciences
EDITORIAL MISSION: Drug Topics is the top-ranked pharmacy resource for community and health-system professionals. Since 1857, readers have turned to Drug Topics for coverage of issues and trends important to the practice of pharmacy, and for a forum in which they can share viewpoints and practical ideas for better pharmacy management and patient care.
Patients with complex drug regimens for multiple disease states can be at high risk for a host of complications, including worsening disease, hospitalization, medication-related problems, and increased cost. Community pharmacists are ideally placed to manage these patients in a way that can positively impact their health outcomes.

“For disease state management, the pharmacist is the social worker that America never knew they had,” said Travis Wolff, PharmD, co-owner of MedWorld Pharmacy in Sapulpa, Oklahoma. “Community pharmacists know the income level, they know the family situation, they know the patients by name, they know if they have transportation or delivery, they know so much about the patients and their lives beyond their drugs, and that knowledge is key.”

**Syncing Up for Success**

For high-risk patients with multiple prescriptions, med sync is essential, experts say. “You can catch so many med errors and improve so many chronic disease states with sync,” Wolff noted.

Not only does med sync simplify refilling prescriptions for patients, said Randy McDonough, PharmD, co-owner and director of clinical services of Towncrest Pharmacy in Iowa City, Iowa, but it also increases efficiency in the pharmacy and allows implementation of an appointment-based model. “When patients come to pick up their prescriptions we can sit down with them to make sure that we’re monitoring their medical conditions and medications appropriately and make any interventions we need to optimize their medications,” he explained.

Keeping track of complicated drug regimens can be overwhelming for patients, so compliance packaging can play a key role in improving adherence. At Towncrest Pharmacy, the most popular option for high-risk patients is what they call “Supersync,” single-dose packets of multiple pills packaged by a robotic dispensing system, Parata PASS. There are various options for
user-friendly prescription packaging, McDonough said, but he cautions that labeling must comply with board of pharmacy regulations.

Holyoke Health Center, with locations in Holyoke and Chicopee, Massachusetts, is a federally qualified health center (FQHC) that serves an underserved, mainly Hispanic population. Its community pharmacy dispenses prescriptions to both health center patients and patients in the community and provides medication therapy management (MTM) for complicated patients. According to chief pharmacy officer Lori Lewicki, RPh, almost all of patients who receive MTM are dispensed their medications in a MedBox: a perforated card with bubble packs for 4 separate daily dosing times. To ensure patient comprehension, MedBoxes are labeled in English, Spanish, and with pictures, since 12% of their patients are illiterate. MedBox use has been shown to significantly improve adherence and decrease overall medical costs.

With any packaging option, Wolff noted that good communication between the patient and pharmacist is essential, because otherwise, serious medication errors can occur if prescriptions are changed mid-month. McDonough explained that when necessary due to medication changes between refills, patients bring back all their medication packets to have them repacked with the correct new drug.

Counseling Points
Pharmacists counseling high risk patients must establish a good rapport with them, McDonough said, “because you’re going to be managing these patients in a different way, it’s more a case management where you’re going to be meeting with them on a regular basis.” Pharmacists should take the time to explain the patients’ conditions and how their medications are affecting the conditions, McDonough added. Motivational interviewing techniques are important, as are asking open-ended questions and identifying what knowledge the patients have and what must be filled in.

Although following practice guidelines is important, Wolff noted that his pharmacy has been successful with patients because “we meet them where they’re at.” He advises that after counseling, particularly regarding non-pharmacological lifestyle changes, the pharmacist should ask the patient, “Is any part of what I told you difficult for you to achieve?” In his diabetes education program, for instance, after reviewing dietary guidelines, pharmacists ask patients, “What are some of the foods you can never give up? What foods are important to your culture, your family?” They then adapt the advice to the patients’ lives, Wolff said, teaching them how to eat the foods they won’t give up in the appropriate quantities and how to adjust their diet elsewhere to compensate.

To effectively manage high-risk patients, pharmacists must understand and address their challenge. Lewicki stressed that pharmacists must consider patients’ health literacy and make sure to convey information in ways their patients can understand. Financial difficulties can pose a barrier to implementing non-pharmacological lifestyle management advice, said Marisa Piers-Gamble, clinical pharmacy coordinator at Holyoke Health Center. “It’s easy for us to tell them how to change their diet, but when they get home it’s a matter of how they can afford it,” she said.

Because many of Holyoke’s patients are Spanish speaking, community health workers (CHW) are a valuable pharmacy resource. In addition to teaching the staff key Spanish words and acting as interpreters for pharmacists during MTM visits and the immunization clinic, they conduct staff cultural competence training in which they explain how illnesses are viewed differently in their patients’ culture. CHWs reach out to patients a few days before their MedBox is set to refill to determine whether there have been changes to the patients’ therapy. MedBoxes are delivered for free; a new program will allow the delivery driver to bring an iPad with which patients with questions can connect to the pharmacist face-to-face. And to overcome transportation difficulties for patients who need to be seen in person at the clinic, Holyoke now uses Uber Health, Lewicki reported.

Collaborative Care
“With high-risk patients it’s important that you’re part of the team,” McDonough noted. High-risk patients often see multiple providers, so communication and coordination of care is vital. As pharmacists identify medication-related problems, they must submit those interventions to prescribers to ensure that patients’ drug therapy is optimized. “You have to do that over time,” McDonough explained. “Because these are complicated patients, we don’t make a lot of changes at one time.” He stressed building rapport with providers so they are more likely to accept clinical recommendations.

Wolff noted that not all prescribers
are used to pharmacists taking an active role in managing patients’ therapy, so it’s important to demonstrate to them that “we’re actually there to help and not to be a threat to the doctor.”

The health care team need not include only physicians, physician’s assistants, and nurse practitioners, McDonough said. Pharmacists at Towncrest have recently begun collaborating with clinical pharmacists embedded in the cardiovascular and internal medicine clinics at the University of Iowa Hospital and Clinics. “There’s information they have that we don’t have and there’s information we have that they don’t normally have,” McDonough explained, “and we’ve found that by combining that information we’ve done a much better job at improving the therapy of our patients.” In the first 6 months of this program, with 129 shared patients, pharmacists identified 45 patients with adherence issues, 30 patients with non-matching medication lists, 15 patients with an incorrect dose, 11 patients who needed additional therapy, and 6 patients with a wrong medication.

Holyoke’s pharmacy is completely integrated into the health center, so pharmacists share information and work closely with the other health care professionals. Providers appreciate that pharmacists keep medication lists updated, and during hospital discharge follow-ups, pharmacists review the patients’ med lists with them before they are seen by other providers, Lewicki reported. Piers-Gamble is involved in a collaborative drug therapy management program where she has full prescriptive authority for hypertension. “We’ve seen clinically significant improvements in the patients who are enrolled in the program because they’re able to have such close monitoring of these specific disease states,” she said.

**Compensation for Clinical Services**

Holyoke Health Center is funded through a Health Resources and Services Administration (HRSA) 330 grant and is part of a Massachusetts accountable care organization (ACO) that focuses on the total cost of care (TCOC). “If we can decrease the TCOC, we can increase our shared savings from the physicians to perform services such as annual care visits in the physician’s office and chronic care management, which requires 20 minutes of phone counseling each month. Transitions of care is another opportunity to get reimbursed for helping high-risk patients, he said. Primary-care physicians are well compensated by Medicare for post-discharge visits within 7 days for complicated patients and 14 days for uncomplicated patients, he said, but they are required to complete a medication reconciliation within 48 hours after discharge. “A lot of physicians don’t know when their patients have been in the hospital, and they don’t find out until after that 48-hour window,” Wolff explained. “But where does the patient go when they leave the hospital? To the pharmacy to fill their meds?” Pharmacists can contract with physicians to perform medication reconciliations, record them in the physician’s electronic health record, and let the office know to schedule an appointment with the patient. “Since they know they don’t get paid at all unless you do that, they’re pretty willing to pay you,” he said.

Pharmacies can offer other services that can be valuable to high-risk patients. Wolff advises pharmacists to look at their patient demographics before choosing appropriate services to offer, such as diabetes education classes (which he feels are most profitable), smoking cessation classes, or COPD or asthma action plans. McDonough noted that, depending on state laws, pharmacists may be able to perform services such as blood pressure monitoring, lipid management, or glucose or hemoglobin A1c monitoring.

Establishing new revenue models to reimburse pharmacists appropriately for the care they provide high-risk patients is crucial, McDonough concluded. “These are patients that we’re trying to keep from being very catastrophic, very high cost... so we need to be paid more appropriately.”

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**Optimizing Outcomes for High-Risk Patients**

These are patients that we’re trying to keep from being very catastrophic, very high cost... so we need to be paid more appropriately.

—RANDY MCDONOUGH, PHARMD
The most effective way to manage a patient’s diabetes, according to the American Diabetes Association (ADA), is with a team-based approach—and that team may be most effective if it includes a pharmacist. A 2018 study, published in the Journal of Managed Care and Specialty Pharmacy, found that adding pharmacists to diabetes care teams not only improves patient outcomes, but can help prevent complications and reduce costs.1

“Whether it’s a member of the rounding team in the hospital or a member of the patient-centered medical home team in the ambulatory care setting, pharmacists are an integral part of the team that cares for each patient,” Sarah L. Anderson, PharmD, FCCP, BCPS, BCACP, associate professor at the University of Colorado Skaggs School of Pharmacy & Pharmaceutical Sciences, said. “Being present allows pharmacists to voice their recommendations and educate the medical team on the evidence that supports it.”

As part of a team, pharmacists can help guide treatment decisions.

Pharmacists Play An Essential Role In A Diabetes Care Team

By Joan Vos MacDonald

The pharmacist’s role in diabetes management is more important than ever before given the number of patients with diabetes and the number of options available for treating them. Sarah L. Anderson, PharmD

“With the ever-growing armamentarium of diabetes medications, pharmacists play a huge role in helping select medications that maximize efficacy, minimize side effects, benefit other concurrent disease states (eg, kidney or cardiovascular disease), and minimize costs,” Anderson said. “The ADA algorithm for treatment of diabetes is somewhat of a ‘choose your own adventure’ path, and pharmacists are key for helping both patients and providers choose the right medication(s) for the patient’s individual situation.”

Knowing how the health system’s formulary works means pharmacists are in a position to help contain costs while still recommending guideline-based medication therapy.

“Pharmacists have a keen understanding of balancing not only benefit versus risk when recommending a medication, but also whether the medication is cost-effective,” Anderson said.

Pharmacists also play an important role in medication adherence, which is more likely when patients know what the medication is expected to do, how to take it, what adverse effects (AEs) to possibly expect, and whether those AEs may be temporary.

“Health system pharmacists help to encourage medication adherence by discussing each patient’s medications with them so that the patient is educated on why they are prescribed each medication,” Anderson said.

It’s easy for a patient to feel overwhelmed when diagnosed with diabetes, since the diagnosis often requires
Diabetes / Pharmacists Play An Essential Role In A Diabetes Care Team

learning how to administer insulin, monitor insulin levels, and make lifestyle changes. A patient may benefit from access to a health system pharmacist who can answer questions, help set up glucose monitors, and make practical recommendations.

“Pharmacists can also help with recommending and assisting the patient in obtaining a pill box and educating the patient on apps or use of alarms on their phones to assist with medication reminders,” Anderson said.

In a hospital setting, clinical pharmacists help monitor patients’ A1C blood sugar levels and markers for other conditions, such as high cholesterol and high blood pressure. Their help can also make it easier for patients to leave the hospital after treatment.

“Pharmacists in the hospital are also great bridges to pharmacists in the ambulatory and community settings and can assist in ‘warm handoffs’ to ensure seamless transitions, as the patient transitions from the hospital back to the ambulatory setting,” Anderson said.

A recent report by the CDC estimates that more than 100 million US adults are now living with diabetes or prediabetes. Diabetes is the seventh leading cause of death in the United States and places individuals at an increased risk of health complications such as vision loss, heart disease, stroke, and kidney failure, as well as amputation of toes, feet, or legs.²

“The pharmacist’s role in diabetes management is more important than ever before given the number of patients with diabetes and the number of options available for treating them,” Anderson said.

As more new diabetes medications come to market, health system pharmacists can aid in the decision-making process to ensure that the medication is necessary and cost-effective. “Newer doesn’t necessarily always mean better,” Anderson said. “Pharmacists can help with cost containment by stepping in with an alternate recommendation if that which is recommended is expensive yet yields little benefit to the patient.”

For references, visit DrugTopics.com
Pharmacists can play an integral role in managing patients with inflammatory bowel disease (IBD) through medication management.

Inflammatory bowel disease (IBD) includes the 2 conditions, Crohn disease and ulcerative colitis (UC), which involve chronic inflammation of the gastrointestinal (GI) tract. Crohn disease is characterized by inflammation that can affect any part of the GI tract. Inflammation occurs in the large intestine (colon) and rectum for UC. Symptoms of IBD include diarrhea, fever, abdominal pain, bloody stool, reduced appetite, and weight loss.

**Treatments and Counseling Points**

Treatment for IBD generally involves either pharmacotherapy or surgery. An important counseling point is to avoid nonsteroidal anti-inflammatory drugs such as ibuprofen or naproxen, as these medications can exacerbate IBD symptoms and increase the risk of bleeding. Pharmacists can recommend acetaminophen for patients with IBD needing pain relief. The American College of Gastroenterology (ACG) clinical guidelines recommend management based upon disease extent, severity, and prognosis.

Many of the same medications can be used to treat both UC and Crohn disease. Patients with mild UC can be treated with anti-inflammatory medications such as aminosalicylate therapies (5-ASA) as a first step in the treatment process. The 5-ASA medications (eg sulfasalazine, mesalamine, olsalazine) are generally well tolerated, and adverse effects may include headache, nausea, abdominal pain, vomiting, rash, and fever. Sulfasalazine has shown to be effective for treating mild-to-moderate symptoms of colonic Crohn disease.

Corticosteroids (eg prednisone, budesonide) are generally reserved for patients with moderate-to-severe UC or Crohn disease. However, long-term use is not recommended due to the high risk of adverse effects including hypertension, increased blood glucose, cataracts, weight gain, osteoporosis, and psychiatric symptoms. One study showed that there was excessive steroid use in approximately 15% of patients with IBD.

Anti-tumor necrosis factor (anti-TNF) medications such as adalimumab (Humira), golimumab (Simponi), or infliximab (Remicade) are biologics that can reduce symptoms and heal the intestine in patients with UC. Adalimumab, certolizumab pegol (Cimzia), and infliximab are the most effective anti-TNF therapies to treat moderate-to-severe Crohn disease. These medications may cause injection site reactions, increase the risk of developing infections, and may cause changes in liver function so patients should be closely monitored.

Biosimilar products are available for many of the anti-TNF drugs, which could make these medications more affordable for patients. Vedolizumab (Entyvio) is a biologic that is another option for UC and Crohn disease in patients who have failed other medications. Tofacitinib (Xeljanz), an immunomodulatory drug that decreases inflammation, is another option for UC. The FDA added a Boxed Warning regarding an increased risk of blood clots in patients taking tofacitinib 10 mg twice daily dose and discussed that this medication should be reserved as second-line therapy for individuals who failed or cannot tolerate anti-TNF drugs. Natalizumab (Tysabri) is effective for Crohn disease in patients who do not respond to conventional therapies, but it is associated with a rare brain disease known as multifocal leukoencephalopathy. Enrolled in a special program to use the medication. Ustekinumab (Stelara) is used for moderate-to-severe Crohn disease that has failed other therapies and just received FDA approval on October 21, 2019 for UC.

For references, visit DrugTopics.com
Debunking 4 Common Myths About the Flu

It’s never too far into flu season to educate patients

By Ronald Richmond, RPh, MPH, Senior Vice President of Provider Relations, Paramount Rx

If you think the flu is like a bad cold, think again. Anyone who has had the virus can tell you that it’s much more severe than a mild case of the sniffles. However, it can be confusing with all the misinformation that floats around this time of year.

Below we break down 4 common myths that many people have about the flu.

**Myth #1: The flu isn’t really that bad.**
The flu isn’t something that anyone should take lightly. Just consider the fact that there were more than 80,000 flu-related deaths in the United States during the winter of 2017-2018. Individuals aged 65 and older accounted for 9 out of 10 of these deaths, but the flu also killed 180 young children and teenagers. Despite the dangers, the CDC estimates that only 37.1 percent of adults 18 or older were vaccinated for flu during the 2017-2018 flu season—down 6.2 percentage points from the year before.

**Myth #2: You don’t need a flu vaccine every year.**
Immune protection from the flu vaccine declines over time, so annual vaccination is critical to provide the best protection. In addition, the strains of flu causing illness can change from year to year. Last year’s flu vaccine may not protect from this year’s flu strains. In fact, multiple strains of the flu circulate every year, and it’s possible to contract different strains of the flu in the same year. To ensure the best protection, it’s best that people get an annual flu vaccine prior to the start of flu season to allow their body’s immune system the time it needs to build up protective antibodies against the virus. Seasonal flu activity often begins as early as October or November and can continue to occur as late as May.

**Myth #3: The flu vaccine will give you the flu.**
If someone feels sick shortly after receiving a flu vaccine, they may think the vaccine caused them to come down with the illness. However, as outlined by the World Health Organization, the flu vaccine is made from an inactivated virus and can’t transmit infection. It can take a week or 2 for a vaccine to become effective, so it’s possible to catch the flu right after receiving the flu shot, before your body’s immune system has built up protection from the virus. There are potential temporary side effects associated with flu vaccine including achiness and fever. These are normal reactions from one’s immune system and should only last a day or 2. If symptoms last longer than a few days, vaccine recipients should check with their health care provider. Severe adverse effects are extremely rare.

**Myth #4: You can run out of time to get vaccinated.**
The fact is it’s never too far into flu season to get a flu vaccine. The vaccine is available for the public at most retail pharmacies, walk-in clinics, and community health centers, as well as from their health care providers, throughout the fall and winter. The flu vaccine works best when the entire community is vaccinated, so even after people have received their annual flu shot— they might want to encourage their neighbor to get theirs as well!

For those that do come down with the flu or other sicknesses this season, there are resources available to help save money on important medications. Programs like Community Cares Rx offer immediate savings to millions of American families who are uninsured or in need, strengthening communities by giving people an easier path to affordable prescriptions.

For references, visit DrugTopics.com.
Pain is a very common and dreaded symptom in oncology patients, reportedly occurring in more than half of patients with active cancer and one-third of cancer survivors. “Unrelieved pain impacts patients’ quality of life and comfort,” said Alison Duffy, PharmD, oncology clinical specialist at the University of Maryland Medical Center and associate professor in the department of pharmacy practice and science at the University of Maryland School of Pharmacy in Baltimore. “Ultimately, their survival outcomes are definitely linked to early and effective palliative care, which includes pain management,” she said.

Pain Causes
Erica Rhein, PharmD, clinical pharmacist at UCHealth Anschutz Cancer Pavilion’s outpatient palliative care and oncology urgent care clinics and assistant professor at the University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences categorizes pain as directly cancer-related or iatrogenic (Fig. 1).

Determining the source of the pain can be tricky and involves listening closely to the patient and using imaging studies when appropriate. Duffy recommends PQRST pain assessment (questioning the patient about Provoking factors, Quality, Region/Radiation, Severity, and Time). The patient’s description of the pain can provide important clues, Rhein said. “Neuropathic pain tends to be hard for patients to localize and has descriptors like burning and shooting,” she explained. “while somatic pain is a lot of times easier for a patient to pinpoint.” There are often multiple sources for the pain requiring treatment with multiple modalities.

Analgesic Options
In this patient population, the usual go-to non-opioid options are fraught with complications.

Although nonsteroidal anti-inflammatory drugs (NSAIDs) should theoretically be ideal, since cancer-related pain frequently has an inflammatory component, they have many potential contraindications, said Rhein. NSAID use is problematic in patients with renal dysfunction due to their cancer (for example, multiple myeloma) or advanced age, Duffy added. In patients undergoing active treatment, Rhein said, NSAIDs can interact with chemotherapeutic agents by increasing cumulative renal toxicity or by decreasing renal clearance of the chemotherapeutic agent so its toxicities are increased. Additionally, the increased risk of bleeding associated with NSAIDs is problematic for patients whose cancer increases bleeding risk (eg, gastrointestinal cancers) or who have chemotherapy-related thrombocytopenia, Rhein added.

Acetaminophen also has its concerns. Its dose is limited in patients with liver impairment due to cancer location, liver metastases, or chemotherapy, Duffy said. It can only be used sparingly in neutropenic patients with hematologic malignancies since acetaminophen can mask fevers. If pain requirements are high, she said she prefers to use another agent. Even when acetaminophen is a safe option, it often is not enough for effective pain relief, Rhein said, so it is often used in conjunction with opioids as an opioid-sparing agent.

Opioids as the Backbone of Treatment
Rhein and Duffy agree that in oncology patients, opioids are often the best and safest option.

The most commonly used opioids in oncology patients are morphine, oxycodone, and hydromorphone. For patients with liver dysfunction, Duffy said, morphine is preferred over oxycodone, and vice versa for patients with kidney dysfunction.

Opioid choice, however, is often dictated by cost and insurance formularies.
“Once patients are getting higher doses of opioids, even medications like morphine that are considered to be more affordable can become very expensive, so the cost is definitely something that we have to consider for our patients,” Rhein noted.

Before patients are started on opioids, they must be screened for risk factors for opioid misuse and addiction. All the information in the media about the opioid epidemic has made some patients wary of taking opioids, Rhein said, and these patients must be educated. “There are certainly patients that have their pain sub-optimally managed because of their concerns about addiction, and some of those challenges are based on the hyperawareness in this country,” Duffy said. Oncology patients with a history of substance use disorder can be very challenging to manage, Rhein said.

This is particularly for opioid naïve patients, who are then usually started at low doses of opioids, said Duffy. Patients with chronic or advanced cancer pain may require long-acting opioids such as extended-release morphine (MS Contin) or oxycodone (OxyContin). Fentanyl patches are also an option, according to Duffy, particularly for patients who have compliance issues or have swallowing difficulties due to head and neck or gastrointestinal cancers.

Rhein reported that she also uses methadone quite a bit in her clinical practice, as it has benefits for both neuropathic and somatic pain and is often better tolerated than very high doses of the opioids. Patients must usually be hospitalized during methadone up-titration, and Duffy cautions that clinicians must be on the lookout for QTC prolongation, particularly in patients taking other drugs that affect the QTC interval.

**Counseling Points for Patients with Cancer**

When counseling patients being treated for cancer pain, particularly with opioids, pharmacists should realize that these patients are often legitimately taking other sedating drugs such as benzodiazepines, Duffy said. These patients must be screened for falling risk and cautioned about the risks of driving while sedated.

Many patients on high doses of opioids also have multiple risk factors for constipation, such as chemotherapy, radiation, and hypercalcemia due to bone metastases. Since constipation increases risk for bowel obstructions, she said, pharmacists should counsel these patients about constipation and ensure that they are on appropriate bowel regimens.

For patients on more than 1 opioid, Duffy said, “make sure they understand the maintenance basal rate of their long-acting control and the bolus nature of the short-acting one.”

Clinicians should understand that drug therapy alone may not be adequate for pain management. “There is a huge psychosocial component of the pain experienced in patients with cancer, and you often have to address that to have any hope of controlling the pain,” Rhein said.

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**Fig. 1 Cancer-related versus iatrogenic pain**

According to Rhein, cancer-related pain can be associated with:

- Invasion of the soft tissue
- Bone metastases (which can also cause painful bone fractures)
- Chronic obstruction of the bowel or ureter
- Central nervous system metastases

Iatrogenic pain may be caused by:

- Diagnostic tests like biopsies and imaging tests
- Therapeutic interventions, including surgery, chemotherapy, and radiation.

For example, Rhein said, radiation therapy for gastrointestinal or genitourinary malignancies can result in painful enteritis, proctitis, or mucositis. Neuropathic pain can be caused by a cancer that affects nerve endings or by chemotherapeutic agents such as vincristine, taxanes, and thalidomide.

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**Fig. 2 Atypical Analgesics Used in the Treatment of Cancer-Related Pain**

<table>
<thead>
<tr>
<th>Agent</th>
<th>Indication</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>Tramadol</td>
<td>Pain</td>
<td>For older, opioid-naive patients. Risk of serotonin syndrome, particularly with concomitant selective serotonin reuptake inhibitors (SSRIs).</td>
</tr>
<tr>
<td>GABA analogues (gabapentin, pregabalin)</td>
<td>Neuropathic pain</td>
<td></td>
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<tr>
<td>Serotonin and norepinephrine reuptake inhibitors (SNRIs, e.g., duloxetine)</td>
<td>Neuropathic pain + anxiety/depression</td>
<td></td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>Bone pain or oncologic emergencies (e.g. spinal cord compression)</td>
<td>Also helps nausea. Avoid long-term use because of immunosuppressive properties</td>
</tr>
<tr>
<td>Lidocaine patch</td>
<td>Procedural or localized pain</td>
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*Sources: Alison Duffy, PharmD, and Erica Rhein, PharmD*
The common cold is frequently attributed to the rhinovirus, but more than 200 viruses can cause the common cold, according to the American Lung Association. Despite the large number of viruses that cause cold symptoms, the common cold usually resolves on its own, giving patients the option to self-medicate with OTC medications to ease their symptoms.

Solid Recommendations Require Detective Work

When making recommendations, pharmacists often have an arsenal of “go-to” drugs they recommend. However, a prudent clinician never proceeds without first collecting information about the patient’s history of present illness.

“Since the common cold has such non-specific symptoms, pharmacists should ask patients about their symptoms,” said Donald Backus, PharmD, a pharmacist at Oregon Health and Science University in Portland. “We should keep track of what they’re presenting with symptom-wise and make sure it’s not something more serious.”

Non-specific symptoms such as headache, fever, and congestion associated with the common cold can often be managed with OTC medications. However, eye exudate and coughing up green phlegm, or seemingly mild symptoms that have persisted for more than a week without improvement, are signs of a more severe illness. Such presentation warrants an immediate referral to the clinic.

If the pharmacist determines that the patient’s symptoms can be self-managed, the next step is to gather information about pre-existing medical conditions as well as prescription and OTC medications and supplements the patient is taking.

Jason Varin, PharmD, director of alumni relations at the University of Minnesota College of Pharmacy in Minneapolis encourages clinicians to find out which medications the patient has tried and whether those medications have worked for them in the past. Of equal importance is to identify the patient’s desires before recommending any OTC drugs.

“If patients have symptoms consistent with a cold, what are they looking for in the way of relief?” he said. “Perhaps a runny nose is not an issue, but they have a cough and want to sleep.” Other patients may seek relief from minor aches and a sore throat.

Gathering background information helps the pharmacist make a well-informed recommendation. Refining the recommendation may involve helping the patient read ingredient labels to identify ingredients that may aggravate pre-existing conditions—such as certain antihistamines that can induce drowsiness, making it dangerous to drive and operate heavy machinery.

For Betty Louton, PharmD, a population health clinical pharmacist at Banner Health in Phoenix, Arizona, simplifying the medication administration regimen helps improve patient reception and adherence.

She said that she finds her patients also enjoy the convenience of 12-hour dosing when many cough and cold medications are dosed twice or more a day with the Alka Seltzer Cold and Flu product line extension. They also reported the reconstituted powder soothed their scratchy throats.

“By default, I look for medications that only have to be taken once a day as opposed to twice daily, or every 4-6 hours, it’s easier—especially for patients who are already taking so many other medications,” Louton said.

For cold-like symptoms that can be managed with OTC medications, pharmacists distinguish their recommendations by the category.

**DECONGESTANTS:** Pharmacist have different preferences when it comes to decongestants. Varin chooses pseu-
doepherdine as his go-to drug because of its potent vasoconstrictive properties. However, side effects such as increased heart rate and insomnia make it unsuitable for patients who have uncontrolled hypertension or heart conditions.

For these and other patients, alternatives include oral phenylephrine and nasal sprays such as oxymetazoline and phenylephrine. Varin pointed out that phenylephrine is less effective than pseudoephedrine but carries a lower risk of affecting blood pressure, the heart, or disrupting sleep. He saves nasal sprays as a last resort—an option he personally reserves when flying with a head cold.

“The eustachian tubes that help the inner ear adjust to changing air pressure become congested, and the inability of the inner ear to depressurize can be extremely painful,” Varin says. “Nasal spray decongestants can be beneficial in this situation.”

However, he advised against using nasal spray decongestants for more than a few doses to avoid rebound congestion and sinus irritation.

**ANTIHIPHATINES:** Antihistamines help dry up excess mucus. While diphenhydramine (Benadryl) is highly effective, it comes with some precautions. The drug can cause severe drowsiness, paradoxical stimulation in children, increased fall risk in elderly patients, and may worsen urinary disorders such as benign prostatic hypertrophy and urinary retention.

For patients on the go, Louton recommended a non-sedating antihistamine such as fexofenadine (Allegra) or loratadine (Claritin) in the morning, while reserving diphenhydramine’s sedative effects to help induce sleep and itching at night.

**COUGH:** To date, guaifenesin remains the only OTC medication on the market for cough. Louton reserves this drug for deeper chest cough. Although there are a variety of guaifenesin-containing products on the market, Louton recommended Mucinex for patients.

“Most of guaifenesin-containing products are 50-100 mg, but that’s not a high enough dose for an adult to thin out thick mucus,” Louton explained. She recommended cough suppressant-containing Mucinex DM for patients with frequent, deep chest cough; but she encourages pharmacists to warn patients of the risks of taking the liquid as opposed to the tablets or capsules.

“People take the liquid more often than they should, and this is especially problematic with the elderly and kids because overusing it causes hallucinations.”

**ANTIHIPRETICS:** Acetaminophen appears to be at the top choice antipyretic among the pharmacists interviewed. Varin recommends acetaminophen for mild-to-moderate fever but reserves ibuprofen for patients who experience moderate fever in addition to pain.

Louton said that acetaminophen has several features that make it her first-line antipyretic recommendation. Among these are its faster onset compared with ibuprofen and longer-duration compared with other commonly used non-steroidal anti-inflammatory drugs (NSAIDs). Additionally, unlike NSAIDs such as ibuprofen, aspirin, and naproxen, acetaminophen does not cause gastrointestinal upset or exhibit blood-thinning effects. However, as with any drug, it has a few drawbacks, perhaps the most important of these being the risk for hepatotoxicity associated with exceeding the recommended maximum daily dose.

Backus and Louton agree that NSAIDs make suitable second-line choices. Backus considers adding an NSAID when staggering antipyretic therapy.

Louton avoids recommending aspirin for several reasons. “Many people take blood-thinning medications, and you certainly don’t know what they’re on if you’re talking to them at the drugstore.”

She also steers clear of recommending the drug for children. Children less than 18 years of age who take aspirin during the course of a prodromal viral illness run the risk of developing Reye syndrome—an aspirin-induced form of hepatotoxicity.

Clinical manifestations include lactic acidosis, microvesicular fat, and hepatic dysfunction accompanied by coma and encephalopathy. Signs of hepatic trauma or failure include elevated serum aminotransferase levels, hyperammonemia, and encephalopathy. Serum bilirubin levels, however, tend to show only moderate elevation in the condition. Nowadays, the condition has become rare—thanks to patient education and prudent avoidance.

**Dietary supplements**

Seventy-seven percent of Americans reported using dietary supplements in 2018, according to the Council for Responsible Nutrition—an all-time high. Given this trend, pharmacists will play an increasingly critical role in educating patients and helping to separate the facts from the hype. However, clinicians agree that many supplements have limited evidence supporting their benefit in mitigating cold symptoms.

Some data suggest that vitamin C, zinc, echinacea, and garlic offer some benefit in reducing both the severity and duration of cold symptoms, but Varin cautioned that evidence is conflicting. Moreover, as with any product ingested, dietary supplements also carry some risks.

For example, garlic can interfere with blood thinners. Although zinc is an essential element and has been shown to help ameliorate some symptoms associated with the common cold, intranasal zinc has been linked to anosmia, or loss of smell—which may be permanent.

For references, visit DrugTopics.com.
How to Be a Good Manager

Tips for getting the best from your team

A good manager is more than just the person in charge. To be truly effective, they must develop leadership skills that motivate each member of their team to realize their greatest potential. Doing so not only contributes to a sense of well-being among employees, but ultimately benefits the business as well.

“Leadership is all about working with a group of people to achieve a certain goal, and convincing the people around you to be able to achieve that goal,” Hashim Zaibak, PharmD and owner of the independent Hayat Pharmacy chain in the Milwaukee area, said.

Setting Standards
Quality managers set high standards for their employees, setting the tone for how they respond, according to Sandra Leal, PharmD and CEO of Tucson-based SinfoniaRx.

“A lot of it is good modeling and the approach that you take so that people see how much you’re invested in them and also in the mission that you’re trying to accomplish,” explained Leal. “I don’t necessarily expect everybody to work to my standard because people have different approaches, but I always try to set a really good example and show what we’re trying to do in a very mission-oriented way, giving them purpose for why they’re doing the work that they’re doing.”

Lead and inspire people.
Don’t try to manage and manipulate people.
Inventories can be managed, but people must be led.

Building the Best Team
When hiring new team members, both Leal and Zaibak look for people who are passionate about what they do.

“They already have this innate way of interacting with people. It’s the way they communicate, it’s empathy, it’s things that they share that you sometimes can’t train,” this is the way Leal describes prime job candidates. “It’s somebody who is willing to learn, who is eager, self-motivated, interested and asking questions that makes it a lot easier to integrate into the culture that we’re trying to build.”

Zaibak gets excited by candidates who have specific skills that help his pharmacies connect in new ways with the communities they serve. “When I’m interviewing somebody and they speak a different language and are willing to be the liaison between us and that community, it usually improves their chances of being hired,” he explained. At last count, 20 different languages are spoken among his employees at 15 locations in southeastern Wisconsin.

Open Communication Is Key
Zaibak also works at keeping open lines of communication with his team members.

“For example, a recent new hire frequently called in sick, which he found unacceptable. But when he met with her in person, he learned that she has type 1 diabetes and had been going without insulin when she didn’t have health insurance.

“By listening, I actually found out that what would have been fair—writing her up—is really not that fair because of her circumstances. It changed my perspective completely,” Zaibak said.

Handling Stress
Feelings of burnout and stress in the workplace is another area where a good manager can make a big difference. Leal recommended mentoring as a way to engage employees more fully in the operation.

“Whenever we support someone with additional training or going out to a meeting or to network, it brings a different perspective to the work that’s being done on a day-to-day basis,” she said. “Meeting motivated individuals, people that are advocating for the profession, seeing what else is happening — that, I feel, really empowers people.”
Minority Representation in Pharmacy

Is there enough diversity in the industry?  By Keith Loria

Despite some data showing the number of minorities in the field of pharmacy are increasing, industry experts still characterize the overall numbers as low.

Deterrents include lack of exposure to the field and barriers to pharmacy school admission, including student and family financial burdens, standardized test-taking challenges, and implicit bias.

Lakesha M. Butler, PharmD, clinical professor of pharmacy and coordinator of diversity and inclusion at Southern Illinois University Edwardsville, as well as president of the National Pharmaceutical Association, said that when assessing the state of minorities in pharmacy it is important to differentiate between the use of the term “minorities” versus “underrepresented minorities.”

“Underrepresented minorities in pharmacy include those racial and ethnic groups that are underrepresented in the profession when compared to their numbers in the general population,” she said. “These groups include African Americans, Hispanic/Latino, American Indian/Alaska Natives, and Native Hawaiian/Pacific Islanders. There has been improvement in the current state of minorities in pharmacy compared to 10 or more years ago. However, there still exists significant disparities in the percentage of minority pharmacists and minority students compared to the US minority population.”

Butler became interested in the field as a college student when she learned of the variety of career options that exist in pharmacy.

“Additionally, I shadowed a minority hospital pharmacist to explore the career,” she said. “I had not previously considered pharmacy because I was not exposed to it. Discovering that I could play an intricate role in the health of patients, specifically through medication and disease state management, and work alongside physicians and other health care workers as a team was intriguing and resulted in me pursuing pharmacy.”

Ahmed Ali, PharmD, owner of Othello Station Pharmacy in Seattle, Washington, is originally from Somalia and studied pharmacy at Washington University. Over the years, he’s managed a Walgreen’s pharmacy, worked at clinics, and now operates the only pharmacy in Seattle owned by someone of his descent. Pharmacists that work there speak 7 different languages to appeal to all types of people.

“I was always interested in starting something in the same neighborhood that took me in when I came here as a refugee in 1997,” he said. “The South Seattle neighborhood has changed significantly since then, but a lot of the same people still live here and I wanted to cater to them and provide a service different than the big-box and chain pharmacies.”

A big reason he believes the industry isn’t as diverse is simply access to proper education, plus money for school and living. He noted unless barriers are removed, there will be a major lag to increase the numbers properly and at the speed many are hoping for.

Nonye Uddoh, PharmD, is an African American woman of Nigerian descent and currently works as a clinical pharmacist at UnitedHealth Group after working for SUPERVALU Pharmacies in Maryland. She became interested in the field because her mom was a pharmacist and told her how much money they were making at the time.

“I was finishing up my degree in biology and considering research, however I applied to Temple Pharmacy School and got in and so abandoned research pursuits,” she said.

In her current role, she has seen an upswing in the amount of minorities in the field and is pleased with the direction hiring is going.

“For example, most of my pharmacy team are minorities—African Americans, many from Nigerian descent, Middle Eastern descent, many Asians and Asian-Americans, many Hispanics, Russians and many women,” she said. “Where I work, the pharmacist who speaks an additional language such as Spanish or Cantonese/Mandarin are in higher demand than their English-speaking counterparts.”

The Road to Ownership
Xavier Bryant, owner and founder of
Bryant Pharmacy & Compounding, located in Decatur, Georgia, noted the road to opening his own pharmacy wasn’t easy. “I couldn’t get a loan so I just ‘bet on black,’ [my wife and I] pooled our funds, took from our 401Ks and invested in an operation that we knew we could perform well in,” Bryant said. “That was 5 years ago and since then, we’ve opened up a couple of other pharmacies and continued to diversify in the health care space.”

For Bryant, opportunities for people of color in the field weren’t easy to come by. As a result, he feels it is his duty to inform minority pharmacy students all they need to know to get a chance at ownership themselves. He regularly talks with students at Mercer University and started his own summer program to teach high school students about the field.

“It is my intention to teach every minority student who comes through my professorship the principals of owning a pharmacy—being creative about finances, location analysis, market analysis—so I plant the seed in their head early,” he said. “I believe pharmacy is an excellent career to go into and a great way to help the community.”

**Taking Action**

John Mansour, who is Egyptian, attended Florida A&M University for pharmacy school following in the footsteps of his mother who is the director of pharmacy for Winter Park Hospital in Orlando. He would like to see more action taken in appealing to children at a young age.

“Minorities in the field, along with their institutions, should go talk to our kids in school during career days and explain what they do, how they got there and let them see that anyone can do it if they work at it,” he said. “It’s really positive to show kids people who look like them working in fields they may not think are accessible. That helps make dreams seem more attainable and it gives students role models.”

Butler agrees that exposure—as early as elementary school—is key for improvement. “This exposure can be accomplished through summer camps, community outreach programs, middle and high school career days, or job shadowing opportunities,” she said. “Implement media and marketing strategies to promote minorities in pharmacy to allow students to see themselves in this career. Make intentional efforts to recruit and retain minority students and faculty into pharmacy school to enhance representation. Also, offer available financial and academic support for those in need to reduce barriers.”

Butler leads a high school summer camp at her institution for minority students interested in health care careers including pharmacy and also participates in numerous community outreach initiatives such as health fairs, flu clinics, and church presentations to showcase minorities in pharmacy.

“I have offered job shadowing to a number of minority students who were exploring health care options and are now in pharmacy school,” she said. “Additionally, in my national pharmacy roles, I advocate for minority representation, diversity education, and diversity and inclusion efforts to be a priority and intentional.”

At Othello Station Pharmacy, Ali brings students of color in for internships and is happy to talk with youngsters who ask how he became a pharmacist. “I didn’t have that experience so I am happy to have that conversation with them,” he said. “When you don’t give students an ability to come and understand what the career path looks like, then they don’t know whether to pursue the career.”

Uddoh feels pharmacy schools can better emphasize their minority associations, such as the Student National Pharmaceutical Association, which is a minority-based pharmacy association. “To make women more interested in the field, pharmacy schools can emphasize the diverse field of pharmacy including pharmacists who work from home and work in offices with 9-5 hours Monday through Friday,” she said.

Personally, she serves as a mentor with Capella University and provides support to colleagues on LinkedIn when needed.

When Ali was in pharmacy school, out of nearly 100 students, there were only 4 students of color. He’s paid attention to the graduation rate over the years and said although it’s better, the numbers are still low. “The way the system is set up, a lot of students of color are not exposed to the pharmacy field or connect with professionals that look like them,” he said. “Pharmacy is a very unique environment and sometimes you have to be connected with one to understand what a pharmacist does and what a career looks like.”

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AHMED ALI, PHARMD

**The way the system is set up, a lot of students of color are not exposed to the pharmacy field or connect with professionals that look like them.**

**AHMED ALI, PHARMD**
Cannabis Use in Health Systems

Lack of quality evidence complicates patient management

By Drew Boxler

As both medical and recreational use of cannabis become more common with increased legalization of these products across the United States, new challenges continue to emerge, including the use of medical marijuana within health systems. At the same time, patients and other health care providers are increasingly looking to pharmacists to field questions around the use of cannabis and cannabidiol (CBD) products.

At the 2019 Annual American Society of Health-System Pharmacists (ASHP) Midyear Clinical Meeting & Exposition, which was held December 8-12 in Las Vegas, NV, pharmacists gathered for a roundtable discussion on this subject, touching on an array of issues including policy confusions, the best practices to reduce stigma, and how to have discussions with primary care providers.

Policy Complications

One pharmacist from the University of Las Vegas Medical Center said that some confusion exists at her hospital about defining those patients who are using products that meet standards set for legal products. Herbal medications, she said, are not allowed.

Another pharmacist brought up the issue of responsibility for potential interactions with CBD use. At his health system, he said patients are allowed to use CBD, but it has to be pure, 100% CBD. If the product doesn’t meet that standard and the patient tests positive for THC, the clinician can be held accountable, since CBD and THC can affect patients differently.

Moreover, since medical marijuana and CBD laws vary by state, pharmacists must stay informed on the most up-to-date policies in their region.

Discussions About Cannabis

Stigma regarding marijuana use was one of the most prominent issues the panel discussed at the roundtable.

A pharmacist that works in an outpatient clinic at the Veterans Affairs (VA) said that she, the VA’s practitioners, and pharmacists always ask about other complementary therapies that the patients may be taking. Although she noted that she couldn’t be certain that patients were telling the complete truth about their marijuana use, she said patients will often be open to the discussion of their cannabis and CBD use. She noted that she doesn’t necessarily tell her patients to stop using marijuana, but she does inform them that the health care industry does not have enough information on the contents of the products and that patients consequently need to use caution.

As an example of the lack of awareness of interactions, she provided a case-based experience from her medical center, specifically, a patient prescribed an opioid who had tested positive for marijuana.

The patient swore he was not taking marijuana, but indicated that he was using CBD oil. “Was it possible that the patient could test positive for THC while using CBD?” the physician asked. The pharmacist responded: yes. She then advised the physician and told the patient that the opioid prescription would stop. To resume treatment, the patient would need to return in a month after suspending use of CBD.

Educating Patients

The roundtable panel agreed that patient education was needed on this topic.

One pharmacist said that his health system had developed an FAQ brochure that addressed basic things patients should look out for, such as drug interactions and adverse effects. The brochure aims to protect patients by ensuring that pharmacists are taking care of patients as best as they can, given the little amount of information currently available.

The ASHP moderator said that they might look into developing a similar education leaflet and will possibly work to provide something similar on their website in the future.

REFERENCE

April 19, 1775 at the Old North Bridge in Concord, Massachusetts was the “shot heard around the world,” which was the beginning of the American Revolution. This first bold statement by the American colonists was the initial phase of what most believe to be the greatest overthrow of tyranny. After many battles and engagements, the war was won, and freedom came to the United States.

“I implore the other makers of insulin to follow suit and come up with their direct-to-patient programs.”

On January 2, 2020 I was reading an article that described Novo Nordisk starting a new program that offered patients insulin for $99 per month. This program will pay for 3 bottles of insulin or 2 boxes of their pens for $99. That’s right, Novo Nordisk is bypassing insurance companies, pharmacy benefit managers, formulary committees, and everyone else who “gets in the way” of patient care. Their program applies to every patient, regardless of insurance. It doesn’t matter whether they have commercial, government or no insurance at all. One picture of Ben Franklin ($100 bill) and you get 3 vials or 2 boxes of pens and a dollar back. Sounds too good to be true.

Back in 1922, Frederick Banting, Charles Best, and James Collip sold their patent for their process on the extraction of insulin to the University of Toronto for $1.00 each. Dr Banting felt it unethical to profit from the discovery of a lifesaving drug that patients needed. How times have changed a century later! I implore the other makers of insulin to follow suit and come up with their direct-to-patient programs to bypass the ridiculous copays, deductibles, donut holes and other schemes the insurance companies, with the government’s help, have come up with.

Eight years ago, at a picnic, Dr Zane Gates challenged my wife Denise and I to come up with a formulary that he could use for his underinsured patient population. With help from Gretchen and Mark Garofoli (our daughter and son-in-law), and Bill Thompson we came up with a robust formulary that is used daily at the Empower-3 clinic. The only 2 disease states that we couldn’t cover are insulin-dependent diabetes and asthma/chronic obstructive pulmonary disease.

Thanks to Novo Nordisk, 1 of the holes in the formulary is plugged. Now I implore the makers of the asthmas inhalers to come up with a similar program to help this patient population. I’m a seasoned pharmacist that remembers 20 years ago when we had $10 inhalers. I challenge inhaler manufacturers to come up with a $40 per month inhaler. This would keep our patients out of the emergency department and save billions for the health care system.

Novo Nordisk has fired the first “shot heard around the health care world.” I’m hoping for a revolution in health care that frees up our patients from a burdensome, expensive, and cumbersome insurance, government, and manufacturer system. I’m hoping for a revolution in health care that frees up our patients from a burdensome, expensive, and cumbersome insurance, government, and manufacturer system.

“I’m hoping for a revolution in health care that frees up our patients from a burdensome, expensive, and cumbersome insurance, government, and manufacturer system.”

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