NoDak Pharmacy

Volume 27, No.3 June 2014

Bowl of Hygeia Recipient Dr. Charles Peterson & Family

A Special Thank You to all the Convention Exhibitors and Sponsors

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2014 Calendar

JUNE

June 6	D Day WW II
June 14	Flag Day
June 15	Father's Day

JULY

July 4	Happy Indepdence Day

SEPTEMBER

Sept 1	Labor Day
Sept 26 & 27	NAPT Fall Conference Bismarck, ND

2014 Award Recipients

Bowl of Hygeia
Charles Peterson,
Mark Jepperson

Distinguished Young Pharmacy Technician
Brittany Sanders,
Sheila Welle, Pharmacists Mutual

Pharmacy Technician of the Year
Lindsey Prochrow,
David DeBuhr

Al Doerr Service Award
Ardell Moe,
Ramona Sorenson

Leadership Award
Incoming President,
Steve Boehning,
Joel Aukes

Distinguished Young Pharmacist
Ramona Sorenson,
Sheila Welle, Pharmacists Mutual

Appreciation for Service
Outgoing President
Joel Aukes

Excellence in Innovation
Joan Slusser

Pharmacy Practice Literature
David Leedahl,
Maari Loy

Friend of NAPT
Gerald Finken

Award of Excellence
in Medication uses
Sanford Health, Bismarck
John Savegeau, Tom Simmer,
Maari Loy

NDPhA 2014 Award Recipients

Lifetime
James Irsfeld,
Joel Aukes

Diamond Award
Eileen Darkow,
Donna Kisse

Generation Rx
NDSU APhA - ASP Chapter
Victoria Okoye,
Lance Mindt

Health System
Pharmacist of the Year
David Sandberg,
Tom Johnson

Tom Johnson Presents
Best Practices Sanford Health Fargo
Antimicrobial Stewardship

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Howard Anderson, Registered Pharmacist

Howard comes to us today bringing with him a wealth of knowledge about Pharmacy, from the perspective of a Pharmacy owner, a State Board Member, a Pharmacy Association President, a developer of the Pharmacy technician program and his primary position of Executive Director of the North Dakota State Board of Pharmacy which he has held since 1997. He has served on numerous committees, including the Executive Committee, for the National Association of Boards of Pharmacy. He serves as 2010 Honorary President of NABP. He is the secretary/treasurer for District V NABP/AACP.

Mr. Anderson has co-authored several documents on Telepharmacy. These documents clearly define the opportunities for the Pharmacy technician in the Telepharmacy setting. He speaks on the Pharmacy laws and rules on many occasions.

Howard graduated from North Dakota State University and joined his father in his pharmacy in Turtle Lake, ND, in 1968. He operated and owned the pharmacy for over 35 years when he sold to a young ND pharmacist. He served as the Pharmacist at Turtle Lake Community Memorial Hospital for 20 years. He was asked to take the position of Executive Director for the ND Pharmacists Association in 1991 and the Pharmacy Service Corporation in 1994. He held that position until asked to take the position of Executive Director for the North Dakota State Board of Pharmacy in 1997. He has held that position since that date.

Anderson is registered as a Pharmacist in the State of Montana and until six years ago owned a Pharmacy in Helena, Montana.

Howard learned to appreciate the value of a technician when he worked side by side with his wife, Joan, Pharmacy technician, in their pharmacy. He has been instrumental across the nation helping other states implement guidelines for Pharmacy technicians. North Dakota was one of the first states registering technicians, beginning in 1993 when Howard was a member of the Board.

NAMENDA XR (memantine hydrochloride) extended release capsules
Brief Summary of full Prescribing Information
Initial U.S. Approval: 2003

INDICATIONS AND USAGE: NAMENDA XR (memantine hydrochloride) extended-release capsules are indicated for the treatment of moderate to severe dementia of the Alzheimer's type.

CONTRAINDICATIONS: Hypersensitivity - NAMENDA XR is contraindicated in patients with known hypersensitivity to memantine hydrochloride or to any excipients used in the formulation *[*See *Description in the full Prescribing Information].*

WARNINGS AND PRECAUTIONS: Genitourinary Conditions - Conditions that raise urine pH may decrease the urinary elimination of memantine resulting in increased plasma levels of memantine. **Seizures -** NAMENDA XR has not been systematically evaluated in patients with a seizure disorder. In clinical trials of memantine, seizures occurred in 0.3% of patients treated with memantine and 0.6% of patients treated with placebo.

ADVERSE REACTIONS: Clinical Trial Data Sources - NAMENDA XR was evaluated in a double-blind placebo-controlled trial treating a total of 676 patients with moderate to severe dementia of the Alzheimer's type (341 patients treated with NAMENDA XR 28 mg/day dose and 335 patients treated with placebo) for a treatment period up to 24 weeks. Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. **Adverse Reactions Leading to Discontinuation -** In the placebo-controlled clinical trial of NAMENDA XR [See *Clinical Studies in the full Prescribing Information*], which treated a total of 676 patients, the proportion of patients in the NAMENDA XR 28 mg/day dose and placebo groups who discontinued treatment due to adverse events were 10.0% and 6.3%, respectively. The most common adverse reaction in the NAMENDA XR treated group that led to treatment discontinuation in this study was dizziness at a rate of 1.5%. **Most Common Adverse Reactions -** The most commonly observed adverse reactions seen in patients administered NAMENDA XR in the controlled clinical trial, defined as those occurring at a frequency of at least 5% in the NAMENDA XR group and at a higher frequency than placebo were headache, diarrhea and dizziness. Table 1 in the full Prescribing Information lists treatment-emergent adverse reactions that were observed at an incidence of ≥ 2% in the NAMENDA XR treated group and occurred at a rate greater than placebo. The first value displays the percentage of patients in the placebo group (N=335) and the second shows the percentage in the group receiving 28 mg of NAMENDA XR (N=341). **Gastrointestinal Disorders:** Diarrhea (4%, 5%), Constipation (1%, 3%), Abdominal pain (1%, 2%), Vomiting (1%, 2%); **Infections and infestations:** Influenza (3%, 4%); **Investigations:** Weight, increased (1%, 3%); **Musculoskeletal and connective tissue disorders:** Back pain (1%, 3%); **Nervous system disorders:** Headache (5%, 6%), Dizziness (1%, 5%), Somnolence (1%, 3%); **Psychiatric disorders:** Anxiety (3%, 4%), Depression (1%, 3%), Aggression (1%, 2%); **Renal and urinary disorders:** Urinary incontinence (1%, 2%); **Vascular disorders:** Hypertension (2%, 4%), Hypotension (1%, 2%). **Vital Sign Changes -** NAMENDA XR and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, diastolic blood pressure, and weight) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. There were no clinically important changes in vital signs in patients treated with NAMENDA XR. A comparison of supine and standing vital sign measures for NAMENDA XR and placebo in Alzheimer's patients indicated that NAMENDA XR treatment is not associated with orthostatic changes. **Laboratory Changes -** NAMENDA XR and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with NAMENDA XR treatment. **ECG Changes -** NAMENDA XR and placebo groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in ECG parameters associated with NAMENDA XR treatment. **Other Adverse Reactions Observed During Clinical Trials of NAMENDA XR -** Following is a list of treatment-emergent adverse reactions reported from 750 patients treated with NAMENDA XR for periods up to 52 weeks in double-blind or open-label clinical trials. The listing does not include those events already listed in Table 1, those events for which a drug cause was remote, those events for which descriptive terms were so lacking in specificity as to be uninformative, and those events reported only once which did not have a substantial probability of being immediately life threatening. Events are categorized by body system. **Blood and Lymphatic System Disorders:** anemia. **Cardiac Disorders:** bradycardia, myocardial infarction. **Gastrointestinal Disorders:** fecal incontinence, nausea. **General Disorders:** asthenia, fatigue, gait disturbance, irritability, peripheral edema, pyrexia. **Infections and Infestations:** bronchitis, nasopharyngitis, pneumonia, upper respiratory tract infection, urinary tract infection. **Injury, Poisoning and Procedural Complications:** fall. **Investigations:** weight decreased. **Metabolism and Nutrition Disorders:** anorexia, dehydration, decreased appetite, hyperglycemia. **Musculoskeletal and Connective Tissue Disorders:** arthralgia, pain in extremity. **Nervous System Disorders:** convulsion, dementia Alzheimer's type, syncope, tremor. **Psychiatric Disorders:** agitation, confusional state, delirium, delusion, disorientation, hallucination, insomnia, restlessness. **Respiratory, Thoracic and Mediastinal Disorders:** cough, dyspnea. **Memantine Immediate Release Clinical Trial and Post Marketing Spontaneous Reports -** The following additional adverse reactions have been identified from previous worldwide experience with memantine (immediate release) use. These adverse reactions have been chosen for inclusion because of a combination of seriousness, frequency of reporting, or potential causal connection to memantine and have not been listed elsewhere in labeling. However, because some of these adverse reactions were reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship between their occurrence and the administration of memantine. These events include: **Blood and Lymphatic System Disorders:** agranulocytosis, leukopenia (including neutropenia), pancytopenia, thrombocytopenia, thrombotic thrombocytopenic purpura. **Cardiac Disorders:** atrial fibrillation, atrioventricular block (including 2nd and 3rd degree block), cardiac failure, orthostatic hypotension, and torsades de pointes. **Endocrine Disorders:** inappropriate antidiuretic hormone secretion. **Gastrointestinal disorders:** colitis, pancreatitis. **General disorders and administration site conditions:** malaise, sudden death. **Hepatobiliary Disorders:** hepatitis (including abnormal hepatic function test, cytolytic and cholestatic hepatitis), hepatic failure. **Infections and infestations:** sepsis. **Investigations:** electrocardiogram QT prolonged, international normalized ratio increased. **Metabolism and Nutrition Disorders:** hypoglycaemia, hyponatraemia. **Nervous System Disorders:** convulsions (including grand mal), cerebrovascular accident, dyskinesia, extrapyramidal disorder, hypertonia, loss of consciousness, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia, transient ischemic attack. **Psychiatric Disorders:** hallucinations (both visual and auditory), restlessness, suicidal ideation. **Renal and Urinary Disorders:** acute renal failure (including abnormal renal function test), urinary retention. **Skin Disorders:** rash, Stevens Johnson syndrome. **Vascular Disorders:** pulmonary embolism, thrombophlebitis, deep venous thrombosis.

The following adverse events have been reported to be temporally associated with memantine treatment and are not described elsewhere in the product labeling: aspiration pneumonia, bone fracture, carpal tunnel syndrome, cerebral infarction, chest pain, cholelithiasis, claudication, depressed level of consciousness (including rare reports of coma), dysphagia, encephalopathy, gastritis, gastroesophageal reflux, intracranial hemorrhage, hyperglycemia, hyperlipidemia, ileus, impotence, lethargy, myoclonus, supraventricular tachycardia, and tachycardia. However, there is again no evidence that any of these additional adverse events are caused by memantine.

DRUG INTERACTIONS: No drug-drug interaction studies have been conducted with NAMENDA XR, specifically. **Use with other N-methyl-D-aspartate (NMDA) Antagonists -** The combined use of NAMENDA XR with other NMDA antagonists (amantadine, ketamine, and dextromethorphan) has not been systematically evaluated and such use should be approached with caution. **Effect of Memantine on the Metabolism of Other Drugs -** *In vitro* studies conducted with marker substrates of CYP450 enzymes (CYP1A2, -2A6, -2C9, -2D6, -2E1, -3A4) showed minimal inhibition of these enzymes by memantine. In addition, *in vitro* studies indicate that at concentrations exceeding those associated with efficacy, memantine does not induce the cytochrome P450 isozymes CYP1A2, -2C9, -2E1 and -3A4/5. No pharmacokinetic interactions with drugs metabolized by these enzymes are expected. Pharmacokinetic studies evaluated the potential of memantine for interaction with donepezil (See *Use with Cholinesterase Inhibitors*) and bupropion. Coadministration of memantine with the AChE inhibitor donepezil HCl does not affect the pharmacokinetics of either compound. Memantine did not affect the pharmacokinetics of the CYP2B6 substrate bupropion or its metabolite hydroxybupropion. **Effect of Other Drugs on Memantine -** Memantine is predominantly renally eliminated, and drugs that are substrates and/or inhibitors of the CYP450 system are not expected to alter the pharmacokinetics of memantine. A clinical drug-drug interaction study indicated that bupropion did not affect the pharmacokinetics of memantine. **Drugs Eliminated via Renal Mechanisms -** Because memantine is eliminated in part by tubular secretion, coadministration of drugs that use the same renal cationic system, including hydrochlorothiazide (HCTZ), triamterene (TA), metformin, cimetidine, ranitidine, quinidine, and nicotine, could potentially result in altered plasma levels of both agents. However, coadministration of memantine and HCTZ/TA did not affect the bioavailability of either memantine or TA, and the bioavailability of HCTZ decreased by 20%. In addition, coadministration of memantine with the antihyperglycemic drug Glucovance® (glyburide and metformin HCl) did not affect the pharmacokinetics of memantine, metformin and glyburide. Furthermore, memantine did not modify the serum glucose lowering effect of Glucovance®, indicating the absence of a pharmacodynamic interaction. **Drugs That Make the Urine Alkaline -** The clearance of memantine was reduced by about 80% under alkaline urine conditions at pH 8. Therefore, alterations of urine pH towards the alkaline condition may lead to an accumulation of the drug with a possible increase in adverse effects. Urine pH is altered by diet, drugs (e.g. carbonic anhydrase inhibitors, sodium bicarbonate) and clinical state of the patient (e.g. renal tubular acidosis or severe infections of the urinary tract). Hence, memantine should be used with caution under these conditions. **Drugs Highly Bound to Plasma Proteins -** Because the plasma protein binding of memantine is low (45%), an interaction with drugs that are highly bound to plasma proteins, such as warfarin and digoxin, is unlikely [See *Drug Interactions*]. **Use with Cholinesterase Inhibitors -** Coadministration of memantine with the AChE inhibitor donepezil HCl did not affect the pharmacokinetics of either compound. In a 24-week controlled clinical study in patients with moderate to severe Alzheimer's disease, the adverse event profile observed with a combination of memantine immediate-release and donepezil was similar to that of donepezil alone.

USE IN SPECIFIC POPULATIONS: Pregnancy - Pregnancy Category B: There are no adequate and well-controlled studies of NAMENDA XR in pregnant women. NAMENDA XR should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Memantine given orally to pregnant rats and pregnant rabbits during the period of organogenesis was not teratogenic up to the highest doses tested (18 mg/kg/day in rats and 30 mg/kg/day in rabbits, which are 6 and 21 times, respectively, the maximum recommended human dose [MRHD] on a mg/m^2 basis). Slight maternal toxicity, decreased pup weights and an increased incidence of non-ossified cervical vertebrae were seen at an oral dose of 18 mg/kg/day in a study in which rats were given oral memantine beginning pre-mating and continuing through the postpartum period. Slight maternal toxicity and decreased pup weights were also seen at this dose in a study in which rats were treated from day 15 of gestation through the post-partum period. The no-effect dose for these effects was 6 mg/kg, which is 2 times the MRHD on a mg/m^2 basis. **Nursing Mothers -** It is not known whether memantine is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when memantine is administered to a nursing mother. **Pediatric Use -** The safety and effectiveness of memantine in pediatric patients have not been established.

DRUG ABUSE AND DEPENDENCE: Memantine is not a controlled substance. Memantine is a low to moderate affinity uncompetitive NMDA antagonist that did not produce any evidence of drug-seeking behavior or withdrawal symptoms upon discontinuation in 3,254 patients who participated in clinical trials at therapeutic doses. Post marketing data, outside the U.S., retrospectively collected, has provided no evidence of drug abuse or dependence.

OVERDOSAGE: Signs and symptoms most often accompanying overdosage with other formulations of memantine in clinical trials and from worldwide marketing experience, alone or in combination with other drugs and/or alcohol, include agitation, asthenia, bradycardia, confusion, coma, dizziness, ECG changes, increased blood pressure, lethargy, loss of consciousness, psychosis, restlessness, slowed movement, somnolence, stupor, unsteady gait, visual hallucinations, vertigo, vomiting, and weakness. The largest known ingestion of memantine worldwide was 2 grams in an individual who took memantine in conjunction with unspecified antidiabetic medications. This person experienced coma, diplopia, and agitation, but subsequently recovered. One patient participating in a NAMENDA XR clinical trial unintentionally took 112 mg of NAMENDA XR daily for 31 days and experienced an elevated serum uric acid, elevated serum alkaline phosphatase, and low platelet count. No fatalities have been noted with overdoses of memantine alone. A fatal outcome has very rarely been reported when memantine has been ingested as part of overdosing with multiple drugs; in those instances, the relationship between memantine and a fatal outcome has been unclear. Because strategies for the management of overdose are continually evolving, it is advisable to contact a poison control center to determine the latest recommendations for the management of an overdose of any drug. As in any cases of overdose, general supportive measures should be utilized, and treatment should be symptomatic. Elimination of memantine can be enhanced by acidification of urine.

Manufactured for:
Forest Pharmaceuticals, Inc.
Subsidiary of Forest Laboratories, Inc.
St. Louis, MO 63045

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Revised: April 2013 62-12000315-BS-A-RMC8791-APR13

Please also see full Prescribing Information at www.namendaxr.com

NAPT Fall Conference
September 26-27, 2014
Bismarck, ND

Congratulations to Steve Irsfeld of Dickinson on his appointment to the State Board of Pharmacy!

Congratulations

2014 NORTH DAKOTA STATE SCIENCE AND ENGINEERING FAIR
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Project in Field of Pharmacology
Junior Division: Cati Silva, Hankinson School District, "The Effects of Flower Power"

Project in Field of Pharmacology
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Invoice for NDPhA Membership

January 1 – December 31, 2014

Or Renew On-line at www.nodakpharmacy.net, select the Join tab on the Right

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CMS Star Ratings and Their Implications on the Future of Pharmacy

How can one truly measure the quality of health care they receive? That is the question behind the drive to define new standards of performance measures in Medicare Advantage and Part D prescription drug plans. The CMS Star Quality Program was established in 2003 as a means of managing and measuring the performance of plans for the consumers' knowledge. Anyone can access this data via Medicare's website to better make informed decisions.

Plans receive a rating from 1 to 5 stars, with 5 stars being the highest rating and incentives given to those plans who receive a higher star rating. These incentives can come in the form of bonus payments to Medicare Advantage plans or enrollment incentives to Part D plans. For example, Part D plans with 5 stars are granted open enrollment year-round. Patients are also able to change from a less than 5-star plan to a 5-star plan at any time during the year.

As you can imagine, these incentives have made plans very interested in their star ratings. A plan receives higher star ratings based on many different criteria. Some of these criteria include things more related to plan management like telephone customer service or website pricing accuracy. However, the single largest performance measure contributing to the plan's star rating is pharmacy-related performance.

This is where we come into play. These pharmacy-driven performance benchmarks are mostly related to patient adherence, but also to patient safety and the reduction of risk, focusing especially on high-risk medications in the elderly. A plan that wants a higher star rating may look to the community pharmacy level to find inadequacies that are bringing their rating down. This means that plans will be looking at data that is collected by CMS from community pharmacy claims to monitor pharmacies in these areas of patient care. One source even claims that plans may look to these performance measures in the future to determine eligibility for sharing bonus payments or inclusion in a preferred network.

In the future, the pay-for-performance structure of healthcare will likely move to include pharmacy. Any retail pharmacy that wants to participate will need to be able to prove their effectiveness at providing safe medication therapy, improving adherence and demonstrating improved outcomes. What does that mean for a typical day at your retail pharmacy? Well, in theory, it shouldn't change much, since we have always been the major advocate for medication adherence and safety, and cost savings in healthcare. Now, we can just actually get incentives for being such.

It really always has been and will continue to be about pro-actively managing the healthcare of patients. Pharmacies that work closely with their patients to educate them and monitor their therapies will find that they are already bettering their outcomes, increasing medication adherence and lower their healthcare costs. These will be the pharmacies that will have no problem proving to CMS that they are ready for a healthcare system that finally recognizes and pays them for the services they provide to their patients.

CMS Star ratings are only the beginning when it comes to monitoring the quality of healthcare that people receive. And though they aren't solely focused on pharmacies, it is becoming more and more evident that CMS and healthcare plans are aware there is a benefit in assuring they are working with high-performing pharmacies. One way to ensure that the pharmacies they work with stay performing at the level they want, is to provide incentives for doing so. It has been a long time coming that pharmacies receive adequate payment for providing the services that they offer. These services which are so crucial to total health care outcomes, including medication adherence, safety and overall cost reduction. It appears the time may finally be near.

Sources

American Pharmacists Association. CMS Star Ratings: Pharmacists can improve Medicare plan star ratings. Dec 2013.

Bow, S, Rasmussen,], Lyman, AE (2013). How We Can Measure Quality and Utilization Outcomes: Are We Being Successful with Our interventions? *California Pharmacist*. Fall 2013

Frederick, I. The Quality Imperative: Performance measures for safety and adherence define new standard. *Drug Store News*. March 26, 2014.

Logan, R, & Logan, T (2013). Your Future is in the Strs: Part D's Rating System could lead to bonus payments for high performing pharmacies. *America's Pharmacist*. Nov 2013.

Pharmacy Time Capsules 2014 (Second Quarter)

1989

The Medicare Catastrophic Act of 1988 was resoundingly repealed after disclosures that insurance coverage could be bought on the open market for a fraction of the surtax imposed by the government,

Epogen (Amgen) the first recombinant human erythropoetin product approved by the FDA for marketing.

1964

Surgeon General Luther Terry made an announcement that cigarette smoking causes lung cancer and probably heart disease.

1939

Joseph Lynch, a 1927 Fordham College of Pharmacy alumni, became a police office was killed disarming a bomb set by Nazi saboteurs at the World's Fair in Flushing Meadows

WW II starts, Germany invades Poland

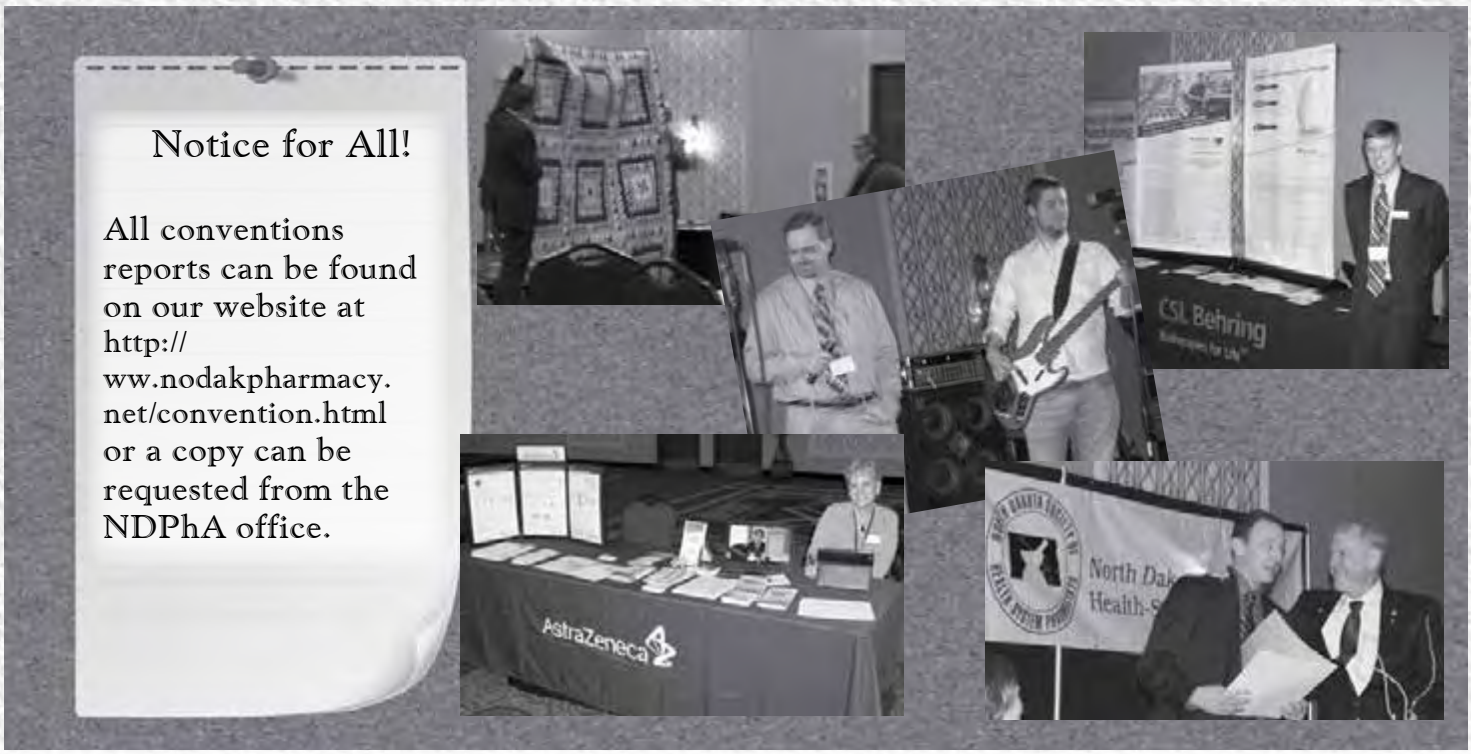
1914

West Virginia University establishes its College of Pharmacy

Franz Ferdinand, Archduke of Austria and his wife are assassinated in Sarajevo by a Serbian nationalist, the justification of World War I.

By: Dennis B. Worthen, PhD, Cincinnati, OH

One of a series contributed by the American Institute of the History of Pharmacy, a unique non-profit society dedicated to assuring that the contributions of your profession endure as a part of America's history. Membership offers the satisfaction of helping continue this work on behalf of pharmacy, and brings five or more historical publications to your door each year. To learn more, check out: www.aihp.org



ElbowoodsMemorial Care Center, New Town: Pharmacist Wanted (5-1-2014)
Full time or part time pharmacist wanted at Elbowoods Memorial Health Center, New Town, ND. Pharmacy hours are M-F 8-5:30pm. Federal Holidays Observed. There is housing available and we offer student loan repayment through the Indian Health Service. Contact Ramona Sorenson at 701-627-7624 or email ramona.sorenson@mhalhealth.com.

Ye Olde Medicine Center, Park River: Pharmacy Technician needed (4-23-2014)
Immediate job opening for a full time pharmacy technician. Competitive wages and benefits package available. Our hours are 8:30 to 6:00 Monday thru Friday and Saturday 8:30 to 12:00. Please call (701) 284-7676 if interested.

Center for Family Medicine Pharmacy, Bismarck (04-09-2014)
is looking for a relief pharmacist with retail experience. Great hours—Monday thru Friday 8am-5pm If interested please call Billie at 701-751-6801 or email billie.krush@med.und.edu

Professional Pharmacy, Bismarck Pharmacy Technician Wanted: (03-2014)
is looking for a full time technician. We have great hours- Monday through Friday 8:30am to 5pm. No weekends – and closed the major holidays! If interested or have questions can call Curt at 701-223-6854 ext. 105 or email curt.mcgarvey@ppltc.com

IHS New Town (2-13-2014) The Healing Staff
is now in search of a North Dakota Registered Pharmacist to work a 5 month locums starting Mid-March 2014 for our Indian Health Elbowoods Memorial Health Care Center in New Town, ND. We are looking for a pharmacist that lives in the area and that can work M-F 8am to 5pm daily. Send us your most current CV to attention: Greg Pugh /Senior Medical Recruiter/ at email: g.pugh@thehealingstaff.com. Phone is 210-317-0806.

Pharmacists Looking for Work:

Pharmacist looking for Full time position
Jennifer Murphy, 21 Penenah Drive, Lincoln, ND 58504, 701-202-9991 (7-16-2013)

Relief Pharmacist
in Bismarck looking to add a couple days per week to schedule. Retail experience. Call 701-391-9900. (04-19-2013)

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With a push from pharmacy, provider status bill introduced in Congress

DIANA YAP

A pharmacists' provider status bill was introduced in the U.S. House of Representatives on March 11. Reps. Brett Guthrie (R-KY), G.K. Butterfield (D-NC), and Todd Young (R-IN) introduced legislation to amend Title XVIII of the Social Security Act to provide for coverage under the Medicare program of pharmacist services.

The bill (H.R. 4190) was referred for consideration to the House Committee on Energy & Commerce and the House Committee on Ways & Means.

"There is currently no mechanism for pharmacists to be reimbursed by the Medicare program. This commonsense bill creates a means for pharmacists to be reimbursed for these services they are already allowed to perform, when performed in medically underserved areas," according to a news release posted on Guthrie's congressional website.

Rep. Todd Young (R-IN) and APhA Executive Vice President and CEO Thomas E. Menighan on Capitol Hill

Pharmacy's reaction

The Patient Access to Pharmacists' Care Coalition (PAPCC) applauded the bill. PAPCC is leading the push for the passage of federal legislation to enable patient access to, and reimbursement for, Medicare Part D services by state-licensed pharmacists in medically underserved communities, the coalition announced March 3. APhA is a member of the coalition.

"We must deploy our highly trained pharmacists to help improve medication use, and the pathway is through coverage and payment of pharmacists' patient care services in the Social Security Act," wrote APhA Executive Vice President and CEO Thomas E. Menighan, BSPharm, MBA, ScD (Hon), FAPhA, in a CEO Blog post published March 11 on pharmacist.com.

Two days after the introduction of H.R. 4190, more than 400 community pharmacists, pharmacy executives, student pharmacists, and other pharmacy advocates from 40 states participated in the National Association of Chain Drug Stores' (NACDS) RxIMPACT Day on Capitol Hill, according to an NACDS news release.

During the NACDS fly-in, Menighan and APhA Senior Lobbyist Michael Spira joined a delegation from Indiana to visit eight congressional offices in the House and Senate. "In every meeting we talked about the value that pharmacists bring to the heatlh care team and how the newly introduced H.R. 4190 will allow us to better serve our patients—their constituents," Menighan wrote in a March 14 CEO Blog post. "We had a great response from every office. Even the offices that were a bit hesitant—for instance, Rep. [Todd] Rokita [R-IN] was concerned about the cost of the bill—believed there is a need for including pharmacists on the health care team."

What's in the bill

If enacted, the legislation would require Medicare to cover pharmacists' patient care services that the licensed pharmacist is legally authorized to perform in the state; that would otherwise be covered if furnished by a physician or incident to a physician's service; and when provided in a health professional shortage area, in a medically underserved area, or for a medically underserved population.

The proposed legislation also would require Medicare to pay pharmacists an amount equal to 80% of the actual charge or 85% of the physician fee schedule amount.

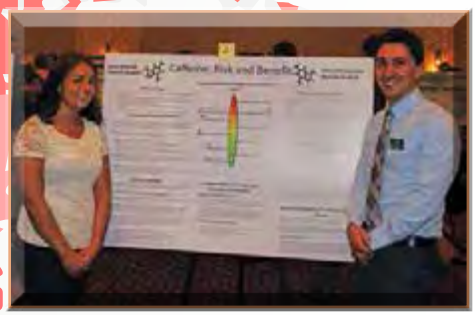
The effective date for Medicare to start covering pharmacists' patient care services would be January 1, 2015. The bill would further require the U.S. Department of Health & Human Services to develop pharmacist-specific codes, as necessary, under the physician fee schedule.

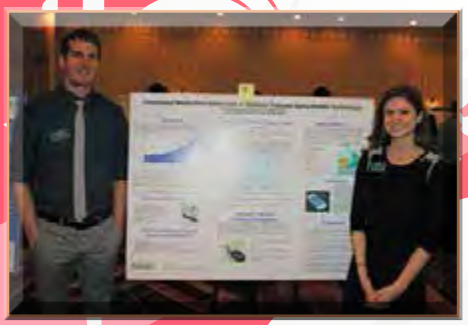
Coalition membership

PAPCC's current membership includes 9 pharmacy associations, 11 chain pharmacies, and 2 drug wholesalers. These include Albertson's, American Association of Colleges of Pharmacy, APhA, American Society of Consultant Pharmacists, American Society of Health-System Pharmacists, Amerisource Bergen, Bi-Lo Pharmacy, Cardinal Health, CVS Caremark, Food Marketing Institute, Fred's Pharmacy, Fruth Pharmacy, International Academy of Compounding Pharmacists, National Alliance of State Pharmacy Associations, NACDS, National Community Pharmacists Association, Rite Aid, Safeway Inc., SuperValu Pharmacies (Cub, New Farm Fresh Pharmacy, New Shoppers Pharmacy, and Shop'n Save Pharmacy), Thrifty White Pharmacy, Walgreens, and Winn-Dixie.

"This group will be knocking on the doors of Congress to ensure that pharmacists are formally recognized for their work as health care providers under federal law," Menighan wrote in a March 4 CEO Blog post. "This will take time, but we are in it for the long haul."

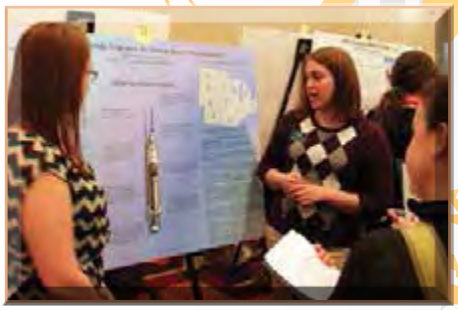
Diana Yap, Senior Assistant Editor

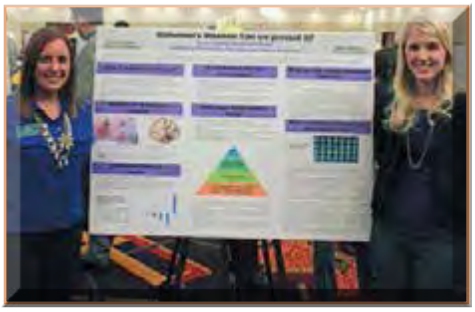


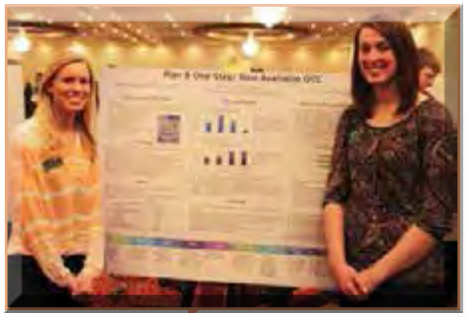


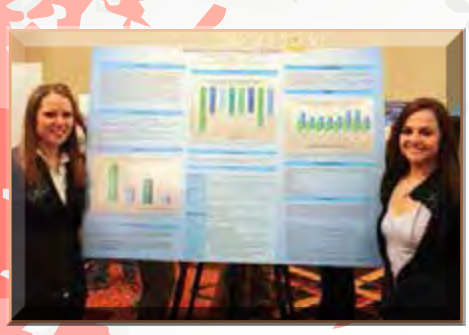


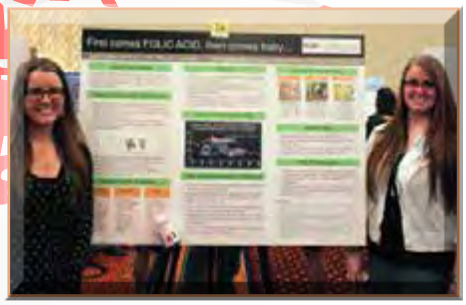


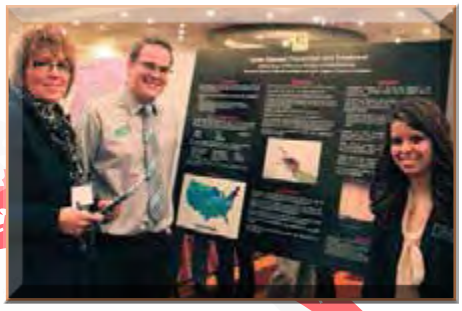



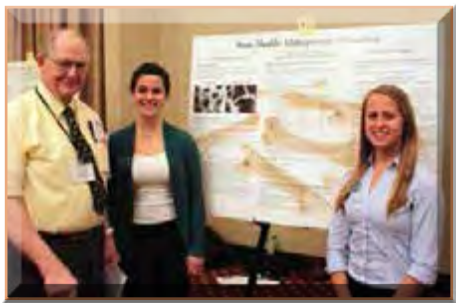


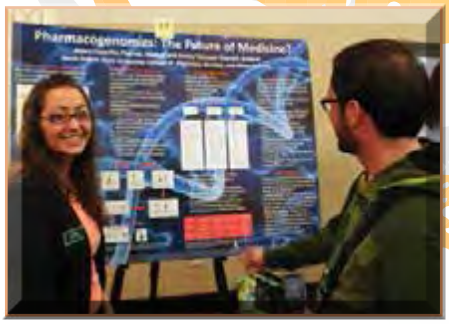











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