The Pharmacist Activist

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Editorial

The Independent Community Pharmacy Summit on Strategy, Structure, and Survival (ICPSSSS)

I attended the annual meeting of the National Community Pharmacists Association (NCPA) in mid-October. I always consider the NCPA meetings to be encouraging and inspiring as I learn about the positive professional initiatives in which independent pharmacists are engaged. I feel that every independent pharmacist would benefit from attending the NCPA annual meeting, and I wish it was possible for every pharmacy student to attend an annual meeting of a national pharmacy organization. The next NCPA annual meeting will be held in October 2018 in Boston, where there are two colleges of pharmacy – Massachusetts College of Pharmacy and Northeastern. I recommended to two NCPA officers with whom I spoke that the association offer a one-day free registration for pharmacy students at these two colleges as an initiative to encourage their participation and learning about the opportunities in independent pharmacy.

The Community Pharmacy Enhanced Services Network (CPESN; www.cpesn.com) was given prominent attention at the NCPA meeting. This is an excellent initiative in which pharmacists from a number of states are participating, and it is growing quickly. However, there are many independent pharmacists who have the potential to be highly effective participants in this program who are not yet aware of it. The profession of pharmacy must give a very high priority to having pharmacists actually provide the services of which we are capable and which we are promoting, and the CPESN is a very positive initiative in this direction. Also of great importance is the need for pharmacists to be equitably compensated for providing these services. Although CPESN does not have the authority for determining compensation, the establishment of a network of pharmacies that are providing expanded services of value will provide the foundation from which equitable agreements with payers may be established.

Regular readers of *The Pharmacist Activist* are aware of my recent 5-part series of editorials in which I urge our profession to establish our own pharmacy care administrator (PCA). The following things must occur if our own PCA is to be established and implemented with the opportunity to attain its full potential for the benefit of our patients and our profession:

1. There must be much more comprehensive and effective communication with and among independent community pharmacists than exists now.
2. Many more independent pharmacists must extend their services for patients beyond the traditional responsibilities and include services such as medication therapy management that will contribute to the attainment of positive therapeutic/clinical outcomes.
3. The provision and value of expanded professional services must be documented.
4. Independent pharmacists and their organizations must be willing to invest in their own future in establishing and owning a new PCA that would be financially competitive with existing prescription benefit programs and pharmacy benefit managers.

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5. The network of participating independent pharmacies must have sufficient size and geographical distribution to serve patients and communities in a convenient manner.

The number of independent pharmacies has declined to the point that there are few communities in which they compete with each other. However, the buying groups, wholesaler collaboratives, and national/regional wholesalers with which independent pharmacies are affiliated are engaged in strong competition with each other. Some have suggested that this situation alone prevents independent pharmacists from communicating and working more closely with each other, because these organizations might anticipate that the initiatives and plans that could emerge from closer working relationships could be a threat to the continued viability of the existing groups. However, this does not have to be the case as these organizations/groups presumably have a common purpose in wanting independent pharmacies to not only survive but thrive. The five criteria identified above as essential for a new PCA to be successful are independent of the decisions, groups, and arrangements through which pharmacies purchase medications. Indeed, more extensive and effective communication and collaboration among these entities offers the hope of synergistic initiatives, rather than a competitive environment.

There is an urgent need to convene what I would designate as the Independent Community Pharmacy Summit on Strategy, Structure, and Survival (ICPSSSS). I recommend that this Summit be convened by the NCPA, in collaboration with the American Pharmacists Association, the American College of Apothecaries, the International Association of Compounding Pharmacists, and other national organizations in which independent pharmacists are the majority of the membership. Participants in the Summit would also include representatives of national/regional wholesalers, buying groups, and other organizations with which independent pharmacists are affiliated. For example, each of these organizations might be invited to send two representatives, one of whom must be the highest-ranking pharmacist in the organization.

The Summit would have at least the following ground rules:

- The focus of the participants would be the determination of a strategy and structure that would best position independent pharmacists for survival and success.
- The emphasis of the discussion will be on initiatives that are collaborative and synergistic, and not on situations in which the participants and their organizations may currently be in competition.
- There will be no specific discussion of compensation, fees, or other financial or organizational considerations that could be considered to have antitrust implications.

I consider the convening of a Summit of the type proposed, as well as the anticipated positive outcomes, as not only important, but essential for the future of independent pharmacy and for the entire profession of pharmacy. Continuing the *status quo* must not be an option because the challenges and threats are becoming even more formidable, and some of these are identified below.

New headlines and threats

If the discussion above is not sufficiently convincing of the need for action by our profession, the following recent headlines should provide the motivation for action.

1. "Amazon threatens to disrupt the prescription drug delivery business, analysts say."
2. "CVS Caremark unveils performance-based Rx network: Pharmacies to include CVS, Walgreens and independents." If this situation did not have the potential for such negative consequences, it would be comical, and a sick joke at that. In my opinion, CVS Caremark should be the very last organization to discuss or mandate performance standards in community pharmacies. Because of the metrics and policies imposed by CVS in its own stores, many CVS pharmacists do not have time to even say "Hello" to a patient, let alone provide them with counseling and other professional services. The performance measures proposed by CVS emphasize improved medication adherence. This is certainly a laudable goal, but it does not have credibility when proposed by CVS because of its initiatives in its own pharmacies to send unrequested and unneeded refills of medications to patients with chronic conditions and call it improved adherence.
3. "CVS, Aetna Plot $66 Billion Tie-Up" is the lead headline story in the October 27 edition of *The Wall Street Journal* (WSJ page A1: D. Mattioli, S. Terlep, and A. W. Mathews). The news quickly sparked an increase in the value of stock shares of Aetna, but the value of CVS shares declined because of the recognition by investors of the amount of risk that CVS would experience with the additional debt, etc. WSJ writer Charley Grant makes a very astute observation: "Given the state of affairs in the drug business, the real risk for CVS shareholders might be standing still" (October 27; page B1)

What is the risk if the profession of pharmacy and our organizations stand still?

Daniel A. Hussar

New Drug Review

Glecaprevir/pibrentasvir
(Mavyret – AbbVie)

Antiviral Agents

New Drug Comparison Rating (NDCR) = 4
(significant advantages)
in a scale of 1 to 5 with 5 being the highest rating

Indication:
Treatment of adult patients with chronic hepatitis C virus (HCV) genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis; is also indicated for the treatment of adult patients with HCV genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both.

Comparable drug:
Sofosbuvir/velpatasvir (Epclusa).

Advantages:
- Has been demonstrated to be effective in an 8-week course of treatment (whereas the recommended duration of treatment for sofosbuvir/velpatasvir is 12 weeks);
- Is effective in patients who have failed certain previous HCV regimens (although the combination of voxilaprevir, sofosbuvir, and velpatasvir [Vosevi] is also effective in patients who have failed certain previous HCV regimens);
- Is not likely to interact with amiodarone and cause bradycardia (a risk that is associated with sofosbuvir);
- Effectiveness has been demonstrated in patients with severe renal impairment.

Disadvantages:
- Is contraindicated in patients with severe hepatic impairment and use is not recommended in patients with moderate hepatic impairment (whereas sofosbuvir/velpatasvir is used with ribavirin in patients with moderate and severe hepatic impairment).

Most important risks/adverse events:
Risk of hepatitis B virus (HBV) infection reactivation in patients coinfecterd with HCV and HBV who are not receiving HBV antiviral therapy (boxed warning; patients should be tested for evidence of current or prior HBV infection before initiating treatment); contraindicated in patients with severe hepatic impairment and is not recommended in patients with moderate hepatic impairment; concentrations are increased by atazanavir and concurrent use is contraindicated because of the increased risk of ALT elevations; concurrent use of ethinyl estradiol-containing products (e.g., combination oral contraceptives) is not recommended because of increased risk of ALT elevations; concentrations may be increased by darunavir, lopinavir, or ritonavir, and concurrent use is not recommended; concentrations may be increased by cyclosporine and use is not recommended in patients requiring stable cyclosporine doses higher than 100 mg per day; concentrations and effectiveness may be reduced by drugs that induce P-glycoprotein/CYP3A (concurrent use with rifampin is contraindicated, and use with carbamazepine, efavirenz, or St. John's wort is not recommended); may increase the concentration and activity of digoxin, dabigatran, and the statins (concurrent use with atorvastatin, lovastatin, or simvastatin is not recommended, and the other statins, as well as digoxin, should be used in lower dosages).

Most common adverse events (incidence in treatment-naïve patients without cirrhosis treated for 8 weeks):
Headache (16%), fatigue (11%), nausea (9%), diarrhea (7%), elevations of total bilirubin (4%).

Usual dosage:
Three tablets once a day with food for 8 weeks in treatment-naïve patients without cirrhosis, and for 12 weeks in patients with compensated cirrhosis; product labeling should be consulted for the recommended duration of treatment for patients previously treated with other HCV regimens.

Product:
Tablets – 100 mg glecaprevir and 40 mg pibrentasvir.

Comments:
Glecaprevir is an HCV NS3/4A protease inhibitor and pibrentasvir is an HCV NS5A inhibitor and is the first antiviral combination that is used in an 8-week course of treatment for all HCV genotypes 1-6 infections in patients without cirrhosis who have not been previously treated. The effectiveness of the combination was evaluated in multiple studies in patients with HCV infection without cirrhosis or with compensated (mild) cirrhosis. The primary endpoint was sustained virologic response 12 weeks following completion of treatment (SVR12). A SVR12 response was experienced by 95% - 100% of the patients in most of the studies. Effectiveness was also demonstrated in patients who had failed certain previous HCV regimens although longer courses of treatment (12-16 weeks) are recommended for most of these patients, as well as for treatment-naïve patients with mild cirrhosis.

Daniel A. Hussar

After 124 Years and Four Generations of Family Pharmacists, Hinkle's Pharmacy Closed on October 25

The announcement stunned the residents of Columbia, PA. Founded in 1893 by Samuel Hinkle, the pharmacy, gift shop, and restaurant, have been a landmark and meeting place in the same "downtown" location of the community of 11,000 and had 71 employees. Samuel Hinkle's son, John Hinkle, joined his father in the pharmacy in 1925 and was followed by his son, John Hinkle Jr, in 1958. John Hinkle III, the fourth-generation pharmacist in the family, all of whom are graduates of the Philadelphia College of Pharmacy, joined the pharmacy in 1990. In the early years of the pharmacy, the Hinkle family developed paint-on Easter egg dyes. When the popularity and distribution of these dyes exceeded the capacity to continue preparing them in the basement of the pharmacy, the family sold the product to the John Wright Company in nearby Wrightsville, PA, which continues to make the product available as Doc Hinkle's Paint On Easter Egg Dye.

The explanation for the closing of Hinkle's Pharmacy is a "declining financial position over the past several years." The mayor of Columbia, in lamenting the pharmacy's closing in an interview with the local paper, noted, "I know this couldn't have been easy….He was there every day. He was there morning, noon, and night." When the decision regarding the closing was announced earlier this month, I spoke with John Hinkle III and asked if there was any way in which the pharmacy could be "rescued." He responded that, very regrettably, there was not an alternative and that the decision to close should have been made several years ago.

I met with John Hinkle Jr., his wife Pat who managed the gift shop, and John Hinkle III on October 23, two days before the pharmacy closed. Their challenges and experience are well known to independent community pharmacists. The compensation for dispensing prescriptions and providing other professional services is abysmal. However, the event that had the largest impact on their financial situation was the decision of one of the largest local employers to use a prescription benefit program that mandated and/or provided financial incentives for its employees to use a mail-order pharmacy. With time, this situation resulted in a substantial reduction in the number of individuals who brought their prescriptions to Hinkle's Pharmacy.

For many previous years, the revenue from the pharmacy helped sustain the operation of the gift shop and restaurant. However, in recent years, the revenue from the gift shop and restaurant has provided financial support for continuing the pharmacy. Although we did not discuss specific financial details, it was clear that the determination of the Hinkle family to try to avoid closing the pharmacy delayed the final decision for several years, and at a significant financial loss for the family. The pharmacy is now closed but, ironically, the purchaser of the property is re-opening the restaurant.

I have the highest respect and commendation for the Hinkle families and for their distinguished service to their patients, community, and the profession of pharmacy. During our discussion, John Hinkle Jr., now 81 years of age, wondered what he would now do. When I responded that he had earned the right to retire and do whatever he wanted on a schedule of his choosing, he responded that he had been in the pharmacy for 60 years and did not anticipate being able to identify another activity that he would enjoy more. The chain pharmacy that bought the prescription files of Hinkle's Pharmacy sent John Hinkle III an email message the evening before I met with them to inform him that he could apply for a position with them. I am certain that he will have better options.

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