

Prescription Drugs

Introduction

Prescription drugs are discussed under these headings:

- Information on prescription drugs
- Processing prescription drug bills
- Controlling prescription drugs costs
- Generic drugs
- Durable medical equipment
- Drugs requiring special consideration
- Drug care plans.

Information on Prescription Drugs

Introduction

The examiner many look to these sources of information on drugs:

- FDA publication
- Physicians Desk Reference
- Orphaned Drug Data
- U.S. Pharmacopoeia
- National Foundation.

Each of these sources are briefly reviewed.

FDA – Approval

This book lists the current marketed prescription drug products that have been approved on the basis of their safety and effectiveness by the Food and Drug Administration.

In addition, it contains therapeutic equivalence evaluations for multiple source drug products which are intended to promote public education in the area of drug product selection, to foster containment of health costs, and to serve state health agencies in the administration of their drug product selection laws.

This book is available through the U.S. Printing Office, Washington, D.C.

Physicians Desk Reference (PDR)

Introduction

These books are published by Medical Economics Company at Oradell, N.J. 07649 (mailing address for books is PO Box 10689, Des Moines, IA 50336). The examiner normally will use these two books:

- Physicians Desk Reference
- PDR – Nonprescription Drugs.

Physician's Desk Reference – Nonprescription Drugs

This text deals with only nonprescription drugs. These are called OTC – or over-the-counter drugs.

Manufacturers Index. In the section are found the manufacturers, their addresses and telephone numbers and their OTC drug products by trade name.

Product Name Index. All of the OTC drugs are listed alphabetically by trade or brand name.

Product Category Index. The OTC drugs are set forth by product categories in accordance with the OTC Review Committee of the FDA.

Active Ingredients Index. The main ingredient of the OTC drug product is shown under which all such trade name products with such active ingredient are listed.

Health Insurance Associations and Organizations. A list by name, address and telephone number of all such organization is shown in this section.

Product Identification Section. Capsules, tablets and packaging are shown in color as an aid to identification in this section. Products are listed by brand name under manufacturer.

Product Information Section. Products are listed in alphabetical order by brand name showing action, uses, administration, doses, precautions and the form in which supplied and other information concerning their use including common names and chemical names.

Diagnostic, Devices and Mechanical Aids. Certain products are described in brand name alphabetical order which are suitable to home use. Essential information for their appropriate understanding are used as described.

Physician's Desk Reference

This text deals only with prescription drugs and is published annually. The text is described by section.

Manufacturers Index. (White) This section names the manufacturers and their addresses and telephone numbers and lists their drug products by trade name.

Product Name Index. (Pink) This section lists the drug in alphabetical order by trade name.

Product Category Index. (Blue) This section groups the drugs by trade name under their use category such as *Anti-Inflammatory*. First section is 2-page quick index guide. Second section gives page number of color photograph if included in PDR, or will give page number of product identification.

Generic and Chemical Name Index. (Yellow) This section lists the trade name products under their chemical name heading. For example under Potassium Chloride would be shown all of the trade name drug products containing such chemical.

Product Identification Section. (Grey) A color photograph of the product (pills, bottle, etc) is shown. This is a quick identification reference, shows actual size of tablet caplet and capsules.

Conversion Tables. These are useful tables to convert metric, apothecary and household measures to each other.

Product Information Section. Each drug product is described as to indications and usage, dosage, administration, description, clinical pharmacology, supply, warnings, contraindications, adverse reactions, overdosages, precautions and other information concerning their use including common names, generic compositions and chemical names.

Discontinued Products. A list of those products discontinued since the previous PDR book.

Diagnostic Product Information. This section sets forth those drug products used only for diagnostic purposes.

Key to FDA Use-in-Pregnancy Ratings. The FDA's Pregnancy Categories are based on the degree to which available information has ruled out risk to the fetus, balanced against the drug's potential benefits to the patient.

Processing Prescription Drug Bills

Receipts from the drugstore are considered adequate documentation of a drug purchase when a small claim is submitted, provided that the receipt indicates: the prescription number or description of the drug, the name of the patient and the date purchased.

When information is requested from the pharmacist, the prescription number and date of each prescription, as well as the name of the physician, if known, should always be obtained. When the examiner suspects fraud such examiner should also request that the pharmacist verify the brand name and charge for each drug. The brand name should be occasionally checked against the *Physician's Desk Reference* (PDR), especially when reviewing expensive and repetitive prescriptions.

A pharmacist's statement can be an important tool not only for containing fraud but also to verify that the medication is:

- Prescription and not over-the-counter (OTC)
- For the covered person and not a friend or other family members
- Not preventive (e.g., birth control medication, such as Ortho Novum)
- For a non mental/nervous condition, which may be payable at a lesser benefit level.

Verification from the attending physician that he prescribed the medication(s) should also be obtained in any case where, in the judgment of the examiner, a charge is questionable.

Situations in which verification should be sought include:

- Apparent excessive charges, questionable relationship of drug to diagnosis, and need for clarification to the patient(s) receiving the drug(s)
- Drug bills which are possibly altered or otherwise falsified (e.g. blank prescription forms completed by someone other than the pharmacist).
- More than one type of handwriting or typewriting appearing on each drug bill.
- Duplicate bills
- Constant photocopying of bills
- Frequent charges for dependency type drugs such as Valium or Darvon.

Examiners should not limit themselves to the covered person but review charges for the entire family in questionable cases.

If more than one bill is suspect, the examiner should refer the matter for careful review.

Claims where \$1,000 or more in medication has been paid in any calendar year period should be reviewed.

Generic Drugs

In General

There are over 8,000 generic drugs in use; such drugs may be priced as low as 30-40% off brand name drugs. Generic drugs account for approximately one-third of all prescriptions filled. Sales are increasing for the generic drugs. The top ten selling generic drugs are as follows:

<u>Brand Name</u>	<u>Generic Name</u>	<u>Use</u>
• Amoxil	amoxicillin trihydrate	antibiotic
• Pen-Vee K	penicillin VK	antibiotic
• Polycillin	ampicillin	antibiotic
• Deltasone	Prednisone	anti-inflammatory
• Tetracycl	tetracycline HCl	antibiotic
• Motrin	ibuprofen	anti-arthritis
• Erythromycin	erythromycin stearate	antibiotic
• Tylenol with codeine	acetaminophen with codeine	analgesic

Plans encourage the use generic drugs in one of two ways:

- Higher deductible for brand than generic
- Generic required for certain drugs.

Federal Legislation

A federal law was enacted in 1984 under the name Drug Price Competition and Patent Term Restoration Act. The law is popularly known as the Generic Drug Law. The law codified requirements for efficient federal approval of generic drugs based on pre-market testing specifically designed to show therapeutic equivalence to brand name counterparts. The law also granted patent extension and guaranteed exclusive marketing periods for certain brand-name drug products, providing additional incentive – even beyond those sponsored by the increased competition from generic drugs – for research and development efforts.

In brief, the law permits consumers to buy medications by their chemical name and not by their brand name. This change results in large savings to the buyer. Penicillin as a generic drug can cost 30%-60% less than the same drug sold under a brand name.

Generic Cost Control

Generics are an important part of controlling health care costs.

- The U.S. government through the VA runs the largest drug program through which the majority of drugs dispensed are generic.

- Medicaid programs either mandate generics or provide financial incentives to use them.
- The cost difference between generic and brand names are 30% to 70% or more.
- 500 million prescriptions or about one-third of all prescriptions filled were generic drugs.
- Between 1991 and 1995 over \$10 Billion worth of brand name drugs will be going off of patent.

Bioequivalence v Therapeutic

Bioequivalence means that a drug reaches the target tissue with the same potency and speed that the brand name product does. Therapeutic means that it has the same medical effect. Brand name companies have argued for years that generic drugs that have different inert ingredients such as binders and coloring agents can alter the drugs overall performance. Some years ago the FDA convened a hearing on this subject. A task force was appointed and reviewed the issues. Their report stated that bioequivalence does equal therapeutic equivalence. Still 60,000 family doctors feel that generics are not chemically the same drug because of the additive and inert compounds. One reason that doctors like brand names over generic may be the fact that brand name firms spend about \$9,000 per year per physician on promotion.

20% Rule

The FDA allows most generics to vary by 20% in either direction. That means that the amount of drug absorbed into the bloodstream and the speed of the absorption can exceed or be less than the brand drug by 20%. Most of the time this variation is not that critical, but for drugs that are more potent where small differences in blood levels will cause toxic results, then only 10% variation is allowed. In the last few years generic drugs have only varied 3.5% from their brand name counterpart. Another interesting point is that most brand name drugs produced for market are not in the same formulation as used for the FDA testing. When the manufacturer produces the drug the batches are increased to production levels and have the same 20% rule as the generic drugs.

Brand Name Drugs

When a brand name drug is about to go off the patent the drug company will almost always raise the price of the drug and continue to raise the price afterwards. The reasoning behind this is that the company is going to lose a certain market share to generic competition but when they lose to market share they'll recoup through increased prices.

Using the Laws Provisions

The buyer may insist on the less expensive generic drug at the point-of-purchase. The pharmacist must comply if the prescribing physician has approved of the alternate by affixing the words *substitute permissible* on the prescription.

Between the high priced brand name and the lowest cost generic name there may be an in between form called the *branded generic*. This is when the drug company combines the brand name and the chemical.

To accomplish a generic/brand substitute there are four simple things to do:

- Ask your physician to put *substitute permissible* on the prescription.
- Tell your pharmacist you want the generic – not the brand or combination form.
- Compare prices at several pharmacies for the lowest price.
- If difficulties arise, contact the local health department.

Drugs Not to Switch

Through a generic drug can be used in place of a brand name drug most of the time, switching can be harmful in some cases. Examples are anti-arrhythmic drugs, loop diuretics, hypoglycemic, theophylline and anticonvulsants. Women over 75 and people with a history of depression, psychoses, asthma, diabetics, congestive heart failure and other heart problems are not good candidates for switching from brand name to generic drugs.

Growth in Generic Drugs

Patents for many of the important drugs have in recent years expired; this gives generic drug manufacturers the opportunity to move in to the market.

Prices of drugs have risen dramatically lately making the interest in lower priced drugs particularly keen.

There has been an acceptance among physicians of the equivalence of brand and generic drugs.

Drug Facts

- A brand name is trademarked so only the manufacturer may sell it (Darvon, e.g.). A generic drug goes by its chemical name (propoxyphene, e.g.) so any manufacturer may sell it.
- The pharmacist may safely substitute because of the FDA drug standards publications and guidelines.
- The physician is the determinant of which is to be used. Dispense as *written* or *substitute permitted* are the key words.
- Most pharmacists carry both; not all drugs have both brand and generic labels.
- FDA laws are equally rigorous to both brand and generic drugs. Generic drugs are as effective as brand drugs.
- Over 30% of drug costs are for persons over age 65.
- Cost of brand drugs rose 80% from 1980 to 1986; cost of generic drugs rose 30% to 40% during this period.
- Physician reluctance toward generic drugs has been breaking down in recent years.

Durable Medical Equipment

The plan document allows as a covered expense the rental of durable medical equipment such as wheelchair, bed, iron lung, etc. In assessing the appropriateness of the equipment these factors should be considered by the examiner:

- The equipment is primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury.
- The equipment can effectively be used in a nonmedical facility (home).
- The equipment can be expected to make a meaningful contribution to the treatment of the illness or injury.
- The cost of the equipment is proportionate to the therapeutic benefits which can be derived from the use of the equipment.
- The equipment is used solely for care and treatment of the patient (thereby excluding home exercise equipment).

An inquiry of the physician will determine the therapeutic purpose as well as its length of use. Descriptive brochures would usually be helpful.

Rental vs. Purchase. Consideration of rental vs. purchase of equipment may be a factor in some cases. While the plan might limit benefits to rental of durable equipment, there may be situations in which purchase of durable equipment is more cost efficient. When it is anticipated that an item will be used over a prolonged period, cost would generally be less than the overall rental if the item is purchased. The cost in such an instance may be covered administratively.

A closer look at durable medical equipment requires these considerations:

- Cost of the repair of durable medical equipment is not covered.
- Durable means the ability of the equipment to withstand repeated use over a period of time.
- To be payable, the equipment had to have been prescribed by the physician prior to purchase or rental.
- Such equipment is not covered unless its primary use is medical.
- Some equipment should be purchased and some should be rented based upon facts and circumstances.
- Separate charge for sale tax is not covered.
- A seat lift mechanism is covered; the entire chair is not covered.
- Supplies and accessories used with rented equipment are not covered.
- Cost of the preparation and delivery of the equipment is not covered.
- Standby equipment is not covered.
- Equipment used in a nursing facility are not covered.
- Returned equipment is not covered.

Special Consideration

Prescription Drugs under the Mental/Nervous Provision. If a plan provides benefits for the outpatient treatment of mental/nervous conditions, the examiner should pay for the cost of prescription drugs used in that treatment at the same rate for which physician's visits are paid. This applies to both standard and state-mandated outpatient benefits. When charges are submitted for more than one condition with one diagnosis in the mental/nervous category, it is not always cost effective for an examiner to check every prescription number to determine if it is related to the mental/nervous diagnosis. In order to expedite minor routine claims where this situation arises, the following guidelines have been developed to assist the examiner in determining whether to pay at 50% (mental/nervous) 80% or 100% (nonmental/nervous):

- If a covered person has other ongoing conditions, which in themselves require medication, and an examiner receives a few prescriptions that are not identifiable, then it is acceptable to pay the charge under one of the nonmental/nervous conditions.
- If the prescription contains either the brand or generic name of the drug, the examiner should use the Physician's Desk Reference book to determine which drugs are used *exclusively* for mental/nervous conditions.
- If a particular medication, which has been identified, can be used for multiple conditions (one of which is mental/nervous) and *if* the covered person has an ongoing claim for one of the other conditions, then it is acceptable for the examiner to pay the charge under the non mental/nervous condition.

Contraceptive Drugs. Contraceptive drugs, *used as a medication* (such as in dysfunctional uterine bleeding), are covered in the absence of a specific exclusion. However, when these drugs are used for contraceptive purposes they are not covered since they are not being used for the treatment of an illness or injury.

Insulin, Needles, Clinitest and Alcohol Swabs. Insulin, needles (in conjunction with diagnosis of diabetes) and clinitests will be considered a covered expense, and will be paid as prescription drugs. However, alcohol swabs will not be considered a covered expense, and should be denied as a nonprescription drug.

Vitamins, Minerals, Food Supplements, etc. Vitamins, minerals and food supplements are generally nonprescription and are not considered to be covered charges. Food supplements and vitamin compounds which can be obtained by prescription only and are medically necessary will be considered on a case-by-case basis.

Antigens. These are protein substances which are introduced into the body to stimulate the production of antibodies. These are not prescription drugs. They should be treated as physician services.

Vaccines. Immunizations are normally not covered expenses. Where the administration of pneumococcal or Hepatitis B vaccine is medically necessary as a treatment of a disease, as opposed to preventive care, such may be paid as physician services.

Blood Clotting Factors. Hemophilia patients often require blood clotting factors to be introduced to control bleeding. Where medically needed or supervised, such will be incurred as physician services.

Prosthetic Devices. Such devices as a cardiac pacemaker, lenses following cataract surgery, e.g., are covered but their replacement cost is not covered. Dentures are not considered to be a prosthetic device.

Artificial Limbs

A prosthetic appliance is defined as a device used to replace a natural part of the body which has been lost. Plans include coverage for the initial purchase required to replace a natural body part lost while the claimant is covered by the plan. These provisions are liberalized administratively as outlined in the following guidelines.

Initial Purchase. The purchase of a prosthetic device is covered administratively whether it is an original or a replacement, if it is the first purchase made by a claimant while covered under the plan.

Subsequent Purchases. A prosthetic replacement is not covered when it is reasonable to assume that medical necessity was not a factor (i.e., the recent replacement was purchased because it had superior enhancements over the old model). A replacement can be given consideration when it is shown that:

- Major growth of the user is a factor. (An example of this would be an adult who was fitted for an artificial leg as a child).
- Major pathological change has occurred at the affected site (e.g., an amputee who has had further amputation of the limb in question).

A statement of the reason for a subsequent prosthetic appliance purchase should be obtained from the attending physician.

Drug Card Plans

Drug Cost Control

The trend to cost control is accelerating as employers struggle to control costs. The reasons are these:

- Drug costs are increasing at a rate far in excess of the medical Consumer Price Index. As the work force is aging, this disparate growth will continue because older persons use drugs more than younger persons. With the gigantic costs of retired life coverage, this cost is of considerable concern to employers.
- The new drugs are rapidly expanding in number and cost. New drugs are the most expensive.
- The new drugs have, in the majority, little therapeutic value over existing drugs.
- New biotechnical drugs, designed to alter DNA, are extraordinarily expensive.

Recent health care reform legislative proposals addressed drug managed Care in these ways:

- A National Drug Price Review Board to be a watchdog over drug prices.
- Guidelines to address such issues as:
 1. Use of therapeutic drug formulas
 2. Drug use review
 3. Therapeutic interchange
 4. Generic substitution
 5. Physician counter dealing
 6. Cost negotiations.
- Drug prices will have to be adjusted for the federal government's developmental investment.
- Limiting the national wholesale price to the price of other countries.

Some form of implicit price controls may be expected. What is being proposed as a possibility is a *capitated* drug plan where the drug plans (and manufacturers) are asked to assume some of the risks.

Other Factors Affecting Plan Drug Costs

- Ingredient pricing, including the markup from average wholesale price
- Generic drug dispensing rate – the higher the dispensing rate of less expensive generic drugs, the lower the average cost of drugs to the plan
- Dispensing fees and administration costs
- Waste and overutilization, including fraud by employees and pharmacies, errors in dispensing, and drug abuse.

Drugs Commonly Excluded

Smoke cessation and contraceptive drugs are several examples.

Drug Card Plan Described

What Is It? Instead of reimbursing individuals for their drug purchases using the standard retrospective reimbursement process (involving claims forms), some employers elect a prescription service plan. All covered individuals are issued prescription drug cards that allow them to charge their drug purchases. The plan sets a deductible amount that must be paid by the insured every time the card is used to purchase a prescription. Typically, this deductible is between \$1 and \$5. The pharmacy collects the deductible, completes the charge slip, and dispenses the drug. The pharmacy bills the prescription drug card company for the drug plus administrative expenses and the prescription card company bills the insurance company (usually monthly) for the batch of prescriptions provided to its insureds. A third-party administrator enrolls and reimburses pharmacies, bill sponsors, provides statistical data, and develops claims control strategies.

What Is Good About It?

- Employees may not realize that their medical plan covers medications.
- High deductibles may preclude reimbursement for medication because many people do not meet the deductible.
- The use of a card eliminates claim forms.
- Year-end submission is reduced, which facilitates processing by the plan.

What Is Not Good About It? A free-standing plan encourages greater utilization of the benefit. At a time when cost management is so important, emphasis is on covering long-term care, catastrophic illness, and other big-ticket items rather than budgetable items such as medications. Moreover, abuse of the benefit as well as overutilization have occurred under the card approach to prescription drugs.

For an employer with a great deal of turnover, the claims liability involved when cards are not recovered from terminated individuals may make a card plan more expensive than it looks at first glance. (Claims submitted by a terminated individual who has retained the card will be paid by a card administrator if it has no records of employee termination.) There are also other loopholes for erroneous claims payment. Another hidden cost is the elimination of coordination of benefits savings. The participant with the drug card will always be considered primary for coverage of family members. The ease and convenience of card plans may promote overuse, higher utilization, lower rates of generic substitution, and use of marginally effective drugs.

Mail Order Drug Plan

Under the mail-order approach, a participant sends the prescription to a designated mail-order supply house that dispenses medications to many members in large volume. Discounts are made possible by economies of scale. This approach works especially well for maintenance drugs for circulatory problems, high blood pressure, or diabetes, and in general for all but about 20% of medications requiring emergency dispensation. One problem associated with such plans is the high volume of drugs they dispense - sometimes 60- or 90- day supplies. This may promote overuse and wastefulness.

Principal Features of the Plan

Prescription drug (or, more simply, drug) coverage may be provided in these ways:

- Through a major medical plan
- A stand alone benefit
- A combination care and mail service plan.

Certain basic definitions are helpful:

Brand Name. This is the trademark name which appears on the packaged label. This is the drug approved by the FDA (Food and Drug Administration) and patented.

Generic Drug. This name identifies non-brand name drugs and are sold at typically lower costs. The generic drug comes into being when the brand name loses its patent protection and may be made by multiple manufacturers.

Single Source Drug. This is a drug marketed or sold by only a single manufacturer or labeler. A single source drug is the brand named drug during the patent protection period.

There are several different ways of describing a drug card plan:

Open v. Closed Panel

An open-panel drug plan allows the employee or covered dependent to go to the pharmacist of choice. The employee completes a claim form, which is sent to the insurer, company, or union for retrospective reimbursement.

A closed-panel plan contracts with a fixed number of pharmacies that dispense medication to members at agreed-upon prices. The employee/dependent pays only a small deductible. The pharmacist bills the insurer directly for the medication, often at cost plus a dispensing fee.

Electronic v. Paper Carve-Out

With the *electronic plan* the participant, with a plastic card, pays a flat copayment *at the window* and druggist of the balance. With the traditional plastic card, the druggist at the window checks for eligibility and performs other edits (duplicates, concomitant therapy, drug interactions, cost controls, e.g.). The plastic card program has numerous managed care features:

- Pharmacy PPO
- Contracted discount prices
- Voluntary formulas
- Drug utilization review
- Clinical management services
- Mail order pharmacy options.

With the paper carve-out plan, there are special drug benefit plans with their own special drug deductibles and copays with such deductibles and copays varying by whether or not:

- Purchase was out-network or in-network.
- Drug was a formulary or a nonformulary.
- Drug was or was not a mail order.

The participant pays the full discounted price at *the window* and submits a claim in the usual manner.

Drug Card Plan Trends

There are numerous trends deserving of mention:

Design of Plan. Some examples are these:

- Separate drug plan
- Pharmacy PPO, with copay variations
- Copay varies by formulary v. nonformulary
- Mail order plan for maintenance drugs
- Plan maximums
- Ability to do coordination
- Sophisticated data reporting and drug reviews
- Reasonable and customary price monitoring.

Exclusive Druggists. These arrangements accomplish the following:

- Shop for bottom dollar prices
- Ability to control prices by zip codes.

Proactive Drug Management. Of particular interest would be clinical appropriateness.

The management is this:

- Criteria and edits spot problem
- Interact through local druggist
- Effective intervention protocols established
- Follow-up monitoring is done.

Clinically-Based Formularies. Formularies are cost containing and are more and more being used in managed care programs. Drugs are preferred based on these features:

- Cost effectiveness
- Quality
- Efficiency.

Education and Intervention. This program seeks to identify and educate physicians who do not prescribe properly. This technique results in formulary compliance and generic substitution.

Case Management. The pharmacists and physicians tag team using technology to best treat an individual patient. The determination of an individual for case management is based upon certain factors, such as cost of therapy, established treatment guidelines, and difficulty of disease/accident.

Performance Expectations and Product Savings. These guarantees such as:

- Relate guarantee from manufacturer
- What is counted toward product savings is clearly defined
- Clear definition of what is counted toward product savings Accurate reports that measure performance guarantees
- Recovery of cost of first time medications.

Capitated Drug programs. While attracted to employers, the vendors must make certain accommodations:

- Good cost/price models
- Accurate projections
- Manufacturers must come into the program.

Control. Certain tools to control drug costs are required:

- Data analysis
- Good formulary management
- Working relationship with providers
- Coordinating use review.

Drug Utilization Review. The review must be convenient and on-line. Inappropriate drug use must be spotted.

Good Service. The service must be both efficient and effective.

Provider and Manufacturer Partnership. Between these two there must be agreements; medical care and drug therapy must be integrated; both performance standards and outcomes research must be factored in.

Geriatric Drugs. The older population are the biggest users of drugs. There should be special geriatric-based formularies, capitation programs, utilization review services and support services.

Therapy Compliance. There must be considerable effort to see that drug regimens are followed. The noncompliance problem is a major one - particularly with the older population.

Reimbursement to Pharmacists. Typically a drug card plan will pay the pharmacist the sum of A and B where:

A is ingredient cost not to exceed the average wholesale price.

B is dispensing fee usually approximating the allowed by Medicaid. Often the larger plans with buying leverage will pay less than A or B as a further discount to the pharmacists.

Plan Design Considerations. These items of plan design need to be considered:

- *Drug Covered*
- All federal legend drugs plus insulin but excluding oral contraceptives are considered.
- *Generic Substitute*
Plan savings are considerable where generic substitution is encouraged.
- *Formulary*
A formulary is a list of covered drugs - generally more restrictive than the list of all legend drugs. The formulary list is a legend list where the most effective drugs for the particular condition are shown.

Utilization Review. With drug utilization, two types of revenue must be considered:

Quantitative

- Number and types of drugs used
- How many narcotic drugs are used
- Activity by types of pharmacists
- Number of drugs by brand and generic
- First order versus refills.

Qualitative

Looks at pattern of drug use - either retrospectively or concurrently.

Mail Service. This service may be significant to the prescription card service. Of particular value with a mail order service is that it increases the use of generic as opposed to brand name drugs. Mail service drugs are primarily for maintenance drug use. One of the problems with mail service is that the dispensing time is excessive.

Company Pharmacy. There are now vendors (pharmacy franchisers) who will set up a company pharmacy. They will plug into your operation a kind of *pharmacist-in-a-box*. They take on complete responsibility for the pharmacy. They hire and train staff, obtain the pharmacy license, purchase inventory, do the billing and the quality assurance. The client would simply have to supply the space and pay a predetermined monthly fee. The in-plant pharmacies would be full-service, in terms of prescription drug needs but would carry few, if any, of the "up-front" items, that is over-the-counter medicines or health and beauty aids. In-plant pharmacies, of course, are not for every company. A sizable employee/dependent/retiree population is required, but even more important is the daily volume of prescriptions. Unless it generates at least 150 scripts per day, an in-plant pharmacy probably cannot be justified in terms of cost vs. benefits.

Drug Card v Traditional Method

Each of these methods has some limitations.

Major Medical Plan

- Difficult to managed what is not known.

- Often drug charges are not identified as such; that is, they are combined with other charges.
- Reserving problems in that the amount of claims incurred but not submitted are not known.
- Difficult for most plans to process high volume, low cost claims.
- Possible to have fraud and abuse with such plans.

Drug Care or Prepaid Plans

- Benefits may be submitted after eligibility stops.
- Such plans have historically been first dollar plans.
- Difficult to educate providers as plans increase in complexity.
- Possible to have fraud and abuse with such plans.

Mail Service Plans

- Usable only for maintenance drugs.
- Provider does not have profile of drug history on participant.
- Difficulty in maximizing generic substitution.