



# Federal Drug Discount and Compliance Monitor

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The Inside Source on the Public Health Service 340B Drug Discount Program

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### Federal Court Hears California County Appeal on Dismissal of Lawsuit Alleging 340B Overcharges *Case May Have Far-Reaching Implications for Future 340B Litigation*

Contracts between the federal government and drug companies for the provision of 340B discounted drugs grant 340B facilities an inherent right to sue the firms for “millions of dollars” in alleged overcharges, a lawyer for Santa Clara County, Calif., and its 340B covered entities recently told a federal appeals court in a closely watched case.

The intent of Pharmaceutical Pricing Agreements that drug companies must sign with the U.S. Secretary of Health and Human Services (HHS) to participate in 340B “could not be clearer,” Sanford Stetkov, the county’s lawyer, told a three-judge panel of the U.S. Court of Appeals for the Ninth Circuit during a March 10 hearing in the case, *County of Santa Clara v. Astra USA, Inc., et al.*

Covered entities that pay for the drugs, Stetkov said, are “the intended direct beneficiaries” of the price discounts the federal government obtains from the manufacturers. That status, he said, automatically grants the entities the right to sue to enforce the contracts’ provisions. Relying on HHS to sue on the entities’ behalf, he told the court, would be “an exercise in futility,” asserting that the agency has never sought to terminate a manufac-

turer from the 340B program for alleged overcharging.

Robert Litt, the drug manufacturers’ lawyer, countered that “there is no indication in [the 340B] statute that Congress ever intended” to grant covered entities a right to sue to recover alleged overcharges. The intended direct beneficiary of the drug discounts, he said, is the federal government itself. The law’s purpose, Litt argued, is to “stretch federal dollars as far as possible” and it is the right and duty of HHS, not covered entities, to see that that purpose is met. The fact that covered entities benefit from reduced drug prices “is not sufficient” grounds for a decision to grant them a right to sue.

A decision in the appeal is expected in the next few months. The outcome of the case will address whether 340B covered entities are third party beneficiaries of the agreement between CMS and manufacturers and thus have standing to sue the manufacturers independently of the federal government. A Santa Clara win would be a major victory for 340B providers and could increase the likelihood of future 340B litigation against manufacturers without HHS involvement.

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## Nevada Denies Hospital Medicaid Drug Reimbursement Due to CMS Regulation

Nevada Medicaid officials have denied a Las Vegas 340B-enrolled safety net hospital reimbursement for its Medicaid patients' drugs due to the hospital's inability to comply with the controversial new National Drug Code (NDC) collection and reporting requirement. And Nevada is just the tip of the iceberg—other states may soon follow suit.

The University Medical Center of Southern Nevada (UMC) is considering whether to sue the state over the denial, which it estimates will deprive it of \$5.1 million in sorely needed revenue annually if allowed to stand. Peter Tibone, the hospital's Cost Reimbursement Manager, says UMC might have to curb services if the state's decision is not reversed.

"We are still caring for our patients, but [the denial] is impacting the financial health of our institution," adds Diana Bond, UMC's Pharmaceutical Services Director.

UMC is the leading provider of charity care in the state, with roughly 57 percent of their patient population either on Medicaid or uninsured, and is the state-designated Level I Trauma Center for Southern Nevada.

A final regulation issued to implement the Deficit Reduction Act of 2005's (DRA) Medicaid and pharmacy provisions requires states to collect NDC numbers on "physician-administered" drugs billed to Medicaid to allow states for the first time to collect rebates from manufacturers for those drugs. States that fail to comply by the January 1 implementation date risk losing their federal Medicaid matching funds.

In a move that has created great anxiety among hospitals, the Centers for Medicare and Medicare Services (CMS) have interpreted the requirement to apply to drugs administered not only in physicians' offices but also in

hospital outpatient settings.

Several hospital groups contend that the new rule misreads Congress' clear intent in the DRA to exempt drugs dispensed in hospital outpatient settings from the requirement. Many hospital outpatient pharmacy departments and clinics, they say, lack electronic billing systems capable of collecting, tracking and submitting NDC numbers for drugs billed to Medicaid.

Without such tools, they say, hospitals will have to add staff to collect and report the data manually, incurring costs that will likely exceed the amount of the rebates. They predict that the resulting losses will almost certainly degrade patient care, most notably for the poor and most vulnerable.

UMC, the hospital at the center of the Nevada dispute, dispenses outpatient drugs both in-house and at its community-based ambulatory care and HIV/AIDS centers. Bond said her hospital simply is not equipped to comply with the new NDC requirements.

CMS has granted a number of states extensions to comply with the new rule. However, those delays are for a maximum period of six months (See January's *Monitor*.)

According to Bond, state Medicaid officials originally indicated that they, too, would seek a waiver. But the state reversed course after Gov. Jim Gibbons (R) ordered \$400 million in state spending cuts—including an 8 percent reduction in state Medicaid spending—to help close a projected \$898 million state budget deficit for the 2007-09 biennium.

"Their decision was to implement the [NDC rule] in January with the intent that they would have help with revenue from rebates," Bond says. "It was done with the intent to try to address the mandate for budget cuts."

<p><b>THE MONITOR</b></p> <p><b>MANAGING EDITOR</b> Katie O'Dowd</p> <p><b>CONTRIBUTING EDITOR</b> Tom Mirga</p> <p><b>SUPERVISING EDITORS</b> Ted Slafsky William von Oehsen</p>	<p>The <i>Federal Drug Discount and Compliance Monitor</i> is a national monthly newsletter that covers the legal and political issues surrounding the Public Health Service 340B drug discount program and other developments in federal drug pricing law and policy. <i>The Monitor</i> also updates subscribers on breaking news stories through e-mail alerts.</p> <p><i>The Monitor</i> is published by Safety Net Hospitals for Pharmaceutical Access, a Washington D.C.-based trade association representing over 400 hospitals in the 340B program.</p> <p style="text-align: center;"><b>Federal Drug Discount and Compliance Monitor</b> 1501 M. Street, NW Washington, DC 20005 Phone: (202) 552-5853 Fax: (202) 552-5868 <a href="http://www.drugdiscountmonitor.com">www.drugdiscountmonitor.com</a></p> <p>For information on <i>The Monitor</i>, including advertising opportunities, contact Katie O'Dowd at <a href="mailto:katie.odowd@drugdiscountmonitor.com">katie.odowd@drugdiscountmonitor.com</a> or (202) 552-5853.</p>
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## OPA Might Be Forced to Seek User Fees to Fund 340B Program

*Mitchell Says He is Paring Back Program "to its Core"*

The cash-strapped Office of Pharmacy Affairs (OPA) might have little choice but to seek approval from the Bush Administration and Congress to begin imposing user fees on 340B health care providers or manufacturers to help stabilize its long-term financing, observers say.

The idea of a user fee, which is used to fund various other government programs such as the Department of Veterans Affairs (VA), is controversial in the 340B community. Safety net hospitals and other 340B participating entities are likely to oppose such fees as a drain on their resources and a deterrent for others to enroll.

But some observers say user fees are one of the few revenue-enhancing options available to the agency that oversees 340B, which is reeling from Congress' last-minute elimination of nearly \$3 million in anticipated line-item funding from the Department of Health and Human Services' (HHS) fiscal year 2008 appropriation. The Bush Administration's HHS budget request for fiscal year 2009 also omitted the line item, which it had sought for the office in its proposed budgets for fiscal years 2007 and 2008 (See January and February's *Monitors*).

The exclusion of funding could have long-term ramifications for the 340B program because OPA has said it needs the money to improve its price verification capabilities and overhaul its database of covered entities and manufacturers.

As in past years, the office must now rely on the Health Resources and Services Administration (HRSA) program management funds and other agency-wide funding sources for support. OPA says it hopes that the Office of the HRSA Administrator, which has previously contributed hundreds of thousands of dollars in discretionary funding to OPA, will pick up the slack.

The President's fiscal 2009 budget proposal, however, seeks just \$5.9 billion in discretionary funding for HRSA, \$1 billion less than it received in fiscal 2008.

"We have a spending plan that was submitted to the [HRSA] Administrator," Mitchell says. "We are optimistic

that it will be approved, but even under the best of circumstances, we are paring back the program to its core."

OPA planned to use part of its anticipated line-item appropriation to begin an annual verification of data submitted by 340B covered entities for the OPA Web site. It also would have used the funds to monitor the accuracy of 340B price files and to publish policies on 340B ceiling price calculations, according to Mitchell.

Mitchell says OPA now has limited ability to perform price comparisons for covered entities or covered entity groups.

Mitchell says that "conceptually" a user fee would be a viable option for the program. Yet Congress would have to grant HRSA permission to use the funds for 340B program activities.

In addition, HRSA would need to get approval from the Bush Administration to pursue this option. And, in the absence of specific 340B authorizing legislation, the funds would go into the general treasury. Mitchell says it is a long process that has not been started yet.

According to Mitchell, the user fee model has been discussed as a funding option for 340B since the program's inception. "The Department of Veterans Affairs (VA) has been a role model for (OPA)," he says.

The VA, which negotiates ceiling prices with drug manufacturers on the Federal Supply Schedule on behalf of the "Big Four" federal agencies that buy pharmaceuticals, finances its administrative costs through an "industrial funding fee." Under the system, manufacturers add a 0.5 percent surcharge to the price of their products that is passed on to the agencies buying them.

"It's the users that pay for it," says Marcus Farbstein, the Director of Government Affairs at biotechnology manufacturer Genentech. "The VA hospitals or military hospitals pay for it in order to fund the organization that gives them the benefits."

There are a number of other ways user fees can be utilized, Farbstein says. An advantage of a user fee, he adds, is that it gives "long term program integrity."

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*"If something isn't  
done there could be  
dire consequences  
to 340B "*

**MARCUS FARBSTEIN**  
DIRECTOR OF GOVERNMENT  
AFFAIRS, GENENTECH

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## IN FOCUS

# STATE DEVELOPMENTS IN THE 340B PROGRAM

### Vermont Bill Aims to Spark Debate on Implications of 340B Expansion

#### *Plans for Statewide Central Fill Pharmacy Move Forward*

#### Vermont

A Vermont bill that would require more than one out of four state residents to obtain their prescriptions through clinics and a hospital participating in the 340B program is mainly aimed at spurring debate on the practical implications of such a bold move, according to a close observer of the program in the state.

The bill, S 328, would require all Vermonters enrolled in Medicaid, the state Health Access Plan for uninsured working-poor adults, the state Employer-Sponsored Insurance Premium Assistance Program, and the state Catamount Health subsidized private health insurance plan to obtain their health care and prescriptions from nearby covered entities participating in 340B. According to data from the Henry J. Kaiser Family Foundation, 26 percent of Vermonters are enrolled in the state Medicaid program alone.

The bill also would require the state corrections department to contract for inmate health care exclusively with providers that are eligible for and make reasonable efforts to participate in the 340B program.

The state Senate Health and Welfare Committee held a hearing on the bill on Jan. 18 but had not yet voted on it as of late March. Vermont lawmakers are expected to end their current session in May.

The bill's sponsor, state Sen. Kevin J. Mullin (R), could not be reached for comment on his measure. But Hunt Blair, director of Vermont public policy for the Bi-State Primary Care Association (BSPCA), says Mullin has told him that he introduced the measure "as a conversation starter as much as anything else" and "didn't expect to see it passed." BSPCA represents community health centers, rural health clinics, and other primary care providers in Vermont and neighboring New Hampshire.

Mullin's bill, Blair says, reflects "the interest he and many other legislators in Vermont have in seeing 340B utilized more fully in the state."

Vermont policymakers have been exploring ways to take greater advantage of 340B drug pricing for the past several years. A 2005 state study commissioned by the legislature concluded that because no Vermont hospitals at the

time were eligible to participate in 340B, federally qualified health centers (FQHCs) represented the best hope for expansion.

According to Blair, Vermont had only two FQHCs with a total of seven satellites in 2001. Thanks to an amalgam of federal, state, and charitable efforts, he says, the state now has seven centers with 27 satellites and expects to add two more centers shortly, "setting the stage for a more thorough tapping into of 340B." In addition, Fletcher Allen Health Care, a Burlington, Vt., disproportionate share hospital that co-sponsors the state's academic medical center with the University of Vermont, became the state's sole hospital participating in 340B in 2005.

Last year, Gov. Jim Douglas (R) signed legislation encouraging the use of 340B discounted pharmaceuticals for Vermont state employees, prisoners, and recipients of workers' compensation, among others. It directed the state health department to publicize the availability of health services at FQHCs and FQHC look-alikes. (See November 2007's *Monitor*.)

Meanwhile, BSPCA began working with the state health department, state and federal rural health officials, and the Heinz Family Philanthropies to create a statewide central fill pharmacy to foster greater use of the 340B program by the state's FQHCs.

In December 2007 BSPCA and five Vermont FQHCs created Pharmacy Network LLC to own and operate the shared pharmacy. The primary care association recently disclosed on its Web site that the company has selected Texas-based Maxor National Pharmacy Services Corp. to manage and staff the facility.

All of the state's 340B-eligible providers and their satellite locations will be allowed to use the facility, which will provide next-day mail delivery of most prescriptions and same-day, on-site delivery of acute medications via secure remote dispensing technology. BSPCA and its partners are seeking an Alternate Methods Demonstration Project (AMDP) waiver from the Office of Pharmacy Affairs (OPA) for the central fill

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## IN FOCUS

# STATE DEVELOPMENTS IN THE 340B PROGRAM

### New Hampshire Commission Gets Extension on 340B Partnership Study

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pharmacy and state Board of Pharmacy approval for the remote dispensing system. Vermont currently has no regulations governing telepharmacy technology.

According to the BSPCA Web site, Pharmacy Network will eventually create a “wrap-around” retail pharmacy network that will permit patients to fill their 340B discounted prescriptions through participating community pharmacies. Multiple contract pharmacy arrangements currently require federal approval via the AMDP program, although OPA has proposed guidelines that would allow multiple contract pharmacies without having to get approval through a demonstration project.

Blair adds that the partners in the endeavor also hope to eventually offer the central fill pharmacy’s services to New Hampshire health centers and their patients, “but right now we have to learn to walk before we can run.”

With the infrastructure for 340B expansion taking shape, discussion in Vermont is turning toward the likely complications of shifting potentially large numbers of Vermonters into the federal drug discount program, as proposed in the Mullin bill.

“Although we have been expanding, there are still parts of Vermont that are not served by [a FQHC],” Blair says. “I’m not sure we can do what the bill calls for.”

He also questions whether federal health officials would grant the freedom-of-choice waivers that would be needed to permit the state to require Medicaid recipients to obtain their health care and, with it, their prescriptions from 340B participating entities.

Blair also says that the state’s health centers have qualms about serving prison inmates, noting that one of the state’s original two FQHCs “did do health service in prisons for a while but stopped.”

“It’s a hard thing to do without sufficient support,” he says. “It’s a hard line of business to be in. The door isn’t closed, but a lot of operational questions remain.”

#### New Hampshire

The New Hampshire House of Representatives has extended the deadline for a state commission’s report on expanding the 340B program at the state and county levels.

The bill granting the extension, HB 1371, was still pending before the state Senate Election Law and Internal Affairs Committee as of late March.

State lawmakers created the 16-member panel last year and originally gave it until Nov. 1, 2007 to issue its recommendations. The group, however, voted to put off its work and seek an extension in light of pending federal legislation, S 1376 and H.R. 2606, that among other provisions would make more rural hospitals and health facilities eligible for the 340B program (See April and November 2007’s *Monitors*). That legislation, if enacted, could potentially expand the drug discount program’s reach in New Hampshire’s rural north.

The commission also sought extra time to consider a Heinz Family Philanthropies study, still in progress, on how the state might use 340B pricing to reduce spending on state prisons and county jails. The commission has been focusing on ways to use 340B pricing to reduce pharmaceutical costs for state prisoners, which exceed the combined costs for their hospital visits, diagnostics, and physicians.

Other states and local governments have linked their corrections systems to the 340B program by contracting for inmate health care with hospitals that participate in the program. But according to state Rep. Cindy Rosenwald (D), no New Hampshire disproportionate share hospitals qualify for the discounts because all fall below the disproportionate share adjustment threshold for eligibility.

Rosenwald, the chief sponsor of the 2007 law that created the panel, also notes that federally qualified health centers (FQHCs) in the state that provide primary care and participate in the 340B program are “already at capacity” and would be hard pressed to accept additional patients from state prisons and local jails.

She says it also might be difficult for the state to require county jails to contract with 340B-eligible entities for inmate health care because the New Hampshire constitution forbids state government from imposing unfunded mandates on its subdivisions, even if such man-

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## IN FOCUS

# STATE DEVELOPMENTS IN THE 340B PROGRAM

## Massachusetts to Consider Bill Requiring 340B Enrollment or Other Savings Steps; Utah to Explore Expanding 340B Hemophilia Program to Other Disease Groups

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-dates are intended to generate savings by expanding access to 340B-discounted pricing.

Despite such hurdles, Rosenwald says a nearly complete draft of the Heinz study that she has seen "seems to indicate there are potential major 340B savings for prisoners, which is what we thought."

"There are ways to approach this in small pieces, say, taking small sets of prisoners with expensive-to-treat diseases and looking for ways to make them patients of a 340B qualified entity," she says. "There are also some county jails in close proximity to FQHCs that might want to explore this as a cost savings measure. Also, one of our state prisons is not that far from a center. There's a lot of interest. It's just a matter of figuring out how to do it right."

Rosenwald says the commission will "pick up where it left off" shortly after the legislature adjourns in June. If the extension bill is passed as is widely expected, the panel's report to legislative leaders and the governor will be due by November 1.

### Massachusetts

The Massachusetts legislature's Joint Committee on Public Health has voted to require all state health facilities eligible for the 340B drug discount program to either join the program or demonstrate to the state health department that they can independently negotiate prices lower than 340B price levels (*See April 2007's Monitor*).

The panel favorably reported the bill, H 2243, to the full House on March 19 and its sponsor, state Rep. John Scibak (D), says he is hopeful he can "get it to the floor for a vote."

"Because so few (House) members are aware of or understand the 340B designation and its impact, we'll have to do some education," Scibak says. He adds that although there is no companion bill in the state Senate, several of its members "understand the issue and are supportive."

Scibak says he has also spoken to state Secretary of Health and Human Services Dr. JudyAnn Bigby and members of the state Department of Public Health staff about the bill "and other options to maximize savings through the 340B program."

According to the Office of Pharmacy Affairs' 340B covered entities database, 53 of the state's 332 covered entities currently are not enrolled in the program.

"I'm hoping that both the [state] and many of our citizens will be able to realize significant savings by having eligible entities participate in the program," says Scibak, who sits on the board of the Mont Marie Health Care Center, a Holyoke, Mass., senior housing facility.

"The reality is that there are thousands of residents across the [state] who are reducing their dosages or failing to get prescriptions because of their cost," he continues. "While programs such as Medicare Part D and Prescription Advantage [a state insurance program] are helpful to some, they are not a panacea and not everyone is eligible to receive these programs. Hopefully, this legislation will provide us with another viable approach to help reduce the cost of prescription drugs."

### Utah

Utah Gov. Jon Huntsman Jr. (R) has signed legislation requiring the state health department to study ways to expand the use of the 340B program among state Medicaid patients and report back to the legislature before the end of May 2008.

The bill, HB 74, directs the department to determine the feasibility and potential cost savings of launching one or more disease-specific 340B programs patterned on the state's highly regarded program for hemophilia patients. In 2003, the state contracted with the University of Utah Health Sciences Center, a 340B participant, to provide 340B discounted blood factor products and related case management services to hemophiliacs statewide, a move that has saved the state \$3 million to date.

According to a June 2005 Congressional Budget Office report, Medicaid pays on average 64 percent of average wholesaler price (AWP), whereas 340B providers only pay 51 percent of AWP. Hence, 340B prices, on average, are significantly below Medicaid drug reimbursement, which is why Medicaid saves when it partners with a 340B provider like the University of Utah.

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# 12th Annual 340B Coalition Conference

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- Impact of Deficit Reduction Act on the 340B discount and Medicaid drug rebate programs
- Status report on efforts to recover 340B overcharges
- Efforts to prevent drug diversion
- Medicaid billing procedures used by 340B providers and the pharmaceutical industry for both self-administered and physician-administered drugs
- State and local government partnerships with providers
- New studies on pharmaceutical manufacturer patient assistance programs

#### 340B Coalition Members

Hemophilia Alliance, Inc.

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National Association of Children's Hospital

National Association of Community Health Centers

National Association of Counties

National Association of Public Hospitals & Health Systems

National Family Planning & Reproductive Health Association

National Health Care For the Homeless Council

National Hemophilia Foundation

National Rural Health Association

Planned Parenthood Federation of America, Inc.

Safety Net Hospitals for Pharmaceutical Access

To register, to go [www.340Bcoalition.org](http://www.340Bcoalition.org). To reserve a room at the Marriott, call 1-800-843-6664. Be sure to mention the "340B Coalition Conference" to get our discounted rate of \$188 per night. Please contact Mike Hess at 202-552-5869 or [mike.hess@safetynetrx.org](mailto:mike.hess@safetynetrx.org) with any questions.

**For more information, go to [www.340bcoalition.org](http://www.340bcoalition.org)**

## Santa Clara Appeals Dismissal

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Santa Clara County filed suit in August 2005 claiming that 10 pharmaceutical manufacturers—AstraZeneca, Aventis, Bayer, Bristol-Meyers Squibb, Pfizer, Schering-Plough, SmithKline Beecham, TAP, Wyeth, and ZLB Behring—overcharged the state's public hospitals and community health centers (CHS) for drug purchases made under the 340B program.

The county accused the companies of unfair competition, making false claims, and of receiving “unjust enrichment” by systematically overcharging county facilities.

U.S. District Court Judge William Alsup of the Northern District of California dismissed the case in an 11-page July 2006 ruling. Specifically, Alsup faulted the county using the reports from HHS's Office of the Inspector General (OIG) to substantiate its overcharge claims.

Central to the county's case is its contention that, since 340B providers have no access to confidential pricing information, the court should regard the OIG's findings of manufacturer overcharging as evidence that the county's health facilities have been overcharged.

Hoping to find more concrete evidence of overcharges, the county included a demand in its lawsuit for an “accounting” of pricing data—which would compel the manufacturers to provide it with currently confidential pricing information so that it can determine if and when overcharges occurred.

The county also alleged that the defendants violated state consumer protection law by not providing it with appropriate 340B pricing, the first time that such claims have been advanced in 340B litigation. In particular, the suit claims that the manufacturers have willfully overcharged California's 340B covered entities and that “[the defendants'] practices are unlawful, deceptive, immoral, unethical, oppressive, and unscrupulous.”

The Santa Clara suit is one of three actions brought by 340B providers against pharmaceutical manufacturers in recent years. Central Alabama Comprehensive HealthCare, a group of federally qualified health centers, and Health Services, Inc., a consolidated health system, dropped its lawsuit against drug manufacturers for alleged 340B overcharges in September 2006 (See October 2006's *Monitor*). Another, brought by the AIDS Healthcare Foundation against GlaxoSmithKline, was dismissed in April 2005 (See June 2006's *Monitor*).

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## OPA Funding Dilemma

*continued from pg. 3*

One option would be to require 340B covered entities and their satellite facilities to pay a fee to be added to the OPA database. "The [fee] would probably only be about \$200 or \$300 a year—not really a lot of money in the grand scheme of things," he observes. A sliding-scale fee could also be established that would vary depending on the size of the entity.

Another option, which is likely to receive a more welcome reception from 340B providers, is to establish a user fee on manufacturers instead of covered entities. Manufacturers already pay a user fee to the Federal Drug Administration to help fund the agency.

Farbstein encourages dialogue among covered entities about OPA's funding woes. "If something isn't done there could be dire consequences for 340B," he says.

## IN FOCUS: Utah 340B Expansion

*continued from pg. 6*

The bill's sponsor, state Rep. David Litvack (D), says he expects the department will focus on cystic fibrosis, HIV/AIDS, and one or two other conditions that, similar to hemophilia, are relatively expensive to treat and "involve more disease management than simply filling a prescription."

"340B has been a huge cost saving tool in terms of state Medicaid dollars spent on those with bleeding disorders," said Litvack, the House minority whip. "Medicaid continues to consume a disproportionate share of our budget. We recognize 340B's limitations. It is a small program and is not the solution to controlling costs. But it can provide us with savings without compromising access to health care and the well-being of Medicaid recipients."

The new law also directs the health department to work with the Association for Utah Community Health (AUCH), which represents the state's Federally Qualified Health Centers (FQHCs), to identify those that do not have 340B drug pricing programs and help them establish such programs either on site or through contracts with pharmacy providers.

According to Bette Vierra, the association's executive director, all of Utah's "eligible community health centers currently offer their non-Medicaid and other uninsured patients the benefits of 340B pricing."

"AUCH and its members are more than willing to work with the state in implementing 340B pricing for their Medicaid patients," she says.

## SNHPA JOB OPPORTUNITY

### Director of Pharmacy and Educational Services

Safety Net Hospitals for Pharmaceutical Access (SNHPA), formerly Public Hospital Pharmacy Coalition, is an organization of over 400 public and private non-profit hospitals and health systems that participate in the Public Health Service 340B drug discount program. SNHPA was formed to increase the affordability and accessibility of pharmaceutical care for the nation's low-income and underserved populations. SNHPA monitors, educates, and serves as an advocate on federal legislative and regulatory issues related to drug pricing and other pharmacy matters affecting safety net providers. SNHPA is dedicated to protecting the 340B program and creating new opportunities for member hospitals to save on pharmaceuticals.

#### About the Position:

SNHPA is hiring a pharmacist or other professional with experience in pharmacy operations to work full time for our Washington, D.C.-based non-profit hospital advocacy organization. Candidate must have experience in analyzing drug pricing data and with participating in the 340B drug discount program, pharmaceutical manufacturer patient assistance programs and, preferably, the Medicare Part D program. Experience at a disproportionate share hospital that participates in the 340B program is a significant plus. Public speaking experience and strong writing skills are also a plus.

#### Responsibilities:

- Provide pharmacy expertise to staff, members and outside organizations
- Take lead role in conducting and supervising various pricing analysis projects for organization
- Recruit new member hospitals and corporate partners to SNHPA
- Recruit exhibitors/sponsors for conferences
- Assume role in coordinating conferences, workshops, teleconferences, web casts, including developing agenda and recruiting speakers
- Liaison to other pharmacy organizations (ASHP, APhA, etc.), industry groups and the 340B Prime Vendor Program, Pharmacy Services Support Center and other 340B-related organizations
- Serve as lead contact with members and industry on patient assistance programs
- Provide support to SNHPA's regulatory and legislative team on pharmacy-related matters
- Draft letters, conference descriptions, policy pieces and other documents as needed
- Assume other duties that require pharmacy expertise
- Pharmacy degree preferable but not required

Pay is based on experience. Please send cover letter and resume to [admin@safetynetrx.org](mailto:admin@safetynetrx.org) or fax to SNHPA Administrator at 202-552-5868. Please state the starting date of your availability, salary requirements and how you became aware of this job.



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