

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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HHS Awards Prime Vendor Contract to HPPI *Texas-Based Organization to Administer the Program*

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The U.S. Department of Health and Human Services (HHS) has granted the 340B prime vendor contract to Healthcare Purchasing Partners International (HPPI), the same entity that has managed the prime vendor program since June 2003. HPPI was selected over two other competitors, *The Monitor* has learned.

On September 9, the Health Resources and Services Administration (HRSA) announced that HPPI has been awarded a 2-year contract with three one-year options. The government has not yet issued a press release on the decision, but the contract was announced on the Fed-BizOpps website.

"We're excited about the opportunity to fill this role," says Chris Hatwig, Senior Director of the prime vendor program, adding that the decision removed a "big barrier" to HPPI's administration of the program.

The Monitor has learned that three bids were received by HRSA before the July 19 deadline. In addition to HPPI, HRSA received bids from MedAssets, Inc., a group purchasing organization based in Alpharetta, GA, and DMS Pharmaceutical Group, Inc., a pharmaceutical wholesaler headquartered in Park Ridge, IL.

In September 1999, the first prime vendor contract was awarded to Bergen Brunswick, a pharmaceutical supply chain management firm that merged with Amerisource in 2002. In June of last year, AmerisourceBergen subcontracted the program to HPPI.

Co-owned by the University Healthsystem Consortium (UHC) and VHA, HPPI believes that it is well situated to operate the prime vendor program based on the fact that these organizations collectively represent 45 percent of all registered 340B hospitals and satellites, which spend more than \$750 million on outpatient 340B drugs annually.

Upon taking control of the program, HPPI hired a team of 340B experts to oversee it, including Hatwig, who had formerly served as Pharmacy Director at the Parkland Health and Hospital System in Dallas, TX. While at Parkland, Hatwig was credited

with negotiating millions of dollars worth of subceiling discounts on 340B drugs.

"I made a major career move in order to take this job," says Hatwig. "I saw a real opportunity for this program to grow."

In its short tenure, Hatwig says that HPPI has helped the program to grow significantly.



PVP Senior Director Chris Hatwig

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CMS Encourages ADAPs to Take Advantage of 340B

The Centers for Medicare and Medicaid Services (CMS) have formally advised AIDS Drug Assistance Programs (ADAP) and other Ryan White titled programs to take advantage of the 340B program as a means of lowering drug costs by purchasing their drugs directly at discounted prices.

In a proposed rule on the Medicare Prescription Drug Benefit printed in the August 3rd edition of the *Federal Register*, CMS points out that nearly all state ADAPs currently participate in the 340B program, though one-half of the ADAPs receive rebates from manufacturers rather than purchasing their drugs with the discounts built into the price or through the prime vendor program.

The 50 state ADAPs provide prescription drugs to approximately 136,000 HIV/AIDS patients each year, or about 30 percent of Americans estimated to be living with the disease. The programs were first granted funding in 1987, and were later incorporated into the Ryan White CARE Act in 1990.

Unlike other 340B entities, ADAPs have the unique option of acquiring 340B discounts through either a direct purchase model or a rebate program.

Under the direct purchase model, ADAPs purchase discounted 340B drugs and dispense them in central pharmacies, such as University hospitals. In

these cases, the drugs may be distributed in a number of ways, including by mail-order. However, because ADAPs function primarily as payers rather than as providers, there is also a system that allows ADAPs to reimburse retail pharmacies for drugs they dispense and request rebates from the manufacturers of the drugs.

A report released by the HHS Office of Inspector General in September 2000 estimated that “rebate ADAPs” saved

“We are worried that CMS is trying to dictate something that is not in their purview.”

**Murray Penner
NASTAD**

significantly less than ADAPs that took advantage of the direct purchase option. At the time, the Health Resources and Services Administration (HRSA) stated that it was committed to helping ADAPs convert to the direct purchase model.

“Studies have indicated that the States receiving an upfront discount benefit more fully from the 340B program than those States receiving a rebate,” the proposed rule states. “States are encouraged to move toward the model of purchasing their drugs directly,

as they can realize more savings than States using the rebate model.”

The National Association of State and Territorial AIDS Directors (NASTAD), a non-profit association of state health department HIV/AIDS program directors, has called CMS’s suggestion into question, arguing that it is very difficult, and may prove to be more costly, for rebate ADAPs to convert to the direct purchase model.

“These studies do not take into account the costs of switching to the direct purchase model, and other studies point in the other direction,” says Murray Penner, Director of NASTAD’s Care and Treatment Program, adding that ADAP clients actually have better access to pharmacy services in rebate states because they can purchase their drugs from their local retail pharmacies.

“We are worried that CMS is trying to dictate something that is not in their purview,” says Penner.

ADAPs and the Medicare Rx Benefit

The proposed rule goes on to state that CMS is soliciting suggestions on how to maximize savings for HIV/AIDS patients in the new Medicare drug benefit, asking specifically whether it is “feasible for ADAP programs to partici-

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<p>The Monitor</p> <p>Managing Editor Jared Bloom</p> <p>Supervising Editors 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 new stories through e-mail alerts.</p> <p><i>The Monitor</i> is published jointly by the Public Hospital Pharmacy Coalition, a non-profit organization that represents more than 200 340B hospitals, and the law firm of Powers, Pyles, Sutter and Verville.</p> <p>Federal Drug Discount and Compliance Monitor 1875 Eye St., NW, 12th Floor Washington, DC 20006 Phone: (202) 349-4244 Fax: (202) 785-1756 www.drugdiscountmonitor.com</p> <p>For information on <i>The Monitor</i>, including advertising opportunities, contact Jared Bloom at jbloom@drugdiscountmonitor.com or (202) 349-4244.</p>
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AIDS Healthcare Foundation Sues GlaxoSmithKline Over 340B Pricing

The AIDS Healthcare Foundation (AHF), which describes itself as the nation's largest specialized provider of HIV care, has filed suit against drug manufacturer GlaxoSmithKline (GSK) alleging that the British company has manipulated its prices for 340B-covered HIV/AIDS treatments.

The suit, filed on September 1 in the Central District of California in Los Angeles, accuses GSK of "federal statutory violations, breach of contract, unjust enrichment, unfair competition, and fraud" and calls for monetary and injunctive relief for all 340B overpayments.

The suit alleges that GSK has failed to accurately report the Medicaid "best price" for its HIV/AIDS drugs, "deliberately causing Medicaid programs and other entities that use Medicaid price calculations as a pricing benchmark—especially 340B Providers like AHF—to substantially overpay for drugs."

AHF plans to seek reimbursements on all purchases dating back to the inception of the 340B program in 1992, says AHF Associate General Counsel Katy Robison.

AHF, which is based in Los Ange-

les, has also asked California State Senator Richard Alarcon (D), Chairman of the State Legislature's Joint Legislative Audit Committee, to lead an investigation of GSK and other drug manufacturers with respect to their Medicaid and 340B pricing practices.

The purpose of the audit, says Robison, is to determine whether Medi-Cal—California's state Medicaid program—has been overcharged due to the

"When it comes to AIDS drug pricing policies, we believe that Glaxo is the original sinner"

Michael Weinstein
AHF President

pricing policies of manufacturers participating in the 340B program. She says that Senator Alarcon's audit will focus on all 340B drugs, not just HIV/AIDS treatments.

OIG Reports Cited As Evidence

The AHF suit is unlike the most recent 340B suit filed by Central Alabama Comprehensive Health Care (CACHC) in July (*The Monitor*, August 2004) in

important respects. In particular, AHF's action targets a single drug manufacturer rather than a large group, and AHF is not seeking to enroll other providers or provider groups in a class action.

According to AHF President Michael Weinstein, the goal of the suit is to "level the playing field by having the court help us and others ascertain accurate, honest information on GSK's true drug costs so that we and other providers may seek relief from the courts for overcharges on these drugs."

However, much like the Alabama suit, AHF's claim relies heavily on the U.S. HHS Office of Inspector General reports on the 340B program released in June (*The Monitor*, July 2004), which estimated that 340B entities were overcharged by more than \$41 million during the course of a single month in 2002.

The report did not identify particular manufacturers or providers involved in the overcharges or attempt to determine why the overcharges took place.

Robison argues that the failure to identify the manufacturers is a sign that the government is complicit with the pharmaceutical companies.

AHF's suit also cites as evidence a

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UPCOMING SUMMIT ON MEDICAID REBATE PROGRAM



September 21-22, 2004

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The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is the most fundamental and structural change our healthcare system has experienced in over a decade, and it brings sweeping changes to the Medicaid Drug Rebate arena. This year's **Summit on the Medicaid Drug Rebate Program & Other Public Sector Reimbursement Programs** will help states and manufacturers address their need to change now and through 2006 and beyond. For the past eight years, the Institute for International Research's (IIR) **Summit on the Medicaid Drug Rebate Program** has provided states and manufacturers with best practices in managing the complex set of rebate responsibilities and avoiding disputes. The event delivers legislative and regulatory Medicaid rebate and pricing policy updates as well as solutions to compliance challenges on a federal level.

For more information, visit www.medicaiddrugrebates.com

STATE WATCH

The Latest on 340B and the States

California Legislature Proposes “340B-Like” Discount Program

The California State Legislature has passed a bill that would require drug manufacturers to offer significant discounts on pharmaceuticals to a group of primary care and other outpatient facilities not eligible for the 340B program. The bill would also require manufacturers to disclose a list of the discounted prices upon request.

The bill is designed to benefit health care providers that are not 340B covered entities but are considered “primary care clinics” by California law, including free clinics, community clinics, and some specialty clinics. Experts estimate that less than 100 clinics would be affected by the measure.

Specifically, the bill calls upon manufacturers to offer drug prices to eligible entities that do not exceed 105 percent of the Medicaid best price for brand name drugs or the 340B ceiling price for generics.

The 105 percent figure was chosen to prevent these discounts from affecting the Medicaid “best price” of brand name drugs, which could otherwise increase the size of the rebates that manufacturers are required to pay to state Medicaid agencies.

SB 1563, introduced by Senator Martha Escutia (D), was passed in both the Senate and the Assembly on August 28 and presented to the Governor on September 3. Once enrolled, the Governor has 30 days to review the bill. If approved, the measures contained in the bill will go into effect on July 1, 2005.

The program proposed in the bill resembles the 340B program in a number of ways. First, the bill includes an anti-diversion clause, stating that the drugs purchased in accordance with the

program “may not be resold or otherwise transferred to a person who is not a patient of the entity.”

The bill also includes a specific definition of “patient” that is similar to the definition used in the 340B statute. According to the bill, a patient may only receive the discounted drugs if (a) the entity has a relationship with the patient and maintains records of the patient’s health care, and (b) the patient receives health care services from a professional who is employed by the entity or under contract with the entity.

with the discounts described in the bill.

SB 1563 is one of a number of bills that have been passed recently by the California Legislature in an effort to expand access to affordable drugs. On the same day that it approved SB 1563, the Legislature approved a package of bills that would make it easier for California residents and state agencies to research prices and purchase drugs from Canada, though it is unlikely that Governor Schwarzenegger (R) will sign these bills into law.

The Legislature also passed a bill recently that would require family planning clinics to bill Medi-Cal for 340B drugs at the lesser of either acquisition cost plus a \$12 dispensing fee or “usual costs charged to the general public.”

The passage of these bills comes just weeks after Schwarzenegger unveiled his plan to help health care providers take advantage of free drug programs sponsored by pharmaceutical companies and to improve the state’s system of negotiating prices.

The Governor’s plan would require participants to receive a card that they could present to pharmacists, who would then be responsible for finding the cheapest drugs for that patient, whether these prices were achieved through patient assistance programs or through negotiations with the state.

Legislators have claimed that Schwarzenegger’s proposals have come too late in the legislative session to be considered, and they plan to take up discussion of his plan next year.

CALIFORNIA RX DISCOUNT BILL

SB 1563

- Passed August 28; Sent to Governor September 3
- Would require drug manufacturers to offer discounts to “eligible entities” similar to those achieved through 340B.
- Would also require manufacturers to disclose a list of their discounted prices to providers that wish to take part in the program.

The bill also stresses that primary responsibility for the patient’s health care must remain with the eligible entity, and includes a provision explicitly stating that manufacturers are allowed to charge prices *below* the “maximum price” described in the legislation.

Unlike the 340B program, which requires pricing data to remain confidential, the California legislation would require manufacturers to disclose the discounted prices upon request to entities that wish to purchase their drugs.

The manufacturer would also be required to verify in writing that the prices they are offering are consistent

STATE WATCH

The Latest on 340B and the States

OIG Report Addresses 340B “Carve-Out” in NY Medicaid Program

The U.S. HHS Office of Inspector General (OIG) has issued a report on the New York State Medicaid Drug Rebate Program recommending that the Department of Health improve its billing, collection, and dispute resolution systems and take advantage of missed savings opportunities.

The OIG audit found that the state had failed to provide accurate and complete information on its rebate activities and needed to address weaknesses in the “processes, controls, and accountability” of their rebate program.

The report, issued on September 1, also claims that the state has failed to take advantage of opportunities to save money by not properly monitoring their rebate practices. In particular, OIG argues that the state could generate \$3.3 million in savings each year by “seeking rebates from 340B entities that do not bill the Health Department at discounted prices.”

Members of the 340B community have been quick to dispute this recommendation. “The report appears to reflect a misunderstanding about a covered entity’s right to ‘carve out’ its Medicaid drugs from its 340B pur-

chases,” says Bill von Oehsen of the Public Hospital Pharmacy Coalition (PHPC). “The proper response is for the Health Department to seek manufacturer rebates for the ‘carved out’ drugs rather than expect the covered entities to pass along 340B discounts that they never received.”

Both the Public Health Service Act and the Social Security Act require state Medicaid agencies to prevent rebate requests that would lead to entities receiving both a 340B discount and a Medicaid rebate.

One common method of avoiding this “double discount” problem is for covered entities to take advantage of the “Medicaid carve-out” option, which was formally recognized by the Health Resources and Services Administration (HRSA) in a *Federal Register* notice issued on March 15, 2000.

Under this arrangement, entities are permitted to purchase their Medicaid drugs at above the 340B price and then bill Medicaid at a non-340B price. In these cases, Medicaid is entitled to request a rebate from the manufacturer, which is what New York’s rebate program has reportedly failed to do.

According to the OIG report, New York does not have an effective mechanism for determining whether 340B entities are billing Medicaid at a discounted price.

OIG encourages the state’s Department of Health to work with the Centers for Medicare and Medicaid Services (CMS) to develop “cost-effective measures” aimed at directing these savings to the Medicaid program.

The Department has responded favorably to the recommendation, acknowledging that it “should be working with CMS to achieve appropriate savings for 340B discounts.” However, the Department argues that “the collection of rebates due from improper billing by 340B entities is a universal concern for all states and requires that CMS take the lead in this effort.”

The report also identifies a number of other issues that must be addressed by the state’s rebate program. For instance, OIG found that the state had understated the Federal share of rebates for drugs used in family planning clinics by approximately \$730,000 a year and had accrued a balance of \$350.6 million in outstanding rebates as of June 2002.



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For more details, visit www.rxforaccess.org

Prime Vendor Program Prepares for Future

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There are currently more than 600 participants in the program, the vast majority of which are disproportionate share hospitals (DSH). Hatwig says that approximately 200 participants have applied since the beginning of September, and with the announcement of the contract, he expects an even larger influx of participants in the near future.

The prime vendor program has also secured a number of significant contracts over the past few months, according to Hatwig. For instance, the program recently entered into a contract with Health Care Diagnostics, Inc., a com-

pany that manufactures diabetic strips and supplies. In accordance with the new contract, participants in the prime vendor program will likely achieve 30 percent savings off of existing private sector prices on supplies such as lancets and strips. Hatwig says the agreement will save one hospital in the program \$600,000 a year.

The prime vendor has also entered into a contract with First Horizon for their drug Sular, a calcium channel blocker that is often used to treat angina and high blood pressure. The Sular contract represents the first instance where the prime vendor program has achieved significant discounts—more than 30

percent below the 340B ceiling price—on a brand name drug.

As for the future, Hatwig says that his focus will be on promoting longer-term contracting, which he believes will be more cost-effective and manageable for both providers and suppliers.

In the meantime, HPPI has committed much of its time to marketing the program to as many covered entity groups as possible. “We’ve been on the road constantly,” Hatwig says, speaking to a wide range of 340B covered entity groups in an effort to broaden the program and improve its ability to secure greater discounts.

ADAPs Wary of New Medicare Regulations

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pate with prescription drug plans so that the drugs offered to individuals with HIV/AIDS can be offered at 340B prices.”

One obstacle that may complicate such partnerships is the provision in the proposed Medicare regulations that states that ADAP spending on HIV/AIDS treatments will not be counted towards the out-of-pocket spending of Medicare beneficiaries. As a result, it is unlikely that ADAP beneficiaries will spend enough money to reach the “catastrophic limit,” the point at which Medicare covers 100 percent of a beneficiary’s drug costs.

This is especially troubling for ADAPs, which would continue to pay the full cost of drugs for those who are in the “doughnut hole,” a spending range where beneficiaries are responsible for all of their own drug costs.

Ann Lefert, a Public Policy Program Associate at NASTAD, says that allowing ADAP spending to count towards the “catastrophic limit” is NASTAD’s most important priority in responding to the proposed regulations.

Another cause for concern among state ADAPs is that Medicare prescription drug plans are permitted to charge coordination fees to groups such as ADAPs that provide insurance. Lefert says that NASTAD is also concerned about the possibility that some Medicare prescription drug sponsors may have formularies that are too restrictive to include all of the drugs used by ADAP clients.

NASTAD is currently developing strategies to create a “win-win” situation with CMS so that both programs are able to benefit from savings on HIV/AIDS treatments.

ADAPs Looking to Contain Costs

The federal funding provided to ADAPs under the CARE Act represents the largest component of the national ADAP budget—the federal earmark made up 72 percent of ADAP funding in FY 2003—though states may also receive funding from other sources.

NASTAD and others are concerned that this funding may not be keeping up with increases in costs. According to the most recent National ADAP Monitoring

Project Annual Report, 35 state ADAPs saw increases in their monthly drug expenditures between April 1, 2003 and March 31, 2004 and 41 of the 50 state ADAPs experienced increases in the number of clients they served.

However, the report also found that a number of states have suffered decreases in funding from various sources, with five states experiencing net decreases in their overall budgets. As a result, many states have implemented “cost-containment measures” to keep down drug costs and maintain the solvency of their programs.

According to the Monitoring Project report, 17 states are currently implementing or planning to implement various cost-containment measures. Some of these measures, including the reduction of formularies and increased cost-sharing, have the potential to limit patient access by either capping the number of patients who can be assisted by the state or requiring patients to help pay for the drugs they receive.

Ultimately, Penner says that the most effective solution to the budget shortfalls facing state ADAPs would be for state and federal legislators to provide more funding for the program.

Schering-Plough Begins to Issue Settlement Checks

340B covered entities that purchased Claritin from 1998-2003 have begun to receive reimbursement checks from Schering-Plough in accordance with a settlement reached in July between the drug company and the federal government.

The settlement stemmed from allegations that Schering-Plough offered concessions to two managed care companies in order to avoid lowering Claritin's Medicaid "best price."

The agreement stated that Schering-Plough had 30 days to issue reimbursement checks following certain events, including the court's acceptance of the company's guilty plea in connection with charges that the company allegedly violated the Anti-Kickback Act.

The guilty plea was entered on August 13. According to a number of 340B participants, checks were issued on September 3.

The settlement set aside \$10.6 million for covered entities, but stated that this figure could be larger depending on the results of an accounting of overcharges conducted by Schering-Plough. The settlement amount represented roughly double damages for 340B entities, according to a number of government sources.

Some hospitals have received checks for over \$100,000 while health centers and other 340B entities are generally receiving smaller allotments, the *Monitor* has learned.

According to the letter that has accompanied the settlement checks, covered entities are also receiving from Schering-Plough a report detailing all of the purchases made by the entity during the quarters covered in the settlement.

These reports, which were not included in similar settlements reached last year, allow covered entities to com-

pare Schering-Plough's records with those maintained by the entities' pharmacies, and display both the "PHS Per Unit Price" (the price paid by the entity) and the "Revised PHS Per Unit Price" for four different forms of Claritin.

The reimbursements cover purchases made by covered entities between the third quarter of 1998 and the second quarter of 2003. This timeframe, which is slightly different from the period cited in the settlement as the timeframe of the underlying best price violations, reflects the fact it generally takes two quarters for changes in a drug's Medicaid "best price" to be reflected in 340B data, according to one of the government attorneys who was involved in the case.

The letter suggests that those who have questions about the settlement contact either the Schering-Plough legal department or the Pharmacy Services Support Center (PSSC).

AIDS Organization Targets GSK for 340B Refunds

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number of other investigations involving improper pricing practices and "best price" violations, both past and ongoing, in which GSK was or is involved.

In justifying the proposed Legislative audit, AHF cites a settlement reached between GSK and the federal government in April 2003 in which GSK agreed to pay \$87.6 million to settle several claims, including allegations that the company had sold pharmaceutical supplies to health management organizations (HMO) at deeply discounted prices and concealed the transactions.

The State Attorneys General also claimed that GSK had re-labeled or re-packaged drugs under HMO labels in order to avoid having to include further discounts on Flonase and Paxil in the drugs' "best price" calculations. As part of the settlement, at least \$9.4 million were delegated to 340B entities affected

by the overcharges.

Based on this settlement, Robison says that there is "every reason to believe" that GSK has continued to defraud the Medicaid and 340B programs.

"When it comes to AIDS drug pricing policies, we believe Glaxo is the original sinner," said Weinstein, referring to AHF's action as an effort to protect its patients from the "grasp, secrecy, and unbridled greed of these huge pharmaceutical companies."

GlaxoSmithKline currently controls 40 to 50 percent of the worldwide market for HIV/AIDS drugs, according to various estimates.

This is not the first time that AHF has brought suit against GSK. "We have a history with them that goes back quite far," says Robison.

For years, AHF has challenged GSK's patent on AIDS drugs such as AZT, claiming that GSK was not actu-

ally responsible for the development of the drugs and are therefore unworthy of the patents. One such suit was dismissed by a federal judge on March 5, 2003.

AHF also has a lawsuit against GSK that will soon be heard in South Africa, according to Robison.

AHF provides healthcare to AIDS patients at 14 locations, including sites in California (12), Florida (1), and New York (1), and runs 7 pharmacies. According to the Pharmacy Affairs Branch (PAB) website, their sites joined the 340B program in 1996.

GSK has not yet released a statement regarding the suit, and did not return multiple phone calls seeking comment.

For information on the suit, including a copy of AHF's press release and excerpts from the complaint, visit www.aidshealthcare.org.

340B Entities Eligible For Free Vials of Taxol

340B entities and other health care providers that treat indigent patients are now eligible to receive free vials of the cancer drug Taxol as a result of a recent settlement reached between the 50 state Attorneys General and drug manufacturer Bristol-Myers Squibb (BMS).

According to the 2003 settlement, which stemmed from allegations that BMS conspired to keep generic alternatives to Taxol off the market, BMS is responsible for providing 13,000 vials of Taxol to low-income cancer patients "to be distributed to DEA-approved health care facilities throughout the United States and its Territories, and administered to cancer patients meeting certain financial requirements."

The Taxol distribution began during the last week of August after two months of preparation.

Taxol, a brand name version of paclitaxel that is also marketed as Onxol, is an intravenous chemotherapy drug that is used to treat diseases such as ovarian cancer, breast cancer, non-small-cell lung cancer, and Kaposi's sarcoma, the most common form of cancer found in AIDS patients. Taxol can sell for up to \$2,000 per vial on the open market.

The state Attorneys General have contracted with RxHope, an internet-based organization with ties to PhRMA, to distribute the drugs. RxHope assists health care providers in applying for patient assistance programs and free

drug samples offered by manufacturers.

"We just want to get the medications to the people who need them," says Mike Larney, one of RxHope's Taxol Program Supervisors, adding that the biggest challenge has been getting the word out to providers who could benefit from the free drugs.

Larney says that RxHope has begun its outreach effort with disproportionate share hospitals (DSHs), but he stresses that any health care provider whose patients meet the requirements of the settlement can apply for the drugs.

According to the application form available online, patients whose income is less than 300 percent of the federal poverty line may be eligible to receive up to three months worth of treatment, though Larney says that the financial requirement is "quite broad" and may allow those who do not qualify for other assistance to receive free Taxol.

On the RxHope website, located at www.rxhope.com, physicians can apply online to receive free drugs by providing their DEA number and financial information about the patient who is requesting the drug.

Large hospitals and clinics can also apply for the free drugs by setting up a special "clinic account" with RxHope, which allows pharmacists or other hospital employees to order the drugs for eligible patients on behalf of registered physicians. Larney says that RxHope created this option because large provid-

ers found it cumbersome to create accounts for each doctor. In order to take advantage of this option, providers must contact RxHope directly.

Once registered on the RxHope website, providers are able to track orders, re-apply, and place new orders for additional patients. According to RxHope, orders will be delivered 7-10 days after the request has been approved.

Larney says that the Taxol supply could last anywhere from 6 months to a year before it is depleted, though he hopes that it can be distributed inside of 10 months. "It's anyone's guess how long [the drugs] will last," he says.

The 2003 settlement also called upon BMS to reimburse state agencies and public hospitals, as well as individual consumers, that overpaid for the drug.

The distribution of settlement funds was approved on March 31 of this year, and the mailing of all payments was completed by June 1. According to the Attorney General of Ohio, more than 12,700 cancer patients have received a portion of the \$55 million settlement.

The suit filed against BMS claimed that over a four-year period the company violated anti-trust rules and extended their patents on Taxol in order to delay the release of cheaper generic versions of the drug.

Though they agreed to the settlement, BMS admitted no wrongdoing in connection with the charges.



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