Widespread Disasters: What Has Katrina Taught Us?

The humanitarian crisis that unfolded on the Gulf Coast in the wake of Hurricane Katrina in the summer of 2005 was unprecedented in scope, directly impacting multiple states and indirectly impacting several others to which evacuees were relocated. Many state boards of pharmacy members, government officials, pharmacists, and other private-sector professionals showed tremendous resourcefulness in dealing with a situation few could have foreseen.

Yet, more than anything, Katrina serves as a warning. The disaster has served as a case study for how state boards of pharmacy, the federal government, and the private sector must coordinate their efforts to ensure the protection of the public health following disasters of such scope. In some cases, Katrina provided only a starting point for discussions on other aspects of disaster relief. State board officials and staff who were involved in the relief efforts noted some situations that were handled well and a few more issues to consider to better prepare the state boards for similar future situations.

Positive Developments

Three positive developments in the area of private sector/government cooperation and coordination within the private sector are a possible model for future responses to catastrophic events:

- Immediate governmental approvals of emergency prescriptions. The Louisiana Board of Pharmacy and the Mississippi Department of Health (on behalf of the Mississippi State Board of Pharmacy, which was temporarily lacking phone service) gave immediate approval of emergency prescription dispensing based on pharmacists’ professional judgment, and a single phone call to the United States Drug Enforcement Administration (DEA) provided a confirmation.

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that this emergency prescription dispensing procedure was acceptable.

Distribution of critical supplies and medicine. Jim Craig, director of the Office of Health Protection in the Mississippi Department of Health, reported that numerous hospitals on the Gulf Coast were running out of medical-grade oxygen. Two late conference calls with oxygen suppliers were held in the storm’s immediate aftermath to determine which suppliers were located nearest to the hospitals. In many cases, normally competing suppliers shared trucks and drivers to deliver the oxygen.

In Louisiana, it was determined that there were enough wholesalers and community pharmacists to serve the entire state, with some coordination. Morris & Dickson, a major drug wholesaler based in Louisiana, and Wal-Mart provided large shipments to shelters and hospitals, and many community pharmacists dispensed emergency medication to those who needed it, per the Board’s emergency dictum.

Information gathering. Bob Dufour, a member of the Arkansas State Board of Pharmacy and director of pharmacy, professional services, and government relations for Wal-Mart Stores, Inc, notes that a key task in distributing supplies to hospitals and emergency shelters in Mississippi and Louisiana was developing a list of these facilities as well as suppliers located nearby. Also, a list of all nursing homes in Louisiana and Mississippi was compiled, and local Wal-Mart pharmacists contacted many of them to determine which supplies they needed. Another coordination effort was daily conference calls among retailers in which retailers “adopted,” i.e., assumed responsibility for providing pharmacy services to, shelters in Louisiana, Texas, and Mississippi. These conference calls prevented duplication of effort.

Issues to Consider
Following their experiences in Katrina’s aftermath, state board of pharmacy members and staff identified some issues that governments and the private sector should consider carefully in planning responses to similar future disasters.

A federal electronic emergency prescription drug plan that would work much like employer-provided pharmacy benefit managers is one possible means for ensuring that patients get the medications they need in a similar future situation, the board officials note. A bank identification number could allow the dispensing of prescriptions at any pharmacy in the nation. Such a plan might provide a better solution than relying on community pharmacies in distressed areas. Following Katrina, many community pharmacists who dispensed medication free of charge were concerned that they would be strapped for cash, jeopardizing their ability to offer long-term disaster relief – not to mention their businesses.

Malcolm J. Broussard, executive director of the Louisiana Board of Pharmacy, notes that with several retailers stepping forward and offering free emergency medication in varying supply amounts – which might not be consistent with state regulations – in the wake of Katrina, standardizing the supply amounts would be possible under such a program.

Model regulations covering such a widespread disaster could standardize patients’ supply of emergency prescriptions, the local board officials note. Given the magnitude of Katrina’s damage in some parts of Louisiana and the fact that Hurricane Rita prolonged the difficulty in other parts, some states should consider revisiting emergency proclamations allowing a 72-hour emergency supply and instead allow two-week or 30-day supplies. Broussard adds that it is unclear whether or not

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Idaho Joins MPJE Program; Time and Place Set for January MPJE State-specific Review

Idaho is the latest state to join NABP's Multistate Pharmacy Jurisprudence Examination® (MPJE®) program, raising the number of participating states to 46. On December 1, 2005, administration of Idaho's MPJE began at Thomson Prometric Testing Centers throughout the United States.

According to Idaho Board of Pharmacy Executive Director Richard K. "Mick" Markuson, "Historically Idaho has developed its own paper- and pencil jurisprudence examination; however, after extensive review, the Board found the MPJE to be a very defensible examination and provides us with the ability to update the examination in a timely manner."

Markuson also notes that reciprocity candidates now will have the option of taking the examination at different sites throughout the country, which could result in a cost savings for these pharmacists.

State-specific Review Meeting

In order to ensure the validity of the MPJE, NABP asks participating boards to attend the annual State-specific Review meeting. The 2006 meeting will take place at the Hilton San Diego/Del Mar, CA, January 19-22, 2006.

It is at this meeting that the boards of pharmacy determine the appropriateness of current examination items for candidates seeking licensure in their state and review new items according to changes in state and federal pharmacy laws. This year, an extra day was added because, in addition to reviewing their operational item pool, state boards will also review and approve about 950 new items for pretest in their pool. The boards that participate in the MPJE program have three primary responsibilities that help ensure the accuracy and timeliness of the examination:

- Develop approximately 30 new questions;
- Review the newly developed questions from all states, to determine which of them apply to their state; and
- Review all questions currently approved for their state to ensure all the items are appropriate.

NABP develops and administers the MPJE at no cost to the participating boards. The boards are required to attend one State-specific Review meeting per year. In addition to evaluating items, boards of pharmacy are responsible for approving candidate eligibility and providing candidates with score reports.

Errata

In the September 2005 NABP Newsletter article "Dextromethorphan Abuse Raises Concerns," it was erroneously reported that the state of New York had passed a law concerning dextromethorphan (DXM) sales. The article stated that "A rare legislative success at the state level occurred in 2005 in New York, when the state assembly amended the state's penal law to disallow the sale of more than two DXM-containing medication containers to any person under 18... [The law] is scheduled to take effect in November 2005." In fact, the bill was committed to rules in June 2005, and, if passed, will not take effect until the November after the bill becomes legislation. As of press time, no further action had been taken on the bill.

Executive Committee

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One-year term

Dennis K. McAllister  
President, District VIII  
One-year term

Lawrence H. Mokhiber  
President-elect, District II  
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Charles R. Young  
Treasurer, District I  
One-year term

Charles Curtis “Curt” Barr  
Member, District V  
Serving second year of a three-year term

Reginald B. “Reggie” Dilliard  
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John R. Durvee, Jr  
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Serving third year of a three-year term

William T. Winsley  
Member, District IV  
Serving first year of a three-year term

NABP's Executive Committee is elected each year at the Association's Annual Meeting. The 102nd Annual Meeting is April 8-11, 2006, at the Westin St Francis in San Francisco, CA.
FDA: Forget Drug Authorization

By Dale J. Atkinson, JD

The contentious and complex issues surrounding the importation and re-importation of drugs from Canada was recently addressed by the United States District Court for the District of Vermont. On September 19, 2005, the Honorable William K. Sessions III, the chief judge, issued an opinion on a matter initiated by the State of Vermont, through its Vermont Agency of Administration (Vermont), against the secretary of Health and Human Services (HHS) and acting commissioner of Food and Drug Administration (FDA).

On August 19, 2004, Vermont filed a lawsuit challenging a decision by FDA that denied its citizen petition seeking allowance for the Vermont State Employee Medical Benefit Plan (Plan) to “establish a program for the orderly individual importation of prescription medications.” Vermont claimed that the denial of the petition by FDA was arbitrary and capricious, and in violation of the Administrative Procedures Act.

Vermont also sought a declaratory judgment that the relevant section of the federal Food, Drug, and Cosmetic Act (FD&C) – implemented through the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) – was unconstitutional as improperly delegating authority to the Executive Branch of the federal government. The statute in question empowers the secretary of HHS to promulgate regulations that facilitate the wholesale importation of prescription medications from Canada only after certification to Congress that implementation of such a program would pose no additional risk to the public health and safety and result in a significant reduction in the cost of drugs to the American consumer.

To date, the current and previous secretaries of HHS have refused to recognize any such certification. In its petition and lawsuit, Vermont explained that it wanted the authority to contract with providers to create a system under which its members would have the option of forwarding a prescription to a Canadian firm where the prescription would be reviewed by a physician familiar with the patient’s medical history. The script would be rewritten by the Canadian prescriber as a Canadian prescription and forwarded to a licensed Canadian pharmacy to be filled and shipped by mail directly to the member in the US.

In the lawsuit, Vermont requested that FDA “issue regulations or otherwise commit to exercise its enforcement discretion to allow the [Plan] to establish a program for the orderly individual importation of prescription medications in a manner that promotes the safety and health of its members.” Vermont also requested that FDA issue guidance that such a program would be lawful under the statutes and regulations enforced by the commissioner. Finally, Vermont requested that FDA promptly establish regulations to provide for the importation of prescription drugs from Canada into the US as provided by the MMA.

As one basis for the lawsuit, Vermont argued...
that FDA is not currently committing resources to controlling importation by individuals for their own use of prescription medications from outside the US. Vermont also argued the close proximity of Canada to Vermont, price differentials, and the fact that the Plan gave control of what would otherwise be an ad hoc approach to importation with no controls over risks and intervention.

FDA argued that the denial of the Vermont petition was based upon the FD&C’s closed system, which strictly limits the importation of prescription medications. Pursuant to FDA, the only importation permitted under the FD&C is the reimportation of prescription drugs that were originally manufactured in the US and only by the manufacturer of the reimported drugs. As one of its bases for denial of the original petition, FDA stated that it would be “extremely unlikely that the State of Vermont could ensure that all Canadian drugs that the [Plan] helped its members obtain were in full compliance with all laws and regulations applicable to FDA-approved drug products.”

FDA also argued that the MMA calls for the issuance of regulations that facilitate the importation of prescription medications from Canada only if the secretary of HHS certifies the risk and cost issues. While conceding that FDA is studying the matter of the importation of drugs in accordance with the MMA and that it “will submit a comprehensive study to Congress on the importation of drugs” as set forth in that law, such does not constitute the certification by the secretary.

Based upon its position, FDA filed a Motion to Dismiss the Vermont litigation arguing that Vermont can prove no set of facts in support of its claim that would entitle it to relief. In considering the facts in light most favorable to Vermont (as required under the applicable Federal Rules of Civil Procedure), the court agreed with FDA and dismissed the lawsuit.

Addressing Vermont’s “arbitrary and capricious” argument, the court held in favor of FDA agreeing that the FD&C creates a closed system of drug distribution in the US and prohibits the introduction of any adulterated drugs into interstate commerce. Under the FD&C, the court noted that no prescription drug may be imported into the US with two exceptions. First, if authorized by the secretary for an emergency; and second, if permitted under the MMA.

The court noted that the MMA authorizes the secretary to promulgate regulations permitting pharmacists and wholesalers to import drugs from Canada into the US. It also noted that the secretary may “grant to individuals, by regulation or on a case-by-case basis, a waiver … under conditions as the secretary determines appropriate.” While the MMA contemplates both commercial and individual importation, these provisions of the MMA, according to the court, become effective only if the Secretary certifies to Congress that importation will be safe and cost effective. No such certification has ever been issued, either under the MMA or the Medicine Equity and Drug Safety Act of 2000, which preceded and has been pre-empted by the MMA.

The court clearly stated that the Vermont Plan would violate the FD&C, related to both prohibitions on reimportation and introduction of unapproved drugs into interstate commerce. Thus, the court addressed the issue of whether or not the Plan would violate the MMA.

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Telepharmacy Offers Convenience, Poses Challenges

Not many years ago, telepharmacy might have been defined as conducting pharmacy business over the telephone – the pharmacist answering a question, for example. With the explosion in communication technology, however, it has come to refer to everything from electronic prescribing in its many variations, to videoconferences that allow the pharmacist to dispense and counsel a hundred miles away from the patient, to Internet sites that facilitate prescription purchases, to the equivalent of automated teller machines (ATMs) that allow patients to pick up their prescriptions in or outside of a pharmacy. While these technologies offer tremendous opportunities for patients and for those interested in promoting the public health, they likewise pose challenges to regulators struggling to take advantage of innovation while maintaining strict standards to protect patients’ well-being and privacy.

In its report issued in early 2005, NABP’s Committee on Law Enforcement/Legislation (LE/L Committee) for 2004-2005 recommended amending the Association’s Model State Pharmacy Act and Model Rules to define the “practice of telepharmacy” as “the provision of Pharmaceutical Care by registered pharmacies and pharmacists located within US jurisdictions through the use of telecommunications and technologies to patients at a distance that are located within US jurisdictions.” Beyond the general definition, the ever-increasing and changing permutations of telepharmacy are now requiring state boards of pharmacy to examine their regulations and policies. Moreover, they must also increasingly take into account interstate issues, as implementation of the federal Medicare Prescription Drug, Improvement, and Modernization Act continues to push states toward a common standard for e-prescribing. State boards have had – and are having to – decide how best to protect the public health by encouraging or discouraging the initiatives taking place throughout the world of pharmacy practice.

Increasing Access
The golden promise of telepharmacy lies in its ability to potentially increase access to health care for those patients currently underserved or underserved. The LE/L Committee, in its 2005 report, recommended “that the practice of telepharmacy be restricted to areas that are considered medically underserved or as the Board deems appropriate.” The Committee noted some of the driving factors behind the move toward telepharmacy, including “an increasing geriatric population, difficulties in attracting health care professionals, and the closure of existing rural pharmacies.” At the same time, telepharmacy has the potential to hold down some costs in a health care industry in which prices seem to spiral out of control. It appeals to state officials seeking to promote and protect the public health; it also offers benefits to health care systems such as that of the Veterans Health
Administration (VA). As pharmacist Kristie L. Carevic and her colleagues noted in a brief evaluation of a VA pilot program that used telepharmacy to monitor patients on long-term anticoagulation treatment, “Telemedicine using Internet-based, two-way interactive audio/visual technology holds the promise of making high-quality health services more accessible and acceptable to remote patients and less costly to their managed care organizations.”

With the current pharmacist shortage heavily impacting rural areas, states with large rural populations have made particular efforts to institute regulations that take advantage of telepharmacy and harness it for its greatest effectiveness. North Dakota in particular has received much attention in recent years for its comprehensive and innovative program to restore and retain pharmacy services throughout the state.

In 2001, the North Dakota State Board of Pharmacy passed rules that allowed a pilot telepharmacy project, established in cooperation with the North Dakota State University (NDSU) College of Pharmacy and the North Dakota Pharmacists Association, to go forward. In 2002, the NDSU College of Pharmacy obtained a federal grant from the Department of Health and Human Services’ Division of Health Resources and Services Administration, Office for the Advancement of Telehealth that funded the pilot program of four central pharmacy sites and six remote telepharmacy sites.

The North Dakota Board established permanent telepharmacy rules in 2003. The NDSU College of Pharmacy obtained a second and then a third year of federal grant funding to assist pharmacies with program equipment costs, and telepharmacy continued to expand. As of September 2005, 17 central pharmacy sites were serving 33 remote sites, and the Minnesota Board of Pharmacy was allowing the telepharmacy project to work across its shared border with North Dakota.

Under the rules, a central pharmacy may have responsibility for up to four remote sites. Each remote site is staffed by a registered pharmacy technician who has constant access to the central pharmacy and its pharmacists via a computer, video, and audio link. In addition, the technician must have graduated from an approved pharmacy technician education program and have at least one year of experience as a registered pharmacy technician in North Dakota. This link allows the pharmacist at the central pharmacy to observe and communicate with the technician as he or she prepares the prescription for dispensing by the pharmacist, and to check the prescription and label as normal. The patient must receive a face-to-face, real-time consultation via these links with the pharmacist on all prescriptions – new or refilled – before they are dispensed. “Satellite consultation sites” are also permitted, where prescriptions previously prepared by the pharmacist at the central pharmacy wait for pickup; regular store clerks are authorized to guide patients to the videoconferencing equipment for the required consultation.

By all accounts, the project has been an overwhelming success. According to the NDSU College of Pharmacy, “Approximately 40,000 rural citizens have had pharmacy services restored, retained, or established through the North Dakota Telepharmacy Project since its inception. The project has restored valuable access to health care in remote medically underserved areas of the state.”

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approving a supply covering more than 30 days would be prudent, but notes that in Louisiana waiver provisions are available that could extend the supply, and that gubernatorial proclamations there cover a 30-day period. That means that a repeat occurrence such as Hurricane Rita could trigger a second proclamation and thus again allow patients to extend their supply of medication.

The amount of emergency prescriptions is the subject of some debate. Seven-day emergency prescriptions of medication no doubt would put less strain on regional distribution centers than 30-day prescriptions, would ensure sufficient supply, and could be replenished after a week. Potential problems with 30-day emergency prescriptions for patients relocated to crowded shelters such as the Houston Astrodome, however, include the hazards inherent in situations where large supplies of medication are potentially accessible to large groups of people in close quarters and the temptations the medications might present to curious children.

Pharmacists’ knowledge of what are reimbursable activities also came to the forefront in the aftermath of Katrina. Fred H. “Freddie” Mills, Jr, RPh, a pharmacist with F&M Bank & Trust and a member of the Louisiana Board of Pharmacy, worked closely with the state’s Department of Health and Hospitals on the distribution of medicine after the storm and on reimbursing pharmacists who dispensed drugs free of charge to those who needed them in Katrina’s aftermath. He recommends the documentation of procedures and educating pharmacists on reimbursable actions they can take in such emergencies according to the procedures. Mills indicates that community pharmacists must have some assurance ahead of time that assisting in relief efforts will not put them out of business.

In the case of a multi-state disaster such as Katrina, Mills adds, a federal program in which the federal government is responsible for reimbursement would simplify the reimbursement issue. He observed several instances where a pharmacist in a relocation state dispensed drugs to patients from a directly affected state and it was unclear which state was responsible for reimbursement. Another recommendation was that the federal government set up a Web-enabled program that emergency responders could use to post specific needs. The Federal Emergency Management Agency or state emergency management authorities could then use this information to coordinate efforts with suppliers and pharmacies at the local level. Authorization for first responders proved to be another barrier after Katrina. Federal or state emergency management agencies should provide the means for first responders and volunteers to quickly obtain authorization to assist in relief efforts, preventing a scenario in which qualified personnel are turned away from a disaster scene by law enforcement or the military.

Guidelines for drug storage and disposal are also important during and after a disaster. Broussard mentions the idea of a pharmacy “disaster response toolbox.” The toolbox would include information that would give emergency personnel the knowledge to prevent further threats to the public health via the medication itself, such as the appropriate temperature for storing drugs and safe disposal of contaminated drugs, an issue in flooded New Orleans.

Some lessons learned from Katrina that authorities and personnel at the state and local level should keep in mind in the event of similar future disasters include:

- Have a list of emergency contacts available to someone with the means to communicate.

Dufour notes that when the Mississippi State Board of Pharmacy was without phone service immediately after the hurricane, Judith Clark, pharmacy director for Mississippi Medicaid, sent an e-mail message from her husband’s law office to out-of-state pharmacies requesting that they take care of the state’s Medicaid patients. The pharmacies were informed that they would be retroactively reimbursed at the prevailing Medicaid rate.

- Determine the location and contact information of emergency shelters in advance of a disaster, if some advance warning is possible. Noting that retail pharmacists were unable to obtain the locations of some emergency shelters on the Gulf Coast from the American Red Cross and had to call local community officials instead, Dufour says that emergency response coordinators should obtain the location, key contact person, and contact information for shelters ahead of time.

- Boards must transform into relief coordinators during a disaster.

Citing the Louisiana Board’s work with the private sector to ensure the distribution of medical supplies and medication, Mills advises state boards of pharmacy to transform during such emergencies from regulatory bodies
to coordinators of efforts to ensure that residents receive the medications they need. The Louisiana Board converted its boardroom into a “war room,” where it coordinated the distribution of medicine to emergency shelters.

NABP: a Central Source of Katrina Relief Information

NABP served as a centralized information source for the issuance of temporary licenses to pharmacists from several states who volunteered to help in the aftermath of Hurricane Katrina. In some cases, these volunteers needed temporary licenses to prescribe medication in states directly affected by Hurricane Katrina and, in others, they needed licenses for states in which evacuees were relocated.

One of NABP’s main tasks was obtaining lists of volunteer pharmacists and verifying through its Disciplinary Clearinghouse that the volunteers had no current disciplinary action on their records. In addition to providing the state boards of pharmacy with verifications of good standing, NABP quickly posted the names of verified volunteer pharmacists on NABP’s Web site, www.nabp.net.

Another important service provided to state boards of pharmacy was the posting of states’ guidelines for the dispensing of drugs under temporary licenses, given the unusual circumstances under which some patients in directly affected or relocation areas attempted to get prescriptions filled. NABP’s Web site provides one location in which volunteer pharmacists can access these guidelines.

Posted on the NABP Web site is an emergency proclamation from the State of Louisiana Governor’s Office that specifies instances in which pharmacists can dispense a one-time 30-day emergency supply of medication, and instances in which pharmacists who are licensed out of state can dispense prescriptions. Similarly, an order from Virginia Governor Mark R. Warner permits prescription dispensing to those displaced by the hurricane under certain conditions, and Tennessee Governor Phil Bredesen issued an executive order allowing the dispensing of an emergency 30-day supply of medication and allowing pharmacists licensed in other states to fill prescriptions in Tennessee for displaced residents of other states.

In addition to notifying pharmacists that a rule allowing one-time 72-hour emergency refills was in effect, the Alabama State Board of Pharmacy requested that Alabama Governor Bob Riley issue two proclamations in the wake of Katrina. One extended the provision for emergency refilling of prescriptions from 72 hours to 30 days. The other approved the issuance of temporary licenses to volunteer pharmacists from other states under Alabama’s reciprocal licensure statute. NABP also posted Alabama’s expedited reciprocal licensure steps for pharmacists from Mississippi and Louisiana who sought to assist relief efforts. Applicants were able to download a Preliminary Application for Transfer of Pharmacist Licensure form from NABP’s Web site and send it to NABP with a payment. NABP verified applicants’ existing licenses before sending them NABP’s Official Application, which applicants completed and sent to the appropriate state board.

The California State Board of Pharmacy’s guidelines advise pharmacists serving patients relocated to California to use professional judgment in deciding whether or not to dispense a reasonable amount of medication to these patients in order to prevent adverse symptoms. Included are tips for verifying the legitimacy and accuracy of the requested medications. Alternatively, the Board advises pharmacists to refer these patients to urgent-care providers for new prescriptions. Finally, the guidelines mandate the details that pharmacists should include on the emergency dispensations for their records.

NABP also posted the Wisconsin Pharmacy Examining Board Patient Care Alert, which details the Board’s Hurricane Katrina Emergency Dispensing Policy. The policy advises Wisconsin pharmacists on the filling of prescriptions for displaced residents of Louisiana, Mississippi, Alabama, and Florida.

Posted Texas Administrative Code sections from the Texas State Board of Pharmacy specified instances in which Emergency Remote Pharmacy Licenses and Emergency Temporary Pharmacist Licenses can be issued. A link to the Texas Health and Human Services Commission Web site provided information about the Texas Medicaid Vendor Drug Program for Texas pharmacies dispensing prescriptions for Louisiana residents displaced to Texas, including downloadable Medicaid enrollment forms. Information was also posted about temporary licenses for pharmacists from other states, emergency remote pharmacy licenses, emergency prescription refills, and information for pharmacy technicians from other states seeking registration in Texas.
Telepharmacy  
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and has added approximately $12 million in economic development to the local rural economy.

North Dakota is not the only state to aggressively pursue a telepharmacy project. Many state boards have addressed or are addressing the issue of telepharmacy in some form or other.

Texas is another state that has been at the forefront of the telepharmacy movement. Legislation in that state was passed in 2001, permitting remote dispensing via audio and video links. In that state, specific restrictions were placed on the location of these remote sites; telepharmacy services are allowed only in medically underserved areas as defined by state or federal law. “Telemedicine and telepharmacy are not panaceas, they’re tools,” says then-state Senator (and bill sponsor) Mike Moncrief, currently mayor of Fort Worth. “They should complement, not replace, traditional hands-on, face-to-face consultations.” Nonetheless, most public safety officials see telepharmacy as preferable to mail order when ensuring access to prescription medications.

Increasing Convenience  
Yet another form of telepharmacy—perhaps more accurately referred to as remote dispensing and/or verification—is arising in the name of increased customer convenience as well as increased access. Often touted in the press as the pharmacy equivalent of an ATM, kiosks that accept prescriptions and others that dispense them are appearing in a number of states throughout the country. When placed in or around community pharmacies in areas of high urban concentration (for example, Southern California or New York City), they are touted specifically as a time-saving convenience for drug store customers. Proponents argue that they do not endanger the public health and, moreover, that they allow overextended pharmacists to spend more time with the patients who most need attention and counseling.

Two manufacturers, Asteres Inc and Distributed Delivery Networks Corp (DDN), are producing substantially similar kiosks. Typically, a customer must register to use the device. After the patient submits a refill request in the usual way, often by phone or computer, the pharmacist fills it as normal and, if no counseling is indicated, places the labeled package in the kiosk for a later pickup. When the patient arrives to pick up the prescription, he or she logs onto the system with a user name and password, swipes a credit or debit card to pay, and the appropriate prescription package drops into the bin for retrieval.

California has become the most widely publicized pioneer in the pharmacy kiosk area. The California State Board of Pharmacy granted a waiver in October 2004, to authorize Longs Drug Stores to install and use 24-hour prescription drop kiosks at its pharmacies. It also waived requirements that

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In agreeing with FDA, the court rejected the arguments of Vermont that the “certification” requirement of the MMA only applies to commercial importations, not individual importations. The court stated that the Vermont argument that the certification requirement was somehow bifurcated was “convoluted and implausible.” The court held that the only plausible reading of the statute is to apply the certifications requirement to the whole applicable section of the MMA. Similarly, the court rejected the argument of Vermont that the certification requirement improperly delegates legislative power to the Executive Branch. Vermont had asked the court to declare unconstitutional that section of the MMA and sever it from the statute. The state argued that if the certification section of the MMA were severed from the statute, it would authorize the commercial and individual importation from Canada. The court held that the MMA establishes an “intelligible principle” to which the secretary of HHS is directed to conform in certifying safety and costs to Congress. As such, the MMA does not improperly delegate legislative authority. In addition, the court opined that the certification provisions of the MMA were vital to the act and, even if there was merit to Vermont’s argument, such provisions could not be severed.

Based upon these and other findings, the court dismissed the Vermont complaint and closed the case on this matter. This opinion represents an essential recognition of the FD&C and its impact upon state initiatives that may not conform to the federal laws. More to come.

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a pharmacist be present when a prescription is dispensed, allowing Longs to install and use what the Board termed an “automated self-service delivery unit” that allows patients access to their refill prescriptions during and after pharmacy hours. Longs unveiled its first prescription kiosk several months later. In the meantime, the Board has granted several other waivers, including to Safeway and Walgreen Co., as well as to the University of California at San Diego, which will conduct a study on the kiosks’ impact on pharmacies and consumers.

The California Board of Pharmacy granted the waiver permitting the dispensing kiosk on several conditions, including that the device be used only for refilled prescriptions, though not in cases where the pharmacist feels that patient consultation is warranted; that the kiosk be located “in reasonable proximity” to the licensed pharmacy premises; that it be able to identify the patient and release only that patient’s prescriptions; that consultation with a pharmacist be available upon request; and that the patient must “opt-in” in order to use the kiosk. The Board has proposed a permanent rule change to permit the devices; a decision is expected from the California Office of Administrative Law in early 2006.

The introduction of prescription drug kiosks has met with some resistance among pharmacists, who fear that they further erode patient care and the face-to-face interaction already threatened by the Internet and mail order pharmacies. Indeed, a group of pharmacists represented by the Pharmacy Defense Fund, a California-based legal foundation, filed suit against the California Board to contest the waiver. “The Board would not have passed or approved the waiver if we felt it impacted patient safety,” Patricia F. Harris, the Board’s executive director, told The San Francisco Chronicle. A second fear is that stores will use the technology as a way of cutting costs by cutting pharmacist hours. Those in favor of kiosks argue that pharmacists must still prepare all the prescriptions, and that the swift pickup of prescriptions not requiring counseling allows pharmacists to spend more time with the patients who do need it. Companies currently installing the kiosks say that they have no plans to cut pharmacist positions.

Virginia and Hawaii have also reportedly issued waivers allowing the pharmacy kiosks. The New York Board of Pharmacy, too, is consulting with its legal counsel to determine whether or not a dispensing device that opened in a Kmart in Penn Station is permitted under existing regulations. “We’re looking at it now,” says Lawrence H. Mokhiber, the Board’s executive secretary, “We’re hoping to resolve the situation in the near future.” He mentioned restrictions similar to the California Board’s; the prescriptions would need to be refills and not require counseling, for example, and could not include controlled substances.

Another type of kiosk has been introduced in New York in the past year or so as well. It receives rather than dispenses prescriptions. This device transmits prescriptions to pharmacies to be filled and picked up there, an activity that fits under existing regulations, says Mokhiber. Introduced by New York pharmacy chain Duane Reade, the kiosks use document-scanning and video conference technology to allow customers to scan paper prescriptions and consult live with a pharmacist. The customer may then pick up the filled prescription from a pharmacy (handing over the paper prescription at that time) or have it sent by mail. “In the event of any technology to transmit a prescription, the fundamental thing we look at is that the patient must have freedom of choice,” says Mokhiber. In other words, the patient must be able to choose the pharmacy where he or she sends the prescription for filling. In other ways, however, transmitting kiosks generally fit much more easily under existing regulations than those devices that dispense.

NABP Actions
While each board of pharmacy must grapple with the telepharmacy issues most relevant to the realities in its state, NABP continues to offer guidance.

NABP last convened a task force to discuss telepharmacy and electronic prescribing issues in 1996. At the Association’s 2004 Annual Meeting, it was resolved that NABP should revisit the issue. Resolution No. 100-3-04 states “that NABP revise the Model State Pharmacy Practice Act and Model Rules of the National Association of Boards of Pharmacy concerning the electronic transmission of prescriptions as a separate provision, and in consideration of the evolving practices of telepharmacy, the central processing of prescriptions, and remote dispensing.” Moreover, among the recommendations listed in its report, NABP’s 2004-05 LE/L Committee advised “that the Executive Committee commission a task force to examine the evolving practices of telepharmacy in the context of the regulatory issues that the state boards of pharmacy are being asked to define and address.” The Task Force on Telepharmacy and the Implementation of the Medicare Drug Benefit Medication Therapy Management Provisions met as this issue of the NABP Newsletter was going.
Sponsorship Provides Pre-NAPLEX Vouchers to Schools and Colleges of Pharmacy

NABP, through sponsorship from GlaxoSmithKline, is providing each school and college of pharmacy in the United States that has final-year PharmD candidates with three vouchers to sit for the Pre-NAPLEX®. The Pre-NAPLEX is a practice examination developed by NABP to familiarize candidates with the North American Pharmacist Licensure Examination™ (NAPLEX®) experience. Distribution of the vouchers shall be at the discretion of each individual school and college of pharmacy. To redeem their voucher recipients may register for the Pre-NAPLEX at www.pre-naplex.com and enter their voucher code. The Pre-NAPLEX was introduced in May 2003 and is currently utilized by 40% of NAPLEX candidates. At the conclusion of each practice examination, candidates receive a scoring estimate of how they may perform on the NAPLEX. Like other practice examinations, a candidate’s score on the Pre-NAPLEX is similar to what he or she can expect to receive on the NAPLEX, but may not be the actual score attained, nor is it a guarantee of passing the actual examination.

102nd Annual Meeting Travel Grant Offered

NABP is pleased to announce that it will again offer a travel grant to voting delegates for its 102nd Annual Meeting, held April 8-11, 2006, at the Westin St Francis in San Francisco, CA. This year the maximum reimbursement for the Annual Meeting Travel Grant Program has been raised to $1,000. For more than 100 years, the Association’s mission has been to aid and support pharmacy regulators in creating uniform standards that protect the public health. It is for this reason that NABP believes Annual Meeting attendance to be of high importance, for it is during the Annual Meeting that Association policies and priorities are voted upon, Executive Committee members and officers are elected, and members are provided with educational opportunities regarding current issues facing pharmacy regulators. NABP realizes that budget limitations can prevent state boards of pharmacy from sending representatives to meetings. As such, the Annual Meeting Travel Grant Program will reimburse designated voting delegates up to $1,000 in travel expenses, including airfare, hotel rooms, meals, taxis, parking, and tips. Monies are limited and grants are available on a first-come, first-serve basis. Grant monies do not include Annual Meeting registration fees. Grant applications may be obtained by contacting NABP Headquarters and must be received at NABP Headquarters prior to the Annual Meeting. NABP will inform applicants whether or not they have qualified for the grant, which is made possible by Pfizer Inc, prior to the event.
FDA, CDC Mobilize to Prepare Countermeasures for Possible Influenza Pandemic

In the event of a possible future flu pandemic, Food and Drug Administration (FDA) and The Centers for Disease Control and Prevention (CDC) have mobilized countermeasures. FDA announced the unveiling of two resources in October 2005:

1. A Rapid Response Team to ensure that antiviral drugs are available to the public. The team is tasked with ensuring that an adequate supply of anti-flu treatments such as oseltamivir phosphate (Tamiflu®) is available. Along with the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institutes of Health, and industry, the team will address barriers to increasing Tamiflu production.

2. Countermeasures to mitigate the sale of counterfeit or fraudulent treatments. Anticipating an increase in the sale of counterfeit or fraudulent Tamiflu treatments, FDA will continue to work with organizations in the US drug distribution system to strengthen the safety and security of the domestic drug supply. FDA will encourage pharmaceutical manufacturers to take advantage of new technologies that provide protective packaging and other features to ensure the authenticity and integrity of their products. Other measures include monitoring of Internet sites and partnering with Internet service providers to stop fraudulent activity, and aggressive pursuit of wrongdoers.

CRA has developed a data-sharing system called the Countermeasure and Response Administration (CRA) system that allows federal and local health officials to coordinate the administration of responses to catastrophic pathogenic outbreaks such as a flu pandemic. In such events, health officials need to determine who has been treated or vaccinated, track countermeasures, and discern countermeasure effectiveness.

The CRA system is part of CDC’s Public Health Information Network (PHIN) initiative, which seeks to implement the sharing of information systems among organizations that are involved in public health protection. CRA, which requires secure connectivity through a Secure Data Network, is a network of information systems used to manage and track the response to serious threats to the public health.

The most notable early use of the CRA occurred in the fall of 2004, when it was discovered that the vaccine supply produced (continued on page 203)

San Francisco Facts

Site of NABP’s 102nd Annual Meeting
April 8-11, 2006, Westin St Francis, San Francisco, CA
San Francisco’s famed cable cars came about as a result of a terrible accident that occurred on a typical damp day in the Golden Gate City in 1869. Five horses were killed when the streetcar they were pulling slid backward down one of the city’s steep streets under the streetcar’s heavy load. After witnessing the accident, Andrew Smith Hallidie developed the city’s extensive cable car railway system to conquer San Francisco’s steep hills. Hallidie immigrated to the United States from England in 1852. His father filed the first patent in Great Britain for the manufacture of wire rope, and Hallidie found uses for this technology in California’s Gold Country.

The Clay Street Line, the first cable car line, went into service on September 1, 1873. It cost an estimated $85,150 to build, a substantial amount at that time. Throughout the years, alternative means of transportation have threatened to eliminate San Francisco’s cable cars, but on August 2, 1973, the city celebrated the centennial of these moving national landmarks. (Source: www.sfoclecar.com/hist1.html)
Safeguards for Severe Acne Medication Announced

Because isotretinoin (Accutane®) carries significant risks of birth defects for women who are pregnant or might become pregnant, Food and Drug Administration has unveiled safeguards for its distribution. (See related article, March 2005 NABP Newsletter, page 61.) The manufacturers of isotretinoin are launching a program called iPLEDGETM in which doctors and patients register with the program and agree to accept certain responsibilities as a condition of prescribing or using the drug. Wholesalers and pharmacies must also comply with the program to be able to distribute and dispense the drug.

In the wake of a February 2004 joint meeting between FDA's Drug Safety and Risk Management Advisory Committee and Ophthalmic Drugs Advisory Committee, major improvements were recommended for the restricted distribution program for isotretinoin, which has proven effective in treating severe recalcitrant nodular acne. Under the recommendations, patients who could become pregnant are to have negative pregnancy testing and birth control counseling before receiving the drug. In addition, patients must complete an informed consent form and obtain counseling about the risks and requirements for safe use of the drug. Starting December 31, 2005, all patients and prescribers must register and comply with requirements for office visits, counseling, birth control, and other program components. After October 31, 2005, wholesalers and pharmacies were required to register with iPLEDGE in order to obtain isotretinoin from a manufacturer.

Program information and registration is available at www.iplerdget.com or 866/495-0654.

For the purpose of increasing available information about isotretinoin and its associated risks, FDA also issued a Public Health Advisory and revised the Patient and Health Care Provider Information Sheets that detail the new patient and practitioner restrictions and responsibilities under the program. A reporting and collection system for serious adverse events associated with the use of the drug has also been established. Pregnancy exposures to isotretinoin must be reported immediately to FDA at the MedWatch phone number (800/332-1088), the iPLEDGE pregnancy registry (866/495-0654), or on the pLEDGE Web site.

Besides approving the iPLEDGE program, FDA approved changes to the existing warnings, patient information, and informed consent form to help patients and prescribers better identify and manage the risks of psychiatric symptoms and depression before and after taking the medication.

Constitutional Amendment Deadline Set

Proposed amendments to NABP's Constitution and Bylaws must be submitted between Monday, January 9, 2006, and Thursday, February 23, 2006, to be considered during NABP's 102nd Annual Meeting, April 8-11, 2006, at the Westin St Francis in San Francisco, CA. Amendments must be submitted in writing to NABP's Office of the Executive Director/Secretary. Submission dates are established by NABP's Constitution and Bylaws, which specifies that proposed amendments may be accepted no earlier than 90 days and no later than 45 days before the Annual Meeting's First Business Session.
Colleague Infusion Pumps Recalled
Baxter Healthcare Corporation is recalling all models of its Colleague® Volumetric Infusion Pumps due to inadvertent shutdowns during infusion therapy. In addition to the shutdowns, the pump's design potentially causes users to press the on/off key instead of the start key when beginning an infusion, and the pump can fail while it is being connected or disconnected from a hospital's monitoring system if the pump is left on.

More than 200,000 pumps have been distributed to physicians, medical facilities, and pharmacies, and the deaths of three patients and serious injuries to six more have been attributed to the pump shutdowns.

While the manufacturer is working to correct these defects, it has recommended several corrective actions for pump users:
- The display of certain failure codes (402, 403, 533, 535, 599, 810:04, and 810:11) means that the user should remove the pump from service.
- Review the event history of every Colleague pump in use. Pumps that have exhibited any of the codes listed previously should be removed from service.
- Have a contingency plan to minimize infusion therapy disruptions, such as having a backup pump available for use.
- Consider not using the pump in situations where a malfunction could be life-threatening or where a replacement pump is not available.
- Significance of Antiplatelet Therapy with Drug-Eluting Stents Stressed
Food and Drug Administration (FDA) recently received several reports of patients experiencing adverse events such as stent thrombosis, myocardial infarction, and death after they received drug-eluting stents and then stopped taking their antiplatelet medication.

These events have been reported with Cordis Corporation's Cypher® and Boston Scientific Corporation's Taxus® stent systems that are currently on the market.

These events have occurred when patients ceased antiplatelet therapy early due to non-compliance, they were told to stop taking medication because they were going to have elective surgical or dental procedures, or because minor bleeding had occurred. As a result, the manufacturers have changed their labeling to stress the importance of patient compliance with the antiplatelet recommendations and the risks of discontinuing the therapy. The labeling also urges physicians to consider whether or not antiplatelet therapy should be used if a medical procedure would necessitate the discontinuation of antiplatelet therapy.

The labeling also warns practitioners that patients who must stop the therapy early should be closely monitored for cardiac events and that antiplatelet medication should be resumed as quickly as possible.

Precautions Advised for Inhaler Capsules Mistaken as Pills
FDA is recommending several precautions to avoid accidental ingestion of capsules intended for use with inhalers that resemble oral medication. While the manufacturers are working on making changes to labeling and packaging to prevent further instances, FDA has issued several precautions for the interim:
- Avoid dispensing the capsules separately from the inhalation device.
- If separate dispensing of the capsules cannot be avoided, affix a cautionary label that reads “For Inhalation Use with Special Inhaler Only.”
- Advise patients to store inhaler capsules with the inhaler and away from oral capsules.

Countermeasures (continued from page 201)
at European manufacturer Chiron Corp's Liverpool, England facility was contaminated, causing a shortfall of 48 million doses in the United States just prior to cold and flu season. CDC was faced with the task of ensuring that replacement vaccine from another supplier, Sanofi Pasteur MSD (formerly Aventis Pasteur), was distributed where needed to make up the shortfall. Although it took several months for Sanofi Pasteur to produce the vaccine, the CRA system allowed CDC to prioritize shipments of the vaccine based on need.

The information system used to manage the vaccine supply chain is based on stringent requirements that CDC has in place for tracing adverse events to the lot numbers of investigational New Drugs. During the 2004 vaccine shortage, the system matched the supply of manufacturers' and distributors' licensed flu vaccine with priority groups' population densities. States could access their monthly appropriations of vaccine online and place orders and track the status of orders.

For more information about CDC's CRA system or PHIN initiative, visit www.cdc.gov/phin.
California Joins Tennessee and Idaho in Awarding CE Credit for PSAM

The California State Board of Pharmacy recently became the third NABP member board of pharmacy to award pharmacists who complete NABP’s Pharmacist Self-Assessment Mechanism™ (PSAM™) with non-Accreditation Council for Pharmacy Education continuing education (CE) credit. The Board approved six hours of CE credit by unanimous action of its board of directors on October 25, 2005.

California followed the Tennessee Board of Pharmacy, which approved CE credit for PSAM on July 13, 2005. Idaho was the first to approve the PSAM for CE credit in June 2005.

The PSAM is a self-assessment tool, available 24 hours a day on www.nabp.net, that assists pharmacists in obtaining objective, non-punitive feedback on their knowledge of current practice therapies.

The Boards’ Involvement
Patricia E. Harris, executive officer of the California State Board of Pharmacy, noted the Board’s strong and unanimous support for this pharmacist assessment tool. “This exam encourages pharmacists to become aware of practice areas in which they are strong as well as those areas in which they need additional education. The result is better pharmacists’ care for the public.”

In its June 2005 Newsletter, the Idaho Board of Pharmacy announced that the state legislature “...found and declared that because of the continuous introduction of new therapeutic and diagnostic agents and the changing concepts in the delivery of health care services in the practice of pharmacy, it is essential that a pharmacist undertake a CE program in order to maintain his or her professional competency and improve his or her professional skills.”

According to Richard K. “Mick” Markuson, executive director of the Idaho Board, “Idaho approved PSAM as a Board-approved CE program that will offer another opportunity for pharmacists to further maintain, improve, and broaden their knowledge and skills. One of the biggest issues the Board of Pharmacy addresses in today’s pharmacy is the continuing professional development and self-assessment of our pharmacists... the Board feels that the opportunity for a pharmacist to broaden [his or her] knowledge base and elevate their professional competency and skills is imperative to the practice of pharmacy.”

After Idaho’s implementation of the PSAM, Tennessee Board President Reginald “Reggie” Dillard encouraged the approval of the PSAM in Tennessee as a useful mechanism; PSAM was passed unanimously for three CE hours in July 2005.

“This is a mechanism for pharmacists to take charge and become familiar with their weaknesses and shape their CE hours accordingly,” states Kendall Lynch, executive director of the Tennessee Board.

The PSAM assessment tool is applicable to general pharmacy practice and all practitioners. It consists of 100 multiple-choice questions and is divided into three sections of equal length. PSAM questions are based on patient profiles and simulate real-life practice situations and patient therapies. Each section can be completed in as little as one hour; a maximum of three hours per section is allowed. Once a section is started, it must be completed.

Since the PSAM is a learning tool, the pharmacist is provided with feedback on each question. The feedback displays each question, the answer selected, the correct answer, a brief rationale for the correct answer, and a reference where more information about the answer or applicable (continued on page 206)
High Attendance at NABP’s Board Training Sessions

With representation by 21 staff members from 20 state boards of pharmacy, NABP’s Board Training Sessions held in August 2005 and September 2005, drew its highest attendance in two years. The sessions served as an opportunity for attendees to learn the policies and procedures of the Association’s programs and services, including licensure transfer, the North American Pharmacist Licensure Examination™, the Multistate Pharmacy Jurisprudence Examination®, the Foreign Pharmacy Graduate Equivalency Examination®, the Clearinghouse, score transfer, the Pre-NAPLEX®, and the Pre-FPGEE®, as well as how to utilize the Lotus Notes® program and retrieve candidate scores. NABP staff also provided an update on the new Verified-Accredited Wholesale Distributors™ (VAWD™) program, which was implemented in February 2005. These review sessions explain how the Association collects and provides data to the boards and how computer software is integrated into and utilized by NABP’s various programs. These sessions also provide board staff with expertise and tips to utilize the tools provided by NABP. Finally, the sessions provide attendees with networking opportunities.

The sessions were held Monday, August 29, 2005, and Friday, September 9, 2005, at NABP Headquarters in Mount Prospect, IL. All attendees received an NABP Program Review and Training User Manual to use as a reference. User Manuals were also sent to all member boards for their use and review.

Overall, the 21 staff members who attended the sessions provided positive feedback regarding the sessions. The attendees said they benefited from the opportunity to meet other board staff members and learned from each other.

“Learning how NABP works with and for the different boards with the testing information, especially the foreign graduates, was particularly valuable to me,” commented Karli Bourne from the Washington State Board of Pharmacy. “It [the session] did give me a broader conception of the scope of NABP’s work. I enjoyed learning how the boards differ in their work approach and how their work load is handled.”

When asked for additional comments, Debbie Anderson of the California State Board of Pharmacy noted, “Overall everything was very well done. I appreciate the opportunity to come to Illinois and meet the people I work with every day. Thanks so much for this invaluable training tool. I wish all staff from all of the pharmacy boards could attend the training sessions.”

Dennis K. McAllister, NABP president, states, “NABP believes that these training sessions serve as an invaluable tool for the board staff to learn about the Association’s programs and services. These sessions also serve as refresher courses for those who have been working with the board and NABP for a while. We are working on ways to make next year’s sessions even more educational and enjoyable.”

Shown at left, in the September 2005 session, are (left to right) Louise Jones, Alabama State Board of Pharmacy; Deborah Anderson, California State Board of Pharmacy; Diana Decker, Florida Board of Pharmacy; and Lisa Atta, Kentucky Board of Pharmacy.

Board Training Sessions gave board staff the opportunity to learn more about NABP’s programs and services. Pictured at right in the August 2005 session (left to right), Richard Cieslinski, RPh, Arizona State Board of Pharmacy; Margaret Lincoat, Arkansas State Board of Pharmacy; Ellen Mitchell, Idaho Board of Pharmacy; and Darla Sayre, Kentucky Board of Pharmacy.
Groups' Web Sites Provide Medicare Part D Information

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides seniors and individuals with disabilities a prescription drug benefit under Medicare Part D that becomes effective January 1, 2006. The following resources provide information about MMA and the prescription drug benefit.

The Centers for Medicare and Medicaid Services (CMS) Web site, located at www.cms.hhs.gov/mmw/default.asp, provides updates on CMS’ efforts to implement the legislation. CMS’ site includes an overview of the MMA statute, day-to-day operating procedures and instructions based on MMA parameters, information for beneficiaries and providers, and information about the Medicare Prescription Drug Discount Card and Transitional Assistance Program. In addition, a link on the home page allows visitors to register for e-mail updates to content on the site.

The American Pharmacists Association (APhA) Web site’s Medicare Resources page contains information to help pharmacists understand various aspects of Medicare Part D. To access the page, visit www.aphannet.org and click on “Government Affairs,” followed by “APhA Resources: Medicare.” The page features links to general information, the drug discount card program, comprehensive drug benefit information, links to other resources, patient educational resources, and an ongoing APhA continuing education series for understanding Medicare reform.

The American Society of Health-System Pharmacists (ASHP) Web site, at www.ashp.org, features a “Medicare Modernization Act” link under “Resources.” In addition to providing links to the CMS Web site, the ASHP site provides links to Medicare Part D, Part B, and Hospital Outpatient Prospective Payment System regulations.

The Century Foundation, a nonprofit public policy research and analytics group, offers an 18-page guide on Medicare Part D titled The Medicare Drug Benefit: Straight Answers to the Toughest Questions, in an Adobe Portable Document Format (PDF) file of the guide, which can be downloaded from the group’s Web site, www.tcfl.org. The document addresses issues such as how seniors will access information about the benefit, special assistance available to low-income beneficiaries, MMA’s effect on the long-term viability of Medicare, how private plans fit into the program, the alignment of employer plans and Part D, and the alignment of state prescription drug programs and Part D.

NABP Directly Operates VAWD Inspection Process

NABP has restructured its relationship with regulatory compliance consultancy BuzzeoPDMA for the administration of NABP’s Verified-Accredited Wholesale Distributors™ (VAWD™) accreditation program. NABP will operate and administer VAWD inspection services; inspections and inspectors will be managed and contracted directly through NABP. BuzzeoPDMA will identify qualified and trained inspectors for use in the VAWD program.

The VAWD program provides assurance that the wholesale distribution facility operates legitimately, is validly licensed in good standing, and is employing security and best practices for safely distributing prescription drugs from manufacturers to pharmacies and other institutions. Applicants for VAWD accreditation undergo a criteria compliance review, licensure verification, an inspection, background checks, and screening through NABP’s Clearinghouse.

For more information on the VAWD program, visit NABP’s Web site at www.nabp.net.
Fourth Annual Poster Session at Annual Meeting: an Information Sharing Opportunity

State boards of pharmacy members and staff and schools and colleges of pharmacy have a unique opportunity to share information about the latest legislative issues, technology, policy development, or disciplinary cases at the Fourth Annual Poster Session held during NABP’s 102nd Annual Meeting. The session will take place Saturday, April 8, 2006, from 1 to 5 pm and Sunday, April 9, 2006, from 8 am to noon during the 102nd Annual Meeting, which will be held April 8-11, 2006, at the Westin St Francis in San Francisco, CA.

State boards of pharmacy as well as schools and colleges of pharmacy students and faculty are encouraged to participate in the Annual Meeting poster session. Encore presentations are accepted and encouraged; posters will not be judged.

Last year’s poster session at the 101st Annual Meeting in New Orleans, LA, featured posters with such titles as “The California Health Communication Partnership,” “Indiana’s Passage of VAWD™: Issues and Obstacles,” “IPS Evolution,” “Nevada’s Innovations Regarding the Regulation of Drug Wholesalers,” “Expanded Pharmacist Practice in New Mexico,” and “Internet Prescribing: The Utah Board of Pharmacy Order for Public Safety and Protection.”

Interested in participating, but not sure where to start? Listed below are some tips on preparing a poster:

- Limit text and utilize graphics; double-check that all items on the poster are necessary for presentation.
- Prepare handouts to provide an overview of poster and/or additional information including contact names, should attendees have questions.
- Keep your poster title short, highlighting the topic.
- Make the font size at least 14 point and double-space paragraph lines to ensure readability from two to four feet.
- Lay out the sections of your poster in a logical order so that the poster is easy to follow. Rather than affixing your documents to one large piece of poster board, which can cause a strain on poster pins, break your materials into three or four sections. You should also be able to move them around on the board.
- Enlist the help of students and/or interns on rotation in your office to prepare the poster.

Each participating board or school/college of pharmacy will be provided with one four-foot by six-foot bulletin board, which should be manned by a board-appointed representative during display times. To participate, interested boards should notify the NABP Meetings Desk by March 3, 2006. Please provide the poster topic.
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Proposed amendments to NABP’s Constitution and Bylaws must be submitted between Monday, January 9, 2006, and Thursday, February 23, 2006, to be considered during NABP’s 102nd Annual Meeting, April 8-11, 2006, at the Westin St Francis in San Francisco, CA.