Essentials for Efficient 340B Pharmacy Management
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This document is the result of collaboration by the Iowa / Nebraska Primary Care Association and the Iowa Prescription Drug Corporation to provide assistance to community health centers (CHCs) in Iowa and Nebraska. The information provided is intended to deliver basic, but important, suggestions on the implementation of 340B pharmacy services in Federally Qualified Health Centers. The text is broken down into sections that include:

A) Identification and Utilization of 340B Online Tools
B) Development of a Formulary
C) Maintaining Adherence to a Preferred Drug List / Formulary
D) Utilization of Alternative Drug Supplies
E) Considerations in Contract Pharmacy Structure
F) Economic Opportunities in 340B

A) Identification and Utilization of 340B Online Tools. The vast majority of pertinent information regarding 340B programs can be accessed through two websites.

1) Pharmacy Services Support Center / Health Resources and Services Administration http://pssc.aphanet.org/

This is a comprehensive website regarding 340B issues and contains details on eligibility, registration, news and other related links. This site should be continually utilized to gain access to program information, regulation, and
other resources. To gain a thorough understanding of 340B program requirements and implementation refer to “The Bridge to 340B: Comprehensive Pharmacy Services Solutions in Underserved Populations.” This training manual can be found under the Resources tab at the top of the website.


Each registered 340B entity should participate in the Prime Vendor Program. There is no fee for participation. The Prime Vendor Program works on eligible entities’ behalf to negotiate wholesale drug costs which are below the 340B ceiling price. Use of the Prime Vendor Program will ensure that medications are purchased at the least possible price. (Note: This is especially important when brand name medications are purchased.) The secure area of this website allows access to negotiated drug pricing, reports of drug pricing changes, contract updates, newsletters, CE’s and more. This site should be utilized continually to help minimize drug costs and maintain affordable formularies.

B) Development of a Formulary. The purpose of a formulary is to identify and utilize the most affordable medications that will provide positive therapeutic outcomes. The medications on the formulary will be those that the 340B entity purchases and subsequently sells or provides to eligible patients. It is important to note that while these medications are not free, they are affordable (often deeply discounted) and will be routinely available to the patient. This is especially important in the CHC setting as patient income and compliance issues are considered. (A further discussion of alternative drug supplies can be found in section D below). Although each CHC will want to customize their formulary in order to serve specific patient populations and prescriber habits, it will be important to limit the number of included medications. Placing a limit on the number of medications within the formulary will enable the CHC to effectively manage drug inventories and their subsequent costs. The development of a preferred drug list (PDL) within the formulary is also recommended. The PDL simply demonstrates the portion of the formulary which is most utilized in practice. In other words, the formulary is the full list of medications that will be made available through the 340B program while the PDL comprises the most commonly used drugs, due to cost or clinical issues, within the formulary. Medications on the formulary should be reviewed for cost on a quarterly basis as new pricing information is released. Formulary medications can be added to or removed from the PDL subsequent to review of the updated pricing. The Formulary
Management Tool found on the Pharmacy Services Support Center website can also be utilized to compare relative medication costs across a therapeutic class. This may facilitate the formulary review and PDL update process.

A formulary has been developed for use within the IANEPCA network. This formulary can be used as a template for CHCs to work from in developing or comparing their own formularies. To view the network formulary click here. In addition, a corresponding network formulary price list utilizing 340B drug costs is available upon request. (Please note: Brand name medications and special “penny-priced” opportunities on the network formulary price list will be reviewed and updated quarterly. Generic medications will be reviewed and updated annually.)

C) **Maintaining Adherence to a Preferred Drug List / Formulary.** Every effort should be made to prescribe and dispense from the established PDL/formulary. Although it will be impossible to achieve a 100% utilization rate, the PDL/formulary should be considered the primary drug supply. The optimal way of achieving a high utilization rate, of course, is to ensure that practitioners prescribe from the list. All prescribing practitioners should have an understanding of its purpose, and be provided a continuously updated list to which they may refer. Copies of the formulary can be printed and given to each practitioner, posted in the exam room, or provided electronically (possibly through a PDA with e-prescribing features). Pharmacy and Therapeutics Committees (P&T) can aid in maintaining adherence as well and are often formed to assess, manage and promote the PDL/formulary. P&T committees are usually made up of physicians, physician assistants, nurse practitioners, pharmacists and members of the administrative staff. The P&T committee should meet on a regular basis (usually quarterly) to update the PDL/formulary, examine dispensing reports, identify possible opportunities and resolve any other pharmacoeconomic matters. Adherence can also be increased on the dispensing side of the equation by promoting therapeutic interchange through direct pharmacist inquiry or by the use of collaborative practice agreements. Collaborative practice agreements allow pharmacists, thru pre-established guidelines, to interchange drug products without having to seek continuous prescriber approval.

D) **Utilization of Alternative Drug Supplies.** Alternative drug supplies are medications which are made available to patients but are not included on the PDL/formulary. Alternative drug supplies include Pfizer’s Sharing the Care program, AstraZeneca’s AZ&Me program, patient assistance programs and physician drug samples. A balanced availability of a broad range of medications, a combination of PDL/formulary and alternative drug
supplies allows for the best approach to positive therapeutic outcomes. However, the over-utilization of alternative drug supplies carries the specter of additional administrative burden as well as an increased risk of poor therapeutic outcomes or patient non-compliance. Therefore these alternative drug supplies should be used secondarily to PDL/formulary medications. Medication usage should be prioritized as follows: PDL/formulary > Pfizer and AstraZeneca > patient assistance programs > physician drug samples. A resource on this topic, “The Limitations of Good Intentions: Prescribing Medications for the Uninsured” further explains this concept.

E) **Considerations in Contract Pharmacy Structure.** Pharmacy services provided by 340B programs will generally be implemented in one of two ways: an in-house pharmacy or a contract pharmacy. A complete differential between the two can be found in the “Bridge to 340B” training manual referenced earlier. While an exhaustive comparison will not be made here, it would be noteworthy to state that in-house pharmacy services are easier to actively manage and therefore health centers have the ability to better monitor drug pricing, increase formulary adherence and provide positive therapeutic outcomes. While it is ultimately easier to see advancement and gain through a larger in-house pharmacy investment, all is not lost on implementing 340B pharmacy services through a contract model. Some techniques can be utilized within the contract pharmacy structure to increase the accessibility of affordable medications to those populations in need.

1) **Review pharmacy fees.** There are several ways to construct a pharmacy fee (again, the “Bridge to 340B” training manual should be referenced for a complete description) and they will vary from clinic to clinic and will differ between in-house and contract models. Pharmacy fees that are commonly used in contract pharmacy arrangements will be specifically examined here.

Generally, the total prescription cost can be broken down into two components: a drug cost and a CHC administrative fee.

$$\text{Total Prescription Price} = \text{Drug Cost} + \text{CHC Admin. Fee}$$

The administrative fee can be set to cover expenses borne by the CHC as well as to cover the contract pharmacy fees paid to dispense 340B medications. The amount charged to cover CHC expenses usually ranges between $1 and $3. Frequently these expense fees are not charged at all.
Contract pharmacy fees are paid by the CHC for professional pharmacy services provided. Professional pharmacy services include dispensing, drug utilization review, allergy screenings, identification of drug interactions, etc. Contract pharmacy fees range between $8.50 and $12 per prescription. CHCs may choose to use a sliding scale for some or all of the costs and fees related to the total prescription price. This allows for subsidization of prescription costs for low income patients.

CHC administrative fees are often higher in the contract arrangement versus those of an in-house model due to the need to specifically collect a portion to offset expenses. This reduces potential savings (particularly on generic medications) offered to the patient through the 340B program.

At this point it may be appropriate to compare a sample of fees that are commonly found in pharmacy contracts as follows:

- Medicare Part D pharmacy fees range from $1.75 to $3.25, and average $2.27 (additional reimbursement is realized by a drug cost mark-up).

- Iowa Medicaid pharmacy fee is currently $4.57 (additional reimbursement is realized by a drug cost mark-up).

- Nebraska Medicaid pharmacy fee is currently $4.66 (additional reimbursement is realized by a drug cost mark-up).

- Contract pharmacies providing 340B services typically charge fees in the $8.50 to $12 range (NO additional reimbursement is realized by a drug cost mark-up).

- Recent studies demonstrate that pharmacy incurred costs relating to one dispensed prescription range between $9.50 and $10.50.

If the contract pharmacy is not meeting the needs of the CHC or its’ patients it may be appropriate to negotiate lower pharmacy fees in exchange for performance based incentives. These incentives could be paid to the contracted pharmacy for the ongoing promotion and utilization of PDL/formulary medications, routine drug
utilization review, inventory control and other attainable goals. This sort of pharmacy fee structure would seemingly be mutually beneficial to the patient, pharmacy, and the health center

Pharmacy fees should be set at the point where they are affordable to the patient population served and will allow the dispensing pharmacy to be reasonably reimbursed.

2) Examine wholesaler agreements/services. Drug wholesalers are primarily interested in the efficient distribution of large quantities of pharmaceutical products and receiving prompt reimbursement. Generally, order volume and payment terms are the areas where CHCs and contract pharmacies will negotiate wholesaler agreements. In 2007 IANEPCA members were surveyed regarding wholesaler agreements. The results of the survey and the subsequent report should be reviewed as they contain valuable explanation, insight and recommendations (see “Navigating Pharmacy Wholesaler Agreements”).

Other recommendations include:

- Refer back to the Prime Vendor Program. The Prime Vendor Program may have pre-negotiated contract terms with your wholesaler. The terms of this collaborative, volume based agreement may be better than what the CHC/contract pharmacy can negotiate alone.

- “Piggy-back” the 340B program drug shipment with the contract pharmacies’ regular order. This may allow for further discounts based on volume.

3) Build in Routine Audits. All aspects of contract pharmacy services should be reviewed on a regular basis. This review may include, but should not be limited to:

- Review of overall vision/purpose of 340B pharmacy services.

- Regular visits to the Prime Vendor Program website to fully capitalize on current incentives

- Examination of contract pharmacy agreements and expectations.
- Assumption that inventory is being managed.
- Report on PDL/formulary adherence and maintenance.

**F) Economic Opportunities in 340B.** Put simply, the single largest economic opportunity for a community health center that is participating in the 340B program is to fill non-Medicaid third party insured prescriptions. More succinctly, 340B participants should increase the capture rate of non-Medicaid third party insured prescriptions.

The capture rate refers to the percentage of prescriptions that are written in a particular CHC and are filled through the health center’s 340B program over a period of time. For example, say there are 1000 prescriptions written by the provider staff per week. Of those 1000 prescriptions, 450 of them are filled through the health center’s 340B program, while the other 550 are taken to other pharmacies for dispensing. The capture rate for the CHC 340B program would be 45%.

The value of filling non-Medicaid third party insured prescriptions stems from the ability to receive the full payment from the third party payer (patient co-pay plus traditional reimbursement). Because the difference between the 340B drug acquisition cost and the third parties’ reimbursement can be significant there is an opportunity for prescriptions covered by commercial health plans or Medicare Part D to generate revenue for the CHC.

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