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Drug Benefit News

News, Data and Business Strategies for Health Plans, Employers, PBMs and Pharma Companies

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PBM Auditing Increases as Rx Costs Rise, But Critics Allege PBMs Are Foiling Audits

Faced with rapidly rising pharmaceutical costs, health plans and employers increasingly are turning to audits to ensure that their PBMs are delivering on contractual promises. While some PBMs willingly open their books, industry critics allege that the auditing process is stymied by PBM gamesmanship, and that clients are losing money as a result. If PBMs would allow better access to their documents, one veteran PBM auditor tells *DBN*, pharmaceutical payers could save up to 10% on their drug spend in some cases.

For their part, PBMs say they recognize the importance of audits and point to an auditing provision that was included by URAC in last year's PBM accreditation standards. And one PBM observer contends that the sheer complexity of the PBM business — with its multiple rebates, fees, discounts and varying pricing formulas — can raise red flags with pharmaceutical payers, even when no wrongdoing exists (see story, p. 7).

But others involved in the PBM auditing process see a pernicious attempt by many PBMs to ensure that full sunshine does not fall on their books. PBMs, they assert, place undue restrictions on the auditing process that skews the audit in favor of the PBM, and can block recoveries of funds due a client. Such practices are enabled by poorly drafted PBM/client contracts and include the following requirements:

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Medicare Part D 2009 Bids, Premiums Rise; Plans Say Beneficiaries Will Likely Stay Put

The average bid submitted by Medicare Part D sponsors for 2009 is almost 5% higher than it was in 2008, an increase that is estimated to boost premiums for basic drug coverage by roughly $3 to $4 per month, according to CMS. While some Part D sponsors could hike premiums significantly more than that, CMS says most beneficiaries will have access to plans with premiums equal to or lower than what they now have. And some Part D stakeholders tell *DBN* that beneficiaries are unlikely to switch plans over modest premium increases.

The findings are part of CMS's Aug. 14 release of average costs for standard Part D coverage next year. Average monthly premiums for basic coverage provided by stand-alone Medicare Prescription Drug Plans (PDPs) will be $31 in 2009, up from $27 this year, CMS said. Average monthly premiums for Medicare Advantage prescription drug (MA-PD) plans will be $21 in 2009, up from $18 this year, the agency added. The premium figures are based on the national average bid of Part D sponsors, which is $84.33 in 2009, up 4.7% from $80.52 in 2008, according to CMS.

CMS did not release premium data for more inclusive Part D plans, which beneficiaries generally select. Individual Part D sponsors also did not release figures, and will not do so until later this fall.

continued

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Most beneficiaries in 2009 will see premium increases, some of which will be significant, Kerry Weems, CMS acting administrator, said in an Aug. 14 news briefing on the data. As such, it is important for beneficiaries to "shop around," he added.

According to CMS, 97% of beneficiaries will have access to plans that would cost them the same or less than what they now have, if they're willing to change plans.

The expected $3 average premium increase in 2009 is due to general trends in drug costs, the phase-out of a CMS demonstration project and higher plan estimates for catastrophic coverage based on prior experience, CMS said.

"Average plan bids have increased at roughly the same rate as drug costs," Paul Spitalnic, director of the Parts C and D Actuarial Group in CMS's Office of the Actuary, said in a prepared statement.

One Part D observer says the industry expected that sponsors would increase their bids.

"After watching some of the health plans release their earnings over the year, they had made comments that they had missed the mark in 2008, and so they were losing some money," says Margaret Nowak, senior manager in the Medicare practice at consulting firm Avalere Health LLC. "We did expect them to go up."

But Nowak says she is surprised by CMS's assertion that beneficiaries are not stable in their plans. Avalere's analysis of CMS data finds that in calculating the average 2009 beneficiary premium, the agency "expects beneficiaries will switch to lower cost plans."

"This was a little surprising, because most individuals talking about this population feel that they're relatively stable and don't switch plans often," Nowak tells *DBN*.

Beneficiaries are unlikely to change plans, for example, if their premiums go up by $4 a month, Nowak asserts. "When you start getting into the $10, $20 [range], it's possible," she says, adding that what will certainly make beneficiaries switch is if their plan stops covering their drug.

Part D Is Still Much Cheaper Than Expected

CMS also pointed out that while average premiums will increase next year, they are still far below the original estimate of $44.12 for the 2009 average premium when the benefit was established under the 2003 Medicare reform law.

Humana Inc., one of the largest Part D sponsors, says this accomplishment shows that market dynamics work well to keep premiums very competitive for consumers. The Part D program "is a great example of the effectiveness of a public-private partnership working to produce value for consumers," Humana spokesman Tom Noland tells *DBN*.

He notes that seniors do tend to be more brand-loyal than their younger counterparts. "But seniors are also very savvy," Noland adds. "If they find that a plan does not meet their changing needs, they will often access medicare.gov and do a thorough analysis of all available alternatives."

And what are these seniors hoping to find? "Consumers tend to look at annual out-of-pocket expenses first when making a plan decision," Noland says.

In addition to releasing bid and premium information, CMS said it will reassign 1.3 million low-income subsidy (LIS) beneficiaries to new PDPs effective Jan. 1, 2009, because their existing plans bid above the 2009 benchmarks.

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This impending reassignment of LIS beneficiaries is significant, according to some industry analysts. "It probably means some PDPs with significant low-income membership today might have very little next year…because they bid above the benchmarks," says Pat Dunks, a principal and consulting actuary with the Milwaukee office of Milliman, Inc.

Contact Nowak at mnowak@avalerehealth.net and Noland at tnoland@humana.com. Visit www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/PartDandMAbenchmarks2009.pdf. ✧

In Their Own Words: Vogenberg Describes Impact of Biomarkers

The following interview is part of an occasional DBN *series that examines hot-button pharmacy benefit issues though the words of the industry's thought leaders. To suggest a topic and commentator, contact Neal Learner at nlearner@aispub.com*.

F. Randy Vogenberg, RPh, Ph.D. is co-founder of Employer-based Pharmaceutical Strategies, LLC., a consulting firm that helps pharmaceutical, biotechnology and medical device manufacturers enhance product sales through the employer market perspective. He is a nationally recognized leader in health policy and economics, and the promotion of value-based health plan principles. *DBN* caught up with Vogenberg recently to get his thoughts on how the increasing use of "biomarkers" is affecting the pharmacy benefit.

DBN: **What are biomarkers, and how are they now being used in the practice of medicine?**

Vogenberg: In medicine, a biomarker is referred to as an indicator of a particular disease state. A [National Institutes of Health] study group committed to the following definition in 1998: "a characteristic that is objectively measured and evaluated as an indicator of normal biologic processes, pathogenic processes, or pharmacologic responses to a therapeutic intervention."

In the past, biomarkers were primarily physiological indicators such as blood pressure, blood chemistry or heart rate. More recently, biomarker is becoming a synonym for molecular biomarker, such as elevated prostate specific antigen (PSA) as a molecular biomarker for prostate cancer. Biomarkers also cover the use of molecular indicators of environmental exposure in epidemiologic studies such as human papilloma virus, smoking or certain markers of cardiovascular risk (hsCRP, HDL).

DBN: **What relevance do biomarkers have for Rx payers and pharmacy benefit managers***?*

Vogenberg: Increasingly, diagnosis, medical management and emerging drug therapy prescribing are determined through the appropriate use of biomarkers. The application of this new technology and understanding of biology fundamentals in human medicine is resulting in a two-edged sword for health care stakeholders.

For Rx payers, there will be significant increases in cost both for (1) traditional drugs whose therapeutic value or safety can be enhanced through biomarker use, and (2) the increasing number of newer specialty drug therapies that require screening before prescribing or molecular monitoring during use. For patients, there is the real opportunity for improved patient care outcomes with medication therapy.

No longer will the drug alone be the single cost factor in determining a value proposition to stakeholders. In fact, in emerging clinical and post-marketing studies, the use of biomarkers with drug therapy already result in patient-specific prescribing (breast cancer), improved care management (anticoagulation), and early detection or identification of risk factors for potentially fatal diseases (heart attack or stroke).

Cardiovascular Therapies Could Benefit

DBN: **Where could biomarkers have the biggest impact — earlier interventions for individuals at risk of cardiovascular disease, for instance?**

Vogenberg: The costliest disease condition for employers and government payers (i.e., CMS) is cardiovascular disease (CVD), including heart attack and stroke. Then you add on common comorbid diagnoses like diabetes or metabolic syndrome to that global diagnosis grouping, and CVD becomes the single most costly disease by an extremely wide margin, even over cancer groupings.

Therefore, the application of our improved knowledge of genetics, atherothrombosis, biomarkers and cardiovascular-related inflammatory processes that lead to cardiovascular disease evolves into the biggest impact for individuals at risk of cardiovascular disease, along with those who bear the burden of that cost.

Obviously, the earlier a disease is identified, the better potential for patient outcomes along with a lower total economic cost as has been demonstrated in cancer and rheumatoid arthritis as well as cardiac care patients. If biomarkers can provide a reliable early predictor for cardiovascular risk, that would have a huge impact on the processes to achieve patient outcome goals by the health care delivery system, payers and patients.

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***DBN:* Would Rx payers realize a return on investment (ROI) by using biomarkers?**

Vogenberg: Depending on who the Rx payer is, an ROI in using biomarkers could be developed from that payer perspective. Given the high expenditures for cardiovascular disease, it is likely that all payers would be able to demonstrate an ROI for the use of biomarkers as has been done already for select cancer treatments.

Employers and government programs similarly would be able to determine significant ROIs with different variables driving the equation. Most likely overall for Rx payers, an ROI within one to two years is likely given the current state of spending for cardiovascular care patients. For patients, the ROI would be clearly demonstrated at a high value to them due to the avoided disease and possible death along with the associated health care costs over any time frame.

***DBN:* What practical challenges confront the use of biomarkers in medication therapy?**

Vogenberg: Despite the promise of biomarkers and improved drug therapies, if the patient does not take the drug therapy, then the expected medical outcome results don't follow. As a result, various collaborative efforts by many different groups around this issue have re-emerged over the past couple of years.

PBM Ingredient Costs for Brand Drugs Top $100; Generics Hold Steady

The average ingredient cost paid by PBMs per brand drug has topped $100 for the past four quarters, according to AIS's exclusive quarterly survey of PBMs conducted for *DBN*. As of the second quarter of 2008, the average ingredient cost per brand Rx was $103.22. Brand-drug ingredient costs have almost doubled from the $53.16 figure calculated in 2000 when the AIS survey began.

By contrast, generic drug ingredient costs have remained much more stable. The average generic ingredient cost in second quarter 2008 was $18.64, compared with $11.35 in 2000. Average generic drug costs rose during the 2002 to 2004 time frame, but have since fluctuated only slightly. Meanwhile, costs of brand-name drugs have maintained a rising trajectory.

Ingredient cost refers to a PBM's cost to acquire the product prior to application of certain discounts, rebates and fees, as determined by average wholesale price (AWP) or other pricing methodologies agreed upon by the PBM and its business partners. Data shown in this analysis, which was calculated from averages of 28 PBMs, represent companies that operate in a traditional retail setting and do not include companies that operate exclusively in the specialty pharmacy arena. However, the average ingredient costs may be calculated using a combination of retail, mail and specialty scripts.

PBMs' Average Ingredient Cost per Rx, 2000-2008

	Brand	Generic
3Q2000	$53.16	$11.35
4Q2000	$52.86	$11.10
1Q2001	$54.46	$11.20
2Q2001	$54.90	$11.05
3Q2001	$56.19	$11.78
4Q2001	$57.80	$12.52
1Q2002	$59.89	$12.77
2Q2002	$64.26	$13.61
3Q2002	$64.92	$14.00
4Q2002	$66.91	$15.55
1Q2003	$68.46	$15.55
2Q2003	$72.50	$17.29
3Q2003	$77.50	$18.68
4Q2003	$79.67	$19.30
1Q2004	$82.32	$19.68
2Q2004	$83.35	$19.68

	Brand	Generic
3Q2004	$85.26	$20.44
4Q2004	$88.48	$20.23
1Q2005	$88.09	$19.93
2Q2005	$89.67	$20.29
3Q2005	$93.33	$20.79
4Q2005	$92.97	$21.09
1Q2006	$94.36	$20.35
2Q2006	$93.98	$19.86
3Q2006	$94.79	$19.40
4Q2006	$93.56	$19.45
1Q2007	$95.51	$19.58
2Q2007	$98.94	$20.45
3Q2007	$100.89	$19.77
4Q2007	$102.47	$19.11
1Q2008	$104.93	$18.69
2Q2008	$103.22	$18.64

SOURCE: AIS's quarterly survey of PBMs and related companies, conducted for *DBN*.
METHODOLOGY: PBMs were asked for their average ingredient cost per prescription for brand and generic drugs across their entire book of business. Responses were then averaged by AIS. More historical data on ingredient costs since 2000 are available from AIS's *2000-2007 Survey Results: Pharmacy Benefit Trends & Data*, which can be purchased for $1,175 at www.aishealth.com/Products/dru.html.

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Patient lack of compliance or adherence to prescribed therapies is emerging as a more costly component of health care than the actual hospitalization or diagnostic portion. Given that most of these conditions are chronic or lifelong, this truly is a significant issue facing a health care system that has traditionally been focused on acute short-term care. As drug therapy and technologies continue to emerge as the new solution to existing chronic medical conditions, this will become our greatest economic and clinically related challenge to overcome. ✧

PBM Audits Are Under Scrutiny

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◆ ***The PBM has a right to "mutually approve" any auditor selected by a client, and can veto any auditor that the PBM doesn't find satisfactory;***

◆ ***The auditor must sign a PBM-drafted "confidentiality agreement" that limits the type of data the auditor may audit, and requires the auditor to provide a draft audit report to the PBM before providing it to the client;***

◆ ***The auditor cannot disclose certain PBM "proprietary" information to the client, such as types of drug manufacturer rebates and amounts of individual rebates;***

◆ ***The auditor cannot copy any confidential information in the PBM offices, and may take notes only on broad findings rather than on detailed underlying data; and***

◆ ***The auditor must pledge not to be involved in any litigation against the PBM, should there be any, nor talk to any news reporters.***

Restrictions, such as the "mutual approval" language, give PBMs undue influence on audits, says Linda Cahn, president of Pharmacy Benefit Consultants and an attorney who has reviewed hundreds of PBM contracts and litigated against PBMs.

"Auditors have to walk a tightrope" she tells *DBN*. "Aware they have obligations to their clients, auditors know they should look for all PBM wrongdoing and disclose all such wrongdoing to their clients. However, aware that PBMs have an almost-universal contract right to 'mutually approve' auditors, many auditors avoid tasks that are likely to result in findings of PBM wrongdoing, and instead conduct audits that are less informative than they should be."

For example, Cahn says, auditors rarely audit "rebate agreements." And even if they do, PBMs generally restrict the number of rebate agreements that can be audited and redact critical information from the agreements, she adds. "As a result, auditors almost never detect, let alone disclose to their clients, the extent to which PBMs are depriving their clients of rebates by calling rebates some other name, such as 'administrative fees' or 'health management fees,'" Cahn asserts.

Cahn also blasts PBMs' frequently applied restrictions on note taking and copying of documents. Audits done in virtually every other industry yield boxes of information that auditors thereafter keep confidential, she contends. "But PBMs force auditors to take such slim notes during PBM audits that when PBMs dispute auditors' final reports, auditors are not in a position to demonstrate the accuracy of their findings," Cahn says.

Audit restrictions are costing clients money, asserts Susan Hayes, principal of Pharmacy Outcomes Specialists. "Clients are losing money because they end up hiring auditors that don't press for all of the documents and end up never getting recoveries," she tells *DBN*.

Hayes, who has been blocked by the "mutual approval" provision from auditing certain large PBMs, says that every one of the more than 500 PBM audits her firm has done has uncovered money that was due back to the client. This figure generally ranges from 2% to 3% of drug spending, but can total up to 10% of a client's overall costs, she says.

Examples of audit findings include a PBM that agreed to prior-authorize the expensive rheumatoid arthritis drug Enbrel (etanercept), but never did, she asserts. Or a PBM that agreed to give the client a better price on drugs by increasing the discount on average wholesale price from AWP minus 14% to AWP minus 15%, but never implemented the change. "The client never knows this because they don't know what AWP minus 15% is," Hayes says of the example.

The lack of access to PBM documents often prevents auditors from finding such recoverable monies in the first place, Hayes says. "But once we find it, it is really the clients' desire to pursue the findings that tends to get them recoveries," she adds.

About half of clients get something back, explains Hayes, who estimates the recovery is about 50 cents on the dollar. "Some clients don't fight to get their money back….some take it in a better renewal rate going forward, some change PBMs," she explains. "Then there are those clients that litigate, on the opposite end of the spectrum."

PBMs Cite Need to Protect Information

Still, even highly transparent PBMs contend that some of their actions are designed to facilitate a smooth auditing process and ensure that information is not improperly used.

continued

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Innoviant, Inc., for example, has used the mutual-approval language not to weed out auditors who take a particularly tough line but to make sure it's dealing with someone who is up to the process, says Mark Campbell, Pharm.D., president and CEO of the pharmacy benefit administrator, which was recently acquired by United-Health Group.

"Because there is a cost to both organizations to doing an audit, you'd like to know it is someone who has done audits before and understands the scope and breadth of what needs to be done, and can do it in an efficient and orderly manner," he says in an interview with *DBN*.

Regarding confidentiality agreements, Campbell says customers should have access to "whatever they need," but at the same time the PBM must ensure it's protecting information to the best of its ability. There is always the danger that information could be used for alternative purposes that would be unsuitable, he says.

"I'm an auditor," Campbell explains as an example. "I'm looking at somebody's contract with a particular pharmacy, and I go, 'Wow, that's a really great rate. I'm going to go back and make sure that when I'm working on the other side of the house, and doing an RFP [i.e., request for proposal] for somebody, I'm going to try and get that rate for everybody.' That would be an unfortunate use of the information, because it's taken out of context."

Similarly, Innoviant makes efforts to control its manufacturer and pharmacy information. "Sharing it with people so they can verify what's going on — triangulate that information against what's actually occurring — that's our purpose and mission here," he says. "But allowing people to reproduce information would make it difficult if not impossible to control where that information goes, so we do restrict that."

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Audit Procedures Are Established in Contract

How can both sides ensure the audit is fair? Procedures for client audits are part of the negotiations that take place during the RFP and contracting process, according to a PBM trade group spokesman.

"Provisions may include mutual agreement on an auditor, scope, timing and confidentiality," says Charles Coté, spokesman for the Pharmaceutical Care Management Association (PCMA). "The standards for client audits are known to both parties at the time of contracting and are part of the client-PBM relationship during the term of the contract," he says.

Audit standards are included in URAC's PBM accreditation standards, which were developed by a broad cross-section of PBM stakeholders in 2007, Coté adds.

Under URAC's standards, PBMs will disclose to clients — if the disclosures are required by the PBM/client contract — various financial model information upon request, including:

◆ ***Existence of organizational arrangements that could potentially create a conflict of interest that affects clinical or financial decisions,***

◆ ***Sources of revenue, and***

◆ ***Pricing structure for PBM services, such as rebate structures and administration fees*** **(DBN 8/17/07, p. 7).**

But getting these points written into the contract can be tricky, some say. Clients and their consultants should focus on a client's audit rights during the RFP process, and before a PBM is selected, says Kevin M. Nagle, president and CEO of Envision Pharmaceutical Services. Unfortunately, many consultants reverse the process, and start the contract negotiation phase after a PBM finalist has been selected in an RFP, he tells *DBN*.

"And what they'll find out is that some of the things they wanted to accomplish in their RFP, they may in fact not be able to, because the PBM has negotiated certain

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clauses which prohibit them from doing the kind of auditing to ultimately get to that transparency component," he says.

The issue also caught the attention of the Texas State Auditor's Office, which issued a report Aug. 20 recommending that state agencies have greater power to audit their PBMs (see brief, p. 8).

Meanwhile, some clients choose not to pursue their audit rights more fully, says Hayes. Most benefit managers would like to find an auditor who is not controversial, and some just want a clean bill of health, she asserts. Hayes recalls the reaction of a large Pennsylvania company after she told them how much money they were losing under the PBM. "They said, 'Oh well, it's a rounding error. Let's move on,'" Hayes says.

But others say PBM auditing is expected to increase as an important business process as pharmaceutical spending continues to balloon the coming years.

Innoviant's Campbell points out that in 2000, the U.S. spent roughly $129 million on prescription drugs. That figure is expected to grow to $540 billion by 2014, he adds. "That got people scrambling a little bit to try and figure out what's driving these expenses," Campbell says.

He also notes the PBM audit process is still relatively new, and lacks standardization within the industry. "The overall process is good," he says. "It's just going to take a little while before there is a bit more commonality in how the process works and what's expected of both parties."

Contact Cahn at (973) 975-0900, Hayes at susan.hayes@pharmout.com, Campbell through Theresa Shin at theresa.shin@rxsol.com and Nagle at (916) 941-3500. ✧

PBM Complexity Presents Moving Target for Auditors

The complexity of the PBM industry and how PBMs price products and services can lead to confusion and consternation during the auditing process, says Jon Warren, director of PBM product management at UMR, the nation's largest third-party administrator, which was acquired last year by UnitedHealthcare.

"People go into it thinking that an audit is going to be very similar to audits that are done in other portions of health care," he tells *DBN*. "It's not. It's very, very complex. This is definitely a moving target. There are lots of pieces of the puzzle that leave it open to gamesmanship."

What clients of PBMs need to understand is that essentially they are buying services for a fee, Warren explains. "But that fee is oftentimes spread over a half a dozen or more pricing components, which may in turn have the fee spread over additional pricing components," he says. "At the end of the day, you have an extremely confusing, complex pricing mechanism. And PBMs are jealous of that information and how they do business — jealous of how much money they're making as they do business.

"That complexity, confusion and hesitancy to release that information has resulted in an industry that is not really trusted by their clients," Warren continues. "The result is the requirement for audits."

The complexity, however, does not necessarily mean that PBMs are engaged in any wrongdoing, Warren adds. Public PBMs have responsibilities to their shareholders, he notes. "If there is an opportunity built into this complex pricing model for me to make more money for my shareholders, it is my obligation to do that," he says as an example.

Mark Pastin, chairman and president of the Council of Ethical Organizations, says any business that runs on rebates, such as the PBM industry, creates a lack of transparency.

"Rebates are given to incentivize," he tells *DBN* of rebates from drug manufacturers to PBMs that accrue when products are sold. "And whether those incentives are in the interest of the patients or the clients is highly subject to debate."

There is a lot of distrust and confusion around pharmaceutical pricing, he says. The honest PBMs naturally do not want to be accused of wrongdoing because of the way pharmaceutical companies manage their rebate programs, he adds. The movement toward transparency in pharmaceutical pricing is great right now, Pastin says, adding that the market is "migrating to an environment in which the rebate model will no longer be tolerated."

In the end, however, pharmaceutical prices are still governed by market factors, Pastin adds. And he doubts there would be huge amounts of money to be recovered if the rebate model goes away. "The appearance of wrongness is probably greater than the underlying wrongness," he adds. "That's all the more reason to get rid of the appearance as well."

Contact Warren through Meghan Bonneville at mbonneville@roepkepr.com.

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NEWS BRIEFS

◆ **The Texas State Auditor's Office issued a report Aug. 20 recommending that state agencies have greater power to audit their PBMs** (see story, p. 1). Current PBM contract provisions restrict access to information necessary to verify prescription drug-plan costs and PBM contractors' compliance with their contracts, the report said. The report recommends that contract provisions be strengthened to: ensure that audit rights are not limited or unreasonably restricted; define prescription drug prices, discounts and other fees; regulate drug substitution practices and formulary management; define whether de-identified prescription data can be sold; and ensure contract monitoring for compliance with disclosure polices or business relationships that could cause a conflict of interest. To read the report, visit www.reducedrugprices.org/read.asp?news=2097. Contact Kristie Zamrazil at (512) 836-8350 ext. 1.

◆ **Prescription Solutions, a PBM unit of UnitedHealth Group, said last month that its medication therapy management (MTM) program on proper statin utilization reduced coronary events for diabetic seniors.** The MTM program — which included educational materials to prescribers — sought to increase the use of statins among Medicare Part D members with diabetes or coronary artery disease who had not filled statin prescriptions in the previous six months. In the four-month follow-up period of the program, 12.1% of the 1,144 members whose prescribers received the MTM intervention initiated therapy, compared with 7.3% of 700 members in a control group, Prescription Solutions said. An estimated $12,323 in cardiovascular costs might be avoided per 220 members through the use of the program, according to the PBM, which published its findings in the August issue of the *Journal of Managed Care Pharmacy*. Contact Theresa Shin at theresa.shin@rxsol.com.

◆ **Prime Therapeutics, a PBM owned by Blue Cross and Blue Shield plans, said Aug. 27 that it had completed a certification process with SureScripts-RxHub that will allow prescribers using SureScripts-RxHub technology to send prescriptions electronically to PrimeMail, Prime Therapeutics' mail-order pharmacy.** In 2007, PrimeMail processed nearly 3.6 million prescriptions, the PBM said. Meanwhile, WellPoint NextRx, the PBM unit of WellPoint, Inc., said Aug. 20 that SureScripts-RxHub connectivity for e-prescribing is now available to physicians in Rhode Island through Blue Cross & Blue Shield of Rhode Island. Contact Chris Medici at chris.medici@bcbsri.org, Rob Cronin at rob.cronin@SureScriptsRxHub.com and Sheila Thelemann at SThelemann@primetherapeutics.com.

◆ **Medco Health Solutions, Inc. on Aug. 18 said it had entered into a research partnership with the FDA to study genetic testing and the impact of genetics on the efficacy of prescription drugs.** Under the partnership, which extends to Aug. 31, 2010, Medco and the FDA will jointly develop research projects, programs and strategies in the area of pharmacogenomics, collectively aimed at improving patient health and quality in the delivery of care, Medco said. "An increasing number of drugs are including genetic information in their labels and we're finding out how genes affect some drugs that have been widely used for generations," Medco Chief Medical Officer Robert Epstein, M.D., said in a prepared statement. Contact Jennifer Luddy at Jennifer_Luddy@medco.com.

◆ **Diplomat Specialty Pharmacy said Aug. 18 that it entered into a corporate agreement with NeedyMeds.com, an online database of available financial assistance programs for patients requiring support with drug access.** Once patients are approved for assistance programs, Diplomat will dispense and coordinate shipment of the needed medication to the patients for no additional charge, the firm said. Contact Leigh Waller at lwaller@diplomatpharmacy.com.

◆ **SXC Health Solutions Corp. a vendor of technology and PBM services, said Aug. 25 that it has expanded its contract with the Arkansas Employee Benefits Division (EBD) to include enhanced data integration and clinical analytical services.** The new agreement builds on the 2004 PBM contract, which covers roughly 79,500 state and public-school employees, SXC said. Under terms of the new agreement, EBD will license Integrail's (a division of SXC) Pathfinder PRO Software to provide the state direct access to integrated medical and pharmacy claims data and risk prediction information. Contact Susan Noonan for SXC at susan@sanoonan.com.

◆ **PEOPLE ON THE MOVE:** PerformRx appointed **John Tobin** vice president of sales and marketing. Tobin was senior vice president of managed care for Argus Health Systems.…Diplomat Specialty Pharmacy promoted **Jennifer Mantovani** to national accounts manager of psoriasis.

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