OBJECTIVES: To assess prescribers’ ability to recognize clinically significant DDIs, to examine how DDIs are identified, and to evaluate the information source from the prescribers’ perspective. METHODS: A postal questionnaire was developed to assess prescribers’ knowledge of interacting medications. Prescribers were asked to classify 14 drug pairs as “contraindicated”, “may be used together but with monitoring”, or “no interaction”. An option of “not sure” was provided. The questionnaires were sent to a national sample of prescribers based on their past history of DDI prescribing which was determined using data from a PBM covering over 50 million lives. RESULTS: Completed questionnaires were obtained from 950 prescribers, giving an overall response rate of 7.9%. The number of drug pairs correctly classified by the prescribers ranged from zero to thirteen, with a mean of 6 pairs correctly classified (42.7%). The percentages of prescribers who correctly classified specific drug pairs ranged from 18.2% for warfarin-cimetidine to 81.2% for acetaminophen with codeine-amoxicillin. Half of the drug pair questions were answered “not sure” by over one-third of the respondents; among which, two were contraindicated. One-fourth of the prescribers reported using PDAs to learn more about a DDI, and another one-fourth used printed materials. A total of 68.4% of the prescribers reported that they were usually informed by pharmacists about their patients’ potential exposure to DDIs. Compared to the prescribers who used other sources, those who used computerized DDI alerts as their usual DDI information source consistently gave a lower rating score to the five statements that assessed the usefulness of the information. CONCLUSION: This study suggests that prescribers’ DDI knowledge is insufficient. Physicians mostly commonly learn about interactions involving their patients from the pharmacy, suggesting further work is needed to improve the drug prescribing process to identify potential safety issues earlier in the medication use process.

COMPARING MEDICATION ADHERENCE AND WASTAGE AMONG THREE DIFFERENT RETAIL PROGRAMS

Comparing adherence and waste among 30-day retail program, mandatory 90-day retail program and voluntary 90-day retail program. METHODS: This analysis was conducted using pharmacy claims data from a pharmacy benefit manager (PBM). Patients who were new to either Ace-Inhibitor, statins or SSRIs in March-May 2005 were identified and followed-up for a period of 12-month to measure adherence and wastage. Patients had retail 30-day supply only during the study period were included in 30-day retail program, patients had mandatory 90-day supply during the study period were in mandatory 90-day retail program, and similarly, patients had voluntary 90-day supply were in voluntary 90-day retail program. Adherence was measured in terms of Medication Possession Ratio (MPR). Medication wastage occurred either when patients switched to a different medication within the same class or to similar medication having different strength and that the patient’s actual day’s supply was less than dispensed day’s supply. Medication wastage was measured by the total day’s supply wasted among a normalized 30-day period. RESULTS: About 955 patients in 30-day retail program, 148 patients in mandatory 90-day retail program, and 582 patients in voluntary 90-day retail program. Adherence was found to be significantly greater in mandatory 90-day (MPR = 0.7543) and voluntary 90-day retail program (MPR = 0.6895) when compared to 30-day retail program (MPR = 0.3999) (P < 0.01). Although medication wastage was found to be relatively higher in mandatory 90-day retail program (2.5 days/30-day-period), followed by retail 30 program (2.3 days/30-day-period) and voluntary 90-day retail program (2.2 days/30-day-period), these comparisons were not significant (P > 0.05). CONCLUSION: Adherence was reported to be significantly better for mandatory 90-day retail program and voluntary 90-day retail program than 30-day retail program; while medication wastage showed comparable results across the three programs. This study showed that 90-day supply polices tend to improve the medication compliance without increasing the medication wastage.

TRENDS IN OUT OF POCKET COST BURDEN FOR PATIENTS WITH CHRONIC CONDITIONS

OBJECTIVES: Recently, coinsurance has become a common cost-sharing feature of benefit plans. The objectives were to study annual trends in out-of-pocket expenditures (OOP) and compare OOP for patients with chronic conditions with and without benefit plans requiring coinsurance. METHODS: Inpatient, outpatient, and prescription utilization and expenditure data from 2002 through 2004 were obtained from the Medstat commercial claims database. Benefit design information was available for 5.9 million adults with claims. Adult patients eligible for both medical and drug coverage with at least one outpatient diagnosis of chronic kidney disease (CKD), multiple sclerosis (MS), rheumatoid arthritis (RA), or diabetes were selected. Total OOP were calculated by summing copayments, coinsurance and deductibles for all pharmacy and medical claims. Annualized OOP for patients whose benefit plans required medical and/or pharmacy coinsurance inside the network were compared with patients whose plans did not have any coinsurance requirements. RESULTS: Total of 32,513 patients with no-coinsurance and 293,907 with co-insurance met all other selection criteria. Average OOP for patients with chronic conditions with and without coinsurance requirements. The trend toward coinsurance requirements may limit health care affordability for many patients with serious and chronic conditions.

MORE POLICY INITIATIVES IN THE AUSTRALIAN NATIONAL REIMBURSEMENT SYSTEM THAT WILL REDUCED COSTS DRAMATICALLY

OBJECTIVES: In the past few years a range of policy initiatives has been introduced into the Australian national reimbursement system. Prior to these initiatives the Australian Government published its “Intergenerational report” which was used to support the argument that the growth in health, and in particular pharmaceutical, spending would create a fiscal crisis over the next 40-years. In late 2006, after extensive negotiation with industry, a raft of policies where announced which detailed substantial