

The community pharmacy's role in patient adherence

Posted by [Andrew Tolve](#) on *Oct 5, 2011*

Andrew Tolve explores how pharma firms can support pharmacies to benefit patients, stakeholders, and their bottom lines

According to the World Health Organization, between 30 and 50 percent of medicines prescribed for chronic diseases are not taken as directed. Statistics for medicines that address acute diseases are better, but not by much. Patients deliberately avoid prescriptions; they forget to pick them up; they take them haphazardly. Non-adherence costs the pharma industry billions every year and leads to both disease escalation and deaths. But pharmacists can help. Not only are pharmacists present at the point of distribution, but patients trust them and are eager for their direction and advice.

By partnering with pharmacies and helping to establish frontline services, pharma companies can help patients, stakeholders, and their bottom lines. The ideal relationship between pharmacies and pharma is one of "partnership," according to Michael Holden, chief executive of the UK National Pharmacy Association. "Pharmacists see patients around four times as often as anyone else in the healthcare system, so we need to leverage that interaction to support adherence." Elizabeth Oyekan, area pharmacy director at Kaiser Permanente, the largest managed care organization in the US, says this can be a "win-win-win" for patients, pharmacists, and pharma. "It's a win for patients because they're healthier," she says. "It's a win for pharmacies because their patients are healthier as is their bottom line. And it's a win for pharma because they sell more drugs and spend less time and money searching for new ones."

Mark Ireland, director of pharmacy contract and project development at Boots, a leading UK pharmacy chain, agrees. "The [pharma] industry invests billions through the medicine development process to prove beyond doubt the clinical effectiveness of its products," he says. "This is hampered by patients failing to adhere to the medicines they are prescribed, causing governments and patients not to realize the full potential benefits."

The trust that patients have in pharmacists and the expertise of pharmacists "needs to be leveraged to solve this issue," according to Ireland. (For more on pharmacists' impact on adherence, see [How pharmacists can help improve patient compliance](#).)

The role of the community pharmacy

The community pharmacy is a good place to start. In the past few years, big box establishments have put community pharmacies under threat. In the US, Wal-Mart, Target, and Walgreens have come to dominate the pharmacy market. Wal-Mart offers \$4 prescriptions for dozens of generic drugs, a tough program for community pharmacies to match.

While some community pharmacies have folded, others on both sides of the Atlantic have proven resilient. They've joined together to negotiate bulk-buying discounts the same way nationwide chains do. More importantly, they've tried to fully embrace the "community" aspect of community pharmacy. Patients, empowered by online information and frustrated with overcrowded doctors' offices, are hungry for personal attention in the pharmacy setting. This is something local pharmacies can provide through drug management and adherence outreach services; they can also use it to distinguish themselves from their big box competitors.

"All of a sudden, throughout community pharmacy, everyone is focused on improving services and offering real value to the patient," says Oyekan. "Year after year, this is becoming more of an expectation and a need." (For the views of Ema Paulino, a member of the board of the Italian National Association of Pharmacies, on pharmacists, see [The pharmacist's role in patient adherence](#).)

The value-added pharmacy

Many pharmacies are already experimenting with value-added services. In community pharmacies in the US, medication therapy management (MTM) programs have become popular. In addition to dispensing drugs, pharmacists in MTM programs provide comprehensive reviews that check for medication appropriateness as well as problems with adherence and side effects or adverse events.

"We believe the pharmacist model of the future is that community pharmacies will be service-based

entities that will encompass a wide variety of these service offerings under the umbrella of medication therapy management,” says Jim Owen, director of professional practice, the American Pharmacists Association. (For more on MTM, see [Patient compliance and medication therapy management](#).)

Meanwhile in Europe, medicine usage reviews and chronic medication services are gaining traction due to growing government awareness and support. Pharmacists on both continents have rolled out campaigns to address and improve patient adherence. These programs often use interactive voice recognition (IVR) tools to reach out to patients who are late picking up drugs. Simpler iterations involve pharmacists and nurses hitting the phone lines on weekends to reach out to patients. For example, CVS recently introduced its Patient Care Initiative and Kaiser unveiled B-SMART, a comprehensive manifesto for medication adherence in its community pharmacies. “We’ve trained our pharmacists so that when a patient is deemed non-adherent, we have a very systematic way of addressing that patient to help them get back on track,” says Oyekan.

The need for systemic support

Despite the momentum behind value-added services, pharmacies still need help. “The pharmacist is at a tipping point when small things can make a big difference,” Holden says. “We have to put more ownership of treatment in the hands of patients and support them through education and behavior change. The pharma industry has a major role in facilitating that.” As Ireland points out, pharmacists manage a very complex supply chain and dispensing process that’s highly regulated and controlled in all European markets. This means that there have to be strong operational processes.

“Trying to overlay medicine adherence services over this from different providers for different medicines creates chaos and poor delivery by pharmacy operators regardless of the effort that they put in,” he observes. So there is a strong need for a more generic service for specific disease areas that pharmacists can offer to all patients, which can then be developed to layer in specific drug services as required by the patient. “I believe that pharma has a lot that it could offer to setting up such a program,” says Ireland.

Holden highlights the usefulness of quick reference guides that provide clinical updates and share tips on how to handle certain situations or certain molecules. Oyekan notes that the need for large-scale, systemic support is equally acute in the US. “If pharma can help community pharmacies work on systematizing and standardizing programs that can then be implemented around adherence and medication optimization, that becomes a value-added service as well as a win-win,” she says.

(For more on standardizing adherence programs, see [The pharmacist as an ally in patient adherence](#) and [Patient Compliance and Specialty Pharmacy Products](#).)

On the adherence front, pharmacies are in need of predictive tools that proactively identify patients at risk of non-adherence. Reaching out to patients after they’ve missed their prescriptions is relatively straightforward. Predicting which patients are likely to do this—and then enrolling them in disease management programs—is much more difficult but also much more valuable.

Again, pharma can help. Merck, for instance, offers the Adherence Estimator, a three-question form that 2010 research showed to be 86 percent accurate in identifying patients at risk of non-adherence. Merck is in the process of partnering with pharmacies. “This will help community pharmacies pursue high-risk patients more aggressively from the start,” says Oyekan.

“The bottom line is that we need to reduce the health burden of the patient, improve the care experience, and reduce overall healthcare costs,” she concludes. “Helping pharmacies better manage and dispense drugs to more adherent patients is a powerful way to accomplish that.”

How pharmacists can help improve patient compliance

Posted by [Peter Mansell](#) on *Feb 9, 2010*

Peter Mansell reports on the changing role of pharmacists in promoting adherence.

With the growing emphasis in healthcare systems on securing value from medicines, it is all the more

imperative to make sure these medicines are taken as directed.

The flipside of the value coin is limited or no access to medicines that do not meet selected value criteria. And the driving force for that process is ultimately cost. The misuse, including under-use, of prescribed drugs is a waste of money.

Not only that, but the adverse reactions and sub-optimal treatment outcomes associated with non-adherence create extra costs for healthcare systems, such as (re)-hospitalization. Ultimately, this rebounds on the supplier.

Any wasted or additive costs arising from non-adherence reduce the available drug budget and the window of opportunity for new medicines that may save healthcare systems money in the long term, including through better adherence.

The role of pharmacists

The PGEU, the European association for community pharmacists, sees pharmacists as ideally placed to tackle non-adherence. They are not only experts on medicines but among the most accessible and most consulted health professionals, according to the PGEU. A number of countries have launched medication review or adherence programs as part of a wider trend towards expanding the pharmacists role in pharmaceutical care.

A number of factors contribute to poor patient adherence, including the challenges of managing a long-term condition, intolerable side-effects, the impact of adverse media coverage, the costs of treatment, asymptomatic conditions, and cutting short treatment as soon as the patient feels better (e.g., with antibiotics).

According to the National Institute for Health and Clinical Excellence, between 33% and 50% of patients in England do not use medicines prescribed for long-term conditions as recommended, while the estimated cost of unused or unwanted drugs to the NHS is more than 100 million a year.

This is also an international phenomenon. According to the PGEU, an estimated 194,500 deaths per year in the EU are down to mis-dosing of, or non-adherence to, prescribed medicines, running up annual costs of around 1.25 billion. In the US, the non-adherence tally is about \$177 billion per year in direct and indirect healthcare costs.

Clinical medication reviews

According to the PGEU, clinical medication review is proven effective at optimizing therapy, improving health outcomes, cutting waste and reducing the likelihood of drug-related problems. In one Swedish study, medication reviews brought the average number of medicines taken by elderly patients down from 12.4 to 10.7, while the average drug cost per patient fell by around 160 per patient per year.

In the UK, the Medicines Use Review (MUR) scheme was introduced in April 2005 as the first advanced service offered under a new contractual framework between community pharmacies and the NHS.

Patients are selected for a consultation to ensure they understand why they are taking a particular medicine and how they should be taking it. Any problems identified in the review can be relayed to the prescriber via an NHS MUR form.

Medicines Use Reviews

MURs are not without their difficulties, though, particularly as the extra workload comes against a backdrop of rising prescription volumes. The scheme was slow to take off, although more recent figures indicate uptake has improved significantly.

Some pharmacists see MURs as a natural and welcome extension of moves to raise their profile in front-line patient management. But others are cynical about the motivations behind a service that involves hitting annual targets to bump up pharmacy revenues. The financial pressure to reach the annual ceiling of 400 reviews per pharmacy per year is detracting from other services, they warn.

A nationwide audit to gauge the effectiveness of MURs was launched in mid-2009 and the first results are imminent. The audit, a partnership between the Royal Pharmaceutical Society of Great Britain (RPSGB), the Royal College of General Practitioners and the Clinical Audit Support Centre, sought feedback from community pharmacy, general practice, primary care organizations and patients who

have undergone an MUR.

The pharmacy skills mix

On the resource issue, the RPSGB suggests boosting the skill mix in pharmacy for example, by developing or employing accuracy-checking technicians can help by enabling the pharmacist to spend more time discussing how patients can get the most out of their medicines.

Another step forward, the Society says, would be original pack dispensing. Pharmacists feel that cutting up packs of pills to match prescriptions can lead to a loss of confidence in the medicine on the part of the patient, which in turn affects compliance.

It can also be confusing for some patients, who then do not take the medicine as intended, the RPSGB adds. And the pharmacist has to spend time sourcing and/or copying additional patient information leaflets (PILs).

The role of pharma

Clearly there is an opportunity not to mention a strong incentive for pharmaceutical companies to step up their support for medicines adherence, be it through the supply of information and guidance to pharmacists involved in MURs (e.g., helping them target patients most likely to stray from the recommended regimen) or through other channels such as the GP or Web/text-based contact with patients.

Some companies already provide support in kind as resource packs and training materials for pharmacists in relevant areas, such as asthma management. Industry-wide, there has been a particular emphasis on ensuring patients are as informed about their medicines as possible, through channels such as PILs and the electronic Medicines Compendium, notes the Association of the British Pharmaceutical Industry (ABPI).

Zeroing in on pharmacists also helps build a relationship that will be all the more valuable to industry as responsibility for drug management/monitoring and some aspects of prescribing shifts increasingly from the GPs surgery to community pharmacies.

All the same, industry has to be careful not to let any of this activity cross the line into explicit inducements. Roche fell foul of this ambiguity last year when the ABPI ruled the company had breached the industrys Code of Practice by running a compliance scheme that involved awarding gift vouchers to children and teenagers who returned caps from the lung treatment Pulmozyme.

The pharmacist's role in patient adherence

Posted by [Les Rose](#) on *Jun 28, 2010*

Emilia Paulino, a member of the board of the Italian National Association of Pharmacies, talks to eyeforpharma about the role of the pharmacist and technology in improving patient compliance.

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E4P: Can you outline how you are getting better treatment adherence from your patients?

EP: We have a software application that stores information on our patients, including compliance data. The system knows when patients should be coming in for repeat prescriptions, and raises alerts if they don't.

What do you do if you dont have everything you need in your database?

Talking to patients is vital. For example, some of them are using advanced delivery devices such as inhalers, and they need to understand how to use them. They are also understandably worried about side effects. The point is that the pharmacy is more available to patients for lengthy discussions. The relationship with their doctor is much more focused on diagnosis than on use of medicines. The pharmacy is much more accessible to the public; they can go in any time without an appointment.

Apart from prescription alerts, what else does the software application provide?

We can issue customized information leaflets for patients. These are especially useful for medical devices and special delivery systems. With regard to side effects, although package inserts do cover these, they are not very easy to read. Anti-depressant drugs are a good example. For these, side effects are very often transient, and patients need to understand that they will mostly disappear after two weeks or so. That's the kind of thing that can be explained face to face, and with the support of an information sheet printed off especially for that patient.

What other types of treatment respond well to this approach?

We have had very good results with products for smoking cessation. The system enables us to follow the patient in the long term, and generally to promote health literacy so the benefits are wider than just getting them to take their medication.

How about interactions with the patient's clinician a three-way partnership among patient, doctor, and pharmacist?

Yes, we are well aware how important that is. We can generate a patient profile from the system, showing among other things how the patient is complying with treatment. We can share that with their doctor, but only with the patient's consent. In fact, it's much better if we give the report to the patient, as a letter that they can give personally to their doctor. That way, the patient has far better ownership of their healthcare. It only works if the patient can feel that they trust the pharmacist.

So how is this going down with patients?

Most of them are very cooperative, and value the relationship they have with us, as well as feeling more valued themselves.

Patient compliance and medication therapy management

Posted by [Andrew Tolve](#) on **Feb 28, 2011**

Andrew Tolve talks to Jim Owen, director of professional practice, the American Pharmacists Association, about how medication therapy management can improve adherence and offer opportunities for pharma

As poor adherence rates persist alongside frequent medication mismanagement, some pharmacists wonder if they can play a more active role in ensuring successful medicine outcomes. Enter medication therapy management (MTM), a new model that expands the pharmacist's role from a mere distributor to a consultant, educator, and conduit between patient and physician and patient and manufacturer. Improving adherence is one piece of MTM, but the larger objective is to guarantee that patients are taking the right medicines, not just adhering to the medicines they have been prescribed.

We feel that pharmacists can play a major role in the appropriate selection, monitoring, and maintenance of those patients on drug products, says Jim Owen, director of professional practice, the American Pharmacists Association. We want to make sure they're getting the proper treatment and the best outcomes that they possibly can. (For more on the pharmacist's role, see [The pharmacist's role in patient adherence](#), [The pharmacist as an ally in patient adherence](#) and [How pharmacists can help improve patient compliance](#).)

As pharmacies launch pilots and search for ways to make MTM viable, pharma will have various opportunities to capitalize on the trend.

MTM as an add-on service

The American Pharmacists Association (APhA) represents 62,000 pharmacists across a range of practice settings: hospitals, long-term care, community pharmacy, and pharmacy academia. In 2003, APhA was notified that Medicare Part D would include a designation for an MTM program for beneficiaries. The association drafted a consensus definition in 2004 and became a hub for MTM Medicare Part D services. More recently, the organization has begun championing a broader

application of MTM.

In conjunction with the National Association of Chain Drug Stores Foundation, APhA has developed a baseline model for community pharmacies and national chains to consider. The model positions MTM as an add-on type service in addition to effectively and faithfully distributing medication, Owen says. Pharmacists will provide comprehensive medication reviews that check for medication appropriateness, problems with adherence, and problems with side effects or adverse events. Pharmacists will then develop a plan to address those problems and work with patients and their healthcare providers to improve medication use and outcomes. In some cases, they may offer pharmacogenomic applications or monitor drug administration, like new forms of injectables.

We believe the pharmacist model of the future is that community pharmacies will be service-based entities that will encompass, in addition to the products they dispense, a wide variety of these service offerings under the umbrella of medication therapy management, Owen says.

MTM in action

Some US national chains have already launched pilot MTM programs. Rite Aid has introduced Rite Care, an MTM service provider under Medicare Part D as well as a pharmacy-oriented profit center. Initial sessions with a pharmacist cost \$80, last 45 minutes, and offer comprehensive reviews of all the patients prescription and over-the-counter medicines. Follow-up visits cost \$10 to \$20. Rite Aid has rolled out Rite Care in Pittsburgh stores. Kroger has embraced MTM pilots as well.

Meanwhile, on the regional level, chains like Kerr Drug in North Carolina have adopted MTM full-force, Owen says. A group of Kerr Drug clinical team members cover the chains region, providing services in stores, in the community, and at employer sites. The chain also has opened facilities in rural North Carolina that have no dispensing pharmacy in them. Instead, they function as healthcare centers that bring in other healthcare providers, like nutritionists, to help with certain disease state management. They have really changed their business model to functionally be healthcare providers, Owen says. He believes that as economic pressures increase on pharmacies, more and more chains will follow Kerr Drugs example. If youre going to strictly rely on the dispensing of medications with the shrinking of margins and the shrinking of reimbursement for pharmacy, in the future thats going to be a very difficult thing to do, Owen says.

Opportunities for pharma

Medication therapy management offers a number of opportunities for the pharma industry. On the adherence front, pharma companies could sponsor MTM sessions to ensure patients have a better understanding of their drugs. The results of a six-month multi-state pilot program of sponsored MTM sessions involving one big pharma firm are scheduled to be published this year. The goal of the pilot is to create a communication strategy for pharmacists when dispensing the companys product. That communication includes counseling and education about adherence.

Obviously, adherence for manufacturers is an entre point, says Owen due to the easily measured outcomes but he believes thats only one of many models for involvement. Another opportunity is risk evaluation and mitigation strategy, or REMS. Manufacturers could use pharmacist MTM sessions with patients as a way to conduct post-marketing surveillance on adverse events, drug-drug interactions, side effects and so on. Some manufacturers are already working with APhA on this front.

When you start looking at individuals that service the number of patients that a regional chain the size of Kerr Drug services, the amount of data you can gather regarding post-marketing surveillance on adverse events and monitoring for REMS is quite astounding, Owen says. (For more on REMS, see [Market access: How to get REMS right](#) and [The Impact of REMS on Market Access](#).)

A third possibility for pharma is sponsoring targeted medication reviews in which pharmacists look for red flags associated with treatment when a patient comes to get a refill or to fill a new prescription. While these targeted reviews may cause a pharmacist to lead a patient away from a brand, Owen says manufacturers are starting to express an altruistic belief that they just dont want people to take medication, they want people to take the right medication. Whatever route pharma decides to go, Owen assures that these options promise a stronger ROI than simply sponsoring pharmacist adherence letters. Personal interaction through medication therapy management whether its addressing adherence or its a targeted intervention or its a comprehensive medication review is going

to be much more effective than the investment you're making into an adherence mailing.

The pharmacist as an ally in patient adherence

Posted by [Les Rose](#) on **Feb 9, 2010**

Stacey Irving, director of channel marketing at McKesson, on how pharmacists can help increase compliance.

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Pharmacists are an underutilized resource in our healthcare system, says Stacey Irving, director of channel marketing at McKesson. She points out that as the process of dispensing prescriptions is now much more efficient, time is freed up that pharmacists can use for patient relationships. To exploit this, partnerships between manufacturers and pharmacies are needed. But retailers don't have the right organizational structures to do this. For this reason, McKesson set up the Pharmacy Outreach Network, which includes 2,500 independent community pharmacies and four regional and national chains. The aim was to increase patient adherence through a series of targeted behavior modification interventions delivered by the pharmacist at point of sale.

Changing health behaviors

Irving explains how the Pharmacy Intervention Program was piloted. An advisory panel, including pharmacists, concluded that there was an average of five minutes available for counseling each patient at the time of dispensing. This time budget was to be spent on interventions based on the principles of health behavior change and motivational interviewing.

Training in these techniques was delivered via the Pharmacy Outreach Network and results were measured using adherence industry best practices in collaboration with the manufacturers' analytics teams. Irving strongly emphasizes the need for an empathic approach by the pharmacy staff delivering the interventions. Pharmacists are at times as guilty as physicians in taking a paternalistic approach, she warns.

Learning to listen

Using mostly online training, a non-judgmental and non-confrontational approach was embedded. Open questioning was a key tool, highlighting the need to listen and not just to talk. Using this technique, patients' acceptance and commitment to behavior change was much more likely to be the outcome.

Pharmacists were trained to listen for key words and phrases that signaled this acceptance. This in particular helped them to become more deeply involved in counseling patients, and they reported back enthusiastically on the successes they were having.

How it works

Irving outlines the intervention model used: When a patient comes in and presents their prescription, we can look at some of the qualities of the claim and apply business rules. If the rules determine that the claim is eligible for one of the sponsored programs, the pharmacist is notified that the relevant intervention can be given. At this time, various counseling reminders can be given, including a fax to the pharmacy.

This works because there is a short time between the claim being notified and the patient collecting their medication. Brand-related patient-facing materials as well as disease-specific materials are often supplied to support the conversation. After the intervention, the pharmacist makes a claim and the cost of the counseling intervention is processed as per a conventional claim. A recent development is the facility to capture counseling opportunities that have been missed, along with the reasons.

Intervention increases adherence

The Pharmacy Intervention Program was piloted in two categories, smoking cessation and COPD, launching in summer 2008. Irving reports that the pilot was very successful, with over 500 pharmacies

participating. In the COPD category, at the seventh prescription fill there was a mean 38% increase in fill rate, showing that pharmacy intervention does increase adherence. This translates into 31 more pills for intervention patients versus controls, and for the whole program a 557% return on investment.

The smoking cessation category would have been expected to be more difficult, Irving considers, as it involved a commitment to move away from an addiction. As expected, there was a sharp decline in overall prescription fill rate, with only 13.5% of control patients coming in for the third fill. However 20% of intervention patients did so, a 48% improvement. These were very difficult patients, Irving emphasizes, and a very short interaction. In the light of the large amounts of clinician time spent on helping people to give up smoking, this program looks like very good value.

Value indeed is a key word for Irving. She recommends looking carefully at the value of pharmacists and the role they can play in healthcare. They have trusted relationships with patients, and are very willing to contribute.

Patient Compliance and Specialty Pharmacy Products

Posted by [Les Rose](#) on *Mar 9, 2010*

Kevin Cast, VP of CuraScript, on how adherence can boost cost-effectiveness and improve forecasting.

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How do we do the best thing for patients taking speciality drugs, while driving cost out of the system? asks Kevin Cast, VP of CuraScript, the specialty drugs arm of Express Scripts, a large pharmacy benefits management (PBM) company. He makes the key point that reducing cost, with some 55 million people enrolled in the company's programs, is a major driver of the business. Specialty drugs for conditions such as multiple sclerosis, hepatitis or cancer are usually expensive, so PBM organizations are supportive of healthcare reform.

Clearly, to improve the cost-effectiveness of drug administration, adherence to treatment has to be addressed, and there are several causes of non-adherence. These include not getting the prescription filled, taking incorrect doses, incorrect timing of doses, missing doses, and stopping early. About 18% of retail prescriptions are never filled, and 69% of medication-related hospitalizations are related to non-adherence, amounting to \$100 billion annually.

Up to half of patients with chronic diseases do not comply with treatment, costing the health system up to \$290 billion annually. Then there are the indirect costs, such as about \$50 billion in lost productivity. These are typical of costs that, if driven out of the system, could pay for a large part of proposed healthcare reforms.

Medication possession ratio

Cast considers that, when trying to measure compliance, the tool used has to be carefully chosen. Simply stating that a patient is 20% compliant because he or she only took two months out of ten months' medication may only tell part of the story. In this example, persistence could be a better measure.

He illustrates the problem with a real life patient with psoriasis, who stopped treatment because she misinterpreted a flare of her condition and thought it was an adverse reaction. Such patients require intensive counselling to improve their understanding and compliance, but importantly they make forecasting extremely difficult.

A better tool is medication possession ratio (MPR), according to Cast. In essence, this compares the measurement period with the period for which treatment was actually available to the patient. For new treatments, there is always a delay until the prescription is filled, and for ongoing therapy the gaps (such as for the psoriasis patient) need to be documented. Treatments for hypertension have MPRs of about 83%, and diabetes is worse at 77%. Specialty drugs have around 80% MPR.

Compliant patients save money

Cast emphasizes that a more compliant patient will ultimately save payers money. MPR is a quite sensitive tool that helps with supply chain planning, and it has been shown that patients receiving drugs from a specialty pharmacy have higher MPRs than patients using retailers.

Such data need to be included in demand forecasting, Cast advises strongly. He cites pretty telling numbers from a study in multiple sclerosis, where there was a clearly developing preference by patients for specialty pharmacies, and considerably higher MPR in the latter over one year 80% versus 68%. This was reflected in a 91-day difference in time on therapy, in favor of specialty pharmacies, and translates into an increased demand of about \$10 million for that manufacturer.

Improving forecasts

These are just a few statistics from a rich output that enables detailed planning by the manufacturer, and ultimately much better forecasts, asserts Cast. In 2008, we drove a lot of patients into specialty pharmacy, he explains in the region of 1,000 patients in this marketplace, equating to a 10% growth. An opportunity is created to build tailored programs for patients, delivered by specialty pharmacies that drive higher MPR and better patient care. In this study, specialty MPR rose from 82% to 88%, while retail MPR stayed about the same.

The bottom line is that the programs work, says Cast. We positively impacted MPR and took really good care of those patients. The take-home question is: Once all the MPR information is available, what do you do with it? You have to maximize your supply chain, which means engaging with brand teams and discussing what MPR is telling you about forecasts. Specifically, it can help with inventory management, sales expectations, and operational metrics. It is powerful knowledge.