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Jacqueline Kurth, Manager
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RE: SB1111

Dear Ms. Jacqueline Kurth:

I had the honor of presenting some of my thoughts about SB1111 to the ICA Commissioners in person on August 23, 2018. Here are my thoughts and concerns in writing.

After my meeting on July 30, 2018, with members of the commission, I walked away understanding the issues were:

1) Custom compounding creams and their cost; and
2) Non-standard dosing of common medications, i.e., 7.5 mg cyclobenzaprine.

I propose the following solutions.

For custom compounded creams with multiple NDCs per prescription, I suggest the following:

1) A separate fee schedule for custom compounded creams;
2) Allowing the least expensive ingredient in the custom-compounded cream to be the only medication billed for; or
3) A maximum allowed charge per month for the custom-compounded cream.

For the non-standard dosing of prescription medications, I propose the following:

1) Using only the original manufactures dosages' AWP for payment; or
2) Averaging the original manufacturer's AWP between dosages for payment.

For example, cyclobenzaprine's initial manufacturer dosing was 5 and 10 mg tablets. If a physician-dispensed a 7.5 mg tablet, the payment should reflect the original AWP pricing for a 5 mg tablet. Alternatively, the AWP pricing should be an average of the 5 and 10 mg tablets.

At the July 30 meeting, it was reported by the commission there are physicians prescribing 75mg strength tramadol. Tramadol immediate release pills only come in 50mg strength. Therefore, using my suggestion above, the 75mg tramadol tablet would be using the pricing of the original manufacturers' AWP for a 50mg tablet.

I recommend keeping the fee schedule as is for pharmacies and physicians. I agree with the data Concentra submitted regarding Arizona's fee schedule. The fee schedule is the same for pharmacy and physician dispensing. Many pharmacies have chosen to negotiate lower payments by making up the difference through increased volume. Doctors and small, independent pharmacies cannot sustain their respective businesses using this model. We do not have the means to increase our volumes to make up for the price differences.

As stated earlier by Commissioner Schultz, this problem applies to a very select number of physicians in the state of Arizona. The figures presented by CopperPoint at the August 23, 2018 hearing, reiterated how insignificant the perceived physician-dispensing problem is. CopperPoint is responsible for insuring about 45% of injured workers in Arizona. The total spent on physician dispensing was $2.1 million as reported during the August 23, 2018, public comment. Had these medications been dispensed by a pharmacy in-network, their costs of $2.1 million would have decreased by approximately 50%.

According to the 2017 annual report submitted by CopperPoint, this amount represents 0.0000000025% of the consolidated group as a whole. The dollar amount of this issue represents 0.00000025% of CopperPoint's gross revenue reported in 2017.

CopperPoint did not mention the patients who run out of medications secondary to the pre-authorization process. The patient is put in harm's way because many medications have serious adverse events occur if stopped suddenly. Physician dispensing eliminates this potential problem since patients leave the office with their medications in hand. Physicians dispense without prior authorization, knowing a percentage of the prescription medications dispensed will not be reimbursed for various reasons.

Pharmacies do not dispense without prior authorization. On the other hand, dispensing physicians prioritize the patient's safety and needs first. CopperPoint stated dispensing physician-patient outcomes are not as good as non-dispensing physician-patient outcomes. The vast majority of dispensing physicians in the state of Arizona, dispense medications to chronically injured patients. This demographic cannot be compared to non-dispensing physician-patient outcomes as these are generally for acute injuries. CopperPoint has not provided data sources and control methods.

The PCG White Paper is outdated and addressed problems dealt with years ago by the Commission and are no longer relevant. For example, payment was set at 0.85 x AWP which is in the lower third of dispensing sates with an AWP fee schedule, and the commission has also required the original manufacturers NDC code on all repackaged medications. Dr. Jeffry Scott has addressed these issue in his written comments as well.

The comments by PCI recommend the commission take away a patients right to get medications from their physician. Physician dispensers in Arizona who utilize SureScripts or other PBMs negate any expressed safety concerns. With SureScripts a physician knows all the medications a patient has filled regardless of insurance and highlighted any drug-drug-interactions.

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The comments by Healthesystems regarding dispensing physicians are incorrect. Physicians that utilize an Electronic Health Record (EHR) are interfaced with SureScripts or other PBM's data to provide pharmaceutical data necessary to come up with a safe an comprehensive treatment plan for the injured worker.

PBM's use Pharmacists as the primary evaluator while dispensing physicians utilize their extensive medical training and PBMs in their respective EHR when prescribing prescription medications to injured workers. Therefore the comments of Heathesystems is inaccurate.

In summary, physician dispensing in the state of Arizona is not the primary issue; instead, it is the pharmacies making the custom-compounded creams and non-traditional medication dosages and the select group of physicians who dispense them.

I would be happy to help in any way should you have any further questions. Thank you for your consideration.

Sincerely,

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