IPA Government Affairs Division Internship Program Description

Organization Description

The Independent Pharmacy Alliance (IPA), is a trade group that provides a full range of services to independent pharmacy owners in New Jersey and 13 other states, including a buying co-op & support services, government affairs advocacy in New Jersey (national issues as well). The issues concern health care, business and professional regulatory issues that affect the independently-owned pharmacies (there are over 740 in NJ) ability to provide pharmacy services to their patients in ways that: 1) are not overly hampered by unnecessary regulatory burdens; and 2) are properly compensated to remain profitable are the major focus of IPA’s Government Affairs Division. More details at the website - http://www.ipagroup.org/site/

Available Opportunities

Unpaid internships are available that offer some very practical experience for students looking to:

1) get exposure to practical application of government, politics, public policy and advocacy
2) learn about health care issues affecting health care providers
3) gain useful experience while in college to build marketable work experiences for future career plans.

The needs are as often as students are available for a semester or over the summer break -- ideally a couple of days during the work week and whatever blocks of hours (at least 3) which can be arranged

Internship Description

Tasks are varied:

- Basic research, but also analysis of information relating to Medicaid, Medicare, state legislation and regulatory issues affecting the operation of independent pharmacies.
- Some basic writing/summaries of issues, events, legislation & policy affecting independent pharmacies
- Some need for clerical organization of Government Affairs materials,
- Doing some basic work that still requires “using your brain”.

Qualifications Needed:

- Willing to do a variety of tasks and projects
- Strong analytical and research skills
- Good writing skills
- Sharp mind
- Strong computer and internet skills
- Interested in health care policy – especially from provider’s perspective

Location:

The office is in a big office park complex at the intersection of Route 130 and Dey Road in Cranbury.
If you have any questions or would like more information, please call IPA at 800-752-6679.

2. LEGISLATIVE DIVISION: IPA employs a Legislative Executive Director of Government Affairs.

3. REBATE PROGRAMS: IPA has a rebate program with Abbott Laboratories. Over 20 years, IPA has been providing services to independent pharmacy owners, helping them save money.

4. THIRD PARTY SUPPORT: IPA provides support and lobbying to third-party payers. IPA members have access to a program with Abbott Laboratories that offers discounts for enrollees in the program.

5. MANAGED CARE NETWORK: IPA is associated with a managed care provider network.

6. CONTINUING EDUCATION PROGRAMS: IPA offers comprehensive education programs as a provider of continuing pharmacy education and is accredited by the Accreditation Council on Pharmacy Education.

7. PHARMACEUTICAL AIDS: IPA provides pharmaceutical aids to its members.

8. BUNNY CO-OP: IPA has a co-op for buying pharmaceutical products, offering discounts to members.

9. ALLIED BUSINESSES: IPA members have access to a variety of businesses, including software providers and suppliers.

10. LEGAL ISSUES: IPA provides legal support to its members.

IPA MEMBERSHIP APPLICATION

Please return this application to IPA.

Please print or type.

IPA members benefit from IPA's networking and legislative efforts. IPA also provides independent pharmacy members with resources to resolve issues. IPA members are provided with information and support in addition to various programs and services.

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What is a 'Pharmacy Benefit Manager'?

By THOMAS GRYTA

Express Scripts Inc.'s plan to buy Medco Health Solutions Inc. for $29.1 billion comes as pharmacy benefit managers are seeking to increase their size and negotiating power while looking for new ways to serve customers.

Pharmaceutical benefit managers process prescriptions for the groups that pay for drugs, usually insurance companies or corporations, and use their size to negotiate with drug makers and pharmacies. This latest deal continues the consolidation trend but also highlights how the industry is becoming more than just an administrator and negotiator.

Pharmacy benefit managers, or PBMs, act as an intermediary between the payor and everyone else in the health-care system. They generally make money through service fees from large customer contracts for processing prescriptions, operating mail-order pharmacies, and negotiating with pharmacies and drug makers. Their contracts can include incentives for cutting costs.

"Some of that savings gets passed on to customers and some of that becomes their earnings," said Kevin Gorman, managing partner of Putnam Associates, a life-sciences strategy consulting firm.

The companies started by processing prescriptions at pharmacies and evolved into taking over the drug benefit portion of health plans. As the cost of drugs has increased, insurers looked for ways to control that spending and PBM services have become more desirable.

"Over the last 40 years, prescription drugs have gone from something that people paid for out of their own pocket to something that is paid for by a third party," said Adam Fein, president of Pembroke Consulting, a pharmaceutical-supply-chain consulting firm.

Aside from purchasing power, PBMs offer attractive scale in terms of claims processing. The top three PBMs each manage about 20% of the almost 4 billion prescriptions dispensed in the U.S. every year, requiring complicated and large infrastructures, Mr. Fein noted.

"PBMs are the power players in the pharmaceutical supply chain," he said.

They also battle with each other over large contracts that can quickly turn around their business. For example, Mr. Gorman said, Medco's fortune has changed dramatically over the past 18 months.

Medco's stock price had been under pressure because concerns about contract losses to CVS Caremark Corp. and the possibility of losing its biggest customer, UnitedHealth Group Inc., after that pact ended next year. It was confirmed Thursday that UnitedHealth is leaving Medco.

Also, changes in the drug world in coming years will force business changes at PBMs as well. They make large profits in the first six months when branded drugs go generic, and over the next 5 years almost $100 billion in branded drugs will go that way. PBMs, though, will need to be prepared when the wave ends, Mr. Fein noted.

As part of their evolution, the big PBMs are moving away from being just administrators and working to offer new services that can help save their clients money. Those include increasing patient compliance with taking prescribed drugs, helping better manage drug formularies, and aiding drug-related decisions with the use of
diagnostics and comparative effectiveness. Also, they are helping to manage spending on expensive specialty drugs, along with helping navigate government bureaucracy that will become increasingly complex.

That focus on innovation doesn't mean that scale won't remain vital to the industry or that consolidation will stop any time soon. Many smaller, regional PBM players remain, and they will have to decide their next move as the top companies get bigger and offer services that the smaller PBMs can't.

"It is going to be hard to compete so you will see continued consolidation," said Jeffery Gruen, head of the health services practice at management consulting firm PRTM.
The death of the corner pharmacy

As more customers choose - or are forced - to fill prescriptions by mail, independent pharmacies are struggling to survive.

By Emily Maltby, CNNMoney.com staff writer
Last Updated: June 16, 2009 12:07 PM ET
NEW YORK (CNNMoney.com) -- Each morning that he unlocks the doors of Cottage Pharmacy, owner Ken Villani fights a losing battle.

Revenue at his Woodbury, N.Y., store has been dropping for months. But unlike at other retail establishments, sales at his pharmacy may not rebound in tandem with consumer confidence. That's because more and more of Villani's customers are getting their drugs in bulk from mail-order companies and no longer need to set foot in his store at all.

"I'm a dinosaur in the industry," Villani says proudly of Cottage Pharmacy, which has been open for more than 30 years and today fills between 300 and 400 scripts a day. "Service has enabled us to survive up to this point, but we're losing the customer traffic we had. If they don't come in for the prescription, the less likely it'll be that they'll come in to buy shampoo or gum."

Villani knows how to beat tough competition. When chains such as CVS (CVS, Fortune 500) and Rite Aid (RAD, Fortune 500) popped up in the Woodbury area, Villani retained customers by beefing up his customer service and by stocking unique gift items the big names didn't carry. But today, Villani can't fight mail order competition through store quality alone. Ironically, he relies on mail-order companies just as much as he contends with them.

The mail-order drug business is run by a few huge corporations that, since the 1980s, have acted as middlemen between drug manufacturers and consumers. Health insurance companies contract with these companies, known as "pharmacy benefit managers" (PBMs), to administer their customers' prescription plans.

How drugs are priced
The three largest PBMs -- Medco Health Solutions, Caremark (acquired by retail giant CVS in 2007) and Express Scripts -- manage drug benefits for more than 200 million Americans, an estimated 95% of those who have prescription drug coverage. Most independent pharmacies sign contracts
with all three -- but they have little say in the terms of the contracts.

"Right now, if I say 'I'd like to negotiate,' the PBM will tell me the customers under their plan can go to the Walgreens (WAG, Fortune 500) down the street. That means I'll lose a chunk of business, but more importantly, I'll lose the 30-year relationship with Mrs. Jones who is covered by that PBM," says Holly Whitcomb Henry, a pharmacy owner in Seattle and a spokesperson for the National Community Pharmacists Association (NCPA).

Independent pharmacies as a group are blocked by antitrust laws from negotiating collectively. The only option they have is to refuse a contract altogether -- essentially the equivalent of turning away up to 30% of their insured customer base.

As the PBMs' market shares have grown, so too has their tendency to play hardball.

"From the outset, PBMs says they'd control costs, and pharmacies went with that pitch initially, agreeing to contracts that would enable blocks of patients to get drugs at our stores," says Brian Caswell, owner of Wolkar Drug in Baxter Springs, Kan., which draws 95% of its revenue from filling prescriptions. "The contracts have become egregious, with 15 to 20 pages of legal documents and red tape that we can't understand. As the PBM industry has shrunk to a handful of companies, they take more and more and give us less and less."

Pharmacists say they're constantly wrangling with the PBMs to get reimbursed correctly for the drugs they dispense. Prices from manufactures can fluctuate multiple times a month; PBMs are notoriously quick to change the reimbursement amount they pay pharmacies when the wholesale price drops but are slow to make the adjustment with the price goes up.

Rebates are another battleground. Drug makers frequently issue rebates to promote certain drugs, but those payments have been known to disappear into the pockets of PBMs instead of making their way to customers, sparking a flurry of lawsuits. One independent study from 2005, conducted by industry researcher Winkelman Management Consulting, found that one of the largest PBMs managed to keep 44% of the rebates it processed in one year, totaling about $1.3 billion.

**Forced march to mail-order**

In the last decade, the problems with the PBM juggernauts have become more intense as they've begun dispensing medication directly to consumers through their own mail-order systems. When they sell direct, PBMs are able to negotiate with manufacturers to price drugs at much lower rates than the prices set for retail pharmacies. That's why they can offer deals like a three-month supply of medication for the cost of one or two months.

Pharmacies see this practice as both discriminatory and a conflict of interest. The PBMs, on the other hand, argue that their pricing differences don't run afoul of antitrust laws. In 2006, several antitrust lawsuits filed years earlier by individual pharmacies against PBMs were consolidated into one sweeping action that is moving toward class-action certification. That case remains pending in a Pennsylvania federal court.

The issue is gaining urgency as PBMs push employers to adopt mandatory mail-order rules. A 2008 survey by Hewitt Associates found that 26% of companies now require their workers to refill ongoing prescriptions by mail. An additional 31% of the companies polled says they're considering
adopting such a rule within the next few years.

"I'm fine if a customer wants to switch to mail order if it's a fair pricing structure, but right now employer groups make contracts [with PBMs] that influence employees to go with their design," says Holly Whitcomb Henry of the NCPA.

That's having a dramatic effect on the bottom line for retail stores. Sales at U.S. independent pharmacies fell from $46.7 billion in 2006 to $43.7 billion in 2008, while mail-order sales rose from $40.9 billion to $55.1 billion in the same period, according to a study by the National Association of Chain Drug Stores.

In the past two years, Villani estimates that he's lost at least 30% of his prescription business to mail order.

But PBMs counter that they're simply trying to save money for their clients. A spokeswoman for CVS Caremark, one of the Big Three, acknowledged that Caremark encourages and sometimes requires its plan participants to use its mail-order pharmacy.

"The costs of using mail service pharmacy are generally lower for both the health plan sponsor and for the plan participant," says spokeswoman Christine Cramer. "In any event, depending on plan design, plan participants are typically able to obtain prescriptions for acute or short-term conditions at any one of the more than 63,000 participating pharmacies in our network."

The NCPA has filed several complaints with the Federal Trade Commission, urging the agency to step in to protect both the 25,000 community pharmacies that are losing business and also their customers, who don't always want to go the mail-order route. Some customers appreciate the convenience, but online forums are filled with complaints from others who are aggravated about shipping delays, confusing prices and incorrect orders.

"Every day we have a number of calls from frustrated people asking about mail-order medication because they can't speak to a human being [at the PBM]. They're wondering why the pills are yellow when the last time they were blue," says Villani's business partner, Larry Sussman.

Mail-order delivery is also a problem for procrastinators. Cottage Pharmacy's customers frequently come by when they've run out of medication before a new refill arrives. "They want us to lend them medication as if we are a library," Sussman says. "We find a way to give them the three-day supply that they need, but then we have to explain that it'll cost $60. So instead of thanking us, they call us thieves."

Reform plans
Washington has been slow to address the growing problem of the uneven playing field.

"Pharmacists aren't political animals. We've been hollering and screaming but we don't have the political clout that the PBMs do," says Caswell of Wolkar Drug, who has spoken to his local Congressional representative about the dire situation he's up against. "PBMs have deep pockets and were protected in the previous administration. But I hope things will change now under Obama, because this administration seems to be more aware of the small business."
In February, Congressman Anthony Weiner, D-N.Y., introduced the Community Pharmacy Fairness Act of 2009, which would grant independent pharmacies a limited antitrust exemption allowing them to band together to collectively negotiate contracts. The bill is an update of a previous version that was introduced in 2007 but died in committee.

With the Obama administration making health-care reform a major priority, the time finally seems right for a serious regulatory look at the PBMs that so heavily influence prescription drug costs. But the clock is ticking. There's a real question as to whether America's Main Street pharmacies, which have historically been the cornerstone of communities, will survive long enough to see changes in the industry.

"The delivery of health care would be severely minimized if indie pharmacies shrivel and go away," says Caswell.

Just recently, he sent a customer to the hospital after he had entered the pharmacy complaining that he didn't feel well. "I took his blood pressure and knew something wasn't right," Caswell says. "He came back days later and says he could have dropped dead from cardiac arrhythmia. Now I have a customer for life. Can mail-order do that?"

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Express Scripts and Medco
A Fallen Giant OR a Bigger Monster?

It was only two months ago that my editorial was on the topic of mail-order pharmacy programs (www.pharmacistaactivist.com; May 2011 - "Mail-Order Pharmacy Programs - Limitations, Inequities, and Deception"). However, the implications and concerns regarding the recent announcement that Express Scripts plans to buy Medco for $20.1 billion warrant further consideration of this topic.

Some background

The administration of prescription benefit programs has been dominated by three pharmacy benefit managers (PBMs) - Medco being the largest and followed in size by CVS Caremark and Express Scripts. Although it usually would not be expected that a smaller company would be in a position to acquire the largest company, Medco has recently lost three huge contracts including one with the insurer United Health Group (which now plans to manage its own prescription program) that accounts for approximately 17% of Medco's business. One suggested explanation underlying the planned acquisition is that Medco, rather than risking a further weakening of its position and unable to rule out the possibility of CVS Caremark selling its PBM to Express Scripts, identified to Express Scripts that it was receptive to being purchased. The proposed name for the combined company is Express Scripts Holdings Company and the current chairman and chief executive of Express Scripts will retain both his titles.

The potential for the new company to control the PBM marketplace in an anticompetitive manner has raised antitrust concerns and expectations of some that the acquisition will not be approved by the Federal Trade Commission (FTC). Others anticipate that the FTC will provide approval based on the reasoning that CVS Caremark, United Health, and smaller PBMs can provide sufficient competition in the marketplace.

Cost savings?

The executives of Express Scripts and Medco are promoting approval of the acquisition based, in large part, on their contention that the combined company will have sufficient influence to reduce the cost of prescription medications. Needless to say, a claim that a company can reduce the cost of any component of health care immediately attracts interest from government agencies, employers, unions, and others. However, before such a claim can be considered credible, important questions must be evaluated.

For a number of years the PBMs have operated in an essentially unregulated manner through which they have attained substantial influence, revenues, and growth. The first question that must be asked is: What has happened to the cost of prescription medications during this period of time in which the PBMs have had such a strong influence? The answer is that the cost of prescription drugs has markedly increased. Although some will quickly blame these increases on the pharmaceutical companies, why were the PBMs not able to reduce, or at least control, the costs of prescription medications in the recent past.
when they suggest they will be able to do so in the future if they are permitted to become bigger?

How will a combined Express Scripts and Medco be able to reduce the cost of prescription medications? The answer is that they will use their greater size and influence to obtain greater rebates from pharmaceutical companies and negotiate lower fees with chain pharmacies. And the independent pharmacies for which the PBMs dictate “take it or leave it” terms will be at an even greater disadvantage than they are now. The challenges that exist even now for independent pharmacies as a consequence of the PBMs’ anticompetitive programs and policies should be reason just by itself for the FTC to reject the plan of Express Scripts to acquire Medco.

As unlikely as a reduction in overall costs of prescription medications would seem to be, some anticipated and unprecedented changes in the marketplace suggest that such a change could occur during the next several years. This is because there will be a large number of widely-prescribed and expensive medications (e.g., Lipitor, Plavix, Zyprexa, Lexapro, Seroquel) for which patent protection will expire and much less expensive generic formulations will become available. However, these opportunities for reduced costs of important medications will result regardless of whether Express Scripts and Medco exist as two companies or one company. Indeed, it will be very interesting to observe whether the PBMs pass on the savings to clients when they experience sharply reduced costs for these generic products.

If a reduction in the cost of prescription medications is attained as Express Scripts and Medco propose, who will be the beneficiaries of the savings? Most certainly these PBMs will retain as much of the savings as they can, and perhaps pass some of it on to their clients. If patients/consumers/public experience any reduction in the cost of their prescription medications, it will be a very small fraction of the amount saved.

As I was writing this editorial, I received a communication from John Buck, the Editor-in-Chief of NEWS-Line Publishing, the organization that publishes The Pharmacist Advocate. He is preparing a commentary regarding the proposed acquisition for another NEWS-Line publication, and shared the following observation:

“In searching for news and opinions about the merger, I found more articles on how to profit from it or on Wall Street’s reaction to it, than its effect on the consumer, healthcare, or community pharmacies. That is just sad.”

His comments are absolutely on target! The quality and scope of the services provided patients by pharmacists, as well as the timely availability and affordability of medications for patients, should receive the highest priority. However, these issues are rarely mentioned in the media coverage. Let me also be considered guilty of an excessive focus on the economic issues, please also read my May 2011 editorial.

Some responses

As noted earlier, one of the ways in which the combined Express Scripts and Medco would expect to reduce the costs of medications is to reduce the compensation to participating community pharmacies. Therefore, not surprisingly, the National Community Pharmacists Association (NCPA) and the National Association of Chain Drug Stores (NACDS) were among the first to respond to the announcement of the planned acquisition with a statement that reads, in part:

"Today’s announcement that Express Scripts will buy Medco creates a middle man that is too big to play fair, and will have immense power to unfairly dominate the market. This combination will monopolize control of the supply line for brand and generic prescription drugs, threaten access to pharmacy patient care, and is a bad deal for America for healthcare plans, for pharmacies, and - most notably - for patients."

I fully concur with this statement. The characterization of “too big to play fair” also invites the observation that these two companies, as well as CVS Caremark, have been viewed by many as being unfair and worse even as separate entities. This is reflected, in part, by their payment of hundreds of millions of dollars to settle claims of fraud and deceptive practices so that these companies can avoid acknowledging any wrongdoing and escape further prosecution. The anticipated consequence of permitting these companies to become bigger and wield more influence would be a further abuse of their power.

It is appropriate that NACDS has taken a strong position against the proposed acquisition. Even though individual chains can negotiate program terms and compensation with the PBMs, most are in a weak bargaining position when dealing with a huge PBM. It is noteworthy that the immediate past chairman of the Board of Directors of NACDS is the president and CEO of CVS Caremark, the strongest competitor of Express Scripts and Medco. The vice chairman of the NACDS Board is the president and CEO of Walgreens. Walgreens recently announced that it would not accept the terms of a new contract (with estimated revenue of more than $5 billion) offered by Express Scripts to participate in its prescription programs. In the face of the implications of the proposed acquisition of Medco, it will be very interesting to observe whether Walgreens stands its ground against Express Scripts or whether it reaches an agreement as it did last year when it threatened to discontinue participation in programs administered by CVS Caremark.

There has been very little comment regarding the proposed acquisition from the pharmaceutical companies that the combined and more powerful PBM will expect to provide greater rebates for their medications. It is ironic that the same pharmaceutical companies that initially caused the chaos regarding the pricing of pharmaceuticals may now be victims of the giant PBMs to whose growth the companies’ pricing policies significantly contributed.

No opportunity to respond

There is another important group who either do not have a forum in which they can respond or there is not enough interest on the part of their company, the media or others in

(Continued on Page 4)
whether they have a response. This group includes the Medco pharmacists and other employees. When a deal valued at $29 billion is planned and implemented, company stock holders are expected to benefit and the highest level executives are provided substantial additional compensation and/or other benefits. Little or no attention is given to the welfare of the employees whose dedication and efforts have significantly contributed to the growth of a company to the point that it motivates another company to acquire it.

As strongly as I feel that the type and scope of pharmacy practice that I advocate can not be provided through a mail-order pharmacy program, I have a genuine concern for the Medco pharmacists and other employees whose lives will be affected by a decision that they probably did not know was even being considered. They have been sold out by their executives. Uncertainties regarding closing of facilities and loss of jobs or need for relocation are challenging at any time but particularly during the current economic climate that includes a tightened employment market for pharmacists.

Actions

Although the proposed acquisition of Medco by Express Scripts would have the largest impact on pharmacy practice and patient care in the community setting, it has important implications for the entire profession of pharmacy. Accordingly, the associations of pharmacy practitioners should object to the acquisition in a unified and strong voice to the FTC and our legislators. However, this should be viewed as a short-term intervention to prevent a bad situation from becoming worse.

The prescription benefit programs that are currently available have serious flaws, are a disservice to patients with respect to their limitations in quality and scope, and are inadequate for pharmacists. The profession of pharmacy must design better prescription benefit plans that give the highest priority to the provision of optimal drug therapy for patients by pharmacists who meet with and participate in the direct care of patients.

I am convinced that better programs can be developed that will also be cost-effective. The flawed programs administered by PBMs "middlemen" are extracting billions of dollars from the health care system without participation in direct patient care and contributing nothing to the overall quality of pharmacy services. These resources must be redirected to programs that will attain positive outcomes.

The profession of pharmacy can not expect that the government, insurance companies, or PBMs will develop prescription benefit programs that will fully utilize the expertise and scope of services of pharmacists for the benefit of patients. As a profession, we must accept the responsibility for the development of a model prescription benefit program and secure the resources to evaluate it on a pilot basis. I am optimistic that a model program can be so successful and cost-effective that the wisdom of using it for much larger programs will be quickly recognized and embraced.

Daniel A. Hussar

New Drug Review (cont.)

Comments:

Vilazodone is a selective serotonin reuptake inhibitor (SSRI) with properties that are most similar to those of citalopram, escitalopram, fluoxetine, paroxetine, and sertraline. It differs from its predecessors by also acting as a partial agonist at serotonergic 5-HT1A receptors; however, it is not known whether this partial agonist action contributes to the antidepressant effect of the drug. The effectiveness of vilazodone has been demonstrated in two 8-week, placebo-controlled trials. It has not been directly compared with other antidepressants in clinical studies, and there are no data to suggest that it is more effective than other SSRIs in the treatment of depression. Most other SSRIs have multiple labeled indications; however, depression is the single labeled indication for vilazodone at the present time.

The drug-related problems associated with the use of vilazodone are generally similar to those for the other SSRIs. Although vilazodone was not observed to cause a significant change in body weight during the 8-week period of the clinical studies, data are insufficient to determine if increases in weight occur over longer periods of treatment, such as have been associated with the continued use of other SSRIs.

Daniel A. Hussar

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