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Specialty Spotlight

Specialty Phone Applications

There are many mobile applications that provide drug information and updates in the world of specialty pharmacy. Many of the apps are free, while some require prior registration. Here is a list of a few apps that are available for download on your local iTunes App Store or GooglePlay Store:

Name	Function	Cost	Availability
BioOncology HD	Updates on latest oncology news, resources, and innovations	Free	Apple Devices
inPractice Applications · HIV, Rheumatology Oncology	Provides specialty topics/updates on specific application edition. Also provides clinical guidelines and article abstracts	Free with registration	Apple or Android Devices
IMS Mobile Insights	Provides IMS reports and analytics from 2013 and onward	Free	Apple Devices
Specialty Pharmacy Times	Updates on key areas surrounding specialty pharmaceuticals	Requires subscription	Apple Devices
UHC RxLink Mobile	Provides members with pharmacy pricing and benchmarking tool	Free for RxLINK users – only for UHC supply chain participants	Apple Devices
NCCN Guidelines	Access to evidence based guidelines in the field of oncology	Free	Apple or Android Devices
Epocrates	Provides drug information and formularies for various drug plans	Free	Apple or Android Devices

Commentary:
These specialty apps offer information and usage criteria for specialty medications. Consider IMS for benchmark financials and NCCN for clinical practice guidelines for oncology. As usual, be particularly careful about webpages and apps that are commercially supported. Always identify who is publishing and supporting this information so that you can factor any potential bias into your usage.

Concerns of Combination Use of Benzodiazepines and Opioids

Benzodiazepines and opioids, separately and together, are among the most frequently abused psychoactive drugs in the world. Together, the two drugs constitute the majority of emergency department visits involving non-medical use of psychotherapeutics. When taken together, benzodiazepines and opiates can lead to co-abuse by exerting significant modulatory effects upon one another. One possible mechanism is that benzodiazepines may increase the serum concentrations of certain opioids, as in the case of diazepam and methadone. Another mechanism is that benzodiazepines increase the rewarding and reinforcing effects of opioids via amplification of mu receptor agonism. Healthcare professionals must be cognizant of patients who are prescribed benzodiazepines and opioids concomitantly and carefully watch for potential of abuse. This can be achieved by avoiding concomitant use when possible and using the minimum effective dose for the shortest effective time when medically necessary to be taken together.

Commentary:

The interaction is of concern because polysubstance abuse has been found to be a significant predictor of drug overdose, leading to fatal toxicities such as respiratory depression. Both drugs can lead to physical dependence as well as withdrawal symptoms. It has also been found that those who abuse both benzodiazepine and opioids are even more likely to abuse additional drugs. Studies have also shown that those who were physically dependent on benzodiazepines were more likely to be prescribed medication for emotional problems and have a much poorer psychiatric status and higher frequency of psychiatric comorbidities. So as it can be seen, not only is it easier to co-abuse benzodiazepines and opioids due to their potentiating effects on each other, but once they are abused together the problem only grows bigger by leading to physical dependence, withdrawal, and possibility of additional drug abuse.

Source:

1. *B.M. Walker, A. Ettenberg (2001). Benzodiazepine modulation of opiate reward. Clinical Psychopharmacology., 9 (2001), pp. 191–197*
2. *J. Ross, S. Darke (2000). The nature of benzodiazepine dependence among heroin users in Sydney, Australia. Addiction, 95 (2000), pp. 1785–1793*
3. *Jones, J., Mogali, S., & Comer, S. (2012). Polydrug abuse: A review of opioid and benzodiazepine combination use. Drug and Alcohol Dependence, 8-18.*
4. *N. Lintzeris, T.B. Mitchell, A. Bond, L. Nestor, J. Strang (2006).*

Validity of Screening Tools: PHQ-9 and MMSE

Depression and dementia are difficult to measure objectively and are frequently screened using the Patient Depression Questionnaire (PHQ-9) and the Mini Mental Status Examination (MMSE), respectively. According to the Journal of General Internal Medicine, the PHQ-9 survey may be used as a reliable source as it was established to have external validity and findings were successfully replicated in different patient populations. It was shown to have a sensitivity (true positive rate) of 88% and a specificity (true negative rate) of 88% for major depression allowing the brief survey to accurately depict the patient's state. Furthermore, MMSE has shown to have the 2nd highest sensitivity rate and 3rd highest specificity rate when compared to DSM-IV criteria, NINCDS criteria, short portable mental status questionnaire, and clinical judgment, inferring low rate of false negatives and false positives, respectively.

Commentary:

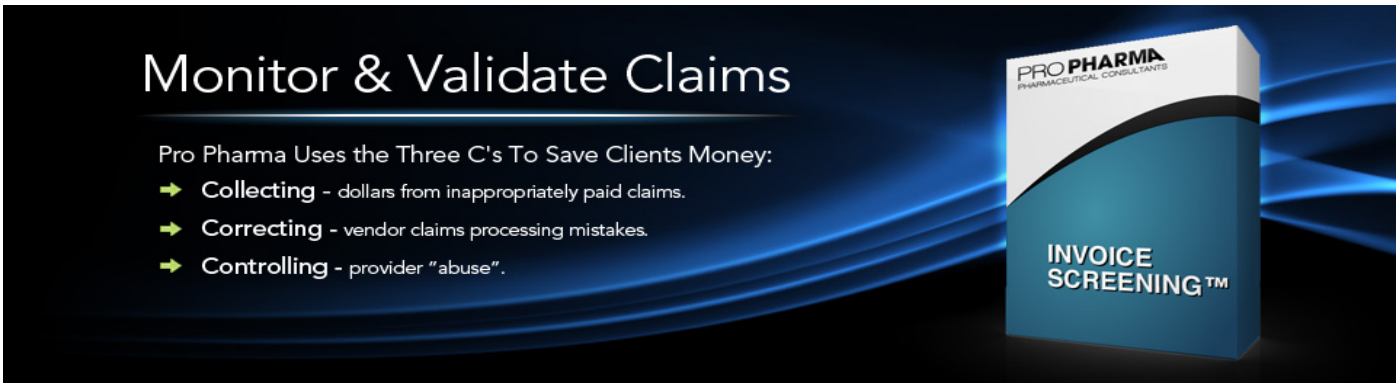
Early diagnosis of depression and dementia are key to their treatment as dementia is irreversible and depression can silently worsen. Although these surveys are shown to be quite reliable sources of screening and a tool for possible diagnosing of their respective disease states, the final diagnosis should be made based on clinical grounds. Clinicians should be aware of the fact that the scores should be considered in light of possible patient specific barriers to the test, such as language and education level, and rule out other treatable conditions that may have similar symptom presentation.

Source:

1. *Alzheimer's Society. (2014). Devon House, London: Alzheimer's Society: Symptoms, diagnosis, and treatment; November 13, 2014*
2. *Grigoletto, F, Zappala, G, Anderson, DW, Lebowitz, BD, Neurology 1999; 53:315.*
3. *Kroenke, K., Spitzer, R. L. and Williams, J. B. W. (2001), The PHQ-9. Journal of General Internal Medicine, 16: 606–613. doi: 10.1046/j.1525-1497.2001.016009606.x*
4. *Shadlen, M., Larson, E., DeKosky, S., & Schmader, K. (2014, February 1). Evaluation of cognitive impairment and dementia. Retrieved November 13, 2014.*
5. *Williams JW, Jr. Update: Depression. In: The Rational Clinical Examination: Evidence-based Clinical Diagnosis, Simel DL, Rennie D (Eds), McGraw-Hill, New York 2009*

Interactions on mixing diazepam with methadone or buprenorphine in maintenance patients. J. Clin. Psychopharmacol., 26 (2006), pp. 274–283

5. *SAMHSA, 2011a. Center for Behavioral Health Quality and Statistics. The DAWN Report: Drug-Related Emergency Department Visits Attributed to Intentional Poisoning, Rockville, MD.*



Invoice Screening ᵀ

Check Your Pharmacy Invoice Like You Check Your Supply Invoices

Invoices for payments to PBMs and Health Plans for prescriptions filled by their network pharmacies (both retail and mail), should be checked – the same way one would check a grocery or restaurant receipt.

The assumption that electronic claim adjudication is without errors can be dangerous for both medical and pharmacy claims. Pro Pharma's experience indicates that at least 5-7% of all paid drug claims are incorrect. Prime areas for errors are eligibility, pricing, claim validity, payments for benefit exclusions, etc

Pro Pharma's Invoice Screening^{T} Tool analyzes pharmacy invoices within seven (7) business days to validate invoices prior to payment.

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has assisted payer and providers for over 29 years to maintain quality while controlling costs.

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