

LETTERS TO THE EDITOR

Alert to Physicians: Possible Interaction of Aggrenox and Adenosine

A new medication, Aggrenox, a formulation of aspirin and extended-release dipyridamole, is now being actively marketed to physicians for the treatment of patients with transient ischemic attacks and ischemic stroke. I believe that physicians involved in pharmacological stress testing should recognize that patients taking this medicine may also be referred for an adenosine pharmacologic stress perfusion test. It would be anticipated that the extended-release formulation of dipyridamole would antagonize the breakdown of adenosine and, thereby, exaggerate adenosine's effects, including the induction of hypotension and atrial-ventricular block. Patients receiving Aggrenox should not receive adenosine but should receive dipyridamole instead. I believe the readers of the *Journal of the American College of Cardiology* (JACC) should be warned of the possible interaction of Aggrenox and adenosine.

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Pharmacists Agree: Stop the Pharmacy Madness

I am writing in response to the editorial in the March issue of the *Journal of the American College of Cardiology* (JACC) (1) concerning the administrative challenges associated with insurance coverage for prescription drugs which struck a resonant chord. As President of the American Pharmaceutical Association (APhA), the national professional society of pharmacists, I can assure you that my profession is equally as frustrated with the inefficiencies and unproductive hassles associated with many managed care programs today. A recent study by Arthur Anderson shows that over 20% of a pharmacist's time is spent directly on activities related to insurance issues (2). These include determining eligibility status, resolving formulary and coverage issues and solving billing problems.

Because community pharmacies provide "point-of-service" claims processing for prescription medications, pharmacists are often placed in a difficult and undesirable position of mediating insurance issues so that the patient can receive the prescribed medication. Often, pharmacists must contact physicians for authorization to change a patient's medication to be compliant with the plan formulary or to receive a prior authorization. These coverage decisions are outside of the control of the pharmacist.

As you describe in your article, contacting the "help-desk" at an insurance company is usually less-than-helpful. These call centers are often understaffed with employees that are poorly trained and unempowered to assist providers by authorizing clinical overrides. This causes significant delays and often forces providers to make decisions based on plan parameters as opposed to patient parameters.

I fully support the principles that you have outlined to "restore rationality" to this process, but I suggest the addition of one point—physicians and pharmacists must work together to ensure changes in the design of health benefits that reduce the administrative burdens for all providers and, more importantly, facilitate the efficient delivery of health care services to our patients.

As frustrating as these administrative barriers are to providers, they are often even more frustrating and confusing for our patients. Physicians and pharmacists must work toward building a medication delivery system where "care" is more important than "coverage."

As you know, there are many other health care delivery issues we could discuss but I am, as usual, tied up on the phone trying to obtain authorization for Mrs. Brown's heart medication which is, not surprisingly, unavailable on her health care plan's formulary.

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REFERENCES

1. Parmley WW. Pharmacy madness. *J Am Coll Cardiol* 2000;35:802-3.
2. Arthur Anderson. Pharmacy Activity Cost and Productivity Study. November, 1999.

The Pharmacy Perspective on Managed Care Madness

I share your frustrations regarding the barriers to patient care as described in your editorial entitled, "Pharmacy Madness" (JACC 2000;35:802-3). However, as a Doctor of Pharmacy (PharmD), I find your description of the issue disturbing. The profession of pharmacy is no more in control of the barriers you described than the medical profession. Consistent with your description of your P&T Committee experience, Managed Care permits medical decisions (such as formulary inclusion or exclusion) to be made based upon business cases and not patient risk versus benefit. This is further perpetuated by patients' willingness to enroll in (and thus support) such healthcare organizations coupled with their lack of willingness to pay for diagnostics or treatments not covered by their plans.

Clinical pharmacists in the hospital setting are under many of the same Managed Care pressures that physicians find themselves under in that there is constant pressure to evaluate the costs most closely tied to their function; while this correlates in part to diagnostic procedures for physicians, it correlates to medications for pharmacists. There is clearly a lack of understanding of the clinical pharmacist's expertise given that you view your institution's pharmacist as nothing more than a "SWAT team whose goal is to reduce inpatient pharmaceutical costs in specific areas."

Community pharmacists practicing in a retail setting are under similar constraints. As pharmacists whose current primary role is to dispense medication and advise regarding those medications, they often find themselves as an involuntary liaison between the insurance plans and the patients who chose to enroll in them.