

Guide for Helping Patients Afford Their Medications

Medication Discount Programs^a					
Program	Cost	Eligibility^b	Enrollment	Formulary	Discount
AARP Prescription Discount Program	\$19.95	Individuals who are 50 years or older who are members of AARP. Those with Part D coverage can use this card as a back-up for medicines not covered by their plans.	877-422-7719	Discounts on more than 5,000 prescription medicines.	Discounts of up to 53%, with an average savings of 20%.
AZ & Me (AstraZeneca)	Free	Uninsured individuals with an income below \$30,000, couples with an income below \$40,000, families of three with an income of less than \$50,000, and so on. Medicare enrollees who are eligible for the Limited Income Subsidy are eligible.	800-292-6363 or AZandMe.com	Many AstraZeneca prescription medicines.	For patients with Medicare Part D, the maximum co-pay for a 30-day supply is \$25, and for a 90-day supply it's \$50. For patients with no insurance, medications are free.
GSK Access (GlaxoSmithKline)	Free	Medicare Part D participants who have spent \$600 on medicines through their Part D plan, and who do not qualify for the Part D Low Income Subsidy. Must have income at or below 250% of the FPL.	866-518-HELP or www.gsk-access.com	Over 50 GSK prescription medicines.	Prescriptions are free.
Bridges to Access (GlaxoSmithKline)	Free	Non-Medicare patients and Medicare participants who do not have prescription drug coverage and who do not qualify for the Part D Low Income Subsidy. Must have income at or below 250% of the FPL.	888-825-5249 or www.bridgestoaccess.com	Over 50 GSK prescription medicines.	\$10 co-pay for a 60-day supply. Refills must be obtained through GSK mail order pharmacy.

More . . .

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Lilly Medicare Answers Program (Eli Lilly)	Free	Medicare Part D participants, not dual-eligible, with incomes at or below a specified percent of the FPL and proof of Low Income Subsidy denial. An assistance program for <i>Forteo</i> is available for non-Medicare patients.	877-RX-LILLY or www.lillymedicareanswers.com	teriparatide (<i>Forteo</i>), olanzapine (<i>Zyprexa</i>), somatropin (<i>Humatrope</i>)	Medication is free.
Merck Patient Assistance Program (Merck)	Free	Those with no prescription drug coverage and an income of 400% or less of the FPL. (Call 800-727-5400 for income limits in Alaska, Hawaii, Puerto Rico, U.S. Virgin Islands, and Guam). Exceptions may be requested.	800-727-5400 or www.merck.com/merckhelps/patientassistance/	Many Merck prescription medicines.	Prescriptions are free.
Merck Prescription Discount Program (Merck)	Free	All uninsured individuals.	800-50-MERCK or www.merck.com/merckhelps/uninsured/home.html	Several Merck prescription medicines.	Savings of 10% to 20%.
Pfizer Pfriends (Pfizer)	Free	All uninsured individuals.	866-776-3700 or www.pfizerhelpfulanswers.com	Many Pfizer prescription medicines.	Estimated average savings of up to 32%.

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Pharmacy Reward (NeedyMeds)	Free	Everyone	www.pharmacyreward.com /needymeds/index.cfm	All Rx drugs. Check website for participating pharmacies.	Participants pay pharmacy's lowest price. Members save money about 90% of the time.
Rx Help for You (Elect Benefits Global Marketing Corp)	Free	Everyone	800-613-4841 or www.rxhelpforyou.com	Many brand name Rx drugs. Check website for participating pharmacies.	Savings of up to 50%.
Together Rx Access Card Abbott Bristol-Myers Squibb GlaxoSmithKline Janssen King McNeil Pediatrics Novartis Ortho-Biotech Ortho-McNeil Pfizer Sanofi-aventis Takeda Tap Tibotec	Free	People who are not eligible for Medicare and have no prescription drug coverage of any kind. Must have incomes of less than \$45,000 per year for a single person, \$60,000 for a family of two, \$75,000 for a family of three, \$90,000 for a family of four, and \$105,000 for a family of five. (Families of six or more and residents of Alaska and Hawaii should contact the Together Rx Access Program at 800-444-4106).	800-444-4106 or www.togetherrxaccess.com	More than 300 brand name medicines (list is continually updated and available at the Together Rx Access website). Savings are also available on generic drugs.	From 25% to 40% on brand name and generic prescription medicines.

Web-based Resources for Patient Assistance Programs	
Information Source	Comments
www.needymeds.com	Site lists brand and generic medications that are available through patient assistance programs. There is also a listing of manufacturers who have patient assistance programs. Information about Medicaid, Medicare, and other state assistance programs is also available.
www.rxassist.org 401-729-3284	Provides information on patient assistance programs through company, brand, and generic name search. Has information for patients describing various options for prescription assistance.
www.pparx.com 888-477-2669	Site sponsored by the Pharmaceutical Research and Manufacturers of America (PhRMA). Allows search for programs by manufacturer (programs from non-member companies are not listed). Also, provides information on other patient assistance programs available.
www.rxhope.com 732-507-7400	Provides patient assistance information through manufacturer or drug search. Advanced search available to help patients determine eligibility for various state- and company-sponsored patient assistance programs. Online applications for patient assistance.
www.benefitscheckup.org	Provides a personalized report of public and private programs available to help reduce costs of prescription drugs. Also includes online application for Medicare Rx Extra Help (low income subsidy information). Site geared toward aiding seniors age 55 and over. Service provided by the National Council on the Aging.
www.accesstobenefits.org 202-479-6670	Provides information on the patient's eligibility for prescription savings programs (utilizing BenefitsCheckUpRx) and available state programs. Enrollment forms for various programs, including Medicare Rx Extra Help (low income subsidy information) are available. Site geared toward low-income Medicare beneficiaries (seniors and younger patients with disabilities).

—Continue to the next page for more cost saving tips—

Other Cost Saving Tips

Review patients' medications. Look for:

- duplicates or overlapping drugs that can be eliminated;
- brand products that can be switched to generics;
- additional switches that can make meds more affordable (check *Consumer Reports Best Buy Drugs* [<http://www.consumerreports.org/health/best-buy-drugs/index.htm>] for medications that are considered best values for treating specific disease states).

Recommend pill splitting when appropriate, for drugs that are priced similarly between strengths. This includes most statins, amlodipine, sertraline, and metoprolol extended-release tablets. *Viagra* is another example of a tablet that can be split to reduce costs.

Suggest purchasing larger quantities of medication at one time. Sometimes a 90- or 120-day supply can cost less and reduce the amount spent on co-pays compared to a 30-day supply.

Drug Samples can save patients money upfront. However, sometimes they can end up costing more in the long run. Patients get stabilized on and have to pay for these meds, which are often newer and more expensive. Save samples for drugs that don't have more affordable alternatives, or are used short term such as antibiotics.

Some **organizations**, like the Leukemia and Lymphoma Society, will help patients pay for the cost of treatments for specific diseases.

^aOnly money paid by STATE assistance programs contributes to out-of-pocket expenses for Medicare Part D participants.

^bFPL is the Federal Poverty Level. For the 48 contiguous states and D.C., the FPL for 2009 for an individual is \$10,830; \$14,570 for a family of two; \$18,310 for a family of three; \$22,050 for a family of four; and \$25,790 for a family of five. For further information and figures for Alaska and Hawaii, go to aspe.hhs.gov/poverty/09poverty.shtml.

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Tablet Splitting: "To Split or Not To Split"

Tablet splitting can save patients money, especially when considering sole-source brand name products. Yet, the practice of tablet splitting can be problematic as a result of failed therapeutic outcomes due to over or under dosing. Also, the stability of a medication might be altered or there may be other unknown reasons not to split a tablet. The following checklist and guide may help you determine which patients are able to split their own tablets and which tablets might safely be split.⁵

A. Patient Considerations:

- a. Physical ability:
 - i. Does the patient or patient's caregiver have the skill, dexterity, strength, and visual ability to split a tablet?
 No, splitting should not be considered
 Yes, go to the next question
- b. Cognitive ability:
 - i. Does the patient or patient's caregiver have the mental ability to select the correct medication and split a tablet?
 No, splitting should not be considered
 Yes, go to the next question

B. Product Considerations (Drug, Potency, and Dosage Form):

- a. Is the active ingredient a narrow therapeutic index product (digoxin, levothyroxine, others)?
 Yes, splitting should not be considered
 No, go to the next question
- b. Is the tablet a controlled- or modified-release product?
 Yes, go to the next question
 1. Is the tablet scored?
 No, splitting should not be considered
 Yes, go to the next question No, go to the next question
- c. Does the tablet contain more than one active ingredient?
 Yes, splitting should not be considered
 No, go to the next question
- d. Does the tablet easily break into pieces with minimal handling (friability)?
 Yes, splitting should not be considered
 No, go to the next question
- e. Is the tablet enteric-coated, sublingual, or buccal
or
does it have a poor taste, is it teratogenic if handled, or can it cause mouth irritation?
(See *Detail-Document # 241204 "Medications That Should Not be Crushed" for a helpful list of these medications*).
 Yes, splitting should not be considered
 No, splitting is possible.

Tablet Splitting: "To Split or Not To Split"

Background

Tablet splitting has been a popular, cost-saving practice among many patients for years. Patients have been able to trim prescription costs by splitting a tablet in halves or quarters. This is achievable because the prices of some drugs are similar despite the strength of the tablet. Now, some HMOs and insurance companies are utilizing tablet splitting as a cost-saving strategy. They are implementing policies that often require patients to split tablets of some commonly used medications.^{1,2} A December 2000 class-action lawsuit in the California court system contends that Kaiser Permanente has required its health plan members to split tablets regardless of the patients' ability to accurately split tablets and the products' suitability for splitting. The lawsuit states that Kaiser's tablet-splitting policy is a violation of the California Business and Professions Code and the state's Consumer Legal Remedies Act.³ National pharmacy and medical societies have expressed several concerns over this controversial issue. Primary concerns have ranged from the patient's ability to accurately split the tablet, the content uniformity of the split tablet, and the possibility of a prescription error if "1/2 tablet" is misinterpreted as "1-2 tablets."⁴⁻⁷

Views of Professional Organizations

The American Pharmacists Association and the American Medical Association are both formally against mandatory tablet splitting.⁵ The American Pharmacists Association (APhA) acknowledges the widespread practice of tablet splitting, and has developed a set of guidelines to evaluate the appropriateness of tablet splitting based on individual patient and product characteristics. The APhA suggests tablets that are uncoated and scored, for example, are often the easiest to split. Tablets that are round, coated, small, or unscored may be difficult to split accurately. The patient or caregiver must also be physically able to divide the tablet as directed.⁵⁻⁷ The American Society of Consultant Pharmacists opposes policies that deny

payment for lower strengths of tablet dosage forms, or policies that mandate tablet splitting by patients.⁴ The Department of Veterans Affairs (VA) has also investigated this issue. Although the VA did not find specific studies indicating tablet splitting was detrimental to patients, the VA does not currently recommend mandatory tablet splitting.⁸

Studies

Rosenberg et al evaluated the weight-variability of twenty-two prescriptions containing 560 pharmacist-dispensed split tablet halves. The *United States Pharmacopeia* (USP) tablet uniformity standards require tablets to contain between 85% and 115% of the labeled dosage, allowing a 6% relative standard deviation in overall drug content. Of the twenty-two prescriptions tested, only seven (31.8%) met USP tablet uniformity standards. In addition, five of the twenty-two products had more than 10% of their fragments beyond this range.⁹

In another study, Teng et al evaluated the accuracy of tablet splitting by a trained individual. In this study, tablets found to be commonly divided were split by hand alone and by a single-edged razor blade. The trained individual split tablets of three products by hand, and tablets of eleven products with a single-edged razor blade. The three hand-split tablet groups and eight of the eleven groups split with a single-edged razor blade failed to meet USP tablet uniformity standards.¹⁰

Polli, et al examined the issue of tablet splitting within the Veterans Affairs (VA) Maryland Healthcare System. In 2001, this regional VA system promoted tablet splitting of products including atorvastatin, citalopram, lovastatin, paroxetine, sertraline, sildenafil, and simvastatin. Patients, however, could opt out of the program if they had difficulty splitting the tablets. The study examined the accuracy of twelve commonly split tablets. A trained pharmacy student split 30 tablets of each product

using a splitter device provided by the VA, and the tablet halves were then assessed for weight uniformity. Eight of the twelve products (67%) tested passed the USP-based uniformity testing, while four failed.¹¹

A separate retrospective study by Gee, et al evaluated the effects of splitting HMG-CoA reductase inhibitors. A total of 2,019 patients were enrolled and evaluated on parameters such as clinical effects, patient satisfaction, compliance, and cost issues. The cost avoidance over a one-year period for splitting atorvastatin, lovastatin, and simvastatin was estimated to be \$138,108, an average of \$68.40 per patient per year. Of the 454 patients who filled out the satisfaction questionnaires, 46% believed it was easier to take medications they did not have to split. However, 74% believed the tablet splitter was not too bothersome or time-consuming. Another 7% believed they had missed more doses during a month of tablet splitting. Of the 512 patients evaluated for laboratory considerations, there was no difference in total cholesterol and triglyceride values before or after tablet splitting was initiated. Statistically significant differences did show for AST (26 versus 28, $p < 0.001$), ALT (24 versus 28, $p = 0.006$), LDL (102 versus 97, $p < 0.001$), and HDL (46 versus 48, $p < 0.001$) after the introduction of the tablet splitting process. It should be noted that the baseline lab panel test results recorded in the study could range from one year before to the day of tablet splitting initiation. Once tablet splitting began, a lab panel could be obtained between six weeks and one year while in the splitting phase of the study.¹²

Conclusion

Mandatory tablet splitting remains a controversial policy. Because of the variability in dose that may occur with tablet splitting, this practice should probably be avoided when accuracy of the dose is crucial. Enteric-coated and certain controlled-release tablets are not intended for splitting. It might be prudent to contact the tablet manufacturer before recommending tablet splitting, when in doubt. The stability of the medication might be altered or there may be other unknown reasons not to split a tablet. The patient's individual ability to accurately split the tablet and the medication itself should continue to be key concerns.

Users of this document are cautioned to use their own professional judgment and consult any other necessary or appropriate sources prior to making clinical judgments based on the content of this document. Our editors have researched the information with input from experts, government agencies, and national organizations. Information and Internet links in this article were current as of the date of publication.

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More . . .

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