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INTRODUCTION

Express Scripts Drug Trend Report 2004

Introduction

KEY EVENTS ON THE 2004 PHARMACY LANDSCAPE

Even though prescription-drug spending was up again in 2004, the year's lone major gain for pharmaceuticals was more than offset by losses.

- In one of the year's few bright spots for the pharmaceutical industry, the overall utilization of cholesterol-lowering drugs known as statins increased by 12% in 2004¹⁰ — boosted in large part by updated clinical guidelines that recommend reduced goal levels of low-density lipoproteins (LDL) for high-risk patients.

In general, however, 2004 was a year of significant problems, not only for the pharmaceutical industry but also for the U.S. Food and Drug Administration (FDA).

- Voluntary removal of Vioxx[®] from the world market in September 2004 and its later reintroduction in some countries focused attention on the prescription-drug approval process in the U.S. Along with other drugs in the COX-2 subclass, Vioxx was advertised heavily in direct-to-consumer (DTC) ads following its U.S. introduction in 1999. Particular emphasis was placed on the stomach-protective effect of COX-2s. However, subsequent research found that individuals who take Vioxx for 18 months or longer are at increased risk for heart attacks and strokes. In December 2004, concerns spread to include all COX-2s after additional information linked Celebrex[®] and Bextra[®] to health problems similar to those seen with Vioxx. As a result, U.S. prescriptions for COX-2s dropped from about 4.5 million to about 2.7 million in the last three months of 2004.¹¹ While an FDA decision in February 2005 allowed some COX-2s to stay on the market, the manufacturer of Bextra suspended its sales in early April after a request for its withdrawal from the FDA. A black-box warning is now required on the labels of all COX-2s still sold in this country. DTC advertising for them has been eliminated, and COX-2 utilization is expected to stay relatively low since physicians are being advised to prescribe them in lower doses and for shorter lengths of time.

¹⁰ IMS Health. 2004 Year-End U.S. Prescription and Sales Information and Commentary. No date given. Available at: http://www.imshealth.com/ims/portal/front/articleC/0,2777,6599_18731_69890098,00.html. Accessed February 25, 2005.

¹¹ IMS Health. 2004 Year-End U.S. Prescription and Sales Information and Commentary. No date given. Available at: http://www.imshealth.com/ims/portal/front/articleC/0,2777,6599_18731_69890098,00.html. Accessed February 25, 2005.

- An FDA advisory in October 2004 addressed issues raised earlier about the use of antidepressants for children and teens. Research that linked suicide attempts and suicidal thoughts among pediatric and adolescent patients to treatment with antidepressant drugs led to both a warning label on all antidepressants and a decrease in antidepressant use among patients aged 18 years and younger.¹²
- Newer, second-generation (atypical) antipsychotic drugs have been associated with higher risks of developing diabetes, high cholesterol and obesity. Early in 2004, four major medical societies, including the American Diabetes Association and the American Psychiatric Association, recommended more frequent and extensive health testing for patients taking a second-generation antipsychotic medication. As a result, expenses on the medical side are expected to increase for these patients.

Recent negative press about prescription drugs is likely to cause changes in the drug-approval process. In February 2005, the FDA announced plans to establish a Drug Safety Oversight Board. The board, consisting of FDA employees and medical personnel from other federal agencies, will consult with independent experts and patients. In addition to posting safety information on a new Drug Watch Web site, the board will also work to improve the printed drug information patients receive with their prescriptions. Additionally, the FDA has stated plans to make its review and decision-making processes more independent and transparent.¹³ Problems with drug safety may also lead to more stringent requirements for clinical trials, slower approval times and less chance of approval for me-too drugs.

Another result of the pharmaceutical industry's recent challenges is a new drive to establish a clinical trials registry. Despite some manufacturer complaints that making their trials public will give competitors unfair advantages, several have set up their own trial-information Web sites.

¹² Center for Drug Evaluation and Research. U.S. Food and Drug Administration. FDA Public Health Advisory. Suicidality in children and adolescents being treated with antidepressant medications. October 15, 2004. Available at: <http://www.fda.gov/cder/drug/antidepressants/SSRIPHA200410.htm>. Accessed March 11, 2005.

¹³ U.S. Food and Drug Administration. FDA Fact Sheet. FDA improvements in drug safety monitoring. February 15, 2005. Available at: <http://www.fda.gov/oc/factsheets/drugsafety.html>. Accessed February 15, 2005.

However, the medical establishment favors an independent repository (such as www.clinicaltrials.gov), which is designed to discourage selective reporting from drug trials and other medical studies. Although trial registration in an independent database is voluntary at this time, the International Committee of Medical Journal Editors has put pressure on pharmaceutical companies to comply. The group, which includes editors of major medical journals such as the *Annals of Internal Medicine*, the *Journal of the American Medical Association*, *Lancet* and the *New England Journal of Medicine*, instituted a new policy in 2004. These editors have stated that effective July 1, 2005, they will not accept for consideration study results that have not been registered in an independent database before patient enrollment begins. According to the group's criteria, the registry must be comprehensive, free, public, maintained by a nonprofit entity and open to all clinical investigators. In addition, it must have a mechanism for validating information, and readers must be able to search the contents electronically.

Dilemmas for the FDA and the pharmaceutical industry were not the only prescription-related issues that made news in 2004. Other dramatic developments may affect prescription-drug benefits for years to come. On the supply side, drug reimportation from Canada and other countries is an ongoing issue. One increasing concern with reimports is the potential for counterfeited drugs, a long-standing problem in many parts of the world. Estimated to affect about 10% of the world's prescription-drug supply, drug counterfeiting recently has become more visible in the U.S. The number of counterfeit drug cases investigated by the FDA increased from five in 2000 to 21 in 2003.¹⁴ In another area of rising concern, supplies of certain vaccines and some other drugs have been inadequate to meet current needs.¹⁵ On the policy side, federal budget cuts threaten to eliminate significant amounts of drug coverage under Medicaid — at the same time that Medicare reform will provide prescription-drug benefits for millions of seniors.

¹⁴ Cockburn R, Newton PN, Agyarko E, Akunyili D, White NJ (2005). The Global Threat of Counterfeit Drugs: Why Industry and Governments Must Communicate the Dangers. *PLoS Medicine* 2(4): e100. Available at: <http://www.plosmedicine.org/periserv/?request=get-document&doi=10.1371/journal.pmed.0020100>. Accessed March 14, 2005.

¹⁵ Marcus AD. Critical cancer drug faces shortage. *The Wall Street Journal*. March 15, 2005. Page D1.

MEDICARE MODERNIZATION ACT (MMA)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) is the most significant recent development affecting prescription-drug coverage in the U.S. MMA expands services for Medicare beneficiaries. Among its major provisions is Part D, which offers Medicare enrollees an optional outpatient prescription-drug benefit that is being implemented in two phases. Beginning in May 2004, enrollees were offered the choice of several prescription discount-card options. These discount programs remain active until either May 15, 2006, or the date that the beneficiary enrolls in a Part D plan, whichever is earlier. The interim cards provide up to an estimated 25% discount on prescription-drug purchases.¹⁶ The full-scale drug-benefit program will go into effect on Jan. 1, 2006. Under Medicare Part D, services will be provided by private plans that will assume some financial risk for the programs.

Exhibit 5

Summary of Medicare Benefits

PART	ALSO KNOWN AS	ENROLLMENT	BENEFICIARIES	COVERAGE
A	Hospital coverage	Automatic	Qualified disabled individuals and Social Security or Railroad Retirement recipients who are 65 or older	Inpatient hospital, nursing home, hospice
B	Supplementary medical coverage	Optional	Individuals entitled to Part A	Doctor's office visits, laboratory testing, outpatient hospital
C	Medicare Advantage (formerly Medicare+Choice)	Optional	Individuals entitled to Part A and enrolled in Part B who choose managed care rather than fee-for-service Medicare	HMO- or PPO-type health-plan coverage
D	Prescription-drug coverage	Optional	Individuals entitled to Part A and enrolled in Part B	Prescription-drug coverage

As shown in Exhibit 6, prescription-drug coverage under Medicare Part D is complex. It includes a monthly premium, a deductible, a copayment for partial coverage up to a specified dollar amount, an out-of-pocket period (the so-called "donut hole"), and then 95% coverage for expenses over a specified amount.

¹⁶ Centers for Medicare & Medicaid Services. Overview. Medicare prescription drug discount card and transitional assistance program. Last modified September 16, 2004. Available at: <http://www.cms.hhs.gov/discountdrugs/overview.asp>. Accessed February 15, 2005.

*Exhibit 6***Medicare Part D Prescription-Drug Coverage 2006
Defined Standard Benefit***

	TOTAL DRUG COST	MEDICARE PAYS	ENROLLEE PAYS**	OUT-OF-POCKET COST TO ENROLLEE
Deductible	Up to \$250	0	100%	Up to \$250
	\$251 to \$2,250	75%	25%	Up to \$750
"Donut Hole"	\$2,251 to \$5,100	0	100%	Up to \$3,600
	\$5,101 and up	95%	5%	\$3,600 and 5% of costs above \$5,100

* The defined standard benefit is the basic plan as outlined in the MMA. Plan sponsors may offer alternative benefits that provide equal or greater value to plan participants.

** Adapted from: Centers for Medicare & Medicaid Services. Alternative part D benefit designs and options for enhancing medicare drug coverage. Issue paper #31. January 19, 2005. Available at: http://www.cms.hhs.gov/medicarereform/issuepapers/title1and2/issue_paper_31_alternative_part_d_benefit_designs_and_options_for_enhancing_medicare_drug_coverage_.pdf. Accessed April 27, 2005.

Individuals eligible for Medicare Part A are also eligible for Part D. Enrollee contributions will be adjusted on an annual basis. Initial costs for each enrollee are shown in Exhibit 7, along with estimates of costs for 2015.

*Exhibit 7***Medicare Part D Enrollee Contributions**

	2006	2015
Drug Premium	\$35/month (est)	\$68/month (est)
Deductible	\$250/year	\$472/year (est)
Maximum Out-of-Pocket Cost	\$3,600	\$6,800 (est)

Sources: Connolly C, Allen M. Medicare drug benefit may cost \$1.2 trillion. *Washington Post*. February 9, 2005; Page A01; and A detailed description of CBO's cost estimate for the Medicare prescription drug benefit. The Congressional Budget Office. July 2004. Available at: <http://www.cbo.gov/ftpdocs/56xx/doc5668/Report.pdf>. Accessed February 9, 2005.

Plans that provide Medicare prescription-drug coverage will serve specified geographical regions. Enrollees who opt for drug coverage will have the choice of joining an integrated medical and prescription-drug plan (Medicare Advantage, also known as an MA-PD); or joining a prescription-drug only plan (PDP). Enrollees in each Medicare-defined region will be able to choose from at least two plans, one of which must be a PDP.

The Congressional Budget Office estimates that around three-quarters of Medicare Part B enrollees will also participate in Part D, with about one-fifth staying in employer-sponsored plans and the remaining individuals choosing either alternate forms of prescription insurance or no coverage.¹⁷

¹⁷ A detailed description of CBO's cost estimate for the Medicare prescription drug benefit. The Congressional Budget Office. July 2004. Available at: <http://www.cbo.gov/ftpdocs/56xx/doc5668/Report.pdf>. Accessed February 9, 2005.

Retirees cannot receive both Medicare Part D and prescription-drug coverage that is completely employer-sponsored. To reduce the possibility that employers might simply drop coverage for retirees when Part D becomes fully operational, MMA also provides incentives to companies that continue providing drug coverage.^{18,19} Options that employers may choose include:

- Maintaining the current plan and receiving a tax-free government subsidy to reimburse 28% of permitted drug costs for each Medicare-eligible retiree who does not enroll in Part D. The plan offered by the employer must be at least equivalent to Part D, and the subsidy will be capped at a maximum amount.
- Adapting the existing drug benefit to coordinate with (or wrap-around) Part D — probably by covering some Part D copayments and deductibles for retirees who choose to enroll in Part D.
- Paying the monthly premiums for eligible retirees who choose Part D.
- Contracting for prescription-drug coverage from a third-party PDP or MA-PD, or becoming a PDP or MA-PD.

As part of MMA, plans that provide Part D prescription-drug benefits will be required to support e-prescribing. Sending electronic prescriptions directly from the prescribing physician to the dispensing pharmacy adds extra dimensions of safety. Difficult-to-read handwriting is eliminated, and chances for alteration or loss of the prescription are minimized. Common access to the patient's prescription history also allows automatic checks for allergies, drug interactions and duplicate therapy at the point of prescribing, as well as at the dispensing pharmacy.

Private efforts are under way to accelerate the adoption of both e-prescribing and the use of electronic medical records — a priority issue for the current administration. Two organizations already exist to facilitate e-prescribing: RxHub[®], a joint effort of the three largest pharmacy benefit managers (PBMs), which handles the electronic transfer of information among

¹⁸ Deloitte. Employer response to Medicare part D prescription drugs — 2005 survey. BenefitsLink. January 10, 2005. Available at: http://www.benefitslink.com/articles/deloitte_part_d_survey.pdf. Accessed February 8, 2005.

¹⁹ Bakich K. Medicare prescription drug law requires new disclosures for retiree health plans. *Employee Benefit News*. December 2004.

physician offices, pharmacies and PBMs; and SureScripts, a similar company founded by the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association (NCPA). Additionally, America's big three car manufacturers — Chrysler, Ford and General Motors — announced in February 2005 their alliance with the three biggest healthcare insurers in Michigan. The car makers and the health plans hope to recruit as many as 17,000 physicians willing to initiate e-prescribing systems funded by the companies, as allowed in the MMA.²⁰

On the public-policy side, the U.S. Departments of Defense, Veterans Affairs, and Health and Human Services announced a collaboration in March 2005. Together, they will create a common set of standards for information-sharing among the health programs — including Medicare — that they oversee. Eight high-technology companies are working with the government to implement guidelines that will assure compatibility among computer systems and software. The new policies are set to take effect concurrently with the full-scale implementation of Medicare Part D prescription-drug coverage on Jan. 1, 2006.

PLAN ACTIONS

Even though the pharmaceutical landscape changed dramatically in 2004, many plan sponsors were able to manage prescription-drug trend. Plan sponsors most successful in controlling trend use a number of different programs that control costs while still preserving adequate coverage. Three-tier formulary programs remain popular, and nearly 70% of Express Scripts clients were using a three-tier formulary by the end of 2004. In a three-tier formulary, generic drugs are covered at the lowest copayment, formulary brands at a higher amount and nonformulary brands at the highest copayment. Among Express Scripts clients, more than 18% are now using Generics Preferred, our mandatory-generic plan design. An additional 49% use a restricted generic policy — Generics Preferred-Physician's Choice — which does not require the member to pay a higher amount if the doctor orders a brand drug.

²⁰ Porretto J. Wagoner: Medical costs huge competitive disadvantage. *Miami Herald*. February 10, 2005.

While formularies are the cornerstone of pharmacy-benefit design, the strategies that best control trend incorporate a variety of programs — all aimed at improving generic penetration. Generic-drug costs average approximately \$45 less than brand costs, and member copayments for generics average \$10 less than brand copayments.²¹ Trend programs should not be implemented abruptly, however. A phase-in approach, which adds programs over a multi-year time frame and uses frequent communications, minimizes member disruption. In addition, Express Scripts recommends that plan sponsors develop a trend strategy that gives members confidence in the continuing ability to afford maintenance drugs. Plan sponsors are advised to set overall member financial contributions between 20% and 35% of drug-ingredient cost.

Generic utilization can be driven by the use of home delivery for maintenance drugs. Across the Express Scripts book of business, each maintenance prescription filled through home delivery costs up to 10% less than the equivalent prescription filled at a local participating (retail) pharmacy. Exclusive Home Delivery, our mandatory-mail program, focuses on drugs that are appropriate for home delivery and results in total average savings of approximately \$35 per member per year (PMPY).

Many Express Scripts clients that initiated step-therapy programs during 2003 added more modules throughout 2004, and more clients adopted at least one step-therapy module. By the end of the year, more than 13 million members were enrolled in step-therapy plans, using an average of seven step-therapy modules. Each module focuses on appropriate utilization in one therapy class (such as antihypertensives) or subclass (such as non-sedating antihistamines). By implementing all the step-therapy modules that Express Scripts offers, some clients have saved 10% or more of overall drug spend through greater generic penetration.

For specific types of drug-delivery systems (such as eye drops or inhalers) that contain measured amounts of drugs or specific numbers of doses, quantity limits ensure that the amount of medication supplied is consistent with both clinical dosing guidelines and the plan sponsor's benefit design.

²¹ Geographic variations in generic fill rate. Express Scripts. No date given. Available at: <http://www.express-scripts.com/outcompany/news/outcomesresearch/onlinepublications/regionalgenericvariation/regionalgenericvariation.pdf>. Accessed February 28, 2005.

As detailed in the Pharmacy Benefit Guide section, quantity limits also help prevent billing errors. As part of the Drug Quantity Management program, Express Scripts also offers concurrent dose consolidation, which recommends a single unit of one drug strength in place of two units that are half that strength when the price for different strengths is similar. The recommendation is relayed to the dispensing pharmacy on the first fill of a new prescription. Some research has touted large savings from retrospective dose consolidation (using prescription claims to identify dose-consolidation opportunities after the prescription has been filled). Express Scripts researchers, however, found savings of only \$0.02 to \$0.03 per member per month (PMPM) for a retrospective dose-consolidation program after savings were calculated using realistic, partial-compliance rates and before administrative costs were considered.²² This research article received the *Journal of Managed Care Pharmacy's* Paper of the Year Award for 2004.

Client interest in newer and developing plan designs is also increasing. For example, as today's consumers are becoming more prepared to participate in healthcare decisions, plan sponsors are recognizing that its members can take more responsibility for those decisions. As a result, consumer-driven healthcare is receiving renewed attention. Express ChoiceSM (Express Scripts' consumer-oriented plan design) allows plan sponsors to offer multiple prescription-drug plans with varying degrees of management. Each member selects the most appropriate plan for his or her given situation. Those who choose more tightly-managed plan designs pay the lowest premiums and copayments, while those who select a richer benefit have higher associated costs. For the more than 2 million members enrolled in Express Choice, the result has been a significant reduction in drug spend while maintaining strong member satisfaction.

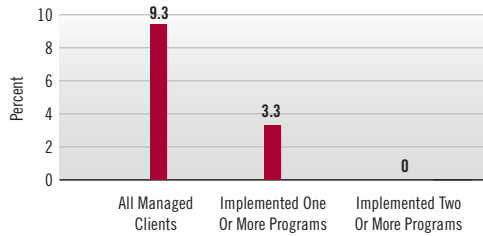
²² Delate T, Fairman KA, Carey SM, Motheral BR. Randomized controlled trial of a dose consolidation program. *Journal of Managed Care Pharmacy*. 2004;10(5):396-403.

TRENDS IN EXPENDITURES FOR PRESCRIPTION DRUGS

Express Scripts clients that used any trend-management program saw a trend increase of 9.3% in 2004. However, those implementing one or more programs for the first time in 2004 saw an average increase of only 3.3%, and those implementing two or more programs had no increase in drug spend (Exhibit 8).

Exhibit 8

Net Drug Trend From 2003 to 2004



MARKET TRENDS IN PRESCRIPTION-DRUG USE

In 2004, prescription-drug costs were affected by many of the same issues that influenced costs in 2003. Movement of key drugs to over-the-counter (OTC) status continued to affect the cost of antihistamines, cough and cold products, and gastrointestinals. This trend is not expected to abate as new strengths of products already available OTC continue to flood the market. Completely new products, never before available without prescriptions, are also expected to enter the OTC market within the next few years.

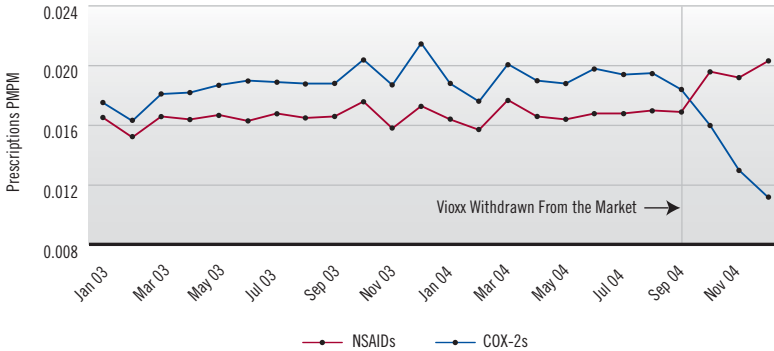
The second continuing trend was the increasing availability of generic alternatives to blockbuster brand drugs. By the end of the fourth quarter of 2004, trend-management programs implemented by Express Scripts clients also helped drive the generic fill rate to 52.7% for the Express Scripts book of business.

The third and potentially most significant issue affecting 2004 drug trend was the body of evidence showing that the long-term side effects of several classes or subclasses of drugs exceeded their treatment benefits. In 2004, information regarding the safety of COX-2 inhibitors led to the withdrawal of Vioxx from the market. Subsequently, utilization

of other COX-2s declined. Exhibit 9 shows the monthly cost of COX-2s and NSAIDs among Express Scripts clients in 2004. When examined on a quarterly basis, costs for the entire class were down 10.5% in the fourth quarter compared with the first-quarter baseline.

Exhibit 9

**Change in COX-2 and NSAID Prescriptions PMPM
January 2003 to December 2004**



Antidepressants also took a hit late in 2004 when the FDA issued a black-box warning on selective serotonin reuptake inhibitors (SSRIs) and selective norepinephrine reuptake inhibitors (SNRIs). The warning followed the results of repeated studies indicating that these antidepressant subclasses increase suicidal tendencies in children and teenagers. Exhibit 10 shows the prevalence of antidepressant use in children and adolescents for 2003 and the first half of 2004. The data, which reveal decreases in either prevalence or prevalence growth, signify the beginning of a trend that continued through the rest of 2004, contributing to the change in overall antidepressant use.

Exhibit 10

Change in Antidepressant Use Among Patients Under 20 Years of Age 2003 to 2004

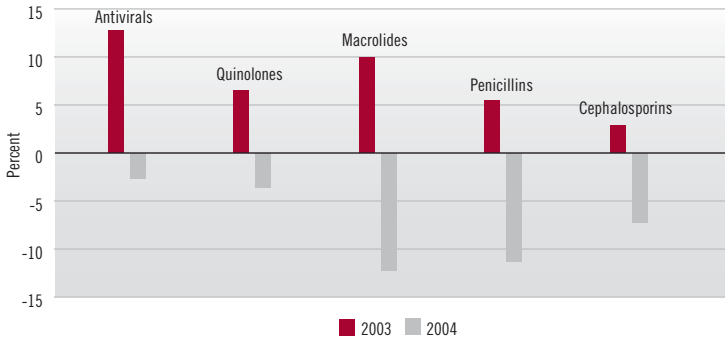
Age Group	PREVALENCE PER 100 CHILDREN						ABSOLUTE CHANGE QUARTER TO QUARTER IN PREVALENCE PER 100 CHILD BENEFICIARIES	
	Q1 2003	Q2 2003	Q3 2003	Q4 2003	Q1 2004	Q2 2004	Q1 03-Q1 04	Q2 03-Q2 04
0-4 yrs	0.049%	0.050%	0.043%	0.040%	0.036%	0.036%	-0.013	-0.014
5-9 yrs	0.555%	0.549%	0.527%	0.560%	0.579%	0.536%	0.024	-0.013
10-14 yrs	1.651%	1.687%	1.602%	1.738%	1.818%	1.741%	0.167	0.054
15-19 yrs	3.244%	3.309%	3.176%	3.431%	3.577%	3.430%	0.334	0.121
0-19 yrs	1.473%	1.499%	1.433%	1.547%	1.612%	1.541%	0.139	0.041

Source: Express Scripts Research — October 2004

Also in 2004, fallout from concerns about the safety of estrogens continued, and estrogen use declined by almost 20%. As a result, the estrogens class dropped out of the top 25 therapy classes. At the same time, the miscellaneous endocrines class, which includes several drugs used to treat the same conditions as estrogens, grew only 8.8% — a far cry from the explosive growth of more than 20% seen in each of the previous three years. Part of the high miscellaneous endocrines trend in previous years was due to the inclusion of drugs now considered in the specialty drug class. However, the relatively low use of these products compared with other drugs in the class indicated that the majority of the trend was due to higher use of non-specialty products. Both classes are returning to more natural utilization rates after estrogens fell dramatically out of favor and patients flocked to miscellaneous endocrines for treating osteoporosis.

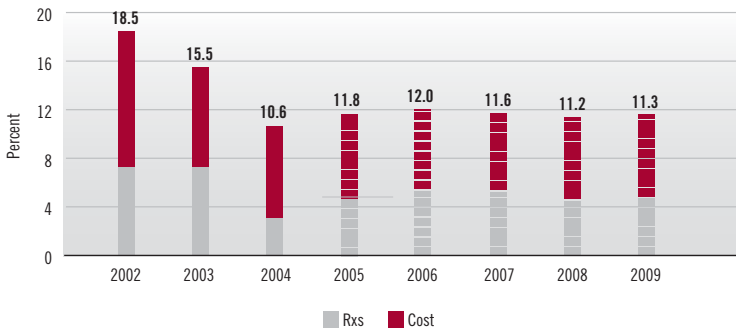
The fact that 2004 was a “healthier” year than 2003 received much less publicity than OTC releases and safety concerns, but it probably had a bigger impact on overall utilization. Exhibit 11 shows the monthly PMPY utilization for five classes of drugs that are usually taken to treat acute conditions. Included are antivirals, quinolones and macrolides — three classes in the top 25 for both 2003 and 2004. Antiviral drug patterns are particularly compelling. Consisting of drugs used to treat conditions as diverse as the flu and HIV, the antivirals saw a large increase for flu treatment in 2003. Flu drugs are typically taken for short durations. In 2004, short-term antiviral drug use was much lower, contributing to the negative 15.3% prevalence change. Quinolones and macrolides, classes used to treat bacterial infections, saw declines of 3.6% and 12.2%, respectively. Decreases in the use of quinolones and macrolides were not offset by corresponding increases in common first-line antibiotics, such as cephalosporins or penicillins. In fact, utilization of cephalosporins and penicillins declined at rates similar to those for other acute drug classes, with respective drops of 7.2% and 11.3%.

Exhibit 11

Changes in the Use of Acute Drug Classes 2003 to 2004

While the trend-management programs detailed in the Pharmacy Benefit Guide section of this Report have shown their ability to control or decrease drug trend, unmanaged trend is expected to continue in double digits. Our projections for the increases in unmanaged PMPY ingredient costs are shown in Exhibit 12.

Exhibit 12

Increases in Unmanaged PMPY Cost 2002 to 2004 (Actual), 2005 to 2009 (Projected)**METHODS**

The analyses included in the *2004 Drug Trend Report* are based on prescription-drug use for a sample of approximately 3 million unique individuals, all members of commercial plans that maintained individual member-eligibility data in both 2003 and 2004. These clients used Express Scripts for both participating-pharmacy and home-delivery services. They also offered a funded benefit, meaning that the client

paid at least some portion of the cost for prescriptions dispensed to its members. Medicaid recipients and Medicare beneficiaries receiving drug coverage through prescription-discount cards are excluded from this study because of their unique demographics and drug-coverage policies. About 70% of the resulting 2004 sample consists of nonmanaged-care commercial members, and about 30% are members of commercial managed-care plans.

Cost data included in the Trend and Therapy Class Review sections are expressed on a discounted Average Wholesale Price (AWP) ingredient-cost basis only. AWP is the retail list price of the medication as reported by First DataBank. Dispensing fees, administrative fees, member contribution and rebates are not included in the cost calculations. Brand and generic discounts are representative of average rates charged across the Express Scripts book of business. It should be noted that while all generics are discounted at the same rate in this Report, actual generic discount rates can vary significantly for specific products. Also, in order to eliminate the impact of any changes in discounts from year to year, the same discount percentages were used in both years.

As in previous Reports, prescription counts have been converted to equivalent quantities that would have been dispensed through participating pharmacies to adjust for differential home-delivery use rates and varying benefit structures. Drugs sold OTC and prescriptions dispensed in inpatient settings are not included in this analysis. In a departure from previous years, drugs that Express Scripts places in the specialty class have been excluded from the final calculations.

Drugs were categorized into therapy classes — groups of pharmaceutical agents that are chemically or therapeutically related. Therapy classes were defined by the first two digits of the 14-digit Generic Product Identifier (GPI) code maintained by the Facts and Comparisons division of Wolters Kluwer Health.