



# September 2009 Monthly Newsletter

## FEATURED ARTICLES

### **Pharmaceutical Manufacturers Gearing Up for Potential Methodology Changes in 2010: HR 3200**

By Lauren Pellicciotti, CIS Compliance Manager

[laurenpellicciotti@cis-partners.com](mailto:laurenpellicciotti@cis-partners.com)

On July 14, 2009, HR 3200, The Affordable Health Choices Act was introduced by Senator John D. Dingell, D-MI. According to the proposed bill, several amendments will be made to the Social Security Act related to payment, coverage, and access with regards to healthcare in the United States. Two of the primary purposes of this new legislation are to expand coverage to more Americans, and to decrease costs incurred by all participants. The primary provisions include, but are not limited to, reducing payments to hospitals to account for excess readmissions, limiting cost-sharing for Medicare Advantage beneficiaries, reducing the coverage gap under Medicaid Part D, providing for increased payment for primary health care services, and prohibiting cost-sharing for covered preventive services.<sup>1</sup>

Amidst the current healthcare debate that fills the daily papers, manufacturers may want to pay attention to the "incremental" changes that are part of HR3200. These changes, if enacted into law, will impact the Federal Programs in which manufacturers participate and, as a result, may have a financial impact on manufacturers. Many of these proposed changes have been seen in various forms of legislation in prior years but may now have more political traction.

An important starting point to reviewing these changes is the proposed budget for 2010, where President Obama outlined his objectives and associated costs for healthcare reform, and detailed changes to the programs in the Financing section, such as raising the base Medicaid rebate. The proposed Omnibus Budget for 2010 estimates the cost of healthcare reform at \$633.8 billion over a 10 year period. The Financing section defines how approximately \$316 Billion of that will be financed, and includes many incremental changes that could have a significant financial impact on manufacturers.

A related issue to keep in mind is the court injunction of Average Manufacturer Price ("AMP"), which was brought by the retail pharmacy industry. Their position is that the definition of AMP in the Final Rule did not accurately reflect the net retail price and should not be used as the basis for reimbursement. This is

important because HR 3200 also redefines some components of AMP and, as a result, manufacturers may see multiple changes to its definition. This may be cause for concern, not only for the financial impact, but also the administrative impact. Pharmaceutical manufacturers are just now settling in with the changes required from the Deficit Reduction Act. They are now questioning how to prepare for the changes to their systems, documentation, methodology, and overall operations that may be required if HR 3200 is passed.

The summary below details the proposed changes in HR3200 that are relevant to manufacturers:

- 1. Payments to Pharmacists.** Current rules for Medicaid payments to pharmacists for multiple-source drugs will be extended through December 31, 2010. Thereafter, payments will be limited to 130% of AMP. In addition, HR 3200 redefines AMP to exclude certain price concessions, including those produced to the Pharmacy Benefit Managers and not passed through to retail pharmacies.
- 2. Medicaid Rebates.** The minimum rebate for brand-name drugs purchased by State Medicaid programs will be increased from 15.1% to 22.1% of AMP, effective January 1, 2010.
- 3. Medicaid Managed Care Organizations (MCO).** Manufacturers will be required to pay rebates to State Medicaid programs for drugs dispensed to Medicaid MCO beneficiaries, effective July 1, 2010.
- 4. Medicare Part D donut hole.** To eliminate the donut hole in Medicare Part D by 2011, pharmaceutical manufacturers will be required to provide Medicaid rebates for drugs dispensed to beneficiaries who are eligible for Medicaid and Medicare.
- 5. Discounts for select Medicare Part D drugs.** The voluntary Pharmaceutical Research and Manufacturers of America (PhRMA) agreement provides discounts of 50% for brand-name drugs used by Medicare Part D enrollees.
- 6. Out-of-Pocket cost for AIDS Drug Assistance Programs and Indian Health Service coverage.** The additional costs that are incurred by these programs will allow individuals to qualify for Medicare Part D catastrophic benefits.

## FEATURED ARTICLES

**Pharmaceutical Manufacturers Gearing Up for Potential Methodology Changes in 2010: HR 3200**

By: Lauren Pellicciotti

**A Quick Look at the 340B Program Improvement and Integrity Act of 2009**

By: Matt Hotz

**Healthcare Reform and Medicaid**

By: Scott Hoffman

**AMP and BP Methodology Changes are a GO!**

By: Debbe Saez

**Thousands Roll Up Their Sleeves for a Shot of the H1N1 Flu Vaccine**

By: Kimberly Gilbert

**Patient Compliance: Did You Take Your Medication Today?**

By: Suzanne Tavares

Continued from Page 1...

The Senate Health, Education, Labor, and Pensions (HELP) Committee has also introduced legislation similar to HR3200, The Affordable Health Choices Act. However, there are differences in the Senate's approach. One significant difference is that Medicaid will be expanded to include all Americans with incomes of up to 150% of the federal poverty level.<sup>2</sup>

It is important to note that there are several areas addressed in both proposals other than those highlighted here. What is evident from both pieces of proposed legislation, and the growing public interest in them, is that our nation will most likely see healthcare reform in the near future. The nature of that reform, whether it is universal healthcare, whether it includes a public option or only incremental changes to the current state, has yet to be determined.

CIS continues to monitor and analyze both the House and Senate bills and related proposed legislation. If you want to know more about this issue, what it could mean to pharmaceutical manufacturers, and what you can do during this interim phase, please contact CIS.

**Sources:**

<sup>1</sup> Summary of the Bill: <http://www.govtrack.us/congress/bill.xpd?bill=h111-3200&tab=summary>

<sup>2</sup> <http://i2.cdn.turner.com/cnn/2009/images/08/14/senate.health.care.bill.pdf> p. 37

## A Quick Look at the 340B Program Improvement and Integrity Act of 2009

By Matt Hotz, CIS Senior Compliance Associate

[matthotz@cis-partners.com](mailto:matthotz@cis-partners.com)

The 340B Program Improvement and Integrity Act of 2009, known as S.1239 [1] in the Senate, would bring some significant changes to the 340B program if enacted. Sponsored [2] by Sen. Jeff Bingaman [D, NM], the bill has been referred to the Senate Committee on Health, Labor, Education, and Pensions for review.

To familiarize our clients and blog readers with the bill and the changes it could bring, CIS has prepared a summary of the proposed changes and what these changes could mean to you.

**Key changes in the bill include:**

- 1. More Covered Entities** – Several new types of facilities, including Children's Hospitals and Disproportionate Share Hospitals, would be eligible to participate as covered entities in the program.
- 2. Broader Coverage** – Discounts would be expanded to cover drugs prescribed in both inpatient and outpatient settings. Currently, the 340B program only covers drugs prescribed in an outpatient setting.
- 3. Integrity and Program Management Improvements** – More administrative structure will be implemented on the management of the program, including guidance around calculations and restatements, and more scrutiny and oversight of manufacturers, wholesalers, and covered entities

**Key components to improve the management and integrity of the program include:**

1. Pricing data submitted by manufacturers will be more closely scrutinized.
2. Recalculations and resubmissions may be required of manufacturers in cases of overcharging covered entities.
3. The Office of Pharmacy Affairs (OPA) will be authorized to establish standard methodologies for calculating prices and to develop a process for handling recalculations and resubmissions.
4. Selective proactive audits of manufacturers and wholesalers may be conducted.
5. Sanctions will be imposed on manufacturers and wholesalers in cases of knowing and intentional overcharging.
6. Sanctions will be imposed on covered entities in cases of knowing and intentional fraud, including the possibility of removal from the 340B program.

Continued on Page 3...

Continued from Page 2...

**Potential impact for manufacturers could include:**

1. Manufacturers may have to revise their PHS policies and procedures to match the standardized methodologies that could be established by the bill, potentially increasing their administrative costs.
2. Manufacturers may also need to calculate two Average Manufacturer Prices (AMPs), one for Medicaid and one for the PHS program. This is one of the biggest areas of uncertainty as there are pending legislative changes with regards to the calculation of AMP on the Medicaid side as well.
3. Administrative costs may increase in cases where recalculations and/or resubmissions are required.
4. The audit risk may increase with increased oversight.
5. Financial exposure may increase with the establishment of sanctions for fraud.
6. Revenues may decrease as the expansion of discounts are required to both inpatient and outpatient eligible entities.

A slightly different version of this bill (HR444) is circulating in the House of Representatives<sup>3</sup>, but the two bills are very similar in both content and their implications for the industry. The main points of both bills are covered in this primer.

CIS continues to monitor and analyze both the House and Senate bills and related proposed legislation. If you want to know more about this issue, what it could mean to pharmaceutical manufacturers, and what you can do during this interim phase, please contact CIS.

**Sources:**

<sup>1</sup> S. 1239: [http://thomas.loc.gov/home/gpoxmlc111/s1239\\_is.xml](http://thomas.loc.gov/home/gpoxmlc111/s1239_is.xml)

<sup>2</sup> Press Release from the Office of Sen. Jeff Bingaman regarding S. 1239: <http://bingaman.senate.gov/news/20090611-02.cfm>

<sup>3</sup> H.R. 444: [http://thomas.loc.gov/home/gpoxmlc111/h444\\_ih.xml](http://thomas.loc.gov/home/gpoxmlc111/h444_ih.xml)

## Healthcare Reform and Medicaid

By Scott Hoffman, CIS Senior Compliance Associate

[scotthoffman@cis-partners.com](mailto:scotthoffman@cis-partners.com)

One of the big issues facing the pharmaceutical industry today is the Obama Administration's mission to bring about healthcare reform. Regardless of your stance on the issue, you have most likely seen all of the news stories detailing everything from the specifics of a government-backed insurance plan, to an \$80 billion deal with the pharma industry, to the supposed effects reform will have on tax payers. While all of these issues are interesting and make for great news, they are mostly speculative and are meant to influence public opinion one way or another. However, in all of my research I noticed one area being largely ignored: Medicaid. Considering the fact that this program is a very large component of today's healthcare and pharmaceutical environment, I am surprised at the lack of coverage it has received to date.

Over the years, Medicaid has been growing at a rate faster than the US economy at large. Medicaid currently represents 7% of the federal budget, and is projected to account for roughly 8.5% by 2013. Total Medicaid expenditures on benefits reached \$329.4 billion in 2007, and according to the Office of the Actuary, they are predicted to increase at an average of 8% to 9% per year for the next 10 years, reaching \$735.2 billion by 2017<sup>1</sup>. With states already facing budget shortfalls (roughly 48 states are facing shortfalls of about \$166 billion, or 24% of their total budgets<sup>2</sup>), the amount of these expenditures could cripple the financial solvency of not only the states, but also the federal government. Current healthcare reform proposals discuss basing eligibility on an income-earned basis, which would make roughly 11 million more people eligible for Medicaid. These new eligible individuals would result in approximately \$438 billion in new costs over a 10 year period, of which the federal government would subsidize only 5 years, leaving the states to pick up the tab for the remaining years<sup>2</sup>. Based on the states' current budget shortages, this is not something they will likely be ready to do. In light of this issue, the states are going to do everything in their power to try and drive down the cost of the programs; and that is where the effects to the manufactures begin.

Continued on Page 4...



Continued from Page 3...

The most important effect on manufacturers would be to the rebate amounts paid under current health plans. Under the current Medicaid Drug Rebate Program, manufacturers' Medicaid rebates are calculated as Average Manufacturers Price (AMP) less 15.1%. Based on the President's budget, that rate could change as soon as 2010, with the new minimum Medicaid rebates increasing from AMP less 15.1% to AMP less 22.1%. The rebates would also be extended to Medicaid managed care organizations<sup>3</sup>. In addition, the rebates would be extended not only to the commercial health plans delivering Medicaid, but also to the 9.6 million individuals who used to get their drugs via Medicaid, but now do so via the less-stringently-discounted Medicare programs<sup>4</sup>. Don't overlook the fact that the potential new mandated minimum Medicaid rebate will also affect the rebates to the dual-eligible population in Medicare. If Medicaid is getting additional discounts, you can be assured the insurers under these plans will also want some kind of additional discount for their customers<sup>4</sup>.

Pennsylvania governor Ed Rendell said, "We would all like to see some federal policy where everyone in the country has access to health care. It's a noble goal. The real question, however, is who should have to pick up the tab<sup>2</sup>." In my own opinion, with federal government debt rising and states already facing budget issues, pharmaceutical manufacturers and taxpayers will be expected to pick up "their share" of the tab.

**Sources:**

<sup>1</sup> This Is Going to Hurt, August 12, 2009

<http://pharmexec.findpharma.com/pharmexec/Web+Exclusives/This-Is-Going-to-Hurt/ArticleStandard/Article/detail/618558?contextCategoryId=47505>

<sup>2</sup> Medicaid and the States: Health-Care Reform's Next Hurdle, July 21, 2009

<http://www.time.com/time/politics/article/0,8599,1911856,00.html>

<sup>3</sup> Fiscal Year 2010 Budget in Brief – Medicaid

<http://www.hhs.gov/asrt/ob/docbudget/2010budgetinbriefm.html>

<sup>4</sup> Brace yourselves for likely Medicaid cuts, August 13, 2009

<http://www.fiercepharma.com/story/brace-yourselves-likely-medicaid-cuts/2009-08-13>

## AMP and BP Methodology Changes are a GO!

By **Debbe Saez**, CIS Senior Compliance Manager

[debbesaez@cis-partners.com](mailto:debbesaez@cis-partners.com)

Do you remember when there was no limit on how many quarters a manufacturer could recalculate AMP or BP? That was more than 6 years ago. On August 29, 2003, CMS issued a final rule, CMS-2175-FC<sup>1</sup>, which implemented the limitation on AMP and BP recalculations to a period not to exceed 12 quarters from the quarter in which the data is due. As clear as that rule is, there were still open questions about AMP and BP recalculations. Does the manufacturer always need CMS' approval to recalculate? What methodology changes, if any, don't require prior approval? What about pending requests for approval of methodology changes?

To clarify some of these questions, CMS issued guidance in Drug Manufacturer Release #78<sup>2</sup> on July 26, 2007. More recently, on August 26, 2009, CMS posted changes to this guidance in the form of a Spotlight on the Policy & Reimbursement section of CMS' website<sup>3</sup>. The table below highlights the key points from Release 78 and the Guidance in the Spotlight.

Continued on Page 5...

Continued from Page 4...

Topic	Release 78 (July 26, 2007)	Spotlight (August 26, 2009)
Treatment of pending recalculation requests due to methodology change...	Implement methodology changes prospectively.	Requests submitted to CMS <b>before</b> the 12-quarter limitation took effect:  Retroactive requests for methodology changes may be implemented, without prior review and approval from CMS, for the period specified in the request.  Requests submitted to CMS <b>after</b> the 12-quarter limitation took effect:  Manufacturers may implement changes and recalculate for a period not to exceed 12-quarters.  (Contact Tamara Bruce at <a href="mailto:MDROperations@cms.hhs.gov">MDROperations@cms.hhs.gov</a> )
New recalculation requests, after the date of the respective guidance, due to methodology changes...	Implement the change on a <b>prospective</b> basis without review by CMS.  Wait for approval from CMS before making <b>retroactive</b> changes.	Both prospective and retroactive changes can made without prior approval by CMS.  Manufacturers are requested to notify CMS of the methodology change.  Retroactive changes are still subject to the 12-quarter limitation.
Additional notes...	None	CMS suggests that manufacturers work with States to prevent undue burden of rebate overpayment recovery.  CMS also suggests limiting the recovery of overpayments to 25% of the rebate payable in quarter.

Until now, manufacturers could not make retroactive methodology changes to their AMP and BP calculations without approval. The downside to this was that with the passing of each quarter, another quarter would fall out of the period available to implement the changes. Now that this is no longer an issue... let the recalculations begin!!

**Sources:**

- <sup>1</sup> <http://edocket.access.gpo.gov/2003/pdf/03-21548.pdf>
- <sup>2</sup> [http://www.cms.hhs.gov/MedicaidDrugRebateProgram/03\\_DrugMfrReleases.asp](http://www.cms.hhs.gov/MedicaidDrugRebateProgram/03_DrugMfrReleases.asp)
- <sup>3</sup> [http://www.cms.hhs.gov/Reimbursement/02\\_Spotlight.asp](http://www.cms.hhs.gov/Reimbursement/02_Spotlight.asp)

## Thousands Roll Up Their Sleeves for a Shot of the H1N1 Flu Vaccine

By Kimberly Gilbert, CIS Compliance Manager

[kimberlygilbert@cis-partners.com](mailto:kimberlygilbert@cis-partners.com)

When considering participating in a clinical trial for an investigational medication, some people might first think of themselves as being a “guinea pig” or need to ask themselves, “do the benefits outweigh the risks” and opt not to participate. However, when faced with the choice to be a participant in a clinical trial testing the new H1N1 flu vaccine, it appears to be a no-brainer. Thousands of volunteers are rolling up their sleeves to participate in clinical studies testing the new H1N1 flu vaccine. The vaccine has been developed in the hopes of stopping the virus known as the “swine flu” that has sparked a global pandemic, killing more than 1,154 people, including at least 436 in the United States, and has been linked to at least 6,506 hospitalizations<sup>3</sup>. According to the World Health Organization, at least 168 countries and territories have reported cases of H1N1 flu, and additional cases are popping up so quickly that national and international agencies have stopped counting<sup>3</sup>. Without vaccination, more than half of the U.S. population could become infected by the virus, with more than a third becoming ill, perhaps seriously, according to estimates by leading influenza researchers<sup>3</sup>. The initial clinical trials for the flu vaccine are considered the “fast-track tests” and must be completed before nationwide distribution of the vaccine can begin, which is currently targeted for mid-October. The goal of the fast track clinical trials, which will take weeks instead of months, is to beat the fall and winter flu season<sup>3</sup>.

Continued on Page 5...

Continued from Page 5...

The clinical trials are being conducted at eight Vaccine Treatment and Evaluation Units across the United States. As many as 2800 volunteers nationwide are expected to participate in five trials of vaccines produced by two manufacturers, Sanofi Pasteur and CSL Biotherapies. The main endpoint of the trials is to see how much vaccine it takes to elicit a strong enough immune response to beat the new virus. Testing began in early August on healthy adults ages 18 to 64, and was followed by shots for volunteers older than 65 and children ages 6 months to 17 years<sup>3</sup>. Participants in the clinical trials receive their first shot of the vaccine and then return eight days later to the study site for blood tests, which will show if they have developed antibodies that indicate they have an immune response to the virus. The participants then return two weeks later for a second injection of the vaccine. There has been no shortage of volunteers willing to participate for a chance to receive immunity from this deadly virus. In fact, at one clinical trial site in Baltimore, the response for volunteers was so overwhelming that they had to use a lottery system to pick the final participants for inclusion into the study<sup>2</sup>.

The clinical trials will test whether one or two shots of the vaccine, at both 15-microgram and 30-microgram doses, are necessary to stimulate immune system protections against the virus. Other studies will determine whether it is safe to give the seasonal flu vaccine along with the H1N1 flu vaccine in adults and children<sup>3</sup>. These studies will also investigate the best time to give the vaccine: before, during, or after the typical vaccination schedule for the seasonal flu<sup>2</sup>. The studies are necessary because so little is known about the pandemic vaccine, though many researchers believe it is likely to act much like seasonal vaccines<sup>1</sup>. The new vaccine is very similar to the seasonal flu vaccine, only with the new strain of the virus added. Researchers expect it to be as safe as the regular shots, with only mild side effects, such as fever in children or redness at the injection site (historically, flu vaccines have had few other side effects). Health officials note that there is no danger that the vaccine will induce flu because it contains only parts of the inactivated virus<sup>3</sup>. Studies of several thousand volunteers are not large enough to determine if more subtle side effects such as Guillain-Barré syndrome, a rare nerve ailment that crops up in one of every million flu vaccine recipients, will be more prevalent. Federal health agencies have ramped up their surveillance efforts to detect any severe side effects that might occur<sup>1</sup>. In a matter of weeks, researchers will have more data about how many doses of the vaccine are needed to be effective. Although the final results for the clinical trials are not expected to be available until late September, United States health officials have predicted that they expect most people would need three flu shots this year: a single shot of the seasonal flu vaccine, followed by two doses of the H1N1 vaccine, given 21 days apart<sup>3</sup>.

If all goes well, US health officials expect to use approximately 200 million doses of the vaccine, which could pose a potential problem since supplies of the vaccine are expected to be scarce, especially in the early weeks<sup>4</sup>. Health officials have recommended that pregnant women, health care workers, children and young adults ages 6 months through 24 years be first in line to receive the vaccine. Parents and, other caregivers of infants and non-elderly adults, with high-risk medical conditions are also on the priority list of people to receive the first vaccines<sup>3</sup>. At this point in time, it seems that the best option is to try to win the lottery and be a clinical trial participant. In my opinion, the benefits definitely outweigh the risks!

**Sources:**

- <sup>1</sup> [http://www.usatoday.com/news/health/2009-08-10-swine-flu\\_N.htm](http://www.usatoday.com/news/health/2009-08-10-swine-flu_N.htm)
- <sup>2</sup> <http://www.baltimoresun.com/health/bal-md.flu11aug11.0.68784.story>
- <sup>3</sup> [http://www.msnbc.msn.com/id/32334093/ns/health-swine\\_flu/](http://www.msnbc.msn.com/id/32334093/ns/health-swine_flu/)
- <sup>4</sup> <http://www.npr.org/templates/story/story.php?storyId=111764500&ft=1&f=1001>

## Patient Compliance: Did You Take Your Medication Today?

By Suzanne Tavares, CIS Compliance Director

[suzannetavares@cis-partners.com](mailto:suzannetavares@cis-partners.com)

You have a sinus infection and the physician prescribes a 10 day course of antibiotics. After 5 days you feel fine and stop taking the medication. How many times have you, or someone you know, done the same thing?

Medication non-compliance results from patients not properly following the instruction traditionally provided by physicians and/or pharmacists. Unfortunately, non-compliance with medication instructions is a costly problem. In the US, patients with serious chronic diseases such as heart disease, diabetes, cancer and depression average only about a 50% compliance rate and, even worse, 33% of their prescriptions are never filled<sup>1</sup>. When patients do not fill their prescriptions or take them as directed, the efficacy of the medication cannot be demonstrated, and the patient does not receive the intended results from treatment with the medication.

Aside from patients not getting the full benefits of their medications, and wasting their precious health care dollars, the Pharmaceutical industry pays a significant price as well. For medication non-compliance, it is approximated that the cost to pharmaceutical companies globally is about \$30 billion a year<sup>1</sup>, and the cost to the US health system as a whole is estimated at \$100 billion dollars a year<sup>2</sup>.

Pharmaceutical marketers are all too familiar with the issues of patient non-compliance. They know that high compliance rates contribute to building the bottom line; they generate increased revenue and brand success. So what are they doing to ensure compliance?

Marketers realize that there is a strong link between patient segmentation and increased compliance, and that increasing patient segmentation will have a positive effect on patient compliance. Marketers traditionally analyze the clinical impact of compliance as well. Marketing programs, in the form of direct to consumer (DTC) advertising, patient call centers, and coupon incentives, are developed, in part, to increase patient compliance<sup>3</sup>.

Continued on Page 7...



Continued from Page 6...

Clinical Research and Development (R&D) teams can contribute to patient compliance as well. One way for researchers to increase compliance is by developing extended release medication that patients take less frequently than traditional formulations. The thinking is that patients will be more likely to take their medicine as prescribed when they only have to take one pill a day, as opposed to two or three. Creating different delivery mechanisms has been shown to increase patient compliance<sup>4</sup>.

Technology can play a role in increasing patient compliance as well. Short Messaging Services (SMS) let patients know how, when, and at what dose to take their medication<sup>1</sup>. Filling automatic teller machines (ATMs) with prescription drugs may sound bizarre, but this technology is supporting patient compliance as well. To boost its patient compliance rate, an urgent care clinic in Oklahoma put an ATM-like machine in their office. Instead of dispensing money it dispenses the medications prescribed by the clinic's physician. Here, patients can see a doctor, get a prescription written and get it filled in one place – one stop shopping.

Additional focus on compliance will come from the health care system. As doctor and hospital reimbursement trends swing from reimbursing physicians, based on the amount of tests and treatments a patient receives, to reimbursing them based on positive patient outcomes, patient compliance issues will become more evident.

In conclusion, non-compliance with prescription medications is costly and detrimental to your health. So when the doctor says take your medicine, take it (all of it) and everyone will benefit.

**Sources:**

<sup>1</sup> <http://www.dtcperspectives.com/content/editor/files/PatientCompliancePrograms.pdf>

<sup>2</sup> <http://health-care-it.advanceweb.com/editorial/content/editorial.aspx?cc=190851>

<sup>3</sup> <http://social.eyeforpharma.com/story/patient-segmentation-improved-compliance-and-better-brand-management>

<sup>4</sup> <http://www.iptonline.com/articles/public/IPTTWELVE80NoPrint.pdf>

<http://gp.cis-pcx.com/>

<http://clinical.cis-pcx.com/>

<http://sales.cis-pcx.com/>

You are receiving this newsletter because you signed up for it online.  
If you would like to subscribe or unsubscribe, please contact Jackie O'Connor at [jacquelineoconnor@cis-partners.com](mailto:jacquelineoconnor@cis-partners.com).