task. More reasonably, it would be advisable for the pharmacist to research why a medication may not be a benefit and provide a broader perspective to the patient. In addition, while we do agree that contacting one's MLA with any type of concern is meritorious, your suggestion to have patients tell their MLAs that decisions to cover medications are not based on evidence is erroneous and misleading. That there is bias in government decisions on drug benefits is not a stance that pharmacists should be promoting, particularly as a foundation of our profession is evidence-based medicine.

In terms of what pharmacy organizations can do, an important distinction needs to be made between clinical guidelines and formulary listings. Clinical guidelines are based on clinical evidence, and most do not take cost into consideration, whereas decisions to list medications on formularies must include both clinical effectiveness and cost-effectiveness. Of course, cost-effectiveness should be considered with drugs as well as any other health intervention. To do otherwise risks inappropriate use of health care resources. As clinicians and tax payers, how could we suggest otherwise?

We fully agree with the point you raised that describes pharmacists as drug experts. However, most pharmacists do not have the time to fully evaluate the literature on which a formulary recommendation is based, nor do most pharmacists have a strong background in pharmacoeconomics to determine if a drug is cost-effective or not. A critique of the evidence and pharmacoeconomics is the process undertaken by drug plans before a listing decision is made. Prior to pharmacy organizations advocating that pharmacists should be the ones deciding if drugs make it onto formularies or not, we feel pharmacists should become familiar with the evidence that has led to those listing recommendations.

Last, there are instances in your article where you suggest pharmacy organizations partner with disease-based charities

or meet with pharmaceutical companies for more information. Yes, these are worthwhile activities to stay up to date and ensure patients receive the best care. However, it is important to distinguish between what their roles are and the roles of pharmacists and pharmacy organizations. Evidence-based medicine is at the core of our profession, and if the evidence, or lack thereof, points to a medication not being cost-effective, then that decision should be supported and communicated to patients, so that we may help them find other solutions. We agree that there are special situations where individual requests can and should be made to drug plans or to manufacturers to try and get medications covered for some of our patients. This is an area where pharmacists can work with their patients, physicians, industry and the drug plans.

This is an important issue and one that we should keep talking about—agreed. Rising drug (and health care) costs are not going away. Hence, we feel it is important that it is recognized that decisions to list (or not) medications on formularies are done with due diligence and based on the best possible evidence available. ■

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Authors' response

Thank you to those who took the time to write to us. This kind of discussion is needed.

We would like to reiterate our main point, which is that drug costs are a small fraction of the health care budget, yet are sometimes unfairly targeted for their contribution to health care costs, and pharmacists get caught in the middle.

High-quality evidence must be the core of formulary and coverage decisions (they aren't always). Finally, it is most certainly the role of pharmacists to advocate for their patients when it comes to access to proven efficacious therapies. To suggest less assertive approaches is a step backwards for pharmacy practice and repudiates our societal responsibility. ■

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