STROUDWATER

UNLOCKING THE POTENTIAL OF 340B: OVERVIEW, THREATS & OPPORTUNITIES

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PILLR HEALTH

AGENDA

1. Review the fundamentals of 340B
2. Recent developments: new legislation, ongoing litigation, and regulatory action
3. Explore practical strategies to optimize capture rates and minimize exposure
4. Examine the value and development of in-house pharmacies
5. Identify emerging trends in outpatient infusion, telehealth, and specialty pharmacy

POLL QUESTION

- What type of organization do you represent?
  - Hospital (CAH or SCH), Hospital (DSH), Hospital (Not 340B), Other
- What is your role?
  - CEO / CFO / COO
  - VP/Director or clinical leader
  - Pharmacy director or 340B leader
  - Other

340B DRUG PRICING PROGRAM OVERVIEW

WHAT IS THE 340B DRUG PRICING PROGRAM?

- Established in 1992, the 340B program requires pharmaceutical manufacturers to discount “covered outpatient drugs” for 340B covered entities, as a condition of Medicaid coverage for those drugs.
- To be eligible, an entity must meet specific criteria – either to be an entity that is eligible by statute (HRSA grantees, including FQHCs, Ryan White clinics, and critical access hospitals) or be a non-profit hospital that serves a disproportionate share of low-income and uninsured patients.
- All participating hospitals must be either private non-profit institutions or publicly owned

Covered entity types for 340B hospitals (after 2010)

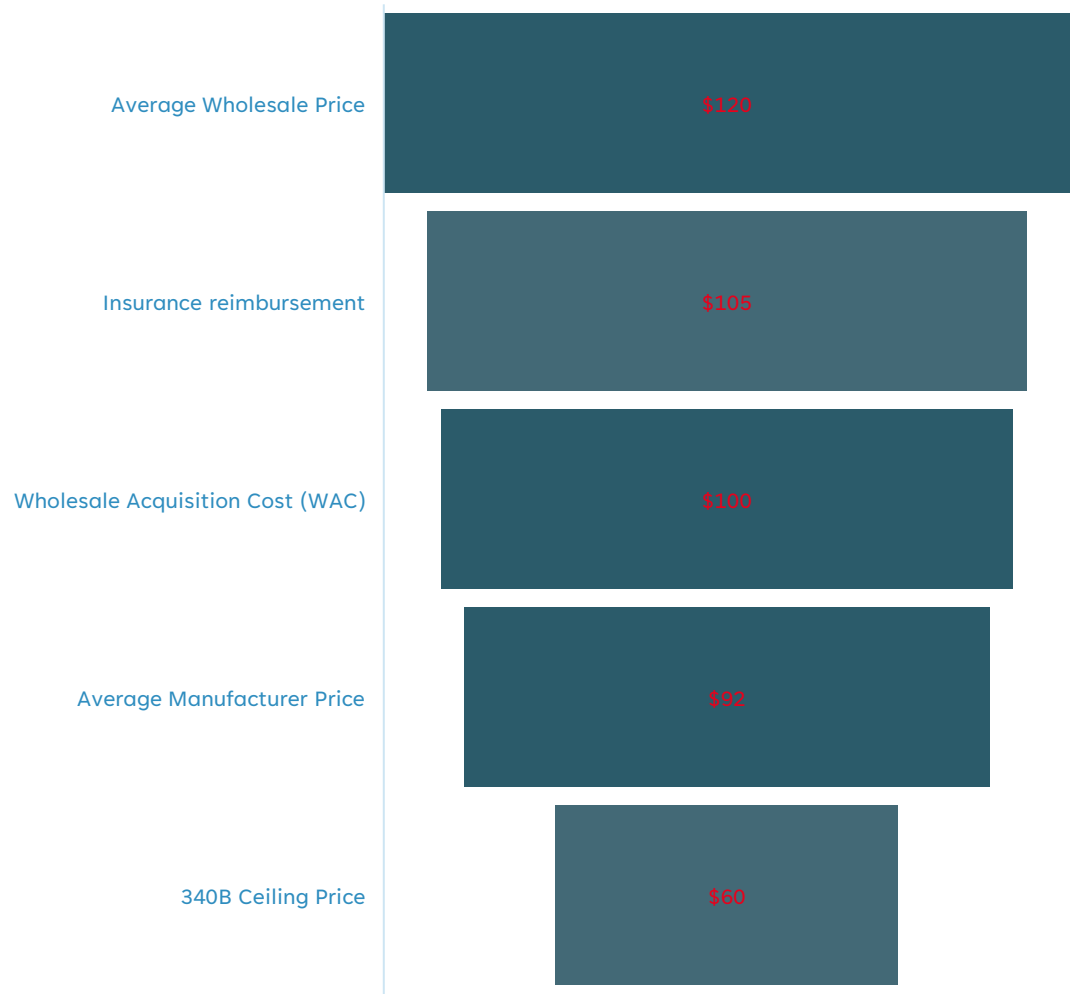
Abbr.	Entity type	DSH %	Allows GPO purchasing	Other requirements
DSH	Disproportionate Share Hospital	> 11.75%	Prohibited	
PED	Children’s Hospital	> 11.75%	Prohibited	Must treat mostly patients under 18
CAN	Free-standing Cancer Hospital	> 11.75%	Prohibited	Must be Medicare PPS exempt cancer hospital
SCH	Sole Community Hospital	≥ 8%	Allowed	Be located at least 35 miles from other hospitals OR Have little overlap with "like" hospitals within 35 miles
RRC	Rural Referral Center	≥ 8%	Allowed	Be located in a rural area and have at least 275 beds OR Meet a complicated set of acuity and/or referral pattern criteria
CAH	Critical Access Hospital	None	Allowed	Be located in a rural area at least 35 miles from another hospital AND Maintain no more than 25 inpatient beds AND have a 24/7 ER

Example: Hospital A has 62 beds and is in a rural area. It had 5,000 total patient days, 1,000 Medicaid/non-Medicare days, 2,000 Medicare Part A days, and 300 Medicare Part A/SSI days. Hospital A’s Medicare DPP is 35%.

$$\text{Medicare DPP} = \frac{\text{300 Medicare Supplemental Security Income Days}}{\text{2,000 Total Medicare Days}} + \frac{\text{1,000 Medicaid, Non-Medicare Days}}{\text{5,000 Total Patient Days}} = .35$$

340B: HOSPITAL ELIGIBILITY

- Entities receive discounted prices on covered drugs and retain the savings when these drugs are billed to patients and/or insurers at the typical rates.
- These savings support the nonprofit missions of these entities, allowing them to provide care to low-income and uninsured patients.
- Note that hospitals that received eligibility from the Affordable Care Act are subject to the "orphan drug exclusion" – manufacturers are not required to offer discounts to these entities for drugs with an orphan drug designation.
- Discounts apply only to covered outpatient drugs; non-drug items (supplies, vaccines, devices, etc.) may be offered with discounts for 340B entities but are not subject to the statutory ceiling price.



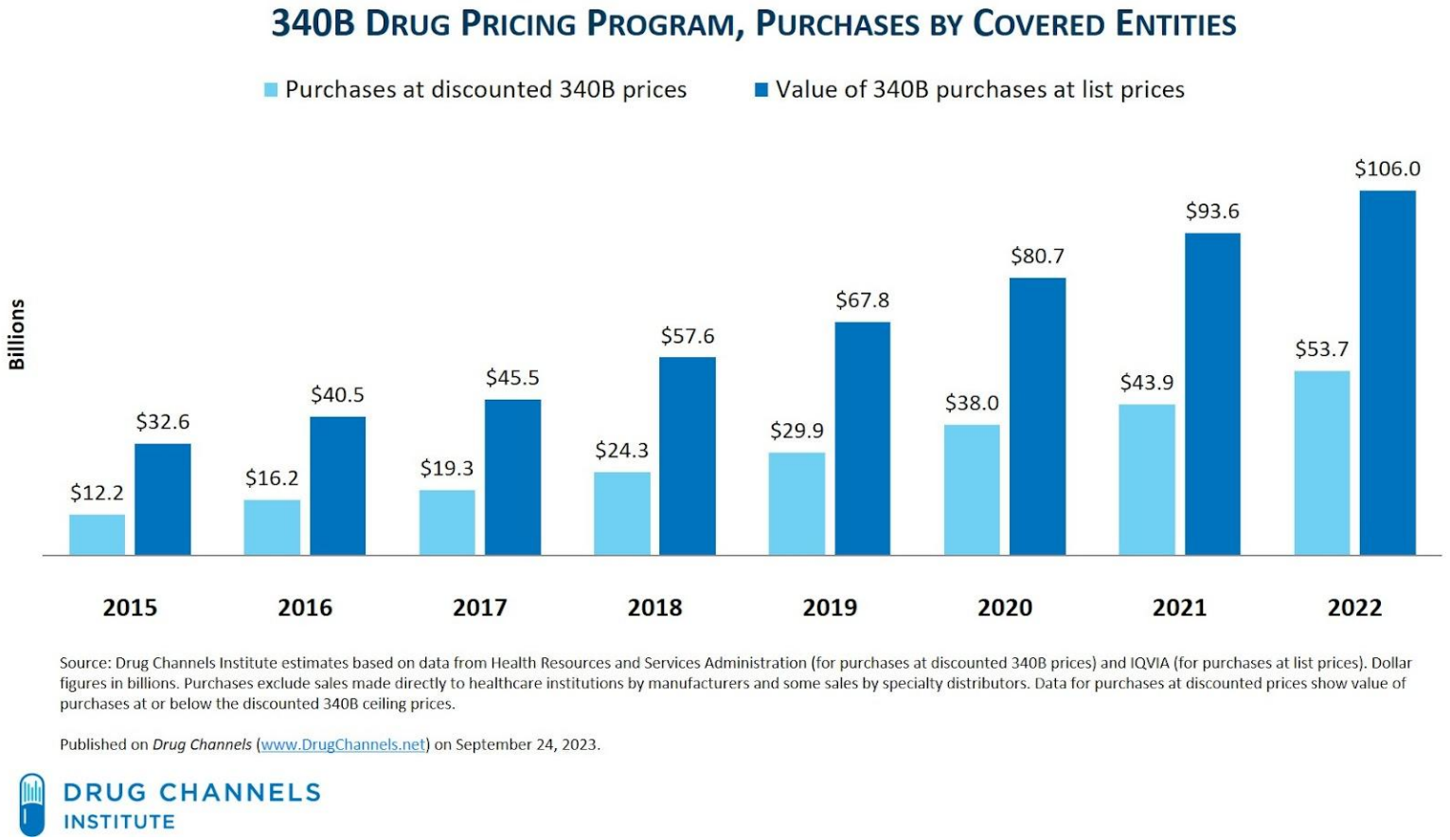
THE “PATIENT DEFINITION”

Federal Register, October 24, 1996:

- Definition of a Patient An individual is a ‘‘patient’’ of a covered entity (with the exception of State-operated or funded AIDS drug purchasing assistance programs) only if:
- 1. The covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual’s health care; and
- 2. The individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity; and
- 3. The individual receives a health care service or range of services from the covered entity, which is consistent with the service or range of services for which grant funding or Federally-qualified health center look-alike status has been provided to the entity. Disproportionate share hospitals are exempt from this requirement.
- An individual will not be considered a ‘‘patient’’ of the entity for purposes of 340B if the only health care service received by the individual from the covered entity is the dispensing of a drug or drugs for subsequent self-administration or administration in the home setting.
- An individual registered in a State-operated or funded AIDS drug purchasing assistance program receiving financial assistance under title XXVI of the PHS Act will be considered a ‘‘patient’’ of the covered entity for purposes of this definition if so registered as eligible by the State program.

PROGRAM GROWTH IN RECENT YEARS

Multiple contract pharmacy arrangements were permitted beginning in 2010.



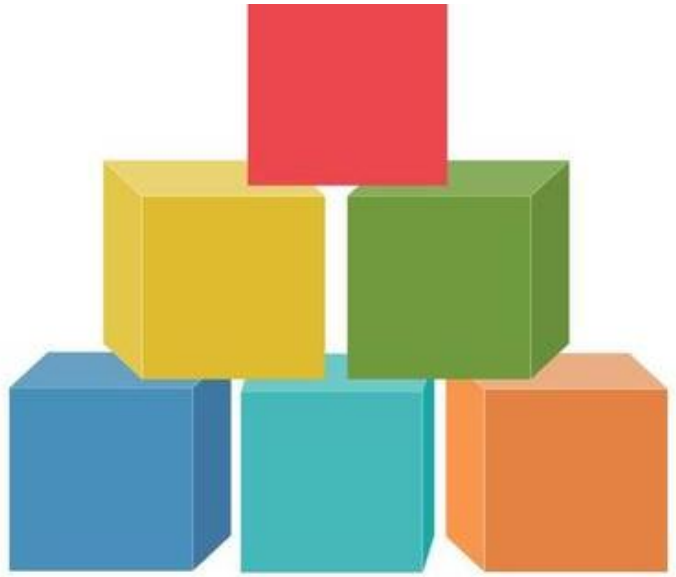
340B: MIXED USE & CONTRACT PHARMACY

- Hospitals participating in 340B derive savings or revenue from two primary areas:
- **Mixed-use savings**: Cost savings on medication administration / dispensation in areas of the hospital that are either outpatient (e.g. outpatient clinics) or both inpatient and outpatient (emergency department). *The majority of this value comes from infused drugs*.
- **Retail pharmacy (in-house and contract pharmacy):** Savings and revenue from drugs dispensed to outpatients for home self-administration. Hospitals contract with outside pharmacies to dispense on hospital's behalf, shipping 340B drugs to those pharmacies. Pharmacies remit the reimbursement they received, minus a dispensing fee.

Prior to 2020, mixed-use savings represented approximately half of the value of the 340B program for hospital covered entities.

340B: BASIC PROGRAM INFRASTRUCTURE

- **Third Party Administration**: Technology services vendor that manages eligibility analysis for mixed use and contract pharmacy dispensing, maintains virtual inventory accumulators, places wholesaler orders, and generates pharmacy invoices. Many entities select their own TPA, and use Verity (owned by Cigna ESI), Wellpartner (owned by CVS) and Walgreens as additional TPAs.
- **340B Manager**: An internal resource to monitor performance, identify new opportunities, manage vendor relationships, arrange compliance management processes and support regulatory interaction. Some entities partly outsource this function.
- **External Auditor:** HRSA expects covered entities to demonstrate good faith effort to maintain compliance with program regulations through an annual, independent audit of the contract pharmacy program.



FURTHER RESOURCES

- Prime Vendor Program:
  - Apexus 340B University (https://www.340bpvp.com/340b-university/online-learning)
  - Apexus Answers (https://www.340bpvp.com/apexus-answers)
- HRSA
  - Educational Resources: https://www.hrsa.gov/opa/educational-resources
  - FAQs: https://www.hrsa.gov/opa/faqs
  - Orphan Drug Designation List: https://www.hrsa.gov/opa/program-requirements/orphan-drug-exclusion
- 340B Report (https://www.340breport.com)
- NRHA 340B Advocacy (https://www.ruralhealth.us/advocacy/advocacy-priority-areas/340b-drug-pricing-program)
  - Rural Fact Sheet: https://www.ruralhealth.us/NationalRuralHealth/media/Documents/Advocacy/2025/Rural-340B.pdf
- 340B Health (https://www.340bhealth.org)

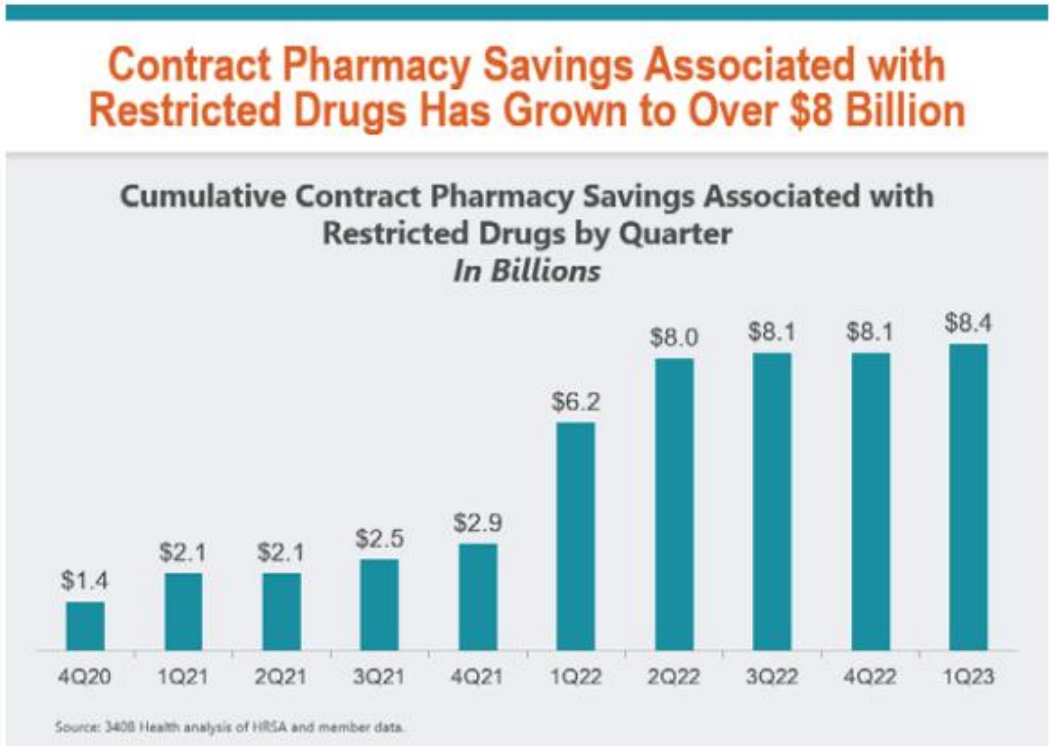
RECENT DEVELOPMENTS IN 340B

340B: REGULATORY BACKGROUND

- 2010 Affordable Care Act created new types of covered entities, permits multiple contract pharmacy arrangements, and imposes orphan drug exclusion on newly eligible entities
- 2014: PhRMA federal lawsuit over orphan drug enforcement limited HRSA's regulatory authority
- 2019: Federal Genesis ruling further limited HRSA's regulatory authority, invalidated prior regulatory guidance outside of HRSA's statutory authority
- 2020: Supreme Court rules (Rutledge v Pharmaceutical Care Management) that states are not pre-empted from regulating PBMs under ERISA.
- 2021-2022: Several federal rulings restrict HRSA's authority to mandate contract pharmacy discounts
- 2022: Supreme Court rules that CMS cannot enforce discriminatory pricing against 340B entities
- 2023: Federal *Genesis* ruling questions HRSA's enforcement of the 340B patient definition
- 2022-2025: Majority of states pass legislation regulating PBMs, many explicitly prohibit PBM discrimination against 340B covered entities. Some states also pass legislation requiring covered entity reporting on 340B participation; more expected to pass in the next year.
- 2025: Executive order and federal legislation authorize CMS to issue a mandatory cost survey to 340B hospitals, a prerequisite to reducing reimbursement for administered drugs following SCOTUS ruling. Expected in 2026.

340B: CONTRACT PHARMACY RESTRICTIONS

- Beginning in 2020, most drug manufacturers restricted access to 340B discounts for drugs shipped to contract pharmacies, sparking litigation at the state and federal levels nationwide.
- PhRMA argues that the 340B statute does not require shipping discounted drugs to contract pharmacies
- By 2025, hospital covered entities will have seen much of their contract pharmacy revenue disappear. DSH hospitals with in-house retail pharmacies have been hit the hardest, losing as much as 90% of their contract pharmacy revenue.



GENESIS & PATIENT DEFINITION

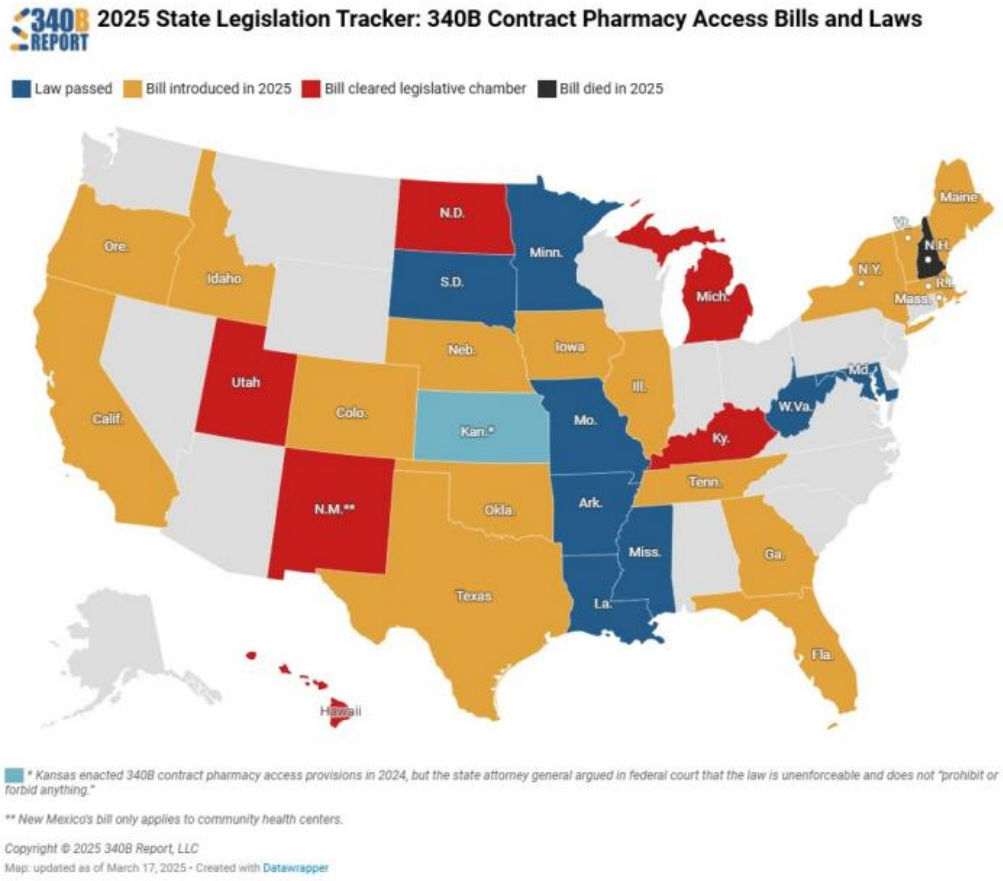
In *Genesis Healthcare v. Becerra (Nov 2023)*, the United States District Court for the District of South Carolina ruled against HRSA's enforcement of its 1996 patient definition.

The ruling has led many covered entities to adjust their program policies to reflect a broader interpretation of the 340B statute's definition of a patient.

Legal Issue	Court Ruling
CE must "initiate" service underlying the prescription	The court ruled that HRSA's requirement that the CE initiate the underlying service conflicts with the plain language of the statute.
CE must have an ongoing relationship with the patient	The court agreed that the relationship must be ongoing, but did not define a lookback period.
HRSA's interpretative authority	The court upheld HRSA's authority to interpret the statute, but struck down its application of the definition to Genesis as inconsistent with the statute
Scope of the ruling	The specific ruling applies only to HRSA's enforcement action against Genesis

340B: CONTRACT PHARMACY LEGISLATION PROGRESS

- As of August 2025, 19 states have passed legislation to protect access to 340B discounts at contract pharmacies.
- States stepped in to act, beginning with Arkansas in 2021, when bills introduced in Congress failed to move forward.
- Litigation against the manufacturers by HHS has had little effect; states have overall prevailed against manufacturers suing to overturn state legislation.
- Note: Many bills introduced in 2025 have passed since the development of this map, including VT, RI, ME, HI, OR, OK, CO, OH, TN.
- These laws are slowly restoring access in these states; however, many manufacturers have not fully restored access under laws passed in 2024-2025, and enforcement in some states is currently paused due to ongoing litigation.



CMS DRUG PRICE NEGOTIATION & 340B

Beginning in 2026, the Inflation Reduction Act requires CMS to negotiate prices on certain high-cost, high-spend drugs.

For claims paid by Medicare Part D, pharmacies' reimbursement will be capped at the "maximum fair price" or MFP.

While the MFP is generally higher than the 340B acquisition price, it is significantly lower than Wholesaler Acquisition Cost (the approximate basis of traditional reimbursement levels).

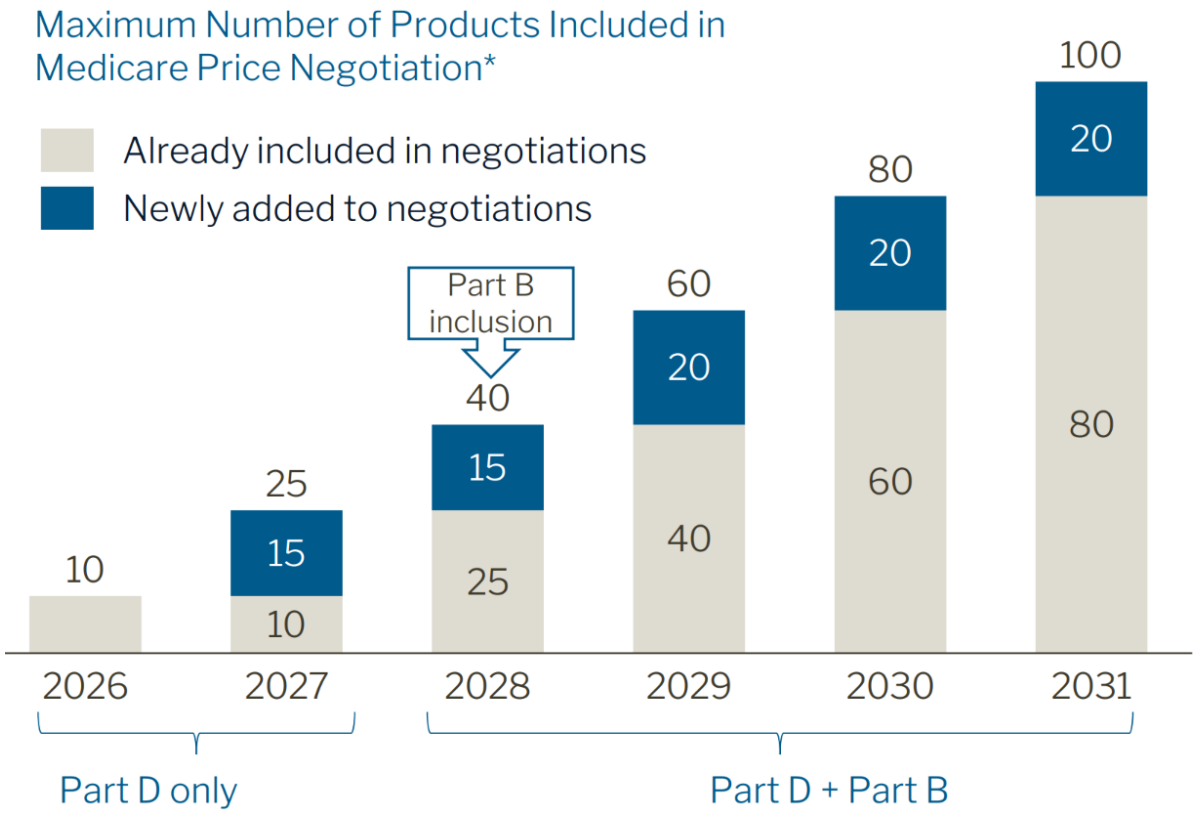
For these products, the savings and revenue offered by 340B discounts will be significantly reduced.

Drug	Manufacturer	Therapeutic Area
Eliquis	BMS	Anticoagulant
Jardiance	BI	Diabetes
Stelara	J&J	Autoimmune
Enbrel	Amgen	Autoimmune
Xarelto	J&J	Anticoagulant
Farxiga	AstraZeneca	Diabetes
Novolog/Fiasp	NovoNordisk	Diabetes
Entresto	Novartis	Heart Failure
Januvia	Merck	Diabetes
Imbruvica	AbbVie	Oncology

DRUG PRICE NEGOTIATION 2026-2031

As the program rolls out fully, it will come to include drugs reimbursed under Part B, and the list of affected drugs will increase to 100 products.

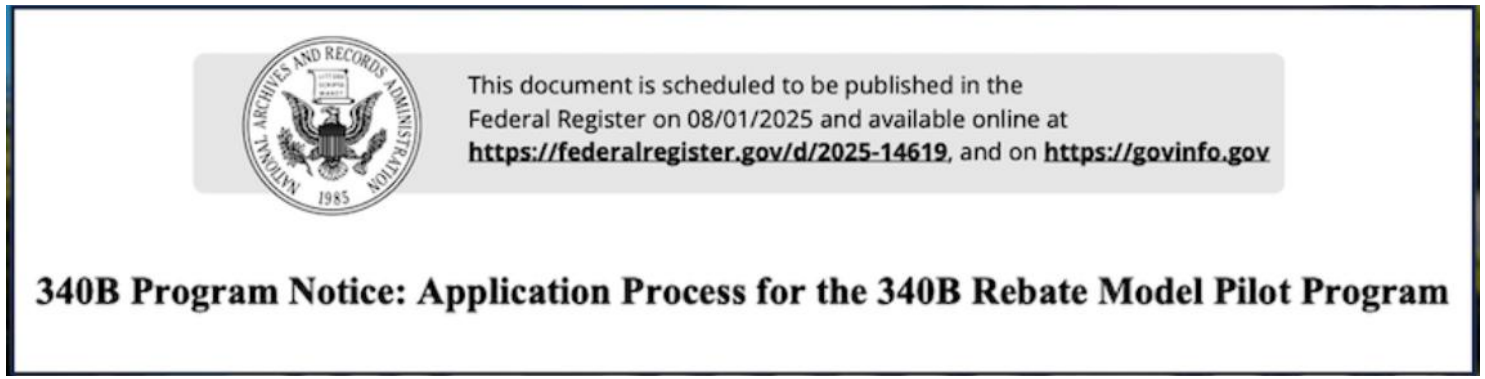
340B savings for these products will be reduced, and some pharmacies may choose to exclude affected drugs from contract pharmacy arrangements due to administrative complexity and timing lags.



* Drugs in the grey bars are no longer subject to negotiated price if/when a generic or biosimilar comes to market. Those drugs are not replaced.

* In future years, if there are not enough negotiation-eligible drugs to reach the number specified in statute (e.g., 20 in 2031) CMS will select available negotiation-eligible drugs

340B: REBATE MODEL



- In 2024, several manufacturers announced that they would transition 340B pricing to a rebate model. HHS ordered manufacturers to abandon this plan, arguing that these changes are illegal unless approved by the federal agency that oversees 340B (HRSA). After federal litigation began in 2024, HHS won a preliminary ruling against J&J in June 2025.
- In August 2025, HRSA announced it would accept proposals to pilot a rebate model in 2026. The 13 manufacturers with drugs included in the Medicare Drug Price Negotiation program are eligible to apply.
- HRSA described the purpose of the pilot as “deduplication” between rebates and the maximum fair price, as well as preventing duplication between discounts and federal Medicaid rebates.
- The rebate model applies *only to the 10 drugs* included in the 2026 Drug Price Negotiation program.
- Manufacturers cannot deny claims based on drug diversion concerns.
- Covered entities must submit claims for rebates **within 45 days** of the claim date of service, and manufacturers must pay rebates **within 10 days** of submission. We anticipate that claims submission and review will be handled by Beacon (owned by BRG, the same parent of 340B ESP) for all manufacturers.
- Approval of manufacturer proposals was scheduled for 10/15/2025 but has been delayed due to the shutdown of the federal government.

COMMON PERFORMANCE OPTIMIZATION TACTICS

POLL QUESTION

- Does your organization perform persistent, comprehensive review of 340B program performance to identify gaps and opportunities?
  - Yes
  - No
  - I don't know

PROGRAM OPTIMIZATION: CONTRACT PHARMACY

- Contract opportunity surveillance – quarterly or semiannually
  - Look for high-volume local pharmacies, moderate volume mail-order pharmacies, and low volume specialty pharmacies
- Regular review intervals for location mapping, provider files, eligibility logic
- Review invoicing and purchasing activity monthly to identify processing anomalies
- Expanded encounter windows - many entities increased the time between episodes of care for their patient definition from 1 year to 2 or longer.
- Follow market trends in contract terms with pharmacies and TPAs (winners only, NDC exclusions, reference-based pricing, pharmacy flat fee pricing for TPAs)
- Submit electronic prescription data to TPA for qualification

PROGRAM OPTIMIZATION: CONTRACT PHARMACY

340B ESP & Managing Pharmacy Designations

- Required in states without a contract pharmacy law, for any contract pharmacy where 340B discounts are accessible
- Manufacturers have different policies about data submission, drug access, pharmacy designation; policy changes must be monitored
- Data submission must be managed routinely. Most TPAs offer to submit data on CE's behalf
- CE's should verify that pricing is restored once data is submitted / designations are completed and periodically re-review
- Designations should be reviewed regularly to ensure optimal capture of financial opportunity

PROGRAM OPTIMIZATION: CONTRACT PHARMACY

- Referral capture: Qualifying prescriptions written by an outside provider for an entity's patient
  - Uses the HRSA 1996 patient definition's criteria for "contractual or other relationships" to qualify high-value prescriptions written by outside specialists for your patients
- Alternative distribution models (ADM)
  - 340B drugs are shipped to the covered entity's inpatient or outpatient pharmacy, and then shipped again to contract pharmacy partners
  - Requires support from TPA 340B TPA
  - May require special licensing under state regulations (e.g. as a distributor or wholesaler)
  - Must remain compliant with DSCSA regulations
  - Some contract pharmacy partners have easy implementation models (largely mail-order specialty pharmacies); if ADM is used at large scale, may require additional space / staffing

PROGRAM OPTIMIZATION: MIXED-USE

For most hospitals, mixed-use savings represents half or more of total 340B opportunity.

- Drugs dispensed at mixed inpatient / outpatient locations (e.g. the ED) and outpatient locations within the hospital or eligible on MCR may be obtained at discounted prices
- Outpatient infusions – often the largest single area of opportunity (infusion centers, infusion suites, ED). All on-site infusions meet the 340B patient definition.
- Mixed-use drugs can be captured using charge data, dispense data, or administration records. Don't get WAC'd – identify areas where opportunity may be missed due to poor data capture. Examples include uncharged or bundled drugs, kit meds, areas where charge capture may be manual (e.g. charge tickets).
- Understand how your patient status classifications change; portions of patient stay that are OP remain eligible. Consider the effect of charge on administration vs. charge on dispense on how your TPA qualifies activity.
- Price verification for 340B and GPO – prices can fall off quarterly, or for other reasons (often wholesaler error). Monitor pricing obtained via 340B accounts for contract attachment status.
- 340B-like and sub-ceiling prices may be available (devices, or excluded drugs like vaccines, orphan drugs, non-drug items like contrast media, etc.)

IN-HOUSE PHARMACY OPPORTUNITY & SPECIALTY PHARMACY

POLL QUESTION

Does your organization own an in-house pharmacy?

- Yes
- No

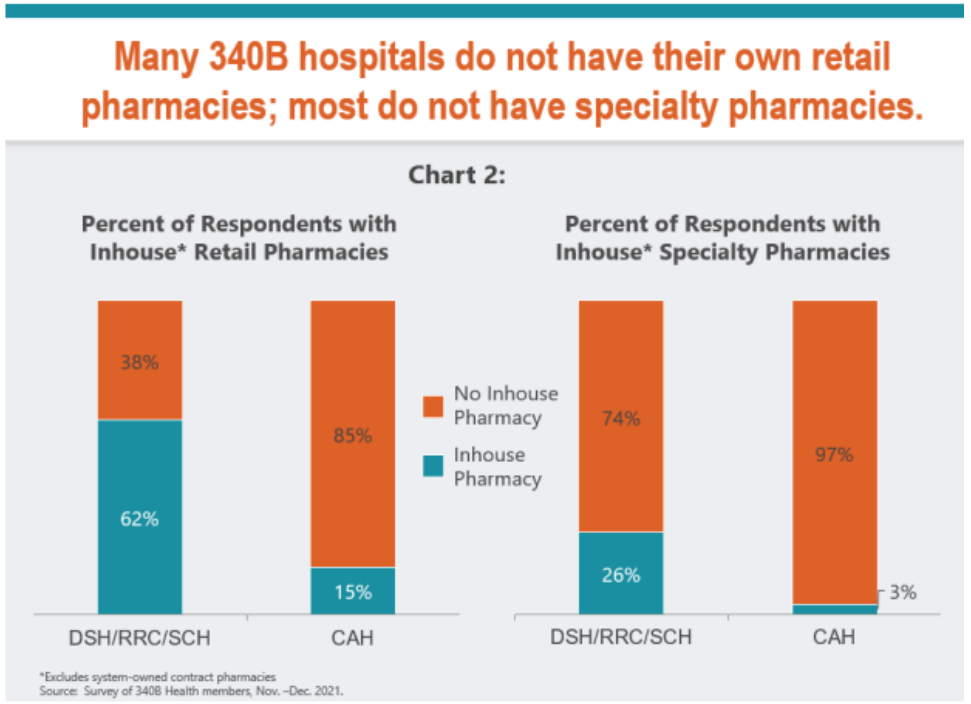
If you have a pharmacy, what proportion of all prescriptions written by your providers are filled there?

- Less than 10%
- 10%-30%
- 30%-50%
- More than 50%
- I don't know

340B: ENTITY-OWNED PHARMACY

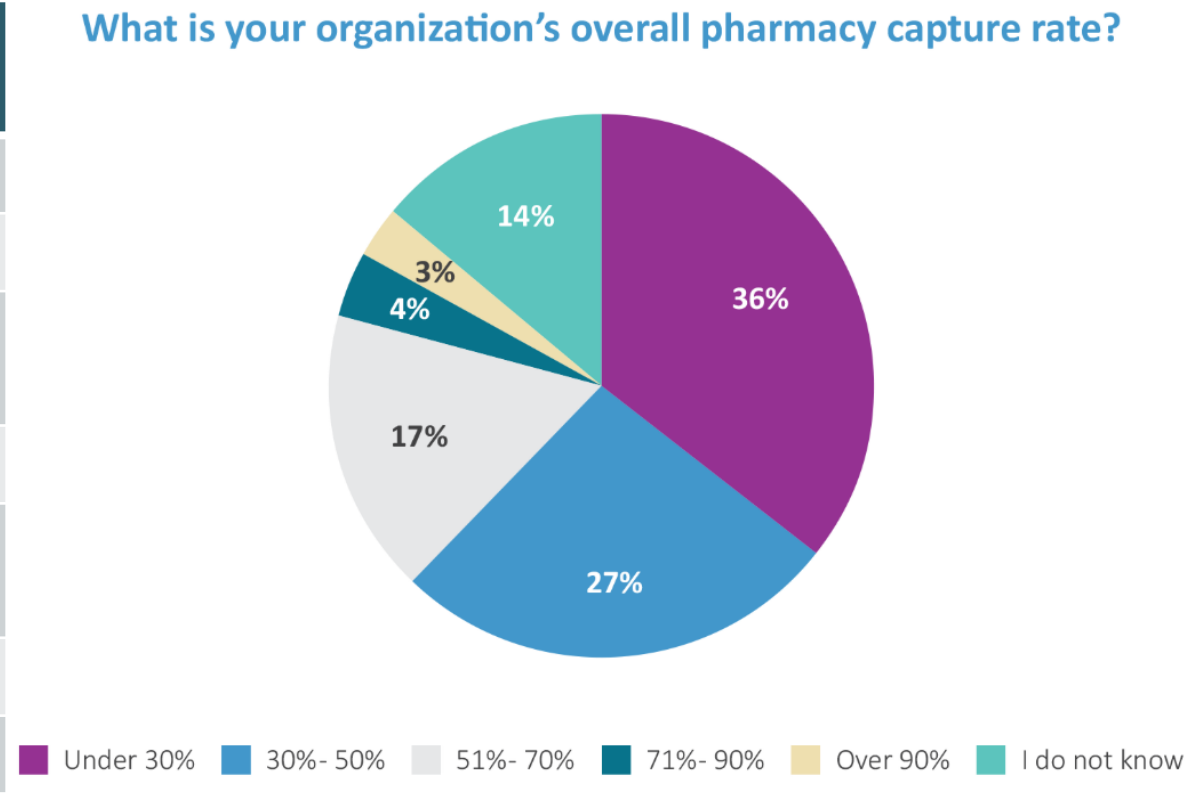
While most larger hospitals and health systems have an in-house retail pharmacy, many smaller entities do not. A small proportion of all hospitals have an in-house specialty pharmacy.

Access to 340B discounts at entity-owned pharmacies cannot be restricted; establishing a pharmacy is the best way for an entity to control its own destiny and protect against future losses.



340B PERFORMANCE MANAGEMENT: CAPTURE RATE

Key Metric	Value	Target Value
Overall capture rate	63%	90%+
Internal capture rate	11%	40%+
Antidiabetics & Weight Loss	6.5%	60%+
HIV	19%	60%+
Specialty & Specialty "Lite"	10%	40%+
Uninsured Patients	15%	
Medicaid patients	23%	



PHARMACY CAPTURE RATE STRATEGIES

340B covered entities can continuously optimize their performance by identifying growth opportunities. In addition to periodically reviewing contract pharmacy networks, common strategies for entity-owned pharmacies include:

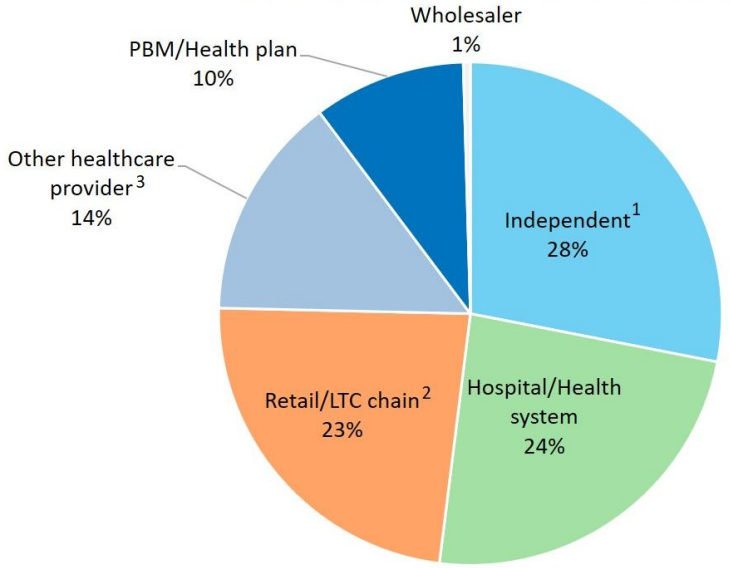
- Expanded on-site infusion offerings
- Mail order pharmacy and delivery services
- Convenience tools for patients (med synchronization, smartphone app, automated refill reminders)
- Clinic-based medication pickup points
- Vaccines, MTM and other services
- Add specialty pharmacy capability

340B: SPECIALTY PHARMACY

- Specialty drug spend has experienced growth rates (CAGR) of 10-20% in recent years, with growth projected to continue at a rapid pace at least through 2030. In 2023, nearly 80% of newly approved drugs were classified as specialty products.
- More than 90% of all specialty drugs are also designated as orphan drugs (approved indication for treating an orphan disease as determined by the FDA).
- **340B covered entities that received eligibility under the Affordable Care Act do not have access to 340B discounts for these drugs.**
- Health-system specialty pharmacy market share reached 27% in 2024, up from 15% in 2017 and 24% in 2023.
- Many steer prescriptions from self-funded health plans into their in-house pharmacies, including mail-order and specialty. This can save these plans more than 30% on the cost of pharmacy benefits.

Accreditation, by Corporate Ownership, 2023

Number of unique pharmacy locations with specialty pharmacy accreditation, 2023 (n=1,749)

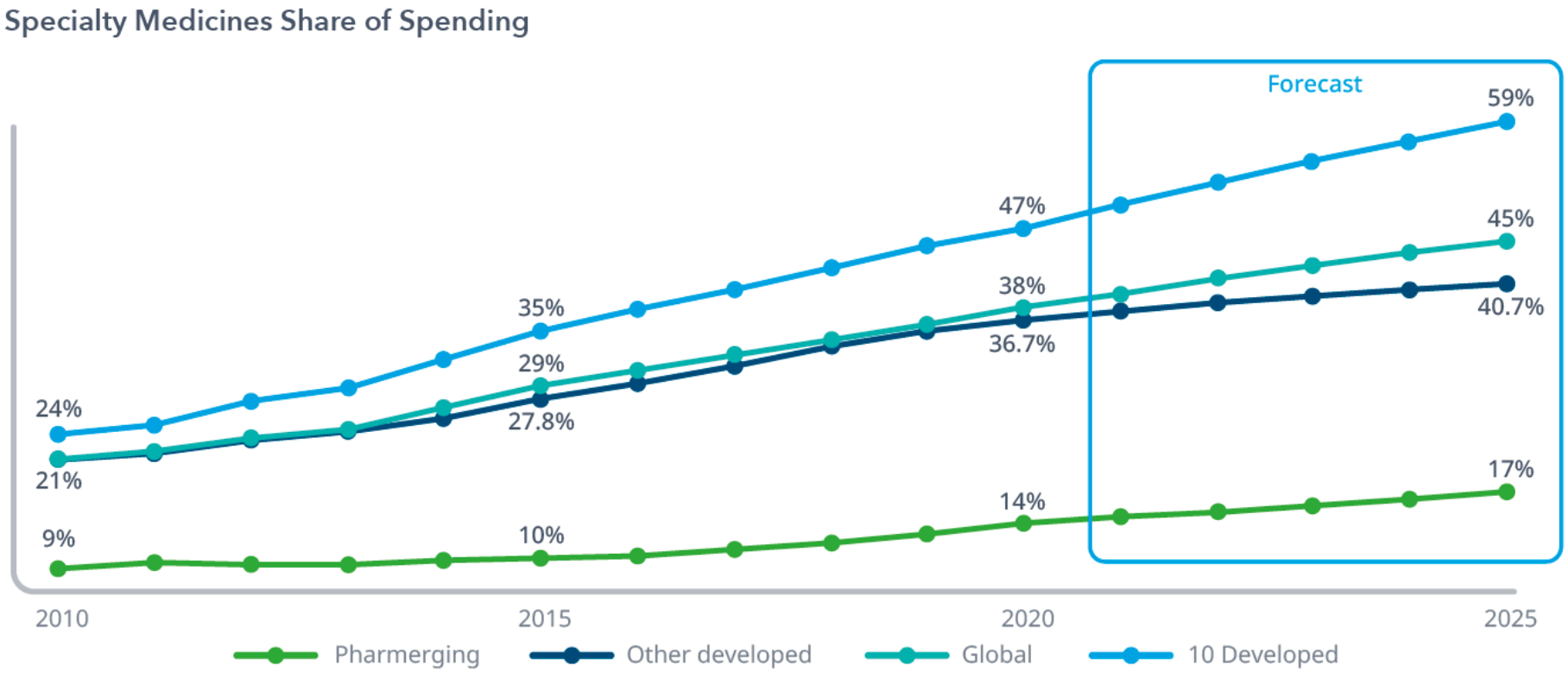


LTC = long-term care; PBM = pharmacy benefit manager
1. Includes private independent pharmacies, pharmacies owned by private equity firms, and independently owned franchise locations.
2. Includes pharmacies owned by physician practices and nonhospital providers.
3. Includes pharmacy locations owned by chain drugstores, grocery chains, and national long-term care pharmacy chains. Figures include 287 Walgreens community-based specialty pharmacy locations that are accredited by URAC and 15 locations that are accredited by both URAC and ACHC.
Source: The 2024 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, Drug Channels Institute, Exhibit 53. Figures show number of unique pharmacy locations accredited by ACHC and URAC as of the end of 2023. For comparability, data for ACHC exclude certain accredited pharmacy spoke locations within retail chains. Figures exclude locations with provisional and conditional accreditation.

REVIEW: TRENDS IN SPECIALTY DRUG SPEND

80% of new drugs approved in 2023 were specialty products[1]

75% of all drugs in development are specialty products[1]



Source: IQVIA Institute, Feb 2021
Report: Global Medicine Spending and Usage Trends: Outlook to 2025. IQVIA Institute for Human Data Science, April 2021

[1] *:* Navigating the Rapid Growth of Specialty Drugs: Opportunities, Challenges, and the Path Ahead. *Pharmacy Times*(9/2/2024)..

RETAIL TO SPECIALTY EXPANSION

Growing a retail pharmacy by adding specialty pharmacy capacity is the most straightforward path for most entities. To become a specialty pharmacy, a retail pharmacy will need:

1) Technology for patient management and patient communications
2) Physical space for specialty workflow, refrigerators/freezers, backup power
3) Specialty pharmacy accreditation
4) Additional payer contracting (to access restricted specialty networks e.g. CVS, Optum, ESI)
5) Clinical pharmacists and prior authorization technicians

PARTNERSHIP OPTIONS

- Launching a specialty pharmacy can be daunting. It requires a very substantial investment in time, energy, financial and other resources. Many potential partner organizations and models are now available to support the development process.
- Development consulting: expert advice and support as you pursue launching a specialty pharmacy
- Managed services: You retain ownership of the pharmacy while a partner manages its operations
- Outsourced services: While you operate the pharmacy, a partner can provide key services – patient management & clinical follow-up, payer contracting, care coordination, etc.

Common Partnership Fee Structures

Gain share: Partner receives a small percentage of incremental revenue or margin increase. Contracts often last 3-5 years.

Flat fee: Fixed monthly fees for a defined period, usually 12 to 24 months.

EMERGING STRATEGIES & NEW TRENDS

340B: EMERGING STRATEGIES

- Utilization of machine learning / automation / AI
  - Price Verification
  - Referral Capture & Missed Opportunities
  - Automated auditing / compliance analysis
  - Analytics
  - Patient outreach & communications tools
- MTM & telehealth encounters to establish or extend 340B eligibility, including as part of a population health strategy; reduces drug costs, improves adherence, and helps avoid preventable complications and avoidable medical spending
- Collaboration between ACA entities (CAHs, SCHs) and DSH hospitals for the delivery of specialty care, specialty medications, and infusion therapies
- Health plan collaboration to provide care to patients receiving high-cost drugs and reduce total costs through 340B discounts
- Infusion strategies, including non-hospital-based ambulatory infusion centers and provider-based ambulatory infusion suites
- Patient drug cost assistance programs to drive pharmacy capture and improve adherence / outcomes

340B: EMERGING STRATEGIES

Integration Model

- **Health Plan Partners**
  Coordinate member benefits and pharmacy networks
- **Telehealth Providers**
  Enable virtual care access and prescription routing
- **Health Systems/Hospitals**
  340B-eligible entities with qualifying pharmacies
- **Limited Pharmacy Networks**
  Strategic network design to capture 340B prescriptions

Dual Value Proposition

1. Reduce Prescription Drug Costs

- Access 340B discounted pricing (avg. 25-50% savings)
- Health plans reduce pharmacy spend
- Lower member out-of-pocket costs
- Enhanced formulary value

2. Drive 340B Revenue to Hospitals

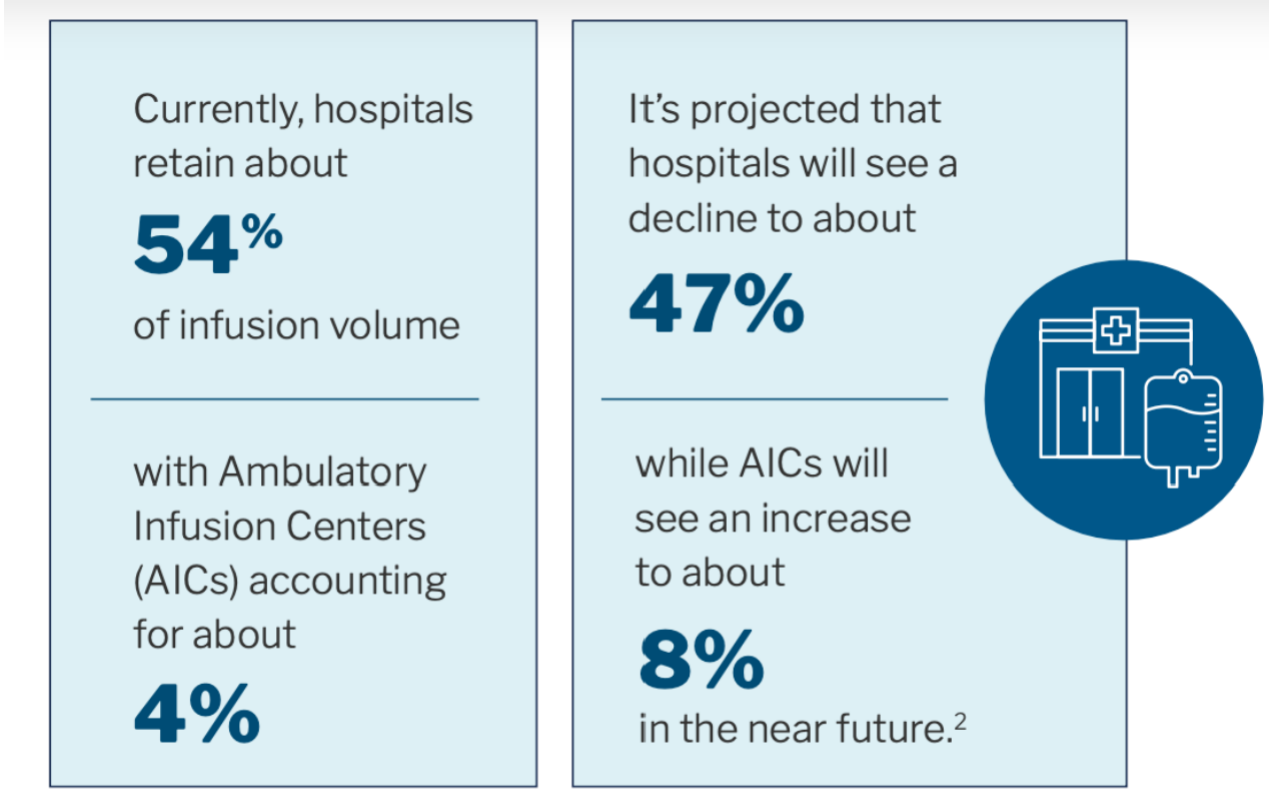
- Direct prescriptions to hospital-owned pharmacies
- Maximize 340B dispensing opportunities
- Generate sustainable revenue stream
- Support hospital community benefit programs

Key Mechanism: Limited pharmacy networks route telehealth prescriptions to 340B-eligible hospital pharmacies, creating mutual value

340B: EMERGING STRATEGIES

Infusion Strategy Considerations:

- Growing competition from for-profit ambulatory infusion centers
- Payer site of care challenges / white bagging demands
- Orphan drug access
- Other RCM complexities
- Local infusion access – particularly in rural areas
- Availability of home infusion
- Possibility of contract infusion partners



2. *https://www.bourne-partners.com/wp-content/uploads/2024/08/Infusion-Therapy-Market-Update.pdf*

PATIENT ASSISTANCE

Many patients may not have access to financial assistance to afford their medications or may be unaware of what sources are available.

Offering an assistance program can help close care gaps and attract patients to your in-house pharmacy.

Source	Parameters
Medicaid	Restrictive eligibility for adults (<138% FPL), asset test
Hospital PFAP	Excludes most medication costs, restrictive eligibility (<250% FPL), usually includes an asset test
Foundation grants	Limited to specific diseases / conditions; up to 500% FPL
Manufacturer programs	Excludes patients with federally-sponsored coverage; limited to specific drugs. No income requirements for coupons. May not count towards deductibles or OOP limits.
Sliding scale discount	Most often 340B AAC + sliding scale dispensing fee. Commonly results in forfeited primary coverage payments. Does not count towards deductibles / OOP limits. Restrictive eligibility (<250%).
In-house assistance program	Can assist patients >200% FPL, with no restrictions on drugs covered. Closes gaps in the availability of support and encourages patients to use in-house pharmacy.

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