The Business of Specialty Pharmacy

(What They Don't Teach You in School)

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Meet the Presenters

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Speaker Disclosures

<NASP will note any speaker disclosures.>

Learning Objectives

1. Describe how product and payment flow among manufacturers, distributors, specialty pharmacies, payers, and plan sponsors, and explain what each party is solving for within that system.
2. Analyze how benefit design, utilization management, and financial assistance affect a patient's time to first fill and long-term persistence on specialty therapy.
3. Identify business competencies and career pathways in specialty pharmacy that extend beyond direct patient care and explain how each contributes to leadership opportunity.

Roadmap & Framing

- Why Specialty Pharmacy Requires Business Fluency
- How the Money Moves
- From Prescription to Patient
- Where the Industry is Headed
- What This Means for Your Career

Why Specialty Pharmacy Requires Business Fluency

There is No Single Definition of "Specialty"

- The usual criteria: high cost, special handling or storage, REMS requirements, limited distribution, complex administration, ongoing monitoring
- CMS uses a specialty-tier cost threshold of $950 per 30-day equivalent ingredient cost
- Commercial plans set their own thresholds and criteria

The Math That Drives Every Decision

- Specialty is projected to exceed 60% of total pharmacy spending in 2026, while representing fewer than 5% of prescriptions
- Specialty market size grew from roughly $92.5B in 2023 to $129.2B in 2024
- Cell and gene therapy spending projected near $25.3B in 2026, with individual treatments from roughly $65,000 to $4.25 million

Why High-Cost, Low-Volume Changes Everything

Prescription Volume Per Site
Retail: roughly 55,000–60,000 prescriptions per year, about 200–220 per day
Specialty: a small fraction of that volume, spread across roughly 1,900 accredited specialty dispensing locations nationally

Cost Per Patient/Per Year
Retail: traditional drugs average roughly $2,500 per year; plan cost averages about $492 per non-specialty patient
Specialty: average annual cost exceeds $84,000; plan cost averages about $38,000 per specialty patient

Cost Per Fill
Retail: most fills are generics in the $10–$50 range
Specialty: commonly $2,000–$6,000 per month, exceeding $20,000 per month in some indications

Gross Margin Percentage
Retail: roughly 21–22% blended, driven largely by generics
Specialty: a 3.5% margin on a $10,000 drug yields about $350; at 5% it yields $500

Why High-Cost, Low-Volume Changes Everything

Gross Margin Dollars Per Fill
Retail: a 25% margin on a $10 generic yields about $2.50
Specialty: a 3.5% margin on a $10,000 drug yields about $350; at 5% it yields $500

Net Margin
Retail: roughly 2–3%
Specialty: thinner still once cost to dispense is subtracted, and negative on a reversed or slow-paying claim

Inventory Carrying Cost
Retail: low unit cost, high turns, minimal capital at risk on any one item
Specialty: a single unit on the shelf can represent more capital than a small pharmacy's monthly payroll

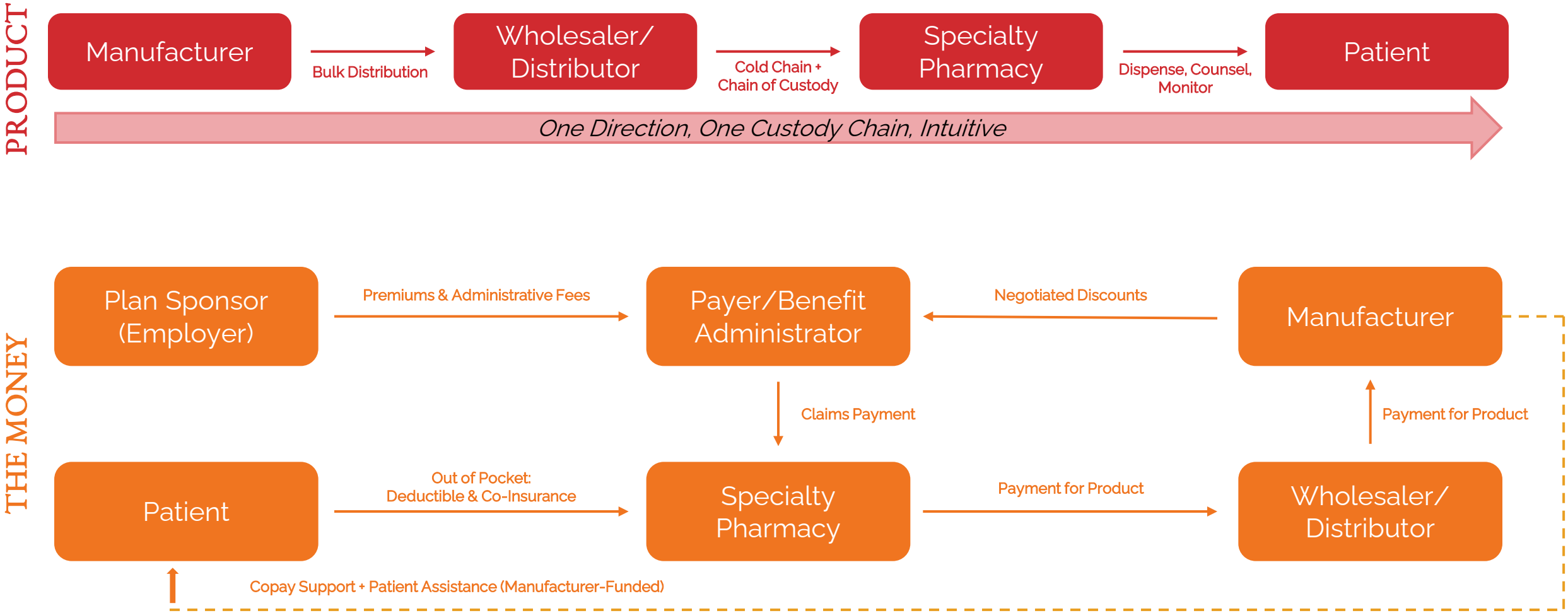
Consequence of a Single Error
Retail: replace a $10 generic
Specialty: a temperature excursion, a reversed claim, or a patient who never starts after shipment can be a five-figure write-off

How the Money Moves

Who is Involved & What They Do

The Who	What They Do
Manufacturer	Researches, develops, and produces the therapy, sets its list price, funds patient support programs, and determines which pharmacies may distribute products that require controlled handling.
Wholesaler/Distributor	Purchases product in bulk from manufacturers and delivers it to pharmacies, maintaining cold chain, chain of custody, and product integrity across the entire journey.
Specialty Pharmacy	Dispenses the therapy and provides the clinical services wrapped around it: counseling, adherence monitoring, side effect management, benefits investigation, financial assistance coordination, and outcomes reporting back to manufacturers and plans.
Payers/Benefit Administrators	Build and operate the pharmacy benefit that the plan sponsor selects, including formulary, pharmacy network, claims adjudication, utilization management, and clinical programs.
Plan Sponsor	The entity paying for the benefit, most often an employer, but also health plans, union trusts, and government programs. It chooses the benefit design and bears its cost.
Provider	Diagnoses the patient, selects the therapy, writes the prescription, and supplies the clinical documentation that supports medical necessity when the plan asks for it.
HUB/Patient Support Services	Manufacturer-funded programs, usually built around a single product, that run benefits verification, prior authorization support, enrollment in financial assistance, nurse education, and injection training.
Patient	Bears the out-of-pocket cost, decides whether to start and whether to continue, and is the only party whose outcome defines whether the system worked.

Product Flows One Way, Money Flows Another



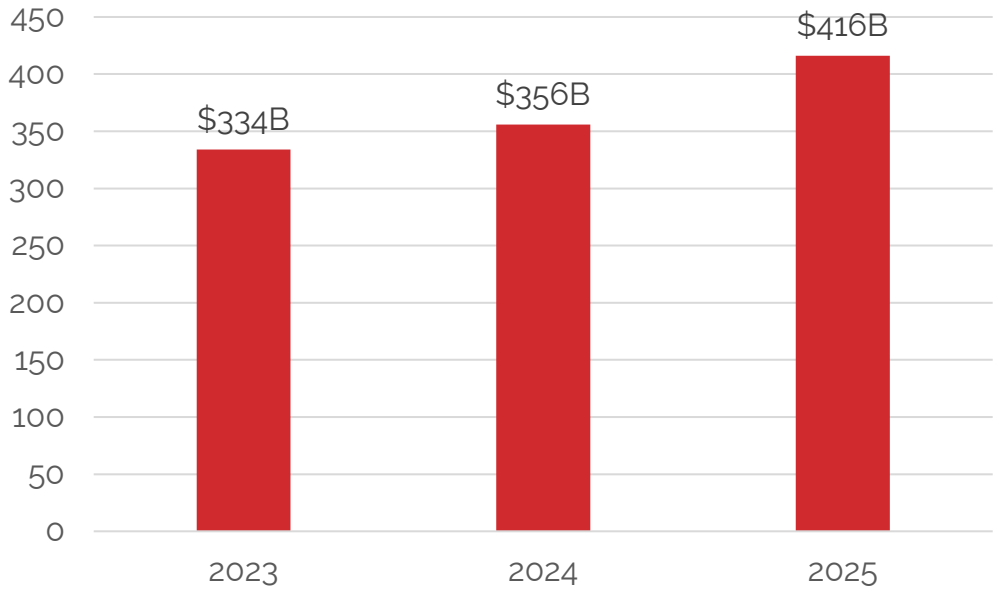
What Each Party is Solving For

Manufacturer	Recoup R&D, drive appropriate uptake, ensure product is handled correctly
Wholesaler/Distributor	Move volume at razor-thin margin, guarantee supply integrity
Specialty Pharmacy	Get the patient on therapy quickly and keep them there, at a cost below reimbursement
Payers/Benefit Administrators	Keep coverage affordable, manage actuarial risk, serve the whole covered population
Plan Sponsor	Fund a benefit the workforce can actually use without breaking the budget
Provider	Choose the right therapy and document medical necessity
Patient	Get the medication, afford it, stay on it

Why List Price and Net Price Diverge

THE GAP, IN DOLLARS

Manufacturer gross-to-net reductions,
U.S. brand-name drugs ($ billions)



Price growth, brand-name drugs. List: 10–15%/yr (2010–2015) → ~5%/yr (2019–2023) → 2.3% (2024). Net: +0.1% (2024), negative in 2025.

No single party designed this. It is an inherited market equilibrium…and it matters to your patient, whose coinsurance may be a percentage of the top line rather than the net.

HOW THIS HAPPENS

1. Formulary position is bid competitively

Plans & their administrators award position based on the discount offered & that discount is measured off the list price.

2. A higher list funds a deeper discount

Raising list & raising the rebate together can win position without reducing what the manufacturer actually collects.

3. Repeat across products & years

List drifts upward, net stays roughly flat, and the gap widens. Every party is responding rationally to the same benchmark.

And it is now reversing…

Brand list prices fell in 2025, and net price growth turned negative. Discounts now average 36% - 60% off list, and contracting is shifting toward net price…reinforced by the 2026 federal reforms.

Source: Drug Channels Institute

How Benefit Design Decisions Get Made

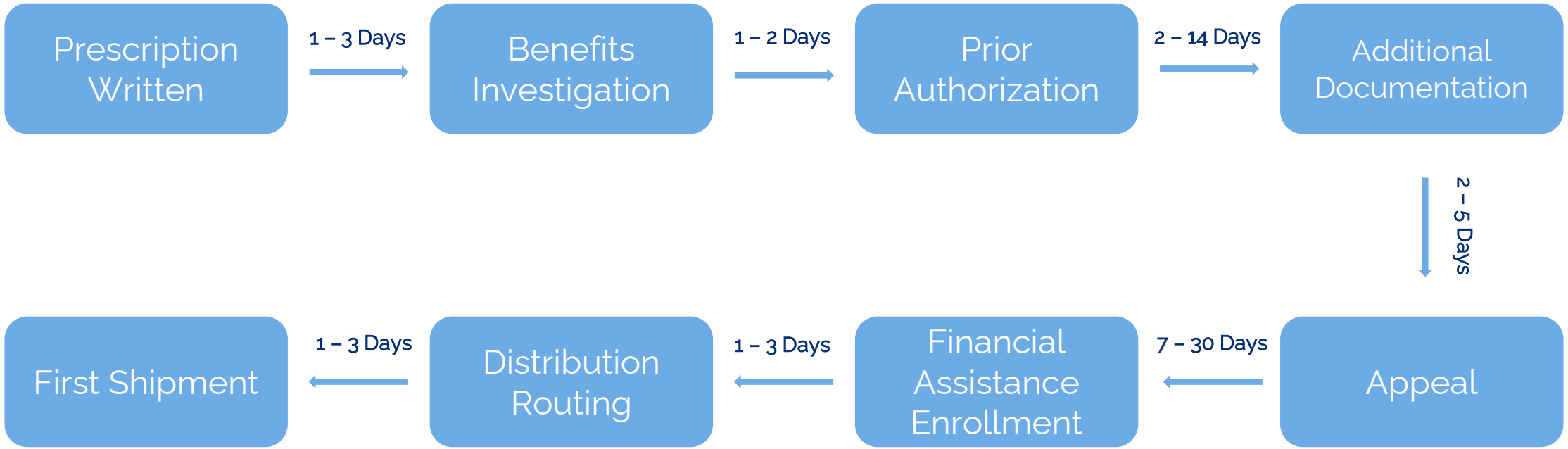
- **What the plan sponsor is buying:** formulary, pharmacy network, claims adjudication, utilization management, clinical programs, negotiating leverage
- **Who actually chooses the design?** The employer or plan sponsor?
- **The trade-off:** broader network vs. lower cost, open formulary vs. lower premium, low copays vs. higher payroll deduction

How Contracts Determine Who Can Dispense

- Three gates before a pharmacy can dispense: manufacturer limited distribution network access, payer network inclusion, and accreditation (URAC / ACHC)
- URAC is preferred by roughly two-thirds of payers; dual accreditation is increasingly standard
- Manufacturers use accreditation as a proxy for operational readiness and require adherence tracking, patient support, and real-time data reporting

From Prescription to Patient

A Patient's First 21 Days



The Utilization Management Toolkit

Tool	Problem(s) Solved	Potential Friction Point(s)
Prior Authorization	Confirms the therapy matches the indication & evidence before the plan commits.	The justification lives in the chart, not in claims, so it has to be gathered by hand.
Step Therapy	Tries a lower-cost, comparably effective option first where the evidence supports it.	Prior trials under a former plan are not in the data, so patients potentially repeat a drug that already failed and in progressive disease that time is not recoverable.
Quantity Limits	Aligns dispensing with labeled dosing and prevents waste of costly product when therapy stops early.	Titration and weight-based dosing fall outside standard limits, forcing repeat overrides.
Formulary Tiering	Creates the negotiating position that produces discounts & holds down the premium funding the benefit.	Specialty tiers use coinsurance, so patient cost is hard to predict & a mid-year change can move a stable patient.
Designated Networks	Concentrates volume in pharmacies that can demonstrate handling, accreditation, & clinical service standards.	The patient may leave a team that knows them, and any transfer risks a gap in therapy.

Financial Assistance & Plan Design

- **Three Assistance Sources:** manufacturer copay support, independent foundation grants, manufacturer patient assistance programs
- **Two plan design choices that determine how assistance is treated:** Copay accumulator and copay maximizer programs
- Why the same copay card produces different results under different plans

Site of Care

Buy & Bill

Hospital Outpatient

Ambulatory Infusion Center

Physician Office

Home Infusion

The Gap Between "Approved" & "On Therapy"

- Abandonment rises sharply with out-of-pocket cost: roughly 1.3% – 10% when cost sharing is $0 - $50, 32% - 75% above $100
- Delayed initiation rises with cost-sharing/higher copayment
- Administrative burden per script; adherence at 12 months

Where the Industry is Headed

What is Changing Right Now

- **The Consolidated Appropriations Act of 2026 (signed February 3, 2026):** flat-fee, service-based compensation delinked from list price, 100% rebate pass-through to plan sponsors, standardized reporting…phasing in 2028–2029
- **Direction of Travel:** net-price contracting, cost-plus reimbursement models, greater transparency for plan sponsors
- **Still Unsettled:** pace of employer adoption, network design, and how cell and gene therapy gets financed at all

Discussion Question 1

What does scale do well, and what does specialization do well, for a complex patient?

Discussion Question 2

In a transparent, net-price market, what is a specialty pharmacy actually paid for?

Discussion Question 3

In ten years, does technology replace the high-touch model or make it more valuable?

What This Means for Your Career

Roles You May Not Know Exist

Role	What it does on a Tuesday
Trade Relations negotiates purchasing agreements with manufacturers and wholesalers and manages those relationships	Reviewing contract terms on a new product launch and modeling what the acquisition cost means for the pharmacy's ability to serve those patients.
Payer Contracting negotiates the reimbursement rates and terms under which a pharmacy participates in a network.	Analyzing whether a proposed rate covers the cost to dispense for a given drug mix and preparing the counterproposal.
Market Access works to ensure a manufacturer's product is covered and reachable for patients.	Building the clinical and economic dossier a plan will review when deciding formulary placement.
Formulary & Clinical Strategy evaluates therapies for coverage and builds the criteria.	Reviewing new trial data and drafting the prior authorization criteria that will govern a drug for the next year.
Specialty Pharmacy Operations runs dispensing, inventory, cold chain, and workflow.	Investigating why time to first fill slipped by two days last month and redesigning the handoff that caused it.
Clinical Program Development designs and proves out the adherence, monitoring, and education programs funded from the margin	Building the outcomes model that will justify staffing a new disease-state program.
Outcomes & Analytics measures whether programs work using claims and clinical data.	Analyzing persistence rates across a patient cohort and preparing findings for a manufacturer or plan partner.
Field Reimbursement helps prescriber offices navigate coverage for a specific manufacturer's product.	Sitting with a practice to work through why their prior authorizations keep getting denied and fixing the documentation.
Hub Strategy designs the patient support program wrapped around a product.	Mapping where patients drop out of the enrollment process and redesigning that step.
Business Development brings on new payer, manufacturer, or health system partners.	Preparing the pitch that explains why this pharmacy should be added to a limited distribution network.

The Skills School Doesn't Grade You On

- Reading a Contract
- Reading a P&L
- Building a Business Case
- Negotiating
- Interpreting Claims Data
- Understanding Margins

How We Got Here

- Lateral moves?
- Detours?
- The decisions that did not work out?

Three Things to Take With You

Clinical excellence without business literacy will cap your influence.

Every barrier your patient hits, was a rational decision by someone balancing a population against a budget…learn to interpret the barrier, so you can help your patient navigate it.

The people who improve this system will be pharmacists who can work across or have working knowledge across every seat at the table.

Q&A


Together We
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