HOUSTON Methodist LEADING MEDICINE

HOUSTON METHODIST
PHARMACY & THERAPEUTICS NEWS

August 2026

FORMULARY UPDATES

Laura M. Blackburn, PharmD

The following medications were reviewed for formulary status

Medication	Formulary Action

Amivantamab-hyaluronidase (Rybrevant Faspro®)	Voting action: Add to formulary
	Restrictions
	• **Specialty:** Hematology/oncology
	• **Indication:** FDA label
	  ○ Locally advanced or metastatic non-small cell lung cancer
	  ○ First-line, EGFR exon 19del or L858R
	  ○ Previously treated, EGFR exon 19del or L858R
	  ○ First-line, EGFR exon 20 insertion mutations
	  ○ Previously treated, EGFR exon 20 insertion mutations
	• **Care setting:** outpatient with prior financial approval

Isavuconazole (Cresemba®)	Voting action: Expand formulary restrictions Restrictions • **Specialty:** Infectious Diseases, Transplant • **Indications include:** ○ Alternative prophylactic agent for invasive fungal infections in high-MELD liver transplant recipients with prolonged QTc (greater than 500 msec) on at least two sequential readings. Patients should switch back to voriconazole once two or more QTc results are less than 500 msec

To request a medication for formulary review, click here

2026 - 2027 FLU VACCINE SEASON BEGINS SEPTEMBER 1st, 2026

Inpatients may be vaccinated under the nurse-driven vaccine protocol with Flucelvax®; a "standard dose", inactivated, three-component flu vaccine or HD Fluzone® based on risk factors. Patients 65 years and older or are Solid Organ Transplant (SOT)/Immunocompromised patients will default in EPIC to receive the High-Dose influenza vaccine (Fluzone®).

Flu*celvax*® is approved for patients 6 months and older and utilizes cell culture technology, not eggs, and does not contain antibiotics or preservatives.

Flu*zone*® contains the same flu strain targets as Flu*celvax*®.

New for this flu season, enhanced Epic functionality will simplify the ordering process once the risk assessment is completed. See the attachment as a guide.

Have a medication-related, cost-saving idea? Submit your idea here
We will research the issue and support approval and implementation.

The *Pharmacy & Therapeutics News* is dedicated to providing the most current information regarding medication-use policy and formulary issues. Each issue details recently approved actions from the system P&T committee as well as relevant patient safety, pharmacotherapy and drug distribution updates. Entity representatives to the system P&T committee structure can be found here.

THERAPEUTIC INTERCHANGE UPDATES

RXMEDTI 142 5HT3 Receptor Antagonists

Triennial review; formulary items are aligned with recommendations for post-op nausea and vomiting management guidelines and National Comprehensive Cancer Network antiemesis guidelines

- Formulary: ondansetron, palonosetron (restricted)
- Non-formulary: granisetron, palonosetron-netupitant, palonosetron-fosnetupitant

RXMEDTI 156 Melatonin to Ramelteon

Triennial review; per System_PCPS198 Herbal and Alternative Therapies, the Department of Pharmacy Services will not purchase, procure, or dispense non-FDA approved medications, such as melatonin, due to safety concerns

- Formulary: ramelteon
- Non-formulary: melatonin

RXMEDTI 135 Sedative Hypnotic Agents

Triennial review; no substantial changes

- Formulary: alprazolam, chlordiazepoxide, clobazam, clonazepam, diazepam, lorazepam, temazepam
- Non-formulary: estazolam, flurazepam, oxazepam, triazolam, quazepam

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MEDSAFETY MATTERS!

Mary Soliman, PharmD

ISMP Acute Care and Nurse AdviseERR Newsletters

Naloxone Continuous Infusion: Concentration Update

Amber M. Hernandez, PharmD

Naloxone infusions may be ordered in the emergency department and intensive care settings for patients with persistent opioid-induced respiratory depression/toxidrome. The standard concentration of 4 mcg/mL requires high volume rates of infusion for patients requiring doses of 1 mg/hr and higher. To prevent unnecessary waste, the 2 mg / 500 mL (4 mcg/mL concentration) will be available, and for patients who require infusions greater than or equal to 1 mg/hr, the 8 mg/250 mL (32 mcg/mL concentration) can be made available when requested from pharmacy.

Racemic Epinephrine Priority Status at Order Entry

Ebony Adams, PharmD

Racemic epinephrine is typically used in acute respiratory situations where timely administration is critical, and the current order default priority status is “routine” instead of “stat” which may contribute to a delay in medication availability. The Epic order configuration will be revised so that racemic epinephrine orders default to “stat” priority upon entry instead of relying on a manual priority change.

POLICY UPDATES

RXP&T 114 Medication Brown, White, Clear Bagging

Daniela Espino, PharmD

Houston Methodist (HM) requires that all medications intended for administration during a hospital-based outpatient department or clinic visit be supplied by the hospital pharmacy. Administration of the patient’s own medication supply, known as “brown bagging”, is only permitted in approved situations (see PCPS 310). Brown Bagging is restricted because the pedigree, storage, and integrity of the medication cannot be verified as required by the Drug Supply Chain Security Act (DSCSA).

“White bagging” is when HM obtains the supply directly from an external pharmacy. White Bagging is also restricted. HM Physician Organization (HMPO) may white bag product under three situations: 1. Insurance payer mandates, 2. limited distribution where HM cannot obtain, or 3. It is not feasible for HM to buy-and-bill the patient’s insurance. If one of the exception criteria are met, the medication is to be shipped directly from the licensed pharmacy to the HMPO clinic (never transported by the patient). This revision maintains the integrity of the medication distribution process for outpatient medications with limited procurement pathways.

“Clear Bagging” is similar to White Bagging but the outpatient pharmacy that provides the medication is HM Specialty Pharmacy.

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Managing Editor: Laura M. Blackburn, PharmD
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POLICY UPDATES CONTINUED

RXMEDTI 161 Deliriogenic Medications in Patients 70 or Greater

Christopher Soujah, PharmD

The American Geriatrics Society Beers Criteria recommends avoiding first-generation antihistamines, including diphenhydramine and hydroxyzine, due to strong anticholinergic effects and increased risk of confusion, constipation, falls, delirium, and dementia. The American Geriatrics Society Beers Criteria also recommends avoiding "z-drugs" such as zolpidem due to minimal improvement in sleep latency/duration and risk of delirium and falls.

The HM interchange reduces exposure of patients 70 years old or greater to medications associated with increased delirium risk and standardizes the therapeutic interchange of select deliriogenic medications (diphenhydramine, hydroxyzine, zolpidem). For itching or allergies, second-generation antihistamines are preferred alternatives due to lower CNS penetration and reduced anticholinergic effects. For insomnia, ramelteon is recommended.

The FDA published a warning about the risk of severe pruritus after discontinuation of long-term use of two second-generation antihistamines, cetirizine and levocetirizine. To avoid new starts of cetirizine following the FDA warning, the interchange from diphenhydramine and hydroxyzine for itching or allergy indications will direct to fexofenadine. Of note, cetirizine remains on formulary and available for use for continuation of home regimens or as a pre-medication.

RXCLIN 147 Pharmacy Consult to Review Medications for Confused Patients/Delirium

Christopher Soujah, PharmD

This pharmacy consult orders a targeted pharmacist review of medications that may worsen confusion or delirium in elderly patients. Consultation is recommended for patients with acute changes in mental status or those at high risk for confusion/delirium and may be ordered through the Delirium Elderly Initial Management order set or as a standalone order. Updates to the consult now guide pharmacists to assess the times of medication administration and advises pharmacists to reschedule scheduled medication administrations outside of the normal sleep times of 9PM to 5AM. These changes minimize nighttime interruptions and promote sleep, thereby reducing the chance our patients develop delirium.

RXCLIN 173 Pharmacy Consult to Manage Infliximab Rapid Infusion

Gia Castorina, PharmD

The consult facilitates the assessment a patient's eligibility to receive a 1-hour infusion of infliximab instead of the traditional 2-hour or longer infusion. Similar to RXCLIN 145 Pharmacy Consult for Review of Rituximab Administration, the pharmacist will review patient inclusion and exclusion criteria and convert the maintenance infusion to the rapid infusion rate per policy thus decreasing patient chair time.

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ANTIMICROBIAL STEWARDSHIP

Shivani Patel, PharmD

Acyclovir & Intravenous (IV) Hydration Reduces Acute Kidney Injury Risk

Xay Pham, PharmD

Acyclovir-induced acute kidney injury (AKI) is a well-recognized complication occurring at a rate of 10-40% according to literature. Acyclovir is highly excreted through the kidneys as unchanged drug and relatively insoluble leading to intratubular precipitation of crystals which can cause kidney injury. To minimize the risk of kidney injury, IV hydration protocols have been implemented though best practice standards for volumes and protocols are lacking.

A HM quality improvement assessment found that the majority (79%) of patients receiving acyclovir did not receive IV hydration. Overall, 24% of patients experienced AKI. There was no statistical difference in incidence of AKI identified between patients who received IV hydration compared to patients who did not receive IV hydration. However, the median length of stay was found to be longer for those not receiving IV hydration (11 vs 18.5, $p < 0.001$).

To improve the consistency of providing adequate hydration, a linked pre-acyclovir hydration order set, similar to that with amphotericin B liposomal, will be created to specify hydration with 0.9% sodium chloride, 250 mL, 500 mL, or a "No hydration" selection option to prompt assessment and facilitate ordering.

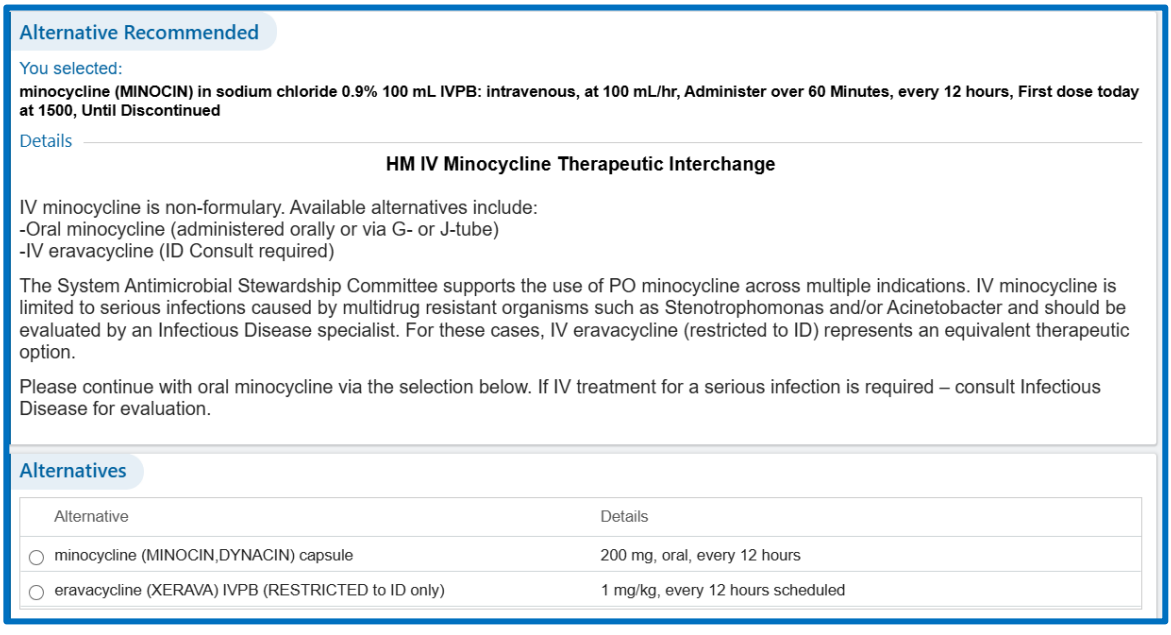
Therapeutic Interchange Minocycline Injection to Eravacycline Injection

Will Musick, PharmD

After an assessment of efficacy, safety and costs, intravenous minocycline was removed from formulary.

If oral minocycline is not viable, physicians will be guided to IV eravacycline.

Eravacycline is restricted to ID physicians.



Alternative Recommended

You selected:

minocycline (MINOCIN) in sodium chloride 0.9% 100 mL IVPB: intravenous, at 100 mL/hr, Administer over 60 Minutes, every 12 hours, First dose today at 1500, Until Discontinued

Details

HM IV Minocycline Therapeutic Interchange

IV minocycline is non-formulary. Available alternatives include:
-Oral minocycline (administered orally or via G- or J-tube)
-IV eravacycline (ID Consult required)

The System Antimicrobial Stewardship Committee supports the use of PO minocycline across multiple indications. IV minocycline is limited to serious infections caused by multidrug resistant organisms such as Stenotrophomonas and/or Acinetobacter and should be evaluated by an Infectious Disease specialist. For these cases, IV eravacycline (restricted to ID) represents an equivalent therapeutic option.

Please continue with oral minocycline via the selection below. If IV treatment for a serious infection is required – consult Infectious Disease for evaluation.

Alternatives

Alternative	Details
○ minocycline (MINOCIN,DYNACIN) capsule	200 mg, oral, every 12 hours
○ eravacycline (XERAVA) IVPB (RESTRICTED to ID only)	1 mg/kg, every 12 hours scheduled

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CHEMOTHERAPY STEWARDSHIP

Erika Brown, PharmD

Exception Review Panel (ERP) Update

Karen Abboud, PharmD

HM formulary restrictions approximates FDA-approved labeling but may be more restrictive at the direction of the medical staff. As outlined in System_RXP&T 001 System Pharmacy and Therapeutics Committee if there are frequent requests within a therapeutic specialty area to use medications outside of HM-approved criteria or there is a need to monitor medication use closely, a specialty standing Exception Review Panel (ERP) may be created.

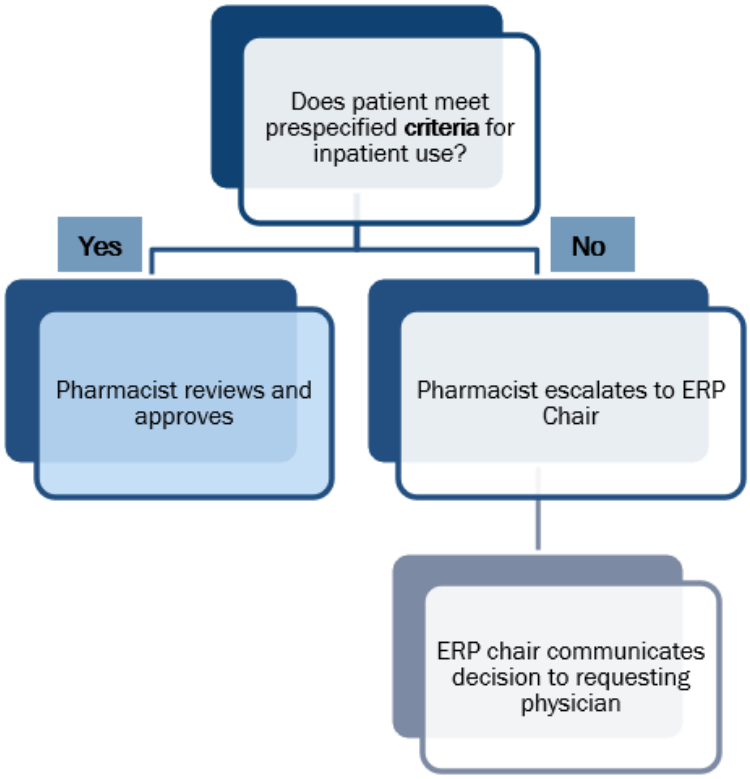
Such is the case for oncology medications that are restricted to the outpatient care setting. Justification for inpatient administration is reviewed through the hematology/oncology ERP. A physician initiates a request to use the medication outside of formulary-approved criteria which is then reviewed by the ERP Chair for approval or denial. ERP outcomes are aggregated and reported at least annually to system oversight committees to inform ongoing formulary restrictions and updates.

The 2025 report showed a steady increase in ERP requests from 90 in 2022 to 141 in 2025. Of the requests in 2025, 83% were approved. The top five most requested medications include daratumumab, pembrolizumab, obinutuzumab, inotuzimab, and glofitamab.

One of the considerations for inpatient administration is inability to complete a timely discharge (within seven days). However, 55.6% of patients were discharged within seven days of the approval.

As a result, several recommendations were approved to optimize the ERP process including formalizing pharmacy involvement in reviewing and approving ERP requests for using clearly defined clinical criteria to ensure consistency and appropriateness and an escalation to ERP chair for situations that fall outside of defined criteria.

Additionally, inpatient immunotherapy use will be limited to situations where postponing administration would result in treatment delays exceeding one cycle.



The revised ERP process is intended to maintain high-quality care delivery while stewarding financial resources.

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LABORATORY MONITORING UPDATES

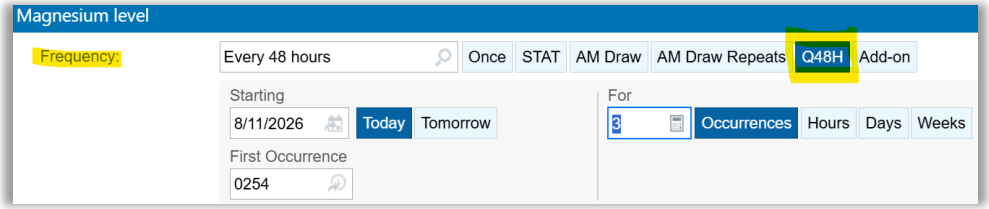
Michael Sirimaturos, PharmD

Magnesium and Phosphorus Lab Order Stewardship

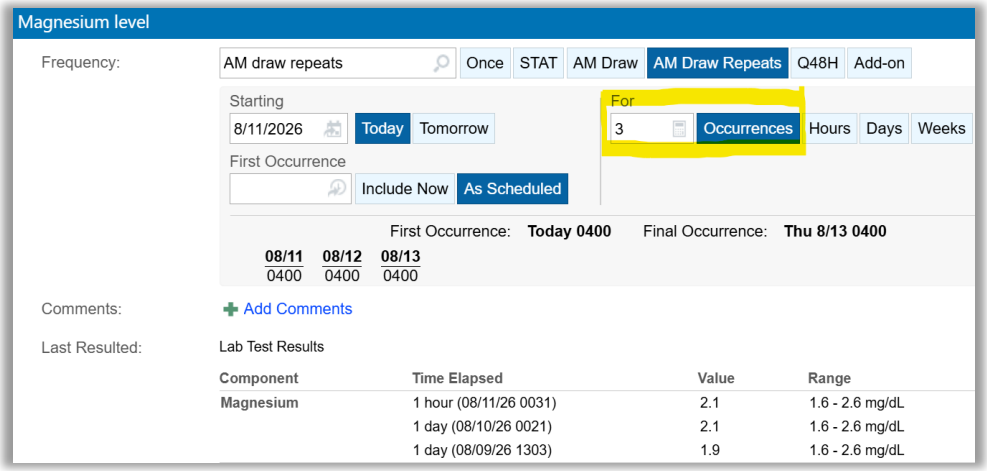
A quality improvement project was conducted to identify opportunities to minimize overutilization of electrolyte laboratory monitoring, specifically magnesium and phosphorus. Results showed that over 60% of magnesium and phosphorus levels were reordered despite the past five consecutive lab results being normal (i.e. magnesium >/= 2 mg/dL and phosphate >/= 2.5 mg/dL).

Unnecessary lab orders in the ICU and acute care patients not only expend nursing and laboratory resources, unnecessarily but increase phlebotomy and blood loss in patients. To encourage thoughtful use practices, the following changes for magnesium and phosphorus lab orders were implemented in Epic effective August 3, 2026:

1) Addition of a new “every 48 hours” frequency button



2) Reduction of the hard stop limit from 7 to 3 occurrences for “AM Draw Repeats” or “every 48 hours”



An Our Practice Alert (OPA) for “AM Draw Repeats” will trigger when a patient has ≥ 3 consecutive results within normal limits from the past 96 hours prompting the physician to consider an alternative frequency (i.e. every 48 hours, Once, AM Draw, etc.). Excluded from the alert will be patients on ICU electrolyte replacements protocols or the CRRT electrolyte replacement protocols.