HOUSTON Methodist LEADING MEDICINE

HOUSTON METHODIST
PHARMACY & THERAPEUTICS NEWS
April 2026

FORMULARY UPDATES

Laura M. Blackburn, PharmD

The following medications and classes were reviewed for formulary status

Medication/Class	Formulary Updates
Ruxolitinib (Jakafi®)	**Formulary Action:** Not added to formulary. Patients may utilize own supply if maintained on a home regimen for chronic GVHD in accordance with System_PCPS194.1 Inpatient Oral Chemotherapy For new starts for acute GVHD, HM Specialty Pharmacy can facilitate prior authorizations and medication delivery. For new starts for chronic GVHD, utilize current processes working through insurance and preferred outpatient pharmacies or HM Specialty Pharmacy

To request a medication for formulary review, click here

MEDSAFETY UPDATES

Mary Soliman, PharmD

Bariatric Surgery Patient Medication Care Updates:

An Alert in Epic will be developed for "do not crush medications" for bariatric surgery patients to ensure appropriate administration of medications.

Haloperidol IV/IM to be Overridable in the Emergency Department for Agitation Management:

To more promptly and efficiently manage agitation in the EDs, haloperidol intravenous/intramuscular injection will be overridable in these locations. Second generation parenteral antipsychotic agents such as ziprasidone and olanzapine are already overridable, therefore, adding a first generation agent to the override list in the ED spaces ensures appropriate and timely care.

Pediatape replaces Rainbow Broselow Tape in Neonatal/Pediatric Crash Carts:

Due to multiple recalls of Broselow tape a readable and readily available alternative has been procured and deployed.

Policy Updates

The following therapeutic interchange triennial reviews were reviewed and approved.

- RXMEDTI 105 Therapeutic Interchange: Nasal Corticosteroids
  - ⇒ Fluticasone (Flonase®) remains the preferred formulary agent
  - ⇒ Beclomethasone dipropionate (Beconase®) and ciclesonide (Zetonna®) were removed
- RXMEDTI 131 Therapeutic Interchange: 5-Alpha Reductase Inhibitors
  - ⇒ Finasteride 5 mg remains the preferred formulary agent
  - ⇒ Combination product of finasteride AND tadalafil (Entadfi®) was added to therapeutic interchange
- RXMEDTI 121 Therapeutic Interchange: Long-Acting Beta Agonists and Inhaled Corticosteroids Combinations
  - ⇒ Fluticasone furoate and vilanterol (Breo Ellipta®) remains the preferred formulary agent
  - ⇒ Fluticasone propionate-salmeterol (Airduo RespiClick®) was removed
- RXMEDTI 168 Therapeutic Interchange LABA/LAMA/ICS Combination Inhalers
  - ⇒ Interchange to nebulized components remains the preferred formulary strategy
- RXMEDTI 114 – Therapeutic Interchange: SSRI Medications
  - ⇒ Reviewed and approved with no changes
  - ⇒ Paroxetine, Olanzapine and Fluoxetine individual products remain the formulary preferred agents

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.

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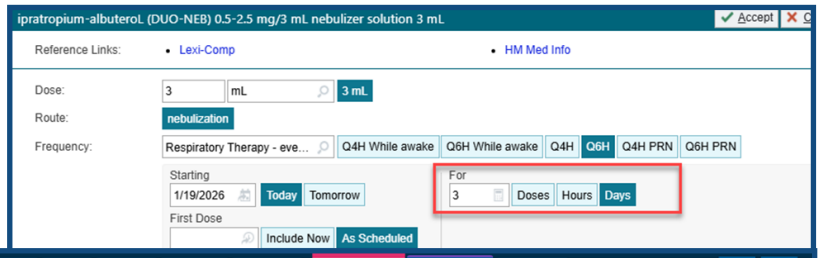
PHARMACY & THERAPEUTIC NEWS

PHARMACOECONOMIC UPDATES

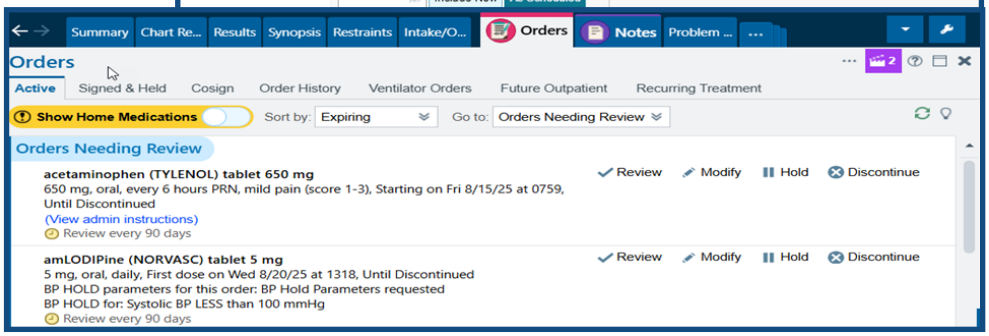
Laura M. Blackburn, PharmD & Jason Bordelon, RRT.

Respiratory Therapy Administered Medication Use Optimization Efforts

On February 24th, Houston Methodist implemented a default, 3-day duration default on respiratory therapy administered orders with the exception of Dry Powder Inhalers (DPIs), anti-infectives, and prostacyclin. This change was implemented to support the review and re-ordering of therapies only when necessary and avoid, carry-on orders when clinical conditions no longer warrant nebulized administration.

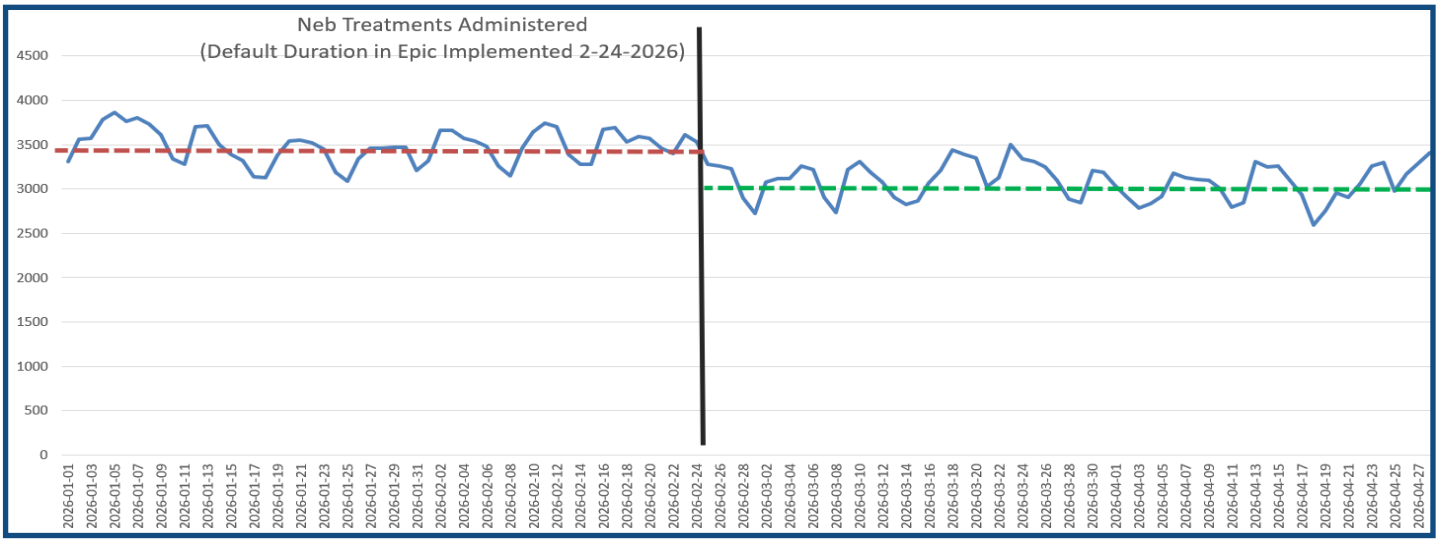


Orders show in the "Orders Needing Review" as they approach the day they would be expiring to enable visibility for re-assessment.



Since implementation of the Epic prompts, the use of nebulized treatments declined by about 14% without compromises to patient care.

Reducing unnecessary treatments allows respiratory therapists to address patients with the greatest need for nebulized therapy and also supports HM formulary strategy of utilizing nebulization-based administration vs. canister-based medication supplies which have a premium acquisition cost and often are manufactured to provide 14—30 day supplies. Use of canister formulations results in substantial waste as the typical inpatient length of stay is approximately 5—7 days.



The next aim for the program is to support patients and facilitate continuation of home-based combination canister-based regimens by expanding application of our HM home-supplied medication use program as they are available and clinically indicated. (reference policy System_RXMEDTI 168). This step will allow patients more convenience while in the hospital and facilitates observations of self-administration techniques with their home canister so patients are better positioned to continue self-care at home.

Have a medication-related, cost-saving idea? **Submit your idea here**

ISMP UPDATES

Mary Soliman, PharmD

ISMP features its Hierarchy of Effective Risk Reduction in the following issue Of the Medication Safety Alert Acute Care edition: Volume 31, Issue 1 January 15, 2026

The article recommends that organizations seek to mitigate inherent, pervasive risks to safety through a multifaceted approaches to risk reduction. High leverage solutions that may be more time consuming to implement often offer robust and sustainable risk reduction. Examples of those initiatives are below:

- **Forcing functions:** These are design features, procedures or tasks that ensure specific actions are completed to prevent errors. Such restrictions eliminate opportunity for undesired outcomes.
- **Barriers and fail-safes:** Initiatives in this category place safeguards designed to prevent undesired actions, reduce dangerous process steps, and minimize potential harm.
- **Automation and computerization:** When implemented effectively, these assure a process is streamlined to decrease unsafe or variable practices. This adds a level of consistency reliability and efficiency while ensuring an interconnected system.

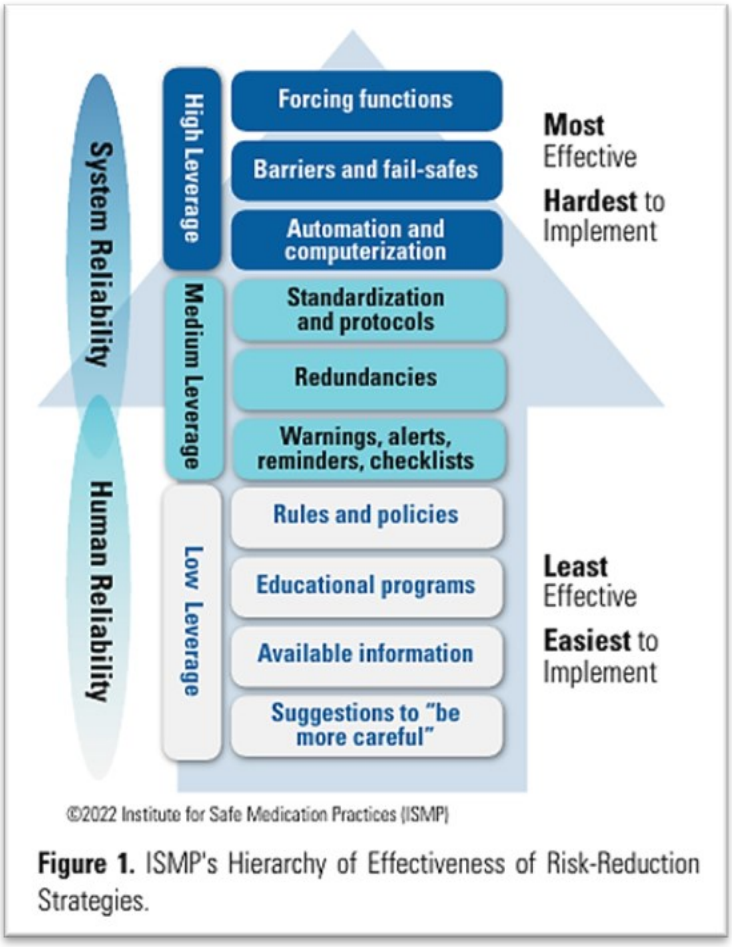


Figure 1. ISMP's Hierarchy of Effectiveness of Risk-Reduction Strategies.

ANTIMICROBIAL STEWARDSHIP

Shivani Patel, PharmD

ED Sepsis Order Set Updates

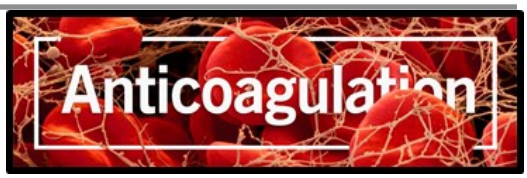
There is evidence suggesting reduced early mortality when β-lactam antibiotics are prioritized for administration before vancomycin in patients with bloodstream infections and suspected sepsis. Additionally, studies support using a standardized vancomycin loading dose of 25 mg/kg, demonstrating improved early clinical response without an increase in acute kidney injury.

To promote alignment across all HM System entities, auto-discontinuation of vancomycin orders with durations exceeding 24 hours should be implemented. In accordance with CMS and ACEP guidelines, ED providers should not place medication orders that extend beyond 24 hours. Furthermore, the admitting team should review the medication list within 6 hours of the admission order.

To facilitate ease of application of these best practices, the following order set updates were approved:

- Removal of the PRE-selected vancomycin consult
- Update all vancomycin loading doses to 25 mg/kg
- Standardize all orders to a 24-hour duration

ANTICOAGULATION COMMITTEE



Michael Sirimaturos, PharmD

While Epic Best Practice Advisory (BPA) alerts play an important role in preventing inappropriate anticoagulation timing, minimizing alert fatigue is essential to preserve their clinical effectiveness. Safety events occurring after BPA alerts during anticoagulation order verification were evaluated. Documented thrombosis and bleeding events were identified and associated with inappropriate anticoagulation initiation timing.

To improve the management of anticoagulation transitions, the following optimizations will be implemented in Epic:

BPA alerts at the time of anticoagulant order verification:

- Integration of embedded hyperlinks within BPA alerts to facilitate rapid access during order verification
  - ⇒ Therapeutic Anticoagulation Transition Guide
  - ⇒ Perioperative Anticoagulation Guidance
  - ⇒ Transitions from Oral Factor Xa Inhibitors to Parenteral Anticoagulation
- Enhance alerting specificity and reduce noise by changing the alert logic to reference the order's "start time" rather than the "order entry" time

Enoxaparin Monitoring Improvements

Enoxaparin is widely used for the prevention and treatment of thromboembolic events. Although standard dosing is appropriate for most patients, dose adjustments are essential in special populations to minimize bleeding risk and ensure therapeutic effectiveness. Renal impairment (creatinine clearance <30 mL/min) is a common source of dosing errors and increases the risk of adverse events.

To address this risk, enoxaparin order sets and electronic clinical surveillance alerting rules will be optimized to enhance dosing accuracy and improve monitoring in patients with renal dysfunction.

Optimization of *therapeutic* enoxaparin order set:

- Auto-select enoxaparin frequency of 1 mg/kg *daily* for patients with CrCl <30 mL/min
- Include alerts for inappropriate twice-daily dosing if the patient's CrCl <30 mL/min
- Create look-back alert for dialysis orders in patients to prevent oversight from one-time orders
- Insert order question if the patients CrCl is less than 30 mL/min to prompt for an assessment that the patient is on dialysis. If the patient is on dialysis physicians will be nudged with a statement relating the general contraindication of use. The alert is configured as a soft stop that can be overridden for rare, but appropriate situations where benefit outweighs risk.

Revise pharmacy consult policy verbiage regarding enoxaparin monitoring using Anti-Xa levels to read:

- Should be drawn as a peak level, 4-6 hours at or after the 3rd dose of enoxaparin
- Supratherapeutic anti-Xa levels will be monitored every 12 hours until the anti-Xa level is LESS THAN 0.8 mg/dL

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System P&T Committee Roster is available to view here.

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