HOUSTON Methodist LEADING MEDICINE

HOUSTON METHODIST
PHARMACY & THERAPEUTICS NEWS
February 2026

FORMULARY UPDATES

Laura M. Blackburn, PharmD

The following medications and classes were reviewed for formulary status

Medication/Class	Formulary Updates
Denosumab-(Stoboclo® / Osenvelt®)	**Formulary Action:** Added to Formulary ⇒ Denosumab (Prolia® / Xgeva®) was removed from hospital formulary ⇒ Denosomuab (Stoboclo® / Osenvelt®) biosimilar was added to formulary **Category:** Bone-Modifying Agent; Monoclonal Antibody **Indication:** Osteoporosis, giant cell tumor of bone, hypercalcemia of malignancy **Restrictions:** Restricted to outpatient administration with prior financial approval **Rationale:** Payer coverage prefers biosimilars
Palivizumab (Synagis®)	**Formulary Action:** REMOVED from Formulary **Rationale:** Nirsevimab and clesrovimab are first line agents for the prevention of RSV, Palivizumab is no longer routinely recommended for use and has been discontinued as of December 31, 2025

To request a medication for formulary review, click here

ATGAM Dose Rounding by Pharmacy Protocol Reviewed

RXP&T 103 was developed to standardize the process for dose rounding this weight-based dosing medication to avoid waste.

The program continues to provide the anticipated value while not compromising patient care. Per policy, pharmacists may automatically round the dose DOWN to the nearest vial size, when the change is less than or equal to 10% of the total ordered dose. Pharmacists will contact prescribers for recommendations if rounding is greater than 10% as needed.

No changes to the current policy and procedure were required.

Have a medication-related, cost-saving idea? Submit it here.
We will research the issue and help you implement.

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.

MEDICATION POLICY UPDATES

The following therapeutic interchanges were had triennial reviews conducted with subsequent updates.

- **RXMEDTI 130 Therapeutic Interchange Moxifloxacin to Levofloxacin — Retired**
  - ⇒ Moxifloxacin clarified as a *formulary restricted* medication and levofloxacin remains the preferred formulary agent
- **RXMEDTI 143 Therapeutic Interchange Ceftazidime to Cefepime — Retired**
  - ⇒ Ceftazidime clarified as a *formulary restricted* medication. Cefepime remains the preferred formulary agent.
- **RXMEDTI 145 Therapeutic Interchange Macrolides**
  - ⇒ Remove clarithromycin from formulary and as a convenience, Epic will re-direct providers to the H.Pylori order set when attempting to order clarithromycin as this was the primary use in practice.
- RXMEDTI 150 Therapeutic Interchange Nitrofurantoin
  - ⇒ Formulary agent remain Nitrofurantoin monodyhydrate/macrocrystals

CHEMOTHERAPY STEWARDSHIP COMMITTEE

Erika Brown, PharmD

System Policy Implementation: Methotrexate for Ectopic Pregnancy

Houston Methodist established a policy for methotrexate for ectopic pregnancy:

- Nurses MAY NOT take/accept/verbal/e-verbal chemotherapy orders or write chemotherapy orders except to hold or stop chemotherapy administration
- Orders must be placed through the **Methotrexate IM for Ectopic Pregnancy order set**
- Methotrexate trained RN (MTX RN) must be an RN in the Emergency Department or Childbirth Center, complete the LMS module related to administering methotrexate for ectopic pregnancy and complete an in-service for methotrexate administration

Optimal Timing of Immunotherapy Administration:

Morning vaccination have been found to elicit more robust B-cell, T-cell, monocytes and dendritic cell responses as native CD4 and CD8 T cells in blood approach nadir around 1600. Enhanced efficacy has been proven of immune check point inhibitors following administration in the morning when immune cells are primarily located in the tumor and its draining lymph nodes. Clinical trials across multiple cancer types (melanoma, kidney, gastrointestinal, and non-small cell lung cancer) found that patients receiving therapy between 1130-1630 have longer overall survival, improved objective response rate, and improved time to treatment failure. Given this evidence, regimens including immunotherapy with immune checkpoint inhibitors will be scheduled in the morning prior to 1200 when possible.

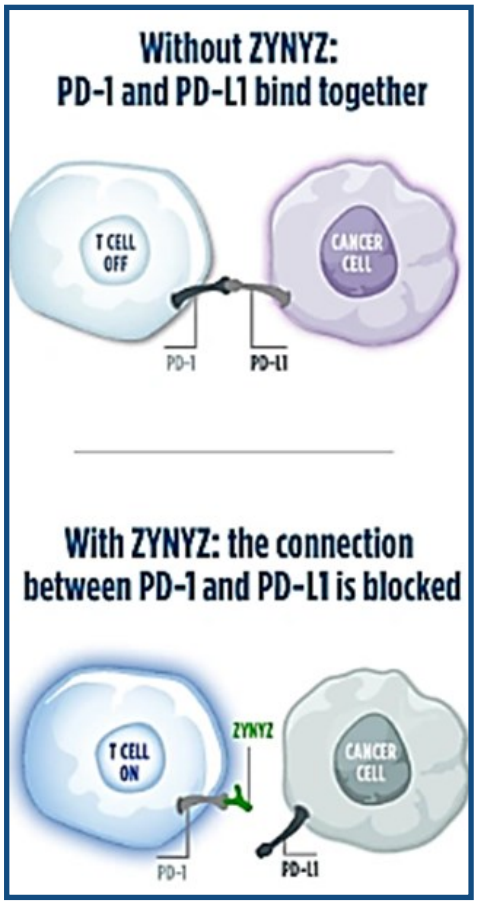
Retifanlimab (ZYNZ®)

Retifanlimab, was added to formulary with restrictions for the hematology/ oncology team and for administration in the outpatient setting in patients with prior financial approval.

Zynz binds to PD-1 and blocks the interaction with PD-L1 to PD-L2 to re-store T-cell activity. Literature shows clinical benefit and a manageable safety profile in first-line advanced squamous cell carcinoma of the anal canal retifanlimab is when used in combination with carboplatin and paclitaxel.

Retifanlimab is dosed at 500 mg as an intravenous continuous infusion over 30 minutes every 4 weeks until disease progression, unacceptable toxicity, or up to 24 months.

Major and severe adverse reactions include immune-mediated reactions such as hypothyroidism, peripheral sensory neuropathy, diarrhea, hyper-thyroidism, and pruritus.



MEDSAFETY UPDATES

Mary Soliman, PharmD

IV Antihypertensive Updates:

An effort to enhance both Esmolol and Nitroglycerin order panels has been approved to ensure accurate and up to date practice for safe patient care. The Esmolol orderable will have an optional bolus added with updated administration instructions included. These updates will also be included in the Alaris Drug Library. The Nitroglycerin set-rate order will be eliminated (titratable order can be edited to set rate) and updated administration guidelines and holding parameters have been added. A new Nitroglycerin High Dose IV for Flash Pulmonary Edema will also be added with important bolus infusion, administration instructions, and monitoring parameters included.

Electrolyte Protocol for Use in the Acute Care Settings:

A physician driven electrolyte placement protocol which ensures safe repletion and monitoring in the Acute Care setting has been approved. This is part of a multi-modal approach of electrolyte replacement optimizations geared towards prescribers, pharmacy, and nursing to ensure best and safest practices. The protocol-based replacements are shown to the right. **IMPORTANT: Choose oral or NG routes for replacement when available. Equivalent effectiveness has been established with this route of administration and reduces costs of care and material waste.**

Potassium [358382]

Potassium Level (mEq/L)	Potassium Chloride Dose	Monitoring
3.5 – 3.7	20 mEq PO or IV	8 hours post administration
3.2 – 3.4	60 mEq PO or IV	
LESS THAN 3.2	80 mEq IV ONLY	2 hours post administration

Select CENTRAL or PERIPHERAL line order options based on available access
Patients tolerating oral feeding without symptomatic electrolyte abnormalities should receive oral replacement.

Normal Magnesium [140201]

Magnesium Level (mg/dL)	Magnesium Sulfate IV Dose	Monitoring
1.5 – 1.9	3 g IV	AM labs
1.0 – 1.4	4 g IV	2 hours post administration
LESS THAN 1.0	4 g IV	2 hours post administration AND Contact MD

Phosphate [360279]

Phosphate Level (mg/dL)	Sodium Phosphate IV Dose	Phospha Neutral 250 PO Dose	Monitoring
2 - 2.4	30 mmol IV	6 (2 tabs q4 hours x3)	AM labs
1.5 – 1.9	40 mmol IV	8 (2 tabs q4 hours x4)	
LESS THAN 1.5	60 mmol IV	--	2 hours post administration

Patients tolerating oral feeding without symptomatic electrolyte abnormalities should receive oral replacement.

Optimizing Stroke Care: Route/Intake OPA and Report:

To ensure optimal care for our stoke population, a Route Mismatch OPA will be implemented to warn physicians and verifying pharmacists that a patient is designated as “intubated” but has medication ordered for a route of per oral. Furthermore, a detailed report for oversight will allow visualization patients who are ordered oral medications with the following designations:

Patients with a diagnosis of “Stroke” AND
- Identified as “Intubated” - OR -
- Has NPO meds designation - OR -
- Failed or incomplete Dysphagia Screen

Absolute Neutrophil Count (ANC) value available for G-CSFs (filgrastim and pegfilgrastim) Orders:

ANC is the primary monitoring parameter used as a holding parameters for G-CSFs (granulocyte colony stimulating factors). Epic will now include the ANC value when available for providers at the point of ordering filgrastim or pegfilgrastim. The standard administration time for G-CSFs for inpatients is 4PM allowing a review the ANC *before* administering the dose.

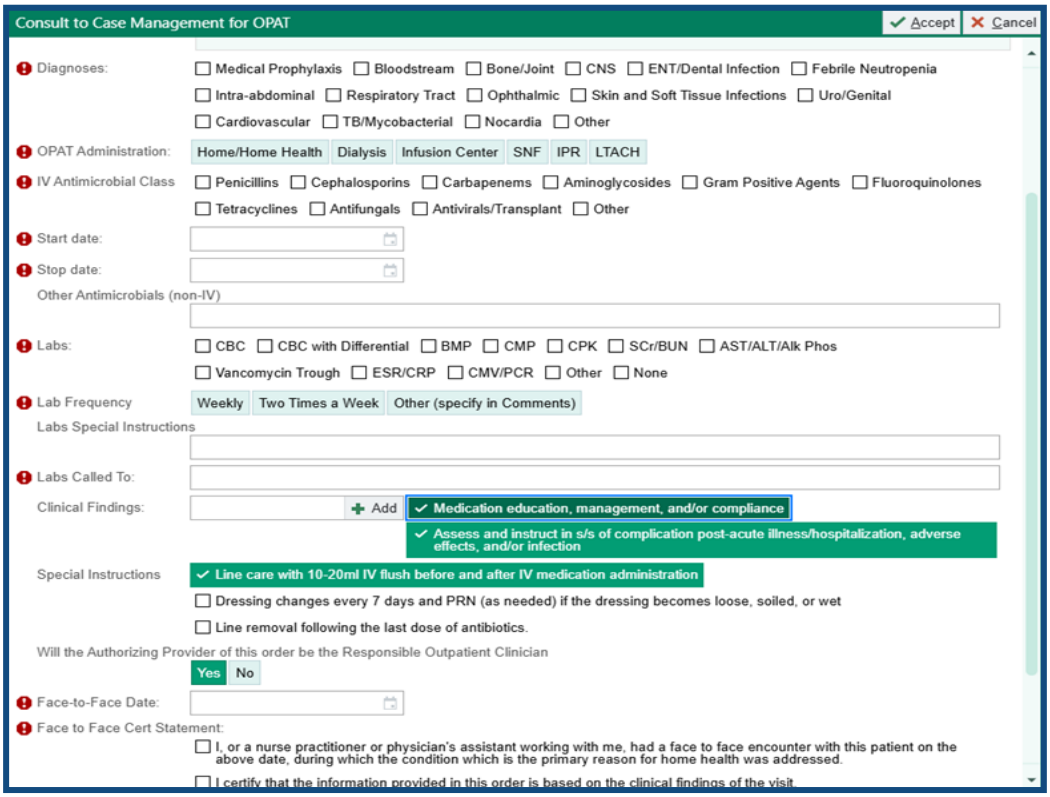
ANTIMICROBIAL STEWARDSHIP

Shivani Patel, PharmD

Outpatient Parenteral Antibiotic Therapy (OPAT) Epic Order Changes: Live: February 18, 2026

To improve the completeness and usefulness of the orders for OPAT, Epic orders have been modified.

The change enables greater visibility of all patients receiving this therapy allowing improved assessment for appropriateness and aligns case-management and pharmacy support for more efficient transitions of care to the outpatient care destination.



Doxycycline Epic Orders Optimized:

The Epic orderable for doxycycline will be converted to an order panel and indication-based doses. The following will be the common uses and associated dosing defaults.

- Pulmonary infections: 100 mg IV x1 dose followed by 100 mg PO x2 days
- Skin/Soft tissue/Bone/Joint infection: 100 mg PO q12, 100 mg PO q12 x7 days
- Sexually transmitted infections: 100 mg PO q12 x7 days
- Other: 100 mg PO q12, provider to set duration
- Suspected/confirmed Vibrio infection: 100 mg IV q12 x3 days, followed by 100 mg PO q12 with provider to set duration

Prevention of Surgical Site Infections Assessment Post PEN-FAST Implementation

Starting in 2024, Houston Methodist introduced PEN-FAST assessments for patients reporting penicillin allergies as a means to better clarify the risk of administering beta-lactam antibiotics. An internal study evaluated the impact of PEN-FAST implementation combined with pharmacist-led antibiotic optimization on pre-operative antibiotic selection in patients with a penicillin allergies.

There has been a 20% improvement (95% versus 75%) in patients receiving optimized pre-operative antibiotic prophylaxis with either with cephalosporin or ertapenem since the program's implantation. Use if less optimal and often more toxic alternatives to a cephalosporin were reduced as a result of the program. No adverse events safety or infection related events have been noted since change.

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