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PHARMACY AND THERAPEUTICS COMMITTEE

DATE: April 13, 2017 CALLED TO ORDER: 7:00 A.M.
LOCATION: Private Dining Room ADJOURNED: 8:00 A.M.

Members Present:		**Members Absent**:	**Guests**:
Richard Pesce, M.D. (Phone)	Sandy Vredeveld, DPh	Nan Payne, RN	Shane Church, PharmD
David Dodson, M.D.	Patrick Ellis, PharmD	Nathan Schatzman, M.D	Justin Reinert, PharmD
Mark Anderson, MD	Lila Heet, PharmD	Shannon Harris, RN	Jenny Gibson, PharmD
Allen Atchley, M.D.	Susan Fuchs, RD	Michael Stipanov, M.D.	Brianna Qualls, Student
Richard Yap, M.D.	Karen Babb, PharmD	Scott Harbaugh, Finance	
Helen Kuroki, MD	Melissa Roden, RN	Jeffrey Mullins, M.D	
F. Hamilton, M.D.	Rodney Elliott	Jamie Barrie, PharmD	
Avni Kapadia, M.D.	Petra Green, RN	Patty Hicks, RN	
Nathan Chamberlain, M.D	Elvira Smith, RN		

This meeting will be convened under the protection of the Tennessee Statute 63-6-219 and the Health Care Quality Improvement Act of 1986, Public Law 99-660. All information, case reviews, meeting minutes, statistics and correspondence are confidential and protected. Included in that protection are those that are involved in the review of the information. Any discussion of this information outside the realm of Peer Review constitutes a breach and violates the protection of the persons involved in the breach.

AGENDA ITEM	FINDINGS OR CONCLUSION	ACTION, RESPONSIBILITY	STATUS
Minutes	The February 9, 2017 minutes were approved as submitted.	Approved	Complete
CHI MUE Committee	The following medications were reviewed: **CHI MUE Committee Decision Brief**: The medications that were reviewed at the March national MUE committee meeting were reviewed with the committee. The only two items that required local P&T review are the following:		
	A. **Sotalol:** Sotalol IV injection was designated non-formulary by the national committee. Dr. Dodson pointed out that this is part of the ACLS pathway for treatment of tachycardia with wide QRS. Dr. Pesce and the committee didn't feel this was necessary as other formulary options such as amiodarone and procainaimide are also options for this same indications.	Non formulary status approved	Complete
	B. **Dantrolene:** Larger vial size formulation (Ryanodex) designated non-formulary by the national committee. This product is currently non-formulary at Memorial facilities and the committee was in support of the national non-formulary designation.	Non formulary status approved	Complete
	C. **Inpatient iron formulary:** No changes to local formulary necessary; current formulary consistent with national decision (ferric gluconate complex OR iron dextran single dose replacement).	No changes necessary	Complete
	D. **SGLT2 inhibitors:** No changes to local formulary necessary; current formulary consistent with national decision (non-formulary, these meds are held during hospitalization).	No changes necessary	Complete
	E. **Long acting bronchodilators:** Formulary preferred products and corresponding therapeutic interchanges for LABA (Brovana), LAMA (Spiriva), and LAMA/LABA (Anoro Ellipta) were designated by the national committee. No changes to local formulary necessary; current formulary consistent with national decision.	No changes necessary	Complete

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Therapeutic Interchanges and Formulary Decisions	1. **Latuda® (lurasidone) –** New atypical antipsychotic indicated for treatment of bipolar depression and schizophrenia. Recently designated as formulary-restricted by national MUE committee to facilities with inpatient psychiatric care facilities. The committee agreed with this recommendation and supported non-formulary designation for all Memorial facilities.	Non-formulary status	Complete
	2. **Invega® (paliperidone) –** New atypical antipsychotic indicated for treatment of schizoaffective and schizophrenia (major metabolite of risperidone). Recently designated as formulary-restricted by national MUE committee to facilities with inpatient psychiatric care facilities. The committee agreed with this recommendation and supported non-formulary designation for all Memorial facilities. An optional therapeutic substitution was offered by CHI although Patrick suggested that due to PK/PD differences between the formulations to designate this as non-formulary and work through non-formulary processes when patients are unable to supply their own home medication for dispensing during hospitalization.	Non-formulary status	Complete
	3. **Relistor® (methylnaltrexone) Therapeutic Interchange –** A potential therapeutic interchange (Relistor → Movantik) was proposed for patients with Relistor orders that are able to tolerate oral medications. This interchange was previously supported and approved by CHI national MUE committee in 2016. Justin reviewed a recent evaluation of Relistor utilization and discovered that 38% of patients that were prescribed Relistor were taking other oral medications at the time of the Relistor order and could have potentially received Movantik as an alternative therapy (significant cost savings opportunity). The majority of all use (70%) was from hospitalist and ED providers. The committee was supportive of this automatic therapeutic interchange and recommended this be approved and implemented at Memorial facilities. Patrick explained that he was still awaiting feedback from GI providers on this interchange and until this feedback is received he suggested that this interchange not involve GI providers and this decision would be modified to include these providers or not based on this specialty's feedback.	Therapeutic interchange approved	Complete
	4. **Reopro® (abciximab) –** Due to minimal use and routine wasting of expired product, Patrick has previously discussed the formulary status of Reopro with the interventional cardiologists. The invasive cardiology committee agreed with the recommendation for formulary removal. Further changes to this class of medications are currently being considered by the national MUE committee and national CV service line with further discussion planned for the May MUE committee meeting.	Removal from formulary approved	Complete
Medication Safety & Policy	1. **Hypertonic saline (3% NS) –** Follow up discussion from previous meeting. Patrick reviewed a proposed policy for use of hypertonic saline. The policy detailed ordering requirements, lab monitoring requirements, criteria for stopping infusion (Na+ increase limits), as well as nursing documentation and monitoring requirements. Additionally, a draft order set was presented that incorporates the various policy requirements that would be required for non-nephrology or critical care physicians to order hypertonic saline for treatment of hyponatremia. Dr. Chamberlain expressed support for both proposed documents (policy and order set) and also suggested that appropriate use criteria also be included on the order set to highlight when this therapy should be utilized (hyponatremia with symptoms). He agreed to help Patrick develop this verbiage. Additional discussion revolved around restricting to critical care areas only, however the committee supported the documents as written without including any additional restrictions to particular patient care units. Patrick agreed to provide education to the	Policy & order set approved, additional education to be provided to hospitalists	Complete

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	hospitalist via their routine monthly staff meeting. 2. **Perioperative medication management –** The updated pre-operative anesthesia orders were reviewed by the committee. Dr. Schatzman, although not in attendance, expressed continued concerns regarding the holding of ACE/ARBs without further communication with MEC and expanded education to surgery providers. The committee still strongly supported this initiative from a patient safety standpoint and Patrick agreed to assist with any additional education needs for eventual inclusion regarding perioperative holding of ACE/ARBs. Dr. Schatzman plans to present this to MEC on April 25th for further discussion. Temporarily the holding of ACE/ARBs statement will be removed from this order set until education plan in place. 3. **PCA smart pump "guardrail" settings** – A recent patient safety event due to a PCA pump programming error (incorrect hydromorphone continuous rate) prompted a review of the existing soft and hard limits for morphine and hydromorphone PCAs. Patrick explained that this review revealed that 45% of all attempted pump programs triggered either a soft or hard limit alert. Additionally, the current soft and hard limits were set at levels that did not mirror typical PCA dosing from routinely used order sets. Patrick reviewed potential changes that should lower the number of unnecessary soft limit alerts and readjust these to levels that will render these alerts more useful and prevent more potential programming errors. These changes will further be reviewed with nursing and implemented with the next scheduled pump update. 4. **Nicardipine IV infusions** – Per Dr. Yap's request, the current hospital policy (*Cardiac IV & Continuous Medication Infusion – Patient Placement & Monitoring Policy*) was reviewed for potential inclusion of nicardipine infusion for traditional telemetry units. After discussion, the physician committee members felt uncomfortable from a patient safety standpoint in modifying the existing policy which limits nicardipine to ICU or SSU units only. The committee felt that IV nicardipine infusions should only be utilized for patients with hypertensive urgency and these situations should be confined to ICU areas. Dr. Atchley suggested IV hydralazine be utilized as an IV agent when patients are experiencing intermittent hypertension uncontrolled by traditional oral medications.	Changes pending Dr. Schatzman's MEC discussion Approved Modifications to existing policy not supported	Pending Complete Complete
Medication Use Evaluation	1. **PPI Stress Ulcer Prophylaxis –** A repeat MUE was conducted to reassess the appropriateness of hospital initiated PPI SUP. This re-evaluation showed improved use among ICU patients although non-ICU utilization was not improved with 80% of all newly initiated use inappropriate (mostly hospitalist providers). Dr. Hamilton suggested re-education for hospitalists with focus on increased risk of Clostridium difficile infection (CDI) in patients on acid suppression therapies. Jenny also explained that ~50% of all inappropriate use originated from 5 hospitalist providers. Melissa suggested letters be sent to these 5 physicians alerting them of their outlier status in regard to PPI prescribing and this was supported by Dr. Hamilton. Patrick has already begun re-education for providers and this will continue until all hospitalist providers have received this education on PPI use and increased CDI risk. 2. **Glycemic Control –** Shane briefly reviewed data from his residency project evaluating glycemic control for hospitalized patients with ICD-10 diagnosis of diabetes. The data has shown a high incidence of hyperglycemia (> 180 mg/dl & > 250 mg/dl) particularly among patients admitted on home insulin regimens. A pilot is currently underway in which pharmacy is working closely with hospitalist providers when hyperglycemia has been identified using the pharmacy's clinical surveillance system.	Education plan in place Information only	Complete Complete

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Nutrition Support	**Diet Manual –** Annual review per policy. There has been no changes of the current Nutrition Care Manual by the Academy of Nutrition and Dietetics since March 2016. Location of the NCM is on MNet, manual discs available per policy in case of emergency. Current attachment to our Diet Manual Policy includes diets that are exceptions to the Nutrition Care Manual. The very restrictive GI Soft Diet that was requested by a physician that no longer practices at Memorial was removed from the exception list.	Approved	Complete
Protocols	**IV Iron Replacement (max dose consideration) –** Patrick reviewed a proposed revision to add a 1.5 gram max dose to the IV Iron Replacement Protocol. A few recent large doses per the standard dose calculation prompted a review of the literature in regard to maximum total iron replacement doses. Although a clear literature recommendation doesn't exist the majority of evidence seems to suggest a 1.5 gram per total dose maximum. This was reviewed with Dr. Stipanov and he agreed with this suggested modification. **Nicotine Replacement Protocol –** Justin reviewed the current NRT protocol and explained that some modifications appear to be needed. The committee agreed with the option to add PRN lozenges as a standard in addition to patch therapies which is consistent with consensus recommendations from USPHS. Additionally, the committee supported Patrick's suggestion to investigate the possibility of automatically initiating the NRT protocol for any patients that are agreeable to cessation therapy while hospitalized without the need for specific physician order (similar to flu vaccination process). Patrick will discuss with Nan Payne to see if a previous MEC approval will allow this or if this will require additional MEC approval. If approved, Patrick will work with clinical informatics to assess feasibility of incorporating this into our current EMR.	Approved Approved	Complete Pending

There being no further business, the meeting was adjourned at 8:00 A.M. The next P&T meeting is **June 8, 2017 at 7:00 a.m.**

Respectfully submitted,
Sandy Vredeveld, D.Ph. Director of Pharmacy
Patrick Ellis, Pharm.D Pharmacy Clinical Coordinator

Approved by,
Richard Pesce, M.D. Chairman