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PHARMACY AND THERAPEUTICS COMMITTEE

DATE: November 16, 2017 CALLED TO ORDER: 7:00 A.M.
LOCATION: Private Dining Room ADJOURNED: 8:01 A.M.

Members Present:		**Members Absent**:		**Guests**:
Richard Pesce, M.D. David Dodson, M.D. Mark Anderson, MD Richard Yap, M.D. Helen Kuroki, MD Nathan Chamberlain, M.D Vimal Ramjee, M.D.	Sandy Vredeveld, DPh Patrick Ellis, PharmD Lila Heet, PharmD Karen Babb, PharmD Melissa Roden, RN Patty Hicks, RN Valerie Daniels, RN Nick Lockhart, PharmD	Nan Payne, RN Shannon Harris, RN Rhonda Polson, CNO Rodney Elliott Scott Harbaugh, Finance Jeffrey Mullins, M.D Jamie Barrie, PharmD Allen Atchley, M.D. Avni Kapadia, M.D Nathan Schatzman, M.D	Elvira Smith, RN Michael Stipanov, M.D. Susan Fuchs, RD	Avery Hart, PharmD Prisca Taylor, PharmD Rima Patel, PharmD Lacey Boutwell PharmD Morgan Stiltner - student Neil Patel - student

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 August 2017 minutes were approved with the below edit: • Mivacron (mivacurium): Patrick relayed that Dr. Schatzman no longer feels that this medication will be necessary for anesthesia use and no appeal to the national non-formulary decision will be needed.	Approved	Complete
CHI MUE Committee	**CHI MUE Committee September Decision Brief**: The medications that were reviewed at the September national MUE committee meeting were reviewed with the committee. All new formulary agents or formulary changes were discussed in detail with the group and described in the "Therapeutic Interchanges and Formulary Changes" section of the minutes below. The below items will either be deferred to a future meeting, not applicable to Memorial hospital practice, or consistent with the current Memorial medication formulary. **A.** **Aptiom (eslicarbazepine):** New medication for partial onset seizures. Due to no official formulary requests in the Chattanooga market Dr. Pesce recommended deferral of this formulary review to a later date. **B.** **Parsibiv (etelcalcetide):** New injectable medication for treatment of secondary hyper-parathyroidism in adults with CKD on dialysis. Dr. Chamberlain felt that this drug's utility was directed primarily for patients on outpatient dialysis and he felt that formulary review was not necessary at this time. **C.** **Smoflipid (injectable lipid emulsion):** Alternative lipid emulsion. Restricted by the national	Approved	Complete

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	committee to pediatric use only due to no outcome data available for treatment of adults. D. **Bovine thrombin:** National decision consistent with Memorial's formulary (only 20k unit vials stocked).		
Therapeutic Interchanges and Formulary Decisions	A. **Portrazza (necitumumab)** – EGFR directed monoclonal antibody indicated for squamous NSCLC in combination with gemcitabine and cisplatin. Despite marginal survival benefit it was recommended by Dr. Stipanov that this agent be added to formulary with restriction to outpatient infusion use only. This therapy may prove useful for some patients due to the minimal treatment options for patients with this form of cancer, especially if they do not qualify for another targeted agent. Processes will be implemented to ensure electrolytes are assessed prior to all infusions.	Approved	Complete
	B. **Rydapt (midostaurin) –** New specialty oral oncology therapy indicated as adjunct therapy for induction and consolidation treatment in patients with FLT3 positive AML. Significant survival benefit observed for midostaurin treated patients and it was recommended by Dr. Stipanov that this be added to formulary. Patrick suggested the following: New orders will be coordinated via specialty pharmacy channels as a patient specific prescription due to the high cost and to ensure patient affordability for continuation of the remainder of the induction cycle. In the event that this is unable to be coordinated prior to day # 8 (treatment initiation day), Rydapt may be ordered by the inpatient pharmacy in order to prevent a delay in therapy initiation.	Approved with restrictions	Complete
	C. **Elitek (rasburicase) –** Order set developed to assist providers in the appropriate ordering and dosing to promote single fixed dose (3-6 mg per dose) therapy in lieu of weight based dosing. Patrick stated that this was developed to assist non-oncology providers in ordering the preferred single fixed dose treatment option.	Approved	Complete
	D. **Bevyxxa (betrixaban) –** New oral factor Xa inhibitor indicated for VTE prophylaxis in at-risk, acutely ill, hospitalized medical patients. Clinical trials showed a modest benefit in reducing VTE as compared to shorter course (6-12 days) enoxaparin. Dr. Ramjee felt that this therapy did not provide an appreciable benefit over other injectable options for short term VTE prophylaxis. Additionally, the committee voiced concern over the long effective half-life (~72 hours) and the potential risk to patient safety for patients needing to undergo invasive procedures during hospitalization. It was recommended by Drs. Dodson, Pesce, and Ramjee to not approve this for formulary addition.	Not approved for formulary addition	Complete
	E. **GLP-1 receptor agonists –** Patrick suggested that the fixed dose long-acting insulin (LAI) + GLP-1 agonists products be designated non-formulary and the LAI component would be substituted to a therapeutically equivalent dose of Levemir during hospitalization. Dr. Yap stated that he felt this was a reasonable option and he didn't feel that non-continuation of the GLP-1 component would have a detrimental impact to patients in terms of glycemic management/control.	Formulary interchange approved	Complete
	F. **Northera (droxidopa) –** New oral specialty drug indicated for treatment of neurogenic orthostatic (NOH) hypotension. Patrick reviewed the available clinical trials for droxidopa and these studies	Not approved for formulary addition; non-formulary use to be considered	Complete

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	only showed a benefit in short-term management of NOH (≤ 2 weeks). Longer duration studies failed to show any statistically significant benefit. The 2017 ACC/AHA/HRS guidelines for treatment of syncope list midodrine, fludrocortisone, and droxidopa all as recommended agents for this indication with IIa strength of recommendation. Dr. Ramjee felt that this medication may prove useful for a very small subset of patients with primary autonomic failure refractory to other therapies. However, Dr. Ramjee did not feel that this need to be added to formulary but rather this could be considered for non-formulary use on an as needed basis following consultation with neurology, EP, or cardiology providers in a limited role when clinically appropriate. Patrick agreed and asked that Dr. Ramjee discuss this recommendation with his partners so they are aware of the potential cost to the patient due to the high monthly cost of this therapy so this can be deliberated when consideration is given to beginning patients on this therapy. **G. Atenolol drug shortage** – Due to an ongoing national shortage of atenolol Patrick presented a proposed interchange that would allow the substitution of metoprolol tartrate if/when the hospital supply is depleted. Atenolol 25 mg = Metoprolol tartrate 25 mg BID. Drs. Atchley and Ramjee supported this temporary formulary conversion.	on a case by case basis. Formulary interchange approved	Complete
Medication Safety & Policy	**Anaphylaxis & Acute Drug Hypersensitivity Reaction Protocol –** Patrick presented a proposed protocol & policy that would provide a protocol to be utilized by nursing to urgently treat a patient experiencing an acute drug reaction to be treated while awaiting call back by the patient's provider. The protocol outlines objective symptoms (mild, moderate, severe) that clearly outlines the medication and dose that should be given based on the patient's acute symptoms. This protocol/policy was designed following an event that occurred when a patient experiencing an acute infusion reaction to rituximab had a lengthy delay in receiving appropriate treatment due to difficulty in reaching the patient's provider for orders to treat the acute (non-anaphylactic) drug reaction. Patrick explained that per current TJC standards for the use of protocols the policy and accompanying orders would be used to delineate care for patients with acute reactions and falls under acceptable use of protocols per TJC guidance. The committee was supportive of both the content and intended use of these orders. Additionally, Dr. Stipanov agreed with the orders/policy and felt this would be a very useful protocol for outpatient infusion patients that frequently receive drugs that can precipitate acute drug reactions. Dr. Pesce recommended that if a patient is treated for a severe reaction necessitating the use of epinephrine that the orders and policy clearly indicate that the patient should be immediately be placed on a monitor following administration. This protocol will require MEC approval prior to initiation and this will be routed to MEC for review later this month. Patrick also recommended that the hypersensitivity reaction treatment orders be added to any existing order sets for drugs with known hypersensitivity reaction risk (rituximab, ocrelizumab, etc.). Dr. Pesce also recommended that this be approved as well. **High Alert Medication policy revision –** *Non-hazardous biologic medications with known risk of acute hypersensitivity/infusion related reactions.* An addition to the high alert medications policy was	Policy & orders approved Policy edits approved	Pending MEC approval Approved

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	presented to require documentation of 2nd nurse verification to be required with every dose administration to verify the drug, concentration, and settings on the infusion pump against the eMAR or provider order. **Ketamine Low Dose (sub-anesthetic dosing) for Pain –** Tabled until February 2018 meeting. **ADR Summary –** Karen reviewed ADR's from March – May 2017. No serious ADR's observed that would require reporting to the FDA's MedWatch program.	 Tabled until February meeting Information only	 Pending Complete
Antibiotic Stewardship	**Acyclovir dosing standardization:** Patrick reviewed a dosing standardization table for stewardship pharmacists to utilize for automatic renal dose adjustments and to assist with IV to PO conversions related to acyclovir therapy. **Automatic Repeat Blood Cultures for Coagulase (-) *Staph* Bacteremia:** Dr. Anderson explained the details of a proposed policy that would allow stewardship pharmacists to automatically order repeat blood cultures when ≥ 2 blood cultures growing CoNS are reported and no active antibiotics received. Dr. Anderson hopes that this will decrease unnecessary antibiotic use in patients with possible contaminated blood cultures due to the high rate of contaminated blood cultures for CoNS.	Approved Policy approved	Complete Complete
Medication Use Evaluation	**Hypoglycemia – patients receiving insulin:** A recent review indicated that approximately 20% of all patients receiving insulin therapies experience at least one hypoglycemic event per admission. Rima reviewed the results of a recent audit of 76 hypoglycemic events to identify potential causes for these hypoglycemic events and to identify possible options to mitigate the risk of hypoglycemia for patients receiving insulin. The following were identified as possible options to decrease the risk of hypoglycemia and this information will be reviewed with the hospitalists at their December team meetings: • Providing snack for patients receiving LAI with bedtime blood glucose < 130 (to decrease incidence of morning/fasting hypoglycemia) • Lantus daily → Levemir daily formulary conversion: data reveals that patients switched from a daily dose of Lantus to a daily dose of Levemir are more susceptible to hypoglycemia 8-10 hours following their daily Levemir dose. This is likely related to the 8-10 hour peak effect of Levemir as opposed to no peak effect with Lantus. • Physician notification of hypoglycemic events: Very few therapies are modified especially when hypoglycemic events occur in the afternoon or evening hours suggesting a potential gap in physician notification of hypoglycemic events.	Information only; to be shared with hospitalist in December	Pending
Policy & Procedure	**Look Alike/Sound Alike Policy –** No changes needed for the annual review of this policy.	Approved	Complete

There being no further business, the meeting was adjourned at 8:01 A.M. The next P&T meeting is **February 8, 2018 at 7:00 a.m.**

Respectfully submitted, Approved by,

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

Richard Pesce, M.D. Chairman