System P&T Formulary Summary 1/19/2022

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I. System Formulary NEW REQUESTS						
Service Line/Site	Medication	Summary	MUSE Review/ Recommendation	Committee Review, Recommendation/Endorsement	System P&T (Formulary) Decision on Committee Recommendation/Endorsement	Local P&T Decision on Recommendation

Ambulatory Clinic and Outpatient Infusion Suites	**Cabenuva (cabotegravir/ rilpivirine)**
	• intramuscular injection
	• cabotegravir 400 mg, rilpivirine 600 mg
		• Requested by OMC-JH Infectious Disease
		• Indication: maintenance treatment of HIV-1 infection in adults
		• Once-a-month injection with ≥ 28 day oral lead-in period (oral cabotegravir 600 mg, rilpivirine 900 mg)
		• Effective in maintaining HIV-1 RNA level suppression of < of 50 copies/mL
		• No data on pediatric, geriatric, pregnancy, lactation, and patient with hepatic impairment Child-Pugh class C
			Recommend to **ADD** Cabenuva (cabotegravir/rilpivirine) intramuscular injection to OH Epic formulary for outpatient use with the following criteria:
			• Indication:
			  ○ Maintenance treatment of HIV in those who are virologically suppressed (HIV-1 RNA < 50 copies/mL) on a stable antiretroviral regimen and no history of treatment failure
			  ▪ Virological suppression for at least 3 months
			• Completed oral lead-in therapy (oral cabotegravir and rilpivirine for ≥ 28 days) with no known or suspected resistance to cabotegravir or rilpivirine
			• Prescribed by an ID provider (preferred) or if not available, a general practice provider
			• Prior authorization
			• Outpatient use, administered in clinics
			• No active or occult HBV infection
			• Not pregnant or not planning to become pregnant
			• Not receiving drugs with significant drug interactions
				6/10/2021 System Clinical Coordinators (RECOMMEND)
				
				10/21/2021 System Ambulatory Subcommittee (ENDORSED) with one amendment: *Cabenuva is restricted to ID providers or provider-based IM physicians in BR*
				
				Note: BR pharmacy will support and manage use in BR
					☒ **Approve**
					☐ Deny
					☐ Table for further discussion
					
					Comments:
						☐ Stock
						☐ Not Stock
						☐ Table for further discussion
						☐ Appeal decision (explain)
						
						Comments:

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Outpatient Infusion	**Monjuvi (tafasitamab-cxix)**
	• IV infusion
	• 200 mg lyophilized powder vial
		• Requested by OMC-JH Hematology/Oncology (Bone Marrow Transplant)
		• New therapy option for patients with relapsed/refractory diffuse large B-cell lymphoma (DLBCL)
		• Approved under accelerated approval based on overall response rate
		• Recommended by the NCCN guidelines for patients with relapsed/refractory DLBCL and non-candidates for transplant (category 2A recommendation)
			Recommend to **ADD** Monjuvi (tafasitamab-cxix) to OH EPIC Formulary for outpatient infusion with the following criteria:
			• Indication: second-line treatment for relapsed/refractory DLBCL in patients who are not candidates for transplant
			• Formulary location: Outpatient Infusion
			• Service Line: Oncology/Hematology
			• Service Location: Infusion Center
			• Prior Authorization Required: Yes
			• Criteria of Use/Restriction: (all apply unless specified)
			  ○ Restricted to Beacon treatment protocol
			  ○ Patients 18 years of age or older
			  ○ Must have a diagnosis of relapsed or refractory diffuse large B-cell lymphoma not otherwise specified, including DLBCL arising from low grade lymphoma
			  ○ Must have previously received one or more lines of systemic therapy
			  ○ Must be ineligible for transplant
				11/11/2021 System Clinical Coordinators (RECOMMEND)
				
				11/23/2021 System Oncology Subcommittee (ENDORSED)
					☒ **Approve**
					☐ Deny
					☐ Table for further discussion
					
					Comments:
						☐ Stock
						☐ Not Stock
						☐ Table for further discussion
						☐ Appeal decision (explain)
						
						Comments:

Outpatient Infusion	**Zynlonta (loncastuximab tesirine-lpyl)** • IV infusion • 10 mg lyophilized powder vial	• Requested by OMC-JH Hematology/Oncology (Bone Marrow Transplant) • First single-agent CD-19 targeted antibody-drug conjugate for relapsed or refractory DLBCL • Recommended by the NCCN guidelines for patients with relapsed or	Recommend to **ADD** Zynlonta (loncastuximab tesirine-lpyl) to OH EPIC Formulary for outpatient infusion with the following criteria: • Indication: Loncastuximab tesirine is indicated for the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy. • Formulary location: Outpatient Infusion • Service Line: Oncology	11/11/2021 System Clinical Coordinators (RECOMMEND) 11/23/2021 System Oncology Subcommittee (ENDORSED)	☒ **Approve** ☐ Deny ☐ Table for further discussion Comments:	☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:

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		refractory DLBCL after 2 or more lines of systemic therapy (category 2A recommendation)	• Service Location: Infusion Center
			• Prior Authorization Required: Yes
			• Criteria of Use/Restriction:
			  ○ Restricted to BEACON treatment protocol
			  ○ Patient 18 years of age or older
			  ○ Adult patients with relapsed or refractory large B-cell lymphoma, including DLBCL not otherwise specified, DLBCL arising from low grade lymphoma, and high-grade B-cell lymphoma
			  ▪ Must have previously received two or more lines of systemic therapy
			  ▪ If any patient previously received CD-19 directed therapy (e.g., tafasitamab), it is required to have a biopsy showing CD-19 expression
			  ▪ Must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0-1			

Outpatient Infusion	**Sarclisa (isatuximab-irfc)** • IV infusion • 100 mg/5 mL (20 mg/mL) vial • 500 mg/25 mL (20 mg/mL) vial	• Requested by Ochsner St. Tammany Cancer Center Hematology/Oncology • NCCN Category 1, preferred options for the treatment of patients with relapsed refractory multiple myeloma	Recommend to **ADD** Sarclisa (isatuximab-irfc) to OH EPIC Formulary for outpatient infusion with the following criteria: • Formulary location: Infusion, Ambulatory • Indication: For adults with multiple myeloma who have received at least two prior therapies including Revlimid and a proteasome inhibitor • Service Line: Oncology • Formulary location: Outpatient, Ambulatory • Service Location: Infusion centers • Prior Authorization Required • Criteria of Use/Restriction:	11/15/2021 System Clinical Coordinators (RECOMMEND) 11/23/2021 System Oncology Subcommittee (ENDORSED)	☒ **Approve** ☐ Deny ☐ Table for further discussion Comments:	☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:

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			○ in combination with pomalidomide and dexamethasone, for the treatment of adult patients with multiple myeloma who have received at least 2 prior therapies including lenalidomide and a proteasome inhibitor. ○ in combination with carfilzomib and dexamethasone, for the treatment of adult patients with relapsed or refractory multiple myeloma who have received 1 to 3 prior lines of therapy.			
Inpatient and Outpatient Infusion	**Nulojix (belatacept)** • IV infusion • 250 mg lyophilized powder vial	• Requested by MUSE to develop criteria of use and Epic updates • Historically, Nulojix was added to OH Epic Formulary prior to development of current standardized system formulary process • Selective T-cell costimulation blocker • Prophylaxis of organ rejection in solid organ transplant recipients • Monthly infusion for outpatient use • Improved renal function outcomes compared to cyclosporine	Recommend to **ADD** Nulojix (belatacept) to OH EPIC Formulary for inpatient and outpatient infusion with the following criteria: • Formulary location: Inpatient, outpatient infusion • Service Line: Transplant • Service Location: Inpatient, outpatient infusion centers • Prior Authorization Required: yes for outpatient infusion • Criteria of Use/Restriction: (All applies, unless specified) **Outpatient (infusion)** • Indication: Prophylaxis of organ rejection ***AND the following:*** • Adult patient 18 years and older receiving kidney transplant • Use only in EBV IgG seropositive • TB screening (QuantiFERON) prior to therapy initiation with documented negative results within the last 3 months	11/11/2021 System Clinical Coordinators (RECOMMEND) 11/18/2021 System Ambulatory Subcommittee (ENDORSED)	☒ **Approve** ☐ Deny ☐ Table for further discussion Comments:	☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:

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			Inpatient
			• One of the following indications:
			  ○ New Start: Prophylaxis of organ rejection (de novo or conversion)
			  ○ Continuation from home therapy: unable to receive infusion +/- 3 days of scheduled infusion
			  AND the following:
			• Adult patient 18 years and older receiving kidney transplant
			• Use only in EBV IgG seropositive
			• TB screening (QuantiFERON) prior to therapy initiation with documented negative results within the last 3 months
			• New start - Outpatient set up completed (BMS PAT number, prior authorization, appointments set up for outpatient infusions)			

Inpatient	**Malarone (Atovaquone/Proguanil)**
	• Oral tablet
	• Adult strength: 250 mg atovaquone, 100 mg proguanil
	• Pediatric strength: 62.5 mg atovaquone,
		• Requested by OMC-JH Infectious Disease
		• Indications:
		  ○ Oral prophylaxis and treatment of uncomplicated P. falciparum malaria
		  ○ Interim treatment of severe malaria regardless of species until IV artesunate is administered
		  ○ Follow-on treatment after IV artesunate
			MUSE recommended TO ADD Malarone (Atovaquone/Proguanil) to OH Epic Formulary for inpatient use with the following criteria:
			• Restrict Malarone to only be available to order through malaria treatment order set
			• Formulary location: Inpatient
			• Indication: Treatment of acute, uncomplicated P. falciparum malaria or severe malaria
			• Service Location: Inpatient
			• Population: pediatric and adult
				11/8/2021 System Antimicrobial Stewardship Subcommittee (**ENDORSED**)
				
				11/11/2021 System Clinical Coordinators (**NOT RECOMMEND**): **not to add**, maintain **NON-FORMULARY** status for the following reasons:
				• Rare use and Epic order set may not be approved
				• Concern about stocking drug and subsequent waste
					☒ **Approve**
					☐ Deny
					☐ Table for further discussion
					
					Comments:
					ADD to formulary, and build in Epic, restricted to ID.
					• A treatment option is needed for malaria. Oral therapy is cost effective and may be used as a
						☐ Stock
						☐ Not Stock
						☐ Table for further discussion
						☐ Appeal decision (explain)
						
						Comments:

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	25 mg proguanil			Need to investigate the possibility of a system centralized stock for rare use medications	bridge therapy for IV therapy (artesunate) • IV therapy is needed in more critical cases and access to the medication will be needed, as stated by Dr Figueroa. IV artesunate is available through wholesaler and CDC. • D Simonson recommended to have a central location to maintain stock, most likely OMC Jeff Hwy	
Inpatient	**Artensunate** • IV bolus 110 mg powder vial	• Requested by OMC-JH Infectious Disease • Indication: initial treatment of severe malaria in adult and pediatric patients • High cost medication	MUSE recommended TO ADD artesunate to OH Epic Formulary for inpatient use with the following criteria: • Formulary location: Inpatient • Indication: Severe malaria • Service Line: Infectious Disease • Service Location: Inpatient, System • Population: Pediatric and adult • Criteria of use/Restriction: Use only in severe malaria • Infectious Disease Service Line ○ Malaria confirmed by microscopy AND	11/8/2021 System Antimicrobial Stewardship Subcommittee (**ENDORSED**) 11/11/2021 System Clinical Coordinators (**NOT RECOMMEND**): **not to add**, maintain **NON-FORMULARY** status for the following reasons: • Rare use (rare cases of severe malaria)	☐ Approve ☒ **Deny** ☐ Table for further discussion Comments: **Non-formulary, Non-Stock** for the following reasons: • Approved Malarone on formulary to use	☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:

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			○ Positive diagnosis of Severe Malaria (at least one of the following) ▪ Parasite density ≥ 5% ▪ Impaired consciousness ▪ Seizures ▪ Shock ▪ Pulmonary edema or acute respiratory distress syndrome (ARDS) ▪ Acidosis ▪ Acute kidney injury ▪ Abnormal bleeding or disseminated intravascular coagulation ▪ Hemoglobin < 7 g/dL ▪ Inability to take oral medications	• Concern about stocking drug and subsequent waste	as a bridge therapy for IV artensunate • Artesunate is available at wholesale distributor and directly through CDC. McKesson has Hotshot Delivery to ship urgent medications overnight. • High cost	
Inpatient	**Lucentis (ranibizumab)** • intravitreal injection • 0.3 mg/0.05 mL (0.05 mL); 0.5 mg/0.05 mL (0.05 mL) singe-use prefilled syringe and vial	• Requested by Ochsner LSU Shreveport Neonatology/Ophthalmology • Treatment of active retinopathy of prematurity (ROP) • Shorter half-life elimination than bevacizumab which potentially has less effect on serum/systemic VEGF levels; however, increased incidence of ROP relapse	Recommended **NOT TO ADD** Lucentis (ranibizumab) to the OH EPIC formulary for inpatient use, maintain **NON-FORMULARY** status for the following reasons: • Ranibizumab with higher incidence of ROP relapse versus bevacizumab (Avastin, which has been used for ROP at Ochsner) ○ ranibizumab: range from 0% to 83% ○ bevacizumab: range from 0% to 10% • Lucentis may be worse than laser therapy (gold standard), based on current literature except for 1 trial - RAINBOW trial - in which it showed better outcomes with Lucentis, but it is not statistically significant • Continued research, including the results of the RAINBOW extension study, are needed to determine the optimal dose, recurrence rate and timing with need for retreatment,	10/14/2021 System Clinical Coordinators (**NOT RECOMMEND**): **not to add**, maintain **NON-FORMULARY** status • OLSH Shreveport pharmacy agreed to table this until trial data is published	☒ **Approve** ☐ Deny ☐ Table for further discussion Comments: **Non-formulary, Non-Stock** for inpatient ROP use If resubmitted, J Chou requested Lucentis to be reviewed by HVDC.	☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:

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			long-term ocular outcomes, and long-term systemic side effects. • Not cost beneficial for inpatient use			

II. System Formulary DELETION						
Service Line/Site	Medication	Summary	Recommendation	Committee Review	System P&T (Formulary) Decision on Committee Recommendation/Endorsemen	Local P&T Decision
None						

III. System Formulary CLASS REVIEW *Class review to evaluate for opportunities for formulary management and cost savings* • Recommendation (*ADD, REMOVE, Restriction/Criteria of Use, Population)* • Committee Review *(committee name, date, RECOMMEND, NOT RECOMMEND, and reason if applicable; DEFER to Executive Summary of System Committee)*		
	System P&T (Formulary) Decision on Committee Recommendation/Endorsement	Local P&T Decision on Recommendation
None		

IV. System Formulary THERAPEUTIC INTERCHANGE *Class review to evaluate for opportunities for formulary management and cost savings through therapeutic interchanges* • Recommendation (*ADD, REMOVE, Restriction/Criteria of Use, Population)* • Committee Review *(committee name, date, RECOMMEND, NOT RECOMMEND, and reason if applicable; DEFER to Executive Summary of System Committee)*

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	System P&T (Formulary) Decision on Committee Recommendation/Endorsement	Local P&T Decision on Recommendation
None		

V. System Formulary CHANGE or LINE EXTENSION						
Service Line/Site	Medication	Summary	MUSE Review/Recommendation	Committee Review, Recommendation/ Endorsement	System P&T (Formulary) Decision on Committee Recommendation/Endorsement	Local P&T Decision on Recommendation
Inpatient	**Calcium gluconate 10,000 mg/1,000 mL D5W (100 mg/mL)** Continuous IV infusion	• Requested by OMC-Jeff Highway • Calcium gluconate is currently not available to order as a continuous IV infusion for the treatment of severe hypocalcemia in adult patients • Custom IV builder is being utilized to create the orders.	Recommend to **ADD**: • New ERX for Calcium gluconate 10,000 mg in 1,000 mL D5W continuous IV infusion for severe hypocalcemia, allow to order in NS if needed ○ To be used in adult and pediatric patients • Create a hypocalcemia order panel to include above ERX and laboratory monitoring	10/14/2021 System Clinical Coordinators (RECOMMEND)	☒ **Approve** ☐ Deny ☐ Table for further discussion Comments: ○ Add to electrolyte concentration and standard concentration policy	☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:

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			○ Orders will have a 24-hour hard stop, requiring providers to reassess continued need			
Inpatient Pediatric	**Biotin, vitamin B7, 5 mg/mL, oral suspension** • Manufactured by Solace Nutrition	• Requested by OLSH • Indication: biotinidase deficiency for neonates • Biotin is a supplement and there is no USP approved product • MUSE able to find an oral suspension 5 mg/mL, available through wholesale distributor	Recommend to **ADD**: • Biotin, vitamin B7, 5mg/mL, oral suspension, manufactured by Solace Nutrition • Inpatient, Pediatric population • Limit procurement manufacturer Solace Nutrition	10/18/2021 System Clinical Coordinators (RECOMMEND)	☒ **Approve** ☐ Deny ☐ Table for further discussion Comments:	☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:
Outpatient Infusion	**Darzalex Faspro (daratumumab/ hyaluronidase)** • Subcutaneous • daratumumab 1,800 mg-hyaluronidase 30,000 units/15 mL	• Requested by OMC-JH Oncology • FDA approved to use subcutaneous daratumumab in DaraPd (daratumumab, pomalidomide, dexamethasone) regimen for multiple myeloma • Faspro ERX is already created	Recommend to: • REMOVE daratumumab IV from DaraPd treatment plan • ADD daratumumab subcutaneous formulation to DaraPd treatment plan	11/01/2021 System Clinical Coordinators (RECOMMEND) 11/23/2021 System Oncology Subcommittee (ENDORSED)	☒ **Approve** ☐ Deny ☐ Table for further discussion Comments:	☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:
Inpatient	**DEKAs Plus (Pediatric Multivitamin ADEK)** • Oral liquid • 60 mL bottle	• Requested by OMC-Baptist • AquaDEKs (fat soluble vitamins A, D, E, and K along with micronutrients) has been discontinued	Recommend to ADD DEKAs Plus to OH Epic formulary for inpatient use: • Change naming of ERX to *pediatric multivitamin (DEKAs Plus) liquid (PEDS)* • Add 1 mL and 2 mL dose button	11/11/2021 System Clinical Coordinators (RECOMMEND)	☒ **Approve** ☐ Deny ☐ Table for further discussion Comments:	☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:

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		• DEKAs Plus is available for purchase as alternative for AquaDEKs • DEKAs Plus ERX is available on Epic database	• Add Order Instruction box with the following information: *Give 0.5 mL of DEKAs Plus if infant is receiving </= 0.5 mL of MVI/MVI with iron* Recommend to REMOVE AquaDEKs from OH Epic formulary			

Ambulatory	**Ferric subsulfate TOPICAL**
	• Paste/solution
	• Brands:
	  ○ Monsel's (manufactured by SKLAR, GYNEX, etc.)
	  ○ AstrinGyn
	• 8 gram or 8 mL vial
		• Requested by Ochsner LSU Shreveport
		• Product formulation identification from different manufacturers varies, which cause confusion:
		  ○ Monsel's from GYNEX identifies paste on the outer packaging and solution on the vial.
		  ○ Monsel's from SKLAR identifies paste on the vial
		  ○ AstrinGyn identifies aqueous on the vial
		• These products are interchangeable
			Recommend to:
			• ADD AstrinGyn product to Epic formulary
			• Create an umbrella record to include GYNEX, SKLAR, and AstrinGyn products
			• Rename Epic ERX to ferric subsulfate TOPICAL solution/paste
				11/29/2021 System Clinical Coordinators (RECOMMEND)
				
				12/16/2021 System Ambulatory Subcommittee (ENDORSED)
					☒ **Approve**
					☐ Deny
					☐ Table for further discussion
					
					Comments:
					Dr. Boucree recommended when end users search for 'Monsel', the appropriate ERX will pull up.
					
					Add synonyms to ERX to allow for ordering generic or any of the brand names.
						☐ Stock
						☐ Not Stock
						☐ Table for further discussion
						☐ Appeal decision (explain)
						
						Comments:

Inpatient, Procedural	**Giapreza (Angiotensin II) 2,500,000 ng in 250 mL NS** • Continuous IV infusion	• Requested by OMC-JH • Literature supports use of Angiotensin II in cardiac surgery patients with refractory vasoplegia • Current OH guidelines limited to prescribing and	Recommend to ADD use criteria to extend to Cardiac Anesthesia in the ORs to prevent delays in patient care (add the below highlighted yellow) • Patients in distributive shock AND	08/12/2021 System Clinical Coordinators (RECOMMEND) 09/28/2021 System Operations (TABLED,	☒ **Approve** ☐ Deny ☐ Table for further discussion Comments: Dr. Boucree asked if this is a standard conc or who will mix.	☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:

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		administration to Medical or Surgical ICU • ICU attendings are not typically in the OR area during these cases and may not be as familiar with the patient prior to arrival to ICUs	• Norepinephrine > 0.2 mcg/kg/min (or its equivalent) AND • Vasopressin 0.04 units/min AND • Under the care of Medical or Surgical ICU and approved by an attending or Cardiac Anesthesia for use in the ORs AND • Life expectancy > 12 hours	pending an operational plan for Giapreza) 01/04/2022 OMC-JH pharmacy discussed with AVP System Pharmacy Operations and System Clinical Leadership (RECOMMEND) with the following: • Weekly audit of charges dropping correctly • Education to Cardiac Anesthesia Providers on criteria and workflow	• It was clarified that pharmacists will verify Giapreza order and mix in the pharmacy; this will not be floor stocked • R Liberto confirmed that Giapreza is on the standard concentration as 2.5 mg/250 mL ○ 2,500,000 ng equals 2.5 mg	

VI. System Formulary NEW INDICATIONS

The medications are approved on the OH Formulary with newly approved FDA indications. Therapy/Treatments Plans for Outpatients will be built to reflect these additions

None

VI. System Formulary MISCELLANEOUS

Inpatient	**Methylnaltrexone (Relistor) Subcutaneous Injection** Methylnaltrexone is a peripherally acting opioid receptor antagonist that can be used for opioid induced constipation. The medication has been well studied for opioid induced constipation in patients with advanced illness on chronic opioids, but its use in patients with more acute forms of opioid induced constipation has not been as well studied. Methylnaltrexone (Relistor) is a relatively expensive medication with a lack of strong evidence supporting its use for acute opioid induced constipation in hospitalized patients. However, it is often ordered for inappropriate indications or before suitable alternative agents have been attempted. The following are recommended changes to formulary and criteria of use: ☐ ADD methylnaltrexone subcutaneous injection (8 mg/0.4 mL subcutaneous syringe, 12 mg/0.6 mL subcutaneous syringe, and 12 mg/0.6 mL subcutaneous vial) to OH EPIC Formulary, build out the following ERXs appropriately, remove all other ERX from OH EPIC formulary, leave on database	System P&T (Formulary) Decision on Committee Recommendation/Endorsement ☒ **Approve** ☐ Deny ☐ Table for further discussion Comments: **Approved with the following amendment:**	Local P&T Decision ☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:

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	☐ ADD methylnaltrexone subcutaneous injection to the Renal Monitoring SOP ☐ REMOVE Methylnaltrexone 150 mg oral tablet for OH EPIC Formulary, keep as Non-formulary, remove oral tablet ERX from OH EPIC formulary, leave on database ☐ CRITERIA OF USE: Methylnaltrexone may be used for acute opioid induced constipation if ALL the following criterial are met: 1. Patient is currently receiving opioid therapy 2. Patient has not had a bowel movement ≥ 48 hours a. Constipation must be refractory to previous laxative therapy 3. Patient must have at least 24 hours of another laxative charted as administered on the MAR (senna, bisacodyl, glycerin suppository, etc.) before attempting methylnaltrexone 4. Methylnaltrexone may only be ordered for up to 3 doses per course of therapy a. If no bowel movement after first course (3 doses), patient should be reassessed for repeat therapy. i. If appropriate, methylnaltrexone may be repeated for another course (3 doses). b. Patient should be reassessed after each course, and in between courses of therapy, to determine appropriateness and repeated dosing. c. If patient has bowel movement during the course of therapy (3 doses), the provider should re-assess the patient to determine if current course should be completed. 5. If a patient becomes constipated after having a bowel movement with methylnaltrexone, the patient will again have to meet criteria 1-4 above to receive subsequent doses of methylnaltrexone. ☐ Build the above criteria as standing order questions for the provider to answer. 10/14/21 System Clinical Coordinators (RECOMMEND)	Change ≥ 48 hours to ≥ 24 hours for criteria of use #2: "Patient has not had a bowel movement ≥ 48 hours." Dr. Boucree requested 6-month MUE.	
Inpatient	**Proton pump inhibitor (PPI) use in patients with ENTERAL TUBES** PPI products being used in patients with enteral tubes (adults and pediatrics) on OH Epic formulary include pantoprazole oral packet, esomeprazole oral packet, and lansoprazole oral disintegrating tablet and suspension (various strengths). These PPI products were reviewed to evaluate opportunities for formulary standardization and potential cost savings. • Adults: Removal of oral packets will be an issue for adult patients without peripheral IV lines. • Pediatrics: ○ Esomeprazole packet is first line for these patients ○ Lansoprazole ODT and its compounded suspension is the best option for pediatric patients with short gut or restricted volume requirement. The following are recommended changes to formulary and criteria of use:	System P&T (Formulary) Decision on Committee Recommendation/Endorsement ☒ **Approve** ☐ Deny ☐ Table for further discussion Comments:	Local P&T Decision ☐ Stock ☐ Not Stock ☐ Table for further discussion ☐ Appeal decision (explain) Comments:

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	☐ Pediatrics with ENTERAL TUBES: 1. KEEP esomeprazole 10 mg packets on formulary restricted to pediatric use. 2. ADD esomeprazole 2.5 mg and 5 mg packets to formulary restricted to pediatric use. 3. ADD restriction criteria for lansoprazole ODT (7.5 mg, 15 mg and 30 mg) and its compounded suspension to be use in the following only: • Pediatric patients with short gut and/or • Pediatric patients with restricted volume ☐ Adults with ENTERAL TUBES: 1. Have pantoprazole 40 mg IV injection as preferred PPI regimen if peripheral IV line is available a. Do not switch to IV pantoprazole if patient is already on pantoprazole oral packet 2. KEEP pantoprazole 40 mg packets on formulary 3. REMOVE esomeprazole 20 mg and 40 mg packets (ERXs: 78615, 78616) from formulary. ☐ ***Pantoprazole in the IV to PO SOP will be updated as follows: • If patient has peripheral IV line AND enteral feeding tubes; leave it as pantoprazole IV injection and do not interchange • If patient has ONLY enteral feeding tubes AND no peripheral IV line, interchange to pantoprazole oral packets 11/01/21 System Clinical Coordinators (RECOMMEND)		

VII. System Formulary **INFORMATIONAL**	
Inpatient	**Multitrace-4 (MTE-4) Neonatal conversion to Multrys (trace element injection 4) for Pediatrics < 10 kg** *EPIC Change effective 12/21/21, process change educations distributed* • American Regent discontinued production of Multitrace-4 Neonatal. • American Regent's new FDA approved product is Multrys (each mL contains zinc 1,000 mcg, copper 60 mcg, manganese 3 mcg, selenium 6 mcg), indicated for neonatal and pediatric patients under 10 kg. • Both NEONATAL and PEDIATRIC TPN order set (peripheral and central) for both CAPS and Non-CAPS sites will be affected. • Multrys dosing regimen (the table) *Zinc: Recommended daily dose 400 mcg/kg/day. Patients < 3 kg, order additional zinc sulfate in TPN for total daily dose of 400 mcg/kg/day. **Copper: Recommended daily dose 20 mcg/kg/day. Patients 0.4 kg to 0.59 kg and 4 kg to 9.9 kg, order additional cupric chloride for total daily dose of 20 mcg/kg/day. ***Selenium: Recommended daily dose 2 mcg/kg/day. Patients 0.4 kg to 0.59 kg and 4 kg to 9.9 kg, order additional selenium for total daily dose of 2 mcg/kg/day. (Reference: Multrys (trace elements injection 4). Package insert. American Regent Inc; 2020.)

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Body Weight	Recommended Daily Volume	Recommended Frequency	Amount of Trace Element Provided by Corresponding Multrys volume			
			Zinc* mcg	Copper** mcg	Manganese mcg	Selenium*** mcg
0.4 kg to 0.59 kg	0.2 mL	**Every other day**	200	12	0.6	1.2
0.6 kg to 0.8 kg	0.2 mL	Daily	200	12	0.6	1.2
0.9 kg to 1.1 kg	0.3 mL	Daily	300	18	0.9	1.8
1.2 kg to 1.4 kg	0.4 mL	Daily	400	24	1.2	2.4
1.5 kg to 1.7 kg	0.5 mL	Daily	500	30	1.5	3
1.8 kg to 2 kg	0.6 mL	Daily	600	36	1.8	3.6
2.1 kg to 2.3 kg	0.7 mL	Daily	700	42	2.1	4.2
2.4 kg to 2.6 kg	0.8 mL	Daily	800	48	2.4	4.8
2.7 kg to 2.9 kg	0.9 mL	Daily	900	54	2.7	5.4
3 kg to 9.9 kg	1 mL	Daily	1000	60	3	6