



PHARMACY AND THERAPEUTICS COMMITTEE

DATE: August 11, 2022

CALLED TO ORDER: 7:00 a.m.
LOCATION: Private Dining Room

ADJOURNED: 8:00 a.m.

| Voting Member Attendance: | | Non-Voting Member Attendance: | Guests: |
|---|--|---|--|
| X Nathan Chamberlain, MD- Chairman X Mark Anderson, MD- Infectious Disease X Justin Blinn, MD- Anesthesiology X David Dodson, MD- Hospitalist X Karen Frank, RN- Quality Sherry Fusco, RN- CNO F. Lee Hamilton, MD- Hospitalist William Haren, MD- Psychiatry | X Matthew Kodsi, MD- Quality Aditya Mandawat, MD- Cardiology Daniel Marsh, PharmD- Director of Pharmacy Chad Paxson, MD- Intensivist Vimal Ramjee, MD- Cardiology James Wahl, MD- Hospitalist, GA Richard Yap, MD- Hospitalist | Karen Babb, PharmD- Manager Jamie Barrie, PharmD- Manager, HX X Kenneth Dyer, PharmD- Operations Manager Rodney Elliott- Purchasing X Lori Hammon, RN- Quality Shannon Harris, RN- Infection Prevention Kevin Hopkins, RT- Director of Resp Therapy X Rachel Kile, PharmD- Clinical Manager X Carey Smith, RPh- Manager, GA | Hallie Butler, Pharmacy Resident Joseph Oh, Pharmacy Resident Jordan Tynes, Pharmacy Resident Chris D'Amico, Pharmacy Resident Petra McWhorter-Green, RN (CNO Proxy) DeAnn Champion, MD-ED |

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 May minutes were approved as submitted. | Approved | Complete |
| CommonSpirit Health System P&T Committee | May 2022 and July 2022 Decision Briefs: The medication decisions that were approved at the CommonSpirit Health System P&T committee meetings were reviewed. All new system formulary medications or changes were either consistent with existing CHI Memorial formulary decisions or are described in the "Formulary Decisions & Therapeutic Interchanges" section of the minutes below, or will be reviewed at an upcoming P&T committee meeting. | Approved | Complete |
| Old Business | A. Sedatives-Hypnotics for Sleep Policy: Rachel reported that they did meet as a sub committee to further discuss the policy and would like to do a project to assess how agents used for sleep are utilized. We will provide another update at the next meeting. | Informational | Complete |
| Formulary Decisions & Therapeutic Interchanges | A. Pentobarbital: Pentobarbital is a barbiturate FDA approved for emergency control of seizures and for use as a sedative/hypnotic. At high doses pentobarbital exhibits anti-seizure properties and reduces brain metabolism and cerebral blood flow to decrease intracranial pressure. It was recommended by the neuroscience service line to add pentobarbital to formulary and adopt the following restrictions (all must apply): a. Status epilepticus restricted to cases refractory to or with contraindications to all other therapies (third line agent) b. Must be ordered by a Neurologist or Neurosurgeon | Approved | Complete |



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| | c. Patient is undergoing invasive mechanical ventilation | | |
|----|--|----------|----------|
| B. | Hepatitis B vaccines: CommonSpirit Health shifted to a GSK/Merck vaccine portfolio to optimize vaccine | Approved | Complete |
| | contracting and improve resource stewardship. At CHI Memorial, Engerix-B and Heplisav are the formulary | | |
| | hepatitis B vaccines, with Engerix B being preferred. Recombivax HB was voted as the formulary preferred | | |
| | hepatitis B vaccine and Engerix was voted as non-formulary at the CSH July 2022 P&T committee meeting. | | |
| | Engerix-B and Recombivax-B are interchangeable for patients that may be partially vaccinated for hepatitis B. | | |
| | It was recommended to align with the system decision, in order to benefit from the contracting opportunity. | | |
| | The current CHI memorial restriction criteria for Engerix-B will apply to Recombivax HB. | | |
| C. | Tezepelumab (Tezspire): Tezepelumab is currently the first and only FDA-approved thymic stromal | | |
| | lymphopoietin (TSLP) monoclonal antibody for add-on maintenance treatment of severe asthma in adults and | Approved | Complete |
| | children aged 12 and above whose asthma cannot be controlled by their existing asthma medication. It is | | |
| | dosed as one injection every 4 weeks and must be administered by a healthcare provider. It can be used | | |
| | regardless of phenotype. It was recommended to add tezepelumab to formulary with restrictions to the | | |
| | outpatient setting subsequent to insurance approval or prior authorization for FDA approved indications or | | |
| | payer approved off-label indications. | | |
| D. | Inclisiran (Leqvio): Inclisrian is an antilipemic-small interfering ribonucleic acid (sIRNA) agent that prevents | Approved | Complete |
| | proprotein convertase subtilisin/kexin type 9 (PSK9) production in the liver. It is very similar to the PSK9 | | |
| | inhibitors, Praluent and Repatha. Rachel reported that this injection demonstrated lowering LDL but did not | | |
| | evaluate any patient-specific cardiovascular outcomes. The cost for inclisiran is \$9,652 for year one and | | |
| | \$6,435 for subsequent years, whereas Repatha costs \$6,183 per year. Inclisiran also has to be administered | | |
| | by a healthcare provider, where Repatha is a self-administered agent. Inclisiran has a novel mechanism of | | |
| | action with the benefit of a twice yearly injection. Due to cost and not having a billing code, it was voted as | | |
| | non-formulary by the CSH System P&T Committee. Due to lack of published data on cardiovascular outcomes | | |
| | in addition to the cost of medication, it was recommended that inclisiran be non-formulary. It will be reviewed | | |
| | again once patient-specific clinical outcomes are published. | | |
| E. | Paricalcitol: Paricalcitol is a synthetic vitamin D analog which binds to and activates VDR in kidneys, | Approved | Complete |
| | parathyroid gland, intestine, and bone, thus reducing PTH levels and improving calcium and phosphate | | |
| | homeostasis. IV paricalcitol has been non-formulary for years, however, oral paricalcitol (1 mcg capsule) is on | | |
| | formulary. Rachel reported that in the past 12 months, oral paricalcitol has only been ordered for one dose for | | |
| | one patient in the ED. It was recommended to remove oral paricalcitol from formulary. Patients will be allowed | | |
| | to continue their own home supply. | | |





| Medication Use | Α. | Anavip Antivenom Treatment Guidelines and Panel: Rachel reported that we have exhausted the | Approved | Complete |
|----------------|----|--|------------------------|----------|
| | - | remaining supply of Crofab, so we have transitioned to Anavip. Anavip has a 133 hour half life, compared to | 7.66.0.0 | Comp.o.c |
| | | the 15 half hour half life of Crofab. 95% of patients do not require a second dose. There was confusion with | | |
| | | dosing Anavip for our first patient, therefore a guideline and EHR ordering panel were developed to provide | | |
| | | dosing guidance. The provider education sheet was also reviewed, and it has already been shared with ED | | |
| | | providers. | | |
| | В. | • | Informational | Complete |
| | | prophylaxis of VTE in medically ill patients was discussed. Rachel reported that we don't have this built into | | ' |
| | | our VTE prophylaxis section of order sets. Rivaroxaban does have a longer half life than heparin or | | |
| | | enoxaparin, which makes it more complicated because you generally have to stop it 2 days before surgery. | | |
| | | There was a clear consensus by the committee to recommend against adopting it for VTE prophylaxis in | | |
| | | medically ill patients at this time. | Approved | Complete |
| | C. | Injectable promethazine: The ISMP 2018-2019 Targeted Medication Safety Best Practices for Hospitals | '' | ' |
| | | recommendation to eliminate injectable promethazine from the formulary resulted in several CHI hospitals and | | |
| | | other large hospitals across the nation eliminating injectable promethazine from their hospital formularies. | | |
| | | ISMP Best Practice 2022-2023 still recommends eliminating promethazine from formulary. Utilization of IV | | |
| | | promethazine in the last 6 months demonstrated for over 5000 doses administered, most are prescribed by | | |
| | | internal medicine and emergency medicine. The primary concern of the committee was whether or not we | | |
| | | have reasonable alternatives. It was suggested that droperidol could be a second line option. It was | | |
| | | recommended approve the following actions: | | |
| | | a. Implement an automatic therapeutic interchange (i.e. LMA pop-up alert) that provides a list of | | |
| | | alternative antiemetics and routes of administration on formulary, provides easy-click ordering | | |
| | | options for a few alternatives, and does not allow the ordering provider to continue with the | | |
| | | current order for injectable promethazine | | |
| | | b. Remove injectable promethazine from all order sets | | |
| | | c. Designate injectable promethazine (IV and IM) as non-formulary and do not stock (including | | |
| | | outpatient infusion center) | | |
| | | d. Do not allow continuation of orders from home | | |
| | | Addendum: On behalf of the ICU intensivist team, Dr. Paxson proposed an appeal to the decision | Approved by email vote | Complete |
| | | to remove injectable promethazine from formulary. The appeal is as follows: allow injectable promethazine to | | |
| | | remain on formulary with restrictions to central line administration only and must have tried and failed another | | |
| | | agent prior to using promethazine (cannot be used as first line agent). Rachel suggested that if approved, IV | | |
| | | push should not be allowed and all doses should be mixed in normal saline administered over 10-15 minutes. | | |
| | | The following actions will be implemented: | | |
| | | a. Implement an automatic therapeutic interchange (i.e. LMA pop-up alert) that provides a list of | | |
| | | alternative antiemetics and routes of administration on formulary, provides easy-click ordering | | |





| | options for a few alternatives, and does not allow the ordering provider to continue with the current order for injectable promethazine b. Remove injectable promethazine from all order sets c. Must have tried and failed another agent prior to using injectable promethazine (cannot be used as first line agent) d. Restricted to central line administration only via slow IV infusion over 10-15 minutes | | |
|-------------------|--|----------|-----------|
| | D. Drug shortages-lorazepam: Rachel reported that a medication use evaluation was conducted to determine the appropriateness of injectable lorazepam prescribing. The prescribing of injectable lorazepam for the prophylaxis and treatment of alcohol withdrawal syndrome (AWS) utilizes a significant amount of IV lorazepam at our institution (approximately 40% of all parenteral lorazepam use). For patients with mild/moderate alcohol withdrawal, the existing AWS order set was rarely optimized to prevent breakthrough symptoms. This could have led to the prescribing of a lorazepam infusion. The order set was incorrectly initiated for patients experiencing severe AWS, and intoxicated patients at risk for AWS were initiated on the order set and started on lorazepam infusions as well. A panel of physician, nursing, and pharmacy leaders met urgently on July 28th to develop shortage strategies. The decisions were as follows: i. Pharmacists may automatically substitute orders for injectable lorazepam to oral lorazepam in a 1:1 ratio if the patient can take oral/NG/FT medications, unless indicated for seizure or alcohol withdrawal (approved emergently on 7/22/22) ii. Benzodiazepine equivalents: Lorazepam 1 mg = Midazolam 1 mg = Diazepam 5 mg iii. IV lorazepam is permanently formulary restricted for the treatment of only acute seizures, alcohol withdrawal, or chemotherapy-induced nausea and/or vomiting iv. Lorazepam infusions are permanently non-formulary (due to availability of safer alternatives for agitation such as propofol, dexmedetomidine, ketamine and risk of propylene glycol toxicity) v. Build a new EHR alert to drive ordering to alternatives (lorazepam PO or midazolam). Alert is suppressed for the alcohol withdrawal order set vi. Update the Midazolam Usage policy to allow administration of midazolam outside of ICU and procedural areas vii. There were six order sets that included IV lorazepam. Lorazepam was either removed from the order set, changed to oral | Approved | Completed |
| Protocol & orders | A. Alcohol Withdrawal Order Set-Phenobarbital: Dr. Tucker and Rachel drafted an order set for phenobarbital for alcohol withdrawal syndrome. This would be a second order set in addition to the existing one. The existing order set is only for mild-moderate alcohol withdrawal syndrome (AWS) and the phenobarbital-based order set is for moderate-severe. Phenobarbital is a safe and effective treatment alternative, especially during a lorazepam shortage. The new order set requires providers to use the PAWSS (Prediction of Alcohol Withdrawal Severity Scale) score to determine the risk of complicated alcohol | Approved | Complete |





| | withdrawal. If the PAWSS score is ≥ to 4, the phenobarbital set should be used. It is RASS based monitoring so hospital-wide nursing education will be required. The committee approved the development of the new order set. | g, | |
|----------|--|------------|-----------|
| Policies | A. Therapeutic Duplication of PRN Medication Orders: This policy was updated to align with EHR workflow and clinically appropriate pain management principles. Updates to this policy are as follows: a. 'Of the medications ordered for a specific given indication, one medication will be considered to the provider's choice for the patient based on pharmacy defined medication hierarchy based on therapeutic potency (least potent agent will be used)' b. 'If no patient preference is specified and multiple home medications are ordered for the same PF indication, one medication will be selected for the patient based on pharmacy defined medication hierarchy based on therapeutic potency (least potent agent will be used)' B. Mandatory ID Consultations: Rachel reported that this policy was only cleaned up for EPIC. There were | e N | Complete |
| | clinical changes. Look Alike Sound Alike Medication List: Humalog and Kenalog were added to the list following a near miss event in the Glenwood surgery department. There will be a Pyxis pop-up warning and they will not be | Approved | Complete |
| | stored next to each other. | Approved | Complete |
| | D. Renal Dose Adjustments: Baricitinib and Paxlovid have been added to the list of pharmacist-automatic renal dose adjusted medications. | Approved | Completed |
| | E. Midazolam Usage: This policy was updated to include 'During clinical shortages of alternative injectable benzodiazepines, midazolam may be administered in doses less than or equal to 2 mg by an RN WITHOU procedural sedation training.' | Γ Approved | Complete |

There being no further business, the meeting was adjourned at 8:00 a.m. The next P&T meeting is October 6, 2022.

Respectfully submitted, Daniel Marsh, Director of Pharmacy; Rachel Kile, PharmD, Pharmacy Clinical Manager Approved by, Nathan Chamberlain, MD, Chairman