



## PHARMACY AND THERAPEUTICS COMMITTEE

DATE: February 9, 2023

CALLED TO ORDER: 7:01 a.m.
LOCATION: SCN Boardroom

ADJOURNED: 8:09 a.m.

Voting Member Attendance:  X Nathan Chamberlain, MD- Chairman X Mark Anderson, MD- Infectious Disease X Justin Blinn, MD- Anesthesiology David Dodson, MD- Hospitalist X Karen Frank, RN- Quality X Sherry Fusco, RN- CNO F. Lee Hamilton, MD- Hospitalist X Matthew Kodsi, MD- Quality Aditya Mandawat, MD- Cardiology  Non-Voting Member Attendance:  Karen Babb, PharmD- Manager Jamie Barrie, PharmD- Manager, HX Karen Babb, PharmD- Manager Jamie Barrie, PharmD- Operations Manager Rodney Elliott- Purchasing Lori Hammon, RN- Quality X Kevin Hopkins, RT- Director of Resp Therapy X Rachel Kile, PharmD- Clinical Manager Aditya Mandawat, MD- Cardiology  X Carey Smith, RPh- Manager, GA	_	EGG/(ITCN: GGIV Boardroom			ADOCOTALD: 0.00 d.m.
X Mark Anderson, MD- Infectious Disease X Justin Blinn, MD- Anesthesiology David Dodson, MD- Hospitalist X Karen Frank, RN- Quality X Sherry Fusco, RN- CNO F. Lee Hamilton, MD- Hospitalist X Matthew Kodsi, MD- Quality X Mark Anderson, MD- Infectious Disease Richard Yap, MD- Hospitalist, GA Richard Yap, MD- Hospi		Voting Member Attendance:		Non-Voting Member Attendance:	Guests:
X Daniel Marsh, PharmD- Director of Pharmacy X Claire Bass, Clinical Dietician		<ul> <li>X Mark Anderson, MD- Infectious Disease</li> <li>X Justin Blinn, MD- Anesthesiology</li> <li>David Dodson, MD- Hospitalist</li> <li>X Karen Frank, RN- Quality</li> <li>X Sherry Fusco, RN- CNO</li> <li>F. Lee Hamilton, MD- Hospitalist</li> <li>X Matthew Kodsi, MD- Quality</li> <li>Aditya Mandawat, MD- Cardiology</li> </ul>	James Wahl, MD- Hospitalist, GA	Jamie Barrie, PharmD- Manager, HX Kenneth Dyer, PharmD- Operations Manager Rodney Elliott- Purchasing Lori Hammon, RN- Quality  X Shannon Harris, RN- Infection Prevention  Kevin Hopkins, RT- Director of Resp Therapy  Rachel Kile, PharmD- Clinical Manager  X Carey Smith, RPh- Manager, GA	Jordan Tynes, Pharmacy Resident Chris D'Amico, Pharmacy Resident Deb McKaig, Pharmacy Administrative

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 December minutes were approved as submitted.	Approved	Complete
CommonSpirit Health System P&T Committee	January 2023 Decision Brief: The medication decisions that were approved at the CommonSpirit Health System P&T committee meeting 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. Hydralazine IV orders: Following incidences of patients receiving PRN IV hydralazine for appropriate blood pressure parameters resulting in subsequent elevated heart rate issues, it was proposed to add hold instructions in all as needed injectable hydralazine orders. An email vote was conducted following the December P&T meeting, with the majority selecting Option 1 - a default in administration instructions to hold for heart rates exceeding 100 beats per minute. Order sets including hydralazine with current administration instructions were excluded. Rachel will continue to update the committee as the EHR build progresses.	Approved	Complete



Imagine better health.™

CHI Memorial Hospital Georgia

				_
Formulary Decisions & Therapeutic Interchanges	A.	Incobotulinum toxin A (Xeomin): Botulinum toxin inhibits the release of acetylcholine at presynaptic nerve terminals within the peripheral nervous system. This will induce local paralysis and selective weakening of muscles. Xeomin is the only botulinum toxin which only contains the 150-kD neurotoxin and is free of the neurotoxin associated proteins. This is proposed to have a lower rate of antibody production however the overall clinical occurrence and significance is not clear. Xeomin as compared to onabotulinumtoxinA (Botox) on a cost per unit basis favors incobotulinumtoxinA as the more cost-effective option. Overall literature supports clinical equivalency between the agents. Xeomin and Botox have been dosed at an equipotent 1:1. Utilization review demonstrated that >60% of use is for urology. All service lines using Botox were agreeable to utilizing Xeomin. It is recommended to designate Xeomin as the preferred botulinum toxin A agent when it can be successfully utilized for FDA approved or payer approved off-label indications. Botox will remain on	Approved	Complete
	B.	formulary for situations when the preferred agent cannot be utilized due to payer restrictions, etc.  Mepolizumab (Nucala): Nucala is an interleukin-5 (IL-5) receptor antagonist and eosinophilic monoclonal antibody. P&T voted Nucala to formulary in 2016 with restrictions to use in the outpatient setting only. With Nucala's unique mechanism of action at the time, it was anticipated the hospital could expect a modest profit. Since 2016, Fasenra (anti-IL-5 agent) was added to the CHI Memorial formulary with the same restrictions. In 2021, both Fasenra and Nucala were reviewed by CommonSpirit Health System P&T with Fasenra preferred for new starts. Currently, CHI Memorial treats 14 patients with Nucala (3 patients failed treatment with Fasenra). Switching the remaining 11 patients from Nucala to Fasenra would increase annual revenue by approximately \$20,000. Some concerns regarding changing to Nucala to non-formulary status were discussed including the following points:  No head to head trials comparing the two agents  Compared to Fasenra, Nucala holds additional FDA indications outside of eosinophilic asthma including hypereosinophilic syndrome and rhinosinusitis with nasal polyps  For patients who require Nucala for these indications, they would then be required to leave Memorial to seek care  If making Nucala non-formulary will impact patient's access to care negatively  Reimbursement is lacking from some payers for cost of Nucala leading to negative overall margins Ultimately, it is recommended to change Nucala formulary status to non-formulary (will permit 3 current patients to remain) since there are two local infusion centers who can offer Nucala to our patients for other indications not covered by Fasenra, in addition to the projected cost savings. If significant issues with patient access to other local infusion centers arise, Nucala may be re-reviewed by this committee.	Approved	Complete
	C.	Pegloticase (Krystexxa): Krystexxa is a PEGylated uric acid specific enzyme indicated for the treatment of chronic gout in adult patients refractory to conventional therapy. Gout treatment options were previously reviewed in a system class review prepared by CHI in March of 2019. The review determined Krystexxa should be non-formulary because it must be given intravenously, is associated with potentially severe side effects, and is prohibitively expensive. Drs. Bragg and Garcia-Rosell with CHI Memorial Arthritis and	Approved	Complete





		riospitai deorg	,
	Rheumatology Associates requested adding Krystexxa to the outpatient infusion center formulary in order to keep CHI Memorial patients within CHI Memorial. Since 2019, primary data has demonstrated increased efficacy and tolerability of pegloticase when combined with methotrexate, which subsequently earned an FDA approval. However, cost remains a concern as a net loss would incur with the payers who comprise over 80% of patient volume for the infusion center. It was recommended to maintain the non-formulary status of Krystexxa since there are two local infusion centers who can offer it to our patients, plus it would prevent a financial loss.		
D.	Clinimix E: Clinimix E is a standardized, commercially available parenteral nutrition product available as multichamber bag parenteral nutrition (MCB-PN). Compared to custom TPN, it requires fewer compounding steps before administration, has reduced infection rates, and comparable nutrition efficacy. Several local and regional hospitals have successfully incorporated use of Clinimix products into their parenteral nutrition protocols. There are considerations for patients with fluid restrictions due to volume delivered, and these cases should be discussed on a per patient basis with Nephrology. Adoption of Clinimix products to formulary would allow for substantial annual cost savings for the hospital as it was estimated that approximately 40 percent of current TPN volume would transition to Clinimix E. It was recommended to:  Approve Clinimix products to formulary  Approve the Consult to Pharmacist for TPN management to allow the pharmacist to use guidelines, existing TPN policy, and clinical judgment to determine if the patient shall be initiated on a Clinimix product or a custom TPN  Do not allow blanket requests by prescribers such as "No Clinimix for any of my patients"  Update the TPN order set to add Clinimix as an option	Approved	Complete
E.	<ul> <li>Pantoprazole infusions: Pantoprazole is a proton pump inhibitor (PPI) that is used as adjunct therapy to endoscopy and is effective pharmacotherapy in high-risk patients with peptic ulcer bleeding. Current treatment of GI bleeds after endoscopy is pantoprazole 80 mg bolus followed by 8 mg/hour continuous infusion for 72 hours. However, studies demonstrate that pantoprazole 40 mg IV given every 12 hours was as effective as a high dose regimen in reducing risk of recurrent bleeding. Pantoprazole infusions are also incompatible with many IV medications and are laborious to compound. Implementing an IV push regimen would allow for easier administration for nurses and does not tie up an IV site. By initiating patients on a 40 mg pantoprazole IV bolus every 12 hours, the hospital would also have a modest cost savings. The following recommendations were made:         <ul> <li>Eliminate the high dose pantoprazole regimen (80 mg IV x 1, followed by 8 mg/hour for up to 72 hours) in lieu of the intermittent low dose bolus regimen (40 mg IV every 12 hours for up to 72 hours)</li> <li>For GI bleeds, a one-time bolus dose of pantoprazole 40 mg IV may be administered in the emergency department (ED), followed by an immediate GI consult</li> <li>Pantoprazole 40 mg IV bolus dose may be administered a second time if endoscopy will not occur within 12 hours after initial dose</li> </ul> </li> </ul>	Approved	Complete





	<ul> <li>Pantoprazole 40 mg IV Q 12 hours should be administered for up to 72 hours after endoscopy</li> <li>Patients should be continued on oral PPI therapy (pantoprazole 40 mg PO Q 24 hours)</li> <li>Patients can be transitioned to oral therapy before 72 hours, if applicable</li> <li>No more than 3 days of an IV PPI should be used after endoscopy unless extenuating circumstances (NPO, etc.)</li> </ul>	Annual	Occupato
	F. Drug shortages update: The injectable lorazepam supply has recovered and lorazepam IV push at 0.5 mg x 1 dose has been requested to be added back to the MCT IP CAR CORONARY CTA PRE MEDICATION ORDERS order set. Dr. Mandawat researched this request and determined that the use of IV lorazepam during this testing is a standard protocol across the country for acute management of anxiety due to bradycardia caused by beta blocker administration 60-90 minutes prior to the study. It is recommended to update the order set and replace the oral tablet with the IV push formulation.	Approved	Complete
	G. Medications for COVID-19: It was recommended to make the Pfizer-BioNTech COVID-19 Vaccine (monovalent) and Bivalent booster vaccines non-formulary due to a lack of usage, high waste with use, and lack of need for administration for patients discharging to SNF/facilities. Paxlovid use inclusion criteria for inpatients was updated to read "diagnosis of COVID-19 with mild to moderate symptoms" in lieu of having a positive Covid test, as per the EUA update.	Approved	Complete
Medication Use	<ul> <li>A. "Once" Medication Orders: This was a proposal from a cross-market pharmacy group including Texas and Kentucky (shared EPIC EHR). "Once" medication orders that are documented as "Not Given" remain active on the MAR and Pyxis. This has led to medication errors including the Once medication being given days later without a new order being obtained from the provider. The question posed to the committee was: "How long should medication orders with the frequency of "once" remain active/available for administration on the MAR if not documented as "not given"?</li> <li>Discussion surrounding the purpose of a Once order along with timing the medication should be given</li> <li>Once orders by providers intended to be given within a timely manner (vs days later)</li> <li>Account for possible patient transfers and time off the floor for diagnostic testing</li> <li>Solution: change Once orders to auto-discontinue after 12 hours</li> <li>The proposed solution will be shared back to the cross-market committee. Rachel will update the committee once a decision is finalized.</li> </ul>	Approved	Complete
Policies	<ul> <li>A. Medication Administration: Timeliness of Scheduled Medications: Updated to align with current EPIC workflows. Changes to the "Standard Scheduled Administration Times" include:         <ul> <li>3 times daily changed to 0900, 1500, 2100</li> <li>Multiple respiratory therapy (RT) timing changes</li> </ul> </li> </ul>	Approved	Complete

There being no further business, the meeting was adjourned at 8:09 a.m. The next P&T meeting is March 30, 2023.

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