



PHARMACY AND THERAPEUTICS COMMITTEE

DATE: June 15, 2023

CALLED TO ORDER: 7:00 a.m.
LOCATION: SCN Boardroom

ADJOURNED: 7:39 a.m.

2007 THOTH COIL BOARDON			7100001111LD. 7.00 d.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	Matthew Kodsi, MD- Quality Aditya Mandawat, MD- Cardiology Daniel Marsh, PharmD- Director of Pharmacy Chad Paxson, MD- Intensivist James Wahl, MD- Hospitalist, GA Richard Yap, MD- Hospitalist	X Karen Babb, PharmD- Manager Jamie Barrie, PharmD- Manager, HX X Kenneth Dyer, PharmD- Operations Manager Rodney Elliott- Purchasing Lori Hammon, RN- Quality Shannon Harris, RN- Infection Prevention Kevin Hopkins, RT- Director of Resp Therapy Rachel Kile, PharmD- Clinical Manager X Carey Smith, RPh- Manager, GA Ingrid Wright, Clinical Dietician	Joseph Oh, Pharmacy Resident Jordan Tynes, Pharmacy Resident Chris D'Amico, Pharmacy Resident Hallie Butler, Pharmacy Resident

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 March minutes were approved as submitted.	Approved	Complete
Old Business	 A. CommonSpirit Health P&T Committee Decision Brief: teclistamab-cqyv (Tecvalyi) is a monoclonal antibody used for patients with multiple myeloma. It was moved from non-formulary status to restricted formulary in May 2023 to the outpatient setting for FDA-approved indications or payer-approved off-label indications subsequent to insurance approval or prior authorization. Tecvalyi still lacks a specific reimbursement J-code (anticipated summer 2023). The EHR design/build for Tecvalyi is being coordinated to assist sites that may need to use this therapy for appropriate individuals. This is an ongoing process at our facility. The current local process has Tennessee Oncology administer Tecvalyi in their office followed by admission to CHI Memorial Hospital for monitoring of possible neurologic and cytokine release syndrome toxicities. B. System P&T also approved levetiracetam doses up to 1.5 gm should be administered as IV push. Currently Memorial gives doses up to 1 gm IV push. Will work to allow doses of up to 1.5 gm to be given as IV push. Approved by the local committee. C. System P&T shared new Controlled Substance Management policies. These will be reviewed and adopted by the local diversion committee. 	Informational Informational	Complete Complete Complete





Formulary Decisions &	Τ_Λ	Vibrary (Cambrer): Vibrary a coloringly activate the D2 advancerie recentor within the bladder to relay the	Approved	Complete
Therapeutic Interchanges	A.	Vibegron (Gemtesa): Vibegron selectively activates the B3 adrenergic receptor within the bladder to relax the detrusor smooth muscle and increase bladder capacity. It is the second B3 agonist to be approved for the	Approved	Complete
Therapeutic interchanges		indication of overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency in		
		adults. Vibegron obtained FDA approval in 2020 based on:		
		EMPOWUR trial demonstrated significant reduces in micturitions, urgency episodes and urge in action action and while increasing unlaws are michaelited with a parameter of the place in action and the place in action action and the place in action action action action action action and the place in action acti		
		incontinence while increasing volume per micturition when compared to placebo		
		Mirabegron is currently on CHI Memorial and Commonspirit Health formulary. No head-to-head trials have		
		been conducted to assess the differences of safety and efficacy of vibegron and mirabegron. However, study		
		results demonstrate with vibegron:		
		A lower risk of drug interactions		
		Lower incidence rates of increased blood pressure		
		A quicker onset of efficacy		
		At the time of this review, vibegron is more expensive than the tablet formulation of mirabegron. It is		
		recommended to adopt the CommonSpirit Health system P&T committee decisions to formulary decisions		
		below including an automatic pharmacist or EHR therapeutic interchange of vibegron 75 mg PO daily to		
		mirabegron 25 mg PO daily.		
		Formulary, restricted Mirabegron to patients who are unable to take antimuscarinic agents and/or		
		continuation from home		
		Non-formulary: Vibegron		_
	B.	Drug shortage update [Solu-cortef (hydrocortisone)]: Solu-cortef is currently a critical shortage item due to	Approved	Complete
		manufacturing delays. Unfortunately a potential alternative, Solu-medrol, is also in shortage for most		
		formulations. The pharmacy was able to procure Solu-medrol 1 gram vials from which we are drawing up 40		
		mg syringes. Solu-medrol can be used as an alternative to Solu-cortef, but lacks mineralocorticoid activity		
		(does not provide benefits for blood pressure support in adrenal insufficiency and septic shock patients). A		
		new LMA displays when a provider attempts to order Solu-cortef:		
		 Hydrocortisone 100 mg (IV/PO) = methylPREDNISolone 20 mg + fludrocortisone 0.2 mg 		
		It is recommended to formulary approve the pharmacist automatic interchange for orders of Solu-medrol 125		
		mg to Solu-medrol 120 mg in order to utilize three of the compounded 40 mg syringes while the 125 mg vials		
		are unavailable during the current shortage.		_
	C.	Electrolyte Replacement Guidelines (Potassium Update): the current guideline states that if a potassium	Approved	Complete
		level is less than or equal to 2.9, replacement can only be accomplished using IV replacement, unless IV		
		access is not available. Every 10 mEq of IV potassium replacement requires a 1 hour infusion time and		
		50-100 mL of fluids. To replace 80 mEq of potassium per the protocol for K < 2.9, a total infusion of 8 hours		
		and 400-800 mL of fluid would be needed. To minimize fluid overload and reduce the time to achieve		
		normalized potassium levels, it is proposed to allow for utilization of a hybrid of both oral or per tube		
		replacement and IV replacement if the patient is able. The proposed verbiage on the order set for potassium		





	level of 2.9 or less would read as: Patients with no IV access: 80 mEq oral potassium Patients with IV access and able to take PO: 40 mEq oral potassium, followed by 40 mEq IV potassium Patients unable to take PO: 80 mEq IV potassium P&T committee approves the above recommendation. There was discussion on addressing other areas of improvement on the electrolyte protocol, specifically on how the orders are worded to have the most direct pathway for nurses to use when conducting electrolyte protocol order. The phosphate order pieces related to potassium have not been altered as part of this recommendation.		
Pharmacy Resident Research	A. Evaluation of weight-based vs fixed dosing of Kcentra in management of DOAC associated bleeding: This retrospective study demonstrated no statistically significant difference in achieving hemostasis between the two dosing strategies while allowing for a decreased average dose per patient by nearly 1500 units. Utilizing the fix-dosing of Kcentra is a more cost effective alternative, allowing for a cost savings of over \$60,000 when comparing study periods. There are currently no modifications to the CHI Memorial Antithrombotic Reversal and Surgical Management Guidelines recommended.	Informational	Complete
	B. Impact of pharmacy-led beta-lactam allergy clarification and delabeling: The antimicrobial stewardship team approved of a beta-lactam allergy guideline to assist clinicians in prescribing antibiotics for inpatients with reported allergic reactions to penicillin or cephalosporin antibiotics. Resources available include a patient allergy assessment tool questionnaire, allergic reaction risk category chart, cross-reactivity matrix, and test dosing procedures (PO and IV). This retrospective study resulted in 167 pharmacy interventions in January 2023 and showed there are substantial opportunities for delabeling with approximately 40% of patients' allergies being categorized as either minimal or low-risk reactions. 72% of patients had their reaction occur >10 years ago. Lastly, 43% of patients had a previous beta-lactam prescription in the last year, further reinforcing the ability for these patients to be capable of utilizing a beta-lactam or penicillin in their therapy to optimize care.	Informational	Complete
	C. Impact of pharmacist intervention on discharge antibiotic therapy for community acquired pneumonia (CAP): It has been shown increasing total antibiotic duration beyond 5 days in clinically stable patients with CAP has no benefit. A pharmacist driven initiative was implemented to target patients with a diagnosis of CAP. Ultimately, implementation of this initiative, particularly at the point of discharge, decreased both total duration of antibiotics and discharge duration of antibiotics by one day. All interventions related to duration of therapy and 100% of those interventions were accepted.	Informational	Complete

There being no further business, the meeting was adjourned at 7:39 a.m. The next P&T meeting is August/September with a specific date TBD.

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