Pharmacy & Therapeutics Committee News May 2021

P & T Committee materials and references available upon request.

IV Levothyroxine Policy Updated

Please be aware that the conversion between oral and intravenous levothyroxine will be updated to reflect current guideline directed standard of care. The IV Levothyroxine Policy and the IV to PO policy have both been updated to reflect that the conversion between an established oral regimen and intravenous levothyroxine is now 75%.

- Example: If a patient is admitted on 100mcg of PO levothyroxine, the IV dose would be 75mcg

A brief drug utilization evaluation was performed and it showed that policy noncompliance contributed to ~$3,500 in waste over a 3 month period of time. Please continue to use the following parameters when converting patients from oral to intravenous levothyroxine as these have not changed.

1. Levothyroxine will be held, and not administered, for the first 4 days a patient is NPO
2. Exceptions: patients with clinical symptoms of myxedema coma, hypothyroidism induced cardiogenic shock or a TSH >50mU/L, organ donor protocol or patients NEVER exposed to levothyroxine with a TSH >10mU/L

Toradol (ketorolac) in ESRD: Prevention of Nephrotoxicity

The Toradol (ketorolac) Policy allows pharmacists to automatically adjust the dose of ketorolac based on the patient's age, weight, and creatinine clearance (CrCl). It was brought to attention this policy does not define an absolute contraindication to ketorolac therapy.

There have been 4 recent cases in which ketorolac was used in patients with renal impairment: 1 patient with known stage 3 CKD, 1 hemodialysis patient, and 2 patients with unknown renal impairment prior to ketorolac administration that were later discovered to be in acute renal failure.

Based on these 4 recent cases, the Toradol (ketorolac) Policy will be revised:

1. Add an absolute contraindication for CKD 4 (calculated CrCl <30ml/min) or peritoneal dialysis
2. For patients not at risk for nephrotoxicity, ketorolac may be ordered/administered prior to serum creatinine resulting based on clinical judgment that the benefit of immediate treatment of the patient's pain outweighs the need of waiting for laboratory results
    a. Example scenario where it would be reasonable to administer ketorolac without lab results:
        i. 28yo with a history of IV drug abuse, no history of nephrotoxicity, no home medications that could cause AKI who presents with acute shoulder pain
3. Recommendation added for the prescriber to contact the patient's nephrologist prior to the ketorolac order if they are already on hemodialysis.
4. Allow doses as low as 10mg IV, primarily for at risk patients that do not have a contraindication.
5. Work with EPIC strategists to gain as much reasonable support for this safety initiative as possible.

Mesalamine Formulary Change Automatic Therapeutic Substitution

Currently, SJH stocks four mesalamine products: Apriso, Pentasa, Delzicol, and Lialda. Literature suggests similar safety and efficacy between mesalamine formulations. Delzicol acts on the proximal colon, Apriso and Lialda act on the proximal and distal colon, and Pentasa acts on the duodenum, jejunum, ileum, and colon. With regard to GI provider perspective, waste minimization, cost savings, and patient satisfaction, the following was decided by the P&T committee:

1. Maintain Apriso (generic only) and Lialda (generic only) on formulary, stocked
2. Asacol (all) and Delzicol (all) are nonformulary, not stocked
3. Pentasa will remain on the formulary until its inventory is depleted and then it will become nonformulary, not stocked

If ordered	Interchange	Notes
Asacol HD	Apriso	
Delzicol	Apriso	
Pentasa	Apriso	Do not start the substitution until all SJH inventory is depleted

For more information on Pharmacy & Therapeutics Committee actions, please contact Karen Whalen, Drug Information Pharmacist 448-6519.

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IV Lipid Formulary Change (Launch June 9th)

The current formulary IV fat emulsion for all patients is Intralipid 20%, a soybean-based emulsion. In June, SJH Pharmacy will convert all adult patients to SMOFlipid 20%. This IV lipid is derived from Soybean oil (30%), Medium-chain triglycerides (30%), Olive oil (25%), and Fish oil (15%). This change is supported by the literature, organized guidelines, and consensus statements. Because this product is partially derived from fish and the manufacturer cannot guarantee it to be shellfish-free, patients with severe fish or shellfish allergies should not receive SMOFlipid. Intralipid 20% will remain available for those patients, NICU and patients requiring lipid treatment of overdose/-caine toxicity.

Phenytoin IV Removed From Formulary And Replaced With Fosphenytin IV (Launch TBD)

Intravenous hydantoins are used to treat seizure disorders when patients are unable to take phenytoin by mouth. SJH formulary included both phenytoin IV and fosphenytoin IV, but there were several restrictions on the use of fosphenytoin. At a date to be decided in June, all phenytoin IV will be removed from inventory. Fosphenytoin IV will be formulary and the previous restrictions will be removed. Safety monitoring will remain in place.

Inapsine (droperidol) IV Mandatory Restrictions

1. Trinity policy: Restricted use to the Emergency Department, Operating areas and Post-operative areas (one time doses) in patients who fail to show an adequate response to other treatments
2. Trinity policy: Any use beyond 2.4mg (single or repeat doses) *must include baseline EKG and 2-3 hours continuous telemetry after the dose is given*
3. Trinity policy: No other doses, repeat doses, locations or indications are allowed
4. SJH P & T: Agitation or headache in the ED: droperidol up to 2.4mg or less (one time dose only), no mandatory monitoring
5. SJH P & T: PONV treatment after inadequate response to prior treatment: 0.625mg IV x1, may repeat x1 for a total dose 1.25mg, no mandatory monitoring

Restricted Medication List Policy Revisions

Restricted Medication	Restrictions
Insulin – U500 (regular)	POM only to refill the patient's insulin pump. All others, including patient cannot supply for their pump, will need to be converted to basal-bolus insulin.
Morphine sulfate ER – Kadian	Kadian is nonformulary, not stocked.
Enlon (edrophonium)	Nonformulary, not stocked.
Vyepti (eptinezumab) IV	Nonformulary, not stocked.
Praluent (alirocumab) SC Repatha (evolocumab) SC	Nonformulary, not stocked. The pharmacist can automatically discontinue the order and must place an EPIC sticky note to communicate this.
Serzone (nefazodone) PO	Nonformulary, not stocked. No longer manufactured. Plan a transition so there is no abrupt discontinuation.
Sandostatin (octreotide) LAR Long-acting depot injection	Nonformulary, not stocked, fast track required
Reyvow (lasmiditan) PO	Nonformulary, not stocked. Not approved for use in the ED.
Dilantin (phenytoin) IV only	Nonformulary, not stocked.

Automatic Therapeutic Substitution Policy Revisions: See the next page

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Automatic Therapeutic Substitution Policy Revisions

If Ordered	Interchange	Notes/Exceptions
Magnesium chloride (Slow-mag) Each tablet 64mg elemental Mg Per single tablet, any schedule	Magnesium L-lactate dihydrate (Mag-Tab SR) 1 tablet per day or BID based on number of Slow-mag tablets	Cannot be put down an enteral feeding tube May dose once or twice daily depending on quantity and drug interactions
Magnesium gluconate 13.5mg Mg per 250mg tab 250 to 1,500mg total daily dose > 1,500mg total daily dose	Magnesium L-lactate dihydrate (Mag-Tab SR) 1 tablet daily 2 tablets daily or 1 tablet BID	Cannot be put down an enteral feeding tube May dose once or twice daily depending on quantity and drug interactions
Magnesium oxide (Mag-Ox) 241 elemental Mg in each	Magnesium oxide (MagOx) as ordered	Can go down enteral feeding tube
All other magnesium products	Magnesium L-lactate dihydrate (Mag-Tab SR) Round to nearest dose based on elemental magnesium content.	Cannot be put down an enteral feeding tube May dose once or twice daily depending on quantity and drug interactions
Azelastine nasal spray (any strength)	Azelastine nasal spray 0.1% twice daily	If there is a shortage of 0.1%, then 0.15% will be substituted.
Ferrous fumarate, slow release iron and iron combination products (not Renavite type)	Ferrous sulfate 324/5mg tablet, once or twice a day (or every other day) based on the home regimen.	• Maximum 324/325mg twice daily. • Doses of more than 1 tablet at a time will be automatically reduced to one tablet. • All oral iron products will be discontinued while the patient is taking antibiotics with a cation-drug-drug interaction. • This does not apply to products used as phosphate binders (ie ferric citrate).
Guaifenesin oral syrup 100-200mg 300-400mg 500-600mg	Guaifenesin oral syrup 200mg 400mg 600mg	

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