Due to travel restrictions and the need to reschedule the PBM-MAP-VPE Meetings where formulary decisions are made, this issue of the EZ Minutes combines two issues in one. Formulary Decisions from August 2015-December 11, 2015 are included in this issue.

**Inside This Issue**

**Posting of National PBM Documents** Aug-Dec 2015

**Posting of VA MedSAFE Documents** Aug-Dec 2015

**National Contract Awards for CY 2015**

**Pharmacy-Prosthetics-Logistics and Acquisitions (PPL) Workgroup** Aug-Dec 2015

**TSOAC to DOAC**

**Reducing Polypharmacy in the Palliative Care Setting**

**PBM-MAP-VPE Webinars**

**Salute to former and New Members**

Happy Holidays and a Safe New Year

The purpose of PBM-MAP-VPE Ez-Minutes Newsletter is to communicate with the field on items which will impact clinical practice in the VA. Please send feedback and/or comments to Janet.Dailey@VA.gov.

The recent issue of Ez Minutes can be read from your smartphone! Put the below link in your browser; hit search...and the current issue from the PBM INTERNet site will be ready to read. http://www.pbm.va.gov/PBM/ezminutes/current/currentEZMinutes.pdf

Don’t forget…you can also subscribe to Ez-Minutes and any documents posted to the VA’s New Section on the PBM INTERNet web site by subscribing to the RSS Feed. http://www.pbm.va.gov/PBM/ezminutes/Whats_New_At_PBM_RSS_Feed.xml

**Posting of National PBM Documents Aug – Dec 16, 2015**

<table>
<thead>
<tr>
<th>ADDED to the VA National Formulary (VANF)</th>
<th>NOT ADDED to the National Formulary (VANF)</th>
<th>Removed from the National Formulary (VANF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-valent HPV vaccine</td>
<td>Adapalene 0.3% and benzoyl peroxide 2.5% topical gel combination</td>
<td>Antipyrine/benzocaine/glycerin Otic</td>
</tr>
<tr>
<td>Bupropion XL (24-hour formulation)</td>
<td>Aflatinib</td>
<td>Chloral hydrate</td>
</tr>
<tr>
<td>Dacatiasvir</td>
<td>Alentuzumab</td>
<td>Ipecac Syrup</td>
</tr>
<tr>
<td>Idarucizumab</td>
<td>Alirocumab</td>
<td>4-valent HPV vaccine</td>
</tr>
<tr>
<td>Lacosamide IV</td>
<td>Brimonidine Topical Gel</td>
<td></td>
</tr>
<tr>
<td>Lidocaine cream/oointment</td>
<td>Carbidopa Levodopa ER</td>
<td></td>
</tr>
<tr>
<td>Lidocaine 5% patch</td>
<td>Edoxaban</td>
<td></td>
</tr>
<tr>
<td>Melatonin (Certified Product Only)</td>
<td>Fluocinolone acetonide 0.19 intravitreal implant</td>
<td></td>
</tr>
<tr>
<td>Paliperidone palmate IM</td>
<td>Glucagon Injection [synthetic] – the VANF</td>
<td></td>
</tr>
<tr>
<td>Phenylephrine (oral)</td>
<td>line item name will be changed to</td>
<td></td>
</tr>
<tr>
<td>Potassium Chloride oral solutionTechnivie</td>
<td>Glucagon Recombinant Injection to</td>
<td></td>
</tr>
<tr>
<td>Tiotropium/olodaterol Inhaler</td>
<td>differentiate between synthetic glucagon</td>
<td></td>
</tr>
<tr>
<td>Ulipristal acetate</td>
<td>(nonformulary) and recombinant glucagon (formulary)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hydrocodone bitartrate ER</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insulin glargine 300U per mL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ivasadrine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leuprolide acetate for depot injection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and norethindrone acetate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lidocane 5% ointment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lidothane 5% ointment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Osemifene</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Omacetaxine Mepesuccinate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Osimifene</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oxycodeone HCl Aetamominophen Extended-Release</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paclitaxel Protein-Bound</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paliperidone palmate IM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ponatinib</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sacubitril Valsartan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tasimelteon</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vedolizumbin Injection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Von Willebrand Factor/Coagulation Factor VIII Complex (human)</td>
<td></td>
</tr>
</tbody>
</table>

**Criteria for Use (CFU)**

- 9-valent HPV vaccine
- Acetylcholinesterase Inhibitors [Updated Dec. 2015]
- Alentuzumab
- Alirocumab
- Brimonidine Topical Gel
- Carbidopa Levodopa ER
- Dacatiasvr
- Ezeimol/Ezelmibe/Simvastatin [Updated Nov. 2019]
- Ivasadrine
- Methylnaltrexone Injection [Updated Dec. 2015]
- Paliperidone
- Pneumococcal 13 Valant Conjugate Vaccine [Updated Oct. 2015]
- Sacubitril Valsartan
- Sofosbuvir and Ledipasvir-Sofosbuvir [Updated Oct. 2015; Dec 2015]
- Tasimelteon
- Tocagrelor [Updated Dec. 2015]
- Varenicline [Updated Dec. 2015]
- Vedolizumbin Injection
- Vildkir Pat and Technivie [Updated Dec. 2015]

**Abbreviated Review**

- 9-valent HPV vaccine
- Hydrocodone bitartrate ER
- Oxycodeone HCl Aetamominophen Extended-Release
- Pasinidote
- Techivie
- Tioptropium/olodaterol Inhaler

**Patient and Provider Letters**

- Digoxin **Patient Letter, Provider Letter**
  
  Digoxin has been removed from the VA Drug Standardization List due to a shortage of the active pharmaceutical ingredient

  Glatiramer **Provider Letter and Patient Letter**

**Drug Monograph**

- Aflatinib
- Alentuzumab
- Alirocumab
- Bosutinib
- Buprenorphine Transdermal System
- Carbodopa Levodopa ER
- Ceftazidime/avibactam
- Edoxaban
- Fluocinolone acetonide 0.19 intravitreal implant
- Glucagon Injection [synthetic] – the VANF line item name will be changed to Glucagon Recombinant Injection to differentiate between synthetic glucagon (nonformulary) and recombinant glucagon (formulary)
- Hydrocodone bitartrate ER
- Insulin glargine 300U per mL
- Ivasadrine
- Leuprolide acetate for depot injection and norethindrone acetate
- Lidocane 5% ointment
- Omacetaxine Mepesuccinate
- Osimifene
- Oxycodeone HCl Aetamominophen Extended-Release
- Paclitaxel Protein-Bound
- Paroxetem mesylate 7.5 mg
- Pasinidote
- Ponatinib
- Sacubitril Valsartan
- Tasimelteon
- Vedolizumbin Injection
- Von Willebrand Factor/Coagulation Factor VIII Complex (human)

**Clinical Recommendations**

- Naloxone Kits and Autoinjector
- Ulipristal acetate

**Additional Information**

- Methylnaltrexone Injection guidelines - indication for opioid-induced constipation in chronic noncancer pain was added
- Oxcarbazepe-Not restricted to neuro

**Other Helpful Resources**

- Cost Comparison for HCV Genotype 3 Regimens [InTRANet only]
- Lidocaine 5% Patch Literature Review
Pharmacy-Prosthetics-Logistics (PPL)* Workgroup

The table below depicts the various products reviewed during July-October 2015 meetings. The X marks which service(s) is responsible for managing the respective products. Please click HERE for previous recommendation and minutes made from earlier meetings.

<table>
<thead>
<tr>
<th>Products</th>
<th>Pharmacy+</th>
<th>Prosthetics+</th>
<th>Logistics+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchor Arthrex Suture (permanent)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Bio-adhesive glue and remover for facial prosthesis</td>
<td>X (outpatients)</td>
<td>X (Initial)</td>
<td></td>
</tr>
<tr>
<td>[Initial supply provide by prosthetics, replacement refills by pharmacy]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefaly used for in migraines</td>
<td>X (outpatients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure devices/cuffs for home use</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopic Bariatric Therapy (gastric balloon)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enteral declogging system (non-drug, e.g., ClogZapper and other similar products) if alternative agents (e.g., pancreatic enzyme products) are deemed ineffective or contraindicated</td>
<td>X (outpatient use)</td>
<td>X (inpatient or clinic use)</td>
<td></td>
</tr>
<tr>
<td>Ful-Glo (fluorescein strips or drops)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GEM 21s, Osteogen and other similar resorbable boney void fillers</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lancets for blood glucose testing</td>
<td>X (outpatients)</td>
<td>X (inpatients and clinics)</td>
<td></td>
</tr>
<tr>
<td>Oral care kit and suctioning system (e.g., Q-Care Kit containing chlorhexidine gluconate 0.12%)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ovulation Kits for female Veterans</td>
<td>X (outpatient use)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rocker cast boots/shoes or post-operative shoes</td>
<td>X (outpatients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rose Bengal</td>
<td>X (inpatient or clinic use)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheepskin</td>
<td>X (outpatient use)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPACEOAR (used prior to radiation of the prostate)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vinyl or plastic pants to wear over adult diapers</td>
<td>X (in properly selected outpatients)</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

+Contingent upon approval from VISN or local Clinical Products Review Committee (CPRC). Implementation of these recommendations should be coordinated between services at local sites to ensure a smooth transition if recommendations lead to a change in responsible service. If you have any questions related to this announcement, please contact the responsible local service (Pharmacy, Prosthetics, or Logistics) for more detailed information.

TSOAC RENAMED TO DOAC (DIRECT ORAL ANTICOAGULANTS)

The Scientific and Standardization Committee (SSC) of the International Society of Hemostasis and Thrombosis (ISTH) recently published recommendations on the use of consistent nomenclature for the newer class of oral anticoagulants that directly inhibit a single target and have similar clinical properties (e.g., dabigatran, rivaroxaban, apixaban, and edoxaban). After evaluation of several possibilities, the SCC of the ISTH recommends DOAC for direct oral anticoagulants. The nomenclature has been endorsed by several professional societies including the Anticoagulation Forum. (J Thromb Haemost. 2015;13:1154-6)

VA had widely adopted the target specific oral anticoagulants or TSOAC nomenclature (e.g., PBM documents, policy, CPRS ordering menus, MUET, etc.) as was originally endorsed by the Anticoagulation Forum and VA subject matter experts. Based on the new ISTH recommendations, the MAP and VPEs (National PBM) agreed that VA should transition from TSOAC to DOAC to be consistent with practices outside of VA.

The field will begin to see the new nomenclature of DOAC in PBM documents, communications, policy, MUET, etc. Facilities are encouraged to re-evaluate local and VISN level use of the TSOAC term and consider transitioning to the DOAC term. It may be helpful to include a reference to the former name of TSOAC (e.g., Direct Oral Anticoagulant [DOAC], formerly called TSOAC).
Reducing Polypharmacy in the Palliative Care Setting

Polypharmacy is a major risk factor for adverse medication reactions and interactions, particularly in the geriatric population. Despite this recognition, there is no uniform or consensus definition of polypharmacy although either “the use of 6 or more concomitant medications” or “use of a potentially inappropriate or unnecessary medication” has been frequently cited. Regardless of the definition employed, we know that there are many drivers of polypharmacy including:

1. Multiple disease specific guidelines in patients with multiple comorbidities
2. Treating acute problems in patients with multiple comorbidities (adding meds to meds)
3. Multiple providers involved in treating multiple comorbidities
4. Misinterpreting and mistreating adverse medication reactions (adding meds to meds)
5. Patient and family perception of medication necessity

How the process of deprescribing is communicated to the patient and family is also critical. Relating it to the goals of care discussion is usually the first step. If symptom relief and/or functional status improvement are the major goals then many medications that do not contribute to achieving those goals can often be discontinued. The language used in this process is also very important – terms like, “optimize, individualize, limit pill burden, maximize benefit and minimize harm” are much better received than terms such as, “stopping, quitting, decrease cost, no longer covered, etc.” As with all issues in Palliative Care, this must be a process of shared decision making so patients and families do not feel like they are being abandoned or that their treating clinicians are “giving up.”

In my experience, many patients who are taking six, eight or ten or more separate medications per day and often twice those numbers in terms of pills per day welcome the opportunity for this regimen to be streamlined. Furthermore, as most of us can attest from experience, many patients do not feel worse as medications are withdrawn but may actually feel better, in which case it becomes much easier to convince them to reduce polypharmacy. The most common classes of medications where there is often great opportunity to “deprescribe” in the Palliative setting with a high likelihood that the benefit (including just reducing the pill “burden” and reducing cost of care) outweighs the harm include:

- Acetylcholinesterase Inhibitors (AChEI) may be efficacious in slowing disease progression for mild to moderate Alzheimer’s Disease, less helpful and more harmful in advanced disease
- Memantine has small beneficial effect at six months only in moderate to advanced dementia and no clear added benefit in combo with AChEI
- Rivastigmine may help in Lewy Body disease but none of these agents are clearly helpful in vascular dementia and may be harmful in Frontotemporal dementia
- Potential side effects including nausea, diarrhea, insomnia, and others not usually well tolerated in Palliative Care population
- It is safest to wean these medications over two weeks when stopping

- Highly prevalent in Palliative Care population (including those with metastatic cancer) for prevention of cardiovascular morbidity which often is no longer relevant
- Recent study showed no difference in mortality at 60 days when statin is discontinued in Palliative Care setting (Kutner JS, et al. Safety and benefit of discontinuing statin therapy in the setting of advanced, life-limiting illness: a randomized clinical trial. JAMA Intern Med. 2015; 175:691-700)
- Many Palliative Care patients have anorexia, weight loss or poor nutrition for which cholesterol lowering no longer makes sense

- The main purpose of these agents is long-term reduction of heart failure, myocardial infarction, stroke, and kidney disease incidence which often become moot in Palliative Care setting
- The agents have minimal role in preventing or avoiding symptoms
- The risks for orthostasis, dehydration, falls and other adverse events or side effects are often higher in Palliative Care population
- If continued, the dose or number of agents can often be reduced and goal blood pressure can be less aggressive

- The main role for long-term prevention of micro and macrovascular disease often becomes moot in Palliative Care population
- The risk of hypoglycemia often increases with occurrence of anorexia, decreased food intake and weight loss in many Palliative Care patients
- Avoiding extremes of blood glucose is usually more sensible than “tight control” in Palliative Care setting

- Vitamin D and calcium for osteoporosis prevention no longer is relevant in most Palliative Care patients
- Anemia of chronic disease is often misdiagnosed as iron deficiency leading to unnecessary supplementation and frequent GI side effects
- Added pill burden and cost for little benefit

Summary and Conclusion: Just as in the geriatric population, in the Palliative Care setting, a “less is more” approach to medication management is often possible. While many patients and their clinicians tend to think of Palliative Care as akin to hospice and only dealing with patients with “terminal” illness, while the limits of curative care are being considered, the many patients who are dying, the real target population for a more conservative medication approach is many patients with a variety of lifelimiting illnesses. While prognostication is fraught with hazard and uncertainty, one of the simple questions Palliative Care clinicians often ask when evaluating a patient is the so-called “surprise” question: “Would I be surprised if this patient were not alive one year from now?” If the answer to this question is, “no” (and clinicians’ gut response to this question is surprisingly accurate) then reconsidering the goals of medication therapy in these patients is very appropriate. Does it really make sense to continue medications designed to reduce mortality and mortality over many years when life expectancy is likely far less than that? Do the benefits of continuing a medication outweigh the risks (side effects, adverse events) and/or disadvantages (inconvenience, cost)? Is a given medication providing any symptomatic relief, or is it actually causing side effects or harm? Frequently reviewing the goals of care for patients with serious illness and engaging in effective communication and shared decision making to guide medication therapy and help achieve those goals is the optimal way to reduce polypharmacy and improve outcomes for Veterans.

Submitted by: Paul E. Stander, MD, MBA, FACP Director, Outpatient Palliative Care Phoenix, VAMC

Editor’s Note: The PBM welcomes Dr. Stander as one of the newest member to the Medical Advisory Panel. Thank you for your contribution to the Ez-Minutes. Due to space constraint, this article was abbreviated. Please click HERE to read the article in its entirety.
If you missed any of the PBM webinars this year…..Below are links to the taped 2015 PBM Webinars.

**JANUARY:** Concomitant use of Benzodiazepines with Opioids
http://va-eerc-ees.adobeconnect.com/p7yhol82cp/

**FEBRUARY:** Hepatitis C Updates
http://va-eerc-ees.adobeconnect.com/p5cvv93tai/

**FEBRUARY:** Naloxone Kit Updates
http://va-eerc-ees.adobeconnect.com/p2sq15b3ano/

**MARCH:** VA/DOD Clinical Practice Guidelines (CPG) for the Management of Dyslipidemia for CV Risk Reduction
http://va-eerc-ees.adobeconnect.com/p5z7u4n3nd2/

**APRIL:** Naloxone Kit Updates
http://va-eerc-ees.adobeconnect.com/p7h3jicoxqd/

**MAY:** Demystifying Statistics for the Clinician Part 1
http://va-eerc-ees.adobeconnect.com/p379bw4ocwr/

**JUNE:** Demystifying Statistics for the Clinician Part 2
http://va-eerc-ees.adobeconnect.com/p4maxlymnl8/

**JULY:** Naloxone Kit Updates
http://va-eerc-ees.adobeconnect.com/p6jfco9rj2o/

**AUGUST:** Transforming Clinical Pharmacy Practice-Highlights from VHA Handbook 1108.01
http://va-eerc-ees.adobeconnect.com/p8bl401up4v/

**SEPTEMBER:** VA/DOD Clinical Practice Guidelines (CPG) for the Management of Dyslipidemia for CV Risk Reduction

**OCTOBER:** Anticoagulation Series Part 1: Anticoagulation Surveillance
http://va-eerc-ees.adobeconnect.com/p9h281rm7mj/

**NOVEMBER:** Anticoagulation Series Part 2: Anticoagulation Key Practices in VHA

**DECEMBER:** PBM EdAC Education and Training Programs in 2016
http://va-eerc-ees.adobeconnect.com/p70stdfyari/

Board Certification Study Groups; DM Moodle Modules, How-To-Videos (Patient Education)

Attention Pharmacist & Pharmacy Technicians
Virtual VHA Board Certification Study Groups will start January 2016. Anyone can participate in the study group even if you are not interested in taking the exam. For additional information contact Janet.Dailey@va.gov and/or the POC for the following respective groups:

- **BCPS:** Kimberly.Schnacky@va.gov
- **BCACP:** Jonathan.Hoffman@va.gov
- **BCOP:** Lindsay.Kaster@va.gov
- **BCCP:** June.Griffith@va.gov
- **CGP:** Martin.Cruz@va.gov
- **PTCB:** Marta.Kane@va.gov/ and/or Jennifer.Suther@va.gov

The PBM-MAP-VPE would like to thank and recognize the following members for their service to the VA and contributions to this committee:

- Retired in 2015
  - Malcolm Weiss (VPE)
  - Carl Hensley (VPE)
  - Robert Rosenstein (MAP)

- Resigned in 2015
  - Lori Highberger (MAP)

Welcome to the new members in 2015:

- Allen Blaivas (MAP)
- Shannon Kligore (MAP)
- Karla Mallo (VPE)
- Paul Stander (MAP)
- Mark Donahue (MAP)
- Bruce Capehart (MAP)
- Matthew Schreiber (MAP)

The PBM-MAP-VPE would like to thank and recognize the following members for their service to the VA and contributions to this committee:

- Retired in 2015
  - Malcolm Weiss (VPE)
  - Carl Hensley (VPE)
  - Robert Rosenstein (MAP)

- Resigned in 2015
  - Lori Highberger (MAP)

Welcome to the new members in 2015:

- Allen Blaivas (MAP)
- Shannon Kligore (MAP)
- Karla Mallo (VPE)
- Paul Stander (MAP)
- Mark Donahue (MAP)
- Bruce Capehart (MAP)
- Matthew Schreiber (MAP)