
Formulary Decisions

<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>Afatinib</td>
<td>Chloral hydrate</td>
</tr>
<tr>
<td>Dadatiasvir</td>
<td>Alemizumab</td>
<td>Ipecac Syrup</td>
</tr>
<tr>
<td>Idarucuzumab</td>
<td>Alirocumab</td>
<td>4-valent HPV vaccine</td>
</tr>
<tr>
<td>Lacosamide IV</td>
<td>Anthemophillic Factor (reombinant), Porcine Sequence</td>
<td>Bosutinib</td>
</tr>
<tr>
<td>Lidocaine cream/oointment</td>
<td>Bosutinib</td>
<td>Buprenorphine Transdermal System</td>
</tr>
<tr>
<td>Melatonin (Certified Product Only)</td>
<td>Brimonidine Topical Gel</td>
<td>Carbipoda Levodopa ER</td>
</tr>
<tr>
<td>Paliperidone palmitate IM</td>
<td>Buprenorphine Transderal System</td>
<td>Ceftazidime/avibactam</td>
</tr>
<tr>
<td>Phenylephrine (oral)</td>
<td>Carbipoda Levodopa ER</td>
<td>Edxoban</td>
</tr>
<tr>
<td>Potassium Chloride oral solution</td>
<td>Ceftazidime/avibactam</td>
<td>Edxoban</td>
</tr>
<tr>
<td>Tiotropium/olodaterol Inhaler</td>
<td></td>
<td>Empagliflozin (Pending: formulary status/update to the SGLT2 Inhibitor CFU)</td>
</tr>
<tr>
<td>Ulipristal acetate</td>
<td></td>
<td>Fluconazole acetone 0.19 intravalter implant</td>
</tr>
</tbody>
</table>

Criteria for Use (CFU)

- 9-valent HPV vaccine
- Acetylcholinesterase Inhibitors (Updated Dec. 2015)
- Alemizumab
- Alirocumab
- Brimonidine Topical Gel
- Carbipoda Levodopa ER
- Dadatiasvir
- Ezetimibe/Ezetimibe+Simvastatin (Updated Nov. 2015)
- Ibabradine
- Myle不行alrexone Injection (Updated Dec. 2015)
- Paliperidone
- Pneumococcal 13 Valant Conjugate Vaccine (Updated Oct. 2015)
- Sacubitil Valsartan
- Sofosbuvir and Ledipasvir-Sofosbuvir (Updated Oct. 2015; Dec 2015)
- Tasimelteon
- Ticagrelor [Updated Dec. 2015]
- Varenicline [Updated Dec. 2015]
- Vedolizumab Injection
- Vinkin Pal and Technivie [Updated Dec. 2015]

Abbreviated Review

- 9-valent HPV vaccine
- Hydrocode bitartrate ER
- Oxycodone HCI Acetaminophen Extended-Release
- Pantoprazole
- Paliperidone palmitate IM
- Tiotropium/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]
- Glatramer Provider Letter and Patient Letter
- Omaluresis
  - Oxacabrezine-Not restricted to neuro

Clinical Recommendations

- Naloxone Kits and Autoinjector
- Ulipristal acetate

Additional Information

- Cost Comparison for HCV Genotype 3 Regimens [InTRAen only]
- Lidocaine 5% Patch Literature Review
- Methylnaltrexone Injection gudidence - indication for opioid-induced constipation in chronic noncancer pain was added
Posting of VAMedSAFE Documents AUG-DEC 2015

- OmniPod Insulin Management System Recall: ADDENDUM [December 14, 2015]
- Auvi-Q (epinephrine injection, USP) Recall - Potential Inaccurate Dosage Delivery [October 30, 2015]
- OmniPod Insulin Management System Recall [September 5, 2015]
- Allergan Ophthalmic Product Recall Due to Particulate Matter: ADDENDUM [September 4, 2015]
- Allergan Ophthalmic Product Recall Due to Particulate Matter [September 2, 2015]
- BD Syringes and Loss of Drug Potency [August 31, 2015]

National Contract Awards for Calendar Year 2015
Click on this link to view the National Contract Awards CY 2015. [InTRAnet only]

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>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></td>
<td></td>
<td>X</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></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>GEM 21s, Osteogen and other similar resorbable boney void fillers</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Lancets for blood glucose testing</td>
<td>X (outpatients)</td>
<td></td>
<td>X (inpatients and clinics)</td>
</tr>
<tr>
<td>Oral care kit and suctioning system (e.g., Q-Care Kit containing chlorhexidine gluconate 0.12%)</td>
<td>X (inpatient or clinic use)</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></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Vinyl or plastic pants to wear over adult diapers</td>
<td>X (in properly selected outpatients)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The PPL workgroup was created to help clarify the responsibility for management (e.g., ordering, storing, purchasing, and/or dispensing) of those products in which it is not clear which service should provide. The workgroup is not responsible for determining formulary status, clinical merit, or appropriate use of the products reviewed.

NEW NAME

DOAC

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 SSC 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, Mueret, 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 PBMs) 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, Mueret, 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:

- **Acetaminophen**
- **Carvedilol**
- **Doxycycline**
- **Lisinopril**
- **Metformin**
- **Rivastigmine**
- **Sildenafil**
- **Torsidezine**

Summary and Conclusion: Just as in the geriatric population, in the Palliative Care setting, a “less is more” approach to medication management is often the most sensible. While many patients and their clinicians tend to think of Palliative Care as akin to hospice and only dealing with patients who are near the end of life, this is not the case. While prognosis 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 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/p2a015b3ano/

**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/p7h3jcxqrd/

**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/p4maxlymni8/

**JULY:** Naloxone Kit Updates  
http://va-eerc-ees.adobeconnect.com/p6ljco9jq2o/

**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  
http://va-eerc-ees.adobeconnect.com/p9h281rm7mj/

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

**NOVEMBER:** Anticoagulation Series Part 2: Anticoagulation Key Practices in VHA  
http://va-eerc-ees.adobeconnect.com/p6lj4rc39nik/

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

All PBM-MAP-VPE webinars are conducted using the same Adobe Connect meeting link and VANTs number.  
VANTS: 1-800-767-1750 Access Code 49792#  
Third Tuesday of the month @ 3 PM ET

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**Attention Pharmacist & Pharmacy Technicians**  
Virtual VA 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  
CSP: Martin.Cruz@va.gov  
PTCB: Marta.Kane@va.gov/ and/or Jennifer.Suther@va.gov

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**ON BEHALF OF THE PBM-VPE-MAP**

**HAPPY HOLIDAYS**

**HAPPY NEW YEAR!**