Pharmacy Benefits Management-Medical Advisory Panel

E_z-Minutes

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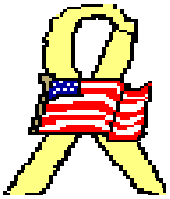
Visit us at www.vapbm.org or vaww.pbm.med.va.gov

Inside this issue:

"Treatment of Dyslipidemia in the High Risk Patient" will be the next CE accredited PBM-MAP Satellite Broadcast Program scheduled for Sept/Oct 2004. Faculty will feature members of the PBM-MAP. Ask your VFLs in the near future for more details. You won't want to miss it.



Have a safe July 4th!
Remember our troops!

Recent National PBM Reviews Postings on Web Site

Criteria for Use

http://www.vapbm.org/PBM/criteria.htm
Sevelamer (Renagel®)
Risperidone Long-acting Injection (Risperdal® Consta™)

Criteria for Nonformulary Use

http://www.vapbm.org/PBM/criteria.htm
Clinically Uroselective Alpha$_1$-Adrenergic Blockers in BPH

Treatment Guidelines

http://www.vapbm.org/PBM/treatment.htm
Combination Therapy for BPH

Drug Class Reviews

http://www.vapbm.org/PBM/reviews.htm
Cholinesterase Inhibitors

PBM Projects in Progress:

Short acting nifedipine Rx Data-Follow-up
Statin-fibrate safety report
Combination therapy for prostatism

Criteria for Use:

Gabapentin
Biologic Agents for Psoriasis
Clopidrogrel/ASA in CABG/PVD

Drug Class Review:

Antiobesity Agents
Dopamine Agonist
Insomnia Drugs
Impotence Agents

Drug Monographs:

Apomorphine
Tiotropium

Drug Monographs

http://www.vapbm.org/PBM/drugmonograph.htm

Adalimumab (Humira®)
Alpha$_1$-Proteinase Inhibitor Human (Zemaira®)
Bevacizumab (Avastin®)
Cefditoren pivoxil (Spectracef®)
Epinastine (Elestat™)
Fondparinux Addendum
Laronidase (Aldurazyme®)
Risperidone Long-acting Injection (Risperdal® Consta ™)

Frequently Asked Questions -NEW!

http://www.vapbm.org/PBM/faq.htm
Reversal and Prove-It Trials

Therapeutic Interchange Guidance

(Formerly Patient and/or Provider Information Letters)
http://www.vapbm.org/PBM/tig.htm
Ribasphere™
Revised PPI Patient Letter
Sevelamer

New Molecular Entities Review

- **Alpha 1-proteinase inhibitor (Zemaira®)**-Not added to VANF or VISN Formularies
- **Risperidone Long-acting Injection (Risperadal® Consta ™)** - Added to VANF and VISN Formularies
- **Cefditoren pivoxil (Spectracef®)**-Not added to national formulary; VISNs may add to local formulary if choose
- **Laronidase (Aldurazyme®)**-Not added to VANF or VISN Formularies
- **Bevacizumab (Avastin®)**-Voting postponed until pending clinical information reviewed.

VHA National AUE Summary Report: Quinolones Causing Dysglycemias

Study Purpose:

A national Appropriateness of Use Evaluation (AUE) was conducted based on concerns expressed from the field regarding the development of dysglycemias with concurrent flouroquinolone medications.

Method:

- Retrospective VA database analysis for FY 2002-03
- Veterans receiving levofloxacin, gatifloxacin, ciprofloxacin and the non-quinolone comparator agent azithromycin were included.
- ICD-9 CM codes for hypoglycemia and/or hyperglycemia were evaluated.
- Dysglycemias occurring 10 days following Rx dispensing were considered.

Results:

- Total number of fluoroquinolone Rxs was 645,592 (Gati = 67,242, Levo = 440,225, Cipro = 138,125, Azithro = 278,599)
- 43.2% Rxs were for azithromycin
- Incidence of hyperglycemia occurred 5.8 cases/1000 patients for quinolones
- Incidence of severe hypoglycemia occurred 1.3 cases/1000 patients for quinolones
- Incidence of hypoglycemia (0.26 cases/1000 pts) and hyperglycemia (3.2 cases/1000 pts) occurred with azithromycin respectively.
- The crude event rates for hyper/hypoglycemia are depicted in Chart 1 and 2 respectively.

Summary:

- Incidence of dysglycemia for quinolones was significantly higher compared to azithromycin
- No significant difference in the development of hyperglycemia between the quinolones.
- Slightly higher incidence of hypoglycemia occurred with gatifloxacin (3.4 cases per 10,000 patients).
- The risk of dysglycemia increases significantly (P<0.0001) in the setting of diabetics vs. patients without diabetes. (Refer to Chart 3)

Recommendation:

The judicious use of fluoroquinolones is key to lessening the development of dysglycemias.

Chart 1: Crude Event Rates for Hyperglycemia

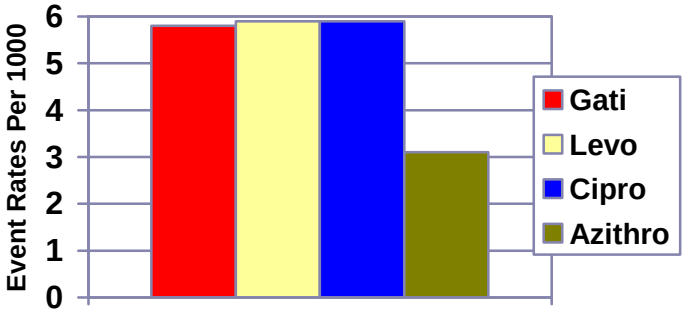


Chart 2: Crude Event Rates for Hypoglycemia

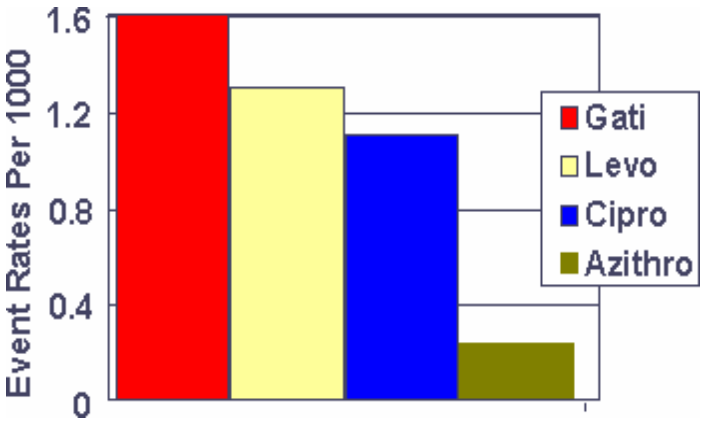
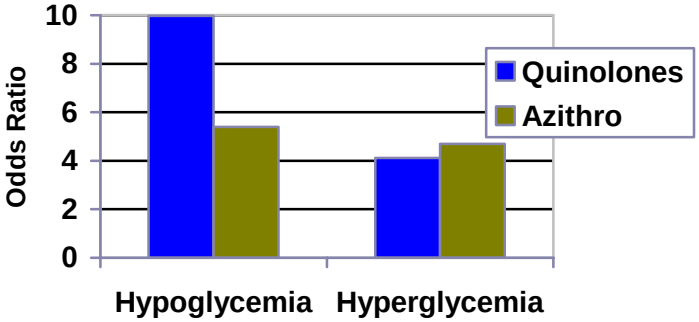


Chart 3: Dysglycemia* in Diabetic Patients vs. Non-diabetics as Comparator



* p = <0.0001 diabetic vs. non-diabetics

VHA ADVERSE DRUG EVENTS (ADEs) REPORTING TRENDS:

Identifying Frequently Reported Primary Suspect Medications*

The VHA ADE database consist of those serious ADE reported by facilities via the FDA MedWatch Form 3500 http://www.fda.gov/medwatch/SAFETY/3500.pdf . Refer to Ez Minutes Vol. 2, Issue 1 for a review of VHA's ADE Reporting Program. http://www.vapbm.org/ezminutes/Ez-MinutesVol2Iss1Jan-March04.pdf. Over 14, 000 unique reports are listed in the VHA ADE database. The database was searched from 1999-2003 for the top ten reported primary suspect medications. Reports with combined secondary and primary suspect medications were not included. 699 unique medications were identified. The highest frequency of serious reports attributed to a primary suspect medication which well surpasses all other medications is warfarin followed by lisinopril and phenytoin. See Table 1 and Chart 4 for the complete list.

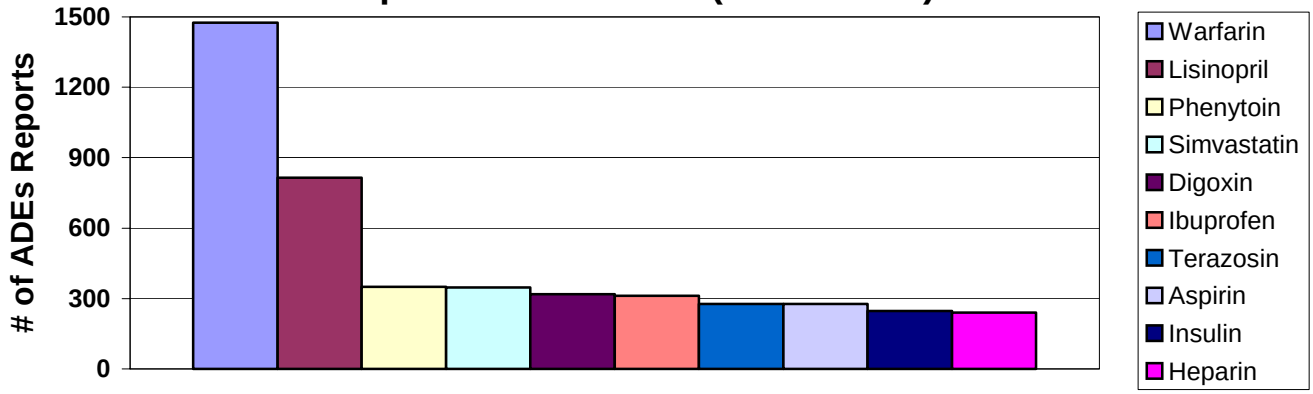
***Suspect Medication: The medication administered before the ADE has begun and is "suspected" by the reporter, manufacturer or agency to have contributed to the ADE**

Conclusion: The compiled data from the ADE reporting efforts by VHA healthcare professionals (pharmacists, physicians, and nurses) aids in educating and increasing the awareness of potential medications causing serious ADEs. ADE reporting depends on healthcare professionals to report serious adverse events observed in daily practice to facilitate further initiatives towards increasing the identification of medications contributing to serious ADEs. Thank you for your continued assistance.

Table 1. # of ADE Reports for the TOP 10 Primary Suspect Meds* 1999-2003

Rank	Medication	# ADE Reports
1.	**Warfarin**	**1475**
2.	Lisinopril	815
3.	Phenytoin	350
4.	Simvastatin	347
5.	Digoxin	319
6.	Ibuprofen	312
7.	Terazosin	277
8.	Aspirin	276
9.	Insulin	246
10.	Heparin	240

Chart 4: VHA's ADE Reports for Top 10 Primary Suspect Medications* (1999 - 2003)



Top 10 Primary Medications

Information Contact: Puri Subramaniam, Pharm.D., Chief, ADE Reporting Programs, PBM/VACO vaiyapuri.subramaniam@hq.med.va.gov

Center of Medication Safety & PBM-MAP: Pharmaceutical Use Outside of Approved Indications: Guidance on "Off Label" Prescribing

Off-label use refers to prescribing that is outside the approved indication(s) by the FDA. Many consider off-label prescribing as using a medication for a different disease or condition than what it was intended for when it was originally approved. However, off-label use may also involve other areas. Additional areas to consider for "off-label" use should be given to medication characteristics related to bioequivalence, dosing, dosing schedules and/or regimens, and chronology. Medication(s) being prescribed outside the specified populations it was originally evaluated and approved in would also be considered off-label use. Off-label use becomes a concern when there is little or no supporting evidence of benefit or safety in a population or for a condition. The Center for Medication Safety in conjunction with PBM and MAP provides some general principles and recommendations when considering pharmaceutical use outside of FDA approved indication. The following are the 7 General Principles for effective use and appropriate understanding of off-label use. Please refer to http://www.vapbm.org/directive/Guidance%20Off%20Label%20Prescribing.pdf for the Executive Summary and the complete document.

1. **Prescribing should be evidence-based, whenever possible.**
2. **The ultimate responsibility for the safety and efficacy of off-label prescribing resides with the prescriber.**
3. **Consultation with the VA P&T Committee is recommended for agents that do not already have established protocols for off-label use.**
4. **Proper assessment of evidence for off-label use should involve a comprehensive and balanced review as possible and feasible.**
5. **P&T Committees, as agents of an institution, and pharmacists can and should assist clinicians, when requested, to assure effective (and cost-effective) and safe use of medications, as substantiated by scientific evidence.**
6. **Clinicians may request review by P&T Committees for off-label use, but equally so, the P&T Committee may ask the requestor to provide evidence of benefit and safety for requests as part of the review process.**
7. **P & T Committees are considered the arbiters of such matters and have the right to approve or disapprove submitted requests, based on the merit of scientific evidence and on local policy and procedures.**

VAMedSAFE

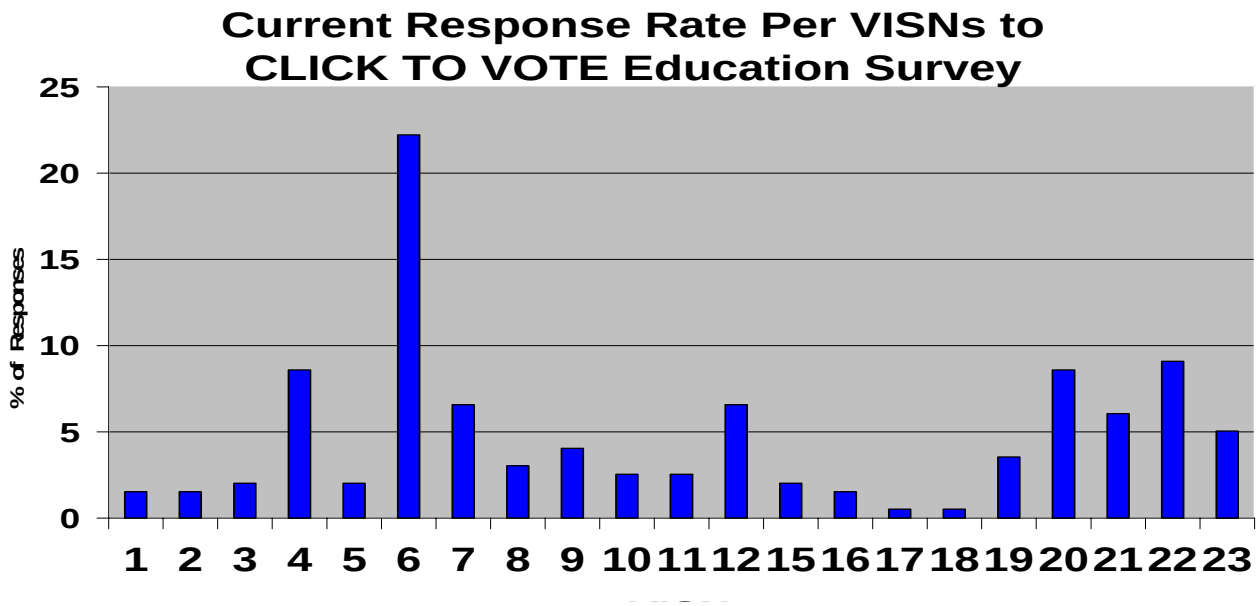
The following programs will remain available for your immediate viewing.

- **"How to Enter an Allergy or Adverse Drug Event (ADE)."** http://www.vapbm.org/vamedsafe/How%20To%20Enter%20an%20Allergy%20or%20Adverse%20Drug%20.ppt.
- **"ADR Frequently Asked Questions"** http://vapbm.org/vamedsafe/Adverse%20Drug%20Reaction.pdf
- **VHA's Adverse Drug Event Reporting Program** http://vapbm.org/Reporting%20Program.pdf

Update on nutriceuticals/ dietary supplements

A work group has been formed to address the appropriate use of nutriceuticals in the VHA. A white paper is being developed to consider the usage of these agents in the veteran population.

The PBM-MAP on-line Education Survey will be extended till July 31st. This is your opportunity to share what topics and/or issues you would like addressed. Based on your valuable input, CE programs will be developed specifically to meet your needs and interests. http://vaww.sites.lrn.va.gov/inquisite/surveys/25BNMC is where you can CLICK TO VOTE. Below is a graph depicting the current standings for response rate per VISN. Congrats to VISN 6 for leading the pack. Way to go! VISNs 4, 7, 12, 20, 21, & 22 are battling for second place. There is still time! To date, pharmacists have provided the most feedback. Great job! All patient care providers are encouraged to click to take the survey. Remember it takes less than 3 minutes to complete. Don't be the last one to take it! Make sure to tell all your colleagues. Results and the winning VISN(s) of the CLICK TO VOTE Campaign will be shared in the next newsletter.



Contract Review Reminder

Gatifloxacin-Tequin® IV/PO added to VANF
Effective Period: **1/15/2004 – 12/31/2005**
Please Note: Gatifloxacin was contracted specifically as the workhorse quinolone for CAP, sinusitis as well as ABECB.
Cipro IV/PO remains on VANF
Lomefloxacin & Levofloxacin PO removed from VANF. The class of fluoroquinolone is an open contract and VISNs may have other agents on local formulary as necessary to provide patient care.

Miscellaneous Information:

Please note: USP has recently changed the chemical name of Hydroxypropyl methylcellulose to Hypromellose. On another note: Tearisol (0.5% hydroxypropyl methylcellulose) is being removed from the market.

Do you want to submit an article to the next PBM-MAP Ez -Minutes? Please e-mail: Editor: Janet Dailey, PharmD at jhdailey@bellsouth.net OR Co-Editor: Pete Glassman, MBBS,MSc at peter.glassman@med.va.gov.