D&T Decisions

… from the Drugs and Therapeutics Committee

The information in this newsletter may also be accessed online. To request a change to the NS Health Hospital Formulary select & complete the online "Drug Request Form":
http://cdhaintra/departmentservices/pharmacy/Formulary/index.cfm

Issue #73: May 18, 2022

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The following policies were approved by the Medical Advisory Committee (Mar 22, Apr 22, May 22) on the recommendation of the Drugs and Therapeutics Committee (Feb 22, Mar 22, Apr 22).

I. Additions to Hospital Formulary

Mifepristone & misoprostol/ *Mifegymiso*

Mifegymiso is a composite pack containing a mifepristone tablet and misoprostol tablets. Mifegymiso has been added to the NS Health Hospital Formulary based on the IWK Health Formulary status.

Arginine/ *L-arginine*
Levocarnitine/ *Carnitor®*

Patients with metabolic deficiencies require individualized management and specific medications to resolve symptoms. Ornithine transcarbamylase (OTC) deficiency is a genetic urea cycle disorder that can cause hyperammonemia that may require arginine therapy. Methylmalonic acidemia is an inherited disorder in which the body is unable to process certain proteins and fats (lipids) that may require levocarnitine therapy. Arginine and levocarnitine were added to the NS Health Hospital Formulary based on the IWK Health Formulary status.

Cinacalcet/ *Sensipar®*

Cinacalcet is an oral calcimimetic that decreases parathyroid hormone (PTH) levels by binding to PTH cells and increasing sensitivity to extracellular calcium. Cinacalcet has been approved by Health Canada for patients with chronic kidney disease (CKD) receiving dialysis for the treatment of secondary hyperparathyroidism (HPT), and for control of PTH, calcium, phosphorous, and serum calcium-phosphorous product (Ca × P). Cinacalcet is also approved for the reduction of hypercalcemia in patients with parathyroid carcinoma or in patients with primary HPT where parathyroidectomy is not clinically appropriate or approved. Due to the risk of hypocalcemia, cinacalcet is no longer approved for use in patients with CKD who are not on dialysis. Cinacalcet can be used alone, or in combination with vitamin D analogues and/or phosphate binders.

Primary HPT or increased parathyroid hormone (PTH) levels are due to overactive parathyroid glands and differ from secondary HPT which can be due to severe deficiencies in calcium, vitamin D, and/or chronic kidney disease (CKD). Secondary HPT is treated by maintaining normal calcium and phosphorous levels and simultaneously managing PTH levels. Treatments include dietary adjustments, dialysis, vitamin D analogues, phosphate binders, calcimimetics, and parathyroidectomy. The difficulty with most treatments is decreasing PTH levels while maintaining

appropriate serum calcium and phosphate levels. In comparison to other treatments for HPT, cinacalcet uniquely can be prescribed in patients with concomitant hyperphosphatemia or hypercalcemia, as it lowers PTH levels without increasing serum calcium or phosphate levels. Lowering of PTH levels with cinacalcet can be seen within a few hours of administration in comparison to vitamin D analogues, which can take from several hours to several days.

The efficacy and safety of cinacalcet in comparison with other treatments for secondary HPT is controversial. A meta-analysis demonstrated that cinacalcet significantly decreased serum PTH and calcium phosphorous product compared to control therapy; however, there was no significant difference in cardiovascular mortality and all-cause mortality. There was a significant increase of adverse effects (nausea, vomiting and hypocalcemia) with calcimimetic therapy compared to control therapy.

Pramipexole/ *Mirapex*®

Pramipexole is a non-ergotamine dopamine agonist with primary selectivity for the D_2 dopamine receptor and some affinity for the D_3 and D_4 receptors. Agonism of these dopamine receptors is believed to stimulate dopaminergic activity in the striatum and substantia nigra, the areas of the midbrain where dopamine deficiency results in parkinsonian movement disorder symptoms. Pramipexole has been approved by Health Canada for symptomatic treatment of Parkinson's disease (PD) and is one of four oral dopamine agonists currently available in Canada.

Levodopa is one of the most widely used antiparkinsonian medications. Non-ergot dopamine agonists, such as pramipexole, are recommended as initial monotherapy in patients under the age of 50 years with early PD experiencing moderate to severe symptoms and are associated with a lower risk of motor complications than levodopa-containing alternatives. In later PD, dopamine agonists are effective options as adjunctive therapy to manage motor complications of levodopa such as "wearing-off" and dyskinesias, as well as to reduce the daily levodopa requirements.

Pramipexole and levodopa may also relieve symptoms of intermittent restless legs syndrome (RLS). However, in chronic persistent RLS levodopa preparations are associated with a paradoxical response, known as augmentation, where RLS symptoms occur earlier in the day with increased severity and there is a reduced response to previously effective treatment. Dopamine agonists are associated with a lower risk of augmentation than levodopa and are recommended as a first-line therapeutic option for symptomatic management of chronic persistent RLS.

The most significant adverse effects associated with pramipexole are somnolence, sudden onset of sleep known as "sleep attacks", impulse control disturbances, visual hallucinations and edema.

Diclofenac/ *Voltaren Emulgel*

Diclofenac is a non-steroidal anti-inflammatory drug (NSAID) that is used in various dosage forms for its anti-inflammatory and analgesic activity. The NS Health Hospital Formulary includes diclofenac oral, rectal and ophthalmic dosage forms; however, the topical dosage forms are not listed. Diclofenac is available as a topical gel (Voltaren Emugel® 1.16%, Voltaren Emugel® Extra Strength 2.32%) and topical solution (Pennsaid®/ generics 1.5%). Topical dosage forms can be advantageous due to their localized therapeutic effect while minimizing systemic exposure and associated systemic adverse effects.

Diclofenac diethylamine 1.16% (Voltaren Emugel® Regular Strength) has been added to the Hospital Formulary. There is a new Formulary therapeutic interchange for other topical diclofenac formulations (refer to Section V).

Nicotine oral inhaler and lozenge

Nicotine replacement therapy (NRT) is considered Formulary at NSH; however, only nicotine gum and patches are listed in the NS Health Hospital Formulary.

An NS Health infographic (developed by the Mental Health and Addiction's Health Promotion Tobacco Action Team) states:
"Quitting smoking is the single most important intervention for the prevention and management of major chronic diseases, including heart disease, stroke and cancer. Admission or ambulatory care in a hospital can provide the ideal conditions for a quit attempt because of the restricted smoking environment, perceived vulnerability to illness and increased patient motivation to quit..."
NRT is considered first line for smoking cessation and the NS Health Smoke and Tobacco Reduction Policy (developed in Oct. 2018) offers the nicotine oral inhaler as an example of an available NRT that can be ordered for patients while in hospital.

The nicotine oral inhaler may satisfy the hand-to-mouth ritual and can be used for intermittent cravings for patients using the nicotine patch. Other advantages of the oral inhaler include a fast delivery of nicotine, flexible dosing and a short action. The nicotine lozenge may be easier to use than gum and may be more appropriate for individuals with dental problems. The nicotine oral inhaler and lozenge have been added to the Hospital Formulary.

Tocilizumab/ *Actemra*®

Tocilizumab is a humanized anti-human IL-6 antibody2 immunosuppressant that binds specifically to both soluble and membrane-bound IL-6 receptors and inhibits IL-6 mediated signaling through these receptors. The indications for tocilizumab include the treatment of patients with chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome (CRS), in accordance with patient populations specified for authorized CAR T cell products. Funding was recently approved for CAR T cell therapy as part of the Nova Scotia Cell Therapy and Transplant Program.

Tocilizumab is first line management of CRS associated with CAR T cell therapy and will be administered in hospital for management of CRS +/- concurrent neurotoxicity. In order to comply with manufacturer and institutional safety standards, tocilizumab is required to be available on site at hospitals where CAR T therapy is given (i.e., the VG Campus, QEII, CZ).

Approved Restriction:
For the management of severe or life threatening chimeric antigen receptor (CAR) T cell related toxicities of cytokine release syndrome (CRS) +/- concurrent neurotoxicity.

Defibrotide/ *Defitelio™*

Defibrotide is an antithrombotic agent approved for the treatment of patients with hepatic veno-occlusive disease (VOD), with renal or pulmonary dysfunction following hematopoietic stem-cell transplantation (HSCT) therapy. HSCT is used to treat patients with congenital or acquired disorders of the hematopoietic system as well as patients with chemo-, radio-, or, immune- sensitive malignancies. HSCT is most commonly indicated to treat leukemia [e.g., acute myeloid leukemia (AML), acute lymphoblastic leukemia (ALL)], solid tumors and non-malignant disorders. VOD, also known as sinusoidal obstruction syndrome (SOS), is a major complication of HSCT (reported incidence of 5.3 to 13.7% or higher depending on the study) that can occur due to endothelial cell damage, sinusoidal narrowing and sinusoidal blockage. High doses of cytoreductive therapy can cause endothelial injury in both small hepatic vessels and sinusoids. Endothelial injury causes activation of the coagulation cascade triggering clot formation. Cellular debris and fibrin deposition further cause veno-occlusion. Hepatic VOD symptoms include painful hepatomegaly, jaundice, weight gain, ascites, and may lead to multi-organ failure (MOF) in 25 to 50% of cases.

Defibrotide is the only licensed drug therapy for severe hepatic VOD that improves patient survival; however, the mechanism of action is not fully understood. Defibrotide maintains sinusoidal vascular integrity within the liver which improves disease symptoms. Defibrotide also protects endothelial cells from further damage and reduces endothelial cells activation allowing the thrombo-fibrinolytic balance to be restored.

Patients treated with defibrotide should be monitored for signs and symptoms of bleeding, hypersensitivity and hypotension. Due to the potential increased risk of bleeding, patients receiving defibrotide must not receive concomitant medications such as heparin, warfarin, alteplase, or other systemic anticoagulant or fibrinolytic therapy (excluding routine maintenance or reopening of central venous lines)

Natural Health Products

The NS Health Natural Health Product (NHP) Policy specifies that only formulary NHPs will be provided during a patient's hospital admission and that non-formulary NHPs will be discontinued or patients may use their own supply. In consultation with NS Health Nutrition and Food Services, a review of inpatient non-formulary NHP usage resulted in a formulary recommendation for five vitamins and minerals that are prescribed and administered to hospitalized patients to address nutritional deficiencies: zinc gluconate, selenium, copper, calcium citrate and iron polysaccharide complex.

Zinc gluconate

In North America, zinc deficiency usually occurs in association with malabsorptive conditions (e.g., after bariatric surgery or inflammatory bowel disease) or chronic disease (e.g., liver, renal, diabetes). Zinc intake has also been found to be marginal in some older adults and those who are food insufficient. Zinc may be prescribed in therapeutic doses for macular degeneration and Wilson's disease. The zinc dosage provided in the Formulary multiple vitamin with minerals may not be adequate to meet the doses required for some hospitalized patients.

Selenium

Although selenium deficiency is rare in North America, people at risk of deficiency may include those undergoing bariatric surgery or kidney dialysis. NS Health dietitians also recommend selenium for people living with HIV and low CD4 counts and for patients with severe burns. More research is needed regarding potential benefits for selenium supplementation in cancer, cardiovascular disease, cognitive decline and thyroid disease.

Copper

Copper deficiency can result in anemia, hypercholesteremia, osteoporosis, ataxia and increased risk of infection, among other effects. People with celiac disease, malabsorption conditions (bariatric surgery, inflammatory bowel disease), Menkes disease (a rare genetic disorder of copper homeostasis), and those taking high doses of zinc are at risk of copper deficiency. Copper supplementation may be recommended for patients taking zinc to reduce the risk of age-related macular degeneration. NS Health dietitians recommend copper for wound healing and burns. More research is needed as to the effect of copper supplementation on cardiovascular disease and Alzheimer's disease.

Calcium citrate

Calcium supplements are used for numerous purposes including calcium deficiency, dyspepsia, hyperphosphatemia and osteoporosis. The NS Health Hospital Formulary includes calcium carbonate in various forms (oral tablet, chewable tablet, oral liquid). Calcium carbonate provides 40% of calcium by weight and calcium citrate provides 21% of calcium by weight. Lower calcium doses (≤ 500 mg) lead to better absorption.

The solubility of calcium carbonate is decreased in people with low stomach acid unless it is taken with food. Since calcium citrate can be taken without food and is more readily absorbable, it is recommended for patients taking acid suppressants (e.g., H2-receptor antagonists or proton pump inhibitors) or those predisposed to a low stomach acid environment (e.g., advanced age) . Calcium carbonate may cause more gastrointestinal side effects (gas, bloating, constipation) than calcium citrate.

Iron polysaccharide complex/ *Feramax*

Iron is a mineral used for the prevention and treatment of iron deficiency anemia. Oral iron is available in multiple salts (e.g., sulfate, fumarate) and complexes (e.g., polypeptide, polysaccharide). None of the iron products have been shown to be more efficacious than the other. Although iron polysaccharide complex is more expensive than alternatives, it has the advantage of once daily dosing and may be better tolerated. Iron polysaccharide complex is the most frequently prescribed iron in the CZ (in terms of numbers of units) with similar trends across the province. NS Health dietitians recommend PIC because of its improved tolerability.

Inhaler Devices

In 2019, NS Health aligned the Hospital Formulary listing of inhaled medications and associated inhaler devices with that of the NS Provincial Drug Plan Formulary (i.e., Pharmacare). Patients with chronic obstructive lung diseases (i.e., COPD, asthma) are frequently hospitalized and this provides an opportunity to start patients on appropriate maintenance inhaled

therapies and/ or continue the treatments that they are already using at home. Since inhaled medications each have a unique inhaler device, hospitalization is an opportunity to assess and teach patients proper inhaler technique. (D&T Decisions #67 Aug. 1, 2019)

Since 2019, three new inhalers have been added to the NS Pharmacare formulary as exception status benefits; therefore, these inhalers have been added to the NS Health Hospital Formulary.

Vilanterol + umeclidinium + fluticasone/ *Trelegy Ellipta*

Long-acting beta2 agonist (LABA) plus long-acting muscarinic antagonist (LAMA) plus inhaled corticosteroid (ICS)

Approved Restriction:

For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometry, in patients who experience inadequate control while being treated with a long-acting beta-2 agonist/long-acting muscarinic antagonist (LABA/LAMA).

Indacaterol + mometasone/ *Atectura® Breezhaler®*

Long-acting beta2 agonist (LABA) plus inhaled corticosteroid (ICS)

Approved Restriction:

For the treatment of moderate to severe asthma in patients who:

- are compliant with inhaled corticosteroids at optimal doses;

AND

- require additional symptom control, (e.g., cough, awakening at night, missing activities such as school, work or social activities because of asthma symptoms);

AND

- require increasing amounts of short-acting beta2-agonists, indicative of poor control.

Indacaterol + glycopyrronium + mometasone/ *Enerzair® Breezhaler®*

Long-acting beta2 agonist (LABA) plus long-acting muscarinic antagonist (LAMA) plus inhaled corticosteroid (ICS)

Approved Restriction:

For the treatment of asthma in adult patients not adequately controlled with a maintenance combination of a long-acting beta2-agonist (LABA) and a medium or high dose of an inhaled corticosteroid (ICS) who experienced one or more asthma exacerbations in the previous 12 months.

II. Revised Restrictions

Inhaler Devices

Since the Formulary alignment of inhaler devices in 2019, the NS Provincial Drug Plan Formulary (i.e., Pharmacare) has updated their inhaler devices exception status criteria for COPD; therefore, some of the NS Health Hospital Formulary restrictions are out of date. The Pharmacare criteria update states "An Atlantic Common Drug Review (ACDR) of inhaler therapy for COPD included a comprehensive review of clinical evidence (meta-analyses, RCTs etc.), consideration of the 2017 Canadian Thoracic Society and international COPD recommendations, and consultation with respiratory specialists in Atlantic Canada. Based on this review the criteria for coverage for inhalers used in COPD has changed (coverage for asthma is unchanged)".

The Hospital Formulary restrictions for the following inhaler devices have been revised to reflect the most up to date NS Pharmacare exception status criteria for COPD (Formulary restrictions for asthma remain unchanged).

Salmeterol, *Serevent Diskus*
Formoterol, *Foradil®*
Indacaterol, *Onbrez® Breezhaler®*

Long-acting beta2 agonist - LABA

Approved Restrictions:

For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometry, in patients who experience:

- persistent symptoms, as defined by Medical Research Council (MRC) Dyspnea Scale of at least Grade 3 or a COPD Assessment test (CAT) score of at least 10 and have a post-bronchodilator FEV1 less than 80% predicted;

OR

- two or more moderate exacerbations of COPD in the previous year requiring treatment with antibiotics and/or systemic corticosteroids;

OR

- at least one acute severe exacerbation of COPD requiring hospitalization.

Salmeterol + fluticasone, *Advair Diskus/ MDI*
Formoterol + budesonide, *Symbicort® Turbuhaler®*
Formoterol + mometasone, *Zenhale® MDI*
Vilanterol + fluticasone, *Breo Ellipta*

Long-acting beta2 agonist (LABA) plus inhaled corticosteroid (ICS)

Approved Restrictions:

For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometry, in combination with a long-acting muscarinic antagonist (LAMA), in patients who experience inadequate control while being treated with a long-acting beta-2 agonist/long-acting muscarinic antagonist (LABA/LAMA).

For the treatment of patients with asthma / chronic obstructive pulmonary disease (ACO) overlap, based on patient history and lung function studies indicating an ACO diagnosis.

Tiotropium, *Spiriva® HandiHaler® & Respimat®*
Aclidinium, *Tudorza® Genuair®*
Glycopyrronium, *Seebri® Breezhaler®*
Umeclidinium, *Incruse Ellipta*

Long-acting muscarinic antagonist - (LAMA)

Approved Restrictions:

For the treatment of chronic obstructive pulmonary disease (COPD), as defined by spirometry, in patients who experience:

- persistent symptoms, as defined by Medical Research Council (MRC) Dyspnea Scale of at least Grade 3 or a COPD Assessment test (CAT) score of at least 10 and have a post-bronchodilator FEV1 less than 80% predicted;

OR

- two or more moderate exacerbations of COPD in the previous year requiring treatment with antibiotics and/or systemic corticosteroids;
  OR
- at least one acute severe exacerbation of COPD requiring hospitalization.

For the treatment of COPD, as defined by spirometry, in combination with a long-acting beta-2 agonist/inhaled corticosteroid (LABA/ICS), for patients who experience inadequate control while being treated with a LABA/ICS or a long-acting beta-2 agonist/long-acting muscarinic receptor antagonists (LABA/LAMA).

III. Therapeutic Interchange

Diclofenac topical

The following therapeutic interchange has been approved:

Preparation:	Dispensed As:
Diclofenac diethylamine 2.32% (Voltaren Emugel® Extra Strength) Diclofenac sodium 1.5% topical solution	Diclofenac diethylamine 1.16% (Voltaren Emugel® Regular Strength)

Natural Health Products:
Calcium carbonate
Iron preparations

The following therapeutic interchange revisions have been approved based on the addition of calcium citrate and iron polysaccharide complex to the NS Health Hospital Formulary:

Preparation:	Dispensed As:
Calcium carbonate (no strength), calcium carbonate 500 mg, calcium oral 500 mg (**Exceptions**: Tums, Calcium citrate)	Elemental calcium 500 mg (as the carbonate)
Iron preparations other than ferrous sulfate, ferrous gluconate or iron polysaccharide complex Examples: • ferrous sulfate slow-release/ Slow-Fe® (50 mg elemental iron) • ferrous fumarate/ Palafer® (100 mg elemental iron)	Ferrous sulfate (plain), nearest available dose of elemental iron: (ferrous sulfate 300 mg = 60 mg elemental iron) • ferrous sulfate 300 mg daily (60 mg elemental iron) • ferrous sulfate 600 mg daily (120 mg elemental iron)

IV. Expanded Guidelines

Brentuximab vedotin/ *Adcetris*®

Two new guidelines have been approved for brentuximab vedotin.

A new guideline has been approved for the role of brentuximab vedotin in combination with AVD chemotherapy for the treatment of patients with previously untreated Stage IV Hodgkin Lymphoma.
Approved Restriction:
In combination with DOXOrubicin, vinBLAStine and dacarbazine (AVD) for the treatment of previously untreated patients with Stage IV Hodgkin Lymphoma (HL).

Treatment with BV + AVD should continue for a maximum of six cycles, or until unacceptable toxicity or disease progression, whichever occurs first.

A new guideline has been approved for the role of brentuximab vedotin as a single agent for the treatment of patients with previously treated cutaneous anaplastic large cell lymphoma (pcALCL) or mycosis fungoides (MF).
Approved Restriction:
For the treatment of adult patients with CD30-positive primary cutaneous anaplastic large cell lymphoma (pcALCL) or mycosis fungoides (MF) who have had prior therapy.

Eligible patients should have good performance status with confirmation of CD30-positivity (defined as having ≥ 10% CD30-positive malignant cells or lymphoid infiltrate). Patients with MF must have received at least one prior systemic therapy and patients with pcALCL must have at least one prior systemic therapy or prior radiation therapy.

Treatment with BV should continue for a maximum of 16 cycles (48 weeks of treatment) or until unacceptable toxicity or disease progression, whichever occurs first.

Atezolizumab/ *Tecentriq*®
Bevacizumab/ *Mvasi*®

A new guideline has been approved for the role of atezolizumab in combination with bevacizumab for the first-line treatment of adult patients with unresectable or metastatic hepatocellular carcinoma who require systemic therapy.
Approved Restriction:
For the first-line treatment of adult patients with unresectable or metastatic hepatocellular carcinoma who require systemic therapy. Patients must have no prior systemic treatment, an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1 and a Child-Pugh class status of A. Treatment with atezolizumab and bevacizumab should continue until loss of clinical benefit or unacceptable toxicity.

Blinatumomab/ *Blincyto*®

A new guideline has been approved for the role of blinatumomab for adult and pediatric patients with Philadelphia chromosome-negative (Ph-), CD19 positive (CD19+), B-cell precursor acute lymphoblastic leukemia (BCP-ALL) who are in first or second hematologic complete remission (CR) and are minimal residual disease positive (MRD+).

Approved Restriction:
As a single agent for the treatment of Philadelphia chromosome-negative (Ph-), CD19 positive (CD19+), B-cell precursor acute lymphoblastic leukemia (BCP-ALL) adult and pediatric patients with good performance status who are in first or second hematologic complete remission (CR) and are minimal residual disease positive (MRD+).

MRD+ disease is defined as MRD detected at a level greater than or equal to 0.1% (i.e., $\geq 10^{-3}$)

Patients should have received over the course of their treatment for BCP-ALL, a minimum of 3 intensive chemotherapy blocks of a treatment regimen that is age-appropriate and given with curative intent before proceeding to blinatumomab therapy

Treatment should be continued until unacceptable toxicity, hematologic relapse, MRD relapse, treatment with hematopoietic stem cell transplant (HSCT), or up to the completion of 4 cycles.
Clinical Notes:
Patients who receive blinatumomab for MRD + BCP-ALL will not be eligible for treatment with blinatumomab in the relapsed/ refractory setting.

V. Medication Policies

The following hospital policies have been approved by the Medical Advisory Committee on the recommendation of the Drugs and Therapeutics Committee.

MM-GA-015	Health Canada Special Access Program Drugs
CAN-GA-025	Administrative Authorization for Non-formulary and Restricted Systemic Therapy for Cancer Drugs.

VI. Order Sets

The following order sets have been approved by the Medical Advisory Committee on the recommendation of the Drugs and Therapeutics Committee.

NS_OSAHMAI Acute Hyperkalemia Management - Adult Inpatients (NS)
NS_OSAOCDU Admission Orders − Cardiac Day Unit and 24-Hour Cardiac Transfer Patient (CZ)
NS_OSADAPE Alteplase and Dornase Alfa for Pleural Effusion (EZ)
NS_OSKIL Ketamine (QEII)
NS_OSIVIGD Intravenous Immunoglobulin (IVIG) Dermatology - Adult and Pediatric (NS)
NS_OSIVIGHA Intravenous Immunoglobulin (IVIG) Hematology – Adult (NS)
NS_OSIVIGHP Intravenous Immunoglobulin (IVIG) Hematology – Pediatric (NS)
NS_OSIVIGID Intravenous Immunoglobulin (IVIG) Infectious Disease - Adult and Pediatric (NS)
NS_OSIVIGIM Intravenous Immunoglobulin (IVIG) - Immunology - Adult and Pediatric (NS)
NS_OSIVIGN Intravenous Immunoglobulin (IVIG) Neurology - Adult and Pediatric (NS)
NS_OSIVIGR Intravenous Immunoglobulin (IVIG) Rheumatology - Adult and Pediatric (NS)
NS_OSIVIGS Intravenous Immunoglobulin (IVIG) Solid Organ Transplant - Adult and Pediatric (NS)
NS_OSSCIGAP Subcutaneous Immunoglobulin (SCIG) - Adult and Pediatrics (NS)
NS_OSODMD Organ Donation Management - Donation after Cardiocirculatory Death (CZ)
NS_OSWMA Withdrawal Management – Alcohol Withdrawal Orders (CZ & NZ)
NS_OSWMB Withdrawal Management – Benzodiazepine Stabilization Orders (CZ & NZ)
NS_OSWMC Withdrawal Management – Cannabis Withdrawal Orders (CZ & NZ)
NS_OSMWI Withdrawal Management – Inpatient Admission Orders (CZ & NZ)
NS_OSWMN Withdrawal Management – Nicotine Replacement Therapy (CZ & NZ)
NS_OSWMO Withdrawal Management – Ongoing Opioid Agonist Therapy (CZ & NZ)
NS_OSWMOO Withdrawal Management – Outpatient Orders (CZ & NZ)
SW_VPPPO Veterans Place Orders (YRH)
NS_OSPNA Parenteral Nutrition (PN), Additional Protein as 10 % Amino Acid (Primene®) (WZ)
NS_OSPNH Parenteral Nutrition (PN), HIGH PROTEIN Pre-mix, 2 in 1 Solution (WZ)
NS_OSPNP Parenteral Nutrition (PN), Pre-mix, 2 in 1 Solution (WZ)
NS_OSPNPP Parenteral Nutrition (PN), Pre-mix, 2 in 1 Solution - Peripheral Administration (WZ)

VII. IV Manual

Since the last D&T Decisions, there has been a NS Health IV Manual & Agilia Drug Library update; refer to link below. Updates are distributed to physicians, Health Service Managers and Nurse Educators in each zone via Executive Directors of Operations and Medicine. If you should be receiving these memos, email theresa.hurley@nshealth.ca to obtain the name of your local contact.

April 25, 2022
https://intra.nshealth.ca/clinical-resources/infusiontherapy/IV%20Drug%20THerapy%20Manual/Update%20Memos/IV%20Manual%20Update%20220425.pdf

These updates may also be accessed on the NS Health IV Manual website under “Update Memos”
http://intra.nshealth.ca/clinical-resources/infusiontherapy/IV%20Drug%20THerapy%20Manual/SitePages/Home.aspx

VIII. Other

NS Health Restricted Drug List Review

A Provincial Pharmacy Working Group reviewed the existing NS Health Hospital Formulary Restricted Drug list. This list consisted of legacy Capital District Health Authority restrictions and those created after approval of the NS Health Hospital Formulary. There were no formal legacy restricted drug lists identified for hospitals outside of Central Zone.

The Working Group reviewed the list of restrictions excluding the following categories of medications: restrictions approved by NS Health D&T after November 2016, oncology, systemic antimicrobials and HIV medications. Many of the restrictions reviewed were considered out of date with current practice and/or unnecessary due to drug cost reductions over the years.

Refer to Appendix 1 for a summary of the recommendations from the Working Group. The updated approvals to the NS Health Formulary Restricted Drug list may be found as part of the on-line Hospital Formulary:
http://webapp2.cdha.nshealth.ca/formulary/

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Appendix 1 – NS Health Hospital Formulary Restrictions Working Group – Recommendations Summary

Remove Restrictions	Modify Restrictions / Modified wording	Keep Restriction Unchanged
Bismuth subsalicylate Octreotide Pantoprazole (injectable) Bacitracin (for irrigation) Ciprofloxacin/Dexamethasone (Otic) Ofloxacin (ophthalmic) Apixaban* Dabigatran* Rivaroxaban* Edoxaban* Bivalirudin Eptifibatide Enoxaparin Fondaparinux Dipyridamole/ASA Ticagrelor* Celecoxib Buprenorphine/naloxone Olanzapine Olanzapine IM (injectable) Quetiapine Risperidone Risperidone Consta* Aripripazole Lurasidone* Asenapine* Ziprasidone Bupropion SR Duloxetine Alprostadil Onabotulinumtoxin A Nimodipine Propofol Tenecteplase Zoledronic Acid Finasteride *restriction removed and replaced with a comment on ensuring 3rd party coverage before discharge: "If patient has NS Pharmacare, consult NS Pharmacare exception status criteria. Third party outpatient coverage should be investigated."	Aflibercept Bevacizumab Ranibizumab Darbepoetin alpha Epoetin alpha Lanthanum Sevelamer Basiliximab Cyclosporine Mycophenolate IV Mycophenolate oral Mycophenolate sodium Sirolimus Tacrolimus Tacrolimus XL Atovaquone and Proguanil Digoxin Immune Fab Argatroban Danaparoid Ketorolac (injectable) Methadone (tablets) Clozapine Adalimumab	Bisacodyl Magic Bullet Methylnaltrexone Idarucizumab Meperidine (injectable) Epoprostonol Epi-pen Ibutilide Insulin Detemir