Hospice Medication Management

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Vice President, Operations
Hospice Medicare Benefit: Which Drugs Should be Covered?

Hospice is responsible for coverage of the drugs considered to be: “reasonable and necessary” for palliation and management of the terminal illness (hospice diagnosis) and related conditions.*

“Curative” drug therapy is discontinued.

*Traditionally, this has meant “medically related” conditions.

More recent interpretation - any diagnosis or health condition that is contributing to the terminal decline.
Changing CMS Guidance to Part D Plans 2014:

As of July 2014 -
Part D Medicare plans required to reject drugs in 4 categories for hospice patients:

1. Analgesics
2. Antianxiety
3. Anti-nauseants
4. Laxatives

Hospice is responsible for coverage of these 4 categories and for all drugs related to the hospice diagnosis that are deemed medically necessary

Part D Plans Do Not Cover

- Cough and cold medications
- Vitamins
- Supplements
- OTC medications
What is a Palliative Medication?

**Palliative meds:**
- Relieve current symptoms of disease
- Provide comfort to the patient
- No intention of prolonging life
- No intention of promoting cure
- No intention of achieving long-term positive outcomes

**Definitive Question** to help identify a palliative medication:

What troublesome symptom will this medication relieve?

*Any medications that do not help patient/family meet the goals of care or enhance comfort should be discontinued*
Patient Factors that Guide Coverage Decisions

• **Primary Factor:** The patient’s terminal diagnosis (hospice diagnosis)
  - Other diagnoses/conditions that are contributing to terminal decline?

• **Patient’s current condition:**
  - Functional status
  - Quality of life
  - PPS (Palliative Performance Scale) score
  - Karnofsky score
  - Prognosis (months, days?)

• **Goals of care:**
  - Comfort only, non-invasive measures
  - Preserving a certain level of functionality
  - Maintaining current quality of life
Common Symptoms Managed via “Hospice Covered” Medications

- Pain
- Nausea/vomiting
- Anxiety, insomnia, agitation
- Depression
  - (if related to terminal illness)
- Psychotic symptoms (delirium)
- Bowel issues:
  - constipation/diarrhea
- Fluid retention
- Loss of appetite -- ?
- Infection
  - (if related to terminal illness)
- Oro-pharyngeal secretions
- Dyspnea
- Coughing
- Epigastric symptoms:
  - (pain, reflux, bloating)
- Seizures
  - (if related to terminal illness)
- Itching
### Examples of Non-Palliative Drugs

#### Not Symptom-Management Therapy

No longer “medically necessary”?....

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol-lowering drugs</td>
<td>Lipitor, Zocor, Lovastatin, Zetia</td>
<td>Long-term therapeutic outcome</td>
</tr>
<tr>
<td>Cognitive enhancing drugs</td>
<td>Aricept, Exelon, Galantamine, Namenda</td>
<td>Lack of evidence for benefit in end stage</td>
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<tr>
<td>Antihypertensive drugs</td>
<td>Catapres patch, Diovan, Cardizem</td>
<td>Long-term therapeutic outcome</td>
</tr>
<tr>
<td>Thomboprophylaxis drugs</td>
<td>Lovenox, Fragmin, Plavix, Pradaxa, Coumadin, Aggrenox</td>
<td>Risk outweighs benefit for many in hospice</td>
</tr>
<tr>
<td>Chemo-therapeutic drugs</td>
<td></td>
<td>Usually curative, not symptom relief</td>
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Case 1 - Dementia

RJ is an 88-year-old female on hospice for end-stage dementia. Lives in Skilled Nursing Home for past several months. Patient has experienced a 12% weight loss in the last 6 months. She is fully dependent for all ADLs. PPS is 20%. Daughter is the primary caregiver and administers all meds.

**Comorbid conditions** (history given by daughter - this is all she could remember):

- Hypertension
- Glaucoma

**Vitals upon admission:**

- BP 125/75
- HR 50
- Temp 98.7
Case 1 Medication List

- Aricept 10 mg PO daily
- Citalopram 10 mg PO daily
- Depakote 250 mg PO BID
- Dronabinol 2.5 mg PO BID
- Omeprazole 20 mg PO daily
- Lisinopril 10mg daily
- Cosopt Opth. Drops 1 drop O.U.  BID
- Senna S 1 daily
- Morphine 20 mg/mL 0.25 mL PO every q4 hour PRN pain
- Lorazepam 2 mg/mL 0.25 mL PO every 6 hours PRN anxiety
- Atropine 1% drops 2 drops sublingually every 4 hours PRN secretions
- ABH (Ativan/Benadryl/Haldol) gel topically every 4 hours PRN agitation
- Abilify 5 mg QD routinely

Which meds would you…

A. Cover?       B. Submit to Part-D?     C. Consider discontinuing?
Diagnosis-Specific Drug Coverage: Dementia

- **Antipsychotic drugs** *(haloperidol, risperidone):*
  - Helpful for hallucinations, paranoia, and agitation

- **Anxiolytic drugs** *(lorazepam, alprazolam, phenobarbital):*
  - Helpful for brief periods of time to provide sedation
  - (benzodiazepines may worsen confusion in dementia, especially when used routinely for extended periods)

- **Cognitive enhancing drugs** *(Aricept, Exelon, Namenda):*
  - Are not continued in hospice patients with a terminal diagnosis of dementia due to lack of effectiveness in end stage (FAST level 7).
  - (risk for adverse drug effects will outweigh any potential benefit at end-stage)
<table>
<thead>
<tr>
<th>Stage</th>
<th>Skill Level</th>
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<tbody>
<tr>
<td>1</td>
<td>No difficulties, either subjectively or objectively. <em>(Normal)</em></td>
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<tr>
<td>2</td>
<td>Complains of forgetting location of objects. Subjective word finding difficulties. <em>(Normal older adult)</em></td>
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<tr>
<td>3</td>
<td>Decreased job function evident to co-workers; difficulty in traveling to new locations. Decreased organizational capacity. <em>(Early Dementia)</em></td>
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<tr>
<td>4</td>
<td>Decreased ability to perform complex tasks (e.g., planning dinner for guests), handling personal finances (forgetting to pay bills), difficulty shopping, etc. <em>(Mild Dementia)</em></td>
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<tr>
<td>5</td>
<td>Requires assistance in choosing proper clothing to wear for day, season, occasion. <em>(Moderate)</em></td>
</tr>
<tr>
<td>6a</td>
<td>Difficulty putting clothing on properly without assistance. <em>(Moderately Severe)</em></td>
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<tr>
<td>6b</td>
<td>Unable to bathe properly (e.g., difficulty adjusting bath water temperature) occasionally or more frequently over the past weeks.</td>
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<tr>
<td>6c</td>
<td>Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.</td>
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<tr>
<td>6d</td>
<td>Urinary incontinence (occasional or more frequent).</td>
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<tr>
<td>6e</td>
<td>Fecal Incontinence (occasional or more frequently over the past week).</td>
</tr>
<tr>
<td>7a</td>
<td>Ability to speak limited to approximately six different words or fewer, in the course of an average day or in the course of an intensive interview (the person may repeat the word over &amp; over). <em>(Severe Dementia)</em></td>
</tr>
<tr>
<td>7b</td>
<td>Speech ability limited to the use of a single intelligible word in an average day</td>
</tr>
<tr>
<td>7c</td>
<td>Ambulatory ability lost (cannot walk without personal assistance).</td>
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<tr>
<td>7d</td>
<td>Ability to sit up without assistance lost (e.g., the individual will fall over if there are no lateral rests [arms] on the chair).</td>
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<tr>
<td>7e</td>
<td>Loss of the ability to smile.</td>
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</table>
ABH Topical Gel Not Effective

(1) Randomized, double-blind, placebo controlled trial (20 cancer patients):
   • **No difference between ABH gel and placebo for nausea**
   • November 2014

(2) Blood Level Study (10 healthy volunteers):
   • 1.0 mL dose of ABH gel applied to the wrist of 10 health volunteers, blood samples obtained at various time points (from 1 to 4 hours)
   • **No significant level of drug detected in any subject**
   • May 2012

References:

Symptom Management: Epigastric Discomfort/Dyspepsia

• Gastric pain, heartburn, reflux are common in hospice patients

• May be related to end-of-life or secondary to a variety of disease states

• May be a side-effect of other hospice-covered meds, like NSAIDs

• Gastric acid blockers are usually covered, unless issue is clearly NOT related to terminal diagnosis (e.g. prior history of GERD or PUD not related to terminal diagnosis)
  • PPIs: omeprazole (Prilosec), pantoprazole (Protonix), others
  • H2 antagonists: ranitidine (Zantac), famotidine (Pepcid), others

• PPIs overused
  • Evaluate for continued need, especially in patients received from the hospital
  • Evaluation difficult in cognitively impaired
Why treat anorexia in hospice patients?

- May reduce anorexia-related symptoms?
  - wasting of muscle mass, fatigue, weakness, lethargy

- May improve impaired QoL?

- Only continue appetite stimulant if demonstrable benefit exists:
  - Weight gain due to the drug
  - Cessation of weight loss due to the drug

- **Often not appropriate** in advanced disease with low level function (PPS or Karnofsky of 40 or less)
# Appetite Stimulants in Hospice

<table>
<thead>
<tr>
<th>Drug/Initial Dosage:</th>
<th>Comments</th>
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</table>
| Dronabinol (Marinol) 2.5 mg bid            | • Also helps with nausea  
• Adverse mental status changes especially in elderly  
• **Very** expensive                                |
| Cyproheptadine (Periactin) 4 mg tid       | • Drowsiness, weak efficacy relative to others                         |
| Megestrol (Megace) 400-800 mg qd          | • Demonstrated efficacy in cancer pts.  
• Risk for DVT and PE in elderly or history of cardiovascular disease (Avoid in these patients) |
| Mirtazapine (Remeron) 15 mg qHS           | • Effective, well tolerated  
• Helps with insomnia                               |
| Dexamethasone (Decadron) 4 mg qd          | • Also helps with nausea, mood  
• SE: fluid retention, hyperglycemia, infection, psychosis (doses > 10mg) |
Summary: Drug List for Case 1 (Dementia)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Palliative or Related?</th>
<th>Medically Necessary &amp; Appropriate?</th>
<th>Coverage Decision?</th>
</tr>
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<tbody>
<tr>
<td>Aricept</td>
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<td>Citalopram</td>
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<td>Depakote</td>
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<tr>
<td>Dronabinol</td>
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<td>Omeprazole</td>
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<td>Cosopt Opth</td>
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<td>Senna S</td>
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<td>Morphine</td>
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<td>Lorazepam</td>
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<td>Atropine 1%</td>
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<td>ABH gel</td>
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<td>Abilify</td>
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<tr>
<td>Aricept</td>
<td>Yes</td>
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<tr>
<td>Citalopram</td>
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<td>Continue &amp; cover</td>
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<tr>
<td>Depakote</td>
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<td>Continue &amp; cover(^1)</td>
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<tr>
<td>Dronabinol</td>
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<td>Discontinue</td>
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<tr>
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<td>Yes</td>
<td>Continue &amp; cover</td>
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<tr>
<td>Lisinopril</td>
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<td>Discontinue</td>
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<tr>
<td>Cosopt Opth</td>
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<tr>
<td>Senna S</td>
<td>Yes</td>
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<td>Discontinue</td>
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<td>Abilify</td>
<td>Yes</td>
<td>Yes</td>
<td>Continue &amp; cover(^3)</td>
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</tbody>
</table>
Case 1: Additional Pharmacist Notes

1. Depakote
   - Used off-label for management of agitation/aggressive behaviors in dementia.
   - Often effective for non-psychotic symptoms

2. Cosopt Ophth. Drops
   - High cost drug for glaucoma.
   - Submit for coverage under Part D

3. Abilify
   - Very high cost antipsychotic drug. No evidence of clinical efficacy over other less costly antipsychotics in management of dementia.
   - Consider change to Haloperidol or Risperidone
Questions about Case 1 (dementia) ??
Case 2 - Heart Failure

BB is a 79-year old man admitted to hospice with a hospice diagnosis of end-stage CHF. PPS is 30%.

Comorbid conditions:
• Atrial fibrillation
• COPD
• Hyperlipidemia
• Type 2 Diabetes
• Osteoarthritis

Vitals on admission:
• BP 135/85
• HR 72
• Temp 99.1
Case 2 Medication List

- Digoxin 0.125 mg PO daily
- Metoprolol 50 mg PO BID
- Lasix 40 mg PO QAM, 20 mg PO at 2 pm
- Lipitor 40 mg PO QHS
- Phenergan 25 mg PO Q 6 hours PRN nausea
- Warfarin 5mg daily
- Metformin 500 mg PO BID
- Glipizide 5 mg PO daily
- Advair 250/50 1 puff inhaled BID
- Spiriva 1 puff daily
- Albuterol HFA 2 puffs every 4 hours PRN shortness of breath
- Celebrex 200 mg PO daily
- Lisinopril 10 mg PO daily
- KCL 20meq daily

Which meds would you…
A. Cover?    B. Submit to Part-D?    C. Consider discontinuing?
Diagnosis-Specific Drug Therapy: Heart Failure

- Standard maintenance therapy is considered both disease modifying and palliative for HF

- Hospice should cover these categories and drugs for ES CHF:
  - Diuretics (and potassium supplement) - Anti-arrhythmics
  - ACE inhibitors or ARBs - Nitrates
  - Beta-blockers - Other vasodilators
  - Digoxin (esp. if atrial fib. present)

- Statins are no longer medically necessary hospice care and should be D/C’ed
Guidance for Anticoagulants/Antiplatelets in Hospice: When to D/C

• For the majority of patients, anticoagulants and antiplatelets should be discontinued upon hospice admission.
  • Not palliative (not relieving any symptom)
  • Typically used for preventative or prophylactic purpose
  • May require invasive administration method or invasive lab monitoring
  • Have significant potential for adverse effects:
    • Hospice patients are at increased risk for serious bleeding episodes
    • A serious bleed can lead to loss of function or death
  • Numerous drug interactions (warfarin)

• Anticoagulants in Atrial fibrillation:
  • Anticoagulants do not reduce symptoms of AF
  • Anticoagulants reduce stroke risk by about 4% per year on average*
  • Actual reduction in stroke risk for hospice patient is very low

* Archives of Internal Medicine 1994; 54: 1449-1457.
Symptom Management: Pain

- Analgesics always covered unless pain clearly NOT related to terminal illness or decline
  - **Non- hospice covered examples:**
    - NSAIDs for rheumatoid or osteoarthritis
    - Lidoderm patch for shingles pain
    - Gout medications: colchicine, indomethacin, allopurinol
    - Migraine headache meds: Imitrex, Cafergot, Excedrin Migraine

- Conversely, **cover “adjuvant analgesics”** if treating pain related to the terminal illness
  - Tricyclic antidepressants (e.g., nortriptyline)
  - Steroids (e.g., dexamethasone)
  - Anticonvulsants (e.g., gabapentin)
  - Muscle relaxants (e.g., baclofen)
## Summary: Drug List for Case 2 (Heart Failure)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Palliative or Related?</th>
<th>Medically Necessary &amp; Appropriate?</th>
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<tbody>
<tr>
<td>Digoxin</td>
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<td>Metoprolol</td>
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<td>Lasix</td>
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<td>Lipitor</td>
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<td>Warfarin</td>
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<td>Metformin</td>
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<td>Glipizide</td>
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<td>Advair</td>
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<td>Spiriva</td>
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<td>Albuterol HFA</td>
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<td>Celebrex</td>
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<td>Metoprolol</td>
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<td>Lasix</td>
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<td>Lipitor</td>
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<td>Discontinue</td>
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<td>Advair</td>
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<td>KCl</td>
<td>Yes</td>
<td>Yes</td>
<td>Continue, cover</td>
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</tbody>
</table>
Case 2: Additional Pharmacist Notes

1. Digoxin
   • May be considered for D/C if there was no Atrial fibrillation diagnosis in this patient..... Evidence for benefit in CHF is not strong

2. Advair, Albuterol, & Spiriva
   • Patient’s ability to use these metered-dose inhalers **effectively** should be evaluated due to advanced disease & probable significant weakness.

   • Consider switch to nebulizer solution therapy:
     • Albuterol-Ipratropium (Duoneb) QID

   • Then must consider if COPD is contributing to terminal decline

   • Cover respiratory drugs on this case too?

...continued on next slide.
3. Celebrex
   • Is expensive & some Part D plans may “push-back” against paying since this may be considered an “analgesic” (hospice covered med).

   Options: a) Hospice covers
   b) Hospice gets Celebrex changed to cost-effective alternative (naproxen, ibuprofen...1/10 the cost)
Questions about **Case 2** (heart failure) ??
Case 3 - Cancer

TN is a 45-year-old woman on hospice for breast cancer with mets to the brain and bone. PPS is 50%.

**Comorbid conditions:**
- Pulmonary embolism (oncologist states: secondary to cancer)
- Depression
- Anorexia with cachexia
- Parkinson’s disease

**Vitals on admission:**
- BP 115/70
- HR 60
- Temp 97.9
Case 3 Medication List

- Fentanyl patch 100mcg/hr Q72h
- Morphine 10 mg PO every 2 hours PRN pain
- Gabapentin 300 mg PO TID
- Dexamethasone 4 mg PO daily
- Keppra 500 mg PO BID
- Lovenox 45 mg (1 mg/kg) subcutaneously BID
- Tamoxifen 20 mg PO daily
- Megace 40 mg/mL 20 mL PO daily
- Ambien 5 mg PO QHS PRN insomnia
- Nystatin 100,000 units/mL swish and swallow 5 mL 4 times daily for 14 days for thrush
- Multivitamin with minerals 1 qd
- Sinemet 25/250 QID
- Senna S 2 tablets PO BID

Which meds would you...

A. Cover?       B. Submit to Part-D?     C. Consider discontinuing?
Diagnosis-Specific Drug Coverage: Cancer

- **Brain cancer/mets**: anticonvulsants, corticosteroids

- **Lung cancer/mets**: bronchodilators (inhaled), steroids (oral and/or inhaled), expectorants, antitussives, mucolytics
  - Significant overlap between Lung CA and COPD symptoms
  - Majority of Lung CA patients also have COPD

- **Pancreatic cancer**:
  - Digestive enzymes (if pt. still eating regular meals)
  - Insulin (pancreatic CA strongly associated with hyperglycemia)

- **Esophageal or stomach cancer**: acid blockers (PPIs, H2RAs, antacids), sucralfate.

- **Bone cancer/mets**: steroids, NSAIDs

- **Liver cancer/mets**: diuretics, lactulose, Xifaxan, cholestyramine (Questran) for itching
Guidance for Anticoagulants/Antiplatelets in Hospice – **When to Continue**

- **Possible exceptions** to stopping therapy - when continued anticoagulants may be warranted in hospice:
  - Reasonable current level of function (PPS ≥ 40) that we would like to preserve…
    - **And** a reasonable QoL …
    - **And** patient is deemed to be at high risk for further thromboembolic event
      - Patients w/ cancer are at increased risk for DVT/thromboembolism
      - Thromboembolic event may result in serious debility or death

- **OR** we are actively treating a clot that is symptomatic or otherwise negative impacting QoL
### Summary: Drug List for Case 3 (Cancer)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Palliative or Related?</th>
<th>Medically Necessary &amp; Appropriate?</th>
<th>Coverage Decision?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fentanyl patch</td>
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<tr>
<td>Morphine</td>
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<td>Gabapentin</td>
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<td>Dexamethasone</td>
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<td>Keppra</td>
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<td>Lovenox</td>
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<td>Tamoxifen</td>
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<td>Megace</td>
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<td>Sinemet</td>
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<tr>
<td>Senna S</td>
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</tbody>
</table>
### Summary: Drug List for Case 3 (Cancer)

**Pharmacist Perspective**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Palliative or Related?</th>
<th>Medically Necessary &amp; Appropriate?</th>
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<tbody>
<tr>
<td>Fentanyl patch</td>
<td>Yes</td>
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<td>Continue &amp; cover&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Morphine</td>
<td>Yes</td>
<td>Yes</td>
<td>Continue &amp; cover</td>
</tr>
<tr>
<td>Gabapentin</td>
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</tr>
<tr>
<td>Tamoxifen</td>
<td>Yes</td>
<td>No</td>
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<tr>
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<tr>
<td>Ambien</td>
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<td>Continue &amp; cover</td>
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<tr>
<td>Nystatin</td>
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<td>Continue &amp; cover&lt;sup&gt;3&lt;/sup&gt;</td>
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<tr>
<td>Multivitamin</td>
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<td>No</td>
<td>Discontinue</td>
</tr>
<tr>
<td>Sinemet</td>
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<td>Continue &amp; not cover</td>
</tr>
<tr>
<td>Senna S</td>
<td>Yes</td>
<td>Yes</td>
<td>Continue &amp; cover</td>
</tr>
</tbody>
</table>
Case 3: Additional Pharmacist Notes

1. Fentanyl patch
   • Is a poor choice for a cachectic patient due to incomplete and erratic transdermal absorption.
   • Consider rotation to Methadone to enhance analgesic effectiveness...

1. Megace
   • Is effective but carries high risk of cardiovascular adverse effects in this patient (DVT & PE described in Case 1).
   • Our patient is being treated for pulmonary embolism. Pt. also on Dexamethasone which is a potent appetite stimulator.

2. Nystatin
   • For thrush is covered
   • May be related to impaired immune system (cancer related) or from previous chemotherapy.
Questions about Case 3 (cancer) ??
Case 4 - COPD

80 yr old man w/ “end stage” Chronic Obstructive Pulmonary Disease. PPS = 30%

• No other comorbidities noted.

• History positive for recurrent respiratory infection and Thrush

• Supplemental oxygen 15 hours/day

• **Significant symptoms of:**
  • Shortness of breath
  • Weakness
  • Fatigue
  • Anxiety
Case 4 Medication List

- Advair Diskus 100mcg/50mcg 1 inhalation BID
- Spiriva Respimat 1 inhalation QD
- Flovent HFA 44mcg 1 inhalation BID
- Albuterol HFA 2 inhalations Q4h prn SOB (pt using this about q1 – 2hr)
- Azithromycin 250mg daily (prophylactic therapy)
- Lorazepam 1mg Q3h prn anxiety (using this around the clock)
- Roxanol 5 – 10mg Q2h prn dyspnea
Potential Problems with Inhaled Respiratory Drugs

• Frequent therapeutic duplications in the drug regimen

• Unnecessary drugs

• Inhaled respiratory medications are expensive

• Three different types of metered-dose inhalers (MDI’s) are available
  • All have different procedures for use
  • Source of confusion for patients

• Many patients with advanced COPD cannot effectively use an MDI due to:
  – Weakness
  – Decreased respiratory capacity, or
  – Cognitive impairment

• Nebulizer therapy more effective for advanced disease

• Routine inhaled steroids are over used in COPD
  – Evidence does not demonstrate therapeutic benefit*
  – Inhaled steroids increase risk for pneumonia & thrush

*Wisdom trial (NEJM, Sept 8, 2014)
What potential problems do you see in Case 4?

• Therapeutic duplication?
• Possible drug toxicity?
• Unnecessary drugs?
• Inappropriate drug delivery systems?
• Other?

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Pharmacist Perspective Case 4

- **Therapeutic duplications?** - Yes.
  - Two inhaled steroids: Fluticasone in both Flovent and Advair

- **Possible drug toxicity or adverse effects?** - Yes.
  - Albuterol inhaler Q1 -2 hr may cause anxiety & tremor
  - Inhaled steroids (Flovent and Advair) increase pneumonia & thrush risk

- **Unnecessary drugs?** - Yes
  - Azithromycin routinely
  - Can cut pneumonia risk by D/C of inhaled steroids

- **Inappropriate drug delivery systems?** - Yes
  - Disease is too far advanced for MDI’s – Pt. still using rescue inhaler q1 -2hr despite all the other routine MDI medications
  - Switch to nebulizer therapy
Recommended Changes for Case 4

- D/C Flovent HFA
- D/C Albuterol HFA
- D/C Azithromycin
- Change Advair & Spiriva to Duoneb nebulizer solution QID routine & q4h prn
- Use Prednisone 40mg daily x 5 days for an acute exacerbation

**Goal of these changes:**
- Increased effectiveness of bronchodilator drugs
- Decreased risk of pneumonia / thrush
- Decreased risk of drug induced anxiety/tremor
- Increased opportunity for compliance with drug regimen
- Decreased cost to the hospice
Some Concluding Thoughts

• Focus on meds for symptom control and comfort care

• Cover meds that are necessary for management of the terminal dx as well as any condition directly related

• Discontinue meds that are no longer medically necessary:
  • Curative only
  • Preventative or providing prophylaxis
  • Associated with long-term therapeutic outcomes

• Coverage decisions may be influenced by individual patient conditions:
  • QoL, level of function, overall prognosis, specific goals of care

• Cognitive enhancing drugs (Aricept, Exelon, Namenda) have not be show to be effective in end stage dementia (FAST -7)