



KEEPING TABS

Absolute Pharmacy
is the prescription
for what ails you.

Welcome to the first issue of Keeping Tabs. In each edition, you'll find news about the latest in pharmacy, new medications, technology and more – all through the lens of what is pertinent to the long-term care (LTC) industry.

Absolute Pharmacy has been serving the LTC industry since 1994. We're a part of a dynamic circle of care that consists of rehabilitation, home health care services, hospice care and much more. We have a rich perspective, and we're thrilled to share what we've been learning from other industry leaders, our employees and our customers – you!

We hope you find the information useful. If you have a suggestion for something you'd like to see, let us know at maryjo.mcelyea@abshealth.com.

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5 Things Patients and Physicians Should Question

by Tracy Penrose, Consultant Pharmacist

Absolute Pharmacy professionals are constantly keeping up on the latest industry news so we're on top of the ever-changing landscape of the long-term care, LTC, setting. We hand-picked this next article to feature in our inaugural newsletter because it illustrates how our industry is developing – what was once commonplace is evolving and improving. Use this article as an insightful set of guidelines to follow when treating elderly patients. Three of these recommendations help reduce unnecessary medication use in long term care facilities.

1. Don't insert percutaneous feeding tubes in individuals with advanced dementia. Instead, offer oral assisted feedings.

Strong evidence exists that artificial nutrition does not prolong life or improve quality of life in patients with advanced dementia. Feeding tubes are often placed after hospitalization, frequently with concerns for aspirations, and for those who are not eating. Contrary to what many people think, tube feeding does not ensure the patient's comfort or reduce suffering. It may cause fluid overload, diarrhea, abdominal pain, local complications, less human interaction and may increase the risk of aspiration.

2. Don't use sliding scale insulin (SSI) for long-term diabetes management for individuals residing in the nursing home.

SSI is a reactive way of treating hyperglycemia after it has occurred rather than preventing it. Good evidence exists that SSI is ineffective in meeting the body's insulin needs and is inefficient in the LTC setting. With SSI regimens, patients may be at risk from prolonged periods of hyperglycemia. The risk of hypoglycemia is a significant concern because insulin may be administered without regard to meal intake. Basal insulin, or basal plus rapid-acting insulin with one or more meals most closely mimics normal physiologic insulin production and controls blood glucose more effectively.

3. Don't obtain a urine culture unless there are clear signs and symptoms that localize to the urinary tract.

Chronic asymptomatic bacteriuria is frequent in the LTC setting, with prevalence as high as 50 percent. A positive urine culture in the absence of localized urinary tract infection (UTI) symptoms (i.e., dysuria, frequency, urgency) is of limited value in identifying whether a patient's symptoms are caused by a UTI. Colonization (a positive bacterial culture without signs or symptoms of a localized UTI) is a common problem in LTC facilities that contributes to the over-use of antibiotic therapy in this setting,

leading to an increased risk of diarrhea, resistant organisms and infection due to *Clostridium difficile*. A patient with advanced dementia may be unable to report urinary symptoms. In this situation, it is reasonable to obtain a urine culture if there are signs of systemic infection such as fever, leukocytosis, or a left shift or chills in the absence of additional symptoms (e.g., new cough) to suggest an alternative source of infection.

4. Don't prescribe antipsychotic medications for behavioral and psychological symptoms of dementia (BPSD) in individuals with dementia without an assessment for an underlying cause of the behavior.

Careful differentiation of the cause of the symptoms (physical or neurological versus psychiatric, psychological) may help better define appropriate treatment options. The therapeutic goal of the use of antipsychotic medications is to treat patients who present an imminent threat of harm to self or others, or are in extreme distress – not to treat nonspecific agitation or other forms of lesser distress. Treatment of BPSD in association with the likelihood of imminent harm to self or others includes assessing for, and identifying and treating, underlying causes (including pain; constipation; and environmental factors such as noise, being too cold or warm, etc.), ensuring safety, reducing distress and supporting the patient's functioning. If treatment of other potential causes of the BPSD is unsuccessful, antipsychotic medications can be considered, taking into account their significant risks compared to potential benefits.

5. Don't routinely prescribe lipid-lowering medications in individuals with a limited life expectancy.

There is no evidence that hypercholesterolemia, or low HDL-C, is an important risk factor for all-cause mortality, coronary heart disease mortality, or hospitalization for myocardial infarction or unstable angina in persons older than 70 years. In fact, studies show that elderly patients with the lowest cholesterol have the highest mortality after adjusting other risk factors. In addition, a less favorable risk-benefit ratio may be seen for patients older than 85, where benefits may be more diminished and risks from statin drugs more increased (cognitive impairment, falls, neuropathy and muscle damage).

About this Article:

American Medical Directors Association (AMDA- the society for post-acute and long term care medicine) convened a professional work group of board certified geriatricians, medical directors, and prescribers from nursing facilities and office based settings with different geographic areas. Ideas for the Five "Don'ts" were submitted, researched, refined and ranked in order of importance until narrowed down to the top five ideas. This initiative, called *Choosing Wisely*, is supported by the American Board of Internal Medicine foundation. AMDA's disclosure policy and list of sources can be found at www.amda.com. The above article is a slightly shortened version. To see the full script including sources, go to www.choosingwisely.org/doctor-patient-lists/amda/

An Overview of Anticoagulants

by Courtney Salvino, PharmD, RPh

There are many anticoagulants on the market, and deciding which one is best for a resident can be tricky. By looking at which medications include proven indications, reversible capabilities, length of medication circulation, or medication-specific properties, providers are able to narrow the options based on patient-specific information. By understanding the components used to choose an anticoagulant, health-care providers can answer resident questions more accurately and efficiently, leading to better care.

Anticoagulants are commonly used today in the long-term care (LTC) industry to prevent the formation of new clots and to keep existing clots from becoming larger. They do not dissolve existing clots; the body will recognize and dissolve the clot overtime. Certain factors increase the risk of thrombosis, including a hypercoagulable states, vascular wall injuries and circulatory stasis. Having more than one risk factor increases the risk of thrombosis.

Anticoagulants work by hindering different parts of the clotting cascade, preventing clot formation. The names of the different classes of medications indicate with which part of the clotting cascade they interfere.



Switching Amongst the Anticoagulants:

When switching from warfarin to the newer agents (such as rivaroxaban and dabigatran), it is not necessary to continue taking warfarin when starting these agents. Once warfarin's last dose is given, these medications are therapeutic before warfarin is completely eliminated from the body due to warfarin's long half-life. For example, when switching patients from warfarin to rivaroxaban, discontinue warfarin and start rivaroxaban when the INR < 3.0. When switching patients from other anticoagulants (besides warfarin) to rivaroxaban, start rivaroxaban \leq 2 hours prior to next scheduled dose or at the time of heparin infusion discontinuation. Each anticoagulant's package insert contains information explicitly explaining the conversion to and from various anticoagulants.

See the Oral and Parenteral Anticoagulant Comparison Charts on page 7. The charts are a tool that can be useful to view some of the major components to aid in the decision process.

New Pneumonia Vaccination: What You Need to Know

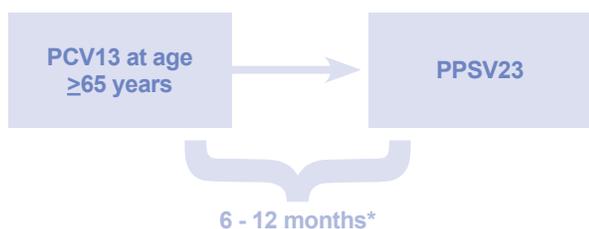
by Eric McCaw, Consultant Pharmacist

A new pneumonia vaccination called Prevnar-13 is making waves as a very effective and vital option for seniors and persons with chronic conditions. Information surrounding this new vaccination can be difficult to wade through, in fact, we've received several inquiries on who and when to administer the new drug. Here's what you need to keep in mind about Prevnar-13.

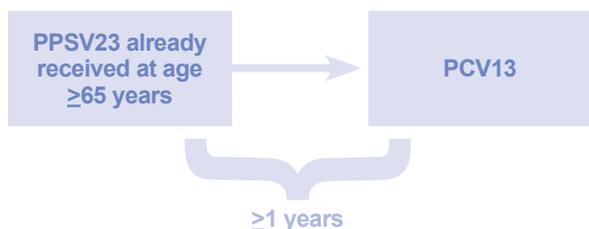
There are more than 90 types of pneumococcal bacteria. PCV13 protects against 13 and PPSV23 protects against 23. The strains covered by these vaccinations cause most severe infections in children and about half of infections in adults.

PPSV23 = Pneumovax 23 | PCV13 = Prevnar 13

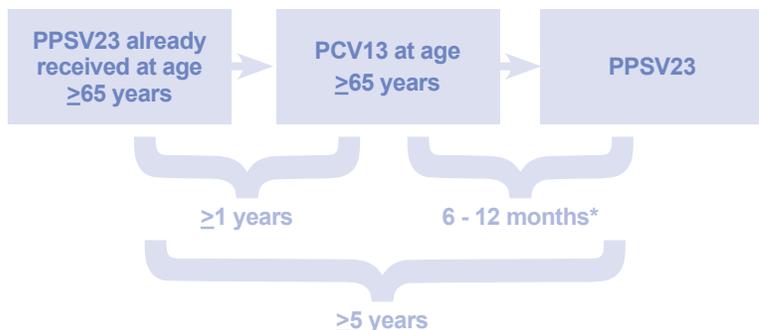
Pneumococcal vaccine-naïve persons aged ≥65 years



Persons who previously received PPSV23 at age ≥65 years



Persons who previously received PPSV23 before age 65 years who are now aged ≥65 years



Abbreviations: PCV13 = 13-valent pneumococcal conjugate vaccine; PPSV23 = 23-valent pneumococcal polysaccharide vaccine.
 *Minimum interval between sequential administration of PCV13 and PPSV23 is 8 weeks; PPSV23 can be given later than 6-12 months after PCV13 if this window is missed.

Advisory Committee on Immunization Practices (ACIP) Recommendations for PCV13 and PPSV23 Use

Both PCV13 and PPSV23 should be administered routinely in series to all adults aged ≥65 years.

Pneumococcal vaccine-naïve persons. Adults aged ≥65 years who have not previously received pneumococcal vaccine or whose previous vaccination history is unknown should receive a dose of PCV13 first, followed by a dose of PPSV23. The dose of PPSV23 should be given 6–12 months after a dose of PCV13. If PPSV23 cannot be given during this time window, the dose of PPSV23 should be given during the next visit. The two vaccines should not be co-administered, and the minimum acceptable interval between PCV13 and PPSV23 is 8 weeks.

Previous vaccination with PPSV23. Adults aged ≥65 years who have previously received ≥1 doses of PPSV23 also should receive a dose of PCV13 if they have not yet received it. A dose of PCV13 should be given ≥1 year after receipt of the most recent PPSV23 dose. For those for whom an additional dose of PPSV23 is indicated, this subsequent PPSV23 dose should be given 6–12 months after PCV13 and ≥5 years after the most recent dose of PPSV23.

Who should get Pneumovax 23 (PPSV)?

All adults 65 years of age and older.

Anyone 2 through 64 years of age who has a long-term health problem such as:

- heart disease
- lung disease
- sickle cell disease
- diabetes
- alcoholism
- cirrhosis
- leaks of cerebrospinal fluid or cochlear implant

Anyone 2 through 64 years of age who has a disease or condition that lowers the body's resistance to infection, such as:

- Hodgkin's disease
- lymphoma or leukemia
- kidney failure
- multiple myeloma
- nephrotic syndrome
- HIV infection or AIDS
- damaged spleen, or no spleen
- organ transplant

New Pneumonia Vaccination: What You Need to Know, continued.

Who should get Pneumovax 23 (PPSV)?

Anyone 2 through 64 years of age who is taking a drug or treatment that lowers the body's resistance to infection, such as:

- long-term steroids
- certain cancer drugs
- radiation therapy

Any adult 19 through 64 years of age who:

- is a smoker
- has asthma

How many doses of PPSV are needed, and when?

Usually only one dose of PPSV is needed, but under some circumstances a second dose may be given.

- A second dose is recommended for people 65 years and older who got their first dose when they were younger than 65 and it has been 5 or more years since the first dose.
- A second dose is recommended for people 2 through 64 years of age who:
 - have a damaged spleen or no spleen
 - have sickle-cell disease
 - have HIV infection or AIDS
 - have cancer, leukemia, lymphoma, multiple myeloma
 - have nephrotic syndrome
 - have had an organ or bone marrow transplant
 - are taking medication that lowers immunity (such as chemotherapy or long-term steroids)
- When a second dose is given, it should be given 5 years after the first dose.

Who Should Get the PCV13 Vaccine?

- All adults 65 years of age or older who have not previously received PCV13.
- Adults 19 years of age or older with certain medical conditions (similar to those listed for Pneumovax), and who have not previously received PCV13



Did you know that at-risk patients are more likely to get vaccinations when health care professionals recommend it? You play a huge part in ensuring that this condition is eradicated. And that's why we're encouraging healthcare professionals everywhere to talk to at-risk patients to get the vaccine.

Citation:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm>

Absolute Insights

Helpful Hints and Tips!

We know you want to provide the very best health services to everyone in your care. That's why Absolute Pharmacy brings you helpful hints and tips in your mission for excellence!

1. IV pumps

Remember to return IV pumps when an order has been completed so they can be cleaned and calibrated at the pharmacy.

2. Refrigerated items

When you receive refrigerated items from pharmacy, immediately place them in the refrigerator. Should an item be left out too long, Absolute will re-send the medication at facility expense.

3. Starter boxes

Always send the name of the resident who used a starter item to ensure a replacement is sent for your starter box as soon as possible.

Update: Insulin Pens

Absolute Pharmacy is now dispensing Insulin pens rather than vials.

This went into effect November 1, 2014 for all new orders. Here's why we made the decision:

- Cost savings
- Decreased risk for errors

Tip! To manage infectious contaminations, use a Clorox wipe to sanitize the pen and store the pen in a Ziploc bag in your med cart.

Needles with auto-shields can be purchased from Absolute Pharmacy. Absolute's prices are competitive to most suppliers. If you'd like to learn more for new staff and residents, please contact your consultant pharmacist.

Put a Face to a Name: Megan Jones



When you hear a friendly "hello" and "thank you for calling Absolute Pharmacy," it is usually Megan Jones. Megan has been with Absolute Pharmacy for 14 years. In addition to taking your calls, she is an

administrative assistant and works on order fulfillment. She spends her free time shopping, vacationing at the beach, and enjoying time with her husband and 3-year-old son.

Find out a little bit more about Megan below!

1. What do you absolutely love about working for Absolute Pharmacy?

A: I love all the wonderful people that I work with at Absolute.

2. What chore do you absolutely hate doing?

A: I hate unloading the dishwasher.

3. What's your favorite indoor/outdoor activity?

A: I love to go swimming in the summer.

See our private pharmacy and gain exclusive views on your facility's performance

Absolute Pharmacy and Absolute Rehabilitation invite you to a "Sneak Peek" event.

- Get an exclusive, **behind-the-scenes tour of the Absolute Pharmacy** and a demo of our newest in-facility solutions and dispensing technology.
- See software that gives you **unparalleled data about your facility**, including Medicare spend per beneficiary, referral data in your vicinity and how you stack up against Medicare's new efficiency standards.
- Enjoy **lunch** and chances to **win prizes**.

Choose from two dates:

February 12, 11:30 a.m. to 1:30 p.m.

March 4, 11:30 a.m. to 1:30 p.m.

Both events will be held at the Absolute Health headquarters, 339 East Maple Street, Suite 100, North Canton, Ohio.

To reserve your spot, contact Mary Jo McElyea at 330-704-6404 or maryjo.mceylea@abshealth.com

Reservations are required. Space is limited in both sessions.



Continued from Drug News

Oral Anticoagulant Comparison Chart

	Labeled Indications	Pharmacotherapy Pearls	Half-Life (t _{1/2})	Reversal Strategies	Monitor
Vitamin K Antagonist					
Coumadin Jantoven (warfarin)	VTE Hyper-coagulable conditions Afib Cardiac valve replacement Post MI	Full effect seen 7-10 days Highly protein bound Many drug and food interactions (consider pre-dose adjustments)	24-72 hours	Vitamin K (route and dose dependent on clinical situation and INR—oral preferred)	PT Hct INR
Direct Thrombin Inhibitor					
Pradaxa (dabigatran)	Nonvalvular afib DVT/PE	Swallow capsules whole Keep in original bottle/blister pack Do not put in NG tube Renal dose adjustment required	12-17 hours	No antidote May consider hemostatic blood elements Can be dialyzed (~60% in 2-3hours)	Not required
Direct Factor Xa Inhibitor					
Xarelto (rivaroxaban) Eliquis (apixaban) *Savaysa (edoxaban)	Nonvalvular afib VTE (tx & px) PE/DVT Nonvalvular afib	Renal dose adjustment required Avoid use in mod-to-severe hepatic impairment Rivaroxaban Afib: take with evening meal VTE: take with food same time each day Hip/knee replacement: take with or without food Edoxaban BBW: reduced efficacy CrCl > 95ml/min in non-valvular afib patients	5-9 hours 12 hours 9-11 hours	No antidote May consider hemostatic blood elements Not dialyzable	Not required

*Agent just approved January 2015

Definitions:

ACS:
acute coronary syndrome

ACT:
activated clotting time

aPTT:
activated partial thromboplastin time

Hct:
hematocrit

HIT:
heparin induced thrombocytopenia

Hgb:
hemoglobin

PCI:
percutaneous coronary intervention

PTCA:
percutaneous transluminal coronary angioplasty

Plt:
platelet

PE:
pulmonary embolism

PT:
prothrombin time

px:
prophylaxis

Scr:
serum creatinine

tx:
treatment

VTE:
venous thromboembolism

Continued from Drug News

Parenteral Anticoagulant Comparison Chart

	Labeled Indications	Pharmacotherapy Pearls	Half-Life (t _{1/2})	Reversal Strategies	Monitor
Indirect Factor Xa Inhibitor					
Arixtra (fondaparinux) SC	VTE (tx & px)	Renal dose adjustment required Do not expel air bubble prior to injection	17-21 hours	No antidote	Plt Hgb, Hct, Scr, Occult blood
Direct Thrombin Inhibitors					
Argatroban SC or IV Angiomax (bivalirudin) SC or IV Iprivask (desirudin) SC	HIT with thrombosis PCI who are at risk for HIT ACS undergoing PTCA and at risk for HIT DVT undergoing hip replacement	Do not expel air bubble prior to injection Argatroban Hepatic dose adjustment required Elevates INR Bivalirudin Renal dose adjustment required Desirudin Renal dose adjustment required	Immediate	No known antidote	aPTT, Plt, Hgb, Hct, Scr ACT
Antithrombin Inhibitor					
Heparin SC or IV	Thromboembolic disorders (tx & px) Extracorporeal and dialysis procedures	Use actual body weight for dosing Monitor for HIT Contains pork products Variable anticoagulant response	20-30 mins	Protamine (1mg reverses ~100 units of heparin in the last 2-2.5 hours; max dose 50mg)	aPTT, Plt, Hgb, Hct
Low Molecular Weight Heparin					
Lovenox (enoxaparin) SC or IV Fragmin (dalteparin) SC Innohep (tinzaparin) SC	ACS VTE (tx & px) NSTEMI/UA VTE (tx & px) DVT with or without PE	Anti-Xa levels can be monitored; but not routine in most patients—pregnancy, mechanical heart valve, renal insufficiency, morbidly obese (obtained 4 hours post dose) Monitor for HIT	3-5 hours 3-5 hours 2-6 hours	No true antidote (May consider hemostatic blood elements or protamine)	Not routine Plt, Hgb, Hct, Scr, Occult blood

Email Mary Jo McElyea to request a two-sided handout of these charts at maryjo.mcelyea@abshealth.com

Citations:

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