

PHARMACY NEWSCAPSULE

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Use of Postoperative Unfractionated Heparin by Barrett Crowther, Pharmacy Intern

Heparin, commonly referred to as unfractionated heparin, is an injectable medication that is used for its anticoagulant properties to prevent the formation of blood clots. Although heparin has several different indications, it is often used to help avoid the formation of a venous thromboembolism (VTE), a blood clot within an intact vein, after a surgical procedure. The usefulness of postoperative heparin is dependent on the type of surgery performed.

Unfractionated heparin is not indicated for surgical patients who undergo minor surgery and who are mobile after the procedure. It is also not indicated for patients at high risk of developing a VTE, such as those patients undergoing a hip or a knee arthroplasty or major trauma patients. For these high risk cases, enoxaparin, tinzaparin, dalteparin, ardeparin, fondaparinux, or warfarin should be utilized. Unfractionated heparin **is** indicated for patients with a moderate risk for developing VTE, such as most general, open gynecologic or urologic surgery patients or medical patients who are on bed rest. In most cases, patients who are high risk for bleeding should not receive anticoagulants such as heparin and should be controlled with intermittent pneumatic compression, venous foot pumps, and/or graduated compression stockings.

The low dose unfractionated heparin (LDUH) regimen is typically utilized to prevent VTE after surgery; a normal dose being 5,000 units twice or three times daily. Due to this low dosage, therapeutic monitoring tests---such as activated partial thromboplastin time (aPTT)---are not always necessary.

It is important that providers closely monitor patients receiving unfractionated heparin for side effects. The most common side effect with unfractionated heparin is bleeding. Providers should periodically check for bleeding episodes, bruising, blood in the stool, and test complete blood counts. A serious, but rare, complication associated with heparin therapy is heparin-induced thrombocytopenia (HIT). In patients who experience HIT, platelet counts fall below 100,000 mm³. According to the CHEST Edition 8 guidelines, post-surgery patients receiving LDUH to prevent VTE are considered high risk for HIT (>1%). It is suggested that platelet count

monitoring occurs at least every other day from days 4 to 14 (or until LDUH is stopped, whichever comes first). For non-surgical, medical/obstetrical patients receiving LDUH to prevent VTE, it is suggested that platelet count monitoring occurs at least every two to three days from days 4 to 14 (or until LDUH is stopped, whichever comes first).

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New Medications

Brand Name	Generic Name	Use
Besivance	besifloxacin	Ophthalmic suspension for bacterial conjunctivitis
Caldolor	ibuprofen	Injectable formulation for pain and fever
Cycloset	bromocriptine	New dosage for type 2 diabetes

Focus Drug by Barrett Crowther, Pharmacy Intern

Pristiq®, desvenlafaxine

Pristiq is used for the treatment of major depressive disorder in adults.

The recommended starting dose for Pristiq is 50 mg administered by mouth once daily. Doses greater than 50 mg per day were not found to be any more effective and caused patients to experience a greater chance for side effects. The standard recommended dose is 50 mg per day. No dosage adjustments are necessary for elderly patients or for patients with liver dysfunction. For patients with severe renal dysfunction, it is recommended to give Pristiq 50 mg tablets once every other day. When discontinuation of the medication is desired, a gradual dose reduction (by giving Pristiq less often) should be followed to avoid discontinuation symptoms.

The most common side effects associated with Pristiq include nausea (which occurred in up to 22% of those patients receiving 50mg per day), headache, loss of appetite, sweating, constipation, dizziness, sexual dysfunction, difficulties associated with sleep, and elevated cholesterol/triglycerides. Rare, but serious, side effects included suicidal thoughts, increased risk for seizure, increased risk of bleeding, elevated blood pressure, increased heart rate, interstitial lung disease, and an allergic reaction.

The benefit of Pristiq improving mood can take up to six to eight weeks in some individuals. Patients should be monitored for improvement in mood, along with other symptoms associated with depression, including difficulties with sleep, loss of interest, change in appetite, feelings of guilt, slowed motor movements, and suicidal ideation. Patients should also be monitored for any of the aforementioned side effects, and possibly, include cholesterol screening.

Pristiq can increase the risk of bleeding and, therefore, should be closely monitored in patients receiving anticoagulant therapy such as warfarin.

Pristiq is an **extended release** tablet and, as such, it should not be crushed, dissolved, broken, or chewed. It can be taken with or without food and should be taken at approximately the same time every day. If a dose is missed, that dose should be taken as soon as possible. If it is almost time for the next dose, the patient should take this next dose and the missed dose should be skipped.

Of note, Pristiq is chemically similar to Effexor® (venlafaxine). There have been no head to head trials comparing Pristiq to any other antidepressants.

Consultant Corner by Doug Englebert, R.Ph.

- 1. We are seeing growing use of Seroquel and Abilify for “depression,” usually---but not always---after other therapies have failed. When the medication is started by a physician for a nursing home resident for depression, do we monitor and complete dosage reduction based on the antipsychotic or antidepressant guidelines?**

First, Abilify carries an approved Food and Drug Administration (FDA) indication for adjunct treatment in major depression. Seroquel does not have this FDA indication.

The survey guidance for nursing homes indicates that antipsychotics could be used for refractory depression or depression with psychotic features. Therefore, the survey guidance would apply the antipsychotic monitoring and dose reduction parameters.

For situations other than refractory depression or depression with psychotic features, use of antipsychotics is not supported by FDA approval. Due to black box warnings, the use of antipsychotics for general depression would appear to be a risky practice as there are other, “safer” options available. Therefore, it would be reasonable that a surveyor ask questions to ascertain that the facility has a strong differential diagnosis, that there are clear distinctive monitoring parameters established, and that the resident is fully informed (understands they are taking an antipsychotic for depression and has been informed that there are other, safer products). At a minimum, if these conditions do not exist, an unnecessary drug will be identified and a citation will be issued.

- 2. If a physician completes a medication review during a clinic visit, is the requirement for the pharmacist annual and psychotropic med change reviews eliminated?**

Chapter DHS 83, Wisconsin Administrative Code, allows medication regimen reviews to be completed by a physician or pharmacist. In addition to the general medication regimen review, a review of psychotropic medication use must be done quarterly by a pharmacist, physician, or registered nurse. For PRN psychotropic medications, a monthly review must be done by an administrator or qualified designee.

These reviews can be done in a variety of combinations. If the physician does one with the annual visit, it can count for the annual and quarterly psychotropic and for the monthly PRN.

A pharmacist may conduct supplementary reviews, as well. Ultimately, the reviews must be done within the required time frames and can be done in multiple combinations.

3. How does a narcotic treatment program handle methadone prescribed for residents of a Community-Based Residential Facility?

First, any methadone that leaves a narcotic treatment program (methadone maintenance program) does so in a “pill” bottle, just like the ones that come from a pharmacy. The narcotic treatment program is required to have a label on the medication bottle that contains the program name, program phone number, patient's name, medication and dosage, and date the medication is to be consumed. Under no circumstances are bottles allowed to leave a program without the proper label.

In addition, narcotic treatment programs also provide a lock-box to CBRF residents who receive methadone. These residents must bring their lock-box to the methadone treatment program in order to take doses of methadone back to the residential facility. All used, take-home dose bottles must be returned to the treatment program in the lock-box with the label intact. If the label has been 'messed with,' the patient is not allowed take doses home for the next 90 days.

CBRF residents are able to have up to a week's supply (with prior approval) of methadone take-home doses; however, there is a procedure. To prevent any one individual from having complete access to the medication, the narcotic treatment program requests that the box to be stored in a secure environment at the CBRF and that the patient retain the key to the box. When it is time to take the daily dose, the box is removed from the secure environment by CBRF staff and given to the patient. While supervised, the patient unlocks the box, drinks the dose, returns the bottle to the box, and locks the box. The patient retains the key and the box is again safely stored in a locked area of the CBRF.

If the CBRF meets the definition of a drug treatment facility, the central storage of self-administered medications is allowed by DHS 83.37(4), Wis. Admin. Code. If the CBRF does not meet the definition as allowed in DHS 83.37(4), has a resident in a treatment program who is self-administering but must centrally store the medication, the CBRF should seek a waiver.

4. In a nursing home, are medication carts required to be bolted to the wall?

Medications must be locked in cabinets or closets near the nursing station. Schedule II medications must also be locked in permanently affixed cabinets. A movable cart is not a closet or cabinet, nor is it permanently affixed.

A medication cart stored in a locked room meets state regulations. If a facility has a cart stored in a hall, there may be issues with state regulations regarding storage near a nursing station or permanently affixed storage. In some cases, facilities have waivers that allow some cart storage away from the nursing station or in other manners. However, if a waiver is not present, a state code violation may exist.