Allergic conjunctivitis affects approximately 25% of the population during their lifetime. This condition is characterized by intense itching, redness and inflammation of the eye and surrounding area. Some common causes of allergic conjunctivitis are hay fever, asthma, eczema, contact allergies (drugs, chemicals, cosmetics), air pollution and soft contact lens use. There are two types of allergic conjunctivitis: seasonal and perennial. Seasonal allergic conjunctivitis is the most common type and occurs during the high pollen count times of the year (i.e. spring, summer). Common allergens of seasonal allergic conjunctivitis include grass, tree and weed pollens as well as molds. Perennial (chronic) allergic conjunctivitis persists throughout the year due to constant exposure to a particular allergen. Patients may still experience acute exacerbations of symptoms. The most common causes of perennial allergic conjunctivitis are dust mites, animal dander and feathers.

There are preventive measures that may be taken to avoid or reduce the symptomatic allergic response, such as avoiding known allergens and washing hands, face and hair often during pollen season. Non-pharmacologic options include cold compresses to alleviate discomfort, and non-preservative lubricants to flush the eye of any debris that may be present.

When non-pharmacologic treatments have failed, there are many classes of medications available for immediate as well as long-term control of allergy symptoms. Treatment is targeted to the specific symptoms present. If the symptoms are acute in onset and include itching and conjunctival hyperemia (“bloodshot eyes”) an over-the-counter (OTC) antihistamine/decongestant combination such as Naphcon-A® (naphazoline/pheniramine) combination might be appropriate. For patients who are primarily experiencing ocular itching, the use of a prescription ophthalmic antihistamine such as Emadine® (emadstine 0.05%) may be effective. Inflammation is often involved, which warrants the use of a topical applied ophthalmic anti-inflammatory such as Acular® (ketorolac). This agent is also available in a preservative-free formulation. All of the mentioned treatments have a rapid onset of action and are intended for short-term use only.

Agents that are indicated for long-term treatment can also be prescribed based upon symptoms present. Mast cell stabilizers are often used for the prevention of symptoms and are commonly used to treat patients who experience the perennial (chronic) allergic conjunctivitis. These agents, as their class name suggests, stabilize the mast cells involved in the allergic response, therefore preventing the release of histamine. Agents included in this class are cromolyn 4% (various brands), Alomide® (lodoxamine 0.1%), Alocril® (nedocromil 2%), and Alamast® (pemirolast 0.1%).

(continued on page 5)
<table>
<thead>
<tr>
<th>Drug</th>
<th>Indication</th>
<th>Starting Dose</th>
<th>Strengths on Formulary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duetact™</strong> (Step Therapy Requirement)</td>
<td>Glycemic control in patients with type 2 diabetes</td>
<td>Initiate therapy from patient’s current regimen of pioglitazone and sulfonylurea</td>
<td>30mg/2mg, 30mg/4mg</td>
</tr>
<tr>
<td><strong>Levemir®</strong></td>
<td>Treatment of patients with type 1 diabetes or patients with type 2 diabetes requiring basal insulin</td>
<td>Dose once or twice daily; adjusting dose according to patient’s blood glucose measurements</td>
<td>100 units/mL</td>
</tr>
<tr>
<td><strong>Alaway™</strong> Zaditor® OTC</td>
<td>Allergic conjunctivitis</td>
<td>One drop in affected eye(s) every 8 to 12 hours</td>
<td>0.025% solution</td>
</tr>
<tr>
<td><strong>Vigamox®</strong> (PA Required)</td>
<td>Bacterial conjunctivitis</td>
<td>One drop in affected eye(s) 3 times a day for 7 days</td>
<td>0.5% (5mg/mL) solution</td>
</tr>
<tr>
<td><strong>Proventil® HFA Ventolin® HFA</strong></td>
<td>Treatment or prevention of bronchospasm</td>
<td>1 to 2 puffs every 4 to 6 hours, as needed</td>
<td>90mcg per a dose</td>
</tr>
<tr>
<td><strong>Relenza®</strong> (One 5-day treatment course per year)</td>
<td>For Influenza: Prophylaxis for patients 5 years of age and older</td>
<td>Prophylaxis - 2 inhalations (one 5mg blister per inhalation) daily for 10 days treatment</td>
<td>5mg blisters of powder for inhalation</td>
</tr>
<tr>
<td></td>
<td>Treatment for patients 7 years of age and older</td>
<td>Treatment - 2 inhalations (one 5mg blister per inhalation) twice daily for 5 days</td>
<td></td>
</tr>
<tr>
<td><strong>Tamiflu®</strong> (One 5-day treatment course per year)</td>
<td>Prophylaxis and treatment of influenza for patients 1 year of age and older</td>
<td>Prophylaxis (13 years and older) - 75mg once daily for 10 days Treatment - 75mg twice daily for 5 days</td>
<td>75mg, 12mg/mL powder for oral suspension</td>
</tr>
<tr>
<td><strong>Rozerem™</strong> (PA Required)</td>
<td>Chronic Insomnia</td>
<td>8mg within 30 minutes of sleep</td>
<td>8mg</td>
</tr>
<tr>
<td><strong>Vytorin™</strong></td>
<td>Hypercholesterolemia</td>
<td>10mg/20mg daily</td>
<td>10mg/10mg, 10mg/20mg, 10mg/40mg, 10mg/80mg</td>
</tr>
<tr>
<td><strong>Lamotrigine</strong> (chewable dispersible tablets)</td>
<td>Epilepsy</td>
<td>Titrate therapy based on weight and current prescribed antiepileptic medications</td>
<td>25mg</td>
</tr>
<tr>
<td><strong>Tramadol</strong></td>
<td>Management of moderate to moderately severe pain in adults</td>
<td>Titrate therapy based on patient’s pain. Do not exceed 400mg/day.</td>
<td>50mg</td>
</tr>
<tr>
<td><strong>Sertraline</strong></td>
<td>Major depressive, Obsessive-compulsive (OCD), Panic, Posttraumatic stress (PTSD), Premenstrual dysphoric (PMDD), and Social anxiety disorders</td>
<td>Major depressive disorder, OCD - 50mg once daily Panic and Social anxiety disorders, PTSD – 25mg once daily PMDD – 50mg/day either daily throughout the menstrual cycle or luteal phase</td>
<td>20mg/mL, 25mg, 50mg, 100mg</td>
</tr>
</tbody>
</table>
**Formulary Update References:**


Both Zelnorm® (tegaserod) and Permax® (pergolide) have recently been withdrawn from the market due to safety concerns. In response to the recent withdrawals of these medications, we have removed Zelnorm from the formulary. Advise patients to contact their doctor(s) immediately to discuss further treatment options, if they are taking either Zelnorm (tegaserod) or Permax (pergolide). To obtain additional information on these recent withdrawals, please contact the FDA at 1-888-INFO-FDA or visit the FDA's website at www.fda.gov.

### Formulary Removals

**Medications Requiring Prior Authorization**

**Prior Authorization Criteria for the following drugs is required.**

**Rozerem™**

Patients must have a diagnosis of insomnia and history of substance abuse or trial and failure or intolerance with any one of the following medications: meprobamate, triazolam, estazolam, temazepam, zaleplon and zolpidem.

**OxyContin®**

Patients must have a diagnosis of chronic pain and trial and failure or an intolerance to maximum doses of sustained release morphine sulfate and fentanyl.

**Vigamox®**

Patients must have a diagnosis of bacterial conjunctivitis and an intolerance or trial and failure to a full 7-day course of therapy with ofloxacin eye drops (if prescriber is not an ophthalmologist).

**Duetact™**

Patients must have an intolerance or a trial and failure to a formulary sulfonylurea, metformin or insulin.

**Patanol®/Pataday™**

Patients must have allergic conjunctivitis and an intolerance or trial and failure to Zaditor® OTC or Alaway™.
**Product Updates**

*Please be aware the information discussed in this section is to provide the reader with product updates only. It is not indicative of what is currently or will be on Keystone Mercy’s formulary.*

The product Tekturna® (aliskiren) is a newly marketed medication. It is the first product in a new class of antihypertensive agents, direct renin inhibitors (DRIs). Tekturna can be used alone or as a combination with other antihypertension products. Use with maximal doses of ACE inhibitors has not been adequately studied. The recommended starting dose of Tekturna is 150mg once daily. If blood pressure is not adequately controlled, the daily dose may be increased to 300mg. Some common side effects are diarrhea, cough, and rash. Tekturna has a black box warning for use in pregnancy. The available dosages of Tekturna are 150mg and 300mg.

**Product Update and Safety Alert References:**

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**Safety Alerts:**

**Revised Product Labeling for Erythropoiesis Stimulating Agents**

The FDA and the manufacturer of erythropoiesis stimulating agents (ESAs), Amgen, have revised the product labeling for Aranesp®, Epogen®, and Procrit®. The revisions include new safety information based on the analysis of four new studies involving cancer and surgery patients. The new product revisions include a new boxed warning, updated warnings, and a change to the dosage and administration sections. Below is a summary of some of the product labeling revisions.

**Recommendation and Consideration**

**For all patients:**
- Use the lowest dose possible to gradually increase the hemoglobin concentration to avoid the need for transfusion.
- Measure hemoglobin twice a week for 2 to 6 weeks after any dosage adjustment to ensure that hemoglobin has stabilized in response to the dose change.
- Withhold the dose of ESA if the hemoglobin increase exceeds 12g/dL or rises by 1g/dL in any 2-week period.

**For cancer patients:**
- Use of an ESA in anemic cancer patients who are not on chemotherapy offered no benefit and may shorten the time to death.
- ESAs are not FDA approved to treat anemia in cancer patients not receiving chemotherapy.

**Label Changes to Sleep Disorder Products**

The FDA has requested that the manufacturers of all sedative-hypnotic agents strengthen their product labeling to include stronger language concerning potential risks. These potential risks include anaphylaxis, angioedema and complex sleep related behaviors. The FDA has also requested that the manufacturers develop Patient Medication Guides for these sedative-hypnotic products.

- There is a potential risk of shortening the time to tumor progression or disease-free survival.
- ESAs are administered only to avoid red blood cell transfusions in cancer patients. ESAs do not improve the outcome of cancer treatment and do not alleviate fatigue or increase energy.

**Dosing and Monitoring Recommendations**

**For chronic renal failure (CRF) patients:**
- Measure hemoglobin twice a week after initiating treatment until hemoglobin has stabilized.

**For cancer patients and zidovudine HIV patients:**
- Measure hemoglobin once a week after initiating treatment until hemoglobin has stabilized.

**For patients with a history of cardiovascular disease or hypertension:**
- Closely monitor and control blood pressure.
Combination ophthalmic antihistamine/mast cell stabilizers are becoming a more popular choice among clinicians based upon their dual effect. The antihistamine component alleviates the acute symptoms of ocular itching, and the mast cell stabilizing property prevents further symptoms. Two products are now available over-the-counter (OTC), Zaditor® OTC (ketotifen 0.025%), and Alaway® (ketotifen 0.025%). Other prescription agents in this class are Optivar® (azelastine 0.05%), Elestat® (epinastine 0.05%), Patanol® (olopatadine 0.1%), and Pataday® (olopatadine 0.2%).

For more severe acute reactions, a short course of ophthalmic corticosteroids may be necessary. These agents should only be used short-term (2-3 weeks) due to the risk of developing cataracts, glaucoma and secondary infections. Some agents currently available are dexamethasone sodium phosphate (various brands), Alrex® (loteprednol 0.2%), Lotemax® (loteprednol 0.5%), prednisolone acetate 1% (various brands), and prednisolone sodium phosphate 1% (various brands).

Allergic conjunctivitis is the most common of the allergic diseases affecting the eyes. When the preferred non-pharmacological options are ineffective, there are many OTC and prescription agents available based upon patient specific signs/symptoms. It is important to keep in mind those products that are intended for short versus long-term use and the risks associated with such agents.

References:

Preventing Medication Errors

According to The National Academies, medication errors are estimated to injure at least 1.5 million Americans and cost $3.5 million annually. These drug-related injuries can vary, from the most common occurring with wrong administration technique down to dispensing unauthorized (wrong) drug. Although not always deadly, these medication errors can be prevented. Pharmacists can help keep the number of errors from climbing by calling prescribers on illegible prescriptions and counseling patients on all new prescriptions since most patients pick up mistakes upon reading the leaflet. Physicians can educate patients on the drug prescribed and its indication. In addition, physicians should ensure that any questions a patient may have are answered prior to the end of the visit. Converting a sloppily hand-written prescription to a typed-up script is one technological approach in reducing the number of medication errors. A universal approach to reducing medication errors, whether it is the health professional or the patient, is through clear, simple, and effective communication. The following are some tips to keep in mind when writing a prescription:

- Write out whole words such as “unit” rather than “U”, which could be mistaken for “0” (zero) or “4” (four).
- Write “daily” rather than “QD”, which could be mistaken for “0.0Xmg” rather than the trailing zero (X.0mg) or lack of the lead zero (.Xmg), which can lead to the wrong dose administration since the decimal point is missed or misread.
- Write only one medication order per prescription.
- Include indications along with directions on a prescription to prevent any mix-ups with look-alike generic names that have overlapping dosages.

References:
Script Notes

We welcome your thoughts, comments and/or suggestions. Do you have an idea for a story? Is there information we can provide to help you?

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