HOSPICE PHARMACY INSIGHTS

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FOR YOUR CONSIDERATION

APPROPRIATE DEPRESCRIBING BECOMES MORE ESSENTIAL

On October 1st of this year, the Centers for Medicare and Medicaid (CMS) moved closer to requiring hospices to cover all (my emphasis) “items, services and drugs” with the implementation of the election statement edits and addendum. Regarding medications, it has always been the hospice clinician’s responsibility to determine which medications are beneficial for the management of a patient’s symptoms and those medications that are of no benefit or are harmful. The hospice clinician has an obligation to discontinue (deprescribe) medications that fall in the latter two categories.

In 2017 the group deprescribing.org published their algorithms for safely deprescribing medications in the following categories: proton pump inhibitors (PPI), antihyperglycemics, antipsychotics, benzodiazepine receptor agonists (BZRA) and cholinesterase inhibitors and memantine. Their algorithms and supporting research are available on their website (www.deprescribing.org). These are available “to use freely, with credit to the authors. Not for commercial use. Do not modify or translate without permission.” There is also a free app, IAM Medical Guidelines.

In November 2020 NHPCO published the Hospice Medication Deprescribing Toolkit by the myNHPCO Pharmacist Community in collaboration with the myNHPCO Physician/Advanced Practice Provider Community and numerous hospice professionals. The categories of medications covered in these guidelines: antiplatelet/anticoagulant, dementia, inhalers, antihyperglycemics, and statins. Contact www.nhpco.org to request a copy.

Both resources provide not only excellent deprescribing guidelines but talking points for addressing patient and/or caregiver concerns.

FOR YOUR CONSIDERATION

A FRESH LOOK AT PARKINSON'S DISEASE

Parkinson's disease is the fastest-growing neurological disorder globally. The stereotypic image of a person with Parkinson's disease is that of an elderly, frail, hunched over, shaking, white male. According to a "Viewpoint" piece published in JAMA in July 2020, this is an inaccurate view of Parkinson's disease.

The highest occurrence of Parkinson's disease is in individuals 70-79 years old. The prevalence of the disease peaks between the ages of 85-89. These groups are considered to be late-onset and only account for 39% of individuals with Parkinson's disease, 51% are middle-onset (50-69 years) and 10% are young-onset (<50 years). Once thought to be a disease seen predominantly in males the male/female predominance ratio is 1.4/1.

Recent subtyping of Parkinson's disease shows that the disabling diffuse malignant form (frailness and disability) is only about 16% of cases. The most prevalent subtype is a mild motor-predominant disease at 49% followed by the intermediate form at 35%. All the phenotypes are progressive.

Mean survival after diagnosis ranges from 20.2 years for motor-predominant to 8.1 years for diffuse malignant form. According to the authors "Parkinson disease subtyping has limitations, and consensus on optimal categorization is lacking."

The authors conclude. "No single image can encapsulate the range of motor and non-motor symptoms experienced by individuals with Parkinson's disease, and there is no one common path. However, it is time that our medical images reflect modern people with Parkinson disease: young and old; male and female; active and debilitated; working, retired, or disabled; and with various symptoms and circumstances."

As research provides greater insight into the nuances of Parkinson's disease, we will be better equipped to provide a more accurate life expectancy prognosis and focus our care and management on the disease subtype. Ultimately this will assist us in formulating plans of care that will enhance our Parkinson patients' quality of life.

JAMA Neurology Published online July 27, 2020; Armstrong, M.J., MD, MSc, Okun, M.S, MD

FOR YOUR CONSIDERATION

OPIOID-INDUCED CONSTIPATION (OIC) IN CANCER AND NON-CANCER PATIENTS

Hospice clinicians are excellent at managing the common symptoms experienced by patients at end of life. You are especially adept at managing constipation. Constipation at end of life results from a variety of circumstances such as disease stage, metabolic changes, inactivity, and medications, especially opioids. Constipation, with attention to detail, is well managed in hospice patients by understanding the etiology of constipation and using the combination of stool softeners and laxatives. However, there are those rare occasions where the constipation is intractable, and these methods are ineffective.

An article, “Rapid Relief of Opioid-Induced Constipation with MNTX”, that was published in Medscape Palliative Care section on November 20, 2020, looked at two studies (see link below-note researchers’ commercial relationships) of patients with OIC. Of the peripherally acting μ-opioid receptor agonists on the market, Relistor (methylnaltrexone) is the only one available as an injectable form. This can be of significant benefit for those patients experiencing nausea and vomiting related to their severe constipation. According to the study, approximately 50% of patients responded within 30 minutes of injection.

While the utilization of a peripherally acting μ-opioid receptor agonist may be warranted where opioids are the cause of constipation, if relief does not occur within 3 days (3 doses) then traditional stool softener/laxative therapy should be reinstated.

DOSING AND PRICING:

- **Relistor (methylnaltrexone)**
  - 450mg (150mg tabs x3) once daily – 9 tablets=$240
  - 8mg subq once daily – 3 doses=$460
  - 12mg subq once daily – 3 doses = $470
- **Movantic (naloxagol)**
  - 12.5 mg tablet once daily – 3 tablets=$60
  - 25mg tablet once daily – 3 tablets=$60
- **Symproic (naldemedine)**
  - 0.2mg tablet once daily – 10 tablets=$140

https://www.medscape.com/viewarticle/941332

REGULATORY CENTER

EXTRAORDINARY CIRCUMSTANCES AS RELATED TO HOSPICE STAFFING REQUIREMENTS

CMS issued a memo in early October of this year addressing the potential nursing shortage as a result of COVID-19 and how hospices may supplement nursing staff. The following is a summary of that memo.

Findings from the Bureau of Labor Statistics continue to forecast a shortage of nurses through 2024 with a job growth rate that is faster than the average. In isolated instances, a hospice agency may find that this shortage of nurses creates a temporary impact on its ability to provide nursing services to patients and as a result may create an access to care concern for hospice beneficiaries.

The regulation allows the hospice to use contract staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances without a waiver or exemption from the State Survey Agency (SA) or CMS Location.

- A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. The regulation allows the hospice to utilize these services temporarily without a waiver or exemption from the State Survey Agency (SA) or the CMS Location.

- Compliance Determination: CMS is updating previous guidance that the hospice agency must notify the CMS of its use of contracted staff during extraordinary circumstances and submit justification for such use to its SA or CMS Location. This notification/justification is not required by 42 CFR 418.64. Compliance with the regulation for use of contracted staff is reviewed as a part of the routine survey process.

- Hospice Responsibility: When contract services are utilized, the hospice agency maintains all professional, financial, and administrative responsibility for the services.

- This policy memorandum supersedes previously issued SC17-01-Hospice

Updated December 2020

DRUG SHORTAGE LIST

- **Albuterol (MDI)** — **10/7/20**
- **Atropine (Inj/Opth)** — **10/26/20**
- **Azithromycin (Inj)** — **10/5/20**
- **Dexamethasone (Inj)** — **10/13/20**
- **Dicyclomine (oral)** — **10/1/20**
- **Doxycycline Hyclate** (Inj) — **10/26/20**
- **Enoxaparin** (Inj) — **6/5/20**
- **Fluticasone (Inhale)** — **10/8/20**
- **Famotidine** (Inj/Tabs) — **10/5/20**
- **Fentanyl** (Inj) — **9/9/20**
- **Furosemide** (Inj/Oral) — **10/5/20**
- **Heparin** (Inj) — **9/18/20**
- **Hydromorphone** (Inj) — **8/12/20**
- **Hyoscyamine** (Inj) — **8/4/20**
- **Ketamine** (Inj) — **9/7/20**
- **Ketorolac** (Inj — **10/26/20**
- **Levetiracetam** (Inj/Tablets) — **10/1/20**
- **Lorazepam** (Inj/Oral) — **8/27/20**
- **Losartan** (Tabs) — **10/15/20**
- **Methadone** (Inj) — **10/13/20**
- **Midazolam** (Inj) — **9/26/20**
- **Morphine** (Inj/PCA vials/IR/tabs) — **9/7/20**
- **Nitrofurantoin** (Suspension) — **10/15/20**
- **Octreotide** (Inj) — **9/22/20**
- **Ondansetron** (HCL (Inj) — **8/12/20**
- **Pantoprazole** (Inj) — **10/28/20**
- **Phenytoin (Inj)** — **10/14/20**
- **Prednisone** (Tablets) — **10/7/20**
- **Prochlorperazine** (Tablets) — **10/30/20**
- **Promethazine** (Inj) — **9/24/20**
- **Sertraline** (Tablets) — **9/18/20**
- **Temazepam** (Capsules) — **7/9/20**
- **Tramadol** (Tablets) — **8/7/20**
- **Valsartan** (Tablets) — **9/10/20**
- **Vancomycin HCL** (Inj) — **10/12/20**
- **Venlafaxine HCL** (Tablets ER) — **10/7/20**
- **IVBags/Solutions** (various) — **10/9/20**