New changes to Star Ratings will affect the way you practice.

Dear Pharmacist:

Why do Star Ratings matter? Think of Star Ratings as similar to Consumer Reports or Yelp for Medicare Part D and Advantage plans. Higher ratings suggest better quality...and more perks for plans, such as possible bonus payments or year-round open enrollment. On the other hand, CMS may drop plans with < 3 stars for 3 years in a row.

CMS doesn’t give Star Ratings to pharmacies...only to health plans. But the plans know they need you to improve their ratings. If your pharmacy helps boost plan ratings, it may be chosen for preferred networks...so your patients have lower co-pays. Plus pay-for-performance programs mean your pharmacy may get paid for good care.

And your performance reviews or bonuses may hinge more on quality. What are key Star Ratings quality measures? Plans are now rated on how many eligible patients get a comprehensive med review (CMR). Also continue to focus on adherence to diabetes meds, statins, and ACEIs or ARBs.

But measures can be moving targets. For example, watch for high-risk meds in the elderly. But this might be removed for 2017 ratings, since med use must be individualized. The measure for use of an ACEI or ARB in diabetes patients with hypertension is now retired...due to updated hypertension guidelines. For 2018 ratings, a NEW measure will likely be statin use in diabetes patients age 40 to 75. Star Ratings are based on data from 2 years prior...so what you do NOW will impact 2018 scores.

How can you impact Star Ratings? Start small, and use our new PL Conversation Starter to maximize each patient visit. Investigate poor adherence...use motivational interviewing...or try med sync if possible.

Divide, conquer, and empower. Techs or students can help schedule CMRs, fax prescribers, document and bill on MTM platforms, etc.

Break tasks into chunks. Get med lists when scheduling CMRs...prioritize problems during the CMR...and resolve them during follow-up.

See our PL Toolbox, Quality Measures for Pharmacies...use our PL Fax Letters to reach out to prescribers...and give your techs our Technician Tutorial, Mastering Med Lists, so your techs can help you with CMRs.

NALOXONE

The new Narcan nasal spray will lead to more emphasis on providing naloxone to patients at risk of opioid overdose.

Over 40 Americans die from Rx opioid overdoses every day...and heroin overdose deaths have more than tripled since 2010.

Having naloxone on hand can save a life in an opioid overdose. Recommend naloxone for opioid patients at risk. For example, look
for patients taking high doses...switching opioids...combining opioids
with benzos or alcohol...or with respiratory conditions (COPD, etc).
Help sort through naloxone options. Explain that Narcan nasal
spray does NOT need to be inhaled...and the Evzio auto-injector
“talks” the user through the injection.
Also consider preparing naloxone rescue kits. For IM use,
include naloxone 0.4 mg/mL vials plus 2 syringes. For intranasal,
use 2 mg/2 mL naloxone prefilled syringes plus 2 atomizers.
A naloxone rescue kit may cost about $50...compared to $125 for
Narcan nasal spray and $750 for Evzio. Most payers will cover some
form of naloxone...but help with switches or prior auths if needed.
Emphasize calling 911...even if naloxone is given. Naloxone only
lasts about 30 to 90 minutes...so symptoms can return after it wears off.
Increase access to naloxone. Reach out to prescribers for an Rx...
and know your state laws.
You may hear naloxone doesn’t need an Rx in some states. But a
standing order or agreement with a prescriber is usually still required.
For more ways you can reduce deaths due to opioid overdose, see
our PL CE LIVE Archived Webinar: Overdose Prevention With Naloxone...our
PL Detail-Document, Naloxone for Opioid Overdose: FAQs...and PL Toolbox,
Appropriate Opioid Use.320102

TOPICAL NSAIDS

We’re getting more questions about using TOPICAL NSAIDs for pain. NSAID safety warnings and concerns about opioid abuse and
misuse leave limited options for treating pain.
Topical NSAIDs are often thought to be safer than orals...since they generally have < 10% systemic absorption compared to orals.
Topicals seem to cause fewer GI adverse effects. But it’s too soon to say they’re clearly safer from a CV or renal standpoint.
They also have the same boxed warnings as orals.
Explain topical NSAIDs may work as well as oral NSAIDs for knee or hand osteoarthritis and acute sprains or strains. But there’s not enough evidence they work for low back pain or neuropathic pain.
Consider a topical NSAID if pain is localized and the patient can afford it. But try to avoid any NSAID in patients at high GI and CV risk.
Educate on proper use, and warn not to use longer than needed.
If appropriate, suggest Rx diclofenac solution (Pennsaid, etc) or gel (Voltaren) for osteoarthritis...or patch (Flector) for acute pain.
The solution has dimethyl sulfoxide (DMSO) to improve penetration. But DMSO may cause more local side effects and garlicky breath.
Expect high price tags. Pennsaid 2% costs about $1500/month for one knee...versus about $300 for the generic 1.5% solution or the gel.
Some pharmacies compound topical NSAIDs...ketoprofen, piroxicam, ibuprofen, etc. Many patients swear they help.
Disourage using topical PLUS oral NSAIDs...the combo doesn’t seem to work better than orals alone and may increase the risk of side effects. Advise patients to skip applying the topical if they need to take an oral NSAID for a headache or other ailment.
See our new PL Chart, Topicals for Pain Relief, for more on the role of other topicals such as lidocaine, capsaicin, arnica, etc.320103

HYPERTENSION

You’ll hear controversy about whether it makes sense to aim for a LOWER systolic blood pressure in hypertensive patients.
Recent guidelines recommend aiming for more relaxed BP goals, such as a systolic < 150 mmHg in patients 60 and older instead of
< 140 mmHg...due to lack of evidence that lower is better.

But the new SPRINT trial suggests that a lower systolic BP may be better for some patients...including those over age 75.

For example, aiming for a systolic < 120 instead of < 140 prevents one more CV event for every 185 patients with CV risks treated/year.

But this benefit may not apply to many of your patients.

For example, it’s too early to say if patients with diabetes, heart failure, or previous stroke benefit from a systolic < 120.

Plus lower goals can be difficult to reach...and can lead to hypotension, electrolyte problems, and bumps in serum creatinine.

Suggest individualizing BP goals based on med tolerability, adherence, cardiovascular risk, comorbidities, etc.

In general, recommend sticking with current guidelines for BP goals. Suggest aiming for < 140/90 in most patients, including those with diabetes or kidney disease...or < 150/90 in those 60 and older.

But be open to a systolic goal closer to 120 in some patients.

For example, consider a lower systolic goal for patients with a previous heart attack or chronic kidney disease...IF they can tolerate higher doses or adding meds to reach the goal.

To hear our team discuss BP goals and measurement with a study author, go to our PL Detail-Document and listen to PL VOICES.

Also see our PL Patient Education Handout, Blood Pressure Meds and You, for counseling tips...and our PL Algorithm, Stepwise Treatment of Hypertension, for help recommending BP meds.\textsuperscript{120104}

**HEPATITIS C**

More hepatitis C patients will now be treated...due to updated guidelines and a push for fewer payer restrictions.

Most patients will be on one or two of the new oral meds, Daklinza (daclatasvir)...Harvoni (ledipasvir/sofosbuvir)...Olysio (simeprevir)...Sovaldi (sofosbuvir)...Technivie (ombitasvir/paritaprevir/ritonavir)...or Viekira Pak (ombitasvir/paritaprevir/ritonavir and dasabuvir).

Expect most patients to be treated for 12, 16, or 24 weeks...often based on whether they have cirrhosis or have been treated before.

The choice of therapy will usually come down to hep C genotype...which meds the payer prefers...and interactions.

Genotype. All of the new meds are effective for the most common genotype 1...except Technivie, which only covers genotype 4.

Combination therapy. These meds are often used with each other...or with ribavirin. For example, expect Sovaldi to usually be added if Daklinza or Olysio is used...and Sovaldi combos to sometimes include ribavirin.

Explain Harvoni rarely requires add-on meds.

Cost. Harvoni costs about $95,000 per 12-week course.

But the cost of therapy with combos adds up. For example, the combo of Sovaldi plus Olysio or Daklinza is around $150,000 for 12 weeks...and Viekira plus ribavirin is about $85,000 for 12 weeks.

See our PL Chart, Helping Patients Afford Meds, to help with costs.

Interactions. Watch for a plethora...especially with Technivie or Viekira. They contain ritonavir, which interacts with many drugs.

For example, avoid Technivie, Viekira, or Olysio with 3A4 INDUCERS (phenytoin, etc)...and Olysio with 3A4 INHIBITORS (clarithromycin, etc).

Also avoid rosuvastatin with Harvoni...and simvastatin or lovastatin with Technivie or Viekira.

Point out that acid reducers can decrease Harvoni’s absorption.

If one is needed, limit doses to omeprazole 20 mg/day, famotidine 40 mg BID, etc...and suggest separating antacids from Harvoni by 4 hours.

Emphasize adherence to boost cure rates and limit resistance.

See our PL Detail-Document for specific hep C regimens, side effects, monitoring, and more.\textsuperscript{120105}
CARDIOLOGY

We’re getting questions about the efficacy of long-term clopidogrel (Plavix, etc)...due to a new report from FDA.

This started because of a study suggesting that coronary stent patients taking clopidogrel plus aspirin have a higher risk of death.

The good news is that this risk doesn’t pan out when data from several trials are combined.

But using clopidogrel plus aspirin for 12 months or more doesn’t reduce mortality compared to using this combo for 6 months or less.

Reassure stent patients that clopidogrel is still an important heart med...and stopping it too soon increases CV risk.

You may hear that Brilinta (ticagrelor) or Effient (prasugrel) plus aspirin are more effective.

It’s true...these combos prevent one more CV event for every 50 stent patients treated for one year versus clopidogrel plus aspirin.

But don’t expect most patients on clopidogrel to switch.

Brilinta is BID...and it may cause shortness of breath.

And Effient causes more bleeding. Avoid it in patients with a history of stroke or TIA...and those who are underweight or over age 75.

Plus Brilinta or Effient cost about $300/month...compared to less than $10 for clopidogrel.

Watch for new guidelines that will help clarify the duration of dual antiplatelet therapy in the next few months. And continue to advise stent patients to use low-dose aspirin indefinitely.

To hear our team debate the pros and cons of antiplatelet combos, go to our PL Detail Document and click on PL VOICES.

See our PL Patient Education Handout, Why It’s Important to Take Your Blood Thinning Meds, for tips on adherence, missed doses, etc.

QUINOLONES

You’ll see more emphasis on limiting the use of quinolones.

It’s coming from more concerns about “collateral damage” leading to resistance...and warnings of tendon rupture, peripheral neuropathy, etc.

Watch for conditions where it may be best to bench quinolones.

Urinary tract infections. Recommend nitrofurantoin or trimethoprim/sulfamethoxazole (TMP/SMX) for most UNcomplicated UTIs.

Nitrofurantoin used to be discouraged in renal insufficiency...but the new thinking is that it’s safe and effective if CrCl ≥ 30 mL/min.

Also expect to see a cephalosporin (cephalexin, etc) or Monurol (fosfomycin) sometimes used...depending on the bug causing the UTI.

Suggest saving quinolones (ciprofloxacin, etc) for COMPLICATED UTIs when appropriate...such as patients with obstruction (kidney stones, etc).

Acute sinusitis. Advise avoiding antibiotics altogether if possible...since over 90% of sinusitis cases are viral.

Suggest antibiotics only for patients with symptoms for at least 10 days without improvement...or severe symptoms such as fever ≥ 102°F.

If antibiotics are appropriate, recommend amoxicillin/clavulanate in most patients...or doxycycline for patients allergic to penicillin.

Acute exacerbations of chronic bronchitis. In general, recommend saving antibiotics for COPD patients with severe exacerbations.

If an antibiotic is needed, recommend amoxicillin/clavulanate, azithromycin, or doxycycline for most patients.

Suggest saving respiratory quinolones (levofloxacin, etc) for complicated patients...frequent exacerbations, over age 65, etc.

To hear our team discuss the appropriate role of fluoroquinolones, go to our PL Detail-Document and click on PL VOICES.

And get our PL Toolbox, Antimicrobial Stewardship, for handouts, posters, and more to increase awareness.
VACCINES

Patients may ask you whether statins reduce flu vaccine efficacy. This stems from new data suggesting that seniors taking a statin have a lower immune response to the inactivated trivalent flu vaccine. Plus other evidence suggests that statin patients vaccinated against flu have more respiratory illness.

The theory is that statins may have anti-inflammatory and immunomodulatory effects...blunting the response to the flu vaccine.

But reassure statin users that they are still protected by the flu vaccine...and the vaccine is still the best way to avoid getting the flu. Advise patients NOT to stop the statin, even temporarily, just because they’re getting the flu vaccine. Some data actually link statin use with REDUCED flu mortality.

Explain that it’s too early to say if statins affect the immune response of nasal, quadrivalent, or high-dose vaccines.

See our PL Chart, Flu Vaccines for 2015-2016, for more on vaccine formulations and dosing recommendations.

ASTHMA

More children will get just ONE or TWO doses of dexamethasone for asthma exacerbations.

We’re seeing a shift away from the typical 3- to 5-day course of prednisone or prednisolone to a 1- to 2-day course of dexamethasone. Dexamethasone is longer acting...and may cause less vomiting. Plus new evidence suggests that a SINGLE dose of dexamethasone seems to improve acute asthma symptoms and prevent hospitalization as well as a 3-day course of prednisolone.

In kids with mild to moderate exacerbations, consider suggesting dexamethasone...especially if adherence or tolerability is a concern. Be prepared for these Rxs by having dexamethasone on hand. Recommend 0.3 or 0.6 mg/kg orally once daily for 1 or 2 days, up to a max of 16 mg/dose...or as one IM dose. For kids who can’t swallow tabs, recommend crushing and mixing them with chocolate pudding or applesauce to help mask the bitter taste. Or suggest dexamethasone 1 mg/mL concentrated solution. Discourage the 0.5 mg/5 mL liquid...due to the large volume.

CONTRACEPTION

Women will ask you if they’re “too old” to take hormonal contraceptives...and when they should stop.

We know that combo OCs can prevent pregnancy in women over 40. And they may also help with vasomotor symptoms (hot flashes, etc). In many perimenopausal women, feel comfortable suggesting a combo OC...and lean toward one with 20 mcg of ethinyl estradiol. If needed, suggest extended- or continuous-cycle OCs to limit hormone-free days. But discourage using combo OCs, the patch, or ring in women over 35 with thrombosis risk factors...smoking, hypertension, etc.

Instead, suggest an IUD (Mirena, etc) or implant (Nexplanon). These are safer in most high-risk women...and have the best efficacy. Dispel myths that hormonal contraceptives speed up or slow down menopause. But be aware some may cause withdrawal bleeding or amenorrhea...making it hard to know when menopause has occurred.

In general, suggest stopping hormonal contraception by age 55...most women have gone through menopause by then.

Or advise women over 50 to switch to a NON-hormonal method...then stop a year after their last period, when menopause can be assumed.
See our PL Chart, Comparison of Contraceptives, to sort through the options...and our PL CE, Choosing Wisely: Contraception.\textsuperscript{120110}

**DIABETES**

Tresiba (treh-SEE-bah, insulin degludec) is a new once-daily ULTRA long-acting insulin.

It lasts about 42 hours...compared to about 24 hours for Lantus or Levemir and a little over 24 hours for Toujeo.

You may hear that Tresiba’s longer duration means it doesn’t need to be used at the same time every day.

But this isn’t necessarily a benefit since it may impact adherence. Explain that Tresiba’s long duration doesn’t seem to lead to “dose stacking” or accumulation...including in patients with renal impairment.

Tresiba lowers A1C about the same as Lantus...and has a similar overall risk of hypoglycemia.

Tresiba 50 units/day costs about $450/month...compared to $400 or less for Lantus, Levemir, or Toujeo...or as little as $25 for NPH.

Don’t expect Tresiba to have much benefit over other longer-acting insulins...including NPH. Point out there ISN’T a big difference in most outcomes between NPH and Lantus or Levemir in most type 2s.

Suggest saving Tresiba if a true once-daily insulin is needed...such as patients who need over 80 units/injection of Lantus, Levemir, or Toujeo pen. The Tresiba 200 unit/mL pen delivers up to 160 units/dose.

Advise patients to try to use Tresiba at the same time each day.

Look for Basaglar, a new, potentially less costly version of insulin glargin, in about a year. It’ll be similar to Lantus.

Get our PL Charts, How to Switch Insulin Products and Comparison of Insulins, to help select insulin.\textsuperscript{320111}

Happy New Year,

Jeff M. Jacob

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