



UPDATE

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Attention: Update Subscribers!

This will be the last copy of the Update mailed to subscribers. If you would like to receive the e-mail newsletter **OR** if you are unable to access the **UPDATE** electronically and need to continue to receive a hard copy of the Update through the U.S. Mail, please let us know.

Just e-mail Carol Scott:
[carol.scott@
amedd.army.mil](mailto:carol.scott@amedd.army.mil)

OR call:
DSN: 421-1271
Commercial:
(210) 295-1271

The UPDATE Goes Electronic!

Editor's Note: My apologies for the hiatus in publication (the PEC has been exceptionally busy over the last few months!) Hopefully the **UPDATE** will return better than ever. For one thing...

We've killed enough trees!

With this issue, we are going to an e-mail newsletter containing article summaries and links to the **UPDATE** on the website. We will maintain our archive of old issues on the website. In addition, we plan to post a downloadable version of the **UPDATE** in Adobe Acrobat (pdf) and/or Microsoft Word format on the website as well, either of which should print out better than the pages on the website. By distributing the **UPDATE** in this way, we hope to accomplish several objectives:

- Make it easy for you to pass the newsletter along to pharmacy personnel, your provider community, and other interested parties. Please disseminate as widely as possible!
- Make it easy for you to adapt articles from the **UPDATE** for use in MTF newsletters and other documents.
- Work around the size restrictions placed on a paper publication. In many cases, we've had much more to say on a given topic than could be easily crammed into 6 to 8 pages... (...thus the **TINY** font sizes...!)
- Encourage feedback and contributions to the PEC newsletter from the field. If you have practice guidelines, drug utilization reviews, research findings, in-services, newsletter articles, tricks, tips, or techniques that you would like to share with the DoD pharmacy community, please contact the editor or any member of the PEC.

In this issue, the PEC is pleased to present an article by Jill Yanchick, Pharm.D., Reynolds Community Hospital, Ft. Sill, Oklahoma, which summarizes the recently released *DoD/VA Clinical Practice Guideline for Asthma Management in the Primary Care Setting*.

Shana Trice, Pharm.D.
UPDATE Editor
shana.trice@amedd.army.mil
DSN: 421-9551
Commercial: 210-295-9551

Highlights of the DoD Pharmacy & Therapeutics Committee Meetings

11 May 00, 24 Feb 00, & the 26 Jan 00 Interim Meeting

BCF Additions

All MTFs must have the following drugs/drug classes on their formularies

Added 26 Jan 00

- Metformin
- Tamoxifen
- Alendronate
- Citalopram
- Fluoxetine
- Paroxetine
- Sertraline
- Sumatriptan autoinjector

At least one agent from each of the following classes:

- Oral serotonin 5-HT₁ receptor agonists (naratriptan, rizatriptan, sumatriptan, zolmitriptan)
- Low molecular weight heparins/heparinoids (ardeparin, dalteparin, danaparoid, enoxaparin)
- Leukotriene antagonists (montelukast, zafirlukast, zileuton)
- Second-generation antihistamines (cetirizine, fexofenadine, loratadine)

Added 11 May 00

- Brimonidine ophthalmic solution
- Metronidazole vaginal gel
- Ethinyl estradiol 30 mcg/1.5 mg norethindrone (Loestrin FE 1.5/30)
- Ethinyl estradiol 35 mcg/1 mg ethynodiol diacetate (e.g., Demulen, Zovia)
- 0.35 mg norethindrone (e.g., Micronor, Nor-Q.D.)
- Extended release morphine (MS Contin or its AB-rated generic only) 15-, 30-, and 60-mg tablets [does not include 100- or 200-mg tablets of MS Contin and does not include other extended release morphine products (e.g., Oramorph SR or Kadian)]

BCF Deletions

MTFs may remove these drugs from their formularies if they so desire

Removed 24 Feb

- Dipivefrin ophthalmic solution (Propine)

Removed 11 May 00

- Betaxolol Ophthalmic Suspension
- Dorzolamide Ophthalmic Solution
- Pilocarpine Ophthalmic Gel

BCF Clarifications

Oxycodone/acetaminophen: the BCF listing for "oxycodone 5 mg /acetaminophen 325 and 500 mg" was clarified to specify that MTFs must have the 5/325 and 5/500 mg strengths of oxycodone/acetaminophen on their formularies but are not required to have the 2.5/325, 7.5/500, and 10/650 strengths.

Minutes available on the PEC website at www.pec.ha.osd.mil (click on DoD P&T Committee)

IN THIS ARTICLE, we attempt to catch up with news from the last two scheduled meetings of the DoD P&T Committee and the interim meeting in Jan 00.

The next meeting of the committee is scheduled for 17 Aug 00. Items for committee consideration should be sent to the PEC by 17 Jul 00.

Highlights of the DoD Pharmacy & Therapeutics Committee Meetings

11 May 00, 24 Feb 00, & the 26 Jan 00 Interim Meeting

Drugs added to the Basic Core Formulary as a result of additional funding related to Program Budget Decision (PBD) 041:

At the January interim meeting, the DoD P&T committee added eight new drugs to the Basic Core Formulary (BCF) and required the addition of at least one agent in four additional classes, as a result of the availability of additional funding for DoD pharmacy. These drugs should now be on all MTF formularies.

In addition, another six agents were added to the BCF at the 11 May meeting and a total of four drugs were removed from the BCF in February and May. See Page 2 for a summary of all BCF changes from the January, February, and May meetings.

Drug Fact Sheets for the oral serotonin 5-HT₁ receptor agonists, LMWHs, leukotriene antagonists, and second-generation antihistamines were distributed to the field in March 00. The fact sheets are archived on the PEC website at www.pec.ha.osd.mil/Drug_Facts.htm.

Advances in Medical Practice (AMP) program:

The committee also selected a list of newly approved, high-cost drugs for reimbursement to MTFs under the AMP program. The list is available as part of the Feb 00 meeting minutes.

Niaspan: The discussion concerning potential addition of the extended release niacin product Niaspan (Kos Pharma) to the BCF concluded in May, when the committee decided that Niaspan does not offer sufficient clinical advantage over immediate release niacin to justify the large increase in cost.

Nasal Corticosteroids: A long-standing item on the agenda regarding the BCF selection for nasal corticosteroids was closed in May after the committee reviewed an analysis of MTF prescription data in order to more closely estimate the relative cost effectiveness of fluticasone and mometasone nasal sprays. Based on prescription directions, the analysis showed a weighted average of 3.57 sprays per day for fluticasone nasal spray and 3.95 sprays per day for mometasone nasal spray. Given the current DAPA prices of \$11.12 per fluticasone inhaler and \$10.49 per mometasone inhaler, fluticasone is still slightly more cost-effective than mometasone.

Since mometasone does not offer any advantage in cost-effectiveness and expert opinion did not indicate the necessity for selecting more than one agent for the BCF in this drug class, the committee decided that fluticasone should remain the only nasal corticosteroid inhaler on the BCF.

Oral Contraceptives: A review of oral contraceptives on the BCF was completed in May, with the assistance and input of a broad spectrum of MTF providers. The review resulted in the addition of three oral contraceptive products to the BCF.

- ❖ Ethinyl estradiol (EE) 30 mcg/1.5 mg norethindrone (Loestrin FE 1.5/30) was added to the BCF as an alternative to EE 30 mcg/0.3 mg norgestrel (e.g., Lo/Ovral, Low-Orgestrel) that offers a significant economic advantage. The current cost per cycle (DAPA as of May 00) for both Lo/Ovral and Low-Orgestrel is \$8.00, while the cost per cycle for Loestrin FE 1.5/30 is \$2.00.
- ❖ EE 35 mcg/1 mg ethynodiol diacetate (e.g., Demulen, Zovia) was added to the BCF because it is a clinically useful alternative for patients with acne, according to military providers. The DAPA price of this combination is less expensive than other combinations touted for use in acne.
- ❖ 0.35 mg norethindrone (e.g., Micronor, Nor-Q.D.) was added to the BCF for women who require a progestin-only oral contraceptive product.

The additions bring the number of oral contraceptive products on the BCF to seven. The committee also recommended that Defense Supply Center Philadelphia (DSCP) explore selection of specific brands for the BCF, using a contracting initiative or other mechanism, in the following specific combinations that are 1) on the BCF and 2) for which more than one brand is available.

- ❖ 35 mcg EE/1 mg norethindrone combination (e.g., Necon, Norinyl, Ortho-Novum)
- ❖ EE 35 mcg/1 mg ethynodiol diacetate (e.g., Demulen, Zovia)
- ❖ EE 30/40/30mcg/levonorgestrel 0.05/0.075/0.125 mcg (e.g., Tri-Levlen, Triphasil, Trivora)
- ❖ 0.35 mg norethindrone (e.g., Micronor, Nor-Q.D)

The committee initially decided to remove one oral contraceptive product, Ortho-Novum 7/7/7, from the BCF due to its relatively high cost through the prime vendor system (\$15.78) and the availability of another BCF selection in the tricyclic class. However, the decision was suspended by co-chairs following the meeting when they became aware of the product's continued availability through the DSCP depot program at a lower cost (about \$5.56, including surcharge). The

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Highlights of the DoD Pharmacy & Therapeutics Committee Meetings

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DSCP product manager anticipates that Ortho-Novum 7/7/7 will continue to be available through the depot until at least 2002. Approximately 63% of purchases of Ortho-Novum 7/7/7 (excluding direct purchases for which no data are available) are made through the depot.

A list of oral contraceptives and their DAPA prices are included as an appendix to the minutes of the May meeting.

Ophthalmic Glaucoma Agents: The committee made several changes in the category of ophthalmic glaucoma agents at the February and May meetings. The committee removed dipivefrin ophthalmic solution (Propine, generics), betaxolol ophthalmic solution (Betoptic S), dorzolamide ophthalmic solution (Trusopt) and pilocarpine ophthalmic gel (Pilopine HS) from the BCF. Brimonidine ophthalmic solution (Alphagan) was added to the BCF.

The net result of the changes is a total of three ophthalmic glaucoma agents on the BCF following the May meeting: timolol ophthalmic solution, brimonidine ophthalmic solution and pilocarpine ophthalmic solution. These drugs were recommended by a group of glaucoma experts from all three services as the minimum core group of medications for MTF formularies. The consultants noted that, depending on their provider base, MTFs might need to carry or continue to carry additional ophthalmic glaucoma agents on their formularies. A summary of the review and recommendations are included as an appendix to the minutes of the May meeting.

As has been the case in the past, the BCF listing for timolol does not include timolol gel-forming solution (Timoptic XE, generics). The consultants felt that it was not necessary to require MTFs to have the gel-forming solution on their formularies in addition to regular timolol solution, although MTFs are free to do so. Although there are DoD/VA mandatory source contracts for both timolol solution and timolol gel-forming solution, these contracts do not mandate BCF status.

Morphine Sulfate Extended Release: Due to an MTF request to address chronic pain medications on the BCF, the committee added morphine sulfate extended release 15-, 30-, and 60-gm tablets (MS Contin or its AB-rated generic only). The BCF listing does not include the 100- or 200- mg strengths of MS Contin and does not apply to other extended release morphine products (e.g., Oramorph SR, Kadian), although MTFs may add these agents to their formularies if they so desire.

Metronidazole Vaginal Gel: The committee added metronidazole vaginal gel to the BCF. Clindamycin vaginal cream remains on the BCF. The decision was primarily due to the recommendations of the 1998 Guidelines for Treatment of Sexually Transmitted Diseases from the Centers for Disease Control and Prevention (CDC) for the treatment of bacterial vaginosis (BV), which state “the use of clindamycin vaginal cream during pregnancy is not recommended, because two randomized trials indicated an increase in the number of preterm deliveries among pregnant women who were treated with this medication.” Metronidazole vaginal gel was added to the BCF to provide a topical treatment option for this patient population. Please see the boxed discussion on Page 5 for a short discussion of the CDC recommendations and the relative cost of oral and topical treatments for BV.

Quantity Limits: Prescription quantity limits applying to the National Mail Order Pharmacy (NMOP) and the retail network were finalized at the May meeting and are posted on the PEC website. The committee noted that the quantity limits have been loaded into the Pharmacy Data Transaction Service (PDTs) and have the potential to affect MTFs as PDTs implementation occurs.

Prior Authorization Forms and Criteria: As discussed at the February meeting, prior authorization forms (for the NMOP) and prior authorization criteria (applying to both the NMOP and retail network) are now on the PEC website. The forms may be filled out by providers and given to patients to be mailed to the NMOP along with the prescription, thus avoiding delay and phone calls to the prescriber. *The forms are not meant to be faxed to the NMOP prior to submitting a prescription.* As agreed at the May meeting, the PEC is revising the forms to include educational /explanatory material detailing the underlying rationale for the prior authorization.

Prior Authorization Criteria for COX-2 inhibitors: The prior authorization criteria for the COX-2 inhibitors were changed at the February meeting to eliminate the provision that patients who had received conventional non-steroidal anti-inflammatory drugs (NSAIDs) for the “last 40 of 60 days” were authorized to receive a COX-2 inhibitor. The committee agreed that there is not enough clinical evidence to justify use of a COX-2 inhibitor solely on the basis of recent use of a NSAID for the last 40 of 60 days.

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Highlights of the DoD Pharmacy & Therapeutics Committee Meetings

11 May 00, 24 Feb 00, & the 26 Jan 00 Interim Meeting

Prior Authorization for Terbinafine and Itraconazole for Onychomycosis: A prior authorization for terbinafine (Lamisil) and itraconazole (Sporanox) was instituted for the NMOP and the retail network. The prior authorization criteria will require the confirmation of an active fungal infection to ensure the clinical appropriateness of therapy for onychomycosis. The prior authorization criteria was broadened to include itraconazole as well as terbinafine because of information indicating that the majority of use of itraconazole in the NMOP and retail network is likely to be for the treatment of onychomycosis. The prior authorization does not apply to treatment of fungal infections other than onychomycosis.

The prior authorization form for the NMOP and the prior authorization criteria for the NMOP and retail network will be placed on the PEC website as soon as this prior authorization goes into effect.

Other Topics: Also discussed at the February and May meetings were the status of ACE inhibitors on the BCF, benefit coverage for fertility drugs, and the current status of national contracts and contracting initiatives. Please see the minutes for more detailed information. The cost avoidance slides presented at the meeting have been posted on the PEC website (www.pec.ha.osd.mil/national_pharm.htm) and will be kept updated on a routine basis.

CDC Recommendations for Treatment of Bacterial Vaginosis & Relative Cost of the Oral and Topical Treatments

Treatment of BV in non-pregnant women: For treatment of bacterial vaginosis (BV) in non-pregnant women, the CDC recommends oral metronidazole (7-day regimen), metronidazole vaginal gel, or clindamycin vaginal cream. The guidelines note that alcohol should be avoided during, and for 24 hours after, treatment with metronidazole and that clindamycin cream is an oil-based product that may weaken latex condoms and diaphragms.

Treatment of symptomatic BV in pregnant women at low risk for premature birth: For treatment of symptomatic BV in pregnant women at low risk for premature birth, the guidelines recommend treatment at the beginning of the second trimester with oral metronidazole (7-day regimen). Alternative treatments listed in the guidelines are oral metronidazole (single dose regimen), oral clindamycin, or metronidazole vaginal gel. The guidelines note that some experts prefer the use of systemic therapy for low-risk pregnant women to treat possible subclinical upper genital tract infections.

Treatment of BV in pregnant women at high risk for premature birth: For treatment of BV in women at high risk for premature birth, the CDC recommends oral metronidazole (7-day regimen), with oral clindamycin and the single dose regimen of oral metronidazole listed as alternatives. Oral metronidazole and oral clindamycin have been shown to reduce the risk of premature birth in high-risk women with BV. Clinical trials with clindamycin vaginal cream not only fail to show a decreased incidence of premature birth compared to placebo, but also demonstrate a non-significantly higher risk among women who received clindamycin vaginal cream. There are no trials with metronidazole gel in pregnant women.

Comparison of topical and oral treatments for BV: Clindamycin vaginal cream and metronidazole vaginal gel are similar in cost (approximately \$17-18 per course of treatment). Both are much more costly than oral metronidazole (less than \$1 per 7-day course of treatment). The topical treatments appear to be comparable in efficacy to oral metronidazole, with the differentiating factors being the greater incidence of systemic side effects and drug-alcohol interactions with oral treatment, the relative lengths of the regimens, and patient preference.

Reference: Centers for Disease Control and Prevention. 1998 guidelines for treatment of sexually transmitted diseases. MMWR 1998; 47(RR-1): 1-118. Available at: <http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/00050909.htm>.

Summary of the DoD/VA Clinical Practice Guideline for Asthma Management in the Primary Care Setting

Jillmarie Yanchick, Pharm.D., C.D.E.

Clinical Coordinator, Ambulatory Care Specialist, &
Director, Drug Therapy Monitoring Clinic, Department of Pharmacy/Primary Care
Reynolds Army Community Hospital, Ft. Sill, Oklahoma

Introduction

The DoD/VA guideline and algorithms summarized in this issue of the **UPDATE** were adapted and updated from the 1997 National Asthma Education and Prevention Program (NAEPP) Expert Panel Report 2. The guideline is available on the MEDCOM Quality Management Office website (www.cs.amedd.army.mil/Qmo/asthfr.htm) in both Adobe Acrobat (pdf) format or as web-navigable algorithms.

The guideline is divided into two main categories: adults and children 6 years of age and older who are able to perform spirometry and children under 6 years of age unable to perform spirometry. For each category, the following topics are addressed: initial diagnosis and management, follow-up, emergency management, and telephone triage. As a result, the guideline is comprised of a total of eight algorithms with accompanying annotations.

Initial Diagnosis & Management

KEY ELEMENTS

- ❑ Establish asthma diagnosis
 - Use spirometry
 - Use trial of medication
- ❑ Determine asthma severity and select appropriate treatment regimen
- ❑ Initiate collaborative patient education beginning with the first visit

Initial Assessment: The initial assessment of asthma should be based on common recurrent respiratory symptoms, patient history, and a focused physical exam.

Diagnosis: Diagnosis of asthma should be based on the patient's medical history, physical examination, previous and present pulmonary function tests, and other laboratory test results. If able, all patients should perform pre- and post-bronchodilator spirometry during the initial assessment of asthma in order to detect the presence of airflow obstruction, define the severity of airflow limitation, and aid in the differential diagnosis of asthma.

Reversible airway obstruction is defined as a FEV₁/FVC ratio < 0.7 (0.8 for children) and an FEV₁ greater than or equal to 12% after administration of an inhaled beta-2 agonist. If obstruction is present but does not reverse with bronchodilators, an improvement in FEV₁ ≥ 12% following a 4- to 6-week therapeutic trial of corticosteroids and PRN inhaled beta-2 agonists can be used to diagnose reversible airway obstruction. If spirometry is normal but clinical suspicion remains high, improvement following a 1- to 4-week trial of PRN inhaled beta-2 agonists can be used to diagnose reversible airway obstruction. However, failure to demonstrate a change with bronchodilators does not exclude a reversible component of airway obstruction.

A peak flow meter can be utilized instead of repeating second spirometry to assess response to therapeutic trials of medication. A ≥ 20% change in post-trial peak expiratory flow (PEF) values also supports the diagnosis of asthma.

Diagnosis of asthma in children who are unable to perform spirometry and who present with intermittent signs and symptoms is based on the results of a therapeutic trial of PRN inhaled beta-2 agonists. A short course of oral corticosteroids can be added if the patient fails to improve or does not respond to a beta-2 agonist PRN. For children presenting with persistent signs and symptoms, a 4- to 6-week trial of a controller asthma medication is added to the beta-2 agonists. Patients should then be reevaluated within 1-4 weeks to determine if treatment was effective.

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Treatment: Once diagnosed, asthma severity must be determined, any special circumstances (e.g., pregnancy) considered, and an appropriate medication regimen selected (see Table 1). Patients should be assigned to the highest asthma severity category for which sign/symptoms are present. Because asthma is highly variable, the general characteristics noted in Table 1 may overlap. An individual's severity classification may change over time.

Medications used to treat asthma fall into two general categories: quick relief medications (inhaled short-acting beta-2 agonists) and long-term control medications (inhaled corticosteroids, inhaled long-acting beta-2 agonists, leukotriene modifiers, theophylline, and oral corticosteroids). Please see Table 2 for estimated comparative daily dosages for low-, medium-, and high-dose regimens of inhaled corticosteroids in adults and children.

Education: Patients at any level of severity can have a mild, moderate, or severe exacerbation. Some patients with intermittent asthma may experience severe and life-threatening exacerbations separated by long periods of

Critical Educational Elements

- ❑ Demonstration of the proper technique for using metered dose inhalers (MDIs) and holding chambers (spacers)
- ❑ Basic pathophysiology of asthma
- ❑ Discussion of medications (therapeutic mechanism, indications and adverse effects)
- ❑ Early recognition and prompt treatment of asthma exacerbations
- ❑ Avoidance or control of important triggers
- ❑ A written *Asthma Action Plan*, including:
 - Current medication and dosages
 - Warning signs/symptoms of asthma exacerbations
 - Instructions for use of asthma medications during exacerbations
 - Instructions (including telephone numbers) for when and whom to call
- ❑ Other instructions, including environmental management and school/day care action plans
- ❑ For patients with persistent asthma, diaries that include symptoms, medications used, and outcomes may be useful.

normal lung function and no symptoms. Collaborative, ongoing patient education beginning with the first visit is essential for successful management of asthma patients.

Follow-up

KEY ELEMENTS

- ❑ Classify severity
 - Use NHLBI standards
 - Use objective measures (peak flow or spirometry)
 - Use patient report of symptoms
- ❑ Treat based on severity using stepcare approach
 - Provide/adjust quick relievers and long-term controllers to attain optimal functioning
 - If use of short-acting inhaled beta-2 agonist increasing, consider intensifying long-term controller therapy
- ❑ Educate patients to manage own care:
 - Understand role of quick relievers and long-term controllers
 - Self-monitor using peak flow meters
 - Recognize signs/symptoms of worsening asthma
 - Know when to call provider
- ❑ Provide and/or reinforce use of written action plan
- ❑ Assess triggers and plan environmental controls with patient
 - Vaccinate for influenza, pneumococcus
 - Smoking cessation counseling for patient and family

After initial diagnosis, patients should be followed-up within 2 to 4 weeks. Each follow-up visit should include a focused physical exam and an interim history addressing exacerbations, hospitalizations, missed school or work days, triggers, PEF values, co-morbidities, aggravating factors, medication adherence and adverse effects. In addition, quality of life should be assessed, asthma severity determined, and educational objectives addressed at each visit.

Daily use or increasing use of a short-acting inhaled beta-2 agonist indicates the need for intensification of long-term controller therapy.

Reassessment of educational objectives at every office visit is critical. At a minimum, education should include a demonstration of techniques for the proper use of inhalers, holding chamber/spacers, and peak flow meter; reinforcement of the asthma action plan; recognition of symptom patterns, avoidance of triggers; discussion of medication; and asthma diary documentation.

Emergency Management

KEY ELEMENTS

- ❑ Initial objective assessment using:
 - Pulse oximetry
 - PEF or FEV-1
- ❑ Treat promptly using:
 - Corticosteroids
 - Beta-2 agonists
- ❑ Assess response to treatment using objective measures:
 - Resolution of signs/symptoms **AND**
 - Maintenance of PEF $\geq 70\%$ of the predicted value or the patient's best value for at least 1 hour (adults). For children, a SaO₂ of $\geq 94\%$ may be used in place of PEF.
- ❑ Discharge with appropriate education, including a written action plan
- ❑ Schedule for follow-up within 7 days

Pulse oximetry should be performed in patients presenting with an acute exacerbation. If the patient is clinically able to do so, peak flow or spirometry can also be performed. The severity of the exacerbation should be assessed based on signs, symptoms, and functional assessment. Inhaled beta-2 agonists and systemic corticosteroids continue to be the mainstay of drug therapy for acute exacerbations; however, addition of anticholinergics in select patients may also be effective.

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The patient may be discharged home after signs and symptoms have resolved and a PEF $\geq 70\%$ of the predicted value or the patient's best value has been

maintained for at least 1 hour. For children, a SaO₂ of $\geq 94\%$ may be used in place of PEF. All patients should be given education, a written action plan and be scheduled for follow-up within 7 days.

Telephone Triage

KEY ELEMENTS

- ❑ Assess severity of the exacerbation
- ❑ If symptoms indicative of severe exacerbation, refer for emergency management
- ❑ If patient has a written action plan and medication at home, instruct patient to follow the action plan
- ❑ Review action plan with patient

The telephone triage algorithms are intended for patients calling health care providers with complaints indicative of an acute exacerbation (e.g., cough, wheeze, shortness of breath). Patients should be referred for emergency management if symptoms are indicative of a severe exacerbation. Patients with a written action plan and medication at home should be instructed to follow the action plan and to seek emergency care if they are in the red zone, or if the action plan is not effective.

Toolkit

Also available on the Quality Management Office website are a number of toolkit items, including patient education handouts and access to other patient education materials, process and outcome metrics, forms, asthma cases for teaching, reminder materials (including a handy pocket card), and implementation information. Four standard forms/notes have been developed to support the guideline, including a standard written action plan, outpatient encounter visit, patient progress flow chart, and an education assessment form.

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Process and Outcome Metrics

The following metrics have been selected for the year 2000:

- Percent of patients with persistent asthma who are prescribed long term controller medication
- Percent of asthmatics 6 years of age and older with spirometry in the past 12 months

- Percent of follow-up visits for asthma with a documented asthma severity level in the medical chart

More information on the process and outcome metrics developed by the Clinical Practice Guideline Workgroup is available on the Quality Management Office website.



Some Asthma Websites

National Heart, Lung and Blood Institute: www.nhlbi.nih.gov

NAEPP Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma:
www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm

Healthy People 2010 Asthma Gateway: hp2010.nhlbihin.net/as_frameset.htm

Asthma Management Model System: www.nhlbisupport.com/asthma/index.html

Lung Information for Healthcare Professionals: www.nhlbi.nih.gov/health/prof/lung/index.htm

Lung Information for Patients and the General Public: www.nhlbi.nih.gov/health/public/lung/index.htm

The Role of the Pharmacist in Improving Asthma Care: www.nhlbi.nih.gov/health/prof/lung/asthma/asmapmcy.htm

American Academy of Allergy, Asthma and Immunology: www.aaaai.org

Allergy and Asthma Disease Management Center: www.aaaai.org/aadmc/default.htm

Update on Pediatric Asthma: Promoting Best Practice: www.aaaai.org/professional/initiatives/pediatricasthma.stm

Allergy & Asthma Advocate (patient newsletter): www.aaaai.org/public/publicedmat/advocate/default.stm

American Medical Association: www.ama-assn.org

AMA Health Insight (Consumer Health Information): Asthma: www.ama-assn.org/insight/spec_con/asthma/asthma.htm

Managing Asthma Today (Continuing Medical Education Series): www.ama-assn.org/med-sci/course/asthma/1home.htm

Asthma, Allergy, & Immunology Online: allergy.mcg.edu/home.html

Global Initiative for Asthma: www.ginasthma.com

Asthma & Allergy Foundation of America: www.aafa.org

Action Against Asthma: Strategic Plan for the Department of Health and Human Services, May 2000: aspe.os.dhhs.gov/sp/asthma/index.htm

Allergic and Asthma Network: Mothers of Asthmatics, Inc.: www.aanma.org

American Lung Association: www.lungusa.org

American Association of Respiratory Care: www.aarc.org

American Academy of Pediatrics: www.aap.org

Virtual Naval Hospital: www.vnh.org/Providers.html

Medscape (requires free registration): respiratorycare.medscape.com

About.com: Asthma: www.asthma.about.com

WebMDHealth: Asthma: my.webmd.com/condition_center/asm

Asthma Management in the Primary Care Setting

TABLE 1: Stepcare Approach for Prescribing Asthma Medications Based on Severity

Severity Level	Signs/Symptoms	Nocturnal Symptoms	Lung Function	Drug Therapy
Mild Intermittent	<ul style="list-style-type: none"> • Symptoms ≤ 2 times/week • Exacerbations brief • Asymptomatic/normal PEF between exacerbations 	<ul style="list-style-type: none"> • ≤ 2 times/month 	<ul style="list-style-type: none"> • FEV₁ or PEF ≥ 80% predicted • PEF variability < 20% 	<p>Quick Relief</p> <ul style="list-style-type: none"> • Inhaled short-acting beta₂-agonist PRN <p>Long-Term Control</p> <ul style="list-style-type: none"> • Usually no daily medication needed
Mild Persistent	<ul style="list-style-type: none"> • Symptoms > 2 times/week but < 1 time/day • Exacerbations can affect activity 	<ul style="list-style-type: none"> • > 2 times/month 	<ul style="list-style-type: none"> • FEV₁ or PEF ≥ 80% predicted • PEF variability 20-30% 	<p>Quick Relief</p> <ul style="list-style-type: none"> • Inhaled short-acting beta₂-agonist PRN <p>Long-Term Control</p> <ul style="list-style-type: none"> • Inhaled corticosteroid (LOW dose) • May also consider theophylline SR, leukotriene modifier, cromolyn or nedocromil • For patients with ASA sensitive asthma, consider using leukotriene modifiers
Moderate Persistent	<ul style="list-style-type: none"> • Symptoms daily • Exacerbations ≥ 2 times/week and affect activity • Daily use of quick relief meds 	<ul style="list-style-type: none"> • > 1 time/week 	<ul style="list-style-type: none"> • FEV₁ or PEF ≥ 60% < 80% predicted • PEF variability > 30% 	<p>Quick Relief</p> <ul style="list-style-type: none"> • Inhaled short-acting beta₂-agonist PRN <p>Long-Term Control</p> <ul style="list-style-type: none"> • Inhaled corticosteroid (MEDIUM dose) OR • Inhaled corticosteroid (LOW-MEDIUM dose) & Inhaled long-acting beta₂-agonist OR • Inhaled corticosteroid (LOW-MEDIUM dose) & theophylline • Consider referral
Severe Persistent	<ul style="list-style-type: none"> • Symptoms continuous • Limited physical activity • Exacerbations frequent 	<ul style="list-style-type: none"> • Frequent 	<ul style="list-style-type: none"> • FEV₁ or PEF < 60% predicted • PEF variability > 30% 	<p>Quick Relief</p> <ul style="list-style-type: none"> • Inhaled short-acting beta₂-agonist PRN <p>Long-Term Control</p> <ul style="list-style-type: none"> • Inhaled corticosteroid (HIGH dose) & inhaled long-acting beta₂-agonist OR • Inhaled corticosteroid (HIGH dose) & theophylline • Oral corticosteroids may be indicated • Consider referral

TABLE 2: Estimated Comparative Daily Dosages for Inhaled Corticosteroids

Adults and Children 6 years of age			
Drug	Low-Dose	Medium-Dose	High-Dose
Beclomethasone dipropionate 42 mcg/puff (MDI) - Vanceril, Beclovent 84 mcg/puff (MDI) - Vanceril DS	168 - 504 mcg 4 - 12 puffs 2 - 6 puffs	504 - 840 mcg 12 - 20 puffs 6 - 10 puffs	> 840 mcg > 20 puffs > 10 puffs
Budesonide - Pulmicort Turbuhaler 200 mcg/inhalation (DPI)	200 - 400 mcg 1 - 2 inhalations	400 - 600 mcg 2 - 3 inhalations	> 600 mcg > 3 inhalations
Flunisolide - Aerobid, Aerobid-M 250 mcg/puff (MDI)	500 - 1000 mcg 2 - 4 puffs	1000 - 2000 mcg 4 - 8 puffs	> 2000 mcg > 8 puffs
Fluticasone - Flovent, Flovent Rotahaler (MDI): 44, 110, 220 mcg/puff (DPI): 50, 100, 250 mcg/inhalation	88 - 264 mcg	264 - 660 mcg	> 660 mcg
Triamcinolone acetonide* - Azmacort 100 mcg/puff (MDI)	400 - 1000 mcg 4 - 10 puffs	1000 - 2000 mcg 10 - 20 puffs	> 2000 mcg > 20 puffs
Children < 6 years of age			
Drug	Low-Dose	Medium-Dose	High-Dose
Beclomethasone dipropionate 42 mcg/puff (MDI) - Vanceril, Beclovent 84 mcg/puff (MDI) - Vanceril DS	84 - 336 mcg 2 - 8 puffs 1 - 4 puffs	336 - 672 mcg 8 - 16 puffs 4 - 8 puffs	> 672 mcg > 16 puffs > 8 puffs
Budesonide - Pulmicort Turbuhaler 200 mcg/inhalation (DPI)	100 - 200 mcg 1 inhalation	400 - 600 mcg 1 - 2 inhalations	> 600 mcg > 2 inhalations
Flunisolide - Aerobid, Aerobid-M 250 mcg/puff (MDI)	500 - 750 mcg 2 - 3 puffs	750 - 1250 mcg 4 - 5 puffs	> 1250 mcg > 5 puffs
Fluticasone - Flovent, Flovent Rotahaler (MDI): 44, 110, 220 mcg/puff (DPI): 50, 100, 250 mcg/inhalation	88 - 176 mcg	176 - 440 mcg	> 440 mcg
Triamcinolone acetonide* - Azmacort 100 mcg/puff (MDI)	400 - 800 mcg 4 - 8 puffs	800 - 1200 mcg 8 - 12 puffs	> 1200 mcg > 12 puffs

MDI = metered dose inhaler; DPI = dry powder inhaler

* Basic Core Formulary item

Contract Update

Cost Avoidance due to National Contracts

As of the second quarter of FY00, the PEC estimates that the cumulative cost avoidance to DoD military treatment facilities (MTFs) as a result of DoD or DoD/VA national pharmaceutical contracts is approximately \$27 million. Because utilization of contract agents is still increasing, it appears likely that cost avoidance for FY00 will be close to the previous estimate of \$55 million.

A set of PowerPoint slides showing monthly cost avoidance and percent use of the contracted agents for each of the above classes is available for download on the PEC website at www.pec.ha.osd.mil/national_pharm.htm. The PEC plans to update this presentation on a routine basis.

How Contracts are Awarded

Defense Supply Center Philadelphia (DSCP) awards national pharmaceutical contracts for DoD. Joint DoD/VA contracts may be awarded either by DSCP or the VA National Acquisition Center (VA NAC) in collaboration with DSCP. One member from each of four organizations—the DoD PEC, the VA Pharmacy Benefits Management Strategic Health Group (VA PBM), DSCP, and the VA NAC—make up a Federal Pharmacy Executive Steering Committee (FPESC) workgroup responsible for developing contracting strategies and technical evaluation factors for DoD/VA joint contracting. All contracting strategies for DoD are reviewed and approved by the DoD Pharmacy & Therapeutics (P&T) Committee. In addition to the DoD P&T Committee, the FPESC and the VA must also approve contracting strategies for DoD/VA joint contracts.

DoD is continuing its efforts to collaborate with the VA in establishing future contracts for drugs and/or drug classes. A complete list of DoD and DoD/VA national pharmaceutical contracts is available on the DSCP website at dscp103.dscp.dla.mil/dmmonline/cbu/pharmaceuticals/natcontract.htm. A summary page is also available on the PEC website at www.pec.ha.osd.mil/national_pharm.htm.

Recently Awarded National Pharmaceutical Contracts

Nicotine Patches - The contract was awarded to Novartis Consumer Health for the Habitrol brand of nicotine 7-, 14-, and 21-mg patches. Purchase of the Habitrol nicotine patch is mandatory for those MTFs (and VA facilities) that have a need for 3-step nicotine patches. The contract does **NOT** mandate inclusion on the BCF and MTFs are **NOT** required to add this item to their formularies. Packaging for this product includes the "Habitrol Take Control Program" consisting of a CD and booklet. Effective date: 1 June 00.

Cost Avoidance to DoD due to National Pharmaceutical Contracts

(MTFs only; does not include the National Mail Order Pharmacy)

Drug	FY99	FY00 (1st 6 Months)
PPIs	NA	\$6,430,552
Statins	\$842,084	\$5,887,742
Lisinopril Tablets	\$1,078,257	\$3,774,674
Diltiazem XR	\$3,406,592	\$2,741,582
Ranitidine Tablets	\$761,614	\$673,201
Albuterol Inhalers	\$1,036,123	\$596,969
Cimetidine Tablets	\$157,488	\$125,000
Human Insulin	NA	(\$346,683)
TOTALS	\$7,282,158	\$19,883,037

Insulin Needles/Syringes* - The contract was awarded to Becton Dickinson for 0.5- and 1 mL insulin syringes with 29G needles, and a 1-mL insulin syringe with a 28G needle (this is a specialty item with a double scale made for the VA). Prices are listed for case packs of 5 (\$20.75, \$20.25, and \$26.25, respectively), resulting in a price of \$4.15, \$4.05, or \$5.25 per box of 100. All MTFs and VA facilities must purchase the Becton Dickinson brand of insulin syringes/needles. Effective date: 1 May 00.

Salsalate* - The contract was awarded to Able Laboratories for salsalate 500- and 750-mg tablets. All MTFs and VA facilities must purchase the Able Laboratories brand of salsalate tablets. Effective date: 15 Mar 00.

Naproxen/Naproxen Sodium* - The contract was awarded to Geneva Pharmaceuticals for naproxen 250-, 375-, and 500-mg tablets and naproxen sodium 275- and 550-mg tablets. All MTFs and VA facilities must purchase the Geneva brand of naproxen or naproxen sodium tablets. Effective date of the contract is 3 Jul 00.

* BCF items

Incentive Price Agreements on the DSCP Website

For a list of incentive price agreements reviewed and approved by DSCP and available to MTFs and/or TRICARE regions that wish to participate, check out the DSCP website at: <http://dscp103.dscp.dla.mil/dmmonline/cbu/pharmaceuticals/incentive.htm>.