

**TDMHMR EXECUTIVE FORMULARY COMMITTEE MINUTES**  
**January 30, 2004**

The Executive Formulary Committee convened on Friday, January 30, 2004 in Room 107D - CO Building 1. The meeting was called to order by Dr. Morgan, Chair, at 9:45 a.m.

Janet Adams, MSN, RN, CNS	Absent	Bernardo C. Tarin-Godoy, M.D.	√
Rosha Chadwick, R.Ph.	√	Jim Van Norman, M.D.	Absent
Erlinda Devera, M.D.	Absent	Robert L. Ward, D.O.	Absent
Emilio Dominguez, M.D.	√	Robert Kifowit	Absent
Jeanna Heidel, Pharm.D.	√	Kenny Dudley	Absent
Robin Mallett, M.D.	√	Gerry McKimney	Absent
Jack McCoy, M.D.	√	Pat Martin	Absent
Victoria B. Morgan, M.D.	√	Earl Matthew, M.D.	Absent
Ann L. Richards, Pharm.D.	√	Camille Hemlock, M.D.	√
Dan Still, Pharm.D.	√	Nina Muse, M.D.	Absent
Cindy Sturdivant, B.S.N., R.N.	Absent	Steven P. Shon, M.D.	Absent

**Guests Present: Sharon Tramonte, Pharm.D., San Antonio State School; Troy Moore, Pharm.D., Resident, San Antonio State Hospital; Chris Wallen, Pharm.D., Resident, San Antonio State Hospital**

**Roll Call, Introductions, and Announcements**

Dr. Jeanna Heidel was introduced as the new Committee member. She is the Pharmacy Director at Rusk State Hospital. Dr. Moore and Dr. Wallen were introduced as guests.

**Approval of Minutes of October 24, 2003**

On a motion of Dr. McCoy seconded by Dr. Tarin-Godoy, the minutes of the October 24<sup>th</sup> meeting were approved as previously distributed.

## **Adverse Drug Reaction Reports**

The Executive Formulary Committee reviewed two adverse drug reactions submitted by Rusk State Hospital. In the first case, a patient was receiving escitalopram (Lexapro®) and trazodone (Desyrel®). The patient was receiving escitalopram routinely and received trazodone once. The patient complained of nocturnal erections lasting greater than 3 hours that were painful but not associated with sexual stimulus. These episodes occurred over several nights but resolved spontaneously after the escitalopram was discontinued.

In the second case, a patient developed possible NMS, acute renal failure, lethargy, low blood pressure, tachycardia, rigidity and stiffness, fever, and elevated CPK after ziprasidone (Geodon®). Prior to hospitalization, the patient was incontinent of urine and had evidence of dehydration. In addition, the patient had a history of a recent rash of unknown origin and possible tissue infection or respiratory tract infection. Due to the patient history, it is unclear whether or not ziprasidone was the cause of the patient's symptoms.

## **New Drug Applications**

**(Please refer to Attachment A for the monograph and application that was considered when determining action by the committee.)**

### **levonorgestrel (Plan B®) – discussed by Dr. Tramonte**

Levonorgestrel packaged as Plan B® is indicated as an emergency contraceptive in preventing pregnancy after known or suspected contraceptive failure or unprotected intercourse. Pregnancy may be prevented through several mechanisms including thickening of cervical mucus, which inhibits sperm passage through the uterus and sperm survival; inhibition of ovulation, from a negative feedback mechanism on the hypothalamus, leading to reduced secretion of follicle stimulating hormone and luteinizing hormone; and inhibition of implantation. Levonorgestrel is not effective once the implantation process has begun. One tablet of levonorgestrel is taken as soon as possible within 72 hours after unprotected sexual intercourse or contraceptive failure. The second tablet should be taken 12 hours after the first tablet. Plan B® may be used at any time during the menstrual cycle. There is some efficacy data that indicates that Plan B might be effective after the 72-hour window.

In discussing this issue, the Committee expressed concern about whether or not this product should be on the TDMHMR Formulary due to the need to treat our priority population. Prior to the marketing of Plan B®, facilities have been utilizing other methods of the morning after pills. **Following discussion, on motion of Dr. Heidel, seconded by Dr. Tarin-Godoy, the request to add levonorgestrel (Plan B®) to the formulary was denied.**

### **memantine (Namenda®) – discussed by Dr. Still**

Memantine is a non-competitive N-methyl-D-aspartate (NMDA) receptor antagonist. It is indicated for the treatment of moderate to severe dementia of the Alzheimer's type. Beta amyloid accumulation found in Alzheimer's disease disrupts the transmission and activation of NMDA receptors. Glutamatergic transmission is thought to be important in learning and memory. In a state of reduced glutamate release, memantine produces improved neurotransmission and activation of neurons. However, in situations of pathologically increased presynaptic release of glutamate, memantine inhibits the excitotoxic action of glutamate by blocking the NMDA receptor. This prevents exposure of the neuron to an excessive influx of calcium, which is thought to be one of the mechanisms responsible for neuronal death.

**Following discussion, on a motion of Dr. McCoy, seconded by Dr. Tarin-Godoy, the request to add memantine (Namenda®) to the Formulary was approved.** The Formulary CheckList was completed. Since this is a new product on the market, it will be reviewed at the July 2004 meeting.

### **bupropion XL (Wellbutrin ®) – discussed by Dr. Wallen**

Bupropion XL is another long acting formulation of bupropion. Currently bupropion is generic and recently a sustained release product of bupropion was also released. Bupropion XL has a half-life of 21 ( $\pm$  9) hours which is similar to bupropion SR. Bupropion XL is taken once daily and the maximum daily dose is 450 mg/day. Bupropion SR is given twice a day and the maximum recommended dose is 400 mg/day. Patients may be switched from one form of bupropion to bupropion XL by giving the same daily dose of bupropion XL. Bupropion XL offers a once a day dosing of bupropion that might increase compliance. There is little evidence that there is any difference between medication adherence for a single daily dose and twice a day dosing.

**Following discussion, on motion of Dr. McCoy, seconded by Ms. Chadwick, the request to add bupropion XL (Wellbutrin XL®) to the formulary was denied.** Two members opposed.

### **Quarterly Non-Formulary Drug Justification Report**

The non-formulary requests for the first quarter were reviewed. Several items requested have since been placed on the Formulary.

### **Non-Formulary Requests – Top Ten Requests by Facility**

At the last meeting, the annual report of the top ten non-formulary requests by volume and dollar volume was reviewed. The Committee requested that these items be reviewed by facility. Dr. Tramonte prepared the information by facility for the last fiscal year. Approximately 21% of the top ten dollar purchases for non-formulary drugs were for celecoxib (Celebrex®) and 16% were due to rofecoxib (Vioxx®). Previously, the Committee has declined to add a COX-2 inhibitor to the Formulary. The most requested item was lovastatin (Mevacor®) which is now generic. It was noted that most patients fail to achieve and maintain low-density lipoprotein (LDL) cholesterol goals established by the National Cholesterol Education Program (NCEP). Studies have shown that patients treated with atorvastatin (Lipitor®) reached their NCEP goals more frequently, at lower doses and with lower total treatment costs when compared to other HMG Co-A reductase inhibitors. The use of lovastatin to treat to NCEP goals generally required the maximum daily dose and resulted in only about a third of the patients reaching goal. In terms of total treatment costs, lovastatin was one of the most expensive HMG Co-A reductase inhibitors when compared to other agents in the class. Fluticasone/salmeterol (Advair®) consisted of 19% of the requests and 10% of the dollars. With changes in the treatment of asthma, it was suggested that the Committee might consider the addition of this product to the Formulary in the near future. It was recommended that facility specific information regarding these non-formulary requests be distributed to the superintendents, clinical/medical directors and pharmacy directors.

### **Restrictive Formulary Feedback**

The Committee did not receive any feedback regarding the possibility of changing the Formulary to a restrictive Formulary. The Committee expressed concern that the field did not have time to respond since the memo was recently sent. The memo will be re-sent to the field.

### **Beta-Blocker Doses for Psychotropic Use**

At the previous meeting, the Psychotropic Dosage Guideline Tables were reviewed. At that time, it was suggested that the doses for beta-blockers be reviewed. In reviewing the literature, Dr. Still noted that the doses for beta-blockers vary widely depending on the indication. Therefore, it was recommended to not make any changes to the tables. The Committee agreed with this recommendation.

## **Medical Drug Preferred Agent List Work Group Update**

The Work Group addressing medical drugs has not met since the last Committee meeting. Currently, the Committee is considering a restrictive formulary, which would replace the function of this Work Group.

## **Consolidation of Prescribing Psychotropic Rules - MHMR**

The proposed consolidated rules have been submitted to Policy Development.

## **Request to Change Nefazodone (Serzone®) to Reserve Status**

The Committee discussed changing nefazodone to reserve status due to its black box warning. It was noted that nefazodone has been pulled from the Canadian market. Since there are other antidepressants on the market that provide efficacy and a safer profile, the question arose as to whether or not nefazodone is needed. **On a motion of Dr. Still, seconded by Dr. Mallett, it was recommended that nefazodone (Serzone®) be removed from the Formulary.** Feedback will be obtained from the field.

## **ePocrates software for PDAs**

It was noted that many clinicians are using Personal Digital Assistants (PDAs) for the care of the patients. The use ranges from reminders of lab work that needs to be obtained to a source of drug information. This portable device makes it easy to access information at anytime. Some of the facilities have even provided their clinicians with PDAs. One source of drug information is ePocrates, which is free software that is downloaded over the Internet. Unfortunately, since it is not approved software, clinicians that have been issued state purchased PDAs, cannot download ePocrates from a state purchased computer. The Committee reviewed several drug information software programs for PDAs. On a motion of Dr. Tarin-Godoy, seconded by Dr. Heidel it was recommended that ePocrates be considered an official software for the agency. This information will be submitted to the Information Management Committee.

## **Atypical Antipsychotic Package Insert Change**

Dr. Richards reported that the package insert for risperidone (Risperdal®) has been revised. The following has been added to the risperidone package insert:

### **WARNINGS:**

#### **Hyperglycemia and Diabetes Mellitus**

Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics including Risperdal®. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent hyperglycemia-related adverse events in patients treated with the atypical antipsychotics. Precise risk estimates for hyperglycemia-related adverse events in patients treated with atypical antipsychotics are not available.

Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes mellitus

(e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect drug.

The Committee recommended that this information be distributed to the field.

### **Atypical Antipsychotic Audit Parameters**

Austin State Hospital requested that the monitoring parameters for atypical antipsychotics be changed. The following is a summary of their recommendation as compared to the current monitoring parameter.

#### Current Monitoring Parameter

- Fasting glucose monitoring (finger stick or serum) every 3 months for olanzapine and clozapine
- No requirements for lipid monitoring

#### Proposed Monitoring Parameter

- Fasting blood glucose baseline and quarterly for all atypical antipsychotics
- Baseline and at least annual fasting lipid panel for all atypical antipsychotics

The Committee reviewed the recommendations made by Austin State Hospital. The Committee noted that currently only two atypicals have announced changes in their package inserts. It is the understanding of several Committee members that some of the drug companies continue to fight this change in their labeling. Any facility can make their own monitoring parameters more stringent than the ones approved by the Committee. Until further information is published or released by the FDA, it was recommended that no action be taken on this request. On a motion by Dr. Tarin-Godoy, seconded by Dr. Heidel, it was recommended that the monitoring parameters for atypical antipsychotics remain the same.

### **Depakote ER® versus Depakote versus valproic acid**

Dr. Moore presented the information on Depakote ER®, Depakote® and valproic acid. See attachment B. Currently Depakote ER® is on the Formulary as a reserve drug for use in migraine headaches and epilepsy. The use of Depakote ER® is increasing but not for these indications. Most clinicians are using Depakote ER® due to its once a day dosing. Once a day dosing is theoretically possible with Depakote® and valproic acid as well. Depakote ER® and Depakote® are not bioequivalent. Previous studies have found that Depakote ER® doses need to be about 20% higher than Depakote® in order to achieve the same serum concentration. The Committee recommended that Depakote ER® be considered as a third line choice for bipolar disorder and used only for failure, intolerance or lack of adherence to any form of valproate therapy. On a motion of Dr. Tarin-Godoy, seconded by Dr. Dominguez, the recommendation was approved. The reserve criteria will be modified to include: Third line choice for the treatment of bipolar disease and use in any psychiatric illness is reserved for intolerance or lack of adherence to any other forms of valproate therapy.

## Recent Drug Safety Information Changes

Dr. Tramonte reported that the package insert for topiramate (Topamax®) has changed. The package insert has been revised to include a warning that topiramate causes hyperchloremic, non-anion gap metabolic acidosis (decreased serum bicarbonate). Generally, decreases in serum bicarbonate occur soon after initiation of topiramate, although they can occur at any time during treatment. Bicarbonate decrements are usually mild-moderate, with an average decrease of 4 mEq/L at daily doses of 400 mg in adults and approximately 6 mg/kg/day in pediatric patients. Rarely, patients can experience decrements to values below 10 mEq/L. The company recommends measuring baseline and periodic serum bicarbonate during topiramate treatment. Based on this information, it was recommended that the topiramate monitoring parameters be changed to include metabolic studies including renal function, hepatic function and serum bicarbonate at baseline and as clinically indicated. On a motion of Ms. Chadwick, seconded by Dr. Still, the recommendation was approved.

Dr. Tramonte reported that the warning section for pergolide (Permax®) has been updated to include the possibility of patients falling asleep while performing daily activities.

## Proposed Drug Deletion List -

## Dermatological Agents, Part I

The Committee did not receive any comments from the field about the proposed deletions for the dermatological agents. On a motion of Dr. Still, seconded by Dr. Tarin-Godoy, the motion to delete the dermatological agents was approved.

## TDMHMR Drug Formulary Sectional Review-

## Dermatological Agents, Part II

Dr. Tramonte provided the review of the dermatological agents with her recommendations. Attachment C. The comparative cost index and dosage availability of these agents was reviewed (included in Attachment C). Dr. Tramonte recommended the addition of desonide (DesOwen®, Tridesilon®), lidocaine/prilocaine (EMLA®), menthol patch (Pain Patch®, Stopain®), tacrolimus (Protopic®) and pimecrolimus (Elidel®) to the TDMHMR Formulary.

Desonide is a corticosteroid with low to medium range of potency as compared to other topical corticosteroids. It has anti-inflammatory, antipruritic and vasoconstrictive properties. The anti-inflammatory mechanism of action of topical steroids, in general, is unclear. However, topical corticosteroids are thought to control the biosynthesis of potent mediators of inflammation such as prostaglandins and leukotrienes by inhibiting the release of their common precursor arachidonic acid. Desonide is indicated for the relief of the inflammatory and pruritic manifestations of corticosteroid responsive dermatoses. Attachment D.

On a motion by Dr. Still, seconded by Ms. Chadwick, it was recommended to add desonide (DesOwen®, Tridesilon®) to the TDMHMR Formulary. The Formulary CheckList was completed.

Lidocaine/prilocaine is a topical cream indicated for local analgesia on normal intact skin, on genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia. Dermal analgesia can be expected to increase for up to 3 hours under occlusive dressing and persist for 1-2 hours after removal of the cream. In adults, a thick layer is applied to intact skin and covered with an occlusive dressing. The dosage in children is determined by age and weight. Attachment E.

On a motion by Dr. Heidel, seconded by Dr. Mallett, it was recommended to add lidocaine/prilocaine (EMLA®) to the TDMHMR Formulary as a psoriatic agent only. The Formulary CheckList was completed.

The patch form of menthol is indicated for the temporary relief of minor aches and pains of muscles and joints associated with arthritis, simple backache, strains, and sprains. Menthol in concentrations of less than 1% depresses cutaneous receptors and exerts an analgesic effect. When menthol is applied to the skin, it stimulates the nerves for the perception of cold, while depressing those that perceive pain. Topical application of counterirritant concentrations of menthol initially produces a feeling of coolness that is soon followed by a sensation of warmth. Attachment F.

On a motion by Dr. Tarin-Godoy, seconded by Ms. Chadwick, it was recommended to add menthol (Pain Patch®, Stopain®) to the TDMHMR Formulary. The Formulary CheckList was completed.

Tacrolimus is indicated for short-term and intermittent long-term therapy in the treatment of mild to moderate atopic dermatitis. The exact mechanism(s) of action of tacrolimus in the treatment of atopic dermatitis has not been elucidated but appears to involve inhibition of the activation of T cells. Tacrolimus also has been shown to inhibit release of mediators from skin mast cells and basophils and to down regulate the expression of high-affinity receptors for immunoglobulin E (IgE) on Langerhans cells. A thin layer is applied to affected skin twice daily and rubbed in gently and completely. All skin surfaces, including the head, neck and intertriginous areas may be treated. Hands should be washed following application. Attachment G.

On a motion by Dr. Tarin-Godoy, seconded by Dr. Dominguez, it was recommended to add tacrolimus (Protopic®) to the TDMHMR Formulary. The Formulary CheckList was completed.

Pimecrolimus (Elidel®) is indicated for the short-term and intermittent long-term therapy in the treatment of mild to moderate atopic dermatitis. The exact mechanism of pimecrolimus has not been elucidated but it is thought to be similar to tacrolimus. A thin layer is applied to affected skin twice daily and rubbed in gently and completely. All skin surfaces, including the head, neck and intertriginous areas may be treated. Hands should be washed following application. Attachment H.

On a motion by Dr. Tarin-Godoy, seconded by Dr. Dominguez, it was recommended to add pimecrolimus (Elidel®) to the TDMHMR Formulary. The Formulary CheckList was completed.

Dr. Tramonte recommended the addition of the following dosage strengths for products currently on Formulary:

- Coal Tar shampoo: 2%, 2.5%, 5%
- Collagenase ointment: 0.03%, 0.1%
- Fluocinolone oil: 0.01%
- Lidocaine injection: 0.4%, 1%, 2%, 4%
- Lidocaine topical liquid: 4%
- Permethrin lotion and shampoo: 1%
- Salicylic acid plaster: 40%

On a motion by Dr. Tarin-Godoy, seconded by Dr. Dominguez, the recommendation to add these dosage strengths was approved.

Dr. Tramonte recommended the addition of the following trade names:

- Pentrax®, Polytar® to coal tar
- Eucerin®, Nutraderm® to Emollient Lotion/Cream
- Aquaphor® to Emollient Ointment
- Compound W®, DuoFilm®, Mediplast® to salicylic acid

On a motion by Dr. Tarin-Godoy, seconded by Dr. Dominguez, the recommendation to add these trade names was approved.

The Formulary Subcommittee recommended the deletion of the following dosage strengths/formulations.

Generic Name	Brand Name	Dosage forms to be deleted	Dosage forms still available
Benzocaine		Mouth/Throat preparations: Ointment: 20%	Topical, for mucous membranes: Gel: 6%, 20% Liquid: 20%  Topical, dermatologic: Cream, topical: 5%, 6% Lotion: 8% Ointment: 5% Spray: 5%, 20%  Mouth/Throat preparations: Gel: 6.3%, 7.5%, 10%, 15%, 20% Liquid: 5%, 6.3%, 10%, 20% Lozenges: 5 mg, 6 mg, 10 mg, 15 mg
Crotamiton	Eurax®	Cream: 10%	Lotion: 10%
Dibucaine	Nupercainal	Cream, topical: 0.5%	Ointment, topical: 1%
Hydrocortisone		Cream, topical 0.1%, 0.2% Lotion, topical: 0.25% Ointment, topical: 0.1%, 0.2% Solution, topical: 0.1%	Injection, as sodium succinate: 100 mg, 250 mg, 500 mg, 1000 mg Suppositories, rectal, as acetate: 10 mg, 25 mg Suspension, oral, as cypionate: 10 mg/5 ml  Hydrocortisone base: Cream, rectal: 1%, 2.5% Tablet, oral: 5 mg, 10 mg, 20 mg  Hydrocortisone, topical: Cream, topical: 0.5%, 1%, 2.5% Lotion, topical: 0.5%, 1%, 2%, 2.5% Ointment, topical: 0.5%, 1%, 2.5%
Lidocaine	Xylocaine®	Cream, topical: 2%	Injection: 10% Gel, topical: 2%, 2.5% Liquid, topical: 2.5% Liquid, viscous: 2%

			Ointment, topical: 2.5%, 5% Solution, topical: 2%, 4%
Lindane		Cream, topical: 1%	Lotion: 1% Shampoo: 1%
Permethrin	Elimite®, Nix®	Liquid, topical: 1%	Cream, topical: 5%
Piperonyl butoxide/pyrethins	A-200® RID®	Gel, topical: 0.3%	Liquid, topical: 0.18%, 0.3% Shampoo: 0.3%, 0.33%
Salicylic acid		Cream, topical: 2% Gel, topical: 5%, 6% Liquid, topical: 13.6%, 16.7% Ointment, topical: 3%	Gel, topical: 17% Liquid, topical: 17% Lotion: 3% Soap: 2%
Silver nitrate		Ointment, topical: 10% Solution, topical: 10%, 25%, 50%	Applicator sticks

On a motion of Dr. Tarin-Godoy, seconded by Dr. Dominguez the motion to delete these products was approved. Feedback will be obtained from the field.

It was recommended that several trade names be deleted from the Formulary. The generic name of these products will remain on Formulary. Furthermore, it was recommended that additional trade names be added to some of the products.

Dr. Tramonte recommended the following changes in the Formulary:

- Add triamcinolone to this section
- For preparations that have no strength/dose associated with the package, remove the volume/package size
- Change Hydrocortisone acetate to Hydrocortisone
- Change generic name of Ben-Gay to reflect it's current formulation of Methyl Salicylate/Menthol

On a motion of Dr. Tarin-Godoy, seconded by Dr. Dominguez the motion to make these changes was approved.

#### **Sectional Review for April 2004**

The psychotropic agents will be reviewed at the next meeting.

#### **TDMHMR Drug Formulary Book**

It was noted that the TDMHMR Formulary Book is reviewed and approved annually at the October meeting. For convenience, the name of the 2003 TDMHMR Drug Formulary Book that was approved at the October meeting has been changed to 2004 TDMHMR Drug Formulary Book. For JCAHO purposes, it is suggested that once the latest version of the TDMHMR Drug Formulary Book is approved, that each MH facility approve it.

In the process of reviewing new drug applications, a Formulary CheckList is completed. The CheckList reviews the product for potential error, for newly marketed drugs the literature is reviewed for published errors or adverse drug reactions and the packaging is reviewed for potential confusion. If there is a high potential for error, then safety checks will be implemented for the drug.

### **Fluconazole (Diflucan®)**

It was noted that fluconazole 150 mg tablet is not on Formulary. On a motion of Ms. Chadwick, seconded by Dr. Dominguez, the recommendation to add fluconazole 150 mg tablets to Formulary was approved.

### **Next Meeting Date**

The next meeting was scheduled for April 16, 2004.

### **Adjourn**

There being no further business, the meeting was adjourned at 1:25 p.m.

Approved: \_\_\_\_\_  
Victoria B. Morgan, M.D., Chairman

### **Attachments**

- Attachment A – New Drug Monographs
- Attachment B – Divalproex Sodium Extended-Release Tablets (Depakote® ER)
- Attachment C – Dermatological Agents Class Review & Cost Review and Alphabetical Listing
- Attachment D – Desonide (DesOwen®) Monograph
- Attachment E – Lidocaine/Prilocaine (EMLA®) Monograph
- Attachment F – Menthol (Pain Patch®, Stopain®) Monograph
- Attachment G – Tacrolimus (Protopic®) Monograph
- Attachment H – Pimecrolimus (Elidel®) Monograph

Minutes Prepared by:  
Ann L. Richards, Pharm.D.  
Rosha Chadwick