# D&T Decisions

*… from the Drugs and Therapeutics Committee*

The information in this newsletter may also be accessed online.
To request a change to the NS Health Hospital Formulary, select & complete the online "Formulary Request Form":
NSH Pharmacy Formulary (nshealth.ca)

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The following policies were approved by the Medical Advisory Committee (Mar 26, Apr 26) on the recommendation of the Drugs and Therapeutics Committee (Feb 26, Mar 26, Apr 26).

# I. Additions to Hospital Formulary

## Icosapent ethyl/ *Vascepa*®

Icosapent ethyl is an oral lipid-regulating agent that was Health Canada approved in 2019 as an adjunct to statin therapy to reduce the risk of cardiovascular (CV) events in statin-treated patients with elevated triglycerides (TG) and established CV disease, or diabetes plus ≥1 additional CV risk factor. Icosapent ethyl is a highly purified and stable ethyl ester of the omega-3 fatty acid eicosapentaenoic acid (EPA).

CV disease remains one of the leading causes of death and hospitalizations in Canada. Despite widespread use of statins for secondary or primary prevention, patients with established CV disease or with diabetes and one or more CV risk factors continue to experience a burden of CV events. In these patients, hypertriglyceridemia is a frequent lipid abnormality and studies have shown that this is an independent marker for an increased risk of ischemic events and mortality. Historically, therapeutic options for hypertriglyceridemia include fibrates, niacin, and mixed omega-3 fatty acid supplements. However, these agents have not demonstrated consistent CV outcome benefits when administered in addition to statins.

Icosapent ethyl lowers TG levels by decreasing production and accelerating the clearance of TG. In addition, it may slow production of VLDL and have anti-inflammatory, antioxidative, plaque-stabilizing, and antithrombotic effects. Although the mechanism of action is not fully understood, it is thought that the fatty acid EPA incorporates into cell membranes and has multi-factorial effects such as reducing TG-rich lipoproteins, improving endothelial cell function, and reducing macrophage accumulation, inflammatory mediators, platelet aggregation and atherosclerotic plaque volume.

Both the 2020 Canada Stroke Best Practice Guidelines (Level B evidence) and the 2022 Canadian Cardiovascular Society Guidelines (high quality evidence) recommend that icosapent ethyl may be considered to reduce the risk of vascular events in ischemic stroke patients as well as decrease the risk of CV events in patients with atherosclerotic CV disease who have elevated serum TG levels despite being on statin therapy.

**Approved Restriction**:
Restricted to individuals:
- Aged 45 years and older with established cardiovascular disease, concomitantly treated with a statin
  AND
- Fasting TG of ≥1.7 mmol/L and <5.6 mmol/L at baseline, measured within the preceding three months before starting treatment with icosapent ethyl
- An LDL > 1.0 mmol/L and <2.6 mmol/L at baseline and be receiving a maximally tolerated statin dose, targeted to achieve an LDL <2 mmol/L, for a minimum of four weeks.

## Cangrelor/ *Kengrexal*®

Approved by Health Canada in 2023, cangrelor is an injectable antiplatelet agent that is indicated for reducing the risk of thrombotic cardiovascular events [periprocedural myocardial infarction (MI), repeat coronary revascularization, stent thrombosis] in patients with coronary artery disease undergoing percutaneous coronary intervention (PCI) who have not been treated with an oral $P2Y_{12}$ platelet inhibitor and are not being given a glycoprotein 11b/111a inhibitor.

A direct inhibitor of the platelet $P2Y_{12}$ receptor, cangrelor subsequently blocks binding of adenosine phosphate (ADP) to its receptor, which inhibits ADP-induced platelet activation and aggregation. Cangrelor, the only $P2Y_{12}$ inhibitor available in Canada administered as an IV infusion, does not require metabolic conversion to an active form; therefore, peak plasma concentrations and onset of platelet inhibition is achieved within 2 minutes of administration. The other marketed $P2Y_{12}$ inhibitors (i.e., ticagrelor, clopidogrel and prasugrel) are oral formulations with a slower onset of action. Since clopidogrel has the slowest onset of action, usage is associated with an increased risk of thrombosis in the acute PCI setting. Compared to clopidogrel, the administration of ticagrelor and prasugrel leads to a faster inhibition of platelets; however, these agents are associated with a higher risk of bleeding.

Cangrelor is considered an alternative to oral $P2Y_{12}$ inhibitors for patients undergoing PCI who cannot receive oral therapy or who may experience a delayed onset of action with the oral formulations [e.g., slowed GI absorption, GI symptoms such as nausea and vomiting secondary to acute coronary syndrome (ACS), hemodynamic instability, opioid use, orotracheal intubation]. The 2023 Canadian Guidelines for the Use of Antiplatelet Therapy note that short acting IV agents like cangrelor may have a role in preventing procedural complications in patients who do not receive pretreatment with $P2Y_{12}$ inhibitors (particularly in ACS).

The efficacy and safety of cangrelor was assessed by the CHAMPION program that included three randomized controlled trials. CHAMPION PCI (2009) and CHAMPION PHOENIX (2013) evaluated a cangrelor infusion versus clopidogrel loading dose at the time of PCI. CHAMPION PLATFORM (2009) evaluated a cangrelor infusion versus placebo infusion, followed by clopidogrel 600 mg (after procedure or infusion). A pre-specified pooled individual patient-level analysis of the three CHAMPION studies was completed in 2013 (N= 24,910) and found that cangrelor reduced the odds of a primary composite outcome of all-cause death, MI, ischemia-driven revascularization (IDR) or stent thrombosis at 48 hours; however, the study was limited by the differences between the outcome definitions that varied between the trials. In this pooled patient level analysis, there was no difference between the cangrelor and clopidogrel groups for the primary safety outcome defined as severe or life-threatening bleeding according to the GUSTO criteria, at 48 hours after PCI.

## Finerenone/ *Kerendia*®

Finerenone is an aldosterone antagonist indicated as an adjunct to standard of care therapy in adults with chronic kidney disease (CKD) and type 2 diabetes (T2D) to reduce the risk of end-stage kidney disease (ESKD) and sustained decrease in estimated glomerular filtration rate (eGFR), cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure.

Hyperglycemia secondary to T2D leads to the production of harmful metabolic products, such as advanced glycation end-products and reactive oxygen species, ultimately resulting in renal tissue injury and renin-angiotensin-aldosterone system (RAAS) activation. There are several drug therapies that target the multifactorial causes of diabetic CKD. Angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs), as well as sodium-glucose costransporter-2 (SGLT2) inhibitors, have demonstrated cardiovascular and renal protection in patients with diabetic CKD. New evidence has also emerged to demonstrate the reduction in the loss of kidney function over time, as well as major cardiovascular events by semaglutide. Steroidal mineralocorticoid receptor antagonists (MRAs), namely spironolactone and eplerenone, reduce blood pressure and albuminuria but have failed to show a significant reduction in the loss of kidney function.

Finerenone is a non-steroidal MRA that has been shown to reduce albuminuria, eGFR decline, and cardiovascular events. There is no evidence to date that it has an effect on A1C. It functions by binding to the mineralocorticoid receptor, thereby blocking the binding of aldosterone. This prevents the overactivation of RAAS and the subsequent accumulation of pro-inflammatory and pro-thrombotic products. Its use in diabetic CKD may provide superior efficacy in prevention of end-stage kidney disease compared to the steroidal MRAs.

Two pivotal randomized controlled trials (FIGARO and FIDELIO) assessed the effect of finerenone versus placebo in patients with CKD and T2D treated with a maximally tolerated dose of a RAAS inhibitor (i.e., ACE inhibitors, ARBs). The FIDELITY trial combined the data from the FIGARO and FIDELIO trials in a prespecified analysis of the safety and efficacy of finerenone compared with placebo. The analysis showed a clear reduction in clinically important cardiovascular and kidney outcomes consistent with the individual trials. The frequency of adverse events was similar in the treatment and placebo group except for hyperkalemia leading to discontinuation which was higher in the finerenone group. Finerenone is recommended by the 2025 Diabetes Canada and the 2022 KDIGO Clinical Practice Guidelines.

**Approved Restriction:**
For the treatment of patients with chronic kidney disease and type 2 diabetes who have an eGFR level of at least 25 mL/min/1.73 m2 and albuminuria level of at least 30 mg/g (or 3 mg/mmol).
(Patients must not have NYHA class II to IV heart failure OR be receiving a mineralocorticoid receptor antagonist)

## Methylphenidate CR/ *Foquest®*

Foquest® is a methylphenidate controlled release once daily capsule that is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients ≥6 years of age. Methylphenidate is a CNS stimulant that is thought to act by blocking the reuptake of norepinephrine and dopamine. Although Foquest® has not been listed on the IWK or NS Health Hospital Formularies, it is an open benefit on the NS Pharmacare Formulary and has been a preferred methylphenidate formulation at the Central Nova Scotia Correctional facility due to a low risk of misuse and diversion. Methylphenidate ER (Concerta®) is currently listed on the NS Health Hospital Formulary and is widely used in the Corrections setting, although misuse and diversion remain a challenge.

Foquest® is a modified-release methylphenidate preparation which utilizes multilayer release (MLR® bead technology), where 20% of the total methylphenidate dose is contained within the immediate release layer and 80% is contained in the delayed controlled release layers, a formulation that demonstrates a biphasic plasma concentration-time profile of methylphenidate release. Foquest® is administered once daily in the morning, with or without food. Adverse events observed with Foquest® treatment mainly reflect side effects commonly associated with methylphenidate use such as headache, insomnia, decreased appetite and abdominal pain. Foquest® capsules can be opened and sprinkled on soft food while maintaining controlled release properties, which offers a distinct advantage.

Foquest® has been added to the NS Health Hospital Formulary to provide a safe, effective treatment option with a potentially reduced risk of misuse/ diversion compared to other methylphenidate products and to facilitate inclusion in the OPOR Oracle Health Computerized Provider Order Entry (CPOE) catalog.

## Meropenem & Vaborbactam/ *Vabomere*

Approved by Health Canada in 2024, meropenem-vaborbactam (Vabomere) is an injectable combination β-lactam-β-lactamase inhibitor indicated for the treatment of select infections known or suspected to be caused by carbapenem-resistant, vaborbactam/ meropenem susceptible Gram-negative bacteria in adults.

Carbapenem resistant Enterobacterales (CRE) are a group of bacteria that are resistant to one or several carbapenem antibiotics (i.e., ertapenem, meropenem, imipenem). One of the mechanisms that CRE develop resistance is by producing carbapenemase enzymes (a subgroup of beta-lactamases) that hydrolyse carbapenems. CRE bacteria are divided into two categories based on whether their resistance to carbapenems is due to production of carbapenemase or not. Carbapenemase-producing Enterobacterales (CPE) can transfer this resistance mechanism to other organisms via mobile genetic elements, increasing the risk of spread and outbreaks. In addition, infections caused by CPE are found to be more than three times more fatal compared to infections caused by carbapenem-susceptible Enterobacteriales. At NS Health, the current formulary medications that can be used for treatment of CRE are monotherapy or combination therapy with carbapenems, aminoglycosides, fluoroquinolones, colistin and tigecycline; however, many CPE are also resistant to these antimicrobials, leaving limited treatment options.

A Public Health Surveillance report published in November 2025 reported that between 2017 and 2024, the incidence rate of CPE has been low but has increased by more than two-fold. In response to the increasing rate of CPE, new antibiotics have been developed including meropenem-vaborbactam. The addition of vaborbactam restores the activity of meropenem against Ambler class A and C β-lactamases but not Ambler classes B and D.

A 2024 systematic review and meta-analysis evaluated the clinical efficacy and safety of meropenem-vaborbactam versus best-available therapy (monotherapy or combination therapy with polymyxins, carbapenems, aminoglycosides, colistin and tigecycline or monotherapy with ceftazidime-avibactam or piperacillin-tazobactam) in patients with CRE. Four studies were included (one retrospective cohort study and three phase 3 trials; n = 858) and meropenem-vaborbactam demonstrated a similar clinical response rate. The 28-day all-cause mortality was found to be lower with meropenem-vaborbactam compared to comparators and meropenem-vaborbactam was found to have a similar rate of adverse events but lower rates of renal adverse events.

Due to the potential for resistance with inappropriate use and high treatment cost, meropenem-vaborbactam has been added to the NS Health formulary stoplight system as a “Red” antimicrobial. Meropenem- vaborbactam is an option for multi-drug resistance infections that are known or suspected to be caused by carbapenem-resistant, meropenem/ vaborbactam-susceptible Gram-negative bacteria in adults with: complicated urinary tract infections (including pyelonephritis); complicated intra-abdominal infection; hospital acquired pneumonia (including ventilator associated pneumonia); bacteremia that occurs in association with, or is suspected to be associated with, any of the infections listed; other infections with limited treatment options.

**Approved Restriction**:
Addition to the systemic antimicrobial formulary as a red category agent (i.e., requiring Antimicrobial Stewardship review within 72 hours). Guidelines for use are available on the NS Health Antimicrobial Stewardship website and app.

## Doxycycline injection

Oral doxycycline is a long-standing Hospital Formulary tetracycline antibiotic with a broad range of clinical uses that include the treatment of community acquired pneumonia (CAP), sexually transmitted infections, and tick-borne illnesses like Lyme and anaplasmosis. In November 2025, IV doxycycline became commercially available in Canada.

Although doxycycline is traditionally administered orally, there are circumstances when oral administration may not be feasible (e.g., decreased level of consciousness, malabsorption). These scenarios may occur during critical illness including severe presentations of anaplasmosis (now considered endemic in NS) for which doxycycline is the only effective treatment. Access to doxycycline IV was previously via Health Canada’s Special Access

Program and approved for the initial treatment of anaplasmosis with critical illness when the placement of an enteral tube was not possible (e.g., severe thrombocytopenia). Other appropriate indications for doxycycline IV may include rare infections such as Q fever and plague that have no other treatment alternatives; however, doxycycline IV is not appropriate for more common infections (e.g., CAP, skin and soft tissue infections) where other IV antibiotic alternatives are readily available.

Given its cost relative to oral, doxycycline IV is approved as a "Red" antimicrobial for select indications only in patients who cannot receive doxycycline enterally. When used, patients will be transitioned to the oral/ enteral route as soon as feasible

**Approved Restriction**:
Addition to the systemic antimicrobial formulary as a red category agent (i.e., requiring Antimicrobial Stewardship review within 72 hours). Guidelines for use are available on the NS Health Antimicrobial Stewardship website and app.

### Lidocaine Topical Cream/ *Zensa*
Lidocaine topical cream has been added to the NS Health Hospital Formulary based on the IWK Health Formulary status.

### Additions to Hospital Formulary to Facilitate CIS Design/ CPOE Process
In 2024, several non-formulary medications were identified and approved for NS Health Hospital Formulary inclusion to facilitate the One Person One Record (OPOR) design of the Oracle Health Computerized Provider Order Entry (CPOE) catalog (D&T Decisions #78: 2024). A subsequent review has identified additional non-formulary medications as appropriate for inclusion in the Hospital Formulary and CPOE catalog.

The Oracle Health Clinical Information System (CIS) CPOE catalog only includes Hospital Formulary medications; therefore, non-formulary medications do not have pre-built order sentences in the CIS. Although there is a non-formulary process, the automation of the order entry process with the CPOE catalogue provides numerous clinical and safety benefits for patients and the healthcare system including reduced medication errors and increased efficiency.

Eighteen medications have been added to the NS Health Hospital Formulary based on Formulary status at the IWK Health Centre. In addition to improved medication and patient safety for CIS implementation, this alignment with the IWK Health Formulary will facilitate standardized care for NS women's health and pediatric patients (Appendix 1).

Medications dispensed by the NS High Cost Drug Program should be listed in the NS Health Hospital Formulary. The current practice is for inpatients to use their own high cost drug supply; however, if that supply is not accessible, the admitting hospital may be required to obtain a new supply from the Program (i.e., VG Hospital Pharmacy, Halifax). To align with the NS High Cost Drug Program, several medications have been added to the NS Health Hospital Formulary (Appendix 2).

A recent medication usage review identified several additional non-formulary medications that are stocked and frequently dispensed for patients admitted to NS Health facilities. Access to a patient's own supply of essential non-formulary medications can be challenging at NS hospitals due to the large geographic area as well as at the QEII Health Sciences Centre since it is a referral center for all the Atlantic provinces. Based on a non-formulary usage review, further medications are approved for inclusion in the NS Health Hospital Formulary and CPOE catalog (Appendix 3).

# II. Expanded Restrictions

### Methoxyflurane/ *Penthrox*®
Methoxyflurane (Penthrox®) is a halogenated hydrocarbon anesthetic volatile liquid for inhalation indicated for the short-term relief of moderate to severe acute pain, associated with trauma or interventional medical procedures, in conscious adult patients. Added to the NS Health Hospital Formulary in 2025, methoxyflurane (Penthrox®) has been restricted to procedural pain during gynecological procedures (IUD insertion or endometrial biopsy) based on the IWK Health Reserved/ Restricted Formulary status (D&T Decisions #80: 2025).

Although the methoxyflurane mechanism of action for analgesia is largely unknown, it's thought to be involved with its effects on substance P and beta-endorphin. Penthrox® is a hand-held inhaler intended for self-administration under the supervision of a healthcare practitioner.

Acute pain is a frequently presenting complaint in the emergency department (ED) that is managed with oral and parenteral analgesics, including non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and opioids. While effective, these therapies may have limitations that impede timely and effective analgesic relief including delayed onset of action, adverse effects, and invasive administration routes.

A 2025 systematic review (n = 1386) assessed the efficacy of inhaled methoxyflurane for acute pain in the ED setting. All included studies (six RCTs and two sub-group analyses of one main study) reported an improvement in pain scores for methoxyflurane compared to placebo or standard analgesics. A shorter time to obtain pain relief was also reported in the methoxyflurane group in all the studies except one that included patients with NRS severe pain scores of at least eight. The most frequent adverse events reported were sedation and mild nausea that were transient in nature. Serious adverse events were rare across trials with no reported incidences of significant respiratory depression or hypotension. Drowsiness and dizziness in the methoxyflurane group were typically self-limiting and thought to be a result of its fast onset of action.

When the Penthrox® inhaler is used with perfect technique, the exhaled methoxyflurane is captured by the charcoal within the Activated Carbon (AC) chamber, reducing the exhaled concentration of methoxyflurane to the environment to zero. However, there is risk of occupational exposure if the inhaler is used without the AC chamber or if the patient fails to exhale into the inhaler; therefore, healthcare professionals should receive training on appropriate Penthrox® device set up and

administration. The NS Health Hospital Formulary restrictions for methoxyflurane Penthrox® have been expanded to include use in the ED.

**Approved Restriction**:
For use in the Emergency Department

### Amphotericin B deoxycholate

Amphotericin B deoxycholate (AmB-d) has been included in the NS Health antimicrobial formulary (stoplight system yellow) with defined criteria for use in compounding of amphotericin-B containing products, including solution for bladder irrigation and ocular injections. AmB-d for systemic use was not added to the formulary due to its high rate of toxicities and the availability of less toxic formulations of amphotericin B (liposomal amphotericin B).

Symptomatic urinary tract infections caused by *Candida* (candiduria) are preferentially treated with fluconazole when the causative *Candida* is susceptible. Fluconazole resistant candiduria is challenging to treat as common antifungals (e.g., echinocandins and liposomal amphotericin B) have limited efficacy due to poor urinary tract penetration; therefore, these agents are not recommended as treatment. The Infectious Disease Society of America recommends systemic AmB-d as treatment for fluconazole resistant candiduria.

Due to its concerning safety and toxicity profile, AmB-d systemic therapy has been added to the NS Health formulary stoplight system as a "Red" antimicrobial, with guidelines for use indicating treatment restricted to candiduria caused by fluconazole resistant organisms.

**Approved Restriction**:
Addition to the systemic antimicrobial formulary as a red category agent (i.e., requiring Antimicrobial Stewardship review within 72 hours). Guidelines for use are available on the NS Health Antimicrobial Stewardship website and app.

# III. Removal of Restrictions

### Sevelamer carbonate

To align with the IWK Formulary, sevelamer carbonate has been designated the NS Health Hospital Formulary product and the Formulary restrictions have been removed (refer to Section IV Automatic Substitution).

# IV. Automatic Substitution

### Sevelamer carbonate

Sevelamer, a phosphate binder indicated for the control of hyperphosphatemia in patients with end-stage renal disease undergoing dialysis, is currently listed with restrictions on the NS Health Hospital Formulary without specification of a preferred sevelamer salt. Sevelamer HCl and sevelamer carbonate (Accel-sevelamer) are interchangeable as exception status drugs on the NS Pharmacare Formulary. These sevelamer products have equivalent dosing (1:1) and no additional monitoring requirements are required when switching sevelamer salts. The IWK Health Centre Formulary lists only sevelamer carbonate (800 mg tablet and 2.4 g/ sachet) as an unrestricted drug.

To align with the IWK Formulary, sevelamer carbonate has been designated the NS Health Hospital Formulary product and an automatic substitution has been approved:

| Preparation: | Dispensed As: |
|---|---|
| sevelamer (any salt) | sevelamer carbonate |

# V. Revised Therapeutic Interchange

### Nasal Corticosteroids

A series of provincial therapeutic interchanges (TI) were approved in 2024 with the goal of streamlining the provincial pharmacy inventory in preparation for OPOR-CIS implementation (D&T Decisions #78: 2024). An exception to the approved TI for nasal corticosteroids has been approved. All new nasal corticosteroid orders will be interchanged to mometasone EXCEPT for patients on a protease inhibitor whose orders will be interchanged to beclomethasone.

| **Ordered as** | | **Interchanged to** |
|---|---|---|
| Beclomethasone 50 mcg/ spray* | Any dose and frequency | Mometasone 50 mcg/ spray 2 sprays each nostril once daily<br>OR<br>1 spray each nostril once daily if age under 12<br><br>(order will remain prn if ordered as prn)<br><br>**<u>*EXCEPTION:</u> patients on a protease inhibitor use beclomethasone 50 mcg/ spray (at prescribed dose)** |
| Budesonide 64 mcg, 100 mcg/ spray | | |
| Ciclesonide 50 mcg/ spray | | |
| Fluticasone furoate 27.5 mcg/ spray | | |
| Fluticasone propionate 50 mcg/ spray | | |
| Triamcinolone 55mcg/ spray | | |

### Metronidazole

In 2019, a metronidazole IV therapeutic interchange (TI) was approved allowing NS Health pharmacists to independently modify metronidazole IV ordered every 6 or 8 hours to an interval of every 12 hours, when clinically appropriate. This metronidazole TI optimizes drug exposure while minimizing costs when treating anaerobic infections. The IV administration was prioritized as the cost of IV metronidazole was significantly higher than oral metronidazole; however, given the similar pharmacokinetics of oral metronidazole to IV, including very high oral bioavailability, it is appropriate to apply the same TI to oral metronidazole to align practice across formulations. The metronidazole TI has been revised to include both IV and oral formulations, when clinically appropriate. *H. pylori* treatment is added as an additional exception to the interchange.

| Antimicrobial order | Interchange |
|---|---|
| Metronidazole _ mg IV/**PO** q 6-8h | Metronidazole _ mg IV/**PO** q12h<br><br><u>Exception</u>**<u>s</u>: *Clostridioides difficile*** infection, subdural empyema, brain abscess, ***H. pylori*** **treatment)** |
| Metronidazole 250 mg PO/IV q12h | Metronidazole 500 mg PO/IV q12h |

# VI. New Guidelines

### Nivolumab subcut/ *Opdivo® SC*

Nivolumab subcutaneous (Opdivo SC) is a new nivolumab formulation recently approved for addition to the NS Health Hospital Formulary with select indications and Guidelines previously approved for the nivolumab IV formulation. Guidelines approved include nivolumab as a single agent (monotherapy and maintenance therapy) and nivolumab in combination with oral systemic therapies for cancer.

# VII. Expanded Guidelines

### Blinatumomab/ *Blincyto®*

Two new guidelines have been approved for blinatumomab.

A new guideline has been approved for the role of blinatumomab in newly diagnosed Ph-negative B-cell acute lymphoblastic leukemia (ALL).

**Approved Restriction:**

For the treatment of adult and pediatric patients with Ph-negative, CD19-positive B-cell acute lymphoblastic leukemia (ALL) in the front-line consolidation phase of multiphase chemotherapy.

A new guideline has been approved for the role of blinatumomab in pediatric patients with Ph-negative B-cell acute lymphoblastic leukemia (ALL) in first relapse.

**Approved Restriction:**

For the treatment of pediatric patients with Philadelphia-chromosome (Ph)-negative B-cell acute lymphoblastic leukemia (ALL) in first relapse.

### Dostarlimab/ *Jemperli*

A new guideline has been approved for the role of dostarlimab in advanced endometrial cancer:

**Approved Restriction**:

For the first-line treatment of adult patients with primary advanced or recurrent endometrial cancer not amenable to curative therapy in combination with carboplatin and paclitaxel.

Patients must meet at least one of the following:

- Primary stage III or IV endometrial cancer
- First recurrence and have not previously received systemic therapy for advanced disease
- Received prior neoadjuvant or adjuvant systemic therapy and have a first recurrence at a minimum of 6 months after completion of treatment

### Polatuzumab vedotin/ *Polivy™*

A new guideline has been approved for the role of polatuzumab vedotin in large B-cell lymphoma (ABC subtype):

**Approved Restriction**:

For the treatment of adult patients with previously untreated CD20-positive large B-cell lymphoma (LBCL) that is classified as activated B-cell-like (ABC) lymphoma subtype, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (NOS), high grade B-cell lymphoma, Epstein-Barr virus-positive (EBV+) DLBCL NOS, and T-cell/histiocyte rich LBCL in combination with rituximab, cyclophosphamide, doxorubicin, and prednisone (R-CHP).

### Nab-PACLitaxel/ *Abraxane®*

New guidelines for Nab-PACLitaxel [nanoparticle, albumin -bound (nab)] have been approved.

Taxane-based therapies are commonly included in a broad range of standard-of-care regimens for both curative and metastatic solid organ malignancies, such as breast cancer, non-small cell lung cancer, gastroesophageal cancer, and gynecological cancers. The two most common taxanes used are paclitaxel and docetaxel, and both require carrier agents (Cremophor EL in paclitaxel; polysorbate 80 in docetaxel) for solubility. While necessary, these carrier agents are also known to cause immediate hypersensitivity reactions (HSRs) in some patients. HSRs can be managed by increasing the intensity of pre-medications and lengthening the overall infusion time, especially if the reaction was only mild or moderate in severity. For more severe reactions, desensitization protocols may be used, although labor intensive for clinic staff (and may not be feasible in all treatment centers). Switching to a different taxane is not recommended due to high rates of cross-reactivity. Stopping the taxane therapy will lead to worse patient outcomes, especially for patients who are being treated in the neoadjuvant, adjuvant, or curative setting.

Using the albumin-bound formulation of paclitaxel, nab-paclitaxel, removes the risk of HSRs as it does not require a carrier for solubility. Hence, the incidence for HSR in patients receiving nab-paclitaxel is reported to be much lower, making it a suitable treatment option for patients who have experienced prior HSRs to traditional taxanes. Nab-paclitaxel is a reasonable alternative for patients who would otherwise need to be desensitized for each dose, for those who experience reactions despite desensitization, when rechallenge is not advisable, or for patients with an intolerance to steroids. The usage of nab-paclitaxel would be infrequent and limited to those who cannot tolerate traditional taxane therapy even with optimal treatment and prevention strategies.

**Approved Restriction**:

For the treatment of solid organ malignancies as an alternative to conventional taxanes in patients who:

- Have moderate to severe hypersensitivity reactions that may not be manageable despite use of pre-medications and prolonged taxane infusions
- Have anaphylaxis or anaphylactoid reactions to conventional taxanes
- Have significant contraindications to taxanes or pre-medications (e.g., high dose steroids).

# VIII. Medication Policies

The following hospital policies have been approved by the Medical Advisory Committee on the recommendation of the Drugs and Therapeutics Committee.

| | |
|---|---|
| MM-MA-030 | Medication Administration using OPOR-CIS |
| MM-MS-040 | Administration of Medically Authorized Cannabis |

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## Appendix I – Additions to NS Health Hospital Formulary to Align with IWK Health Centre Formulary (to Facilitate CIS Design/ CPOE Process)

Progesterone oral
Atomoxetine
Guanfacine
Lidocaine/epinephrine/tetracaine (LET) topical anesthetic
Dexamethasone suspension
Ruxolitinib
Methylphenidate SR tablets (for Ritalin SR)
Methylphenidate CR capsules (for Biphentin)
Nitrazepam
Anakinra subcutaneous/intravenous
Desmopressin tablets and melt tablets
Sodium chloride hypertonic nebules 7% (4 mL)
Ferric subsulfate topical paste
Paliperidone SR tablets
Leuprolide
Lorazepam sublingual tablets
Carboprost
Eltrombopag

## Appendix 2 – Additions to NS Health Hospital Formulary of Drugs Dispensed by the High Cost Drug Program (to Facilitate CIS Design/ CPOE Process)

Abacavir-Dolutegravir-Lamivudine
Abacavir-Lamivudine
Cabotegravir
Doravirine
Eculizumab – Restriction: for Paroxysmal Nocturnal Hemoglobinuria patients with DHW pre-approval
Efavirenz-Emtricitabine-Tenofovir
Glatiramer Acetate
Interferon Beta-1a Cartridge (rebif)
Interferon Beta-1a Inj (rebif)
Interferon Beta-1a Inj (avonex)
Interferon Beta-1a Pen (avonex)
Interferon Beta-1b (betaseron)
Lamivudine/Dolutegravir
Peginterferon Beta-1A
Rilpivirne/cabogegravir
Treprostinil
Voretigene neparvovec

## Appendix 3 – Additions to NS Health Hospital Formulary to Facilitate CIS Design/ CPOE Process

Tetrabenazine
Memantine
Desvenlafaxine
Bacitracin-Gramicidin-Polymyxin ointment (triple ointment)
Proparacaine HCl Soln 0.5% Ophth
Buprenorphine patches
Ropinirole
Abiraterone
Modafinil
Lid Care Towelettes
Trimipramine
Bicalutamide
Levomilnacipran
Exemestane
Estradiol patches
Norethindrone
Denosumab
Ketorolac ophthalmic
Terbinafine 1% cream
Fulvestrant injection
Clotrimazole 1%/betamethasone 0.05% cream (lotriderm)
Vaginal moisturizer (replens)
Imiquimod cream 5%
Metformin SR products
Deferasirox
Enzalutamide
Romiplostim