# Summer 2020

## Gulf Coast Society of Health-System Pharmacists (GCSHP) Newsletter

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# President's Letter

Dear GCSHP Members,

I am honored to serve as the 2020 – 2021 President for the Gulf Coast Society of Health-System Pharmacists. I want to thank you for your dedication during these challenging times when established norms have been disrupted and expectations have had to be adjusted. You have supported each other and the community by providing compassion and essential care for those in need. I am incredibly proud to be a part of the pharmacy phamily!

I joined the Board of Directors in 2016 and have thoroughly enjoyed getting to know more of my fellow pharmacists and future pharmacists who have served on the Board and who I have had the pleasure of speaking with at events. I am excited to be working with such an energized group of individuals on the Board this year as we navigate this dynamic environment. I look forward to words of wisdom from Ardath Mitchell as she moves into her role as the Immediate-past President. I am thrilled to welcome Jordan Burdine to the President-elect position, in addition to Christina York as Director who joins Thomas Roduta. Noor Zaidan comes highly recommended and will serve as New Practitioner Ambassador. We are fortunate to have Amanda Beck and Stella Kim continuing their roles as Treasurer and Recording Secretary, respectively. Ian Dunne is continuing his role as Communications Secretary where he continues to develop amazing newsletters with our Newsletter Chair, Meghan Ha. We are always looking for content, so don't be shy about submitting an article! If you haven't had the opportunity to read the newsletters or just want to know more about the Board members, please check out the website which looks fantastic after being revised by our new Website Manager, Niha Zafar.

We had a great year collaborating with our industry partners to provide many educational events coordinated by Chib Amuneke-Nze as Education Chair. Rick Ulasewich continues to be our Industry Liaison to engage our industry colleagues for support. We were privileged to have Kathy Salinas from the Texas State Board of Pharmacy provide Law and Opioid continuing education sessions at local facilities as well to contribute to licensure renewal requirements. I am grateful that Chib is continuing his role and joined by Natalie Finch to research new opportunities to provide valuable programming during the pandemic and coming months. As we look forward to what we can accomplish this next year to engage our pharmacy technician colleagues, Samantha Hanner has joined as Technician Chair to lead that charge.

Reba Forbess does an excellent job keeping us updated on membership activity. The chapter has steadily grown to over 500 members and remains the largest chapter of the Texas Society of Health-System Pharmacists. Forty percent of our membership is comprised of our inquisitive and enthusiastic future pharmacists who are represented by Ariba Abbas from the University of Houston, Andre Phillips from Texas Southern University, and Eza Ali from Texas A&M University. There are some incredible members in our community, and we want to recognize you! GCSHP offers several awards and scholarships annually including Outstanding Pharmacist, Outstanding Technician, Outstanding Student, Outstanding Industry Member, GCSHP Leadership Scholarship, and the Richard Cadle Mentoring Scholarship. Check out the website for a full description of qualifications. The call for nominations was emailed out so please nominate a well-deserving colleague!

Together we are committed to providing events and opportunities to meet the membership needs through the pandemic and beyond. We have sent out a survey to better understand how to meet member needs and provide support for you. Educational offerings approved for continuing education that have been postponed to later in the year include Emerging Perspectives in CKD Anemia, Enhanced Recovery after Surgery (ERAS), and Immune Globulin Stewardship Series. If we are unable to support in-person events, virtual platforms are being explored as well. TSHP is offering the Webinar Series on essential and emerging topics which are ACPE-approved and free to members! We are evaluating the possibilities for Casino Night as well as future networking and volunteer events based on member responses. Keep an eye on your email and check the website for updates!

Thank you for your continued support, and we look forward to seeing you at an event soon! Stay safe!

Respectfully yours,

**Laura Blackburn**

# Education - Updates to the 2020 Year

The Gulf Coast Society of Health System Pharmacists (GCSHP) Education Chairs are committed to both the safety and education engagement of our partners and members.

In light of the continued health risks of COVID-19 accompanied by the maintenance of executive orders reopening the state of Texas with social distancing, GCSHP will seek to hold virtual sponsored & CPE events with the goal to maintain the educational engagement with our members and partners. Though event dates and times are still "to-be-determined". We are hoping to hold virtual events that fulfill the coming TSBP changes (amendment to Board Rule 295.8) for licensure renewals as well as other relevant topics.

### Current topics being considered for the remainder of 2020:

- Human Trafficking Prevention
- Pain Management
- Prescribing and Monitoring Controlled Substances
- Pharmacy Law
- CKD Anemia
- Immune Globulin Stewardship

Image Source: Dgytal

We will extend postponing all in-person educational events through at least August 31st, 2020. We hope you are all doing well and staying safe during these times.

# Anticoagulation in Obese and Morbidly Obese Patients with Venous Thromboembolism

**Noor Zaidan, PharmD** – PGY1 Pharmacy Resident, UTMB Health **Preceptor: Eddie Lee, PharmD, BCPS**

There is controversy surrounding the use of direct oral anticoagulants (DOACs) for the treatment of venous thromboembolism (VTE) in morbidly obese patients defined as a BMI greater than 40 kg/m$^2$ or a weight greater than 120 kg. In 2016, the International Society on Thrombosis and Haemostasis (ISTH) recommended to avoid the use of DOACs for the treatment of VTE in patients with a BMI greater than 40 kg/m$^2$ or a weight greater than 120 kg due to lack of clinical data in this population.[1] The 2018 American Society of Hematology (ASH) guidelines for management of VTE discussed dosing low-molecular-weight heparin in obese patients based on actual body weight and recommended against using anti-factor Xa concentration monitoring to guide dose adjustment, while use of DOACs in obese patients was not reviewed.[2] The 2016 CHEST Guidelines for Antithrombotic Therapy recommended treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE) with a DOAC over warfarin, but did not address treatment with DOACs in morbidly obese patients.[3] However, very recently published primary literature has evaluated the use of DOACs for treatment of VTE in obese and morbidly obese patients.

Coons et al conducted a retrospective, matched cohort study which evaluated DOACs versus warfarin for the treatment of acute VTE in obese patients.[4] The primary outcome was recurrence of VTE within 12 months of the index admission date. Secondary outcomes included occurrence of PE, DVT, and bleeding within 12 months of the index admission date. A total of 1,840 patients with a weight greater than 100 kg and less than 300 kg were included, with 632 patients in the DOAC group and 1,208 patients in the warfarin group. Of the 632 patients in the DOAC group, 580 patients received rivaroxaban, 33 patients received apixaban, and 19 patients received dabigatran. Recurrence of VTE within 12 months of the index admission date did not differ in the DOAC and warfarin groups [41 (6.5%) vs. 77 (6.4%), p-value 0.93]. The occurrence of DVT or PE individually also did not differ between the DOAC and warfarin groups. Finally, the occurrence of bleeding did not differ between the DOAC and warfarin groups [11 (1.7%) vs. 14 (1.2%), p-value 0.31]. In conclusion, no differences were noted in the occurrence of VTE, PE, DVT, or bleeding within 12 months of the index admission date between DOAC-treated and warfarin-treated obese patients. This is the largest published study demonstrating that patients with obesity may be safely treated with a DOAC for acute VTE. Major limitations of the study were its retrospective design and lack of randomization to the anticoagulation treatment groups.

Kushnir et al performed a single center, retrospective chart review evaluating DOACs versus warfarin for the treatment VTE or atrial fibrillation in patients with morbid obesity.[5] A total of 795 patients were included in the study with 366 patients in the VTE cohort. Patients with a BMI greater than 40 kg/m$^2$ were included in the VTE cohort if prescribed apixaban, rivaroxaban, or warfarin for treatment of VTE. Outcomes included recurrent VTE and bleeding complications beginning with the first prescription date for apixaban, rivaroxaban, or warfarin until the earliest date of a thrombotic event, medication discontinuation, death or end of the study. In the VTE cohort, 199 patients received a DOAC while 167 patients received warfarin. Of the 199 patients in the DOAC group, 47 patients received apixaban and 152 patients received rivaroxaban. The incidence of recurrent VTE did not differ among the apixaban, rivaroxaban, or warfarin groups [1 (2.1%) vs. 3 (2%) vs. 2 (1.2%), respectively, p-value 0.74]. Also, the incidence of major bleeding did not differ between the apixaban, rivaroxaban, or warfarin groups [1 (2.1%) vs. 2 (1.3%) vs. 4 (2.4%), respectively, p-value 0.77). A subgroup analysis was also conducted which included patients with a BMI greater than 50 kg/m$^2$. The subgroup analysis included 92 patients being treated for a VTE with 10 patients receiving apixaban, 30 patients receiving rivaroxaban, and 52 patients receiving warfarin. This subgroup analysis demonstrated no difference between the apixaban, rivaroxaban, or warfarin groups with respect to VTE recurrence and major bleeding in patients with a BMI greater than 50 kg/m$^2$. In conclusion, this study displayed a low incidence of recurrent VTE and major bleeding in morbidly obese patients with a BMI greater than 40 kg/m$^2$ treated with apixaban, rivaroxaban, or warfarin. A strength of the study was that it is the largest study to date to examine only morbidly obese patients receiving DOACs for VTE. Major limitations of the study included its retrospective and single-center design.

Finally, Perales et al conducted a retrospective chart review evaluating VTE treatment and prevention of stroke in patients with a BMI greater than 40 kg/m$^2$ or weight greater than 120 kg.[6] The primary outcome in the VTE cohort was the incidence of clinical failure defined as VTE recurrence or mortality within 12 months of initiation of rivaroxaban or warfarin, while a secondary outcome included bleeding complications. A total of 176 patients met the study's inclusion criteria and 109 patients were included in the VTE treatment cohort. In the VTE cohort, 47 patients received rivaroxaban and 62 patients received warfarin. The incidence of clinical failure was not different between the rivaroxaban and warfarin groups [4 (8.5%) vs. 9 (14.5%), p-value 0.33]. The incidence of recurrent VTE was not statistically significantly different between

the rivaroxaban and warfarin groups [2 (4.3%) vs. 4 (6.5%), p-value 0.61]. There were more bleeding complications in the rivaroxaban group than the warfarin group, but this was not significantly different [3 (6.4%) vs. 2 (3.2%), p-value 0.65]. In conclusion, this study demonstrated no difference in the incidence of clinical failure, recurrence of VTE, or bleeding complications between rivaroxaban or warfarin in morbidly obese patients with VTE. The non-randomized, retrospective design and provider bias in selecting warfarin or rivaroxaban for specific patients based on co-morbidities were limitations of the study. **Table 1** summarizes the three studies reviewed.

**Table 1: DOACs vs. Warfarin in Obese and Morbidly Obese Patients with VTE**

| Study | Study Design | Primary Efficacy Outcome | | | | Primary Safety Outcome | | | |
|---|---|---|---|---|---|---|---|---|---|
| Coons et al, 2020[4] n = 1,840 | Retrospective matched cohort study | Recurrence of VTE within 12 months of admission | | | | Bleeding within 12 months of admission | | | |
| | | DOAC (n = 632) | Warfarin (n = 1208) | p-value | | DOAC (n = 632) | Warfarin (n = 1208) | p-value | |
| | | 41 (6.5%) | 77 (6.4%) | 0.93 | | 11 (1.7%) | 14 (1.2%) | 0.31 | |
| Kushnir et al, 2019[5] n = 795 VTE = 366 | Single center retrospective chart review | Recurrent VTE from the 1st prescription date to the earliest of a thrombotic event, medication discontinuation, or death with a BMI > 40 kg/m² | | | | Major bleeding from the 1st prescription date to the earliest of a thrombotic event, medication discontinuation, or death with a BMI > 40 kg/m² | | | |
| | | Apixaban (n = 47) | Rivaroxaban (n = 152) | Warfarin (n = 167) | p-value | Apixaban (n = 47) | Rivaroxaban (n = 152) | Warfarin (n = 167) | p-value |
| | | 1 (2.1%) | 3 (2%) | 2 (1.2%) | 0.74 | 1 (2.1%) | 2 (1.3%) | 4 (2.4%) | 0.77 |
| | | Recurrent VTE from the 1st prescription date to the earliest of a thrombotic event, medication discontinuation, or death with a BMI > 50 kg/m² | | | | Major bleeding from the 1st prescription date to the earliest of a thrombotic event, medication discontinuation, or death with a BMI > 50 kg/m² | | | |
| | | Apixaban (n = 10) | Rivaroxaban (n = 30) | Warfarin (n = 52) | p-value | Apixaban (n = 10) | Rivaroxaban (n = 30) | Warfarin (n = 52) | p-value |
| | | 0 | 0 | 2 (3.8%) | 0.63 | 0 | 0 | 2 (3.8%) | 0.63 |
| Perales et al, 2019[6] n = 176 VTE = 109 | Retrospective chart review | Clinical failure, defined as VTE recurrence or mortality, within 12 months of initiation | | | | Bleeding complications within 12 months of initiation | | | |
| | | Rivaroxaban (n = 47) | Warfarin (n = 62) | p-value | | Rivaroxaban (n = 47) | Warfarin (n = 62) | p-value | |
| | | Clinical failure: 4 (8.5%) / VTE: 2 (4.3%) | Clinical failure: 9 (14.5%) / VTE: 4 (6.5%) | Clinical failure: 0.33 / VTE: 0.61 | | 3 (6.4%) | 2 (3.2%) | 0.65 | |

In conclusion, the recurrence of VTE and bleeding in obese and morbidly obese patients with VTE did not differ between DOACs and warfarin in the reviewed studies. However, major limitations of the reviewed studies included retrospective study design and lack of randomization in all three studies plus relatively small numbers of patients in two studies. Rivaroxaban was by far the most examined DOAC in these three studies, so the results of these studies should not be extrapolated to other DOACs. Until better designed studies are published using DOACs for the treatment of VTE in obese or morbidly obese patients, it may be prudent to follow the 2016 ISTH recommendation to avoid DOACs for VTE treatment in patients with a BMI greater than 40 kg/m² or a weight greater than 120 kg.

**References**


1. McLintock C, Pabinger I, Bauer KA, et al. International Society on Thrombosis and Haemostasis core curriculum project: core competencies in clinical thrombosis and hemostasis. Journal of Thrombosis and Haemostasis 2016;14(1):3-27.
2. Witt DM, Nieuwlaat R, Clark NP, et al. American Society of Hematology 2018 guidelines for management of venous thromboembolism: optimal management of anticoagulation therapy. Blood Adv 2018;2(22):3257–3291.
3. Kearon C, Akl EA, Ornelas J, et al. Antithrombotic therapy for VTE disease. Chest 2016;149(2):315-352.
4. Coons JC, Albert L, Bejjani A, et al. Effectiveness and safety of direct oral anticoagulants versus warfarin in obese patients with acute venous thromboembolism. Pharmacotherapy 2020;40(3):204-210.
5. Kushnir M, Choi Y, Eisenberg R, et al. Efficacy and safety of direct oral factor Xa inhibitors compared with warfarin in patients with morbid obesity: a single-centre, retrospective analysis of chart data. The Lancet Haematology 2019;6(7):e359-365.
6. Perales IJ, Agustin KS, Deangelo J, Campbell AM. Rivaroxaban versus warfarin for stroke prevention and venous thromboembolism treatment in extreme obesity and high body weight. Annals of Pharmacotherapy 2019;54(4):344-350.

# Texas State Board - Continuing Education

## Pharmacist Continuing Education (CE) Requirement Breakdown

### Board Rule §295.8

**30 total hours** are required per renewal period, which include the following:

| | |
|---|---|
| **2 Hours (1 hour annually)** | Must be related to **pain management.**<br><br>***Special note:***<br>You must be sure to obtain at least one hour **annually** (as specified in House Bill 3285). For example, a single two-hour course would not meet requirements as outlined by House Bill 3285 or Board rule 295.8. Requirement must be met for all renewals received ***after*** August 31, 2021 and ***before*** September 1, 2023. |
| **2 Hours** | Must be related to **prescribing and monitoring controlled substances** (as specified in House Bill 2174).<br><br>A pharmacist shoudl take the controlled substance CE ***no later than September 1 2021*** and submit this CE on the new renewal after September 1, 2021. |
| **1 Hour** | Must be related to **mental health awareness.**<br><br>Requirement must be met for all renewals receiged ***after*** August 13, 2021 and ***before*** September 1, 2023. |
| **1 Hour** | Must be related to **Texas-specific pharmacy laws and/or rules.** |
| **24 Hours** | Can be **any subject**; can also consist of any **special certification CE requirements**, if applicable (for example, sterile compounding, immunization, preceptorship, etc.; see special CE requirements). |

## Other Training Requirements:

### Human Trafficking Prevention Course Requirement (Mandatory)

For renewals received after August 31, 2020 and before September 1, 2022, a pharmacist must have completed the human trafficking prevention course required in §116.002 of the Texas Occupations Code. As specified in House Bill 2059, 86th Legislature, Regular Session, the Executive Commissioner of the Texas Health and Human Services Commission (HHSC) shall approve training courses on human trafficking prevention, including at least one course that is available without charge. A list of the approved courses will be posted on the commission's internet website. Newly licensed pharmacists are **not** exempt from this requirement.

### Supplemental Training (Non-Mandatory)

House Bill 3285 (86R) mandates that the board encourage pharmacists to participate in a program that provides a comprehensive approach to the delivery of early intervention and treatment services for persons with substance use disorders and persons who are at risk of developing substance use disorders, such as a program promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the United States Department of Health and Human Services. The Providers Clinical Support System (PCSS) is funded by a grant from SAMHSA and offers a free activity for pharmacists on its website: Opioid Use Disorder and Pain Management Assessment Tool.

# Texas State Board - Continuing Education (Cont'd)

## Newly Licensed Pharmacist Continuing Education (CE) Requirement Breakdown Board Rule §295.8

**At least 4 total hours** are required in your initial renewal period, which include:

Per Board rule 295.8(d)(4)(A), you are **exempt** from these requirements

| | |
|---|---|
| **2 Hours (1 hour annually)** | Must be related to **pain management.**<br><br>***Special note:***<br>You must be sure to obtain at least one hour **annually** (as specified in House Bill 3285). For example, a single two-hour course would not meet requirements as outlined by House Bill 3285 or Board rule 295.8. Requirement must be met for all renewals received ***after*** August 31, 2021 and ***before*** September 1, 2023. |
| **2 Hours** | Must be related to **prescribing and monitoring controlled substances** (as specified in House Bill 2174).<br><br>A pharmacist shoudl take the controlled substance CE ***no later than September 1 2021*** and submit this CE on the new renewal after September 1, 2021. |
| **1 Hour** | Must be related to **mental health awareness.**<br><br>Requirement must be met for all renewals received ***after*** August 13, 2021 and ***before*** September 1, 2023. |
| **1 Hour** | Must be related to **specific pharmacy laws and/or rules.** |
| **24 Hours** | Can be **any subject**; can also consistent of any **special certification CE requirements**, if applicable (for example, sterile compounding, immunization, preceptorship, etc.; see special CE requirements). |

EXEMPT

## Other Training Requirements:

### Human Trafficking Prevention Course Requirement (Mandatory)

For renewals received after August 31, 2020 and before September 1, 2022, a pharmacist must have completed the human trafficking prevention course required in §116.002 of the Texas Occupations Code. As specified in House Bill 2059, 86th Legislature, Regular Session, the Executive Commissioner of the Texas Health and Human Services Commission (HHSC) shall approve training courses on human trafficking prevention, including at least one course that is available without charge. A list of the approved courses will be posted on the commission's internet website. Newly licensed pharmacists are **not** exempt from this requirement.

### Supplemental Training (Non-Mandatory)

House Bill 3285 (86R) mandates that the board encourage pharmacists to participate in a program that provides a comprehensive approach to the delivery of early intervention and treatment services for persons with substance use disorders and persons who are at risk of developing substance use disorders, such as a program promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the United States Department of Health and Human Services. The Providers Clinical Support System (PCSS) is funded by a grant from SAMHSA and offers a free activity for pharmacists on its website: Opioid Use Disorder and Pain Management Assessment Tool.

# Texas State Board - Continuing Education (Cont'd)

## Pharmacy Technician Continuing Education (CE) Requirement Breakdown Board Rule §297.8

**20 total hours** are required per renewal period, which include:

| | |
|---|---|
| **1 Hour** | Must be related to **Texas-specific pharmacy laws and/or rules**. |
| **19 Hours** | Can be **any subject;**<br><br>Can also consist of any special certification CE requirements, if applicable (for example, sterile compounding). |

## Other Training Requirements:

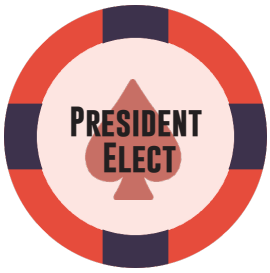
### Human Trafficking Prevention Course Requirement (Mandatory)

For renewals received after August 31, 2020 and before September 1, 2022, a pharmacist must have completed the human trafficking prevention course required in §116.002 of the Texas Occupations Code. As specified in House Bill 2059, 86th Legislature, Regular Session, the Executive Commissioner of the Texas Health and Human Services Commission (HHSC) shall approve training courses on human trafficking prevention, including at least one course that is available without charge. A list of the approved courses will be posted on the commission's internet website. Newly licensed pharmacists are **not** exempt from this requirement.

# GCSHP Board of Directors


**Laura Blackburn**

PharmD, BCPS, BCCCP

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