Making the Right Medication Coverage Decisions in Hospice

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Hospice Medicare Benefit:
What drugs should be covered??

Hospice is responsible for coverage of the drugs considered to be reasonable and necessary for palliation and management of the terminal illness (hospice diagnosis) and related conditions.

Medicare does not specify which drugs are deemed palliative

Source: Medicare Hospice General Requirements
Hospice Medication Coverage: Admission considerations

- Patient’s plan of care (patient, doctor, hospice team)
- Patient/family goals of care
- Medications needed to achieve the goals*
- Hospice agency’s “palliative philosophy”
- Hospice agency’s financial capabilities

*Any medications that do not help patient/family meet the goals of care or enhance comfort should be D/C’d

General Questions and Answers About Palliative Medications

Palliative meds:
- relieve current symptoms of disease
- provide comfort to the patient
- no intention of prolonging life
- no intention of promoting cure
- no intention of achieving long-term positive outcomes

Definitive Question:
What troublesome symptom will this medication relieve?

Can this question be answered succinctly?

Patient factors that may guide the decision for hospice drug coverage

- The patient’s terminal diagnosis (hospice diagnosis) – primary factor
- Patient’s current condition
  - functional status
  - quality of life
  - PPS rating (Palliative Performance Scale)
  - Karnofsky score
- Goals of care
  - comfort only, non-invasive measures
  - preserving a level of functionality
  - maintaining current quality of life
- Overall prognosis – life expectancy (months, days?)
Symptoms managed via “hospice covered” medications

- Pain
- Nausea-vomiting
- Anxiety, insomnia agitation
- Depression (related to terminal illness)
- Psychotic symptoms (delirium)
- Bowel issues: constipation/diarrhea
- Fluid retention
- Loss of appetite
- Infection
- Oro-pharyngeal secretions
- Dyspnea
- Coughing
- Epigastric symptoms (pain, reflux, bloating)
- Seizures (related to terminal illness)
- Itching

Examples of Non-Palliative Drugs Often Not Covered by Hospice

- Cholesterol lowering drugs (statins): Lipitor, Zocor, Simvastatin, Lovastatin
- Cognitive enhancing drugs: Aricept, Exelon, Galantamine, Namenda
- Hematopoetic drugs: Epogen, Procrit, Aranesp
- Thromboprophylaxis drugs (anticoagulants): Lovenox, Fragmin, Plavix, Pradaxa, Coumadin, Aggrenox
- Chemo-therapeutic drugs

Diagnosis-specific drug coverage: Cancer

- Brain cancer/mets: anticonvulsants, corticosteroids
- Lung cancer/mets: bronchodilators (inhaled), steroids (oral and/or inhaled), expectorants & anti-tussives, mucolytics
- Pancreatic cancer: digestive enzymes – if pt. still eating regular meals
- Esophageal or stomach cancer: acid blockers (PPIs, H-2 antagonists, antacids); metoclopramide
- Bone cancer/mets: steroids, NSAIDs
- Liver cancer/mets: diuretics, lactulose, Xifaxan, cholestyramine (itching)
### Diagnosis-specific drug coverage: CVA/Stroke

- Possible CVA related symptoms include:
  - Seizures, muscle spasms
- Hospice would cover anticonvulsants and muscle relaxants
- Anticoagulants +/- antiplatelet drugs often stopped:
  - (Lovenox, Fragmin, Coumadin, Pradaxa +/- Aggrenox, Plavix)*

*Often not continued for terminal diagnosis of CVA when admitted to hospice - risks outweigh benefits (more on following slides)

### Challenges with Anticoagulants in Hospice Patients

**Cardiovascular adverse event risk:**
- Patients w/ cancer are at increased risk for DVT / thromboembolism
- Thromboembolic event may result in serious debility or death
- Atrial fibrillation:
  - anticoag do not reduce symptoms of AF
  - anticoags reduce stroke risk by about 4% per year*
  - actual reduction in stroke risk for hospice pt. very low (since avge length of stay is about 20 days)

**Anticoagulant adverse effect risk & other negatives:**
- Hospice patients are at increased risk for serious bleeding episodes (malnutrition, tumor infiltration, renal and/or hepatic impairment)
- Numerous drug interactions (Warfarin)
- Burden associated with invasive therapy and/or lab monitoring
- Potentially high costs to hospice and/or patient for questionable benefit

*Archives of Internal Medicine 1964;54: 1449-57

### Reasons For & Against Anticoagulant Therapy in Hospice

<table>
<thead>
<tr>
<th>Rationale to continue</th>
<th>Rationale to stop</th>
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<tbody>
<tr>
<td>Prevent further loss of function due to stroke</td>
<td>Avoid risk of serious bleeding</td>
</tr>
<tr>
<td>Prevent death due to thromboembolism</td>
<td>Prevent further loss of function or death secondary to hemorrhage</td>
</tr>
<tr>
<td>Preserve current level of function - “buy time”? (more time to “get affairs in order”)</td>
<td>Spare the patient from invasive therapy or invasive lab monitoring</td>
</tr>
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<td></td>
<td>Avoid prolonging poor QoL</td>
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</table>
Guidance for Anticoagulants in Hospice

Rationale for D/C of anticoagulants in hospice patients:

- Not palliative drugs
- Often are used for preventative or prophylactic purpose
- May require invasive administration method or lab monitoring which is not consistent with hospice principles
- Have significant potential for adverse effects which will often outweigh potential benefits in hospice patients

Possible exceptions to above:
- reasonable current level of function (PPS of 40 or better)
- and a reasonable QoL
- and is deemed to be at high risk for further thrombotic events.

Diagnosis-specific drug coverage:  Dementia

- Antipsychotic drugs: helpful for hallucinations, paranoia, and agitation (haloperidol, risperidone)

- Anxiolytic drugs: helpful for brief periods of time to provide sedation (lorazepam, alprazolam, phenobarbital) (benzodiazepines may worsen confusion in dementia, especially when used routinely for extended periods)

- Cognitive enhancing drugs (Aricept, Exelon, Namenda): are not continued in hospice patients with a terminal diagnosis of dementia due to lack of effectiveness in end stage (FAST level 7). (risk for adverse drug effects will outweigh any potential benefit at end-stage)

Diagnosis-specific drug therapy:  CHF

- Standard maintenance therapy is considered both disease modifying and palliative for HF.

- Hospice to cover these categories and drugs: Diuretics, ACE inhibitors or ARBs, Beta blockers, Digoxin, and Nitrates for as long as patient can take them

- Oral morphine or Roxanol is very helpful for dyspnea related to end stage HF (all opioids are beneficial for dyspnea)

- Statins have no place in hospice care and should be D/C’d
Diagnosis-specific drug therapy: **COPD**

- Includes COPD, Emphysema, Pulmonary fibrosis
- Covered meds may include one or more of the following:
  - Beta-agonist bronchodilators: Albuterol, Serevent, Brovana
  - Anticholinergic bronchodilators: Spiriva, Atrovent
  - Steroids: Flovent, Q-var, Pulmocort, Prednisone (oral)
  - Combinations: Duoneb, Advair, Symbicort
- Avoid unnecessary therapeutic duplications (very costly):
  - Nebulizer and MDI therapy with same drug
  - Two steroids
  - Two bronchodilators with same mechanism of action

Diagnosis specific drug therapy: **Debility & Decline**

- Often there is one or more conditions that collectively contribute to D&D
- Cover all meds related to “contributing conditions” as well
- **Example:**
  - Pt. with hospice diagnosis of D&D
  - Co-morbidity of CHF and renal insufficiency
  - **Cover:** traditional palliative meds plus meds considered reasonable & necessary for management of CHF & renal disease
- If no co-morbidities: just cover traditional palliative meds

Infections: what about antibiotics?

Cover antibiotics and/or antifungals if:
- infection related to the terminal diagnosis
- infection may be a causative factor of terminal decline
- the patient is expected to live long enough to benefit

Situations when anti-infective drugs are often covered:

<table>
<thead>
<tr>
<th>Type of infection</th>
<th>Terminal diagnosis</th>
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<tbody>
<tr>
<td>Thrush</td>
<td>Debility &amp; decline</td>
</tr>
<tr>
<td>Respiratory infection</td>
<td>COPD</td>
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<tr>
<td>UTI</td>
<td>Prostate Cancer</td>
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Why treat anorexia in hospice patients?

- Reduce the constellation of anorexia-related symptoms:
  - wasting of muscle mass, fatigue, weakness, lethargy
- Address impaired QoL
- Reduce risk for additional medication side effects
- Only continue appetite stimulant med if demonstrable benefit exists:
  - wt. gain due to the drug
  - cessation of wt. loss due to the drug
- May not be appropriate in advanced disease with low level function (PPS or Karnofsky of 40 or less)

Appetite stimulants in hospice

<table>
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<tr>
<th>Drug</th>
<th>Initial Dosage</th>
<th>Comments</th>
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| Dronabinol (Marinol) | 2.5 mg bid | - also helps with nausea  
- adverse mental status changes especially in elderly  
- very expensive |
| Cyproheptadine (Periactin) | 4mg tid | - drowsiness, weak efficacy relative to others |
| Megestrol (Megace) | 400 - 800mg qd | - risk for DVT and PE in elderly or history of cardiovascular disease (Avoid in these patients) |
| Mirtazepine (Remeron) | 15mg qHS | - effective, well tolerated  
- helps with insomnia |
| Dexamethasone (Decadron) | 4mg qd | - also helps with nausea, mood  
- SE: fluid retention, hyperglycemia, infection, psychosis (doses > 10mg) |

Cost-effective alternatives: L.A. Opioids

<table>
<thead>
<tr>
<th>High cost drugs</th>
<th>Cost effective alternatives</th>
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<tr>
<td>Oxycontin</td>
<td>Methadone tabs or solution</td>
</tr>
<tr>
<td>Fentanyl patch</td>
<td>Morphine Ext Release tablet</td>
</tr>
<tr>
<td>Opana ER</td>
<td></td>
</tr>
<tr>
<td>Avinza capsule</td>
<td></td>
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<tr>
<td>Kadian capsule</td>
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Cost Comparison: Long Acting Opioids

Hospice cost (AWP) of a 15 day supply of equi-analgesic doses:

<table>
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<tr>
<th>Dosage</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Oxycontin 80mg Q12h</td>
<td>$422.00</td>
</tr>
<tr>
<td>Opana ER 40mg Q12h</td>
<td>$400.00</td>
</tr>
<tr>
<td>Fentanyl Patch 100mcg Q72h</td>
<td>$185.00</td>
</tr>
<tr>
<td>Morphine ER tablet 100mg Q12h</td>
<td>$110.00</td>
</tr>
<tr>
<td>- Avinza capsule 240mg Q24h</td>
<td>$210.00</td>
</tr>
<tr>
<td>- Kadian capsule 200mg Q24h</td>
<td>$190.00</td>
</tr>
<tr>
<td>Methadone 10mg Q12h</td>
<td>$12.00</td>
</tr>
</tbody>
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Cost-effective alternatives: Antipsychotics

Hospice cost (AWP) of a 15 day supply of equivalent doses:

**Second generation (atypicals)**
- Aripiprazole (Abilify) 5mg QD $300
- Olanzapine (Zyprexa) 2.5mg BID 190
- Ziprasidone (Geodon) 30mg BID 125
- Quetiapine (Seroquel) 100mg BID 120
- Risperidone (Risperdal) 1mg BID 80

**First generation**
- Chlorpromazine(Thorazine) 50mg BID $30
- Haloperidol (Haldol) 1mg BID 10

Pros & Cons: Haloperidol (Haldol)

Uses – very effective for the following:
- psychotic symptoms (hallucinations, paranoia, delusions)
- agitation (related to delirium, dementia)
- terminal delirium
- nausea/vomiting

EPS risk is greater than with second generation atypical agents (Risperidone, Quetiapine, Olanzapine)
- EPS uncommon at lower doses of < 5mg/day haloperidol
- Parkinson’s patients and pediatric pts. at greater risk
- Risperidone is preferred if EPS risk is a concern
Cost-effective alternatives: Hypnotic drugs

Hospice cost of a 15 day supply of equivalent doses:

- Lunesta 2mg $110
- Rozaem 8mg 90
- Ambien CR 6.25mg 75
- Zolpidem (Ambien) 35
- Trazadone (Desyrel) 50mg 14
- Temazepam (Restoril) 15mg 11

Special case: Temazepam 7.5mg (single source): $110
- alternative is Trazadone 25mg Qhs

Cost-effective alternatives: PPI’s (acid blockers)

Proton pump inhibitors: Hospice cost of a 15 day supply of equivalent doses:

Brand only:
- Aciphex (rabeprazole) $140
- Nexium (esomeprazole) 105
- Dexilant (dexlansoprazole) 72

Generic available:
- Lansoprazole (Prevacid) $65
- Pantoprazole (Protonix) 35
- Omeprazole (Prilosec capsule) 35
- Omeprazole (Prilosec OTC tab – do not crush) 12

PPI therapy for patients that can’t swallow pills

- Omeprazole (Prilosec OTC) tablets should not be crushed (loss of effectiveness) – do not use
- Omeprazole (Prilosec Rx) capsules can be opened and contents put in apple juice or applesauce (must be slightly acidic juice)
- For G-tube: administer capsule contents in 30ml apple juice
Questions
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