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Gov't Pharmacy Signs Off

It was inevitable. The ever-lengthening list of backorders told us the end was near. On October 1st, Ontario Government Pharmacy (OGP) will cease to exist. What does this mean for LTC facilities? The answer: I'm not exactly sure, but I have some thoughts.

The best news is that there will be no more approval authorization requests to send to OGP. All orders for listed products (the list is unchanged) are preapproved and can be sent directly to GeriatRx. Another positive is that some products which are currently ordered in bulk, can now be ordered per resident. Isopto Tears is the best example of this. We will label it like other Rx eyedrops. This will eliminate compliance concerns as each dropper will have an Rx#, resident name, date, and directions.

Bulk ordering is still available. Products like Vaseline, body lotion, and zinc ointment are examples. Please place these orders before your current supply is exhausted so we have adequate time to get you what you need. To reduce delivery volumes of heavy items, modest order quantities would be appreciated.

Some facilities manage their OGP products differently than others. Products like Barriere Cream or A535/Vitarub may be ordered in bulk by some and per resident by others. Individual ordering has the same labeling advantages as Isopto Tears and is very useful if these products are stored in a treatment cart. If most residents are using one of these products, however, individualized ordering will be challenging and cart storage, impossible. MOH asks that facilities make a choice between bulk and individual ordering for each product.

You should continue to use your current OGP supplies in the home until diminished. At that point, stock bottles of some products (e.g., Senokot, acetaminophen) should be retained for PRN use. When the supply runs low you can order more from us. I expect I will have more to say as this process plays out. If you have any other specific questions please give me a call or speak to your consultant pharmacist.

Stop Warfarin – Not So Fast

Back in 2009, I wrote an article entitled "The End of INRs". Dabigatran and rivaroxaban were the new anticoagulants (NOACs) being used post-hip and knee replacements. They were being studied for clot prevention in atrial fib, and we know how that turned out. I thought the writing was on the wall for warfarin. Rather than be driven to extinction it has stubbornly held on and is still used for patients with mechanical heart valves or severe liver or kidney disease.

While most residents taking warfarin for atrial fib have been switched to a NOAC, some have had consistent INRs and been event-free. There may be a temptation to avoid blood testing and convert these residents. A new study, FRAIL-AF says NO.

Prior studies comparing NOACs to warfarin enrolled very few frail elderly patients. FRAIL-AF included only frail elderly (1400 entrants; average age 83 years) with multiple morbidities (CHA2DS2-VASc mean score = 4). The NOAC group had more major bleeds (15.3% vs. 9.4%). Excess bleeding in the NOAC group began after 100 days and increased thereafter. Clotting events in the two groups occurred at a similar, non-significant rate (2.4% warfarin vs. 2% in the NOACs).

Major bleeds halted the study. Rivaroxaban and apixaban were each culpable. My earlier warfarin eulogy may indeed have been premature.

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