



# Newsletter

## Laboratory Monitoring in Hospice Care: Why, What, and When?

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Safe and effective medication use is critical to quality patient care. Laboratory monitoring can be an important part of medication safety and efficacy. The goal of hospice care is to palliate symptoms rather than diagnose and cure disease, so routine laboratory assessment is greatly reduced and often suspended in hospice patients. In certain circumstances, monitoring parameters must remain in place to preserve patient safety and quality of life. There are three components of medication use that are important for healthcare professionals to understand: which medications generally require laboratory monitoring, signs and symptoms of medication adverse effects, and



discussing medication risks and benefits with our patients.

Some medications have a narrow therapeutic index (NTI), meaning that only a small difference separates a therapeutic drug level from a toxic drug level. Laboratory monitoring helps healthcare professionals ensure the amount of drug in a patient's body stays in the safe range, between these two levels. Other medications call for lab assessments to detect adverse effects of therapy such as hyper- or hypokalemia, hypoglycemia, or excessive anticoagulation. Situations warranting ongoing lab monitoring for patients receiving hospice care are listed in Table 1. Drug concerns vary according to

*Continued on page 2*

**Table 1. Laboratory Monitoring Parameters for Medications**

Ongoing lab monitoring and patient assessment required		
Drug Concern	Parameter	Drugs
Bleeding risk	INR	Warfarin
Hypoglycemia	FBG*	Insulin
Thromboembolism	Hgb	EPO agents (Aranesp®, Procrit®)
Lab monitoring may be discontinued, but ongoing careful patient assessment required		
Drug Concern	Parameter	Drugs
Abnormal Movement	AIMS	Antipsychotics
Hepatotoxicity	LFTs	Amiodarone
Hyperglycemia	FBG*	Antipsychotics, corticosteroids, niacin
Hypoglycemia	FBG*	Oral hypoglycemics
Hyperkalemia	Serum K+	Aldosterone antagonists, potassium supplements, ACE-Is, ARBs
Hypokalemia	Serum K+	Diuretics
Metabolic effects	Lipids	Antipsychotics
Narrow therapeutic index (NTI)	Trough level	Carbamazepine, cyclosporine, digoxin, disopyramide, lithium, phenytoin, procainamide, quinidine, valproic acid, xanthines
Renal impairment	sCr and BUN	Digoxin, metformin
Rhabdomyolysis	Creatine kinase	Fibrates, statins
Thyroid dysfunction	TSH	Amiodarone, levothyroxine, liothyronine, liotrix, desiccated thyroid

AIMS – Abnormal Involuntary Movement Scale, BUN – Blood Urea Nitrogen, CBC – Complete Blood Count, FBG – Fasting Blood Glucose (\*finger stick), Hgb – Hemoglobin, Hct – Hematocrit, INR – International Normalized Ratio, LFT – Liver Function Test, NTI – Narrow Therapeutic Index, sCr – Serum Creatinine, TSH – Thyroid Stimulating Hormone

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The HospiScript Newsletter is a quarterly publication for the clients of HospiScript Services. Articles for publication consideration may be submitted to the attention of the Managing Editor, Kim Konczal (kkonczal@hospi-script.com). The clinical information contained in this newsletter is not medical advice. Health care providers should exercise independent clinical judgment. Some information cites the use of a product in a manner or for an indication other than that recommended in the product labeling. Accordingly, the official prescribing information should be consulted before any such product is used.

the pharmacologic activity profile of the medication: lab monitoring, parameter to monitor, and risks, are provided for each concern. Certain medications should always have lab monitoring or assessment for safe use.

While all of the medications in Table 1 have valid indications for assessing lab values, they do not absolutely require lab monitoring to be used safely and effectively. When assessing lab values for these medications, they should be checked at least every six months. If a patient prefers not to have lab work and shows no signs of toxicity or adverse effects, lab monitoring may be discontinued. The best way to maintain patient safety upon discontinuation of lab monitoring is to be aware of signs and symptoms of toxicity from these medications (Table 2). Healthcare professionals must also educate families and caregivers about observing patients for these signs and evaluate risks versus benefits. Due to the risk of adverse effects, lack of palliative symptom benefit, and patient/caregiver desire to reduce the number of medications taken, in many cases the safest approach may be to simply discontinue the medication.

Lab monitoring is necessary for safe use of warfarin, erythropoietin-stimulating (EPO) agents, and insulin. This is due to the severity of adverse effects and risks associated with these drugs. Familiarity with signs of toxicity from these drugs and how often to monitor them is especially important (Table 3).

If a patient shows some sign or symptom of toxicity, an intervention is always warranted. Risk-versus-benefit decisions are an important aspect of this process. Some medications, such as statins and fibrates, provide no symptom management benefit and may be discontinued. The following steps should be taken upon sign or symptom of toxicity:

- Discuss symptoms with patient or caregiver
- Determine onset, description, severity, duration, and frequency of symptoms
- Review all potential causes of the patient's symptoms, both drug and disease related

If a drug or drug interaction can be identified as the most probable cause of symptoms:

- reduce the dose

**Table 2. Adverse Effects and Toxicity of Medications**

Drug Class (Example)	Toxicity Concern	Signs of Toxicity
ACE-Inhibitors (lisinopril)	Hyperkalemia	Nausea, fatigue, muscle weakness or tingling, bradycardia
Aldosterone antagonists (spironolactone)	Hyperkalemia	Nausea, fatigue, muscle weakness or tingling, bradycardia
Amiodarone	Hepatotoxicity and Thyroid Dysfunction	Lethargy, peripheral edema, weight loss, cough, pleuritic pain
ARBs (losartan, valsartan)	Hyperkalemia	Nausea, fatigue, muscle weakness or tingling, bradycardia
Antipsychotics (haloperidol, olanzapine)	Abnormal movements	Akathisia, tongue protrusion, dyskinesia, dystonia
Carbamazepine	NTI	Excessive sedation, vomiting, mouth pain, bruising, bleeding
Corticosteroids	Hyperglycemia	Increased thirst, increased urination, nocturia
Cyclosporine	NTI	Hypertension, headache, recurrent infection, fluid retention
Digoxin	NTI	Nausea, vomiting, confusion, vision changes
Disopyramide	NTI	Confusion, agitation, urinary retention, palpitations
Diuretics (furosemide)	Hypokalemia	Dehydration, muscle weakness or cramping, palpitations
Fibrates (fenofibrate)	Rhabdomyolysis	Muscle pain and weakness, jaundice
Lithium	NTI, SIADH	Confusion, increased urination, muscle cramping and weakness, tremors
Metformin	Lactic acidosis	Nausea, vomiting, hyperventilation, lethargy, hypotension (increased risk of lactic acidosis with renal impairment; avoid use when CrCl <60ml/min)
Niacin	Hyperglycemia	Nausea, fever, malaise
Oral hypoglycemic (glipizide, glyburide)	Hypoglycemia	Diaphoresis, tachycardia, tremor, headache, nausea
Phenytoin	NTI	Blurred vision, ataxia, slurred speech, lethargy, nausea, vomiting
Potassium supplements	Hyperkalemia	Nausea, fatigue, muscle weakness or tingling, bradycardia
Procainamide	NTI	Chest pain, palpitations, acute diarrhea, fatigue
Quinidine	NTI	Chest pain, palpitations, tinnitus, fatigue
Statins (simvastatin, atorvastatin)	Rhabdomyolysis	Muscle pain and weakness, jaundice
Valproic acid	NTI	Lethargy, mental status changes, headache, nausea, vomiting
Xanthines (theophylline)	NTI	Tachycardia, tremor, gastrointestinal effects, headache

- discontinue the medication
- consider alternative medications

To illustrate this process, imagine a hospice patient taking warfarin notices increased bruising; the first course of action is to discuss with the patient or caregiver when the bruising began and assess the severity of bruising. During this discussion, the objective is to identify precipitating factors associated with the symptom; decline in nutritional intake, a new medication or supplement, or worsening liver function may be increasing the anti-coagulation effects of warfarin. If something can be identified as causing the bruising, the solution is to correct this cause if possible. If no precipitating factor can be found, the warfarin dosage must be decreased. At this time, an INR would be needed to help guide dosage adjustments. In addition, a discussion with the patient or caregiver

should include a review of why the patient is taking warfarin and whether or not it is necessary to continue. For example, patients taking warfarin for primary prevention of stroke due to underlying atrial fibrillation may choose to discontinue or change to low dose aspirin therapy, while those taking warfarin for treatment of a recent DVT may choose to continue. Recognition that bruising is a sign of warfarin toxicity was necessary to appropriately address the patient's symptom. Becoming familiar with signs of medication toxicity can prevent a large number of adverse effects, especially for those medications with a narrow therapeutic index or prominent adverse effects. Recognizing these signs in hospice care is even more important, as laboratory monitoring is frequently reduced or discontinued. Knowledge of the proper way to monitor and assess patients on these medications can greatly improve the safety and quality of life for hospice patients.

#### References

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**Table 3. Recognizing Toxicity from Drugs Requiring Laboratory Monitoring**

Drug/Class	Toxicity Concern	Signs/Symptoms of Toxicity	Monitoring and Frequency
Warfarin	Hypocoagulation	Bleeding, bruising, petechiae	INR every 2-4 weeks
EPO agents	Thromboembolism	Hgb levels should typically not exceed 10 g/dL	Hgb (CBC) every 2-4 weeks
Insulin	Hypoglycemia	Diaphoresis, tachycardia, tremor, headache, nausea	FBG daily or prior to any insulin injection

## Nortriptyline and Gabapentin for Neuropathic Pain

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David Weissman, MD

Neuropathic pain was first described by the International Association for the Study of Pain in 1994 as pain “initiated or caused by a primary lesion or dysfunction in the nervous system.” It is felt to affect 2-3% of the general population through such disorders as cervical/lumbar radiculopathy, diabetic polyneuropathy, post-herpetic neuralgia, cancer and specific cancer related treatments like chemotherapy. Neuropathic pain can have a devastating impact on one’s mood, quality of life, occupational performance and ability to function. Over the last 15 years, researchers and clinicians have used different classes of medications to treat this type of pain via anti-epileptics like gabapentin, tri-cyclic anti-depressants like nortriptyline and selective serotonin reuptake inhibitors like fluoxetine, in addition to more traditional pain relieving medications such as opioids and acetaminophen. Unfortunately, when these drugs are used as monotherapy, they are likely to provide relief in only 40-60% of patients and are rarely able to reduce pain by more than 60%. Consequently, neuropathic pain is recognized as an often difficult to treat pain syndrome.

A significant clinical question, that has remained relatively unstudied, is whether a combination of medications from different classes could improve our ability to improve neuropathic pain. Gilron, et al performed a double-blind, double-dummy crossover trial of gabapentin and nortriptyline alone and in combination, for patients with neuropathic pain from diabetic polyneuropathy or post-herpetic neuralgia that was recently published in the *Lancet*. The researchers enrolled 56 patients from a single site in Canada and randomized them into three groups. Each of the three groups underwent three 6-week treatment periods in which they sequentially received gabapentin alone, nortriptyline alone and the two medications in combination. The only difference in the three groups was the order they underwent the three treatment periods.

A standard protocol of drug titration was followed for all patients and treatment periods to obtain maximum tolerated doses of each medication. To assess medication efficacy and tolerability, a research nurse, who was blinded to the study, telephoned patients twice a week to document pain levels and adverse events.

The results showed that the baseline level of pain for these patients was 5.4 on a 10 point scale. Pain levels decreased to 3.2 out of 10 when patients used gabapentin alone, 2.9 out of 10 with nortriptyline alone and 2.3 out of 10 when both medications were used in combination. Pain with combination treatment was found to be significantly lower than treatment with gabapentin or nortriptyline alone (respective *p* values 0.001 and 0.02). The most common adverse effect was dry mouth, which was significantly less frequent in patients on gabapentin alone than in the other treatment groups.

These results suggest that the combination treatment of gabapentin and nortriptyline is more efficacious than either medication alone. Therefore, combination therapy would be an attractive treatment option in patients who are showing only a partial response to either agent alone. It is tempting to generalize this data to suggest that combination therapy would be equally efficacious between any approved anti-epileptic and tri-cyclic anti-depressant for neuropathic pain control. Further research is needed to explore whether synergistic interactions occur between these drug classes.

**Reference:** *Gilron I, Bailey JM, Tu D, Holden RR, Jackson AC, Houlden RL. Nortriptyline and gabapentin, alone and in combination for neuropathic pain: a double-blind, randomized controlled crossover trial. Lancet Oct 2009; 374: 1252-61.*

## IN THE SPOTLIGHT

### Order Your Copy Today!

The Palliative Care Consultant (PCC) is a reference guide for symptom management in palliative and end-of-life care. It provides easy access for physicians, nurses and other healthcare providers with information and guidelines on management of pain and other distressing symptoms. Produced in a handy format, this book is a must for anyone who cares for patients with cancer, chronic diseases and life-limiting illnesses. It is among the few resources that addresses both the pharmacologic and non-pharmacologic approaches to a broad array of diseases and symptom management issues. We feel this handbook represents the most complete and up-to-date hospice reference guide ever developed for hospice nurses and will become an indispensable tool for hospice staff. The list price for this publication is \$39.95, but as an added benefit, HospiScript clients will receive a discounted rate of just \$25 (plus shipping)! Please contact your Account Manager to request an order form.



## HospiScript Regional Conference — Mark Your Calendar!

The next HospiScript Services Regional Conference will be held June 17-18, 2010 and is sure to please with an information-packed educational lineup mixed with some old-fashioned southern hospitality! This two-day event includes a pre-conference “train the trainer” pharmacotherapy program as well as the general educational program on day two. In addition, a “Welcome Reception” will be held the evening of day one which will give everyone even more time to mingle and network with other hospice professionals. This conference (which offers continuing education credit) is offered to HospiScript clients free of charge, but registration is required. Space is limited so be sure to sign up early.



The Marriott Resort & Spa at Grande Dunes in Myrtle Beach, South Carolina has been selected as the conference site. This four diamond hotel offers something for everyone with dining options to please every palate and mood, indoor and outdoor pools as well as a water slide, state-of-the-art health club and a European spa. A discounted room rate of \$199 is available which will be honored 3 days before and after the meeting dates. Be sure to reserve your room before the **May 17th** cut-off date by calling 1-877-251-2121 and referencing Group Rate Code HOS.

Please visit [www.hospiscript.com](http://www.hospiscript.com) for additional information and to register (see quick links section).

## Broken Heart Syndrome (Takotsubo Cardiomyopathy)

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Tough break-up? Missing love? Grieving? Family feud? Can patients break their hearts? Yes! Still a mystery, but the power of psychological stress is confirmed by current medical studies. No longer a coined phrase indicating emotional dismay, medical literature within the last decade confirms patients can physically injure their hearts with unmanaged emotions.

Japanese physicians first described this condition as Takotsubo cardiomyopathy. The heart disorder is often a reversible form of cardiomyopathy that is generally precipitated by acute emotional stress. "Takotsubo" is the name of the fishing pot that Japanese fishermen use to trap octopus. The shape of the left ventricle of the heart, in patients suffering from Takotsubo cardiomyopathy, closely resembles the narrow neck and wide base fishing pots used by the octopus fisherman. Currently, Takotsubo cardiomyopathy is also known as stress cardiomyopathy, apical ballooning (*enlarged shape of the apical portion of the heart*) and broken heart syndrome (*due to recorded patient cases following the death of a loved one*). Broken heart syndrome is now recognized internationally with the understanding that many emotional scenarios can cause this condition to occur, yet the myocardium usually can fully recover weeks after the event in most patient cases.

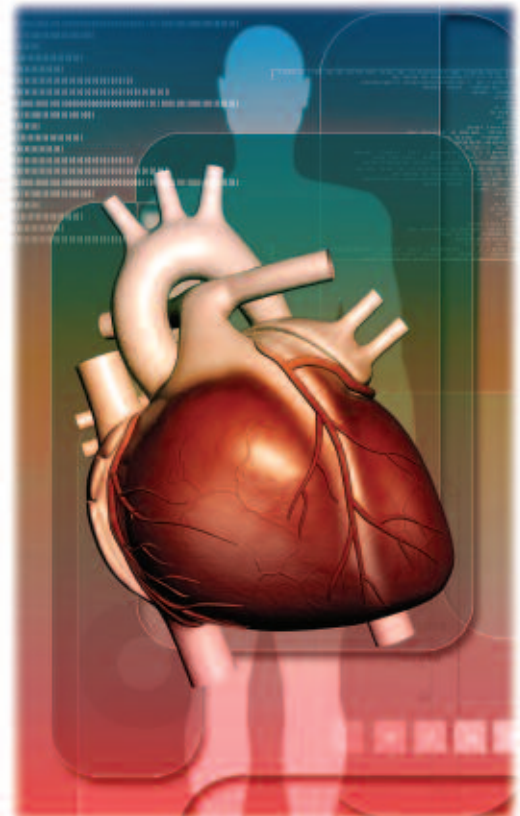
Broken heart syndrome is characterized by intense emotional stress that leads to a sudden temporary weakening of the heart muscle. The condition is recorded in all patient populations; however, it is most commonly seen in post-menopausal women with about 82% of reported cases in women between the ages of 62 to 75 years.<sup>1</sup> Symptoms are similar to acute coronary syndrome: chest pain, shortness of breath and electrocardiogram (EKG) changes. The most common EKG change seen upon preliminary diagnosis is ST-segment elevation. T-wave inversion can also be seen and blood work may confirm increased troponin levels (*an indicator of damage to*

*cardiac muscle*). Unlike acute coronary syndrome, cardiac function is normalized within a few weeks with emotional support and medications if necessary. Relatively few cases have been reported as detrimental on patients' life spans; however, it is still felt by the medical community that many cases are unrecognized and misdiagnosed.

The exact physiological mechanism behind broken heart syndrome is still unknown, but theories include: coronary artery spasm, impaired cardiac vascular function, perfusion abnormalities and catecholamine release. Medical literature is currently most receptive towards the theory of excessive release of catecholamines as the primary cause. These are the same stress-induced chemical messengers that elevate during our sympathetic response known as "flight and fight". Fortunately, mortality is uncommon in patients and long-term complications rarely occur. Emotional stressors may still remain and patients should be monitored.

At present, there is no standardized treatment for broken heart syndrome. Since broken heart syndrome presents similar to acute coronary syndrome, initial treatment is often based upon current cardiac guidelines. Physicians may prescribe medications to reduce the physical stress on the heart and may recommend chronic therapy to lower the risk of recurrence including: angiotensin-converting enzyme inhibitors (ACE-I), beta blockers, diuretics, and antidepressants. Supportive physiological care is usually sufficient once acute coronary syndrome is ruled out and broken heart syndrome is confirmed. Left ventricular function usually recovers within one to three months after the stressful episode. Complications are uncommon, but can include hemodynamic instability, arrhythmias and heart failure.

Awareness of the power of emotions is essential! Broken heart syndrome is an example of how



patients' mental wellbeing affects physiological health. Social workers, volunteers, chaplains, art therapists, musical therapists and other non-traditional medical personnel are vital hospice team members ensuring not only quality end-of-life care for the hospice patient, but also care for caretakers during life and bereavement.

### References:

1. Bybee K, Prasad A. Stress-related cardiomyopathy syndromes. *Circulation*. 2008;118:397-409.
2. Akashi YJ, Goldstein DS, Barbaro G, Ueyama T. Takotsubo cardiomyopathy. *Circulation*. 2008;118:2754-2762.
3. Virani S, Khan A, Mendoza C, et al. Takotsubo cardiomyopathy or broken-heart syndrome. *Texas Heart Institute Journal*. 2007;34:76-79.
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5. Wittstein IS, Thiemann DR, Lima JAC, et al. Neurohumoral features of myocardial stunning due to sudden emotional stress. *N Engl J Med* 2005;352:539-548.
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## More Training Options



HospiScript Services has established a live online training program to assist hospices with training both new and existing staff members on how to use the HospiScript program. The Hospice "In-Service" Webinar Training is designed to explain the program including the procedures for adding patients and making formulary changes. Registration is required on or before the 1st of each month for this live training, which is led by the Client Services Department. It is scheduled on the second Tuesday each month at 11:00 AM CT and includes plenty of time for a Question & Answer session with the participants. This program is an excellent addition to your new employee orientation program or as a refresher for existing staff. To register or for more information, please contact your Account Manager or send an email request via the Contact Us link at [www.hospiscript.com](http://www.hospiscript.com).



# FDA NEWS

## Resolved Drug Shortages: Morphine Sulfate Oral Solution

Roxane Laboratories has recently received FDA approval for Morphine Sulfate Oral solution 100mg per 5ml (20 mg/ml). This is the only FDA approved morphine sulfate oral solution available at this concentration. The firm has sufficient supply to meet the entire market demand and no shortage is anticipated. Morphine 20mg/5ml and 10mg/5ml remain available as approved products as well. For the morphine 100mg per 5ml (20mg/ml), there will be a transition period to the new packaging, labeling, and NDC numbers. In the meantime, please continue to use the following NDC numbers:

-NDC 0054-0352-44 Morphine Sulfate Oral Solution CII, 20mg/ml 30ml Bottle.

-NDC 0054-0352-50 Morphine Sulfate Oral Solution CII, 20mg/ml 120ml Bottle.

Available from: <http://www.fda.gov/Drugs/NewsEvents/ssLINK/ucm050793.htm#morphine>.

## New Safety Requirements for LABAs and ESAs

FDA is announcing its recommendations to change how long-acting inhaled medications called Long-Acting Beta-Agonists (or "LABAs" for short) are used in the treatment of asthma. These changes are based on FDA's analyses of studies showing an increased risk of severe exacerbation (worsening) of asthma symptoms, leading to hospitalization in pediatric and adult patients as well as death in some patients using LABAs for the treatment of asthma. Medications included are Symbicort (formoterol/budesonide), Foradil (formoterol), Serevent (salmeterol), Advair (salmeterol/fluticasone), Brovana (arformoterol). FDA is also requiring a risk management program called a risk evaluation and minimization strategy (REMS) to help ensure the safe use of these products. Available from: <http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm200719.htm>.

The FDA is requiring all drugs called Erythropoiesis-Stimulating Agents (ESAs) to be prescribed and used under a risk management program, known as a risk evaluation and mitigation strategy (REMS), to ensure the safe use of these drugs. The ESAs that are part of the REMS are marketed under the names Epogen, Procrit (epoetin alfa), and Aranesp (darbepoetin alfa). FDA required Amgen, the manufacturer of these products, to develop a risk management program because studies show that ESAs can increase the risk of tumor growth and shorten survival in patients with cancer who use these products. Studies also show that ESAs can increase the risk of heart attack, heart failure, stroke or blood clots in patients who use these drugs for other conditions. Available from: <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm200297.htm>.

On a Lighter Note...

*“A happy person is not a person in a certain set of circumstances, but rather a person with a certain set of attitudes.”*

– Hugh Downs

REGISTER ONLINE TODAY!

## “Lunch & Learn” Teleconference Schedule

Hospiscript strives to meet your educational needs. Every month, Hospiscript hosts a teleconference presentation “Lunch & Learn” on topics of special interest to hospice staff. The presenter for each conference will address individual questions following each seminar. All Hospiscript clients are encouraged to participate

free of charge. Continuing Education Credits are also available for a nominal processing fee. If you would like additional information or want to know how to get involved, please contact your Account Manager, call us at (866) 970-7500, or visit [www.hospiscript.com](http://www.hospiscript.com) and click on the Event Registration link to register.

### MARCH 2010

Grief & Bereavement: Assessment and Management of Complications,  
John Shuster, Jr., MD, Balm of Gilead Palliative Care Center, Cooper Green Mercy Hospital

Tuesday – 03/23/10 – 11:00 AM ET  
Wednesday – 03/24/10 – 12:00 PM ET  
Thursday – 03/25/10 – 2:00 PM ET

### APRIL 2010

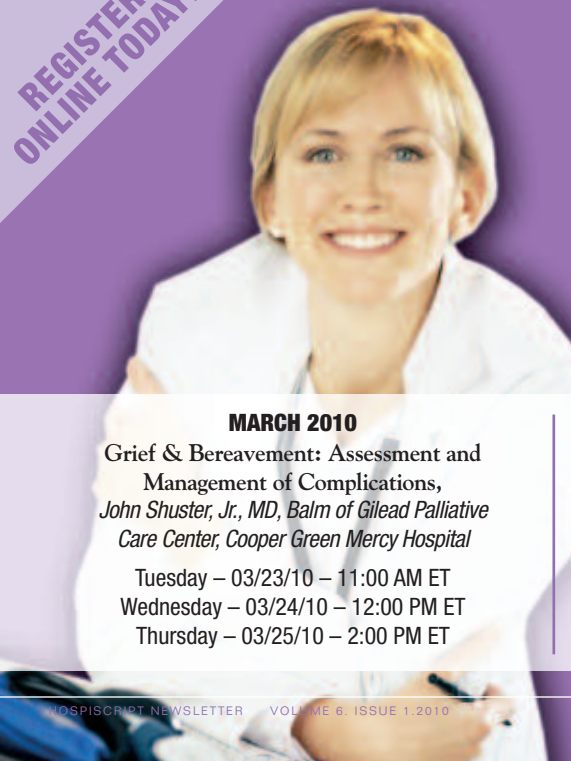
Caring for Hospice Patients with Mental Disorder,  
John Shuster, Jr., MD, Balm of Gilead Palliative Care Center, Cooper Green Mercy Hospital

Tuesday – 04/20/10 – 11:00 AM ET  
Wednesday – 04/21/10 – 12:00 PM ET  
Thursday – 04/22/10 – 2:00 PM ET

### MAY 2010

Methadone,  
Phyllis A. Grauer, R.Ph, Pharm.D,  
CGP, Clinical Consultant

Tuesday – 05/18/10 – 11:00 AM ET  
Wednesday – 05/19/10 – 12:00 PM ET  
Thursday – 05/20/10 – 2:00 PM ET



# “Ask HospiScript”

The “Ask HospiScript” column shares information and updates about the HospiScript program for our clients. Please forward your comments or questions to [info@hospiscript.com](mailto:info@hospiscript.com).

## I frequently use the new HospiDirect™ application for entering patients into the system. What do I do if I get locked out due to entering an incorrect password?

For security purposes, password lock outs occur when a user has incorrectly entered the User ID/Password combination three consecutive times. This situation will require you to contact HospiScript for assistance. The best way to avoid this issue is to keep track of your current user name and password. However, if you forget or are unsure of your password, select the <Forgot your password?> link located on the login page. You will be asked to re-enter your User ID and click the **Submit** button. The system will generate a temporary password and send it to the users email address on file. Once logging in using the new password, you will be prompted to change your password as if it were the first time being used.

## During a recent training session, our Account Manager reviewed the “client exclusive” section of your Web site. Will you tell me more about the features in this section?

Absolutely. As a HospiScript client, you now have hospice-specific tools and resources at your fingertips through our Web site, [www.hospiscript.com](http://www.hospiscript.com). The client section is designed exclusively for our hospice clients and includes many features that are not available to the general public.

From this section, you have convenient access to:

- **Audio “Lunch & Learn” Seminars** on many topics that interest hospice can be accessed at your convenience. This recorded series offers CE's through our independent study program.
- **Guidelines for Effective Management of Symptoms**, our own GEMS are

invaluable clinical tools developed through collaboration between the HospiScript Clinical Team and hospice and palliative care experts throughout the country.

- **Fast Facts and Concepts** which are peer reviewed one-page outlines of key information on important end-of-life clinical topics for educators and clinicians. This resource is provided through the End of Life/Palliative Education Resource Center which is supported by the Medical College of Wisconsin.
- **Educational & Training Resources** to fit the unique needs of your hospice such as previous editions of the HospiScript Newsletter can be accessed.
- **Lexi-Comp® Online™** is a comprehensive drug database that includes 14 clinical databases. The core drug database, Lexi-Drugs offers over 1600 drug monographs containing up to 55 fields of information. Lexi-Comp® Online™ also includes: Adult & Pediatric Patient Advisory Leaflets in up to 18 languages; Lexi-Interact™ for patient specific drug interaction screening; Lexi-Drug ID™ for pill identification; King® Guide to Parenteral Admixtures; Web Search to review other medically-based websites; and Pharmacy Quick Links with information on New Drugs/Special Alerts/FDA Shortages & Recalls.

We suggest that you take some time to visit the Web site and review these resources. When reviewing the drug database, you will notice that online assistance is offered, including an online tour. Be sure to take this tour since it has been set up to show you the basic features of Lexi-Comp's award-winning online software. It won't take long and you will wonder how you got along without these resources. As always, your Account Manager is available to answer any questions about getting your hospice started using this online feature and will also assist you with coordinating any of your training needs.