

# ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System

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## Purpose

These guidelines outline important considerations and recommend processes for formulary system

management within the context of a hospital or health system. Pharmacist responsibilities and roles in managing the formulary system in partnership with other healthcare professionals are embedded throughout. These guidelines also provide assistance to pharmacists in the organization and operation of the pharmacy and therapeutics (P&T) committee or equivalent body, evaluation of medications for formularies and consideration of rational use of medications, and development and implementation of strategies to optimize medication use through the formulary system. A glossary of terms is provided in the [Appendix A](#).

## Formulary and formulary system

A *formulary* is a continually updated list of available medications and related information, representing the clinical judgment, resulting from a review of the clinical evidence, of physicians, pharmacists, and other clinicians in the diagnosis, prophylaxis, or treatment of disease and promotion of health. A formulary includes, but is not limited to, a list of medications and medication-associated products or devices, medication-use policies, important ancillary drug information, decision-support tools, and organizational guidelines. A *formulary system* is the ongoing process through which a healthcare organization establishes policies regarding the use of drugs, therapies, and drug-related products, including medication delivery devices, and identifies those that are most medically appropriate, safe, and cost-effective to best serve the health interests of a given patient population.<sup>1</sup> Formulary systems are used in many different settings, including hospitals, acute care facilities, home care settings, and long-term care facilities, as well as by payers such as Medicare, Medicaid, insurance companies, and managed care organizations. Many organizations

have policy statements on the use of formularies.<sup>2-8</sup> These guidelines focus on the use of formulary systems in hospitals and health systems, in both inpatient and outpatient settings.

## Evolution of formularies

Formulary systems have evolved over time. Early formularies began as rudimentary drug lists developed by the military as early as the Revolutionary War and came into more widespread use during the 1950s.<sup>9</sup> Pharmacists, in conjunction with their organizations, developed policies to dispense generic equivalent drugs when a specific brand-name drug was prescribed. In the late 1950s, the ASHP minimum standard for pharmacies in hospitals called for the implementation of a formulary system.<sup>10</sup>

During the 1960s, the concept of a hospital formulary continued to grow. Hospitals developed policies that authorized pharmacists to make generic interchanges in an institutional formulary system based on prior consent from physicians.<sup>11</sup> ASHP and the American Hospital Association (AHA) issued joint statements on the legality of formularies.<sup>12,13</sup> The American Medical Association (AMA) and the American Pharmaceutical (later Pharmacists) Association (APhA) subsequently joined with ASHP and AHA to revise the statements.<sup>14</sup> In 1965, two significant events occurred: (1) Medicare listed formularies as a reimbursement eligibility requirement<sup>15</sup> and (2) the Joint Commission on Accreditation of Hospitals (now known as the Joint Commission) included an active P&T committee in its accreditation requirements.<sup>16</sup> Even with these actions, formularies were typically no more than lists of drugs stocked by the pharmacy.

By the 1980s, literature describing the clinical and economic value of well-designed formularies emerged. Evidence from the hospital setting was published first, soon followed by

evidence from the ambulatory care environment.<sup>11</sup> This literature led to more widespread acceptance of formularies by providers, payers, and industry.<sup>5,17</sup>

Today, formulary systems are considered an essential tool for healthcare organizations to foster interprofessional efforts to promote the rational use of medications. Formularies have grown from simple drug lists to comprehensive systems of medication-use policies intended to ensure safe, appropriate, and cost-effective use of pharmaceuticals in patient care.<sup>18</sup>

### P&T committee

The P&T committee is generally the medical staff committee responsible for managing the formulary system. The P&T committee provides an evaluative, educational, and advisory service to the medical staff and organizational administration in all matters pertaining to the use of available medications. The P&T committee should be responsible for overseeing policies and procedures related to all aspects of medication use within an institution.

The P&T committee's organization and authority should be outlined in the organization's medical staff bylaws, medical staff rules and regulations, and other organizational policies, as appropriate. The description of organization and authority becomes even more important as healthcare facilities merge into larger health systems.

Typically, P&T committee member appointments and voting rights are made based on guidance from the medical staff and other affected stakeholders. Voting members may include facility medical staff, other prescribers, pharmacists, nurses, and administrators, and are a representative sample of the organization. If the scope of the P&T committee includes a health system, site representation needs to be addressed to ensure equitable input and voting authority from each facility. Additional supporting P&T committee members may include quality improvement managers, medication safety leaders, informaticists, other

healthcare professionals and staff who participate in the medication-use process, and patient and family engagement advisors.

The P&T committee should have the following administrative components in place to maximize meeting effectiveness:

- Charter
- Role of the P&T secretary and/or formulary manager
- Committee and subcommittee(s) responsibility and scope
- Process to track attendance
- Definition of quorum
- Process to allow (or disallow) delegation of vote
- Process to appeal committee decisions
- Defined term limits for members
- Process for identifying, disclosing, addressing, and reporting conflicts of interest (COIs)
- Policy and procedures
- Approach to voting, including roll call votes to ensure transparency
- Scope of committee responsibility (eg, specific site or entire system; inpatient or outpatient sites; drugs, devices, and biologics)
- Process for managing minutes, agendas, record keeping, and communication of decisions made

Other responsibilities of the P&T committee include medication-use evaluation (MUE), adverse drug event monitoring and reporting, medication error prevention, medication safety, and development of clinical care plans and medication management initiatives (eg, delegation and practice protocols, restrictions, guidelines and clinical pathways). Information about these activities is available in ASHP guidelines on the topics.<sup>19-22</sup>

Oversight of a formulary system and the capacity to make appropriate formulary decisions requires consideration of patient care factors and a thorough, unbiased review of the biomedical literature. Voting members should be

required to provide COI statements to avoid actual or perceived interference with evidence-based decisions.<sup>23</sup> Some healthcare organizations exclude healthcare professionals with COIs from P&T committee membership, whereas others allow participation in committee discussions but prohibit voting on particular items. Practitioners requesting additions or changes to the formulary should also be required to disclose financial relationships with pharmaceutical companies, payers and insurance companies, and other potential COIs to the P&T committee. Management of COI should be specified in organizational policies and procedures.

### Managing the formulary system

Health systems should develop, maintain, and implement a formulary management process. This evidence-based process should not be based solely on economic factors. The formulary system should have aspects of financial stewardship incorporated and be standardized within integrated health systems when standardization leads to improved patient outcomes, safety, and cost-effectiveness. Decisions on the management of a formulary system should be founded on the evidence-based clinical, ethical, legal, social, logistical, philosophical, quality-of-life, safety, and economic factors that result in optimal patient care.<sup>24-26</sup> The process must include the active and direct involvement of physicians, pharmacists, and other appropriate healthcare professionals, as well as representatives with expertise in finance, law, and informatics.

Management of a formulary system is a significant component of a healthcare organization's ongoing medication-use policy development process. A comprehensive, well-maintained formulary is tailored to the organization's patient care needs, policy framework, and medication-use systems while ensuring alignment with medication management standards of accrediting organizations.<sup>27</sup>

A well-managed formulary system ensures a close relationship among the organization's medication-use policies, the therapies offered by the organization, and the medications routinely stocked in the pharmacy. A formulary also identifies those medications that are most medically appropriate and cost-effective to best serve the health interests of the health system's patient population. The P&T committee should review all medications (see [Appendix A](#)) used in the health system. These may include alternative remedies (herbals and supplements), nonprescription drugs, blood derivatives, contrast media, and other diagnostic and treatment agents.<sup>27</sup> Institutional policies may need to be created for P&T committee evaluation of agents not approved by the Food and Drug Administration (FDA) (eg, herbal supplements).

The formulary system should review and approve all policies related to the medication-use process; all medication-use policies, regardless of their origination, should flow through the P&T committee. The organization's medical staff leadership (ie, the body to which the P&T committee reports) should complete the final policy approval. Policy review and revision should occur as new information becomes available and at regularly established intervals (eg, annually). The organization should have medication-use policies that address the following:

- How medications are requested for addition to or deletion from the formulary
- How medications are reviewed for addition to or deletion from the formulary, including who performs the reviews
- How and when drug class reviews are conducted
- The process for developing, implementing, and monitoring medication-use guidelines
- Methods and policies for ensuring the safe procurement, prescribing, distribution, administration, and monitoring of medications

- Methods for selection of suitable manufacturers for specific medications (ie, the pharmacy department is responsible for specifications for the quality, quantity, and source of supply of all medications, chemicals, biologicals, and pharmaceutical preparations used in the diagnosis and treatment of patients)<sup>28</sup>
- The process for using nonformulary agents within the hospital and health system
- The process for managing radiopharmaceuticals
- The process for managing drug product shortages
- The process for developing an organization or health system-specific MUE plan
- Policies regarding specific medication-use processes (eg, procurement, prescribing, distribution, administration, monitoring, automation, and technology)
- The process for disseminating medication-use policies and how users will be educated regarding the process
- Process for accountability over medication delivery devices (eg, infusion pumps, dose error reduction software, intranasal atomizers)
- Consideration of medication access through prior authorization processes and patient assistance programs
- Implementation of P&T committee decisions into the electronic health record (EHR)

A formal process to review medication-use policies should be in place. This process may include the use of expert panels or subcommittees of the P&T committee. Expert panels or subcommittees should serve in an advisory role to the P&T committee, and their membership should include recognized experts in their areas of practice. The P&T committee may also find subcommittees that address specific therapeutic areas to be beneficial (eg, pediatrics, antimicrobial, oncology therapy, cardiovascular, adverse drug reaction, pharmacogenomics, or biotechnology

subcommittees). Panels and subcommittees are helpful in applying clinical study results to specific patient populations and developing recommended strategies for the safe and effective use of medications. Subcommittee and panel members can help educate groups of clinicians, who ultimately drive prescribing behaviors, about significant formulary changes. User groups, representing those primarily affected by the policy, may also be helpful.

The P&T committee should have formal interactions (ie, communication lines) with other committees whose functions may affect the medication-use process. These committees would include those responsible for developing tools to facilitate medication use (eg, forms or order set review committee, computerized provider order entry committee), those concerned with safety or performance improvement (eg, quality improvement or patient safety committees), those involved in developing patient care policies (eg, medical and nursing committees), those involved with investigational medications (eg, investigational review boards), and other committees whose actions may affect medication use (eg, nutrition, equipment and supply, and finance committees or patient and family engagement advisors). Recommendations from other committees, subcommittees of the P&T committee, expert panels, and others should be submitted to the P&T committee for review. P&T committee decisions on recommendations should be communicated to the recommending group in a timely fashion.

Finally, the role of pharmaceutical company representatives and medical science liaisons in a healthcare organization should be carefully considered. Organizational guidelines should define appropriate relationships and interactions with such individuals. At a minimum, these guidelines should address the provision of pharmaceutical samples, indirect or direct funding support, and educational programming regarding formulary and nonformulary

medications. Applications for formulary additions should be initiated and completed independently by the requesting healthcare provider and not by an industry representative or vendor. Refer to ASHP's Guidelines on Pharmacists' Relationships with Industry for more information on appropriate interactions with industry.<sup>29</sup>

### Evaluating medications for inclusion in the formulary

The P&T committee should use a structured, evidence-based process in the evaluation of medications for formulary consideration. The P&T committee should be provided with information that reflects a thorough, accurate, and unbiased review and analysis of the evidence available in the scientific literature. The evaluation process should encourage objective consideration of clinical and care delivery information, facilitate communication, foster positive patient outcomes, and support safe and effective medication ordering, dispensing, administration, and monitoring. Decisions made by the P&T committee should support improved patient care outcomes across the continuum of care, including considerations regarding patient access to medications upon discharge.

**Evidence-based evaluation.** Evidence-based medicine is a systematic approach to the evaluation of biomedical literature and application to clinical practice and should be applied to formulary decision-making for medication product selection.<sup>25</sup> Evidence-based decision-making standardizes and improves the quality of patient care and promotes cost-effective prescribing.<sup>25,26</sup> To practice evidence-based medicine, practitioners must be proficient in retrieving, evaluating, and applying the biomedical literature to clinical practice. Inclusion of a medication on a health system's formulary or the adoption of a medication-use guideline should reflect an evidence-based evaluation.

Evidence-based decision-making incorporates the systematic approach to reviewing, evaluating, and applying the biomedical literature to guide

formulary decisions. Various types and strengths of evidence (eg, randomized clinical trials, meta-analyses, case reports, association consensus statements) may be useful in the decision-making process. Although different types of evidence are available for application, those with stronger evidence should be used to drive formulary decisions (eg, meta-analyses, randomized controlled trials). Other types of evidence have a role in the decision-making process, however, and may be appropriate when stronger evidence is not available. Observational studies (ie, case-control and cohort studies), case reports, and consensus opinions may be valuable even when stronger evidence is available. Some organizations find it useful to grade evidence when evaluating formulary requests; several tools are available for this purpose.<sup>30-34</sup>

Published evidence and expert opinion are not the only resources available to aid in the formulary decision-making process. Internal data and prescribing and outcomes information may be helpful in formulary decision-making. When published data are not available, it may be appropriate to incorporate expert opinion into the review process. Experts in practice areas sometimes have access to unpublished data or reports that may offer insight into difficult formulary decisions.

The formulary decision-making process should be guided by an independent review of evidence published in the biomedical literature, application of expert opinion, and use of internal data and benchmarking programs (see [Appendix B](#) for a description of the 4 major types of reviews used in such evaluations). If a P&T committee uses medication dossiers prepared by a pharmaceutical manufacturer, it should do so with the utmost caution, since the objectivity of these documents may be challenged.

Information used in the formulary decision-making process should be provided to the P&T committee in a written document with a standard format (eg, a drug monograph, drug

review, drug-evaluation document).<sup>35</sup> All information provided in the drug-evaluation document should be referenced to the evidence or identified as a conclusion supported by evidence. Any areas of consensus recommendations or opinion should be clearly identified.

Formulary status recommendations (eg, from drug information services or expert groups) may be included in the drug-evaluation document. Recommendations should consider the formulary status (addition or rejection) of a medication, as well as the need for restrictions, educational efforts, or policies and procedures to ensure safe and appropriate use within the health system.

**Pharmacoeconomic assessments.** Rigorous pharmacoeconomic evaluations can and should be conducted in some cases when reviewing new medications. These evaluations should explicitly state the perspective of the analysis (eg, patient, healthcare provider, payer) and should include consideration of all costs and consequences relevant to that perspective. When new medications being considered are found to be therapeutically equivalent to existing alternatives (ie, having equivalent efficacy and safety), then the cost-minimization approach is appropriate. In these circumstances, it is important to consider costs associated with the medication and non-medication-related costs (eg, costs of administration, monitoring, prolonged hospital stay, operational costs, and laboratory test monitoring; costs to patients and providers).

While cost-effectiveness analysis (evaluating the incremental difference in investment necessary to produce an incremental difference in clinical outcome) is another potentially useful analytic approach, it is not often used for formulary decision-making because of its complexity and need for strong evidence or data. The academic value of this approach lies in its ability to show how little (or how much) must be spent to achieve a particular margin of clinical advantage when comparing an alternative that is more expensive but safer or more efficacious. No

standards currently exist to determine what cost is reasonable for a given improvement in outcome; however, it is unreasonable to recommend alternatives of lower quality simply to achieve cost savings. This approach can be used to demonstrate how a decrease in clinical outcomes associated with the use of a less expensive agent can be offset by investing the savings achieved in other interventions that produce even greater total benefits. When evaluating cost-effectiveness, it is important to consider the site of care for administration of the drug.

Cost-utility evaluations (evaluating the incremental difference in investment necessary to produce an incremental difference in quality-of-life-adjusted clinical outcome [eg, incremental cost per quality-adjusted life-years gained for one medication vs another]) may also be beneficial by serving to reflect patient preference in formulary decision-making. However, the same concerns related to the use of cost-effectiveness evaluations apply to this approach.<sup>36-38</sup>

Decision analysis models incorporating local data can be employed when published pharmacoeconomic data are limited or unavailable. Probabilities for each outcome can be extracted from the published literature or drawn from local data sources, which would provide a more relevant local perspective on outcomes. Costs associated with medications and outcomes should reflect those of the healthcare system.

Pharmacoeconomic analyses published in the medical literature or provided in the manufacturer's formulary dossier should be analyzed carefully before being included as part of the review process. Particular attention should be paid to the assumptions made in these studies. In many situations, assumptions made to simplify economic studies are not valid in particular institutions. Institution-specific costs are often different from the costs used in published studies, and local data should be used when incorporating their results into medication reviews.<sup>39,40</sup>

Even if a formal pharmacoeconomic evaluation is not included in a drug review document, a financial evaluation must be conducted, including consideration of site of care, non-medication-related costs, and financial consequences to the pharmacy and to the organization as a whole.

**Formulary exceptions.** Exclusion of a medication from a formulary may affect coverage of and access to the medication. In a closed formulary system, for example, only medications listed on the formulary are covered under the patient's drug benefit. Regardless of health-system setting, the formulary system should include an exception process that provides prescribers and patients with timely access to medications that are not on the formulary but are medically necessary for the care of the patient. The underlying principle for such a process is that unique patient needs may not be satisfied by use of the formulary medications. The formulary exception process should generate information on nonformulary medication use that will enable the P&T committee to evaluate trends in such use. Criteria for approval of nonformulary medications should be developed (eg, allergy to or therapeutic failure of formulary alternative, condition not treatable by formulary medications) and guidelines for use should be considered for nonformulary medications if they carry patient safety risks, have a Risk Evaluation and Mitigation Strategy (REMS), are expensive, and require complicated preparation.

**Subformularies.** Depending on state regulations, subformularies may be developed and maintained, using the same evidence-based process, to provide lists of appropriate and approved medications for furnishing by nonphysician providers or to specific patient subsets, such as Medicare patients. Health systems must follow specific rules and regulations provided under the Medicare Modernization Act of 2003 in their evaluation and inclusion of medications in a Medicare formulary for those medications to be covered.<sup>41</sup>

## Strategies for managing medication use

Common strategies for managing medication use via the formulary include use of generic drugs, biosimilars, and specialty medications; therapeutic interchange; guided-use policies, clinical practice guidelines; and MUE.

**Generic drugs.** Optimizing the number of medication entities and products available from the pharmacy can produce substantial patient care and financial benefits. These benefits are greatly increased through the use of generic equivalents (drugs considered bioequivalent by FDA [ie, AB-rated drug products<sup>42</sup>]). The use of generic equivalents is encouraged in order to provide the best possible care at an affordable cost. Use of generic drugs that have been deemed bioequivalent by FDA does not require review or approval by the P&T committee, although a review of all new generic medications for key safety issues (eg, look-alike, sound-alike concerns) should be conducted to prevent medication errors when possible. For some drug categories, such as those with a narrow therapeutic range, a more thorough evaluation of the bioequivalency data and approval of experts or the P&T committee should be considered before implementing a generic substitution.

The P&T committee should establish policies and procedures governing the dispensing of generic equivalents when branded products are ordered. These policies and procedures should include the following points:

- The pharmacist is responsible for selecting from available generic equivalents those drugs to be dispensed pursuant to a prescriber's order for a particular medication.
- The prescriber has the option, at the time of prescribing, to specify the brand or supplier of the drug to be dispensed for that particular medication order if considered clinically justified.
- The prescriber's decision should be based on pharmacologic or therapeutic considerations (or both) relative to that patient.

**Biosimilars.** A biosimilar is a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference product.<sup>43</sup> Several entities have been approved as biosimilars by FDA, and inclusion of these products on formulary should be considered as a strategy for management of the medication-use system. Biosimilars are not generically equivalent to the reference product, so the P&T committee should be involved in the decision to include these products on formulary. The implications for patients must also be considered, including legal and regulatory restrictions, coverage and reimbursement models of payers, differences in clinical indications or activity between the reference product and the biosimilar, and contractual obligations.

There are several considerations when evaluating biosimilars. When there are multiple biosimilars available for the same reference product, a close review of indications for each of the biosimilars should occur, as the indications that each biosimilar has may differ compared to each other and the reference product. FDA can deem a biosimilar as interchangeable, however, even if a product does not have this status noted in its labelling. Available switching data should be reviewed closely to determine whether patients currently receiving treatment with the reference product can be switched to the biosimilar. In instances in which FDA has determined a biosimilar product to be interchangeable, state regulations should be reviewed to determine actions required by the pharmacist when dispensing a biosimilar with an interchangeable status. In instances in which an institution may elect to have both a reference product and a biosimilar on formulary, careful attention should be paid to how these are built in the EHR to ensure the appropriate product is utilized.

**Therapeutic interchange.** Therapeutic interchange is the authorized exchange of therapeutic alternatives in accordance with previously established and approved written guidelines,

or policies, or protocols within a formulary system.<sup>1,44</sup> Drugs appropriate for therapeutic interchange are drug products with different chemical structures that are expected to have similar therapeutic effects and safety profiles when administered to patients in therapeutically equivalent doses. Therapeutic interchange provides pharmacists with the authorization to use a formulary therapeutic alternative in place of a nonformulary medication or a nonpreferred formulary medication without having to contact the prescriber. Ideally, therapeutic interchanges are built into the EHR to allow for seamless substitution of formulary products. A process should be established for when the prescriber wishes to opt out of the interchange. Adequate educational initiatives should be undertaken to ensure that everyone affected (prescribers, patients, pharmacists, nurses, and other healthcare professionals) is notified of the therapeutic interchange.

**Guided-use strategies.** Medications may be added to the formulary with additional processes in place to guide the use of the medications to improve therapeutic outcomes, prevent adverse events, or reduce costs. All guidelines for use for both on- and off-label indications should be developed using evidence-based decisions, based on the current medical literature.<sup>45</sup> Examples of strategies to help guide the use of medications may include the following.

*Established-use criteria.* Patients must meet the established criteria before the medication is dispensed. A process should be developed to cover situations in which the patient does not meet the established criteria but the medication is nevertheless determined to be medically necessary. This strategy may also be useful when medications are in short supply.

*Restricting drug use by specialty service.* A specific service must approve the use of the drug before dispensing. This strategy can be used when inappropriate use or severe adverse effects may occur, and it can also be employed for antimicrobial agents when inappropriate use or overuse can result in

resistant organisms and pose a danger to the general patient population or the public. Alternatively, ordering of a specific medication may be limited to a specific group of prescribers (eg, restricting use of chemotherapy agents to oncologists).

*Designating medications for use in specific areas.* Such policies can be helpful when administration of a medication requires special equipment or staff with particular skills to use the medication safely (eg, limiting neuromuscular blockers to operating rooms and critical care areas).

*Approval of medical director (or designee) before drug use.* This strategy is particularly appropriate when the P&T committee has reviewed a high-cost medication and determined that the drug has little or no role in the care of patients at that organization but a prescriber would like to use the medication on a nonformulary basis. This strategy may also be used as an approval pathway for medications requested for use outside of established criteria outlined in the formulary.

**Clinical practice guidelines.** Clinical practice guidelines are developed and disseminated by national and international organizations, but they can also be developed locally. Whether the medication formulary is a reflection of existing clinical practice guidelines in a particular organization or vice versa, it is critical that the guidelines and formulary are consistent. If a specific medication is recommended by a clinical practice guideline, it should in the majority of cases be on the formulary. As formulary changes are made, agents may need to be removed from or replaced in existing guidelines. Guidelines should avoid recommending use of nonformulary medications, and they can be useful in discouraging nonformulary medication use and guiding the appropriate use of formulary products when necessary.

Guidelines are frequently developed to address complex or particularly expensive medication therapies. However, complicated specialty therapies that will affect the care of very

few patients may not justify the time and resources necessary to develop and maintain a guideline. Guidelines may be medication specific or disease oriented and may overlap in their scope of coverage.

The development of a clinical practice guideline should begin with the synthesis of all available biomedical evidence addressing the guideline topic. In many cases, guidelines from other organizations, both national and local, can be used as a starting point for development. The subsequent consensus process, eliciting feedback and input from local stakeholders, is critical. Data from the organization should be used to make informed decisions during the consensus process. After the consensus process is completed, the guideline should be reviewed and approved by the P&T committee.

The dissemination and implementation of guidelines in the practice environment must also be carefully executed. Communication about the availability of guidelines is necessary. Guidelines should be readily available through existing health-system platforms. If feasible, it is recommended to build the guidelines into the computerized provider order entry system (eg, through order set creation) to facilitate the appropriate care of the patient. Every guideline should include a time frame for future review and revision.

If utilization of a medication is being requested outside established health-system guidelines for appropriate use, scientific evidence to support safety and efficacy should be provided and reviewed to substantiate the request.

**Specialty medications.** P&T committees should be involved in the organization's approach to managing specialty medications to ensure the pharmacy has the ability to provide medications in a timely manner, to support patient access to medications, and provide continuity of care. ASHP has resources to aid in specialty pharmacy management, including the ASHP Specialty Pharmacy Resource Guide.<sup>46</sup> This guide provides guidance on dispensing the medication directly

to the site of care for patient administration (white bagging) or to the patient, who then carries it to the site of care for administration (brown bagging). Another strategy to consider in management of specialty pharmaceuticals is clear bagging. Clear bagging is the delivery of a patient-specific specialty pharmaceutical directly from a health system's specialty pharmacy directly to the health-system site of service, where it is then administered.<sup>47</sup>

**MUE process.** MUE is a quality improvement activity, but it can also be considered a formulary system management technique. MUEs have traditionally involved evaluating evidence-based criteria to determine the health system's compliance with established standards. Interventions could then be used to improve any aspect of the medication-use process based on MUE data analyses.

MUE can be simply informative (collecting data to guide decision-making) or used to measure the effect of interventions, such as the addition of a new agent to the formulary or the implementation of a new medication-use policy. While MUE often focuses on problem-prone, high-risk, or high-cost medications, MUE can be used to examine any aspect of medication use that is problematic to the institution conducting the evaluation. Medications recently added to the formulary should be evaluated, especially if there is the potential for inappropriate use or adverse effects. This review should occur 6 to 12 months after their addition to the formulary. High-cost, high-use, or problem-prone medications and outcomes of specific disease states are also good candidates for evaluation.

A systematic plan to monitor, evaluate, and improve medication use should be established within the organization.<sup>19</sup> Such a plan is an accreditation requirement for many organizations (eg, Joint Commission<sup>27</sup>). The P&T committee, or its equivalent, should be involved in the MUE process. Refer to ASHP's Guidelines on Medication Use Evaluation for more detailed information conducting an MUE.<sup>19</sup>

## Incorporating patient safety issues in the decision-making process

The P&T committee should systematically address medication and patient safety issues as part of its deliberations. The P&T committee should ensure that medication-use policies adequately address potential risk and safety issues. Hospital or health-system medication-event data, including near misses, should consistently be reviewed by the P&T committee, along with recommendations to prevent future events. The P&T committee should also review available information on medication or patient safety events reported by other organizations to identify ways to prevent medication events and disseminate the information to healthcare providers and, when appropriate, patients.

When evaluating a medication for inclusion on the formulary, the P&T committee and its supporting subcommittees or panels should consider adverse effects, preparation issues, sound-alike or look-alike potential, practitioner safety, and dosing or administration issues. If a product has a REMS program, the requirements of this program should be carefully reviewed to ensure the institution can meet the requirements. When implementing formulary decisions for medications that have REMS, there should be processes in place to ensure compliance both during implementation and on an ongoing basis. Proactive assessments should be conducted to identify potential safety concerns posed by use of the medication, and proposed strategies to mitigate those risks should be implemented by the P&T committee. In addition, quality improvement projects to improve the safety of specific medications or to evaluate the processes involved should be conducted and reviewed by the P&T committee. The P&T committee should champion evidence-based fail-safe techniques (eg, bar coding) to prevent medication events.

Resources that provide information on medication or patient safety events include the Institute for Safe Medication Practices ([www.ismp.org](http://www.ismp.org))

and Medwatch. The Joint Commission, Institute for Healthcare Improvement, and National Center on Patient Safety provide information about conducting and examples of failure mode and effects analysis (FMEA) projects on their websites ([www.jointcommission.org/](http://www.jointcommission.org/), [www.ihl.org/](http://www.ihl.org/), and [www.patientsafety.va.gov](http://www.patientsafety.va.gov)).

### Implementation of formulary decisions into the EHR

Use of the EHR to implement, guide, and evaluate decisions made by the P&T committee is essential. EHR technology functionality should be maximized to support drug policy and formulary management decisions. The EHR should provide guidance on dosing, monitoring, and restrictions/limitations at the point of prescription and verification. A standard process, including established expectations for timeliness, should be developed to consistently and efficiently implement these decisions into the EHR. Multihospital systems and integrated delivery networks that share the same EHR platform and formulary review process should centralize the coordination of implementation.<sup>48</sup> EHR implementation efforts should be coordinated with operational changes and education requirements identified in the decision-making process. Finally, resources and personnel available to support implementation into the EHR should interface with the P&T committee to ensure understanding and shared expectations of the EHR technology functionality. In addition, key content experts charged with evaluating and proposing drug policy and formulary management decisions should collaborate with informatics personnel on the design and validation of EHR content.

### Drug product shortages

Health systems frequently need to address drug product shortages. Drug product shortages disrupt patient care and impact all aspects of the medication-use system, including purchasing, storage, automation systems, the EHR,

preparation, administration, monitoring, and education.

During a drug product shortage, the P&T committee plays an important role. The P&T committee needs to develop strategies to address shortages in a timely manner, including designating appropriate therapeutic alternatives, identifying strategies for mitigating use of available drug product, and establishing use restrictions. All of these strategies should be developed based on available literature and best practices. Therapeutic interchange can be useful in dealing with critical drug product shortages. The P&T committee should work collaboratively with other committees and departments, such as specific medical departments, nursing, and risk management (when necessary) to develop effective management plans for addressing shortages. Given the dynamic nature of drug shortages, it is not always possible to obtain approval from P&T committee members prior to implementation of strategies if there is a need for urgent changes. To make sure the P&T committee is aware of all changes related to drug shortages, organizations should include a drug shortage update as a regular agenda item for the P&T committee. Communication with patients and staff is crucial to effectively manage shortages.

Effective integration of these strategies into the EHR is key for successful implementation of a drug shortage plan. Various strategies exist for communication in the EHR, including placing electronic alerts on medications, blocking the ordering of medications on shortage, and facilitating the build of new medication records or order sets to guide use of alternative agents during the time of the shortage.

More information about managing drug product shortages can be found in the ASHP Guidelines on Managing Drug Product Shortages.<sup>49</sup>

### Implementing medication-use policies

Various tools can be used to implement medication-use policies. The

policy should be integrated directly into the therapeutic decision-making processes that guide the use of a medication during order entry or incorporated into a diagnosis-specific electronic treatment plan. Other specific ways of communicating information about a medication-use policy may include the use of

- Inservice education,
- Facility-approved social media,
- Grand rounds,
- Communication between pharmacists and prescribers
- Staff meetings,
- E-mail,
- Electronic newsletters,
- Prescriber detailing, and
- Pharmacy or institutional websites.

Outcome-driven projects may be beneficial in illustrating the value of a new medication-use policy and support further expansion.

### Reimbursement strategies and considerations

New payment models require that P&T committee members are astute in their understanding of the hospital and health system's payment policies and reimbursement strategies related to medications. A balanced approach to managing a hybrid reimbursement structure between traditional fee-for-service models and emerging value-based contracts will be required. Financing and reimbursement for medications is complex; hospitals and health systems can no longer exclusively focus on manufacturing contracts, wholesaler agreements, and inpatient reimbursement. Large health systems and integrated systems must consider implications of medication reimbursement by Medicare, Medicaid, commercial, and private payers. If applicable, 340B Drug Pricing Program policies must also be considered. Prior to approval of high-cost drugs, in collaboration with the finance department, there should be a benefits investigation conducted, factoring in local payer mix, plans for financial



monitoring, and payer negotiations. The organization should have a defined process and responsible department for validating reimbursement of therapy and financial outcomes over time. Factors include site of care decisions in determining where a medication will be administered. Each organization should have policies on the use of medications not directly procured by the hospital pharmacy. For example, some specialty medication payer agreements circumvent traditional buy-and-bill dispensing channels and instead use white or brown bagging strategies.<sup>47</sup> Furthermore, patient access to medications upon discharge or during transitions of care between care settings needs to be evaluated, and systems need to be in place to ensure continuity of medication use and to decrease the potential to prolong length of stay due to medications initiated during an inpatient stay that may be restricted elsewhere.

## Conclusion

A formulary system is the multidisciplinary, evidence-based process employed by an organization to select and use medications that offer the best therapeutic outcomes while minimizing potential risks and costs for patients. Organizations should employ the MUE process to continually improve how medications are used within the organization at all steps in the medication-use process. Medication use is an inherently complex process that requires constant evaluation. Organizations need to implement all necessary tools and processes to meet the goals of safe and effective medication use. Professionals involved in the medication-use process need to know and understand how the organization's medication-use policies and processes can be incorporated into their daily work to ensure medications are used appropriately and safely. Technology offers many opportunities to make those processes more effective and efficient. Communicating the actions related to medication use is a constant

challenge that organizations need to address.

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## Additional information

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## References

1. Principles of a sound drug formulary system. In: Hawkins B, ed. *Best Practices for Hospital and Health-System Pharmacy: Positions and Guidance Documents of ASHP*. American Society of Health-System Pharmacists; 2018:233-236.

2. American Heart Association. American Heart Association policy statement on drug formularies. Published 2018. Accessed October 14, 2020. <https://www.heart.org/-/media/files/about-us/policy-research/prevention-nutrition/drug-formulary-statement-2018.pdf>
3. American College of Physicians. Position paper: therapeutic substitution and formulary systems. Published 1990. Accessed October 14, 2020. [https://www.acponline.org/acp\\_policy/policies/therapeutic\\_substitution\\_formulary\\_systems\\_1990.pdf](https://www.acponline.org/acp_policy/policies/therapeutic_substitution_formulary_systems_1990.pdf)
4. Laing R, Tisocki K. How to develop a national formulary based on the WHO model formulary. Published 2004. Accessed October 14, 2020. [http://archives.who.int/EMLib/docs/National\\_MF\\_Manual2004-8.pdf](http://archives.who.int/EMLib/docs/National_MF_Manual2004-8.pdf)
5. American Medical Association. Policy H-125.991: drug formularies and therapeutic interchange. Accessed October 14, 2020. <https://policysearch.ama-assn.org/policyfinder/detail/formulary?uri=%2FAMADoc%2FHOD.xml-0-227.xml>
6. American Medical Association. Policy H-285.965: managed care cost containment involving prescription drugs. Accessed October 14, 2020. <https://policysearch.ama-assn.org/policyfinder/detail/drug%20formularies%20?uri=%2FAMADoc%2FHOD.xml-0-2089.xml>
7. Academy of Managed Care Pharmacy. AMCP format for formulary submissions. Accessed June 3, 2019. <http://www.amcp.org/practice-resources/amcp-format-formulary-submissions/>
8. American Academy of Family Physicians. Patient-centered formularies. Accessed October 14, 2020. <https://www.aafp.org/about/policies/all/patient-formularies.html>
9. Balu S, O'Connor P, Vogenberg FR. Contemporary issues affecting P&T committees. Part 1: the evolution. *P T*. 2004;29:709-711.
10. American Society of Hospital Pharmacists. Minimum standard for pharmacies in hospitals. *Am J Hosp Pharm*. 1958;15:992-994.
11. May JR. Formulary systems. In: DiPiro JT, ed. *Encyclopedia of Clinical Pharmacy*. Marcel Dekker; 2002.
12. Willcox AM. The legal basis of the formulary system. *Am J Hosp Pharm*. 1960;17:603-608.
13. American Society of Hospital Pharmacists, American Hospital Association. Statement of guiding principles on the operation of hospital formularies. *Am J Hosp Pharm*. 1960;17:609-610.

14. American Society of Hospital Pharmacists, American Hospital Association, American Pharmaceutical Association, et al. Statement of guiding principles on the operation of hospital formularies. *Am J Hosp Pharm.* 1964;21:40-41.
15. Social Security Administration. Conditions of participation for hospitals. *Am J Hosp Pharm.* 1966;23:179-180.
16. Lammy PP, Flack HL. Pharmacy and therapeutics committee, consent, and the hospital formulary. *Am J Hosp Pharm.* 1966;23:662-672.
17. American Medical Association. AMA policy on drug formularies and therapeutic interchange in inpatient and ambulatory patient care settings. *Am J Hosp Pharm.* 1994;51:1808-1810.
18. Heindel GA, McIntyre CM. Contemporary challenges and novel strategies for health-system formulary management. *Am J Health-Syst Pharm.* 2018;75:556-560.
19. American Society of Health-System Pharmacists. ASHP guidelines on medication-use evaluation. Published 2020. Accessed October 14, 2020. <https://www.ashp.org/-/media/assets/policy-guidelines/docs/guidelines/medication-use-evaluation-current.ashx>
20. American Society of Health-System Pharmacists. ASHP guidelines on adverse drug reaction monitoring and reporting. *Am J Health-Syst Pharm.* 1995;52:417-419.
21. American Society of Health-System Pharmacists. ASHP guidelines on preventing medication errors in hospitals. *Am J Health-Syst Pharm.* 2018;75:1493-1517. Accessed October 14, 2020. <https://www.ashp.org/-/media/assets/policy-guidelines/docs/guidelines/preventing-medication-errors-hospitals.ashx>
22. American Society of Health-System Pharmacists. ASHP guidelines on the pharmacist's role in the development, implementation, and assessment of critical pathways. *Am J Health-Syst Pharm.* 2004;61:939-945.
23. Brennan TA, Rothman DJ, Blank L, et al. Health industry practices that create conflicts of interest: a policy proposal for academic medical centers. *JAMA.* 2006;295:429-433.
24. Nair KV, Ascione FJ. Evaluation of P&T committee performance: an exploratory study. *Formulary.* 2001;36:136-146.
25. Nakahiro S. Contemporary issues in formulary management. In: Millares M, ed. *Applied Drug Information: Strategies for Information Management.* Applied Therapeutics Inc; 1998:8.1-8.43.
26. Nakahiro RK, Ho SS, Okamoto MP. Concepts of pharmacoeconomics. In: Millares M, ed. *Applied Drug Information: Strategies for Information Management.* Applied Therapeutics Inc; 1998:7.1-7.37.
27. The Joint Commission. *Comprehensive Accreditation Manual for Hospitals.* The Joint Commission; April 2018.
28. ASHP guidelines for selecting pharmaceutical manufacturers and suppliers. *Am J Hosp Pharm.* 1991;48:523-524.
29. American Society of Hospital Pharmacists. ASHP guidelines on pharmacists' relationships with industry. *Am J Hosp Pharm.* 1992;49:154.
30. Briss PA, Zaza S, Pappaioanou M, et al. Developing an evidence-based guide to community preventive services—methods. *Am J Prev Med.* 2000;18(suppl 1):35-43.
31. Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ.* 2004;328:1490-1498.
32. Guyatt G, Gutterman D, Baumann MH, et al. Grading strength of evidence of recommendations and quality of evidence in clinical guidelines: report from an American College of Chest Physicians task force. *Chest.* 2006;129:174-181.
33. Harbour R, Miller J. A new system for grading recommendations in evidence based guidelines. *BMJ.* 2001;323:334-336.
34. Corman SL, Skledar SJ, Culley CM. Evaluation of conflicting literature and application to formulary decisions. *Am J Health-Syst Pharm.* 2007;64:182-185.
35. Sterné SC, Uchida KM, Itean SA. Improving the presentation of drug information to pharmacy and therapeutics committees for formulary decisions. *Am J Health-Syst Pharm.* 1996;53:1162-1164.
36. Reeder CE. Overview of pharmacoeconomics and pharmaceutical outcomes evaluations. *Am J Health-Syst Pharm.* 1995;52(19)(suppl 4):S5-S8.
37. Drummond MF, Sculpher MJ, Torrance GW, et al. *Methods for the Economic Evaluation of Health Care Programmes.* 3rd ed. Oxford University Press; 2005:137-189.
38. Gold MR, Siegel JE, Russell LB, et al, eds. *Cost-Effectiveness in Health and Medicine.* Oxford University Press; 1996:176-213.
39. Sanchez LA. Applied pharmacoeconomics: evaluation and use of pharmacoeconomic data from the literature. *Am J Health-Syst Pharm.* 1999;56:1630-1638.
40. Ofman JJ, Sullivan SD, Neumann PJ, et al. Examining the value and quality of health economic analyses: implications of utilizing the QHES. *J Manag Care Pharm.* 2003;9:53-61.
41. U.S. Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Pub L No. 108-173.
42. Food and Drug Administration. *Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book).* Accessed October 4, 2020. [www.fda.gov/cder/ob/](http://www.fda.gov/cder/ob/)
43. Food and Drug Administration. Biosimilars. Accessed October 4, 2020. <https://www.fda.gov/drugs/therapeutic-biologics-applications-bla/biosimilars>
44. Gray T, Bertch K, Galt K, et al. Guidelines for therapeutic interchange—2004. *Pharmacotherapy.* 2005;25:1666-1680. Accessed October 4, 2020. [https://www.accp.com/docs/positions/guidelines/Pharm2511\\_ACCP-TherapIntchg.pdf](https://www.accp.com/docs/positions/guidelines/Pharm2511_ACCP-TherapIntchg.pdf)
45. American Society of Hospital Pharmacists. ASHP statement on the use of medications for unlabeled uses. *Am J Hosp Pharm.* 1992;49:2006-2008.
46. American Society of Hospital Pharmacists. ASHP Specialty Pharmacy Resource Guide. Accessed October 4, 2020. <https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/specialty-pharmacy/specialty-pharmacy-resource-guide.ashx>
47. McCain J. Part I: distribution models for biologics and other specialty pharmaceutical products. *Biotechnol Healthc.* 2012;9:8-13.
48. Knoer SJ, Riffle AR. Multihospital health systems: seize the opportunity. *Am J Health-Syst Pharm.* 2018;75(7):423-429.
49. ASHP guidelines on managing drug product shortages. *Am J Health-Syst Pharm.* 2018;75: 1742-1750. Accessed October 4, 2020. <https://www.ashp.org/-/media/assets/policy-guidelines/docs/guidelines/managing-drug-product-shortages.ashx>
50. Jamison DT, Breman JG, Measham AR, et al, eds. *Priorities in Health. Chapter 3: Cost-Effectiveness Analysis.* International Bank for Reconstruction and Development/World Bank; 2006.
51. Robinson R. Cost-utility analysis. *BMJ.* 1993;307(6908):859-862. doi:10.1136/bmj.307.6908.859
52. Centers for Medicare & Medicaid Services. Electronic health records. Accessed October 14, 2020. <https://www.cms.gov/Medicare/E-Health/EHealthRecords/index.html>

## Appendix A—Glossary of terms

### Cost-Effectiveness Analysis.

A method for assessing the gains in health relative to the costs of different health interventions.<sup>50</sup>

**Cost Utility Analysis.** A comparison of the costs of different procedures with their outcomes measured in “utility based” units—that is, units that relate to a person’s level of well-being and are most often expressed as quality adjusted life year(s).<sup>51</sup>

**Electronic Health Record.** A digital version of a patient’s medical history that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that person’s care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports.<sup>52</sup>

**Formulary.** A continually updated list of medications and related information, representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis, prophylaxis, or treatment of disease and promotion of health.

**Formulary System:** An ongoing process whereby a healthcare organization, through its physicians, pharmacist, and other healthcare professionals, establishes policies on the use of drug products and therapies and identifies drug products and therapies that are the most medically appropriate and cost-effective to best serve the health interests of a given patient population.<sup>1</sup>

**Generic Substitution.** The substitution of drug products that contain the same active ingredient or ingredients and are chemically identical in strength, concentration, dosage form, and route of administration to the drug product prescribed.<sup>1</sup>

**Medication.** Any prescription medications, sample medications, herbal remedies, vitamins, nutraceuticals, vaccines, or over-the-counter drugs; diagnostic and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions;

radioactive medications, respiratory therapy treatments, parenteral nutrition, blood derivatives, and intravenous solutions (plain, with electrolytes and/or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug. This definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases.<sup>27</sup>

### Medication-Use Evaluation.

A systematic and interdisciplinary performance improvement method with an overarching goal of optimizing patient outcomes via ongoing evaluation and improvement of medication utilization.<sup>19</sup>

**Pharmacy and Therapeutics (P&T) Committee.** An advisory committee that is responsible for developing, managing, updating, and administering a formulary system. Institutions may refer to this committee by a different name.<sup>1</sup>

**Therapeutic Alternatives.** Drug products with different chemical structures but of the same pharmacologic or therapeutic class and usually have similar therapeutic effects and adverse-reaction profiles when administered to patients in therapeutically equivalent doses.<sup>1</sup>

**Therapeutic Interchange.** Authorized exchange of therapeutic alternatives in accordance with previously established and approved written guidelines or protocols within a formulary system.<sup>1,44</sup>

**Therapeutic Substitution.** The act of dispensing a therapeutic alternative for the drug product prescribed without prior authorization of the prescriber. This is an illegal act because only the prescriber may authorize an exchange of therapeutic alternatives.<sup>1</sup>

## Appendix B—Drug evaluation process

There are 4 major types of drug reviews: new drug monographs, reevaluations of previous formulary decisions, therapeutic class reviews, and expedited reviews of newly approved medications. Because of the expertise and training of pharmacists (drug information specialists in particular), pharmacists should

play an integral part in the preparation and presentation of the drug review document to the pharmacy and therapeutics (P&T) committee.

**New drug monographs.** When the Food and Drug Administration (FDA) approves a new drug for marketing that is relevant to the health system, a drug monograph should be prepared for formulary consideration by the P&T committee. New chemical entities warrant a thorough evaluation and a written drug monograph. A short (eg, one-page) summary could be provided along with the full monograph.<sup>35</sup> Some organizations use an executive summary format. A new drug that is significantly similar to other available therapeutic alternatives may be presented in a more abbreviated manner (eg, an abbreviated monograph) provided that the P&T committee or experts agree that the drug is therapeutically equivalent to agents already available on the formulary.

**Addenda to original monographs used to reevaluate previous formulary decisions.** Formulary decisions may need to be reassessed based on relevant new information or in light of newly marketed drugs or dosage forms. New data on safety, efficacy, stability, methods of administration, cost, or pharmacoeconomics may warrant a reevaluation of the drug or dosage strengths or formulations stocked by the health system. An addendum to the original monograph summarizing the new information should be developed for evaluation by the P&T committee. The P&T committee may want to establish reassessment dates at the time of formulary review so that the committee can reassess the effect of a formulary decision on quality or cost of care.

### Therapeutic class reviews.

Review of an entire therapeutic class of drugs should be performed at regular intervals, which may be determined by the P&T committee or influenced by regulatory agencies. A therapeutic class review should include all formulary and nonformulary medications within the class and may include institutional utilization or outcomes data and newly published information. Therapeutic class

reviews may lead to formulary removal of therapeutically equivalent drugs or a change in restriction or guideline status for a drug.

**Expedited reviews.** A process should be available for the P&T committee to conduct an expedited review

of a new drug, new indication for a drug, or reevaluation of a previous formulary decision. Criteria should be in place to describe when an expedited review is warranted. For example, approval of a new chemical entity for a disease with no therapeutic alternative

may warrant an expedited review to ensure availability of the drug for patients who need it. Likewise, a significant new safety concern may warrant an expedited review for addition of restrictions or removal from the formulary.