DRAFT 6/23/00
OMNICARE MEMORANDUM
Professional Services

DATE: **June 26, 2000**

TO: **Regional Vice Presidents**
Omnicare Operations Managers (copy and distribute to all Omnicare pharmacists)
Regional Clinical Directors

FROM: **Mark E. Lehman, Pharm.D. FASCP**
Director, Clinical Services

RE: **Definition of Clinical Priorities/Initiatives**

CC: **Patrick E. Keefe, R.Ph.**
Timothy E. Bien, R.Ph., FASCP
Lisa R. Welford, R.Ph., FASCP

As we approach the end of the second quarter of 2000, I feel it is appropriate to provide a treetops view of our clinical priorities from an Omnicare corporate perspective as you direct the activities of your professional staff.

1. **Formulary Management Programs (goal%):** a continued emphasis on formulary management and the PSTI process, including histamine-2 antagonists (95%), Risperdal® (65%), Zestril® (70%), Prevacid® (95%), Levaquin® (70%), KCl (75%) and the addition of Celebrex® (75%) as the "selected" COX-2 inhibitor.
   As operations managers, you must make sure that the physician authorization letter (PAL) process is strictly enforced in all pharmacies, and that a zero-tolerance mentality be implemented for letting eligible prescriptions slip through due to staffing concerns or other confounding variables. Our lack of rapid progress with the Lipitor® program and a slippage in our Levaquin® market share may be the beginning signs of problems with the prospective intervention processes we worked so hard to develop and implement. This cannot be allowed to happen.

2. **Re*View Health Management:** Omnicare's program to address under recognition, under diagnosis and under treatment of conditions common in the elderly, including:

- Heart Failure - ACE inhibitors and spironolactone
- Osteoporosis - PIXI® testing and adding appropriate therapies such as Vitamin D/calcium, Fosamax®, Actonel®, Miacalcin®, Evista® or estrogen therapy
- Depression - under recognition of depression and changing potentially inappropriate treatment, moving from older TCA's (amitriptyline, imipramine, trazodone and doxepin) to the SSRI's
- Immunization - for influenza and pneumococcus
- Pain Management - including moving from "unacceptable" analgesics such as propoxyphene to more appropriate, effective alternatives, while assessing the overall analgesic therapy
- Behavior Management in Dementia - encompassing the appropriate use of antipsychotics and going from the typical to the newer and better tolerated atypical antipsychotics; also focuses on the treatment of aggression and the use of Depakote®
- Urinary Health Management - focusing on recognition and treatment of urinary incontinence
- Dementia/Early Alzheimer's disease - a program in development, highlighting the prevalence of undiagnosed or unrecognized cognitive impairment, and highlighting early treatment.

3. Moving "unacceptable" and Beers' criteria medications to more appropriate alternatives, and moving from high-risk medications to safer, equally effective alternatives. Examples include:
   - Propoxyphene to acetaminophen, Ultram® or a COX-2 inhibitor
   - Traditional NSAID's to COX-2 inhibitors in residents at risk for NSAID gastropathy or with a GI history (ibuprofen, naproxen, diclofenac, etc. to Celebrex®)
   - Typical antipsychotics to atypicals (thioridazine, chlorpromazine, haloperidol to Risperdal®)
   - Sucralfate tablets and liquid to Prevacid® as the preferred medication for both PUD and GERD
   - Clonidine, terazosin, doxazosin and methyldopa (central and peripheral alpha-blockers) to better tolerated antihypertensive therapy in the elderly such as Zestril®
   - Inappropriate sleep medication to better, safer alternatives, such as flurazepam and estazolam to Ambien® or temazepam

This is far from a comprehensive list, just a few examples to help you focus on the most important tasks at hand, namely to be responsible for managing the drug therapy of the residents we serve. If we are unable to comprehensively and consistently impact the prescribing habits of the physicians we work with, we have failed in our attempts to be both resident advocates and a clinical company.

This effort requires close cooperation and communication between the operations managers and staff, and the clinical coordinators and their staff. I urge you to continue to strive to be the best clinical force in the long-term care industry. We cannot afford to rest on our laurels.

As always, I greatly appreciate your dedication, efforts and support and welcome any and all questions or comments. Thank you.