

PALLIATIVE PEARLS

Approach to Formulary Alternative Decisions: When To Switch and When Not To February 2026

Hospice is a Medicare Part A benefit in which hospice providers are responsible for the provision of all care related to a terminal diagnosis and comorbidities at no cost to the patient. This includes medications. While Medicare Part D plans may cover medications determined to be unrelated to the patient's hospice enrollment, current regulatory guidance from the Centers for Medicare and Medicaid Services states that billing for unrelated services during hospice enrollment should be "exceptional, unusual and rare."¹

Common hospice pharmacy utilization management strategies include the below practices. Intertwined in these strategies is clinical decision-making integral to the palliation of end-of-life symptoms:²

- **Strategic dispensing:** Recognition of factors that go into the total cost of dispensing a medication, beyond the price of the medication itself, and implementing best practices to mitigate fees.
- **Proactive prescribing:** The placement of "as needed" medications in the patient residence anticipating future urgent needs for managing common end-of-life symptoms.
- **Incorporating deprescribing tools:** Resources, including algorithms and clinician & patient/caregiver education, that bring awareness to the benefits of dose reduction and/or stopping a medication, with the intentions of ensuring the use of the lowest, most effective dose while reducing side effects, drug interactions & pill burden, and focusing on goals of care and their continual evaluation.³
- **Adhering to a hospice formulary:** A hospice formulary is a continually updated list of medications, often customized by an organization, representing hospice clinician clinical judgment.

Hospice formularies encompass most medications commonly used in pain and symptom management however they are not intended to cover every medication a patient may need.⁴ Maintaining a formulary serves to familiarize clinicians with cost-effective medication therapy but should not be used as a means of restriction. Interrupting or switching therapy for the sake of formulary status and/or cost savings in the absence of patient symptom and medication history assessment may precipitate symptom exacerbation.

This article aims to provide scenarios when a pause to identify impact of switching therapy is necessary. The approach to identifying alternative medication necessity includes assessment of medication therapy, hospice formulary, and therapeutic alternatives.

MEDICATION THERAPY ASSESSMENT

Review the current patient medication list, including scheduled and "as needed" therapies, and confirm that each medication meets the following criteria:⁵

1. Manages or palliates condition(s) identified in the hospice plan of care.
2. Appropriate and clinically necessary for palliating pain and/or symptom management.
3. **Not** a candidate for deprescribing. To rule out medications commonly targeted for deprescribing and those requiring continual reevaluation for continued benefit, see **Table 1** for examples.

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Table 1: Candidates for Deprescribing⁶	
Targeted Medication(s) Cited Broadly in Deprescribing Literature (includes examples, deprescribing rationale and links providing additional detail)	
Antimicrobials ^{7,8}	<ul style="list-style-type: none"> e.g., antibiotics, antivirals, antifungals. Side effects and drug interactions. See Antibiotic Use: Decision-Making Guidance for Hospice Care⁷
Dementia medications ^{9,10}	<ul style="list-style-type: none"> e.g., donepezil (Aricept[®]), memantine (Namenda[®]), rivastigmine (Exelon[®]) Not beneficial for most in advanced stages. See Dementia Medications & Deprescribing¹¹ and Reconsidering Pharmacological Interventions for Dementia¹²
Inhalers (hand-held)	<ul style="list-style-type: none"> e.g., metered dose (MDI)(albuterol), soft mist (SMI)(Combivent[®] Respimat), and dry powder (DPI)(Advair[®] Diskus) inhalers Improper inhaler technique due to dexterity issues and/or inability to deep breathe or hold breath for effective delivery to lungs. See Understanding Dyspnea in End-Stage COPD¹³ and Inhaled Therapy Palliative Pearls¹⁴
Oral hypoglycemics & insulins ^{15,16}	<ul style="list-style-type: none"> e.g., glipizide (Glucotrol[®]), metformin (Glucophage[®]); regular (Novolin[®] R), NPH (Novolin[®] N), rapid-acting (Humalog[®]), and long-acting (Lantus[®], Levemir[®], Semglee[®], Basaglar[®]) insulins Risk of hypoglycemia as terminal disease advances and oral intake diminishes. See Diabetes Management Case Study¹⁷ and Switching or Deprescribing Insulins¹⁸
Proton pump inhibitors (PPI) ^{19,20}	<ul style="list-style-type: none"> e.g., omeprazole (Prilosec[®]), pantoprazole (Protonix[®]) Continued use despite no longer indicated for use (e.g., hospital discharge). Research has associated PPI use with greater susceptibility to <i>C difficile</i> and pneumonia.
Require Frequent Evaluation for Continued Benefit and Care Goal Alignment (includes examples, deprescribing rationale and links providing additional detail)	
Anticoagulants	<ul style="list-style-type: none"> e.g., warfarin (Coumadin[®]), apixaban (Eliquis[®]), dabigatran (Pradaxa[®]), enoxaparin (Lovenox[®]) Risk of bleeding events may outweigh benefit of thrombotic event prevention. May no longer be indicated.

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Table 1: Candidates for Deprescribing ⁶
<p>Antiplatelet agents</p> <ul style="list-style-type: none">• e.g., aspirin, clopidogrel (Plavix[®]), dipyridamole (Persantine[®]), prasugrel (Effient[®]), ticagrelor (Brilinta[®])• Risk of bleeding events may outweigh benefit of thrombotic event prevention.• May no longer be indicated.
<p>Antiglaucoma eye drops</p> <ul style="list-style-type: none">• e.g., brimonidine (Alphagan[®]), dorzolamide (Trusopt[®]), latanoprost (Xalatan[®], Xelpros[®]), netarsudil (Rhopressa[®]), timolol (Betimol[®], Timoptic[®]), travoprost (Travatan[®])• Glaucoma progression is often slow—patient may not experience benefit.• Side effects such as headache, eye pain, stinging, and discharge.• Administration becomes more difficult as overall function declines.
<p>Blood pressure lowering cardiovascular medications</p> <ul style="list-style-type: none">• e.g., beta-blockers, diuretics, ACE inhibitors, ARBs, calcium channel blockers• Risk of hypotension as patient ages and terminal disease progresses.• See Approach to Blood Pressure Lowering Agents in Hospice Care²¹
<p>Immunosuppressants</p> <ul style="list-style-type: none">• e.g., azathioprine (Imuran[®]), cyclosporine (Neoral[®]), mercaptopurine (Purixan[®]), sirolimus (Rapamune[®]), tacrolimus (Prograf[®])• Commonly indicated for anti-rejection following organ transplant.• Side effects include acute cardiorespiratory failure, bradycardia, atrial fibrillation, skin issues, acidosis, abdominal distension/pain, anorexia, nausea/vomiting, hiccups, and bladder spasms.
<p>Ivabradine (Corlanor[®])</p> <ul style="list-style-type: none">• Indicated for symptomatic (NYHA class II to III) stable chronic HFrEF (LVEF ≤35%), on a beta blocker at maximum tolerated dose, and are in sinus rhythm with a heart rate of ≥70 bpm at rest.• Assess if patient still meets criteria.
<p>Overactive bladder medications²²</p> <ul style="list-style-type: none">• e.g., oxybutynin (Ditropan[®]), tolterodine (Detrol[®]), mirabegron (Myrbetriq[®])• Utilized for incontinence issues and/or bladder spasms; may not be indicated in urinary-catheterized patients.• Anticholinergic side effects increase risks of falling, constipation, urinary retention, dry mucous membranes (eyes, nose, mouth).

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Table 1: Candidates for Deprescribing ⁶
<p>Pancreatic enzymes²³</p> <ul style="list-style-type: none">• e.g., lipase/protease/amylase (Creon®, Viokace®, Zenpep®)• Must be taken with a meal or snack; as appetite/food intake decreases, product strength and dose prescribed must be adjusted accordingly.• Discontinue if patient is no longer eating.
<p>Rheumatoid arthritis agents</p> <ul style="list-style-type: none">• e.g., leflunomide (Arava®), methotrexate (Trexall®)• Associated with side effects including alopecia, gastrointestinal disturbances, headache, hypertension, infection, rash, and elevated liver enzymes.• May not improve quality of life.• See Symptom Management of Rheumatoid Arthritis²⁴
<p>Ranolazine (Ranexa®)</p> <ul style="list-style-type: none">• Indicated for chronic stable angina and typically prescribed with beta-blockers, calcium channel blockers, and nitrates.• May reduce frequency of anginal episodes, reduce use of nitroglycerin tablets, and improve exercise tolerance.• Associated with drug interactions and side effects (dizziness, constipation, fatigue).
<p>Thyroid replacement agents</p> <ul style="list-style-type: none">• e.g., Levothyroxine (Synthroid®, Levoxyl®, Levothroid®, Unithroid®), liothyronine (Cytomel®, Triostat®), thyroid desiccated (Armour Thyroid®)• Appropriate dosing and effectiveness is driven by lab monitoring, an intervention that is typically contrary to hospice care goals.• Drug-drug and drug-food interactions.• See Thyroid replacement Therapy in Hospice: Assessing Continued Benefit²⁵

HOSPICE FORMULARY ASSESSMENT

Determine which medications are on your hospice formulary and which medications are not on your hospice formulary. It is expected that a portion of hospice covered medications will fall outside of a hospice's formulary and may precipitate review of cost impact and/or identification of alternative products.

Recognize, at this point in the decision-making process, the medication continues to be beneficial for pain and/or symptom management, aligns with patient goals of care, and is not a candidate for deprescribing, therefore it is the responsibility of the hospice to cover it.

For “non-formulary” medications, the next step is to identify therapeutic alternatives, if any.

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THERAPEUTIC ALTERNATIVE ASSESSMENT

Therapeutic alternatives are products with different chemical structures but of the same pharmacologic or therapeutic class; usually with similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses.^{26,27}

1. Medications with an appropriate therapeutic alternative on formulary:
 - Examples may include, however not limited to, antihypertensives, antihistamines, pain & discomfort medications (non-steroidal anti-inflammatory drugs (e.g., ibuprofen), opioids, muscle relaxers), benzodiazepines, sleep aids, oral & topical corticosteroids, and oral & topical antimicrobials.
 - Formulary agents may provide the same therapeutic effect however be available in a different form:
 - i. Release form (e.g., regular-release (Prozac®) vs. extended-release (Prozac® Weekly))
 - ii. Procurement process (e.g., compounded product (oxycodone 40mg/ml oral solution vs. commercially manufactured product (OxyFast® 20mg/ml oral solution))
 - iii. Overall form (combination product (e.g., lisinopril-HCTZ) vs. individual medications (e.g., lisinopril and HCTZ dispensed separately)
 - iv. Route of administration (e.g., oral (tablet) vs. rectal (suppository) vs. parenteral (intramuscular))
2. Medications without an appropriate therapeutic alternative on your hospice formulary:
 - Identify the most cost-effective therapeutic alternative regardless of formulary status.
 - See **Table 2** for scenarios where a viable therapeutic alternative may not exist or where it is not advised to substitute without care goal assessment and recognition of medical history.

Table 2: Scenarios Where Substitution with Alternative Products Prompts a Pause First

Medical Safety Issues

Medication allergies and intolerances, adverse reactions, and drug-drug, drug-disease & drug-food interactions.

Specific Drug Needs

Brand-name necessity, inactive ingredient intolerance, or sensitivity requiring consistency with a specific generic manufacturer.

Patient Stability Interruptions

Patients who have undergone considerable trial and error of medications and titrations to reach stability (common with refractory neurological conditions such as epilepsy or mental health conditions such as depression and schizophrenia).

Seizure Management²⁷

- Substituting long-term, or maintenance, antiepileptic medications may result in triggering breakthrough seizures, increased side effects, or toxic, sub-therapeutic, or supra-therapeutic drug levels.
- While generics are safe, minor differences in absorption, pharmacokinetics, or tablet appearance can disturb the narrow therapeutic range required for seizure control, potentially leading to hospitalization and breakthrough seizures.

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Table 2: Scenarios Where Substitution with Alternative Products Prompts a Pause First

Depression

- When changing from one antidepressant to another, consider the patient’s history and prognosis first. If a patient has a history of depression and symptoms have been stabilized on their current medication, it may be more beneficial for the patient to continue that medication, especially if the prognosis is limited.
- If symptoms are new and/or the patient has been on an antidepressant for a brief time, switching agents may be more appropriate.
- See section titled, “How do I manage the switch from one antidepressant to another?” in: [Depression Management Case](#)²⁸

Antipsychotic use, especially clozapine, in patients with a history of treatment resistant schizophrenia

- When patients with a history of treatment resistant conditions become stabilized on clozapine and then elect hospice care, it is important to maintain therapy to prevent relapses, when feasible.
- Clozapine is typically reserved for treatment resistant conditions—patients typically have a history of relapse and failed several courses and dose titrations of other antipsychotics. Switching from clozapine to another antipsychotic after a first relapse in a patient with schizophrenia more than doubles the risk of a second relapse.
- See section titled, “Considerations for Hospice Care” in: [Clozapine Therapy: Overview and Place in Hospice & Palliative Care](#)²⁹

Unique Medication Class Needs

Conditions for which only specific medications are indicated and provide symptom relief.

Pulmonary hypertension (PH)

- Few, if any, hospice formularies include PH medications with no direct formulary alternatives. Recognizing that hospice coverage of medications is formulary agnostic, decisions on PH medications need to balance short-term symptom management benefits with primary therapy and symptom-based care, quality of life, and cost factors.
- Deprescribing advanced therapies can be complicated with limited published guidance on proper steps. In addition, discontinuation of such therapy can increase anxiety in patients due to concern of rapid development of distressing symptoms.
- See section titled, “Considerations for Hospice Care” in: [Managing Pulmonary Hypertension in Hospice Care: A Revision](#)³⁰

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SUMMARY

Hospice providers often use strategies like formularies, deprescribing tools, and strategic dispensing to manage medication costs, ensuring they align with palliative care goals and symptom management. Medications are reviewed to confirm their appropriateness, with certain drugs being candidates for deprescribing, such as antimicrobials, dementia medications, and oral hypoglycemics. If a medication is deemed necessary but non-formulary, providers must evaluate therapeutic alternatives or consider the best cost-effective option while assessing any risks or complications that may arise from switching therapies.

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