Updates on Medication Recalls

Digitek® (digoxin tablets, USP) – Class I Recall

On April 28, 2008 the FDA notified healthcare professionals that all strengths of DIGITEK (digoxin tablets) were being voluntarily recalled by the manufacturer due to the possibility that some tablets may be twice the usual thickness and therefore contain twice the approved level of active ingredient. The products, manufactured by Actavis, are distributed by Mylan Pharmaceuticals Inc., under a "Bertek" label and by UDL Laboratories, Inc. under a "UDL" label. The existence of double strength tablets poses a significant health risk from digitalis toxicity in patients with renal dysfunction. Digitalis toxicity can cause nausea, vomiting, dizziness, low blood pressure, cardiac instability, and bradycardia. Several reports of illnesses and injuries have been reported.

DIGITEK® is a generic version of LANOXIN®. DIGITEK® from both Mylan Bertek and UDL is currently unavailable and the companies cannot estimate a future availability date. The recall directs retail pharmacies to return the product to the manufacturer. Other generic digoxin 0.25mg & 0.125mg products continue to be covered at Tier one, however, those manufacturers are also experiencing backorder problems because of the increased demand from the DIGITEK recall. Lastly, the brand name product LANOXIN® has been added to the Medicare Part D formularies at Tier 2 until the end of 2008.

Starting May 19, 2008 our pharmacy provider (Prime Therapeutics) distributed Safety Alert letters to all affected providers and members alerting them to the safety concerns involved with this recall. Members are being instructed to contact their pharmacist for details on how to receive a new supply of digoxin. Providers can be expected to be contacted with questions from their patients on this topic as well.

NEUPRO (rotigotine) – Manufacturer Voluntary Recall

Neupro® (rotigotine transdermal system), indicated for the treatment of early stage Parkinson's disease, is being recalled voluntarily by Schwartz Pharma. The product is being recalled due to manufacturing problems that lead to the formation of rotigotine crystals in the patches. The formation of crystals may result in suboptimal amounts of drug being available for absorption through the skin and the efficacy of the product may vary. Neupro® will be recalled in the United States by the end of April 2008 and the product will not be available in the marketplace after this date.

Healthcare professionals should be careful not to initiate any new patients on Neupro®. All patients currently using Neupro® should begin down-titration of their dose per the guidelines in the product labeling (reduce by 2 mg/24 hours with a dose reduction preferably every other day). It is strongly advised that patients do not abruptly discontinue therapy. Abrupt withdrawal of dopamine agonists has been associated with a syndrome resembling neuroleptic malignant syndrome or akinetic crises. Members should contact their physician for alternative agents e.g., Mirapex® (pramipexole) and Requip® (ropinirole).

Our pharmacy provider (Prime Therapeutics) is planning to notify all Medicare Part D members via the April Medicare Part D Explanation of Benefits (EOB) mailing. The EOB mailing to all members should be completed by the beginning of June.

Intravenous Heparin

Since the beginning of 2007, nearly 800 injuries and over 80 deaths in the U.S. have been linked to allergic reactions with the use of unfractionated heparin solutions. Serious adverse reactions have been reported in patients who received rapid administration of bolus doses and include allergic or hypersensitivity-type reactions (e.g. oral swelling, nausea, and vomiting, sweating, shortness of breath) and cases of severe hypotension requiring prompt treatment. Most incidents developed within minutes of heparin administration at hemodialysis centers. In early January 2008 clusters of these unusual allergic
reaction event reports came to the attention of the Centers for Disease Control (CDC) and Baxter. This resulted in Baxter recalling nine lots of its heparin sodium products on January 17, 2008. Subsequent reports of adverse events, mostly with the multiple dose products, after the January recall indicated that adverse events were not limited to the recalled lots only. As a result, on February 28, 2008 Baxter announced a further recall of all outstanding heparin lots and ceased further heparin manufacturing.

A contaminant (oversulfated chondroitin sulfate) that looks like heparin under standard testing but is much less expensive to manufacture has been detected in the suspected heparin solutions. Chondroitin sulfate is derived from animal cartilage and is used as a dietary supplement. It's not clear yet if the contamination was intentional. It does seem likely that there is a definite link between the contamination and the adverse reactions and deaths.

The contaminated heparin appears to come from Chinese manufacturing plants. Baxter, the supplier of about 50% of heparin sold in the U.S. gets its heparin products from China. In addition to the recalls mentioned above Baxter is not currently shipping any heparin vials or heparin flush products and as a result heparin is in short supply. Luckily, the recall has not involved Baxter's premixed heparin IV solutions in bags. Other U.S. manufacturers (e.g. B. Braun, Covidien, and Hospira) have also recalled lots of heparin, including large volume infusions. APP Pharmaceuticals, the other major U.S. heparin supplier, is ramping up production to try and meet the entire U.S. demand. So far, the contaminant has not been detected in APP Pharmaceuticals products. Low-molecular-weight heparin products have not been affected by the contaminant or been recalled in either Canada or the U.S.

Since heparin and other anticoagulants are high-alert drugs, which means heparin errors are more likely to have severe consequences, changing products and/or changing usual ordering or dispensing procedures could be risky. It's important to make sure that any temporary changes are communicated effectively and executed correctly. The use of other anticoagulants, such as argatroban, lepirudin, fondaparinux and low-molecular heparins, may present suitable alternatives when utilized appropriately. Specific alternative agents, clinical indications, and their doses can be found at the American Society of Health-System Pharmacists Drug Shortage information page. (www.ashp.org)

The current heparin situation is a good reminder that it’s important to report all suspected adverse drug reactions. To report unexpected adverse or serious events associated with the use of heparin or any medication please contact the FDA's MedWatch Program by phone at 800.FDA.1088, by fax at 800.FDA.0178, by mail at MedWatch, HF-2, FDA, 5600 Fishers Lane, Rockville, M.D. 20852-9787, or on the MedWatch Web site at www.fda.gov/medwatch.

For further information or questions pertaining to this newsletter, e-mail Richard Reynolds at Richard_g_reynolds@bcbsnm.com.

References:
Anon. heparin injection, digoxin tablets, rotigotine transdermal systems. American Society of Health-System Pharmacists. Internet: http://www.ashp.org/s_ashp/bulletin (Assessed 5.23.08)