

The Curbside Consult

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UPDATES IN RESEARCH

The Women's Health Initiative (WHI): The Estrogen-only Arm

**Effects of Conjugated Equine Estrogen in
Postmenopausal Women with Hysterectomy**
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Background: In 2002, the WHI estrogen plus progestin study was stopped early due to health risks of coronary heart disease, stroke, venous thromboembolism, and breast cancer outweighing the benefits of reductions in colorectal cancer and fractures. At that time, these risks were not seen in the estrogen alone group. The trial was terminated early on March 1, 2004 when risks of estrogen alone were deemed by the National Institute of Health to outweigh any health benefits.

Purpose: To determine whether the conjugated equine estrogens (CEE, Premarin®), the most commonly used estrogen replacement, when used in women with a hysterectomy, is associated with a decrease in coronary heart disease (CHD) incidence, while not increasing the incidence of breast cancer.

Methods: This study was a randomized, double-blind, placebo-controlled trial of 10,739 generally healthy women, aged 50-79 years, with prior hysterectomy, of which 4.1% had a prior MI or coronary revascularization. Women with life-expectancy less than three years, safety issues (e.g. prior breast or other cancers, except melanoma), adherence concerns, or judged by the health care practitioner to need hormone replacement, were excluded from the trial. Participants were randomized to receive 0.625 mg per day CEE or matching placebo. Follow-up was at 6 weeks and every six months by telephone, with a required annual clinic visit. EKGs were conducted at years three, six, and nine and annual mammograms clinical breast exams were conducted.

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Results: The average follow-up in this study was 7 years. CEEs were not shown to alter the risk of CHD. An increased risk of stroke was seen in patients taking CEE ($p=.007$, Absolute Risk Index [ARI]=12%), which caused the trial to be stopped early. In a subanalysis, this risk was the same regardless of previous reported stroke. The risk of venous thromboembolism (VTE) was increased in the CEE group (ARI=7%), with only the increased risk of DVT showing significance ($p=0.03$). Invasive breast cancer was diagnosed 23% less in the CEE group, however this was not statistically significant ($p=0.06$, Absolute Risk Reduction [ARR]=7%). No difference in colorectal cancer risk was seen. As expected, women taking CEE had a lower rate of fractures (hip, $p=0.01$; vertebral, $p=0.02$; total fractures, $p<0.001$). CEE did not affect total mortality.

Conclusions: Conjugated equine estrogens (Premarin®) significantly increase the risk of stroke in generally healthy women with prior hysterectomy. The absolute risk increase in stroke was 12% for women taking CEE. For every eight patients treated with CEE, approximately one will have a stroke (NNH=8). This study was unable to confirm the perception that estrogen replacement decreases the risk of CHD, which has been historically seen in observational studies. As expected, estrogen replacement increases the risk of VTE and decreases the risk of fractures.

Take Home Message: As was seen in the WHI estrogen plus progestin trial, hormone replacement therapy with CEE increases a woman's risk of stroke. It is unknown whether all formulations of

estrogens and progestins carry these risks; however, these results have led the FDA to request a Black Box Warning on all postmenopausal hormone labels:

- *Estrogens and progestins should not be used for the prevention of cardiovascular disease*
- *Other doses of CEE and medroxy progesterone acetate (MPA), and other combinations of estrogens and progestins were not studied in the WHI and, in the absence of comparable data, these risks should be assumed to be similar.*
- *Because of these risks, estrogens with or without progestins should be prescribed at the lowest effective doses and for the shortest duration consistent with treatment goals and risks for the individual woman.*

Hormone replacement therapy should no longer be used for CHD prevention and other products, such as bisphosphonates should be used when no contraindications exist) for osteoporosis treatment. HRT has fallen by the wayside, yet many women continue to be taking these products for the wrong reasons. Patients should be assessed regularly to determine whether treatment of symptoms associated with menopause could be discontinued.

JAMA;291(14):1701-1712

Topiramate for Migrane Prevention

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Background: Migraine headache is a common neurologic disorder that can cause significant disability and decrease quality of life. It is estimated that 11% of the US population experiences migraine headaches. Of the migraine patients who do seek treatment, less than 33% of patients report consistent efficacy with their current therapeutic regimens. Recently, research has shown that overuse of acute medications for the treatment of migraines can lead to chronic daily headaches in these patients, making preventative therapy desirable for patients with frequent migraines. Small, open-label trials have indicated that topiramate may be effective in preventing migraines. Topiramate inhibits voltage-gated sodium channels, inhibits high voltage-activated calcium channels, inhibits the glutamate-mediated neurotransmission at α -amino-3-hydroxy-5-methylisoxazole-4- propionic acid (non-N-methyl-D-aspartate subtype) and kainate receptor subtypes, and enhances GABA-receptor mediated chloride flux. It is unclear which mechanism or combination of mechanisms contributes to the prevention of migraine headaches.

Purpose: To determine if topiramate is a safe and effective option for migraine prophylaxis.

Methods: This is a 26-week, randomized, double blind, placebo-controlled study conducted at 52 North American clinics. Patients were 12 to 65 years of age and had a six-month history of migraine based on the International Headache Society criteria. Patients were randomized to one of four treatment groups: placebo or topiramate 50 mg/day, 100 mg/day, or 200 mg/day. The main outcome measure was change from baseline in mean monthly migraine frequency. Secondary endpoints included proportion of patients responding to treatment (as measured by a 50% or more reduction in monthly migraine frequency); the mean change in monthly migraine days, severity and duration; and change in number of days requiring rescue medication per month. A total of 468 patients were in the intended-to-treat population and 255 patients completed the study.

Results: The primary analysis showed that topiramate was associated with a greater reduction in mean monthly migraine frequency than placebo. Migraine frequency decreased from 5.4 to 4.1 in patients taking 50 mg/day, from 5.8 to 3.5 in patients taking 100 mg/day, and from 5.1 to 3.0 for patients treated with 200 mg/day compared to a decrease from 5.6 to 4.5 in the placebo group. The changes from baseline monthly migraine frequency was statistically significant in the 100 mg/day group ($P=0.008$) and the 200 mg/day group ($P<0.001$) when compared to placebo. For patients in the 50 mg/day group, the comparison to placebo was not statistically significant ($P=0.48$). The proportion of patients responding to treatment with topiramate was significantly larger than placebo at all doses (50 mg/day, $P=0.01$; 100 mg/day, $P<0.001$; 200 mg/day, $P<0.001$). The mean reduction in the number of monthly migraine days was statistically significant for the topiramate 100 mg/day group ($P=0.003$) and the 200 mg/day group ($P<0.001$). The mean reduction in monthly number of days when acute rescue medication was used was significantly greater for patients treated with topiramate 100 mg/day ($P=0.01$) and 200 mg/day ($P=0.005$) compared to placebo. The number of days when acute rescue medication was used in the topiramate 50 mg/day group was not significant when compared to placebo. The most common treatment-emergent adverse events commonly associated with topiramate were paresthesia (50%), fatigue (14%), anorexia (13%), diarrhea (11%), weight loss (11%), hypesthesia (11%), difficulty with memory (10%), and nausea (10%). These side effects were more commonly seen at doses above 100 mg/day, and lead to discontinuation of the drug in less than 10% of study participants taking 100 mg/day.

Conclusion: Topiramate showed significant efficacy in migraine prevention for the duration of the study at doses of 100 mg/day and 200 mg/day when compared to placebo.

Take home message: Although comparative data is not available, the efficacy of topiramate in migraine prophylaxis appears to be comparable with that of many of the other commonly used agents such as beta-blockers, valproate, and tri-

cyclic antidepressants. Unlike some of the other options for migraine prevention, topiramate is not available generically and costs \$307.99 for a 60-day supply of the 200 mg tablets (walgreens.com). The side-effect profile as well as patient preference should be reviewed before deciding which agent should be used for the prevention of migraine headaches.

JAMA 2004; 291:965-973.

NEW DRUG UPDATES

Ketek®

telithromycin (Aventis)

Indication: Telithromycin is only approved for use in adults, age 18 or older. The indicated infections and susceptible microorganisms are:

- Acute bacterial exacerbation of chronic bronchitis due to *Strep pneumoniae*, *H. influenzae*, or *M. catarrhalis*.
- Acute bacterial sinusitis due to *Strep pneumoniae*, *H. influenzae*, *M. catarrhalis*, or *Staph aureus*.
- Community-acquired pneumonia (of mild to moderate severity) due to *Strep pneumoniae*, (including multi-drug resistant isolates, such as penicillins and macrolides), *H. influenzae*, *M. catarrhalis*, *Chlamydia pneumoniae*, or *Mycoplasma pneumoniae*.

Mechanism of Action Telithromycin is the first in a new class of antibiotics, called ketolides. It is structurally similar to the macrolides and works by blocking protein synthesis.

Dosage: The dose of telithromycin is 800 mg by mouth once daily, with or without food. It should be given for 5 days for sinusitis or chronic bronchitis. Community acquired pneumonia should be treated for 7-10 days. There is no dosage adjustment needed for hepatic impairment or mild to moderate renal impairment. It should not be given to patients with severe renal impairment (CLcr < 30 ml/min) or undergoing dialysis, as the dose has not been established.

Pharmacokinetics: Telithromycin is a strong inhibitor of the cytochrome P450 3A4 system. Concomitant use with any medications primarily metabolized by CYP 3A4 should be used with caution. Avoid use with 3A4 inducers (rifampin,

phenytoin, carbamazepine, or phenobarbital). Concomitant use with atorvastatin, simvastatin, or lovastatin should be avoided. Hold statin during treatment with telithromycin. Monitoring is recommended for concomitant use with digoxin or midazolam (and other benzodiazepines metabolized by CYP 3A4).

Safety Issues: Use is contraindicated in patients sensitive to macrolides. The most common adverse effects are diarrhea, nausea, and dizziness. Visual disturbances, including blurred vision, double vision, and difficulty focusing may occur and last several hours. This typically has been observed after the first or second dose and may recur with subsequent doses. It is more common in women and in younger patients (under 40). Telithromycin has the potential to prolong the QTc interval. Patients with prolonged intervals or taking Class IA or III antiarrhythmics should not take telithromycin.

How Supplied & Cost: Although the recommended dose is 800 mg, it is available only as 400 mg tablets. Ketek Pak™ comes as a ten-tablet card for a five-day supply. Cost is not available at this time. Ketek will be available in pharmacies starting in July.

Place in Therapy: This is an entirely new class of antibiotics, however, it is similar to the macrolides. It does provide benefit for multi-drug resistant *Strep pneumoniae*. It is an option when there is resistance to two or more of the following antimicrobials: penicillin, 2nd generation cephalosporins (e.g. cefuroxime), macrolides, tetracyclines, and trimethoprim/sulfamethoxazole.

Kelly Ruby, Pharm.D.
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Blood Pressure Taken in the Home vs. in the Physician's Office

Jean Moon, PharmD, CUHCC

Key Point: Home blood pressure (BP) readings can complement conventional office measurements and can identify patients with white-coat hypertension.

Background: A previous 1997 study looked at antihypertensive treatment based on ambulatory monitoring of BP instead of conventional BP in the physician's office. After six months follow-up, this study observed less intensive drug treatment with preservation of BP control, general well-being, and inhibition of left ventricular enlargement associated with the use of home BP measurements. The study did not note a reduction in costs of antihypertensive treatment.

Antihypertensive Treatment Based on Blood Pressure Measurement at Home or in the Physician's Office. JAMA 291(8):955-964, 2004 Feb 25.

In this randomized controlled trial, the investigators wanted to reexamine the 1997 study and see if home BP readings instead of ambulatory monitoring would reduce the cost of treatment when compared to measurements in a physician's office. Out of 400 patients, 203 patients were assigned to receive antihypertensive treatment prescribed based on home BP readings and 197 patients were adjusted based on measurements taken in the clinic. Patients were followed for one year.

Interventions were made in a stepwise fashion (described below) determined by their diastolic BP (DBP) measured at home (the average of 6 measurements per day during the first week) or the average of three sitting DBP at the physician's office. A blinded physician-investigator intensified treatment when DBP > 89 mmHg, left it unchanged when DBP 80-89 mmHg, or reduced it when DBP < 80 mmHg based on the target DBP.

All patients began or switched to lisinopril 10 mg daily (Step 1). The guideline intensified increase therapy in the following manner: lisinopril 20 mg daily (Step 2); combination of lisinopril with hydrochlorothiazide 25 mg daily or amlodipine 5 mg daily (Step 3); adding amlodipine 5 mg daily for the lisinopril/HCTZ group or prazosin 6 mg daily in the lisinopril/amlodipine group (Step 4). Patients with contraindications to ACE-I were given atenolol 50 mg (Step 1) or 100 mg (Step 2).

Adjustment of antihypertensive treatment based on home BP led to less intensive drug treatment, less BP control, and marginally lower costs compared to office BP reading adjustments. There were no differences in general well-being or left ventricular mass. Home BP readings allowed for identification of white-coat hypertension patients.

Take Home Point: Self-measurement of BP in the home is *complementary* to the conventional office measurement and should not be used alone for the adjustment of antihypertensive treatment until further evaluation of normal home BP ranges can be established.

Intensive Statin Therapy

Kelly Ruby, PharmD, Bethesda Clinic

Key Point: Although current guidelines (ATP III) recommend an LDL goal of less than 100 mg/dL in patients with coronary artery disease or acute coronary syndromes, recent studies suggest even lower LDL goals may prove beneficial to patients.

Nissen S, et al. Effect of intensive compared with moderate lipid-lowering therapy on progression of coronary atherosclerosis. JAMA 2004;291:1071-1080. (The REVERSAL Study)

The REVERSAL study is a double-blind, randomized, active-control, multi-center trial. This study compared intensive (atorvastatin 80 mg) to moderate (pravastatin 40 mg) lipid lowering in patients aged 30 to 75 with coronary artery disease (CAD) over an 18 month period. There were 654 patients who were randomized and received study drug, of whom 502 patients had evaluable intravascular ultrasounds at baseline and 18 months. The primary efficacy parameter was the percentage change in atheroma volume measured by intravascular ultrasound. Baseline mean LDL was 150.2 mg/dL in both groups. Not surprising, the more intensive treatment had significantly lower total cholesterol, LDL, Apolipoprotein B, and C-reactive protein. After treatment the moderate group LDL was reduced to 110 mg/dL and to 79 mg/dL in the intensive group (P<0.001). The intensive treatment group had a significantly lower progression rate in percentage of atheroma volume (P=0.02). This included change in total atheroma volume (P=0.02), change in percentage atheroma volume (P<.001), and change in atheroma volume in the most severely diseased 10-mm vessel subsegment (P<0.01). The progression rate was significantly lower in the intensive group compared

to the moderate intensity group ($P=0.02$). When compared to baseline, this rate was positive in the moderate group (2.7%, $P=0.001$), and negative in the intensive group (-0.4%, $P=0.98$). This demonstrated an inverse relationship between percent LDL reduction and atherosclerosis progression (determined by atheroma volume). The authors found that over 18 months, each 10% reduction in LDL level resulted in a percent change of 1% in atheroma volume.

This study does not tell us if the difference lies solely in the reduction of LDL, or other factors such as reduction in C-reactive protein, lipoproteins, or differences between the two medications. Nor does this study address the more important morbidity and mortality endpoints, or the relationship between the progression of atheroma volume and clinical outcome. Perhaps, in patients with CAD we should push the LDL goal of 100 mg/dL lower, but from this study alone, it does not warrant changes in the current guidelines.

Cannon P, et al. Intensive versus moderate lipid lowering with statins after acute coronary syndromes. *N Engl J Med*. 2004;350:1495-1504. (The PROVE-IT TIMI 22 Study)

The PROVE-IT TIMI study also looked at intensive (atorvastatin 80 mg) versus moderate (pravastatin 40 mg) lipid lowering. This was a double-blind, randomized, multi-center trial, designed as a non-inferiority study. The subjects had to have been hospitalized for an acute coronary syndrome in the previous ten days. The study followed 4162 patients for 18 to 36 months (mean 24). The primary outcome was a composite of death from any cause, myocardial infarction, documented unstable angina requiring hospitalization, revascularization (30 days or more after randomization), and stroke. The goal was to get the moderate intensity patients to a LDL level less than 100 mg/dL and the intensive group to an LDL level less than 70 mg/dL. The resulting median LDL values were 95 mg/dL in the moderate intensity group and 62 mg/dL in the intensive group ($P<0.001$). They authors determined the two regimens were not equivalent. Fewer patients in the intensive group reached a composite primary endpoint after two years (22.4%) compared with the moderate intensity group (26.3%, $P=0.005$). Median HDL levels rose in each group, 8.1% in the moderate group, and 6.5% in the intensive group ($P<0.001$). Median C-reactive protein levels dropped from 12.3 mg/L at baseline to 2.1 mg/L in the moderate group and to 1.3 mg/dL in the intensive group ($P<0.001$). This study favors intensive lipid-lowering over standard regimens in patients with recent acute coronary syndromes. The atorvastatin 80 mg dose was safe and well tolerated, compared to the pravastatin 40 mg. At

two years, 33.0% of the pravastatin group discontinued the drug, compared to 33.0% of the atorvastatin group ($P=0.11$). Only 1.1% of the pravastatin group and 3.3% of the atorvastatin group had elevations in AST greater than three times the upper limit of normal ($P=0.001$). There were no cases of rhabdomyolysis in either group, and the rates of myalgias or creatine kinase elevations were similar in for pravastatin (2.7%) and atorvastatin (3.3%, $P=0.23$).

Again, this study does not tell us if the difference is attributable solely to greater LDL lowering or to other factors. Studies addressing intensive LDL lowering on morbidity and mortality, in other conditions and using the same medication will clarify unanswered questions.

Take Home Point: Patients with acute coronary syndromes and coronary artery disease may benefit from intensive lipid-lowering with LDL levels lower than 100 mg/dL, the current recommended goal. You may consider increasing the dose or changing to a more potent statin in these patients. The benefits of lowering the LDL for secondary prevention are well documented; however, we are still asking "how low is too low?" These studies still do not answer that question, but they may be persuasive in changing the guidelines to recommend lower LDL goals.

An Overview of OTC Weight Loss Products

Paul Cihunka, PharmD, Westside CHC

Introduction: Obesity is a major public health problem that leads to complications such as diabetes, osteoarthritis, dyslipidemia, hypertension, sleep apnea, and cancer. Many patients use OTC diet medications to treat obesity despite the fact that few studies support their effectiveness and safety. Also, many of the studies related to herbal supplements were conducted in animals, not humans. The majority of popular OTC supplements for weight loss (Trimspa®, Hydroxycut®, etc.) contain more than one herbal preparation. Since there are few clinical trials that study specific OTC herbal combinations it is difficult to tell if herbal combinations work better than individual preparations. Also, many combination products that have been studied contain ephedrine, which has been banned by the FDA. Since weight loss could have been due to ephedrine, current formulations of herbal diet supplements may not be effective. This article reviews some trials available on herbal dietary supplements in humans.

Green Tea: Green tea is derived from the *Camelia sinensis* leaf and is consumed as a tea or as a powder in dietary supplements. Catechins, including epigallocatechin gallate, are the main active components of green tea. They inhibit catechol-O-methyl transferase (COMT) which is the enzyme responsible for the breakdown of norepinephrine. Green tea preparations also contain caffeine. It is difficult to discern if the weight loss benefits are due to the green tea or caffeine. A rationale for the use of green tea for the treatment of obesity is that it increases resting energy expenditure. Ten men were given placebo, 50mg of caffeine, or a proprietary green tea blend that contained 50mg of caffeine and 90mg of epigallocatechin gallate three times a day for 24 hours on three separate occasions. Compared to placebo, the green tea extract increased energy expenditure by 3.5% versus placebo ($p < 0.01$) and by 2.8% ($p < 0.01$) versus caffeine.

A green tea extract of 450 mg or placebo was given to 104 overweight subjects (18-60 years of age, BMI 25 – 35) for 13 weeks that lost an average of 6.4 lbs (SD 1.9) previously on a standardized diet. The study was randomized, placebo controlled and it tested if green tea would prevent rebound weight gain. Green tea had no significant effect on rebound weight gain compared to placebo. Patients taking green tea gained back 30.5% (SD = 61.8%) of weight previously lost versus 19.7% (SD = 56.9%) for patients on placebo.

Adverse events of green tea are mild and include excess gas, upset stomach, nausea, heartburn, abdominal pain, dizziness, headache, and muscle pain. Side effects did not occur more than placebo. Supplements containing green tea: Trimspa[®], Hydroxycut[®], Xenadrine EFX[®].

White Kidney Bean Extract: Phaseolus vulgaris is the active ingredient of white kidney bean extract, and it inhibits alpha-amylase in vitro. Alpha amylase is secreted by the pancreas and the salivary glands, and is responsible for the breakdown of complex carbohydrates. Theoretically, inhibition of this enzyme will result in decreased absorption of carbohydrates, and decrease caloric intake.

A randomized, double-blind placebo controlled trial compared the effects of 1500 mg of “Phase 2” a supplement containing white kidney bean extract (amount not specified) versus placebo. The study consisted of 39 subjects and was eight weeks in duration. All subjects were on a high fiber/ low fat diet that consisted of a total complex carbohydrate intake of 100 to 200 grams. The “Phase 2” group lost 3.79 pounds versus 1.65 pounds in placebo in eight weeks which was not statistically significant

($p=0.35$). However, the “Phase 2” group did report a statistically significant decrease in triglycerides (26.3 mg/dl vs. 8.2 mg/dl ($p=0.07$)).

Side effects. In this study, one patient reported tension headaches. Supplements that contain phaseolus vulgaris: Carb Intercept[®].

Garcinia Cambogia: Hydroxycitric acid is the active component of *Garcinia Cambogia*, and its mechanism of action is inhibition of fatty acid synthesis via inhibition of adenosine-triphosphate-citrate-(pro – 3S)-lyase. This enzyme catalyzes the first step in fatty acid synthesis. Inhibition of this enzyme may lead to improvements in body weight and body composition.

A 12-week randomized, double blind, placebo controlled trial supports the use of *Garcinia Cambogia* for weight loss. Eighty-nine mildly obese patients (10 to 50 lbs over ideal body weight) on a 1200 calorie/day diet were given 400mg capsules of *Garcinia Cambogia* or placebo for 12 weeks. Mean weight loss on treatment was 3.7 ± 3.1 kg versus 2.4 ± 2.9 kg ($p = 0.026$). However the main focus of this trial was on feelings of hunger determined by patients completing a questionnaire at 4, 8, and 12 weeks of the study. There were no significant differences in feelings of hunger between placebo and treatment groups.

A twelve week randomized, double blind, placebo controlled trial compared body weight change and fat mass change in 135 subjects with an average BMI of 32 kg/m^2 . Subjects received either 1500mg of hydroxycitric acid or placebo, and were on a low calorie, high fiber diet. Both groups had significant weight loss compared to baseline, but the hydroxycitric acid group did not perform better than placebo (mean 3.2 (SD = 3.3) kg weight loss for treatment vs. 4.1 kg (SD = 3.9) weight loss for placebo, $p = 0.14$). Fat mass loss was also not significant (mean fat mass loss placebo 2.16% ($\pm 2.06\%$) vs. treatment 1.44% (± 2.15)).

*Side effects include headache, upper respiratory tract symptoms, GI tract symptoms. Supplements containing *Garcinia Cambogia*: Hydroxycut[®].*

Chromium Picolinate: Chromium is an essential trace mineral and a cofactor for insulin. Its mechanism of action involves enhancing the activity of insulin, which improves lipid, carbohydrate, and protein metabolism resulting in decreased body fat and increases metabolism.

A meta-analysis of 10 randomized controlled trials demonstrated that chromium caused an average of 1.1 kg reduction in body weight versus placebo

(95% CI -1.8 to -0.4). All trials had to be randomized, double blind, placebo controlled, and measure body weight to be included in the analysis. Duration of treatment was 6 to 14 weeks and BMI averaged 28 to 37. However, a sensitivity analysis revealed that most of this difference was due to the effect of one trial. Also, low calorie diets can achieve similar results in one week versus 6 to 14 weeks (1.5 to 2.5 kg/week and 0.5 to 0.6 kg/week loss respectively).

Possible side effects of chromium are hypoglycemia, insomnia, and irritability. Supplements containing chromium: Trimspa[®], Hydroxycut[®].

Conclusion: Based on the trials reviewed, individual herbal weight loss supplements have little or no effect on weight loss. These trials did not demonstrate significant safety issues with these products, but there is not enough data available to establish general safety. It is possible that combinations of these medications act synergistically, but randomized, placebo controlled trials with specific clinical endpoints must be completed before efficacy can be established.

Miscellaneous News

Medicare Prescription Benefit: Phase 1 Begins!!

Leslie Helou, Pharm.D., UM College of Pharmacy

In December 2003, the landmark Medicare Prescription Drug, Improvement, and Modernization Act was signed into law. The prescription coverage (Medicare Part D) begins this summer with Phase 1, a discount prescription card program, until the actual Medicare coverage begins in 2006. The drug discount cards are available to all Medicare beneficiaries, except Medicaid covered persons or those receiving prescription benefits through the Veterans Affairs Department. These cards will be administered by private parties (e.g. pharmacy benefit managers, pharmaceutical companies, pharmacies, etc.) who meet specific Medicare plan requirements, and coverage will vary by card. The cards will be available at no higher than a \$30 annual enrollment fee.

On April 29th, 2004, the Centers for Medicare and Medicaid Services (CMS) launched a website (<http://www.medicare.gov>) designed to aid seniors in choosing between the 39 national and 33 regional Medicare approved cards. This site allows the enrollee to highlight up to 25 drugs and dosages, and compare the cost of a 30-day supply for each card, as well as indicates which pharmacies in their area accepts each card. Coverage among cards will vary, making it important for Medicare beneficiaries to compare coverage of their particular medications before signing up. Those beneficiaries who are part of a Medicare + Choice health insurance plan are restricted to the discount card offered by their plan (e.g. UCare Minnesota and Medica in Minnesota). Some discount cards will be offered by pharmaceutical companies. These cards will cover only those drugs manufactured by the particular company, which will limit the true benefit for the enrollee if they are on many drugs. It is estimated

that these Medicare approved cards will save beneficiaries 10-15% on their total prescription medication costs.

For low-income beneficiaries whose income is less than 135% of the federal poverty level, and who don't have prescription coverage from certain other programs, transitional assistance will be available in the form of a \$600 per year credit. For those who enroll in 2004, any unused money will rollover and be added to the \$600 for 2005. A higher level of assistance will be available to those beneficiaries with an income less than 100% of the federal poverty level.

Enrollment for the discount cards began in May, and discounts will begin to be applied in June. Open enrollment will occur again in November for those who want to change to a different card. For those Medicare beneficiaries who have supplemental prescription coverage or other discount cards that are not Medicare approved, they can continue to use that coverage if desired and enroll for a Medicare approved card as well. However, only one discount can be applied per 30-day supply of a medication.

Patients can be referred to any of the following contacts if they have difficulty navigating this new program. Callers should have the names and dosages of their medications available during the call.

- <http://www.medicare.gov>
- Medicare: 1-800-633-4227
- Minnesota Senior Linkage Line: 1-800-333-2433
- Minnesota Senior Federation Health Plan Information Center: 651-645-0261 ext. 145, or 1-877-645-0261 ext. 145