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PHARMFACTS BULLETIN

The latest news and updates from The Christ Hospital Pharmacy Department

IN THIS ISSUE

P&T Updates *Shannon Saelinger, PharmD, PGY1 Pharmacy Resident*

Formulary Updates as of March 31st, 2025

- **Cabergoline** was added to formulary.
- **Bempedoic Acid** was reviewed and not added to formulary due to due to the prolonged time to see benefit, low utility in the acute care setting, and increased cost.
- The committee approved changing the preferred neonatal vitamin K to **preservative free Vitamin K**.
- **Sofosbuvir/velpatasvir (Epclusa®)** was added to formulary restricted to use in transplant for HCV uninfected patients receiving organs from HCV positive donors.
- **Zanidatamab (Zihera®)** was added to formulary, non-stock, restricted to outpatient use. Zanidatamab is indicated for cholangiocarcinoma or biliary tract cancer (BTC) that is human epidermal growth factor receptor 2 (HER2)-positive (IHC 3+).
- **Isatuximab (Sarclisa®)** was added to formulary, non-stock, restricted to outpatient use. Isatuximab is indicated for the treatment of adult patients with multiple myeloma after prior lines of therapy or in patients who are not eligible for autologous stem cell transplant.
- **Zolbetuximab-clzb (Vyloy®)** was added to formulary, non-stock, restricted to outpatient use. Zolbetuximab is indicated in combination with fluoropyrimidine and platinum-containing chemotherapy for first-line treatment of adults with locally advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-negative gastric or gastroesophageal junction adenocarcinoma whose tumors are claudin (CLDN) 18.2.
- **Amivantamab-vmjw (Rybrevant®)** was added to formulary, non-stock, restricted to outpatient use. Amivantamab is indicated in combination therapy for the treatment of adults with locally advanced or metastatic NSCLC with specific EGFR mutations.

*****Attention Providers*****
Reading the PharmFacts Bulletin can be used to earn CME! Just complete the CME quiz on the last page of the issue, submit the quiz as directed, and score a passing grade to earn CME.

Spotlight: Anticipating New Indications for Guselkumab

Internal Medicine: Anticipating New Indications for Guselkumab

Marcella Babatunde, PharmD Candidate 2025; Natalie Delozier, PharmD

Guselkumab (Tremfya®) is a human monoclonal antibody approved for moderate-to-severe plaque psoriasis, active psoriatic arthritis, and moderate-to-severe ulcerative colitis.[2] Guselkumab works by selectively binding to interleukin 23 (IL-23) which inhibits IL-23 from binding to the IL-23 receptor. Ultimately, this inhibits the release of proinflammatory cytokines.[4] Two studies estimated to be completed in 2025 could lead to new indications: Low Body Surface Area (BSA) Moderate Plaque Psoriasis (PsO) and Moderately to Severely Active Crohn's Disease (CD).[1]

In 2017, guselkumab was approved for moderate-to-severe plaque psoriasis from the VOYAGE II trial which demonstrated superior efficacy and comparable adverse effect rates to placebo and adalimumab (Humira®).[5] These findings established guselkumab as an alternative for psoriasis management. In 2020, guselkumab gained FDA approval for active psoriatic arthritis from the DISCOVER I trial.[2,6] Guselkumab significantly improved signs and symptoms of psoriatic arthritis compared to placebo and had adverse events consistent with other IL-23 inhibitors.[6] Most recently in 2024, guselkumab was approved for moderate-to-severe ulcerative colitis from the QUASAR Phase 2b Induction Study.[2,7] The objective was to evaluate the efficacy and safety of guselkumab in patients with moderate to severe active ulcerative colitis with prior inadequate response to immunosuppressants, corticosteroids or advanced therapy.[7] Guselkumab demonstrated significantly higher rates of clinical response, clinical remission, and endoscopic improvement compared to placebo. [7]

The Phase 3b SPECTREM study, estimated to be completed in April 2025, is analyzing guselkumab versus placebo in adults with low body surface area (BSA) moderate PsO with special site involvement who failed topical treatment.[1] Low BSA is defined as < 5% of the body – face, scalp, or genitals.[1] The GRAVITI phase 3 study evaluating guselkumab subcutaneous induction therapy in patients with moderate to severe Crohn's Disease (CD) who experienced an inadequate response or failed to tolerate conventional therapy released results in February 2025. Guselkumab resulted in significant clinical remission and endoscopic response at 48 weeks.[1] An application for the treatment of moderately to severely active CD is currently under FDA review.

With several approved indications and two on the horizon, it is important to distinguish the dosing schedules for each approved indication (Table 1). Patients and providers should monitor for side effects such as respiratory infections, headache, arthralgia, diarrhea, bronchitis, and injection site reactions.[3,4] Providers should also check complete blood counts and liver function tests every 3-6 months.[3,4] Prior to initiation, patients should be tested for tuberculosis.[3,4] Guselkumab is not on hospital formulary since it is intended to be given in the office setting or at home by patient self-administration. The cost of a prefilled syringe can be up to $17,000.[3]

Table 1 – *Summary of Guselkumab Dosing Schedules for FDA Approved Indications*

Indication	Dosing
Moderate-to-Severe Plaque Psoriasis	SC: 100 mg at weeks 0, 4, and then every 8 weeks thereafter
Active Psoriatic Arthritis	SC: 100 mg at weeks 0, 4, and then every 8 weeks thereafter
Moderate-to-Severe Ulcerative Colitis	Induction IV: 200 mg on weeks 0, 4, and 8 Maintenance SC: 100 mg every 8 weeks beginning at week 16 or 200 mg every 4 weeks beginning at week 12

References: 1. Halpern L, ed. New guselkumab data indicate robust effectiveness in crohn disease, plaque psoriasis. Pharmacy Times. November 4, 2024. 2. Johnson & Johnson. TREMFYA® (guselkumab) receives U.S. FDA approval for adults with moderately to severely active ulcerative colitis, strengthening Johnson & Johnson's leadership in inflammatory bowel disease. Published October 20, 2023. 3. Guselkumab. In: Lexi-Drugs. Lexidrug, Inc. Updated November 20, 2024. 4. TREMFYA. Package insert. Janssen Pharmaceuticals Inc; 2024 5. Reich K, Armstrong AW, Foley P, et al. Efficacy and safety of guselkumab, an anti-interleukin-23 monoclonal antibody, compared with adalimumab for the treatment of patients with moderate to severe psoriasis with randomized withdrawal and retreatment: Results from the phase III, double-blind, placebo- and active comparator-controlled VOYAGE 2 trial. *J Am Acad Dermatol*. 2017;76(3):418-431. doi:10.1016/j.jaad.2016.11.042 7. Deodhar A, Helliwell PS, Boehncke WH, et al. Guselkumab in patients with active psoriatic arthritis who were biologic-naive or had previously received TNFα inhibitor treatment (DISCOVER-1): a double-blind, randomised, placebo-controlled phase 3 trial [published correction appears in Lancet. 2020 Apr 4;395(10230):1114. doi: 10.1016/S0140 8. Peyrin-Biroulet L, Allegretti JR, Rubin DT, et al. Guselkumab in Patients With Moderately to Severely Active Ulcerative Colitis: QUASAR Phase 2b Induction Study. *Gastroenterology*. 2023;165(6):1443-1457. doi:10.1053/j.gastro.2023.08.038

POP QUIZ

What are the new indications for guselkumab that may be approved in the coming months? Select all that apply.

A. Moderate to severe Ulcerative Colitis
B. Moderate to severe active Crohn's Disease
C. Active Psoriatic Arthritis
D. Low BSA Moderate Plaque Psoriasis

Answer: B and D

CME

Cardiology: The Next Generation of Anticoagulation: Factor XIa Inhibitors

Madeline Jager, PharmD, MBA, PGY2 Cardiology Pharmacy Resident

Oral anticoagulation has been a mainstay of therapy for the treatment and/or prevention of thrombus formation since the 1950s with the use of vitamin K antagonists (VKAs). Decades later, two classes of direct oral anticoagulants (DOACs) were found to be either superior or noninferior to VKAs while showing a significantly lower risk of intracranial hemorrhage. The newest anticoagulants undergoing clinical trials target factor XI, located further upstream in the coagulation cascade compared to factor Xa and thrombin.[1] Factor XI is essential in thrombus formation but plays a minimal role in hemostasis.[1] Therefore, targeting factor XI could potentially decrease thrombus formation without significantly impacting bleeding.[1]

Table 1 – *Summary of factor XI/XIa inhibitors undergoing clinical trials.*[1]

Medication	Route	Frequency	Mechanism
Milvexian	Oral	Once or twice daily	Small molecule factor XIa inhibitor
Asundexian	Oral	Once daily	Small molecule factor XIa inhibitor
Osocimab	Intravenous	One time dose in post-operative setting	Monoclonal antibody factor XIa inhibitor
Abelacimab	Subcutaneous	Monthly	Monoclonal antibody factor XI and factor XIa inhibitor

Factor XI/XIa inhibitors were evaluated in phase 2 studies for venous thromboembolism (VTE) prophylaxis after total knee arthroplasty, atrial fibrillation (AF), and after myocardial infarction and stroke, finding similar or reduced rates of bleeding versus active comparator or placebo.[1] These results should be interpreted cautiously since most studies were not powered for efficacy in preventing thrombotic events. A few trials in the post-operative VTE prophylaxis space found these agents to be either noninferior or superior to enoxaparin.[1] However, The OCEANIC-AF trial, comparing asundexian to apixaban in patients with AF, found higher incidence of stroke/ embolism in the asundexian group, which led to termination of the study.[2]

The LILAC-TIMI 76 trial is an ongoing phase 3 trial assessing both safety and efficacy of abelacimab compared to placebo in patients with AF who are unsuitable for oral anticoagulation.[3] This trial, expected to be completed in 2026, may hold the key to a common clinical dilemma in patients who have both high thrombotic risk and bleed risk. Though more data is needed to evaluate safety and efficacy, factor XI/XIa inhibitors offer a novel mechanism to prevent thrombus formation while limiting bleeding complications.

References: 1. Harrington, J, Piccini, J, Alexander, J. et al. Clinical Evaluation of Factor XIa Inhibitor Drugs: *JACC* Review Topic of the Week. *JACC.* 2023 Feb, 81 (8) 771–779. 2. Piccini JP, Patel MR, Steffel J, et al. Asundexian versus apixaban in patients with atrial fibrillation. *N Engl J Med* 2025;392:23-32. 3. Study to evaLuate the efficacy and Safety of abeLacimab in High-risk Patients With Atrial Fibrillation Who Have Been Deemed Unsuitable for Oral antiCoagulation. ClinicalTrials.gov identifier: NCT05712200.

POP QUIZ

What was the main finding from the OCEANIC-HF Trial?

A. In patients with AF, asundexian resulted in lower incidence of stroke and systemic embolism compared to apixaban.
B. In patients with AF, asundexian resulted in higher incidence of stroke and systemic embolism which led to early termination of the study.
C. In patients needing VTE prophylaxis after TKA, asundexian resulted in reduced rates of bleeding versus active comparator.
D. The OCEANIC-HF trial is still ongoing and studying the safety and efficacy of abelacimab compared to placebo in patients with AF who are unsuitable for anticoagulation.

Answer: B

Congratulations to the Pharmacy Residency Matches for 2025-2026

PGY1s

Anna Madding (Butler University)
Grace Paustian (University of Cincinnati)
Brittany Vu (University of Cincinnati)
Ryan Rhodes (University of Kentucky)

PGY2s

Internal Medicine: Shannon Saelinger (University of Cincinnati, TCH PGY1)
Cardiology: Xinyue (Ariel) Zhang (Ohio Northern University, Miami Valley PGY1)
Ambulatory Care: Abbey Bush (Ohio State University, St. Vincent de Paul PGY1)

CME

Ambulatory Care: Semaglutide in Chronic Kidney Disease for Patients with Type 2 Diabetes

Josh Willoughby, PharmD, BCACP

Semaglutide (Ozempic©) is a glucagon-like peptide-1 receptor agonist (GLP-1 RA) approved for type 2 diabetes (T2DM) to improve glycemic control and reduce major cardiovascular events in adults with cardiovascular disease.[1] On January 28th 2025, the FDA announced a new indication for semaglutide: adults with T2DM and chronic kidney disease (CKD) to reduce estimated glomerular filtration rate (eGFR) decline, end-stage kidney disease (ESKD), and cardiovascular death.[2]

CKD is a common complication of uncontrolled diabetes affecting approximately 40% of patients with T2DM and 37 million adults in the United States.[3] Unfortunately, with the aging population and increased prevalence of diabetes, prevalence of CKD is anticipated to grow. CKD increased the risk for cardiovascular events, kidney failure, and death in patients with diabetes.[4] Current guideline-recommended treatments for CKD in T2DM include renin-angiotensin system (RAS) inhibitors, sodium-glucose cotransporter 2 (SGLT2) inhibitors, and finerenone.[5,6] However, since these guidelines were published, GLP-1 RAs have been studied as an additional option for treatment of CKD in patients with diabetes.

The 2024 FLOW trial demonstrated semaglutide's superiority over placebo when added to standard of care.[7] The primary composite outcome combined the onset of kidney failure (dialysis, transplantation, or an eGFR of <15 ml/minute/1.73 m^2), ≥50% reduction in eGFR from baseline, or death from kidney-related or cardiovascular causes.[7] Semaglutide was shown to reduce the incidence of the primary composite outcome with a 24% relative risk reduction of worsening kidney disease, end-stage kidney disease, and death due to cardiovascular disease (HR, 0.76; 95% CI, 0.66 to 0.88; P=0.0003).[7] Additionally, a 4.9% absolute risk reduction was reported after 3 years of treatment.[7] Results for the renal-specific components of the primary composite outcome proved to be comparable (HR, 0.79; 95% CI, 0.66 to 0.94).[7] Furthermore, at 2 years, the urinary albumin-to-creatinine ratio was reduced by 12% in the placebo group, compared to 40% in the semaglutide group.[7]

Patients with T2DM and CKD may benefit from a GLP1-RA in reducing the risk for renal, cardiovascular, and diabetic complications. Given the availability of multiple evidenced-based treatment options, clinicians will be tasked with choosing the order and priority of use of semaglutide versus alternative therapies, which will be better clarified with future guideline updates. Current evidence supports semaglutide as a preferred treatment option in this high-risk patient population.

References: 1. Ozempic® (semaglutide) injection [package insert]. Plainsboro, NJ: Novo Nordisk Inc; 2024. 2. Novo Nordisk. FDA approves Ozempic® (semaglutide) as the only GLP-1 RA to reduce the risk of worsening kidney disease and cardiovascular death in adults with type 2 diabetes and chronic kidney disease [press release]. 3. Feng X (Snow), Farej R, Dean BB, et al. CKD prevalence among patients with and without type 2 diabetes: regional differences in the United States. *Kidney Med*. 2022;4(1):100385.doi:10.1016/j.xkme.2021.09.003. 4. GBD Chronic Kidney Disease Collaboration. Global, regional, and national burden of chronic kidney disease, 1990- 2017: a systematic analysis for the Global Burden of Disease Study 2017. *Lancet.* 2020;395(10225):709-733.doi:10.1016/S0140-6736(20)30045-3. 5. de Boer IH, Khunti K, Sadusky T, et al. Diabetes management in chronic kidney disease: a consensus report by the American Diabetes Association (ADA) and Kidney Disease: Improving Global Outcomes (KDIGO). *Diabetes Care.* 2022;45(12):3075-3090.doi:10.2337/dci22-0027. 6. Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. KDIGO 2024 clinical practice guideline for the evaluation and management of chronic kidney disease. *Kidney Int.* 2024;105(4)Suppl S117-S314.doi.10.1016/j.kint.2023.10.018. 7. Perkovic V, Tuttle KR, Rossing P, et al. Effects of semaglutide on chronic kidney disease in patients with type 2 diabetes. *N Engl J Med*. 2024;391(2):109-121.doi:10.1056/nejmoa2403347.

Oncology: Old(er) Drugs, New REMS Requirements

Shelby Moore, PharmD, BCOP

Ravulizumab-cwvz (Ultomiris) and eculizumab (Soliris) are complement inhibitors indicated for the treatment of paroxysmal nocturnal hemoglobinuria (PNH), atypical hemolytic uremic syndrome (aHUS), generalized myasthenia gravis (gMG), and neuromyelitis optica spectrum disorder (NMOSD).[1,2] At The Christ Hospital, Ravulizumab-cwvz is restricted to outpatient use pending insurance approval. Eculizumab is restricted to outpatient use pending insurance verification, while inpatient use is reviewed on a case-by-case basis.

Because these medications block terminal complement activation, there is increased risk of infections, especially those caused by encapsulated bacteria such as *Streptococcus pneumoniae, Escherichia coli,* and *Neisseria meningitidis*. Due to the risk of meningococcal infections, ravulizumab-cwvz and eculizumab require healthcare settings, providers, and pharmacies to be enrolled in the ULTOMIRIS and SOLIRIS Risk Evaluation and Mitigation Strategy (REMS) program.[3] The aim of the REMS program is to ensure that patients are vaccinated against *Neisseria meningitidis* serogroups A, C, W, Y, and B. The REMS program requires prescribers to counsel patients about the risk of meningococcal infections and assess patients' vaccination status. Patients should be vaccinated at least 2 weeks prior to starting treatment. If urgent treatment is required for unvaccinated patients, patients should be vaccinated as soon as possible and receive prophylaxis with penicillin (or a macrolide if penicillin allergic) for 2 weeks after vaccination.

The Advisory Committee on Immunization Practices (ACIP) recommends serogroups A, C, W, and Y meningococcal conjugate vaccines and serogroup B meningococcal vaccines.[4] For MenACWY, patients should receive a primary vaccination with 1 dose followed by a booster dose every 5 years. For serogroup B vaccines, patients should receive a primary vaccination with 2 doses (MenB-4C) or 3 doses (MenB-FHbp) followed by a booster dose 1 year after completion of primary vaccination and every 2-3 years thereafter. As of September 2024, healthcare settings and pharmacies are required to confirm prescriber certification and patient compliance with vaccinations.

References: 1. Ultomiris (ravulizumab) [prescribing information]. Boston, MA: Alexion Pharmaceuticals Inc; June 2024. 2. Soliris (eculizumab) [prescribing information]. Boston, MA: Alexion Pharmaceuticals Inc; September 2024. 3. ULTOMIRIS and SOLIRIS Risk Evaluation and Mitigation Strategy (REMS). Accessed February 20, 2025. https://ultsolrems.com/#Main. 4. Mbaeyi SA et al. Meningococcal Vaccination: Recommendations of the Advisory Committee on Immunization Practices, United States, 2020. *MMWR*. 2020; 69(9):1–41.

CME

Not all Fiber is Created Equal

Kate Martin, PharmD, Certified Pain Educator

While the benefits of dietary fiber from fruits, vegetables, legumes, and whole grains have been clearly demonstrated, it may be challenging to meet the recommended 25 grams per day of fiber from diet alone. Fiber supplements are often used to fill the gap, but patients are often left to figure out on their own which supplement to choose. Since health benefits of various fiber supplements are dependent on the type (Table 1), recommendations to patients should be specific.[1]

Fortunately, it's not necessary to memorize the benefits of every marketed fiber supplement. In almost all cases, psyllium is the clear winner, having the preponderance of positive data. For constipation, psyllium is specifically recommended over other fiber supplements by the American Gastroenterological Association-American College of Gastroenterology guidelines for chronic idiopathic constipation.[2] *(It is worth noting, however, that AGA does not recommend any fiber for opioid induced or other slow transit constipation[2,3])* Additionally, a non-fermented fiber, psyllium is not broken down by gut bacteria and is therefore less likely to produce gas and bloating.

The drawback to psyllium is the same property that makes it efficacious… it forms a gel. This can make it unpalatable to some patients. Fortunately, in addition to flavored powder to be mixed with water and a plain powder suitable for adding to food, psyllium is available as a capsule and wafer. Alert patients to avoid fiber gummies or powders that claim to be "clear" as these products won't contain psyllium, even if they are made by the same manufacturer. Psyllium (and all gel forming fibers) should be avoided in patients with difficulty swallowing. *Remember, avoid saying "fiber" if what you really mean is psyllium!*

Table 1 – *Summary of Properties of Different Types of Fiber - adapted from McRorie, 2015*

	Insoluble	Soluble, nonviscous		Soluble, viscous	Soluble, viscous, gel forming		
	Wheat bran	**Wheat dextran**	**Inulin**	**Methylcellulose**	**Guar gum**	**Oats/ barley**	**Psyllium**
Fermentation	Minimal	Yes	Yes	None	Yes	Yes	None
Cholesterol lowering					+/-[a]	+[b]	+
Glycemic control					+/-[a]	+[b]	+
Satiety						+[b]	+
Constipation	+[c]			+/-[d]			+
Diarrhea					+[e]		+
IBS							+

Blank cells indicate negative clinical data or lack of clinical data. "+" indicates at least 2 well controlled trials

[a] dependent on degree of hydrolysis: if little/no viscosity when mixed (i.e., "clear" fiber supplements), may not exhibit health benefits

[b] Only if minimally processed

[c] Must be coarse; finely ground bran is ineffective

[d] approved indication but AGA determined insufficient evidence

[e] benefit shown for tube feeding associated diarrhea

References: 1. McRorie J. W., Jr (2015). Evidence-Based Approach to Fiber Supplements and Clinically Meaningful Health Benefits, Part 2: What to Look for and How to Recommend an Effective Fiber Therapy. *Nutrition today*, *50*(2), 90–97. https://doi.org/10.1097/NT.0000000000000089 2. Crockett, S. D., Greer, K. B., Heidelbaugh, J. J., Falck-Ytter, Y., Hanson, B. J., Sultan, S., & American Gastroenterological Association Institute Clinical Guidelines Committee (2019). American Gastroenterological Association Institute Guideline on the Medical Management of Opioid-Induced Constipation. *Gastroenterology*, *156*(1), 218–226. https://doi.org/10.1053/j.gastro.2018.07.016 3. Chang, L., Chey, W. D., Imdad, A., Almario, C. V., Bharucha, A. E., Diem, S., Greer, K. B., Hanson, B., Harris, L. A., Ko, C., Murad, M. H., Patel, A., Shah, E. D., Lembo, A. J., & Sultan, S. (2023). American Gastroenterological Association-American College of Gastroenterology Clinical Practice Guideline: Pharmacological Management of Chronic Idiopathic Constipation. *Gastroenterology*, *164*(7), 1086–1106. https://doi.org/10.1053/j.gastro.2023.03.214

POP QUIZ

Which of the following is true of psyllium? Select all that apply.

A. It is broken down by gut bacteria so causes more gas and bloating than other forms of fiber
B. It forms a gel, so should be avoided in patients with swallowing difficulties
C. It is the recommended form of fiber by the AGA for chronic idiopathic constipation
D. Psyllium is the same as wheat bran. They are all "fiber"!

Answer: B and C

CME

Name (Required): Date:

Email:

Submit quiz to Alissa Lee by email (Alissa.Lee@thechristhospital.com) or fax (513-585-3438). Receipt of completed quiz will be confirmed by email. To receive CME credit, one must score at least 80%. Submissions are due by April 30, 2026. If a participant received a score below the minimum requirement, he/she will be contacted and asked to resubmit. Two attempts are the maximum each participant is allowed. Each question is worth 1 point and the quiz is worth a total of 10 points.

1. What are the new indications for guselkumab that may be approved in the coming months? Select all that apply.
   a. Moderate to severe Ulcerative Colitis
   b. Moderate to severe active Crohn's Disease
   c. Active Psoriatic Arthritis
   d. Low BSA Moderate Plaque Psoriasis

2. What was the main finding from the OCEANIC-HF Trial?
   a. In patients with AF, asundexian resulted in lower incidence of stroke and systemic embolism compared to apixaban.
   b. In patients with AF, asundexian resulted in higher incidence of stroke and systemic embolism which led to early termination of the study.
   c. In patients needing VTE prophylaxis after TKA, asundexian resulted in reduced rates of bleeding versus active comparator.
   d. The OCEANIC-HF trial is still ongoing and studying the safety and efficacy of abelacimab compared to placebo in patients with AF who are unsuitable for anticoagulation.

3. Which of the following is true of psyllium? Select all that apply.
   a. It is broken down by gut bacteria so causes more gas and bloating than other forms of fiber
   b. It forms a gel, so should be avoided in patients with swallowing difficulties
   c. It is the recommended form of fiber by the AGA for chronic idiopathic constipation
   d. Psyllium is the same as wheat bran. They are all "fiber"!

4. Which study evaluating guselkumab subcutaneous induction therapy in patients with moderate to severe Crohn's Disease (CD)?
   a. GRAVITI phase 3
   b. Phase 3b SPECTREM
   c. DISCOVER I
   d. VOYAGE II

5. What is true about the dosing regimens for asundexian and apixaban?
   a. They are both dosed twice daily
   b. Asundexian is a monthly injection, and apixaban is dosed twice daily
   c. Asundexian is dosed once daily, whereas apixaban is dosed twice daily
   d. Asundexian is dosed three times daily, whereas apixaban is dosed twice daily

6. Which of the following is NOT an FDA approved indication for Semaglutide?
   a. Adults with T2DM and chronic kidney disease (CKD) to reduce estimated glomerular filtration rate (eGFR) decline, end-stage kidney disease (ESKD), and cardiovascular death
   b. Adults with T2DM to improve glycemic control
   c. Adults with cardiovascular disease to reduce major cardiovascular events
   d. Adults with non-alcoholic steatohepatitis

7. What is the main conclusion from the 2024 FLOW Trial?
   a. Demonstrated semaglutide's superiority over placebo when added to standard of care for patients with CKD
   b. Demonstrated no difference in Semaglutide vs dulaglutide when added to standard of care for patients with CKD
   c. Demonstrated no difference with Semaglutide vs standard of care in patients with CKD
   d. Demonstrated no difference with dulaglutide vs standard of care in patients with CKD

8. Why do ravulizumab-cwvz (Ultomiris) and eculizumab (Soliris) require REMS programs?
   a. Risk of serious thromboembolic events
   b. Risk of neutropenia
   c. Risk of teratogenicity with pregnancy
   d. Risk of meningococcal infections

9. What is the mechanism of action of Abelacimab?
   a. Small molecule factor XIa inhibitor
   b. Small molecule factor Xa inhibitor
   c. Monoclonal antibody factor XI and factor XIa inhibitor
   d. Monoclonal antibody XIa inhibitor only

10. How does the dosing of guselkumab for Moderate-to-Severe Ulcerative Colitis differ from the dosing for Moderate-to-Severe Plaque Psoriasis and Active Psoriatic Arthritis?
    a. Dosing for UC requires an initial induction phase, followed by a maintenance phase
    b. There is no difference in the dosing schedules for these indications
    c. Dosing for UC is weekly
    d. Dosing for UC is IV only

Date originated: April 30, 2025 **CME credit designation expiration: April 30, 2026**

Disclosure Information: The authors, planners, and CME Committee members have indicated no significant financial interest or arrangements with any organization that could be perceived as a real or apparent conflict of interest in the context of this activity's subject matter. There is no commercial support or sponsorship for this activity.

Objectives: At the conclusion of this educational activity, participants should be able to: (1) Explain changes to the formulary, (2) Implement guidelines and best practices relating to the usage of the drugs and topics discussed, and (3) Assist with carrying out of Antimicrobial Stewardship efforts and other Network initiatives.

Accreditation & Credit Designation: The Christ Hospital Health Network is accredited by the Ohio State Medical Association to provide continuing medical education for physicians. The Christ Hospital Health Network designates the enduring-material CME activity for a maximum of 1.0 AMA PRA Category 1 Credit™.

In order to obtain the above credits, physicians and/or allied health members must complete the following steps:

1. Read the April 2025 PharmFacts Bulletin. The estimated time to complete this activity is 1 hour.
2. Score at least 80% on the post quiz. If a participant receives a score below the minimum requirement, he/she will be contacted and asked to resubmit. Two attempts is the maximum amount each participant is allowed.