MSHP Massachusetts Society of Health-System Pharmacists

NEWSBRIEFS

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Massachusetts Society of Health – System Pharmacists

Massachusetts Society of Health System Pharmacists (MSHP)

From MSHP President Paul Baker:



For those I haven't yet had the chance to meet, my name is Paul, and it is a privilege to serve as President of MSHP. Volunteering with this organization has provided me with truly wonderful opportunities—connecting with colleagues across the state, collaborating on our Annual Meeting, and working alongside dedicated professionals who care deeply about advancing pharmacy practice. These experiences have strengthened my commitment to MSHP and deepened my appreciation for the incredible work our members do every day.

To those of you who have volunteered to take part in a committee, thank you. Your work as volunteers is what drives this Society forward. MSHP thrives because of your energy, your ideas, and your willingness to give your time to support our mission.

I'm also excited to share how much I'm looking forward to working with newly elected President-Elect Jigar Mehta, Secretary Emily Messing, and re elected Board Member Lindsay Arnold, along with the rest of our dedicated Board. Their leadership, passion, and commitment to MSHP will help guide our Society through the year ahead, and I'm energized by the work we will accomplish together.

As summer draws to a close, I find myself reflecting on both the accomplishments of the past few months and the opportunities that lie ahead for the MSHP. The changing of seasons often brings a sense of transition. While many of us are savoring the final days of summer, we are also preparing for a busy and important period for our profession. Across the Commonwealth, pharmacists, technicians, residents, students, and pharmacy leaders continue to push onward in these uncertain headwinds, advancing patient care, innovating pharmacy practice, and demonstrating the value of our profession every day.

The months ahead will undoubtedly present both opportunities and challenges. Among the most significant areas of uncertainty is the future of the 340B Drug Pricing Program. As discussions and policy changes continue to evolve, the impact on patient access, healthcare systems, and the communities we serve remains a critical concern. MSHP will continue to advocate for policies that support access to care and ensure that pharmacists have a strong voice in shaping the future of healthcare in Massachusetts and beyond.

At the same time, we have much to celebrate. I am especially looking forward to this year's Webb Lecture, where the 2026 recipient, David Chen, will speak. David's longstanding contributions to pharmacy practice, leadership, and professional advancement have inspired countless pharmacists across the country. His insights and vision for the future of our profession promise to make this year's event both memorable and motivating.

We are also excited to share that MSHP has remodeled our website to make it more modern, accessible, and member-focused. This refreshed platform will serve as a central hub for education, advocacy, resources, and community engagement. To make it truly valuable, we need your

QUICK LINKS

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President's Message *Continued*

input. Your ideas, your needs, and your experiences should shape the content and tools we provide. Like our Society, the website needs volunteers like you to engage. For those of you involved with our committees, we'll be asking you to share feedback on what you want to see—whether it's updated practice resources, policy updates, professional development opportunities, or ways to highlight member achievements. Your voice will help us build a website that reflects and supports our entire MSHP community.

As we move into the fall, I encourage each of you to stay engaged with MSHP. Whether through education, advocacy, networking, mentorship, or volunteer service, every member plays a role in strengthening our profession and advancing patient care.

Thank you for your continued commitment to MSHP and to the patients and communities we serve. Together, we will continue building a stronger future for health system pharmacy.

Paul Baker
President
Massachusetts Society of
Health-System Pharmacists

Delegates from Massachusetts at ASHP Futures Meeting June 2026



Delegates: Neil Gilchrist, Jason Lancaster, Erica Housman, Russel Roberts

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Installation of MSHP Officers April 2026

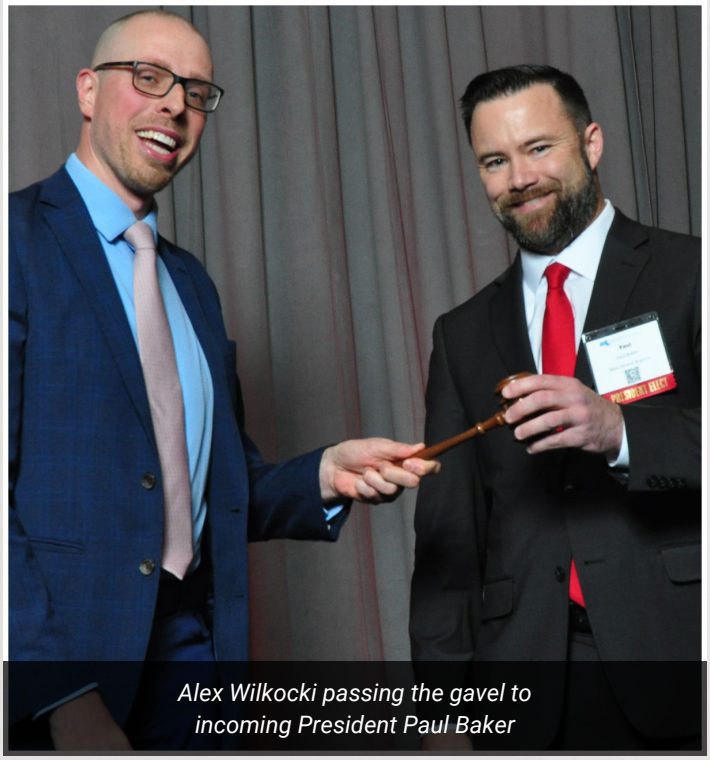
(PHOTOS BY STEVE ALFANO)



Immediate Past President Erin Taylor and Outgoing President Alex Wilkocki



Alex Wilkocki, Incoming Secretary Emily Messing, Incoming President-Elect Jigar Mehta (not pictured-Incoming Director Lindsay Arnold)



Alex Wilkocki passing the gavel to incoming President Paul Baker



Incoming President Paul Baker

Residents and Fellows Welcome Event 2026

On Thursday, August 13th, the MSHP Residency Program Committee hosted its annual Residents and Fellows Welcome Event at Night Shift Brewing at Lovejoy Wharf. Attendees included approximately 140 pharmacy residents, fellows, preceptors, and residency program directors that represented institutions from across the state of Massachusetts. Highlights of the night included lively networking, a variety of delicious appetizers, and Night Shift Brewing drinks. The evening started off with a warm welcome by our current MSHP president, Dr. Paul Baker, on behalf of MSHP Leadership and Dr. Dawn Pluckrose, Chair of the Residency Program Committee. The event was an excellent opportunity for the new residents and fellows to get know colleagues from other programs as well as learn about the vast resources and opportunities available to MSHP members. We are grateful for the state – wide participation at this successful event, and we are already looking forward to future opportunities to connect throughout the year!













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Residents and Fellows Welcome Event 2026 *Continued*

















MSHP Legislative Update

PHARMACY PRIORITIES AFTER JULY 31, 2026

The Massachusetts Legislature concluded its regularly scheduled formal sessions on July 31, but several priorities being monitored by MSHP may still have a path forward during the remainder of the legislative session.

MSHP has been following four significant pharmacy policy areas:

- **H.785, An Act protecting 340B contract pharmacies**, would address manufacturer and distributor restrictions affecting access to 340B drugs through contract pharmacies. The bill received a favorable report before being referred to Health Care Financing. Its most recent reporting deadline was July 31. The Legislature currently shows no subsequent action.
- **H.4494, An Act prohibiting PBMs from discriminating against hospitals and patients participating in the 340B drug discount program**, would prohibit discriminatory reimbursement, fees, network restrictions, claim requirements and patient steering involving 340B covered entities. It also received a favorable report and was referred to Health Care Financing, with its most recent reporting deadline extended through July 31.

  Importantly, the substance of H.4494 was offered during House consideration of S.3141 as Amendment 68. That amendment specifically proposed adding the 340B PBM discrimination protections to the broader health care legislation.
- **H.1313, relating to patient choice in dispensing of clinician administered drugs**, has a different and more favorable procedural posture. H.1313 was redrafted as H.4956. H.4956 received a favorable report from Financial Services, was referred to Health Care Financing, and its reporting deadline was extended to December 31, 2026. The proposal would protect patient and provider choice for clinician administered drugs and restrict health plans from requiring use of a particular specialty pharmacy or steering patients away from their provider or pharmacy of choice.

  The H.4956 language was also offered during House consideration of S.3141 as Amendment 21, demonstrating that lawmakers considered adding this patient choice policy directly to the broader health care legislation now in conference.
- **H.4332, An Act relative to pharmacists as healthcare providers**, would permit pharmacists to test, screen and initiate treatment for specified health conditions. The bill received a favorable report from Financial Services and remains before Health Care Financing. Its most recent reporting deadline was extended through July 31, and the Legislature currently shows no subsequent action.

ANALYSIS & NEXT STEPS

July 31 did not produce the same outcomes for all four MSHP priorities.

The strongest standalone opportunity is currently H.4956, the successor to H.1313. Its Health Care Financing deadline has been extended through December 31, meaning the Legislature has expressly preserved additional time to consider the bill. MSHP will continue treating this as active legislation and will continue to closely follow.

Both the patient choice provisions now contained in H.4956 and the 340B PBM protections in H.4494 were offered as amendments to a separate Senate bill (S.3141 – An Act relative to primary care for you) during the House process. Although neither amendment ultimately appears in H.5630, their introduction demonstrates a clear effort to connect these pharmacy issues to the broader health care affordability debate.

That does not automatically place either issue before the Senate and House conference committee. We should therefore avoid viewing these provisions as part of the formal House and Senate disagreement. The better advocacy argument is that lawmakers have already identified these policies as relevant to the broader health care legislation, and MSHP will continue pressing leadership and conferees to address them wherever procedurally possible.

H.4494 presents the strongest 340B conference argument because it addresses PBM conduct, reimbursement, networks and patient steering, issues closely related to the PBM oversight already contained within the House health care proposal.

H.785 remains a more difficult conference fit because its primary focus is manufacturer and distributor restrictions involving 340B contract pharmacies. MSHP should continue advocating for the bill, while recognizing that it may require a separate legislative path.

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MSHP Legislative Update *Continued*

H.4332 should remain part of the broader access to care discussion. Expanding pharmacists' ability to test and treat aligns with the Legislature's focus on primary care capacity and access, even though the proposal is not currently contained in the conference legislation.

The July 31 deadline narrowed some pathways, but it did not end our legislative agenda. We will continue pursuing H.4956 directly, advocate for the H.4494 protections through the ongoing PBM and health care affordability discussion, continue seeking a viable path for H.785, and keep H.4332 positioned as part of the Commonwealth's broader effort to expand access to care.

Technician Spotlight: Tyler Darcy, MBA, CPhT-Adv



Tyler Darcy, MBA, CPhT-Adv, is Manager, Pharmacy Technician Training and Education at Mass General Brigham. He has a BS degree in Applied Social Sciences from New England College and an MBA in Healthcare Administration from Western Governors University.

Tyler is a pharmacy technician who is committed to investing in and developing fellow technicians. For the longest time, he wanted to be a high school teacher. Tyler originally enrolled in the Secondary Education program at Rhode Island College while working part-time as a pharmacy technician at CVS, a position he took because it paid slightly more than his previous grocery store job. That all changed when Tyler received a job offer from Omnicell and had to choose between pursuing the path he was currently on or seeing where pharmacy would lead him. Ultimately, he has landed at a place in his career where he is able to combine his pharmacy skills with his passion for education and he could not be happier.

In his current role as the Manager of Pharmacy Technician Training and Education, Tyler oversees training and education for Pharmacy Technicians across the Massachusetts General Brigham system. On the education side, his work includes managing technician trainee programs, developing partnerships with external technician education programs, and leading internal efforts to support pharmacy technicians in pursuing national and advanced certifications.

Some of the greatest impacts on his career have come through mentorship from incredible pharmacy professionals. Tyler often speaks about the importance of “professionalizing” the technician workforce, and in his experience, one of the most powerful ways to accomplish is through mentorship. Tyler strives to provide that same mentorship he received to the technicians he works with and encourage other pharmacy leaders to serve as role models and mentors to their technician teams. He believes there is tremendous potential within the technician workforce, and with the right support, guidance, and opportunities, that potential can be unlocked.

Tyler has been heavily involved with ASHP and recently served as the chair for the ASHP Pharmacy Technician Executive Committee. At the 2025 MSHP Annual Meeting, he presented a CE titled “Health System and Community Partnership Technician Training Programs” with fellow technician Brian Gavin. MSHP is excited to welcome Tyler as the chair for the MSHP Pharmacy Technician Committee this year and is lucky to have his passion and expertise brought to the team.

Practice Developments

Editor: Jonathan Zand, PharmD BCPS

Contributors: Katherine Lee, PharmD BCPS, and MaryRose Maiullari, PharmD BCPS

The views expressed are those of the contributing authors and cited sources and do not necessarily reflect the official positions, policies, or statements of MSHP or ASHP.

RECENT GUIDELINES

Beta-Lactam Dose Individualization (ACCP, IDSA, others)

"One size fits all" beta-lactam dosing often results in highly variable drug exposures in acutely ill patients. This multi-society guideline recommends dose individualization, using proactive Model-Informed Personalized Dosing (MIPD) over traditional reactive therapeutic drug monitoring (TDM) to increase the likelihood of achieving effective exposures and clinical cure in acutely and critically ill hospitalized patients, including those with augmented renal clearance, those receiving kidney replacement therapy, and ECMO.

Source: Barreto EF, McCreary EK, Mangalore RP, et al. Consensus guidance for beta-lactam antibiotic dose individualization in acutely ill patients: endorsed by the American College of Clinical Pharmacy, European Society of Clinical Microbiology and Infectious Diseases, European Society of Clinical Microbiology and Infectious Diseases PK/PD of Anti-Infectives Study Group, Infectious Diseases Society of America, International Association of Therapeutic Drug Monitoring and Clinical Toxicology, Society of Critical Care Medicine, and the Society of Infectious Diseases Pharmacists. Pharmacotherapy. 2026;46(8):e70181 PMID 42487243

Drug Excipient Hypersensitivity (EAACI)

Some drug hypersensitivity reactions are caused not by the active drug, but by inactive ingredients. Clinicians should suspect an excipient allergy when patients react to multiple unrelated medications or certain formulations, as failure to recognize the excipient can lead to recurrent reactions, including anaphylaxis. Common culprit excipients include polyethylene glycol (PEG), gelatin, povidone, mannitol, and methylcellulose.

Source: Garvey LH, Brockow K, Barbaud A, et al. Hypersensitivity to Excipients in Drugs: a European Academy of Allergy and Clinical Immunology (EAACI) Position Paper. Allergy. 2026;81(7):2250-2275 PMID 41952048

Dyslipidemia (ACC/AHA)

The 2026 ACC/AHA multisociety guidelines provide updated recommendations to emphasize earlier, more intensive lipid-lowering strategies. After moving toward percentage-based lipid reduction goals in prior guidelines, the updated guidelines return to specific LDL-C and non-HDL-C treatment goals, including LDL-C <70 mg/dL for high-risk patients and <55 mg/dL for very high-risk ASCVD patients. The PREVENT-ASCVD equation is now the preferred risk calculator for identifying patients at elevated risk. Statin therapy remains first-line, with expanded use of newer, more intensive nonstatin therapies (e.g., PCSK-9 inhibitors and bempedoic acid) and newer biomarkers of ASCVD risk.

Source: Blumenthal RS, Morris PB, Gaudino M, et al. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. J Am Coll Cardiol. 2026;87(19):2624-2757. PMID: 41824590

Gram-Negative Infections (IDSA)

These guidelines provide updated treatment recommendations for infections caused by ESBL-producing and AmpC-producing Enterobacterales, carbapenem-resistant Enterobacterales (CRE), difficult-to-treat resistant *Pseudomonas aeruginosa*, carbapenem-resistant *Acinetobacter baumannii* (CRAB), and *Stenotrophomonas maltophilia*. The document incorporates evolving susceptibility data and appropriate use of new FDA-approved agents, including oral sulopenem etzadroxil-probenecid, pivmecillinam, gepotidacin, IV fosfomycin, and cefepime-enmetazobactam. Notable updates reaffirm avoiding ertapenem in critically ill patients or those with hypoalbuminemia because of accelerated drug clearance. For resistant *P. aeruginosa*, the guidelines clarify that ceftolozane-tazobactam, a preferred option for many isolates, lacks activity against KPC-producing strains, while cefiderocol is now the preferred treatment for metallo-beta-lactamase (MBL)-producing isolates.

Source: Tamma PD, Bonomo RA, Heil EL, Justo JA, Satlin MJ, Mathers AJ. Infectious Diseases Society of America 2026 Guidance on the Treatment of Antimicrobial-Resistant Gram-Negative Infections. Clin Infect Dis. 2026;ciag481. PMID 42570093

Obesity Management (ACP)

The ACP developed a living clinical guideline on pharmacologic treatment of overweight and obesity in nonpregnant adults. Lifestyle modification, including

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Practice Developments *Continued*

improved nutrition and physical activity, remains the foundation of management. For adults with obesity (BMI ≥30 kg/m²), ACP recommends adding pharmacotherapy when appropriate, with semaglutide and tirzepatide as preferred first-line options, followed by phentermine-topiramate, liraglutide, and naltrexone-bupropion. For adults with overweight (BMI 27 to <30 kg/m²) and at least one obesity-related comorbidity (type 2 diabetes, dyslipidemia, hypertension, obstructive sleep apnea, or cardiovascular disease), semaglutide or tirzepatide are preferred first-line agents, with liraglutide as a second-line option. Medication selection should be individualized based on efficacy, adverse effects, comorbidities, patient preferences, access, and cost.

Source: Qaseem A, Cross JT, Harrod CS, Owens DK, Balk EM, Crandall CJ. Pharmacologic Treatments With Lifestyle Modifications in Nonpregnant Adults With Overweight or Obesity in Outpatient Settings: A Living Clinical Guideline From the American College of Physicians. Ann Intern Med. 2026;179(8):1177-1185. PMID: 42296496.

Rheumatoid Arthritis (EULAR)

Key changes from prior guidance include a stronger emphasis on adding a biologic DMARD after inadequate response to methotrexate (typically within 3 to 6 months) rather than cycling through additional conventional DMARDs, and more explicit guidance on the use of JAK inhibitors (e.g., tofacitinib, baricitinib, upadacitinib) with careful consideration of cardiovascular, malignancy, and thromboembolic risks. The guideline also provides updated recommendations on DMARD tapering in sustained remission, while cautioning against complete discontinuation due to the risk of flare.

Source: Smolen JS, Edwards CJ, Konzett V, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biologic disease-modifying antirheumatic drugs: 2025 update. Ann Rheum Dis. 2026;85(6):991-1009. PMID 41826212

FDA

Vitamin B6 Deficiency and Seizures Associated with Carbidopa-levodopa

Following an FDA safety review, a new warning is being added to the prescribing information for all carbidopa-levodopa products to alert clinicians that these medications can cause vitamin B6 (pyridoxine) deficiency, which may lead to seizures. Many reported seizures were refractory to conventional antiseizure medications but improved with vitamin B6 replacement. The FDA recommends obtaining a baseline vitamin B6 level before initiating therapy, monitoring levels periodically, and providing vitamin B6 supplementation when indicated, particularly when signs of vitamin B6 deficiency are present, including confusion, depression, numbness, tingling, muscle weakness, and seizures.

Source: FDA Is Requiring Warning about Vitamin B6 Deficiency and Associated Seizures for Drug Products Containing Carbidopa/Levodopa. Food & Drug Administration. March 20, 2026. https://www.fda.gov/drugs/drug-safety-communications/fda-requiring-warning-about-vitamin-b6-deficiency-and-associated-seizures-drug-products-containing

Peptides

Peptide therapies continue to attract widespread interest for purported benefits in tissue repair, weight management, metabolic health, cognition, and healthy aging. Popular examples include BPC-157, TB-500, MOTS-c, Semax, and Epitalon, which are commonly administered by injection or intranasally and are often marketed through wellness clinics and compounding channels. Most of these products are not FDA-approved, and evidence supporting their safety and effectiveness remains limited or nonexistent. In July 2026, the FDA's Pharmacy Compounding Advisory Committee (PCAC) reviewed several commonly marketed peptides and recommended that many be considered for inclusion on the Section 503A bulk drug substances list, which would permit compounding under specific conditions. These recommendations are advisory only and do not constitute FDA approval. FDA reviewers expressed ongoing concerns regarding limited clinical evidence, incomplete safety data, immunogenicity, and product quality, and the agency has not yet issued final regulatory decisions on these peptides.

Sources: US Food & Drug Administration; July 23-24, 2026: Meeting of the Pharmacy Compounding Advisory Committee https://www.fda.gov/advisory-committees/advisory-committee-calendar/july-23-24-2026-meeting-pharmacy-compounding-advisory-committee-07232026 and https://time.com/article/2026/07/23/fda-committee-peptides/ and https://www.fda.gov/advisory-committees/advisory-committee-calendar/july-23-24-2026-meeting-pharmacy-compounding-advisory-committee-07232026

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Practice Developments *Continued*

OTC Orlistat Warning

In June 2026, the FDA updated the OTC orlistat (Alli®) label to warn about the rare risk of kidney stones and acute kidney injury. Although uncommon, these events can be serious and have led to some hospitalizations. Patients with a history of kidney disease or kidney stones should consult their healthcare provider before use, and all patients should be counseled to discontinue therapy and seek medical attention if they develop symptoms such as back or groin pain, painful urination, hematuria, edema, or decreased urination. Pharmacists should be prepared to help patients determine whether orlistat therapy is appropriate, identify those with a history of kidney disease or kidney stones, and counsel patients to seek medical attention if symptoms of kidney injury occur.

Source: US Food and Drug Administration. FDA Approves Labeling Changes for Over-the-Counter (OTC) Weight Loss Drug alli (Orlistat) to Warn of Risk of Kidney Stones and Kidney Injury. Published June 10, 2026. https://www.fda.gov/safety/medical-product-safety-information/fda-approves-labeling-changes-over-counter-otc-weight-loss-drug-alli-orlistat-warn-risk-kidney

GENERAL PRACTICE

Apixaban vs Rivaroxaban in VTE Treatment

The COBRRA trial compared apixaban and rivaroxaban in 2,760 patients with acute venous thromboembolism (VTE). During the initial 3 months of treatment, rates of recurrent VTE were similar between groups, but bleeding (major or clinically relevant nonmajor bleeding) occurred in 3.3% of patients receiving apixaban versus 7.1% receiving rivaroxaban (RR 0.46, 95% CI 0.33-0.65; p<0.001). Major bleeding was less common with apixaban (0.4% vs 2.4%), and no deaths related to bleeding or recurrent VTE were reported in either treatment arm. The investigators noted that most bleeding events with rivaroxaban occurred during the initial higher-dose treatment phase. Using the FDA-approved regimens studied in COBRRA, apixaban was associated with a lower risk of clinically relevant bleeding than rivaroxaban during the first 3 months of VTE treatment.

Source: Castellucci LA, Chen VM, Kovacs MJ, et al. Bleeding Risk with Apixaban vs. Rivaroxaban in Acute Venous Thromboembolism. N Engl J Med. 2026;394(11):1051-1060. PMID : 41812192

Cefazolin May Offer a Safer Alternative for MSSA Bacteremia

Two randomized trials from the Staphylococcus aureus Network Adaptive Platform (SNAP) evaluated alternatives to antistaphylococcal penicillins (ASP) for *S. aureus* bacteremia. In the MSSA bacteremia trial, 1,341 patients were randomized to cefazolin or an ASP (flucloxacillin or cloxacillin). Ninety-day mortality was similar between groups (15% vs 17%), demonstrating noninferiority of cefazolin, while cefazolin was associated with lower rates of acute kidney injury (14% vs 20%) and treatment discontinuation due to adverse effects. A companion SNAP trial in penicillin-susceptible *S. aureus* (PSSA) bacteremia was stopped early because of excess AKI in the ASP group. Together, these findings support cefazolin as an effective and better-tolerated alternative to traditional antistaphylococcal penicillins for MSSA bacteremia.

Sources: Lee TC, Barina LA, Walls G et al. Cefazolin for Methicillin-Susceptible Staphylococcus aureus Bacteremia. N Engl J Med. 2026;394(23):2329-2339. PMID 42308484 and Staphylococcus aureus Network Adaptive Platform (SNAP) Trial Group. Benzylpenicillin versus flucloxacillin or cloxacillin for the treatment of penicillin-susceptible Staphylococcus aureus bacteraemia (SNAP): an international, multicentre, open-label, non-inferiority randomised controlled trial. Lancet. 2026;408(10550):141-152. PMID 42309115

Iloprost for Severe Frostbite

A retrospective cohort study compared iloprost-based therapy with non-iloprost management for severe frostbite in two Canadian cities. Iloprost, a prostacyclin analogue marketed as Aurlumyn®, became the first FDA-approved treatment for severe frostbite in 2024 and is indicated to reduce the risk of digit amputation. In this study, iloprost use was associated with a significantly lower likelihood of amputation (OR 0.49, 95% CI 0.25-0.96). Iloprost was administered IV daily using a standardized protocol. The most reported adverse effect was headache. These findings provide additional real-world evidence supporting iloprost as an effective treatment option for severe frostbite.

Source: O'Dochartaigh D, Douma MJ, Picard C et al. Comparison of iloprost therapy versus non-iloprost therapy for severe frostbite: a retrospective cohort study of two Canadian cities. BMJ Open. 2026;16(5):e110475. doi:10.1136/bmjopen-2025-110475. PMID: 42150831

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