Welcome Packet for Advanced Pharmacy Practice Experience (APPE)

Outpatient Care Ambulatory Clinical

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Table of Contents

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APPE Clinical and Research Rotation

Goals:

By the end of the rotation, the student should:

1. Thoroughly understand the pathophysiology and treatment options of disease states commonly seen in the community.
2. Participate in patient consultations for various disease states, geriatric patients, and any specialty areas as opportunities arise.
3. Enhance literature evaluation skills.
4. Develop a basic understanding of research processes and the importance of literature evaluations and conducting research.

Objectives:

1. Perform 2 literature evaluations and present findings to pharmacy staff and fellow students
2. Counsel patients on various disease states including, but not limited to:
    a. Diabetes mellitus
    b. Hypertension
    c. Dyslipidemia
    d. Osteoporosis
3. Complete and present at least one patient care plan and other assignments as detailed in the student manual
4. Gain proficiency and experience in counseling patients on usage of medical devices (i.e. insulin pumps, glucometers, insulin pens, blood pressure monitors, etc.)
5. Learn how to answer physician questions in an accurate, efficient, professional manner
6. Perform at least one community outreach event
7. Present to pharmacy staff and students on a current topic related to rotation focus

Standard Operating Procedures

VascuScript Pharmacy Mission

The VascuScript pharmacy strives to be an independent community pharmacy with a focus on providing a unique combination of free in-home delivery and clinical pharmacy services. By optimizing the workflow process and establishing collaborative relationships with various inpatient and outpatient practices, the VascuScript pharmacy is dedicated to committing a minimum of 50% of their hours to clinically oriented services in addition to standard dispensing functions.

Scheduling Expectations

As stipulated in the Advanced Pharmacy Practice Experience Program Manual, the minimum number of hours you can expect to commit on a weekly basis shall be 40 hours. Important to consider is that any of the VascuScript pharmacists may exceed 60-80 hours per week to maintain long-term relationships with their patients or collaborating practitioners. Concordantly, it should be your expectation that to meet the needs of your patients and your experiential requirements, there shall be no pre-specified maximum number of hours worked per week, nor will there be restrictions applied to weeknights or weekends.

Pharmacist Training Modules

All training pharmacists are required to complete the three six-week VascuScript Pharmacy rotation modules. As VascuScript pharmacists in training, all students are expected to assist with daily pharmacy activities (i.e. answering phone calls, making patient calls, etc.) when in the pharmacy, regardless of their rotation's focus. VascuScript Pharmacy is a team-oriented environment; students are expected to ask for help from fellow students or rotation preceptors should they need it, and the students and preceptors are expected to assist, even if it is not the focus of their current rotation. The following are areas in which training pharmacists will gain exposure throughout the three six-week VascuScript Pharmacy rotation modules:

a. Prescription Intake, Data Entry, and Dispensing
b. Compounding
c. Delivery and Mail Preparation
d. Bariatric Surgery Medication Reconciliation and Care Planning
e. Buffalo Medical Group Transitions in Care Medication Counseling & Reconciliation
f. ECMC HIV Clinic Medication Counseling & Reconciliation
g. Independent Health Care Partners Counseling & Reconciliation
h. Mobile Primary Care Counseling and Reconciliation
i. Drug Information Retrieval and Therapeutic Recommendations
j. Business and Administration

Training Pharmacist Assignments

All training pharmacists are required to complete the following tasks during their time with the VascuScript Pharmacy. The assignments below are intended to be a listing of the types of assignments that you may encounter and the preceptor shall retain the right of requesting assignments to be redone or alternatively to add assignments if the quality of work is determined to be below average or poor. It shall be the training pharmacist's responsibility to create a folder with all necessary grading forms and to engage the preceptor for completion of the mandatory and preceptor selected assignments. Failure to complete an assignment on time is ultimately the responsibility of the training pharmacist.

Potential Mandatory Assignments

Assignment	Total Required	Points
Pharmaceutical Care Plan (Appendix A2)	1	40
SOAP Note (A5)		
Medication Therapy Management Form (A7)		
Site Specific Documentation		

Potential Preceptor Selected Assignments

Assignment	Total Required	Points
Prescription Patient Counseling	1	20
OTC Patient Counseling	1	20
Drug Information (Long: Written formally)	1	30
Drug Information (Real-time)	1	12
Patient Case and/or Disease State Presentation (Formal)	1	20
Patient Case and/or Disease State Presentation (Informal)	1	5
Verbal Communication to Physician	1	20
Note to Prescriber (Formal)	1	20
Compounded Prescription	1	12
Medical Device Counseling	1	18
Medication Reconciliation/Discharge Counseling	1	22
Universal Assignment – Reflection & Growth (Pre-post)	1	15
		214

Mandatory Sign-Offs

Assignment	Total Required
Timetable for Assignment Completion	1 (Training Pharmacist to Develop Form)
Interim Evaluation	1
Final Evaluation	1
Assignment Submission Checklist	1
Patient Documentation Form	1
APPE Portfolio	1
Subjective Evaluation	1

Tentative Schedule of Assignment Due Dates

Students are required to have 1 Patient Care Plan and a minimum of 5 Preceptor Selected Assignments completed by the end of this rotation. It is the student's responsibility to make sure all of the assignments needed are assigned and graded. With that in mind, if you feel that something would be worth grading, please let us know BEFORE completing the task that you would like the product graded. We are requiring a minimum of 1 Patient Care Plan, 1 Formal Patient Case Presentation (same patient as your care plan), 1 Long or Short DI paper, 1 Topic Presentation, and 1 Med Rec. or Med Device Counseling. Any other assignment(s), and the corresponding due dates, will be at the discretion of the Preceptor.

Tentative Schedule							
	Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Week 1	Day off	Orientation: 8:00 am with Dr. Monte				Due: Community Outreach Event Ideas	
Week 2	Day off			Due: Find Patient for Care Plan		Journal Club Presentation 7:45 am	
Week 3	Day off	Due: Subject for Topic Presentation	Med Rec. and/or Med Device Counseling should be graded by now	Bring Paperwork for Interim Evaluation		9:00am: Student Presentation	
Week 4	Day off	Patient Care Plan is Due- Presentation during this week				9:00am: Student Presentation	
Week 5	Day off	Long or Short DI Paper is Due Patient Care Plan is due if revisions were needed				9:00am: Student Presentation	
Week 6	Day off			Journal Club Presentation 7:45 am	Bring Paperwork for Final Evaluation		

Pharmaceutical Care Plan (Due 1-week prior to the end of the Rotation)

From the pool of BMG patients reviewed, or a VascuScript Pharmacy patient, select one patient that meets the following minimum criteria:

- Obesity (BMI >30 kg/m^2)
- Type 2 Diabetes Mellitus
- Dyslipidemia
- Hypertension
- Recent laboratory data available for glucose (HbA1C), lipid (LDL, HDL, TG), and blood pressure

A formal presentation of the PCP (15-30min) to the clinical preceptors and pharmacy department will be required.

Required Reading

The article below is required reading for students PRIOR to the first day; it may have been e-mailed to you with this document. We will discuss this during your orientation on the first day of the rotation. Please come prepared so we can enjoy an engaging discussion.

Vetter, Marion, et.al. Narrative Review: Effect of Bariatric Surgery on Type 2 Diabetes Mellitus. Annals of Internal Medicine. 2009; 150: 94-103.

APPENDIX

00 IU (D3, Cholecalciferol)	1000 IU (D3, Cholecalciferol)	400 IU (D3, Cholecalciferol)	400 IU (D2, Ergocalciferol)	400 IU (D3, Cholecalciferol)	Calcium Cit
)1U	30 IU	500 IU	30 IU	30 IU	Calcium Lac
mg	0 mg	160 mcg	10 mcg	0 mg	Carbonyl Iro
1 mg	6 mg	1.5 mg	1.5 mg	1.5 mg	Ferrous Fur
7 mg	3.4 mg	1.7 mg	1.7 mg	1.7 mg	Ferrous Sul
) mg	50 mg	20 mg	20 mg	15 mg	Ferrous Glu
) mg	20 mg	10 mg	10 mg	10 mg	
mg	4 mg	2 mg	2 mg	2 mg	
00 mcg	600 mcg	300 mcg	45 mcg	40 mcg	Recommen
00 mcg	800 mcg	800 mcg	400 mcg	400 mcg	B12
00 mcg	100 mcg	500 mcg	6 mcg (Cyanocobalamin)	6 mcg	Calcium
200 mg (Carbonate/Citrate)	200 mg (Calcium Citrate)	400 mg (Calcium Carbonate)	108 mg (Calcium Carbonate)	100 mg (Calcium Phosphate)	Iron
) mg (Ferrous Fumarate)	0 mg	30 mg	18 mg (Carbonyl Iron)	18 mg (Ferrous Fumarate)	Vitamin D
mg	0 mg	50 mg	50 mg	100 mg	Thiamine
30 mcg	0 mg	150 mcg	150 mcg	150 mcg	
00 mg	50 mg	400 mg	40 mg	20 mg	
) mg	22.5 mg	30 mg	15 mg	12 mg	
) mcg	201 mcg	70 mcg	0 mg	0 mcg	
mg	1.5 mg	2 mg	2 mg	2 mg	
mg	2 mg	2 mg	1 mg	0 mg	
20 mcg	150 mcg	120 mcg	20 mcg	0 mcg	
5 mcg	111 mcg	75 mcg	20 mcg	0 mcg	
mcg	37.5 mcg	0 mcg	0 mcg	0 mcg	
	18.6	0	0	0	
mg	7.5 mg	0 mg	0 mg	0 mg	
0	Yes	No	Yes	Yes	
0	Yes	Yes	Yes	Yes	
0	Yes	No	No	No	
	6	6	4	4	
4.99	$16.95	$27.99	$3.00	$3.50	
1.00	$5.00	$0.00	$5.00	$5.00	
1.00	$10.00	$10.00	$10.00	$10.00	
1.00	$5.00	$5.00	$0.00	$0.00	
4.99	$36.95	$42.99	$18.00	$18.50	

RYGB: Absorption and Management Considerations for Select Pharmacotherapeutic Agents

Drug/Formulation	Absorption Considerations	Management Considerations
Extended or Sustained Release Formulations	Decreased absorption	Use immediate release formulations with increased dosing frequency.
NSAID's (diclofenac, ibuprofen, ketoprofen, indomethacin, ketorlac, meloxicam, naproxen, nabumetone, oxaprozin)		Ulceration, generally avoid after gastric bypass procedure. In a comparative trial with normal GI structure, Meloxicam has been shown to have fewer GI side effects versus diclofenac. May consider use of PPI to decrease risk of marginal ulceration.

Salicylates (e.g. aspirin, magnesium salicylate, salsalate)		Ulceration, consider risk:benefit ratio on an individual basis. Lack of literature to support or oppose use of daily aspirin. Co-treatment with PPI may be considered.
Antiplatelet Agents (Clopidogrel)		Clopidogrel associated with increased risk of upper GI bleeding. Co-treatment with PPI recommended if treatment is to be continued.
Oral Bisphosphonates (alendronate, etidronate, ibandronate, risedronate)		Increased risk of gastrointestinal ulceration. Consider alternative treatment options (calcitonin, teriparatide, raloxifene (women))
Zolpidem	Absorbed rapidly and completely; absorption affected by food.	Absorption time may increase, resulting in delay to take effect. Take on empty stomach.
Thyroxine	1 case report of a woman requiring 0.6 mg after JIB vs. 0.2 mg before JIB. After JIB reversed 0.2 mg dose was sufficient to normalize TSH. Additional case report suggested a 0.5 mg dose (3x's greater) to maintain normal thyr0id function.	Monitor TSH. Consider dose titration.
Oral Antibiotics	Decreased absorption	Consider liquid formulations if no response to oral formulations
Amoxicillin	1 case report of a woman w/ UTI requiring IV antibiotics after oral medication failed (Gastric Bypass).	Controlled comparisons do not show alterations for the following antibiotics: 1. Erythromycin base (250 mg single) 2. Penicillin (1 g single dose)
Ampicillin	1 case report post JIB suggest significantly reduced bioavailability.	
Sulfisoxazole	Slight reduction in bioavailability observed post JIB.	
Nitrofurantoin (Macrodantin)	1 case report of a woman w/ UTI requiring IV antibiotics after oral medication failed (Gastric Bypass).	
Antifungal Agents (Ketoconazole)	Likely absorbed in stomach because acidic medium required for absorption.	Absorption likely to be negligible; consider alternative agents.
Antihypertensive Agents		May require decreased dosages as weight loss occurs. Recommend home blood pressure monitoring (morning, evening) to determine viability of eliminating medications.
Hydrochlorothiazide	Controlled comparison suggests significant AUC reduction (JIB)	Consider alternative agent or increase dose. Monitor blood pressure.
Enalapril	Hydrolyzed to active form (enalprilat) in stomach; absorbed in	May exhibit decreased activity; consider other ACE-Inhibitors.

	small intestine	
Ramipril	Unknown site of absorption. Decreased absorption documented in patients with steatorrhea and malabsorption.	Consider other agents; monitor blood pressure in the postoperative period; need for antihypertensive therapy may decrease with weight loss.
Metoprolol Tartrate	Absorbed rapidly and completely, indicating stomach and duodenum absorption.	Monitor blood pressure, heart rate. Medication requirements may decrease as weight loss occurs
Antidiabetic Agents		May require decreased dosages as weight loss occurs. Recommend interval blood glucose monitoring (fasting, pre-prandial, post-prandial) to determine if medications may be discontinued or require optimization.
α-glucosidase Inhibitors (acarbose, miglitol)	Gastrointestinal absorption is negligible (local action). Will inhibit carbohydrate absorption throughout small intestine.	Commonly associated with gastrointestinal adverse effect (bloating, flatulence). Alternative agents recommended.
Biguanide (metformin)	Slowly and incompletely absorbed in the duodenum.	Ensure hydration status, CrCl >60ml/min. Increase requirement for blood glucose monitoring. Drug requirements may decrease with weight loss.
Basal & Bolus Insulin	N/A (subcutaneous administration)	Insulin requirements may decrease substantially (50%-100%). Diminish basal/bolus requirements to 50% during first 1-month of management. Patient to conduct interval blood glucose monitoring (fasting, pre-prandial, post-prandial) to determine if regimen is still required or requires optimization.
Sulfonylureas (glyburide, glipizide, glimepiride)	Rapid and complete absorption from the gastrointestinal tract	Discontinue following surgery. If additional oral secretory agent is required consider meglitinide or DPP-IV inhibitor (sitagliptin).
Meglitinides (nateglinide, repaglinide)	Bioavailability: 50-75% Peak concentration <1-hour	Absorption likely to be affected by RYGB. May consider prior to initiating or reinitiating bolus insulin therapy. Monitor efficacy with SMBG.
Thiazolidinediones (rosiglitazone, pioglitazone)	Serum concentrations appear within 30 minutes. Food alters time to peak, but not extent. Steady state reached in approximately 7-days. RYGB not expected to significantly impact long-term dosing strategies.	Rosiglitazone associated with cardiovascular outcomes. Both rosiglitazone and pioglitazone associated with increased fat mass. If thiazolidinedione agent is required consider only after weight loss has reached a plateau.
Incretin Mimetic/DPP-IV Inhibitors	Exenatide – N/A (subcutaneous)	No literature to evaluate use of either

(exenatide, sitagliptin)	Sitagliptin – peak concentrations occur in 1-4 hours. Steady state is reached with repeated dosing and not expected to be altered by RYGB.	agent after RYGB. Consider use of sitagliptin (+/-) metformin prior to initiation of exenatide due to known GLP-1 increases post RYGB.
Pramlintide	N/A (subcutaneous)	No literature to support use. Only indicated after failure of optimal insulin titration with or without use of metformin and/or sulfonylurea agents.
Antihyperlipidemic Agents		May require decreased dosages as weight loss occurs. Recommend lipid panel follow-up every 3-months to determine if medications may be discontinued or require optimization.
Simvastatin	Absorption site unknown, must be hydrolyzed to active form (stomach)	Consider other agents; monitor serum lipids.
Niacin	Primarily absorbed in duodenum.	Administer w/ low-fat snack to maximize absorption.
Antipsychotic Agents		
Olanzapine (Zyprexa)	Stomach.	Monitor for decreased efficacy; switching to orally disintegrating tablet will NOT increase absorption (stomach).
Quetiapine (Seroquel)	Exact location of absorption unknown. Likely location is stomach and duodenum due to rapid absorption.	Monitor for decreased efficacy.
Anticonvulsants		
Phenytoin (Dilantin)	2 case reports suggest the potential for decreased drug absorption with JIB. 1 controlled comparison confirms significant AUC reduction.	Monitor for decreased efficacy. May require increased dosage.
Ethosuximide (Zarontin)	1 case reports suggest the potential for decreased drug absorption w/JIB	Monitor for decreased efficacy. May require increased dosage.
Lamotrigine (Lamictal)	Likely to be stomach and proximal small intestine secondary to rapid and complete absorption.	Monitor for decreased efficacy.
Digoxin	Conflicting evidence (1/1) that serum AUC may be decreased	Consider monitoring serum drug concentrations
Oral Contraceptives		Consider patches, vaginal rings, injectable contraceptives, intrauterine devices, and barrier contraception.
Norethisterone/L-norgestrel	Controlled analysis suggests diminished absorption	Consider alternative agents or strategies for contraception.
D-norgestral/oestradiol	No significant change in absorption	Consider secondary protection.

Availability of Liquid Formulations

Category	Drug Name	Liquid Available	Dose
Antidepressant Agents			
SSRI	**citalopram**	Y	10mg/5ml

SSRI	**escitalopram**	Y	5mg/5ml
SSRI	**fluoxetine**	Y	20mg/5ml
SSRI	**fluvoxamine**	N	
SSRI	**paroxetine**	Y	10mg/5ml
SSRI	**sertraline**	Y	20mg/1ml
Dopamine Reuptake Inhibitor	**buproprion**	N	
Serotonin/Norepinephrine Reuptake Inhibitors	**duloxetine**	N	
Serotonin/Norepinephrine Reuptake Inhibitors	**desvenlafaxine**	N	
Serotonin/Norepinephrine Reuptake Inhibitors	**venlafaxine**	N	
5HT2 Receptor Antagonists	**nefazodone**	N	
5HT2 Receptor Antagonists	**trazadone**	N	
Noradrenergic Antagonist	**mirtazapine**	N	
Monoamine Oxidase Inhibitors	**isocarboxazid**	N	
Monoamine Oxidase Inhibitors	**phenelzine**	N	
Monoamine Oxidase Inhibitors	**tranylcypromine**	N	
Tricyclic Antidepressants	**amitryptiline**	N	
Tricyclic Antidepressants	**clomipramine**	N	
Tricyclic Antidepressants	**desipramine**	N	
Tricyclic Antidepressants	**doxepin**	N	
Tricyclic Antidepressants	**imipramine**	N	
Tricyclic Antidepressants	**maprotiline**	N	
Tricyclic Antidepressants	**nortriptyline**	Y	10mg/5ml
Tricyclic Antidepressants	**protriptyline**	N	
Tricyclic Antidepressants	**amoxapine**	N	
Anti-Diabetic Agents			
Alpha-Glucosidase Inhibitors	**acarbose**	N	
Alpha-Glucosidase Inhibitors	**miglitol**	N	
Biguanides	**metformin**	Y	500mg/5ml (Riomet)
Dipeptidyl Peptidase-4 inhibitor	**saxagliptin**	N	
Dipeptidyl Peptidase-4 inhibitor	**sitagliptin**	N	
Meglitinides	**nateglinide**	N	
Meglitinides	**repaglinide**	N	
Sulfonylureas	**chlorpropamide**	N	
Sulfonylureas	**glimepiride**	N	
Sulfonylureas	**glipizide**	N	
Sulfonylureas	**glyburide**	N	
Sulfonylureas	**tolazamide**	N	
Sulfonylureas	**tolbutamide**	N	
Thiazolidinediones	**pioglitazone**	N	
Thiazolidinediones	**rosiglitazone**	N	
Antihyperlipidemic Agents			
Bile Acid Sequestrants	**cholestyramine**	Y	4g Powder for Oral Susp.
Bile Acid Sequestrants	**colesevelam**	Y	3.75g Powder for

			Oral Susp.
Bile Acid Sequestrants	**colestipol**	Y	5g Granules for Oral Susp.
Cholesterol absorption inhibitor	**ezetimibe**	N	
Fibrates	**fenofibrate**	N	
Fibrates	**gemfibrozil**	N	
HMG-CoA Reductase Inhibitors	**atorvastatin**	N	
HMG-CoA Reductase Inhibitors	**fluvastatin**	N	
HMG-CoA Reductase Inhibitors	**lovastatin**	N	
HMG-CoA Reductase Inhibitors	**rosuvastatin**	N	
HMG-CoA Reductase Inhibitors	**simvastatin**	N	
Nicotinic Acid	**Niacin**	N	
Antihypertensive Agents			
Loop Diuretics	**bumetanide**	N	
Loop Diuretics	**furosemide**	Y	40mg/5ml, 40mg/5ml
Loop Diuretics	**torsemide**	N	
Thiazide diuretics	**chlorothiazide**	Y	250mg/ml
Thiazide diuretics	**HCTZ**	N	50mg/5ml
Thiazide diuretics	**indapamide**	N	
Thiazide diuretics	**metolazone**	N	
ACE Inhibitors	**benazepril**	N	
ACE Inhibitors	**captopril**	N	
ACE Inhibitors	**enalapril**	N	
ACE Inhibitors	**enalaprilat**	N	
ACE Inhibitors	**fosinopril**	N	
ACE Inhibitors	**lisinopril**	N	
ACE Inhibitors	**moexipril**	N	
ACE Inhibitors	**perindopril**	N	
ACE Inhibitors	**quinapril**	N	
ACE Inhibitors	**Ramipril**	N	
ACE Inhibitors	**trandolapril**	N	
Angiotensin II Receptor Blockers	**candasartan**	N	
Angiotensin II Receptor Blockers	**eprosartan**	N	
Angiotensin II Receptor Blockers	**irbesartan**	N	
Angiotensin II Receptor Blockers	**Losartan**	N	
Angiotensin II Receptor Blockers	**olmesartan**	N	
Angiotensin II Receptor Blockers	**telmisartan**	N	
Angiotensin II Receptor Blockers	**valsartan**	N	
Direct Renin Inhibitor	**Aliskiren**	N	
Beta Blockers	**acebutolol**	N	
Beta Blockers	**atenolol**	N	
Beta Blockers	**betaxolol**	N	
Beta Blockers	**bisoprolol**	N	

Beta Blockers	**carteolol**	N	
Beta Blockers	**carvedilol**	N	
Beta Blockers	**esmolol**	N	
Beta Blockers	**labetalol**	N	
Beta Blockers	**metoprolol**	N	
Beta Blockers	**nadolol**	N	
Beta Blockers	**penbutolol**	N	
Beta Blockers	**pindolol**	N	
Beta Blockers	**propranolol**	Y	40mg/5ml
Beta Blockers	**sotalol**	N	
Beta Blockers	**timolol**	N	
Calcium Channel Blockers	**amlodipine**	N	
Calcium Channel Blockers	**felodipine**	N	
Calcium Channel Blockers	**isradipine**	N	
Calcium Channel Blockers	**nicardipine**	N	
Calcium Channel Blockers	**nifedipine**	N	
Calcium Channel Blockers	**nimodipine**	N	
Calcium Channel Blockers	**nisoldipine**	N	
Calcium Channel Blockers	**verapamil**	N	
Calcium Channel Blockers	**diltiazem**	N	
Central Acting Antiadrenergic Agents	**clonidine**	N	
Central Acting Antiadrenergic Agents	**guanabenz**	N	
Central Acting Antiadrenergic Agents	**guanfacine**	N	
Central Acting Antiadrenergic Agents	**methyldopa**	N	
Alpha- Adrenergic Blockers	**alfuzosin**	N	
Alpha- Adrenergic Blockers	**doxazosin**	N	
Alpha- Adrenergic Blockers	**prazosin**	N	
Alpha- Adrenergic Blockers	**silodosin**	N	
Alpha- Adrenergic Blockers	**tamsulosin**	N	
Alpha- Adrenergic Blockers	**terazosin**	N	
Aldosterone Antagonist	**epleronone**	N	
Potassium Sparing Diuretics	**amiloride**	N	
Potassium Sparing Diuretics	**spironolactone**	N	
Potassium Sparing Diuretics	**triamterene**	N	