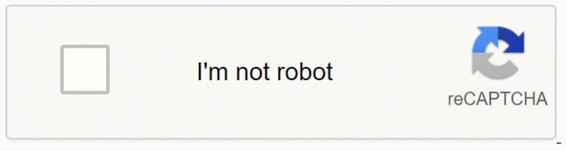

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Beers medication list pdf

From THE AMERICAN GERIATRICS SOCIETY

A POCKET GUIDE TO THE 2019 AGS BEERS CRITERIA®

This guide has been developed as a tool to assist healthcare providers in improving medication safety in older adults. The role of this guide is to *inform* clinical decision-making, research, training, quality measures and regulations concerning the prescribing of medications for older adults to improve safety and quality of care. It is based on *The 2019 AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults.*

Originally conceived of in 1991 by the late Mark Beers, MD, a geriatrician, the Beers Criteria catalogues medications that cause side effects in older adults due to the physiologic changes of aging. In 2011, the AGS sponsored its first update of the criteria, assembling a team of experts and using an enhanced, evidence-based methodology. Since 2011, the AGS has been the steward of the criteria and has produced updates using an evidence-based methodology and rating each Criterion (quality of evidence and strength of evidence) using the American College of Physicians' Guideline Grading System, which is based on the GRADE scheme developed by Guyatt et al.

The full document, along with accompanying resources, can be found in its entirety online at geriatricscareonline.org.

INTENDED USE

The goal of this guide is to improve care of older adults by reducing their exposure to Potentially Inappropriate Medications (PIMs).

- This should be viewed as a guideline for identifying medications for which the risks of their use in older adults outweigh the benefits.
- These criteria are not meant to be applied in a punitive manner.
- This list is not meant to supersede clinical judgment or an individual patient's values and needs. Prescribing and managing disease conditions should be individualized and involve shared decision-making.
- These criteria also underscore the importance of using a team approach to prescribing and the use of non-pharmacological approaches and of having economic and organizational incentives for this type of model.
- A companion piece that addresses the best way for patients, providers, and health systems to use (and not use) the AGS Beers Criteria® was also developed. The document can be found on geriatricscareonline.org.

The criteria are not applicable in all circumstances (i.e. patients receiving palliative and hospice care). If a provider is not able to find an alternative and chooses to continue to use a drug on this list in an individual patient, designation of the medication as potentially inappropriate can serve as a reminder for close monitoring so that adverse drug effects can be incorporated into the electronic health record and prevented or detected early.

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Geriatric Health Professionals.
Leading change. Improving care for older adults.

TABLE 1. 2019 American Geriatrics Society Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults

Organ System, Therapeutic Category, Drug(s)	Recommendation, Rationale, Quality of Evidence (QOE), Strength of Recommendation (SOR)
Anticholinergics*	
First-generation antihistamines ■ Brompheniramine ■ Carbinoxamine ■ Chlorpheniramine ■ Clemastine ■ Cyproheptadine ■ Dexbrompheniramine ■ Dexchlorpheniramine ■ Dimenhydrinate ■ Diphenhydramine (oral) ■ Doxylamine ■ Hydroxyzine ■ Meclizine ■ Promethazine ■ Pyrilamine ■ Triprolidine	***Avoid*** Highly anticholinergic; clearance reduced with advanced age, and tolerance develops when used as hypnotic; risk of confusion, dry mouth, constipation, and other anticholinergic effects or toxicity Use of diphenhydramine in situations such as acute treatment of severe allergic reaction may be appropriate *QE = Moderate; SR = Strong*
Antiparkinsonian agents ■ Benztropine (oral) ■ Trihexyphenidyl	***Avoid*** Not recommended for prevention of extrapyramidal symptoms with antipsychotics; more effective agents available for treatment of Parkinson disease *QE = Moderate; SR = Strong*
Antispasmodics ■ Atropine (excludes ophthalmic) ■ Belladonna alkaloids ■ Clidinium-Chlordiazepoxide ■ Dicyclomine ■ Hyoscyamine (excludes ophthalmic) ■ Hyoscyamine ■ Methscopolamine ■ Propantheline ■ Scopolamine	***Avoid*** Highly anticholinergic; uncertain effectiveness *QE = Moderate; SR = Strong*
Antithrombotics	
■ Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin)	***Avoid*** Rationale: May cause orthostatic hypotension; more effective alternatives available; IV form acceptable for use in cardiac stress testing *QE = Moderate; SR = Strong*

*See also criterion on highly anticholinergic antidepressants

CNS = central nervous system; NSAIDs = nonsteroidal anti-inflammatory drugs; SIADH, syndrome of inappropriate antidiuretic hormone

Table 1 (continued on page 3)

Table 1 Continued

Organ System, Therapeutic Category, Drug(s)	Recommendation, Rationale, QE, SR
Anti-infective	
■ Nitrofurantoin	***Avoid in individuals with creatinine clearance <30 mL/min or for long-term suppression*** Potential for pulmonary toxicity, hepatotoxicity, and peripheral neuropathy, especially with long-term use; safer alternatives available *QE = Low; SR = Strong*
Cardiovascular	
Peripheral alpha-1 blockers for treatment of hypertension ■ Doxazosin ■ Prazosin ■ Terazosin	***Avoid use as an antihypertensive*** High risk of orthostatic hypotension and associated harms, especially in older adults; not recommended as routine treatment for hypertension; alternative agents have superior risk/benefit profile *QE = Moderate; SR = Strong*
Central-alpha agonists Clonidine for first-line treatment of hypertension Other CNS alpha-agonists ■ Guanabenz ■ Guanfacine ■ Methyldopa ■ Reserpine (>0.1 mg/d)	***Avoid clonidine as first-line antihypertensive. Avoid other CNS alpha-agonists as listed*** High risk of adverse CNS effects; may cause bradycardia and orthostatic hypotension; not recommended as routine treatment for hypertension *QE = Low; SR = Strong*
Disopyramide	***Avoid*** May induce heart failure in older adults because of potent negative inotropic action, strongly anticholinergic; other antiarrhythmic drugs preferred *QE = Low; SR = Strong*
Dronedarone	***Avoid in individuals with permanent atrial fibrillation or severe or recently decompensated heart failure*** Worse outcomes have been reported in patients taking dronedarone who have permanent atrial fibrillation or severe or recently decompensated heart failure *QE = High; SR = Strong*
Digoxin for first-line treatment of atrial fibrillation or of heart failure	***Avoid this rate control agent as first-line therapy for atrial fibrillation. Avoid as first-line therapy for heart failure. If used for atrial fibrillation or heart failure, avoid dosages >0.125 mg/d*** Use in atrial fibrillation: should not be used as a first-line agent in atrial fibrillation, because there are safer and more effective alternatives for rate control supported by high-quality evidence. Use in heart failure: evidence for benefits and harms of digoxin is conflicting and of lower quality; most but not all of the evidence concerns use in heart failure with reduced ejection fraction (HFrEF). There is strong evidence for other agents as first-line therapy to reduce hospitalizations and mortality in adults with HFrEF. In heart failure, higher dosages are not associated with additional benefit and may increase toxicity. Decreased renal clearance of digoxin may lead to increased risk of toxic effects; further dose reduction may be necessary in those with Stage 4 or 5 chronic kidney disease. *QE = Atrial fibrillation: Low; Heart failure: Low; Dosage >0.125 mg/d: Moderate; SR = Atrial fibrillation: Strong; Heart failure: Strong; Dosage >0.125 mg/d: Strong*
Nifedipine, immediate release	***Avoid*** Potential for hypotension; risk of precipitating myocardial ischemia *QE = High; SR = Strong*
Amiodarone	***Avoid as first-line therapy for atrial fibrillation unless the patient has heart failure or substantial left ventricular hypertrophy*** Effective for maintaining sinus rhythm but has greater toxicities than other antiarrhythmics used in atrial fibrillation; may be reasonable first-line therapy in patients with concomitant heart failure or substantial left ventricular hypertrophy if rhythm control is preferred over rate control *QE = High; SR = Strong*
Central nervous system	
Antidepressants, alone or in combination: ■ Amitriptyline ■ Amoxapine	***Avoid*** Highly anticholinergic, sedating, and cause orthostatic hypotension; safety profile of low-dose doxepin (≤6 mg/d) comparable to that of placebo

EPOC Study (N = 240)

	Beers Medication Exposure			M
E ht[a]	Standard Weight[b]	Yes (n = 106)	No (n = 134)	p Value[c]	(n
	2	0.30	0.16	0.289	
	2	0.53	0.36	0.422	
	3	1.4	1.0	0.321	
	3	0.82	0.69	0.906	
	1	0.31	0.22	0.228	
	1	0.81	0.55	0.029	
	2	2.6	2.5	0.960	
	2	6.3	5.1	0.007	
	1	0.75	0.68	0.738	
	1	1.2	1.1	0.940	
		2.7	1.9	0.063	

Veterans Affairs Enhanced Pharmacy Outpatient Clinic; MAI = Medication
agement.
ssessing ADE risk, using the specified item weights as an alternative to st

PIMs medications	Frequency	Drug Class	Rationale	Beers Criteria Recommendation
1. Pantoprazole	37	Proton pump inhibitors (PPIs)	Risk of Clostridium difficile infection and bone loss and fractures.	Avoid scheduled use for >8 weeks (**Avoided with exceptions**)
2. Furosemide	28	Diuretic	May exacerbate or cause syndrome of inappropriate antidiuretic hormone secretion or hyponatremia; monitor sodium level closely when starting or changing dosages in older adults.	Use with caution
3. Omeprazole	19	Proton pump inhibitors (PPIs).	Risk of Clostridium difficile infection and bone loss and fractures	Avoid scheduled use for >8 weeks. (**Avoided with exceptions**)
4. Enoxaparin	26	Anticoagulant	In CrCl<30 Increased risk of bleeding	**Reduce dose**
5. Corticosteroids	12	Anti-inflammatory medications	1. Potential of inducing or worsening delirium. 2. Corticosteroids with NSAIDs increased risk of Peptic ulcer disease or gastrointestinal bleeding.	1. **Avoid** in older adults with or at high risk of delirium. 2. **Avoid**, if not possible, provide gastrointestinal protection
6. Alprazolam	11	Antianxiety	1. Older adults have increased sensitivity to benzodiazepines and decreased metabolism of long-acting agents. 2. May cause ataxia, impaired psychomotor function, syncope, additional falls; shorter-acting benzodiazepines are not safer than long-acting ones	1. **Avoid** 2. Avoid in patients with History of falls or fractures unless safer alternatives are not available; (**Avoided with exceptions**)
7. Iansoprazole	8	Proton pump inhibitors (PPIs).	Risk of Clostridium difficile infection and bone loss and fractures.	Avoid scheduled use for >8 weeks. (**Avoided with exceptions**)
8. Thiazide	5	Diuretics	May exacerbate or cause syndrome of inappropriate antidiuretic hormone secretion or hyponatremia; monitor sodium level closely when starting or changing dosages in older adults.	Use with caution
9. Esomeprazole	5	Proton pump inhibitors (PPIs).	Risk of Clostridium difficile infection and bone loss and fractures.	Avoid scheduled use for >8 weeks. (**Avoided with exceptions**)
10. Spironolactone	4	Potassium-sparing diuretic	In CrCl<30 Increased potassium	**Avoid**
11. Digoxin	4	Antiarrhythmic	1. Use in atrial fibrillation 2. Use in heart failure	1. **Avoid as first-line** therapy for atrial fibrillation 2. **Avoid as first-line** therapy for heart failure.
12. Amiodarone	4	Antiarrhythmic	Amiodarone is effective for maintaining sinus rhythm but has greater toxicities than other antiarrhythmics used in atrial fibrillation.	**Avoid** amiodarone as first-line therapy for atrial fibrillation unless patient has heart failure or substantial left ventricular hypertrophy.
13. Diazepam	4	Antianxiety"calming agent"	May be appropriate for seizure disorders, rapid eye movement sleep disorders, benzodiazepine withdrawal, ethanol withdrawal, severe generalized anxiety disorder, and perioperoedural anesthesia	
14. Ranitidine	3	Histamine H2 receptor antagonis	1. Potential of inducing or worsening delirium.	1. **Avoid** in older adults with or at high risk of delirium.
15. Olanzapine	3	Atypical antipsychotic	1. Increases risk of orthostatic hypotension or bradycardia	1. **Avoid** in patient with Syncope
16. Famotidine	3	Histamine H2 receptor antagonist	1. Potential of inducing or worsening delirium.	1. **Avoid** in older adults with or at high risk of delirium.
17. Citalopram	3	Antidepressant	1. May exacerbate or cause syndrome of inappropriate antidiuretic hormone secretion or hyponatremia; monitor sodium level closely when starting or changing dosages in older adults 2. Use with ≥2 other CNS-active drugs increased risk of Falls	1. **Use with caution** 2. **Avoid** total of ≥3 CNS-active drugs; minimize number of CNS- active drugs
18. Tramadol	2	Narcotic-like pain reliever.	1. Lowers seizure threshold; may be acceptable in individuals with well-controlled seizures in whom alternative agents have not been effective. 2. CrCl<30/CNS adverse effects	1. Avoid (**Avoided with exceptions**) 2. Immediate release: **reduce dose** Extended release: **avoid**
19. Doxazosin	2	Alpha-adrenergic blockers	1. Increases risk of orthostatic hypotension or bradycardia 2. Aggravation of incontinence	1. **Avoid** in patient with Syncope. 2. Avoid in women (**Avoided with exceptions**)
20. Aspirin	2	NSAIDs	1. Aspirin >325 mg/d: Increased risk of gastrointestinal bleeding or peptic ulcer disease Primary prevention of: Lack of evidence of benefit versus risk in adults aged ≥80 ≥80.	1. Avoid chronic use, or with history of gastric or duodenal ulcers (**Avoided with exceptions**) 2. **Use with caution** in adults aged ≥80.
21. Terazosin	1	alpha-adrenergic blockers	1,2. Increases risk of orthostatic hypotension or bradycardia	1. **Avoid** in patient with Syncope.
22. Modafinil	1	Wakefulness-promoting agent.	CNS stimulant effects	Avoid in Insomnia
23. Clonazepam	1	Anti-anxiety and anti-convulsant	May be appropriate for seizure disorders, rapid eye movement sleep-disorders, benzodiazepine withdrawal, ethanol withdrawal, severe generalized anxiety disorder, and perioperoedural anesthesia	–
24. Ibuprofen	1	Nonsteroidal anti-inflammatory drug (NSAID)	Increased risk of gastrointestinal bleeding or peptic ulcer disease	Avoid chronic use (**Avoided with exceptions**)
25. Rivaroxaban	1	Anticoagulants	In Crcl 30-50 increased risk of bleeding	**Reduce dose**
26. Atropine	1	Anticholinergic	(excludes ophthalmic) Highly anticholinergic, uncertain effectiveness	**Avoid**
27. Mirtazapine	1	atypical antipsychotic	May exacerbate or cause syndrome of inappropriate antidiuretic hormone secretion or hyponatremia; monitor sodium level closely when starting or changing dosages in older adults	**Use with caution**
28. Nitrofurantoin	1	Antibiotic	Potential for pulmonary toxicity, hepatotoxicity, and peripheral neuropathy, especially with long- term use	Avoid in individuals with creatinine clearance <30mL/min or for long-term suppression of bacteria, (**Avoided with exceptions**)
29. Metoclopramide	1	Dopamine receptor blocker	1. Can cause extrapyramidal effects, including tardive dyskinesia.	1. Avoid, unless for gastroparesis (**Avoided with exceptions**)
30. Scopolamine	1	Anti-motion sickness	Highly anticholinergic, uncertain effectiveness	**Avoid**

Object Drug and Class	Interacting Drug and Class	Risk Rationale	Recommendation	Quality of Evidence	Strength of Recommendation
ACEIs	Amiloride or triamterene	Increased risk of Hyperkalemia	Avoid routine use; reserve for patients with demonstrated hypokalemia while taking an ACEI	Moderate	Strong
Anticholinergic	Anticholinergic	Increased risk of Cognitive decline	Avoid, minimize number of anticholinergic drugs (Table 7)	Moderate	Strong
Antidepressants (i.e., TCAs and SSRIs)	≥2 other CNS-active drugs[a]	Increased risk of Falls	Avoid total of ≥3 CNS-active drugs[a]; minimize number of CNS-active drugs	Moderate	Strong
Antipsychotics	≥2 other CNS-active drugs[a]	Increased risk of Falls	Avoid total of ≥3 CNS-active drugs[a]; minimize number of CNS-active drugs	Moderate	Strong
Benzodiazepines and nonbenzodiazepine, benzodiazepine receptor agonist hypnotics	≥2 other CNS-active drugs[a]	Increased risk of Falls and fractures	Avoid total of ≥3 CNS-active drugs[a]; minimize number of CNS-active drugs	High	Strong
Corticosteroids, oral or parenteral	NSAIDs	Increased risk of Peptic ulcer disease or gastrointestinal bleeding	Avoid; if not possible, provide gastrointestinal protection	Moderate	Strong
Lithium	ACEIs	Increased risk of Lithium toxicity	Avoid, monitor lithium concentrations	Moderate	Strong
Lithium	Loop diuretics	Increased risk of Lithium toxicity	Avoid, monitor lithium concentrations	Moderate	Strong
Opioid receptor agonist analgesics	≥2 other CNS-active drugs[a]	Increased risk of Falls	Avoid total of ≥3 CNS-active drugs[a]; minimize number of CNS drugs	High	Strong
Peripheral Alpha-1 blockers	Loop diuretics	Increased risk of Urinary incontinence in older women	Avoid in older women, unless conditions warrant both drugs	Moderate	Strong
Theophylline	Cimetidine	Increased risk of Theophylline toxicity	Avoid	Moderate	Strong
Warfarin	Amiodarone	Increased risk of Bleeding	Avoid when possible; monitor international normalized ratio closely	Moderate	Strong
Warfarin	NSAIDs	Increased risk of Bleeding	Avoid when possible; if used together, monitor for bleeding closely	High	Strong

[a]Central nervous system (CNS)-active drugs: antipsychotics; benzodiazepines; nonbenzodiazepine, benzodiazepine receptor agonist hypnotics; tricyclic antidepressants (TCAs); selective serotonin reuptake inhibitors (SSRIs); and opioids.
ACEI = angiotensin-converting enzyme inhibitor; NSAID = nonsteroidal anti-inflammatory drug.

Research and Reports

Use of 2015 Beers Criteria Medications by Older Medicare Beneficiaries

Raju Patel, Leona Zhu, Dilraj Sohal, Elena Lenkova, Nichole Koshki, Joseph Woelfel, Carly Ranson, Cynthia S. Valle-Oseguera, Edward L. Rogan

OBJECTIVE: To examine the prevalence of potentially inappropriate medications (PIMs) in community-dwelling Medicare beneficiaries based on the updated 2015 American Geriatrics Society Beers criteria.
DESIGN: Cross-sectional study.
SETTING: Thirteen mobile Medicare clinics were held throughout Northern and Central California during the fall of 2015.
PATIENTS, PARTICIPANTS: Noninstitutionalized Medicare beneficiaries 65 years of age and older taking one or more medications.
INTERVENTIONS: Pharmacy students under direct supervision of licensed pharmacists performed medication therapy management (MTM). Drug and disease state data were collected and used to identify PIMs based on the 2015 Beers criteria.
MAIN OUTCOME MEASURES: Number of beneficiaries who are taking a PIM, have a potential drug-drug or drug-disease interaction, and common factors associated with receiving a PIM.
RESULTS: MTM services were provided to 703 beneficiaries 65 years of age or older taking 1 or more medications. In total, 204 (29%) beneficiaries were taking 1 or more PIM. Drug-drug interactions were found in 54 beneficiaries, and 12 beneficiaries were found to have a significant drug-disease interaction. PIM prescribing was associated with certain chronic conditions (e.g., pain and insomnia). The prevalence of PIM use was significantly higher in women compared with men, whites compared with non-whites, and low-income beneficiaries compared with high income.
CONCLUSION: Prescribers and pharmacists should work in concert to minimize PIM use in older adults. Practitioners knowledgeable about the updated 2015 Beers criteria may monitor drug use more closely, hopefully minimizing potentially harmful drug and/or disease-state problems, and preventing avoidable health-related sequelae.

KEY WORDS: Beers criteria, Elderly, Medicare, Medication therapy management, Pharmacists, Potentially inappropriate medications.
ABBREVIATIONS: CNS – Central nervous system, ED – Emergency department, IR – Immediate release, MTM – Medication therapy management, PIM – Potentially inappropriate medication.
Consult Pharm 2018;33:48-54.

Introduction

Inappropriate prescribing in older adults is associated with negative health care outcomes, including increased adverse drug events and hospitalizations.[1] In response, there have been a number of resources created which aim to minimize the use of potentially inappropriate medications (PIMs).[2] PIMs are defined as "medications or medication classes that should generally be avoided in persons 65 years or older because they are either ineffective or they pose an unnecessarily high risk for older persons and a safer alternative is available."[2-4] Avoiding the use of PIMs is an important step in reducing drug-related problems, decreasing downstream health care costs, and improving an individual's quality of life.

The Beers criteria were first developed more than 25 years ago to provide guidance on PIM use in older adults. The criteria have been instrumental in reducing drug-related problems, improving medication prescription safety, and medication selection in older adults. As new clinical information becomes available, the Beers criteria continue to evolve and undergo multiple updates.[2,5] In November 2015, the American Geriatrics Society made the latest revision to these criteria.[2,5,6] The update included the addition of two new sections: 1) drugs to be avoided or which require adjustments based on the individual's underlying renal function, and 2) certain drug-drug interactions that have been documented to be harmful in older adults.[5]

In addition to their utility in encouraging appropriate medication use in older adults, the Beers criteria also impact each Centers for Medicare & Medicaid Services Part D plan star rating system. A plan's star rating summarizes its overall quality and performance in many different areas.[6] One of the performance measures

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