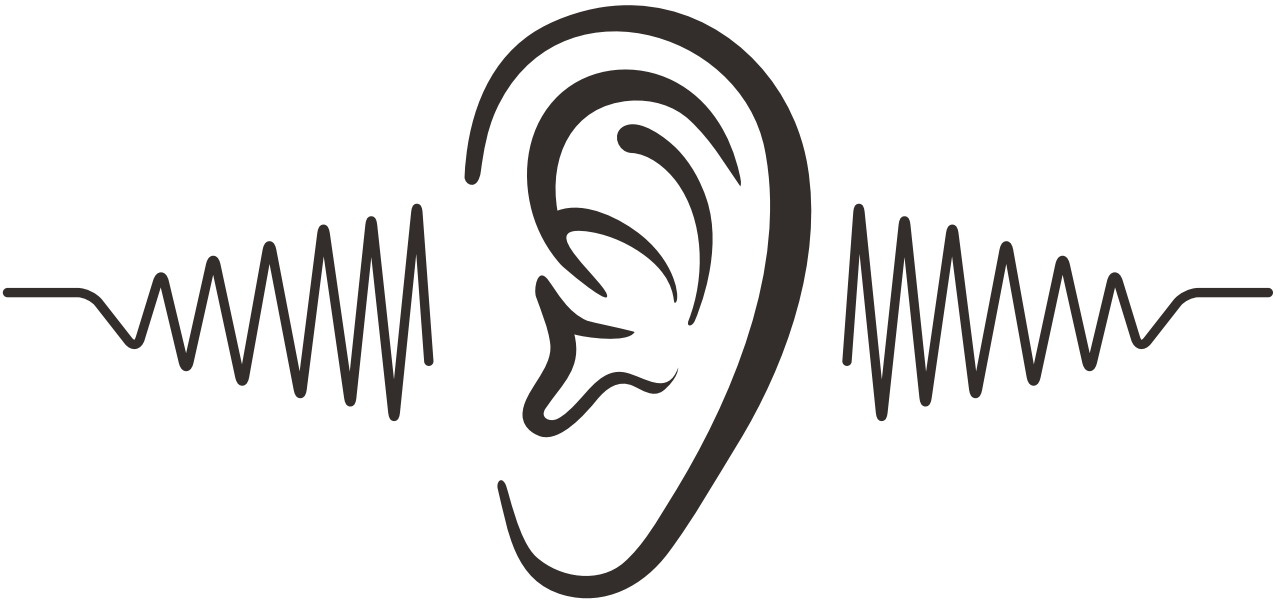

What the Rx Name Sounds Like May Not Be What It Is

A nurse from a physician's office called in a prescription to an outpatient pharmacy for PREVPAC (lansoprazole, amoxicillin, clarithromycin) for 14 days and asked the pharmacist if he could "make it" for the patient since it would be less expensive than using a manufacturer's combination "pack." However, the pharmacist misheard the nurse and thought the doctor had prescribed a "Pred-Pak," or a predniSONE "dose pack" with tapered dosing. Although the nurse had not specified a starting dose, the pharmacist filled the prescription beginning with a typical 30 mg dose (divided into three 10 mg doses on day 1), with tapering doses so therapy would be complete after 14 days. Since the pharmacist was asked to "make it" rather than dispense the prepackaged drug, he did not question the 14-day therapy instead of the usual 6- or 12-day schedules. The pharmacist had rarely dispensed Prevpac but had been dispensing predniSONE regularly. This is why he thought he heard "Pred-Pak" rather than "Prevpac." Fortunately, the patient read the leaflet about the newly dispensed medication and then called her doctor to ask why she was receiving a steroid to treat her duodenal ulcer and *Helicobacter pylori* (H. pylori) infection. The next day, the prescriber called the pharmacy to clarify the order.

These look- and sound-alike names, Prevpac and "Pred-Pak," demonstrate why telephone orders must be transcribed and read (and spelled) back. This includes the product name, dose, route, and directions for use. Unfortunately, in this case, the names are so close that, even with read back, the error might not have been detected unless the interpretation of "Pred-Pak" (predniSONE dose pack) was included in the read back process. The atypical duration of therapy and the absence of a starting dose should have prompted the pharmacist to verify the order. However, the pharmacist was uncomfortable "bothering" the physician, as he had been difficult to deal with many times in the past. While this can be a powerful disincentive to speak up, it is paramount to ask questions when the safety or quality of drug therapy is uncertain. Providing an indication with the prescription also could have helped to prevent an error, and patient counseling before leaving the pharmacy might have as well.

FARXIGA AND FETZIMA MIX-UPS

The Food and Drug Administration is aware of several reported mix-ups due to name confusion between FARXIGA (dapagliflozin) and FETZIMA (levomilnacipran). Farxiga was approved in January 2014 to lower blood glucose levels in adults with type 2 diabetes when used along with diet and exercise. It is available in 5 and 10 mg tablets. Fetzima was approved in July 2013. It is a selective norepinephrine and serotonin reuptake inhibitor for major depressive disorder.

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The drug is available in 20, 40, 80, and 120 mg extended-release capsules.

Upon review of the medication error reports received by FDA, it is believed that the errors can largely be attributed to the drugs being approved and marketed within six months of one another. Both drug names begin with the letter F and end with the letter A, and are of the same length and number of syllables. Prescribers and pharmacists may choose the wrong item from computer screens. Furthermore, the container labels might appear similar since both display the proprietary name of the product in red font.

The Institute for Safe Medication Practices has added this name pair to the *ISMP List of Confused Drug Names* (www.ismp.org/Tools/Confused-Drug-Names.aspx). Consider adding computer alerts to verify the indication for these drugs. Prescribers should include the indication with prescriptions. Pharmacists should educate all patients before dispensing these drugs to confirm the indication. ■

This article is from the Institute for Safe Medication Practices (ISMP). The reports described were received through the USP–ISMP Medication Errors Reporting Program. Errors, near misses, or hazardous conditions may be reported on the ISMP website at www.ismp.org. ISMP can be reached at 215-947-7797 or ismpinfo@ismp.org.