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Revision History

May 2023	2022-2023 VMFH Pharmacist Residents[1] Lee Newkirk, MD, Medical Director, Anesthesiology, SJMC; Chai Kanithanon, MD, Anesthesiology, SMMC; Jennifer Evans, MD, Medical Director, Anesthesiology, SANH; Todd Loutzenheiser, MD, Medical Director, Anesthesiology, SMMC; David Reeder, MD, Medical Director, Anesthesiology, SEH; Ryan Anderson, MD, Medical Director, Anesthesiology, SAH, SCH, GHSDSC, SEH, Jon Barnier, MD, Medical Director, Anesthesiology, SFH
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May 2013	Stephanie Friedman, PharmD, FHS Pharmaceutical Services Erik White, MD, and William B. Cammarano, MD, Medical Director, Anesthesiology, SJMC Approved by the FHS PT&T Committee on May 10, 2013
May 2012	Spartak Mednikov, PharmD, FHS Pharmaceutical Services William B. Cammarano, MD, Medical Director, Anesthesiology, SJMC Approved by the FHS PT&T Committee on May 11, 2012

September 2011	Mike Bonck, RPh, Manager, Pharmaceutical Services Minor edits upon request from the Medical Directors of Anesthesiology for FHS
May 2011	Sundari Poegoeh, PharmD, FHS Pharmaceutical Services William B. Cammarano, MD, Medical Director, Anesthesiology, SJMC Approved by the FHS PT&T Committee on May 13, 2011
May 2009	Jamie Billotti, PharmD, FHS Pharmaceutical Services William B. Cammarano, MD, Medical Director, Anesthesiology, SJMC Approved by the FHS PT&T Committee on May 8, 2009
May 2004	Amber O. Lienemann, PharmD, FHS Pharmaceutical Services James Stangl, MD, Prescreening Clinic (PSC) Working Group of the SJMC Anesthesia Section

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
ACNE AGENTS				
Retinoic Acid Derivative	Trifarotene Aklief®	May be continued before surgery.	No specific contraindication or interactions using this drug in the perioperative period. Avoid use on or near the surgical site.	
Topical Androgen Receptor Inhibitor	Clascoterone (Winlevi®)	Is administered as a topical agent twice daily to the affected areas of skin. No specific drug inter-actions or contraindications to using this drug in the perioperative period. Avoid surgery site. Discuss with prescribing provider.	No specific contraindications or interactions to using this drug in the perioperative period. Avoid surgery site. Discuss with prescribing provider.	

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
ALZHEIMER'S MEDICATIONS				
IgG1 Monoclonal Antibodies	aducanumab-avwa (Aduhelm)	Consult with your prescribing physician	Consult with your prescribing physician	
ANALGESIC AGENTS				
Non-selective NSAIDs	**Short $t_{1/2}$:** Ibuprofen Indomethacin Diclofenac Ketoprofen Etodolac Ketorolac **Intermediate $t_{1/2}$:** Naproxen Sulindac Diflunisal Meloxicam **Long $t_{1/2}$:** Nabumetone Piroxicam	Short half-life (2 to 6 hours): discontinue on the day before surgery Intermediate half-life (7 to 20 hours): discontinue 3 to 4 days before surgery Long half-life (>20 h): discontinue 10 days before surgery **Some physicians recommend stopping all NSAIDs 10 days before surgery*	May resume when risk of bleeding is acceptable and intravascular volume status is normal	Discontinuation 5 half-lives prior to surgery should be sufficient, except in individuals with hepatic or renal dysfunction Although some experts recommend discontinuing NSAIDs based on half-life, there's a poor correlation between COX inhibition and effects on platelet aggregation. May need to consider alternative analgesics or low-dose corticosteroids for arthritis patients who are NSAID-dependent perioperatively
COX-2 Inhibitors	Celecoxib (Celebrex®)	Stop 1-2 days before surgery, unless elimination half-life warrants earlier discontinuation **Some physicians recommend stopping 1 week before surgery*	May resume when volume status and renal function is stable	Have much less effect on platelet function than aspirin or non-selective NSAIDs Have similar effects on renal function as non-selective NSAIDs Because of lack of effect on platelet function, may not require discontinuation if benefit > risk

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Opioids	Morphine Oxycodone Fentanyl Methadone Buprenorphine Oliceridine (Olinvyk®)	Continue with minimal interruption in the perioperative period Anticipated minimal post-op pain: continue buprenorphine Moderate-severe post-op pain: if elective surgery, may consider discontinuing buprenorphine a week before surgery and transitioning to another opioid, if necessary Administered as an acute pain management agent. Recommend continuing chronic opioid regimen throughout the peri-operative period, unless reduction or discontinuation is part of the perioperative analgesic plan. Abrupt discontinuation of opioids may cause withdrawal symptoms and/or increased pain.	Intravenous preparations are available; transdermal fentanyl (Duragesic®) can also provide flexible dosing and delivery Maximize non-opioid analgesia. Resume buprenorphine once post-op pain has resolved. Administered as an acute pain management agent. Recommend continuing chronic opioid regimen throughout the peri-operative period, unless reduction or discontinuation is part of the perioperative analgesic plan. Abrupt discontinuation of opioids may cause withdrawal symptoms and/or increased pain.	When used chronically, patients are subject to physiologic and psychological dependence. Both opioids and benzodiazepines are used frequently and safely in the routine care of perioperative patients Patients on buprenorphine may present a challenge for postoperative pain control due to antagonist effect at the kappa opioid receptor. Opioids decrease bowel motility; monitor for decreased bowel motility in post-operative patients receiving opioids. Use with caution in the perioperative setting; individualize treatment when transitioning from parenteral to oral analgesics.
Urinary Analgesics	Pentosan polysulfate sodium (Elmiron®)	Hold 12 to 24 hours prior to surgery	Depending on the type of surgery, Elmiron should be re-started at physician's discretion	Elmiron is a low-molecular weight heparin-like compound with anticoagulant and fibrinolytic effect. It is a weak anticoagulant with 1/15 the activity of heparin. Bleeding complications of ecchymosis, epistaxis, and gum hemorrhage have been reported.
Antimigraine	Atogepant (Qulipta ®)	Discuss with prescribing provider	Discuss with prescribing provider	Aimovig®, Ajovy®, and Emgality® Given monthly or every three months and can likely

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Eptinezumab-jjmr (Vyepti®) Erenumab-aooe (Aimovig®) Fremanezumab-vfrm (Ajovy®) Galcanezumb-gnlm (Emgality®) Rimegepant (Nurtec ODT®) Ubrogepant (Ubrelvy®)			be held and given post-operatively when the patient is stable (non-formulary agents) Ubrelvy® Taken as needed, adverse reactions primarily consist of nausea and somnolence. Drug-drug interactions are common as this medication is metabolized by CYP3A4.
ANTICOAGULANTS				
Vitamin K Antagonists ***See Perioperative Anticoagulation Management Guidelines from the IntraNet homepage. OneNet → Resources → Anticoagulation Therapy → Perioperative or Procedural Guidelines Updated 2023*	Warfarin (Coumadin®)	Should be stopped >5 days prior to surgery if INR supratherapeutic, 5 days prior if INR therapeutic, 3-4 days if INR subtherapeutic In patients who require temporary interruption of Warfarin and whose INR is still above 1.5 one to two days prior to surgery, 2.5 mg of oral vitamin K is suggested ***See Vitamin K – INR Reversal Protocol for patients with elevated INR despite discontinuation of warfarin* ***Bridging recommendations:*	Resume warfarin on evening of or the morning after procedure or surgery The traditional management of perioperative anticoagulation, referred to as "bridging" therapy, uses preoperative and postoperative therapy with LMWH when an alternative is needed after oral anticoagulant therapy is discontinued for several days ***Bridging recommendations: see preoperative recommendations*	*Considerations:* 1. The risk of thromboembolism if anticoagulation is discontinued (the risk is related to the indication for anticoagulation as well as the postoperative risk induced by the procedure 2. Risk of bleeding if anticoagulant is continued (procedural risk and patient-specific risk) 3. Effectiveness and safety of alternative anticoagulant interventions (i.e. "bridging" therapy) Please refer to: ACCP Evidence-Based Clinical Practice Guidelines (9t Edition) [Chest **2012;141(2)(*Suppl):e*326S-*e*350S]** and 2017: ACC Expert Consensus Decision Pathway for NVAF. ***JACC* 2017;69:**

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
		*Use **therapeutic-dose** SC LMWH > IV UFH in patients with mechanical heart value, atrial fibrillation or VTE at moderate or high risk for thromboembolism*		Douketis JD, et al. (2022). Perioperative Management of Antithrombotic Therapy: An American College of Chest Physicians Clinical Practice Guideline. Chest. September 23, 2022: e1-e36.
Thrombin Inhibitor ***See Perioperative Anticoagulation Management Guidelines from the IntraNet homepage. OneNet → Resources → Anticoagulation Therapy → Perioperative or Procedural Guidelines Updated 2023*	Dabigatran (Pradaxa®)	Surgery with low/mod risk of bleeding: CrCl ≥50: discontinue ≥24 hours before surgery CrCl <50: discontinue ≥48 hours before surgery Surgery with high risk of bleeding: CrCl ≥50: discontinue ≥48 hours before surgery CrCl <50: discontinue ≥96 hours before surgery	Peak plasma level 6 hours post-surgery. Once hemostasis has been established: Low/mod post-procedural bleeding risk: wait 24 hours following procedure. If thrombotic risk is high, prophylactic dose on the evening after procedure can be considered High post-procedural bleeding risk: 48-72 hours following procedure	Extreme caution must be considered before performing neuraxial anesthesia Dabigatran should not be used for bridging warfarin due to lack of supporting literature and the perioperative bleed risk Please refer to: 2017 ACC Expert Consensus Decision Pathway for NVAF. ***JACC* 2017;69:** Douketis JD, et al. (2022). Perioperative Management of Antithrombotic Therapy: An American College of Chest Physicians Clinical Practice Guideline. Chest. September 23, 2022: e1-e36.
Unfractionated Heparin (UFH) ***See Perioperative Anticoagulation Management Guidelines from the IntraNet homepage.*	Heparin	Stop heparin infusion 4 to 6 hours prior to surgery Stop SQ heparin 6 hours prior to surgery If patient receiving UFH infusion: Stop heparin infusion at least 4-6 hours before	Restarting UFH should be done at the surgeon's discretion For minor surgical/invasive procedures or low/mod bleeding risk resume therapeutic dose UFH ~24 hours after procedure (or next day)	Establish that hemostasis has been achieved, procedure specific bleeding complications have been considered, and patient-specific bleeding have been evaluated. Observe epidural catheter limitations.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
OneNet → Resources → Anticoagulation Therapy → Perioperative or Procedural Guidelines Updated 2023		puncture/removing epidural catheter If patient receiving SubQ UFH: Stop heparin infusion at least 10 hours before puncture/removing epidural catheter	For major surgery or a high bleeding risk delay initiation for ~48 to 72 hours post-op OR administer low-dose UFH after surgery when hemostasis is secured Neuraxial Block/Epidural Catheter: If a patient received UFH infusion: heparin may be resumed 2 hours after puncture/catheter removal If a patient received prophylactic SubQ UFH, the SubQ heparin may be resumed a minimum of 2 hours after puncture/epidural catheter removal	
Low-molecular weight heparin (LMWH) ***See Perioperative Anticoagulation Management guidelines under quick-links on FHS home page*	Enoxaparin (Lovenox®) Dalteparin (Fragmin®)	*Enoxaparin and Dalteparin:* Hold prophylactic LMWH for at least 12 hours preop and therapeutic LMWH for at least 24 hours preop for either general anesthesia or regional (epidural/spinal) anesthesia. Hold first LMWH prophylactic or therapeutic dose until 4	Restarting LMWHs or Anti-Xa Inhibitors should be done at the surgeon's discretion For minor surgical/invasive procedures: resume therapeutic dose LMWH ~24 hours after procedure (or next day) and Anti-Xa Inhibitors ~6-8 hours after procedure	Please refer to: ACCP Evidence-Based Clinical Practice Guidelines (9t Edition) [Chest 2012;141(2)(*Suppl):e*326S-*e*350S]

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
OneNet → Resources → Anticoagulation Therapy → Perioperative or Procedural Guidelines Updated 2023		hours after epidural catheter removal	For major surgery or a high bleeding risk: delay initiation for ~48 to 72 hours post-op OR administer low-dose LMWH or prophylactic fondaparinux after surgery when hemostasis is secured	
Indirect Factor Xa Inhibitor ***See Perioperative Anticoagulation Management guidelines under quick-links on FHS home page* *OneNet → Resources → Anticoagulation Therapy → Perioperative or Procedural Guidelines Updated 2023*	Fondaparinux (Arixtra®)	Due to 17-hour half-life, hold at least 36 to 48 hours prior to major surgery Hold for 72 hours prior to neuraxial anesthetic. **Consult anesthesiologist	For minor surgical/invasive procedures: resume ~6-8 hours after procedure Recommended duration of bridging overlap with fondaparinux and warfarin is 5-9 days	Avoid use in spinal injury or surgery patients Extreme caution must be considered before performing neuraxial anesthesia

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Direct Factor Xa Inhibitor ***See Perioperative Anticoagulation Management guidelines under quick-links on FHS home page* *OneNet → Resources → Anticoagulation Therapy → Perioperative or Procedural Guidelines Updated 2023*	Rivaroxaban (Xarelto®) Apixaban (Eliquis®) Edoxaban (Savaysa®)	Surgery with low risk of bleeding: Rivaroxaban, apixaban: CrCl >30 ml/min: Discontinue ≥24 hours before surgery CrCl 15-29 ml/min: Discontinue ≥36 hours before surgery CrCl <15 ml/min: ≥48 hours before surgery Surgery with moderate or high risk of bleeding: Rivaroxaban, apixaban: CrCl >30 ml/min: Discontinue ≥48 hours before surgery CrCl <30 ml/min: Discontinue ≥72 hours before surgery Edoxaban: discontinue 24 hours prior to procedure	Once hemostasis has been established: Low post-procedural bleeding risk: resume DOAC within 24 hours following procedure (consider lower dose on evening of procedure) High post-procedural bleeding risk: 48-72 hours following procedure	Avoid use in spinal injury or surgery patients Extreme caution must be considered before performing neuraxial anesthesia. **The manufacturer of edoxaban does not specify the difference between standard and high-risk surgery, but for patients with high bleed risk, may consider holding ~48 hours prior to surgery due to T ½ of ~10-14 hours. Please refer to 2017 ACC Expert Consensus Decision Pathway for NVAF. ***JACC* 2017;69:**

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
ANTIEPILEPTICS				
	Brivaracetam Carbamazepine Cannabidiol Cenobomate Clobazam Eslicarbazepine Ethosuximide Gabapentin Ganaxolone Levetiracetam Lacosamide Lamotrigine Felbamate Pregabalin Phenytoin Topiramate Zonisamide Valproic acid	Continue medications during the perioperative period An antiseizure medication is typically administered for breakthrough or acute seizure If patient will be admitted after surgery and will be NPO for 24 hours, consider obtaining baseline preoperative serum drug levels if available	Continue patient's regular schedule; if oral intake is not possible, utilize intravenous preparations IV Formulations: • Levetiracetam • Fosphenytoin, phenytoin • Valproate • Phenobarbital • Lacosamide • Diazepam, lorazepam, and midazolam • Propofol (used in small doses to halt seizures in operating room)	In outpatients who have been stable on their AED regimen with a long-standing seizure-free history, there is probably no need to routinely check serum levels If patient is being treated with a drug for which there is no intravenous form and delay in postoperative oral intake is anticipated, preoperative conversion to a drug for which an intravenous form is available may be considered Levetiracetam is increasingly administered rather than phenytoin for seizure prophylaxis. • Not associated with hypotension during administration • No serum-level monitoring May increase or decrease the metabolism of some anesthetic agents, especially neuromuscular blocking agents Patients with epilepsy have an increased risk for postoperative complications
ANTIHYPERLIPIDEMICS				
Bile Acid Resins	Cholestyramine (Questran®) Colesevelam Colestipol (Colestid®)	Discontinue the day before surgery to allow for drug elimination	Resume postoperatively when patient is stable and eating a full diet	Bile sequestrants can interfere with bowel absorption of medications that may be required perioperatively

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Fibric Acid Derivatives	Gemfibrozil (Lopid®) Fenofibrate	Discontinue the day before surgery to allow for drug elimination	Resume postoperatively when patient is stable and eating a full diet	Niacin, fibric acid derivatives such as gemfibrozil, and the statins all have the potential to cause myopathy and rhabdomyolysis, especially if used in combination Muscle injury may occur during the perioperative period. Evidence suggests that HMG-CoA reductase inhibitors (statins) may prevent vascular events in the perioperative period.
Supplement	Niacin	Discontinue the day before surgery to allow for drug elimination	Resume postoperatively when patient is stable and eating a full diet	
HMG-CoA Reductase Inhibitors ("statins")	Simvastatin (Zocor®) Atorvastatin (Lipitor®) Lovastatin (Mevacor®) Rosuvastatin (Crestor®) Pitavastatin (Pivalo®) Pravastatin (Pravachol®) Fluvastatin	Continue preoperatively and throughout the hospital stay without interruption, if possible	Resume postoperatively when patient is stable and eating a full diet	
Cholesterol absorption inhibitor	Ezetemibe (Zetia®)	Discontinue the day before surgery to allow for drug elimination	Resume postoperatively when patient is stable and eating a full diet	
PCSK9 Inhibitors	Evolocumab (Repatha®) Alirocumab (Praluent®)	Can continue preoperatively Repatha $t_{1/2}$: 11-17 days Praluent $t_{1/2}$: 10-20 days	Resume postoperatively when appropriate	SQ injections given every 14 days, missed doses may be administered within 7 days of scheduled administration date
Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitor	Bempedoic acid (Nexletol®)	Discuss with prescribing provider	Discuss with prescribing provider	Usually taken in conjunction with statin therapy to lower LDL-C Warnings include hyperuricemia (gout) and risk for tendon rupture

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
				Associated with persistent changes in laboratory tests within the first four weeks of treatment, including increases in creatinine and blood urea nitrogen, decreases in hemoglobin and leukocytes, increases in platelet counts, increases in liver enzymes (AST and/or ALT), and increases in creatine kinase.
ANGPTL3 (angiopoietin-like 3) Inhibitor	Evinacumab (Evkeeza®)	Discuss with prescribing provider Monthly injection with long half-life, so if procedure not planned around next dose then limited options	Resume postoperatively when appropriate	This drug is administered IV over 60 minutes once a month, so surgeries should ideally be planned around infusion days.
ANTIHYPERTENSIVES				
ß-blockers	Atenolol Bisoprolol Carvedilol Metoprolol Propranolol	Continue preoperatively and throughout the hospital stay without interruption, if possible while weighing risks vs. benefits	Resume postoperatively Several intravenous β-blockers are available for patients who have not resumed taking oral medications when postoperative doses are due	Beta blockers may have benefits when taken perioperatively by decreasing ischemia via decreased oxygen demand and by preventing/controlling arrhythmias. Potential adverse effects of perioperative beta blockage include bradycardia and hypotension Nonselective beta blockers can interact with epinephrine, often used for infiltration anesthesia, but patients who are taking a nonselective beta blocker (eg, propranolol) chronically do not need to be switched to a beta 1 selective agent perioperatively Intravenous forms of beta blockade, such as metoprolol, propranolol, and labetalol, should be considered if the patient cannot take oral medications

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Angiotensin-Converting Enzyme Inhibitors (ACE-Inhibitors)	Lisinopril Enalapril Captopril Benazepril Ramipril Quinapril	For most patients, hold on day of procedure If patient is taking ACE-I/ARB for Heart Failure, or poorly controlled hypertension, verify with anesthesiologist to continue or not continue	Resume postoperatively as long as the patient is not hypotensive and has not suffered acute renal injury Intravenous enalaprilat may be used if the patient becomes hypertensive before resuming oral medications	Exaggeration of hemodynamic lability after induction of anesthesia has been reported with patients taking ACEIs/ARBs. While controversial, the evidence seems to support holding ACEIs/ARBs the day of surgery. It is recommended that ACE-I/ARB's be continued during perioperative phase if treating for Heart Failure, or poorly controlled hypertension to avoid further exacerbation of these conditions.
Angiotensin Receptor Blockers (ARBs)	Valsartan Irbesartan Losartan Candesartan Olmesartan			
Calcium Channel Blockers (CCBs)	Amlodipine Nifedipine Diltiazem Verapamil	Continue preoperatively and throughout the hospital stay without interruption, if possible, as long as heart rate and blood pressure are stable	Resume postoperatively Intravenous verapamil and diltiazem are available for patients who have not resumed taking oral medications when postoperative doses are due	Concerns have been raised about CCB's having increased risk of bleeding. Two large trials did not find any association. Withholding these agents for significant bradycardia or hypotension should not result in withdrawal effects.
Centrally Acting Sympatholytics	Clonidine Methyldopa Guanfacine	Continue perioperatively to avoid withdrawal effects, most significant with clonidine Avoid initiation, no benefits seen Will patient be able to take oral meds within 12 hours of preoperative dose? *If not, see next column*	If a surgical patient who is taking oral clonidine is expected to resume it within 12 hours of the preoperative dose, oral dosing may continue If more than 12 hours are expected to pass, conversion from oral clonidine to a clonidine patch *at least 3 days before surgery* should be considered	If prolonged NPO expected, then prior to surgery, discontinue the oral dose by tapering over 2 to 3 days while initiating an equivalent dose of a clonidine patch. This provides steady dosing during the conversion. Transdermal patch (Catapres-TTS) is available. Steady-state levels are achieved 2-3 days after application. Each patch is used for 7 days.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Direct Renin Inhibitors	Aliskiren (Tekturna®)	Hold on day of procedure	Resume postoperatively as long as patient is not hypotensive and has not suffered acute renal injury	Assess risk vs. benefit between hyper- and hypotensive events intraoperatively
Direct vasodilators and alpha-adrenergic blockers	Hydralazine Prazosin Terazosin	Continue perioperatively when possible	Use intravenous preparations postoperatively if blood pressure is elevated and patient is unable to resume oral intake	IV hydralazine is a potent arterial dilator and may cause reflex tachycardia Use caution with intravenous formulations as the dose required is lower than the oral dose
ANTIHYPERTENSIVES (COMBINATION)				
HCTZ/ACE-Inhibitors	Benazepril/ HCTZ (Lotensin®) Captopril/HCTZ (Capozide®)	Hold on day of procedure	Resume postoperatively as long as patient is not hypotensive and has not suffered acute renal injury Assess needs for volume overload and if patient can tolerate PO medications	Refer to HCTZ and ACE-I's
HCTZ/ARBs	Losartan/HCTZ (Hyzaar®) Valsartan/HCTZ (Diovan®)	Hold on day of procedure	Resume postoperatively as long as the patient is not hypotensive and has not suffered acute renal injury Assess needs for volume overload and if patient can tolerate PO medications	Refer to HCTZ and ARB's
ACE-Inhibitors or ARBs & CCBs	Benazepril/ Amlodipine (Lotrel®) Enalapril/ Felodipine (Lexxel®)	Hold on day of procedure	Resume postoperatively as long as the patient is not hypotensive and has not suffered acute renal injury	Refer to ACE-I's, ARB's, and CCB's

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Trandolapril/ Verapamil (Tarka®) Valsartan/ Amlodipine (Exforge®) Perindopril arginine/ amlodipine (Prestalia®)			
HCTZ/ARBs/CCBs	Olmesartan/ HCTZ/ Amlodipine (Tribenzor®) Valsartan/ Amlodipine/ HCTZ (Exforge HCT®)	Hold on day of procedure	Resume postoperatively as long as the patient is not hypotensive and has not suffered acute renal injury Assess needs for volume overload and if patient can tolerate PO medications	Refer to HCTZ, ARB's, and CCB's
HCTZ/ ß-blockers	Bisoprolol/ HCTZ (Ziac®) Metoprolol/ HCTZ (Lopressor HCT®)	Continue without interruptions	Resume postoperatively Assess needs for volume overload and if patient can tolerate PO medications	Refer to HCTZ and ß-blockers
ARBs/Direct Renin Inhibitor	Aliskiren/ Valsartan (Valturna®)	Hold on day of procedure	Resume postoperatively as long as patient is not hypotensive and has not suffered acute renal injury	Refer to ARB's and Direct Renin Inhibitor

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
CCBs/Direct Renin Inhibitor	Aliskiren/ Amlodipine (Tekamlo®) Aliskiren/ Amlodipine/ HCTZ (Amturnide®)	Hold on day of procedure	Resume postoperatively as long as patient is not hypotensive and has not suffered acute renal injury	Refer to CCBs and direct renin inhibitors
ARB/ARNI	Sacubitril/ Valsartan (Entresto®)	Hold on day of procedure	Resume postoperatively as long as the patient is not hypotensive and has not suffered acute renal injury	Refer to ARBs
ANTI-INFECTIVE AGENTS				
Aminoglycoside	Plazomicin (Zemdri®)	Continue until the time of surgery	Resume postoperatively	May cause nephrotoxicity; monitor renal function closely May cause neuromuscular blockade in patients receiving concomitant neuromuscular blocking agents and/or with underlying neuromuscular disorders
Antileishmanial/ Antiparasitic Medications	Miltefosine Abametapir (Xeglyze®) Artesunate	Continue until the time of surgery Hold for two serum half-lives prior to surgery (~1.5 hours)	Resume when the patient's GI tract is functioning properly Resume postoperatively Restart after completed wound healing.	While there are no specific recommendations, antimalarials are generally continued perioperatively due to the low risk presented in surgery. The perioperative risk of treatment with biologics is still far from clear.
Antiprotozoal and Anthelminthic	Benznidazole Moxidectin	Continue until time of surgery Consult with infectious disease specialists	Resume postoperatively Tafenoquine: resume when GI tract is functioning properly	Continue medication for duration of therapy Benznidazole: Bone marrow depression has been reported in post-marketing case reports, but frequency is not defined.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Tafenoquine (Krintafel®) Triclabendazole (Egaten®) Nifurtimox (Lampit®) Fexinidazole	Monitor for anemia	Nifurtimox: if vomiting occurs within 30 minutes of dose, repeat the same dose. If vomiting occurs within 30 to 60 minutes of dose, a half dose should be given.	The mean plasma half-life is 13 hours. Triclabendazole: Short course of therapy for fascioliasis - only 2 doses given 12 hours apart. Fexinidazole: may cause hypertension
Antifungal Agent, Azole Derivatives	Isavuconazole (Cresemba®) Oteseconazole Vivjoa®	Continue until the time of surgery	Resume postoperatively	The half-life of isavuconazole is 130 hours. The half-life of oteseconazole is 138 days. Oteseconazole is taken weekly. Based on this data, if the doses must be held for a short period of time pre- and post-operatively, this shouldn't affect overall patient exposure to the medication.
Glucose synthase inhibitor	ibrexafungerp (Brexafemme®)	Consult with ID specialist	Consult with ID specialist	
Antitubercular	Pretomanid	Continue until the time of surgery Consult with infectious disease specialists.	Resume postoperatively	Non-formulary. Consult with infectious disease specialists prior to approval. Taken in combination with bedaquiline and linezolid, which confers a risk of anemia and thrombocytopenia that may increase bleeding times.
Carbapenem	Imipenem, cilastatin, relebactam (Recarbrio®)	Continue until the time of surgery	Resume postoperatively	Non-formulary. Consult with infectious disease specialists prior to approval. May have augmented renal clearance with surgery.
H. Pylori Agent (Potassium-Competitive Acid Blockers)	Vonoprazan, amoxicillin, and clarithromycin (Voquezna®)	Continue until the time of surgery	Resume postoperatively	Contains the following three drug products: - Tablets: Vonoprazan 20 mg - Tablets: Clarithromycin 500 mg - Capsules: Amoxicillin 500 mg

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
				Vonoprazan has been shown reduce post- ESD bleeding and promote ulcer healing if used peri-operatively
Pleuromutilin	Lefamulin Xenleta®	Continue until the time of surgery and consult with infectious disease specialists	Resume postoperatively	The half-life of this medication is approximately 8 hours Continue medication for duration of therapy Non-formulary. Will have to be given as a patient own medication.
Siderophore Cephalosporins	Cefiderocol (Fetroja®)	Continue until the time of surgery	Resume postoperatively	The half-life of this medication is 2-3 hours. Primarily excreted unchanged via the kidneys; monitor renal function. May have augmented renal clearance with surgery.
Tetracycline derivatives	Seysara® Nuzyra® Xerava®	Continue until the time of surgery.	Resume postoperatively.	Non-formulary. Will have to be given as patient own medication
Antiviral (benzimidazole riboside)	Maribavir (Livtencity®)	Consult ID specialist.	Consult ID specialist.	Maribavir is a twice daily oral agent indicated for refractory or treatment of cytomegalovirus (posttransplant)
Antiviral (herpesvirus nucleoside analog DNA polymerase inhibitor)	Valacyclovir Acyclovir	Continue until the time of surgery.	Resume postoperatively.	
Antiviral (ribonucleotide analogue vRNA polymerase inhibitor)	Remdesivir (Veklury®)	Consult ID specialist.	Resume postoperatively.	Known to cause bradycardia and increase in LFTs.
Antiviral (monoclonal antibody)	Altotivimab, maftivimab, and	Consult ID specialist.	Consult ID specialist. Typically dosed as a one-time infusion.	Typically dosed as a one-time infusion. Can cause infusion-related reactions, fever, and hypotension.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	odesivimab (Inmazeb®) Ansuvimab-zykl (Ebanga®)			Consider starting postoperatively if surgery cannot be delayed.
ANTIMOTILITY AGENT				
Sodium/Hydrogen Exchanger (NHE3) Inhibitor	Tenapanor (Ibsrela®)	Medication can be taken up to the day of surgery	Resume when patient is hemodynamically stable	Medication is known to cause diarrhea and may cause dehydration among critically ill patients
Osmotic Laxatives	Lactitol (Pizensy®)	Recommend coordination of perioperative medication management plan with surgeon and prescribing providers.	Recommend coordination of perioperative medication management plan with surgeon and prescribing providers.	Lactitol may reduce the absorption of concomitantly administered oral medications. Administer oral medications at least 2 hours before or 2 hours after lactitol. Drug Not Available in US and Canada
ANTIMUSCARINICS				
Oral antimuscarinics for overactive bladder	Oxybutynin Mirabegron Vibegron (Gemtesa®)	May be continued prior to surgery.	May be continued when the patient is able to tolerate oral medications.	
ANTINEOPLASTICS				
Oral Chemotherapy Medications	Afinitor® Alecensa® Asparlas® Ayvakit® Braftovi® Calquence® Copiktra® Cotellic® Cyclophosphamide Danyelza® Daurismo® Elahere® Erleada® Etoposide Nerlynx® Ninlaro® Nubeqa® Odomzo® Orgovyx® Piqray® Pomalyst® Polivy® Qinlock® Rezlidhia® Revlimid® Retevmo® Rolzytrek® Rubraca® Rydapt®		Consult with patient's oncologist for all oral chemotherapy medications prior to surgery.	All medications confer a risk of thrombocytopenia which may increase bleeding times. Each medication should be carefully reviewed for contraindications due to surgery complications by the oncologist, surgeon, and pharmacist post-operatively once the patient is stable.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Exkivity ® Farydak® Fotivda® Gavreto® Gilotrif® Gleevec® Hydroxyurea Ibrance® Idhifa® Inrebic® Inqovi® Imbruvica® Kimmtrak® Krazati® Lenvatinib Lonsurf® Lorbrena® Lumakras® Lynparza® Lytgobi® Mekinist® Mektovi® Mercaptopurine Rylaze®	Scemblix® Sutent® Tabrecta® Tafinlar® Tagrisso® Talzenna® Tarceva® Tazverik ® Tecvayli® Tepmetko® Tibsovo® Truseltiq® Turalio® Ukoniq® Varubi® Verzenio® Vitrakvi® Vizimpro® Welireg® Xeloda® Xospata® Zejula® Zokinvy® Zydelig® Zykadia®		
Injectable Chemotherapy Medications	Arzerra® Blenrep® Beleodaq® Blincyto® Darzalex® Elzonris® Lumoxiti® Empliciti® Entyvio®	Lutathera® Margenza® Monjuvi® Onivyde® Opdivo® Opdualag® Pepaxto® Pluvicto®* Portrazza®	Consult with patient's oncologist for all injectable chemotherapy medications prior to surgery.	Many injectable chemotherapy medications are given in cycles and/or regimens, and it may be reasonable to schedule surgery after the completion of a cycle/regimen. However, one must always consult the patient's oncologist to prevent interruption in the appropriate management of the patient's disease.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Gazyva® Imjudo® Imlygic® Jemperli® Keytruda® Libtayo® Lumoxiti® Lunsumio	Poteligeo® Rybrevant® Sarclisa® Tecentriq® Tivdak ® Trodelvy® Unituxin® Uplinza® Xpovio® Yondelis® Zynlonta® *Radiopharmaceutical		
JAK Inhibitor	Pacritinib Vonjo®	Hold pacritinib for 7 days prior to elective surgery or invasive procedure	Reinitiate pacritinib only after hemostasis is established	This is due to the risk of severe hemorrhage Includes vascular procedures and cardiac cath in invasive procedures
Topical antineoplastic	Tirbanibulin (Klisyri®)	May be used prior to surgery.	Should not be applied to the treatment area until it has fully healed from surgery.	Must be applied to the face/scalp once daily for 5 consecutive days Consider finishing full treatment prior to surgery (if the face/scalp will be affected).
Ophthalmic Agent- Vascular Endothelial Growth Factor (VEGF) Inhibitor	Brolucizumab (Beovu®)	Hold for at least 28 days before intraocular surgery	Hold for at least 28 days after surgery and the wound is fully healed.	VEGF medications have the potential for arterial thromboembolic events (5%). Long half-life. Injections are given every 4 weeks initially, then increased to 12 weeks over time.
Ophthalmic Agent -	Faricimab-svoa (Vabysmo®)	Discuss with the provider, limited data.	Discuss with the provider, limited data.	VEGF medications have the potential for arterial thromboembolic events (5%).

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Vascular Endothelial Growth Factor (VEGF) Inhibitor + Angiopoietin-2 (Ang-2) inhibitor		Try to plan procedure around time of next dose (4-16 week intervals)	Try to restart medication at time of next dose (4-16 week intervals)	Long half-life. Injections are given every 4 weeks initially, then upwards of 16 weeks thereafter.
Antineoplastic / alkylating agent	Lurbinectedin (Zepzelca®)	Consult with patient's oncologist prior to surgery.	Consult with patient's oncologist prior to surgery.	Zepzelca has risk of thrombocytopenia which may increase bleeding times, especially in patients > 65 years of age. Can cause extravasation and tissue necrosis. Use should be reviewed by the oncologist, surgeon, and pharmacist if surgical complications occur post-operatively. Zelpzelca is given once every 21-day treatment cycle. It may be reasonable to schedule surgery after the completion of a cycle/regimen. However, one must always consult the patient's oncologist to prevent interruption in the appropriate management of the patient's disease.
ANTIPARKINSON AGENTS				
Adenosine Receptor Antagonist	Istradefylline (Nourianz®)	Medication can be taken up to the day of surgery	May resume when patient is able to take oral medication	Monitor for potential increase in serum glucose (1-2%)
Dopamine Precursor	Carbidopa/ Levodopa (Sinemet®)	Continue during the perioperative period, discontinuation may cause parkinsonian crisis, no IV form available	Resume medications at same doses as soon as possible. If a patient has a nasogastric tube, a levodopa/carbidopa solution can be delivered to the duodenum via a weighted feeding tube.	Without treatment, muscle rigidity increases which may complicate medical care Carbidopa/levodopa interacts with many drugs used in anesthesia, increasing the risk for arrhythmias – but the benefits of continued therapy outweigh the risks

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
			Otherwise, for patients who are NPO, there are few effective alternatives that may be given IV/IM: - trihexyphenidyl - benztropine - diphenhydramine	
Dopamine Agonists	Bromocriptine Pramipexole Ropinirole	Dopamine agonists should be discontinued the evening before surgery to avoid postural hypotension in the perioperative periods	May be restarted when the patient resumes oral intake	
Dopamine Antagonist	Amisulpride (Barhemsys®)	May be administered prior to surgery at the time of induction of anesthesia	Can be intravenously administered immediately after surgery	Causes dose- and concentration-dependent QT prolongation. Recommended to avoid with other drugs known to prolong the QT interval (e.g. ondansetron).
Monoamine Oxidase Inhibitor (MAOIs) used in Parkinson's	Selegiline (Eldepryl®) Pargyline Phenelzine Safinamide (Xadago®)	Consult anesthesiologist FLAG CHARTS to alert that patient is on an MAOI and place stickers on chart *cautioning against the use of meperidine and indirect sympathomimetics (i.e. ephedrine)*		MAO inhibition becomes non-selective in doses greater than 10 mg/day AVOID meperidine and indirect sympathomimetics (i.e. ephedrine), as these drugs may cause neuroleptic malignant syndrome**.** (Doak GH) Increased risk of serotonin syndrome in patients who receive methylene blue intraoperatively. Combination should be avoided unless benefit outweighs risk. Patients should not be forced to discontinue these agents. If discontinuation is warranted, taper off slowly over 2 weeks; but still follow recommended

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
				precautions above since discontinuation does not guarantee complete elimination
COMT Inhibitors	Entacapone (Comtan®) Opicapone (Ongentys®) Tolcapone (Tasmar®)	Continue up to the time of surgery	For patients who are NPO, there are few effective alternatives that may be given IV/IM: - trihexyphenidyl (Artane®) - benztropine (Cogentin®) - diphenhydramine (Benadryl®)	Work by extending the duration of action of levodopa No specific contraindications regarding their use perioperatively Abrupt withdrawal can cause a syndrome similar to neuroleptic malignant syndrome (as can carbidopa/levodopa)
ANTIPLATELET AGENTS				
Salicylates	Aspirin (ASA)	Preoperative decisions regarding discontinuation of aspirin administered for antiplatelet effects should be individualized and based upon conversation between the patient's surgeon, PCP, neurologist, or cardiologist. For patients at high risk for cardiovascular events (e.g. cardiac stents, CAD, DM, CHF, renal insufficiency, cerebrovascular disease) and those requiring CABG surgery it is recommended that ASA be continued through the operative period. Stop 5-10 days prior to surgery.	Resume ~24 hours after surgery (next morning) assuming risk of bleeding has diminished Prompt resumption of ASA should be considered for patients with or at high risk for atherosclerosis	Aspirin is continued preferentially in many cardiac surgeries because of its positive effects on mortality and cardiac morbidity. Preoperative use of aspirin has been shown to reduce early mortality, acute kidney failure, and MI. Widely published experience exists regarding the safety of aspirin and NSAID use in the setting of regional anesthesia *Recommend continuing dual antiplatelet therapy perioperatively in patients with coronary stents if surgery is required within 30-90 days of bare metal stent placement or within 12 months of drug-eluting stent placement. Elective surgery should not be performed during these critical periods. Patients with bare metal stents older than 30-90 days or drug-eluting stents older than 12 months should continue ASA therapy perioperatively with the exception of intracranial, ophthalmic and*

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
		Stop at least 5-10 days prior to surgery. The decision to hold aspirin earlier prior surgery sometimes depends on whether the surgery is cardiac versus noncardiac.		*intermedullary spinal cord surgery when the risk of bleeding exceeds the risk of major cardiac event from in stent rethrombosis.*
Other Antiplatelet Drugs	Vorapaxar (Zontivity®)	Preoperative decisions regarding discontinuation of antiplatelet agent should be individualized and based upon conversation between the patient's surgeon, PCP, neurologist, or cardiologist. Significant inhibition of platelet aggregation remains **4 weeks** after discontinuation due to long half-life of parent drug and active metabolite (T ½ 72-96 hours; terminal T ½ 5-13 days)	Resume ~24 hours after surgery, when hemostasis is secured	Vorapaxar is typically taken in combination with aspirin and/or clopidogrel in patients with diabetes and a history of MI. (Circulation. 2015;131(12):1047-53.) Contraindicated in patients with a history of stroke, TIA, ICH, or active pathological bleeding. The risk of bleeding is proportional to the patient's underlying bleeding risk.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Ticagrelor (Brilinta®)	Preoperative decision regarding discontinuation of antiplatelet agent should be individualized and based upon conversation between patient's surgeon, PCP, neurologist, or cardiologist. Discontinue 5 days before surgery	Resume ~24 hours after surgery, when hemostasis is secured	Do not start in patients planned to undergo urgent CABG. Maintenance doses of aspirin above 100mg reduce the effectiveness of ticagrelor In patients scheduled for neuraxial anesthesia, a discontinuation interval of 5 to 7 days is recommended to reduce the potential risk of bleeding complications Postponing cardiac surgery for at least 2 to 3 days might relevantly reduce the risk for significant perioperative bleeding *Recommend continuing dual antiplatelet therapy perioperatively in patients with coronary stents if surgery is required within 30-90 days of bare metal stent placement or within 12 months of drug-eluting stent placement. Elective surgery should not be performed during these critical periods. Patients with bare metal stents older than 30-90 days or drug-eluting stents older than 12 months should continue ASA therapy perioperatively with the exception of intracranial, ophthalmic and intermedulary spinal cord surgery when the risk of bleeding exceeds the risk of major cardiac event from in stent rethrombosis.*

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Clopidogrel (Plavix®)	Preoperative decision regarding discontinuation of antiplatelet agent should be individualized and based upon conversation between patient's surgeon, PCP, neurologist, or cardiologist. Discontinue *at least* 5-7 days before surgery. The decision to hold clopidogrel earlier prior surgery sometimes depends on whether the surgery is cardiac versus noncardiac.	Resume ~24 hours after surgery (next morning), when hemostasis is secured	Neuraxial anesthesia is relatively *contraindicated* if these antiplatelet agents are not discontinued 7-10 days preoperatively Consider discussing with surgeon and cardiologist about whether or not a loading dose of clopidogrel should be given at the time of resumption, since reinitiation of maintenance dose would take 5-10 days to attain maximal platelet function inhibition Postponing cardiac surgery for at least 2 to 3 days might relevantly reduce the risk for significant perioperative bleeding *Recommend continuing dual antiplatelet therapy perioperatively in patients with coronary stents if surgery is required within 30-90 days of bare metal stent placement or within 12 months of drug-eluting stent placement. Elective surgeries should not be performed during these critical periods. Patients with bare metal stents older than 30-90 days or drug-eluting stents older than 12 months should continue ASA therapy perioperatively.*

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Prasugrel (Effient®)	Preoperative decision regarding discontinuation of antiplatelet agent should be individualized and based upon conversation between patient's surgeon, PCP, neurologist, or cardiologist. Discontinue at least 5-7 days before surgery. The decision to hold clopidogrel earlier prior surgery sometimes depends on whether the surgery is cardiac versus noncardiac.	Resume ~24 hours after surgery, when hemostasis is secured	
Combination Drugs	Aspirin/ dipyridamole (Aggrenox®)	Stop 7-10 days before surgery	Resume after procedure or surgery when the risk of bleeding has diminished	
Phosphodiesterase Inhibitor	Cilostazol (Pletal®)	Stop at least 5 days before surgery **In patients who cannot discontinue 7-10 days in advance, stopping 3 days in advance may be acceptable*	Resume after procedure	Antiplatelet actions and vasodilatory effects When stopped, claudication symptoms may recur; symptoms should subside once cilostazol is reinitiated post-op.
ATTENTION DEFICIT HYPERACTIVITY DISORDER MEDICATIONS				
Stimulants	Amphetamine (Adzenys®, Dyanavel®, Evekeo®), Amphetamine/dextroamphetamine (Adderall®) dextroamphetamine	Continue perioperatively to avoid withdrawal effects, most significant with clonidine Will patients be able to take oral meds within 12 hours of preoperative dose? *If not, see next column* Hold the day of surgery	If a surgical patient who is taking one of these agents is expected to resume it within 12 hours of the preoperative dose, oral dosing may continue If not, resume postoperatively when patient is stable	If prolonged NPO expected, then discuss w/ prescribing provider on best management strategy to help manage withdrawal May cause cardiovascular effects (hypertension, tachycardia) May increase risk of sudden increase in blood pressure and heart rate during surgery if used in

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	(Dexedrine®, Adderall XR®) Dexmethylphenidate (Focalin®, Focalin XR®) Amphetamine sulfate (Evekeo®) Lisdexamfetamine (Vyvanse®), Serdexmethylphenidate/dexmethylphenidate (Azstarys®) Viloxazine (Qelbree®) Methylphenidate (Ritalin®, Ritalin SR®, Ritalin LA®, Concerta®, Quillivant XR®, Quillichew ER®)		There are no available IV or IM alternatives if patient is NPO	conjunction with halogenated anesthetics. Monitor vital signs closely in this setting.
Non-Stimulants	Atomoxetine (Strattera®)	Continue perioperatively to avoid withdrawal effects	May continue when able to tolerate oral medications	May cause cardiovascular effects (hypertension, tachycardia). May enhance the hypertensive and/or tachycardic effect of sympathomimetics

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
AUTOIMMUNE DISEASE AGENTS				
Complement Inhibitor	Avacopan (Tavneos®) Pegcetacoplan (Empaveli ®)	Discuss with prescribing provider	Discuss with prescribing provider	Empaveli is a twice weekly subcutaneous infusion;consider scheduling surgery around this schedule if possible
	Sutimlimab-jome (Enjaymo®)	Discuss with the provider Try to plan procedure around time of next dose (1-2 week intervals)	Discuss with the provider Try to restart medication at time of next dose (1-2 week intervals)	Dosed once weekly for 2 weeks, then every 2 weeks thereafter. Try to schedule surgery around this schedule if possible.
Monoclonal Antibody: Type I Interferon Receptor Antagonist	Anifrolumab-fnia (Saphnelo®)	No specific recommendations available, discuss with prescribing provider	No specific recommendations available, discuss with prescribing provider	May cause immunosuppression and increase risk of infections
Anti-Transthyretin Small Interfering Ribonucleic Acid (siRNA) Agent	Vutrisiran (Amvuttra®)	No specific recommendations available, discuss with prescribing provider	No specific recommendations available, discuss with prescribing provider	Dosed every 3 months Can lead to a decrease in vitamin A which may impair wound healing
BENZODIAZEPINES				
	Lorazepam Diazepam Alprazolam Temazepam Chlordiazepoxide	Continue with minimal interruption in the perioperative period IV preparations are available if needed	Resume when patient is hemodynamically stable If patient NPO, parenteral diazepam and lorazepam are available	May cause delirium in elderly patients Abrupt withdrawal can result in agitation, hypertension, delirium, and seizures
CARDIOVASCULAR MEDICATIONS				
Antianginal Medications	Nitrates Ca^{2+} Channel blockers (CCBs)	*All* antianginal medications should be *continued* in the perioperative period	Nitrates: Once-daily oral and transdermal nitrate formulations available	*Nitrates*: Transdermal nitrates may lose effectiveness if skin perfusion decreases during or after surgery

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	B blockers Ivabradine (Corlanor®)	Abrupt discontinuation of calcium channel blockers may cause vasospasm Ivabradine is used for angina as an off-label indication	CCBs: IV verapamil and diltiazem available ß-blockers: IV form available **Continue IV preparation until patient can resume regular PO medications**	*Calcium channel blockers* should be continued because there have been no major adverse reactions reported in the perioperative period – they appear safe and have theoretical benefit including reduced mortality in cardiac surgery and reduced ischemia in noncardiac surgery ß *blockers* should be continued to avoid withdrawal effects; use of β-blockers has been shown to reduce cardiovascular morbidity and mortality postoperatively in some patient populations
Cardiac Glycoside	Digoxin (Lanoxin® Digitek®)	Continue perioperatively to provide stability, especially for arrhythmias Check serum digoxin and potassium levels preoperatively if clinically indicated	Due to long half-life of digoxin, it is permissible to miss one dose If patient is unable to resume oral intake of medications, it is acceptable to give IV digoxin **When switching a patient from intravenous to oral digoxin, allowances must be made for differences in bioavailability (digoxin tablets are ~60-80% bioavailable)	Patient is at risk for digoxin toxicity due mainly to physiologic stress effects, particularly acidosis, electrolyte abnormalities (especially hypokalemia), hypoxia and increased catecholamines If a pressing reason exists *or* if the physiologic status of the patient is significantly altered, a serum digoxin level should be measured preoperatively and/or postoperatively, but generally a drug level is not required
Cardiac Myosin Inhibitors	Mavacamten (Camzyos ®)	Discuss with the provider	Discuss with the provider	Terminal half-life is ~6-9 days
Antiarrhythmics	Amiodarone Sotalol Procainamide Diltiazem Verapamil Dofetilide	Continue all antiarrhythmic agents for prevention of arrhythmias intra- and postoperatively	Cardiologist should be consulted if patient is taking an antiarrhythmic that has no alternative preparation, other than oral, and will be NPO for some time	Given the relative risk of therapy vs. that of rhythm disturbances, these drugs are usually prescribed for significant arrhythmias

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
			Multiple IV preparations available (i.e. amiodarone, diltiazem, etc.)	Hypokalemia, hypomagnesemia, and hypocalcemia can all increase risk of dangerous dysrhythmias with certain antiarrhythmic agents
Alpha-/Beta-Agonist	Droxidopa	Can be continued at physician's discretion. However, it is recommended that patients be evaluated for supine hypertension while on the medication. If supine hypertension persists and surgery requires supine positioning, droxidopa can be held approximately 8 hours prior to surgery.	Resume postoperatively.	US Black Box Warning: Droxidopa may cause or exacerbate supine hypertension. Patients who are being treated for *neurogenic orthostatic hypotension* are sensitive to catecholamines secondary to up-regulation of catecholamine receptors Short-term supine hypertension can be managed with transdermal nitrates if no contraindications exist.
Neprilysin Inhibitor/ARB	Sacubitril / valsartan (Entresto)	Refer to ARBs section above		
Transthyretin Stabilizer	Tafamidis (Vyndamax®) Tafamidis meglumine (Vyndaqel®)	Continue until time of surgery	Resume postoperatively when patient is stable and able to swallow the capsule whole	Vyndamax and Vyndaqel have not been thoroughly studied during perioperative and postoperative phases of care but does not appear to affect wound healing.
Soluble Guanylate Cyclase Stimulator	Vericiguat (Verquvo)	No specific recommendations for preoperative management exist - management strategy should be collaboratively decided between providers	No specific recommendations for postoperative management exist - management strategy should be collaboratively decided between providers	
CHOLESTATIC PRURITUS				
Ileal Bile Acid Transporter Inhibitor	Maralixibat (Livmarli ®)	No data available on discontinuation prior to surgery		Need to be administered 30 minutes before first meal of the day and patient should be seated upright or standing for a few minutes after administration.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
				If missed dose > 12 hr, omit dose and resume dosing at original dosing schedule
CKD-ASSOCIATED PRURITUS MEDICATIONS				
Kappa Opioid Receptor Agonists	Difelikefalin (Korsuva®)	Discuss with prescribing provider	Discuss with prescribing provider	This medication is administered IV at the end of each HD session. The half-life of difelikefalin in HD subjects prior to dialysis ranged between 23 and 31 hours. HD reduced the plasma concentrations by 70-80% and difelikefalin was not detectable in plasma after 2 dialysis cycles.
CORTICOSTEROIDS				
	Prednisone Methyl-prednisolone Hydrocortisone	Can be held at physician's discretion; however, it is recommended that patients continue their usual dose through the day of surgery. Possible perioperative complications include wound infections but risk is low Suggested perioperative stress corticosteroid coverage for suppressed HPA axis patients: Minor procedures or surgery under local anesthesia (eg, inguinal hernia repair): take usual morning steroid dose Moderate surgical stress (eg, lower extremity revascularization, total joint replacement): Give 50 mg hydrocortisone IV right before surgery followed by 25 mg IV every 8 hours for 24 hours	Minor to moderate surgical stress: resume home dose Major surgical stress: decrease prednisone dose by 50% per day to the usual daily dose Monitor closely for infection as glucocorticoids may suppress fever response	If a patient is taking ≥20 mg/day of prednisone or equivalent steroid for more than three weeks or on steroids for Cushing's Syndrome, perioperative coverage with hydrocortisone is necessary in accordance with magnitude of the stress. If a patient is taking doses of 5-20 mg/day or higher of prednisone or equivalent steroid, perioperative coverage with hydrocortisone may be necessary due to variability in HPA axis suppression. Suggested that the following groups do not need additional glucocorticoid coverage because of they do not have suppression of their HPA axis: ● On glucocorticoid for less than 3 weeks ● Morning doses of <5mg/day of prednisone or its equivalent for any length of time ● Doses of <10mg/day of prednisone or its equivalent every other day For patients currently off glucocorticoids but history of use in the past year, it is suggested to preoperatively assess the HPA axis beginning with checking a morning serum cortisol. Clinicians may consider withholding steroids, watching BP, and

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
		Major surgical stress (eg, esophagogastrectomy, total proctocolectomy, open heart surgery): Take usual morning steroid dose. Give 100 mg hydrocortisone IV before induction of anesthesia followed by 50 mg IV every 8 hours for 24 hours.		administering a dose of hydrocortisone if the patient develops hypotension. Steroid equivalencies: Prednisone 5 mg = Methylprednisolone 4 mg = hydrocortisone 20 mg = dexamethasone 0.75 mg
COSMETIC MEDICATIONS				
Neuromuscular Blocking Agent/Acetylcholine Release Inhibitor	Prabotulinum-toxin A-xvfs (Jeuveau®) Daxibotulinumtoxin A-lanm (Daxxify®)	Given as a one-time IM injection for glabellar lines. Given as five equal IM injections for glabellar lines Do not administer on same day as surgery	Patients may receive injection after recovery from procedure	Effects may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death.
DERMATOLOGICAL AGENTS				
Janus Kinase Inhibitor	Abrocitinib (Cibinqo®)	Discuss with the provider	Discuss with the provider	The half-life of this medication is 3-5 hours. Abrocitinib can decrease immune function thereby increase risk for infections and increase risk of thromboembolism.
DIABETIC MEDICATIONS				
Biguanide	Metformin (Glucophage®)	Hold the morning of surgery. Temporarily discontinue for 48 hours following the administration of iodine contrast media **only** in patients with acute kidney injury, severe chronic kidney disease (stage	May restart drug after procedure once patient resumes a normal diet and it is certain that no acute renal dysfunction has developed (e.g. eGFR >30); until then utilize insulin. In high-risk patients undergoing radiology	Calculate eGFR; discontinue immediately or do not resume therapy if eGFR is <30 mL/min/1.73 m^2. Assess the benefit of continuing metformin treatment in patients whose eGFR falls below 45 mL/min/1.73m^2. Metformin does not typically cause hypoglycemia unless combined with a sulfonylurea.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
		IV/V, eGFR <30) or in those undergoing arterial studies. Withhold metformin for cardiac cases and cases in which significant blood loss is expected.	procedures using contrast, wait 48 hours before resuming. Preferred inpatient treatment is insulin-only management.	Risk factors for developing lactic acidosis: - Renal impairment - CHF - Inadequate renal perfusion/hypovolemia
Sulfonylureas	*Short-acting*: Glyburide Glipizide Glimepiride *Long-acting:* Chlorpropamide (rarely used)	*Short-acting:* Hold the day of surgery *Long-acting:* Stop 72 hours before surgery	Do NOT restart until patient resumes a normal diet; until then utilize insulin Preferred inpatient treatment is insulin-only management	Potential for hypoglycemia It is imperative that patient eats regular meals when this medication is resumed A step-up approach can be used for patients on high dose sulfonylureas, starting at low doses and adjusting them until the usual dose is reached
Thiazolidinedione **"Glitazones"**	Rosiglitazone (Avandia®) Pioglitazone (Actos®)	Discontinue on the morning of surgery	Continue once patient can tolerate oral medications Preferred inpatient treatment is insulin-only management	Will not cause hypoglycemia when used as monotherapy; improves insulin sensitivity at peripheral sites and in the liver, but does not stimulate insulin release Avoid use if patients develop congestive heart failure or problematic fluid retention, or if there are liver function abnormalities
Glucagon-like Peptide (GLP-1) analogs	Exenatide (Byetta®, Bydureon®) Liraglutide (Victoza®) Dulaglutide (Trulicity®) Albiglutide (Tanzeum®)	Discontinue on the morning of surgery	Do NOT restart until patient resumes a normal diet; until then utilize insulin Preferred inpatient treatment is insulin-only management	May cause hypoglycemia when combined with a sulfonylurea It is imperative that patient eats regular meals when this medication is resumed May alter gastrointestinal (GI) motility and worsen postoperative state

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Lixisenatide (Adlyxin®)			
Dual GIP/GLP-1 receptor agonist	Tirzepatide (Mounjaro®)	Plan surgery around dosing schedule	Resume normal schedule post surgery	Steady-state plasma tirzepatide concentrations were achieved following 4 weeks of once-weekly administration. Tirzepatide is highly bound to plasma albumin (99%). The elimination half-life of tirzepatide is approximately 5 days.
Dipeptidyl Peptidase-4 Inhibitor	Sitagliptin (Januvia®) Saxagliptin (Onglyza®) Alogliptin (Nesina®) Linagliptin (Tradjenta®)	Discontinue on the morning of surgery	Do NOT restart until patient resumes a normal diet; until then utilize insulin Preferred inpatient treatment is insulin or Alogliptin ± metformin	May alter gastrointestinal (GI) motility and worsen postoperative state
α-Glucosidase Inhibitors	Acarbose (Precose®) Miglitol (Glyset®)	Discontinue on the morning of surgery	Do NOT restart until patient resumes a normal diet; until then utilize insulin Preferred inpatient treatment is insulin or Alogliptin± metformin	MUST be taken with meals for efficacy.
Amylin Analog	Symlin (Pramlintide®)	Discontinue on the morning of surgery	Do NOT restart until patient resumes a normal diet; until then utilize insulin Preferred inpatient treatment is insulin or Alogliptin ± metformin	

<table>
<tr><th>Drug Class</th><th>Examples</th><th>Preoperative Recommendations</th><th>Postoperative Recommendations</th><th>Considerations & Caveats</th></tr>
<tr><td>Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitor

“gliflozin”</td><td>Dapagliflozin (Farxiga®)
Canaglifozin (Invokana®)
Empagliflozin (Jardiance®)

Ertugliflozin (Steglatro®)</td><td>Discontinue at least three days before scheduled surgery

Discontinue at least four days before scheduled surgery</td><td>Do NOT restart until patient resumes a normal diet; until then utilize insulin

Preferred inpatient treatment is insulin or Alogliptin ± metformin</td><td>Monitor renal function postoperatively. If patient’s eGFR <45 (or <30 for Invokana and Jardiance), therapy should be held.

Not recommended in volume-depleted patients.</td></tr>
<tr><td>Anti-CD3 antibody</td><td>teplizumab-mzwv (Tzield®)</td><td>Plan surgery around dosing schedule

Given 14 day course, avoid starting treatment overlapping with a planned surgery.</td><td>Discuss with prescribing provider</td><td>Tzield is given daily for 14 days,</td></tr>
<tr><td>Insulin</td><td colspan="4">The following recommendations are for basic overview of insulin management perioperatively and do not represent comprehensive blood glucose management guidelines due to the wide variability of diabetic pathology and insulin responsiveness.
● Ideally consult anesthesiologist, endocrinologist, pharmacist or internist. May refer to CHI Franciscan Health Perioperative Glycemic Control Guidelines for more specific recommendations
● <u>Short procedure (for procedures less than two hours):</u>

<table>
<tr><th colspan="2">Day</th><th colspan="2">Glargine
Detemir
Degludec</th><th colspan="2">70/30
70/25</th><th colspan="2">NPH or U-500</th><th colspan="2">Lispro
Aspart
Glulisine
Regular</th><th>Insulin Pump</th></tr>
<tr><td colspan="2"></td><td>AM Dose</td><td>PM Dose</td><td>AM Dose</td><td>PM Dose</td><td>AM Dose</td><td>PM Dose</td><td>AM Dose</td><td>PM Dose</td><td>All Day</td></tr>
<tr><td colspan="2">Day before surgery</td><td>Usual Dose</td><td>80%</td><td>Usual Dose</td><td>Usual Dose</td><td>Usual Dose</td><td><u>Dinner:</u> Usual dose
<u>Bedtime:</u> 50%</td><td>Usual Dose</td><td>Usual Dose</td><td>Usual basal rate and boluses for carbs</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Drug Class</th><th colspan="2">Examples</th><th>Preoperative Recommendations</th><th>Postoperative Recommendations</th><th>Considerations & Caveats</th></tr>
<tr><td></td><td rowspan="2">Day of surgery</td><td>Type 1 DM</td><td>Give AM basal insulin dose as follows:
• NPH or U-500 insulin: 50% of usual AM dose at home
• Glargine/detemir/degludec: 75% of usual AM dose at home
• Pre-mixed insulin: 50% of usual AM dose at home
• Short acting: HOLD any meal bolus doses

If correction scale: treat any BG > 180 mg/dl</td><td rowspan="2"></td><td rowspan="2">75-100% of usual basal rate; no boluses

Check blood sugar q2h or sooner if you experience symptoms of hypoglycemia</td></tr>
<tr><td>Type 2 DM</td><td>Give AM basal insulin dose as follows:
• If on basal insulin and oral diabetes medications—give 50% dose of basal (NPH, U-500, glargine/detemir/degludec insulin).
• If on basal insulin and meal-time insulin (with or without oral medications)—give 75% of basal insulin and hold prandial insulin.
• Pre-mixed insulin: 30% of usual AM dose at home
• Insulin/GLP1 combinations: 50% of usual AM dose if also on other oral medications, otherwise give 75% of usual AM dose

If on correction scale, treat any BG > 180 mg/dl</td></tr>
<tr><td></td><td colspan="5">• <u>Complex procedure (e.g., open heart, complex bowel surgery) or major surgery lasting greater than two hours</u>:
o Hold previous insulin regimens. Continuous insulin infusion is recommended.

• <u>Other:</u>
o For Type 1 diabetics an insulin infusion should be strongly considered.
o It is recommended to start dextrose containing IV fluids while patients are NPO if BG drops below 150 mg/dL
o For DM patients on nutritional or meal-bolus insulin, hold this insulin until after surgery; may resume when eating well.
o After surgery, evaluate resuming basal insulin. If NPO, it is recommended to resume only 50% of total daily dose of insulin as basal. If on an insulin mix (e.g. 70/30), patients need to be eating well to resume. If not, convert them to a different basal insulin in the interim.
o As diet resumes, consider nutritional insulin when appropriate</td></tr>
<tr><td>Mineralocorticoid (Aldosterone) Receptor Antagonist</td><td colspan="2">finerenone (Kerendia®)</td><td>Consult the prescribing doctor</td><td>Consult the prescribing doctor</td><td>There are ongoing clinical studies to assess efficacy and safety</td></tr>
</table>

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
DIURETICS				
Potassium-sparing diuretics	Triamterene Amiloride Spironolactone	May continue without interruptions if clinically appropriate	Oral diuretics should be restarted if needed for control of hypertension, volume overload or when a normal diet is resumed. IV diuretics are good option until oral intake is adequate	The conversion from oral diuretics to IV diuretics is not equal *(example: furosemide 80 mg PO daily = furosemide 40 mg IV daily)* Consider refraining from taking diuretics the morning due to concern of hypovolemia or hypokalemia. Quick diuresis can be obtained via IV route if the need is discovered during surgery. Hypokalemia, caused by select diuretics, can theoretically increase the risk of perioperative arrhythmia, potentiate the effects of muscle relaxants, or provoke paralytic ileus.
Thiazide diuretics	HCTZ Metolazone	May continue without interruptions if clinically appropriate		
Loop diuretics	Furosemide (Lasix®) Torsemide (Demadex®) Bumetanide (Bumex®) Ethacrynic Acid (Edecrin®)	Continue without interruption if patient is on potassium supplement		
ELECTROLYTES				
	Potassium supplements	Consider checking potassium level Continue the day of surgery	Restart when patient on oral liquids May use IV riders to correct electrolyte disturbances if	Hypokalemia can theoretically increase the risk of perioperative arrhythmia, potentiate the effects of muscle relaxants, or provoke paralytic ileus.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
			patient is unable to tolerate PO intake	Discontinue on the day of surgery if potassium-wasting diuretics are held (i.e. furosemide, HCTZ, torsemide, budesonide, chlorthalidone, indapamide, ethacrynic acid)
ENZYME REPLACEMENT THERAPY				
Hydrolytic lysosomal glycogen-specific enzyme	Avalglucosidase alfa-ngpt (Nexviazyme®)	Discuss with prescribing provider	Discuss with prescribing provider	This medication is administered IV every two weeks. The mean plasma elimination half-life is 1.6 hours.
Recombinant Human Acid Sphingomyelinase	Olipudase alfa-rpcp (Xenpozyme®)	Discuss with hematologist/oncologist,	Discuss with hematologist/oncologist,	Adverse effects include hypersensitivity reactions, infusion associated reactions, and elevated liver function enzymes A dose is considered missed when not administered within 3 days of scheduled date
GENETIC DISORDERS AGENTS				
C-type Natriuretic Peptide	Vosoritide (Voxzogo®)	Discuss with prescribing provider	Discuss with prescribing provider	Vosoritide is a C-type natriuretic peptide that is a daily subcutaneous injection indicated for children greater than 5 years old with achondroplasia. Monitor body weight, growth, and physical development every 3 to 6 months.
GROWTH FACTOR AGENTS				
Leukocyte growth factor	eflapegrastim-xnst (Rolvedon)	Discuss with hematologist/oncologist,	Discuss with hematologist/oncologist,	Rolvedon is a subcutaneous injection given 24 hours after cytotoxic chemotherapy once for febrile neutropenia Do not administer within 14 days before to 24 hours after administration of cytotoxic chemotherapy. half life for those with breast cancer is 36.4 hours

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
HEMATOLOGIC AGENTS				
Aminolevulinate Synthase 1-Directed Small Interfering Ribonucleic Acid (siRNA)	Givosiran (Givlaari®)	Discuss with prescribing provider	Discuss with prescribing provider	Given monthly as a subcutaneous injection by healthcare provider. It is not recommended to miss monthly doses. Elevated ALT levels (3-5x ULN) have been observed within the first 3-5 months of initiating therapy. Monitor for hepatic toxicity. Monitor for signs and symptoms of anaphylaxis.
Hemoglobin S polymerization inhibitor	Voxelotor (Oxbryta®)	Continue until time of surgery	Resume postoperatively	Patients with sickle cell disease should be assessed for serum hemoglobin levels prior to surgery. Half-life of this drug is 35.5 hours, so minor interruptions in therapy will not impact treatment. Voxelotor may interfere with high-performance liquid chromatography measurement of Hb subtypes (HbS, HbF, HbA).
Monoclonal antibody; Anti-P-selectin	Crizanlizumab (Adakveo®)	Can continue up to the month of surgery	Resume postoperatively on regularly scheduled administration day	This drug is administered IV over 30 minutes once a month, so surgeries should ideally be planned around infusion days. Crizanlizumab may falsely decrease platelet counts, particularly when collected in tubes with ethylenediaminetetraacetic acid (EDTA). Collect blood samples in citrate-containing tubes and run samples within 4 hours of collection. Half-life of drug is 7.6 days.
HEMATOPOIETIC AGENTS				
Activin Receptor Ligand Trap	Luspatercept (Reblozyl®)	Consult with hematology specialists.	Resume postoperatively	Non-formulary. Thromboembolism risk – use with caution in patients with known thrombotic risk. Monitor closely.
Anti-Von Willebrand Factor;	Caplacizumab (Cablivi®)	Hold for 7 days prior to invasive procedure, dental procedures and elective surgeries.	Resume postoperatively after risk of surgical bleeding has resolved.	Caplacizumab increases the risk of bleeding; bleeding events are common. Severe bleeding events (epistaxis, gingival bleeding, UGIB, metrorrhagia) were reported

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Monoclonal Antibody				in clinical trials. Monitor closely for signs and symptoms of bleeding if caplacizumab is restarted.
Colony-Stimulating Factors	Lusutrombopag (Mulpleta®)	Begin medication 8 – 14 days prior to scheduled procedure. **3 mg daily for 7 days** Undergo procedure 2-8 days after the last dose	Not indicated postoperatively	Do not use to normalize platelet counts in patients with chronic liver disease. Obtain platelet count prior to therapy administration and no more than 2 days before procedure Thromboembolism risk – use with caution in patients with known thrombotic risk and patients with chronic liver disease. Monitor closely.
Cyclin-dependent kinases (CDK)4/6 inhibitor	Trilaciclib (Cosela®)	Discuss with prescribing provider	Discuss with prescribing provider	Trilaciclib is used to decrease the incidence of chemotherapy-induced myelosuppression in adult patients when administered prior to a platinum/etoposide-containing regimen or topotecan-containing regimen for extensive-stage small cell lung cancer
Mono-pegylated interferon alfa-2b	Ropeginterferon alfa-2b-njft (Besremi®)	Discuss with prescribing provider	Discuss with prescribing provider	Ropeginterferon alfa-2b-njft is a biweekly subcutaneous injection indicated for polycythemia vera. Interferon alfa products may cause or aggravate fatal or light-threatening neuropsychiatric, autoimmune, ischemic, and infectious disorders.
Oral Iron Replacement	Ferric maltol (Accrufer®)	Continue during perioperative period	Continue during postoperative period	If patient is NPO, can consider IV iron formulations, if necessary for iron deficiency anemia and concerns for surgery recovery: ● Ferric carboymaltose ● Ferric gluconate ● Iron sucrose

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Tyrosine Kinase Inhibitor	Fostamatinib (Tavalisse®)	Continue during perioperative period	Continue during perioperative period	Fostamatinib is utilized for chronic immune thrombocytopenia. Monitor CBC and ensure patient's platelet levels are adequate to proceed with surgery.
	deucravacitinib (Sotyktu)	Discuss with prescribing provider,	Discuss with provider	Deucravacitinib is tyrosine kinase 2 inhibitor used for mod-severe plaque psoriasis in those who need systemic therapy or phototherapy. Dosed PO once daily
Thrombopoietin receptor agonist	Avatrombopag (Doptelet®)	Begin therapy 10 to 13 days prior to the scheduled procedure for 5 days. Patients should undergo procedure 5 to 8 days after the last dose.		Platelet count should be obtained prior to therapy initiation and on the day of the procedure.
Pyruvate Kinase Activator	Mitapivat (Pyrukynd®)	Discuss with provider, avoid dosing interruptions	Discuss with provider, avoid dosing interruptions	Avoid abrupt interruption or abrupt discontinuation to minimize the risk of acute hemolysis. A gradual reduction in dosing rather than abrupt cessation is recommended when possible. Oral medication given twice daily unless tapering off.
HERBAL SUPPLEMENTS				
Echinacea		No data on discontinuation		Echinacea is associated with allergic reactions and immune stimulation. There is potential to decrease metabolism of certain perioperative medications such as cyclosporine, midazolam, lidocaine, and CCBs.
Ephedra (ma huang)		Discontinue at least 24 hours before surgery		Ephedra may increase the risk of heart attack, seizure, stroke, and psychosis.
Garlic		Discontinue at least 14 days before surgery	Herbal supplements are not part of hospital formulary. Patients must bring their own supply if continuation after surgery is indicated.	Garlic irreversibly inhibits platelet aggregation in a dose-dependent manner, which may increase risk of bleeding Garlic may lower blood pressure, along with fasting blood glucose levels in patients with diabetes.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Gingko biloba		Discontinue at least 14 days before surgery		Gingko may cause inhibition of platelet-activating factor, which increases risk of bleeding after surgery
Ginseng	American Ginseng Asian Ginseng	Discontinue at least 14 days before surgery		Ginseng may cause hypoglycemia, tachycardia, and hypertension. It may also irreversibly inhibit platelet aggregation.
Kava		Discontinue at least 14 day before surgery		Kava may increase sedative effect of anesthetics by potentiating GABA inhibitory neurotransmission.
St. John's Wort		Discontinue at least 14 days before surgery		St. John's Wort is known to cause an increase in metabolism of certain perioperative medications such as cyclosporine, midazolam, lidocaine, and CCB.
Valerian		Discontinue at least 14 day before surgery Ideally tapered weeks before surgery; if not withdrawal is treated with benzodiazepines.		Valerian may increase the sedative effect of anesthetics and can be associated with benzodiazepine-like withdrawal.
All other unlisted herbals and Vitamin E supplements	Black Cohosh Chamomile CoQ10 Feverfew Ginger Goldenseal Saw Palmetto	Discontinue at least 14 days prior to surgery. There are some recommendations to avoid all supplements at least 7 days prior to surgery.		Various coagulation disorders, sedation, hemodynamic changes, electrolyte disturbances, and other unknown complications.
HEPATITIS C MEDICATIONS				
NS3/4A Protease Inhibitors (PIs)	Sofosbuvir (Sovaldi®) Simeprevir (Olysio®) Ledipasvir/ Sofosbuvir	Discuss with prescribing provider. If DAA therapy needs to be withheld, all components of the regimen should be stopped.	Discuss with prescribing provider. If DAA therapy was withheld, resume all drugs together in full doses when the patient's GI tract is functioning properly	Prevention of drug resistance is paramount and irregular dosing should be avoided Elective surgeries should not be performed on patients with active HCV medications, indicating active HCV

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	(Harvoni®) Ombitasvir/ Paritaprevir/ Ritonavir/ Dasabuvir (Viekira Pak®) Glecaprevir/ pibrentasivir (Mavyret™) Sofosbuvir/ velpatasvir/ voxilaprevir (Vosevi®) Elbasvir/grazopr evir (Zepatier®)			There is potential for fatal drug interactions between steroids and other CYP3A4-metabolized drugs; consult pharmacist if concomitant use
NS5A Inhibitors	Daclatasvir (Daklinza) Or in combinations seen above	Discuss with prescribing provider.	Discuss with prescribing provider.	Elective surgeries should not be performed on patients with active HCV medications indicating active HCV
Pegylated Interferon Alfa	Pegasys®	Discuss with prescribing provider.	Discuss with prescribing provider.	Elective surgeries should not be performed on patients with active HCV medications indicating active HCV
Nucleoside Analogs	Ribavirin	Discuss with prescribing provider.	Discuss with prescribing provider.	Elective surgeries should not be performed on patients with active HCV medications indicating active HCV
HIV MEDICATIONS				
Antiretrovirals	Abacavir Atazanavir Bictegravir Cabotegravir Cobicistat	Continue through perioperative period with as little interruption as possible. For patients who are not able to	Resume all drugs together, in full doses, when the patient's GI tract is functioning properly	Prevention of drug-resistance is paramount and irregular dosing should be avoided. It is crucial to continue ART, particularly in patients who are co-infected and being actively treated with ART for hepatitis B virus (HBV).

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Darunavir Didanosine Dolutegravir Doravirine Efavirenz Elvitegravir Emtricitabine Enfuvirtide Etravirine Fosamprenavir Fostemsavir (Rukobia®) Ibalizumab-uiyk Indinavir Lamivudine Lopinavir Maraviroc Nelfinavir Nevirapine Raltegravir Rilpivirine Ritonavir Saquinavir Stavudine Sunlenca Tenofovir Tipranavir Zidovudine	receive medications orally, a temporary period of holding ART will be necessary. If ART needs to be withheld, all components of the regimen should be stopped.		CYP3A4 inhibitors/inducers may affect the metabolism of both ART and commonly used anesthetic drugs. This can lead to increased or decreased drug concentrations allowing for potential ART drug resistance. Prolonged midazolam effects have been observed with some antiretroviral medications. Protease inhibitors (E.g., atazanavir, darunavir, indinavir, ritonavir) decrease midazolam metabolism, leading to prolonged sedation and respiratory depression
HORMONES				
Oral Contraceptives (OCs)	Estrogen Progestin	Final decision should be based upon the clinical judgment of the anesthesiologist, consulting surgeon, or prescribing physician.	If decision is *not* to discontinue OCs, then continue perioperatively without interruption; however, patient	The risk of thrombosis increases within four months of initiation and decreases to previous levels within three months of stopping treatment. Therefore, it may be wise to stop OCs at least 4-6 weeks before surgery – especially for high-risk surgeries (such as major

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
		Low to moderate risk of VTE: May continue up to and including the day of surgery for procedures with low to moderate risk of venous thromboembolism. High risk of VTE: Discontinue 4 to 6 weeks before surgery for procedures with high risk of venous thromboembolism. Instruct on alternate forms of contraception and obtain serum pregnancy test immediately before surgery if OC is held. Consider DVT prophylaxis for major/high-risk surgery If the plan is to continue OC therapy during hospital stay, then patient must bring their own, since hospital will not provide OCs	must bring own OCs (hospital will not supply OCs) If OCs were discontinued preoperatively, resume when the period of elevated risk or postoperative immobility has passed and patient experiences first menstruation cycle. Some OC manufacturer package inserts recommend restarting 2 weeks after major surgery.	orthopedic surgeries). Instruct on alternate forms of contraception and obtain serum pregnancy test immediately before surgery if OC is held. The medical risks of unanticipated pregnancy may outweigh the increased protection of VTE. Estrogen is the major hormonal risk for the increased risk of VTE, but progestin may also play a role. Oral contraceptives with greater estrogen content (≥35 mcg) have a higher risk of thromboembolism compared with those with lower estrogen content (≤30 mcg).
Hormone Replacement Therapy (HRT)	Alora® Angeliq® Climara® Climara Pro® Combipatch® Delestrogen® Duavee® Estraderm® Estrasorb®	Final decision should be based upon the clinical judgment of the anesthesiologist, consulting surgeon, or prescribing physician. Continue up to and including the day of surgery for procedures	Resume when tolerating oral medications and the period of elevated risk or postoperative immobility has passed.	Major concern related to the perioperative period is for increasing the risk of venous thromboembolism (VTE). It is most prudent to discontinue HRT since the risks of stopping therapy are very small, however, comfort issues can exist if HRT is discontinued preoperatively.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Femring® Osphena® Prefest® Prempro® Premarin® Vivelle®	with low to moderate risk of venous thromboembolism. When possible, discontinue 4 to 6 weeks before surgery for procedures with high risk for thromboembolism. Consider DVT prophylaxis for major/high-risk surgery		May consider discontinuing therapy *at least* 4 weeks or more before any major surgery if patient is at high-risk for VTE. The Heart and Estrogen/progestin Replacement Study (HERS) convincingly demonstrated that hormone replacement therapy increases risk of VTE. Risks increase with lower-extremity fractures, inpatient surgery and non-surgical hospitalizations (increased risk for up to 90 days).
Alpha-Melanocyte Stimulating Hormone Analog	Afamelanotide (Scenesse)	Do not administer on the same day of surgery	Patients may receive injection after recovery from procedure	Adamelanotide is administered as an implant every 2 months. Apparent half-life is 15 hours and may undergo hydrolysis, however its metabolic profile has not been fully characterized.
Growth hormone	Somapacitan-beco (Sogroya®) Lonapegsomatropin-tcgd (Skytrofa®)	Recommend coordination of perioperative medication management plan with surgeon, anesthesiologist, and prescribing provider.	Recommend coordination of perioperative medication management plan with surgeon, anesthesiologist, and prescribing provider.	These medications are contraindicated in acute critical illness after open-heart surgery, abdominal surgery or multiple accidental trauma, or those with acute respiratory failure because of the risk of increased mortality with use of pharmacologic dose of somapacitan-beco or lonapegsomatropin-tcgd.
Melanocortin receptor antagonist	Setmelanotide (Imcivree®)	Can continue preoperatively	Resume postoperatively when appropriate	If a dose is missed, resume the once daily regimen as prescribed with the next scheduled dose.
SMALL MOLECULES				
Antilipemic Small Interfering Ribonucleic Acid (siRNA) Agent	Inclisiran (Leqvio®)	No specific recommendations. Discuss with surgeon, anesthesiology and prescribing provider	No specific recommendations. Discuss with surgeon, anesthesiology and prescribing provider	Missed doses can be given w/in 3mo of the intended date without disruption of dosing schedule

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Hydroxyacid oxidase 1 (HAO1)-directed small interfering ribonucleic acid (siRNA)	Lumasiran (Oxlumo®)	Can continue preoperatively	Resume postoperatively when appropriate	If a dose is delayed or missed, administer as soon as possible. Resume prescribed monthly or quarterly dosing from the most recently administered dose.
Ileal Bile Acid Transporter Inhibitor	Odevixibat (Bylvay®)	No specific recommendations. Discuss with surgeon, anesthesiology and prescribing provider	No specific recommendations. Discuss with surgeon, anesthesiology and prescribing provider	
HYPNOTICS & SLEEP AIDS				
Benzodiazepines (Short Acting)	Temazepam Triazolam	If taken more than 8 hours prior to anesthesia or used chronically, patient may have a dose the night before surgery If elderly (greater than 65 years old) consult physician or anesthesiologist IV alternatives for benzodiazepines may be available if patient is NPO	Resume when patient is hemodynamically stable postoperatively	Abrupt withdrawal of chronic benzodiazepines may lead to consequences such as agitation, hypertension, delirium, and seizures; must evaluate risk vs. benefit in individual patients. Since hypnotics are sometimes dosed prior to surgery, anesthesiologist should be informed if patient has taken hypnotic the night before
Benzodiazepines (Long Acting)	Estazolam Flurazepam Quazepam			
Non-Benzodiazepine Hypnotics	Eszopiclone Zolpidem Zopiclone Zaleplon			
Melatonin and Melatonin Receptor Agonists	Melatonin Bremelanotide (Vyleesi ®) Ramelteon (Rozerem®) Tasimelteon (Hetlioz®)			
Orexin Receptor Antagonist	Suvorexant (Belsomra®)	Not enough data to support use prior to surgery. Recommend holding bedtime dose the night prior to operation		Medication has a half-life of up to 12 hours and residual levels of drug can remain in the blood well after waking

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Daridorexant (Quviviq®)			Medication has a half-life of up to 8 hours and residual levels of drug can remain in the blood well after waking
LONG-CHAIN FATTY ACID OXIDATION DISORDER MEDICATION				
Anaplerotic agent; nutritional supplement	Triheptanoin (Dojolvi®)	Not enough data to support use prior to surgery. Recommend consulting prescribing doctor to devise a perioperative plan.	Not enough data to support use prior to surgery. Recommend consulting prescribing doctor to devise a perioperative plan	Pancreatic insufficiency: Avoid use in patients with pancreatic insufficiency; reduced absorption leading to insufficient supplementation of medium-chain fatty acids may occur. Do not use DOJOLVI in feeding tubes made of polyvinyl chloride (PVC). Monitor the feeding tube to make sure it is working properly.
MOLYBDENUM COFACTOR DEFICIENCY MEDICATIONS				
Molybdenum Cofactor Deficiency Type A	Fosdenopterin (Nulibry®)	Discuss with prescribing provider	Discuss with prescribing provider	
MULTIPLE SCLEROSIS MEDICATIONS				
Disease Modifying Agents	Aubagio® Avonex® Betaseron® Copaxone® Extavia® Fingolimod (Gilenya®) Glatopa® Interferon (Rebif®) Lemtrada®	Consult prescribing doctor to devise a perioperative plan.	Consult prescribing doctor to devise a postoperative plan.	Cardiotoxicity and hepatotoxicity are possible side effects with Gilenya®, Novantrone® (mitoxantrone), Ponvory®, and Zeposia®. Preoperative EKG is recommended. Novantrone® (mitoxantrone), Rebif®, Tysabri®, and Zinbryta®: monitor closely surrounding surgery. Preoperative clinical examination is recommended. Lemtrada® can cause severe, life-threatening autoimmune conditions, such as immune

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Mitoxantrone® (Novantrone®) Ocrevus® Ozanimod (Zeposia®) Plegridy® Ponvory® Relyvrio® Siponimod (Mayzent®) Tecfidera® Tysabri® Zinbryta®			thrombocytopenia and anti-glomerular basement membrane disease. Monitor CBC with differential and SCr closely. Respiratory function decreases have been reported with Gilenya®, Mayzent®, Ponvory®, and Zeposia®. Careful preoperative lung auscultation examination is recommended. ***All drugs decrease immune function and increase risk for infections*** ***Agents are typically recommended to be stopped 1 – 2 weeks before a procedure and resumed 1 – 2 weeks after surgery to lower the risk of surgical site infections; consult with orthopedics and rheumatology regarding specific medications***
Monoclonal Antibody CD20	ublituximab-xiiy (Briumvi)	Consult prescribing doctor to devise a perioperative plan	Consult prescribing doctor to devise a postoperative plan	There have not been adequate studies to assess its use preoperatively and postoperatively.
MUSCULAR DYSTROPHY				
Antisense Oligonucleotide	Golodirsen (Vyondys 53) Viltolarsen (Viltepso®) Casimersen (Amondys 45)	Administered as an injection once weekly Recommend to not administer on the same day of surgery due to risk of injection site reactions and ability to heal. Recommend coordination of perioperative medication management plan with surgeon, anesthesiologist, and prescribing provider.	No specific contraindications related to resuming postoperatively. Recommend to avoid injection in surgical sites.	Golodirsen has an accelerated approval in December 2019 for Duchenne muscular dystrophy. There have not been adequate studies to assess the use of antisense oligonucleotide preoperatively and postoperatively.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Survival of Motor Neuron 2 (SMN2)-Directed RNA Splicing Modifier	Risdiplam (Evrysdi®)	Administer at same time as home dosing. Must administer ≤6 hours from home dosing; therefore, if surgery is required, schedule dosing around surgery if possible. If patient is unable to swallow, dose may be administered through a nasogastric or gastrostomy tube. Flush tube with water following administration.	May resume after surgery. If > 6 hours since usual administration, skip missed dose and administer next dose at usual administration time the next day	There have not been adequate studies to assess its use preoperatively and postoperatively.
MYASTHENIA GRAVIS (MG) MEDICATIONS				
Acetylcholinesterase Inhibitors	Pyridostigmine (Mestnion®) Neostigmine (Prostigmin®)	Continue the morning of surgery to prevent muscle weakness that could impair weaning from mechanical ventilation and surgical recovery	Intravenous preparations of these drugs at 1/30 the oral dose are given every 4 to 6 hours when surgery begins and are continued until the patient resumes oral intake	Note: Acetylcholinesterase inhibitors may diminish effects of non-depolarizing NMBA while increasing effects of succinylcholine. Succinylcholine should be avoided due to risk of prolonged neuromuscular blockade.
Glucocorticoids	Prednisone Dexamethasone Prednisolone	Continue regimen if: any dose <3 weeks, morning prednisone <5 mg (or equivalent) for any duration, or <10 mg prednisone (or equivalent) every other day are not at risk for HPA suppression Stress-dose glucocorticoids should be administered prior to induction for patients who have been taking prednisone 20 mg or greater (or equivalent) for >3 weeks		Patients whose treatment for MG includes glucocorticoids may be at risk for hypothalamic pituitary axis suppression (HPA) and adrenal insufficiency in the perioperative period, and may require administration of stress-dose glucocorticoids, depending on the surgical procedure

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Immunotherapy	Azathioprine Cyclophosphamide Cyclosporine Methotrexate Mycophenolate Rituximab Tacrolimus Voclosporin (Lupkynis®) Belumosudil (Rezurock®)	No published data Consult patient's neurologist IV cyclosporine and azathioprine are available Perioperative therapy interruptions are not likely to have significant symptomatic effect for this indication	Consult patient's neurologist	Voclosporin is newly approved as of January 2021; currently no data to recommend perioperative management. These agents may cause immunosuppression and increase risk of infections
Neonatal Fc Receptor Antagonist	efgartigimod alfa-fcab (Vyvgart®)	No recommendations from manufacturer - discuss with ordering physician	No recommendations from manufacturer - discuss with ordering physician	This medication is given week;ly; if able, plan surgery around these infusions If a dose is missed for surgery, administer as soon as possible within 3 days after the missed dose
OSTEOPOROSIS AGENTS				
Selective Estrogen Receptor Modulators	Tamoxifen Raloxifene (Evista®)	Stop at least 4 weeks before surgery to prevent thrombotic risk, UNLESS these drugs are being used to treat breast cancer, if so – contact an oncologist. May be continued for low-risk surgeries.	Resume when period of postoperative immobilization has passed (non-oncologic surgeries)	Have either estrogen receptor agonist or antagonist effects, depending on the tissue in which they are acting Both quantitatively increase the risk of VTE, similar to estrogen
Bisphosphonates	Alendronate (Fosamax®) Ibandronate (Boniva®) Risedronate (Actonel®)	Hold day of surgery Discontinue agents for 3 months before elective dental surgery, if bisphosphonate treatment exceeds 3 years or if glucocorticoids are used	Recommendation to hold this medication postoperatively Dental surgery: hold 3 months following surgery	Given the difficulty for hospitalized patients to comply with the requirement to remain upright for 30 min and take with a full glass of water, it is more practical to withhold this medication

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Calcitonin	Miacalcin® (nasal spray)	May be continued before surgery	No specific contraindications or interactions to using this drug in the perioperative period	
Monoclonal Antibody	Romosozumab (Evenity®) Denosumab (Prolia®)	Osteoporosis agents are generally recommended to be discontinued preoperatively due to the increased risk for perioperative adverse outcomes. May cause osteonecrosis of the jaw. Dentists or oral surgeons should be consulted prior to dental procedure and discontinue treatment based on risk / benefit assessment.		Administered subcutaneously once monthly for 12 months; anabolic effects wane after 12 months of use.
PHARMACOLOGIC CHAPERONE				
Fabry's Disease	Migalastat (Galafold®)	Discuss with prescribing provider	Discuss with prescribing provider	Note: may continue throughout perioperative period
PSORIASIS MEDICATIONS				
Aryl Hydrocarbon Receptor Agonist	Tapinarof (Vtama®)	Can continue up to day of surgery	May be used preoperatively-avoid surgical site until fully healed	Comes in a cream formulation only
DMARDs, PDE-4 Inhibitors	Otezla® (apremilast)	Discuss with providers prior to surgery as apremilast may increase risk of infection	Discuss with providers prior to surgery	Conflicting data were found regarding whether apremilast should be held per- and post-surgery.
Topical Corticosteroid	Calcipotriene and betamethasone dipropionate (Enstilar®)	May be continued before surgery	No specific contraindications or interactions to using this drug in the perioperative period. Avoid surgery sites.	

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
IgG monoclonal antibody	Brodalumab (Siliq®) Guselkumab (Tremfaya®) Risankizumab (Skyrizi®) Secukinumab (Cosentyx®) Tildrakizumab (Ilumya®) Ustekinumab (Stelara®)	Biologic agents are commonly recommended to be STOPPED prior to surgery and recommended that surgery is scheduled at the end of the dosing cycle.	Discuss with the prescribing provider.	Most are given weekly to monthly and can likely be held and given postoperatively when the patient is stable. Risankizumab may increase risk of infections (22% of patients experienced infection in clinical trials). RESUME medications ≥4 days after surgery as long as the patient is not experiencing wound healing problems, surgical site infection(s), or systemic infection.
Interleukin-13 Antagonist; Monoclonal Antibody	Tralokinumab-ldrm (Abdry®)	No recommendations from manufacturer - discuss with ordering physician	No recommendations from manufacturer - discuss with ordering physician	This medication is dosed every 2 to 4 weeks; if able, plan surgery around these injections If a dose is missed for surgery, administer the missed dose as soon as possible, then resume dosing at the regular scheduled time
Interleukin-36 Receptor Antagonist: Monoclonal Antibody	Spesolimab-sbzo (Spevigo®)	Discuss with prescribing provider	Discuss with prescribing provider	Adverse effects include increase the risk of infections, tuberculosis, and hypersensitivity
Please see Rheumatoid Arthritis section for other medications used for psoriasis				
PSYCHIATRIC MEDICATIONS				
$GABA_A$ Receptor Positive Modulator	Brexanolone (Zulresso®)	No compelling reason to avoid brexanolone within a certain time frame of surgery. Postpone surgery until continuous infusion is complete.	May give brexanolone after surgery.	Brexanolone is given as a continuous IV infusion over 60 hours for postpartum depression. REMS program associated with use. Major side effects: Excessive sedation and hypoxia. Monitor patients closely.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
		Can interrupt infusion if needed and resume later. Lack of data on how long "interruption" can be.		
Anorexiants	Bupropion/ naltrexone (Contrave®)	Hold Contrave for at least 24 hours prior to surgery (due to naltrexone's 5-hour half-life) but ideally for up to 48 hours prior to surgery to allow for complete cessation of opioid antagonism	Resume Contrave 7 days after cessation of opioid therapy	Continue the bupropion component of Contrave during the perioperative period. Naltrexone component is an opioid antagonist and there are case reports of patients on Contrave having inadequate pain control post-operatively. If Contrave is not held >24 hours prior to surgery, monitor patient's response to opioids and be prepared to decrease opioid doses once naltrexone is eliminated from body/opioid antagonism is overcome.
Tricyclic Antidepressants (TCAs)	Amitriptyline Nortriptyline Imipramine Desipramine	May be continued preoperatively with caution Continue therapy up to and including day of surgery for patients on high doses. Patients on low doses and in whom perioperative arrhythmia is a concern should be tapered off 7-14 days prior to surgery. May increase anesthetic requirement due to inhibition of reuptake of norepinephrine.	May restart when patient is tolerating oral medications	**If hypotension is encountered, and a vasopressor is needed, the response to therapy may be difficult to predict** Most authors recommend cautious continuation of these agents through the perioperative period, since serious perioperative problems attributed to TCAs are rare. Increased risk of serotonin syndrome in patients who receive methylene blue intraoperatively. Combination should be avoided unless benefit outweighs risk. Continuation may increase the potential for arrhythmias. Close monitor of ECG for arrhythmias is recommended. Abrupt withdrawal can lead to insomnia, nausea, headache, increased salivation, and increased sweating.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
SSRIs (including agents with partial SSRI activity), SNRIs	Fluoxetine (Prozac®) Escitalopram Sertraline Paroxetine (Paxil®) Venlafaxine Duloxetine Vortioxetine (Trintellix®)	No compelling indications to withhold SSRIs perioperatively Discontinue therapy 3 weeks prior to surgery in patients undergoing high bleed risk procedures (such as certain CNS procedures)	Restart once patient can take oral meds – mainly agents that may result in a withdrawal syndrome after discontinuation (i.e., paroxetine and venlafaxine) Recommend alternative therapy if patient requires antiplatelet agents as secondary prevention	There have been reports of serotonin syndrome after concurrent use with other serotonergic agents such as tramadol (Ultram®); may also increase INR if patients are on warfarin Increased risk of serotonin syndrome in patients who receive methylene blue intraoperatively. Combination should be avoided unless benefit outweighs risk.
Monoamine Oxidase Inhibitor (MAOIs)	Selegiline (Eldepryl®) Pargyline Phenelzine	Consult anesthesiologist & psychiatrist FLAG CHARTS to alert that patient is on an MAOI and place stickers on chart *cautioning against the use of meperidine and indirect sympathomimetics (i.e. ephedrine)* Make every effort to continue perioperatively since patients on MAOIs tend to have severe depression refractory to other agents In patients with severe, life-threatening depression, in whom the risk of suicide with discontinuation of MAOIs is significant, consideration should be given to continuing MAOI therapy perioperatively combined with an appropriate anesthetic technique		MAO inhibition becomes non-selective in doses greater than 10 mg/day AVOID meperidine and indirect sympathomimetics (i.e. ephedrine) may cause neuroleptic malignant syndrome and severe hypertensive crisis**.** (Doak GH) Patients should not be forced to discontinue these agents If discontinuation is warranted, taper off slowly over 2 weeks; but still follow recommended precautions above since discontinuation does not guarantee complete elimination Increased risk of serotonin syndrome in patients who receive methylene blue intraoperatively. Combination should be avoided unless benefit outweighs risk.
Antipsychotics	Olanzapine (Zyprexa®)	May continue perioperatively if QTc remains stable.	Make sure to restart medication once patient is able to take oral medications	Alpha-adrenergic blockade with risperidone can be significant

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Ziprasidone (Geodon®) Risperidone (Risperdal®)	May need to consider holding dose after consultation with a psychiatrist or utilizing agents with shorter half-life or reduced dose if medications that can prolong QTc are used during or after surgery.	Parenteral formulations are available for haloperidol, chlorpromazine, aripiprazole, olanzapine, and ziprasidone if therapy is needed but patient is NPO.	There have been reports of IV use of antipsychotics increasing risk of sedation, hypotension, or QTc prolongation. Atypical antipsychotics may increase risk of tachycardia Avoid ketamine use as this may decrease the seizure threshold
Combination Antipsychotics	Olanzapine + samidorphan (Lybalvi®)	Discontinue at least 5 days before opioid treatment and start olanzapine or another antipsychotic if needed.		The potential safety concerns related to samidorphan's opioid antagonist effects in various real-world settings of opioid use warrant careful consideration. Concerns include the potential for opioid withdrawal, inadequate analgesia, and opioid overdose.
Mood Stabilizer	Lithium (Lithobid®) Valproate (Depakote®)	May be continued preoperatively. If patient undergoing major surgery, consider discontinuation 2-3 days before If medically indicated. If serum levels are not in toxic range, renal function is normal and fluid/electrolyte levels are stable, lithium may be continued before minor surgery.	Serum drug levels should be monitored before and after surgery and any time that renal clearance may be affected	Lithium may potentiate the effect of depolarizing and competitive neuromuscular blocking agents Assess risk vs benefit of holding medication in patients with a history of psychosis. If patient stable, may disrupt mental state Lithium may require increased monitoring of fluid, electrolyte, and thyroid hormone levels
Other Commonly Used Antidepressants	Bupropion (Wellbutrin®) Venlafaxine (Effexor®)	No compelling indications to withhold preoperatively	Restart once patient can take oral medications	These agents do not have any known interactions with anesthetic agents Venlafaxine is associated with withdrawal syndromes and should be restarted once patient is able to tolerate
Stimulants	Phentermine (Adipex-P®)	Hold medication 7 days prior to surgery	Restart when patient can take oral medications and is clinically stable	Phentermine may be associated with hypotension perioperatively due to catecholamine depletion.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
				Hypertension was observed in patients using phentermine during the induction phase intraoperatively. Monitor blood pressure and body temperature for any autonomic impairment
PULMONARY MEDICATIONS				
PDE Inhibitor - Nonselective	Theophylline TheoDur®	Discontinue evening before surgery. Use nebulized or inhaled beta agonists or anticholinergics	Resume with PO intake.	There is no data indicating whether continuation of theophylline in the perioperative period decreases pulmonary complications. Theophylline has the potential to cause arrhythmias and neurotoxicity at a level beyond the therapeutic range, and theophylline metabolism is affected by many common perioperative medications. No known adverse effects but very narrow range between therapeutic and toxic level.
Inhaled Medications	Albuterol Duoneb® QVAR® Pulmicort® Symbicort® Breo Ellipta® Anoro Ellipta® Incruse Ellipta® Arnuity Ellipta® Flovent® Xopenex® Asmanex® Dulera® Serevent® Advair® Spiriva® Alvesco®	Continue until surgery PLEASE have patient bring their inhalers (MDIs) to the holding area.	Continue through perioperative period May substitute nebulized treatments (i.e. albuterol and ipratropium) until patient can resume inhalers	PLEASE have patient bring their inhalers (MDIs) to the holding area **Some patients may require an increase in their steroid dose for 1-2 weeks preoperatively

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
	Striverdi Respimat® Stiolto Respimat® Utibron Neohaler® Trelegy Ellipta® Yupelri®			
Cystic Fibrosis Transmembrane Conductance Regulator Corrector	Symdeko® Trikafta®	Continue until time of surgery Consult with infectious disease specialists	Resume postoperatively	If a dose is missed ≤6 hours of the usual time it is taken, take the dose as soon as possible; if >6 hours has passed since the missed dose, skip the missed dose and resume the normal dosing schedule.
Oral Medications	Zafirlukast (Accolate®) Montelukast (Singulair®) Zileuton (Zyflo®) Pirfenidone (Esbriet®) Nintedanib (Ofev®) Roflumilast (Daliresp®)	Consider continuing through the morning of surgery	May be started after surgery following the patient's normal schedule for taking these drugs	Little is known about the implications of stopping treatment and there are no known drug interactions between these agents and anesthetics
Monoclonal Antibodies	tezepelumab-ekko (Tezspire®)	No recommendations from manufacturer - discuss with ordering physician	No recommendations from manufacturer - discuss with ordering physician	This medication is given every 4 weeks; if able, plan surgery around these injections

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
PULMONARY HYPERTENSION & ERECTILE DYSFUNCTION MEDICATIONS				
PDE-5 Inhibitors	Sildenafil (Viagra®) (Revatio®) Tadalafil (Cialis®, Adcirca®) Vardenafil (Levitra®, Staxyn®)	Erectile dysfunction: discontinue at least 7 days before surgery Pulmonary Hypertension: continue during the perioperative period as discontinuation may be fatal. Benign prostatic hyperplasia (BPH): Coordinate use with anesthesiologist, surgeon, and prescribing provider preoperatively.		PDE-5 Inhibitors increase concentration and half-life of cGMP, which leads to relaxation of pulmonary arterial smooth muscle, and subsequently decrease pulmonary pressure PDE-5 Inhibitors are vasodilators, when combined with other vasodilators can result in life-threatening hypotension Patients with PAH are at high risk of complications and death when undergoing anesthesia, mechanical ventilation, and major surgery. There is not a clear standard but in general PAH medications should be continued without interruption.
Endothelin Receptor Antagonist	Bosentan (Tracleer®) Ambrisentan (Letairis®) Macitentan (Opsumit®)	Should be continued during perioperative period	Should be continued during the postoperative period	Patients with PAH are at high risk of complications and death when undergoing anesthesia, mechanical ventilation, and major surgery. There is not a clear standard but in general PAH medications should be continued without interruption.
Soluble Guanylate Cyclase Stimulator	Riociguat (Adempas®)	Discuss alternative treatment options to manage pulmonary hypertension preoperatively.	Discuss with prescribing provider	Phase 4 trials showed increase rates of non-surgical bleeds with possibility of fatal outcome. Risk versus benefit and alternative therapy preoperatively should be considered.
Prostacyclin receptor agonist (selective)	Selexipag (Uptravi®)	Continue during perioperative period	Continue during the postoperative period	Current adverse events do not show increased bleeding or hypotension with use. Does not appear to have drug interactions with typical anesthetic agents.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
DIAGNOSTIC AGENTS				
Radioactive diagnostic agent	Fluoroestradiol F-18 (Cerianna®) Plarify® (Piflufolastat F18) Tauvid® (Flortaucipir F-18) Detectnet® (copper Cu 64 dotatate) Gadopiclenol (Elucirem®)	Discuss with prescribing provider.	Discuss with prescribing provider.	Of note, at 20 minutes after injection, approximately 20% of circulating radioactivity in the plasma is in the form of non-metabolized fluoroestradiol F-18. At 2 hours after injection, circulating fluoroestradiol F-18 levels are less than 5% of peak concentration, so unlikely that it will interfere with surgery. Flortaucipir F-18 and Detectnet® are not expected to impact surgery. Elucirem used with MRIs to detect lesions in the CNS and body
Non-radioactive diagnostic agent	pafolacianine (Cytalux®)	Recommended dosage is 0.025 mg/kg diluted in 250 mL of 5% Dextrose Injection, administered over 60 minutes using a dedicated infusion line, 1 to 9 hours prior to surgery.	Discuss with prescribing provider.	Cytalux® should only be used by surgeons who have completed a training program on the use of NIR imaging systems for fluorescence imaging during surgery. Training is provided by the device manufacturer.
	hyperpolarized Xe-129 Xenoview	Schedule surgery after use for lung nodule assessment.	N/A	N/A

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
REVERSAL/ANTIDOTES				
Potassium Antidote	Lokelma® Patiromer (Veltassa®) Sodium polystyrene sulfonate (Kayexalate®)	May continue through day before surgery if clinically appropriate	Resume on outpatient basis as clinically appropriate	Oral medications should not be administered 2 hours before or after Lokelma Oral medications should not be administered 6 hours before or 6 hours after Veltassa® Avoid use in patients with abnormal post-operative bowel motility disorders.
Alpha$_2$-Adrenergic Agonist	Lofexidine (Lucemyra®)	Discuss with prescribing provider	Discuss with prescribing provider.	*Discontinuation of therapy:* Decrease dose gradually over 2 to 4 days. Abrupt discontinuation may cause marked rise in blood pressure, anxiety, chills, and diarrhea. Patients who have been treated with lofexidine may respond to lower opioid doses than previously used.
Hypoglycemia Antidote	Dasiglucagon (Zegalogue®)	Discuss with prescribing provider.	Discuss with prescribing provider.	*Hypersensitivity reactions* have been reported with administration of glucagon products. Monitor for anaphylaxis, hypotension, respiratory distress.
Monoclonal antibody	Lanadelumab-flyo (Takhzyro®)	Discuss with prescribing provider.	Discuss with prescribing provider.	It is critical to develop definitive perioperative plans for angioedema prophylaxis, intraoperative management, and rescue if indicated for patients with hereditary angioedema (HAE) or acquired angioedema (AAE). Takhzyro is dosed every 2 weeks to every 4 weeks. Other agents can be dosed as frequent as every other day or twice weekly and have short-term/pre-procedural prophylaxis dosing.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
RHEUMATOID ARTHRITIS MEDICATIONS				
Antimetabolite	Methotrexate (MTX)	Recommended to continue perioperatively in patients with normal renal function and held for 2 weeks preoperatively in patients with renal impairment, infection, or bone marrow suppression **Contact patient's rheumatologist	Physician's discretion whether to continue or not– check serum creatinine Some physicians hold MTX for 2 weeks postoperatively to ensure appropriate wound healing Some physicians restart MTX ASAP after surgery to avoid a rebound flare in arthritis	Concerns exist regarding the effect of MTX on wound healing. Recent data suggests that MTX did not cause significant problems with wound healing
Antirheumatic (dihydroorotate dehydrogenase inhibitor)	Leflunomide (Arava®)	Some physicians recommend stopping 2-3 weeks before surgery given the long half-life, however lack of known risk increase suggests it is reasonable to continue the drug up until surgery Contact patient's rheumatologist	Some physicians recommend holding leflunomide for 2 weeks after surgery	Use caution in patients with renal failure or sepsis Studies have shown leflunomide to be associated with an increased risk of post-operative wound complications
Disease Modifying Agents	Upadacitinib Rinvoq®	Consult prescribing doctor to devise a perioperative plan	Consult prescribing doctor to devise a postoperative plan	The half-life of this medication is 8-14 hours. Upadacitinib can decrease immune function thereby increase risk for infections and increase risk of thromboembolism.
TNF-alpha inhibitors	Etanercept (Enbrel®) Infliximab (Remicade®) Adalimumab (Humira®)	Recommend holding at least 1 week before surgery Contact patient's rheumatologist	Recommend holding 1 week after surgery Consider resuming once the wound is fully healed. Contact patient's rheumatologist	

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Antirheumatic	Sulfasalazine, azathioprine	Some physicians recommend continuing during the perioperative period and holding it the day of surgery. Contact patient's rheumatologist	Resume after surgery	
	Hydroxy-chloroquine	Continue without interruption	May continue when able to tolerate oral medications	
	Colchicine, gold, cyclo-phosphamide	Discontinue the night before surgery		
Interleukin-6 Antagonist	Satralizumab-mwge (Enspryng®) Tocilizumab (Actemra®)	Recommend coordinating interleukin-6 blocker perioperative medication management plan with surgeon and prescribing provider	Recommend coordinating interleukin-6 blocker perioperative medication management plan with surgeon and prescribing provider	IL-6 antagonists may affect postoperative wound healing due to modulation of the immune system. Consult with specialist prior to use.
STIMULANTS or ANTI-NARCOLEPTICS				
Central Nervous System Stimulant	Pitolisant (Wakix®)	It has been reported that central nervous system stimulants can be used safely during the preoperative period.		Pitolisant is primarily used to increase wakefulness in patients with narcolepsy. Relevant adverse effects include prolonged QT interval and tachycardia.
Dopamine and Norepinephrine Reuptake Inhibitor	Solriamfetol (Sunosi®)	No compelling reason not to take up to the day of surgery.	No compelling reason not to resume the day after surgery if desired. Risk/benefit discussion should be had with patient; patient may be able to withhold drug while inpatient and can resume once recovered from surgery.	May cause dose-dependent increases in BP and heart rate.

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
ADRENAL MEDICATIONS				
Cortisol Synthesis Inhibitor	Osilodrostat (Isturisa®)	Consult endocrinologist or prescribing provider to devise a perioperative plan.	Consult endocrinologist or prescribing provider to devise a perioperative plan.	May cause adrenocortical insufficiency resulting in hypoglycemia, hyponatremia, hypotension, nausea, vomiting, weakness QTc prolongation may occur due to electrolyte imbalances.
THYROID MEDICATIONS				
Thyroid Products	Levothyroxine Synthroid® Levothroid® Levoxyl® Liothyronine (Cytomel®)	Continue medications during the perioperative period	Resume patient's usual schedule If NPO status is prolonged greater than 5 days, intravenous L-thyroxine may be administered	Levothyroxine has a long half-life (6-7 days), missing several doses is unlikely to adversely affect patient's thyroid status For patients with predicted NPO post-operatively may give a full week of PO levothyroxine as one dose the day prior to surgery.
Antithyroid Medications	Propylthiouracil Methimazole (Tapazole®)	Continue medications during the perioperative period	Resume patient's usual schedule May be given via the nasogastric tube, if necessary, during the perioperative period	Maintaining control of hyperthyroidism is necessary for safe surgery and recovery Methimazole has a longer duration of action and may be given once a day, making it preferable for patients undergoing long surgery ß-blockers may be used to control the effects of hyperthyroidism **In patients who exhibit thyroid storm, propranolol should only be administered with caution due to possibility of cardiovascular collapse**

Drug Class	Examples	Preoperative Recommendations	Postoperative Recommendations	Considerations & Caveats
Insulin-like growth factor-1 receptor inhibitor	Teprotumumab-trbw (Tepezza®)	Contact prescribing physician	Contact prescribing physician	This medication is dosed every 3 weeks and has a long half-life of 20 days Infusion related reactions including hypertension, tachycardia, dyspnea, feeling hot, headache, and muscular pain have been reported with this medication.
Parathyroid	Recombinant human parathyroid hormone Natpara®	Continue medications during perioperative period	Continue during postoperative period	The manufacturer of Natpara recommends avoiding abrupt interruption or discontinuation.

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