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Brighton and Hove CCG
High Weald Lewes Havens CCG

South Scripts

Prescribing Bulletin - Issue 4 November 2019

All the latest prescribing news from your Medicines Management Team at the CCG.

To read this issue online, please follow this link

This newsletter is produced by the Medicines Management Team at the CCG, and is sent to all local GPs and Locums, Practice Nurses, Practice Managers and Community and Practice Pharmacists. We would welcome any feedback on the content and usefulness of the newsletter and suggestions for future topics.
With many thanks to neighbouring CCGs who have contributed material to this newsletter.

Welcome to the 4th issue of *South Scripts*, the prescribing bulletin for healthcare colleagues across Brighton and Hove and High Weald Lewes Havens.

What's included in this issue?

World Antibiotic Awareness Week (18th-24th November)

This year's World Antibiotic Awareness Week campaign is the first of a new five-year UK National Action Plan for antimicrobial resistance, which contains stretching ambitions for reducing inappropriate prescriptions; as well as controlling and preventing infections.

The Keep Antibiotics Working campaign which launched on the 5th November aims to alert the public to the risks of antibiotic resistance, urging people to always take their doctor, pharmacist or nurse's advice on antibiotics. Please consider displaying some posters in your waiting rooms and consultation rooms.

ACTION: HCPS to take a look at the Antibiotics Guardian website and consider showing the video in waiting rooms and becoming an antibiotic guardian! Also make use of the range of resources available on the TARGET website to support the message for reducing inappropriate antimicrobial prescribing.

LABA/LAMA inhalers and LABA/ICS inhalers for COPD should NOT be prescribed together

It has been reported to us that recently there have been some patients with COPD who are taking BOTH a LABA/LAMA inhaler (Spiolto, Duaklir, Ultibro) as well as a LABA/ICS inhaler (Fostair, Symbicort, AirfluSal, Seretide etc.). These patients would therefore be receiving double the recommended dose of LABA as well as being on triple therapy (which may not be the intention).

In particular, it seems there is sometimes confusion as the name and device appearance of Spiolto Respimat (Tiotropium and olodaterol) is very similar to Spiriva Respimat (Tiotropium).
GP practices have been contacted by email and respiratory leads asked to review their COPD patients on LABA/LAMA inhalers to ensure they are not also prescribed a LABA/ICS.

If they are, depending on the desired treatment, patients should either stop their ICS/LABA and reduce their ICS slowly or be taken off the LABA/LAMA and put back on a LAMA.

ACTION: Prescribers to be aware of these similar sounding names and ensure no patients are co-prescribed LABA/LAMA inhalers and LABA/ICS inhalers

Key

COPD	Chronic Obstructive Pulmonary disease
ICS	Inhaled corticosteroid
LABA	Long acting beta agonist
LAMA	Long acting muscarinic antagonist

NICE encourages use of Greener inhalers

To encourage awareness of the environmental impact of respiratory inhalers used to treat asthma and COPD, NICE have updated their Patient Decision Aid for clinicians and patients. This tool provides information on the characteristics of different inhalers including their environmental impact. The decision aid facilitates discussions with patients and families about which inhaler best aligns with their priorities and will support carbon reduction targets without compromising clinical care. Where several inhalers could be viable options, patients can opt for the more environmentally friendly option which will help to cut the NHS's carbon footprint.
It has been identified that metered dose inhalers (MDIs) have a considerably larger impact on global warming potential than dry powder inhalers (DPIs). The problem is that MDIs have hydrofluorocarbon propellants that contain greenhouse gases and these persist in the atmosphere for between 14 and 260 years. Metered dose inhalers have an estimated carbon footprint of 500 g CO2 equivalents per dose (2 puffs), which compares with just 20 g in dry powder inhalers. It is estimated that 5 doses of an MDI inhaler (10 puffs) has approximately the same carbon footprint as an average trip (9 miles) in a car. Currently about 70% of all the inhalers prescribed in the UK are MDIs, which makes up 26 million inhalers.
"People who need to use metered dose inhalers should absolutely continue to do so," said Gillian Leng, deputy chief executive of NICE. "But if you have the choice of a green option, do think about the environment." Helen Stokes-Lampard, chair of the Royal College of General Practitioners, said that GPs and other healthcare professionals will aim to recommend the best type of inhaler for their patients, bearing in mind their needs and preference. "When a more environmentally friendly option is readily available and will have comparable benefit for the patient, it should certainly be considered," she said.
The new NICE Patient decision aid also encourages patients to return used inhalers to local pharmacies for environmentally safe disposal or recycling. Many pharmacies have special recycling bins for this purpose. If every inhaler user in the UK returned their inhalers to their community pharmacy for recycling for 1 year, this could save 512,330 tonnes of carbon dioxide, the same as a Volkswagen Golf being driven around the world 88,606 times. [1]
It is important to stress that there remains an important role for pressured metered dose inhalers where there is a clinical need or where dry powder inhalers may not be suitable for the patient (e.g. patients unable to generate an adequate inspiratory flow). However, where clinically appropriate, patients should be offered a lower carbon inhaler choice which, together with environmentally safe disposal, will make a positive impact on the environment.

ACTION: Clinicians to make themselves aware of the NICE Patient Decision Aid to support discussions with respiratory patients when choosing an inhaler. Also highlight to your patients about returning their used inhalers to their pharmacies for recycling.

[1] data from GSKs complete the cycle campaign

Benzodiazepine and Hypnotic Prescribing

SPFT have updated their policy on **'Benzodiazepine and Hypnotic Prescribing'** which has been shared with their clinicians via their most recent internal Drugs & Therapeutics newsletter. This will also sit within their formulary (https://www.sussexpartnership.nhs.uk/formularies-trust-and-ccgs-and-detailed-psychotropic-prescribing-guidelines)

Benzodiazepine and Z-drug prescribing can create long-term problems for patients. Long-term use in exceptional circumstances may be warranted, but any such decision must be fully discussed with the patient, and carer if

appropriate. GPs must be given clear reasons for the decision and this decision must be reviewed at regular intervals. The Trust's Formulary carries the following general guidance :

1. Benzodiazepines/hypnotics are not to be initiated when there is a history of any dependency or potential for abuse - either directly by the client or through onward sale.
2. The use and problems associated with benzodiazepines/hypnotics should be discussed fully with the patient, and the carer if appropriate. Patient leaflets on the subject are available.
3. No patient should be discharged from hospital on a benzodiazepine/hypnotic unless:
   - He or she was admitted on it **and it had not been initiated within a few weeks of admission**, or
   - Continued use is supported by the documented recommendation of a consultant psychiatrist.
4. Any patient discharged or initiated in the community on a short course of hypnotics/benzodiazepines must have this explained to them, emphasizing that they will not be getting a repeat from their GP. Prescribe enough to complete the course.
5. If the GP is expected to continue the prescribing of a new benzodiazepine/hypnotic then full information must be provided on why the medicine was started, whether the treatment is long term or short term and what information the patient or carer has been given.
6. Junior doctors only have authority to prescribe inpatients hypnotics/benzodiazepines for 48 hours (72 at weekend). Continued use to be supported by the consultant.
7. An inpatient admission should be seen as an opportunity to wean a patient off benzodiazepines/hypnotics if deemed clinically appropriate. **Gradual dose reductions are likely to be necessary.** Discontinuing benzodiazepines, particularly short acting ones, can however increase the risk of suicide.
8. Particular caution should be used when prescribing benzodiazepines/hypnotics for patients with personality disorders as the risk of misuse, non-adherence, disinhibition, paradoxical aggression and dependency may be greater than in other patient groups.

Trust pharmacists have the authority to discontinue inpatient 'prn' hypnotics if they have not been required within a two week period. Similarly, they may also discontinue inpatient 'prn' anxiolytics, after confirming there is no continuing need with nursing staff.

Antidepressant discontinuation: "go slow as you go low" (From SPFT's Drugs & Therapeutics newsletter)

Given the current topical nature of the potential for withdrawal or discontinuation effects with antidepressants, and the recent publication of a paper in the Lancet Psychiatry by Dr Mark Horowitz and Prof David Taylor, this topic has been reviewed by the Mental Elf (https://www.nationalelfservice.net/treatment/antidepressants/antidepressant-withdrawal-slower-and-lower-tapering-of-ssris/), highlighting tapering as a potential option to mitigate withdrawal effects.

The authors conclude that slowly reducing SSRIs (and potentially all antidepressants) allows for more time for the individual to adapt to a lower amount of serotonin. This in turn should reduce the severity of withdrawal / discontinuation symptoms. As such the authors recommend a pause between reducing the dose of medication.

It is important to note that not everyone will experience withdrawal from antidepressants and that discontinuation effects are more likely in those individuals who have received high doses for prolonged periods of time. This may aid clinicians in identifying which patients may need extra care re: withdrawal when stopping antidepressants.

The authors suggest that the aid memoir for clinicians when tapering SSRIs should be "go slow as you go low" as the most significant discontinuation effects appeared to occur at the end of a reducing dose. Vitally, tapering (as with all prescribing) should be an individualised process, as there will likely be differences in withdrawal symptoms in different patients, e.g. dependant on dose, length of treatment course, previous withdrawal experiences.

If any generalities are to be made it would be that reducing the dose more slowly at the end of the tapering period and over a longer time period overall seems to be the safest option. It is also key to consider that a patient may have waited a long time to reduce their medication. As such good communication from the outset regarding expected treatment trajectory may prevent challenges around self-discontinuation of medication.

Further information can be found in the Royal College of Psychiatrists, Position statement on antidepressants and depression https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps04_19---antidepressants-and-depression.pdf?sfvrsn=ddea9473_5

Proshield Plus Skin Protectant

Our lead Tissue Viability Nurses (TVN) would like GPs to be reminded that Proshield is to be prescribed only on the advice of the TV service. This is due to its misuse, overuse and links to deteriorating wounds when used with pressure damage rather than moisture lesions.

Medi Derma S sachets or Zerolon tubes are the only barrier creams available on the joint formulary locally, and should be the first choice. Should care / nursing homes have patients with more challenging moisture damage that they feel would benefit from Proshield barrier cream then the home should refer to TVN for advice and monitoring.

If you have care or nursing homes you feel require further education please contact susan.martin16@nhs.net (HWLH) or valerie.dowley@nhs.net (B&H) who will be able to arrange this with the clinical trainer.

ACTION: If you require this product then you need to send justification to the TV service for its authorisation. It is still recommended in severe, wet moisture damage where other barrier products have proven ineffective.

Medicinal Cannabis– Interactions and Adverse Effects

The Specialist Pharmacy Service has produced a document on potential drug -drug interactions with cannabis-based medicinal products and other medications or substances. Additionally, the Q&A cannabidiol oil potential adverse effects documents risks from self-administration of over-the-counter bought cannabidiol oil which is becoming increasingly popular.

ACTION: All HCPs should be aware of both interactions and adverse effects of cannabis-based medication and supplements.

Falsified Medicines Directive (FMD)

The EU Falsified Medicines Directive (FMD), applied in the UK from 9 February 2019. This introduces the need for healthcare institutions to 'verify and decommission' medicines supplied or administered directly to patients. All GP practices 'personally administer' some medications (namely Vaccines/Immunisations) and so practices would need to scan a barcode when medication is administered in order to decommission it.
The CCG has confirmed with NHS Digital that there is no need for non-dispensing practices to do anything at this time but it is likely practices will need to be start decommissioning medication (e.g.by scanning a barcode before medicine is administered) by January 2020. We will keep you updated as we get a clearer picture in terms of what practices need to do, what equipment is needed and who will fund it.
If you would like further information in the meantime you may wish to have a look at the toolkit recently published by NHS Digital for practices (click here).

OptimiseRx in TPP SystmOne – feature change

OptimiseRx is delighted to announce that following requests from users, TPP have recently released a change to the way Alternative Products are presented by OptimiseRx in SystmOne.
The 'Hide drugs with warnings' tick box on the Alternative Products dialogue box is now defaulting to 'unticked'; this means that all Alternative Products are revealed when the user sees the dialogue box. Alternative Products that have drug interactions or contraindications will be displayed in grey, but will by default be visible and available for the prescriber to select.
Practices have been informed via SystmOne Change Notifications. Further information can be found HERE.

Dosette boxes / multicompartment compliance aids

The Medicines Management Team have received several queries recently about changes to local pharmacies' policies on supplying dosette boxes / multicompartment compliance aids. It is believed that national guidance may follow on this issue, but in the meantime, the local situation is summarised below.
The supply of dosette boxes to patients in general is not an NHS contracted service and pharmacies are only obliged to provide dosette boxes where the dosette box is judged to be part of a reasonable adjustment under the Equality Act 2010. The pharmacy has a duty under the Equality Act 2010 to assess and decide which reasonable adjustments are necessary for the individual person; there are many other reasonable adjustments available such as large print labels and non-click lock bottle tops.

ACTION: If a prescriber or agency e.g. adult social care thinks a person may benefit from a dosette box, they should refer the person to their pharmacy for an assessment of their needs. Provision of dosette boxes for any other reason is beyond the remit of the NHS and a pharmacy may opt to charge a patient for the provision of this service.
Seven day prescriptions are not a prerequisite for dosette boxes and should only be issued where the prescriber has concerns that the person may be at risk of harm if they have more than one week's supply of medicine in their possession.

Community pharmacy email addresses (as an alternative to faxing)

Now that faxes are no longer to be used in the NHS, email is becoming a more widely used means of secure communication when using NHS.net accounts.

ACTION: All local pharmacies have NHS.net addresses. Please ensure that you liaise with your local pharmacies to inform them that you will be using email as a means of secure communication from a particular date.

Drug and Device Safety Updates, Product Recalls, and Licensing amendments – how to stay up-to-date

Just a reminder to healthcare professionals and surgery staff alike, that the Medicines and Healthcare products Regulatory Agency (MHRA) provide useful information relating to drug safety updates, product recalls, and changes in product licensing. To save remembering to access this information regularly, you can sign up to receive email updates on the areas of interest via their website: https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency/email-signup
The MHRA will be taking over the responsibility for issuing all Central Alerting System (CAS) alerts from 1st October 2019.

ACTION: All GP practices are required to register to receive CAS alerts from the MHRA by 13th September. Please refer to the letter from the Director of Primary Care Commissioning for full details and the new contractual requirements for practices here.

Drug Safety Updates

Magnesium sulfate: risk of skeletal adverse effects in the neonate following prolonged or repeated use in pregnancy

Maternal administration of magnesium sulfate for longer than 5–7 days in pregnancy may be associated with adverse effects in the foetus, including hypocalcaemia, skeletal demineralisation, osteopenia, and other skeletal adverse effects. If prolonged or repeated use of magnesium sulfate occurs during pregnancy (for example, multiple courses or use for more than 24 hours), consider monitoring of neonates for abnormal calcium and magnesium levels and skeletal adverse effects.

Direct-acting oral anticoagulants (DOACs): increased risk of recurrent thrombotic events in patients with antiphospholipid syndrome

A clinical trial has shown an increased risk of recurrent thrombotic events associated with rivaroxaban compared with warfarin, in patients with antiphospholipid syndrome and a history of thrombosis. Other direct-acting oral anticoagulants (DOACs) may be associated with a similarly increased risk. DOACs are not recommended in patients with antiphospholipid syndrome, particularly high-risk patients (those who test positive for all 3 antiphospholipid tests — lupus anticoagulant, anticardiolipin antibodies, and anti-beta 2 glycoprotein I antibodies). Review whether continued treatment with a DOAC is appropriate for patients diagnosed with antiphospholipid syndrome, particularly high-risk patients, and consider switching to a vitamin K antagonist such as warfarin.

GLP-1 receptor agonists: reports of diabetic ketoacidosis when concomitant insulin was rapidly reduced or discontinued

Diabetic ketoacidosis has been reported in patients with type 2 diabetes on a combination of a GLP-1 receptor agonist and insulin who had doses of concomitant insulin rapidly reduced or discontinued. GLP-1 receptor agonists are not substitutes for insulin, and any reduction of insulin should be done in a stepwise manner with careful glucose self-monitoring. Abrupt discontinuation or reduction in insulin doses can lead to poor glycaemic control, with a risk of diabetic ketoacidosis. Serious and life-threatening cases of diabetic ketoacidosis have been reported in association with exenatide, liraglutide, and dulaglutide, particularly after discontinuation or reduction of concomitant insulin. Blood glucose self-monitoring is necessary when adjusting the dose of insulin, particularly when GLP-1 receptor agonist therapy is initiated and insulin is reduced. If the insulin dose is to be reduced, a stepwise approach is recommended. Discuss with patients the risk factors for and signs and symptoms of diabetic ketoacidosis and advise them to seek immediate medical advice if these develop.

Oral retinoid medicines▼: revised and simplified pregnancy prevention educational materials for healthcare professionals and women

New prescriber checklists, patient reminder cards, and pharmacy checklists are available to support the Pregnancy Prevention Programme in women taking acitretin, alitretinoin, and isotretinoin. Advice about the risk of neuropsychiatric reactions has been made consistent for all oral retinoid medicines.

Febuxostat (Adenuric): increased risk of cardiovascular death and allcause mortality in clinical trial in patients with a history of major cardiovascular disease

Avoid treatment with febuxostat in patients with pre-existing major cardiovascular disease (for example, myocardial infarction, stroke, or unstable angina), unless no other therapy options are appropriate. Findings from a phase 4 clinical study (the CARES study) in patients with gout and a history of major cardiovascular disease show a higher risk for cardiovascular-related death and for all-cause mortality in patients assigned to febuxostat than in those assigned to allopurinol. Avoid treatment with febuxostat in patients with pre-existing major cardiovascular disease (for example, myocardial infarction, stroke, or unstable angina), unless no other therapy options are appropriate. Note the clinical guidelines for gout (see below), which recommend treatment with febuxostat only when allopurinol is not tolerated or contraindicated.

Rivaroxaban (Xarelto▼): reminder that 15 mg and 20 mg tablets should be taken with food

MHRA has received a small number of reports suggesting lack of efficacy (thromboembolic events) in patients taking 15 mg or 20 mg rivaroxaban on an empty stomach; remind patients to take 15 mg or 20 mg rivaroxaban tablets with food. For patients who have difficulty swallowing, tablets can be crushed and mixed with water or apple puree immediately before taking; this mixture should be immediately followed by food. Rivaroxaban 2.5 mg and 10 mg tablets can be taken with or without food.

Hormone replacement therapy (HRT): further information on the known increased risk of breast cancer with HRT and its persistence after stopping

New data have confirmed that the risk of breast cancer is increased during use of all types of HRT, except vaginal estrogens, and have also shown that an excess risk of breast cancer persists for longer after stopping HRT than previously thought. Prescribers of HRT should discuss the updated total risk with women using HRT at their next routine appointment. A new meta-analysis of more than 100,000 women with breast cancer has shown that some excess risk of breast cancer with systemic HRT persists for more than 10 years after stopping; the total increased risk of breast cancer is therefore higher than previous estimates. Prescribers of HRT should inform women who use or are considering starting HRT of the new information about breast cancer risk at their next routine appointment (see resources provided on page 4). Only prescribe HRT to relieve post-menopausal symptoms that are adversely affecting quality of life and regularly review patients using HRT to ensure it is used for the shortest time and at the lowest dose. Remind current and past HRT users to be vigilant for signs of breast cancer and encourage them to attend for breast screening when invited.

Montelukast (Singulair): reminder of the risk of neuropsychiatric reactions

Prescribers should be alert for neuropsychiatric reactions in patients taking montelukast and carefully consider the benefits and risks of continuing treatment if they occur. Be alert for neuropsychiatric reactions in patients taking montelukast; events have been reported in adults, adolescents, and children (see list of reported events below). Advise patients and their caregivers to read carefully the list of neuropsychiatric reactions in the patient information leaflet and seek medical advice immediately should they occur. Evaluate carefully the risks and benefits of continuing treatment if neuropsychiatric reactions occur. Be aware of newly recognised neuropsychiatric reactions of speech impairment (stuttering) and obsessive–compulsive symptoms.

That's NICE

NICE Bites June 2019 This guideline covers the management of ulcerative colitis (UC) in children, young people and adults. It aims to help professionals to provide consistent high-quality care and it highlights the importance of advice and support for people with UC.

NICE Bites July/August 2019 This guideline covers the diagnosis and management of hypertension in adults, including people with type 2 diabetes. It aims to reduce the risk of cardiovascular problems such as heart attacks and strokes by helping healthcare professionals to diagnose hypertension accurately and treat it effectively.

NICE Bites September 2019 This guideline sets out an antimicrobial prescribing strategy for adults, young people, children and babies aged 72 hours and over with a confirmed diagnosis of community-acquired pneumonia. It aims to optimise antibiotic use and reduce antibiotic resistance.

Brighton Area Prescribing Committee and Joint Formulary Update

The Brighton APC makes decisions concerning the Joint Formulary. The following summarises decisions relevant to primary care, made by the APC in June 2019 and July 2019. (The APC did not sit in August 2019.)

The **wound care formulary** has been reviewed and updated.

NEW TO FORMULARY

- **Zetuvit E Sterile Pads** have replaced **Mesorb** pads as the 2nd choice for superabsorbent pads – they are not to be used under compression (Kliniderm only) but are as effective, with a cost saving and in line with formularies in other local areas. Zetuvit E non sterile remains on the formulary.
- **Kerralite Cool and Kerralite Cool border –** have replaced **Actiform cool** as the hydrogel. This product is actually the newer version of Actiform cool. A bordered version has also been added so that small haematomas can be dressed without the need for heavy bandages to keep the product in place.
- **KerraCel range** has replaced **Durafiber range –** as the second choice Hydrofiber dressings. This is both due to cost and equal effectiveness in use. It holds its shape better and expands when wet to fill up space within a wound cavity.
- **Aquacel Foam Adhesive –** has been added, following successful trials in HWLH CCG. This product should only be used for wounds that are relatively superficial and may require a layer of primary Aquacel or Durafiber underneath (which is now contained within the dressing or smaller cavity wounds with moderate exudate (where Kliniderm is no longer required).
    - A waterproof top layer that permits evaporation of excess moisture while protecting against viral/bacterial penetration,*[1] allowing the patient to shower and bathe
    - A soft, absorbent foam pad to enhance patient comfort and absorb excess fluid
    - A Hydrofiber® layer that gels on contact with wound fluid and helps provide an optimal environment for wound healing
    - A gentle silicone adhesive that provides secure, skin-friendly adhesion, easy removal and demonstrated low potential for dermal irritation or allergic contact sensitisation[2]
- **Debrisoft Lolly shape –** has been added to the range for the debridement of deep wounds. Please copy and paste the link below to watch the manufacturers video on the use of the product.
    - https://www.lohmann-rauscher.com/en/products/wound-care/debridement/debrisoft-lolly/
- **Zerolon Barrier Cream –** has replaced **Mediderma S barrier cream –** but there may be a delay to the inclusion on ONPOS (BH CCG only) due to manufacturing issues.
- **Aproderm colloidal oat cream -** a non-paraffin based emollient cream for those who have a known paraffin allergy or have been risk assessed as high risk of fire hazard if using other emollients. This will be Tissue Viability Approval only so justification and completion of a relevant risk assessment will need to be in place before authorising this product.
- **Appeel Adhesive remover wipes** - have been added to help with the breakdown of adhesive on dressings for fragile skin or when dressing removal is painful.
- **Devon foam utility pad and Devon foam heel protectors** (heel protectors currently not available so looking at an alternative product)

CHANGES TO THE FORMULARY

- **Proshield Plus Skin Protectant –** is now **Tissue Viability only approval** due to its misuse, overuse and links to deteriorating wound when used with pressure damage rather than moisture lesions. If you require this product then you need to send justification to the TV service for its authorisation. It is still recommended in severe, wet moisture damage where other barrier products have proven ineffective.

REMOVED FROM FORMULARY

- **Biatain Adhesive range** has been removed from the formulary as there were too many options available for foam dressings, most of which have been superseded by the silicone range.
- **Carboflex –** has been removed from the formulary due to its high cost level and misuse. Clinisorb remains the charcoal dressing available.

A new version of the **hydroxychloroquine information sheet** was approved to reflect updated guidance from the Royal College of Ophthalmologists, on patient monitoring. A service for such patient is now available at BSUH. The info sheet can be found here: https://www.gp.brightonandhoveccg.nhs.uk/file/3376

A new version of the **anti-dementia information sheet** was approved to reflect updates to NICE TA217 (Alzheimer's Dementia), NICE NG71 (Parkinson's Disease dementia), NICE NG97 (Dementia with Lewy bodies)

A new version of the **testosterone enantate 250mg/mL oily injection information sheet** was approved to correct minor typos.

Pitolisant was added to the Joint Formulary as RED (specialist only)

Teromeg® (omega 3 acid ethyl esters) was added to the Joint Formulary as BLUE (lipid clinic recommendation only). This is the preferred brand of omega 3. If all prescribing of omega 3 and Omacor was changed to Teromeg in BH and HWLH CCGs this would save £13,000 per annum.

Diazepam (for fear of flying) was added to the Joint Formulary as BLACK (not routinely prescribed)

Norethisterone (for postponement of menstruation for a holiday or event) was added to the Joint Formulary as BLACK (not routinely prescribed)

Medroxyprogestesterone (for postponement of menstruation for a holiday or event) was added to the Joint Formulary as BLACK (not routinely prescribed)

Ertugliflozin with metformin and a dipeptidyl peptidase-4 inhibitor for treating type 2 diabetes was added as GREEN as per NICE TA583

For more information on any of the content in this bulletin, please contact bhccg.medicinesmanagement@nhs.net.