CITY SCRIPTS

Brighton and Hove Clinical Commissioning Group

Prescribing Newsletter February 2015

This newsletter is produced by the Medicines Management Team at the CCG, and is sent to all local GPs, Practice Nurses and Community Pharmacists. We would welcome any feedback on the content and usefulness of the newsletter and suggestions for future topics. With thanks to the MM teams of Surrey CCGs

Update on the Changes to the Drug Driving legislation

Section 4 of the 1988 Road Traffic Act makes it an offence to drive whilst impaired through drugs, whether due to non-medical use or legitimate use. This offence remains in force alongside the new drug driving offence due to come into force on 2nd March 2015.
This new additional legislation makes it an offence to drive whilst above 'specified limits' for 16 named drugs. Enforcement of these specified limits will be via road side screening of saliva to identify whether a driver has taken one of these named drugs. A positive screen will be followed up with a request to provide a blood sample.

The named drugs fall into 2 groups:

- Those commonly abused drugs [cannabis (THC), MDMA (ecstasy), ketamine, methylamphetamine, cocaine (including BZE), LSD, Heroin] for which low limits have been set
- Those used for medicinal purposes, though with a potential for misuse (clonazepam, diazepam, lorazepam, oxazepam, temazepam, flunitrazepam*, methadone and morphine) whose specified limit allows for the normal recommended doses that most patients would be prescribed. *(not licensed in UK)

A provision in the legislation allows for a 'medical defence' if the drug was prescribed for a medical purpose and it was taken in accordance with advice given when prescribed and supplied, provided driving was not impaired (in accordance with Section 4 of the 1998 Road Tariff Act).

It may therefore be helpful for patients to keep some suitable evidence with them when driving, ideally in a confidential manor that preserves sensitivity, such that it provides evidence that they are taking the said drug as a medicine prescribed or supplied by a healthcare professional in case that patient was ever stopped by the police. If the police are satisfied that driving was not impaired and the driver is taking the relevant medicine upon the advice of a healthcare professional, the police will not prosecute for this offence.

However, it remains the driver's responsibility to decide whether they consider their driving is, or might be, impaired on any given occasion, for example if they feel sleepy, and, if in doubt, drivers should not drive.
The MHRA has produced a very useful guidance leaflet for patients and a copy can be found at the link:
www.mhra.gov.uk/home/groups/dsu/documents/publication/con437439.pdf

Action: It is the responsibility of prescribers and suppliers of medicines to give suitable clinical advice to patients regarding the likely risks of their medicines. Such advice (e.g. particular care when starting new medicine, changing doses, addition of new medicines or use of alcohol, illness with weight-loss etc) is highlighted in the DH Guidance which can be found via:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/325275/healthcare-profs-drug-driving.pdf

Reminder - Prescribing Incentive Scheme (PIS) 2014-15 submissions deadline.

General Practices are reminded that their submissions for the PIS reviews are due in by the **15th of March 2015**. Practices can contact their CCG Pharmaceutical Advisor where an extension may be necessary. Benzodiazepine receptor drugs indicators will be measured via ePACT when year-end data is available.

Oxycodone 10mg/ml - pick list problems

There have been a flurry of CD incidents nationally relating to prescriber picking errors of oxycodone 10mg/ml (at top of pick list on EMIS) instead of oxycodone 5mg/5ml, resulting in at least two being hospitalised. The MM Team have put a warning reminder message on ScriptSwitch regarding this.

Action:

- Pharmacists are asked to check all new scripts for oxycodone 10mg/ml are as intended with the prescriber
- Prescribers should be aware of this risk and put in steps to minimise it, such as ensuring ScriptSwitch is activated to receive such safety messages. Also be alert to queries from community pharmacists

People without a valid medical exemption certificate fined for claiming free prescriptions

According to Diabetes UK, a growing number of people with diabetes are being fined up to £100 for claiming free prescriptions, despite using medication to manage their diabetes. This is because they do not have a **medical exemption certificate,** possibly because of a widespread lack of awareness amongst people with diabetes and healthcare professionals about the need for a valid medical exemption certificate.

A spokesman from NHS Business Services Authority (NHSBSA) have told us that: where a patient has declared on the prescription form that they don't have to pay because they are named on a medical exemption certificate, maternity exemption certificate, prescription prepayment certificate, NHS Tax Credit Exemption Certificate or HC2 certificate, they are responsible for verifying those claims and if they can't find a record of a valid certificate for that patient, they'll write to them and ask them to either provide confirmation or pay the outstanding prescription charges, plus a penalty charge of up to £100 in relation to making an incorrect declaration. Prescriptions are checked at random, and diabetic patients are not being targeted in particular. Therefore, GPs, pharmacy and practice staff has an important role to play in ensuring that their patients can access the treatment they're entitled to.

The NHSBSA sends a reminder to medical exemption certificate holders one month before their certificate's expiry date (this is one reason why it's important for patients to let them know of address changes). To reapply, they need a new FP92A from their GP.

For full legislation regarding prescription charge exemption, please see Regulation 7 of The National Health Service (Charges for Drugs and Appliances) Regulations 2000 (as amended) at www.legislation.gov.uk.

Action

- Please make accessible to patients, the 'Claiming free prescriptions?' booklets and posters sent to all GP practices and pharmacies in September 2014. If you have not received these materials, please contact nhsbsa.communicationsteam@nhs.net
- **GPs** have responsibility for signing and submitting the application forms for the medical exemption certificate, **FP92A**, including renewals – please ensure these are done when applicable
- **As a Pharmacist**: You have a crucial role for checking that people do have a certificate when they collect their prescription. If people do not have a certificate, pharmacists should advise people to pay for their prescription and to take a **FP57 receipt** and **refund form**. This way they can apply for a certificate, which is backdated by one month from the date the application is received, and claim back for that prescription once the certificate has been issued.

Claiming for Flu Vaccinations

Practices are reminded that they should not make claims under personal administration arrangements to the NHSBSA on form FP34P/D or FP10 for vaccines that have been centrally procured for them through Public Health England via a vaccine ordering facility, such as ImmForm. Examples of vaccines include: Fluenz Tetra nasal spray suspension influenza vaccine, NeisVac-C vaccine and Boostrix IPV injection.
An FP34P/D appendix or FP10 form should **only** be submitted for payment to cover the 'dispensing' of the vaccine for personal administration where the vaccine has been purchased by the practice.
Action: Practices who have incorrectly submitted centrally procured vaccines to NHSBSA Prescription Services should contact nhsbsa.repricingrequest@nhs.net for a payment adjustment, and also inform their Practice Pharmaceutical Advisor, if they have not done so already.

New Contractual requirement on Repeat Dispensing for Community Pharmacy

From March 2015, the community pharmacy Terms of Service will require that: pharmacy contractors must ensure that appropriate advice about the benefits of repeat dispensing is given to any patient who:

1. has a long term, stable medical condition (that is, a medical condition that is unlikely to change in the short to medium term), and
2. requires regular medicine in respect of that medical condition, including, where appropriate, advice that encourages the patient to discuss repeat dispensing of that medicine with a prescriber at the provider of primary medical services whose patient list the patient is on.

The intention is to help significantly increase the proportion of patients using the service, which can free up time for GP practices; provide a more convenient service for patients; and also help pharmacies to manage their repeat prescription workload more efficiently. http://psnc.org.uk/our-news/new-contractual-requirement-to-commence-from-march/

Generic Pregabalin – available but only for epilepsy and GAD until July 2017

The patent for pregabalin for epilepsy and generalised anxiety disorder (GAD) expired in July 2014. However, for neuropathic pain, Lyrica (Pfizer) brand of pregabalin still has patent protection until July 2017. Until this patent expires generic pregabalin products will not be licensed for neuropathic pain and the use of generic pregabalin for this condition would be off-label and may infringe the patent.
Action: Due to licensing, when prescribing pregabalin for neuropathic pain, clinicians should use the branded version Lyrica until July 2017, whilst using the generic pregabalin for all other indications.

Pregabalin and gabapentin misuse – guidance from Public Health England

Public Health England (PHE) have alerted prescribers to the potential risk of dependence, misuse and diversion of pregabalin and gabapentin. Appropriate prescribing should minimise these risks.
Other key points about pregabalin and gabapentin include:

- Pregabalin appears to be more sought after for misuse with a growing illegal market
- Prescribing these drugs for patients with a known or suspected propensity to misuse, divert or become dependent upon, may place these people at greater risks from their use
- Less harmful, alternative drugs can often be first-line treatments for the indicated conditions for which pregabalin and gabapentin are used. These are preferential options in higher risk settings or in patients who may be more likely to be harmed by the drug
- Prescribers should engage in a fully informed discussion regarding benefit and risks (e.g. potential for abuse or dependence) with patients before initiating therapy
- If more than one CNS depressant is taken, impairment of cognitive and motor function may be additive (e.g. pregabalin with oxycodone) and patients should be informed accordingly
- When prescribing for unlicensed indications (e.g. fibromyalgia), document informed patient consent
- The drugs do not work for everyone when prescribed for neuropathic pain or fibromyalgia (unlicensed use). Therefore they should be prescribed for a test period to ascertain if they are effective. The dose should be titrated up to the maximum tolerated within the suggested dose range. If there is no symptom improvement, the drug should be reduced and stopped. If its use is successful, there should be a reduction on an annual basis to ascertain on-going effectiveness.
  www.gov.uk/government/publications/pregabalin-and-gabapentin-advice-for-prescribers-on-the-risk-of-misuse

Brighton Area Prescribing Committee and Joint Formulary Update

Brighton APC makes decisions concerning additions to the Joint Formulary. The following summarises decisions made by the APC in January and February 2015:

Joint Formulary (JF) Chapter	Preparation	Decision	Notes
January 2015			
JF chapter 4 - CNS	Anti-dementia drugs	Changed from Amber to BLUE (Specialist initiation / recommendation only)	With the use of an information sheet
JF chapter 15 - Anaesthesia	Glycopyrronium bromide injection	Added to the JF as GREEN	Chapter created to include palliative care drugs.
JF chapter 1 - GI	Ranitidine Syrup	Removed	
JF chapter 1 - GI	Ranitidine SF solution	Added to the JF as GREEN	
February 2015			
JF chapter 6 - Endocrine	Omnican Fine pen needles	Added to the JF as GREEN	For use in new patients and existing patients (at time of review)
	MyLife Penfine Classic pen needles		
	GlucoMen Areo Sensor	Added to the JF as GREEN	For use in new patients and existing patients where an informed switch has been made between the patient and the clinician. (Also, where their current test strips are >£10 per 50 strips.) **Further communications from the Medicines Management Team to follow.**
	Contour TS test strips		
	WaveSense JAZZ test strips		
	Omnitest 3 test strips		
	MyLife Pura test strips		
	SuperCheck 2 test strips		

Patient Safety Alerts issued by NHS England include:

- Potassium Permanganate safety and the risk of death or serious harm from the accidental ingestion of potassium permanganate preparations (solution or tablets for solution), which are for external uses only and can be fatal if ingested
- Low Molecular Weight Heparins (LMWH) and failure to appropriately risk assess the patient for pharmacological or clinical contraindications has resulted in a reported 16 incidence of severe harm or death. Contraindications include but are not limited to: active bleeding; acquired bleeding disorder (such as acute liver failure); concurrent use of anticoagulants known to increase risk of bleeding; concurrent use of antiplatelets and other interacting medicines; or, lumbar puncture/epidural/ spinal anaesthesia within the previous 4 hours, or expected within the next 12 hours.

MHRA Drug Safety Updates includes advice on:

December 2014

- **Ivabradine** (*Procoralan*®) in the treatment of **symptomatic angina** has been linked with **bradycardia**, **atrial fibrillation** and other **cardiovascular risks** and the following new recommendations have been made: only start ivabradine if the resting heart rate is at least 70 beats per minute; do not prescribe with other medicines that cause bradycardia, such as verapamil, diltiazem or strong CYP3A4 inhibitors; monitor patients regularly for atrial fibrillation, and if atrial fibrillation occurs, carefully reconsider whether the benefits of continuing ivabradine treatment outweigh the risks; consider stopping if there is no or only limited symptom improvement after 3 months
- **Isotretinoin** (*Roaccutane*®) reminder - only prescribe under **specialist supervision** and warn patients and their family that the treatment might cause psychiatric disorders such as depression, anxiety, and in rare cases suicidal thoughts. Reporting of such symptoms should be encouraged and appropriate action taken if they arise; simply stopping isotretinoin may not be enough to alleviate symptoms.

January 2015

- **Aceclofenac** (Preservex), structurally similar to diclofenac is now contraindicated in patients with certain established cardiovascular diseases
- **Oral diclofenac is no longer available without prescription** due to its association with a small increased risk of serious cardiovascular side effects. Topical preparations remain for sale over the counter
- Advice for prescribing any NSAID includes basing the decision to prescribe on an assessment of each patient's individual risk factors including any history of cardiovascular, gastrointestinal and renal illness. The lowest effective dose for the shortest duration possible should be used
- **Yellow Card extended to include devices, counterfeits and defective medicines** www.gov.uk/yellowcard
- **Medicines related to valproate: risk of abnormal pregnancy outcomes** with the following main advice:
    - *valproate should not be prescribed to female children, female adolescents, women of childbearing potential or pregnant women unless other treatments are ineffective or not tolerated*
    - *valproate treatment must be **started and supervised by a doctor experienced in managing epilepsy or bipolar disorder***
    - *carefully balance the benefits of valproate treatment against the risks when prescribing valproate for the first time, at routine treatment reviews, when a female child reaches puberty and when a woman plans a pregnancy or becomes pregnant*
    - ensure that all female patients are informed of and understand: risks associated with valproate during pregnancy; need to use effective contraception; need for regular review of treatment and *the need to rapidly consult if she is planning a pregnancy or becomes pregnant.*
- **Mycophenolate mofetil (CellCept) and mycophenolic acid (Myforttic): risk of hypogammaglobulinaemia** (which can be associated with recurrent infections) **and bronchiectasis** bronchiectasis (which can sometimes occur years after starting treatment).

February 2015

- **Tiotropium delivered via Respimat compared with Handihaler: no significant difference in mortality in TIOSPIR trial.** This is **reassuring** however patients with **certain cardiac conditions** were **excluded** from the trial. As such it is still recommended to take into consideration the risk of cardiovascular side effects in patients with certain cardiovascular conditions including:
    - recent myocardial infarction < 6 months
    - any unstable or life threatening cardiac arrhythmia
    - cardiac arrhythmia requiring intervention or a change in drug therapy in the past year
    - hospitalisation of heart failure (NYHA Class III or IV) within the past year

That's NICE ..... www.nice.org.uk/Guidance/Date

December 2014 - three clinical guidelines and one technology appraisal that impact upon primary care:

- **Antenatal and postnatal mental health** clinical guideline (CG192) offers evidence-based advice on the recognition**,** assessment**,** care and treatment of mental health problems in women during pregnancy and the postnatal period (up to 1 year after childbirth), and in women who are planning a pregnancy
- **Colorectal Cancer** clinical guideline (CG 131) - diagnosis and management of colorectal cancer
- **Pneumonia** clinical guideline (CG191) - advice on the care and management of adults with community- and hospital-acquired pneumonia
- **Dabigatran: deep vein thrombosis and/or pulmonary embolism** technology appraisal (TG327) recommends this treatment as a possible treatment for adults with deep vein thrombosis or pulmonary embolism.

NICE Bites - Bipolar disorder provides a summary of CG 185 which covers the recognition, assessment and management of bipolar disorder in children, young people and adults.

January 2015 - Gastro-oesophageal reflux disease: recognition, diagnosis and management in children and young people clinical guideline **(NG1)** emphasises distinction between gastro-oesophageal reflux (GOR – common and does not require treatment) and the pathological variant GORD. Clinicians should be alert to **red flag symptoms** which may suggest GORD or other disorders. In formula-fed infants with frequent regurgitation associated with marked distress, the feeding history should be reviewed, the feed volumes reduced if excessive for the infant's weight and a trial of smaller, more frequent feeds offered while maintaining an appropriate total daily amount of milk. If the feeds are already small and frequent, then a trial of thickened formula can be offered. In formula-fed infants, alginate therapy may be offered for a trial period of 1-2 weeks if the stepped-care approach is unsuccessful. Continue with alginate if successful but treatment should be stopped at intervals to see if the infant has recovered.
Acid-suppressing drugs, such as PPIs or H2 receptor antagonists should not be offered to treat overt regurgitation in infants and children occurring as an isolated symptom. Metoclopramide, domperidone or erythromycin to treat GOR or GORD should not be offered without seeking specialist advice and taking into account their potential to cause adverse events.
This is also the first guideline issued in a new number system introduced this year.

February 2015 - three guidelines that impact upon primary care:

- **Bladder cancer** clinical guideline (NG2) - **diagnosis** and **management** of bladder cancer in adults
- **Diabetes in pregnancy** clinical guideline (NG3) advice on **managing diabetes** and its complications in women who are **planning** pregnancy and those who are **already pregnant**. It focuses on areas where additional or different care should be offered to women with diabetes and their newborn babies
- The **Irritable bowel syndrome in adults'** clinical guideline (CG61) - an update to the original guideline from 2008. It contains advice on the **diagnosis** and **management** of irritable bowel syndrome and details the circumstances when people need to be **referred** to a specialist. Recommendations for ovarian cancer screening as well as dietary and lifestyle advice and pharmacological therapy have been added to and updated.

Key therapeutic topics - medicines management options for local implementation 2015 has been updated by the **Medicines and Prescribing Centre** at NICE . Although not formal NICE guidance, it summarises the evidence base on topics identified to support Medicines Optimisation and identifies potential **opportunities** for maintaining or **improving quality** and **improving value**.
This update has retained the previous 14 therapeutic topics, **updating** in the light of new guidance and important new evidence. Changes include:

- KTT2: Renin-angiotensin system drugs. The addition of a table summarising NICE recommendations on the use of renin-angiotensin system drugs in various indications
- KTT3: Lipid-modifying drugs. Updated to reflect recommendations in the NICE guideline on lipid modification, published in July 2014
- KTT4: Omega 3 fatty acid supplements. Updated to reflect recommendations in the NICE guideline on MI – secondary prevention, published in November 2013 and the NICE guideline on lipid modification, published in July 2014
- KTT9: Antibiotic prescribing – especially broad spectrum antibiotics. Updated in line with Public Health England guidance on managing common infections, which was updated in November 2014
- KTT10: Three-day courses of antibiotics for uncomplicated urinary tract infection. Updated in line with Public Health England guidance on managing common infections, which was updated in November 2014

Action: Quarterly KTT-QIPP dashboard detailing practice performance on prescribing indicators will be forwarded to practices for internal review.

