CITY SCRIPTS

NHS
Brighton and Hove
Clinical Commissioning Group

Prescribing Newsletter June 2014

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.

Prescribing Incentive Scheme (PIS)

- Details of this current year's PIS 2014-15 is available on the CCG website
- Details of practice achievement of last year's PIS 2013-14 has been disseminated to Practice Managers

Inhaled Corticosteroid (ICS) card

Practices will shortly be receiving a small number of ICS cards, produced by the London Respiratory Network. They are intended to be used as a tool to support stepping down inhaled steroid doses in asthma patients (see Prescribing Incentive Scheme indicator)
They provide the patient with good reasons for using the lowest possible dose of inhaled steroids. They have been used successfully in London to persuade patients with stable disease who are wary of reducing their ICS dose of the advantages of stepping down.
They are not intended for routine use in COPD patients using high dose ICS, or for asthma patients for whom step down is not feasible.

Joint Formulary

Brighton APC makes decisions concerning additions to the Joint Formulary. The following summarises decisions made by the APC in April 2014:

Preparation	Decision	Notes
Tapentadol	Approved – **AMBER** – Supported for Pain Clinic Specialist initiation only	Awaiting Shared Care Guidelines (SCG)
Aflibercept	Approved - **RED** – Supported for inclusion onto the joint formulary for specialist use only	In line with NICE TA305
Triptorelin	Defer until further clarity/information brought back to APC	
Aripiprazole Long Acting Injection	Approved - **RED** – Supported for specialist use only (SPFT)	
Accrete D3	Approved - **GREEN** - 1st line choice rather than Adcal D3	
Lucette	Approved – GREEN preferred brand rather than Yasmin (3rd line use)	
Repinex XL	Approved – BLUE preferred brand of Ropinirole XL (specialist initiation)	
Fesoterodine fumerate	Not approved - **BLACK** – not routinely supported and not for inclusion onto the joint formulary)	

The Medicines Management Team has had a number of queries regarding **Mirvaso** (brimonodine), which is an anticholineric gel recently licensed for symptomatic treatment of facial erythema of rosacea in adult patients. It is not on the Joint Formulary (JF). Until an application is submitted and approved for inclusion in the JF, it should not be prescribed. Standard treatment options for rosacea are detailed in CKS

CCG Website Updates on Prescribing Policy and links to useful resources

- Repeat Prescribing Protocol Template
- List of common non-mapped drugs for EPS2
- Understanding your medication – benzodiazepine & Z drug patient information leaflet – updated version

Product news: Glucophage (metformin) sachets are to be discontinued by Merck Serono. Recent ePACT data identified 23 practices as having prescribed it. Where a liquid formulation is deemed necessary (i.e. for a patient with a PEG), then the only other licensed alternative is Metformin oral solution 500mg/5ml. This is a significantly more expensive preparation (£0.03p per 500mg tablet vs £0.11 per 500mg sachet dose vs £2.33 per 500mg liquid dose), and switching to this will result in an increase in annual prescribing costs within Brighton and Hove of £60,000, and over £14million nationally.
Action: Review all patients on the metformin sachets and only switch to the licensed oral liquid when a liquid formulation is considered essential

Getting ready for EPSR2

The full Electronic Prescription Service Release 2 (EPSR2) is live in Sackville Medical Centre, Ardingly Ct Surgery and Stanford Medical Centre.
EPSR2 will be rolled out in the remaining practices across the city later this year, as part of a planned implementation programme. To ensure that your practice is ready for a smooth transition to electronic prescribing, we are highlighting the following areas around medicine management housekeeping that may need attention before going live:

- Synchronise drug quantities in line with practice repeat protocol. Please refer to the Repeat Prescribing Protocol Template on the website
- Synchronise authorised issues or review dates (or both if used)
- Switch non DM+D drugs to mapped alternative
- Ensure preferred community pharmacy/script destination matches nominated pharmacy
- Ensure personal demographic service (PDS) data is synchronised

Changes to Controlled Drug (CD) Regulations

The Home Office has acted on advice of the Advisory Council on the Misuse of Drugs (ACMD) by changes to CD classification for a number of drugs, due to their harmfulness when misused. The implementation date was **10th June 2014**. The changes affect:

1. **Tramadol,** which is now Class C **schedule 3 CD** (CD No Register POM) with the following implications:
    - Tramadol can **no longer be prescribed using Repeat Dispensing or the Electronic Prescription Service (EPS).**
    - CD Prescription writing requirements for schedule 2 and 3 CDs, as detailed in the BNF apply [e.g. must clearly state the form (e.g. tablets, capsules); strength; dose (which must be as specific as possible i.e. 'Take One as directed' not 'Take as directed'); the quantity prescribed must be written in **words and figures**.]

      *The dispensing pharmacist is **not** allowed to dispense a Controlled Drug unless all the information required by law is given on the prescription. In the case of a prescription for a Controlled Drug in Schedule 2 or 3, a pharmacist can amend the prescription if it specifies the total quantity **only** in words or in figures or if it contains **minor typographical errors**, provided that such amendments are indelible and clearly attributable to the pharmacist. Failure to comply with the regulations concerning the writing of prescriptions will result in inconvenience to patients and delay in supplying the necessary medicine*
    - Tramadol prescriptions are **only valid for 28 days** (from appropriate date recorded on prescription) and not the 6 months it previously was
    - Prescribers are reminded of DH guidance of **limiting supplies up to 30 day**; exceptionally, to cover justifiable clinical need and after consideration of any risk, quantities covering a longer period can be prescribed, but the reasons should be documented in the patient's notes.

    Action:

    - Tramadol prescriptions not compliant to CD prescription writing requirements, (for reasons such as being written prior to and presented for dispensing after 10th June or GP systems have not been updated and Pharmacists amendments would not make the prescription compliant), will need to be re-issued by the Prescriber in a compliant form.
    - Pharmacists will check all NHS repeat dispensing prescriptions that they currently hold for tramadol**,** assess them for clinical appropriateness and contact the prescriber to request a review and if the Prescriber decides that it is appropriate, a replacement prescription complying with CD Prescription writing requirements on an FP10 should be provided.
    - Prescribers are advised to review patients on on-going tramadol in due course, in view of tramadol prescribing points below and taking in to account the intended spirit of the legislative changes – namely to reduce the prescribing of tramadol.
2. **Lisdexamfetamine** is being classed as **schedule 2** (requiring safe storage and register keeping), in line with dexamphetamine
3. **Zopiclone and zaleplon** to be classed as **schedule 4 CDs** with the benzodiazepines and zolpidem. Prescriptions are valid for 28 days

Prescribing Points for Tramadol

Tramadol, a synthetic analogue of codeine is liable to be misused. The reclassification as a Class C Schedule 3 drug was prompted by increasing reports of misuse and harm. Tramadol's unique dual-action (opioid agonist and inhibitor of the re-uptake of serotonin and noradrenaline), increases the potential for adverse effects, especially in overdose. Tramadol overdose results in drowsiness, constricted pupils, agitation, tachycardia, hypertension and nausea, vomiting and sweating. Seizures occur in up to 15% of cases; this is more common than with other opioids. In severe poisoning, coma, seizures and hypotension can occur. Overdose can also cause serotonin syndrome which is potentially fatal.

- Tramadol is neither more effective nor better tolerated than other weak opioid analgesics for moderate to severe pain.
- The need for continued treatment should be assessed at regular intervals as withdrawal symptoms and dependence have been reported with prolonged administration of tramadol. **CSM advised that treatment should be short and intermittent**.
- Consider using MR preparation if needed for long term use, except in the over 75's and those with renal impairment, where the elimination may be prolonged, and therefore doses and frequency may need to be reduced
- Should not be co-prescribed with serotonergic drugs, such as SSRIs, SNRIs, MAO inhibitors, tricyclic antidepressants and mirtazapine as this may cause serotonin toxicity
- Tramadol should not be given to patients suffering from uncontrolled epilepsy
- The most commonly reported adverse reactions are nausea, dizziness and constipation. Patients may also experience sleep disturbance, anxiety, confusion, nightmares and hallucinations.

With thanks to the MM teams of Surrey CCGs

MHRA Drug Safety Update May 2014 contains articles on the following

Domperidone - is associated with a small increased risk of serious cardiac side effects.
Its use is now restricted to:

- the relief of symptoms of nausea and vomiting, and it should no longer be used for bloating and heartburn
- the recommended dosages have been reduced
- duration of treatment has been reduced to a maximum of 1 week [48 hours if over the counter (OTC) use].

Domperidone is **contraindicated** in people with underlying cardiac condition; those receiving other medications known to prolong QT or potent CYP3A4 inhibitors and those with severe hepatic impairment
Action: Patients with these contraindications or on long-term treatment should have their treatment reviewed at their next routine appointment and be switched to an alternative treatment if required.

Voriconazole is known to be associated with a risk of liver toxicity, phototoxicity and squamous cell carcinoma. Liver function should be tested before and during treatment and patients should avoid sunlight exposure. Voriconazole is classified as a **RED** drug locally and so should not be prescribed by GPs

Adrenaline auto-injector advice - warnings have been strengthened for people at risk of anaphylaxis. These include:

- carrying **two** adrenaline auto-injectors at all times for emergency on- the- spot use.
- After every use of an adrenaline auto injector, an **ambulance should be called** (even if symptoms are improving);
- the individual should generally lie down with legs raised (if breathing difficulties sit up to make breathing easier) and not be left alone.

The auto-injectors licensed in the UK are Jext®, EpiPen® and Emerade®. Injection technique varies between injectors so it is important people with allergies and their carers have been trained to use the auto-injector prescribed and also to check expiry dates.
Patient Information Adrenaline Auto-Injectors is available on the MHRA website.

Statins update - The MHRA has reassured patients of the beneficial effects of statins after the BMJ withdraws a statement that suggested side effects occurred in up to 20 per cent of patients who used these drugs. People should continue to take their statins as prescribed because their benefits continue to outweigh the risks of any side effects.

Hypnotics

Current advice on hypnotics is to only initiate a short course (after exploring the alternatives) if symptoms of insomnia are severe, acute and disabling.
Hydroxyzine is often used for short term (2-4 weeks) relief of insomnia as an alternative to benzodiazepines (benzos) and z-drugs, but if a benzo or z-drug is considered necessary, zolpidem has been the local first choice. It has a shorter duration of action than zopiclone, so less likely to cause hangover effects.
However, the European Medicines Agency has recently reviewed the data on zolpidem and recommended that changes are made to the Summary of Product Characteristics (SPC), to include warnings about risks of next-morning reduced mental alertness and impaired driving ability. The zopiclone SPC already includes such warnings. There is also a reminder that these drugs are metabolized more slowly in older patients, so doses greater than 5mg zolpidem or 3.75mg zopiclone should not be prescribed.

Action:

- If initiating zolpidem or other hypnotics, prescribers should advise patients not to drive within 8 hours of taking the dose
- Older patients should be prescribed the lower dose.
- The updated Understanding your medication – benzodiazepine & Z drug patient information leaflet is a useful resource to signpost patients to.

Buprenorphine tablets in prisons

There is a growing trade in buprenorphine in prisons - this is a national problem, with 8mg tablets being traded for £50 each.
HMP Lewes report that it is the most commonly confiscated drug from visitors and prisoners returning from short term release trying to smuggle it in.

Action: Prescribers should be aware of the possibility of diversion.

Reporting of Adverse Prescribing and Medication Issues

There are different routes of reporting medication issues that prescribers should be aware of:

- **Feedback on Secondary Care Adherence to Joint Formulary**
  Use the feedback on providers address bhccg.fop@nhs.net for raising issues relating to prescribing from secondary care that does not follow the Joint Formulary guidelines or which may raise quality issues relating to prescribing requests.
  This will allow us to collate and feedback to the BSUHT Specialists and therefore improve the quality of prescribing in the City.
  Examples are: benzodiazepines started without a management plan; requests for prescribing of unlicensed or non-formulary medications or requests for medications requiring specialised monitoring
- **Medication administration errors**
  Near miss incidents of potential harm or errors of omission related to medication/prescribing should be reported via the National Reporting & Learning System (NRLS) https://www.eforms.nrls.nhs.uk/gpreport/
  Examples include prescribing errors, incorrect issuing of medication by pharmacies or administration of medication by carers
- **Adverse Events causing harm to patient**
  This is still the yellow card reporting system found at www.mhra.gov.uk/yellowcard or in the back of the BNF

Ophthalmology Specials

The Royal College of Ophthalmologists and the UK Ophthalmic Pharmacy Group are concerned about the suitability and the cost of certain unlicensed ophthalmic preparations prescribed and dispensed in primary care. As a result, they have jointly produced Ophthalmic Specials Guidance which gives licensed alternatives and advice on many commonly prescribed unlicensed eye preparations. The guidance will be reviewed every 6 months. For further advice, please consult your Primary Care Pharmacist.