CITY SCRIPTS

Brighton and Hove Clinical Commissioning Group

Prescribing Newsletter January 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.

Reminder - Prescribing Incentive Scheme (PIS) submissions deadline.

General Practices are reminded that their submissions for the PIS reviews are due in by the **15th of March 2014**. Practices can contact their CCG Pharmaceutical Advisor where Medicines Management Team support for the Action Plan commenced in 2014 **and** where an extension may be necessary. Formulary adherence and Benzodiazepine receptor drugs indicators will be measured via ePACT and Eclipse when year-end data is available.

Relvar Ellipta (fluticasone furoate/ vilanterol, 92/22mcg and 184/22mcg)

This new combination steroid/ long acting beta agonist inhaler was launched at the beginning of January. It is licensed both for COPD (the lower strength only) and for asthma (both strengths)

Prescribers are reminded that it is not in the Joint Formulary and should not be prescribed.

From the information that is available, the following are of concern:

- Cases of pneumonia, some fatal, were reported in the trials used for licensing.
- Fluticasone furoate is approximately **ten times** the potency of beclometasone dipropionate, therefore both doses represent **Step 4** of the BTS Asthma guidelines, and there is no option for stepping down the dose.
- There is no evidence of clinical superiority over existing treatments.
- The device is contained within a sealed foil pouch, once opened, the shelf life is 6 weeks, which may increase the risk of patients using expired inhaler
- Although dosing is once a day, the SPC notes that **if a dose is missed**, **no dose should be taken before the next day's dose is due**

Costs of these products are £27.80 and £38.87 respectively, less than existing combination products. Despite this, it is important to note that wider management of COPD and asthma is more than just simple drug acquisition cost and should include the tailoring of treatment and the management of exacerbations and hospitalisation.

Action: **Prescribers are reminded that it is not in the Joint Formulary and should not be prescribed.**

Treatment of UTIs

Since the MHRA's Drug Safety Update August 2013 highlighted nitrofurantoin's contraindication in patients with creatinine clearance (Cr Cl) less than 60ml/min, BSUH microbiology have started releasing MSU sensitivities to cefalexin and co-amoxiclav.

Trimethoprim remains the first line empirical choice for patients with renal impairment and eGFR >30ml/min/1.73m^2. This is because:

- Approximately 35% of MSUs show resistance to trimethoprim, however these are likely to over-represent resistance in the general population since MSUs are more likely to be sent if there has been treatment failure.
- Cefalexin and co-amoxiclav are broad spectrum antibiotics and are therefore more likely to be associated with C.*difficile* infection and ESBL (Extended Spectrum beta lactamase) producing organisms, which are resistant to many commonly prescribed antibiotics.

ACTION

Prescribe trimethoprim or nitrofurantoin for UTIs where possible; reserve cefalexin and co-amoxiclav for cases which are trimethoprim resistant **and** where renal function precludes the use of nitrofurantoin

ScriptSwitch update

- **New Scriptswitch Feedback Function** is now available to prescribers in order to comment on messages. It is intended for general comments on the usefulness or otherwise of the switch. It is not intended for comments on individual patients such as "patient has tried this drug before".
- For magnesium glycerophosphate 97.2mg (4mmol) , we are currently recommending **Magnaphate** 4mmol tablets which are should be readily available from main wholesalers **(**pip code 349-4945**)**
- Switch from piroxicam gel to **Fenbid** (ibuprofen gel) is now recommended due to supply problems
- The **warfarin - clarithromycin interaction** was highlighted in City Scripts October 2012 and Scriptswitch. Prescribers are reminded that doxycycline is preferable to clarithromycin in patients on warfarin since it is less likely to cause problems with INR

Brighton Area Prescribing Committee (Brighton APC)

Brighton APC makes decisions concerning additions to the Joint Formulary. Below are the recent decisions made by the APC:

Summary of Brighton Area Prescribing Committee (APC) decisions			
Meeting month	**Item**	**Decision**	**Restriction**
October 2013	**Linaclotide**	**NOT APPROVED – DO NOT PRESCRIBE**	
November 2013	**Perampanel**	APPROVED AMBER = specialist initiation	Under shared care, BSUH to monitor
January 2014	**Dapagliflozin**	APPROVED - BLUE	in line with NICE TA288.
	Lixisenatide	APPROVED - AMBER	in line with NICE CG87 for GLP-1
	Renavit	APPROVED - GREEN	Alternative to Ketovite
	Ocriplasmin for vitreomacular traction	APPROVED RED= Hospital ONLY	in line with NICE TA297.
	Ranibizumab for myopic CNV	APPROVED RED = Hospital ONLY	in line with NICE TA298.
	Insulin degludec	**NOT APPROVED – DO NOT PRESCRIBE**	

MHRA Drug Safety Update

December 2013 issue reports on:

- rare but serious condition of **acquired haemophilia** associated with **clopidogrel which may be missed** due to the established risk of bleeding associated with clopidogrel treatment
- awareness of increased risk of eye injuries from the use of new winged tip designed of Cosopt (**dorzolomide / timolol**) preservative-free single-dose eye drops, which may necessitate assistance or additional education**.** Whilst a revised design will be introduced early in 2014, new interim container will be available from 10th February

January 2014 reports on optimal timing of dose of prasugrel for PCI; hepatic injury associated with temozolomide and severe skin reactions with capectiabine

Non-Medical Prescribers joining practices

Practices with recent additions of Non- Medical Prescriber (NMP/Nurse Prescriber) are directed to anne.smith4@nhs.net who currently manages the process to enable all NMPs to prescribe on behalf of their practice. This process can take approximately two weeks, provided relevant forms are submitted in a timely manner. NMP can also benefit from supportive supervision and educational sessions support by the Medicine Management Team.

Although every effort is made to ensure this newsletter is accurate, the producers can accept no responsibility for errors or omissions in information provided by external organisations. Any opinions expressed are those of the editor and do not necessarily represent the opinions of Brighton and Hove CCG, 2 of 2