Medicines Management newsletter

Issue 9 - June 2018

NHS
Halton Clinical Commissioning Group

Pan Mersey Area Prescribing Committee

RECOMMENDATIONS SPECIFICALLY RELEVANT TO PRIMARY CARE

Guidance on Prescribing in Primary Care following a Private Consultation

NHS prescribers are often asked to issue an NHS prescription for a patient who is paying for private medical treatment. This is because many medications are more costly to the patient when issued privately than by the NHS.

This can raise questions about whether the patient would have received the same treatment if they had been diagnosed or treated on an NHS pathway and hence cause a dilemma for the prescriber as to whether they should issue an item on an NHS prescription or refuse.

This guidance is designed to clarify some of the issues which arise. The principles of this document apply equally to any provider delivering NHS commissioned care.

In summary

- If a private consultation identifies a long-term condition or a need for medication which is available as routine NHS treatment, this should be provided as such by the patient's usual primary care prescriber if they are satisfied it is appropriate, and the private provider issues the first prescription. The GP should be asked to take over prescribing only when the patient is stabilised on the medication. This applies whether the referral was by an NHS clinician or the patient self-referred.
- The responsibility for prescribing rests with the prescriber who has clinical responsibility for a particular aspect of the patients' care.
- There is no obligation on behalf of the primary care prescriber to prescribe the recommended treatment if it is contrary to his/her normal clinical practice.
- If the private/consultant prescribing recommendation does not follow Pan Mersey Area Prescribing Committee (APC), local or national guidance or policy, then the primary care prescriber may substitute a medicine with a clinically appropriate alternative.

The NHS Halton CCG Medicines Management Group has suggested that prescribers may wish to include this document or a link to the document when making private referrals and to make reference to it in any communications should an inappropriate request to prescribe be received. The Medicines Management Team will work with practices to embed the document into any their current administrative processes for referrals and to support with any templates that may be helpful. http://www.panmerseyapc.nhs.uk/guidelines/documents/G46.pdf

RECOMMENDATIONS

BLACK ULIPRISTAL 5mg tablets (Esmya®) for uterine fibroids
Monitor liver function in current and recent users; do not initiate treatment in new users or those between treatment courses.

RED BRODALUMAB solution for injection (Kyntheum®▼)
The Pan Mersey Area Prescribing Committee recommends the prescribing of BRODALUMAB solution for injection (Kyntheum®▼), by specialists only, for treating plaque psoriasis in accordance with NICE TA511.

AMBER Direct oral anticoagulants (DOACs) (previously known as NOACs) for the treatment and prevention of Deep Vein Thrombosis (DVT) and/or Pulmonary Embolism (PE)
DOACs are recommended as an option for treating and/or preventing recurrent DVT and/or PE where an oral anticoagulant is indicated following specialist initiation.

GREEN Direct Oral Anticoagulants (DOACs) (previously known as NOACs) in Non Valvular Atrial Fibrillation: a multiple prescribing statement for Apixaban, Dabigatran, Edoxaban and Rivaroxaban
DOACs are recommended as treatment options for the prevention of stroke and systemic emboli in non-valvular atrial fibrillation where an oral anticoagulant is indicated.

SHARED CARE AND PRESCRIBING SUPPORT

DAPSONE for dermatology indications
Issued: April 2018 | Review: April 2021

Low Molecular Weight Heparin (LMWH) for adults
Issued: April 2018 | Review: April 2021

Medicines Management Work plan 2018/19

During **June** and **July 2018** the NHS Halton CCG Medicines Management Team will be doing the following pieces of work:

- **Seretide Inhalers** - Highlighting of patients prescribed Seretide® inhalers in Chronic Obstructive Pulmonary Disease for potential switch to formulary choice inhalers where clinically appropriate in line with Pan Mersey guidance.
- **Valproate Safety Review** - Identification of female patients currently prescribed valproate (sodium valproate/valproic Acid) for review by practice in line with Pregnancy Prevention Programme (Prevent) recommendations as highlighted in last month's newsletter.
- **GLP-1 Agonists** - Review of the prescribing of Glucagon-Like Peptide-1 Receptor (GLP-1) Agonists (liraglutide, exenatide, lixisenatide) including review of:
    - Prescribed quantities and ordering frequency of GLP-1 agonists.
    - Patients prescribed GLP-1 agonists for response against NICE criteria for continuation.
- **Dual antiplatelet therapy (DAPT)** - Review of patients prescribed dual antiplatelet therapy (DAPT) to ensure the duration of therapy is appropriate, and those prescriptions of a limited duration have a recorded stop date as highlighted below.

Hot Topic - Dual Antiplatelet Therapy (DAPT)

The NHS Halton CCG Medicines Management Team will be reviewing patients prescribed more than one antiplatelet drug, to ensure the duration of therapy is appropriate, and that prescriptions of a limited duration have a recorded stop date. Patients requiring review will be highlighted to the prescriber.

Dual antiplatelet therapy (DAPT) is well established in post-acute coronary syndrome (ACS) which encompasses a range of conditions, including:

- Unstable angina
- Non-ST-segment-elevation myocardial infarction (NSTEMI)
- ST-segment-elevation myocardial infarction (STEMI)

People experiencing the above, benefit from treatment to reduce the risk of another event and to slow the progression of Coronary Heart Disease (CHD). According to NICE [CG172] November 2013 (https://www.nice.org.uk/guidance/cg172) all patients who have had an acute myocardial infarction should be offered dual antiplatelet therapy (aspirin plus a second antiplatelet agent).

DAPT has benefits in terms of reducing cardiovascular morbidity and mortality; however, the risk of a serious bleed increases with increasing length of dual therapy.

DAPT is usually indicated for a period of 12 months, however, this can vary for example; complex patients and patients experiencing further cardiovascular events whilst on DAPT may need longer treatment duration.

The three antiplatelet drugs recommended in combination with low-dose aspirin are:

- Clopidogrel
- Ticagrelor (Brilique®)
- Prasugrel (Efient®)

DAPT is initiated in hospital and secondary care providers should include details of the indication, dose and duration of dual antiplatelet therapy in discharge letters to primary care.

GPs and other healthcare professionals should not prescribe without these clear directions.

Practices should:

- Include the indication, dose and duration of dual therapy on the patient's records
- Calculate a stop date for the patient's records
- Consider including a stop date on the prescription
- Consider need for appropriate gastro-protection (see below)

Gastro-protection & dual antiplatelet therapy:

A patient may be need to be started on a proton-pump inhibitor (PPI) or H2 antagonist when dual anti-platelet therapy is initiated - due to the increased bleeding risk. When choosing the gastro-protective drug, take into consideration the risk of interactions e.g. clopidogrel and omeprazole, as well as ensuring the dose is appropriate. Ongoing treatment with PPI/H2 antagonist should be reviewed when dual anti-platelet therapy is stopped.

Information for pharmacies

- Utilise the New Medicines Service (NMS) for newly initiated antiplatelet drugs and/or Medicines Use Reviews (MURs).
- Check antiplatelet prescriptions for stop dates and highlight to the practice any that have expired.
- Highlight interactions between omeprazole and clopidogrel where appropriate and alert the patient of any OTC interactions e.g. NSAIDs.
- Counsel patients regarding the potential side effects of antiplatelet use i.e. nosebleeds, bruising and cuts bleeding for longer than usual.

Safety

HOME USE AND POINT OF CARE BLOOD GLUCOSE MONITORING SYSTEM: ACCU-CHEK AVIVA, ACCU-CHEK PERFORMA AND ACCU-CHEK INFORM II TEST STRIPS – RISK OF STRIP ERROR MESSAGES AND FALSE HIGH AND LOW BLOOD GLUCOSE RESULTS

A Medical Device Alert has been issued for Accu-Chek Aviva, Accu-Chek Performa, and Accu-Chek Inform II test strips. Affected strips, manufactured by Roche Diabetes Care, may give increased strip error messages prior to dosing with blood and in some cases may give false high or low readings, which may be hard to detect.
https://www.gov.uk/drug-device-alerts/home-use-and-point-of-care-blood-glucose-monitoring-system-accu-chek-aviva-accu-chek-performa-and-accu-chek-inform-ii-test-strips-risk-of-strip-error-messages-and-false-high-and-low-blood-glucose-results

Action

Healthcare personnel who manage patients using these devices:

- Identify patients who use Accu-Chek Aviva, Accu-Chek Aviva Nano, Accu-Chek Aviva Expert, Accu-Chek Aviva Combo, Accu-Chek Aviva Insight, and Accu-Chek Performa Nano meters.
- Advice patients to discontinue use of Accu-Chek Aviva and Accu-Chek Performa blood glucose test strips with affected lot numbers, see Field Safety Notice. https://mhra.filecamp.com/public/file/2sgf-9jpfi8kq
- Return affected test strips to the pharmacy where they were dispensed or purchased from for replacements.
- Ensure that patients are aware of this information and that they have an alternative testing means, if required.
- Ensure the patient can continue to monitor their blood glucose effectively.
- If patients are concerned about their blood glucose readings when using this meter, advise them to contact their healthcare professional.

Healthcare personnel who use Accu-Chek Inform II test strips with Accu-Chek Inform II and Accu-Chek Performa meters:

MHRA understands that Accu-Chek Inform II test strips have only been supplied by Roche for professional use in the UK.

- Ensure all relevant members of staff receive the FSN and can continue to monitor patient's blood glucose effectively, using an alternative means if required.
- Dispose of any affected lots.

BRALTUS (TIOTROPIUM): RISK OF INHALATION OF CAPSULE IF PLACED IN THE MOUTHPIECE OF THE INHALER

MHRA have received reports of patients who have inhaled a Braltus capsule from the mouthpiece into the back of the throat, resulting in coughing and risking aspiration or airway obstruction.

Advice for healthcare professionals:

- Train patients in the correct use of their inhaler; a placebo device is available for training purposes and instructions for patients are provided in the patient information leaflet and on the carton.

- Tell patients to store capsules in the screw-cap bottle provided (never in the inhaler) and to always check the mouthpiece is clear before inhaling.
- Pharmacists dispensing Braltus capsules should remind patients always to read the instructions for use in the package leaflet and that they must never place a capsule directly into the mouthpiece.
- Please continue to report adverse incidents during use of the inhaler as well as suspected adverse reactions to the medicine on a Yellow Card.

https://www.gov.uk/drug-safety-update/braltus-tiotropium-risk-of-inhalation-of-capsule-if-placed-in-the-mouthpiece-of-the-inhaler

Controlled Drugs: Risk of confusion between Oxycodone Modified Release Preparations

Oxycodone Modified Release Preparations - Take care when prescribing and dispensing.

Oxycodone modified release is available as 12 hourly AND 24 hourly formulations. Although oxycodone 24 hourly preparations are NOT currently on Pan Mersey formulary there is potential for error through incorrect product selection at the point of prescribing, dispensing, supply and administration.

12-hourly modified release preparations include the branded products:

- **Longtec® (CCG recommended cost-effective product)**
  - Abtard®, Carexil®, Leveraxo®, Oxeltra®, OxyContin®, Oxylan®, Reltebon®, and Zomestine®
  - Strengths available: 5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg and 120 mg

24-hourly modified release preparation:

- Onexila® XL is a newly licensed **ONCE DAILY** Oxycodone modified release preparation.
  - Strengths available: 10mg, 20mg, 40mg and 80mg

Risk recognition for oxycodone modified release preparations

Drug tariff.	Lists the same dm+d description for the generic 12 hourly and 24 hourly formulations in section VIIIa of the drug tariff.
Electronic prescribing and dispensing systems.	List the same description for both 12 hourly and 24 hourly generic formulations
Pharmacokinetics.	**12 hourly formulations** are biphasic with an initial early onset of analgesia followed by a more controlled release. The maximum plasma concentration is achieved at 3 hours which remains at plateau for approximately the first 4 hours. The onset of analgesia occurs within 1 hour in most patients. **24 hourly formulation** is single phasic controlled release with a slower onset of action. Onexila® XL pharmacokinetics are characterised by an increase of plasma concentration over 4 hours, a plateau for approximately 10 hours, followed by a gradual decline until 24 hours after dosing. The onset of analgesia is gradual over the first four hours after administration.

Mis-selection of the product at prescribing or dispensing process.	This could result in the wrong daily dose and/or frequency of oxycodone being received with potential serious adverse effects (too high a dose) or compromise of pain control (too low a dose).
The risk of the wrong product being supplied at transitions of care between sectors, with the risk heightened by poor communication.	Patients / carers may not be aware of vigilance of formulation as modified release prescribing is usually a 12 hourly formulation. Health care organisations have different formulary choices. Patients/ carers are used to receiving different looking packaging and may not query a change in packaging or read the label carefully.

ACTION

To maintain patient safety and stop confusion

Prescribers:

- **ALWAYS** prescribe Oxycodone preparations by BRAND name as per CQC recommendations.

Pharmacists/dispensers:

- TAKE EXTRA CARE when storing, dispensing and giving out or delivering Oxycodone modified release preparations.
- If you receive a generically written prescription for Oxycodone Modified Release (for any strength) then please contact the prescriber to confirm the intended formulation and to highlight the requirement to prescribe by brand in future.
- You may wish to record the brand dispensed on the PMR but it is recommended to contact the prescriber if prescriptions continue to be written generically as well as confirming with the patient that the brand to be supplied is the same as previously dispensed.
- ALWAYS confirm with the patient / representative/ carer their understanding of how to take the controlled drug correctly.
- Endorse the BRAND supplied on the prescription and practice electronic system for a clear audit trail.
- Store the formulations separately in the CD cupboard.

Links to useful resources:

- **Care Quality Commission** Safer Use of Controlled Drugs - Preventing Harm From Oral Oxycodone Medicines http://webarchive.nationalarchives.gov.uk/20161108035823/https:/www.cqc.org.uk/sites/default/files/documents/safer_use_of_controlled_drugs_-_guidance_for_the_web_-_preventing_harm_from_oral_oxycodone_medicines_v2.0.pdf
- **Faculty of Pain** Medicines Guidelines and Publications https://www.rcoa.ac.uk/faculty-of-pain-medicine/guidelines
- **Special Pharmacy Services** UKMi Product Safety assessment on Onexila® XL (oxycodone once daily prolonged release tablets https://www.sps.nhs.uk/articles/in-use-product-safety-assessment-report-onexila-xl-oxycodone-once-daily-prolonged-release-tablets/

Amendments to Prescriber Details against Prescribing Codes and Performers List

Due to a number of recent issues the Medicines Management Team have looked into how GPs are added/removed/amended with regards to the practice prescribing code. There has been some incorrect information sent out stating that it is the CCG's responsibility to do this and the Head of Medicines Management is the authorised signatory for this. Amending doctors against prescribing codes is linked directly to the performers list and as such needs to be done via the correct process.

We have now clarified the process and hope this will reduce delays and improve the process for everyone.

Amendments for Medical Prescribers

1. NHS Halton CCG is not responsible for authorising amendments to the performers list and this includes additions/deletions against practice prescribing codes (for doctors), change of performers name, address, status or practice.
2. All communications regarding doctors leaving/joining a GP practice should be directed to Primary Care Support England (PCSE).
3. After speaking to PCSE- Back Office Tel: 0333 0142884 the correct process is as follows.
    - Log onto https://www.performer.england.nhs.uk/Documents.
    - Click Performers List Application form & Notes.
    - Scroll down to NPL3: Change in registered address, practice within existing locality or status of inclusion and open document.
    - This form should be completed by the performer.
    - The form MUST be sent to pcse.performerlists@nhs.net .
    - **Note do not send to NHSE Area team as per information on NPL 3 document.**
    - The form is for any changes to the performers list (not just removing them) but also if they have moved practices.

Amendments to Non-medical Prescribers (NMPs), Cost centres and Spurious Codes

1. NHS Halton CCG Head of Medicines Management is the authorised signatory for adding/removing/amending NMPs against CCG prescribing codes and for CCG cost centre codes.
2. Please contact Lucy Reid on 01928 593452 or via lucy.reid@haltonccg.nhs.uk for advice on how to proceed.

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