Prescribing Points

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Oxfordshire Cinical Commissioning Group

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This newsletter is uploaded to the OCCG website . For queries, contact jane.lynch@oxfordshireccg.nhs.uk
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Management of Over Active Bladder

The Overactive Bladder Prescribing Guidance has been updated. It is available on our intranet here. A summary of the drug treatment choices is below:

1st line option:
Tolterodine 2mg standard release bd
If not tolerated due to side effects e.g. dry mouth reduce dose to 1mg bd
(28 days treatment 2mg £2.88, 1mg £2.56)

⇩

2nd line options:

Fesoterodine 4mg od titrating to 8mg od if necessary.
(28 days treatment £25.78)

Patients with swallowing difficulties ONLY
***Oxybutynin patches** 3.9mg/24hrs*
8 patches (4 weeks supply) £27.20 (traffic lighted brown)

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On specialist (including nurse specialist) recommendation only:
Mirabegron 25mg to 50mg od
(30 days treatment £29.00)
Following referral mirabegron may be recommended before considering other treatment options. Mirabegron should be used in accordance with the NICE Technology Appraisal Guidance 290 and should therefore be reserved for patients who have exhausted the other anticholinergics detailed above or in whom anticholinergics are contraindicated.

So what?

The first line choice of antimuscarinic is now tolterodine 2mg standard release bd; if side effects are an issue, reduce to 1mg bd.
If tolterodine is ineffective consider Fesoterodine 4mg increasing to 8mg if needed.
Mirabegron may be used on specialist recommendation if other options have been exhausted.
Solifenacin is no longer an option in the updated pathway and should not be initiated.
Regular review is needed with consideration given to stopping treatment to assess continued effectiveness.

Type 2 Diabetes Prescribing Update

Bydureon – new device

A new pre-filled pen device of Bydureon (once weekly exenatide) was launched recently. This offers a simpler method of administration to patients at no extra cost. Patient education will be required for new patients and those switching from the original format.
The place of Bydureon in therapy has **not** changed. It should only be used when there is a significant benefit to once weekly administration (e.g. when the medication is administered by a carer or practice nurse) in line with local guidance.

Choice of Gliptin (DPP-4 inhibitors)

Alogliptin (Vipidia) is first choice gliptin. It is indicated in adults aged 18 years and older with type 2 diabetes mellitus to improve glycaemic control in combination with other glucose lowering medicinal products including insulin, when these, together with diet and exercise, have not provided adequate glycaemic control.
Linaglipitin (Trajenta) is the gliptin of choice in renal impairment.
Both gliptins are available in a combination formulation with metformin; however, we advise that the combination products are avoided.

Melatonin Prescribing In Primary Care – Reminder

Over the past 12 months £147,196 has been spent on melatonin prescriptions within Primary Care in Oxfordshire with the majority being both inappropriately requested and high cost unlicensed specials.
Currently the only approved indication for which GPs should provide prescriptions for melatonin is under an individual Shared Care Protocol (SCP) for patients who are under the care of the paediatric neurology team at the OUH. All other requests from Oxford Health (often PCHAMHS), the Sleep Clinic at the OUH, community teams and other specialities within secondary care, as well as all requests for adults, are inappropriate and should be passed back to the initiator and reported into the DATIX system.

Oxford Health have agreed to arrange for all prescribing initiated by them to be repatriated back to their prescribers. This will result in the most cost effective product for the NHS being provided, as well as providing timely reviews by the appropriate specialists. If you have details of patients you feel would fall into this category, please discuss this with the Prescribing Adviser attached to your practice. Once repatriation has occurred, Oxford Health will arrange for the provision of any appropriate melatonin for your patients.

So What?
GPs should not initiate or continue any melatonin treatment unless the patient is under the Paediatric Neurology team at the OUH and a unique SCP has been drawn up. All other requests are inappropriate and should not be continued within Primary Care.

Prescribing of budesonide/formoterol combination inhalers

There are now two inhalers available on the market containing both budesonide and formoterol: Symbicort® Turbohaler® and DuoResp® Spiromax®.

Although they both contain the same active ingredients at the same strength there are some key differences:

- they are presented as different inhaler devices that require different inhaler technique;
- the strength is stated differently on the packaging of each brand. In the case of Symbicort® this is the metered dose and in the case of DuoResp® this is the delivered dose (i.e. the dose that leaves the mouthpiece).

When a budesonide/formoterol combination inhaler is prescribed generically, either Symbicort® or DuoResp® can legally be supplied. This has resulted in some patients locally receiving an inhaler they are not familiar with using or having a supply of both brands in their home thinking they need to use both.

So What?
Prescribing budesonide/formoterol combination inhalers by the brand Symbicort® is recommended to ensure consistency of supply

COPD Management in Primary care – New Guidance

New local COPD prescribing guidance has been developed in conjunction with the OUH/OH respiratory team, local GPs and practice nurses. It is now available on the CCG intranet here and a summary of the treatment pathway is given on the following page of this newsletter.
The guidance aims to offer a stepwise approach to inhaled therapy depending on the severity of disease categorised by FEV1 % predicted (confirmed by spirometry), symptoms and exacerbations. It also stresses the importance of smoking cessation, vaccinations and pulmonary rehabilitation in the management of COPD.

Key Changes from 2011 Guideline

- Second line long acting muscarinic antagonist (LAMA) added – aclidinum bromide (Eklira Genuair) to be used if patient is unable to use tiotropium handihaler device.
- LAMA is the first line long acting bronchodilator option. Long acting beta agonists (LABA) should be used as a single bronchodilator if a LAMA is contraindicated, gives no benefit or is not tolerated due to side effects.
- Addition of LAMA/LABA combination inhaler – aclidinium/formoterol (Duaklir Genair) - as dual bronchodilator option. To be used if patient shows response to a LAMA but symptoms are not controlled or increase.
- Changes to inhaled corticosteroid/LABA choices to include Fostair MDI as a first line option (alongside symbicort) and inclusion of Relvar Ellipta as a second line option.
- Seretide 500 Accuhaler is no longer included as an option because it includes a higher dose of steroid than the other ICS/LABA inhalers licensed for COPD. Patients who are currently maintained on this should be assessed for ongoing appropriateness at their next routine review.
- The addition of a supporting document giving further information about each of the inhaler choices on the guidance to aid decision making with the patient.

So What?

Prescribers and other healthcare professionals working with COPD patients should be aware of the updated guidance and use it when reviewing patients therapy and when starting patients on new treatments

*****Diagnosis should be confirmed with spirometry, co-existing asthma and COPD may need to be treated differently.*****

For patients at all stages :

- Offer referral to a smoking cessation service to any person with COPD who continues to smoke
- Offer pneumococcal and annual influenza vaccination
- Refer to Pulmonary Rehabilitation especially if MRC grade is 3 or above (forms available here)
- Check inhaler technique with every device used
- Treatment with metered dose inhalers is much more effective if used with a spacer, especially in exacerbations. Ensure every person with COPD has a spacer to use with their metered dose inhaler(s) and knows how to use it
- All trials of inhaler treatment should be assessed for effect on symptoms (e.g. using CAT scores) and treatment should be withdrawn if no benefit is given

Mild

- FEV_1 % predicted ≥80%

(based on post bronchodilator FEV_1 in patients with FEV_1/FVC <0.7)

and/or

- Few symptoms

and/or

- ≤ 1 exacerbation per year

Moderate

- FEV_1 % predicted 50-79%

(based on post bronchodilator FEV1 in patients with FEV1/FVC <0.7)

and/or

- ≤ 2 exacerbation per year

and/or

- Daily symptoms

Increasing severity

Severe and very severe

- FEV_1 % predicted <50%

(based on post bronchodilator FEV1 in patients with FEV1/FVC <0.7)

and/or

- ≥ 3 excerbations per year

Offer SABA (short acting beta agonist) when required

salbutamol 100mcg/dose (MDI preferred, always use with spacer for greater effectiveness)

Two puffs when required up to four times a day

Alternative options: Easyhaler salbutamol (dry powder)

Bricanyl (terbutaline) Turbohaler

Offer LAMA (long acting muscarinic antagonist)

Continue SABA prn

1st line tiotropium 18mcg inhalation powder (Handihaler device)	1 inhalation once daily
2nd line (if handihaler device not suitable) *aclidinium bromide (Eklira Genuair) 322 micrograms/inhalation*	1 inhalation twice daily
3rd line (if dry powder not suitable) *tiotropium respimat 2.5mcg/ inhalation* (avoid in unstable cardiac rhythm disorders)	2 puffs once daily

Alternative option

Offer LABA (long acting beta agonist)

Offer only if LAMA unsuitable (side effects, no benefit or contraindicated)

1st line— formoterol 12 mcg easyhaler or OXIS 12mcg turbohaler	1-2 puffs twice a day
2nd line— Salmeterol evohaler 25mcg	2 puffs twice daily

If the patient shows a response to a LAMA but symptoms are still not controlled or symptoms increase:

Offer LABA + LAMA

1st line— aclidinium/formoterol (Duaklir Genuair) 340 micrograms /12 micrograms	1 inhalation twice daily

If all other treatment options have been tried (including pulmonary rehab) and patient still symptomatic/frequent exacerbations:

Inhaled Corticosteroid/LABA +/- LAMA

1st line—Beclomethasone/ formoterol (Fostair) 100/6 MDI (with spacer) Or Symbicort (budesonide/formoterol) 200/6 turbohaler	2 puffs twice daily
2nd line—Relvar Ellipta (fluticasone furoate/vilanterol) 92/22	1 puff once daily

All of these three options give a daily ICS dose equivalent to 800-1000 mcg of HFA - beclometasone. Be aware of potential of developing side effects (including pneumonia) in people with COPD treated with ICS and be prepared to discuss this with patients

Modified Release Galantamine – Choice of Product

Gatalin XL contains modified release galantamine and is available in 8mg, 16mg and 24mg strengths. Gatalin XL is available at half the drug tariff price and if all prescriptions for MR galantamine were prescribed as Gatalin XL this would be a saving of approx. £66,000 per year for the CCG. A suggestion for the change will appear on ScriptSwitch. Your prescribing adviser will be able to advise you on how much this switch could save your practice, as well as help implement the change if required.

So what?
Consider switching all prescriptions for modified release galantamine to Gatalin XL

Legislative changes to prescription writing requirements for Temazepam

As of **1st June 2015** prescriptions for Temazepam must fully comply with the prescription writing requirements for Schedule 3 controlled drugs.
Prescriptions for Temazepam must now contain the following information:

- dose
- form
- strength (where appropriate)
- total quantity of the preparation in both words and figures

So What?
Prescribers must ensure that all prescriptions for temazepam now comply with the new requirements or they will not be legally valid

Choice of Magnesium Supplement

Magnesium-L-aspartate (Magnaspartate®) is now the preferred choice in Oxfordshire for the treatment and prevention of magnesium deficiency when clinically appropriate. It is the only UK licensed oral magnesium preparation for these indications. It has been added to Joint Oxfordshire Formulary as 'yellow' following specialist initiation. This is also in line with recent advice from UKMI.
It is available as a powder for oral solution, with each sachet containing magnesium aspartate dihydrate equivalent to 243 mg (10 mmol) of magnesium at a dose of 1-2 sachets daily for adults. A pack of 10 sachets costs £8.95.

So what?
All new patients requiring magnesium should now be prescribed magnesium aspartate. Prescribers may wish to consider reviewing patients currently taking unlicensed magnesium products.

Anticoagulation for DVT/PE patients

A reminder that patients discharged with a DVT or a PE should be under the care of the DVT clinic at the Churchill Hospital who will prescribe anticoagulation for three months. If, after this time, the DVT clinic has advised longer term treatment anticoagulation prescribing then becomes the responsibility of the GP. Further guidance on the treatment and prevention of DVT and PE in Primary Care is available here

Switching Between Warfarin and NOACs

The anticoagulation service at OUH is receiving an increasing numbers of queries regarding switching from warfarin to a NOAC. The information can be found in a national document produced by UKMi. Please see this link for further information

Switching information is also available within the Summary of Product Characteristics for the relevant product and it can be found here:www.medicines.org.uk.