Prescribing Points

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Oxfordshire
Clinical Commissioning Group

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Please let us know if you are receiving this newsletter and it is no longer relevant to you by contacting Sue Keating, Team Administrator, on susan.keating@oxfordshireccg.nhs.uk.

OUHFT supply of NOACs for acute VTE

As of 1st May 2016, OUHFT (and the DVT service) will supply each patient with 3 weeks of NOAC. This has reduced from the previous supply of 3 months. Further supplies will therefore need to be obtained from the patient's GP. OUHFT will provide clear written communication regarding diagnosis, medication commenced including dosing regime and likely duration of therapy (if known at that stage). Please ensure that patient's therapy (NOAC) is reviewed and if indicated, stopped after completion of the intended course (as per OUHFT letter).

Shared Care Protocol Update

The azathioprine and mycophenolate mofetil shared care protocols have been updated to include renal indications. Under the shared care protocol, azathioprine and mycophenolate mofetil can be used for systemic lupus erythematosus, systemic vasculitis and occasionally for patients with nephritis. Use in kidney and pancreas transplant patients is not covered by this protocol as supply and monitoring is undertaken by Oxford Transplant Centre. The mycophenolate protocol was also updated to include the MHRA safety update on pregnancy-prevention for women and men.

The document Shared Care Responsibilities outlines the responsibility of the Specialist, the GP and the patient. GPs should not agree to shared care of a patient if they do not have the appropriate information from secondary care. If a copy of the shared care protocol is not sent with the request, it is available on the intranet and DXS for reference. Any incomplete or inappropriate requests should be reported on Datix as soon as possible.

Work is being initiated with secondary care to improve the process at the initiation stage.

So What?
Prescribers should be aware of YELLOW shared care drugs. Starting inappropriate or incomplete requests can have potentially fatal consequences for patients. Help the OCCG assess the situation by filling out Datix reports or making your prescribing adviser aware of any issues.

Fosfomycin for resistant urinary tract infections (UTIs)

At the January meeting of the OCCG Area Prescribing Committee (APCO), the decision was taken for the traffic light classification of fosfomycin to be changed from RED (specialist prescribing only) to BROWN (use only in restricted circumstances). See box below for inclusion criteria.

Inclusion Criteria

- The patient must be suffering from an acute uncomplicated lower UTI
- The patient must be suffering from a symptomatic UTI.
- A urine specimen must have been examined by the laboratory.
- There must be a significant growth of a fosfomycin - sensitive organism in the sample.
- There must be **no other suitable oral treatment alternative**, either because of bacterial resistance, or because of patient allergy or intolerance to suitable antimicrobials.

Background

In recent years there has been a marked increase in the prevalence of UTIs caused by coliforms that are resistant to both penicillins and cephalosporins (i.e. extended spectrum beta lactamase [ESBL] producing organisms). Many of these organisms also carry additional resistance mechanisms which mean all currently available UK licensed oral antibiotics are ineffective.

Multi-resistant coliforms tend to occur in the elderly and in many cases bacteriuria is asymptomatic and does not require antibiotic therapy. However in patients with symptomatic or otherwise clinically significant infection, which may lead to bacteraemia, treatment is indicated.

Fosfomycin is an orally active, bactericidal antibiotic that inhibits bacterial cell wall production. It is well absorbed after oral administration (but absorption can be reduced if taken with food) and excreted unchanged in the urine. After a 3g dose, very high urine levels are achieved, urine concentrations remaining above the minimum inhibitory concentration of sensitive organisms for up to 48 hours.

Prescribing and administration details

Dose: Female patients: 1 x 3g sachet (unlicensed)
Male patients: 1 x 3g sachet and then a further 3g, 3 days later (unlicensed)

Contraindications: Patients with severe renal insufficiency (eGFR <10ml/min/1.73m^2) or undergoing haemodialysis.

Method of administration: fosfomycin should be taken on an empty stomach, either 1 hour before or at least 2 hours after meals, and preferably before bedtime after emptying the bladder. The contents of the sachet should be dissolved in a glass of water and taken immediately after preparation.

Cost: £54.45 per sachet (6 tablets trimethoprim 200mg £1.14, 6 tablets nitrofurantoin MR 100mg £4.07 [Drug Tariff May 2016])

So What?

Consider prescribing oral fosfomycin for patients with an acute, uncomplicated urinary tract infection if they fit the following criteria:

- Have a symptomatic urinary tract infection
- The lab has identified significant growth of a fosfomycin- sensitive organism in the urine sample
- There is **no other suitable oral treatment alternative**, either because of bacterial resistance, or because of patient allergy or intolerance to suitable antimicrobials

ISO Standards for Blood Glucose Meters

New ISO standards for blood glucose meters were drawn up in 2013. The ISO guidelines for blood glucose meters are a detailed set of standards which blood glucose meters should meet. All meters must meet these standards by **May 2016**. The current set of standards which need to be met are the set of standards that were published in 2003 (ISO: 15197:2003). The move to the tighter 2013 standards is a positive advance as it will result in more accurate blood glucose meters and will therefore provide greater confidence to users of the meters. They will also help to ensure that the blood glucose monitors we use are sufficiently reliable on a day to day basis.

In 2015, the NHS Greater Manchester Medicines Management Group (GMMMG) published a review of blood glucose meters which included the accuracy of blood glucose test strips. To help with interpreting results, a list was produced which states which meters fall into the accuracy groups defined by the GMMMG. The list is available on the Diabetes UK website here.

As a result of these changes, test strips for non-compliant meters will start to become unavailable from May. The British In Vitro Diagnostic Association (BIVDA) believe up to a third of patients are still on non-compliant meters. It is therefore vital that healthcare professionals ensure their patients are upgraded to compliant meters. To establish whether a meter is compliant, healthcare professionals should consult the website or customer care line of the relevant manufacturer. The table below shows strips for blood glucose meters that are compliant with the new ISO standards **and** meet the OCCG policy of selecting strips which cost <£10 for 50 (Drug Tariff March 2016). GlucoRx Nexus is still the local first choice for appropriate patients.

Contour	Mylife Pura	SuperCheck Plus
Contour TS	Mylife Unio	SuperCheck 2
Element	Omnitest 3	TEE2
GlucoMen Areo Sensor	OneTouch Select Plus	TRUEyou
GlucoRx Nexus Strips	Performa	WaveSense JAZZ
GluNEO	SD Codefree	WaveSense JAZZ Duo Active

Further OCCG guidance around SMBG can be found in Prescribing Points 21.01 and Prescribing Points 22.02.

So What?
Healthcare professionals need to ensure that their patients are upgraded to compliant meters, which meet the new ISO standards, as test strips for non-compliant meters will start to become unavailable from May.

Diabetes Foot care

Thames Valley Strategic Clinical Network (TVSCN) Diabetic Foot Reference Group issued the Diabetes Foot Care Pathway in October 2015. This pathway provides advice about foot care in diabetes and includes the annual foot check process; what to look out for, what good foot care looks like and how to carry out foot examinations.

The Diabetes Foot Care Pathway document can be downloaded from the Oxfordshire CCG intranet http://occg.oxnet.nhs.uk/GeneralPractice/Pages/diabetes-ClinicalGuidelines.aspx.

Please note that there is a section on the Oxfordshire CCG intranet dedicated to diabetes care, please follow the link: http://occg.oxnet.nhs.uk/GeneralPractice/Pages/DiabetesEducationOxfordshire.aspx

High strength, fixed combination and biosimilar insulin products

Several new insulin products are available on the market; three high strength insulins which have concentrations greater than 100 units/mL (Tresiba, Humalog, Toujeo), a fixed combination of insulin degludec and liraglutide (Xultophy) and a biosimilar of insulin glargine (Abasaglar).

Healthcare professionals and patients need to understand the insulin strength of these products and how to use them correctly to minimise the risk of medication errors such as the wrong insulin dose being prescribed or administered (MHRA drug safety update April 2015).

As a reminder **always refer to subcutaneous insulins by brand name** and ensure insulin prescriptions include the correct administration device.

Details of the new products are as follows:

Active substance	Brand name	Strengths available	Administration devices
Insulin degludec	Tresiba	100 units/mL	FlexTouch prefilled pen; cartridge ('Penfill' for use in Novo Nordisk reusable pen
		200 units/mL	FlexTouch prefilled pen
Insulin lispro	Humalog	100 units/mL	KwikPen prefilled pen; vial; cartridge
		200 units/mL	KwikPen prefilled pen
Insulin glargine	Lantus	100 units/mL	SoloStar prefilled pen; vial; cartridge
	Toujeo	300 units/mL	SoloStar prefilled pen
Insulin degludec and liraglutide	Xultophy	100 units/mL of insulin degludec and 3.6 mg/mL of liraglutide	Prefilled pen
Insulin glargine	Abasaglar	100 units/mL	KwikPen prefilled pen; cartridge (for use in Lilly reusable pen)

- Abasaglar has been approved locally for initiation in patients new to insulin glargine in line with local type 2 diabetes and national type 1 diabetes guidance.

- Toujeo and Xultophy should **NOT** be initiated in primary care. They should only be initiated by local diabetes consultants according to agreed criteria and following successful completion of a Prior Approval Process (approved by OCCG).

- Tresiba should only be initiated by a diabetes specialist centre in line with local guidance.

So What?

Always refer to subcutaneous insulins by brand name. This is increasingly important because bio-similar products are now available. For example, there are now THREE glargine products:

1)Lantus
2)Abasaglar
3)Toujeo

It is vital to ensure insulin prescriptions includes the correct administration device, and to give patients a patient information booklet and Insulin Passport. GP practices can obtain supplies of Insulin Passports and patient information booklets through their Local Area Team stores.

Acute Kidney Injury (AKI) – Sick day rules

Dehydration can be a significant risk for people taking certain medicines. If these medicines are continued while a person is dehydrated, there is an increased risk of adverse outcomes, significantly an increased risk of acute kidney injury (AKI). AKI is a clinical syndrome that is common, harmful and often avoidable. It encompasses a spectrum of injury from minor changes in kidney function to acute failure requiring renal replacement therapy.

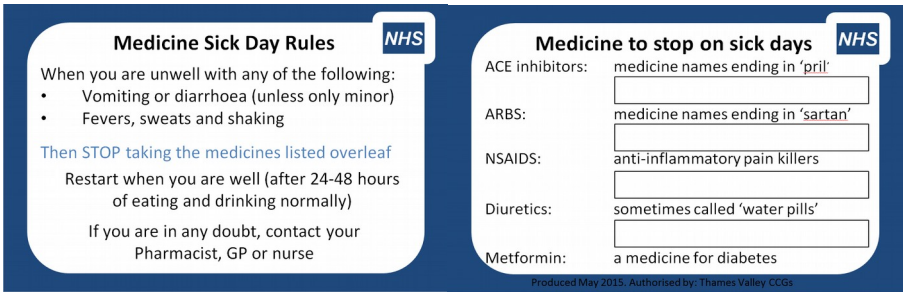
The main risk factors for development of AKI are:

- Age over 65 years
- Nephrotoxic drugs (particularly NSAIDs, ACE inhibitors, angiotensin-II receptor antagonists, diuretics)
- Previous AKI
- Chronic kidney disease
- Heart failures
- Diabetes
- Liver disease
- Severe diarrhoea

AKI, irrespective of severity, increases the risk of chronic kidney disease and further episodes of acute injury. It is associated with greater use of healthcare resources, including an increase in frequency, intensity and duration of hospitalisation, at an estimated annual cost of over £1 billion in England. In Oxfordshire there were 365 AKI admissions between January and December 2014 at a cost of £1.3 million.

AKI often starts in the community when a vulnerable patient develops an inter-current illness such as diarrhoea, vomiting or infection which leads to dehydration. Recent National Institute for Health and Care Excellence (NICE) guidance on acute kidney injury focuses on improving the management of episodes of these acute illness including the use of 'medicine sick day rules' that recommend the temporary cessation of potentially nephrotoxic drugs. This is especially important in patients who already have some level of renal impairment or are taking more than one of these medicines.

One scheme, originally developed by NHS Highland, aimed to promote 'sick day rules' by providing credit card sized patient information cards to those who may be at risk, and similar cards (see below) have now been developed for use across Thames Valley with input from local renal consultants, GPs and pharmacists.



Action points – AKI sick day rules

- Be aware that patients taking certain drugs (particularly ACE inhibitors, angiotensin-II receptor antagonists, diuretics NSAIDs and metformin) are vulnerable to acute kidney injury when suffering from illnesses that may cause them to become dehydrated
- Patients should be advised to stop these medicines when unwell and to ensure that they are taking plenty of fluids and restart these medicines once they are better.
- Encourage the patient to contact the practice/pharmacy if they are ever unsure about what they should do.
- More information on AKI is available on the 'Think Kidneys' website https://www.thinkkidneys.nhs.uk

If you would like further supplies of the 'Medicine Sick Day Rules' cards please email liz.edwards@oxfordshireccg.nhs.uk

So What?

Cards were supplied to all GP practices and community pharmacies across Oxfordshire. We have also issued further cards to Out of Hours Urgent Care Services. We would now like some feedback about how these cards have been received and potentially benefited your patients. Please could you take a few minutes to complete our survey:
https://www.surveymonkey.co.uk/r/medicinesickdayrulescardsAKI

Medication supply issues and price increases

Drug	Price increase / supply issue	Alternative	Alternative price
Desmopressin 10mcg/ dose nasal spray	Some supply issues with generic product.	Price concession has been in place since February 2016 increasing the cost.	Desmopressin 10mcg/ dose nasal spray (60) - £24.00 (previously £13.77).
Flecainide 50mg, 100mg tablets	Some supply issues with generic product.	Price concession has been in place since December 2015 increasing the cost.	Flecainide 50mg tablets (60) - £7.50 (previously £3.35). Flecainide 100mg tablets (60) - £10.73 (previously £4.32).
Fluorinef (Fludrocortisone) 0.1mg tablets (100)	Aspen have discontinued Fluorinef tablets but now supply a generic Fludrocortisone.	Fludrocortisone 0.1mg tablets (30).	Fludrocortisone 0.1mg tablets (30) - £30.00.
Fluphenazine (modecate) depot	There is currently a temporary supply problem with fluphenazine depot due to manufacturing issues. Stocks of fluphenazine 100mg/ml (Modecate Concentrate) have been completely depleted and there are also only very limited supplies of the lower strength left (Modecate 25mg/ml).	Unlicensed fluphenazine depot 100mg/ml. As a temporary measure community pharmacists can obtain an imported fluphenazine depot. Current indications are that the supply problem will be resolved by the summer.	Prices may vary. <u>Recommendation</u>: do not start any new patients on fluphenazine depot.
Isosorbide mononitrate 10mg, 20mg, tablets	Some supply issues with generic product.	Price concession is in place, increasing the cost.	Isosorbide mononitrate 10mg tablets (56) – £16.05 (previously £1.75). Isosorbide mononitrate 20mg tablets (56) - £10.50 (previously £1.37).
Nitrofurantoin 50mg, 100mg tablets	Some supply issues with generic product.	Price concession has been in place since April 2016 increasing the cost.	Nitrofurantoin 50mg tablets (28) - £11.50 (previously £8.23). Nitrofurantoin 100mg tablets (28) - £12.50 (previously £2.88).