

# Prescribing Points



Oxfordshire

Cinical Commissioning Group

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This newsletter is written by the Medicines Optimisation Team, Oxfordshire CCG (OCCG), Jubilee House, Oxford Business Park South, Oxford, OX4 2LH. It is for all health professionals in Oxfordshire and is uploaded to the OCCG website. For queries, contact [OCCG.medicines@nhs.net](mailto:OCCG.medicines@nhs.net).

Please let us know if you are receiving this newsletter and it is no longer relevant to you by contacting [OCCG.medicines@nhs.net](mailto:OCCG.medicines@nhs.net).

## Generic Email Address for Queries

The Medicines Optimisation team now has a single email address for any medicines or prescribing related queries and communications to the team. The new email address is [OCCG.medicines@nhs.net](mailto:OCCG.medicines@nhs.net) and is now live. This will enable the team to answer any queries you may have in a timely and efficient manner through dedicated support on a daily basis. Please do not hesitate to contact the team with your prescribing queries.

## Buprenorphine Patches (Butec®)

Butec® is a 7 day buprenorphine patch which is identical in formulation to Butrans® and has the same manufacturing and supply chain. It is available in strengths of 5, 10 and 20 mcg/hour. The Department of Health have approved the new NHS list price of Butec®. From 1<sup>st</sup> October Butec® will be 55% lower in price than Butrans®. Prescribing Butec® (7 day buprenorphine patches) by brand will offer significant savings, see table below;

Patch Strength	Pack Size (28 days supply)	Butec® patch	Butrans® patch
5 mcg/hr	4	£7.92	£17.60
10 mcg/hr	4	£14.20	£31.55
20 mcg/hr	4	£25.86	£57.46

While codeine and tramadol remain first- choice opiates on Step 2 of the Oxfordshire CCG's [Opioid Prescribing Guidelines for Non Cancer Pain](#), we would ask that you to prescribe Butec® for any new patients only when recommended by a specialist, and to consider switching existing patients using buprenorphine 7 days patches to Butec®. Buprenorphine patches should be prescribed as Butec® brand to ensure continuity of supply.

## Emollients – Cost Effective Replacements

The Medicines Optimisation team have been reviewing emollients currently on the market and have found that there are preparations available that have the same ingredients, same quality for patients whilst also being cost effective.

The cost effective products are listed below:

Currently Used	Cost effective Replacement
Doublebase Gel	Zerodouble Gel
Hydromol Ointment	Zeroderm Ointment
Aqueous Cream	ZeroAQS Cream
Aveeno Cream	Aproderm Colloidal Oatmeal Cream
Diprobace Cream	EpiMax Cream
Epaderm Ointment	Zeroderm Ointment
E45 Cream	Zerocream
Unguentum M	Zeroguent Cream

By switching to these products there is a potential saving of **£125,000** for Oxfordshire. We have been in contact with the relevant manufacturers to discuss stock levels and have assurances that there are more than adequate stock levels for supply and also a quick turnaround for new stock.

ScriptSwitch has been updated to display the message for the relevant products when applicable. Please continue to follow the relevant guidance when treating patients who present for conditions requiring emollients.

If you have any questions, please do not hesitate to contact the Medicines Optimisation team.

## Vitamin B12 (Cyanocobalamin) 1mg Tablets

Cyanocobalamin 1mg tablets when ordered on a FP10 prescription can be an extremely expensive special drug – prices can be in excess of £700 for 100 tablets. If written as vitamin B12 it would be blacklisted on a FP10 prescription, but is readily available in pharmacies and health food stores as well as online. It is not possible to supply OTC vitamin B12 1mg tablets against a prescription for cyanocobalamin as most OTC vitamins are classified as food supplements because marketing authorisation (formerly a product licence) to be used as a medicine has not been obtained.

Hydroxocobalamin 1mg/ml injection via intramuscular injection is the alternative vitamin B12 drug of choice, it costs £7.11 for 5 ampoules (Drug Tariff Oct 2016), and should be used until a suitable oral alternative is available.

## Licensed Glycopyrronium bromide solution

Until recently all glycopyrronium bromide oral preparations were unlicensed and the associated cost to the CCG high, especially for the 1mg tablets. There is now, however, a licensed oral solution which is more cost effective than the tablets which GPs should prescribe.

Scripts for this should be written as glycopyrronium bromide 1mg/5ml oral solution sugar free. This comes in 150ml bottle from the manufacturer Colonis Pharma Ltd. Switching patients over to the licensed product will reduce spend on glycopyrronium bromide by approximately £50,000 over the course of a year.

## Public Health England Publishes New Advice On Vitamin D

Public Health England (PHE) has issued [new advice on vitamin D](#) based on the recommendations of the Scientific Advisory Committee on Nutrition. The advice notes that vitamin D is made in the skin on exposure to UVB in sunlight but since this is difficult to quantify a daily dietary intake of 10 micrograms is being recommended.

PHE advises that in spring and summer, the majority of the population get enough vitamin D through sunlight on the skin and a healthy, balanced diet. During autumn and winter there is less exposure to sunlight, therefore it is difficult for people to meet the 10 microgram recommendation from consuming foods naturally containing or fortified with vitamin D, so people should consider taking a daily supplement containing 10 micrograms of vitamin D.

People whose skin has little or no exposure to the sun, like those in institutions such as care homes, or who always cover their skin when outside, risk vitamin D deficiency and need to take a supplement throughout the year. Ethnic minority groups with dark skin, from African, Afro-Caribbean and South Asian backgrounds, may not get enough vitamin D from sunlight in the summer and therefore should consider taking a supplement all year round.

PHE also advice that children aged 1 to 4 years should have a daily 10 microgram vitamin D supplement. PHE recommends that babies are exclusively breastfed until around 6 months of age. As a precaution, all babies under 1 year should have a daily 8.5 to 10 microgram vitamin D supplement to ensure they get enough. Children who have more than 500ml of infant formula a day do not need any additional vitamin D as formula is already fortified. Vitamin D supplements are available free-of-charge for low-income families on the Healthy Start scheme.

The OCG [Vitamin D Supplementation in Primary Care](#) guideline outlines when to test Vitamin D levels, when Vitamin D should be prescribed and the recommended cost effective products. Testing should only be carried out when the patient has at least one persistent symptom, suggesting Vitamin D deficiency such as: insidious onset widespread bone pain, tenderness or muscle weakness. Routine testing of at risk groups is not recommended. **Patients at high risk should access vitamin D via Healthy Start vouchers or purchase supplementation, which is readily available at low cost from pharmacies, supermarkets, and health food stores.**

### So What?

Clinicians should be aware of this new advice. The advice consistently refers to "dietary sources" of vitamin D including foods naturally containing or fortified with vitamin D and supplements. **As such prescribing of vitamin D purely for supplementation following this advice should be resisted.**

## Area Prescribing Committee Oxfordshire (APCO) Update

APCO considers new drugs and prescribing guidelines and provides recommendations on prescribing and medicines optimisation across the Oxfordshire Health Economy. The group considers any new NICE guidance including drugs. APCO classifies drugs according to the local 'Traffic Light' system. Following ratification by the Clinical Ratification Group (CRG), the key points from each APCO meeting are circulated as bullet points. APCO bullet points are available on the intranet [here](#).

## Lipid Modification Guidance Update

Oxfordshire CCG's [Lipid Modification Guidance](#) has been updated to reflect NICE TA385 on ezetimibe for treating primary heterozygous-familial and non-familial hypercholesterolaemia. This guidance updates and replaces NICE TA132. The updated guidance states:

Ezetimibe, alone, is recommended as an option for the treatment of primary (heterozygous-familial or non-familial) hypercholesterolaemia in adult patients in whom initial statin therapy is contraindicated, or who are intolerant of initial statin therapy.

Ezetimibe, in combination with initial statin therapy, is also recommended as an option for the treatment of primary (heterozygous-familial or non-familial) hypercholesterolaemia in adult patients when:

- Serum total or low-density lipoprotein (LDL) cholesterol concentration is not appropriately controlled either after appropriate dose titration of initial statin therapy or because dose titration is limited by intolerance to the initial statin therapy **and**
- A change from initial statin therapy to an alternative statin is being considered.

When prescribing ezetimibe in combination with statin, ezetimibe should be prescribed on the basis of lowest acquisition cost.

## Information Leaflet For Patients Taking Proton Pump Inhibitors (PPIs)

Recently there have been concerns raised over the increased risks of some uncommon but serious adverse effects associated with long-term use of PPIs, such as *Clostridium difficile* infection, bone fractures and rebound acid hypersecretion syndrome etc.

The Medicines Optimisation team has been encouraging practices to review patients on long-term PPIs (i.e. continuously for over a year), and this is also available as one of the audit options in the Prescribing Incentive Scheme for 2016-17. A patient information leaflet has since been produced by the team to support conversations with patients starting on, stepping down and/or stopping PPI treatment. This can be downloaded from the OCCG intranet [here](#) .

## Melatonin Shared Care Protocol

At the September APCO meeting, a new shared care protocol for melatonin was approved which is available on the intranet [here](#). The protocol covers sleep disorders in children and young people with complex neurological/neurodevelopmental disorders (age 1-18 years). This protocol is for use alongside the **community paediatrics and paediatric neurology teams only**. The consultant will initiate melatonin in appropriate patients and prescribe the first month's supply. The GP will be asked to take over prescribing once it has been confirmed that the melatonin is effective and the dose has been stabilised.

This is the only approved shared care protocol in Oxfordshire, no other requests from secondary care for GPs to prescribe should be accepted. Patients under the care of Oxford Health will continue to receive their prescription and supply of melatonin from Oxford Health.

It may be appropriate to review the formulation given to current patients, as the majority of patients can use the most cost effective formulation, Circadin® 2mg MR Tabs (30 tabs for £15.39). The new shared care protocol offers the following guidance on choosing formulations:

- If the patient is able to swallow tablets Circadin® modified release tablets (unlicensed use) may be swallowed whole and given with or without food.
- If the patient is unable to swallow tablets whole, Circadin® tablets can be halved (using a tablet cutter) or crushed if necessary. NOTE: crushing the MR tablet will mean that it is no longer modified release.
- For children with difficulties swallowing, Circadin® can be crushed to a fine powder and mixed with water or given with cold soft food such as a teaspoon of yoghurt or jam. Use a small amount of food to ensure the full dose is taken. The prescription should state that the medication is to be crushed prior to administration.
- For administration via an enteral feeding tube, Circadin® can be crushed to a fine powder and added to 5 - 10ml of water and mixed well.
- Melatonin oral solution 5mg/5ml in 200ml can be prescribed only for patients with fine-bore enteral feeding tubes (gauge less than 9) where there is risk of tube occlusion.
- Doses should be titrated in increments of 2mg.

### So What?

- You may start to get appropriate requests from community paediatrics and paediatric neurology team, please make sure you are familiar with the protocol and the responsibilities of the GP and Specialist.
- Make sure your current patients are on the most cost effective formulation.

## Dalteparin Guideline and Shared Care Protocol

The [Dalteparin Guideline and Shared Care Protocol for Primary Care](#) have been updated to reflect;

1. The change to the review period for cancer-related VTE, as hospital guidelines now recommended a review at 3 months (in line with all other patient groups) rather than 6 months for on-going anticoagulation.
2. The management of superficial thrombophlebitis as the DVT clinic have updated their guidance on how to manage this.

## Colesevelam for Bile Acid Malabsorption

Colesevelam for bile acid malabsorption has been approved by APCO (Sep 2016) for use only in patients with a true intolerance to colestyramine and colestipol, on recommendation by gastroenterology only. **'Prior Approval' by the Medicines Optimisation team is required before GPs undertake prescribing.** GPs will be notified by the Medicines Optimisation team if approved for use in individual patients. APCO has classified this drug as **YELLOW** continuation.

## Sacubitril Valsartan For Heart Failure

Sacubitril valsartan has been licensed for treating adults who have symptomatic heart failure with reduced ejection fraction. The active metabolite of sacubitril inhibits the enzyme neprilysin, an endopeptidase that degrades vasoactive natriuretic peptides. Valsartan is an angiotensin II receptor antagonist.

Sacubitril valsartan has evidence with encouraging data of preventing deaths from the PARADIGM-HF study, a large multicentre study covering 47 countries. In April 2016 NICE issued a positive technology appraisal ([TA388](#)) and APCO classified this drug as **RED** for specialist use only in May 2016. The results of this trial are encouraging and show sacubitril valsartan may offer an advantage over treatment with an ACE inhibitor for some patients with heart failure with reduced ejection fraction. However, APCO believe that there needs to be a managed approach to its introduction in to clinical practice. Specialists at OUHFT are in the process of developing local guidance that may include primary care prescribing. Until the review and then agreement at APCO, **GPs should not prescribe this drug.**

## Vortioxetine (Brintellix) For Depression

Vortioxetine (Brintellix) is licensed for treating adults with major depressive episodes. NICE ([TA367](#)) recommends vortioxetine as an option for treating major depressive episodes in adults whose condition has responded inadequately to 2 antidepressants within the current episode.

Vortioxetine is from a new class of psychotropic drugs, it acts on the serotonin system and is described as having a 'novel multimodal mechanism of action' as *in vivo* non-clinical studies have demonstrated that vortioxetine modulates neurotransmission probably also on the norepinephrine, dopamine, histamine, acetylcholine, GABA and glutamate systems. Vortioxetine has pro-cognitive effects and NICE suggests that it may be a valuable treatment option for people experiencing cognitive dysfunction as part of their depression.

The Oxford Health's Drugs and Therapeutics Group has included vortioxetine on the formulary as a restricted medicine. It should only be used according to NICE TA367. Oxford Health has produced a Medicines Information Bulletin on the use of vortioxetine in depression which can be found [here](#). APCO classified this drug as **YELLOW** continuation (May 2016), following specialist recommendation.

As with all new drugs, vortioxetine is a black triangle drug ( ▼ ) and all suspected adverse reactions should be reported to the MHRA via the yellow card scheme ([www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard)).

## Alfentanil And Ketamine

Alfentanil and ketamine have been classified by APCO (July 2016) as **YELLOW** continuation on recommendation of a specialist (previously RED – specialist prescribing only). GPs would be expected to continue the prescription if a patient was discharged into the community and required these drugs. GPs should be aware that a Patient Specific Protocol would be required for each patient before these drugs are prescribed.

## Ivermectin Cream For Rosacea

Papulopustular rosacea is one of the four common clinically recognised subtypes of rosacea. Mild or moderate papulopustular rosacea is generally treated with a topical drug. Treatments for mild-moderate papulopustular rosacea include topical metronidazole or azelaic acid. Ivermectin 10mg/g (1%) cream has received marketing authorisation for the treatment of inflammatory lesions of papulopustular rosacea in adults. The mechanism of action in rosacea is not known but the Summary of Product Characteristics ([SPC](#)) suggests that it may be due its lethal effects on the *Demodex* mite and/or its anti-inflammatory effects.

Ivermectin cream for rosacea was considered in The Drugs and Therapeutics Bulletin (DTB) in November 2015. The authors of the DTB article described 2 double blind randomised controlled trials (Stein Gold et al. 2014a and Taieb et al. 2015) which found ivermectin cream to produce a statistically significant reduction in the number of lesions compared with the vehicle cream and an increase in the percentage of subjects who achieved a clinician rating of 'clear' or 'almost clear'.

NICE published an Evidence Summary [ENSM 68](#): Inflammatory lesions of papulopustular rosacea - ivermectin 10 mg/g cream in January 2016. NICE concluded that local decision makers will need to consider the available evidence on efficacy and safety, as well as cost and individual patient factors, when making decisions about using ivermectin cream or another topical treatment for papulopustular rosacea. APCO has classified this drug as **GREEN** (July 2016), suitable for prescribing in primary care for patients with papulopustular rosacea.

The dose is one daily application for up to 4 months. Treatment should not be continued if there is no improvement after 3 months. One application consists of a pea-sized amount applied to each of five areas of the face (forehead, chin, nose and both cheeks) and spread as a thin layer across the entire face, avoiding eyes, lips and mucosa. Cosmetics can be applied after the product has dried. The treatment course may be repeated. Once the tube has been opened, the contents should not be used after 8 weeks.

## Skinnies Garments

There are three distinct types of 'Skinnies' garments:

1. Skinnies Viscose
2. Skinnies Silk
3. Skinnies Web

APCO reviewed the use of Skinnies garments in July 2016 and has classified Skinnies Viscose as **YELLOW** continuation on recommendation by a specialist nurse. Skinnies Silk and Web have been classified as **BLACK**, not suitable for prescribing.

Skinnies Viscose can be used in the treatment of eczema, where a patient requires hydration and/ or steroid creams to hold and improve cream absorption. They can be used as part of the overall options for management for childhood atopic eczema. They do not suit all children so they are not a routine part of the treatment plan but used as needed and as appropriate.

The benefits of Skinnies Viscose include; seamfree technology therefore no friction, they are available in different colours which improves compliance in children and they withstand more washes and therefore last longer. They also provide less gaps for a child's fingers to access, so also prevent scratching.

## ONPOS (Online Non-Prescription Ordering Service)

ONPOS (Online Non-Prescription Ordering Service) enables all practices, district nursing teams and nursing homes to order the majority of formulary dressings quickly and easily and have them delivered within a short period of time.

### Why should practices use ONPOS?

- Items ordered through ONPOS are paid for by the CCG through a top-slicing of the prescribing budget so in using the system it will mean less scripts are required to be issued and a lower practice prescribing budget spend.
- Ordering dressings through ONPOS will reduce wastage on dressings as single dressings or lengths of adhesive tape can be given to patients. If whole boxes are given via FP10 the patient may end up discarding several dressings if they are no longer required – stock cannot be returned to pharmacies to be re-used.

### Points to Remember with ONPOS

- Utilise the practice nursing team to manage the ONPOS ordering and direct all dressing queries through them to ensure the best use of the system.
- If writing scripts for dressings consider whether the items requested, or similar alternatives, could be ordered through ONPOS.

#### So What?

Ordering items through ONPOS is more cost effective for practices and reduces wastage.

## Scriptswitch

Oxfordshire CCG practices achieve, on average, 11.1% of the potential savings that they could from the recommendations offered by Scriptswitch. In 2015/16 this equated to an annual saving of £497,000 against a potential savings figure of £4.5M. This compares with a national average acceptance rate of 18.1%.

There is also a large variation in the acceptance range between Oxfordshire practices from 47% down to 1%. Scriptswitch is not wholly a medication savings package. Messages are added to inform prescribers of useful information such as local guidance and out of stock problems.

Members of the local Medicines Optimisation team are responsible for updating the switches and information messages. The team are currently in the process of updating information, tidying up out-of-date links and making the text more concise and clearer.

If there are any discrepancies please feedback this information through the feedback button on Scriptswitch. When doing so, please also add your name so that the team can come back to you to let you know when any change has been implemented.

There is a new interface due to be released in Oxfordshire within the next 2 months which should be more user-friendly and allow for clearer messages to be implemented.

#### So What?

Scriptswitch benefits patients and prescribers as it provides patient safety information messages, drug switch recommendations and dosage optimisation information right at the point of prescribing.

## Medication supply issues

There are still supply issues with Insuman® insulin products. The shortage is due to limited capacity at the manufacturing site, **not due to any safety issues**, and Insuman® currently on the market can continue to be used. The Medicines Optimisation team will continue to monitor the situation.