Prescribing Points

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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 .

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Prescribing Incentive Scheme 2017-18 - Update

The OCCG Prescribing Incentive Scheme for 2017-18 is underway. Many practices have held meetings with the Medicines Optimisation Team and plans have been approved for all practices. Emails sent to practices confirming practice plan approval also advise of the practice assigned Medicines Optimisation Prescribing Adviser.

Information and resources are available on the Prescribing Incentive Scheme webpage. These resources include links to relevant guidance, policies, patient leaflets, posters, audit templates, EMIS se and prescribing data.
The new Prescribing Dashboard, planned for publication in late summer, will include data and graphics for common Incentive Scheme priorities. This will enable practices and localities to monitor their achievement monthly as the year progresses. Estimated savings will be profiled over the year in the same way as the practice budget.
There will be additional practice reports for 'over the counter' product prescribing.

Assigned Prescribing Advisers are able to support practices with monitoring the individual practice specific priorities included in the scheme plans. Prescribing Advisers will be contacting practices over the coming weeks.

Antimicrobial Prescribing Quality Scheme

In addition to the Prescribing Incentive Scheme, a Prescribing Quality Scheme promoting antimicrobial stewardship in line with national policy and the Quality Premium is also going to be running in Oxfordshire.
This has been delayed due to the inclusion of new indicators that rely on data from the new Epact 2 system which has only recently become available. Practices will be sent full details of this shortly, but please note it is in the same format as previous years and will include indicators on total antibiotic prescribing, the appropriate prescribing of cephalosporins, quinolones and co-amoxiclav and new indicators for prescribing in urinary tract infections. These focus on reducing *E.coli* bacteraemia by promoting the use of nitrofurantoin as the first line option and reducing the use of trimethoprim in patients over the age of 70. These are both in line with Public Health England guidance

Formulary update

Fiasp

Fiasp is a fast acting insulin aspart, with a quicker onset and offset of action than Novorapid (insulin aspart). **Fiasp is not interchangeable with Novorapid, so care must be taken when issuing insulin aspart to prescribe by brand.** Fiasp has been classified as **AMBER** on the formulary, as it must be recommended by a specialist (OCDEM or Community Diabetes Service). Patients appropriate for Fiasp are those who are already on a rapid acting insulin analogue (i.e. Novorapid, Humalog, Apidra), but have a mismatch between insulin rise and post prandial glucose rise.

Saxenda

Saxenda is liraglutide 6 mg/ml solution for injection in pre-filled pen. Saxenda is licensed for weight loss in specific patient groups. Saxenda is the same preparation as Victoza, which is licensed for use in patients with Type 2 Diabetes to improve glycemic control. Therefore, care must be taken when issuing liraglutide to prescribe by brand. APCO had concerns around long term safety data for Saxenda, as well as cost effectiveness. Therefore, it has been classified as **BLACK** until further NICE guidance, specific for liraglutide in obesity, becomes available.

The Oxfordshire Formulary can be found here:
www.oxfordshireformulary.nhs.uk

Qtern

Qtern is a combination of dapagliflozin and saxagliptin. In Oxfordshire, neither of these drugs are first line in their class. The combination of dapagliflozin and saxagliptin is not in line with NICE recommendations. Therefore, Qtern has been classified as **BLACK** – no prescribing.

Accu-Chek Mobile

The test cassettes for the Accu-Chek® Mobile blood glucose monitoring system are being reduced in price to £9.99 for 50, from 1st September 2017. **This makes the Accu-Check mobile system a cost effective choice.** Therefore, there is no need to switch patients on this meter to an alternative on the basis of cost**.** The Choosing a Blood Glucose Monitoring Meter document will be updated to reflect the price change in September.

Espranor (Buprenorphine oral lyophilisate)

Espranor is licensed for substitution for opioid dependence. It is not interchangeable with other buprenorphine sublingual products (bioavailability 25-30% higher) therefore has the potential for dispensing and prescribing errors and there is no lower strength available for dose reduction. It is not being used or requested by the local substance misuse service provider Turning Point. It has therefore been classified as **BLACK** on the formulary – no prescribing.

Resp-Ease Hypertonic Saline (sodium chloride 7%)

Hypertonic saline is used as a mucolytic in bronchiectasis. Resp-Ease is more cost-effective than Nebusal. OUH intend to use Resp-Ease and the respiratory specialist pharmacist confirms that substitution is permitted. Resp-Ease is similarly presented in plastic vials. Resp-Ease has been designated as **AMBER CONTINUATION** following specialist initiation. Nebusal and MucoClear are now **BLACK** -no prescribing.

Optimising Self Care by appropriate use of Over-the-counter Medicines (Restricted Prescribing List)

It has been a long standing policy in Oxfordshire that medicines which can be bought over the counter (OTC) should be considered low priority for prescribing. While some prescribers adhere to this quite rigidly, others find it more difficult leading to variation in practice and prescriptions being written for products which are readily available to buy, often at reasonable prices. Last year, GP practices in Oxfordshire spent over £3.3 million on prescribing medicines for a range of conditions which, in some cases, could have been appropriately treated using OTC products. An additional burden was the unnecessary use of GP appointments for conditions where self-care could have been appropriate.

Revised policy

Oxfordshire CCG has therefore re-issued the Commissioning Policy Statement (previously Lavender statement) in a clearer, strengthened format with examples of how it can be applied in practice in order to make it easier for prescribers to follow.

The main focus of the revised policy is to promote self-care while encouraging the appropriate use of OTC medicines and the expertise of Community Pharmacists. As an increasing range of medicines is available to buy, it is expected that patients purchase such medicines after seeking appropriate advice from a Community Pharmacist or other healthcare professional. This is particularly (but not exclusively) the case in short-term, self-limiting conditions. These medicines can be purchased from community pharmacies and/or other shops (e.g. supermarkets), which are often open until late. Pharmacists are a relatively under-utilised resource in primary care and could have a much greater role if patients used their expertise rather than visiting their GP. It is therefore expected that the main benefit of promoting self-care in this way would be a reduction in unnecessary GP appointments.

If a patient has any condition (including a long term one) about which they may or may not have consulted their GP, and if the required treatment is available to buy OTC then they might be expected to do so. The revised policy contains a 'Restricted Prescribing List' and recommends that all treatments on this list should be considered a low priority and are therefore classified as BROWN on the Oxfordshire formulary i.e. drugs which should only be prescribed in restricted circumstances.

Clinical judgement should be used when considering whether it is acceptable to ask a patient to purchase their medication. GPs will be expected to use their discretion where they consider there are exceptional circumstances or patient factors (e.g. an unsupported patient with advanced dementia, someone with learning difficulties, extreme hardship) when they would prescribe for these patients.

Supporting resources

Further information is available eg. via NHS Choices (http://www.nhs.uk). In addition, two resources have been specifically adapted for use across Oxfordshire CCG. These are:

- "How to manage your conditions" poster
- "Treating Minor Conditions" leaflet

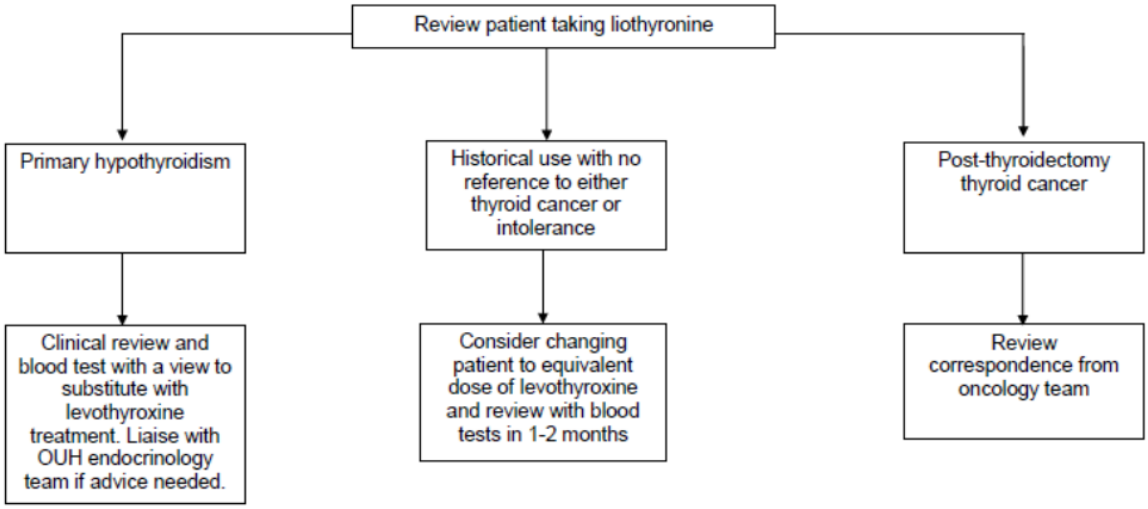
We will distribute printed copies of the leaflets and a poster to each GP practice. In addition, practices may wish to consider using their waiting room television screens to display the poster.

So What?

Review prescribing of products which are available to buy over the counter and encourage patients to self care where appropriate.

Guidance on the Prescribing of Liothyronine

Guidance on the prescribing of liothyronine has been developed in conjunction with the OUH Endocrinology department and is available on the CCG website here. This guideline aims to support GPs who manage patients currently on liothyronine to review the need for continued prescription. There are three different patient groups that may be taking liothyronine and the review process for each is outlined below:



If a switch to levothyroxine is undertaken please note that this may result in a period of instability due to the long half-life of levothyroxine and short half-life of liothyronine. Therefore a gradual reduction in liothyronine whilst titrating the dose of levothyroxine may be a preferable option.
Liothyronine should be prescribed/continued in primary care on the advice of **NHS consultants only.**

So What?
Patients currently prescribed liothyronine should be reviewed for ongoing appropriateness

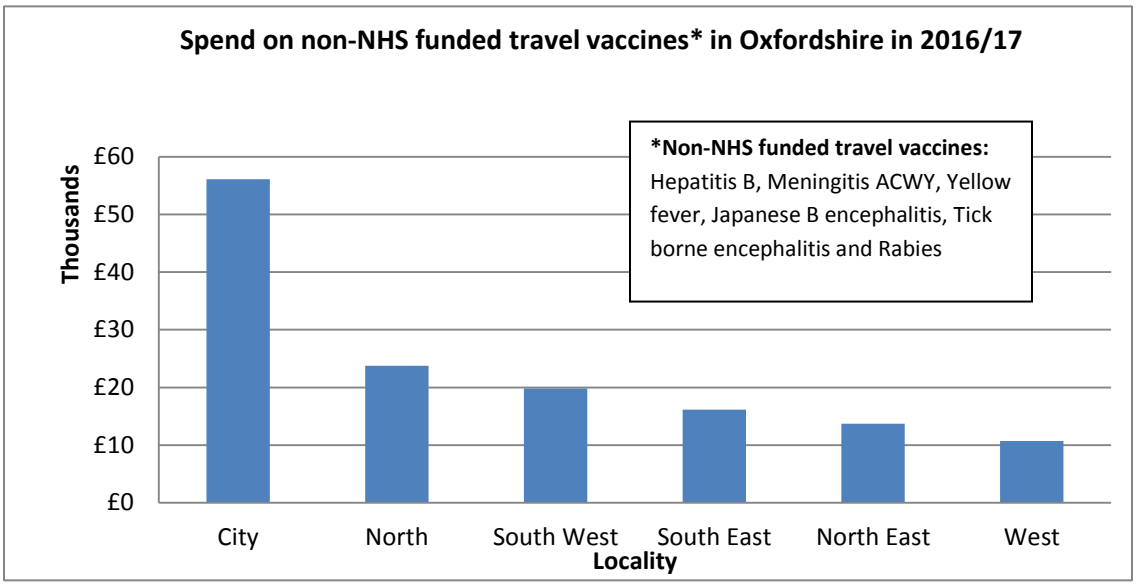
Travel Vaccines: Update and Reminder

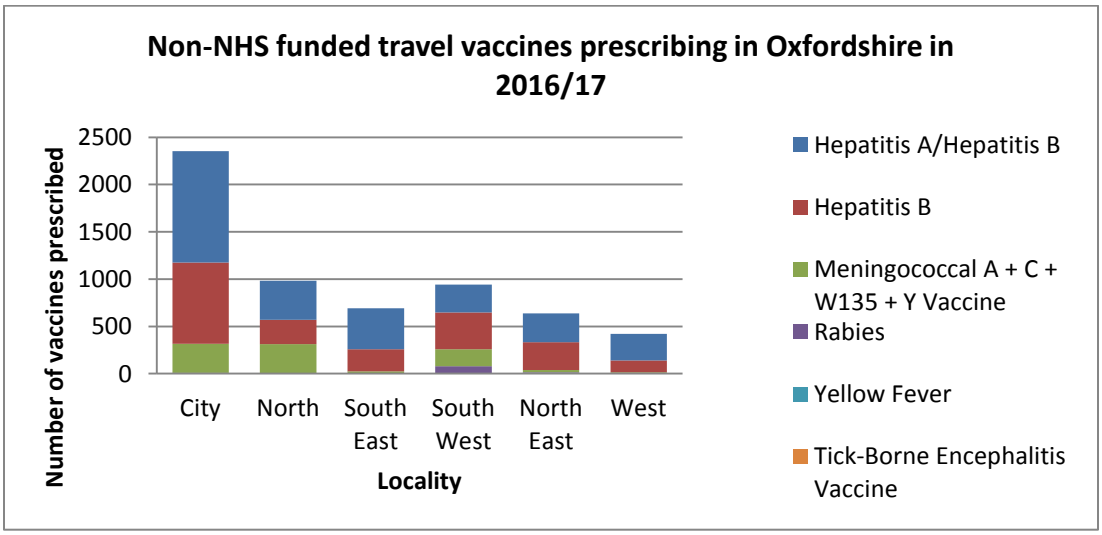
Background
Some vaccines are available on the NHS because they protect against diseases thought to represent the greatest risk to public health if they were brought into the country. However, a number of travel vaccines are not remunerated by the NHS as part of additional services and an FP10 **must not** be used to provide these vaccines. Travel immunisations that cannot be given as an NHS service are:

- Hepatitis B
- Meningitis ACWY
- Yellow fever - This can only be given at an approved yellow fever vaccination centre
- Japanese B encephalitis
- Tick borne encephalitis
- Rabies

The practice should therefore charge a registered patient for the immunisation if requested for travel. The patient may either be given a **private prescription** or be charged for stock purchased and held by the practice. The process of administering the vaccine is also chargeable.
There is some ambiguity over the combined hepatitis A and B vaccination. Hepatitis B vaccination is not commissioned under the NHS and this vaccine should be prescribed privately. Combined Hepatitis A and B vaccines should not be prescribed, rather, it should be prescribed as separate components: Hepatitis A on NHS and Hepatitis B privately.

Current prescribing/ spending
Oxfordshire spend over £90K on vaccines that should not be prescribed on the NHS and can be prescribed privately if required by patients for travel. This figure assumes a local commissioning policy not to prescribe Hepatitis A and B combined vaccine on the NHS. For practice specific data please email OCCG.medicines@nhs.net.





OCCG formulary status

- Combined Hepatitis A/ Hepatitis B (Ambirix®, Twinrix®) – **Black** for travel purposes.
- Combined Hepatits A/ Typhoid (Hepatyrix®, ViATIM®) – **Black** for travel purposes. This combined vaccine is blacklisted because prescribing Hepatitis A and Typhoid separately is cheaper than the combined vaccine and more appropriate as they have different booster dosage schedules.

Stock availability

The CCG has been made aware of recurrent supply issues of some travel vaccines. Please see the table below for stock availability for some of the vaccines. **Practices should contact the manufacturers for most up-to-date information on stock issues.**

Vaccine	Brand	Manufacturer	Stock information
Hepatitis A	Avaxim®	Sanofi Pasteur	Out of stock (OOS), no date
	Havrix® Junior	GSK	OOS until mid-October 2017 (Singles) Intermittent supply until early August 2017 (Pack of 10s)
	Havrix® Adult	GSK	OOS until Q1 2018
	VAQTA® Paediatric	MSD	OOS until late August 2017
	VAQTA® Adult	MSD	OOS, no date
Typhoid	Typherix®	GSK	OOS until 2019
	TYPHIM Vi®	Sanofi Pasteur	In stock, no order restrictions
	Vivotif® (oral)	PaxVax	In stock
Combined Hepatitis A / Hepatitis B	Twinrix®Junior	GSK	limited stock, intermittent supply until Q4 2017 (order restrictions)
	Twinrix® Adult	GSK	OOS until Aug 2017. May be Intermittent supply until Q4 2017 (order restrictions)
Combined Hepatitis A/ Typhoid	ViATIM®	Sanofi Pasteur	Intermittent supply until October 2017 (order restrictions)
	Hepatyrix®	GSK	OOS until 2019

In response to the continuous global shortage of monovalent Hepatitis A vaccines which has severely impacted the UK supply, NHS England issued temporary recommendations on Hepatitis A vaccination in July, which include updated travel vaccine and temporary dose sparing advice. This is to reserve and prioritise monovalent hepatitis A vaccine stock for special risks groups, such as those who are immunocompromised. An effective risk assessment will ensure vaccine recommendations are appropriate and to help identify higher risk travellers.

Please click on the link for details on dose sparing advice for pre and post exposure immunisation and boosting in both adults and children.

Patient Group Directions (PGDs)

NHS England South (South Central) has made available PGDs for Hepatitis A (adult and paediatric) and Typhoid (Injection). Health professionals who are not independent prescribers must use a Patient Specific Direction to supply or administer products off-label, which may be relevant in some of the Hepatitis A dose sparing recommendations.

So What?

Practices should ensure that travel vaccines not available at NHS expense are only prescribed and administered privately if being used for the purpose of travel abroad. Practices should note the advice about the availability of Hepatitis A and follow NHS England guidance on prioritisation for special risk groups

Teoptic 1% eye drops discontinued

Teoptic 1% eye drops are being discontinued, however the 2% strength will continue to be available. The advice from OUH ophthalmology is that patients currently on the 1% strength can be switched to 2%. Both have the same effect on intraocular pressure lowering but the 2% may have more systemic side effects.

So What?
Any remaining patients on Teoptic 1% should be switched to the 2% strength

Strontium ranelate discontinued

Strontium ranelate (Protelos®) sachets will be discontinued at the end of August 2017 and any stock in the supply chain is expected to be exhausted at this time also. Information from the manufacturer can be found here. If you have any patients on strontium it is important to know that stopping the drug leads to a rapid loss of benefit and potential increase in fracture risk.
While an update to the osteoporosis guidelines are being worked on, specialists at the Metabolic Bone Clinic recommend a reassessment of why patients were started on strontium and consider that they are switched to either an oral bisphosphonate or denosumab if appropriate. They do not recommend re-checking the bone mineral density as strontium falsely elevates the results.

So What?
Any remaining patients on strontium should be reviewed and switched to an alternative
For further advice regarding patients currently taking strontium please contact the Metabolic Bone Clinic: ox.GPosteop@nhs.net

Quetiapine and olanzapine supply issues

There are currently issues with obtaining immediate release quetiapine and generic olanzapine. Advice on how to manage this is provided below:

Quetiapine Immediate Release
Use quetiapine XL (modified release). The most cost effective brand is Sondate XL but there are also some supply issues with this product following an increase in uptake as a result of the shortage of the immediate release quetiapine. We have been advised that more stock of Sondate XL should be available in mid-August, in the meantime follow recommendations on ScriptSwitch for alternative brands. Prescribers should consider prescribing the total immediate release daily dose as a single daily modified release dose, this suggestion has been added to Scriptswitch.
Further advice on dose conversion is available here
The supply problem is likely to continue for at least a few weeks but no firm resolution date is available.

Generic Olanzapine Standard Tablets
Use generic 5mg and 10mg **orodispersible** tablet (**not sugar free**) If a 2.5mg dose is required please see further advice here
The supply problem is likely to continue until at least the end of 2017. No firm resolution date is available.

Generic Alimemazine Price Increase

Following the withdrawal of the brand Vallergan®, generic versions of alimemazine have significantly increased in price.

Product	Previous price	Current price (July 17 DT)
10mg tablets (28)	£4.28	£112.85
7.5mg/5ml solution (100ml)	£4.88	£179.55
30mg/5ml solution (100ml)	£7.55	£243.51

Alternative first generation antihistamines, such as chlorphenamine or promethazine, offer a more cost effective option and therefore any patients currently prescribed alimemazine should be reviewed with a view to switching to a more cost effective alternative.

COPD Management in Primary Care – Inhaled Therapies

OCCG COPD guidance has been revised and updated in conjunction with the OUH/OH respiratory teams, local GPs and practice nurses. This update focuses on inhaler device type and adherence as the main considerations. The full guidance can be found here and a summary of the treatment pathway is given on the following page of this newsletter. This revised OCCG guidance is broadly based on the GOLD 2017 Global Strategy for the Diagnosis, Management and Prevention of COPD report.

Key themes

- As COPD progresses patients can use a range of different inhalers, which can cause confusion and may require a different technique and breath type to operate them effectively. Following the revised guidance, clinicians should assess the patient's inspiratory flow and then select either:

    - the metered dose inhalers (MDI) on the left hand side of the pathway (LOW inspiratory flow <30L/min 'Long and Slow')
    - the dry powder inhalers (DPI) right hand side of the pathway (HIGH inspiratory flow >30L/min 'Quick and fast')

  The choice of devices in the revised guidance has been limited to 6 inhaler types to encourage consistency of device during disease progression. The aim of the new guidance is to have patients either using all MDI and mist-haler products; or all dry powder. The objective is to improve adherence as the patient will not need to alter the breath required to get the greatest benefit from their inhalers. This aims to improve overall control of the patients' symptoms.

- Spiriva 18mcg Handihaler is no longer included in the OCCG COPD guidance and is therefore listed as 'BROWN' (restricted) on the Oxfordshire formulary and should not be initiated in new patients with COPD. However, people whose treatment with Spiriva® 18mcg is not recommended in the guidance, but was started within the NHS before this guidance was published, should be able to continue treatment until they and their NHS clinician consider it appropriate to stop or switch to an alternative device.

- A new version of the In-Check device which also has a handihaler setting is available and it is suggested that this can be used as a guide to help assess a patient's inspiratory flow. An Inhaler Standards and Competency Document (produced by the UK Inhaler Group) is available for staff to assess both themselves and their patients. A new app called 'RightBreathe' designed for smartphones (for both apple and android) is now available which contains videos demonstrating inhaler technique for all the different devices on the market. This was developed by a group of pharmacists and GPs in London in conjunction with the NHS London Procurement Partnership. Clinicians may find this useful in their counselling of patients.

- All ICS/LABA inhalers included in the guidance provide a daily steroid dose equivalent to ≥ 800mcg beclomethasone dipropionate. Patients require monitoring and counselling for potential adverse effects including pneumonia. The four inhalers containing corticosteroids are graded 'BROWN' on the Oxfordshire Formulary for COPD so that they should be prescribed in restricted circumstances in line with the updated guidance.

So What?
Prescribers and other healthcare professionals working with COPD patients should be aware of the updated guidance and use it when reviewing a patient's therapy and when starting patients on new treatments

Guidance on COPD Management in Primary care—Inhaled Therapies

NHS Oxfordshire Clinical Commissioning group

*****Co-existing asthma and COPD may need to be treated differently*****

For ALL patients:

- Diagnosis should be confirmed with symptoms and spirometry.
- 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 (forms available here); *repeat attendance may be appropriate.*
- Prescribe according to inspiratory flow (guidance how to assess here) - and check inhaler technique with every device used and **any change** in device (promotional videos on inhaler technique available online). Check inspiratory flow at all reviews.
- Prescribe by brand name to avoid confusion. Refer to BNF/individual Summary of Product Characteristics (SPC) for full prescribing details. Doses shown do not reflect those for special patient populations, and are sourced from SPCs (accessed 16/12/16).
- Specialist opinion suggests promoting the use of a spacer for all MDI prescribing and confirming technique. Please note not all MDI devices are licensed for use with a spacer. Respimat devices are not licensed for use with a spacer.
- Standby antibiotics and oral corticosteroids for frequent exacerbator patients (advice can be found here).
- All patients with COPD should have oxygen saturations monitored at each review. Patients with oxygen saturations that are 92% or below when clinically stable should be referred to the COPD clinic for consultant review and will then be referred onwards for oxygen assessment.

Aim to have same device delivery, either Metered dose inhaler (MDI) or Dry powder inhaler (DPI), for all classes of drug

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

Inspiratory Flow Prescribe device according to inspiratory flow – check inhaler technique with every device used	
LOW <30L/min MDI/soft mist: 'Long and Slow'	**HIGH** >30L/min DPI: 'Quick and fast'

Mild Disease

Few symptoms, no history of exacerbations *and/or* FEV_1 % predicted ≥80%*

OFFER Short Acting β_2 Agonist (SABA) FOR USE AS REQUIRED	
Ventolin 100mcg Evohaler®(salbutamol) 1-2 puffs prn up to QDS	Easyhaler Salbutamol 100mcg 1-2 puffs prn up to QDS **OR** Bricanyl Turbohaler®500mcg (terbutaline) 1 puff prn up to QDS

Moderate

Daily symptoms of dyspnoea, cough, sputum production
and/or
Infrequent exacerbation history ≤1 in last year (not leading to hospital admission)
and/or
FEV_1 % predicted 50-79%*

Increasing severity

MONO BRONCHODILATOR THERAPY Continue prn SABA **Offer Long Acting Muscarinic Antagonist (LAMA)**	
Spiriva Respimat® 2.5mcg/dose (tiotropium) 2 puffs OD	Eklira Genuair® 322mcg/dose (aclidinium) 1 puff BD **OR** Incruse Ellipta® 55mcg/dose (umeclidinium) 1 puff OD
OR Offer Long Acting β_2 Agonist (LABA)	
Atimos Modulite® 12mcg pMDI (formoterol) 1 puff BD **OR** Striverdi Respimat® 2.5mcg/dose (olodaterol) 2 puffs OD	Oxis 12 mcg Turbohaler® (formoterol) 1 puff OD or BD **OR** Formoterol 12mcg Easyhaler 1 puff BD

ONGOING SYMPTOMS and/or INCREASE IN EXACERBATIONS **COMBINATION DUAL BRONCHODILATOR THERAPY** *Choices depend on which mono-therapy was initiated – use same inhaler device if patient technique good.*	
Spiolto Respimat® 2.5/2.5mcg (tiotropium/olodaterol) 2 puffs OD	Duaklir Genuair® 340/12mcg (aclidinium/formoterol) 1 puff BD **OR** Anoro Ellipta® 55/22mcg (umeclidinium/vilanterol) 1 puff OD

Severe and very severe

Daily symptoms of dyspnoea, cough, sputum production
and/or
Frequent exacerbations ≥2 per year (or ≥1 leading to hospital admission)
and/or
FEV_1 % predicted <50%*

COMBINATION DUAL BRONCHODILATOR THERAPY *Choices depend on which mono-therapy was initiated – use same inhaler device if patient technique good.*	
Spiolto Respimat® 2.5/2.5mcg (tiotropium/olodaterol) 2 puffs OD	Duaklir Genuair® 340/12mcg (aclidinium/formoterol) 1 puff BD **OR** Anoro Ellipta® 55/22mcg (umeclidinium/vilanterol) 1 puff OD

ONGOING SYMPTOMS and/or INCREASE IN EXACERBATIONS *Add Inhaled Corticosteroid (ICS) to combination dual bronchodilators ('triple' therapy)*	
Fostair®pMDI 100/6mcg (beclometasone/formoterol) 2 puffs BD + Spiriva Respimat® 2.5mcg/dose (tiotropium) 2 puffs OD **OR** Symbicort® pMDI 200/6mcg (budesonide/formoterol) 2 puffs BD + Spiriva Respimat® 2.5mcg/dose (tiotropium) 2 puffs OD	Symbicort Turbohaler® 200/6mcg (budesonide/formoterol) 2 puffs BD + Eklira Genuair® 322mcg/dose (aclidinium) 1 puff BD **OR** Relvar Ellipta® 92/22mcg (fluticasone furoate/vilanterol) 1 puff OD + Incruse Ellipta® 55mcg/dose (umeclidinium) 1 puff OD
Issue of a steroid card should be considered for the ICS options above (all ICS doses equivalent to ≥800mcg/day beclometasone dipropionate). All ICS options above give potential steroid side effects (including pneumonia).	