Prescribing Points

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Oxfordshire Cinical Commissioning Group

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GLP-1 Receptor Agonists in Type 2 Diabetes Guideline

The GLP-1 Receptor Agonists in Type 2 Diabetes Guideline has been updated and was approved at APCO in July 2017. The main changes are as follows:

- Exenatide (both daily and weekly doses) are no longer included in the guidance as exenatide has no cost or clinical benefit over the other options. Patients who are currently being successfully treated on exenatide do not need to be switched.
- Lixisenatide is the first line daily GLP-1 receptor agonist. If the patient fails on lixisenatide due to side effects or an inadequate response, then liraglutide is the second line option.
- Dulaglutide (Trulicity) is now the weekly GLP-1 receptor agonist of choice. Dulaglutide benefits from a safer, easier to use injection device. Patients should only be started on dulaglutide if there is significant benefit to once weekly administration e.g. administration by a carer.
- Liraglutide can be increased to 1.8mg on **specialist advice only** (OCDEM or Community Diabetes Service) in patients who have an inadequate response to the 1.2mg dose.

The Patient Agreement Form and Checklist has also been updated. This can be used to assess suitability for treatment with a GLP-1 receptor agonist and also to gain patient agreement to a 6 month trial. After 6 months of treatment, patients should be assessed in line with the NICE criteria for continuation. Reasonable benefit is defined by NICE as a reduction in HbA1c of 1% point (DCCT units) or 11mmol/mol (IFCC units) or more, and a reduction in weight of 3% or more after 6 months of treatment.

So What?
Prescribers should ensure that they are aware of the latest GLP-1 Receptor agonist guidance when initiating in new patients or reviewing existing treatment

Formulary update

Degarelix

Degarelix (Firmagon®) is a gonadotrophin-releasing hormone antagonist licensed for treating advanced hormone-dependent prostate cancer. It has been classified as amber continuation and may be initiated by specialists in men presenting with newly-diagnosed prostate cancer with spine metastases and backpain requiring more than simple analgesia, or patients with associated neurological deficit (spinal cord or nerve root compression clinically or on MRI imaging).

So what?
Specialists will prescribe the two initial degarelix injections (240mg total dose) in the hospital and patients will receive them in the clinic. These patients will not be prescribed bicalutamide 50mg as degarelix does not induce a transient testosterone surge at the start of therapy.
GPs will then be asked to prescribe and administer subsequent injections (80mg) every 4-weekly.
This is in line with NICE TA404: Degarelix for treating advanced hormone-dependent prostate cancer.

Midodrine for autonomic dysfunction in cardiac disorders

Midodrine is now classified as Amber continuation on the Oxfordshire formulary for both new and existing patients. An amber continuation guideline is available on the CCG website which outlines the responsibilities of the specialist and the GP as well as prescribing information, monitoring requirements and information about treatment discontinuation. The specialist should initiate treatment, assess response and prescribe until the dose is stable before transferring prescribing to the GP

So what?
Ensure amber continuation guideline is followed when continuing treatment from secondary care and when reviewing patients especially if a trial stop is being considered

Freestyle Libre – interim BLACK (no prescribing) classification

The Freestyle Libre is a flash intermittent glucose monitoring system which allows people to check interstitial glucose levels and trends without regularly performing capillary (fingerprick) testing. A sensor, with a microfilament sited in the skin is placed on the back of the arm and the reader, when passed over the sensor, displays interstitial glucose levels. There are limitations to the system e.g. not appropriate for DVLA regulations or people who have loss of hypoglycaemia awareness, delayed indication of true blood glucose levels and it does not provide alerts. The system does not fully replace traditional capillary testing, and requires user commitment and education. Local specialists have suggested a limited cohort of patients for whom this system is appropriate.

There are reports that GPs have received requests to prescribe Freestyle Libre, from healthcare providers, from patients who may have purchased privately and from patients anticipating the addition of the system to the November Drug Tariff. Freestyle Libre is not approved by the Department of Health to prescribe on FP10 until November 1st 2017. Oxfordshire Area Prescribing Committee (APCO) has not approved the system for local prescribing. An application has not been received for this to add to the local formulary. An interim decision has been made to classify Freestyle Libre and sensors as BLACK (no prescribing) until APCO has considered it fully.

So What?
ACTION for GPs receiving prescribing requests

- From NHS Trusts: requests from the trust must be declined until a decision is made by the Area Prescribing Committee on ongoing local formulary classification.
- From patients currently privately funding the product: please refer to the local policy; Managing the boundaries of NHS and privately funded healthcare. This policy states that private patients wishing their treatment to be managed on the NHS have to follow the same pathway as NHS patients.
- From new patients anticipating Drug Tariff inclusion November: advise that Freestyle Libre is not currently approved for primary care prescribing in Oxfordshire and will not be prescribed on FP10 as currently classified as BLACK on the OCCG formulary.

Anticoagulation Medicines Optimisation Project: 6 month review

The Anticoagulation Training and Direct Oral Anticoagulants (DOAC) Support Service has been available to help support GPs and community pharmacists to optimise anticoagulation since March 2017. This 12 month project is collaboration between OUHFT, OCCG and AHSN to complement the warfarin OUHFT service already available (ac.service@nhs.net). The following gives a summary of the results of the first six months:

1. GP practice support

Contact made from 34 practices (49%):

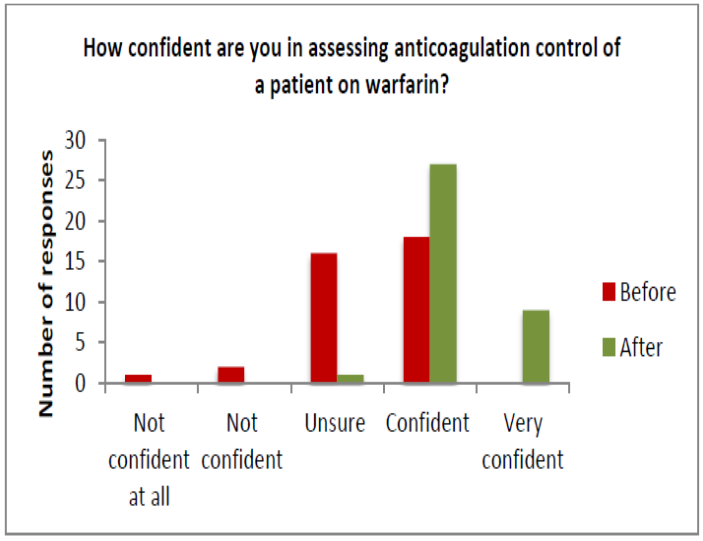
- 12 practice visits completed: 12 educational sessions and 6 patient review sessions
- 15 practice visits pending
- 5 requests for TTR lists
- 3 practices not replying after first contact made

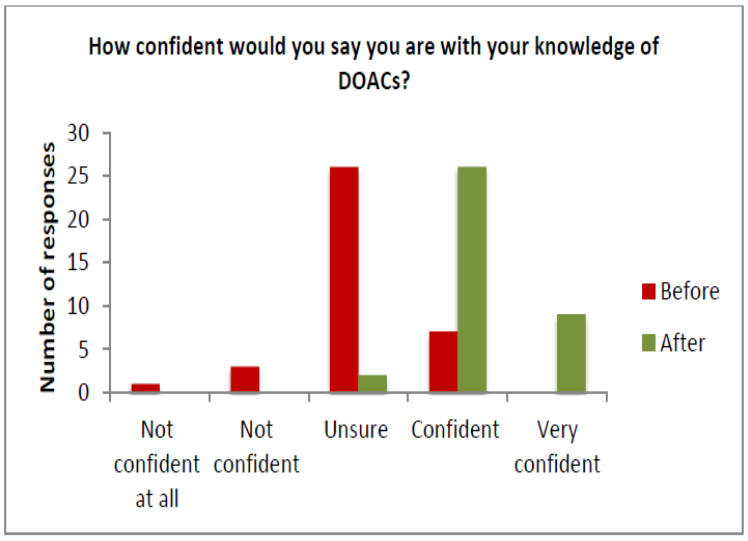
First practice visit made on 25th April 2017

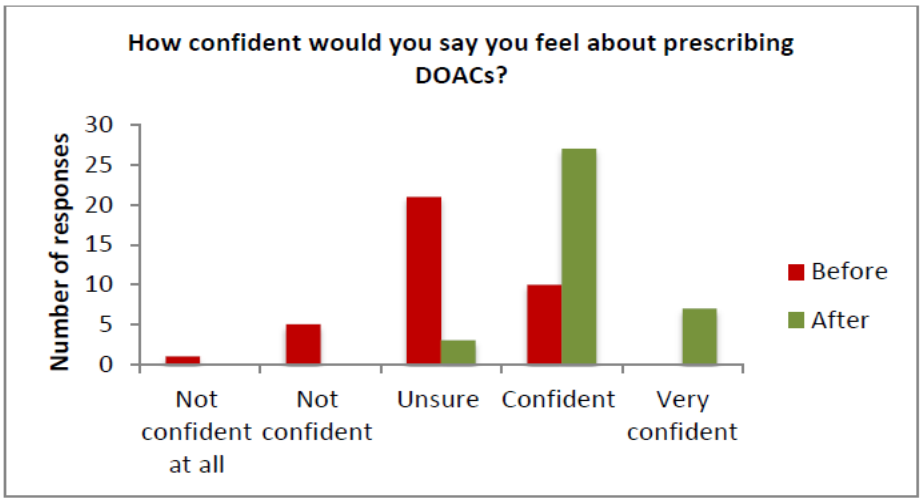
2. GP feedback

37 feedback forms completed following delivery of educational session.

- All GPs would recommend the educational session to colleague.
- 95% agreed or strongly agreed that the content, structure and presentation of the session were at the appropriate level and well executed.
- The following graphs show the responses before and after the educational session:







3. Advice line support

- 29 email enquiries from 15 different GP practices and 2 OUH Consultants
- Themes: 18/29 switch from warfarin to DOAC (13/18 poor TTR, 5/18 other reasons), 3 initiation of anticoagulant for AF, 3 side effects of a DOAC/ongoing anticoagulant management , 4 suitability of continuing current anticoagulant and 1 to pass on information to service
- More enquires made by practices prior to education sessions than after
- 5 patients followed up post TTR reviews

4. Overall RAID (warfarin service) data

	28th Feb 2017	31st Aug 2017
No. of active patients on RAID	**6770**	**6347**
No. eligible for TTR	6416	6024
Total no. TTR less than 65%	1880 (29.3%)	1655 (27.5%)
No. of patients with AF eligible for TTR	**4751**	**4213**
No. of patients with AF & TTR < 65%	1266	1094
No of pts - other diagnosis & eligible TTR	**1899**	**1811**
No. of pts with other diagnosis & TTR <65%	614	561

This demonstrates that since the project started 6th March 2017, there are 225 fewer patients poorly controlled on warfarin, 172 of these with an indication of AF. This translates to 5.6 strokes averted per annum.

Support available:

- Email advice line: **doacsupport.ox@nhs.net.**
  (For best advice provide as much information as possible: patient's indication for anticoagulation, age, weight, recent eGFR/creatinine, LFT, FBC, medicines and adherence, alcohol intake, need for dosette box).
- Telephone advice: Bleep 4177 via switchboard (0300 304 7777).
- Request a list of patients on warfarin whose 'time in therapeutic range' (TTR) is sub-optimal (<65%) and who should therefore be reviewed as per NICE guidance.
- Practice visit from specialist anticoagulation pharmacist to:
  - Give education session, practical advice and highlight resources.
  - Support review of warfarinised patients with low TTR.
  - Aid assessment of AF patients with CHA_2DS_2-VASc ≥1 not anti-coagulated (optional).

  BOOK NOW! (email **doacsupport.ox@nhs.net**)
- Locum backfill payment for 1-2 sessions (Pharma funded) for practice GP to work on project with/without pharmacist support.
- Training for community pharmacists to support and counsel patients on DOACs highlighting key issues such as side effects, interactions and adherence.
- Assist in the provision of the new medicines service (NMS) relating to anticoagulation.

Anticoagulation Optimisation Project supported by a Medical and Educational Goods and Services (MEGS) grant from Pfizer.

Lithium Shared Care protocol – Calcium Monitoring

The current Lithium Shared Care protocol does not mention the need for calcium monitoring, however this should be part of the montioring regime and should be carried out annually in patients taking long term lithium. The Shared Care Protocol is in the process of being updated and this recommendation will be included shortly.

So What?
Practices should ensure that calcium levels in patients on long term lithium are monitored on a yearly basis

Miconazole oral gel and warfarin interaction

Bleeding events, some with fatal outcome, have been reported with use of miconazole oral gel by patients on warfarin.Patients taking warfarin should not use over-the-counter miconazole oral gel available from pharmacies. If the concomitant use of miconazole oral gel with an oral anticoagulant such as warfarin is planned, exercise caution and ensure that you monitor and titrate the anticoagulant effect carefully. Advise patients taking prescription-only miconazole oral gel and warfarin that if they experience signs of over-anticoagulation, such as sudden unexplained bruising, nosebleeds, or blood in urine, they should stop using miconazole and seek immediate medical attention

Loperamide (Imodium): reports of serious cardiac adverse reactions with high doses of loperamide associated with abuse or misuse

Serious cardiovascular events (such as QT prolongation, torsades de pointes, and cardiac arrest), including fatalities, have been reported in association with large overdoses of loperamide. Healthcare professionals are reminded that if symptoms of overdose occur, naloxone can be given as an antidote. Since the duration of action of loperamide is longer than that of naloxone (1–3 hours), repeated treatment with naloxone might be indicated; patients should be monitored closely for at least 48 hours to detect possible CNS depression as for all medicines, pharmacists should remind patients not to take more than the recommended dose on the label. Report all suspected adverse reactions, including those associated with abuse or misuse, to the Yellow Card Scheme

Ketone Meters and SGLT2 Inhibitor Reminder

It is recommended that all settings possess a blood ketone meter and in-date blood ketone test strips to ensure timely diagnosis of Diabetic Ketoacidosis (DKA). This is particularly important for patients with type 1 diabetes, pregnant patients with diabetes and patients with type 2 diabetes taking sodium-glucose co-transporter-2 (SGLT2) inhibitors (dapagliflozin, canagliflozin, empagliflozin).
SGLT2 inhibitors have been associated with cases of DKA.

In Oxfordshire these drugs should only be initiated on recommendation of a member of the diabetes specialist team (e.g. OCDEM/CDS nurse or doctor in specialist diabetes service). Serious, sometimes life-threatening cases of DKA have been reported in patients on SGLT2 inhibitor treatment. In a number of these reports, the presentation of the condition was atypical with only moderately increased blood glucose levels observed. Such atypical presentation of diabetic ketoacidosis in patients with diabetes could delay diagnosis and treatment. Patients on SGLT2 inhibitors should be tested for ketones when they present with symptoms of acidosis in order to prevent delayed diagnosis and patient management.

So what?
All settings should try and ensure that a blood ketone meter is available to test patients when appropriate and be aware of the SGLT2 potential to cause DKA at normal blood glucose levels.
Resources on SGLT2 inhibitor induced DKA can be found here, this includes a patient information leaflet and information on how patients presenting with symptoms should be managed in primary care.

Report Illicit Drug Reactions (RIDR) website

A pilot reporting website, the Report Illicit Drug Reaction form, will be available for one year for healthcare professionals across the UK who come into contact with patients experiencing harm associated with use of illicit drugs, particularly new psychoactive substances (formally known as 'legal highs'). The pilot aims to better collect data on harms from illicit drug use, to support provision of clinical guidance to professionals.
Hospital admissions for poisoning by psychostimulants with abuse potential have increased by 44% in England and Wales from the period 2009–10 to 2014–15. At present, evidence is lacking about the long-term harms to health associated with use of such illicit substances, and more monitoring in this area is needed.
The form is intended to be used by health professionals who work in emergency departments, general practice, drug treatment services, sexual health services, mental health services, and any other services who come into contact with people who have developed acute or chronic problems associated with use of new psychoactive substances.
More information from the MHRA is available here

Rivaroxaban 2.5mg strength

A reminder that the 2.5mg strength of rivaroxaban is only licensed for use in the prophylaxis of atherothrombotic events following an acute coronary syndrome with elevated cardiac biomarkers. There has been some local prescribing of this strength recently, although local acute trusts have indicated that they will not routinely be using this drug for this indication.

So what?
Prescribers should ensure that the correct strength of rivaroxaban is used for the relevent indication. In prophylaxis of stroke and systemic embolism in patients with non-valvular atrial fibrillation and in secondary prevention of DVT/PE this is 20mg once daily and in treatment of DVT/PE this is 15mg twice daily for 21 days, then 20 mg daily

Teoptic (carteolol) eye drops – discontinued

Following the withdrawal of Teoptic 1% eye drops in June, we have been advised that Teoptic 2% eye drops have also been discontinued.
OUH ophthalmology have advised that affected patients should be switched to timolol 0.25% (1 drop BD)

So what?
Any remaining patients using Teoptic eye drops should be switched to timolol 0.25%

Forged Prescriptions

We have been made aware of an issue recently where a pharmacy was presented with a handwritten forged prescription for diazepam and opiates. It was written on a blank prescription form (FP10SS) usually used in surgery printers.

So What?
Prescribers are asked to please ensure they consider the security of printers and prescription forms when patients are in their consulting rooms

Pregabalin Prescribing Update

The Lyrica patent for neuropathic pain expired in July 2017. A number of generic versions have gradually become available at significantly reduced prices. The August drug tariff saw the introduction of very low category M prices. Following a challenging period of supply issues and variation in NCSO price agreements, the reimbursement prices for generic prescriptions have now settled. The generic NCSO prices are now generally lower than those of the branded generics.

So What?
It is now recommended that all pregabalin is prescribed generically

Prescribing Rationalisation Tool

A Prescription Rationalisation Tool for use in polypharmacy medication reviews is now available on the CCG website here. This has been largely based on the PrescQIPP IMPACT (Improving Medicines and Polypharmacy Appropriateness Clinical Tool) and has been amended by the Oxfordshire CCG Medicines Optimisation for use locally within Oxfordshire. It is suggested that it is used by prescribers as a practical decision aid in conjunction with other relevant patient-specific data when reviewing older patients.

So What?
The suggestions provided within this tool for consideration are intended to optimise medicines use. Further advice, where appropriate, is provided to assist in stopping/discontinuing and withdrawing medicines and if a medicine is considered appropriate it should be continued.

Truss Measuring and Fitting

Recently a patient in South Oxfordshire had difficulty finding a local pharmacy that would measure and fit a truss. This highlighted the need to ensure GPs and pharmacists can signpost patients to pharmacies that are able to provide truss measuring and fitting services.
The Local Pharmaceutical Committee (LPC) have now put together a list of pharmacies in Oxfordshire that do provide this service. This list should shortly be available on the LPC's website, but in the meantime enquires can be made through the Medicines Optimisation Team email OCCG.medicines@nhs.net

Antimicrobial Resistance Public Health Campaign and e-learning package

During October, Public Health England (PHE) will launch a national campaign across England to support the government's efforts to reduce inappropriate prescriptions for antibiotics by raising awareness of the issue of antibiotic resistance and reducing demand from the public. A national media campaign involving TV and radio advertising will be running but GP practices and pharmacies will also be able to order leaflets and posters to support the campaign.
The **free resources** (leaflets, posters and the 'treating your infection' checklist) from Public Health England are available to order here and will be distributed from 16th October.
In addition, a free e-learning session from Health Education England 'Reducing Antimicrobial Resistance: An introduction' is available here. It is aimed at all health and social care staff to help understand the threats posed by antimicrobial resistance and the ways they can help to tackle it
It provides key facts about antimicrobial resistance and describes the important role everyone working in a health and care environment has in tackling it. It also discusses relevant aspects of the antimicrobial prescribing and stewardship competences.
The Antimicrobial Resistance programme is also available to NHS healthcare staff via the Electronic Staff Record (ESR). Accessing this e-Learning via ESR means that your completions will transfer with you throughout your NHS career. Further details are available here.

NICE Guidance - Parkinson's Disease in Adults

NICE recently issued an updated guideline on Parkinson's Disease in Adults https://www.nice.org.uk/guidance/ng71. This guideline is an update of NICE guideline CG35 (published June 2006) and replaces it. New recommendations have been added on treating Parkinson's disease symptoms, deep brain stimulation, monitoring and managing impulse control disorders, and palliative care. These are marked as **[2017]**. Where recommendations end **[2006]**, the evidence has not been reviewed since the original guideline.
A useful summary of the recommendations can be found here:
NICE Bites Aug 2017 No99 Parkinson's disease

Some of the **Do Nots** include:

- **Do NOT** withdraw antiparkinsonian drugs (so called 'drug holidays') to reduce motor complications because of the risk of neuroleptic malignant syndrome.
- **Do NOT** offer ergot-derived dopamine agonists as first-line treatment.
- **Do NOT** offer anticholinergics to people with Parkinson's disease who have developed dyskinesia and/or motor fluctuations.
- **Do NOT** treat hallucinations and delusions, if they are well tolerated by the person with Parkinson's disease and their family members/carers.
- **Do NOT** offer olanzapine to treat hallucinations and delusions in people with Parkinson's disease.
- **Do NOT** offer creatine supplements to people with Parkinson's disease
- **Do NOT** use vitamin E as a neuroprotective therapy
- **Do NOT** use co-enzyme Q10, dopamine agonists or MAO-B inhibitors, except in the context of clinical trials, as neuroprotective therapies

NICE Quality Statement - Low back pain and sciatica in over 16s

This quality standard covers the assessment and management of non-specific low back pain and sciatica in young people and adults aged 16 years and over. The recommendations are:

- Primary care services have an approach to risk stratification for young people and adults presenting with a new episode of low back pain with or without sciatica.
- Young people and adults with low back pain with or without sciatica do not have imaging requested by a non-specialist service unless serious underlying pathology is suspected.
- Young people and adults with low back pain with or without sciatica are given advice and information to self-manage their condition.
- Young people and adults are not given paracetamol alone, anticonvulsants or antidepressants to treat low back pain without sciatica.
- Young people and adults are not given opioids to treat chronic low back pain without sciatica.
- Young people and adults do not have spinal injections for low back pain without sciatica with the exception of radiofrequency denervation for people who meet the criteria.