Oxfordshire
Cinical Commissioning Group

Prescribing Points

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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 of Freestyle Libre sensors

FreeStyle Libre® is a new product that allows easy monitoring of glucose levels aimed at people with diabetes. The device consists of a sensor and reader that has the potential to improve quality of life for patients and supports self-management. However, there is currently no National Institute for Health and Care Excellence (NICE) recommendation on the use of the system.
Prescribing Freestyle Libre sensors has been approved by OCCG via the Oxfordshire Area Prescribing Committee, in line with a new local criteria-based policy statement.

The policy was produced following a review of the evidence available and with the involvement of local NHS specialists. It is based on the Regional Medicines Optimisation Committee statement with a number of local additions to ensure we prioritise those patients considered most likely to benefit. Patients most likely to benefit will be identified by their NHS specialist clinic so that they receive training and education on use of the device and how to interpret and act on the readings.

Prescribing of Freestyle Libre sensors will only be started by a specialist NHS diabetes service, during a routine appointment, on a 6 month trial basis. It is available for people with Type 1 diabetes, aged four and above who attend specialist Type 1 care and need multiple daily injections or use insulin pump therapy. These people will have been assessed by the specialist clinician and will meet one or more of the following criteria:

- Patients who undertake intensive self-monitoring of blood glucose (SMBG) at least 8 times daily and actively manage their insulin use based on the results.
- Those who meet the current NICE criteria for insulin pump therapy (HbA1c ≥8.5% (69.4mmol/mol) or disabling hypoglycaemia (as described in NICE TA1514) where a successful trial of FGS may avoid the need for pump therapy.

- Those who have impaired awareness of hypoglycaemia. It is noted that for persistent hypoglycaemia unawareness, NICE recommend continuous glucose monitoring with alarms and FGS does currently not have that function.
- Frequent admissions (more than 2 per year) with diabetic ketoacidosis (DKA) or hypoglycaemia.
- Those who require third parties to carry out monitoring and where conventional blood glucose testing is not possible.

The NHS clinic will request that GPs continue prescribing via outpatient letter accompanied by a copy of a completed patient/carer agreement (adult or paediatric) which outline criteria, target outcomes, patient requirements and clinic/patient/GP responsibilities. Continuation beyond 6 months is subject to confirmation that criteria continue to be met. Patients who are currently self-funding must wait for their next routine clinic appointment to be considered for NHS sensor prescribing.

Any ongoing prescriptions for blood glucose test strips must be for the locally agreed cost-effective options (approx. < £10) unless specifically required for insulin pump or carbohydrate calculator compatibility. Pharmacies and dispensing practices must arrange for a direct account with Abbott to receive sensor stock. Patients are encouraged by Abbott to return faulty systems and sensors directly to them for replacement. GPs should not prescribe extra prescriptions to replace faulty devices/sensors.

So What?
Prescribers in primary care are requested to only prescribe Freestyle Libre® sensors on an NHS prescription, in line with OCCG policy, following receipt of an NHS specialist clinic request accompanied by a completed patient/carer agreement form. Prescribing should only be undertaken for 6 months unless the clinic confirms continuation for individual patients.

Shared Care Update

Midodrine in Primary Care

Midodrine tablets (Bramox) has been approved for limited primary care prescribing in Oxfordshire in line with the Midodrine for Autonomic Dysfunction in Cardiac Disorders, Amber Continuation Guideline. OUH cardiologists estimate that this will be prescribed for approximately 20 patients in a year. Prescribing data indicates that current prescribing of midodrine exceeds this estimate, and therefore practices are encouraged to review patients and confirm diagnosis and clinical appropriateness of treatment.

Melatonin Shared Care Protocol

The OCCG/OUH Melatonin Shared Care Protocol has been reviewed and updated. The key changes are:

- the emphasis on communication to the patient/carer that there is no safety or efficacy evidence available to support long-term use
- that prescribing should be retained by specialist until dose is stable and benefit has been confirmed
- that prescribing should only be as Circadin 2mg tablets except for patients with small bore enteral feeding tubes
- the consideration of annual drug holidays, as recommended by the specialist
- that a plan must be agreed with patient/carer for transition to adult services or discharge

Roflumilast Amber Continuation Guideline

An amber continuation guideline for the use of roflumilast in COPD patients in line with NICE TA 461 is now available on the CCG website. Roflumilast will be initiated by the specialist and transferred to GP prescribing after three months. It is estimated that roflumilast will only be started in 10-20 patients per year. The specialist will provide the patient with a treatment card and GPs will also be provided with a treatment leaflet.

ADHD Shared Care Protocol Update

The ADHD shared care protocol has been updated to include:

- The addition of lisdexamfetamine to the formulary as amber shared care (previously available as specialist only prescribing). The specialist will initiate and, once stable, shared care will be requested. Lisdexamfetamine is the only licensed stimulant for use in adults and is now included as a 1st/2nd line option in adults (in addition to methylphenidate) and a 2nd/3rd line option in children and adolescents.
- The service provided to newly diagnosed adults (the SCP already included adults transferred from CAMHS)
- The addition of Delmosart and Xaggitin XL (branded generic methylphenidate modified release) as the formulary choice for all new patients started on methylphenidate MR and, for existing patients, consideration of a switch at the next patient review. Both brands offer a 50% saving on the current product used.
- A link to the new primary care pathway for foreign visitors (all ages) taking ADHD medication, including information on when to refer, when medication can be provided and switching from Adderall/Adderall XR, which is not available in the UK

In addition the Treatment pathway for adults with attention deficit hyperactivity disorder (ADHD) Thames Valley Priorities committee Commissioning Policy Statement has also been updated and is available here

So What?
Prescribers should ensure that they refer to the updated shared care protocol when prescribing for ADHD

Dalteparin – VTE prophylaxis in pregnancy

It is essential that patients with a high risk of thromboembolism receive preconception counselling at an early stage, via referral to the Silver Star Obstetric physician/haematology team for expert advice. Please see Dalteparin guideline and shared care protocol.

High risk patients:

- Single previous VTE and thrombophilia or family history (1st degree relative)
- Single unprovoked/oestrogen related VTE
- Previous recurrent VTE >1

Antenatal patients identified as high risk should begin treatment with dalteparin as soon as a pregnancy is confirmed with a positive pregnancy test and be continued until the patient attends their first appointment with the specialist, at which stage **secondary care will assume responsibility for continued treatment**. In order to avoid delay, it would therefore be appropriate for GPs to provide this therapy whilst waiting for a referral to the Silver Star obstetric team to be processed.

Traffic light classification: AMB SCP For first doses in high risk of VTE in pregnancy.

Intermediate risk patients:

Intermediate risk patients should be referred to the obstetric team for consideration of whether antenatal prophylaxis is required. For intermediate risk patients **dalteparin treatment will be provided by secondary care.**

Traffic light classification: RED Specialist prescribing for intermediate risk of VTE in pregnancy.

So What?
Ensure that any antenatal patients identified as high risk of thromboembolism are prescribed treatment with dalteparin as soon as the pregnancy is confirmed – this can be initiated by the GP until the patient is seen in by Silver Star where treatment will be continued by the specialist. Patients at intermediate risk will be assessed and treated by the specialist team if prophylaxis is required.

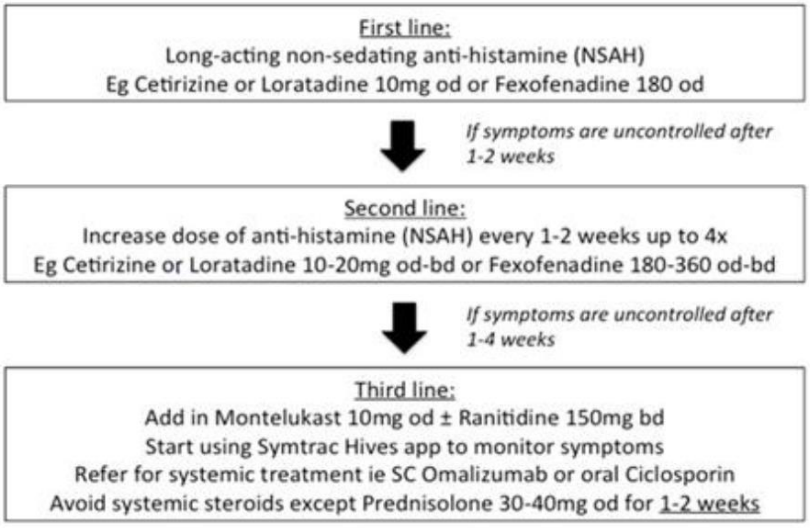
Ibandronic acid as an adjuvant treatment in early breast cancer

A new local guideline on Adjuvant Bisphosphonate treatment for Post-Menopausal Women with Early Breast Cancer at intermediate or high risk of recurrence of cancer is now available on the CCG website.
This provides the treatment pathway for patients depending on whether they will be initated on an IV zolendronic acid (patients who will be receiving chemotherapy and cannulated) or oral ibandronic acid. Patients starting on IV zolendronic acid will receive 6 weekly treatments for 3 cycles alongside chemotherapy and then converted to oral Ibandronic acid for a further 30 months. Patients starting on ibandronic acid should continue for 36 months. The first month of ibandronic acid in both cases will be provided by the hospital and then the GP will be requested to continue prescribing. Ibandronic acid is therefore now classified as Amber Continuation on the Oxfordshire formulary for this indication.

So what?
Prescribers should refer to the new guidance if a request to prescribe ibandronic acid as an adjuvant treatment in early breast cancer is received

Spontaneous Urticaria Guideline

OCCG have recently approved a Management Guideline for Spontaneous Urticaria with/without Angioedema in Adults. This offers guidance on diagnosis and management in primary care, and when to refer to specialist Dermatology. A summary of the prescribing recommendations in the guideline is below:



So What?
Prescribers should refer to this updated guidance when considering treatment options for spontaneous urticaria

Trimethoprim PGD for Pharmacies– practice notification of treatment

The Trimethoprim PGD is now available in many pharmacies around the county. Pharmacists record the consultation on Pharmaoutcomes and a notification letter is sent to the patient's GP practice, either to the practice secure email address or by post, if an email address for the practice is not available. Practices are asked to ensure that this notification is added to the patient's GP record.
If you have any patients presenting with treatment failure after a course of trimethoprim provided via this service, please inform Ailsa Whyte (ailsa.whyte@oxfordshireccg.nhs.uk). Please do not include patient identifiable information.

Syringe drivers and Injections suitable for use

The symptom management of patients for palliative and or end of life care is often managed by the subcutaneous route once the oral route for medicines becomes unreliable. The choice of drugs can be individualised to the patient's symptoms, pharmacokinetic parameters and co-morbidities. Many injections can be given by the subcutaneous route but few are licensed for this route and none for combination in a continuous subcutaneous infusion via syringe driver.

There is little clinical evidence and most choices are based on good clinical experience. There are many factors which can affect the stability and/or compatibility of drugs in syringe drivers including drug concentration, formulation, diluent, infusion time, exposure to light, temperature, order of mixing. The main criteria physically tends to be the pH of the injection so those that are too acidic (pH<2) or too alkaline (pH>11) tend to be irritant and mixtures are often chemically incompatible. Excipients such as preservatives and solubilizing agents e.g. sodium benzoate and polyethylene glycol can further increase the irritation. Most injections are formulated as salts of weak acids or bases e.g. morphine sulfate and changing the salt can alter solubility characteristics. If the pH is changed by mixing drugs then this too can affect solubility. The solution can appear cloudy which may disappear on mixing and agitation indicating a temporary shift in pH which resolves on dilution with the rest of the contents of the driver. If the solution remains cloudy then this is precipitate and the combination should be abandoned. There is also the potential that a combination of drugs on initial cloudiness which then clears could give an incorrect impression of stability which may then either have little pharmacological activity or indeed form a soluble but potentially toxic compound. Laboratory analysis would be needed to best determine stability and compatibility but as there are potentially over 50,000 combinations of these drugs within a syringe driver with a range of diluents, concentrations and temperatures used this is unlikely to happen.
Best practice is therefore based on observational data and previous clinical practice. The Syringe Driver Policy and End of Life Prescribing Guidance collates such practice. Any more unusual combinations of injectables should be confirmed with the Palliative Care teams or CCG pharmacists. There are texts [1,2], and websites [3] available as guidance based on observational data.
Drugs **commonly given** by subcut infusion: cyclizine, diamorphine, glycopyrronium, haloperidol, hyoscine butylbromide, levomepromazine, metoclopramide, midazolam, morphine, oxycodone.
Drugs **not suitable** for subcut infusion: diazepam, prochlorperazine.

So What?
Regular monitoring of all syringe drivers is essential. Any syringe driver which results in precipitation or change in colour should **not** be used; more unusual combinations of drugs and further guidance or advice can be sought by contacting the Community Palliative Care teams: Sobell House Hospice 01865 257036 or Katharine House Hospice 01295 811866 or Sue Ryder at Nettlebed 01491 641384.

1. The Syringe Driver 4th edition 2016 Dickman A, Schneider J, Oxford University Press
2. Palliative Care Formulary PCF5 2014 Twycross R, Wilcock A, palliativedrugs.com
3. www.palliativedrugs.com

Scriptswitch Dosage Instructions

We have been notified of a potential issue with Scriptswitch whereby, for a number of switches, dosages are copied as written by the prescriber for the original product into the new product's instructions if the instructions have been free-typed. This does, potentially, create a problem when switching between different drugs as follows:
Original Product – canagliflozin 100mg tablets '**Take 100mg daily**' (as free-typed by GP)
The switch is accepted and the dose is copied over to,
Replacement Product – empagliflozin 10mg tablets '**Take 100mg daily**' (this is 10 times the recommended dose)

So What?
Could prescribers please be aware that this is a risk for free-typed instructions and be assured we are working with Scriptswitch in order to establish a resolution for this problem

Mycophenolate – Updated Contraception Guidance

The European Medicines Agency (EMA) has updated recommendations for contraception in men and women taking mycophenolate medicines which are used to prevent rejection of transplanted organs**.** Mycophenolate medicines are known to increase the risk of malformations and miscarriages during pregnancy if the fetus is exposed to them in the womb. EMA has now concluded that current evidence does not indicate a risk of malformations or miscarriages when the father has taken mycophenolate, although the risk of genotoxicity cannot be completely ruled out.
For male patients, EMA now recommends that either the male patient or his female partner use reliable contraception during mycophenolate treatment and for at least 90 days after stopping treatment. The previous recommendation that male patients should use condoms in addition to their female partners using a highly effective method of contraception has now been removed as this does not reflect the level of risk.
For female patients, the risk is unchanged. These medicines must not be used in pregnant women unless there are no suitable alternatives to prevent transplant rejection. In addition, female patients who can become pregnant must use at least one reliable form of contraception before, during and for 6 weeks after stopping treatment. Two forms of contraception are preferred but no longer mandatory.

So What?
The local shared care protocol, available here, will be updated to reflect this change.

Ribena to treat hypoglycemia

It has been brought to our attention that Ribena Blackcurrant is sometimes used by people with diabetes to help manage their blood sugar levels. As part of their commitment to reduce the sugars and kcal content of their drinks, Lucozade Ribena Suntory (LRS) are reducing the sugar content of Ribena Blackcurrant (Ready To Drink and squash by approximately 55%). This follows on from outreach undertaken in 2017 to inform healthcare professionals of the sugars reduction to Lucozade Energy.

So What?
People with diabetes who may be using Ribena to help manage their blood sugar levels should be advised that from February 2018, new Ribena Blackcurrant formulations will start appearing on shelves and for a time new and old formula may be present at the same time. It is essential that consumers check the label.
Ribena Blackcurrant Ready To Drink and squash (when mixed 1 part with 4 parts water) will change from 10g sugars per 100ml to 4.6g sugars per 100ml.

Co-dydramol: prescribe and dispense by strength to minimise risk of medication error

The MHRA drug safety update has recently issued the following advice about the prescribing and dispensing of co-dydramol. Previously co-dydramol (dihydrocodeine/paracetamol) was available only in the ratio 1:50 (co-dydramol 10/500 mg). Two products are now available with a higher strength of dihydrocodeine (co-dydramol 20/500 mg and 30/500 mg tablets). It is therefore important that co-dydramol products are prescribed and dispensed by strength to minimise dispensing errors and the risk of accidental opioid overdose

So What?
When prescribing co-dydramol, clearly indicate tablet strength and dose and when dispensing co-dydramol, ensure patients receive the prescribed strength of co dydramol, and, if in doubt, contact the prescriber.Report suspected adverse drug reactions with opioids, including any harm from medication error, via the Yellow Card Scheme

Parents and carers advised to inspect Buccolam oral syringes before use

The European Medicines Agency (EMA) has reiterated safety messages on Buccolam oral syringes for parents and caregivers. In an alert issued last year, healthcare professionals were asked to speak to parents and carers about carefully inspecting Buccolam pre-filled plastic syringes before giving the medicine. A defect with some syringes has been reported. In a small number of cases, the translucent (white) tip-cap can sometimes remain attached to the syringe after the red cap has been taken off - this is a choking hazard.

This is not a new issue, the MHRA previously issued this alert in December 2017. However, they are now aware of a few rare reports in Europe of a child breathing in or swallowing the tip-cap and the EMA have added guidance on their website. Please see the alert for full details.

So What?
As outlined in the direct healthcare professional communication from the company, healthcare professionals are asked share this information with patients' parents and caregivers, and with age-appropriate patients, during interactions with them going forward to ensure they are aware of this issue when handling the product.

Testosterone transdermal products – discontinuations and supply issues

There are currently supply issues with Testogel 50mg/5g sachets and Testim 50mg/5g gel. There is currently no date for the resolution of the issue with Testogel sachets and the manufacturers of Testim have advised that the product is being discontinued.
The testosterone transdermal products remaining available are: Tostran 2% gel (60g multidose pump) and Testogel 16.2mg/g gel (88g multidose pump)

For testosterone replacement therapy (see shared care protocol) OUH Endocrinology recommend as follows:

- Tostran 2% gel – 10mg per actuation – convert to equivalent dosage. E.g. one sachet will equate to 5 actuations.

For use in menopause (in line with Oxfordshire HRT formulary and treatment guidance) advice from the OUH menopause clinic is:

- Tostan 2% gel – 10mg (0.5g of gel or one actuation) every other day

So What?
Patients currently prescribed Testogel sachets and Testim gel should be prescribed an alternative product as detailed above. Once the supply issue is resolved, patients can be switched back to Testogel sachets.

Vaginal Discharge - Point of care testing for pH

The OCCG Investigation and Management of Vaginal Discharge in Adult Women guidance recommends that most patients should have bedside pH testing of vaginal discharge in preference to taking a HVS (exceptions are listed in the guidance).
However, there have been a number of queries from practices about where to source the litmus paper for this test. The recommendations were based on the Public Health England guidance which is available here . This suggests sourcing the litmus paper from Camlab (www.Camlab.co.uk) and specifically mentions the following:
'Camlab UK indicator papers CE marked for conformity pH 3.1-8.3 narrow range see here for further information'
Alternatively, some practices have obtained supplies from Williams Medical Supplies, Alliance or Amazon

OCCG Prescribing Support Dietitian – Update on progress

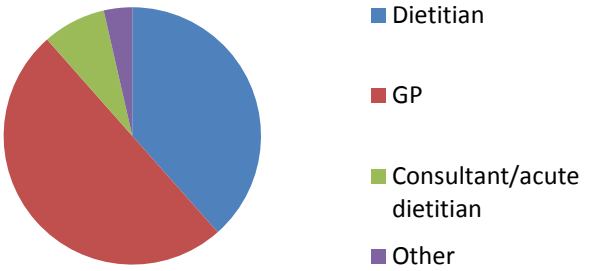
In March 2017, OCCG seconded a dietitian to focus on Oral Nutrition prescribing –part of the Prescribing Incentives Scheme (including Oral Nutritional Supplements, Infant Formulas and Gluten Free prescribing). *42 practices have been visited* and *113 audits completed*. *Clinics* have been run to review patients on ONS and Infant formulas in 11 practices, post audit. A number of initiatives have been introduced in the *acute sector* to reduce the number of patients being discharged with sip feeds on their take home prescription (TTOs), including promotion of the Food First message to junior doctors who prescribe patients' TTOs, and training of housekeeping staff. These initiatives have led to a reduction in the number of patients prescribed sip feeds on TTOs.

Oral Nutritional Supplements (ONS)

The Commissioning Policy Statement 277, Oral Nutritional Supplements (Adults) clarifies which patient groups qualify for sip feeds and is in addition to the Commissioning Policy Statement 2015, regarding the prescribing of sip feeds to care home patients. The Malnutrition Guidelines produced in 2014 have now been updated and are available on the CCG website. They include a Pathway to guide prescribers through the process of assessing nutritional status and appropriate treatment. The Food First approach is first line treatment in the majority of cases of diagnosed weight loss, unless sip feeds have been suggested and justified by a dietitian. Resources are available on the CCG website using the hyperlink to support Food First.

Audit Findings:

- *57.4% patients reviewed have a BMI over 20kg/m^2* i.e. are healthy weight, overweight or obese. Patients need ONS for differing reasons including patients with pressure damage, head and neck cancers, IBD, enterally fed ONS as boluses and CKD5. However, there were also patients with none of the Commissioning Policy Statement 277 criteria who do not need ONS.
- *49.7% of prescriptions for ONS were initiated by GPs*, 38.6% by dietitians.



- *74.8% of ONS initiations were appropriate* and for 72.4% of patients an appropriate product was prescribed. 25.2% ONS initiations were therefore inappropriate – reasons including Care Home/Nursing Home residents (58 patients accounting for 5.2% of ONS prescriptions), patients overweight or obese with no reason for ONS specified, pregnant patient with hyperemesis, patients prescribed OTC products with no reason specified and prescription requested by relatives with no specified reason.
- *38% of prescriptions were for powdered ONS* (first line choice for the CCG). Powdered shakes are suitable for the majority of patients but not for patients with lactose intolerance, patients with CKD stages 4 and 5 due to the high potassium and phosphate content, or patients enterally fed as the tube could block with powder residue.

The Malnutrition Guidelines (2014) have been updated and are available on the CCG website. They include a Pathway to guide prescribers through the process of assessing nutritional status and appropriate treatment based on this assessment.

Infant Formulas

New Infant Feeding Guidelines are now available on the CCG website to clarify the prescribing of Infant Formulas and the Commissioning Policy Statement for Infant Formulas has been updated. These are all in line with the new iMAP Guidelines which came out earlier this year. Included in the guidelines are algorithms to guide through the diagnosis process and appropriate treatment based on the diagnosis and an updated version of the Milk Ladder for reintroduction of dairy foods.

Audit Findings:

- There are babies on prescribed infant formulas *beyond 18 months* when not under the care of paediatrics or a paediatric dietitian which is contrary to the Guidelines. The audits showed children up to 10 years still on prescribed infant formulas.
- At diagnosis, EHf should be continued for at least 2 -4 weeks and if symptoms improve, *Home Reintroduction* should be performed after 2-4 weeks of starting EHf to confirm the diagnosis of CMPA. Infants are often left on formulas with no challenge – they may not even have a cow's milk intolerance/allergy which can only be confirmed with a challenge;
- Infants initiated on a formula due to *prematurity* should only stay on the formula until 6 months corrected age, unless directed by paediatrics.
- *Support is available* from the OUH with queries regarding cow's milk intolerance at the consultant lead allergy advice service commissioned from OUH: **oxon.paedsallergyadvice@nhs.net**

Gluten Free Prescribing

Commissioning Policy Statement 42c NHS prescribing of gluten-free foods states that all patients with diagnosed Coeliac Disease are entitled to 8 units of gluten free products a month on prescription regardless of age or gender.

Bread/rolls/baguettes: 400 g = 1 unit. Flour /bread mix: 500 g = 2 units

Audit findings:

- 30 audits have been completed on gluten free prescribing and have found some patients having gluten free products prescribed *without a diagnosis of Coeliac Disease*
- Several patients are *over ordering* products each month (4675 units a year across Oxfordshire, amounting to £35,220 per annum)
- Ordering products other than breads or flour/bread mixes (including pizza bases, pasta, GF oats). There are now a wide range of Gluten Free products widely available in supermarkets for people wanting items other than breads or flour/bread mixes

So what?

- If you require dietetic input with Oral Nutrition prescribing contact the OCCG dietitian by email at occg.dietitian@nhs.net with queries.
- Reviewing Oral Nutrition prescribing can result in more appropriate prescribing and cost savings.