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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Inside this issue:

Open Prescribing - Cost Effectiveness and Patient Safety

OpenPrescribing is a search interface built by the EBM DataLab at the University of Oxford, to help make raw prescribing data files published by NHSBSA more accessible and more meaningful on a practical level. The Medicines Optimisation Team has extracted some prescribing measures which may be useful for practices to consider and review where necessary – these are divided into two main categories:

(i) cost effectiveness
(ii) patient safety

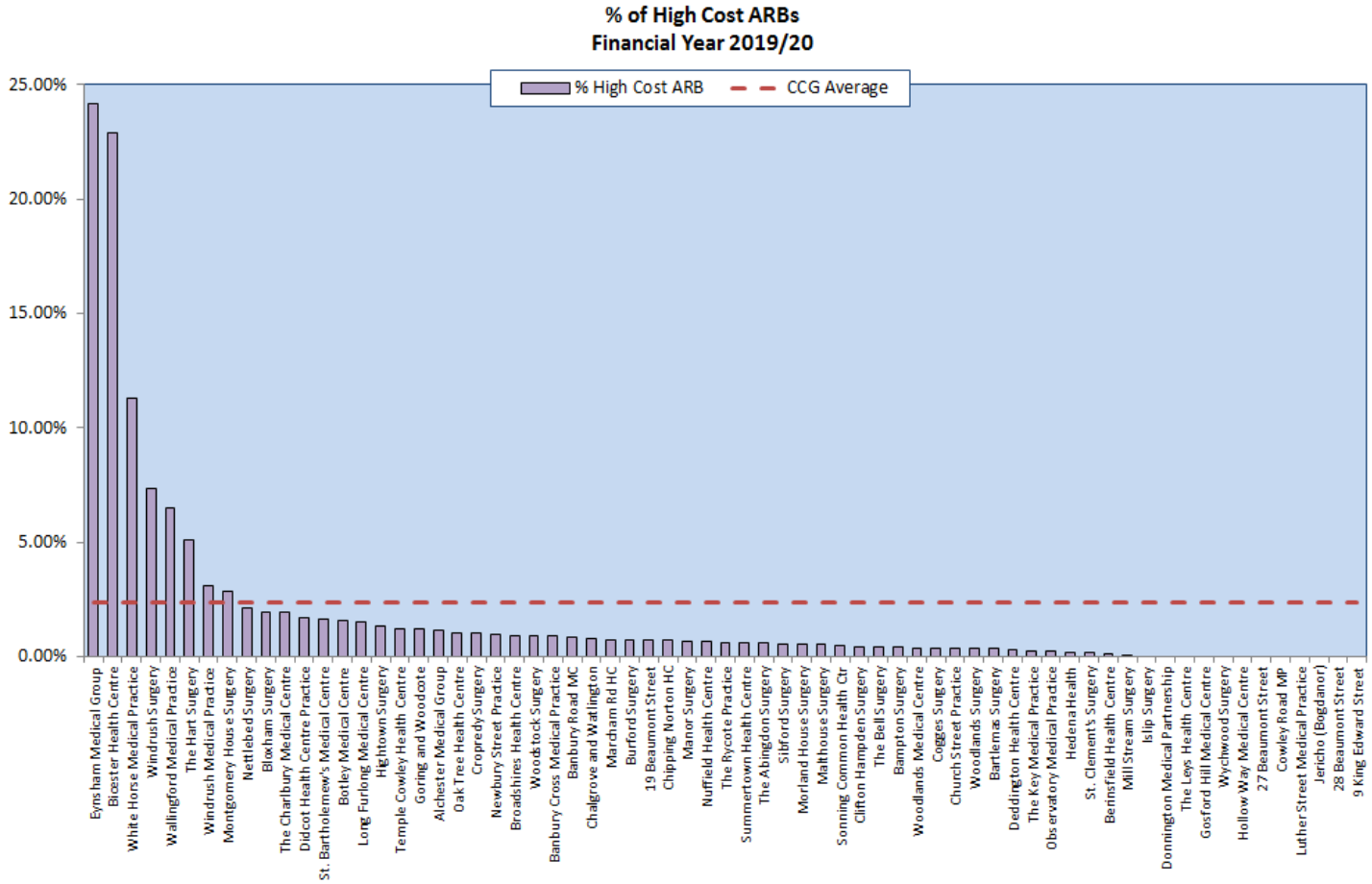
OCCG are encouraging all practices to look into the following cost effective switches and patient safety indicators; if you require any support in running searches and/or actioning switches, please let us know by either contacting your link Prescribing Adviser directly or via OCCG.medicines@nhs.net.

Cost Effectiveness

Prescribing of high-cost Angiotensin-II receptor blockers (ARBs)

Practices are advised to look at patients who are currently prescribed ARBs to make sure they are receiving the most cost-effective ARB in line with the OCCG formulary and NICE guidance. In Oxfordshire, our first line is candesartan and second line losartan. The highest non-formulary ARBs prescribed are valsartan and

eprosartan. The graph below shows percentage of high cost ARBs prescribed in Oxfordshire during financial year 2019/20, by practice.



Data suggests that prescribing cost-effective ARBs in line with national median could have generated a potential savings of £19,560 over the past six months. The following table shows a breakdown of the prescribing costs of non-formulary ARBs (including combination products) prescribing in Oxfordshire (2019/20):

Non-formulary ARBs	Items	Actual Costs
Valsartan	4227	£75,194.49
Eprosartan	4708	£74,507.93
Telmisartan	2577	£23,357.48
Olmesartan medoxomil	6611	£18,151.02
Azilsartan medoxomil	10	£265.55

Prescribing Nebivolol 2.5mg instead of 5mg tablets

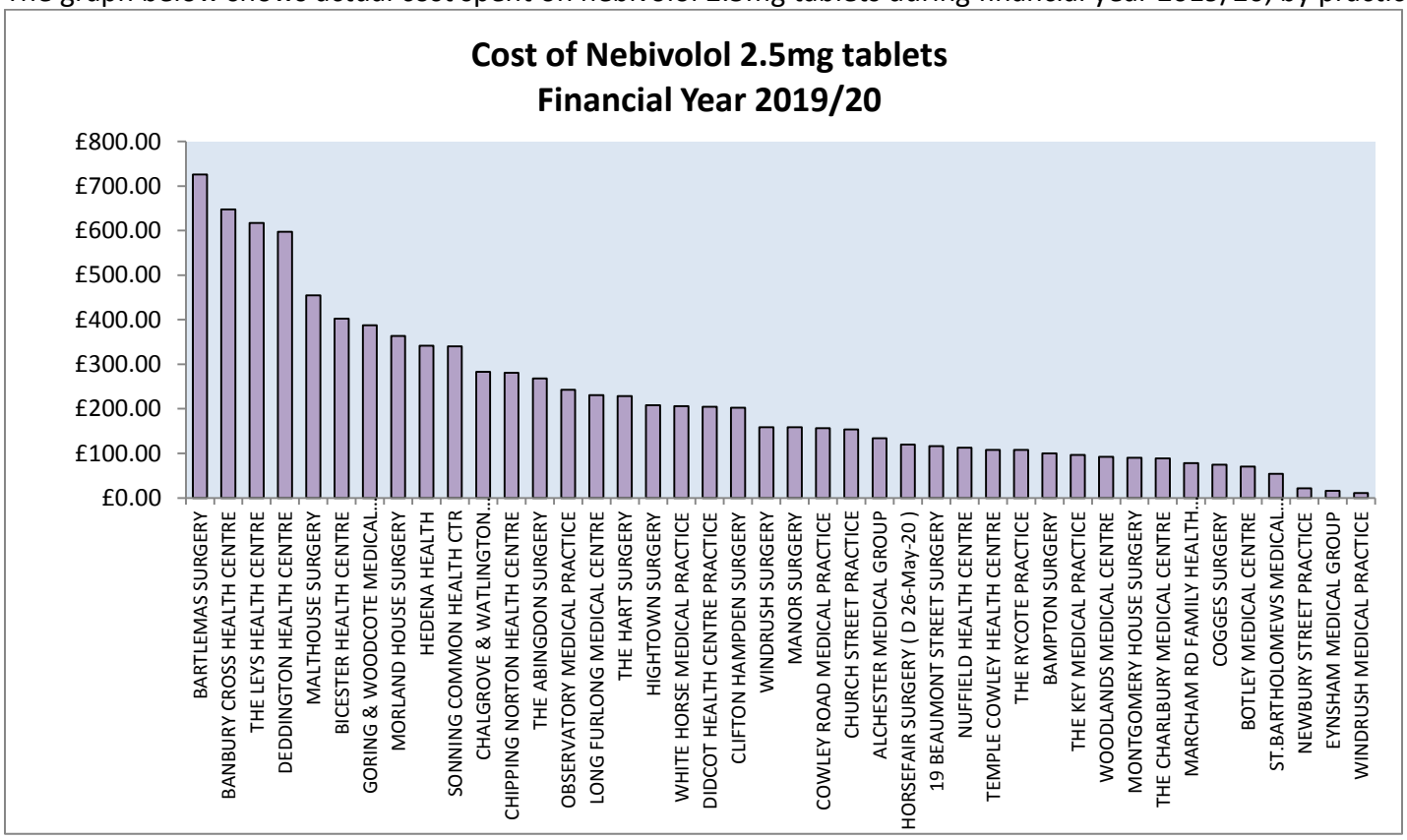
Many patients cannot tolerate a full dose of 5mg Nebivolol, which is a beta blocker commonly used in heart failure. The 2.5mg tablet is about 5 times more expensive than the 5mg tablet, as follows (Drug Tariff, September 2020):

- Nebivolol 2.5mg x 28: £13.42
- Nebivolol 5mg x 28: £2.82

According to the manufacturers' Summary of Product Characteristics, nebivolol 5mg tablets are cross-scored and they are licensed to be broken in half or even quarters at equivalent doses. Some Patient Information Leaflets may contain instructions for patients on how to break nebivolol 5mg into halves or quarters, by hands, along the break marks. If a tablet cutter is required, patients should be advised to purchase this from pharmacies.

Practices are advised to review patients on 2.5mg nebivolol, and switch to 5mg tablets where appropriate. To avoid risks of overdosing, please ensure patients are properly informed of the switch and the new requirement to break their tablets to appropriate doses.

The graph below shows actual cost spent on nebivolol 2.5mg tablets during financial year 2019/20, by practice.



Please note that on the OCCG formulary nebivolol is restricted to the 3rd line beta blocker option for treating heart failure, after bisoprolol and carvedilol.

Prescribing other lipid-modifying drugs

NICE guidance (CG181) states that for the majority of people who require treatment for high cholesterol, bile acids sequestrants, fibrates, nicotinic acid, and omega-3 fatty acid compounds should not be used. This is also included in NICE 'Do Not Do Recommendation'. NHS England has also included Omega-3 fatty acid compounds in its guidance on 'Items which should not routinely be prescribed in primary care'.

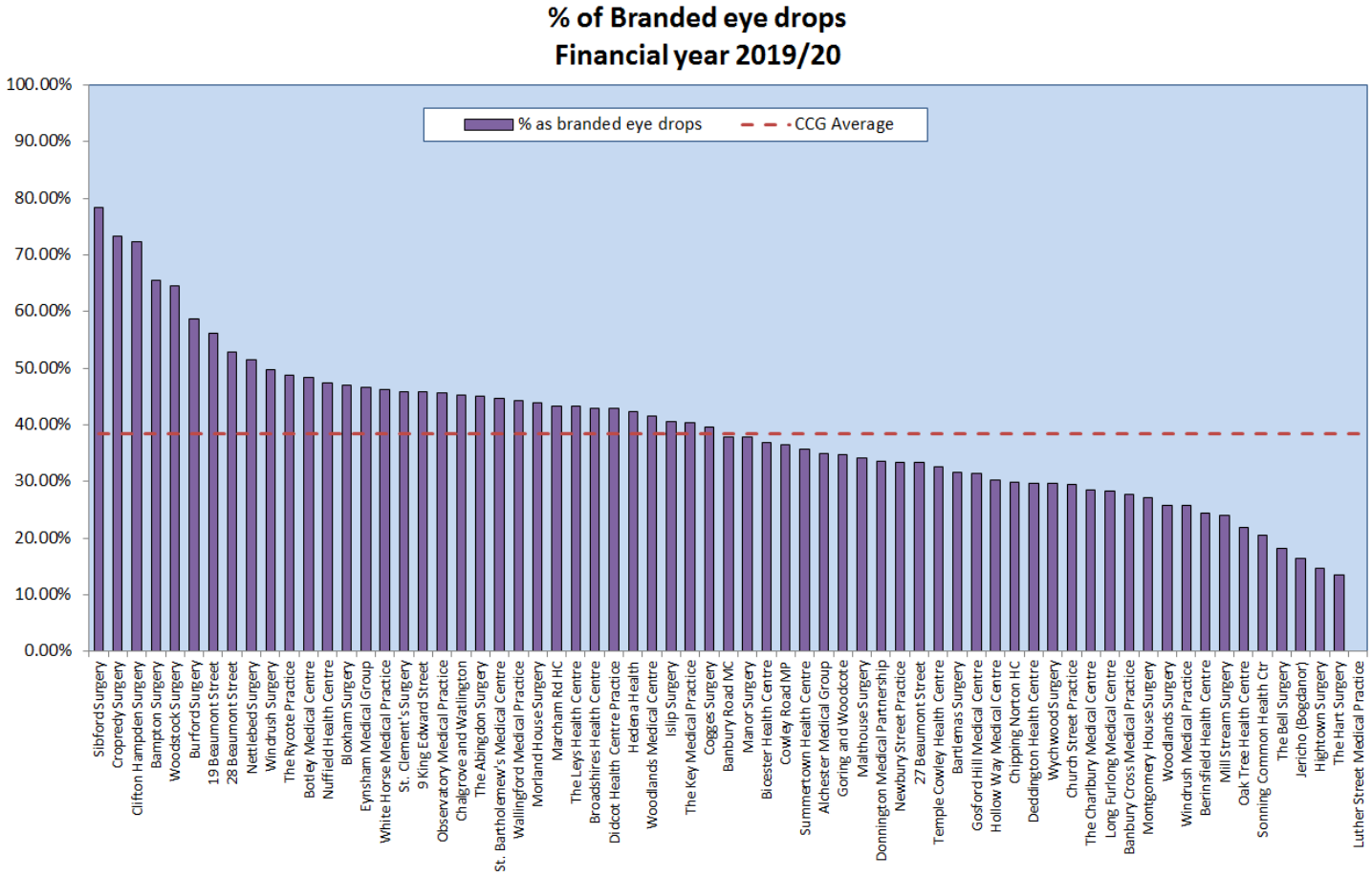
Practices are advised to review patients who have been prescribed any of these drugs, and consider switching to a suitable alternative in line with local guidance on lipid modification. In cases where specialist input is required, please contact oxon.diabetes_lipidsadvice@nhs.net for advice or support.

Data suggests Oxfordshire CCG could have saved £64,768 over the past 6 months if prescribing of these drugs had been reduced to national median.

Prescribing of branded formulations of eye drops to treat glaucoma

Many practices are prescribing branded eye drops for the treatment of glaucoma when there are generic cost-effective alternatives available. Prescribers are advised to review their prescribing of branded formulations of eye drops and consider switching over to cost effective generic versions, in line with local guidance.

The graph below shows percentage of branded eye drops (glaucoma) prescribed in Oxfordshire during financial year 2019/20, by practice.



Patient Safety

Prescribing generic diltiazem modified-release preparations

The BNF states: Different versions of modified-release preparations containing more than 60 mg diltiazem hydrochloride may not have the same clinical effect. To avoid confusion between these different formulations of diltiazem, prescribers should specify the brand to be dispensed. Prescribers are advised to review any generic prescribing of diltiazem MR formulations more than 60mg; and check with the patients which particular brands they receive from pharmacy. To avoid confusion between these different formulations of diltiazem, prescribers should specify the brand to be dispensed on prescriptions.

Oxfordshire is an outlier on the prescribing of generic ditiazem. In 2019/20, the national average prescribed as generic was 13.06% and the Oxfordshire average was 23.44%.

Prescribing generic ciclosporin and tacrolimus preparations

The BNF recommends that prescriptions for ciclosporin and tacrolimus are prescribed and dispensed by brand name, to reduce the problems of patients switching formulations. The Medicines and Healthcare products

Regulatory Agency (MHRA) have issued a safety alert (reissued 2014) which advises that oral tacrolimus products should be prescribe and dispense by brand name only, in order to minimise the risk of inadvertent switching between products, which has been associated with reports of toxicity and graft rejection.

Practices are advised to review all generically prescribed ciclosporin and tacrolimus to branded product, by checking first with the patients which particular brand they have been receiving from the pharmacy.

Oxfordshire is an outlier on generic prescribing of ciclosporin and tacrolimus. In 2019/20, the national average was 12.95% prescribed as generic and the Oxfordshire average was 18.57%.

Prescribing four pens per prescription of Semaglutide

Semaglutide is a new (glucagon-like peptide-1) GLP-1 agonist used to treat diabetes. It comes as a pre-filled pen and is used weekly. Each of these pens contains four doses and a single pen will usually last for one month. However, there have been some reports that prescribers are requesting four pens per month in error. This is unlikely to be required and likely to be caused by the dose and quantity being confused on a picking list.

Practices are advised to ensure 1 pen per month is prescribed for semaglutide; this will help towards preventing any potential errors for patients and reducing waste (note: the pens must be used within 6 weeks of opening).

Prescribing NSAIDs excluding ibuprofen and naproxen

There have been a number of concerns about the safety of a number of non-steroidal anti-inflammatory drugs (NSAIDs), including COX-2 inhibitors and some 'traditional' NSAIDS, for their effects on the stomach, kidneys and the risk of blood clots. NICE recommends that as ibuprofen and naproxen are two of the drugs with a lower level of risk, and these should prescribed to patients before trying the others anti-inflammatory agents.

Prescribers are advised to consider these risks when prescribing NSAIDs, and where clinically appropriate, ensure ibuprofen or naproxen are trialed first before moving onto other NSAIDs.

Oxfordshire is a slight outlier on the prescribing of non-preffered NSAIDs as a percentage of all NSAIDs. In 2019/20, the national average was 20.94% and Oxfordshire avergae 22.45%.

Prescribing dipyridamole

NICE Technology Appraisal TA210 (2010) suggests to use dipyridamole for the prevention of further Transient Ischaemic Attacks (TIA), and the guidance from the Royal College of Physicians (2016) states that the Working Party considers that a unified approach to the treatment of TIA and ischaemic stroke is more appropriate. Whilst clopidogrel does not have a licence for use after TIA, the Working Party considers that the benefits of

recommending this drug first-line outweigh any disadvantages. For long-term vascular prevention in people with ischaemic stroke or TIA without paroxysmal or permanent atrial fibrillation, clopidogrel 75mg daily should be the standard antithrombotic treatment. Aspirin 75 mg daily with modified-release dipyridamole 200 mg twice daily should be used for those who are unable to tolerate clopidogrel; and aspirin 75mg daily should be used if both clopidogrel and modified-release dipyridamole are contraindicated or not tolerated. Modified release dipyridamole 200 mg twice daily should be used if both clopidogrel and aspirin are contraindicated or not tolerated.