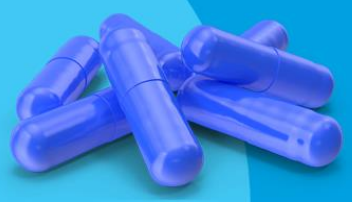
Medicines Management newsletter

Halton Clinical Commissioning Group



Issue 11 – October 2018

Guidance on Prescribing in Primary Care following a Private Consultation

Due to the high numbers of queries the Medicines Management Team receive regarding prescribing in Primary Care following a private consultation we would like to highlight the following guidance again.

NHS prescribers are often asked to issue an NHS prescription for a patient who is paying for private medical treatment. This is because many medications are more costly to the patient when issued privately than by the NHS.

This can raise questions about whether the patient would have received the same treatment if they had been diagnosed or treated on an NHS pathway and hence causes a dilemma for the prescriber as to whether they should issue an item on an NHS prescription or refuse. This guidance is designed to clarify some of the issues which arise. The principles of this document apply equally to any provider delivering NHS commissioned care.

In summary

- If a private consultation identifies a long-term condition or a need for medication which is available as routine NHS treatment, this should be provided as such by the patient's usual primary care prescriber if they are satisfied it is appropriate, and the private provider issues the first prescription. The GP should be asked to take over prescribing only when the patient is stabilised on the medication. This applies whether the referral was by an NHS clinician or the patient self-referred.
- The responsibility for prescribing rests with the prescriber who has clinical responsibility for a particular aspect of the patients' care.
- There is no obligation on behalf of the primary care prescriber to prescribe the recommended treatment if it is contrary to his/her normal clinical practice.
- If the private/consultant prescribing recommendation does not follow Pan Mersey Area Prescribing Committee (APC), local or national guidance or policy, then the primary care prescriber may substitute a medicine with a clinically appropriate alternative.

The NHS Halton CCG Medicines Management Group has suggested that prescribers may wish to include this document or a link to the document when making private referrals and to make reference to it in any communications should an inappropriate request to prescribe be received. The Medicines Management Team will work with practices to embed the document into any their current administrative processes for

referrals and to support with any templates that may be helpful.
https://www.panmerseyapc.nhs.uk/media/1563/private_201804_g46_v0100.pdf

Medicines Management Work Plan 2018/19

During **October** and **November 2018** the NHS Halton CCG Medicines Management Team will be doing the following pieces of work:

- **Quetiapine MR Review** - Review of patients prescribed modified release (MR) quetiapine for potential switch to immediate release (IR) quetiapine, the preferred Pan Mersey formulation (https://www.panmerseyapc.nhs.uk/recommendations/documents/PS86.pdf?UNLID=1447932042018813155137). For patients identified as not suitable for switch to the IR formulation a branded generic formulation (Sondate®) will be considered.
- **Duloxetine 30mg and 60mg Capsules –** Switch of generically written duloxetine and Cymbalta® 30mg and 60mg gastro resistant capsules to branded generic Depalta® GR Capsules.
- **Mesalazine Review -** Switch of generic mesalazine and Asacol® 400mg & 800mg Tablets to Octasa® Tablets in line with Pan Mersey statement for safety and cost effectiveness purposes. https://www.panmerseyapc.nhs.uk/media/1599/mesalazine_201802_ps230_v0101.pdf
- **Dicycloverine Review –** review of prescribing of dicycloverine for the treatment of irritable bowel syndrome (IBS) or diverticular disease for potential switch to more cost effective alternative formulary treatments.
- **Epipen Junior Supply issues –** supporting practices with identification and review of patients currently prescribed Epipen Junior who may need reviewing with a view to switch to a 300mcg device if over 25kg as detailed in safety section below.
- **Dosulepin Review –** review of the prescribing of dosulepin in depression for potential de-prescribing due to the risk of harm and overdose. This is in line with the recommendations of NICE CG90: Depression in Adults which recommends:
  "Do not switch to, or start, dosulepin because evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose."

Hot Topic –Risk of confusion between strengths of Oramorph® Oral Solution

Oramorph® liquid is available as two strengths, one of which is **ten times** the concentration of the other:

- Oramorph® Oral solution containing morphine sulphate 10mg/5ml
- Oramorph® Concentrated Oral solution containing morphine sulphate 100mg/5ml

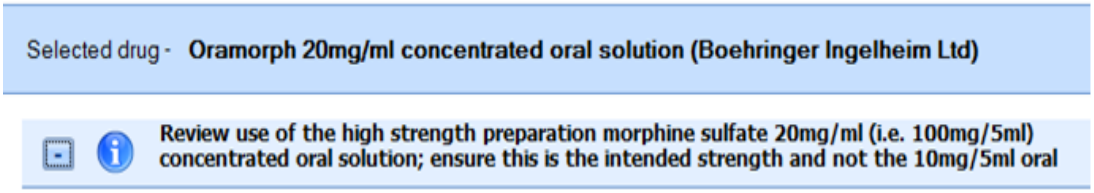
Safety incidents have occurred both locally and nationally due to confusion over the different strength liquids. We would like to remind Healthcare Professionals of the recommendations in the National Patient Safety Alert (NPSA) Rapid Response Report on reducing dosing errors with ALL Opioid Medicines:
http://webarchive.nationalarchives.gov.uk/20171030131053/http:/www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59888&p=3

When opioid medicines are prescribed, dispensed or administered, in anything other than acute emergencies, the healthcare practitioner concerned, or their clinical supervisor, should:

- Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. This may be done for example through discussion with the patient or their representative (although not in the case of treatment for addiction), the prescriber or through medication records.
- Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not normally more than 50% higher than the previous dose).
- Ensure they are familiar with the following characteristics of that medicine and formulation: usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, common side effects.

Please be aware when prescribing Oramorph® that:

- Two different strengths of this product exist and extra care is needed to ensure the correct product is selected;
- Oramorph® oral solution 10mg/5ml is a schedule 5 Controlled Drug so appears in black on the EMIS picklist whereas Oramorph® concentrated oral solution 100mg/5ml is a schedule 2 CD and as such appears in RED;
- Oramorph® concentrated oral solution 100mg/5ml appears on the EMIS picklist as Oramorph® 20mg/ml;
- EMIS will trigger a high severity alert if the higher strength product is chosen stating: **"Caution high strength preparation: confirm product strength"**
- An Optimise Rx message will trigger if the higher strength product is selected stating:



- Community pharmacists should be aware that the higher strength product is rarely prescribed and as such we would recommend clarifying the intention with the prescriber if you are not sure that this is the intended product.

Safety

VALPROATE PREGNANCY PREVENTION PROGRAMME: ACTIONS REQUIRED NOW FROM GPS, SPECIALISTS, AND DISPENSERS

Valproate medicines must not be used in women of childbearing potential unless the Pregnancy Prevention Programme is in place. If you are involved in the care of female patients on valproate in the UK, a reminder of actions required for this medicine can be found via the link below. If you have not yet received a pack of information materials, or if you are near to running out of any materials, you can order more via the link below.

https://www.gov.uk/drug-safety-update/valproate-pregnancy-prevention-programme-actions-required-now-from-gps-specialists-and-dispensers

EPIPEN AND EPIPEN JUNIOR (ADRENALINE AUTO-INJECTOR DEVICES) – SUPPLY DISRUPTION

An Alert regarding the disruption of supply of Epipen and Epipen Junior auto-injector pens was issued by the Central Alerting System (CAS) on Friday 28th September. It states,

'*EpiPen and EpiPen Junior will be subject to limited availability for the remainder of 2018. Mylan are now out of stock of EpiPen Junior and interruptions in the supply are anticipated to continue for the coming months.'*

An **UPDATED** version of the original Alert was issued Monday 15th October 2018 which included some important additional information highlighted in red text in the alert:
https://www.cas.mhra.gov.uk/ViewAndAcknowledgment/viewAttachment.aspx?Attachment_id=103105

We would urge everyone to be aware of the differences between the original and updated alert and of any actions recommended in the updated alert as this has implications for both GP Practices and Community Pharmacy.

The updated alert lists the following actions:

All health care professionals in primary, secondary or specialist healthcare services who prescribe, dispense or administer adrenaline auto-injectors, or who advise patients and their carers, should ensure that:

- Adult and child auto-injectors are only prescribed and dispensed to those who truly need them, as any additional issuing to patients who are worried about the shortages could exacerbate the overall supply situation.
- It is important to note that when validating the expiry date of an adrenaline auto-injector, the product expires on the last day of the month indicated e.g. a device labelled 'April 2019' does not expire until the end of April 2019.
- Certain batches of adult EpiPen can be safely used for four months after the expiry date has passed (batch numbers are detailed in the alert). Where possible, prescribers should not prescribe a replacement Adult EpiPen whilst the original is within the extended use by date.
- Patients should be advised not to dispose of their expired devices until they have replaced them. If no new devices can be obtained parents / patients should be advised to use expired devices in an emergency as this is safer than not using them, it will not be dangerous but the potency of the adrenaline may have reduced.
- Due to ongoing constraints affecting EpiPen 300mcg and Epipen 150mcg devices, some adults and children may need to switch from their usual device to other alternative adrenaline auto-injector devices that may be more readily available. The different brands of adrenaline auto-injectors are not used in exactly the same way and therefore specific training and advice is required for each of the devices - please see link below for information on these alternative devices:
https://www.sps.nhs.uk/wp-content/uploads/2018/09/Summary-of-the-key-differences-between-3-presentations-of-adrenaline-prefilled-syringes-final.pdf
- Junior adrenaline auto-injectors (150mcg) in all 3 brands – Epipen, Jext and Emerade - should be reserved for children weighing under 25 kg during this shortage period. Children weighing more than 25 kg should be given adult auto-injectors (300 mcg) – see the alert for further guidance.

- Prescribers should work in close collaboration with their local pharmacies to understand which devices are available. Prescribers and pharmacists should work together to ensure patients who are switched to an alternative device are trained appropriately and understand how to use the new device.
- To manage the existing supply of EpiPen Junior® and other replacement products over this short-term period it has been necessary to put in place national contingency arrangements to ensure that those patients with the greatest short-term need have priority access to the 150mcg adrenaline auto-injectors as they become available. We are therefore asking community pharmacies and dispensing practices to validate prescription requests before supply by wholesalers on an individual patient basis in the short term until national supplies can be replenished over the coming months. Specific guidance on this will be issued directly to pharmacies and dispensing practices in the next 24 hours (see below).
- A patient/parent letter about the EpiPen Junior shortage and relevant advice can be found via the link:
  https://www.cas.mhra.gov.uk/ViewAndAcknowledgment/viewAttachment.aspx?Attachment_id=103106
  GPs and Pharmacists should share this with patients/parents affected by this shortage.
- Prescribers and pharmacies should regularly check the following Specialist Pharmacy Services website for additional updates to supply and clinical guidance.
  https://www.sps.nhs.uk/articles/shortage-of-epipen/

It is important all Health Care Professionals are familiar with the full details given within the alert and we would encourage everyone to follow the link below for more information:
https://www.cas.mhra.gov.uk/ViewAndAcknowledgment/viewAttachment.aspx?Attachment_id=103105

For Community Pharmacies

A validation protocol for supply of adrenaline auto-injectors (owing to the ongoing supply issues) has been developed to ensure consistent practice nationally and to prevent the need for any local re-interpretation:
https://www.rpharms.com/Portals/0/RPS document library/Open access/Support/Support Alert/EpiPen 150 microgram validation protocol - Final.pdf

A related Q&A has also been produced:
https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Support/Support%20Alert/Final%20AAI%20QAs%20for%20Pharmacies%20and%20Dispensing%20Practices%2016.10.2018.pdf

NHS IMPROVEMENT: ADRENALINE FOR ANAPHYLAXIS KITS - A REMINDER TO HEALTH CARE PROFESSIONALS

Following the original CAS Alert, NHS Improvement issued a memo specifically for Health Care Professionals regarding the use of adrenaline ampoules to treat anaphylactic reactions.

Epipen or other Adrenaline Auto-Injector pens should not be held in anaphylaxis kits. There are concerns that some healthcare professionals may be holding EpiPen or other Adrenaline Auto-Injector pens, in preference to adrenaline ampoules to treat anaphylactic reactions and this should not be necessary.

Due to the shortage, when there is a need to renew the adrenaline in anaphylaxis kits, these should be ampoules (ensuring you also include dosing charts, needles and syringes) and not Adrenaline Auto-Injector pens. This will reduce the reliance on Adrenaline Auto-Injector pens and therefore preserve essential EpiPen stocks for patients, parents, carers, teachers, etc. who, as lay persons, cannot be expected to administer adrenaline via a needle and syringe.

It advises supplies of adrenaline ampoules are currently available and there is an expectation that healthcare professionals should use these in preference to the EpiPen or similar devices.

All healthcare professionals providing services where anaphylaxis treatment may be required, including but not exclusive to flu vaccination services, should have the competency to draw up and administer adrenaline from ampoules with a normal syringe and needle.

The Green Book and Resus Council guidance provides additional advice to healthcare professionals on the use of adrenaline in response to anaphylaxis. Pharmacists providing vaccination services may also wish to refer to PSNC FAQs.
This information is now also available within the updated alert.
https://psnc.org.uk/wp-content/uploads/2018/10/20181009-EpiPen-Advice-NHSI-Final.pdf

Medicines Supply Issues Update

Below is a link to the September issue of the 'Supply issues update for primary care'. This report has been produced by the Department of Health and Social Care (DHSC) Medicine Supply team and provides an update on current primary care medicine supplies issues.
http://www.haltonccg.nhs.uk/members-practices/medicines-management/medicines-supply-issues

Antimicrobial Stewardship Resources – Back-up (delayed) prescribing

A back-up (delayed) prescription is a prescription (which can be post-dated) given to a patient or carer, with the assumption that it will not be dispensed immediately, but in a few days if symptoms worsen.
When using back-up (delayed) antibiotic prescribing, patients should be offered:

- reassurance that antibiotics are not needed immediately because they are likely to make little difference to symptoms and may have side effects (for example, diarrhoea, vomiting and rash)
- advice about using the back-up (delayed) prescription if symptoms get significantly worse
- advice about how long they should expect their symptoms to last
- advice about re-consulting if symptoms get significantly worse despite using the back-up (delayed) prescription.

A back-up (delayed) prescription with instructions about use can either be given to the patient or left at an agreed location (for example, the local pharmacy) to be collected at a later date.

NICE guideline (NG15), Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use, recommends that:
"If immediate antimicrobial prescribing is not the most appropriate option, discuss with the patient and/or their family members or carers (as appropriate) other options such as:

- self-care with over-the-counter preparations

- back-up (delayed) prescribing
- Other non-pharmacological interventions, for example, draining the site of infection."

Antimicrobial stewardship NICE Quality standard [QS121] – statement 2 states:

"Prescribers in primary care can use back-up (delayed) antimicrobial prescribing when there is clinical uncertainty about whether a condition is self-limiting or is likely to deteriorate."

If you would like to discuss how best to implement back-up (delayed) prescribing then please speak to your practice pharmacist or technician.

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