NHS FORTH VALLEY FORMULARY 17th Edition v1 March 2018

Date of First Issue	31/07/2012
Approved	30/08/2012
Current Issue Date	09/03/2018
Review Date	After each ADTC New Drug Sub Group Meeting
Version	Version 1 (17th Edition)
EQIA	NO
Author / Contact	NHS FV Prescribing Support Team fv-uhb.prescribingsupport@nhs.net
Group Committee –	ADTC New Drugs Sub Group

Consultation and Change Record – for ALL documents

Contributing Authors: NHS Forth Valley Acute & Primary Care Staff

Consultation Process: Approval by ADTC New Drugs Sub Group
Acute Specialist Services

Distribution: Forth Valley Doctors and Consultants
Forth Valley GPs, Practice Managers, Nurse Prescribers
Forth Valley Pharmacy Staff
Forth Valley Community Pharmacy Contractors

Change Record			
Date	**Author**	**Change**	**Version**
23/02/2018	T. Anderson	Updated Oral Hypoglycaemic information in Appendix 11.	1.0 (17th Edition)
29/12/2017	T. Anderson	Evolocumab in section 2.12	

Contact numbers

Primary Care Pharmacy

Prescribing Support Team
Primary Care Pharmacy Office
Ground Floor,
Falkirk Community Hospital
Falkirk
FK1 5QE

Director of Pharmacy	Page 07825 843190	01324 673610
Prescribing Support Team		01324 673603
Clinical and Community Services Office (Mental Health, Learning Disabilities & Vaccines) Pharmacy Department Forth Valley Royal Hospital Stirling Road Larbert FK5 4WR		01324 566728 & 01324 566729
On-call service	contact Switchboard	01324 566000

Acute Services Pharmacy

Opening hours -	8.30 am – 5.00 pm	Monday to Friday
	10.00 am – 4:30 pm	*Saturday*
	10.00 am – 2.30 pm	*Sunday*

On-call service out-with these hours - Contact the pharmacist through the unit page holder.

Forth Valley Royal Hospital

01324 566000

Stores & Distribution	01324 566702
Dispensary	01324 566701 / 700
Aseptic Office	01324 566709 / 710 / 711
Medicines Information	01324 566725
Kirsty Peacock (CD Inspection Officer)	01324 566725

Contents

Contents

Introduction

The formulary is produced by the New Drugs Sub Group of the Forth Valley Area Drug and Therapeutics Committee (ADTC), and the contents reflect wide consultation with a range of practitioners in medicine and pharmacy.

Aims and objectives

The main aim of this formulary is to promote rational, safe, clinical- and cost-effective prescribing in both Primary and Secondary Care. The BNF contains several thousand medicines and is designed to be comprehensive. The Forth Valley Formulary is a list containing fewer medicines, which provide appropriate treatment for the vast majority of patients, are approved for use in hospital and general practice. The modest size of the list should enhance the quality of prescribing as familiarity with the limited range of medicines will be readily acquired. Clinical units, Community Health Partnerships (CHPs) and general medical practices may wish to use the complete Forth Valley Formulary or may restrict the number of items further to suit local circumstances.

Using the Formulary

Medicines are presented according to the BNF classification. This enables the formulary to be used in conjunction with the current BNF, which prescribers are asked to use as their primary reference source for information regarding dosages, contra-indications and adverse reactions. Generally, formulations and strengths of preparations have been omitted to allow flexibility of prescribing, except when a particular formulation is not approved. Drugs are referred to throughout by generic name, with some exceptions. Where proprietary names are given, this indicates either a compound product or a product with unique characteristics and no substitutions should be made. Some brief prescribing points have been added and have been reviewed by general practitioners and specialists working together.

Formulary Management

The printed version of the formulary will be updated annually at the start of August to respond to the outcome of the Scottish Medicines Consortium assessment of new drugs and local requirements, as discussed and reviewed by the New Drugs Sub Group of the ADTC following assessment by the SMC. The formulary is also available on the NHS Forth Valley intranet and this electronic version will be updated after each New Drugs Meeting.

The formulary process is quite separate from any licensing restriction which might apply, details of which can be found in the BNF or Summary of Product Characteristics. The final decision on the formulary status of a new drug is made by the ADTC. Throughout the year, ADTC decisions of formulary amendments will be routinely communicated to Drug and Therapeutics Committees and Prescribing Groups, CHPs and general practitioners via *ADTC News* bulletin.

There is an area wide process for requesting drugs for inclusion in the Forth Valley Formulary. This involves the requestor completing a New Drugs Proforma available within electronic versions of the Formulary at the following link.
http://www.nhsforthvalley.com/__documents/qi/ce_guideline_prescribing/Formulary-and-non-formulary-request-processes.pdf

Completed forms for Primary Care to be submitted to Primary Care Pharmacy Services, Ground Floor, Falkirk Community Hospital, Westburn Avenue, Falkirk, FK1 5QE and Acute forms submitted to Pharmacy Department, Forth Valley Royal Hospital.

Scottish Medicines Consortium (SMC)

The remit of the Scottish Medicines Consortium (SMC) is to provide advice to the NHS Boards and their Area Drug and Therapeutics Committees (ADTCs) across Scotland about the status of all newly licensed medicines, all new formulations of existing medicines and any major new indications for established products. Locally the process for considering SMC recommendations has been finalised and and can be found on the following link http://www.nhsforthvalley.com/__documents/qi/ce_guideline_prescribing/Formulary-and-non-formulary-request-processes.pdf
Prescribers will be updated via the ADTC News bulletin and the formulary web site.

The ADTC advises prescribers **not** to prescribe any drug that has been rejected by SMC or has not been considered by SMC **unless there is evidence to justify prescribing in the light of particular circumstances of an individual patient.**

Where a medicine is not recommended for use by the Scottish Medicines Consortium (SMC) for use in NHS Scotland, including those medicines not recommended due to non-submission, this will be noted by the Area Drug and Therapeutics Committee New Drug Sub Group and the medicine will not be added to the NHS Forth Valley Joint Formulary.

Where a medicine that has not been accepted by the SMC or NHS HIS following their appraisal on clinical and cost-effectiveness, there is a **Individual Patient Treatment Request (IPTR)** process which provides an opportunity for clinicians i.e. hospital Consultants or General Practitioners to pursue approval for prescribing, on a "case by case" basis for individual patients.
A copy of this policy can be found at the Pharmacy page on the Intranet on the following link:
http://www.nhsforthvalley.com/__documents/qi/ce_guideline_prescribing/individualpatienttreatmentrequestprocess.pdf

Full details of all drugs that have been considered by the SMC can be found on their website
http://www.scottishmedicines.org.uk/

NICE guidance

NHS Quality Improvement Scotland (NHS QIS) reviews NICE (National Institute for Health and Clinical Excellence) Multiple Technology Appraisal (MTA) and decides whether the recommendations should apply in Scotland.
Where NHS QIS decides that an MTA should apply in Scotland, the NICE guidance supersedes SMC advice. Unlike the SMC process, MTAs examine a disease area or a class of drugs and usually contain new evidence gathered after the launch of drugs or new economic modelling.

SMC is the source of advice for Scotland on new drug therapies and the NICE Single technology Appraisal (STA) process therefore has no status in Scotland. If a NICE STA endorses a drug that was not recommended by the SMC, it is open to the manufacturers to resubmit the drug to SMC with new evidence.

This information is reviewed by the New Drugs Sub Group on a routine basis.

Paediatric Declaration

Children, and in particular neonates, differ from adults in their response to drugs. Pharmacokinetic changes in childhood are important and have a significant influence on drug absorption, distribution, metabolism and elimination and need to be considered when choosing an appropriate dosing regimen for a child. Where possible, children and neonatal medications should be prescribed within the terms of the product licence (market authorisation). However, many children may require medicines not specifically licensed for paediatric use.

Recommendations have been drawn up by the Standing Committee on Medicines, a joint committee of the RCPCH and the Neonatal and Paediatric Pharmacists Group on the use of medicines outwith their product licence. The recommendations are:

- Those who prescribe for a child should choose the medicine which offers the best prospect of benefit for that child, with due regard to cost
- The informed use of some unlicensed medicines or licensed medicines for unlicensed applications is necessary in paediatric practice
- Health professionals should have ready access to sound information on any medicine they prescribe, dispense or administer, and its availability
- In general, it is not necessary to take additional steps, beyond those taken when prescribing licensed medicines, to obtain the consent of parents, carers and child patients to prescribe or administer unlicensed medicines or licensed medicines for unlicensed applications
- NHS Forth Valley and Health Authorities should support therapeutic practices that are advocated by a respectable, responsible body of professional opinion

Forth Valley Formulary should not be used in isolation when prescribing medications for children/neonates. It is recommended that Medicines for Children (a Royal College of Paediatric & Child Health Publication) is used where possible or the Childrens BNF or BNF. For neonates e.g. in SCBU, the relevant formularies available on the ward should be used. Many of the drugs stated in the formulary will be used in paediatrics but not at the dosages stated.

In addition sugar free medicines should be used as much as possible when prescribing in children/neonates.

Website

An Adobe® Acrobat® version of the formulary can be found on the Forth Valley Pharmacy Services intranet site at the following address:

http://staffnet.fv.scot.nhs.uk/index.php/a-z/pharmacy/

The web-based version of the formulary will be updated after each ADTC meeting and will represent the most up to date version at any point in time.

Formulary Status

The formulary is intended for use across both primary and secondary care. The key for use has been agreed as follows:

✓	- Initiate and continue
⌖	- Continue where appropriate

GPs should not normally be expected to prescribe non-formulary drugs on the recommendation of hospital specialists unless sound clinical reasons are given in writing. If this does not happen, the GP can contact the specialist concerned. This requirement also extends to patients attending outpatient clinics.

Appeals

If a drug has been omitted from the formulary, and a consultant or GP maintains that such an omission could compromise patient care, the case for formulary inclusion can be reconsidered. Appeals against any formulary decisions should be made with full supporting evidence to the New Drugs Sub Group via the Medicines Information department at Forth Valley Royal Hospital. Final decisions on appeals are taken by the ADTC.

Non-formulary drug supply

In exceptional clinical circumstances a non-formulary medicine may be required for a particular patient. For certain non-formulary drugs which are being continuously monitored and for recent non-formulary decision this will require completion of a non-formulary request form by the consultant or clinical pharmacist for all hospital initiated non-formulary drugs.

Within primary care, it would be expected that the majority of prescribing would be from formulary choices.

Non-formulary drug use is reviewed by Drug and Therapeutics Committees, and thereafter by the ADTC.

An example of the Non-formulary request form has been included. This is available within the electronic version of the Formulary at the following link
http://www.nhsforthvalley.com/__documents/qi/ce_guideline_prescribing/Formulary-and-non-formulary-request-processes.pdf

Guidance on prescribing

Local and National Guidance

The appendices of this formulary include Primary Care, Secondary Care and area-wide Forth Valley Guidelines. Where national guidance is applicable references to web addresses have been included (as links in the electronic version). Prescribers are reminded that the electronic document is a dynamic document, which will be updated after each New Drugs Sub Group meeting. Similarly local and national guidance is continually updated and may influence prescribing. Some useful web addresses are included below to provide access to the latest national guidelines:

British Hypertension Society	http://www.bhsoc.org/
British Thoracic Society	http://www.brit-thoracic.org.uk/
National Institute for Health and Clinical Excellence	http://www.nice.org.uk/
Scottish Intercollegiate Guidelines Network	http://www.sign.ac.uk/

In hospitals

A Medicines Code of Practice is in existence within Forth Valley Royal Hospital that gives guidance on the writing of prescriptions and the safe and secure handling of medicines.

Combination products

Please note: Whenever possible prescribe individual drug components rather than a fixed ratio combination as it allows flexibility of dosing and is usually more cost effective.

Unlicensed Medicines

The New Drugs Sub Group is aware of several preparations being used out-with their licences, and some of these have been included within the formulary. Prescribers can still obtain unlicensed preparations in the same manner as they did prior to the launch of the Formulary.

In primary care, prescribers should note that if prescribing a preparation for an unlicensed indication, the liability for its use lies with the prescriber.

Therapeutic drug monitoring

Guidelines on therapeutic drug monitoring for antibiotics and other drugs can be found in Appendix 5.

Advice

Information and advice on medicine use is available from your local community pharmacist, Medicine Information Centre, Prescribing Support Team, practice or clinical pharmacist.

Feedback

The success of the formulary depends on feedback from the users and is most welcome. The formulary will be updated regularly.

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
1	**Gastro-intestinal System**			
1.1	***Dyspepsia and Gastro-oesophageal Reflux Disease***			
Comment	Forth Valley Dyspepsia Management Guidelines. http://www.qifv.scot.nhs.uk/CE_ClinicalGuidelines.asp			
1.1.1	Aluminium and Magnesium containing antacids			
	Co-magaldrox	✓	✓	✓
	Altacite Plus®	✓	✓	✓
Comment	Maalox® is the contract product for supply in Secondary Care. Mucogel® has the same formulation and is more cost-effective in Primary care.			
1.1.2	Other drugs for dyspepsia and GORD			
	Acidex®	✓	✓	✓
	Gaviscon Advance® **(2nd Line)**	✓	✓	✓
	Peptac® **(1st Line)**	✓	✓	✓
	Infant Gaviscon®	✓	✓	✓
1.2	***Antispasmodics and other drugs altering gut motility***			
	Mebeverine (not MR preparation) **(1st Line)**	✓	✓	✓
	Hyoscine Butylbromide **(2nd Line)**	✓	⌖	✓
	Dicycloverine [Dicyclomine]	✓	✓	⌖
	Peppermint Oil	✓	⌖	⌖
	Metoclopramide (Refer to Drug Safety Update August 2013)	✓	✓	✓
	Domperidone (Refer to MHRA Safety Update May 2014-risks-of-cardiac-side-effects	✓	✓	✓
1.3	***Ulcer-healing Drugs***			
1.3.1	H2-receptor antagonists			
	Ranitidine	✓	✓	✓
1.3.3	Chelates and complexes			
	Sucralfate	⌖	⌖	✓
1.3.5	Proton pump inhibitors			
	Omeprazole Capsules **(1st Line)**	✓	✓	✓
	Lansoprazole Capsules **(2nd Line)**	✓	✓	✓
	Esomeprazole **(Restricted to specialist recommendation only within FV guideline)**	⌖	⌖	✓
	Esomeprazole (I.V.) [Nexium I.V.®]			✓
	Pantoprazole (I.V.)			✓
1.4	***Antidiarrhoeal Drugs***			
1.4.1	Absorbents and bulk-forming drugs			
	Methylcellulose Tablets (see section 1.6.1)	✓	✓	✓
1.4.2	Antimotility drugs			
	Codeine Phosphate	✓	✓	✓
	Loperamide (High doses used in Short bowel patients)	✓	✓	✓
Comment	Prevention of electrolyte depletion and replacement of electorlyte is 1st line treatment in acute diarrhoea. Oral rehydration therapy is listed in section 9.2. Codeine recommended only in short-term use due to CNS side effects and dependence.			

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
1.5	***Chronic Bowel Disorders***			
1.5.1	Aminosalicylates			
	Balsalazide Sodium	⌖	⌖	✓
	Mesalazine	⌖	⌖	✓
	Sulfasalazine [Sulphasalazine]	⌖	⌖	✓
Comment	Biologic therapies can only be prescribed by consultant gastroenterologist			
1.5.2	Corticosteroids			
	Prednisolone (Budenofalk®/Predenema®/Predsol®)	⌖	⌖	✓
1.5.3	Drugs affecting the immune response			
	Azathioprine	⌖	⌖	✓
	Ciclosporin	⌖	⌖	✓
	Mercaptopurine	⌖	⌖	✓
	Methotrexate	⌖	⌖	✓
	Adalimumab	⌖	⌖	✓
	Infliximab	⌖	⌖	✓
Comment	Consultant Gastroenterologist initiation only			
1.6	***Laxatives***			
Comment	**Please refer to the relevant Constipation Management Guidelines** http://www.qifv.scot.nhs.uk/CE_ClinicalGuidelines.asp			
1.6.1	Bulk-forming laxatives			
	Ispaghula Husk **(2nd Line)**	✓	✓	✓
	Methylcellulose Tablets (use in diarrhoea)	✓	✓	✓
1.6.2	Stimulant laxatives			
	Bisacodyl	✓	✓	✓
	Docusate (Norgalax Micro-enema®) - **For midwife initiation only**	⌖	⌖	✓
	Glycerol	✓	✓	✓
	Senna	✓	✓	✓
	Co-danthramer (terminal care only)	✓	✓	✓
1.6.4	Osmotic Laxatives			
	Laxido®	✓	✓	✓
	Laxido Paediatric®	✓	✓	✓
Comment	Prolonged use is not recommended.			
	Lactulose **(1st Line)**	✓	✓	✓
Comment	Lactulose may take up to 48 hours to act and is therefore unsuitable for relief of acute symptoms and for "prn" prescribing.			
	Fleet® Ready-to-use Enema	✓	✓	✓
	Phosphate enema	✓	✓	✓
	Sodium Citrate Enema (Micralax®)	✓	✓	✓
1.6.5	Bowel cleansing solutions			
	Moviprep®			✓
	Picolax®			✓
1.6.7	$5HT_4$-receptor agonists and guanylate cyclase-C receptor agonists			
	Linaclotide**(Restricted to SMC Guidance)**	✓	✓	✓
1.7	***Preparation for Haemorrhoids***			
	Anusol® Cream	✓	✓	✓
	Anusol® Suppositories	✓	✓	✓
	Anusol HC® Ointment	✓	✓	✓
	Anusol HC® Suppositories **For midwife initiation only**	⌖	⌖	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
	Uniroid – HC® Ointment	✓	✓	✓
	Uniroid – HC® Suppositories	✓	✓	✓
Comment	Uniroid - HC ® 1st line if steroid containing preparation with anaethetic required, but steroid preparations are not 1st line and should only be used for a few days.			
	Xyloproct® Ointment	✓	✓	✓
	Lidocaine [lignocaine] Gel (see section 15.2)			✓
1.8	***Stoma Care***			
Comment	Specialist advice - contact Stoma Care Nurse.			
1.9	***Drugs affecting intestinal secretions***			
1.9.1	Drugs acting on the gall bladder			
	Ursodeoxycholic Acid	⌖	⌖	✓
1.9.2	Bile acid sequestrants			
	Colestyramine	⌖	⌖	✓
	Colestipol	⌖	⌖	✓
1.9.4	Pancreatin			
	Pancrex®	⌖	⌖	✓
	Pancrex V®	⌖	⌖	✓
	Creon®	⌖	⌖	✓
Comment	Specialist Consultant recommendation.			

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
2	**Cardiovascular System**			
Comment	For Hypertension guidance, Please refer to NICE Hypertension Guidance http://guidance.nice.org.uk/CG127 and the British Hypertension Society www.bhsoc.org			
2.1	***Positive inotropic drugs***			
	Digoxin	✓	✓	✓
	DigiFab®			✓
2.2	***Diuretics***			
2.2.1	Thiazides and related diuretics			
	Bendroflumethiazide [Bendrofluazide]	✓	✓	✓
	Indapamide **(1st Line)**	✓	✓	✓
	Metolazone	⌖	⌖	✓
2.2.2	Loop Diuretics			
	Furosemide [Frusemide] **(1st Line)**	✓	✓	✓
	Bumetanide **(2nd Line)**	✓	✓	✓
Comment	Although the efficacy of bumetanide is the same as furosemide, it is much more expensive to prescribe in Primary Care. It should therefore be used 2nd line.			
2.2.3	Potassium-sparing diuretics			
	Spironolactone **(1st Line)**	✓	✓	✓
	Eplerenone **(2nd Line)**	✓	✓	✓
2.2.4	Potassium-sparing diuretics with other diuretics			
	Co-amilofruse	✓	✓	✓
Comment	Please specify strength of Co-amilofruse.			
2.2.5	Osmotic Diuretics			
	Mannitol			✓
Comment	Diuretics should be prescribed separately except for patients with poor compliance, where combination products may be indicated. Potassium containing diuretic combinations: The majority of patients do not require potassium supplementation. For those patients who may require potassium supplements, potassium-sparing diuretics should be used. Potassium containing diuretics do not contain adequate amounts of potassium to match the patients' requirements and are therefore not advised for use.			
2.3	***Anti-arrhythmic Drugs***			
	Verapamil (see section 2.6)	Cardiology recommendation		
	Amiodarone	Cardiology recommendation		
	Dronedarone (Multaq®)	Cardiology recommendation		
	Propafenone	Cardiology recommendation		
	Lidocaine [Lignocaine]			✓
	Disopyramide	Cardiology recommendation		
	Adenosine			✓
	Flecainide	Cardiology recommendation		
2.4	***Beta-Blockers***			
	Propranolol (see section 4.1.2)	✓	✓	✓
	Atenolol	✓	✓	✓
	Bisoprolol **(1st Line)**	✓	✓	✓
	Carvedilol	Cardiology Recommendation		
	Esmolol (I.V. for arrythmia)			✓
	Labetalol	Cardiology Recommendation		
	Metoprolol	✓	⌖	✓
	Nebivolol **(2nd Line)**	Cardiology Recommendation		

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
2.5	***Drugs affecting the renin-angiotensin system and some other antihypertensive drugs***			
2.5.1	Vasodilator antihypertensive drugs			
	Riociguat f/c tablets (Adempas®)-initiated by a tertiary centre	⌖	⌖	✓
	Macitentan (Opsumit®)	⌖	⌖	✓
	Hydralazine	⌖	⌖	✓
	Sildenafil (Revatio®) – (Paediatrics – Continuation of treatment from tertiary centres)	⌖	⌖	✓
2.5.2	Centrally acting antihypertensive drugs			
	Methyldopa	⌖	⌖	✓
2.5.4	Alpha-adrenoceptor blocking drugs			
	Doxazosin (**Not** M/R)	✓	✓	✓
2.5.5.1	Angiotensin-converting enzyme inhibitors			
	Lisinopril	✓	✓	✓
	Ramipril	✓	✓	✓
	Perindopril	✓	✓	✓
2.5.5.2	Angiotensin-II receptor antagonists			
	Candesartan (**1st Line**)	✓	✓	✓
	Irbesartan	✓	✓	✓
	Losartan	✓	✓	✓
	Sacubitril/valsartan (Entresto®) -***as per local guidance***	⌖	⌖	✓
	Valsartan (**2nd Line**)	✓	✓	✓
Comment	Evidence base is changing in this area and will be kept under review.			
2.6	***Nitrates, Calcium channel blockers, and Potassium-channel activators***			
Comment	Products marked with an * are available as both standard release and sustained release preparations. Sustained release preparations may be produced by many different manufacturers and may not have the same bioavailabilities, therefore, these products should be prescribed by brand name (the locally recommended brands are specified). Standard release preparations may be prescribed generically.			
2.6.1	Nitrates			
	Glyceryl Trinitrate	✓	✓	✓
Comment	Patches not recommended due to tolerance problems			
	Isosorbide Mononitrate	✓	✓	✓
2.6.2	Calcium-channel blockers			
	Diltiazem * (Tildiem LA® & Retard®)	✓	✓	✓
Comment	Only use generic Nifedipine in Raynaud's. Not to be used sublingually			
	Verapamil *	✓	✓	✓
	Amlodipine (**1st Line**)	✓	✓	✓
	Felodipine (**2nd Line**)	✓	✓	✓
2.6.2	Calcium-channel blockers			
	Ivabradine -**3rd line after beta-blockers & diltiazem for IHD Heart Failure as per SMC guidance**	✓	✓	✓
	Nicorandil	✓	✓	✓
2.6.4.1	Peripheral vasodilators			
	Naftidrofuryl	✓	✓	✓
Comment	Use as per SIGN Guideline 89			
2.7	***Sympathomimetics***			
2.7.1	Inotropic Sympathomimetics			
	Dobutamine			✓
	Dopamine			✓
	Dopexamine			✓
2.7.2	Vasoconstrictor sympathomimetics			
	Noradrenaline [Norepinephrine]			✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
2.7.3	Cardiopulmonary resuscitation Adrenaline[Epinephrine]			✓
2.8	***Anticoagulants and Protamine***			
2.8.1	Parenteral anticoagulants			
	Heparin			✓
	Enoxaparin			✓
	Argatroban Monohydrate			✓
	Fondaparinux sodium inj. (to be used with guidance)			✓
2.8.2	Oral anticoagulants			
	Warfarin **(First Line for AF)**	✓	✓	✓
	Phenindione			✓
	Apixaban – (**follow SMC guidance)**	⌖	⌖	✓
	Rivaroxaban **(First Line for DVT & PE)**			
	Rivaroxaban **(Second Line for AF)** – refer to full guidance Rivaroxaban for Stroke Prevention in Atrial Fibrillation	⌖	⌖	✓
Comment	Warfarin is first line choice of anticoagulant. Rivaroxaban will be second line and remain according to SMC restrictions (intolerant to warfarin or have poor control defined as an INF in target range on <60% of readings). Apixaban and Dabigatran are alternative agents that should be continued in Forth Valley if they have been prescribed for a patient from another Health Board. Rivaroxaban, Apixaban and Dabigatran should only be considered if the risk benefit calculation for anticoagulation would not prelude the use of warfarin.			
2.8.3	Protamine			✓
2.9	***Antiplatelet Drugs***			
	Aspirin	✓	✓	✓
	Clopidogrel	✓	✓	✓
	Prasugrel – ***(For clopidogrel intolerance, stent thrombosis on clopidogrel or for continuation of therapy recommended by tertiary centre)***	⌖	⌖	✓
	Ticagrelor – **Specialist initiation only**	⌖	⌖	✓
Comment	Ticagrelor – Continuation of treatment initiated in a tertiary centre - ACS patients intolerant of clopidogrel - Stent thrombosis while on clopidogrel - Consultant cardiologist initiation for ACS patients with positive troponins			
	Tirofiban			✓
2.10	***Fibrinolytics***			
	Alteplase (For Ischaemic Stroke & For Life Threatening P.E)			✓
	Tenecteplase (For ST Elevation M.I.)			✓
2.11	***Antifibrinolytics***			
	Tranexamic Acid	✓	✓	✓
	Etamsylate [Ethamsylate]			✓
2.12	***Lipid-regulating Drugs***			
Comment	Ensure that statins and ezetimibe are prescribed in accordance with Forth Valley Lipid Lowering Guidelines			
	Bezafibrate **(2nd Line)**	⌖	⌖	✓
	Fenofibrate (Lipantil®) **(1st Line)**	⌖	⌖	✓
	Atorvastatin	✓	✓	✓
Comment	Chewable Atorvastatin tablets **not** to be prescribed			
	Pravastatin	✓	✓	✓
	Rosuvastatin (limited indications, see Forth Valley Guideline	✓	✓	✓
	Simvastatin **(1st Line)**	✓	✓	✓
	Evolocumab	⌖	⌖	✓

Comment	Evolocumab is for initiation by specialist only

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
	Ezetimibe (limited indications, see FV Guideline	✓	✓	✓
3	**Respiratory System**			
Comment	Local guidance is available from the Forth Valley Asthma Online Resource Asthma Guidelines and COPD Guidance with links to national guidance (COPD)			
3.1	***Bronchodilators***			
3.1.1	Adrenoceptor stimulants			
	Short acting Beta$_2$ agonists			
	Salbutamol **(1st Line)**	✓	✓	✓
	Terbutaline **(2nd Line)**	✓	✓	✓
	Long acting Beta$_2$ agonists			
	Formoterol Easyhaler**(1st Line)**	✓	✓	✓
	Indacaterol Breezhaler **(2nd Line)**	✓	✓	✓
	Salmeterol	⌖	⌖	⌖
Comment	Salmeterol remains formulary for patients already established on this therapy			
3.1.2	Long acting Antimuscarinic bronchodilators			
	Incruse Ellipta (1st line)	✓	✓	✓
	Eklira Genuair (2nd line)	✓	✓	✓
	Tiotropium 2.5 microgram solution for inhalation (Spiriva® Respimat®)	✓	✓	✓
3.1.3	Theophylline			
	Aminophylline Injection			✓
	Uniphyllin®	✓	✓	✓
Comment	Different brands of theophylline modified release preparations have different bioavailabilities.Products are NOT INTERCHANGEABLE, prescribers should specify the brand on which a patient is stabilised.			
	Combination bronchodilator preparations			
	Beta$_2$ agonists / inhaled corticosteroid			
	Asthma			
	Fostair® (1st Line)	✓	✓	✓
Comment	Fostair® shelf life is 5 months – prescribe appropriate quantities to avoid unnecessary wastage			
	Symbicort® **(2nd Line)**	✓	✓	✓
	Flutiform® **(2nd Line)**	✓	✓	✓
	Seretide® **(2nd Line)**	✓	✓	✓
	Relvar Ellipta **(Consultant initiation only)**	⌖	⌖	✓
	COPD			
	Relvar Ellipta 92/22 (1st line)	✓	✓	✓
	Fostair 100/6 NEXThaler or MDI(2nd line)	✓	✓	✓
	Duoresp 320/9 DPI (3rd line)	✓	✓	✓
	Beta$_2$ agonists / antimuscarinic bronchodilator			
	Combivent® nebules	✓	✓	✓
	Long acting beta$_2$ agonists / antimuscarinic bronchodilator			
	Anoro Ellipta (1st line)	✓	✓	✓
	Duaklir Genuair (2nd line)	✓	✓	✓
	Long acting antimuscarinic bronchodilator			
	Incruse Ellipta (1st line)	✓	✓	✓
	Eklira Genuair (2nd line)	✓	✓	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
3.1.5	Peak flow meters, inhaler devices and nebulisers	Peak Flow Meter		
	(Mini-Wright® Adult & Paediatric)	✓	✓	✓
	Inhaler spacer device	✓	✓	✓
Comment	Spacer devices are recommended in preference to dry powder or breath actuated inhalers particularly in young children.			
	Emergency Drugs			
	Adrenaline (Epinephrine)	✓	✓	✓
	Specialist Products			
	Caffeine Citrate			✓
Comment	Caffeine Citrate is the oral xanthine of choice in neonates			
3.2	***Corticosteroids***			
	Beclometasone Dipropionate **(Clenil Modulite®1st line)**	✓	✓	✓
	Budesonide **(2nd Line)**	✓	✓	✓
	Fluticasone	✓	✓	✓
	Hydrocortisone IV (See section 6.3.2)			
	Prednisolone Oral (See section 6.3.2)			
	Other Compound Preparations- ***See section Beta$_2$agonists/inhaled corticosteroid***			
Comment	Refer to Guidance on Issuing Steroid Cards (Appendix1).			
3.3	***Cromoglicate, related therapy and leukotriene antagonists***			
3.3.2	*Leukotriene receptor antagonists*			
	Montelukast	✓	⌖	✓
3.4	***Allergic Disorders***			
3.4.1	Antihistamines			
	Cetirizine **(1st Line)**	✓	✓	✓
	Loratadine **(2nd Line)**	✓	✓	✓
	Alimemazine [Trimeprazine] (Paediatrics)	✓		✓
	Chlorphenamine [Chlorpheniramine]	✓	✓	✓
	Promethazine (Paediatrics)	✓		✓
Comment	For drugs acting on the nose see section 12.2			
3.4.2	Allergen Immunotherapy			
	Omalizumab (Xolair®)		Specialist Use Only	
3.4.3	Allergic emergencies			
	Epipen®	✓	✓	✓
	Icatibant Injection (Firazyr®)			✓
3.5	***Respiratory Stimulants and Pulmonary Surfactants***			
3.5.2	Pulmonary Surfactants			
	Caffeine base 5mg/ml Sol'n for injection			✓
	Poractant alfa			✓
3.7	***Mucolytics***			
	Carbocisteine **(1st Line)**	✓	✓	✓
	Mannitol (Bronchitol®) **(Continuation of therapy from specialist centre)**	⌖	⌖	✓
3.11	***Antifibrotics***			
	Pirfenidone **(Specialist Recommendation only)**	⌖	⌖	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
4	**Central Nervous System**			
4.1	***Hypnotics & Anxiolytics***			
Comment	All sedative hypnotics and anxiolytic products are licensed for short term use only and should be reserved for short courses to alleviate acute conditions after causal factors have been established. Refer to Guidance on Benzodiazepine Prescribing: Management of Dependence in Primary Care			
4.1.1	Hypnotics			
	Zopiclone **(1st Line)**	✓	✓	✓
	Temazepam **(2nd Line)**	✓	✓	✓
4.1.2	Anxiolytics			
	Diazepam **(1st Line)**	✓	✓	✓
	Chlordiazepoxide **(use in alcohol detoxification)**	✓	✓	✓
Comment	Refer to Alcohol Dependence -In-patient Management of Alcohol Withdrawal , Alcohol Dependence-Community Management of Alcohol Withdrawal & Alcohol Dependence- Maintenance of Abstinence			
	Lorazepam	✓	✓	✓
Comment	Lorazepam - Short term use only. Shorter acting compounds may be preferred in patients with hepatic impairment but they carry a greater risk of withdrawal symptoms.			
	Propranolol (see section 2.4)	✓	✓	✓
4.2	***Drugs in psychoses and related disorders***			
4.2.1	Antipsychotic Drugs			
Comment:	Refer to Prescribing Guidelines • Emergency Sedation Prescribing Guideline • Monitoring Guidance for Patients Receiving Atypical Antipsychotic Therapy • Integrated Care Pathway for Schizophrenia			
	Chlorpromazine **(1st Line in Primary Care)**	✓	✓	✓
	Haloperidol (Baseline ECG Required)	⌖	✓	✓
	Levomepromazine [Methotrimeprazine] **(Palliative Care)**	✓	✓	⌖
	Trifluoperazine	⌖	✓	⌖
	Zuclopenthixol Dihydrochloride (Clopixol® tabs)	⌖	✓	⌖
	Zuclopenthixol Acetate (Clopixol Acuphase®)		✓	⌖
	Amisulpride	⌖	✓	⌖
	Lurasidone (Latuda®)	⌖	✓	⌖
	Aripiprazole	⌖	✓	⌖
	Clozapine	⌖	✓	⌖
Comment	Clozapine used for treatment resistant schizophrenia only.			
	Olanzapine	⌖	✓	⌖
	Quetiapine	⌖	✓	⌖
	Risperidone	⌖	✓	⌖
4.2.2	Antipsychotic Depot Injections			
	Aripiprazole Inj	⌖	✓	⌖
	Flupentixol Decanoate Inj	⌖	✓	⌖
	Fluphenazine Decanoate Inj	⌖	✓	⌖
	Haloperidol Decanoate Inj	⌖	✓	⌖
	Olanzapine (See protocol for IM use)	⌖	✓	⌖
	Paliperidone Inj	⌖	✓	⌖
	Pipotiazine Palmitate Inj	⌖	✓	⌖
	Risperidone	⌖	✓	⌖
	Zuclopenthixol Decanoate Inj	⌖	✓	⌖

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
4.2.3	Antimanic Drugs			
Comment	Refer to Integrated Care Pathway for Bipolar Disorder			
	Carbamazepine	⌖	✓	⌖
	Valproate Semisodium (Depakote®)	⌖	✓	⌖
Comment	Valproate Semisodium (Depakote®) is licensed for the treatment of manic episodes associated with bipolar disorder but is not currently licensed for the maintenance treatment of bipolar affective disorder. It has been agreed by the Forth Valley New Drugs Sub Group that if prophylaxis is needed, following stabilisation of the episode of acute mania with Depakote® and prior to discharge, sodium valproate should be substituted.			
	Lithium (**Priadel®** is now 1st choice of lithium brand prescribed for all **new patients** started on this medication.)	⌖	✓	⌖
Comment	Lithium products Priadel® and Camcolit® have different bioavailabilities, therefore brand must be specified when prescribing. Liquid preparations Priadel® and Li-Liquid® also have different bioavailabilities. Refer to Guideline for the Management of Patients on Lithium - http://www.qifv.scot.nhs.uk/			
4.3	***Antidepressants***			
Comment	Refer to Guidance for Mangement for Depression			
4.3.1	Tricyclic and related Antidepressant Drugs			
	Amitriptyline	✓	✓	✓
	Clomipramine	⌖	✓	⌖
	Lofepramine	✓	✓	✓
	Trazodone	✓	✓	✓
4.3.2	Monoamine-oxidase Inhibitors			
	Phenelzine (dietary / interaction advice required)	⌖	✓	⌖
	Moclobemide	⌖	✓	⌖
4.3.3	Selective Serotonin Re-uptake Inhibitors			
	Citalopram	✓	✓	✓
	Fluoxetine	✓	✓	✓
	Sertraline	✓	✓	✓
4.3.4	Other Antidepressant Drugs			
	Mirtazapine	✓	✓	✓
	Venlafaxine	✓	✓	⌖
4.4	***Central nervous system stimulants***			
	Atomoxetine	⌖	✓	⌖
	Dexamfetamine (Not first line)	⌖	✓	⌖
	Lisdexamfetamine (Not first line)	⌖	✓	⌖
	Methylphenidate (1st line)	⌖	✓	⌖
Comment	Refer to SMC recommendation on sustained release methylphenidate and Atomoxetine preparations.http://www.scottishmedicines.org.uk/			
4.5	***Drugs used in the treatment of obesity***			
	Orlistat *(Prescribing in Primary Care Restricted – on the advice of Weight Management Service only*	⌖	⌖	✓
Comment	To be prescribed in conjunction with NICE guidelines.			

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
4.6	***Drugs used in Nausea & Vertigo***			
Comment	Choose the correct antiemetic based on the likely cause of the symptoms			
	Haloperidol **(palliative care) (see section 4.2)**	⌖	⌖	✓
	Levomepromazine [Methotrimeprazine] **(palliative care) (see section 4.2)**	⌖	⌖	✓
	Cinnarizine	✓	✓	✓
	Cyclizine	✓	✓	✓
	Prochlorperazine **(2nd Line)**	✓	✓	✓
	Domperidone **(1st Line)** (Refer to Alert Safety Update May 2014	✓	✓	✓
	Metoclopramide (Refer to Drug Safety Update August 2013)	✓	✓	✓
	Ondansetron (Restricted – oncology & anaesthetics)			✓
	Fosaprepitant (Ivemend®)	Restricted use West of Scotland Cancer Network		
	Hyoscine Hydrobromide	✓	✓	✓
	Betahistine	✓		
4.7	***Analgesics***			
Comment	Refer to Primary Care Guidance on Use of Oral Analgesics (Appendix 2) and also to Forth Valley Palliative Care Guidelines and Specialist Formulary Refer to Guidance on Pain Management in a Person with a Substance Misuse Problem (In-Patient)			
4.7.1	Non-opioid Analgesics			
	Paracetamol **(1st Line)**	✓	✓	✓
	Co-codamol 8/500	✓		
	Co-codamol 30/500	✓	✓	✓
Comment	N.B. increased opioid side-effects and risk of dependence with co-codamol. Also, effervescent preparations of compound analgesics may contain high levels of sodium. For patients requiring low sodium intake please refer to individual Summary of Product Characteristics. Refer also to Primary Care Guidance on Use of Oral Analgesics (Appendix 2) and Acute Pain Service Guideline for In-patient Acute Pain			
Comment	Codeine should only be used to relieve acute moderate pain in children older than 12 years and only if it cannot be relieved by other painkillers such as paracetamol or ibuprofen alone. Furthermore, a significant risk of serious and life-threatening adverse reactions has been identified in children with obstructive sleep apnoea who received codeine after tonsillectomy or adenoidectomy (or both). Codeine is now contraindicated in all children younger than 18 years who undergo these procedures for obstructive sleep apnoea.			
4.7.2	Opioid Analgesics			
	Dihydrocodeine	✓	✓	✓
	Morphine	✓	✓	✓
Comment	Morphine to be used first line over Diamorphine			
	Diamorphine	✓	✓	✓
	Diamorphine hydrochloride nasal spray (Ayendi®) – Only for use in the emergency setting in hospital			✓
Comment	Ayendi Nasal Spray should be administered in the emergency setting by practitioners experienced in the administration of opioids in children and with appropriate monitoring.			
	Cyclimorph®	✓	✓	✓
	Fentanyl Patch–**(Prescribe by brand–Matrifen®)**	✓	✓	✓
	Fentanyl [Fentanyl Injection for Acute Services refer to section 15.1.4.3]	⌖	⌖	✓
Comment	Fentanyl indicated 3rd line or if GI absorption issues. See Prescribing Guideline. West of Scotland Chronic Non Malignant Pain Opioid Prescribing Guideline Fentanyl Patch indicated for patient with severe pain with swallowing difficulties or intractable nausea and vomiting. (SIGN 106 – Control of Pain in Adults withCancer) & Forth ValleyPalliative Care Guidelines and Specialist Formulary. Refer to manufacturers information for oral morphine to transdermal route conversion ratios vary, so should be used only as an initial approximate guide, or West of Scotland Chronic Non Malignant Pain Opioid Prescribing Guideline			

Chapter/Section/Drug	Primary Care: CHPs	Primary Care: Mental Health Specialties	Acute Services
Oxycodone **(Restricted use in patients intolerant** to Morphine) **to Morphine)** Refer to West of Scotland Chronic Non Malignant Pain Opioid Prescribing Guideline & Forth ValleyPalliative Care Guidelines and Specialist Formulary	⌖	⌖	✓
Comment To convert oral morphine to oral oxycodone divide total 24 hours dose of morphine by 2 to determine the total dose of oxycodone in 24 hours. No advantage using oxycodone over morphine in stage 1 -3 renal impairment, refer to West of Scotland Chronic Non Malignant Pain Opioid Prescribing Guideline			
4.7.3 Neuropathic Pain			
Amitriptyline-unlicensed [see section 4.8] **(1st Line)**	✓	✓	✓
Gabapentin [see section 4.8] **(2nd Line)**	✓	✓	✓
Pregabalin	✓	✓	✓
Duloxetine [see section 7.4.2]	⌖	⌖	✓
(SMC advice, restricted to initiation by prescribers experienced in the management of diabetic peripheral neuropathic pain as 2nd or 3rd line therapy.)			
Comment Refer to Local Neuropathic Pain Guidelines (Appendix 3)			
Carbamazepine (see section 4.8)	✓	✓	✓
Sodium Valproate (see section 4.8)	✓	✓	✓
4.7.4 Antimigraine Drugs			
Sumatriptan **(1st Line)**	✓	✓	✓
Rizatriptan	✓	⌖	⌖
Pizotifen	✓	✓	✓
Topiramate (Initiation by specialists)	⌖	⌖	✓
4.8 Antiepileptics			
Comment Refer to NICE guideline No 76 "Newer Drugs for Epilepsy in Adults" and No 79 "Newer Drugs for Epilepsy in Children" for guidance on the use of oxcarbazepine, levetiracetam, tiagabine and topiramate and SIGN guideline No 70 "Diagnosis and Management of Epilepsy in Adults"			
4.8.1 Control of Epilepsy			
Carbamazepine	⌖	✓	✓
Gabapentin	⌖	✓	✓
Pregabalin	⌖	✓	✓
Lamotrigine **(1st Line in women of child bearing potential)**	⌖	✓	✓
Levetiracetam **(2nd Line)**	⌖	✓	✓
Comment Lamotrigine and Levetiracetam 1st Line in obstetric epilepsy			
Phenobarbital [Phenobarbitone](Paediatrics)	⌖		✓
Phenytoin	⌖	✓	✓
Retigabine **(for specialist use only)**	⌖	⌖	✓
Rufinamide **(for specialist use only)**	⌖	⌖	✓
Zonisamide **(for specialist use only)**	⌖	⌖	✓
Lacosamide **(for specialist use only)**	⌖	⌖	✓
Topiramate **(under specialist supervision)**	⌖	✓	✓
Sodium Valproate **(1st Line)**	⌖	✓	✓
Clobazam	⌖	⌖	✓
Clonazepam	⌖	⌖	✓
Comment Many antiepileptic products are available as generic products which may vary in bioavailability, therefore, not interchangeable. It is recommended that prescribing should be by brand name to ensure continuity of supply.			
4.8.2 Drugs used in Status Epilepticus			
Diazepam (rectal)	✓	✓	✓
Diazemuls®	✓	✓	✓
Lorazepam I.V. **(1st Line)**			✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
Midazolam,oromucosal sol'n **(Buccolam®) (Prescribe by brand)**		⌖	✓	✓
Comment	While Buccolam® is only licensed in paediatrics, the New Drugs Group supports the use of this product in all new patients including adults.			
Phenytoin I.V. **(2nd Line)**				✓
Comment	Refer to Acute Phenytoin Loading Guidelines (Appendix 4)			
4.9	***Drugs used in Parkinsonism and related disorders***			
4.9.1	Dopaminergic Drugs used in Parkinsonism			
	Apomorphine	**Refer to Clinic for Specialist Consultant Recommendation**		
	Entacapone	**Refer to Clinic for Specialist Consultant Recommendation**		
	Madopar®	**Refer to Clinic for Specialist Consultant Recommendation**		
	Pramipexole	**Refer to Clinic for Specialist Consultant Recommendation**		
	Ropinirole	**Refer to Clinic for Specialist Consultant Recommendation**		
	Rotigotine Patch	Specialist Initiation Only		
	Sinemet®	✓	✓	✓
	Duodopa®	✓	✓	✓
	Selegiline	⌖	✓	✓
	Stalevo®	✓	✓	✓
	Amantadine	Specialist Initiation Only		
Comment	Ideally patients should be referred to a specialist clinic untreated with any dopaminergic drug.			
4.9.2	Antimuscarinic Drugs used in Parkinsonism			
	Orphenadrine	⌖	✓	✓
	Procyclidine	✓	✓	✓
Comment	Anticholinergics should only be initiated in Parkinson's Disease on specialist recommendation			
4.9.3	Drugs used in Essential Tremor, Chorea, Tics and Related Disorders			
	Propranolol (see section 2.4)	✓	✓	✓
	Primidone **(on specialist recommendation)**	⌖	⌖	✓
	Botulinum Toxin Type A (Xeomin®)			✓
	Botulinum Toxin Type A (Dysport®)			✓
4.10	***Drugs used in Substance Dependence***			
Comment	See Section 4.1.2 and Refer to links Alcohol Dependence -In-patient Management of Alcohol Withdrawal, Alcohol Dependence-Community Management of Alcohol Withdrawal & Alcohol Dependence – Maintenance of Abstinence			
	Acamprosate	✓	✓	✓
	Nicotine Products	✓	✓	✓
	Varenicline	✓	✓	✓
	Bupropion	✓	⌖	✓
Comment	Refer to FV Smoking Guideline http://www.qifv.scot.nhs.uk/			
	Disulfiram	✓	✓	⌖
	Buprenorphine (Substance Misuse Prescribing Services)	⌖	✓	⌖
	Buprenorphine/naloxone (Substance Misuse Prescribing Services) Suboxone®	⌖	✓	⌖
	Methadone (Substance Misuse Prescribing Services)	✓	✓	⌖
Comment	Refer to following links Methadone Assisted Treatment Programme Buprenorphine Assisted Treatment Programme Guidance on the Management of Opioid Dependence: Buprenorphine detoxification			
	Naltrexone (Substance Misuse Prescribing Services)	⌖	✓	⌖

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
4.11	***Drugs for Dementia***			
Comment	Refer to Integrated Care Pathway for Dementia Guideline for the use of Cognitive Enhancing Drugs			
	Donepezil		✓	
	Galantamine		✓	
	Memantine	⌖	✓	⌖
	Rivastigmine		✓	
5	**Infections**			
Comment	Please refer to appropriate guidelines for specific indications • Primary Care Management of Infection Guidance • Forth Valley GUM List (Appendix 6) • Patients receiving Chemotherapy Who Become Unwell –Guidance for Community Healthcare Practitioners British Lymphology Society – Consensus Document on the Management of Cellulitis in Lymphoedema http://www.lymphoedema.org/lsn			
5.1	***Antibacterial drugs***			
5.1.1	Penicillins			
	Benzylpenicillin	✓	✓	✓
	Penicillin V	✓	✓	✓
	Flucloxacillin	✓	✓	✓
	Amoxicillin	✓	✓	✓
	Co-amoxiclav **(Generally not 1st line in Primary Care)**	✓	✓	✓
	Piperacillin and tazobactam (Tazocin®)			✓
Comment	Tazocin® only to be used following microbiological advice.			
5.1.2	Cephalosporins, cephamycins and other beta-lactams			
	Cefalexin (for UTI)	✓	✓	✓
	Cefotaxime (I.V.)	✓		✓
Comment	Cefotaxime I.V restricted for paediatrics / neonates. Use in Primary Care for Treatment of Invasive Meningococcal disease in children and young people – SIGN 102			
	Ceftazidime			✓
	Ceftriaxone			✓
	Meropenem- (Restricted use, seek microbiology advice)			✓
Comment	Aztreonam used only following microbiological advice in Cystic Fibrosis.			
5.1.3	Tetracyclines			
	Doxycycline	✓	✓	✓
	Lymecycline (2nd line in acne)	✓	✓	✓
	Oxytetracycline	✓	✓	✓
	Tetracycline	✓	✓	✓
Comment	Oral Tetracycline in combination with other agents for MRSA infection only. Tetracycline Injection is an unlicensed preparation			
5.1.4	Aminoglycosides			
	Gentamicin			✓
	Neomycin			✓
	Tobramycin (Paediatric Cystic Fibrosis only)	⌖		✓
Comment	Tobramycin restricted to use in Cystic Fibrosis only.			
5.1.5	Macrolides			
	Erythromycin	✓	✓	✓
	Azithromycin **(For use in P.C. for Chlamydia)**	✓		✓
	Clarithromycin	✓	✓	✓
5.1.6	Clindamycin			
	Clindamycin			✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
5.1.7	Some other antibacterials			
	Chloramphenicol			✓
	Sodium fusidate	✓	✓	✓
	Vancomycin	⌖		✓
	Teicoplanin (Restricted use–Haematology or on Microbiology advice)			✓
	Linezolid (Restricted use, seek microbiology advice)			✓
	Colistimethate [Colistin] (Cystic Fibrosis only) ⌖			✓
	Rifaximin (Targaxan®) **Recommended by Specialist**			
Comment	Sections 5.1.6 & 5.1.7 - Above products only to be used following microbiological advice.			
5.1.8	Sulphonamides and trimethoprim			
	Trimethoprim	✓	✓	✓
	Co-Trimoxazole	✓	✓	✓
Comment	Co-trimoxazole to be restricted for treatment and prophylaxis of Pneumocystis Pneumonia, Stenotrophomonas multiphilia or following microbiological advice			
5.1.9	Antituberculous drugs			
	Ethambutol Hydrochloride	⌖	⌖	✓
	Isoniazid	⌖	⌖	✓
	Pyrazinamide	⌖	⌖	✓
	Rifampicin	⌖	⌖	✓
	Rifater®	⌖	⌖	✓
	Rifinah® 150 & 300	⌖	⌖	✓
	Streptomycin	⌖	⌖	✓
	Amikacin (see section 5.1.4)	⌖	⌖	✓
	Ciprofloxacin (see section 5.1.12)	⌖	⌖	✓
5.1.10	Antileprotic drugs			
	Dapsone	⌖	⌖	✓
5.1.11	Metronidazole and tinidazole			
	Metronidazole	✓	✓	✓
5.1.12	Quinolones			
	Ciprofloxacin (**1st line use only in acute pyelonephritis & prostatitis)**	✓	✓	✓
	Moxifloxacin			✓
	Norfloxacin (Spontaneous Bacterial Peritonitis prophylaxis)	✓	✓	✓
	Ofloxacin			✓
	Levofloxacin (Quinsair®)	⌖	⌖	✓
Comment	Moxifloxacin restricted to 2nd line treatment in Community Acquired Pneumonia and in exacerbations of COPD in penicillin allergic patients. Ofloxacin restricted to Orchitis, prostatitis and Pelvic Inflammatory Disease only. Norfloxacin for prostatitis and prophylaxis of infection in ascites.			
5.1.13	Urinary-tract infections			
	Nitrofurantoin	✓	✓	✓
5.2	***Antifungal drugs***			
	Amphotericin (I.V.)			✓
	Fluconazole (IV & Oral)	✓	✓	✓
Comment	Fluconazole capsules 1st line in oral thrush in adults. (50mg daily for 7 – 14 days) Nystatin oral suspension for Orophanyngeal fungal infections in children (see section 12.3.2)			
	Flucytosine (IV)			✓
	Itraconazole	✓	✓	✓
	Nystatin	⌖	⌖	✓
	Posaconazole Infusion (Noxafil)			✓

Chapter/Section/Drug		Primary Care: CHPs	Primary Care: Mental Health Specialties	Acute:	Acute: Services
	Voriconazole (IV & Oral)				✓
	Terbinafine	✓	✓		✓
Comment	Voriconazole should only be used following microbiological advice				
5.3	***Antiviral drugs***				
5.3.1	HIV Infection				
Comment	See F.V. GUM list (Appendix 6)				
5.3.2	Herpes virus infections				
	Aciclovir **(1st line)**	✓	✓		✓
	Famciclovir (**2nd line** if compliance is a problem)	✓	✓		✓
5.3.3	Viral Hepatitis **(for specialist use only)**				
	Adefovir dipivoxil (Restricted use Follow West of Scotland Guidelines)				✓
	Dasabuvir (Exviera®)	⌖	⌖		✓
	Entecavir (Baraclude®)	⌖	⌖		✓
	Tenofovir	⌖	⌖		✓
	Boceprevir				✓
	Daclatasvir f/c tablets (Daklinza®)	⌖	⌖		✓
	Simeprevir (Olysio®)	⌖	⌖		✓
	Sofosbuvir (Sovaldi®)	⌖	⌖		✓
	Ledipasvir / sofosbuvir®) (Harvoni®)	⌖	⌖		✓
	Ombitasvir / paritaprevir / ritanavir(Viekirax®)	⌖			✓
5.3.4	Influenza				
	Oseltamivir (Tamiflu®)	✓	✓	✓	✓
5.3.5	Respiratory syncytial virus				
	Ribavarin 200mg Capsules-(In combination with Viraferon & IntronA)				✓
5.4	***Antiprotozoal drugs***				
5.4.1	Antimalarials				
Comment	Treatment of Malaria is prescribable on the NHS. Prophylaxis is not prescribable at NHS expense but private prescriptions can be provided.				
	Chloroquine	✓	⌖		✓
	Primaquine	✓	⌖		✓
	Proguanil Hydrochloride	✓	⌖		✓
	Pyrimethamine with Sulfadoxine (Fansidar®)	✓	⌖		✓
	Pyrimethamine with Dapsone (Maloprim®)	✓	⌖		✓
	Quinine Sulphate	✓	⌖		✓
	Hydroxychloroquine Sulphate (see section 10.1.3)	✓	⌖		✓
Comment	Prescribe following discussion with Infectious Diseases.				
5.4.2	Amoebicides				
	Diloxanide Furoate	✓	⌖		✓
	Metronidazole	✓	✓		✓
Comment	Prescribe following discussion with Infectious Diseases.				
5.5	***Anthelmintics***				
	Mebendazole	✓	✓		✓
	Piperazine	✓	✓		✓

Chapter/Section/Drug		Primary Care: CHPs	Primary Care: Mental Health Specialties	Acute Services
6	**Endocrine System**			
Comment	Please Refer to Forth Valley Management Programme for Diabetes Mellitus, Guidance on Hypogylcaemic Agents on formulary –Please refer to (Appendix 7) Blood Glucose Meters- Formulary Choices (Appendix 8)			
6.1	***Drugs used in Diabetes***			
6.1.1 Insulins				
Insulins		✓	✓	✓
(Recommendation by Practitioner experienced in management of diabetes)				
6.1.2	Oral Antidiabetic Drugs			
6.1.2.1	Sulphonylureas			
	Gliclazide **(1st Line SU)**	✓	✓	✓
	Glimepiride (only if problems with compliance or polypharmacy) **(2nd Line)**	✓	✓	✓
6.1.2.2	Biguanides			
	Metformin	✓	✓	✓
6.1.2.3	Other Antidiabetics			
	Pioglitazone **(Dual or Triple Therapy with Metformin/SU)**	✓	✓	✓
	Alogliptin- **(1st Line DPP4 for new patients)**	✓	⌖	✓
	Linagliptin **(DPP4 of choice in renal impairment)**	✓	⌖	✓
	Sitagliptin – **(Patients already prescribed this or intolerant to other DPP4)**	✓	⌖	✓
	Empagliflozin- **(1st choice SGLT2 for new patients)**	✓	⌖	✓
	Canagliflozin **(2nd choice SGLT2)**	✓	⌖	✓
	Dapagliflozin**- patients already prescribed or Intolerant to other SGLT2**	✓	⌖	✓
	Exenatide **(Initiate by practitioners experienced in diabetes)**	✓	⌖	✓
	Liraglutide **(Initiate by practitioners experienced in diabetes)**	✓	⌖	✓
	Xultophy® **(Initiate by practitioners experienced in diabetes)**	✓	⌖	✓
Comment	The Forth Valley Diabetes team have reviewed the formulary choices and produced a table which includes each Oral Hypoglycaemic Drugs on the formulary - Please refer to (Appendix 11).			
6.1.4	Treatment of Hypoglycaemia			
	Glucagon	✓	✓	✓
	Glucogel	✓	✓	✓
	Glucose 50%	✓	✓	✓
6.2	***Thyroid and Antithyroid Drugs***			
6.2.1	Thyroid Hormones			
	Levothyroxine [Thyroxine] Sodium **(1st Line)**	✓	✓	✓
	Liothyronine Sodium	⌖	⌖	✓
6.2.2	Antithyroid Drugs			
	Carbimazole **(1st Line)**	✓	✓	✓
	Propylthiouracil	✓	✓	✓
	Potassium iodide			✓
	Propranolol	✓	✓	✓
6.3	***Corticosteroids***			
6.3.1	Replacement Therapy			
	Fludrocortisone Acetate	✓	✓	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
6.3.2	Glucocorticoid Therapy			
	Hydrocortisone Tablets	⌖	⌖	✓
	Hydrocortisone Injection	✓	✓	✓
	Dexamethasone	✓	⌖	✓
	Methylprednisolone	✓	✓	✓
	Prednisolone	✓	✓	✓
Comment	Consider osteoporosis prevention treatment if corticosteroids used long term. Please refer to Forth Valley Osteoporosis Guidelines			
6.4	***Sex Hormones***			
6.4.1	Female Sex Hormones			
6.4.1.1	Oestrogens and HRT			
	Tibolone	✓	✓	✓
With uterus	Premique® (Includes low dose)	✓	✓	✓
	Prempak-C®	✓	✓	✓
	Femoston®	✓	✓	✓
	FemSeven Conti®	✓	✓	✓
	FemSeven Sequi®	✓	✓	✓
	Elleste Duet®	✓	✓	✓
	Evorel (includes Conti)	✓	✓	✓
	Elleste Duet Conti®	✓	✓	✓
	Kliovance®	✓	✓	✓
Without uterus	Premarin®	✓	✓	✓
	Elleste Solo®	✓	✓	✓
	Estraderm MX®	✓	✓	✓
	Oestrogel®	✓	✓	✓
6.4.1.2	Progestogens			
	Progesterone (Cyclogest® for subfertility)			✓
	Dydrogesterone	✓	✓	✓
	Ulipristal acetate (Esmya®)	✓	✓	✓
	Medroxyprogesterone	✓	✓	✓
	Norethisterone	✓	✓	✓
6.4.2	Male Sex Hormones & Antagonists			
	Testosterone	⌖	⌖	✓
	Cyproterone Acetate	⌖	✓	✓
	Finasteride	✓	⌖	✓
6.5	***Hypothalamic and pituitary hormones and anti-oestrogens***			
6.5.1	Hypothalamic and anterior pituitary hormones and anti-oestrogens			
	Clomifene Citrate			✓
	Chorionic Gonadotrophin (HCG)			✓
	Follicle Stimulating Hormone (FSH)			✓
	Gonadorelin (LH-RH)			✓
	Tetracosactrin (Synacthen®)			✓
	(Synthetic Human Growth Hormone)			✓
Comment	Specific recommendation from Dr McQueen. All products for assisted conception are funded centrally and **GPs should not prescribe.**			
6.5.2	Posterior Pituitary Hormones and Antagonists			
	Desmopressin	✓	⌖	✓
	Terlipressin (oesophageal varices)			✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
6.6	***Drugs affecting bone metabolism***			
6.6.1	Calcitonin Parathyroid hormone 100mcg powder for injection			✓
	Salcatonin Nasal Spray			✓
	Teriparatide			✓
Comment	Teriparatide -restricted use refer to SMC Guidance			
6.6.2	Bisphosphonates			
Comment	Please refer to Hypercalcaemia of Malignancy Treatment Guideline & Suspected Hypercalcaemia of Malignancy Guideline for Primary Care- (http://www.qifv.scot.nhs.uk/CE_ClinicalGuidelines.asp)			
	Alendronic Acid **(1st Line)** (prophylaxis and treatment in men and women)	✓	✓	✓
	Risedronate Sodium (prophylaxis and treatment in women only) **(2nd Line in patients with G.I. problems)**	✓	✓	✓
Comment	Risedronate 2nd Line if GI intolerance of alendronic acid. Recommended in G.I problems. Caution ensure correct strength is prescribed for indication.			
	Disodium Pamidronate(I.V.)- **(1st Line for hypercalcaemia)**			✓
	Zoledronic Acid Sol'n **(2nd line)**			✓
	Ibandronic Acid-**(3rd Line)**	✓		✓
	Denosumab			✓
Comment	Denosumab restricted to specialist recommendation in secondary care in women only, also available in line with West of Scotland Cancer Network Protocols			
	Strontium ranelate (Protelos®)	✓	✓	✓
Comment	Strontium ranelate 2nd Line to bisphosphonates for patients who cannot tolerate bisphosphonates			
	Raloxifene	✓	✓	✓
Comment	Rafoxifene may be used for patients where bisphosphonates and Stontium are contra indicated or not tolerated			
6.7	***Other endocrine drugs***			
6.7.1	Bromocriptine and other dopamine-receptor stimulants			
	Bromocriptine	✓	✓	✓
	Cabergoline	⌖	⌖	✓
	Quinagolide	⌖	⌖	✓
6.7.2	Drugs affecting gonadotrophins			
	Danazol	⌖	⌖	✓
	Naferelin	⌖	⌖	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
7	**Obstetrics, gynaecology and urinary tract disorders**			
7.1	***Drugs used in obstetrics***			
7.1.1	Prostaglandins and oxytocics			
	Carboprost			✓
	Dinoprostone			✓
	Ergometrine Maleate			✓
	Syntometrine®			✓
	Oxytocin			✓
7.1.1.1	Ductus arteriosus			
	Alprostadil (restricted to paediatrics)			✓
7.1.2	Mifepristone			
	Mifepristone			✓
	Misoprostol (NB. Unlicensed indication)			✓
7.1.3	Myometrial Relaxants			
	Atosiban			✓
	Terbutaline			✓
7.2	***Treatment of vaginal and vulval conditions***			
Comment	See also Forth Valley GUM List (Appendix 6)			
7.2.1	Preparations for vaginal and vulval changes			
	Conjugated oestrogens (Premarin® cream)	✓	✓	✓
	Estradiol [Oestradiol] (Vagifem®, Estring®)	✓	✓	✓
	Estriol [Oestriol] (Ovestin®)	✓	✓	✓
	Relactagel	✓	✓	✓
7.2.2	Vaginal and vulval infections			
	Clotrimazole	✓	✓	✓
	Miconazole	✓	✓	✓
	Clindamycin			✓
	Povidone Iodine (Betadine®)	✓	✓	✓
7.3	***Contraceptives***			
7.3.1	Combined hormonal contraceptives			
	Loestrin20®	✓	✓	✓
	Logynon®	✓	✓	✓
	Tri-Regol®	✓	✓	✓
	Microgynon30®	✓	✓	✓
	Rigevidon®	✓	✓	✓
	Marvelon®	✓	✓	✓
	Gedarel® 30/150	✓	✓	✓
	Mercilon®	✓	✓	✓
	Gedarel® 20/150	✓	✓	✓
	Femodene®	✓	✓	✓
	Millinette® 30/75	✓	✓	✓
	Femodette®	✓	✓	✓
	Millinette® 20/75	✓	✓	✓
	Cilest®	✓	✓	✓
	Evra® Patch	✓	✓	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
7.3.2.1	Oral Progestogen-only contraceptives			
	Desogestrel	✓	✓	✓
	Femulen®	✓	✓	✓
	Norethisterone	✓	✓	✓
7.3.2.2	Parenteral Progestogen-only contraceptives			
	Medroxyprogesterone acetate (Depo-provera®)	✓		✓
	Sayana Press®	✓		✓
	Nexplanon®	✓		✓
7.3.2.3	Intra-uterine progestogen-only contaceptive			
	Mirena® **(not 1st line)**	✓		✓
	Jaydess®	✓		✓
7.3.4	Contraceptive devices			
	Nova-T ® 380	✓	✓	✓
	Multiload ® Cu375	✓	✓	✓
	T-Safe® CU 380A	✓	✓	✓
7.3.5	Emergency contraception			
	Levonorgestrel	✓	✓	✓
Comment	Levonorgestrel only effective if taken within 72 hours. Taking the dose as soon as possible increases efficacy.			
	EllaOne®	✓	✓	✓
Comment	EllaOne® not to be used 1st line unless patient presents after 72 hours.			
7.4	***Drugs for genito-urinary disorders***			
7.4.1	Drugs for urinary retention			
	Tamsulosin	✓	⌖	✓
	Alfuzosin	⌖	⌖	✓
Comment	Alfuzosin is available as both standard release and M/R formulations. If prescribing M/R preparation, please prescribe by brand.			
7.4.2	Drugs for urinary frequency, enuresis and incontinence			
	Darifenacin	⌖	⌖	✓
	Duloxetine (restricted use refer to SMC Guidance)	⌖	⌖	✓
	Fesoterodine fumarate	⌖	⌖	✓
	Oxybutynin – **m/r or patch only**	⌖	⌖	✓
	Propiverine	⌖	⌖	✓
	Solifenacin Succinate	✓	✓	✓
	Tolterodine	✓	✓	✓
	Trospium chloride	⌖	⌖	✓
	Mirabegron	✓	⌖	✓
	Botulinum toxin type A (Botox®) - ***(For neurogenic detrusor overactivity or idiopathic detrusor overactivity)***			✓
Comment	See FV Guideline for the Initial Management of Urinary Incontinence - http://www.gifv.scot.nhs.uk/ Tolterodine IR (immediate-release tablets) should be tried first. If this is effective, but the patient experiences side-effects, try Tolterodine MR. If Tolterodine is ineffective a trial of Solifenacin would be advocated. Mirabegron is available where an adequate trial of two anti-cholinergics has proved ineffective, the drugs were not tolerated or are contraindicated.			
	Desmopressin (see section 6.5.2)	✓	✓	✓
Comment	Desmopressin **Spray** is no longer indicated for nocturnal enuresis unless treatment is associated with multiple sclerosis			
7.4.3	Drugs used in urological pain			
	Potassium citrate (Effercitrate®)	✓	✓	✓
7.4.4	Bladder instillations and urological surgery			
	Sodium chloride	✓	✓	✓
	Dimethyl sulphoxide			✓
	Mitomycin-C			✓
	Epirubicin			✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
7.4.5	Drugs for impotence			
Comment	National guidance for prescribing drugs for erectile dysfunction (and other schedule 11 drugs) is available at the following web link http://www.show.scot.nhs.uk/sehd/pca/pca1999(m)9(p)3.htm			
	Alprostadil	✓	✓	✓
	Sildenafil	✓	✓	✓
	Tadalafil	✓	✓	✓
	Vardenafil	✓	✓	✓
8	**Malignant disease and immunosuppression**			
Comment	Please refer to Superior Vena Cava Obstruction Treatment Guideline for Acute Services, Superior Vena Cava Obstruction Guideline for Primary Care, Malignant Spinal Cord Compression Guideline for Seconday Care & Malignant Spinal Cord Compression Guideline for Primary Care (http://www.gifv.scot.nhs.uk/CE_ClinicalGuidelines.asp)			
Comment	Prescribing of anti-cancer medicines should be in accordance with West of Scotland Cancer Network approved clinical management guidelines and chemotherapy protocols, where available			
8.1	***Cytotoxic drugs***			
8.1.1	Alkylating drugs			
	Bendamustine			✓
	Chlorambucil			✓
	Cyclophosphamide	⌖		✓
	Folinic acid			✓
	Ifosfamide			✓
	Melphalan			✓
	Lomustine			✓
	Busulfan	To be prescribed only by West of Scotland haemopoietic stem cell transplant team with HSCT protocols		
	Mesna (urothelial toxicity)			✓
	Treosulfan			✓
8.1.2	Cytotoxic antibiotics			
	Bleomycin			✓
	Doxorubicin			✓
	Epirubicin			✓
	Idarubicin			✓
	Mitomycin-C			✓
	Mitozantrone			✓
	Daunorubicin			✓
8.1.3	Antimetabolites			
	Capecitabine			✓
	Cladribine			✓
	Cytarabine			✓
	Fludarabine Phosphate			✓
	5-Fluorouracil (cream - in liaison with Dermatologist)	⌖		✓
	Pemetrexed			✓
	Nelarabine			✓
	Gemcitabine			✓
	Methotrexate	⌖	⌖	✓
Comment	For patients, who are receiving S/C Methotrexate use licensed pre-filled syringe.			
	Mercaptopurine			✓
	Tioguanine			✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
8.1.4	Vinca alkaloids and etoposide			
	Etoposide			✓
	Vinblastine			✓
	Vincristine			✓
	Vinorelbine			✓
8.1.5	Other antineoplastic drugs			
	Aflibercept (Zaltrap®)			✓
	Bortezomib			✓
	Panobinostat (Farydak®)			✓
	Brentuximab vedotin			✓
	Carboplatin			✓
	Cisplatin			✓
	Hydroxycarbamide	⌖	⌖	✓
Comment	A shared care policy is in place for the prescribing and monitoring of hydroxycarbamide in the community			
	Procarbazine			✓
	Amsacrine			✓
	Bevacizumab (Avastin®)			✓
	Cetuximab			✓
	Ipilimumab			✓
	Pembrolizumab			✓
	Dacarbazine			✓
	Everolimus			✓
	Gefitinib			✓
	Imatinib			✓
	Irinotecan			✓
	Bosutinib			✓
	Ceritinib (Zykadia®)			✓
	Dabrafenib			✓
	Idelalisib			✓
	Nilotinib			✓
	Ponatinib			✓
	Regorafenib			✓
	Ruxolitinib			✓
	Sorafenib (Nexavar®)			✓
	Sunitinib			✓
	Vemurafenib (Zelboral®)			✓
	Afatinib (Giotrif®)			✓
	Lipegfilgrastim (Lonquex)			✓
	Oxaliplatin			✓
	Paclitaxel			✓
	Topotecan			✓
	Trastuzumab			✓
	Nintedanib			✓
	Cabazitaxel			✓
	Docetaxel			✓
	Temozolomide			✓
	Eribulin (mesilate)			✓
	Tretinoin			✓
	Erlotinib			✓
	Axitinib (Inlyta®)			✓
	Crizotinib (Xalkori®)			✓
	Cabozantinib (Cabometyx®)			✓
	Carfilzomib (Kyprolis®)			✓

8.2	***Drugs affecting the immune response***			
8.2.1	Antiproliferative immunosuppressants			
	Azathioprine	⌖	⌖	✓
	Mycophenolic acid	⌖	⌖	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
8.2.2	Corticosteroids and other immunosuppressants			
	Ciclosporin [Cyclosporin]	⌖	⌖	✓
	Prednisolone	✓	✓	✓
	Methylprednisolone	⌖	⌖	✓
	Tacrolimus	⌖	⌖	✓
8.2.3	Rituximab			
	Rituximab 10mg/ml Concentrate for infusion (MabThera®)			✓
	Alemtuzumab (Lemtrada®)			✓
	Obinutuzumab			✓
	Blinatumomab (Blincyto®)			✓
	Nivolumab (Opdivo®)			✓
8.2.4	Other immunomodulating drugs			
	Interferon-alfa (Haematology use only)	⌖		✓
	Peginterferon Alfa (Pegasys®)			✓
	Viraferon® (Hepatitis B)			✓
	Interferon alfa 2b (Viraferon & Intron A) 18 million IU. Solution For injection, multidose pen in Combination with ribavarin (Rebetol®) capsules 200mg			✓
	Peginterferon Solution for Injection (Plegridy®) **(Restricted Specialist Use)**			✓
	Dimethyl Fumarate (Tecfidera®)**(Restricted Specialist Use)**			✓
	Fingolimod (Gilenya®) **(Restricted Specialist Use)**			✓
	Glatiramer Acetate (Copaxone) **(Restricted Specialist Use)**			✓
	Mifamurtide			✓
	Lenalidomide (Revlimid®)			✓
	Pomalidomide			✓
	Thalidomide **(Restricted to Consultant Haematologist use only)**			✓
	Mifamurtide			✓
	Natalizumab **(Specialist Initiation)**			✓
	Teriflunomide (Aubagio®) **(Restricted Specialist Use)**			✓
	Others			
	BCG bladder instillation			✓
8.3	***Sex hormones and hormone antagonists in malignant disease***			
8.3.1	Oestrogens			
	Ethinylestradiol [Ethinyloestradiol]	⌖	⌖	✓
8.3.2	Progestogens			
	Medroxyprogesterone acetate	✓	✓	✓
	Megestrol acetate	✓	✓	✓
	Norethisterone	✓	✓	✓
8.3.4	Hormone antagonists			
	Tamoxifen	⌖	⌖	✓
	Abiraterone Acetate			✓
	Anastrozole			✓
	Degarelix	⌖	⌖	✓
	Histrelin	⌖	⌖	✓
	Letrozole	⌖	⌖	✓
	Cyproterone acetate	⌖	⌖	✓
	Enzalutamide (Xtandi®)	⌖	⌖	✓
	Flutamide	⌖	⌖	✓
	Bicalutamide	⌖	⌖	✓
	Goserelin	⌖	⌖	✓

Exemestane	⌖	⌖	✓
Leuprorelin (Prostap DCS®)	✓	✓	✓
Octreotide	⌖	⌖	✓
Pasireotide (Signifor®)	⌖	⌖	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
9	**Nutrition and Blood**			
9.1	***Anaemias and some other blood disorders***			
9.1.1	Iron-deficiency anaemias			
9.1.1.1	Oral Iron			
	Ferrous sulphate	✓	✓	✓
	Ferrous fumarate (Fersamal) **(1st Line)**	✓	✓	✓
	Pregaday®	⌖	⌖	✓
	For midwife initiation only			
	Ferrous gluconate	✓	✓	✓
	Sodium feredetate	✓	✓	✓
9.1.1.2	Parenteral Iron			
	Ferric Carboxymaltose			✓
	Iron Sucrose (Venofer®)			✓
9.1.2	Drugs used in megaloblastic anaemias			
	Folic Acid	✓	✓	✓
	Hydroxocobalamin	✓	✓	✓
Comment	Giving vitamin B12 without further investigation, due to macrocytic anaemia, can prevent subsequent accurate diagnosis. Intrinsic factor antibody test cannot be interpreted in the presence of high levels of high levels of B12 (serum B12 levels are not relevant after B12 has been given). If there is clinical suspicion of sub-acute combined degeneration, treatment should be initiated immediately after generous samples for analysis are taken. Refer to B12 and Folate:PracticalGuide			
9.1.3	Drugs used in hypoplastic, haemolytic, and renal anaemias			
	Darbepoetin alfa	⌖	⌖	✓
	Epoetin delta	⌖	⌖	✓
	Epoetin alfa	⌖	⌖	✓
	Epoetin beta	⌖	⌖	✓
	Epoetin zeta	⌖	⌖	✓
	Deferasirox	⌖	⌖	✓
Comment	Epoetin for renal unit/shared care use only.			
9.1.4	Drugs used in platelet disorders			
	Anagrelide Available in line with West of Scotland Cancer Network Protocols			
	Eltrombopag (Revolade)			✓
9.1.6	Drugs used in neutropenia			
	Filgrastim (restricted - haematology/oncology use only)			✓
9.1.7	Drugs used to mobilise stem cells			
	Plerixafor (Mozobil®) [for use upon Tertiary Recommendation]			✓
9.2	***Fluids and electrolytes***			
9.2.1	Oral preparations for fluid and electrolyte imbalance			
	Potassium chloride (Sando-K®, Kay-Cee-L syrup®)	✓	✓	✓
	Calcium polystyrene sulphonate (Calcium resonium®)			✓
	Sodium polystyrene sulphonate (Resonium A®)			✓
	Oral rehydration salts	✓	✓	✓
	Sodium bicarbonate	⌖	⌖	✓
9.2.2	Parenteral preparations for fluid and electrolyte imbalance			
9.2.2.1	Electrolytes and water			
	Sodium chloride		✓	✓
	Sodium chloride/glucose			✓
	Sodium chloride with Potassium		✓	✓

	Glucose		✓	✓
	Glucose with Potassium		✓	✓
	Potassium chloride strong solution			✓
	Sodium bicarbonate			✓
Chapter/Section/Drug		**Primary Care**		**Acute**
		CHPs	**Mental Health Specialties**	**Services**
9.2.2.2	Plasma and plasma substitutes			
	Volulyte®			✓
9.4	***Oral Nutrition***			
	Dietetic recommendation			
9.5	***Minerals***			
Comment	Refer to Hypomagnesaemia in Adults Guideline and Hypophosphataemia in Adults Guideline (Appendix 11).			
9.5.1	Calcium and magnesium			
	Sandocal®	✓	✓	✓
	Calcium-Sandoz® syrup	✓	✓	✓
	Calcium Gluconate Injection			✓
	Magnesium aspartate dehydrate (Magnaspartate®)	✓	✓	✓
	Magnesuim sulphate injection			✓
9.5.2	Phosphorus			
9.5.2.2	Phosphate binding agents			
	Aluminium hydroxide			✓
	Calcium Salts **(1st Line)**	✓	✓	✓
	Lanthanum	✓	✓	✓
	Sevelamer **(2nd Line)**	✓	✓	✓
9.5.4	Zinc			
	Zinc sulphate (Solvazinc®)			✓
9.6	***Vitamins***			
9.6.1	Vitamin A			
	Vitamins A and D	✓	✓	✓
	Vitamins A C and D	✓	✓	✓
9.6.2	Vitamin B			
	Thiamine (Vit B1)	✓	✓	✓
	Pyridoxine (Vit B6)	✓	✓	✓
	Nicotinamide	✓	✓	✓
	Vitamins B and C IV/HP (Pabrinex®)		✓	
9.6.3	Vitamin C			
	Ascorbic acid	✓	✓	✓
9.6.4	Vitamin D			
	Ergocalciferol (readily available as calcium and ergocalciferol)	✓	✓	✓
	Alfacalcidol	⌖	⌖	✓
	Calcium and colecalciferol (Adcal-D3® & Calfovit D3®)	✓	✓	✓
	Colecalciferol drops & solution (InVita D3®)	✓	✓	✓
Comment	Refer to Investigation and Treatment of Vitamin D Deficiency in Adults			
	Colecalciferol (800iu equiv. to 20 micrograms vitamin D^3)	✓	✓	✓
9.6.6	Vitamin K			
	Phytomenadione	✓	✓	✓
	Menadiol sodium phosphate	⌖		✓
	Konakion MM®	⌖		✓
	Konakion MM Paediatric®	✓		✓

9.6.7	Multivitamin preparations			
	Vitamin A, B group, C,and D (Abidec® & Dalivit®)	✓	✓	✓
	Forceval ®(+/-junior) Capsules	✓	✓	✓
	Vitamin Capsules BPC	✓	✓	✓
Chapter/Section/Drug		**Primary Care**		**Acute**
		CHPs	**Mental Health Specialties**	**Services**
9.8	***Metabolic disorders***			
9.8.1	Drugs used in matabolic disorders			
	Betaine anhydrous oral powder (Cystadane®) **(restricted use-specialist Initiation only)**	⌖	⌖	✓
10	**Musculoskeletal and joint diseases**			
10.1	***Drugs used in rheumatic diseases and gout***			
10.1.1	Non-steroidal anti-inflammatory drugs			
	Ibuprofen	✓	✓	✓
	Diclofenac sodium (not M/R product)	✓	✓	✓
	Diclofenac 75mg/2ml Sol'n for intravenous injection (Dyloject®) **(Restricted use for post operative pain)**			✓
	Naproxen	✓	✓	✓
	Celecoxib **(not 1st line)**	✓	✓	✓
	Etoricoxib (Alternative to Celecoxib)	✓	✓	✓
10.1.2	Corticosteroids			
	Triamcinolone hexacetanide	✓		✓
	Methylprednisolone acetate	✓		✓
	Hydrocortisone acetate	✓		✓
10.1.3	Drugs which suppress the rheumatic disease process			
	Sodium aurothiomalate	⌖	⌖	✓
	Penicillamine	⌖	⌖	✓
	Hydroxychloroquine sulphate	⌖	⌖	✓
	Cyclophosphamide	⌖	⌖	✓
	Azathioprine	⌖	⌖	✓
	Ciclosporin (Prescribe by brand)	⌖	⌖	✓
Comment	Due to differences in bioavailability ciclosporin brand should be specified.			
	Mycophenolate	Specialist recommendation by Rheumatology expert for SLE only		
	Methotrexate	⌖	⌖	✓
	Leflunomide	Rheumatology recommendation only		
	Abatacept	⌖	⌖	✓
	Adalimumab	Rheumatology recommendation only		
	Certolizumab	Rheumatology recommendation only		
	Etanercept	Rheumatology recommendation only		
	Golimumab	Rheumatology recommendation only		
	Infliximab	Rheumatology recommendation only		
	Rituximab	Rheumatology recommendation only		
	Ustekinumab (Stelara®)	Rheumatology recommendation only		
	Tocilizumab (RoActemra®)			✓
	Sulphasalazine (EC formulation)	⌖	⌖	✓
10.1.4	Drugs for treatment of gout			
	Colchicine (acute attack)	✓	✓	✓
Comment	Caution with course length/total dose of colchicine - refer to BNF.			
	Allopurinol (prophylaxis)	✓	✓	✓

Chapter/Section/Drug	Primary Care		Acute
	CHPs	Mental Health Specialties	Services
Febuxostat (Adenuric®) **(Restricted specialist initiation only)**	⌖	⌖	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
10.2	***Drugs used for neuromuscular disorders***			
10.2.1	Drugs which enhance neuromuscular transmission			
	Neostigmine	⌖	⌖	✓
	Distigmine (see section 7.4.1)	⌖	⌖	✓
	Edrophonium chloride	⌖	⌖	✓
	Pyridostigmine bromide	⌖	⌖	✓
10.2.2	Skeletal muscle relaxants			
	Baclofen	⌖	✓	✓
	Dantrolene	⌖	⌖	✓
	Diazepam (short term use)	✓	✓	✓
	Quinine Sulphate (300mg)	✓	⌖	✓
10.3	***Drugs for the relief of soft-tissue disorders and topical pain relief***			
10.3.1	Enzymes			
	Collagenase Clostridium Histolyticum (Xiapex®)			✓
	Hyaluronidase			✓
10.3.2	Rubefacients, topical NSAIDs, capsaicin and poultices			
	Ibuprofen	✓		
	Capsaicin	✓	⌖	✓
	Capsaicin Patch 8% (Qutenza®) – (Recommended by pain clinic only. Specialist training is required for application of patch)	⌖	⌖	✓
	Algesal®	✓		
11	**Eye**			
Comment	Optometrist **Independent Prescribers (IPs)** working in the Acute Services will be eligible to prescribe any item considered suitable for an ophthalmologist to prescriber			
11.3	***Anti-infective eye preparations***			
11.3.1	Antibacterials			
	Chloramphenicol	✓	✓	✓
Comment	Chloramphenicol eye drops are well tolerated and the recommendation that they should be avoided because of increased risk of aplastic anaemia is not well founded.			
	Fusidic acid	✓	✓	✓
	Gentamicin	✓	✓	✓
	Ofloxacin **(IPs)**	⌖	⌖	✓
	Levofloxacin (drops and preservative free)	⌖	⌖	✓
	Brolene® & Chlorhexidine (for acanthamoeba)	Ophthalmologist use only		
11.3.3	Antivirals			
	Aciclovir (on advice from secondary care) **(IPs)**	⌖	⌖	✓
11.4	***Corticosteroids and other anti-infalmmatory preparations***			
11.4.1	Corticosteroids			
Comment	Ophthalmologist recommendations - GPs should not initiate corticosteroids without advice.			
	Betamethasone (Betnesol® Drops & Oint, Betnesol-N® Drops) **(IPs)**	⌖	⌖	✓
	Dexamethasone (Maxidex® Drops & Maxitrol® Oint.) **(IPs)**	⌖	⌖	✓
	Dexamethasone Minims®) **(IPs)**	Ophthalmologist use only		
	Fluorometholone) **(IPs)**	Ophthalmologist use only		
	Prednisolone (Minims®) **(IPs)**	⌖	⌖	✓
	Prednisolone 0.1% & 0.03%) **(IPs)**	Ophthalmologist use only		
	Rimexolone **(IPs)**			✓

	Dexamethasone (Ozudrex®) **(IPs)**	Ophthalmologist use only

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
11.4.2	Other anti-inflammatory preparations			
	Olopatadine **(IPs)**	✓	✓	✓
	Antazoline (Otrivine-Antistin®)**(IPs)**	✓	✓	✓
Comment	Otrivine-Antistin® also contains the sympathomimetic xylometazoline. It should be avoided in angle-closure glaucoma.			
	Azelastine **(IPs)**	⌖	⌖	✓
	Lodoxamide **(IPs)**	⌖	⌖	✓
	Nedocromil (2nd line) **(IPs)**	✓	✓	✓
	Sodium Cromoglicate **(IPs)**	✓	✓	✓
11.5	***Mydriatics and cycloplegics***			
	Atropine 1% (Drops & Minims®)**(IPs)**	⌖	⌖	✓
	Cyclopentolate (Drops & Minims®)**(IPs)**	⌖	⌖	✓
	Tropicamide 1% (Drops & Minims®)**(IPs)**	✓	⌖	✓
	Phenylephrine (10% Drops, 2.5% & 10% Minims®) **(IPs)**	⌖	⌖	✓
11.6	***Treatment of glaucoma***			
Comment	Where clinically indicated preservative-free versions of all glaucoma eye drops should be available.			
	Pilocarpine	⌖	⌖	✓
	Brimonidine	⌖	⌖	✓
	Betaxolol	⌖	⌖	✓
	Timolol	✓	✓	✓
	Timolol 0.5% preservative free	✓	✓	✓
Comment	Please refer to CSM guidance on Beta-blocker use. Combination products can be prescribed where appropriate if both constituents are on the formulary.			
	Acetazolamide	⌖	⌖	✓
Comment	Acetazolamide can be initiated in Primary Care under ophthalmologist advice			
	Brinzolamide	⌖	⌖	✓
	Dorzolamide (drops & preservative free)	⌖	⌖	✓
	Bimatoprost	⌖	⌖	✓
	Latanoprost	⌖	⌖	✓
	Tafluprost (if proven sensitivity to benzalkonium chloride)	⌖	⌖	✓
	Travoprost	⌖	⌖	✓
11.7	***Local anaesthetics***			
	Proxymetacaine Minims® (less stinging than others)	✓		✓
	Lidocaine and Fluoresceine Minims®			✓
	Oxybupricaine Minims® **(IPs)**			✓
	Tetracaine [Amethocaine] 1% Minims® **(IPs)**			✓
	Cocaine10% paste			✓
	Cocaine 4% drops & 10% paste			✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
11.8	***Miscellaneous ophthalmic preparations***			
11.8.1	Tear deficiency, ocular lubricants and astringents			
	Acetylcysteine	⌖	⌖	✓
	Carbomer980(polyacrylic acid)0.2% **(1st Line)**	✓	✓	✓
	Carmellose sodium 0.5% (drops & p.f.)	✓	✓	✓
	Hydroxyethylcellulose	✓	✓	✓
Comment	Preservative free for use in patients with allergy to preservatives or patients receiving more than 4 doses of preservative per day.			
	Hydroxypropyl guar (drops & preservative free)	✓	✓	✓
	Hypromellose 0.3% (drops & preservative free)	✓	✓	✓
	Liquid paraffin	✓	✓	✓
	Sodium hyaluronate (0.1% & 0.2% drops and 0.2% preservative free)	✓	✓	✓
	Optive® Fusion	✓	✓	✓
11.8.2	Ocular diagnostic and peri-operative preparations and photodynamic treatment			
	Fluorescein sodium (Minims®)	✓	✓	✓
	Fluorescein sodium (Strips)	✓	✓	✓
	Acetylcholine	⌖	⌖	✓
	Apraclonidine(0.5% drops & 1% preservative free)	⌖	⌖	✓
	Diclofenac Sodium 0.1%	⌖	⌖	✓
	Flurbiprofen 0.3%	⌖	⌖	✓
	Flurbiprofen 0.3% and Penicillin 0.3% eye drops	⌖	⌖	✓
	Ketorolac 0.5%	⌖	⌖	✓
	Nepafenac	⌖	⌖	✓
	Aflibercept (Eylea®)			✓
	Ocriplasmin (Jetrea®)			✓
Comment	Severe corneal infection (keratitis) should be managed with ofloxacin initially pending microbiology sensitivities.			
	Cefuroxime 5% eye drops (severe keratitis)			✓
	Penicillin 0.3% eye drops (severe keratitis)			✓
	Gentamicin 1.5% eye drops (severe keratitis)			✓
	Natamycin (fungal keratitis)			✓
Comment	Severe intraocular infection (endophthalmitis) should be managed as per Royal College of Ophthalmologist guidelines and following discussion with the local Vitreoretinal unit. http://www.reophth.ac.uk/docs/scientific/IVTRevisionfinal2009.pdf http://www.mrcophth.com/focus1/endophthalmitis.html			
	Vancomycin (endophthalmitis)			✓
	Amikacin (endophthalmitis)			✓
	Ceftazidime (endophthalmitis)			✓
	Amphoteracin B (endophthalmitis)			✓
	Ranibizumab (Specialist Use Only according to SMC Restriction)			✓
	Others			
	Ciclosporin eye drops			✓
	Dexamethasone sodium injection preservative free			✓
	Disodium edetate (EDTA) 0.37% eye drops (corneal burns)			✓
	Fluorescein IV 20%			✓
	Hyaluronidase 1500 units			✓
	Hydroxyamphetamine eye drops (for pupil testing)			✓
	Potassium ascorbate (ascorbic acid 10%)			✓
	Povidone-iodine 5%			✓
	Trifluorothimidine eye drops (**2nd line** after Aciclovir)			✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
12	**Ear, Nose and Oropharynx**			
12.1	***Drugs acting on the ear***			
12.1.1	Otitis externa			
	Betamethasone sodium phosphate (Betnesol®)	✓	✓	✓
	Betnesol-N®	✓	✓	✓
	Flumetasone Pivalate (Locorten-Vioform®)	✓	✓	✓
	Gentisone HC®	✓	✓	✓
	Prednisolone (Predsol®)	✓	✓	✓
	Predsol-N®	✓	✓	✓
	Gentamicin (Genticin®, Garamycin®)	✓	✓	✓
	Triadcortyl-Otic®			✓
12.1.3	Removal of ear wax			
	Cerumol®	✓	✓	✓
	Sodium bicarbonate 5%	✓	✓	✓
12.2	***Drugs acting on the nose***			
12.2.1	Drugs used in nasal allergy			
	Azelastine Hydrochloride	✓	✓	✓
	Beclometasone Dipropionate **(1st Line)**	✓	✓	✓
	Betamethasone sodium phosphate	✓	✓	✓
	Budesonide	✓	✓	✓
	Fluticasone	✓	✓	✓
Comment	Avamys is the most cost-effective fluticasone–containing option for prohylaxis and treatment of allergic rhinitis. Flixonase Nasule 1st Line for nasal polyps			
	Mometasone Furoate (Nasonex®) **(2nd line)**	✓	✓	✓
	Sodium Cromoglicate	✓	✓	✓
12.2.2	Topical nasal decongestants			
	Ephedrine Hydrochloride (under 12 year olds)	✓	✓	✓
	Sodium Chloride 0.9% (for infants)	✓	✓	✓
	Xylometazoline Hydrochloride	✓	✓	✓
	Ipratropium Bromide (Rinatec®)	✓	✓	✓
12.2.3	Nasal preparations for infection and epistaxis			
	Mupirocin (Bactoban Nasal®)	✓	✓	✓
	Naseptin®	✓	✓	✓
12.3	***Drugs acting on the oropharynx***			
12.3.1	Drugs for oral ulceration and inflammation			
	Benzydamine Hydrochloride	✓	✓	✓
	Adcortyl in Orabase®	✓	✓	✓
	Hydrocortisone pellets (Corlan®)	✓	✓	✓
	Choline salicylate dental gel BP (Bonjela®, Teejel®)	✓	✓	✓
12.3.2	Orophanyngeal anti-infective drugs			
	Amphotericin	✓	✓	✓
	Miconazole	✓	✓	✓
	Nystatin **(1st Line)**	✓	✓	✓
12.3.3	Lozenges and sprays			
	Benzalkonium chloride (Bradosol®)	✓	✓	✓
12.3.4	Mouthwashes, gargles and dentifrices			
	Chlorhexidine gluconate	✓	✓	✓
	Povidone-Iodine	✓	✓	✓
	Thymol	✓	✓	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
12.3.5	Treatment of dry mouth			
	AS Saliva Orthana®	✓		
	Glandosane®	✓	✓	✓
	Oralbalance Gel®	✓	✓	✓
Comment	General Practitioners with special interest (GPSIs) are based in primary care but may prescribe or make recommendations on behalf of Acute Services			
13	**Skin**			
13.2	***Emollient and barrier preparations***			
Comment	Please refer to Forth Valley Dermatology Guidelines & Emollient guide: This guide is to aid in the choice of a FV formulary product			
13.2.1	Emollients			
Comment	Aveeno products are expensive and non-formulary			
	Emulsifying Ointment	✓	✓	✓
	White soft paraffin	✓	✓	✓
	50:50 Ointment (Liq paraffin/White soft paraffin)	✓	✓	✓
	Cetraben® – alternative for patients unable to use an oily product)	✓	✓	✓
	Dermamist	✓	✓	✓
	Dermacool (Menthol & Aqueous Cream)	✓	✓	✓
	Diprobase® cream	✓	✓	✓
	Doublebase®	✓	✓	✓
	Doublebase Dayleve Gel (only for patient undergoing UVB treatment)	✓	✓	✓
	Emollin	✓	✓	✓
Comment	Dermamist and Emollin are only for use in children whose skin cannot be touched and in adults who need to apply emollients to parts of their body which are difficult to reach			
	Epaderm®	✓	✓	✓
	Hydromol Ointment	✓	✓	✓
	Oilatum®	✓	✓	✓
	Ultrabase®	✓	✓	✓
	Oilatum®	✓	✓	✓
	Zerobase Cream	✓	✓	✓
	Zerocream Cream	✓	✓	✓
	Zeroderm Ointment	✓	✓	✓
Preparations containing urea (for exceptionally dry skin)				
	Balneum Plus® **(1st line)**	✓	✓	✓
	Calmurid® cream	✓	✓	✓
	Eucerin intensive lotion 10%	✓	✓	✓
Emollients with antibacterials				
	Dermol ®	✓	✓	✓
	Eczmol Cream	✓	✓	✓
	Oilatum plus	✓	✓	✓
13.2.2	Barrier preparations			
Comment	Barrier preparations are not appropriate for use in the treatment of eczema			
	Conotrane	✓	✓	✓
13.3	***Topical local anaesthetics and antipruritics***			
	Calamine oily lotion	✓	✓	✓
Comment	The oily lotion gives a more prolonged effect, but contains peanut oil.			
	Crotamiton (Eurax®)	✓		✓
	Doxepin Hydrochloride	⌖	⌖	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
13.4	***Topical corticosteroids***			
Mild	Hydrocortisone - cream/oint	✓	✓	✓
	Haelan ® Tape (Hospital initiation only)	✓	✓	✓
	Haelan® Cream (Hospital initiation only)			
Mild with	Timodine®	✓	✓	✓
Antimicro-bials	Fucidin H®	✓	✓	✓
	Nystaform-HC ® (peri-oral use)	⌖	⌖	✓
	Canesten HC®	✓	✓	✓
	Daktacort®	✓	✓	✓
Moderate	Eumovate® - cream/oint	✓	✓	✓
	Moderate with antimicrobials → Trimovate®	✓	✓	✓
Potent	Betnovate® - cream/oint	✓	✓	✓
	Diprosone® - cream/oint **(2nd line)**	✓	✓	✓
	Betacap®	⌖	⌖	✓
	Betamousse®	⌖	⌖	✓
	Synalar® gel - for scalp use	✓	✓	✓
	Elocon® (Once daily application)	✓	✓	✓
	Potent with antimicrobials →			
	Lotriderm ® **(2nd line)**	⌖	⌖	✓
	Fucibet®	✓	✓	✓
	Betamethasone and clioquinol	⌖	⌖	✓
Very Potent	Clobetasol Propionate	✓	✓	✓
	Clobetasol with neomycin & nystatin	⌖	⌖	✓
	Diprosalic® - oint/scalp application	✓	✓	✓
	Nerisone Forte® **(2nd line)**	⌖	⌖	✓
	Topical cortico-steroids with salicyclic acid Diprosalic ointment/scalp application	⌖	⌖	✓
13.5	***Preparations for eczema and psoriasis***			
Comment	Extemporaneous preparations of "nostrums" containing Ichthammol, Coal Tar or Salicylic acid are no longer "cheap" options. It is highly likely that these will require to be produced by a "Specials" manufacturer at very high cost (upwards of 10 times the expected cost).Therefore, if possible prescribe proprietary preparations which correspond closest to the formulation and strength required.			
13.5.1	Preparations for eczema			
	Ichthammol ointment	✓	⌖	✓
	Zinc paste and ichthammol bandage	⌖	⌖	✓
	Alitretinoin **(Restricted use consultant dermatologists only)**	⌖	⌖	✓
	Steripaste bandage (hospital initiation only)	⌖	⌖	✓
	Silk Clothing (hospital initiation only)	⌖	⌖	✓
	DermaSilk	⌖	⌖	✓
	DreamSkin	⌖	⌖	✓
13.5.2	Preparations for psoriasis			
	Salicylic acid (as part of extemporaneous preparation) (see comments above)	✓	✓	✓
	Calcipotriol	✓	✓	✓
	Dovobet®	✓	✓	✓
	Enstilar®	✓	✓	✓
	Calcitriol Ointment	✓	✓	✓
	Psoriderm	✓	✓	✓
Comment	Psoriderm has been added since Carbo-Dome and Alphosyl HC are no longer available			
	Exorex® - lotion **(2nd line)**	✓	✓	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
	Dithranol	✓	✓	✓
	Acitretin			✓
13.5.3	Drugs affecting the immune response			
	Ciclosporin	⌖	⌖	✓
	Methotrexate	⌖	⌖	✓
Comment	Ciclosporin and Methotrexate – Near patient testing under supervision of consultant dermatologist			
	Tacrolimus - ointment (**in accordance with SMC guidance)**	⌖	⌖	✓
	Adalimumab (Humira®)			✓
	Etanercept (Enbrel®)			✓
	Infliximab (Remicade®) **Restricted Advice, Follow SMC Advice**			✓
	Secukinumab (Cosentyx®)			✓
	Ustekinumab (Stelara®)			✓
	Apremilast (Otezla®)			✓
13.6	***Acne and rosacea***			
13.6.1	Topical preparations for acne			
	Benzoyl peroxide (Panoxyl®)	✓	✓	✓
	Benzoyl peroxide and clindamycin gel (Duac®)	✓	⌖	✓
	Azelaic acid **(2nd line)**	✓	⌖	✓
	Clindamycin	✓	⌖	✓
	Erythromycin (Topical)	□□□□✓	□□ ✓	□□□✓
	Zineryt® lotion	✓	✓	✓
	Adapalene (Differin®) (less irritant than tretinoin)	✓	✓	✓
	Adapalene, Benzoyl peroxide (Epiduo®)	✓	✓	✓
	Isotrex® gel **(1st line)**	✓	✓	✓
	Isotrexin® gel	✓	✓	✓
	Nicotinamide gel	✓	✓	✓
13.6.2	Oral preparations for acne			
	Isotretinoin (specialist use only)			✓
	Co-cyprindiol 2000/35	✓	✓	✓
13.6.3	Brimonidine (Mirvaso®)	✓	⌖	✓
	Invermectin (Soolantra®)	✓	⌖	✓
13.7	***Preparations for warts and callouses***			
	Salicylic acid (Salactol®, Occlusal®) *(Verrugon® - for plantar warts only)*	✓	✓	✓
	Podophyllotoxin - Cream & Solution (Warticon®)		⌖	✓
13.8	***Sunscreens and camouflagers***			
13.8.1	Sunscreen preparations			
	Sunsense® Ultra	✓	✓	✓
	SpectraBan®	✓	✓	✓
	Uvistat® SPF30	✓	✓	✓
	Diclofenac 3% in sodium hyaluronate gel (Solaraze®)	✓	✓	✓
	Fluorouracil 5% cream	✓	✓	✓
	Fluorouracil 0.5% / salicylic acid 10% cutaneous solution (Actikerall®)	⌖	⌖	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
	Imiquimod (Aldara)	✓	✓	✓
	Methly-5-aminolevulinate cream **(Hospital initiation only)**			✓
Comment	Imiquimod - Where surgery is not appropriate or in patients unresponsive to conventional therapy For information and guidelines on the treatment of actinic keratosis please refer to the Primary Care Dermatology Society website at the following link **http://www.pcds.org.uk/clinical-guidance/actinic-keratosis-syn.-solar-keratosis**			
	Ingenol mebutat 150 & 500mg gel	✓	✓	✓
13.8.2	Camouflagers			
Comment	Camouflagers are prescribable for postoperative scars, other deformities, and as an adjunctive therapy for emotional disturbances due to disfiguring skin disease e.g. vitiligo. Prescriptions should be endorsed as "ACBS"			
13.9	***Shampoos and other scalp preparations***			
	Capasal®	✓	✓	✓
	Dermax®	✓	✓	✓
	Ketoconazole shampoo (Nizoral®)	✓	✓	✓
	Polytar®	✓	✓	✓
	Sebco®	✓	✓	✓
	T/Gel®	✓	✓	✓
	Hirsutism			
	Eflornithine 11.5% **(Restriced to SMC Advice)**	✓	✓	✓
13.10	***Anti-infective skin preparations***			
13.10.1	Antibacterial preparations			
	Mupirocin (Bactroban®)- restrict for MRSA	✓	✓	✓
	Silver sulfadiazine (for burns)	✓	✓	✓
	Fusidic acid	✓	✓	✓
	Metronidazole	✓	✓	✓
13.10.2	Antifungal preparations			
	Amorolfine (for fungal nail infections)	✓	✓	✓
	Clotrimazole	✓	✓	✓
	Ketoconazole cream (Nizoral®)	✓	✓	✓
Comment	Nizoral® cream is only prescribable for seborrhoeic dermatitis and pityriasis versicolor and must be endorsed "SLS".			
	Miconazole Nitrate	✓	✓	✓
	Terbinafine	✓	✓	✓
	Tioconazole	✓	✓	✓
13.10.3	Antiviral preparations			
	Aciclovir	✓	✓	✓
13.10.4	Paracitical preparations			
	Dimeticone Lotion (Hedrin®)	✓	✓	✓
	Malathion (Derbac M®)	✓	✓	✓
	Lyclear® Dermal Cream	✓	✓	✓
Comment	Refer to Forth Valley Headlice Policy			
13.10.5	Preparations for minor cuts and abrasions			
	Histoacryl®	✓	✓	✓
13.11	***Skin cleansers, antiseptics, and desloughing agents***			
13.11.1	Alcohols and saline			
	Industrial Methylated Spirit	✓	✓	✓
	Sodium Chloride 0.9%	✓	✓	✓
13.11.2	Chlorhexidine salts			
	Chlorhexidine	✓	✓	✓
13.11.4	Chlorine and iodine			
	Povidone-iodine	✓	✓	✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
13.11.5	Phenolics			
	Triclosan		✓	✓
13.11.6	Oxidisers and dyes			
	Crystacide® **(Only for use if resistance develops)**	✓	✓	✓
	Potassium permanganate	✓	✓	✓
13.12	***Antiperspirants***			
	Aluminium Salts	✓		

14	Immunological products and vaccines			
Comment	Refer to Forth Valley Vaccine Handling Guidelines These include a down-loadable temperature recording chart for refrigerators			
14.4	***Vaccines and antisera***			
	BCG vaccines intradermal			✓
	Tuberculin PPD RT 23 SSI 2T.U/0.1ml Solution for Injection			✓
	Tuberculin PPD RT 23 SSI 10T.U/0.1ml Soution for Injection			✓
	Oral Cholera Vaccine	✓		✓
	Diphtheria, Tetanus, Pertussis, Polio, Hib (Pediacel)	✓		✓
	Diphtheria, Tetanus, Pertussis Polio (Repevax®, Infanrix IPV®)	✓		✓
	Menitorix® (combined Hib & MenC)	✓		✓
	Hepatitis A vaccine	✓		
	Hepatitis A/B vaccine (Twinrix®)	✓		
	Hepatitis A and Typhoid vaccine	✓		
	Hepatitis B vaccine	✓		✓
	Human Papilloma Virus Vaccine (Gardasil®, Cervarix®)	✓		✓
Comment	Gardasil® first line unless completing a course already started with Cervarix®			
	Influenza vaccine	✓	✓	✓
	MMR vaccine	✓		✓
	Meningococcal Group C Conjugate Vaccine	✓		
	Meningococcal Polysaccharide A, C, W135 and Y vaccine	✓		
	Meningococcal group A,C,W,135 and Y Conjugate vaccine	✓		
	Pneumococcal Polysaccharide (23-valent) Vaccine	✓	✓	✓
	Pneumococcal Polysaccharide (13-valent) Conjugated Vaccine (Prevenar13)	✓	✓	✓
	Rabies vaccine	✓		
	Diphtheria (low dose), Tetanus and Inactivated Poliomyelitis Vaccine (Revaxis®)	✓	✓	✓
	Typhoid vaccine	✓		
	Yellow Fever vaccine	✓		
	Varicella – zoster vaccine	✓		
	Botulinum A Toxin (Haemagglutanin complex see BNF section 4.9.3)			✓
14.5	***Immunoglobulins***			
	Please contact the Consultant Haematologist			

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
15	**Anaesthesia**			
15.1	***General anaesthesia***			
15.1.1	Intravenous anaesthetics			
	Thiopental Sodium			✓
	Etomidate			✓
	Ketamine			✓
	Propofol		✓	✓
15.1.2	Inhalational anaesthetics			
	Desflurane			✓
	Enflurane			✓
	Halothane			✓
	Isoflurane			✓
	Sevoflurane			✓
	Nitrous oxide			✓
	Entonox®/Equanox®			✓
	Oxygen (refer to section 3.6)			✓
15.1.3	Antimuscarinic drugs			
	Atropine sulphate			✓
	Glycopyronium bromide			✓
15.1.4	Sedative and analgesic peri-operative drugs			
15.1.4.1	Anxiolytics and neuroleptics			
	Diazepam			✓
	Midazolam			✓
	Temazepam			✓
	Alimemazine [Trimeprazine] (see section 3.4.1)			✓
15.1.4.2	Non-opioid analgesics			
	Diclofenac (See section 10.1)			✓
	Ibuprofen (See section 10.1)			✓
	Tenoxicam Injection (See section 10.1)			✓
	Co-codamol (see section 4.7.1)			✓
15.1.4.3	Opioid analgesic			
	Alfentanil			✓
	Fentanyl			✓
	Remifentanil			✓
15.1.4.4	Other drugs for sedation			
	Dexmedetomidine (Dexdor®)			✓
15.1.5	Muscle relaxants			
	Atracurium besilate			✓
	Cisatracurium			✓
	Mivacurium			✓
	Rocuronium bromide			✓
	Vercuronium bromide			✓
	Suxamethonium chloride			✓
15.1.6	Anticholinesterases used in anaesthesia			
	Edrophonium chloride			✓
	Neostigmine metilsulfate			✓
	Robinul-Neostigmine®			✓
	Sugammadex			✓
15.1.7	Antagonists for central and respiratory depression			
	Doxapram hydrochloride			✓
	Flumazenil			✓
	Naloxone hydrochloride			✓
15.1.8	Drugs for malignant hyperthermia			
	Dantrolene sodium			✓

Chapter/Section/Drug		Primary Care		Acute
		CHPs	Mental Health Specialties	Services
15.2	***Local anaesthesia***			
	Lidocaine [Lignocaine] HCl			✓
	Lidocaine [Lignocaine] and Epinephrine [Adrenaline]	✓		✓
	Lidocaine [Lignocaine] and Prilocaine (Emla®)	✓		✓
	Bupivacaine HCl			✓
	Bupivacaine and Glucose			✓
	Bupivacaine and Epinephrine [Adrenaline]			✓
	Bupivacaine and Fentanyl			✓
	Levobupivacaine			✓
	Prilocaine HCl			✓
	Ropivacaine HCl			✓
	Tetracaine [Amethocaine]			✓

Appendices

Pharmacy Services

Guidance on Issuing Steroid Cards

This advice has been produced by the Forth Valley Airways Group

Inhaled Steroids

Steroid Cards should be issued to the following patients[1,2,3]

	Inhaled Steroid	Threshold Dose (per day)
Adults	Beclometasone	Dose > 1000mcg[4]
	Budesonide	Dose > 800mcg[4]
	Fluticasone	Dose > 500mcg[4]
	Mometasone *(Non – Formulary)*	Dose > 800mcg[4]
	Ciclesonide *(Non – Formulary)*	Dose > 320mcg[4] **Unlicensed dose**

Children	Beclometasone	Dose > 400mcg[1] (age not stated)
	Budesonide	Dose > 800mcg[1] (12 years and under)
	Fluticasone	Dose > 400mcg[1] (4-16 years)
	Mometasone *(Non – Formulary)*	Dose > 800mcg[1] (12-16 years)
	Ciclesonide *(Non – Formulary)*	Dose > 320mcg[4] (12-16 years) **Unlicensed dose**

Systemic Steroids

Steroid Cards should be issued to the following patients[1,2,3]

Adults

- Receiving repeated courses, 2-3 courses per year (particularly if taken for longer than 3 weeks)
- Taking a short course within 1 year of stopping long-term therapy
- Receiving more than 40mg prednisolone daily (or equivalent)
- Receiving repeated doses in the evening
- Receiving more than 3 weeks treatment
- Patients with other possible causes of adrenal suppression

Children

- As above except[5]:
  - Receiving more than 20mg prednisolone daily for children < 5 years
  - Receiving more than 30mg prednisolone daily for children > 5 years

These patients are at risk of disease relapse and/or hypoadrenalism if treatment is withdrawn rapidly[2]

Chemotherapy Patients – Acute Pharmacy Services

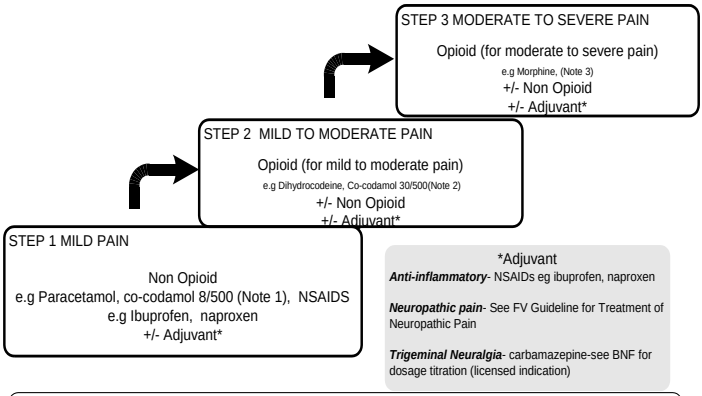
Pharmacists providing clinical check on chemotherapy prescriptions will endorse any prescription that requires a steroid card to be given

References:*1. CSM. Current problem in pharmacovigilance. May 2006; 31:5 2. Scottish Executive. Steroid treatment cards. SEHD/CMO (2006) 10. 26th July 2006 3. BNF 52. BMJ/RPS. September 2006 4. GINA Guideline 2006 5. Personal correspondance. Dr. McFadyen. Consultant Paediatrician. Stirling Royal Infirmary. 27.10.2006. Lead Pharmacsit Clare Colligan* ***Review August 2014***

Appendix 2

The Use of Oral Analgesics for Pain in Primary Care

The World Health Organisation's three-step analgesic ladder for cancer pain (see below) may also be used for non-malignant chronic or acute nociceptive pain. Analgesics should be started at the 'step' most appropriate to the patient's level of pain. Decision on analgesic choice depends on the type of pain, patient factors and supporting clinical evidence. For pain that is present constantly, analgesia should be prescribed regularly and not on an "as required" basis. For more detailed guidance on the management of chronic non malignant pain, please refer to **West of Scotland Chronic Non Malignant Pain Opioid Prescribing Guideline**



NOTE 1:
Compound analgesics containing a low dose of opioid (e.g 8mg of codeine phosphate per tablet) are commonly used, but the advantages have not been substantiated. Effervescent preparations of compound analgesics may contain high levels of sodium. For patients requiring low sodium intake please refer to individual Summary of Product Characteristics.

NOTE 2:
Prescribe regular laxatives when opioids are being taken regularly

NOTE 3 : Advice regarding strong opioids
Distinguish between malignant and non malignant chronic pain and refer to guideline as appropriate. In non malignant chronic pain max recommended morphine equivalent dose is 60mg bd (or fentanyl 25mcg patch) before considering pain clinic referal. Avoid short acting opioids for breakthrough in non malignant chronic pain.
Malignant
Use oral route first, start with normal release oral morphine eg 5-10mg every 4 hours and as required for breakthrough pain.
A 2.5mg dose may be enough in the elderly or those with renal impairment. Consider alternative opioids ony if experiencing side effects to morphine or can no longer manage oral route
Every patient on regular opioid should have access to breakthrough analgesia (equivalent to 1/6th total dose oral morphine).
Start regular laxative and prophylactic ant-emetic as required for 7-10 days

NOTE 4: Consider self help booklets and pain assessment tools in non malignant pain.
e.g. PADT (http://www.healthinsight.org/Internal/assets/SMART/PADT.pdf) , NRS, VAS and opioid risk tools..

Date of Approval	August 2013
Review Date	August 2014
References	BNF March 2013, Relief of Pain and Related Symptoms – The Role of Drug Therapy - Scottish Partnership Agency

Pharmacist Lead: Moira Baillie

Appendix 2

General Advice on Pain Management in Non Malignant Chronic Pain

Accurate assessment should be undertaken to determine the cause, type and severity of pain and effect on patient (anxiety/depression, neuropathic, mechanical, psychosocial).

Non-pharmacological interventions
Consideration should be given **at all stages** to utilising non-pharmacological interventions eg TENS, acupuncture, physiotherapy, weight loss, exercise, stress management counselling, pain management programmes, Pain Association Scotland and self management booklets available in practices.

1. **Optimise non-opioid (ie paracetamol and/or NSAID) or opioid treatment**
    - Titrate doses to achieve optimal balance between analgesic benefit, side effects and functional improvement
    - For continuous pain, ensure maximum **tolerated** dose is prescribed on a regular basis, by the clock, not 'prn'.
2. **Add in adjuvant**
    - Consider adjuvant drugs (any drug that has a primary indication other than for pain management but is analgesic in some painful conditions) and choose the class of drug according to **your assessment** of type of pain (see shaded box on the WHO analgesic ladder)[(1)].
    - Adjuvants can provide greater pain relief and less toxicity with lower doses of each drug given. **Start low and go slow (for TCA's and anticonvulsants)**
    - Topical NSAIDs are recommended for short term usage (up to 6 weeks) for small joint pain – wrist, elbow, knees and ankles [(2)]
3. **Give adequate length of trial**
    - neuropathic / inflammatory pain – 2-4 weeks to take effect and continue for 8 weeks, if tolerated, then assess
    - non-opioid / opioid – 1 month at regular, maximal doses
4. **Assess regularly using PADT or Numerical Rating Scale (ask the patient to rate their pain on a score of 1 to 10) or Visual Analogue Scale and consider stop if 30% improvement and / or significant improvement in functional ability is not achieved.**
5. If pain treatment effective, **consider withdrawal of treatment after significant improvement every 6 months** with careful review [(3)]
6. If pain management still uncontrolled, **refer to pain clinic or if non malignant pain if no/little pain relief on equivalent daily dose morphine 60mg bd**

Appendix 2

Tramadol in Non Malignant Pain

If co-codamol 30/500 + adjuvant drug therapies are ineffective or side-effects are not tolerated, tramadol could be considered. Tramadol should **not be co-prescribed with co-codamol** and should **not be considered as first line therapy.**

Tramadol is licensed for moderate to severe pain and is approximately twice as potent as codeine[3]. It is promoted as between WHO step 2 analgesics for moderate pain (eg codeine) and WHO step 3 analgesics (morphine). Hallucinations, confusion and convulsions as well as drug dependence, abuse and withdrawal are reported at therapeutic doses. There is some evidence for Tramadol in the treatment of neuropathic pain.
Consultation is out whether to re classify as a schedule 3.

Ref

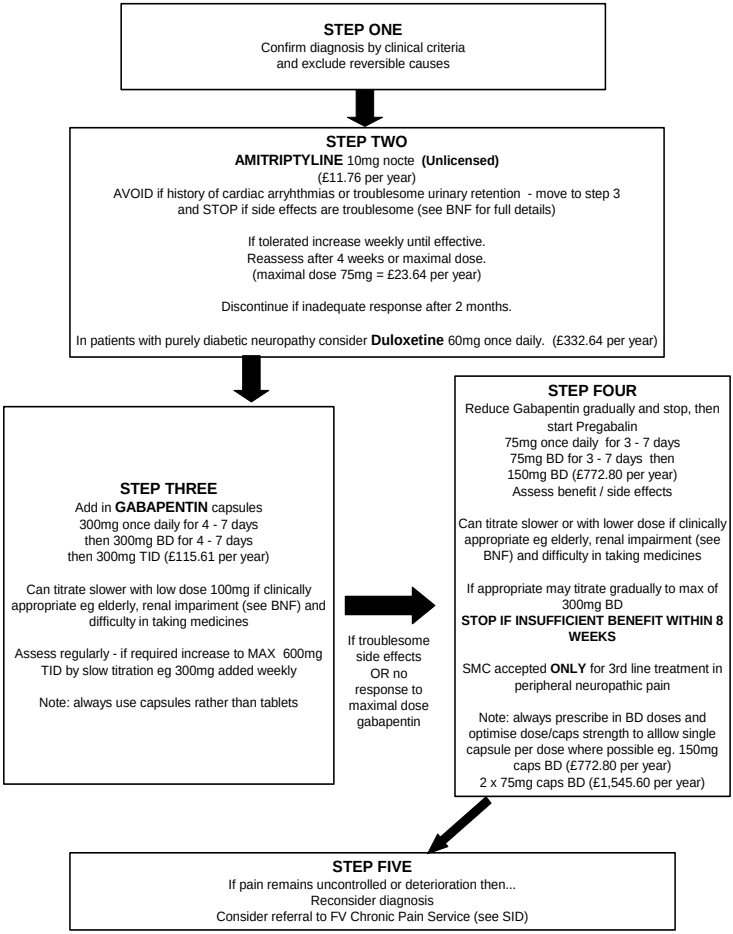
1.SIGN 106. Control of pain in adults with cancer November 2008
2.NICE Osteorthritis February 2008
3. MeReC Briefing. Issue 22, 2003.The use of strong opioids in palliative care
4. Cochrane Database Systematic Review 2006 July 19; (3):CD003726

Appendix 3

*Forth Valley Guideline for Treatment of Neuropathic Pain**

Forth Valley Guideline for Treatment of Neuropathic Pain*

This guidance EXCLUDES Trigeminal Neuralgia (use Carbamazepine first line)



Neuropathic pain* - Pain caused by a lesion or disease of the somatosensory nervous system

(International Association for the Study of Pain July 2011) Ref. BNF, NICE, SIGN 116, prices based on MIMS Novemeber 2011 and Scottish Drug Tariff November 2011 Version 4 30/11/11

Acute Services
Phenytoin Loading Guidelines For Status Epilepticus

Parenteral Phenytoin is an antiepileptic used for the control of status epilepticus and seizures due to head trauma. **These guidelines apply to adults only**.

Drug Presentation:
Phenytoin is available as a 50mg/ml (250mg/5ml) injection. If the injection or infusion has precipitated or is hazy it should be discarded.

- Continuous ECG monitoring is mandatory when administering this drug.
- For administration on designated areas only - A&E, Intensive Care areas, Acute Admissions Unit.

Status Epilepticus-Loading Dose
1. For patients not previously receiving phenytoin **:** 18mg/kg

Preparation:
Dilute with sodium chloride 0.9% to a maximum concentration of 10mg/ml e.g. 1000mg in 100ml.

The solution must be given immediately.

Administration:
DO NOT ADMINISTER INTRAMUSCULARLY

Intravenous Bolus:
Rate should **NOT** exceed 50mg/min (e.g. 20 minutes for a 1000mg dose). Administer into a large vein via a large gauge needle or IV catheter.

Intravenous Infusion:
Rate should NOT exceed 50mg/min. The infusion must be completed within one hour. Administer via an in-line filter (0.22-0.5micron) which is available on the ward. Sterile saline should be administered prior to and following phenytoin administration through the same access site to avoid local irritation and to ensure adequate venous flow.

Important Side-effects:
CNS and cardiac depression, hypotension, local tissue irritation, arrhythmias. Cardiac resuscitation equipment should be available.

Monitoring:
ECG, blood pressure, signs of respiratory depression.
Blood levels should only be taken if the patient shows signs of toxicity or is uncontrolled. This should be taken immediately prior to the next dose and levels of 10-20mg/litre aimed for.

References:
1. British National Formulary
2. Manufacturers Datasheet Compendium 2010.
3. Handbook of Clinical Drug Data, 8th Edition, 1997-98.
4. A Thomson, Clinical Pharmacokinetics Unit, Glasgow, November 1995

Acute Services
Phenytoin Guidelines For Maintenance therapy

Maintenance Dose : 5mg/kg/day (IV or oral as appropriate)

Monitoring Concentrations

Target Range : 10 – 20 mg/L

Sampling Time : predose not critical
Ideally samples should be taken after at least 5 days of maintenance therapy but may be taken earlier if toxicity is suspected or if a patient fails to respond. Steady state may not be reached until 2-3 weeks treatment at a constant dose.

Dose Adjustment
The relationship between phenytoin dose and steady state concentration is non-linear i.e. when the dose is doubled the concentration will increase disproportionately. The following guidelines may be useful if a dosage adjustment is clinically indicated.

Concentration (mg/L)	Dose	Dose Increase
<5	<4mg/kg/day	100mg
<5	4.5-6.0mg/kg/day	check compliance
5 - 10	4.5-6.0mg/kg/day	50mg
5 - 10	>6mg /kg/day	check compliance
>10		25mg

Phenytoin Formulations
Phenytoin sodium 100mg capsules/tablets/ injection = phenytoin suspension 90mg in 15ml

Factors Affecting Phenytoin Concentrations

Protein Binding Binding can be reduced in renal impairment, hypoalbuminaemia and pregnancy. This affects the interpretation of concentration measurements.

The following equation can be used to correct the total phenytoin concentration for low albumin:

$$\text{Corrected concentration} = \frac{\text{Concentration observed}}{(0.9 \times \text{albumin concentration} / 44\ \text{g/L}) + 0.1}$$

Drug Interactions
Phenytoin concentrations can be increased or decreased by other drugs. Check the current BNF for details.

References:
1. British National Formulary
2. Manufacturers Medicines Compendium 2010.
3.A Thomson, Clinical Pharmacokinetics Unit, Glasgow, November 1995

Pharmacist Lead : C. Monaghan

Therapeutic Drug Monitoring Guidelines

DRUGS				
Drug	**Time to steady state**	**Ideal Sampling time**	**Target range**	**Comments**
Carbamazepine	2-3 weeks (new therapy) 2-4 days (dose change)	Pre dose (not critical)	4 – 12 mg/L	Metabolised by the liver, autoinduction See BNF for interactions
Digoxin	7-10 days (depends on renal function)	> 6 hours post dose	0.5 – 2.0μg/L	Mainly renal excretion See BNF for interactions
Lithium	5-7 days	12 hours post dose	0.4-1.0 mmol/L	Renal excretion
Phenytoin	2-3 weeks	Pre dose (not critical)	10-20 mg/L	Metabolised in liver. Non linear increase in conc with dose.
Theophylline	2-3 days	8-12 hours post dose	10-20 mg/L	Metabolised in the liver.
Valproic acid	3 days	Pre dose	40-100 mg/L	Metabolised in the liver. Levels do not correlate well with therapeutic effect

Genito-Urinary Medicine List

The following products are not included in the Formulary but are available for restricted use by GUM Clinics:-

Antimicrobials

Erythromycin capsules
Procaine Benzylpenicillin[Procaine penicillin] injection (UNLICENSED PRODUCT)
Spectinomycin injection (UNLICENSED PRODUCT)
Benzathine penicillin (UNLICENSED PRODUCT)

Antiretrovirals

Nucleoside Reverse Transcriptase Inhibitors (NRTIs)
Abacavir
Didanosine
Emtricitabine
Lamivudine
Stavudine
Tenofovir
Zidovudine

Combined NRTIs
Elvitegravir + cobicistat + emtricitabine + tenofovir (Stribild®)
Elvitegravir + cobicistat + emtricitabine + tenofovir (Genvoya®)
Emtricitabine/Tenofovir (Truvada®)
Abacavir / Lamivudine (Kivexa®)
Abacavir / Lamivudine / Zidovudine (Trizivir®)
Lamivudine / Zidovudine (Combivir®)
Atazanavir / cobicistat 300mg/150mg (Evotaz®)

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)
Efavirenz
Etravirine
Nevirapine
Rilpivirine (Edurant®)

NRTI & NNRTI Combination Product
Efavirenz/emtricitabine/tenofovir (Atripla®)
Emtricitabine/Tenofovir/Rilpivirine (Eviplera®)
Emtricitabine/Tenofovir/Alafenamide (Descovy®)
Rilpivirine/emtricitabine/tenofovir alafenamide (Odefsey®)

Protease Inhibitors (PIs)
Atazanavir
Fosamprenavir
Lopinavir / Ritonavir (Kaletra®)
Ritonavir
Saquinavir
Tipranavir
Darunavir
Darunavir 800mg, cobicistat 150mg f/c tablets (Rezolsta®)

Other Antiretrovirals
Raltegravir (As per SMC Guidance)
Maraviroc
Dolutegravir (Tivicay®)

Topical preparations

Clindamycin 2% cream, Econazole 1% cream, Imiquimod 5% cream
Unguentum M cream

Recommendations for Blood Glucose Monitoring

Type 1 diabetes

All patients with Type 1 diabetes need to be able to self-monitor blood glucose – the extent to which they do this will reflect how useful they find the information it. Driving legislation states that patients with type 1 diabetes should test before driving every time, and every 2 hours during long car journeys.

Type 2 diabetes

Patients on insulin or sulphonylurea medication are at risk of hypoglycaemia and should be able to monitor blood glucose to identify this. The driving rules also apply to patients with type 2 diabetes who use insulin.
Patients who combine nocturnal insulin with oral hypoglycaemic agents will need to test fasting blood glucose in order to dose-titrate.
Some patients who manage their diabetes with diet or on metformin and are therefore not at risk of hypoglycaemia, will nonetheless find it helpful to be able to test their blood glucose periodically, e.g. to confirm a stable level of glycaemic control or during a period of ill-health. Those who periodically are treated with steroids may find it useful to be able to test at these times – some patients use sulphonylureas or even insulin during a course of prednisolone, reverting to diet alone afterwards.
If there is a suspicion that a patient with Type 2 diabetes is likely to become insulin-requiring it is prudent to ensure they are able to blood glucose monitor.

However in patients at no risk of hypoglycaemia who would not gain any benefit from self blood-glucose monitoring, regular HbA1c checks is an acceptable way of assessing glycaemic control.

Target blood glucose levels

Target blood glucose levels should be individualised.
Textbook values would be 4-7 mmols fasting, 7-8 mmols pre-meals and less than 9 mmols post-prandially. However, whilst we recognise an HbA1c < 48mmol/mol greatly reduces the risk of microvascular complications, it increases the risk of hypoglycaemia. Those with a short life expectancy, impaired awareness of hypoglycaemia, mobility or visual problems may benefit from a higher target blood glucose range. Furthermore introduction of very tight glycaemic control may increase morbidity and mortality in those at risk of ischemic heart disease.

Lead Dr. Alison MacKenzie /Dr. Linda Buchanan

Appendix 8

Blood Glucose Meter Recommendations

BLOOD GLUCOSE METER RECOMMENDATIONS
Forth Valley Diabetes Specialist Group Review Date October 2016

TYPE 2 DIABETES METERS		
Meter Name	TRUEyou®	GlucoRx Nexus®
Manufacturer	Nipro Diagnostics (UK) Ltd	GlucoRx
Strip Name	TRUEyou®	GlucoRx Nexus®
Cost of Strips	£9.92 (50)	£9.95(50) PIP Code 355-2726
Careline	Customer Service 0800 0858808	Customer Service 0800 0075892

FreeStyle Libre Flash Glucose Monitoring – Initiation will be controlled b the specialist diabetes team in line with Scottish Guidance.

There are no meter restrictions for patients with Type 1 Diabetes.

Date of next review: October 2018

Appendix 9

FORTH VALLEY ACUTE HOSPITALS
PRESCRIBING GUIDELINES PHARMACY DEPARTMENT

HYPOPHOSPHATAEMIA in ADULTS

Risk factors for hypophosphataemia include critical illness, a period of starvation prior to nutritional support, malnutrition, alcoholism, and respiratory alkalosis.

Phosphate supplementation should be considered where there is evidence of phosphate deficiency. Serum phosphate does not always correlate to total body stores as most phosphate is stored intracellularly. The onset and severity of symptoms will determine the need for and type of treatment

Drug Presentation:

Addiphos® 20ml vial containing : phosphate 40 mmol (2mmol phosphate /ml)
potassium 30 mmol
and sodium 30 mmol

No other drugs should be added to a phosphate infusion.

No other drugs should be co administered at a Y site with phosphate.

Caution should be used if the patient has renal impairment.

Mild to moderate deficiency : usually associated with levels of 0.3-0.6mmol/l and is usually asymptomatic

Severe deficiency: usually associated with levels less than 0.3mmol/l, especially if symptomatic.

Drugs and Administration

INTRAVENOUS:

In acute deficiency, or when a clinical difference to serum phosphate needs to be assured quickly.

- 20mmols phosphate (10mls Addiphos) over 6 hours in 100mls 0.9% N Saline through a central line, or 20mmols phosphate (10mls Addiphos) in 500mls 0.9% N Saline over 12 hours through a peripheral line.
- In cases where the hypophosphataemia is symptomatic, or if prolonged phosphate wastage has occurred, then the dosage may be repeated within 12 hours and a level obtained several hours after the end of the infusion

Oral – see notes on diarrhoea before contemplating oral replacement

- 1-2 Phosphate Sandoz ® tablets (see BNF) three times a day (provides 48 - 96mmol phosphate, 60-120mmol sodium and 9-18mmol potassium per day)
- Continued therapy may be required depending on clinical response/adverse effects.
- Oral phosphate is slow to effect and should be used in slow-losers of phosphate only, and not when a rapid response is required.

Appendix 9

Important side effects[2]

Hyperphosphataemia	Symptoms may be those of resultant hypocalcaemia namely, muscle cramps, tetany and convulsion and metastatic calcification.
Hyperkalaemia and Hypernatraemia	As a result of infusion of these elements along with phosphate
Hyperphosphataemia Hypotension Hypocalcaemia	High dose rapid infusions of phosphate. Excessive doses of phosphates may cause hypocalcaemia and metastatic calcification; it is **essential** to monitor closely plasma concentrations of calcium, phosphate, potassium and other electrolytes. Treatment of adverse effects involves withdrawal of phosphate infusion, general supportive measures and correction of serum electrolyte concentrations, especially calcium.
Diarrhoea with oral therapy	Oral phosphate is poorly absorbed from the gut and may cause diarrhoea, with the potential to exacerbate losses of Magnesium, Sodium, Potassium and water. .

Precautions

In renal impairment, Addisons disease and where restricted sodium or potassium intake is required e.g.. cardiac failure, hypertension, hyperkalaemia, severe oedema. Care should be taken when replacing phosphate to minimise electrolyte disturbances and the biochemist should be contacted for advice.

Monitoring

Blood pressure monitoring is advised
Calcium, magnesium, phosphate, potassium and other electrolyte monitoring is essential. Phosphate levels should be checked at least 6 hours after the end of the infusion[3]

Acknowledgements

Jane Sillars Senior Dietitian
Mark Holliday Consultant Biochemist

References June 2012-

1. Walmsley RN, Guerin MD. Disorders of fluid and electrolyte balance. Bristol 1984. Wright publishing
2. Thatte L, Oster J et al. Review of literature: Severe Hyperphosphataemia. Am J Med Sciences 1995; 310(4):167-174
3. Bugg NC, Jones A Hypophosphataemia. Anaesthesia 1998;53:895-902

Note: June 2012 This guideline is currently under review

Pharmacist Lead: Peter Buckner

Appendix 10

Emollient guide: This guide is to aid in the choice of a FV formulary product.

(3:1 products can be used as bath additive, soap substitutes and as 'leave on' emollients)

VERY GREASY OINTMENT
Liquid and White Soft Paraffin Ointment
White soft paraffin
GREASY OINTMENT
Zeroderm ointment (3:1)
Hydromol ointment (3:1
Epaderm ointment (3:1)
Emulsifying ointment BP
Dermamist spray*
Emollin (liquid paraffin 50%, white soft paraffin 50%) spray*
GEL
Doublebase gel
Doublebase Dayleve gel – only for patients undergoing UVB treatment
CREAM
Zerobase cream
Ultrabase cream
Epaderm cream
Diprobase cream
Cetraben cream
Oilatum cream
CREAM WITH ANTIBACTERIALS
Dermol cream
Eczmol cream
CREAM WITH UREA (FOR EXCEPTIONALLY DRY SKIN)
Balneum plus (urea 5%)
Calmurid (urea 10%)
LIGHT CREAM
Zerocream (same as E45)
Dermol 500 lotion (with antimicrobial)
Eucerin intensive lotion (with urea 10%)
EMOLLIENT BATH AND SHOWER PREPS WITH ANTIMICROBIALS
Dermol 600 bath emollient
Oilatum plus
* Dermamist and Emollin are only for use in children whose skin cannot be touched and in adults who need to apply emollients to parts of their body which are difficult to reach.

Appendix 11 **FURTHER GUIDANCE ON ORAL HYPOGLYCAEMIC AGENTS ON FORTH VALLEY FORMULARY**

This appendix provides detailed guidance on the formulary choices for oral hypoglycaemic agents. The drug classes are colour coded, with the place in therapy of each drug within that group highlighted. Please refer to the FV diabetes management guidelines available on the intranet for the place in therapy for each class

DRUG	CLASS	PLACE IN THERAPY	DOSE	DOSE CHANGES	CAUTIONS/CONTRAINDICATIONS
METFORMIN	BIGUANIDE	FIRST LINE CAN BE COMBINED WITH ALL ORAL AND INJECTABLE HYPOGLYCAEMIC AGENTS	INITIALLY 500MG DAILY INCREASING TO 2 GRAMS DAILY	STOP IF eGFR <30	• TAKE WITH FOOD • CHANGE TO MR IF GI INTOLERANT • AVOID IN KETOACIDOSIS • CHECK VITAMIN B12 ANNUALLY IF LONGTERM USE • AVOID IF IODINE CONTAINING CONTRAST USED
GLICLAZIDE	SULPHONYLUREA	USE IF BMI<25 or symptomatic or metformin intolerant DOSE SHOULD BE REVIEWED IF ANOTHER ORAL HYPOGLYCAEMIC AGENT ADDED	40-320MG DAILY	AVOID IN SEVERE RENAL IMPAIRMENT AVOID IN HEPATIC IMPAIRMENT	• HYPOGLYCAEMIA • WEIGHT GAIN • AVOID IN PREGNACY AND BREASTFEEDING • REVIEW DOSE IN ELDERLY PATIENTS (>75 YEARS)
GLIMEPIRIDE	SULPHONYLUREA	ALTERNATIVE TO GLICLAZIDE IF COMPLIANCE PROBLEMS DOSE SHOULD BE REVIEWED IF ANOTHER ORAL HYPOGLYCAEMIC AGENT ADDED	1-6MG DAILY WITH BREAKFAST	AVOID IN SEVERE RENAL AND HEPATIC IMPAIRMENT	• HYPOGLYCAEMIA • WEIGHT GAIN • AVOID IN PREGNACY AND BREASTFEEDING • REVIEW DOSE IN ELDERLY PATIENTS (>75 YEARS)
PIOGLITAZONE	THIAZOLIDINEDIONE (TZD)	DUAL OR TRIPLE THERAPY WITH METFORMIN/SU	15-45MG DAILY	**AVOID IN HEPATIC IMPAIRMENT** DIP URINE BEFORE INITIATING TREATMENT AND IF MICROSCOPIC HAEMATURIA PRESENT DO NOT PRESCRIBE **CAN BE USED WITH INSULIN UNDER SPECIALIST SUPERVISION**	• AVOID IF HEART FAILURE • ACTIVE OR HISTORY BLADDER CANCER • UNINVESTIGATED MACROSCOPIC HAEMATURIA • AVOID IN ELDERLY • AVOID IF HIGH FRACTURE RISK • MONITOR LFT BEFORE AND DURING TREATMENT • AVOID PREGNANCY AND BREASTFEEDING

Appendix 11 **FURTHER GUIDANCE ON ORAL HYPOGLYCAEMIC AGENTS ON FORTH VALLEY FORMULARY**

This appendix provides detailed guidance on the formulary choices for oral hypoglycaemic agents. The drug classes are colour coded, with the place in therapy of each drug within that group highlighted. Please refer to the FV diabetes management guidelines available on the intranet for the place in therapy for each class

ALOGLIPTIN	DPP4 INHIBITOR	FIRST CHOICE DPP4 DUAL THERAPY WITH EITHER METFORMIN OR SU, TRIPLE THERAPY (SEE CONSENSUS STATEMENT) INSULIN ADD ON	25MG ONCE DAILY	eGFR 30-50: 12.5mg eGFR <30 : 6.25mg DOSES OF SU, INSULIN MAY REQUIRE TO BE REDUCED IF USED CONCOMITANTLY	• CAUTION IN MODERATE / SEVERE HEART FAILURE • AVOID IF HISTORY ACUTE PANCREATITIS • AVOID PREGNANCY / BREASTFEEDING • AVOID SEVERE HEPATIC IMPAIRMENT • AVOID IN KETOACIDOSIS
LINAGLIPTIN	DPP4 INHIBITOR	DPP4 FOR PATIENTS WITH RENAL IMPAIRMENT MONO, DUAL WITH METFORMIN OR TRIPLE (METFORMIN /SU) USE WITH INSULIN	5MG ONCE DAILY	NONE DOSES OF SU, INSULIN MAY REQUIRE TO BE REDUCED IF USED CONCOMITANTLY	• AVOID PREGNANCY / BREASTFEEDING • AVOID IF HISTORY ACUTE PANCREATITIS • CAUTION IN HEPATIC IMPAIRMENT
EMPAGLIFLOZIN	SGLT2 INHIBITOR	FIRST CHOICE SGLT2 MONO DUAL TRIPLE INSULIN ADD ON	10MG ONCE DAILY	CAN CONTINUE IF eGFR < 60 WHEN ON TREATMENT IF eGFR <45 STOP DOSES OF SU, INSULIN MAY REQUIRE TO BE REDUCED IF USED CONCOMITANTLY	• NO INTIATION IF eGFR <60 • AVOID IN SEVERE HEPATIC IMPAIRMENT • AVOID PREGNANCY / BREASTFEEDING • AVOID IN PATIENTS >85 YEARS • AVOID IF ON LOOP DIURETICS • CORRECT HYPOVOLAEMIA BEFORE INITIATION • AVOID IF KETOACIDOSIS • CAUTION IF RECURRENT UTI / GENITAL INFECTION • REINFORCE THE IMPORTANCE OF GOOD FOOTCARE • STOP IF DEVELOP ANY FOOT COMPLICATIONS AND CONSIDER ALTERNATIVE CLASS

Appendix 11 FURTHER GUIDANCE ON ORAL HYPOGLYCAEMIC AGENTS ON FORTH VALLEY FORMULARY

This appendix provides detailed guidance on the formulary choices for oral hypoglycaemic agents. The drug classes are colour coded, with the place in therapy of each drug within that group highlighted. Please refer to the FV diabetes management guidelines available on the intranet for the place in therapy for each class.

Appendix 11 **FURTHER GUIDANCE ON ORAL HYPOGLYCAEMIC AGENTS ON FORTH VALLEY FORMULARY**

DAPAGLIFLOZIN	SGLT2 INHIBITOR	PATIENTS ALREADY PRESCRIBED OR INTOLERANT TO OTHER SGLT2 DUAL WITH METFORMIN TRIPLE INSULIN ADD ON	10MG DAILY	5MG IN SEVERE HEPATIC IMPAIRMENT	• AVOID IF eGFR <60 • AVOID PREGNANCY(2 /3 TRIMESTER) / BREASTFEEDING • AVOID IN PATIENTS >75 YEARS • AVOID IF ON LOOP DIURETICS • AVOID IF ON PIOGLITAZONE • CORRECT HYPOVOLAEMIA • AVOID IN KETOACIDOSIS • REINFORCE THE IMPORTANCE OF GOOD FOOTCARE • STOP IF DEVELOP ANY FOOT COMPLICATIONS AND CONSIDER ALTERNATIVE CLASS
EXENATIDE	GLP1	HBa1C >59 SECOND LINE TREATMENT IF BMI > 40 THIRD LINE IF BMI>30 AND DIABETES <10 YEARS	2MG WEEKLY (BYDUREON)	AVOID IF eGFR<50 AVOID IF LFT'S ARE ABNORMAL	• AVOID PREGNANCY AND BREASTFEEDING • AVOID SEVERE GI DISEASE/ GASTROPARESIS • AVOID IN PANCREATITIS / CHOLECYSTITIS/ HIGH ALCOHOL INTAKE • HbA1C MUST REDUCE BY 11mmol/mol AT 3 MONTHS TO CONTINUE
LIRAGLUTIDE	GLP1	FIRST CHOICE IF PATIENT <55 YEARS HBa1C >59 SECOND LINE TREATMENT IF BMI > 40 THIRD LINE IF BMI>30 AND DIABETES <10 YEARS	0.6 mg ONCE DAILY TITRATED TO A MAXIMUM 1.8MG DAILY	AVOID IF eGFR <30 AVOID IF LFT'S ARE ABNORMAL	• AVOID PREGNANCY AND BREASTFEEDING • AVOID SEVERE GI DISEASE/ GASTROPARESIS • AVOID IN PANCREATITIS / CHOLECYSTITIS • HbA1C MUST REDUCE BY 11mmol/mol AT 6 MONTHS TO CONTINUE
XULTOPHY	BASAL INSULIN / GLP1	ADD ON TO EXISTING ORAL HYPOGLYCAEMIC AGENTS	INITIALLY BETWEEN 10-16 DOSE STEPS ONCE DAILY MAXIMUM 50 DOSE STEPS DAILY	AVOID IN HEPATIC AND SEVERE RENAL IMPAIRMENT	• AVOID PREGNANCY AND BREASTFEEDING • AVOID SEVERE GI DISEASE/ GASTROPARESIS • AVOID IN PANCREATITIS / CHOLECYSTITIS

Index

Publications in Alternative Formats

NHS Forth Valley is happy to consider requests for publications in other language or formats such as large print.

To request another language for a patient, please contact 01786 434784.

For other formats contact 01324 590886,

text 07990 690605,

fax 01324 590867 or

e-mail - fv-uhb.nhsfv-alternativeformats@nhs.net