NHS Forth Valley

Prescriberfile

From the Primary Care Prescribing Group

MHRA Drug Safety Updates

Selected highlights from recent Drug Safety Update Bulletins from the MHRA (https://www.gov.uk/drug-safety-update)

Prescribers are encouraged to subscribe directly to the Drug Safety Updates Bulletin which is only available by email.

www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency/email-signup

New Restrictions and Precautions for use of Fluoroquinolone Antibiotics

Following an EU-wide review of safety, new restricted indications have been introduced for fluoroquinolone antibiotics (ciprofloxacin, levofloxacin, moxifloxacin, norfloxacin, ofloxacin).

Disabling, long-lasting or potentially irreversible adverse reactions affecting musculoskeletal and nervous systems have been reported very rarely with fluoroquinolone antibiotics.

Patients should be advised to stop treatment at the first signs of a serious adverse reaction, such as tendinitis or tendon rupture, muscle pain or weakness, joint pain or swelling, peripheral neuropathy, and central nervous system effects, and to contact their doctor immediately for further advice.

Fluoroquinolones should **not** be prescribed in the following instances –

- for non-severe or self-limiting bacterial infections
- avoid use in patients who have previously had serious adverse reactions with a quinolone or fluoroquinolone antibiotic
- for some mild to moderate infections (such as in acute exacerbation of chronic bronchitis and chronic obstructive pulmonary disease) unless other antibiotics that are commonly recommended for these infections are considered inappropriate
- ciprofloxacin or levofloxacin should no longer be prescribed for uncomplicated cystitis unless other antibiotics that are commonly recommended are considered inappropriate

Caution in use -

- prescribe with special caution for people older than 60 years and for those with renal impairment or solid-organ transplants because they are at a higher risk of tendon injury
- avoid use of a corticosteroid with a fluoroquinolone since co-administration could exacerbate fluoroquinolone-induced tendinitis and tendon rupture

For further information on the updated safety advice relating to quinolones refer to MHRA Drug Safety Update March 2019

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Please Circulate to All Staff

Inside this issue:

Key Points of interest:

- Updated restrictions for prescribing quinolones
- Risk of congenital malformations and risk of acute pancreatitis with carbimazole
- Effective contraception for medicines with teratogenic potential.
- Clinitas is preferred brand for carbomer gel
- BD Viva is formulary choice insulin pen needles
- Review sundry products for patients prescribed Freestyle Libre®
- New risk acknowledgement form to be used when reviewing valproate patients

Carbimazole - New Safety Concerns

Strengthened advice on contraception due to increased risk of congenital malformations

There is an increased risk of congenital malformations when carbimazole is used during pregnancy, especially in the first trimester or at doses of 15mg daily or more.

It is now advised that carbimazole is **only used in women of childbearing potential if using effective contraception**. Advice on effective contraceptive methods for drugs with teratogenic potential is available in the MHRA Drug Safety Update March 2019 (see below).

Carbimazole should only be **used in pregnant women after an individual assessment of benefits and risk**. Carbimazole should only be prescribed at the lowest effective dose and with careful monitoring of mother/foetus/neonate.

See MHRA Drug Safety Update February 2019 for further information.

Risk of acute pancreatitis

Acute pancreatitis has been reported as a rare side-effect of carbimazole.

If acute pancreatitis occurs during treatment with carbimazole, immediately and permanently stop treatment. Re-exposure to carbimazole may result in life-threatening acute pancreatitis with a decreased time to onset.

For further information on the updated safety advice relating to carbimazole refer to MHRA Drug Safety Update February 2019.

Medicines with teratogenic potential: what is effective contraception and how often is pregnancy testing needed?

Some medicines are known or suspected to have the potential to increase the risk of birth defects and development disorders (teratogenic potential) when taken during pregnancy, especially during the first trimester (up to week 12 of pregnancy), when a woman may not know she is pregnant. The product information for these medicines advise that pregnancy should be avoided during treatment, with advice on the need to use contraception including, in some cases, formal pregnancy prevention programmes.

When using any medicine with teratogenic potential, a woman should be advised of the risks and encouraged to use the most effective contraceptive method taking into account her personal circumstances.

The Medicines for Women's Health Expert Advisory Group of the Commission on Human Medicines has developed an aide-memoire table to provide guidance to prescribers of medicines with teratogenic potential on the frequency of pregnancy testing needed to avoid exposure in pregnancy during treatment, depending on the chosen contraceptive method. The aide-memoire table provides a summary of the pregnancy testing advice for the most common contraceptive methods. The table is colour-coded according to the most reliable methods and is reproduced on the next page.

For further information refer to MHRA Drug Safety Update March 2019.

Pregnancy testing and contraception for pregnancy prevention during treatment with medicines of teratogenic potential

Risk of pregnancy should be assessed prior to each teratogen prescription -

- Risk of pregnancy may be high at start of a method or when switching between methods due to risk of pregnancy from unprotected sex prior to starting the method, unreliable use of the previous contraceptive method, and/or time needed to establish contraceptive efficacy at the start of the new method.
- Pregnancy tests at start of contraceptive method may not detect an early pregnancy following unprotected sex in the last three weeks;

Any starter on a new method of contraception should have a repeat pregnancy test at 3 weeks if there is any risk of pregnancy at start of contraceptive method

The duration of teratogen prescriptions may need to be shortened for patients who use contraceptive methods that require frequent pregnancy testing.

Effectiveness of contraceptive in typical use[1]	Contraceptive method	Duration contraceptive method used / other situations	Pregnancy test needed before next teratogen prescription?
Highly effective methods **(Typical use failure rates less than 1%)**	Copper intrauterine device (copper IUD)	Established user more than 3wks to 5-10 yrs (depending on IUD[2])	No
	Levonorgestrel-releasing intrauterine system (LNG-IUS)	Established user more than 3wks to 3-5 yrs (depending on IUS[2])	No
	Progestogen Implant	Established user more than 3wks to 3yrs	No
		Established user (more than 3wks), but concurrent use of interacting medicines which may affect efficacy[3]	Yes + review / refer for contraceptive advice
Effective methods **(Typical use failure rates greater than 1%)** **Additional barrier methods are advised during teratogen use**	Depot medroxyprogesterone acetate (DMPA) subcutaneous (SC) or intramuscular (IM) injections[4]	Established user (more than 3wks + repeat injections on schedule) and less than 13 wks since last injection + documented as administered by healthcare professionals	No
		Established user (more than 3wks + repeat injections on schedule and less than 13 wks since last injection) but self-administered or undocumented administration	Yes, test if any suspected risk of pregnancy
		More than 13 wks since last injection (ie beyond recommended duration of use of last injection)	Yes + review / refer for contraceptive advice
	Combined hormonal contraceptives (pills, patches or vaginal ring) or progestogen-only pills	Established user (more than 3wks), reliable and consistent use	Yes, test if any suspected risk of pregnancy
		Established user (more than 3wks) but with unreliable or inconsistent use of method, eg: • missed pills, late patch • Diarrhoea or vomiting; • use of other interacting medicines that may affect efficacy[3]	Yes + review / refer for contraceptive advice
	Other methods or no contraception	Any duration of use of other methods	Yes + review / refer for contraceptive advice;
		No contraception	Assess need for contraception + test if any suspected risk of pregnancy + review / refer for contraceptive advice;

***Explanatory notes*:**

1. Effectiveness of methods are based on failure rates in typical use (which includes risk of user error) rather than perfect use. Perfect use failure rates are similar for specific methods listed (0.03 – 0.6%) but risk of user error is higher for daily methods than for long acting reversible contraceptive (LARC) methods and are highest for methods used at time of sexual intercourse. Highly effective methods are based on less than 1% failure rate in typical use; Less effective methods are based on greater than 1% failure rate (6 – 9%) in typical use (Trussell J Contraceptive failure in the United States Contraception. 2011 May;83(5):397-404. doi: 10.1016/j.contraception.2011.01.021. Epub 2011 Mar 12)
2. Refer to Product Information for specific products; patients should be reviewed / referred for contraception advice at the end of the recommended duration of use
3. Implants are only considered as highly effective and combined hormonal contraceptives and progesterone-only pills are only considered as effective if interactions with any concurrent medicine are not a concern (see FSRH guidance on drug interactions with hormonal contraception)
4. DMPA (IM or SC) injection can be considered as highly effective if it is administered by healthcare professionals and continuous repeat use is documented as occurring within recommended duration of action (equivalent to perfect use, failure rate = 0.2%). Otherwise it is considered an effective contraceptive (typical use failure rate =6%). The same rationale should be used for other injection products with different recommended duration of action (eg Norethisterone Enanthate)

Source: MHRA Drug Safety Update March 2019

FV Formulary Changes

The following changes are reflected in the FV EMIS Formulary and the FV Formulary online documents:

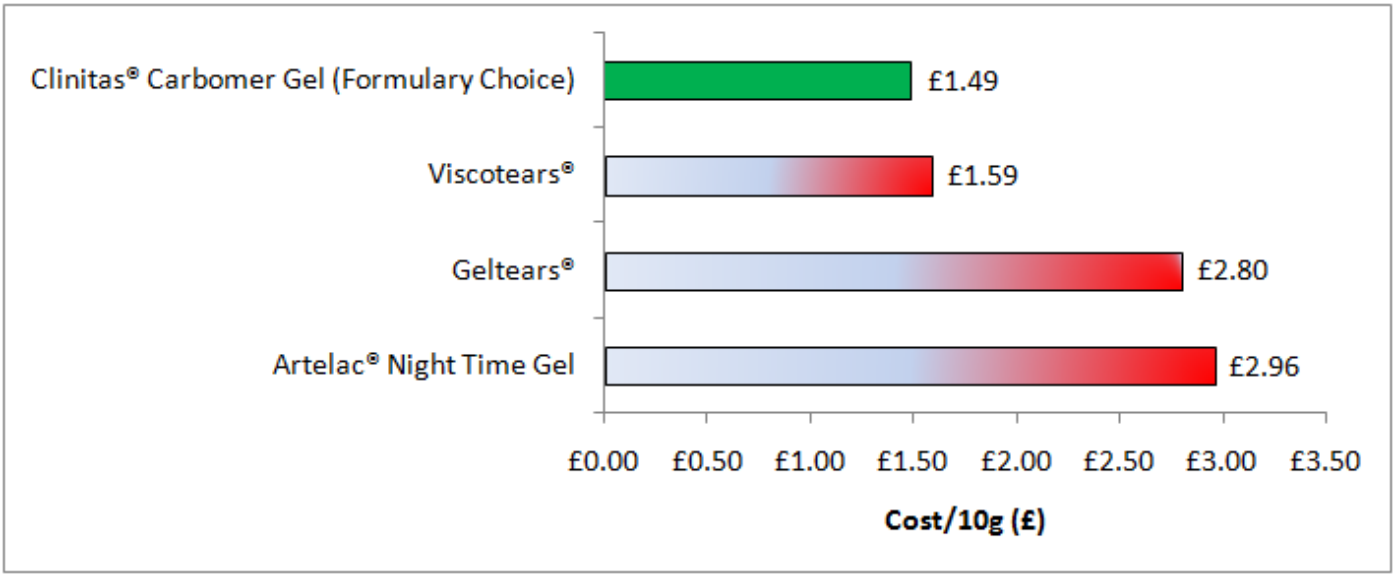
Carbomer 0.2% Eye Gel— Clinitas® Carbomer Eye Gel now preferred brand

Clinitas® Carbomer gel is now the preferred brand for carbomer gel. To ensure that the most cost-effective carbomer gel product is dispensed, this should be prescribed by **brand name** as Clinitas®. This will ensure that community pharmacists dispense the cost-effective Clinitas® brand rather than other more expensive alternative carbomer brands (see graph below).

The FV EMIS Formulary and Scriptswitch have been updated to highlight that the FV Formulary choice is **branded Clinitas® Carbomer Gel.**

Comparative costs of Carbomer Eye Gels. Formulary choice in GREEN/Solid colour, NON-Formulary preparations in RED/Gradient fill.

Prices from Scottish Drug Tariff (June 2019) or dm+d



Insulin Pen Needles

It has been agreed with the diabetes specialists that the preferred insulin pen needles are **BD Viva® needles 4mm or 5mm**. This will ensure that the most cost-effective pen needles are issued to patients.

The FV EMIS Formulary and Scriptswitch have been updated to highlight the FV Formulary choice.

Change of Preferred Spacer Device

Following a request from the FV Respiratory Team, the preferred Spacer Device is now Aerochamber Plus **Flow-Vu** +/- mask (this replaces the Aerochamber Plus).

Freestyle Libre® Flash Glucose Sensor

Skin Reactions

Some patients using the Freestyle Libre® sensor may experience skin hypersensitivity reactions to the sensor adhesive (erythema, itching, blistering). **Patients should be advised not to apply creams or sprays under the sensor** to minimise the skin reactions as this may affect the sensor performance.

Patients experiencing ongoing skin reactions are advised to be switched to an alternative blood glucose monitoring system.

Updated Advice Regarding Driving

The DVLA have agreed that Freestyle Libre® can now be used to monitor glucose levels before and while driving Group 1 Vehicles (cars and motorcycles). Previously, only finger-prick testing was accepted for checking glucose levels while driving.

When patients are switched over to Freestyle Libre® **a review of their current prescription should be undertaken with a view to reducing the quantities of blood glucose test strips and lancets that are prescribed** as these products will only be required on an infrequent basis.

FV EMIS Formulary or Scriptswitch Amendment Requests

When using the FV EMIS Formulary and ScriptSwitch, if prescribers note any omissions or entries where different information or doses would be preferred (e.g. Formulary choices, dosage instructions) it would be helpful to feedback this information to the Central Prescribing Support Team via the generic e-mail address:

FV-UHB.prescribingsupport@nhs.net

The Central Team can then review the information in a timely manner and update ScriptSwitch and the FV EMIS Formulary where necessary.

For Scriptswitch messages there is a feedback button available on EMIS which can again be used to provide feedback on messages. Where an issue with ScriptSwitch is considered urgent, prescribers should notify the Prescribing Support Team via the Generic Email address or by phone to allow timely action.

Prescribers are asked to direct any queries on content or change requests to the Central Prescribing Support Team.

This will ensure that all users benefit from any amendments, and ensures that any suggestions are checked to make sure that they are consistent with current local or national advice

Valproate medicines and serious harms in pregnancy: New Updated Annual Risk Acknowledgement Form

As of March 2019, the new **updated** Annual Risk Acknowledgement Form should be completed by specialists for all girls and women of child-bearing potential at initiation of valproate medicines and at the annual reviews.

It is the prescriber's responsibility to ensure women and girls of childbearing potential (from menarche to menopause) who are taking a valproate medicine, irrespective of indication, fulfil all the requirements of the Pregnancy Prevention Programme. These responsibilities include that the patient (or responsible person) and their specialist must complete the Annual Risk Acknowledgement Form at each annual review.

The form can now be used to record when the specialist considers the patient not to be at risk of pregnancy, either permanently or until the date of the next annual review. Patients or their responsible person must countersign this section to confirm details given are correct.

Contact Information:
General Primary Care Prescribing Advice:
Contact your Primary Care Pharmacist; or alternatively
Primary Care Prescribing Support Team on 01324 566722

For Advice Related to Management of Controlled Drugs:
Kirsty Peacock, Inspection Officer for Controlled Drugs,
NHS Forth Valley, Forth Valley Royal Hospital Tel: 01324-566743