NHS Forth Valley

# Prescriberfile

From the Primary Care Prescribing Group

## Prescribing Improvement Initiative Update

We would like to thank Practices for their support in taking forward the work of the Prescribing Improvement Initiative (PII) to date. This is particularly the case given the current challenges during the pandemic.

Practices have been notified recently that, with the support of the GP Sub-committee and the NHS Board, the Primary Care Medicines Resource Group has extended the completion date for the PII to 31st July 2021 - to allow practices to complete the work they are currently undertaking and carry out additional reviews to release further recurrent efficiencies.

**Additional Prescribing Switches have been identified which Practices are asked to progress:**

- **Branded or generic ropinirole tablets (all formulations) to Ipinnia® XL** – there are some exclusions.
- **Cellcept® and Myfenax® 500 mg tablets and capsules to generic mycophenolate mofetil**.
- **Branded or generic methylphenidate XL tablets (18mg, 27mg, 36mg or 54mg) to Xaggitin® XL**.
- **Pramipexole Prolonged Release (PR) tablets (branded or generic) to Pipexus® PR.**
- **Estriol (Gynest®) intravaginal cream 0.01% with applicator to Ovestin® Intravaginal Cream 0.1% with applicator**. Certain groups of patients will be excluded from the switch.
- **Stalevo® Tablets to Stanek® Tablets**. **NB:** Patients with documented allergies to food additives, particularly food dyes, should not be switched to Stanek® 10mg/25mg/200mg or 150mg/37.5mg/200mg strengths.

- Support documentation and EMIS Web searches are available from your Practice Primary Care Pharmacy Team.
- Practices are advised to submit claim forms for completed workstreams as soon after completion as possible – please ensure you use the updated forms provided to Practice Managers.
- The closing date for final submissions is **31st July 2021.**

## Prescribing of Mycophenolate Mofetil

When mycophenolate mofetil first became available as a generic, around 10 years ago, we advised that transplant patients should be prescribed mycophenolate mofetil by the brand name of the product specified by Transplant units. This was not required for other indications.

Current prescribing of mycophenolate mofetil has been reviewed recently. The Transplant Units in Lothian and GGC have both indicated that generic prescribing of mycophenolate mofetil is clinically appropriate in transplant patients and that patients are advised of this by the Units.

Forth Valley ADTC have agreed that mycophenolate mofetil can now be **prescribed by generic name** for all patients, including transplant patients.

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**Please Circulate to All Staff**

### Inside this issue:



### Supply issues

For the latest Supply Issues affecting Primary Care and local associated guidance see here

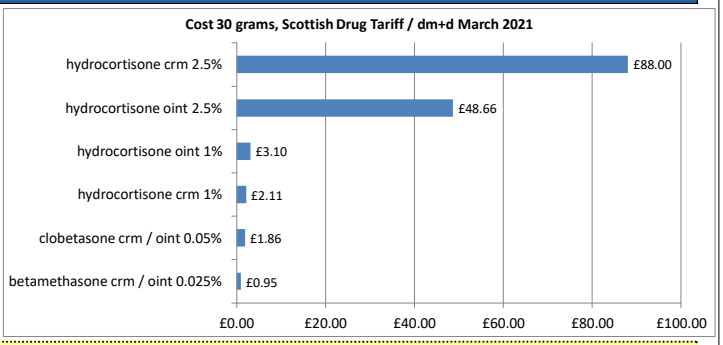
### Key Points of interest:

- Prescribing Improvement Initiative extended.
- Prescribe mycophenolate mofetil generically.
- Do not prescribe hydrocortisone 2.5%.
- Formulary changes to ophthalmology, epilepsy and movement disorder sections.
- Updated B12+folate guidance.
- Must record day of the week methotrexate is taken.

# Reduce harm, waste and unwarranted variation

## Hydrocortisone 2.5% - a wasteful choice?

Hydrocortisone 2.5% is often prescribed as a 'stronger' alternative to hydrocortisone 1% where an increased potency topical steroid may be required. However, the BNF lists hydrocortisone 1% and 2.5% both as **mild potency** topical steroids. The cost of hydrocortisone 2.5% can be **80 times** that of betamethasone 0.025% (Betnovate RD®) and **40 times** that of hydrocortisone 1% and clobetasone butyrate 0.05%. **Local dermatology specialists do not routinely recommend hydrocortisone 2.5%**.




- Hydrocortisone 2.5% offers no significant benefits to patients or NHS Forth Valley.
- Do not start any new patients on hydrocortisone 2.5%.
- Review existing patients: if a mild potency steroid is required consider hydrocortisone 1%; if a moderate potency steroid is required consider clobetasone butyrate 0.05% / betamethasone 0.025%.

# Updates to the NHS Forth Valley Formulary

The following changes to the Forth Valley Formulary have been agreed by the New Drugs & Formulary Group. Additions and deletions of medicines are based on formulary submissions, new drug assessment requests or formulary section reviews. ADTC decisions relating to SMC assessments can be accessed here. *ScriptSwitch*® messages to support prescribers in primary care will be added to the clinical system.

## Eye conditions

Following a multi-disciplinary review involving stakeholders from Ophthalmology, Pharmacy and Community Optometrists the following Formulary changes were agreed:

- **Atropine 1% Minims are preferred** to the standard 10ml bottle. Atropine 1% Minims cost £15.10 for 20 unit doses compared with £131.89 for the 10ml bottle.
- **Formulations for dry eye** are now listed by disease severity and by Brand preference (preferred brands updated). They should be prescribed by Brand when a brand is specified.
- **Ganciclovir eye gel** is the formulation of choice for treatment of acute herpetic keratitis in preference to aciclovir.
- **Fusidic acid is no longer routinely recommended** for the treatment of bacterial eye infections and should be reserved for when chloramphenicol is ineffective or not tolerated. It is expensive at £35 per 5g tube.

## Epilepsy and Movement Disorders

In conjunction with Forth Valley neurology specialists the Formulary sections for Movement Disorders and Epilepsy were recently reviewed.

Key changes for epilepsy include:

- **Categorisation of all epilepsy medicines** in line with MHRA guidance.
- **Tegretol® Retard** as the carbamazapine brand of choice for patients with epilepsy.
- **Trileptal®** as the oxcarbazepine brand of choice for patients with epilepsy.
- **Generic prescribing of lamotrigine and levetiracetam** unless brand prescribing is requested by specialist.

Key changes for movement disorders include:

- **Ipinnia® XL** as the ropinirole formulation of choice for movement disorders.
- **Pipexus® PR** as the pramipexole prolonged release (PR) formulation of choice for movement disorders.
- **Stanek®** as the formulation of choice where a combination Levodopa + Carbidopa + Entacapone product is required.

# Guideline news

The following guidelines were updated on StaffNet Guideline Store.

The Forth Valley B12 and Folate Guidance was recently updated. Points of interest:

- Addition of guidance on management of B12 in patients prescribed metformin and on borderline results.
- No evidence of benefit from injections more frequently than 3 monthly once stabilised, unless neurological condition.
- **Intramuscular** (IM) hydroxocobalamin **remains the route of choice** when B12 replacement is indicated.
- High-dose oral B12 is reserved for patients unable to tolerate IM B12 and **only on recommendation from Haematology**. Cyanocobalamin 1mg tablets are now licensed as the brand Orobalin® and included in the Formulary for specialist initiation.
- A useful flowchart is included to aid decision making.

# 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**

## Methotrexate - new safety measures

In autoimmune conditions methotrexate should be taken only once a week; however, the MHRA continues to receive reports of inadvertent overdose due to more frequent dosing (including daily administration).

The MHRA has implemented **new measures** to prompt healthcare professionals to record the day of the week for intake and to remind patients of the dosing schedule and the risks of overdose – including changes to the product information leaflets, inclusion of a patient card highlighting weekly dosing and signs/symptoms of overdose, and an area on the packaging which highlights the weekly dosing.

**Prescribers are reminded to:**

- Make sure that the patient is able to understand and comply with **once-weekly** dosing and understand the risks of taking more frequently.
- Consider the patient's overall polypharmacy burden when deciding which formulation to prescribe – **in Primary Care only the 2.5mg strength of tablets should be prescribed** (in line with national advice implemented locally in 2012.)
- Agree and note the day of the week to take the methotrexate on the prescription. Usual local advice is **M**ethotrexate on a **M**onday and **F**olic Acid on a **F**riday (see June 2018 Prescriberfile).

For further information and for advice for patients and their families see MHRA Drug Safety Update September 2020

## Bupropion (Zyban®): risk of serotonin syndrome

Bupropion (Zyban®) is less commonly prescribed in Forth Valley but remains an option for patients who previously had a successful quit attempt with bupropion, or for whom NRT or varenicline are unsuitable or were unsuccessful. Cases of serotonin syndrome have been reported in patients taking bupropion with other serotonergic drugs, such as selective serotonin re-uptake inhibitors (SSRIs) - **recommended doses of bupropion should not be exceeded**. See the Nov 2020 update for further information.

## Macrolides and DOACs

Erythromycin and clarithromycin, as CYP3A4 and P-glycoprotein inhibitors, reduce the metabolism of rivaroxaban and thereby increases the bleeding risk. This is especially important in renal impairment and doses should be adjusted accordingly. This interaction also affects other direct acting oral anticoagulants (DOACs). For further information see June 2020, December 2020 updates and individual product SPCs.

## Erythromycin and QT prolongation

Marolides are known to cause QT prolongation. Erythromycin should no longer be given to patients with a history of QT prolongation or ventricular cardiac arrhythmia, including torsades de pointes, or patients with electrolyte disturbances. The Dec 2020 update gives guidance on those in whom particular caution is needed.

## Antiepileptic drugs in pregnancy: updated advice

Valproate remains contraindicated in women of childbearing potential unless a pregnancy prevention programme is in place. Continue to identify and review all female patients prescribed valproate for any indication, and provide them with the patient information materials every time they attend their appointments or receive their medicines (including the patient information leaflet at dispensing). Educational materials to support healthcare professionals and female patients on valproate are available.
Lamotrigine and levetiracetam are the safer options during pregnancy. Studies do not suggest an increased risk of neurodevelopmental disorders or delay associated with in-utero exposure to either drug; however, an increased risk cannot be excluded. For information on the other key antiepileptic drugs see January 2021 Drug Safety Update.

**Contact Information:**
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