Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

January 2020

CCG Prescribing Group
6th November 2019

- Potential targets for the 2020/21 Prescribing Incentive Scheme were discussed.
- Eye screening for patients on hydroxychloroquine was raised – please see item on Page 4.
- The continuing problems with the formulary website were noted. Work is underway to establish a new platform for the formulary. We will let you know when it is up and running.
- The Group discussed a report on OptimiseRx acceptance. Acceptance of Red messages (hospital only medicines) is only about 50%. This means that the CCG is charged for medicines instead of NHS England. Please make every effort to accept these messages and refer prescribing back to the hospital.

Milton Keynes Prescribing Advisory Group (MKPAG)
27th November 2019

- Revised antimicrobial guidance was approved. This was circulated at the beginning of December.
- Agreement was reached for the use of lidocaine patches (see later).
- Solifenacin was added to the formulary for second line use in LUTS.
- A Patient Information Leaflet on the use of azithromycin in bronchiectasis was agreed.
- Fentanyl immediate release buccal tablets were reclassified as Amber 3 – only to be prescribed at the request of Palliative Care services once the patient has been stabilised on an appropriate dose.

Minutes of MKPAG and CCG Prescribing Group meetings can be found on the formulary website. For now, the formulary may be accessed via mobiles only at **https://tinyurl.com/y2wsmu9a**

MHRA Update

The MHRA has warned about the risk of neuropsychiatric reactions with **montelukast (Singulair)**. They advise prescribers to:

- be alert for neuropsychiatric reactions in patients taking montelukast; events have been reported in adults, adolescents, and children (see list of reported events below)
- advise patients and their caregivers to read carefully the list of neuropsychiatric reactions in the patient information leaflet and seek medical advice immediately should they occur
- evaluate carefully the risks and benefits of continuing treatment if neuropsychiatric reactions occur
- be aware of newly recognised neuropsychiatric reactions of speech impairment (stuttering) and obsessive–compulsive symptoms
- report suspected adverse drug reactions associated with montelukast to the Yellow Card Scheme.

For more information, please see:
https://www.gov.uk/drug-safety-update/montelukast-singulair-reminder-of-the-risk-of-neuropsychiatric-reactions?utm_source=e-shot&utm_medium=email&utm_campaign=DSU_September2019split1

Yellow fever vaccine now carries stronger precautions in people with weakened immunity and in those aged 60 years or older. Strict adherence to contraindications and precautions is essential to reduce the risk of very rare but potentially fatal adverse reactions.

https://www.gov.uk/drug-safety-update/yellow-fever-vaccine-stronger-precautions-in-people-with-weakened-immunity-and-in-those-aged-60-years-or-older?utm_source=e-shot&utm_medium=email&utm_campaign=DSU_November2019Main1

Recording medicines prescribed elsewhere - Clozapine

As mentioned in the previous edition of Prescribing News, it is good practice to record any medicines prescribed or supplied elsewhere. This may include antiretrovirals, renal medicines, depot injections or medications obtained elsewhere such as issued privately by online clinics e.g. antimalarials, erectile dysfunction medicines or an out of hours/emergency supply. This can be done within SystmOne.

On the **Clinical Tree**, select **Medication,** right click and select **Record Other Medication.** Add the medication and select the **Hospital Medication choice**. There is an option to add in doses. **Press OK**. This is now in the patient record in the Other Medication section, showing as a hospital medication. Potential interactions with the patient's regular medicines will now be highlighted.

Action: Following a serious incident review, CNWL has written to GPs to let them know which patients are being prescribed Clozapine. Please ensure that your patient records are annotated with this information.

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Spotlight on Safe Prescribing of methotrexate

There continues to be incidents and issues with prescriptions for methotrexate, so please be aware of the following good practice guidance. It is also an area that CQC frequently checks. Community pharmacists can help support safe use of methotrexate and other high risk medicines at the point of dispensing by checking that the patient is up to date with blood tests and understands the dosing regimen.

On-going monitoring is required every 2-3 months. No matter what indication the methotrexate is being prescribed for, FBC, U&Es, renal function and LFTs need to be undertaken once the dose is stabilised. These tests will be more frequent when starting methotrexate and after dose changes.

NHS Never Event: Overdose of methotrexate for non-cancer treatment (January 2018)
Patients given methotrexate, by any route, for non-cancer treatment should not be given more than their intended **weekly** dose.

Weekly dosing
Note that the dose is a **weekly** dose. To avoid error with low-dose methotrexate, it is recommended that:

- the patient is carefully advised of the **dose** and **frequency** and the reason for taking methotrexate and any other prescribed medicine (e.g. folic acid);
- only one strength of methotrexate tablet (usually 2.5 mg) is prescribed and dispensed;
- the prescription and the dispensing label clearly show the dose and frequency of methotrexate administration; consider putting agreed (with the patient) day of week on the label
- the patient is warned to report immediately the onset of any feature of blood disorders (e.g. sore throat, bruising, and mouth ulcers), liver toxicity (e.g. nausea, vomiting, abdominal discomfort, and dark urine), and respiratory effects (e.g. shortness of breath).

In 2006 the National Patient Safety Agency (NPSA) recommended that patients on oral methotrexate should be prescribed this as a single strength. Milton Keynes still has high prescribing of the 10mg strength tablets rather than all prescriptions being the 2.5mg strength. There are also some large quantities being prescribed.

The CCG Medicines Management team has some suggested wording for a patient letter that can be sent to advise patients currently being prescribed both 10mg & 2.5mg strengths for their dose that we are promoting prescribing as a single strength, for safety reasons the surgery would like to update their repeat to prescribe only the 2.5mg strength tablets. If patients wish to remain on both strengths then we suggest this is stated by the patient in writing and recorded in the notes. It would be good practice to send this letter out every 2 years.

Clinical Reports on SystmOne

There are reports on SystmOne to pro-actively find patients that do not have recent blood tests in their record. They can be found under: Clinical reporting> System wide reports> Drugs require monitoring> patients on antimetabolites without total white blood cell count in last 12 weeks. This also flags patients on azathioprine.

You can set a message in the action group descriptions for patients that states on every methotrexate (and also azathioprine) prescription "**Patients taking this medication usually require a blood test at least every 12 weeks."**

This can be done under Set up> Prescribing> action group descriptions> antimetabolites. You can also pull in the latest white blood cell count so it shows on the repeat template.

Best practice and Safety messages enabled on Optimise Rx to support prescribers

- Methotrexate: monitor and record full blood counts at least every 3 months
- Methotrexate: monitor and record liver function tests at least every 3 months
- Methotrexate: consider co-prescribing folic acid
- Methotrexate: co-prescription of 2.5mg tablets and 10mg tablets not recommended
- Trimethoprim: concomitant use with methotrexate is strongly discouraged

Eclipse Radar tool:

There are amber alerts for methotrexate that will flag a patient who has had their monitoring but their results are not in range. There are also blue alerts which highlight patients who have not had monitoring.

Escalation process

While it is useful to have various tools at our disposal to ensure patients' monitoring is up to date, these do not replace effective processes within a practice. We are aware of recent incidents where patients have gone without timely monitoring but continue to receive prescriptions for methotrexate. In some instances the patients was contacted for monitoring but this was not followed up. There are various methods for recalling patients in a timely manner. We would encourage you to consider using more than one method and including the process in your high risk drugs monitoring policy.

Other information

- Patients should be advised to avoid self-medication with over-the-counter aspirin or ibuprofen.
- Patients should be counselled on the dose, treatment booklet, and the use of NSAIDs.
- If the patient is prescribed Methotrexate injection, make sure they have a purple lidded sharps bin for disposing of the used syringes.

Repeat prescriptions for people in prison

A letter has been issued by the Department of Health and Justice to raise awareness and suggest actions to manage a medicines safety issue that has been identified about the supply of repeat medicines by community prescribers (e.g. GPs) for people that are detained in custodial secure environments.

It has been reported that detained people are continuing to have repeat medication prescribed by community prescribers via requests that occur on-line or via repeat prescription requests made by their representatives. These requests can include dependence forming medications (DFM), such as pregabalin, gabapentin and opioids.

As the detainee may be in custody for several months, a large stock of medicines could be collected and accumulate. This has the following risks of harm:

- The medicines could be taken inappropriately by the detainee on release, especially if the medicine has been stopped or the dose altered during their time in custody.
- The supply could be used illicitly by the detainee post-release or by their representative.

Suggested actions to reduce the risk of harm

On admission, it is usual practice for detained people to receive a full medicines reconciliation and information is requested from the community GP or community pharmacy about the person's medication and health needs. A prompt response to such requests is appreciated and improves overall patient safety and alerts all parties to medicines risks and benefits of timely medicines information sharing. When contacting the community services to request this information, it is recommended that providers include in their communication a request that **the GP or pharmacy record is amended so that repeat medicines cannot be ordered**. On release, a discharge letter should include the current list of medicines being taken by the detained person so that the GP can update their records and provide continued supply of relevant medication.

By autumn 2020, NHS England will introduce GMS registration into custodial secure environments, along with GP2GP data-sharing, which should resolve this issue. In the meantime, however, we appreciate your support in helping to address this issue.

Coroner's Regulation 28 Letter – Oxycodone and amitriptyline

Following a death, a Coroner has issued a Regulation 28 letter about the potential adverse effects of taking oxycodone and amitriptyline together. The Coroner noted that

The Deceased died in a road traffic accident as a result of sedation through taking a combination of Oxycodone and Amitriptyline prescribed to him by health professionals. The combination of the drugs is known to carry a risk of over-sedation. Despite exhibiting signs of over-sedation particularly following a doubling of his Amitriptyline dose on 23 May2018, his prescription remained unaltered.

Please therefore exercise caution and monitor patients carefully when prescribing amitriptyline and oxycodone (or any other opioid) simultaneously. Local ePACT2 data shows 57 patients currently receiving the combination in Milton Keynes. Your CCG pharmacist will be able to provide data for your own practice.

Lidocaine patches

As agreed at MKPAG, lidocaine patches for pain other than post-herpetic neuralgia should only be prescribed in primary care after a two month trial supplied and monitored for effectiveness by the Milton Keynes Hospital Pain Team. They will only initiate the patches after failure of other options and the prescription has been validated by one of the hospital pharmacists. If you are asked to prescribe lidocaine patches you should be provided with full details as to the reason along with advice about reviewing patients and discontinuing treatment. Please be aware that the most cost-effective way to prescribe is by brand - Ralvo.

Iopidine eye drops 0.5% and 1%

Lopidine® (apraclonidine) eye drops are indicated for short term use only. There is a risk that they are added to repeat prescription and continued long term. There has also been an increase in the use of the preservative free higher strength Iopidine® 1% eye drops compared to the lower strength Iopidine® 0.5% eye drops in England. This raises potential patient safety concerns if the higher strength formulation is being used as a preservative free alternative to Iopidine® 0.5% eye drops.

Recommended usage:

Iopidine® eye drop preparation	Licensed indication and administration	Treatment duration
Iopidine® 1% Eye Drops (apraclonidine 1%) (unit dose vials preservative free) Single use	To control or prevent post-surgical elevations in intraocular pressure that occurs in patients after anterior segment laser surgery. One drop is instilled into the eye one hour before laser surgery and a second drop immediately after laser surgery.	One hour before and immediately after laser surgery only.
Iopidine® 5mg/ml Eye Drops, Solution (apraclonidine 0.5%) (5ml bottle contains benzalkonium chloride) Discard 4 weeks after opening.	Short-term adjunctive therapy of chronic glaucoma in patients on maximally tolerated medical therapy who requires additional intraocular pressure (IOP) reduction to delay laser treatment or glaucoma surgery. Administration is one drop into the affected eye(s) three times per day.	The maximum recommended duration of therapy is **one month** due to loss of effect over time (tachyphylaxis)

Please review and ensure patients are not continuing treatment beyond the recommended duration and push back to the Specialists if requested to prescribe long term.

Hydroxychloroquine

There was a discussion at the November Prescribing Group meeting about hydroxychloroquine and the Group requested that information was provided in Prescribing News.

The Royal College of Ophthalmologists issued guidance for screening for patients prescribed Hydroxychloroquine in February 2018. This is included in the MK Shared Care Protocol for DMARDs:

All patients planning to take hydroxychloroquine long term i.e. over five years must have a baseline examination in a hospital eye department ideally within six months, but definitely within 12 months, of starting therapy with a colour retinal photograph and spectral domain optical coherence tomography (SD-OCT) scans of the macula.

Patients should be referred for annual screening after five years of therapy and be reviewed annually thereafter whilst on therapy. At each screening visit patients should undergo 10-2 Humphrey visual field testing, followed by pupillary dilation and imaging with both SD-OCT and wide field fundus autofluorescence imaging (FAF). If wide field FAF is not available, FAF can be acquired in several photographic fields to encompass the macula and extra-macular areas. Patients with abnormalities on wide field FAF with normal 10-2 visual field test results should undergo 30-2 visual field testing on another date. Patients with persistent and significant visual field defects consistent with hydroxychloroquine retinopathy, but without evidence of structural defects on SD-OCT or FAF may be considered for multifocal electroretinography.

Screening may be commenced before five years of therapy if additional risk factors exist e.g. very high dose of drug therapy, concomitant tamoxifen therapy or renal insufficiency.

If you have patients on long term hydroxychloroquine, please ensure that they are referred for ophthalmology screening at the correct intervals. You are advised to run a report to identify patients and flag them.

The Pharmaceutical Advisers can be contacted on 01908 278744 or 278713 or speak to your CCG practice pharmacist