Milton Keynes Clinical Commissioning Group

PRESCRIBING NEWS

October 2020

CCG Prescribing Group 2nd September 2020

A virtual meeting was held to discuss several topics:

- Prescribing Incentive Schemes for 2020-21. This was finalised and has been sent out to practices. The scheme will run from 1st October '20 to 31st March '21.
- There was a discussion about expenditure allowed under the Prescribing Incentive Scheme. More information will be supplied when practices are informed about their payments for the 2019-20 scheme (Mid-November)
- Asthma/COPD telephone review protocol and guidance on lowering the carbon footprint of inhalers were approved and have been circulated.

Milton Keynes Prescribing Advisory Group (MKPAG) 23rd September 2020

A virtual meeting was held, and the following decisions were made:

- Oral Semaglutide approved for addition to the formulary. Amber 1 for patients not already on injectable Semaglutide and amber 3 if switching (so the specialists manage the conversion)
- Several hospital only medicines were approved including moxifloxacin eye drops. These are designated as red on the formulary and should not be prescribed in primary care.
- The recent NPSA alert on steroid emergency cards was discussed. The hospital pharmacy will issue warning cards for out-patients and in-patients. Practices have been sent information and should ensure patients receive letters and cards. Community Pharmacies have been asked to support practices with this.

Minutes of MKPAG and CCG Prescribing Group meetings can be found on the formulary website https://www.formularymk.nhs.uk/Default.asp

MHRA Safety Alerts

1. Denosumab; Denosumab 60mg (Prolia) is indicated for the treatment of osteoporosis and bone loss, The Commission on Human Medicines' Pharmacovigilance Expert Advisory Group has considered EU and worldwide safety data, together with data submitted by the manufacturer, suggesting an increased risk of multiple vertebral fractures after stopping denosumab for osteoporosis, alongside national and international clinical guidance advising of the potential risk on treatment cessation. The MHRA has therefore issued the following advice to clinicians:

- Patients should not stop denosumab without specialist review
- The optimal duration of denosumab treatment for osteoporosis has not been established; re-evaluate the need for continued treatment periodically based on the expected benefits and potential risks of denosumab on an individual patient basis, particularly after 5 or more years of use
- Risks of long-term treatment with denosumab include rare cases of osteonecrosis of the jaw and atypical femoral fractures; osteonecrosis of the external auditory canal has also been reported in association with denosumab
- NICE rapid guidance (30 April 2020) advises not to postpone ongoing treatment with denosumab during the coronavirus (COVID-19) pandemic

There is a local Shared Care Guideline covering Denosumab (available on the formulary website.) Practices should have a system for recalling patients within the timeframe (the injections must be given every 6 months plus or minus no more than 2 weeks. Blood tests are needed before each injection to check serum adjusted calcium and vitamin D are normal and eGFR is > 30 ml/min within the 4 weeks before each injection.

Please order the injections directly from Movianto rather than writing an FP10 (details in the Shared Care Guideline https://formularymk.nhs.uk/docs/Shared%20Care%20Guidelines/).

2. Clozapine

The MHRA has warned that patients being treated with Clozapine may require monitoring of clozapine levels in certain circumstances including when:

- a patient stops smoking or switches to an e-cigarette
- concomitant medicines may interact to increase blood clozapine levels
- a patient has pneumonia or other serious infection
- poor (reduced) clozapine metabolism is suspected
- toxicity is suspected

This is in addition to the regular blood tests to manage the risk of agranulocytosis.

Clozapine must be recorded as a "Hospital medicine" on the patient's medical records. This can be done on SystmOne via medication> record other medication.

Colleagues from CNWL have provided the following guidance:

Smoking cessation or reduction has been reported to increase clozapine plasma levels by up to 72%[3], which can lead to clozapine toxicity (e.g. excess sedation, seizures). Chemicals in cigarette smoke (not the nicotine) may induce the metabolism of clozapine leading to decreased serum levels. As a result, smokers are usually prescribed a higher dose of clozapine than a non- smoker would be. When prescribing nicotine replacement therapy (NRT) or providing smoking cessation advice for someone on clozapine who is stopping smoking cigarettes, be mindful that this may lead to high clozapine levels, and toxicity.

If a patient taking clozapine wants to quit/cut down smoking inform the psychiatric team. A clozapine dose reduction may be appropriate when stopping smoking. Side effects of clozapine should be reviewed regularly during the period of cutting down.

Pneumonia or other serious infection – patients should have urgent full blood count (FBC) if signs of infection including sore throat & 'flu-like' symptoms and referral to mental health services for clozapine plasma level test. You can set up a protocol on SystmOne for patients on clozapine for a pop up message with this information to present as a reminder when the patient record is retrieved.

Drug interactions

Clozapine is contraindicated with:

- other medicines with a substantial potential to depress bone marrow function e.g. carbamazepine, chloramphenicol, sulphonamides, cytotoxic agents.

Clozapine is cautioned with:

- other medicines with anticholinergic effects (additive effect)
- other medicines with hypotensive effects (additive effect)
- erythromycin and ciprofloxacin, may increase clozapine levels (monitor for adverse effects. Refer to mental health team if toxicity suspected)
- alcohol, due to potential for sedation
- benzodiazepines, due to increased risk of circulatory collapse.
- Combined hormonal contraceptives may increase the concentration of clozapine (monitor for adverse effects and refer to mental health team for clozapine dose adjustment if required).

(This list is not exhaustive. Please refer to the BNF & Summaries of Product Characteristics for further information.)

3. Fentanyl patches

Considerable concern has been raised regarding the prescribing of opioids in the UK (see Drug Safety Update on risk of dependence and addiction with opioids https://www.gov.uk/drug-safety-update/opioids-risk-of-dependence-and-addiction). In 2019, the Commission on Human Medicines (CHM) convened an Expert Working Group to examine the benefits and risks of opioids in the relief of non-cancer pain.

During this review it was noted that there have been reports of serious harm, including fatalities, associated with fentanyl patches in both opioid-naive patients and opioid-experienced patients.

There is considerable risk of respiratory depression with the use of fentanyl especially in opioid-naive patients. There is also significant risk with too rapid an escalation of dose, even in long-term opioid users.

Good practice guidance includes:

- do not use fentanyl patches in opioid-naive patients
- use other analgesics and other opioid medicines (opioids) for non-cancer pain before prescribing fentanyl patches
- if prescribing fentanyl patches, remind patients of the importance of:
    - not exceeding the prescribed dose
    - following the correct frequency of patch application, avoiding touching the adhesive side of patches, and washing hands after application
    - not cutting patches and avoiding exposure of patches to heat including via hot water (bath, shower)
    - ensuring that old patches are removed before applying a new one
    - following instructions for safe storage and properly disposing of used patches or patches that are not needed; it is particularly important to keep patches out of sight and reach of children at all times
- make patients and caregivers aware of the signs and symptoms of fentanyl overdose and advise them to seek medical attention immediately (by dialing 999 and requesting an ambulance) if overdose is suspected
- remind patients that long-term use of opioids in non-cancer pain (longer than 3 months) carries an increased risk of dependence and addiction, even at therapeutic doses (see Drug Safety Update on risk of dependence and addiction with opioids); before starting treatment with opioids, agree with the patient a treatment strategy and plan for end of treatment

- Don’t forget that a fentanyl 25 microgram patch is equivalent to 60mg morphine per day, whereas buprenorphine 5 microgram patch is equivalent to 12mg morphine per day.

The CCG Pain Resource Pack contains lots of useful information and support materials. It is available on the formulary website and also on SystmOne.

Prescribing Safety Indicators in OptimiseRx

Prescribers will be aware that OptimiseRx fires messages to alert the clinician to potential safety concerns when a new medicine is added. It is disappointing to note the low acceptance of these messages as it may indicate that patients are being put at risk of potential adverse drug reactions and harm.

Data for four of these messages:

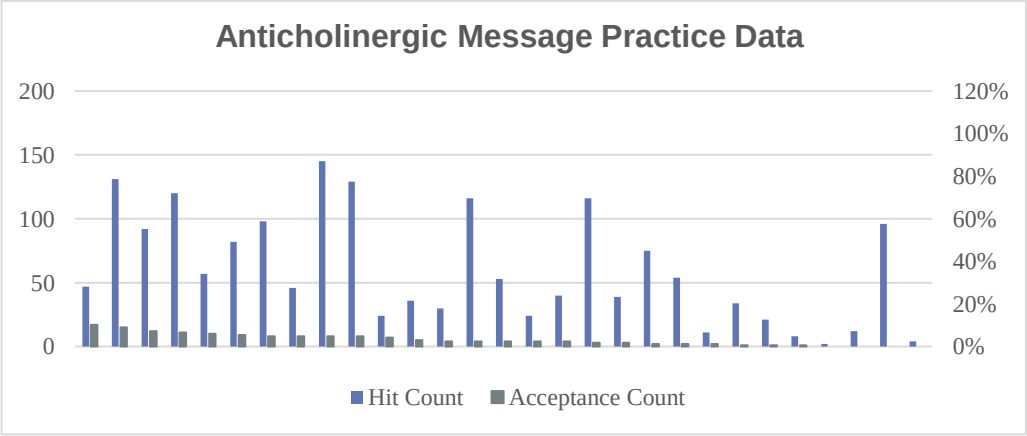
- Anticholinergics: review use of anticholinergic burden (ACB) score 3 medications in patients with dementia: CCG acceptance rate 8% vs national rate 12%
- Anticholinergics: review use of anticholinergic burden (ACB) score 3 medications in vulnerable patients: CCG acceptance rate 9% vs national rate 11%
- NSAIDs: increased risk of acute kidney injury when co-prescribed with both diuretics and renin-angiotensin system (RAS) drugs: CCG acceptance rate 11% vs national rate 17%
- Nitrofurantoin: contraindicated in patients with severe renal impairment: CCG acceptance rate 56% vs national rate 43%. This is the only indicator where the CCG performance is better than the national average but still room for improvement.

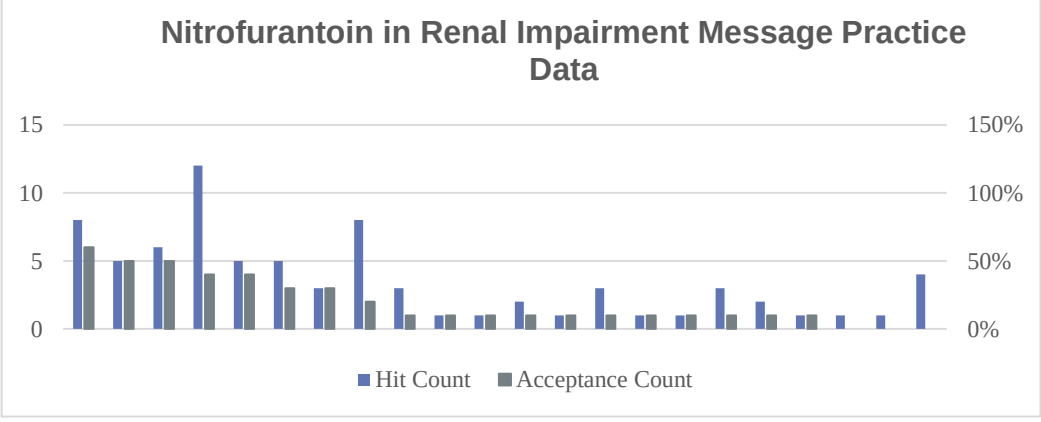
The reasons for rejecting the messages did not give a valid justification. Some included

- in a dosette box
- low dose
- Patient’s insistence
- on a PPI
- Patient has issue getting medicines

Message rejection reasons are looked at by the Optimise Rx company to help them with reviewing messages to make sure they are current and to avoid message fatigue - so wherever possible please add a reason if rejecting a message.

These graphs show a couple of examples of the range of acceptance rates across practices. For more details on your own practice rates, please contact your CCG Pharmacist.





A consideration of these and other safety factors should be an integral part of the DES Structured Medication Reviews.

Sharps Bins

There is sometimes confusion about which Sharps Bins should be prescribed. The lids are colour coded:

- Yellow = for the disposal of Sharps contaminated with medicinal products and their residues (other than cytotoxic and/or cytostatic medicines)
- Purple = for the disposal of Sharps including those contaminated with cytotoxic and/or cytostatic medicinal products and their residues (anything that changes the cell structure)
- Orange = for the disposal of Sharps, excluding those contaminated with medicinal products and their residues eg sharps used for blood sampling

Sharps bins come in a range of sizes from 1 Litre to 9 Litres in capacity. Patients using Freestyle Libre sensors will require a 4L sharps bin as the sensors do not fit in the smaller ones.

Prescribing Incentive Scheme DOAC Review

Practices have recently submitted reports on the DOAC reviews that were undertaken as part of the 2019-20 Prescribing Incentive Scheme.

Whilst a full numerical analysis could not be carried out, there were a number of themes that emerged. The practices were able to show improvement between the first data collection and their final reports which is encouraging. Overall many patients on DOACs were on the correct dose taking into account weight, renal function, age etc and had regular blood tests. Most were also compliant (as evidenced by computer records, although of course this does not confirm that the patients are taking their medication properly). A small but significant number of patients had fallen through the safety net of regular monitoring. Please note that a patient being over 80 years of age on its own is not a reason for reducing the dose - it has to be in combination with either low body weight or raised creatinine /compromised renal function.

With the increasing usage of DOACs, it is important that the learning is not lost. Key factors to consider when the decision has been made to prescribe a DOAC (following discussion of the risks and benefits with the patient) include:

Baseline tests prior to initiation:

- ✓ U+Es
- ✓ Creatinine clearance (CrCl) calculated using Cockcroft Gault equation, NOT eGFR)
- ✓ FBC
- ✓ Clotting
- ✓ LFTs
- ✓ Weight

Routine monitoring

- ✓ If CrCL >60ml/min then check U&Es, FBC and LFT annually
- ✓ If CrCl 30 – 60ml/min check U&E every six months and FBC and LFT annually
- ✓ Check weight annually

Patients should return on a regular basis for on-going review of their treatment, but as a minimum annually as per NICE CG180.

At each review visit;

- Assess compliance and reinforce advice regarding regular dosing schedule.
- Enquire about adverse effects such as bleeding.
- Assess for the presence of thromboembolic events
- Enquire about other medicines, including OTC medicines especially aspirin and NSAIDs
- Consider other side effects and carefully assess relation with DOAC, decide for continuation (and motivate), temporary cessation or change of anticoagulant drug.

Choice of medication

For many patients with AF, Edoxaban represents the most cost-effective choice of DOAC but there are a number of factors which should be taken into account when selecting a DOAC. For example:

- If CrCl >30 but <50ml/min then apixaban is preferred
- If the patient is being treated for long term VTE prophylaxis – rivaroxaban and apixaban both have lower doses which are effective and minimize bleeding risks.
- Interacting medication – see BNF for full details

The current local guidance can be found at
https://formularymk.nhs.uk/docs/formulary/02/Anticoagulation%20Guidance%20Jan%202019.pdf

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

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