Prescribing Points

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Oxfordshire Cinical Commissioning Group

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This newsletter is uploaded to the OCCG website . For queries, contact louisa.griffiths@oxfordshireccg.nhs.uk
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Seasonal Influenza programme – Claiming for Vaccines

Practices are reminded that where vaccines have been centrally procured for the practice through Public Health England, you should **not** make a claim under personal administration arrangements to the NHS Business Services Authority (NHSBSA) on form FP34P/D Appendix or FP10.

Last year NHSBSA Prescription Services identified a higher number of FP34P/D Appendix forms and FP10 forms claiming payment for Fluenz Tetra nasal spray suspension Influenza vaccine, as well as claims for NeisVac-C vaccine, Boostrix IPV injection and Zostavax vaccine where practices later verified these had been centrally procured via a vaccine ordering facility, such as ImmForm. In 14/15 this affected 27 Oxfordshire practices.

Practices must not submit payment claims for vaccines or injections obtained in this way to the NHSBSA.

An FP34P/D appendix or FP10 form should only be submitted for payment to cover the 'dispensing' of the vaccine for personal administration where the vaccine has been purchased by the practice.
More information on how flu vaccines are supplied is available in the annual flu letter published by the Department of Health here

So What?
Practices should ensure that any vaccines centrally purchased are not claimed for on form FP34P/D or FP10.
All flu vaccines for under 18s will be centrally purchased, whereas flu vaccines for adults will be purchased by the practice.
Please ensure all relevant staff know the correct claiming methods.

Children's Flu Information and Immunisation 2015/16 – Website

The Oxford AHSN Children's Network have created a new section of their website to host links to relevant information, resources and advice about children's flu and the vaccination programme for 2015/16.
It is aimed as a helpful resource for families, relevant professionals and those working in settings where the eligible cohorts of children might be and has various 'zones' for different groups to get advice.
The website can be accessed here

High strength, fixed combination and biosimilar insulin products

A number of new products have recently been launched or are due to become available in September 2015. The risk of medication errors was summarised recently by MHRA.

Key feature	Active substance	Brand name	Strengths (units/ml)	Device	Availability
High strength	Insulin degludec	Tresiba	100	FlexTouch prefilled pen	Current
			200		Current
	Insulin lispro	Humalog	100	KwikPen prefilled pen	Current
			200		Current
	Insulin glargine	Lantus	100	SoloStar prefilled pen	Current
		Toujeo	300		September 2015
Fixed combination	Insulin degludec & liraglutide	Xultophy	Degludec 100 & liraglutide 3.6mg/ml	Prefilled pen	Current
Biosimilar	Insulin glargine	Abasaglar	100	Kwikpen prefilled pen & cartridges	September 2015

High strength products

High strength insulin products have been developed for patients with large daily insulin requirements to reduce the number and volume of injections.

The safe use of the higher strength formulations of Tresiba and Humalog has been addressed previously by the manufacturers. Dose conversion is NOT necessary when switching to these high strength insulins. One dose-step for Humalog is equivalent to 1 unit, while one dose-step for Tresiba is 2 units. The 'dose step' is a new term to define how patients dial up the required drug dose on the prefilled pen.

Toujeo is NOT bioequivalent to Lantus and therefore not interchangeable. A dose adjustment may be required when switching between basal insulins. One dose-step is equivalent to 1 unit.

The dose-counters for all of the above display units.

Fixed combination products

Xultophy (degludec and liraglutide) will be reviewed by APCO this month. Prescribers are requested to await local guidance following the review. Current guidance states that degludec should only be initiated by specialist.

Biosimilar insulin glargine

Abasaglar (biosimilar insulin glargine) is expected to be launched in September 2015. Prescribers are requested to await local guidance once a decision has been made regarding its place in therapy.

So what?

Prescribers should be aware of the new insulin products available and the potential for errors to occur especially with the higher strengths. Local guidance on the place in therapy of the fixed combinations and biosimilar agents will be available soon

MHRA Warning -Accu-Chek Mobile meter and Accu-Chek Mobile test cassette may give falsely high readings

The MHRA have issued a Medical Device Alert warning that the Accu-Chek Mobile meter may give falsely high readings if the specific testing procedure is not followed and, as a consequence, patients may take insulin when they don't need it. More information and advice can be found here.

Risk of diabetic ketoacidosis during treatment with SGLT2 inhibitors

Prescribers are asked to ensure all patients on sodium-glucose co-transporter-2 (SGLT2) inhibitors (dapagliflozin, canagliflozin, empagliflozin) receive education on symptoms of ketosis and what action needs to be taken if it occurs or is suspected.

101 cases of diabetic ketoacidosis in type 2 diabetes patients on SGLT2 inhibitors, out of an estimated 500,000 patient-years, have been reported worldwide to Eudravigilance. The European Medicines Agency has commenced a review in light of these reports, and the MHRA have issued a drug safety alert. A letter for health care professionals is now available.

OCDEM have made the decision to make the SGLT2 inhibiters **consultant initiation only** medicines pending further review.

- Serious, sometimes life-threatening cases of diabetic ketoacidosis have been reported in patients on SGLT2 inhibitor treatment (canagliflozin, dapagliflozin or empagliflozin) for type 2 diabetes.
- In a number of these reports, the presentation of the condition was atypical with only moderately increased blood glucose levels observed. Such atypical presentation of diabetic ketoacidosis in patients with diabetes could delay diagnosis and treatment.
- Patients on SGLT2 inhibitors should be tested for ketones when they present with symptoms of acidosis in order to prevent delayed diagnosis and patient management.
- Cases of diabetic ketoacidosis were also reported in patients with type 1 diabetes who were given SGLT2 inhibitors. Prescribers are reminded that type 1 diabetes is not an approved indication for this drug class.

So what?

- Prescribers should inform patients of the signs and symptoms of metabolic acidosis (such as nausea, vomiting, anorexia, abdominal pain, excessive thirst, difficulty breathing, confusion, unusual fatigue and sleepiness) and advise them to immediately seek medical advice if they develop such signs and symptoms.
- It is recommended that patients taking SGLT2 inhibitors should be assessed for ketoacidosis when they present with signs or symptoms of metabolic acidosis in order to prevent delayed diagnosis and patient management. If ketone levels are greater than 1.0mmol/l then seek help.
- Further advice may be sought from the on-call diabetes registrar at the Churchill Hospital on 01865 741841.
- Further information regarding the risk of diabetic ketoacidosis and SGLT2 inhibitors will be given in the coming months once a more detailed review has been made.

Licensed Vitamin D Drops for Children

A new product has been added to the vitamin D guidance found here.
Fultium D3 drops is a 25ml bottle (£10.70) containing 41 drops per ml.
3 drops contain 200IU.
The following doses may be used in children with vitamin D deficiency:

- 0-2 years 6-15 drops daily
- 2-11 years 6-30 drops daily
- 12-18 year 6-60 drops daily

For more information see the SPC.

Apixaban for Venous Thromboembolism

The Primary Care guideline for NOACs for the treatment and prevention of DVT and PE has been updated in line with new NICE guidance: apixaban (TA 341) and dabigatran (TA327). This is in addition to the previous NICE TA for rivaroxaban (TA 261). Apixaban, dabigatran and rivaroxaban all now have NICE approval for DVT and PE. Updated guidelines can be found here.

The Trust has started to use apixaban for VTE. Therefore, it is likely that there will be a greater number of discharge prescriptions for apixaban and requests to prescribe as long term secondary prevention from the VTE clinic. OUH protocols have been updated and are available to view here: http://oxford-haematology.org.uk/clinical-services/haemophilia-thrombosis/gp-area.

Prescribing to Care & Nursing Homes

Medication Waste

As a result of work carried out as part of the CCG's Medication Waste Project it was identified that several homes across Oxfordshire have been operating a policy of discarding all their medication at the end of each cycle regardless of their expiry dates.
This has resulted in a very large volume of viable medication being destroyed unnecessarily, with initial calculations putting a figure of approximately £200,000 to this.
Whilst meetings have taken place with the homes involved, it would be worth considering whether any other homes are also doing this. It would also be useful to highlight to all prescribers that this practice is not acceptable and generates a huge level of waste. There are clear guidelines in place for homes to follow which give staff directions on expiries for the different types of medication here.

So What?
Homes should not be discarding all medication at the end of every cycle. *PRN* medications, creams, inhalers etc. should be used and discarded in accordance with CCG guidance. Any prescriber concerned with the practice at a home they visit should contact Ross Burton at ross.burton@oxfordshireccg.nhs.uk

Medication Directions

During recent visits from CQC inspectors to care and nursing homes in Oxfordshire it has been identified that the directions on certain groups of medicines are often insufficient. This has led to homes receiving advice that these directions should be amended in order to ensure the safety of the resident is not at risk.
It is imperative that directions for items such as creams, eye drops, *PRN* medications and nasal sprays are written in full at the time of prescribing. This will allow the dispensing pharmacy to put adequate instructions on both the medication and MAR sheets to avoid any potential misunderstandings.
e.g. 'As required into the affected eye(s)' should be replace with 'One drop into the right eye twice a day'
'Apply to affected area as directed' should be replaced by 'Apply to left knee twice a day'

So What?
Prescribers should ensure instructions for all medications are clear and accurate to avoid potential risk to the residents within the care home setting

Proactive Medical Support for Care Homes

A reminder that this is an OCCG scheme to pair care homes with a local GP practice, so that a single named GP visits the home on a weekly basis. Residents who are registered with the practice (subject to their right to choose their GP) will receive proactive medical care, with the aim of reducing the number of emergency and non-elective admissions they might have. Feedback so far has been positive, and practices who have signed up to the scheme have said that, after some initial work, it saves GP time and improves patient care. Currently there are 32 GP practices signed up to the scheme, covering 44 care homes.

More information:

- Care home scheme newsletter available here
- Practices already signed up to the scheme received a recent communication about modifications to the scheme. This information can be found here

MDS Dispensing in the Community

It has become clear that there is variation in the level of monitored dosage system (MDS) dispensing by community pharmacies across the county. This has resulted in situations where a risk has been highlighted to us, around quality and safety, and we have had a report of a potentially serious incident.

Community pharmacists are required to assess and make reasonable adjustments for patients where appropriate, in line with the Equality Act 2010 (previously Disability Discrimination Act, DDA), and are funded for this as part of their negotiated service. However, there is also considerable demand for MDS from other sources; but there is no legal or contractual requirement for pharmacies to provide MDS outside of the DDA.

Pharmacies are expected to provide sufficient support and resources to ensure that the accepted level of MDS dispensing does not negatively impact the quality or safety of the essential services to patients. Sufficient capacity must be maintained by pharmacies to accommodate DDA patients who choose to use their services; therefore, non-DDA patients should be signposted to alternative pharmacies if dispensing capacity has been met.

Requests for 7 day prescriptions to support MDS when there are no clinical, safety or waste concerns are not appropriate.
7 day prescriptions must be dispensed and handed out to patients/carers at 7 day intervals (allowing for exceptional circumstances such as holidays)

So what?
Prescribers are asked to:

- Support community pharmacists' decisions on reasonable adjustments for your patients.
- Only use repeat dispensing for patients who are NOT expected to have regular changes to their medicines.
- Only issue 7 day prescriptions for patients where there is an appropriate clinical need to supply at 7 day intervals e.g. expected regular changes to medicines, compliance, safety.
- Issue 28 day prescriptions for patients who are clinically appropriate for 28 day dispensing intervals.
- If medicines change after MDS has already been dispensed then prescriptions must be reissued for ALL medicines to allow fresh trays to me made up.

Nutriprem 2 Liquid

Nutriprem 2 Liquid has been mistakenly categorised as NOT available on the NHS (NHS) on Emis Web. This has resulted in practices being unable to print FP10 prescriptions for this product, for patients in whom the milk is newly prescribed (repeat prescriptions appear to be unaffected). This problem can be rectified by clicking on "change all" on the issue screen on Emis Web and selecting the option to print an NHS prescription.
Both Nutriprem 2 Liquid and Powder are only ACBS approved for "catch-up growth in pre-term infants (i.e. less than 35 weeks at birth) and small for gestational age infants, **until 6 months corrected age**."
However, in 2014/15, nearly £35,000 was spent on Nutriprem 2 milk in Oxfordshire. Over half of this cost was for the liquid preparation. Nutriprem 2 Liquid is considerably more expensive than the powder. It is also required to be placed in a fridge once opened and discarded within 24 hours, so there is potential for waste.
Before issuing a prescription for Nutriprem 2 Liquid it would be useful to consider:

- **Does the patient comply with the ACBS indications?**
- **Does the baby require the liquid or would the powder suffice?**

Rifaximin for Hepatic Encephalopathy

Rifaximin is now recommended as an option for a small group of patients to reduce recurrence of episodes of overt hepatic encephalopathy in line with NICE TA 337.
It has been agreed that should be prescribed **in secondary care only** (red) and therefore GPs should not be expected to prescribe this drug.

So what?
Rifaximin is now an option in overt hepatic encephalopathy but should only be prescribed in secondary care