PostScRxipt – PrimaRxy Care

August 2008

CONTROLLED DRUGS: PRESCRIPTION VALIDITY PERIOD AND QUANTITY TO BE PRESCRIBED: HDL(2006)27 Safer Management of Controlled Drugs (CDs): Private CD Prescriptions and Changes to NHS Prescriptions highlighted several changes to regulation for CD scripts.

Since June 2006, scripts for schedule 2, 3 and 4 CDs are valid for only 28 days from the date issued or from the specified start date. If the script is presented for dispensing after the 28 days have elapsed, CDs must not be supplied. Pharmacists who cannot supply the full amount at the first presentation of the script must ensure the patient knows to return for the remainder before the 28 days have elapsed, as owings cannot be issued once the script ceases to be valid.

However, for instalment dispensing, only the first instalment must be dispensed within the 28 day limit, with the remainder dispensed in accordance with the prescribed instructions. This means that scripts for longer than 28 days can continue to be supplied after that.

This circular also notes that **other than in exceptional circumstances, prescribers are strongly advised to restrict prescribing of schedule 2, 3 and 4 CDs to a maximum of 30 days supply**. Where a prescriber considers it **clinically appropriate** to supply more than this and it does not pose an unacceptable risk to patient safety, the patient's notes should be annotated to that effect. **Prescribers who issue more than a 30 day supply should be prepared to justify their decision.** Prescribing for long periods is likely to lead to increased waste of dispensed medicines due to changes in a patient's clinical condition. It may also contribute to diversion.

UNSIGNED PRESCRIPTIONS: Every month across the health board, nearly 2,000 unsigned prescriptions are dispensed. Prescribers are reminded to check that all prescriptions are signed before they are issued. This will save patients an extra journey and the surgery wasted time.

GGC FORMULARY 2ND EDITION: This will be published and distributed in August 2008. Following user feedback a new feature is an index located at the back containing all drugs listed in the Formulary. The structure of the Formulary is the same with the **Preferred List** for drugs appropriate for initiation in general practice and by those prescribing outwith their speciality area and the **Total Formulary** containing all other formulary drugs including those for specialist initiation and use. See: http://tinyurl.com/5fkwjf

MIDAZOLAM: From 1st January 2008, the legal classification of midazolam changed from a Schedule 4 Part 1 controlled drug (CD) to Schedule 3. This applies to all midazolam products including midazolam injection 10mg/2ml, 10mg/5ml, 50mg/50ml and the named patient preparation, buccal midazolam liquid 10mg/ml (Epistatus®). Midazolam is the only Schedule 3 CD that, in certain circumstances can be included in a PGD.

- **Full CD prescription writing requirements are now necessary for all midazolam products. This includes dose, formulation, strength and total quantity in both words and figures.**
- Midazolam does not legally need storage in a CD cabinet and records are not required to be kept in the CD register.

GOODBYE ALISTER AND LAURA: Two more of our prescribing team are leaving to take up new posts. Alister MacLaren as Lead Pharmacist Clinical Governance and Laura Hendry as the Lead Pharmacist Prescribing and Clinical Pharmacy in South East Glasgow CHCP. Alister has been with the team for eight years and integral in developing the prescribing support services. Laura a key pharmacist for prescribing indicators also leaves after over three years. Both will be greatly missed but we wish them all the best in their new posts.

AUDIT OF ALENDRONATE 70mg PRESCRIBING FOR OSTEOPOROSIS IN NHS GREATER GLASGOW AND CLYDE

In January 2006, the Osteoporosis Group agreed that generic alendronate 70mg weekly was the preferred oral bisphosphonate of choice for osteoporosis.

Since then the prescribing of generic alendronate has increased. A report in March 2007 however, indicated that there was a lower than average proportion of generic alendronate prescribed in the South of Glasgow. This report was presented to the Osteoporosis Group and as a result the group requested that a bisphosphonate prescribing audit be carried out within primary care in order to establish the source and the reasons for non alendronate 70mg prescribing.

The audit was carried out in selected practices with lower than average use of alendronate 70mg of all weekly and monthly oral bisphosphonates (≤85%). Data was collected for 526 patients in 37 GP practices across 7 CH(C)Ps. Patients ranged in age: 24yrs – 93yrs with an average age of 67yrs. 84% of patients were female.

For the purpose of this report, a sample was taken in order to summarise the number of patients who were initiated on a bisphosphonate other than generic alendronate 70mg between 1st November 2006 and the 1st November 2007 (n = 74).

Results

- 61% of patients who were initiated on a bisphosphonate other than alendronate 70mg were initiated by the hospital, with 82% of these patients originating from an out-patients setting
- 59% of out-patients were seen by the Bone Mineral Metabolism Clinic.
- The majority of patients (53%) initiated on a bisphosphonate other than alendronate 70mg originated from the Southern General Hospital (SGH), however there were a number of limitations associated with this, since most of the patient data gathered were from GP practices in the South of Glasgow.
- Only 27% of hospital patients had reasons documented for why alendronate 70mg was not suitable.
- The most common reason for not prescribing alendronate 70mg was a previous intolerance
- Risedronate 35mg was the most commonly prescribed bisphosphonate (other than alendronate 70mg) with 76% of patients being prescribed this.

Conclusion

The full audit report was presented to the Osteoporosis Prescribing Short Life Working Group on the 14th December 2007. At this meeting, it was noted that throughout Greater Glasgow and Clyde, the prescribing of generic alendronate constituted between 78 and 85 percent of all oral bisphosphonate prescribing. There were variations within the city, with higher risedronate prescribing in the South. It was agreed unanimously that generic alendronate was the preferred first choice bisphosphonate and where generic alendronate was not an appropriate treatment choice, clinicians should be explicit in sharing justification of that decision with primary care prescribers in order that they understand why they are being asked to prescribe an alternative.

Recommendations

- **Generic alendronate remains the preferred oral bisphosphonate treatment of choice in NHSGGC, with the 70mg weekly formulation the preferred option for osteoporosis.**
- Where generic alendronate 70mg is not suitable, reasons why this treatment option is not appropriate should be clearly documented.

BNF e-NEWSLETTER: The BNF and BNFC have launched an electronic newsletter recently. This will provide updates, tips, links to case studies and examples of prescribing excellence. To subscribe go to: http://bnf.org/newsletter

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