PostScRxipt – PrimaRxy Care

March 2009

CIALIS®: Cialis® has recently been licensed for once daily use for the 2.5mg and 5mg strengths. Scottish Medicines Consortium advice on use in this regime is expected in June. Until this time it should only be prescribed on a 'when required' basis. See last month's bulletin for advice on prescribing for erectile dysfunction.

NEW NAME FOR ASCENSIA MICROFILL STRIPS®: Bayer Diagnostics® have changed the name of Ascensia Microfill Test Strips to Contour Test Strips®. Prescribers should now use the new name. Until all prescribing software is updated, pharmacists should endorse prescriptions bearing the old name with 'Contour'.

NHS Greater Glasgow and Clyde

RIMONABANT®: The EMEA recommended the suspension of the marketing authorisation for rimonabant (Acomplia®) in October 2008. In December 2008 the marketing authorisation holder (Sanofi-Aventis) notified the European Commission of its decision to voluntarily withdraw its marketing authorisation. The company stated that no additional clinical data will now be available to lift the suspension for Acomplia following its decision to discontinue the ongoing rimonabant clinical development program in all indications.

On 16th January 2009, the European Commission issued a decision to withdraw the marketing authorisation for Acomplia®. Pursuant to this decision the European Public Assessment Report for Acomplia® will be updated to reflect that the marketing authorisation is no longer valid.

CARE HOME SIP FEED PROJECT: Prescribing of oral nutritional products in care homes has been raised as a concern for the past three to four years. In 2008 funding was agreed to audit the use of sip feeds within the care homes covered by the Nursing Home Medical Practice. Residents on sip feeds and Calogen® were identified and assessed by the project dietitian. Recommendations were then made as to the ongoing need for these prescriptions.

RESULTS: 262 residents were reviewed over a 6 month period = 321 prescriptions (21% of residents were on 2 or more products per day)

- **23%** (112) of the initial sample of residents were seeing a dietitian
- **50%** (130) were on sip feeds including Calogen® for over 1 year
- **80%** had been on them for over 6 months *(evidence suggests sip feeds are of limited benefit after 6 months)*
- **66%** of the 321 scripts were for the formulary 'Forti' range and 21% were for Calogen®

Following dietetic input, 66% of prescriptions were reduced or discontinued.
This resulted in a cost saving of £404.00 per day for all the changes made.
Prescribing data revealed a saving of £80,000 over the 6 month period of the project.

CONCLUSION:

- Sip feeds should only be used in 'high risk' residents where 'food first' approaches have failed after 4 weeks
- Clear instructions and goals should be given as to how and when sip feeds should be used for each resident eg not with meals
- If prescribed, sip feeds should only be used in the short term and reviewed regularly. Anyone on sip feeds should be reviewed every three to six months by dietician or trained professional
- Avoid the use of modular products eg Calogen®, Maxijul® without dietetic input /advice

A management toolkit for under-nutrition including prescribing guidelines for nursing homes is to be rolled out in 2009. For a copy of the full report / executive summary or if you have any queries please contact Hilary Hogan (project dietitian) on 0141 201 5197 or hilary.hogan@ggc.scot.nhs.uk

To receive this bulletin electronically, send an e-mail to nhsggc-postscript-subscribe@googlegroups.com
Send comments, contributions or suggestions to prescribing@ggc.scot.nhs.uk

RATIONAL PRESCRIBING INCENTIVE SCHEME 2009/2010

The Rational Prescribing Incentive Scheme for 09/10 has been agreed by the Prescribing Management Group (Primary Care). The scheme will consist of one CH(C)P fixed prescribing indicator and two practice specific prescribing indicators. As in previous years the indicators will be selected based on the potential to generate the most savings for the CH(C)P and the GP practice. A payment of £200 for every 1000 patients will be paid for each target achieved with a bonus of £100 per 1000 patients where all three indicator targets have been met. The baseline data for the setting of indicators is from October to December 2008. The final measurement will be using ***Oct-Dec 2009*** data. The three prescribing indicators for the scheme are selected from the following:

INDICATOR	TARGET
Lansoprazole and omeprazole (excluding FasTabs & MUPS) as a % of all oral PPIs Rationale: *Lansoprazole and omeprazole are the PPIs of choice in the Preferred List*	**≥90%** (or abs increase of 5%)
Standard ISMN as a % of all ISMN Prescribing Rationale: *There is no evidence that modified-release nitrates are more effective or improve compliance compared to standard. Standard release ISMN is more cost-effective.*	**≥70%** (or abs increase of 10%)
Co-codamol 8/500, co-codamol 30/500 and paracetamol tablets, capsules or caplets as a % of all solid dose co-codamol and paracetamol Rationale: *Effervescent formulations contain significant amounts of sodium which can affect control of hypertension and are premium priced. The Preferred List restricts use of effervescent formulations to those with swallowing difficulties. Co-codamol 8/500 and 30/500 are the only strengths in the Preferred list, all other strengths are non-Formulary.*	**≥90%**
Clopidogrel as a % of all antiplatelet drugs Rationale: *GP Audits have suggested that clopidogrel is being used outwith the antiplatelet guidelines. This has a significant cost implication. Inappropriate combination use with aspirin raises potential safety issues.*	**≤10%** (or abs decrease of 5%)
Levocetirizine and Desloratadine as a % of all non-sedating antihistamines Rationale: *Levocetirizine and Desloratadine are non-Formulary antihistamines and offer no real advantages over Formulary choices. They are also less cost-effective.*	**≤5%**
Standard diclofenac sodium, ibuprofen & naproxen as a % of all NSAIDS (inc. Cox-2s) Rationale: *Diclofenac & ibuprofen are drugs of first choice in the Preferred List. The MHRA noted naproxen may be less likely than other NSAIDs to have adverse CV events.*	**≥70%**
Alendronate as a % of all bisphosphonates prescribed for osteoporosis (excluding daily doses) Rationale: *This is the oral bisphosphonate of choice for osteoporosis in the Formulary*	**≥90%** (or abs increase of 10%)
Fluoxetine & Citalopram as a % of all SSRIs, duloxetine, mirtazapine, reboxetine and venlafaxine Rationale: *Fluoxetine and citalopram are both drugs of choice in the Preferred List. Where fluoxetine or citalopram are ineffective or not tolerated then mirtazapine or lofepramine may be prescribed as an alternative. Both drugs are listed as alternative antidepressant treatments in the Preferred List and in the antidepressant guidelines*	**≥65%** (or abs increase of 5%)
Simvastatin as a % of all statins Rationale: *Simvastatin is the statin of choice in the Preferred List and in the Cholesterol guidelines*	**≥65%** (or abs increase of 10%)
Solid dose ferrous fumarate as % of solid dose ferrous fumarate and ferrous sulphate *NEW* Rationale: *Ferrous fumarate is more cost-effective compared to ferrous sulphate.*	**≥80%**
Tramadol as a % of all Tramadol, Tramadol SR and Tramacet prescribing *NEW* Rationale: *Standard oral tramadol is cost-effective compared to SR formulations. Tramacet is non-Formulary.*	**≥90%**
Ketoprofen & Piroxicam as a % of all Topical NSAIDS *NEW* Rationale: *Ketoprofen and Piroxicam are the Formulary listed topical NSAIDs.*	**≥80%**
Escitalopram as a % of all SSRIs *NEW* Rationale: *Escitalopram is non-Formulary and significantly more expensive than citalopram.*	**≤5%**
Antibiotic DDDs / 1000 weighted patients *NEW* Rationale: *Overuse of antibiotics is known to increase the problems of resistance eg MRSA Prescribing trends have increased recently despite this.*	**1950**

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