PostScRxipt
from the
NHSGGC Area Drug & Therapeutics Committee
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REDUCING THE QUANTITY OF UNUSED PRESCRIBED MEDICINES

The issue of unused medicines within the NHS is receiving increasing scrutiny from the government and the media. The Department of Health estimates that 10% of all drugs prescribed in primary care are not taken and destroyed. Across primary care in NHSGGC, that would account for approximately £24 million annually.

Evidence from Wales shows that abolishing prescription charges leads to increased prescribing. Concerns have been raised that the Scottish Government's commitment to abolishing prescription charges by 2011 could lead to increased levels of unused medicines.

What has been done already?
In January 2008, a publicity campaign (**news.bbc.co.uk/1/hi/scotland/glasgow_and_west/7529452.stm**) was launched in a number of CH(C)Ps across NHSGGC to raise awareness of the safety and cost issues associated with over ordering of medicines. The message to patients was "Only order what you need". Posters and leaflets were displayed in GP surgeries, community pharmacies, hospitals and appropriate community venues. Carers and patients were encouraged to only order repeat prescriptions they needed. The campaign highlighted the dangers associated with hoarding medicines and the fact that unused medicines cannot be recycled.

Evaluation of the campaign took place in three CH(C)Ps in March 2008. Patients were asked to complete an evaluation form by their GP practice staff, community pharmacy staff or through the CH(C)P patient forums. The views of participating practice staff and community pharmacy staff were also sought.

In total, 707 patient forms, 45 practice staff forms and 40 community pharmacy staff forms were returned.

Patient views
A sample of key results from patients who responded included:

Issue	Before	After
Do you check if you need all repeat medicines before ordering?	72%	91%
Will you tell your surgery or pharmacy if you are no longer taking a medicine?	59%	90%
Do you return unwanted medication to the pharmacy for safe disposal?	48%	86%

Staff views
Common themes from staff were that the campaign was successful but needed to be higher profile. There was support for the materials used and for the fact that the campaign highlighted the important role of GP practice and pharmacy staff.

Future plans
Unused medicines continue to be a priority at national and board level and a re-launch of the campaign in 2009 is planned. The 'Building a Better Scotland Efficient Government' programme will include a focus on reducing waste of prescribed medicines in future years. The chronic medication service within the new community pharmacy contract will change the way repeat prescribing is managed and should also make a significant contribution to this initiative.

Efforts to reduce waste must tackle all aspects of medicines use and ordering. Some aspects are listed below, and many personnel are involved at each stage.

• PATIENTS
Patients should carefully review what is required before ordering repeat medicines and not order medicines they do not plan to take. Reasons could include the medicine being stopped, no perceived benefit, development of side effects or sufficient supplies already at home.

• PRACTICES
Repeat prescribing systems must be carefully managed with synchronisation of repeat intervals, alerts when medicines are ordered too frequently, removal of drugs no longer required etc. Audit and review work is being undertaken in practices to support this.

• PHARMACIES
Staff should check that the patient requires the drugs before dispensing, be alert to over-ordering and link with the practice and patient to ascertain reasons. The 'Not Dispensed' initiative is ongoing.

• HOSPITALS
In hospitals work continues on the roll out of 'Making the Most of Your Medicines' with the use of patients' own medication while in hospital.

For all article references, check our website www.ggcformulary.scot.nhs.uk

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Website
http://www.ggcformulary.scot.nhs.uk

Alphabetical list of most recent ADTC decisions

For full details of SMC advice, visit **www.scottishmedicines.org** For NICE advice, visit **www.nice.org.uk**
For previous ADTC decisions, visit **www.ggcformulary.scot.nhs.uk**

Drug	Indication under consideration (There may be other licensed indications)	NHSGGC decision	
Aripiprazole (Abilify®)	Moderate to severe manic episodes in bipolar 1 disorder and for the prevention of a new manic episode in patients who experienced predominantly manic episodes and whose manic episodes responded to aripiprazole treatment.	Non-*Formulary*.	x
Capecitabine (Xeloda®)	Metastatic colorectal cancer.	Total *Formulary*. Acknowledge new indication. Restricted to use in accordance with regional protocol.	√R
Cinacalcet (Mimpara®)	Reduction of hypercalcaemia in patients with primary hyperparathyroidism for whom parathyroidectomy would be indicated on the basis of serum calcium levels (as defined by relevant treatment guidelines), but in whom parathyroidectomy is not clinically appropriate or is contraindicated.	Non-*Formulary* for this indication.	x
Dexrazoxane (Savene®)	Anthracycline extravasation.	Non- *Formulary*.	x
Duloxetine (Cymbalta®)	Generalised Anxiety Disorder.	Non- *Formulary* for this indication.	x
Maraviroc (Celsentri®)	In combination with other antiretroviral medicinal products, for treatment-experienced adult patients infected with only CCR5-tropic HIV-1 detectable.	Non- *Formulary*.	x
Nelarabine (Atriance®)	Treatment of patients with T-cell acute lymphoblastic leukaemia and T-cell lymphoblastic lymphoma whose disease has not responded to, or has relapsed following, treatment with at least two chemotherapy regimens.	Total *Formulary*. Restricted to specialist use in accordance with regional protocol.	√R
Nilotinib (Tasigna®)	Treatment of chronic phase Philadelphia chromosome positive chronic myelogenous leukaemia in adult patients resistant to or intolerant of at least one prior therapy including imatinib.	Total *Formulary*. Restricted to specialist use in accordance with regional protocol.	√R
Pegylated liposomal doxorubicin (Caelyx®)	Treatment of progressive multiple myeloma in patients who have received at least one prior therapy and who have already undergone or are unsuitable for bone marrow transplant in combination with bortezomib.	Non-*Formulary*.	x
Ropinirole (Requip® XL)	Treatment of idiopathic Parkinson's disease in patients already taking ropinirole immediate release tablets and in whom adequate symptomatic control has been established.	Total *Formulary*. Acknowledge new formulation. Restricted to use on the advice of consultants with a special interest in Parkinson's disease or movement disorders.	√R
Salbutamol (Salbulin® MDPI Novolizer)	For use in patients with reversible airways obstruction such as asthma for relief and prevention of asthma symptoms.	*Formulary* Preferred List. Acknowledge new formulation.	√
Sitagliptin (Januvia®)	For patients with type 2 diabetes mellitus to improve glycaemic control in combination with a sulphonylurea when diet and exercise plus maximal tolerated dose of a sulphonylurea alone do not provide adequate glycaemic control and when metformin is inappropriate due to contraindications or intolerance; or in combination with a sulphonylurea and metformin when diet and exercise plus dual therapy with these agents do not provide adequate glycaemic control.	Total *Formulary*. Acknowledge new indication. Restricted to specialist initiation when used in combination with a sulphonylurea when metformin is contraindicated or not tolerated or in combination with a sulphonylurea and metformin. In primary care it is expected that initiation would follow interaction between the GP/Diabetic Specialist Nurse and the consultant contact within the acute sector.	√R
Zoledronic acid (Aclasta®)	Treatment of osteoporosis in post-menopausal women at increased risk of fractures.	Total *Formulary*. Acknowledge new indication. Restricted to specialist use in patients who are unsuitable for, or unable to tolerate, oral treatment options for osteoporosis.	√R

√ = *Formulary* √R = *Formulary* (restricted) **x** = non-*Formulary* **?** = awaiting final decision

Formulary news

Two new monoclonal antibodies added to the NHSGGC *Formulary*

Monoclonal antibody technology is leading to the development of a range of new drugs for conditions such as rheumatoid arthritis, diabetes, psoriasis, macular degeneration and various types of cancer. Two such drugs have recently been added to the Total *Formulary*.

Natalizumab
Natalizumab has been added to the Total *Formulary* for restricted use by specialists in accordance with the local protocol. It is used as single disease modifying therapy in highly active relapsing remitting multiple sclerosis (RRMS) only in patients with rapidly evolving severe RRMS. This is defined by two or more disabling relapses in one year and with one or more gadolinium-enhancing lesions on brain MRI or a significant increase in T2 lesion load compared with a previous MRI.

Natalizumab is thought to act by inhibiting the migration of leukocytes into the CNS so leading to a reduction of inflammation and demyelination. In trials, it is associated with a clinically significant reduction in the annualised relapse rate. There was a statistically significant reduction in the probability of sustained progression of disability over two years compared with placebo; however, the clinical significance of this was unclear.

Omalizumab
Omalizumab has been added to the Total *Formulary* restricted to initiation and monitoring by hospital physicians experienced in the diagnosis and treatment of severe persistent allergic asthma for use in line with the nationally agreed protocol. It is restricted to patients who are prescribed chronic systemic steroids and in whom all other treatments have failed. The response to omalizumab treatment should be assessed in all patients at 16 weeks and treatment should be discontinued in patients who have not shown a marked improvement in overall asthma control.

Omalizumab is a recombinant humanised anti-immunoglobulin E (anti-IgE) antibody. It prevents human IgE from binding to its receptor on mast cells and basophils, thus inhibiting the histamine release response normally triggered by exposure to allergens.

SMC has accepted it as add-on therapy, for its steroid sparing effect, to improve asthma control in adult and adolescent patients (12 years of age and above) with severe persistent allergic asthma. It is restricted to initiation and monitoring by hospital physicians experienced in the diagnosis and treatment of severe persistent asthma and to patients who are prescribed chronic systemic steroids and in whom all other treatments have failed. The response to omalizumab treatment should be assessed in all patients at 16 weeks and treatment should be discontinued in patients who have not shown a marked improvement in overall asthma control.

Dr Christine Bucknall, Respiratory Physician at Stobhill Hospital, is one of the clinicians using this new product. In her experience, this drug has led to dramatic improvements in quality of life and asthma control in a carefully selected group of patients. Those most likely to benefit are patients with proven allergic asthma who have had co-morbid conditions which may be contributing to symptoms controlled and yet still have steroid dependent asthma - this is the approach taken in Difficult or Problem Asthma Clinics being run in different parts of the city.

STOP PRESS

Withdrawal of rimonabant

The European Marketing Authorisation for rimonabant (Acomplia®) has been suspended because the benefits do not outweigh the risks. The most recent assessment showed that there was approximately a doubling of the risk of psychiatric disorders in obese or overweight patients taking rimonabant compared to those taking placebo. Patients who may be at highest risk of psychiatric reactions cannot be identified reliably.

At the time of approval, psychiatric side-effects (particularly depression) were identified as the most important safety issue. Relevant warnings have been included in the product information since its first authorisation. The measures and clinical advice implemented to date to try to reduce the frequency of psychiatric reactions (particularly depression) with rimonabant have not adequately controlled this risk.

Formulary treatments for obesity
Orlistat and sibutramine, two other treatment options for obesity, are included in the NHSGGC *Formulary*. These drugs should be prescribed only through the Glasgow and Clyde Weight Management Service. Both are restricted to use for patients with BMI >30 with relevant co-morbidities and BMI >35 without co-morbidities. Other conditions for prescribing should be in accordance with NICE CG43 (**www.nice.org.uk/CG43**).

Advice for patients
- Patients currently taking rimonabant should consult their doctor or pharmacist when convenient to discuss their treatment.
- Patients who wish to stop taking rimonabant can do so at any time.

Advice for healthcare professionals
- Prescribers should not issue any prescriptions for rimonabant.
- Prescribers should review the treatment of patients currently taking the medicine.
- For further information please go to the EMEA website **www.emea.europa.eu**

Alendronate prescribing for osteoporosis

In January 2006, the Osteoporosis Group agreed that generic alendronate 70mg weekly was the preferred oral bisphosphonate for osteoporosis. It is listed as first choice in the *Formulary* Preferred List. Risedronate is second line, restricted for use in patients who fail to tolerate alendronate due to gastrointestinal side effects, despite the addition of a PPI.

To support this *Formulary* decision, a prescribing indicator was introduced for GP practices that alendronate should account for at least 85% of all oral bisphosphonates prescribed for osteoporosis (excluding daily doses) or the practice should demonstrate an absolute increase of 10%. Before being designated as the preferred option, alendronate accounted for 80.9% of prescribing across GGC; this has risen to 87.2% in the latest financial quarter for which data is available.

Primary care prescribing of these drugs is significant, with over 40,000 prescriptions in the latest financial quarter. Although 12% of prescriptions issued are for risedronate, this drug accounts for 33% of costs. The preferred option, alendronate 70mg, has an average cost per item dispensed of £5.43 compared to £30.76 for the risedronate 35mg.

Approved name	Prescriptions	Cost
Alendronate	35,475	£196,481
Disodium etidronate	257	£5,264
Ibandronic acid	635	£60,350
Risedronate	4,818	£149,938
Sodium clodronate	137	£26,874
Strontium	535	£17,133
Tiludronic acid	2	£396
Grand total	41,859	£456,436

Detailed analysis of prescribing data after the Osteoporosis Group agreed that alendronate was to be first choice indicated that the proportion of alendronate was low in the south of Glasgow. The Osteoporosis Group asked for an audit to be carried out within primary care in order to establish the source and the reasons for prescribing of other bisphosphonates.

Data was collected for 526 patients in 37 GP practices across 7 CH(C)Ps. Patients ranged in age from 24 to 93 years with an average age of 67 years. The majority (84%) were female.

Results

• 61% of patients who were initiated on a bisphosphonate other than alendronate 70mg were initiated by acute care (the Southern General in more than half of cases). 82% of these patients had therapy initiated in an out-patient setting.
• Only 27% of hospital patients had documented reasons why alendronate 70mg was not suitable. The most common reason was previous intolerance.
• Risedronate 35mg was the most commonly prescribed alternative.

The full audit report was presented to the Osteoporosis Prescribing Short Life Working Group. It was agreed unanimously that generic alendronate was the preferred choice bisphosphonate. Where generic alendronate was not appropriate, 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.

Implementing change

A significant amount of work has been undertaken by GP practices and prescribing support teams within the CH(C)Ps to implement the recommended changes. Patient notes were reviewed to ascertain if the people receiving drugs other than the preferred choice had been given alendronate in the past. A substantial number of patients were switched over to the alendronate 70mg preparation. This has resulted in increased use of alendronate and CH(C)P results for the prescribing indicator for the most recent quarter are given below. Only two areas now fall below the target of 85%.

CH(C)P	alendronate as % of all oral bisphosphonates for osteoporosis (excluding daily doses)
Inverclyde	92.1%
Renfrewshire	89.3%
West Dunbartonshire	89.0%
South Lanarkshire	88.2%
West Glasgow	88.1%
East Glasgow	88.1%
North Lanarkshire	87.8%
North Glasgow	87.2%
South West Glasgow	86.3%
East Dunbartonshire	86.2%
East Renfrewshire	84.3%
South East Glasgow	83.7%

Recommendations

• Generic alendronate remains the oral bisphosphonate treatment of choice for osteoporosis. 70mg weekly is the preferred formulation for women.
• Where generic alendronate 70mg is not suitable, reasons should be clearly documented in the clinical notes and correspondence.

NHS Greater Glasgow and Clyde

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