NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Area Prescribing Committee / Interface Update

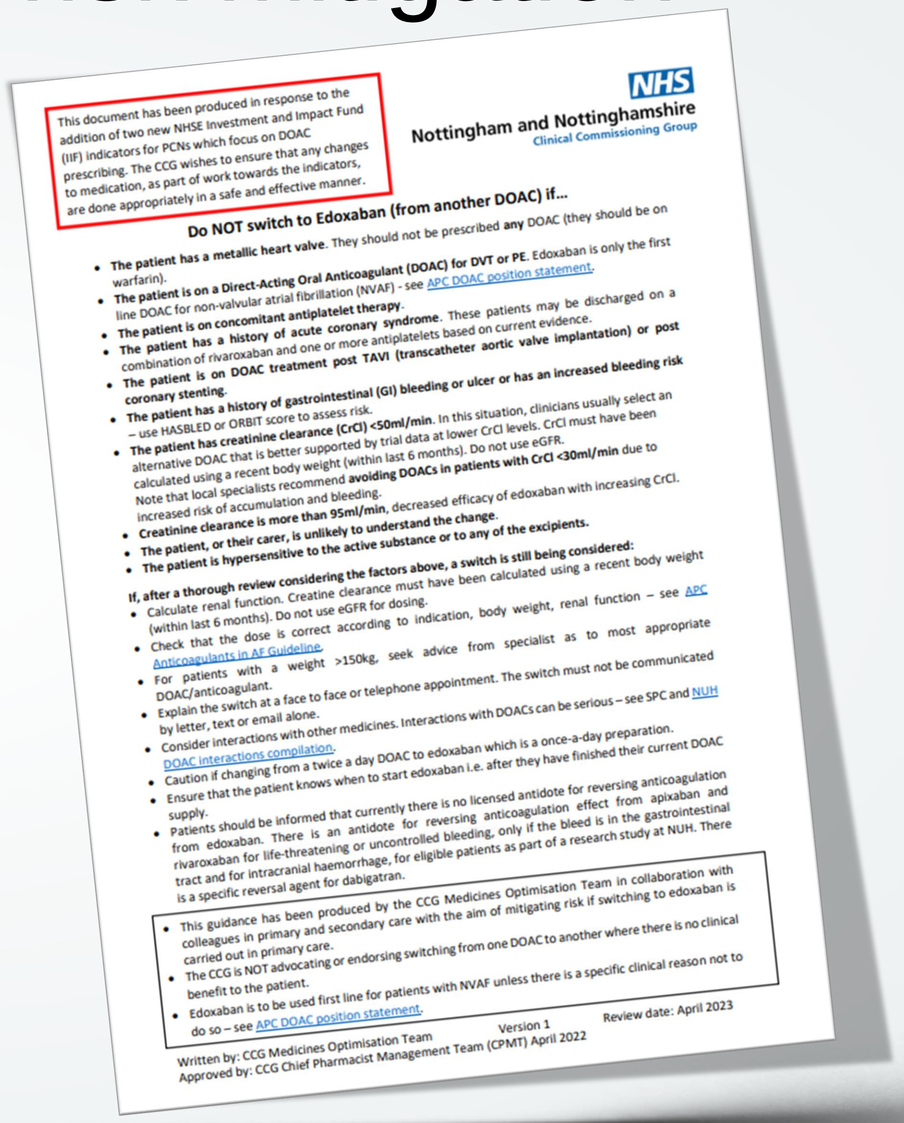
May / June 2022

Please direct queries to your CCG medicines optimisation pharmacist or nnccg.nottsapc@nhs.net

Edoxaban switching – risk mitigation

- NHSE IIF (Investment and Impact Fund) includes two new indicators related to DOACs.
- Aims to increase DOAC treatment in patients with NVAF.
- Also incentivises increasing edoxaban prescribing compared to other DOACs for NVAF – cost effective.
- New patients should be started on edoxaban if all else clinically equal – see position statement.
- Switching existing patients not endorsed by specialists or CCG.
- If considering switching, follow principles to avoid unintended harm.

Click here for link to principles on TeamNet



This document has been produced in response to the addition of two new NHSE Investment and Impact Fund (IIF) indicators for PCNs which focus on DOAC prescribing. The CCG wishes to ensure that any changes to medication, as part of work towards the indicators, are done appropriately in a safe and effective manner.

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Do NOT switch to Edoxaban (from another DOAC) if…

- **The patient has a metallic heart valve**. They should not be prescribed **any** DOAC (they should be on warfarin).
- **The patient is on a Direct-Acting Oral Anticoagulant (DOAC) for DVT or PE**. Edoxaban is only the first line DOAC for non-valvular atrial fibrillation (NVAF) - see APC DOAC position statement.
- **The patient is on concomitant antiplatelet therapy**.
- **The patient has a history of acute coronary syndrome**. These patients may be discharged on a combination of rivaroxaban and one or more antiplatelets based on current evidence.
- **The patient is on DOAC treatment post TAVI (transcatheter aortic valve implantation) or post coronary stenting**.
- **The patient has a history of gastrointestinal (GI) bleeding or ulcer or has an increased bleeding risk** – use HASBLED or ORBIT score to assess risk.
- **The patient has creatinine clearance (CrCl) <50ml/min**. In this situation, clinicians usually select an alternative DOAC that is better supported by trial data at lower CrCl levels. CrCl must have been calculated using a recent body weight (within last 6 months). Do not use eGFR.
  Note that local specialists recommend **avoiding DOACs in patients with CrCl <30ml/min** due to increased risk of accumulation and bleeding.
- **Creatinine clearance is more than 95ml/min**, decreased efficacy of edoxaban with increasing CrCl.
- **The patient, or their carer, is unlikely to understand the change**.
- **The patient is hypersensitive to the active substance or to any of the excipients.**

If, after a thorough review considering the factors above, a switch is still being considered:

- Calculate renal function. Creatine clearance must have been calculated using a recent body weight (within last 6 months). Do not use eGFR for dosing.
- Check that the dose is correct according to indication, body weight, renal function – see APC Anticoagulants in AF Guideline.
- For patients with a weight >150kg, seek advice from specialist as to most appropriate DOAC/anticoagulant.
- Explain the switch at a face to face or telephone appointment. The switch must not be communicated by letter, text or email alone.
- Consider interactions with other medicines. Interactions with DOACs can be serious – see SPC and NUH DOAC interactions compilation.
- Caution if changing from a twice a day DOAC to edoxaban which is a once-a-day preparation.
- Ensure that the patient knows when to start edoxaban i.e. after they have finished their current DOAC supply.
- Patients should be informed that currently there is no licensed antidote for reversing anticoagulation from edoxaban. There is an antidote for reversing anticoagulation effect from apixaban and rivaroxaban for life-threatening or uncontrolled bleeding, only if the bleed is in the gastrointestinal tract and for intracranial haemorrhage, for eligible patients as part of a research study at NUH. There is a specific reversal agent for dabigatran.

- This guidance has been produced by the CCG Medicines Optimisation Team in collaboration with colleagues in primary and secondary care with the aim of mitigating risk if switching to edoxaban is carried out in primary care.
- The CCG is NOT advocating or endorsing switching from one DOAC to another where there is no clinical benefit to the patient.
- Edoxaban is to be used first line for patients with NVAF unless there is a specific clinical reason not to do so – see APC DOAC position statement.

Written by: CCG Medicines Optimisation Team Version 1 Review date: April 2023
Approved by: CCG Chief Pharmacist Management Team (CPMT) April 2022

New Submissions

- **Pridinol (Myopridin®) – added as GREY (non formulary)**
  - Treatment of muscle spasms, lumbar pain, torticollis and general muscle pain in adults
  - Insufficient published evidence to support use
- **Rivaroxaban (Xarelto®) – added as AMBER 2**
  - Licensed for treatment and recurrence prevention of venous thromboembolism (VTE) in **children.**
  - Short courses (3 months) to be provided by secondary care. Where treatment is required for > 3 months, primary care to prescribe.
  - Unlike in adults, it is not required to monitor renal function in children.
- **Testosterone gel – to be added as AMBER 2 once information sheet is developed**
  - Menopause (loss of libido in post-menopausal women)
  - Prescribing information sheet to follow
  - NICE guideline 23 – Menopause: diagnosis and management
- **Progesterone micronised vaginal capsules (Utrogestran®) – added as GREY (no formal assessment)**
  - For recurrent miscarriage
  - Deferred to NUH and SFH drug and therapeutic committees for consideration of RED traffic light classification.

NICE Technology Appraisals

- **Empagliflozin (Jardiance®) – added as AMBER 2**
  - Symptomatic chronic heart failure with reduced ejection fraction
  - As an add-on to optimised standard care
  - NICE TA773

- **Dapaglifozin (Forxiga®) – added as AMBER 3**
  - Chronic kidney disease in adults. It is only recommended if:

  1) it is an add-on to optimised standard care including the highest tolerated licensed dose of angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs), unless these are contraindicated, and
  2) people have an estimated glomerular filtration rate (eGFR) of 25 ml/min/1.73 m^2 to 75 ml/min/1.73 m^2 at the start of treatment and:
  3) have type 2 diabetes or have a urine albumin-to-creatinine ratio (uACR) of 22.6 mg/mmol or more.

  - NICE TA775

Antimicrobial Guidelines

Acute sinusitis (UPDATED)

Main changes:

- Increased self-care information and links to patient information leaflets.
- Guidance added for if patients have had symptoms for > or < 10 days.
- Information regarding use of corticosteroid nasal spray added.

Chronic bacterial sinusitis (UPDATED)

Main changes:

- Increased self-care information and links to patient information leaflets.
- Information regarding use of corticosteroid nasal spray added.
- No antibiotic information included as on the advice of a specialist only.

Dental abscess (UPDATED)

Main changes:

- Increased self-care information and links to patient information leaflets.
- Definitive and appropriate treatment can only be given by a dentist. Medication will not eliminate the source of infection and serious complications can occur if not treated properly.
- Clindamycin removed as antibiotic option.

Antimicrobial Guidelines continued

Hidradenitis suppurativa (NEW)

The guideline includes definitions, features and stages of hidradenitis suppurativa, general measures for patients, general and medical management, and indications for referral.

Urinary tract infections (UPDATED)

Main changes:

- New table linked from MHRA highlighting safety issues with ciprofloxacin.

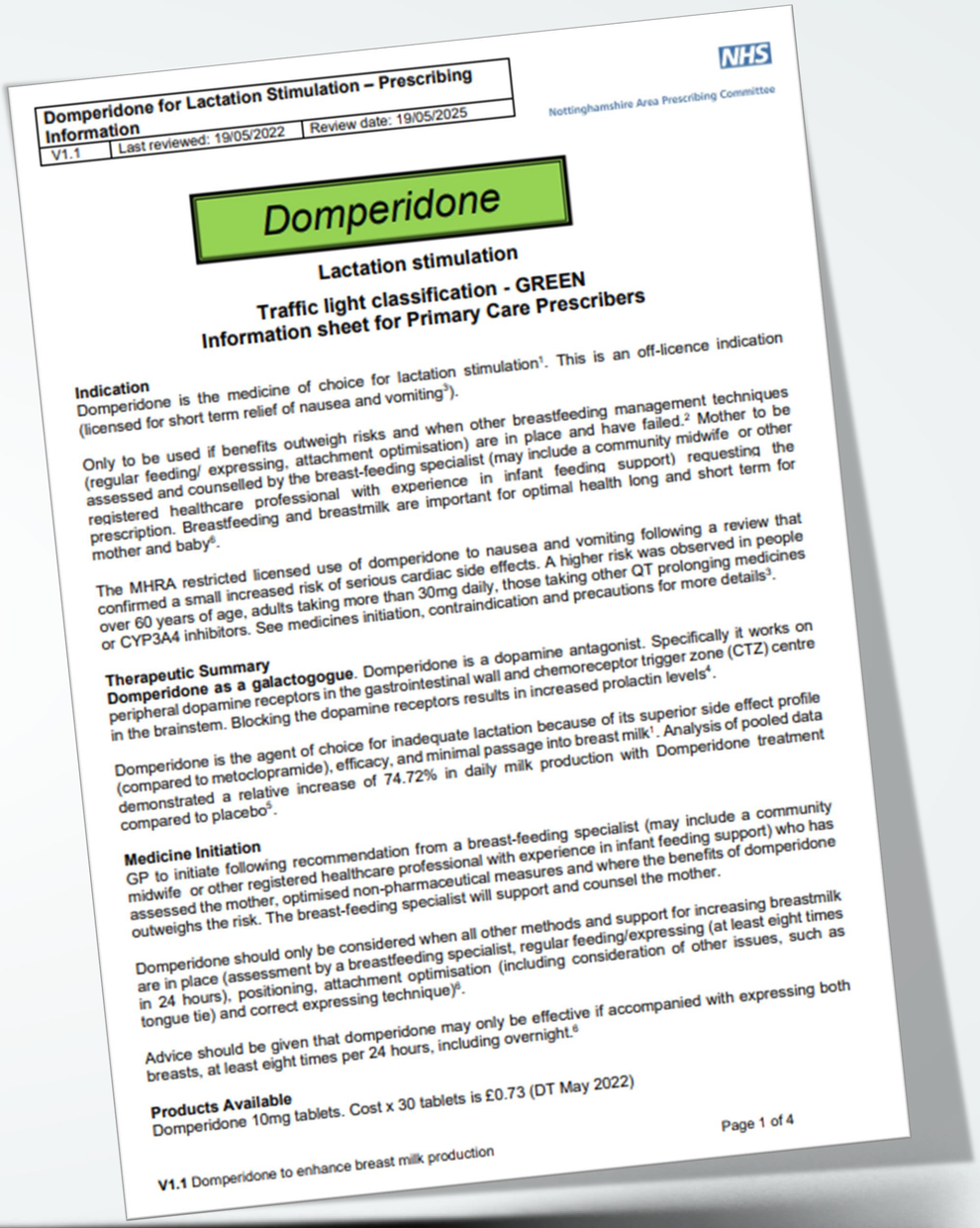
UTI Prophylaxis guideline and PIL are being reviewed in conjunction with NUH.

Guidelines

Domperidone for lactation stimulation (UPDATED)

A new prescribing information sheet and updated standard letter to be sent by breast feeding specialists* when requesting that GPs prescribe domperidone for lactation stimulation (off-label indication).

- Duration of treatment increased from 7 days to 10-14 days in line with National Infant Feeding Network (NIFN) advice. Little evidence to support continuing beyond 14 days.
- *Clarified that assessment for domperidone may be done by community midwife or other **registered healthcare professional** with experience in infant feeding support.



Domperidone for Lactation Stimulation – Prescribing Information

V1.1 | Last reviewed: 19/05/2022 | Review date: 19/05/2025

NHS Nottinghamshire Area Prescribing Committee

Domperidone

Lactation stimulation

Traffic light classification - GREEN

Information sheet for Primary Care Prescribers

Indication

Domperidone is the medicine of choice for lactation stimulation[1]. This is an off-licence indication (licensed for short term relief of nausea and vomiting[3]).

Only to be used if benefits outweigh risks and when other breastfeeding management techniques (regular feeding/ expressing, attachment optimisation) are in place and have failed.[2] Mother to be assessed and counselled by the breast-feeding specialist (may include a community midwife or other registered healthcare professional with experience in infant feeding support) requesting the prescription. Breastfeeding and breastmilk are important for optimal health long and short term for mother and baby[6].

The MHRA restricted licensed use of domperidone to nausea and vomiting following a review that confirmed a small increased risk of serious cardiac side effects. A higher risk was observed in people over 60 years of age, adults taking more than 30mg daily, those taking other QT prolonging medicines or CYP3A4 inhibitors. See medicines initiation, contraindication and precautions for more details[3].

Therapeutic Summary

Domperidone as a galactogogue. Domperidone is a dopamine antagonist. Specifically it works on peripheral dopamine receptors in the gastrointestinal wall and chemoreceptor trigger zone (CTZ) centre in the brainstem. Blocking the dopamine receptors results in increased prolactin levels[4].

Domperidone is the agent of choice for inadequate lactation because of its superior side effect profile (compared to metoclopramide), efficacy, and minimal passage into breast milk[1]. Analysis of pooled data demonstrated a relative increase of 74.72% in daily milk production with Domperidone treatment compared to placebo[5].

Medicine Initiation

GP to initiate following recommendation from a breast-feeding specialist (may include a community midwife or other registered healthcare professional with experience in infant feeding support) who has assessed the mother, optimised non-pharmaceutical measures and where the benefits of domperidone outweighs the risk. The breast-feeding specialist will support and counsel the mother.

Domperidone should only be considered when all other methods and support for increasing breastmilk are in place (assessment by a breastfeeding specialist, regular feeding/expressing (at least eight times in 24 hours), positioning, attachment optimisation (including consideration of other issues, such as tongue tie) and correct expressing technique)[6].

Advice should be given that domperidone may only be effective if accompanied with expressing both breasts, at least eight times per 24 hours, including overnight.[6]

Products Available

Domperidone 10mg tablets. Cost x 30 tablets is £0.73 (DT May 2022)

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V1.1 Domperidone to enhance breast milk production

Guidelines continued

Emollient formulary (UPDATED)

- Severely dry skin section - Emulsifying ointment no longer first choice.
- Emulsifying ointment and 50:50 ointment must be prescribed by brand.
- Self-care advice enhanced, NHSE guidance and PIL links added.
- Risk of burns information relevant to all emollients. Link to patient and HCP leaflets added.
- Discontinued products – Diprobase®, ImuDerm cream 5%® (relaunched as ImuDERM® emollient), Eucerin Intensive ® 10% lotion (relaunched as Eucerin UreaRepair Plus® 10% lotion).
- Epimax® range renamed but product specifications remain the same.

End of life guideline (UPDATED)

- Anticipatory medicines doses have been updated in line with the Palliative Care Formulary and Nottinghamshire Palliative Care Pocketbook.
- A new section on the APC website had been created for information about the local palliative care medicines stockist scheme. **https://www.nottsapc.nhs.uk/guidelinesformularies/palliative-care-stockist-scheme/**

Guidelines continued

Hypothyroidism in pregnancy (NEW)

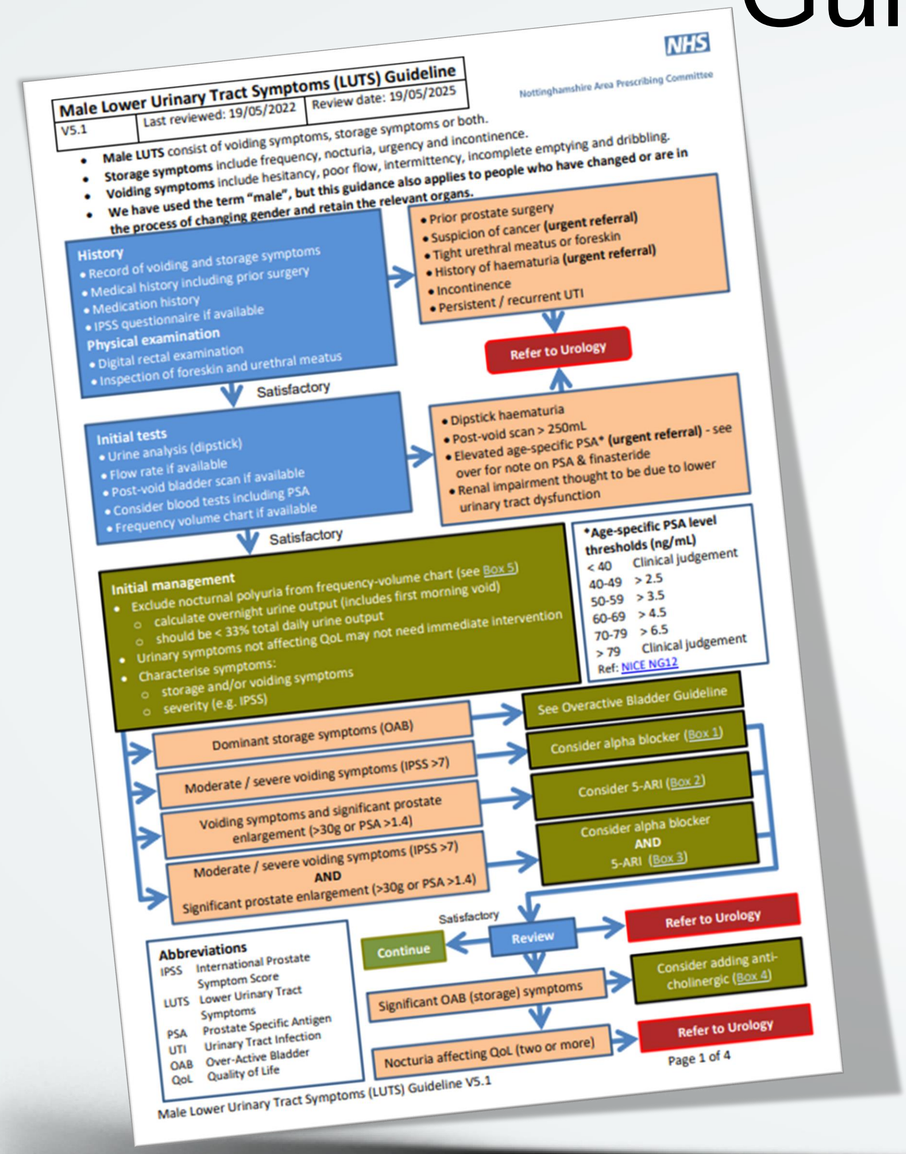
Requested by GPs as there are currently two different pathways for the management of hypothyroidism in pregnancy.

- There has been a change to the NUH service pathway, and these patients should now be managed and monitored in primary care.
- SFH remains a shared care service between community midwives and the obstetric-endocrine clinic.
- Community midwifery teams will action initial TFT bloods at initial booking appointment whether patient is under NUH or SFH.
- Interim guidance as the two pathways will be aligned in the future.

Amiodarone shared care protocol (UPDATED)

- Updated to confirm that TSH alone can be used as primary screening to monitor thyroid function in amiodarone treated patients.
- If TSH is out of range, T3 and T4 would be tested automatically by the lab.

Guidelines continued



Male Lower Urinary Tract Symptoms (LUTS) Guideline

V5.1 | Last reviewed: 19/05/2022 | Review date: 19/05/2025

NHS Nottinghamshire Area Prescribing Committee

- **Male LUTS** consist of voiding symptoms, storage symptoms or both.
- **Storage symptoms** include frequency, nocturia, urgency and incontinence.
- **Voiding symptoms** include hesitancy, poor flow, intermittency, incomplete emptying and dribbling.
- **We have used the term "male", but this guidance also applies to people who have changed or are in the process of changing gender and retain the relevant organs.**

History
- Record of voiding and storage symptoms
- Medical history including prior surgery
- Medication history
- IPSS questionnaire if available

Physical examination
- Digital rectal examination
- Inspection of foreskin and urethral meatus

- Prior prostate surgery
- Suspicion of cancer **(urgent referral)**
- Tight urethral meatus or foreskin
- History of haematuria **(urgent referral)**
- Incontinence
- Persistent / recurrent UTI

Refer to Urology

Satisfactory

Initial tests
- Urine analysis (dipstick)
- Flow rate if available
- Post-void bladder scan if available
- Consider blood tests including PSA
- Frequency volume chart if available

- Dipstick haematuria
- Post-void scan > 250mL
- Elevated age-specific PSA* **(urgent referral)** - see over for note on PSA & finasteride
- Renal impairment thought to be due to lower urinary tract dysfunction

Satisfactory

Initial management
- Exclude nocturnal polyuria from frequency-volume chart (see Box 5)
  - calculate overnight urine output (includes first morning void)
  - should be < 33% total daily urine output
- Urinary symptoms not affecting QoL may not need immediate intervention
- Characterise symptoms:
  - storage and/or voiding symptoms
  - severity (e.g. IPSS)

***Age-specific PSA level thresholds (ng/mL)**

< 40	Clinical judgement
40-49	> 2.5
50-59	> 3.5
60-69	> 4.5
70-79	> 6.5
> 79	Clinical judgement

Ref: NICE NG12

Dominant storage symptoms (OAB)	See Overactive Bladder Guideline
Moderate / severe voiding symptoms (IPSS >7)	Consider alpha blocker (Box 1)
Voiding symptoms and significant prostate enlargement (>30g or PSA >1.4)	Consider 5-ARI (Box 2)
Moderate / severe voiding symptoms (IPSS >7) **AND** Significant prostate enlargement (>30g or PSA >1.4)	Consider alpha blocker **AND** 5-ARI (Box 3)

Satisfactory

Continue ← Review → Refer to Urology

Significant OAB (storage) symptoms → Consider adding anti-cholinergic (Box 4)

Nocturia affecting QoL (two or more) → Refer to Urology

Abbreviations

IPSS	International Prostate Symptom Score
LUTS	Lower Urinary Tract Symptoms
PSA	Prostate Specific Antigen
UTI	Urinary Tract Infection
OAB	Over-Active Bladder
QoL	Quality of Life

Male lower urinary tract symptoms (UPDATED)

The guideline is in line with NICE guidance (NICE CG97)

Main changes:

- Added generic dutasteride/tamsulosin combination (AMBER 3) - more cost effective than prescribing dutasteride and tamsulosin separately. Combodart® remains GREY.
- Updated age-specific PSA level thresholds in line with NICE CG12.
- Added desmopressin to possible management options (AMBER 2 - specialist recommendation)

Traffic light changes

- **Ibandronic acid 50mg tablets** – **AMBER 2** as adjunct in breast cancer (in line with NICE guidance). A business case has been approved.
- **Sodium Zirconium Cyclosilicate (Lokelma®)** – **AMBER 2** (was RED) for hyperkalaemia in adults
- **Typhoid vaccine (Typhim Vi®)** – GREEN. Typherix® has been discontinued.
- **Estradiol pessaries (Vagirux®)** – GREEN. Preferred brand over Vagifem®.
- **Alprostadil (Viridal Duo®)** – GREY. The Caverject® shortage has now resolved.
- **Tipranavir (Aptivus®)** – capsules have been discontinued.
- **Clonidine 100 microgram tablets** – added (25 microgram tablets already on formulary).
- **Potassium permanganate (Permitabs®)** – MHRA safety alert link added.
- **Sharps bins** – GREEN. Information added on prescribing and waste collection.
- **Ethyl Chloride BP** – GREEN. Can not be prescribed on FP10.
- **Combodart®** – GREY (non formulary).
- **Generic dutasteride/tamsulosin capsules** - **AMBER 3**

Traffic light changes (continued)

- **Atorvastatin oral solution** – GREY. Significant alcohol content. The licensed chewable tablets are available as an alternative.
- **Liothyronine hard capsules (Roma Pharmaceuticals) –** GREY (non formulary)
- **Sereflo Ciphaler DPI (fluticasone/salmeterol)** – GREY (non formulary)
- **Calcipotriol 50mcg & betamethasone dipropionate 0.5mg cream (Wynzora®) –** GREEN
- **Testosterone gel sachets (Testogel®) –** AMBER 2
- **Calcium polystyrene sulfonate (calcium resonium) 99.75% powder for oral/rectal suspension –** AMBER 2 – more cost effective than calcium resonium®.
- **Slo milkshakes** - AMBER 2 on dietician recommendation
- **Aymnes ActaGain 600** - AMBER 2 on dietician recommendation
- **Nualtra Altraplen Energy** - AMBER 2 on dietician recommendation
- **Aymes Shake Fibre** - AMBER 2 on dietician recommendation
- **Aymes Actacal Crème** - AMBER 2 on dietician recommendation

Horizon scanning – GREY – no formal assessment

- Inpremzia (human insulin)
- Truvelog Mix 30 (insulin aspart)
- NovoPen 6 & NovoPen Echo® Plus smart insulin pens
- Finerenone tablets (Kerendia®) for CKD associated with T2DM in aduts– awaiting NICE TA
- Morphine sulphate orodispersible tablets (Actimorph®)
- Buprenorphine hydrochloride 74.2mg implant (Sixmo®▼) for opioid dependence
- Daridorexant (Quviviq®▼) tablets for insomnia
- Relugolix (Orgovyx®▼) tablets for advanced prostate cancer
- Rimegepant (Vydura®▼) oral lyophilizate for migraine treatment and prevention
- Atogepant (Qulipta®▼) tablets for migraine prevention
- Ubrogepant (Ubrelvy®▼) tablets for migraine treatment
- Lasmiditan (Reyvow®▼) tablets for migraine treatment

Horizon scanning – GREY – no formal assessment

- Icosapent (Vazkepa®▼) Risk reduction in patients with high CV risk with elevated triglycerides
- Epinephrine nasal spray (Neffy® and BRYN-NDS1C®) for severe allergic reactions
- Apomorphine (Kynmobi®) sublingual film for “off” episodes in Parkinson’s Disease
- Relugolix / estradiol / norethisterone / linzagolix (Yselty®▼) for endometriosis
- Budesonide - oral (Nefecon®▼) for IgA nephropathy
- Potassium bicarbonate/ potassium citrate (Sibnayal®) prolonged-release formulation for distal renal tubular acidosis
- Netarsudil (Rhopressa®▼) ophthalmic solution for glaucoma
- Sibnayal® (potassium bicarbonate/ potassium citrate prolonged-release formulation
- Yselty®▼ film coated tablet (relugolix, estradiol, norethisterone, linzagolix 100mg and 200mg)

Miscellaneous

Alternatives to using an unlicensed “special” (UPDATE)

- DOAC – detail on crushing tablets (licensed for edoxaban, rivaroxaban & apixaban).
- SGLT2 inhibitors – no licensed liquids, added advice on crushing tablets from regional MI centre (off licence)
- Atorvastatin – licensed liquid is non-formulary (significant alcohol content and expensive), use chewable tablets instead.

Work Plan

Guidelines going to next APC meeting:

- Alcohol dependence guidelines (update)
- Transgender Collaborative Care Protocol and Prescribing Information Sheets (new)
- Naltrexone information sheet (update)
- Antimicrobial guidelines (update)
- Overarching pain guideline (new)
- Gastroprotection (with PPI) for patients on NSAID or antiplatelet (new)
- Testosterone for women information sheet (new)
- Midodrine information sheet (update)
- Home oxygen pathway for cluster headaches (update)
- Bariatric surgery – medication and monitoring (update)
- Asthma – greener inhalers position statement

Further Information

- Nottinghamshire Area Prescribing Committee Website
- Nottinghamshire Joint Formulary Website

- Nottinghamshire Area Prescribing Committee Bulletins
- Nottinghamshire Area Prescribing Committee Meeting Minutes

- CCG Preferred Prescribing List
- Guide to setting up SystmOne formulary in GP practices
- Report non-formulary requests from secondary care via eHealthscope (no patient details)

https://ehsweb.nnotts.nhs.uk/Default.aspx?tabid=223

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