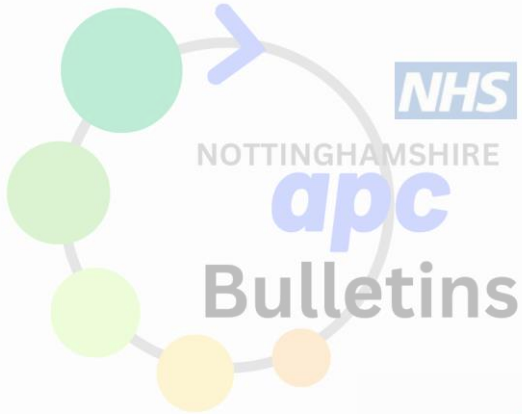
NHS
Nottingham and Nottinghamshire

Area Prescribing Committee / Interface Update.

November 2024 - January 2025 meetings.



Please direct queries to your ICB Medicines Optimisation Pharmacist

or e-mail nnicb-nn.nottsapc@nhs.net

February 2025

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Contents

- **Guidelines:**
  - Osteoporosis
  - Overarching CKD Guidelines and SGLT2i pathway
  - Gastroprotection (with PPI) for patients on NSAIDS or antiplatelet
  - Antimicrobial – Hidradentis Suppurativa, Dermatophyte of nail
  - DOACs for DVT & PE guidance

- **Shared Care Protocols:**
  - Amiodarone

- **Prescribing Information sheets:**
  - Enoxaparin

- **Formulary - new:**
  - Antipsychotics for Chorea in Huntington's Disease – local submission
  - Relugolix for treating hormone-sensitive prostate cancer - NICE TA995

- **Formulary – amendments**
- **Management of overweight and obesity**
- **Insulin discontinuations**
- Work plan

Osteoporosis and fracture prevention

February 2025

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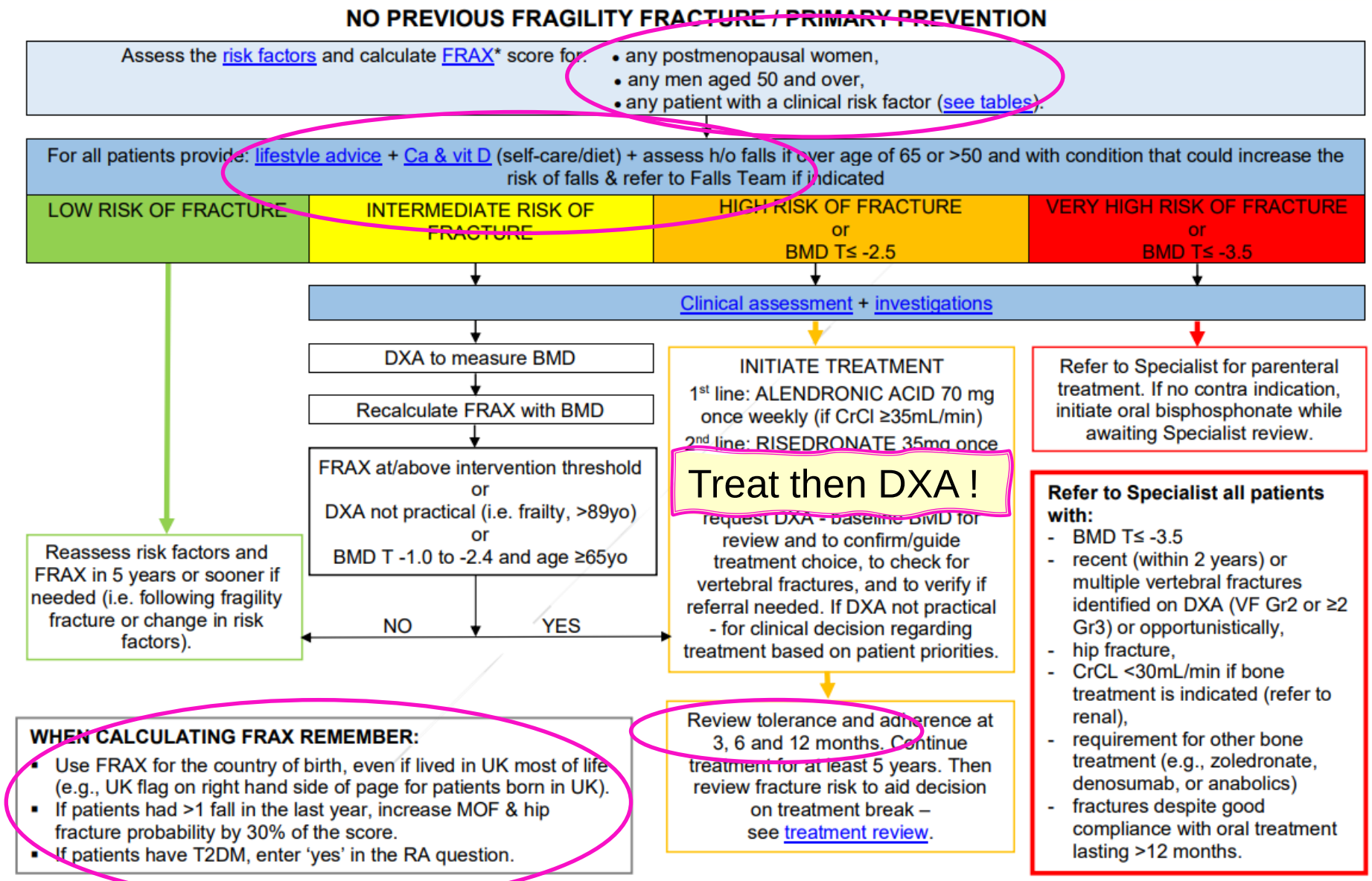

Holistic assessment – based on risk factors, not just FRAX.

Use the highest of the two FRAX scores.

If under 40yo with significant risk – use BMD not FRAX.

90yo and over – all at high risk – use shared decision based on life expectancy and risk vs benefits for the individual.

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HISTORY OF FRAGILITY FRACTURE / SECONDARY PREVENTION

Post-fracture, all patients who are not under the ongoing care of Bone Health Specialist/Service, should be followed up in Primary Care at 4 and 12 months with aim to:

- review medication and risk factors which may increase the risk of falls/fracture (calculating FRAX score if not already done following recent fracture),
- ensure optimised intake of calcium and vitamin D, and
- monitor adherence to any bone treatment prescribed (and if no treatment, review if this is clinically appropriate).

Patients aged ≥50 years and life expectancy >12 months presented in Primary Care

For all patients provide: lifestyle advice + Ca & vit D (self-care/diet) + falls risk assessment & falls prevention if indicated

HIP FRACTURE

1st line: ZOLEDRONIC ACID (initiated during hospital admission, dose and duration advised by Specialist)

Based on individual assessment other bone treatments may be indicated (i.e. oral bisphosphonates, denosumab, or anabolics).

3 years treatment followed up by the review and fracture risk assessment to aid decision on treatment change/ continuation/ break (within Specialist services).

NON-HIP FRACTURE

Clinical assessment + investigations + assess the risk factors and calculate FRAX* score (repeat after any new fracture) + DEXA to measure BMD

NORMAL/ LOW RISK OF FRACTURE or BMD T> -1	INTERMEDIATE RISK OF FRACTURE or BMD T≤ -1 to T≥ -2.4	HIGH RISK OF FRACTURE or BMD T≤ -2.5	VERY HIGH RISK OF FRACTURE or BMD T≤ -3.5
h/o VERTEBRAL FRACTURE	h/o VERTEBRAL FRACTURE		Irrespective of h/o vertebral fractures

NO / YES

h/o ≥2 fragility fractures

YES → **INITIATE TREATMENT**

1st line: ALENDRONIC ACID 70 mg once weekly (if CrCl ≥35mL/min)
2nd line: RISEDRONATE 35mg once weekly (if CrCl ≥30mL/min)

Review tolerance and adherence to oral treatment at 3, 6 and 12 months. Continue treatment for at least 5 years. Then review fracture risk to aid decision on treatment break – see treatment review.

NO

Provide **LIFESTYLE ADVICE**
No bone treatment required.

NO / YES

YES

Refer to Specialist for consideration of anabolic treatment. If no contra indication, initiate oral bisphosphonate while awaiting Specialist review.

Refer to Specialist all patients with:

- BMD T≤ -3.5 or T≤ -2.5 and vertebral fractures
- recent (within 2 years) or multiple vertebral fractures identified on DXA (VF Gr2 or ≥2 Gr3) or opportunistically,
- hip fracture,
- CrCL <30mL/min if bone treatment is indicated (refer to renal),
- requirement for other bone treatment (e.g., zoledronate, denosumab, or anabolics),
- fractures despite good compliance with oral treatment lasting >12 months.

Hip fracture – iv zol

Any other fractures – think about the spine!

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CLINICAL ASSESMENT and INVESTIGATIONS in appx 2 (DIAGNOSING OSTEOPOROSIS)

MONITORING ?

Initiation of oral bisphosphonate
Fasting CTx as a baseline

At **3 and 6 months** test fasting CTx & review tolerance and adherence

Annually review:
- tolerance and adherence
- risk factors and FRAX score – to ensure fracture risk has not reached referral threshold for Specialist treatment
- height and symptoms suggestive of vertebral fracture
- renal function tests
- fasting CTx
- bone profile
- vitamin D (serum 25-hydroxyvitamin D)

No benefit of DEXA to guide treatment length – continue for up to 10 years!

After 5 years of treatment

CONTINUE FOR ADDITIONAL 5 YEARS
up to 10 years of max treatment time (DEXA is not required) for patients:
- aged ≥70 at the treatment initiation,
- with h/o hip fracture,
- with h/o vertebral fracture,
- with h/o fragility fracture sustained during the bone treatment and consider referral to Specialist – see box below,
- on high dose of glucocorticoids or any dose with h/o fragility fracture.

YES

Reassess risk factors + FRAX + DEXA (if practical) & recalculate FRAX with BMD

FRAX score >NOGG intervention threshold
or
BMD T≤ -2.5 or high risk of fracture

NO

TREATMENT BREAK/ CESSATION

Reassess fracture risk factors and FRAX after:
- 2 years treatment break from alendronic acid,
- 1 year treatment break from risedronic acid or ibadronic acid,
- 3 years following cessation of zoledronic acid treatment,
- recently sustained fracture,
- known change to fracture risk factors.

Refer to Specialist all patients with:
- BMD T≤ -3.5
- recent (within 2 years) or multiple vertebral fractures identified on DXA (VF Gr2 or ≥2 Gr3) or opportunistically,
- hip fracture,
- CrCL <30mL/min if bone treatment is indicated (refer to renal),
- requirement for other bone treatment (e.g., zoledronate, denosumab, or anabolics)
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Management CKD for adults - New

February 2025

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- Developed to assist Primary Care identify CKD early, reduce variability in detection & management, & optimise interventions. Podcast available here

3 Step Solution for the Management of CKD

Step 1

Early diagnosis and identification

- Failure to identify and treat CKD doubles mortality
- Screen at risk groups
- Lifelong monitoring U&E, eGFR, uACR & BP in those at risk and with CKD
- Ensure on CKD register

Step 2

Medicine Optimisation

- RAASi blockade (titrated to highest tolerated dose)
- SGLT2i if on maximum tolerated RAASi unless contraindicated & not T1DM or previous DKA

CV risk reduction

- Statin (primary & secondary preventation of CV)
- Optimise BP (target BP depends on uACR)
- Consider aspirin for CV risk reduction

- Finerenone if T2DM with CKD 3/4 with albuminuria. Podcast here
- Stop nephrotoxics

Step 3

TIMELY REFERRAL to secondary care of those at risk of progression to end stage renal disease

Guidelines for the Management of Chronic Kidney Disease (CKD) for Adults

Contents	Page

February 2025

NHS Nottingham and Nottinghamshire

Clinical pathway for the use of Sodium- Glucose Co-transporter-2 inhibitors (SGLT-2 i) in Chronic Kidney Disease (CKD) and Type 2 Diabetes Mellitus (T2DM) - Update

- Pathway redesigned & updated to include empagliflozin following NICE TA
- T1DM-unlicenced indication only secondary care to initiate and maintain (contraindicated in the previous pathway)
- Canagliflozin guidance for T2DM and T2DM with CKD ,no current recommendation for CKD alone as unlicenced indication
- Ertugliflozin excluded in the pathway, as currently licenced only for T2DM
- Heart failure treatment with SGLT2is excluded due to being AMB 2
- eGFR values may differ from SPC - reflect trial evidence used by NICE
- Podcast on SGLT2i can be found here

Drug	Indication	Dosing	CKD & DM guidance
Canagliflozin	For T2DM For T2DM with CKD	100-300mg od Maximum dose 100mg daily if eGFR<60 ml/min	**DM or DM with CKD:** eGFR 30-90 ml/min & urine ACR >30mg/mmol
Dapagliflozin	For T2DM For CKD	10mg od 5mg if severe hepatic impairment	**CKD with DM:** eGFR 25-75 ml/min **CKD without DM** eGFR 25-75 mL/min/1.73m2 **and** UACR of ≥22.6 mg/mmol
Empagliflozin	For T2DM For CKD	10mg od but can increase to 25mg od for T2DM if eGFR ≥60 ml/min	**CKD & DM:** eGFR 60-90 ml/min and T2DM eGFR 25-60 ml/min & urine ACR ≥22.6mg/mmol **CKD without DM:** eGFR 20-44 ml/min irrespective of urine ACR eGFR 45-90 ml/min & urine ACR ≥22.6mg/mmol

Gastroprotection (with PPI) for patients on NSAID or antiplatelet

Advisory guidance on when to initiate a PPI with a NSAID (or antiplatelet) for gastro-protection. - Update

- Hypomagnesaemia section updated:
  - Although PPIs cause hypomagnesaemia, routinely monitoring of magnesium levels on patients on long –term PPIs is not recommended by specialist but should be considered in those taking digoxin or drugs which may cause hypomagnesaemia (such as diuretics)
  - Digoxin does not cause hypomagnesaemia but is potentiated by hypomagnesaemia which in turn increases the risk of digoxin toxicity
  - Symptoms added to clarify when monitoring might be appropriate.

New Submissions

February 2025

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Antipsychotics for Chorea in Huntington's Disease. AMB 2

- Off- label use of neuroleptic medication is considered first-line treatment for Chorea in Huntington's Disease. Olanzapine is used most commonly, but risperidone, sulpride, amisulpride and haloperidol might also be used.
- Historically these medications have been prescribed in Primary Care on specialist advice.
- Doses used are generally lower than those used for psychosis. For further information about this indication see BNF and guidance from the Huntington's Disease Association.
- Expectations for monitoring of antipsychotic medication for individual patients will be documented in ReSPECT forms.
- Clinicians are encouraged to discuss with the Specialist should queries arise about individual patients.

New Submissions

February 2025

Nottingham and Nottinghamshire

Relugolix for treating hormone-sensitive prostate cancer AMB 2

- For use in accordance with NICE TA995 .
- Relugolix is an alternative androgen deprivation therapy (ADT) to GnRH agonists such as triptorelin, and degarelix (for those with spinal metastases).
- Relugolix is given orally. Dose= 120mg once daily (following an initial loading dose of 360 mg on the first day).
- Classification is in line with alternative treatment options.

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Formulary Amendments and Traffic light changes

- Budesonide 4mg suppositories AMB 2 - cost-effective alternative to prednisolone suppositories ~£185 pm vs £707 pm.

- Methenamine for UTI prevention in men, trans women and non-binary people with a male genitourinary system AMB 2
  - Nb. No changes regarding use in women, trans men and non-binary people with a female urinary system.

Tirzepatide for managing overweight and obesity

February 2025

NHS Nottingham and Nottinghamshire

- Tirzepatide for managing overweight and obesity is classified as GREY
- Although NICE published TA guidance NICE TA1026 on 23rd of December
- Tirzepatide to be made **available by NHS in a Specialist Weight Management Service (SWMS) within 90 days** and **in Primary Care within 180 days of** TA publication.
- NICE has tasked NHS England with defining cohorts .
- Awaiting commissioning guidance from NHS England and the ICB is reviewing commissioning options for suitable services
- Until a position is reached by ICB, **tirzepatide should NOT be prescribed** managing overweight and obesity.
- For further details about access to tirzepatide and specialist weight services in Nottingham and Nottinghamshire see here

NICE Webinar

- NICE also published updated overweight and obesity management guidance NG246 on 14th of January
- To support the implementation of the guideline and the associated technology appraisals (TA1026 Tirzepatide, TA875 Semaglutide, TA664 Liraglutide), NICE will be offering webinars to demonstrate the resource impact template. Link to webinar to be shared once available.

Novonordisk insulin discontinuation guidance

Nottingham and Nottinghamshire

Novorapid (insulin aspart) **FlexTouch** pre-filled pen only

AMB 2

March 2025

1st line choice:

Trurapi Solostar (rapid acting biosimilar insulin aspart)

AMB 3

2nd line choices:

Novorapid Penfill

AMB 2

Novorapid FlexPen

AMB 2

Insulatard (isophane human) **Penfill** only

GREEN

March (June) 2025

1st line choice:

Humulin I KwikPen (isophane human) 100 units/ml suspension for injection 3ml pre-filled pens.

GREEN

Additional BG monitoring!
Check Hb1Ac 3-6 months

Levemir (insulin detemir) – all remaining presentations i.e. FlexPen, Penfill

AMB 2

December 2026

Long acting insulin analogues AMB 3 :

- Semglee (glargine biosimilar) - the most cost-effective
- Abasaglar (glargine biosimilar),
- Lantus (glargine).

Glargine does not have the same action profile as Levemir and is only licensed to be given once daily.

Area Prescribing Committee Work Plan

February 2025

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Going to forthcoming APC meetings:

- Vitamin B 12 guideline
- Asplenic patients
- Growth Hormone SCP
- Opioids for non-cancer pain

Formulary meeting

- Tirzepatide for management of overweight and obesity NICE TA
- Liraglutide biosimilars
- Antipsychotics in treatment resistant depression
- Sulfasalazine

Further Information

- Nottinghamshire Area Prescribing Committee Website
- Nottinghamshire Joint Formulary Website

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

- ICB Preferred Prescribing List
- Guide to setting up SystmOne formulary in GP practices

- Report non-formulary requests from secondary care via eHealthscope (no patient details)

Please direct queries to your ICB medicines optimisation pharmacist or e-mail nnicb-nn.nottsapc@nhs.net