NHS
Nottingham and Nottinghamshire

Area Prescribing Committee / Interface Update May 2024

Please direct queries to your ICB Medicines Optimisation Pharmacist

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

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New Submissions

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Cytisine for smoking cessation – RED

- Cytisine is an alternative for smokers who are unable to tolerate or who have not managed to quit smoking using Nicotine Replacement Therapy.
- Acts as a partial agonist at nicotine receptors, causing a limited amount of activation of neural pathways (enough to control urges to smoke) and blocking the receptor so that nicotine (e.g. from smoking a cigarette) cannot attach itself to it.
- It is taken as a course over 25 days with a gradually decreasing frequency and a quit date set no longer than day 5.
- Generally, well tolerated. Gastrointestinal adverse effects are most common.
- There is interest in making this available for patients in Primary Care via smoking cessation services. However, currently services in Nottinghamshire do not have prescribers so there is no facility for the supply of prescription only products (POM).
- Nottingham Smoking Cessation position statement has been updated.

thriving NOTTINGHAM

Your Health Notts

Acute Exacerbation of COPD

Nottingham and Nottinghamshire

Consider **steroids** for wheezy patients who do not require antibiotics.
Remember:
- risks of repeated steroid doses
- bone protection.

Clarithromycin should not be prescribed for patients taking azithromycin prophylaxis.

If no improvement in symptoms after 2-3 days of treatment, obtain a sputum sample.

Co-trimoxazole now preferred over levofloxacin

Risks/limitations of fluoroquinolones:
- increased risk of tendon damage if a co-prescribed a corticosteroid.
- review/consider penicillin allergy status before a fluoroquinolone is considered.

Treatment options for adults 18 years and older:

Antibiotic[1]	Dosage	Duration
Empirical treatment guided by most recent sputum culture and susceptibilities		
First line choice (not in penicillin allergy):		
Amoxicillin	**Adult:** 500mg three times a day	5 days
Alternative first line choices (if penicillin contraindicated or not tolerated)		
Doxycycline[2] (Not suitable in pregnancy)	**Adult:** 200mg day one, then 100mg once daily.	5 days
Clarithromycin[3] (if penicillin and doxycycline not suitable). Not in patients taking azithromycin prophylaxis.	**Adult:** 500mg twice a day	5 days
Second line choice – *If there is no improvement in symptoms on first choice taken for at least 2 to 3 days send a sputum sample for culture and susceptibility testing.* Use alternative first line (from a different class) if suitable.		
If higher risk of treatment failure, treat options according to sputum culture: *guided by microbiology sensitivities*		
Co-amoxiclav **Plus** Amoxicillin (**ONLY** If reported sensitivity to Co-amoxiclav is "I" **)	**Adult:** 625mg three times a day **Adult:** 500mg three times a day	5 days
Co-trimoxazole	**Adult:** 960mg twice a day	5 days
Levofloxacin **Note:** Fluoroquinolones should only be used when other antibiotics are inappropriate. If a penicillin allergy is recorded, the exact nature of the reaction should be clarified including whether other beta lactams (e.g., cephalosporins) have been previously tolerated.	**Adult:** 500mg once a day (**ONLY** Increase frequency to twice a day if reported sensitivity to Levofloxacin is "I" **)	5 days

May 2024

Bronchiectasis

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- Updated in collaboration with the ICS Respiratory Group and Microbiology specialists, in response to MHRA advice on fluoroquinolone use.
- No change to empirical antibiotic treatment options.
- Clarithromycin should not be prescribed for patients taking azithromycin prophylaxis.
- Link to Nottinghamshire Bronchiectasis Self-Management Plan added.
- Information added about the risks and limitations of fluoroquinolones.

Empirical treatment in adults with a previous growth of ciprofloxacin sensitive *Pseudomonas aeruginosa.*
Ciprofloxacin dose increased to 750mg twice a day

NUH summary of sensitivity results webpage added.
Provides up-to-date information on antibiotic doses depending on sensitivity results.

Interpreting Sensitivity Results

In line with new European reporting requirements, the microbiology laboratory report susceptibility results in three categories: S, I or R.

For some bug-drug combinations, there is no "S" category. Susceptibilities will be reported as either "I" or "R".

- "**S**" = susceptible at a **standard** dosing regimen.

This means there is a high likelihood of therapeutic success using standard doses and dosing intervals.

- "**I**" = susceptible at **increased drug exposures.**

This means there is a high likelihood of therapeutic success if antibiotic exposure is optimised by using higher doses or increasing dosing frequency.
Please see below table for recommended doses and frequency for organisms with "I" susceptibility.

Fluoroquinolones

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The **UK indications for systemic fluoroquinolones** have been updated (MHRA Jan 2024). They must only be used when other antibiotics commonly recommended for the infection are inappropriate.

All antimicrobial guidelines including a fluoroquinolone have had warning information added:

Note: fluoroquinolones can cause long-lasting (up to months or years), disabling, and potentially irreversible side effects, sometimes affecting multiple systems, organ classes, and senses. Please refer here for further information on MHRA alerts.

Added to all.

If a penicillin allergy is recorded, the exact nature of the reaction should be clarified including whether other beta lactams (e.g., cephalosporins) have been previously tolerated.

Added where appropriate.

Chlamydia Trachomatis – ofloxacin removed.

Pelvic Inflammatory Disease – ofloxacin removed.

Prostatitis (acute) – ofloxacin removed.

Vitamin D Guidelines for Adults

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Five major key changes to the current clinical practice:

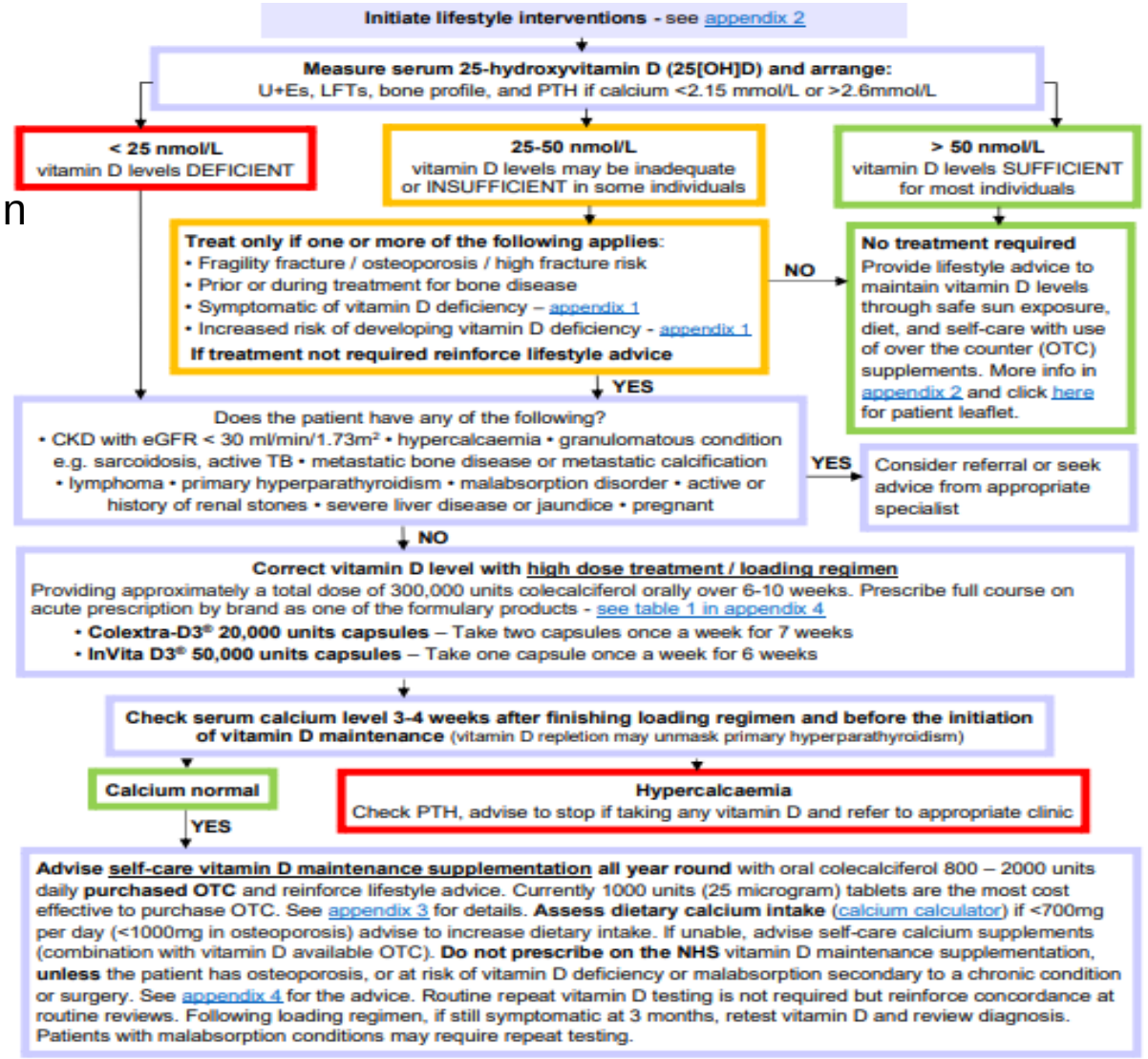
- Routine vitamin D **testing in "at high risk" cohorts' no longer recommended**.
- Vitamin D level **deficiency threshold changed from 30 nmol/L to 25 nmol/L** – as per current NICE and national recommendation.
- Local pathology labs at NUH and SFH have updated the test ranges and descriptors accordingly. DBHT (Doncaster and Bassetlaw) provide no descriptors for ranges below 50 nmol/L.
- Where corrective **treatment is required only rapid regimen over 6 or 7 weeks is to be prescribed with the preferred brands** Invita D3 50,000 units once weekly over 6 weeks or Colextra-D3 40,000 units once weekly over 7 weeks. This includes patients with deficiency and symptomatic insufficiency of vitamin D. The slow correction regimen with 1,000 units daily if vit D below 50 nmol/L is locally no longer recommended. This is to reduce the initiation and ongoing prescribing of the maintenance dose of vitamin D where not indicated.
- Where in exceptional circumstances, NHS prescribing of maintenance/ preventative dose is required **Valupak 1,000 units tablets once daily remains the most cost-effective option** (food supplement, unlicensed). Where a licensed product is required, or to reduce the pill burden, additional prescribing options have been agreed with once monthly administration of 25,000 units as Colextra-D3 or Invita D3. Monthly maintenance with Valupak – cost £0.35/patient/28 days, Colextra - £1.03, and Invita - £1.32.
- For the treatment of deficiency prescribers are requested to issue **acute and branded prescriptions only,** to reduce ongoing unintended prescribing on completion of loading regimen.

Vitamin D Guidelines for Adults continued

Nottingham and Nottinghamshire

Other changes include:

- Introduced **Colextra** (for treatment or once monthly
- dosing prevention) – a new, cost-effective brand launched in March 2024, widely available from suppliers.
- Referral criteria include **seeking advice for pregnant patients** – as per NICE. Local Primary Care guideline to manage vit D deficiency in pregnancy is under development.
- New information on Secondary Care Inpatient rapid high dose loading – for information only, full course to be supplied by Trusts – no prescribing outside of the guideline should be requested from Primary Care.
- Added the following risk factors for vitamin D deficiency: bariatric surgery, liver disease, obesity, pregnant and breast-feeding patients, and updated the list of predisposing medicines.
- Stexerol brand removed – no longer cost effective.



Vitamin D Patient Information Leaflet

The following advice added:

- People **previously deficient** in vitamin D or at "**high risk groups**" may require **all year-round supplementation**. This is in addition to the existing seasonal advice to prevent vitamin D deficiency.
- Fresh or canned tuna added to the list of vitamin D-rich foods.

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Vitamin D

Everyone could benefit from taking vitamin D supplements to prevent low levels of vitamin D.

Why do we need Vitamin D?

Vitamin D is needed to keep bones, teeth, and muscles healthy. If you have low levels of vitamin D you may feel tired or have aches and pains, though some people don't have any symptoms at all. If vitamin D levels fall very low (known as vitamin D deficiency) bones can become softer and weakened, which can lead to other problems.

How can I increase my vitamin D levels?

Go outside: Our main source of vitamin D is from the action of sunlight on our skin. Small amounts of sunlight all through the year, even on cloudy days, during your daily activities (for example, for 10-30 minutes each day), may help to boost your vitamin D levels. Even just exposing your face and forearms to the daylight can be enough.

But you must be careful not to burn in the sun, especially in the summertime. Take care to protect your skin with sunscreen so that it doesn't start to turn red or burn. People with dark skin, such as those of African, African-Caribbean or south Asian origin, will need to spend longer in the sun to produce the same amount of vitamin D as someone with lighter skin.

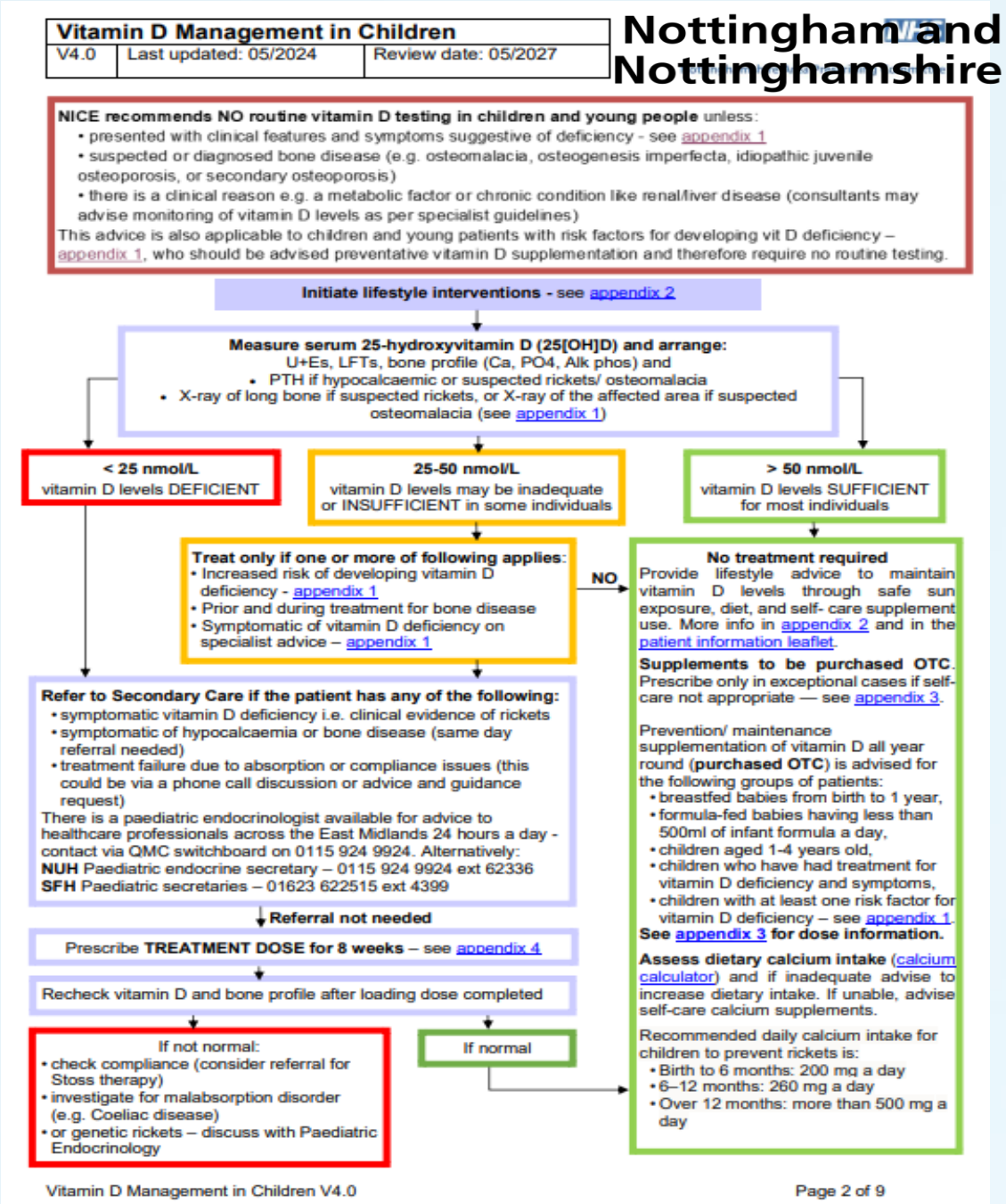
Eat foods that contain higher amounts of vitamin D as part of a healthy balanced diet, such as:

- Oily fish like mackerel, salmon, sardines, and herring
- Liver
- Egg yolks
- Tinned tuna
- Mushrooms
- Red meat
- Cheese
- Fortified foods – such as most fat spreads, soy yoghurts, soy milk, almond milk, some orange juices, and some breakfast cereals

Vitamin D Guidelines for Children

Contains the following 5 major key changes to the current clinical practice:

- Vitamin D level **deficiency threshold changed from 30 nmol/L to 25 nmol/L** (same as for adults)
- Children who are diagnosed with **vitamin D insufficiency (level 25-50 nmol/L) and do not have associated symptoms** of low vitamin D, are to be advised **daily maintenance/preventative dose of vitamin D via self-care to prevent vitamin D deficiency**. Previous version advised to prescribe treatment dose for this cohort.
- For children who require corrective treatment (deficiency with vitamin D levels below 25 nmol/L or children with insufficiency levels of 25-50 nmol/L who are at risk, or have symptoms of low vitamin D levels, or are due bone therapy) **the duration of vitamin D replacement has been extended from 7 to 8 weeks**, to deliver a total dose in line with national recommendations.
- Added **U&E and LFT** into the recommended investigation list and replaced X-ray of wrist and knee with **X-ray** of long bone for suspected rickets and X-ray of affected area for suspected osteomalacia – in line with NICE CKS guideline.
- Added **follow-up calcium monitoring** (recommended on completion of replacement and before initiation of vitamin D maintenance) and **calcium intake recommendation** (within management flow chart).



Vitamin D Management in Children

V4.0	Last updated: 05/2024	Review date: 05/2027

Nottingham and Nottinghamshire

NICE recommends NO routine vitamin D testing in children and young people unless:
- presented with clinical features and symptoms suggestive of deficiency - see appendix 1
- suspected or diagnosed bone disease (e.g. osteomalacia, osteogenesis imperfecta, idiopathic juvenile osteoporosis, or secondary osteoporosis)
- there is a clinical reason e.g. a metabolic factor or chronic condition like renal/liver disease (consultants may advise monitoring of vitamin D levels as per specialist guidelines)

This advice is also applicable to children and young patients with risk factors for developing vit D deficiency – appendix 1, who should be advised preventative vitamin D supplementation and therefore require no routine testing.

Initiate lifestyle interventions - see appendix 2

Measure serum 25-hydroxyvitamin D (25[OH]D) and arrange:
U+Es, LFTs, bone profile (Ca, PO4, Alk phos) and
- PTH if hypocalcaemic or suspected rickets/ osteomalacia
- X-ray of long bone if suspected rickets, or X-ray of the affected area if suspected osteomalacia (see appendix 1)

< 25 nmol/L vitamin D levels DEFICIENT

25-50 nmol/L vitamin D levels may be inadequate or INSUFFICIENT in some individuals

> 50 nmol/L vitamin D levels SUFFICIENT for most individuals

Treat only if one or more of following applies:
- Increased risk of developing vitamin D deficiency - appendix 1
- Prior and during treatment for bone disease
- Symptomatic of vitamin D deficiency on specialist advice – appendix 1

NO

No treatment required
Provide lifestyle advice to maintain vitamin D levels through safe sun exposure, diet, and self- care supplement use. More info in appendix 2 and in the patient information leaflet.

Supplements to be purchased OTC. Prescribe only in exceptional cases if self-care not appropriate — see appendix 3.

Prevention/ maintenance supplementation of vitamin D all year round (**purchased OTC**) is advised for the following groups of patients:
- breastfed babies from birth to 1 year,
- formula-fed babies having less than 500ml of infant formula a day,
- children aged 1-4 years old,
- children who have had treatment for vitamin D deficiency and symptoms,
- children with at least one risk factor for vitamin D deficiency – see appendix 1.

See appendix 3 for dose information.

Assess dietary calcium intake (calcium calculator) and if inadequate advise to increase dietary intake. If unable, advise self-care calcium supplements.

Recommended daily calcium intake for children to prevent rickets is:
- Birth to 6 months: 200 mg a day
- 6–12 months: 260 mg a day
- Over 12 months: more than 500 mg a day

Refer to Secondary Care if the patient has any of the following:
- symptomatic vitamin D deficiency i.e. clinical evidence of rickets
- symptomatic of hypocalcaemia or bone disease (same day referral needed)
- treatment failure due to absorption or compliance issues (this could be via a phone call discussion or advice and guidance request)

There is a paediatric endocrinologist available for advice to healthcare professionals across the East Midlands 24 hours a day - contact via QMC switchboard on 0115 924 9924. Alternatively:
NUH Paediatric endocrine secretary – 0115 924 9924 ext 62336
SFH Paediatric secretaries – 01623 622515 ext 4399

Referral not needed

Prescribe **TREATMENT DOSE for 8 weeks** – see appendix 4

Recheck vitamin D and bone profile after loading dose completed

If not normal:
- check compliance (consider referral for Stoss therapy)
- investigate for malabsorption disorder (e.g. Coeliac disease)
- or genetic rickets – discuss with Paediatric Endocrinology

If normal

Vitamin D Management in Children V4.0 Page 2 of 9

Vitamin D Guidelines for Children

NHS
Nottingham and Nottinghamshire

continued

Other changes include:

- In addition to once-a-week treatment regimen with Invita D3 (off-label use), included a daily dosing treatment with **Thorens oral drops** – a licensed product, equally cost-effective, dose recommendation tabulated as per age group. Fultium drops are no longer cost effective for treatment of deficiency (now only an option for maintenance).
- Where in exceptional circumstances, NHS prescribing of maintenance/ preventative dose is required, the selection of locally recommended products is now limited to only 4 and include: Valupak 1,000 units tablets, Fultium drops, Abidec and Dalivit (tabulated in order of increasing NHS cost).
- Added advice on all-year-round maintenance supplementation for babies fed with less than 500ml of formula milk, all children aged 1-4 and over the age of 4 if at least one risk factor or previously deficient, (within management flow chart).
- Clarification added that adequate sun exposure may be sufficient during summer months only for children above the age of 5 years (not younger).
- Contact telephone numbers for referrals to paediatric teams at NUH and SFH were moved from appendix 4 and now included in the referral box on the first page for ease of access.
- Removed monitoring of response to Stoss therapy (applicable to Secondary Care only, not relevant for Primary Care).

Shared Care Protocols

NHS
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Standardised national templates have been cross-referenced against the existing APC overarching shared care protocols and the individual information sheets in collaboration with consultants at NUH and SFH.

No changes to the overall shared care process, but RMOC contraindications, cautions and parameters have been adopted.

Dermatological Conditions – Methotrexate SCP

- Height, weight, and blood pressure removed from baseline investigations.
- Type III procollagen peptide (PIIINP) removed as part of baseline and primary care monitoring as it is not considered a reliable measure of liver disease.
- The specialist team are responsible for investigating any potential for metabolic dysfunction-associated steatotic liver disease (MASLD) at the initial assessment.

Motor Neurone Disease – Riluzole SCP

- Riluzole orodispersible films added for use in exceptional circumstances following a multidisciplinary team (MDT) recommendation that crushed tablets are not suitable.

Neuroinflammatory Conditions – Azathioprine SCP

Shared Care Protocols

Nottingham and Nottinghamshire

Azathioprine for IBD in Children and Young People (update)

- No National SCP for this use of azathioprine in children, but in line with other SCPs, the standard NHS England template has been adopted.
- Reviewed and approved by the Specialist team at the NUH's tertiary centre for the paediatric IBD service.
- Main changes:
  - Transition of care advice now mirrors the information in the children's ADHD SCPs.
  - Patients retained by secondary care for the first 4 months of treatment (as per current arrangements).
  - Oral suspension added for those unable to take tablets.
  - Trimethoprim/co-trimoxazole may be co-prescribed in this patient cohort e.g., for Pneumocystis jirovecii pneumonia (PCP) prophylaxis.
  - Specialist team advise to avoid live vaccines, e.g. Intranasal influenza vaccine.

- **Note** – although children aged ≥12 years can have their blood testing performed in Primary Care, the children's phlebotomy service varies across the ICB.

Position statement

Nottingham and Nottinghamshire

Treatment Options for Diabetic Hypoglycaemia in Children and Adults: Position Statement

- Guidance for prescribers when advising diabetic patients to purchase food product(s) to keep with them to treat hypoglycaemia.
- It is recommended that patients/parents/carers forward plan to effectively treat hypoglycaemia and have the persons choice of product e.g. high sugar drink, jelly babies available at any time in case of hypoglycaemia.

- ✔ 200ml (a small carton) of smooth orange juice
- ✔ 60 ml Glucojuice or Lift
- ✔ 5 glucotabs
- ✔ 6 dextrose tablets
- ✔ 5 jelly babies

Emollient Formulary

NHS
Nottingham and Nottinghamshire

- No change to the preferred brands and no significant change to prices.
- Soap substitute symbol removed:

  Most leave-on emollients can be applied before showering and then rinsed off. Although they generally don't foam, they are effective at cleaning the skin.

- Ovelle® brand of emulsifying ointment is no longer available. In Primary Care, prescribe as **Emulsifying Ointment (Ennogen)**.
- New format allows emollient constituents to be listed:

Bath additives should **NOT** be prescribed due to the lack of evidence of efficacy (guidance) and have not been included on this formulary (see above for further advice)

Prescribers should use the clinically appropriate emollient with the lowest acquisition cost first line. First line - Green Second line - Blue
Please note that as there can be stock shortages, if the preferred brands are not available, please change to a different brand of similar cost with similar ingredients.

Indication	Consistency/ Formulation	Preferred Products	Advice/Criteria	Cost	Constituents	Other
Severe dry skin or scaly patches	Very greasy ointment	White soft paraffin in liquid paraffin (50:50). ^ Prescribe as **Fifty:50**.	Tub.	£3.92 500g	LP 50% + WSP 50%	
	Ointments	Epimax® ointment ^	Tub.	£3.19 500g	LP 40%+YSP 30% + cetomacrogol emulsifying wax cetostearyl alcohol + macrogol cetostearyl ether	Hydromol®, Epimax®, Zeroderm® and Epaderm® ointments are comparable.
		Zeroderm® ointment ^	Tub.	£4.29 500g	WSP 14.5% w/w, LP 12.6% w/w, Water, Cetyl Alcohol, Glyceryl Monostearate, Sodium Cetostearyl Sulfate, Lanolin, Citric Acid Monohydrate, Carbomer, Sodium Hydroxide, Sodium Methyl Hydroxybenzoate, Sodium Propyl Hydroxybenzoate, BHT	
		Emulsifying ointment ('Ennogen' must be specified in primary care)	Tub.	£4.15 500g	WSP 50% + EW 30% + LP 20%, cetostearyl alcohol, sodium laurylsulfate	
		Hydromol® ointment ^	Tub.	£5.50 500g	Yellow soft paraffin 32%, cetomacrogol emulsifying wax 25.5%, liquid paraffin 42.5%	

Information and Guidance on Prescribing in Transgender Health Position Statement

NHS
Nottingham and Nottinghamshire

- The ‘Children and Young People’s Gender Services’ section has been rewritten following the publication of The Cass Review, April 2024, and implementation of NHSE advice.
- This includes the publication of a new interim service specification, clinical policy on puberty suppressing hormones and the prescribing of gender-affirming hormones.
- These state that puberty suppressing hormones will not be routinely available and gender-affirming hormones would only be available for eligible patients from around their 16th birthday.

March 2024

Insulin Chapter Formulary Review: Tresiba

Nottingham and Nottinghamshire

Insulin	Formulary	
degludec (Tresiba®) BNF SPC BNF C x2 (101)	Amb2	Note that there are two strengths of insulin degludec. **Do not convert (ie, recalculate) doses when transferring patients from one strength of insulin degludec to another—the Tresiba® FlexTouch® pen delivery device shows the number of units of insulin to be injected irrespective of strength.** 100 units / ml cartridges, 100 units / ml FlexTouch® prefilled pens. ® Initiation would be for only : • Children and young people aged 18 or under diagnosed with Type 1 or Type 2 diabetes. • **Type 1** diabetes in adults: insulin detemir and insulin glargine remain first line options for basal insulin in accordance with NICE guidance NG17. Tresiba® can be considered as an alternative in patients where there is a particular concern about nocturnal hypoglycaemia OR for patients who need help from carer or healthcare professional to administer injections. • **Type 2** diabetes currently treated with insulin glargine where existing basal insulin is running out OR with poor compliance OR requiring flexibility of administration OR with recurrent, particularly nocturnal, severe hypoglycaemia. When choosing an alternative insulin regimen, take account of: • the person's preferences • comorbidities • risk of hypoglycaemia and diabetic ketoacidosis • any concerns around adherence • acquisition cost Supply issue with 100units/ml prefilled pens. Anticipated resupply date **31/12/2024**. • See Notts APC advice about managing current patients. • See Medicine Supply Notification advice. • For patients switching from Tresiba FlexTouch® prefilled pens to Tresiba® cartridges, please see link re the use of NovoPen® 6.

Date

Traffic light changes

Nottingham and Nottinghamshire

RED:

- **Bowel cleansing preps** e.g. Moviprep®, Picolax®.

AMBER 2:

- **Viridal® duo** reclassified from **GREY** due to supply problems with Caverject®.
- **Vital 1.5kcal® 200ml sip feed** and **Peptisip® Energy HP:** temporary reclassification during Pancreatic Enzyme Replacement Therapy (PERT) shortages, as recommended in a national Position Statement. Any patient requiring such an alternative treatment should be reviewed by the Specialist team.

GREEN:

- **Tadalafil 5mg tablets**: daily tadalafil 5mg reclassified to **GREEN** for those anticipating sexual activity >2/week (in line with license). The **2.5mg tablet** will remain **GREY** as this is significantly more expensive.

GREY:

- **Ogluo®** reclassified as supply problems with GlucaGen ® have been resolved. **Note for treatment of hypoglycaemia – food/drink products are first line**
- **Avanafil** is no longer more cost-effective and has been reclassified as **GREY** to simplify treatment options available.

Formulary amendments

Nottingham and Nottinghamshire

- **Bibecfo® Metered Dose Inhaler:** This is a cost-effective alternative to Fostair® MDI for patients who do not tolerate Luforbec® MDI. Both Bibecfo® MDI and Luforbec® MDI are price equivalent.
- **Goserelin (Zoladex LA®) 10.8mg for breast cancer:** The product license has been updated and the 3-monthly goserelin implant is now also indicated for breast cancer. It has been added to the Joint Formulary as Amber 2 for this indication. The 3-monthly formulation offers reduced frequency of administration with benefits to patients and reduced NHS workload. The Gonadorelin analogues (GnRH) position statement has been updated accordingly to include both Zoladex® and Zoladex LA® formulations.
- **Innolet devices containing Insulin Levemir® and Insulatard®** have been discontinued and will be removed from the diabetes guideline and the Joint Formulary.
- **Estriol 0.1%:** Ovestin® brand has been discontinued and has been removed from the Joint Formulary.
- **Salbutamol nebules**: additional information has been added about actions to take during shortages of 2.5mg/2.5ml nebules.

Area Prescribing Committee Work Plan

NHS Nottingham and Nottinghamshire

See our most recent work plan on the [APC website]

July Guideline meeting

Take home naloxone guidance

Bupropion information sheet

Parkinson's Disease information sheets

Vitamin D in pregnancy

Currently in development

Summary of SGLT2i indications and SGLT2i pathway

Overarching CKD guidelines

TOP 10 CKD Tips and CKD in Primary Care Infographic

Vitamin B12 Guidelines

Osteoporosis Guidelines

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

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