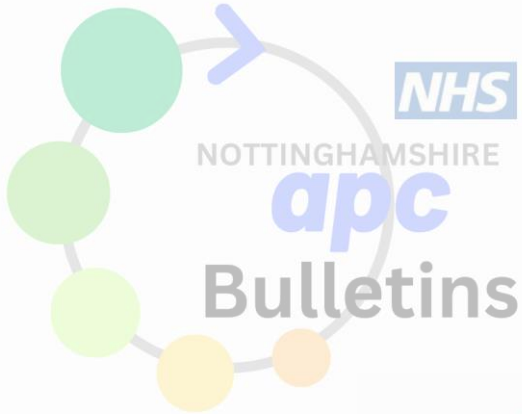
NHS
Nottingham and Nottinghamshire

Area Prescribing Committee / Interface Update.

February 2025 - March 2025 meetings.



Please direct queries to your ICB Medicines Optimisation Pharmacist

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

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Nottinghamshire Heart Failure - Quick Guide

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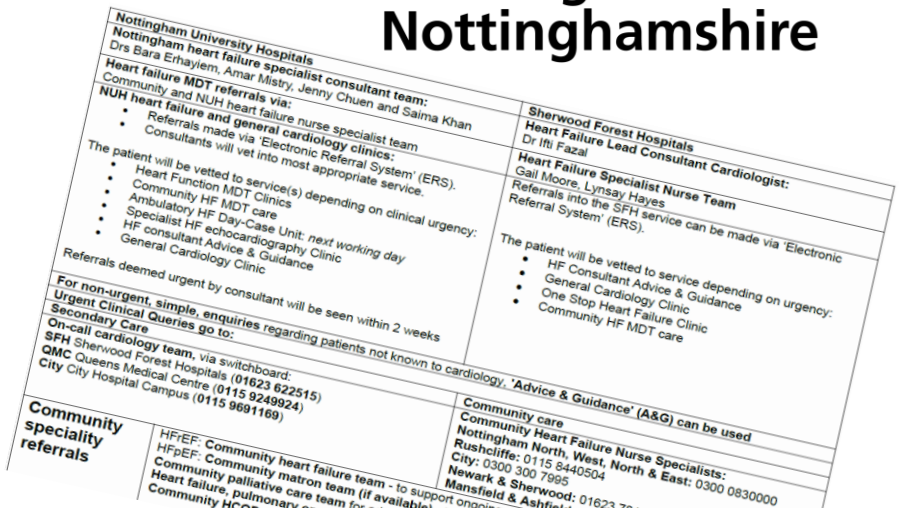
- In 2021 the European Society of Cardiology published updated advice on treating HF.
- In 2022 the American Heart Association followed on with the same new approach in treating HF.

Both recommended quadruple therapy vs step approach.

- In 2025 NICE is also reviewing the HF treatment recommendations, expected publication in Aug-Sep 2025.
- Notts HF quick guide is a new document intended to provide support for Primary and Secondary Care on the diagnosis, management, and referral of patients with or suspected of having heart failure.
- It resulted from collaboration between HF specialists across the County.



Nottingham University Hospitals

Nottingham heart failure specialist consultant team:
Drs Bara Erhayiem, Amar Mistry, Jenny Chuen and Saima Khan

Heart failure MDT referrals via:
Community and NUH heart failure nurse specialist team

NUH heart failure and general cardiology clinics:
- Referrals made via 'Electronic Referral System' (ERS).
- Consultants will vet into most appropriate service.

The patient will be vetted to service(s) depending on clinical urgency:
- Heart Function MDT Clinics
- Community HF MDT care
- Ambulatory HF Day-Case Unit: *next working day*
- Specialist HF echocardiography Clinic
- HF consultant Advice & Guidance
- General Cardiology Clinic

Referrals deemed urgent by consultant will be seen within 2 weeks

For non-urgent, simple, enquiries regarding patients not known to cardiology, **'Advice & Guidance' (A&G) can be used**

Urgent Clinical Queries go to:

Secondary Care

On-call cardiology team, via switchboard:
SFH Sherwood Forest Hospitals (**01623 622515**)
QMC Queens Medical Centre (**0115 9249924**)
City City Hospital Campus (**0115 9691169**)

Sherwood Forest Hospitals

Heart Failure Lead Consultant Cardiologist:
Dr Ifti Fazal

Heart Failure Specialist Nurse Team
Gail Moore, Lynsay Hayes
Referrals into the SFH service can be made via 'Electronic Referral System' (ERS).

The patient will be vetted to service depending on urgency:
- HF Consultant Advice & Guidance
- General Cardiology Clinic
- One Stop Heart Failure Clinic
- Community HF MDT care

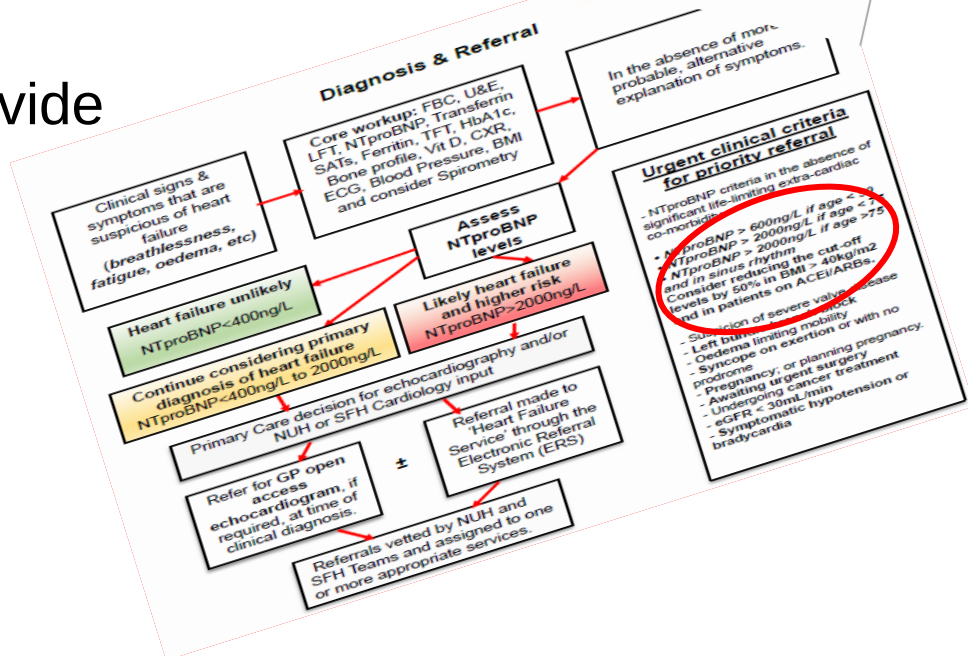
Community care

Community Heart Failure Nurse Specialists:
Nottingham North, West, North & East: 0300 0830000
Rushcliffe: 0115 8440504
City: 0300 300 7995
Newark & Sherwood: 01623 781891
Mansfield & Ashfield: 01623 781891

Community heart failure nurse specialists support ongoing cardiac therapy titrations and MDT support.
Community palliative care team for advancing heart failure and co-morbidity: see page 16.
Heart failure, pulmonary or cardiac rehabilitation referral for all patients, as available.
Community HCOP referral for patients with significant frailty and co-morbidities.

Community speciality referrals

HFrEF: **Community heart failure team** - to support co-morbidity, frailty and diuretic management.
HFpEF: **Community matron team (if available)** - to support co-morbidities.



Nottinghamshire Heart Failure - Quick Guide

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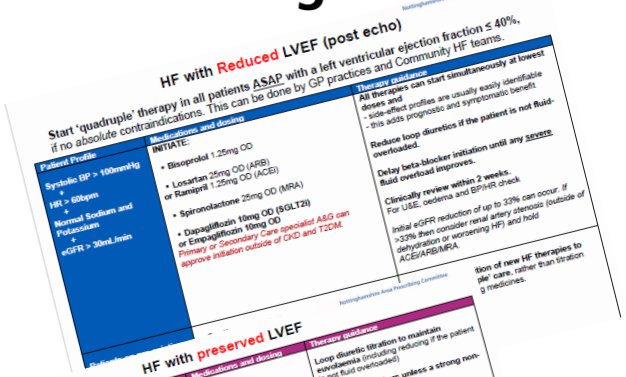
- **Supports the initiation of 'quadruple' therapy,**

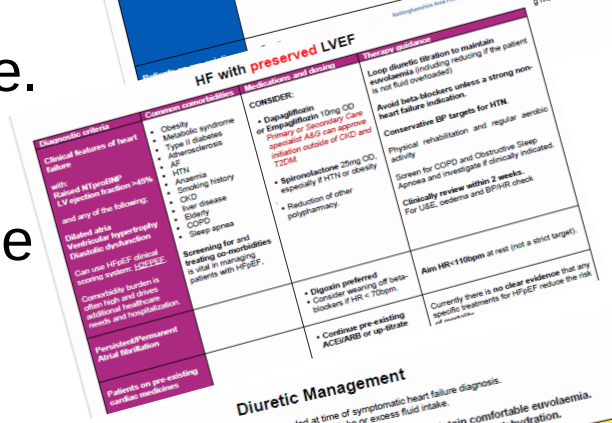
in patients with HFrEF, if no *absolute* contraindications.

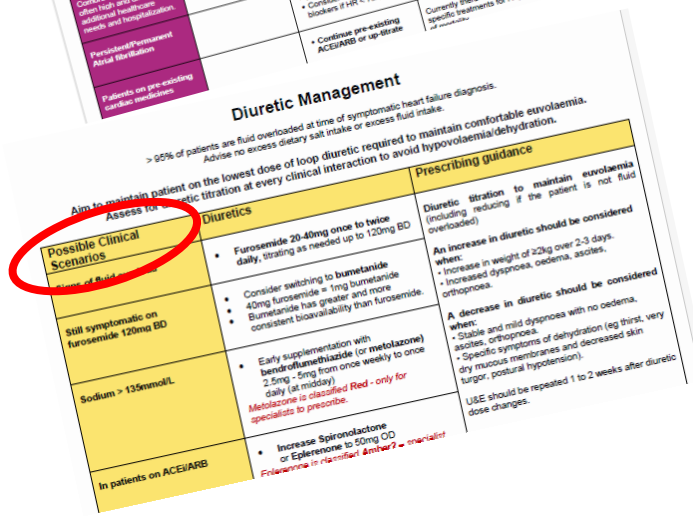
This can be done by GP practices and Community HF teams.

- It recommends the use of SGLT2i as per NICE TAs.
- Flags the medicines that are Amber 2 and required specialist advice.
- Clearly flags the patients requiring early cardiology referral.
- The core and adjunct therapies in HFrEF are tabled on the last page summarising the start and target doses, titration, monitoring and special considerations.


HF with Reduced LVEF (post echo)

Start 'quadruple' therapy in all patients ASAP with a left ventricular ejection fraction ≤ 40%, if no absolute contraindications. This can be done by GP practices and Community HF teams.


HF with preserved LVEF


Diuretic Management

Heart Failure with reduced Ejection Fraction: core therapies

Heart Failure Medication	Starting Dose	Target Dose	Titration steps	Ensure			
				Heart Rate > 50bpm	Systolic BP > 110mmHg	Potassium <5.5mmol/L	eGFR reduction <33%
Beta-blocker: Bisoprolol	1.25mg once daily	10mg once daily Or 5mg BD if OD not tolerated	1.25mg - increase every 2 weeks	√	√		
ACE-inhibitor: Ramipril	1.25mg once daily	10mg once daily Or 5mg BD if OD not tolerated	1.25mg - increase every 2 weeks		√	√	√
Angiotensin Receptor Blocker (ARB): Losartan	25mg once daily	150mg once daily	50mg - increase every 2 weeks		√	√	√
Aldosterone Antagonist (MRA): Spironolactone or Eplerenone	25mg once daily	50mg once daily	25mg - increase at 4 weeks		Doesn't cause hypotension at these doses.	√	√
SGLT2 inhibitor: Dapagliflozin or Empagliflozin	10mg once daily	10mg once daily	Do not give in Type I Diabetes		Does not cause hypotension at these doses.		√
Neprilysin inhibitor and ARB: Sacubitril/ Valsartan	24/26mg twice daily	97/103mg twice daily	Double dose every 2-4 weeks		√	√	√

Heart Failure with reduced Ejection Fraction: Adjunct Therapies

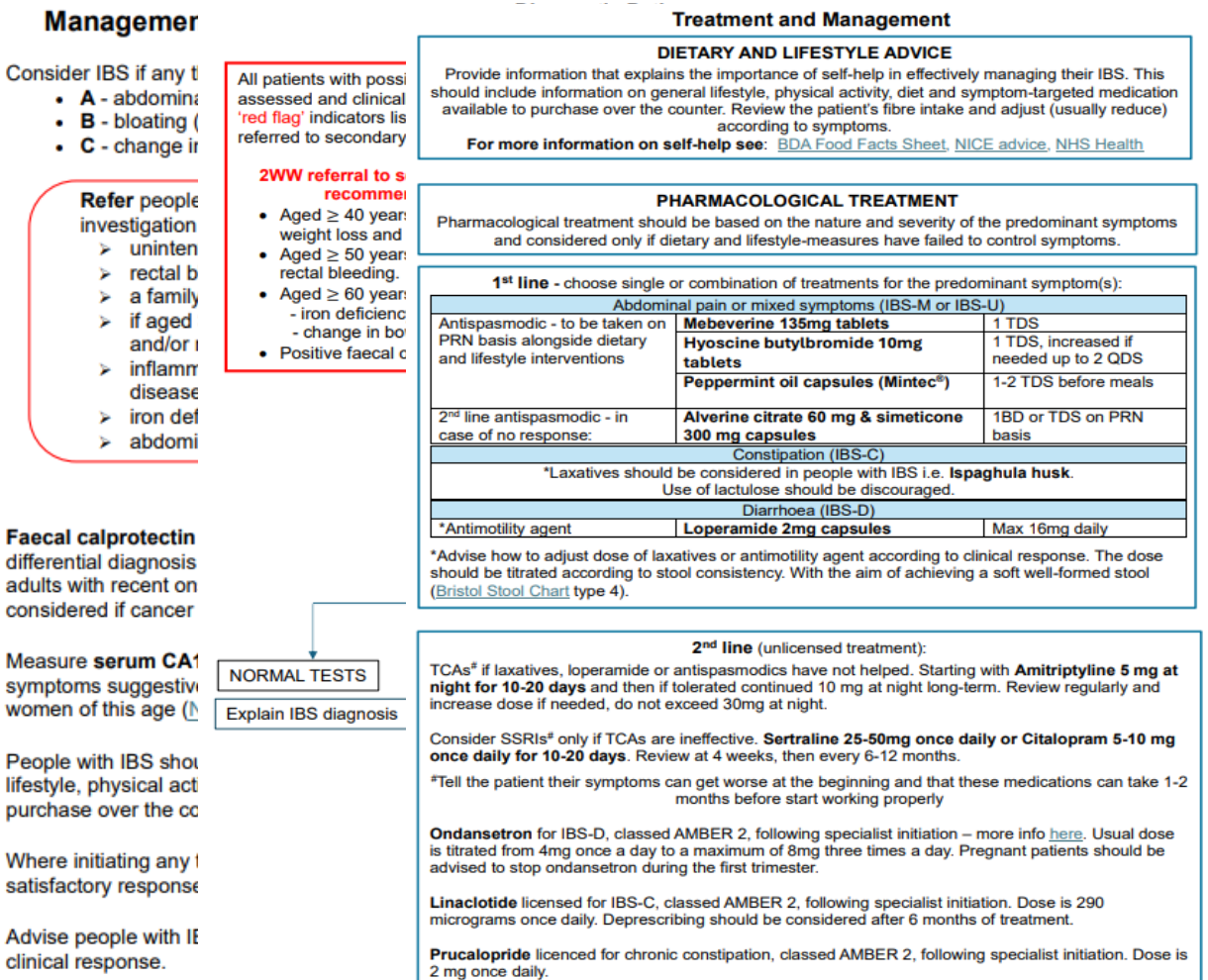
Heart Failure Medication	Indication	Starting Dose	Titration or referral steps
Ivabradine (Amber2)	Symptomatic HF with LVEF < 35% On beta-blocker Sinus rhythm Heart rate > 75bpm and BP > 90mmHg	**HF specialist opinion first** 2.5mg twice daily	2.5mg increase every 2-4 weeks Target heart rate <75bpm Ensure systolic BP > 90mmHg Maximum dose 7.5mg twice daily
Digoxin	Worsening HF despite optimal therapy. Whether patient in AF or sinus rhythm	**HF specialist opinion if in sinus rhythm.** 62.5mcg once daily if in AF	Maintenance dose usually 125mcg OD
Nitrate/ Hydralazine (Amber2)	Worsening HF despite optimal therapy Especially if African/Caribbean And/or ACEI/ARB dosing limitation And/or if severe hypertension	**HF specialist opinion first.** ISMN MR 30mg OD Hydralazine 25mg TDS	Titrate to symptoms; maximum dosing ISMN MR 120mg once daily Hydralazine 75mg three times daily
Potassium Binder: Sodium Zirconium Cyclosilicate (Amber 2)	If persistent hyperkalaemia Serum potassium > 6mmol/L Despite low potassium diet If limiting ACEI/ARB/MRA optimisation	**HF specialist opinion first.** 10g TDS loading dose for up to 72 hours, followed by maintenance dose 5g OD Specialists may consider earlier initiation, before potassium reaches 6mmol/L, in selected patients.	Titrate to potassium levels; Maintenance dose range: 5g alternate day to 10g once daily
Intravenous Iron (Red)	Symptomatic HF with LVEF < 45% Ferritin <100mcg/L Ferritin 100-300mcg/L if TSATs < 20%	N/A	IV Iron Referral Form to NUH HF Team Refer for IV Iron to KMH via Community HF Nurses. Check bone profile and vitamin D

Management of Irritable Bowel Syndrome

April 2025

Nottingham and Nottinghamshire

- A brand new local prescribing guideline.
- Developed in response to the local need captured in the local survey to support Primary Care clinicians.
  Thank you to those who responded!
- Aims to help to educate patients with lifestyle measures in management of IBS and to guide the treatment decisions.



Managemer

Consider IBS if any t
- **A** - abdomina
- **B** - bloating (
- **C** - change ir

Refer people
investigation
- uninten
- rectal b
- a family
- if aged and/or
- inflamm disease
- iron def
- abdomi

Faecal calprotectin differential diagnosis adults with recent on considered if cancer

Measure **serum CA1** symptoms suggestiv women of this age (N

People with IBS shou lifestyle, physical act purchase over the co

Where initiating any satisfactory response

Advise people with IB clinical response.

All patients with possi assessed and clinical 'red flag' indicators lis referred to secondary

2WW referral to s recomme
- Aged ≥ 40 years weight loss and
- Aged ≥ 50 years rectal bleeding.
- Aged ≥ 60 years - iron deficienc - change in bo
- Positive faecal c

NORMAL TESTS

Explain IBS diagnosis

Treatment and Management

DIETARY AND LIFESTYLE ADVICE

Provide information that explains the importance of self-help in effectively managing their IBS. This should include information on general lifestyle, physical activity, diet and symptom-targeted medication available to purchase over the counter. Review the patient's fibre intake and adjust (usually reduce) according to symptoms.

For more information on self-help see: BDA Food Facts Sheet, NICE advice, NHS Health

PHARMACOLOGICAL TREATMENT

Pharmacological treatment should be based on the nature and severity of the predominant symptoms and considered only if dietary and lifestyle-measures have failed to control symptoms.

1st line - choose single or combination of treatments for the predominant symptom(s):

Abdominal pain or mixed symptoms (IBS-M or IBS-U)		
Antispasmodic - to be taken on PRN basis alongside dietary and lifestyle interventions	**Mebeverine 135mg tablets**	1 TDS
	Hyoscine butylbromide 10mg tablets	1 TDS, increased if needed up to 2 QDS
	Peppermint oil capsules (Mintec®)	1-2 TDS before meals
2nd line antispasmodic - in case of no response:	**Alverine citrate 60 mg & simeticone 300 mg capsules**	1BD or TDS on PRN basis
Constipation (IBS-C)		
*Laxatives should be considered in people with IBS i.e. **Ispaghula husk**. Use of lactulose should be discouraged.		
Diarrhoea (IBS-D)		
*Antimotility agent	**Loperamide 2mg capsules**	Max 16mg daily

*Advise how to adjust dose of laxatives or antimotility agent according to clinical response. The dose should be titrated according to stool consistency. With the aim of achieving a soft well-formed stool (Bristol Stool Chart type 4).

2nd line (unlicensed treatment):

TCAs# if laxatives, loperamide or antispasmodics have not helped. Starting with **Amitriptyline 5 mg at night for 10-20 days** and then if tolerated continued 10 mg at night long-term. Review regularly and increase dose if needed, do not exceed 30mg at night.

Consider SSRIs# only if TCAs are ineffective. **Sertraline 25-50mg once daily or Citalopram 5-10 mg once daily for 10-20 days**. Review at 4 weeks, then every 6-12 months.

#Tell the patient their symptoms can get worse at the beginning and that these medications can take 1-2 months before start working properly

Ondansetron for IBS-D, classed AMBER 2, following specialist initiation – more info here. Usual dose is titrated from 4mg once a day to a maximum of 8mg three times a day. Pregnant patients should be advised to stop ondansetron during the first trimester.

Linaclotide licensed for IBS-C, classed AMBER 2, following specialist initiation. Dose is 290 micrograms once daily. Deprescribing should be considered after 6 months of treatment.

Prucalopride licenced for chronic constipation, classed AMBER 2, following specialist initiation. Dose is 2 mg once daily.

Includes:

- Diagnostic pathway listing “red flags” and symptoms where secondary care input should be considered, clinical investigations.
- Dietary and lifestyle advice – should always be trialled first to improve the IBS management. Supported with patients' resources within dedicated section including videos, information websites and dietary advice leaflets.
- Pharmacological treatment options mapped to the predominant presenting symptoms. Divided into two tiers: 1st and 2nd line treatment options, some of which may require Specialist initiation.
- Management Pathway.
- Patients’ resources.

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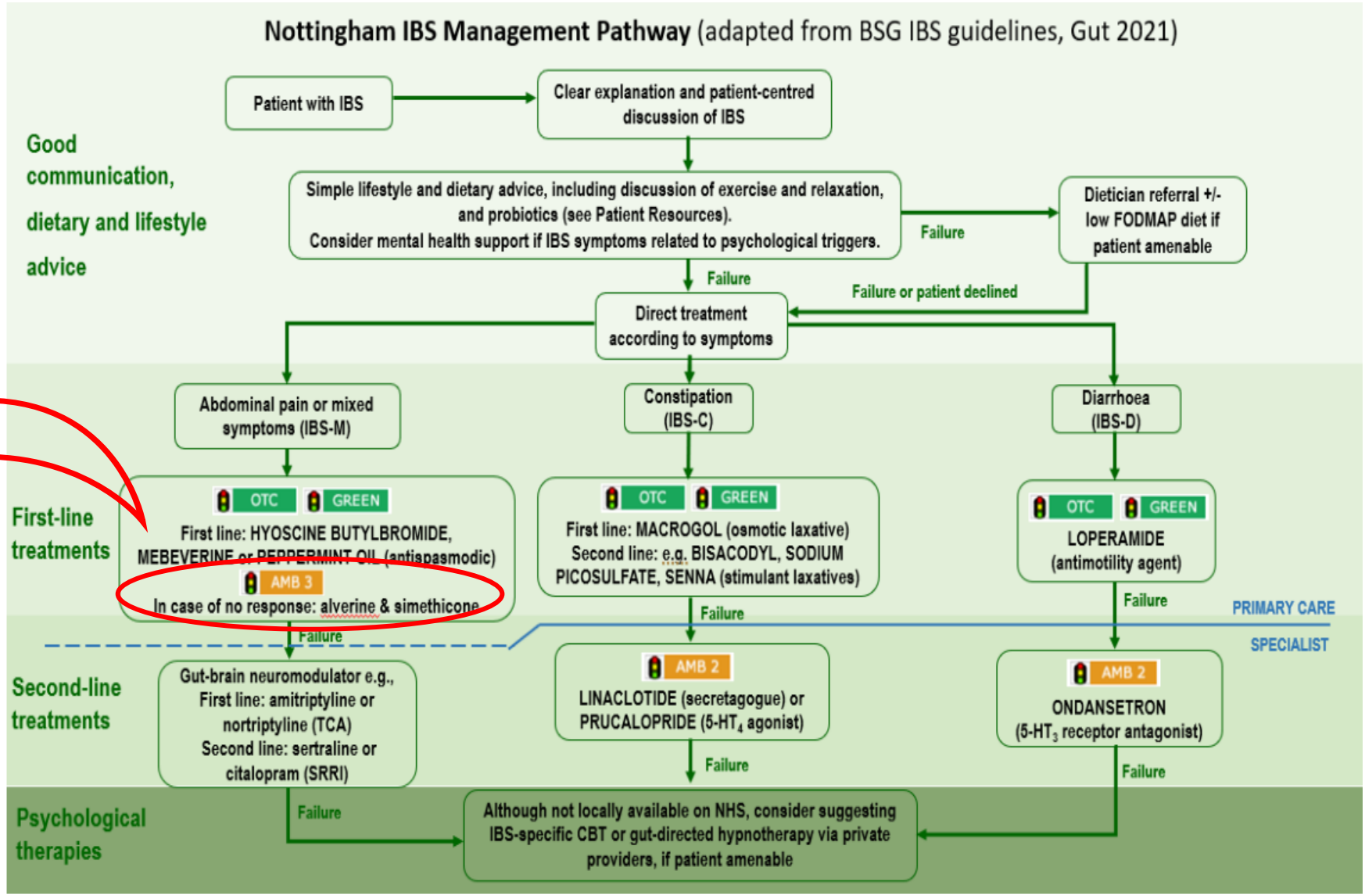
Management of Irritable Bowel Syndrome

As a result, the temporary classification (Amber 2) of **alverine 60mg/simeticone 300mg capsules** for pain/discomfort associated with IBS has been revised and updated to **AMBER 3**.

This combination product remains **a second line treatment only** if symptoms have not responded to the first line therapeutics like mebeverine, peppermint oil capsules or hyoscine butyl bromide.



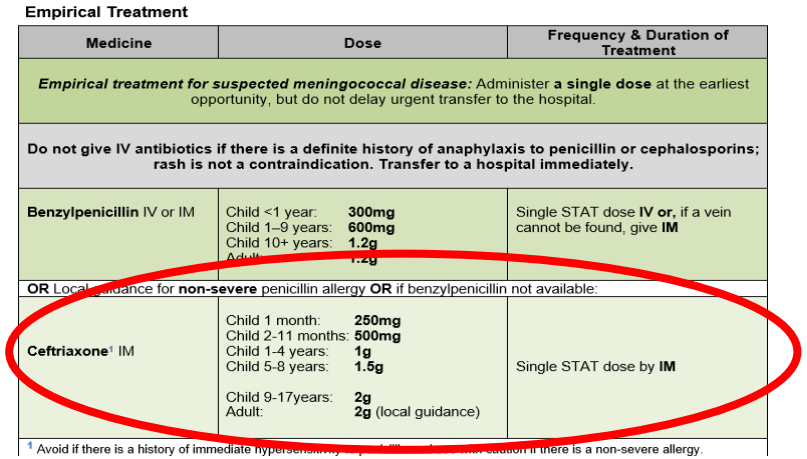
Antimicrobial guidelines updates

April 2025

Nottingham and Nottinghamshire

Meningitis

- Contacts updated, meningitis needs to be phoned Through, link to online notification form was removed.
- Cefotaxime removed, NICE recommends single dose ceftriaxone or benzylpenicillin.
- Maximum daily dose of ceftriaxone in children was changed to 2g as per NICE.
- **Ceftriaxone** dose has adopted the dose banding recommended in BNFc and is only recommended for IM administration.
- The use of lidocaine in the IM ceftriaxone injection has been removed.
- Prophylaxis considerations added as per NICE.



Empirical Treatment

Medicine	Dose	Frequency & Duration of Treatment
Empirical treatment for suspected meningococcal disease: Administer **a single dose** at the earliest opportunity, but do not delay urgent transfer to the hospital.		
Do not give IV antibiotics if there is a definite history of anaphylaxis to penicillin or cephalosporins; rash is not a contraindication. Transfer to a hospital immediately.		
Benzylpenicillin IV or IM	Child <1 year: **300mg** Child 1–9 years: **600mg** Child 10+ years: **1.2g** Adult: **1.2g**	Single STAT dose **IV or,** if a vein cannot be found, give **IM**
OR Local guidance for **non-severe** penicillin allergy **OR** if benzylpenicillin not available:		
Ceftriaxone[1] IM	Child 1 month: **250mg** Child 2-11 months: **500mg** Child 1-4 years: **1g** Child 5-8 years: **1.5g** Child 9-17years: **2g** Adult: **2g** (local guidance)	Single STAT dose by **IM**

[1] Avoid if there is a history of immediate hypersensitivity [illegible] if there is a non-severe allergy.

Splenectomy

- This interim review aligns with NUH recommendations for Adults and Children Guidelines for Patients with Absent or Dysfunctional Spleen, updated in December 2024. SFHT are in the process of reviewing its splenectomy guidance, and it will most likely align with NUH updates.
- **Lifelong prophylaxis** is recommended, where compliance is an issue, the duration was changed from **2 years to 1-3 years.**
- **Children must have prophylaxis up to 5 years of age** and for a minimum of 2 years.
- Statin in pen allergic patients on macrolide long term.

Shared Care Protocols

April 2025

Nottingham and Nottinghamshire

ADHD Adults SCP (Atomoxetine, Dexamfetamine, Lisdexamfetamine, Methylphenidate) –update

No updates from NICE (Sep 2019) or RMOC

Harmonisation with Children & Young People (CYP)

- Most of the updates made do align Adult SCP with CYP SCP for consistency where appropriate (e.g. clearer baseline monitoring , adverse effects guidance & CV risks)

Transfer of care:

- Adults: 12 weeks post-initiation(unchanged)
  CYP: 4 weeks.(unchanged)
- New clause: If dose/formulation is adjusted, transfer back to Primary Care after ≥ 4 weeks of stability.

Drug Shortages

- Refer to APC ADHD Shortages Page

Methylphenidate

⚠ Priapism added as rare side effect – urgent attention advised.

💊 New 8-hour release capsule brand: **Focusim XL**.

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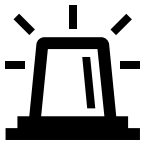
Shared Care Protocol - Amiodarone

- Minor update
- Following updated monitoring advice published by SPS in February 2025 (the local SCP was only updated in January 2025).

- Baseline investigations – responsibility of initiating Specialist:
  - **INR** – in patients on Warfarin – measure at baseline and at least weekly during the loading regimen - **continue for two months or until stabilised.**
  - **TFTs** - if borderline at baseline, consider **repeating every 6 weeks until stable**.
- Ongoing monitoring – **suspected chest toxicity**, monitor for signs and symptoms in Primary Care, refer to initiating Specialist for chest **CT scan** (previously chest Xray).



breathlessness, new/worsening cough, shortness of breath or deterioration in general health (e.g. fatigue, weight loss, fever)

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New Submissions

Amantadine & modafinil for fatigue in MS- AMBER 2

- Off- label indication but in line with NICE NG220.
- Lifestyle measures usually recommended first-line but in some cases insufficient.
- Will be initiated by a Specialist in MS.
- Amantadine *capsules*- dosing as per BNF.
- Modafinil as per Prescribing Information sheet.
- Modafinil reminders:
  - BP/ HR monitoring required (as per narcolepsy indication)
  - Contraception precautions in those of childbearing potential.

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New Submissions

Trifarotene cream (Aklief®)-GREEN

- Topical retinoid for acne, alternative to adapalene.
- Single agent topical treatment is an option if combination treatment not tolerated or if one component is contraindicated.
- Included in APC Acne guidance
- 75g pack size vs 45g which may be helpful for those with truncal acne.

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New Submissions

Deflazacort for DMD- AMBER 2

- Corticosteroid approved for the treatment of Duchenne Muscular Dystrophy.
- May be considered as an alternative to prednisolone if there are concerns about undesirable effects of prednisolone.

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Nottingham and Nottinghamshire

New Submissions

Calcifediol monohydrate (Domnisol®) - **AMBER 2**

- Activated vitamin D3 metabolite which does not require hepatic metabolism.
- **Locally approved indication:** for adults with vitamin D deficiency **who failed to respond to two courses of standard vitamin D loading treatment within past 6 months** i.e. remain symptmatic with serum vitamin D level <50nmol/L.
- Initial treatment of deficiency to be completed with Metabolic Medicine Specialist and once serum vitamin D level improves >50nmol/L, **the ongoing prescrbing of maintenance therapy may be requested from Primary Care.**
- **Dose** - ongoing maintenance: calcifediol monohydrate 266 micrograms (one capsule) orally **once a month**. See Vitamin D prescribing guidelines for the initial treatment course (to be completed in Secondary Care).

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The local Vitamin D Management in Adults guidelines updated - **page 3 flowchart.**

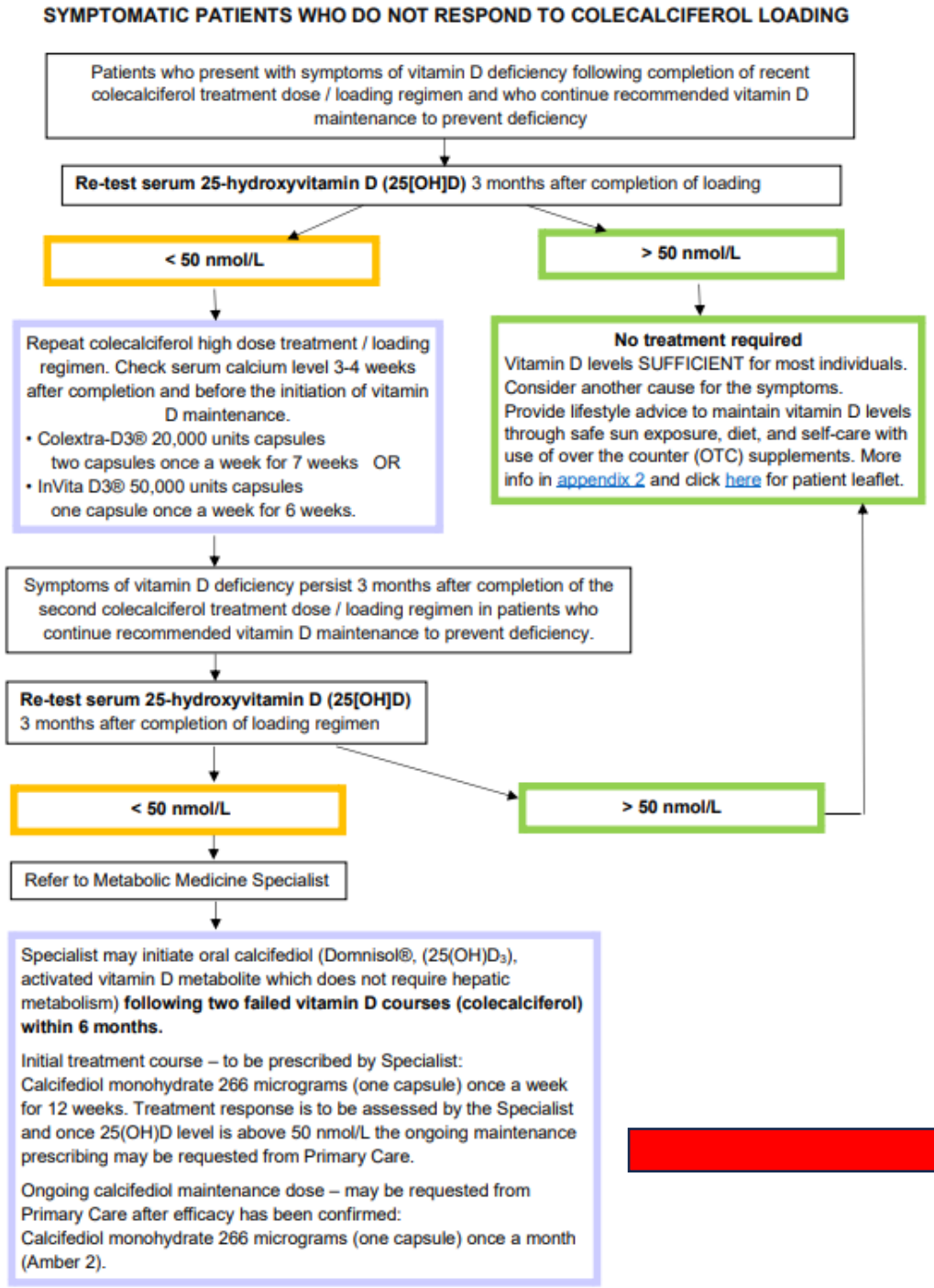


Table 2: Maintenance and prevention of deficiency

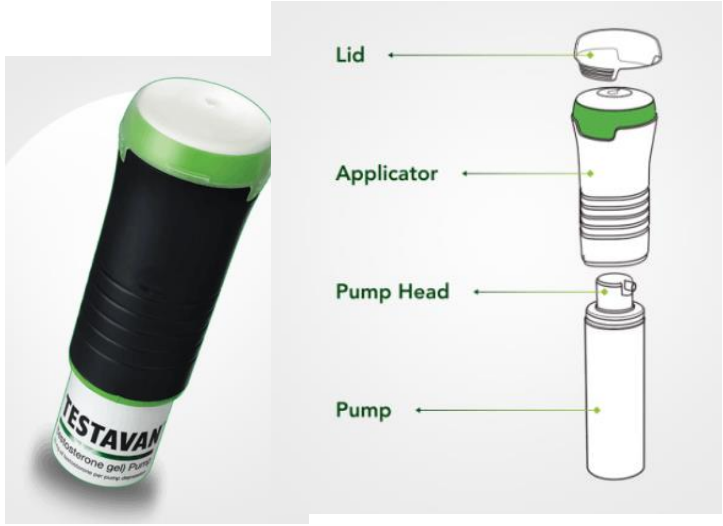
Products listed below are only to be prescribed if the patient meets the exception criteria listed in the local position statement e.g. the patient has osteoporosis, or at risk of vitamin D deficiency or malabsorption secondary to a chronic condition or surgery (excluding bariatric surgery). All other patients should be advised to **purchase** a vitamin D supplement which will provide 800 to 2000units per day (click here for patient information leaflet).

PRODUCT Prescribe by brand name	Dose	Monthly cost (NHS)	Cost per pack (NHS)	Pack size	Notes
ValuPak® Vitamin D3 1000 units tablets (food supplement)	One to be taken daily	**£0.35**	£0.75	60	The most cost-effective option. Food supplement, unlicensed product. Gelatin free.
Colextra-D3® 25,000 units tablets	One to be taken **once a month**	**£1.03**	£12.40	12	Licensed product. Gelatin free.
Invita D3® 25,000 units capsules	One to be taken **once a month**	**£1.32**	£3.95	3	Licensed product. Contain glycerol and gelatin.
InVita D3® 25,000 units/ 1ml oral solution unit dose ampoules sugar free	One to be taken **once a month**	**£1.48**	£4.45	3	Licensed product. Gelatin free. Suitable for a vegetarian diet. Lactose free, nut free and soya free.
Calcifediol (Domnisol®) 266 micrograms capsules	One to be taken **once a month**	**£2**	£1.99	1	Amber 2 For patients who do not respond to colecalciferol. Ensure other Vitamin D preparations are not co-administered (prescription or OTC).
			£5.97	3	

Nottingham and Nottinghamshire

Formulary Amendments and Traffic light changes

- Testavan (testosterone transdermal gel) *refill pack*- equivalent in cost to the standard pack but offers a more sustainable option as it does not contain the non-recyclable applicator.



- Wound care products for infected wounds reclassified as AMB 3 in line with Guideline for Wound Infection:
  -Atrauman Ag, Aquacel Ag, Octenillin wound irrigation solution, Flaminol Forte and Hydro

April 2025

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Tirzepatide for managing overweight and obesity

- NICE TA1026 published on 23 December 2024 & NHS England (NHSE) was tasked by NICE with defining and phasing eligible cohorts.
- NHSE has now published an interim commissioning guidance recommending the following:

Year 1 (12 months)	**Cohort 1**	**BMI ≥40 kg/m² + ≥4 *qualifying comorbidities**
Year 2: (9 months)	**Cohort 2**	**BMI 35–39.9 kg/m² + ≥4 *qualifying comorbidities**
Years 2–3(15 months)	**Cohort 3**	**BMI ≥40 kg/m² + ≥3 *qualifying comorbidities**
* Type 2 diabetes, hypertension, Obstructive Sleep Apnoea (OSA), Dyslipidaemia, Atherosclerotic cardiovascular disease (ASCVD)		

Tirzepatide availability:

Specialist Weight Management Service (SWMS) from end of March 2025 (via Right to Choose):

- Referral limited to small cohort **(cohort 1)**
- Those not meeting the criteria will **not be NHS-funded**

Primary Care : available from end of June 2025

- Development currently underway for integrated local weight management pathways
- Eligibility: meet NHSE cohort criteria (**cohort 1**) **and** engage with wrap around care (a reduced calorie diet and increased physical activity)
- **DO NOT PRESCRIBE UNTIL LOCALLY COMMISIONED SERVICE IS IN PLACE**

- For more details and up to date information please see weight management services page on Teamnet

Area Prescribing Committee Work Plan

April 2025

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Going to forthcoming APC Guidelines meetings:

- Vitamin B 12 guideline
- Opioids for non-cancer pain
- Neuropathic pain
- Asthma in adults

APC Formulary meeting:

- Doxylamine/ pyridoxine (Xonvea) for Nausea and Vomiting in Pregnancy
- Nebivolol

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