Area Prescribing Committee Bulletin May 2025

1 - Link to APC website

2 - Link to APC Joint Formulary

New Formulary Submissions

Amantadine and modafinil for fatigue in Multiple Sclerosis (MS) - AMBER 2

Indication:

- Off- label use for fatigue in MS in line with in line with NICE NG220.
- Lifestyle measures are recommended first-line, but in some cases, these are insufficient.

- Will be initiated by a Specialist in MS.
- Amantadine *capsules*- dosing as per BNF (liquid is significantly more expensive and unlikely to be indicated).
- Modafinil as per the Prescribing Information sheet.
- Modafinil reminders:

  - BP/ HR monitoring required (as per narcolepsy indication)

  - Contraception precautions in those of childbearing potential.

Deflazacort for Duchenne Muscular Dystrophy - AMBER 2

Indication:

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

Trifarotene cream for acne - 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.

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 symptomatic with serum vitamin D level <50nmol/L.

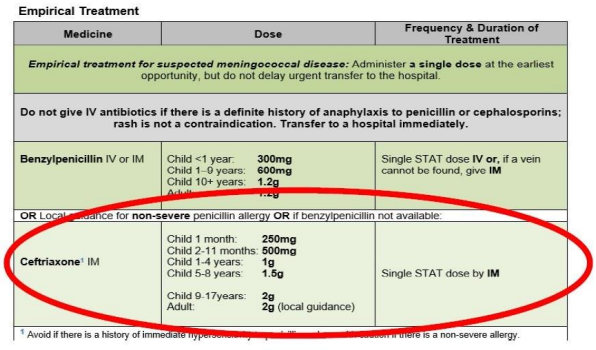
- Initial treatment of deficiency to be completed with Metabolic Medicine Specialist and once serum vitamin D level improves >50nmol/L, **the ongoing prescribing of maintenance therapy may be requested from Primary Care.**
- **Dose** - ongoing maintenance: calcifediol monohydrate 266 micrograms (one capsule) orally **once a month**. See Vitamin D prescribing guidelines for the initial treatment course (to be completed in Secondary Care).

News from the APC - new and updated documents

Antimicrobial Guidelines:

Meningitis (update)

- 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.
- Removed the use of lidocaine in the IM ceftriaxone injection.
- Prophylaxis considerations added as per NICE.



Empirical Treatment

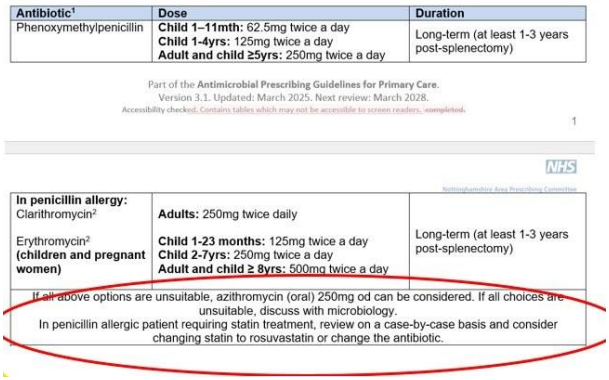
Medicine	Dose	Frequency & Duration of Treatment
Empirical treatment for suspected meningococcal disease: Administer **a single dose** at the earliest opportunity, but do not delay urgent transfer to the hospital.		
Do not give IV antibiotics if there is a definite history of anaphylaxis to penicillin 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† 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**

† Avoid if there is a history of immediate hypersensitivity to penicillins and cephalosporins or if there is a non-severe allergy.

Splenectomy (update)

- 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 currently reviewing their guidance.

- **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.**
- Azithromycin was added as a third line option available for patients allergic to penicillin and unable to tolerate clarithromycin- as per NUH guidance.
- Advice regarding the choice of statin was added for patients with confirmed penicillin allergy on long term macrolide treatment.



Antibiotic[1]	Dose	Duration
Phenoxymethylpenicillin	**Child 1–11mth:** 62.5mg twice a day **Child 1-4yrs:** 125mg twice a day **Adult and child ≥5yrs:** 250mg twice a day	Long-term (at least 1-3 years post-splenectomy)

Part of the **Antimicrobial Prescribing Guidelines for Primary Care**.
Version 3.1. Updated: March 2025. Next review: March 2028.
Accessibility checked. Contains tables which may not be accessible to screen readers, ~~completed~~.

1

NHS

Nottinghamshire Area Prescribing Committee

In penicillin allergy: Clarithromycin[2] Erythromycin[2] **(children and pregnant women)**	**Adults:** 250mg twice daily **Child 1-23 months:** 125mg twice a day **Child 2-7yrs:** 250mg twice a day **Adult and child ≥ 8yrs:** 500mg twice a day	Long-term (at least 1-3 years post-splenectomy)
If all above options are unsuitable, azithromycin (oral) 250mg od can be considered. If all choices are unsuitable, discuss with microbiology. In penicillin allergic patient requiring statin treatment, review on a case-by-case basis and consider changing statin to rosuvastatin or change the antibiotic.		

Other antimicrobial updates:

- Wound infection podcast
- Wound Infection presentation

- APC Antimicrobial Bulletin April 2025

Other guidelines, Shared Care Protocols and Information sheets

- **Heart failure guidelines (new)**
- Management of Irritable Bowel Syndrome (IBS) **- new local prescribing guideline**
- **VTE management in pregnancy – treatment & prophylaxis**
- **Attention Deficit Hyperactivity Disorder (ADHD) in adults- Shared Care Protocols (SCP)- updates**

- Atomoxetine for patients within adult services

- Dexamfetamine for patients within adult services

- Lisdexamfetamine for patients within adult services

- Methylphenidate for patients within adult services

- Amiodarone for patients within adult services **(minor update to SCP)**
- Monoamine-oxidase-B Inhibitors (MAOI's) in Patients with Off Periods Without Dyskinesia as an Adjunct to Levodopa **(minor update)**
- Clonidine for tic disorders **- information sheet (update)**
- Continence formulary **- update of the Catheters & Accessories section**
- Blood Glucose & Ketone Meter Formulary **- interim update**
- Blood Glucose and Ketone Testing - Frequency and Eligibility **- interim update**

For further information and a full explanation of changes, please see the latest APC update or watch our latest webinar.

Horizon scanning, formulary amendments and traffic light changes

- **Testavan** (testosterone transdermal gel) *refill pack* AMBER 2 🟠 - 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 AMBER 3 🟠 in line with the Wound Infection guideline: Atrauman Ag, Aquacel Ag+, Octenillin wound irrigation solution, Flaminal Forte Gel.
- **FreeStyle Libre® 3 Plus**. AMBER 2 🟠 This will replace the FreeStyle Libre 3 as it will be discontinued in September 2025. These sensors are used for hybrid closed loop systems only.

Publications

3 - Link to APC webinars

APC Webinars: You can find our April 2025 APC presentation on the APC website.

We are trying to share the webinar recording differently this time, directly from SharePoint, rather than uploading on YouTube. It is the first time we share the recording like this. If you did not register for the webinar, you may not be able to access it. Please be in touch and we can give you access. For future webinars, try and register even if you are not sure 100% about attending as this way you can have access to the recording.

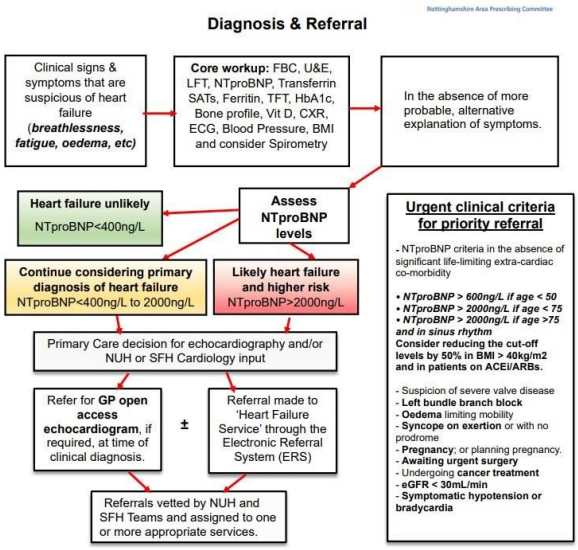
4 - Link to APC podcasts

Our Podcasts:

After a break of a few months, we are back again with a new episode about Wound Infection. Our guests, Annabel Wilson, Tissue Viability Nurse and Dr Rodric Francis, Microbiology and Infectious Disease Consultant, talks us through the updated guideline for Wound Infection.

The link to the presentation about infected wounds that is mentioned in the episode can be found on the APC website and is linked also in the episode notes.

Feature of the month: Heart Failure guideline



Nottinghamshire Heart Failure 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 is the result of collaborative work between HF specialists across Nottinghamshire and it was written having in mind the latest clinical research, and NICE/ESC guidance, considering our local structure, logistics and capacity.

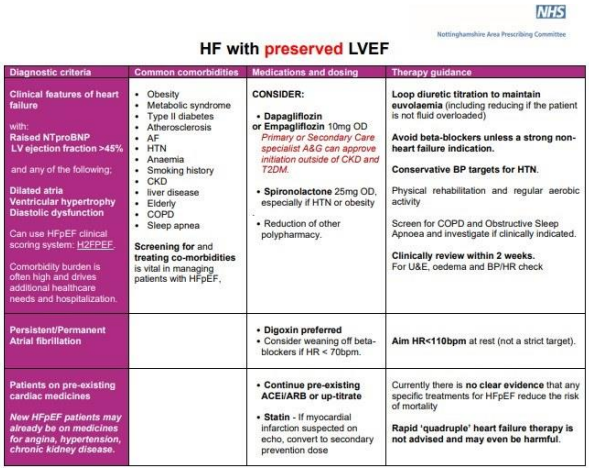
- The guideline supports the initiation of 'quadruple' therapy, in all patients with a left ventricular ejection fraction ≤ 40% if no *absolute* contraindications. This can be done by GP practices and Community HF teams.
- Medicines classified as Amber 2 and requiring specialist advice are clearly marked throughout the document.
- The guideline encourages communication between Primary and Secondary care and tries to help decision making at the point of prescribing by giving examples of potential patient profiles, how to treat and when to refer.
- The core and adjunct therapies in HFrEF are tabled on the last page summarising the start and target doses, titration, monitoring, and special considerations.

The guideline includes in addition to treatment recommendations:

- HF services available in both Trusts, along with contact numbers
- diagnosis and referral pathway - clearly described in a flowchart
- urgent criteria for referral flagged.

Particular attention was given to keep the guidance short and to clearly mark all sections, ensuring it is easy to navigate.

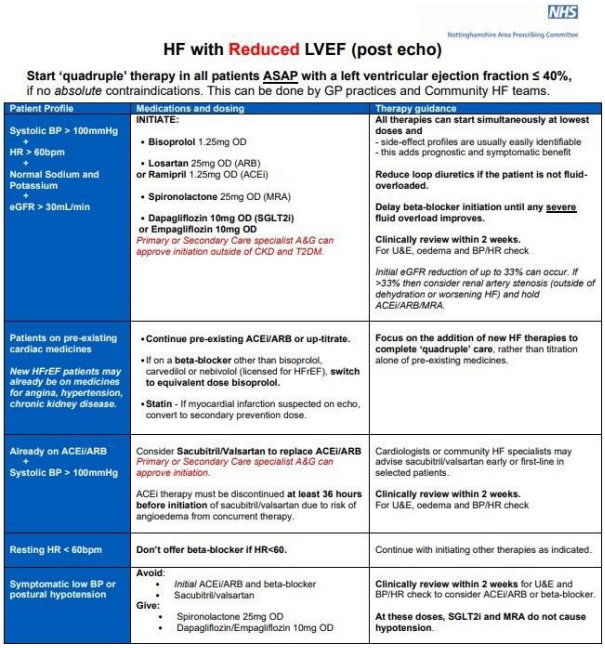
For any comments, suggestions, or feedback, please get in touch with the Interface team on nnicb-nn.nottsapc@nhs.net .



NHS
Nottinghamshire Area Prescribing Committee

HF with preserved LVEF

Diagnostic criteria	Common comorbidities	Medications and dosing	Therapy guidance
Clinical features of heart failure with: **Raised NTproBNP** **LV ejection fraction >45%** and any of the following; **Dilated atria** **Ventricular hypertrophy** **Diastolic dysfunction** Can use HFpEF clinical scoring system: H2FPEF. Comorbidity burden is often high and drives additional healthcare needs and hospitalization.	• Obesity • Metabolic syndrome • Type II diabetes • Atherosclerosis • AF • HTN • Anaemia • Smoking history • CKD • liver disease • Elderly • COPD • Sleep apnea **Screening for** and **treating co-morbidities** is vital in managing patients with HFpEF.	**CONSIDER:** • **Dapagliflozin or Empagliflozin** 10mg OD *Primary or Secondary Care specialist A&G can approve initiation outside of CKD and T2DM.* • **Spironolactone** 25mg OD, especially if HTN or obesity • Reduction of other polypharmacy.	**Loop diuretic titration to maintain euvolaemia** (including reducing if the patient is not fluid overloaded) **Avoid beta-blockers unless a strong non-heart failure indication.** **Conservative BP targets for HTN.** Physical rehabilitation and regular aerobic activity Screen for COPD and Obstructive Sleep Apnoea and investigate if clinically indicated. **Clinically review within 2 weeks.** For U&E, oedema and BP/HR check
Persistent/Permanent Atrial fibrillation		• **Digoxin preferred** • Consider weaning off beta-blockers if HR < 70bpm.	**Aim HR<110bpm** at rest (not a strict target).
Patients on pre-existing cardiac medicines ***New HFpEF patients may already be on medicines for angina, hypertension, chronic kidney disease.***		• **Continue pre-existing ACEi/ARB or up-titrate** • **Statin** - If myocardial infarction suspected on echo, convert to secondary prevention dose	Currently there is **no clear evidence** that any specific treatments for HFpEF reduce the risk of mortality **Rapid 'quadruple' heart failure therapy is not advised and may even be harmful.**



NHS
Nottinghamshire Area Prescribing Committee

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.

Patient Profile	Medications and dosing	Therapy guidance
Systolic BP > 100mmHg + **HR > 60bpm** + **Normal Sodium and Potassium** + **eGFR > 30mL/min**	**INITIATE:** • **Bisoprolol** 1.25mg OD • **Losartan** 25mg OD (ARB) **or Ramipril** 1.25mg OD (ACEi) • **Spironolactone** 25mg OD (MRA) • **Dapagliflozin 10mg OD (SGLT2i)** **or Empagliflozin 10mg OD** *Primary or Secondary Care specialist A&G can approve initiation outside of CKD and T2DM.*	**All therapies can start simultaneously at lowest doses and** - side-effect profiles are usually easily identifiable - this adds prognostic and symptomatic benefit **Reduce loop diuretics if the patient is not fluid-overloaded.** **Delay beta-blocker initiation until any severe fluid overload improves.** **Clinically review within 2 weeks.** For U&E, oedema and BP/HR check *Initial eGFR reduction of up to 33% can occur. If >33% then consider renal artery stenosis (outside of dehydration or worsening HF) and hold ACEi/ARB/MRA.*
Patients on pre-existing cardiac medicines ***New HFrEF patients may already be on medicines for angina, hypertension, chronic kidney disease.***	• **Continue pre-existing ACEi/ARB or up-titrate.** • If on a **beta-blocker** other than bisoprolol, carvedilol or nebivolol (licensed for HFrEF), **switch to equivalent dose bisoprolol.** • **Statin** - If myocardial infarction suspected on echo, convert to secondary prevention dose.	**Focus on the addition of new HF therapies to complete 'quadruple' care**, rather than titration alone of pre-existing medicines.
Already on ACEi/ARB + **Systolic BP > 100mmHg**	Consider **Sacubitril/Valsartan to replace ACEi/ARB** *Primary or Secondary Care specialist A&G can approve initiation.* ACEi therapy must be discontinued **at least 36 hours before initiation** of sacubitril/valsartan due to risk of angioedema from concurrent therapy.	Cardiologists or community HF specialists may advise sacubitril/valsartan early or first-line in selected patients. **Clinically review within 2 weeks.** For U&E, oedema and BP/HR check
Resting HR < 60bpm	**Don't offer beta-blocker if HR<60.**	Continue with initiating other therapies as indicated.
Symptomatic low BP or postural hypotension	**Avoid**: • *Initial* ACEi/ARB and beta-blocker • Sacubitril/valsartan **Give:** • Spironolactone 25mg OD • Dapagliflozin/Empagliflozin 10mg OD	**Clinically review within 2 weeks** for U&E and BP/HR check to consider ACEi/ARB or beta-blocker. **At these doses, SGLT2i and MRA do not cause hypotension.**

Please see below the PLT dates for PCDC Heart Failure teaching. For colleagues to book a place, they will need to have an account with PCDC. They can click here to book - https://www.pcdcportal.org/SignedOut/Register

Mid Notts (15:00 – 17:00):

- 11th June – Newark & Sherwood (online via Zoom)
- 25th June – Mansfield & Ashfield (online via Zoom)

South Notts (15:15 – 17:00):

- 12th June – Group 1 at Notts County Football Ground
- 19th June – Group 2 at Notts County Football Ground

Notts City (15:15 – 17:00):

• 18th November – online via Zoom

• 25th November – online via Zoom

🗓️ Coming Soon

- Vitamin B12
- Opioids for chronic non-cancer pain
- Neuropathic pain
- Adult asthma
- Antimicrobial guidelines

Let us know what you think!

The work of the Nottinghamshire Area Prescribing Committee is supported and managed by the interface team.

We can be contacted via

📧 Email: nnicb-nn.nottsapc@nhs.net

🌐 **Visit:** Nottinghamshire APC Website

📄 **View: Meeting Minutes, Bulletins, Formularies on Teamnet**