NHS
Shropshire
Clinical Commissioning Group

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To: All Shropshire CCG GP Practices

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Dear Colleague

Changes to medicines or treatments prescribed on the NHS

Shropshire CCG is adopting the '**National policy on items which should not be routinely prescribed in Primary Care**' and we would encourage all GP practices to actively review patients currently prescribed medicines on the below list. The CCG medicines management team will be contacting practices to support you to action this new national policy.

NHS England guidance recommends that the following medicines or treatments should not be prescribed any more or should only be prescribed in special circumstances.
This is because they are:

- Not as safe as other medicines OR
- Not as good (effective) as other medicines OR
- More expensive than other medicines that do the same thing OR
- Shouldn't be available on the NHS in some circumstances.

• Co-proxamol	• Dosulepin	• Liothyronine
• Doxazosin MR	• Herbal treatments	• Lutein and antioxidants
• Fentanyl IR	• Homeopathy	• Omega 3 fatty acids
• Glucosamine and Chondroitin	• Lidocaine plasters	• Oxycodone and naloxone combination
• Paracetamol and tramadol combination	• Perindopril arginine	• Tadalafil once daily
• Trimipramine	• Rubefacients*	

*Not including non-steroidal anti-inflammatory drugs.

The full guidance can be found here: **Items which should not be routinely prescribed in primary care.** This document will explain the changes, why they are happening and where you can get more information and support.

Appendix 1 contains a brief summary of recommended actions for each medicine.
Information leaflets for patients are available on the CCG website.

Implementing the new national guidance is a key part of this year's QIPP plans for primary care and as such forms a key part of 2018-19 Prescribing Development Scheme (PDS) for practices.

The PDS will support practices to adopt the national policy by funding the additional capacity required to see these patients. Where practices have limited capacity to do this work we would ask that they prioritise the changes and focus initially on those that will generate the maximum saving. Practices also have the option to review patient's medicine at the next medication review, however it may affect the overall practice saving. Your locality pharmacists will be contacting you shortly to arrange a meeting to discuss this.

We look forward to your continuing support.

Yours sincerely

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Appendix 1

The following is intended as a summary of actions required. Some items are straight forward and can be stopped immediately and new patients should not be initiated whilst others may require a review to determine a suitable alternative for existing patients. The medicines management team can run searches to determine which patients are prescribed these drugs and will need to be reviewed.

1. **Lutein and antioxidents** eg.ICAPS, visioncare etc.

   New patients: Do not initiate
   Existing patients: Stop prescribing
   Reason: lack of evidence
   Exceptions: None
   Action required: Practice or technicians to contact patients and stop.

1. **Omega-3 Fatty Acid Compounds**

   New Patients: Do not initiate
   Existing patients: Stop prescribing
   Reason: Lack of evidence
   Exceptions: None
   Action required: Practice or technicians to contact patients and stop.

2. **Rubefacients** (excluding topical NSAIDs)

   New Patients: Do no initiate
   Existing patients: Stop prescribing
   Reason: The BNF states *"The evidence available does not support the use of topical rubefacients in acute or chronic musculoskeletal pain."*
   NICE have issued the following "Do not do" recommendation:
   Do not offer rubefacients for treating osteoarthritis.
   Exceptions: None
   Action required: Practice or technicians to contact patients and stop

3. **Perindopril Arginine**

   New patients: Do not initiate. Use perindopril erbumine instead
   Existing patients: Review patients and switch to perindopril erbumine if an ACE inhibitor is still appropriate treatment**.**
   Reason: National Institute for Health and Care Excellence (NICE) hypertension guidelines advise prescribing non-proprietary drugs of low acquisition cost as first line choices of drug therapy. Coversyl® Arginine (perindopril arginine) has no clinical benefit over generic perindopril erbumine and is more costly.
   Exceptions: None
   Action required: Practices to work with medicines management team to switch patients to perindopril erbumine

4. **Oxycodone and Naloxone combination product (**Targinact®)

   New patients: Do not initiate.
   Existing patients: Patients will need to be reviewed by GP face to face and changed to alternative opioid, preferably morphine sulfate modified release (MR), but oxycodone if morphine modified release (MR) unsuitable. Laxatives should also be prescribed.
   Reason: The naloxone component in Targinact® tablets is intended to counteract opioid-induced constipation. Trials conducted with Targinact® in patients with moderate to severe non-cancer pain have shown no difference in pain control against oxycodone. Targinact® tablets reduced pain but did not eliminate the need for laxatives. However, the trials did not use regular stool-softening and stimulant laxatives, as is standard practice.
   Exceptions: If there is a clinical need for oxycodone and naloxone combination product to be prescribed in primary care, this should only be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional.
   Action required: Practice to review all existing patients on oxycodone/naloxone combination and switch to morphine or oxycodone plus laxatives.

5. **Paracetamol and Tramadol combination product**. Tramacet®

   New Patients: Do not initiate this combination.
   Existing patients: Review and deprescribe or change to alternative
   Reason: The combination of tramadol and paracetamol has not been found to be more effective or safer than the individual drugs and is more expensive.
   Exceptions: None
   Action required: Practice to review all existing patients on tramadol/paracetamol combination and switch to alternative pain relief. There are three potential switch options from Tramacet® or its generic equivalent product (tramadol 37.5mg/ paracetamol 325mg), although clinicians may choose other options according to the clinical need of the patient. These include:
   1. Paracetamol 1g QDS*
   2. Codeine 30mg-60mg QDS*
   3. Paracetamol 1g QDS with codeine 30mg-60mg prn (max 240mg daily)*
   *For frail elderly patients with low bodyweight, a lower maximum dose of paracetamol and opioids should be considered.

6. **Herbal treatment**

   New patients: Do not initiate.

   Existing patients: Stop prescribing

   Reason: Under a Traditional Herbal Registration there is no requirement to prove scientifically that a product works, the registration is based on longstanding use of the product as a traditional medicine.

   Exceptions: None

   Action required: Practice or technicians to contact patients and stop.

7. **Once daily Tadalafil (Cialis)**

   New patients: Do not initiate.

   Existing patients: Switch patients to alternative.

   Reason: Tadalafil can be taken in two different ways. A single, higher strength tablet can be taken "when required" just before sex or a lower strength tablet can be taken once-daily, every day. There are several "when required" medicines that are much less expensive than once-daily tadalafil, so it is not good value for money. There is not enough evidence to recommend once-daily tadalafil rather than the "when required" medicines.

   The National Institute for Health and Care Excellence (NICE) says that there is not enough evidence to support the prescribing of once-daily tadalafil in benign prostatic hyperplasia. There is also not enough evidence to support the prescribing of once-daily tadalafil for long term problems with erections after removal of all or part of the prostate gland after surgery.

   Exceptions: Pulmonary hypertension- **To be prescribed by specialist centres only**

   Action required: Practice to discuss alternative treatment with patient and switch.

   -For ED deprescribing supported for all existing patients and switch to "when required" treatment (10 or 20 mg generic tadalafil) or other PDE5 inhibitor.

   -For Benign prostatic hyperplasias (BPH) contact/write to the specialist for advice on alternative evidence based treatment.

8. **Travel Vaccines**

   New patients:

   Vaccines for cholera, diptheria, tetanus, polio, hepatitis A, may be given for the purposes of travel on the NHS.

   Vaccines for Hepatitis B, Japanese Encephalitis, Meningitis ACWY, Yellow Fever, Tick born encephalitis, Rabies and BCG for the purposes of travel must be **funded by the patient.**

   Reason: This is a restatement of existing regulations and no changes have been made as a result of this guidance.

   Exceptions: None

   Action required: Practice to ensure compliance with guidance.

9. **Trimipramine**

   New patients: Do no initiate.

   Existing patients: Review and switch to alternative. Reason: Tricyclic antidepressants (TCAs) should not be used first line for the treatment of depression. Selective Serotonin Reuptake Inhibitors (SSRIs) are recommended by NICE as they are equally effective and have a more favourable risk-benefit ratio.

   Reason: TCAs should not be used first line for the treatment of depression. SSRIs are recommended by NICE as they are equally effective and have a more favourable risk-benefit ratio.
   Where a TCA is indicated in accordance with NICE, trimipramine should not be prescribed as it is not considered to be cost effective for prescribing on the NHS.

   Exceptions: None

   Action required: Practice to review the prescribing of trimipramine. If an SSRI represents a clinically appropriate alternative for the individual patient, then a managed switch from trimipramine to SSRI should be tried. Guidance on '**Trimipramine Withdrawal and Cross Tapering'** agreed with SSSFT mental health trust. Awaiting detailed guidance document from SSSFT

10. **Homeopathic remedies**

    New Patients: Do not initiate.

    Existing patients: Deprescribe.

    Reason: Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns

    Exceptions: None

    Action required: Practice or technicians to contact patients and stop.

11. **Herbal remedies**

    New Patients: Do not initiate

    Existing patients: Deprescribe

    Reason: Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns.

    Exceptions: None

    Action required: Practice or technicians to contact patients and stop.

12. **Glucosamine and chondroitin**

    New patients: Do not initiate.

    Existing patients: Deprescribe.

    Reason: Glucosamine and Chondroitin are nutraceuticals which used to improve pain associated with osteoarthritis. The BNF states '*The mechanism of action is not understood and there is limited evidence to show it is effective.'*

NICE CG177: *Do not offer glucosamine or chondroitin products for the management of osteoarthritis*
Exceptions: None
Action required: Practice or technicians to contact patients and stop.

13. **Co-proxamol**

New patients: Do not initiate.
Existing patients: Review all patients still being prescribed co-proxamol with a view to assess their pain management and switch them to an alternative pain management regime (either drug or non-drug treatment). If a patient is unable to stop co-proxamol, refer them to a specialist for a review of their pain management and support to switch to suitable alternative.

Reason: Co-proxamol was a pain-killer which was previously licensed in the UK until being fully withdrawn from the market in 2007 due to safety concerns. All use in the UK is now on an unlicensed basis. Since 1985 advice aimed at the reduction of co-proxamol toxicity and fatal overdose has been provided, but this was not effective and resulted in withdrawal of co-proxamol by the MHRA. Since the withdrawal, further safety concerns have been raised which have resulted in co-proxamol being withdrawn in other countries.
Exceptions: None
Action required: Practice to review all existing patients and move to alternative choices.

14. **Dosulepin**

New Patients: Do not initiate.
Existing Patients: Review and switch to alternative. This may be complex if starting another drug. Withdrawal must be gradual. *We are currently awaiting guidance from SSSFT.*
Reason: Dosulepin, formerly known as dothiepin, is a tricyclic antidepressant. NICE CG90: Depression in Adults has a "do not do" recommendation: "*Do not switch to, or start, dosulepin because evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose."*

Exceptions: In exceptional circumstances, if there is a clinical need for dosulepin to be prescribed in primary care, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional
Action required: Practice to review all existing patients. Practice will be provided with a guide to withdrawal agreed with SSSFT.

15. **Prolonged release doxazosin:**

New Patients: Do not initiate.

Existing Patients: Practises should move patients to immediate release doxazosin.

Reason: Doxazosin is an alpha-adrenoceptor blocking drug that can be used to treat hypertension and benign prostatic hyperplasia. There are two oral forms of the medication (immediate release and prolonged-release) and both are taken once daily.
NICE CG127 Hypertension in adults: diagnosis and management recognises that doxazosin should be used in treatment but does not identify benefits of prolonged-release above immediate release.
NICE CG97 Lower urinary tract symptoms in men: management recommends Doxazosin as an option in men with moderate to severe lower urinary tract symptoms. It does not identify benefits of Prolonged-release above immediate release.

Exceptions: None

Action required: Practices to work with medicines management team to switch patients to immediate release doxazosin**.**

16. **Immediate release Fentanyl**

New patients: Do not initiate.

Existing patients: Patients should be reviewed

Reason: Immediate release fentanyl is only licensed for the treatment of breakthrough pain in adults with cancer who are already receiving at least 60mg oral morphine daily or equivalent.

Exceptions: Patients undergoing palliative care treatment.
Action required: Medicines management team to support practices to identify patients who are outside of the exceptions listed for review

17. **Lidocaine plasters**

New patients: Do not initiate except for exceptions listed.

Existing patients: Deprescribe except unless exceptions listed apply.

Reason: Lidocaine plasters can be applied for pain relief and are licensed for symptomatic relief of neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia, PHN) in adults.
NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings does not recommend lidocaine plasters for treating neuropathic pain.

Exceptions: Patients who have been treated in line with NICE CG173 *Neuropathic pain in adults: pharmacological management in non-specialist settings* but are still experiencing neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia).

Action required: Medicines management team to support practices to identify patients who are outside of the exceptions listed for review.

18. Liothyronine preparations

New Patients: Do not initiate.

Existing Patients: Patients currently prescribed liothyronine should be reviewed by a NHS consultant endocrinologist with consideration given to switching to levothyroxine where clinically appropriate. Requests will require pre-approval via blutec. Patients who are currently under an NHS Endocrinologist can be asked for advice and guidance.

Reason: It has a similar action to levothyroxine but is more rapidly metabolised and has a more rapid effect. It is sometimes used in combination with levothyroxine in products.

The price (NHS Drug Tariff) of liothyronine has risen significantly and there is limited evidence for efficacy above Levothyroxine.

The British Thyroid Association, in their 2015 position statement, state "*There is no convincing evidence to support routine use of thyroid extracts, L-T3 monotherapy, compounded thyroid hormones, iodine containing preparations, dietary supplementation and over the counter preparations in the management of hypothyroidism".*

Due to the significant costs associated with liothyronine and the limited evidence to support its routine prescribing in preference to levothyroxine, the joint clinical working group considered liothyronine suitable for inclusion in this guidance.

Exceptions: The British Thyroid Association (BTA) advise that a small proportion of patients treated with levothyroxine continue to suffer with symptoms despite adequate biochemical correction.

In these circumstances, where levothyroxine has failed and in line with BTA guidance, endocrinologists providing NHS services may recommend liothyronine for individual patients after a carefully audited trial of at least 3 months duration of liothyronine.

Action required. Medicines management team will assist practices to audit patients for referral to endocrinology.