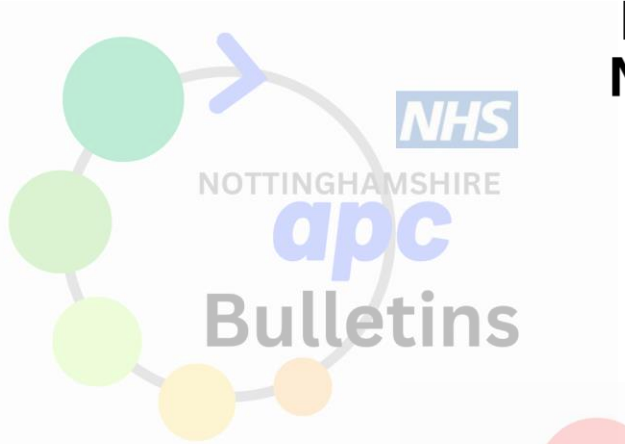
NHS
Nottingham and Nottinghamshire

Area Prescribing Committee / Interface Update.

Sept - Oct 2024 meetings.

Please direct queries to your ICB Medicines Optimisation Pharmacist

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



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  - Varicella Zoster / Chicken Pox / Herpes Zoster / Shingles
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New Submissions

Vibegron for overactive bladder AMB 3

Nottingham and Nottinghamshire

- Cost effective alternative to mirabegron (£26.68 vs £29 for 30 tablets). Approved in NICE TA guidance.
- Same place in therapy as mirabegron - if antimuscarinic medicines are not suitable, do not work well enough or have unacceptable side effects.
- Dose = 75mg daily.
- Does not affect blood pressure - mirabegron is contraindicated in those with severe hypertension and requires regular blood pressure monitoring.
- Tablets can be crushed for those with swallowing difficulties (mirabegron is MR).

No

First Line: Generic anticholinergics

NICE NG123: when offering antimuscarinics "take account of other existing medication affecting total anticholinergic load". Consider calculating the anticholinergic burden score using the ACB calculator.

These medicines can potentially cause an increase in falls risk. See Medicines and Falls Chart

Anticholinergic medications have similar efficacy and side-effect profiles, therefore select one with the lowest acquisition cost.

If the initial choice is not effective, or has troublesome side effects, consider lowering dose/strength, or a trial of an alternative medicine from the first line options.

Medicine	Strength	Dose	Cost/28days (Dec 22)
Oxybutynin IR*	2.5mg	Twice a day	£1.52
Oxybutynin IR*	5mg	Twice a day (titrate to three times a day as tolerated)	£1.41 - £2.12
Tolterodine*	2mg	Twice a day	£3.06
Solifenacin	5-10mg	Once a day	£3.04 - £3.56
Trospium	20mg	Twice a day	£4.93
*Do not offer oxybutynin or tolterodine to frail, elderly patients.			
If swallowing difficulties or unable to tolerate solid formulations			
1st: Oxybutynin patches	36mg (3.9mg/24hrs)	Apply twice weekly	£27.20
2nd: Solifenacin liquid	5-10mg	Once a day	£27.62 - £55.24

Review at 4-8 weeks → Improved → Continue

Troublesome side effects/lack of efficacy

Second line medication β-3 agonist (non-anticholinergic):
Vibegron 75mg tablet once a day (£24.90)
or
Mirabegron 50mg MR tablet once a day (£27.07).
Reduce to 25mg once a day if moderate hepatic impairment or eGFR <30ml/min.
(mirabegron contra-indicated in severe uncontrolled hypertension systolic ≥ 180 or diastolic ≥110mmHg)
Blood pressure should be taken before starting mirabegron and monitored regularly during treatment.

Troublesome side effects → Review at 4-8 weeks → Improved → Continue

New Submissions

Nottingham and Nottinghamshire

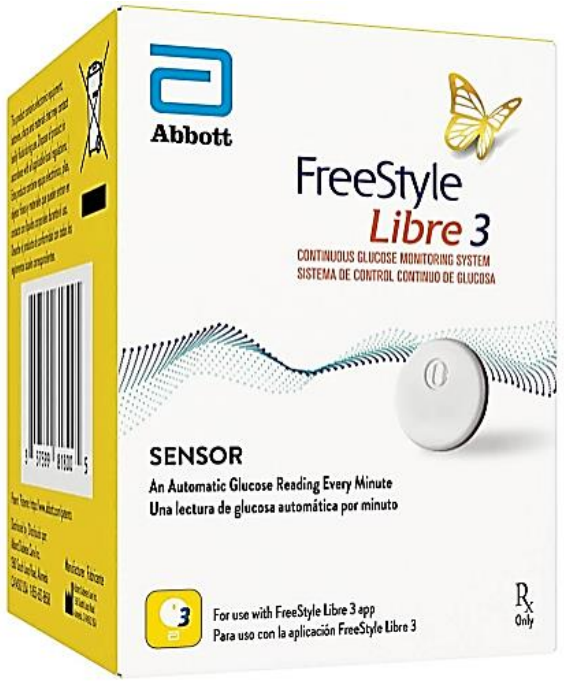
Latanoprost & netarsudil eye drops (Roclanda®) AMB 2

- NICE recommended in TA guidance as 2nd/ 3rd line option for glaucoma or ocular hypertension after a prostaglandin analogue alone has not reduced IOP enough if
    - a fixed-dose combination treatment containing beta-blockers is unsuitable or a fixed-dose combination treatment has been tried and it has not reduced IOP enough.
- Usage guided by Ophthalmology.
- Once daily treatment option. May allow 1 bottle of eye drops vs 2 bottles in some people.
- More expensive than generic options (£10 per 2.5ml bottle).
- Conjunctival hyperaemia (red eye) was the most frequently reported adverse reaction in trials - attributed to the netarsudil component. Usually mild and sporadic.

New Submissions

Nottingham and Nottinghamshire

Freestyle Libre 3 AMB 2



- Only for patients with Type 1 diabetes who are 4 years or older for use as part of a hybrid closed loop (HCL) system only AND where a lower costing Freestyle Libre 2 Plus has been considered first and deemed not appropriate or not compatible with the chosen insulin pump.
- Also, as first line CGM sensor for use as part of HCL in pregnancy and in preconception in line with ICB HCL commissioning policy. Patients initiated on the Freestyle Libre 3 in pregnancy, may continue with the device post-partum.
- Recently included in the Drug Tariff and therefore available for prescribing in Primary Care on an FP10 following the initiation by Secondary Care. Supply via FP10 is more cost-effective to the NHS.
- HCL systems will continue to only be initiated by Secondary Care.
- Companies offer training and links are available for Primary Care prescribers.

Pharyngitis/Sore Throat/Tonsillitis

NHS
Nottingham and Nottinghamshire

Most sore throats **DO NOT** require antibiotics.

Simple analgesia and throat sprays can be used for effective symptom management.

FeverPAIN is a clinical scoring tool that can help identify whether antibiotics are required or not. It can be found on the GP clinical systems.

The majority of sore throats are **viral** but there is clinical overlap between viral and streptococcal infections.

Organisms:

- **Viral:** Epstein Barr Virus, Enteroviruses, Adenoviruses, Cytomegalovirus.
- **Bacterial:** Group A streptococcus (*Streptococcus pyogenes*) (25-33% of cases), Group C and G streptococcus (role less clear).

Consider **diphtheria** if recent foreign travel e.g. former USSR/ Africa/ Middle East/ South Asia.

Sore throat due to a viral or bacterial cause is a self-limiting condition which generally resolves within two weeks.
90% of sore throats resolve within 7 days and antibiotics only shorten the duration of symptoms by 16 hours.
Symptoms can be relieved with simple analgesics such as paracetamol and ibuprofen.
Throat sprays can be considered for symptom management.

The **FeverPAIN** score predicts the likelihood of Streptococcus as the causative organism.

Antibiotic[1]	Dose	Duration
First-line Phenoxymethylpenicillin	**Child 1–11 months:** 62.5mg four times a day or 125mg twice a day **Child 1-5 yrs:** 125mg four times a day or 250mg twice a day **Child 6-11yrs:** 250mg four times a day or 500mg twice a day **Adult and child ≥12yrs:** 1g twice a day or 500mg four times a day	5 or 10 days

5- or 10-days' supply of **Penicillin V**

10 days is more effective at **microbiological** clearance.

5 days MAY be enough for symptomatic cure (e.g. >5 years with no significant medical issues).

Always prescribe 10 days for patients with a positive throat swab for, or suspected, Group A Streptococcus, or multiple comorbidities

How to set up a Delayed Antimicrobial Prescription on SystmOne

November 2024

Antimicrobial Guidelines

Nottingham and Nottinghamshire

Splenectomised Patients and Those With an Afunctional Spleen.

No change to the preferred treatments or combinations in NICE or local guidelines.

Varicella Zoster / Chicken Pox / Herpes Zoster / Shingles

Contact numbers updated.

UTI in Pregnancy.

Interim update: Cefalexin dose changed from 500mg twice a day to three times a day (in line with NICE and Acute Trust guidance). Full guideline review due May 2025.

Complicated UTI.

Interim update: If treating a catheter-associated UTI, the catheter should be changed as possible after starting antibiotics, unless it has been changed in the previous 7 days.

Hypothyroidism in Pregnancy – Primary Care Guide

NHS
Nottingham and Nottinghamshire

Interim guidance has been updated due to some differences between NUH and SFHT being aligned.

	Process	Further information
Pre-conception *FOR ALL*	Adjustment of the preconception levothyroxine dose with aim to keep **TSH <2.5 mU/L.** If opportunity arises, make a plan with patients so they can self-initiate an agreed increase in dose whilst they wait to see a GP and have TFT levels checked.	Refer patients with persistent clinical or sub-clinical hyperthyroidism (<0.35mU/L) to endocrine pre-conception as per NICE guidance. All women with **clinical/sub-clinical pregestational thyrotoxicosis** should be referred to endocrine pre-conception if possible.
Once pregnancy confirmed *FOR ALL*	**Increasing the levothyroxine dose is recommended as early as possible in pregnancy and if possible, should not wait until the booking appointment.** **Immediately on notification of pregnancy:** • Arrange TFT's (specify pregnancy and gestation on ICE request to ensure correct gestational reference ranges are applied) **and** • Immediately increase levothyroxine as per table opposite whilst awaiting up to date TFT results. Advise patients to self-refer to midwifery services promptly. Initial TFT's will be undertaken by CMW with booking bloods if not already done by GP (usually at 8-10 weeks). **Remember to specify pregnancy and gestation on ICE request.**	**Dose in micrograms (mcg)** Pre-pregnancy dose / Dose increase / Resulting dose 50mcg / 12.5mcg (25%) / 62.5mcg 62.5mcg / 12.5mcg (20%) / 75mcg 75mcg / 25mcg (33.3%) / 100mcg 87.5mcg / 25mcg (28.6%) / 112.5mcg 100mcg / 25mcg (25%) / 125mcg 112.5mcg / 25mcg (22.2%) / 137mcg 125mcg / 25mcg (20%) / 150mcg 150mcg / 27.5mcg (25%) / 187.5mcg 175mcg / 37.5mcg (21%) / 212.5mcg 200mcg / 50mcg (25%) / 250mcg 225mcg / 50mcg (22.2%) / 275mcg 250mcg / 50mcg (20%) / 300mcg
Management plan during pregnancy	***GP led management at NUH*** **Referral to antenatal endocrine clinic is recommended for women**: • with sub-clinical/clinical hyperthyroidism (not on levothyroxine), • who are hypothyroid after thyroidectomy or radio-iodine treatment for thyrotoxicosis. **GP to:** • **Check TSH every 4-6 weeks until 20 weeks' gestation** • **Check TSH once more at 28-30 weeks' gestation** • **Titrate levothyroxine** to achieve TSH as per laboratory gestational reference range. If there are difficulties with management, ask CMW to refer to antenatal endocrine clinic (GP to provide up to date management information).	***Antenatal Endocrine clinic led management at SFH*** Patient manage via shared care between CMW and obstetric-endocrine clinic.
Following delivery *FOR ALL*	• Reduce to pre-pregnancy dose on next dose after pregnancy ends. • If not on replacement therapy pre-pregnancy, reduce in 50mcg increments (stop if on ≤50mcg). • If on levothyroxine preconception solely for TSH optimisation/sub-clinical hypothyroidism, levothyroxine should be stopped completely. • **Check TFTs 6 weeks after delivery for all women** prescribed levothyroxine during pregnancy and adjust levothyroxine dose if required.	Patients with thyroid antibodies are at greater risk of **post-partum thyroiditis**, usually presenting around 3-4 months post-partum with symptoms of hyperthyroidism followed by a period of hypothyroidism before returning to normal (usually within 1 year of birth). Consider further repeat TFT's if concerned. Post-partum thyroiditis Patient Information Leaflet Thyroid UK.
Anytime	Refer to antenatal endocrine clinic if there are concerns	

Ongoing management stills remains different –

- NUH is GP led monitoring,
- SFH is antenatal/ endocrine clinic led.

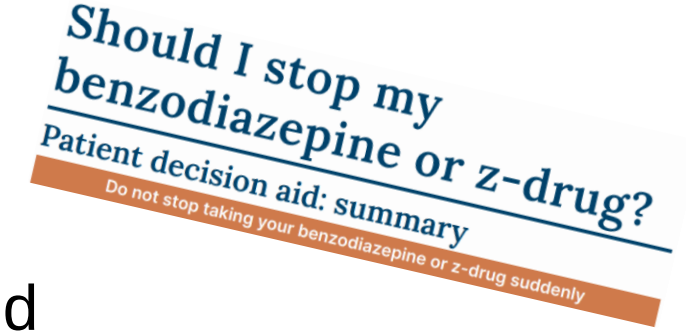
Recommended dose increases of levothyroxine have been aligned and a dose increase table added.

November 2024

Benzodiazepines and Z-hypnotics – Guidance on Prescribing and Deprescribing

NHS Nottingham and Nottinghamshire

- Links to NICE patient decision aid throughout the document.
- Additional information on the use of propranolol in anxiety added, highlighting the risk of harm in overdose.
- Clonazepam has been removed from Appendix Two: treatment of anxiety and insomnia are not formulary-approved indications.
- Information on access to local services updated.



Agomelatine Information Sheet

- Minimal changes, updated links and references.

Inflammatory Bowel Disease – Methotrexate Shared Care Protocol

Nottingham and Nottinghamshire

- No changes to the overall shared care process; national contraindications, cautions and parameters have been adopted.

Unlicensed ‘Specials’ – Alternatives and Options for Prescribing

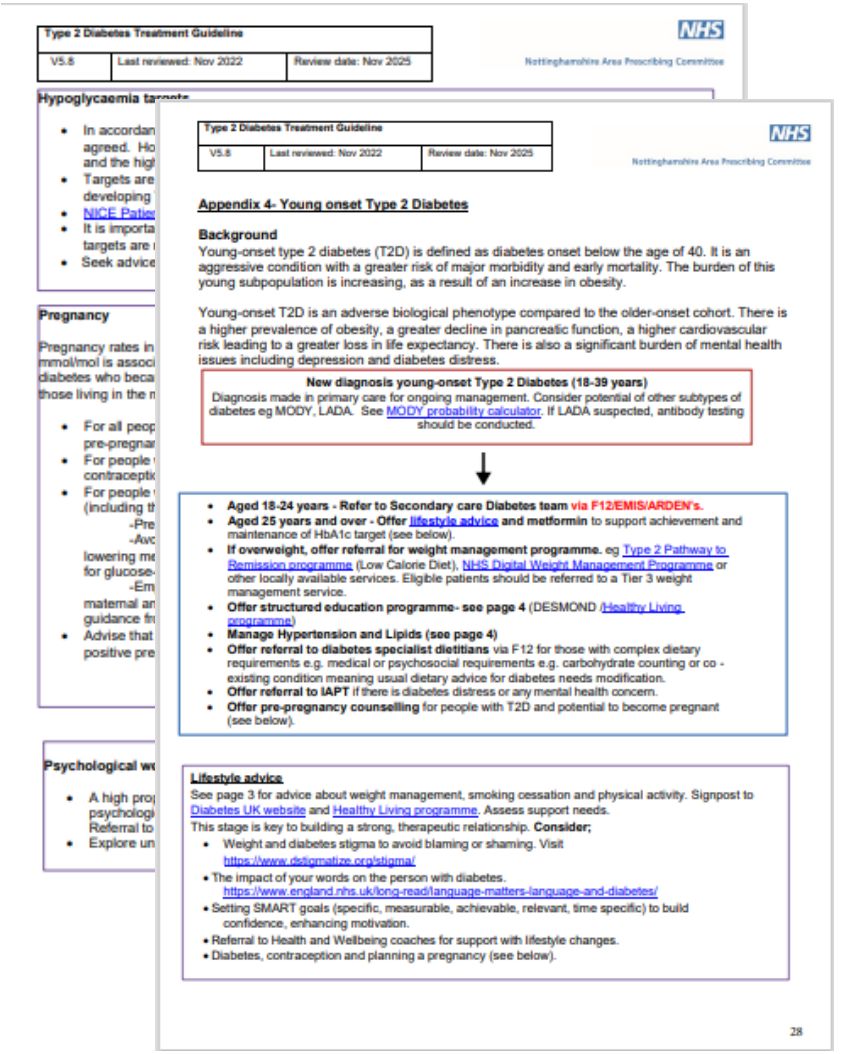
- The local guideline has been retired and superseded with the PrescQIPP database.
- PrescQIPP will be updating their database every 6 months.
- The link on the APC website takes you to an Excel workbook, so it can be accessed even if you don’t have PrescQIPP access.

Type 2 Diabetes Treatment Guideline update

NHS
Nottingham and Nottinghamshire

Management of Type 2 Diabetes in Young Adults

- Appendix 4 of Notts APC Type 2 diabetes guidance.
- Covers the management of Type 2 diabetes in ages 18-40 years.
- No specific pharmacological treatment differences in this age group.
- Signposting guidance of key considerations when managing this cohort.
- Aligns with the priorities of the T2Day project.



Type 2 Diabetes Treatment Guideline

V5.8	Last reviewed: Nov 2022	Review date: Nov 2025

Nottinghamshire Area Prescribing Committee

Appendix 4- Young onset Type 2 Diabetes

Background

Young-onset type 2 diabetes (T2D) is defined as diabetes onset below the age of 40. It is an aggressive condition with a greater risk of major morbidity and early mortality. The burden of this young subpopulation is increasing, as a result of an increase in obesity.

Young-onset T2D is an adverse biological phenotype compared to the older-onset cohort. There is a higher prevalence of obesity, a greater decline in pancreatic function, a higher cardiovascular risk leading to a greater loss in life expectancy. There is also a significant burden of mental health issues including depression and diabetes distress.

New diagnosis young-onset Type 2 Diabetes (18-39 years)
Diagnosis made in primary care for ongoing management. Consider potential of other subtypes of diabetes eg MODY, LADA. See MODY probability calculator. If LADA suspected, antibody testing should be conducted.

- **Aged 18-24 years - Refer to Secondary care Diabetes team via F12/EMIS/ARDEN's.**
- **Aged 25 years and over - Offer lifestyle advice and metformin** to support achievement and maintenance of HbA1c target (see below).
- **If overweight, offer referral for weight management programme.** eg Type 2 Pathway to Remission programme (Low Calorie Diet), NHS Digital Weight Management Programme or other locally available services. Eligible patients should be referred to a Tier 3 weight management service.
- **Offer structured education programme- see page 4** (DESMOND (Healthy Living programme)
- **Manage Hypertension and Lipids (see page 4)**
- **Offer referral to diabetes specialist dietitians** via F12 for those with complex dietary requirements e.g. medical or psychosocial requirements e.g. carbohydrate counting or co - existing condition meaning usual dietary advice for diabetes needs modification.
- **Offer referral to IAPT** if there is diabetes distress or any mental health concern.
- **Offer pre-pregnancy counselling** for people with T2D and potential to become pregnant (see below).

Lifestyle advice

See page 3 for advice about weight management, smoking cessation and physical activity. Signpost to Diabetes UK website and Healthy Living programme. Assess support needs.
This stage is key to building a strong, therapeutic relationship. **Consider;**

- Weight and diabetes stigma to avoid blaming or shaming. Visit https://www.dstigmatize.org/stigma/
- The impact of your words on the person with diabetes. https://www.england.nhs.uk/long-read/language-matters-language-and-diabetes/
- Setting SMART goals (specific, measurable, achievable, relevant, time specific) to build confidence, enhancing motivation.
- Referral to Health and Wellbeing coaches for support with lifestyle changes.
- Diabetes, contraception and planning a pregnancy (see below).

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Formulary Amendments and Traffic light changes

Nottingham and Nottinghamshire

- **Torasemide** - reclassified as GREY – supply problems with loop diuretics now resolved.
- **Insulatard Penfill cartridges** and **Novorapid FlexTouch pre-filled pens** - discontinued from March 2025. No new patients to be initiated.
- **Levemir –** all presentations to be discontinued from December 2026. Local guidance is being developed.
- **Macrogol 3350** - added as GREY, not a cost-effective product. Macrogol should be prescribe generically as macrogol compound (not macrogol 3350).
- **Tirzepatide** for overweight and obesity- holding statement added to formulary:

Obesity

- Tirzepatide for managing overweight and obesity is classified GREY. NICE are expected to publish TA guidance in December 2024. There will then be an implementation period to manage the adoption of the recommendations made by NICE; **tirzepatide should NOT be prescribed for managing overweight and obesity** until NICE has published and a position is reached by the ICB.

Area Prescribing Committee Work Plan

NHS
Nottingham and Nottinghamshire

Going to forthcoming APC meetings:

- Osteoporosis
- Overarching CKD guidelines
- SGLT2i pathway
- Vitamin B12 guidelines
- Wound infection antimicrobial guideline
- Clostridioides difficile antimicrobial guideline
- Enoxaparin in pregnancy – treatment and prophylaxis
- Melatonin Use in Sleep Problems in Children
- Novo Nordisk Insulin discontinuation
- Deflazocort (formulary submission)
- Heylo® sensor (new submission)

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)

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