NHS
Hampshire and Isle of Wight

Prescribing and Medicines Optimisation Guidance

Issue: 94 **Date: 5th January 2024**

Safety guidance

1. **MHRA: Aripiprazole (Abilify and generic brands): risk of pathological gambling** Link

Healthcare professionals prescribing aripiprazole are reminded to be alert to the risk of addictive gambling and other impulse control disorders. Healthcare professionals should advise patients, their families and friends to be alert to these risks.

2. **MHRA: Vitamin B12 (hydroxocobalamin, cyanocobalamin): advise patients with known cobalt allergy to be vigilant for sensitivity reactions** Link

The medicines used to treat vitamin B12 deficiency (hydroxocobalamin, cyanocobalamin) contain cobalt. There are case reports in the literature describing cobalt sensitivity-type reactions in patients being treated for vitamin B12 deficiency. Healthcare professionals prescribing vitamin B12 products to patients with known cobalt allergy should advise patients to be vigilant for signs and symptoms of cobalt sensitivity and treat as appropriate.

3. **Improving the safe use of denosumab (Prolia) in care homes** LINK

We know from anecdotal evidence that six-monthly doses of denosumab are sometimes missed or delayed in the care home setting due to the multiple factors involved in its administration, especially in a non-nursing, residential care setting. An intervention brief has been prepared to help facilitate improvement. A common source of error is on transfer of care. Information for care staff is found within the linked document and all prescribers of denosumab (Prolia) injection are encouraged to use clear dosage instructions: Give 60mg via subcutaneous injection every six months. Blood tests to be undertaken and confirmed before each dose given. Further resources for professionals working with care homes can be found on the ICB's Medicines Optimisation pages: LINK

Local guidance

4. **Formulary status change of fentanyl patches to amber (specialist recommendation only) for chronic non-cancer pain.** Link

There is little evidence that opioids are helpful for long-term pain. Strong opioids are no longer recommended for chronic non-cancer pain due to poor efficacy and high risk of harm. The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit (Opioids Aware). Problems associated with long-term opioid use include osteoporosis, increased risk of falls and fractures, depression and fatigue, sleep

problems (including sleep apnoea), cognitive impairment, respiratory depression and reduced ability to fight infections.

In Hampshire and IOW, there are currently over 2,000 patients who have been prescribed opioids long-term (over 6 months) at a dose over 120mg oral morphine equivalent per day.

Fentanyl is a particularly potent opioid which is 100 to 150 times stronger than morphine. A fentanyl 50mcg/hr patch is equivalent to at least 120mg morphine per day. Once started, patches are difficult to taper due to the large increments between available strengths. This makes fentanyl patches particularly unsuitable for chronic non-cancer pain. Therefore, the formulary status for fentanyl patches has recently been changed to 'amber recommended' (suitable for prescribing in primary care following recommendation by a specialist) for the treatment of chronic non-cancer pain to discourage its initiation.

Please can prescribers consider reviewing all non-cancer patients currently prescribed fentanyl patches, particularly those on doses of 50mcg/hr and above.

Further information about opioids can be found in the chronic pain prescribing guideline and the Wessex Opioid pages.

Fentanyl patches remain suitable for prescribing in primary and secondary care for use in chronic pain associated cancer or palliative pain. (Green formulary status)

National guidance

5. DHSC: Flu season declared LINK

UKHSA surveillance data indicates that influenza is circulating in the community. Prescribers working in primary care may now prescribe and community pharmacists may now supply antiviral medicines (oseltamivir and zanamivir) for the prophylaxis and treatment of influenza at NHS expense. Antiviral medicines may be prescribed for patients in clinical at-risk groups as well as anyone at risk of severe illness and/or complications from influenza if not treated.

NICE guidelines

6. Acne vulgaris: management - updated guidance (NG198) LINK

Recommendations on oral isotretinoin treatment clarified in line with the 2023 MHRA advice on the introduction of new safety measures.

7. Cardiovascular disease: risk assessment and reduction, including lipid modification - updated guidance (NG238) Link

This guideline updates and replaces CG181 (July 2014). There is a new recommendation on target lipid level for secondary prevention of CVD for adults on lipid-lowering treatment, to aim for LDL cholesterol levels of ≤2.0 mmol/L, or non-HDL cholesterol levels of ≤2.6 mmol/L.

Other

8. SPS: Deprescribing of antidepressants for depression and anxiety LINK

This Specialist Pharmacy Service (SPS) guidance highlights resources to help plan and support safe deprescribing of antidepressants in practice including NICE guidelines, CKS, Maudsley prescribing guidelines and guidance from Royal College of Psychiatrists . Resources are also provided to signpost to patients.

9. New Legislation to allow paramedic independent prescribers to prescribe certain controlled drugs

The legislative change in relation to paramedic prescribing has now come into effect from 31st December. Amongst other things, it will allow the prescribing of five controlled drugs by paramedic independent prescribers. These are covered by insertion of regulation 6D The Misuse of Drugs (England and Wales and Scotland) (Amendment) (No. 2) Regulations 2023 (legislation.gov.uk)

A paramedic independent prescriber may prescribe any of the following controlled drugs for the treatment of organic disease or injury provided the controlled drug is prescribed to be administered by the specified method:

(a) Morphine sulphate by oral administration or by injection;
(b) Diazepam by oral administration or by injection;
(c) Midazolam by oromucosal administration or by injection;
(d) Lorazepam by injection;
(e) Codeine phosphate by oral administration.

This list is based on the original consultation on paramedic prescribing dating back to 2015. Paramedic roles have changed considerably since then, so careful consideration needs to be made to ensure that they are only able to prescribe within this limited list and that there are mechanisms for monitoring this and providing necessary support and guidance, as appropriate.

10. Community Pharmacy England :Briefing for local medical committees and general practices on the Pharmacy First service LINK

This national briefing document provides a helpful summary of the new Pharmacy First service, as well as highlighting the expansion of the Pharmacy Contraception Service and the Hypertension Case-Finding Service.

The Pharmacy First service is due to go live on 31st January 2024. This is an advanced service, therefore optional for pharmacy owners to provide. However, since it builds on the existing Community Pharmacist Consultation Service (CPCS), which most pharmacies in England provide, there is an expectation that most pharmacy owners will choose to provide the extended Pharmacy First service. Please note GP practices will still be required to make formal referrals for the minor illness consultations with a pharmacist and the clinical pathway consultation parts of the Pharmacy First service.

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Local medicines optimisation teams can be contacted via their generic team mailbox: See LINK
Previous bulletins can be found hosted on the ICS website here: link