Department of Health
An Roinn Sláinte
Mannystrie O Poustie
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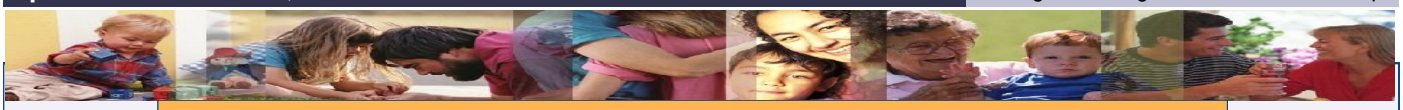
NORTHERN IRELAND MEDICINES MANAGEMENT

April 2022 Volume 13, Issue 4 **NEWSLETTER** Strategic Planning and Performance Group



In This Issue

Clozapine Risk Awareness

Measures should be in place to ensure that clozapine as a red list drug, is NOT prescribed or dispensed in primary care. It should be listed in the patient's medication record for interaction checking and to assist with monitoring of clinical risks. 'Hospital issue only' should be stated in the dose/directions. Detailed directions or dosage should not be included, as these are subject to change and could be misinterpreted if viewed on NIECR.

Clozapine is a second generation antipsychotic, predominantly used for Treatment Resistant Schizophrenia (TRS). It is associated with a number of serious clinical risks, of which all healthcare professionals should be aware. Those in the table below are being highlighted as they are issues that can escalate quickly and result in immediate safety risks to patients. However it should be recognised that this list is non-exhaustive.

Issue	Action
Neutropenic sepsis Clozapine can cause neutropenia and agranulocytosis	• Additional full blood count should be carried out as a precaution, results MUST be shared with secondary care • If the patient is clinically unwell and neutropenic sepsis is suspected, consider urgent referral to Emergency Department (ED) for further assessment
Myocarditis or Cardiomyopathy Symptoms may be suggestive of heart failure or myocardial infarction and include palpitations, chest discomfort, fatigue, dyspnoea, fever and myalgia. Clinical signs include persistent tachy-cardia at rest, tachypnoea, arrhythmias, pyrexia	• The patient should be urgently reviewed by the GP • Consider urgent referral to ED for further assessment • Where there is diagnostic uncertainty and if symptoms are mild discuss with consultant psychiatrist for advice on further management
Constipation A very common side effect, under-reported by patients. Constipation should not be ignored as deaths from paralytic ileus have been reported	• Routinely ask patients about their bowel movements • Take action on any signs of constipation • Many patients will require regular laxatives including stool softener and stimulants
Smoking Cessation Stopping smoking, switching to NRT or vaping may significantly increase plasma clozapine levels leading to toxicity	• The patient's community mental health keyworker should be informed if patients change their smoking habits • A dosage adjustment may be necessary
Treatment breaks If clozapine treatment is stopped for more than 48 hours then it MUST be re-titrated	• The patient's community mental health keyworker should be informed if a patient has a clozapine treatment break • Re-titrations MUST be done under the direct supervision of the mental health team

Metformin MR: Prescribe Generically

Sukkarto® has been the least expensive brand of metformin MR for several years, costing even less than the Drug Tariff generic. This cost effective choice (CEC) recommended by the Pharmacy and Medicines Management team has generated savings of **£1.8 million**. Despite the default position on most drugs being to prescribe generically, it is recognised that NI clinicians made sustained efforts to change to this CEC thus contributing to significant efficiency savings to spend on healthcare locally.

Recently, the price of generic modified release metformin has dropped to a lower tariff price than Sukkarto® so this brand will be removed from the CEC list. Prescriptions should now be written generically.

Action for GP Practices: Prescriptions for modified release metformin should be written generically.
Action for Community Pharmacists: Counselling patients to avoid confusion and support safe medicines use.

Thanks to all for your efforts!

Deprescribing – Cow's Milk Allergy (CMA)

The Regional guidance for management of mild-moderate non- IgE mediated cows' milk allergy (CMA) has recently been updated to support appropriate initiation and review of prescribing. The recording of an infant nutrition training session led by a paediatric dietitian and accompanying powerpoint slides are available on the Primary Care Intranet.

Actions for Prescribers

- Where exclusive breastfeeding* is not possible, extensively hydrolysed formula (EHF) is recommended first line for treatment of CMA for most infants.
- An Amino Acid Formula (AAF) should only be initiated following a trial of EHF for 2-4 weeks that showed no clear improvement but where CMA is still suspected. Refer to the local paediatric allergy service.
- Initially an acute prescription of 1-2 tins should be issued until suitability is established and quantities kept small thereafter to avoid wastage.
- Prescribing of infant formula should be regularly reviewed to ensure it is still appropriate and should not normally be continued beyond 15+ months.
- Prescribing should be stopped if an infant can take any dairy foods e.g. cheese, yogurt, ice cream, chocolate.
- Infant formula shouldn't be added to the repeat record, unless a diagnosis of CMA has been confirmed following a cow's milk elimination trial and subsequent home reintroduction and a review process is established.

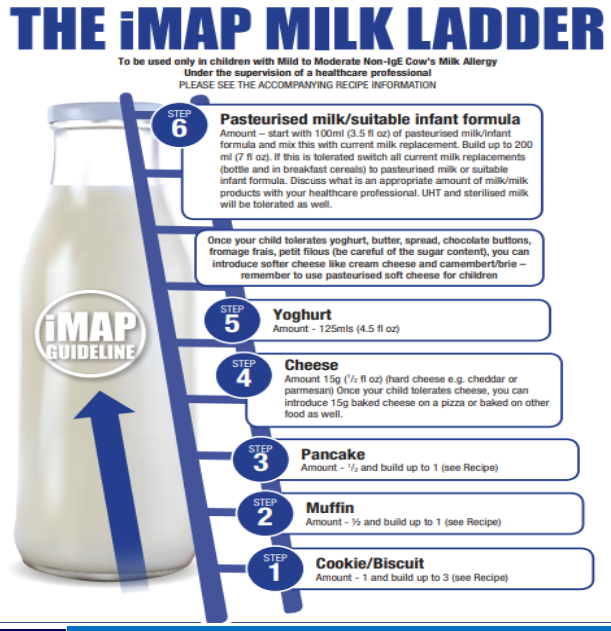
Actions for Community Pharmacists

- Support parents/carers by highlighting resources, patient zone, imap initial factsheet for parents, imap home reintroduction protocol , imap milk ladder.
- Support prescribing review and direct to purchase milks as appropriate.

Age of child	Tins / 28 days
< 6 months	4-14 x 400g or 2-7 x 900g
6-9 months	8 x 400g or 4 x 900g
9-12 months	6 x 400g or 3 x 900g
> 12 months**	6 x 400g or 3 x 900g

*Breast milk remains the optimal nutrition for infants.

**under dietetic review



NICE GUIDANCE

NICE TA 769 Palforzia for treating peanut allergy in children and young people

NICE TA 770 Pembrolizumab with carboplatin and paclitaxel for untreated metastatic squamous non-small-cell lung cancer (review of TA600)

NICE TA 772 Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma after stem cell transplant or at least 2 previous therapies

NICE TA 773 Empagliflozin for treating chronic heart failure with reduced ejection fraction

NICE TA 775 Dapagliflozin for treating chronic kidney disease

NICE TA 776 Pitolisant hydrochloride for treating excessive daytime sleepiness caused by obstructive sleep apnoea

NICE TA 777 Solriamfetol for treating excessive daytime sleepiness caused by obstructive sleep apnoea

NICE TA 778 Pegcetacoplan for treating paroxysmal nocturnal haemoglobinuria

NICE TA 779 Dostarlimab for previously treated advanced or recurrent endometrial cancer with high microsatellite instability or mismatch repair deficiency

NICE TA 780 Nivolumab with ipilimumab for untreated advanced renal cell carcinoma (review of TA581)

MANAGED ENTRY DECISIONS

Cannabidiol (Epidyolex®)

Pembrolizumab (Keytruda®)

Pitolisant (Ozawade®)

Tucatinib (Tukysa®)

Fremanezumab (Ajovy®)

Solriamfetol (Sunosi®)

Odevixibat (Bylvay®)

Betula verrucosa (Itulazax®)

Pembrolizumab (Keytruda®)

Hydrocortisone - extended release formulation (Efmody®)

Dostarlimab (Jemperli®)

see Managed Entry section of NI Formulary

This newsletter has been produced for GPs and pharmacists by the Regional Pharmacy and Medicines Management Team. If you have any queries or require further information on the contents, please contact one of the Pharmacy Advisors .