NORTHERN IRELAND
MEDICINES MANAGEMENT

Pharmaceutical Clinical Effectiveness (PCE)

July 2026

Pharmaceutical Clinical Effectiveness (PCE) 2026 / 2027 — New Projects

The HSC Pharmaceutical Clinical Effectiveness (PCE) Plan sets out a range of initiatives founded on the principle that improving the quality and safety of medicines will deliver better health outcomes alongside greater efficiencies.

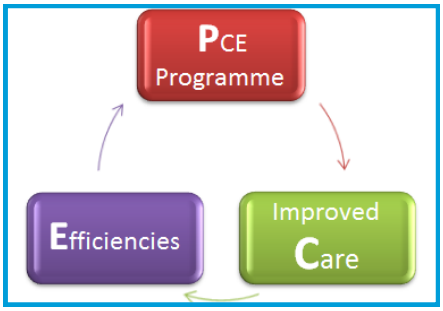
Achieving efficiencies is particularly critical in the current financial climate, where funding and resources are limited, making it essential to maximise the effective use of Health Service resources.

Delivering both improvements and efficiencies across the HSC depends on strong collaboration across all key stakeholders. It is therefore important that community pharmacists, GP practices, and Trusts actively consider implementing the actions outlined in this bulletin, with a focus on medicines review and deprescribing.

This bulletin outlines **new projects** that have been incorporated into the PCE Plan for 2026/2027. The three new projects with greatest potential efficiencies (in order), Dapagliflozin, DOACs and Laxatives.

Legacy projects with greatest potential efficiencies include generic levetiracetam (category 3 AED), generic lamotrigine (category 2 AED) and Opioids. See Primary Care intranet for the full PCE Plan and supporting materials.

All generic costs within this bulletin are taken from the NI Drug Tariff June 2026.



Initiatives

* Generic Dapagliflozin—Potential £4 million Savings
* Cost-Effective Doxazosin Prescribing
* Cost-Effective DOAC Prescribing – NI Formulary Update
* Nebivolol 1.25mg tablets – high-cost item
* Review Prescribing of Combination Nasal Sprays
* Vitamin Additions to Limited Evidence List
* Cost-effective inhaler choices
* Haloperidol 500mcg tablets – high-cost item
* Targeted Actions to Reduce Laxative Spend
* Review Methocarbamol Prescribing

Actions for Healthcare Professionals

- Share this bulletin with all prescribers and staff involved in managing prescriptions
- Prioritise changes associated with **greatest efficiencies or safety benefits** — see practice Compass report for further information.
- GP practices should advise community pharmacies of any planned changes, to ensure consistent handling of patient queries and to support effective stock control
- All healthcare professionals should counsel and reassure patients when their medication or prescriptions have been changed

Generic Dapagliflozin—Potential £4 million Savings

Switching from higher-cost SGLT2 inhibitors could release **£4 million annually across Northern Ireland**, whilst maintaining comparable clinical outcomes (See Table 1).

SGLT2 inhibitors are a cornerstone of management for type 2 diabetes, heart failure and chronic kidney disease, delivering significant cardiovascular and renal benefits. NICE recommends use of the least costly option where more than one agent is clinically appropriate.

Generic dapagliflozin is the first-line SGLT2 inhibitor on the Northern Ireland Formulary. Following consultation with clinicians across all five HSC trusts, **SPPG now recommends generic dapagliflozin as 1st-line option** where appropriate. Its introduction provides an opportunity to optimise prescribing, improve patient access and deliver best value.

Table 1: SGLT2 acquisition cost

Name of SGLT2	Strength	*Cost for 28 day supply
Dapagliflozin	5mg	**£4.95**
Dapagliflozin	10mg	**£3.50**
Canagliflozin (Invokana®)	100mg & 300mg	£39.20
Empagliflozin (Jardiance®)	10mg & 25mg	£36.59
Ertugliflozin (Steglatro®)	5mg & 15mg	£29.40

Actions for GP practices

- Identify eligible patients not currently prescribed an SGLT2 inhibitor and **initiate dapagliflozin where appropriate**
- Review patients on alternative SGLT2 inhibitors and **switch to dapagliflozin**, where appropriate
- Communicate changes clearly to patients
- Provide patient counselling on benefits, sick day rules and DKA risk, supported by the SPPG patient leaflet
- Inform community pharmacies to support patient messaging and stock control.

Actions for Community Pharmacies

- Support patients during initiation or switching, addressing any concerns.
- Reinforce key safety messages, including sick day rules, side-effect awareness and signpost to the SPPG patient leaflet.

For more detailed information and resources to support the switch, please refer to the SPPG dapagliflozin letter issued in June 2026.

Cost-Effective Doxazosin Prescribing

Doxazosin Strength	IR tablets cost per 28
1mg	**£0.68**
2mg	**£0.70**
4mg	**£0.78**
8mg	£41.51

Doxazosin is commonly prescribed for hypertension and benign prostatic hyperplasia (BPH). Currently the cost difference between Doxazosin Immediate Release (IR) strengths is significant. Hence the NI formulary lists the 1mg, 2mg and 4mg IR tablets as first-line choices. Doxazosin IR 8mg tablets are significantly more expensive than other strengths.

There is no clinical disadvantage for many patients to doubling up on 4 mg tablets to achieve the same total daily dose. Prescribers should consider prescribing 2 x 4mg IR tablets instead of 1 x 8mg IR tablet.

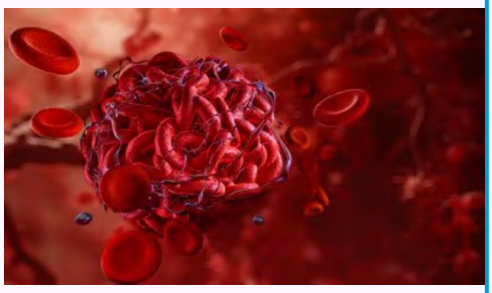
Actions for Prescribers

- New patients should be prescribed 1mg, 2mg or 4mg tablets in quantities required for their total daily dose. Doxazosin IR 8mg tablets should be avoided.
- Patients currently prescribed doxazosin IR 8mg tablets should be reviewed and switched to 2 x 4mg tablets where appropriate.

Cost-Effective DOAC Prescribing – NI Formulary Update

Direct Oral Anticoagulants (DOACs) continue to represent an area of significant prescribing expenditure within primary care, approximately £4.4 million being spent on DOAC prescribing in NI last year. The Northern Ireland Formulary has recently been updated to clarify preferred DOAC choices in atrial fibrillation (AF):

- **Apixaban** remains the recommended first-line DOAC
- **Rivaroxaban** is the most cost-effective DOAC option where once-daily dosing is preferred—this is a new recommendation. It is important to note that rivaroxaban should be taken with food to ensure optimal absorption and efficacy.



This information is intended to support prescribing decisions for newly initiated patients. **It is not recommended to routinely switch stable patients from other anticoagulants.**

Action: When initiating DOACs follow the NI Formulary recommendations as above and refer to the Northern Ireland Formulary anticoagulation guidance.

Nebivolol 1.25mg—high-cost item

Nebivolol is a beta-blocker used to treat essential hypertension and as an adjunct in stable mild to moderate chronic heart failure. While most strengths are now low cost, **nebivolol 1.25mg tablets remain very expensive**.

A 28-day supply of nebivolol 1.25mg costs **£172.48**, compared with **£2.20** for 2.5mg tablets. Prescribing half a 2.5mg tablet daily instead of a 1.25mg tablet can save around **£2,200 per patient per year**.

Nebivolol 1.25mg is mainly used as a starting dose in heart failure. Patients on this dose should be reviewed to ensure appropriate up-titration where suitable.

Actions for Prescribers

- New patients needing 1.25mg daily should be prescribed 2.5mg tablets with instructions to take half a tablet, if clinically appropriate
- Patients on 1.25mg tablets should be reviewed to consider switching to half a 2.5mg tablet daily
- Confirm that patients on 1.25mg have a valid clinical reason and are not unintentionally remaining on a titration dose

Potential annual saving: Approximately **£2,200 per patient switched** from nebivolol 1.25mg tablets to half a 2.5mg tablet daily.

Review Prescribing of Combination Nasal Sprays

1. Combination nasal sprays **are not recommended first line,** e.g. fluticasone propionate and azelastine (Dymista®) or mometasone and olopatadine (Ryaltris®).

If symptoms are uncontrolled on a regular intranasal corticosteroid (INCS):

- Check adherence and technique
- Assess for other causes of treatment failure
- If still symptomatic, consider step-up treatment based on predominant symptoms, in line with NICE CKS

2. If a combination product is clinically required, the **generic fluticasone/azelastine** spray should be prescribed (see table).

Product	**Cost**
Fluticasone propionate 50micrograms/dose / Azelastine 137 micrograms/dose 120 dose nasal spray	£5.60
Dymista® 120 dose nasal spray	£14.80
Ryaltris® 240 dose nasal spray	£13.32

- £840,000 was spent on Dymista® in 24/25. A switch to generic prescribing could reduce this spend by over 60%, saving over £300,000 annually.

Actions for GP practices

- Do not initiate combination nasal sprays as first-line
- Review and switch patients from Dymista® to generic alternative
- Avoid co-prescribing oral and intranasal antihistamines as this is not recommended

Vitamin Additions to Limited Evidence List

Additional vitamins have been added to the vitamin section of the Limited Evidence List :

- Riboflavin (Vitamin B2)
- Niacin (Vitamin B3)
- Pyridoxine (Vitamin B6)

Patients should be advised that if they wish to try these vitamins for general wellbeing or non-ACBS* indications, then they should purchase a dietary supplement. Further information is available in the vitamin section of the primary care intranet.

*Advisory Committee on Borderline Substances

Cost-effective inhaler choices

Combination inhalers should be prescribed by brand, rather than generically. Prescribing the following cost-effective inhaler brands (see CEC list), could generate efficiencies of £3.4 million annually across NI:

- Luforbec® or Proxor® are recommended as cost-effective choices for Beclometasone/ Formoterol pMDIs (alternative to Fostair etc) - potential efficiency savings £2.1 million annually
- Avenor® or Combisal® are recommended as cost-effective choices for fluticasone/salmeterol pMDIs (alternative to Seretide, Sirdupla etc) - potential efficiency savings £1.3 million annually

Actions for GP Practices:

- Prescribe these preferred brands for new patients
- Review all patients currently prescribed other brands or generics, and consider switching to one of these brands where appropriate

SOPs have been developed to help practices identify suitable patients and these are available along with sample patient letters at link.

Haloperidol 500mcg tablets – high-cost item

Haloperidol 500microgram tablets are an **EXTREMELY HIGH-COST ITEM,** costing £300.37 per 28 tablets (£10.73 per tablet). In the 6-month period Sept to Feb 2026 over **£1 million** was spent on this one item, in primary care in NI.

Haloperidol Formulation	Pack size	Cost
200mcg/ml oral solution	100mls	£185.00
5mg/5ml oral solution SF	100mls	£22.83
10mg/5ml oral solution	100mls	£4.45
500mcg tablets	28 tablets	£300.37
1.5mg tablets	28 tablets	£4.40
5mg tablets	28 tablets	£4.55
10mg tablets	28 tablets	£17.87

Prescribing **haloperidol 5mg /5ml oral solution sugar free*** rather than haloperidol 500microgram tablets would generate a saving of **£10.62** per 500microgram dose. Note that some haloperidol 5mg/5ml oral solutions have an **expiry date of 30 days** once opened.

To reduce expenditure, a number of local Trusts have switched to using haloperidol **5mg/5ml oral solution sugar free** instead of 500microgram tablets **in all suitable patients**. All remaining Trusts plan to make this switch imminently. Trusts will continue to prescribe tablets for doses of haloperidol 1.5mg or greater, where clinically appropriate.

Action Required by Primary Care

SHARE this information with all prescribers.
STOP prescribing haloperidol 500microgram tablets for new patients. Consider alternative formulations to provide appropriate clinical dose.

REVIEW Current patients prescribed haloperidol 500microgram tablets.

- Review ongoing need and consider deprescribing as appropriate (this may require linking with secondary care colleagues). If still clinically indicated, consider suitability to switch to the most cost-effective formulation/strength. Ensure patients/carers are made aware of any changes in formulation/strength or prescribed preparations.
- Give reasonable notice to community pharmacy colleagues of planned prescribing changes. This will allow them to confirm stock availability, reassure patients about any changes to their medicines and adjust their stock levels.

Please note formulation and strength suitability will be dependent on the clinical dose required and clinical needs of the individual patient.

Targeted Actions to Reduce Laxative Spend

Promote guideline-based, stepwise treatment of constipation, and review

- First-line therapy for uncomplicated constipation should be dietary modification with increased fibre and fluid intake. Constipating medication should be adjusted.
- Patients should be advised that laxatives may be purchased OTC for acute, uncomplicated constipation. Please note constipation is not covered under the Pharmacy First service.
- See patient information leaflet about constipation self-management and when to seek medical help.

Consider bulk-forming laxatives first (eg ispaghula husk)

- An option for OTC purchase for short-term constipation where appropriate
- May be used first-line where appropriate but should not be continued indefinitely

Review patients regularly

- Ensure regular medication reviews to avoid long-term use — add review date to prescription
- See patient laxative review template to invite patients to attend laxative review
- Reinforce trial of bulk-forming laxatives where appropriate, followed by osmotic laxatives (e.g. macrogol), before stimulant or newer therapies
- Reduce inappropriate combinations such as two drugs in the same class together e.g. lactulose plus a macrogol
- Review patients on multiple agents and rationalise to single-agent therapy where possible
- Withdraw when regular bowel movements occur without difficulty, reducing one laxative at a time

Product	Size	Cost
Senna tablets 7.5mg	60	£1.16
Sodium picosulfate 5mg/5ml oral solution SF	300ml	£17.00
Sennosides 7.5mg/5ml oral solution SF	500ml	£11.14

Optimise lowest-cost stimulant laxatives choices:

- Stimulant laxatives should only be used short-term
- Senna is the preferred stimulant laxative in the NI Formulary
- Liquid formulations should be reviewed to consider switching to a more cost-effective liquid or tablet

Rationalise Lactulose use

- Lactulose should generally be reserved for patients where bulk-forming, macrogol and stimulant laxatives are unsuitable, and avoided in irritable bowel syndrome constipation predominant (IBS-C)
- PRN prescribing should be avoided
- Long-term use in the elderly should be avoided due to potential for fluid and electrolyte imbalance

Reduce inappropriate prescribing of enemas

- Only prescribe enemas for clear indications
- Avoid repeat prescribing and discourage use in frail or renal impairment patients

Carry out structured deprescribing of second line treatments

- Identify patients on **prucalopride** and **linaclotide** for review in line with local guidance SPPG Letter review of 2nd Line treatments

Review Methocarbamol Prescribing

Methocarbamol is indicated for symptomatic treatment of painful muscle tension, particularly low back pain. Treatment duration depends on symptoms, although some SPCs specify that use should not exceed 30 days. The BNF states methocarbamol is less suitable for prescribing, therefore it is on the **NI Limited Evidence List**.

Action for GP Practices

- Review patients ensuring that they only use methocarbamol for periods of muscle tension then stop. The dose needs to be reduced slowly if treatment has been ongoing for more than 3 weeks (see review advice).
- Regular orders should be reviewed to avoid continuous use—don't put methocarbamol on the repeat list.
- The anticholinergic and sedative effects may increase fall, fracture and confusion risk.
- Ensure all prescribers and staff are informed of changes

Review Advice

Attempt dose reduction by 25% per week for patients who have been on methocarbamol daily for more than 3-4 weeks (week 1: 75% of dose, week 2: 50% of dose, week 3: 25% of dose). Extend intervals or decrease dose reductions as necessary. Slower dose reduction may be necessary when reaching smaller doses. The approach should be a shared decision with patients.

A more gradual taper may be necessary if intolerable withdrawal symptoms such as muscle pain or spasm occur (usually 1-3 days after dose change) - return to previously tolerated dose until resolved.

Dose reduction should be considered in older patients. The SPC notes that in the elderly 'Half the maximum dose or less may be sufficient to produce a therapeutic response.' Consider increasing the dose interval in chronic hepatic disease as elimination half-life may be prolonged.

Action for Community pharmacists

- Highlight long-term methocarbamol prescribing to prescribers
- Counsel patients on appropriate use

Action for Trusts

- If methocarbamol is recommended by the Trust, ensure discharge information/ outpatient advice gives clear treatment goals, expected treatment duration and review plans.
- If patient taking methocarbamol is admitted, consider initiating deprescribing if no apparent benefit or reducing dose in appropriate elderly patients.