NORTHERN IRELAND MEDICINES MANAGEMENT
Newsletter
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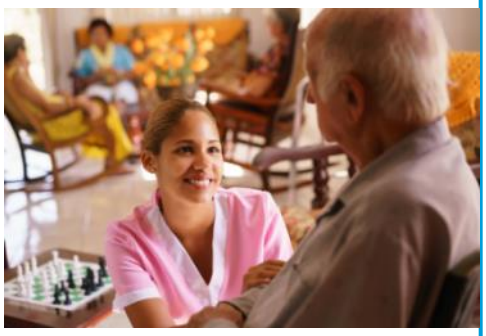
Prescribe Rivastigmine Transdermal Patches by BRAND

Rivastigmine transdermal patches are licensed for the symptomatic treatment of mild to moderately severe Alzheimer's dementia. These are significantly more expensive than first-line oral preparations. The NI Formulary states that these patches may be an option where a trial of oral medicine is poorly tolerated.



Most patients use a **daily patch**, Exelon® or Almuriva® (4.6mg, 9.5mg, 13.3mg/24 hours), however rivastigmine patches are also now available as a **twice weekly patch,** Zeyself® (4.6mg, 9.5mg/24 hours). The formulations appear the same when the dose is described in mg/24h (see SPCs). Errors have recently occurred in other UK regions, caused by a mix-up between the daily and twice weekly patches. Previous adverse incidents with rivastigmine patches included:

- mixing up daily and twice weekly patches
- lack of patch removal
- application of more than one patch at the same time
- application of the patch to non-recommended sites
- patch application to the same area for several weeks
- cutting the patch into several pieces

Rivastigmine patches should be prescribed by **brand name** to reduce the risk of errors (Generic Exception list). See below NI prescribing data (Oct-Dec 2025). It is concerning that 89% of all rivastigmine patches are prescribed generically.

Rivastigmine Transdermal Patch	NI Prescriptions (Oct-Dec 2025)	Percentage
Generic Patches	2069	89.3%
Branded Daily Patches (Exelon®, Almuriva®, Erastig®*)	246	10.6%
Branded Twice Weekly Patches (Zeyself®)	2	<1%

*recently discontinued

Action for Prescribers—review prescribing

- Ensure that rivastigmine patches are prescribed by **brand name only**
- Specify in the directions for “daily” or “twice weekly” application
- Put measures in place to minimise the risks highlighted by previous errors

Discontinuation of Specific Debrisoft® Pads

Debrisoft® Pad **10cm x 10cm** and Debrisoft® Pad **13cm x 20cm** only, will be removed from the NI Drug Tariff from 1st April 2026, although these may appear on GP clinical systems for up to three months. Prescriptions dispensed for these products from 1st April 2026 will **NOT** be reimbursed by BSO.

Actions for GP Practices

- Review patients currently being prescribed these dressings
- If ongoing wound care is necessary, refer to the NI Drug Tariff to select a cost-effective alternative.

Action for Community Pharmacies

Any prescriptions for these products received from 1st of April 2026 should be returned to the practice and an alternative requested.

In this Issue

NICE Guidance Recently published:

NICE TA1129
NICE TA1056
NICE TA1130

Managed Entry decisions:

Budesonide suppository (Budenofalk®)
Cemiplimab (Libtayo®)
Mercaptamine (Procysbi®)
Glofitamab (Columvi®)
Talquetamab (Talvey®)
Vutrisiran (Amvuttra®)
Dostarlimab (Jemperli®)
Abiraterone
Durvalumab (Imfinzi®)
Iptacopan (Fabhalta®)
Maralixibat (Livmarli®
Trastuzumab deruxtecan (Enhertu®)
Obecabtagene autoleucel (Aucatzyl®)
Acoramidis (Beyonttra®)
Somapacitan (Sogroya®)
Amivantamab Infusion (Rybrevant®)

Reviewing Propranolol Prescribing for Anxiety

An increase in propranolol prescribing nationally has been accompanied by a marked increase in **severe and fatal overdoses**. More than 300 intentional propranolol overdoses were reported in the UK in 2022–23, including 12 associated deaths (see HSIB and NPIS for detail on safety concerns).

Prescribing of propranol is not recommended by NICE or the British Association for Psychopharmacology (BAP), for generalised anxiety disorder (GAD) or social anxiety disorder, due to insufficient evidence. The SPPG has added propranolol for anxiety to the Limited Evidence List, to discourage initiation and promote review.

A structured review of all patients currently prescribed propranolol is recommended for all GP practices. Prescribers should consider discontinuing prescribing for anxiety, or switching to an alternative treatment option, in line with relevant NICE guidelines. **Propranolol must not be stopped abruptly but should be tapered down to avoid rebound symptoms.** Advice should be sought from specialists for more complex cases.

The following patients should be prioritised for review:

- patients prescribed propranolol for anxiety
- patients prescribed propranolol plus an SSRI (co-administration with an SSRI may increase the risk of severe toxicity in those taking propranolol overdoses)
- any other patient considered at higher risk of harm

There have recently been national shortages of propranolol modified-release (MR) 80 mg and 160 mg capsules. Prescribers are advised to review for ongoing clinical need as described above. Propranolol MR should not be initiated until supply stabilizes. An equivalent dose of propranolol immediate-release (IR) tablets should be used for all indications where propranolol treatment must continue, if the MR product cannot be obtained. The SPC for propranolol IR tablets should be consulted to determine the licensed dose frequency. It is important to ensure that the patient can adhere to a divided-dose regimen and understands the reason for the change. Equivalent instalment dispensing instructions if previously used should be considered for carry over to the new prescription as appropriate.

Equivalent Benzodiazepine doses for withdrawal

Prescribing of benzodiazepines per head of the population in Northern Ireland has steadily decreased over the last nine years but continues to be higher than any other part of the UK (see graph).

A previous newsletter article in February 2025 highlighted the success of one local practice in reducing benzodiazepine prescribing and shared their top tips for doing this, highlighting that reduction or withdrawal of **benzodiazepines can be approached in two different ways:**

- slow dose reduction of the patient's current benzodiazepines OR
- switching to an equivalent dose of diazepam, before tapering down

It is important to note that equivalent doses of oral benzodiazepines **are not exact.** Specialist Pharmacy Service has developed a useful resource entitled 'Oral benzodiazepines and choosing equivalent doses' which highlights factors that prescribers must consider before switching.

For further information on benzodiazepines withdrawal , see NICE NG215 and NICE CKS Benzodiazepine and z-drug withdrawal .