

NORTHERN IRELAND MEDICINES MANAGEMENT Newsletter

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Prescription Security Guidance Update

The **Guidance for Prescription Security in Primary Care** has been updated and is available on the [primary care intranet](#). This includes significant updates relating to the management of missing and stolen prescriptions with particular regards to:

- Blank prescription forms which cannot be accounted for on the premises
- A patient reporting a completed prescription as lost
- Prescriptions unaccounted for in transfer from GP practice to pharmacy
- Updated contact details / routes for SPPG, PSNI, Counter Fraud and CDAO
- Changes to the cipher processes for Non-Medical Prescribers in GP practices

All practice staff involved in prescribing, prescription handling, and prescription security should read this guidance and familiarise themselves with the changes.

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Tackling Risk with Fentanyl Patches

The Controlled Drugs Accountable Officer (CDAO), Dr Lisa Byers, is asking for particular vigilance when prescribing, dispensing and monitoring **fentanyl patches**. This follows several regional safety incidents, including the return of sixty unused fentanyl 50 mcg patches to a community pharmacy. Coroners have also raised concerns regarding the number of fentanyl-related deaths.

Fentanyl is a **high-potency opioid** associated with serious risks, including overdose, accidental exposure, dependence and avoidable patient harm. Risks are further increased for patients on more than one opioid. A fentanyl **50mcg** patch equates to 120-149mg oral morphine equivalent (OME) per day. **Strong opioids including fentanyl**, are not included in the [NI Formulary](#) for chronic non-malignant pain*. Fentanyl patches may have a role within palliative care for carefully selected patients with stable pain, where the transdermal route offers a clear advantage. They are not suitable for acute pain or rapid opioid titration.

Actions for Prescribers

- Identify all patients on fentanyl patches (consider [GPIP opioid dashboard](#))
- Aim to gradually reduce and stop treatment as appropriate
- Ensure that all patients have a documented management plan
- Prioritise for review patients on >1 opioid, reducing one opioid at a time
- Reinforce safe-use messages at every opportunity
- Report incidents or concerns to the CDAO via CD reporting

Advice for sharing with patients and carers

- Apply, rotate, replace and remove patches correctly
- Avoid heat sources which can increase fentanyl absorption and overdose risk (hot water bottles, electric blankets, hot baths)
- Store patches securely, out of sight and reach of others
- Fold patches adhesive-side together before safe disposal
- Return unused patches to community pharmacy for disposal
- Seek urgent medical attention if signs of opioid toxicity occur (excessive drowsiness, confusion or breathing difficulties)

*[NICE](#) disease-specific guidance should be followed.



Recent NICE Guidance

[NICE TA 1181](#)
[NICE TA 1045](#)
[NICE TA 1087](#)
[NICE TA 1184](#)
[NICE TA1185](#)

Managed Entry decisions

Tafasitamab (Minjuvi®)
Niraparib / abiraterone (Akeega®)
Nintedanib (Ofev®)
Daratumumab (Darzalex®)
Durvalumab (Imfinzi®)
Lisocabtagene maraleucel (Breyanzi®)
Risdiplam (Evrysdi®)
Nusinersen (Spinraza®)
Serplulimab (Hetronifly®)
Mepolizumab (Nucala®)
Teplizumab (Tzield®)
Cemiplimab (Libtayo®)
Fezolinetant (Veoza®)
Atogepant (Aquipta®)
Capsaicin (Qutenza®)
Seladelpar (Livdelzi®)
Mirvetuximab soravtansine (Elahere®)

Fentanyl Patch e.g. Mezolar®, Durogesic® Replace patch every 3 days

Fentanyl Patch (microgram/hr)	Equivalent 24 hourly Oral Morphine Dose (mg)
12	30-59
25	60-89
37	90-119
50	120-149

The [Faculty of Pain Medicine](#) recommended maximum opioid threshold is **90mg OME/day** in chronic non-malignant pain (ideal maximum 50mg OME/day). Primary care prescribers should not exceed 90mg OME/day without specialist advice.

Smoking Cessation: Caution with Clozapine

A [Coroner's investigation](#) recently highlighted the death of a 29-year-old of clozapine toxicity. The patient, who was a smoker, was on clozapine for schizophrenia and had been regularly advised that any cessation of smoking would increase clozapine levels. The patient stopped smoking tobacco in October 2025 and died about three days later. The Coroner noted it was likely that the smoking cessation had led to a fatal increase in clozapine blood levels.

The [BNF](#) warns that clozapine dose adjustment might be necessary if smoking is started or stopped during treatment. In 2020, following fatal cases involving toxicity of clozapine and other antipsychotic medicines the [MHRA](#) recommended monitoring blood concentration of clozapine for toxicity in certain clinical situations including when a patient stops smoking or switches to an e-cigarette.

Actions

- Clozapine is a [red list drug](#) in Northern Ireland. If a patient taking clozapine wishes to reduce or stop smoking, their primary care prescriber should contact the relevant specialist for advice.
- Community pharmacists should advise such patients on clozapine not to change their smoking habits without speaking to their prescriber / consultant.

Potential misuse of the Emergency Supply Service

The **Community Pharmacy Emergency Supply Service (ESS)** is a core pharmaceutical service that must be offered by all community pharmacies across NI. The service allows patients registered with a Health Service GP practice in NI to obtain an urgent supply of their regular repeat medication, regardless of which community pharmacy they usually attend. Key benefits include:

- accessing repeat medicines when patients run out or forget it while away from home
- reducing pressure on out-of-hours medical services by providing an accessible alternative for obtaining repeat medicines (*excluding most controlled drugs and privately prescribed items*).

Pharmacists must exercise professional judgement and undertake appropriate due diligence before making an emergency supply. This includes being satisfied that the medicine has previously been supplied on repeat prescription from the GP and remains clinically appropriate, for example where routine monitoring may be required or where treatment may have been discontinued. Community pharmacists have access to the NIECR to support the safe and effective delivery of this service.

Timely communication between community pharmacies and GP practices is essential:

- Pharmacists should provide GP practices with a record of any emergency supply issued, ideally within 48 hours, by forwarding a carbon copy of the Pharmacy Voucher (PV1)
- GP practices should update the patient's medical record, preferably within the prescribing module.

Both pharmacists and GP practices should remain alert to potential misuse of the service, particularly where requests involve medicines that may be liable to abuse or misuse, such as codeine-containing products, or where patients may be seeking supplies from multiple pharmacies. If fraudulent use of the ESS is suspected, concerns should be reported to [Counter Fraud and Probity Services](#) (CFPS) or the Police Service of Northern Ireland via 101 for advice and investigation, where appropriate.