NORTHERN IRELAND MEDICINES MANAGEMENT

Health and Social Care Board

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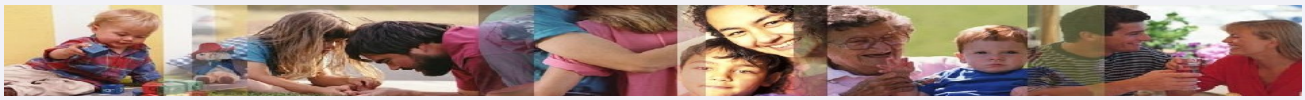
NEWSLETTER



In This Issue

Prescribing Generics by Manufacturer is NOT Recommended

Current health policy in NI is that medicines should be prescribed generically in all appropriate circumstances. There are a number of exemptions to this rule — see Generic Exceptions list and Cost-effective Choices list.

Feedback from community pharmacists at recent BSO roadshows is that they are seeing an increasing number of generics which are being prescribed by specific manufacturer, e.g. Teva / Genus.

The Northern Ireland Drug Tariff Part 1 (http://www.hscbusiness.hscni.net/pdf/DT_PART_1-1805.pdf) provides details on reimbursement for the majority of generically prescribed medicines. According to the Drug Tariff, if a medication is written generically on a prescription and listed in Part I of the Drug Tariff, reimbursement will be at the Drug Tariff price irrespective of the actual price that an individual manufacturer is charging the community pharmacist.

Action

- GPs are advised **NOT** to specify manufacturers when prescribing any medication generically.

Low Dose Naltrexone for MS?

Naltrexone is licensed in the UK as 50mg tablets (for adjunctive prophylactic treatment in the maintenance of detoxified, formerly opioid dependent patients) and as a combination product with bupropion 90mg/8mg (for adjunctive management of weight in clinically obese adult patients).

Low dose naltrexone (LDN) has been trialled for the treatment of autoimmune diseases such as multiple sclerosis (MS). In such cases an unlicensed formulation is used, usually at doses of 3mg to 4.5mg daily.

Currently there is not enough evidence to prove LDN is an effective treatment. LDN is not in the Northern Ireland Formulary and is not recommended to be prescribed in primary care because (i) there is no robust clinical evidence available to indicate that it is beneficial in the treatment of autoimmune diseases and (ii) it is not licensed for treatment of such indications. As such, it has been added to the HSCB Limited Evidence and Stop list.

Patients should only receive LDN as part of a clinical trial in secondary care. For further information see HSCB letter January 2017.

Action for GP practices:

- Do not start new patients on LDN.
- Review existing patients who are being prescribed LDN and stop treatment if not beneficial to the patient. Where there is any uncertainty, the initiating specialist should be consulted.

Seeking GP Representatives for PGEG

HSCB is seeking to appoint three GPs to represent the Belfast, Western and Southern LCG areas on the Prescribing Guidance and Editorial Group (PGEG). The group meets quarterly and is responsible for ensuring that the NI Formulary and other pieces of prescribing guidance are of a high quality and are of practical benefit for local healthcare professionals. The role will entail reviewing and providing constructive input into development and implementation of prescribing guidance.

If you are interested or would like further information please email medicines.management@hscni.net by 12th October 2018.

Place in Therapy for Targinact® (oxycodone/naloxone)?

Targinact® prolonged release tablets are indicated for severe pain that can be adequately managed only with opioid analgesia. Naloxone is added to counteract opioid-induced constipation. Last year £422,000 was spent on Targinact® in primary care in Northern Ireland. But where do guidelines suggest its place in therapy lies?

Oral sustained-release (SR) *morphine* is the Northern Ireland Formulary 1st line choice in patients with persistent pain who require strong opioids. This is in line with the SIGN guideline on *Management of Chronic Pain* and the NICE guideline CG140 *Palliative care for adults: strong opioids for pain relief.* There is a lack of evidence from high quality comparative trials that other opioids have advantages over morphine in terms of either efficacy or side effects. Morphine should therefore be used in preference to oral oxycodone (or other oral opioids/patches) in all appropriate circumstances.

The naloxone in Targinact® is added to block the action of oxycodone at opioid receptors in the gut, thereby counteracting opioid-induced constipation. However, there are no published trials comparing Targinact® with other oral strong opioids given with regular stool-softening and stimulant laxatives. **Targinact® reduces but does not eliminate the need for laxatives.** Therefore the clinical benefit in patients receiving regular laxative therapy is uncertain. Current NICE guidance states that when introducing an opioid, a stimulant laxative (e.g. bisacodyl, senna) and a softening laxative (e.g. docusate) should be prescribed at the time of the first prescription — constipation is one of the most common adverse effects from opioids and tolerance to this adverse effect does not develop on long-term use.

Action for GP practices:

- New patients requiring strong opioid therapy should be prescribed morphine sulfate SR.
- All patients taking regular long-term strong opioids should be prescribed regular laxatives which should be optimised before considering changing oral opioid therapy.
- Patients on long term opioid therapy for non-cancer pain should be reviewed regularly to assess whether there is a continued need for treatment.
- Prescribers should be aware of the abuse potential of all opioids.

NICE GUIDANCE — NORTHERN IRELAND SERVICE NOTIFICATIONS

Service Notifications have been issued in Northern Ireland for the following:

NICE TA512 — Tivozanib for treating advanced renal cell carcinoma.
NICE TA513 — Obinutuzumab for untreated advanced follicular lymphoma.
NICE TA517 — Avelumab for treating metastatic Merkel cell carcinoma.
NICE TA518 — Tocilizumab for treating giant cell arteritis.
NICE TA520 — Atezolizumab for treating locally advanced or metastatic non-small-cell lung cancer after chemotherapy.
NICE TA523 — Midostaurin for untreated acute myeloid leukaemia.

MANAGED ENTRY DECISIONS

The following medicines were considered in September as part of the Northern Ireland Managed Entry process. **Please refer to the Managed Entry section of the Northern Ireland Formulary website for full details on Managed Entry decisions:** http://niformulary.hscni.net/ManagedEntry/MEDecisions/Pages/default.aspx

177 Lu-dotatate (lutetium) (Lutathera®)	Midostaurin (Rydapt®)
Alectinib (Alecensa®)	Ocrelizumab (Ocrevus®)
Brentuximab (Adcetris®)	Patiromer - oral suspension (Veltassa®)
Cenegermin (Oxervate®)	Pembrolizumab (Keytruda®) - two decisions
Dinutuximab beta (Qarziba®)	Raltegravir (Isentress®)
Dupilumab (Dupixent®)	Sorafenib (Nexavar®) and Lenvatinib (Lenvima®)
Everolimus dispersible tablets (Votubia®)	Telotristat ethyl (Xermelo®)
Ledipasvir + sofosbuvir (Harvoni®)	

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 of this newsletter, please contact one of the Pharmacy Advisors in your local HSCB office:

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