# TAYSIDE PRESCRIBER

# Tayside DTC Supplement No. 52

July 2005

*Produced by NHS Tayside Drug and Therapeutics Committee Medicines Advisory Group (MAG)*

In this issue:



## SMC Advice Issued in June & July 2005

### Aripiprazole 5mg (Abilify®) – schizophrenia

**SMC recommendation**

**Advice:** following an abbreviated submission

Aripiprazole tablets 5mg (Abilify®) are accepted for restricted use in NHS Scotland for the treatment of schizophrenia. Where aripiprazole is an appropriate antipsychotic, this new dosage is restricted to patients who may benefit from a dose reduction to 5mg daily, taking account of SMC advice issued in August 2004. The 5mg tablet is the same price as the 10mg and 15mg tablets.

**Tayside recommendation**

Recommended within specialist treatment pathway (GPs may prescribe under the direction of a psychiatrist)

***Points for consideration:***

- Advice on the use of aripiprazole is available in Tayside Prescriber DTC Supplement No. 43, August 2004.
- The dose of aripiprazole should be reduced in patients receiving concomitant CYP3A4 inhibitors (eg ketoconazole, itraconazole and HIV protease inhibitors) or CYP2D6 inhibitors (eg fluoxetine and paroxetine). The 5mg tablet allows this flexibility in dose reduction.

## Atomoxetine (Strattera®) – attention-deficit/hyperactivity disorder (ADHD)

**SMC recommendation**
**Advice:** following a full re-submission
Atomoxetine (Strattera®) is accepted for restricted use within NHS Scotland for the treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in children of 6 years and older or in adolescents. It is restricted to use in patients who do not respond to stimulants or in whom stimulants are contraindicated or not tolerated. It is restricted to use by physicians with appropriate knowledge and expertise in treating ADHD. This advice concerns use in children and adolescents only and does not cover use in adults.
Atomoxetine (Strattera®) is not a Controlled Drug under the Misuse of Drugs regulations 2001.
*Click here for SMC link*

**Tayside recommendation**

Recommended within specialist treatment pathway (GPs may prescribe under the direction of a specialist in childhood behavioural disorders)

***Points for consideration:***

- Refer to Tayside Prescriber DTC Supplement No. 49, Mar 2005.
- Six-week comparative data shows a lower ADHD response rate for atomoxetine compared to prolonged-release methylphenidate (45% versus 56%). In this study, patients were excluded if they had failed to respond to prior stimulants or if stimulants were poorly tolerated or contra-indicated, which may have biased the response rates in favour of methylphenidate. 45% of methylphenidate non-responders became responders when switched to atomoxetine.
- **Atomoxetine is recommended locally for the treatment of ADHD in the following groups of children/adolescents:**
  - **those who have not responded to stimulant medication**
  - **those who have been unable to tolerate stimulant medication (eg due to decreased appetite, growth problems, sleep disturbance, depressed mood or mood lability or exacerbation of comorbid tics)**
  - **those in whom stimulant medication is contraindicated (such as those with co-morbid chronic motor tics or Tourette's syndrome**

  **Treatment should be under the direction of a specialist in childhood behavioural disorders. <u>The first three months of treatment should be prescribed by the Child & Adolescent Mental Health Service (CAMHS).</u>**
- A local ADHD shared care protocol detailing aspects of care for which the CAMHS and general practitioners are responsible has recently been approved by the DTC. Specific information on atomoxetine is provided in an appendix to this protocol.
- Updated NICE guidance on ADHD is due for issue in August 2005.

## Ciclesonide inhaler (Alvesco®) – asthma

**SMC recommendation**
**Advice:** following a full submission
Ciclesonide (Alvesco®) is accepted for use within NHS Scotland for the prophylactic treatment of persistent asthma in adults (18 years and older).
Ciclesonide is restricted to asthma patients who require once a day administration and whose treatment is at step 2 or step 3 of the British Guideline on the Management of Asthma. Alternative inhaled steroids are available at lower costs.
*Click here for SMC link*

**Tayside recommendation**

Recommended within formulary (prescribing note)

***Points for consideration:***

- Ciclesonide is a pro-drug that is metabolised to a corticosteroid with anti-inflammatory activity in the lung. Ciclesonide 160mcg ex-actuator is equivalent to a 200mcg metered dose (ie prior to deposition in the aerosol valve and mouthpiece).
- The usual maximum dose of ciclesonide is 160mcg once daily (roughly equivalent to CFC

*Continued over*

*Ciclesonide continued*

beclometasone 200mcg twice daily) administered either evening or morning via a CFC-free metered dose inhaler (MDI). Note that ciclesonide is not licensed in children and adolescents.

- Comparative 12-week studies show that ciclesonide 160mcg once daily provides similar improvements in lung function and asthma control as dry powder budesonide 200mcg twice daily and fluticasone 100mcg twice daily in adults with mild to moderate asthma.
- There are no data on the impact of ciclesonide on clinical outcomes such as asthma exacerbations, hospitalisations, quality of life and long-term adverse events.
- Short-term comparative studies indicate that ciclesonide may have less effect on cortisol production and may be associated with less oral candidiasis than fluticasone. Oropharyngeal side-effects are usually only a problem at higher doses eg >800mcg CFC beclometasone daily.
- Whilst ciclesonide is less expensive than other once daily inhaled steroids it is considerably more expensive than standard twice daily beclometasone. (28 days treatment with ciclesonide 160mcg once daily costs £7.80 versus £4.80 for CFC-free beclometasone (Qvar®) 100mcg twice daily, £10.40 for dry powder budesonide 400mcg once daily, and £11.20 for mometasone 200mcg once daily.)
- Twice daily beclometasone is recommended as the first-line inhaled steroid in the Tayside Area Prescribing Guide (TAPG). Studies on the effectiveness of once daily versus twice daily inhaled steroids in terms of compliance are inconclusive.
- **Locally, ciclesonide is recommended as an alternative to existing once daily inhaled corticosteroids (ie dry powder budesonide and mometasone) in adult patients at steps 2 or 3 of the BTS/SIGN asthma guideline who require once daily administration. It may also be considered in patients who experience unacceptable oropharyngeal side-effects despite mouth rinsing and use of spacer device.**
- Advice on the management of asthma is available in the SIGN/BTS Guideline and within the Respiratory Guidance Notes in the TAPG.

## Ezetimibe/simvastatin (Inegy®) – hypercholesterolaemia

**SMC recommendation**

**Advice:** following an abbreviated submission

Ezetimibe/simvastatin (Inegy®) is accepted for restricted use in NHS Scotland only for patients who have failed to achieve target cholesterol levels after titration and optimisation of statin monotherapy and where the combination of ezetimibe 10mg and simvastatin 20mg, 40mg or 80mg is appropriate.

This reflects advice on ezetimibe issued by the Scottish Medicines Consortium in September 2003 (61/03) and is based on the combined tablets being priced at approximately the same level as the individual ingredients.

**Tayside recommendation**

Recommended within formulary (prescribing note)

***Points for consideration:***

- The use of statins in the primary and secondary prevention of coronary heart disease is supported by evidence of reductions in cardiovascular events and mortality. Whereas, data on long-term outcomes associated with ezetimibe are currently unavailable (refer to Tayside Prescriber; DTC Supplement No.31, Sept 2003).
- Liver function tests should be performed before treatment with Inegy® begins and thereafter when clinically indicated. Patients titrated to the 10/80mg dose should receive an additional test prior to titration, three months after titration and periodically thereafter (eg every 6 months) for the first year of treatment.
- The cost of Inegy® is at parity with ezetimibe and generic simvastatin.
- Cholesterol targets can be achieved in the majority of patients (around 95%) if statin therapy is properly titrated. **Statins should therefore be titrated to maximum tolerated dose prior to addition of ezetimibe**.
- **Locally, Inegy® is reserved for patients unable to reach target cholesterol levels despite treatment with titrated/optimised statins alone and who require a more convenient dosing regimen than the separate individual constituents**.
- Guidance on the use of lipid regulating drugs is available within the recently updated cardiovascular section of the Tayside Area Prescribing Guide (TAPG).

## Fentanyl transdermal patches (Durogesic D Trans®) – non-malignant pain

**SMC recommendation**
**Advice:** following an abbreviated submission
Transdermal fentanyl (Durogesic D Trans®) patch is accepted for restricted use within NHS Scotland for patients with chronic intractable pain due to non-malignant conditions.
It should be considered as a second-line alternative, reserved for patients whose pain has initially been controlled by oral means, the pain being stable. Its use should focus on patients who have difficulty swallowing or have opiate induced constipation.
This reiterates advice issued by SMC in January 2003 following the extension of the licence for transdermal fentanyl (Durogesic®) patch to include non-malignant pain. SMC has not assessed transdermal fentanyl in its original indication for intractable pain due to cancer.

**Tayside recommendation**

Non-formulary

***Points for consideration:***

- Refer to Tayside Prescriber; DTC Supplement No. 24, Mar 2003.
- Durogesic D Trans® patches are "matrix" patches with the fentanyl dissolved evenly in each layer compared to the original Durogesic® patches which used reservoir technology. Durogesic D Trans® patches are bioequivalent, but smaller and thinner and will succeed the original patches.
- **Locally, fentanyl patches are reserved for patients with stable pain unable to take oral morphine eg due to dysphagia, unacceptable morphine toxicity, persistent nausea or vomiting, gastrointestinal obstruction, or opioid-induced constipation.**

## Fosamprenavir (Telzir®) – HIV

**SMC recommendation**
**Advice:** following a full submission
Fosamprenavir (Telzir®) in combination with low dose ritonavir is accepted for use within NHS Scotland for the treatment of Human Immunodeficiency Virus Type 1 (HIV-1) infected adults in combination with other antiretroviral medicinal products. It should be prescribed by HIV specialists only.
*Click here for SMC link*

**Tayside recommendation**

Recommended within specialist treatment pathway – HOSPITAL ONLY

***Points for consideration:***

- Lopinavir/ritonavir (Kaletra®) is recommended as the first-line protease inhibitor locally. In moderately antiretroviral experienced patients, fosamprenavir in combination with low dose ritonavir has not been shown to be as effective as Kaletra®.
- **Locally, fosamprenavir is considered as a second or third-line protease inhibitor dependent on viral resistance testing. Use is restricted to the HIV clinic.**

## Galantamine prolonged release (Reminyl XL®) – Alzheimer's dementia

**SMC recommendation**
**Advice:** following an abbreviated submission
Galantamine hydrobromide as Reminyl XL® prolonged-release capsules is accepted for use in NHS Scotland for the treatment of mild-to-moderately severe dementia in Alzheimer's disease in patients for whom therapy with galantamine is appropriate. It allows the reduction of dosing frequency to once daily and, at given dose, involves no additional cost compared with immediate-release formulations of galantamine.

**Tayside recommendation**

Recommended within specialist treatment pathway (GPs may prescribe under the direction of a dementia specialist)

*Continued over*

*Reminyl XL® continued*

***Points for consideration:***

- Standard release galantamine is administered twice daily, once daily dosing offers an advantage in terms of compliance. Donepezil is also administered once daily and, to date, has been considered the first-line cholinesterase inhibitor locally.
- **Reminyl XL® is recommended as an alternative to standard release galantamine in patients with mild to moderate Alzheimer's dementia. Treatment should be under the direction of a specialist in dementia.**
- A local shared care protocol on the use of cholinesterase inhibitors in Alzheimer's dementia is available.

## Insulin detemir (Levemir®) – diabetes mellitus in children and adolescents

**SMC recommendation**

**Advice:** following an abbreviated submission

Insulin detemir is accepted for restricted use in Scotland in the treatment of children and adolescents with diabetes mellitus. The licence has been extended to include these patient groups and the restriction reflects similar advice from the Scottish Medicines Consortium (August 2004) when insulin detemir was reviewed as a new product for adult patients only.

**Tayside recommendation**

Recommended within specialist treatment pathway (GPs may prescribe under the direction of the diabetic clinic)

***Points for consideration:***

- Refer to Tayside Prescriber; DTC Supplement No. 43, Aug 2004.
- The licence extension covers children aged 6 years and older.
- Insulin detemir is the same cost as insulin glargine (also licensed in children over 6 years).
- **Insulin detemir is recommended locally as an alternative to insulin glargine in children aged 6 years and older who are unable to achieve optimal glycaemic control with established insulins due to risk of hypoglycaemia.**

## Modafinil (Provigil®) – shift work sleep disorder

**SMC recommendation**

**Advice:** following a full submission

Modafinil (Provigil®) is not recommended for use within NHS Scotland for the treatment of excessive sleepiness associated with moderate to severe shift work sleep disorder.

Modafinil demonstrated a modest improvement in sleepiness and quality of life, the clinical significance which is difficult to estimate. The submitted health economics case does not demonstrate cost-effectiveness of the therapy.

*Click here for SMC link*

**Tayside recommendation**

Not recommended

***Points for consideration:***

- Modafinil is also licensed for the treatment of excessive sleepiness associated with chronic pathological conditions, including narcolepsy and obstructive sleep apnoea/hypopnoea syndrome. The narcolepsy indication was approved pre-SMC. Advice in relation to the obstructive sleep apnoea/hypnoea indication is given below. The SMC has not received a submission for excessive sleepiness associated with other chronic condition such as multiple sclerosis or Parkinson's Disease.
- Modafinil has not been compared with other strategies for alleviating the problems associated with shift work, such as scheduled naps, bright light therapy and caffeine.

## Modafinil (Provigil®) – obstructive sleep apnoea/hypopnoea

**SMC recommendation**
**Advice:** following a resubmission
Modafinil (Provigil®) is not recommended for use within NHS Scotland for the treatment of excessive sleepiness associated with obstructive sleep apnoea/hypopnoea syndrome.
Modafinil demonstrated modest improvement in sleepiness and quality of life, the clinical significance of which is difficult to estimate. The submitted health economic case had some uncertainties and failed to demonstrate cost effectiveness.
*Click here for SMC link*

**Tayside recommendation**

Not recommended

***Points for consideration:***

- Refer to Tayside Prescriber; DTC Supplement No. 32, Oct 2003.
- Whilst modafinil has been shown to reduce daytime sleepiness in patients with sleep apnoea, it has been shown to reduce patients' use of continuous positive airways pressure (CPAP) therapy. This therapy is used by patients with obstructive sleep apnoea to prevent their throat closing during the night. Reduction in its use could potentially be harmful.

## Montelukast (Singulair®) – seasonal allergic rhinitis (SAR) in patients with asthma

**SMC recommendation**
**Advice:** following a full submission
Montelukast (Singulair®) is accepted for restricted use within NHS Scotland for the symptomatic relief of seasonal allergic rhinitis (SAR) in adult patients in whom montelukast is indicated in asthma, as add-on oral therapy at steps 3 and 4 of the BTS/SIGN asthma guidelines.
Other more effective and cost-effective treatment for SAR are available for patients in whom montelukast is not required for the treatment of asthma.
*Click here for SMC link*

**Tayside recommendation**

Non-formulary

***Points for consideration:***

- Short-term placebo controlled studies indicate that montelukast provides some reduction in SAR symptoms in patients with asthma and co-morbid SAR.
- A recent meta-analysis indicates that montelukast is as effective as antihistamines but less effective than nasal steroids in improving symptoms and quality of life in patients with SAR.
- **Inhaled long-acting beta$_2$-agonists (LABAs) are first-line add-on therapy for adults at step 3 of the BTS/SIGN asthma guideline. Montelukast is one of a range of oral therapies indicated when asthma control remains inadequate despite a trial of add-on LABA and increased dose of inhaled steroid.** Patients with co-morbid SAR receiving montelukast for asthma may benefit from some relief of SAR symptoms over the hay fever season.
- Advice on the management of asthma is available in the SIGN/BTS Guideline and within the Respiratory Guidance Notes in the TAPG.

## Pegylated interferon alfa 2a (Pegasys®) – hepatitis B

**SMC recommendation**
**Advice:** following a submission
Pegylated interferon alfa 2a (Pegasys®) is accepted for use within NHS Scotland for the treatment of HbeAg-positive or HbeAg-negative chronic hepatitis B in adult patients with compensated liver disease and evidence of viral replication, increased ALT and histologically verified liver inflammation and/or fibrosis.
Compared with conventional interferon alfa 2a, it offers comparable efficacy and the convenience of once-weekly rather than three-times weekly subcutaneous administration. It has been shown to be cost-effective when compared to a number of comparator medicines in a range of patient groups.
*Click here for SMC link*

*Continued over*

*Pegylated interferon alfa 2a continued*

**Tayside recommendation**

Recommended within specialist treatment pathway – HOSPITAL ONLY

***Points for consideration:***

- Pegylated interferon alfa is also licensed for the treatment of chronic hepatitis C.
- The pegylated formulation costs considerably more than conventional interferon alfa. A fixed period of 48 weeks treatment of Pegasys® costs £6,200 compared to £2,200-£3,800 for 24 weeks of conventional interferon alfa 2a (Roferon A®).
- NICE guidance on the use of pegylated interferon alfa 2a in the treatment of chronic hepatitis B is expected in February 2006.
- **Pegylated interferon alfa 2a is recommended locally, under the direction of a specialist in hepatitis B, as an alternative to conventional interferon alfa used first-line in the treatment of chronic hepatitis B infection.**

## Rosiglitazone (Avandia®) – triple therapy in type 2 diabetes

**SMC recommendation**

**Advice:** following an abbreviated submission

Rosiglitazone (Avandia®) is accepted for restricted use in NHS Scotland as triple oral therapy in combination with metformin and a sulphonylurea in patients (particularly overweight patients) who are unable to achieve sufficient glycaemia control despite dual oral therapy and where patients are unable or unwilling to take insulin.

It should be initiated and monitored only by physicians experienced in the treatment of diabetes mellitus who will be able to identify and manage patients who might benefit.

**Tayside recommendation**

Recommended within specialist treatment pathway (GPs may prescribe under the direction of the diabetic clinic)

***Points for consideration:***

- Insulin remains the most appropriate treatment option for most patients who are uncontrolled on metformin and a sulphonylurea.
- Local guidance on diabetes care is available in the Tayside Diabetes Handbook.

## Vinorelbine oral (Navelbine® oral) – stage III or IV non-small-cell lung cancer (NSCLC)

**SMC recommendation**

**Advice:** following a full submission

Vinorelbine capsule (Navelbine® Oral) is accepted for restricted use within NHS Scotland for the first line treatment of stage III or IV non-small-cell lung cancer. It is restricted to use by specialist oncologists as an alternative to the intravenous formulation of vinorelbine. It is more expensive than the intravenous formulation of vinorelbine. However, its use may allow changes to service delivery that have individual patient or organisational benefits.

*Click here for SMC link*

**Tayside recommendation**

Not currently recommended – pending NSCLC protocol

***Points for consideration:***

- Vinorelbine is a semi-synthetic vinca alkaloid used for the treatment of advanced NSCLC and advanced breast cancer. The oral formulation is currently only licensed for NSCLC.
- Studies indicate that oral vinorelbine has comparable efficacy to IV vinorelbine.
- The oral formulation offers patient choice, greater convenience and possibly less time spent on hospital visits. It may also provide benefits to the oncology service in terms of service delivery.
- Oral vinorelbine is considerably more expensive than the IV formulation. (£240-£310 per oral dose versus £140-£170 per IV dose).
- The place of oral vinorelbine in the treatment of advanced NSCLC, and in relation to the IV

*Continued over*

*Vinorelbine oral continued*

formulation, will be addressed by the Oncology and Haematology Medicines Management Group within a local NSCLC protocol.

- Oral vinorelbine is not stocked by the hospital pharmacy.
- Guidance on the management of patients with lung cancer is available within recently published SIGN Guideline No.80 and NICE Guideline No.24.

## TAPG Update

Below are the changes to the TAPG agreed by the Medicines Advisory Group and approved by the Drug & Therapeutics Committee in July 2005. Updated sections are available on the TAPG pages of the DTC intranet site – these can be printed off to replace the old sections in the hard copy ring binder. Where possible and appropriate, first line drug choices are clearly indicated in reviewed sections. An updated GPASS-TADF fly file for use in general practice will also be available shortly.

| | TAPG section | Drug(s) / topic | Changes |
|---|---|---|---|
| **1.1** | Antacids | Co-magaldrox<br>Gaviscon®/Peptac® | Co-magaldrox 1st choice antacid<br>Peptac® suspension replaces Gaviscon® liquid/tablets |
| **1.2** | Antispasmodics | Metoclopramide<br>Domperidone | Metoclopramide 1st choice motility stimulant.<br>Domperidone suppositories added to range of available formulations |
| **1.3** | Ulcer healing drugs | Omeprazole<br>Lansoprazole | Omeprazole 1st choice PPI.<br>Orodispersible lansoprazole tablets added to range of available formulations |
| **1.4** | Antidiarrhoeal drugs | Loperamide | Loperamide 1st choice antidiarrhoeal |
| **1.5** | Inflammatory bowel disease | Mesalazine | Mesalazine 1st choice aminosalicylate |
| **1.6** | Laxatives | Magnesium hydroxide<br>Senna<br>Arachis oil | Magnesium hydroxide 1st choice osmotic laxative.<br>Senna 1st choice stimulant laxative.<br>Arachis oil enema added to range of preparations.<br>Notes added on management of constipation in the elderly |
| **2.12** | Lipid regulating drugs | Inegy®*<br>(ezetimibe/simvastatin) | Added (as prescribing note) for patients who require a more convenient dosing regimen than the separate individual constituents |
| **3.2** | Inhaled corticosteroids | Ciclesonide* | Added (as prescribing note) as an alternative once daily inhaled steroid, also for consideration in patients who experience unacceptable oropharyngeal side effects despite mouth rinsing and use of spacer |
| **4.8** | Antiepileptics | Antiepileptics | Statement of possible bioavailability variations amended. |
| **11.3** | Antibacterial eye preparations | Chloramphenicol<br>Framycetin | Chloramphenicol 1st choice.<br>Framycetin drops/oint added as an alternative |
| **11.8** | Tear substitutes | Hypromellose | Hypromellose 1st choice tear substitute |
| **12.1** | Drugs acting on the ear | Otosporin® | Otosporin® removed (BNF indicates that it is a less suitable preparation) |
| **12.2** | Drugs acting on the nose | Beclometasone Sodium cromoglicate | Beclometasone 1st choice nasal steroid.<br>Sodium cromoglicate removed (children not covered in core formulary). |
| **12.3** | Drugs acting on the oropharynx | Nystatin | Nystatin first choice for oropharyngeal fungal infection |
| **18** | Therapeutic Drug Monitoring | Theophylline | Therapeutic interval for theophylline in neonates added |

* SMC accepted medicine

## Caspofungin Update

The January 2005 SMC advice for the use of caspofungin in the empirical treatment of invasive fungal infections in neutropenic patients was deferred to the ASD Anti-Infectives Committee. See below for final decision:

**Tayside recommendation**
Recommended within specialist treatment pathway – **HOSPITAL ONLY**

- Caspofungin is recommended first-line for the empirical treatment of invasive fungal infections, such as *Candida* or *Aspergillus*, in neutropenic adults undergoing chemotherapy for haematological malignancy if persistent fever after 96 hours of antibacterial therapy. In all other cases treatment must be under the direction of a specialist in infectious diseases or microbiology

## Forthcoming SMC Advice

| Gastro-intestinal system |
|---|
| Esomeprazole (Nexium®) |
| Beclometasone Dipropionate 5mg (Clipper®) |
| Glyceryl trinitrate 0.4% ointment |
| **Cardiovascular system** |
| Perindopril (Coversyl®) |
| Cilostazol (Pletal®) – ***Re-submission*** |
| Bemiparin (Zibor®) |
| Atorvastatin (Lipitor®) - ***Abbreviated*** |
| Anagrelide (Xagrid®) - ***Re-submission*** |
| Nebivolol (Nebilet®) |
| **Respiratory** |
| Beclometasone (Clemil Modulite) |
| **Central nervous system** |
| Pregabalin (Lyrica®) – ***Re-submission*** |
| Buprenorphine patch (Transtec®) |
| Tramadol/paracetamol (Tramacet®) |
| Ropinirole (Adartrel®) |
| Rivastigmine (Exelon®) |
| Palonosetron (Aloxi®) |
| Oxycodone (OxyContin®) |
| Duloxetine (Cymbalta®) |
| Aprepitant (Emend®) - ***Abbreviated*** |
| **Infections** |
| Voriconazole (Vfend®) |
| **Endocrine system** |
| Strontium ranelate (Protelos®) |
| Pioglitazone (Actos®) - ***Re-submission*** |
| Triptorelin (Decapeptyl SR® 11.25mg) - ***Abbrev*** |
| Alendronate/colecalciferol (Fosavance®) - ***Abbrev*** |

| Obstetrics, gynae and urinary-tract disorders |
|---|
| Oxybutynin transdermal patch (Kentera®) |
| Tamsulosin (Flomaxtra®) |
| Solifenacin (Vesicare®) – ***Re-submission*** |
| Drospirenone/oestradiol (Angeliq®) |
| **Malignant disease & immunosuppression** |
| Pemetrexed (Alimtra®) |
| Gliadel wafer |
| Docetaxel (Taxotere®) |
| Oxaliplatin (Eloxatine®) |
| Fludarabine (Fludara® Oral) |
| Erlotinib (Tarceva®) |
| Capecitabine (Xeloda®) |
| Bevacizumab (Avastatin®) |
| Anastrazole (Arimidex®) |
| Exemestane (Aromasin®) |
| Cetuximab (Erbitux®) - ***IRP*** |
| **Nutrition & Blood** |
| Darbepoetin alfa (Aranesp®) |
| Lanthanum carbonate (Fosrenol®) |
| **Musculoskeletal & joint diseases** |
| Lumiracoxib (Prexige®) |
| Diclofenac (Voltarol® Gel Patches 1%) |
| Infliximab (Remecade®) - ***Re-submission*** |
| Etanercept (Enbrel®) |
| **Eye** |
| Brimonidine/timolol (Combingan®) - ***Abbreviated*** |
| **Skin** |
| Calcipotriol/betamethasone (Dovobet®) |

**Contact details:** Local implementation of SMC recommendations is being taken forward by the Tayside Medicines Unit – contact Jan Jones, Pharmaceutical Prescribing Adviser (jan.jones@tpct.scot.nhs.uk) if you have any queries in relation to the introduction of new drugs within NHS Tayside