TAYSIDE PRESCRIBER

NHS Tayside

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Respiratory MCN Formulary Update

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Introduction

In the last two years there have been changes to:

- The British Guideline on the Management of Asthma, Scottish Intercollegiate Guidelines Network (SIGN) no.101(revised June 2009).
- Guidance on the management of chronic obstructive pulmonary disease (COPD) from the National Institute for Health and Clinical Excellence (NICE) June 2010.

As a result, the NHS Tayside Respiratory Managed Clinical Network, Formulary Group, has recently reviewed the sections of the Tayside Area Formulary (TAF) relating to asthma and COPD.

The formulary changes were agreed at the August meeting of the Respiratory Formulary Group and approved by the Medicines Advisory Group (MAG) in October.

2010/11 Seretide® Cost-minimisation initiative

This initiative encourages practitioners to prescribe cost-effective licensed medicines. Details of this cost-minimisation initiative, along with other initiatives for 2010/11 were outlined in a recent Tayside Prescriber, Issue 116, September 2010. These initiatives also form part of the NHS Tayside Medicines Management Locally Enhanced Service (LES) for 2010/11 that general practices are invited to participate in.

A considerable cost difference exists between the high strength combination inhalers. See table 1. If an inhaled steroid (and long-acting beta$_2$ agonist) is required in COPD, only Seretide® 500 Accuhaler® and Symbicort® 200/6 and 400/12 Turbohaler® are licensed.

Key prescribing point:

All patients currently prescribed Seretide® 250 Evohaler® for COPD should be reviewed in primary care. They should be transferred to a licensed combined inhaled steroid and long-acting beta$_2$ agonist dry powder device.

Following advice from the NHS Tayside Respiratory MCN, the Seretide® cost-minimisation initiative has now been amended so that the following dry powder inhalers can be considered for people currently prescribed Seretide® 250 Evohaler®:

- Symbicort® 400/12 Turbohaler® (1 puff twice daily)
- Symbicort® 200/6 Turbohaler® (2 puffs twice daily)

Use of Symbicort® Turbohaler® will be considered when assessing the final Seretide® LES target for general practices.

Table 1

	Licensed for COPD	Cost (£) for 1 years treatment
Seretide® 250 Evohaler® (2 puffs twice daily)	x	721.69
Seretide® 500 Accuhaler® (1 puff twice daily)	✔	496.50
Symbicort® 400/12Turbohaler® (1 puff twice daily)	✔	461.07

Doses given do not imply therapeutic equivalence

Practitioners should consider the following when reviewing patients:

1. Is the criteria for treatment with combination high dose inhaled corticosteroids met?

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2010/11 Seretide® Cost-minimisation initiative (continued…..)

i.e. persistent breathlessness and/or repeated exacerbations with FEV_1 <50% of predicted. Treatment may be considered in those with FEV_1 ≥50% of predicted, if there is persistent breathlessness and/or repeated exacerbations despite treatment with long-acting $beta_2$ agonist or long-acting muscarinic antagonist (LAMA).

2. Is transfer to a dry powder device inappropriate for the patient (exclusion criteria)?

- The inspiratory flow rate is < 30L/min and is unlikely to generate sufficient inspiratory flow during exacerbations
- Poor technique with dry powder device
- History of recurrent candidiasis of the mouth or throat
- Medication is administered by a carer
- The device is unacceptable to the patient

Similarly, patients newly prescribed Seretide® for COPD should be prescribed the 500 Accuhaler® device, 1 puff twice daily unless they fall within the exclusion criteria described above.

Although the cost minimisation initiative is primarily aimed at COPD, efficiencies can also be achieved through review of asthma patients.

Patients with asthma should be maintained at the lowest effective dose of inhaled steroid and consideration should be given to stepping down treatment once asthma is controlled.

NHS Tayside Area Formulary: Updates to Section 3 Respiratory system

Following the October meeting of MAG, the following changes have been made to Section 3 Respiratory system and guidelines:

- Addition of an introduction section and changes to the layout throughout with information from formulary sections moved into guidance sections.

Section 3.1 Bronchodilators

- Expansion of dose information in line with BNF for the $beta_2$ agonists.

Section 3.2 Inhaled corticosteroids

- Change in layout in line with BNF - compound preparations are listed under each inhaled steroid, rather than a separate section at the end.
- Expansion/updating of dose/prescribing information in line with BNF for beclometasone, budesonide, Fostair®, Symbicort® and Seretide®.
- Amendment to local restriction on use of Symbicort® SMART® regimen to be in line with SIGN/BTS asthma guideline update from June 2009 – may also be used in those on SIGN/BTS step 2 who are poorly controlled (above beclometasone dipropionate (BDP) 400mcg/day).

A previous addition (July 2010) to this section is the combined inhaled corticosteroid/long-acting $beta_2$ agonist, Fostair®▼ (beclometasone/formoterol) for prophylaxis of asthma in adults 18 years and over on step 3 or above of the BTS/SIGN asthma guidelines.

Notes on Managing Chronic Asthma

- Guidance on inhaled steroids added here (taken from previous formulary section 3.2).

Chronic Obstructive Pulmonary Disease (COPD) Guidelines

- Updated in line with revised Respiratory MCN COPD manual.
- Stepped approach to pharmacological therapy updated in line with NICE guidance on COPD (June 2010).
- Tiotropium as Respimat®▼ (solution for inhalation) is highlighted within the stepped approach to COPD as being recommended in patients already using other MDI devices. Tiotropium as HandiHaler® (dry powder inhaler) is to be used in patients already using other dry powder devices (Accuhaler® or Turbohaler® devices).

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Updates to Section 3 Respiratory system (continued…….)

- The SMC restriction on Respimat®▼ is in patients with poor manual dexterity. The NHS Tayside Respiratory MCN has taken a pragmatic approach to this advice for MDIs. They recognise that Respimat®▼ may be required in some patients where a dry powder device is inappropriate. This ties in with exclusion criteria for the Seretide® cost-minimisation initiative.
- Update to guidance on treatment of COPD exacerbation in the community. Link to Tayside GP Antibiotic Man for assessment and treatment of community acquired pneumonia inserted.

Guidance on Inhaler Devices 12 years+

- Updated in line with BNF and removal of inhaler device algorithm. Choice of inhaler device should be tailored to the needs of individual patients, taking into account licensed indications and cost. Metered dose inhalers (MDIs) are a reasonable choice in many situations provided the correct inhalation technique can be taught.

Local interpretation of NICE guidance

NICE published updated guidance on the management of stable COPD in primary and secondary care in June 2010 which has been adopted by the British Thoracic Society. Previous Tayside COPD guidance was based on the original NICE guidelines from 2004. Therefore in the absence of Scottish guidance, the Respiratory MCN Formulary Group has updated their recommendations for the pharmacological management of COPD in line with the updated NICE guidance.

Main changes to pharmacological management of COPD from NICE guidance 2010

- Inhaled short-acting beta$_2$ agonist or short-acting muscarinic antagonist (SAMA), is now recommended **as required** and may be continued through all stages of COPD.
- Once-daily LAMA should be offered in preference to four-times-daily SAMA to people with stable COPD who remain breathless or have exacerbations despite using short-acting bronchodilators as required, and in whom a decision has been made to commence regular maintenance bronchodilator therapy with a muscarinic antagonist.
- The use of combined inhaled corticosteroid and long-acting beta$_2$ agonist is initially restricted to those with FEV_1 < 50% predicted. However in those with persistent breathlessness and/or repeated exacerbations despite treatment with long-acting beta$_2$ agonist or LAMA, when $FEV_1 \geq$ 50% of predicted, treatment with combined inhaled corticosteroid and long-acting beta$_2$ agonist may be considered. Evidence was not strong enough for this to have been recommended to be offered routinely within the NICE guidance.

The Respiratory MCN Formulary Group took into account the aims of treatment with combined inhaled corticosteroid and long-acting beta$_2$ agonist in COPD (to reduce exacerbation rates, ease breathlessness and slow the rate of decline in health status), in their decision to update their recommendations for the pharmacological management of COPD, which is in line with updated NICE guidance and reflects current practice.

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