TAYSIDE PRESCRIBER

ADTC Supplement No. 20

October 2002

In this issue:

Annual Report

The Annual Report of the Area Drug and Therapeutics Committee and TUH Drugs & Therapies and TPC Drug & Therapeutics Committee and their various Sub-Committees will soon be available on the ADTC website (www.show.scot.nhs.uk/thb/adtc).

Tayside Area Prescribing Guide (TAPG)

The 1st edition of the TAPG was issued at the start of August 2002. Implementation of key sections of the prescribing guide will be taken forward through the agreed prescribing priorities of the Tayside Medicines Management Strategy. Work on Edition 2 of the TAPG will commence shortly. Specialist formulary sub-groups will be introduced to develop guidance notes for the treatment of pain, diabetes and osteoporosis. A further sub-group will produce advice on paediatric prescribing. Edition 2 will see the merger of Primary Care and Hospital Prescribing Guides to give a single version containing the Tayside Area Drug Formulary, prescribing guidelines and antibiotic policies relevant to both primary and secondary care.

TAPG Erratum

An error has been identified in Edition 1 of the TAPG within the dosage instructions for alfuzasin m/r tablets (Xatral XL), page 84. Dosage should read: 10mg once daily. Replacement stickers have been issued.

The second contents page in some copies of the primary care and hospital prescribing guides was unfortunately swapped over during the printing process. Contact Jan Jones (jan.jones@tpct.scot.nhs.uk) if you require a replacement page.

Scottish Medicine Consortium (SMC) update

The SMC evaluation of new drugs (and in future new formulations and indications) is underway and is being used as the basis for advising on the use of new drugs in Tayside. The following should be noted:

- Drugs should not normally be prescribed until advice is received from the SMC and processed by the New Drug Implementation Panel (NDIP), a new Sub-Committee of the Area Drug & Therapeutics Committee (ADTC).
- The NDIP/ADTC's role is to engage local specialists in determining the impact of new drugs and to advise on their introduction and so inform decisions around prioritisation and funding.
- There may be exceptional cases where a new drug is considered clinically justified before the above process is completed. In such circumstances the drug can only be prescribed and supplied from secondary care on a named-patient basis with the prior approval of the Clinical Group Director (TUH) or Clinical Director (TPC) and the Chair of the ADTC.
- Note that GPs will be supported in their decision to await advice from NDIP/ADTC before prescribing new drugs.
- Where a drug is evaluated and not recommended by SMC it should not normally be prescribed. If necessary, a formal case including an explanation as to why an alternative treatment cannot be found should be approved by the Clinical Group Director (TUH) or Clinical Director (TPC) and the Chair of the ADTC.

New drugs evaluated by the SMC

The table below details recommendations issued by the SMC and supported locally (also available from the ADTC website: www.show.scot.nhs.uk/thb/adtc).

Name of Drug	Status	Recommendation	SMC No
Imatinib (Glivec®)	Restricted use	*Indication: Chronic myeloid leukaemia* Approved for treatment of chronic myeloid leukaemia (CML) under the overall supervision of haematologists/oncologists, within the context of the current guidelines on this medicine issued by the British Society of Haematology (Nov 2001). Imatinib is the first treatment to offer major cytogenic responses in CML. This approach appears to provide a significant advance in the treatment of a hitherto fatal haematological malignancy.	1/02
Pegylated interferon alfa-2b (ViraferonPeg®)		*Indication: Hepatitis C* Pegylated interferon alfa-2b is an appropriate treatment for the management of adult patients with chronic hepatitis C under the overall supervision of specialists experienced in the management of this disorder. This treatment involves a once weekly injection which hence reduces inconvenience to patients whilst increasing the response rate in both monotherapy and in combination with ribavirin.	2/02

Tenofovir (Viread®)		*Indication: Combination viral therapy-AIDS* Recommended in combination with other antiretroviral agents in HIV infected patients over 18 years who are experiencing virological failure. Tenofovir produces a clinically relevant viral response in heavily pre-treated patients experiencing early virological failure. Tenofovir should be initiated under the supervision of specialists experienced in the management of HIV/AIDS patients	03/02
Anakinra (Kineret®)	Not recommended	*Indication: Rheumatoid arthritis* At present, anakinra offers no proven clinical advantages over the other biological agents (infliximab and etanercept) for the treatment of rheumatoid arthritis. Economic assessment performed by SMC suggests that NNT to achieve a clinical response and cost/responder were higher for ankinra than for other biological agents. There is no evidence that anakinra provides benefit in patients who do not respond to anti-TNF biological agents.	05/02
Biphasic insulin aspart 30 (Novomix 30®)	Not recommended	*Indication: Diabetes* This drug reduces blood sugar to a greater extent after breakfast and evening meal, but to a lesser extent after lunch, than existing treatment. It has no clear advantage in terms of global glycaemic control as demonstrated by HbA_{1c}. There is no reduction in hypoglycaemic episodes to justify the overall increase in cost.	06/02
Bimatoprost (Lumigan®)	General use	*Indication: Glaucoma & ocular hypertension* Recommended as adjunctive therapy to β-blockers or as monotherapy in patients insufficiently responsive to, intolerant of, or contra-indicated to first-line glaucoma therapy. It should be used under the direction of an ophthalmologist.	07/02
Imatinib (Glivec®)	Restricted use	*Indication: Non-resectable or metastatic gastrointestinal tumours* Under the supervision of an oncologist for patients with Kit-positive gastrointestinal stromal tumours (GIST).	08/02
Calcipotriol and betametasone dipropionate ointment (Dovobet®)	Not recommended	*Indication: Psoriasis* Given its higher cost, value for money has not been demonstrated for this product. For patients who may benefit from a combination of corticosteroid and calcipotriol in the treatment of chronic plaque psoriasis, it may be more appropriate to have independent control over the potency, dosing and duration of steroid than to use a fixed dose combination involving a very potent steroid.	09/02
Pegylated interferon alfa-2a (Pegasys®)	Restricted use	*Indication: Hepatitis C* Pegylated interferon alfa-2a is an appropriate treatment for the management of adult patients with chronic hepatitis C under the overall supervision of specialists experienced in the management of this disorder. This treatment involves a weekly injection from a pre-filled syringe that reduces inconvenience to patients whilst increasing the response rate over interferon alfa-2a alone or in combination with ribivirin.	10/02

The following recommendations have also been issued by the SMC. Pending the establishment of the New Drug Implementation Panel (NDIP), a local recommendation will be agreed by the Chair of the ADTC in consultation with the relevant Clinical Group Director (TUH) or Clinical Director (TPC).

Methyphenidate OROS (Concerta XL®)	Restricted use	*Indication: Attention Deficit Hyperactivity Disorder (ADHD)* Treatment with methylphenidate should be part of a comprehensive treatment programme for attention-deficit hyperactivity disorder (ADHD) when remedial measures alone prove insufficient (under specialist supervision). Because of its substantially greater costs, methylphenidate OROS should be restricted to second line therapy and used only in exceptional circumstances where the supervising clinician has clear evidence of compliance problems. As for other methylphenidate preparations, initiation should be on the recommendation of a specialist in childhood behaviour disorders.	04/02
Insulin glargine (Lantus®)	Restricted use	*Indication: Diabetes* Insulin glargine is an acceptable treatment for patients with diabetes melitus. Pending further studies, its use should be targeted on patients who are at risk of, or experience, unacceptable frequency and/or severity of nocturnal hypoglycaemia on attempting to achieve better hypoglycaemic control during treatment with established insulins. It is also acceptable as a once daily insulin therapy for patients who need assistance with their injections. It is not recommended for patients with type 2 diabetes unless they suffer from recurrent episodes of hypoglycaemia or require assistance with their insulin injections.	11/02
Tacrolimus ointment (Protopic®)	Restricted use	*Indication: Atopic dermatitis* Tacrolimus ointment offers a treatment option for adults with atopic dermatitis intolerant of or unresponsive to conventional treatments, and for children aged 2 years or over who are unresponsive to conventional topical therapies. It is a potent immunosuppressant which can be absorbed systemically following topical application, and there are unresolved concerns about possible adverse effects arising from this. Its use should, therefore, be considered prior to oral therapy when it is deemed that other appropriate options for topical therapy have been exhausted. Its use should be initiated and supervised by dermatologists within secondary care who have experience of treating atopic dermatitis using immunomodulatory therapy. In order to facilitate further investigation of long-term effects of the use of tacrolimus ointment, it is advised that a register of recipients should be established and maintained.	12/02

Drotrecogin alfa (activated) (Xigris®)	Restricted use	*Indication: Severe sepsis* Drotrecogin alfa (activated) is a significant advance in the treatment of patients with severe sepsis with multiple organ failure. It supplements the existing treatment strategies of infection eradication and support for failing organs/systems. When added to the best standard care of patients with severe sepsis it significantly reduces mortality in the most severely ill patients i.e. those with more than one new failing organ/system and/or those with an APACHE II score >25. A register of recipients of this treatment should be established and maintained to provide additional information about its effectiveness and safety in the clinical setting.	13/02

Extending Independent Nurse Prescribing

The SEHD has published A Guide for Implementation of the above that will result in a substantial increase in the range of medicines that nurse prescribers are able to provide. In response, the ADTC has agreed the administrative and procedural steps for nurses to prescribe from the extended formulary together with the provision of information on good practice set out in the Summary of Recommendations and Implications for Tayside, September 2002.

Further information on these documents can be obtained from the ADTC Secretary (doreen.wilkie@tuht.scot.nhs.uk).

Symptomatic Relief Policy

TUH and TPC have jointly agreed a Generic Symptomatic Relief Policy that enables suitably qualified nurses and midwives to administer a range of medicines for common conditions set out in an agreed list to patients aged 16 years and over *once such treatment has been deemed appropriate* by the relevant medical practitioner. A Symptomatic Relief Policy has operated in TUH for some years and has allowed nurses to treat patients timeously with drugs such as analgesics for mild to moderate pain, laxatives, antacids and treatments for other common GI complaints.

The Generic Symptomatic Relief Policy is published on the ADTC website.

Future dissemination of Tayside Prescriber and ADTC Supplement

An e.mail list will allow future dissemination of the Tayside Prescriber and the ADTC Supplement electronically via a cascade to all prescribing staff within NHS Tayside.

Note that this edition of the ADTC supplement is sent in hard copy and via e.mail.

Comments on issues raised in this bulletin and other matters to be raised with the Area Drug & Therapeutics Committee should be sent to Doreen Wilkie, Pharmacy Department, Ninewells Hospital. **doreen.wilkie@tuht.scot.nhs.uk**