PostScRxipt – PrimaRxy Care

March 2007

VARENICLINE (CHAMPIX®): This new product for smoking cessation has been added to the *Formulary*. It is restricted to use:

- in those who have previously attempted to quit smoking using NRT for at least a four-week period,
- where that quit attempt was more than six months ago,
- for patients linked to one of the recognised smoking cessation support programmes, eg Starting Fresh or CHP Smoking Concerns groups.

GPs should initially prescribe a two week supply to be dispensed weekly. After two weeks, the patient should be involved with the smoking cessation services and the GP should issue a weekly dispensed script for up to a further ten weeks' supply. After 12 weeks of treatment most patients will not receive further treatment. A second 12 week course may be issued to those who meet specific criteria. The Starting Fresh and Smoking Concerns services will be ready to accept patients on varenicline from 14th March 2007 (No Smoking Day). A flowchart detailing the expected prescribing and support of patients on varenicline can be found at www.glasgowformulary.scot.nhs.uk.

RIMONABANT (ACOMPLIA®): The SMC has **not** recommended rimonabant for use within NHS Scotland as an adjunct to diet and exercise for the treatment of obese (BMI >30 kg/m^2) or overweight patients (BMI >27 kg/m^2) with risk factors such as type 2 diabetes or dyslipidaemia. Rimonabant gave a mean weight reduction of about 4-5kg over placebo. However, this weight was generally regained within one year of stopping treatment. Based on the SMC decision, rimonabant has **not** been added to the *Formulary*. GPs asked to prescribe this by specialists should question why *Formulary* options are not suitable.

2007 – 2008 MED 6 VISITS, MED 10 PRESCRIBING INDICATORS AND INCENTIVE SCHEME: The CHP prescribing leads through the MRMG have agreed the principles to operate across NHS Greater Glasgow and Clyde in the next financial year.

INCENTIVE SCHEME: It is planned that practices will be allocated three prescribing areas to target and that achievement of specific targets will result in payments based on list size. Two targets will be based on the greatest possible financial impact to the CHP; the third will have the greatest financial impact in the practice. Full details, including payments, have yet to be finalised.

MED 6 PRESCRIBING VISITS: The annual prescribing visits will be run jointly between the CHP prescribing teams and the central prescribing team in 2007 – 2008. You will be contacted by someone from your CHP over the coming months to arrange a suitable date and time. It is hoped that most of the visits can be carried out by the end of December 2007.

MED 10 INDICATORS: As has been the case in Glasgow for the past two years, practices will be offered the choice of three actions from a set list of agreed prescribing indicators with specific targets attached. A list of the top five indicators which have not been met (excluding those used for the incentive scheme) will be sent to all practices with their baseline figures from October – December 2006. **Practices who do not wish to choose from the list may come up with their own suggestions** for areas of prescribing to be tackled over the coming year. These will need to be agreed with the prescribing team. The full list of indicators is shown overleaf.

MONITORING PROGRESS: Practices will be able to monitor their own progress through standard PRISMS queries which we plan to publish on the website. Those who have not yet registered for use should visit www.prismsweb.scot.nhs.uk. Training can be undertaken on-line or face-to-face at the practice in a half or full day and is suitable for clinical staff or practice managers. In time, use of PRISMS will replace the quarterly letters sent from the Prescribing Team.

PRESCRIBING INDICATORS FOR 2007 -2008

1	**Lansoprazole and omeprazole (excluding FasTabs & MUPs) as % of all single agent oral PPIs.** **Rationale:** Lansoprazole and omeprazole are drugs of choice in the *Formulary*.
2	**A2RA as % of all ACEI and A2RAs.** **Rationale:** National and local guidelines suggest that ACEI should be first line with A2RAs reserved for patients who cannot tolerate ACEIs. This is an indicator of prescribing efficiency from Audit Scotland.
3	**Standard ISMN as % of all ISMN prescribing.** **Rationale:** This was highlighted by Audit Scotland as prescribing of "premium priced preparation". Standard ISMN is the formulation of choice in the *Formulary*.
4	**Dispersible 75mg aspirin as % of all 75mg aspirin items.** **Rationale:** Enteric coated and plain aspirin are premium priced products and do not have additional clinical benefit. Dispersible aspirin is the formulation of choice in the *Formulary.*
5	**Clopidogrel as % of all antiplatelet drugs.** **Rationale:** Audit suggests clopidogrel is being used outwith the antiplatelet guidelines. This has a significant cost implication. Inappropriate combination use with aspirin raises potential safety issues.
6	**% of *Formulary* choices of all prescribing in BNF 2.12 and simvastatin as % of all statins.** **Rationale:** Simvastatin is the drug of choice in the *Formulary*.
7	**Loratadine and cetirizine as % of all non-sedating antihistamines.** **Rationale:** These are two of the three non-sedating antihistamines in the *Formulary*.
8	**"Z" drugs (zopiclone, zaleplon, zolpidem) Defined Daily Doses / 1000 patients / quarter.** **Rationale:** Z hypnotics have no clinical benefits over traditional drugs and are significantly more expensive. They are non-*Formulary*.
9	**Fluoxetine and citalopram as % of all antidepressants (excluding tricyclics).** **Rationale:** This builds on an indicator in Audit Scotland referring to switches to fluoxetine. Fluoxetine and citalopram are both drugs of choice in the *Formulary*.
10	**Co-codamol 8/500, co-codamol 30/500 and paracetamol tablets, capsules or caplets as % of all solid dose co-codamol and paracetamol.** **Rationale:** Effervescent formulations contain significant amounts of sodium which can affect control of hypertension and are premium priced preparations. This indicator was highlighted by Audit Scotland. The *Formulary* restricts use to those with swallowing difficulties.
11	**Alendronate as % of all bisphosphonates prescribed for osteoporosis (excluding daily doses).** **Rationale:** This is the drug of choice in the *Formulary*.
12	**Standard diclofenac sodium, ibuprofen and naproxen as % of all NSAIDS including COX-2s.** **Rationale:** Diclofenac and ibuprofen are drugs of choice in the *Formulary*. The MHRA noted naproxen may be less likely than other NSAIDs to have adverse cardiovascular events.
13	**NSAID Defined Daily Doses / 1000 patients / quarter.** **Rationale:** MHRA advice is that NSAIDs should be prescribed at the lowest effective dose for the shortest possible time.
14	**Potential generic savings as a % of total expenditure.** **Rationale:** This is an indicator of prescribing efficiency as highlighted by Audit Scotland. Generic prescribing allows use of lower cost medicines with no detriment to patient care.
15	**Top 4 prescribed SMC non-approved drugs (items / 1000 patients) (excluding drugs with other indications that have been approved by SMC, eg pregabalin).** **Rationale:** National guidance is that SMC non-approved drugs should not move into routine clinical practice. They are all non-*Formulary*.

The incentive scheme and nGMS indicators will all be taken from this list. Details of baseline position and targets will be sent to each practice as early in the new financial year as possible.

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