NHS Cumbria Clinical Commissioning Group

PRESCRIPTION PAD

The Newsletter of the Cumbria Area Prescribing Committee

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Clinical policy and Formulary news	Recommendations on new medicines	NICE Guidance
Guidelines for the management of recurrent urinary tract infections Pregabalin and gabapentin misuse Sativex®	Azelastine hydrochloride plus fluticasone propionate nasal spray (Dymista®) – perennial allergic rhinitis Brinzolamide + brimonidine eye drops (Simbrinza®) – open-angle glaucoma or ocular hypertension Certolizumab (Cimzia®) - ankylosing spondylitis. Certolizumab (Cimzia®) - active psoriatic arthritis and xial spondyloarthritis without radiographic evidence of AS (nr-axSpA) Denosumab (Prolia®) – osteoporosis in men	Dabrafenib – melanoma Lenalidomide – transfusion-dependent anaemia caused by myelodysplastic syndrome Erythropoesis-stimulating hormones – cancer chemotherapy-associated anaemia Nalmefene – reducing alcohol consumption Imatinib – gastrointestinal stromal tumours CG186 – multiple sclerosis CG189 - obesity

Clinical Policy and Formulary News

Guidelines for the management of recurrent urinary tract infection	Guidance on the treatment of recurrent urinary tract infections have recently been approved by the Area Prescribing Committee. These are available at http://www.networks.nhs.uk/nhs-networks/nhs-cumbria-ccg/medicines-management/guidelines-and-other-publications/antibiotic-management-of-recurrent-urinary-tract-infections-in-adults/file_popview
Pregabalin and gabapentin misuse	Pregabalin and gabapentin are now well recognised as potential drugs of abuse. As single agents, they are not likely to be abused, but when mixed with a variety of drugs such as opiates and benzodiazepines, they have an additive effect. People who misuse the drugs do so because of the feelings of euphoria they can create; they are commonly used alongside - and as enhancers to - other drugs, such as alcohol, opiates such as heroin or methadone, and diazepam. Users describe the effects as the "ideal psychotropic drug," "great euphoria," "disassociation," and "opiate buzz," and are achieving these effects by taking large quantities as a single dose. Accordingly there is a growing black market, and these drugs are being bought through online pharmacies. Pregabalin and gabapentin are easily available on the illicit market in 25mg to 800mg capsules, changing hands for between 50p and £2. A couple of recent publications have highlighted this problem: Advice for prescribers on the misuse of pregabalin and gabapentin. This was published in December 2014 and highlights the risk of additive effects when mixed with a wide variety of psychoactive drugs. Drugscope's recent publication, 'Down a stony road' (2015) identified an increased use of gabapentin and pregabalin chiefly among opiate users and prisoners. Figures from the Office of National Statistics reported on the number of death certificates where either pregabalin or gabapentin were mentioned as a possible cause of death. The last year that they reported on, 2013, had 9 deaths associated with gabapentin and 33 with pregabalin. The impression is that this is increasing, but figures as yet are not available. Prescribers should bear in mind that there is a significant of misappropriation and abuse potential. In the last NICE guidance on neuropathic pain CG173, November 2013), it recommended a choice of any of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia), and carbamazepine as initial treatment for trigeminal neuralgia. Amitriptyline has a lower risk of misuse than either pregabalin or gabapentin.

	Pregabalin is occasionally used for the treatment of epilepsy, but in this situation, it should only be initiated by a neurologist or other specialist. For generalised anxiety disorder, NICE recommends offering sertraline first (though not licensed specifically for GAD; obtain and document informed consent) because it is clinically effective in mixed anxiety and depressive disorder and is the most cost-effective. If sertraline is ineffective after 2 months at the maximum therapeutic dose, offer an alternative SSRI (escitalopram or paroxetine) or an SNRI (duloxetine or venlafaxine). Prescriptions for other, unlicensed indications should be returned to secondary care, if they have originated from there.
Sativex®	As mentioned in the NICE Clinical Guideline (later in this newsletter), Sativex® should not be offered to treat spasticity because it is not a cost-effective treatment. In addition, the Northern Treatment Advisory Group has recommended that it should not be prescribed for the treatment of non-MS pain. Nearly £26,000 was spent on Sativex® in primary care in the last 12 months.

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Recommendations on New Medicines

The following drugs have been recommended as suitable for use:	Azelastine hydrochloride plus fluticasone propionate nasal spray (Dymista®)	Relief of symptoms of moderate to severe seasonal and perennial allergic rhinitis if monotherapy with either intranasal antihistamine or glucocorticoid is not considered sufficient.	GREEN
	Brinzolamide + brimonidine eye drops (Simbrinza®)	Decrease of elevated intraocular pressure (IOP) in adult patients with open-angle glaucoma or ocular hypertension for whom monotherapy provides insufficient IOP reduction.	AMBER
	Certolizumab (Cimzia®)	Ankylosing spondylitis. Axial spondyloarthritis without radiographic evidence of AS (nr-axSpA)	RED
	Certolizumab (Cimzia®)	In combination with methotrexate, for the treatment of active psoriatic arthritis in adults when the response to previous DMARD therapy has been inadequate.	RED
The following drugs were <u>not approved</u> by SMC and LJF, on the basis that a cost-effectiveness case was not supported by local specialists:	Denosumab (Prolia®)	Osteoporosis in men at increased risk of fractures.	BLACK

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NICE guidance

These are brief summaries. The complete guidance should be consulted (www.nice.org.uk)

	Drug	Condition	Resume
TA321	Dabrafenib	Melanoma (unrescetable or metastatic BRAF V600 mutation-positive)	Recommended as an option for treating unresectable or metastatic BRAF V600 mutation-positive melanoma. **RED**
TA322	Lenalidomide	Transfusion-dependent anaemia, caused by low- or intermediate-1 risk myelodysplastic syndromes associated with an isolated deletion 5q cytogenetic abnormality	Recommended as an option. **RED**
TA323	Erythropoiesis-stimulating hormones (epoetin and darbepoetin)	Cancer chemotherapy-associated anaemia	Recommended as possible treatments for anaemia in people having chemotherapy to treat cancer. **RED**
TA325	Nalmefene	Reducing alcohol consumption in people with alcohol dependence	Nalmefene (Selincro®) is recommended as a possible treatment for people with alcohol dependence who: • are still drinking more than 7.5 units per day for men and more than 5 units per day for women 2 weeks after an initial assessment **and** • do not have physical withdrawal symptoms **and** • do not need to either stop drinking straight away or stop drinking completely. Nalmefene should only be taken if the person is also having on-going support to change their behaviour and to continue to take their treatment, to help them reduce their alcohol intake. **GREEN**
TA326	Imatinib	Gastrointestinal stromal tumours (adjuvant therapy)	Recommended as a possible treatment for up to 3 years, for people who had gastrointestinal stromal tumours that were removed by surgery, when there is a high risk that the tumour may come back. **RED**

CG186	Multiple sclerosis	Mainly covers diagnosis, symptom management and rehabilitation Amantadine may be used to treat fatigue. Consider a combination of baclofen and gabapentin for treating spasticity in people with MS if: • individual drugs do not provide adequate relief or • side effects from individual drugs prevent the dose being increased. Consider tizanidine or dantrolene as a second-line option to treat spasticity in people with MS. Consider benzodiazepines as a third-line option to treat spasticity in MS and be aware of their potential benefit in treating nocturnal spasms. Do not offer Sativex® to treat spasticity in people with MS because it is not a cost-effective treatment. Consider gabapentin as a first-line drug to treat oscillopsia in people with MS. Consider memantine as the second-line treatment for oscillopsia in people with MS. Consider amitriptyline to treat emotional lability in people with MS. Develop local guidance and pathways for timely treatment of relapses of MS. Ensure follow-up is included in the guidance and pathway. Non-specialists should discuss a person's diagnosis of relapse and whether to offer steroids with a healthcare professional with expertise in MS because not all relapses need treating with steroids. Offer treatment for relapse of MS with oral methylprednisolone 500mg daily for 5 days. Consider intravenous methylprednisolone 1 gram daily for 3–5 days as an alternative for people with MS: • in whom oral steroids have failed or not been tolerated or • who need admitting to hospital for a severe relapse or monitoring of medical or psychological conditions such as diabetes or depression.
CG189	Obesity	Guidance on the diagnosis, classification and lifestyle changes for patients with obesity. It recommends pharmacological treatment as an option for patients over 12 years, only after dietary, exercise and behavioural approaches have been started and evaluated. Consider drug treatment for people who have not reached their target weight loss or have reached a plateau on dietary, activity and behavioural changes.

		Only prescribe orlistat as part of an overall plan for managing obesity in adults who meet one of the following criteria: • a BMI of 28 kg/m^2 or more with associated risk factors • a BMI of 30 kg/m^2 or more. It also makes recommendations on surgery.

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