

Medicines Optimisation Newsletter

[November 2024] (Issue No.64)



- [Kent and Medway ICB Pain Services Community of Practice Webinar](#)
- [Rivaroxaban – generic available – All DOACs MUST be prescribed generically](#)
- [Independence Wound Protection and Collection Pouches \(VAP range\) – Non formulary items](#)
- [Reminder – Kent and Medway ICB Forceval® capsules Position Statement](#)
- [Opioids- Safer Prescribing and Preferred Cost-effective Brands. Information for General Practice](#)
- [MHRA Drug Safety Update – October 2024](#)
- [Shortages Summary](#)
- [Discontinuation NovoRapid® \(insulin aspart\) FlexTouch® 100units/ml solution for injection 3ml pre-filled pens](#)
- [Reminder for East Kent Practices – Oral Morphine Prescribing Resources](#)

Kent and Medway ICB Updates

Kent and Medway ICB Pain Services Community of Practice Webinar

The Kent, Surrey and Sussex Patient Safety Collaborative, and Medway and Swale Health and Care Partnership invite you to attend a pain services community of practice designed to support clinicians to reduce harm from dependence forming medicines within their practice place on **Thursday the 28th of November from 2:30 pm - 4:00 pm.**

This online webinar will feature presentations from colleagues working within the health and justice sector to share learning, inform best practice and generate thought-provoking discussion.

<https://www.eventbrite.co.uk/e/medway-and-swale-hcp-pain-services-community-of-practice-webinar-tickets-1067247980439>

Please feel free to share the registration link with others in your network who may have an interest in this area.

We look forward to seeing you on Thursday the 28th of November from 2:30 pm - 4:00 pm.

Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: kmicb.medicinesoptimisation@nhs.net

Rivaroxaban – generic available – All DOACs MUST be prescribed generically

Generic Rivaroxaban is now available and in the Drug Tariff. Please prescribe it generically.

NHS England have updated their DOAC commissioning recommendations [Commissioning recommendations for national procurement for direct-acting oral anticoagulant\(s\) \(DOACs\) on the 6th of September 2024](#).

The Kent and Medway position statement document will be reviewed ASAP, via the normal ICB governance process, to reflect the current NHSE recommendations.

Apixaban

Please also note that Apixaban is off patent and can also be prescribed generically.

Independence Wound Protection and Collection Pouches (VAP range) – Non formulary items

Items within this product range are **not recommended** for prescribing in primary care and therefore have not been assessed for formulary inclusion in Kent and Medway:

- Independence wound drainage bag with extra dressing (VAP1)
- Independence Xtra large wound drainage bag with extra dressing (VAP2)
- Independence small wound drainage bag with extra dressing (VAP3)
- Independence Easy Access wound drainage bag (EA1)
- Independence Extra Sticky wound drainage bag (EA2)

These products are designed for haemodialysis patients with a central venous catheter to protect the catheter insertion site and surrounding dressing during bathing or swimming in order to reduce the risk of infection.

Advice from Renal Specialists

Samples and booklets provided by company representatives in the hospital Trust's Renal Units may have led patients to believe that these products could be prescribed by their GPs, which may have led to the prescribing of these items.

The various Trusts have now taken action to make sure that these samples and leaflets have been taken out of the Renal Units and do not recommend using these products. Instead, they advise the following:

“Do not get your dressing wet, take a shower, or go swimming whilst you have a line. A shallow bath is okay but do not pour water over your line. If the dressing gets wet, bacteria may enter the exit site or line and cause an infection. Ask your dialysis nurse for further advice.”

Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: kmicb.medicinesoptimisation@nhs.net

Actions for Practices

- Please review any existing prescribing of these products in your practice.
- Please **DO NOT** accept requests directly from patients without contacting your Medicines Optimisation Team first.
- Please **DO NOT** accept any requests from a 3rd party DACS (Dispensing Appliance Company) without contacting your Medicines Optimisation Team first.
- Please **DO NOT** accept requests from other specialties without contacting your Medicines Optimisation Team first.

Reminder - Forceval® capsules Position Statement

The Medicines Optimisation Team would like to remind colleagues that in line with NHS England guidance Kent and Medway ICB does **not** support the routine prescribing of Forceval® capsules on prescription, unless indicated for a diagnosed vitamin or mineral deficiency.

- Maintenance or preventative treatment is not an exception.
- Following bariatric surgery, patients should purchase Forceval® capsules over the counter (OTC) or choose a suitable alternative A-Z multivitamin and mineral preparation for supplementation.

Please see the Kent and Medway ICB Forceval position statement for Primary Care attached below for further information.



kent-and-medway-ic
b-forceval-position-st

Opioids – Safer Prescribing and Preferred Cost-effective Brands. Information for General Practice

Please see the below attachment shared as a reminder of the preferred cost-effective brands of opioids in primary care in Kent and Medway and for information on the safer prescribing of opioids.



opioid comms v.1.pdf

Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: kmicb.medicinesoptimisation@nhs.net

National Updates

MHRA Drug Safety Update – October 2024

The latest MHRA Drug Safety Updates can be accessed at [Drug Safety Update - GOV.UK \(www.gov.uk\)](https://www.gov.uk/drug-safety-update) . This includes links to alerts, recalls and safety information and to the monthly Drug Safety Update PDF newsletter.

The October Drug Safety Update includes:

[GLP-1 receptor agonists: reminder of the potential side effects and to be aware of the potential for misuse - GOV.UK](#)

MHRA advice for healthcare professionals:

- inform patients upon initial prescription and when increasing the dose about the common risk of gastrointestinal side effects which may affect more than 1 in 10 patients. These are usually non-serious, however can sometimes lead to more serious complications such as severe dehydration, resulting in hospitalisation
- be aware that hypoglycaemia can occur in non-diabetic patients using some GLP-1RAs for weight management; ensure patients are aware of the symptoms and signs of hypoglycaemia and know to urgently seek medical advice should they occur
- patients should also be warned of the [risk of falsified GLP-1RA medicines for weight loss if not prescribed by a registered healthcare professional, and be aware that some falsified medicines have been found to contain insulin^{\[footnote 1\]}](#)
- be aware there have been reports of potential misuse of GLP-1RAs for unauthorised indications such as aesthetic weight loss
- report suspected adverse drug reactions to the [Yellow Card scheme](#)

MHRA advice for healthcare professionals to provide to patients:

- GLP-1RAs are prescription-only medicines to be used under medical supervision and should only be prescribed by a registered healthcare professional
- the benefits and risks of using a GLP-1RAs for weight loss outside of the licensed indications have not been studied
- common gastrointestinal side-effects of GLP-1RAs treatment (including nausea, vomiting, diarrhoea and constipation) can persist for several days and may affect more than 1 in 10 patients. This may result in

Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: kmicb.medicinesoptimisation@nhs.net

dehydration, which if severe may lead to other serious health complications such as kidney damage resulting in hospitalisation

- throughout treatment stay well hydrated by drinking plenty of fluids (such as water) to avoid dehydration, which can sometimes occur after experiencing gastrointestinal side-effects including vomiting and diarrhoea
- other serious but less common side-effects of GLP-1RAs include acute gallstone disease, pancreatitis, and serious allergic reactions
- if obtaining a private prescription (from a non-NHS prescriber), ensure that this is dispensed from authorised sources, such as registered online pharmacies, to avoid the risk of receiving falsified pens
- carefully read the instructions for use in the Patient Information Leaflet, and use the prescribed dose
- if you are concerned about any side-effects, speak to a healthcare professional

[Insulin pumps and continuous glucose monitoring \(CGM\) equipment: guidance for users on reporting suspected adverse incidents and safety concerns to the MHRA's Yellow Card scheme - GOV.UK](#)

MHRA advice for healthcare professionals:

- insulin pumps and continuous glucose monitoring (CGM) devices are complex devices with the potential to result in serious harm in the event of error. To aid the MHRA in early identification of safety concerns associated with these devices, users of the equipment need to know how to report safety issues to the MHRA
- [we have published guidance](#) to explain to users of all medical devices manufactured for diabetes management how to report safety concerns to the MHRA using the Yellow Card scheme
- this guidance is expected to improve the quality of information the MHRA receives and should the need arise, support a thorough investigation of the relevant equipment
- [highlight the guidance](#) to patients using insulin pumps, insulin pens and CGM devices
- remind patients that if they suspect a problem with their device, they should be advised to use an alternative method to manage their diabetes
- we are also [providing a poster](#) with a direct link to the guidance (QR code) which can be printed to display in your clinic waiting room

Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: kmicb.medicinesoptimisation@nhs.net

- healthcare professionals should also speak to their local Medical Device Safety Officer (MDSO) on how you can support the reporting of adverse incidents with these medical devices
- report problems and adverse incidents associated with medical devices used in the management of diabetes on a [Yellow Card](#)

[Bromocriptine: monitor blood pressure when prescribing bromocriptine for prevention or inhibition of post-partum physiological lactation - GOV.UK](#)

A safety review has been conducted by the MHRA following a Yellow Card report concerning a patient who was taking bromocriptine. The review concluded that blood pressure monitoring of patients prescribed with this drug is essential especially during the first days of treatment.

MHRA advice for healthcare professionals:

- bromocriptine should only be prescribed to suppress post-partum physiological lactation, where it is medically indicated such as intrapartum loss, neonatal death, or in some cases of HIV infection of the mother
- bromocriptine should not be used for routine lactation suppression, or for relieving symptoms of postpartum breast pain and engorgement, which can be adequately treated with non-pharmacological interventions (such as firm breast support, ice application) and simple analgesics
- use is contraindicated for patients with uncontrolled hypertension, hypertensive disorders of pregnancy (including eclampsia, pre-eclampsia or pregnancy-induced hypertension), hypertension post-partum and in the puerperium, a history of coronary artery disease or other severe cardiovascular conditions
- particular caution is required in patients who are on concomitant therapy or recent treatment with drugs that can alter blood pressure
- when prescribing bromocriptine for any of its indications, carefully monitor for an increase in blood pressure, especially during the first days of therapy and with any subsequent dose increases
- if patients prescribed bromocriptine present with signs and symptoms of hypertension, treatment should be discontinued, and the patient evaluated promptly by healthcare professionals
- clinical guidance^[footnote 1] recommends cabergoline as the preferred drug for prevention or inhibition of post-partum physiological lactation, owing to the single dose regime and lower rates of rebound breast activity and adverse events. However, blood pressure monitoring is still necessary when taking cabergoline as both cabergoline and bromocriptine are dopamine agonists and should not be given to women with hypertension or pre-eclampsia

Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: kmicb.medicinesoptimisation@nhs.net

- healthcare professionals are encouraged to read the Summary of Product Characteristics (SmPC) for special warnings and contraindications for the use of bromocriptine and cabergoline
- report suspected adverse drug reactions to bromocriptine or cabergoline to the [Yellow Card scheme](#)

[Letters and medicine recalls sent to healthcare professionals in September 2024 - GOV.UK](#)

****Please follow the link in the titles above for more information and resources.****

NATIONAL CAS ALERTS (National Patient Safety Alerts and CMO Messages):

The MHRA Central Alerting System alerts can be accessed at [CAS - Home \(mhra.gov.uk\)](#)

21.10.24 [UPDATE: Discontinuation of Kay-Cee-L \(potassium chloride 375mg/ml\) \(potassium chloride 5mmol/5ml\) syrup](#)

Shortages

Shortages Summary

From February 2024 onwards, the monthly Medicines Optimisation newsletter will no longer contain the medicines shortages update document, which was compiled each month from the shortages listed on the SPS (Specialist Pharmacy Services) Medicines Supply tool. The information published on the SPS Medicines Supply tool is provided by DHSC and NHSEI Medicines Supply Teams and was not formally reviewed by the NHS Kent and Medway Medicines Optimisation team.

During the time that the shortages update was compiled and included in the Medicines Optimisation newsletter, practices and healthcare professionals were still encouraged to **register for free access to the [SPS website](#)** and to **access the SPS Medicines Supply tool directly** in real time, to have access to the most up-to-date and complete information and advice available. Now that the shortages update will no longer be compiled by the Medicines Optimisation team for inclusion in the newsletter, healthcare professionals will be required to access the SPS Medicines Supply tool to access information on the latest shortages. Serious Shortage Protocols (SPPs) can be found on the NHS BSA website [here](#).

Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: kmicb.medicinesoptimisation@nhs.net

Discontinuations

Discontinuation NovoRapid® (insulin aspart) FlexTouch® 100units/ml solution for injection 3ml pre-filled pens

The Kent and Medway Medicines Optimisation Team would like to remind colleagues about the Medicine Supply Notification (MSN) from the DHSC on the **discontinuation** of **NovoRapid® (insulin aspart) FlexTouch® 100units/ml solution for injection 3ml pre-filled pens**. Stock is anticipated to be exhausted **by March 2025**. This MSN was issued on the 16th of October 2024 and then cascaded to all practices and PCN teams. The MSN is attached:



MSN_2024_103
NovoRapid insulin aspart

In addition to the information and actions in the MSN which should be read in full, such as **“Do not initiate new patients on NovoRapid® FlexTouch® pens”**, the Medicines Optimisation Team would like to supplement this with the following information:

- The recommendation is that patients currently prescribed NovoRapid® FlexTouch® pens are pro-actively **reviewed and switched to Trurapi®**, where clinically suitable in line with NICE guidelines on an individual patient basis.
- In Kent and Medway Trurapi® is the **preferred/first-line brand** of the rapid-acting insulin aspart, in view of the cost to the NHS because of the potential cost savings from using Trurapi® instead of NovoRapid®. This is in line with NICE guidance, NHS England, and Kent and Medway PRGC Policy Recommendations in relation to biosimilar medicines.
- Trurapi® is a **biosimilar insulin** of the originator insulin, NovoRapid®. Trurapi® has been shown to be equivalent to NovoRapid® in its pharmacokinetic and pharmacodynamic properties.
- Trurapi® is licensed, identically to the originator insulin (NovoRapid®), for the treatment of type 1 and type 2 diabetes mellitus in adults, adolescents and children aged 1 year and above. Trurapi is not licensed for children under 1 year old (exclusion).
- For any patients where switching to either the first line alternative Trurapi®, or to an alternative NovoRapid® preparation (pre-filled FlexPen or cartridge) as the second line option, is not suitable please seek advice from the patient’s specialist diabetes team for advice on alternatives.
- Fiasp®, a newer formulation of the insulin aspart product NovoRapid®, is not listed as an alternative in the national advice in the MSN. **Please note that Fiasp® and NovoRapid are not interchangeable due to differences in bioavailability; Fiasp® has a quicker onset of action and shorter duration. Therefore, a switch to this product is not recommended without specialist input.**

Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: kmicb.medicinesoptimisation@nhs.net

Preparations & Dosing

- Trurapi® is available as:
 - 100units/ml solution for injection in 3ml pre-filled **SoloStar® pens**
 - NovoRapid® FlexTouch® pen delivers 1 to 80 units in 1-unit increments
 - Trurapi® in pre-filled pen delivers 1 to 80 units in 1-unit increments.
 - 100units/ml 3ml **cartridges**, designated to be used in the following pens available in the UK:
 - AllStar® PRO, delivers 1 to 80 units in 1-unit dose increments
 - JuniorSTAR®, delivers 1 to 30 units in 0.5-unit dose increments.
- Both pens and cartridges remain available and can support a full increase in demand.
- **When switching between NovoRapid® and Trurapi® it is a unit:unit conversion, i.e. prescribe a 1:1 dose.**

Monitoring

- As a precaution, advise closer monitoring of blood glucose levels required initially, and dose may need to be adjusted if required (see supporting information in MSN).
- In the event of concerns with new glucose excursions (high or low glucose readings), the patient should be advised to seek advice from their specialist diabetes team.

Counselling

- When switching a patient's insulin, ensure that the patient is informed of the reason for the switch, provided with appropriate counselling, education and training to ensure they can use the new device correctly and administer the correct dose, considering manual dexterity, vision, and whether additional support is required for administration (see supporting information in MSN).

Local Resources

Local "[Kent and Medway Guidance on Biosimilar Insulin Prescribing](#)" and "[Kent and Medway Guidance on Safe Insulin Prescribing](#)" summarise the biosimilar insulins available currently in the UK and can support healthcare professionals, within different healthcare settings, engaged in the care of patients with diabetes/using insulin, in the safe and appropriate prescribing and dispensing of insulins and biosimilar insulins (these documents can also be found on all local formulary websites).

HCP Specific Newsletter Updates – East Kent

Reminder for East Kent Practices - Oral Morphine Prescribing Resources

The East Kent primary care formulary ([here](#)) hosts a number of resources to support safe prescribing of oral morphine:

[morphine-liquid-appropriate-use-guidance.pdf](#)

[prescribing-liquid-morphine-position-statement.pdf](#)

[actimorph-gp-printout-004-upload-21feb2023.pdf](#)

Actimorph orodispersible tablets are on formulary in NHS Kent and Medway. East Kent Hospitals will be starting to use this preparation from mid November 2024. Prescribers, please familiarise yourself with this preparation and the resources above.

Every effort is made to ensure that the information contained in this newsletter is accurate and up to date at the time of publication. Please be aware that information about medicines and therapeutics will change over time, and that information may not be current after the initial date of publication. Please take note of the publication date and seek further advice if in any doubt about the accuracy of the information. The information contained in this newsletter is the best available from the resources at our disposal at the time. Acronyms used are standard formulary. This newsletter is produced by the NHS Kent and Medway Medicines Optimisation Team on behalf of the Kent & Medway ICB. For all correspondence including any queries, please contact the Medicines Optimisation team email: kmicb.medicinesoptimisation@nhs.net