Medicines Optimisation and Pharmacy update

Please find below some of current issues regards community pharmacies and medicines stock supplies. Also, included are some of the FAQ being raised locally and nationally regarding medication and pharmacy issues.

Community pharmacy

Please be aware of the very high demand, in community pharmacies, for face to face and telephone consultations, for deliveries and for OTC medicines. Community pharmacies are advised to reinforce the message with patients that they should not stock pile any medicines as this might exacerbate the situation.

If under significant pressure, at the discretion of the responsible pharmacist, pharmacies may close their doors to the public for up to 2.5 hours a day, including lunch.

Further guidance on community pharmacy including information on new ways of working and home deliveries can be found in the Standard Operating Procedure for Community Pharmacy which was published on Sunday 22 March.

Electronic repeat dispensing

General practices have been asked to consider putting all suitable patients on electronic repeat dispensing as their next repeat prescriptions are issued. More information on electronic repeat dispensing can be found here: https://digital.nhs.uk/services/electronic-prescription-service/electronic-repeat-dispensing-for-prescribers

Prescription duration

Longer duration prescriptions should not be issued by GPs at this time to protect the supply chain. **We strongly recommend 28 days' supply of medication for ALL prescriptions requests.**

Requests for COPD Rescue packs

At present you are asked not to change current guidance. DO NOT issue rescue medication for patients that do not fit normal national guidance. Before issuing rescue medication it is imperative that the patient has a self-management plan, and fully understands when rescue therapy is required. Over use of antibiotics at this critical time would not adhere to Anti-microbial stewardship guidance. Following a viral infective exacerbation, due to COVID 19, there is an additional risk of bacterial super-infection, approximately 10-14 days later. This may then necessitate a course of antibiotic treatment. This guidance is in agreement with the respiratory consultants at MFT.

https://cks.nice.org.uk/chronic-obstructive-pulmonary-disease
http://www.medwayswaleformulary.co.uk/media/1163/medway-swale-copd-guidelines-final-2018-updated-160818.pdf

Requests for salbutamol inhalers

When considering supplying a salbutamol inhaler for a patient with COPD or Asthma, who has not requested an inhaler for some time, you should consider clinical appropriateness. Although initially, local consultants felt that salbutamol inhalers were unlikely to harm a patient with COVID symptoms or otherwise, we now need to consider the stress this may cause for the supply chain. We would now recommend that you follow National guidance when prescribing SABA inhalers, and if necessary an appropriate clinician should consider a clinical assessment. This assessment could be over the telephone where patients could be asked why they feel they need the inhaler, and what symptoms they currently have. The dry cough associated with COVID is unlikely to be relieved by a salbutamol inhaler. If salbutamol supply is deemed necessary we would advise one inhaler at a time only. Patients with asthma should continue to use their inhaled corticosteroids, despite the media advice that corticosteroids are not indicated for COVID. Failure to do so could result in an acute exacerbation.

https://cks.nice.org.uk/asthma
https://ginasthma.org/recommendations-for-inhaled-asthma-controller-medications/

NSAIDS

New interim guidance on the use of NSAIDs to relieve COVID-19 symptoms is now available and a CAS alert was issued on 17 March:
www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103001

Paracetamol is the preferred treatment pending a rapid review of the evidence. Those patients prescribed NSAIDs for other conditions should continue as normal unless advised otherwise by their doctor

Medication stock situation update – 23/03/20
ICS inhalers:

Brand	Drug	Type	Supply	Alternative
Clenil	Beclomethasone	MDI	Out of stock, stock expected end of April	**1st line – Soprobec 2nd line – Kelhale** See notes below
Qvar	Beclomethasone	MDI (extrafine)	Awaiting confirmation	
Soprobec	Beclomethasone	MDI	Stock freely available, AAH will be fully stocked within the next couple of days. If showing o/s stock will be on its way	
Kelhale	Beclomethasone	MDI (extrafine)	Stock freely available from AAH, Alliance and Phoenix.	
Easyhaler Beclomethasone	Beclomethasone	DPI	Stock freely available	
Easyhaler Budesonide	Budesonide	DPI	Stock freely available	
Pulmicort	Budesonide	DPI	Awaiting confirmation	
Budelin	Budesonide	DPI	Cartridges out of stock, cartridge with device in stock, but only small supplies available	
Alvesco	Ciclesonide		Many depots stock freely available. 2 depots lower levels of stock	
Flixotide	Fluitcasone	MDI and DPI	Stock freely available	
Asmanex	Mometasone	DPI	Out of stock, due mid April	**No alternative, consider other ICS options of equivalent dose**

Action – Re; Clenil
1st line;
The most suitable alternative to Clenil inhalers, due to the current out of stock situation, would be Soprabec. This is dose equivalent to Clenil, and the device has the same design and functioning. Stock is currently freely available. Soprabec is also 25% cheaper than Clenil.
2nd line;
If Qvar inhalers were to go out of stock, Kelhale would be the most suitable alternatives (as it is an extra fine particle inhaler). Kelhale is produced as an MDI but unlike Qvar, does not have an easi-breathe format. These patients would need to be considered separately, and if inspiratory flow allows (and dose equivalent).

Table 1 ICS dosages for adults aged 17 years and over

	Low dose	Moderate dose	High dose
Beclometasone dipropionate[1]			
Standard particle CFC-free inhalers	200–500 micrograms per day in 2 divided doses	600–1,000 micrograms per day in 2 divided doses	1,200–2,000 micrograms per day in 2 divided doses
Extra-fine particle CFC-free inhalers[2]	100–200 micrograms per day in 2 divided doses	300–400 micrograms per day in 2 divided doses	500–800 micrograms per day in 2 divided doses
Budesonide			
Dry powder inhalers	200–400 micrograms per day as a single dose or in 2 divided doses	600–800 micrograms per day as a single dose or in 2 divided doses	1,000–1,600 micrograms per day in 2 divided doses
Ciclesonide			
Metered dose inhaler	80–160 micrograms per day as a single dose	240–320 micrograms per day as a single dose or in 2 divided doses	400–640 micrograms per day in 2 divided doses
Fluticasone propionate			
Metered dose and dry powder inhalers[3]	100–250 micrograms per day in 2 divided doses	300–500 micrograms per day in 2 divided doses	600–1,000 micrograms per day in 2 divided doses
Fluticasone furoate[4]			
Dry powder inhaler	–	100 micrograms as a single daily dose	200 micrograms as a single daily dose
Mometasone furoate			
Dry powder inhaler	200 micrograms per day as a single dose a day	400 micrograms per day in 2 divided doses	Up to 800 micrograms per day in 2 divided doses

[1] CFC-containing beclometasone dipropionate MDIs are no longer available, so are not included. The MHRA advises that beclometasone dipropionate CFC-free inhalers should be prescribed by brand name (Drug safety update, July 2008).

NHS England Frequently asked questions:

1. *Sudden cessation of compliance aid filling by community pharmacy - advice and contractual status?*

   Business continuity is a real issue in community pharmacy as the demand for their services is exceptional right now, and this has been escalated up

2. *Supply chain for end of life drugs - demand is high already as people anticipate the worst*

   Supply chain is being bolstered by increased manufacturing and a restriction on exporting. People should not stockpile or prescribe for patients that they would not have done normally. Good anticipatory prescribing guidance still stands. The supply chain will not cope with a sudden inappropriate surge in demand. Challenge any suggestions of 'blanket prescribing' of end of life medication (reference the Report of the Gosport panel)

4. *CEBM has issued guidance advocating 'Just in case prescribing of antibiotics' - stress on supply chain and pharmacy, appropriate?*

   From here - https://www.cebm.net/rapidly-managing-pneumonia-in-older-people-during-a-pandemic/. Concerns have been escalated up

5. *Basic inhalers now in short supply, supply chain not coping*

The supply chain will not cope with a sudden inappropriate surge in demand. Inappropriate requests need to be challenged and concerns have been escalated up

6. *Trusts discharging patients on specialist drugs with no support for GP (GST NHSFT)*

   Specific examples will need to be taken up with the Trust, please send more detail to us?

7. *DOAC changes - could the supply chain really cope? (500k people on warfarin), need for INR checks when switching.*

   The supply chain will not cope with a sudden inappropriate surge in demand. This has been escalated up

8. *Supporting community pharmacy as clearly business continuity is fragile*

   Business continuity is a real issue in community pharmacy as the demand for their services is exceptional right now. Primary care cell working on this.

9. *Issues for vulnerable substance misuse patients as prescribing and dispensing services struggle at this time.*

   Substance misuse providers and commissioners issuing guidance for patients and pharmacies now.

10. *Patients requesting medication they have not had for a long time.*

    Inappropriate requests need to be challenged and concerns have been escalated up.

11. *How to move patients to on-line ordering at scale - GDPR issues?*

    The NHS app is a way for patients to register for on-line services without needing the practice to set this up for them
    https://www.nhs.uk/using-the-nhs/nhs-services/the-nhs-app/
    https://digital.nhs.uk/services/nhs-app/prepare-your-practice-for-connection-to-the-nhs-app/information-for-staff-on-the-nhs-app

(locally within Medway and Swale the Medicines Optimisations teams will be building on the work already done regards eRD and supporting practices, where possible, to increase their eRD rates)

12. *Demand for medication causing prescription ordering hubs to struggle.*

    Inappropriate requests need to be challenged but has been escalated up