IMPACT

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Pregabalin & Gabapentin – Dose Rationalisation

In August 2017 Pfizer lost their patent for their brand of pregabalin, Lyrica® and the local response to switch to generic prescribing has been excellent – thank you. It is therefore disappointing that there has only been a very small price reduction of pregabalin in the Scottish Drug Tariff. This has put significant cost pressure on the prescribing budget within Primary Care. Whilst it is still hoped that the tariff price will reduce we can also do other things to ensure that where pregabalin is prescribed it is done in the most cost effective manner possible.

Pregabalin is currently flat priced – this means that all pregabalin strengths are priced at the same cost per capsule. All strengths cost 80.5p per capsule. As a result it is therefore more cost effective to prescribe pregabalin twice daily rather than the same total daily dose given in three divided doses. The SPC for Lyrica® states that pregabalin has been studied in controlled clinical trials with twice a day dosing and three times a day dosing. Overall, the safety and efficacy profiles for twice a day and three times a day dosing regimens were similar.

Pregabalin Total daily dose	**Option 1 Cost per month £45.08***	Option 2 Cost per month £67.62*
150mg	**75mg twice daily**	50mg three times daily
300mg	**150mg twice daily**	100mg three times daily
600mg	**300mg twice daily**	200mg three times daily

*Prices obtained from the Scottish Drug Tarriff Part 7 – January 2018.

In the examples above the saving equates to £270 per patient per year.
Prescribers are therefore requested to review all patients currently prescribed a three times daily dose of pregabalin and, where possible, switch the patient to the more cost effective, twice daily dosing schedule. Note: Patients should also be reviewed considering any risks and co-morbidities as described overleaf.

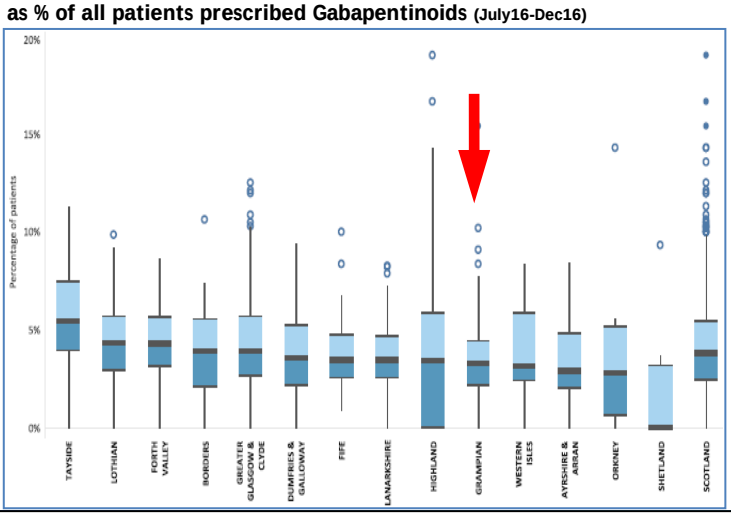
Gabapentin has a different pricing structure. However, there are still opportunities for cost effective gabapentin prescribing through the use of 100mg capsules in preference to other strengths of gabapentin.

Gabapentin	**Cost per 100 tab/cap***	**Cost per tab/cap**	**Cost per '100mg'**
100mg capsules	£1.91	2p	2p
300mg capsules	£13.95	14p	4.7p
400mg capsules	£12.00	12p	3p
600mg tablets	£8.72	8.7p	1.4p
800mg tablets	£30.68	30.7p	3.8p

Gabapentin 300mg prescribed as 3 x 100mg capsules is more cost effective than 1 x 300mg capsule. The 100mg strength capsules should be used in preference to other strengths for initial titration. It is also more cost effective to prescribe 2 x 400mg capsules than 1 x 800mg tablet. ScriptSwitch will be used to highlight cost effective prescribing of pregabalin and gabapentin.

Pregabalin & Gabapentin – Licensed Maximum Daily Doses

No. Patients Prescribed More than Maximal Dose (>2DDDs) Gabapentinoids as % of all patients prescribed Gabapentinoids (July16-Dec16)



In Grampian approximately 1 in 25 patients appear to be prescribed doses of gabapentinoids greater that the licensed maximum.
Pregabalin maximum 600mg daily
Gabapentin maximum 3.6g daily
(neuropathic pain).

This is a patient safety issue. It is essential to ensure the prescribed (and taken) dose is within the therapeutic licensed range.
Prescribers are requested to review all patients on higher than licensed doses and reduce this slowly. Treatment should be reviewed regularly and discontinued, slowly, if ineffective.

Gabapentinoids – Prescribing Risks

The use of gabapentin in combination with opioids has been linked to respiratory depression. MHRA recently published Gabapentin (Neurontin):risk of severe respiratory depression. This document highlights the risks of gabapentin causing CNS depression, including respiratory depression **even without** concomitant opioid therapy.
Healthcare professionals are advised to consider whether dose adjustments are necessary in patients at higher risk of respiratory depression, including the elderly, patients with compromised respiratory function, respiratory or neurological disease or renal impairment and those taking other CNS depressants.

The combination of gabapentin and opioids should ideally be avoided. Where gabapentinoids are being introduced to patients on opioid treatment, this should be undertaken with lower doses and slow titration in order to monitor for signs of CNS depression, e.g. increased sedation.

As highlighted previously the increasing use of gabapentinoids continues to be a concerning trend with evidence highlighting the abuse potential and diversion risk of these drugs, particularly in the substance misuse patient population. There are also concerns regarding the implications of gabapentinoids as a factor in drug related deaths across Scotland, including Grampian. In addition, higher doses are likely to have a higher street value where supplies are diverted. All prescribers are recommended to remain vigilant when prescribing these products, ensuring appropriate clinical review. It is also important that for patients accessing specialist services, e.g. SMS/GP that there are robust communication arrangements regarding drugs being prescribed to minimise risks. In cases of concern doses should be reduced and consideration given to daily or weekly dispensing intervals.

Careful consideration should be given before prescribing pregabalin or gabapentin in patients with a history of substance misuse, co-prescribed an opioid or in those at higher risk of CNS/respiratory depression, with treatment being reviewed regularly.

There is a current Home Office consultation seeking views on whether, and how, to schedule pregabalin and gabapentin under the Misuse of Drugs Regulations 2001. This follows the recommendation by the Advisory Council on the Misuse of Drugs (ACMD) that these drugs should be controlled as Class C drugs under the Misuse of Drugs Act 1971 ('the 1971 Act') and placed in Schedule 3 to the Misuse of Drugs Regulations 2001. The outcome of this consultation and implications for prescribing will be shared with prescribers when concluded during 2018.

Good Prescribing Guide – Primary Care

The Good Prescribing Guide – Primary Care has recently been reviewed and updated.

This document is intended for use by primary care prescribers and all pharmacists. It is an excellent resource to support good prescribing practice. This document provides guidance on practical ways in which prescribers can help the NHS to meet the challenges of optimising medicine use and maximising cost efficiencies.

The document contains a range of useful information for all members of the GP practice team including:

- Sources of prescribing support, e.g. apps, websites, formulary.
- Aspects of prescribing in Primary care, e.g. prescribing quantities, intervals, travellers, emergencies.
- Medication review guidance, e.g. polypharmacy, medicines reconciliation.
- Stock order forms (GP10A), e.g. appropriate stock order items.

Maalox – Formulation Change

In August 2017, Maalox® oral suspension (195mg magnesium/220mg aluminium per 5mL; 500mL pack) was discontinued and replaced by an oral suspension containing 200mg magnesium and 175mg aluminium per 5mL in a 250mL pack. The reason for the reformulation was to remove parabens and replace the preservative system in the product, and to standardise the formulation across Europe. The new formulation has a 6 month shelf-life once opened.

Mucogel® and Maalox®, as co-magaldrox 195/220, are currently included on formulary, and in the local guidance for the management of hypomagnesaemia in adults. Compared to the previous formulation the new Maalox® formulation has a marginally different magnesium and aluminium content, but in a smaller pack size (with only a marginal drop in price). The dose has remained the same, resulting in the price per dose of Maalox® increasing by about 40%. It is now approximately 1.6 times more expensive than Mucogel®.

Mucogel® (co-magaldrox 195/220) is now regarded as the first-choice simple antacid. ScriptSwitch will be used to highlight prescribing by brand, Mucogel®. The hypomagnesaemia policy and the formulary will be updated to reflect this change.

NHS Grampian Joint Wound Care Formulary

The NHSG Joint Wound Care Formulary has been updated. The Quick Reference Guide and Primary Care Order Form were updated November 2017. The Quick Reference Guide is designed to support choice of the most appropriate type and size of dressings. Please note first and second choice options. Also note recommendations for acute service/PECOS orders only or Primary Care prescribing only options.