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**Medicines Optimisation Newsletter**

**[August 2024] (Issue No. 61)**

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**Kent and Medway ICB Updates**

**Ongoing GLP-1 RA Supply Issues – Quantities and Incidents**

An updated medicine supply notification (MSN) for the management of the national supply issues of glucagon-like peptide-1 receptor agonists (GLP-1 RAs) used in the management of type 2 diabetes was released on the 18th of March 2024.  The MSN, accompanying clinical guidance from the ABCD/PCDS, and a supplementary local update and flowchart from Kent and Medway have been circulated to practices previously as well as being included in the June 2024 MO newsletter. The [Specialist Pharmacy Service (SPS) medicines supply tool](https://www.sps.nhs.uk/shortages/shortage-of-glp-1-receptor-agonists-semaglutide-dulaglutide-liraglutide-exenatide/) has the contents of the MSN, advice on how to manage supply and should be used for **up-to-date information on supply** for individual GLP-1 RAs (free subscription required).

**Please continue to ensure that all staff, especially those involved in the management of diabetes and prescribing, continue to follow the national actions and guidance within the MSN** to manage adult patients with type 2 diabetes who are on GLP-1 RAs, whilst the **supply issues continue until the end of 2024**.

* **Quantities:**

We would like to remind colleagues **not to prescribe more than one month’s supply** of GLP-1 RAs and Mounjaro® (tirzepatide) for patients as per national advice in the MSN. Also, as per the MSN, **do not double up a lower dose preparation** where a higher dose preparation of a GLP-1 RA is not available.

* **Incidents:**

In response to managing supply issues, patients may have been appropriately switched to an alternative GLP-1 RA. However, a small number of patients have been **incorrectly prescribed and issued** **both** their existing GLP-1 RA as well as the new GLP-1 RA. Such **incidents** have involved both of the following: multiple injectable forms of GLP-1 RAs being prescribed/issued, or different formulations being prescribed/issued (e.g. one injectable GLP-1 RA and one oral (tablet) GLP-1 RA).

These **errors** could inadvertently lead to patients using/administering two different GLP-1 RAs which could potentially cause patient harm. To **avoid this potential therapeutic duplication**, when switching patients to a new GLP-1 RA, please ensure the patients’ medication records are **updated** so that patients are **not inadvertently prescribed and issued two GLP-1 RAs.**

**FreeStyle Libre 3**

**FreeStyle Libre 3 is for “hospital only” prescribing as per the Kent and Medway formularies.** We would like to remind colleagues that although FreeStyle Libre 3 is available in the drug tariff and is available for prescribing on FP10 prescriptions, **practices are asked not to prescribe this item.**

The integration of FreeStyle Libre 3 aligns with the [NICE technology appraisal on hybrid closed loop technology](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.nice.org.uk%2Fguidance%2Fta943&data=05%7C02%7Cj.hardwick-smith%40nhs.net%7Cfe4f6aafa2694b81f5cd08dc12a46cfc%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638405744599594452%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=eUC3mN3uN0NnmGjlcSmUVnzklg7BAcXk6JSgX8LDZho%3D&reserved=0). This is part of a comprehensive 5-year rollout plan currently under development in collaboration with specialists and guidance from NHS England.

Further details regarding its prescribing position will be disseminated post-approval through ICB governance processes and pathway development.

**Clozapine Fact Sheet for Primary Care Clinicians**

We would like to remind colleagues that **clozapine should not be prescribed in primary care,** it is classed as a RED drug which means it must **only be prescribed by secondary care mental health services.**

Please find a Clozapine Fact Sheet for Primary Care Clinicians, produced by Kent and Medway NHS and Social Care Partnership Trust, attached below:



**An Update on Metolazone (Xaqua®) Prescribing in Kent and Medway ICB**

Historically, metolazone was only available in the UK as an unlicensed medicine. Metolazone is now available as a licensed medicine under the brand name: **Xaqua® 5mg Tablets** (Renascience Pharma).

In January 2023, the Medicines and Healthcare products Regulatory Agency (MHRA) issued a drug safety alert cautioning the switching of Metolazone brands without specialist input due to bioavailability concerns [(Xaqua MHRA Alert)](https://www.gov.uk/drug-safety-update/xaqua-metolazone-5mg-tablets-exercise-caution-when-switching-patients-between-metolazone-preparations).

There are key safety concerns around significant variation in bioavailability between alternative preparations of Metolazone. **The bioavailability of Xaqua® is approximately two-fold greater than unlicensed/generic forms of metolazone.**

**IMOC outcomes**

Following the June IMOC governance process the decision was made to update the formulary status of metolazone across Kent and Medway ICB to **specialist initiation**.

In addition, a position statement was recently released that states metolazone should always be prescribed by the preferred licensed brand, Xaqua® across Kent and Medway ICB.

* New patients starting metolazone should be initiated on Xaqua® and at any points of transfer of care this should be clearly documented.
* Patients currently on metolazone need to be safely switched to Xaqua® by their specialist service in a secondary care or community setting and subsequent prescriptions should be brand specific- at any points of transfer of care this should be clearly requested and documented.



**Information for patients**

A patient information leaflet (PIL) has been created by Kent and Medway ICB to assist your patients with the change to the Xaqua® brand. The patient should only get this PIL from their clinician during the prescribing process once they have safely switched from generic metolazone to Xaqua®. As a result, this will confirm to the community pharmacies or dispensing practices that the patient has been switched to Xaqua® safely.



**Xaqua® Ordering Process for Community Pharmacies and GP dispensing practices**

**Warning:** Please check the prescription states Xaqua®, confirm with the patient that they have been safely switched to Xaqua® and been provided with a patient information leaflet.

**Please Note:** The preferred route for ordering Xaqua® is via Oxford Pharmacy Stores as other wholesalers list Xaqua® as a special.

Xaqua® is supplied via two main wholesalers Oxford Pharmacy Stores and Alliance Healthcare.

**Oxford Pharmacy Stores**

|  |  |  |  |
| --- | --- | --- | --- |
| **Xaqua® 5mg Tablets (Metolazone)**  **Pack size: 20 Tablets** (divisible as 2.5mg [half tablet] or 5mg [whole tablet] strength) | | | |
| Order via: | Telephone | Fax | Email: |
| 01865 904 141 | 01865 337 550 | ops.orders@oxfordhealth.nhs.uk |
| Catalogue number: | Xaqua® 5mg Tablets (Metolazone) – XAQ001 | | |
| PIP code: | 4222402 | | |
| EAN code: | 5060512180053 | | |

**Alliance Healthcare**

Alliance customers are advised to order the product via its specials number Telephone: 0344 854 4998; Email: specials.orders@alliance-healthcare.co.uk Fax: 0845 051 877.

The choice to have Xaqua® supplied via this team as a specialist product is purely an Alliance Healthcare decision.



**National Updates**

**OpenPrescribing Webinar for Primary Care Teams**

OpenPrescribing is holding a webinar on **Monday, September 16, 2024,** for healthcare professionals who work in general practice (GP) practices or across Primary Care Networks. **The webinar will support GP practices in accessing their practice data for the new Kent & Medway Medicines Quality, Innovation, Productivity and Prevention (M.QIPP) scheme.** The webinar will cover how OpenPrescribing measures and tools can help analyse prescribing variation, monitor trends and identify potential cost-saving opportunities.

Register for the session using the link below:

* [16/09/2024 13:00-14:00 - Register here](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fevents.teams.microsoft.com%2Fevent%2Fa61372c6-e476-45da-be86-685a1c1b89be%40cc95de1b-97f5-4f93-b4ba-fe68b852cf91&data=05%7C02%7Cj.hardwick-smith%40nhs.net%7C7a1f33fb9d3546c0f79f08dcbd08c1f5%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638593092533370922%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=nh9SVp9ZXF2tEiswqPY57kSnCuc%2FKoetM%2FA%2Fcld2Nbo%3D&reserved=0)

**Polypharmacy: Medicines and the Risk of Falls in Older People Lunchtime Masterclass**

The Health Innovation Network National Polypharmacy Programme is running a series of lunchtime masterclasses with the next one on **10 October 2024, 12-1:30pm** looking at Medicines and the risk of falls in older people.

The series is open to GPs, Pharmacists, Nurse prescribers and other interested health professionals. [**Book your free place.**](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fevents.weahsn.net%2FPolypharmacyMedicinesandtheRiskofFallsinOlderPeopleLunchtimeMasterclass&data=05%7C02%7Cj.hardwick-smith%40nhs.net%7C62567c0d1f6144b7741608dcc38bc89f%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638600252332983986%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=lb5OresLTnI9ljDZoXXsQu2374AAjSic6BTAeDeENf8%3D&reserved=0)

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**MHRA Drug Safety Update – July 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 July Drug Safety Update includes:**

* [**Epimax Ointment and Epimax Paraffin-Free Ointment: reports of ocular surface toxicity and ocular chemical injury - GOV.UK (www.gov.uk)**](https://www.gov.uk/drug-safety-update/epimax-ointment-and-epimax-paraffin-free-ointment-reports-of-ocular-surface-toxicity-and-ocular-chemical-injury)

Epimax Ointment and Epimax Paraffin-Free Ointment can harm the eyes if used on the face. Do not prescribe these ointments for use on the face. Tell patients to wash their hands and avoid touching their eyes after using these products.

* [**Letters and medicine recalls sent to healthcare professionals in June 2024 - GOV.UK (www.gov.uk)**](https://www.gov.uk/drug-safety-update/letters-and-medicine-recalls-sent-to-healthcare-professionals-in-june-2024)

**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)**](https://www.cas.mhra.gov.uk/Home.aspx)

* 26.07.24 [Shortage of Kay-Cee-L (potassium chloride 375mg/5ml) (potassium chloride 5mmol/5ml) syrup](https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103254)
* 30.07.24 [Shortage of Human Albumin 4.5% and 5% dose vials](https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103255)

**NICE News – August 2024**

Please find the NICE News for August 2024 attached below:



**Shortages**

**Specialist Pharmacy Service (SPS) support for medicines shortages - PERT**

[**Prescribing and ordering available pancreatic enzyme replacement therapies**](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fspecialistpharmacyservice.cmail19.com%2Ft%2Fj-l-gjktkx-juqpjuyk-n%2F&data=05%7C02%7Cj.hardwick-smith%40nhs.net%7Ce93c1de7537a43a61d7008dcb2dc7373%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638581907126420623%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=6LEvRpJwv30JZr%2B1AK%2BgKBbVbpMbR0HjXQ1146NByaQ%3D&reserved=0)

(Last updated 26 July 2024)

**Updates:**

* Updated advice on switching between products for adults and children -  link to a new [mini-tool](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fspecialistpharmacyservice.cmail19.com%2Ft%2Fj-l-gjktkx-juqpjuyk-p%2F&data=05%7C02%7Cj.hardwick-smith%40nhs.net%7Ce93c1de7537a43a61d7008dcb2dc7373%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638581907126427605%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=NvHzqlPvPdGL50dt4vscBQXXiIma6AWa%2FW8T8Nog5TQ%3D&reserved=0) to help identify equivalences and alternatives.
* Clinigen added as provider of unlicensed PERTs.

**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](https://www.sps.nhs.uk/home/tools/medicines-supply-tool/) 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](https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/serious-shortage-protocols-ssps).