The Interface Formulary For Adults

An introduction

The purpose of the formulary is to promote rational, safe and cost-effective prescribing and to help promote seamless care at the primary-secondary care interface. This formulary has been developed by the Formulary Working Group, which has medical and pharmaceutical representation from Heart of England NHS Foundation Trust, Birmingham Cross City CCG, Solihull CCG and South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group.

Prescribers can nominate a preparation for consideration by the Formulary Working Group via

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The content of the formulary reflects **nationally recognised evidence** or consensus opinion at the time of compilation. Evidence or opinion may change over time and it is the responsibility of the prescriber to ensure that new evidence or national guidelines are taken into account in their prescribing. The individual prescriber remains responsible for the patient's care and the prescription written.

The formulary will be updated to reflect additions, removals or other changes **approximately** every 3 months. Any **changes will be documented from page 3 for easy reference.**

The Traffic Light System The medicines included in the formulary have been classified using a traffic light system.

Green	These preparations are prescribable within primary and secondary care and are considered first line
Yellow	These preparations are prescribable within primary and secondary care and are considered as either second line **or** they are restricted in some other way e.g. the use may be unlicensed/off label. Where a restriction applies, it is stated in the additional information section.
Double Yellow	These preparations are prescribable within primary and secondary care and however their use is **further restricted.** – Restrictions are stated in the additional information section. In addition to the restrictions, medicines in this column may require an **ESCA** (Effective Shared Care Agreement) or a **RICaD** (Rationale for Initiation, Continuation and Discontinuation)to be completed before prescribing can be undertaken in Primary care. ESCAs and RICaDs are developed via collaboration between the Formulary Working Group and the relevant specialists.
Red	These drugs are for specialist use only. They should not be prescribed in primary care unless by a "GP with special interest"

Funding in Primary Care

Inclusion within the green, yellow or double yellow columns implies that funding from primary care prescribing budgets has been agreed, provided prescribing lies within any stated restrictions (e.g. within documented shared care agreements)

Additional Information

Where £, ££ or £££ is shown, this indicates a greater cost when compared to similar medicines used for identical indications.

Some preparations have been assessed by the Formulary Working Group as suitable for prescribing in primary care following

Specialist initiation	Preparation deemed appropriate for the patient by the specialist, for which the patient receives an initial prescription from the specialist.
Specialist recommendation	Preparation deemed appropriate for the patient by the specialist. The specialist provides the GP with a formal letter in support of the recommendation. Provision of a "HEFT pink recommendation slip" alone is not acceptable.

Links

The formulary has many links to online resources throughout the document; these can be accessed by either clicking on the link OR clicking on the link whilst holding down your control (ctrl) key.

Searches

You can search for text by selecting ***Find*** from the ***Formulary*** menu in the menu bar above and typing what you want to search for
This formulary should be used in conjunction with the BNF and additional prescribing information should be obtained from the Summary of Product Characteristics.

Recent Changes to the formulary

This section details the outcome of applications made to the Formulary Working Group (FWG) over an approximate rolling two year period.

Date	Consideration	Outcome
April 2011	Logynon ®	APPENDIX– for women already established on Logynon ® or who wish to return to Logynin® following a break from OCP New Patients should not be offered Logynin ®
April 2011	Pravastatin	MOVED – now YELLOW was previously Double yellow
April 2011	Saxagliptin	YELLOW - Saxagliptin is the first "gliptin" to have gained a licence for the management of type 2 diabetes in patients with moderate to severe renal impairment,
April 2011	Vildagliptin	MOVED TO APPENDIX – existing patients only
May 2011	Tapentadol	DECLINED • It is not appropriate for primary care to initiate tapentadol. Switching therapy to tapentadol is not straightforward • The level of detail in studies is not sufficient to assess the comparative use of laxatives across the treatment arms, making it difficult to assess the overall balance of pain relief and adverse effects, and any additional costs associated with laxative prescribing • GPs have experience of using oxycodone (originating in Palliative care) and are familiar with its pros and cons
May 2011	Midodrine (unlicensed)	RED – For initiation and maintenance in secondary care only. GPs must not be asked to prescribe midodrine
May 2011	Elleste and Evorel range	Green - Approved as 1st line options for women when started by HEFT immediately post hysterectomy.
May 2011	Dapsone	Double Yellow – with ESCA
June 2011	Nuvaring ®	APPENDIX – for women already established on Nuvaring ® or who wish to return to Nuvaring® following a break from OCP. New patients should not be offered Nuvaring ®
June 2011	Qlaira ®	APPENDIX– for women already established on Qlaira ® or who wish to return to Qlaira® following a break from OCP New Patients should not be offered Qlaira®
June 2011	Danazol	RED – Hereditary angioedema - off label as an unlicensed indication Double yellow – specialist recommendation -Severe pain and tenderness in benign fibrocystic breast disease not responding to other treatment .

Date	Consideration	Outcome
June 2011	Stanozolol	RED – Hereditary angioedema - this is an unlicensed product. GPs must not be asked to prescribe this product
June 2011	Aluminium acetate 13% ear drops	RED – Unlicensed product for use by ENT only. GPs must not be asked to prescribe this product.
June 2011	TauroLock 500 ®	RED – This is a CE marked medical device. For use in home TPN patients only, GPs must not be asked to prescribe this product
June 2011	Trichloroacetic acid 90%	RED – Dermatology directorate only for the treatment of xanthelasma
June 2011	Emla cream	Green
June 2011	Ametop gel	Green
June 2011	Clomipramine	APPENDIX – Existing patients only
June 2011	Acamprosate	Double Yellow – Specialist initiation
June 2011	Testosterone undecanoate capsules	Double Yellow – specialist initiation. Dr Dyer's team only
June 2011	Flutamide	Double yellow with ESCA
June 2011	Otovent balloons	Double Yellow – Spec recommendation
June 2011	Lacosamide	Double yellow – Specialist initiation and stabilization with ESCA
June 2011	Hyoscine patch	Yellow
June 2011	Hyoscine hydrobromide tablets	Yellow
June 2011	Roflumilast	DECLINED – SMC = The manufacturer did not present a sufficiently robust economic analysis to gain acceptance by SMC. MTRAC = can not be recommended for prescribing because of inadequate evidence of efficacy and /or safety.
June 2011	Sodium hyaluronate	DECLINED – 1.4.4.2 NICE CG 59 intra-articular injections of hyaluranon injections are not recommended for the treatment of osteoarthritis.
June 2011	Combodart ®	DECLINED – The Interface Formulary places finasteride as the first line treatment. The Interface Formulary rarely includes combination oral products. Combodart ® is less cost effective than using first line treatment and tamsulosin as separate agents.
June 2011	Capsaicin 8% patch	RED – For prescribing to a maximum of 10 patients by the Pain Team only for use strictly in accordance with licence.
June 2011	Romiplostim	RED – For use in Oncology and Haematology strictly in accordance with NICE TA 221
June 2011	Corticorelin	RED – For use as a diagnostic agent
July 2011	Tapentadol	DECLINED – The level of detail in studies is not sufficient to assess the comparative use of laxatives across the treatment arms, making it difficult to assess the overall balance of pain relief and adverse effects, and any additional costs associated with laxative prescribing

Date	Consideration	Outcome
July 2011	Indacaterol	DECLINED - Available evidence proves non inferiority only, Long term patient follow up data is not “good”.The quicker onset of action of indacaterol is not thought to be advantageous as this is a maintenance therapy. There is a narrow licence for indacaterol as COPD only. FWG aim to keep the formulary simple. To this end having multiple options in each drug class is not desirable.
July 2011	Sativex	DECLINED - The balance of evidence between benefits and side effects does not support its introduction to the formulary. MTRAC verdict = cannot be recommended for prescribing because of inadequate evidence for efficacy and/or safety. SMC = Not Recommended
July 2011	Fesoterodine	DECLINED - The side effects of fesoterodine fumarate are similar to those of other related medicines; it is as effective and costs the same as Tolterodine.The patent on Tolterodine will shortly expire. Continued use of Tolterodine after this point will offer a cost saving.
July 2011	Lacosamide	Double Yellow – Specialist recommendation (Usually from UHB)
August 2011	Phlexy-Vits sachets	RED - To be used for adult patients, in accordance with NICE CG 32 and HEFT Guidelines for the Prevention & Management of Refeeding Syndrome (March 2008) on the recommendation of HEFT Clinical Nutrition team
August 2011	Artesunate	RED - Treatment of severe falciparium malaria, an alternative to i/v quinine.
September 2011	Rivaroxaban	RED - Prophylaxis of VTE following total knee or hip replacement as per NICE TA 170. As GPs should not be asked to prescribe, sufficient medication to complete the full course of treatment is to be supplied at discharge.
September 2011	Dabigatran	RED - Prophylaxis of VTE following total knee or hip replacement as per NICE TA 157. As GPs should not be asked to prescribe, sufficient medication to complete the full course of treatment is to be supplied at discharge.
September 2011	Diazoxide	DOUBLE YELLOW – Treatment of chronic intractable hypoglycemia
October 2011	Dexamethasone intravitreal implant	RED – For the treatment of macular oedema secondary to retinal vein occlusion as per NICE TAG 229 only.
October 2011	Golimumab	RED - As per NICE guidelines within licence and for those patients identified as suitable below. Patients receiving warfarin (and in particular requiring maintenance of a higher INR) that are prone to bruising an bleeding, patients required to travel for periods greater than 2 weeks at a time, patients with a genuine fear of injections.

Date	Consideration	Outcome
October 2011	Dexrazoxane	RED – To be used in strict accordance with HEFT protocols for suspected anthracycline extravasation. It must only be used as per licence and must be prescribed in the same way as any other cytotoxic drug. Only one pack per Trust will be stocked at any one time. FWG must be notified of every occasion that it is used and provided with a summary of the event from the discovery of the potential/actual extravasation due to anthracycline administration, to the eventual outcome for the patient.
November 2011	Abatacept	RED – For use within licence in accordance with NICE TA 195
November 2011	Fosfomycin infusion	RED - to treat severe respiratory infections due to multiresistant gram negative organism especially Pseudomonas aeruginosa in CF patients. All prescribing must de bone via HEFT. GPs must not be asked to prescribe this medication.
November 2011	Lignocaine, adrenaline and tetracaine Gel (LAT Gel)	RED **-** for use in A & E as recommended in the Association of paediatric anaesthetists – Good practice in post operative and procedural pain guidelines.
November 2011	Nevirapine Prolonged release	RED - For use within licence only. All prescribing to remain the responsibility of HEFT. The formulary status of nevirapine prolonged release will be reviewed in December 2012 when generic alternatives may be available.
December 2011	Ranolazine	Double – Yellow with a RICaD - for use as per NICE guidance within licence. The use of ranolazine will be audited in 6 months time
December 2011	Scheriproct®	Green – Replaces Xyloproct ®
January 2012	LMX 4 gel	RED – For use in Paediatrics
February 2012	Ethylenediaminetetraacetic Acid (EDTA) 0.37% drops	RED – For use in Ophthalmology only for chelation of calcium deposited on corneal surface (Band keratopathy) as per Moorfields Handbook. This is an unlicensed product.
February 2012	Linagliptin	Yellow - All for use as per licence and in line with NICE guidance. Saxagliptin to move to the appendix for continued use in patients established on therapy

Date	Consideration	Outcome
February 2012	Testosterone 2% gel (Tostran ® 10mg metered application 60g multidose dispenser)	Green – For use within licence only
February 2012	Fluticasone furoate nasal spray (Avamys®)	Yellow – For use within licence. This preparation replaces fluticasone propionate (Flixonase ® and Nasofan®) which will move to the appendix for use in existing patients only.
February 2012	Hyaluronidase 1,500 units	RED – For use in ophthalmology
March 2012	Aquadeks liquid/softgels and chewable tablets	Declined - This is a multivitamin preparation specifically formulated for cystic fibrosis patients • This is an unlicensed product in the UK and would be classified as a “special” if prescribed in Primary Care. • The cost of specials in Primary care is largely unregulated and much work is underway to reduce its financial burden to the local health economy. FWG could not add Aquadeks to the formulary as it is inappropriate for prescribing in Primary care (Unlicensed) and impractical for HEFT to maintain the prescribing responsibility as would be required by a red classification.
March 2012	Moviprep orange/ lemon flavoured sachets	RED - For use in line with licence. Prescribing by HEFT staff only.
March 2012	Optison (*Protein-type A injectable microspheres suspension)*	RED - For use within cardiology directorate only under the direct supervision of suitably trained medical staff
March 2012	Dovobet Gel	GREEN – for use within licence for scalp and body use
April 2012	*VSL#3 Sachets*	Double Yellow with the support of a RICaD. The initial prescription MUST be provided by HEFT. Prescribing data will be audited to ensure that clinicians are complying with formulary restrictions and to determine the continued appropriateness of VSL#3 position on the formulary
April 2012	Indacaterol maleate (Onbrez Breezhaler ®)	DECLINED The evidence provided failed to add anything to what has already been considered in the 2 previous submissions . Indacaterol will not be considered again by FWG unless there is NICE guidance and or NEW evidence.

Date	Consideration	Outcome
April 2012	Temocillin (Negaban®)	RED - For use within licence on recommendation of ID or Microbiology only. Temocillin must only be prescribed by HEFT clinicians
April 2012	Fultium – D3	Green - Each capsule of Fultium – D3 contains colecalciferol 800IU, which is equivalent to 20 microgram vitamin D_3.
April 2012	Rifaximin	PENDING – awaiting input from the Directorate Manager
May 2012	Boceprevir	RED - For use within licence and in direct concordance with NICE TAG 253
May 2012	Telaprevir	RED - For use within licence and in direct concordance with NICE TAG 252
May 2012	Dabigatran etexilate (for the treatment of AF)	Double Yellow - For use within licence for AF and within the scope of NICE TAG 249. The Birmingham and Solihull NHS Cluster has developed guidance and patient discussion aids etc to support the implementation of TAG 249. **The initial prescription for dabigatran must be provided by a clinician who routinely initiates warfarin.** **This may be the GP (in some instances) but more frequently will be a secondary care specialist. In these circumstances on-going prescribing will be the undertaken by the GP with the aid of a RICaD**
May 2012	Rifapentine (Priftin ®)	RED - Treatment of latent TB in specific circumstances where directly observed therapy (DOTS) is needed on the recommendation of a TB consultant only. (Unlicensed medicine)
May 2012	Exenatide MR injectin (Bydureon®)	DOUBLE YELLOW – For use within license and as per HEFT GLP-1 flow chart. Specialist initiation with support of RICaD ongoing treatment can be prescribed by GP.
June 2012	Ferric Carboxy maltoside (Ferinject®)	PENDING – awaiting combined input from Gastroenterology and Renal directorates
June 2012	RespeRate ®	DECLINED – The quality of evidence for the Medical Device, RespeRate is poor therefore it will not be added to the Interface Formulary
June 2012	Nicorette quickmist ® single mouth spray	GREEN – for use within licence and with the support of local “Stop Smoking Services”
June 2012	Nicotinell patches ®	GREEN – for use within licence and with the support of local “Stop Smoking Services
June 2012	Nicorette inhalator ® 10mg	GREEN – for use within licence and with the support of local “Stop Smoking Services
July 2012	Indacaterol inhaler	PENDING – awaiting the publication of new evidence
	Phlexy-vits ®	• RED - For patients at risk of re-feeding syndrome who are unable to tolerate or swallow Forceval capsules or who are enterally fed. • For post bariatric surgery patients (that as a result of complications or delays in progression from liquid diet require a soluble vitamin supplement beyond 10 days and possibly for the duration of the inpatient stay.

Date	Consideration	Outcome
July 2012	Ciclosporin	ESCA s are no longer required for this preparation.
August 2012	Ulipristal acetate (Esmya®)	DOUBLE YELLOW – For use within licence for the pre-operative treatment of fibroids. HEFT to supply initial prescription with an ESCA, GPs will prescribe for the remaining 2 months of treatment.
August 2012	Lofexidine	RED – for use as per licence as part of the SAFE project
September 2012	Grazax ®	RED – for use within licence to treat adults meeting the Directorates criteria for treatment. Al prescribing will remain the responsibility of HEFT clinicians.
Sept ember 2012	Rivaroxaban for AF	DOUBLE YELLOW – For use within licence for AF and within the scope of **NICE TAG 256** The Birmingham and Solihull NHS Cluster has developed guidance and patient discussion aids etc to support the implementation of TAG. **The initial prescription for rivaroxaban must be provided by a clinician who routinely initiates warfarin.** **This may be the GP (in some instances) but more frequently will be a secondary care specialist. In these circumstances on-going prescribing will be the undertaken by the GP with the aid of a RICaD**
October 2012	Rivaroxaban for DVT	DOUBLE YELLOW – For use within licence as per **NICE TAG 261** in line with approved HEFT pathway
October 2012	Bicalutamide	ESCA s are no longer required for this preparation
November 2012	Icatibant	RED- For use in line with licence by Immunology Department. Patients that have had more than 1 attack (requiring treatment with icatibant/C1 inh) in a 12 month period may be offered icatibant for self administration
November 2012	C1-esterase inhibitor (Cinryze®)	RED - For use in line with licence by immunology department.
November 2012	Palonosetron	RED - For use as a single dose prior to chemotherapy in secondary care only
November 2012	Peristeen anal irrigation	DOUBLE YELLOW - For initiation, assessment and stabilization in secondary care under the expert guidance of the colorectal team before transferring ongoing prescribing responsibility to GP
December 2012	Ticagrelor	DOUBLE YELLOW with a RICaD- In line with TA 236

Date	Consideration	Outcome
December 2012	Rotigotine	MOVED from RED to **DOUBLE YELLOW WITH RICaD -** 1. In patients who cannot swallow or their gut is not working. 2. Patients with poor overnight control of PD. Rotigotine can be considered after CR L dopa preparations and long half life oral DAs (e.g. ropinirole and pramipexole) 3. Patients with erratic motor control during the daytime despite using oral long acting DAs, e.g. ropinirole or pramipexole either as standard TDS regimes or once daily SR preparations. In this setting rotigotine patch can be useful before considering sc apomorphine infusion of enteral duodopa infusion. The latter two treatment options are much more invasive and expensive. **4.** Patients intolerant of current first line DAs (ropinirole and pramipexole) should be considered for rotigotine before abandoning the DA class of drugs.
December 2012	*Collagenase* Clostridium histolyticum injection (Xiapex®)	PENDING
December 2012	Colesevelam	DECLINED - Colesevelam is more costly than existing treatment options. In the absence of any head to head trial, the application was declined
December 2012	Fidaxomicin	RED - for patients with first relapse of C-diff and requiring concomitant antibiotic therapy. Restricted to Infectious Diseases, Microbiology Consultants only.
December 2012	Mucous clearing device (Flutter ®)	RED - To be prescribed and supplied by Secondary Care for appropriate patients. GPs must not be asked to prescribe this item. Patients may purchase this OTC, however the cost is likely to be in the region of £70.
December 2012	Glycopyrronium inhaler (▼Seebri Breezhaler ®)	YELLOW - For use in line with licence and MTRAC recommendations. The addition of glycopyrronium to the formulary prompted a review of section 3.1.2. No further applications for medications in this section will be considered for a minimum of 12 months (unless NICE approved). The Respiratory Directorate is aware of this and the implications for other products such as aclidinium inhaler.
December 2012 (revised Feb 2013)	Flutiform ▼® (Fluticasone propionate/formoterol fumarate aerosol inhaler**)**	GREEN = Moved from YELLOW - For use in clinically appropriate situations. FWG acknowledge that this may include off label use of Flutiform in COPD patients
February 2013	Apixaban	RED – In line with NICE TA 245

Date	Consideration	Outcome
February 2013	Denosumab (Xgeva®)	RED – In line with NICE TA 265
February 2013	Bivalirudin	RED – In line with NICE TA 230
February 2013	Retigabine	RED – In line with NICE TA 232
February 2013	Tapentadol (for neuropathic pain)	DECLINED – insufficient evidence to consider adding to the formulary at the present time
February 2013	Trospium XL	YELLOW – in line with draft NICE guidance. Solifenacin will be moved to the appendix as this does not currently feature in the draft NICE guidance. This decision will be reviewed once a TA is published.
February 2013	Loteprednol Etabonate 0.5% Eye Drops, suspension	RED – to replace rimexolone.
February 2013	Sevikar ®	DECLINED - This is a combination product which includes olmesartan, which is non-formulary The Interface Formulary for Adults has a preference to avoid combination products unless there is an overwhelming advantage. FWG did not judge there to be such an advantage in this instance
February 2013	Fampridine	DECLINED – UHB declined the addition of the drug onto the formulary due to the limited trial data available at present and the marginal efficacy of the drug. FWG support this decision and fampridine will not be added to the interface formulary for adults
February 2013	Insuman®	APPENDIX – EXISTING PATIENTS ONLY. NOT FOR INITIATION
March 2013	The Interface Formulary for Adults has been updated to include “hyperlinks” to active NICE TAs. If the TA is applicable to an area of practice represented in the local health economy and specific preparations are recommended within it; these preparations are also listed in the formulary.	
April 2013	Actikerall (0.5% fluorouracil, 10% salicylic acid solution)	GREEN – As an alternative to 5% fluorouracil cream for patients that have a layer of **thick** hyperkeratotic skin over the actinic keratosis lesions.
April 2013	Desunin ® (Colcalcifeol 800 IU)	GREEN
May 2013	Fumaric esters	RED - (unlicensed)- For use in Dermatology Directorate only.
May 2013	Fostair ®	GREEN – Moved from yellow to green in line with local COPD diagnosis and management guidelines
May 2013	Gelaspan	RED
May 2013	Geloplasma	RED

Date	Consideration	Outcome
May 2013	Dimeticone	GREEN – replaces permethrin which is active against head lice but the formulations and licensed methods of application of the current products make them unsuitable for the treatment of head lice.
May 2013	Quinagolide	DOUBLE YELLOW – for specialist initiation
June 2013	Dapagliflozin	RED – temporary formulary position. For use in line with NICE TA 288. For review at July FWG
June 2013	Ferrinject ® (feric carboxymaltose)	RED – For use in the renal department only
June 2013	Forceval ® Soluble	RED - Forceval soluble – (replaces Phlexy-vits) **prevention of re-feeding syndrome** as per HEFT guidelines on recommendation of clinical nutrition team. Also **post bariatric surgery patients** (that as a result of complications or delays in progression from liquid diet cannot tolerate vitamin supplementation tablets/capsules form and will need a soluble vitamin supplement beyond 10 days and possibly for the duration of their in-patient stay).
June 2013	Phlexyvits	REMOVED from the formulary and replaced with Forceval soluble
June 2013	Capsaicin cream	YELLOW – moved from red to yellow in line with UHB formulary
June 2013	Proflavine cream	RED – Theatres only
June 2013	Dehydroepiandosterone	RED – Endocrinology only
June 2013	Rifaximin	RED (Via specialized commissioning PbR included) - Gastroenterology Directorate only – for recurrent hepatic encephalopathy despite lactulose and optimal medical management. Not for GP prescribing.

Gastro Intestinal System

1.1 Dyspepsia and gastro-oesophageal reflux disease

Notes on class
• Liquid preparations are generally more effective than solid dosage forms • Antacids commonly interact with other drugs, particularly enteric coated drugs • Magnesium salts can be laxative whilst aluminium salts tend to constipate • Alginate preps should only be used for reflux -they are relatively poor neutralizers and have a relatively high electrolyte content • Efficacy may be reduced in patients with very low levels of gastric acid production (e.g. due to PPI)

Green	Yellow	Double Yellow	Red
Antacids			
Magnesium trisilicate mixture	Co-magaldrox suspension [A] When a lower sodium content is required		Antacid and oxetacaine – specialist only, post head and neck radiotherapy
Alginates			
Peptac ® – for reflux only (same components as Gaviscon ®)	Gaviscon Advance [B] £ - for reflux only (primary care only)		
	Gastrocote ® £ - When a lower sodium content is required		

Additional information		
Drug specific notes	[A]	Combination of aluminium and magnesium salts may reduce GI side effects
	[B]	Gaviscon liquid (not Advance ®) is now only available as an OTC preparation and should not be prescribed (£)
NICE guidance	NICE CG 17: Managing dyspepsia in adults	
MTRAC / Prodigy / other guidance	Prodigy: Dyspepsia with ulcer; Prodigy: Dyspepsia GORD; Prodigy: Dyspepsia without ulcer Prodigy: Dyspepsia symptoms; Prodigy: NSAIDs	
PCT information	**Drug Tariff**	

1.2 Antispasmodics and other drugs altering gut motility

Notes on class
• Antimuscarinics tend to have more side effects than the 'other antispasmodics'
• 'Other antispasmodics' directly relax intestinal smooth muscle and are therefore useful in IBD and diverticular disease; there are no serious side effects

Green	Yellow	Double Yellow	Red
Antimuscarinics			
Hyoscine butylbromide injection (Buscopan ®) - For treatment of excessive bronchial secretions in end of life care			Hyoscine butylbromide tablets (for ureteric colic)
Dicycloverine			
Hyoscine butylbromide tablets (dysmenorrhoea, and palliative care)			
Other antispasmodics			
Mebeverine	Alverine citrate (for dysmenorrhoea)		Peppermint B.P. water
	Peppermint oil capsules		
Motility stimulants (Section 4.6 BNF)			
Metoclopramide [A]	Domperidone (when metoclopramide is inappropriate)		

Additional information		
Drug specific notes	[A]	Not effective in postoperative nausea and vomiting and not 1st choice in patients under 20 years of age.
NICE guidance		
MTRAC / Prodigy / other guidance	Prodigy: Irritable Bowel Syndrome	
PCT information	**Drug Tariff**	

1.3 Ulcer Healing Drugs

Notes on class
• Treatment doses are rarely needed for longer than two months (NICE) and should be stepped down • Avoid prescribing treatment doses on repeat prescriptions • Consider step down from PPI to H2 antagonist to ensure cost effective prescribing • For gastro-protection with NSAID, omeprazole is recommended

Green	Yellow	Double Yellow	Red
1.3.1 H2 antagonists			
Ranitidine [D]	Cimetidine [A]		
1.3.4 Prostoglandin analogues			
			Misoprostol –Obs and Gynae (off-label)
1.3.5 Proton Pump Inhibitors			
Omeprazole capsules [E]	Lansoprazole FasTabs ® £ [B]		Omeprazole injection [F]
Lansoprazole capsules[E]	Omeprazole MUPS ® £ [C]		Sucralfate – specialists in oncology , gastroenterology and haematology

Additional information		
Drug specific notes	A B C D E F	Do not use effervescent preparations. Avoid when patient taking phenytoin, warfarin or theophylline Patients with naso-gastric tube, who are dysphagic or nil by mouth only. Paediatrics only Do not use effervescent preparations Tablet preparations are considerably more expensive than capsule formulations Reserved for gastroenterologists, GI surgeons, critical care and oncology
NICE guidance	NICE CG 17: Managing dyspepsia in adults	
MTRAC / Prodigy / other guidance	Prodigy: Dyspepsia with ulcer; Prodigy: Dyspepsia GORD; Prodigy: Dyspepsia without ulcer Prodigy: Dyspepsia symptoms; Prodigy: NSAIDs	
PCT information	**Drug Tariff**	

1.4 Acute diarrhoea

Notes on class
• First line treatment for acute diarrhoea is rehydration therapy • Antibiotics are rarely indicated for the treatment of infective diarrhoea as it is usually viral in the UK

Green	Yellow	Double Yellow	Red
Oral rehydration salts	**Specialist recommendation**		Co-phenotrope [B]
Loperamide [A]	St Mark's solution [C] (unlicensed)		
Codeine phosphate			

Additional information		
Drug specific notes	[A]	1. Also available as OTC 2. Do NOT prescribe loperamide where *C.diff* infection is a potential diagnosis
	[B]	GU medicine patients only
	[C]	Available as a special from BCM specials – 0800 952 1010
NICE guidance		
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

1.5 Chronic Bowel Disorder

Notes on class
• Differential diagnosis includes irritable bowel syndrome, malabsorption syndromes, ulcerative colitis, Crohn's disease, diverticular disease and pseudomembranous colitis. • Patients receiving aminosalicylates should be advised to report any unexplained bleeding, bruising, purpura, sore throat, fever and malaise that occur during treatment. A blood count should be performed and the drug stopped immediately if there is any suspicion of a blood dyscrasia.

Green	Yellow			Double Yellow	Red (as per NICE TAs)
	Consultant initiation			Azathioprine - **ESCA**	Adalimumab
	Sulfasalazine [A]			Ciclosporin (cyclosporin)	Infliximab
	Mesalazine [B]			Methotrexate - **ESCA**	
	Oral	1st choice	*Pentasa* ®		
		2nd choice	*Asacol* ®		
		3rd choice	Mezavant XL [C] ®		
	Rectal	1st choice	suppositories		
		2nd choice	Enemas		
	Prednisolone tablets & suppositories			Balsalazide (specialist recommendation)	
	Hydrocortisone foam enema			Budesonide capsules	
	Prednisolone foam enema **£££**			Mercaptopurine **ESCA**	
	Prednisolone retention enema				

Additional information		
Drug specific notes	A B C	Many patients intolerant. Stains contact lenses. EC more expensive than standard tablets Should be prescribed by brand For use within licensed indications where compliance is an issue. Patients that are stable on effective prescriptions should not be changed to this preparation.
NICE guidance		NICE TA 40 – Infliximab in Crohn's disease NICE TA 140 Ulcerative colitis (subacute manifestations) - infliximab NICE TA 163 Infliximab for acute exacerbations of ulcerative colitis NICE TA 187 Crohn's disease - infliximab and adalimumab NICE 199 Psoriatic arthritis - etanercept, infliximab and adalimumab
MTRAC / Prodigy / other guidance		Prodigy: Irritable Bowel Syndrome Prodigy: Diverticular disease
PCT information		**Drug Tariff**

1.6 Laxatives

Notes on class
• Patients taking bulk forming laxatives should by advised to increase fluid intake • **Stimulant laxatives are unsuitable for long-term use. They can precipitate onset of an atonic non-functioning colon and significant electrolyte imbalance. However extended use may be justified to counter the constipating effects of other drugs (e.g. opioids, anticholinergics)** • Tolerance to osmotic laxatives may develop with prolonged use. • Avoid stimulant laxatives in intestinal obstruction • Use bulk and fluids first before using osmotic laxatives

Green	Yellow	Double Yellow	Red
1.6.1. Bulk forming laxatives			
Ispaghula sachets [A]			
1.6.2. Stimulant laxatives			
Glycerin suppositories	Bisacodyl		Sodium picosulfate (Dulcolax ®)
Senna	Co-danthramer (palliative care)		
Docusate sodium £ [B]			
1.6.3. Faecal softeners			
	Arachis oil enema [D]		Liquid Paraffin – Palliative Care Team recommendation only for patients with bowel obstruction

Green	Yellow	Double Yellow	Red
1.6.4. Osmotic laxatives			
Sodium citrate enema	Macrogol powders (Laxido®/Movicol ®) [E]		
Phosphate enema	Lactulose (hepatic encephalopathy and paediatrics only) [C]		
1.6.4. Bowel cleansers			
			Sodium picosulfate (sodium picosulphate) – Picolax ®
			Klean-Prep ®
			Fleet Phospho-soda ®
			Moviprep ®

Green	Yellow	Double Yellow	Red
1.6.7 5HT$_4$-receptor agonists			
		Prucalopride - With a **RICaD** - as per NICE TA 211	

Additional information		
Drug specific notes	A B C D E	Combination Ispaghula/senna combinations will be changed on admission to secondary care Slower onset 1-2 days Avoid 'prn' dosing Contraindicated in peanut allergy Movicol is recommended for use in faecal impaction, chronic idiopathic constipation and opioid induced constipation, not controlled by 1st line treatments individually or in combination
NICE guidance		
MTRAC / Prodigy / other guidance		Prodigy: Constipation NICE TA 211 Constipation (women) - prucalopride
PCT information		**SCT & HEFT laxative policy** Request a copy from HEFT **Drug Tariff**

1.7 Local preparations for anal and rectal disorders

Notes on class
• Soothing agents should be considered first line and are freely available OTC • Products containing corticosteroids may cause atrophy if use is prolonged: some products are available OTC • Tolerance to osmotic laxatives may develop with prolonged use. • Avoid stimulant laxatives in intestinal obstruction • Use bulk and fluids first before using osmotics

Green	Yellow	Double Yellow	Red
1.7.1 Soothing preparations			
Anusol ®			
1.7.2 Compound preparations			
Anusol-HC ®	Uniroid-HC ® [B] £		
Scheriproct ®			
1.7.3 Rectal scleroscants			
			Oily phenol
1.7.4. Treatment of anal fissure			
	GTN 0.4% ointment ££ Rectogesic ®		Diltiazem 2% cream [A] ££ (unlicensed) Specialist initiation

Additional information		
Drug specific notes	[A]	Recommendation of colorectal surgeons for chronic anal fissure for patients unable to tolerate or with contra indications to GTN. Unlicensed formulations are generally made by "Specials" manufacturing units at considerable cost (usually above £70 per tube) and have only a four week shelf life
	[B]	Uniroid-HC ® formulation is the same as that of Proctosedyl ®
NICE guidance		
MTRAC / Prodigy / other guidance	Prodigy: Anal fissure	
PCT information	**Drug Tariff**	

1.8 Stoma Care

1.9 Drugs affecting intestinal secretions

Green	Yellow	Double Yellow	Red
	Specialist initiation		Ursodeoxycholic acid for cholestasis of pregnancy (off label)
	Pancreatin formulations £		
	Colestyramine (cholestyramine)		
	Ursodeoxycholic acid - for use in gastroenterology and cystic fibrosis patients only		

Miscellaneous

Green	Yellow	Double Yellow	Red
	Octreotide £££ – "off label" Specialist initiation in palliative care	VSL#3 Sachets – **RICaD**[A]	Octreotide £££ – "off label "use – Gastroenterologists and GI surgeons
		Peristeen anal irrigation – specialist initiation, assessment and stabilisation	Terlipressin – "off label" use – gastroenterologists and palliative care
			Phlexy-vits ®[B]

Additional information		
Drug specific notes	[A]	For the maintenance of remission of ileoanal pouchitis only in adults.
	[B]	For patients at risk of re-feeding syndrome who are unable to tolerate or swallow Forceval capsules or who are enterally fed. For post bariatric surgery patients (that as a result of complications or delays in progression from liquid diet require a soluble vitamin supplement beyond 10 days and possibly for the duration of the inpatient stay.
PCT information	**Drug Tariff**	

2 CARDIOVASCULAR SYSTEM

2.1 Positive Inotropic Drugs

Notes on class
• Positive inotropic drugs increase the force of contraction of the myocardium.

Green	Yellow	Double Yellow	Red
2.1.1 Cardiac Glycosides			
Digoxin [A]			Digibind®
2.1.2 Phosphodiesterase Inhibitiors			
			Enoximone [B]

Additional information		
Drug specific notes	[A]	Indicated in supraventricular arrhythmias (e.g. A.F) and heart failure. Levels can be useful to assess toxicity, but need taking at least 6 hours post dose, best to give at night. In A.F. pulse rate at rest is best guide to dose
	[B]	Enoximone exerts most of its effect on the myocardium. Sustained haemodynamic benefit has been observed after administration, but there is no evidence of any beneficial effect on survival.
NICE guidance	NICE clinical guideline 5: Chronic Heart Failure	
MTRAC / Prodigy / other guidance	Prodigy: Heart Failure Prodigy: All cardiovascular topics MEREC: Diagnosis and drug treatment of heart failure (2001)	
PCT information	**Drug Tariff**	

2.2 Diuretics

Notes on class
Notes on class • Thiazide type diuretics are first line treatments for hypertension in the majority of cases • Act within 1-2 hours of oral administration and most have duration of 12-24 hours • Administer early in the day to avoid interference with sleep • Diuretics aggravate gout

Green	Yellow	Double Yellow	Red
2.2.1 Thiazides and related diuretics			
Bendroflumethiazide (bendrofluazide) [A]	Indapamide £££ [A]	Indapamide M/R ££	
Chlortalidone £	Metolazone – Specialist recommendation (unlicensed)		
2.2.2 Loop diuretics			
Furosemide (Frusemide) [B]			
Bumetanide ££ [B]			
2.2.3 Potassium-sparing diuretics			
Amiloride [C]			
2.2.3 Aldosterone antagonists			
Spironolactone [D]		Eplerenone – **RICaD** In line with NICE CG 48 [E]	
2.2.4 Potassium-sparing diuretics with other diuretics			
Co-amilofruse			
2.2.5 Osmotic diuretics			
			Mannitol (cerebral oedema, glaucoma)
2.2.6 Carbonic anhydrase inhibitors			
2.2.7 0smotic diuretics			
			Acetazolamide Ophthalmology and ITU

Additional information			
Drug specific notes	A B C D E	2.5mg dose (higher doses not indicated in hypertension) Most patients do not develop hypokalaemia. Suggest check potassium level one month after initiation and annually thereafter. (MeReC 10/94) Monitor potassium level. Indicated in pulmonary oedema. Need large doses in renal failure Caution with ACE inhibitors. A weak diuretic. Retains potassium Useful in liver cirrhosis and congestive heart failure usually with loop diuretic. Monitor potassium levels carefully For initiation in secondary care during the immediate post MI period in direct concordance with NICE CG48. Primary Care may continue prescribing under a RICaD and transfer suitable patients to spironolactone (in accordance with its licence) after 6 months treatment. Eplerenone may be used in place of spironolactone in extremis	
NICE guidance		NICE CG 05 Chronic Heart Failure NICE CG 34 Hypertension NICE CG48 Secondary prevention in primary and secondary care	
MTRAC / Prodigy / other guidance		Prodigy: Hypertension ; Prodigy: All cardiovascular topics	
PCT information		Combination diuretics should be avoided unless compliance is an issue.	

2.3 Anti-arrhythmics

Notes on class
• Anti-arrhythmics are generally initiated in hospital

Green	Yellow	Double Yellow	Red
	Specialist initiation	**Specialist initiation**	Adenosine
	Amiodarone [A]	Dronedarone **ESCA** [B] - NICE TA 197	Lidocaine hydrochloride (lignocaine hydrochloride)
	Flecainide		
	Disopyramide		
	Propafenone hydrochloride		
	Procainamide hydrochloride		
	Quinidine (unlicensed)		
	Mexiletine hydrochloride		

Additional information		
Drug specific notes	A	LFTs and TFTs need baseline and 6 monthly monitoring. Observe for other side effects e.g. micro corneal deposits, photosensitivity and lung disorders
	B	For use within the parameters of the NICE TAG 197, the option to use dronedarone should be exercised only for the following groups of patients: • patients with both left ventricular hypertrophy and hypertension (requiring antihypertensive medication from two different classes), who do not have structural heart disease. • patients meeting the NICE criteria who have thyroid disease and who would otherwise require amiodarone An ESCA must be used when transferring prescribing and clinical responsibility to the GP
NICE guidance		NICE TA 197 Atrial fibrillation - dronedarone
MTRAC / Prodigy / other guidance		Prodigy: All cardiovascular topics
PCT information		**Drug Tariff**

2.4 Beta blockers

Notes on class
• Beta blockers are not recommended for initiation as first line therapy for patients with hypertension • Significant morbidity and mortality benefits have been demonstrated with beta blockers post MI and for licenced beta blockers in CHF • Beta blockers also retain an important role in the management of angina • Beta blockers tend to be less effective (as monotherapy) in black patients due to suppressed renin-angiotensin system • Reduce dose gradually if beta blocker is to be stopped

Green	Yellow	Double Yellow	Red
Atenolol [A]	Labetalol (specialist initiation in pregnancy)		Esmolol
Propranolol [B]	Nebivolol – specialist recommendation for hypertension in those with concomitant LVD or with co-morbidity of CAD		Labetolol injection
Metoprolol	Sotalol (arrhythmia) – Specialist initiation		
	Timolol -Specialist initiation post MI		
	Carvedilol – for heart failure. Specialist initiation or initiation by GP following approved local protocol		
	Bisoprolol (heart failure – Specialist initiation or initiation by GP following approved local protocol) [C]		

Additional information		
Drug specific notes	A B C	Hypertension up to 50mg, 100mg may be justified in angina LA preparations ££ has a **restricted use** verdict from MTRAC and should be initiated by GPwSI in HF (or on the recommendation of specialist cardiac nurses under local protocol) or by consultants and subsequently managed in primary care.
NICE guidance		NICE CG 34 Hypertension NICE CG 5 Chronic Heart Failure
MTRAC / Prodigy / other guidance		Bisoprolol has a **restricted use** verdict from MTRAC and should be initiated by GPwSI in HF (or on the recommendation of specialist cardiac nurses under local protocol) or by consultants and subsequently managed in primary care. Prodigy: All cardiovascular topics ; Prodigy: Hypertension
PCT information		**Drug Tariff**

2.5 Hypertension and heart failure

Notes on class
• Vasodilators are very potent drugs, especially when used in combination with a beta blocker and a thiazide • ACE inhibitors are indicated for all grades of heart failure and post MI with systolic LVD/HF • ACE inhibitors/ARBs may be less effective in black patients due to suppressed renin-angiotensin system • ACE/ARBs require renal function tests before and after initiation (and at dose changes) • ARBs should only be used where ACE induced cough is a problem and other hypertensives are poorly tolerated. In clinical trials incidence of cough with ACE was only 4-6% greater than in placebo arm. In HF cough may indicate worsening pulmonary oedema. • ACE/ARBs are foetotoxic • **There is no evidence of any specific agent offering advantages – use most cost effective choice**

Green	Yellow	Double Yellow	Red
2.5.1 Vasodilators			
	Specialist recommendation		Sodium nitroprusside (hypertensive crisis)
	Hydralazine tablets		Diazoxide injection
	Minoxidil		Hydralazine
2.5.2 Centrally acting antihypertensives			
	Methyldopa – specialist recommendation in pregnancy		Clonidine
	Moxonidine – specialist recommendation		
Green	**Yellow**	**Double Yellow**	**Red**
2.5.3 Adrenergic neurone blockers			
			Guanethidine
2.5.4 Alpha blockers			
Doxazosin [A B]	Phenoxybenzamine – specialist initiation	Doxazosin M/R £ - for patients for whom there is no alternative antihypertensive and for whom the hypotensive adverse effects are intolerable	Phentolamine mesilate
2.5.5.1 ACE inhibitors			
Ramipril [C] capsules	Perindopril erbumine [D] £		
Lisinopril			
Enalapril			
2.5.5.2 Angiotensin Receptor Blockers			
Irbesartan – if micro/macro albuminuria in T2DM	Valsartan [F]		
Losartan [G] £			
Candesartan [E]			
2.5.5.3 Renin Inhibitors			
		Aliskiren [H] **RICaD**	
2.5.6 Ganglion – blocking drugs			
			Trimetaphan camsilate
2.5.7 Tyrosine hydroxylase inhibitors			
			Metirosine

Additional information		
Drug specific notes	A B C D E F G H	Alpha blockers are usually fourth/fifth line unless there is co-existing benign prostatic hypertrophy Doxazosin may induce first dose hypotension Ramipril has a solid evidence base and should be considered first line Perindopril has no evidence of superiority over other ACEs. Candesartan is only ARB licensed for heart failure; first line choice Valsartan is licensed for use in LVF/LVSD post MI Losartan is licensed in diabetic nephropathy and heart failure (Irbesartan is licensed for renal disease with hypertension) For treatment of hypertension in step four of the ACD algorithm in patients with BP >140/90 despite previous treatment with 3 or more antihypertensive agents. A **RICaD** is required for prescribing in primary care.
NICE guidance		NICE CG 05 Chronic Heart Failure NICE CG 34 Hypertension
MTRAC / Prodigy / other		Prodigy: Hypertension ; Prodigy: All cardiovascular topics MEREC 2002: Place of ARBs in therapy

2.6 Nitrates, calcium-channel blockers & potassium-channel activators

Notes on class
NItrates • Glyceryl trinitrate sprays are more cost effective for infrequent users, patches are expensive and need to be removed overnight **Calcium – channel blockers** • There are important differences between diltiazem and verapamil and dihydropyridine calcium channel blockers • Prescribe nifedipine and diltiazem sustained release preparations by brand (for bioavailability reasons). Once a brand is selected, exclusive use should be maintained. • Use diltiazem cautiously with beta blockers • Sudden withdrawal can exacerbate angina

Green	Yellow	Double Yellow	Red
2.6.1 Nitrates			
Glyceryl Trinitrate (Spray / tablets SL)	Glyceryl trinitrate patches £ – for pts unable to take/tolerate oral/sublingual preparations		GTN injection
Isosorbide mononitrate tablets S/R [A]			Isosorbide dinitrate injection
			Glyceryl trinitrate buccal tablets

2.6.2 Calcium channel blockers			
Nifedipine SR [C]	Felodipine	Nifedipine capsules –"off label Palliative Care Team recommendation for tenesmus	Nimodipine
Amlodipine **maleate** [B D]			
Verapamil £			
Diltiazem oral preparations			
2.6.3 Potassium channel activators			
Nicorandil		Ivabradine – specialist recommendation for angina	
		Ivabradine – specialist initiation and **RICaD** for heart failure- NICE TA 267	
		Ranolazine – **RICaD**	
2.6.4 Peripheral vasodilators			
			Temazoline
			Naftidrofuryl oxalate

Additional information		
Drug specific notes	[A]	Isosorbide mononitrate may be given as twice a day asymmetric dosing or once daily sustained release. Isosorbide XL / MR preparations should be prescribed by brand
	[B]	Prescribe as 'amlodipine' or 'amlodipine maleate'
	[C]	Nifedipine prescribed as Adalat is generally more expensive
	[D]	Agent of choice where CCB indicated for hypertension in patient with HF
NICE guidance	NICE CG 34 Hypertension NICE TA 223 Peripheral arterial disease - cilostazol, naftidrofuryl oxalate, pentoxifylline and inositol nicotinate NICE TA 267 Chronic heart failure - ivabradine	
MTRAC / Prodigy / other guidance	Prodigy: Hypertension ; Prodigy: All cardiovascular topics	
PCT information	In Primary Care, either GTN sprays or S/L tablets should be used. Use Monomil® tablets as first choice. If another brand has been chosen by the practice, there is no need to change	
	Preferred brands Felodipine Diltiazem Nifedipine	 Cardioplen Angitil/Slozem **od:** Adipine LA, Coracten XL, **bd:** Adipine SR, Coracten SR

2.7 Sympathomimetics

Green	Yellow	Double Yellow	Red
			Dobutamine, dopamine, ephedrine, metaraminol (named patient) phenylephrine, noradrenaline, adrenaline/epinephrine

Unlicensed

Green	Yellow	Double Yellow	Red
			Midodrine – **Unlicensed** Endocrinology only

2.8 Anticoagulants & Protamine

Green	Yellow	Double Yellow	Red
2.8.1 Parenteral anticoagulants			
		Enoxaparin[A] (specialist initiation) **ESCA**	Epoprostenol
			Danaparoid
			Fondaparinux
			Heparin (specialist initiation)
			Tinzaparin (within licence for renal dialysis patients only)
2.8.2 Oral anticoagulants			
Warfarin		Phenindione (specialist initiation)	Rivaroxaban – NICE TA170 **VTE prophylaxis only**
		Dabigatran – with a **RICaD** NICE TA 249	Dabigatran – NICE TA 157 **VTE prophylaxis only**
		Rivaroxaban – with a **RICaD** NICE TA 261 and TA 256	Protamine sulphate
			Apixaban - NICE TA 245
			Bivalirudin – NICE TA 230
			Rivaroxaban – TA 287 Temporary Formulary position

2.8.3 Protamines			
			Protamine sulfate

Green	Yellow	Double Yellow	Red
(medical device)			
			TauroLock
			TauroLock - HEP 500

Additional information		
Drug specific notes	A	ESCA available for the treatment of and prevention of Venous Thromboembolism in general medical patients.
NICE guidance		NICE TA 157 Venous thromboembolism - dabigatran NICE TA 170 Venous thromboembolism - rivaroxaban NICE TA 230 Myocardial infarction (persistent ST-segment elevation) - bivalirudin NICE TA 245 Venous thromboembolism - apixaban (hip and knee surgery) NICE TA 249 Atrial fibrillation - dabigatran etexilate NICE TA 256 Atrial fibrillation (stroke prevention) - rivaroxaban NICE TA 261 Venous thromboembolism (treatment and long term secondary prevention) - rivaroxaban NICE TA 275 Stroke and systemic embolism (prevention, non-valvular atrial fibrillation) - apixaban NICE TA 287 Rivaroxaban for treating pulmonary embolism and preventing recurrent venous thromboembolism
MTRAC / Prodigy / other guidance		Prodigy: Atrial fibrillation ; Prodigy: All cardiovascular topics MEREC 2001: Atrial Fibrillation in Primary Care
PCT information		**Drug Tariff**

2.9 Antiplatelet drugs

Green	Yellow	Double Yellow	Red as per NICE TAs
Aspirin dispersible [A]	Clopidogrel [C] £	Prasugrel – Specialist initiation **RICaD** [D]	Tirofiban
Dipyridamole MR [B]		Ticagrelor – Specialist initiation **RICaD -** NICE TA 236	Abciximab
Asasantin Retard ® [B C]			Eptifibatide [E -]

Additional information		
Drug specific notes	A	In acute severe dyspepsia don't forget to counsel pc dosing, If pc dosing fails, try aspirin plus omeprazole before clopidogrel
	B	Dipyridamole indicated in combination with aspirin for 2 years post Occlusive (neurological) Vascular Event, then revert to aspirin
	C	Clopidogrel indicated as monotherapy if patient has a documented hypersensitivity to aspirin or has severe acute dyspepsia associated with aspirin. Combination therapy with aspirin post ACS, PCI or CABG for maximum 12 months, then revert to aspirin. **There are no proven benefits to using enteric coated aspirin**
	D	For specialist initiation with a **RICaD** in patients who • suffer a stent thrombosis • receive stent angioplasty following STEMI (for patients under 75, weighing more than 60kg and never having had a stoke) Prasugrel is not available for any other indication
	E	1)Prevention of early myocardial infarction in patients with unstable angina or non-ST segment elevation myocardial infarction and with last episode of chest pain within 24 hours (use under specialist supervision) this is a licensed indication 2) an adjunct to primary PCI for patients with **STEMI (this is an unlicensed indication)**
NICE guidance		NICE TA 47 Acute coronary syndromes - eptifibatide and tirofiban NICE TA 80 Acute coronary syndromes - clopidogrel NICE TA 182 Acute coronary syndrome - prasugrel NICE TA 210 Vascular disease - clopidogrel and dipyridamole NICE TA 236 Acute coronary syndromes - ticagrelor

	NICE CG 94 unstable angina and NSTEMI
MTRAC / Prodigy / other guidance	Guidance on clopidogrel, dipyridamole. Prodigy: Aspirin for the prevention of CV events ; Prodigy: TIA (not in AF) ; Prodigy: All cardiovascular topics
PCT information	**Drug Tariff**

2.10 Fibrinolytic Drugs

Notes on class

Green	Yellow	Double Yellow	Red
			Alteplase
			Reteplase
			Streptokinase
			Urokinase (off licence)
			Tenectoplase

2.11 Anti- Fibrinolytic Drugs & Haemostatics

Notes on class

Green	Yellow	Double Yellow	Red
Tranexamic acid (oral)			Tranexamic acid injection
			Etamsylate
			Factor VII

Additional information	
Drug specific notes	
NICE guidance	NICE TA 52 - Myocardial infarction - thrombolysis (alteplase, reteplase, streptokinase and tenecteplase) NICE TA 84 (withdrawn) Sepsis (severe) - drotrecogin NICE TA 264 alteplase for treating acute ischaemic stroke
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

2.12 Lipid-regulating drugs

Notes on class
• Current National Service Framework guidance recommends treating cholesterol to a target of 5mmol/litre or a 30% reduction from baseline, whichever is greater • NICE guidance (Jan 2006) recommends considering primary prevention statin treatment for all patients with a 10year CVD risk of 20% or greater

Green	Yellow	Double Yellow	Red
Simvastatin [A]	Atorvastatin ££	Ezetimibe [B] NICE TA 132	
Bezafibrate	Colestyramine (cholestyramine)	Rosuvastatin (specialist initiation lipid clinic only)	
	Fenofibrate	Fluvastatin (specialist recommendation in renal patients only)	
	Omacor ® as second line agent in hypertriglyceridemia or secondary prevention in post MI patients intolerant of oily fish.	Tredaptive M/R – specialist recommendation only	
	Nicotinic acid		
	Pravastatin		

Additional information		
Drug specific notes	[A] [B]	Evidence base suggests 40mg starting dose When prescribed in accordance with NICE TA 132 Clinical Guidelines. Specialist initiation when used as monotherapy.
NICE guidance	NICE TA 94 Cardiovascular disease - statins NICE TA 132 Hypercholesterolaemia - ezetimibe NICE CG 48: MI - Secondary Prevention	
MTRAC / Prodigy / other guidance	Prodigy: All cardiovascular topics ; Prodigy: Hyperlipidaemia MEREC: Lifestyle measures to reduce CV risk MEREC: Update on statins	
PCT information	Simvastatin 40mg should be used in preference to atorvastatin 10mg	

2.13 Local sclerosants

Notes on class

Green	Yellow	Double Yellow	Red
			Sodium tetradecyl sulphate
			Ethanolamine oleate

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

Miscellaneous

Green	Yellow	Double Yellow	Red
			Optison ® for use within cardiology directorate only under direct supervision of suitably trained staff

3 RESPIRATORY SYSTEM

3.1 Bronchodilators

3.1.1 Beta adrenoceptor agonists

Notes on class
• NICE guidance: All inhalers should be prescribed as MDI / MDI plus spacer unless co-ordination / compliance is a problem. Spacer devices now available as AeroChamber ® adult (blue) with or without mask, infant (orange) or child (yellow). • GSK have announced the re-introduction of the Volumatic device from February 06 following Committee on Human Medicines (formerly CSM) advice that AeroChamber ® is not suitable for GSK inhalers (*Ventolin, Becotide, Serevent, Flixotide, Seretide*) • Avoid use of dry powder formulations if MDIs are suitable (diskhalers, accuhalers etc) • Long Acting beta Agonists (LABAs) should be trialled for four weeks and withdrawn if no benefit observed • Committee on Human Medicines (formerly CSM) has issued a reminder that in asthma, LABAs should only be used in conjunction with inhaled corticosteroids • Salbutamol: High doses in severe asthma does warrant regular checking of Us & Es, especially if prescribed with theophylline

Green	Yellow	Double Yellow	Red
3.1.1.1 Adrenoceptor agonists			
Short acting			
Salbutamol	Terbutaline £		
Salbutamol (nebulised) [A]			
Long acting			
Salmeterol £			
Formoterol £ (eformoterol) [B]			

Additional information		
Drug specific notes	[A]	Secondary care and emergency use in primary care. Regular use in primary care on recommendation of specialist. Salbutamol and spacer should be used before resorting to nebuliser
	[B]	Available as dry powder turbohaler. New MDI formulation requires refrigeration
NICE guidance	NICE TA 10 (Asthma - children under 5 - inhaler devices) NICE TA 38 (Asthma - older children - inhaler devices)	
MTRAC / Prodigy / other guidance	SIGN Guideline No. 63: British Guideline on the Management of Asthma; Prodigy: Asthma ; Prodigy: COPD ; MEREC: Management of COPD	
PCT information	**Drug Tariff**	

3.1.2 Antimuscarinic bronchodilators

Notes on class
• NICE guidance: All inhalers should be prescribed as MDI / MDI plus spacer unless co-ordination / compliance is a problem. Spacer devices now available as AeroChamber adult (blue) with or without mask, infant (orange) or child (yellow). • GSK have announced the re-introduction of the Volumatic device from February 06 following Committee on Human Medicines (formerly CSM) advice that AeroChamber is not suitable for GSK inhalers (*Ventolin, Becotide, Serevent, Flixotide, Seretide*)

Green	Yellow	Double Yellow	Red
Short acting			
Ipratropium	Glycopyrronium [B]		
Ipratropium (nebulised) [A]			
Long acting			
	Tiotropium ££ [C]		

Additional information		
Drug specific notes	[A]	Secondary care and emergency use in primary care. Regular use in primary care on recommendation of specialist
	[B]	As per licence and MTRAC recommendations
	[C]	Safety concerns have been expressed around the Respimat device. NELM Systematic review and meta analysis questions safety of tiotropium Respimat inhaler in COPD
NICE guidance		Clinical guideline 12: Chronic Obstructive Pulmonary Disease
MTRAC / Prodigy / other guidance		Prodigy: COPD ; MEREC: Management of COPD MTRAC summary Glycopyrronium
PCT information		Launch of CFC free formulations does not require change to prescription **Drug Tariff**

3.1.3 Theophylline

Notes on class
• Xanthines have a narrow therapeutic index so measuring plasma levels is recommended. • Theophylline levels may rise when patient stops smoking, • Modified release products should be prescribed by brand • Xanthine naive patients should be initiated on theophylline

Green	Yellow	Double Yellow	Red
Theophylline [A]			
Aminophylline [B]			

Additional information		
Drug specific notes	A B	At appropriate stage of relevant guideline. At appropriate stage of relevant guideline.
NICE guidance	NICE CG 12: Chronic Obstructive Pulmonary Disease	
MTRAC / Prodigy / other guidance	; SIGN Guideline No. 63: British Guideline on the Management of Asthma; Prodigy: Asthma ; Prodigy: COPD ; MEREC: Management of COPD	
PCT information	**Drug Tariff**	

3.1.4 Compound bronchodilators

Notes on class

Green	Yellow	Double Yellow	Red
	Combivent ® [A]		

Additional information	
Drug specific notes	[A] Nebuliser solution only available
NICE guidance	NICE CG 12: Chronic Obstructive Pulmonary Disease
MTRAC / Prodigy / other guidance	; SIGN Guideline No. 63: British Guideline on the Management of Asthma Prodigy: Asthma ; Prodigy: COPD ; MEREC: Management of COPD
PCT information	**Drug Tariff**

3.1.5 Peak flow meters, inhaler devices and nebulisers

Notes on class
Peak flow meters were changed in 2004 to European standards. The older peak flow meters should be used with older charts as the old and new scales are not equivalent

Green	Yellow	Double Yellow	Red
Peak flow meters			
Spacers			

3.2 Corticosteroids

Notes on class
• As with bronchodilators, MDIs should be used first line in conjunction with a spacer. Spacers should be used for all inhaled steroids, especially high dose steroids (above 800 micrograms) • AeroChamber ® Spacer devices: adult (blue) with or without mask, infant (orange) or child (yellow). Not suitable for GSK inhalers (*Ventolin, Becotide, Serevent, Flixotide, Seretide*) – use Volumatic. Not suitable for Bricanyl/Pulmicort • Oral hygiene should be emphasised to reduce risk of oral thrush • Committee on Human Medicines (formerly CSM) Guidance for high dose fluticasone Current problems in pharmacovigilance August 2001 – High dose fluticasone and on risk of adrenal suppression in children Oct 2002 • Committee on Human Medicines (formerly CSM) guidance that LABA should only be used in conjunction with an inhaled steroid MHRA updates on LABAs in asthma • CFC – free beclometasone preparations are not interchangeable and should be prescribed by brand (MHRA August 2006)

Green	Yellow	Double Yellow	Red
Beclometasone (beclomethasone)	Fluticasone £		
	Budesonide £		
3.2.1.1. Combination Corticosteroid Inhalers – if compliance is a problem			
Flutiform ® [B]	Symbicort ®		
Fostair ®	Low dose Seretide ® £		
	High dose Seretide ® £ [A]		

Additional information		
Drug specific notes	[A]	250 micrograms and above: Specialist recommendation if to treat asthma
	[B]	For use in clinically appropriate situations. Formulary working group acknowledge that this may include off label use of Flutiform in COPD patients. Patients stable on other therapies should not be switched to Flutiform on the basis of formulary category alone. However it is appropriate to consider Flutiform at an asthmas review and or step up or step down.
NICE guidance	NICE CG 12: Chronic Obstructive Pulmonary Disease NICE TA 131 Inhaled corticosteroids for the treatment of chronic asthma in children under 12 years NICE TA 138 Asthma (in adults) - corticosteroids (TA138)	
MTRAC / Prodigy / other guidance	SIGN Guideline No. 63: British Guideline on the Management of Asthma Prodigy: Asthma ; Prodigy: COPD ; MEREC: Management of COPD	

3.3 Cromoglicate, related therapy and leukotriene receptor antagonists

Notes on class

Green	Yellow	Double Yellow	Red
Montelukast [A]			Zafirlukast (off label in GU medicine)
Zafirlukast			

Additional information		
Drug specific notes	[A]	For addition to therapy only at appropriate step
NICE guidance	NICE TA 244 Chronic obstructive pulmonary disease - roflumilast	
MTRAC / Prodigy / other guidance	SIGN Guideline No. 63: British Guideline on the Management of Asthma; Prodigy: Asthma ;	
PCT information	**Drug Tariff**	

3.4 Antihistamines, hyposensitisation and allergic emergencies

Notes on class

Green	Yellow	Double Yellow	Red
3.4.1 Antihistimines			
Non-sedating antihistamines			
Loratadine	Fexofenadine £		
Cetirizine £			
Sedating antihistimines			
Chlorphenamine (chlorpheniramine)	Alimemazine (trimeprazine)		
	Hydroxyzine [A]		
	Promethazine [B]		
3.4.2 Hyposensitisation			
			Pharmalgen (treatment of Bee & wasp allergy)
			Grass & tree pollen extracts
			Grazax ® [D]
			Omalizumab – NICE TA 278
3.4.3 Allergic emergencies			
Adrenaline injections (Jext ® and Epipen®)			Icatibant [C] For the treatment of hereditary angio-oedema patients
			C1 esterase inhibitor (Cinryze ®and Berinert®)
			Conestat alpha (Ruconest®) (Via specialized commissioning)

Additional information		
Drug specific notes	A	For pruritus
	B	For hyperemesis
	C	Patients that have had more than 1 attack (requiring treatment with icatibant/C1 inh) in a 12 month period may be offered icatibant for self administration
	D	For use as per licence in adult patients meeting the Directorate criteria for treatment

NICE guidance	NICE TA 278 Omalizumab for treating severe persistent allergic asthma (review of technology appraisal guidance 133 and 201) NICE TA 246 Venom anaphylaxis - immunotherapy pharmalgen

3.5 Respiratory stimulants and pulmonary surfactants

Green	Yellow	Double Yellow	Red
3.5.1 Respiratory stimulants			
			Caffeine (unlicensed) [A]
			Doxapram
3.5.2 Pulmonary surfactants			
			Poractant alpha

Additional information		
Drug specific notes	[A]	Neonates only – unlicensed use
NICE guidance		
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

3.6 Oxygen

Green	Yellow	Double Yellow	Red
Oxygen			

3.7 Mucolytics

Green	Yellow	Double Yellow	Red
	Carbocisteine [A] specialist recommendation	Dornase alfa **Patients established on therapy prior to 31/3/13 will continue to receive treatment under an ESCA**	Dornase alfa **Patients starting therapy on 1/04/13 or later will receive treatment at HEF (via specialised commissioning**
		Acetylcysteine sachets – off label use –specialist recommendation for the treatment of distal intestinal obstruction syndrome in cystic fibrosis	Acetylcysteine – other off label use
			Erdosteine. Respiratory Directorate only. For inpatients and TTO only. Not for GP prescribing.

Devices

Green	Yellow	Double Yellow	Red
			Flutter ® Mucous clearing device

Additional information		
Drug specific notes	[A]	NICE CG 12: Chronic Obstructive Pulmonary Disease
NICE guidance	NICE CG 12: Chronic Obstructive Pulmonary Disease	
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

3.8 Aromatic inhalations

Green	Yellow	Double Yellow	Red
Menthol & eucalyptus			

3.9 Cough preparations

Notes on class

Green	Yellow	Double Yellow	Red
Simple linctus	Pholcodine linctus – limited role	Methadone linctus 2mg/5ml [A] Palliative care only	

3.10 Systemic nasal decongestants

Green	Yellow	Double Yellow	Red

3.11 Antifibrotics

Green	Yellow	Double Yellow	Red
			Pirfenidone – NICE TA 282 (via specialised commissioning)

Miscellaneous

Green	Yellow	Double Yellow	Red
Nebusal ® (Sodium chloride 7% nebuliser solution) for CF patients			Inhaled mannitol

Additional information	
Drug specific notes	[A] Specialists in palliative care only
NICE guidance	NICE TA 266 Cystic fibrosis - mannitol dry powder for inhalation NICE TA 282 Pirfenidone for treating idiopathic pulmonary fibrosis
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff** Pseudoephedrine (Drugs of limited Clinical Value) is of limited use; available OTC

4 CENTRAL NERVOUS SYSTEM

4.1 Hypnotics and Anxiolytics

Notes
Committee on Human Medicines (formerly CSM) 1. Benzodiazepines are indicated for the short term relief (two to four weeks only) of anxiety that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic or psychotic illness. 2. The use of benzodiazepines to treat short-term ‘’mild’ anxiety is inappropriate and unsuitable. 3. Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or subjecting the individual to extreme distress. Z-drugs should be used for a maximum of two to four weeks in line with their product licence and are not superior to benzodiazepines
General notes No hypnotic is licensed for more than 28 days use Prescribers should routinely provide information on promotion of good sleep habits (“sleep hygiene”) Link to Prodigy PIL Prevention of insomnia

Green	Yellow	Double Yellow	Red
Hypnotics			
Temazepam	Zolpidem – NICE TA 77		Chloral hydrate syrup - paediatrics
	Zopiclone £ - NICE TA 77		Triclofos - Paediatrics
	Promethazine – for hyperemesis		
	Zaleplon – NICE TA 77		

Anxiolytics			
Diazepam [A]	Chlordiazepoxide [B]		Lorazepam injection
	Lorazepam		Diazepam injection

Additional information		
Drug specific notes	A B	Not recommended due to long duration of action compared to temazepam For alcohol withdrawal
NICE guidance	NICE TA 51 Depression and anxiety - computerised cognitive behavioural therapy; NICE TA 77 -Insomnia newer hypnotic drugs	
MTRAC / Prodigy / other guidance	Prodigy: Hypnotic and anxiolytic dependence ; Prodigy: Insomnia	

4.2 Drugs used in psychoses and related disorders

Notes on class

The Committee on Human Medicines (formerly The Committee on the Safety of Medicines) has advised that:

- Risperidone or olanzapine should not be used for the treatment of behavioural symptoms of dementia
- Use of risperidone for the management of acute psychotic conditions in elderly patients who also have dementia should be limited to the short-term and should be under specialist advice (olanzapine is not licensed for management of acute psychoses)
- Prescribers should consider carefully the risk of cerebrovascular events before treating any patient with a previous history of stroke or TIA.
- Consideration should also be given to other risk factors for cerebrovascular disease including hypertension, diabetes, current smoking and AF
- Increased risk of cerebrovascular events when antipsychotics used to treat behavioural or psychotic symptoms of dementia. See NICE Clinical Guideline
- The NICE Clinical guideline on Dementia states that antipsychotics should only be considered for patients with *severe* non-cognitive symptoms (psychosis &/or agitated behaviour causing significant distress), after very careful assessment of risks and benefits. The dose must be carefully titrated, and use should under close supervision on a time-limited basis with changes in target symptoms regularly assessed and recorded. CG42 Dementia: NICE guideline (Word) see section 1.7.2 p34

Furthermore, the CHM notes that although there is currently insufficient evidence to include other antipsychotics in these recommendations, prescribers should bear in mind that a risk of stroke cannot be excluded, pending the availability of further evidence. Patients with dementia who are currently treated with an atypical antipsychotic drug should have their treatment reviewed.

Green	Yellow	Double Yellow	Red
4.2.1 Antipsychotic drugs			
Chlorpromazine [B]	Olanzapine [C] -Consultant initiation	Aripiprazole -Consultant recommendation	Clozapine (Mental Health Trust)

Haloperidol	Risperidone - Consultant initiation		
	Amisulpride -Consultant recommendation		
	Quetiapine -Consultant recommendation		
Green	**Yellow**	**Double Yellow**	**Red**
4.2.2		**Consultant initiation**	
		Zuclopenthixol	
		Flupentixol (flupenthixol)	
		Fluphenazine	
4.2.3 Antimanic drugs			
		Lithium [A]	
		Valproate acid (BSMHFT)	

Additional information		
Drug specific notes	A B C	Must state brand as different formulations / salts are not interchangeable Not for use in the management of agitation in dementia or delirium Oro-dispersible can be considered for compliance issues
NICE guidance		NICE CG 1 Clinical Guidance on Schizophrenia; NICE CG 38 bipolar disorder NICE CG 82 schizophrenia NICE CG42 Dementia NICE TA 66 Bipolar disorder - newer drugs NICE TA 213 Schizophrenia - aripiprazole
MTRAC / Prodigy / other guidance		Olanzapine and Risperidone initiation in secondary care – GPs can continue prescribing Olanzapine for bipolar disorder - initiation in secondary care. GPs can continue prescribing Lithium ESCA is being developed by B&S MHT Prodigy: Schizophrenia
PCT information		Birmingham and Solihull Mental Health Trust guidelines on antipsychotics (http://nww.pctnet.wmids.nhs.uk/z_internet_hob/schz_guidelines/default.htm) **Drug Tariff**

4.3 Antidepressants

Notes on class
All of the SSRI antidepressants are of similar efficacy to one another and slightly better than placebo SSRI antidepressants are not licensed for under 18s

Green	Yellow	Double Yellow	Red
SSRIs			
Fluoxetine	Citalopram		
Sertraline [A]			
Tricyclics			
Amitriptyline			
Lofepramine			
Other Antidepressants			
	Mirtazapine	Duloxetine –within licence as per NICE CG96 for diabetic peripheral neuropathic pain	
	Venlafaxine		

Additional information	
Drug specific notes	[A] Has most evidence in cardiovascular disease
NICE guidance	NICE guidance on mental health and behavioural conditions NICE CG 96 Neuropathic pain_pharmacological management
MTRAC / Prodigy / other guidance	Prodigy: Depression
PCT information	**Drug Tariff**

4.4 CNS Stimulants and other Drugs used for attention deficit hyperactivity disorder

Notes on class

Green	Yellow	Double Yellow	Red
		Methylphenidate **ESCA**	Dexamfetamine (dexamphetamine)
		Atomoxetine **ESCA** [A]	
		Modafinil for narcolepy **ESCA** [B]	Modafinil (as a consequence of sleep apnoea) [C]

Additional information		
Drug specific notes	[A]	The MHRA has announced that it is investigating the risks and benefits of atomoxetine (for ADHD), following research that has identified a possible increase in suicidal thoughts and behaviour in children treated with the drug. In the mean time the MHRA advises that children taking the drug should be monitored for signs of depression, suicidal thoughts or behaviour, and referred for appropriate treatment if necessary. Patients (and carers) should be advised to watch for relevant behaviours. Children who are taking atomoxetine who are feeling well should not be concerned and there is no need to stop it as the benefits will outweigh the risks for most children.
	[B] [C]	For treatment of narcolepsy only. Patients who are stable and being treated with modafinil for excessive daytime sleepiness (in relation to sleep apnea) may continue treatment under the ESCA. Following a Safety and Effectiveness review by the EMEA – Modafinil for the treatment of excessive daytime sleepiness as a consequence of sleep apnoea has been moved to the red section of the formulary. NEWLY diagnosed patients requiring treatment with modafinil will receive all of their medication from HEFT and GPs will not be asked to prescribe.
NICE guidance		NICE TA 98 Attention deficit hyperactivity disorder (ADHD) NICE TA 139 Sleep apnoea - continuous positive airway pressure (CPAP)
MTRAC / Prodigy / other guidance		Guidance available for both atomoxetine and methylphenidate Prodigy: ADHD
PCT information		ESCAs for both methylphenidate and atomoxetine are available. **Drug Tariff**

4.5 Drugs used in obesity

Notes on class
• Drugs in this class are subject to inclusion criteria based on patients current physical condition and progress with unassisted weight loss prior to commencing medication. Refer to BNF 4.5 Drugs used in the treatment of obesity: British National Formulary

Green	Yellow	Double Yellow	Red
Orlistat			

Additional information	
Drug specific notes	Rimonabant – The European Medicines Agency (EMEA) recommended the suspension of the marketing authorisation for Acomplia (rimonabant) from Sanofi-Aventis. The EMEA's Committee for Medicinal Products for Human Use (CHMP) has concluded that the benefits of Acomplia no longer outweigh its risks and the marketing authorisation should be suspended across the European Union (EU). EMEA information regarding rimonabant
NICE guidance	NICE CG 43 Obesity
MTRAC / Prodigy / other guidance	Prodigy: Obesity
PCT information	Practices should have a prescribing protocol in place **Drug Tariff**

4.6 Drugs used in nausea and vomiting

Green	Yellow	Double Yellow	Red
Betahistine	Hyoscine hydrobromide		Ondansetron (Hyperemesis / paeds)
Cinnarizine	Hyoscine hydrobromide patch		Granisetron
Cyclizine			Levomepromazine (Palliative Care)
Prochlorperazine			Aprepitant (Emend ®) [B]
Metoclopramide [A]			Droperidol injection [C]
Domperidone			Palonosetron

Additional information		
Drug specific notes	A	Not effective in postoperative nausea and vomiting and not 1st choice in patients under 20 years of age
	B	For use as per Pan Birmingham Cancer Network guidelines
	C	Reserved for those patients in whom other agents have failed to control PONV or are otherwise unsuitable for treatment with other agents
NICE guidance	PBCN Anti Emetic Guidelines for Adults receiving chemotherapy	
PCT information	**Drug Tariff**	

4.7 Analgesics

Notes on class

• Where ever possible, avoid the use of combination products. Use paracetamol and codeine separately. All combination products of paracetamol and codeine / dihydrocdeine are deemed products less suitable for prescribing in the BNF
• Co-codamol 8/500 is similar in efficacy to paracetamol and should be avoided
• Most drugs in section 4.7.2 are subject to the Misuse of Drugs Act. Handwriting exemptions have recently been lifted to allow computer generated scripts. These prescriptions still require all of the previous details.
  ○ Patients name and address
  ○ Name of preparation. The form and where appropriate the strength of the preparation
  ○ The total quantity of the preparation or the number of dose units in both words and figures
  ○ The dose

Green	Yellow	Double Yellow	Red
4.7.1 Non-opioid anlgesics			
Paracetamol	Co-codamol 30/500 *		Paracetamol injection [D]
	Co-codamol 30/500 *effervescent (high sodium content) £		
	Paracetamol soluble £ (high sodium content)		
4.7.2 Opioid analgesics			
Morphine salts	Buprenorphine 200 microgram S/L tablets	Hydromorphone (palliative care recommendation only)	Papaveretum
Codeine phosphate	Fentanyl patch [A] £££	Oxycodone £££ - usually on palliative care recommendation	Meptazinol – obstetric pain and renal colic only
Diamorphine salts	Tramadol [CB]		Pethidine
			Sublingual fentanyl –Palliative Pain Team Recommendation only - for the management of breakthrough pain in adults using opioid therapy for chronic cancer pain & who are unsuitable for other short acting opioids

4.7.2 Opioid analgesics continued			
Dihydrocodeine		Methadone liquid - Palliative Care Team recommendation only	Transtec ® patches prescribing restricted to Dr Meystre - during end of life care only
			Fentanyl lozenge – Palliative Care Team recommendation only
4.7.3 Neuropathic pain			
Amitriptyline (off label use)	Carbamazepine – trigeminal neuralgia only	Pregabalin – specialist initiation and stablilisation	Capsaicin 8% patch - 10 patients only via Pain Team
	Gabapentin £££		
	Clonazepam – (off-label) palliative care only		
4.7.4 Antimigraine drugs			
4.7.4.1 Migraine treatment			
Sumatriptan	Rizatriptan £		
Migraleve ® pink	Sumatriptan injection [A]		
	Naratriptan **(Primary Care only)**		
	Zolmitriptan **(Primary Care only)**		
4.7.4.2 Migraine prophylaxis			
Propranolol (section 2.4)	Pizotifen		
Amitriptyline			

Additional information		
Drug specific notes	A B C D *	These products should only be used if oral treatments are not effective Post operatively or Pain Team advice only. Not to be used in conjunction with other regular opiates. Combination products containing tramadol are NON-FORMULARY For use in patients that are unable to tolerate oral paracetamol and have established IV access. Paracetamol injection is a more cost effective option than paracetamol suppository **Caution in elderly patients (over 69)**
MTRAC / Prodigy / other guidance	Prodigy: Palliative Care series ; Prodigy: Migraine ; Prodigy: Musculoskeletal problems	
PCT information	Migraleve yellow tablets are co-codamol 8/500 and should be avoided alone or as part of Migraleve duo packs. Refer to palliative care dose conversion charts for equivalent dosings and formulations	

4.8 Antiepileptics

4.8.1 Control of epilepsy

Notes on class
Anti epileptic medications are prone to interactions; check with BNF

Green	Yellow	Double Yellow	Red
	Specialist recommendation		Retigabine – NICE TA 232
Carbamazepine	Clonazepam	Primidone (also for essential tremor – section 4.9.3)	
Sodium valproate	Lamotrigine	Zonisamide **ESCA**	
Diazepam rectal (section 4.1.2)	Gabapentin	Lacosamide **ESCA**	
	Levetiracetam		
	Phenytoin **capsules**		
	Topiramate		
	Phenobarbitone		
	Vigabatrin		

Additional information		
Drug specific notes		Phenytoin capsules cost 3p per 100mg phenytoin tablets cost £2.22 per 100mg
NICE guidance		NICE CG 137- Diagnosis and management of the epilepsies in adults and children in primary and secondary care NICE TA 232 Epilepsy (partial) - retigabine (adjuvant)
MTRAC / Prodigy / other guidance		CSM statement regarding vigabatrin Phenobarbital (phenobarbitone) and primidone, whilst still used in primary care are rarely initiated

4.8.2 Drugs used in status epilepticus

Green	Yellow	Double Yellow	Red
Diazepam rectal tubes		Midazolam buccal liquid – (unlicensed) Paediatric patients only	Diazepam injection (diazemuls)
			Paraldehyde (unlicensed)
			Lorazepam injection
			Phenytoin sodium injection
			Phenobarbital sodium injection

4.9 Drugs used in parkinsonism and related disorders

4.9.1 Dopaminergic drugs used in parkinsonism

Green	Yellow	Double Yellow	Red
Selegiline	Co-beneldopa (modified release)	**Specialist initiation**	
Co-beneldopa	Co-careldopa (modified release)	Entacapone **ESCA** - [A]	
Co-careldopa		Apomorphine (consultant initiation)	
		Stalevo ® **ESCA** - [A]	
		Pramipexole **ESCA** - [A]	
		Ropinirole **ESCA** - [A]	
		Rasagiline **ESCA**	
		Amantadine	
		Bromocriptine	
		Rotigotine patches [B]	

4.9.2 Antimuscarinic drugs used in parkinsonism

Green	Yellow	Double Yellow	Red
		Specialist initiation in Parkinson's disease	
Procyclidine (for drug –induced parkinsonism/dystonia)		Benzatropine (benztropine)	
		Orphenadrine	
		Trihexyphenidyl (benzhexol)	
		Procyclidine (Parkinsons disease)	

Additional information		
Drug specific notes	A B C	ESCA required if prescribed in primary care For use within licence in these specific circumstances • In patients who cannot swallow or their gut is not working. • Patients with poor overnight control of PD. Rotigotine can be considered after CR L dopa preparations and long half life oral DAs (e.g. ropinirole and pramipexole) • Patients with erratic motor control during the daytime despite using oral long acting DAs, e.g. ropinirole or pramipexole either as standard TDS regimes or once daily SR preparations. In this setting rotigotine patch can be useful before considering sc apomorphine infusion of enteral duodopa infusion. The latter two treatment options are much more invasive and expensive. • Patients intolerant of current first line DAs (ropinirole and pramipexole) should be considered for rotigotine before abandoning the DA class of drugs. NICE state that "newer drugs" should be used in patients refractory to treatment with older AEDs or for whom older drugs are contraindicated. Combination therapy should be used only when monotherapy has failed.
NICE guidance		NICE CG 137 Diagnosis and management of epilepsy in adults and children
MTRAC / Prodigy / other guidance		CSM statement regarding pergolide CSM statement regarding fibrotic reactions with pergolide and other ergot-derived dopamine receptor agonists

4.9.3 Drugs used in essential tremor, chorea, tics, and related disorders

Green	Yellow	Double Yellow	Red
Primidone	Haloperidol	Riluzole ESCA – NICE TA 20	Botulinum A toxin
Propranolol	Piracetam		
	Tetrabenazine		

Additional information		
Drug specific notes		
NICE guidance		NICE TA 20 Motor neurone disease - riluzole NICE TA 260 Migraine (chronic) - botulinum toxin type A
MTRAC / Prodigy / other guidance		

4.10 Drugs used in substance dependence

Green	Yellow	Double Yellow	Red
Nicotine replacement therapy (Patch – considered first line)	Bupropion	Methadone mixture 1mg/ml – [A] on advice of substance misuse team only (NICE TA 114)	Lofexidine - for use within licence as part of the SAFE project
	Varenicline £££– when NRT inappropriate or has failed. One 12 week cycle only	Buprenorphine- On advice of substance misuse team only (NICE TA 114)	Naltrexone – substance misuse team only
		Acamprosate	

Additional information		
Drug specific notes		
NICE guidance		NICE TA 20 (Motor neurone disease - riluzole) NICE PH 10 Smoking cessation services NICE TA 114 Drug misuse - methadone and buprenorphine NICE TA 115 Drug misuse - naltrexone NICE TA 123 Smoking cessation - varenicline
MTRAC / Prodigy / other guidance		

4.11 Drugs for dementia

Notes on class

Green	Yellow	Double Yellow	Red As per NICE TAs
			Donepezil
			Galantamine
			Rivastigmine
			Memantine

Additional information	
Drug specific notes	
NICE guidance	NICE TA 217 Alzheimer's disease - donepezil, galantamine, rivastigmine and memantine
MTRAC / Prodigy / other guidance	
PCT information	Patients living within the Birmingham and Solihull areas are treated by the Birmingham and Solihull Mental Health Trust with all prescribing undertaken by the Mental Health Trust.

5. Infections

Guidance for the Management of Infection in Primary Care

Notes

- Prescribe an antibiotic only when there is likely to be a clear clinical benefit i.e. clinical indication of infection. Apply lower threshold for antibiotics in immunocompromised or those with multiple morbidities. Collect cultures where appropriate.
- A dose and duration for adults is suggested, but may need modification for age, weight or renal function. In severe or recurrent cases consider a larger dose or longer course. Please refer to BNF for further dosing and interaction information (e.g. interaction between macrolides and statins) if needed and please check for hypersensitivity
- Paediatric doses stated in BNFc may be found at Appendix 1. Refer to the BNF and BNFc for further dosing information.
- Consider a no, or delayed, antibiotic strategy for acute self-limiting upper respiratory tract infections. Avoid broad spectrum antibiotics (co-amoxiclav, 2nd and 3rd generation cephalosporins, quinolones) if possible as they increase risk of *Clostridium difficile*, MRSA *(both not as much a concern for children)* and UTIs caused by multi-drug-resistant organisms.
- Limit prescribing over the telephone to exceptional cases.
- In pregnancy AVOID tetracyclines, aminoglycosides, quinolones, and high dose metronidazole. Short term use of nitrofurantoin is unlikely to cause problems to the foetus; nor is trimethoprim unless poor dietary folate intake or taking another folate antagonist e.g. antiepileptic.
- Clarithromycin is an acceptable alternative in those who are unable to tolerate erythromycin because of side effects.
- Avoid widespread use of topical antibiotics, especially those agents also available as systemic preparations e.g. fusidic acid.
- Where a 'best guess' therapy has failed or special circumstances exist, microbiological advice can be obtained from 0121 424 2000 and ask for the duty microbiologist on call. Send appropriate specimens wherever indicated.
- The content of the formulary reflects evidence or consensus opinion at the time of compilation. Evidence or opinion may change over time and it is the responsibility of the prescriber to ensure that new evidence or national guidelines are taken into account in their prescribing. The individual prescriber remains responsible for the patient's care and the prescription written.
- There are useful resources on antibiotics including patient information leaflets, antibiotic posters, training programmes on antibiotics available at the following website TARGET antibiotics resources

Index of sections

Click on the link below:

Illness	Comments	First Line	Second Line
MENINGITIS			
Suspected meningococcal disease HPA	**Transfer all patients to hospital immediately.** If time before admission, **and non-blanching rash** give either IV benzylpenicillin or cefotaxime unless definite history of hypersensitivity. i.e. history of difficult breathing, collapse, loss of consciousness, or rash. If history of anaphylaxis with penicillins or cephalosporins, seek urgent advice from on-call microbiologist via BHH switchboard 0121 424 2000.	IV# Benzylpenicillin Children <1 yr: 300 mg Children 1 - 9 yr: 600 mg Other: 1200 mg IV# Cefotaxime ≥ 12yrs 1g < 12 yrs 50mg/kg (max 1g) # Give IM if vein cannot be found	
Prevention of secondary case of meningitis: Only prescribe following advice from a Public Health Doctor 0121 352 5345 or 5349. Out of hours contact duty microbiologist via Heartlands switchboard 0121 424 2000.			
EMERGENCY TREATMENT FOR COMMUNITY ACQUIRED PNEUMONIA IN ADULTS			

Illness	Comments	First Line	Second Line
Community acquired pneumonia	Use CRB65 score to help guide and review: Each scores 1: New **C**onfusion (AMT<8); **R**espiratory rate >30/min; **B**P systolic <90 or diastolic ≤ 60 Age ≥ **65** years **Score 3-4: urgent hospital admission**	If delayed admission (> 6 hours) / life threatening **Unless history of** hypersensitivity[Ω] IM or iv Benzylpenicillin 1200 mg OR IM or iv Cefotaxime 1g OR Amoxicillin 1000mg by mouth Ω See under meningitis above	
UPPER RESPIRATORY TRACT INFECTIONS:			
Common Cold CKS Common Cold		Symptomatic treatment	

Illness	Comments	First Line	Second Line
Influenza HPA Influenza NICE TA 158 Influenza prophylaxis	Annual vaccination is essential for all those at risk of influenza. See DoH Guidance for definition of at risk groups and vaccination schedule including pandemic influenza vaccination where appropriate Treat 'at risk' patients **only** when influenza is circulating in the community as confirmed by the DoH, within 48 hours of onset. Offer post-exposure prophylaxis only in line with NICE During epidemic follow HPA or equivalent national/local guidance.	**Treatment** Oseltamivir 75mg BD for 5 days * *Adult dose – for children see BNFc **Prophylaxis** Oseltamivir 75mg OD for 10 days * *Adult dose – for children see BNFc	If there is resistance to oseltamivir or if pregnant **Treatment** Zanamivir 10mg BD (2 inhalations by diskhaler) for 5 days* *Adult dose – for children see BNFc **Prophylaxis** Zanamivir 10mg OD (2 inhalations by diskhaler) for 10 days* *Adult dose – for children see BNFc

Illness	Comments	First Line	Second Line
Acute Sore Throat CKS Acute Sore Throat SIGN Guideline 117 (2010) NICE CG69 (2008)	The majority of sore throats are viral; most patients do not benefit from antibiotics. 90% of acute sore throats will resolve in 7 days without antibiotics and pain is only reduced by 16 hours Antibiotics to prevent Quinsy NNT>4000 Antibiotics to prevent Otitis media NNT 200 Use Clinical Prediction Rule to estimate likelihood of Group A beta haemolytic Streptococcus If Centor score 3 or 4 (fever, no cough, lymphadenopathy, tonsillar exudate), consider 2-3 day delayed, or immediate antibiotics. If the patient reconsults then a swab should be taken	Symptomatic treatment **If antibiotics indicated, consider delayed prescription, held in the practice as per original study**[λ] Phenoxymethylpenicillin 500mg QDS for 10 days * (Syrup has unpleasant taste – use tablets wherever possible) *OR (if allergic to penicillin)* Clarithromycin 500mg BD for 5 days * (for child, consider erythromycin) * Adult doses – for children see Appendix 1	[λ] Little P, Williamson I, Warner G et al. (1997) Open randomised trial of prescribing strategies in managing sore throat. BMJ 314: 722-7

Illness	Comments	First Line	Second Line
Acute Otitis Media CKS	**Children** Evidence suggests that slightly more children will be pain free at 2 days if they take ibuprofen TDS than if given paracetamol TDS. However, use of ibuprofen may be associated with a slightly higher risk of mild nausea, vomiting or abdominal pain Avoid antibiotics as 60% are better in 24 hours without; they only reduce pain at 2 days (NNT 15) and do not prevent deafness Consider 2 or 3 day-delayed or immediate antibiotics for pain relief if: • <2yrs with bilateral AOM NNT4 • All ages with otorrhoea NNT3 Antibiotics to prevent Mastoiditis NNT > 4000 Macrolides are not the drug of choice against Haemophilus.	If no vomiting or temp <38.5°C optimise analgesia with paracetamol or ibuprofen. **Consider delayed prescription, held in practice as per original study.** If antibiotics indicated: Amoxicillin 500mg TDS for 5 days* *OR (if allergic to penicillin***)** For children Erythromycin Doses see Appendix 1 For adults Clarithromycin 500mg BD for 5 days* * Adult doses – for children see Appendix 1	

Illness	Comments	First Line	Second Line
Acute Otitis externa CKS	First use aural toilet (if available) and analgesia. Cure rates similar at 7 days for topical acetic acid or antibiotic +/- steroid If cellulitis or disease extending outside aural canal, start oral antibiotics and refer. (see cellulitis) In children with "grommets", topical treatment should be used with care. In the immunocompromised or (older) diabetic patient where *Pseudomonas aeruginosa* is identified in an ear swab, **malignant otitis externa** must be considered. This invasive infection is associated with severe pain. Immediate referral to the ENT surgeon is necessary.	Acetic acid 2% (Earcalm® ear spray is available to the public): 1 spray TDS to affected ear(s) for 7 days. After topical treatment has been applied, the patient must lie with the ear "up" for at least 10 minutes to enable maximum contact with the lining of the ear.	Dexamethasone 0.1%, neomycin sulphate 3250 units/mL, glacial acetic acid 2%. (Otomize) 1 spray TDS to affected ear(s) for 7days.

Illness	Comments	First Line	Second Line
Rhinosinusitis acute or chronic CKS	Avoid antibiotics as 80% resolve in 14 days without, and they only offer marginal benefit after 7 days NNT 15 Reserve antibiotics for severe symptoms +/or >10 days Use adequate analgesia Consider 7-day delayed or immediate antibiotic when purulent nasal discharge NNT 8	Do not prescribe OR Amoxicillin 500mg TDS for 7 days (Adult dose – for children see Appendix 1) *OR* Doxycycline 200mg stat, then 100mg daily (7 day course) (Adult dose. Not for use in children under 12 years or in pregnancy or lactation.) Seek expert advice for child allergic to penicillin.	

Illness	Comments	First Line	Second Line
LOWER RESPIRATORY TRACT INFECTIONS			
Do NOT use quinolone (ciprofloxacin, ofloxacin) first line due to poor pneumococcal activity. Reserve all quinolones for **proven** resistant organisms			
Acute cough, bronchitis Clinical Knowledge Summaries: Acute bronchitis - adult NICE CG69 (2008)	Antibiotics have little benefit if no co-morbidity Symptom resolution may take 3 weeks Consider 7day delayed antibiotic with symptomatic advice/leaflet Consider immediate antibiotics if > 80yr and ONE of: hospitalisation in past year, oral steroids, diabetic, congestive heart failure OR> 65yrs with 2 of above	Do not prescribe OR Amoxicillin 500mg TDS for 5 days * *OR (if allergic to penicillin)* Clarithromycin 500mg BD for 5 days * For child, consider erythromycin * Adult doses – for children see Appendix 1	Doxycycline 200mg stat then 100mg OD. 5 day course. (Adult dose. Not for use in children under 12 years or in pregnancy or lactation.)

Illness	Comments	First Line	Second Line
Acute exacerbation of COPD Adults only Clinical Knowledge Summary - Management of exacerbation of COPD NICE COPD guidelines CG 101	Antibiotics are not indicated in the absence of purulent sputum, unless consolidation on chest radiograph or clinical signs of pneumonia Treat exacerbations promptly with antibiotics if purulent sputum **and** increased shortness of breath **and/or** increased sputum volume *Risk factors for antibiotic resistant organisms include co-morbid disease, severe COPD, frequent exacerbations, antibiotics in last 3 months*	Amoxicillin 500mg TDS for 5 days *OR* Doxycycline 200mg stat then 100mg OD for 5 days (not for use in pregnancy or lactation) *In penicillin allergy:* Clarithromycin 500mg BD for 5 days	*3rd line if clinical failure to other antibiotics/resistance risk factors*: Co-amoxiclav 625mg TDS for 5 days

Illness	Comments	First Line	Second Line
Community-acquired pneumonia: ADULTs Treatment in the community Clinical Knowledge Summary (Prodigy) - Community acquired pneumonia BTS CAP Guidelines Updated 2009	Use CRB65 score to help guide and review: Each scores 1: New **C**onfusion (AMT<8); **R**espiratory rate >30/min; **B**P systolic <90 or diastolic ≤ 60; Age ≥ **65** years Score 0: suitable for home treatment; Score 1-2: hospital assessment or admission **Score 3-4: urgent hospital admission** Give immediate IM Benzylpenicillin or amoxicillin 1g orally if delayed admission (> 6 hours) / life threatening Mycoplasma infection is rare in over 65s	**IF CRB65 = 0 :** Amoxicillin 500mg TDS for 7 days *OR* Clarithromycin 500mg BD for 7 days *OR* Doxycycline 200mg stat/100mg OD for 7 days (Adults only. Not for use in pregnancy or lactation.) **If CRB65 = 1 & AT HOME** Amoxicillin 500mg TDS AND clarithromycin 500mg BD for 7 – 10 days OR Doxycycline alone 200mg stat/100mg OD for 7–10 days	

Illness	Comments	First Line	Second Line
Community- acquired pneumonia CHILDREN Treatment in the community Clinical Knowledge Summary - Community Acquired Pneumonia in children	CRB65 scoring system not appropriate CKS CAP in children Risk Assessment tool For children who are managed at home advise carers to: Control fever and maintain hydration with self-care measures. Check on the child regularly, including through the night, and seek medical advice if the child deteriorates or the carers are unable to cope. **Arrange a review of the child and refer for hospital assessment if:** The child deteriorates on treatment. The child does not improve after 48 hours of treatment.	For child well enough to be treated in the community **Child under 5 years of age** Amoxicillin 1 month – <1 year: 125mg TDS 1 - <5 years: 250mg TDS All for 5 - 7 days OR *(if allergic to penicillin*) Erythromycin ethylsuccinate SF suspension 1 month - < 2years: 250mg QDS for 7 days ≥ 2 years: 500mg QDS for 7 days **Child ≥5 years of age** Amoxicillin ≥ 5 years: 500mg TDS for 5 – 7 days OR *if allergic to penicillin* OR during known *Mycoplasma* outbreak Erythromycin ethylsuccinate SF suspension ≥ 2 years: 500mg QDS for 7 days	Ref: NHS Clinical Knowledge summary NHS Clinical Knowledge Summaries - Clinical topic - Cough - acute with chest signs in children Accessed 04.11.10

Illness	Comments	First Line	Second Line
URINARY TRACT INFECTIONS **People >65yrs: do not treat asymptomatic bacteriuria;** it is common but is not associated with increased morbidity **Catheter in situ: antibiotics will not eradicate asymptomatic bacteriuria;** only treat if systemically unwell or pyelonephritis likely **Do not use prophylactic antibiotics for catheter changes unless history of catheter-change associated UTI** **Please do not use ciprofloxacin unless no other option available**			
Uncomplicated UTI in men and non-pregnant adult females (i.e. no fever or flank pain) HPA UTI quick reference guide ESBLs Clinical Knowledge Summary - UTI in women over 14 years Clinical Knowledge Summary - UTI (lower) men	Uncomplicated lower UTI in non pregnant women (Birmingham and Solihull August 2012) Women with severe/≥ 3 symptoms: treat Women with mild/ ≤ 2 symptoms: use dipstick to guide treatment. Men: send pre-treatment MSU OR if symptoms mild/non-specific, use –ve nitrite and leucocytes to exclude UTI	Trimethoprim 200mg BD or Nitrofurantoin 100mg m/r BD Women for 3 days Men for 7 days	Community multi-resistant E. coli with Extended-spectrum Beta-lactamase (ESBL) enzymes are increasing so perform culture in all treatment failures. ESBLs may be sensitive to nitrofurantoin. Seek specialist advice.
Acute prostatitis BASHH Guidelines Clinical Knowledge Summaries	Consider referral for GUM opinion Send MSU for culture and start antibiotics 4 weeks treatment may prevent chronic infection Quinolones achieve higher prostate levels	Ciprofloxacin 500mg BD for 28 days	Trimethoprim 200mg bd for 28 days

Illness	Comments	First Line	Second Line
UTI in pregnancy HPA UTI quick reference guide CKS	Send pre-treatment MSU for culture & sensitivity and commence empirical antibiotics. In pregnancy, short term use of trimethoprim or nitrofurantoin is unlikely to cause problems to the foetus Avoid trimethoprim if low folate status or on folate antagonist (eg antiepileptic or proguanil)	Cefalexin 500mg TDS for 7 days	Nitrofurantoin 100mg m/r BD for 7 days OR Trimethoprim 200mg (off label) BD for 7 days Give folic acid if first trimester

Illness	Comments	First Line	Second Line
UTI in Children CKS NICE CG54 Urinary tract infection in children: diagnosis, treatment and long-term management: Quick reference guide See pp 8 & 9 NICE CG 47 Feverish Illness in Children	Children <3mths: refer urgently for assessment Child ≥3mths: assess and manage in line with NICE 54 and 47. Start antibiotic treatment, unless high risk of serious illness in child < 3 years of age, then refer urgently. If suspect upper UTI seek specialist advice	Co-amoxiclav < 1 year Consult BNFc 1 – 6 years 5ml of 125/31mg suspension TDS 6 – 12 years 5ml of 250/62mg suspension TDS >12 years 1 x 250/125mg tablet TDS All doses are for 3 days	Cefalexin in divided doses 3mths - 1 yr 125mg BD 1-5 yrs 125mg TDS 5-12 yrs 250mg TDS > 12 years 500mg TDS All doses are for 3 days
Acute pyelonephritis (adults) Clinical Knowledge Summary (Prodigy) - Acute pyelonephritis	If admission not required, send MSU for culture & sensitivities and start antibiotics. If no response to treatment within 24 hours admit.	Co-amoxiclav 625mg TDS for 10 days OR For patients with penicillin allergy Ciprofloxacin 500mg BD for 7 days	

Illness	Comments	First Line	Second Line
Recurrent UTI in non-pregnant women **≥3 UTIs/year**	Consider STIs Emphasise good fluid intake, and post-coital micturition. Cranberry products OR Post-coital OR standby antibiotics may reduce recurrence Post coital prophylaxis is as effective as prophylaxis taken nightly. Nightly prophylaxis: reduces UTIs but adverse effects Review every 3 months.	Nitrofurantoin 50- 100mg OR Trimethoprim 100mg BOTH: stat post coital (off-label) OR OD at night	

Illness	Comments	First Line	Second Line
GASTRO-INTESTINAL TRACT INFECTIONS			
Eradication of H.pylori NICE CG17 Dyspepsia: Quick reference guide HPA QRG Diagnosis of H.pylori in dyspepsia Clinical Knowledge Summaries - Dyspepsia unidentified cause Clinical Knowledge Summaries - H.pylori eradication in PU disease **Managing symptomatic relapse** DU: Duodenal ulcer GU: Gastric ulcer NUD : Non ulcer dyspepsia GORD: Gastro oesophageal reflux disease	Eradication beneficial in DU, GU, and low grade MALToma, For NUD, the NNT is 14 for symptomatic relief Consider test & treat in persistent uninvestigated dyspepsia Do not offer eradication in GORD – it is not effective Do not use clarithromycin or metronidazole if used in the past year for any infection. DU/GU relapse – retest for *H. pylori* if symptomatic using breath test OR consider endoscopy for culture & susceptibility NUD- Do not retest, treat as functional dyspepsia offer PPI or H_2RA	PPI (cheapest) Full dose BD AND Clarithromycin 250mg BD AND Metronidazole 400mg BD all for 7 days *or* PPI (cheapest) Full dose BD AND Clarithromycin 500mg BD AND Amoxicillin 1g BD all for 7 days	PPI (cheapest) Full dose BD AND Bismuthate (De-nol tab®) 120mg QDS AND 2 unused antibiotics: • Amoxicillin 1g BD • Metronidazole 400mg TDS • Tetracycline 500mg QDS Relapse or MALToma – 14 days

Illness	Comments	First Line	Second Line
Clostridium difficile HPA	Stop unnecessary antibiotics and/or PPIs and/or laxatives 70% respond to Metronidazole in 5 days; 92% in 14 days If severe symptoms or signs (below) or for relapses seek specialist advice. Admit if severe: T >38.5; WCC >15, rising creatinine or signs/symptoms of severe colitis	**1st / 2nd episodes** Metronidazole 400mg TDS for 14 days	**3rd episode / severe** Seek specialist advice
Infectious diarrhoea CKS	Refer previously healthy children with acute painful or bloody diarrhoea to exclude *E. coli* 0157 infection. **Antibiotic therapy not indicated unless systemically unwell**. If systemically unwell and campylobacter suspected (e.g. undercooked meat and abdominal pain), consider clarithromycin 500 mg BD for 5–7 days if treated early. Beware of haemolytic uraemic syndrome (HUS) following VTEC 0157 which is increased with antibiotics		
Traveller's Diarrhoea **Clinical Knowledge Summaries - Travellers Diarrhoea**	**Only consider standby antibiotics for** remote areas or people at high-risk of severe illness with travellers' diarrhoea If stand-by treatment appropriate give: ciprofloxacin 500mg BD x 3 days **This would be a private prescription** If quinolone resistance high (e.g. South Asia): consider bismuth subsalicylate (PeptoBismol) 2 tablets QDS as prophylaxis or 2 days treatment (bought OTC from pharmacy)		

Illness	Comments	First Line	Second Line
Threadworms Clinical Knowledge Summary - Threadworm BNF for Children: 5.5.1 Drugs for threadworms	Treat household contacts at the same time PLUS Advise on hygiene measures for 2 weeks (hand hygiene, pants at night, morning shower) PLUS Wash sleepwear, bed linen, dust and vacuum on day one BNFc 2013 states that mebendazole is the drug of choice in children > 6 months. Reinfection is common and a second dose may be required after 2 weeks. Use under the age of 2 years is off-label	Adult and child > 6 months Mebendazole 100mg stat (Off label if < 2 years) Infant 3-6 months Piperazine + sennoside preparation (Pripsen) 2.5ml spoon stat and repeat after 2 weeks Infant < 3 months Six weeks hygiene	
Other worms	Seek advice from ID specialist	Treatment to be prescribed by ID specialist (not GP).	

Illness	Comments	First Line	Second Line
GENITAL TRACT INFECTIONS			
Vaginal candidiasis Guidelines - BASHH STI screening Clinical Knowledge Summaries	All topical and oral azoles give 75% cure In pregnancy avoid oral azole - use intravaginal for 7 days People with risk factors should be screened for chlamydia, gonorrhoea, HIV, syphilis. Refer individual and partners to GUM service. Risk factors: no condom use, recent (<12m) or frequent change of sexual partner, symptomatic partner.	Clotrimazole 10% 5g vaginal cream stat OR Clotrimazole 500mg pessary stat OR Fluconazole 150mg orally stat	
Chlamydia trachomatis Management of abnormal vaginal discharge SIGN BASHH **HPA** **BKS**	Ideally, refer all patients with positive result to open access GUM service for treatment, contact screening and investigation for further STIs.	Azithromycin 1g stat 1 hour before food OR Doxycycline 100mg BD x 7 days	Doxycycline 100mg BD for 7 days (not for use in pregnancy or lactation)
Bacterial vaginosis BASHH Clinical Knowledge Summaries HPA Management of abnormal vaginal discharge	Pregnancy or breastfeeding: Oral metronidazole (MTZ) is as effective as topical but cheaper Less relapse with 7 day 1gm 2gm stat, at 4 weeks Pregnant/breast feeding: avoid 2g stat Treating partner(s) does not reduce relapse	Pregnancy: Clotrimazole 100mg pessary at night x 6 nights Metronidazole 2% cream 5g intravaginally BD x 7 days OR Metronidazole 400mg BD for 7 days or 2g stat OR Amoxicillin 500mg TDS for 7 days	Metronidazole 0.75% vaginal gel 5g applicatorful at night x 5 nights OR Clindamycin 2% cream 5g applicator full at night for 7 days
	For all age groups, send a urine sample for Chlamydia and GC PCR, need to specifically request BOTH of these tests. “First-catch” urine, 5-10 mL, should be collected into a RED top sterile container, at least 1 hour (preferably 2), after the last micturition. For patients with urethral discharge, confirmed N.gonorrhoea or Chlamydia refer to GUM clinic Need for urgent scrotal U/S should be made on an individual patient basis.	Beta-lactam allergy: monotherapy with ofloxacin 400 mg bd for 14 days	

Trichomoniasis BASHH Clinical Knowledge Summaries HPA Management of abnormal vaginal discharge	Ideally, refer all patients to open access GUM service for treatment, contact screening and investigation for further STIs.	Metronidazole 400mg BD for 5 - 7 days OR Metronidazole 2g in a single dose (Avoid single dose regimen in pregnancy or breastfeeding) OR Clotrimazole 100mg pessary at night for 6 nights (Gives symptomatic relief - not cure).	

Pelvic Inflammatory Disease (PID) BASHH RCOG Clinical Knowledge Summaries	Refer woman and contacts to GUM clinic. Essential to test for Chlamydia and *N. gonorrhoeae.* 28% of gonorrhoea isolates now resistant to quinolones. If gonorrhoea likely (partner has it, severe symptoms, sex abroad) avoid ofloxacin regimen Admit in pregnancy or lactation as primary care antibiotic regimens are not suitable	Metronidazole 400mg BD for 14 days PLUS Ofloxacin 400mg BD for 14 days OR if high risk of GC Cefixime 400mg stat PLUS Metronidazole 400mg BD for 14 days PLUS Doxycycline 100mg BD for 14 days	

Illness	Comments	First Line	Second Line
SKIN/SOFT TISSUE INFECTIONS			
Impetigo Clinical Knowledge Summary - Impetigo	As resistance is increasing reserve topical antibiotics for very localised lesions only. For extensive, severe, or bullous impetigo, use oral antibiotics Reserve Mupirocin for MRSA.	Flucloxacillin (suspension has unpleasant taste – use capsules wherever possible.) 500mg QDS for 7 days * *OR (if allergic to penicillin)* Clarithromycin 250 – 500mg BD for 7 days * (for child, consider erythromycin) * Adult doses – for children see Appendix 1	Fusidic acid topically TDS for 5 days OR Mupirocin topically TDS for 5 days (for MRSA only)

Illness	Comments	First Line	Second Line
Eczema Clinical Knowledge Summary - Atopic eczema	Using antibiotics does not improve healing. In absence of visible signs of infection, use of antibiotics (alone or with steroids) encourages resistance. No evidence for use of combined topical antibiotics and steroids. In presence of visible signs of infection use treatment as in impetigo. Visible signs of infection • Cellulitis, spreading necrosis • Markedly increasing exudate • Increasing pain and swelling at eczema sites		

Illness	Comments	First Line	Second Line
Cellulitis in adults CKS	If febrile and ill, consider referral to Home iv service Solihull CCG protocols available at IV therapy and cellulitis Tel: 0121 746 4499 (Solihull Community IV therapy team) BEN protocols available at Link to be added here Tel 0845 600 4550 or admit for IV treatment If afebrile and otherwise healthy, other than cellulitis, use flucloxacillin alone Discuss with microbiologist where river or sea water exposure Treatment generally 7 days but if slow response continue for a further 7 days	Flucloxacillin 500mg QDS * Treatment generally 7 days but if slow response continue for a further 7 days Suspension has unpleasant taste – use capsules wherever possible *OR (if allergic to penicillin)* Clarithromycin 500mg BD * (for child, consider erythromycin) Treatment generally 7 days but if slow response continue for a further 7 days **In facial cellulitis** Co-amoxiclav 500/125mg TDS * Treatment generally 7 days but if slow response continue for a further 7 days **In periorbital cellulitis** Admit Adult doses – for children see Appendix 1	

Illness	Comments	First Line	Second Line
MRSA HPA MRSA quick reference guide.	**For MRSA screening and suppression, see HPA MRSA quick reference guide.** For active MRSA infection: Use antibiotic sensitivities to guide treatment, seek advice from microbiologist For queries on colonisation, contact Infection Prevention team Solihull tel 0121 713 8886 BEN tel _____	If active infection confirmed, antibiotic treatment guided by sensitivities, seek specialist advice. If tetracycline sensitive MRSA strain: Doxycycline 100mg BD for 7 days	
PVL HPA QRG	Panton-Valentine Leukocidin (PVL) is a toxin produced by 2% of *S. aureus*. Can rarely cause severe invasive infections in healthy people. Send swabs if recurrent boils/abscesses. At risk: close contact in communities or sport; poor hygiene [1C]		
Leg Ulcers HPA QRG CKS **Diabetic Leg Ulcer**	Ulcers always colonised. Antibiotics do not improve healing unless active infection. Active infection if cellulitis/increased pain/pyrexia/purulent exudate/odour. If active infection, send pre-treatment swab Review antibiotics after culture results	If active infection: Flucloxacillin 500mg QDS OR Clarithromycin 500mg BD for 7 days but if slow response continue for further 7 days	

Illness	Comments	First Line	Second Line
	Not all diabetic ulcers should be considered infected. A simple ulcer with exudates does not on its own merit antimicrobial therapy Not infected – no cellulitis, no signs of inflammation Mild infection – superficial cellulitis <2cm, 2 of the following symptoms of inflammation around ulcer erythema, pain, warmth, induration, Moderate infection – cellulitis >2cm, signs of inflammation around ulcer PLUS lymphangitic streaking +/or localised dry gangrene +/or deep tissue involvementRefer for specialist opinion if severe infection	Not infected – no antibiotics Mild infection Flucloxacillin 1g qds Moderate infection Co-amoxiclav 625mg TDS for 7 days and review (adult dose)	

Illness	Comments	First Line	Second Line
Bites Animal Bite CKS Human Bite	Surgical toilet most important. Assess tetanus and rabies risk. Antibiotic prophylaxis should be given for – • cat bite/puncture wound; • bite involving hand, foot, face, joint, tendon, ligament; • immunocompromised, diabetics, elderly, asplenic, cirrhotic Antibiotic prophylaxis is advised. Assess tetanus and HIV/Hep B & C risk – discuss with virologist **as a matter of urgency**	**Prophylaxis or treatment:** Co-amoxiclav 375-625mg TDS for 7 days* OR (If penicillin allergic) Cat/dog/human bite Metronidazole 200-400mg TDS for 7 days* PLUS Doxycycline 100mg BD for 7 days (not for use in pregnancy or lactation) *OR* Human bite Metronidazole 200 – 400mg TDS for 7 days * PLUS Clarithromycin 250 – 500mg BD for 7 days* (for child, consider erythromycin) **In all cases review at 24&48 hours** * Adult doses – for children see Appendix 1	

Illness	Comments	First Line	Second Line
Conjunctivitis CKS	Most bacterial infections are unilateral and self-limiting 65% resolve on placebo by day five. If a sore throat is also present then it is probably a virus and so antibiotics are not indicated. In newborn consider gonococcus, chlamydial or herpetic conjunctivitis - Send bacterial AND viral eye swabs and take history of vaginal discharge or lesions from mother. Infant will require systemic treatment – refer to paediatrics and ophthalmology for assessment and treatment Refer mother and partner(s) to GUM for assessment and treatment	Consider delayed prescription If severe: Chloramphenicol 0.5% drops 2 hourly for 2 days then reducing to every four hours whilst awake.. AND Chloramphenicol eye 1% ointment at night. Continue for 48 hours after resolution	

Illness	Comments	First Line	Second Line
Scabies Clinical Knowledge Summary - Scabies	Treat whole body from ear/chin downwards and under nails. If under 2yrs/elderly include scalp & face. Treat all household and sexual contacts within 24h.	Permethrin 5% cream. If allergy: malathion 0.5% aqueous liquid Use TWO applications one week apart	
Dermatophyte infection - nail HPA Fungal Skin and Nail Infections Clinical Knowledge Summaries - Fungal nail infections	**Take nail clippings**: **Start therapy only if infection is confirmed by laboratory.** Terbinafine is more effective than azoles For infections with yeasts and non-dermatophyte moulds use itraconazole. Liver reactions rare with oral antifungals For children – seek specialist advice	Terbinafine 250mg OD. 6-12 weeks for fingers and 3-6 months for toes. (adult dose) Itraconazole (Adult dose) 200mg BD for first 7 days of 28 day cycle. Two cycles for fingers. Three cycles for toes.	***Superficial only:*** Amorolfine 5% nail lacquer once or twice weekly.(adult dose) 6 months for fingers and 12 months for toes.

Illness	Comments	First Line	Second Line
Dermatophyte infection of the skin HPA Fungal Skin and Nail Infections Clinical Knowledge Summaries - Fungal Skin Infections - Body & Groin Clinical Knowledge Summaries - Fungal Skin Infections - Foot Clinical Knowledge Summaries - Fungal Skin Infections - Scalp	Terbinafine is fungicidal thus shorter treatment time required than with fungistatic imidazoles If candida possible use imidazole If intractable: Take skin scrapings for culture. If infection confirmed, use *oral* terbinafine/itraconazole Discuss scalp infections with dermatology specialist.	Topical terbinafine BD x 1 – 2 weeks *OR (athlete's foot only):* Topical undecanoates (Mycota®) BD for 1 -2 weeks after healing (i.e. for 4-6 weeks)	Topical imidazole BD for 1 – 2 weeks after healing (i..e. for 4 – 6 weeks)
Acne **CKS - Acne vulgaris**	Topical treatments for acne should be used first line (see section 13.6.1 of interface formulary) Co-cyprindiol contains an anti-androgen. It is no more effective than a broad spectrum antibacterial but is useful in women who also wish to receive oral contraception. Oral antibiotics should be reserved for acne if topical treatment is not adequately effective or if it is inappropriate. Minocycline is associated with increased rates of adverse effects compared to other tetracyclines and has no clear evidence of being more effective or better tolerated	Topical treatments for acne – if not effective or inappropriate Oxytetracycline 500mg bd (not for use in pregnancy or lactation)	Doxycycline 100mg od (not for use in pregnancy or lactation) OR Lymecycline 408mg od (not for use in pregnancy or lactation) Third line (reserved for patients not responding to other antibiotics – specialist recommendation only) Minocycline MR 100mg od (not for use in pregnancy or lactation)

Illness	Comments	First Line	Second Line
Varicella zoster/ Chicken pox & **Herpes zoster/ Shingles** CKS (chicken pox) CKS (shingles)	If pregnant or immunocompromised or neonate: seek urgent specialist advice. **Chicken pox**: Clinical value of antivirals minimal unless adult with severe pain or dense/oral rash or on steroids or secondary household case or smoker **AND** treatment started <24h of onset of rash – consider aciclovir **Shingles**: Treat if • active ophthalmic, or Ramsay Hunt syndrome, or eczema OR • over 50 years and within 72 hrs of onset of rash (post herpetic neuralgia rare if < 50 years)	*Where indicated:* Aciclovir 800mg five times a day for 7 days * Emphasise importance of compliance with regimen * Adult doses – for children see Appendix 1	**In exceptional cases only** Valaciclovir 1g TDS* OR Famciclovir 250mg TDS* Both for 7 days **NOTE: Ten to twenty times cost of aciclovir – only use if serious compliance problems in shingles** * Adult doses

Illness	Comments	First line	Second line
DENTAL INFECTIONS – derived from the Scottish Dental Clinical Effectiveness Programme 2011 SDCEP Guidelines			
• This guidance is not designed to be a definitive guide to oral conditions. It is for GPs for the management of acute oral conditions pending being seen by a dentist or dental specialist. GPs should not routinely be involved in dental treatment and, if possible, advice should be sought from the patient's dentist, who should have an answer-phone message with details of how to access treatment out-of-hours, or NHS Direct on 0845 4657			
Mucosal ulceration and inflammation (simple gingivitis)	• Temporary pain and swelling relief can be attained with saline mouthwash • Use antiseptic mouthwash: If more severe & pain limits oral hygiene to treat or prevent secondary infection. • The primary cause for mucosal ulceration or inflammation (aphthous ulcers, oral lichen planus, herpes simplex infection, oral cancer) needs to be evaluated and treated.	Simple saline mouthwash - ½ tsp salt dissolved in glass warm water Always spit out after use. Use until lesions resolve or less pain allows oral hygiene	Chlorhexidine 0.12-0.2% (Do not use within 30 mins of toothpaste) - Rinse mouth for 1 minute BD with 5 ml diluted with 5-10 ml water. Hydrogen peroxide 6% (spit out after use) Rinse mouth for 2 mins TDS with 15ml diluted in ½ glass warm water Always spit out after use. Use until lesions resolve or less pain allows oral hygiene
Acute necrotising ulcerative gingivitis	Commence metronidazole and refer to dentist for scaling and oral hygiene advice Use in combination with antiseptic mouthwash if pain limits oral hygiene	Metronidazole 400mg TDS for 3 days Chlorhexidine or hydrogen peroxide (see above dosing in mucosal ulceration). Until oral hygiene possible	

Pericoronitis	Refer to dentist for irrigation & debridement. If persistent swelling or systemic symptoms use metronidazole. Use antiseptic mouthwash if pain and trismus limit oral hygiene	Amoxicillin 500mg TDS for 3 days Metronidazole 400mg TDS for 3 days Chlorhexidine or hydrogen peroxide see above dosing in mucosal ulceration Until oral hygiene possible	
Dental abscess	• Regular analgesia should be first option until a dentist can be seen for urgent drainage, as repeated courses of antibiotics for abscess are not appropriate; Repeated antibiotics alone, without drainage are ineffective in preventing spread of infection. • Antibiotics are recommended if there are signs of severe infection, systemic symptoms or high risk of complications. • Severe odontogenic infections; defined as cellulitis plus signs of sepsis, difficulty in swallowing, impending airway obstruction, Ludwigs angina. Refer urgently for admission to protect airway, achieve surgical drainage and IV antibiotics • The empirical use of cephalosporins, co-amoxiclav, clarithromycin, and clindamycin do not offer any advantage for most dental patients and should only be used if no response to first line drugs when referral is the preferred option.		
	If pus drain by incision, tooth extraction or via root canal. Send pus for microbiology. *If spreading infection* (lymph node involvement, or systemic signs ie fever or malaise) ADD metronidazole[8-10C]	Amoxicillin 500mg TDS Up to 5 days review at 3d *True penicillin allergy:* Clarithromycin *500 mg BD Up to 5 days review at 3 days*	Severe infection add Metronidazole 400mg TDS

Additional information	
CT information	Drug Tariff

References:	Health Protection Agency: Management of Infection - Guidance for Primary Care BNF 64 (Sept 2012) BNF for Children 2013
Development Group	Dr D Pillay, Dr K Nye, Dr K Struthers, Microbiology, HEFT Dr S Welch, Dept of Paediatrics, HEFT Karen Ennis, Mark Dasgupta, NHS BEN; Kate Arnold, SCT Update May 2013 Dr D Pillay, Rakhi Aggarwal, Bethan Knight, Shahzad Razaq
Consultation	Dr D Pillay, Dr K Nye, Microbiology, HEFT, & HEFT Antimicrobial committee Dr S Hackett, Dr S Welch, Dept of Paediatrics, HEFT Dr Jenny Short, Consultant ID Physician, HEFT Dr Husam Osman, Consultant Virologist, HEFT
Approval	Trust Antimicrobial Committee, Formulary Working Group, Solihull CCG Drug and Therapeutics Committee; BCCCCG Medicines Management Group

APPENDIX 1

Doses for children		
Drug	**BNFc 2012-13 doses**	**Notes**
Phenoxymethylpenicillin	1 month - 1yr 62.5mg QDS † 1-6 yrs 125mg QDS † 6-12 yrs 250mg QDS † >12 yrs 500mg QDS (1g QDS in severe infection) † May be increased to 12.5mg/Kg QDS in severe infection	Syrup has unpleasant taste – use tablets wherever possible
Amoxicillin	1 month - 1 yrs 62.5mg TDS 1- 5yrs 125mg TDS 5 - 18yrs 250mg TDS Dose doubled in community acquired pneumonia or other severe infection.	Dose also doubled in salmonellosis or Lyme disease (not featured in this guideline)
Flucloxacillin	1 month - 2 yrs 62.5 - 125mg QDS 2-10 yrs 125 - 250mg QDS >10yrs 250 - 500mg QDS	Suspension has unpleasant taste – use capsules where possible
Co-amoxiclav	< 1 year Consult BNFc 1 – 6 years 5ml of 125/31mg suspension TDS 6 – 12 years 5ml of 250/62mg suspension TDS >12 years 1 x 250/125mg tablet TDS Dose doubled in severe infection	
Cefalexin	1m - 1 yr 125mg BD 1-5 yrs 125mg TDS 5-12 yrs 250mg TDS > 12 years 500mg BD – TDS (increased to 1 – 1.5g 3-4 times daily for severe infection)	

Erythromycin	1m – 2yr 125mg QDS 2 – 8 yr 250mg QDS >8 yr 250 – 500mg QDS Dose doubled in severe infection	Total daily dose may be given in two divided doses
Clarithromycin	Child 1m – 12 years – dose by bodyweight Body-weight < 8kg 7.5mg/Kg BD Body-weight 8 – 11 Kg 62.5mg BD Body-weight 12 – 19Kg 125mg BD Body-weight 20 – 29Kg 187.5mg BD Body-weight 30 – 40Kg 250mg BD 12+ years 250mg BD (may be doubled in severe infections for max 14 days)	
Trimethoprim	6 weeks – 6 months 25mg BD 6m – 6 years 50mg BD 6 – 12 years 100mg BD 12+ years 200mg BD	
Nitrofurantoin	3m – 12 years 750 microgram/Kg QDS 12+ 50mg QDS; may be increased up to 100mg QDS in severe chronic recurrent infections	
Metronidazole	Consult BNFc	
Aciclovir Chickenpox and herpes zoster infection Other indications – see cBNF	1m - 2 years: 200mg QDS for 5 days 2-6 years: 400mg QDS for 5 days 6-12 years: 800mg QDS for 5 days 12+ (Adult dose) 800mg FIVE times daily for 7 days	

APPENDIX 2

<table>
<tr><th colspan="2">Clinical Prediction rules for Group A beta haemolytic streptococcus in tonsillitis</th></tr>
<tr><td>Centor Criteria

Ref: Centor RM et al. Med Decision Making 1981; 1 : 239 – 246

Back to acute sore throat</td><td>Assess
• History of fever
• Absence of cough
• Swollen tender anterior cervical lymph nodes
• Tonsillar Exudate

If none of the above – likelihood of GABHS < 3%
If 3 of 4 criteria present – likelihood of GABHS ca 40%</td></tr>
<tr><td>McIsaac Clinical Prediction Rule

Ref: McIsaac WJ et al, JAMA 2004; 291:1587-1595

Back to acute sore throat</td><td>Assess and score
• Temperature > 38 C = 1 point
• Absence of cough = 1 point
• Swollen tender anterior cervical lymph nodes = 1 point
• Tonsillar swelling or exudate = 1 point
• Age
➢ 3 – 14 years = 1 point
➢ 15 – 44 years = 0 point
➢ 45 years or older = subtract 1 point

<table><tr><th>Score</th><th>Risk of GABHS</th></tr><tr><td>0 or <0</td><td>1-2.5%</td></tr><tr><td>1</td><td>5-10%</td></tr><tr><td>2</td><td>11-17%</td></tr><tr><td>3</td><td>28-35%</td></tr><tr><td>4</td><td>51-53%</td></tr></table></td></tr>
</table>

INFECTIONS (SECONDARY CARE SPECIFIC)

This chapter is under development. Currently only medicines that are specifically subject to a positive NICE TA appear.

Green	Yellow	Double Yellow	Red as per NICE TAs
5.1.9 Antituberculosis			
All antituberculosis preparations are classified as RED and should be prescribed by HEFT			
5.3.1 HIV Infection			
			Tenofovir disoproxil
			Lamivudine
5.3.3 Viral hepatitis			
5.3.3.1 Chronic hepatitis B			
			Entecavir
			Adefovir dipivoxil
5.3.3.2 Chronic hepatitis c			
			Telaprevir
			Boceprevir
5.3.5 Respiratory syncytial virus			
			Palivizumab
			Ribavirin

Additional information	
NICE guidance	NICE TA 75 Hepatitis C - pegylated interferons, ribavirin and alfa interferon NICE TA 096 Hepatitis B (chronic) - adefovir dipivoxil and pegylated interferon alfa-2a NICE TA 106 Hepatitis C - peginterferon alfa and ribavirin NICE TA 153 Hepatitis B - entecavir NICE TA 154 Hepatitis B - telbivudine NICE TA 173 tenofovir disoproxil - chronic hepatitis B NICE TA 200 Hepatitis C - peginterferon alfa and ribavirin NICE TA 252 Hepatitis C (genotype 1) - telaprevir NICE TA 253 Hepatitis C (genotype 1) - boceprevir

MTRAC / Prodigy / other guidance	
PCT information	

ENDOCRINE SYTEM

6.1 Drugs used in diabetes

Notes on class
Insulins • Recent discontinuations include *Pork Actrapid, Pork Mixtard, Human Monotard, Human Insulatard, Humulin I* • Devices (syringe/pen/pre-filled pen) should be chosen to suit patient Oral antidiabetics • UKPDS study demonstrates compelling evidence for the use of metformin as first line therapy • Sulphonylureas are second line therapy • Glitazones are indicated in patients unable to tolerate a metformin/sulphonylureas combination or if either element is contra indicated (NICE 2003)

Green	Yellow	Double Yellow	Red
6.1.1 Insulins			
6.1.1.1 Short Acting Insulins			
Soluble insulin (e.g. Actrapid ® Humulin S ®)			
Insulin aspart			
Insulin glulisine			
Insulin lispro			
6.1.1.2 Intermediate & Long Acting Insulins			
Insulin glargine – NICE TA 53			
Insulin detemir			
Novomix 30 ®			
Humalog ® Mix			
6.1.2 Oral antidiabetics			
6.1.2.1 Sulphonylureas			
Gliclazide	Glibenclamide [A]		
Tolbutamide	Gliclazide M/R		

6.1.2.2 Biguanides			
Metformin	Metformin M/R [C] – ONLY for patients intolerant of slowly titrated standard release metformin		
6.1.2.3 Other antidiabetics			
	Rosiglitazone [B] - Specialist recommendation – in line with NICE	Exenatide [D] - Specialist Initiation with **RICaD**	Dapagliflozin – in line with NICE TA 288 Temporary Formulary position
	Pioglitazone -Specialist recommendation - in line with NICE	Liraglutide – Specialist Initiation with **RICaD**. Maximum formulary dose 1.2mg per day as per NICE TA 203.	
	Nateglinide- Specialist recommendation – in line with NICE	Exenatide M/R injection. Specialist initiation with **RICaD** NICE TA 248	
	Repaglinide- Specialist recommendation – in line with NICE		
Sitagliptin	linagliptin		
6.1.3 Ketoacidosis			
			IV fluids
			Soluble insulin
6.1.4 Hypoglycaemia			
Glucagon			Glucose 50 %
			Diazoxide
6.1.6 Diagnostics			
Refer to local guidelines			

Additional information		
Drug specific notes	[A]	Longer acting; avoid in elderly
	[B]	Patients admitted on combination (*Avandamet* ®) will be supplied metformin and rosiglitazone whilst in hospital
	[C]	Prescribing of Metformin M/R is expected to be in the region of 5% of the total of oral diabetic drugs. Medicines Management in Primary and Secondary care will monitor this.
	[D]	For use within licence, following specialist initiation as per NICE guidance. A **RICaD** must be provided to GPs if they are asked to take over prescribing. (NICE CG87 relating to exenatide)

NICE guidance	NICE TA 53 Diabetes (types 1 and 2) - long acting insulin analogues NICE TA 60 - Patient education models NICE CG 66 Type 2 diabetes NICE CG 87 Type 2 diabetes - newer agents NICE TA 151 Diabetes - insulin pump therapy NICE TA 203 Diabetes (type 2) - liraglutide NICE TA 248 Diabetes (type 2) - exenatide (prolonged release) NICE TA 288 Dapagliflozin in combination therapy for treating type 2 diabetes
MTRAC / Prodigy / other guidance	MEREC: Blood glucose management in type 2 diabetes ; MEREC: Managing CV risk in diabetes Prodigy: Diabetes management series
PCT information	Insulin Pumps are subject to a commissioning approval **Drug Tariff**

6.2 Thyroid & antithyroid drugs

Notes on class
• Carbimazole is associated with rare cases of neutropenia and agranulocytosis due to bone marrow suppression – Patients should be advised to report symptoms suggestive of infection, especially sore throat – Blood cell count should be performed if clinical evidence of infection – Carbimazole should be stopped if clinical/lab evidence of neutropenia

Green	Yellow	Double Yellow	Red
6.2.1 Thyroid Hormones			
Levothyroxine [A]			Liothyronine
6.2.2 Antithyroid			
Carbimazole [B]	Propylthiouracil [B]		Aqueous iodine

Additional information		
Drug specific notes	[A]	Start at 25 micrograms in elderly or in cardiac states and increas by 25 micrograms every 4-6 weeks
	[B]	Regular thyroid function tests required
NICE guidance		
MTRAC / Prodigy / other guidance	Prodigy: Hyperthyroidism ; Prodigy: Hypothyroidism	
PCT information	**Drug Tariff**	

6.3 Corticosteroids

Notes on class
• In Addisons Disease or following adrenalectomy, physiological replacement is achieved with hydrocortisone supplements with fludrocortisone to augment mineralocorticoid effect • Glucocorticoid equivalent   ○ Prednisolone 5mg ≡ dexamethasone 750 microgram ≡ hydrocortisone 20mg ≡ methylprednisolone 4mg ≡ triamcinolone 4mg • If an equivalent of >7.5mg prednisolone daily long term (>3 months) assess for osteoporosis risk In asthma a two week acute course of 40mg daily of prednisolone or equivalent or less does not need stepping down BNF - withdrawal of corticosteroids

Green	Yellow	Double Yellow	Red
6.3.1 Replacement Therapy			
Fludrocortisone			
6.3.2 Glucocorticoids			
Hydrocortisone			Betamethasone - parenteral
Prednisolone			
Dexamethasone			
Methylprednisolone - parenteral			
Triamcinolone - parenteral			

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

6.4 Sex hormones
6.4.1 Female sex hormones

Notes on class
Notes on class **Heart of England NHS Foundation Trust will usually commence women on a product from the Elleste or Evorel range immediately following hysterectomy.** • HRT no longer recommended as first choice for prevention of osteoporosis (MHRA) • HRT beneficial in quality of life vs risk balance, however, lowest effective dose used for shortest time possible, evaluate every 12 months (Committee on Human Medicines (formerly CSM) • <50 yrs do not use for first line treatment of osteoporosis • <50 yrs used as first line for premature menopausal symptoms > 50 HRT second line treatment should be considered • HRT increases risk of venous thromboembolism, stroke and endometrial and breast cancer Hormone replacement therapy: British National Formulary • Evidence suggests transdermal oestrogens do not produce the same degree of favourable alterations of lipoprotein cholesterol levels as oral oestrogens. However, oral therapy can raise triglyceride levels. Transdermal therapy may be appropriate in patients with hypertension, gall bladder disease, hypertriglyceridaemia, oral intolerance

Green	Yellow	Double Yellow	Red
6.4.1.1 Oestrogens and HRT			
Oral Combination Products			
Prempak C ® [A]			
Premique ® cycle			
Elleste-Duet ®			
Femoston ®			
Oral Oestrogen Only			
Conjugated oestrogens (Premarin ®)			
Estradiol (Elleste-Solo ®)			
Period-Free Combination (Estradiol/Norethisterone) [B]			
Premique ®			
Premique low dose ®			
Femoston-Conti ®			
Kliovance ®			

Transdermal Oestrogen Only			
	When oral therapy inappropriate		
	Estradot ® when oral therapy inappropriate		
	Evorel ® - when oral therapy inappropriate		
	FemSeven ® £- when oral therapy inappropriate		
Transdermal Combination			
	When oral therapy inappropriate	Evra® **-** Double yellow £££– for women for whom neither an oral preparation nor a long acting reversible contraceptive technology is appropriate	
	Evorel ® Sequi- when oral therapy inappropriate		
	Evorel ® Conti – when oral therapy inappropriate		
Other			
	Tibolone		
	Raloxifene [D]		
6.4.1.2 Progestogens			
Norethisterone [C]		Ulipristal acetate (Esmya ®) **ESCA** [E]	
Mirena ® - intra-uterine system			
Duphaston ® HRT			

Heart of England NHS Foundation Trust will usually commence women on a product from the Elleste or Evorel range immediately following hysterectomy.

Additional information		
Drug specific notes	A B C D E	Start with one month to ensure patient suitability, discussion of risks vs benefits essential Suitable for post menopausal, non-hysterectomised women who have not had natural period for at least one year Tranexamic acid is the first line treatment for menorrhagia, progestogens relatively ineffective, still useful to delay menses (start 3 days before period due) Raloxifene is indicated as second line for secondary prevention of osteoporotic fractures For use as per licence for pre-operative treatment of fibroids. HEFT to supply first month and ESCA and the GP to provide the further 2 months supply.
NICE guidance	NICE TA 087 Osteoporosis - secondary prevention (bisphosphonates, raloxifene and teriparatide)	
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

6.4.2 Male sex hormones

Green	Yellow	Double Yellow	Red
Finasteride [A]	Dutasteride – when finasteride has failed or is contraindicated	Testosterone undecanoate capsules – specialist recommendation only	
Testosterone implants [B]	Nebido ® injection		
Cyproterone acetate			
Testosterone 2% gel (Tostran ® 10mg metered application 60g multidose dispenser)			

Additional information		
Drug specific notes	A B	Only effective in men with enlarged prostates >40ml; useful in benign prostatic hyperplasia if alpha blockers not tolerated Transdermal formulations not currently on formulary
NICE guidance		
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

6.5 Hypothalamic and pituitary hormones and anti-oestrogens

Green	Yellow	Double Yellow as per NICE TAs	Red
6.5.1 Hypothalamic and anterior pituitary hormones and anti-oestrogens			
Anti-oestrogens			
			Clomifene citrate (clomiphene)
Anterior Pituitary Hormones			
		Somatropin	Tetracosactide (tetracosactrin)
			Chorionic gonadotrophin (human chorionic gonadotrophin HCG)
			Human menopausal gonadotrophins
Hypothalmic Hormones			
			Gonadorelin (gonadatrophin – releasing hormone GnRH, LH-RH)
			Protirelin (thyrotrophin-releasing hormone TRH)
			Corticorelin – diagnostic use only
6.5.2 Posterior pituitary hormones and antagonists			
Posterior pituitary hormones			
Desmopressin			Argipressin (synthetic vasopressin)
			Terlipressin

Antidiuretic Hormone Antagonists			
			Demeclocycline (unlicensed)
			Tolvaptan [A]

Additional information		
Drug specific notes	[A]	**TEMPORARILY** added to the red section of the formulary. It will be available only to consultants specialising in either diabetes and endocrinology, renal medicine and biochemistry.Tolvaptan will be available for 5 inpatients or for a period of 6 months (whichever is sooner). Dr Shakher will appraise FWG of the effects it had on the patients treated. FWG will then review the position of tolvaptan on the formulary.
NICE guidance	NICE TA 064 - Growth hormone deficiency in adults -somatropin NICE TA 188 Growth hormone deficiency in children - somatropin	

6.6 Drugs affecting bone metabolism

Notes on class
• NICE Guidance specifies alendronic acid/risedronate as first line for secondary prevention of fractures • People at risk of osteoporosis need to maintain an adequate intake of calcium and vitamin D; vitamin D dosage should be 800iu per day

Green	Yellow	Double Yellow	Red
Alendronic acid [A C] ££	Risedronate [A] ££	Ibandronic acid **50mg ESCA**	Disodium pamidronate
	Etidronate [A] ££	Sodium clodronate **ESCA** (Haematology	Zoledronic acid (Aclasta ® and Zometa ®) - [D]
	Strontium ranelate [B] ££		Teriparatide
			Denosumab (Prolia®) NICE TA 204
			Denosumab (Xgeva ®) NICE TA 265

Additional information		
Drug specific notes	A B C D	Tablets must be taken on rising, swallowed whole with a full glass of water, 30 minutes before food. Patient must remain upright for 30 minutes post dose For treatment of postmenopausal osteoporosis for women who can not tolerate or comply with bisphosphonate therapy Available generically and should be used first line where appropriate Zometa ® For the treatment of Paget's bone disease in patients for whom the use of a bisphosphonate is appropriate OR Aclasta ® The treatment of osteoporosis in post-menopausal women at increased risk of fractures who are unsuitable for or unable to tolerate oral treatment options for osteoporosis.
NICE guidance	NICE TA 087 Osteoporosis - secondary prevention (bisphosphonates, raloxifene and teriparatide) NICE TA 160 Osteoporosis - primary prevention NICE TA 204 Osteoporotic fractures - denosumab NICE TA 265 Bone metastases from solid tumours - denosumab NICE TA 161 Osteoporosis - secondary prevention including strontium ranelate	
MTRAC / Prodigy / other guidance	Prodigy: Osteoporosis: Treatment and prevention of fragility fractures	
PCT information	**Drug Tariff**	

6.7 Other endocrine drugs

Green	Yellow	Double Yellow	Red
6.7.1 Bromocriptine and Other Dopaminergic Drugs			
	Cabergoline (specialist recommendation)	Quinagolide – specialist initiation	
6.7.2 Drugs affecting gonadotrophins			
	Buserelin *(Suprefact)* ££	Goserelin (Zoladex ®) - for endometreosis or breast cancer ££	Goserelin - for assisted conception ££
		Danazol – specialist recommendation benign fibrocystic breast disease	Danazol – hereditary angiodema (off label)
	Leuprorelin (*Prostap*) ££		Buserelin- for assisted conception ££
6.7.3 Metyrapone and trilostane			
	Trilostane (specialist initiation)		
6.7.4 **Somatomedins**			
			Mecasermin (Increlex®) Specialist paediatricians only for ”named patients” only

Green	Yellow	Double Yellow	Red
Unlicensed			
			Stanozolol – hereditary angiodema
			Dehydroepiandosterone – Endocrinology only

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	Cabergoline, is appropriate for Primary Care prescribing after confirmation of hyperprolactinaemia by specialist

PCT information	**Drug Tariff**

7 OBSTETRICS, GYNAECOLOGY AND URINARY-TRACT DISORDERS

7.1 Drugs used in obstetrics

Notes on class

Green	Yellow	Double Yellow	Red
7.1.1 Prostaglandins and oxytocics			
			Carboprost
			Dinoprostone
			Ergometrine maleate
			Oxytocin
			Syntometrine
			Misoprostol (off label)
7.1.1.1 Ductus arteriosus			
			Indometacin (indomethacin) Indocid PDA ®
			Alprostadil
7.1.2 Mifepristone			
			Mifepristone
7.1.3 Myometrial			
			Atosiban
			Salbutamol

Additional information	
Drug specific notes	
NICE guidance	NICE CG 70 induction of labour CG70

7.2 Treatment of vaginal and vulval conditions

Notes on class

Green	Yellow	Double Yellow	Red
7.2.1 Preparations for vaginal atrophy			
Estradiol (Vagifem ® vaginal tablets and Estring ®)			
Estriol (Ovestin ® and Ortho-Gynest ®			
7.2.2 Vaginal and vulval infections			
Clotrimazole [A]	Dalacin ®		Econazole pessaries
Miconazole	Zidoval ®		Nystatin pessaries **(unlicensed)**
			Amphotericin in KY jelly **(unlicensed)**
			Amphotericin + flucytosine in KY jelly **(unlicensed)**
			Boric acid pessaries **(unlicensed)**

Additional information		
Drug specific notes	[A]	All formulations
NICE guidance		
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

7.3 Contraceptives

Notes on class
There is an increased risk of venous thromboembolic disease (particularly during the first year) in users of oral contraceptives but this risk is considerably smaller than that associated with pregnancy (about 60 cases of venous thromboembolic disease per 100 000 pregnancies). In all cases the risk of venous thromboembolism increases with age and in the presence of other risk factors for venous thromboembolism (e.g. obesity). The risk of venous thromboembolism with transdermal patches is not yet known. The incidence of venous thromboembolism in healthy, non-pregnant women who are not taking an oral contraceptive is about 5 cases per 100 000 women per year. For those using combined oral contraceptives containing second-generation progestogens e.g. levonorgestrel, this incidence is about 15 per 100 000 women per year of use. Some studies have reported a greater risk of venous thromboembolism in women using preparations containing the third-generation progestogens desogestrel and gestodene; the incidence in these women is about 25 per 100 000 women per year of use.

7.3.1 Combined hormonal contraceptives

Green	Yellow	Double Yellow	Red
Low dose preparations			
Loestrin 20 ® (norethisterone acetate 1mg ethinyloestradiol 20 micrograms)	Mercilon® (desogestrel 150 micrograms, ethinyloestradiol 20 micrograms)		
	Femodette® (gestodene 75 micrograms, ethinyloestradiol 20 micrograms)		
Standard Dose Preparations			
Microgynon 30 (ethinyloestradiol 30 micrograms, levonorgestrel 150 micrograms)	Marvelon ® (ethinyloestradiol 30 micrograms, desogesterol 150 micrograms) [A]		
	Femodene ® (gestodene 75 micrograms, ethinyloestradiol 30 micrograms) [A]		
	Cilest ® (norgestimate 250 micrograms ethinyloestradiol 35 micrograms) [A]		

	Loestrin 30® (norethisterone acetate 1.5mg, ethinylestradiol 30micrograms)		
7.3.2 Progestogen only contraceptives			
7.3.2.1 Oral Progestogen-only contraceptives			
Micronor ® (norethisterone 350micrograms)	Femulen ® (etynodiol diacetate 500 micrograms) – for heavy bleeding		
Cerazette® (desogestrel 75 micrograms) -for younger women, previous ectopic pregnancy or >70kg			
Noriday® (norethisterone 350 micrograms) - for older women or whilst breast feeding			
Norgeston® (levonorgestrel 30 micrograms)			
7.3.2.2 Parenteral Progesterone only Preparations			
Etonogestrel implant 68mg (Implanon ®)			
Medroxyprogesterone acetate 150mg			
7.3.2.3 Intra-uterine progesterone			
Mirena ® (releasing 20 micrograms levonorgestrel in 24 hours)			

7.3.5 Emergency Hormonal Contraception			
Levonorgestrel 1.5mg	Ulipristal acetate (EllaOne) [B]		

Additional information		
Drug specific notes	[A]	The progestogens desogestrel, drospirenone, and gestodene (in combination with ethinylestradiol) may be considered for women who have side-effects (such as acne, headache, depression, weight gain, breast symptoms, and breakthrough bleeding) with other progestogens. However, women should be advised that desogestrel and gestodene have also been associated with an increased risk of *venous thromboembolism*
	[B]	As an option for women who have has unprotected intercourse between 72 and 120 hours previously who do not wish the fitting of a copper-bearing intrauterine device or for whom it is not possible to fit a copper-bearing intrauterine device. Women presenting within 72 hours of unprotected intercourse who do not wish the fitting of a copper-bearing intrauterine device should be offered levonelle.
NICE guidance	NICE CG 30 The effective and appropriate use of long-acting reversible contraception	
PCT information	**Drug Tariff**	

7.4 Drugs for genito-urinary disorders

Green	Yellow	Double Yellow	Red
7.4.1 Drugs for urinary retention			
Tamsulosin [A]	Alfuzosin (specialist initiation) [B]		Alfuzosin (off-label) to ease passing of renal stones
Distigmine bromide	Alfuzosin MR – specialist initiation		
7.4.2 Drugs for urinary frequency, enuresis and incontinence			
Oxybutynin	Oxybutynin XL ££	Oxybutynin patches (Kentera®) – specialist recommendation	Amitriptyline (off-label)
Tolteridine	Tolteridine XL ££		Imipramine (off-label)
	Trospium XL		Desmopressin (off-label)
7.4.3 Drugs used in urological pain			
Refer to BNF for preps			
7.4.4 Bladder instillations and urological surgery			
Chlorhexidine			Cystistat ®
Dimethyl sulphoxide			Uracyst ®
Glycine			
Sodium chloride			
Sodium citrate solution			
7.4.5 Drugs for erectile dysfunction [D]			
Sildenafil [D]	Papaverine [D]		
	Tadalafil [CD]		
	Alprostadil		

Additional information		
Drug specific notes	[A]	Flomaxtra was launched at the patent expiry of its predecessor Flomax. Prescribers are advised to prescribe tamsulosin capsules
	[B]	For two to three days post catheterisation and one day post removal
	[C]	Tadalafil daily dosing is considered appropriate for men experiencing sexual activity on two or more occasions per week who have previously responded to on demand PDE5I treatment.
	[D]	Not prescribable at SHH or BHH
NICE guidance	Health Service Circular 1999/148 treatment of impotence	

8 MALIGNANT DISEASE AND IMMUNOSUPPRESSION

8.1 Cytotoxic drugs

Notes on class
Notes on class • The chemotherapy of cancer is complex and should be confined to specialists in oncology/haematology. • All chemotherapy drugs cause side-effects and a balance has to be struck between likely benefit and acceptable toxicity

8.1 Cytotoxic drugs

Double Yellow	Red
	Dexrazoxane – for suspected anthracycline extravasation. Use as per HEFT policy
	Calcium folinate (folinic acid/calcium leucovorin)

Double Yellow	Red – as per NICE TA's where they exist (or via other specific formal agreement e.g. IFR)
8.1.1 Alkylating drugs	
Cyclophosphamide(oral) **ESCA**	Bendamustine
	Cyclophosphamide
8.1.2 Cytotoxic metabolites	
	Pegylated liposomal doxorubicin hydrochloride
8.1.3 Antimetabolites	
Methotrexate **ESCA**	Gemcitabine
	Fludarabine
	Capecitabine
	Tegafur with uracil
	Pemetrexed
	Fluorouracil
	Azacitidine

Double Yellow	Red – as per NICE TA's where they exist (or via other specific formal agreement e.g. IFR)
8.1.4 Vinca alkaloids and etoposide	
	Vinorelbine
8.1.5 Other neoplastic drugs	
	Bevacizumab – Off label use only for DMO [C]
	Bortezomib
	Cetuximab
	Cisplatin
	Dasatinib
	Docetaxel
	Erlotinib
	Gefitinib –
	Imatinib
	Ipilimumab
	Irinotecan
	Lapatinib
Hydroxycarbamide **ESCA** - for myeloproliferative disorders	Nilotinib
	Oxaliplatin
	Paclitaxel
	Pazopanib
	Sunitinib
	Temozolomide
	Topotecan
	Trabectedin
	Trastuzumab
	Vemurafenib

Additional information	
NICE guidance	NICE TA 023 Brain Cancer - temozolomide NICE TA 025 - Pancreatic cancer - gemcitabine NICE TA 029 - Leukaemia (lymphocytic) - fludarabine NICE TA 034 Breast cancer - trastuzumab NICE TA 055 Ovarian Cancer - paclitaxel NICE TA 061 - colorectal cancer - capecitabine and tegafur uracil NICE TA 070 -Leukaemia (chronic myeloid) - imatinib NICE TA 086 - Gastrointestinal stromal tumours - imatinib NICE TA 091 - Ovarian cancer (advanced) - paclitaxel, pegylated liposomal doxorubicin hydrochloride and topotecan NICE TA 99 Renal transplantation - immunosuppressive regimens for children and adolescents NICE TA 100 Colon cancer (adjuvant) - capecitabine and oxaliplatin NICE TA 101 Prostate cancer (hormone-refractory) - docetaxel NICE TA 107 Breast cancer (early) - trastuzumab NICE TA 108 Breast cancer (early) - paclitaxel NICE TA 109 Breast cancer (early) - docetaxel NICE TA 116 Breast cancer - gemcitabine NICE TA 118 coloectal cancer (metastatic) - bevacizumab and cetuximab (partially updated by TA242) NICE TA 119 Leukaemia (lymphocytic) - fludarabine NICE TA 121 Glioma (newly diagnosed and high grade) - carmustine implants and temozolomide (Glioma is not treated at HEFT, but patients would be suitably referred) NICE TA 124 Lung cancer (non-small-cell) - pemetrexed NICE TA 129 Multiple myeloma - bortezomib NICE TA 135 Mesothelioma - pemetrexed disodium NICE TA 145 Head and neck cancer - cetuximab NICE TA 162 Lung cancer (non-small-cell) - erlotinib NICE TA 169 Renal cell carcinoma (advanced/metastatic) - sunitinib NICE TA 172 Head and neck cancer (squamous cell carcinoma) - cetuximab NICE TA 176 Colorectal cancer (first line) - cetuximab NICE TA 178 bevacizumab (first-line), sorafenib (first- and second-line), sunitinib (second-line) and temsirolimus (first-line) for the treatment of advanced and/or metastatic renal cell carcinoma NICE TA 179 Gastrointestinal stromal tumours - sunitinib NICE TA 181 Lung cancer (non-small-cell, first line treatment) - pemetrexed NICE TA 183 Cervical cancer (recurrent) - topotecan

NICE guidance	NICE TA 184 Lung cancer (small-cell) - topotecan NICE TA 185 Soft tissue sarcoma - trabectedin NICE TA 189 Hepatocellular carcinoma (advanced and metastatic) - sorafenib (first line) NICE TA 190 Lung cancer (non-small-cell) - pemetrexed (maintenance) NICE TA 191 Gastric cancer (advanced) - capecitabine NICE TA 192 Lung cancer (non-small-cell, first line) - gefitinib NICE TA 196 Gastrointestinal stromal tumours - imatinib (adjuvant) NICE TA 208 Gastric cancer (HER2-positive metastatic) - trastuzumab NICE TA 209 Gastrointestinal stromal tumours (unresectable/metastatic) - imatinib NICE TA 189 Hepatocellular carcinoma (advanced and metastatic) - sorafenib (first line) NICE TA 190 Lung cancer (non-small-cell) - pemetrexed (maintenance) NICE TA 191 Gastric cancer (advanced) - capecitabine NICE TA 192 Lung cancer (non-small-cell, first line) - gefitinib NICE TA 193 Leukaemia (chronic lymphocytic, relapsed) - rituximab NICE TA 196 Gastrointestinal stromal tumours - imatinib (adjuvant) NICE TA 208 Gastric cancer (HER2-positive metastatic) - trastuzumab NICE TA 209 Gastrointestinal stromal tumours (unresectable/metastatic) - imatinib NICE TA 212 Colorectal cancer (metastatic) - bevacizumab NICE TA 214 Breast cancer - bevacizumab (in combination with a taxane) NICE TA 215 Renal cell carcinoma (first line metastatic) - pazopanib NICE TA 216 Leukaemia (lymphocytic) - bendamustine NICE TA 218 Myelodysplastic syndromes - azacitidine NICE TA 219 Everolimus for the second-line treatment of advanced renal cell carcinoma NICE TA 222 Ovarian cancer (relapsed) - trabectedin NICE TA 227 Lung cancer (non-small-cell, advanced or metastatic maintenance treatment) - erlotinib (monotherapy) NICE TA 228 Multiple myeloma (first line) - bortezomib and thalidomide NICE TA 241 Leukaemia (chronic myeloid) - dasatinib, nilotinib, imatinib (intolerant, resistant) NICE TA 242 Colorectal cancer (metastatic) 2nd line - cetuximab, bevacizumab and panitumumab (review) NICE TA 243 Follicular lymphoma - rituximab NICE TA 250 Breast cancer (advanced) - eribulin NICE TA 251 Leukaemia (chronic myeloid, first line) - dasatinib, nilotinib and standard-dose imatinib NICE TA 255 Prostate cancer - cabazitaxel NICE TA 257 Breast cancer (metastatic hormone-receptor) - lapatinib and trastuzumab (with aromatase inhibitor)

		NICE TA 258 Lung cancer (non small cell, EGFR-TK mutation positive) - erlotinib (1st line) NICE TA 263 Bevacizumab in combination with capecitabine for the first-line treatment of metastatic breast cancer NICE TA 268 Melanoma (stage III or IV) - ipilimumab NICE TA 269 Melanoma (BRAF V600 mutation positive, unresectable metastatic) - vemurafenib NICE CG 024 Lung cancer - docetaxel, paclitaxel, gemcitabine and vinorelbine NICE CG 081 Advanced Breast Cancer NICE CG 131 Colorectal cancer
MTRAC / Prodigy / other guidance		
PCT information	C	For the treatment of diabetic macular odema (only) in patients that have a) Failed laser treatment with gradual reduction of vision or b) Involvement of central macula by DME where laser is risky. Each patient may have up to three injections per affected eye as is clinically appropriate. This must be performed as a day case in theatre. **NB Primary Care will not fund the drug cost or the day case fee (Sept 10)** These drugs are excluded from PbR **Drug Tariff**

8.2 Drugs affecting the immune response

Green	Yellow	Double Yellow as per NICE TA's where they exist	Red – as per NICE TA's where they exist (or via other specific formal agreement e.g. IFR)
8.2.1 Antiproliferative immunosuppressants			
		Azathioprine	Mycophenolate
8.2.2 Corticosteroids and other immunosuppressants			
		Ciclosporin	
		Tacrolimus [A]	Sirolimus
8.2.3 Rituximab & alemtuzumab			
			Rituximab
			Alemtuzumab
8.2.4 Other immunomodulating drugs			
			BCG – Bladder instillation
			Peginterferon alfa
			Thalidomide
			Mifamurtide
			Lenalidomide
			Interferon alfa
			Interferon beta
			Interferon gamma

8.2 continued Drugs affecting the immune response

Additional information	
Drug specific notes	[A] There are two formulations of tacrolimus which are not interchangeable – Please prescribe by brand
NICE guidance	Rituximab for follicular NHL (March 2002) Rituximab for aggressive NHL (Sept 2003) NICE TA 032 - beta interferon and glatiramer acetate (not recommended MS)TA32) NICE TA 085 - Renal transplantation - immunosuppressive regimens (adults) (basiliximab, daclizumab are indicated in the acute period post operatively – this is not applicable at HEFT as transplants are not undertaken) NICE TA 065 Non hodgkin's lymphoma NICE TA 099 - Renal transplantation - immunosuppressive regimens for children and adolescents NICE TA 106 Hepatitis C - peginterferon alfa and ribavirin NICE TA 127 Multiple sclerosis - natalizumab (Multiple sclerosis is not a specialty represented at HEFT) NICE TA 137 Lymphoma (follicular non-Hodgkin's) - rituximab NICE TA 171 Multiple myeloma - lenalidomide NICE TA 174 Leukaemia (chronic lymphocytic, first line) - rituximab NICE TA 193 Leukaemia (chronic lymphocytic, relapsed) - rituximab NICE TA 200 Hepatitis C - peginterferon alfa and ribavirin NICE TA 202 Chronic lymphocytic leukaemia - ofatumumab NICE TA 226 Lymphoma (follicular non-Hodgkin's) - rituximab NICE TA 228 Multiple myeloma (first line) - bortezomib and thalidomide NICE TA 235 Osteosarcoma - mifamurtide NICE TA 243 Rituximab for the first-line treatment of stage III-IV follicular lymphoma NICE TA 254 Multiple sclerosis (relapsing-remitting) - fingolimod (Multiple sclerosis is not a specialty represented at HEFT)
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

8.3 Sex hormones and hormone antagonists for malignant disease

Green	Yellow	Double Yellow	Red
8.3.1 Oestrogens			
		Diethylstilboestrol (Consultant Initiation)	
8.3.2 Progestogens			
	Medroxyprogesterone acetate		
8.3.3 Androgens (none used)			
8.3.4 Hormone antagonists			
8.3.4.1 Breast cancer			
Green	**Yellow**	**Double Yellow (as per NICE TA's where they exist)**	**Red – as per NICE TA's where they exist**
Tamoxifen		Anastrozole **ESCA**	
		Exemestane **ESCA**	
		Letrozole **ESCA**	
8.3.4.2 Prostrate cancer and gonadorelin analogues			
Cyproterone	Goserelin £ (First line parenteral)	Bicalutamide £	Abiraterone
	Leuprorelin £ (Second line parenteral)	Flutamide **ESCA**	
8.3.4.3 Somatostatin analogues			
	Octreotide [A] £	Lanreotide [A] ££	

Additional information		
Drug specific notes	[A]	Palliative care use only – off label use. Specialist prescribing through Cancer Network
NICE guidance		NICE TA 112 Breast cancer (early) - hormonal treatments NICE TA 239 Breast cancer (metastatic) - fulvestrant NICE TA 259 Prostate cancer (metastatic, castration resistant) - abiraterone (following cytoxic therapy) NICE TA 272 Urothelial tract carcinoma (transitional cell, advanced, metastatic) - vinflunine
MTRAC / Prodigy / other guidance	MTRAC guidance (1998; archived) advises against prescribing either octreotide or lanreotide	

9.Nutrition

9.1 Anaemias and some blood disorders

Green	Yellow	Double Yellow	Red
9.1.1 Iron-deficiency anaemias			
9.1.1.1 Oral iron			
Ferrous sulphate	Ferrous fumarate liquid (Fersamal ®)		
Sodium feredetate (Sytron ®) – for paediatrics	Ferrous gluconate – if patient intolerant of sulphate		
	Ferrous fumarate		
9.1.1.2 Parenteral iron			
			Iron dextran (CosmoFer ®)
			Iron sucrose (Venofer ®)
			Iron isomaltoside (Monofer) ® [B]
			Feric carboxymaltose (Ferinject ®)
9.1.2 Drugs used in megaloblastic anaemias			
Hydroxocobalamin injection	Cyanobalamin oral preparations, for dietary vitamin B12 deficiency. (Non- NHS prescribable in primary care unless endorsed SLS)		
Folic acid			
9.1.3 Drugs used in hypoplastic, haemolytic, and renal anaemias *			
			Epoetin
			Darbepoetin alfa
			Desferrioxamine mesilate (desferoxamine mesilate)
			Deferiprone
			Deferasirox [A]
			Micera ®
			Aranesp ®

9.1.4 Drugs used in platelet disorders			
			Anagrelide
			Romiplostim
9.1.5 G6PD deficiency – for drugs to avoid or used with caution consult the BNF			
9.1.6 Drugs used in neutropenia			
			Filgrastim
			Lenograstim
			Pegfilgrastim

Additional information		
Drug specific notes	A	Modified release preparations of iron are licensed for once daily dosage but have no therapeutic advantage and should not be used. Compound preparations – there is no justification for the inclusion of other ingredients such as the B group of vitamins (except folic acid for pregnant women) For patients where desferrioxamine has proved inadequate or the patient can't tolerate or fails to respond to deferiprone
	B	To treat iron deficiency in pregnant women whose Hb falls below 10.5g/dl during the 2nd and 3rd trimester and post delivery patients who have failed to respond or tolerate standard oral treatment due to moderate or severe intolerance or poor absorption of oral preparations For high risk situations such as severe anaemia (Hb<7.0) post 36 weeks gestation or at an increased risk of bleeding e.g. placenta previa and patients who refuse blood transfusion where oral iron response would be too slow
NICE guidance		NICE TA 48 - home versus hospital haemodialysis NICE TA 142 Anaemia (cancer-treatment induced) - erythropoietin (alfa and beta) and darbepoetin NICE TA 221 Thrombocytopenic purpura - romiplostim
MTRAC / Prodigy / other guidance		
PCT information		* Patients treated at HEFT or UHB – funding transferred to specialist. GPs should refer any request to prescribe back to the hospital Patients treated at BCH or other providers – GP prescribing under ESCA

9.2.2Fluids and electrolytes

Green	Yellow	Double Yellow	Red
9.2.1 Oral preparations for fluid and electrolyte imbalance			
9.2.1.1 Oral potassium			
Potassium chloride			
Potassium removal			
			Calcium Resonium ®
			Resonium A ®
9.2.1.2 Oral sodium and water			
	Sodium chloride MR – specialist recommendation		Sodium chloride 1mmol/l oral solution
Oral rehydration salts (ORS)			
9.2.1.3 Oral bicarbonate			
Sodium bicarbonate			
9.2.2 Parenteral preparations for fluid and electrolyte imbalance			
9.2.2.1 Electrolytes and water			
Sodium chloride			Sodium chloride/glucose infusion
Glucose			Hartmanns solution
Water for injections			Potassium chloride infusions
			Sodium bicarbonate
9.2.2.2 Plasma and plasma substitutes			
			Dextran 40 ®
			Dextran 70 ®
			Gelofusine ®
			Etherified starch
			Volulyte ®
			Voluven ® (if Volulyte ® unavailable)
			Gelaspan ®
			Geloplasma ®

Additional information	
NICE guidance	NICE TA 74 - Trauma Fluid replacement therapy

9.3 Intravenous nutrition

Notes on class
Notes on class • All patients who require parenteral nutrition must be referred to the Parenteral Nutrition Team. • For patients who require home care, arrangements for discharge must be made as early as possible. • Basic regimes are stocked for emergencies but wherever possible treatment must be tailored to the needs of the patient. These regimens are required to be ordered specially and may take a few days to arrive.

9.4 Oral Nutrition- Sip Feeds

Notes on class
Notes on class • The use of sip feeds should usually only be considered when food boosting dietary measures alone have failed to improve nutritional intake or status after 4 weeks. • The community nutritional screening tool (below) should be used to identify patients who need food boosting dietary measures • ACBS. In certain clinical conditions some foods may have the characteristics of drugs and ACBS advises as to the circumstances in which such foods may be regarded as drugs and so can be prescribed in the NHS. Prescriptions should be endorsed ACBS. Refer to appendix 7 in the BNF. • The ACBS approved categories for prescribing sip feeds are; Shortbowel syndrome, Intractable malabsorption, Pre-operative preparation of patients who are malnourished, Proven inflammatory bowel disease, Total gastrectomy, Dysphagia and Disease related malnutrition (this can incorporate a range of conditions and is open to interpretation) • Full details of the appropriate use of sip feeds can be found in the SCT Guidelines for The Use of Sip Feeds

Green	Yellow	Double Yellow	Red
Food Boosting Dietary Measures (see below)	Fortisip Bottle	Scandishake Mix	
	Fortisip Multifibre	Calogen	
	Fortijuce		
	Fortisip Yogurt Style		
	Fortisip Extra (Protein)		
	Fortimel [A]		
	Forticreme [A]		
	Fortisip Fruit Dessert [A]		

Additional information	
Main Aspects of Food Boosting Dietary Measures. See SCT Guidelines for The Use of Sip Feeds for further details	• Use at least one pint of full fat milk each day • Little and often – have nourishing snacks or drinks between meals and a snack supper before bed • Enrich food and drinks such as cereals, milk puddings, canned fruit, potatoes, soups and vegetables with cream, butter, margarine, cheese, evaporated milk or sugar • Drink more milk based drinks e.g. milky coffee, malted milk, hot chocolate and milkshakes • Encourage full fat, high sugar varieties to provide more calories instead of low fat, low sugar products • 'Food Boosters' Leaflets are available from the Nutrition Support Service, Freshfields: (01564) 732803 and available on the SCT intranet from January 2009 • This leaflet is not suitable for special diets e.g. people with diabetes or for people who require modified textures e.g. soft, puréed or liquid foods
Drug specific notes	• The use of sip feeds needs **regular monitoring** and they should only be used for an appropriate amount of time. • Initial prescription should be for one weeks supply and marked 'mixed flavours' • Solihull Care Trust has a contract via the HPC with Nutricia. A rebate is made on Nutricia products that are prescribed on an FP10 prescription. [A] Dessert like sip feeds should not be used on a regular basis. These may be appropriate for patients with swallowing difficulties. Patients should be encouraged to follow food boosting advice and have real desserts.
NICE guidance	NICE GC 32 Nutrition Support in Adults
PCT information	SCT Guidelines for The Use of Sip Feeds The guidelines are a result of collaboration between the Nutritional Support Service and Medicines Management. They include a nutritional screening tool which identifies patients at risk of malnutrition and then a course of action once this risk has been identified.

See below for summary of the community nutritional screening tool and oral nutritional support flow chart.

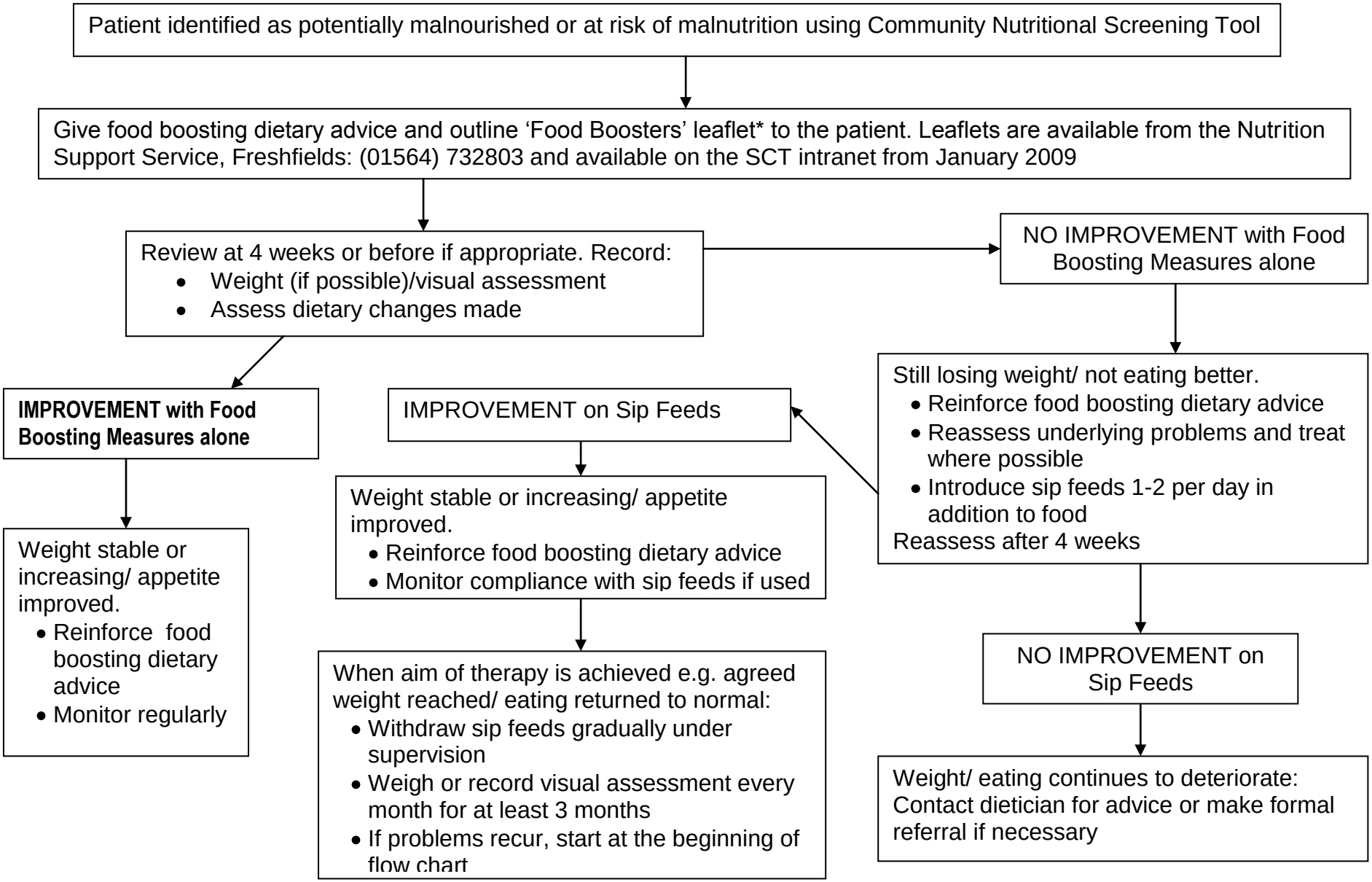
COMMUNITY NUTRITIONAL SCREENING TOOL

Select one score from each Criterion then add together for total score

CRITERION 1:	CRITERION 2:	CRITERION 3:
Visual Assessment of Body Weight- use body mass index (BMI) if height and weight are available)	**Unintentional Weight Loss**	**Problem with intake of Food and Fluids**
Visually, weight is acceptable (or BMI > 20) **Score: 0** Visually, thin (or BMI 18.5 – 20) **Score: 1** Visually, very thin (or BMI < 18.5) **Score: 3**	ght loss **Score: 0** 3–6 kg within 12 months (½ - 1 stone) **Score: 2** > 6kg within 12 months (> 1 stone) **Score: 3** > 3kg within 3 months (> ½ stone) **Score: 3**	No problems **Score: 0** Some problems with intake of food & fluids for > 3 days **Score: 1** Severe problems with intake of food & fluid for > 3 days **Score: 3**

Score	Action Required
0	**No further action required**
1-2	**Monitor weight where possible/repeat screening tool in 4 weeks**
3+	**Patient potentially malnourished or at risk of malnutrition** **Food Boosting Dietary Measures required- refer to Food Booster Leaflet** **See Oral Nutritional Support Flow Chart below**

ORAL NUTRITIONAL SUPPORT FLOW CHART



9.5 Minerals

Green	Yellow	Double Yellow	Red
9.5.1 Calcium and magnesium **9.5.1.1 Calcium supplements**			
Adcal-D3 preparations	Calcium Sandoz ® specialist recommendation (paeds) for children on milk-free diets or for endocrine/renal use post parathyroidectomy		Calcium gluconate injection
			Calcium chloride injection
9.5.1.2 Hypercalcaemia and hypercalciuria			
			Cinacalcet – renal directorate - NICE TA 117
9.5.1.3 Magnesium			
	Magnesium glycerophosphate (unlicensed) – specialist initiation and stabilisation		Magnesium sulphate injection
9.5.2 Phosphorus **9.5.1.2 Phosphorus supplements**			
			Potassium acid phosphate
			Joulies phosphate solution - paediatrics
			Phosphate-Sandoz ®
			Addiphos ®
9.5.2.2 Phosphate-binding agents			
	Aluminium hydroxide – specialist recommendation	**Patients established on therapy prior to 31/3/13 will continue to receive treatment under an ESCA**	**Patients starting therapy on 1/04/13 or later will receive treatment at HEF (via specialised commissioning)**
	Calcium salts – specialist recommendation	Sevelamer **ESCA**	Sevelamer
	Osvaren® - specialist recommendation	Lanthanum **ESCA**	Lanthanum

9.5.3 Fluoride			
9.5.4 Zinc			
Zinc sulphate			

Additional information	
NICE guidance	NICE TA 117 Hyperparathyroidism - cinacalcet

9.6 Vitamins

Green	Yellow	Double Yellow	Red
9.6.1 Vitamin A			
	Vitamins A & D – specialist recommendation		Vitamin A drops paediatric directorate only (unlicensed)
9.6.2 Vitamin B group			
Thiamine			Pabrinex ® injection
Pyridoxine			Nicotinamide - unlicensed
Vitamin B Compound Strong			Vigranon B ®
9.6.3 Vitamin C			
Ascorbic acid			
9.6.4 Vitamin D			
Calcichew D3 Forte ®	Colecalciferol drops – specialist recommendation		Paricalcitol – renal directorate
Calcichew D3 ®			
Alfacalcidol			
Vitamin D (colecalciferol) 800 units (Fultium ® and Desunin ®)			
9.6.5 Vitamin E			
	Alpha tocopheryl acetate capsules – CF patients only		Vitamin E suspension
9.6.6 Vitamin K			
Menadiol sodium phosphate			
Phytomenadione			

9.6.7 Multivitamin preparations			
	on recommendation of gastroenterologist or dietician		Forceval soluble – **prevention of re-feeding syndrome** as per HEFT guidelines on recommendation of clinical nutrition team. Also **post bariatric surgery patients** (that as a result of complications or delays in progression from liquid diet cannot tolerate vitamin supplementation tablets/capsules form and will need a soluble vitamin supplement beyond 10 days and possibly for the duration of their in-patient stay).
Vitamin A.B,C and D drops	Ketovite ®		
Multivitamins	Forceval ®		

9.7 Bitters and tonics

Green	Yellow	Double Yellow	Red

9.8 Drugs used in metabolic disorders

Notes on class
Notes on class • BNF may be consulted for a list of drugs unsafe for use in acute porphyrias

Green	Yellow	Double Yellow	Red
9.8.1 Drugs used in metabolic disorders			
		Penicillamine – For Wilson's disease (with ESCA)	Arginine
			Carnitine – for canite deficiency (paediatric directorate only)
			Mercaptamine (cysteamine)
			Sodium phenylbutyrate

			Sodium benzoate
9.8.2 Acute porphyrias			
			Haem arginate

9 MUSCULOSKELETAL AND JOINT DISEASES

9.1 Drugs used in rheumatic diseases and gout

10.1.1 Non Steroidal anti-inflammatory drugs

Notes on class
• For ALL NSAIDs use lowest dose of least toxic agent for shortest duration • Assess GI, CV and renal risk, monitor regularly • Safety of selective and non-selective NSAIDs: MHRA Oct 06

Green	Yellow	Double Yellow	Red
Ibuprofen	Diclofenac [B, C]	Etodolac [D]	
Naproxen	Celecoxib ££ [A]		Sulindac – in renal impariment only
Mefenamic acid (for dysmenorrhoea)	Meloxicam		
	Indometacin (indomethacin)		
	Aspirin [B]		

Additional information		
Drug specific notes	A	Celecoxib is associated with fewer GI effects over the shorter term. Contraindicated in CV disease – See NICE CG 59 and CG 79
	B	Gastro-intestinal discomfort or nausea, ulceration with occult bleeding common with anti-inflammatory doses **There are no proven benefits to using enteric coated aspirin**
	C	CV risk comparable with coxibs: see MeReC_Extra_No30
	D	See NICE CG 59 and CG 79
NICE guidance	NICE CG 59 Osteoarthritis NICE CG 79 Rheumatoid Arthritis	
MTRAC / Prodigy / other		

guidance	
PCT information	There is poor outcome evidence for meloxicam. **Drug Tariff**

10.1.2 Local corticosteroids

Notes on class

Green	Yellow	Double Yellow	Red
Triamcinolone acetonide			
Methylprednisolone acetate			
Methylprednisolone acetate with lidocaine (lignocaine)			

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

10.1.3 Drugs which suppress the rheumatic disease process

Notes on class
Efaluzimab -**Marketing authorisation was withdrawn by EMA after publication of TA103.**

Green	Yellow	Double Yellow	Red as per NICE TA's where they exist
		Methotrexate **ESCA** [A]	Adalimumab
		Ciclosporin **ESCA**	Infliximab
		Penicillamine **ESCA**	Etanercept
		Sulfasalazine **ESCA**	Certolizumab
		Sodium aurothiomalate **ESCA**	Tocilizumab (Rheumatology only)
		Leflunomide **ESCA**	Golimumab
		Hydroxychloroquine **ESCA**	Abatacept
		Azathioprine **ESCA** [B]	Rituximab

Additional information		
Drug specific notes	A B	Should only be prescribed as 2.5mg tablets (National Patient Safety Agency) ESCAs for Gastroenterological, rheumatological and dermatological conditions Azathioprine ESCA available for the treatment of patients with unresponsive chronically active Crohn's disease, resistant or frequently relapsing cases of Crohn's disease or Ulcerative colitis and as second-line treatment for fistulating Crohn's disease and continued as maintenance (all unlicensed indications. However an established therapy in these conditions) and autoimmune hepatitis (licensed indication)
NICE guidance		NICE TA 035 - Arthritis (juvenile idiopathic) - etanercept NICE TA 130 Rheumatoid arthritis - adalimumab, etanercept and infliximab NICE TA 143 Ankylosing spondylitis - adalimumab, etanercept and infliximab NICE TA 186 Rheumatoid arthritis - certolizumab pegol NICE TA 195 adalimumab etanercept infliximab rituximab and abatacept for the treatment of rheumatoid athritis after the failure of a TNF inhibitor NICE TA 199 Etanercept, infliximab and adalimumab for treatment of psoriatic arthritis NICE TA 220 Psoriatic arthritis - golimumab NICE TA 223 Ankylosing spondylitis - golimumab

	NICE TA 225 Rheumatoid arthritis (after the failure of previous anti-rheumatic drugs) - golimumab NICE TA 280 Abatacept for treating rheumatoid arthritis after the failure of conventional disease-modifying anti-rheumatic drugs (rapid review of technology appraisal guidance 234) NICE TA 238 Arthritis (juvenile idiopathic, systemic) - tocilizumab NICE TA 247 Tocilizumab for the treatment of rheumatoid arthritis
MTRAC / Prodigy / other guidance	
PCT information	Enhanced services in place for monitoring **Drug Tariff**

10.1.4 Gout and cytotoxic induced hyperuricaemia

Notes on class

Green	Yellow	Double Yellow	Red
Allopurinol	Febuxostat - in line with NICE TA 164		Probenecid - prevention of nephrotoxicity associated with some anti-infective agents
Colchicine			Rasburicase – Onc and Haem

Additional information	
Drug specific notes	
NICE guidance	NICE TA 164 Hyperuricaemia - febuxostat
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

10.2 Drugs used in neuromuscular disorders

10.2.1 Drugs which enhance neuromuscular transmission

Notes on class

Green	Yellow	Double Yellow	Red
	Pyridostigmine bromide (specialist recommendation)		Edrophonium chloride (diagnostic)
	Neostigmine		
	Distigmine		

10.2.2 Skeletal muscle relaxants

Green	Yellow	Double Yellow	Red
Baclofen	Tizanidine – specialist initiation and stabilisation		
Dantrolene			
Diazepam			
Quinine sulphate			

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

10.3 Drugs for the relief of soft tissue inflammation

10.3.1 Enzymes

Green	Yellow	Double Yellow	Red
			Collagenase Clostridium (Xiapex®) [A]

Additional information		

Drug specific notes	[A]	• Restricted to use as an alternative to limited fasciectomy in adult patients with Dupuytren's contracture of moderate severity (as defined by the British Society for Surgery of the Hand (BSSH), with a palpable cord and up to two affected joints per hand, who are suitable for limited fasciectomy, but for whom percutaneous needle fasciotomy is not considered a suitable treatment option.
		
		• And in line with "Procedures of Limited Clinical Value commissioning policy". This states treatment of moderate to severe is appropriate where patients meet either of the following criteria:
		  • moderate metacarpo-phalangeal joint contracture (greater than 30 degrees).
		  • any proximal inter-phalangeal joint contracture.
		  • First web contracture
		The above eligibility criteria is in line with the BSSH - The British Society for Surgery of the Hand - Evidence for Surgical Treatment Dupuytren's Disease.
		http://www.bssh.ac.uk/education/guidelines/dd_guidelines.pdf

NICE guidance		
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

10.3.2 Rubifacients and other topical antirheumatics

Green	Yellow	Double Yellow	Red
Algesal ®	Ibuprofen gel [A]		
Transvasin ® cream	Capsaicin cream		

Additional information		
Drug specific notes	[A]	Topical NSAIDs should be considered ahead of oral NSAIDs, COX-2 inhibitors. Be aware of systemic absorption.
NICE guidance	NICE CG 59 Oesteoarthritis	
MTRAC / Prodigy / other guidance		
PCT information		

Miscellaneous

Green	Yellow	Double Yellow	Red

11 EYE

11.3 Anti-infective eye preparations

Notes on class
• **Preservative free preparations are only indicated where there is demonstrable clinical need**

Green	Yellow	Double Yellow	Red
11.3.1 Antibacterials			
Chloramphenicol [B]	Fusidic Acid [A]		Gentamicin 0.3% drops- ophthalmologist recommendation when sensitivity confirmed
	Ciprofloxacin – for corneal ulcers		Cefuroxime 5% drops (unlicensed) Ophthalmologists only
	Ofloxacin – ophthalmologist initiation		Neomycin sulphate 0.5% drops and ointment – neonates only
			Penicillin 5000 units in 1ml eye drops (unlicensed) – ophthalmologists only
11.3.2 Antifungals [C]			
11.3.3 Antiviral			
Aciclovir (acyclovir) 3% eye ointment – for herpes simplex			Trifluorothymidine drops

Additional information		
Drug specific notes	A B	Useful in staphylococcal infections Broad spectrum and treatment of choice for superficial eye infections
NICE guidance		
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

11.4 Corticosteroids and other anti-inflammatory preparations

Notes on class
• Ocular corticosteroids are associated with serious long term adverse effects and their use should be under specialist supervision • Prodigy recommend against GPs starting corticosteroids for ophthalmic conditions unless they have access to a slit lamp and the necessary expertise • For some chronic conditions e.g. uveitis, patients may be required to use steroid eye drops in the longer term under the advice and continuing review of a specialist. Long-term use is not covered by the licences for these eye drops, so the risks and benefits should be carefully considered and discussed with the patient before use. • There is no stated limit for steroid eye drop use (in terms of days/weeks), it would seem sensible to ensure all patients using a corticosteroid eye drop receive regular reviews regarding its use. • Therapy started for acute conditions should be stopped once the course is completed. Therapy for chronic conditions should be under the advice and continuing review of a specialist.

Green	Yellow	Double Yellow	Red
11.4.1 Corticosteroids			
Betamethasone 0.1% drops [B] – Short term only – unless ophthalmologist recommendation	Maxitrol ® drops and ointment		Dexamethasone intravitreal implant – NICE TAG 229
Dexamethasone 0.1% drops– Short term only – unless ophthalmologist recommendation	Prednisolone 0.5% drops – ophthalmologists recommendation		Loteprednol Etabonate 0.5% Eye Drops
	Prednisolone 1% drops – ophthalmologist recommendation		
	Rimexolone drops – ophthalmologist recommendation		
	Fluorometholone drops – Short term only - ophthalmologist only		

11.4.2 Other anti-inflammatories			
Sodium cromoglicate (sodium cromoglycate) 2% drops	Antazoline sulphate (with xylometazoline) drops £		
	Olopatadine [C] £		

Additional information		
Drug specific notes	[A]	BNF states that use of combination products is rarely justified
	[B]	SPCs state that 'after more prolonged treatment (over 6 to 8 weeks), the drops should be withdrawn slowly to avoid relapse'.
	[C]	For children with severe allergic eye disease when compliance with the more frequent dosage schedule of the other agents is an issue and treatment with sodium nedocromil has failed
NICE guidance	NICE TA 229 Macular oedema (retinal vein occlusion) - dexamethasone NICE TA 271 Diabetic macular oedema - fluocinolone acetonide intravitreal implant	
PCT information	**Drug Tariff**	

11.5 Mydriatics and cycloplegics

Notes on class
•

Green	Yellow	Double Yellow	Red
	Atropine sulphate 0.5% drops - Ophthalmologist recommendation		Phenylephrine hydrochloride drops – For clinic/practice use, not prescribable
	Atropine 1% ointment - Ophthalmologist recommendation		Tropicamide drops –For clinic/practice use, not prescribable
	Cyclopentolate hydrochloride drops - Ophthalmologist recommendation		

11.6 Treatment of glaucoma

Notes on class
• All treatments for glaucoma should be hospital initiated

Green	Yellow	Double Yellow	Red
Beta Blockers [A]			
	Timolol drops		
	Betaxolol drops		
	Carteolol drops		
	DuoTrav ®		
Prostaglandin analogues			
	Latanoprost drops		
	Travaprost drops		
	Xalacom ® drops		
	Tafluprost ® preservative free drops [B]		
Sympathomimetics			
	Brimonidine 0.5% drops		
Carbonic anhydrase inhibitors and systemic drugs			
	Acetazolamide – oral		
	Brinzolamide drops		
	Dorzolamide 2% drops		
	Cosopt ® - drops		
Miotics			
	Pilocarpine drops and ophthalmic gel		

Additional information		
Drug specific notes	A	Beta blockers should not be used in patients with asthma or a history of obstructive airways disease unless no alternative treatment is available
	B	For use within licence for those patients requiring a preservative free preparation
PCT information	**Drug Tariff**	

11.7 Local anaesthetics

Notes on class
• These are obtainable for clinical practice; not prescribable

Green	Yellow	Double Yellow	Red
			For clinic/practice use, not prescribable
			Oxybuprocaine hydrochloride (benoxinate) drops
			Lignocaine and fluorescein drops
			Tetracaine hydrochloride drops (amethocaine hydrochloride)
			Proxymetacaine hydrochloride
			Proxymetacaine hydrochloride and fluorescein

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

11.8 Miscellaneous ophthalmic preparations

Green	Yellow	Double Yellow	Red
11.8.1 Preparations For Tear Deficiency			
Hypromellose drops	Viscotears ® liquid gel single dose units – for patients that can not tolerate preservatives		Acetylcysteine 5% eye drops 5% eye drops (Euronac®) – Unlicensed [A]
GelTears ®	Celluvisc ® drops - for patients that can not tolerate preservatives		
Lacri-Lube ®	Artificial Tears ® drops for patients that can not tolerate preservatives		
Sno Tears ®	Sodium hyaluronate eye drops – ophthalmologist initiation		
Simple eye ointment – yellow soft paraffin			
Sodium Chloride 0.9% drops			
11.8.2 Ocular Diagnostic and Perioperative Preparations			
	Apraclonidine drops – Ophthalmologist initiation		Fluorescein sodium drops – For clinic/practice use, not prescribable
	Diclofenac sodium drops – Ophthalmologist initiation		Rose Bengal ®drops – For clinic/practice use, not prescribable
	Ketorolac trometamol – Ophthalmologist initiation		Acetylcholine chloride solution for intra-ocular irrigation – Ophthalmologists only
			Ranibizumab - NICE TA 155, TA 274 and TA 283

Additional information	
Drug specific notes	[A] Unlicensed product manufactured in France. It has a shelf life of 15 days once opened
NICE guidance	NICE TA 068 Macular degeneration (age related) photodynamic therapy NICE TA 155 Macular degeneration (age-related) - ranibizumab and pegaptanib NICE TA 274 Macular oedema (diabetic) - ranibizumab

	NICE TA 283 Ranibizumab for treating visual impairment caused by macular oedema secondary to retinal vein occlusion

Miscellanous

Green	Yellow	Double Yellow	Red
			5FU drops
			Balanced salt solution –
			Sodium chloride 5% drops
			Ciclosporin (cyclosporin)
			Mitomycin drops
			Ethylenediaminetetraacetic acid (EDTA) 0.37% drops
			Hyaluronidase 1500 units

12 EAR, NOSE AND OROPHARYNX

12.1 Drugs acting on the ear

Notes on class
• Inflammatory reaction of skin, usually responds to gentle syringing or dry mopping. • Most effective treatment is ribbon gauze soaked in corticosteroid eardrops. • Exclude perforation before using topical amino glycosides (risk deafness). Committee on Human Medicines (formerly CSM) warning: topical aminoglycosides are contraindicated in patients with tympanic perforation • Products containing anti-bacterials should be used for up to a week to prevent fungal complications which require specialist treatment

Green	Yellow	Double Yellow	Red
12.1.1 Otitis externa			
Anti-inflammatory preparations			
Single agent preparations			
Betamethasone sodium phosphate			
Prednisolone sodium phosphate – Predsol ®			
Compound preparations			
Betamethasone sodium phosphate with neomycin (Vista-methasone N ®)	Dexamethasone with neomycin and glacial acetic acid – (Otomize ®)		
Prednisolone with neomycin (Predsol N ®)	Hydrocortisone with gentamicin – (Gentisone HC ®) specialist receommendation. Not for use in tympanic perforation		
	Flumetasone with clioquinol – (Locorten-Vioform ®)		
	Tri-Adcortyl OTIC ® – specialist recommendation		
	Sofradex ®		

Anti-infective preparations			
Clotrimazole solution	Ciprofloxacin 0.3% drops – Specialist recommendation (off label of eye drops)		
Unlicensed			
			Aluminium acetate 13% drops
12.1.2 Otitis Media			
Refer to antimicrobial formulary			
12.1.3 Removal of wax			
Olive oil			
Sodium bicarbonate 5% ear drops			

Green	Yellow	Double Yellow	Red
Unlicenced (medical device)			
		Otovent balloons – specialist recommendation	

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

12.2 Drugs acting on the nose

Notes on class
•

Green	Yellow	Double Yellow	Red
12.2.1 Drugs used in nasal allergy			
Beclometasone (beclomethasone) dipropionate nasal preparations	Fluticasone furoate nasal spray (Avamys ®) £ [B]		Fluticasone furoate nasal drops – for use post operatively
Betamethasone sodium phosphate nasal preparations	Mometasone – for use in Children only (Nasonex ®) £ [B]		
Budesonide nasal spray			
12.2.2 Topical nasal decongestants			
Sodium chloride 0.9% drops	Ephedrine hydrochloride 0.5% and 1% drops. [C]		
12.2.3 Anti infective nasal preparations			
	Mupirocin 2% nasal ointment - (Bactroban®) [(A)]		Bismuth subnitrate and iodoform
Chlorhexidine plus neomycin – (Naseptin ® cream)			
12.2.4 Other nasal			
Sodium chloride nasal drops			

Additional information		
Drug specific notes	A B C	For methicillin resistant strains No evidence to demonstrate superior efficacy over beclomethasone Short term use only – efficacy limited
NICE guidance		
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

12.3 Drugs acting on the oropharynx

Notes on class
•

Green	Yellow	Double Yellow	Red
12.3.1 Drugs for oral ulceration and inflammation			
Choline salicylate dental gel	Benzydamine hydrochloride £		
Orabase ® paste			
Adcortyl in Orabase ®			
12.3.2 Oropharyngeal anti-infective drugs			
Amphotericin lozenges and suspension			
Miconazole oral gel			
Nystatin pastilles and suspension			
12.3.3 lozenges and sprays			
Benzydamine hydrochloride spray			
12.3.4 Mouthwashes, gargles and dentifrices			
Chlorhexidine gluconate 0.2% as mouthwash			
12.3.5 Treatment of dry mouth			
Glandosane ® spray [A]			
Salivix ® pastilles [A]			
Oral balance oral gel [A]			

Additional information	
Drug specific notes	[A] Endorse ACBS in primary care
NICE guidance	
MTRAC / Prodigy / other guidance	MHRA alert ref Choline salicylate in under 16s
PCT information	**Drug Tariff**

13 SKIN

13.2 Emollients

Notes on class
• Should be applied frequently as effects are short-lived. • Preparations containing an antibacterial should be avoided unless infection is present or a frequent complication • Generally the best emollient will have a high lipid content,, which is lowest in lotions, intermediate in creams and highest in ointments i.e. the greasier the emollient the better it is. However, it is important to remember that emollient choice for an individual patient involves consideration of patient preference, other ingredients (does it contain potential allergens) and cost.

Green	Yellow	Double Yellow	Red
13.2.1 Emollients			
Aqueous cream	Oilatum ® cream £		
Emulsifying ointment	Diprobase ® cream ££		
White soft paraffin	Doublebase ® gel ££		
Yellow soft paraffin	Unguentum M ® cream ££		
Liquid paraffin/ white soft paraffin 50/50	Hydromol ® cream £££ Hydromol ® ointment		
Cetraben ® emollient cream £	Hydrous ointment BP		
E45 ® cream (contains lanolin)	Dermol ® 500 lotion (contains antimicrobials)		
Epaderm ® ointment (contains lanolin)	Dermol ® 200 shower emollient (contains antimicrobials)		
Aquadrate ® cream (contains urea)	Balneum ® Plus cream (contains urea) £		
	Calmurid ® cream (contains urea) ££		
	Eucerin ® (contains urea) ££		

13.2.1.1 Emollient Bath Additives			
Oilatum ® emollient bath additive (contains wool fat)	Dermol ® 600 (contains antimicrobials) £££		
Oilatum ® fragrance free ££ (contains wool fat)	Aveeno colloidal ® bath additive £££		
Cetraben® bath additive	Oilatum ® Plus bath additive £££		
Balneum ® bath oil ££	Aveeno Bath ® oil £££		
Balneum Plus ® £££	Emulsiderm		
Hydromol ®			
13.2.2 Barrier preparations			
Zinc and castor oil ointment (contains peanut oil)	Metanium ® ointment £££		Sprilon®
Conotrane ® cream	Sudocrem ® cream £££ - Paediatrics only		

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

13.3 Topical local anaesthetics and antipruritics

Notes on class
•

Green	Yellow	Double Yellow	Red
Calamine lotion – do not use on insect stings	Crotamiton cream £ (pruritis after scabies)		
	Doxepin hydrochloride cream £££. (Caution – possible systemic effects)		

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

13.4 Topical corticosteroids

Notes on class

- Topical corticosteroids are contra-indicated in rosacea

Notes:
Apply once or twice daily.
Max quantities per week for an adult:

Face/Neck	15-30g		
Both legs	100g	Both arms	30-60g
Scalp	15-30g	Both hands	15-30g
Trunk	100g	Groins	15-30g

Formulation depends on lesion/site; cream is better for moist weepy lesions. Ointment useful for scaly, lichenfied areas.

- Occlusion increases absorption (+side effects) use only on thick skin in short term

Patients receiving regular topical steroids should be reviewed regularly. GPs should ensure patients are told about potential side effects and are advised that this advice, together with frequency of usage is documented in patient's notes.

Green	Yellow	Double Yellow	Red
Mild			
Hydrocortisone 0.5% and 1%			
Moderately potent			
Clobetasone butyrate 0.05% (Eumovate ®)	Haelan ® Tape – Specialist recommendation		
	Alclometasone cream and ointment (Modrasone ®)		
	Betamethasone 0.025% (*Betnovate RD*)		
Potent			
Betamethasone 0.1% (Betnovate ®)	Beclometasone dipropionate (beclomethasone dipropionate) cream ointment and scalp application		
Betacap ® scalp application	Hydrocortisone butyrate cream, lipocream, ointment and scalp lotion ££		
	Mometasone furoate cream, ointment and scalp lotion £££		
	Diflucortolone valerate 0.1% oily cream £££		
Very potent			
Clobetasol propionate (Dermovate ®) cream ointment & scalp application (for short term treatment max 4 weeks)	Diflucortolone valerate 0.3% oily cream £ (short term treatment of severe exacerbations only) £		

Additional information	
Drug specific notes	Requesting a topical steroid to be diluted is not recommended and is expensive. Prescribe a less potent steroid
NICE guidance	NICE TA 81 - Atopic dermatitis - topical steroids
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

Green	Yellow	Double Yellow	Red
With Antifungal			
Daktacort [A] (hydrocortisone 1%, miconazole nitrate 2%)	Nystaform-HC ® cream [A]		
CanestenHC [A] (clotrimazole 1%, hydrocortisone 1%)	Lotriderm ® cream [C]		
With antibacterial			
Vioform-Hydrocortisone [A E] (clioquinol 3%, hydrocortisone 1%)	Locoid C ® cream and ointment [C E]		
Betnovate C ® [C E] (betamethasone 0.1%, clioquinol 3%)	FuciBet [C E] (betamethasone 0.1%, fusidic acid 2%)		
Other compound preparations			
Eurax -Hydrocortisone ® cream [A]	Calmurid HC ® cream [B]		
With antibacterial and antifungal			
Timodine [A] (nystatin 100,000u per g, hydrocortisone 0.5%, dimethicone 10%)			
Trimovate [B] (clobetasone butyrate 0.05%, nystatin 100,000u per g, oxytetracycline 3%)			
With salicylic acid			
	Diprosalic ® [B](betamethasone 0.05%, salicylic acid 3%)		

Additional information		
Drug specific notes	A B C D E	Steroid potency –mild Steroid potency –moderately potent Steroid potency –potent Steroid potency-very potent Visibly infected eczema should be treated with oral antibiotics. **Topical antimicrobial/corticosteroid combinations** have been shown to be no more effective than topical corticosteroid alone in treating either visibly infected or uninfected flare-ups

NICE guidance	NICE TA 81 Atopic dermatitis –topical steroids
MTRAC / Prodigy / other guidance	Prodigy guidance on combined topical steroid/antibacterial preparations

13.5 Preparations for Eczema and psoriasis

Green	Yellow	Double Yellow	Red
Calcipotriol cream, ointment and scalp solution [A]	Calcitriol ointment £		Acitretin – Dermatologists and paediatricians only
Coal Tar preparations (proprietary e.g. Exorex ® lotion & Polytar Emollient ® bath additive (contains peanut oil)	Tazarotene gel ££		**Alitretinoin -** Dermatologists only in line with **NICE TA 177**
Dithrocream ® cream	Tacalcitol (face and flexures) £££		
Micanol ® 3% cream	Dovobet ® ointment [A B] – 4 weeks therapy only. Specialist initiation. Maximum 15g per day or 100g per week		
Alphosyl HC ® cream (contains wool fat)	Coal tar specials ££ - (see Specials section)		
Sebco ® ointment	Dovobet ® Gel – for use on scalp and or body		
Zinc and salicylic acid paste			

13.5.3 Drugs affecting the immune response			
Green	**Yellow**	**Double Yellow**	**Red**
	Tacrolimus ointment – Specialist recommendation	Methotrexate – specialist initiation and stabilisation, then suitable for GP prescribing with an ESCA	Ustekinumab – Dermatologists only in line with NICE TA 180
	Pimecrolimus cream – Specialist recommendation	Ciclosporin - specialist initiation and stabilisation	Infliximab
			Etanercept
			Adalimumab

Additional information		
Drug specific notes	A	Maximum 100g in one week
	B	Use for four weeks and then assess. Subsequent courses repeated after an interval of at least 4 weeks. Continuous use is not recommended due to the possibly of skin atrophy
NICE guidance	NICE TA 082 Atopic dermatitis (eczema) - pimecrolimus and tacrolimus NICE TA 103 - Psoriasis - efalizumab and etanercept NICE TA 134 Psoriasis - infliximab NICE TA 146 Psoriasis - adalimumab NICE TA 177 for the treatment of severe chronic hand eczema NICE TA 180 Treatment of adults with moderate to severe psoriasis with ustekinumab	
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

13.6 Acne and rosacea

13.6.1 Topical preparations for acne			
Green	**Yellow**	**Double Yellow**	**Red**
Azelaic acid cream	Dalacin T ® [A]		
Benzoyl peroxide	Duac ® 4% gel [A]		
Adapalene – Avoid in pregnancy	Benzamycin gel ® £££ [A]		
Isotretinoin 0.05% gel – Avoid in pregnancy	Nicotinamide 4% gel		
Tretinoin preparations (Retin- A ®) [B] Avoid in pregnancy			

13.6.2 Oral preparations for acne (see also antimicrobial formulary for oral preparations)			
Green	**Yellow**	**Double Yellow**	**Red**
Co-cyprindiol (Dianette ®) [C]	Trimethoprim –Specialist initiation " off label use"	Clindamycin – specialist initiation	Isotretinoin- Dermatologists only. Contraindicated in pregnancy
Oxytetracycline	Minocycline £££–	Rifampicin – specialist initiation	
Erythromycin £££			

Additional information		
Drug specific notes	[A]	BNF No 51 'Topical antibiotics are probably best reserved for patients who wish to avoid oral antibacterials or who cannot tolerate them' 'To avoid antibiotic resistance: • where possible use non-antibiotic antimicrobials such as benzoyl peroxide • avoid concomitant treatment with different oral and topical antibiotics • if a particular antibiotic is effective, use it for repeat courses if needed. (short intervening courses of a topical antibacterial such as benzoyl peroxide may eliminate any resistant propionibacteria)
	[B]	Useful for comedonal acne
	[C]	CSM guidance on hormone treatment for acne
MTRAC / Prodigy / other guidance	Prodigy guidance Acne vulgaris	
PCT information	**Drug Tariff**	

13.7 Preparations for warts and calluses

Green	Yellow	Double Yellow	Red
	Specialist Initiation		Formaldehyde solution 10%
Glutaraldehyde 10% solution	Imiquimod 5% cream		
Salicylic acid (Verrugon ® Occlusal ® Salactol ®)	Podophyllotoxin (Warticon ® and Warticon Fem ®)		
Silver nitrate applicators (40%,75% and 95%)			

13.8 Sunscreens and camouflagers

Green	Yellow	Double Yellow	Red
13.8.1 Sunscreen preparations			
Sunsense ® Ultra lotion	Roc Total Sunblock ® - tinted cream – for patients with vitiligo		Methyl aminolevulinate cream (Metvix®)
Uvistat ® cream and ultrablock cream	Diclofenac sodium 3% gel – Specialist initiation [A.]		
Actikerall [® B]	Fluorouracil 5% cream		
13.8.2 Camouflagers			
	Veil ® - for prescribing in primary care following specialist recommendation (contains wool fat)		
	Dermablend ® - for prescribing in primary care following specialist recommendation		

Additional information		
Drug specific notes	A	For patient who have experienced an adverse effect to topical fluorouracil. (Maximum treatment period 90 days. Optimum effect seen 4 weeks after ceasing therapy)
	B	As an alternative to fluorouracil 5% cream for patients that have a layer of thick hyperkeratotic skin over the actinic keratosis lesions.
NICE guidance		

MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

13.9 Shampoos and Other preparations for scalp and hair conditions

Green	Yellow	Double Yellow	Red
Alphosyl 2 in 1 ® shampoo	Capasal ® shampoo -		
Selsun ® shampoo application	Polytar plus ® liquid		
Polytar ® liquid (contains peanut oil)	TGel ® shampoo		
Ketoconazole 2% shampoo - for seborrhoeic dermatitis and pityriasis versicolor. Primary care prescriptions must be endorsed SLS	Ceanel Concentrate ® shampoo		
	Eflornithine		

13.10 Anti-infective skin Preparations

Green	Yellow	Double Yellow	Red
13.10.1.1 Antibacterial preparations only used topically			
Fusidic acid 2%	Mupirocin 2% cream and ointment For MRSA.		
Polyfax ointment			
13.10.1.2 Antibacterial preparations also used systemically			
Fusidic acid 2% cream and ointment (ointment contains wool fat)			
Metronidazole 0.75% gel (Rosex ®) – Acne rosacea			
Metronidazole 0.8% gel (Metrotop ®) – Malodorous tumours and skin ulcers			

Metronidazole 0.75% (Anabact ®) - gel Malodorous tumours and skin ulcers			
13.10.2 Antifungal preparations			
Green	**Yellow**	**Double Yellow**	**Red**
Clotrimazole	Amorolfine cream and nail lacquer £££ consultant initiation		
Miconazole	Monphytol paint – consultant initiation		
	Terbinafine cream £££		
	Tioconazole nail solution £££		
	Ketoconazole cream		
	Nystatin cream and ointment		
13.10.3 Antiviral preparations			
Aciclovir 5% cream – limited value unless started early			
13.10.4 Parasitical preparations			
Malathion	Carbaryl		
Dimeticone			
13.10.5 Preparations for minor cuts and abrasions			
Magnesium sulphate paste			
			Collodion flexible BP – not prescribable, to be applied by appropriately trained healthcare professional
			Dermabond ® – not prescribable, to be applied by appropriately trained healthcare professional
			Proflavine cream

Additional information		
Drug specific notes		

NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

13.11 Skin Cleansers and antiseptics

Green	Yellow	Double Yellow	Red
13.11.1 Saline			
Irriclens			
Steripods			
Normasol sachets			
13.11.2 Chlorhexidine			
Hibitane Obstetric ® cream			
Tisept ® solution			
Hibiscrub ® solution			
13.11.4 Iodine			
Povidone iodine preparations			
13.11.5 Phenolics			
	Aquasept ® For MRSA		
13.11.6 Astringents, oxidisers and dyes			
	Hydrogen peroxide		
	Potassium permanganate solution tablets		
	Crystacide ® cream		

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

13.12 Antiperspirants

Green	Yellow	Double Yellow	Red
13.12 Antiperspirants			
Aluminum salts			

13.13 Topical circulatory preparations

Green	Yellow	Double Yellow	Red
13.14 Topical circulatory preparations			
			Heparinoid 0.3% cream

Miscellaneous

Green	Yellow	Double Yellow	Red
			Botulinum A Toxin-Haemagglutinin complex – For hyperhidrosis of axillae*
			Depigmenting (tretinoin – Manchester Formula) cream
			Hydroquinone 2% and 4% cream
	Doxepin 5% cream		Trichloroacetic acid 90%
			Fumaric esters

Additional information		
Drug specific notes	*	This is classified as a procedure of low clinical value. See link to Primary Care policy on PLCV below
NICE guidance	NICE TA 260 Migraine (chronic) - botulinum toxin type A	
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff** PLCV Policy	

Specials.

Compounds	Compounds	Compounds	Compounds
	Dermovate ® cream 25% and propylene glycol 40% in Unguentum M ®		
	Emulsifying ointment 25% in coconut oil		
	Sulphur 2% and salicylic acid 2% in Unguentum M ®		
Coal Tar preparations	Coal Tar preparations	Coal Tar preparations	Coal Tar preparations
	Coal tar solution 5% and Betnovate ® ointment 25% in Unguentum M ®		
	Coal tar solution 3%, 5% and 6%in yellow soft paraffin		
	Crude coal tar 1 to 10% in yellow soft paraffin		
Dithranol	Dithranol	Dithranol	Dithranol
	Dithranol 0.1%, 0.25%, 0.5% 1%, 2%, and 5% in yellow soft paraffin or zinc and salicylic acid paste		
Other	Other	Other	Other
	Salicylic acid 2%, 10% and 20% in white soft paraffin		
	Menthol 1% in aqueous cream		
	Metronidazole 2% in aqueous cream		

Heart of England NHS Foundation NHS Trust, Solihull Care Trust and Birmingham East and North Primary Care Trust agree that those specials included in the British Association of Dermatologists (BAD) "preferred list of specials" are all by default included in the Interface Formulary as an option for appropriate prescribing. BAD Preferred list of specials

14 VACCINES AND ANTISERA

This chapter is under development. Currently only medicines that are specifically subject to a positive NICE TA appear

14.5.3.

Green	Yellow	Double Yellow	Red
ANTI-D (Rh0) immunoglobulin			
			Anti-D (Rh0) immunoglobulin

Additional information	
Drug specific notes	NICE TA 156 Pregnancy (rhesus negative women) - routine anti-D
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

15 ANAESTHESIA

15.1.1 Intravenous anaesthetics

Green	Yellow	Double Yellow	Red
Barbiturates			
			Thiopental sodium
Other intravenous anaesthetics			
			Etomidate
			Ketamine
			Propofol

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

15.1.2 Inhalational anaesthetics

Notes on class
•

Green	Yellow	Double Yellow	Red
			Isoflurane
			Sevoflurane
			Nitrous oxide

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

15.1.3 Antimuscarinic drugs

Notes on class
•

Green	Yellow	Double Yellow	Red
	Hyoscine patch		Atropine sulphate
	Hyoscine hydrobromide		Glycopyrronium bromide

Additional information		
Drug specific notes		
NICE guidance		
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

15.1.4.Sedative and analgesic peri-operative drugs

Notes on class
• Do not prescribe tramadol and codeine phosphate together

Green	Yellow	Double Yellow	Red
15.1.4.1 Anxiolytics and neuroleptics			
			Diazepam
			Lorazepam
			Midazolam
			Temazepam
15.1.4.2 Non-opioid analgesics			
Diclofenac – post operative use			Ketorolac
			Parecoxib
			Etoralac
			Tenoxicam
15.1.4.3 Opioid analgesics			
			Alfentanil
			Alfentanil intensive care ® -**High strength** - Palliative Care Team recommendation during end of life care only
			Alfentanil nasal spray (unlicensed)- Palliative Care Team during end of life care for the relief of incident pain
			Fentanyl
			Remifentanil
			Morphine
			Pethidine
			Tramadol

15.1.5 Neuromuscular blocking drugs

Notes on class
•

Green	Yellow	Double Yellow	Red
Non-depolarising muscle relaxants			
			Atracurium
			Mivacurium
			Pancuronium
			Rocuronium
			Vecuronium
Depolarising muscle relaxants			
			Suxamethonium

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

15.1.6 Anticholinesterases used in anaesthesia

Green	Yellow	Double Yellow	Red
			Edrophonium chloride
			Neostigmine
			Sugammadex [A]

Additional information		
Drug specific notes		
	[A]	For use within the terms of its licence when 1) Approved by a Consultant Anesthetist either at the time of the emergency or as soon as practical post emergency 2)Suxamethonium is contraindicated
NICE guidance		
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

15.1.7 Antagonists for central and respiratory depression

Notes on class
•

Green	Yellow	Double Yellow	Red
			Flumazenil
			Naloxone

Additional information	
Drug specific notes	
NICE guidance	
MTRAC / Prodigy / other guidance	
PCT information	**Drug Tariff**

15.1.8 Drugs for Malignant hyperthermia

Green	Yellow	Double Yellow	Red
			Dantrolene sodium

15.2 Local anaesthesia

Notes on class

Green	Yellow	Double Yellow	Red
Emla cream		Lidocaine 5% patches - [A] specialist initiation.	Lidocaine
Ametop cream			Bupivacaine
			Levobupivacaine
			Prilocaine
			Ropivacaine
			Tetracaine
			Articaine hydrochloride
			LAT gel (unlicensed product)
			LMX gel - paediatrics only

Additional information		
Drug specific notes	[A]	GP to receive clear information regarding the choice of therapy and the steps that should be taken if treatment is deemed successful or not within a specified time frame
NICE guidance		
MTRAC / Prodigy / other guidance		
PCT information	**Drug Tariff**	

APPENDIX

The following drugs are <u>not</u> considered appropriate for initiation. HOWEVER if patients are stable on these medications there is no requirement to change them to an alternative.

BNF Category	Drug
2.2.2 Loop diuretics	Torasemide
2.5.5.2 Angiotensin Receptor Blockers	Eprosartan,
	Telmisartan
	Olmesartan
2.6.1 Nitrates	Isosorbide dinitrate (oral)
2.6.2 Calcium channel blockers	Lacidipine
	Lercanidipine
	Nicardipine
2.8 Anticoagulants and protamine	Dalteparin
	Tinzaparin
	Lepiridin
4.1 Hypnotics and anxiolytics	Clomethiazole (chlormethiazole)
	Nitrazepam
4.3	Escitalopram
4.7.1 Non-opioid analgesics	Co-dydramol
4.7.2 Opioid analgesics	Dipipanone hydrochloride
	Buprenorphine patches (Transtec®)
4.8.1 Control of epilepsy	Ethosuximide Clobazam
4.9.1 Dopaminergic drugs used in parkinsonism	Pergolide
	Cabergoline
	Bromocriptine
6.1.1.1 Short Acting Insulins	Inhaled Insulin (Exubera ®) as part of Extended Transition Programme in Secondary Care only
6.1.2.3	Vildagliptin
	Saxagliptin
6.3.2 Glucocorticoids	Cortisone

6.4.2 Male sex hormones	Sustanon ® preparations
7.3.1 Combined hormonal contraceptives	NuvaRing ®
	Qlaira ®
	Yasmin ®
	Logynon ®
7.4.2 Drugs for urinary frequency, enuresis and incontinence	Propiverine
	Solifenacin
11.6	Bimatoprost drops
	Ganfort ®
12.2.1	Fluticasone propionate (Flixonase ® and Nasofan ®)