



imPACT

Prescription Pricing Authority Newsletter

The New Pharmacy Contract

The new contractual framework for community pharmacy agreed for England and Wales between the Department of Health (DH), the Pharmaceutical Services Negotiating Committee (PSNC) and the NHS Confederation was introduced on 1 April 2005. That is for prescriptions dispensed in April 2005, submitted to the PPA in May 2005 and for which payment is made on 1 July 2005.

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Details of the changes to remuneration, payments for essential and advanced services and changes to the prescription submission process can be found on the PPA website at: http://www.ppa.org.uk/ppa/contract_framework_for_community_pharmacy.htm

Patients claiming exemption on age grounds



Following amendments to the NHS Charges Regulations, there is no longer a requirement for certain age exempt patients to complete the exemption declaration on the back of the prescription form.

This relaxation of the Regulations only applies to those prescriptions dispensed in England where the patient's date of birth or age is computer generated on either a paper prescription form or appears as part of an electronic prescription message (ETP). This also includes repeat prescriptions where the patient's date of birth or age is computer generated. Those patients claiming exemption on age grounds, but whose date of birth or age is handwritten, will have to continue to make a signed declaration.

Previously, as a temporary measure, the PPA would not switch age exempt prescriptions submitted as Group 1 where the declaration was not completed but a computer generated age or date of birth was printed. The changes to the NHS Charges Regulations mean that this temporary arrangement will now continue permanently.

Future Events

The PPA will be attending the following exhibitions over the next three months. Our stand will be in place with information on our products and services and the opportunity to discuss our current and future plans:

- The British Computer Society's Primary Healthcare Specialist Group, Summer Conference at Heythrop Park, Oxfordshire on 5 and 6 July.
- British Pharmaceutical Conference, at the Bridgewater Hall, Manchester on 26 to 28 September.

We would like to take the opportunity to invite you to come and talk to us on our stand over the coming months.

Contents Read about:

June 2005

Pact Centre Pages - Cardiovascular Prescribing

p2

Hints and Tips

p4

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NHS

Prescription Pricing Authority

PACT Centre Pages

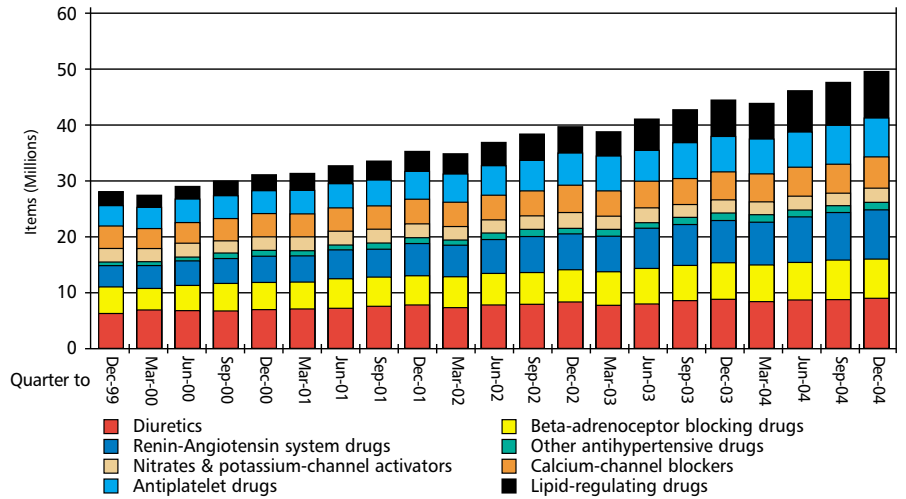
The PACT Centre Pages report on Cardiovascular prescribing, issued to general practitioners in May 2005, is reproduced here for readers with an interest in patterns and trends of prescribing.

Cardiovascular disease (CVD) is the main cause of death in the UK (238,000 deaths in 2002, of which 67,000 were premature deaths before the age of 75). Around half of these deaths are due to coronary heart disease (CHD) and about a quarter are from stroke.¹ Prescription items for drugs to prevent and treat CHD have increased by 76% in the last five years to nearly 50 million per quarter. The cost of these drugs has increased to £529 million per quarter. The largest increases in prescribing have occurred in lipid regulating drugs, drugs affecting the renin-angiotensin system and antiplatelet drugs (charts 1 and 2).

We are now halfway through the ten-year programme set out in the CHD National Service Framework (NSF). The NSF included a target of a 40% reduction in the inequalities gap between the whole population and the fifth of areas with the worst health and deprivation indicators, for the death rate from heart disease, stroke and related diseases in under 75's by 2010. Between 1995/6/7 and 2001/2/3 the inequalities gap has decreased from 37.2 to 28.7 excess deaths per 100,000 (22% reduction in absolute gap).² The NSF also set out guidelines to improve the use of effective medicines for patients following a myocardial infarction (MI). Recent data show that more than 90% of patients are given appropriate drugs, such as aspirin, beta-blockers or statins on discharge from hospital to help prevent another MI.²

Individual changes to diet, smoking and level of physical activity can potentially decrease the burden of CVD. The risk of CHD almost doubles in people who are physically inactive. Eating at least 5 portions of fruit and vegetables per day could lead to an estimated reduction of 20% in overall deaths from chronic diseases, such as heart disease, stroke and some cancers. Adult smoking prevalence has decreased from 28% (2000) to 25% (2003).³ A six-point programme is in place to reduce smoking prevalence, including media and education campaigns and reducing availability and supply of tobacco. In England the number of people who quit smoking at four-week follow up increased by 65%

Trends in Prescribing of Cardiovascular Drugs (Chart 1)



from 124,100 in 2002/03 to 204,900 in 2003/04 (57% of those setting a quit date).² Around 277,000 (77% of those setting a quit date received nicotine replacement therapy, 30,200 (8%) received bupropion and 3,800 (1%) received both.

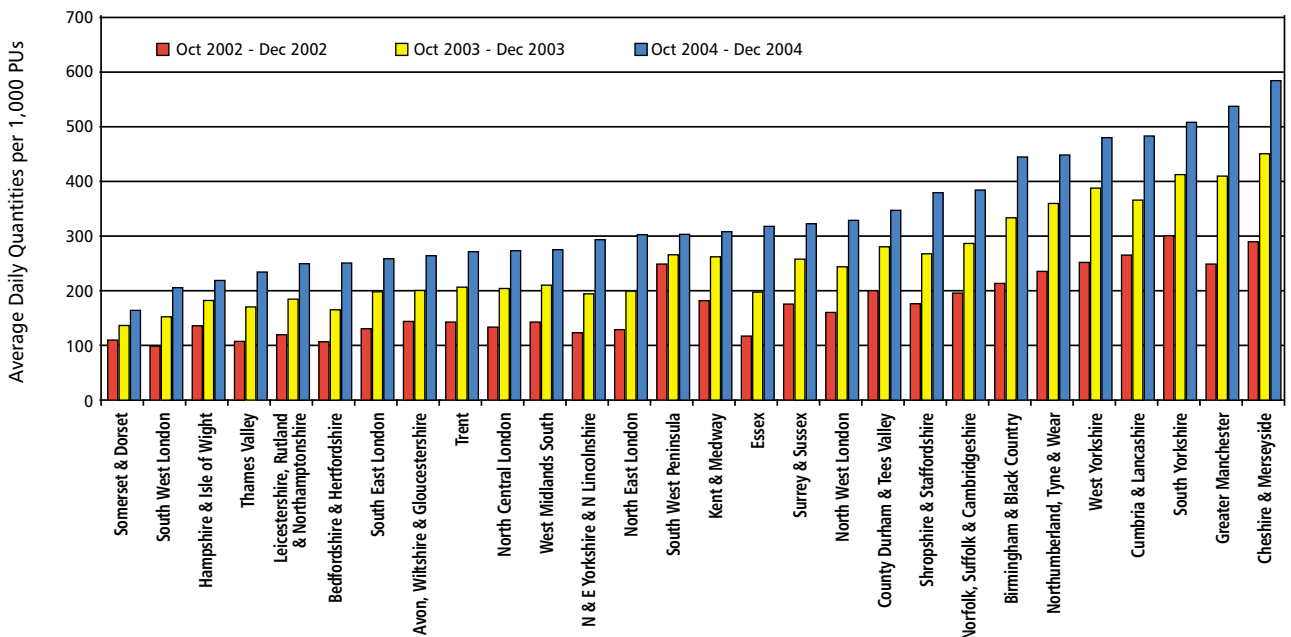
The Joint British Societies Coronary Risk Prediction charts aim to assess ten-year risk of CVD (including non-fatal MI and stroke) rather than risk of CHD.³ A ten-year CVD risk of 40% is approximately equal to a ten-year CHD risk of 30%.⁴ The UK Prospective Diabetes Study Risk Engine is a specific risk calculator based on 53,000 patient years of data; it is useful for estimating risk in patients with type two diabetes not known to have heart disease.⁵ Research has shown that moderate reductions in several risk factors may be more beneficial than major reductions in one.⁶ The approach to CVD treatment is moving away from treating individual risk factors to assessment of absolute risk of CVD; this may vary more than 20-fold in patients with the same cholesterol or blood pressure levels.⁶

Hypertension

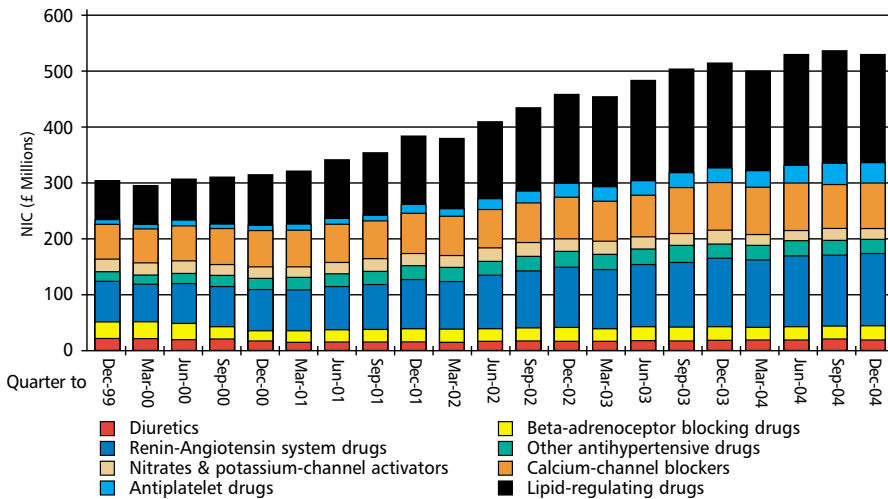
Antihypertensive therapy should be offered to patients with either persistent high blood pressure

=160/100mmHg or patients with persistent blood pressure =140/90 mmHg with raised cardiovascular risk (ten-year risk of CHD =15% or CVD =20% or existing CVD or target organ damage).⁷ There has been considerable debate over the different approaches to starting treatment taken by the British Hypertension Society (BHS) compared to NICE. However the BHS guidelines agree with NICE that the least expensive drug (usually a thiazide diuretic) should be chosen first line where there are no compelling indications to use an alternative.^{3,7} NICE recommends that a beta-blocker is added if necessary.⁷ If the patient is at raised risk of new-onset diabetes then an angiotensin-converting enzyme (ACE) inhibitor should be added instead of the beta-blocker. If further drug treatment is required then a dihydropyridine calcium-channel blocker can be added third line.⁷ More than one drug is usually required to reach target blood pressure. Angiotensin-II receptor antagonists (AIIIRAs) are a suitable alternative to ACE inhibitors where cough is a limiting adverse effect. NICE recommends offering patients over 80 years the same treatment as younger patients, taking account of their co-morbidity and existing burden of drug use.

Variation Between Strategic Health Authorities in Prescribing of Clopidogrel (Chart 3)



Trends in Spending on Cardiovascular Drugs (Chart 2)



Hyperlipidaemia

The NSF target for primary prevention is to lower total cholesterol to <5mmol/l (low-density lipoprotein (LDL) cholesterol to <3mmol/l) or by 30% whichever is greater in those with a ten-year CHD risk greater than 30%. Although the BHS guidelines advise more rigorous targets of <4mmol/l (LDL cholesterol to <2mmol/l) or by 25% (LDL cholesterol by 30%), for primary prevention in those with a ten-year CHD risk of 20% this is not national policy.³ NICE is reviewing national clinical policy to take into account recent outcome data, this is due for publication in September. Statins are usually only prescribed for high risk patients, which could partly account for the modest decline in standardized admission ratios for acute MI between 1996 and 2002, since MIs often occur in people with lower risk.⁸ Choice of statin therapy depends on clinical evidence and cost-effectiveness, currently simvastatin is the cheapest and is a reasonable first-line choice. Debate continues around the benefit of treating all patients at high risk of CVD with a statin regardless of pre-treatment cholesterol level. The effectiveness of atorvastatin 10mg daily was assessed against placebo in primary prevention of CVD in patients with type 2 diabetes. The results were similar to the Heart Protection Study where the benefit from statin treatment appeared to be independent of the initial LDL cholesterol level.⁹ To prevent one CVD event, 27 patients would need to be treated for four years with atorvastatin 10mg. Allocation of 1,000 patients to atorvastatin would lead to a reduction of 50 first or subsequent major cardiovascular events over a four year follow-up period.⁹ People at lower risk (10-15% ten-year risk of CHD) in addition to reducing their risk by lifestyle modification have the option of purchasing simvastatin 10mg over the counter. For these people, one out of every 20 to 30 who take simvastatin 10mg for three years will have a major cardiovascular event prevented.⁴

Antiplatelet drugs

Low dose aspirin is recommended for patients with CHD or other occlusive arterial disease. There is no good evidence to suggest that any other antiplatelet therapy is more effective than aspirin for long-term secondary prevention of serious vascular events.¹⁰ For people who are intolerant of aspirin (proven hypersensitivity to aspirin or a history of severe dyspepsia induced by low dose aspirin) and either have experienced an occlusive vascular event or have symptomatic peripheral arterial disease then clopidogrel alone is recommended.¹¹ Chart 3 shows the year on year increase in prescribing of clopidogrel with a 3.5-fold variation across strategic health authorities. A combination of MR dipyridamole and

aspirin is recommended for people who have had an ischaemic stroke or transient ischaemic attack for a period of two years from the most recent event; thereafter, or if MR dipyridamole is not tolerated, the preventative therapy should revert to standard care (including low dose aspirin).¹¹

Prescribing data

Diuretics are the most commonly prescribed cardiovascular drugs, 9.4 million items at a cost of £16.8 million, quarter to December 2004 (excluding diuretics in combination with other antihypertensive drugs). Thiazides account for over 56% of all diuretic items: bendroflumethiazide is most commonly prescribed (4.9 million items and £5.4 million). Furosemide is the most commonly prescribed loop diuretic (2.6 million items and £3.2 million). Potassium sparing diuretics in combination with other diuretics account for 764,000 items, £3.1 million while spironolactone accounts for 365,000 items and £1.5 million.

There are 6.9 million items for beta-blockers (£24.9 million), quarter to December 2004. Of these prescriptions over 65% are for atenolol (22% of total spending on beta-blockers). Bisoprolol is the second most commonly prescribed beta-blocker at 0.7 million items, costing £7.5 million. Over the past five years prescribing of beta-blockers has increased by 56%.

Prescribing of renin-angiotensin system drugs has more than doubled in the past five years to 8.8 million items and £129.1 million, quarter to December 2004. ACE inhibitors account for 6.5 million items with 2.3 million items for AIIAs. Ramipril is the most commonly prescribed ACE inhibitor (2.4 million items, £30.3 million) and losartan is the most commonly prescribed AIIA (0.7 million items, £21.1 million).

Prescribing of lipid regulating drugs has risen by over 250% while spending has risen by 170% over the last five years (8.2 million items and £192.8 million, quarter to December 2004). Statins account for 95% of items for lipid regulating drugs (simvastatin 3.6 million and atorvastatin 3.1 million items per quarter). Twice as much is now spent on atorvastatin than simvastatin (£100.2 million compared to £51.4 million). Ezetimibe prescribing and spending has risen to 107,000 items and £3.7 million.

Prescribing of antiplatelet drugs has shown an 83% increase over the past five years, with cost increasing almost 5-fold. In the quarter to December 2004, aspirin accounts for 86% of the 7.2 million antiplatelet items prescribed and 14% of the £39.7 million cost. Clopidogrel is the second most commonly prescribed antiplatelet at 0.7 million items and 75% (£30.4 million) of cost for this group.

Moderate reductions in several cardiovascular risk factors are probably more beneficial than a major reduction in one.

Low dose thiazide diuretics are usually the starting point for treatment of hypertension, however, more than one drug is often required to achieve current blood pressure targets.

Simvastatin is a rational first line choice for lipid lowering based on clinical evidence and cost-effectiveness.

Aspirin is still the most cost-effective therapy for long-term secondary prevention of serious vascular events.

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- 3 British Hypertension Society guidelines for hypertension management 2004: summary. BMJ 2004; 328: 634-640.
- 4 National Prescribing Centre. Updating local policies for reducing the impact of cardiovascular disease. Where does OTC simvastatin fit in? December 2004.
- 5 UKPDS Risk Engine. www.dtu.ox.ac.uk/riskengine.
- 6 Jackson R, Lawes C, Bennett D, Milne R, Rodgers A. Treatment with drugs to lower blood pressure and blood cholesterol based on an individual's absolute cardiovascular risk. Lancet 2005; 365: 434 - 441.
- 7 NICE. Management of hypertension in adults in primary care. August 2004.
- 8 Majeed A, Aylin P, Williams S, Bottle A, Jarman B. Prescribing of lipid regulating drugs and admissions for myocardial infarction in England. BMJ 2004; 329: 645.
- 9 Colhoun H, Betteridge D, Durrington P, Hitman G, et al. Primary prevention of cardiovascular disease with atorvastatin in type two diabetes in the Collaborative Atorvastatin Diabetes Study (CARDS): multicentre randomised placebo-controlled trial. Lancet 2004; 364: 685 - 697.
- 10 Clinical Evidence freelance writers. Stroke prevention. Clinical Evidence 2004;12: 253 - 284.
- 11 NICE. Clopidogrel and modified-release dipyridamole in the secondary prevention of occlusive vascular events. October 2004.

The NSF can be found on the following website - www.dh.gov.uk

Our Centre Pages article can also be found on - www.ppa.nhs.uk

Hints and Tips

Not Prescribable on Dental Forms FP10D

Please note - The following products have recently been disallowed when ordered on FP10D.

Contractors are reminded that these items cannot be reimbursed:

- Ibuprofen Susp 100mg/5ml - only Sugar Free can be prescribed.
- Amoxicillin 250mg tabs.

Only those products listed in Part XVIIA can be prescribed by dentists and dispensed on the prescription form FP10D.

Any product not listed will be disallowed.

Supplementary Prescribing

Controlled Drugs

Changes to the GMS/PMS regulations enable the prescribing of Controlled Drugs by Supplementary Prescribers (nurses and pharmacists) in primary care from 14 April 2005.

Nurse and pharmacist Supplementary Prescribers can prescribe Controlled Drugs for a patient as part of a patient's Clinical Management Plan agreed with a doctor.

Unlicensed Medicines

Recent amendments to the Medicines Act Regulations, NHS Regulations and Home Office Misuse of Drugs Regulations together enable the expansion of non-medical prescribing. This enables the widening of supplementary prescribing for nurses and pharmacists, to include unlicensed medicines.

Instalment Prescribing

Please note - With effect from 14 April the regulations have been amended to extend the requirements for supply in instalments to Diazepam. This applies only to the non-electronic form provided specially for the purpose of supply by instalments. (FP10MDA form).

The PPA receives many requests on how to complete the right hand side of the FP10MDA form. Pharmacists should ensure that the right hand side of the form is fully completed as part of their Standard Operating Procedures. This will of course facilitate any subsequent internal audit and clinical governance requirements.

The more complete the information is, the easier it is for the PPA to determine the number of additional fees to apply.

Elastic Hosiery

Please note - The only Elastic Hosiery items allowed on FP10 must state on the packaging that they conform to Drug Tariff Specification 40:

For below knee and thigh length standard stock sized garments (where there is no indication that 'made to measure' has been supplied) the only knit available is circular knit. Therefore, in this case, if the prescription hasn't been endorsed with the knit, 'circular knit' will be the default for payment. The style (e.g. below knee or thigh length) and the compression class must still be clearly marked on the prescription for the PPA to make the correct payment. If this is not included on the prescription, the prescription will be returned.

Soffban Natural Bandage 10cm x 3.5m

For information - Soffban Natural Bandage 10cm x 3.5m is no longer listed in Part IXA of the Drug Tariff. Only appliances listed in Part IX of the Drug Tariff can be prescribed on NHS prescriptions. Therefore, Soffban Natural Bandage 10cm x 3.5m can no longer be prescribed on a NHS prescription.

The Soffban Natural 10cm x 3.5m pack was changed to Profore #1 over a year ago. The Drug Tariff listed both the old and new names for 12 months but the listing for Soffban has now been removed.

If prescriptions are received for Soffban 10cm x 3.5m, they should be returned to the prescriber to be amended to read "Profore #1."

Normal Saline Nasal Drops/ Sodium Chloride Nose Drops

Please note - Normal Saline Nasal Drops/Sodium Chloride Nose Drops are not listed in Part VIII of the Drug Tariff, so contractors must endorse prescriptions for this product with information on what has been dispensed to ensure correct payment.

There are currently two options available to contractors dispensing this product:

1. Sodium Chloride 0.9% Solution (Part VIII, Category E Product). If the product is dispensed extemporaneously, pharmacies can endorse and claim an extemporaneous dispensing fee. Payment based on the Part VIII Price.
2. Tubilux Nasal Drops (Tubilux Pharma/Proprietary Product). A number of manufacturers of Normal Saline Nasal Drops have registered their products as medical devices (including Alpharma, Sandoz and Galpharma). Only medical devices listed in Part IXA of the Drug Tariff can be dispensed on NHS prescriptions. At present Tubilux is the only Normal Saline Nose Drops product listed in Part IXA of the Drug Tariff. We are currently unaware of any Sodium Chloride Nasal Drops that are classed as medicinal products. Payment for Tubilux is based on the Part IX Drug Tariff Price.