

imPACT

Prescription Pricing Authority Newsletter

Revised 'Schedule of Payments' for pharmacy contractors

The current pharmacy Schedule of Payments has been enhanced to incorporate the new payments and fees being introduced under the pharmacy contract from April 2005. The new fees and the Drug Tariff Part VIII Category M, generic prices will be applied to prescriptions dispensed in April which will be visible on your payment due 1 July 2005. Changes to the schedule are highlighted as shown here.

Schedule of Payments		NHS	
Dispensing month: Apr 2005		Prescription Pricing Authority	
For:	A N CHEMISTS	123 MAIN ROAD	
T/A:	A N PHARMACY	NEW TOWN ESTATE	
OCS code:	FA123	NEW TOWN	
		N12 13A	
Net payment made by PPA on 01 Jul 2005 by BACS		112,182.49	£
SUMMARY OF PAYMENT AMOUNTS			
Total of drug and appliance costs		109,479.42	£
Total of all fees		14,259.29	£
Total of drug and appliance costs plus fees		123,738.71	£
Total of charges (including FP57 refunds)		-8,908.80	£
Total of account		114,829.91	£
Recovery of advance payment		-88,263.42	£
Recovery of advance payment in respect of a late registered batch		0.00	£
Balance due in respect of Apr 2005		26,566.49	£
Payment on account for May (8692 items less 1397 charges)		85,344.80	£
Advance payment in respect of a late registered batch		0.00	£
Other adjustments		0.00	£
Total amount authorised by PPA		111,911.29	£
Total amount authorised by PCT		201.20	£
Total of other amounts authorised		70.00	£
Net payment made by PPA		112,182.49	£
DRUG AND APPLIANCE COSTS			
Total of basic prices at standard discount rate		108,157.54	£
Discount @ 11.70 %		-12,654.43	£
Total of basic prices at zero discount		13,512.55	£
Sub total of basic prices		109,015.66	£
Out of Pocket expenses		44.08	£
Container allowance 9202 @ 3.24 p		298.14	£
Oxygen cylinders and masks		72.77	£
Oxygen expenses		0.00	£
Oxygen adjustment		0.00	£
Adjustment Division Adjustment for 200405 prescriptions		48.77	£
Total of drug and appliance costs		109,479.42	£
PRESCRIPTION FEES			
Professional fee 9202 @ 90.00 p		8,281.80	£
Pharmacy contract transition payment		731.50	£
Repeat dispensing fee		125.00	£
Practice payment		2,227.85	£
Additional fees		1.55	£
2A extemporaneously dispensed preparations		55.04	£
2B elastic hosiery and trusses measured and fitted		28.16	£
2D limited stability (<14 days) extra supplies		0.00	£
2E controlled drug schedules 2 and 3		521.16	£
2F expensive prescription fees 96		353.81	£
Manually priced		0.00	£
Establishment payment		1,818.42	£
Sub total of prescription fees		14,144.29	£
Other fees Medicines use reviews		115.00	£
Total of all fees		14,259.29	£

Either Protected Additional Professional Payment or Establishment Payment will be displayed. Where a contractor receives neither the line will be suppressed.

Expensive prescription items fee is now 2F.

Advanced service: Medicines use review.

Schedule of Payments		NHS	
Dispensing month: Apr 2005		Prescription Pricing Authority	
For:	A N CHEMISTS	123 MAIN ROAD	
T/A:	A N PHARMACY	NEW TOWN ESTATE	
OCS code:	FA123	NEW TOWN	
		N12 13A	
CHARGES			
Collected excluding elastic hosiery	1390 @ 6.40	-8,896.00	£
Collected elastic hosiery	0 @ 6.30	0.00	£
FP57 refunds		-51.20	£
Total of charges (including FP57 refunds)		-8,908.80	£
DETAILS OF LOCAL AMOUNTS AUTHORISED BY XXXXX PCT			
Oxygen Therapy Service (Hardware)		10.40	£
Oxygen Therapy Service (Service Element)		190.80	£
Total amount authorised by PCT		201.20	£
DETAILS OF OTHER AMOUNTS AUTHORISED			
Pharmacy Reward Scheme		70.00	£
Total of other amounts authorised		70.00	£
PRESCRIPTION DATA			
Total forms received		5138	
Items at zero discount rate, for which a fee is paid		763	
Items at standard discount rate, for which a fee is paid (including oxygen)		8443	
Total of items, for which a fee is paid		9206	
Average item value		13.43	
Referred back items		146	
Referred back forms		70	
Medicines use reviews declared		5	
Dispensing staff (full time equivalent) declared		2	
FP57 forms declared		2	
ITEMS TRANSFERRED BETWEEN EXEMPT AND CHARGEABLE GROUPS			
Exempt to Chargeable		17	
part 3 unsigned by patient/patient rep.		6	
part 2 contains charge rate		11	
Exempt to Chargeable (old rate)		0	
Chargeable to Exempt		3	
declaration shows claim for exemption		3	
Chargeable (old rate) to Exempt		0	
Contraceptive to Chargeable		0	
Contraceptive to Chargeable (old rate)		0	
Key			
Part 2 - Prescription charge box on reverse of prescription form			
Part 3 - Patient/representative signed declaration section on reverse of prescription form.			

From April this will show the amount declared for FP57 refunds.

Additional data as declared on the submission document.

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NHS

Prescription Pricing Authority

PACT Centre Pages

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

Non-steroidal anti-inflammatory drugs (NSAIDs) are widely prescribed in primary care, mainly for osteoarthritis and back pain. Over 9 million people suffer with arthritis; osteoarthritis being the most prevalent form. On average, people visit their doctor every five months about their osteoarthritis, but a third never visit.¹ Of those patients taking medication, 32% use NSAIDs, 18% use cyclo-oxygenase II (Cox-II) selective inhibitors and 15% use paracetamol to manage their osteoarthritis pain.¹ Prescribing of NSAIDs has increased gradually over the last 5 years (Chart 1), wholly due to the rise in prescribing of Cox-II selective inhibitors. Cost has risen significantly (Chart 2) because the Cox-II selective inhibitors are more expensive than standard NSAIDs. Rofecoxib was withdrawn from the market in September 2004; it accounted for approximately 200,000 prescription items per month. Data for November 2004 shows that prescriptions for celecoxib, ibuprofen and diclofenac have increased to 15%, 23% and 36% of all NSAID items respectively, compared to 12%, 21% and 34% in September 2004. Most of the increase in prescribing of these three drugs is probably due to patients being switched from rofecoxib.

Managing pain in osteoarthritis

Paracetamol is effective in relieving pain in osteoarthritis and should be tried first line based on its favourable safety profile compared to NSAIDs.² There is little evidence to suggest that NSAIDs are significantly different from paracetamol in providing pain relief. Non-drug therapies or topically applied products can be

tried in addition to or as alternatives to paracetamol before trying an oral NSAID. In osteoarthritis of the knee, oral glucosamine (1500mg daily) probably provides moderate relief of symptoms and similar efficacy to NSAIDs and is another treatment option.³ A systematic review concluded that there is insufficient evidence of benefits from chondroitin in osteoarthritis.⁴ Trial evidence (although limited by reporting issues and methodology) has shown that exercise, physical therapy and acupuncture reduce pain and disability in people with knee or hip osteoarthritis.^{4,5} In an Arthritis Care survey 57% of respondents used exercise to help manage their osteoarthritis.¹

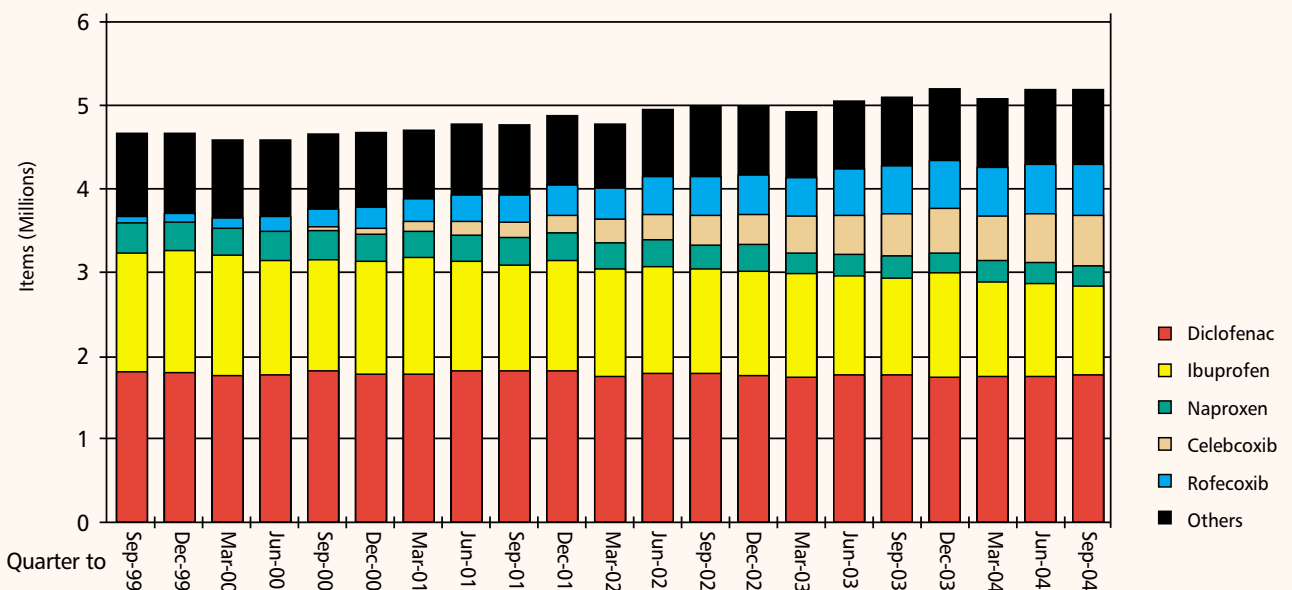
A recent meta-analysis compared topical NSAIDs with placebo or oral NSAIDs in patients with evidence of osteoarthritis.⁶ In the first two weeks of treatment topical NSAIDs were superior to placebo in relieving pain due to osteoarthritis. There is no evidence to support the long term use of topical NSAIDs in osteoarthritis.⁶ A review of rubefacients containing salicylates showed that they help in relieving acute pain (number needed to treat (NNT) 2.1 for at least 50% pain relief at 7 days compared to placebo). They perform less well in relieving chronic arthritic and rheumatic pain (NNT 5.3 for at least 50% pain relief at 14 days compared to placebo).⁷ A meta-analysis including 23 trials with 10,485 patients (7,767 received oral NSAIDs, 3,078 received placebo) measured the change in overall intensity of pain. It showed that oral NSAIDs reduce pain in the short term for osteoarthritis of the knee, however the advantage over placebo is small.⁸ Evidence is lacking for the efficacy of long term oral NSAIDs.

Cardiovascular adverse events

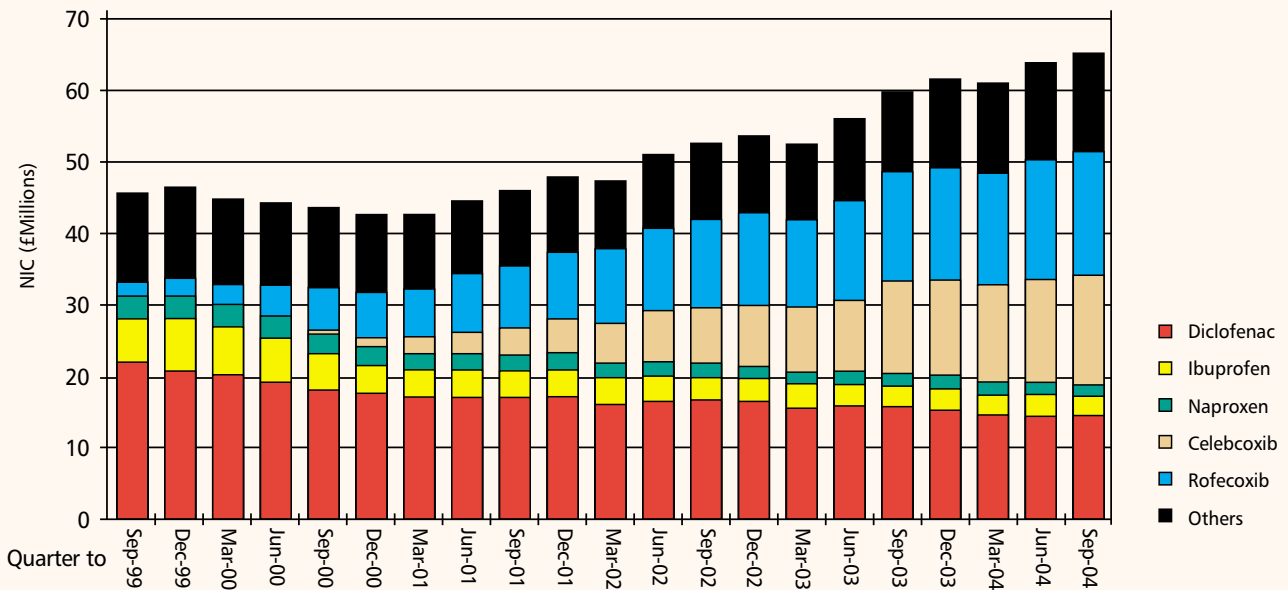
All NSAIDs have the potential to cause adverse effects such as fluid retention, oedema and hypertension. Caution is required when prescribing any NSAID in patients with renal, cardiac or hepatic impairment, particularly in older patients who are at higher risk of these problems. Rofecoxib was withdrawn from the market on 30 September 2004 because of concerns raised by the adenomatous polyp prevention on Vioxx (APPROVe) study, which showed increased risk of heart attack and stroke after 18 months of treatment compared with placebo. Following the withdrawal of rofecoxib, the European Medicines Agency (EMA) is reviewing all Cox-II selective inhibitors to look at aspects of cardiovascular safety including heart attack, stroke, hypertension, oedema and cardiac failure. The EMA recently released a statement advising patients and prescribers about the safety of valdecoxib.⁹ A higher rate of cardiovascular thromboembolic events compared to placebo has been shown in studies involving coronary artery bypass graft surgery. The reported rate of serious skin reactions (some with fatal outcome) appears to be higher with valdecoxib than other Cox-II selective inhibitors.⁹

New data from a trial of celecoxib showed that the risks of a major fatal or non-fatal cardiovascular event were 2.5 and 3.4 times higher than placebo at 400mg and 800mg doses respectively. A second celecoxib trial did not appear to confirm the same level of risk.¹⁰ The Medicines and Healthcare products Regulatory Agency (MHRA) has advised prescribers to switch

Trends in Prescribing of NSAIDs in General Practice in England (Chart 1)



Trends in Spending on NSAIDs in General Practice in England (Chart 2)



patients treated with any Cox-II selective inhibitor who have established ischaemic heart disease or cerebrovascular disease to alternative treatment (non Cox-II selective) as soon as convenient. In all patients alternative treatment should be considered in light of assessment of risks and benefits of Cox-II selective inhibitors.¹⁰ NICE recommends that Cox-II selective inhibitors should not be used in preference to standard NSAIDs in people with cardiovascular disease or in those taking low dose aspirin.¹¹

Gastrointestinal adverse events

Before prescribing an NSAID (including Cox-II selective inhibitors) the risk of a gastrointestinal (GI) adverse event versus the benefit of treatment should be assessed. In a meta-analysis the pooled relative risk of serious upper GI complications associated with NSAIDs was 3.8 (95% confidence

interval 3.6-4.1).¹² The burden of adverse drug reactions (ADR) as a cause of hospital admissions was investigated in an observational study. NSAIDs were implicated in 30% (363 cases) of admissions due to an ADR. Aspirin was associated with the most adverse events, rofecoxib and celecoxib also caused ADRs resulting in admission.¹³

Factors associated with a high risk of GI adverse events from NSAIDs include:

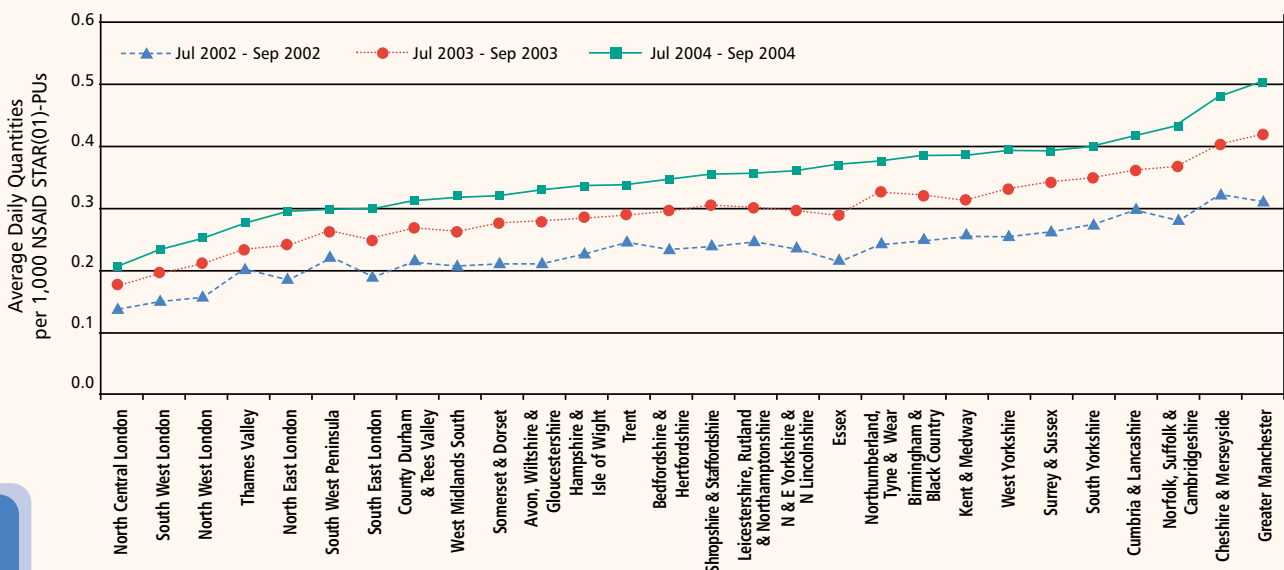
- age over 65 years
- use of other medicines known to increase the chance of upper GI adverse events
- serious co-morbidity
- prolonged use of maximum recommended doses of standard NSAIDs
- previous history of peptic ulcer disease/dyspepsia.¹¹

Cox-II selective inhibitors should only be considered instead of standard NSAIDs in people

with rheumatoid arthritis or osteoarthritis who may be at high risk of developing serious GI problems. The alternative is to prescribe a standard NSAID with gastroprotection. Misoprostol reduces serious upper GI complications in high risk patients compared to placebo and significantly reduces NSAID associated gastric and duodenal ulcers found on endoscopy.¹⁴ Proton pump inhibitors or double dose H2-receptor antagonists also reduce the risk of endoscopic gastric and duodenal ulcers.¹⁴ Eradicating *Helicobacter pylori* before commencing an NSAID is useful in patients with previous history of or at high risk of peptic ulcer disease.¹²

Chart 3 shows the year on year increase in prescribing of Cox-II selective inhibitors for Strategic Health Authorities for the last three years. There is a 2.5 fold variation in prescribing of Cox-II selective inhibitors across Strategic Health Authorities.

Variation Between Strategic Health Authorities in Use of Cox-II Selective Inhibitors (Chart 3)



Prescribing data

Diclofenac is the most commonly prescribed NSAID, 1.8 million items (34% of all NSAIDs) in the quarter to September 2004, followed by ibuprofen, 1.1 million items (20%). Prescribing of ibuprofen has decreased significantly (25%) over the last 5 years with diclofenac prescribing falling only slightly (2%). The amount spent on ibuprofen has more than halved (£2.9 million, quarter to September 2004) while spending on diclofenac has fallen by 35% (£14.1 million per quarter). In the quarter to September 2004 one-third of all NSAID prescriptions (1.7 million items) and 66% of cost (£42.7 million) were for the Cox-II selective inhibitors (rofecoxib, celecoxib, etoricoxib, valdecoxib, etodolac and meloxicam).

Overall the number of non-opioid analgesics items (8.4 million, quarter to September 2004) has shown little change over the last 5 years. 97% of non-opioid analgesics items and 98% of cost are for paracetamol and paracetamol combination products. Prescriptions for paracetamol and paracetamol with codeine have both risen by about 25% in the last 5 years (2.9 million and 2.5 million items per quarter, £3.4 million and £14.2 million respectively). Prescriptions for paracetamol with dextropropoxyphene and paracetamol with dihydrocodeine have decreased by 26% and 4% respectively to 1.8 million and 1 million items per quarter, while cost has fallen by 38% and 12% respectively (£2.5 million and £2.6 million, quarter to September 2004). The increase in paracetamol with codeine items over the last 5 years is due to greater prescribing of preparations containing at least 30mg codeine (up by 57% to 1.3 million items, £10.8 million in the quarter to September 2004). The cost of 28 days treatment for preparations of paracetamol combined with 30mg codeine is 1.25 times the cost of prescribing these two drugs separately. Total prescribing of rubefacients and topical NSAIDs has decreased by 11% and cost has fallen by 9% over the last 5 years. Topical NSAIDs account for 0.67 million items and topical rubefacients 0.45 million items, quarter to September 2004, while their cost is £4.3 million and £2.2 million respectively. Movelat[®] accounts for more than half of all topical rubefacient items, 0.26 million (58%) and £1.4 million per quarter. Over the counter sales of topical products are not included in these figures and these may be substantial.

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- 9 European Medicines Agency. EMEA public statement on valdecoxib (bextra/valdyn) and parecoxib sodium (dynastat/rayzon). Cardiovascular risks in coronary artery bypass graft (CABG) surgery and serious adverse skin reactions. December 2004 www.emea.eu.int/pdfs/human/press/pus/20480204en.pdf
- 10 Medicines and Healthcare products Regulatory Agency. Advice on the use of celecoxib and other selective cox-2 inhibitors in light of concerns about cardiovascular safety. December 2004 www.mhra.gov.uk/news/2004/celecoxibhealthlink201204doc.pdf
- 11 National Institute for Clinical Excellence. Guidance on the use of cyclo-oxygenase (Cox) II selective inhibitors, celecoxib, rofecoxib, meloxicam and etodolac for osteoarthritis and rheumatoid arthritis. Technology Appraisal Guidance No. 27, July 2001
- 12 National Prescribing Centre. NSAIDs and gastroprotection. *MeReC Briefing* 2002; 20: 1-4
- 13 Pirmohamed M, James S, Meakin S, Green C, Scott A K, Walley T J, et al. Adverse drug reactions as a cause of admission to hospital: prospective analysis of 18,820 patients. *BMJ* 2004; 329: 15-19
- 14 Rostom A, Dube C, Wells G, et al. Prevention of NSAID-induced gastroduodenal ulcers (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2004

Summary

Paracetamol should be prescribed first for pain in osteoarthritis before trying an NSAID.

Rubefacients and topical NSAIDs can be useful to relieve osteoarthritic pain in the short term.

Patients with ischaemic heart disease or cerebrovascular disease taking Cox-II selective inhibitors should be switched to a non Cox-II selective alternative.

Misoprostol prescribed with a standard NSAID can reduce the risk of serious GI adverse events in patients at high risk.

In those with a previous history of, or at high risk of peptic ulcer disease, eradication of *Helicobacter pylori* is useful before starting a patient on an NSAID.

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

Changes to design of FP10 stationery

The design of the FP10SS prescription form has changed. This has primarily been done in order to facilitate NPfIT's move towards ETP. These prescriptions may now be presented for dispensing in England.

The key changes that you may notice on the new version of the FP10SS include:

- The version number on the prescription form has changed from 0404 to 0105.
- The version number on the front of the prescription has moved from the right-hand column to the bottom of the form.
- The line separating the prescribing area from the endorsement area has changed from blue to green (Please restrict any dispensing endorsements to this left-hand column only).
- The version number on the reverse of the prescription has moved from the bottom to the top of the form.
- The Patient name and address section on the reverse of the prescription (Part 3) has reduced from 3 lines to 2.
- The "Patient Notes Overleaf" prompt has been moved from the left-hand page of the FP10SS to the right.

Similar design changes are likely to be implemented across the whole range of FP10 stationery over the coming months. The version number of these prescriptions will change accordingly. Previous versions of the FP10SS prescription form continue to be valid for prescribing and dispensing purposes.



BACS Payment Dates

The following table highlights the payment dates up to the end of 2005 for pharmacy contractors.

- 01 April 2005
- 29 April 2005
- 01 June 2005
- 01 July 2005
- 01 August 2005
- 01 September 2005
- 30 September 2005
- 01 November 2005
- 01 December 2005
- 30 December 2005

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Hints and Tips

Prescribing Restrictions on Tamiflu and Relenza

Please note - With effect from 3 January 2005 Oseltamivir (Tamiflu) and Zanamivir (Relenza) were added to Schedule 2 of the Regulations (i.e. the Selected List Scheme). Thus, prescriptions for either of these drugs must be endorsed "SLS" by the prescriber before they can be reimbursed.

Supplementary Prescribing

For information - We continue to receive queries from contractors asking whether or not a supplementary prescriber can prescribe a particular item. Put simply, supplementary prescribing is a three-way prescribing partnership between the independent prescriber (generally the medical practitioner), the supplementary prescriber and the patient. Supplementary prescribers are subsequently able to prescribe:

- All General Sales List (GSL) medicines, Pharmacy (P) medicines, appliances and devices included in Drug Tariff Part IX, foods and other borderline substances approved by the Advisory Committee on Borderline Substances.
- All Prescription Only Medicines with the current exception of Controlled Drugs. (NB DH Officials continue to work with the Home Office on proposals for changes to the Misuse of Drugs regulations to enable supplementary prescribing of Controlled Drugs. Any changes to regulations are now unlikely before Spring 2005).

Glucosamine Sulphate

A reminder - Generic orders for Glucosamine Sulphate (which is a "Recommended International Non-proprietary Name" (rINN)) can be met by supplying any branded product, whether or not the brand supplied is included in Schedule 1 of NHS (GMS) (Prescription of Drugs etc) Regulations 2004.

Multi-layer Compression Bandaging Kits

Please note - A separate prescription charge is payable for each element of a multi-layer bandage system kit, unless the patient is exempt from prescription charges.

"CE" Marked Devices

A reminder - There continues to be a number of products which appear at first glance to be medicinal products but which are subsequently found to be registered as devices. The best advice we can give is, before you dispense against a prescription, check whether the product bears a "CE" mark - if it does, and the product isn't listed in Part IX of the Drug Tariff, it won't be reimbursable.

Dental Prescribing

For information - The Dental Prescribers Formulary (which is reproduced in Part XVIIA of the Drug Tariff) lists Hydrogen Peroxide Mouthwash BP; the BP monograph states that Hydrogen Peroxide Solution 6% is Hydrogen Peroxide Mouthwash. Thus only the 6% solution can be dispensed against an order for Hydrogen Peroxide Mouthwash on a Form FP10D.

Elastic Hosiery

A reminder - The Drug Tariff requires that complete details are needed before a prescription for elastic hosiery can be reimbursed (i.e. whether a single piece or a pair, the article required and the Compression Class). In order to ensure that reimbursement is correct, incomplete prescriptions will need to be referred back.

To summarise:

- Make sure that the doctor has endorsed "SLS" before you dispense a prescription for Tamiflu (Oseltamivir) or Relenza (Zanamivir).
- Supplementary prescribers may prescribe most products that a doctor can prescribe, the main exclusions being controlled drugs and the majority of unlicensed medicines.
- Glucosamine Sulphate is a rINN and, if prescribed, can be met by supplying any branded equivalent product.
- Each component of a multi-layer kit attracts a prescription charge, if applicable.
- Take care when dispensing products bearing a CE mark - if the item isn't listed in Part IX of the Drug Tariff it won't be reimbursable on Form FP10.
- Only the 6% strength of Hydrogen Peroxide Solution is allowed on a dental form (FP10D).
- Ensure that all details relating to elastic hosiery appear on the prescription form before submitting it.