Kettering General Hospital NHS Trust
Northamptonshire Clinical Commissioning Group
Northamptonshire General Hospital Trust
Northamptonshire Healthcare Foundation Trust

Northamptonshire Prescribing Advisory Group NPAG

Primary Care

Drugs Formulary

This document will be updated as required.

Last Update 11/11/21

Introduction

All drugs recommended by a NICE technology appraisal are available within NHS Northamptonshire Clinical Commissioning Groups (CCG) as a treatment option for the disease or condition covered, if the patient meets the clinical criteria set out in the guidance. If the clinician concludes and the patient agrees that the drug recommended by the NICE technology is the most appropriate one to use, based on a discussion of all available treatments, then that treatment can be chosen.

This Primary Care Drugs Formulary lists medicines that are preferred choice within Northamptonshire.

Please check the traffic light section on the NHS Northamptonshire CCG Primary Care Portal for listings of amber (recommended and/or initiated in secondary care), red (hospital only) and double red (prior approval required) drugs.

BNF Chapter 1 - Gastro-intestinal System

1.1 ***Antacids (All available OTC)***

Co-Magaldrox - Low Na^+ **-** cheaper if prescribed as Mucogel Brand

Alginate-containing (Reflux only)

Peptac Liquid - available as aniseed and peppermint flavour

Gastrocote Suspension - if Low Na^+ is required (more expensive than Peptac)

Topal tablets

1.2 ***Antispasmodics***

Mebeverine

(135mg strength available OTC)

1.3 ***Ulcer Healing Drugs***

Concomitant use of **clopidogrel and omeprazole or esomeprazole** is to be discouraged unless considered essential **MHRA - Drug Safety Update** - **link**

Omeprazole 20mg Capsules

Omeprazole 2 x 20mg Capsules - (not as 40mg strength)

Lansoprazole 15mg Capsules – maintenance

Lansoprazole 30mg Capsules – treatment dose

Ranitidine Tabs 150mg & 300mg

***NSAID Prophylaxis* - Omeprazole 20mg Capsules Daily**

1.4 ***Anti-motility***

Loperamide 2mg Caps – available OTC

1.5 ***Aminosalicylates***

Mesalazine – prescribe by brand. Preferred brands are **Octasa** or **Pentasa**

Sulfasalazine - prescribe by brand. Preferred brand **Salazopyrin**

Corticosteroids

Hydrocortisone 10% foam (Colifoam)

Budesonide 2mg foam enema (Budenofalk)

Prednisolone foam enema

1.6 ***Laxatives - First line options also available OTC***

Senna Tabs

Bisacodyl Tabs

Ispaghula Husk and Lactulose both need to be used regularly. Ensure adequate fluid intake

Ispaghula Husk

Lactulose - 15ml BD then adjusted to patient's needs.

Macrogol '3350' cheaper if prescribed as Laxido Sugar-Free or Cosmocol brand.

Relaxit Microenema

Prucalporide (under recommendation of secondary care only – Amber 2)

Prucalopride for the treatment of chronic constipation in women (NICE TA 211 December 2010)
Prucalporide is an option for the treatment of chronic constipation in women for whom treatment with at least 2 laxatives from different classes, at the highest tolerated recommended doses, for at least 6 months, has failed and invasive treatment is being considered. Prucalopride should be prescribed only by clinician's experienced in the treatment of chronic constipation. Treatment should be reviewed if prucalopride is not effective after 4 weeks - **link**

1.7 **Anusol cream / ointment** available OTC
Scheriproct ointment / suppositories

BNF Chapter 2 - Cardiovascular System

2.1 Positive Inotropic drugs

Digoxin

2.2 Diuretics

Indapamide 2.5 mg

> Indapamide 2.5mg is now the diuretic of choice in hypertension. For people who are already having treatment with bendroflumethiazide and whose blood pressure is stable and well controlled, continue treatment with the bendroflumethiazide. ACEI/ARB or CCBs should be considered before thiazide- like or thiazide diuretics for most patients.
> **NICE CG 127 - Clinical management of primary hypertension in adults - link**

Bendroflumethiazide 2.5 mg

Furosemide

Co-amilofruse 5/40

Spironolactone

> Offer spironolactone in addition to an ACE inhibitor (or ARB) and beta-blocker, to people who have heart failure with reduced ejection fraction if they continue to have symptoms of heart failure. NICE Guideline NG106-Chronic heart failure in adults: diagnosis and management Link

Eplerenone

> **Eplerenone -** NPAG recommended that spironolactone should continue to be the first line mineralocorticoid receptor antagonist at all stages of heart failure. Eplerenone should be reserved for patients who have had a MI or side effects with spironolactone e.g. gynaecomastia. This is on the basis that spironolactone has high quality, randomised controlled trial evidence of effectiveness from the RALES study in heart failure NYHA class III or IV and established data for hyperkalaemia risks. It is likely (but not known) that spironolactone would also be effective at other stages of heart failure as well as NYHA III and IV, and it has a broad licence for congestive cardiac failure which is not restricted to any heart failure class

2.4 ***Beta-adrenoreceptor blocking drugs***

Atenolol

Propranolol

Bisoprolol

Carvedilol

Beta-blockers and ACE inhibitors are first line treatment for heart failure. A Beta-blocker licensed for heart failure should be used e.g. Bisoprolol or Carvedilol. Dose titration is required-see below

NICE Guideline NG106 Chronic heart failure in adults: diagnosis and management Link

	Heart failure (target doses of preferred beta-blockers-if tolerated)
Bisoprolol	10mg OD
Carvedilol	25mg BD (if body weight < 85kg) 50mg BD (if body weight >85 kg)

2.5 ***Alpha-Adrenoceptor Blockers***

Doxazosin

Alpha- blockers only as 4th line antihypertensive agents, unless there is compelling indication for their use e.g. prostatism.
NICE CG 127– Clinical management of primary hypertension in adults (August 2011) - link

Do NOT use **Doxazosin XL** as it is “Double Red”.

2.5.5.1 ***Angiotensin- converting enzyme inhibitors***

Ramipril

Lisinopril

Perindopril

2.5.5.2 ***Angiotensin-II-receptor antagonists***

ACEI are first line for all indications where a Renin Angiotensin Drug is required except for hypertension. In the NICE hypertension guidance an ACEI or an Angiotensin II Receptor Antagonists can be considered when a Renin Angiotensin Drug is recommended, except for patients of African or Caribbean family origin when an Angiotensin II Receptor Antagonists is preferred. In all other indications the Angiotensin II Receptor Antagonists should only be used where patients have a cough that cannot be tolerated.

Losartan
Candesartan – drug of choice in heart failure if AIIRA required.

	Heart failure (target doses of preferred ACEi and ARB-if tolerated)
Ramipril	10mg OD
Lisinopril	30mg OD
Perindopril	4mg OD
Candesartan	32mg OD
Losartan	150mg OD

Dapagliflozin

Dapagliflozin is recommended as a treatment option for symptomatic heart failure with reduced ejection fraction in adults, as an add-on to optimised standard care.

NICE TA679 Dapagliflozin for treating heart failure with reduced ejection fraction link

Sacubitril valsartan (Entresto®)

Sacubitril valsartan is amber 2 for treating symptomatic heart failure with reduced ejection fraction in adults with NYHA class II-IV symptoms **and** LVEF of 35% or less, who are already staking a stable dose of an ACE or AIIRA.

NICE TA388 Sacubitril valsartan for treating symptomatic chronic heart failure with reduced ejection fraction link

2.6.2 ***Nitrates, calcium-channel blockers and potassium channel activators***
Glyceryl Trinitrate – Spray and tablets
Monomil XL – first line nitrate
Isosorbide mononitrate - standard release asymmetric dosing (e.g. 8 am & 2 pm),
Amlodipine
Verapamil

Diltiazem m/r – prescribe by brand. Preferred brands are
Zemtard OR Viazem XL– ONCE a day preparation
Tildiem Retard – TWICE a day preparation

2.6.3 Nicorandil
Ivabradine – Amber 2 for both angina and heart failure
NICE TA 267 - Ivabradine for treating chronic heart failure (November 2012) link

2.6.4 ***Peripheral Vasodilators and related drugs***

Naftidrofuryl oxalate

Naftidrofuryl oxalate is recommended by NICE as an option for the treatment of intermittent claudication in patients with peripheral arterial disease in patients in whom vasodilator therapy is considered appropriate.
NICE TA 223 - Cilostazol, naftidrofuryl oxalate, pentoxifylline and inositol nicotinate for the treatment of intermittent claudication in people with peripheral arterial disease (May 2011) - link

2.8 ***Anticoagulants***

Warfarin

Edoxaban
Apixaban
Dabigatran
Rivaroxaban

Edoxaban, Apixaban, Dabigatran and Rivaroxaban **are categorised:**

GREEN for Stroke prevention in Atrial Fibrillation.
AMBER 2 for treatment and prevention of DVT and PE
RED for prevention of DVT post-knee and hip replacement

NICE TA 355 Edoxaban for preventing stroke and systemic embolism in people with non-valvular atrial fibrillation link

NICE TA 275 - Apixaban for preventing stroke and systemic embolism in people with nonvalvular atrial fibrillation (February 2013) link

NICE TA 249 - Dabigatran etexilate for the prevention of stroke and systemic embolism in atrial fibrillation link

NICE TA 256 - Atrial fibrillation (stroke prevention) – rivaroxaban link

NICE TA 261 - Rivaroxaban for the treatment of deep vein thrombosis and prevention of recurrent deep vein thrombosis and pulmonary embolism
link

NICE TA 287 - Rivaroxaban for treating pulmonary embolism and preventing recurrent venous thromboembolism link

2.9 *Antiplatelet drugs*

The NICE guidance "**Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events**" (TA 210) **link** advises that:

After an ischaemic stroke: Generic clopidogrel is recommended as first choice. Aspirin plus MR dipyridamole is now recommended **only** if clopidogrel is contraindicated or not tolerated. There is no limit on duration.

After a transient ischaemic attack (TIA): This NICE guidance recommends aspirin plus MR dipyridamole as the first choice for people who have had a TIA. However the latest edition of the RCP's "National clinical guideline for stroke" (2012) recommends clopidogrel as the first line treatment also for patients after a TIA. The guideline states that whilst clopidogrel is not licensed for the management of TIA the working group believed that clopidogrel should be recommended first line as it is more cost-effective and better tolerated. Furthermore it was felt that a unified approach to the treatment of TIA and ischaemic stroke would be appropriate. The Northamptonshire Prescribing Advisory Group decided to adopt the RCP recommendation that **clopidogrel should be the treatment of choice for patients following a TIA and ischaemic stroke**. This decision has been endorsed by the KGH and NGH stroke physicians.

After a myocardial infarction (MI): Aspirin remains first line choice for long- term prophylaxis. This guidance should be considered alongside existing NICE guidance on clopidogrel in combination with aspirin in people with unstable angina or NSTEMI (see **CG94**), ticagrelor for the treatment of acute coronary syndromes (see **TA236**) and those who have had an MI (see **CG48**) and Prasugrel for the treatment of acute coronary syndromes with percutaneous coronary intervention (see **TA317**)

Peripheral arterial disease (PAD) or multi-vascular disease: Clopidogrel is recommended as the first choice option for patients with PAD or multi-vascular disease.

Note - This guidance does not apply to people with atrial fibrillation (AF). NICE guidance on prophylaxis of stroke in people with AF is given in **CG36**. It also does not apply to those who need treatment to prevent occlusive events after coronary revascularisation or carotid artery procedures.

Clopidogrel - prescribed as the generic
Prasugrel
Ticagrelor

Dipyridamole 200mg m/r

2.12 *Lipid-regulating drugs*

Lipid modification
NICE CG181 (July 2014) Lipid modification; cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease - link

Atorvastatin

Simvastatin

Pravastatin – for use patients co-prescribed warfarin

Simvastatin: Increased risk of myopathy at high dose (80 mg)
MHRA (May 2010)
There is an increased risk of myopathy associated with high-dose (80 mg) simvastatin. The 80-mg dose should be considered only in patients with severe hypercholesterolaemia and high risk of cardiovascular complications who have not achieved their treatment goals on lower doses, when the benefits are expected to outweigh the potential risks.

Ezetimibe

Do not prescribe as Ezetrol® brand as it is “double red”

NICE CG181 (July 2014) - Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease – link

Ezetimibe should only be considered as a treatment option for the treatment of adults with primary (heterozygous-familial or non-familial) hypercholesterolaemia

PCSK9 Inhibitors

The PCSK9 inhibitors Alirocumab and Evolocumab are “red” (specialist prescribing in secondary care only).

BNF Chapter 3 - Respiratory System

Which inhalation device?
Inhalation devices of **first choice** for children under 5 are pressurised metered-dose inhalers (**pMDI**), used with or without a **spacer device** (see 3.2.5) **link**

For older children, pMDI plus spacer is the first choice device for inhaled corticosteroids; however, for the short-acting bronchodilator (reliever), consideration should be given to a wider range of devices, depending on the needs of the individual. **link**

Patients and prescribers should also take into account the carbon footprint of the inhaler device. The NHS has committed to reducing its carbon footprint by 51% by 2025 to meet the target in the Climate Change Act, including a shift to dry powdered inhalers (DPI) to deliver a reduction of 4%. DPIs and other newer types of inhalers like soft mist inhalers are less harmful to the environment than traditional metered dose inhalers (MDIs) and the NHS long term plan supports the use of these inhalers where it is clinically appropriate. NICE has produced a inhaler decision aid to facilitate discussion about inhaler options.
https://www.nice.org.uk/guidance/ng80/resources/inhalers-for-asthma-patient-decision-aid-pdf-6727144573

Patients should be given adequate **training** in the proper use of the device at initial prescription and their inhaler technique **assessed** from time to time thereafter.

In brief, to achieve optimum lung deposition, the inspiratory effort should be:
pMDI (aerosol) SLOW AND STEADY
DPI (dry powder inhaler) QUICK AND DEEP

Videos on how to use various inhaler devices can be found on the Asthma UK website:
https://www.asthma.org.uk/advice/inhaler-videos/#Videos

Before stepping up treatment for a patient, consideration should be given to the possibility that **poor compliance, lack of understanding** or poor inhaler technique could contribute to the apparent lack of symptom control by the medication.

Second choice of inhalation device is dependent on the needs of the patient, the reasons why the pMDI is deemed unsuitable, and the availability of a suitable alternative within the same drug group.

3.1 *Bronchodilators*

3.1.1.1 *Selective beta2 agonists*

Short-acting

Easyhaler Salbutamol Dry Powder inhaler
100 microgram per inhalation. (low carbon footprint)

Salbutamol CFC-free pMDI 100microgram per inhalation (high carbon footprint)

Long acting

CHM advice for asthma:
Long Acting Beta Agonists (LABAs) should

- Be added only if regular use of standard-dose ICS has failed to control asthma adequately;
- Not be initiated in patients with rapidly deteriorating asthma;
- Be introduced at a low dose and the effect properly monitored before considering dose increase;
- Be discontinued in the absence of benefit;
- Be reviewed as clinically appropriate: stepping down therapy should be considered when good long-term asthma control has been achieved.

Formoterol Easyhaler (low carbon footprint)

Olodaterol Soft Mist Inhaler (Striverdi Respimat) – low carbon footprint
Formoterol pMDI (high carbon footprint)
Salmeterol pMDI* or Accuhaler
*NB Some generic salmeterol pMDIs contain soya oil

3.1.2 ***Antimuscarinic bronchodilators***

Short Acting
Ipratropium pMDI (high carbon footprint)

Long Acting
Aclidinium (Eklira Genuair) for COPD only
Tiotropium via "Zonda" device ("Braltus") for COPD only
Tiotropium via "Respimat" device if unable to use "Zonda" device

NB: Take the risk of cardiovascular side effects into account when prescribing tiotropium delivered via Respimat or Handihaler (or Zonda) to patients with certain cardiac conditions, who were excluded from clinical trials of tiotropium (including TIOSPIR) See MHRA statement Feb 2015 Link

Spiriva Respimat in asthma: specialist use only.

3.1.3 ***Theophylline***
Modified Release Theophylline tablet – *prescribe by brand*

3.1.4 **Compound bronchodilator preparations**
Prescribe by BRAND

- Aclidinium bromide (LAMA) + formoterol fumarate (LABA) = **Duaklir Genuair**)
- Tiotropium bromide (LAMA) + olodaterol hydrochloride (LABA) = **Spiolto Respimat**

3.1.5 *Spacer devices and Peak Flow Meters*

It is recommended that spacers are used in the following way:

- Use repeated single actuations of the MDI into the spacer, each followed by inhalation as soon as possible
- Tidal breathing is as effective as single breaths
- Clean **monthly**
- Replace at least every 12 months

NICE NG 115 - COPD(Dec 2018) - https://www.nice.org.uk/guidance/NG115

A2A spacer

Volumatic

Aerochamber Plus

Peak Flow Meter

3.2 *Corticosteroids*

High doses of inhaled corticosteroids used for prolonged periods can induce adrenal suppression. Patients using such high doses should be given a "**steroid card**" and may need corticosteroid cover during period of stress.

High doses are >800 microgram (BDP or equivalent) daily for adults and >400 microgram (BDP or equivalent) daily for children.

Monitoring of patients on inhaled corticosteroids:

- Physicians should remain vigilant for the development of pneumonia and other infections of the lower respiratory tract e.g. bronchitis in patients with COPD who are treated with inhaled drugs that contain steroids because the clinical features of such infections and exacerbation frequently overlap. Any patient with severe COPD who has had pneumonia during treatment with inhaled drugs that contain steroids should have their treatment reconsidered.
  Drug Safety Update October 2007 link

- Psychological and behavioural side effects may occur in association with use of inhaled and intranasal formulations of corticosteroids
  Drug Safety Update September 2010 link

When switching between corticosteroid products beware of dose inequivalence.

Single component inhaled corticosteroid products are only licensed for use in asthma.

Beclometasone:

Prescribing should be for a **named brand** of "CFC-Free" beclomethasone as brands are **NOT THERAPEUTICALLY EQUIVALENT** at the same dose. See **Appendix 1 "Inhaled Corticosteroid products with BDP equivalent" of**

Budesonide Easyhaler – low carbon footprint

Soprobec (replaces Clenil) (Beclometasone) cfc-free pMDI (high carbon footprint) plus spacer

Combination (LABA/ICS) inhalers:

If both ICS and LABA are required, a combination device may be used, depending on the needs of the individual; the cheapest device available should be chosen **TA131** and **TA138**

Inhalers which combine a LABA with a corticosteroid have **not** been shown to improve **compliance** in the medium to long-term or to have a clinically significant difference **in efficacy** from the same ingredients inhaled separately. However, in order to ensure that a LABA is not taken without an ICS, where LABAs are prescribed for people with asthma, they should be prescribed with an ICS in a single combination inhaler. https://www.nice.org.uk/advice/ktt5/chapter/evidence-context

Prescribe by brand

Fobumix Easyhaler (Budesonide plus formoterol DPI)
Low carbon footprint.
Licensed for asthma and COPD in adults. Three strengths, equivalent to Symbicort Turbohaler range.

Fostair 100/6 and 200/6 (Formoterol plus fine-particle beclomethasone) beware of dose inequivalence if switching "from" or "to" another inhaler.

NB Fostair 100/6, as pMDI and NEXThaler (DPI), is licensed for use in COPD and asthma in those over 18 years.

Fostair 200/6 (high strength) (as pMDI or NEXThaler) is licensed only for use in asthma in those over 18 years.

Symbicort Turbohaler (Budesonide plus formoterol DPI) licensed for asthma, from 6 years, and for COPD in adults.

Symbicort 200/6 pMDI (Budesonide 200 microgram plus formoterol 6 microgram per actuation) licensed in COPD, in adults, only.

AirFlusal Forspiro: fluticasone 500 microgram plus salmeterol 50 microgram per actuation DPI) licensed for severe asthma and for COPD, in adults only.

AirFlusal 25/250 (pMDI): Fluticasone and salmeterol, high dose ICS; asthma only, adults only.

Combisal (pMDI): Fluticasone and salmeterol: 25/50 low dose ICS option for Asthma only, 4 Y+. 25/125 moderate dose ICS option for asthma only, 12Y+

Consider using a single combination inhaler as a "preventer" and "reliever" for patients with troublesome or on-going exacerbations eg. Fobumix Easyhaler, Symbicort Turbohaler (SMART) or Fostair (MART). Not suitable for products containing salmeterol as LABA. Licensed options are age-dependent.

Triple therapy:

Patients with severe COPD which is not controlled on two inhaled drugs should be offered a third inhaled drug.

For patients already on triple therapy using 2 devices (e.g. LAMA plus LABA/ICS) it may be cost effective to prescribe this as a single fixed dose device.

Trimbow pMDI (Beclometasone (fine particle) 100micrograms plus formoterol 6 micrograms plus glycopyrronium 10 micrograms per metered actuation) for use with a spacer.

3.3 ***Cromoglicate, related therapy and leukotriene antagonists***

If asthma is uncontrolled on a low dose of ICS as maintenance therapy, offer a leukotriene receptor antagonist (LTRA) in addition to the ICS and review the response to treatment in 4 to 8 weeks.
https://www.nice.org.uk/guidance/ng80/chapter/Recommendations#principles-of-pharmacological-treatment

Montelukast (licensed from age 6 months)

3.4 ***Antihistamines (available OTC)***

Cetirizine
Loratidine
Chlorphenamine

NB Desloratadine (as Neoclarityn liquid only) and Rupatadine are double red.

3.7 ***Mucolytics***

4 week trial; stop if no benefit seen

Carbocysteine 375mg capsules
Acetylcysteine (NACSYS brand) effervescent tablets 600mg if liquid preparation required (115mg Na+ per tablet = 1/20th daily intake).

BNF Chapter 4 - Central Nervous System

Hypnotics and Anxiolytics

4.1

Insomnia Newer Hypnotic Drugs
NICE TA77 – (April 2004)

- When, after due consideration of the use of non-pharmacological measures, hypnotic drug therapy is considered appropriate for the management of severe insomnia interfering with normal daily life, it is recommended that hypnotics should be prescribed for short periods of time only, in strict accordance with their licensed indications.

- It is recommended that, because of the lack of compelling evidence to distinguish between zaleplon, zolpidem, zopiclone or the shorteracting benzodiazepine hypnotics, the drug with the lowest purchase cost (taking into account daily required dose and product price per dose) should be prescribed.

- It is recommended that switching from one of these hypnotics to another should only occur if a patient experiences adverse effects considered to be directly related to a specific agent. These are the only circumstances in which the drugs with the higher acquisition costs are recommended.

- Patients who have not responded to one of these hypnotic drugs should not be prescribed any of the others.

Benzodiazepine indications

1. Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling, or causing the patient 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.
3. Benzodiazepines should be used to treat insomnia only when it is severe, disabling or causing the patient extreme distress - BNF

Diazepam (if liquid formulation required prescribe as Oral Suspension)
Zoplicone

Zaleplon, zolpidem and **zopiclone** are non-benzodiazepine hypnotics, but they act as the benzodiazepine receptor. They are not licensed for long-term use; dependence has bene reported in a small number of patients.

4.3 ***Antidepressant drugs***

Depression
(NICE CG90, April 2018) (NICE CG91, October 2009)

First prescribe an SSRI in generic form unless there are interactions with other drugs; consider using citalopram or sertraline because they have less propensity for interactions.

When prescribing antidepressants, be aware that:

- dosulepin should not be prescribed
- non-reversible monoamine oxidase inhibitors (MAOIs; for example, phenelzine), combined antidepressants and lithium augmentation of antidepressants should normally be prescribed only by specialist mental health professionals.

Take into account toxicity in overdose when choosing an antidepressant for patients at significant risk of suicide. Be aware that:

- compared with other equally effective antidepressants recommended for routine use in primary care, venlafaxine is associated with a greater risk of death from overdose
- tricyclic antidepressants (TCAs), except for lofepramine, are associated with the greatest risk in overdose.

When prescribing antidepressants for older people:

- prescribe at an age-appropriate dose taking into account the effect of general physical health and concomitant medication on pharmacokinetics and pharmacodynamics
- carefully monitor for side effects

Fluoxetine
Citalopram
Sertraline (for patients with co-existing CHD)
Venlafaxine

4.6 ***Drugs used in nausea and vertigo***
Metoclopramide not recommended for patients <20 yars
Prochlorperazine
Betahistine

4.7 ***Analgesics***

Limited amount of evidence that combinations containing low doses of opioid e.g. 8 mg codeine are more effective than aspirin or paracetamol alone. Soluble products not included due to high sodium content.

Paracetamol available OTC
Co-codamol tablets 8/500 **available OTC**

High strength

1st line - Co-codamol tablets 30/500

2nd line - Co-codamol capsules 30/500

No longer cheaper to prescribe separately

Codeine phosphate

Drugs in terminal care

Morphine – prescribe by brand, which must stay consistent

Preferred brand **– Zomorph® capsules (twice a day preparation)**

ZOMORPH capsules can be swallowed whole or opened and sprinkled on food.

Diamorphine

Fentanyl patches (pack of 5 only) preferred brand

Matrifen

Dexamethasone

Midazolam

Cyclizine

Levompromazine

4.7.4 ***Antimigraine drugs***

Simple Analgesic plus anti-emetic

Several combination products are available

Reserve triptans for patients in whom adequate doses of analgesics and anti-emetics are not effective. Monitor patients and review if patient over using as potential for medication overuse headache.

Sumatriptan 50mg

Zolmitriptan 2.5mg tabs/orodispersible tabs

BNF Chapter 5 - Infection

PHE/NICE Summary of anti-microbial prescribing guidance - managing common infections LINK

PHE guidance on the management and treatment of Clostridium difficile infection LINK

5.1 ***Anti-bacterials***

5.1.1 ***Penicillins:***
Phenoxymethypenicillin (Pen V)
Amoxicillin
Flucloxacillin

Pivmecillinam 200mg for lower UTI only.

5.1.2 ***Cephalosporins:***
Cefalexin

5.1.3 ***Tetracyclines:***
Oxytetracyline
Lymecycline
Doxycycline

5.1.5 ***Macrolides:***
Clarithromycin (first choice macrolide)

Erythromycin (preferred for some indications in pregnancy and breast feeding) - see Summary link above LINK)

Azithromycin or Doxycycline for Chlamydia treatment

5.1.8 **Trimethoprim –** nitrofurantoin is preferred for most patients especially where risk of resistance is high e.g. over 70s. Trimethoprim should only be used in over 70s only where sensitivity has been confirmed on MSU.

5.1.11 **Metronidazole**

5.1.13 **Nitrofurantoin** prescribe as m/r capsules

5.2 ***Antifungal drugs***
Fluconazole
Itraconazole
Nystatin oral suspension

Treat fungal nail infections only after confirmed mycology. Topical preparations should be purchased rather than prescribed.

Terbinafine

5.3.2 ***Herpes virus infections***

Aciclovir

5.3.4 ***Influenza prophylaxis***

Oseltamivir
Zanamivir

NICE technology appraisal (TA168) (February 2009)

Oseltamivir and Zanamivir re recommended as possible treatments for people with flu if all of the following apply:

- **The person is in an 'at risk' group**
- **The person has a 'flu-like illness' and can start treatment within 48 hours (36 hours for Zanamivir treatment in children) of the first sign of symptoms.**
- **The Department of Health and Social Care has confirmed that the flu virus is known to be circulating and it is likely that a flu-like illness has been caused by the flu virus.**

BNF Chapter 6 - Endocrine System

6.1 ***Drugs used in diabetes***

Insulins

Type 2 diabetes - The management of type 2 diabetes - link
Offer intermediate acting **human isophane insulin (human NPH insulin)**, taken once or twice-daily according to need, consider starting both NPH and short acting either separately or pre-mixed human insulin.
Long acting Insulin analogues, Detemir and Glargine may be ***considered*** if:

- help is needed injecting insulin and a long acting analogue would reduce injections from twice to once daily
- lifestyle is restricted by recurrent symptomatic hypoglycaemic episodes
- would otherwise need twice daily NPH insulin in combination with oral blood glucose lowering drugs.

Intermediate acting human isophane insulin
Insulin detemir
Insulin glargine –Semglee and Lantus are not interchangeable so prescribe by brand. Semglee is recommended for new initiations.

Antidiabetic drugs

Metformin is the **first line** choice in type 2 diabetics unless it is contraindicated or not tolerated. **Type 2 diabetes in adults: Management, NICE guidelines NG28 (Dec 2015) link**

Metformin
Metformin MR

Metformin MR should only be used were patients are unable to tolerate the standard release tablets, despite gradual dose-titration. The standard release formulation should always be used first line.

Sulphonylurea (SU) plus metformin is a dual therapy option in patients with type 2 diabetes with inadequate blood glucose control. It can be ***considered*** for triple therapy with metformin plus a DPP-4i or pioglitazone or SGLT-2i.
Type 2 Diabetes in adults: management, NICE guidelines NG28 link

Gliclazide

Pioglitazone plus metformin is a dual therapy option in patients with type 2 diabetes with inadequate blood glucose control. It can be *considered* for triple therapy with metformin plus a SU or SGLT-2i. **Type 2 Diabetes in adults: management, NICE guidelines NG28 link**

Pioglitazone is contra-indicated in patients with cardiac failure or history of cardiac failure, hepatic impairment, diabetic ketoacidosis, history of bladder cancer, un-investigated macroscopic haematuria. Caution elderly.

Pioglitazone

Gliptins plus metformin is a dual therapy option in patients with type 2 diabetes with inadequate blood glucose control. They can be *considered* for triple therapy with metformin plus a SU. **Type 2 Diabetes in adults: management, NICE guidelines NG28 link**

Alogliptin*

Linagliptin (if eGFR is below 60ml/min, consider linagliptin as it is excreted by the biliary system and no dose adjustment is required)

Saxagliptin*

Sitaglitin

Vildegliptin

*** The FDA, April 2016 has added warnings about heart failure risk to labels of medicines containing saxagliptin and alogliptin as a safety review they conducted found that they may increase the risk in patients with heart/kidney disease. http://www.fda.gov/downloads/Drugs/DrugSafety/UCM493965.pdf**

Canagliflozin (**NICE TA 315 link)** can be considered for treating Type 2 diabetes

- dual therapy regimen in combination with metformin if a sulfonylurea is contraindicated or not tolerated or the person is at significant risk of hypoglycaemia or its consequences.
- triple therapy regimen in combination with:
  - metformin and a sulfonylurea or
  - metformin and a thiazolidinedione.

Dapagliflozin (NICE TA 288 link) can be considered treating type 2 diabetes,

- in a dual therapy regimen in combination with metformin only if it is used as described for (DPP-4i)
- in combination with insulin with or without other antidiabetic drugs.
- It is **NOT** recommended in a triple therapy regimen in combination with metformin and a sulfonylurea.

Empagliflozin (**NICE TA 336 link)** is recommended as an option for treating type 2 diabetes

- in a dual therapy regimen in combination with metformin, only if a sulfonylurea is contraindicated or not tolerated, or the person is at significant risk of hypoglycaemia or its consequences.
- triple therapy regimen is recommended with:
  - metformin and a sulfonylurea or
  - metformin and a thiazolidinedione.
- in combination with insulin with or without other antidiabetic drugs

Canagliflozin and canagliflozin/metformin formulation
Dapagliflozin and dapagliflozin/ metformin formulation
Empagloflozin and emapgliflozin/metformin formulation

Glucagon-like-peptide-1 analogue can be ***considered*** in combination with metformin and a SU or if triple therapy is not effective, not tolerated, or contra-indicated, for adults with BMI of 35 or higher **and** medical problems associated with obesity or a BMI lower than 35 in whom insulin isn't suitable. **Type 2 Diabetes in adults: management, NICE guidelines NG28** link

Dulaglutide
Liraglutide
Semaglutide (s/c and oral)

Blood Glucose Testing strips and lancets

Ensure patient education re appropriateness (or otherwise) of testing. Only one type of strip should be prescribed for each patient. Quantities should be appropriate to the frequency of testing. Test strips are not recommended to be put on repeat for patients not on insulin.

FineTest Lite test strips
GlucoRx HCT Ketone (for ketone testing in Type 1 diabetes)

Lancets
Greenlan

Safety Lancet
Microdot

Insulin Pen Needles
Carefine
GlucoRx Carepoint

Needle length should be no longer than necessary; 8mm needle should be the routine maximum length for adults. For children and adolescents, a 4mm or 6mm needle is recommended, depending on the degree of sub-cutaneous fat.

Insulin Safety Needles
Mylife Clickfine

6.4 ***Sex Hormones***

HRT

HRT increases the risk of venous thromboembolism, of stroke and, after some years of use, endometrial cancer (reduced by a progestogen) and of breast cancer. The CSM advises that the minimum effective dose should be used for the shortest duration, for the relief of menopausal symptoms. Treatment should be reviewed at least annually and for osteoporosis alternative treatments considered (BNF section 6.6). HRT does not reduce the incidence of coronary heart disease and it should not be prescribed for this purpose.

HRT may be used in women with early natural or surgical menopause (before age 45 years), since they are at high risk of osteoporosis. For early menopause, HRT can be given until the approximate age of natural menopause (i.e. until age 50 years). Alternatives to HRT should be considered if osteoporosis is the main concern. In healthy women without symptoms, the risk of using HRT outweighs the potential benefit of preventing osteoporosis.

Women without uterus **Elleste Solo** 1mg, 2mg Evorel patches 25,50,75,100

Women with uterus
Cyclical therapy

- **Elleste Duet** 1mg, 2mg

Continuous combined therapy

- **Kliofem**
- **Kliovance**

6.6 ***Drugs affecting bone metabolism***
Alendronic acid (sodium alendronate)

Prescribe as **Alendronate** 70mg once a week for the treatment of post-menopausal osteoporosis.
Prescribe as **Alendronate** 10mg once a day for osteoporosis treatment in men and prevention of corticosteroid induced osteoporosis

Risendronate

BNF Chapter 7 - Genito-urinary System

7.3 *Contraceptives*

COCs

Combined oral contraceptive content	Available products. Preferred formulary choices in bold	Notes
Ethinylestradiol 30mcg levonorgestrel 150mcg	**Levest** **Rigevidon** **Maexeni** Ovranette Microgynon 30 Microgynon 30 ED	*Progestogen dominant pill*
Ethinylestradiol 35mcg norethisterone 500mcg	**Brevinor**	*Oestrogen dominant pill*
Ethinylestradiol 30mcg desogestrel 150mcg	**Cimizt 30/150** Gedarel 30/150 Marvelon	*Consider in mild acne* *Note: MHRA advice on risk of VTE*
Ethinylestradiol 20mcg desogestrel 150mcg	**Bimizza** **Gedarel 20/150** Mercilon	
Ethinylestradiol 30mcg gestodene 75mcg	**Millinette 30/75** Katya 30/75 Femodene	*Improved cycle control* *Note: MHRA advice on risk of VTE*
Ethinylestradiol 20mcg gestodene 75mcg	**Millinette 20/75** Sunya Akizza Femodette	
Ethinylestradiol 30mcg Levonorgestrel 50mcg Ethinylestradiol 40mcg Levonorgestrel 75mcg Ethinylestradiol 30mcg Levonorgestrel 125mcg	**TriRegol** Logynon	*Tri-phasic preparation* *Improved cycle control but requires better compliance*
Ethinylestradiol 35 mcg norgestimate 250mcg	**Lizinna** **Cilique**	
Co-cyprindiol 2000/35 (cyproterone acetate 2mg, ethinylestradiol 35mcg)	**Clairette** Clairette Dianette	*Severe acne, moderately severe hirsuitism.* *Prescribe generically* ***Co-cyprindiol*** *should not be prescribed for the sole purpose of contraception. Prescriptions should be endorsed with the female symbol* ♀

The risk of VTE in association with drospirenone-containing pills, including Yasmin, is higher than that for levonorgestrel-containing 'second generation' pills and may be similar to the risk for 'third-generation' pills that contain desogestrel or gestodene. See full MHRA warning link
If Yasmin is still needed, please prescribe as Yacella, Yiznell or Dretine brand (≡Yasmin; Ethinylestradiol 30mcg, Drospirenone 3mg)

The MHRA in Feb 2014
https://www.gov.uk/drug-safety-update/combined-hormonal-contraceptives-and-venous-thromboembolism-review-confirms-risk-is-small
confirmed the small VTE risk of COCs and recommended that prescribers consider risk factors and remain vigilant for signs and symptoms. A prescribing checklist is available in the annex of the CAS letter sent to prescribers link

Noriday (≡norethisterone 350mcg)
Norgeston (levonorgestrel 30mcg)
Desogestrel 75mcg (≡Cerazette)

Desogestrel has a 12-hour missed pill window and may be useful where poor compliance is likely. However, it is only recommended for use in women who cannot tolerate oestrogen-containing contraceptives or in whom these preparations are contraindicated.

Emergency Contraception
Ulipristal acetate 30mg
Emerres 1.5mg (Levonorgestrel 1500mcg)

For choice of product see decision making algorithm in FSRH guideline on Emergency Contraception
https://www.fsrh.org/standards-and-guidance/documents/ceu-clinical-guidance-emergency-contraception-march-2017/

Levonorgestrel 1500mcg Available OTC as **Levonelle One Step** from all pharmacies for over-16s. Available from many pharmacies under PGD, including for under 16s

Ulipristal acetate 30mg Available OTC as **ellaOne** from all pharmacies

Drugs for urinary retention

7.4.1

Doxazosin tablets (not m/r)
Tamsulosin 400mcg m/r capsules (prescribe as Pamsvax XL)

7.4.2 ***Drugs for urinary frequency, enuresis, and incontinence***

Tolterodine (immediate release)
Solifenacin

NICE advises that the drug with the lowest acquisition cost should be chosen.
Treatment should be reviewed 4 weeks after the start of each new OAB drug treatment.
Consider offering referral to secondary care if trials of 2-3 of these anticholinergic drugs are not successful.

7.4.5 ***Drugs for erectile dysfunction***

Sildenafil - "SLS" criteria no longer apply to **generic** sildenafil. Max 8 tablets per month
Tadalafil (PRN, NOT daily preparation) – "SLS" criteria apply. Max 8 tablets per month

Vardenafil, Avanafil, daily Tadalafil, Cialis® and Viagra® (all "SLS") are double red and require prior approval. DH guidance on prescribing for erectile dysfunction recommends that quantities supplied should usually be one tablet per week (although discretion may be used). The Northamptonshire Commissioning Delivery Executive has recommended for new initiations prescribing should be limited to 4 doses per month.

BNF Chapter 9 - Nutrition and Blood

9.1.1.1 ***Oral Iron***

Ferrous Fumarate 305mg capsules
Ferrous Fumarate 210mg
Ferrous Sulphate 200mg

If liquid preparation is essential:
Ferrous fumarate 140mg/5ml oral solution
Sodium Feredetate (Sytron®)

9.6.4 ***Vitamin D***

Only prescribe for *treatment* of vitamin D deficiency.
Subsequent maintenance should be purchased unless patient has osteoporosis or returns to deficiency following a treatment course.
Patients with "insufficiency" of vitamin D and those at risk of deficiency [as per CMO letter Feb 2012*] should purchase OTC or obtain via www.healthystart.nhs.uk if eligible.

*http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132508.pdf

InVitaD3 50,000IU soft gelatine capsule
InVitaD3 50,000IU/ml oral solution 1ml ampoule
InVitaD3 25,000 IU/ml oral solution 1ml ampoule
InVitaD3 800IU soft gelatine capsule
Colecalciferol/Desunin 4000IU tablet
Colecalciferol/Desunin 800 IU tablet
Aciferol D3 10,000 IU tablet (Fontus Health)
Aciferol D3 3,000 IU/ml solution (Fontus Health)
Pro D3 Liquid Drops 100 IU/drop [2,000 IU/ml] pack of 20ml

Vitamin D With calcium

Calci D chewable tablets (once daily dose)
Evacal D3 chewable tablets
Accrete D3 film-coated tablets (swallowed whole or halved)
Adcal D3 caplets if struggling with above options
Adcal D3 dissolvable only if swallowing problems or PEG

BNF Chapter 10 - Musculoskeletal System

10.1 *Non-steroidal anti-inflammatory drugs*

NPAG does not recommend the use of coxibs. In high GI risk patients where simple analgesics provide inadequate relief then prescribe a traditional NSAID with omeprazole 20mg daily.

Ibuprofen available OTC
Naproxen

Naproxen - Avoid M/R preparations and E/C versions as they are considerably more expensive without additional benefits.

Diclofenac

Diclofenac - There are now concerns about the cardiovascular safety which appear to have a similar risk to coxibs

10.3 *Drugs for the relief of soft-tissue inflammation*

NICE Guidance: Osteoporosis. Consider topical NSAID if needed and no contra-indications (particularly if hand or knee involvement). Link

Fenbid Gel (£1.50 for 100g C+D Dec 2018) – available OTC
(Ibuprofen 5% gel but should prescribe as Fenbid 100g)

BNF Chapter 11- Eye

11.3 ***Anti-infective eye preparations***

Consider delayed script as 50:50 chance it is a viral infection rather than bacterial.

Chloramphenicol 0.5% eye drops or ointment- available OTC for acute bacterial conjunctivitis in adults and children over 2 years.

Fusidic Acid

11.4 ***Corticosteroids and other anti-inflammatory preparations (Corticosteroids on specialist recommendation)***

Sodium cromoglicate 2% eye drops 13.5 ml – Sign post to self- care and purchase OTC.
Azelastine eye drops for allergic conjunctivitis or
Antazoline eye drops (also contains sympathomimetic
Xylometazoline and available as Otrivine Antistin). Sign post to self-care and purchase

11.6 ***Treatment of glaucoma***
On specialist recommendation.

11.8 ***Miscellaneous ophthalmic preparations***

Ocular Lubricant Guidance- currently under review.

First line choices
Hypromellose 0.3% eyedrops or Carbomer 980 eye drops 10g
Xailin night time gel
Vita-POS preservative free® ointment (Lasts 6 months from opening)

Advise self –care where possible and advise patient to purchase.

If medium viscosity is required other recommended products are:
Evolve HA (sodium hyaluronate 0.2%)
Evolve Carmellose

BNF Chapter 12 - Ear, Nose and Oropharynx

12.1 *Drugs acting on the ear*

Acute otitis externa
First use aural toilet (if available) and simple analgesia.
Acetic Acid 2% ear spray (Earcalm® spray) - available over-the-counter (OTC)
Acetic Acid 2%/Dexamethasone 0.1%/Neomycin 0.5% ear spray (Otomize® ear spray)

Removal of ear wax
Sodium bicarbonate 5% ear drops - available OTC

12.2 *Drugs acting on the nose*

Drugs used in nasal allergy
Mild to moderate hay fever/seasonal rhinitis is listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. **link**

Beclometasone 0.05% aqueous nasal spray 200 dose (180 dose OTC only)
Budesonide 64mcg/dose nasal spray (Rhinocort® Aqua nasal spray)
Fluticasone furoate 27.5mcg/dose (Avamys® nasal spray) - second line
Ipratropium 21mcg/dose nasal spray (Rhinatec® nasal spray)

Topical nasal decongestants
Sodium chloride 0.9% nasal drops - available OTC

Nasal preparations for infection
Chlorhexidine 0.1% and neomycin 0.5% cream (Naseptin® nasal cream)

12.3 *Drugs acting on the oropharynx*

Dry Mouth (artificial saliva products)
Saliveze® Oral spray
Biotene Oralbalance® gel

ACBS: patients suffering from dry mouth as a result of radiotherapy, or sicca syndrome

Oral hygeine, oral ulceration and inflammation
Chlorhexidine mouthwash 0.2% - available OTC
Benzydamine mouthwash (Difflam® oral rinse) - available OTC

Oropharyngeal infections
Miconazole oromucosal gel 80g (Daktarin® oral gel) - 15g size available OTC
Nystatin oral suspension 100,000 units/ml

BNF Chapter 13 - Skin

There is no advantage in prescribing these products by generic name. Choice is largely based on patient preference. 'Zero®' products from Thornton and Ross provide cost effective equivalents to many commonly used emollients and soap substitutes and are suitable for initial prescribing in most cases.

13.1 *Dry and Scaling Skin Disorders - Emollient and barrier preparations*

Atopic eczema in under 12s: diagnosis and management (NICE CG 57 December 2007). link

Use emollients frequently and continuously (at least 3-4 times a day). The greasier the preparation, the better the emollient effect, but very greasy ointments may not be acceptable to some patients. Emollient use should exceed steroid use by 10:1 in terms of quantities for most patients.

The use of bath emollients has been questioned, as there are no published RCTs and no consensus of clinical opinion that such therapy is effective. Topical emollients applied directly to the skin have much better evidence in the management of patients with atopic eczema (DTB Vol 45 No 10 October 2007).

There is some evidence that aqueous cream when used as a moisturiser may worsen symptoms of eczema due to its high sodium lauryl sulphate content. For this reason it should not be prescribed as an emollient but is suitable to use as a soap substitute.

MHRA/CHM advice (updated December 2018): Emollients: new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients. link

Emollients are an important and effective treatment for chronic dry skin disorders and people should continue to use these products. However, healthcare professionals must ensure that patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk. There is a fire risk with all paraffin-containing emollients, regardless of paraffin concentration, and it cannot be excluded with paraffin-free emollients. A similar risk may apply to products that are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days.

Healthcare professionals should advise patients not to smoke or go near naked flames because clothing, bedding, dressings, and other fabrics that have been in contact with an emollient or emollient-treated skin can rapidly ignite. Washing these materials at high temperature may reduce emollient build-up but not totally remove it.

Emollients

Mild dry skin is listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments**.** Emollients can continue to be prescribed for patients with long term dermatological conditions such as eczema and psoriasis**.** link

‘Zero®’ products are similar to other branded products but are less costly. These should be first choice. Patients already established on more expensive products may be willing to try the equivalent ‘Zero®’ product.

Creams
Zero Cream® (similar to E45® cream) for mild dry skin
Epimax® or Zeroveen® (similar to Aveeno) for mild/drug skin
Note – Aveeno® is classed as Borderline Substances and have been classed as Double Red. They are available “over the counter” if patients prefer to purchase them instead of the formulary choices.
Zerobase® (similar to Diprobase®) for moderate dry skin

Rich Cream
Zeroguent® (similar to Unguentum M) for mild dry skin

Gel
Zerodouble Gel® (similar to Doublebase®) for moderate dry skin

Ointment
Zeroderm® (similar to Epaderm® or Hydromol®) for severe dry skin

Other Emollients
For mild dry skin
Dermol® 500 lotion (for washing and when infection is a concern)
Cetraben® lotion

For moderate dry skin
Cetraben® cream
Adex® gel
Eucerin® Intensive cream
Balneum® cream (useful for itch)
Balneum Plus® cream (useful for itch)
Oilatum® cream
Dermol® cream

For severe dry skin
Hydromol® ointment
Doublebase Dayleve® gel
Ultrabase® cream

Paraffin free emollient
Nutraplus 10% cream (for patients at high fire risk as per NPSA safety alert)

Soap Substitutes
ZeroAQS® (similar to aqueous cream, does not contain sodium lauryl sulphate)
Aqueous cream (contains sodium lauryl sulphate)
Emulsifying ointment

Emollient Bath and Shower Preparations
These are not recommended due to lack of evidence of efficacy. All the emollients listed above can be used as soap substitutes. Preparations are available to purchase OTC if required.

Exceptions:

Balneum Plus® bath oil - used as a soak for managing itch that remains a problem despite optimum therapy.
Dermol 600® bath emollient - used in recurrent infection especially in children. It should be reviewed 6 monthly.

Nappy Rash
Nappy rash is listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. link

13.2 ***Infections of the skin - Anti-infective skin preparations***

Anti-bacterial infection preparations
Fusidic acid 2% cream (Fucidin® cream) - up to 10 days only, to prevent resistance
Metronidazole 0.75% cream or gel (prescribed as Rozex® brand)
Silver sulphadiazine 1% cream (Flamazine® cream) - for infection in burns wounds

Anti-fungal infection preparations
Clotrimazole 1% cream (Canesten® cream) - available OTC
Miconazole 2% cream (Daktarin® cream) - available OTC

Fungal nail infections
Fungal nail infections are listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. link

Fungal nail preparations are 'Double Red' and should not be prescribed in primary care. They are available to purchase OTC.

Parasitic skin Infection preparations

On current evidence it seems reasonable to regard dimeticone as a first-line alternative to malathion or permethrin (Ref DTB Vol 45 No 7 July 2007)

Dimeticone 4% lotion - available OTC
Malathion 0.5% liquid - available OTC
Permethrin 1% liquid - available OTC

13.4 ***Inflammatory Skin Conditions - preparations for eczema and psoriasis***

Topical corticosteroids

Hydrocortisone preparations Prices vary considerably between pack sizes; prescribe 1% preparations as multiples of 30g, not 50g. Hydrocortisone 2.5% is much more expensive than 1% and is 'Double Red'. Consider clobetasone preparations if hydrocortisone 1% is not effective.

Mild potency steroids:
Hydrocortisone 1% cream/ointment - available OTC
Hydrocortisone 0.5% cream/ointment

Moderate potency steroids:
Betametasone 0.025% (Betnovate RD®) cream/ointment
Clobetasone butyrate 0.05% (Eumovate®) cream/ointment -15g cream available OTC

Potent steroids:
Betamethasone 0.1% (Betnovate®) cream/ointment

Very potent steroid:
Clobetasol propionate 0.05% (Dermovate®) cream/ointment

Mild steroids with anti-microbial:
Hydrocortisone 1%/miconazole 2% cream/ointment (Daktacort® cream/ointment) - 15g cream available OTC
Hydrocortisone 1%/clotrimazole1% cream (Canesten HC®) - 15g available OTC

Preparations for eczema and psoriasis (specialist led)
Calcipotriol (Dovonex®)
Dithranol preparations
Coal tar preparations
Salicylic acid preparations

Immunosuppressants

Tacrolimus and pimecrolimus for atopic eczema NICE TA 82 (Aug 2004)
Only use when atopic eczema is not controlled by maximal topical corticosteroid treatment. Initiation by Specialist or GP with special interest and experience. **link**

13.6 ***Rosacea and Acne***

Mild acne is listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. **link**

Mild Acne
Adapalene 0.1% cream/gel (Differin®)
Benzoyl peroxide - available to buy OTC (PanOxyl®)
Clindamycin 1% topical lotion/solution (Dalacin T®)

Moderate Acne
Adapalene 0.1% with benzoyl peroxide 2.5% gel (Epiduo®)

13.7 ***Scalp and Hair Conditions - Shampoos and other scalp preparations***

Dandruff is listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. **link**

Coal tar with salicylic acid and sulfur ointment (Cocois® ointment) - available OTC
Ketoconazole 2% shampoo - available OTC
Coal Tar Extract Alcoholic 5% Alphosyl 2 in 1® shampoo - available OTC

13.8 ***Skin Cleansers and Antiseptics***

Sodium chloride 0.9% solution
Potassium permanganate 0.1% solution diluted 1 in 10 to provide a 0.01% solution

13.12 ***Warts and callouses***

Warts and verrucas are listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. **link**

Wart and verruca preparations are ‘Double Red’ and should not be prescribed in primary care. They are available to purchase OTC.

Salicylic acid with lactic acid (Salatac® gel or Salactol® paint) - available OTC
Salicylic acid (Occlusal® liquid) - available OTC