



RE-HEALTHY
FORMULARY
FOR
2007-08

Thank you, once again, to everyone who helped with the review of this chapter.

The up dated chapter can be found at www.paif.plymouth.nhs.uk .

There is lots of prescribing advice and information in this chapter, we have tried to rationalise some of the appendices, hopefully making them easier to use.

Some of the other changes include, the changing of **venlafaxine** from a specialist initiate drug (yellow) to second line (blue). This is because of the relaxing of some of the precautions for its use by the MHRA. **Zopiclone** has been changed to first line (green), with **Temazepam** as second line (blue).

A reminder has also been added that temazepam is a schedule 3 controlled drug, so it is good practice only to prescribe a maximum of 30 days treatment on each prescription. Lormetazepam has been deleted from the formulary because of its high cost. **Loprazolam** has been added; this is a similarly short acting hypnotic.

The PAJF group are also concerned about the amount of **nitrazepam** being prescribed in primary care, which is not included in the formulary because of its prolonged action. There is also a significant amount of **lorazepam** being used in primary care, which is in the formulary as a secondary care (red) drug only.

Methadone tablets for the treatment of chronic pain

Following a request from the pain clinic Methadone 5mg tablets have been added to the PAJF **for the treatment of chronic pain only. Treatment must be initiated solely by the pain clinic.** Once the patient is stabilised treatment may be continued in primary care.

It will only be used in a very small group of patients. Methadone has no active metabolites therefore avoiding the toxicity of other opioids associated with metabolite accumulation. It may be used in those experiencing, or at risk of toxicity associated with metabolite accumulation. It may also have a place where intolerable side effects to another opioid have limited further dose escalation. It has a long duration of action with chronic use therefore allowing less frequent dosing than other opioids. It should not be given more frequently than every 12 hours on prolonged use.

May we take this opportunity to remind prescribers that Methadone tablets should not be prescribed for treatment of opioid dependence except in extenuating circumstances eg. a client travelling abroad.

Pregabalin for Neuropathic Pain

Pregabalin has recently been added to the PAJF as a third line treatment for neuropathic pain. It has been added as "yellow" (specialist initiated) for use by the pain clinic, diabetologists, neurologists, oncologists, palliative care, and any other consultant or GP who considers they have the expertise to initiate treatment. Treatment may then be continued by the GP.

Patients should have trialled **Amitriptyline** (or other tricyclic) and then **Gabapentin** before Pregabalin is considered. Pregabalin should not be initiated unless Gabapentin has been ineffective at the maximum tolerated dose or at least 1800mg daily. It should be noted that only approximately one third of patients who fail to respond to Gabapentin will respond to Pregabalin.

Following dose titration, Pregabalin should be continued as a single capsule on a twice-daily basis (due to the flat pricing structure) to a final dose of 300mg twice daily if tolerated. GPs are asked to review patients after 14 days of treatment before issuing a further supply of capsules. If it has not proven helpful by day 14 Pregabalin should be withdrawn over 2 further weeks.

Where drug therapy is successful in alleviating symptoms of neuropathic pain, trials of reduced dosage and cessation of therapy should be considered after 6 months of treatment. The prescribing team in Primary Care will be auditing the use of Pregabalin in primary care as part of this year's Prescribing Incentive scheme.

Effective Prescribing in the Plymouth Health Community

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