PrescQIPP Community Interest Company

Items which should not routinely be prescribed in primary care

This is the overarching document to a number of bulletins providing further information on medicines that should be given a low priority for prescribing on the NHS, are poor value for money, suitable for self care or for which there are safer more suitable alternatives. This guidance will support Clinical Commissioning Groups (CCGs) in taking action on items that should not routinely be prescribed in primary care or on the NHS. The guidance supports the implementation of the NHS England guidance, which is available here: https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/

Recommendations

- Review all patients prescribed a medicine in the 'items which should not routinely be prescribed in primary care' list.
- Determine whether to:
  - Stop prescribing the medicine and provide the patient with advice on self care or non drug alternatives.
  - Change the medicine to a more cost-effective/safer choice and provide the patient with information on why their medicine has been changed.
  - If it is appropriate in exceptional circumstances to continue treatment, ensure that the patient is assessed and managed through a multidisciplinary team as appropriate.
- For items available to purchase over-the-counter (OTC), recommend self care and purchase of the medicine OTC with support and advice from the community pharmacist wherever appropriate.

Supporting information

Supporting resources are available for each of the 18 treaments set out in this document: https://www.prescqipp.info/drop-list/headline-areas/the-prescqipp-drop-list#low-value-medicines-lvm

These resources will support medicines optimisation by ensuring:[1]

- Treatments of limited clinical value are not used and medicines no longer required are stopped.
- Optimal patient outcomes are obtained from choosing a medicine using the best available evidence.
- Medicines wastage is reduced.
- The NHS achieves greater value from money invested in medicines.
- Patients are more engaged, understand more about their medicines and are able to make choices, including choices about prevention and healthy living.
- It becomes routine practice to signpost patients to further help with their medicines and to local patient support groups.
- Incidents of avoidable harm from medicines are reduced.

The treatments included in this guidance are listed in table 1 on page 2.

Table 1: Items which should not routinely be prescribed in primary care list and total annual spend in England (extrapolated from ePACT April 2017 to August 2017 data)

Item	England NHS annual spend
Liothyronine in primary hypothyroidism	£28,852,310
Lidocaine plasters	£18,190,339
Trimipramine	£18,095,158
Tadalafil once daily (Cialis® once-a-day)	£10,808,774
Fentanyl immediate release formulations	£10,170,290
Travel vaccines not prescribable on NHS	£8,850,672
Doxazosin MR (Cardura® XL)	£6,383,294
Co-proxamol (paracetamol/dextropropoxyphene)	£6,213,328
Rubefacients (excluding topical NSAIDS)	£5,503,512
Omega-3 fatty acids and other fish oils	£4,810,480
Oxycodone/Naloxone (Targinact®)	£4,296,897
Dosulepin	£1,990,915
Lutein and antioxidant vitamins	£1,669,051
Paracetamol/tramadol (Tramacet®)	£1,535,813
Perindopril arginine (Coversyl® Arginine) and branded Coversyl®	£1,319,409
Glucosamine	£336,840
Herbal supplements with THR license from the MHRA	£119,652
Homeopathy	£73,629
	£129,220,363

Rationale for inclusion in the list

In certain circumstances, prescribing medicines considered to be less suitable for routinely prescribing in primary care may be appropriate. However the spend in the areas listed in the table shows there is a significant opportunity to promote self care and reduce prescribing of drugs of limited clinical value or switch to an alternative product which offers better value for money.

Table 2 explains:

- Why the medicine is included in the guidance.
- Where use might be appropriate.
- Suggested alternatives.
- Links to associated resources to support change (if available).
- Indicative savings if the change is made (based on average costs across a range of strengths and products).

Table 2: Supporting information for drugs included in the list

Drug/medicine	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual saving
Liothyronine (L-T3) in primary hypothyroidism	For primary hypothyroidism, UK and international guidelines have found no consistently strong evidence for the superiority of alternative preparations (L-T4/L-T3) combination therapy or thyroid extract therapy – preparations containing dried animal thyroid extracts, such as Armour Thyroid) over monotherapy with levothyroxine in improving health outcomes.[2-4] Many clinicians may not agree that a trial of L-T4/L-T3 combination is warranted and their clinical judgment must be recognised as being valid given the current understanding of the science and evidence of treatments.[3] Natural thyroid extract products are not licensed in the UK. The variation in hormonal content may lead to increased serum levels of T3 and subsequent thyrotoxic symptoms, such as palpitations and tremor.[5]	Some patients, who have unambiguously not benefited from L-T4, may benefit from a trial of L-T4/L-T3 combination therapy. This is considered experimental. They should be supervised by accredited endocrinologists with documentation of agreement after a fully informed and understood discussion of the uncertain benefits, likely risks of over replacements, potential adverse consequences and lack of safety data. Treatment should be discontinued if no improvement is seen after three months.[2-4] Liothyronine is used for patients with thyroid cancer, in preparation for radioiodine ablation, iodine scanning, or stimulated thyroglobulin test. In these situations it is appropriate for patients to obtain their prescriptions from the centre undertaking the treatment and not be routinely obtained from primary care prescribers.	Levothyroxine (L-T4)	Difficult to quantify £14.5 million Based on a 50% reduction in prescribing.

Drug/medicine	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual saving
Lidocaine plasters (Versatis®, Ralvo®)	NICE CG173 on neuropathic pain does not make a recommendation on the use of lidocaine patches as a treatment option due to limited clinical evidence supporting its use.[6] The Scottish Medicines Consortium (SMC) advised that lidocaine plasters (as Versatis®) are accepted for restricted use for the treatment of post herpetic neuralgia in patients intolerant of first-line systemic therapies or where they are ineffective.[7]	Post herpetic neuralgia if patient is intolerant of first line systemic therapies or where they have been ineffective or are contra-indicated.	Capsaicin 0.075% cream apply 3 to 4 times daily 45g per month. Gabapentin 3600mg daily in 3 divided dose.	£13.6 million Assuming 75% is not for post herpetic neuralgia where other first line therapies are not suitable. Savings will be offset against alternative treatments prescribed.
Trimipramine	Trimipramine is a tricyclic antidepressant (TCA) that has been subject to significant price increases.[8] Consequently, it does not represent a cost-effective choice. The cost per 28 days for trimipramine is currently £380 (based on a maintenance dose of 100mg daily).[8] The comparative cost of an alternative TCA, imipramine, is £2.64 (based on a maintenance dose of 75mg daily).[8] Where an SSRI would be more appropriate, sertraline costs £1.10 for a 28 day supply (based on a maintenance dose of 100mg daily).[8] SSRIs are recommended first-line as they have a more favourable risk-benefit ratio.	If alternative antidepressants are unsuitable for the individual patient or the risk of uncontrolled symptoms of depression means a switch is unfavourable. If being used for an unlicenced indication (e.g. pain), review in collaboration with appropriate specialist.	Discontinuation depending on the duration of therapy and risk of relapse (in accordance with NICE)[9] Alternatives: Sertraline if an SSRI is a suitable alternative (better risk:benefit profile). OR imipramine if an alternative TCA is indicated – cost effective and like for like dose (after appropriate cross-tapering).	£17.7 million based on the assumption that products being switched to are 98% cheaper.

Drug/medicine	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual saving
Tadalafil once daily (Cialis® lower doses taken once daily)	Not recommended for erectile dysfunction as not cost-effective in most patients. 'On demand' tablets taken when required are the preferred option.[10,11] Generic sildenafil is still the least costly option.[8] For benign prostatic hyperplasia, there is not enough evidence to recommend phosphodiesterase inhibitors in routine clinical practice.[12]	None foreseen	Sildenafil £0.78-0.90/4 tablets vs. £54.99/28 tadalafil daily tablets (2.5mg and 5mg).[8]	£10.6 million
Fentanyl immediate release formulations	Morphine is the most appropriate cost-effective opioid for severe pain.[13] Fentanyl is significantly more expensive and there are potential safety problems presented by these products, which provide relatively high doses of a potent opioid and are associated with complicated titration and maintenance instructions.[14] In addition immediate release fentanyl is only licenced for the treatment of breakthrough pain in adults with cancer who are already receiving at least 60mg oral morphine daily (or equivalent) This recommendation does not apply to longer sustained release versions of fentanyl which come in patch form.	Where a patient is unable to take immediate-release morphine for breakthrough cancer pain (or where breakthrough pain is of rapid onset and not controlled by oral morphine). These patients should have their care managed by a multidisciplinary team.	Morphine oral solution 10mg/5ml (Oramorph®) 18p per 20mg dose (10ml).	£5 million Assuming 50% is suitable for switching.

Drug/medicine	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual saving
Travel vaccines	The following vaccines for travel to high risk areas are not available for prescribing on the NHS for the purpose of travel:[15] • Hepatitis B • Japanese encephalitis • Meningitis ACWY • Yellow fever • Tick-borne encephalitis, • Rabies • BCG. NHS England has asked Public Health England to review vaccines currently available on the NHS for travel for appropriateness of prescribing on the NHS and if they should still be available on the NHS. These include:[16] • Cholera • Diphtheria/tetanus/polo • Hepatitis A • Typhoid. As hepatitis B is not available on the NHS for travel, consider whether the combined hepatitis A and B vaccination should be given for travel.	The vaccines not currently available on the NHS for travel may continue to be offered on the NHS for purposes other than travel and as part of national immunisation programmes. They should also continue to be recommended for travel and paid for by the traveller.	Private prescription for non-prescribable travel vaccines if they are being used for the purposes of travel.	£4.4 million (assuming 50% is for travel)

Drug/medicine	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual saving
Doxazosin MR (Cardura® XL)	No good evidence of additional benefit over immediate release doxazosin. Both formulations provide effective blood pressure control and are effective at controlling the symptoms of BPH and improving maximum urinary flow rate.[17] The long half-life of immediate release doxazosin allows once daily dosing.[13] Doxazosin is recommended only as a fourth-line antihypertensive.	None foreseen.	Generic immediate release doxazosin - average 3p per dose (based on doxazosin 4mg £0.82/28 tablets).[8]	£4.8 million Based on switching to immediate release preparation, which is on average 75% cheaper.
Co-proxamol	Markedly more toxic in overdose than paracetamol. Withdrawn from market in 2005 due to safety concerns and marketing authorisations cancelled at end of 2007.[18] Withdrawal has saved the lives of around 300-400 people per annum in the UK from self-poisoning of which around a fifth were accidental. The MHRA did state during the withdrawal phase that there would be a small group of patients who may find it very difficult to change from co-proxamol when alternatives appear not to be effective or suitable. However as the drug was withdrawn in 2007, patients should be reviewed in line with current pain management guidelines.	None foreseen. Unlicensed so clinical and product liability lies with the prescriber.[18]	Paracetamol 500mg £2.13/100 tablets[8] Co-codamol 30/500 £3.72/100 capsules	£6.2 million based on nil prescribing, however costs will be offset against alternative prescription if appropriate.

Drug/medicine	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual saving
Rubefacients	Topical rubefacient preparations may contain nicotinate and salicylate compounds, essential oils, capsicum, and camphor which are all irritant.[13] The evidence available does not support the use of topical rubefacients in acute or chronic musculoskeletal pain.[13] Rubefacients should not be offered to treat osteoarthritis.[19] Stop any prescribing of rubefacients for osteoarthritis. NICE states that capsaicin patches should not be used for neuropathic pain in non-specialist settings, unless advised by a specialist.[20]	NICE states that capsaicin cream should be considered for people with localized neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments and patches for neuropathic pain should be used on the advice of a specialist.[20] The NICE Clinical Guideline for osteoarthritis states that topical capsaicin should be considered as an adjunct to core treatments for knee or hand osteoarthritis.[19]	Purchase OTC alternatives for acute musculoskeletal pain. Topical NSAIDs prescribed for chronic pain in appropriate patients.	£2.7 million assuming some reduction in prescribing and some switching to an NSAID preparation where appropriate.

Drug/medicine	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual saving
Omega-3 fatty acids and other fish oils	For secondary prevention of myocardial infarction NICE CG172 states: "Do not offer or advise people use omega-3 fatty acid capsules or omega 3 fatty acid supplemented foods to prevent another MI." "Advise people to eat a Mediterranean-style diet (more bread, fruit, vegetables and fish; less meat; and replace butter and cheese with products based on plant oils)".[21] NICE CG170 states "Do not use omega-3 fatty acids to manage sleep problems in children and young people with autism".[22] NICE do not recommend fish or algal oils solely with the aim of preventing hypertensive disorders in pregnancy[23] or omega-3 fatty acid supplements for familial hypercholesterolaemia.[24] NICE CG181 states "omega-3 fatty acid compounds should not be offered for primary or secondary prevention of CVD, alone or in combination with a statin, including in people with CKD or type 1 or type 2 diabetes'. Moreover, the guideline recommends that healthcare professionals should tell people that there is no evidence that omega-3 fatty acid compounds help to prevent CVD.[25] NICE NG49 states "Do not offer omega-3 fatty acids to adults with non-alcoholic fatty liver disease because there is not enough evidence to recommend their use".[26] NICE CG186 states "Do not offer omega-3 or omega-6 fatty acid compounds to treat multiple sclerosis (MS). Explain that there is no evidence that they affect relapse frequency or progression of MS".[27] NICE Evidence summary 19 states there is a lack of evidence to support use in schizophrenia "The randomised controlled trial (RCT) evidence for using omega-3 fatty acid medicines in people with schizophrenia is limited and the results are not consistent"[28]	None foreseen. Review in association with psychiatrist in schizophrenia indication.[28]	Patients should eat a Mediterranean style diet. If people choose to purchase omega-3 fatty acid capsules or eat omega-3 fatty acid supplemented foods, be aware that there is no evidence of harm.[21]	£3.6 million assuming 75% reduction in prescribing.

Drug/medicine	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual saving
Oxycodone/ naloxone (Targinact®)	Randomised controlled trials have only compared Targinact® with standard-release oxycodone, NOT with other strong opioids such as morphine, with regular laxatives. Naloxone element has no effect on risk of overdose as it is not absorbed – it just acts on the GI tract. There are also no data showing that combined oxycodone and naloxone reduce the need for laxatives in the long term. Poor cost-effectiveness. Rejected by SMC.[30]	None foreseen.	Morphine sulfate modified release plus senna or lactulose.	£3.2 million (assuming alternatives 75% less costly).
Dosulepin	NICE CG90 for depression in adults states: "Do not switch to, or start, dosulepin because evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose."[9]	None foreseen.	SSRIs are first-line. Where non SSRI antidepressants are required, prescribers should follow the NICE CG.[9]	£1.6 million Based on 80% reduction in prescribing, savings will be offset by alternative treatment if appropriate.
Lutein and other antioxidant vitamins	Evidence base does not show that antioxidant vitamins to treat or prevent the progression of AMD are beneficial.[31] Products are food supplements and not licensed medicines.	None foreseen.	Purchase OTC.	£1.7 million
Paracetamol with tramadol (Tramacet ® combination product)	Fixed dose combination of 37.5mg tramadol plus 325mg paracetamol per tablet.[13] No more effective than established analgesics in acute or chronic pain,[32] contains a sub-therapeutic amount of paracetamol and is more expensive than alternatives.[8] There are safety concerns with tramadol (harms and misuse) as well as an increased number of deaths.[33]	None foreseen.	Paracetamol £2.13/100 tablets vs. £15.37/100 paracetamol/ tramadol combined.[8]	£1.3 million

Drug/medicine	Why is it included in the list?	Circumstances in which use might be appropriate	Suggested alternative(s)	Indicative annual saving
Perindopril arginine (Coversyl® Arginine and Coversyl® Arginine Plus)	No benefit over generic perindopril erbumine and is more costly.[34] Coversyl® prescribed by brand name will be dispensed as Coversyl® arginine.	None foreseen.	Perindopril erbumine.	£1.1 million Based on perindopril erbumine being 85% cheaper than perindopril arginine.
Glucosamine containing products for osteoarthritis	Do not do recommendation in NICE CG177.[35] "Do not offer glucosamine or chondroitin products for the management of osteoarthritis."	None foreseen.	Purchase OTC if patient wants to take the supplement.	£337,000
Herbal supplements with a Traditional Herbal Registration (THR) license from the MHRA	The MHRA allows herbal products to be marketed for minor health conditions that don't require medical supervision, upon receipt of a Traditional Herbal Registration (THR).[36] Claims to treat major health conditions are not allowed under a THR and would need a marketing authorisation. Under a THR there is no requirement to prove scientifically that a product works, the registration is based on longstanding use of the product.[36]	None foreseen.	Purchase OTC if patient wants to take the herbal product.	£120,000
Homeopathy	The MHRA register homeopathic medicines under two different regulatory schemes.[37] No therapeutic claims are allowed for registration through the simplified registration scheme whereas the national rules scheme allows claims for the relief of minor symptoms and conditions which don't require the supervision of a doctor. In 2010, a report by the House of Commons Science and Technology Committee found that the use of homeopathy was not evidence base and any benefits to patients was down to placebo effect.[38]	None foreseen.	Purchase OTC if patient wants to take the homeopathic product.	£73,000
			INDICATIVE TOTAL	**£92.5 million**

References

1. NHS England. Our Work: Medicines Optimisation. Available at: https://www.england.nhs.uk/ourwork/pe/mo-dash/ Last accessed 25/07/2017.
2. National Institute for Health and Care Excellence (NICE). Clinical Guideline 90. Depression in adults: recognition and management. October 2009, updated April 2016. Available via www.nice.org.uk Last accessed 24/07/17.
3. Okosiemi, O, Gilbert J, Abraham P et al. Management of primary hypothyroidism: statement by the British Thyroid Association Executive Committee. Clinical Endocrinology 2015;0:1-10.
4. Jonklaas J, Bianco AC, Bauer AJ , Burman KD, Cappola AR, Celi FS et al for the American Thyroid Association Task Force on Thyroid Hormone Replacement. Guidelines for the treatment of hypothyroidism. THYROID 2014; 24 (12)
5. Wiersinga WM, Duntas L, Fadeyev V et al. 2012 ETA Guidelines: The Use of L-T4 + L-T3 in the Treatment of Hypothyroidism. Eur Thyroid J 2012;1:55–71.
6. National Institute for Health and Care Excellence (NICE). Clinical guideline 173. Neuropathic Pain in adults – pharmacological management in non-specialist settings. November 2013. Available at http://www.nice.org.uk/guidance/cg173 Last accessed 26/07/2017.
7. Scottish Medicines Consortium (SMC). Lidocaine 5% medicated plaster (Versatis). August 2008. Available at https://www.scottishmedicines.org.uk/SMC_Advice/Advice/lidocaine_5__plaster__Versatis____334-06_/lidocaine_5__medicated_plaster__Versatis_ Last accessed 26/07/2017.
8. National Health Service Business Services Authority. Department of Health Drug Tariff. September 2017. Available at http://www.drugtariff.nhsbsa.nhs.uk Last accessed 25/07/2017.
9. National Institute for Health and Care Excellence (NICE). Clinical Guideline 90. Depression in adults: recognition and management. October 2009, updated April 2016. Available via www.nice.org.uk Last accessed 24/07/17.
10. NPC Rapid Review. DH Clarify Guidance around new daily dose treatments for impotence. March 2009. Available at: https://www.centreformedicinesoptimisation.co.uk/dh-clarify-guidance-around-new-daily-dose-treatments-for-impotence/
11. UKMi. Medicines Q&As. What is the rationale and evidence for the use of phosphodiesterase-5 inhibitors for erectile dysfunction after radical prostatectomy? August 2014. Available at: https://www.sps.nhs.uk/wp-content/uploads/2016/03/PDE5Is_prostatectomy_128_2_final.doc
12. National Institute for Health and Care Excellence (NICE). Clinical Guideline 97. Lower urinary tract symptoms in men: management. May 2010. Last Updated June 2015. Available at https://www.nice.org.uk/guidance/cg97 Last accessed 26/07/2017.
13. Joint Formulary Committee. British National Formulary (online) London: BMJ Group and Pharmaceutical Press; July 2017. Available at https://www.medicinescomplete.com/ Last accessed 25/07/2017.
14. Medicines and Healthcare products Regulatory Agency (MHRA). Drug Safety Update. Serious and fatal overdose of fentanyl patches. September 2008. Available at https://www.gov.uk/drug-safety-update/serious-and-fatal-overdose-of-fentanyl-patches Last accessed 26/07/2017.
15. NHS Choices. Last updated November 2015. http://www.nhs.uk/Conditions/Travel-immunisation/Pages/Introduction.aspx Last accessed 22/09/17.
16. NHS England and NHS Clinical Commissioners. Items which should not routinely be prescribed in primary care: Guidance for CCGs. November 2017 available at https://www.england.nhs.uk/wp-content/uploads/2017/11/items-which-should-not-be-routinely-precscribed-in-pc-ccg-guidance.pdf accessed 01/12/17
17. UKMi. Medicines Q&As. How should conversion between doxazosin formulations be carried out? July 2013. Available at http://www.medicinesresources.nhs.uk/upload/documents/Other%20Library%20Updates/Drug_Discont_Shortage/Doxazosin_conversion_2013.doc Last accessed 22/09/2017.

18. MHRA Media Centre: European Medicines Agency (EMEA) recommends withdrawal of dextropropoxyphene-containing medicines (including co-proxamol). June 2009. Available at http://webarchive.nationalarchives.gov.uk/20141206024321/http://www.mhra.gov.uk/NewsCentre/CON049300http://www.mhra.gov.uk/NewsCentre/CON049300. Last accessed 27/07/2017.
19. National Institute for Health and Care Excellence (NICE). Clinical guideline 177. Osteoarthritis:care and management February 2014. Available at http://www.nice.org.uk/guidance/cg177/evidence/cg177-osteoarthritis-full-guideline3 Last accessed 25/07/2017.
20. National Institute for Health and Care Excellence (NICE). Clinical guideline 173. Neuropathic Pain – pharmacological management. November 2013. Available at https://www.nice.org.uk/guidance/cg173 Last accessed 25/07/2017.
21. National Institute for Health and Care Excellence. Clinical Guideline 172. Myocardial Infarction: cardiac rehabilitation and prevention of further cardiovascular disease. November 2013. Available at http://guidance.nice.org.uk/CG172 Last accessed 26/07/17.
22. National Institute for Health and Care Excellence. Clinical Guideline 170. Autism-spectrum disorder in under 19s: support and management. August 2013. Available at http://guidance.nice.org.uk/CG170 Last accessed 26/07/2017.
23. National Institute for Health and Care Excellence. Clinical Guideline 107. Hypertension in pregnancy – diagnosis and management. August 2010. Last updated January 2011. Available at https://www.nice.org.uk/guidance/cg107 Last accessed 26/07/2017.
24. National Institute for Health and Care Excellence. Clinical Guideline 71. Familial hypercholesterolaemia - identification and management. August 2008. Last updated July 2016.. Available at https://www.nice.org.uk/guidance/cg71 Last accessed 26/07/2017.
25. National Institute for Health and Care Excellence. Clinical Guideline 181. Cardiovascular disease: risk assessment and reduction, including lipid modification. July 2014. Available at https://www.nice.org.uk/guidance/cg181 Last accessed 26/07/2017.
26. National Institute for Health and Care Excellence (NICE). NICE guideline. Non-alcoholic fatty liver disease (NAFLD); assessment and management. Available at: https://www.nice.org.uk/guidance/ng49 Last accessed 22/09/2017.
27. National Institute for Health and Care Excellence (NICE). Clinical Guideline. Multiple Sclerosis in adults: management. October 2014. Available at: https://www.nice.org.uk/guidance/cg186 Last accessed 22/09/2017.
28. National Institute for Health and Care Excellence (NICE). Evidence Summary. Schizophrenia: omega 3 fatty acid medicines. September 2013. Available at: https://www.nice.org.uk/advice/esuom19/chapter/Key-points-from-the-evidence Last accessed 22/09/2017.
29. National Institute for Health and Care Excellence (NICE). Key therapeutic topic. Lipid Modifying Drugs. January 2015. Available at: https://www.nice.org.uk/advice/ktt3 Last accessed 22/09/2017
30. Scottish Medicines Consortium (SMC). Oxycodone/ naloxone (Targinact®). March 2009. Available at https://www.scottishmedicines.org.uk/SMC_Advice/Advice/541_09_oxycodone_naloxone__Targinact_ Last accessed 27/07/2017.
31. AMD Guidelines Group. The Royal College of Opthalmologists. Age Related Macular Degeneration. Guidelines for Management. (Chapter 6). September 2013. Available at https://www.rcophth.ac.uk/wp-content/uploads/2014/12/2013-SCI-318-RCOphth-AMD-Guidelines-Sept-2013-FINAL-2.pdf Last accessed 27/07/2017.
32. Scottish Medicines Consortium (SMC). Tramadol 37.5mg/paracetamol 325mg tablet (Tramacet®) Advice. Available at https://www.scottishmedicines.org.uk/SMC_Advice/Advice/Tramadol_37.5mg_paracetamol_325mg_tablet__Tramacet__174__ Last accessed 25/07/2017
33. Advisory Council on the Misuse of Drugs (ACMD) consideration of tramadol. February 2013. Available at https://www.gov.uk/government/publications/acmd-advice-on-tramadol Last accessed 25/07/2017
34. Hughes DA, Ferner RE. New drugs for old: disinvestment and NICE. BMJ 2010;340:C572.

35. National Institute for Health and Care Excellence (NICE). Clinical guideline 177. Osteoarthritis. February 2014. Available at http://www.nice.org.uk/guidance/cg177/evidence/cg177-osteoarthritis-full-guideline3 Last accessed 27/07/2017.
36. Medicines and Healthcare products Regulatory Agency (MHRA). Guidance: apply for a traditional herbal registration (THR). December 2014. Last updated September 2016. Available at https://www.gov.uk/guidance/apply-for-a-traditional-herbal-registration-thr Last accessed 27/07/2017.
37. Medicines and Healthcare products Regulatory Agency (MHRA). Guidance: register a homeopathic medicine or remedy. January 2015. Last updated January 2017. Available at https://www.gov.uk/guidance/register-a-homeopathic-medicine-or-remedy Last accessed 27/07/2017.
38. House of Commons. Science and Technology Committee – Fourth Report. Evidence check 2 – Homeopathy. February 2010. Available at https://publications.parliament.uk/pa/cm200910/cmselect/cmsctech/45/4502.htm Last accessed 27/07/2017.

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