Prescribing and Dispensing Newsletter
impact
November 2008

Free NHS prescriptions

for recipients of Income-Related Employment and Support Allowance

From 27th October 2008 the Department of Work and Pensions will replace Incapacity Benefit (IB) with a new benefit, Employment and Support Allowance (ESA), for people who become incapable of work from that date or after. There are two strands of the new benefit, income-related, which is means tested, and contribution based. Only those on the income-related strand will be 'passported' to free prescriptions.

Details of the arrangements

People who are included in an award of income-related Employment and Support Allowance should tick box H '*gets Income Support or income-related Employment and Support Allowance', on the reverse of the new prescription form (version 0608) to claim free prescriptions.

If the old version of the prescription form is presented for dispensing, the person should be instructed to tick box H '*gets Income Support'.

Evidence should be provided in the form of an Employment and Support Allowance award notice. Note: receipt of the contribution based Employment and Support Allowance on its own does not entitle a patient to free prescriptions. However, if not otherwise exempt they may qualify for help if they make an NHS Low Income Scheme claim.

FP57 Prescription Refund forms

Patients who are included in an award of Income Related Employment and Support Allowance requesting a refund of prescription charges using an FP57 form should tick the Income Support box until new stocks of FP57 forms are available.

Existing Benefit Recipients

Arrangements for those in receipt of Incapacity Benefit remain unchanged. If they are in receipt of Income Support and Incapacity Benefit, they can tick the Income Support box H on the reverse of the prescription form.

If they receive only Incapacity Benefit and are not entitled to free prescriptions by another route, they may wish to make a NHS Low Income Scheme claim. An HC1 application form is available by phoning the NHS forms order line on **0845 610 1112**.

Alternatively, the patient may wish to purchase a prescription pre-payment certificate. A 12 month certificate can be purchased by direct debit (or by lump sum) by phoning **0845 850 0030**. A 3 month certificate is available by phoning the same number and making a lump sum payment of £27.85. Applications can be made by post if the patient completes an FP95 form, or online by visiting **www.dh.gov.uk/helpwithhealthcosts**.

You can order a free supply of FP95 application forms from your local PCT Forms Supply Unit, or NHS Trust.

Four PPD processing offices remaining...

The NHS Business Services Authority's Prescription Pricing Division (NHBSA PPD) is consolidating all of its processing sites into three regional ones based in the North East (Newcastle), North West (Middlebrook) and Yorkshire (Wakefield). This year we have closed six offices.

As of November 2008 there are four processing offices remaining:

- **Middlebrook**
- **Newcastle**
- **Wakefield**
- **West Bromwich**

As contractors have moved on to the new system and prescription processing offices have closed we have written to contractors to tell them where to send their batches to, which included a supply of address labels.

Please remember to use the most recent address labels provided by the NHSBSA PPD to prevent delays in processing your batch. If you use a courier service please remind the courier to deliver your batch according to the address label.

Details of our office closures are published on our website, **http://www.ppa.org.uk/news/closures.htm**

For more information about where to send your batch please phone our helpdesk 0845 610 1171.

Category M Price Changes

Department of Health have announced the price changes for products listed in the Drug Tariff, part VIII category M which will apply to prescriptions dispensed from the 1st October 2008. You can find a full list on our website, **www.ppa.org.uk**

Pharmacy contractors will receive payment for items dispensed in October 2008 on 1st January 2009 and we would advise contractors to be aware of this when looking at their schedule for their January payment.

New NHS Business Services Authority **website** launching soon

A new customer focused website for the NHS Business Services Authority (NHSBSA) will be launching at the end of November.

The website, which aims to bring all five current existing websites for the organisation together under one roof, will be customer focused and based around stakeholder needs.

Its structure has been designed based on feedback collected from a number of people who use the full variety of services on offer from the NHSBSA.

The home page will act as a portal to help direct people to the particular source of information they require but there will be mini home pages for each of the services including prescription pricing.

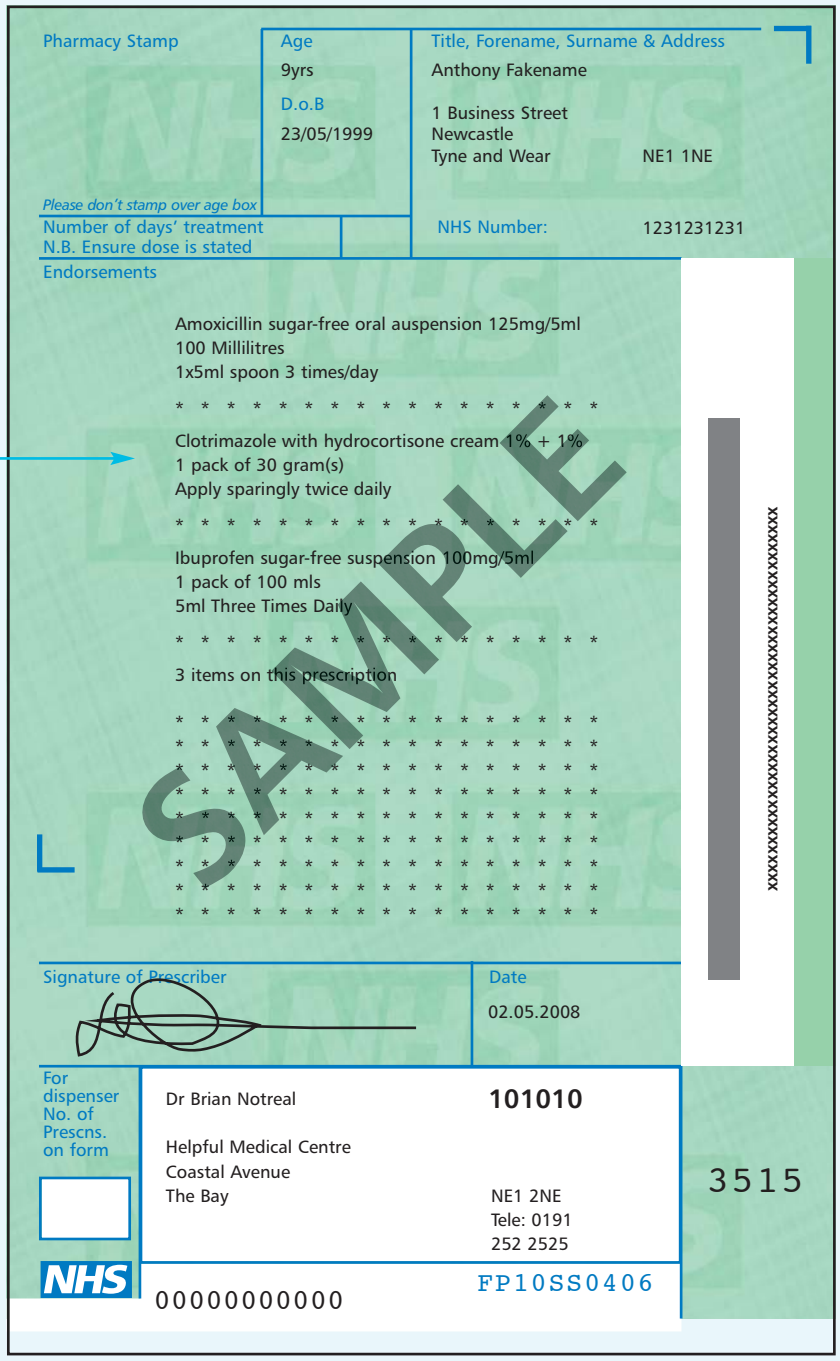
The new website represents a new era for the NHSBSA in terms of how we present ourselves to our stakeholders as being customer and service based rather than organisationally structured.

You can visit the portal at **www.nhsbsa.nhs.uk** or the mini home pages **www.nhsbsa.nhs.uk/prescriptionservices** from the end of November.

Returned submissions explained

We've had some enquiries asking us to explain what the new look returned submission means. Below is an example with an explanation of the key things you should be looking out for. The form will only show you the item we need further explanation for so we only withhold payment for that item rather than every item on the original prescription form. Sometimes before we can process an item on a prescription for payment we need to get further information from you. Under our old system we used to send back the original prescription form to you, but now we send you a copy of the prescription instead. We send you a returned submission for every item on a form that we need further information for.

First 5 digits are the account number → FMT44 200805 ← **Year and month of dispensing. In this example it is from May 2008**



This is the item we need more information about.

Charge status:

C - Chargeable

E - Exempt, if used there will be another letter to show the exempt category. If it is **Z** we have recorded as exempt but category was unclear (eg 2 exemptions ticked)

This is our code for why it has been returned

RB1 Item 2

Form type → FPS10SS C

This is the date that we produced the returned submission.

09 July 2008

For orders that are not listed in Part VIII of the Drug Tariff the following endorsements are required. Supplier, pack size, and basic price (excluding VAT). If a formula has been dispensed and any of the ingredients are not listed in Part VIII, please supply the above information.

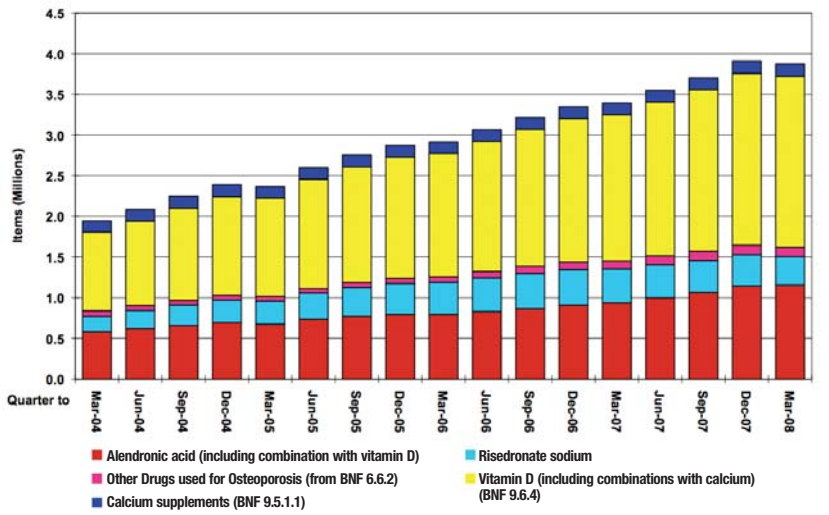
Additional information -

This is your space to tell us the information or endorsement we've asked for.

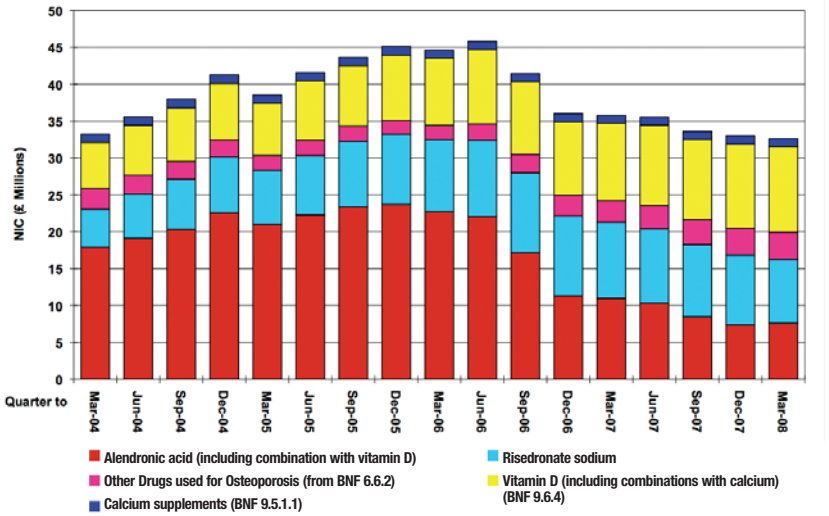
Prescribing Review Report on Osteoporosis Drugs

The Prescribing Review report on Drugs used for Osteoporosis, available to general practitioners in August 2008, is reproduced here for readers with an interest in patterns and trends of prescribing.

Trends in Prescribing of Drugs for Osteoporosis in General Practice in England (Chart 1)



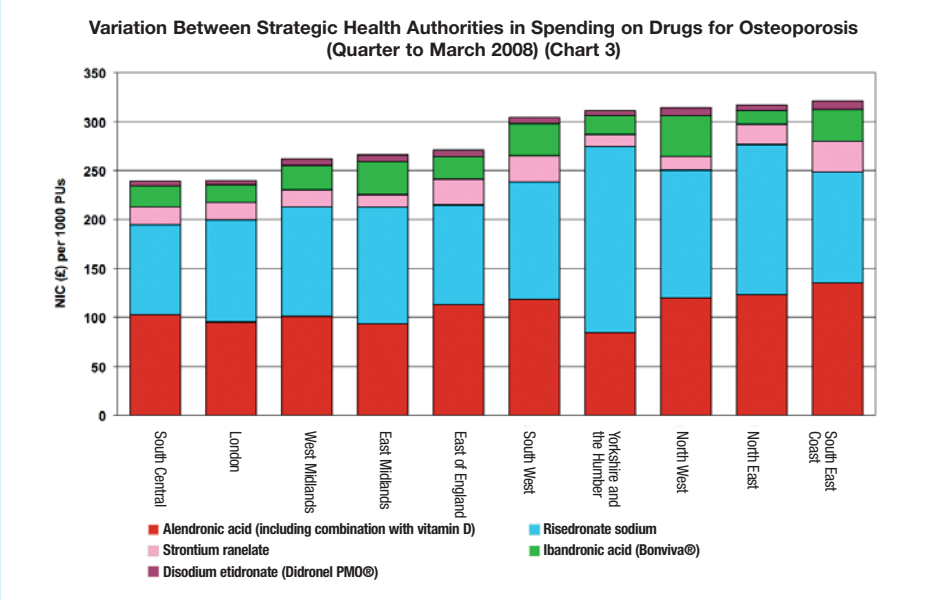
Trends in Spending on Drugs for Osteoporosis in General Practice in England (Chart 2)



It is estimated that more than two million women in England and Wales have osteoporosis.[1] There are approximately 70,000 hip fractures, 25,000 clinically apparent vertebral fractures and 41,000 wrist fractures in England and Wales annually.[1] It is thought that most vertebral fractures (50 to 70%) do not come to clinical attention although the lifetime risk of a vertebral fracture among women > 50 years is 1 in 3, and 1 in 5 for a hip fracture.[1] All postmenopausal women with an initial fracture are at substantially increased risk of subsequent fractures.[1] Vertebral fractures can be associated with increased complications (e.g. curvature of the spine resulting in breathing problems) and increased mortality. In contrast, 20% of people with a hip fracture die within six months, and 50% of patients with hip fracture cannot live independently.[2] Osteoporosis is defined as a Bone Mineral density (BMD) at least 2.5 standard deviations (T-score –2.5) below the average for a 25 year-old woman. BMD is measured by a dual-energy x-ray absorptiometry (DXA) scan at the femoral neck.[3] Prescribing of drugs for the prevention and treatment of osteoporosis has doubled in the last four years while spending has been reined back (Please see charts 1 and 2). About 480,000 women are prescribed drugs for osteoporosis in the UK.[4] Osteoporosis is also common among older men, who have a lifetime fracture risk of 21%.[5] This review covers the prevention and treatment of osteoporosis in postmenopausal women.

Risk factors

Bone loss accelerates after the menopause and the prevalence of osteoporosis increases from 2% at 50 years to over 25% at 80 years.[1] Independent risk factors for fracture include parental history of hip fracture, alcohol intake of >4 units per day, long-term systemic use of corticosteroids and long-term rheumatoid arthritis.[1] Other indicators of low BMD include smoking, body mass index <22 kg/m^2, untreated



premature menopause, medical conditions such as ankylosing spondylitis and Crohn's disease, and prolonged immobility.[1] Afro-Caribbean women have a higher BMD than Caucasian women at all ages.[2] The World Health Organization Collaborating Centre at Sheffield University has developed a computer based risk assessment model (FRAX™) which, unlike BMD, takes account of several independent risk factors, however it has not yet been validated for population screening.[6]

Prevention of osteoporosis

Postmenopausal women should take regular exercise and stop smoking. Calcium intake should be increased to 1,000 milligrams/day, either from dietary intake or calcium supplements.[2] The recommended intake of vitamin D for women >65 years is 10 micrograms/day (400 IU), which in most cases is only achieved by taking a supplement.[2] In women at risk of vitamin D deficiency (for example if housebound), the recommended dose is 20 micrograms/day (800 IU).[2] Trials of drug treatment for fracture prevention have all included calcium and vitamin D supplementation. Hormone replacement therapy (HRT) should be reserved for women unable to use other treatments for osteoporosis.[7] Although HRT prevents bone loss, it is associated with increased cardiovascular risk (particularly in women aged >60 years and in women at increased baseline risk) and a small increased risk of cancer.[7]

Prevention of fractures

Individuals at risk of falls should be offered advice about prevention. Gait and balance should be assessed in older people who fall to determine whether strength and balance training, vision assessment and medication review might help.[8] NICE recommends considering multifactorial intervention to reduce falls[8] but a recent analysis found limited evidence to support this approach.[9] NICE technology appraisals of drug treatment for the primary and secondary prevention of fragility fractures in postmenopausal women with osteoporosis and a clinical guideline on the management of osteoporosis are in preparation. The Final Appraisal Determinations (FADs) on drug treatment for primary and secondary prevention of osteoporotic fractures provide guidance on the use of bisphosphonates (alendronate, etidronate and risedronate), raloxifene, strontium ranelate and teriparatide.[1,10] NICE has received appeals for both FADs and the guidance may yet change.

For primary prevention, NICE recommends alendronate when the T-score is <–2.5 for:

- women aged >70 years who have an independent clinical risk factor for fracture or an indicator of low BMD. In women aged >75 years who have two or more independent clinical risk factors for fracture or indicators of low BMD, a DXA scan may not be required if the responsible clinician considers it to be clinically inappropriate or unfeasible,
- women aged 65-69 years who have an independent clinical risk factor for fracture, and;
- postmenopausal women <65 years with additional indicators of low BMD and one independent clinical factor for fracture.

The alendronate preparation with the lowest acquisition cost should be chosen. The FAD Assessment Group performed a meta-analysis comparing alendronate to placebo and found a Relative Risk (RR) of vertebral fracture of 0.56 (95% CI: 0.46 to 0.68, four RCTs, n = 7039), and a RR of hip fracture of 0.62 (95% CI 0.40 to 0.98, three RCTs, n = 7455). Risedronate and etidronate are recommended as alternative options for the primary prevention of osteoporotic fragility fractures in postmenopausal women who are unable to follow dose instructions for alendronate, or for whom it is contraindicated or poorly tolerated, provided they are at higher fracture risk (the thresholds are defined by T-score, age and clinical risk factors). In deciding between risedronate and etidronate, clinicians and patients need to balance the overall proven effectiveness profile of the drugs against their tolerability and adverse effects in individual patients. Strontium ranelate is recommended as third-line therapy at higher risk thresholds but raloxifene is not recommended for primary prevention.

For secondary prevention, NICE recommends alendronate for postmenopausal women with a T score of <–2.5. The recommendations for risedronate and etidronate are similar to those for primary prevention, except that the threshold risk at which treatment is indicated is lower. Raloxifene and strontium ranelate are recommended for women who cannot tolerate alendronate or risedronate and who meet additional criteria for increased risk. Teriparatide is recommended for women >65 years who cannot take alendronate, risedronate or strontium ranelate and who are at very high risk according to criteria listed in the appraisal. Ibandronic acid is not included in the NICE appraisal. It is taken orally (150 mg once-monthly) or by intravenous injection (3 mg every three months) for the treatment of osteoporosis in postmenopausal women at increased risk of fracture.

Many patients do not take bisphosphonate treatment as prescribed. A recent meta-analysis estimated that only 53% were still adherent (that is, taking at least 80% of prescribed doses) six months after beginning treatment, decreasing to 43% for the next 18 months.[11] Adherence was particularly low (34%) among new users.[11] Factors associated with low adherence include concern about adverse effects, frequent dosing and practical difficulties taking the

Prescribing Review report (Cont.)

dose.[12] Higher adherence rates are associated with a significantly lower risk of fracture.[13] Patients prescribed a bisphosphonate should therefore undergo frequent medication review that addresses their concerns and beliefs about osteoporosis and its treatment. Bisphosphonates have been associated with osteonecrosis of the jaw.[14,15] Most reported cases occurred in patients undergoing dental procedures who were receiving a parenteral bisphosphonate but oral bisphosphonates have also been implicated. Risk factors include tooth extraction, osteomyelitis, cancer chemotherapy and corticosteroid use.

Prescribing Data
(reporting quarter = Jan-Mar 2008, index quarter = Jan-Mar 2004)

Spending on drugs used for prevention and treatment of osteoporosis (selected from BNF 6.6.2) varies by about one-third across strategic health authorities (Please see chart 3). Over the past four years, prescribing in this category has almost doubled to 1.6 million items per quarter but the cost has fallen by 23% to £20 million. Alendronate (including in combination with vitamin D) accounts for 71% of items but for 38% of the cost (1.2 million items, £7.6 million). In contrast, risedronate represents 21% of items (346,000) and 43% of the cost (£8.6 million). Etidronate items have decreased by 70% to 20,000 and cost by 84% to £440,000. There are 55,000 items for ibandronic acid at a cost of £1.9 million; strontium ranelate accounts for 44,000 items, £1.4 million and raloxifene for 35,000 items, £962,000. Calcium prescribed alone (BNF 9.5.1.1) accounts for 14,000 items, £1.1 million. Prescribing of vitamin D and its analogues (BNF 9.6.4) has increased by 117% to 2.1 million items (an 85% increase in cost to £11.6 million). Calcium is usually prescribed with vitamin D or a vitamin D analogue. Over the past four years, Adcal D3® items have increased to 673,000 and the cost has risen to £2.7 million. Prescribing of Calcichew D3® Forte has increased by 74% to 572,000 items, £2.6 million. Prescribing of Calcichew D3® has decreased by 27% to 94,000 items costing £917,000.

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14. Medicines and Healthcare products Regulatory Agency. Hormone replacement therapy: updated advice. Drug Safety Update 2007;1 (Issue 3):7. www.mhra.gov.uk/Publications/Safetyguidance/DrugSafetyUpdate/CON2032518
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Key Messages

Patients should be encouraged to address lifestyle measures such as stopping smoking and taking regular exercise to reduce their osteoporosis risk. Calcium intake should be increased to 1,000 milligrams/day, either from dietary intake or calcium supplements.

In preliminary guidance, NICE recommends alendronate for both primary and secondary prevention of osteoporosis in postmenopausal women at increased risk of fracture, as defined by T-score, age and clinical risk factors. The product with the lowest acquisition cost should be prescribed.

Risedronate and etidronate are recommended as options when alendronate is inappropriate, subject to higher thresholds of fracture risk.

Higher risk thresholds apply to the use of strontium ranelate for primary and secondary prevention, and to raloxifene for secondary prevention; teriparatide is recommended as secondary prevention for women at very high risk when other drugs are not suitable.

Adherence to bisphosphonate treatment is often low; frequent medication review may be needed.

Calendar pack sorting requirements

For our new prescription processing system we ask pharmacies to sort their calendar pack prescriptions. We would like to clear up what we mean by this. This sorting **only** applies where:

- the quantity ordered is **not** equal to, or multiples of, the pack size/sub-pack size **and**
- the exact prescribed quantity is supplied.

Contractors should sort these prescriptions separately and put them at the top of the batch they send to us for reimbursement.

Contractors do not need to sort separately any calendar pack prescriptions which do not fall under these criteria.

You can find further guidance on sorting the monthly prescription submission on our website. Or you can phone our helpdesk.

http://www.ppa.org.uk/ppa/disp_contract_sorting.htm

Online information film

about our new processing system

We have worked with the Pharmaceutical Services Negotiating Committee (PSNC) to produce a short information film about the new processing system we've been rolling out over the last year. Staff show you around the system and explain how it works and what they do. It is aimed at contractors who aren't able to come to one of our open days and was launched on both websites on 22nd August.

It only lasts about 16 minutes and includes how we prepare and scan bundles, how we process them and customer service.

You can watch it both on our epact site and on the ppa.org site. There's a useful link to it in the 'links' area on the right hand side of the home page.

The film is available in four different formats, iPod, mobile phone, AVI and MPEG4. Download time will depend on the speed of your internet connection.

"I thought [the video] was phenomenally useful and have shown it to my two dispensers who agreed." *Dr Lisa Silver*

If after you've watched the film you've got any comments or feedback then please send them to Fiona Punchard, Communications Manager. fiona.punchard@ppa.nhs.uk

www.ppa.org.uk/cip/movie.htm **www.psnc.org.uk**

Hints&Tips

Incontinence pads

Contractors should note that incontinence pads are not listed in Drug Tariff Part IX and therefore they will not be reimbursed for supplying these products. Incontinence pads are supplied and paid for by the health trust providing other health care in the community. Supply may be direct to the patient's home or the patient may be asked to collect from a central point.

Identifying whether a medical device will be reimbursed on FP10

Contractors will only be reimbursed for supplying medical devices if they are listed in Drug Tariff Part IX. All medical devices will bear a CE mark to show that they comply with the E.U. Medical Devices Directive.

If you receive a prescription for a new or unusual product, the packaging should be checked for the following detail:

- no marketing authorisation, and
- CE mark on the packaging.

Before dispensing the product refer to Drug Tariff Part IX. If it is not listed then the product may not be reimbursed when dispensed on FP10.

The following are examples of CE-marked products not listed in Drug Tariff Part IX which cannot therefore be supplied on an NHS prescription:

- Biofreeze pain relief gel
- Cryospray verruca and wart remover
- Neilmed SinuRinse / nasal rinse
- Systane eye drops

Information can also be found on the Dictionary of Medicines and Devices (dm+d) at:
http://www.ppa.org.uk/systems/pcddbrowserv2_3/index.htm
or alternatively contact the Prescription Processing Help Desk on the number below.

Changes to the list of items for which discount is not deducted

From November 2008 the way that 'Drugs for which discount is not deducted list' information will appear in the Drug Tariff Part II will change to make it clearer. Criteria for addition or deletion of products will remain the same and although it will appear shorter the total number of active items in the list will be unchanged.

- **Change 1:** Group entries (e.g. Cytotoxic/Cytostatic items) will be listed at the front of the list, not placed within it. 'Cold Chain Storage' will be a new group entry.
- **Change 2:** Where all available strengths of a medicine qualify for entry onto the list, the product will only be listed once and indicated by an '(ALL)' marker in Drug Tariff. Where some available strengths of a product do not qualify for entry onto the list, those strengths that do qualify will continue to be listed separately.

Further information is available on the NHSBSA Prescription Pricing Division Website at:
http://www.ppa.org.uk/index.htm#

Out of pocket expenses

Dispensing contractors can claim 'out of pocket expenses' for their costs to get a drug, appliance or chemical reagent. But the cost of the product supplied must **not** be included in the claim.

The Drug Tariff Part II Clause 12, provides the detail on which products are eligible for claims for out of pocket expenses.

FP34C

As well as endorsing each prescription form with the details of any claims for out of pocket expenses, dispensing contractors should declare the total value and number of out of pocket expense claims on the FP34C submission document.

You can find guidance on how to fill in your FP34C submission document on our website, or you can phone our helpdesk.

http://www.ppa.org.uk/ppa/disp_contract_sorting.htm

Contact details for the NHSBSA

For enquiries relating to Pharmacy Processing, Prescription Searches, Personal Administration, Dispensing Doctors and Contractor Payment Information contact the new Prescription Processing Help Desk on:

0845 610 1171

This number should be used with immediate effect and replaces any existing numbers you currently use.

www.ppa.nhs.uk
www.nhsbsa.nhs.uk

NHS
Business Services Authority