NHS
West Essex
Clinical Commissioning Group

Example Repeat Prescribing Policy

Acknowledgements:
Adapted for our use with kind permission from Surrey Downs Clinical Commissioning Group.

NOTE: Practices need to define parameters for areas of policy denoted in red

CONTENTS

POLICY ON REPEAT PRESCRIBING

Person Responsible for policy:
Include version and reference number
Date policy approved:
Date of policy review:

1. INTRODUCTION

1.1. Repeat prescribing is a partnership between patient and prescriber that allows the prescriber to authorise a prescription so it can be repeatedly issued at agreed intervals, without the patient having to consult the prescriber at each issue. The community pharmacy may order the repeat on behalf of the patient under the managed prescription sevice.

1.2. The National Audit Office (NAO) in their report "Repeat Prescribing by General Medical Practitioners in England (HC 897)" states that a good repeat prescribing system should be accurate, flexible and produce prescriptions promptly, as well as incorporating effective record keeping, compliance checks and quality assurance.

1.3. The production of repeat prescriptions is a team approach with input not only from the GP, but also from the receptionist and practice manager and the dispensing pharmacist. Effective teamwork is therefore needed to produce high standards of practice and care.

1.4. A robust repeat prescribing system has benefits to patients, practices and the CCG:

Benefits to patients

- Better access to their medication
- Defined process
- Full instructions on dosage etc.
- Reduced risk of errors

Benefits to practices

- Able to manage own workload
- Fewer queries/complaints
- Better use of staff time
- Less stress improves morale
- Achievement of indicators in the General Medical Services (GMS) Contract
- Able to adopt new initiatives

Benefits to the CCG

- Less waste
- Assurance that medicines are used in a safe, effective and appropriate manner
- Reduced risk of adverse incidents

2. PURPOSE / SCOPE

2.1. The purpose of this policy is to set out the practice policy for prescribing medication on a repeat basis.

- To standardise repeat prescribing processes and protocols within general practice
- To enable staff to understand their roles and responsibilities around repeat prescribing
- To provide guidance on good repeat prescribing process and procedures

- To ensure safeguards are in place to minimise error and reduce risk

2.2. The policy includes all activity within the practice by all staff involved in the repeat prescribing process both clinical and non-clinical.

2.3. The policy will be reviewed and updated annually by the practice.

3. DEFINITIONS

3.1. Where the term "repeat prescribing" is used, this refers to the supply of "batch" prescriptions/ "batch" dispensing as well as the supply of standard prescriptions for repeat supplies of medicines.

NOTE: Where this policy states GP, this can also mean any other qualified prescriber in the Practice (e.g. nurse practitioner)

4. DECIDING TO PRESCRIBE ITEMS ON A REPEAT BASIS

4.1. The decision to transfer a drug from an acute prescription to a repeat prescription will always be made by the **doctor** after careful consideration of whether the drug has been effective, well tolerated and is required long term. The community pharmacist may highlight acute medications which may be suitable to added to the patients repeat. The patient should be seen, or at least spoken to, at this stage, to ascertain the above and to check compliance. It is the duty of the doctor at this stage to ensure that the patient understands the repeat prescribing process and what is required of them.

4.2. A suggested list of medicines that should remain as "acute" can be found in appendix 1 (practice to define list).

4.3. Care should be taken to ensure the repeat record is accurate, quantities for each drug are synchronised where possible (to reduce waste medicines), and the appropriate review dates are entered.

4.4. Drugs prescribed should be linked to medical conditions within the clinical system where possible and where appropriate and flagged for appropriate monitoring including blood tests

5. REQUESTS FOR A REPEAT SUPPLY OF MEDICATION

5.1. The following personnel are allowed to request repeat prescriptions (practice to define who and circumstances):

- Patient
- Carer
- District and specialist nurses
- Pharmacist
- Care home staff

5.2. Where practices allow third party requests, they must:

- Ensure patient confidentiality is maintained
- Ensure the correct information is accurately exchanged, when those making the request are not fully aware of the patient's medications / health condition
- Ensure the request is genuine. The practice should be confident that the person making the request has the patients' permission to do so.

5.3. Requests should be received by one of the following methods: (practice to define list)

- Right hand side of prescription (preferred)
- In writing (other than counterfoil)
- On-line
- Email request

5.4. Written requests are preferable because they are more likely to be accurate, and there is a reduced opportunity for errors and misunderstandings.

5.6. A lockable box is situated in the practice reception for patients to post their requests in. It should be emptied daily.

5.7. The following information must be obtained before a request is processed:

- Patient's full name
- Patient's address or date of birth
- Name/strength/ form and dosage of medication(s)

Any queries arising from the request should be clarified at this stage *N.B. It is NOT acceptable for a patient to request "all repeats" or their "blue tablets", or use a description of medication rather than specify the name (e.g. heart tablets, pain killers)*

5.8. The patient or his/her representative must have an active role in requesting the repeat prescription and should be encouraged to indicate on the repeat request slip which medications are required. If the form has been left blank and it is not otherwise obvious which medications are required, then the patient should be contacted to allow the agreed 48 hour turn-around (if possible).

5.9. Community pharmacy staff (and dispensing staff in dispensing doctor surgeries) offering should routinely ask patients if they require all their prescribed medication. This will reduce the potential for medicines to be stockpiled and/or wasted.

5.10. Where prescribing and dispensing for patients resident in care homes, checks should be made that all the medicines requested are required, particularly in relation to medicines that are "when required". Check when the PRN medication was last requested. If this is regularly this should be investigated.

5.11. Patients should allow at least 48 hours for repeat prescriptions to be processed. Where it has been requested that the prescription is sent to the patient by post, the turnaround time should be one week. See section 8.4 for dealing with urgent requests.

5.12. Patients should be encouraged to speak to their GP/nurse or pharmacist if they have concerns about taking any of their medicines, or if they do not take them as prescribed. This will allow the repeat prescribing system to be updated to accurately reflect the medicines the patient is taking.

5.13. Prescriptions should not be supplied more frequently than at the interval agreed with the patient, without prior agreement (e.g. holiday).

6. PRODUCTION OF REPEATS

6.1. The practice computer system must be used for generation of all repeat prescriptions to ensure a clear record of supplies.

6.2. The list of medications which are not permitted in the practice repeat system is enclosed as Appendix 1, and should be available to staff generating repeat prescriptions.

6.3. A counterfoil (medication list) must be generated with every prescription.

6.4. When the quantity of repeat medicines has been changed the GP should be alerted.

6.5. Prescriptions should not be "directed" to any particular pharmacy or appliance contractor. The GMC makes this clear in their Good Practice in Prescribing Medicines (2006) guidance:

"You should respect patients' freedom to choose where to have their prescribed medicines dispensed. "*You must not pressurise patients to use a particular pharmacy in any event, either personally or through an agent*"

6.6. Where repeat prescription collection services are in place, the pharmacy or appliance contractor used should be chosen by the patient. Practice staff should not influence the choice of pharmacy for prescriptions to be sent to.

7. PROCESSING A REQUEST FOR A REPEAT PRESCRIPTION

7.1. Check that the items requested are on the patients" **current** repeat list. If the patient requests any items not on the list, this must be referred to a GP. Verify that the items requested are suitable as repeat medication (see Appendix 1, for list of items that are NOT suitable).

7.2. If the requested item appears on the repeat medicines list, check the name, form, strength and dosage instructions are identical to the request. Any discrepancies must be referred to a GP.

7.3. If the authorised number of issues has been met, do not issue the prescription but refer the request to the GP for review. Patients on batch prescriptions should make an appointment for a review before a new batch is generated.

7.4. Check medication review date has not been exceeded – refer to GP to see if he/she wishes to see patient / update review. If there is no review date set, follow procedures agreed in the surgery to set a review date.

7.5. Where prescription requests are earlier or later than expected, and may indicate over or under use of that item, refer the request to a GP so that they can find out why the patient is not using the medication as intended.

7.6. Refer requests for repeat medicines that have not been ordered for one year or more to the GP for consideration of removing from the repeats list, exceptions are seasonal medications e.g. hay fever.

7.7. Align supply to 28/56 days (where appropriate – to be defined by practice and which patient groups). It is good practice to limit supply of newly prescribed medication to no more than 28 days' supply, or ideally less to minimise wastage.

7.8. The supply of schedule 2 and 3 controlled drugs (CDs) should always be limited to a maximum of 30 days.

7.9. Any decision to prescribe seven-day prescriptions should be made solely on clinical grounds. It may, for example, be appropriate to prescribe only seven days at a time for an unstable patient rather than risk generating a lot of waste, or when a patient is considered to be misusing or over-

using medication. In the latter example, the patient should have a "Major Alert" placed on their clinical record and a nominated GP.

7.10. Processing Repeat Prescriptions

7.10.1. Repeat prescriptions should only be signed by a prescriber who knows the patient, or at least has direct access to the patient's clinical records at the time of signing the prescription.

7.10.2. Once the prescription had been signed, it should be returned to the receptionist for collection by the patient or patient's representative.

7.10.3. The signed prescription should be stored in a secure, supervised place, out of reach of the public, as it contains confidential information about the patient.

7.10.4. The patient's name, address, and date of birth should be checked with the person collecting the repeat prescription to confirm the identity of the patient.

7.10.5. Any prescriptions being collected by an outside agency i.e. a community pharmacy, will have been agreed with the patients and recorded in the patients notes. This should be checked if the receptionist is not aware of such an arrangement.

7.10.6. Practice to define policy on collection of prescriptions by anybody under 16 years of age.

7.10.7. A repeat prescription that has gone missing should not automatically be reproduced and, depending on the medication, patients may be encouraged to contact the police for a crime reference number. Following a thorough investigation; the script should be re-printed rather than re-issued and a note should be included in the patient record. If there is a problem with an electronic prescription print a token , do not generate a new prescription

7.10.8. Prescriptions not collected after 4 weeks after issue should be highlighted to the prescriber. They should be shredded, and the issue should be deleted from the issue record. The READ code "prescription not collected" should be added to the patient's record.

7.10.9. If a review date is required or overdue, the patient should be advised of this by (practice to define how this is done) and requested to make an appointment and attend before any further scripts are generated.

8. MANAGEMENT CONTROL

8.1. Authorisation

8.1.1. Only practice clinical staff can add authorised medications, or make changes to a patient's repeat medication list (with the exception of appliances).

8.1.2. Only a qualified prescriber can authorise repeats, and indicate the number of repeats allowed. The number of repeats allowed must not cover a time period exceeding one year. After that time the patient's medicines must be reviewed by the prescriber.

8.1.3. When a medication is first added to a repeat prescription, it should be noted clearly why it was started in the first place, use the linking facility in the clinical system to do this.

8.1.4. Often newly prescribed medication (until suitability is confirmed) and medication with frequent dose changes would be better set up as an acute prescription.

8.1.5. The number of repeats, or the period of time, allowed before the next review should be defined, this must be done by the GP. As a minimum all patients should have an annual medication review (any additional criteria to be defined by the practice).

8.1.6. If a request is placed for a drug that is not authorised as a **repeat** item, a prescription must **not** be generated. The patient's GP should be informed. If the GP decides to authorise the prescription, ensure any message from the GP to the patient is communicated to the patient, (practice to define how this is done).

8.2. Compliance check

8.2.1. If a patient is significantly over or under using medication, a prescription must **not** be generated.

- The GP should be informed; and
- An explanatory note should be attached to the patient' record (practice to define how this is done)

If the GP decides to authorise the prescription, ensure any message from the GP to the patient is communicated to the patient (practice to define how this is done).

8.3. Flagging of problems

If there is any query about the request for repeat medication, the prescription must **not** be generated.

- The GP should be informed; and
- An explanatory note should be attached to the patient' record (practice to define how this is done)
- The requesting pharmacy may need to be notified

If the GP decides to authorise the prescription, ensure any message from the GP to the patient is communicated to the patient (practice to define how this is done).

8.4. Urgent requests

Immediately pass the request to the receptionist dealing with repeats highlighting the urgency and approach the GP at the end of surgery. *Note: production and management control criteria are still valid for urgent requests for repeat prescriptions.*

8.5. Hospital Discharge Medication / Outpatient attendance / Home Visits

8.5.1. Patients who have been discharged from hospital or seen in outpatients often have their medication changed. This can potentially lead to serious problems if strict procedures are not followed. The discharge medication/hospital letter must be reviewed and actioned by the GP **in conjunction** with details of the patient's current medication.

8.5.2. Hospital communications should be made available to the GP at the end of the next surgery following their receipt. Hospital communications must **not** be filed until:

- The patient's GP has reviewed the letter and decided on appropriate action;
- The GP has conducted a review and medicines reconciliation
- Where appropriate an appointment or domiciliary visit has been made and:
  - › It has been verified that the patient has enough medication;
  - › It has been determined if there is any need for an acute prescription;
  - › The patient has been asked to bring all their medication to surgery (if applicable);
  - › The patient's review date has been appropriately updated

8.5.3. Non-clinical staff should not examine medication dispensed to the patient as a means of verifying amendments made to a patient's regimen. In particular reception staff must not transcribe from the labels of such items, to request a repeat prescription.

8.5.4. If a patient requests a supply of medication before the hospital communication has been received, a faxed copy must be requested from the hospital. The urgency placed upon this request should be guided by the duration of the patient's remaining supply and clinical need.

8.5.5. The GP should indicate that the computer records have been updated by signing and dating the discharge letter, or adding the medicines reconciliation READ code to the consultation record or journal. Checks should include:

- Duplication of same drug or same drug class
- Duplication of drug by brand and generic name
- Delete medication that has been discontinued
- Appropriate dose and dosage form
- Appropriate quantity

8.5.6. Any changes to medicines should be entered into the patient's medical record by the GP or a non-medical prescriber performing the medicines reconciliation process. Use of the READ codes below will enable information relating to the medicines reconciliation process to be placed into the consultation. Appropriate free text can then be added if required for clarification.

Emis Web

- 8B318 Medicines reconciliation
- 8B316 - Medication Changed
- 8B3A1 - Medication Increased
- 8B3A2 - Medication Decreased
- 8B313 - Medication Commenced
- 8B3A3 - New Medication Commenced
- 8B3R - Drug Therapy Discontinued
- 8B396 - Treatment Stopped – alternative therapy undertaken
- 67IM - Advice to GP to Change Patient Medication
- 8B3S0 – Post hospital discharge medicines reconciliation with the patient

SystemOne

- XaRF0 - Medicines reconciliation
- 8B316 - Medication Changed
- 8B3A1 - Medication Increased
- 8B3A2 - Medication Decreased
- 8B313 - Medication Commenced
- 8B3A3 - New Medication Commenced
- XM18N - Drug Therapy Discontinued
- 8B396 - Treatment Stopped – alternative therapy undertaken
- XaJC3 - Advice to GP to Change Patient Medication

8.5.7. Where possible, all medication supplies should be aligned so that the supplies all run out together, to simplify the repeat process.

8.5.8. Any alterations to a patient's condition or medication, outside of a practice consultation, (e.g. home visit), must be updated in the patient's medical record at the earliest opportunity by the GP.

8.5.9. Handwritten prescriptions must be entered onto the computer system at the earliest opportunity to reduce inadvertent duplication of prescribing, to reduce the possibility of unintentional drug interactions and to provide an adequate audit trail.

8.5.10. If a patient requests a supply of medication that has been issued on a handwritten prescription, but is not on the computer record:

- The GP should be informed; and
- An explanatory note should be attached to the patient' record (practice to define how this is done)

9. CLINICAL CONTROL

9.1. General

9.1.1. Medication review is the periodic review of the patient at which the continuing need for acceptability and safety of medication on the repeat prescription are considered.

9.1.2. A medication review date should be set by the prescriber for all patients receiving repeat prescriptions. Instigating a medication review in the patients birthday month may serve as a reminder.

9.1.3. A system should also be in place to ensure that patients who do not order their medication are also reviewed. (To be defined by practice - For example electronic record can be automatically tagged to indicate underuse, and a prompt for staff to open that record and assimilate the information).

9.1.4. Ideally medication review should be conducted by the GP, nurse or clinical pharmacist face to face with the patient; telephone consultations may also be used.

9.1.5. Practice staff should inform the prescriber when a patient fails to attend a medication review when requested to do so.

9.2. Initiation

9.2.1. The prescriber must be satisfied that drug treatment is appropriate and necessary.

9.2.2. Consideration should be given to non-drug treatments and lifestyle interventions.

9.2.3. The patient must be reviewed at least once before granting a prescription repeat status.

9.2.4. Medication should be prescribed to only cover the period until assessment of suitability.

9.2.5. Patient sensitivities, allergies and significant interactions should be considered. Drug allergy status should be recorded as drug allergy, none known or unable to ascertain. If a drug allergy is recorded information should be included about the drug involved, type of reaction including severity and when the reaction occurred.

9.2.6. Prescribing should be generic, unless there is a specific clinical reason for prescribing by brand (for example, drugs with a narrow therapeutic range). Medicines to be prescribed by brand are listed in Appendix 2.

9.2.7 The dose and frequency must be specified and will help facilitate compliance checks:

- The instruction "as directed" should not be used (unless a variable dose medication);
- The instruction "when required" should not be used alone.

9.2.8 The patient should be given an explanation of what is being prescribed and why. The patient understands whether the drug is an addition to or replacement for current medication should be verified. An explanation as to how the drug(s) is administered (demonstrated, if appropriate).

9.2.9 Common adverse effects should be discussed; consider if the patient might be concerned by the manufacturer's patient information leaflet.

9.3. Authorisation of repeat prescriptions

9.3.1. The GP must have an allocated time set aside each day for signing / reviewing repeat prescriptions.

9.3.2. In order to authorise the request for repeat medication, the prescriber should be satisfied:

- The drug is effective (look for objective evidence)
- The patient is concordant and able to take the medication i.e. (inhaler)
- There is no short or longer term risk of important adverse effects
- There is no short or longer term risk of interaction with other medication
- The drug is for a stable, chronic condition – other items should not should enter the repeat system

9.3.3 The prescriber should check the following:

- Drug name, strength, form and dose;
- Indication for each drug;
- Whether appropriate monitoring has been undertaken, and if an adjustment to medication is required in response to results of monitoring,
- Date of next review

9.3.4 Repeat prescriptions should where ever possible be reviewed and signed by the GP who knows the patient. The patient's medical notes should be available if needed. All drugs requested within the system should be regularly reviewed.

9.3.5 A system should be in place for distributing a GP's prescriptions during cases of absence.

10. SECURITY

10.1. Blank prescriptions must never be signed by a prescriber, for later completion by practice staff. To do this is in breach of terms of service.

10.2. Unused space should be cancelled out under the last drug by a computerised mechanism or by the doctor deleting the space manually.

10.3 The practice has a policy which covers the safe and secure storage and handling of prescriptions in line with the NHS Business Service Authority policy.

11. INFORMATION FOR PATIENTS

Make sure patients are aware of:

- The procedure for ordering repeat prescriptions

- The time it takes to turn them around (including arrangements for weekends, bank holidays etc.)
- When they will be ready for collection
- Letting the practice know if they have stopped taking anything on the prescription
- Asking the doctor, nurse or pharmacist if they are unsure about any of their medicine
- A practice repeat prescribing leaflet should be available, located at the point where repeat prescriptions are collected
- The message section of the counterfoil should be used to inform the patient of the repeat prescribing policy.

12. PATIENT SAFETY INCIDENTS

12.1. GP practices are encouraged to report all patient safety incidents identified relating to prescribing and the practice repeat prescribing system to NRLS (National Reporting and Learning System).

Including your practice name will allow your report to be shared with your NHS Area Team, and if you opt to do so, your CCG. If you don't include the ODS code the incident report will not be passed to your AT or CCG and learning will not be shared.

13. DUTIES/RESPONSIBILITES AND ACCOUNTABILITY (practice to define)

GP

- Responsible for overall clinical control and accountability
- Signing prescriptions and all legal requirements for prescription writing are met
- An appropriate cost effective drug is chosen
- Possible interactions with other medications are taken into account
- The medicines is added to the repeats when appropriate
- Appropriate quantities are prescribed
- Suitable number of authorisations are set before a review is needed
- Where possible the amount given is synchronised with other medicines on repeat
- The most appropriate strength is prescribed (dose optimisation)
- The drug is written generically (or branded where appropriate)
- Clear instructions are given on the prescription
- Patients have the opportunity to discuss the likelihood of benefit & risks of harm of the therapy
- Hand written prescriptions or alterations made away from the surgery are also electronically recorded
- On ordering a prescription, the prescriber should act on any problems highlighted with under or over-ordering of prescriptions as appropriate
- Additions, deletions and other changes to prescriptions
- Re-authorising repeat medicines when appropriate to do so
- Perform an annual full clinical medication review
- Report and investigate medication related safety incidents

Practice Manager

- Overall management control of repeat prescribing system
- Overseeing training of practice staff
- Liaison with local community pharmacists
- Security and storage of prescription forms

Reception staff

- Day to day running of the system
- Following practice policy and protocols for repeat prescribing

Ordering Repeats:

- To ensure that the patient has clearly indicated what items they need. Where possible when this has not been done the patient or their representative should be contacted to confirm, rather than just providing all the items
- Only select the items the patients has requested
- To discourage patients from over ordering or hoarding medicines.

Generating Repeats:

- Staff are responsible for making sure this is completed in a safe manner with attention to detail and must refer on any queries which they are unable or unauthorised to handle
- The last issue should always be checked before another issues is made to check for under or over ordering
- Staff must check the correct prescription reaches the correct patient by checking their name and address

Flagging up Problems/Potential Changes:

- Generic and inappropriate Generic Prescribing
- Prescriptions with no directions or as directed with no specific instructions (excludes variable dose medications e.g. Warfarin, Insulin)
- Items which are not normally allowed on long term repeat as agreed in the practice policy
- To make sure all requests for repeats are appropriate
- To consider/recommend synchronisation where appropriate in order to reduce waste
- Prescription queries raised by the community pharmacy

Review & Re-authorisation:

- Re-enforcing with the patient the need to attend regular reviews
- Flagging up certain issues and mentioned above and addressing them within the time frame

14. TRAINING AND CONTINUING PROFESSIONAL DEVELOPMENT

14.1 All staff involved in the production of repeat prescriptions must have access to and are able to use the most recent version of the British National Formulary.

14.2. **ALL** staff involved in repeat prescribing must undertake repeat prescribing training. It would be advisable for new staff to shadow a trained member of staff for at least one month, or until senior staff feel they are competent.

14.3. Practice staff involved in the preparation of repeat prescriptions should be appropriately trained in the practice protocols for repeat prescribing, including their responsibilities, accuracy and when to refer the request for a repeat prescription to a GP. All staff engaged with the prescription process should spend one morning with the community pharmacist to better understand the process when items are dispensed and collect by the patient.

15. SCRIPTSWITCH

15.1 ScriptSwitch activates on new repeats i.e. addition of a medication to the repeat template and repeat re-authorisations i.e. start of a new cycle. It is NOT triggered by a repeat issue. Please refer to page 13 in the appropriate user manual for other “trigger points”.


Emis Web Full User Manual - v4.7.pdf


INPS Full User Manual - v4.7.pdf


TPP Full User Manual - v4.7.pdf

West Essex CCG encourages that ScriptSwitch is set up only for clinicians from a safety aspect but any user can be set up to view ScriptSwitch on the clinical system. The user manuals also include how to enable and disable ScriptSwitch users on the clinical system.

Doctors should aim to use Scriptswitch whenever it is safe to change to an alternative medication (and add a message on the prescription to explain the change, whenever necessary).

16. Electronic Prescription Service (EPS)

The Electronic Prescription Service (EPS) makes the prescribing and dispensing process more efficient and convenient for patients and staff.

Patients on a repeat prescription collection service or existing repeat dispensing patients are ideal groups to discuss EPS and nomination with.

Repeat dispensing is an alternative model for prescribing and dispensing regular medicines to patients on stable long-term treatment, where repeat supplies are managed by the patient's pharmacy of choice. There are a number of differences and added benefits between the repeat dispensing model and traditional repeat prescribing processes, including:

For the GP and practice:

- reduction in workload issuing and re–authorising repeat prescriptions
- reduced medicines waste
- earlier detection of medicines–related problems

For the patient:

- improved access to regular medicines
- simplified one–stop process for obtaining next supply of medicines
- regular contact with pharmacist to discuss medicines–related issues
- pharmaceutical support for self–care and the management of long–term conditions

Appendix 1

Medicines Not Suitable for Repeat Prescribing

List to be defined by the practice

Potential medicines for consideration on the list:

- Antibiotics / antifungals / antivirals
- Medicines with special monitoring needs e.g. warfarin, methotrexate
- Oral chemotherapy e.g. cyclophosphamide, methotrexate, mercaptopurine
- Oral corticosteroids
- Potent topical corticosteroids
- Varenicline / buproprion
- Antipsychotics in the elderly
- Hypnotics e.g. zopiclone, temazepam and other benzodiazepines
- Pseudoephedrine
- Medicines subject to misuse e.g. strong opioids
- Dressings
- Nutritional supplements

Appendix 2

Medicines that should be prescribed by brand / not suitable for generic prescribing

Some medicines need to be prescribed by brand due to, for example, critical bioavailability or the availability of a modified-release or complex formulation. In a few cases, this is crucial to the patient receiving a safe and effective therapeutic dose. In the case of immunosuppressants, the Medicines and Healthcare products Regulatory Agency (MHRA) has issued safety warnings recommending brand prescribing due to bioavailability differences between brands. With some modified release preparations, variation between brands can lead to differences in clinical effects, e.g. lithium, theophylline, nifedipine and diltiazem.

This list of medicines may not be comprehensive.

Drug or drug class	Reason for considering brand-name prescribing
Adrenaline (epinephrine) pre-filled syringes	Patient familiarity with one brand is important; instructions for use vary between preparations.
Aminophylline modified release preparations	MR preparations have different release characteristics and are not interchangeable. Aminophylline has a narrow therapeutic index.
Antiepileptic drugs: **Category 1** - Phenytoin, carbamazepine, phenobarbital and primidone. **Category 2 -** Sodium valproate, lamotrigine, perampanel, retigabine, rufinamide, clobazam, clonazepam, oxcarbazepine, eslicarbazepine acetate, topiramate and zonisamide. **Category 3 -** Levetiracetam, lacosamide, tiagabine, gabapentin, pregabalin, ethosuximide and vigabatrin.	**Category 1**: Specific measures are necessary to ensure consistent supply of a particular product (which could be either a branded product or a specified manufacturer's generic product). **Category 2**: The need for continued supply of a particular manufacturer's product should be based on clinical judgement and consultation with patient and/or carer. **Category 3**: No specific measures are normally required and these AEDs can be prescribed generically and without specifying a specific manufacturer's product
Buprenorphine patches	Patches have different wear times. Patient familiarity with one brand is important.
Colecalciferol (vitamin D)	Prescribing by generic names may lead to the item being dispensed as an unlicensed high cost Special.
Contraceptives	Different brands of the same formulation are available. Patient familiarity with one brand is important.
Diltiazem modified release preparations	MR preparations have different release characteristics and are not interchangeable.
Fentanyl patches	Patches are available as matrix and reservoir formulations. Patient familiarity with one brand is important.
Immunosuppressant therapy: Azathioprine, mycophenolate mofetil, ciclosporin, tacrolimus	It is important not to change formulation except on the advice of a transplant specialist. Prescribing by brand name will avoid inadvertent switching.
Inhalers	Patient familiarity with one brand is important; instructions for use vary between preparations. Note: Beclometasone dipropionate CFC-free inhalers to treat asthma – there are two inhalers that contain the same active substance (beclometasone dipropionate), but one is much stronger.

Insulins	Patient familiarity with the same brand is important; training is required in the use of specific devices for self-injection.
Lithium preparations	Preparations vary widely in bioavailability. Changing the preparation requires the same precautions as initiation of treatment. Lithium has a narrow therapeutic index.
Mesalazine oral preparations	The delivery characteristics of oral mesalazine preparations may vary and should not be considered interchangeable.
Methylphenidate modified release preparations	MR preparations contain different proportions of immediate-release and modified-release methylphenidate.
Morphine oral modified release preparations	MR preparations have different release characteristics. Patient familiarity with one brand is important.
Nifedipine modified release preparations	MR preparations have different release characteristics and are not interchangeable.
Theophylline modified release preparations	MR preparations have different release characteristics and are not interchangeable. Theophylline has a narrow therapeutic index.