



SMC 'not recommended' advice:
an investigation of medicines use across NHSScotland



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Scottish Medicines Consortium Evaluation Programme

SMC 'not recommended' advice - an investigation of medicines use across NHSScotland

Executive Summary and Full Report

Prepared by the SMC Evaluation Project Team

This work was undertaken by the National Medicines Utilisation Unit, Information Services Division, NHS National Services Scotland in collaboration with the Scottish Medicines Consortium

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Executive summary

Introduction

The remit of the Scottish Medicines Consortium (SMC) is to provide advice to NHS boards and their Area Drug and Therapeutics Committees (ADTCs) across Scotland about the status of all newly licensed medicines, all new formulations of existing medicines and new indications for established products (licensed from January 2002). Advice is made available as soon as practical after the launch of the medicine. NHS board ADTCs advise clinicians not to prescribe a new medicine prior to the publication of SMC advice. The SMC issues three categories of advice: 'accepted for use', 'accepted for restricted use' and 'not recommended'. A medicine is 'not recommended for use' if there is a lack of evidence of clinical and/or cost effectiveness.

This study investigates, where data were available, the use of medicines across NHSScotland for which the SMC has issued 'not recommended' advice.

Methods

Medicine definition

In this study 'not recommended' status was defined as all medicines that had ever received 'not recommended' advice from the SMC. Between January 2002 and December 2005, the SMC issued 'not recommended' advice for 57 medicines. Medicines were excluded from the study if they were predominantly used in secondary (hospital) care, due to the lack of available national data, and/or had multiple indications that limited interpretation of medicines use for the SMC advice issued. This resulted in the identification of 20 medicines.

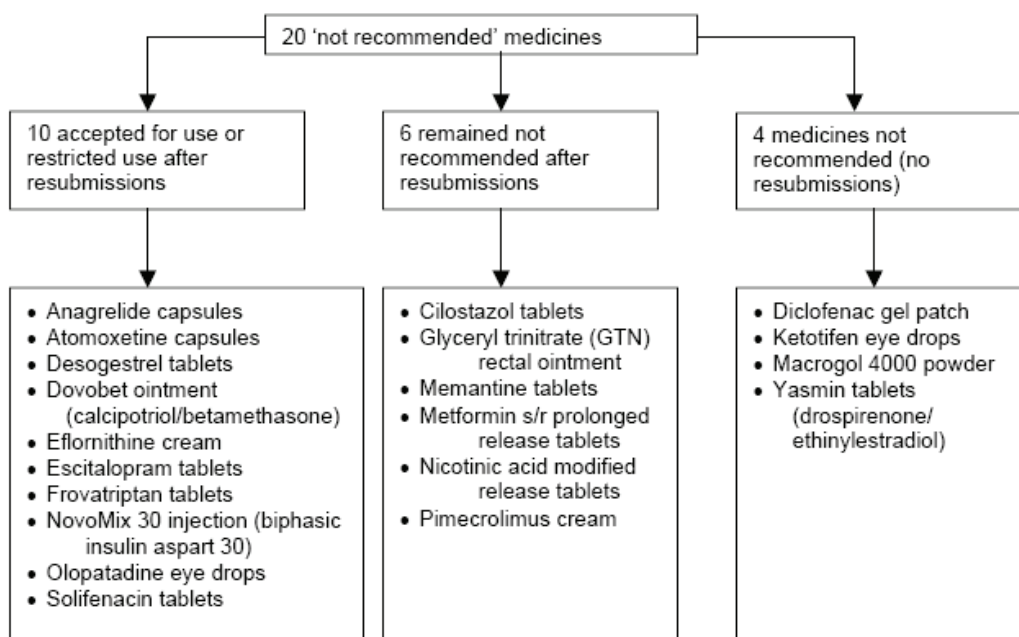
Medicine use

A 'medicine profile' was developed for each of the 20 medicines identified. The profile included: the SMC advice; a description of the epidemiology of the indication for the medicine; NHSScotland medicines use over time, annotated with key milestones; a comparison of the actual versus estimated manufacturer's budget impact; and potential factors that may be influencing medicines use within NHSScotland. From these data, actual expenditure and an estimate of the number of patients treated were calculated at defined time periods. In addition, a qualitative review of the medicine profiles was undertaken to identify potential factors to explain the patterns of medicines use.

Key findings

Figure 1 (page 5) presents the 20 medicines included in the study. Ten medicines had subsequent SMC 'accepted for use' (n=6) or 'accepted for restricted use' (n=4) advice issued. The remaining 10 medicines either had no further advice issued (n=4) or had further 'not recommended' advice issued (n=6).

Figure 1: Summary of all SMC advice issued for medicines in the study (n=20)



Use before SMC ‘not recommended’ advice

SMC advice was issued within 6 months of launch for 65% of medicines that were subsequently not recommended. A total of £1.4 million was spent in NHSScotland on the 20 medicines prior to issuing of SMC advice. This is in the context of a cumulative spend in the primary care drugs bill, over the study period (2002–2003 to 2005–2006), of £3.7 billion.

The top 5 medicines by expenditure were: Dovobet® (calcipotriol/betamethasone dipropionate) ointment (29%); escitalopram tablets (15%); Yasmin® (drospirenone/ethinylestradiol) tablets (14%); cilostazol tablets (8%); and memantine tablets (7%). Table 1 (page 6) summarises the factors identified from the qualitative review that may explain some of the patterns of medicines use.

Use after SMC ‘not recommended’ advice

Approximately £1 million was spent in NHSScotland in 2005–2006 (0.1% of the primary care drugs bill) on 10 medicines that remained ‘not recommended’ throughout the period of investigation. The top five medicines by expenditure were: Yasmin® tablets (45%), memantine tablets (17%), cilostazol tablets (13%), metformin s/r tablets (7%) and Macrogol® powder (7%), with use either stabilising or increasing. Factors identified to help to explain medicines use are presented in Table 1 (page 5).

Table 1: Factors that may help to explain patterns in medicines use before and after SMC ‘not recommended’ advice

Factor *	Use before SMC ‘not recommended’ advice (n=20)	Use after SMC ‘not recommended’ advice (n=10)
Delay between UK launch of medicine and initial SMC advice (> 9 months)	cilostazol tablets ketotifen eye drops Macrogol® powder memantine tablets Yasmin® tablets	n/a
Limited use relative to alternative treatments	escitalopram tablets Yasmin® tablets atomoxetine capsules	Macrogol® powder metformin s/r tablets nicotinic acid m/r tablets
No alternative licensed products	glyceryl trinitrate (GTN) rectal ointment	GTN rectal ointment memantine tablets
Influence of pharmaceutical industry marketing strategy**	escitalopram tablets NovoMix 30® injection Dovobet® ointment	
Variation in advice issued by national bodies to NHS boards and clinicians	n/a	cilostazol tablets pimecrolimus cream
Lack of engagement of relevant clinical experts in early stages of SMC	n/a	Yasmin® tablets

n/a – not applicable

*factor applied to medicines with expenditure >£20,000 for NHSScotland

**Highlighted in feedback from the clinical community

Modifiable factors

The factors identified from the medicine profiles provide a number of areas where action can be taken which may further facilitate the effective use and monitoring of medicines:

- Time from UK launch to initial SMC advice - the need for timely SMC advice, as early as possible following UK launch appears to be substantiated in this study, where there was a pattern of increasing use of the new medicine the further the SMC advice was issued from the launch date.
- Consistency of advice issued by national bodies – variation in advice provided by national bodies was shown to change the pattern of medicine use, potentially due to a lack of consistent clinical guidance to NHS boards and clinicians.
- Engagement of clinical experts in SMC processes – where there was lack of clinical engagement in SMC processes, the pattern of medicines use appeared to be little changed on issue of SMC ‘not recommended’ advice.

Conclusions

NHS board ADTCs advise clinicians not to prescribe a new medicine prior to SMC advice or following SMC 'not recommended' advice. In the context of the overall primary care drugs bill, expenditure on the study medicines both before and after SMC 'not recommended' advice, was small.

Primary care data on the use of medicines are available nationally, however this is not the case for secondary (hospital) care data. Consequently, this study was limited to medicines used mainly in primary care with a single indication, as there are currently no data on individual patient use of medicines nationally available. This lack of data limits our current ability to monitor the use of medicines.

Review of the individual medicine profiles in this study identified a series of factors that may help to explain the pattern of medicines use before and after SMC 'not recommended' advice.

These factors are useful in understanding the challenges in the assessment, uptake and monitoring of new medicines in NHSScotland.

Full report

Background

The remit of the Scottish Medicines Consortium (SMC) is to provide advice to NHS boards and their Area Drug and Therapeutics Committees (ADTCs) across Scotland about the status of all newly licensed medicines, all new formulations of existing medicines and new indications for established products (licensed from January 2002). Advice is made available as soon as practical after the launch of the medicine. ADTCs advise clinicians not to prescribe a new medicine prior to SMC advice. The SMC issues three categories of advice: 'accepted for use', 'accepted for restricted use' and 'not recommended'. A medicine is 'not recommended for use' if there is a lack of evidence of clinical and/or cost effectiveness.

To understand the effect of SMC 'not recommended' advice on medicine use, it is necessary to examine individual medicines and also to explore if there are any patterns in medicines use. A literature review identified no standard method to measure 'successful' implementation of health technology assessment (HTA) guidance, rather several approaches identifying variable factors that should be considered. This study investigates, where data were available, the use of medicines across NHSScotland for which the SMC had issued 'not recommended' advice over the period January 2002 to December 2005.

Method of study

Medicine Definition

In this study 'not recommended' status was defined as all medicines that had ever received 'not recommended' advice from the SMC. Between January 2002 and December 2005, the SMC issued 'not recommended' advice for 57 medicines.

Medicines were excluded from the study if they were predominantly used in secondary (hospital) care, due to the lack of available national data, and/or had multiple indications that limited interpretation of medicines utilisation for the SMC advice issued. This process identified 20 medicines for which data were sourced through the national primary care prescribing database, the PRescribing Information System for Scotland (PRISMS).

Medicine use

A 'medicine profile' was developed for each of the 20 medicines identified and included: the SMC advice; a description of the epidemiology of the indication for the medicine; NHSScotland medicines use over time annotated with key milestones ; a comparison of the actual versus estimated manufacturer's budget impact; and potential factors that may be influencing medicines use within NHSScotland. A more limited medicine profile was created for four of these medicines, where the NHSScotland quarterly usage was less than £10,000.

Medicines use was defined as Gross Ingredient Cost (GIC) over the time period July 2001 to March 2006. This was presented graphically at national level, annotated with key milestones including medicine launch

and SMC advice. From these data, actual expenditure and an estimate of the number of patients treated were calculated at defined time periods, for the medicines in the study, where appropriate.

A qualitative review of the medicine profiles was then undertaken to identify potential factors to explain the patterns of medicines use. This process initially focused on the top five medicines by expenditure, to identify potential factors. These factors were then applied to the remaining medicines to provide an indication of how often they helped to explain medicines use.

Key findings

Table 2 (page 14) summarises the 20 medicines included in the investigation. These cover a broad range of therapeutic areas and clinical conditions. Appendix 1 (page 18) presents the NHSScotland utilisation over time for each medicine. A full medicine profile for each medicine is available at <http://www.scottishmedicines.org.uk/>

Use before SMC 'not recommended' advice

NHS board ADTCs advise clinicians not to prescribe a new medicine prior to SMC advice. Table 3 (page 15) quantifies the individual medicine and total expenditure in primary care, with an estimate of the number of patients treated, prior to the issuing of SMC 'not recommended' advice.

SMC advice was issued within 6 months of launch for 65% of medicines that were subsequently not recommended. A total of £1.4 million was spent in NHSScotland on the 20 medicines prior to issuing of SMC advice. This is in the context of a cumulative spend in the primary care drugs bill, over the study period (2002–2003 to 2005–2006) of £3.7 billion.

The top five medicines by expenditure were: Dovobet[®] (calcipotriol/betamethasone dipropionate) ointment (29%); escitalopram tablets (15%); Yasmin[®] (drospirenone/ethinylestradiol) tablets (14%); cilostazol tablets (8%); and memantine tablets (7%).

Review of the medicine profiles identified four factors that may help to explain some of the patterns in medicines use. Table 4 (page 16) quantifies these factors as applied to all medicines with NHS expenditure >£20,000 for NHSScotland before SMC advice and is supported by the following qualitative information:

Factor: Delay between UK launch of medicine and initial SMC advice

The time between UK launch and initial SMC not recommended advice was > 9 months in three of the top five medicines by expenditure (Yasmin[®], cilostazol, memantine) (Table 3). Another example where the initial SMC 'not recommended' advice was issued > 9 months from launch was ketotifen, eye drops. In this case, the licence holder did not present a submission to SMC. Evolving SMC processes, in dialogue with the pharmaceutical industry, established that SMC 'not recommended' advice should be issued in the absence of a submission. For ketotifen eye drops this occurred 19 months from initial launch in the

UK and at the end of the second season of ketotifen's use in the management of seasonal allergic conjunctivitis, when use was increasing in primary care.

Factor: Limited use relative to alternative treatments

Use of escitalopram tablets, one of a number of selective serotonin re-uptake inhibitors (SSRIs) used in the management of depression, equated to ~2% of overall SSRI expenditure in primary care. Similarly, investigation of Yasmin[®] tablets identified that use at this time attributed to ~10%, by expenditure, of all combined oral contraceptive use in primary care.

Factor: No alternative licensed products

GTN rectal ointment for pain associated with chronic anal fissures was the only licensed product specific for this indication. Use increased quickly following the launch and may have been due to clinicians moving from the unlicensed (specials) medicine product available at this time to a licensed product.

Factor: Influence of pharmaceutical industry marketing strategy

Escitalopram tablets were launched in the UK at a time when the patent for citalopram was coming to an end. SMC advice indicated that no clear benefits were demonstrated compared to citalopram. This strategy may have contributed to the use of this isomer of citalopram.

Dovobet[®] ointment for stable plaque psoriasis was a licensed combination product of a steroid and calcipotriol. SMC 'not recommended' advice indicated that given its higher costs, value for money was not demonstrated for this product. This product was actively promoted at this time and may have contributed to the pattern of medicine use.

Use after SMC 'not recommended' advice

Of the 20 medicines identified, 10 had subsequent SMC 'accepted for use' (n=6) or 'accepted for restricted use' (n=4) advice issued. The remaining 10 medicines either had no further advice issued (n=4) or had further 'not recommended' advice issued (n=6). This is presented in Figure 2.

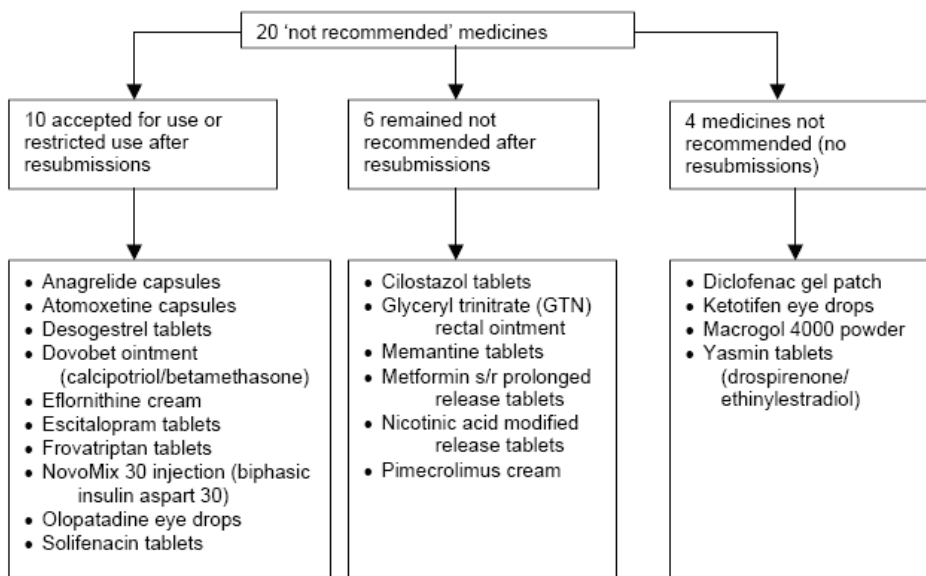


Figure 2: Summary of all SMC advice issued for medicines in the study (n=20)

For the 10 medicines with subsequent SMC ‘accepted for use’ or ‘accepted for restricted use’ advice, the initial ‘not recommended’ advice was issued within 6 months of launch for 80% of medicines. The overall pattern observed for the majority of these medicines was an increase in use following the ‘not recommended’ advice. For the 10 medicines with subsequent SMC accepted for use/accepted for restricted use, this advice was issued within 6 months in 50% of medicines and within 11 months in 70% of medicines. The overall pattern observed for the majority of these medicines was either a stabilising or increase in use.

Table 5 (page 17) presents the 10 medicines where SMC ‘not recommended’ advice remained. Medicine use is described as increasing, decreasing or stabilising. In addition, a review of expenditure and the estimated treated patients for a 12-month period (April 2005– March 2006) is presented, where this is applicable. Approximately £1 million was spent in NHSScotland in 2005–2006 (0.1% of the primary care drugs bill) on these medicines. The top five medicines by expenditure were: Yasmin[®] tablets (45%), memantine tablets (17%), cilostazol tablets (13%), metformin s/r tablets (7%) and Macrogol[®] powder (7%), with medicine use either stabilising or increasing.

Review of the medicine profiles identified four factors that may help to explain some of the patterns in medicines use. Table 4 (page 16) quantifies these factors as applied to all medicines with NHS expenditure >£20,000 for NHSScotland after SMC advice and is supported by the following qualitative information:

Factor: Lack of engagement of relevant clinical experts in early stages of SMC

Yasmin[®] tablets use increased from launch. Use increased from launch of the medicine and continued to increase following SMC ‘not recommended’ advice, issued 11 months after launch. On further investigation, it was identified that the absence of family planning experts amongst those clinical experts

consulted by SMC in the early stages of the developing SMC processes may have influenced the outcome. The licence holder presented no subsequent resubmission.

Factor: Limited use relative to alternative treatments

Use of three medicines was considered under this factor:

- Macrogol[®] powder use stabilised, was minimal in the context of use of osmotic laxatives, and subsequently discontinued by the licence holder in January 2007.
- Metformin s/r tablets represented <0.1% of the total number of items dispensed for metformin in the management of diabetes in 2005–2006.
- Nicotinic acid m/r tablets for the management of dyslipidaemia increased, however expenditure and estimated patient numbers were small for this common clinical condition.

Factor: No alternative licensed products

Use of memantine tablets in the management of moderately severe to severe Alzheimer's disease rose quickly following launch of the medicine, at a time when there were no other licensed medicines available. SMC 'not recommended' advice was issued 10 months from the launch date and subsequent use stabilised but did not decline. This may be partly explained by the identified lack of evidence of an optimal duration of treatment, stated within the SMC advice.

Factor: Variation in advice issued by national bodies to NHS boards and clinicians

SMC 'not recommended' advice for cilostazol tablets in intermittent claudication was issued 20 months following medicine launch. This delay may have contributed to increasing use across NHSScotland, when other medicines for this condition were described as of limited clinical value in the British National Formulary (BNF), the main prescribing handbook used by clinicians. Use continued to rise following subsequent SMC 'not recommended' advice, issued in November 2005. This stated that the efficacy and safety profile in Scottish patients, concomitantly treated with an antiplatelet drug, was unclear. At this time the Scottish Intercollegiate Guidelines Network (SIGN) was preparing guidance on the diagnosis and management of peripheral arterial disease. This guidance, issued in October 2006, recommended the use of cilostazol thus presenting conflicting advice to NHS boards and their ADTCs. This situation provided the stimulus to put in place systems to support dialogue between national bodies issuing advice and provide a clear direction to NHS boards and prescribers on the application of such advice in clinical practice.

Some use of pimecrolimus cream in the treatment of mild to moderate atopic dermatitis was observed prior to initial SMC 'not recommended' advice, issued 2 months from the medicine launch date. Subsequently, use stabilised and remained so following the issue of SMC 'not recommended' advice on two subsequent occasions. At the time of the last SMC advice, the National Institute for Health and Clinical Excellence (NICE) issued advice that recommended the restricted use of pimecrolimus in a sub-population, based on a different economic case from that presented to SMC. This multiple technology assessment superseded SMC advice in NHSScotland, and a small increase in use was observed before

reverting back to the previous baseline. The European Medicines Agency (EMA) issued further safety advice on the use of pimecrolimus in March 2006.

Conclusion

NHS board ADTCs advise clinicians not to prescribe a new medicine prior to SMC advice or following SMC 'not recommended' advice. In the context of the overall primary care drugs bill, expenditure on the study medicines both before and after SMC 'not recommended' advice was small.

Primary care data on the use of medicines are available nationally, however this is not the case for secondary (hospital) care data. Consequently, this study was limited to medicines used mainly in primary care with a single indication, as there are currently no data on individual patient use of medicines nationally available. This lack of data limits our current ability to monitor the use of medicines.

Review of the medicine profiles identified six factors that may help to explain the pattern of medicines use before and after SMC 'not recommended' advice:

- Limited use relative to alternative treatments
- No alternative licensed products
- Delay between UK launch of medicine and initial SMC advice (>9months)
- Influence of pharmaceutical industry marketing strategy
- Variation in advice issued by national bodies to NHS boards and clinicians
- Lack of engagement of relevant clinical experts in early stages of SMC.

These factors are useful in understanding the challenges in the assessment, uptake and monitoring of new medicines in NHSScotland.

SMC seeks to provide advice to NHS boards within three months of launch of a medicine. This appears to be substantiated in this study where more use was observed for medicines when SMC advice was issued further from the launch date. In 2007, 54% of SMC advice was issued within six months of launch of the medicine.

The challenge of providing robust evidence-based advice in a timely manner and ensuring consistency and/or clarity of advice to clinicians is critical. This study identified two occasions where different national bodies provided variable advice within similar timeframes. SMC has used these examples to put in place systems to support dialogue between national bodies and provide a clear direction to NHS boards and clinicians.

Table 2: Summary of medicines for which SMC ‘not recommended’ advice was issued (January 2002–December 2005), where national data available

Medicine	Clinical Condition	British National Formulary (BNF) section
Anagrelide capsules	Thrombocythaemia	Cardiovascular
Atomoxetine capsules	Attention deficit hyperactivity disorder (ADHD)	Central nervous system
Cilostazol tablets	Intermittent claudication	Cardiovascular
Desogestrel tablets	Contraception	Obstetrics, gynaecology and urinary tract disorders
Diclofenac gel patch	Pain from sprains	Musculoskeletal
Dovobet® ointment (calcipotriol/betamethasone dipropionate)	Stable plaque psoriasis	Skin
Eflornithine cream	Facial hirsutism	Endocrine
Escitalopram tablets	Depression	Central nervous system
Frovatriptan tablets	Migraine	Central nervous system
Glyceryl trinitrate (GTN) rectal ointment	Chronic anal fissure	Gastro-intestinal
Ketotifen eye drops	Seasonal allergic conjunctivitis	Eye
Macrogol 4000 powder	Constipation	Gastro-intestinal
Memantine tablets	Alzheimer's disease	Central nervous system
Metformin s/r tablets	Type 2 diabetes	Endocrine
Nicotinic acid m/r tablets	Dyslipidaemia / hypercholesterolaemia	Cardiovascular
NovoMix® 30 injection (biphasic insulin aspart)	Type 1 diabetes	Endocrine
Olopatadine eye drops	Seasonal allergic conjunctivitis	Eye
Pimecrolimus cream	Mild to moderate atopic dermatitis	Skin
Solifenacin tablets	Urge incontinence	Obstetrics, gynaecology, and urinary-tract disorders
Yasmin® tablets (drospirenone/ethinylestradiol)	Contraception	Obstetrics, gynaecology and urinary tract disorders

Table 3: Medicine use before SMC 'not recommended' advice

Medicine	Time from launch of medicine to initial SMC advice (months)	Total GIC from launch to initial SMC advice (£)	Total estimated number of patients treated from launch to initial advice** (n)
Anagrelide capsules	4	£7,754	<10
Atomoxetine capsules	9	£89,039	100-1,000
Cilostazol tablets *	20	£104,214	100-1,000
Desogestrel tablets	5	£7,178	100-1,000
Diclofenac gel patch	4	£1,122	10-100
Dovobet® ointment * (calcipotriol/betamethasone dipropionate)	4	£399,520	>1,000
Eflornithine cream	8	£15,468	100-1,000
Escitalopram tablets *	5	£209,651	>1,000
Frovatriptan tablets	3	£2,006	100-1,000
Glyceryl trinitrate (GTN) rectal ointment	5	£33,489	>1,000
Ketotifen eye drops	19	£22,640	100-1,000
Macrogol 4000 powder	24	£72,368	100-1,000
Memantine tablets *	10	£97,579	100-1,000
Metformin s/r tablets	2	£2,646	100-1,000
Nicotinic acid m/r tablets	5	£2,684	10-100
NovoMix® 30 injection (biphasic insulin aspart)	4	£78,641	100-1,000
Olopatadine eye drops	5	£2,394	100-1,000
Pimecrolimus cream	2	£22,254	100-1,000
Solifenacin tablets	2	£17,725	100-1,000
Yasmin® tablets * (drospirenone/ethinylestradiol)	11	£185,980	> 1,000
	Total	£1,374,352	

GIC – Gross Ingredient Cost

Data source: PRISMS, ISD, Scotland from dispensed items. Excludes private prescriptions

* top 5 by expenditure

**figures relating to patient numbers are estimates based on the Gross Ingredient Cost (GIC). The actual patient base is not known.

Table 4: List of factors that may help to explain patterns of medicine use before and after SMC 'not recommended' advice

Factor *	Use before SMC advice (n=20)	Use after SMC not recommended advice (n=10)
Delay between UK launch of medicines and initial SMC advice (> 9 months)	cilostazol tablets ketotifen eye drops Macrogol [®] powder memantine tablets Yasmin [®] tablets	n/a
Limited use relative to alternative treatments	escitalopram tablets Yasmin [®] tablets atomoxetine capsules	Macrogol [®] powder metformin s/r tablets nicotinic acid m/r tablets
No alternative licensed products	glyceryl trinitrate (GTN) rectal ointment	GTN rectal ointment memantine tablets
Influence of pharmaceutical industry marketing strategy**	escitalopram tablets NovoMix 30 [®] injection Dovobet [®] ointment	
Variation in advice issued by national bodies to NHS boards and clinicians	n/a	cilostazol tablets pimecrolimus cream
Lack of engagement of relevant clinical experts in early stages of SMC	n/a	Yasmin [®] tablets

n/a – not applicable

* factor applied to medicines with expenditure >£20,000 for NHSScotland

**highlighted in feedback form the clinical community

Table 5: Medicine use following SMC ‘not recommended’ advice

Medicine	Medicine use post SMC advice	GIC* April 2005–March 2006	Estimated treated patients** April 2005–March 2006 (n)
Cilostazol tablets *	Increasing	£ 135,944	100-1,000
Diclofenac gel patch	Insufficient data	n/a	N/a
Glyceryl trinitrate (GTN) rectal ointment	Insufficient data	n/a	N/a
Ketotifen eye drops	Decreasing	£ 12,392	100-1,000
Macrogol 4000 powder *	Stabilising	£ 67,577	100-1,000
Memantine tablets*	Stabilising	£ 175,913	100-1,000
Metformin s/r tablets*	Increasing	£ 75,449	100-1,000
Nicotinic acid m/r tablets	Increasing	£20,123	10-100
Pimecrolimus cream	Stabilising	£ 65,584	>1,000
Yasmin® tablets*	Increasing	£ 461,000	>1,000
		Total £1,013,982	

n/a – not available due to timeframe of study,

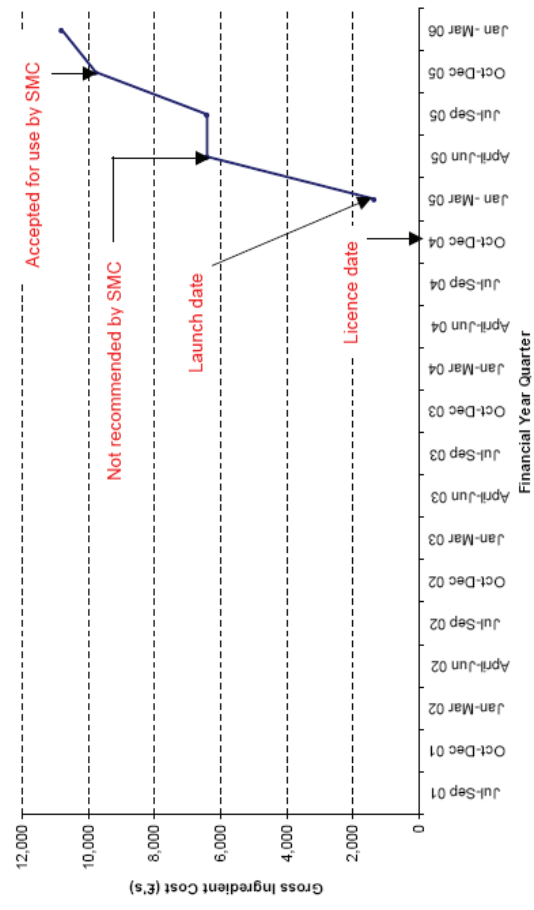
GIC – Gross Ingredient Cost

* top 5 by expenditure, data source: PRISMS, ISD, Scotland from dispensed items. Excludes private prescriptions.

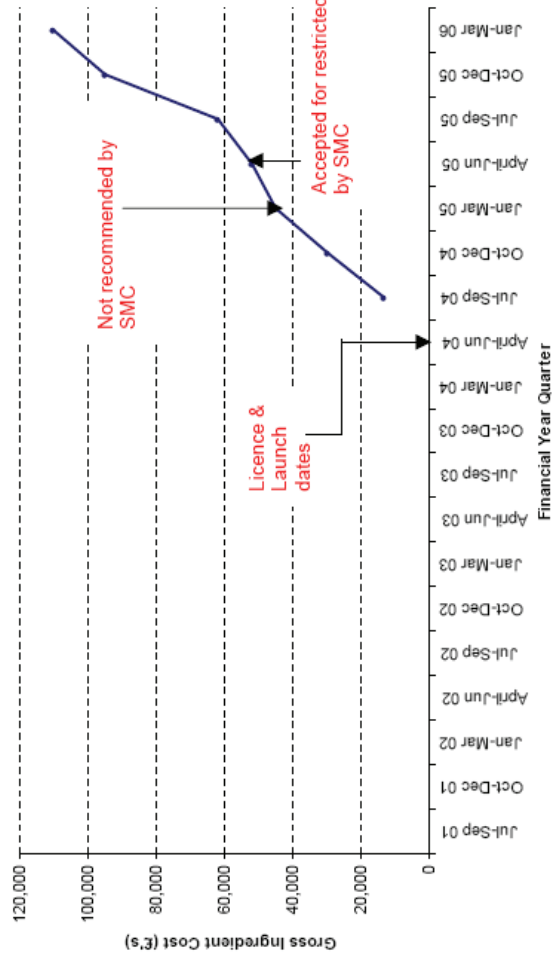
**Figures relating to patient numbers are estimates based on the Gross Ingredient Cost (GIC). The actual patient base is not known

Appendix 1: Medicines utilisation

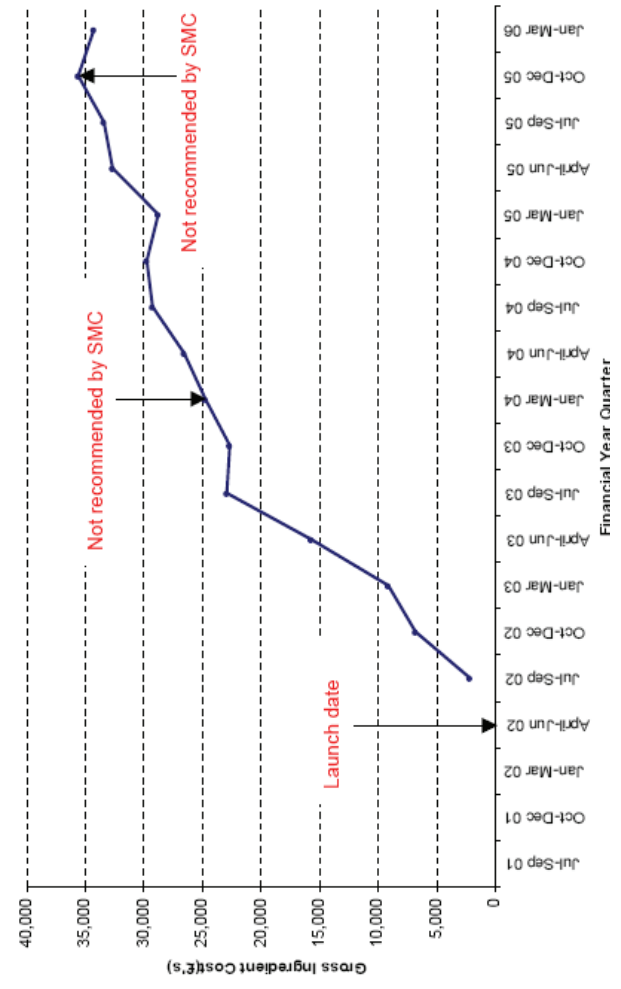
NHS Scotland- Utilisation of Anagrelide 0.5mg capsule (Xagride®) in Primary Care



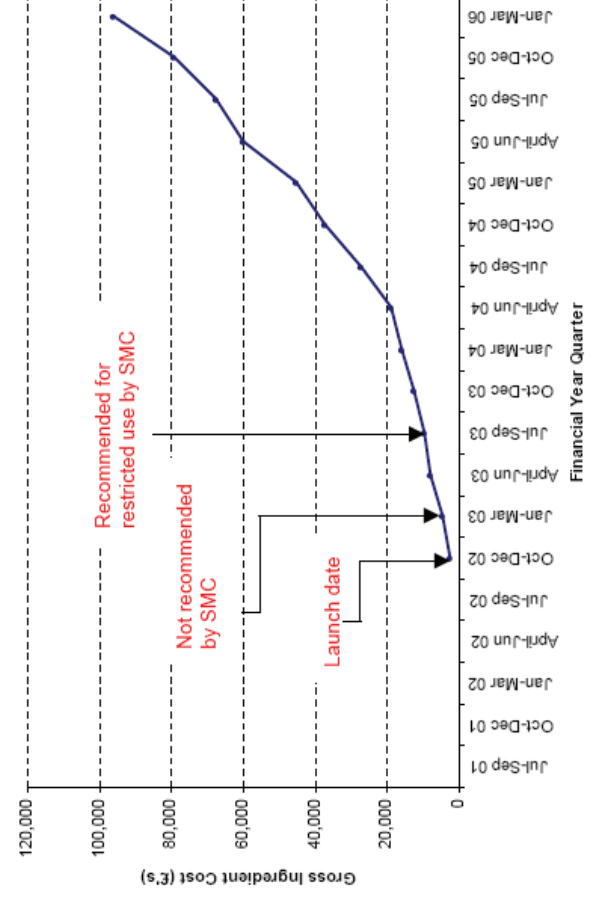
NHS Scotland- Utilisation of Atomoxetine capsules (Strattera®) in Primary Care



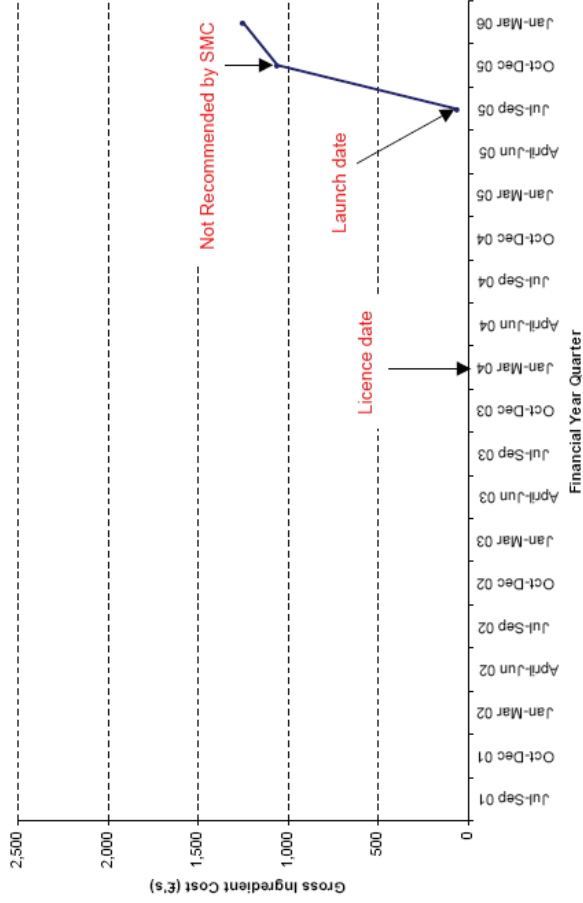
NHS Scotland- Utilisation of Cilostazol (Pletal®) in Primary Care



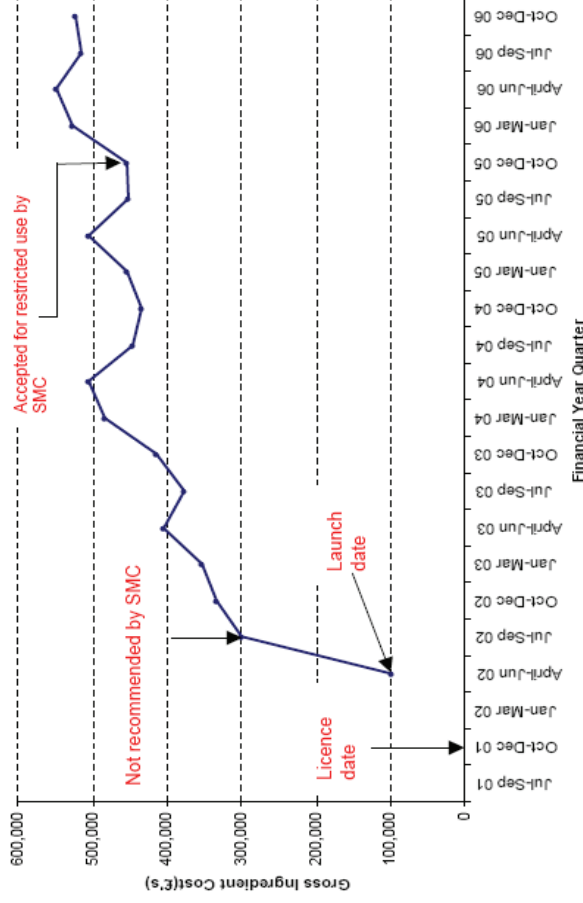
NHS Scotland- Utilisation of Desogestrel (Cerazette®) in Primary Care



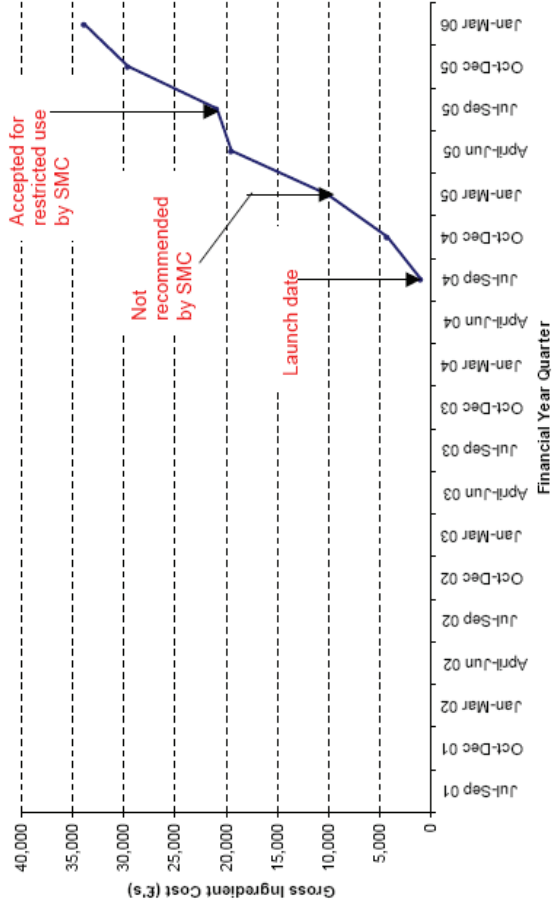
NHS Scotland - Utilisation of Diclofenac 1% gel patches (Voltarol Gel Patch®) in Primary Care



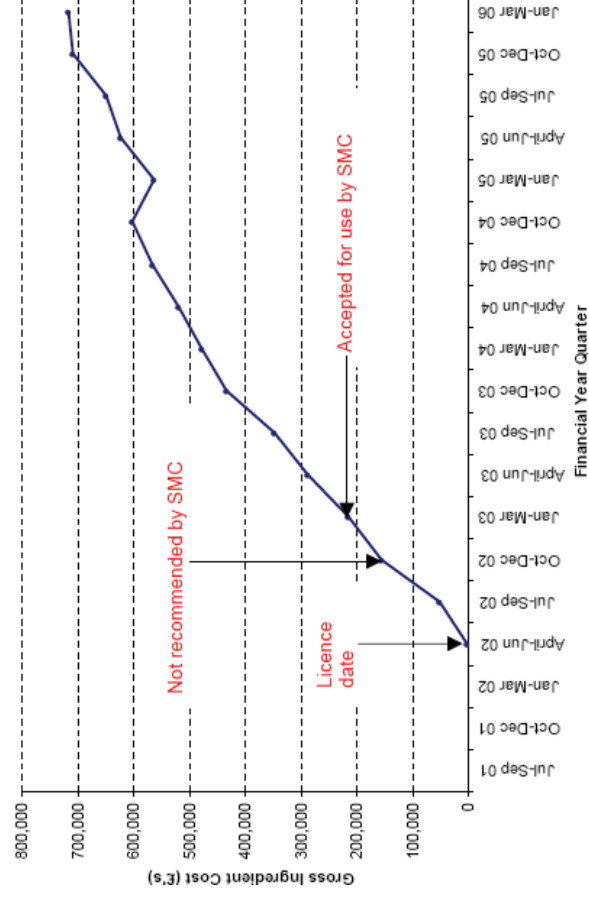
NHS Scotland - Utilisation of Calcipotriol/betamethasone dipropionate (Dovobet®) in Primary Care



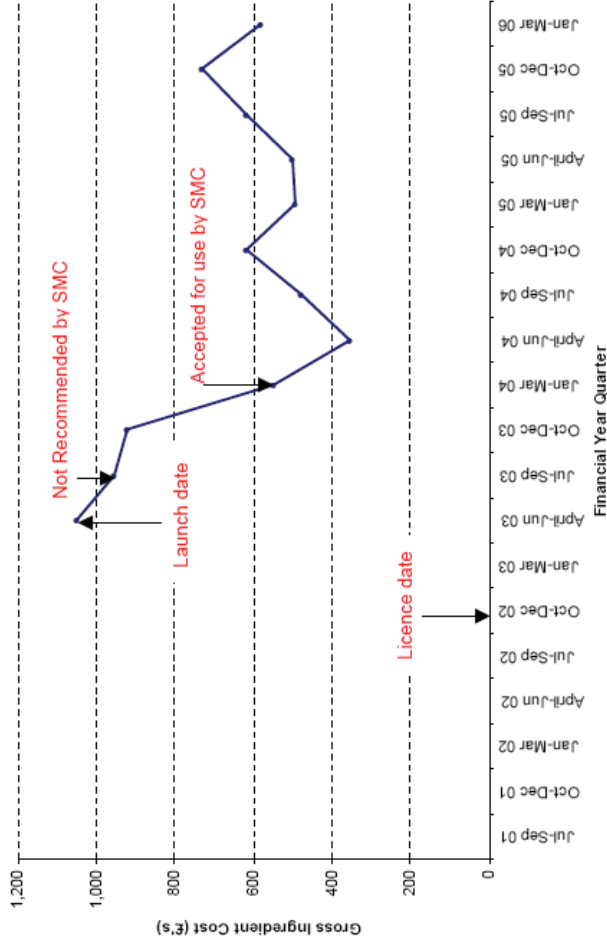
NHS Scotland - Utilisation of Eflornithine (Vaniqa®) cream in Primary Care



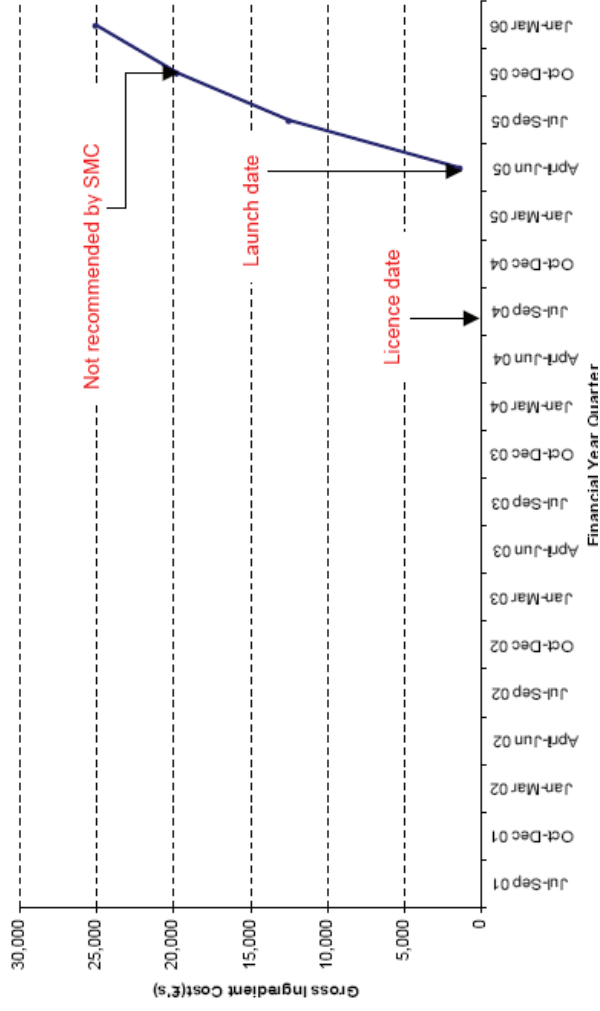
NHS Scotland - Utilisation of Escitalopram (Ciprax®) in Primary Care



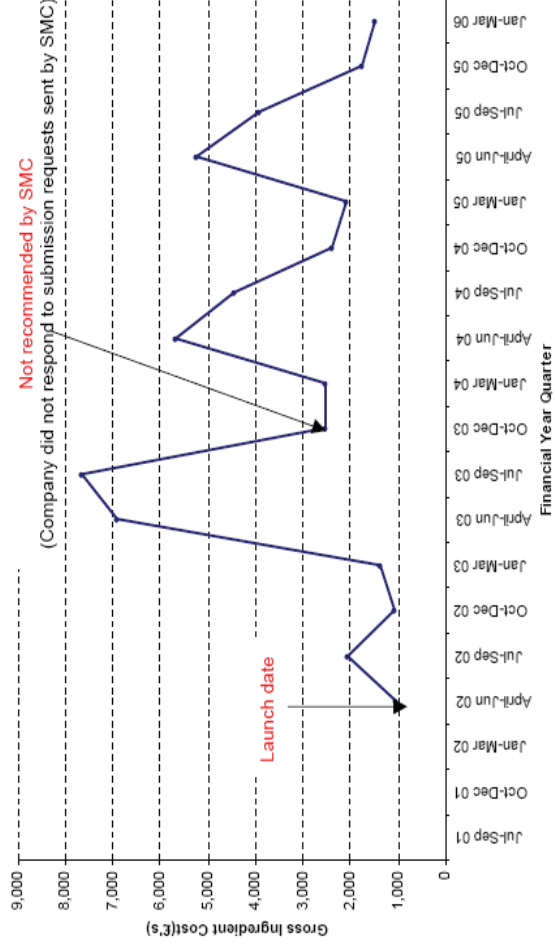
NHS Scotland- Utilisation of Frovatriptan (Migard®) in Primary Care



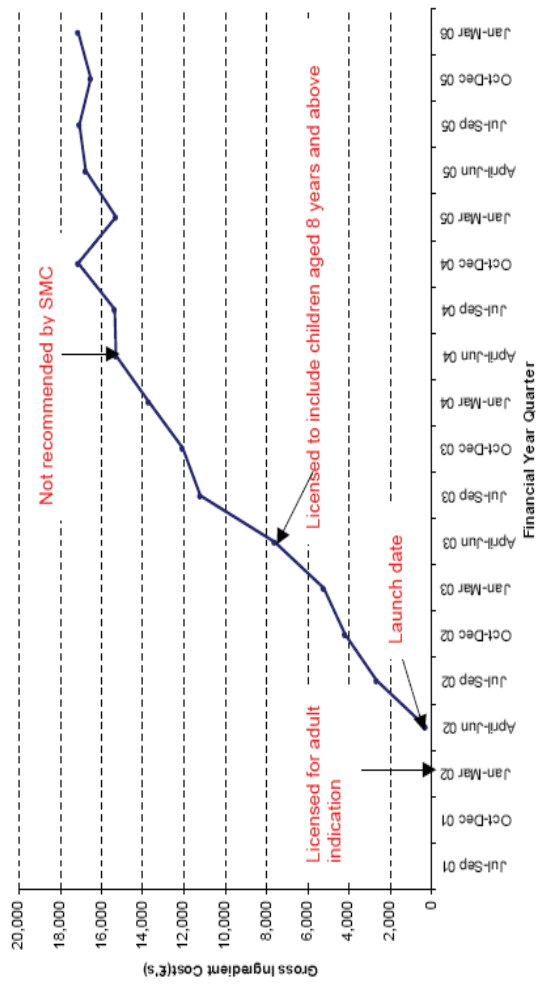
NHS Scotland- Utilisation of Glyceryl trinitrate (GTN), 0.4% w/w (4mg/g) rectal ointment (Rectogesic®) in Primary Care



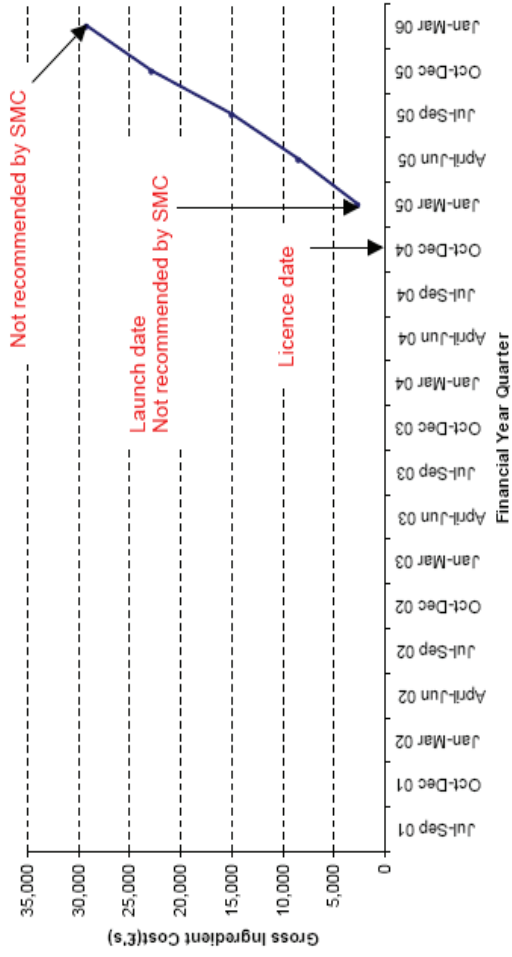
NHS Scotland- Utilisation of Ketotifen hydrogen fumarate (Zaditen®) eye drops in Primary Care



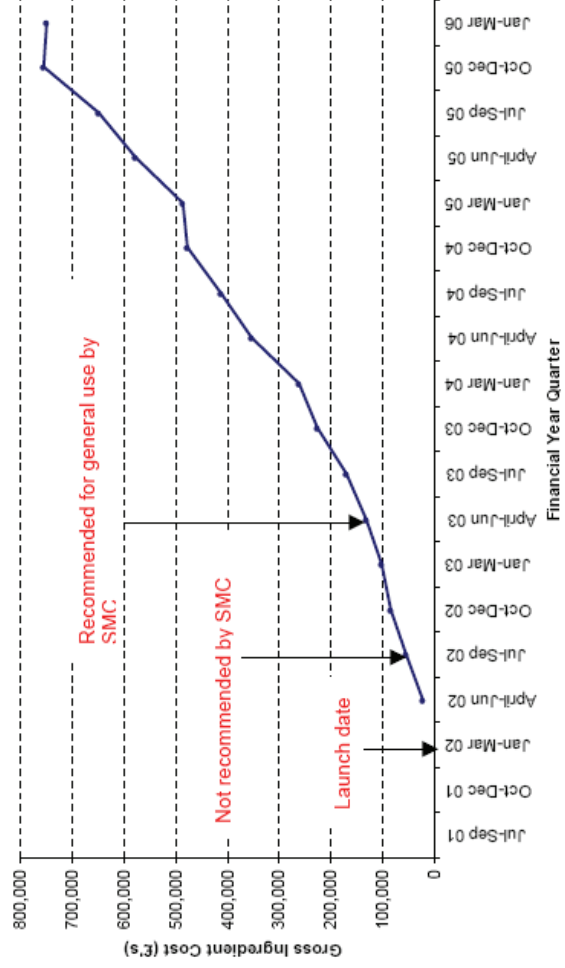
NHS Scotland- Utilisation of Macrogl 4000 (Idrolax®) in Primary Care



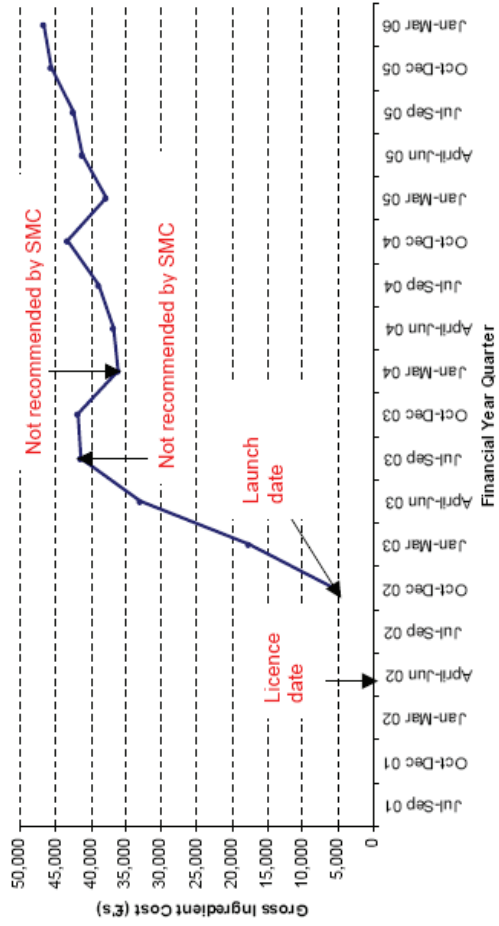
NHS Scotland - Utilisation of Metformin hydrochloride SR tablets (Glucophage® SR) in Primary Care



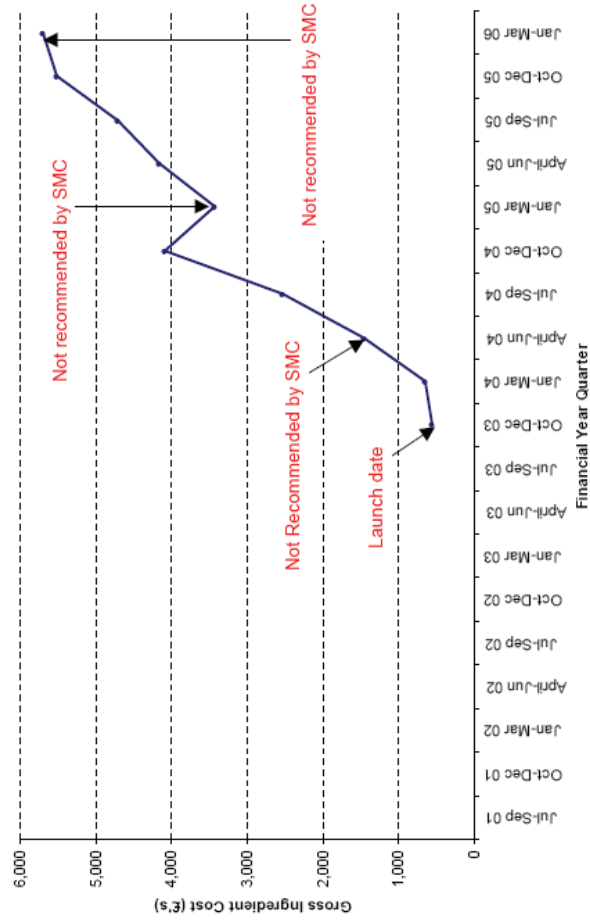
NHS Scotland - Utilisation of Biphasic insulin aspart 30 (NovoMix30) in Primary Care



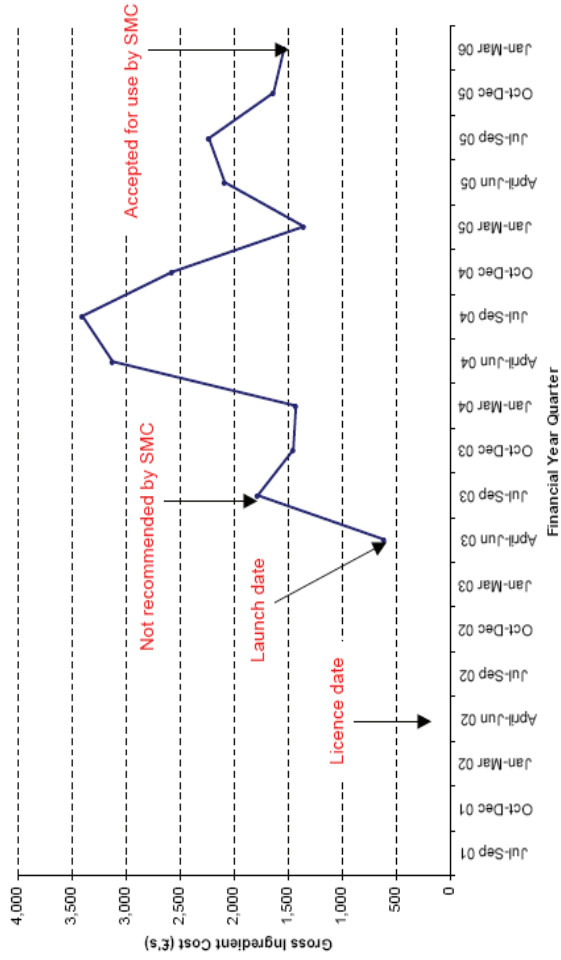
NHS Scotland - Utilisation of Memantine (Ebixa®) tablets 10mg in Primary Care



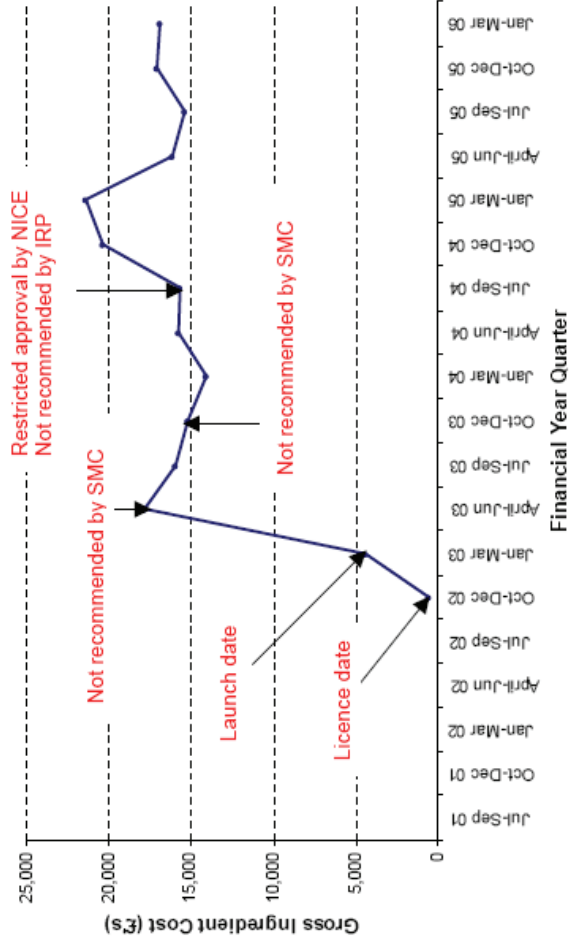
NHS Scotland - Utilisation of Nicotinic acid modified release tablets (Niaspan®) in Primary Care



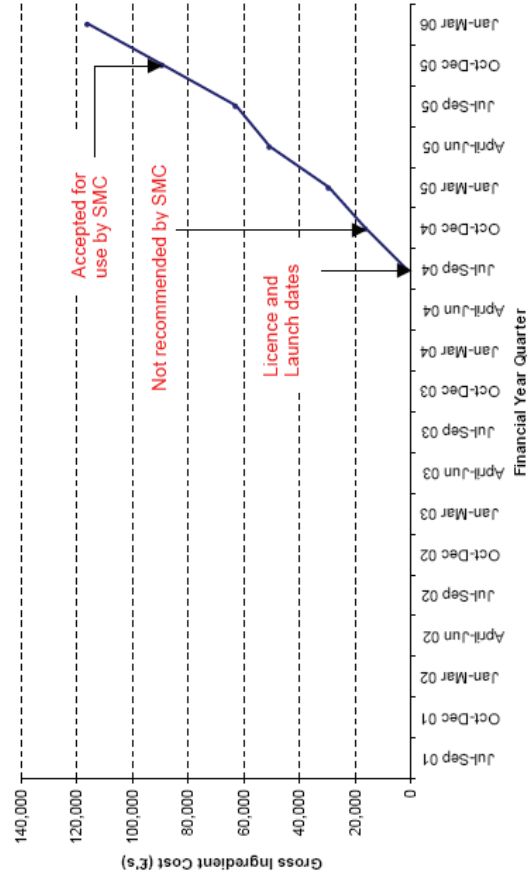
NHS Scotland- Utilisation of Olopatadine 1mg/ml eye drops, solution (Opatanol®) in Primary Care



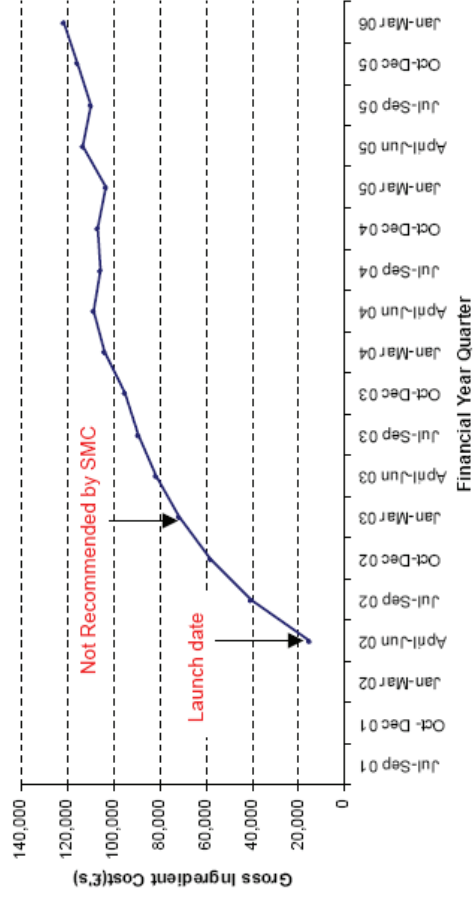
NHS Scotland- Utilisation of Pimecrolimus 1% cream (Eidel®) in Primary Care



NHS Scotland- Utilisation of Solifenacin succinate (Vesicare®) in Primary Care



NHS Scotland- Utilisation of Drospirenone 3mg, ethinylestradiol 30mcg (Yasmin®) in Primary Care



Scottish Medicines Consortium

Delta House, 50 West Nile Street, Glasgow. G1 2NP

Telephone 0141 225 6999/6989

www.scottishmedicines.org.uk