To: General Practitioners & Community Pharmacies for cascade to relevant staff including locums

04 June 2013

Dear Colleague

Longtec® (oxycodone MR tablets) – Implementation in Trusts

Recently, several branded generic preparations of oxycodone modified release (MR) have become available and this letter is to advise that Longtec® has been awarded the secondary care contract in Northern Ireland.

Hospital sites across N Ireland will be actively switching to the Longtec® brand of oxycodone MR. Therefore patients will receive Longtec® as their brand of oxycodone MR during hospital stay and at discharge.

Patients who have their medication switched will have the change explained verbally and via patient leaflet. This information will reinforce risks of duplication with any stock of medicines at home. Discharge documentation to GPs will also be clearly annotated.

It should be emphasised that whilst only a small number of in-patients will be affected initially, this policy will have a longer term impact on primary care prescribing.

General information

Longtec® is available in five strengths (5mg, 10mg, 20mg, 40mg, 80mg). Prescribing information can be found at www.medicines.org.uk

It should be noted that where necessary, patient’s dosage requirements will be made from a combination of Longtec® strengths rather than mixing different brands which have additional strengths commercially available e.g. to facilitate a regimen of 120mg BD, Longtec® 80mg and 40mg strengths will be co-prescribed.

HSCB policy is for modified release controlled drugs to be prescribed by brand name (ref HSCB generic exception list April 13). We recommend that where appropriate, practices prescribe oxycodone MR as the Longtec® brand to avoid confusion and ensure consistency of supply across primary and secondary care.

Action for Practices

- Patients commenced on Longtec® in secondary care should have their GP prescribing records updated to ensure they are maintained on Longtec® following discharge.

- Particular care should be taken to ensure that prescribing records are amended appropriately to avoid duplication of therapy, i.e. other brands/strengths of oxycodone MR should be removed.
• Practices should ensure that when oxycodone (any formulation) is prescribed, the formulation is written as a brand, and **not** prescribed generically.

• Practices may wish to review patients currently taking other brands of MR oxycodone (e.g. Oxycontin®) and consider a switch to the preferred product if clinically appropriate to do so. Any switches made should be fully explained to the patient.

• Management of the transition should pay due regard to individual patients and their needs as well as practical issues such as stock wash out from local community pharmacies.

**Action for Community Pharmacies**

• If presented with a prescription for generic oxycodone MR, the brand required should be confirmed with the patient, or prescriber if necessary, before dispensing to ensure consistency of product supplied.

• Where appropriate, the pharmacist should reinforce the dose of oxycodone to be taken and the risks associated with duplication, especially if there has been a change in the brand or dose prescribed.

Please ensure this information is cascaded to relevant personnel and that all staff taking prescription requests or involved in the dispensing process are aware of this information.

Should you have any queries please contact your Medicines Management Adviser.

Yours sincerely

Mr J Brogan

[Signature]

Asst Director Integrated Care
Pharmacy & Medicines Management

cc
Prescribing Leads for onward cascade to MMTs
Dr Jill Mairs for onward cascade to RPCEG/SGCE members
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