Appendix 1

Non-ARV Medicines in HIV Outpatient Care

Principles for prescribing - October 2014

Background

In addition to antiretroviral medicines, outpatient HIV care and treatment services may need to prescribe medicines for the specific treatment of HIV or HIV associated side effects or adverse reactions.

In the past, the lack of primary care engagement in the care of people with HIV has meant that HIV outpatient services have taken the lead in managing the prescribing needs of people living with HIV. There is currently variation in this area both in terms of clinical practice and in the payment arrangements for such prescribing.

In order to support appropriate clinical governance of medicines management and reduce variation of practice, the HIV Clinical Reference Group has drawn up a list of drugs used in the treatment pathway of people living with HIV and identified the most appropriate prescribing lead to ensure clinical safety and governance. Some HIV services are integrated either with GU medicine or infectious diseases (or there may be joint clinics in place), and so it will be necessary to confirm contract arrangements at local level.

Although a national currency for HIV outpatients has now been mandated, local pricing remains in place. This non ARV list will be used to inform the national pricing for the for HIV outpatient tariff.

The list can also be used by Trusts to guide practice and by Area Teams to agree local pricing, activity reporting and invoicing by Trusts.

Principles for non ARV prescribing in HIV:

1. Safeguarding clinical safety and governance of medicine management is a priority. HIV specialist teams have a role in providing advice to patients and clinical teams to ensure that all prescribers involved in treating patients living with HIV are aware of potentially significant drug-to-drug interactions resulting from antiretroviral treatment. In some cases this will impact on choice and cost.
2. Non-ARVs prescribing may need to occur in outpatient or inpatient settings. These will be drugs to treat HIV related complications of the virus or side effects of ARVs.

3. For all other prescribing, this should be undertaken by the GP or other appropriate clinician for clinical governance reasons, even where costs may be mitigated through home delivery or other options. Clinical safety and governance also mean that the appropriate clinical team or specialist should prescribe for the non HIV needs of people living with HIV.
4. It is important that patients have a GP and that appropriate prescribing is undertaken by them for the benefit of the patient.
5. Where appropriate, shared-care arrangements should be established with a patient's GP so that there is clarity about any potential risks associated with discontinuing treatment or prescribing a less clinically appropriate drug. Including the risk of drug –drug interactions on GP letters is an example of good practice,
6. The drugs groups listed below are those which may be used to treat HIV patients with complications or comorbidities. As this is not intended to be a detailed formulary or drug list, specific drugs are not mentioned.
7. Funding arrangements for non ARVs will depend on prescribing clinician and will vary across ATs. Factors affecting funding will also include whether the drug is a) PbR excluded or not, b) is a commissioning responsibility of NHS England and is on the NHS England published drug list, c) subject to an NHS England commissioning policy, d) used in outpatient, inpatient or day case settings, e) part of local pricing arrangements.
8. Where clinically appropriate to do so, the lowest acquisition cost product should be used.
9. There should be transparency regarding all ARV and non ARV prescribing in outpatient and inpatient care, reporting and invoicing to support appropriate clinical governance and activity validation. Specific arrangements at Trust level will be subject to agreement with the Area Team.
10. Clinically, short term initiation of treatment may be required. Prescriptions should usually be for a maximum of four weeks duration to allow time for referral to the GP for continuation treatment where this is necessary. In some cases, more time may be required to monitor and stabilise a patient and up to three months' supply may be required before discharge to GP can occur. In exceptional circumstances, where the use of monitored dosage system is required, incorporating both ARVs and non-ARVs, supply may be made through the hospital pharmacy or homecare provider.

Actions for Area Teams

Area Teams should discuss this guidance and take the necessary action to amend contract terms with providers to ensure that this improvement in value to patients is achieved. Area Teams to note this will be reflected in work on the development of national tariff.

Suggested lines of enquiry for contract discussions

- Confirm non ARV prescribing in current contract terms / funding
- Establish current clinical practice
- Establish change in practice from baseline to proposed
- Calculate financial adjustment accordingly.

Further advice available from the HIV CRG and Accountable Commissioner: claireforeman@nhs.net

Prescribing of Non-ARV Medicines in HIV				
Indication/Drug Group	**Use or indication**	**Should initiation of prescribing be by the HIV speciality?**	**Should continuation of prescribing be by the HIV speciality?**	**NOTES**
	Is it for the treatment of ARV side effect or HIV specific complication?	***(e.g. for ARV side effects or HIV specific complication)***	***If "no" patients should be referred to their GP***	***Refer to NHS England drugs lits / policies for specific drug to confirm inclusion*** ***Refer to national tariff drug exclusions for specific drugs***
Antivirals - Injectable	Yes - Opportunistic Infection	Yes	Yes - patients need to be monitored to determine when discontinuation is appropriate	Injectable anti-virals, including those administered on a day patient basis, considered part of inpatient arrangements
Antivirals – Oral	Yes	Yes	Yes	
Antifungals – Injectable	Yes	Yes	Yes	Injectable anti-fungals, including those administered on a day patient basis considered part of inpatient arrangements
Antifungals - Oral Only	Yes - opportunistic infection	Yes	Yes for all except terbinafine	
Pneumocystis, Toxoplasmosis - Oral	Yes	Yes	Yes	Atovoquone use only as third line treatment option Injectable drugs are considered part of inpatient arrangements
Antivirals - Herpes	Yes - if severe or recurrent	Yes	Yes	GUM clinic attendances funded by local authorities Aciclovir first choice, then valaciclovir in exceptional cases only
Hepatitis C	No - co-infection	No - specialist ID / hepatobiliary services	No	

Hepatitis B	No - co-infection ~~See note re Truvada~~	No – GU / specialist ID services	No	All antiretrovirals irrespective of indication are funded by NHS England
Anti-Mycobacterial Drugs	Yes	Joint with specialist ID services	Yes	Regular follow-up and monitoring required undertaken by HIV/TB services. Important for effective treatment, management of drug interactions and to ascertain the right time to complete treatment Potential joint management within guideline
Lipid Lowering Drugs	Yes	Yes	No	Initiation and stabilisation by hospital with subsequent referral to GPs. Shared care with GP needed to ensure drug-drug interactions avoided e.g. simvastatin is contraindicated for HIV patients

Indication/Drug Group	Use or indication	Should initiation of prescribing be by the HIV speciality?	Should continuation of prescribing be by the HIV speciality?	NOTES
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Neurological Conditions	Yes	Yes	No	
Erectile Dysfunction	No	No - specialist clinics	No	GPs or through GU, endocrine or urology clinics
Immunoglobulins	No	No - Specialist input only	No	National register
Anabolic Steroids	Yes	No - specialist clinics	No	GPs or through metabolic or endocrine clinics
Antidepressants & Antipsychotics	No - unless patient is unwell at clinic and has efavirenz induced sleep disorder	No - specialist clinics	No	Initiation and stabilisation by hospital (one month supply) for patients who are unwell with subsequent referral to GPs. Guidelines needed to advise GPs and patients of risks associated with potential drug interactions after switching
Imiquimod Cream	No	Yes but only AIN and molluscum	Yes	Prescribing for genital warts should be via GUM Clinics
Other Drug Groups				

Analgesics (including opiates)
Anticonvulsants
Antidiabetics
Antiemetics
Antihistamines
Antihypertensives
Antimicrobials (for simple infections, except for those listed in the main Non-ARVs Table)
Anxiolytics
Bisphosphonates
Emollients and other topical preparations
Endocrine drugs
ENT preparations
Eye Drops
Gastro-intestinal drugs
Hypnotics
Nutrition/supplements
Steroids
Vitamin D

Drugs in the groups listed in this section should not be routinely prescribed on an on-going basis for patients

1. The drugs are not high-cost PbR exclusions.
2. Initiation of prescribing should be by GP or other clinician unless the patient is unwell presenting at HIV clinic.
3. Continuation of prescribing should be through referral to the patient's GP other than in exceptional circumstances where this is not achievable.