Generic Prescribing Position Statement

East Lancashire and BwD Clinical Commissioning Groups want to commission the best treatments for local patients and want the right clinician to have responsibility for those treatments. We want patients to have access to medicines which improve the quality of their care, that have demonstrated safety and cost effectiveness .

Pennine Lancashire Clinical Commissioning Groups are keen to ensure that only treatments that are clinically effective and provide a clear health benefit to patients are prescribed on NHS prescriptions. This is to ensure that East Lancashire and BwD Clinical Commissioning Group resources provide interventions with a proven health gain for the population.
Resultantly, East Lancashire and BwD Clinical Commissioning Groups prioritise resources based on evidence of the clinical effectiveness, the safety of treatments, their cost effectiveness, and on which interventions provide the best health outcomes. All other treatments should be considered as less suitable for prescribing on NHS prescriptions. This supports GMC guidance *'You must make good use of the resources available to you'.*

In 2016-17 East Lancashire Clinical Commissioning Group estimates there is more than £240,000 of potential annual savings from changing patients from unnecessary brand prescribing to generic prescribing. Patients who unreasonably demand branded prescribing are reducing NHS resources for other health services.

When and why is generic prescribing appropriate?

Generic prescribing is the preferred option in the vast majority of cases, on the grounds of cost and the ability to source drugs as generic prescribing allows pharmacists to choose from a range of procurement options.
Within East Lancs and BwD Clinical Commissioning Groups where generic prescribing is more cost effective than brand prescribing prescribers should NOT prescribe brands unless exceptions detailed below - 'when is branded prescribing justified'.

The licensing process for medicines assures bioequivalence between brands and therefore on scientific grounds (with a few notable exceptions) there is no reason why a patient should not be switched from a branded product to the generic equivalent.

There is little robust evidence that switching between different manufacturers of the generic product is clinically significant.

Initiating generic prescribing from the outset removes the need for future review of repeats when brand patents expire and enables cost benefits to be realised faster.

Prescribers should avoid referencing a specific salt within their prescription, as this may lead to a requirement for a brand to be dispensed e.g. amlodipine rather than amlodipine besilate / maleate and this may incur unnecessary cost, with no additional clinical value.

Prescribers should use this information to reinforce the stance of generic prescribing with patients who demand branded option.
It is both East Lancashire and BwD Clinical Commissioning Groups policy that all prescriptions should be prescribed generically unless the exceptions described below apply.

Should legitimate clinical needs require a brand then the brand should be provided on the NHS. Prescribers should be sure that the clinical needs are legitimate and where patients state a generic is not 'as good' or causes unexpected adverse effects should report this to the MHRA.

If a patient requests a particular branded product, despite local NHS policy to prescribe generically, the prescriber must offer the option of an NHS prescription, which should be generically prescribed. If the patient still wishes to have a particular brand , this should be clearly documented in the patient's notes. A private prescription can be written generically and the patient should be informed to request the branded equivalent at the point of dispensing. This negates the need to enter the branded drug onto the patients' clinical notes and thus avoid the risk of the branded product accidentally appearing on subsequent NHS prescriptions. The patient should be informed that the pharmacist will charge them accordingly and the prescriber must NOT levy a charge for the issue of a private prescription under these circumstances. Consistency in prescribing behaviour is paramount to this being fairly implemented across Pennine Lancashire.

When is branded prescribing justified? (Exceptions)

Branded Prescribing is appropriate for:

-True clinical hypersensitivity to any of the excipients in particular product (which applies to branded products also). Such cases tend to be rare and should not have a significant impact on generic prescribing rates.

-Narrow therapeutic index drugs e.g. phenytoin, carbamazepine, ciclosporin and lithium

-Certain modified or extended release products e.g. MR diltiazem, nifedipine, mesalazine

-When there are formulation differences between medicines e.g. transdermal strong opioids are available as fentanyl matrix brand (suitable to be cut) and fentanyl reservoir brands (unsuitable for cutting)

-Certain administration devices e.g. salbutamol dry power inhalers have rather different mechanisms of deployment

-Products of the same drug but with different bioavailability Qvar® v Clenil® beclometasone inhalers

-Multiple ingredient products: oral contraceptives / hormone replacement therapy and emollients

- Difference licensed indications of the same product e.g. Cymbalta®/ Yentreve® (duloxetine)

-Biological rather than chemical medicines e.g. erythropoietin.

-ELMMB approved branded generics