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Items which should not routinely be prescribed in primary care: policy guidance

This policy guidance provides recommendations for items which should not be prescribed in primary care because they are unsafe, ineffective for some or all patients, or are not cost-effective. It is for integrated care boards, other organisations commissioning services, and prescribing healthcare professionals, and updates and replaces the guidance published in June 2019.

Publication (/publication)

Content

This policy guidance is issued as general guidance under s14Z51 of the NHS Act 2006 (https://www.legislation.gov.uk/ukpga/2006/41/section/14Z51) to reduce unwarranted variation, improve patient outcomes and provide value for money for the NHS. It provides recommendations for items which should not routinely be prescribed in primary care because:

- there are significant safety concerns with the item
- there is a lack of robust evidence of clinical effectiveness for the item
- the item is clinically effective but more cost-effective interventions are available
- the item is clinically effective but deemed a low priority for NHS funding.

These items include medicines, devices, food supplements and other treatments.

This guidance is for:

- integrated care boards (ICBs)
- organisations commissioning services.
- prescribing healthcare professionals.

It updates and replaces the guidance published in June 2019. More detail about how this guidance was developed and what has been updated can be found in the frequently asked questions (https://www.england.nhs.uk/long-read/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance-frequently-asked-questions/).

About the recommendations

The policy recommendations are grouped under two categories:

1. Items where no prescribing is appropriate (no exceptions apply).
2. Items where prescribing may be appropriate in some exceptional circumstances.

The following policy recommendations apply to all items in both categories:

- do not initiate in primary care
- deprescribe in patients currently prescribed this item.

The following policy recommendations apply to some items in the second category due to one or more exceptions:

- prescribe only if no other item or intervention is clinically appropriate.
- prescribe only if no other item or intervention is available.
- prescribe only if the item is for an indication named in this guidance.

Additional prescribing guidance is provided for some items, including alternatives and where a multidisciplinary approach is required. Prescribers should also follow local prescribing policies.

The recommendations do not override the individual responsibility of healthcare professionals to support their patients in agreeing the most appropriate treatment options for them through taking a shared decision-making (https://www.england.nhs.uk/personalisedcare/shared-decision-making/) approach.

Policy recommendations

Items where no prescribing is appropriate (that is, no exceptions apply)

Items where no prescribing is appropriate because there are significant safety concerns or there is no evidence of clinical effectiveness for all patient populations.

Recommendations

- Do not initiate in primary care.
- Deprescribe in patients currently prescribed this medicine.

These recommendations apply to:

- co-proxamol
- glucosamine and chondroitin
- herbal treatments and other natural products
- homeopathy
- minocycline for acne
- omega-3 fatty acid compounds (excluding icosapent ethyl [Vazkepa (https://www.nice.org.uk/guidance/TA805)®])
- silk garments.

Further detail, including useful references and the rationale for an item's inclusion, can be found in the Appendix (https://www.england.nhs.uk/long-read/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance/#appendix-further-detail-for-each-item).

Items where prescribing may be appropriate in some exceptional circumstances

For all items, if no other item is clinically appropriate or available it may be appropriate to prescribe following a shared decision-making (https://www.england.nhs.uk/personalisedcare/shared-decision-making/about/) conversation between the prescriber and patient, based on evidence-based good quality information, clinical judgement and the patient's values and preferences.

For some items there are also named exceptional circumstances where it is clinically justifiable to prescribe.

Recommendations (1)

- Do not initiate in primary care.
- Deprescribe in patients currently prescribed this item.
- Prescribe only if no other item or intervention is clinically appropriate.
- Prescribe only if no other item or intervention is available.

These recommendations apply to:

- aliskerin
- bath and shower preparations for dry and pruritic skin conditions:
  - substitute with ‘leave-on’ emollients.
- dosulepin:
  - prescribing decision should be made after a multidisciplinary team discussion
- doxazosin (prolonged release)
- lutein and antioxidants
- oxycodone and naloxone combination product:
  - prescribing decision should be made after a multidisciplinary team discussion
- paracetamol and tramadol combination product
- perindopril arginine
- rubefacients, benzydamine, mucopolysaccharide and cooling products (excluding NSAIDs and capsaicin)
- trimipramine.

Further detail, including useful references and the rationale for an item’s inclusion, can be found in the Appendix (https://www.england.nhs.uk/long-read/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance/#appendix-further-detail-for-each-item).

Recommendations (2)

- Do not initiate in primary care.
- Deprescribe in patients currently prescribed this item.
- Prescribe only if no other item or intervention is clinically appropriate.
- Prescribe only if no other item or intervention is available.
- Prescribe only if for an indication named in this guidance.

These recommendations apply to:

- amiodarone:
  - may be suitable in patients prior and post cardioversion
  - may be suitable in patients who also have heart failure or left ventricular impairment
  - must be initiated by a specialist

    - if a patient is taking amiodarone, implementation of a shared care arrangement is recommended, if not already in place, to ensure safe and appropriate prescribing (see NICE Guideline on atrial fibrillation management (https://www.nice.org.uk/guidance/ng196) and the NHS England shared care protocol Amiodarone for patients within adult services (https://www.england.nhs.uk/publication/shared-care-protocols/))
- dronedarone:
    - may be used for the maintenance of sinus heart rhythm after cardioversion in clinically stable patients with paroxysmal or persistent atrial fibrillation, when alternative treatments are unsuitable
    - must be initiated by a specialist and a shared care arrangement should be used – see NICE Guideline on atrial fibrillation management (https://www.nice.org.uk/guidance/ng196) and the NHS England shared care protocol Dronedarone for patients within adult services (https://www.england.nhs.uk/publication/shared-care-protocols/)
- immediate release fentanyl:
    - the recommendations do not apply to patients undergoing palliative care treatment and where the recommendation to use immediate release fentanyl, in line with the NICE Guideline opioids in palliative care (https://www.nice.org.uk/guidance/CG140), has been made by a multidisciplinary team and/or other healthcare professional with a recognised specialism in palliative care
- lidocaine plasters:
    - the recommendations do not apply to patients who have been treated in line with NICE guidance on chronic pain but are still experiencing neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia) – see NICE guideline Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain (https://www.nice.org.uk/guidance/NG193)
- liothyronine:
    - follow NHS England prescribing advice on liothyronine (https://www.england.nhs.uk/long-read/liothyronine-advice-for-prescribers/) when initiating or reviewing the prescribing of liothyronine
    - the recommendations do not apply to patients who have already been reviewed by an NHS consultant endocrinologist
    - all other patients currently taking liothyronine should be reviewed by an NHS consultant endocrinologist to determine future treatment plans
    - new patients with overt hypothyroidism whose symptoms persist on levothyroxine may be prescribed liothyronine after a 3-month or longer review by an NHS consultant endocrinologist
- needles for pre-filled and reusable insulin pens:

    - these recommendations do not apply when the cost is <£5 per 100 needles
- travel vaccines: only the following vaccines may be administered on the NHS exclusively for the purposes of travel, if clinically appropriate:
    - cholera
    - diphtheria/tetanus/polio
    - hepatitis A
    - typhoid.

Further detail, including useful references and the rationale for an item's inclusion, can be found in the Appendix (https://www.england.nhs.uk/long-read/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance/#appendix-further-detail-for-each-item).

Implementation

ICBs will need to make implementation decisions locally, ensuring they consider their legal duties to advance equality and have regard to reducing health inequalities.

Effective implementation of the policy recommendations requires engagement across primary and secondary care, and development and use of shared care arrangements where appropriate. ICBs should follow guidance on Shared care for medicines (https://www.sps.nhs.uk/wp-content/uploads/2020/01/RMOC-Shared-Care-for-Medicines-Guidance-A-Standard-Approach-Live-1.0.pdf) and Responsibility for prescribing between primary and secondary/tertiary care (https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/).

Support for patients who may request a change to their current prescription is also recommended.

To allow commissioners to monitor prescribing, dashboards showing current prescribing patterns for the items included in this guidance are available to them from NHS Business Services Authority (NHSBSA) in ePACT2 (https://www.nhsbsa.nhs.uk/access-our-data-products/epact2), PrescQIPP (https://www.prescqipp.info/our-resources/data-and-analysis/strategic-activity-reports/low-priority-prescribing/) and OpenPrescribing.net. (https://openprescribing.net/) Data on spend and volume is summarised by item and is available at regional, area team, integrated care system (ICS), primary care network (PCN) and practice level. When monitoring, the clinical exceptions defined in this guidance should be taken into account and care taken to ensure that zero prescribing goals are not used inappropriately.

Appendix: Further detail for each item

Aliskiren (updated 2023)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available.
Named exceptions and further recommendations	None
Category	Items which are clinically effective but more cost-effective products are available, including products that have been subject to excessive price inflation.

Background and rationale	Aliskiren is a direct renin inhibitor; renin converts angiotensinogen to angiotensin. It is indicated for essential hypertension either alone or in combination with other antihypertensives. The patent expired April 2020 but no generics are available yet. NICE states (https://www.nice.org.uk/guidance/ng136) there is insufficient evidence of its effectiveness to determine its suitability for use in resistant hypertension. While aliskiren has shown comparable efficacy to other antihypertensive agents in terms of blood pressure reduction, its effects on mortality and long-term morbidity are currently unknown.

Amiodarone (updated 2023)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available. • Prescribe only if for a named indication in this guidance.

Named exceptions and further recommendations	May be suitable in patients prior and post cardioversion or in specific patients who also have heart failure or left ventricular impairment. Must be initiated by a specialist and only continued under a shared care arrangement for patients where other treatments cannot be used, have failed or is in line with NICE Guidance CG180 (https://www.nice.org.uk/guidance/cg180/resources/atrial-fibrillation-management-pdf-35109805981381). Where there is an existing cohort of patients taking amiodarone who are not currently under shared care, it is recommended that these patients are reviewed to ensure that prescribing remains safe and appropriate and a shared care arrangement is introduced.
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	Treatment of arrhythmias, particularly when other medicines are ineffective or contra-indicated, including paroxysmal supraventricular, nodal and ventricular tachycardias, atrial fibrillation and flutter, ventricular fibrillation and tachyarrhythmias associated with Wolff-Parkinson-White syndrome (initiated in hospital or under specialist supervision). Amiodarone has an important place in the treatment of severe cardiac rhythm disorders where other treatments either cannot be used or have failed. It has potential major toxicity and its use requires monitoring both clinically and via laboratory testing. NICE guidance on atrial fibrillation puts greater emphasis on rate rather than rhythm control, and has clarified the place of amiodarone in the treatment pathway. NICE has issued the following ‘do not do’ recommendation: **Do not offer amiodarone for long-term rate control.**

Further resources and guidance for ICBs and healthcare professionals	NICE NG196: Atrial fibrillation: diagnosis and management (https://www.nice.org.uk/guidance/ng196) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets) RMOC: Shared care for medicines guidance (https://www.sps.nhs.uk/articles/rmoc-shared-care-guidance/) SPS National shared care protocol: Amiodarone for patients within adult services (https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2022%2F07%2FB1612_i_amiodarone-for-patients-within-adult-services.docx&wdOrigin=BROWSELINK)

Bath and shower preparations for dry and pruritic skin conditions (updated 2023)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available.

Named exceptions and further recommendations	Substitute with leave-on emollients.
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.
Background and rationale	NICE guidance (https://www.nice.org.uk/guidance/cg57) recommends that emollient bath additives should not be offered to children under the age of 12 for the management of atopic eczema, because they are not clinically- or cost-effective. 'Leave-on' emollient moisturisers can still be used for treating eczema. These emollients can also be used as a soap substitute. It is recognised that this recommendation applies only to children; however, it was agreed that it is acceptable to extrapolate this recommendation to apply to adults until other good quality evidence emerges.

Further resources and guidance for ICBs and healthcare professionals	Specialist Pharmacy Service bath and shower preparations evidence review (https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-evidence-reviews/) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Co-proxamol (updated 2023)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine.
Named exceptions and further recommendations	None
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	The Medicines and Healthcare products Regulatory Agency (MHRA) (https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency/about) fully withdrew the painkiller co-proxamol from the UK market in 2007 due to safety concerns. All use in the UK is now on an unlicensed basis. Prescribing an unlicensed medicine should be in line with General Medical Council (GMC) guidance (Good practice in prescribing and managing and devices, 2021 (https://www.gmc-uk.org/-/media/documents/prescribing-guidance-before-cie_pdf-85261358.pdf#:~:text=Good%20practice%20in%20prescribing%20and%20managing%20medicines%20and,satisfied%20that%20the%20medicine%20serves%20your%20patient%E2%80%99s%20need.)), which states suitably licensed alternatives need to be considered and the prescriber must be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy. Since 1985 advice aimed at the reduction of co-proxamol toxicity and fatal overdose has been provided, but this was not effective and resulted in withdrawal of co-proxamol by the MHRA (https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency/about). In 2011 MHRA reported that the withdrawal of co-proxamol from the UK had saved an estimated 300 to 400 lives each year from self-

	poisoning, around a fifth of which would have been accidental. Since the withdrawal, further safety concerns have been raised, resulting in co-proxamol being withdrawn in other countries. Due to the significant safety concerns, the joint clinical working group considered co-proxamol suitable for inclusion in this guidance. Co-proxamol is no longer manufactured or supplied in the UK and any use on an unlicensed basis requires it to be imported for individual use, at an increasing cost to the NHS and the environment. The average cost per item is £265 (January 2022), which is an increase of £44 since 2021.

Further resources and guidance for ICBs and healthcare professionals	MHRA Drug Safety Update: November 2007 (https://www.gov.uk/drug-safety-update/co-proxamol-withdrawal-reminder-to-prescribers), January 2011 (https://www.gov.uk/drug-safety-update/-dextro-propoxyphene-new-studies-confirm-cardiac-risks) PrescQIPP CIC Drugs to review for optimised prescribing – co-proxamol (https://www.prescqipp.info/resources/category/90-co-proxamol) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets) NICE NG215: Medicines associated with dependence or withdrawal symptoms (https://www.nice.org.uk/guidance/ng215) NHS England Optimising personalised care for adults prescribed medicines associated with dependence of withdrawal symptoms (https://www.england.nhs.uk/long-read/optimising-personalised-care-for-adults-prescribed-medicines-associated-with-dependence-or-withdrawal-symptoms/)

Dosulepin (2017)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available. • Prescribe only if the decision has been made after a multidisciplinary team discussion.
Named exceptions and further recommendations	None
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	Dosulepin, formerly known as dothiepin, is a tricyclic antidepressant. NICE guidance on depression in adults has a ‘do not do’ recommendation: Do not switch to, or start, dosulepin because evidence supporting its tolerability relative to other antidepressants is outweighed by the increased cardiac risk and toxicity in overdose. Due to the significant safety concerns advised by NICE, the joint clinical working group considered dosulepin suitable for inclusion in this guidance.
Further resources and guidance for ICBs and healthcare professionals	NICE CG90: Depression in Adults (https://www.nice.org.uk/Guidance/CG90)PrescQIPP CIC Drugs to Review for Optimised Prescribing – Dosulepin (https://www.prescqipp.info/resources/category/313-dosulepin-drop-list) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Doxazosin (prolonged release) (also known as doxazosin modified release) (2017)

Recommendation	• Do not initiate in primary care. • Deprescribe in patients currently prescribed this item. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available.
Named exceptions and further recommendations	None
Category	Items which are clinically effective but more cost-effective products are available, including products that have been subject to excessive price inflation.

Background and rationale	Doxazosin is an alpha-adrenoceptor blocking drug that can be used to treat hypertension and benign prostatic hyperplasia. There are two oral forms of the medication (immediate release and prolonged release) and both are taken once daily. Prolonged-release doxazosin costs approximately six times more than doxazosin immediate release (NHS Drug Tariff (https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff)). NICE guidance on hypertension recognises that doxazosin should be used in treatment but does not identify any benefits of prolonged release over immediate release. NICE guidance recommends doxazosin as an option in men with moderate to severe lower urinary tract symptoms. It does not identify benefits of prolonged release over immediate release. Due to the significant extra cost of prolonged-release doxazosin and the availability of once daily immediate-release doxazosin, the joint clinical working group considered prolonged-release doxazosin suitable for inclusion in this guidance.

Further resources and guidance for ICBs and healthcare professionals	NICE CG127 Hypertension in adults: diagnosis and management (https://www.nice.org.uk/guidance/cg127/resources/hypertension-in-adults-diagnosis-and-management-pdf-35109454941637) NICE CG97 Lower urinary tract symptoms in men (https://www.nice.org.uk/guidance/cg97/resources/lower-urinary-tract-symptoms-in-men-management-pdf-975754394053) PrescQIPP CIC Drugs to review for optimised prescribing – prolonged release doxazosin (https://www.prescqipp.info/resources/category/55-doxazasin) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Dronedarone (2019)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available.

Named exceptions and further recommendations	Must be initiated by a specialist and only continued under a shared care arrangement for patients where other treatments cannot be used, have failed or is in line with NICE guidance on atrial fibrillation.
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	Dronedarone is used for the maintenance of sinus heart rhythm after cardioversion in clinically stable patients with paroxysmal or persistent atrial fibrillation, when alternative treatments are unsuitable (initiated under specialist supervision). Dronedarone was originally approved to prevent atrial fibrillation from coming back or to lower the heart rate in adults who have had or have non-permanent atrial fibrillation. In September 2011 this indication was restricted to the maintenance of normal heart rhythm in 'persistent' or 'paroxysmal' atrial fibrillation after normal heart rhythm has been restored. This followed a review of data that became available since its authorisation, including data from the PALLAS study (https://www.nejm.org/doi/full/10.1056/nejmoa1109867). NICE guidance puts greater emphasis on rate rather than rhythm control and clarifies the place of dronedarone in the treatment pathway.

Further resources and guidance for ICBs and healthcare professionals	NICE NG196 Atrial fibrillation: diagnosis and management (https://www.nice.org.uk/guidance/ng196) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets) NHS England, Responsibility for prescribing between Primary & Secondary/Tertiary Care (https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf) SPS National shared care protocol: Dronedarone for patients within adult services (https://www.england.nhs.uk/publication/shared-care-protocols/#heading-6)

Immediate release fentanyl (updated 2023)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available. • Prescribe only if for a named indication in this guidance.

Named exceptions and further recommendations	These recommendations do not apply to patients undergoing palliative care treatment and where the recommendation to use immediate-release fentanyl in line with NICE guidance (see below) has been made by a multidisciplinary team and/or other healthcare professional with a recognised specialism in palliative care.
Category	Items are clinically effective but more cost-effective products are available, including products that have been subject to excessive price inflation.

Background and rationale	Fentanyl is a strong opioid analgesic. It is available as an immediate-release substance in various dosage forms; tablets, lozenges, films and nasal spray. Immediate-release fentanyl is licensed for the treatment of breakthrough pain in adults with cancer who are already receiving at least 60mg oral morphine daily or equivalent. NICE CG140 Opioids in palliative care (https://www.nice.org.uk/guidance/CG140) states: “Do not offer fast-acting fentanyl as first-line rescue medication”. This recommendation does not apply to longer sustained release versions of fentanyl, which come in patch form. Due to the recommendations from NICE and immediate-release fentanyl only being licensed for use in cancer, the joint clinical working group considered immediate-release fentanyl was suitable for inclusion in this guidance with specific exceptions for people receiving palliative care, reflecting NICE and the terms of the product licence. The recommendations also reflect findings from the PHE Prescribed Review (September 2019 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/940255/PHE_PMR_report_Dec2020.pdf)), which outlined the risks of prescribing that can cause dependence or withdrawal and could cause problems for people

	taking them or coming off them, especially those who have been taking them for a long time.

Further resources and guidance for ICBs and healthcare professionals	Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid for pain (https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware) [accessed October 2022] PrescQIPP CIC Drugs to review for optimised prescribing – immediate release fentanyl (https://www.prescqipp.info/resources/category/51-fentanyl) Faye's story: good practice when prescribing opioids for chronic pain (https://www.england.nhs.uk/patient-safety/fayes-story-good-practice-when-prescribing-opioids-for-chronic-pain/) [accessed October 2022] Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets) NICE NG215: Medicines associated with dependence or withdrawal symptoms (https://www.nice.org.uk/guidance/ng215) NHS England Optimising personalised care for adults prescribed medicines associated with dependence of withdrawal symptoms (https://www.england.nhs.uk/long-read/optimising-personalised-care-for-adults-prescribed-medicines-associated-with-dependence-or-withdrawal-symptoms/)

Glucosamine and chondroitin (2017)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine.
Named exceptions and further recommendations	None
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	Glucosamine and chondroitin are nutraceuticals used to improve pain associated with osteoarthritis. The BNF (https://bnf.nice.org.uk/drug/glucosamine.html) states: “The mechanism of action is not understood and there is limited evidence to show it is effective”. NICE guidance on osteoarthritis care and management has the following ‘do not do; recommendation: Do not offer glucosamine or chondroitin products for the management of osteoarthritis. Due to the recommendation from NICE and the lack of evidence as advised by the BNF, the joint clinical working group considered glucosamine and chondroitin suitable for inclusion in this guidance.
Further resources and guidance for ICBs and healthcare professionals	NICE CG177: Osteoarthritis care and management (https://www.nice.org.uk/guidance/cg177/resources/osteoarthritis-care-and-management-pdf-35109757272517) PrescQIPP CIC Drugs to Review for Optimised Prescribing – Glucosamine (https://www.prescqipp.info/resources/category/373-glucosamine) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Herbal treatments and other natural products (updated 2023)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine.
Named exceptions and further recommendations	None
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	Under a traditional herbal registration (THR) there is no requirement to prove scientifically that a product works; the registration is based on longstanding use of the product as a traditional medicine. Due to the lack of scientific evidence required to register these products with the MHRA, the joint clinical working group felt that they were suitable for inclusion in this guidance. In addition to herbal treatments with a THR, other natural products without robust evidence of clinical effectiveness should not be prescribed at NHS expense and fall within these recommendations. These products do not have a THR, are not recognised as supplements in the NHS Drug Tariff and do not appear as in the BNF. These include: • natural oils, eg eucalyptus and almond • coenzyme Q10 (ubiquinone and ubidecarenone) • evening primrose (gamolenic acid). MHRA withdrew the licence for 2-gamolenic acid preparations in 2002 due to a lack of evidence of efficacy.

Further resources and guidance for ICBs and healthcare professionals	GOV.UK Traditional herbal medicines : registration form and guidance (https://www.gov.uk/government/collections/traditional-herbal-medicines-registration-form-and-guidance) GOV.UK Herbal medicines granted a traditional herbal registration (THR) (https://www.gov.uk/government/publications/herbal-medicines-granted-a-traditional-herbal-registration-thr) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Homeopathy (2017)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine.
Named exceptions and further recommendations	None
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	Homeopathy seeks to treat patients with highly diluted substances that are administered orally. During the consultation we received a range of submissions pertaining to homeopathy and it was deemed necessary to have a further review to include the up to date evidence; this was conducted by the Specialist Pharmacy Service. This review found no clear or robust evidence to support the use of homeopathy on the NHS.
Further resources and guidance for ICBs and healthcare professionals	Specialist Pharmacy Service homeopathy evidence review (https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-evidence-reviews/) GOV.UK Register a homeopathic medicine or remedy (https://www.gov.uk/guidance/register-a-homeopathic-medicine-or-remedy) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Lidocaine plasters (updated 2023)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available. • Prescribe only if for a named indication in this guidance.
Named exceptions and further recommendations	Prescribe to patients who have been treated in line with NICE guidance on chronic pain but are still experiencing neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia, PHN). Prescribe only if the decision has been made after a multidisciplinary team discussion.
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	Lidocaine plasters are licensed for symptomatic relief of neuropathic pain associated with previous herpes zoster infection (PHN) in adults. NICE guidance on chronic pain does not recommend lidocaine plasters for treating neuropathic pain. The joint clinical working group also considered a PrescQIPP CIC review (https://www.prescqipp.info/-lidocaine-plasters/send/54-lidocaine-plasters/852-bulletin-51-lidocaine-plasters), and during the consultation more evidence was provided and an up to date evidence summary was deemed necessary and prepared by the Specialist Pharmacy Service to inform the joint clinical working group's recommendations. Based on this review, lidocaine plasters can be prescribed only for patients who are intolerant of first-line systemic therapies for PHN or where these therapies have been ineffective. Lidocaine plasters are not an alternative to an opioid-based medicine when concerned about dependence and withdrawal.

Further resources and guidance for ICBs and healthcare professionals	NICE Clinical Knowledge Summaries – post-herpetic neuralgia (https://cks.nice.org.uk/post-herpetic-neuralgia#!scenario) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets) Specialist Pharmacy Service lidocaine plasters evidence review (https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-evidence-reviews/) NICE NG193: Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain (https://www.nice.org.uk/guidance/NG193)

Liothyronine (including Armour Thyroid and liothyronine combination products) (updated 2025)

Recommendation	• Do not initiate in primary care. • Initiations can be made in secondary care in line with NHS Liothyronine – advice for prescribers (https://www.england.nhs.uk/long-read/liothyronine-advice-for-prescribers/). • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available. • Prescribe only if for a named indication in this guidance.
Named exceptions and further recommendations	Follow NHS England prescribing advice on liothyronine when initiating or reviewing the prescribing of liothyronine.
Category	Items which are clinically effective but more cost-effective products are available, including products that have been subject to excessive price inflation.

Background and rationale	Liothyronine (sometimes known as T3) is used to treat hypothyroidism. It has a similar action to levothyroxine but is metabolised faster and has a quicker effect. It is sometimes used in combination with levothyroxine in products. Prior to 2017, the price (NHS Drug Tariff (https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff)) of liothyronine rose significantly and there is limited evidence for efficacy above levothyroxine for most patients. Since 2017, the price of liothyronine has fallen but it is still significantly higher than the price of levothyroxine tablets. The British Thyroid Association (BTA) and Society for Endocrinologists 2023 joint consensus statement (https://onlinelibrary.wiley.com/doi/full/10.1111/cen.14935) states “There is no convincing evidence to support routine use of thyroid extracts, L-T3 monotherapy, compounded thyroid hormones, iodine containing preparations, dietary supplementation and over the counter (OTC) preparations in the management of hypothyroidism”. Due to the significant costs associated with liothyronine and the limited evidence to support its routine prescribing in preference to levothyroxine, the joint clinical working group considered liothyronine suitable for inclusion in this guidance. However, during the consultation, we

	heard and received evidence about a cohort of patients who require liothyronine, and the clinical working group felt it necessary to include some exceptions based on guidance from the BTA. These exceptions are clarified in the NHS England Liothyronine – advice for prescribers (https://www.england.nhs.uk/long-read/liothyronine-advice-for-prescribers/). NHS England and the British Thyroid Association (BTA) advise that a small proportion of patients treated with levothyroxine continue to have symptoms despite adequate biochemical correction. Liothyronine may be appropriate for these patients. Where symptoms persist on levothyroxine, and in line with NHS England and BTA prescribing advice on liothyronine, endocrinologists providing NHS services may initiate liothyronine for new patients after a carefully audited trial of liothyronine lasting at least 3 months. For patients currently prescribed liothyronine who have not already had a review, an NHS consultant endocrinologist should review them to consider switching to levothyroxine where clinically appropriate. Prescriptions for individuals already receiving liothyronine should continue until that review has taken place. Liothyronine is used for patients with thyroid cancer, in preparation for radioiodine ablation, iodine scanning or stimulated thyroglobulin test. In these situations, it is appropriate for

	patients to obtain their prescriptions from the centre undertaking the treatment and not routinely obtained from primary care prescribers.
Further resources and guidance for ICBs and healthcare professionals	NICE NG145: Thyroid disease: assessment and management (https://www.nice.org.uk/guidance/ng145) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Lutein and antioxidants (updated 2023)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine • Only prescribe if no item or intervention is clinically appropriate • Only prescribe if no item or intervention is available .
Named exceptions and further recommendations	None

Category	**Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.**

Background and rationale	The supplements lutein and antioxidants (e.g. vitamin A, C, E and zinc) are sometimes recommended for age-related macular degeneration (AMD). A variety of supplements are available to purchase in health food stores and other outlets where they are promoted to assist with 'eye health'. Two Cochrane reviews have been conducted on this topic: 1. Antioxidant vitamin and mineral supplements for preventing age-related macular degeneration (https://www.cochrane.org/CD000253/EYES_antioxidant-vitamin-and-mineral-supplements-prevent-development-age-related-macular-degeneration-amd). The authors conclude: "There is accumulating evidence that taking vitamin E or beta-carotene supplements will not prevent or delay the onset of AMD. There is no evidence with respect to other antioxidant supplements, such as vitamin C, lutein and zeaxanthin, or any of the commonly marketed multivitamin combinations". 2. Antioxidant vitamin and mineral supplements for slowing the progression of age-related macular degeneration. (https://www.cochrane.org/CD000254/EYES_antioxidant-vitamin-and-mineral-supplements-slow-down-progression-age-related-macular-degeneration) The authors conclude: "People with AMD may experience delay in progression of the disease

	with antioxidant vitamin and mineral supplementation. This finding is drawn from one large trial conducted in a relatively well-nourished American population. The generalisability of these findings to other populations is not known". PrescQIPP CIC has issued a bulletin (https://www.prescqipp.info/-lutein-and-antioxidant-vitamins/send/133-lutein-and-antioxidant-vitamins/1706-bulletin-86-lutein-and-antioxidant-vitamins-drop-list) that did not find evidence to support prescribing of lutein and antioxidants routinely on the NHS. NICE guidance on AMD includes a recommendation for research on the effectiveness and cost-effectiveness of lutein and antioxidants, which is currently a gap in the research.

Further resources and guidance for ICBs and healthcare professionals	PrescQIPP CIC Drugs to review for optimised prescribing – lutein and antioxidants (https://www.prescqipp.info/-lutein-and-antioxidant-vitamins/category/133-lutein-and-antioxidant-vitamins) NICE NG82: Age-related macular degeneration (https://www.nice.org.uk/guidance/ng82) Royal College of Ophthalmologists – AMD commissioning guidance (https://www.rcophth.ac.uk/resources-listing/commissioning-guidance-age-related-macular-degeneration-services/) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Minocycline for acne (2019)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine.
Named exceptions and further recommendations	None

Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.
Background and rationale	Minocycline is a tetracycline antibiotic that can be used for many indications. In primary care it is mainly used for acne. There are various safety risks associated with its use. NICE guidance on acne vulgaris management advises: “Minocycline is not recommended for use in acne as it is associated with an increased risk of adverse effects such as drug-induced lupus, skin pigmentation and hepatitis.” A PrescQIPP CIC review found no evidence to support the use of one tetracycline over another in terms of efficacy for the treatment of acne vulgaris, and alternative once daily products are available.
Further resources and guidance for ICBs and healthcare professionals	NICE NG198: Acne vulgaris: management (https://www.nice.org.uk/guidance/ng198/chapter/Recommendations) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Needles for pre-filled and reusable insulin pens (2019)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available. • Prescribe only if for a named indication in this guidance.
Named exceptions and further recommendations	These recommendations do not apply to insulin pen needles that cost <£5 per 100 needles.
Category	Items which are clinically effective but more cost-effective products are available, including products that have been subject to excessive price inflation.

Background and rationale	Pen needles are available in sizes from 4mm to 12mm and cost from £3.95 to £30.08 for 100 (NHS Drug Tariff). Different needles will fit different pens, but some fit all major insulin delivery pen devices currently available. Rationalising use ensures that the most cost-effective options are used first line. The Forum for Injection Technique (FIT) UK (http://fit4diabetes.com/united-kingdom/) considers the 4mm needle to be the **safest** pen needle for adults and children, regardless of age, gender and body mass index (BMI). Using shorter length needles helps prevent intramuscular injection of insulin. (IM injection of insulin can result in unpredictable blood glucose levels.) Therefore, the most cost-effective 4mm needle should be chosen. For patients currently using longer pen needle lengths (8mm, 12mm), changing to a shorter length (6mm or less) is advised, but only after discussion with a healthcare professional to ensure they receive advice on the correct injection technique. For patients who cannot self-administer, it may be appropriate for the healthcare professional to use a safety needle; however, this would not need to be supplied on prescription.

Further resources and guidance for ICBs and healthcare professionals	PrescQIPP CIC Drugs to review for optimised prescribing – needles for pre-filled and reusable insulin pens (https://www.prescqipp.info/our-resources/bulletins/bulletin-103-insulin-needles/) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Omega-3 fatty acid compounds (excluding icosapent ethyl [Vazkepa®]) (Updated 2023)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine.
Named exceptions and further recommendations	None
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	Omega-3 fatty acid compounds are essential fatty acids that can be obtained from the diet. They are licensed for adjunct to diet and statin in Type IIb or III hypertriglyceridaemia; adjunct to diet in Type IV hypertriglyceridaemia; adjunct in secondary prevention in those who have had a myocardial infarction in the preceding 3 months. The summary of national guidance for lipid management (NHS Access Collaborative, December 2021 (https://www.england.nhs.uk/aac/wp-content/uploads/sites/50/2020/04/Summary-of-national-guidance-for-lipid-management-for-primary-and-secondary-prevention-of-cardiovascular-disea.pdf)) outlines the clinical pathway for primary and secondary prevention of cardiovascular disease (CVD). It states that omega-3 fatty acids should not be offered alone or in combination with a statin for the prevention of CVD. This pathway should be followed for lipid management. NICE recommends that only one omega-3 fatty acid compound is recommended in specific clinical circumstances – icosapent ethyl [Vazkepa®] (NICE TA805 (https://www.nice.org.uk/guidance/TA805)), and that all other omega-3 fatty acid compounds are not suitable for prescribing: Do not offer or advise people to use omega-3 fatty acid capsules or omega-3 fatty acid supplemented

	foods to prevent another myocardial infarction. If people choose to take omega-3 fatty acid capsules or eat omega-3 fatty acid supplemented foods, be aware that there is no evidence of harm. (https://www.nice.org.uk/donotdo/do-not-offer-or-advise-people-to-use-omega3-fatty-acid-capsules-or-omega3-fatty-acid-supplemented-foods-to-prevent-another-miif-people-choose-to-take-omega3-fatty-acid-capsules-or-eat-omega3-fatty) Do not offer omega-3 fatty acid compounds for the prevention of cardiovascular disease to any of the following: people who are being treated for primary prevention, people who are being treated for secondary prevention, people with chronic kidney disease, people with type 1 diabetes, people with type 2 diabetes. (https://www.nice.org.uk/donotdo/do-not-offer-omega-3-fatty-acid-compounds-for-the-prevention-of-cvd-to-any-of-the-following-people-who-are-being-treated-for-primary-prevention-people-who-are-being-treated-for-secondary-prevention-people-with-ckd-people-with-type-1-diabetes-people-with-t) Do not offer the combination of a bile acid sequestrant (anion exchange resin), fibrate, nicotinic acid or omega-3 fatty acid compound with a statin for the primary or secondary prevention of CVD. (https://www.nice.org.uk/donotdo/do-not-offer-the-combination-of-a-bile-acid-sequestrant-anion-exchange-resin-fibrate-nicotinic-acid-or-omega-

	3-fatty-acid-compound-with-a-statin-for-the-primary-or-secondary-prevention-of-cvd) Do not offer omega-3 fatty acids to adults with non-alcoholic fatty liver disease because there is not enough evidence to recommend their use. (https://www.nice.org.uk/donotdo/do-not-offer-omega-3-fatty-acids-to-adults-with-non-alcoholic-fatty-liver-disease-because-there-is-not-enough-evidence-to-recommend-their-use) Initiation of omega-3-acid ethyl esters supplements is not routinely recommended for patients who have had a myocardial infarction (MI) more than 3 months earlier. (https://www.nice.org.uk/donotdo/initiation-of-omega3acid-ethyl-esters-supplements-is-not-routinely-recommended-for-patients-who-have-had-an-myocardial-infarction-mi-more-than-3-months-earlier) Do not use omega-3 fatty acids to manage sleep problems in children and young people with autism. (https://www.nice.org.uk/donotdo/do-not-use-omega3-fatty-acids-to-manage-sleep-problems-in-children-and-young-people-with-autism) People with familial hypercholesterolemia (FH) should not routinely be recommended to take omega-3 fatty acid supplements. (https://www.nice.org.uk/donotdo/people-with-familial-hypercholesterolemia-fh-should-not-routinely-be-recommended-to-take-omega3-fatty-acid-supplements)

	Do not offer omega-3 or omega-6 fatty acid compounds to treat multiple sclerosis (MS). Explain that there is no evidence that they affect relapse frequency or progression of MS. (https://www.nice.org.uk/donotdo/do-not-offer-omega3-or-omega6-fatty-acid-compounds-to-treat-ms-explain-that-there-is-no-evidence-that-they-affect-relapse-frequency-or-progression-of-ms) The joint clinical working group agreed with NICE recommendations and considered omega-3 fatty acid compounds suitable for inclusion in this guidance.
Further resources and guidance for ICBs and healthcare professionals	PrescQIPP CIC Drugs to review for optimised prescribing – omega-3 fatty acids (https://www.prescqipp.info/-omega-3-fatty-acids/category/85-omega-3-fatty-acids) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Oxycodone and naloxone combination product (2017)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available.
Named exceptions and further recommendations	None. Prescribe only if the decision to prescribe has been made after a multidisciplinary team discussion.
Category	Items which are clinically effective but more cost-effective products are available, including products that have been subject to excessive price inflation.

Background and rationale	Oxycodone and naloxone combination product is used to treat severe pain and can also be used second line in restless legs syndrome. The opioid antagonist naloxone is added to counteract opioid-induced constipation by blocking the action of oxycodone at opioid receptors in the gut. PrescQIPP CIC has issued a bulletin (https://www.prescqipp.info/-oxycodone/naloxone-prolonged-release-tablets/send/105-oxycodone-naloxone-prolonged-release-targinact-tablets/1307-bulletin-56-oxycodone-naloxone-prolonged-release), which does not identify a benefit of oxycodone and naloxone in a single product over other analgesia (with laxatives if necessary). Due to the significant cost of the oxycodone and naloxone combination product and the unclear role of the combination product in therapy compared with individual products, the joint clinical working group considered oxycodone and naloxone suitable for inclusion in this guidance.

Further resources and guidance for ICBs and healthcare professionals	Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid for pain (https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware) [accessed October 2022] Faye's story: good practice when prescribing opioids for chronic pain (https://www.england.nhs.uk/patient-safety/fayes-story-good-practice-when-prescribing-opioids-for-chronic-pain/) [accessed October 2022] PrescQIPP CIC drugs to review for optimised prescribing – oxycodocne and naloxone combination product (https://www.prescqipp.info/-oxycodone/naloxone-prolonged-release-tablets/category/105-oxycodone-naloxone-prolonged-release-targinact-tablets) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets) NICE NG215: Medicines associated with dependence or withdrawal symptoms (https://www.nice.org.uk/guidance/ng215) NHS England Optimising personalised care for adults prescribed medicines associated with dependence of withdrawal symptoms (https://www.england.nhs.uk/long-read/optimising-personalised-care-for-adults-prescribed-medicines-associated-with-dependence-or-withdrawal-symptoms/)

Paracetamol and tramadol combination product (updated 2023)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available.
Named exceptions and further recommendations	None
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	Although the combination product has reduced in price since this guidance was first published in 2017, there is no further evidence that indicates significant advantages over individual products. A PrescQIPP CIC bulletin (https://www.prescqipp.info/-tramacet/send/59-tramacet/946-bulletin-62-tramacet) did not identify any significant advantages over individual products; however, it recognised that some people may prefer to take one product instead of two. While the strengths of tramadol (37.5mg) and paracetamol (325mg) in the combination product are lower than those in commonly available individual preparations of tramadol (50mg) and paracetamol (500mg), the PrescQIPP CIC review (https://www.prescqipp.info/-tramacet/send/59-tramacet/946-bulletin-62-tramacet) found no evidence that the combination product is more effective or safer than the individual preparations.

Further resources and guidance for ICBs and healthcare professionals	PrescQIPP CIC drugs to review for optimised prescribing – paracetamol and tramadol combination product (https://www.prescqipp.info/-tramacet/category/59-tramacet) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets) NICE NG215: Medicines associated with dependence or withdrawal symptoms (https://www.nice.org.uk/guidance/ng215) NHS England Optimising personalised care for adults prescribed medicines associated with dependence of withdrawal symptoms (https://www.england.nhs.uk/long-read/optimising-personalised-care-for-adults-prescribed-medicines-associated-with-dependence-or-withdrawal-symptoms/)

Perindopril arginine (2017)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available.

Named exceptions and further recommendations	None
Category	Items which are clinically effective but more cost-effective products are available, including products that have been subject to excessive price inflation.
Background and rationale	Perindopril is an ACE inhibitor used in heart failure, hypertension, diabetic nephropathy, and prophylaxis of cardiovascular events. The perindopril arginine salt version is more stable in extremes of climate than the perindopril erbumine salt, which gives it a longer shelf-life. However, perindopril arginine is significantly more expensive than perindopril erbumine and a PrescQIPP CIC review (https://www.prescqipp.info/-perindopril-arginine/send/89-perindopril-arginine/1009-bulletin-59-perindopril-arginine) of the topic found no clinical advantage for the arginine salt. NICE guidance on hypertension in adults recommends that prescribing costs are minimised. Due to the significant extra costs of the arginine salt and the availability of the erbumine salt, the joint clinical working group considered perindopril arginine suitable for inclusion in this guidance.

Further resources and guidance for ICBs and healthcare professionals	NICE NG136: Hypertension in adults: diagnosis and management (https://www.nice.org.uk/guidance/ng136) PrescQIPP Bulletin 209 – perindopril arginine Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Rubefacients, benzydamine, mucopolysaccharide and cooling products (excluding topical NSAIDs* and capsaicin) (updated 2023)

* This does not relate to topical non-steroidal anti-inflammatory drug (NSAID) items such as ibuprofen and diclofenac.

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available.
Named exceptions and further recommendations	None
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	Rubefacients are topical preparations that cause irritation and reddening of the skin due to increased blood flow. They are believed to relieve pain in various musculoskeletal conditions and are available on prescription and in OTC remedies. They may contain nicotinate compounds, salicylate compounds, essential oils and camphor. The BNF states (https://bnf.nice.org.uk/treatment-summary/soft-tissue-disorders.html): "The evidence available does not support the use of topical rubefacients in acute or chronic musculoskeletal pain". NICE has issued the following 'do not do' recommendation: Do not offer rubefacients for treating osteoarthritis. (https://www.nice.org.uk/donotdo/do-not-offer-rubefacients-for-treating-osteoarthritis) Due to limited evidence and NICE recommendations, the joint clinical working group considered rubefacients (excluding topical NSAIDs) suitable for inclusion in this guidance. Other miscellaneous topical analgesics containing benzydamine, mucopolysaccharide polysulphate or cooling ingredients fall under this category. Benzydamine and mucopolysaccharide are weak prostaglandin inhibitors and are therefore pharmacologically different from those routinely referred to as

	NSAIDs in current practice (such as ibuprofen and diclofenac), so it cannot be presumed that the clinical evidence relating to NSAIDs can be extrapolated to benzydamine or mucopolysaccharide polysulphate containing products (Rubefacients and miscellaneous topical analgesics, PrescQIPP, July 2021 (https://www.prescqipp.info/our-resources/bulletins/bulletin-287-rubefacients/)). The Clinical Knowledge Summary on sprains and strains (NICE, 2020 (https://cks.nice.org.uk/topics/sprains-strains/)) does not specifically discuss cooling sprays and gels, but does suggest ice is used for self-management strategies in the first 48–72 hours after injury. Due to limited evidence and the NICE recommendations, the joint clinical working group considered these additional products suitable for inclusion in this category.
Further resources and guidance for ICBs and healthcare professionals	PrescQIPP CIC drugs to review for optimised prescribing – rubefacients (https://www.prescqipp.info/media/1639/b114-rubefacients-21.pdf) Patient information leaflets (https://www.prescqipp.info/our-resources/webkits/drop-list/low-value-medicines-lvm/patient-information-pdf-versions/)

Silk garments (2019)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine.
Named exceptions and further recommendations	None
Category	Items of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or significant safety concerns.

Background and rationale	Silk garments are typically prescribed for eczema or dermatitis. These products are knitted, medical grade silk clothing that can be used as an adjunct to normal treatment for severe eczema and allergic skin conditions. Four brands of knitted silk garments are currently listed as an appliance in part IX A in the NHS Drug Tariff (https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff) and are relatively expensive. The PrescQIPP document on silk garments (https://www.prescqipp.info/media/1659/b160-silk-and-antimicrobial-garments-20.pdf) states that the evidence relating to their use is weak and is of low quality. In addition, due to limited evidence supporting the efficacy of silk clothing for the relief of eczema, the NIHR HTA programme commissioned the CLOTHES trial (https://www.nottingham.ac.uk/research/groups/cebd/projects/clothes/index.aspx), to examine whether adding silk garments to standard eczema care reduced eczema severity in children with moderate to severe eczema, compared to use of standard eczema treatment alone. The trial concluded that using silk garments for the management of eczema is unlikely to be cost-effective for the NHS.

Further resources and guidance for ICBs and healthcare professionals	Specialist Pharmacy Service silk garments evidence review (https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-evidence-reviews/) PrescQIPP CIC Drugs to Review for Optimised Prescribing – silk garments (https://www.prescqipp.info/our-resources/bulletins/bulletin-160-silk-and-antimicrobial-garments/) Patient information leaflets (https://www.prescqipp.info/our-resources/webkits/drop-list/low-value-medicines-lvm/patient-information-pdf-versions/)

Travel vaccines (vaccines administered exclusively for the purposes of travel) (2017)

Recommendation	• Do not initiate. • Prescribe only for an indication named in this guidance.
Named exceptions and further recommendations	The recommendations do not apply to the following vaccines when administered exclusively for the purposes of travel, if clinically appropriate: • cholera • diphtheria/tetanus/polio • hepatitis A • typhoid.

Category	Items which are clinically effective but due to the nature of the product, are deemed a low priority for NHS funding.
Background and rationale	This guidance covers the following vaccinations that should not be prescribed on the NHS exclusively for the purposes of travel: • hepatitis B • Japanese encephalitis • meningitis ACWY • yellow fever • tick-borne encephalitis • rabies • BCG. These vaccines should continue to be recommended for travel but the individual traveller will need to bear the cost of the vaccination. For all other indications, as outlined in Immunisation Against Infectious Disease – the Green Book – the vaccine remains free on the NHS.

Further resources and guidance for ICBs and healthcare professionals	The Green Book (https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book) Travel Health Pro (NaTHNaC) (https://travelhealthpro.org.uk/) PrescQIPP CIC drugs to review for optimised prescribing – travel guidance (https://www.prescqipp.info/-travel-vaccines/category/123-travel-vaccines-drop-list) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

Trimipramine (2017)

Recommendation	• Do not initiate. • Deprescribe in patients currently prescribed this medicine. • Prescribe only if no other item or intervention is clinically appropriate. • Prescribe only if no other item or intervention is available.
Named exceptions and further recommendations	None

Category	Items which are clinically effective but more cost-effective products are available, including products that have been subject to excessive price inflation.
Background and rationale	The tricyclic antidepressant (TCA) trimipramine is significantly more expensive than other antidepressants. NICE guidance on depression in adults recommends selective serotonin reuptake inhibitor (SSRI) antidepressants first line if are indicated as they have a more favourable risk-to-benefit ratio compared to TCAs. However, if a TCA is required, more cost-effective TCAs than trimipramine are available. Due to the significant cost associated with trimipramine and the availability of alternative treatments, the joint clinical working group considered trimipramine suitable for inclusion in this guidance.
Further resources and guidance for ICBs and healthcare professionals	NICE CG90: Depression in adults (https://www.nice.org.uk/Guidance/CG90) NICE Clinical Knowledge Summaries – depression (https://cks.nice.org.uk/depression) Patient information leaflets (https://www.prescqipp.info/items-which-should-not-routinely-be-prescribed-patient-leaflets)

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