## Public Consultation on the Proposed Amendments to the Poisons Standard

## Notice under subsections 42ZCZL of the Therapeutic Goods Regulations 1990 (the Regulations)

A delegate of the Secretary to the Department of Health publishes herein all valid public submissions made in response to the invitation for public submissions on the proposed amendments to the Poisons Standard. These submissions were considered by the March 2016 meetings of the Advisory Committee on Chemicals Scheduling (ACCS) #16, the Advisory Committee on Medicines Scheduling (ACMS) #17 or the Joint Advisory Committee on Chemicals and Medicines Scheduling (ACCS-ACMS) #12.

In accordance with the requirements of subsection 42ZCZL of the Regulations these submissions have had confidential information removed.

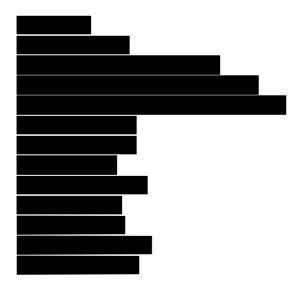
Material claimed to be commercial-in-confidence was considered against the guidelines for the use and release of confidential information set out in Chapter 6 of the Scheduling Policy Framework for Medicines and Chemicals (SPF, 2015), issued by the Australian Health Ministers Advisory Council (AHMAC). The SPF is accessible at:

https://www.tga.gov.au/publication/ahmac-scheduling-policy-framework-medicines-and-chemicals.

From: To: Subject: Date: Attachments:	chemicals.scheduling@health.gov.au; Medicines Scheduling Pelargonic/Nonanoic acid - Schedule 5 entry at 3% cut-off Tuesday, 2 February 2016 1:48:12 PM 20160202124606.pdf
Dear Sirs,	
On behalf of	we wish to make the following comments:
irritant and ar the dilution of show the irrita	stituent technical pelargonic acid (nonanoic acid) was shown to be a mild skin a eye irritant in the submission to the APVMA under file number. At f technical active that is used in the RTU formulation (APVMA file number) the pH falls within the range of human sweat (4.0-6.8) so the RTU would not ent effects that are observed for the technical active. The active was shown to be by other routes. A report confirming the pH of the product formulation is a attachment.
irritant effects given to raisin	ne 36.8 g/L nonanoic acid formulation is in the range that it is unlikely to cause in the event of accidental skin or eye contact, requests that consideration be gethe minimum concentration for inclusion in Schedule 5 to 4% from the proposed of 4% would allow the marketing of to householders without an S5 signal heading.

Copy of our internal pH testing report attached for your record.

## Kind regards



pH report Date:2/2/2016 . The meter has a A YSI EcoSense pH100A Meter was used for testing a solution of resolution of 0.01 units and accuracy of ±0.1% ± 2 digit. The meter was calibrated using a commercial pH4 buffer solution immediately before measurements were taken. **Test solution** 36.8g/L Pelargonic acid (nonanoic A 1L sample of a 1000L commercial batch of acid) was obtained. A pH reading was carried out on both the RTU concentrate and a 1% solution by extracting 10ml of the RTU concentrate using a pipette and added to 1L of Sydney town water with a pH 7.24. Results 36.8g/L Pelargonic acid Concentrate pH 4.92 @ 25°C 1% Solution pH 5.17 @ 25℃ 0.368g/L Pelargonic acid Conclusion containing active constituent Pelargonic acid 36.8 g/L is at a concentration > 3% w/v but has a pH that falls within the range of human sweat (pH 4-6) and hence should be exempt from S5 Scheduling.





18 February 2016

The Secretary Scheduling Secretariat GPO Box 9848 Canberra ACT 2601

Email: Medicines.Scheduling@tga.gov.au

Dear Sir or Madam,

Notice inviting public submissions under Reg. 42ZCZK / 42ZCZL of the Therapeutic Goods
Regulations 1990
Scheduling proposals to be considered at the ACCS and ACCS-ACMS Meetings, March 2016

We refer to the notice inviting public comment under Regulation 42ZCZK / 42ZCZL of the Therapeutic Goods Regulations and would like to provide comment on some of the scheduling proposals that will be referred to the March 2016 meetings of the ACCS and ACCS-ACMS.

appreciates the opportunity to provide public comment in relation to the scheduling proposals below. We wish to address relevant matters under section 52E of the Therapeutic Goods Act 1989.

#### **ACCS Meeting**

notes that the majority of the scheduling proposals that will be considered by the ACCS relate to chemicals for cosmetic and industrial uses. There are however three scheduling proposals for substances that have ingredient entries in the ARTG and would like to bring this to the attention of the committee, so that any unintended impact on the scheduling of therapeutic goods may be avoided.

#### Crystal Violet and related dyes

notes that the proposed scheduling amendment is for the creation of a new group Schedule 6 entry for Crystal Violet and related dyes to regulate their use in hair dye products and to provide appropriate exemptions.

Crystal Violet, also known as Gentian Violet, is used in topical antiseptic products and is entered in the ARTG as a 1% topical antiseptic solution.

requests that therapeutic goods should be exempted from any proposed Schedule 6 entry for Crystal Violet.

#### Methyldibromo glutaronitrile

notes that Methyldibromo glutaronitrile is entered in the ARTG ingredient list and is allowed in therapeutic goods as an excipient in OTC medicines.

requests that the ACCS considers the possible use of the substance in therapeutic goods and that the schedule entries should include exemptions (from either Schedule 6 or Schedule 10, as appropriate) for the use of the substance as an excipient in therapeutic goods, with a suitable cut-off concentration if appropriate.

#### Nonanoic acid

Nonanoic acid is entered in the ARTG ingredient list and may have a use as an excipient in fragrances.

requests that the ACCS considers the use of the substance in therapeutic goods and that any proposed Schedule 5 entry should include an exemption for the use of the substance as an excipient in therapeutic goods, with a suitable cut-off concentration if appropriate.

#### Joint ACCS-ACMS meeting

#### Symphytum spp (Comfrey)

notes that there are a number of dermal non-prescription products (creams and ointments) entered in the ARTG that contain Symphytum officinale.

believes that the current Schedule 5 entry for Symphytum spp. in dermal therapeutic goods is appropriate and that there should be no overall increase in regulatory burden in the form of scheduling controls or labelling requirements.

However, considers that it may be appropriate to ensure that there is no ambiguity between the Schedule 5 and Schedule 10 entries and would appreciate the opportunity to make further comment on this agenda item following the publication of the Delegate's interim decisions.

## **Conclusion**

As an industry representative, is a key stakeholder in scheduling matters and we are keen to provide further input as required. We look forward to the Delegate's interim decisions and greater detail on the final scheduling proposals.
Please contact me should you require any further clarification relating to this submission.
Yours sincerely,

The Secretary Scheduling Secretariat GPO Box 9848 CANBERRA ACT 2601

Email: chemicals.scheduling@health.gov.au

Dear Sir/Madam

#### Public Comment Submission to the March 2016 meeting of the Advisory Committee on Chemicals Scheduling (ACCS)

We refer to the notice published on 21 January 2016 inviting public submissions, with respect to certain substances, addressing a matter raised in s.52E of the *Therapeutic Goods Act 1989*.

wishes to provide information on:

- 2,4-diamino-5-methylphenetole;
- 2-chloro-5-nitro-N-hydroxyethyl-p-phenylenediamine;
- 2-methylresorcianol;
- Bis-isobutyl PEG/PPG-20/35/amodimethicone copolymer;
- Chrysoidine base and its salts;
- Crystal Violet and related dyes (group);
- Disperse Yellow 3;
- Methyldibromo glutaronitrile;
- p-aminophenol; and
- Potassium hydroxide and sodium hydroxide.

for consideration at the March 2016 meeting of the ACCS.

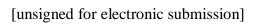
Please see the attached submission for details.

is an interested party and stakeholder with regard to the nominated substances and would appreciate being advised of the Committee's considerations and the Delegate's interim decision, with the opportunity for further submission, if appropriate.

We look forward to further advice from the ACCS and the Delegate. Should the Committee or the Delegate require any additional information from at this stage please do not hesitate to contact me on

Yours Sincerely





18 February 2016

## ACCS meeting: March 2016

#### 2,4-diamino-5-methylphenetole

has no objections to aligning the scheduling controls for this substance with the EU.

We note that 2,4-diamino-5-methylphenetole is listed in Annex II of the EU Cosmetics Regulations and cannot be used in cosmetics in the EU.

## 2-chloro-5-nitro-N-hydroxyethyl p-phenylenediamine

has no objections to aligning the scheduling controls for this substance with the EU.

We note that 2-chloro-5-nitro-*N*-hydroxyethyl-*p*-phenylenediamine is listed in Annex II of the EU Cosmetics Regulations and cannot be used in cosmetics in the EU.

## 2-methylresorcisol

has no objections to aligning the scheduling controls for this substance with the EU. We note that 2-methylsorcisol is included in Annex III of the EU Cosmetics Regulations, restricting its use to hair dyes with in-use concentration not exceeding 1.8%.

In line with recent decisions on hair dye ingredients, proposes the following schedule entry.

#### Schedule 6 - New Entry

#### 2-METHYLRESORCISOL except:

a. in non-oxidative hair dye preparations and eyebrow/eyelash colouring products containing 1.8 per cent or less of 2-methylresorcisol when the immediate container and primary pack are labelled with the following statements:

KEEP OUT OF REACH OF CHILDREN, and

WARNING - Hair colourants can cause severe allergic reactions.

Written in letters not less than 1.5 mm in height; or

b. in oxidative hair dye preparations and eyebrow/eyelash colouring products containing 1.8 per cent or less of 2-methylresorcisol after mixing under oxidative conditions when the immediate container and primary pack are labelled with the following statements:

KEEP OUT OF REACH OF CHILDREN, and WARNING - Hair colourants can cause severe allergic reactions. Written in letters not less than 1.5 mm in height.

Further, in line with recent decisions on hair dye ingredients, we request a later implementation date to allow time for relabelling of products that are already on the market.

#### Bis-isobutyl PEG/PPG-20/35/amodimethicone copolymer

notes that the bis-isobutyl PEG/PPG 2-/35/amodimethicone copolymer is intended to be used in rinse off cosmetic products. We also note that available data suggests that the polymer is a severe eye irritant.

While we agree that the hazard profile of the substance merits scheduling consideration, we question whether the risks posed require risk mitigation.

We understand that the intended use of the polymer is in rinse-off cosmetic preparations in low concentrations. Given this use, we question risk mitigation that would deliver safety benefits for the end user. We believe that the use of the Poisons Standard first aid statement E1 "If in eyes wash out immediately with water.", which would normally apply to severe eye irritants is redundant. Under the intended use situation (rinse-off cosmetic, e.g. shampoo or conditioner), if the product was to enter the eye, the user would instinctively wash the eye immediately under water.

We also note that currently there does not appear to be any restrictions on the use of this polymer internationally.

We therefore suggest that if any scheduling restrictions are considered, the focus should be on uses that are not its current intended use to deter unintended uses, and allow this polymer to remain unscheduled when in rinse-off cosmetic preparations.

## Chrysoidine base and its salts

has no objections to aligning the scheduling controls for this substance with the EU.

We note that all of the chrysoidine base and its salts identified in the NICNAS IMAP report are listed in Annex II of the EU Cosmetics Regulations and cannot be used in cosmetics in the EU. The CAS numbers identified in the IMAP report are:

- 495-54-5;
- 532-82-1;
- 63681-54-9;
- 75660-25-2;
- 79234-33-6; and
- 94247-67-3.

The schedule entry for Chrysoidine base and its salts should specifically identify the above listed CAS numbers for restriction to ensure that no other substances that may be in use are captured unintentionally. This would be in line with the current schedule entry for Benzidine-based azo dyes.

If the ACCS believes that the schedule entry should be broadened to capture more substances than considered by the IMAP report, we would appreciate additional time to provide further information. Industry would require additional time to consider current product formulations in detail to ensure that substances currently in use are not inadvertently captured.

#### Crystal Violet and related dyes (group)

has no objections to aligning the scheduling controls for this substance with the EU. However, we are unsure whether this could be achieved in a single schedule entry for crystal violet and related dyes that groups all substances considered by the IMAP.

We note that four of the six CAS numbers in the NICNAS IMAP list are on the EU Cosmetics Regulations Annex II (i.e. banned from cosmetic use). The CAS numbers for these substances are:

- 548-62-9.
- 1694-09-3,
- 2390-59-2, and
- 2390-60-5.

has no objections to the above identified chemicals being added to Schedule 10, similar to the Benzidine-based azo-dyes schedule entry.

However, one of the substances in the IMAP list, CI 44045 (CAS number 2580-56-5) is listed in EU Cosmetics Regulations Annex IV, colourants allowed in cosmetics, with a restriction that it is not to be used in products applied to mucous membranes. We also note that this dye is not allowed to be used in hair dyes.

For CI 44045, we believe scheduling controls should be worded such that it allows continued use of the dye in cosmetics, except in hair dyes and in products intended to be in contact with mucous membranes.

For another substance in the IMAP list, CAS number 72102-55-7, we were unable to find any information relating to its use in cosmetics or any restrictions relating to consumer products. We understand that this dye is generally used in newsprints. Noting this use, we believe any consideration of scheduling controls should focus on this specific use.

### **Disperse Yellow 3**

has no objections to aligning the scheduling controls for this substance with the EU.

We note that Disperse Yellow 3 is listed in Annex II of the EU Cosmetics Regulations and cannot be used in cosmetics in the EU.

#### Methyldibromo glutaronitrile

supports the proposed clarification of the current Schedule entries for methyldibromo glutaronitrile to remove any ambiguities. We believe that following amendments to Schedule 6 entries for methyldibromo glutaronitrile would address the concerns raised.

#### Schedule 6 (amended entry)

Methyldibromo glutaronitrile except when included in Schedule 10.

If the ACCS believes further consideration of methyldibromo glutaronitrile is required beyond providing clarification i.e. the scope identified in the pre-meeting notice, we would appreciate additional time to provide further comments.

#### *p*-aminophenol

has no objections to aligning the scheduling controls for this substance with the EU. We note that *p*-aminophenol (or 4-aminophenol) is included in Annex III of the EU Cosmetics Regulations, restricting its use to oxidative hair dyes with in-use concentration not exceeding 0.9%.

In line with recent decisions on oxidative hair dye ingredients, proposes the following schedule entry.

#### Schedule 6 - New Entry

4-AMINOPHENOL **except** in hair dye preparations containing 0.9 per cent or less of 4-aminophenol after mixing under oxidative conditions when the immediate container and primary pack are labelled with the following statements:

#### KEEP OUT OF REACH OF CHILDREN, and

WARNING - Hair colorants can cause severe allergic reactions. Read and follow instructions. This product is not intended for use on persons under the age of 16. Temporary 'black henna' tattoos may increase your risk of allergy. Do not colour your hair if: — you have a rash on your face or sensitive, irritated and damaged scalp, — you have ever experienced any reaction after colouring your hair, — you have experienced a reaction to a temporary 'black henna' tattoo in the past

Written in letters not less than 1.5 mm in height.

Further, in line with recent decisions on hair dye ingredients, we request a later implementation date to allow time for relabelling of products that are already on the market.

#### Potassium hydroxide and sodium hydroxide

supports the proposed clarification of the current Schedule entries for potassium hydroxide and sodium hydroxide to remove any ambiguities. We believe that following amendments to Schedule 6 entries for potassium hydroxide and sodium hydroxide would address the concerns raised.

Schedule 6 (amended entries)

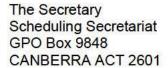
Potassium Hydroxide (excluding its salts and derivatives) except:

- (a) when included in Schedule 5 or 10; or
- (b) in preparations containing 5 per cent or less of potassium hydroxide being:
- (i) solid preparations, the pH of which in a 10 g/L aqueous solution is 11.5 or less; or
  - (ii) liquid or semi-solid preparations, the pH of which is 11.5 or less.

Sodium Hydroxide (excluding its salts and derivatives) except:

- (a) when included in Schedule 5 or 10; or
- (b) in preparations containing 5 per cent or less of sodium hydroxide being:
- (i) solid preparations, the pH of which in a 10 g/L aqueous solution is 11.5 or less; or
- (ii) liquid or semi-solid preparations, the pH of which is 11.5 or less.

If the ACCS believes further consideration of potassium hydroxide or sodium hydroxide is required beyond providing clarification i.e. the scope identified in the pre-meeting notice, we would appreciate additional time to provide further comments.



Email: <a href="mailto:chemicals.scheduling@health.gov.au">chemicals.scheduling@health.gov.au</a>

Dear Sir/Madam

Public Comment Submission to the March 2016 joint meeting of the Advisory Committee on Medicine Scheduling (ACMS) and the Advisory Committee on Chemicals Scheduling (ACCS)

We refer to the notice published on 21 January 2016 inviting public submissions, with respect to certain substances, addressing a matter raised in s.52E of the *Therapeutic Goods Act 1989*.

wishes to provide information on *Symphytum spp*. (Comfrey) for consideration at the March 2016 meeting of the ACMS/ACCS.

Please see the attached submission for details.

is an interested party and stakeholder with regard to the nominated substances and would appreciate being advised of the Committees' considerations and the Delegate's interim decision, with the opportunity for further submission, if appropriate.

We look forward to further advice from the ACMS, ACCS and the Delegate. Should the Committees or the Delegate require any additional information from at this stage please do not hesitate to contact me

Yours Sincerely

[unsigned for electronic submission]

## ACMS/ACCS meeting: March 2016

## Symphytum spp. (Comfrey)

We understand that the discussion of comfrey will be limited to providing a clarification that comfrey is included in Schedule 10 (prohibition of sale, supply and use) for therapeutic uses except when included in Schedule 5.

supports

supports this purpose and recommends an amended Schedule 5 entry as below:

#### Schedule 5 (amended)

SYMPHYTUM spp. (Comfrey) for dermal use except when included in Schedule 10.

If the Committees believe further consideration of comfrey is required beyond the scope identified in the pre-meeting notice, we would appreciate additional time to provide further comment.

Thank you for giving us the opportunity to respond to the advisory Committee on Medicines Scheduling.

we believe no HERB should need to come under such scheduling especially when used for personal use. Herbs grown commercially need to come under some food possibly be scheduled under 2-tharmacy medicine as they are part of God's tharmacy or under section 5-caution.

There is world unde self-evidence to show the healing properties of comnabis and it seems there has never been any recorded deaths from cannabis. There is the justifiable reason to schedule cannabis as a prohibited substance. It is unjust to have the growing, proccessing and supply cannabis deemed illegal. It seems to us that this control over medications is being dictated purely by big cooperate pharmeucutical companies thus deriging us civil rights of having freedom of choice of our own health matters and health management.

be clegal (It has never done anything bad or harmful or broken any law). all plants were created for some benifical purpose. In the Bible God says everything he made is good. He also said, "I've given you every sort of seed bearing plant on earth and every kind of fruit Therefore Hippocrates sure got it right when he said, "Let

your food be your medicine and your medicine be your food; What can and should be deemed Megal is people misusing and abusing plant derived products in such a way that harm is caused to society as a result of irresponsible actions eg the over consumption of alcohol Leading to anti-social detrimental behaviour, hops are three of the most common plants used to produce alcohol but they are not scheduled as being problematic in any way. in any way, "To schedule cannabis (and comfrey) is discrimination- discrimination against a plant that in turn discriminates against vunerable, sick desperate people who only want the right to health, healing and hope. We do not understand how a plant such as cannabis can be singled out as being so harmful that it is declared a prohibited substance when common household them such as nutmeg is deemed a safe plant and food product but if misused can be harmful Nutmeg-large amounts can cause renal toxicity, transient

psychosis, hallicinations and even death. The dose needed to produce hallucinorgenie effects is dangerously close to

the toxic dose. NB The are many other plants and botanically dervived materials that can have harmful side-effects of musused and abused.

It all comes down to people being educated and taking responsibility, then all plants and botanical materials, will be used for the good God created them for and the upholding of free choice!

Suggestions (what we believe is just, justifable, protective while maintaining freedom of choice and upholding auch uberty/rights).

· all australians should have the right to grow and for access cannabis and connabis products in the same way they can any other medicinal plants. That should include a) the exchanging/giving of the

herb to family / friends

(b) being able to purchase cannabis products such as oil and tinctures at affordable prices at health shops and pharmacies in exactly the same way other medicinal herbs are available in such places. This includes a pharmacest/herbalist being able to make up prescriptions simtable for individual needs.

- as different illnesses need different varieties for maximum effectiveness.
- (1) the right to obtain the varieties of cannabes and cannabes products best suited to the need and need varieties with high CBD and a mixture of varieties but some people need varieties higher in THC in order to receive the best health results le for chronic pain etc.
- (d) the form in which cannabis is taken for medicinal purposes should be individual choice (oil, tincture, smoking, eating row product-leaves, seeds) just as a patient has choices of other forms of medications. But at all times the person must take responsibility for using the product safely (in our case as cares we take responsibility for what we administer to our son)
- (e) anyone selling cannabis and cannabis products should registered in some way so ensure safe, responsible practises are upheloi and ensure produce is of good, consistant quality. This should be in line with legislation for any other medicinal products.
- (t) for people like ourselves who grow, process and supply a family member with cannabis we should be allowed to grow the amount and varieties that adequatly supplies our needs without any restrictions being imposed (just as we do other medicinal herbs). If however, we deade to grow commercially we would need to resigster and come under standards for quality and quanty. It all comes back to personal responsibility and liability.

(9) have the right to teach others how to grow and process connabis and cannabis produces and educate people on responsible use of the herb as cannabis, like many other plants needs to be used with caution and respect. (We must use all plants sensibly and respectfully for even lettuce can produce intoxication in the form of intense sleepiness — Beatrix Potter's burnies in Mr Macgreggor's garden for example).

(1) anyone processing cannabis (oil / tinctures etc) commercially must be registered to ensure quality etc.

## In conclusion;

- (1) Cannabis and any plant/plant product can never be compared to synthetically produced pharmaceutical products. Man made synthetic products must come under strict regulations and scheduling. Plants and natural products have already passed their Makers (God) scruting, and been fully approved!
- (2) Australia has many experts on cannabis -people who know and use the herb. These people can come forward with their knowledge and skills as soon as cannabis is decrimalised. While cannabis is a prohibited substance such people cannot come forward openly. Open the doors! Australians and our Nation will benefit health wise and economically as soon as cannabis is decriminalised and given its rightful status as a self evident medicinal plant. Millions of people have known this for hundreds of years and respect and greatly appreciate this plant that can give health, healing and hope!
- Face the challenge! Make the change!

  Give us all the right to simply exercice choice.

  It is simply about the right to live a fulfilling, healthy and happy life. It is about morality, not legality!

# Proposed Amendments to Poisons Standard –ACMS meeting, March 2016

Comments by \_\_\_\_\_\_ to the proposed amendments referred by the delegate for scheduling advice for consideration by the Advisory Committee on Medicines Scheduling

**Ketoprofen – Amend Schedule 3 entry** 

**Loratadine – Amend Schedule exemption** 

Naproxen - Schedule exemption

Paracetamol – Amend Schedule 2 entry

**December 2015** 

#### **KETOPROFEN**

Proposal to amend the scheduling of ketoprofen to include divided preparations for oral use containing 200 mg or less of ketoprofen per dosage unit in in Schedule 3.

#### **Overview**

has concerns regarding this proposal. The GI side effects are worse for ketoprofen compared to other NSAIDs. Alternatives NSAIDs that are available in Schedule 3 such as ibuprofen and naproxen are safer alternatives. In addition, since ketoprofen is specifically indicated for the treatment of rheumatoid and osteoarthritis (conditions which require diagnosis by a doctor), questions the appropriateness of amending the schedule. Overall believes the current scheduling remains appropriate.

#### The risk and benefits of the use of the substance<sup>1</sup>

Studies have shown that ketoprofen is higher risk for gastrointestinal complications compared to other NSAIDs available over-the-counter.<sup>2</sup> There is also a higher risk of peptic ulcer complications.<sup>3</sup>

Common adverse events associated with NSAIDs include nausea, dyspepsia, GI ulceration or bleeding, diarrhoea, headache, dizziness, salt and fluid retention and hypertension.<sup>4</sup> Ketroprofen is contraindicated in patients with severe heart or renal failure or heptatic insufficiency.<sup>5</sup>

There are also precautions for use in patients who suffer from asthma, hypertension experience gastrointestinal problems.<sup>6</sup>

Studies analysing the varying risk of upper GI bleeding across for NSAIDs have found those that have a long half-life or slow-release formulation and/or are associated with profound and coincident inhibition of both COX isozymes are associated with a greater risk of upper GI bleeding/perforation.<sup>7</sup>

## The purposes for which a substance is to be used and the extent of use of a substance<sup>8</sup>

The Australian Medicine Handbook recommends that before commencing an NSAID to treat a chronic condition, a patient's complete blood count, haemoglobin, BP, weight and liver function should all be measured. These tests should be repeated once a year during continued treatment. Given this information and the fact ketoprofen is primarily indicated to treat chronic conditions such as arthritis, these assessments should be undertaken in consultation with a general practitioner or specialist prior to the patient commencing treatment with ketoprofen.

<sup>&</sup>lt;sup>1</sup> Section 52E(1a)- Therapeutic Goods Act 1989

<sup>&</sup>lt;sup>2</sup> Henry, D., Lim, L. L., Rodriguez, L. A. G., Gutthann, S. P., Carson, J. L., Griffin, M., & Hill, S. (1996). Variability in risk of gastrointestinal complications with individual non-steroidal anti-inflammatory drugs: results of a collaborative meta-analysis. *Bmj*, 312(7046), 1563-1566.

<sup>&</sup>lt;sup>3</sup> Langman, M. J. S., Weil, J., Wainwright, P., Lawson, D. H., Rawlins, M. D., Logan, R. F. A., Colin-Jones, D. G. (1994). Risks of bleeding peptic ulcer associated with individual non-steroidal anti-inflammatory drugs. *The Lancet*, 343(8905), 1075-1078.

<sup>&</sup>lt;sup>4</sup> Australian Medicine Handbook online- Ketoprofen

<sup>&</sup>lt;sup>5</sup> MIMS online- Orudis ® product information

<sup>&</sup>lt;sup>6</sup> IBID

<sup>&</sup>lt;sup>7</sup> Rodríguez, L. A. G., & Tolosa, L. B. (2007). Risk of upper gastrointestinal complications among users of traditional NSAIDs and COXIBs in the general population. *Gastroenterology*, *132*(2), 498-506.

<sup>8</sup> Section 52E(1a)- Therapeutic Goods Act 1989

#### **Summary**

Given the indications for this medicine and the increased risks associated with ketoprofen compared to other OTC NSAID, believes the current scheduling for ketoprofen remains appropriate.

#### LORATADINE

Proposal to increase the pack size of unscheduled loratadine (10 mg or less) divided oral preparations from 5 dosage units to 10 dosage units when used in adults and children 12 years of age and over for the treatment of seasonal allergic rhinitis.

#### **Overview**

does not support this proposal and is not supportive of loratadine being exempt from scheduling. Irrespective of loratadine's reasonable safety profile, there are still public risks associated with its use.

does not believe it is in the public interest to further increase the scheduling exemption to allow larger doses of loratadine to be available in general retail where there is no access to health professional advice.

## The risk and benefits of the use of the substance9

#### **Use in pregnancy**

Loratadine has a pregnancy category rating of B1<sup>10</sup> and loratadine in medicines for oral use must be accompanied by the following advisory statement: "If you are pregnant or breastfeeding, check with your doctor or pharmacist before using this medicine."<sup>11</sup> arguest this is unlikely to occur if loratadine is purchased in general retail where there is no ready access to either of these health professionals.

While labelling may provide useful guidance for woman who are pregnant or breastfeeding, studies suggest not all consumers read information provided with the medicine. A survey of 1000 people conducted in Northern Ireland identified only 80% of participants always or often read the instructions on non-prescription medicine packages and that 3.4% rarely or never read the information. Coupled with participants that only sometimes read the manufacturer's information, 10% of people could be at risk of misusing these medicines.<sup>12</sup>

Given this proposal would double the maximum dose that could be sold in general retail, this exacerbates the current risk on non-adherence to important advisory statements.

#### **Sedating effect**

Although loratadine is classified as a 'non-sedating' antihistamine, some studies have indicated that loratadine can have a negative effect on simple and choice reaction times, the respiratory muscle strength (RMS) and peak power amplitude of postural tremor, as well as autonomic cardiac regulation at

<sup>9</sup> Section 52E(1a)- Therapeutic Goods Act 1989

<sup>&</sup>lt;sup>10</sup> Prescribing medicines in pregnancy database – Accessed 8/12/2015 <a href="https://www.tga.gov.au/prescribing-medicines-pregnancy-database">https://www.tga.gov.au/prescribing-medicines-pregnancy-database</a>

<sup>11</sup> Medicines Advisory Statements Specification 2014 https://www.comlaw.gov.au/Details/F2015C00557

M Wazaify, E Shields, CM Hughes et al; Societal perspectives on OTC medicines; Family Practice 2005 22:170-176

10mg doses. <sup>1314</sup> These studies suggest that taking non-sedating antihistamines to avoid the adverse reaction of drowsiness may not avoid unwanted motor control side-effects. <sup>15</sup>

The risk of cognitive impairment is also more likely when people take the medicine sporadically, as tolerance to these effects usually develop with regular use. There may be a greater risk that people accessing small packs of antihistamines from non-pharmacy sources are treating an acute condition and they may be unfamiliar with how the medicine affects them and hence may be more susceptible to its adverse effects. Furthermore, other studies note that consecutive daily doses of loratadine cause an increase in tremor amplitude.<sup>16</sup>

While the overall risk of drowsiness/sedation is low for consumers who adhere to the recommended dose of 10mg per day, allergic rhinitis is a common condition where any impact on patient cognitive function and performance is important, particularly for duties such as driving in which the use of loratadine has been assessed as representing a low to moderate risk of causing impairment.<sup>17</sup>

In addition, when medicines are available for sale in general retail there are generally no controls or limits on the number of packs a consumer can purchase. This increases the risk of medicine misadventure. When loratedine is used at higher than recommended doses, there is an increased risk of impaired acuity and drowsiness.<sup>18</sup>

## The purposes for which a substance is to be used and the extent of use of a substance<sup>19</sup>

Doubling the maximum number of dosage units available in general retail, may lead to consumers using loratedine products for conditions other than allergic rhinitis such as dermatitis, soap allergies or severe reactions to substances or insect bites. As mentioned, when medicines are sold outside pharmacy, there is no access to health professional advice regarding diagnosis nor the appropriateness of particular treatments.

The extended period of use that would be enabled under this scheduling proposal, combined with the fact there are generally no restrictions on the number of packs that can be purchased in a single transaction, could result in a greater number of consumers self-medicating for undiagnosed conditions other than the product indications (allergic rhinitis).

#### **Consumer Health literacy**

Previous research conducted by the Australian Bureau of Statistics, identified that almost 60 per cent of adult Australians have low health literacy. This means that they may not be able to effectively exercise their choice when making healthcare decisions. <sup>20</sup> It has been estimated that people with low individual health literacy are between one-and-a-half and three times more likely to experience an adverse medicine outcome. More specifically, low individual health literacy has found to be associated with a lesser ability to demonstrate taking medications appropriately and interpret labels and health messages.

<sup>&</sup>lt;sup>13</sup> Kavanagh, J. J., Grant, G. D., & Anoopkumar-Dukie, S. (2012). Low dosage promethazine and loratadine negatively affect neuromotor function. *Clinical Neurophysiology*, *123*(4), 780-786.

<sup>&</sup>lt;sup>14</sup> Baumann-Birkbeck, L., Grant, G. D., Anoopkumar-Dukie, S., & Kavanagh, J. J. (2014). Drowsiness and motor responses to consecutive daily doses of promethazine and loratadine. *Clinical Neurophysiology*, *125*(12), 2390-2396.

<sup>&</sup>lt;sup>15</sup> Kavanagh et al (2012). ). Low dosage promethazine and loratadine negatively affect neuromotor function. *Clinical Neurophysiology* 

<sup>&</sup>lt;sup>16</sup> Baumann-Birkbecket al (2014). Drowsiness and motor responses to consecutive daily doses of promethazine and loratadine.

Drummer, O. H., Gerostamoulos, J., Batziris, H., Chu, M., Caplehorn, J., Robertson, M. D., & Swann, P. (2004). The involvement of drugs in drivers of motor vehicles killed in Australian road traffic crashes. *Accident Analysis & Prevention*, *36*(2), 239-248.
 BL Spangler & S Brunton; Efficacy and central nervous system impairment of newer-generation prescription antihistamines in seasonal allergic rhinitis; 2006 <a href="https://www.medscape.com/viewacticle/540559">www.medscape.com/viewacticle/540559</a>

<sup>&</sup>lt;sup>19</sup> Section 52E(1a)- Therapeutic Goods Act 1989

<sup>&</sup>lt;sup>20</sup> Australian Bureau of Statistics. *Health Literacy, Australia*. Canberra: Australian Bureau of Statistics, 2008

Consequently, it is the view of that consumers need and want advice on the correct and proper use of medicines and this is best achieved by supplying medicines exclusively in a pharmacy. In particular, it is essential to protect the most vulnerable consumer groups, particularly children, the elderly, those from low socio-economic and/or culturally and linguistically diverse backgrounds as well as those with chronic or multiple disease conditions. Providing consumer access to information via hand-outs or labelling is not sufficient for such an important area such as health, especially given the low level of health literacy in Australia as outlined above. Facilitating access to professional advice for the prescribing and supply of medicines is the best way to maintain safe and cost-effective access to medicines.

#### **Summary**

does not support the scheduling exemption for loratadine and consequently does not support any further scheduling exemptions.

Given the potential risk relating to use while pregnant or breastfeeding, concerns regarding consumer using loratedine for conditions other than allergic rhinitis and potential cognitive impairment and sedation, believes loratedine should be a scheduled substance so it is only available in pharmacy with ready access to pharmacy staff who can provide appropriate advice on quality use of medicines.

#### **NARPOXEN**

Proposal to amend the Schedule 2 naproxen entry to exclude naproxen (i.e. make it available for sale outside pharmacy) when containing 200mg or less of naproxen per dosage unit in packs of 12 or less dosage units when not labelled for the treatment of children under 12 years of age.

#### **Overview**

does not support this proposal and believes the current scheduling remains appropriate.

notes a near identical proposal was considered by the ACMS and the scheduling delegate in November 2014, which both formed the view that the current scheduling of naproxen remained appropriate. Given the short time frame since this proposal was last considered, does not believe there could be any new fundamental evidence that warrants the current scheduling to be amended.

#### The risk and benefits of the use of the substance<sup>21</sup>

#### **Proposal considered recently**

As mentioned, this proposal was considered by the ACMS at its November 2014 meeting. In our pre-meeting submission at the time, did not support the proposal citing the increased cardiovascular risks of NSAIDs, with elderly consumers being at particular risk. This risk is magnified with concomitant use with oral and topical NSAIDs or aspirin which are currently available from general retail.

The ACMS in its advice to the delegate considered the current scheduling of naproxen to be appropriate, particularly noting the GI risk with naproxen is greater than with ibuprofen (which is exempt from scheduling in small dosages and pack sizes.) The scheduling delegate also formed the same view.<sup>22</sup> Given these fundamental concerns, does not believe any scheduling exemptions could be supported given the short time frame since the proposal was last considered.

<sup>&</sup>lt;sup>21</sup> Section 52E(1a)- Therapeutic Goods Act 1989

<sup>&</sup>lt;sup>22</sup> https://www.tga.gov.au/consultation/consultation-review-cardiovascular-safety-non-steroidal-anti-inflammatory-drugs-and-safety-review-diclofenac

#### NSAID review and subsequent labelling changes

■ notes in November 2014 the TGA conducted a review of cardiovascular safety of non-steroidal anti-inflammatory drugs and a safety review of diclofenac. The review led to a TGA decision to impose new conditions of registration on all currently supplied oral OTC medicines containing NSAIDs. These requirements will result in these products being required to display the following warning statement: "Excessive use can be harmful and increase the risk of heart attack, stroke or liver damage" (or words to that effect) to be present on the affected labels by 1 July 2016.<sup>23</sup>

As a result of these changes, OTC naproxen is now required to carry up to 7 advisory statements advising consumers of particular risks associated with this medicine.<sup>24</sup>

is not opposed to the inclusion of additional mandatory warning labels. However, we believe products that are deemed to have such risk that they require multiple labels advising consumers of potential life threatening adverse events, should not be available outside pharmacies. There must be consistency between warning labels and scheduling classifications.

## The dosage formulation, labelling packaging and presentation of a substance 25

Under this proposal consumer safety would rely entirely on labelling advisories and consumers reading and understanding these advisories. As mentioned previously, although advisory labels would inform consumers of some of the risks relating to the product, risk cannot be addressed by warning labels alone. While the availability of clear and concise warnings may assist to some extent in reducing consumer harm from medicine misadventure, it is not sufficient as a stand-alone approach.

Consumer surveys conducted by the manufacturers themselves show that a large number of consumers never read the instructions on the pack and a media release sent to the Australian Journal of Pharmacy on behalf of one of the manufacturers made reference to "a relaxed attitude towards commonly used pain relievers, with close to 20 percent of Australians not likely to read the label on non-prescription pain relievers when using a brand for the first time."26

#### **Summary**

does not support the current proposal and believes that the current scheduling remains appropriate.

Both the ACMS and the scheduling delegate only recently considered this proposal and came to the view that the current schedule was appropriate, noting that the GI risk with naproxen is greater than with ibuprofen.

Naproxen and other commonly available NSAIDs are associated with increased cardiovascular risks with elderly consumers being particularly at risk. This risk is magnified with concomitant use with oral and topical NSAIDs or aspirin which are currently available from general retail.

Given a recent TGA review has highlighted an increased risk of cardiovascular events associated with considers it would be inappropriate to allow naproxen to be sold in general retail. The risks highlighted above are best mitigated if these products remain in pharmacy.

<sup>&</sup>lt;sup>23</sup> https://www.tga.gov.au/submissions-and-tga-response-non-steroidal-anti-inflammatory-drugs-diclofenac-flurbiprofen-ibuprofenketoprofen-mefenamic-acid-and-naproxen-proposed-additional-advisory-statement-medicines

<sup>24</sup> Medicines Advisory Statements Specification 2014 <a href="https://www.comlaw.gov.au/Details/F2015C00557">https://www.comlaw.gov.au/Details/F2015C00557</a>

<sup>&</sup>lt;sup>25</sup> Section 52E(1d)- Therapeutic Goods Act 1989

<sup>&</sup>lt;sup>26</sup> Suitability and choice of simple analgesics – balancing benefits and risks. Presented by Dr Alison Jones at the 25th Annual Scientific Meeting of the Australian Pain Society Meeting, Canberra 10th March 2004.

#### **PARACETAMOL**

Proposal to amend the Schedule 2 entry of paracetamol to:

- restrict the pack size requirements to no more than 100 tablets or capsules per pack and no more than 50 wrapped powders or sachets of granules per pack for domestic supply, and
- specifically limit bulk pack sizes of paracetamol for supply only to hospital, nursing homes and pharmacies for dispensing purposes.

#### **Overview**

supports the intent of this scheduling proposal and believes consideration should be given to further restricting the maximum pack size in the Schedule 2 category to 50 tablets or capsules per pack and no more than 25 wrapped powders or sachets.

In the context of this scheduling proposal, consideration should also be given as to whether the lack of controls over the number of paracetamol products that can be purchased outside pharmacy is consistent with the intent of the proposed amendment to the Schedule 2 classification.

## The risk and benefits of the use of the substance<sup>27</sup>

While paracetamol is a low risk medicine when taken as directed in low doses, hepatotoxicity has been reported at doses within the therapeutic range of paracetamol (in some cases at doses less than the recommended 4 g/day), although why certain individuals may be at greater risk of toxicity is unclear.<sup>28</sup>

Paracetamol was the most commonly misused over-the-counter analgesic in Australia in 2013.<sup>29</sup> In 2009–2010 around 14% of all accidental poisoning cases were due to non-opioid analgesics, antipyretics and antirheumatics, with the majority of these cases caused by paracetamol.<sup>30</sup> Furthermore, between 1997 and 2005, paracetamol was implicated in around 5% of drug-related deaths in Australia.<sup>31</sup>

argues restricting access to larger pack sizes (greater than 50 tablets or 25 wrapped powders or sachets) to Pharmacist Only (Schedule 3) will reduce the likelihood of excess consumption and overdose occurring.

#### Previous decision to reduce pack sizes

In 2013, the TGA reduced the maximum pack size for paracetamol that could be exempt from scheduling to twenty tablets (previously twenty five) with the belief that it would result in fewer people requiring medical intervention following a paracetamol overdose.<sup>32</sup> While welcomed this change, there are questions about the actual impact this change would have, given there were generally no restrictions on the number of packs a consumer can purchase in a single transaction from general retail. Therefore, the current scheduling exemption for paracetamol should also be considered in the context of this scheduling proposal, specifically whether the lack of controls over the number of paracetamol products

<sup>&</sup>lt;sup>27</sup> Section 52E(1a)- Therapeutic Goods Act 1989

<sup>&</sup>lt;sup>28</sup> Amar PJ and Schiff ER. Acetaminophen safety and hepatotoxicity--where do we go from here? Expert Opin Drug Saf 2007;6:341–55. Sourced from NPS MedicineWISE – Accessed 8/12/2015 <a href="http://www.nps.org.au/publications/health-professional/health-news-evidence/2015/reducing-paracetamol-misuse#">http://www.nps.org.au/publications/health-professional/health-news-evidence/2015/reducing-paracetamol-misuse#</a> FNREF 10

evidence/2015/reducing-paracetamol-misuse# ENREF 10

29 Australian Institute of Health and Welfare. National drug strategy household survey detailed report. Canberra: Australian Institute of Health and Welfare, 2014. [Online] (accessed 27 April 2015) Sourced from NPS MedicineWISE

http://www.nps.org.au/publications/health-professional/health-news-evidence/2015/reducing-paracetamol-misuse#\_ENREF\_10 Tovell A, McKenna K, Bradley C, et al. Hospital separations due to injury and poisoning, Australia. Canberra: Australian Institute of Health and Welfare, 2012. [Online] (accessed 27 April 2015) Sourced from NPS MedicineWISE 8/12/2015

<sup>&</sup>lt;sup>31</sup> Drug Free Australia. Australian Bureau of Statistics - Deaths collection. Broadview, South Australia: Drug free Australia, 2007. [Full text] (accessed 27 April 2015) Sourced from NPS MedicineWISE 8/12/2015

https://www.tga.gov.au/media-release/paracetamol-changes-pack-size Accessed 8/12/2015

that can be purchased outside pharmacy is consistent with the intent of the proposed amendment to the Schedule 2 classification.

# The purposes for which a substance is to be used and the extent of use of a substance<sup>33</sup>

Furthermore, consumers who require packs of paracetamol larger than 50 tablets or 25 sachets are likely to be using paracetamol to treat a chronic pain condition. In such instances, believes it is important for these consumers to have regular discussions regarding their treatment and condition with a pharmacist, or doctor if required. Having pack sizes larger than 50 tablets or 25 sachets only available as Schedule 3 medicines will help facilitate these discussions. The argues a pack size of 50 tablets or 25 sachets available in the Schedule 2 classification is adequate for patients who require paracetamol to treat acute pain conditions and/or have some tablets/sachets on 'stand by' at home.

#### Summary

supports the intent of this proposal and believes consideration should be given to further restricting the maximum pack size in the Schedule 2 category to 50 tablets or capsules per pack and no more than 25 wrapped powders or sachets. Having larger pack sizes only available as Schedule 3 medicines is likely to reduce the likelihood of excess consumption and facilitate discussion where consumers are using paracetamol to treat a chronic pain condition.

In the context of this scheduling proposal, believes it is also pertinent to consider the current scheduling exemption for paracetamol as there are generally no restrictions on the number of packs a consumer can purchase in a single transaction from general retail. Consideration should be given as to whether the scheduling exemption is consistent with the intent of the proposed amendment to the Schedule 2 classification.

<sup>33</sup> Section 52E(1a)- Therapeutic Goods Act 1989

## **Purpose**

i di pose
The makes this submission on proposed amendments to the Poisons Standard referred by the delegate for scheduling advice for consideration by the Advisory Committee on Medicines Scheduling in March 2016.
comments relate to proposed amendments to ketoprofen, loratadine, naproxen and paracetamol.

## Summary of position

#### Ketoprofen

does not support the proposal to amend the scheduling of ketoprofen to include divided preparations for oral use containing 200 mg or less of ketoprofen per dosage unit in Schedule 3. In the context of recent safety reviews of non-steroidal anti-inflammatory drugs and the overall safety profile of the substance, believes this rescheduling proposal for ketoprofen is not warranted or in the patient's best interest.

#### Loratadine

does not support the proposal to increase the pack size of unscheduled loratadine (10 mg or less) divided oral preparations from 5 dosage units to 10 dosage units when used in adults and children 12 years and over for the treatment of seasonal allergic rhinitis. believes the current availability of small packs sufficiently accommodates the needs of consumers who may require rapid and short term relief and an increase is not warranted from a perspective of good clinical practice and optimal therapeutic outcomes.

#### Naproxen

is opposed to the proposal to amend the Schedule 2 naproxen entry to exclude naproxen when containing 200 mg or less per dosage unit in packs of 12 or less when not labelled for the treatment of children under 12 years of age. believes that overall in the context of currently available evidence such an amendment is not in the interest of medication safety. Greater emphasis should be placed on communicating to consumers relevant risk factors and the need to limit dose and duration of treatment.

#### **Paracetamol**

supports the proposed amendments to the Schedule 2 entry of paracetamol as it provides clarity and consistency.

#### Ketoprofen

Proposal to amend the scheduling of ketoprofen to include divided preparations for oral use containing 200 mg or less of ketoprofen per dosage unit in Schedule 3.

Ketoprofen is currently included in the Poisons Standard<sup>2</sup> as follows:

- Schedule 3 in divided preparations for oral use containing 25 mg or less per dosage unit in a pack containing 30 or less dosage units
- Schedule 4 except: in preparations for dermal use, or when included in Schedule 3.

Australian Government Department of Health. Poisons Standard October 2015. At: https://www.comlaw.gov.au/Details/F2015L01534/Download

Ketoprofen is available on the Pharmaceutical Benefits Scheme in two forms:

- 200 mg modified release capsules as a Restricted Benefit for "chronic arthropathies (including osteoarthritis) with an inflammatory component"
- 100 mg suppositories (general benefit).

Registered indications for ketoprofen products (on the Australian Register of Therapeutic Goods) containing 200 mg in modified release capsules and 100 mg in suppositories are rheumatoid arthritis and osteoarthritis. Ketoprofen can be used for other conditions such as: ankylosing spondylitis, acute articular and peri-articular disorders (bursitis, capsulitis, synovitis, tendonitis), cervical spondylitis, low back pain (strain, lumbago, sciatica, fibrositis), musculo-skeletal inflammation and injury, musculotendinous bruising and swelling, and dysmenorrhoea.

The Therapeutic Goods Administration (TGA) in recent times has completed a comprehensive review of eight non-steroidal anti-inflammatory drugs (NSAIDs) with regards to cardiovascular safety. We note that ketoprofen was not included in this report. Nevertheless, recommendations arising from the review included the need to carefully assess cardiovascular and gastrointestinal risks for each patient and to prescribe the most appropriate medicine and individualise treatment accordingly. While it was considered overall that the availability of over-the-counter (OTC) NSAIDs could remain unchanged, the inclusion of substantially stronger warnings on the labels of NSAIDs and reminders for patients were recommended.

Ketoprofen 200 mg or less per dosage unit is a strength currently included in Schedule 4 and substantially greater than the 25 mg per dosage unit upper limit for Schedule 3. Ketoprofen is generally regarded to carry a higher risk of gastrointestinal and cardiovascular adverse effects compared to other NSAIDs such as ibuprofen, diclofenac and naproxen. The relative risk of gastrointestinal complications with ketoprofen has been reported to be as much as four times that of ibuprofen.<sup>4</sup>

Further, the TGA's *Required advisory statements for medicine labels No. 2* which comes into effect on 12 December 2015 includes required warning statements for ketoprofen use in relation to stomach ulcers, asthma and pregnancy.<sup>5</sup> It is also not recommended for use while breastfeeding and there is an increased risk of adverse effects (e.g. gastric ulceration, renal impairment, dizziness, sodium and water retention, heart failure) in the elderly.<sup>6</sup>

These considerations mean that ketoprofen is generally not regarded as the NSAID of choice for their anti-inflammatory and analgesic effects. Furthermore, usually the minimum effective dose is recommended and for the shortest duration.

Australian Government Department of Health. Review of cardiovascular safety of non-steroidal anti-inflammatory drugs. Version 2.1. 2014; Oct. At: https://www.tga.gov.au/sites/default/files/medicines-review-nsaid.pdf

Ong CKS, Lirk P, Tan CH, Seymour RA. An evidence-based update on nonsteroidal anti-inflammatory drugs. Clin Med Res 2007;5(1):19–34.

Medicines Advisory Statements Specification 2014. At: https://www.comlaw.gov.au/Details/F2015C00557/Download

Sansom LN, ed. Australian pharmaceutical formulary and handbook. 23rd edn. Canberra: Pharmaceutical Society of Australia; 2015. p. 334.

In the context of the findings of the TGA review for the NSAID drug class and the general substance profile for ketoprofen, considers the current proposal to be a significant amendment. At this time, we do not believe there is adequate evidence to suggest OTC availability of prescription strength ketoprofen is warranted, safe or in the patient's best interest.

therefore does not support the proposed amendment to ketoprofen in Schedule 3.

#### Loratadine

Proposal to increase the pack size of unscheduled loratadine (10 mg or less) divided oral preparations from 5 dosage units to 10 dosage units when used in adults and children 12 years and over for the treatment of seasonal allergic rhinitis.

Seasonal allergic rhinitis is one of the two most common respiratory conditions affecting an estimated 3.7 million Australians.<sup>7</sup> notes that allergic rhinitis is classified according to pattern of symptoms (intermittent or persistent) and severity (mild or moderate-to-severe) rather than the previously used terms of seasonal and perennial.<sup>8</sup>

The goals of treatment are to reduce symptoms and to improve daily functioning and quality of life. 9 Optimal management of allergic rhinitis can also have other benefits such as reducing the risk of developing asthma or obstructive sleep apnoea. 10

A range of OTC medicines is available for the management of symptoms and include intranasal corticosteroids, oral and intranasal antihistamines, and topical and oral decongestants. Oral antihistamines can provide rapid relief of symptoms such as sneezing, itching and rhinorrhoea and often (but not always) a preference is shown for less sedating antihistamines. Treatment guidelines<sup>11,12,13</sup> however generally recommend intranasal corticosteroids as first line therapy for adults and children although maximal effect requires regular use. It would therefore seem unnecessary to increase pack size of unscheduled loratadine from five to 10 dosage units.

Current arrangements with the availability of small packs of loratadine already cater for five days of therapy with the advice that if the condition does not improve or is not well controlled after a

Australian Institute of Health and Welfare. Australia's health 2014. Australia's health series no. 14. Cat. No. AUS 178. Canberra: AIHW; 2014.

Bousquet J, Khaltaev N, Cruz AA, et al. Allergic rhinitis and its impact on asthma (ARIA) 2008. Allergy 2008;63(Suppl. 86):8–160.

Sansom LN. op. cit. pp. 577–80.

Australasian Society of Clinical Immunology and Allergy, Allergy and Anaphylaxis Australia. National Allergy Strategy. 2015; Aug. At: www.nationalallergystrategy.org.au/images/doc/NAS\_Document\_Final\_WEB.pdf

Bousquet J. op. cit. pp. 55–7.

Walls RS, Heddle RJ, Tang MLK, Basger BJ, Solley GO, Yeo GT. Optimising the management of allergic rhinitis: an Australian perspective. Med J Aust 2005;182:28–33. At: <a href="https://www.mja.com.au/system/files/issues/182\_01\_030105/wal10248\_fm.pdf">https://www.mja.com.au/system/files/issues/182\_01\_030105/wal10248\_fm.pdf</a>

Seidman MD, Gurgel RK, Lin SY, et al. Clinical practice guideline: allergic rhinitis. Otolaryngology – Head and Neck Surgery 2015;152(1 Suppl.):S1–S43.

few days the patient should seek advice from a doctor or pharmacist. would contend that an increase in pack size of unscheduled loratedine to 10 dosage units is therefore not warranted from a therapeutic perspective.

It is reported that when a health professional such as a pharmacist guides allergic rhinitis management the patient experiences better outcomes than those who set their own goals for treating the disease. <sup>14</sup> Consistent with this, strongly favours arrangements which promote the opportunity for patients and carers to discuss their allergic rhinitis management with a pharmacist. The support of pharmacists is important for those who self-manage effectively with OTC medicines or non-pharmacological measures and is also beneficial in assisting those who have an allergic rhinitis treatment plan <sup>15</sup> developed through a medical or nurse practitioner. Providing patient education, and assisting and monitoring tailored treatments are important areas that pharmacists have a core role in supporting individuals.

In summary, does not support the proposal to increase the pack size of unscheduled loratadine from five to 10 dosage units. We believe current availability is adequate in meeting any immediate needs of consumers and further, an increase in pack size is not consistent with optimal therapeutic management of allergic rhinitis.

#### Naproxen

Proposal to amend the Schedule 2 naproxen entry to exclude naproxen (i.e. make it available for sale outside pharmacy) when containing 200 mg or less of naproxen per dosage unit in packs of 12 or less dosage units when not labelled for the treatment of children under 12 years of age.

Naproxen has a range of uses including: headache, sinus pain, cold and flu symptoms, acute and chronic inflammatory pain, dysmenorrhoea, gout, acute migraine, rheumatoid arthritis, ankylosing spondylitis and osteoarthritis.

The current Schedule 2 entry for naproxen is "in divided preparations containing 250 mg or less of naproxen per dosage unit in packs of 30 or less dosage units". <sup>16</sup>

Short term use of NSAIDs for relief of pain, inflammation and fever is well established. The risks associated with NSAID use are also well known, in particular, the need to exercise caution for people over 65 years of age, those at risk of stomach and heart problems, or those with asthma. NSAIDs are "more likely than paracetamol to cause side effects", especially for the elderly as well as people with conditions including: arthritis pain, chronic pain, high blood pressure, asthma, heart failure, impaired kidney or liver function and inflammatory bowel disease. <sup>17</sup>

Australian Institute of Health and Welfare. Allergic rhinitis ('hay fever') in Australia. Cat. No. ACM 23. Canberra: AIHW; 2011. At: www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737420519

Australasian Society of Clinical Immunology and Allergy. Treatment plan for allergic rhinitis (hay fever). 2015. At: www.allergy.org.au/images/pcc/ASCIA\_Treatment\_Plan\_for\_Allergic\_Rhinitis\_2015.pdf

Australian Government Department of Health. Poisons Standard October 2015. p. 44. At: https://www.comlaw.gov.au/Details/F2015L01534/Download

NPS MedicineWise. Nonsteroidal anti-inflammatory drugs (NSAIDs). At: www.nps.org.au/conditions/nervous-system-problems/pain/for-individuals/medicines-treatments-for-pain/nsaids\_pain\_relievers

NSAIDs are considered to be one of several groups of medicines known to be associated with the most severe adverse events and accounting for a large percentage of fatal and non-fatal events. Analgesics, including NSAIDs, were reportedly responsible for around 17% of over 37,000 hospital admissions attributed to adverse drug reactions.

Among the NSAIDs, naproxen is regarded as having a medium to high risk of upper gastrointestinal bleeding or perforation.<sup>20</sup> Compared with ibuprofen, for example, naproxen is more than twice as likely to cause upper gastrointestinal bleeding or perforation.<sup>21</sup> It is also acknowledged that naproxen may be risk-neutral with regard to cardiovascular events.<sup>22</sup>

The TGA's cardiovascular safety review of NSAIDs<sup>23</sup> concluded that overall, the current evidence suggests that OTC naproxen has cardiovascular risks similar to those associated with other OTC NSAIDs. While changes to OTC availability were not recommended based on currently available data, stronger warning labels and better consumer awareness of cardiovascular and gastrointestinal risks were recommended for naproxen and other NSAIDs.

There are clearly many issues impacting on the safe and optimal use of naproxen and all NSAIDs. believes options for pain management and analgesia through self-medication are legitimate needs for many Australian consumers. Access to these options must be delivered in an environment that supports public health and patient safety, facilitates appropriate risk assessment and gives due consideration to the best use of medicines.

As such, believes the pharmacy profession's fundamental role around balancing risks and benefits for each person, tailoring general advice and medicine information, preventing medication misadventure, promoting optimal therapy and supporting consumers to improve health literacy must be promoted. Such considerations cannot be fulfilled in general retail outlets where professional oversight or input in the supply of therapeutic goods is not available and a person's health and wellbeing in the context of medication safety is not a primary consideration.

In summary, is opposed to the proposal to amend the Schedule 2 entry to exempt naproxen from scheduling in light of currently available safety evidence and quality use of medicines considerations.

NPS MedicineWise. High-risk medicines: how to avoid errors. 9 Jul 2014. At: www.nps.org.au/publications/health-professional/health-news-evidence/2014/high-risk-medicines

NPS MedicineWise. Medicines to avoid in older people. At: www.nps.org.au/topics/ages-life-stages/for-individuals/older-people-and-medicines/for-health-professionals/inappropriate-prescribing/medicines-to-avoid

Massó González EL, Patrignani P, Tacconelli S, et al. Variability among nonsteroidal anti-inflammatory drugs in risk of upper gastrointestinal bleeding. Arthritis Rheum 2010;62(6):1592–1601.

Castellsague J, Riera-Guardia N, Calingaert B, et al. Individual NSAIDs and upper gastrointestinal complications: a systematic review and meta-analysis of observational studies (the SOS project). Drug Saf 2012;35(12):1127–46.

Peterson K, McDonagh M, Thakurta S, et al. Drug class review: nonsteroidal anti-inflammatory drugs (NSAIDs). Final update 4 report. Portland: Oregon Health & Science University; 2010, Nov.

Australian Government Department of Health. Review of cardiovascular safety of non-steroidal anti-inflammatory drugs. Version 2.1. 2014; Oct. At: https://www.tga.gov.au/sites/default/files/medicines-review-nsaid.pdf

#### **Paracetamol**

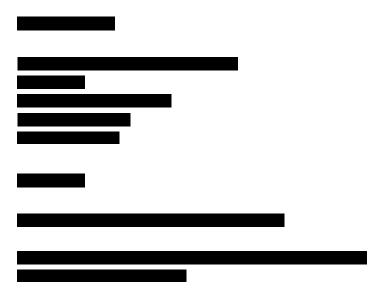
Proposal to amend the Schedule 2 entry of paracetamol to:

- restrict the pack size requirements to no more than 100 tablets or capsules per pack and no more than 50 wrapped powders or sachets of granules per pack for domestic supply, and
- specifically limit bulk pack sizes of paracetamol for supply only to hospital, nursing homes and pharmacies for dispensing purposes.

notes that the current Schedule 2 entry of paracetamol provides a pack size limit to defin when paracetamol is exempt from scheduling but not an upper limit for inclusion in Schedule 2	
Given the imminent delisting of OTC paracetamol medicines from the Pharmaceutical Benefits Scheme (PBS), believes the proposal to place an upper limit on pack size of Schedule 2 paracetamol medicines is not unreasonable and consistent with quality use of medicines principles.	

notes that, for chronic arthropathy patients currently being prescribed 300 dosage units per dispensing, this may initially pose some confusion as the patients or carers may have an expectation that they can continue to access PBS maximum quantities.

Nevertheless believes the inclusion of an upper limit on pack size quantity provides clarity and consistency with the paracetamol entry in Schedule 2 and therefore supports this proposal.



10 December 2015