[redacted]

PROPOSED AMENDMENTS TO POISONS STANDARD

ACMS Meeting June 2018

Comments by The Pharmacy Guild of Australia to the proposed amendments referred by the delegate for scheduling advice for consideration by the Advisory Committee on Medicines Scheduling

1. **Budesonide**
2. **Ibuprofen combined with paracetamol**
3. **Codeine**
4. **Sildenafil**

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BUDESONIDE

- Amend the S2 entry for budesonide to increase the dose per actuation from 50 to 64 micrograms and;
- Remove the limit of 200 actuations

Overview

We note that this submission is similar to the recent fluticasone proposal with respect to the number of actuations and our view on this proposal is consistent with our previous submission.

We also note that this proposal would down schedule the 64 microgram dose product to S2. Given that the S2 product that provides a dose of 32 microgram could be used to obtain a dose of 64 microgram by using multiple applications we would not oppose the proposal.

We note other corticosteroids entries for similar indications such as seasonal allergic and perennial rhinitis have the following wording:

> BECLOMETASONE in aqueous nasal sprays delivering 50 micrograms or less of beclometasone per actuation when the maximum recommended daily dose is no greater than 400 micrograms and when packed in a primary pack containing 200 actuations or less, for the prophylaxis or treatment of allergic rhinitis for up to 6 months in adults and children 12 years of age and over.
>
> MOMETASONE in aqueous nasal sprays delivering 50 micrograms or less of mometasone per actuation when the maximum recommended daily dose is no greater than 200 micrograms for the prophylaxis or treatment of allergic rhinitis for up to six months in adults and children 12 years of age and over.
>
> TRIAMCINOLONE in aqueous nasal sprays delivering 55 micrograms or less of triamcinolone per actuation when the maximum recommended daily dose is no greater than 220 micrograms, for prophylaxis or treatment of allergic rhinitis for up to 6 months in adults and children 12 years of age and over.
>
> FLUTICASONE in aqueous nasal sprays delivering 50 micrograms or less of fluticasone per actuation when the maximum recommended daily dose is no greater than 400 micrograms and when packed in a primary pack containing 200 actuations or less, for the prophylaxis or treatment of allergic rhinitis for up to 6 months in adults and children 12 years of age and over.

We note that the indications for the above substances are as follows:

> BECLOMETASONE
> Short-term prophylaxis (up to 6 months), treatment of allergic rhinitis in adults, children ≥12 yrs
>
> MOMETASONE
> Prophylaxis or treatment of allergic rhinitis for ≤ 6 mths in adults, children ≥ 12 yrs
>
> TRIAMCINOLONE
> Allergic rhinitis, short-term treatment (3-6 mths)
>
> FLUTICASONE
> for the prophylaxis and treatment of allergic rhinitis for up to 6 months in adults 18 years and over.

We also note that the Therapeutic Guidelines entry for Intranasal corticosteroids state the following[1]

> Intranasal corticosteroids are particularly useful for more severe allergic rhinitis. They are more effective than oral antihistamines and are especially effective for congestive symptoms. Systematic analyses also indicate significant reduction of ocular symptoms.
>
> It is important to explain to patients that intranasal corticosteroids do not relieve symptoms at the time of use; their role is to prevent symptoms. They usually start relieving symptoms within a few days but a minimum trial of a month is needed to establish efficacy.
>
> To reduce the likelihood of systemic adverse effects, use the minimum dose needed to control symptoms. Tailor the duration of treatment to the patient's symptoms and any drug adverse effects. Intranasal corticosteroid treatment may need to be continued for lengthy periods, even for many years.

Given the advice that treatment may need to be continued for lengthy periods "even for many years" the inclusion of a maximum number of actuations may be unnecessary and be related to the expiry date of the particular formulation after opening. An inspection of the product's information documents provide the following advice on expiry dates:

Beconase Allergy and Hayfever 12 Hour® (beclometasone)
Storage Store below 30° C. Shelf life of 2 years. Protect from light, do not refrigerate. This preparation should be discarded 3 months after first using the spray.

Rhinocort® (budesonide)
Storage Rhinocort Hayfever Nasal Spray has a shelf life of 2 years and should be stored in temperatures not exceeding 30° C. Do not freeze.

Nasonex® (mometasone)
Storage Store Nasonex Aqueous Nasal Spray 0.05% below 25° C. Do not freeze.

Telnase® (triamcinolone)
Storage Store below 25° C. The bottle should be discarded after 120 actuations or within two months of starting treatment.

Flixonase® Allergy & Hayfever 24 Hour (fluticasone)
Should be stored below 30ºC. Protect from light. Do not freeze.

We note that triamcinolone has a recommendation to discard contents after 120 actuations but there is no primary pack limitation in the SUSMP entry. On the other hand beclometasone should be discarded after 3 months but given that the dose is 2 sprays each nostril bd (=4 per day) and a maintenance dose of 1 spray each nostril bd (=2 per day) one would assume that if used as directed a primary pack would last from 50 to 100 days and there may therefore be little to discard.

We suggest that if there is no clinical justification for the inclusion of *"containing 200 actuations or less"* in the beclometasone and budesonide entries then for the sake of consistency it could be removed to reflect the mometasone and triamcinolone entries. Alternatively if there is a justifiable clinical reason that nasal

[1] https://tgldcdp.tg.org.au/viewTopic?topicfile=rhinitis-rhinosinusitis&guidelineName=Respiratory#toc_d1e70

corticosteroids should be supplied in packs of not more than 200 acutations then it should be added to mometasone and triamcinolone. We are not aware of any clinical data to suggest one or the other.

Summary

We do not oppose this proposal but for consistency would recommend all the entries for nasal corticosteroids be reconsidered.

2. IBUPROFEN COMBINED WITH PARACETAMOL

Amend the S3 entry for paracetamol to allow the S3 primary pack size, when combined with ibuprofen, to be increased from 30 to 50 dosage units and amend the S4 entry to reflect this change.

Overview

We do not believe it is warranted to increase the limit from 30 to 50.

Given that the TGA has only recently up-scheduled codeine + paracetamol combination medicines we do not think that it is appropriate to increase the pack size of a medicine that the TGA recommended on its Codeine Hub[2] as an alternative to these medicines. Consumers who may have been inappropriately using codeine combination medicines for chronic pain may consider the paracetamol + ibuprofen combination as a safe alternative. As the indication is for the *"temporary relief of acute (short-term) pain"* there should be no need for a size larger than 30.

The risks and benefits of the use of a substance

We note that these combination products have not been on the market for long so we would be cautious in increasing the pack size from 30 to 50.

With the up-scheduling of codeine combination products there may well be an increase in the use of these combinations by those consumers seeking an alternative and this may well highlight some unknown risks.

The purposes for which a substance is to be used and the extent of use of a substance

These medicines are used for the **temporary** relief of pain and inflammation associated with headache (including migraine, tension), toothache, dental procedures, muscular, period, sinus pain, backache, tennis elbow, rheumatism, arthritis, sore throat, pain associated with colds and flu.

As these products are for the temporary relief of pain, we do not believe there is a need for large sizes to be available. If pain persists then the consumer should be seeking medical care from a healthcare professional.

The toxicity of a substance

We note from the TGA approved PI for Nuromol® the following information on overdosage:

Paracetamol.
Liver damage is possible in adults who have taken 10 g (equivalent to 20 tablets) or more of paracetamol. Ingestion of 5 g (equivalent to 10 tablets) or more of paracetamol may lead to liver damage if the patient has one or more of the risk factors listed below:

a) Is on long-term treatment with carbamazepine, phenobarbitone, phenytoin, primidone, rifampicin, St John's wort or other drugs that induce liver enzymes.
b) Regularly consumes alcohol in excess of recommended amounts.
c) Is likely to be glutathione depleted, e.g. eating disorders, cystic fibrosis, HIV infection, starvation, cachexia.

[2] https://www.tga.gov.au/codeine-info-hub

Management.
Immediate treatment is essential in the management of paracetamol overdose. Despite a lack of significant early symptoms, patients should be referred to hospital urgently for immediate medical attention. Symptoms may be limited to nausea or vomiting and may not reflect the severity of overdose or the risk of organ damage. Treatment with activated charcoal should be considered if the overdose has been taken within 1 hour. Plasma paracetamol concentration should be measured at 4 hours or later after ingestion (earlier concentrations are unreliable). Treatment with N-acetylcysteine may be used up to 24 hours after ingestion of paracetamol, however the maximum protective effect is obtained up to 8 hours post ingestion.

Ibuprofen.
Symptoms. Most patients who have ingested clinically important amounts of NSAIDs will develop no more than nausea, vomiting, epigastric pain, or more rarely diarrhoea. Tinnitus, headache and gastrointestinal bleeding are also possible. In more serious poisoning, toxicity is seen in the central nervous system, manifesting as drowsiness, occasionally excitation and disorientation or coma. Occasionally patients develop convulsions. In serious poisoning, metabolic acidosis may occur and prolong the prothrombin time (PT) and increase the international normalised ratio (INR), probably due to interference with the actions of circulating clotting factors. Acute renal failure and liver damage may occur if there is coincident dehydration. Exacerbation of asthma is possible in asthmatics.

Management. Management should be symptomatic and supportive and include the maintenance of a clear airway and monitoring of cardiac and vital signs until stable. Consider oral administration of activated charcoal if the patient presents within 1 hour of ingestion of a potentially toxic amount. If frequent or prolonged, convulsions should be treated with intravenous diazepam or lorazepam. Give bronchodilators for asthma.

Given that liver damage is possible in adults who have taken 10 g (equivalent of 20 tablets) of paracetamol we would question the need for this product or indeed any analgesic product indicated for the use of short term pain to be available in larger quantities than is necessary.

We believe that the easy access to paracetamol and ibuprofen either in combination or as individual ingredients poses a risk to the public and that in general analgesics should be available from outlets where professional advice is available.

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

Nuromol®
Adults under 65 and children from 12 years.
1 tablet every 8 hours as necessary (maximum 3 tablets in 24 hours).

Nuromol should not be used for more than 3 days at a time (or not more than 2 days at a time for adolescents aged 12 to 17 years).

Not recommended for children under 12 years of age.
Not recommended for adults 65 years and over.
Monitoring advice. If symptoms persist please consult your healthcare professional.

As the medicine should not be used for more than 3 days at a time then 30 tablets is sufficient for 3 courses of treatment of 3 days each.

Maxigesic®
Adults and children over 12 years.
The usual dosage is one to two tablets taken every six hours, as required, up to a maximum of eight tablets in 24 hours.
Children under 12 years. Maxigesic is not recommended for children under 12 years.

30 tablets of Maxigesic at 8 per day is 3.75 days' supply. This should be sufficient for a course of treatment for one episode of acute pain. If pain persists a healthcare professional should be consulted.

The potential for abuse of a substance

There would appear to be little potential for abuse of this particular products but as there may be some consumers who were taking codeine + paracetamol combinations for use in chronic conditions they may seek an alternative and use this product inappropriately. It is these consumers that would benefit from consultation with a health care professional rather than access to an even larger quantity of a medicine that may be inappropriate for their condition.

Any other matters necessary to protect public health

We believe that the availability of large quantities of any analgesic increase the likelihood of misadventure and as a general principle consumers should only have access to clinically appropriate quantities.

Summary

Given that these medicines are for the use of the temporary relief of mild to moderate pain, and they should not be used long term without consultation with a health professional, we believe that the current scheduling remains appropriate.

3 CODEINE

- *Up-schedule codeine from S4 to S8 when in divided preparations containing more than 12 mg of codeine per dosage unit;*
- *Up-schedule codeine from S4 to S8 when in undivided preparations containing more than 0.25 per cent of codeine; and*
- *Amend both S4 and S8 entries for codeine to reflect these changes.*

Overview

We agree that these particular medicines should be subject to Real Time Monitoring but that it is unnecessary to up-schedule to Schedule 8 for this to occur.

We note that in Tasmania under the DORA system Schedule 4 codeine in addition to tramadol and dextropropoxyphene have been monitored since 1 April 2018[3]. We also understand that the Victorian SafeScript system which is planned to be launched in October 2018 will include all Schedule 8 medicines, such as oxycodone, morphine, alprazolam, methylphenidate and dexamphetamine, and some Schedule 4 medicines including all benzodiazepines such as diazepam, 'Z-drugs' such as zolpidem, and quetiapine. Codeine will be included at a later stage to allow clinicians time to adjust to the rescheduling of over-the-counter codeine products to prescription only.[4]

The logistics of this proposal will be a huge impost on all pharmacies and we do not believe it will have the intended effect on prescribing habits. Larger Controlled Drug safes in pharmacies is not the answer to the problem of opioid abuse but it is the prescribing behaviours that need to be monitored to prevent inappropriate use, misuse and abuse.

Given that only Tasmania has an electronic Real Time Monitoring system all other jurisdiction's Health Departments would struggle to effectively manage the volume of information on paracetamol + codeine prescriptions that they would receive in order to meet the requirements associated with up-scheduling.

There would also be a number of additional financial costs that would impact numerous parts of the medicine supply chain. It would increase costs for wholesalers, pharmacies, aged care facilities and the Commonwealth through increased Controlled Drug dispensing fees.

Pharmacies must store Schedule 8 medicines in a Controlled Drug safe that meets jurisdictional requirements. Such medicine safes have a limited storage capacity and with more Schedule 8 medicines being prescribed, pharmacies must assess and resolve the storage requirements. Replacing a safe or installing an additional one can be costly, and some pharmacies may not have the space for such measures without a significant refit of the dispensary. The proposed change is likely to have a similar impact on the pharmacy wholesalers as well. Acute care and aged care facilities will also be significantly affected with facilities requiring extra security for the storage of the additional Schedule 8 medicines as well as the administrative burden for staff in storing, handling, administering and recording paracetamol + codeine as an Schedule 8 medicine. Another unintended consequence will be the effect on the use of the National Residential Medication Chart as Schedule 8 medicines require a separate prescription.

Alternatively if the proposal seeks to address an inconsistency with codeine then this could be rectified by down-scheduling codeine from Schedule 8 to Schedule 4. We note that the Medicines Classification

[3] http://www.dhhs.tas.gov.au/psbtas/publications/document_list/newsletter_53_codeine_scheduling_changes
[4] https://www2.health.vic.gov.au/public-health/drugs-and-poisons/safescript

Committee in New Zealand have proposed to down schedule codeine as a single ingredient for sale over the counter from 31 January 2020[5].

The risks and benefits of the use of a substance

Whilst we accept that codeine medicines are not without risk and this was identified in the RIS, we do not believe that up scheduling to Schedule 8 is the answer. Keeping these medicines in a locked safe is not the solution to the problem of opioid misuse and abuse.

The problem is the inappropriate prescribing of these medicines and this often happens because prescribers do not have access to a Real Time Monitoring system that would allow them to check on the current use of codeine and other medicines of concern. If RTM was compulsory in every state and territory as it is in Tasmania, and shortly to be the case in Victoria, then there would be no need to up-schedule these products to Schedule 8. As in Tasmania, States and Territories could include any Schedule 4 medicine of concern in their Real Time Monitoring system to prevent the inappropriate prescribing and dispensing of these medicines if and when they develop them. To date only Tasmania has a Real Time Monitoring system.

The purposes for which a substance is to be used and the extent of use of a substance

We note that combination products containing paracetamol 500 mg + codeine 30 mg are indicated for the "*relief of moderate to severe pain, and fever*".

We also note that the indication for codeine 30 mg tablets is *"for the relief of mild to moderate pain"* and codeine linctus is indicated for the *"relief of unproductive, dry and intractable coughs associated with colds and flu".*

There would appear to be an anomaly in that a medicine used for **moderate to severe pain and fever** (codeine with paracetamol) has a lower scheduling classification than a medicine for the relief of **mild to moderate pain** (codeine as a single ingredient).

In an even more interesting inconsistency codeine linctus, a medicine used for a **dry and intractable cough**, is Schedule 8 whilst its chemical derivative dihydrocodeine which is indicated for dry cough is Schedule 3. The ACMS has already considered dihyrocodeine at is meeting in March 2017 and decided that Schedule 3 was appropriate and stated in its decision, amongst other things that *"there is a lack of evidence of abuse of the current product to justify removing it from Schedule 3".* Perhaps to address this inconsistency codeine linctus should be re-scheduled as Schedule 3.

The toxicity of a substance

We accept that theoretically codeine can be a toxic substance in overdose and can also lead to overdose of other ingredients if combined with paracetamol or ibuprofen. However we would highlight the following from Roxburgh et al (2015)[6]

> *"Missing data on the origin of codeine products consumed prior to death (prescribed or OTC) limits inferences about the source of codeine in these deaths, and hence inferences about the extent to which the diversion of prescribed codeine contributed to these deaths. It also limits inferences that can be drawn about the likely impact of reducing OTC codeine availability on the prevalence of codeine-related mortality."*

[5] http://www.medsafe.govt.nz/profs/class/Minutes/2016-2020/mccMin7Nov2017.htm
[6] https://www.mja.com.au/system/files/issues/203_07/10.5694mja15.00183.pdf

Given that it is difficult to determine if it is either the low-dose codeine or high dose codeine or other medicines taken in combination with codeine we would caution the ACMS on a reactive measure to up-schedule large dose combination medicines simply to ensure consistency. It would make more sense to implement a nationally co-ordinated Real Time Monitory system that would include all suspect medicines be they Schedule 4 or Schedule 8 rather than to store all paracetamol + codeine 30mg in a safe which will not be monitored by any State or Territory in real time other than in Tasmania.

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

The dosage of paracetamol 500mg + codeine 30 mg is as per the TGA Approved PI for Panadeine Forte®:

> *The initial dose is 1 tablet, repeated every 4 to 6 hours if necessary for mild to moderate pain. The initial dose is 2 tablets repeated every 4 to 6 hours if necessary (maximum 8 tablets per day) for severe pain.*

It also states in the Precautions

> *Codeine should be used with caution in patients with a history of drug abuse. Prolonged use of high doses of codeine may produce dependence and/or addiction. Tolerance may also result following repeated administration. Codeine has a primary potential for dependence. Tolerance, psychological and physical dependence develop with prolonged use of high doses with withdrawal symptoms after sudden discontinuation of the drug. Cross-tolerance with other opioids exists. Rapid relapses can be expected in patients with pre-existing opiate dependence (including those in remission). Administration must be discontinued gradually after prolonged treatments.*

Given the warning against prolonged use of high doses of codeine, we question the availability of an Authority Required listing in the Schedule of Pharmaceutical Benefits for 60 tablets that can be increased on request to Medicare to 240 tablets per month for up to 6 months. Whilst we accept that this is not an issue of scheduling but subsidy, it is an example of the broader issue of the use of opioids and one that we have suggested is best managed by a nationally co-ordinated Real Time Monitoring System.

Summary

We do not support this proposal.

However, the Guild supports these and other Schedule 4 medicines that are subject to misuse and abuse (e.g. tramadol and dextropropoxyphene as in Tasmania) being monitored using a Real Time Monitoring System by the State and Territory Health Departments as is their responsibility under their respective poisons legislation.

We note that it was agreed at the 16 April 2018 COAG Health Council[7] to progress national real time prescription monitoring as a federated model with jurisdictions committed to progressing development and adaptation of systems to connect to and interface with Commonwealth systems to achieve a national solution.

We have welcomed this commitment made by all State and Territory health ministers as we have been calling for such a system for many years. We are ready to assist in the implementation of a national system to address prescription drug abuse. We believe the solution must be nationally consistent to be fit

[7] http://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20130418_corrected_1.pdf

for purpose and connect prescribers and dispensers in real time so that clinicians can be informed and make decisions to minimise the risk of drug abuse and death.

3 SILDENAFIL

- *Create a new S3 entry for sildenafil in oral preparations containing 50 mg of sildenafil per dosage unit in packs containing not more than 8 dosage units;*
- *To include sildenafil in Appendix H to permit advertising; and*
- *To include sildenafil in Appendix M to provide additional controls or supply requirements to allow sildenafil to be supplied by a pharmacist.*

Overview

We note that this is a similar proposal to that considered by the ACMS in July 2017. We have not changed our position on this matter.

Rather than repeat our previous submission which the TGA has on record, we have addressed each of the Delegate's reasons for rejecting the previous proposal.

The reasons for the interim decision and our response are:

a. the risks and benefits of the use of a substance: ◦

- ***Adverse events and drug interactions of sildenafil can be potentially severe. The adverse event profile requires medical monitoring. Drug interactions may potentiate sildenafil toxicity.***

We note in the TGA approved PI[8] for sildenafil that it was administered to over 3700 patients (aged 19-87) during clinical trials worldwide. Over 550 patients were treated for longer than one year. Treatment with sildenafil was well tolerated. In placebo controlled clinical studies, the discontinuation rate due to adverse events was low and similar to placebo. The adverse events were generally transient and mild to moderate in nature.

Across trials of all designs, the profile of adverse events reported by patients receiving sildenafil was similar. In fixed dose studies, the incidence of adverse events increased with dose. The nature of the adverse events in flexible dose studies, which more closely reflect the recommended dosage regimen, was similar to that for fixed dose studies.

When sildenafil was taken as recommended (on an as needed basis in flexible dose placebo controlled clinical trials) the adverse events shown in Table 1 were reported.

[8] http://tga-search.clients.funnelback.com/s/search.html?collection=tga-artg&profile=record&meta_i=64435

Viagra **Table 1**

Adverse events reported by ≥ 2% of patients treated with Viagra or placebo in PRN flexible dose phase II/III studies

Adverse event	Percentage of patients reporting event	
	Viagra (N = 734)	Placebo (N = 725)
Headache	16%	4%
Flushing	10%	1%
Dyspepsia	7%	2%
Nasal congestion	4%	2%
Urinary tract infection	3%	2%
Abnormal vision+	3%	0%
Diarrhoea	3%	1%
Dizziness	2%	1%
Rash	2%	1%

+ Abnormal vision: mild and transient predominantly colour tinge to vision, but also increased perception to light or blurred vision. In these studies, only one patient discontinued due to abnormal vision. This effect was more common at doses of 100 mg or more.

Other adverse reactions occurred at a rate of > 2%, but equally commonly on placebo: respiratory tract infection, back pain, flu syndrome and arthralgia. In fixed dose studies, dyspepsia (17%) and abnormal vision (11%) were more common at 100 mg than at lower doses. At doses above the recommended dose range, adverse events were similar to those detailed above but generally were reported more frequently. No cases of priapism were reported during controlled clinical trials.

We also note that the post-marketing experience of cardiac disorders and vascular disorders. Serious cardiovascular events, including myocardial infarction, sudden cardiac death, ventricular arrhythmia, cerebrovascular haemorrhage, transient ischaemic attack and hypertension have been reported postmarketing in temporal association with the use of sildenafil. However we would highlight that most, but not all, of these patients had pre-existing cardiovascular risk factors. Many of these events were reported to occur during or shortly after sexual activity, and a few were reported to occur shortly after the use of sildenafil without sexual activity. Others were reported to have occurred hours to days after the use of sildenafil and sexual activity. It is not possible to determine whether these events are related directly to sildenafil, to sexual activity, to the patient's underlying cardiovascular disease, to a combination of these factors or to other factors. Tachycardia, hypotension, syncope and epistaxis have also been reported postmarketing. Rare spontaneous reports have been received of hypotensive events after the use of sildenafil in combination with alpha-blockers.

Whilst we accept that sildenafil has the potential to cause cardiovascular events in patients with pre-existing conditions the protocol will identify these patients and the pharmacist will refer the patient to a medical practitioner for follow-up. It is widely accepted that many men do not regularly attend a GP for opportunistic check-ups and by having a pharmacist follow a protocol as they do in New Zealand these consumers will be identified and referred.

- ***There is increasing evidence of a direct link between erectile dysfunction and cardiovascular disease. Erectile dysfunction is a marker of early atherosclerosis and as an independent predictor of cardiovascular events and all-cause mortality.***

As mentioned above, as part of the new Appendix M pharmacists will need to follow a protocol before the supply of sildenafil. Those patients identified to be at risk will be referred to a general practitioner for further investigation.

- ***There is evidence to suggest that the combination of type 2 diabetes and ED with significantly increased risk of cardiovascular disease.***

Again, as part of the protocol, pharmacist will need to identify patients using the protocol for which sildenafil is inappropriate and refer these patients to their GP.

Any patient who has been diagnosed with type 2 diabetes would be under the care of a general practitioner and would be regularly consulting with them on the management of their condition. This regular consultation would provide the opportunity for the man to discuss any concerns he may have with ED. In those men who may have undiagnosed type 2 diabetes a consultation with a pharmacist would provide the opportunity for the pharmacist to use the protocol to screen those patients who would benefit from a consultation with a medical practitioner.

- ***Risk of worsened health outcomes is heightened by the possibility of men never going to their doctor for assessments and obtaining repeat supplies from pharmacists.***

We believe that men are more likely to go to their doctor as pharmacists will be screening them for risk factors using the protocol and identifying those that need assessments.

As pharmacists are one of the most accessible health care practitioners men are more likely to consult a pharmacist than their doctor (if they even have a regular doctor) and this can be an opportunity for the pharmacist to screen patients who are at risk of cardiovascular disease or diabetes. The pharmacist can then refer the patient to a medical practitioner. Rather than heightening the risk of worsened health outcomes we believe that this is an opportunity for pharmacists to identify those men who would benefit from a referral to a doctor.

- ***Potential for incorrect assessment of ED and lack of screening of underlying and asymptomatic chronic conditions leading to a worsened health outcome due to self-management.***

As part of the new Appendix M the supply of sildenafil will be contingent on the pharmacist following a protocol to identify underlying chronic conditions and referring these patients to a doctor. In fact we believe that more men will be identified as part of this protocol than would be identified if men never went to a doctor which is currently the case.

It's a well reported problem that men are more reluctant to go to a doctor but we believe that they would be more likely to speak to their pharmacist initially[9]. If during the consultation they were identified with a risk factor then the pharmacist could refer them to a doctor.

- ***The proposed warning statements by the applicant actually reinforce the requirement for medical assessment before prescribing.***

Again we would argue that the warning statements would encourage men to discuss their condition with their pharmacist during the consultation and the protocol will act as a screening tool to identify those patients at risk. If any issues were identified then a referral to a doctor would be made by the pharmacist.

- ***Risk it would be used by men who are unfit and/or by those who have contraindications and are not prepared to tell pharmacist.***

[9] https://theconversation.com/men-more-reluctant-to-go-to-the-doctor-and-its-putting-them-at-risk-57420

Pharmacists have been repeatedly voted as one of the top three regarded profession in Australia[10] and we do not believe that men would be reluctant to discuss their health with their local pharmacist. In fact in many cases men would be more likely to discuss this matter with their pharmacist than another health professional as they see their pharmacist more often than any other health professional.

- ***Risk is heightened by the possibility of some consumers never going to their doctor for assessment, and obtaining repeat supplies through a pharmacist.***

As previously stated we believe that men are more likely to go to their doctor for an assessment after being screened by their pharmacist using the protocol as stipulated in Appendix M. Repeat supplies for this medicine would still require assessment using the protocol to ensure that the patient's condition had not changed.

- ***Any benefits of improved access for consumers are greatly outweighed by the risk of improper diagnosis or treatment of ED or associated risk factors by a pharmacist.***

As mentioned above the inclusion of a protocol as part of Appendix M will ensure that men who would not otherwise visit a doctor are screened for cardiovascular risk factors and referred to the doctor for follow-up.

b. the purposes for which a substance is to be used and the extent of use of a substance:

- ***The proposed Schedule 3 entry is intended for use in men aged 18 years old and older, with no upper age limit.***

We note that the TGA-approved PI states that:

> ***Elderly.*** *Healthy elderly volunteers (65 years or over) had a reduced clearance of sildenafil, with free plasma concentrations approximately 40% greater than those seen in younger volunteers (18-45 years). However, analysis of the safety database showed that age had no effect on the incidence of adverse events.*

We also note that sildenafil was administered to over 3700 patients aged 19-87 during clinical trials and it was well tolerated.

We do not believe that the proposed Schedule 3 entry with no upper age limit is a reason for rejection.

- ***Approximately 20% of Australian men greater than 40 years suffer from ED with a significantly increased risk with aging and cardiovascular disease.***

We do not believe that this is a reason for rejection but is simply a demographic statistic of the prevalence of a condition in Australian men. If 20% of men over 40 years of age suffer from ED and some of these do not regularly visit their doctor for ED or other medical conditions then this is an opportunity for pharmacists to use the protocol as part of Appendix M to identify men who may be at risk. Those that are identified to be at risk could then by referred to a doctor for further investigation.

[10] http://www.roymorgan.com/findings/7244-roy-morgan-image-of-professions-may-2017-201706051543

c. the toxicity of a substance:

- ***Safety data indicates that NAION and priapism are potential serious AEs, as are interactions with nitrates and some other drugs metabolised via CYP450.***

We agree that nonarteritic anterior ischaemic optic neuropathy (NAION) is a serious adverse event but as we note in the PI, NAION has been reported rarely postmarketing in temporal association with the use of PDE5 inhibitors, including sildenafil and most, but not all, of these patients had underlying anatomical or vascular risk factors for developing NAION, including but not necessarily limited to low cup to disc ratio (crowded disc), age over 50, diabetes, hypertension, coronary artery disease, hyperlipidaemia and smoking. It is for this reason that the Appendix M will include a protocol that the pharmacist will follow to identify patients at risk and refer to a medical practitioner.

Also we note that priapism (painful erections greater than 6 hours) has been reported infrequently since market approval of sildenafil. In the event of an erection that persists longer than four hours the patient should seek immediate medical assistance and this would be highlighted by the pharmacist during the consultation.

As for interactions with nitrates and "some other drugs" metabolised via CYP450 we note that the pharmacist would investigate all other medicines a patient was currently prescribed or taking. We note that nitrates.

Nitrates

The sildenafil PI state under Contraindications that:

> *"Nitrates and sildenafil must not be used concomitantly. Sildenafil was shown to potentiate the hypotensive effects of both acute and chronic nitrate administration and therefore, its coadministration with NO donors, organic nitrates or organic nitrites in any form, either regularly or intermittently is contraindicated. Drugs which must not be used concomitantly include glyceryl trinitrate (injection, tablets, sprays or patches), isosorbide salts, sodium nitroprusside, amyl nitrite, nicorandil or organic nitrates in any form. The coadministration of PDE5 inhibitors, including sildenafil, with guanylate cyclase stimulators, such as riociguat, is contraindicated as it may potentially lead to symptomatic hypotension"*

We would highlight that any patient who was taking any of the above medicines would have been prescribed these by their medical practitioner and would be aware of their clinical diagnosis. As they would have to be regularly visiting their doctor for prescriptions for these medicines they would have the opportunity to discuss their suspected ED with their doctor. In the event that they requested a supply of sildenafil from a pharmacist these medicines would be identified as part of the protocol and the pharmacist would refer them back to their doctor.

We accept that there is an interaction with nitrates but do not believe that this is a reason for rejection as this can be managed by use of the protocol stipulated in Appendix M of the SUSMP.

Drugs metabolised via PYP450

The PI states that

> *"Population pharmacokinetics analysis of clinical trial data indicated a reduction in sildenafil clearance when administered with CYP3A4 inhibitors (such as ketoconazole, erythromycin, cimetidine).* ***However, there was no increased incidence of adverse events in these patients.*****"**

Even if a patient were taking ketoconazole or erythromycin these are Schedule 4 medicines and would have been prescribed by a medical practitioner. The patient would have had the opportunity to discuss his

ED with the medical practitioner who prescribed these medicines. Even if they had not done so then then the pharmacist would have identified all other medicines a patient was currently taking when completing the protocol following a request for sildenafil as a Schedule 3 medicine.

We note that ketoconazole tablets appear to have been discontinued as it is no longer listed on the TGA's ARTG[11]. This should not pose a problem for a patient taking sildenafil.

Erythromycin is an antibiotic used most often as a short term course for infections and rarely for moderate to severe acne long term. Cimetidine whilst very popular many years ago it appears to have been superseded by other H2 receptor blockers and PPIs. We note that the only product still listed on the PBS (Magicul®) was dispensed only 2,920 times in the period from May 2016 to June 2017[12]. In the unlikely event that a patient was taking any of these medicines they would be identified by the pharmacist by using the protocol stipulated in Appendix M.

- ***Sildenafil has a significant AE profile that requires medical monitoring.***

We note again the TGA approved PI states that sildenafil was administered to over 3700 patients (aged 19-87) during clinical trials worldwide. Over 550 patients were treated for longer than one year. Treatment with sildenafil was well tolerated. In placebo controlled clinical studies, the discontinuation rate due to adverse events was low and similar to placebo. The adverse events were generally transient and mild to moderate in nature.

We also note the Database of Adverse Event Notifications[13] shows that in the period from 1 Jan 2000 to 31 December 2017 there were 275 reports for sildenafil with 238 cases where TGA thinks there is a possibility that the medicine caused the adverse event. There were 10 cases where a death was a reported outcome which may or may not have been the result of taking a medicine.

- ***Drug-drug interactions may potentiate sildenafil toxicity.***

The TGA-approved PI for sildenafil states that:

> *sildenafil metabolism is principally mediated by the cytochrome P450 (CYP) isoforms 3A4 (major route) and 2C9 (minor route). Therefore, inhibitors of these isoenzymes may reduce sildenafil clearance and inducers of these isoenzymes may increase sildenafil clearance.*
>
> *Population pharmacokinetics analysis of clinical trial data indicated a reduction in sildenafil clearance when coadministered with CYP3A4 inhibitors (such as ketoconazole, erythromycin, cimetidine). However, there was no increased incidence of adverse events in these patients.*

As noted above we do not believe that ketoconazole, erythromycin or cimetidine interactions are clinically significant as ketoconazole is no longer available in Australia and erythromycin and cimetidine usage would be identified in the pharmacist's protocol. A pharmacist could suggest that the patient finish the course of erythromycin before using sildenafil and suggest an alternative to cimetidine.

> *Coadministration of the HIV protease inhibitor saquinavir, also a CYP3A4 inhibitor, at steady state (1200 mg three times daily) with sildenafil (100 mg single dose) resulted in a 140% increase in sildenafil Cmax and a 210% increase in sildenafil AUC (see Dosage and Administration).*

[11] http://tga-search.clients.funne back.com/s/search.html?query=ketoconazole&collection=tga-artg

[12] http://medicarestatistics.humanservices.gov.au/statistics/do.jsp?_PROGRAM=%2Fstatistics%2Fpbs_item_standard_report&itemlst=%2701158Y%27&ITEMCNT=1&LIST=1158Y&VAR=SERVICES&RPT_FMT=1&start_dt=201605&end_dt=201706

[13] https://apps.tga.gov.au/PROD/DAEN/daen-report.aspx

Stronger CYP3A4 inhibitors such as ketoconazole and itraconazole would be expected to have still greater effects.

Coadministration with the HIV protease inhibitor ritonavir, which is a highly potent P450 inhibitor, at steady state (500 mg twice daily) with sildenafil (100 mg single dose) resulted in a 300% (4-fold) increase in sildenafil Cmax and a 1000% (11-fold) increase in sildenafil plasma AUC. At 24 hours the plasma levels of sildenafil were still approximately 200 nanogram/mL, compared to approximately 5 nanogram/mL when sildenafil was dosed alone. This is consistent with ritonavir's marked effects on a broad range of P450 substrates

As above if a pharmacist using the protocol stipulated in Appendix M identified a patient taking saquinavir, itraconazole or ritonavir then they would highlight that these medicines interact with sildenafil. However, all these medicines are used for conditions for which the patient would be under close medical supervision and it would be unlikely that these patients would not have already discussed their ED with their treating physician. These are the very patients who are under close medical supervision and are unlikely to be requesting this medicine from their pharmacist.

*Population pharmacokinetics analysis showed **no effect** of concomitant medication on sildenafil pharmacokinetics when grouped as CYP2C9 inhibitors, CYP2D6 inhibitors (such as selective serotonin reuptake inhibitors, tricyclic antidepressants), thiazide and related diuretics, loop and potassium sparing diuretics, ACE inhibitors, calcium channel blockers, beta-adrenoreceptor antagonists or inducers of CYP450 metabolism (such as barbiturates).*

The above indicates that CYP2D6 inhibitors (which include some very common medicines taken by men in Australia) showed **no effect** on sildenafil pharmacokinetics. However, as all these medicines are Schedule 4 medicines that require ongoing supervision by a medical practitioner we would argue that patients taking these medicines are already under medical monitoring and the patient would have already had the opportunity to discuss their ED concerns with their treating doctor. These are not the patients who are likely to be requesting sildenafil from their pharmacist as they would already have discussed this matter with their doctor.

Riociguat. Preclinical studies showed an additive systemic blood pressure lowering effect when PDE5 inhibitors were combined with riociguat. In clinical studies, riociguat has been shown to augment the hypotensive effects of sildenafil. There was no evidence of favourable clinical effect of the combination in the population studied. Concomitant use of riociguat with PDE5 inhibitors, including sildenafil, is contraindicated as it may potentially lead to symptomatic hypotension

As above, we believe that any patient currently being treated with a medicine to treat pulmonary arterial hypertension would unlikely to be requesting sildenafil from a pharmacist and already be under expert specialist care.

d. the dosage, formulation, labelling, packaging and presentation of a substance:

- ***Proposed pack size of eight (8) units does not appropriately address the risk of harms brought on by a lack of medical oversight in supply of sildenafil.***

We do not believe that this is a valid reason for rejection. There will not be a “lack of medical oversight” as suggested by the Delegate in the supply of sildenafil because the patient will have to discuss their request with a pharmacist who will use the protocol developed in line with the requirements of Appendix M. If the patient does not qualify under the protocol then they will be referred to a medical practitioner for further assessment of their medical condition.

- ***Sildenafil has a wide therapeutic index and the proposed 50 mg dose is the recommended starting dose, 1 hour before sexual activity. The PI states that 100 mg is the maximum dose.***

We do not believe that because sildenafil has a wide therapeutic index that this is a reason not to include in Schedule 3. In fact a wide therapeutic index is by definition a safe medicine.

The Therapeutic Index is a ratio that compares the blood concentration at which a drug becomes toxic and the concentration at which the drug is effective. If a drug has a narrow therapeutic index (i.e. the difference between the two concentrations is very small) then the drug must be dosed carefully and the patient should be monitored very closely for any signs of drug toxicity.

As sildenafil has a wide therapeutic index then it is by definition a safe medicine and is suitable for Schedule 3.

We note that in the Scheduling Policy Framework[14] that Factors for Pharmacy Only Medicines (S3) it states:

> **The medicine is substantially safe with pharmacist intervention to ensure the quality use of the medicine. There may be potential for harm if used inappropriately.**

We believe that this medicine, which has a wide therapeutic index, is substantially safe and the pharmacist intervention using the Appendix M protocol will ensure the quality use of the medicine as this will identify those patient (eg on nitrates) that should consult their doctor.

e. the potential for abuse of a substance:

- ***Possible misuse and/or abuse by men who do not have ED, or by men who take other drugs.***

We do not believe this is a valid reason for rejection. As sildenafil is not addictive and has been shown to be well tolerated in clinical trials there would be no adverse effects if used in men who do not have ED. In fact we would argue that men who do not have ED will not benefit from using this product.

We would refer the ACMS to the comments made in the MHRA's Public Assessment Report[15] when it considered the down scheduling of sildenafil;

> *"There is no indication from controlled clinical trial or post-marketing data that patients develop dependence or addiction to sildenafil. There are no underlying pharmacological mechanisms or neural or behavioural signs and symptoms that suggest that sildenafil would induce drug-seeking behaviour. There have been no reports of drug abuse or drug dependence associated with the use of sildenafil in clinical trials."*

We also do not understand what is meant by *"or by men who take other drugs".* The PI states under "Interactions" that:

> *Nitrates and sildenafil must not be used concomitantly. Sildenafil was shown to potentiate the hypotensive effects of both acute and chronic nitrate administration and therefore, its*

[14] https://www.tga.gov.au/book-page/scheduling-factors

[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662968/Viagra_Connect_POM_to_P_PAR_FINAL.pdf

coadministration with NO donors, organic nitrates or organic nitrites in any form, either regularly or intermittently is contraindicated.

Drugs which must not be used concomitantly include:

- *glyceryl trinitrate (injection, tablets, sprays or patches),*
- *isosorbide salts,*
- *sodium nitroprusside,*
- *amyl nitrite,*
- *nicorandil or organic nitrates in any form.*

The coadministration of PDE5 inhibitors, including sildenafil, with guanylate cyclase stimulators, such as riociguat, is contraindicated as it may potentially lead to symptomatic hypotension.

The drugs listed as contraindicated would be identified by the pharmacist when using the protocol as stipulated in Appendix M and as mentioned before if any man was currently on these medicines (which are all Schedule 4) then they would already be under medical supervision and would have had ample opportunity to discuss their ED with their treating doctor. These men will not be requesting sildenafil from their pharmacist.

An analysis of the *Database of adverse event notifications* (DAEN) attributable to all products containing the active ingredients tadalafil, sildenafil or vardenafil indicate that in total between 2007 and 2017 there were only 15 reported incidents that could be reasonably categorised as wilful inappropriate use of those medicines with just two of those incidents recorded specifically as intentional misuse of the product.[16]

We again note the comments made by the MHRA in its Public Assessment Report with respect to incorrect use:

> *There is evidence that sildenafil, often obtained illegally, is used with the recreational use of other drugs (for example, methamphetamine, methylenedioxy-N-methylamphetamine, poppers (e.g. amyl nitrate), and opioids) in people who do not normally have erectile dysfunction. This appears to be mainly in healthy men who use erectile dysfunction medicines to counteract effects of recreational drugs. It is unknown whether these users would purchase Viagra Connect from a pharmacy if that option was available, so it is not known whether reclassification would have any effect on this group.* ***However, there appears to be little evidence of harm from this intentional incorrect use that leads to a direct or indirect danger to health and it is considered that the second prescription only medicine criteria is not fulfilled.***
>
> *The concurrent use with poppers, including amyl nitrate, causing blood vessel dilation and blood pressure drop leading to myocardial infarction is a well-established concern.* ***Use with amyl nitrate is contraindicated in the product information, and it is considered that this is an acceptable risk minimisation measure.***

f. any other matters that the Secretary considers necessary to protect public health: ◦

- ***Good clinical practice mandates a cardiovascular assessment and history in all patients presenting with erectile dysfunction. This is best done by a patient's general practitioner.***

We do not disagree that cardiovascular risk factors are important but as previously mentioned these would be identified as part of the Appendix M protocol.

[16] Database of Adverse Event Notifications – medicines . Sildenafil, Vardenafil and Tadalafil adverse events occurring between 1 January 2007 and 18 February 2017. Unapproved indication, off-label use, sexual abuse and intentional product misuse categorised as inappropriate use. Database accessed 9/06/2017

We would remind ACMS that New Zealand and more recently the United Kingdom have made sildenafil available with a prescription. As noted by the MHRA in its Public Assessment Report:

> *It is considered that the risks of men intentionally using the product inappropriately are outweighed by the benefits that the pharmacy route of supply can bring – by providing a more convenient way to obtain sildenafil, thus bringing a hard-to-reach group into healthcare earlier with the potential to increase identification of cardiovascular disease and also reducing the risks of men obtaining counterfeits via the internet.*

- ***Internet purchasing is recognised, as is counterfeiting, however increased access through down-scheduling is not considered an appropriate mechanism to address this issue.***

We do not accept that down-scheduling is an inappropriate mechanism to address this issue.

If men could access these medicines from a pharmacist following a consultation they would be less likely to purchase counterfeit medicines from internet websites. Patients consulting their pharmacist are more likely to engage with their doctor if the pharmacist has identified any risk factor. If they are purchasing medicines from the internet they are never likely to engage with a health care professional and will likely suffer ill effects from medicines that generally don't contain any active ingredient or worse contain other chemical compounds that can cause ill effects as highlighted by the TGA's website: https://www.tga.gov.au/community-qa/buying-medicines-and-medical-devices-online

- ***Consumer education and information is a better avenue to help overcome the stigma of ED and improve treatment rates.***

We agree with these sentiments and suggest that there would be no better way to provide consumer education and information by having men discuss their health issues with a pharmacist who by following the Appendix M protocol could identify underlying health problems and refer the patient to a doctor. Sometimes this initial consultation with a pharmacist is the catalyst needed to encourage men to visit a doctor who they may not normally do.

- ***Although reticence to speak to GP about ED it not likely to be easier to speak to unknown pharmacists with whom there is no on-going relationship.***

We do not accept that this is a valid reason to reject this proposal.

We do not believe that men are less reticent to speak to their pharmacist than their GP. In fact pharmacists are the most accessible health care professional in Australia with approximately 5,700 pharmacies spread throughout the country. Analysis undertaken by MacroPlan Dimasi[17] found that consumers have a very high level of access to community pharmacy. In capital cities, the average resident is located one kilometre from the nearest pharmacy, while 95% of consumers are no further than two and a half kilometres from a pharmacy. In regional areas, on average consumers are six and a half kilometres from the nearest pharmacy, with 72% being able to access a pharmacy within two and a half kilometres. The average Australian visits a pharmacy 14 times a year and we would argue that there is indeed an ongoing relationship with pharmacies.

In fact one of the key findings the Consumer Needs Project[18] commissioned as part of the Fifth Community Pharmacy Agreement was that *"82% of participants reported going to the same pharmacy for*

[17] MacroPlan Dimasis Analysis 2016

[18] http://6cpa.com.au/resources/fifth-agreement-rd/consumer-needs-project/

most of their [pharmacy needs (ie more than 75% of the time). This proportion increased with age (from 74% in the 18-24 age group to 95% in the over 65 age group)". Another key finding was that *"the vast majority of participants (98%) reported no difficulty in access community pharmacy."*

We believe that a man is more likely to speak to a pharmacist than a doctor as there is no need to make an appointment. Community pharmacies in Australia have long provided services related to sexual health through the provision of a range of expert information and advice, in addition to offering a wide variety of sexual health products. These community pharmacies also can be a primary source of emergency hormonal contraception, as well as being centres for providing advice on the safe and effective use of contraceptive methods and engaging in safe sexual practices. Many pharmacies now have private consultation rooms where customers can speak to their pharmacist away from other pharmacy customers.

- ***Low public health benefit as access is still outweighed by risks.***

We do not agree that there is a low public health benefit. In fact we believe that it would encourage men who never or rarely go to their doctor to visit a pharmacist and engage with a health care profession to discuss their concerns. We believe it is better that this patient population engage with their pharmacist than to source these types of medicines online as the risk could be even greater especially if they are buying counterfeit medicines often with dangerous chemicals replacing the expected active ingredient. As highlighted in many of the TGA Safety Advisories online medicines often contain other ingredients such as glibenclamide https://www.tga.gov.au/alert/african-superman-tablets

We note that the MHRA stated in its Public Assessment Report[19] when it considered the down-scheduling of sildenafil that:

> *"There is a low risk of masking underlying disease (an 'indirect danger' under criterion 1). However, this is considered to be minimised by the supply model provided and also outweighed by the benefits of patients being able to access a legitimate supply from a pharmacist who can provide healthcare advice and signpost the patient to their GP if appropriate"*

- ***Men do not see GP often anyway, so any opportunity to review for holistic review is good.***

Again we find this reasoning illogical. If men are never going to visit a GP then keeping a medicine, that is considered safe but requires professional advice from a pharmacist, as a Schedule 4 medicine will never make these men visit a GP. What may encourage them to do so is to visit a pharmacist for a preliminary assessment and if the pharmacists identifies any risks then they can refer them to a GP for follow up.

Allowing controlled access to sildenafil without a prescription has led to an increase in discussions between men and healthcare providers in New Zealand, where erectile dysfunction medicines are already available for supply by pharmacists under certain conditions.

In an article published by The Pharmaceutical Journal[20] Natalie Gauld provides the following insights from reclassification in New Zealand:

- The switch to Schedule 3 medicine enables more widespread availability and reduces the burden on GPs.

[19] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662968/Viagra_Connect_POM_to_P_PAR_FINAL.pdf

[20] https://www.pharmaceutical-journal.com/opinion/comment/viagra-from-the-pharmacist-insight-from-reclassification-in-new-zealand/20204320.article#fn_2

- A decrease in the use of online products for erectile dysfunction
- Sales over the internet typically involve no input from a health professional, and PDE5 inhibitors bought online are likely to be counterfeit, contain more (or less) of the drug than stated, and contain other related compounds and other drugs entirely; for example, hypoglycaemics.
- Anecdotal evidence from New Zealand suggests that some men who have previously purchased ED medicines over the internet are now purchasing from the pharmacist without a prescription instead. Following the reclassification in late 2014, fewer packs containing sildenafil were intercepted at the border,
- Helping to treat men early in their experience of ED is a second important benefit of reclassifying sildenafil. The condition can negatively affect relationships and quality of life, but many men do not seek treatment because they are embarrassed or do not see the condition as a medical complaint, for example.
- A third benefit, and one of the most important, is the potential to identify underlying problems before they develop into serious conditions, during consultation in the pharmacy. ED can be a sign of underlying cardiovascular disease, diabetes and myriad other conditions. Pharmacists should consider measuring blood pressure and blood glucose, and refer men who have not had a medical check recently.
- Men in New Zealand who request sildenafil from the pharmacist have commonly been referred to the GP for high blood pressure that the man might have been unaware of or ignored, or in cases where the man had not seen a GP for a number of years. Referral can save lives.
- A man treated by a pharmacist I know returned to the pharmacy to thank her for saving his life. When he requested sildenafil, he had been in denial of his “outrageous” blood pressure and other cardiovascular risk factors. The pharmacist took time to discuss with him her concerns about his cardiovascular risk and his need to take prompt action. She refused to supply sildenafil and booked a GP appointment for him. The man took the necessary steps with his GP to deal with his hypertension and other risk factors, for which he was extremely grateful.
- Pharmacists have the opportunity to improve men’s lives with sildenafil’s reclassification. Pharmacists must conduct appropriate screenings using the screening tool, consider underlying issues and refer where necessary so that men can continue to obtain treatment for ED through the pharmacy in the future.

We also not that the MHRA reclassified sildenafil to pharmacy medicine in the UNK in November 2017[21].

We would highlight the following from the MHRA Press Release:

- The medicine will be sold from pharmacies following a discussion with the pharmacist.
- Will not be sold to those with severe cardiovascular disorders; at high cardiovascular risk; liver failure; severe kidney failure; or taking certain interacting medicines.
- Making this medication more widely available will help direct men who might not otherwise seek help into the healthcare system and away from the risks that come with buying medicines from websites operating illegally.
- Erectile dysfunction medicines are a popular target for criminals selling unlicensed and counterfeit medicines. Over the past 5 years, investigators from MHRA have seized more than £50 million of unlicensed and counterfeit erectile dysfunction medicines.

Summary

We believe that with the additional controls included in Appendix M sildenafil would meet the requirements for a Schedule 3 medicine.

[21] https://www.gov.uk/government/news/mhra-reclassifies-viagra-connect-tablets-to-a-pharmacy-medicine

We would be happy to work with the profession to agree on a professional standard for the supply of this medicine that would include:

- Protocol and guidance for supply
- Inclusion criteria for supply
- Recording processes
- Training requirements
- Education standard
- Advice on an appropriate professional consultation fee

We believe that when this medicine is supplied it should be recorded against a professional standard and this information should be accessible for audit and reporting.

The proposal to list sildenafil in Appendix H is not supported at this time.