Consultation: Proposed amendments to the Poisons Standard - Advisory Committee on Medicines Scheduling meeting, June 2018

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Purpose

The Pharmaceutical Society of Australia (PSA) makes this submission on proposed amendments to the Poisons Standard being referred to the June 2018 meeting of the Advisory Committee on Medicines Scheduling (ACMS) for scheduling advice.

PSA's comments relate to proposed amendments to budesonide, codeine and sildenafil.

About PSA

PSA is the peak national professional pharmacy organisation representing Australia's 30,000 pharmacists[1] working in all sectors and locations.

PSA's core functions relevant to pharmacists include:

- providing high quality continuing professional development, education and practice support to pharmacists
- developing and advocating standards and guidelines to inform and enhance pharmacists' practice, and
- representing pharmacists' role as frontline health professionals.

PSA is also a registered training organisation and offers qualifications including certificate and diploma-level courses tailored for pharmacists, pharmacy assistants and interns.

[1] Pharmacy Board of Australia. Registrant data. Reporting period: 1 October 2017 – 31 December 2017. At: http://www.pharmacyboard.gov.au/documents/default.aspx?record=WD18%2f24764&dbid=AP&chksum=%2fhTqAUMulEVk8XqLHBFjcg%3d%3d

Summary of PSA's position

Budesonide *– PSA has no objections to the proposed amendment to the Schedule 2 entry.*

Codeine *– PSA does not support the proposed amendment to the S4 and S8 entries.*

Sildenafil *– PSA supports the proposed new S3 entry for sildenafil, and this being contingent on the inclusion of sildenafil in Appendix M to restrict supply.*

Comments on specific substances

Budesonide

Summary of proposal (extracted from consultation notice)

Current scheduling	Budesonide is currently in Schedules 2 and 4 of the Poisons Standard as follows: **Schedule 2** BUDESONIDE in aqueous nasal sprays delivering 50 micrograms or less of budesonide 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. **Schedule 4** BUDESONIDE **except** when included in Schedule 2.
Proposed scheduling	A request has been made to: • Amend the Schedule 2 entry for budesonide to increase the dose per actuation from 50 to 64 micrograms; and • Remove the limit of 200 actuations. **Schedule 2 – Amend Entry** BUDESONIDE in aqueous nasal sprays delivering ~~50~~64 micrograms or less of budesonide 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.
Reasons for proposal	• Allergic rhinitis (AR) it is of substantial public health significance and is widely considered as the most common chronic respiratory disorder. • Symptoms of AR can have a significant impact on the quality of life. • AR is a condition that has been well established as suitable for both self-diagnosis and self-treatment. • People who need to continue with the maximum dose of budesonide to maintain symptom control will benefit from the proposed Schedule 2 64 µg strength, which requires only 4 sprays per day compared to the current 8 sprays per day.

	• The proposed amendment to the Schedule 2 entry for budesonide is likely to have a potentially broad positive healthcare impact by improving AR compliance and treatment outcomes.

The primary goals of treatment of allergic rhinitis are to reduce symptoms, and to improve quality of life and daily functioning. Intranasal corticosteroid sprays have high efficacy in controlling symptoms of allergic rhinitis and a good safety profile with minimal risk of systemic side effects due to their low bioavailability. They are well tolerated and PSA is not aware of any significant adverse events attributable to budesonide nasal sprays since their inclusion in Schedule 2. Intranasal corticosteroids are more effective than oral antihistamines for allergic rhinitis and is recommended for first-line therapy if symptoms are persistent and/or moderate to severe.[2]

PSA notes that a similar rescheduling proposal was recently listed for consideration by the ACMS for fluticasone. Given all intranasal corticosteroid sprays have similar efficacy, the comments outlined for fluticasone in PSA's recent submission apply similarly to budesonide.

The recommended dose of budesonide nasal sprays is 32–128 micrograms into each nostril daily[3] and this is reflected in the proposed amendment.

Overall PSA has no objections to the proposed amendment for budesonide.

Codeine

Summary of proposal (extracted from consultation notice)

Current scheduling	Codeine is currently in Schedules 4 and 8 and Appendix K of the Poisons Standard.
Proposed scheduling	A request has been made to amend the Schedule 4 and 8 entries for codeine to: • Up-schedule codeine from Schedule 4 to Schedule 8 when in divided preparations containing more than 12 mg of codeine per dosage unit; • Up-schedule codeine from Schedule 4 to Schedule 8 when in undivided preparations containing more than 0.25 per cent of codeine; and • Amend both Schedule 4 and 8 entries for codeine to reflect these changes. **Schedule 4 – Amend Entry** CODEINE when compounded with one or more other therapeutically active substances: • in divided preparations containing ~~30~~12 mg or less of codeine per dosage unit; or • in undivided preparations containing ~~1~~0.25 per cent or less of codeine. **Schedule 8 – Amend Entry**

[2] Sansom LN ed. Australian pharmaceutical formulary and handbook. 24th edn. pp. 550-554. Canberra: Pharmaceutical Society of Australia; 2018.

[3] Sansom, op. cit., p. 271.

	CODEINE alone or when compounded with one or more other therapeutically active substances: a. in divided preparations containing more than 12 mg of codeine per dosage unit; or b. in undivided preparations containing more than 0.25 per cent of codeine **except** when included in Schedule 4.
Reasons for proposal	• The proposal seeks to address scheduling inconsistencies highlighted in the Regulation Impact Statement (RIS). This will be achieved by moving high dose codeine-containing medicines and single ingredient 30 mg codeine into Schedule 8 where, as suggested by the RIS, these products belong. • By up-scheduling high dose codeine-containing medicines to Schedule 8, they will be monitored by State and Territory Real Time Monitoring systems.

Previous scheduling inconsistencies

The **Codeine re-scheduling regulation impact statement** (RIS; published in December 2016) pointed out that there were significant inconsistencies in the restrictions on codeine availability between Schedules 2, 3, 4 and 8. The examples provided were as follows.

Active ingredient(s)	Combination	Combination	Single
Codeine per dosage unit	15 mg	30 mg	30 mg
Total dosage units in maximum pack size	40	50	20
Total codeine content per pack	600 mg	1500 mg	600 mg
Schedule	S3	S4	S8

In the **Scheduling handbook**, "scheduling" is described as "a regulatory intervention to reduce public health risk to an acceptable level". Scheduling decisions in Australia are made through the application of a 'cascading principle', assessment against a set of factors for each schedule as well as consideration of any other evidence or information relevant to the risk-benefit analysis.

In the case of codeine-containing products, particularly in divided preparations, mitigation of risk to patient safety or public health can be achieved through, for example, consideration of:

- whether the formulation consists of a single active ingredient (codeine only) or combination of active ingredients
- amount of codeine per dosage unit
- total amount of codeine per pack.

Note that, with the rescheduling of codeine in February 2018, the S3 combination product example in the table above is now S4. This has resulted in greater consistency in scheduling

since the single ingredient products remain in S8 and combination products (containing codeine, when compounded with one or more other therapeutically active substances) are in S4.

In the **Poisons Standard**, "compounded" in relation to a substance means "combined with one or more other therapeutically active substances in such a way that it cannot be separated from them by simple dissolution or other simple physical means". The distinction between a substance being used as a single active ingredient or compounded in a divided preparation product provides a degree of mitigation of risk and is adopted for other substances. For example, ethylmorphine is S8 but is included in the less restrictive schedules of S4 or S2 when in compounded form. Similarly dihydrocodeine is included in multiple schedules (S8, S4 or S3) but in compounded form in the lower schedules.

PSA believes therefore that the proposed amendments to the current S4 and S8 entries for codeine do not require amendment.

PSA acknowledges, however, that there may be scope to consider introducing a restriction to the total quantity of codeine per pack to help address this anomaly.

Real-time recording and reporting

In the context of this proposal, PSA re-iterates its strongest support for the implementation of a nationally uniform real-time recording and reporting system. This is a high priority from a patient safety and public health perspective.

Previously there was a focus on real-time monitoring systems to capture Controlled Drugs (for example, the Electronic Recording and Reporting of Controlled Drugs (ERRCD) system). PSA is not certain if the current rescheduling proposal was influenced by this i.e. whether the aim is to include most of the codeine products in S8 so that they can be captured by an ERRCD-type system.

However, the Tasmanian Drugs and Poisons Information System Online Remote Access (DORA) already includes codeine as a relevant substance for real-time reporting, and PSA understands codeine will also be included in SafeScript in Victoria.

Further, PSA welcomes the recent announcement[4] of the COAG Health Council that federal, state and territory Health Ministers agreed 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.

Sildenafil

Summary of proposal (extracted from consultation notice)

Current scheduling	Sildenafil is currently in Schedule 4 of the Poisons Standard.
Proposed scheduling	A request has been made to:

[4] COAG Health Council. Communique, 13 April 2018.

	• Create a new Schedule 3 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. **Schedule 3 – New Entry** SILDENAFIL in divided preparations for oral use containing 50 mg of sildenafil per dosage unit in packs of not more than 8 dosage units when compliant with the requirements of Appendix M. **Schedule 4 – Amend Entry** SILDENAFIL **except** when included in Schedule 3. **Appendix M – New Entry** Supply of Schedule 3 sildenafil will be contingent on: • the sponsor making Continuing Professional Development (CPD) accredited training available to pharmacists; and • the sponsor providing a patient assessment tool to facilitate screening and counselling by the pharmacist. **Appendix H – New Entry** SILDENAFIL.
Reasons for proposal	• Non-prescription availability of sildenafil 50 mg with appropriate informative consumer and pharmacist educational programmes, and advertising of Schedule 3 sildenafil 50 mg, will help to reach many men with erectile dysfunction (ED) who currently do not seek help from their doctor about their condition. It will also direct men away from the unregulated supply of purported ED medications. • The proposed re-scheduling will help destigmatise ED, raise awareness of the causes of ED and its association with more chronic conditions such as cardiovascular disease (CVD) and diabetes, encourage treatment seeking behaviour, and will offer the potential for earlier and more frequent interaction with the primary healthcare system. • The important risks for non-prescription sildenafil 50 mg are consistent with those that have been established for sildenafil in the prescription setting. These risks can be effectively managed in the pharmacy setting through routine risk minimisation measures that have been specifically tailored for non-prescription use. Benefits outweigh the risks, and all risks can be appropriately managed through Schedule 3 availability. Any incremental risks associated with non-prescription availability and advertising of sildenafil 50 mg can be effectively managed in the pharmacy setting through key measures such as pharmacist intervention at the point of sale, pharmacist training and consumer education.

Despite the high prevalence of erectile dysfunction (ED) reported in many studies, evidence is demonstrating that this is underdiagnosed and undertreated. Comparable to many overseas studies, the prevalence of ED reported in Australian and New Zealand studies has ranged

between 25-40% of men.[5,6] Yet these same studies note that only 14-16% of men sought a medical diagnosis and treatment to manage their condition. This is despite the increase in public awareness and acknowledgement of ED since the development of effective pharmacological treatments such as sildenafil. Furthermore, some researchers have suggested that ED in younger men (<40 years of age) is likely to be overlooked and dismissed without performing any medical assessment, due to the assumption that ED in younger men is a self-limiting condition.[7]

Data from systematic reviews, case reports and pharmacovigilance monitoring systems support the safety and tolerability of phosphodiesterase type 5 inhibitors (PDE5s). Acknowledging the limitations of spontaneous adverse event monitoring, the TGA's Database of Adverse Event Notifications (DAEN) reports for sildenafil products indicate relatively minor adverse events that mostly align with that described in the Product Information. Considering the history and expected extent of sildenafil prescribing in Australia, the number of reports is also relatively minor.

Acknowledging the safe history of use, the PSA recognises there are clinical circumstances which absolutely contraindicate sildenafil use. PSA also recognises that ED can be an early indicator of general vascular disease and cardiovascular risk. However considering the under-diagnosis and under-treatment of ED, PSA supports the proposed amendment for sildenafil to become a Schedule 3 medicine to permit supply in specific circumstances.

Permitting the supply of sildenafil by pharmacists will provide an opportunity to identify men who are otherwise not engaging with their general practitioner, and through an evidence-based assessment process permit supply to men with low risk for use, or refer those at higher risk to their general practitioner for a full medical investigation.

This opportunity for pharmacists to identify risk and appropriately manage men seeking sildenafil is demonstrated by a recent study published of the New Zealand experience - which found that pharmacists identified and referred over half of new requests for sildenafil to a medical practitioner.[6] Further recognition has been provided by the British Society for Sexual Medicine, who specifically noted their support for the pharmacist supply of sildenafil in their 2017 Guidelines on the Management of Erectile Dysfunction in Men "*as way for men who do not currently seek help through normal health care routes to access assistance*" and expressing hope that the initiative would "*aid in the detection of important comorbidities*".[8]

It is essential that any pharmacist considering the supply of sildenafil is able to accurately and consistently assess those men for the presence of any signs, symptoms or personal history which would indicate an unacceptable clinical risk for supply without a full medical investigation. The recent rescheduling of sildenafil in New Zealand and the United Kingdom to permit pharmacist supply was made possible by clearly identifying a range of clinical criteria which would assist pharmacists to identify a population of men in whom sildenafil use would pose minimal risk.

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[5] Chew, KK, Stuckey B, Bremner A, Earle C, Jamrozik K. Male Erectile Dysfunction: Its Prevalence in Western Australia and Associated Sociodemographic Factors. Journal of Sexual Medicine. 2008; 5(1): 60–69. Available via: https://doi.org/10.1111/j.1743-6109.2007.00548.x

[6] Quilter M, Hodges L, Von Hurst P, Borman B, Coad J. Male Sexual Function in New Zealand: A Population-Based Cross-Sectional Survey of the Prevalence of Erectile Dysfunction in Men Aged 40–70 Years. Journal of Sexual Medicine. 2017;14(7): 928–36. Available via: https://doi.org/10.1016/j.jsxm.2017.05.011

[7] Rastrelli G and Maggi M. Erectile Dysfunction in Fit and Healthy Young Men: Psychological or Pathological? Translational Andrology and Urology. 2017;6(1):79–90. Available via: https://doi.org/10.21037/tau.2016.09.06

[8] Hackett G, Kirby M, Wylie K, et al. British Society for Sexual Medicine Guidelines on the Management of Erectile Dysfunction in Men - 2017. The Journal of Sexual Medicine. 2018;15(4):430-57. Available via: https://doi.org/10.1016/j.jsxm.2018.01.023

The clinical and professional practice requirements for assessment and supply must be well understood by pharmacists. This can be achieved through education that delivers learning outcomes that update clinical awareness of the risks and benefits of sildenafil use, the regulatory requirements for supply – as determined by the medicine classification, National Competency Standards Framework,[9] Professional Practice Standards,[10] applicable Codes of Practice including Pharmacist Code of Ethics and the Australian Privacy Principles, and any specific S3 (pharmacist-only medicine) guidance document.

Standards for education of pharmacists and any requirement to successfully complete an education program accredited against those standards would be described in the professional practice guidance for sildenafil supply.

PSA's role in developing standards and guidelines for professional practice, including the provision of S3 medicines, has been recognised through government-appointed national peak health body status, and compliance with these is required by the Pharmacy Board of Australia.

PSA standards and guidelines are also referenced in Federal legislation with compliance being a mandatory requirement for pharmacists dispensing PBS prescriptions under the *National Health (Pharmaceutical Benefits) Determination 2017*.[11] In addition, the *National Health (Continued Dispensing) Determination 2012*[12] requires pharmacists to specifically consider PSA's *Guidelines for the Continued Dispensing of eligible prescribed medicines by pharmacists* as describing the conditions necessary to permit Continued Dispensing.

This background of professional and regulatory recognition, provides PSA with the authority to develop and define expected standards of professional practice when pharmacists are assessing the safe and appropriate supply of non-prescription medicines.

PSA's S3 Guidelines documents (sometimes described as a 'supply protocol') describe a series of recommended steps for pharmacists to follow. They are decision support tools that present a systematic, evidence-based procedure to assist pharmacists to fulfil their professional obligations.

Should the proposed rescheduling of sildenafil be recommended by the delegate, PSA would develop a practice standard and guideline to incorporate any patient-characteristics or clinical criteria that may be defined to restrict supply within the pharmacist scope of practice. This can also accommodate any requirements defined by the Minister's Delegate related to the specific supply of sildenafil by pharmacists; including but not limited to any requirements described in Appendix M of the Poisons Standard.

Key elements of guidelines will consider similar professional guidance prepared for sildenafil reclassification in New Zealand and the United Kingdom, but would be contextualised for Australian practice. This would provide a robust, evidence-based clinical assessment process to identify men with an appropriate level of risk for supply, and expectations for medical referral

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[9] National Competency Standards Framework for Pharmacists in Australia 2016. Pharmaceutical Society of Australia. Available via: http://www.psa.org.au/wp-content/uploads/National-Competency-Standards-Framework-for-Pharmacists-in-Australia-2016-PDF-2mb.pdf

[10] Professional Practice Standards. Version 5. 2017. Pharmaceutical Society of Australia. Available via: http://www.psa.org.au/practice-support-and-tools/psa-professional-practice-standards

[11] *National Health (Pharmaceutical Benefits) (Conditions of approval for approved pharmacists) Determination 2017* (PB 70 of 2017) s6.

[12] *National Health (Continued Dispensing) Determination 2012*. s2.01(2)

when not appropriate. Guidelines would consider regulatory and professional practice obligations, assessment of patient need based on applicable signs/symptoms, comprehensive history and/or limited investigations (eg. blood pressure), determining appropriateness of supply through consideration of contraindications and precautions, medicine interactions, other more appropriate treatment options (including non-pharmacological), provision of counselling information including treatment expectations, adverse effects, lifestyle factors, follow-up advice and proactive recommendation to see their GP if they have not had a recent cardiovascular or diabetes check.

PSA understands that many pharmacists already document the supply of an S3 medicine by "dispensing" as one would a prescription or medication order. This provides documentation of patient, quantity, date and the "dispensing pharmacist". We also understand that some pharmacies and banner groups encourage the documentation of the assessment and consultation process through pharmacy-specific patient management systems. PSA would encourage this as good patient management, as well as supporting the pharmacist and patient from a professional indemnity perspective.

Maintaining appropriate documentation of the assessment and consultation is a required criteria of existing Professional Practice Standards. PSA expects this to also be specified within professional standards and guidelines for the supply of sildenafil.

PSA therefore supports the proposal for a new Schedule 3 entry for "*sildenafil in divided preparations for oral use containing 50 mg of sildenafil per dosage unit in packs of not more than 8 dosage units when compliant with the requirements of Appendix M*".

Noting the range of controls and restrictions for supply and referral, including education and consultation documentation, PSA supports a new entry in Appendix M which requires the supply of S3 sildenafil to be contingent on:

- Pharmacists supplying sildenafil in accordance with professional standards and guidelines for supply of medicines for erectile dysfunction issued by the Pharmaceutical Society of Australia.

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