AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

TRIM: D19 - 8671

Transparency, Reforms and Evaluation Support Section
Prescription Medicines Authorisation Branch
Therapeutic Goods Administration
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To whom it may concern

Proposed criteria for Appendix M of the Poisons Standard to support rescheduling of substances from Schedule 4 to Schedule 3

I am pleased to provide a response to the Therapeutic Goods Administration (TGA) Consultation: Proposed criteria for Appendix M of the Poisons Standard to support rescheduling of substances from Schedule 4 (Prescription only) to Schedule 3 (Pharmacist only).

This response has been informed by the Antimicrobial Stewardship Advisory Committee (the Committee) of the Australian Commission on Safety and Quality in Health Care (the Commission), specific to antimicrobials. The Commission suggests that specific provisions should be included in the criteria to exclude antimicrobials from rescheduling from Schedule 4 (prescription only) to Schedule 3 (pharmacist only). This advice is consistent with a specific recommendation of the World Health Organization that over the counter dispensing of antimicrobials for human and animal health not be permitted, with the aim of reducing the risk of contributing to the development of antimicrobial resistance (AMR).

It is noted with some concern, that rescheduling from Schedule 4 (prescription only) to Schedule 3 (pharmacist only) has already occurred for some antimicrobials in Australia, including oral famiciclovir, oral fluconazole and chloramphenicol eye drops. It is suggested that any further rescheduling of antimicrobials in any formulation would impact on effective antimicrobial stewardship and efforts to prevent and contain AMR in Australia.

It is acknowledged that over the counter provision of medications is a core competency and activity of community pharmacists. However, there is no comprehensive framework to support pharmacists in the appropriate use of antimicrobials.

The AURA Surveillance System was established in 2014 by the Commission to provide a nationally coordinated system for surveillance of AMR and antimicrobial use for human health. The AURA National Coordination Unit collects data from hospital and community settings to provide a comprehensive national and regional picture of antimicrobial use and AMR.

The Commission has considered the significant and growing body of evidence regarding high rates of inappropriate prescribing of first line antimicrobials in Australian hospital and community settings, along with high rates of AMR in these settings. This information is available in a range of reports published by the

Commission using data as part of the AURA Surveillance System (https://www.safetyandquality.gov.au/antimicrobial-use-and-resistance-in-australia/). The *AURA 2017 Second Australian report on antimicrobial use and resistance in Australia* is the latest national report, but I am pleased to advise that the *AURA 2019 Third Australian report on antimicrobial use and resistance in Australia*, will be published in May 2019. It builds on analyses regarding antimicrobial use and appropriateness to inform strategies to improve the utilisation of antimicrobials. If it would be of benefit for your process, the Commission's AURA National Coordination Unit would be happy to meet to discuss these data in more detail.

The Commission wishes to raise specific concerns regarding inclusion trimethoprim on the list of priority substances proposed for re-scheduling from Schedule 4 to Schedule 3 by the Pharmaceutical Society of Australia, as described on the TGA scheduling news website page. These concerns are summarised in the attachment to this letter to provide information to support restriction of antimicrobials to Schedule 4 (prescription only).

The Commission strongly recommends that, prior to any proposed rescheduling of antimicrobials, advice be sought from the Australian Strategic and Technical Advisory Group on AMR (ASTAG). ASTAG is co-chaired by [redacted] to develop and provide expert advice on AMR-related issues.

I hope these comments, and the attached information regarding concerns about proposed rescheduling of trimethoprim are useful for you. If you have any queries, please contact [redacted]

Yours sincerely

[redacted]

29 March 2019

[redacted]

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Comments on regarding proposed rescheduling of antimicrobials from Schedule 4 (Prescription only) to Schedule 3 (Pharmacist only): trimethoprim specific issues

In response to the proposal to re-schedule trimethoprim from Schedule 4 to Schedule 3 by the Pharmaceutical Society of Australia, for treatment of urinary tract infection, the following issues should be noted:

- The World Health Organization has advised that over the counter dispensing of antimicrobials for human and animal health not be permitted, with the aim of reducing the risk of contributing to the development of antimicrobial resistance (AMR).[1]
- Cystitis (urinary tract infection) is one of the most common indications for antibiotic prescribing.[2]
- Cystitis is not necessarily easy to diagnose and manage; the process requires consideration of the interaction of many differential diagnoses, antimicrobial resistance and potential for sepsis. From an antimicrobial stewardship (AMS) point of view, improving prescribing requires dedicated and sustained education from specialist providers about correct sampling, patient risk factors, antimicrobial resistance (AMR) and appropriate antibiotics. Increasing access to antimicrobials such as trimethoprim by allowing them to be dispensed over the counter may undermine these efforts.
- Pharmacists are not able to order diagnostic testing such as urine cultures or review previous pathology results. Urine cultures are a key component of appropriate antimicrobial use in urinary tract infection (UTI). The Therapeutic Guidelines: Antibiotic recommend that urine cultures are performed for pregnant women, men, aged-care facility residents, patients recently receiving antibiotics, and those that have recently travelled internationally. There may be very few cases where urine cultures are not required, so the perceived benefits of antimicrobials such as trimethoprim being available without a prescription may be outweighed by the potential for unintended patient consequences.
- Trimethoprim remains a first-line empirical agent for acute cystitis, but rising trimethoprim resistance amongst *Eschericia coli* urinary isolates (21.8%), as noted by the Pharmaceutical Society of Australia, is threatening the role of trimethoprim for this indication.[3] Therefore, the likelihood of inappropriately providing an antibiotic such as trimethoprim in certain patients is high, even for general practitioners with access to urine culture. It is likely that urine culture in the era of increasing resistance will become more important to inform appropriate care.
- It is well known that countries that allow over the counter sales of antibiotics have higher rates of AMR.[4, 5]
- Antimicrobial prescribing in the community is an important area of focus for AMS initiatives in response to evidence regarding inappropriate prescribing of antimicrobials.[6]
- Whilst the provision of Schedule 3 medications is not outside the scope of practice for pharmacists, antimicrobial prescribing is quite complex. The Antimicrobial Use and Resistance in Australia (AURA) Surveillance System demonstrates that there are high rates of inappropriate prescribing of antimicrobials in acute and primary care settings, and high rates of AMR in both settings.

- Data from contributing NPS MedicineWise MedicineInsight practices show that only 44.9% of GPs prescribe trimethoprim for UTI. There can be many reasons for trimethoprim not being an appropriate antimicrobial for UTI, including prior antibiotic exposure, known patient drug resistance, travel history and anatomical complexity; consideration of all of these factors requires the expertise of a medical prescriber.
- There is evidence that non-steroidal anti-inflammatory drugs are effective for a significant proportion of patients presenting with uncomplicated UTI symptoms, making empirical antimicrobials without prior testing a less favoured approach to treatment.[7]
- Rescheduling, as proposed, would require a robust framework to support patient assessment and referral processes and provide for training and credentialing of pharmacists, audit, feedback and clinical review processes. There would be significant requirements for initial and ongoing training, audit and clinical review to effectively and safely support pharmacists to dispense trimethoprim for UTI; this may not be sustainable for small and/or isolated community pharmacies.
- If rescheduling were to proceed, it will be essential to determine the target patient population. For example, it may be appropriate for a pharmacist to provide trimethoprim as empiric therapy for first time UTI in non-allergic women of child-bearing age; for other patients further investigation, that is beyond remit of community pharmacists, is often needed. This includes access to diagnostic testing and medical advice.
- It is unclear whether it is intended to introduce a fee for providing trimethoprim (and/or other antimicrobials). If this were to be the case, it may be an incentive for inappropriate dispensing, and it may increase costs for patients, while also exposing them to increased risk of development of resistance or inadequate treatment.
- One rationale for the proposal to introduce over the counter dispensing of trimethoprim and other antimicrobials is improved patient access to healthcare, particularly in rural and regional areas where there may be medical workforce shortages. However, it does not appear that the potential negative patient safety outcomes and risk of development of AMR have been considered. Other models of service delivery to achieve increased access such as telehealth, and the involvement of advanced practice registered nurses with the capacity to order the necessary pathology tests.

References

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