MEDSAFE
NEW ZEALAND MEDICINES AND MEDICAL DEVICES SAFETY AUTHORITY
A BUSINESS UNIT OF THE MINISTRY OF HEALTH

Comments on Agenda Items for the 58th meeting of the Medicines Classification Committee on Tuesday 16 May 2017

Public Consultation

Medsafe
April 2017

MINISTRY OF HEALTH
MANATU HAUORA

New Zealand Government

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

2 March 2017

The Secretary
Medicines Classification Committee
Medsafe
PO Box 5013
WELLINGTON 6145

Dear Secretary

Reclassification of Local Anaesthetic Agents for use by Oral Health Therapists

The Dental Council has applied to widen the classification of the following prescription medicines: Articaine, Prilocaine, Lignocaine, and Felypressin, to include Oral Health Therapists. (Oral Health Therapists have a 'dual' qualification as both a dental hygienist and a dental therapist.) The use provision already applies to dental therapists to administer these local anaesthetics (LA) on patients up to 18 years of age. Dental hygienists currently administer these agents under direct clinical supervision of a dentist/dental specialist.

Oral Health Therapists should be able to administer the listed LA medicines without need for a prescription or standing order within their scope of practice. They can do this safely as this aligns with their scope of practice and is an area in which they have trained and are competent. It would be appropriate for this extension to be made to ensure that Oral Health Therapists can fully perform their duties and that patients are not disadvantaged in any way.

It is to be noted that Oral Health Therapy is intended to be carried out in the context of there being a consultative professional relationship with one or more dentists and/or dental specialists.

Thank you for your attention to this matter.

Yours sincerely

Dr Riana Clarke
National Clinical Director, Oral Health

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Campus

Medicine and Health Science
The University of Auckland
Private Bag 92019
Auckland, New Zealand

Head of Department
Department of Paediatrics: Child and Youth Health

Room 12.031 Level 12,
Auckland Hospital Support Building
Park Road, Grafton
Telephone: 64 9 - 373 7999
Facsimile: 64 9 - 373 7486

28th January 2017

Medicines Classification Committee
Ministry of Health
PO Box 5013, Wellington

Dear Sir/Madam,

I am writing this letter in support of the submission from Dr. Natalie Gauld to have the minimum age of people to whom pharmacists are permitted to give Tetanus-Diphtheria-Acellular Pertussis vaccine (TdaP) reduced from 18 to 13 years. Pharmacists are likely to play an important role in the implementation of the current Ministry of Health strategy to prevent severe early infant pertussis disease by providing a booster dose of TdaP to all pregnant women.

Currently pharmacists have a minimum age restriction of 18 years applied to those to whom they can give DtaP. We need to reduce this to 13 years to enable all pregnant women to receive this vaccine. The infants of young pregnant women are a group at particular risk of life threatening vaccine preventable disease.

The excellent safety profile of DtaP and lack of any measureable difference in safety or efficacy of the vaccine in adolescents compared with adults provided additional support the rationale for this age change.

Thank you for your consideration of this request.

Yours faithfully,

Dr. Cameron Grant FRACP PhD
Head of Department - Paediatrics: Child & Youth Health
Professor in Paediatrics, The University of Auckland
Associate Director – The Centre for Longitudinal Research – He Ara ki Mua and *Growing Up in New Zealand* www.growingup.co.nz
Paediatrician, Starship Children's Health Park Road, Auckland, New Zealand

4 April 2017

The Secretary
Medicines Classification Committee
MEDSAFE
PO Box 5013
WELLINGTON

By email: committees@moh.govt.nz

Dear Hannah

Re: Agenda for the 58th meeting of the Medicines Classification Committee

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[redacted] to comment on the **Agenda item 5.6.3**, which proposes two amendments to the restricted medicine entry of sildenafil.

i. to remove the requirement that it must be supplied in an original manufacturer's pack

[redacted] not support the proposal to remove the requirement for the product being dispensed in the manufacturer's original pack.

The proposal is based on reasoning that patients can often not afford to purchase a pack of 4 tablets. The cost paid by the patient (typically in the range of $28-32 for a pack of 4 tablets) is predominately driven by the pharmacy mark-up and professional consultation fee and not the cost of the product. Due to the number of brands available, the cost to pharmacy is now as low as under $1 for a 4-pack of 25mg or 50mg tablets and approximately $3 for a 4-pack of 100mg tablets. Therefore, decreasing the number of tablets to below 4 is unlikely to have a significant effect on the cost to the patient as the consultation fee, which is the majority of the cost, would remain the same.

Additionally, sale in the original pack ensures that the patient receives the full packaging, which includes the batch and expiry details. If a blister strip was cut or the product was dispensed into another container, these details would not always be provided to the patient. Lack of batch details would be an issue in the case of safety alert or recall, and lack of expiry could result in the patient taking the medicine after the expiry, which is especially important for a medicine like sildenafil that is taken as required. Sildenafil is also one of the most common medicines counterfeited and illegally supplied throughout the world, so provision in the original packaging aids identification of genuine product in cases of misappropriation.

[redacted]

ii. to amend the age limit from 35 – 70 years in the classification text to 25 – 70 years

[redacted] the current age limit of 35 to 70 years be retained.

Because erectile dysfunction (ED) is traditionally seen in the aging male population, studies regarding ED tend to be more frequently carried out among middle-aged and elderly men rather than in young men. Prevalence reported in studies of ED is also highly variable in this younger population.
In a study conducted in a Urology Clinic, it has been observed that one in four men seeking medical care for ED was younger than 40 years[i]. A multi-centre worldwide study, involving more than 27,000 men from eight countries[ii], showed an ED prevalence of 8% among men aged 20–29 years and 11% among those aged 30–39 years.

ED is a complex disorder with multifactorial aetiology. It can be due to organic, psychogenic, or a mixture of both organic and psychogenic factors[iii]. According to a study with 1873 younger ED patients, scale score showed that organic, relational and intrapsychic conditions are all significant risk factors for ED[iv]. All these components must be critically assessed for appropriate clinical management. One main challenge for healthcare providers, especially the pharmacist, is to differentiate organic pathologies from psychological and relational ones. It might be time consuming and a difficult discussion.

Among the organic conditions contributing to the onset of ED, metabolic and cardiovascular (CV) risk factors are surprisingly of particular relevance in this age group. In this view, the assessment of a possible organic component of ED in younger individuals is very important, because it offers the unique opportunity to detect the presence of CV risk factors, thus allowing effective preventive interventions. Testosterone (T) deficiency may also be considered[iv].

Reclassification of sildenafil had also highlighted concern of misuse of ED drugs[v]. Lowering the age limit may also exacerbate potential recreational misuse.

[redacted]

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[i] Capogrosso P et al. One patient out of four with newly diagnosed erectile dysfunction is a young man—worrisome picture from the everyday clinical practice. J Sex Med 2013;10:1833–1841.

[ii] Rosen RC et al. The multinational Men's Attitudes to Life Events and Sexuality (MALES) study: I. Prevalence of erectile dysfunction and related health concerns in the general population. Curr Med Res Opin. 2004 May;20(5):607-17.

[iii] Arduca P. Erectile dysfunction: A guide to diagnosis and management. Aust Fam Physician 2003; 32(6): 414-420.

[iv] Rastrelli G, Maggi M. Erectile dysfunction in fit and healthy young men: psychological or pathological? Translational Andrology and Urology. 2017;6(1):79-90.

[v] Bechara A, et al. Recreational use of phosphodiesterase type 5 inhibitors by healthy young men. J Sex Med. 2010 Nov;7(11):3736-42

[redacted]

Medicines Classification Committee
PO Box 5013
Wellington 6145

Dear Sir/Madam,

Re: Tdap age extension, item 5.6.2 at the Medicines Classification Committee meeting

For the upcoming Medicines Classification Committee meeting I wish to comment on the Tdap vaccine proposal. Dr Natalie Gauld consulted with myself in January about this proposal. We both agreed with their proposed change to allow pharmacists to provide the vaccine to people aged 13 years and over (rather than the current 18 years and over).

Pertussis is an important preventable reason for infant hospitalisation in New Zealand. Maori and Pacific infants have been affected disproportionately by hospitalisation and intensive care use.[1 2] The key preventions for pertussis in infants are infant vaccination with pertussis on-time, and vaccination of pregnant women at 28-38 weeks of pregnancy with Tdap. Tdap is fully funded (free to the woman) through general practice at this time.

Although exact figures are not available, available data indicate that the majority of New Zealand women are not currently accessing the Tdap vaccination during their pregnancy, and improving access will help. More access options may be particularly important for pregnant teenagers who are more likely to be living in crowded environments.

Pharmacy usually has a “drop-in” service and extended opening hours. These may be particularly beneficial for teenage women who are pregnant, and help to address existing disparities in infant hospitalisations.

There are no safety issues associated with the use of Tdap in pregnancy,[3,4]

We support this change and note an urgency to it. The last epidemic peaked in 2012, with epidemics about every five years. An increase in incidence is expected at any time. Ideally this change needs to be in place prior to the epidemic to provide flexibility to allow pharmacists to vaccinate teenagers who are pregnant.

Any member of the Medicines Classification Committee is welcome to call me to discuss this further.

Yours sincerely,

Dr Helen Petousis-Harris,
Senior Lecturer
Department General Practice and Primary Health Care
University of Auckland
h.petousis-harris@auckland.ac.nz

1. Macdonald-Laurs E, Ganeshalingham A, Lillie J, et al. Increasing incidence of life-threatening pertussis: A retrospective cohort study in New Zealand. Pediatric Infectious Disease Journal 2017;**36**(3):282-89.
2. Ganeshalingham A, Grant C, Anderson BJ, et al. Economic evaluation of severe and life threatening pertussis in New Zealand. NZ Med J 2016;**129**(1445):75-82.
3. Petousis-Harris H, Walls T, Watson D, et al. Safety of Tdap vaccine in pregnant women: an observational study. BMJ Open 2016;**6**(4):e010911.
4. Kharbanda, E. O., Vazquez-Benitez, G., Lipkind, H. S., Klein, N. P., Cheetham, T. C., Naleway, A. L., ... & McCarthy, N. (2016). Maternal Tdap vaccination: Coverage and acute safety outcomes in the vaccine safety datalink, 2007–2013. Vaccine, 34(7), 968-973.

MCC 58th Meeting 16 May 2017

Comment on Agenda Item

To: The MCC Secretary

I refer to the agenda for the 58th meeting of the MCC to be held on the 16th May 2017 and specifically to item: 5.6.3 Sildenafil - proposed amendment to the prescription medicine except classification where it is proposed to:

i. to remove the requirement that it must be supplied in an original manufacturer's pack

ii. to amend the age limit from 35 – 70 years in the classification text to 25 – 70 years.

i. Douglas Pharmaceuticals Ltd is opposed to removal of the requirement for supply in an original manufacturer's pack for the following reasons:

- Being able to sell the tablets in packaging other than the manufacturer's pack removes traceability of supply which will be problematic where a consumer recall could be issued. The Batch and expiry for the tablets appears once on the blister and on the carton. In the event that a 4 tablet pack for example is broken down to single tablet blisters at the pharmacy level, even if the manufacturer's carton is used for sale of one of the tablets, three of the four will lose the batch identification.
- Sale of sildenafil in any packaging other than the manufacturer's original pack increases the potential for counterfeiting.
- Douglas Pharmaceuticals Ltd is assessing the feasibility of new product entering the NZ market in the near future containing a consumer medicines information leaflet. Dispensing smaller amounts as broken packs will mean some people will miss out on this leaflet.
- Branding is important to businesses involved in the pharmaceutical market. Douglas Pharmaceuticals Ltd has invested considerable time and energy into developing a process that met the requirements of the Medicines Classification Committee and saw patients being referred to their GP for a heart health and diabetes check, or where other concerns arose. NZ men have benefited from the widened access to the medicine and screening and referral. Douglas has also invested in education of pharmacists, printing materials, and advising men of the availability and the need for a pharmacist's check on suitability. This has been done with input from both cardiac and sexual health experts. Douglas is the only company providing hard copy consumer medicines information sheets which include important advice for pharmacist-supply e.g. the need for regular GP check-ups, and information on lifestyle improvements. If men do not know the brand of the medicine this will affect the ability of manufacturers or distributors to provide this support, and to get a reasonable return on the investment made in doing the reclassification. Ultimately reasonable consumer access to medicines will be affected as reclassifications will become even less likely.

Instead of allowing for sale in packaging other than the manufacturer's original pack, the recommendation arising from review of this submission could be for: "Medsafe to work with manufacturers to make other pack sizes with inserts available".

ii. In relation to the second part of the submission, Douglas Pharmaceuticals Ltd would support the proposal to amend the age limit from 35 – 70 years to 25 – 70 years since the present age range included in the original submission by Douglas was based on UK patient group directions (PGD) along with advice from the cardiologist and Sexual Health experts with whom we consulted. It was a conservative approach to facilitate acceptance of the submission with the potential to extend the age range at a later date as experience with OTC sale by Pharmacist review and recommendation was gained. In that regard

- A UK PGD now has a range of 30 – 75 years. We are advised that the UK is currently considering rescheduling sildenafil 50 mg to pharmacy-only medicine with a minimum age of 18 years and no upper age limit.
- There appears to have been no significant increase in sildenafil AEs in New Zealand since the reclassification.
- The approved screening tool used by Pharmacists and the annual consultation review using that tool prior to continuing prescribing of sildenafil appears to be successful in picking up conditions that require referral to a doctor instead of sale.

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

6th April 2017

Dear Medicine Classifications Committee

Re: Access to Tdap vaccination in pregnancy

Pertussis vaccination is recommended in every pregnancy in order to protect newborn babies from pertussis until the infant series of immunisations can commence. Mortality and morbidty is highest in youngest infants, particulary for Maori and Pacific infants, who experience significantly more hospitalisations for pertussis[1].

Ministy of Health commissioned research found that difficulty in accessing immunisaton was a barrier to uptake for pregnant women. Specifically this research found that:

> "*The pathway for pregnant women receiving immunisation is not convenient and women face many barriers accessing immunisation through their general practice. Māori and Pacific pregnant women face more barriers to accessing immunisation through their general practice than Pākehā pregnant women. These barriers include transportation, arranging childcare and time off work. Some women are also reluctant to visit their general practice, if they owe money for consultations and prescriptions*" [2]

Maori and Pacific women, younger women and those living in more deprived communities register later in pregnancy for maternity care with a Lead Maternity Carer midwife. [3] [4] These are the groups of women whose infants are more likely to suffer morbidity from pertussis. Maori and Pacific women giving birth are a younger cohort of women than other ethnicities.[5]

In order to reduce barriers to pertussis vaccine in pregnancy, wide ranging strategies are needed. It would seem logical to enable all pregnant women (regardless of their age) access to pharmacist

[1] http://www.hqsc.govt.nz/assets/CYMRC/Publications/pertussis-special-report-Dec-2015.pdf

[2] https://www.health.govt.nz/publication/immunisation-pregnant-women-audience-research-pregnant-women

[3] http://www.hqsc.govt.nz/assets/PMMRC/Publications/tenth-annual-report-FINAL-NS-Jun-2016.pdf

[4] https://www.health.govt.nz/publication/report-maternity-2014

[5] https://www.health.govt.nz/publication/report-maternity-2014

376 Manchester Street PO Box 21106 Edgeware Christchurch Telephone 03 377 2732 Facsimile 03 377 5662 email nzcom@nzcom.org.nz

provided vaccination as this will reduce access barriers, specifically for those groups who are at greatest risk. The College of Midwives is supportive of this as long as there are clear expectations on pharmacists to notify midwives involved in women's care that the vaccine has been provided.

Yours sincerely

Alison Eddy

Midwifery Advisor

New Zealand College of Midwives

376 Manchester Street PO Box 21106 Edgeware Christchurch Telephone 03 377 2732 Facsimile 03 377 5662 email nzcom@nzcom.org.nz

MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

10 April 2017

Hannah Hoag
Advisor Science (MCC secretary)
Medsafe

Dear Hannah

Submission for extension of current classification of Tetanus-Diphtheria-Pertussis (Tdap) vaccination by Green Cross Health Ltd and Natalie Gauld Ltd

Thank you for the opportunity to provide feedback on this submission.

Support for the submission

The Ministry of Health's (the Ministry) Immunisation team supports the submission to widen access to the Tdap vaccine for pregnant women by pharmacist vaccinators providing this vaccine in community pharmacies. Widening access would support the National Immunisation Programme's general immunisation priorities, direction of travel and the pertussis prevention strategies to protect those most at risk from severe disease (ie, those aged under one year).

The submission by Green Cross Health Ltd proposes to expand Tdap vaccinations by community pharmacists to include pregnant women from 13 years and over. We would recommend the removal of the age linked to pregnant women as this would be consistent with the funding access criteria used for the funded influenza vaccine which is stated as 'pregnant women'. Please refer to the PHARMAC website (below) for more information. We are aware however that, although the influenza vaccine funding criteria for pregnant women is for any age, the Medicines reclassification age for influenza vaccine given by a registered pharmacist is 13 years and over.

A small study in a recently published paper highlights that vaccination with Tdap in pregnant women was well tolerated with no serious adverse events likely to be caused by the vaccine.[1]

Funding of pharmacy vaccinations services and vaccines delivered via pharmacy

Our support does not in any way represent the views or decisions of PHARMAC, which is responsible for the procurement and funding of vaccines (including setting the eligibility criteria for access to funded vaccines). Pharmacists' ability to offer funded vaccines would therefore require a change to eligibility criteria determined by PHARMAC.

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[1] Petousis-Harris H, Walls T, Watson D, *et al* Safety of Tdap vaccine in pregnant women: an observational study. *BMJ Open* 2016;**6**:e010911. doi:10.1136/bmjopen-2015-010911

As you may be aware the Ministry, district health boards (DHBs), Central TAS and PHARMAC have been working to enable pharmacist vaccinators to provide funded influenza to individuals aged 65 years and over and pregnant women. From 1 April, PHARMAC changed the New Zealand Pharmaceutical Schedule to enable pharmacists to provide funded influenza vaccine to these vulnerable individuals and DHBs made amendments to the pharmacy service agreements to enable payment of pharmacy service fees for influenza vaccinations. Please refer to PHARMAC's website for more information on its decision to fund the influenza vaccine in pharmacies at www.pharmac.govt.nz/news/notification-2017-03-15-influenza-vaccine-pharmacy.

We are also aware that PHARMAC has given permission to Waikato DHB for it to fund pharmacists to give funded Tdap vaccinations to pregnant women for the duration of a research project. Currently community pharmacists in the other DHBs are not able to provide funded Tdap vaccination to any pregnant women or individuals under 18 years.

While the Ministry is responsible for implementing the National Immunisation Schedule, including any changes to it, as noted above, decisions regarding changes to it are made by PHARMAC. This would include any decision for Tdap vaccination provided by community pharmacists to pregnant women to be reimbursed/funded by PHARMAC. Further amendments to pharmacy service agreements to enable payment of pharmacy service fees for Tdap vaccinations may also be necessary

Therefore, a reclassification of this vaccine at this time would not mean that pregnant women would be able to receive funded Tdap vaccination in community pharmacies. Applications to PHARMAC for funding variations can be made by anyone. Please refer the PHARMAC website for more information at www.pharmac.govt.nz/medicines/how-medicines-are-funded/new-funding-applications/

Yours sincerely

Rayoni Keith
Manager, Immunisation
System Outcomes
Ministry of Health

Johnson & Johnson Pacific

10th April 2017

Medicines Classification Committee
Medsafe
PO Box 5013
Wellington 6145

Dear Sir/Madam,

Re: Item 6.1 Codeine - Proposed reclassification of the pharmacy only medicine entry to a more restricted medicine classification (Medsafe)

Johnson & Johnson (New Zealand) Limited (J&J) appreciates the opportunity to provide comment on agenda item 6.1 *Proposed reclassification of the pharmacy only medicine entry to a more restricted medicine classification,* to be discussed at the 58th meeting of the Medicines Classification Committee.

The submission was made following the recommendation made at the 57th meeting that an item should be added to the agenda for the 58th meeting for the possible harmonisation with Australia of all pharmacy only entries of codeine. As well as for Medsafe to review the relationships between the Australian and New Zealand markets, the role of codeine in cough and cold products and whether the benefit of its use outweighs the risk of harm.

J&J is the sponsor of medicines that contain codeine, in combination with paracetamol and phenylephrine (PE). These products are indicated for the relief of symptoms associated with colds and flu under the brand name of Codral, a local brand that can only be found in Australia and New Zealand. J&J does not market single active or combination analgesics in either Australia or New Zealand.

The most recent classification change for codeine was made at the 42nd meeting on 3 November 2009. At this meeting the Committee recommended changing the classification of analgesic medicines containing codeine in combination with other ingredients to restricted medicines. The Committee expressed concerns that people addicted to codeine would seek alternative sources from cough and cold medicines. However, the Committee subsequently decided to allow codeine in cough and cold preparations to remain as pharmacy-only.

Since the MCC decision in 2009, J&J stands by its position that there has been very limited evidence in New Zealand to suggest that any transferred abuse has occurred to codeine containing cold and flu preparations, and therefore any decision made by MCC needs to be evidence based.

A summary of codeine use in New Zealand was presented to Sarah Reader and Andrea Kerridge in June 2015 and we also provided comment at the MCC 55th meeting in 2016. Consistent with the situation in Australia, restricting the access to codeine containing analgesics has not resulted in

category cross-over with products that contain codeine (i.e. the is no transfer of users from codeine containing analgesics to codeine containing cold and flu products). Further there is limited evidence of codeine abuse with codeine containing cold and flu products within New Zealand.

The TGA concluded that Australian Standard for the Uniform Scheduling of Medicines and Poisons (the Poisons Standard) will be amended to delete the codeine entries from Schedule 2 (pharmacy only medicines) and Schedule 3 (restricted medicines), leaving only the codeine entries in Schedule 4 (prescription only medicine) and Schedule 8 (controlled drug) on 1 February 2018, as the public health benefits do not outweigh the risks. At this meeting it was noted there is much less abuse/addiction risk of codeine containing cold and flu products, however given codeine is present in cold and flu products as an analgesic the committee decided that scheduling should be consistent.

If despite the above, MCC decides that the benefits of codeine do not outweigh the risks for cold and flu products and harmonises its decision with the TGA, we request that MCC grant a 2-year implementation timeframe to consider the seasonal nature of the codeine containing cold & flu products and supply complexities.

J&J source the Active Pharmaceutical Ingredient (API) codeine from a source in the United States. The FDA stipulate that any API codeine imported from the United States can only be re-exported (even once converted into finished product), for a period of six-month after shipment from the source. This means that once codeine is shipped to Australia for manufacture into the Finished product, J&J only have six months to receive, manufacture and export to New Zealand.

To accommodate this FDA requirement, J&J have already manufactured and supplied New Zealand with sufficient codeine containing Codral to cover anticipated sales until the end of 2018.

To ensure codeine containing stock is cleared from Pharmacy shelves in New Zealand we would request that implementation of codeine re-classification in New Zealand to occur approximately in March 2019.

J&J would like to thank the MCC for this opportunity to provide comment on the reclassification proposals for Codeine in New Zealand. Please feel free to contact me should you need provide further data or information.

[redacted]

[redacted]

National Office
Level 6
203 - 209 Willis Street
PO Box 11-515
WELLINGTON 6142

T: (04) 384 4349
F: (04) 382 8356
familyplanning.org.nz

Charities # CC11104

10 April 2017

Ms. Hannah Hoang
Medsafe
Ministry of Health
PO Box 5013
Wellington 6145

Comments on proposed agenda item for the 58th meeting of the Medicines Classification Committee

Thank you for the opportunity to provide comment on the following proposed agenda item for the 58th meeting of the Medicines Classification Committee (MCC):

8.2.2 Decisions by the Delegate – July 2016

b. Ulipristal
The Australian Delegate recommended that a new Schedule 3 (restricted medicine) entry should be created for ulipristal for emergency post-coital contraception.

As New Zealand's largest provider of sexual and reproductive health services and information, Family Planning is a key stakeholder in conversations about medicines used for contraception.

Family Planning operates 30 clinics throughout New Zealand, as well as school and community-based services, and provides over 161,000 consultations in our clinics annually. Our health promotion teams run professional training and workshop programmes in schools and the community. We are a registered private training establishment offering clinical training and development for doctors, nurses and other clinicians, including pharmacists. Family Planning is committed to increasing health equity as a strategic priority, with a focus on improving Māori sexual and reproductive health and rights.

Family Planning welcomes the opportunity to have ulipristal acetate (UPA) approved for use as emergency contraception in New Zealand.

UPA has been used effectively as emergency contraception in other countries, such as the United States and European countries, for some years. We are aware that it has just been approved for use in Australia. UPA has been found to be more effective than the current levonorgestrel emergency contraceptive pill (LNG ECP). A meta-analysis published in 2010[1] gives an odds ratio for UPA emergency contraceptive pill (ECP) of 0.35 for pregnancy risk compared to LNG ECP if taken within 24 hours, 0.58 if taken within 72 hours and 0.55 if taken within 120 hours from unprotected sexual intercourse.

In addition to efficacy, there are other benefits of UPA ECP.

- As UPA ECP can delay ovulation closer to ovulation than LNG ECP, it is recommended for use when a woman is seen very close to ovulation.
- UPA ECP can be used up to 120 hours after unprotected sexual intercourse to prevent an unintended pregnancy, where levonorgestrel can only be used for 72 hours after unprotected sexual intercourse.
- UPA ECP does not appear to be less effective for women with a high BMI as levonorgestrel may be.

These benefits of ulipristal acetate could contribute to greater success avoiding unintended pregnancies for individuals than current emergency contraception options. There are health, social and economic benefits to reducing unintended pregnancies. Groups that currently experience barriers to health care, such as Māori and Pacific people and people in rural communities and on a low-income, may particularly benefit from emergency contraception that can be used 120 hours after unprotected sexual intercourse, instead of only 72 hours.

There are some disadvantages of ulipristal acetate.

- The use of progestogen before or after UPA ECP use may interfere with the effectiveness of either emergency contraception or subsequent hormonal contraceptive use. This means that in some circumstances, it is better not to use ulipristal acetate for emergency contraception; for example, if a hormone pill was taken within the last few days. The use of hormonal contraception should be delayed for 5 days after taking UPA for emergency contraception. This is a significant drawback because ECPs work by delaying ovulation for about 5 days, and hormonal methods of contraception cannot be taken within that timeframe. A person must either abstain from sexual intercourse, use a barrier method or a

[1] Glasier, A.F. et al (2010) Ulipristal acetate versus levonorgestrel for emergency contraception: a randomised non-inferiority trial and meta-analysis. *The Lancet*;375(9714):555-62. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/20116841

copper IUD in this timeframe. There is no such restriction with LNG ECP so that hormonal methods can be started on the same day as taking the LNG ECP.

- Breast feeding women are advised not to breastfeed a baby for one week after UPA ECP use.
- Other emergency contraception methods cannot be used within the same menstrual cycle because of the effect of progestogen on the effectiveness of UPA ECP.

It will be particularly important to retain availability of a subsidised LNG ECP so that those women who will not be suitable for UPA ECP can still have access to an emergency contraceptive pill.

Overall, Family Planning supports approval of ulipristal acetate for emergency contraception in New Zealand. If approved, it will be important for PHARMAC to consider funding it for emergency contraception as cost will be a barrier to equitable access, negating any potential for this medicine to reduce disparities in rates of unintended pregnancies.

Thank you for the opportunity to provide comment.

Ngā mihi

Jackie Edmond
Chief Executive

10th April 2017

Attention: Medicines Classification Committee (MCC) Secretary

Comments for 58th Meeting of the Medicines Classification Committee (Tuesday 16th May 2017)

Subject: Codeine – proposed reclassification of the pharmacy only medicine entry to a more restricted medicine classification

With regard to the possible classification options for codeine-containing medicines to be discussed at the 58th meeting of the Medicines Classification Committee, we wish to register our support for the up-scheduling of all codeine-containing medicines to Prescription Only, in line with the recent decision made by the TGA in Australia.

With this submission we have included recent [redacted] that confirms the significance of OTC codeine use as an analgesic of choice in New Zealand. For the [redacted] codeine-containing analgesics accounted for [redacted] of total analgesic tablet packs sold in New Zealand pharmacies, and [redacted] of the total value. Codeine in combination with other analgesics (paracetamol and ibuprofen) is the [redacted] in New Zealand pharmacies, and this significant use represents the ongoing potential for misuse and abuse by consumers. As with the Australian situation there is widespread use of OTC codeine analgesics in New Zealand, and the risk-benefit profile between the two countries would undoubtedly be very similar.

The primary reasons behind the Australian up-scheduling decision are equally as relevant for the New Zealand situation:

- There is substantial evidence of harm from the abuse and misuse of low dose codeine-containing medicines (sample of media articles from New Zealand and Australia provided separately).
- For most individuals, there is little evidence that low-dose codeine medicines are more effective than alternative medicines without codeine.
- The presence of low-dose codeine in widely accessible OTC combination medicines, and the development of tolerance and subsequent dependence on codeine, contributes to severe adverse health outcomes, including liver damage and death.
- Low-dose codeine-containing medicines are not intended to treat long term conditions; however public consultation in Australia indicated that this is how most consumers use these medicines and it is likely that consumer behaviour in New Zealand would be similar.
- Some individuals, especially children, experience serious adverse reactions when given codeine, such as difficulty breathing and death.
- The proposal to up-schedule codeine in Australia was strongly supported and advocated by medical experts there, and we would expect the equivalent bodies in New Zealand to take the same position as their Australian counterparts.
- The Regulation Impact Statement and Modelling Report carried out by KPMG in Australia found that a net benefit to society could be achieved only when all OTC codeine products are up-scheduled to Prescription Only, and that this was the only scenario resulting in a net economic benefit to society. Up-scheduling of codeine was estimated to deliver significant protection to

public health and safety as a result of positive changes in consumer behaviour, raising awareness of codeine dependency and increased exploration of alternative therapeutic and treatment pathways for pain management.

Throughout the process leading up to the Australian up-scheduling decision, it was clear that there was a prevailing public perception that codeine-containing analgesics are safe and represent the strongest and most effective form of OTC pain relief available in Australian pharmacies, while at the same time there was a lack of awareness about alternative pain medications that could also address their needs. Codeine users too often confuse the euphoric effect they get from using the drug with an analgesic effect and this potentially feeds an ongoing dependence on these products, particularly when alternatives are not known or promoted to them. In amongst the highly emotive responses preceding and following the Australian scheduling decision one key piece of information was often overlooked – the evidence that there are alternative OTC analgesics that are more effective in providing pain relief than codeine-containing OTC analgesics, which has been demonstrated in a number of clinical studies.

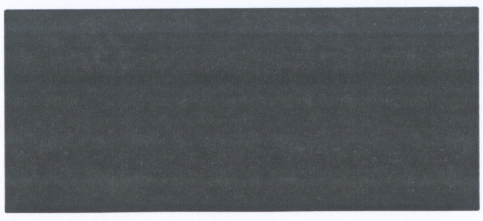
Ultimately codeine-containing analgesics are ineffective, but still potentially harmful, in up to the 10% of the population (poor metabolisers), and 4-10% of the population are ultra-rapid metabolisers for whom codeine poses a potentially life-threatening risk. For the remainder of the population, OTC codeine-based analgesics still pose the risk of abuse, misuse, dependence and harm without providing any significantly greater analgesic effect than the accompanying drug in combination. Combination analgesics are currently available in New Zealand that provide greater efficacy than codeine combinations without the same risks of harm, in addition to established single drug and combination analgesics that are also equally effective to codeine combinations and suitable for treating acute pain.

Codeine is also a prescription medicine in many countries around the world, including the USA, Hong Kong, Iceland, India, Japan, the Maldives, Romania, Russia, the United Arab Emirates, Austria, Belgium, Croatia, the Czech Republic, Finland, Germany, Greece, Italy, Luxembourg, Portugal, Slovakia, Spain and Sweden. With Australia about to join these ranks in 2018, there seems no logical reason why New Zealand should not fall into line with these countries particularly when more effective and less harmful alternatives are widely available over-the-counter.

The up-scheduling of OTC codeine products will help protect consumers from the harm that these drugs can and have caused over many years, enable safer and more effective analgesic treatments for acute pain to be promoted to consumers in their place, and ensure that the need for any form of treatment with codeine-based products is appropriately assessed by a medical practitioner on an individual basis.

Given all of these issues, it is clear that stricter regulatory controls are required to drive public health benefits that outweigh the known risks of codeine use. Therefore we endorse the option to up-schedule all OTC codeine products, and encourage the MCC to proceed with this recommendation at their May 2017 meeting to bring New Zealand into line with the Australian scheduling decision.

Yours sincerely,



The Royal Australian & New Zealand College of Psychiatrists
Te Te Akuaku Roa
New Zealand National Office

Your Health in Mind

10 April 2017

Dr S Jessamine
Chair
Medicines Classification Committee
Medsafe
PO Box 6145
Wellington

By email: committees@moh.govt.nz

Dear Dr Jessamine

Re: Classification of Codeine-containing Medicines

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has reviewed the recent recommendations made by the Medicines Classification Committee (MCC). The New Zealand National Committee and the New Zealand Faculty of Addiction Psychiatry strongly support the proposed changes to classify all medicines containing the opiate codeine to be available only by prescription.

The RANZCP's Comments on the Proposal
The RANZCP endorses option 5, as outlined in the document *'Reconsideration of the classification of codeine',* that seeks to 'change the classification for all codeine containing medicines to prescription only'.

Our rational is based on the following principles:
a. Combined Codeine products are potentially harmful
Combining a dependence-forming controlled drug with a potentially harmful drug (paracetamol or ibuprofen) can expose users of the product to risk. Should codeine-containing combined products such as Nurofen Plus and Panadeine Forte be taken above the recommended dose, as in the case of codeine abuse, misuse or dependence, significant harm can arise from the ibuprofen or paracetamol (Karamatic, 2011). The associated morbidity includes hepatotoxicity, gastric ulceration, renal tubal acidosis and subsequent hypokalaemia, renal impairment as well as death. (Robinson, 2010, Dutch 2008, Frei 2010, Ernest 2010, Ng 2011, Evans, 2010, McAvoy, 2011 and Lambert, 2005).

In addition, codeine toxicity itself can also be fatal: the TGA reported that codeine was a contributory factor in 1437 deaths over a 13 year period (TGA, 2017). Codeine toxicity is hard to predict as people have different metabolism rates of codeine (which is metabolised to morphine in the body), meaning that for a given codeine dose, toxicity may arise in one individual but not another (Gasche et al, 2004).

b. There are few regulations governing over the counter access to codeine
The RANZCP is concerned that currently there are few regulations around the access to codeine-containing medicines in New Zealand. We argue that whilst in 2010 some attempts were made to regulate pack size and ensure pharmacist oversight, access to these potentially harmful products remains, allowing customers to give any name and address to any pharmacy, with the information

Box 10669, Wellington 6143 New Zealand
T +64 4 472 7247 F +64 4 472 7246
ranzcp.nz@ranzcp.org www.ranzcp.org

being variably recorded or not at all. This does little to protect the customer from opioid abuse, misuse or dependence.

c. Unknown scope of problem

It is well recorded in the literature that codeine products can be addictive (Good, 2007, MHRA, 2009, McDonough, 2011). On account of dispensing data of over the counter (OTC) codeine-containing products not being readily available, and not linked to client data, the scope of the problem is not fully known. Many clients dependent on OTC medication do not present to addiction services (Neilson, 2011). Anecdotally, some addiction psychiatrists are diagnosing and treating an increasing number of people presenting with a dependency on OTC codeine-containing products with as many as 20% of new assessments to an opioid treatment service being for dependence on primarily OTC codeine-containing products. (Schwarcz, unpublished 2016). Anecdotal data also suggests misuse of these easily available products by the youth, who mix it with energy drinks (Ernest, 2010). Evidence from the United States demonstrates that dependence on prescription opioids is increasing and therefore it would be prudent for New Zealand to limit the access to medicines with significant abuse and addictive potential (Chou et al, 2009). Making codeine products available only by prescription would reduce the risks of abuse and dependence and provide general practitioners (GPs) with greater opportunities to monitor and refer dependent patients for treatment.

d. Lack of necessity of combination products

Because there are no synergistic effects between paracetamol and codeine, or ibuprofen and codeine, there are no pharmacological advantages in combining the products. In a systematic review combining the products produced only mildly increased analgesia over paracetamol alone (de Craen, 1996). Given the potential harm, the lack of improved efficacy and lack of synergism negates the need for ready access of these combined products.

Recommendation:

The RANZCP recommends that the reclassification of codeine-containing combined products is added to the agenda of the 58th MCC meeting for the harmonisation with Australia, making all pharmacy-only and pharmacist-only entries of codeine to be amended to a restricted medicine.

Additional Comments on the Classification of Codeine Medicines: Liaison, Workforce impact and Implementation

We consider that there is sufficient lead-in around the proposed changes so health professionals and the public can have the opportunity to be informed about the new regulations.
A recent study indicated that GPs may need to be upskilled so they are able to identify patients who may be misusing or dependent on codeine and are able to direct these patients to relevant treatment services. (NZ Doctor, 2016). We would support implementing this proposal within two years to allow for a period of adjustment.

We note that making codeine a prescription medicine is likely to impact on the addiction medicine and addiction psychiatry workforce, as currently we have no reliable data that adequately quantifies the scope of codeine addiction in New Zealand. The RANZCP reports that currently we are only working with those people who have sought assistance regarding their addiction or who have presented with physical symptoms indicting codeine misuse.

GPs will play a critical role in implementing this proposed policy and therefore consideration should be given to the potential impact on the GP workforce, noting the current GP shortage and that some practices are closing their books (NZ Doctor, 2017). The workforce situation may make it difficult for patients in some locations to readily obtain prescriptions for codeine-based products.

The Ministry of Health (e.g. Director of Mental Health and Health Workforce New Zealand), NGO's eg Matua Raki, and the Royal New Zealand College of General Practitioners need to be appraised of the situation, to monitor and evaluate the potential impact this new policy will have upon addiction services and workforce.

The RANZCP considers that public opinion on this proposed change will need to be managed carefully (The Age, 2016). The public are unlikely to be supportive of this proposal: it will impact them financially e.g. paying to visit their GP and they are also unaware of the toxicity associated with codeine overuse. We recommend that a well-developed and targeted public health strategy is implemented to educate the public about the harm associated with codeine-based products and the reasons behind the move to prescription only access.

If you have any further question regarding this submission please contact the RANZCP's New Zealand National Manager, Rosemary Matthews who supports the New Zealand National Committee. Rosemary can be contacted on 04 472 7265 or by email Rosemary.Matthews@ranzcp.org.

Ngā mihi nui

Dr Mark Lawrence FRANZCP
Chair, New Zealand National Committee
Tu Te Akaaka Roa

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SMI
New Zealand
Self-Medication Industry
Association Inc.

10th April 2017

The Secretary
Medicines Classification Committee
Ministry of Health

Email: committees@moh.govt.nz

Dear Sir or Madam

We wish to make comments on Item 6.1 of the Agenda for MCC 58 – scheduling of Codeine.

NZSMI (New Zealand Self Medication Industry Association) is the peak body representing companies involved in the manufacture and distribution of consumer health care products (non prescription) in New Zealand. NZSMI also represents related businesses providing support services to manufacturers, importers and distributors including advertising, public relations, legal, statistical and regulatory advice.

NZSMI appreciates the opportunity to provide comment in relation to agenda item and to the "Options" paper submitted by Medsafe to guide the MCC.

As an industry representative, NZSMI is a key stakeholder in scheduling matters and we are keen to provide further input as required. Please contact me should you require any further clarification relating to this commentary.

Yours sincerely

Scott Milne
Executive Director

P +64 9 528 8217
M +64 21 876 326
E scott.milne@nzsmi.org.nz
W www.nzsmi.org.nz
4 Colenso Place, Mission Bay, Auckland 1071, New Zealand
PO Box 6473, Auckland, New Zealand

NZSMI COMMENT TO THE 58th MCC COMMITTEE MEETING
REGARDING RECLASSIFICATION OF CODEINE

Background

1. NZSMI has provided commentary and submission on all changes and suggested changes to the scheduling of codeine at previous MCC meetings. While we have outlined feedback below we would expect that a full consultation on codeine containing products currently classified at Pharmacist Only is released prior to any decision to upschedule

2. The NZSMI position on OTC codeine containing analgesics is:

   2.1 The majority of people who use OTC codeine containing analgesic medicines do so responsibly.

   2.2 Although there has been evidence of adverse events and morbidity reported as a result of dependence on codeine containing analgesics, NZSMI believes that the incidents are low in comparison to the volume of sales and many published reports predate the regulatory action and the intensified monitoring and recording of codeine containing analgesics from 2010 to 2014.

   2.3 There will be potential negative consequences to changing OTC codeine containing analgesics to prescription only. These include increased costs to government through prescription subsidy and additional pressure on GPs and medical centres, many of whom are currently experiencing long waiting times. Consumers may also be faced with reduced choice and increased out of pocket expenses and the possibility that they may be prescribed higher strength opiates in larger pack sizes as these are currently subsidised by the government.

   2.4 There is a strong contention that upscheduling alone will not reduce the incidence of codeine abuse and addiction but will simply give access to higher strength codeine products via "Doctor Shopping" depriving those whose pain management is currently satisfied by lower strength OTC codeine options.

3. NZSMI therefore does not support the up-scheduling of OTC codeine containing analgesics to prescription only and maintains the current scheduling of OTC codeine containing analgesics is appropriate.

4. NZSMI however, does support other risk mitigating measures, such as improvement in the monitoring system currently used by pharmacists to record purchasing and sales data from patients. NZSMI is also happy to discuss whether improved labelling for codeine containing analgesics is possible or appropriate.

5. In relation to OTC codeine containing cough and cold products that are currently pharmacy only, the NZSMI position is:

   5.1 Cold and flu products typically also contain a decongestant such as phenylephrine in addition to a non-opiate analgesic such as paracetamol. The product indications include pain, however, this is always in the context of, or associated with cold and flu symptoms. These medicines should not be confused with or classed as analgesics.

5.2 There has been no evidence of wide spread abuse or misuse of OTC containing cold and flu medicines currently pharmacy only. It is also interesting to note that when recording processes for codeine containing analgesics were intensified, there was no concurrent shift to cough and cold preparations as a source of codeine for abuse.

6. NZSMI therefore believes the current scheduling of these products is appropriate and we do not support up-scheduling to restricted medicine or prescription only.

Supporting evidence

7. NZSMI supports the separation of pharmacy only OTC codeine containing cough and cold products from analgesics and cough and cold products currently restricted medicines. These two categories should rightly be viewed differently and the evidence relating to misuse and potential risk supports this distinction.

8. Pharmacy only cold and flu products have different labelling, different indications and multiple ingredients, which collectively mitigate the risk of misuse. These products should not be conflated with codeine containing analgesics.

9. There is no specific evidence to justify up-scheduling and the scheduling decision should not be made without considering the different labelling, different indications and presence of other ingredients such as decongestants.

10. Sales data on cold and flu products indicates that the product usage is largely seasonal and there has been no indication of any growth in demand since the codeine containing analgesics were part of the intensified reporting system by New Zealand pharmacists.

11. There is therefore little evidence that any change to pack sizes is needed. However, NZSMI does believe that a discussion on improved labelling may be warranted. NZSMI notes particularly the recent research regarding children under 18, particularly those with breathing difficulties, and particularly those who have had tonsillectomies or similar surgery.

12. NZSMI concludes that improved statements could be added to the current list which includes:

- Do not use for more than 3 days;
- Codeine is an addictive substance;
- Do not use if you are breastfeeding except on doctor's advice;
- This medicine may cause drowsiness;
- If affected, do not drive a vehicle or operate machinery.

13. NZSMI believes discussion and consultation would be valuable around including statements like:

- Do not use in children or adolescence under the age of 18;
- Do not use following tonsillectomy, throat surgery or patients experiencing breathing difficulties.

Pack size reduction

14. In response to Medsafe's discussion paper Option 4, which proposes amended labelling statements and restriction of pack size and age of use, NZSMI makes the following comment:

There is no evidence that a change to pack size is needed for cold and flu products. Cold and flu medicines are for seasonal use and are used for a condition that is episodic in nature.

Limiting the pack size to 3 days may help mitigate against consumers using the product for a prolonged period once purchased for a cold or flu episode and there will be a lesser likelihood of excessive quantities of codeine containing medicine being stored, however, there is no evidence that the use of these medicines has been inappropriate, outside the recommended duration or that stockpiling of these medicines is taking place. It will also mean that consumers who require repeated supply will be visiting the pharmacy more frequently, providing an opportunity for them to discuss symptoms with their pharmacist and referral for medical advice if needed. It is for this reason that NZSMI would prefer to see increased reporting and monitoring systems established rather than reduction in pack size.

15. It is NZSMI's view that codeine containing cold and flu medicines still meet the scheduling factors for pharmacy only. The medicine is for a minor ailment or symptoms that can easily be recognised and are unlikely to be confused by the consumer with other more serious diseases or conditions. Treatment can be managed by the consumer without the need for medical intervention. However, the availability of a pharmacist at the point of sale supports the consumer in selecting and using the appropriate medicine. Consumers are able to recognise the symptoms of cold and flu and manage their treatment. Cold and flu, as previously stated, are seasonal and episodic in nature and usually there is a short duration of treatment. Consumers typically consult their doctor when they experience persistent cold and flu symptoms or complications and it is well understood by consumers that cold and flu products are used for temporary relief of symptoms as per the label statements.

16. The use of the medicine is substantially safe for short term treatment and the potential harm from inappropriate use is low. The safety of these combination products is well established and there is no evidence of actual or potential misuse or use by consumers who seek codeine. The presence of additional ingredients, such as decongestants, also mitigates risk in this regard.

17. The use of the medicine that establish therapeutic dosage levels is unlikely to produce dependency and the medicine is unlikely to be misused, abused or illicitly used. There is no evidence of addiction or dependency occurring from codeine used as per the instructions on the label of OTC codeine containing analgesics or codeine containing cough/cold preparations.

18. It is the NZSMI's contention that the risk profile of these medicines is well defined and the risk factors can be identified and managed by the consumer with appropriate packaging, labelling and consultation with the pharmacist if required. There is a low and well characterised incidents of adverse effects, interactions with commonly used substances or food and contra indications. The safety of these combination products is well established and adequate warnings regarding interactions, contraindications and precautions currently appear on the labelling.

19. It is also contended that the use of the medicine at established therapeutic dosage levels is not likely to mask the symptoms or delay diagnosis of a serious condition. It is important to be reminded of what is trying to be achieved here and NZSMI believes that appropriate labelling and packaging with increased pharmacist involvement in sales and recording can manage risks.

Codeine containing analgesics

20. NZSMI agrees with the current scheduling of codeine containing medicines as restricted medicines and that these are appropriately different to codeine containing cough and cold preparations which are pharmacy only. The restricted medicine codeine containing analgesics

should not be considered to have the same risk profile as the OTC pharmacy only cold and flu medicines.

21. NZSMI is prepared to further discuss the net overall value of reducing the pack size of codeine containing analgesics to not more than 3 days' supply and also to include warning labels that codeine can cause addiction, however, it is our contention that this change on its own will not prove to be useful in reducing the abuse of codeine containing analgesics. NZSMI contends, and has a preferred position, that a more comprehensive real-time reporting of sales and purchaser data is a far more effective and professionally orientated intervention rather than regulated minimum pack sizes.

Intensified reporting and monitoring (IRAM) of codeine containing medicines

22. It is a well-known fact that New Zealand does not suffer from the same extent of codeine addiction and OTC abuse evidenced in Australia. It is our contention that improved recording systems adopted in 2012 have seriously mitigated the risk and ability for potential addicts to shop around for multiple packs of codeine containing analgesics. It is interesting to note in the Medsafe paper around this issue the MCC discussion that took place on 17 September 1985 where the MCC received an update on the abuse of codeine and noted that 20 new patients per month were being treated in Auckland. While NZSMI does not have clinical data around the numbers currently being treated, it is noted that in all the research papers referred to in the Medsafe commentary to the MCC, the numbers of those abusing codeine appeared to be considerably lower than 1985 (egg 1 adverse reaction report as of February 2016, 49 cases over 5 years reported to the Poisons Centre) What is concerning is the high level of misuse that occurs in the very low numbers who do choose to abuse this medicine.

23. If a real-time recording system were to be developed and compulsorily integrated into New Zealand pharmacy, the overall health benefits could be substantial.

24. The Pharmacy Guild is considering the implementation of ta system based on the Australian software package known as Med Assist. This was a voluntary real-time recording system taken up by some 80% of Australian pharmacists and was an extension of the Australian pseudoephedrine sales recording system currently in use there.

25. NZSMI contends that a joint effort is required to develop and implement a similar system in New Zealand. NZSMI believes that a multidisciplinary, multi-partner approach will be necessary, including the Pharmacy Guild, the Pharmaceutical Society, Green Cross Health, pharmacy marketing groups, medicine manufacturers and the Ministry of Health.

26. NZSMI suggests that a two year moratorium on rescheduling of codeine containing analgesics should be considered to allow the development of a nationwide, improved, real-time sales and patient data recording system for pharmacy. The benefits of such a system will be obvious:

- Only pharmacists on the system would be allowed to sell codeine containing analgesics and pharmacies must have standardised instant live reporting software.
- Patients would be clearly informed that due to the nature of this medicine their details are required and are held for recording. This highlights the extraordinary or exclusive nature of this particular class of analgesic and lends weight to the need to carefully follow instructions and warnings.

- The need to produce unique photo ID, e.g. driver's licence, will make life extremely difficult for those wishing to abuse the system as multiple identities would be necessary.

- Illicit codeine abuse will be simply and accurately monitored and the reporting system will flag, very quickly, potential abusers.

- Of more importance, the system will also highlight the over-user who is **unintentionally** 'abusing' codeine containing analgesics and the reporting system provides an easy opening to allow better patient counselling referral and discussion around a potential health issue that is more than a minor ailment.

- Such a reporting system will also improve the relationship between doctors and pharmacists as patients flagged with multiple purchases will activate a response from one or both health professionals.

- In time the system could also be used for other medicines or medicine classes where current reporting systems are seen as inadequate or fragile. This could lead to a greater ease of SWITCH products being accepted for over the counter sales.

- The costs of establishing IRAM (Intensified Reporting and Monitoring) can be discussed with all participating stakeholders: Guild, Society, Green Cross Health, marketing groups, manufacturers, MOH etc.

27. This most important benefit of the proposed real-time monitoring system is that it will be able to accurately identify consumers who visit multiple pharmacies to access products, allowing pharmacists to provide appropriate information and advice to assist consumers who may be having problems with chronic pain, dependence or misuse. There are no comparable software systems in place that record or identify *"doctor shoppers / pharmacy shoppers"* who may have problems with dependence or misuse of prescription opiates.

28. Pharmacists will be able to review other recent purchases to assist in assessing how to best manage the consumer's request. Information entered into the system will be linked in real-time allowing pharmacy shoppers to be identified and referred to their GP or pain clinic as appropriate. This data will also be collected and reported and will provide valuable usage and metadata for better understanding analgesic use in a broad patient base in New Zealand.

Other initiatives

29. The intensified reporting and monitoring also opens the door for better patient education by pharmacists on appropriate use of analgesics, not just codeine containing product. NZSMI would like to discuss with Medsafe, the Pharmacy Guild, the Pharmaceutical Society , Green Cross Health and major pharmacy marketing groups, along with the Self Care Alliance of New Zealand (SCANZ) on how best to develop a consumer and Health care Professional education package around appropriate analgesic use.

Conclusion

In referring to the Medsafe "possible options the Committee should consider" NZSMI supports an amended Staus Quo (Option 1) believing that, currently, other regulation will not improve health outcomes but that this decision should be re-visited in two years. The current scheduling categories for analgesics and cough/cold preparations are appropriate.

In addition, NZSMI suggests that, in this interim, the development of an enhanced, real time recording and monitoring system is developed with input and contribution from a wide range of stakeholders. This intensified reporting and monitoring (IRAM) system would be compulsory for pharmacies wishing to stock codeine containing products and that additional training for pharmacists would accompany participation in the scheme.

NZSMI believes that there may be some merit in considering labelling changes but contends that a more comprejensive public education initiative, alongside IRAM, will lead to better outcomes.

If the committee should decide that a re-classification of codeine containing products is desirable and that this suggestion is not acceptable, NZSMI would like to be part of a much more comprehensive consultation process.

PHARMACY GUILD OF NEW ZEALAND

10 April 2017

Medicines Classification Committee Secretary
Medsafe
Wellington

Sent via email to: committees@moh.govt.nz

Dear Sir/Madam

RE: AGENDA FOR THE 58th MEETING OF THE MEDICINES CLASSIFICATION COMMITTEE

Thank you for the opportunity to provide feedback on the agenda for the 58th meeting of the Medicines Classification Committee (MCC), to be held on Tuesday 16 May 2017.

The Pharmacy Guild of New Zealand (Inc.) (the Guild) is a national membership organisation representing the majority of community pharmacy owners. We provide leadership on all issues affecting the sector.

Our feedback covers eight agenda items. These are:

- Agenda item 5.3: Update on the classification of nicotine and the regulation of e-cigarettes.
- Agenda item 5.4: Final version of the document titled 'How to change the legal classification of a medicine in New Zealand'.
- Agenda item 5.5: Medicine reclassification – proposed additional process when considering the reclassification of prescription medicine to restricted medicine (Pharmacy Council).
- Agenda item 5.6.1: Articaine, lignocaine and prilocaine with or without felypressin – proposed amendment of the classification wording (Dental Council).
- Agenda item 5.6.2: Diphtheria, tetanus and pertussis (acellular, component) vaccine – proposed amendment to the prescription medicine except classification.
- Agenda item 5.6.3: Sildenafil – proposed amendment to the prescription medicine except classification (Individual submission).
- Agenda item 6.1: Codeine – proposed reclassification of the pharmacy only medicine entry to a more restricted medicine classification (Medsafe).
- Agenda item 6.2: Sedating antihistamines – proposed amendment and reclassification of non-prescription medicine entries to prescription medicine (Medsafe).
- Agenda item 8.2.2.b: Ulipristal.

Each of these agenda items are discussed below.

Pharmacy House, Level 3, 124 Dixon Street, Te Aro, Wellington 6011 | PO Box 27 139, Marion Square, Wellington 6141
P. 04 802 8200 F. 04 384 8085 E. enquiries@pgnz.org.nz www.pgnz.org.nz

Agenda item 5.3: Update on the classification of nicotine and the regulation of e-cigarettes.

The Guild **supports** the regulation of e-cigarettes in New Zealand and recommends a review on nicotine classification.

On 29 March 2017 the Government announced their plan to legalise e-cigarettes in an effort to make New Zealand smokefree by 2025. This will see the sale of nicotine e-cigarettes and e-liquid made legal late next year. We understand the Government's intention is to increase accessibility of e-cigarettes to reduce harm from smoking or vaping.

There is a general consensus that e-cigarettes are less harmful than traditional tobacco products. However, the evidence on their safety is still to be demonstrated. While e-cigarettes may be safer than traditional tobacco products, nicotine is still an addictive product, and the use of e-cigarettes still increases the risk of diseases associated with smoking such as chronic obstructive pulmonary disease, lung cancer, and possibly cardiovascular disease. While the magnitude of these risks is likely to be smaller than from smoked tobacco products, the potential for harm is still of concern. Without robust clinical evidence of reduced harm with use of e-cigarettes we are concerned that the availability of e-cigarettes will be viewed as an additional nicotine product and the result may be one harm being replaced with another.

In addition, we do not consider that placing an age restriction on the sales of e-cigarettes, in the same way as smoked tobacco products will be enough, and further restrictions on supply and advertising are required. Since the Government's objective is to reduce the harm from smoking and vaping, this implies that e-cigarettes are to be used as a smoking cessation tool and we consider they should be available only when included as part of a nicotine replacement therapy or other smoking cessation therapy provided at pharmacies or other smoking cessation clinics. Pharmacists already provide smoking cessation advice on a regular basis and provide products such as nicotine replacement therapy.

We would therefore recommend that e-cigarettes and their related equipment should only be available through smoking cessation providers, such as community pharmacy. This would provide access to those wanting to quit smoking and reduce the uptake by non-smokers.

Agenda item 5.4: Final version of the document titled 'How to change the legal classification of a medicine in New Zealand'.

We would like to reiterate the comments that we made on this issue for the 57th meeting of the MCC. Our position is still that we are **strongly opposed** to reference lists, training or other supporting material being made publicly available.

We remain concerned that updating the guidance document titled 'How to change the legal classification of a medicine in New Zealand' will result in a disincentive for companies, organisations and individuals who wish to submit a proposal to reclassify a medicine in New Zealand. We are aware that a recent proposal on the agenda for the

upcoming 58th meeting, agenda item '6.2 Melatonin – proposed reclassification from prescription medicine to prescription medicine except when supplied by a pharmacist in specific circumstances' was withdrawn by the submitters. Our understanding is that the submitter did not wish for some of the information in the proposal to be published as this would have been commercially disadvantageous to them. We understand that European medicines regulatory authorities respect the intellectual property of the applicants and publish very little of the application.

We expect that having to withdraw an application before the meeting agenda is heard, and making the decision not to continue with the reclassification process would have been very disappointing and costly to the applicant. This action sets a precedent and may mean that other pharmaceutical companies, organisations and individuals are dissuaded from making reclassification applications in the future.

Should multi-national pharmaceutical companies be discouraged from making new applications, there is potential for beneficial prescription to restricted or pharmacy only reclassifications to cease. We believe this would limit improved access to medicines for patients in the future and be to the detriment of the New Zealand health system.
As stated in our last submission we believe that the members of the MCC have the skill sets required to make decisions on the material provided with the applications or alternatively the MCC could seek confidential specialist input where required.

Agenda item 5.5: Medicine reclassification – proposed additional process when considering the reclassification of prescription medicine to restricted medicine (Pharmacy Council).

The Guild **strongly supports** the Pharmacy Council's proposed additional process when considering the reclassification of prescription medicine to restricted medicine.

As stated in our submission to the Medicines Classification Committee 57th agenda, we believe this joint competence framework between the Pharmacy Council and the Pharmaceutical Society will result in a more robust reclassification process.

We believe that consistency in the reclassification process is very important. A joint framework will ensure that both those applying for a reclassification, as well as pharmacists who will be affected by the outcome of any future reclassifications, will have a thorough understanding of the process involved in reclassifications from prescription to restricted medicines.

We agree that the proposed framework will provide efficiencies and ensure that there is no duplication of training or educational tools required as a condition of the reclassification.

We would like to be clear that it is important that there is a degree of flexibility built into the reclassification of prescription to restricted medicines. Not all reclassifications to restricted medicines will require a pharmacist to undertake further training. Many reclassifications should sit within the pharmacist's current scope of practice. We do not believe that there should be extra training required for pharmacists for the sake of it – it must be necessary and intended for the safety of patients.

Overall, we believe that having a common, standardised, clear and robust competence framework may result in more reclassifications of appropriate prescription medicines and improve consumer access to beneficial medicines.

Agenda item 5.6.1: Articaine, lignocaine and prilocaine with or without felypressin – proposed amendment of the classification wording (Dental Council).

The Guild **supports** the Dental Council's application for the amendment of the classification wording for articaine, lignocaine and prilocaine with or without felypressin.

The Dental Council is the responsible authority created by the Health Practitioners Competence Assurance Act 2003 to regulate the oral health professions. It will also regulate oral health therapists from 1 November 2017.

Until 1 November 2017 oral health graduates register as dental hygienists and/or dental therapists. Dental therapists can administer local anaesthetic on children up to 18 years of age without any direct supervision by a dentist, or dentist on-site. A dental hygienist can only administer local anaesthetic when a dentist is on the premises. The new category will allow oral health therapists to use selected local anaesthetics (with or without vasoconstrictors) without needing a dentist to be on-site and this reclassification would enable this. There would not be an upper age limit for the treatment of patients for oral health therapists.

It is our understanding that the training that is undertaken by oral health graduates is more thorough and now at a three-year degree level, than that of dental therapists, who have been delivering local anaesthetic injections without the supervision of a dentist for many years.

Without this classification change, there would be restrictions in the usage of local anaesthetics by oral health therapy graduates that would potentially hinder the treatment of patients. Patients may choose to have their treatment without local anaesthetic and experience pain or discomfort, or they may decide to delay or cancel their treatment altogether.

In New Zealand, there is evidence of significant unmet need in relation to dental care. The Ministry of Health survey on older people's oral health showed there "are disparities in oral health within this population group, particularly among Māori and Pacific older adults, older adults of lower socioeconomic status, and those living in residential aged-care facilities".[i]

While the Ministry of Health New Zealand Health survey showed "Nearly half of adults with natural teeth visited a dental health care worker in the past year"[ii], this implies that over 50% have not visited a dental health care worker. The study also showed "Māori and Pacific children and adults, and those living in the most deprived areas have high rates of tooth extractions in the past year".

We believe this proposal would help increase access to dental care. Oral health therapists would be able to provide remote dental services in rest homes, residential care facilities, schools and maraes. By increasing ease of access of dental care for our vulnerable populations, the disparities described in the Ministry of Health survey could start to be addressed.

Agenda item 5.6.2: Diphtheria, tetanus and pertussis (acellular, component) vaccine – proposed amendment to the prescription medicine except classification.

The Guild **supports** the proposed amendment to the prescription medicine except classification for the diphtheria, tetanus and pertussis vaccine.

We understand that the classification sought is for "Prescription only medicine except when administered in a single dose to a person 18 years of age or over or to pregnant women 13 years and above by a registered pharmacist who has successfully completed a vaccinator training course approved by the Ministry of Health and who is complying with the immunisation standards of the Ministry of Health".

Pertussis is one of the most infectious and transmissible vaccine-preventable diseases. We believe that this is a timely application considering the many recent reports in the media regarding concerns that the number of whooping cough cases are on the rise. This has been reported by DHBs since 2015 in various areas such as Auckland, Rotorua, and Nelson.

It was reported in April 2016 that there had been a 108% increase nationally in the illness from the previous year, with doctors calling for parents to ensure that their children were vaccinated.[iii]

More than 30 cases of whooping cough were recorded in Rotorua in 2016 (to November). The jump, up from just nine cases in 2015 and 15 in 2014, has been put down to the ongoing outbreak affecting much of the country.[iv]

Whooping cough notifications also rose across the whole of the Bay of Plenty last year, and already in 2017 several small children have been admitted to hospital. Toi Te Ora - Public Health Service was notified of 95 people with whooping cough in the Bay of Plenty and Lakes districts in 2016, up from 34 in 2015. In 2016, ten cases were babies aged one year and under and 11 were young children aged from one to four years old. Whooping cough can be a very serious disease for babies, often requiring intensive hospital treatment and can in some cases be life-threatening. The mortality rate in infants is high, with Maori and Pacific Island infants at most risk.

A cluster of whooping cough cases in Wellington were reported to the Medical Officer of Health in December 2016. Fifteen cases were confirmed, two adults, two teenagers and the rest children aged between 3 and 11.

The last outbreak of this disease in New Zealand was between 2011 and 2013 and typically reoccurs as a large scale outbreak every two to five years, indicating that the country is due for an outbreak. In April 2016, Fiona Miles, a Starship Hospital paediatric

doctor warned New Zealand was in line for a whooping cough epidemic. She said while the disease was always present in the community, it tended to work in a four-year cycle. There had been a doubling of cases and a big surge in cases in Australia, meaning an epidemic was highly likely.

Up to 70% of babies aged under one who caught whooping cough would end up in hospital, with one child in 100 dying of the disease. As stated by Fiona Miles, "this is a preventable disease so we shouldn't be losing anyone"[v]. The Immunisation Handbook states that of infants with pertussis sufficiently severe to require intensive care admission, one in six will either die or be left with brain or lung damage.

It has been estimated that widespread immunisation in pregnancy during an outbreak could reduce the number of children under 12 months who get whooping cough by up to a third, and hospitalisations by 40%.[vi]

"There is evidence for the efficacy of pertussis vaccination in women who are pregnant, in providing immunity to both the mother and the infant, and it is considered safe. In one large United States study analysing a birth cohort of 131,019 infants, vaccination during pregnancy (between 28-38 weeks) reduced infant pertussis cases by 33%, hospitalisations by 38% and deaths by 49%.

It has been estimated that the uptake of the pertussis vaccine in New Zealand women who are pregnant is very low, around 13%.[vii]

Considering this low estimate, the fact that this disease is much more severe in infants and combined with the risk of an outbreak, it is important that efforts are made to ensure vulnerable new babies are given the best means of protection. As this comes from immunising their mothers between weeks 28 and 38 to give the babies some form of passive immunity to the whooping cough bacteria, increasing immunisation rates is vital. Babies do not begin their vaccinations until 6 weeks of age, so for this time period, they remain unprotected and reliant on the passive immunity they have from their mother. We believe this proposal would go some way to improving this vaccination rate for what is a preventable disease.

The last funded vaccine on the Immunisation Schedule is a booster shot at age 11 years. Immunity to the disease begins to wane within several years of this dose. It is likely that many young pregnant mothers will no longer have immunity to this disease.

On 15 March this year PHARMAC announced, changes to the Pharmaceutical Schedule to fund the provision of influenza vaccine to people aged 65 years and over and pregnant women in community pharmacies from 1 April 2017. This acknowledges that community pharmacies are now widely considered to be a convenient place for people to access vaccinations and that vaccination in community pharmacy is working. We are hopeful following this decision more vaccinations will be approved for funding in community pharmacy in the future.

One DHB has already begun funding pharmacies to provide the pertussis vaccine to pregnant women. Waikato DHB made the funding available to improve pregnant women's access to the vaccine. Increasing the age band as suggested by this proposal would mean pregnant teenagers are also eligible for this service from pharmacies.

Pharmacists providing this service have found difficulties with the current classification age of 18 for this vaccine. If a pregnant woman under 18 goes into the pharmacy for the Tdap vaccine they need to be referred by the pharmacist back to their GP for immunisation at the surgery, or alternatively the patient can organise a prescription from their doctor and go back to the pharmacy. Given that these women are some of the most vulnerable in the community it would be preferable for them to be vaccinated on the spot, if they are eligible and consent to the pharmacist administering the vaccine to them.

While we understand that funding of whooping cough vaccine is an issue separate to this application, MCC approval of this application would set the stage for government funding to follow – increasing the chance that this vulnerable group of young women and their babies will be vaccinated against this preventable disease.

We feel that if this proposal goes ahead it will enhance patient care, and collaboration between health professionals rather than lead to fragmentation of care. As most midwives are not themselves vaccinators they frequently recommend this vaccine to their patients. Being able to access this vaccine from pharmacy would increase its accessibility, in particular for a very vulnerable group – pregnant teenage mothers.

Pharmacists are required to inform the patient's GP of their vaccination if the patient consents to this and should this proposal go ahead, they would be expected to also inform the patient's Lead Maternity Carer (LMC). In turn the LMC would be referring some of their patients to their local pharmacy for a whooping cough vaccination. These types of interactions all increase the relationships between health care professionals.

Agenda item 5.6.2: Sildenafil – proposed amendment to the prescription medicine except classification (Individual submission).

We **support** the intent of the submission that proposes two amendments to the restricted medicine entry of sildenafil.

Condition 1 "...when sold in the manufacturer's original pack...'
We support the proposal that the requirement for sildenafil to be sold in the manufacturer's original pack be removed.

While the price of this medicine has reduced in recent times since the drug has come off patent, it can still be expensive for some patients. It is our opinion that it would be very rare circumstances that a patient would be able to afford to purchase a pack size of 12 tablets, most would opt for the smaller pack of four tablets.

Patients who receive a prescription from their doctor for this medicine get it dispensed unsubsidised ('NSS') at their pharmacy. The pharmacist is able to dispense this medicine in any amount requested by the patient because the dispensing rules do not apply to an NSS medicine. This means that many patients will pay for one or two tablets at a time, and this spreads the cost for them significantly.

We believe that the current classification may be limiting access of this medicine to some patients in need due to the financial constraints. More men may be able to afford the medicine if there was an opportunity to purchase it in smaller amounts.

Another advantage of being able to supply sildenafil in broken packs is that it allows pharmacists to supply patients with an adequate trial quantity following the initial consultation. This ensures that if the medicine is not right for the patient, he will not have excess unneeded medicine in his home. We are aware that people often share their medicines and this will therefore reduce the chances of sildenafil being given to another person who has not been screened by a doctor or pharmacist.

The submitter is correct in stating that there is no additional information provided on or in the original packaging to the patients when they purchase this medicine. It is part of the pharmacist consultation that they receive information on how the medicine works, its side effects and any drug interactions. The Pharmacy Council 'Protocol for the Sale and Supply of Pharmacist-Only Medicines for Chronic Conditions' requires that pharmacists provide their patients written information to reinforce the verbal communication in the consultation.

Another requirement of the supply of sildenafil is that a sildenafil assessment form/algorithm must be followed. It is not considered a guide for pharmacists, but an actual requirement for the supply and must be completed for every patient. A final requirement for supply is that all men are given a sildenafil information sheet.

We believe these requirements ensure that every patient is fully informed about the medicine and leaves the pharmacy with information that they can refer back to in their own time. We believe this negates the current requirement for the medicine to be sold in the manufacturer's original pack as there is no extra safety information that would be lost if the medicine was to be repacked into an unmarked pharmacy skillet. Should this proposal go ahead, we suggest that it is made clear that a requirement of the sale of sildenafil would be to include a Medsafe patient information leaflet with every dispensing regardless of whether it is for one tablet or 12.

If this proposal does not go ahead, we suggest that manufacturers of sildenafil supply sildenafil in single unit packages at a price that is affordable for the consumer.

Condition 2 "...aged 35 – 70 years..."

We understand that the decision to set an age range of 35 to 70 years when sildenafil was initially reclassified as a restricted medicine was because erectile dysfunction (ED) mainly affects men over the age of 40. An age limit starting at 35 was to reduce the risk of use without need.

As part of this proposal the risks and benefits of increasing access of sildenafil to men under 35 needs to be assessed. We believe a benefit of reducing the age restriction could result in more young men, who are perhaps less likely to visit a GP, making contact with a health professional and undergoing a consultation with a pharmacist. During the consultation, the pharmacist screens for depression and other conditions and may pick up those patients who may not normally access health services. This has certainly been the case with the initial reclassification of sildenafil.

We are aware that New Zealand Customs intercepts a reasonable volume of sildenafil illegally imported from overseas, and it is likely not all illegal imports are intercepted. We believe the majority of illegally imported sildenafil has not had its efficacy or safety approved by Medsafe and has the potential to cause harm. Thus, lowering the age might reduce the number of young males illegally importing sildenafil.

We are aware that the MCC had genuine concerns of abuse potential. Our own research does suggest that sildenafil is more prone to abuse and use as a lifestyle drug in younger men. Anecdotally it has been reported that some young healthy men who wish to enhance their sexual performance are requesting or abusing sildenafil. In some cases they are combining it with other drugs and narcotics. This has health officials in several countries concerned about the long term mental health consequences as well as the more immediate physical dangers.

The mental health risks of using sildenafil without need also concerns us. A psychosexual counsellor in central London was quoted as saying that every month he treats about 15 young men - with an average age of 32 - who have become dependent on sildenafil to improve their sexual performance.[viii] These men have no physical problems that would cause erectile difficulties but have become reliant on the drug psychologically. Sildenafil should not be given to young healthy men to improve their erections and patients should be advised against recreational abuse of the drug.[ix]

We feel to support this proposal there needs to be convincing evidence of a clinical need for sildenafil in younger males. We are satisfied with the reasoning behind the MCC's initial decision and feel comfortable that this age range remains. While we agree with the individual submitter that pharmacists will find themselves facing men with a genuine need who meet the criteria for supply, but are under the age of 35, as he himself points out, there will always be patients just outside the age range set.

Agenda item 6.1: Codeine – proposed reclassification of the pharmacy only medicine entry to a more restricted medicine classification (Medsafe).

The Guild **supports** reclassification of the pharmacy only medicine entry for codeine to a Pharmacist Only (restricted) medicine classification.

The Guild is **opposed** to a reclassification of codeine products that would reduce direct access through a pharmacist.

We believe that all over-the-counter (OTC) codeine products should be classified as Pharmacist Only medicines or Prescription Only except when sold by a pharmacist. This would ensure that all combination products containing codeine that are currently available for the treatment of acute pain and coughs and colds would be required to be sold by a pharmacist.

There are many reasons that we feel a prescription only classification is unnecessary. Such a reclassification could result in:

- patients undertreating their pain or not treating it at all
- there could be prescribing of more potent medicine once seen by a doctor, when an OTC medicine would have sufficed

- increased difficulty for low income patients to access primary care if their medicine is now only available from a prescriber
- increased GP workload from patients experiencing only minor, self-limiting acute illnesses/pain
- increased burden on hospital emergency departments from those patients who cannot afford to see a GP
- restriction of consumer choice
- a reduction in effective acute pain management services provided by community pharmacy
- patients less able to self-treat minor illnesses
- an increase in government spending on health and pharmaceuticals.

A prescription only classification for codeine products would restrict access for people who genuinely need these medicines for legitimate purposes. Cough and cold products are very effective for the symptomatic relief of self-limiting respiratory illnesses. If these products were to be reclassified as prescription only this would mean an entire group of useful medicines are made difficult to access.

All medicines have the potential for misuse and abuse, and prescription only opioid analgesics are also associated with inappropriate use and abuse. If codeine is up-scheduled it will merely shift the misuse to prescription codeine or another potentially more potent medicine. We believe there should be more effort directed towards the prevention and early identification of misuse and abuse of medicines and treatment for those patients who have dependence issues.

It appears that there is still no data or studies specific to New Zealand on the extent of this perceived growing problem of OTC codeine misuse and abuse. There has been a long history of this issue being raised at the MCC. We are aware of the difficulties in quantifying the extent of OTC codeine misuse – no real-time monitoring, and different types of potential misuse such as self-medicating at higher than recommended doses and/or for longer than is recommended, to use outside the medical guidelines.

We believe there is a pressing need to identify risk profiles for those patients who will develop problematic codeine use in order to better understand the extent of the problem, and the path to misuse and dependence in a New Zealand context. We also need to understand the public's awareness of the potential risks of codeine use, misuse and dependence.

While we understand the decision that Australia has made is based on the evidence found in Australia, we don't believe that this can be generalised to the New Zealand population. We would like to suggest that some studies (both quantitative and qualitative) on the harm of OTC codeine, and the potential for misuse/abuse in New Zealand are undertaken to get specific data before any further up-scheduling of codeine.

Pharmacist screening of patients has the ability to find those at risk of developing dependence to codeine. As described in a study exploring the characteristics of nontreatment–seeking OTC codeine users, "many of the cases had initiated codeine use for acute pain, then escalated their dose over time, experiencing severe morbidity."[x] It is important for pharmacists to intervene early when patients commence pain treatment. Ensuring all OTC codeine products are classified as Restricted Medicine or Prescription

Medicine except when sold by a pharmacist enables pharmacists to screen and intervene early.

We believe that a more detailed screening for all people requiring codeine-based treatment using a universal precautions approach would help to identify those at greater risk of developing dependence. There is clear evidence that frequent "questioning about the use of codeine products has been reported by codeine-dependent people to be one of the reasons that they eventually sought help for their codeine use"[xi]. This screening would be over and above the pharmacist consultation that already takes place as part of the sale of restricted medicines.

Pharmacists are required to adhere to the joint statement by Council and Society on the "Sale of Codeine Containing Analgesics" published in February 2016. This prevents them from supplying unnecessary and excessive quantities of OTC codeine. Before any supply takes place, they must establish that there is a therapeutic need for the medicine and that it is suitable for the patient. The pharmacist must be assured that the patient is using it for acute use only. They are expected to be vigilant about frequent purchasers and ideally confirm the patient's identity when they record the purchaser details.

It would be unjustifiable to reduce access to a medicine effective in managing acute pain without research that demonstrates reasonable harm in the New Zealand context.
A recent study[xii] reviewed the current evidence of the benefits and risks of paracetamol on its own and with codeine for mild to moderate pain in adults. This was then compared to the respective safety and efficacy of non-steroidal anti-inflammatory drugs (NSAIDs).

It was found that for NSAIDs there is a clear strong association of gastrointestinal (GI) and cardiovascular (CV) morbidity and mortality. Contrary to this finding the study found there is evidence for paracetamol with and without codeine to support its use even in most vulnerable individuals, such as the elderly, pregnant women, alcoholics, and compromised GI and CV patients. The researchers recommended that paracetamol alone and with codeine is a safe and effective option in adults, whilst NSAIDs are less safe as alternatives, given the risk of potentially fatal GI and CV adverse effects.

We believe this study show there is a place for codeine as an effective treatment for mild to moderate pain, and raises questions as to the safety of the commonly used NSAID alternatives. Should common NSAIDs be found to require an upscheduled classification due to safety concerns, the selection of safe analgesics available for patients to purchase over the counter would be severely limited.

Agenda item 6.2: Sedating antihistamines – proposed amendment and reclassification of non-prescription medicine entries to prescription medicine (Medsafe).

We **support** the proposed amendment and reclassification of non-prescription medicine entries to prescription medicine for sedating antihistamines.

The safety concerns raised by Medsafe are significant, notably risk of sedation and respiratory depression, and we feel that for the indications of nausea, vomiting and

travel sickness, for children under the age of six, these medicines are best for prescribers to recommend to their patients.

Medsafe has stated that "there is a paucity of information relating to potency, efficacy and safety" of first generation (sedating) antihistamines, and for this reason alone we feel it is better that young children are not exposed to these medicines. First-generation antihistamines have never been adequately studied for paediatric age groups. In contrast, studies in children have been made with the second-generation antihistamines, allowing us to better know their safety profile.[xiii]

First generation antihistamine-induced sedation has been described to occur in more than 50% of patients receiving therapeutic dosages.[xiv]

We agree that the proposal should apply to all sedating antihistamines in order to avoid confusion amongst prescribers, pharmacists and patients. It is important that it is very clear that there are different permissible ages dependent on the indication of the drug.

We expect that there will be requirements made for the manufacturers to ensure that all packaging is labelled with the age relevant dose for all of the indications for each individual sedating antihistamine.

Agenda item 8.2.2.b: Ulipristal

The Guild **supports** the new entry of ulipristal as a Restricted Medicine for emergency post-coital contraception in New Zealand as recommended by the Australian delegate in July 2016.

We note that at the 54th meeting of the Medicines Classification Committee the Committee recommended that ulipristal be classified as a prescription medicine. A further recommendation was that the Committee should encourage health care professionals to put forward a submission for reclassification once there is useful information suggesting it should be reclassified. We consider the classification of ulipristal should be aligned with the classification of levonorgestrel.

Ulipristal acetate 30mg is currently available in 25 European countries and Australia without a prescription for emergency contraception. We believe ulipristal meets the criteria for a Restricted Medicine in New Zealand, on the same basis as the current scheduling of levonorgestrel.

Pharmacists in New Zealand have been supplying levonorgestrel since 2002. It has now become the norm for women to access emergency contraception promptly and appropriately from a pharmacy without needing to see a doctor.

While being comparable to levonorgestrel in adverse event profile, clinical and biological evidence demonstrate that ulipristal acetate 30mg is more effective than levonorgestrel, especially when taken within the first 24 hours of unprotected sexual intercourse (UPSI), a timeframe in which the vast majority of women already ask for emergency contraception from a pharmacy. When taken in the first 24 hours following UPSI there is only a 0.9% risk of becoming pregnant after taking ulipristal, compared to a 2.3% risk

after taking levonorgestrel.[xv] In addition, ulipristal is effective with 5 days (120 hours) of UPSI compared to 3 days (72 hours) for levonorgestrel.

Ulipristal has been available in Australian pharmacies since 1 February 2017, however it was first marketed in 2009 and has been taken by many women internationally. During this time its safety has been well established and there is no evidence of abuse. The most commonly reported side effects are headache, nausea, abdominal pain and dysmenorrhea.

In public health terms ulipristal offers a reduction in unintended pregnancies (and possibly abortions) and gives women additional options, for instance where more than 3 days has elapsed since UPSI (noting that for maximum efficacy ulipristal should be taken as soon as possible after UPSI).

Since levonorgestrel was classified as a Restricted Medicine the Pharmacy Council has set the standards for the supply of emergency contraception by pharmacists. To comply with these standards pharmacists cannot supply emergency contraceptive medicines unless they have successfully completed an education programme accredited by the Pharmacy Council and become accredited providers of emergency hormonal contraception. We believe this is sufficient training to enable pharmacists to supply ulipristal, and it is our expectation that pharmacists who are already accredited providers of emergency hormonal contraception will not require any additional mandatory training to supply ulipristal. While we understand that there are some key differences between ulipristal and levonorgestrel, we feel that being familiar with medicines, including ulipristal, rests within a pharmacist's existing professional responsibility.

We would be supportive of ulipristal being available in pharmacies as a Restricted Medicine as it would provide more choice to women who require emergency contraception. We look forward a product being available in New Zealand in the near future from the health professional people see most often.

Thank you for considering our feedback. If you have any questions about our feedback, please contact our Guild Pharmacist, Sarah Bannerman at s.bannerman@pgnz.org.nz or 04 802 8209.

Yours sincerely,

Nicole Rickman
General Manager – Membership and Professional Services

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GREEN CROSS HEALTH

10th April 2017

Secretariat
Medicines Classification Committee
Medsafe
PO Box 5193
Wellington 6145

Dear Committee Members,

Re: Multiple Items for the 58th Medicines Classification Committee Agenda

Thank you for the opportunity to comment on the Agenda items for the 58th Meeting of the Medicines Classification Meeting to be held on the 16th May 2017.

Item 5.6.3 Sildenafil
We are comfortable with continuing to supply sildenafil in approved packaging rather than breaking packs. We would prefer that companies include appropriate consumer information in their packs consistent with pharmacist-supply to support the pharmacist's verbal advice, and help pharmacists meet their requirements under the Pharmacy Council guidance for supply of such medicines. We would also be comfortable with a reduction in age range, e.g. from 30 years.

Item 6.1 Codeine in pharmacy-only medicines
Thank you for the opportunity to comment on the Medsafe proposal to reclassify codeine currently classified as a pharmacy medicine to a more restrictive classification.
Codeine is only classified as a pharmacy medicine as follows:

> *in medicines for oral use, containing not more than 15 milligrams of codeine per solid dosage unit or per dose of liquid with a maximum daily dose not exceeding 100 milligrams of codeine, when combined with 1 or more active ingredients in such a way that the substance cannot be recovered by readily applicable means or in a yield that would constitute a risk to health, for the treatment of the symptoms of cough and cold and when sold in a pack of not more than 6 days' supply, approved by the Minister or the Director-General for distribution as a pharmacy-only medicine*

This submission therefore only deals with codeine as a medicine for cough and colds. We expect that if this consideration widens beyond the cough and cold area, it would return to a future Medicines Classification Committee meeting and be subject to further consultation.
Reviewing the minutes for the previous meeting (November 2016, 57th meeting), the item arose from Trans-Tasman Harmonisation. The minutes reported that:

> *The outcomes of the Australian Committee on Medicine Scheduling (ACMS) meeting in August 2015 were released to the Committee. The Committee reviewed the outcomes regarding the classification of codeine and signalled it would consider harmonising with the Australian Schedule.*

Unichem life Pharmacy

Phone 09 571 9080 Fax 09 571 9081
Ground Floor, Building B, Millennium Centre,
602 Great South Road, Ellerslie, Auckland
Private Bag 11906, Ellerslie, Auckland 1542

The recommendation in the minutes from the MCC 57th meeting was:

> *That an item to consider the reclassification of codeine should be added to the agenda for the 58th meeting for the possible harmonisation with Australia of all pharmacy only entries of codeine to be amended to restricted medicine.*
> *That Medsafe should review the relationships between the Australian and New Zealand markets, the role of codeine in cough in cold products and whether the benefit of its use outweighs the risk of harm.*

For codeine in cough cold remedies to be reclassified upwards to pharmacist-only medicines, we would expect to see misuse issues and/or indications of harm greater than other cough-cold ingredients not being considered.

Misuse

Despite being more easily accessible (as pharmacy-only medicines) than codeine-containing analgesics (which are pharmacist-only), feedback from pharmacists suggests most have not had any indications of concern. We have canvassed pharmacists working in a variety of pharmacies throughout NZ from 7-day mall pharmacies to local suburban pharmacies. These pharmacists were selected as top practitioners who would be particularly aware of any issues. We have also spoken with a retail manager who looks after these medicines. All but one stated that they had not seen any behaviour of concern with these medicines. One pharmacist was aware of a single repeat purchaser only. As coughs and colds are typically reasonably short-lived, remedies for their treatment will be used for short durations only, with no opportunity for the development of dependence over this time. We also note that none of the publications mentioning codeine listed in Table 5 of the Medsafe document for this agenda item mentions codeine in cough-cold products.

We note the Poisons Centre reports codeine-containing cough and cold remedies being used in 3 out of 49 of their reports of overdose between 2011 and 2019. We suspect this is probably not reflective of an ongoing misuse situation, but other reasons common to Poisons Centre reports such as a suicide attempt, childhood poisoning or inadvertent additional doses in which the codeine content was not targeted. If asked about pholcodine, there would probably be a similar number of combination cough-cold products used for overdose.

Feedback from pharmacists has been that misuse with codeine-containing cough/cold medicines is virtually unheard of. However, anecdotal feedback would indicate that dextromethorphan is being sought in some areas from time to time, and some pharmacies are choosing to remove the sought-after products from self-select or have only the empty boxes on the shelf, remembering that Pharmacists do use their professional right to refuse supply of any product at all times. WHO reports that the potency of dextromethorphan in suppressing cough is "nearly equal to that of codeine". However, it does not work on opiate pathways, and its hallucinogenic actions in excessive dosing occur through its actions on NMDA receptors (like ketamine and phencyclidine). In NZ, dextromethorphan is a general sales medicine under certain criteria.

Adverse events

We have considered NZ reports of adverse event information for the codeine-containing cough-cold remedies from the Suspected Medicine Adverse Reaction Search (SMARS) database. From 1 January 2000 until early 2017 there were eight reports of adverse reactions with codeine in cough-cold remedies (see Attachment 1). For context, dextromethorphan-containing medicines had 39 reports over the same period. For pholcodine, there were 14 reports over this period. There did not appear to be any real difference in severity between the products. It is likely that dextromethorphan-containing medicines outsell those containing codeine, given the wider range of products using this as an ingredient, and the fact that dextromethorphan is a general sales medicine for those 13 years and over.

Other
Codeine is a long-established medicine. Like many older medicines (prescription and non-prescription), large scale randomised controlled studies have not been carried out for this medicine. Small studies may be underpowered to find a statistically significant effect, or may not be in populations in which it is mostly used, and older studies will typically have methodological deficiencies.

Codeine-containing analgesics
We recognise that this consideration is about the cough and cold area. However, we want to indicate our actions in the codeine-containing analgesic area. A minority of people are misusing codeine- containing analgesics, based both on the case reports and pharmacist feedback. However, pharmacists will be able to help prevent this from occurring, and manage people in whom it occurs with the right messages, language and targeting. In 2009, pack sizes were reduced, a warning about addiction was included on the label, and codeine containing analgesics were moved up to pharmacist-only. Unfortunately, no education specific to this for patients was available at the time of these changes. Written material for patients would be helpful. As well as ensuring pharmacists understand the typically accidental nature of this misuse, and therefore how to best prevent this occurring (including key statements), as well as identifying the early signs of misuse of codeine and how best to manage these instances (including key questions) will be very helpful. We will shortly convene a group with expert input to consider how we can best minimise the risk of this concern with prescription and non-prescription products.
In summary, the key issues for codeine-containing cough and cold remedies are existence of misuse, and harm from inclusion of codeine versus another cough suppressant ingredient in these remedies. The evidence we have found indicates that neither misuse nor harm is problematic in NZ. On this basis, we recommend that codeine remains a pharmacy-only medicine in cough and cold remedies.

Item 8.2.2 Ulipristal
We support the reclassification of ulipristal from prescription-only to pharmacist-only medicine. This is in line with levonorgestrel for which pharmacists have been trained and supplying as emergency contraception for 15 years. It is helpful to have a medicine than can be used for up to 5 days after unprotected sexual intercourse versus the 3 days for levonorgestrel, as people do attend pharmacies after the three-day period, often with very limited options for the pharmacist if it is the weekend when they present.
Ulipristal acetate can be taken within 120 hours (5 days).[1] The product information from Australia (attached) shows that pooled analysis indicated efficacy advantages over levonorgestrel.[1] There is no caution in this product information from Australia where Body Mass Index indicates obesity.[1] A recent pharmacokinetic study supports this situation.[2]
Currently pharmacists who have successfully completed specified training are able to supply levonorgestrel as an emergency contraceptive without a prescription.[3] This change was first gazetted in 2001, so there has been 16 years' experience with such supply.

Ulipristal acetate has been available in Europe for emergency contraception since 2009, initially as a prescription medicine, then since 2015 as a pharmacy-only medicine in at least 25 European countries. The European CHMP statement is attached. Ulipristal acetate was approved by the FDA for the US market in 2010 where it is a prescription medicine. Ulipristal acetate was approved in Canada in 2015 where it is a prescription medicine.
In New Zealand, the Pharmacy Council of New Zealand has a prescribed standard which requires that pharmacists can only supply the emergency contraceptive pill if they have successfully completed the appropriate training and are accredited. The Pharmacy Council of New Zealand, and the Pharmaceutical Society of New Zealand have a joint Best Practice Guideline for supply of the emergency contraceptive pill, effective July 2014. With the training and guideline, pharmacists in NZ are extremely well prepared for the provision of emergency contraceptives, including questioning and counselling required. These skills will be very transferable to ulipristal acetate supply. Pharmacists who have been accredited with the emergency contraceptive pill will be able to access information

on ulipristal acetate from the NZ data sheet (once registered), and we anticipate that pharmacy organisations will provide information and update their screening tools.
Levonorgestrel has the following classification as a restricted medicine:

> *in medicines for use as emergency post-coital contraception when in packs containing not more than 1.5 milligrams **except** when sold by nurses recognised by their professional body as having competency in the field of sexual and reproductive health*

The prescription medicine classification statement is as follows:

> *except when specified elsewhere in this Schedule; except in medicines for use as emergency post-coital contraception when sold by nurses recognised by their professional body as having competency in the field of sexual and reproductive health; except when supplied for oral contraception to women who meet the clinical and eligibility criteria of the Pharmacy Council and the Pharmaceutical Society of New Zealand approved training programme on oral contraception when sold in the Medsafe approved manufacturer's original pack containing not more than six months' supply by a registered pharmacist who has successfully completed the approved training programme*

Similar wording around emergency post-coital contraception could be used for ulipristal acetate.
Ulipristal acetate can interfere with hormonal contraception, affecting women presenting with a missed dose of their oral contraceptive.[1] Additionally, if a woman is breast feeding, expression and disposal of the breast milk is recommended for one week.[1] Thus, there are a couple of key differences between the existing emergency contraceptive pill in NZ and ulipristal acetate that all health professionals involved in emergency contraceptive prescribing or supply would need to become familiar with. Pharmacists will quickly learn the key differences in supply of ulipristal acetate versus levonorgestrel, through the datasheet. We will also provide information about key differences to pharmacists working in Unichem and Life pharmacies, and we have no doubt that there will be other dissemination through pharmacy organisations and the product distributor.

Given the reclassifications of ulipristal in Europe and Australia, the familiarity that accredited pharmacists and nurses have with emergency contraceptives, and the few differences between the products that will quickly become known, ulipristal acetate should be given a similar classification to levonorgestrel on the basis of Trans-Tasman Harmonisation.

Thank you once again for our opportunity to comment. Please do not hesitate to contact me should you require any further information or clarification

Yours sincerely,

ALISON VAN WYK
Executive – Professional Services
Green Cross Health

Attachment 1

The guidelines for the use of this SMARs information are as follows:

Suspected Medicine Adverse Reaction Search

Essential information about the Suspected Medicine Adverse Reaction Search (SMARS)

An assessment of the safety of a medicine cannot be made using only the information contained in SMARS. Medsafe advises patients not to make any changes to their medicine treatment based on information contained in SMARS. Changes to treatment should only be made following consultation with a healthcare professional.

When using SMARS you should remember that:

- The likelihood of experiencing an adverse reaction to a medicine cannot be estimated from this database as there is no information on how many people have taken the medicine and the extent of underreporting is not known.
- For these reasons, it is also not possible to directly compare the risks of different medicines using SMARS.
- Reports are sent to the Centre for Adverse Reactions Monitoring (CARM) if the reporter *suspects* that a medicine caused a reaction. This does not necessarily mean that the medicine did cause the reaction.
- CARM and Medsafe staff consider many factors when assessing whether a medicine has caused an adverse reaction.
- The number of reports for a medicine can be influenced by how many patients are taking the medicine, media attention, the nature of the reactions and other factors which vary over time.
- The quality of the information in SMARS is limited by the quality of the original report.
- The information contained in SMARS may change over time due to quality control procedures and/or receipt of further information.
- Reactions may also be caused by other ingredients in the medicine (excipients).

SMARS contains anonymised information from reports of suspected adverse reactions to medicines but does not include the following:

- Reports not causally related to the medicine (assessed by CARM).
- Any report where it is considered that the patient may be identifiable (e.g. due to the rareness of the reaction).
- Reports from the last three months.

Please note that some non-causally related suspected adverse reactions may be included in SMARS if the report also contained a causally related suspected adverse reaction.

About the release of this information

This information is released in keeping with the purpose of the Official Information Act 1982 to progressively increase the availability of official information to the people of New Zealand. The data contained in SMARS does not include any personal information within the meaning of the Privacy Act 1993.

Use of SMARS data

If you wish to copy or circulate information from SMARS please ensure that a copy of these guidelines is provided. Prior to any publication of this data you must contact CARM and Medsafe and include in the publication:

- the source of the information
- the limitations of the information
- that the information does not represent the opinion of CARM or Medsafe.

Further information

If you require further information please contact Medsafe by emailing medsafeadrquery@moh.govt.nz or by telephoning 04 819 6800.

Table 1 SMARs data 1 Jan 2000 to 31 Jan 2017

52249	Jul 2002	Female	58	Codral Cold & Flu oral (Suspect) Medroxyprogesterone oral (Concomitant) Prednisone oral (Concomitant)	Angioedema
59721	Mar 2004	Male	49	Codral Cold & Flu oral (Suspect)	Urinary retention
87307	Nov 2009	Male	56	Bendroflumethiazide oral (Concomitant) Codral Day & Night (new formula) oral (Suspect)	Face oedema Urticaria
90122	May 2010	Female	43	Codral Day & Night (new formula) oral (Suspect)	Confusional state Hallucination Nightmare Somnolence
97347	Sep 2011	Female	0	Codral Day & Night (new formula) oral (Suspect) Celecoxib oral (Concomitant) Vitamin B Complex oral (Concomitant)	Syncope
101064	Apr 2012	Female	51	Codral Cold & Flu oral (Suspect) Estriol oral (Concomitant) Metoprolol oral (Concomitant) Cilazapril; Hydrochlorothiazide oral (Concomitant)	Abdominal pain Hepatic enzyme increased
110552	Mar 2014	Female	45	Codral Day & Night (new formula) oral (Suspect) Maxigesic oral (Concomitant)	Angioedema Bronchospasm
116423	May 2015	Female	52	Codral Cold & Flu oral (Suspect) Lemsip oral (Suspect)	Angioedema Dizziness Urticaria

EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

21 November 2014
EMA/710568/2014
Press Office

Press release

EMA recommends availability of ellaOne emergency contraceptive without prescription

Change in status to facilitate access for women in the European Union

The European Medicines Agency's Committee for Medicinal Products for Human Use (CHMP) has recommended a change in classification status from prescription to non-prescription for the emergency contraceptive ellaOne (ulipristal acetate). This means that the medicine could be obtained without a prescription in the European Union (EU).

ellaOne is an emergency contraceptive used to prevent unintended pregnancy if taken within 120 hours (five days) of unprotected intercourse or if a contraceptive method has failed. It works by preventing or delaying ovulation. ellaOne works best if taken within 24 hours. Removing the need to obtain a prescription for this medicine should speed up women's access to the medicine and therefore increase its effectiveness.

Based on the assessment of available information, the CHMP found that ellaOne can be used safely and effectively without medical prescription. ellaOne has been authorised in the EU since 2009 and extensive information on its risks and benefits has been collected and studied. Its safety profile is comparable to levonorgestrel-containing emergency contraceptives, which are the most frequently used emergency contraceptives in the EU. Levonorgestrel-containing emergency contraceptives are already available without prescription in most EU countries and are registered for use up to 72 hours after unprotected intercourse or contraceptive failure.

This CHMP recommendation will now be sent to the European Commission for a legally binding decision.

Notes

1. This press release, together with related documents, is available on the Agency's website.
2. The marketing authorisation holder for ellaOne is Laboratoire HRA Pharma.
3. This is a type II procedure where the marketing authorisation holder is requesting a change of legal status for ellaOne, i.e. a change of classification for its supply from 'medicinal product subject to medical prescription' to 'medicinal product not subject to medical prescription' in the EU.

30 Churchill Place • Canary Wharf • London E14 5EU • United Kingdom
Telephone +44 (0)20 3660 8427 **Facsimile** +44 (0)20 3660 5555
E-mail press@ema.europa.eu **Website** www.ema.europa.eu

4. The full European Public Assessment Report (EPAR) for ellaOne can be found here.
5. Levonorgestrel-containing emergency contraceptives, for example Norlevo, Levonelle, Postinor, have a non-prescription status in 23 European countries. Exceptions are Malta, in which levonorgestrel-containing emergency contraceptives are not marketed, and the following countries in which levonorgestrel-containing emergency contraceptives are only available on prescription: Croatia, Germany, Greece, Hungary, Italy, Liechtenstein and Poland.
6. When assessing a switch from prescription-only to non-prescription status for a medicine, EMA's role is to assess whether it can be used in a safe and effective manner without prescription and make a recommendation to the European Commission on the re-classification of this medicine. If granted by the European Commission, such a re-classification to non-prescription status would in principle need to be implemented by all Member States. Any exception regarding the non-prescription status of this medicine falls within the responsibilities of the Member States.
7. More information on the work of the European Medicines Agency can be found on its website: www.ema.europa.eu

Contact our press officer

Monika Benstetter

Tel. +44 (0)20 3660 8427

E-mail: press@ema.europa.eu

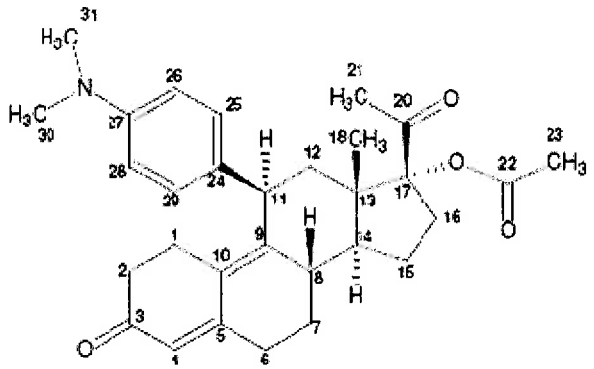
NAME OF THE MEDICINE

EllaOne® (30 mg ulipristal acetate Tablet)

Australian Approved Name (AAN): ulipristal acetate

Chemical name: 17α-acetoxy-11β -(4-N,N-dimethylaminophenyl)-19-norpregna-4,9-diene-3,20-dione

Chemical structure:



Molecular formula: $C_{30}H_{37}NO_4$ Molecular weight: 475.619

CAS number: 126784-99-4

DESCRIPTION

Tablet is a white to off-white, round tablet engraved on both faces with the code "ella".

Each tablet contains 30 mg of ulipristal acetate. Ulipristal acetate is a white to yellowish crystalline powder. It is freely soluble in dichloromethane, soluble in methanol, acetone and ethanol and insoluble in water.

The tablet also contains the following inactive ingredients: Lactose, Povidone, Croscarmellose sodium and Magnesium stearate.

PHARMACOLOGY

Pharmacodynamic properties

Pharmacotherapeutic group: Sex hormones and modulators of the genital system, emergency contraceptives. ATC Code: G03AD02.

Ulipristal acetate is an orally-active synthetic selective progesterone receptor modulator that acts via high-affinity (nanomolar) binding to the human progesterone receptor. Its major metabolite, monodesmethyl ulipristal, has comparable affinity for the progesterone receptor. When used for emergency contraception the mechanism of action is inhibition or delay of ovulation via suppression of the lutenising hormone (LH) surge. Pharmacodynamic data show that even when taken immediately before ovulation is scheduled to occur (when LH has already started to rise), ulipristal acetate is able to postpone follicular rupture for at least 5 days in 78.6% of cases ($p<0.005$ vs. levonorgestrel and vs. placebo) (see Table 1).

Table 1: Prevention of ovulation[1,§]

	Placebo n=50	**Levonorgestrel** n=48	**Ulipristal acetate** n=34
Dose	-	1.5 mg	30 mg
Treatment before LH surge	0.0%	25.0%	100% p<0.005*
Treatment after LH surge but before LH peak	10.0%	14.3% NS†	78.6% p<0.005*
Treatment after LH peak	4.2%	9.1% NS†	8.3% NS*

1: Brache et al, Contraception 2013
§: defined as presence of unruptured dominant follicle five days after late follicular-phase treatment
*: compared to levonorgestrel
NS: non statistically significant
†: compared to placebo

Ulipristal acetate also has high affinity for the glucocorticoid receptor and, antiglucocorticoid effects have been observed *in vivo* in animals. However, in humans, no such effect has been observed even after repeat administration at a daily dose of 10 mg. Ulipristal acetate has weak affinity for the androgen receptor and negligible affinity for the human oestrogen and mineralocorticoid receptors.

Pharmacokinetic properties

Absorption

Following oral administration of a single 30 mg dose, ulipristal acetate is rapidly absorbed, with a peak plasma concentration of 176 ± 89 ng/mL occurring approximately 1 hour (0.5-2.0 h) after ingestion, and with an $AUC_{0-\infty}$ of 556 ± 260 ng.h/mL.

The mean absolute bioavailability of ulipristal acetate is 27% [22.0 to 33.0%].

Administration of ulipristal acetate together with a high-fat breakfast resulted in approximately 45% lower mean C_{max}, a delayed T_{max} (from a median of 0.75 hours to 3 hours) and 25% higher mean $AUC_{0-\infty}$ compared with administration in the fasted state. Similar results were obtained for the active mono-demethylated metabolite.

Distribution

Ulipristal acetate is highly bound (>98%) to plasma proteins, including albumin, alpha-l-acid glycoprotein, high density lipoprotein and low density lipoprotein.

Ulipristal acetate is a lipophilic compound and is distributed in breast milk, with a mean daily excretion of 13.35 µg [0-24 hours], 2.16 µg [24-48 hours], 1.06 µg [48-72 hours], 0.58 µg [72-96 hours], and 0.31 µg [96-120 hours]. The average distribution volume is 3470 L.

Metabolism

Ulipristal acetate is extensively metabolised to mono-demethylated, di-demethylated and hydroxylated metabolites. The mono-demethylated metabolite is pharmacologically active. In vitro data indicate that this is predominantly mediated by CYP3A4.

Excretion

The main route of elimination is through faeces and less than 10% is excreted in the urine. The terminal half-life of ulipristal acetate in plasma following a single dose of 30 mg is to be about 32.4 ± 6,3 hours, with a mean oral clearance (CL/F) of about 76.8 ± 64.0 L/h.

Special populations

No pharmacokinetic studies with ulipristal acetate have been performed in females with impaired renal or hepatic function.

CLINICAL TRIALS

Two multicenter phase III clinical studies evaluated the efficacy and safety of EllaOne® up to 120 hours after unprotected intercourse. A single-blind comparative study (HRA2914-513 study) provided the primary data to support the efficacy and safety of ulipristal acetate for emergency contraception when taken 0 to 72 hours after unprotected intercourse and provided supportive data for ulipristal acetate for emergency contraception when taken > 72 to 120 hours after unprotected intercourse. An open-label study (HRA2914-509 study) provided the primary data to support the efficacy and safety of ulipristal acetate for emergency contraception when taken 48 to 120 hours after unprotected intercourse. Additionally, one phase II study contributed to establishing efficacy of EllaOne® compared to levonorgestrel within 72 hours of unprotected intercourse. The three studies are described below.

i) Single-Blind Comparative Study

This study was a multi-centre, single-blind, randomized comparison of the efficacy and safety of 30 mg ulipristal acetate (EllaOne®) to levonorgestrel (another drug used for emergency contraception). Main inclusion criteria were women presenting for emergency contraception within 120 hours of unprotected intercourse, 16 years or more in UK (except Northern Ireland), 17 years or more in Northern Ireland (UK) and 18 years or more in Ireland and US, with regular cycle length (24 to 35 days).

In total, 2,221 healthy women with a mean age of 25 years who requested emergency contraception within 120 hours of unprotected intercourse were enrolled and randomly allocated to receive EllaOne® (n=1,104) or levonorgestrel 1.5 mg (n=1,117).

The primary efficacy measurement was the pregnancy rate, calculated as the number of pregnancies after administration of emergency contraception, divided by the number of subjects administered emergency contraception.

In the EllaOne® a group, 16 pregnancies occurred in 844 women aged 16 to 35 years when emergency contraception was taken 0 to 72 hours after unprotected intercourse. The number of pregnancies expected without emergency contraception was calculated based on the timing of intercourse with regard to each woman's menstrual cycle; EllaOne®

significantly reduced the pregnancy rate, from an expected 5.6% to an observed 1.9%, when taken within 72 hours after unprotected intercourse (p=0.001). There were no pregnancies observed in the women who were administered EllaOne® more than 72 hours after unprotected intercourse (10% of women who received EllaOne®).

ii) Open-Label Study

This study was a multi-centre open-label trial designed to support the efficacy and safety of ulipristal acetate for emergency contraception when taken 48 to 120 hours after unprotected intercourse. Main inclusion criteria were women, 18 or greater years of age, with regular cycle length (24 to 35 days) presenting for emergency contraception between 48 hours and 120 hours of unprotected intercourse. In total, 1,533 healthy women with a mean age of 24 years received a dose of 30 mg ulipristal acetate (EllaOne®).

The primary efficacy measurement was the pregnancy rate, calculated as the number of pregnancies after administration of emergency contraception, divided by the number of subjects administered emergency contraception. Twenty-seven pregnancies occurred in 1,242 women aged 18 to 35 years evaluated for efficacy for a pregnancy rate of 2.1%. The number of pregnancies expected without emergency contraception was calculated based on the timing of intercourse with regard to each woman's menstrual cycle. EllaOne® significantly reduced the pregnancy rate, from an expected rate of 5.5% to an observed rate of 2.2%, when taken 48 to 120 hours after unprotected intercourse (p<0.001).

iii) Phase II Comparative Study

Study HRA2914-507 was a randomized double-blind study conducted in healthy cycling women at least 18 years old and who requested emergency contraception at one of the participating clinical sites in the US within 72 hours (3 days) of unprotected intercourse. It was designed as a non-inferiority trial to test the following hypothesis that 50 mg unmicronized ulipristal acetate had a pregnancy rate no worse than that of levonorgestrel with a non-inferiority margin of 2%. The efficacy evaluable (EE) population included 1,546 women (773 the ulipristal acetate group and 773 in the levonorgestrel group).

The pregnancy rate and prevented fraction for the EE population administered ulipristal acetate were, respectively, 0.91% (0.365-1.857) and 85% (68-93).

Pooled Analysis

Results from the two independent randomized controlled trials (studies HRA2914-507 and HRA2914-513 - see Table 2) showed the efficacy of ulipristal acetate to be non-inferior to that of levonorgestrel in women who presented for emergency contraception between 0 and 72 hours after unprotected intercourse or contraceptive failure. When the data from the two trials were combined via pooled analysis, the risk of pregnancy with ulipristal acetate was significantly reduced compared to levonorgestrel, regardless of whether treatment occurred within 24 (p=0.035), 72 (p=0.046) or 120 hours (p=0.025) of intercourse (Glasier et al, Lancet 2010).

Table 2: Results of Randomised Controlled Clinical Trials

Randomised controlled trial	**Pregnancy rate (%) within 72h of unprotected intercourse or contraceptive failure[2]**		**Odds ratio [95% CI] of pregnancy risk, ulipristal acetate vs levonorgestrel[2]**
	Ulipristal acetate	Levonorgestrel	
HRA2914-507	0.91 (7/773)	1.68 (13/773)	0.50 [0.18-1.24]
HRA2914-513	1.78 (15/844)	2.59 (22/852)	0.68 [0.35-1.31]
Pooled analysis	1.36 (22/1617)	2.15 (35/1625)	0.58 [0.33-0.99]

2: Glasier et al, Lancet 2010

Data from the two phase III studies were pooled to provide a total efficacy population of women treated with ulipristal acetate up to 120 hours after unprotected intercourse (Table 3). Time trend analysis for the five 24-hour intervals from 0 to 120 hours between unprotected intercourse and treatment was conducted. There were no significant differences in the observed pregnancy rates across five time intervals.

Table 3: Summary of Clinical Trial Results for Women Who Received a Single Dose of EllaOne® (30 mg Ulipristal Acetate)		
	Open-Label Study 48 to 120 Hours *	**Single-Blind Comparative Study 0 to 72 Hours ***
	N = 1,242	N = 844
Expected Pregnancy Rate **	5.5	5.6
Observed Pregnancy Rate ** (95% confidence interval)	2.2 (1.5, 3.2)	1.9 (1.1, 3.1)

* Time after unprotected intercourse when EllaOne® was taken

** Number of pregnancies per 100 women at risk for pregnancy

A post-marketing observational study evaluating efficacy and safety of EllaOne® in 279 adolescents aged 17 and younger showed no difference in the safety and efficacy profile compared to adult women aged 18 and older.

INDICATION

Emergency contraception within 120 hours (5 days) of unprotected sexual intercourse or contraceptive failure.

CONTRAINDICATIONS

Hypersensitivity to the active substance or to any of the listed excipients.

EllaOne® should not be given to pregnant women. If menstrual bleeding is overdue, if the last menstrual period was abnormal in timing or character or if pregnancy is suspected for any other reason, pregnancy should be excluded (by pregnancy testing or pelvic examination) before treatment is given.

If a woman has had unprotected intercourse more than 120 hours earlier in the same menstrual cycle, conception may have already occurred. Treatment with EllaOne® following the second act of intercourse may therefore be ineffective in preventing pregnancy.

PRECAUTIONS

EllaOne® does not prevent pregnancy every time

EllaOne® inhibits or postpones ovulation. If ovulation has already occurred, EllaOne® is no longer effective. The timing of ovulation cannot be predicted and therefore EllaOne® should be taken as soon as possible after unprotected intercourse.

No data are available on the efficacy of EllaOne® when taken more than 120 hours (5 days) after unprotected intercourse.

Women who become pregnant after taking EllaOne® should contact their doctor. If the next menstrual period is more than 7 days late, if the menstrual period is abnormal in character or if there are symptoms suggestive of pregnancy or in case of doubt, a pregnancy test should be performed. As with any pregnancy, the possibility of an ectopic pregnancy should be considered. It is important to know that the occurrence of uterine bleeding does not rule out ectopic pregnancy.

After EllaOne® intake menstrual periods can sometimes occur a few days earlier or later than expected. In approximately 7% of the women, menstrual periods occurred more than 7 days earlier than expected. In 18.5% of the women a delay of more than 7 days occurred, and in 4% the delay was greater than 20 days.

Exclude pregnancy if suspected clinically before EllaOne® is administered.

Concomitant use of ulipristal acetate with an emergency contraceptive containing levonorgestrel is not recommended.

Repeated use of EllaOne® in the same menstrual cycle is not recommended. Women who present for repeated courses of emergency contraception should be advised to consider a long-term method of contraception, as emergency contraception is not as effective as conventional regular methods of contraception.

Use in women with severe asthma treated with oral glucocorticoids is not recommended.

Contraception after EllaOne® intake

EllaOne® is an emergency contraceptive that decreases pregnancy risk after unprotected intercourse but does not confer contraceptive protection for subsequent acts of intercourse. Therefore, after using emergency contraception, women should be advised to use a reliable barrier method until the next menstrual period.

EllaOne® is for occasional use only. It should in no instance replace a regular contraceptive method. In any case, women should be advised to adopt a regular method of contraception.

Because EllaOne® binds to the same progesterone receptor as regular hormonal contraception, using them together could reduce contraceptive action. After using EllaOne®, if a woman wishes to initiate or resume regular hormonal contraception, she should do so no sooner than 5 days after the intake of EllaOne®, provided that she uses a reliable barrier method until the next menstrual period.

Specific populations

This medicine contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption, should not take this medicine.

Effects on fertility

A rapid return of fertility is likely following treatment with EllaOne® for emergency contraception. Women should be advised to use a reliable barrier method for all subsequent acts of intercourse until the next menstrual period.

Use in pregnancy

Pregnancy Category D

EllaOne® should not be taken by any woman suspected or known to be pregnant.

Ulipristal acetate caused embryofetal lethality following repeated administration in the period following implantation in rats, rabbits and monkeys at subclinical doses (based on body surface area), occurring in the absence of maternotoxicity. *In utero* exposure to ulipristal acetate during gestation did not lead to increases in fetal malformations, skeletal anomalies or other developmental toxicity in surviving fetuses, including the fertility of surviving offspring. The clinical relevance of these findings is uncertain.

Available human data regarding pregnancy exposure to EllaOne® do not suggest any safety concern with use during early pregnancy.

Use in lactation

Ulipristal acetate is excreted in breast milk. The effect on newborn/infants has not been studied. A risk to the breastfed child cannot be excluded. After intake of EllaOne®, breastfeeding is not recommended for one week. During this time it is recommended to express and discard the breast milk in order to stimulate lactation.

Paediatric use

Post-pubertal adolescents: No differences in safety or efficacy have been shown compared to adult women aged 18 and older.

Genotoxicity

In vitro tests for mutagenicity in bacterial and mammalian cells and for chromosomal damage *in vitro* and *in vivo* (mouse micronucleus test) revealed no genotoxic activity for ulipristal acetate.

Carcinogenicity

Oral carcinogenicity studies were performed with ulipristal acetate in rats (2 years duration) and transgenic mice (6 months). No carcinogenic effect was observed with treatment at up to 10 mg/kg/day in rats (yielding 26-times the plasma AUC in patients after a 30 mg dose) or up to 130 mg/kg/day in mice (122-times the clinical AUC).

Effect on laboratory tests

No laboratory test interactions were observed during clinical evaluations.

INTERACTIONS WITH OTHER MEDICINES

- *Potential for other medicines to affect ulipristal acetate:*

Hormonal contraceptives

Pharmacodynamic data show that progestin-containing contraceptives may impair the ability of EllaOne® to delay ovulation. The initiation of a desogestrel-only pill the day after EllaOne® intake during the follicular phase was associated with a higher incidence of ovulation in the five days following EllaOne® intake. Therefore, if a woman wishes to initiate or resume regular hormonal contraception, she should do so no sooner than 5 days after the intake of EllaOne®, provided that she uses a reliable barrier method until the next menstrual period.

Concomitant use of ulipristal acetate emergency contraception and levonorgestrel emergency contraception is not recommended.

CYP3A4 inducers and inhibitors

Ulipristal acetate is metabolised by CYP3A4 *in vitro*

- *CYP3A4 inducers*

In vivo results show that the administration of ulipristal acetate with a strong CYP3A4 inducer such as rifampicin markedly decreases C_{max} and AUC of ulipristal acetate by 90% or more and decreases ulipristal acetate half-life by 2.2-fold corresponding to an approximately 10-fold decrease of ulipristal acetate exposure. Concomitant use of EllaOne® with CYP3A4 inducers (e.g. rifampicin, phenytoin, phenobarbital, carbamazepine, efavirenz, fosphenytoine, nevirapine, oxcarbazepine, primidone, rifabutine, St John's wort/Hypericum perforatum) therefore reduces plasma concentrations of ulipristal acetate and may result in a decreased efficacy of EllaOne® and is not recommended.

- *CYP3A4 inhibitors*

In vivo results show that administration of ulipristal acetate with a potent and a moderate CYP3A4 inhibitor increased C_{max} and AUC of ulipristal acetate with a maximum of 2- and 5.9-fold, respectively. The effects of CYP3A4 inhibitors are unlikely to have any clinical consequences.

The CYP3A4 inhibitor ritonavir can also have an inducing effect on CYP3A4 when ritonavir is used for a longer period. In such cases ritonavir might reduce plasma concentrations of ulipristal acetate. Concomitant use is therefore not recommended. Enzyme induction wears off slowly and effects on the plasma concentrations of ulipristal acetate may occur even if a woman has stopped taking an enzyme inducer within the last 2-3 weeks.

Medicines affecting gastric pH

Administration of ulipristal acetate (10 mg tablet) together with the proton pump inhibitor esomeprazole (20 mg daily for 6 days) resulted in approximately 65% lower mean C_{max}, a delayed T_{max} (from a median of 0.75 hours to 1.0 hours) and 13% higher mean AUC. This interaction is not expected to have an impact on the efficacy of ulipristal acetate single dose for emergency contraception.

- *Potential for ulipristal acetate to affect other medicines:*

Hormonal contraceptives

Pharmacodynamic data suggest that EllaOne® may impact the effect of progestin-containing hormonal contraceptives: The initiation of a desogestrel only pill the day after EllaOne® intake during the follicular phase was associated with a higher incidence of ovulation in the five days following EllaOne® intake and a slower onset of mucus blockage compared to desogestrel without prior EllaOne® intake, suggesting an effect of prior use of EllaOne® on the ability of desogestrel to inhibit mucus permeability. When a combined oral contraceptive pill (COCP) was started the day after EllaOne® intake during the follicular phase, EllaOne® did not interfere with COCP's ability to induce ovarian quiescence, but ovulation occurred later in the cycle in some women. Therefore, if a woman wishes to initiate or resume regular hormonal contraception after using EllaOne®, it is recommended that for subsequent acts of intercourse she uses a reliable barrier method until the next menstrual period.

In vitro data indicate that ulipristal acetate and its active metabolite do not significantly inhibit CYP1A2, 2A6, 2C9, 2C19, 2D6, 2E1, and 3A4, at clinically relevant concentrations. After single dose administration induction of CYP1A2 and CYP3A4 by ulipristal acetate or its active metabolite is not likely. Thus, administration of ulipristal acetate is unlikely to alter the clearance of medicines that are metabolised by these enzymes.

P-gp substrates

In vitro data indicate that ulipristal acetate may be an inhibitor of P-gp at clinically relevant concentrations. Results *in vivo* with the P-gp substrate fexofenadine were inconclusive. The effects of P-gp substrates are unlikely to have any clinical consequences.

BCRP substrates

BCRP (Breast Cancer Resistance Protein) transporters

In vitro data indicate that ulipristal acetate may be an inhibitor of BCRP at the intestinal level at clinically relevant concentrations. However, the effects of ulipristal acetate on BCRP are unlikely to have any clinical consequences given the pattern of clinical use of this product and the rapid absorption of ulipristal acetate from the GI tract.

ADVERSE EFFECTS

Summary of the safety profile:

The safety of ulipristal acetate has been evaluated in 4,718 women during the clinical development program.

The most commonly reported adverse reactions were headache, nausea, abdominal pain and dysmenorrhea.

Tabulated list of adverse reactions

The adverse reactions reported in the phase III program of 2,637 women are provided in the table below.

Adverse reactions listed below are classified according to frequency and system organ class. Within each frequency grouping, adverse reactions are presented in order of decreasing frequency.

The table lists adverse reactions according to system organ class and frequency: very common (≥1/10), common (≥ 1/100 to <1/10), uncommon (≥ 1/1,000 to <1/100) and rare (≥1/10,000 to <1/1,000).

MedDRA	**Adverse reactions (frequency)**			
System Organ Class	**Very Common**	**Common**	**Uncommon**	**Rare**
Infections and infestations			Influenza	
Metabolism and nutrition disorders			Appetite disorders	
Psychiatric disorders		Mood disorders	Emotional disorder Anxiety Insomnia Hyperactivity disorder Libido changes	Disorientation
Nervous system disorders		Headache Dizziness	Somnolence Migraine	Tremor Disturbance in attention Dysgueusia Syncope
Eye disorders			Visual disturbance	Abnormal sensation in eye Ocular hyperaemia Photophobia
Ear and labyrinth disorders				Vertigo
Respiratory, thoracic and mediastinal disorders				Dry throat
Gastrointestinal disorders		Nausea* Abdominal pain* Abdominal discomfort Vomiting*	Diarrhoea Dry mouth Dyspepsia Flatulence	
Skin and subcutaneous tissue disorders			Acne Skin lesion Pruritus	Urticaria
Musculoskeletal and connective tissue disorders		Myalgia Back pain		
Reproductive system and breast disorders		Dysmenorrhea Pelvic pain Breast tenderness	Menorrhagia Vaginal discharge Menstrual disorder Metrorrhagia Vaginitis Hot flush Premenstrual syndrome	Genital pruritus Dyspareunia Ruptured ovarian cyst Vulvovaginal pain Hypomenorrhea*
General disorders and administration site conditions		Fatigue	Chills Malaise Pyrexia	Thirst

*Symptom which could be related to a pregnancy (and thus to a possible ectopic pregnancy) and could delay the diagnosis of pregnancy if misdiagnosed as related to drug intake

Adolescents: the safety profile observed in women less than 18 years old in studies and post-marketing is similar to the safety profile in adults during the Phase III program.

Post-marketing experience: the adverse reactions spontaneously reported in post-marketing were similar in nature to the safety profile described during the Phase III program.

Description of selected adverse reactions:

The majority of women (74.6%) in the Phase III studies had their next menstrual period at the expected time or within ± 7 days, while 6.8% experienced menses more than 7 days earlier than expected and 18.5% had a delay of more than 7 days beyond the anticipated onset of menses. The delay was greater than 20 days in 4 % of the women.

A minority (8.7%) of women reported inter-menstrual bleeding lasting an average of 2.4 days. In a majority of cases (88.2%), this bleeding was reported as spotting. Among the women who received EllaOne® in the Phase III studies, only 0.4% reported heavy inter-menstrual bleeding.

In the Phase III studies, 82 women entered a study more than once and therefore received more than one dose of EllaOne® (73 women enrolled twice and 9 enrolled three times). There were no safety differences in these subjects in terms of incidence and severity of adverse events, change in duration or volume of menses or incidence of inter-menstrual bleeding.

In a pharmacodynamic study, where 23 subjects had multiple intakes in the same cycle, EllaOne® was well tolerated with a safety and bleeding profile similar to that observed for a single 30 mg dose.

DOSAGE AND ADMINISTRATION

The treatment consists of one tablet to be taken orally as soon as possible, but no later than 120 hours (5 days) after unprotected intercourse or contraceptive failure.

The tablet can be taken with or without food.

EllaOne® can be taken at any time during the menstrual cycle. If vomiting occurs within 3 hours of EllaOne® intake, another tablet should be taken.

If a woman's menstrual period is late or in case of symptoms of pregnancy, pregnancy should be excluded before EllaOne® is administered.

EllaOne® is more effective if taken in the first 24 hours following unprotected intercourse.

Special populations

Renal impairment: No dose adjustment is necessary.

Hepatic impairment: No alternate dose recommendations for EllaOne® can be made.

*Paediatric population (*Adolescents): No differences in safety or efficacy have been shown compared to adult women aged 18 and older.

OVERDOSAGE

Experience with ulipristal acetate overdose is limited. Single doses up to 200 mg have been used in women without safety concern. Such high doses were well-tolerated. There are no antidotes and further treatment should be symptomatic.

For information on the management of overdose, contact the Poisons Information Centre on 13 11 26 (Australia).

PRESENTATION AND STORAGE CONDITIONS

PVC-PE-PVDC-Aluminium blister of 1 tablet.

The carton contains one blister of one tablet.

Store below 25°C. Store in the original packaging to protect from moisture. Keep the blister in the outer carton to protect from light.

NAME AND ADDRESS OF THE SPONSOR

MS Health Pty Ltd.,
Suite 60, 278 Church Street,
Richmond, VIC, 3121, Australia

EllaOne® is a product of Laboratoire HRA Pharma, 15 rue Béranger, Paris, 75003 France

POISON SCHEDULE OF THE MEDICINE

Schedule 4

DATE OF FIRST INCLUSION IN THE AUSTRALIAN REGISTER OF THERAPEUTIC GOODS (THE ARTG)

06 March 2015

DATE OF MOST RECENT AMENDMENT

24 March 2017

The prescriber must ensure that consent and treatment of the patient is in accordance with the appropriate state or territory legislation.

Role for Pharmacists in Screening, Assessing and Managing ACC Clients with Acute and Chronic Pain.

Briefing paper prepared on behalf of the
Pharmaceutical Society of New Zealand and Pharmacy Guild of New Zealand

ACC is redesigning the way pain management services are provided to ensure their clients have easy access to more timely professional input that will result in improved client understanding, improved collaboration and better health outcomes.

Background

The pharmacy profession in New Zealand is made up of approximately 3500 registered practising pharmacists. 2700 practising in community pharmacy and 470 in hospital practice with the remainder working in primary-care, industry, teaching/research and other pharmacy-related areas.

There are 956 community pharmacies in New Zealand with an average of more than two pharmacists per pharmacy. In some suburbs and small towns there will only be one pharmacist per pharmacy. Pharmacists are the health professional seen most often and are the place clients are most likely to ask for advice on common ailments. Pharmacists will see patients without the need to for an appointment. Every day community pharmacists around New Zealand triage, treat and refer patients and the help patients to navigate the health system.

Pharmacy Services

Pharmacists dispense medicines pursuant to a prescription and provide patients with advice on how to take the medicine, what to expect from it, potential side effects, and other advice to help ensure they get the best use of their medicines. Some medicines that were previously prescription medicines are now available after a consultation with a trained pharmacist for instance antibiotic eye drops, first line antibiotic treatment for urinary tract infections and emergency contraception.

In addition to the dispensing activity, pharmacists in the community also provide advice on medicines, self-management of health conditions, and over the counter medicines. Pharmacists assess and advise on health concerns and refer patients to their doctor when medical diagnosis or prescribed treatment is required.

Pharmacists provide immunisations and public health advice, as well as screening and testing services such as blood pressure monitoring, glucose and cholesterol testing. A number of pharmacies have DHB contracts for delivering a warfarin management service in collaboration with local GPs.

The Problem: Pain Management Issues Identified by Pharmacists

A number of analgesic products are available over the counter from a pharmacy, those for strong pain being classified as Pharmacist-Only Medicines and may only be sold by a pharmacist. As with other common ailments, patients often come into a pharmacy as the first point of call seeking advice and management of pain complaints. Pharmacists are careful to ensure that supply of any medicine over the counter is appropriate to the individual and when required refer patients to their GP for further management.

After an injury event causing pain, patients are often prescribed analgesics/anti-inflammatories or seek these medications over the counter in a pharmacy or off the shelf (if a general sale medicine). Depending on the severity or nature of the pain, patients may choose to self-manage their analgesia after completing their initial prescription. This is particularly common if the medicines they had

prescribed are available over the counter. Even if the patient could be prescribed greater quantities of funded analgesics, they will often purchase these medicines over the counter to avoid the inconvenience and cost of making an appointment to see their GP.

Analgesics classified as prescription medicines require a prescription for supply, however where there are barriers for patients to obtain a prescription or meet the required payments for a prescription, they may attempt to self-manage as best they can with over-the-counter analgesics. Often before seeing a medical practitioner, or even after a medical assessment and initial prescription, patients WILL seek to purchase analgesics over the counter if their pain is not being managed adequately, or if there are barriers to seeing their prescriber for ongoing management.

Patients being discharged from secondary care are frequently prescribed a number of analgesics from different pharmacological classes without advice on how to use these, such as: how long they may be required for, which should be taken regularly for 'background' pain relief (eg. paracetamol), compared to those which should be reserved for taking during periods of experiencing strong pain (eg. stronger opioids: codeine, tramadol, morphine), how the frequency of dosing of each can differ, safe use of anti-inflammatories, what side effects could be experienced and how to manage these, and when to seek professional input to help them adjust their medicines either up or down depending on their pain levels. Alternatively they may have been given advice and not taken it in if they are just being discharged from hospital.

When prescriptions are written for the maximum period of supply (three months for prescription medicines, one month for controlled drugs), this can leave some patients with amounts of medicines excessive to their needs – especially if these are dispensed all at once or 'stat'. This can lead to safety concerns when a patient is confused about the purpose of each medicine, is unsure about dosing frequency or if they have a sudden increase in pain.

When patients self-select or self-manage their pain management with over the counter medicines, there is a significant risk that their pain is not being managed optimally. A targeted consultation with the pharmacist could identify if pain is being managed, whether treatment can be optimised – either through targeted advice on how to use prescribed treatment in a more effective manner, OR how over the counter analgesics could be used safely and effectively, OR referring the patient to a medical practitioner for a more detailed assessment with suggestions for treatment optimisation to personalise the regimen.

<u>The Solution: ACC Pharmacy Pain-Support Services</u>

Pharmacists are able to offer a range of medicines-related services that can assess and manage patients' pain management from a simple level of ensuring that prescribed treatment is being used safely and optimally while assisting understanding and adherence, to synchronising and managing frequency of dispensing to suit individual patients and help monitor treatment, to providing a comprehensive clinical review of treatment with a purpose to optimise treatment and make treatment recommendations to the prescriber.

Along with these kinds of services to ensure the patient is getting maximum benefit from their medications, pharmacists can also screen an identified group of ACC clients to see how pain management with medications is going, if they require one of the medication management services above, what options are available to improve functioning etc.

Drawing on already established services described in the National Framework for Pharmacist Services, there is a potential for an ACC Pharmacy Pain Service(s) to be made available to eligible ACC clients under defined criteria.

A **Medicines Use Review (MUR)** service delivered to ACC clients would comprehensively evaluate and support understanding and adherence so as to receive optimal pain relief from the prescribed treatment. The pharmacist identifies and addresses factors linked to non-adherence behaviours as well as minimising pharmaceutical waste.

A **Medicines Therapy Assessment (MTA)** service delivered to ACC clients would provide a systematic, patient-centred clinical assessment of all medicines currently taken by a patient, identifying, resolving and preventing medication-related problems as well as optimising the effectiveness of medication treatment. A report is provided to the prescriber describing a pharmaceutical care plan along with any recommendations for optimising treatment. This is particularly appropriate for people on multiple medicines or with multiple health conditions.

Underlying expectations

- Patient involved in decision making process
- Pharmacist to work with others involved in the care of the patient to ensure there is repetition of the same messages e.g. expectations for full recovery (or not)
- Both review processes would also incorporate mechanisms to identify when the client should be referred to their prescriber, ACC case manager or other members of the multidisciplinary team, as appropriate.

Please refer to the attached National Pharmacist Services Framework for full service descriptions of MUR and MTA, as well as other services currently available. Some DHBs currently fund MUR services for specific patient groups, while funded MTA services are being piloted in some areas. The opportunity exists to use these same services or tailor a modified service description for an ACC funded equivalent to meet the specific needs of ACC clients.

We acknowledge that the following would require defining:

- Eligibility criteria for clients
- Expected activities for specific client types/needs
- Expected outputs of the service e.g. reporting, documentation, performance indicators, referral process
- Criteria for progressing clients through differing “levels” of service according to need

As an example, a ‘patient journey’ could be:

<u>Initial MUR consultation</u>:

- Patient’s condition, what has happened, pain score (WHODAS), how long they have been in pain, is it becoming worse, staying the same or has the patient never felt their pain level was under control?
- Check other medicines they are taking
    - over the counter/alternative treatments they are using for pain
    - prescribed and OTC medicines for anything else
    - any interactions or any side effects they are dealing with and how to cope with them
    - check whether side effects have prevented them being adherent
    - are they swallowing the medicine whole, crushing it? (can contribute to side effects and lower efficacy)
- Develop medicine management plan
- Adherence advice regarding regular medicines for pain relief, and action plans for what they are using sporadically.
- Consider blister packing if appropriate

- How to space the medicines for maximum pain relief and least side effects (some with meals, some every 8 hours others every 4 hours, whether to take the two or three different pain medicines at the same time or to stagger them)
- Goal setting
    - return to/continue to work
    - pain free through the day so they can continue with regular activities
    - pain free through the night so they sleep and can cope during the day
- Lifestyle advice e.g. keep moving, triggers, flare-ups and how to combat these
- Family / social support
- Consider referrals e.g. OT or social workers

<u>Follow up:</u>

- Jointly decide on when to follow up - One or two weeks or one month?
- Repeat pain score (WHODAS), perception of the pain – is it still chronic / unremitting, going up or down, or intermittent.
- How is condition progressing: improving, staying the same, getting worse
- Ask them about adherence: has this improved, stayed the same, become worse? If there has been improvement, has this reduced the pain? Are they able to reduce use of PRN medicines?
- Potential to refer at this stage e.g. psychological help with withdrawing if there appears to be medicines addiction, back to GP for lower strengths, different medicines.
- Pharmacist to write a report to the regular prescriber/s and ACC case manager

We also know from the United Kingdom that:
The NHS chronic pain service had the following reported outcomes from pharmacist involvement in helping manage chronic pain:

- ***Safe***: reduced risk of harm from medicines
- ***Effective***: patients are better able to manage their pain, using their pain medication more appropriately
- ***Patient centred***: patient empowerment/ self- management; care delivered close to patient
- Multi-disciplinary partnership of care for patients with chronic pain
- Utilises pharmacist's clinical skills

We would welcome an opportunity to discuss this brief and how we see the pharmacy profession being able to contribute to the safe and optimal use of medication treatment by ACC clients.

Bob Buckham
Chief Pharmacist Advisor
Pharmaceutical Society of New Zealand

Linda Caddick
Professional Services and Support Manager
Pharmacy Guild of New Zealand

PHARMACEUTICAL SOCIETY
of New Zealand Incorporated

PHARMACY GUILD
OF NEW ZEALAND

PHARMACEUTICAL SOCIETY
of New Zealand Incorporated

10 April 2017

The Secretary
Medicines Classification Committee
via email: committees@moh.govt.nz

Dear Laurence,

Re: Agenda for the 58th Meeting of the Medicines Classification Committee

Thank you for the opportunity to submit comments to the 58th MCC Meeting agenda.

The Pharmaceutical Society of New Zealand Inc. (the Society) is the professional association representing over 3,000 pharmacists, from all sectors of pharmacy practice. We provide to pharmacists professional support and representation, training for continuing professional development, and assistance to enable them to deliver to all New Zealanders the best pharmaceutical practice and professional services in relation to medicines. The Society focuses on the important role pharmacists have in medicines management and in the safe and quality use of medicines.

Regarding the agenda for the 58th Meeting of the Medicines Classification Committee, the Pharmaceutical Society of New Zealand would like to make the following comments:

5.6 Amendments to classification wording

5.6.1 Articaine, lignocaine and prilocaine with or without felypressin – proposed amendment of the classification wording (Dental Council)

The Society supports the proposed amendment from the Dental Council, noting that the current classification wording already accommodates dental therapists. The additional inclusion for the oral health therapist scope of practice is reasonable. We would note our support for the classification wording of topical anaesthetic agents such as those containing benzocaine, could also be considered for rewording, in order to permit use by dental therapists and/or oral health therapists. We understand topical anaesthetic agents can be more favourable in paediatric dental procedures.

5.6.2 Diphtheria, tetanus and pertussis (acellular, component) vaccine – proposed amendment to the prescription medicine except classification (Green Cross Healthcare Ltd and Natalie Gauld Ltd)

The Society supports the proposed amendment to the classification of the diphtheria, tetanus and pertussis vaccine, for the reasons described in the agenda item submission. We believe widening access to the Tdap vaccine through pharmacists would support availability to pregnant teenagers, particularly in areas where DHBs may also provide funded access through pharmacists. Lowering the age of availability from a pharmacist could remove a regulatory barrier to a health need in the community.

5.6.3 Sildenafil – proposed amendment to the prescription medicine except classification (Individual submission)

The Society believes the use of sildenafil in men from the age of 18 would have no additional risk than in men over the age of 35 years. We would wish to confirm that the aetiology of erectile dysfunction in this younger age group was no different to men aged 35 years and older who are more likely to have "age-related" factors. While the risks may even be lower in younger men who would have generally lower cardiovascular risk, we would advise

Level 10, Grand Arcade Tower, 16-20 Willis Street, PO Box 11640, Manners Street, Wellington, 6142, New Zealand
TEL 04 802 0030 **FAX** 04 382 9297 **EMAIL** p.society@psnz.org.nz **WEB** www.psnz.org.nz

pharmacists to refer these men for a medical assessment at the first instance. Following this, ongoing supply could certainly be managed safely and appropriately by a pharmacist.

The Society acknowledges the benefits provided in providing original pack dispensing of sildenafil, in communicating warning information and advice. However, this wording in classification statements has created the perception in some that only original, intact packs of tablets may be supplied – ie. either the 4 tablet pack or 12 tablet pack that is available. The Society has taken the view that so long as tablets are supplied in the original packaging, any quantity of sildenafil tablets up to the maximum permitted 12, may be supplied within that packaging. For instance, if a man only wished to purchase two tablets, two tablets from a 4-tab pack could be removed and only two supplied. We believe this meets the requirement to supply no more than 12 tablets only, while recognising the use of original manufacturer's packaging and the supporting information along with this.

We seek the Committee's documented clarification of this interpretation which removes cost barriers for some men who may not wish to purchase only a box of 4 tablets or a box of 12. Some pharmacists have reported that pharmacy audits are requiring pharmacists to only supply in whole boxes of product, which we believe is unnecessary and is a barrier to care.

6 SUBMISSIONS FOR RECLASSIFICATION

6.1 Codeine – proposed reclassification of the pharmacy only medicine entry to a more restricted medicine classification (Medsafe)

The Pharmaceutical Society acknowledges the risks reported with over-the-counter combination codeine products in various reports, publications and discussions, most recently regarding the upscheduling to prescription medicines status in Australia.

The Pharmaceutical Society's and pharmacists' perspective of combination paracetamol/codeine or ibuprofen/codeine products is that these are used for short-term over-the-counter (OTC) management of acute moderate pain. There are many scenarios which describe the types of patients who present to a pharmacy seeking one of these products, or are offered by the pharmacist. For example

- an inadequate analgesic response to an initial trial of paracetamol or ibuprofen
- paracetamol alone is insufficient and addition of an NSAID is clinically contraindicated
- "a packet" of paracetamol/codeine was recommended by a prescriber, for example by a dentist for the acute period post dental procedure

Actual Magnitude of Risk is Unknown
In the vast majority of cases, patients take the medication short term for the acute period required, and with no untoward effects. However, a number of factors may lead to a patient taking excessive doses and/or for a more prolonged treatment period than recommended. Various scenarios may lead to this, such as if the pain is not adequately managed, if there are barriers to accessing their GP for a medical review or prescription (which may be perceived or real), such as ability to pay for the consultation or a lack of perceived benefit in seeing the GP for a medical review "they just soldier on".

Many published reports note the risk of dependence from misuse of codeine combination products, however we do not have a clear understanding of the true magnitude or incidence of this risk when we do not have a set of denominator data of the overall consumption of these products in New Zealand. Reports from addiction and drug and alcohol centres are perfectly valid, however their cases are naturally skewed to those already with a demonstrated

dependence. The 'New Zealand experience' of OTC codeine dependence often uses the widely quoted McAvoy paper published in 2011 in the NZMJ. The paper certainly describes local cases with a considerable risk of dependence and harmfully excessive dosing of OTC codeine products, however it only reports a total of 22 clients from an open access clinic and detoxification unit.[1]

Similarly, reports from toxicologists would focus to their own field of experience and those samples analysed, while the scope of practice of pain specialists would have a natural bias focussing towards more severe and complex cases. The Society would equally acknowledge the experience of pharmacists in seeing greater numbers of patients whom they supply OTC codeine products without being made aware of any obvious result in harm. However, pharmacists do see patients presenting again to the pharmacy seeking a further supply of analgesics, and this can be a valuable trigger to assess need against a management plan, to refer earlier and reduce the risk of potential misuse and development of dependence.

Considering the extensive use and long history of OTC codeine products being available, data from spontaneous adverse reaction reporting in New Zealand and the United Kingdom does not provide a strong signal for significant risk of harm or dependence, acknowledging the limitations of such data.[2,3] However the Society certainly acknowledges risk does exist from long-term use of OTC codeine products, particularly in the unintentional or intentional misuse which may lead to dependence, and the risk from excessive dosing, particularly from the paracetamol and/or NSAID component. We also acknowledge risks of using OTC codeine products outweighs benefits for certain indications, and for at risk groups such as children.

A study published in the NZMJ last year by the expert advisory group from the Health Quality & Safety Commission's New Zealand Atlas of Healthcare Variation, refers to the complexity of pain management in primary care. While made in the context of aged residential care, the authors noted that[4]:

> *Staffing issues and lack of access to specialist pain and palliative services means requests for relief from bad pain are often met by nurses or clinicians unaware of the pain history, and who may not have the time or training to design a tailored pain management program or initiate de-escalation of analgesia. (It is instructive to note there are only 11.5 full-time equivalent pain specialists in New Zealand,[33]*

Risks and Benefits

Codeine Pharmacokinetics

The analgesic effect of codeine is predominantly derived from metabolism to the active metabolite morphine, via the cytochrome P450 enzyme CYP2D6, accounting for around 5-10% of codeine's clearance.[6] Other opioids that are also metabolised to more potent metabolites via CYP2D6 include tramadol, dihydrocodeine, hydrocodone, and oxycodone.

CYP2D6 is subject to genetic polymorphism and there are large interethnic differences in the frequencies of the variant 2D6 genes. This results in a small proportion of people (~5-10%) having poor 2D6 enzymatic activity and will fail to produce sufficient active metabolite to elicit an adequate therapeutic response ('poor metabolisers'). While ~1-2% of the population have higher than usual 2D6 expression, and greater amounts of the active metabolite are produced ('ultra-rapid metabolisers'). Approximately 77-92% of people are 'extensive metabolisers' who express 'normal' enzyme activity.[6]

The greater risk of toxicity for ultra-rapid metabolisers taking codeine has gained recognition in a number of reports. However, the context of many of the primary studies needs to be considered, as the risk of opiate intoxication would be much greater in prescribed doses of codeine (eg. 30-60mg every 4 hours maximum 240mg daily, for adult dosing). As one study of the pharmacokinetics of codeine in ultra-rapid metabolisers noted, they did not see any severe adverse effects following a 30mg codeine dose in their rapid metaboliser group.[7]

Efficacy

Many reports have questioned the efficacy of codeine. However, depending on the underlying study design, this may be in part due to poor-metaboliser status, the dose of codeine studied, or perhaps the context of the treatment setting. For instance the perspective of managing acute moderate-strong pain say in a primary care environment (eg. dental procedure), differs from more chronic or severe pain settings such as secondary care or patients being managed by specialist pain centres, who have a natural bias towards more complex pain.

The Australian and New Zealand College of Anaesthetists (ANZCA) and Faculty of Pain Medicine (FPM) 2015 publication 'Acute Pain Management: Scientific Evidence'[5], notes that evidence supports a superior level of analgesic effect of NSAIDs over paracetamol or codeine or combinations of paracetamol/codeine for the relief of pain following dental extraction. However, for many patients NSAID use will be contraindicated.

The ANZCA Acute Pain Management document notes that combination paracetamol 300mg with codeine 30mg provided a greater analgesic effect and longer duration of analgesia than paracetamol alone.[5] While noting a lack of data at combinations with less than 30mg of codeine. The document references a Cochrane Review in noting that:

> *Oral paracetamol combined with codeine is more effective than either medicine alone and shows a dose-response effect (**U**) (**Level I** [Cochrane Review])*[8]

In the context of acute, short-term pain management, evidence of the efficacy of the combination of paracetamol with codeine is widely available, particularly in oral surgery settings.[9,10] One 2013 review of the use of opioids following oral surgery notes the analgesic response to codeine alone was poor, but was effective when used in combination with paracetamol.[9] However the analgesic efficacy of codeine combined with ibuprofen compared to either agent alone appears less clear.[11]

Analgesic Prescribing and Pain Management

The HQSC Atlas of Healthcare Variation provides some useful information about prescribing rates of opioids, including the indication that rates of weak opioid dispensing per 1000 people increase significantly with age (on average 1 in 7 people aged 80+ received a weak opioid in 2015).[12] However this does not provide us with a clear picture for informing the use of paracetamol/codeine combination products as these were specifically excluded from the data.

Pain management is complex and multifaceted and information from patients suggests deficiencies in addressing pain needs. A 2012 report published in the New Zealand Journal of Primary Health Care reports patient concerns including with taking medication, variability in coping with pain, and difficulty in having inadequate pain management recognised and/or addressed by GPs and practice nurses.[13] Patients reported a range of statements that indicate lack of overall recognition of the individual's experience of pain, difficulty in effective analgesic prescribing, lack of continuity of care, and a lack of a clear treatment plan for managing the pain.[13]

As also recommended by a New Zealand Medical Journal report on the patterns of prescription drug misuse presenting to provincial drug clinics:

> *There is a need for better information and support for doctors on analgesic-ladder prescribing, guidelines for opioid treatment of chronic non-malignant pain, and strategies to monitor patient compliance with medication.*[14]

Medication Misuse and Dependence

Management of dependence and misuse of medicines is also complex. The results of a survey of New Zealand GPs published in 2012 reported approximately two-thirds of GPs had diagnosed at least one patient with a prescription drug misuse problem in the previous 12 months.[15] The report notes:

> *The action usually taken by the greatest number of GPs once they suspected PDM [prescription drug misuse] was to 'document it' (97.9%) followed closely by 'suggest an alternative drug' (96.7%) and 'refrain from prescribing the drug' (91.9%).*

What we are not made aware of, is the cause behind the misuse or drug seeking behaviour, for instance if poor pain management is creating a dependence or the perception of drug-seeking behaviours. The paper reports GPs would favour support for a range of interventions including training, access to a central database, working with drug and alcohol specialists, more time to attend to each patient, and increased cooperation with pharmacists.[15] The Pharmaceutical Society would strongly support an integrated approach to the identification and management of patients with potential medication dependence and/or an improved model of care supporting patients with inadequately controlled pain.

An enhanced role for pharmacists in the screening, assessment and management of pain was the subject of a briefing paper The Society and Pharmacy Guild of New Zealand jointly submitted to ACC's pain programme review in 2015. A problem identification was described from the perspective of pharmacists, along with a range of potential solutions pharmacists could provide (including an interprofessional, integrated care approach). However the outcome of ACC's programme review was only to mention medication reviews by a pharmacist as a potential option should ACC providers consider this beneficial. A copy of the paper is provided to the Committee as an extra attachment to this submission.

The Pharmaceutical Society's view is that the use of combination codeine products over-the-counter is appropriate for adults for acute pain conditions. That the combination of paracetamol and codeine is more effective than either agent alone, and is safe and appropriate for the majority of patients. However we also acknowledge that better systems and models of care to identify and manage inadequately managed pain by the health system are required. These would aim to prevent inadequate pain management that may lead to misuse of these products which can progress to dependence and risk of harm. More widespread availability of shared care systems such as HealthOne and Testsafe would support this, by documenting the supply of medicines bought over-the-counter, for all health care providers approached by a patient.

The Society believes that combination codeine products are appropriate for supply by a pharmacist under a Restricted Medicine classification. Upscheduling these products to prescription medicine would increase the burden on General Practitioners to manage misuse and dependence. While some patients may switch to taking higher doses of paracetamol

and/or ibuprofen, where unrestricted quantities may be purchased unsupervised from supermarkets.

A clear treatment plan should be discussed and agreed with all patients when analgesics are prescribed or supplied over-the-counter. The expected aims and duration of treatment needs to be understood, with mechanisms and advice put in place to monitor and review. Non-pharmacological forms of treatment should also be considered as part of overall pain management, and referral to appropriate experts made as required.

A clearer understanding of the magnitude of the problem of dependence, misuse and harm is needed, as are the causes of poorly managed pain which lead patients trying to self-manage. Simply upscheduling codeine combination products would not address this, and may also lead to greater risk of harm for some patients. The Society would strongly support a multidisciplinary approach to manage the appropriate use of OTC codeine products that were restricted to pharmacist-only supply, and provided an integrated model of care for pain management in primary care.

6.2 Sedating antihistamines – proposed amendment and reclassification of non-prescription medicine entries to prescription medicine (Medsafe)
Brompheniramine, chlorpheniramine, cyclizine, dexchlorpheniramine, diphenhydramine, doxylamine, meclizine, promethazine, trimeprazine.

The Pharmaceutical Society supports greater clarity in aligning the classification wording of the various sedating antihistamines in accordance with age-related risk and approved indications. However The Society strongly opposes a blanket approach to making all sedating antihistamines prescription medicines for all indications in children under 6 years of age.

The Society participated as a member of Medsafe's Cough and Cold Review Group in 2009 and supported the recommendations from that group. The Society has supported dissemination of the age-related restrictions and indications linked to the classification of the various medications, through our guidance and communications to pharmacists. This has been provided on an ongoing basis as pharmacists sought advice and clarification by contacting the Pharmaceutical Society.

The Society recommends retaining a restricted medicine classification for those products with clear dosing guidelines that are indicated for nausea and vomiting and travel sickness from the age of two years. Motion sickness in children can be a considerably problematic issue for parents to manage in a society that is very mobile and travels often. Pharmacists are very careful to supply those indicated antihistamines appropriately and safely, to provide piece of mind and comfort to young families travelling. We believe the judicial use of an approved antihistamine that has clear dosing instructions is very appropriate for pharmacists to supply and upscheduling to prescription status places an unnecessary burden on families and general practice.

We note in the proposal references to many overseas jurisdictions that permit the pharmacist-supply of specific antihistamines for nausea and vomiting and motion sickness. We also note MARC's recommendation to retain pharmacist-only supply for allergic conditions from the age of 2 years, and we would contend that the potential risk associated with a (usual) single dose of a sedating antihistamine prior to travelling to prevent motion sickness would be much less than the administration of several doses required for managing allergic conditions. Similarly for short-term management of nausea and vomiting. Therefore we would support a prescription

medicine classification for those indications under the age of two years, but recommend use from 2 years to 6 years of age be pharmacist only.

This classification is safe and appropriate, and would support the government aims to enhance the role of pharmacists in the provision of health care, and to support care 'close to home'.

8 HARMONISATION OF THE NEW ZEALAND AND AUSTRALIAN SCHEDULES

8.2 Decisions by the Secretary to the Department of Health and Aging in Australia (or the Secretary's Delegate)

8.2.2 Decisions by the Delegate – July 2016

Ulipristal

The Pharmaceutical Society notes the recent decision to classify ulipristal as a pharmacist-only medicine in Australia. While we do not currently have an approved product in New Zealand, should it enter the market, the Society would strongly support making it available for approved pharmacists to supply as an emergency hormonal contraceptive (ECP). Levonorgestrel supply as an ECP requires pharmacists to successfully complete mandatory training, and has become an extremely beneficial service for women since 2002. The Society would support any introduction of ulipristal with appropriate modification of our professional guidance for the provision of emergency hormonal contraception, and would deliver education to the profession to update practice to accommodate it's availability.

Thank you for consideration of this submission. I would be happy to discuss any aspect of this submission further, if required.

Yours sincerely,

Bob Buckham
Chief Pharmacist Advisor
p: 04 802 0036
e: b.buckham@psnz.org.nz

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Sale of Codeine Containing Analgesics
Joint Statement

1. Pharmacist only sales of codeine containing analgesics are intended for acute use only. The features of acute conditions are described in the Council's statement, *Protocol for the Sale and Supply of Pharmacist Only Medicines for Chronic Conditions* as usually having a rapid onset and often lasting less than three weeks. They may recur from time to time, may or may not resolve on their own and may or may not require referral to a doctor.

2. Repeat sales of codeine containing analgesics within a short timeframe are likely to be inappropriate in the majority of cases. An alternative, clinically suitable non-codeine containing analgesic should be offered or the patient referred to an appropriate health professional for a full diagnostic assessment so that the optimal management can be identified.

3. Pharmacists must be vigilant about frequent purchasers and use clinical judgement about whether supply of the requested codeine containing analgesic is appropriate. Codeine seekers usually provide false details about symptoms and do not accept offered alternatives.

4. Codeine seekers are known to offer false names or addresses when attempting to purchase from the same pharmacy. It is advisable to consider requesting photo identification to confirm patient identity when recording purchaser details, particularly if there are concerns about the legitimacy of the request. Recording details of the sale in an electronic database, such as your dispensary system provides additional information regarding patient medication use particularly in areas where a shared patient record is accessible. Any concerns about frequent purchasers should be reported to Medicines Control.

5. Pharmacist Only Medicines must not be available for patient self-selection. It is the responsibility of the pharmacist to ensure that the patient receives safe, clinically appropriate assessment before a decision on management can be made.

6. To ensure that patients continue to have access to codeine containing analgesics as Pharmacist Only Medicines, it is vital that best practice principles through strong clinical and ethical decision making are adhered to at all times.

7. Due to their potential for misuse, advertisements related to codeine-containing analgesics are subject to extra restrictions in the joint *Pharmacy Council and Pharmaceutical Society Advertising Guidelines*, on the Council's and Society's websites.

Dummy boxes

8. The placement of dummy boxes of codeine containing analgesics on over the counter shelves could be viewed as a form of advertising and could in some instances, be seen as a breach of a pharmacist's obligations to prevent misuse of substances of abuse. A pharmacist must be able to refuse the sale of any product that is unsuitable for a patient or where misuse is suspected.

9. By permitting a customer to self-select a codeine containing analgesic dummy box the patient has already made a decision about the choice of analgesic and it then may be more difficult for the pharmacist to decline the sale. It is preferable for the pharmacist to make a clinical decision regarding the most appropriate choice of analgesia for the patient in response to patient symptoms and medical history.

Code of Ethics 2011

10. The Council's Code of Ethics 2011 addresses the sale of products of potential misuse in many clauses:

- *"Clause 1.2 – Take appropriate steps to prevent harm to the patient and the public.*
- *Clause 1.7 – Only supply a medicine, complementary therapy, herbal remedy or other healthcare product to a patient when you are satisfied that the patient understands how to use it safely and appropriately*
- *Clause 6.12 – Make certain the public cannot self-select medicines you know or should reasonably be expected to realise are likely to cause or have a potential for misuse, abuse or dependency.*
- *Clause 6.13 – Take appropriate steps to prevent the supply, by any means, of unnecessary or excessive quantities of any medicine or healthcare product which you know or should reasonably be expected to realise is likely to cause or have a potential for misuse, abuse or dependency."*

What is an appropriate supply?

11. Pharmacists should not engage in the sale of multiple packets of codeine containing analgesics in one transaction or repeat, frequent sales to one patient. This practice is likely to breach the Council's Code of Ethics 2011. There may be limited situations when a subsequent sale is necessary, for example when access to medical or dental care is not immediately available.

12. Treatment for a period of up to one week can be considered appropriate in certain circumstances but, medical attention is essential if a longer period of treatment is requested.

13. Pharmacists are experienced health professionals and highly qualified medicines experts capable of using clinical and ethical judgement to assess the patient and recommend the most appropriate analgesic for patient management.

14. It is essential that pharmacists adhere to the highest practice standards to ensure patient and public safety.

Effective date

15. Effective: February 2016.

10 April 2017 Our Ref: MT17-229

Hannah Hoang
Advisor Science (MAAC and MCC Secretary)
Medsafe
Ministry of Health
PO Box 5013
WELLINGTON 6145

Email committees@moh.govt.nz

Dear Hannah

Thank you for the opportunity to comment on the agenda of the 58th meeting of the Medicines Classification Committee (MCC) of Medsafe.

Introduction to general practice and the College

General practice is the medical specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end; and with the most inseparable intertwining of the biomedical and the psychosocial. General practitioners (GPs) treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, the Royal New Zealand College of General Practitioners (the College), is the largest medical college in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists, and sets standards for general practice. The College has a commitment to embed the three principles (participation, partnership and protection) of Te Tiriti o Waitangi (Treaty of Waitangi) across its work, and to achieving health equity in New Zealand.

Health equity is the absence of avoidable or remediable differences in health outcomes and access to health services among groups of people, whether those groups are defined socially, economically, demographically, or geographically (WHO). To achieve health equity, we advocate for:

- A greater focus on the social determinants of health (including labour, welfare, education, housing, and the environment).
- Funding and support to sustain the development of a GP workforce of sufficient capacity to meet population need for access to quality primary medical care, particularly in rural and high need areas.
- Sustained focus on measures to reduce smoking and to increase healthy food options for low-income families.
- Improved integration of primary, community, and secondary care health and social services which ensures the provision of high quality services.
- Universally accessible free primary health care for children and low-income families, because health inequities begin early and compound over the life course.
- A review of the funding model for primary care to ensure that resourcing is allocated equitably across diverse populations with differing needs.

Submission

The College would like to comment on two agenda items

Item 5.5 Medicine reclassification - Proposed additional process when considering the reclassification of prescription medicine to restricted medicine (Pharmacy Council)

Item 8.2.2b Ulipristal.

Item 5.5 Medicine reclassification - Proposed additional process when considering the reclassification of prescription medicine to restricted medicine (Pharmacy Council)

The College would like to thank the Pharmacy Council and the Pharmaceutical Society for the work they have done to develop a process to allow recommendations to be made to the MCC regarding the circumstances under which medications reclassified from prescription to restricted can be safely supplied.

The College is of the opinion that the Pharmacy Council is the appropriate body to determine whether additional training for pharmacists is required should medicines be down scheduled from prescription to restricted. In recent years, such recommendations have often be made by the pharmaceutical company or pharmacy organisation proposing the reclassification. Such organisations have a commercial imperative and given the profits to be made following down scheduling there is a risk that patient safety considerations may be given less weight than they should be.

We note that the "Council framework" will be established in collaboration with the Pharmaceutical Society. This framework "will set out any training programme requirements and mandatory patient consultation outcomes "[1]. It is unfortunate that this framework is not already available to allow it to be considered alongside this proposal. It is important that in the development of the framework issues of conflict of interest are dealt with appropriately.

The College applauds the inclusion of consideration of collaboration with other health professions as a favourable factor when assessing proposals. However we would like to recommend a small edit to the wording. We suggest that footnote 2, which refers to favourable consideration of evidence that there had been collaboration with other health professionals, should be altered to read health professional organisations. This would prevent communication with an individual practitioner who may have views that are out of step with the majority of the profession on a particular reclassification, being put forward as evidence of "collaboration."

Item 8.2.2b Ulipristal

Pharmacists are able to supply other emergency contraceptive pills (ECPs) only if special training has been undertaken. The College considers that the provisions that relate to pharmacist supply of other ECPs should also be applied to Ulpristal should it become available in New Zealand.

We hope you find our submission helpful. Should you require any further information or clarification please contact the College's policy team at policy@rnzcgp.org.nz.

Yours sincerely,

Michael Thorn
Manager – Strategic Policy

[1] http://www.medsafe.govt.nz/profs/class/Agendas/agen57PharmacyCouncil.pdf

[redacted]

ACC has recently researched prescription opioid use after injury. Our research showed that although codeine is the main prescription opioid used after injury or surgery, it tends to only be used for 7 – 14 days in the majority of claims. ACC Research did not identify to it being a significant contributor to opioid harm when used after injury. (Whether our clients continue to purchase it for self management of pain symptoms after injury is unknown).

We note the various options in the Medsafe paper to manage the potential harm for codeine when it is used as an analgesic. Although Australia has decided to make codeine a prescription only medicines, the studies quoted in the Medsafe paper about harm from codeine have small study cohorts. Whether they can be reliably translated into a population policy to restrict access to pain medicine is unclear.

For self limiting conditions such as headaches, coughs and colds, maintaining over the counter pharmacy access would enable the population to self manage conditions with the support of pharmacists who are readily accessible in community. This can also increase the health literacy of the population around safe medicine use and good pain management strategies, which is of societal benefit.

To mitigate potential harm from community access to opioids (for all age groups - whether it be for self limiting conditions or chronic pain conditions), there is merit in considering restricting all codeine products to pharmacist only. This should include a requirement for pharmacists to use a pain management protocol to

- assess patients to determine if the codeine use is appropriate or whether they should be referred to their doctor, allied health or other social support agencies
- educate patients on the use of multimodal therapy to manage chronic pain conditions
- refer to community based social support where identified as a need during the assessment
- record the pharmacist only sale of codeine as a mandatory addition to a patient health record, enabling a more holistic view of medicines used by the NZ population.

I am happy to speak to this comment, if it would assist the Committee's discussion.

Kind regards

[redacted]

Accident Compensation Corporation (ACC)