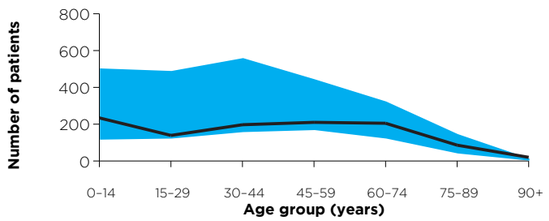
Practice profile

Age profile of patients in your practice is provided to help you interpret your prescribing data.

Age profile of your patients

(1 January 2016 to 31 December 2016)



The black line represents the age profile of patients in your practice. The shaded area lies between the 25th and 75th percentile for GPs in your RA[b].

Your RA peer group is 1

Your total Medicare patients and concession card holders

(1 April 2016 to 30 June 2016)

Patients	You	Median of GPs in your RA[b]
Total Medicare	631	644
Concession card holders Includes those reaching Safety Net	164	66

Data from a 3-month period that represent patient mix have been provided. Department of Veterans' Affairs health card holders are not included.

Confidentiality

NPS MedicineWise has a contract with the Department of Human Services for the supply of both MBS and PBS data which contain individual provider names and numbers, and aggregated patient data. This information is stored by NPS MedicineWise in Australia and is protected using multiple layers of accredited security controls, including best-practice encryption methods. This information is only accessed by NPS MedicineWise staff who have obtained an Australian Government security clearance.

Disclaimer

This information is derived from a critical analysis of a wide range of authoritative evidence and guidelines. Great care is taken to provide accurate information at the time of creation. This information is not a substitute for medical advice and should not be exclusively relied on to manage or diagnose a medical condition. NPS MedicineWise disclaims all liability (including for negligence) for any loss, damage or injury resulting from reliance on or use of this information.

Discrepancies may occur between the data provided and your own practice. This may be due to inaccurate recording of your provider number within the system or use of your provider number by someone else.

Contact

For queries about your data or any of this information, contact NPS MedicineWise:

02 8217 8700 @ info@nps.org.au

This mailout is sent to your preferred mailing address, as held at the Department of Human Services (DHS). To update your preferred mailing address:

- use Health Professional Online Services (HPOS) as a self-service option at https://www.humanservices.gov.au/organisations/health-professionals.
- @ send your full name, provider number and new preferred mailing address to Provider.Registration@humanservices.gov.au from a personal email address that clearly identifies you, or is the email address stored on the Medicare Provider Directory.

References

References available online at: nps.org.au/pbs-lipids.

Notes

a. Data shown are an aggregate of all your provider locations.
b. The comparator group 'RA' includes all general practitioners currently located in a similar geographical location (ie, 1. major city, 2. inner regional, 3. outer regional, 4. remote, 5. very remote).
c. Aggregate MedicineInsight data on 1 August 2017.
d. Includes ezetimibe products with an approved indication for statin-related clinically important adverse events as per the following authority codes: 5562/3731 (ezetimibe 10 mg); 4353 (atorvastatin 10 mg + ezetimibe 10 mg); 4147 (rosuvastatin 10 mg + ezetimibe 10 mg; simvastatin 10 mg + ezetimibe 10 mg; simvastatin 20 mg + ezetimibe 10 mg). For more information see: nps.org.au/pbs-lipids.
e. According to PBS criteria, a clinically important adverse event is defined as severe myalgia (muscle symptoms without creatine kinase elevation); myositis (clinically important creatine kinase elevation with or without muscle symptoms) or unexplained, persistent elevations of serum transaminases during statin treatment.

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NPS MEDICINEWISE PROFESSIONAL

MANAGING LIPIDS
STATINS REVISITED

Practice Review: PBS data November 2017

⊢ 000001 000 DHS1
Dr Sam Sample
123 Sample Street
SAMPLETOWN ABC 1234

Your PBS data are provided confidentially to you only and are intended for personal reflection on your practice. **Data are not used for any regulatory purposes.**

Additional **MedicineInsight** general practice cohort data are included to complement your PBS data.

30 November 2017

Dear Dr Sample,

NPS MedicineWise supports clinicians in professional development and continuing quality improvement, with a focus on quality use of medicines and medical tests. As part of a national educational program on Managing lipids, the enclosed data focus on your prescribing of medicines for lipid management.

Statins are first-line lipid-modifying medicines for patients at high CV risk
Statins have robust evidence for efficacy and safety. They reduce CV morbidity and mortality and have low rates of serious adverse events associated with long-term use. Statins are the most effective oral LDL-C-lowering medicine class.[1] Statin monotherapy lowers LDL-C levels by 21% to 55% on average[2] while ezetimibe monotherapy lowers LDL-C levels by 18% to 20% on average.[3] Australian guidelines recommend adequately optimising statin therapy before adding a second-line medicine such as ezetimibe.[1]

Adherence to medicines is suboptimal
Up to 67% of patients do not adhere to prescribed statin treatment after 12 months.[4] Patients who take < 80% of their prescribed statin dose have a 45% relative increase in total mortality and a 15% relative increase in CVD events compared to more adherent patients.[5,6]

Manage statin-associated muscle symptoms (SAMS) in a systematic way
Concern about, or experience of, SAMS is a major reason for non-adherence.[7] True SAMS are rarely life-threatening and have a lower incidence than is commonly reported.[8] Many patients with reported statin intolerance can tolerate a decreased dose, a different statin or alternate day dose therapy.[9]

Reflect on your prescribing
The enclosed PBS data provide you with an opportunity to reflect on your practice and your prescribing patterns for lipid-modifying medicines. To complement your individual PBS data, additional information from the **MedicineInsight** general practice database has been included. To interpret your data in the context of your own clinical practice, this information provides further insights into national prescribing patterns for lipid-modifying medicines.
See: nps.org.au/medicine-insight.

Learn more
Our national program, Managing lipids, provides a range of clinical tools and patient resources as well as CPD activities for GPs:

- Case study – Optimising statin therapy
- Clinical e-Audit – Statins: who, when and how?

Yours sincerely,

Lynn Weekes

Lynn Weekes AM, Chief Executive

For more information about this Practice Review and how to interpret your data, or to provide feedback, see: nps.org.au/pbs-lipids.

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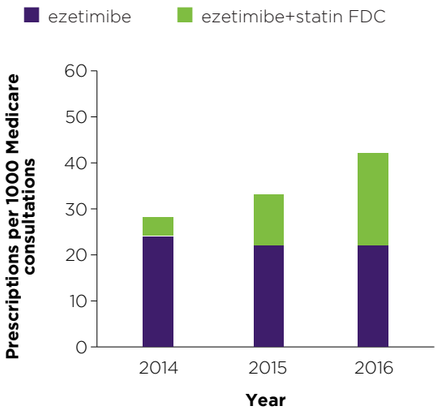
Independent, not-for-profit and evidence based, NPS MedicineWise enables better decisions about medicines and medical tests. This program is funded by the Australian Government Department of Health.

NPS MedicineWise ABN 61 082 034 393

Your confidential prescribing data

NPS MedicineWise provides this information for your reflection only. The data are from the Department of Human Services and include all PBS prescriptions for all statin and ezetimibe medicines that you prescribed that were dispensed. The indication for prescribing cannot be determined from PBS data. Consider the data in relation to your patients and their indications for treatment.

How has your prescribing of ezetimibe changed over time?



Points for reflection

- The number of people using ezetimibe alone or in combination with a statin is steadily increasing.[10]
- Consider ezetimibe when there is a contraindication to a statin, when a clinically important adverse event occurs with statins or when treatment targets are not achieved with an adequate trial of a statin alone.[1]
- An adequate trial of a statin involves regularly monitoring adherence to medicines and lifestyle modifications and up-titrating the dose of the statin to the maximum tolerated dose to achieve target lipid levels.[9]
- Maximum tolerated dose is the highest dose of the medicine that does not cause adverse effects that are unacceptable for the patient.[11]

How adherent are your patients to statin treatment?

		Number of statin prescriptions dispensed in 2016							
	Number of patients who had statin monotherapy dispensed in 2016	1-3		4-6		7-9		≥10	
You	128	17	13%	19	15%	21	16%	71	55%
Mean in your RA[b]		28%		27%		14%		31%	

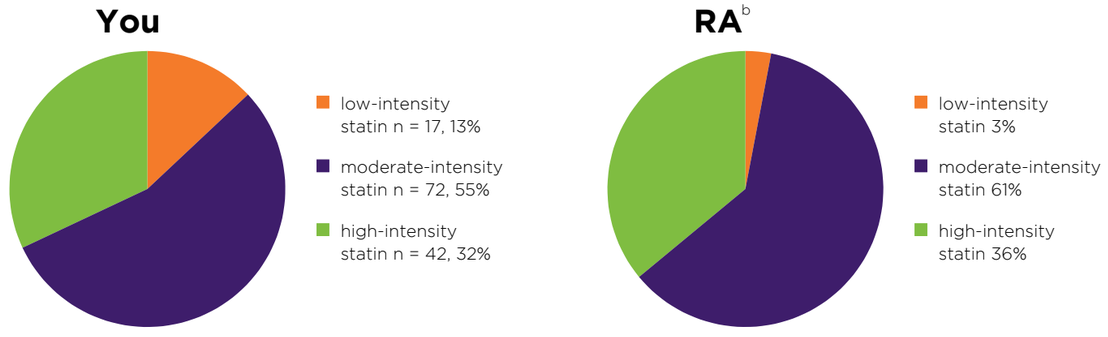
Note: Each pack of statins should last 28-30 days; a patient taking a statin once daily would require 12 prescriptions per year.

Points for reflection

- Non-adherence to lipid-modifying medicines is a key factor in lipid targets not being met.[12]
- A range of factors can contribute to non-adherence, such as beliefs, attitudes to, and understanding of the importance of medicines, polypharmacy and adverse effects.[13]
- Patients who are better informed and more involved in decisions about their care are more likely to continue statin treatment.[14]
- Assess adherence on an ongoing basis (eg, at every consultation). Identifying the reasons for poor adherence and applying strategies to address these barriers may improve adherence.
- Consider providing resources that explain CV risk and statins. The MedicineWise app may be useful to remind patients to take their medicine and to refill prescriptions. See: medicinewiseapp.com.au.

MedicineInsight data show that 43% of patients using lipid-modifying medicines are not achieving target lipid levels and 39% do not have their lipid levels recorded within the previous 12 months.[c]

What intensity of statin treatment do you prescribe?



Note: Due to rounding, percentages may not total 100%. n = number of patients. Data reflects prescriptions dispensed in 2016. Low-intensity statin: simvastatin 5 mg, 10 mg, pravastatin 10 mg, 20 mg; moderate-intensity statin: atorvastatin 10 mg, 20 mg, rosuvastatin 5 mg, 10 mg, simvastatin 20 mg, 40 mg, 80 mg, pravastatin 40 mg, 80 mg, fluvastatin 80 mg; high-intensity statin: atorvastatin 40 mg, 80 mg, rosuvastatin 20 mg, 40 mg.

Points for reflection

- When LDL-C response to statin treatment is inadequate despite adherence to medicines and lifestyle modifications, consider increasing the dose of statin to the maximum tolerated dose or switching to an alternate, more potent statin, before adding a second lipid-modifying medicine such as ezetimibe.[1]
- In the context of secondary prevention, patients with existing CVD benefit from more aggressive lipid-lowering treatment.[15] Consider starting a potent statin at higher doses for secondary prevention.
- Monitor response to statin treatment every 4-8 weeks when starting treatment,[1] then every 6-12 months once lipid targets are achieved.[16] Studies show lack of monitoring contributes to poor adherence.[9]

MedicineInsight data show that 68% of patients using statin treatment with a recorded statin strength and recorded LDL-C level > 2.0 mmol/L were using either a low- or a moderate-intensity statin.[c]

How many of your patients started ezetimibe[d] due to a clinically important adverse event[e] with a statin?

	2014		2015		2016	
You	7	35%	6	29%	10	42%
Mean in your RA[b]	9%		8%		6%	

Points for reflection

- SAMS are a major reason for statin non-adherence.[7] Advise the patient to contact you or their pharmacist if they experience muscle symptoms, and not to stop using their statin.[8]
- Consider possible causes and risk factors to determine whether muscle symptoms are truly associated with statins, such as location and timing of symptoms as well as drug interactions.[17]
- If SAMS are present, temporarily ceasing the statin and then resuming the statin at a lower dose, switching to an alternative statin or trialling intermittent dosing may improve symptoms.[9]
- 92% of patients reporting SAMS with one statin are able to tolerate an alternative statin and approximately 70% can tolerate intermittent dosing with the same statin.[7,18]

MedicineInsight data show that, on average, patients will trial only one statin before starting ezetimibe.[c]