Kimberley Standard Drug List (KSDL)

17th EDITION

November 2022

Kimberley Aboriginal Health Planning Forum

kahpf.org.au

Contents

About the KSDL

In consultation with a number of stakeholders, the Kimberley Aboriginal Medical Services Ltd (KAMS) and WA Country Health Service (WACHS) Kimberley have developed a recommended drug list for the Kimberley.

This drug list is intended for use in remote clinics, including remote Government clinics and Aboriginal Community Controlled Health Services (ACCHS's) in the Kimberley.

Although Kimberley hospitals will have the opportunity to have a much larger imprest, the standard drug list has also been planned to be reflected in hospital imprests.

The steering committee has recommended a two part approach to the clinic imprest, as outlined below:

1) Essential Drug list:

This list consists of drugs that the steering committee recommends should be easily accessible to the Kimberley population and hence, included in all clinic and hospital medication imprests.

2) Supplementary list:

This list consists of drugs that should be able to be accessed across the Kimberley, but will not be required by all clinics. Therefore, it is at the discretion of the local senior clinicians as to whether or not these drugs are included on the clinics imprest.

The Standard Drugs list also includes:

1) Emergency Drug list:

Drugs for inclusion in Emergency drug kits.

2) Vaccines

3) Non-prescription medicines:

The list does not preclude prescribers from working outside this list, but rather provides a useful guide to medication which is readily available in the Kimberley for continued treatment.

Following is the recommended drug list. This is the result of numerous meetings of the steering committee, as well as consultation with specialists who practice within the region.

Further information about the rationale behind this list can be accessed at

https://kahpf.org.au/standard-drug-list/

Note: Shaded items are non-PBS.

Green Shaded: East Kimberley only

Kimberley Standard Drug List Review Committee

The Standard Drug List is a constant work in progress, and is reviewed and updated bi-annually.

The current KSDL Review Committee members are as follows:

- Dr Lorraine Anderson (Medical Director, KAMS)
- Ms Hannah Mann (Pharmacist, KAMS & KPS)
- Dr Emma Griffiths (Renal General Practitioner, Kimberley Renal Services)
- Mr Roy Finnigan (Hospital Pharmacist, WACHS)
- Dr Lydia Scott (Physician, WACHS Kimberley)
- Dr Jonathan Blundell (General Practitioner, BRAMS)
- Ms Michelle Harvey (Nurse Practitioner, OVAHS)

The project was initially completed by a Standard Drug List Working Party.

The original members and their positions were as follows:

- Dr Alex Balzarelli (BRAMS)
- Dr Graeme Maguire (WACHS Community Physician)
- Dr Anne Cawley (BRAMS)
- Dr Richard Murray (KAMS Medical Director)
- Mr Roy Finnigan (Hospital Pharmacist, WACHS)
- Dr Carmel Nelson (DAHS)
- Dr Cherelle Fitzclarence (BRAMS)
- Dr David Shepherd (BRAMS)
- Ms Cathy Larkin (KAMS Pharmacist)
- Dr Alice Tippetts (OVAHS)
- Dr Conrad Macrokanis (Broome Hospital)

Contributors

Throughout the development of the Standard Drug List there were a number of Specialists and specialist services consulted.

These participants included:

- Dr Lindsay Adams (Paediatrician, WACHS)
- Dr Siva Bala (Psychiatrist, North West Mental Health)
- Dr Murray Chapman (Psychiatrist, North West Mental Health)
- Dr Dave Cutts (Psychiatrist, North West Mental Health)
- Dr Clayton Golledge (Senior Consultant in Clinical Microbiology & Infectious Diseases, Sir Charles Gardiner Hospital
- Mr Lou Leidwinger (Audiologist, WACHS)
- Dr Ross Littlewood (Opthamologist)
- Dr Alastair Mackendrick (Southern Corridor ENT Services)
- Ms Maree McGrath (Diabetes Educator, Broome Hospital)
- Dr Jacki Mein (Senior Medical Officer, Kimberley Public Health Unit)
- Dr Jock Murray (Obstetrician, WACHS)
- Dr Dermot Roden (Opthamologist)
- Dr James Rohr (Dermatologist, Dermatology WA)
- Dr Kevin Warr (Renal Physician)
- Dr Keith Woollard (Cardiologist, WA Cardiology)

Clinic Imprest Amendments and Additions

[1] Amended/Added August 2006,

[2] Amended/Added May 2007,

[3] Amended/Added June 2008,

[4] Amended/Added June 2009,

[5] Amended/Added November 2010,

[6] Amended/Added October 2011,

[7] Amended/Added October 2012

[8] Amended/Added November 2013

[9] Amended/Added November 2014,

[10] Amended September 2015,

[11] Amended/Added November 2016,

[12] Amended/Added October 2017,

[13] Amended/Added September 2018,

[14] Amended/Added November 2019,

[15] Amended/Added November 2020,

[16] Amended/Added November 2021,

[17] Amended/Added November 2022

Cardiovascular Drugs

Class	Essential List	Supplementary List
ACE-Inhibitors	Ramipril (2.5mg, 5mg tab, 10mg cap)	Enalapril (5mg, 10mg, 20mg tab) Perindopril (5mg tab)[14]
AII-Antagonists	Irbesartan (75mg, 150mg, 300mg tab)	Irbesartan/HCT (300mg/12.5mg tab)
Anti-angina therapy	GTN (400mcg spray) Isosorbide mononitrate (60mg, 120mg tab)	Nicorandil (10mg tab)
Anti-arrhythmics	AmiODARONe (200mg tab) Digoxin (62.5mcg, 250mcg tab)	Sotalol (80mg tab) Verapamil CR (180mg, 240mg tab)
Anticoagulants	Rivaroxaban (15mg, 20mg tab)[8] Warfarin (Marevan®) (1mg, 3mg, 5mg tab)	Apixaban (2.5mg, 5mg tab)[17] Enoxaparin (40mg, 60mg, 100mg inj)[16]
Antiplatelet therapy	Aspirin (100mg, 300mg tab) Aspirin + Clopidogrel (100mg +75mg tab)[5] Clopidogrel (75mg tab)	DiPYRIDAMOLe/Aspirin (200mg/25mg cap)[8] Ticagrelor (90mg tab)[10]
Beta-blockers	Atenolol (50mg tab) BisOPROLOl (2.5mg, 5mg, 10mg tab)[5] Metoprolol (50mg, 100mg tab)	Labetalol (100mg tab) Metoprolol CR (95mg tab)[14] PropRANOLol (10mg, 40mg tab)[2]
Calcium Channel Blockers	AmLODIPine (5mg, 10mg tab) NiFEDIPine oros (30mg, 60mg tab)	
Centrally acting antihypertensives	Methyldopa (250mg tab)	
Diuretics	Furosemide (frusemide) (20mg, 40mg, 500mg tab) HydrOCHLOROTHIAZIDe (25mg tab)[5] Spironolactone (25mg tab)	
Dyslipidaemia Agents	Atorvastatin (20mg, 40mg, 80mg tab)[10] Ezetimibe (10mg tab)[1] Fenofibrate (48mg, 145mg tab)[5]	Rosuvastatin (10mg,20mg,40mg tab)[7]

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Diabetic Drugs

Class	Essential List	Supplementary List
Glucagon-like peptide 1 analogue	Dulaglutide 1.5mg injection (Trulicity®)[14]	
Insulin	Short acting, neutral (Actrapid® penfill cartridges) Recommended insulin pen: Novopen Insulin glargine (Optisulin® penfill cartridges[2])* Insulin glargine (Optisulin® Solostar Disposable Pen)[3]*	Protaphane® Innolet Isophane insulin (Protaphane® penfill cartridges)[14]
Oral drugs for diabetes	Empagliflozin (10mg, 25mg tab) [14, 16] GliCLAZide (30mg MR, 60mg MR tab)[5] Linagliptin (5mg tab)[14] Metformin (500mg, 1g, XR 500mg, XR 1g tab) SiTagliptin (25mg, 50mg, 100mg tab)[8] SiTagliptin + Metformin XR (JanuMET XR 50mg/1g, 100mg/1g tab)	

*Reminder of increased risk of Ketoacidosis, dehydration and infection with Empagliflozin
*When switching from:
(i) Once daily dose of Protaphane® to LanTUs®, the initial dose of LanTUs® can be administered at the same dose in units as the Protaphane®.
(ii) Twice daily dose of Protaphane® to LanTUs®, the initial dose of LanTUs® should be reduced by approximately 20% of previous total IU of insulin. Carefully monitoring and dosage adjustment is recommended during the first week of transfer treatment, and then dosage adjustments should be made based on patient response, as recommended in the Product Information Guide, June 2007.

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Other Endocrine and Metabolic Disorder Drugs

Class	Essential List	Supplementary List
Corticosteroids	Prednisolone (5mg, 25mg tab, 5mg/mL liquid)	Prednisolone (1mg tab)
Osteoporosis therapy	Calcium carbonate (equiv.Ca 600mg tab) (Calci-Tab 600®)[5] Calcitriol (0.25mcg cap)	
Thyroid	Levothyroxine sodium (Eltroxin) (50mcg, 75mcg 100mcg tab)[11]	CarbiMAZOLe (5mg tab) PropRANOLol (10mg, 40mg tab)[2]
Phosphate Binders	Sevelamer Carbonate (800mg tab)[5]	

Gastrointestinal Drugs

Class	Essential List	Supplementary List
Anti-emetics	Metoclopramide (10mg tab) Ondansetron (4mg wafer, 2mg/mL inj) ProCHLORPERazine (5mg tab)	
Antispasmodics and anti-motility drugs	Loperamide (2mg cap) (quantity 12)[11]	Hyoscine butylbromide (10mg tab, 20mg/mL inj)
H2 Antagonists and Antacids	Antacid® suspension Nizatidine (150mg tab)[16]	
Laxatives	Coloxyl with Senna® Tab Micolette® enema	Lactulose liquid
ORT	Repalyte® sachets Hydralyte® icypoles (apple/blackcurrant & orange)	
PPIs	NexIUM HP7 Omeprazole (20mg tab)	Pantoprazole (20mg tab)[14]
Portal Hypertension		PropRANOLol (10mg, 40mg tab)[2]

Respiratory Drugs

Class	Essential List	Supplementary List
Inhaled and oral preventer medication	Fluticasone MDI (50mcg, 125mcg, 250mcg)	Montelukast (5mg chewable tab)
Bronchodilators (SABA)	Salbutamol MDI (100mcg)	
LAMA	Umeclidinium 62.5mcg powder for inhalation (Incruse Ellipta)[11]	Handihaler device [13] Tiotropium (18mcg caps) [13]
LABA/LAMA	Umeclidinium/Vilanterol (62.5mcg/25mcg) (Anoro Ellipta®)[11]	
ICS/LABA	Fluticasone/Vilanterol (100mcg/25mcg and 200mcg/25mcg) [12] (Breo Ellipta) Fluticasone/Salmeterol Accuhaler (250mcg/50mcg, 500mcg/50mcg)	Fluticasone/Salmeterol MDI (250mcg/25mcg)
ICS/LABA/LAMA	Fluticasone/Umeclidinium/Vilanterol (100mcg/62.5mcg/25mcg) [13] (Trelegy Ellipta)	

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Analgesics

Class	Essential List	Supplementary List
Anti-gout preparations	Allopurinol (100mg, 300mg tab) Colchicine (500mcg tab)	
DMARDS		Hydroxychloroquine (200mg tab) Methotrexate (2.5mg tab), (10mg tab (15tabs)) SulfaSALazine EN (500mg tab)
Migraine therapy		PropRANOLol (10mg, 40mg tab[2])
Non-opioid analgesics	Paracetamol liquid (240mg/5mL) Panamax® brand Paracetmol modified release (665mg tabs) Paracetamol tab (500mg tab) tRAMadol (50mg cap, 100mg SR tab)	
NSAIDs	Ibuprofen (400mg tab)	Ibuprofen liquid (100mg/5mL) Naproxen (SR 1g tab) Celebrex (100g, 200mg cap) Diclofenac 1% gel[15]
Other	Methylprednisolone acetate (40mg injection)[5]	
Opioid Analgesics/ combinations	Paracetamol / codeine (500mg/30mg tab)	Fentanyl injection 100mg/2ml – for administration as Intranasal Fentanyl[11]
Adjuvant Analgesics	AmiTRIPTYline (10mg, 25mg tab)[12] Pregabalin[11] (25mg, 75mg, 100mg, 150mg caps)	

Psychotropics

Class	Essential List	Supplementary List
Antipsychotics	Benztropine (2mg tab) Haloperidol (5mg tab)[12] Olanzapine (2.5mg, 5mg, 10mg tab) Olanzapine (5mg, 10mg wafer) RiSPERIDONe (1mg tab)	ARIPiprazole (10mg tab) ARIPiprazole depot inj (300mg,400mg) [12,15] Paliperidone depot inj (75mg, 100mg, 150mg)[8] Paliperidone (6mg MR tab)[12] Sodium valproate (200mg, 500mg tab) QUETIApine (25mg, 100mg, 300mg tab)[4] Zuclopherthixol depot (200mg/ml inj)
Benzodiazepines	Diazepam (5mg tab)	
Others	Venlafaxine (37.5mg, 75mg XR, 150mg XR cap)	Mirtazapine (15mg, 30mg tab) [15]
SSRI's	Citalopram (20mg tab) SERTRALine (50mg tabs)[8]– breastfeeding	Escitalopram (10mg, 20mg tab) [15] Fluoxetine (20mg cap)

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Neurological Drugs

Class	Essential List	Supplementary List
Anti-epileptics	CARBAMazepine (200mg CR tab) Levetiracetam (500mg tab) Phenytoin (100mg cap) Sodium valproate (200mg, 500mg tab)	CARBAMazepine (20mg/ml liquid) Gabapentin (300mg cap) LamOTRIGine (50mg, 100mg tab) Sodium valproate (40mg/ml s/f liquid)
Drugs for Parkinsonism		Levodopa/Carbidopa (100mg/25mg scored tab)[2]

Obstetric, Gynaecological and Genitourinary Drugs

Class	Essential List	Supplementary List
Antimenorrhagic	Tranexamic Acid (500mg tab)[4]	
Contraceptives	Ethinyloestradiol /Levonorgestrel (30mcg /150mcg tab) Etonogestrel implant (Implanon®) Levonorgestrel (30mcg tab) Medroxyprogesterone (150mg/mL depot) (Depo Ralovera®)	
Emergency contraception	Postinor-1® (levonorgestrel 1.5mg tab) Ulipristal (30mg Tab)[16]	
Genitourinary Drugs	Dutaseride +Tamsulosin (500mcg + 400mcg cap) Prazosin (1mg tab)	
HRT	Norethisterone (5mg tab)	Estriol 0.1% cream Estradiol (10mcg pessaries) (Vagifem Low)[11]
Other	Progesterone (200mg pessaries) [16]	

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Antibiotics

Class	Essential List	Supplementary List
Cephalosporins	CefaLEXin (500mg cap, 250mg/5mL syrup)	
Macrolides	AziTHROMYCIN (500mg tab, 200mg/5mL syrup)	
Others	Clindamycin (150mg cap) Metronidazole (400mg tab, 200mg/5mL syrup) Probenecid (500mg tab) TrimETHOPRIM (300mg tab)	Nitrofurantoin (100mg cap)
Penicillins	Amoxicillin (500mg cap, 250mg/5mL syrup) Amoxicillin/Clav.acid (875/125mg tab, 400mg/5mL syrup) Benzathine penicillin (1.2MIU/2.3mL inj)[3] Flucloxacillin (500mg cap, 250mg/5mL syrup) Phenoxymethylpenicillin (500mg cap, 250mg/5mL syrup [6])	
Quinolones	CiPROFLOXAcin (500mg tab)	
Sulphonamides	Co-trimoxazole (TrimETHOPRIM + Sulfamethoxazole) (160mg/800mg tab)[9] Co-trimoxazole (TrimETHOPRIM + Sulfamethoxazole) (8mg and 40mg/ml liquid)[13]	
Tetracyclines	Doxycycline (100mg tab)	

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Antifungals

Class	Essential List	Supplementary List
Antifungals	Clotrimazole 1% 6 Day vaginal cream Fluconazole (200mg cap) Ketoconazole 2% cream 30g[2]* Ketoconazole 2% shampoo 60ml (Nizoral®)* Nystatin (100,000U/mL oral drops) Selsun® Yellow shampoo Terbinafine 1% Cream 15g[3] Terbinafine (250mg tab)	

* Not to be used in pregnancy

Antivirals

Class	Essential List	Supplementary List
Antivirals	Aciclovir (500mg/20ml inj)[7] Famciclovir (250mg tab) Molnupiravir (200mg cap)[17] Oseltamivir (30mg, 75mg cap)[14] Paxlovid Composite Pack [17]	

Antithelmintics

Class	Essential List	Supplementary List
Antithelmintics	Albendazole (200mg, 400mg tab) Ivermectin (3mg tab)* Pyrantel (250mg tab)	

Scabies and Head Lice Preparations

Class	Essential List	Supplementary List
Scabacides	Dimethicone 4% headlice treatment [8] Permethrin 5% cream	

Ear and Nasal Preparations

Class	Essential List	Supplementary List
Ear preparations	CiPROFLOXAcin 0.3% Ear Drops[2] Ciproxin HC Ear drops[16] Dexamethasone/framycetin/ Gramicidin ear drops (Sofradex®/Otodex®) Flumethasone/clioquinol.02%/1% Ear drops[7] Triamcinolone/nystatin/ Gramicidin/neomycin oint (Kenacomb®/Otocomb®)	
Nasal preparations	Mupirocin Nasal Ointment[5]	Mometasone nasal spray (50mcg spray)[15]

* If prescribing for Strongyloides or scabies, consider referral to Environmental Health Services

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Eye Preparations

Class	Essential List	Supplementary List
Allergic and Inflammatory Eye conditions	Ketotifen eye drops[9]	
Anti-infectives	Chloramphenicol (drops & ointment) CiPROFLOXAcin (0.3% eye drops)[2]	Aciclovir (3% eye ointment)
Glaucoma	Latanoprost (0.005% eye drops) Timolol (0.5% eye drops)	
Lubricants	Polytears® Viscotears®	
Others	Fluorescein Minims (1% eye drops) Phenylephrine Minims (2.5% eye drops) Prednefrin Forte® (eye drops) Tropicamide Minims (1% eye drops)	

Vitamins/supplements

Class	Essential List	Supplementary List
Vitamins/supplements	Colecalciferol (D3) (1000iu tab) (Ostevit® tab)[5] Folic acid (0.5mg, 5mg tab) Hydroxocobalamin (Neo-B12® inj) Iodine - Folic Acid (Blackmores I-Folic®)[5] Magnesium aspartate (500mg 50 tab) Potassium chloride (600mg tab) Sodium bicarbonate (840mg caps)[1] (Sodibic®) Thiamine (100mg tab)	Calcium Carbonate (equiv.Ca.600mg Calci-Tabs 600®)
Drugs for Hyperkalaemia	Sodium Resonium powder (Resonium A)*[9]	
Iron Preparations	Ferric Carboxymaltose (500mg inj)[9] Ferro-liquid® elixir Ferrous Fumarate (200mg tab) (65mg elemental iron)[6] FerrumH®/ Ferrosig® inj[1]	

*Calcium carbonate (Calci-tabs) are S100 for hyperphosphataemia associated with chronic renal failure;
*To be kept at non-town based clinics (i.e. sites remote from hospital) for initial management of hyperkalaemia pending evacuation

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Dermatologicals

Class	Essential List	Supplementary List
Topical Corticosteroids	Hydrocortisone (1% cream, oint 50g) Betamethasone Diproprionate (0.05% cream, ointment 15g) Mometasone (0.1% lotion) Adapalene 0.1% + Benzoyl peroxide 2.5% Gel (Epiduo®)Gel) Methylprednisolone 0.1% cream (Avantan®) Methylprednisolone 0.1% Fatty Ointment (Advantan)[12]	Betamethasone valerate (0.02% cream, oint. 100g) Calcipotriol/Betamethasone (Daivobet 50/500 oint) [0]
Others		

Immunosuppressants

Class	Essential List	Supplementary List
Immunosuppressants	Prednisolone (5mg, 25mg tab, 5mg/mL liquid)	AzATHIOPRINE (50mg tab) Prednisolone (1mg tab)

Smoking Cessation Therapy

Class	Essential List	Supplementary List
Oral Therapy	Varenicline (0.5mg, 1mg tab)[4] Nicotine Chewing Gum (2mg, 4mg)[3]	
Transdermal Therapy	Nicotine Patch 25mg/16 Hrs (28 patch /box)[5] Nicotine Patch, 21mg [6] (28 patch /box)[8]	Nicotine Patches 7mg, 14mg (28 patch /box)

Antihistamines

Class	Essential List	Supplementary List
Antihistamines	Loratadine (1mg/ml syrup)[12] Loratadine (10mg tab)[3] ProMETHazine (10mg ,25mg tabs) [1]	ProMETHazine (5mg/5ml liquid)[12]

NDSS

Class	Essential List	Supplementary List
Meters	Contour Optium Freestyle (If Monitoring Ketones)[15]	
BG Test strips	Contour Optium Freestyle[15]	
Lancets	Accu-Chek Safe-T Pro disposable lancets[15]	

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Emergency Drug List

Essential List	Supplementary List
TOWN-BASED CLINICS (i.e. hospital access 5mins and no after hours emergency care) are not required to keep all listed essential drugs. The decision for which emergency drugs to be kept should be made by the representative SMO for each clinic[7]	Bupivacaine 0.5% (Coastal communities – marine envenomations)
Acetylcysteine 6g/30ml inj[16] Adenosine 6mg/2ml ampoules[11] Adrenaline (epinephrine) 1:10,000 minijet Adrenaline (epinephrine) 1:1000 ampoules[11] AmiODAROne IV 150mg/3ml[6] inj Ampicillin 1g inj[3] Aspirin 300mg disp tab Atropine 600mcg/ml inj Benztropine 2mg/2ml inj Benzyl penicillin 600mg inj[3] Betamethasone 5.7mg/ml inj Calcium gluconate 10% inj Cefepime 2g inj [17] CefTRIAXONE 500mg and lg inj[2] CephaZOLin 1g and 2g inj[10] Charcoal, activated (without sorbitol) 50g (300ml) Dextrose 50% 50ml inj Dexamethasone 4mg tab[16] Dexamethasone 4mg/ml inj[15] Droperidol 2.5mg/ml inj[14] Flucloxacillin 1g inj Flumazenil 0.5mg/5ml inj Furosemide (frusemide) 20mg/2ml inj Gentamicin 80mg/2ml inj Glucagon pen Glucose oral gel GTN patch 5mg GTN spray 400mcg Haloperidol 5mg/ml inj Heparin injection 5000U/5ml amps[11] HydrALAZINe 20mg inj[3] Hydrocortisone 100mg/2ml powder for inj Indomethacin supp 100mg Ipratropium neb 500mcg KetOROLAC 10mg inj[4] Levetiracetam 500mg/5ml inj Lidocaine (lignocaine) 1% (50mg/5mL) inj Lignocaine 1% with Adrenaline 1:1000 inj[16] Magnesium Sulphate 2.47g/5mL[3] Metaraminol 5mg/10ml inj[11] Methoxyflurane inhalation soln (Penthrox®)[7] Metoclopramide 10mg/2ml inj Metronidazole 500mg/100ml IV infusion[16] Midazolam 5mg/ml inj Misoprostol 200mcg tabs[3] Morphine 10mg/ml inj* Naloxone 400mcg/ml inj 1mL syringe (Mini-jet)[7] Noradrenaline 4mg inj[17] Pantoprazole 40mg inj[17] Paracetamol supp 125mg Phenobarbitone 200mg/ml inj Phenytoin IV 250mg/5ml inj[6] Phytomenadione 2mg/0.2ml inj Potassium Chloride 10mmol 100ml bag[16] Salbutamol neb 5mg/2.5ml Sodium bicarbonate 8.4% 50mL[7] Sodium Chloride with Glucose (0.45% & 2.5%) 500ml Sodium Chloride 0.9% 10ml inj Sodium Chloride 0.9% 500ml sUMATRIPTAn nasal spray 20mg/0.1ml Tranexamic Acid 500mg/5ml ampoules[11] Vancomycin 500mg inj (peritonitis in patients on CAPD)[3] Vecuronium 10mg[6] Water injection BP	**High Risk Intubation Drugs** (*Essential but see criteria below*)[7] Ketamine 200mg/2mL[7*] Suxamethonium 100mg/2ml[6*] Vecuronium 10mg[6] For storage and use only if the following criteria are met; i) Ketamine is licensed to be kept under the current poisons permit for the AHS ii) The standards of S8 storage are met iii) There is safe and appropriate storage available including a lockable fridge for suxamethonium iv) A protocol is in place for their use v) Clinic staff training/education is current for their use **Emergency Obstetric Drugs** (*Essential*)[7] Syntocinon 10 IU inj Syntometrine (oxyctocin 5IU & ergometrine 500mcg) inj[3] Misoprostol 200mcg tabs[3] Salbutamol Obstetric 5mg/5ml inj[2] Magnesium sulphate 2.5g/5mL NiFEDIPine 10mg tab (SAS) **Emergency Palliative Care Drugs** (*Essential*) Midazolam 5mg/ml inj Haloperidol 5mg/ml inj Metoclopramide 10mg/2ml inj Hyoscine 20mg/ml inj Morphine 10mg/ml in* Fentanyl 100mcg/2ml inj* Hydromorphone 2mg/ml, 10mg/ml inj*[16]

* Must be ordered by prescription

[1] Amended/Added August 2006, [2] Amended/Added May 2007, [3] Amended/Added June 2008, [4] Amended/Added June 2009, [6] Amended/Added October 2011, [7] Amended/Added Nov 2013, [8.] Amended/Added Nov 2014, [9.] Amended/Added Nov 2016, [10.] Amended/Added Oct 2016, [11] Amended/Added Nov 2017, [15] Amended/Added Nov 2020, [16] Nov 2021, [17] Nov 2022

Vaccines

Adult Diptheria & Tetanus (ADT®)

Supplementary Non-Prescription Medicines

Auralgan ear drops
Cerumol®
Cetomacrogol cream (Sorbolene cream)
Clotrimazole 3 day cream
Clotrimazole 500mg pessaries
Emla® cream/Patches
Ichthammol
Methyl salicylate liniment Magnoplasm®
Metsal®/Dencorub®/ Deep Heat®
Multivitamin
Oil of Cloves
Pholcodine Linctus
Povidone iodine 10% antiseptic solution
Proctosedyl® ointment
Senega and Ammonia mixture
SM33 gel®
Sodium chloride nasal spray
Solosite® gel
Ural®
Vicks Vapour rub
Xylocaine® Viscous
Zinc and castor oil cream

Drug Transfer Protocols

Drug Transfer Protocols have been included as a guide only and require that users exercise independent professional judgment, at all times.

The drug transfer protocols represent the consensus of the Standard Drug List working party and while every effort has been made to ensure information is in accordance with current recommendations, there may be sound clinical reasons for alternative dose transfers.

All alterations in drug therapy are ultimately at the discretion of the Local Medical Officers.

All drug transfers should be accompanied with appropriate monitoring of clinical response and tolerability. Suggested monitoring has been provided for each class. However, in the presence of different drug therapies and health conditions, more stringent monitoring requirements may apply.

Medication management is a dynamic process and as drug information continues to expand, recommendations and guidelines will also change. Professional judgment in the context of current clinical practice is recommended.

Switching Ace-inhibitors

Change to → Change from ↓	Enalapril (Once daily dosing)	Quinapril (Once daily dosing)	Ramipril (Once daily dosing)
CaPTOPRil			
CaPTOPRil 12.5mg daily	Enalapril 2.5mg[1]	Quinapril 2.5mg	Ramipril 1.25mg
CaPTOPRil 25mg daily	Enalapril 5mg[1]	Quinapril 5mg	Ramipril 1.25-2.5mg
CaPTOPRil 50mg daily	Enalapril 7.5mg[1]	Quinapril 10mg	Ramipril 2.5-5mg
CaPTOPRil 100mg daily	Enalapril 20mg[1]	Quinapril 20mg	Ramipril 5-10mg[2]
CaPTOPRil 150mg daily	Enalapril 40mg	Quinapril 40mg	Ramipril 10mg
Fosinopril			
Fosinopril 5mg daily	Enalapril 5mg	Quinapril 5mg	Ramipril 1.25mg
Fosinopril 10mg daily	Enalapril 10mg	Quinapril 10mg	Ramipril 2.5mg
Fosinopril 20mg daily	Enalapril 20mg	Quinapril 20mg	Ramipril 5mg
Fosinopril 40mg daily	Enalapril 40mg	Quinapril 40mg	Ramipril 10mg
Lisinopril			
Lisinopril 5mg daily	Enalapril 5mg	Quinapril 5mg	Ramipril 1.25mg
Lisinopril 10mg daily	Enalapril 10mg	Quinapril 10mg	Ramipril 2.5mg
Lisinopril 20mg daily	Enalapril 20mg	Quinapril 20mg	Ramipril 5mg
Lisinopril 40mg	Enalapril 40mg	Quinapril 40mg	Ramipril 10mg
Perindopril			
Perindopril 2mg daily	Enalapril 5-10mg	Quinapril 5-10mg	Ramipril 2.5mg
Perindopril 4mg daily	Enalapril 10mg-20mg	Quinapril 10mg-20mg	Ramipril 5mg
Perindopril 8mg daily	Enalapril 20-40mg	Quinapril 20-40mg	Ramipril 10mg
Trandolapril			
Trandolapril 0.5mg d	Enalapril 5mg	Quinapril 5mg	Ramipril 1.25mg
Trandolapril 1mg daily	Enalapril 10mg	Quinapril 10mg	Ramipril 2.5mg
Trandolapril 2mg daily	Enalapril 20mg	Quinapril 20mg	Ramipril 5mg
Trandolapril 4mg daily	Enalapril 40mg	Quinapril 40mg	Ramipril 10mg

1: Doses have been rounded to nearest convenient dose form. A dose equivalency between enalapril:caPTOPRil of 1:7.5 is suggested for the treatment of hypertension. (Micromedex Healthcare series, Vol 119)

2: Ramipril 5-10mg daily is considered equivalent to CaPTOPRil 50mg bd for the treatment of hypertension (Micromedex Healthcare series, Vol 119)

There are few studies comparing equivalent doses of ACE-inhibitors, for specific indications. Therefore, the above recommendations are based on clinical experiences and are not specific for any indication.

Monitoring requirements when switching ACE-inhibitors

- Serum Potassium levels
- Renal function (Creatinine clearance)
- Blood pressure
- Care should be taken in patients on diuretic therapy (monitor for hypotension).

Dosage range for ACE-Inhibitors[3]

CaPTOPRil	12.5 – 150mg daily (in 2 or 3 divided doses)
Enalapril	2.5 – 40mg daily
Fosinopril	5 – 40mg daily
Lisinopril	2.5 – 40mg daily
Perindopril	2 – 8mg daily
Quinapril	2.5 – 40mg daily
Ramipril	1.25 – 10mg daily
Trandolapril	0.5 – 4mg daily

3: Cardiovascular Therapeutic Guidelines, 2003.

ALWAYS INITIATE THERAPY WITH LOW DOSE

Switching AII-Antagonists

Change to → Change from ↓	Irbesartan (Once daily doses)
Candesartan	
Candesartan 4mg daily	Irbesartan 75mg
Candersartan 8mg daily	Irbesartan 150mg
Candersartan 16mg daily	Irbesartan 300mg
Eprosartan	
Eprosartan 400mg daily	Irbesartan 75mg
Eprosartan 600mg daily	Irbesartan 150mg
Eprosartan 800mg daily	Irbesartan 300mg
Losartan	
Losartan 50mg daily	Irbesartan 75mg
Losartan 100mg daily	Irbesartan 150mg[4]
Telmisartan	
Telmisartan 40mg daily	Irbesartan 150mg
Telmisartan 80mg daily	Irbesartan 300mg

There are few studies to compare equivalent doses of AII-Antagonists, for specific indications. Therefore, the above recommendations are based on clinical experiences and are not specific for any indication.

Dosage range[5]

Candesartan	8 – 16mg daily
Eprosartan	400 - 800mg daily
Irbesartan	75mg - 300mg daily
Losartan	25mg - 100mg daily
Telmisartan	20 - 80mg daily

Monitoring requirements when switching AII-Antagonists

- Serum Potassium levels
- Renal function (Creatinine clearance)
- Blood pressure

4: One study has shown irbesartan 300mg once daily to be superior to both irbesartan 150mg and losartan 100mg, once daily while the later 2 treatments did not differ in response (Micromedex Healthcare series, Vol 119).
5: Comparative Dosage Table – Angiotensin II Receptor Antagonists (Micromedex Healthcare series, Vol 119)

Switching Calcium channel blockers

Change to → Change from ↓	amLODIPine (Once daily doses)	NiFEDIPine oros (Once daily doses)
Felodipine		
Felodipine 2.5mg daily	amLODIPine 2.5mg	
Felodipine 5mg daily	amlodpine 5mg	niFEDIPine oros 30mg daily
Felodipine 10mg daily	amLODIPine 10mg	niFEDIPine oros 60mg daily
Lercanidipine		
Lercanidipine 10mg	amLODIPine 5mg	niFEDIPine oros 30mg daily
Lercanidipine 20mg	amLODIPine 10mg	niFEDIPine oros 60mg daily

There are few studies to compare equivalent doses of calcium channel blockers, for specific indications . Therefore, the above recommendations are based on clinical experiences and are not specific for any indication.

Dosage range

amLODIPine	2.5-10mg daily
Felodipine	2.5-10mg daily
Lercanidipine	10-20mg daily

Monitoring requirements when switching calcium channel blockers

- Blood pressure
- Monitor for peripheral oedema

NB: amLODIPine has a comparatively slower onset of action.

Switching Statins

Change to → Change from ↓	Simvastatin	Atorvastatin
Pravastatin		
Pravastatin 10mg daily	Simvastatin 10mg daily	Atorvastatin 10mg daily
Pravastatin 10mg – 20mg daily	Simvastatin 20mg daily	Atorvastatin 20mg daily
Pravastatin 20mg daily	Simvastatin 40mg daily	Atorvastatin 40mg daily
Pravastatin 40mg daily	Simvastatin 80mg daily	Atorvastatin 80mg daily
Fluvastatin		
Fluvastatin 20mg daily	Simvastatin 10mg-20mg daily	Atorvastatin 10mg - 20mg daily
Fluvastatin 40mg daily	Simvastatin 20mg-40mg daily	Atorvastatin 20mg - 40mg daily
Fluvastatin 80mg daily	Simvastatin 80mg daily	Atorvastatin 80mg daily

This conversion chart is based on recommended statin doses for the treatment of hypercholesterolemia and does not take into account variants within the lipid profile.

Monitoring requirements when switching Statins

- Liver function tests (ALT, AST) before switching therapy and at 1 month after switching.
- Creatine kinase (CK). In patients who are also taking a fibrate, CK should be monitored as per the Lipid Management Guidelines 2001 (with the 1st 6 weeks and then at 6-monthly intervals).
- Lipid profile.
- Symptomatic monitoring: myalgia, myopathy.
- INR in patients on warfarin (Simvastatins may increase the INR).

Dosage range

Atorvastatin	10mg-80mg daily
Fluvastatin	20mg-80mg daily
Pravastatin	10mg-40mg daily
Simvastatin	10mg-80mg daily

Switching Sulphonylureas

Change to → Change from ↓	gliCLAZide 80mg	gliCLAZide MR 30mg*
gliBENCLAMide		
gliBENCLAMide 2.5mg bd	gliCLAZide 40mg bd	gliCLAZide MR 30mg daily
gliBENCLAMide 5mg bd	gliCLAZide 80mg bd	gliCLAZide MR 60mg daily
gliBENCLAMide 10mg bd	gliCLAZide 160mg bd	gliCLAZide MR 120mg daily
gliMEPIRide		
gliMEPIRide 1mg daily	gliCLAZide 40mg bd	gliCLAZide MR 30mg daily
gliMEPIRide 2mg daily	gliCLAZide 80mg bd	gliCLAZide MR 60mg daily
gliMEPIRide 3mg daily	gliCLAZide 120mg bd	gliCLAZide MR 90mg daily
gliMEPIRide 4mg daily	gliCLAZide 160mg bd	gliCLAZide MR 120mg daily
gliPIZide		
gliPIZide 5mg bd	gliCLAZide 40mg bd	gliCLAZide MR 30mg daily
gliPIZide 10mg bd	gliCLAZide 80mg bd	gliCLAZide MR 60mg daily
gliPIZide 20mg bd	gliCLAZide 160mg bd	gliCLAZide MR 120mg

*One 80mg gliCLAZide tablet is equivalent to one 30mg gliCLAZide MR tablet.

Monitoring requirements when switching sulphonylureas

- BSL
- HbA1c
- Monitor for symptoms of hypoglycaemia (tremor, sweating, intense hunger, light-headedness)
- Weight gain

Dosage range

gliBENCLAMide	2.5–20mg daily in 2 divided doses
gliCLAZide	40–320mg daily in 2 divided doses
gliCLAZide MR	30–120mg daily
gliMEPIRide	1–4mg daily
gliPIZide	5–40mg daily in 2 divided doses

Switching Proton-pump inhibitors

Change to → Change from ↓	Omeprazole (once daily)
Esomeprazole[7]	
20mg daily	20mg daily
40mg daily	40mg daily
Lansoprazole	
15mg daily	10mg daily
30mg daily	20mg daily
Pantoprazole	
20mg daily	10mg daily
40mg daily	20mg daily
RABEprazole	
10mg daily	10mg daily
20mg daily	20mg daily

There is limited literature on equivalent doses of proton pump inhibitors. This table is an estimate of comparative doses and therefore, appropriate monitoring should accompany any switch in proton pump inhibitor.

Monitoring requirements when switching proton pump inhibitors

- Omeprazole is an inhibitor of Cytochrome P450 and can therefore interact with the following drugs[8]:
  - **Warfarin:** increased warfarin levels. Monitor INR.
  - **Phenytoin:** increased phenytoin concentration. Monitor phenytoin concentrations.
  - **Benzodiazepines:** increased benzodiazepine concentrations. Monitor benzodiazepine effect.
- Monitor clinical response.

Dosage range

Esomeprazole	20mg – 40mg daily
Lansoprazole	15mg – 60mg daily
Omeprazole	10mg – 40mg daily
Pantoprazole	20mg – 40mg daily
RABEprazole	20mg – 40mg daily

7: Acid suppression studies show that esomeprazole has superior efficacy to omeprazole. 8: Australian Medicines Handbook. 2000.

Switching Contraceptives

Monofeme® (30mcg ethinyloestradiol & 150mcg levonorgestrel) is the combined oral contraceptive of choice in the Kimberley.

Changing from another combined oral contraceptive to Monofeme®[13]

Women changing from another combined oral contraceptive product should start Monofeme 28 on the day after the last active tablet of her previous combined oral contraceptive, by taking the first tablet corresponding to that day of the week from the shaded section of the package. This will shorten the last cycle of the previous combined oral contraceptive, and may prevent or reduce withdrawal bleeding at the end of that cycle. The first cycle with Monofeme 28 may also be shorter.

During the first Monofeme 28 cycle, a nonhormonal backup method of contraception (other than the rhythm or temperature methods) should be used until one active tablet has been taken daily for seven consecutive days.

If transient spotting or breakthrough bleeding occurs, the woman is instructed to continue the regimen since such bleeding is usually without significance. If the bleeding is persistent or prolonged, the woman is advised to consult her doctor.

Changing from a progesterone only method (tablet, injection, implant) to Monofeme®[14]

Women may switch any day from the progestogen only tablet and should begin Monofeme 28 the next day. She should start Monofeme 28 on the day of an implant removal or, if using an injection, the day the next injection would be due. In all these situations, women should be advised to use a nonhormonal backup method of contraception (other than the rhythm or temperature methods) until one active tablet has been taken daily for seven consecutive days.

13: EMIMS Australia (1st February 2004 – 30th April 2004).

Switching inhaled corticosteroids

Change to → Change from ↓	Fluticasone (Total Daily dose)
Beclomethasone (CFC containing): Becotide®, Becloforte®	
200-250mcg	100mcg
400-500mcg	200-250mcg
800-1000mcg	400-450mcg
1200-1500mcg	600-750mcg
1600-2000mcg	1000mcg
Beclomethasone (CFC-free)[14]: QVAR®	
100mcg	100mcg
200mcg	200-250mcg
400mcg	400-450mcg
600mcg	600-750mcg
800mcg	1000mcg
BuDESONide[15]	
200mcg daily	100mcg
400mcg	200-250mcg
800mcg	400-450mcg

NB: This table has been modified from QVAR® Product information (EMIMS Exp Apr 04).

Fluticasone has been included on the essential drug list in both the accuhaler dose form and the metered dose inhaler.

Monitoring requirements for patients transferring to fluticasone

- Monitor inhaler technique, particularly if a new device is being introduced.
- Clinical response to therapy (symptom severity, PEF).
- Usage rates of reliever medication.

Dosage range

	Fluticasone	BuDESONide	Beclomethasone
Mild asthma	100-250mcg bd		
Moderate asthma	250mcg bd	100-400mcg bd	50-200mcg bd
Severe asthma	500mcg bd	up to 800mcg daily	up to 400mcg bd

14: CFC-free preparations are now the only preparations of beclomethasone available on the market and the PBS. CFC-free preparations of beclomethasone (QVAR®) are considered more potent than CFC-containing preparations (Becotide®, Becloforte®).
15: Fluticasone has approximately twice the potency of buDESONide (Asthma Management Handbook 2002).

Anticoagulants

There are two brands of warfarin on the market and they are:

- CoUMADIN® (1mg, 2mg, 5mg)
- Marevan® (1mg, 3mg, 5mg)

These brands are not considered bioequivalent and therefore should not be used interchangeably.

Marevan® is the brand that is has been included on the essential drug list and therefore should be stocked in the clinic.

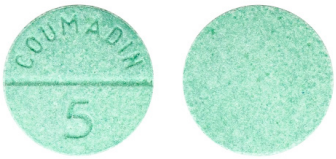
Transfering patients from CoUMADIN® to Marevan®:

- The dose transfer is 1mg CoUMADIN®:1mg Marevan®.
- Clinicians should check INR one week after transfer and subsequently, as required, to achieve appropriate INR.

When considering the use of warfarin, the following issues should be considered:

- Warfarin has a delayed onset of action and peak effect of a dose is not seen for 2-3 days.
- CoUMADIN® and Marevan® tablets are different in appearance and colour and therefore may cause patient and clinician confusion.
- Many drugs interact with warfarin and continued care with drug combinations is recommended.

Anticoagulants

CoUMADIN®16	Marevan®
	
CoUMADIN 1mg (Brown)	Marevan 1mg (Brown)
	
CoUMADIN 2mg (Mauve)	Marevan 3mg (Blue)
	
CoUMADIN 5mg (Green)	Marevan 5mg (Pink)

Psychotropic Prescribing Guidelines

The Standard Drug List provides clinicians with a guide to the availability of medicines in the Kimberley and has been designed to ensure best practice care is available to as many Kimberley residents as possible.

There are a number of factors to consider when managing psychotropic therapy:

1. Initiating psychotropic therapy:

   The KSDL committee recommends new patients are started on psychotropic drugs listed in the KSDL.

2. Contraindicated or unsuccessful treatment with KSDL therapies:

   If all agents from the KSDL have been tried successfully, other agents may be prescribed.

3. Continuing established psychotropic therapy:

   In contrast to all other drugs in the KSDL, switching psychotropics may not be appropriate for stabilised patients. Although there is little variability in efficacy between drugs within a class, individual patient responses may vary. Therefore if a patient has shown improvement and is stable on a certain agent, clinical judgement should be exercised before changes are made. Factors such as the severity of illness should be considered.

4. Supply arrangements:

   Where patients are to remain on psychotropic medications that are not on the KSDL, providing support with prescription supply may be required. For some patients, this may mean the health service provides assistance with prescription co-payments.

When making decisions about the prescribing psychotropic therapy, clinicians should consider the following:

- Clinical response to previous therapy
- Concurrent medical and psychiatric illnesses
- Patient acceptability
- Patient tolerability of prior treatment
- Drug interaction potential
- Side effect profile
- Patient compliance
- Dependence and tolerance
- Long term treatment plan for patient.

Consultation with North West Mental Health clinicians is welcomed.

Contact details:

Broome Office:	(08) 9192 3322
Derby Office:	(08) 9193 1633
Kununurra Office:	(08) 9168 3055

Psychotropic Prescribing Guidelines

Change to → Change from ↓	Citalopram	Venlafaxine
fluoxetine	Cease fluoxetine for 1 week prior to commencing citolapram. Tapering of fluoxetine dose is required prior to cessation.	Cease fluoxetine for 1 week prior to commencing venlafaxine. Tapering of fluoxetine dose is required prior to cessation.
Citalopram, fluVOXAMine, PARoxetine,SERTRALine, nefazodone, mianserin, mirtazepine	Cease 2–4 days prior to commencing citolapram.	Cease 2–4 days prior to commencing venlafaxine.
TCA's[11]	Cease TCA 2–4 days prior to commencing citolapram.[11]	Cease TCA 2–4 days prior to commencing venlafaxine.[11]
Moclobemide	Cease moclobemide 1–2 days prior to commencing citolapram.[12]	Cease moclobemide 1–2 days prior to commencing venlafaxine.[12]
Reboxetine	Cease reboxetine 1–2 days prior to commencing citolapram.	Cease reboxetine 1–2 days prior to commencing venlafaxine.
Venlafaxine	Cease venlafaxine 1–2 days prior to commencing citolapram.	-
Irreversible nonselective MAOI	Cease 2 weeks prior to commencing citolapram.	Cease 2 weeks prior to commencing venlafaxine.

Note: The risk of adverse effects needs to be weighed against the risk of undue delay in each individual case.

This table has been adapted from 'Antidepressant-free intervals recommended when changing from one antidepressant to another' (Psychotropic Therapeutic Guidelines, 2003).

10: fluoxetine has a longer half-life than other SSRIs, leading to meaningful levels of fluoxetine or its active metabolite being present for about 5 weeks after cessaion.
11: TCA concentrations may be elevated for at least several weeks due to persisting SSRI-induced cytochrome P450 inhibition.
12: Hall, M. Serotonin Syndrome. Aust Prescr 2003;26(3):62-3.13 EMIMS Australia (1st February 2004 – 30th April 2004).

Monitoring requirements when changing antidepressants

1. The wash out period between antidepressants is required to avoid serotonin syndrome. Serotonin syndrome is described as a toxic state caused mainly by excess serotonin within the central nervous system and is nearly always caused by a drug interaction involving 2 or more serotonergic drugs (see below).[12]

Symptoms of serotonin syndrome include:

- Abdominal cramps
- Agitation
- Diarrheoa
- Myoclonus
- Tremulousness
- Coma
- Tachycardia
- Hypotension
- Confusion
- Disorientation
- Profuse sweating
- Hyperpyrexia

Patients should be encouraged to report any of these symptoms.

2. Choice of antidepressant medication should be made on the basis of individual patient acceptability, clinical response, prior drug responses and tolerability and individual drug side effect profile.
3. Citolapram and Venlafaxine are weak inhibitors of CYP2D6. Care should be taken when initiating citolapram or venlafaxine in the presence of drugs that are metabolized by CYP2D6.

12: Hall, M. Serotonin Syndrome. Aust Prescr 2003;26(3):62-3.13 EMIMS Australia (1st February 2004 – 30th April 2004).

Footnotes

[1] Doses have been rounded to nearest convenient dose form. A dose equivalency between enalapril:caPTOPRil of 1:7.5 is suggested for the treatment of hypertension. (Micromedex Healthcare series, Vol 119).

[2] Ramipril 5-10mg daily is considered equivalent to CaPTOPRil 50mg bd for the treatment of hypertension (Micromedex Healthcare series, Vol 119).

[3] Cardiovascular Therapeutic Guidelines, 2003.

[4] One study has shown irbesartan 300mg once daily to be superior to both irbesartan 150mg and losartan 100mg, once daily while the later 2 treatments did not differ in response (Micromedex Healthcare series, Vol 119).

[5] Comparative Dosage Table – Angiotensin II Receptor Antagonists (Micromedex Healthcare series, Vol 119).

[6] Australian Medicines Handbook, 2000.

[7] Acid suppression studies show that esomeprazole has superior efficacy to omeprazole.

[8] Australian Medicines Handbook, 2000.

[9] WADTC. Rationale for Antipsychotic Drug Guidelines.

[10] fluoxetine has a longer half-life than other SSRIs, leading to meaningful levels of fluoxetine or its active metabolite being present for about 5 weeks after cessation.

[11] TCA concentrations may be elevated for at least several weeks due to persisting SSRI-induced cytochrome P450 inhibition.

[12] Hall, M. Serotonin Syndrome. Aust Prescr 2003;26(3):62-3.

[14] CFC-free preparations are now the only preparations of beclomethasone available on the market and the PBS. CFC-free preparations of beclomethasone (QVAR®) are considered more potent than CFC-containing preparations (Becotide®, Becloforte®).

[15] Fluticasone has approximately twice the potency of buDESONide (Asthma Management Handbook 2002).

[16] MIMS Australia (1st February 2004 – 30th April 2004).

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kahpf.org.au/standard-drug-list/