

# Medical Clinician view of QH SDL

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# Background

- QH SDL significantly smaller formulary than PBS
- For many drug classes, similar clinical outcomes (eg ACE inhibitors, PPI) so minimise drug duplication
- Maintain “non-interchangeable” drugs eg different brands of warfarin & cyclosporin
- Some accepted “high cost drugs” have their use supported by auditable local MS (or delegate) approval protocols
- Eg. Gabapentin for neuropathic pain, activated protein C for severe sepsis, methylphenidate LA

# Structure of Drug Access

- Mechanisms exist for access to drugs beyond the SDL but the majority of use restricted to QH SDL
- IPA guidelines developed centrally & disseminated statewide (eg cinacalcet, Factor VII for major haemorrhage, Parecoxib)
- Some large hospitals – High Cost Drug Evaluation groups for individual patient requests (inter-communicate to maintain access equity)

# Benefits

- Equity of drug access
- Limits duplication of resources (particularly, assessment process)
- Ease of use & education of staff (particularly for junior staff)
- Re-distribution of stock for uncommon emergency use (eg artesunate for malaria)
- Optimal use of limited physical stock space
- Mechanism remains for non-SDL use

# Risks & Frustrations

- Continuity of therapy
- Approval process for non-SDL drugs (especially for drugs on PBS but not the SDL eg riluzole for MND, some combination anti-Parkinsonian meds)
- Re-education of staff when new drug for that class accepted on tender (eg 3 years ago when changed from pantoprazole to omeprazole)

# Conclusion

- Personal bias favouring statewide versus individual hospital formulary
- Benefits of unifying the drug approval & accessibility process outweigh the risks & frustrations
- Particular strengths – equitable drug access & minimizing duplication
- Some limitations that require cultural change