

Prescribing Hints & Tips

November 2025

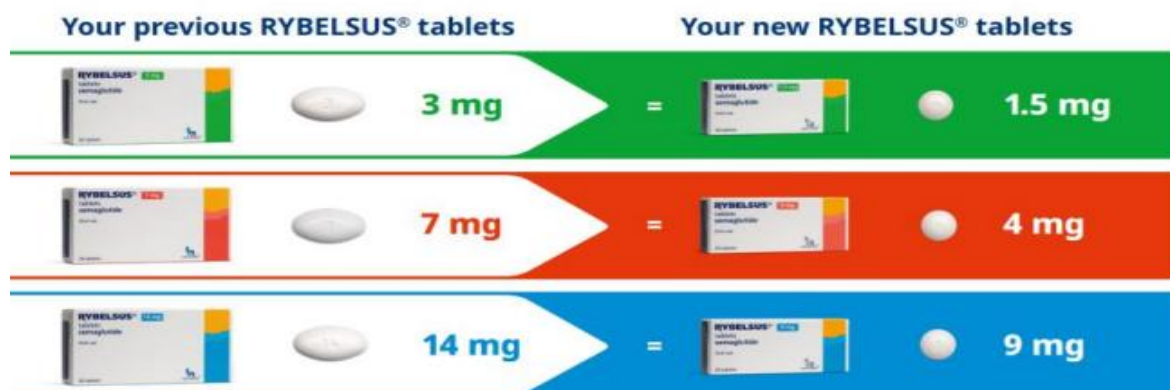
RYBELSUS® (ORAL SEMAGLUTIDE) – A NEW FORMULATION TO REPLACE THE CURRENT FORMULATION

Rybelsus is an oral GLP1 agonist, which can be prescribed on specialist recommendation as add on therapy in line with Nottinghamshire diabetes guidelines.

A new formulation of Rybelsus is now available (1.5 mg, 4 mg, 9 mg tablets) to prescribe on SystmOne and will shortly be available on Emis Web (Nov 25).

The SystmOne formulary and Optimise Rx have been updated.

This new formulation has increased bioavailability versus the original formulation resulting in smaller packaging and doses. The new tablets are smaller and round, while the old ones were oval. The current formulation (3 mg, 7 mg, 14 mg tablets) is being phased out and expected to be unavailable from early 2026.



Practices should take a proactive approach to this reformulation of Rybelsus to prevent medication errors and manage the transition smoothly as the two formulations will temporarily coexist.

Practices should aim to:

- Start all new patients on the new formulation.
- Liaise with local pharmacies regarding current stock and make all practice staff aware.
- Switch current patients from the initial formulation to the new lower bioequivalent dose.
- Review compliance and dosing with patients and reinforce administration technique i.e. take one tablet once a day on an empty stomach with up to 120ml of water and wait at least 30 minutes before eating, drinking, or taking other oral medication.

• Provide/direct to product information e.g. Patient Information Leaflet
<https://www.medicines.org.uk/emc/rmm/105214/Document?UNLID=47500983820251117213526>

- Adverse Event Reporting: Encourage patients and staff to report any side effects or medication errors. Forms and information can be found at [Yellow Card](#).

URGENT SAFETY NOTICE – FREESTYLE LIBRE® 3 AND FREESTYLE LIBRE® 3 PLUS SENSORS

Abbott, the manufacturer of Freestyle Libre® 3 and Freestyle Libre® 3 Plus sensors, have recently identified that some of the sensors may be providing incorrect low glucose readings. Abbott are attempting to notify patients but are also asking that anyone involved in the prescribing of these devices also notifies their patients of the issue. Please find attached to this bulletin the full information from Abbott about how patients can check if they have an affected sensor and what action to take.

IBANDRONIC ACID 150MG TABLETS – SUPPLY NOTIFICATION

Ibandronic acid 150mg tablets, the only licensed once monthly bisphosphonate, are in limited supply until March 2026. Alendronic acid 70mg tablets and risedronate sodium 35mg tablets (once weekly bisphosphonate presentations) remain available and can support increased demand.

Clinicians should not initiate new patients on ibandronic acid 150mg tablets until the supply issue has resolved.

Where existing patients have insufficient supply to last until the resupply date, clinicians should review patients as per the information in [The Medicines Supply Notification](#).

LIQUID MORPHINE (ORAMORPH®) PRESCRIBING ERROR:

- There has been a local incident where **Oramorph® concentrate (20 mg/ml)** was wrongly selected instead of the standard **10 mg/5 ml** preparation.
- The concentrate is **10 times stronger**, which creates a serious risk of overdose.
- Fortunately, the patient was not opioid naïve and came to no harm.
- OptimiseRx has been updated to ensure a warning message triggers every time the concentrate is prescribed.

NEW: DEPRESCRIBING TOOL GUIDE

Reducing polypharmacy remains a critical priority in improving patient safety, minimising medication-related harm, and enhancing quality of life—particularly for those with multimorbidity or frailty. Structured Medication Reviews (SMRs) offer a valuable opportunity for GPs and practice pharmacists to take a proactive, person-centred approach to deprescribing, ensuring that every medicine has a clear, ongoing indication and benefit.

To support this, we've developed a practical '[Deprescribing Tool Guide](#)' designed to navigate the many tools available and help identify and safely reduce unnecessary or potentially harmful medications. In addition, our recently updated [SMR Best Practice Standards](#) provides practical and evidence-based strategies to optimise the SMR process. Both resources will be available on our APC website to support your clinical decision-making and enhance patient outcomes.

DIRECTION TO ADMINISTER FORMS UPDATE – (PREVIOUSLY KNOWN AS COMMUNITY NURSING FORMS)

We would like to thank everyone for implementing the use of Direction to Administer (DA) forms which have already demonstrated significant benefits such as timely patient

care, reducing risk of patient harm, saving of staff time and environmental benefits in terms of decreased fuel use.

Useful reminders to prevent delays in patient care are:

1. Ensure the DA forms on SystmOne are saved as 'final'. The governance policy for community nurses to administer medicines specifies that the form must be the final version, so that no further edits can be made.
2. Include GMC/registration number so that nurses can verify prescriber registration.
3. Inform the nursing team that a new DA has been completed when medication or dosing schedule has been changed.

A new feature has been introduced to improve clarity on the use of DA forms. The **Discontinued DA form** feature allows the clear labelling of forms that are no longer in use due to a medication or dose change. The aim is to streamline navigation to help ensure that teams are working with the most current forms.

How to guides are linked here for [EMIS](#) and [SystmOne](#) practices.

Please note that all resources related to DA forms can be found on the [Nottinghamshire APC page](#).

The Direction to Administer group continues to meet regularly to review progress and suggestions for improvements. We welcome your feedback at nnicb-nn.medsman@nhs.net

APC AND INTERFACE UPDATE

The latest updates from APC can be found on their website [here](#).

MAILING LIST

If you wish to be added or removed from the Prescribing Hints and Tips mailing list, please email e.moncrieff@nhs.net



November 2025

Urgent Field Safety Notice
FreeStyle Libre 3 and FreeStyle Libre 3 Plus Sensors

Reference: ADC FA1002-2025
Communication from Manufacturer

Dear Customer,

We're reaching out to you about an issue that may affect your **FreeStyle Libre 3 and FreeStyle Libre 3 Plus sensors**. This issue does not apply to any other Libre sensors, apps or readers available in the UK.

What you need to know

Abbott has recently identified that certain FreeStyle Libre 3 and FreeStyle Libre 3 Plus sensors may provide incorrect low glucose readings.

Potential harm

If undetected, incorrect low glucose readings over an extended period may lead to wrong treatment decisions for people living with diabetes, such as excessive carbohydrate intake or skipping or delaying insulin doses. These decisions may pose serious health risks, including potential injury or death, or other less serious complications.

Actions to be taken

This issue affects only a subset of FreeStyle Libre 3 and FreeStyle Libre 3 Plus sensors. To determine if your current sensor or any unused sensor(s) are potentially affected, please visit www.FreeStyleCheck.com and select "CONFIRM SENSOR SERIAL NUMBER." You will need to locate your sensor serial number to determine if your sensor is potentially affected.

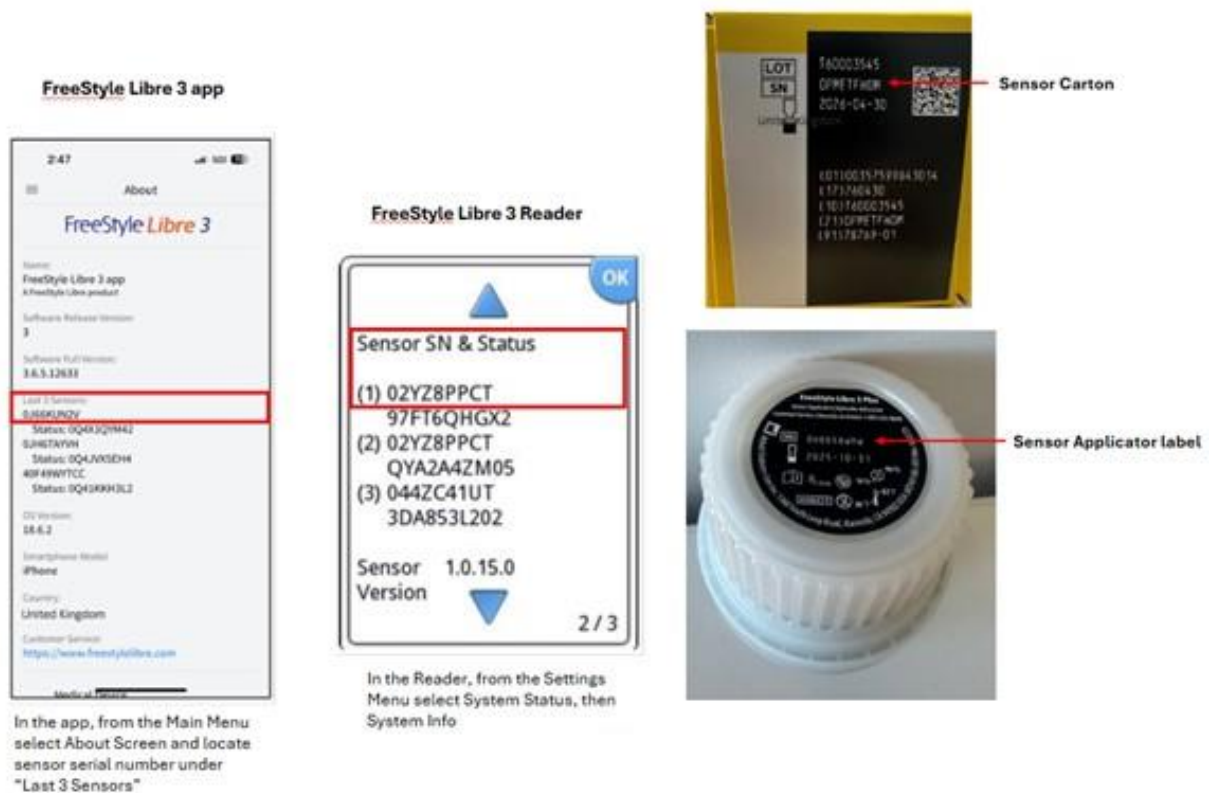
If you are currently wearing or have a FreeStyle Libre 3 or FreeStyle Libre 3 Plus sensor that has been confirmed as potentially affected on www.FreeStyleCheck.com or by a customer service representative, immediately discontinue use and dispose of the affected sensor(s).

You can request a replacement for any potentially affected sensor(s) on www.FreeStyleCheck.com. Select "CONFIRM SENSOR SERIAL NUMBER" and enter a valid serial number. If your sensor is potentially impacted, you will be instructed to enter your contact information so a replacement product can be sent to you at no cost.

Use a blood glucose meter or the built-in meter in your FreeStyle Libre 3 Reader to make treatment decisions when your sensor readings don't match your symptoms or expectations.

How to locate the sensor serial number

If you are wearing a FreeStyle Libre 3 and FreeStyle Libre 3 Plus sensor, you can find the serial number in the app or reader. The serial number can also be found on the label on the bottom of the sensor applicator or carton. (If you are using a sensor with a connected insulin delivery device, please refer to the connected insulin delivery device user manual on how to locate the sensor serial number.)



We have notified the Medicines and Healthcare products Regulatory Agency (MHRA).

If you have additional questions or need to report any adverse reactions or quality problems experienced with the use of FreeStyle Libre 3 or FreeStyle Libre 3 Plus sensors, please call Abbott Customer Service on 0800 170 11 77 Mon - Fri (8.00 - 20.00) and Sat, Sun & Bank Holidays (9.00 - 17.00).

Thank you for your attention to this urgent field safety notice. We sincerely apologise for any inconvenience this may have caused.

Sincerely,
Abbott

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Registered Number: 329102 England.

Registered Office: Abbott House, Vanwall Business Park, Vanwall Road, Maidenhead, Berkshire, SL6 4XE

ADC-123633 v1.0 11/2025



November 24, 2025

Urgent Field Safety Notice

FreeStyle Libre 3 and FreeStyle Libre 3 Plus Sensors

Reference: ADC FA1002-2025
Communication from Manufacturer

To whom it may concern:

This communication is to notify you that Abbott has initiated an urgent field safety notice. This urgent field safety notice only applies to certain **FreeStyle Libre 3 and FreeStyle Libre 3 Plus** sensors. This issue does not apply to any other Libre sensors, apps or readers available in the UK.

What you need to know

Abbott has recently identified that certain FreeStyle Libre 3 and FreeStyle Libre 3 Plus sensors may provide incorrect low glucose readings.

We are attempting to notify your patients using FreeStyle Libre 3 and FreeStyle Libre 3 Plus sensors about this issue through various means, including direct notifications through their app and by email (if provided). Your patients are instructed to visit www.FreeStyleCheck.com to determine if they have any affected sensors.

Potential harm

If undetected, incorrect low glucose readings over an extended period may lead to wrong treatment decisions for people living with diabetes, such as excessive carbohydrate intake or skipping or delaying insulin doses. These decisions may pose serious health risks, including potential injury or death, or other less serious complications.

Actions to be taken

1. Inform your patients

Please instruct your patients to visit www.FreeStyleCheck.com to confirm if their sensors are potentially impacted. To help you with this, we've enclosed a communication you may use with your patients.

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ADC-124419 v1.0 11/2025

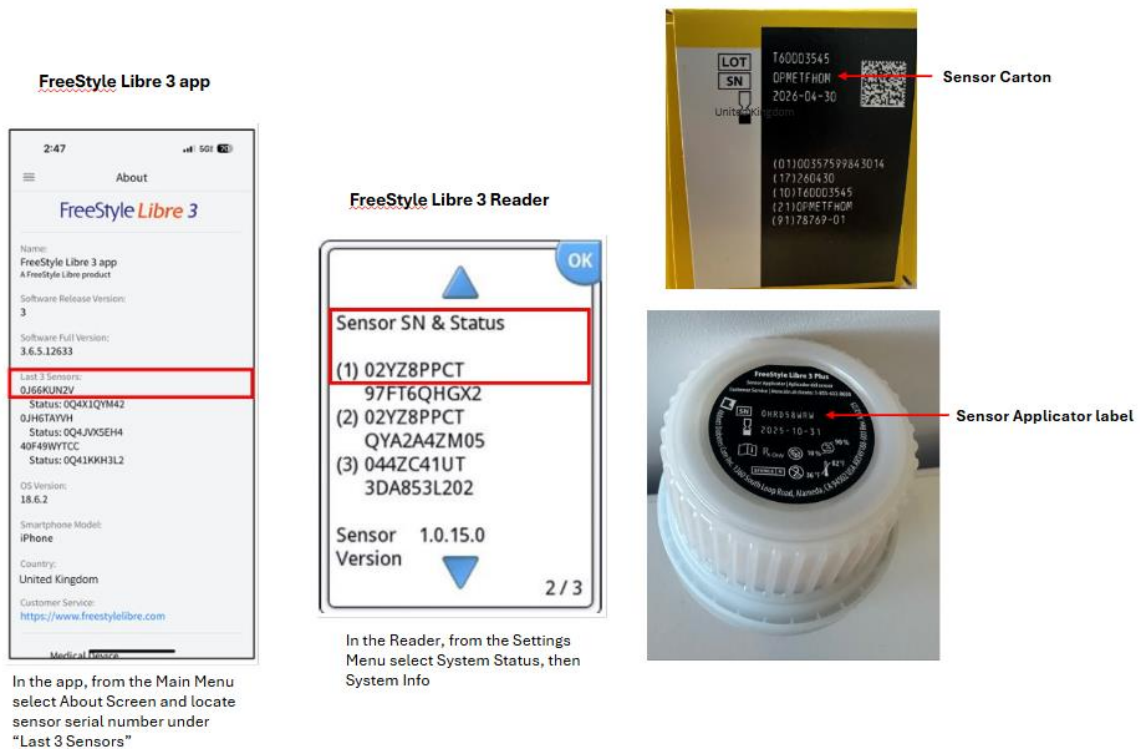
- If a patient is currently wearing or has a FreeStyle Libre 3 and FreeStyle Libre 3 Plus sensor that has been confirmed as potentially affected on www.FreeStyleCheck.com or by a customer service representative, have them immediately discontinue use and dispose of the affected sensors.

Patients can request a replacement for any potentially affected sensor(s) on www.FreeStyleCheck.com. They can select “CONFIRM SENSOR SERIAL NUMBER” and enter a valid serial number. If their sensor is potentially impacted, they will be instructed to enter their contact information so a replacement product can be sent to them at no cost.

Patients can use a blood glucose meter or the built-in meter in the FreeStyle Libre 3 Reader to make treatment decisions when sensor readings don't match symptoms or expectations.

How to locate the sensor serial number

Patients wearing a FreeStyle Libre 3 and FreeStyle Libre 3 Plus sensor can find the serial number in the app or reader. The serial number can also be found on the label on the bottom of the sensor applicator or carton. (If patients are using a sensor with a connected insulin delivery device, they can refer to the connected insulin delivery device user manual for guidance on how to locate the sensor serial number.)



We have notified the Medicines and Healthcare products Regulatory Agency (MHRA).

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