Derbyshire JAPC Bulletin

www.derbyshiremedicinesmanagement.nhs.uk

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Derbyshire Joint Area Prescribing Committee (JAPC)

This is a countywide group covering NHS North Derbyshire, South Derbyshire, Hardwick and Erewash clinical commissioning groups, Derbyshire Community Health Services Trust, Derbyshire Healthcare Foundation Trust, Derby and Chesterfield Royal Hospitals. It provides recommendations on the prescribing and commissioning of drugs. See **http://www.derbyshiremedicinesmanagement.nhs.uk/home**

KEY MESSAGES FROM THE JAPC JANUARY 2015 MEETING

CLINICAL GUIDELINES

1. Amiodarone monitoring protocol – updated with no major changes. JAPC members reflected on the limited role and length of treatment in light of the recent NICE Atrial fibrillation guideline and noted that our monitoring protocol (Appendix 3 of the document) offers practical advice on reviewing and stopping treatment. Practice audits across Derbyshire in the past may have highlighted monitoring could be improved in this area. JAPC encourages a re-audit of the monitoring requirements and for practices to have a robust recall system for patient reviews.
2. The Antimicrobial Treatment Guidelines – now updated to include advice from NICE CG on pneumonia. JAPC were reminded of recent MHRA advice that Nitrofurantoin is now contraindicated in most patients with an estimated glomerular filtration rate (eGFR) of less than 45 ml/min/1.73m2. The MHRA went on to advise that a short course (3 to 7 days) may be used with caution in certain patients with an eGFR of 30 to 44 ml/min/1.73m2. JAPC following local consultant microbiologist and nephrologist advice have decided not to include the eGFR 30-44ml/min/1.73m2 in local guidance. They cite that it would be permissible in exceptional circumstances to prescribe a short course only in the situation of, suspected or proven multi drug resistance where the benefits outweigh the risk of side-effects and preferably after a dialogue with the microbiologist.
3. Management of Recurrent UTIs in adult females (not pregnant) – Updated with no major changes.
4. Management of Emergency Contraception with ulipristal acetate – Updated with no major changes
5. Lipid modification – This is a new JAPC guideline reflecting NICE CG 181. This guideline represents a major stepwise change for example lowering the threshold for primary prevention (>10% CVD risk over 10 years) and the use of high intensity statins (atorvastatin). JAPC acknowledges that for existing patients on simvastatin 40mg there is marginal benefit in switching patients to high intensity statins JAPC feels that this is a low priority for CCGs.

SHARED CARE GUIDELINES

1. Denosumab for the prevention of osteoporotic fractures in post-menopausal women – last month JAPC agreed an update that included recent MHRA monitoring requirements of calcium and vitamin D at baseline and calcium levels before each injection. Local shared care also advocates vitamin D levels before each injection, this advice is outside of the SPC and MHRA and is taken from our osteoporosis specialists reflecting that many of the patients treated are elderly and despite supplementation are found to have suboptimal vitamin D levels. For this and the reason of accessibility of the test JAPC has endorsed this monitoring schedule.

ASPIRIN: PRIMARY PREVENTION OF CANCER AND CARDIOVASCULAR DISEASE

A NICE Medicines Evidence Commentary adds to emerging evidence that long-term prophylaxis with aspirin (5-10 years or longer) could have net clinical benefits in the general population. The review has limitations, for example it uses combined RCT and observational data (prone to confounding and can only suggest association, not causation), a range of aspirin doses were used (75-325mg) and there are unknown long term risks (e.g. age-related macular degeneration). JAPC acknowledge the review but is unable to endorse aspirin to be taken on a population level for reducing the risk of fatal and non-fatal cancer and thromboembolic cardiovascular events. The decision advising patients to take aspirin for these indications should be made at a patient level.

MHRA DRUG SAFETY UPDATE VOLUME 8, ISSUE 5, DECEMBER 2014

Ivabradine may be associated with the risks of bradycardia, atrial fibrillation, and other cardiovascular risks. The drug is already classified as **GREEN** **after specialist or consultant initiation** only if the resting heart rate is at least 70 beats per minute. Prescribers are asked not prescribe ivabradine with other medicines that cause bradycardia, to monitor patients regularly for atrial fibrillation and consider stopping ivabradine if there is only limited symptom improvement after 3 months

Comments? Contact the JAPC secretary – Slakahan.dhadli@southernderbyshireccg.nhs.uk

Drug	BNF	Date considered	Decision	Details
Para-aminosalicylic acid (GranuPAS)	5.1.9	January 2015	RED	Multi-drug resistant tuberculosis
Insulin degludec + liraglutide (Xultophy)	6.1.2.3	January 2015	BLACK	Neutral soluble long acting insulin analogue + glucagon-like peptide-1 analogue JAPC diabetes guideline does not recommend GLP1 In combination with basal insulin, furthermore monotherapy either of these drugs is not listed as first line options.
Peginterferon beta-1a (Plegridy)	8.2.4	January 2015	RED	Multiple sclerosis, relapsing-remitting in adults
Sofosbuvir + ledipasvir (Harvoni)	Not yet listed	January 2015	RED	Combination product for the treatment of chronic hepatitis C virus infection in adults
Darunavir (Prezista)	5.3.1	January 2015	RED	HIV infection
Idelalisib	8.1.5	January 2015	BLACK	NICE TA 328 for treating follicular lymphoma that is refractory to 2 prior treatments (terminated appraisal)

DERBYSHIRE MEDICINES MANAGEMENT, PRESCRIBING AND GUIDELINES WEBSITE

This website is the first port of call for information on local NHS decisions and guidance on medicines use. It includes: local prescribing formularies, JAPC decisions, traffic lights, shared care guidelines, medicines guidelines, newsletters, controlled drug resources, and other medicines management resources. The site improves upon previous sites in several ways. It is faster, more reliable, has its own search engine, and it is easier to find information. Content is constantly being updated and you can sign up for e-mail alerts to keep you up to date.

Definitions:

RED: drugs are those where prescribing responsibility lies with a hospital consultant or a specialist.

AMBER: drugs are those that although usually initiated within a hospital setting, could appropriately become the responsibility of the GP, under a shared care agreement.

GREEN: drugs are regarded as suitable for primary care prescribing.

BROWN: drugs are those that JAPC does not recommend for use, except in exceptional circumstances, due to lack of data on safety, effectiveness, and/or cost-effectiveness.

BLACK: drugs are **not** routinely* recommended or commissioned (*unless agreed through the individual funding request route)

CONSULTANT/SPECIALIST INITIATION: consultant/specialist issues the first prescription usually following a consultation because:

a. The patient requires specialist assessment before starting treatment and/ or
b. Specialist short term assessment of the response to the drug is necessary.

GPs will be asked to continue prescribing when the patient is stable or predictably stable

CONSULTANT/SPECIALIST RECOMMENDATION: consultant/specialist requests GPs prescribe initial and on-going prescriptions, but ensures:

a. There is no immediate need for the treatment and is line with discharge policies and
b. The patient response to the treatment is predictable and safe