Derbyshire JAPC Bulletin

www.derbyshiremedicinesmanagement.nhs.uk

December 2013

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 DECEMBER 2013 MEETING

CLINICAL GUIDELINES (LINK)

Vitamin D guidance – updated to include HuxD3 (suitable for vegetarians and halal) as the preferred high strength vitamin D product. ProD3 remains a second line option and is more suitable for children and patients with swallowing difficulties and allows for flexible dosing. Clinical changes to the guidance include the vitamin D level used for diagnosis and dosing in children >6 months of age.

Varenicline prescribing guidance- updated with minor changes.

Antidepressant in moderate and severe unipolar depression- updated to include detailed advice on reviewing patients taking citalopram following previous MHRA advice on maximum dosing and QTc effects.

SHARED CARE (LINK)

The shared care guidelines review dates for the immunomodulating drugs (azathioprine, ciclosporin, D penicillamine, leflunomide, methotrexate, sodium aurothiomalate, sulfasalazine) has been extended, for all the agreed indications to April 2014.

DAPOXETINE BLACK

Dapoxetine is a very short acting SSRI and the first drug to be marketed in England for the treatment of premature ejaculation (PE). JAPC has classified it locally as BLACK. The decision is based on several factors examples which include; no universally accepted definition of PE, the prevalence of PE being uncertain and possibly underestimated in the literature due to under-reporting and population mix, other established cost effective off-label options as recognised by the European Association of Urology and the treatment of PE considered to be a low priority area for CCGs. A Derbsyhire wide position statement on dapoxetine and treatment guideline to treat PE will follow.

HYPERTENSION AND INDAPAMIDE BROWN

There are two agreed pathways of drug treatment for hypertension across Derbyshire. This is dependent on whether ambulatory blood pressure monitoring (ABPM) or clinic blood pressure monitoring (CBPM) is used at the point of diagnosis. JAPC had agreed following NICE CG127 2011 to recommend indapamide 2.5mg as the preferred thiazide-like diuretic when hypertension is diagnosed using ABPM. However the price of indapamide 2.5mg has increased since the publication and so after careful consideration JAPC does not consider this as a cost effective choice. For patients already having treatment with indapamide 2.5mg and whose blood pressure is stable and well controlled may continue with indapamide 2.5mg or consider using the cheaper form of modified release. Bendroflumethiazide is the preferred diuretic for new patients diagnosed with hypertension (using ABPM or CBPM) or those uncontrolled on indapamide.

DUTASTERIDE AND COMBODART BROWN

Finasteride is the preferred enzyme inhibitor of 5-alpha reductase to treat BPH. Both dutasteride and Combodart (dutasteride plus tamsulosin) have been classified as BROWN. A review of the literature suggests that dutasteride has no real advantage over finasteride and that where combination treatments to treat BPH are necessary and more cost effective options are available. This advice is broadly in line with NICE CG97, the European Association of Urology 2013 guidance and a Canadian Health Technology appraisal.

MHRA – DRUG SAFETY UPDATE NOVEMBER 2013 (LINK)

JAPC made a special note to raise awareness of the new advice on the prescribing of anti-epileptic drugs (AEDs). AEDs have been divided into three categories. Each category giving advice and indication when there is a requirement for continuity of supply from the same manufacturer. This advice relates only to AED use for treatment of epilepsy; it does not apply to their use in other indications (e.g. mood stabilisation or neuropathic pain).The medicines management teams across Derbyshire will be working with prescribers on how best to implement this advice. For other MHRA updates see link above.

. METOCLOPRAMIDE USE IN PALLIATIVE CARE

A recent MHRA Drug Safety Update on metoclopramide advises on the risk of neurological adverse effects with details of restricted dose and duration of use. This has caused concern amongst palliative care specialists locally who may want to use metoclopramide orally and parentally long term for their patients. The association for Palliative Medicines has corresponded with the EMA who have confirmed that "…if off-label metoclopramide was previously recognised as standard practice by specialists in palliative care, that should not necessarily change as a consequence of the CHMP's review". Both CRH and RDH will therefore continue to use metoclopramide longer than 5 days in their palliative care patients where appropriate.

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Drug	BNF	Date considered	Decision	Details
Dutasteride	6.4.2	December 2013	Brown	Restricted to men that are eligible for finasteride but are either intolerant or do not respond after an adequate trial
Combodart (dutasteride+ tamsulosin)	7.4.1	December 2013	Brown	Finasteride plus tamsulosin is the cost effective option where a combination of an alpha blocker+ 5 alpha reductase inhibitor is indicated.
Indapamide 2.5mg	2.2.1	December 2013	Brown	Currently not a cost effective option. Where hypertension currently controlled with indapamide 2.5mg clinicians may continue treatment or consider the modified release formulation.
Dapoxetine	Not yet listed	December 2013	Black	Other cost effective treatment options used off-label available. Low priority for CCGs across Derbyshire.
Raloxifene	6.6	December 2013	Green (as per NICE TA 161)	Not previously classified – see local osteoporosis guidance and NICE TA 161.
Hux D3	Not listed	December 2013	Green (1st line treatment for Vitamin D deficiency)	HuxD3 is the preferred cost effective formulary choice for high dose colecalciferol.
ProD3	Not listed	December 2013	Green (2nd line treatment for Vitamin D deficiency)	ProD3 with a wider range of formulations is still an option for children allowing flexible dosing and where swallowing is a problem.
Ranibizumab	11.8	December 2013	Red	As per NICE TA 298 for treating choroidal neovascularisation associated with pathological myopia.
Bosutinib	8.1	December 2013	Black	As per TA299 not recommended within its marketing authorisation for treating Philadelphia-chromosome-positive chronic myeloid leukaemia
Fluocinolone acetonide intravitreal implant	11.4	December 2013	Red	Reclassification from black. As per NICE TA 301 recommended as an option for treating chronic diabetic macular oedema that is insufficiently responsive to available therapies.
Canakinumab	8.2	December 2013	Black	As per TA302 NICE **is unable to make a recommendation** in systemic juvenile idiopathic arthritis.

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.

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 recommended or commissioned

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