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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 8 January 2013

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Glycopyrronium bromide inhaler	BROWN second line LAMA
Aclidinium inhaler	BROWN third line LAMA
Racecadotril	BLACK
Atorvastatin 10mg	GREEN second line to simvastatin 40mg
Atorvastatin 80mg for ACS	GREEN
Ezetimibe	BROWN as per NICE TA 132
Omega 3	BROWN
Ivacaftor	RED
Intrinsa (testosterone patch)	BLACK
Ipilimumab	RED as per TA 268
Vemurafenib	RED as per TA 269
Decitabine	BLACK as per TA 270

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Present:	
NHS Derbyshire County	
Dr J Bell	Assistant Director of Public Health (Chair)
Dr J Ashcroft	GP - Erewash CCG
Dr C Emslie	GP – North Derbyshire CCG
Mr S Hulme	Head of Prescribing – Southern Derbyshire CCG
Dr A Mott	GP – Southern Derbyshire CCG
Mrs K Needham	Head of Medicines Management North – North Derbyshire CCG
Dr T Parkin	GP – Hardwick CCG
Dr I Tooley	GP – Southern Derbyshire CCG
Derbyshire Community Health Services NHS Trust	
Mr M Steward	Head of Medicines Management
NHS Derby City	
Mr S Dhadli	Specialist Commissioning Pharmacist
Mrs L Hunter	Assistant Head of Finance – Southern Derbyshire CCG
Derby Hospitals NHS Foundation Trust	
Dr F Game	Chair – Drugs and Therapeutic Committee.
Mr D McLean	Senior Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Ms B Thompson	Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
In Attendance:	
Mr A Thorpe	NHS Derby City (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr D Fitzsimons.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Apixaban	
4.	**MINUTES OF JAPC MEETING HELD ON 11 DECEMBER 2012**	
	The minutes of the meeting held on 11 December 2012 were agreed as a correct record after the following amendments: Summary Points: Prucalopride Amend to: – BROWN (gastro specialist initiation as monotherapy). Prucalopride – Amend to 'It was noted that the SMC had rejected prucalopride in 2010 and again in 2011.' Carbamazepine – Amend to 'Patients should not be switched to the controlled-release formulation of carbamazepine if their seizure control was good and not experiencing adverse reactions.'	
5.	**MATTERS ARISING**	
a.	**Coenzyme Q10** Mr Dhadli reported that a decision from the Sheffield APC was still awaited.	
b.	**Fluorouracil 5% Cream** Mr Dhadli reported that a decision from Dr Kin Wan-Shum and the East Midlands Cancer Network was still awaited.	
c.	**Transgender** Mr Dhadli reported that a shared care agreement was awaited from Nottingham.	
d.	**Co-dydramol and Co-codamol** Mr Hulme would prepare a paper for the February JAPC meeting.	**SH**
e.	**Heart Failure Guideline** Mr Dhadli reported that the guideline had now been updated, placed on the website and now included ivabradine.	
f.	**Phosphate Binders** Mr Dhadli advised that the phosphate binders shared care had been updated to include the new drugs	
g.	**QIPP Switching of Dipyridamole to Clopidogrel Following TIA** Mr Dhadli reported that the local guidance had now been updated.	
h.	**Prucalopride** Mr Dhadli advised that the prucalopride flowchart was now on the website.	

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i.	**Rufinamide** Mr Hulme would establish a group with representation from CRH, RDH, DHcFT and a medicines management representative to develop guidelines for the use of anti-epileptic drugs including shared care agreements and a report back given to the May JAPC meeting. A verbal update would be given at the February JAPC meeting.	**SH**
j.	**TTR Values for the New NOACs** Dr Ashcroft advised that Dr McKernan, Consultant Haematologist, had now indicated that she would prefer a higher therapeutic threshold and was keen that this be re-looked at again. Mr Dhadli stated that this would be considered again and consequently a short expiry date had been given. Dr Bell commented that the guideline had been developed to support a phased implementation and would be reviewed.	
6.	**NEW DRUG ASSESSMENT/FORMULARY ADDITION**	
a.	**Glycopyrronium bromide inhaler** Mr Dhadli stated that glycopyrronium bromide was a new once daily inhaled long-acting muscarinic receptor antagonist (LAMA) to relieve symptoms of COPD in adults. The other LAMAs were tiotropium (green) and aclidinium which had previously been classified as a brown drug by JAPC. The evidence for glycopyrronium came from three phase 3 randomised control trials in approximately 2,000 patients with moderate to severe COPD. The GLOW 1 and GLOW 2 trials were double-blind, placebo-controlled trials that evaluated glycopyrronium over 26 and 52 weeks respectively and measured lung function, breathlessness and quality of life via the St George's Respiratory Questionnaire. The GLOW 2 trial also included an open-label tiotropium treatment arm. GLOW 3 was a short, 21-day placebo-controlled crossover trial that evaluated the efficacy of glycopyrronium in improving exercise tolerance in patients with moderate to severe COPD. The trials revealed that glycopyrronium had a greater effect on lung function, exercise endurance and disease specific patient reported outcomes than placebo. Trial limitations were noted and in particular no direct powered or designed study comparison against tiotropium and longer term data was lacking. The device itself gave visual and auditory feedback and was a low resistance inhaler which may be advantageous in some patients. JAPC then considered the positioning of glycopyrronium with aclidinium in the COPD treatment pathway. Aclidinium was re-classified as having smaller studies with shorter duration and reduced COPD exacerbations. **Agreed:** Glycopyrronium classified as a **BROWN** second line drug to tiotropium. **Agreed:** Aclidinium re-classified as a **BROWN** third line drug.	**SD** **SD**
b.	**Racecadotril** Mr Dhadli reported that racecadotril was an enkephalinase inhibitor licensed for symptomatic treatment of acute diarrhoea in infants, children and adults. Enkephalinase inhibitors reduced hyper-secretion of intestinal water and electrolytes and it did not modify intestinal transit. Racecadotril was the first in	

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Item		Action
	a new class of drugs in the UK, but not worldwide, for acute diarrhoea that reduced intestinal secretion of water and electrolytes by inhibiting the breakdown of encephalins. Evidence came from nine clinical trials in children, of which eight were hospital based. The SMC review only considered trials from Europe. Mr Dhadli highlighted that the SMC had indicated that clinical experts had advised that the current practice of rehydration, usually oral, was sufficient in almost all cases of acute diarrhoea in children. Most UK and international guidance suggested that further research was needed to determine the place of racecadotril in therapy. In addition a CRD systematic review in 2007 for racecadotril in the treatment of acute diarrhoea in children concluded that there was limited evidence in flavour of using racecadotril compared with placebo or no intervention for the reduction of stool output and duration of diarrhoea in children with acute gastroenteritis. A RDTC review in November 2012 highlighted the advice of NICE of fluid management and non-recommendation of anti-diarrhoeal medication. It was also stated that "no robust evidence that it (racecadotril) reduces the need for IV rehydration, leads to more rapid discharge or helps conserve healthcare resources" Dr Bell highlighted that the trials were done on hospital population and did not reduce hospital admissions. There was already a means of controlling acute diarrhoea in children, which was a very common condition, and it would be necessary to determine what value this drug added. Dr Ashcroft stated that racecadotril had been available in may other countries for many years and there may be more evidence available as to its efficacy. Dr Bell stated that there had only been one trial in a community setting and those children who could not be controlled within this ended up in hospital. Mrs Needham stated that neither of the acute hospitals currently used racecadotril and suggested that a black drug classification be given. **Agreed:** Racecadotril classified as a **BLACK** drug.	
c.	**<u>Degarelix</u>** Dr Game advised JAPC that degarelix was licensed for the management of advanced hormone-dependent prostate cancer. There was a particular clinical need for immediate rapid testosterone suppression in a small number of high-risk patients presenting with symptoms such as impending spinal cord compression (SCC), impending renal failure due to ureteric obstruction and those with severe symptoms and who required hospitalisation. The drug caused a rapid reduction in PSA without androgen surge and consequently would be used for a very small sub-group of patients. It was also noted that, although degarelix had not yet received NICE approval for England, it was approved in both Wales and Scotland. Leicester and Nottingham were also already using this drug. Mr Dhadli reported that there had been a pivotal phase 3 CS21 study which compared degarelix and leuprorelin in prostate cancer patients. The study had concluded that it was unclear whether degarelix offered any clinical benefit in terms of avoidance of testosterone flare over LHRH provided an anti-androgen was given comittently. The 7.5 mg dose of leuprorelin used in	

Item		Action
	the study was not currently licensed in the UK and requires a monthly injection requiring reconstitution. A further critical review had concluded that degarelix at the current list price was not cost effective but if reduced it might reduce overall costs associated with the treatment of advanced prostate cancer. The biggest uncertainties concerned the price of degarelix, the rate of disease suppression and the proportion who suffer spinal chord compression with LHRH initiation. Discussion followed and Dr Bell queried the statement in the summary which referred to the clinical need for patients with severe symptoms warranting hospitalisation such as bone pain. Dr Game agreed to re-word this section. Dr Mott highlighted some potential issues associated with implementation as this was not covered by the current LES, as the LES was very specific to LHRH agonists, and how the rebate scheme offered by the manufacturer would operate in primary care and the different contractual arrangements in the City and County. Mr Shepherd advised that this drug had been adopted by CRH for approximately two years and no adverse consequences had been noted as a result of switching back to LHRH agonists. Dr Bell queried whether there was a sub-group of patients for whom the arrangements for LHRH were not satisfactory. In connection with rebates Mr Hulme commented that as a principle rebate schemes should not determine clinical need and there was a choice as to whether to participate or not. Mr Dhadli also highlighted that the rebate offer required commercial confidentiality which goes against the principles of rebate policy which is currently being drafted. **Action:** Mr Shepherd would ascertain whether there was any clinical data available from clinical colleagues at CRH for switching back to a LHRH agonist following degarelix initiation and bring back to the February JAPC meeting.	**MS**
7.	**CLINICAL GUIDELINES**	
a.	**<u>Lipid and Familial Hypercholesterolaemia</u>** Dr Bell stated that the existing guidelines needed to be reviewed. Two lots of papers were submitted to JAPC, a RDH proposal and a paper from Mr Dhadli. Mr Dhadli's paper included an update to the existing policy whereas the RDH proposal included some fundamental changes. Mrs Bell recognised a considerable amount of work is needed to be undertaken before JAPC could agree. It was therefore proposed that a sub-group be established to work on the detail and develop revised guidelines. Dr Bell highlighted three areas for discussion and decision by JAPC to be made at this meeting: • Compliance with NICE TA 132 Ezetimibe for the treatment of primary (heterozygous and non-familial) hypercholesterolaemia • Use of atorvastatin in cases of intolerance to simvastatin • Atorvastatin in the event of Acute Coronary syndromes (ACS). During discussion on these points Dr Bell commented that the NICE TA on ezetimibe was specific on its use and, based on evidence of effectiveness, had previously been classified as a brown drug. Dr Bell proposed to JAPC	

Item		Action
	that ezetimibe continues to be classified as brown but with the addition of a statement on adherence to NICE TA 132. Simvastatin 40mg would remain first line statin choice. Atorvastatin 10mg would be green second line to simvastatin 40mg. With MHRA warnings of simvastatin 80mg JAPC endorsed the use of atorvastatin 80mg for ACS. Dr Tooley then referred to discussions about switching from atorvastatin 80mg to simvastatin 40mg for ACS and an appropriate length of time. This would be considered by the sub-group. **Agreed:** Ezetimibe classified as a **BROWN** drug to include a reference to NICE TA 132. **Agreed:** Atorvastatin 10mg classified as a **GREEN** drug for second line after simvastatin 40mg **Agreed:** Atorvastatin 80mg classified as a **GREEN** drug for ACS. **Agreed:** A sub-group would be established to review the Familial Hyperlipidaemia guideline and statin policy with the following representatives suggested: RDH – Dr J Barron and Mr D Anderton. CRH – Mr Shepherd would discuss representation with the cardiologists. GPs – Dr J Ashcroft and Dr A Mott. Medicines Management – Mrs Needham and Mr Hulme would decide on representation from both north and south. **Agreed:** A holding statement would be produced about the decisions made today and the existing guidelines reviewed.	**SD** **SD** **SD** **MS** **KN/SH** **SD**
b.	**Breastfeeding** Mr Dhadli stated that Mandy Abbott, Infant Feeding Specialist, had highlighted some problems concerning prescribing advice conveyed to GPs. In particular the prescribing of domperidone in lactation. Dr Mott queried whether the guidance needed to be promoted for use by GPs. Dr Bell commented that consideration of all the guidance's was beyond the scope of JAPC but it would be helpful to pull out the prescribing related sections particularly concerning domperidone and the evidence for the choice of anti-depressants. However it was unclear what would happen to the guidelines after this had been done. Dr Mott queried whether a traffic light classification was appropriate for domperidone under specialist advice and that the evidence in the UKMI document should be provided to practices. **Agreed:** Dr Bell would take back the guidelines to their source and explain that JAPC was only able to discuss the prescribing elements in them. **Agreed:** A briefing on the use of domperidone would be put in the bulletin and a link provided to the UKMI briefing paper.	**JB** **SD**
8.	**MISCELLANEOUS**	
a.	**Omega-3 Fatty Acid Supplementation**	

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Item		Action
	Mr Dhadli reported that the November 2012 Drugs and Therapeutic Bulletin (DTB) had referred to a new systematic review and meta-analysis published in JAMA which found that the evidence for omega-3 PUFAs did not justify their use in everyday clinical practice. The current classification was brown and it was listed in our cardiovascular chapter based on the NICE Clinical guideline published in May 2007 which referred to secondary and primary care for patients following a myocardial infarction. Mr Dhadli added that the DTB recommended that prescribers should discuss the option of discontinuation supplementation with patients at their next drug review. Discussion followed during which Dr Game referred to the other licensed indication of hypertriglyceridaemia. It was suggested that this should be further discussed by the sub group looking at the lipid modification policies. Dr Mott commented that a brown classification should continue as there were a small number of patients with hypertriglyceridaema who would benefit and these would need to be defined to aid review in general practice. **Agreed:** A reference to the NICE evidence would be put in the bulletin and review of patients recommended. **Agreed:** The sub-group would be requested to recommend the place of Omega-s PUFAs for the management of hypertriglyceridaemia.	**SD** **Working Group**
b.	**<u>Prescribing Specification</u>** Mr Dhadli stated that prescribing specification had been circulated for consultation and feedback had been received from Mr Steward concerning the appropriateness of primary care representative on the DCHS Medication Safety Group and the reference in the performance indicators to the requirement for a multidisciplinary Drugs and Therapeutic Committee (MDTC). Mr Steward advised that the Medication Safety Group discussed most aspects which would be discussed by a MDTC and the primary care formulary was mainly used together with the formularies of the two Derbyshire Acute Trusts. **Agreed:** Mr Steward would send the minutes of the DCHS Medication Safety Group for inclusion with the JAPC agenda papers. Dr Parkin pointed out that the reference to NHS Derby City and NHS Derbyshire County would no longer be appropriate after 1st April 2013. Mr Dhadli would amend this to refer to the Derbyshire CCGs. Mr Dhadli highlighted to JAPC the changes made to the prescribing specification: • Page 6 Section 9 - Need for health and social care staff to focus on medicines optimisation. • Page 11 - Reference to high cost drugs related solely to those commissioned by CCGs. • Page 12 Section 11- Disclosure of any financial and non-financial incentive schemes offered to the Provider Trust from the manufacturers.	**MS** **SD**

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Item		Action
	• Page 12 Section 12 – Support for innovation by Provider Trusts and reference to a risk share agreement between provider and commissioner. • Page 12 Section 13 – Need for exit strategies in clinical trials and who would continue to fund these patients at the end of a trial. • Page 12 Section 14 – NICE TAs had a generic statement with the option to continue until patients and their clinicians considered to stop. If initiated under a trial, continuation of treatment under the NHS should not be assumed unless there is evidence the patient meets or would have met the eligibility criteria of NICE. In connection with section 14 Dr Game commented that the Ethics Committee patient consent form referred to what would happen at the end of a trial. Mr McLean commented that some of the clinical trials which patients would exit from were in existence before NICE and new commissioning policies could not be retrospectively applied. Dr Game commented that it was usual practice to have exit strategies from clinical trials. Dr Mott highlighted that appendix 1 'Prescribing Indicators of QIPP' may need to be updated in the light of new indicators. Mr Dhadli would review appendix 1 in accordance with the next set of indicators and amend the ezetimibe section to reflect that the prescribing of ezetimibe would be allowed under the NICE TA.	**SD**
c.	**<u>Ivacaftor</u>** Mr Dhadli informed JAPC that ivacaftor for cystic fibrosis had previously been classified as a black drug but a recent statement from the North of England Specialised Commissioning Group had confirmed that with effect from 1st January 2013 ivacaftor should be made available to NHS patients aged six years and over with the G551D gene mutation in England as set out in the licensed indication. There it was classified as red. **Agreed:** Ivacaftor classified as a **RED** drug.	**SD**
d.	**<u>Intrinsa</u>** Mr Dhadli reported that Intrinsa was indicated for the treatment of hypoactive sexual desire disorder in bilaterally oophorectomised and hysterectomised women receiving concomitant oestrogen therapy and had been approved in 2006. In 2012 the marketing authorisation had been withdrawn for commercial reasons and the manufacturer had cancelled the product licence with effect from 30th September 2012 so Intrinsa was now an unlicensed medication. Mr Dhadli highlighted the cost increase of £47,601 over the BNF listed price and there were nine patients on Intrinsa in Derbyshire. MTRAC did not consider it suitable for prescribing based on clinical evidence and short term trials indicated small benefits and questionable long term placebo effects. **Agreed:** Intrinsa re-classified as a **BLACK** drug.	**SD**

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	Action: Medicines Management would identify the practices to which the nine patients belonged to and discuss further with them.	**KN**
e.	**Developing and Updating Local Formularies** JAPC noted the paper for information. Mr Dhadli stated that some aspects such as patient/public involvement would need to be taken into account when the terms of reference for JAPC were being reviewed.	
f.	**NICE TA Adherence** Mrs Qureshi explained that Medicines Management had reviewed all the JAPC decisions for the NICE TAs which had been published between April 2011 and October 2012. JAPC was referred to the table which indicated the drugs about which JAPC had made decisions but were not explicitly included in the traffic light database. It was therefore proposed that all TA positive appraisals, not already included in the traffic light list, would be classified as red and all negative or terminated drug appraisals for TAs to be classified as black. Mrs Qureshi highlighted the following TAs with variation to the above suggestion: • TA231 - originally classified as brown but due to termination of the TA re-classified as BLACK. • TA 239 – originally classified as red but now re-classified as BLACK. • TA 251 – multiple appraisals where all three drugs had been classified as red but due to negative appraisals re-classified as BLACK. Mr Dhadli advised that each time a TA for a red drug had been considered by JAPC these had been classified as red and negative appraisals as black.	
10.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance: **TA 268 Ipilimumab for previously treated advanced (unresectable or metastatic melanoma)** Ipilimumab classified as a **RED** drug. **TA 269 Vemurafenib for treating locally advanced or metastatic BRAF V600 mutation-positive malignant melanoma** NICE costing template indicated that there would be two patients in the City and five patients in the County who would be eligible for treatment at a cost of £100,000 and £250,000 respectively. Vemurafenib classified as a **RED** drug. **TA 270 Decitabine for the treatment of acute myeloid leukaemia** Terminated appraisal. Decitabine classified as a **BLACK** drug.	

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11.	**JAPC BULLETIN**	
	The amended JAPC bulletin was ratified by JAPC.	
12.	**GUIDELINE GROUP**	
	The Guideline Group action tracker was ratified by the JAPC.	
13.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications • Glycopyrronium – BROWN second line • Aclidinium – BROWN third line • Racecadotril – BLACK • Atorvastatin 10mg– GREEN second line • Atorvastatin 80mg for ACS – GREEN • Ezetimibe – BROWN and reference to NICE TA 132 • Omega 3 – BROWN • Ivacaftor – Re-classified RED • Intrinsa – BLACK • Ipilimumab – RED • Vemurafenib – RED • Decitabine – BLACK	
14.	**ACTION SUMMARY**	
	The action summary was noted and amendments made: Shared Care Disulfiram/Acamprosate – Beverley Thompson contact Ms Caroline Jones about the update of the guidance with JAPC recommendations. Antipsychotics – Paper prepared on QT intervals and requirements for CCGs. Dr Bell would check on progress. Co-codamol/Co-dydramol – Mr Hulme would prepare a short paper on traffic light classification for the February JAPC meeting. Seretide – Mrs Qureshi to produce children's asthma guidance on cost effective products and devices for the February JAPC meeting. Rufinamide – DHCFT/RDH and CRH to agree and propose antiepileptic drugs to be agreed locally and pathways where appropriate (May 2013). Shared Care – Feedback from provider trusts on shared care to be considered by the Prescribing Groups.	**BT** **JB** **SH** **SQ** **SH-working group**
15.	**MHRA DRUGS SAFETY UPDATE**	
	The MHRA Drug Safety Alert for December 2012 was noted. Mr Dhadli highlighted that the risk of serious skin reactions induced by	

Item		Action
	carbamazepine may be increased in patients of European descent or Japanese origin with the *HLA-A*3101* allele.	
16.	**MINUTES OF OTHER PRESCRIBING GROUPS FOR INFORMATION**	
	• CRH Drugs and Therapeutic Committee 20/11/12 • Sheffield Area Prescribing Committee 16/10/12 • STAMP 13/11/12 • Burton Drugs and Therapeutic Committee 19/11/12 • STAMP 11/12/12 • Nottingham Area Prescribing Committee November 2012	
17.	**ANY OTHER BUSINESS**	
	Mr Hulme referred to the forthcoming NICE TA on apixaban for VTE	
18.	**DATE OF NEXT MEETING**	
	Tuesday, 12 February 2013 at 10.30 pm in The Rangewood Room, Post Mill Centre, South Normanton.	