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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 8 December 2015

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Eflornithine Cream	BROWN for facial hirsutism in women (see BNF chapter for exceptionalities)
Midrodine	BROWN after specialist/consultant initiation and dose titration for orthostatic hypotension.
Rivastigmine	GREEN after specialist initiation, titration and dose stabilisation for Parkinson's Disease Dementia Complex (PDDC) (note dual classification of amber for dementia)
Alirocumab	BLACK
Asfotase alfa	RED (NHS England commissioned drug)
Naloxegol	BROWN as per NICE TA 345 (note dual classification of BROWN for palliative care)
Sebelipase alfa	RED (NHS England commissioned drug)
Sinecatechins	BLACK
Ledipasvir	RED as per NICE TA 363
Daclatasvir	RED as per NICE TA 364
Ombitasivir	RED as per NICE TA 365
Pembrolizumab	RED as per NICE TA 366
Vortioxetine	RED as per NICE TA 367
Apremilast	BLACK as per NICE TA 368
Dulaglutide	BROWN weekly GLP1 alongside exenatide MR in line with local guidance

Patient Group Directions

Tetanus/Diphtheria and inactivated poliomyelitis
Shingles/Zostavax

Shared Care Guidelines

Riluzole for the treatment of the Amyotrophic Lateral Sclerosis (ALS) form of Motor Neurone Disease (MND)
Rivastigmine for behavioural problems and psychosis in patients with Parkinson's Disease Dementia Complex (PDDC) - Shared care removed reclassified GREEN specialist initiation

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Present:	
Southern Derbyshire CCG	
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mrs L Hunter	Assistant Chief Finance Officer
Mr S Hulme	Director of Medicines Management
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Mr R Coates	Management Accountant (also representing Hardwick CCG)
Dr C Emslie	North Derbyshire CCG - GP (Chair)
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Hardwick CCG	
Ms D Bennett	Assistant Director of Transformation
Dr T Parkin	GP
Erewash CCG	
	Represented by Mr S Hulme
Derby City Council	
Dr R Dewis	Acting Director of Public Health
Derbyshire County Council	
Derby Hospitals NHS Foundation Trust	
Dr W Goddard	Chair - Drugs and Therapeutic Committee
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Trust	
In Attendance:	
Dr M Mehta	F2 Doctor, Derby City Public Health
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Ms S Bassi, Dr D Fitzsimons, Dr A Mott, Mr C Newman, Ms J Shaw, Mr M Steward and Ms J Town.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	Omalizumab for previously treated chronic spontaneous urticaria.	
4.	**MINUTES OF JAPC MEETING HELD ON 10 NOVEMBER 2015**	
	The minutes of the meeting held on 10th November 2015 were agreed as a correct record after the following amendment: Local PGDs – Amend to: Hepatitis A Vaccine Adult – The following amendments were agreed: Frequency of administration – Amend to second booster dose (Vaqta after 18 months) following initial dose.	
5.	**MATTERS ARISING**	
a.	**Bridging Therapy for Low Weight Molecular Heparin (LWMH)** Mr Dhadli reported that requests had been received for GPs to prescribe LMWH outside shared care when the International Normalised Ratio (INR) for warfarin was below therapeutic range. It had therefore been agreed that additional bridging guidance for inclusion in the oral anticoagulant warfarin monitoring guideline should be drafted. The draft guidance had been based on the internal guidelines used in CRHFT and produced by Ms A Braithwaite, CRHFT Principal Pharmacist Clinical Services. Mr Dhadli highlighted that no comments had been received from the DTHFT haematologists and Dr Goddard agreed to contact them in order to ascertain their views.	**WG**
b.	**JAPC Terms of Reference** Mr Dhadli explained that references to medical devices and the Guideline Group had now been added to the JAPC terms of reference. Mr Dhadli also referred to the list of named JAPC members which would be amended in the light of recent changes to the membership. **Agreed:** JAPC ratified the terms of reference with the inclusion of the agreed amendments.	**SD**
c.	**Haloperidol Position Statement** Mr Dhadli advised JAPC that a haloperidol position statement had now been agreed between JAPC meetings by the palliative care consultants in response to the shortage of supplies of haloperidol injection. In the event of supplies of haloperidol not being available or obtainable the position statement aimed to support prescribers on alternative treatment options such as levomepromazine which could be used as a second line antiemetic. Mrs Needham highlighted that levomepromazine and diamorphine were compatible in a syringe driver. However if other combinations needed to be put into a syringe driver then specialist advice regarding compatibility should be obtained. JAPC also noted that this is a live document that would be updated as more advice becomes available.	

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d.	**Immunomodulating Drugs** Mr Dhadli stated that it had been highlighted in a previous JAPC meeting that the proposed addition of the live herpes zoster vaccine (Zostavax) was not in line with the British Society for Rheumatology (BSR) and the green book for all the immunomodulating drugs. Whilst looking into this query it was noted that variations were found on monitoring that could not be explained by the products SPC or BSR guidance. It had therefore been decided to request the consultants to review the variations in the shared care on an individual basis and this would inevitably be a time consuming process.	
e.	**Falls Guidance** It was reported that the falls guidance had been discussed by the Guideline Group and it had been decided to emphasise the target audience in the introduction and also to clarify the red and amber classifications. The guidance was currently being updated to incorporate these changes. Guidance agreed pending these changes.	
6.	**NEW DRUG ASSESSMENTS**	
a.	**Eflornithine** Mr Dhadli reported that eflornithine cream had previously been assigned a traffic light classification of BROWN for facial hirsutism in women with the following exceptionality criteria: • Treatment did not remove hairs but slowed down hair growth such that users required less frequent hair removal by other methods. • Women should be advised about other local methods of hair removal • Treatment should be discontinued if no effects were seen within four months Following discussion by the Guideline Group and, in the light of the SMC review in 2005 and the DTB review in 2007, the following points were highlighted: • Women who were overweight or obese should be encouraged to lose weight. • Women should be advised about other local methods of hair removal such as shaving and waxing • Eflornithine should only be considered for use in women where alternative drug therapy e.g. co-cyprindiol, was ineffective, not recommended, contra-indicated or considered inappropriate • Noted that treatment with eflornithine did not remove hairs but slowed down hair growth so that users required less frequent hair removal by other methods. • Treatment should be discontinued if no effects were seen within four months. **Agreed**: Eflornithine classified as a **BROWN** drug for facial hirsutism in women with the revised exceptionality.	**SD**
b.	**Midrodine** Mr Shepherd reported that midodrine was currently classified as RED due to its unlicensed status.	

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	A licensed version (Bramox 5 mg tablets) had now been made available in 2015 only for patients with orthostatic hypotension due to autonomic dysfunction. Mr Dhadli advised that there were three NICE CGs which related to postural hypotension but none referred to any pharmacological strategies. A SMC review had accepted the licensed version as bioequivalent to the unlicensed product which was currently used (Gutron). The NICE Evidence Summary on midodrine for orthostatic hypotension due to autonomic dysfunction was based on two RCTs which found that midodrine 10 mg three times daily increased standing blood pressure statistically significantly more than placebo; one hour after the dose was taken. It was highlighted that patient orientated primarily looking at blood pressure changes were limited but there was significantly less light-headedness, including dizziness and unsteadiness, seen with midodrine 10 mg three times daily than with placebo at week two of the treatment period. In terms of safety most of the common side effects were less serious but there was a risk of supine hypertension. The European Federation of Neurological Societies recommended individually tailored therapy for orthostatic hypertension. Non-pharmacological management options were considered primary strategies and included compression stockings, blood pressure monitoring and increased water and salt ingestion. In the event that these did not alleviate symptoms, pharmacological treatment with fludrocortisone or midodrine, alone or in combination, could be considered. The usage of both of these drugs was 'off-label' for orthostatic hypotension when the guidance had been updated in 2011. Dr Goddard stated that the DTHFT Drugs and Therapeutic Committee had discussed the use of the licensed version of midrodine at the meeting in November 2015. Dr Jane Youde, Consultant for Medicine for the Elderly, had attended the meeting and highlighted the licence was solely for autonomic postural hypotension due to autonomic dysfunction and that there was another group of people who had pure orthostatic hypotension. The drug would be initiated in clinic and, once the patient had been stabilised, then treatment could be continued in primary care. The measurement of blood pressure aimed to ensure that patients were not significantly hypotensive. Dr Youde had agreed to develop some guidance for information. In the case of the licensed indication those patients with autonomic failure were likely to have multiple problems and would therefore be closely managed within a clinic setting. The other group of idiopathic orthostatic hypertensive patients would be easier to manage although the drug was not licensed for this indication. Mr Hulme highlighted that for most patients the licensed drug would therefore be used in an unlicensed way and it would need to be determined whether GPs were prepared to do this. Mrs Needham advised that the drug was now in the BNF with prescribing information. Mr Dhadli stated that it would be necessary to individualise treatment for a particular patient, including a starting dose, and titrate up accordingly and then for GPs to monitor standing and supine blood pressure.	

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	Dr Emslie highlighted that most patients would not be seen by primary care after discharge from hospital and it would be difficult therefore to titrate the dose. It was agreed that it would be important for patients only to be discharged from hospital when the dose was stable. Mr Dhadli referred to the estimated additional annual cost to the CCGs if prescribing transferred to primary care of £62,031. Ms Bennett highlighted the importance of indicating on the JAPC front sheet whether there were any Equality and Diversity implications. Mr Dhadli stated that this had been omitted on this occasion from the front sheet but there were no Equality and Diversity implications. **Agreed:** Midrodine classified as a **BROWN** drug after specialist initiation and dose titration for orthostatic hypotension.	**SD**
c.	**<u>Promixin</u>** Mr Shepherd advised that Promixin was currently classified as a RED drug for cystic fibrosis but not listed for bronchiectasis. A shared care guideline had been developed for Colomycin in the treatment of adults with bronchiectasis. Two patients at CRHFT had experienced difficulty in tolerating the use of nebulised colistimethate injection but had managed to tolerate the Promixin nebuliser. It had therefore been proposed that the use of Promixin should be included as a second line option to colomycin in the shared care guideline for the treatment of pseudomonas aeruginosa lung infections in adults with bronchiectasis who were non cystic fibrosis patients. Mr Dhadli queried the definition of intolerable and stated that the respiratory nurses had indicated that Promixin could be used for those patients who experienced manipulation problems with the preparation of colomycin but not as a drug intolerance. However it was highlighted that Promixin was available, both in powder form and as IV solution, and also required the use of the IAAD nebuliser. This was supplied free of charge by the company only if the powder vial was supplied. Mr Dhadli stated that this would still require the same manual dexterity as that for Colomycin. It was agreed that, due to the low numbers of patients involved, that Mr Shepherd would reconsider the proposal.	**MSh**
d.	**<u>Ulipristal Acetate for Uterine Fibroids</u>** Mr Shepherd reported that ulipristal acetate, an oral drug for pre-operative treatment of moderate to severe symptoms of uterine fibroids in adult women of reproductive age, was currently classified as a RED drug. This classification had been assigned as it was a new drug and required specialist assessment for patient selection, assessment and on-going monitoring. It was noted that the licence was restricted to pre-operative treatment of moderate to severe symptoms of uterine fibroids in adult women of reproductive age. The licence had subsequently been extended to allow intermittent treatment of moderate to severe symptoms of uterine fibroids in women of reproductive age. A request had subsequently been made by a CRHFT consultant gynaecologist for the traffic light classification to be changed to allow for its use.	

Item		Action
	Dr Goddard advised that ulipristal actetate had been placed on the DTHFT formulary and a protocol had been developed for its use according to the original licence conditions. At the time JAPC had decided to classify ulipristal acetate for this indication as RED it had been highlighted that a clear pathway was needed. It was agreed that a guideline and patient pathway was still needed before any decision could be made concerning its traffic light classification. CRHFT and DTHFT were requested to outline a pathway and business case to JAPC.	
7.	**CLINICAL GUIDELINES**	
a.	**Chlamydia Testing and Screening Management** Mr Dhadli reported that the existing chlamydia testing and screening management guidance had been updated in line with the recent British Association of Sexual Health and HIV (BASHH) guidance. The following sections were highlighted: • Treatment options – Dr Dewis explained that the guidance was available for GPs to treat chlamydia but that all individuals who tested positive should be referred to treatment services to have contact tracing undertaken. • Which antibiotic: Suspected Chlamydial PID – Amend to doxycycline 100mg bd 14 days and Metronidazole 400mg bd 14 days. • Gonorrhoea suspected or at risk – For men over 30 years of age deemed to be low risk treat with doxycycline and metronidazole or ofloxacin. High risk cases should be referred to the Integrated Sexual Health Service clinic. • Who to Screen: Outside of screening programme – Dr Parkin highlighted the potential for an additional workload for GPs and additional costs for the CCGs. Dr Dewis stated that this was a guideline for GPs to use if chlamydia was identified and was not asking for additional activity beyond that already included within the Primary Care contract (or also LES contract for County practices). The National Chlamydia Screening Programme referred to opportunistic testing for chlamydia for this age group and was not for symptomatic or people who considered themselves to be at risk. It could not be considered a full screening programme with a call and recall system. It was discussed that this guidance was particularly pertinent for those patients who did not wish to attend the GUM Clinic. **Agreed:** The amended guidelines would be brought back to the January JAPC meeting for further discussion.	**SD**
8.	**PATIENT GROUP DIRECTIONS**	
a.	**Tetanus/Diphtheria** Mr Dhadli advised that the PGD for the administration of low-dose diphtheria, tetanus and inactivated poliomyelitis vaccine had been authorised for use by Derbyshire and Nottinghamshire NHS England (North Midlands) as the commissioner of NHS immunisation programmes for use across Derbyshire and Nottinghamshire including primary care. **Agreed:** JAPC agreed the Patient Group Direction for Tetanus/Diphtheria.	**SD**

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b.	**Shingles/Zostavax** Mr Dhadli advised that the PGD for the administration of Zostavax® reconstituted lyophilised suspension (shingles vaccine, live) by currently registered nurses or paramedics to individuals who are eligible for the national shingles immunisation programme, for the prevention of herpes zoster ("zoster" or shingles) and herpes zoster-related post-herpetic neuralgia (PHN) had been authorised for use by Derbyshire and Nottinghamshire NHS England (North Midlands) as the commissioner of NHS immunisation programmes for use across Derbyshire and Nottinghamshire including primary care. **Agreed:** JAPC agreed the Patient Group Direction for Shingles/Zostavax.	**SD**
9.	**SHARED CARE GUIDELINES**	
a.	**Riluzole** Mr Dhadli reported that the existing shared care guideline for riluzole for the treatment of the Amyotrophic Lateral Sclerosis (ALS) form of Motor Neurone Disease (MND) had been updated. Mrs Needham advised that the requirement that patients should be warned to report respiratory symptoms to their physician should be highlighted in the consultant responsibilities section. Dr Emslie commented that it would be advantageous if the GP monitoring could be highlighted on the front page of the guidance for ease of reference. It was suggested that a link to all the relevant monitoring to be undertaken by primary care be added to the list of GP responsibilities on the first page of the guidance. **Agreed:** JAPC ratified the shared care guideline for riluzole for the treatment of the Amyotrophic Lateral Sclerosis (ALS) form of Motor Neurone Disease with the agreed amendments.	**SD**
b.	**Rivastigmine for behavioural problems and psychosis in patients with Parkinson's Disease Dementia Complex (PDDC)** Mr Dhadli reported that the existing shared care guideline for rivastigmine for behavioural problems and psychosis in patients with Parkinson's Disease Dementia Complex (PDDC) had been updated. There were no major changes to the shared care guideline but a request had been received to re-classify rivastigmine for this indication from AMBER to GREEN after specialist recommendation noting no biochemical monitoring was required. Dr Watkins and Dr Emslie expressed some concern that the dose of rivastigmine was listed to be escalated by the GP in line with advice from secondary care, therefore it was agreed that the dosage should be stabilised by secondary care before asking primary care to prescribe. It was highlighted that there would be regular follow up of patients by consultants. **Agreed:** Rivastigmine classified as a **GREEN** drug after specialist initiation, titration and dose stabilisation for Parkinson's Disease Dementia Complex (PDDC). **Agreed:** Rivastigmine to remain classified as an **AMBER** drug for all other indications within a shared care guideline.	**SD** **SD**

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10.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches: Alirocumab (Praluent) – NICE TA expected in June 2016. Classified as **BLACK.** Asfotase alfa (Strensiq) – NHS England commissioned line. Classified as **RED.** Naloxegol (Moventig) – Already classified as BROWN for use in palliative care following NICE TA 345 for treating opioid induced constipation. It was agreed that naloxegol be classified as **RED** for use in the pain and gastroenterology clinics. Sebelipase alfa (Kanuma) – NHS England commissioned line. Classified as **RED.** Sinecatechins (Catephen) – For the treatment of external genital and perianal warts in immunocompetent adults. Classified as **BLACK** due to lack of evidence and cost effectiveness. Dr Dewis undertook to obtain a public health view on this drug.	**SD** **SD** **SD** **SD** **SD** **RD**
11.	**MISCELLANEOUS**	
a.	**<u>British National Formulary Version Update</u>** Mr Dhadli reported that there had been an update to the September 2015 edition of British National Formulary (BNF) 70 and its format had been amended. Mr Dhadli added that UKMi, the Neonatal and Paediatrics Pharmacy Group and the BNF had issued a letter which referred to a number of discussions concerning the BNF for Children 2015-2016 and BNF 70. The background to these changes and further explanatory comments had been added to the letter as an appendix. **Agreed:** Mr Dhadli would highlight the clarification and omissions in the BNF in the bulletin.	**SD**
b.	**<u>Dulaglutide</u>** Mr Dhadli reported that JAPC had assigned a traffic light classification of BROWN 2nd line to exenatide MR for the once weekly preparation of dulaglutide in October 2015. However since that decision the price of dulaglutide had reduced and it was now considered to be another cost effective weekly treatment option. **Agreed:** Dulaglutide classified as a **BROWN** if a weekly GLP1 is needed in line with local diabetes guidance is needed drug alongside exenatide MR Mr Dhadli tabled the NICE algorithm for blood glucose lowering therapy in adults with type 2 diabetes and highlighted that there could be significant changes to the existing guidance. A reference would be placed in the bulletin to indicate that the local guidance was being reviewed in the light of the NICE algorithm but would remain in effect until this had been completed.	**SD** **SD**
c.	**<u>General Medical Council Update on Unlicensed Medicines</u>** Mr Dhadli reported that the General Medical Council (GMC) had issued guidance on unlicensed medicines. The GMC guidance was noted by JAPC.	

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d.	**Naloxone** Mr Dhadli reported that regulations had been introduced on 1st October 2015 which had widened the availability of naloxone used to reverse the effects of a heroin or other opiate overdose. The new regulations for naloxone were noted by JAPC. Mr Dhadli highlighted that, although the new regulations enabled lawful drug treatment services to supply naloxone to individuals without the need for a prescription, the issue of funding would need to be resolved as it was unclear where the responsibility for this would lie.	
e.	**Prescribing Specification** Mr Dhadli reported that the prescribing specification had now been updated as follows: • Statement added on free of charge schemes in the HCD section. • Trusts would be expected to horizon scan and engage with clinicians and medicines management in preparation for the uptake of biosimilars. The planned uptake should be agreed and shared with commissioners. • Reference to EAMs included. • Safe use of controlled drugs included. • Reference to free of charge schemes added. • QIPP indicators updated. • PINCER indicators added.	
12.	**JAPC BULLETIN**	
	The November JAPC bulletin was ratified.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for November 2015 was noted. Mr Dhadli highlighted that there no items in the November MHRA Drug Safety Update relevant to primary care.	
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in November 2015: TA363 Ledipasvir–sofosbuvir for treating chronic hepatitis C – Previously classified as a **RED** drug. TA 364 Daclatasvir for treating chronic hepatitis C – Previously classified as a **RED** drug. TA 365 Ombitasvir–paritaprevir–ritonavir with or without dasabuvir for treating chronic hepatitis C – Previously classified as a **RED** drug.	

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	TA 366 Pembrolizumab for advanced melanoma not previously treated with ipilimumab – Classified as a **RED** drug (NHS England high cost drug) TA 367 Vortioxetine for treating major depressive episodes – Previously classified as a **RED** drug. TA 368 Apremilast for treating moderate to severe plaque psoriasis – Re-classified from RED to **BLACK.**	**SD** **SD**
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Eflornithine Cream – **BROWN** for facial hirsutism in women (see BNF chapter for exceptionalities). Midrodine – **BROWN** after specialist initiation and dose titration for orthostatic hypotension. Rivastigmine – **GREEN** after specialist initiation, titration and dose stabilisation for Parkinson's Disease Dementia Complex (PDDC). Alirocumab – **BLACK** Asfotase alfa – **RED** (NHS England commissioned drug) Naloxegol – **BROWN** as per NICE TA 345 Sebelipase alfa – **RED** (NHS England commissioned drug) Sinecatechins – **BLACK** Ledipasvir –**RED** as per NICE 363 Daclatasvir – **RED** as per NICE TA 364 Ombitasvir – **RED** as per NICE TA 365 Pembrolizumab – **RED** as per NICE TA 366 Vortioxetine – **RED** as per NICE TA 367 Apremilast – **BLACK** Dulaglutide – **BROWN** alongside exentatide MR.	
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Grazax – To be brought to the June JAPC 2016 meeting. Immunomodulating drugs – Consultant Rheumatologists to be asked for their views on the drugs on a rolling basis. Midodrine – To be taken off the list. Prescribing specification – To be taken off the list. Pain Guidance – To be brought to the January or February JAPC 2016 meeting. Management of Overactive Bladder – To be brought to the February 2016 JAPC meeting. Chlamydia Guidance – To be brought back to the January 2016 JAPC meeting.	**SD** **SD** **SD** **SD** **SD** **SD** **SD**

Item		Action
	LMWH Bridging Guidance – To be brought to the February or March 2016 JAPC meeting.	**SD**
17.	**GUIDELINE GROUP**	
	The summary of key messages arising from the meeting held in November 2015 was noted. Mr Dhadli highlighted the following: • Buspirone classified as BROWN – SSRIs were usually considered first line for GAD. Venlafaxine and then pregabalin would also be considered ahead of buspirone • Hydrocortisone sodium phosphate injection – The brand Efcortesol had been discontinued but could now be prescribed generically. • Best practice guidance for GP practices, community pharmacists and care home providers - Previously there had been three separate best practice guidelines for each group. These had now been amalgamated into one and updated in line with NICE guideline SC1: Managing Medicines in Care Homes. • Vitamin D guidance – Licensed preparations were now available but were significantly more expensive than the unlicensed preparations. The Guideline Group had discussed the issue of licensed and unlicensed preparations at length. Mr Dhadli reported that he had requested lists of the licensed and unlicensed preparations together with those which were gelatine and nut free. Dr Parkin queried whether it would be necessary to consult with patient groups about their possible support for the use of unlicensed versus licensed products in the light of the very significant savings which could be made and that they were equally effective to the licensed products. Mr Hulme highlighted the need for consistent discussions as any final decisions would need to be ratified by the CCG Governing Bodies. Following a discussion about prescribing for clinical need, and prescribing on the NHS. Mrs Needham suggested that the Guideline Group could develop basic principles relevant to both City and County about the use of licensed and unlicensed drugs, as well as prescribing for clinical need which could follow on from the initial discussions at the north prescribing sub-group. Dr Emslie stated that there may need to be public consultation before any decisions were made about future action. • PPI and Nebuliser Guidance – This would be discussed by JAPC at the January meeting. • Dapoxetine position statement – This would be discussed by JAPC at the January meeting.	**SD** **SD**
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• DTHFT Drugs and Therapeutic Committee 20/10/15 • Sheffield Area Prescribing Group 16/07/15 • Sheffield Area Prescribing Group 17/09/15	

Item		Action
	Mr Dhadli highlighted magnaspartate, which was licensed for the treatment and prevention of magnesium deficiency, and queried whether GPs would be expected to prescribe this on a long-term basis. Dr Goddard commented that its use would be restricted to people with short bowel or intolerant to Maalox and its likely traffic light classification would be RED.	
19.	**ANY OTHER BUSINESS**	
	Mr Dhadli tabled a letter from NHS England which stated that omalizumab for the indication of previously treated chronic spontaneous urticaria was now no longer a NHS England commissioned line and would move over to CCGs. The number of patients was anticipated to be small but there could be a cost pressure for the CCGs and would be need to be highlighted to the Trust Finance groups. Omalizumab for this indication had previously been assigned a traffic light classification of RED as a NHS England specialised commissioned drug but this would need to be re-looked at by JAPC.	**SD**
20.	**DATE OF NEXT MEETING**	
	Tuesday, 12th January 2016 at 1.30pm in the Post Mill Centre, South Normanton.	