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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 10 February 2015

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Calcium + Ergocalciferol (generic)	BLACK (prescribe by brand instead)
Perindopril arginine	BLACK
Perindopril erbumine	BROWN (on the advice of stroke physician)
Gliclazide MR	BROWN (may be beneficial where once daily dosing aids compliance)
Doxazosin MR	BROWN (for patients not able to tolerate IR version)
Dabigatran for the treatment and secondary prevention of DVT and/or PE	GREEN 2nd line following specialist initiation (NICE TA 327)
Cinacalcet	Reclassified from RED to AMBER
Vigabatrin	AMBER for treating epilepsy in children for Derby Hospitals Foundation Trust (remains RED for North Derbyshire)
Daranuvir + cobicistat (Rezolsta)	RED
Pasireotide	RED (but not routinely funded by NHS England)
Eculizumab for treating atypical haemolytic uraemic syndrome	RED (NICE HST 1 (commissioned by NHS England))
Metformin	GREEN
Gliclazide	GREEN

Clinical Guidelines Approved
Psoriasis Pathway/Dovobet Guidance

Shared Care Guidelines Approved
Cinacalcet for the treatment of primary hyperparathyroidism
Vigabatrin for children with tuberous sclerosis or resistant epilepsy

Patient Group Directions agreed for Derby Urgent Care Centre (under One Medical Group)
Amoxicillin capsules and suspension
Codeine
Doxycycline capsules
Erythromycin tablets and suspension
Ibuprofen suspension
Ibuprofen tablets
Nitrofurantoin MR capsules
Paracetamol suspension
Paracetamol tablets
Phenoxymethylpenicillin tablets and suspension
Trimethoprim tablets and suspension

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
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
North Derbyshire CCG	
Dr C Emslie	GP
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Dr M Henn	GP
Derby City Council	
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	
Mr M Steward	Head of Medicines Management
In Attendance:	
Ms S Smith	Commissioning Accountant, Southern Derbyshire CCG
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Dr D Fitzsimons, Ms J Towne, Mr C Newman and Dr M Watkins.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	Mrs Needham requested an update with regards to the pregabalin patent expiry.	
4.	**MINUTES OF JAPC MEETING HELD ON 13 JANUARY 2015**	
	The minutes of the meeting held on 13 January 2015 were agreed as a correct record after the following amendments: Traffic Lights: Remove Posaconazole (Noxafil), as no change was made. Clinical Guidelines: Amend to: Amiodarone Monitoring Protocol and add Lipid Guidelines LWMH to be LMWH throughout. Travel Vaccinations: Amend to: 'It was agreed that Mr David Fagg, Equality Adviser from the Greater East Midlands Commissioning Unit, and PrescQIPP both be contacted to obtain their views on this. Derbyshire Health United (DHU) Governance for Updating PGDs – Amend to: 'JAPC was informed that DHU had now obtained the services of two pharmacists and a committee had been established in order to improve their governance processes for PGDs. New Drug Assessments Evidence Reviews – Amend to: JAPC had classified Flutiform as a BROWN drug because formulary 1st and 2nd line combination steroid inhalers are more cost effective. Amend to: JAPC reflected that these reviews were useful and no action was required on past decisions. Monthly Horizon Scan – Insulin degludec + liraglutide classified as black Liraglutide is not the preferred GLP1 and insulin degludec has a limited role locally. HIV Guidance on Non Anti-retroviral (ARV) Prescribing – Amend to: The document was noted as a useful reference by JAPC but there were no such reported issues in Derbyshire. Off Licence Prescribing of Pregabalin and Aripiprazole – Amend to: Mr Dhadli would consider two position statements; one for pregabalin and for aripiprazole. The pregabalin document would include a reference to the protected patent and licensed indications and that its place in therapy should be reviewed and stopped if necessary. The two papers would be brought back to the April JAPC meeting.	

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	NICE Summary – Amend to: Mr Dhadli would develop a paper to indicate the position of the NOACs in the formulary. A traffic light classification for dabigatran for the treatment and secondary prevention of DVT would be assigned at the next JAPC meeting. TA 328 Idelalisib for treating follicular lymphoma that is refractory to two prior treatments - Terminated appraisal. Classified as BLACK accordingly.	
5.	**MATTERS ARISING**	
a.	**Meningitis ACWY** Mr Dhadli reported that a letter had been received from Mr David Fagg, Equality and Human Rights Project Manager, providing advice about the equality implications of the decision to classify Meningitis ACWY as black for travel. Mr Fagg had advised that there were two views about this; one from the British Medical Association and the other from PrescQIPP and had asked whether both or either of these would be adopted as formal guidance with an additional explanation as to why the decision had been made. Mr Dhadli stated that JAPC had decided to follow the advice given by PrescQIPP that Meningitis ACWY should not be prescribed for travel on the NHS. PrescQIPP had also been contacted and a reply had been received which indicated that in their view the guidance does not create an equity issue for Muslims who attended Hajj nor did it pose any public health risk as the vaccination is a requirement for entry into Saudi Arabia. JAPC agreed that the decision made at the January meeting should remain unchanged.	
b.	**Pathology Lipid Reporting** Mr Dhadli stated that Dr Paul Masters, Consultant Chemical Pathologist, had put forward some recommended wording for inclusion in the pathology reports sent to GPs from RDH and CRH which were consistent with local guidance and NICE lipid guideline (CG181). This was agreed by JAPC. In connection with the reporting of non-HDL cholesterol levels Mr Dhadli referred to an email received from Dr Penelope Blackwell (SDCCG) which indicated that a guideline was in the process of being written by Dr Roger Stanworth and Dr Paul Masters and training was to be provided for GPs. Mr Dhadli would contact Dr Masters directly to ascertain when the non-HDL level would be routinely reported and copy Dr Mott into this email.	**SD**
6.	**NEW DRUG ASSESSMENTS**	
a.	**Jaydess** Mr Dhadli advised that DTB had published a review on Jaydess which had previously been given a traffic light classification of GREEN. The DTB review had concluded that, in the absence of any major advantage in terms of efficacy, safety, user acceptability or cost there was little reason to use Jaydess in preference to Mirena. This is commissioned by Public Health and the review had been seen by Dr Robyn Dewis, Consultant in Public Health Medicine Derby City Council, and the specialist sexual health service. It was felt that there was no need to change the current position that Jaydess should be used as appropriate. This has already been communicated to all GP practices by public health.	

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b.	**PrescQIPP** Mr Dhadli reported that PrescQIPP had first produced a DROP-List of Drugs of Low Priority in 2012 and subsequently an updated list had been developed. This has been reviewed by the guideline group in order to make recommendations to JAPC. The guideline group had decided that from the list, generic calcium and ergocalciferol, doxazosin MR, perindopril arginine and gliclazide MR should be considered by JAPC. Calcium and ergocalciferol – Mr Dhadli stated that this was on both RDH and CRH formularies. PrescQIPP had advised that, when prescriptions were written as calcium and ergocalciferol or calcium and vitamin D without a strength, they would be dispensed as the generic product containing 400 units of ergocalciferol per tablet at a cost of £12.48 for 28 tablets. Alternative branded calcium and vitamin D products with the correct daily dose of calcium and vitamin D for the prevention of osteoporosis should be recommended. Generic calcium and ergocalciferol classified as a **BLACK** drug as it is less cost effective than current standard therapy. Perindopril arginine – PrescQIPP had advised that this offered no benefit over perindopril erbumine and was more expensive. Perindopril arginine classified as a **BLACK** drug due to being less cost effective than current standard therapy. Perindopril erbumine classified as a **BROWN** drug restricted for use on the advice of stroke physicians. Gliclazide MR - This was approximately equivalent in therapeutic effect to standard formulation gliclazide but more expensive. However it was felt that in certain patients its use may be appropriate. Gliclazide MR classified as a **BROWN** drug for exceptional use in certain patients with compliance issues that would benefit from once daily dosing. Doxazosin MR – There was no good evidence of increased benefit over immediate release doxazosin and a review of doxazosin MR versus standard release had revealed that both formulations provided effective blood pressure control and were effective at controlling the symptoms of benign prostatic hypoplasia and improving maximum urinary flow rate. Some low level evidence had indicated that a limited cohort of patients tolerated doxazosin MR better than the immediate release preparation. Doxazosin MR classified as a **BROWN** drug for patients not able to tolerate the side effects of the immediate release preparation.	
c.	**Relvar** Mr Dhadli advised that Relvar for asthma had previously been assigned a traffic light classification of BLACK based on lack of evidence. The manufacturers had revised the colour scheme of the inhalers as some CCGs had decided not to include it in their formularies due to the association with the term 'reliever' and its original blue colour. Mr Dhadli referred JAPC to the lack of evidence which had been considered at the time the original decision had been made which included the absence of clinical effectiveness versus other licensed inhalers and the safety concerns of using high potency steroids. In addition, Relvar has a relatively short shelf-life of six weeks once	

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	opened. Dr Goddard reported that the RDH respiratory physicians had indicated that they wished to use Relvar in a very small and supervised cohort of asthmatic patients. An application had therefore been made for its use to RDHs Trust Drugs and Therapeutic Committee and it was suggested that these should be managed on a concession basis within RDH until they had gained more experience with the inhaler. **Agreed:** Relvar to remain classified as a **BLACK** drug due to lack of evidence.	**SD**
d.	**<u>Rivaroxaban and Dabigatran</u>** Mr Dhadli advised JAPC that the introduction of the novel oral anticoagulants (NOACs) for varying indications has led to a number of multiple traffic light classifications and the need to ensure compliance with the various NICE TAs. Indications for the NOACs were summarised and presented to JAPC members. Mr Dhadli highlighted that it would be necessary to assign a traffic light classification for dabigatran etexilate for the treatment and secondary prevention of DVT and/or PE according to TA 327 In relation to treatment and secondary prevention of DVT and/or PE Dr Mott referred to the need to use low molecular weight heparin with dabigatran at initiation which meant that it was difficult to recommend it over the use of rivaroxaban which does not need LMWH use and is the NOAC with which we have more local experience with. It was agreed that dabigatran should be an option for the treatment and secondary prevention of DVT and/or PE as per the NICE TA 327, and hence it was classified as **GREEN second line,** following specialist initiation. In connection with rivaroxaban (TA 261), it has previously been classified as GREEN following specialist initiation as an option for treating DVT and preventing recurrent DVT and PE after a diagnosis of acute DVT in IV drug users over 18 years of age, and in place of long term LMWH. It was agreed that this be classified as **GREEN** following specialist initiation for all patient groups.	**SD** **SD**
e.	**<u>Umeclidinium</u>** Mr Dhadli reported that umeclidinium was a long-acting muscarinic antagonist (LAMA) for COPD that had been launched in December 2014 and highlighted in the JAPC monthly horizon scan. Mr Dhadli referred to the NICE evidence review which mainly came from two RCTs both using improved FEV1 as primary outcome measures. One had compared umeclidinium with placebo over 12 weeks and the other compared umeclidinium/vilanterol, umeclidinium alone and vilanterol alone with placebo over 24 weeks only. Secondary outcomes had involved a Transition Dyspnoea Index (TDI) and St George's Respiratory Questionnaire (SGRQ). There was limited evidence to support the use of umeclidinium alone (trials had allowed the use of inhaled corticosteroids), limited evidence for the next step as triple therapy if patients were still exacerbating, no data to demonstrate increased safety over other LAMAs and LABAs and limited comparative data with tiotropium. Mr Dhadli added that JAPC had previously assigned traffic light classifications for the	

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	other LAMAs. Tiotropium remained the formulary LAMA classified as GREEN first line and with glycopyrronium bromide and aclidinium BROWN second line and third line. It was noted that tiotropium, although the most expensive LAMA, had better outcome data and its patent expired in March 2016. **Agreed:** Umeclidinium would be left unclassified pending the outcome of the COPD review being undertaken by the guideline group. Dr Mott noted that RDH has a LAMA algorithm and requested the guideline group look at this as part of their COPD guideline review.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**Psoriasis** Mr Dhadli advised that an existing prescribing guideline for Dovobet (calcipotriol and betamethasone) had missed its review date. It has been reviewed in conjunction with RDH and CRH consultant dermatologists. The guideline is now included as an appendix to the psoriasis pathway in the skin formulary which indicates when to prescribe the ointment or gel and the duration that this should be used for. It was agreed that the Dovobet guideline be added back to the skin chapter with a reference to indicate that it had been updated. **Agreed:** JAPC ratified the updated psoriasis guideline.	**SD**
8.	**PATIENT GROUP DIRECTIONS (PGDs)**	
a.	Mr Hulme stated that the new Derby Urgent Care Centre contract was due to commence on 1st April 2015 at Osmaston Road, Derby. A number of PGDs were already in use at the existing Walk-In Centre and these had now been brought to JAPC in order to approve their use after 1st April 2015 with sign-off by Southern Derbyshire CCG. The PGDs concerned were: Amoxicillin capsules and suspension Codeine Doxycycline capsules Erythromycin tablets and suspension Ibuprofen suspension Ibuprofen tablets, Nitrofurantoin MR capsules Paracetamol suspension Paracetamol tablets Phenoxymethyl penicillin tablets and suspension Trimethoprim tablets and suspension **Agreed:** JAPC agreed the Patient Group Directions for One Medical Group.	**SD**
9.	**SHARED CARE GUIDELINES**	
a.	**Cinacalcet** Mr Dhadli reported that a new shared care guideline for cinacalcet had been discussed by JAPC in December 2014 for the treatment of acute hypercalcaemia due to primary hyperparathyroidism for patients when parathyroidectomy was contraindicated or not clinically appropriate, and the treatment of hypercalcaemia in patients who were significantly symptomatic	

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	and awaiting surgery. A DTB review had stated that surgery was the first choice for the vast majority of patients, but for those where surgery was not available or appropriate cinacalcet and alendronate were the recommended choice of drugs for the reduction of serum calcium levels. A shared care guideline had therefore been developed by the CRH and RDH endocrinologists but there had been some queries which had now been answered by Dr Roger Stanworth, Consultant Endocrinologist as follows: • The shared care agreement referred to the monitoring of serum calcium to be carried out every two months but the SPC stated that once stabilised after titration to the maximum dose this should be monitored periodically. Dr Stanworth had indicated that there was minimal chance of hypocalcaemia for patients established on stable doses and therefore six monthly checks were recommended instead. This had now been included in the shared care. • The proposed shared care was not clear about PTH testing/bone profile if there was 3-4 monthly monitoring. Dr Stanworth had indicated that PTH/full bone profile would be annually at the discretion of the consultant endocrinologist and that patients should still return to the endocrine clinic on an annual basis. It was agreed that it should be highlighted that the PTH/bone profile was outside the SPC recommendation. • There had been a query concerning calcium levels if <2.2. Dr Stanworth had updated the shared care with a very helpful table to indicate the ranges of calcium levels and actions to be taken. • JAPC had queried that the patient pathway for the newer proposed indication of 'the treatment of hypercalcaemia (Ca >3.0mm/l) in patients who were significantly symptomatic and awaiting surgery' be described to ascertain why this is included in the shared care for what appeared to be a short course. Dr Stanworth had stated that patients were either referred to endocrinology or admitted acutely with severe hypercalcaemia for a Sestamibi scan and subsequent parathyroid ultrasound. There was only one consultant radiologist who could undertake this particular ultrasound in Derby and patients were referred to Nottingham if localisation studies failed. The period of wait would warrant a shared care • It had been queried that the doses within the proposed shared care were different from those recommended by the SPC. Dr Stanworth had stated that the most frequent dose was twice daily but between one and four doses per day had been used on specialist advice. Mrs Needham highlighted the need for clear notification of surgery dates to prevent waste when prescribing. It was agreed to add this to the consultant responsibilities. Mr Dhadli informed JAPC that some standard wording in the share care were missing and asked for these to be added.. Mr Dhadli queried whether it would be necessary to highlight that this shared care excluded the use of cinacalcet for complex treatment or patients on dialysis as this is NHSE funded – this would be checked. **Agreed:** JAPC ratified the cinacalcet shared care guideline with the agreed amendments.	**SD**

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	Agreed: Cinacalcet re-classified as an **AMBER** drug from the previous classification of RED.	**SD**
b.	**Hyperprolactinaemia** Mr Dhadli advised that there was a current shared care guideline for hyperprolactineamia which recommended as 1st line drug choice cabergoline or bromocriptine and 2nd line quinagolide for patients who were intolerant of cabergoline/bromocriptine or with known or suspected cardiac valvulopathy or pleural/peritoneal fibrosis. The consultant endocrinologists at both RDH and CRH had also proposed that the shared care agreement should be replaced with 'Green following consultant/ specialist advice'. During discussion Mr Dhadli referred to the treatment of hyperprolactinaemic disorders, fibrotic reactions and the expectation that all patients would need a baseline echo within a few months of starting treatment and according to the SPC at 6-12 month intervals. Dr Stanworth had responded to this stating the majority of patients will remain under the follow-up of an endocrinologist and that 2-5 yearly echos would be recommended. Dr Parkin commented on the GP responsibility to adjust the dose as advised by the specialist and that the shared care agreement offered some support for GPs. Dr Emslie and Dr Henn stated that the shared care was a useful resource. **Agreed:** JAPC agreed that hyperprolactinaemia should remain as a shared care.	**SD**
	Action: Mr Dhadli would bring back the hyperprolactaemia shared care to a future JAPC meeting to be updated.	**SD**
c.	**Vigabatrin** Dr Goddard referred to the proposal for the use of vigabatrin in children with Tuberous Sclerosis (TS) submitted by Dr Will Carroll, RDH Consultant Paediatrician. Dr Carroll had highlighted that vigabatrin is usually well tolerated in the recommended doses but can be associated with visual field defects. Dr Carroll had confirmed that the children were all followed up by paediatrics and they would ensure ophthalmologist review as per the SPC. **Agreed:** JAPC ratified the shared care guideline for the use of vigabatrin in children with Tuberous Sclerosis. It would be specified that the shared care guideline applied to Derby Hospitals only, as specialist services in north Derbyshire is provided by Sheffield.	**SD**
	Agreed: Vigabatrin classified as an **AMBER** drug for use in children with Tuberous Sclerosis/resistant epilepsy for Derby. To remain RED for North Derbyshire.	**SD**

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10.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and drug discontinuations in December 2014: New drug launches in the UK: Indacaterol + glycopyrronium (Ultibro Breezhaler) - Already classified by JAPC as **BLACK** in May 2014. New formulation launches in the UK: Darunavir + cobicistat (Rezolsta) – Classified as **RED** (NHS England high cost drug). Licence extensions: Enzalutamide (Xtandi) – already classified as RED Pasireotide (Signifor) – Classified as **RED**. NHS England commissioned for Cushing's disease (but not routinely funded). Drug discontinuations (January 2015): Caprilon Fortisip Savoury Multi Fibre XLEU Faladon	
11.	**MISCELLANEOUS**	
a.	**<u>Biosimilars</u>** Mr Dhadli explained that biosimilars are biologic medicines developed to have a very similar pharmacological effect to that of an original branded biologic products and with the same dose regimen, but without an identical chemical structure. Biosimilars are marketed after the patent for the originator product has expired. Although they might be regarded as 'generic' medicines they are not chemically identical, so the process for approval of licences for marketing is not the same as it is for generic drugs. Biosimilars go through broadly the same process for approval by the European Medicines Agency (EMA) as other generic pharmaceuticals although there are more stringent checks during the manufacturing process and clinical trials are required to demonstrate efficacy. In clinical trials, more attention is paid to immunogenicity, development of antibodies to the new product, adverse reactions and safety. Once the new biosimilar has been tested in one or more indications it is not considered necessary for trials to be done in every type of indication where that agent might be used as its biological action is considered to be proven. NICE would consider similar biological medicinal products notified to it for referral to the Technology Appraisal topic selection process. Mr Dhadli highlighted issues of governance associated with the use of biosimilars and that potential savings could be made. It would be necessary to hold discussions with the hospitals about the future use of biosimilars. Dr Mott commented on the need to be confident about safety and quality although there were opportunities for savings in the future.	
b.	**<u>Dementia Toolkit</u>** Mr Dhadli reported that a JAPC joint position had been produced in conjunction with DHcFT to highlight where the recommendations within the national 'Dementia Revealed' toolkit varied from local guidance.	

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c.	**Agreed:** The JAPC joint position statement was ratified and would be placed on the website with a signpost to the national document. **Value Based Pricing** Mr Dhadli stated that the Government proposed moving towards a broader value-based system for assessing and pricing branded drugs. This aimed to ensure that the price the NHS pays for a medicine better reflects its benefits. JAPC noted the value based pricing briefing for information.	**SD**
12.	**JAPC BULLETIN**	
	Mrs Needham referred to the Antimicrobial Treatment Guidelines and an amendment to be made by Dr Diane Harris. Mr Dhadli would delay the despatch of the bulletin until this had been checked with Dr Harris. Dr Mott suggested that an amendment be made to the lipid modification section to indicate that the CCGs could consider this to be a low priority – this was agreed. The January 2015 JAPC bulletin was ratified.	**SD** **SD** **SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for January 2015 was noted. Mr Dhadli highlighted the following: • Valproate presents a risk of abnormal pregnancy outcomes and is now a black triangle medicine subject to additional monitoring. Any suspected side effects to valproate should be reported via the Yellow Card scheme. • Ustekinumab (Stelara): risk of exfoliative dermatitis. This was currently classified as RED as it is a high cost drug. • Mycophenolate mofetil (CellCept) and mycophenolic acid: risk of hypogammaglobulinaemia and risk of bronchiectasis. • Aceclofenac (Preservex): updated cardiovascular advice in line with diclofenac and COX-2 inhibitors. • Yellow Card now extended to include devices, counterfeits and defective medicines. The shared care guidelines may need to be updated to include this.	
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in January 2015: HST1 (Highly Specialised Technology Guidance) Eculizumab for treating atypical haemolytic uraemic syndrome – Classified as **RED** as commissioned by NHS England. NG1 (National Guidance) Gastro-oesophageal reflux disease: recognition, diagnosis and management in children and young people – Mrs Qureshi highlighted that PPIs or H2 receptor antagonists (H2RAs) could be offered as a four week trial for infants for overt regurgitation and unexplained feeding	

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	difficulties or if they were distressed or had faltering growth. Dr Mott commented that a local guideline was needed due to over-treatment as a condition and mis-diagnosis. The Guideline Group would be requested to develop a local guideline by May 2015.	**SQ**
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Calcium + Ergocalciferol generic – BLACK (prescribe by brand instead) Perindopril arginine – BLACK Perindopril erbumine – BROWN (restricted for certain stroke patients) Gliclazide MR – BROWN (restricted for certain patients to aid compliance) Doxazosin MR – BROWN (for patients not able to tolerate IR version) Dabigatran – GREEN 2nd Line (TA 327) Cinacalcet – Reclassified from RED to AMBER Vigabatrin – AMBER for Derby Hospitals Foundation Trust Daranuvir + carbistat (Rezolsta) – RED Pasireotide – RED (not routinely funded by NHS England) Eculizumab for treating atypical haemolytic uraemic syndrome – RED (NICE HST 1 commissioned by NHS England)	
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Lipid Guidance – To be removed from the list, as completed. Fluticasone propionate nasal drops (nasules) – To be brought to the March JAPC meeting. Vigabatrin – To be removed from the list, now completed. Cinacalcet – To be removed from the list, now completed. Clozapine – To be brought to the March JAPC meeting. Rivaroxaban/NOACs – To be removed from the list, now completed. Aripiprazole and pregabalin – In connection with pregabalin Mrs Needham suggested that a holding statement be issued to practices to say that the prescribing should remain as generic while the price remained listed as Lyrica. No information had yet been issued to practices. Mr Hulme advised that a court case was ongoing with the generic manufacturers and an interim decision had been made that the generic manufacturer could not be stopped from going ahead but they would need to contact the CCGs to indicate that their generic product could not be used for neuropathic pain and labels would need to put on the packaging to this effect. Information had been received that due to the ongoing court case the Drug Tariff price would not drop and most CCGs were not issuing advice at this stage. Mr Hulme added that some CCGs in the West Midlands area were seeking legal advice and this could be used to influence the local position. It was agreed that no action would be undertaken at this time due to awaiting the legal position.	**SD** **WG** **SD** **SD** **SD** **SD**

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17.	**GUIDELINE GROUP**	
	The summary of key messages arising from the meeting held in January 2015 was noted. Mr Dhadli highlighted the following: Nicorandil now classified as a GREEN drug.	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Sheffield Final Area Prescribing Group minutes 20.11.14 • DHcFT Drugs and Therapeutic Committee draft summary and minutes 27.11.14 • DHFT Drugs and Therapeutic Committee draft minutes 16.12.14 • CRH Drugs and Therapeutic Committee minutes 20.1.15 • MOST minutes 21.1.15 Mr Dhadli highlighted the following items from the Sheffield Area Prescribing Group minutes: • Needle free insulin delivery services classified as RED due to specialist use and consideration to be given to how patients who require these devices have their future insulin. • Gender dysphoria – Discussed whether this should this be funded at tertiary/area team level rather than primary care. • Dementia shared care – Discussed whether this should this be replaced with a guideline. • Lithium monitoring CG185 Bipolar Disorder – Ms Beverley Thompson at DHcFT had been contacted to check whether the monitoring requirements in the Derbyshire shared care guideline were different to the clinical guideline.	
19.	**ANY OTHER BUSINESS**	
	Alogliptin Dr Goddard reported that Dr Game was in discussion with physicians at CRH about JAPC's decision and the licensing. A response is expected in due course. Mr Dhadli suggested that the MTRAC summary about the licensing of the different gliptin drugs be included in the diabetes guidance.	
20.	**DATE OF NEXT MEETING**	
	Tuesday, 10 March 2015 at 1.30pm in the Post Mill Centre, South Normanton.	