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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 12th July 2016

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Olodaterol+tiotropium (Spiolto Respimat)	To remain BLACK
Tamoxifen	GREEN specialist initiation to prevent bicalutamide induced gynaecomastia
MacuLEH Light	BLACK
Necitmumab	RED
Adalimumab	RED as per NICE TA 392
Ceritinib	RED as per NICE TA 395
Trametinib	RED as per NICE TA 396
Belimumab	RED as per NICE TA 397
Empagliflozin	GREEN- Preferred 1st line SGLT2 inhibitor
Canagliflozin and dapagliflozin	BROWN- Alternatives to empagliflozin if intolerant or restriction by licensing.
Liraglutide and exenatide (daily dosing)	BROWN-Alternatives to lixisenatide if intolerant or restriction by licensing.
Repaglinide	BROWN- Limited for use in patients with early diabetes or in patients with erratic lifestyles

Clinical Guidelines

Extension of Management of Hypertension Using ABPM guideline for two years

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mr S Hulme	Director of Medicines Management (also representing Erewash CCG)
Mrs S Qureshi	NICE Audit Pharmacist
Ms N Smith	Finance Officer
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Mrs K Needham	Head of Medicines Management (also representing Hardwick CCG)
Ms J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Derby City Council	
Derbyshire County Council	
Derby Teaching 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	
Ms C Duffin	Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Ms J Shaw	Principal Pharmacist
In Attendance:	
Mr T Goodwin	Pharmacist, Southern Derbyshire CCG
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Ms S Bassi, Dr R Dewis, Dr M Henn, Dr T Narula and Mr C Newman.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	No declarations of any other business were made.	
4.	**MINUTES OF JAPC MEETING HELD ON 14 JUNE 2016**	
	The minutes of the meeting held on 14th June 2016 were agreed as a correct record after the following amendments: Deletion of Dr C Emslie from the list of attendees. Olodaterol and Tiotropium – Amend to 'Results from the studies for lung function improvement were in the main non-clinically significant (<100mls).'	
5.	**MATTERS ARISING**	
a.	**Osteoporosis Guideline** Mr Dhadli reported that the draft guidance had been sent to Dr Stanworth who would be meeting with colleagues on 22nd July to discuss the key proposed changes. A copy also sent to CRHFT. The draft guideline would be discussed by JAPC at the August 2016 meeting.	**SD**
b.	**Shingles Patient Group Direction - Zostavax®** The short expiry date had been queried at the last meeting and Mr Dhadli advised that a revised version of the shingles PGD would be circulated by NHS England.	
c.	**Buccal Midazolam Information Sheet** Mrs Needham reported that work was in progress to look at the trends by CCG in the prescribing of the unlicensed product Epistatus. The letter to be signed by Dr Mott would be sent to Ms Gaynor Ward once this information was available.	
d.	**Oral Nutrition Support (ONS) Guidelines for Adults** Mr Dhadli advised that, following a pharmacy educational event delivered by the lead dietitian from DTHFT (Fiona Moor), some minor changes needed to be made to the ONS guidelines concerning a change to the MUST scoring and the need to avoid stopping abruptly. In addition, the pharmacists had requested a reference to re-feeding syndrome, a serious potential complication of commencing feeding in children and young people who had experienced starvation, had now been added. The guideline had been approved by Ms J Barratt and Ms F Moore, but comments were still awaited from Ms Melanie Coy from CRHFT. The addition of a standard referral form would also be considered as an appendix if agreed Derbyshire wide. It was highlighted that the referral criteria had not been changed on the website but there was a need for the dietitians to agree the levels for the referral form. **Agreed:** The guideline would be brought back to JAPC after comments had been received from Ms Coy**.**	**SD**

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6.	**NEW DRUG ASSESSMENTS**	
a.	**LABA and LAMA Combination inhalers for COPD** Mr Dhadli referred to the discussion at the June 2016 JAPC meeting about tiotropium and olodaterol (Spiolto Respimat) which was the first LABA/LAMA combination to include JAPC formulary choice LAMA tiotropium. The NICE Evidence Summary of New Medicines Review for Spiolto Respimat® had been looked at and it had been agreed that a review should be undertaken of all the LAMA/LABA products in order to determine whether JAPC still agreed with the decisions which had been made about their place in therapy and the traffic light classifications which had been assigned. In addition, it would need to be determined whether the current traffic light classification of BLACK for Spiolto Respimat® should be changed. Mr Dhadli had therefore developed a summary table which contained the NICE Evidence Summary Reviews for indacaterol/glycopyrronium (Ultibro Breezhaler®, aclidinium/formoterol (Duaklir Genuair®), umeclidinium/vilanterol (Anoro Ellipta®) and tiotropium/olodaterol (Spiolto Respimat®). The evidence for each product using primary and secondary endpoints from the main studies had been presented in the table for its effect on exacerbations, SGRQ health status, dyspnoea and lung function FeV1. Discussion followed and Mr Dhadli highlighted that all of the LAMA/LABA combination products had a low level of evidence in terms of primary relevant clinically significant outcomes for FEV1 and secondary patient orientated outcomes and this was the reason why they had not been given a classification of GREEN. This was particularly relevant concerning Anoro Ellipta® and Spiolto Respimat® versus placebo; both of which had limited or no patient orientated outcomes. However Spiolto Respimat® was used once daily and was an inhalation solution compared to the other LAMA/LABA combination inhalers which were dry powder inhalers. Dr Henn had previously pointed out that despite this it was not particularly user friendly and that indacaterol/glycopyrronium was also a once-daily combination. **Agreed:** JAPC noted the review of the LAMA/LABA products and agreed that Spiolto Respimat should remain classified as **BLACK** and existing classification for all other LABA/LAMAs remain**.**	**SD**
b.	**Tamoxifen** Dr Goddard reported that tamoxifen for the treatment of bicalutamide-induced gynaecomastia had been discussed by the DTHFT Drugs and Therapeutic Committee (DTC). NICE had issued guidance on the diagnosis and management of prostate cancer which indicated that radiotherapy could be given and then followed by treatment with weekly tamoxifen off-licence but further evidence had emerged that recommended the use of daily dose tamoxifen. Radiotherapy would only be used for those patients who were not suitable for tamoxifen. The DTHFT DTC had supported this approach but it had been highlighted that primary care would need to provide tamoxifen, together with bicalutamide, and its use for the treatment of gynaecomastia is off-licence. Mr Dhadli advised that bicalutamide was used as an adjuvant to primary treatments (radical prostatectomy or radiotherapy) or as monotherapy in men with locally advanced, non-metastatic prostate cancer.	

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	However, in the early prostate cancer programme, the incidence of gynaecomastia was 68.3% to 73.6% with symptoms developing within the first six to nine months of bicalutamide use in most cases with a significant number (17%) then discontinuing treatment. A number of treatments were used to prevent or alleviate bicalutamide-induced gynaecomastia and these included radiation therapy, surgery and hormonal therapy with tamoxifen and anastrozole. There was concern that the use of radiotherapy could be related to cardio toxicity in men under the age of 60 years which could lead to secondary malignancies. The NICE guideline on the diagnosis and management of prostate cancer had been issued in 2008 and recommended the use of radiotherapy as first line treatment to be followed by a weekly dose of tamoxifen based on the evidence presented by the Lorenzo study (2005). More trial evidence was now available. Long term use of tamoxifen would need discussion between the clinician and patient as to risks and benefits and there was no monitoring requirement for its use. Dr Emslie and Dr Parkin advised that there were no concerns about the use of tamoxifen in primary care as it was a familiar drug to GPs. **Agreed:** Tamoxifen classified as a **GREEN specialist/consultant initiation** drug for the treatment of bicalutamide induced gynaecomastia as patients would require specialist initial and short-term assessment.	**SD**
c.	**<u>MacuLEH Light</u>** Mr Dhadli reported that MacuLEH Light was the first drug tariff listed vitamin and antioxidant product for patients with age related macular degeneration (ARMD) and an accompanying statement had been produced to indicate that this product may help maintain vision following assessment by a Consultant Ophthalmologist for patients with a specific stage of ARMD. The evidence for these type products comes primarily from just one clinical trial the Age-Related Eye Disease Study (AREDS) on the effect of high doses of vitamin C, vitamin E, beta-carotene and zinc on the progression of ARMD and cataracts. It was noted that MacuLEH contained the same formulation as the products which had been assessed in the AREDS study (including Viteyes). Mr Dhadli drew attention to the paper on antioxidants and zinc for ARMD prepared by the UK Medicines Information (2011) and a publication from the Northern Treatment Advisory Group and the concerns expressed about their long-term safety. **Agreed:** MacuLEH Light classified as a **BLACK** drug/medical device due to lack of data on cost effectiveness and safety.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**<u>Management of Hypertension</u>** JAPC was advised that there were no changes to the existing guideline which was due to expire at the end of July 2016. **Agreed:** JAPC ratified an extension to the Management of Hypertension Guideline of two years.	**SD**
b.	**<u>Management of Type 2 Diabetes in Adults</u>** Mrs Qureshi reported that the draft diabetes guidance had been sent out and amended accordingly in the light of comments received from the consultees from the acute trusts.	

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	Mrs Qureshi highlighted some of the main changes to the guidance: • Section on bariatric surgery and weight loss had been included. • A note had been added to repaglinide to indicate that it was limited for use in early diabetes and should not be included in the algorithm. • Addition of ABCD approach in the individualised care section. • Links included to other NICE guidance in dietary advice section. • Inclusion of traffic light classifications for high strength insulins. • Inclusion of insulin cost comparison chart and licenced and NICE approved insulin combinations. • Addition of NICE approved dual therapy combinations in appendix one and triple therapy combinations in appendix two. • Glycaemic control in type 2 diabetes using a GLP1 amalgamated into one page. Mr Hulme queried whether there was a referral form for the X-PERT health diabetes programme to be used in Southern Derbyshire and Erewash CCGs. Mrs Qureshi would contact Mr M Burrows at Southern Derbyshire CCG to clarify the method of making referrals to the programme. Mrs Needham also suggested that the weight loss section should be amended to read Bariatric Surgery – this was agreed. Mrs Qureshi referred to the proposed changes to the traffic light classifications for the diabetes drugs: • Metformin – GREEN 1st line • Metformin MR - GREEN 2nd line (JAPC agreed to indicate that Sukkarto ® was the preferred brand) • Gliclazide – GREEN Immediate Release/BROWN Modified Release • Pioglitazone – BROWN at the request of the consultants due to safety concerns about risk of heart failure and bladder cancer • Alogliptin – GREEN 1st line gliptin • Linagliptin – GREEN alternative 1st line for renal and hepatic impairment. JAPC agreed that the wording for this should be reviewed. • Sitagliptin – BROWN • Saxagliptin - BROWN • Vildagliptin - BROWN • Empagliflozin – JAPC agreed to amend to GREEN 1st line • Canagliflozin – JAPC agreed to amend to BROWN • Dapagliflozin –JAPC agreed to amend to BROWN • Lixisenatide – GREEN 1st line • Liraglutide – JAPC agreed to amend to BROWN • Exenatide – JAPC agreed to amend to BROWN • Exenatide MR – BROWN (when weekly preparation was indicated) • Dulaglutide - BROWN **(**alongside exenatide weekly) • Albiglutide - Unclassified • Repaglinide – BROWN (limited for use in early diabetes) Discussion followed on the current traffic light classification of BROWN which had been assigned to pioglitazone in view of the safety concerns which had been highlighted. It was noted that pioglitazone was a cost effective option and there could be some merit in re-classifying to GREEN.	**SQ**

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	Dr Emslie and Dr Parkin commented that the consultant diabetologists had indicated that a traffic light classification of BROWN was appropriate and this would highlight the need to be cautious with the use of pioglitazone. There would also be a need to ascertain that the safety issues were of sufficient concern to influence the decision to be made about a traffic light classification. **Agreed:** In view of the need to resolve the safety issues concerning pioglitazone it was agreed that the diabetes guidance would be discussed and ratified by JAPC at the August 2016 meeting. **Action:** Mrs Qureshi and Mr Dhadli would check the safety issues around the use of pioglitazone with NICE and via the General Practice Research Database.	**SD** **SQ/SD**
8.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: Dequalinium chloride (Fluomizin) for bacterial vaginosis in adults – Mr Dhadli advised that this drug had been discussed with Dr A Apoola, DTHFT GUM Consultant, and would be left unclassified pending a request from the specialist sexual health service. Dr Watkins queried when a traffic light classification would be assigned - Mr Dhadli would check with Dr D Harris, Specialist Antimicrobial Pharmacist. Necitumumab (Portrazza) – NHS England. Classified as **RED.** Safinamide (Xadago) MAO inhibitor – For Parkinson's disease, mid-to late-stage, in adults – add-on therapy to levodopa alone or in combination with other drugs. It was highlighted that the US Food and Drug Administration had requested clinical evaluation of the potential effect of safinamide on behaviours relating to abuse liability and dependence/withdrawal effects. New formulation launches in the UK: Betamethasone dipropionate + calcipotriol (Enstilar) foam preparation for psoriasis vulgaris in adults. The cream and gel is already on the formulary with guidance and it was queried whether the new formulation would be covered by the current traffic light classification/formulary. The Guideline Group would be requested to discuss and come back to JAPC if it was decided that further discussion was needed.	**SD** **SD** **SD**
9.	**MISCELLANEOUS**	
a.	**<u>Constipation Drug Reviews</u>** Mr Dhadli reported that the BMJ had published a systematic review and network meta-analysis of the efficacy of pharmacological treatments for chronic idiopathic constipation (CIC). The efficacy of the existing drugs for the treatment of CIC compared to placebo had been undertaken using Bayesian network meta-analysis. The BMJ review and meta-analysis was noted by JAPC.	

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b.	**Sacubitril Valsartan** Mr Dhadli referred to the Drugs and Therapeutic Bulletin (DTB) review study on sacubitril valsartan which was a new oral drug licensed for the treatment of symptomatic chronic heart failure in adults with reduced ejection fraction. The review highlighted the PARADIGM-HF study which had been a large multicentre (1,043 centres in 47countries) double-blind randomised controlled trial that investigated the superiority of sacubitril valsartan over enalapril in addition to existing therapy. There were some shortfalls with the study in that the trial results may not reflect the tolerability and efficacy of sacubitril valsartan in an older population. In addition, the dosage of enalapril and valsartan was lower than what would be used in clinical practice and only 0.7% of patients had severe disease (NYHA class IV). Mr Dhadli commented that, in the light of the results of the study, it would be necessary for the clinicians to carefully determine the place in therapy of sacubitril valsartan and which cohorts of patients would benefit. Dr Goddard advised that sacubritil valsartan was to be discussed by the DTHFT Drugs and Therapeutic Committee. The DTB study was noted by JAPC.	
c.	**ICS Inhalers in COPD** JAPC was informed that the European Medicines Agency (EMA) had completed a review of the known risk of pneumonia (lung infection) in patients who had taken inhaled corticosteroid (ICS) in medicines to treat chronic obstructive pulmonary disease (COPD). The EMA had concluded that there was no conclusive clinical evidence for intra-class differences in the magnitude of the risk among ICS products and, although there was some evidence of an increased risk of pneumonia with increasing steroid dose, this has not been demonstrated conclusively across all studies. Healthcare professionals were therefore advised to look out for possible development of pneumonia in patients with COPD as the clinical features of such infections overlap with the symptoms of COPD exacerbations. The EMA study was noted by JAPC together with the need to step down where possible the administration of ICS in order to avoid the risk of possible side effects. JAPC agreed that this does not change JAPC advice with Fostair as the preferred LABA steroid combination for COPD when indicated.	
d.	**JAPC Stakeholder Map** Mr Dhadli stated that the JAPC Stakeholder Map would be included in the JAPC terms of reference and the Annual Report. Derbyshire Health United (DHU) would be added to the map and Mr Hulme advised that a reference to medicines safety accountability to JAPC was being developed for inclusion in the committee's terms of reference.	
e.	**JAPC Annual Report** The draft JAPC Annual Report April 2015 to March 2016 was noted. Dr Mott advised that the prescribing specification was still to be added and members were requested to convey any minor amendments to Mr Dhadli within two weeks. The final version of the Annual Report would be brought to the August 2016 JAPC meeting for information.	**All Members SD**

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10.	**JAPC BULLETIN**	
	The bulletin was ratified by JAPC.	**SD**
11.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for June 2016 was noted. Mr Dhadli highlighted the following MHRA advice: • Canagliflozin: signal of increased risk of lower extremity amputations in trial in high cardiovascular risk patients. • Nexplanon (etonogestrel) contraceptive implants: reports of device in vasculature and lung. • Topical miconazole, including oral gel: reminder of potential for serious interaction with warfarin.	
12.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in June 2016. TA 392 Adalimumab for treating moderate to severe hidradenitis suppurativa - Classified as a **RED** drug (NHS England). TA 393 Alirocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia – Alirocumab was recommended as an option for treating primary hypercholesterolaemia or mixed dyslipidaemia only if the maximum dose had been reached or further titration was limited by intolerance (as defined in NICE's guideline on familial hypercholesterolaemia: identification and management). It was highlighted that a definition of the patient cohort was needed together with numbers who were intolerant to statins. Previously classified as a **RED** drug. TA 394 Evolocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia - Evolocumab was recommended as an option for treating primary hypercholesterolaemia or mixed dyslipidaemia, only if the maximum dose had been reached, or further titration was limited by intolerance (as defined in NICE's guideline on familial hypercholesterolaemia: identification and management). It was highlighted that a definition of the patient cohort was needed together with numbers who were intolerant to statins. Previously classified as a **RED** drug. TA395 Ceritinib for previously treated anaplastic lymphoma kinase positive non-small cell lung cancer - Classified as a **RED** drug (NHS England). TA396 Trametinib in combination with dabrafenib for treating unresectable or metastatic melanoma – Classified as a **RED** drug (NHS England). TA397 Belimumab for treating active auto antibody positive systemic lupus erythematosus – Classified as a **RED** drug (NHS England).	**SD** **SD** **SD** **SD**
13.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Spiolto Respimat – to remain **BLACK**	

Item		Action
	Tamoxifen – **GREEN** specialist initiation to prevent bicalutamide induced gynaecomastia MacuLEH Light – **BLACK** Necilimumab – **RED** Adalimumab – **RED** as per NICE TA 392 Certinib – **RED** as per NICE TA 395 Trametinib – **RED** as per NICE TA 396 Belimumab – **RED** as per NICE TA 397 Empagliflozin – **GREEN** – Preferred 1st line SGLT2 inhibitor Canagliflozin and dapagliflozin – **BROWN** Alternatives to empagliflozin if intolerant or restriction by licensing. Liraglutide and exenatide (daily dosing) – **BROWN** Alternatives to lixisenatide if intolerant or restriction by licensing. Repaglinide – **BROWN** – Limited for use in patients with early diabetes or in patients with erratic lifestyles	
14.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Management of Type 2 Diabetes in Adults – To be finalised at the August 2016 JAPC meeting. PCSK9 inhibitors – To be brought to the September 2016 JAPC meeting. Guanfacine – To be brought to the January 2017 JAPC meeting. Buccal Midazolam – To be taken off the list. LABA/LAMA combination products – To be taken off the list.	**SD** **SD** **SD** **SD** **SD**
15.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in May 2016 was noted. Mr Dhadli highlighted the following: • Eflornithine cream, goserelin, oestradiol gel, cyproterone acetate, dianette, spironolactione, medroxyprogesterone acetate (oral) and finasteride classified as GREEN as per the NHS England transgender circular. • The following insulins had been included in traffic light database as GREEN: Soluble insulin (Actrapid, Humulin S, Insuman Rapid), Insulin aspart (Novorapid), Insulin lispro (Humalog), Isophane insulin (Insulatard, Humulin I, Insuman Basal), Biphasic aspart (Novomix), Biphasic insulin lispro (Humalog Mix 25, Humalog Mix 50). • Minoxidil classified as a BLACK drug. • Diagnosis and management of lower UTIs – Mr Dhadli would liaise with Dr Diane Harris to confirm a date for completion. • Infant feeding guidelines – Mr Dhadli would check on progress.	**SD** **SD**

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16.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Burton Drugs and Therapeutic Committee 09/05/16 • DTHFT Drugs and Therapeutic Committee 17/05/16	
17.	**ANY OTHER BUSINESS**	
	No items of any other business were transacted.	
18.	**DATE OF NEXT MEETING**	
	Tuesday, 9th August 2016 at 1.30pm in the Post Mill Centre, South Normanton.	