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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 10th May 2016

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Benzbromarone	RED
Saline nasal sprays (e.g. Sterimar® , Aqua Maris®)	BLACK
Spironolactone	GREEN
Metolozone	GREEN after specialist recommendation
Fultium D3®	GREEN preferred formulary choice for treatment of Vitamin D deficiency. Cost effective choice for treatment and maintenance
Invita D3®	GREEN cost effective option in patients with swallowing difficulties for treatment and maintenance
Desunin®	GREEN as alternative formulary choice for maintenance
ProD3® and Hux D3® to be removed from traffic light classification	
Clevidipine	RED
Osimertimib	RED (NHS England)
Talimogene laherparepvec	RED (NHS England)
Ticagrelor (60mg dose)	BLACK for MI
Abiraterone	RED as per NICE TA 387
Sacubitril valsartan	RED as per NICE TA 388
Paclitaxel	RED as per NICE TA 389
Doxorubicin hydrochloride (PLDH)	RED as per NICE TA 389
Gemcitabine	BLACK as per NICE TA 389
Trabectedin	BLACK as per NICE TA 389
Topotecan	BLACK as per NICE TA 389

Clinical Guidelines

Domperidone - Off-licence use Metoclopramide use in gastro-paresis and other gastric outlet physiological impairment.
Management of Heart Failure with Reduced Ejection Fraction.
Midodrine prescribing for orthostatic hypotension.
North Derbyshire Algorithm for Antiplatelet Therapy in Primary PCI - STEMI.
Management of Sub-therapeutic INR
Fosfomycin for multi-resistant UTIs
Prevention, Diagnosis and Management of Vitamin D Deficiency in Primary Care.

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Patient Group Directions
Meningococcal Group C
Levonorgestrel 1500 microgram tablet (Levonelle®).

Shared Care Guidelines
Methotrexate (oral/subcutaneous/intramuscular preparations for CRHFT/North Derbyshire and oral only preparations for DTHFT/South Derbyshire).

Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mr S Hulme	Director of Medicines Management
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Dr T Narula	GP
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Ms J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Dr M Henn	GP
Derby City Council	
Dr R Dewis	Consultant in Public Health Medicine
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
Dr W Goddard	Chair - Drugs and Therapeutic Committee
Mr C Newman	Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Ms S Bassi	Chief Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Mr M Steward	Head of Medicines Management
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Mrs L Hunter.	
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 12 APRIL 2016**	
	The minutes of the meeting held on 12th April 2016 were agreed as a correct record after the following amendments: Summary Points – Amend to: Ruxolitinib RED (re-classified from BLACK) as per NICE TA 386. Add: Nitisinone (Orfadin) – RED References in the minutes to PSV to be amended to PPV throughout.	
5.	**MATTERS ARISING**	
a.	**Ulipristal** Mr Dhadli reported that a number of questions had been developed by the Guideline Group in relation to the place of ulipristal acetate in the single shared care pathway for symptomatic fibroids in pre-menopausal women. The following queries had been conveyed to Ms J Parratt, CRHFT Consultant Gynaecologist from the Guideline Group: • What treatment should have been tried before a patient was referred into the pathway suggested? • Which sections in the flowchart should be for acute use? • How many cycles should be given to a patient? • What advice should be given to GPs about clinical criteria when referring back to secondary care while a patient was on treatment? • Clarification of responsibility for undertaking ultrasound scans. • An idea of patient numbers for North and South Derbyshire in order to determine budget impact. Mr Dhadli also advised that a NICE Clinical Guideline for Heavy Menstrual Bleeding that would include ulipristal acetate was due to be published in August 2016 and that it currently had a traffic light classification of RED. Mr Shepherd agreed to contact Ms Parratt about the queries which had been raised by the Guideline Group.	**MSh**
6.	**NEW DRUG ASSESSMENTS**	
a.	**Benzbromarone** Dr Goddard advised that a recent incident had led to the prescribing of benzbromarone in primary care although it was only normally prescribed by a specialist in secondary care after treatment with allopurinol and febuxostat, the preferred treatments for gout, were found to be unsuitable and then only via a concessionary process. It was noted that benzbromarone was unlicensed in the UK and required some degree of monitoring. **Agreed:** Benzbromarone classified as a **RED** drug.	**SD**

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b.	**Saline nasal spray** Mr Dhadli reported that the evidence for saline preparations had been discussed by the Guideline Group in the light of the PrescQIPP statement on the nasal spray forms, Sterimar® and Aqua Maris®, and these were considered to be less effective than higher volume nasal irrigation. The Guideline Group had recommended that these drugs should not be commissioned. **Agreed:** Saline nasal sprays, including Sterimar® and Aqua Maris®, classified as **BLACK** medical devices due to lack of data on effectiveness compared with standard therapy.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**Domperidone** Mr Dhadli advised that no update was required for the position statement for the use of domperidone in off-license indications which had been produced in May 2014 following the MHRA Drug Safety Alert. **Agreed:** JAPC ratified an extension of two years for the off-licence use of domperidone for gastroparesis and other gastric outlet physiological impairment; babies and children (normally prescribed by specialists) and nursing mothers to promote lactation.	**SD**
b.	**Metoclopramide** Mr Dhadli advised that no update was required for the clinical guideline for the use of Metoclopramide in gastro-paresis and other gastric outlet physiological impairment. **Agreed:** JAPC ratified an extension of two years for the clinical guideline for metoclopramide.	**SD**
c.	**Management of Heart Failure** Mr Dhadli stated that the local Heart Failure guidance had expired in October 2014 but the Scottish Intercollegiate Guidelines Network (SIGN) 147 'Management of Chronic Heart Failure' had been used as a reference to update this local guidance. During the update NICE had published NICE TA 388 for the use of sacubitril valsartan for the treatment of symptomatic chronic heart failure with Reduced Ejection Fraction. The local guidance had been circulated to the cardiologists at CRHFT and DTHFT, and also to the DCHSFT specialist heart failure nurses, and comments had now been received. Mr Dhadli advised that two versions of the guidance had been produced: Management of Heart Failure with Reduced Ejection Fraction (HFREF) and Management of Heart Failure with HFREF that included sacubitril valsartan. Mr Dhadli highlighted the following changes which had now been made to the guidance for the management of heart failure with HFREF: • Left ventricular systolic dysfunction had now been replaced with the term “reduced ejection fraction”. • Clearer recommendations of the baseline tests which should be undertaken.	

	• Monitoring requirements had been strengthened. • Specific reference to the diuretic drugs to be used and how the dosing should be increased. • Management of diuretic resistance after specialist initiation and assessment. • SIGN guidance had been used to inform the renal function section in ACE inhibitors and ARBs. • Beta-blocker monitoring updated in line with SIGN recommendations. • Diagnosing heart failure - When questioning the diagnosis in patients on treatment, the medication should be stopped for three days before taking the test or leave on treatment and obtain an ECHO. • Spironolactone to be used on specialist initiation only. Monitoring has been updated after local agreement for repeat U&Es at 5 to 7 days post initiation; then at 4, 8 and 12 weeks and then 6 monthly thereafter. Three monthly or more intensively may be necessary if there are clinical reasons why the patient is at increased risk of renal impairment. • Patient information for beta-blockers in heart failure updated with drug tables. • Appendix included the DCHS heart failure referral form. • Addition of reference in the resource section to indicate that clinicians should be alert to the development of Acute Kidney Injury in patients being treated for heart failure and using sick day guidance. • Angiotensin receptor blockers - The combination of ACE+ARB+ mineralocorticoid receptor antagonist together is not recommended. During discussion Dr Narula referred to the serum peptide levels in the diagnosing heart failure section and highlighted an apparent discrepancy with the levels recorded at CRHFT. Mrs Needham and Mr Shepherd would check this via the CRHFT Drugs and Therapeutic Committee. Dr Parkin highlighted that, although some GPs may be experienced in the use of spironolactone, the guidance indicated that this should only be used on specialist initiation only. In addition, metolazone should only be recommended by a specialist although this had previously been prescribed in primary care. It would therefore be advantageous if there was some flexibility about this and the use of spironolactone. Dr Mott commented that national advice indicated that patients should be referred in for spironolactone but it would be useful for GPs if this could be on specialist recommendation rather than initiation to allow GPs to prescribe if they felt comfortable to do this and seek advice if necessary. Dr Mott commented that for other indications, for example hypertension, GPs may be the initiating clinician. **Action:** Mr Dhadli would amend this section to reflect the discussions concerning spironolactone and metolazone and send to Dr Mott and Dr Parkin for comment. **Agreed:** Spironolactone classified as a **GREEN** drug. **Agreed:** Metolozone classified as **GREEN** after specialist recommendation drug. **Agreed:** A reference to sacubitril valsartan as per NICE TA 388 for the treatment of symptomatic chronic heart failure with reduced ejection fraction would be added to the guidance at a later stage.	**KN/MSh** **SD** **SD** **SD** **SD**

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	Agreed: JAPC ratified the Management of Heart Failure with Reduced Ejection Fraction guidance with a two year review date.	**SD**
d.	**Midodrine** Mrs Qureshi reported that comments had been received from Dr J Youde, DTHFT Consultant in Medicine for the Elderly, concerning the midodrine prescribing guidance for orthostatic hypotension. Dr Youde had highlighted the following points in the guidance: • It would be difficult to evidence how injury could be prevented in the goals of treatment section. JAPC agreed that this should be retained in the guidance as a key goal, however recognised that it would be difficult to evidence this. • Large carbohydrate meals should be removed from the advice on factors that influenced blood pressure. • Reference to physical measures of leg crossing, bending or squatting to be removed. • Reference to abdominal compression bands to be removed. • Reference to elastic TED stockings to be retained, although it was highlighted that these were non-prescribeable on an FP10. **Agreed:** JAPC ratified the advisory guidance on the prescribing of midodrine with the agreed amendments. **Action:** The guidance would be added to the website.	**SD** **SD**
e.	**North Derbyshire Algorithm for Antiplatelet Therapy in Primary PCI- STEMI Guidance** Mr Shepherd reported that there were no current changes to the STEMI guidance for North Derbyshire but this was under review. **Agreed:** The North Derbyshire Algorithm for Antiplatelet Therapy in Primary PCI-STEMI Guidance to be extended until the review had been completed.	**SD**
f.	**Management of Sub-Therapeutic INR** Mr Dhadli reported that the Guideline Group had discussed the management of sub-therapeutic INR and a consensus statement had been produced to deal with the situation when a patient's INR level dropped below a target value and when Low Molecular Weight Heparin (LMWH) should be used based on the guidance from the British Committee for Standards in Haematology (BCSH). Mr Dhadli added that references to this advice were now included in the BNF chapter, the oral anticoagulation guidance and the shared care agreement for LMWH. **Agreed:** JAPC ratified the statement for the management of sub-therapeutic INR. **Action:** The statement would be included in the anticoagulation guidance and LMWH shared care.	**SD** **SD**

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g.	**Vitamin D Guidance** Mr Dhadli advised that Ms J Theobald, Practice Pharmacist, had made changes to the Vitamin D Guideline which now included recommendations made by the National Osteoporosis Society (NOS) about the management of vitamin D deficiency in children and guidance in NICE PH 56. It was noted that only licensed vitamin D preparations had been included in the guideline which were Fultium D3 and Invita D3 (treatment doses) and Fultium D3, Invita D3 and Desunin (maintenance doses). Mr Dhadli stated that if licenced preparations were used over the current unlicensed locally preferred product of Hux D3® there would be an incremental cost to the prescribing budget across Derbyshire of approximately £111,000. During discussion Mr Newman commented that a special clinical need was needed to justify the use of an unlicensed medicine and there was a range of licensed vitamin D products now available which would cover aspects such as gelatin free and cultural/religious considerations. Mr Newman added that the guideline indicated that prescribing should be done by brand name although this is not done for therapeutic reasons. It was agreed that, in the event that a brand name was used, this would only be to ensure that this was a licensed cost effective product that was used – branded prescribing is recommended in primary care to ensure cost effective products are dispensed, this would be included in the guideline. Dr Narula also highlighted that there was a discrepancy in the vitamin D levels indicated in the guideline and that specialist dermatologists often recommended higher doses of vitamin D than the stated cut-off for high dose vitamin D prescription. Mr Dhadli commented that all specialties should follow this guidance for the treatment and deficiency of vitamin D and any deviation should be queried with the requesting clinician. It was noted that the shorter treatment length had been a local decision in order to improve compliance. **Agreed:** The recommended licensed vitamin D products would be included in the guideline.	**SD**
	Agreed: JAPC ratified the Guidance on the Prevention, Diagnosis and Management of Vitamin D deficiency in Primary Care with the agreed amendments.	**SD**
h.	**Fosfomycin** Mr Dhadli advised that the oral fosfomycin guidance had been extensively amended and it had been highlighted that a licensed preparation was available. There was some discussion about the supply of fosfomycin and the action which would need to be taken in the event that community pharmacists were unable to obtain it from wholesalers on such occasions as Bank Holidays. Mr Newman advised that supplies of fosfomycin could be obtained by community pharmacists from the DTHFT pharmacy. **Action:** A version of the fosfomycin guidance without the track changes and colours would be circulated for comment to JAPC.	**SD**

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8.	**PATIENT GROUP DIRECTIONS**	
a.	**Meningococcal Group C Vaccine** **Agreed:** JAPC agreed a date extension to the Public Health England/NHS England Patient Group Direction for the Administration of Meningitec, Menjugate Kit and NeisVac-C.	**SD**
b.	**Levonorgestrel 1500 microgram Tablet (Levonelle®)** Dr Dewis explained that DCHSFT operated the contract for the county community pharmacists to give levonorgestrel but it was also necessary to approve a PGD for Derby City Council in order to allow for its use in the City community pharmacies. **Agreed:** JAPC agreed the PGD for Levonorgestrel 1500 microgram tablet (Levonelle®) with an amended review date of November 2017.	**SD**
9.	**SHARED CARE GUIDELINE**	
	Methotrexate Mr Dhadli advised that the shared care guideline covered oral/subcutaneous/intramuscular preparations for CRHFT/North Derbyshire and oral only preparations for DTHFT and South Derbyshire. The guideline had been amended and updated in the light of comments received from DTHFT and CRHFT consultants as follows: • Consultant responsibilities – Chest x-ray to be included and advice to be given on the suitability for herpes zoster vaccination in accordance with the national screening programme. • Advice included on the use of folic acid to be prescribed at a dose of 5mg once weekly, preferably the day after the methotrexate. • Variance between the local guidance and British Society of Rheumatology guidance concerning the monitoring of FBC, LFT and U&Es. Dr Raj, DTHFT Consultant Rheumatologist, had indicated that monitoring would be undertaken fortnightly from any dose change so it was felt that the wording in the shared care did not need to be changed. **Agreed:** JAPC ratified the shared care guideline for methotrexate (oral/subcutaneous/intramuscular preparations for CRHFT/North Derbyshire and oral only preparations for DTHFT/South Derbyshire).	**SD**
10.	**HORIZON SCAN**	
a.	**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: Clevidipine (Cleviprex) – Secondary care – Classified as **RED.** Osimertinib (Tagrisso) - NICE TA expected October 2016 – NHS England. Classified as **RED.** Talimogene laherparepvec (Imlygic) - NICE TA expected July 2016 – NHS England – Classified as **RED.** New formulation launches in the UK: Ticagrelor 60mg (Brilique®) – For the prevention of atherothrombotic events in adults with previous myocardial infarction and at high risk of developing an atherothrombotic event - NICE TA expected in December 2016.	**SD** **SD** **SD**

	Highlighted that this was a 60mg dose and would be classified as **BLACK** for the indication of MI as not recommended or commissioned - to be reviewed after NICE guidance published.	**SD**
b.	**NICE Horizon Scan** The Clinical Guidelines, NICE Technology Appraisals and NICE New Evidence Summaries were noted for information. Mr Dhadli highlighted the following: Clinical Guidelines: Heavy Menstrual Bleeding expected August 2016. NICE Technology Appraisals: Diabetes (type 2) - canagliflozin, dapagliflozin and empagliflozin (monotherapy). Ankylosing spondylitis – secukinumab (after DMARDs, TNF-alpha inhibitors). Macular oedema (branch retinal vein occlusion) – aflibercept. Rheumatoid arthritis – certolizumab pegol (after TNF inhibitor). Adalimumab for hidradenitis suppurativa (moderate, severe) – It was highlighted that this had received a positive NICE Final Appraisal Determination (FAD). NICE Evidence Summaries: Tiotropium/olodaterol for maintenance bronchodilation in COPD. This would be brought to a future JAPC meeting.	**SD**
11.	**MISCELLANEOUS**	
a.	**NICE Controlled Drugs: Safe Use and Management** JAPC noted that NICE had published a guideline to cover the systems and processes for using and managing controlled drugs safely in all NHS settings except care homes. The guideline aimed to improve working practices to comply with legislation and have robust governance arrangements and to reduce the safety risks associated with controlled drugs. It was reported that a summary of the main points in the guideline was being prepared for the prescribing groups.	
b.	**Out of Area Traffic Lights** Mr Dhadli reported that a consultant pharmacist at Doncaster and Bassetlaw Hospital had highlighted that the traffic light classification on the local formulary for the LABA/LAMA combination umeclidinium/vilanterol (Anoro®) for COPD was GREEN but that JAPC had given it a classification of BLACK. This had raised an interface issue concerning those Derbyshire patients who attended Doncaster and Bassetlaw Hospital who had been started on Anoro® but their consultants had subsequently been informed that JAPC had assigned a traffic light classification of BLACK due to lack of data on effectiveness. The Guideline Group had therefore considered a number of options to resolve this discrepancy. Discussion followed and it was agreed that the hospital should be contacted to highlight that JAPC had previously made a decision to classify Anoro® as BLACK due to lack of evidence and it was therefore not commissioned in Derbyshire.	

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	In the event that a LABA/LAMA combination was recommended for an out of area patient the hospital would be requested to prescribe one which had received a traffic light classification of BROWN in Derbyshire. JAPC would be prepared to review this decision in the light of any new evidence which may become available.	
c.	**<u>Primary Care Responsibilities in Prescribing and Monitoring Hormone Therapy for Transgender and Non-Binary Adults</u>** Mr Dhadli reported that a Specialised Services Circular had been sent out by NHS England and was an update on the previous one issued in March 2014 which had informed GPs about their role and responsibilities in prescribing hormone therapy for transgender and non-binary adults. The General Medical Council had published guidance for GPs in March 2016 on the treatment of transgender patients and the legal protection against discrimination and harassment given to trans people by The Equality Act 2010 and Gender Recognition Act 2004. The guidance also referred to the necessity to prescribe unlicensed medicines when this was required to meet the specific needs of the patient and where there was no suitably licensed medicine to meet the needs of the patient. Mr Dhadli advised that JAPC had a position statement on the Derbyshire Medicines Management website to assist GPs to understand how the services with Gender Identity Clinics (GICs) were set up, their expected role and give advice about the prescribing of drugs such as hormone treatment some of which fell outside of their licenced indications. **Action:** The existing JAPC position statement on hormone therapy would be replaced by a link to the NHS England Specialised Services Circular and highlighted in the bulletin.	**SD**
d.	**<u>Psychotropic Drug Prescribing for People with Intellectual Disability, Mental Health Problems and/or Behaviours that Challenge: Practice Guidelines</u>** JAPC noted the practice guidelines on psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviours that challenge which had been produced by the Royal College of Psychiatrists Faculty of Psychiatry of Intellectual Disability. Dr Parkin reported that the Learning Disabilities Clinical Reference Group had agreed to audit all people known to the City and County Learning Disabilities Team. The City Learning Disabilities Team had already completed their audit and the County Team were currently undertaking this work. A further meeting of the Learning Disabilities Clinical Reference Group would be held in three weeks to finalise the audit for General Practice. Dr Parkin added that the second stage of this work would be to undertake an in depth prescribing review for all the patients who had been identified via the audits.	
e.	**<u>Primary Care Rebates</u>** Mrs Qureshi advised that the following new rebate has been agreed across Derbyshire: • Fentanyl patch (Mezolar Matrix®) • GlucoRx® testing medley • Insulin Degludec (Tresiba®)	

	In connection with insulin degludec (Tresiba®) Mrs Qureshi added that there would be a NHS price list reduction shortly and the rebate would then stop.	
12.	**JAPC BULLETIN**	
	The following changes were noted: • Amend to: Neonatal Hepatitis B Immunisation Programme and the correct test to be used to be the surface antigen test. The numbers of affected babies in Derbyshire is expected to be low although there may be higher numbers in some practices of Derby City. • Two Lipid-Regulating Drugs: The names of the PCSK9 inhibitors to be included. The revised bulletin was ratified by JAPC.	**SD** **SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for April 2016 was noted and items relating to primary care were discussed. Mr Dhadli highlighted the following MHRA advice: • SGLT2 inhibitors: updated advice on the risk of diabetic ketoacidosis. • Apomorphine with domperidone: minimising risk of cardiac side effects. Mr Dhadli stated that advice about the need to check QT intervals would therefore be added to the consultant responsibilities section in the shared care agreement. A reference would also be included in the patient responsibilities section on the necessity of informing their doctor of changes which could increase the risk of arrythmias. The Guideline Group would discuss this further at a future meeting. • Aflibercept (Zaltrap▼®): minimising the risk of osteonecrosis of the jaw. • Live attenuated vaccines: avoid use in those who are clinically Immunosuppressed. Mr Dhadli advised that the relevant shared care agreements had been updated accordingly. • Meprobamate: licence to be cancelled. This had already been classified as a BLACK drug by JAPC. • Paraffin-based skin emollients on dressings or clothing: fire risk.	
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in April 2016: TA387 Abiraterone for treating metastatic hormone-relapsed prostate cancer before chemotherapy is indicated - Classified as a **RED** drug (NHS England). It was noted that on publication of this guidance abiraterone would be moved out of the Cancer Drugs Fund and into NHS England routine commissioning. TA388 Sacubitril valsartan for treating symptomatic chronic heart failure with reduced ejection fraction – Classified as a **RED** drug. TA389 Topotecan, pegylated liposomal, doxorubicin hydrochloride, paclitaxel, trabectedin and gemcitabine for treating recurrent ovarian cancer - Paclitaxel as monotherapy and pegylated liposomal doxorubicin hydrochloride (PLDH) as monotherapy were both recommended as options for the treatment of ovarian cancer.	**SD** **SD**

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	Paclitaxel and PLDH classified as **RED** drugs. Gemcitabine in combination with carboplatin, topotecan and trabectedin in combination with PLDH were not recommended. Gemcitabine in combination with carboplatin, topotecan and trabectedin in combination with PLDH classified as **BLACK** drugs.	**SD**
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Benzbromarone – **RED** Nasal Saline sprays - **BLACK** Sterimar® – **BLACK** Aqua Maris® – **BLACK** Spironolactone – **GREEN** Metolozone – **GREEN** specialist recommendation Fultium D3® - **GREEN** Invita D3® – **GREEN** Desunin® – **GREEN** ProD3® and Hux D3® to be removed from classification Clevidipine – **RED** Osimertimib – **RED** (NHS England) Talimogene laherparepvec – **RED** (NHS England) Ticagrelor (60mg dose) **BLACK for MI** Abiraterone – **RED** as per NICE TA 387 Sacubitril valsartan – **RED** as per NICE TA 388 Paclitaxel – **RED** as per NICE TA 389 Doxorubicin hydrochloride (PLDH) – **RED** as per NICE 389 Gemcitabine – **BLACK** as per NICE TA 389 Trabectedin – **BLACK** as per NICE TA 389 Topotecan – **BLACK** as per NICE TA 389	
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Grazax® – To be taken off the list and discussed via DTHFT Drugs and Therapeutic Committee. Immunomodulating drugs (methotrexate) – To be taken off the list. LMWH bridging guidance – To be taken off the list. Ulipristal for uterine fibroids – Await NICE Guideline. Diabetes Type 2 guidance – To be brought to the June 2016 JAPC meeting. Heart Failure – To be taken off the list. PCSK9 – To be brought to the July 2016 JAPC meeting.	**AM/WG** **SD** **SD** **SD** **SD** **SD** **SD**
17.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in March and April 2016 was noted.	

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	Mr Dhadli highlighted the following: • Fluphenazine injection – Included in the CNS formulary but not in the traffic light database. Added as a GREEN drug after consultant/specialist recommendation. • Advice added to cardiovascular formulary: No patient should receive three drugs which block the renin-angiotensin-aldosterone system as hyperkalaemia and renal dysfunction will be common. The safety and efficacy of combining an ACE inhibitor, an ARB and mineralocorticoid receptor antagonist (MRA) was uncertain and the use of these three drugs together was not recommended. • Amiodarone guidance – Link to QT tables on credible medicines website included in the guidance. Advice about dosage adjustment when prescribed with dabigatran had also been included. • Alirocumab was only available via homecare or direct from the manufacturer to secondary care. The guideline table for JAPC was discussed: • Osteoporosis – It was highlighted that the existing guideline was now out of date. Agreed that the osteoporosis guideline would be brought to JAPC for update if necessary. • Diagnosis and management of lower UTI – Dr D Harris to be contacted as the guidance was now out of date. • Infant feeding guidelines – Decision to be made as to whether this should be taken off the list.	**SD** **SD** **SD**
16.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Nottinghamshire Area Prescribing Committee 19/11/15 • Clinical Commissioning Policy Advisory Group 14/01/16 • Sheffield Area Prescribing Group 18/02/16 • Sheffield Area Prescribing Group 17/03/16 • Burton Drugs and Therapeutic Committee 14/03/16 • DTHFT Drugs and Therapeutic Committee 15/03/16 Mr Dhadli highlighted the following items from the minutes: Sheffield Area Prescribing Group - Prescribing guidance in self-monitoring of blood glucose and the requirement that all testing meters would need to comply with stringent ISO standards by the end of May 2016. Mr Dhadli confirmed that the two preferred JAPC formulary choices complied with the ISO standards. Sheffield Area Prescribing Group – Vortioxetine had been classified as a GREEN drug. However it was highlighted that JAPC had assigned a traffic light classification of RED for vortioxetine.	
17.	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
18.	**DATE OF NEXT MEETING**	
	Tuesday, 14th June 2016 at 1.30pm in the Post Mill Centre, South Normanton.	