For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@southernderbyshireccg.nhs.uk

DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 8th August 2017

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Ciprofibrate	BLACK
Dicycloverine	BLACK
Vitamin B compound tablets	BLACK
Liothyronine	BLACK for hypothyroidism AMBER for depression RED for cancer
Monuril® (preferred cost effective brand for fosfomycin)	BROWN after consultant/specialist recommendation
Calcium folinate	BROWN (tablet) for patients who can not tolerate folic acid tablets RED (intravenous) for anaemia, neutropenia and poisoning
Ceftazidine	GREEN as part of the OPAT service between DCHSFT and CRHFT
Tafluprost + timolol (Taptiqom®) preservative free UDVs	GREEN after consultant initiation
Bimatoprost + timolol (Ganfort®) preservative free UDVs	BROWN after consultant initiation
Bezlotoxumab (Zinplava®)	BLACK
Meningococcal group B vaccine (Trumenba®)	BLACK except for use as part of the national immunisation programme
Naltrexone/Bupropion (Mysimba®)	BLACK
Ibrutinib	BLACK (as per NICE TA 452)
Bortezomib	BLACK (as per NICE TA 453)
Daratumumab with lenalidomide and dexamethasone	BLACK (as per NICE TA 454)
Adalimumab, etanercept and ustekinumab	RED (NHS England) as per NICE TA 455
Ustekinumab	RED (as per NICE TA 456)
Carfilzomib	RED (NHS England) as per NICE TA 457
Trastuzumab emtansine	RED (NHS England) as per NICE TA 458
Collagenase clostridium histolyticum	RED (as per NICE TA 459)
Adalimumab and dexamethasone	RED (NHS England/CCG) as per NICE TA 460
Roflumilast	RED (as per NICE TA 461)
Nivolumab	RED (NHS England) as per NICE TA 462

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Clinical Guidelines

Liothyronine position statement.
Cabergoline and quinagolide for hyperprolactinaemia.
Oral Fosfomycin for the Treatment of Uncomplicated Lower Urinary Tract Infections by multi resistant bacteria.
Treatment of Chronic Open Angle Glaucoma and Ocular Hypertension.
North Derbyshire OPAT (Outpatient Parenteral Antimicrobial Therapy) Pathway for Primary Care.

Patient Group Directions

Amoxicillin, flucloxacillin, phenoxymethylpenicillin (Pen V), trimethoprim, nitrofurantoin, codeine phosphate and paracetamol for use in Derby Urgent Care Centre.
Levonorgestrel in emergency contraception.

Shared Care Guidelines

Ciclosporin.
Sulfasalazine.
Acamprosate and disulfiram (Derbyshire County).

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Present:	
Southern Derbyshire CCG	
Mr S Dhadli	Specialist Commissioning Pharmacist (Professional Secretary)
Mrs L Hunter	Assistant Chief Finance Officer
Mrs S Qureshi	NICE Audit Pharmacist
Ms H Murch	Pharmacist (also representing Erewash CCG)
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP (Chair)
Dr T Narula	GP
Ms M North	Pharmacist
Ms J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Mr M Scott	Chief Finance Officer
Erewash CCG	
Derby City Council	
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	
Dr S Taylor	Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Ms J Shaw	Principal Pharmacist
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Dr M Henn, Mr S Hulme, Dr A Mott and Mrs K Needham.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	Dr Emslie reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of JAPC. No conflicts of interest were declared.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Pathology Sub-Group	
4.	**MINUTES OF JAPC MEETING HELD ON 11 JULY 2017**	
	The minutes of the meeting held on 11th July 2017 were agreed as a correct record.	
5.	**MATTERS ARISING**	
a.	**Modecate® Injection (Fluphenazine decanoate)** Mr Dhadli reported that the DHcFT Drugs and Therapeutic Committee had received a paper from Sanofi about the discontinuation of the Modecate® injection from mid 2018. Dr Taylor commented that this had limited use within the Trust but prescribing advice was available on alternative treatment options.	
b.	**Delay of Menstruation** Mr Dhadli referred to the query raised by Dr Henn at the last meeting, regarding a safety issue for norethisterone, which is a drug used in the private service offered by a community pharmacy chain for delay of menstruation. There was no change to the evidence or advice and norethisterone was therefore still the first line recommended drug in those at low risk of VTE. There had been one small study that suggested that medroxyprogesterone was as effective as norethisterone but, due to the size of the study, was normally reserved for those women who were obese, immobile, about to have surgery or with a family history of venous thromboembolism. Dr Parkin added that the JAPC working group would be discussing whether norethisterone should be prescribed for the delay of menstruation during foreign travel holidays or whether this should be done as part of a private service. A report would be made to a future JAPC meeting.	
c.	**Primary Care Management of Irritable Bowel Syndrome** Mr Dhadli reported that there was ongoing work between DTHFT and CRHFT consultants to standardise the calprotectin values and referral criteria between the two Trusts. In addition, there was wider group around all shared care pathology which aimed to adopt a unified approach across Derbyshire when patients should be referred in. Dr Narula referred to the county-wide shared care pathology group but highlighted that there was no representation from the GPs in North Derbyshire on this. Dr Watkins commented that representation from the north would be welcomed on the group but it should be noted that there was no funding allocated for clinician time and was voluntary.	

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Item		Action
	Dr Emslie advised that this group did not provide advice for GPs who would normally obtain this from the relevant consultants. However this group could facilitate consensus between the laboratories on a standard references.	
d.	**Calcium Folinate** Mr Dhadli referred to the decision made at the last JAPC meeting to classify a number of high cost drugs and cytotoxic agents as RED with the possible exception of calcium folinate as there was some low level prescribing of this. Ms North queried whether the classification of RED covered calcium folinate in both the oral tablet form and infusion. Dr Emslie stated that calcium folinate tablets were being prescribed on the recommendation of the CRHFT rheumatology service for those people who could not tolerate folic acid which was usually the standard. Dr L Babcock, DTHFT Consultant Rheumatologist, had advised that calcium folinate was used to diminish the toxicity and counteract the action of folic acid antagonists such as methotrexate in cytotoxic therapy and was usually used in secondary care. It was agreed that the oral tablet for the reduction of methotrexate side effects should be classified as **BROWN** due to its exceptional use within primary care. Calcium folinate (intravenous) would remain as RED for anaemia, neutropenia and poisoning.	**SD**
6.	**NEW DRUG ASSESSMENTS**	
a.	**Ciprofibrate, Dicyloverine and Vitamin B Compound** Mr Dhadli reported that the guideline group had recommended that ciprofibrate, dicyloverine and vitamin B compound should be assigned a traffic light classification of BLACK due to lack of cost effectiveness and the availability of suitable alternatives. Fibrates were not routinely recommended by NICE for use in primary/secondary CVD prevention where statins were not tolerated or contraindicated, although there may be some historical prescribing and use in situations where statins were not tolerated. It was noted that the lipid specialists at both acute trusts did not object to the proposed BLACK traffic light classification. Dicyloverine was the least cost-effective choice of treatment for smooth muscle spasm associated with irritable bowel syndrome. Mr Dhadli advised that the relevant DTHFT and CRHFT gastro-enterology consultants had been requested to give their opinion on a possible change of traffic light classification and all their responses had agreed that a BLACK traffic light classification would be acceptable for dicyloverine. Mr Dhadli added that Vitamin B compound tablets did not feature in any current Derbyshire guidance, apart from vitamin supplementation in alcohol misuse, when Vitamin B compound strong tablets may be required to be continued in primary care after initiation in secondary care. **Agreed:** Ciprofibrate, Dicyloverine and Vitamin B Compound tablets classified as **BLACK** drugs as less cost-effective than current therapy.	**SD**

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Item		Action
7.	**CLINICAL GUIDELINES**	
a.	**Liothyronine** Mr Dhadli reported that JAPC had produced a position statement in June 2017 on liothyronine which stated that its use for the treatment of hypothyroidism was not recommended due to lack of cost-effectiveness and robust clinical evidence. However it was noted that liothyronine was also used as part of thyroid cancer treatment and for treatment resistance depression. Further discussions had subsequently been held with the endocrinologists and the position statement had been amended to indicate that it was supported by local primary care clinicians and developed in consultation with endocrinologists from provider organisations across Derbyshire. In addition, the position statement did not cover its use in treatment for depression but it would be necessary to determine whether the evidence submitted by DHcFT justified the use of liothyronine in treatment resistant depression. Dr Taylor referred to the presentation by Stephen Jones which had indicated that liothyronine for the treatment of resistant depression was a rarely used, but potentially useful drug. In addition, an alternative was tranylcypromine but this was similarly very expensive. Mr Dhadli stated that there were a few number of studies which supported the efficacy of liothyronine augmentation with trycyclics but these had been small sample sizes and mainly open-label. There were even fewer studies on liothyronine augmentation with selective serotonin reuptake inhibitors (SSRI) antidepressants. However liothyronine had shown non-inferiority to lithium and was better tolerated so there could be a small cohort of patients who could potentially benefit from the use of liothyronine. During discussion Ms North queried whether any information about the time interval between dose changes could be added to the steps outlined in the review and management section of existing patients being treated with liothyronine. It was agreed that the time period of four to six weeks indicated in the second step should be included in the other two steps for clarification. Dr Watkins referred to the difficulty of managing the group of patients who were taking liothyronine for hypothyroidism. Dr Parkin also highlighted that it would be important to refuse to prescribe the drug unless supported by an Individual Funding Request and that the review period could be an opportunity to switch the patients. **Agreed:** Liothyronine for the treatment of hypothyroidism classified as **BLACK** as less cost-effective than current standard therapy with referral to the JAPC position statement. **Agreed:** Liothyronine remained classified as an **AMBER** drug for treatment resistant depression as it required specialist assessment to enable patient selection and initiation of treatment and short or medium term specialist monitoring of efficacy or until the patient was stable. **Agreed:** Liothyronine classified as **RED** for oncology treatment and for diagnostic purposes in line with the British Thyroid Cancer guidelines as it required specialist assessment to enable patient selection, initiation and short duration of treatment.	**SD**

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Item		Action
	Action: The ePACT data for the prescribing of liothyronine for the treatment of hypothyroidism would be checked in 12months.	**SD**
b.	**Cabergoline (Dostinex®) and Quinagolide for Hyperprolactinaemia** Mr Dhadli advised that the shared care guidance for cabergoline and quinagolide for hyperprolactinaemia had been updated by Dr R Stanworth, DTHFT Consultant Endocrinologist, with new supporting safety evidence for cardiac valve fibrosis. Dr Stanworth had also proposed that the traffic light classifications for cabergoline and quinagolide should be changed from GREEN specialist initiation to GREEN specialist recommendation as it would be easier for patients to pick up the first prescription from GP rather than making another trip to hospital. The current traffic light classification of GREEN specialist initiation to remain as the committee felt that the baseline monitoring, counselling and dose titration to assess response should remain with the specialist. **Agreed:** JAPC ratified the shared care guidance for cabergoline and quinagolide for hyperprolactinaemia with a two year review date.	**SD**
c.	**Oral Fosfomycin for the Treatment of Uncomplicated Lower Urinary Tract Infections** Mr Dhadli reported that the oral fosfomycin guidance had now been updated with the main change to highlight the licensed preparation and that oral fosfomycin 3g sachets should now be prescribed as Monuril® 3g sachets which was the cost effective brand. **Agreed:** JAPC ratified the prescribing guideline for Oral Fosfomycin for the Treatment of Uncomplicated Lower Urinary Tract Infections with a two year review date.	**SD**
d.	**Treatment of Chronic Open Angle Glaucoma and Ocular Hypertension** Mr Dhadli reported that Mr J Tildsley, DTHFT Consultant Ophthalmologist, had updated the guidance for the treatment of chronic open angle glaucoma and ocular hypertension. Mr Tildsley had proposed that Ganfort® (bimatoprost 0.3 mg/ml and timolol 5mg/ml) preservative free Unit Dose Vials (UDVs) be replaced with Taptiqom® (tafluprost 4.5 mg/ml + timolol 1.5mg/ml) as the preservative free prostaglandin and beta-blocker combination treatment option. The guideline had also been discussed by the DTHFT Drug and Therapeutics Committee. Mr Dhadli advised that a comparison of tafluprost + timolol compared with either tafluprost or timolol preservative free had demonstrated a difference in occular pressure in favour of the combination product. There had also been a comparison with tafluprost + timolol as two separate eye drops and this had shown non-inferiority. The Hollo et al study had undertaken a review of double masked, controlled clinical trials assessing four fixed combination products and it had been concluded that all four products could be considered equally efficacious. It was noted that the draft NICE glaucoma guidance referred to the use of combination products when monotherapy was ineffective and the SMC had also accepted the use of Taptiqom®.	

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Item		Action
	Mr Shepherd commented that no comments had yet been received from the CRHFT consultant ophthalmologists but no objections were anticipated. **Agreed:** JAPC ratified the guideline for the treatment of chronic open angle glaucoma and ocular hypertension. **Agreed:** Taptiqom® (tafluprost + timolol) classified as **GREEN** after consultant initiation. **Agreed:** Ganfort® (bimatoprost + timolol) re-classified as **BROWN** after consultant initiation from GREEN after consultant initiation as not recommended for use except in exceptional circumstances.	**SD** **SD** **SD**
e.	**<u>North Derbyshire OPAT (Outpatient Parenteral Antimicrobial Therapy) Pathway for Primary Care</u>** Ms Shaw reported that the OPAT guidance aimed to provide pathways and clinical guidelines for initiation of IV antibiotics to treat specific infections in community patients and reduce the need for hospital admissions for intravenous antibiotics. The OPAT service provided IV antibiotics to patients outside of the acute hospital inpatient setting and was provided by CRHFT working in partnership with the DCHSFT Rapid Response Team (RRT). It was noted that JAPC had classified Ceftriaxone 1g and 2g, Ertapenem 1g, Teicoplanin 800mg, Tazocin 4.5g and Meropenum 1g as GREEN drugs at the February 2017 meeting. During discussion Ms Shaw confirmed that the pathway only covered specific places in North Derbyshire at present but it was intended that this would cover all of this part of the county, including Hardwick CCG, when fully rolled out. Dr Narula queried whether the flucloxacillin infusion was a third line IV antibiotic in the formulary table. Dr Emslie advised that there was a planned launch during 2017 for the use of flucloxacillin infusion in cellulitis but ceftriaxone would continue to be the first line agent until then. Dr Narula also queried whether the Single Point of Access (SPA) contact number could continue to be used for referral purposes by Chesterfield GPs to the Rapid Response Team (RRT). Ms Shaw advised that calls to this number would be re-diverted to the number indicated in the guideline as DCHSFT wanted to receive referrals via the RRT only. In connection with the references to the dose for Teicoplanin on pages three and nine, it was highlighted that this should indicate adult body-weight 70 Kg and above - Initially 6mg/kg every 12 hours for 3 doses, then 6mg/kg OD – not Adult body-weight up to 70 kg and above. **Agreed:** JAPC ratified the North Derbyshire OPAT Pathway for Primary Care subject to a check being made about the use of the SPA number, inclusion of the appropriate organisational logos and amendment of the typographical error in the Teicoplanin dose section. **Agreed:** Ceftazidine classified as **GREEN** as part of the OPAT service.	**JS** **SD**

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Item		Action
8.	**PATIENT GROUP DIRECTIONS**	
	Derby Urgent Care Centre Patient Group Directions: Mr Dhadli reported that revised Patient Group Directions (PGDs) for Amoxicillin, Flucloxacillin, Phenoxymethylpenicillin (Pen V), Trimethoprim, Nitrofurantoin, Codeine Phosphate and Paracetamol from Derby Urgent Care Centre (DUCC) had been re-submitted to JAPC for approval. A query had been raised about the authorisation of antibiotics to go through the DUCC without the involvement of a microbiologist. Mr Dhadli stated that the NICE guideline, which covered good practice for the development, authorisation, use and update of patient group directions, had indicated that PGDs should not be developed without microbiology input. It was noted that local microbiologists had agreed and been involved in the development of local antimicrobial guidance from where these were adopted and, by doing this, had adopted the principles contained in the NICE guidance. A further query had been raised as to whether the eGFR values would be known to non-medical prescribers for those patients who were on trimethoprim and nitrofurantoin. It was pointed out that staff in the walk-in centres would not know all the contraindications and cautions associated with the antibiotics used. However it would be necessary to minimise this risk and it had therefore been proposed to exclude the over 65 age group and to put down the eGFR values when exclusion from the PGD was being considered. During discussion about the PGDs the following points were made: • Flucloxacillin - There was a reference to 250mg flucloxacillin capsules on page five but 500mg in the remainder of the PGD. • Amoxicillin - In the inclusion criteria in the community acquired pneumonia section the stated CRB65 scores were inaccurate and the recommended use of amoxicillin in combination with clarithromycin if the CRB65 score was ≥1 would only be valid via a PGD for the latter antibiotic. • Amoxicillin - The reference in the inclusion criteria to the use of amoxicillin where first-line treatment with doxycycline was not suitable or tolerated would require clarification. • Paracetamol - The reference to some patients may be at increased risk of experiencing toxicity at therapeutic doses, particularly those with a body-weight under 50 kg and those with risk factors for hepatotoxicity, should be included in the exclusion section not the caution section. • Paracetamol – There was a reference to a 100 tablets pack but the PGD was only for a maximum of sixteen doses and therefore this required amendment. **Agreed:** JAPC agreed the Patient Group Directions for amoxicillin, flucloxacillin, phenoxymethylpenicillin (Pen V), trimethoprim, nitrofurantoin, codeine phosphate and paracetamol with the agreed amendments. Levonorgestrel: Mr Dhadli stated that the PGD provided emergency contraception using levonorgestrel 1500mg tablets for use by community pharmacists, DCHSFT emergency practitioners and nursing staff working in the Derbyshire Integrated Sexual Health Service. The PGD had been updated in the light of the publication of recent Faculty of Sexual and Reproductive Healthcare (FSRH) guidelines.	**SD**

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Item		Action
	Agreed: JAPC agreed the PGD for the use of Levonelle® in emergency contraception.	**SD**
9.	**SHARED CARE GUIDELINES**	
a.	**Ciclosporin** Mr Dhadli reported that the shared care guideline for patients with rheumatological disease prescribed ciclosporin had been further updated within the standard local DMARDs template. Mr Dhadli highlighted the additional changes which had been made: • The British Society for Rheumatology (BSR) had recommended monthly monitoring for twelve months. However, following discussion with local consultant rheumatologists, this had been increased to eighteen months for the duration of treatment. • The BSR had recommended consideration for the monitoring of therapeutic drug levels for patients receiving ciclosporin. The only time this would be necessary was when ciclosporin was used for renal transplant and advice on doses for this had been added accordingly. • Addition of 'Contact specialist urgently and consider interruption' on all DMARD shared guidelines with the exception of transplant indications. • The BSR guidance referred to the need for glucose monitoring and HbA1c and this had therefore been added. It had been proposed that HbA1c testing be undertaken on a three monthly basis and specialist opinion had been requested about this, but there had been no feedback to date. • Advice has been added to all the shared care agreements about vaccinations for the live shingles vaccine and this now stated 'The Green Book advice is that the shingles vaccine can be given with standard DMARDs as long as the person is not on high dose steroid' on the advice of Dr L Badcock, DTHFT Consultant Rheumatologist. • The reference to the need for a pro-collagen III test had been removed from all the shared care guidelines except methotrexate. • Eosinophilia monitoring had been retained in all the shared care guidelines as per BSR. • The organ transplant dose had been confirmed as initially 6.5mg/kg every 12 hours then reduced to maintenance therapy of 2-6mg/kg daily in divided doses'. **Agreed:** JAPC ratified the shared care guideline for ciclosporin with the agreed amendments for a period of two years.	**SD**
b.	**Sulfasalazine** Mr Dhadli reported that the shared care guideline for patients with rheumatological disease prescribed sulfasalazine had been further updated within the standard local DMARDs template. Mr Dhadli highlighted the additional changes which had been made: • The current monitoring referred to FBC and LFTs two weeks for the first three months of therapy. This could then be reduced to monthly for three months and thereafter once every three months and after twelve months of stability as clinically indicated. Dr L Badcock had advised that this should be changed to six monthly intervals thereafter.	

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Item		Action
	Agreed: JAPC ratified the shared care guideline for sulfasalazine with the agreed amendments for a period of two years.	**SD**
c.	**Acamprosate and Disulfiram** Mr Dhadli reported that some changes had been made to the shared care guideline for acamprosate for alcohol abstinence and disulfiram for maintenance of alcohol abstinence: • Clarification for consultant review of patients on disulfiram every two weeks for the first two months and then four weekly up to six months. The patient would be transferred to the care of primary care once stable. • Changes to contact details and out of hours contacts and procedures to include advice to attend GP out of hours or NHS 111 as in previous guidance. • It would be highlighted on the cover sheet that the shared care was for use in Derbyshire County only and provided by the Drugs and Alcohol Recovery Partnership. **Agreed:** JAPC ratified the shared care guideline for acamprosate and disulfiram.	**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: Bezlotoxumab (Zinplava®) – **BLACK**. NICE TA expected May 2018. Etanercept biosimilar (Erelzi®) and Rituximab biosimilar (Rixathon®, Riximyo®) – To be discussed by the Drugs and Therapeutic Finance Committee and information conveyed to JAPC about launch dates and opportunity costs. Meningococcal group B vaccine (Trumenba®) – **BLACK** except for use as part of the national immunisation programme. New formulation launches in the UK: Bupropion + naltrexone (Mysimba®) – **BLACK**. For weight management in adults who were obese or those who were overweight and had one or more complications related to their weight. NICE TA awaited. Ticagrelor (Brilique®) – No action needed. Licence extensions: Bevacizumab (Avastin®) - Already **RED** as per NHS England commissioning intentions for CDF. Ceritinib (Zykadia®) - Already **RED** as per NHS England commissioning intentions. Nepafenac (Nevanac®) - Already **RED**. Nivolumab (Opdivo®) - Already **RED** as per NHS England commissioning intentions.	

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Item		Action
b.	**Quarterly NICE Updates** Mr Dhadli referred JAPC to the NICE horizon scan and highlighted the following: Clinical Guidelines: • Asthma – Diagnosis/monitoring and asthma management. • Cataracts in adults: management. This was part of the Procedures of Limited Clinical Value (PLCV) policy developed by the CCGs. • Glaucoma: diagnosis and management (update). • Heavy menstrual bleeding (update). NICE Technology Appraisals: • Naltrexone + bupropion for obesity and overweight with risk factors – this had received a negative NICE Final Appraisal Determination (FAD). • Eluxadoline for Irritable bowel syndrome (diarrhoea).	
11.	**MISCELLANEOUS**	
a.	**Items Not Routinely Prescribed – Consultation and Review** Mr Dhadli reported that NHS Clinical Commissioners had published a consultation on guidance for CCGs for items which should not routinely be prescribed in primary care. This consultation would be open from 21st July to 21st October 2017 and involved eighteen products which had been identified as being of low clinical value and/or comparatively expensive for one or more of these reasons: • Items of low clinical effectiveness - where there was a lack of robust evidence of clinical effectiveness or there were significant safety concerns. • Items which were clinically effective but where more cost-effective products were available including products that had been subject to excessive price inflation. • Items which were clinically effective but considered a low priority for NHS funding. It had been decided that the joint clinical working group would prioritise items based on safety issues; evidence of efficacy; degree of variation in prescribing; cost to the NHS and strong clinician or patient feedback. Mr Dhadli advised that the following items had been identified as requiring further discussion and action: • Dosulepin – Currently classified by JAPC as BROWN due to exceptional use. However there were significant safety concerns so it was proposed that this classification be changed to BLACK. • Immediate Release Fentanyl – Concern about the number of opioid overdose deaths being fuelled by this drug. Also classified as BROWN after palliative care specialist initiation: all non-transdermal preparations classified as BROWN recognising the limited use in cancer patients. The working group had concluded that there was only a small number of people involved and therefore current prescribing volumes were not justified. • Herbal medicines and homeopathy – These were not included in the BNF. • Omega-3 Fatty Acid Compounds – NICE had reviewed the evidence and advised they were not suitable for prescribing by the indication of 'Do not do' recommendations.	

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Item		Action
	• Paracetamol and Tramadol Combination Product – The CCGs would be advised that prescribers in primary care should not initiate paracetamol and tramadol combination products for any new patients. During discussion Dr Emslie highlighted that there was a risk that any decision by JAPC to change traffic light classifications before the end of a public consultation could be challenged. The outcomes of the national consultation could provide support for any local decision to change the traffic light classifications of certain drugs. Mr Scott highlighted that there was risk about any local decisions to restrict prescribing in advance of the national consultation which may not support this could be challenged. However, the safety issues associated with dosulepin should require immediate action to restrict prescribing. Mr Scott also referred to the current financial situation in Derbyshire which could also require action to be taken in advance of the national consultation. Mr Dhadli commented that JAPC had also reviewed some items, such as rubefacients and lidocaine plasters, which had been re-classified due to lack of data on effectiveness compared with standard therapy. Mr Dhadli stated that the consultation would end in October 2017 and the paper would then be re-presented to JAPC for further discussion. Mr Dhadli highlighted that the consultation outcome would nevertheless be advisory and, unless added to the national black list, would still require a local review through JAPC. **Agreed:** In advance of the national consultation the use of dosulepin for depression would be discussed with DHcFT. Similar discussions would be held with the palliative care consultants about the use of immediate release fentanyl and the issues which would be associated with a change of traffic light classification. The other products were already classified as BLACK but there would need to have a discussion about possible change of wording.	**SD**
b.	**<u>The Interface between Primary and Secondary Care</u>** Mr Dhadli advised that a report had been produced on the interface between primary and secondary care which referred to the roles and responsibilities of primary and secondary care including referrals into secondary care; managing DNAs and re-referrals; managing patient care and investigations onward referrals; discharge summaries and clinic letters and communicating with patients and responding to their queries. There was also a section on medication and shared care protocols and some of this could be included in the prescribing specification. Mr Newman highlighted the reference to the minimum period of seven days medication on discharge following hospital and that the local position was a minimum of fourteen days. For outpatients twenty-eight days medication was supplied which allowed sufficient time for GPs to receive the discharge letters.	
c.	**<u>DTB Update on Liraglutide (Saxenda®) for Obesity</u>** Mr Dhadli advised that Saxenda® was a new GLP1 receptor agonist which was licenced as an adjunct to a reduced-calorie diet and increased physical activity for weight management in adults. It had been discussed by JAPC at the July 2017 meeting and classified as BLACK. A Drugs and Therapeutics Bulletin (DTB) review on Saxenda® had now been produced and concluded that it was not clear whether any benefit was maintained without continued treatment.	

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Item		Action
	The DTB did not recommend Saxenda® due to modest weight loss, concerns over adverse effects, high dropout rates, inconvenience of a daily subcutaneous injection and high cost.	
d.	**Traffic Light Resource** Mr Dhadli referred to previous discussion about the presentation of the traffic light classification for prescribing list to JAPC. A one sheet summary of preferred formulary choices had therefore been developed which could be a more useful resource for a newly qualified clinician or junior doctor. A fuller document had also been produced by Mrs Qureshi which was updated every month but was considered to be too lengthy. Following discussion it was agreed that a paper document was not needed and that the Medicines Management website was the comprehensive resource which should be used in future.	**SD/SQ**
e.	**Useful Resource Signposting** Antimicrobial: Mr Dhadli advised that a guide to resources when dealing with antibiotic or infection management related queries had been produced by the Southern Derbyshire CCG Medicines Safety Pharmacist with input from the CRHFT Antimicrobial Pharmacist. The guide had been originally developed for the use of the Medicines Management Team but had now been adapted for primary care use and signposted to local primary and secondary antimicrobial formularies and national resources from Public Health England and NICE Clinical Knowledge Summaries. This was agreed by JAPC and would be advertised via the bulletin.	**SD**
	Substance Misuse: Mr Dhadli advised that a similar resource document for primary care clinicians for the management of opioid and alcohol had now been developed in the light of the changes to the substance misuse and alcohol services. The document signposted to local services, including relevant shared care guidelines, national guidance and resources for patients via NHS Choices and the 'Frank' drugs advice. This was agreed by JAPC and would be advertised via the bulletin.	**SD**
f.	**Pregabalin** Mr Dhadli highlighted that the drug tariff price of pregabalin had fallen very significantly. Dr Narula queried whether pregabalin was now cheaper than gabapentin – this would be checked by Medicines Management. Dr Emslie highlighted that the price of pregabalin may fluctuate in the coming months. Mr Dhadli also warned of the drug abuse seen with pregabalin and cautioned its wider use.	**SD**
12.	**JAPC BULLETIN**	
	The bulletin was tabled for information and ratified by JAPC. The following was highlighted: The production of strontium ranelate (Protelos®) would cease at the end of August 2017.	**SD**

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@southernderbyshireccg.nhs.uk

Item		Action
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for July 2017 was noted.	
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in July 2017. TA 452 Ibrutinib for untreated chronic lymphocytic leukaemia without a 17p deletion or TP53 mutation (terminated appraisal) – Classified as a **BLACK** drug. TA 453 Bortezomib for treating multiple myeloma after second or subsequent relapse (terminated appraisal) – Classified as a **BLACK** drug. TA 454 Daratumumab with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma (terminated appraisal) – Classified as a **BLACK** drug. TA 455 Adalimumab, etanercept and ustekinumab for treating plaque psoriasis in children and young people – Classified as **RED** drugs (NHS England). TA 456 Ustekinumab for treating moderately to severely active Crohn's disease after previous treatment – Classified as a **RED** drug. CCG commissioned drug. TA 457 Carfilzomib for previously treated multiple myeloma – Classified as a **RED** drug (NHS England). TA 458 Trastuzumab emtansine for treating HER2-positive advanced breast cancer after trastuzumab and a taxane - This guidance replaced TA 371 and was now recommended. Classified as a **RED** drug (NHS England). TA459 Collagenase clostridium histolyticum for treating Dupuytren's contracture – Part of an ongoing clinical trial (HTA-15/102/04) which compared collagenase clostridium histolyticum (CCH) with limited fasciectomy to run from May 2017 to October 2021 and DTHFT was a participating centre. Classified as a **RED** drug. CCG commissioned drug. TA 460 Adalimumab and dexamethasone for treating non-infectious uveitis – Classified as **RED** drugs. Dexamethasone was CCG commissioned and adalimumab was NHS England commissioned. TA 461 Roflumilast for treating chronic obstructive pulmonary disease - This guidance replaces TA 244 which was previously negative and classified as BLACK. Treatment with roflumilast should be started by a specialist in respiratory medicine. Classified as a **RED** drug. TA 462 Nivolumab for treating relapsed or refractory classical Hodgkin lymphoma – Classified as a **RED** drug (NHS England).	

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Item		Action
15.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in July 2017 was noted. Mr Dhadli highlighted the following: • Azithromycin eye drops classified as RED based on duration and three day course. • Bendamustine, Clofarabine, Nelarabine, Pegylated Liposomla. Doxorubicin, Ponatinib, Vandetinib and Vismodegib classified as RED from National Cancer Drug Fund list. • Indacaterol and glycopyrronium inhaler (Ultibro®) classified as GREEN from BROWN as 1st line LABA/LAMA combination as per JAPC COPD guideline. • Flucoxacillin (oral) as per JAPC antimicrobial guideline and IV as per OPAT Pathway for Primary Care classified as GREEN.	
16.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Ciprofibrate – **BLACK** Dicycloverine – **BLACK** Vitamin B compound tablets – **BLACK** Liothyronine – **BLACK** for hypothyroidism/**AMBER** for depression/**RED** for cancer Monuril® (preferred cost effective brand for fosfomycin) – **BROWN** after consultant/specialist recommendation Calcium folinate – **BROWN** (tablet) for patients who could not tolerate folic acid tablets/**RED** (intravenous) for anaemia, neutropenia and poisoning Ceftazidine – **GREEN** as part of the OPAT service Tafluprost + timolol (Taptiqom®) – **GREEN** after consultant initiation Bimatoprost + timolol) (Ganfort®) – **BROWN** after consultant initiation Bezlotoxumab (Zinplava®) – **BLACK** Meningococcal group B vaccine (Trumenba®) – **BLACK** Naltrexone/Bupropion – **BLACK** Ibrutinib – **BLACK** (as per NICE TA 452) Bortezomib – **BLACK** (as per NICE TA 453) Daratumumab with lenalidomide and dexamethasone **– BLACK** (as per NICE TA 454) Adalimumab, etanercept and ustekinumab – **RED** (NHS England) as per NICE TA 455 Ustekinumab – **RED** (as per NICE TA 456) Carfilzomib – **RED** (NHS England) as per NICE TA 457 Trastuzumab emtansine – **RED** (NHS England) as per NICE TA 458 Collagenase clostridium histolyticum – **RED** as per NICE TA 459) Adalimumab and dexamethasone – **RED** (NHS England/CCG) as per NICE TA 460 Roflumilast – **RED** (as per NICE TA 461) Nivolumab – **RED** (NHS England) as per NICE TA 462	

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Item		Action
17.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: DMARDS/Immunomodulating Shared Care – This was a rolling programme and methotrexate shared care was to be added.	**SD**
	Juxta Cures – To be discussed by DTHFT Drugs and Therapeutic Committee in August 2017.	**SD**
	Suspected DVT - NOAC/D-dimer – To be brought to the September 2017 JAPC meeting.	**SD**
	NRT and service provision – To be brought to the October 2017 JAPC meeting.	**SD**
	Rosuvastatin – To be brought to the December JAPC meeting.	**SD**
	Etanercept 'Lifmior' biosimilar/Rituximab biosimilar – Awaiting contract agreement.	**SD**
	ADHD monitoring in adults – To be brought to the October 2017 JAPC meeting.	**SD**
	Rituximab biosimilar – To be brought to the September 2017 JAPC meeting.	**SD**
	Traffic light list – To be taken off the list.	**SD**
	Dosulepin – To be discussed with DHcFT and brought back to a JAPC meeting.	**SD**
	Immediate release fentanyl – To be discussed with the palliative care consultants and brought back to a JAPC meeting.	**SD**
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• DHcFT Drug and Therapeutics Committee 23/03/17 • Clinical Policy Advisory Group 09/03/17 • Clinical Policy Advisory Group 13/04/17 • Clinical Policy Advisory Group 11/05/17 • JAPC Working Group 09/05/17 • Burton Hospitals Drug and Therapeutic Committee 08/05/17 • Sheffield Area Prescribing Group 13/05/17 Mr Dhadli highlighted the following item from the minutes: Clinical Policy Advisory Group – Continuous blood glucose and PLCV policies approved.	
19.	**DATE OF NEXT MEETING**	
	Tuesday, 12th September 2017 at 1.30pm in the Post Mill Centre, South Normanton.	