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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 12th September 2017

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Eluxadoline	RED (as per NICE TA 471)
Juxta CURES	BROWN specialist nurse and/or TVN initiation and training in select patients
Brodalumab	BLACK pending NICE guidance
Ofatumumab	BLACK (terminated appraisal). Note this has dual classification - NHS England
Asfotase alfa	RED (NHS England HST6)
Cabozantinib	RED (NHS England as per NICE TA 463)
Olaratumab with doxorubicin	RED (NHS England as per NICE TA 465)
Baricitinib	RED (as per NICE TA 466)
Holoclar	RED (NHS England as per NICE TA 467)
Idelalisib with ofatumumab	BLACK (as per NICE TA 470)
Obinutuzumab with bendamustine	RED (as per NICE TA 472)

Clinical Guidelines
Management of Dyspepsia and Gastro-oesophageal Reflux Disease (GORD)

Patient Group Directions
Influenza vaccine nasal spray suspension (Fluenz Tetra®▼)
Influenza vaccine as per national programme
Hexavalent combination DTaP/IPV/Hib/HepB vaccine for individuals from six weeks (routinely 8 weeks) to under ten years of age – update of existing PGD
DTaP/IPV/Hib vaccine for individuals from three years and four months to under ten years of age

Shared Care Guidelines
Azathioprine/6-mercaptopurine for patients aged 16+ years
Sodium Aurothiomalate (Myocrisin® Gold Injection)
Leflunomide

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Professional Secretary)
Mr S Hulme	Director of Medicines Management (also representing Erewash CCG)
Mrs L Hunter	Assistant Chief Finance Officer
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Dr T Narula	GP
Mrs K Needham	Assistant Chief Quality Officer (Medicines Management) (also representing Hardwick CCG)
Hardwick CCG	
Erewash CCG	
Derby City Council	
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
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	
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 C Emslie, Dr W Goddard, Dr M Henn and Dr T Parkin. The meeting was confirmed as being quorate.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	Dr Mott 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**	
	There were no declarations of any other business.	
4.	**MINUTES OF JAPC MEETING HELD ON 8 AUGUST 2017**	
	The minutes of the meeting held on 8th August 2017 were agreed as a correct record.	
5.	**MATTERS ARISING**	
a.	**Items Not Routinely Prescribed – Consultation and Review** Mr Dhadli reported on the action concerning two of the items which had been highlighted as requiring further discussion and action. Dosulepin would be discussed at the meeting of the DHcFT Drug and Therapeutic Committee to be held on 22nd September 2017. The palliative care consultants had been requested for feedback about access and governance arrangements concerning the use of immediate release fentanyl – feedback was awaited.	
b.	**Roflumilast** Mr Dhadli stated that roflumilast had been classified as RED (as per NICE TA 451) at the last JAPC meeting. However Mr Dhadli highlighted to JAPC that the Scottish Medicines Consortium (SMC) had just published a review which did not recommend the use of roflumilast for maintenance treatment of severe chronic obstructive pulmonary disease (COPD) as the submitting company had not presented a sufficiently robust clinical or economic analysis to gain acceptance by them.	
c.	**Derby Urgent Care Patient Group Directions** Mr Dhadli reported that further PGDs for the antibiotics referred to in those previously agreed by JAPC were currently under development. These would be presented to JAPC at a future meeting.	**SD**
6.	**NEW DRUG ASSESSMENTS**	
a.	**Eluxadoline** Mr Dhadli reported that NICE CG61 'Irritable Bowel Syndrome (IBS) in adults: diagnosis and management' recommended the use of loperamide as the 1st line antimotility agent for diarrhoea associated with IBS followed by 2nd line option TCAs or SSRIs if the TCAs were ineffective. Eluxadoline was an opioid receptor agonist and delta opioid-opioid receptor antagonist which slowed down the movement of food through the gastrointestinal system.	

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	The initial dose was 100mg bd orally which could be reduced to 75mg bd if not tolerated. NICE TA471 had recommended eluxadoline as an option for treating irritable bowel syndrome with diarrhoea in adults only if the condition had not responded to other pharmacological treatments, pharmacological treatments were contraindicated or not tolerated and if it had been commenced in secondary care. NICE evidence for eluxadoline came from three double-blind randomised controlled trials which included a phase 2 trial and two phase 3 trials. The populations were diagnosed with IBS‑D using the Rome III criteria and in all the three trials eluxadoline was compared with placebo. A DTB review on eluxadoline had used two double-blind phase 3 RCTs which supported the licensing. The primary outcome measures to assess efficacy was the normally daily worst abdominal pain, the Bristol stool form scale, IBS-D global symptom score and adequate relief of symptoms. Efficacy had been assessed over a 26 week period which was followed by either a safety assessment over 26 additional weeks of double blind treatment or a 4 week cross over period during which patients only received placebo to assess for rebound worsening of symptoms. The results had shown an increase of about 11% in the proportion of people who had achieved the primary composite outcome measure with the 100mg dose of eluxadoline compared with placebo. The EMA had considered the magnitude of the treatment effect to be of limited clinical relevance. The difference in the primary outcome between eluxadoline 75mg and placebo was around 7%. It had been noted that only a third of people in either of the eluxadoline groups in the two studies had responded. Pain was not significantly different between eluxadoline and placebo in either study. The EMA noted that there had been a statistically significant difference from placebo in terms of stool consistency. The limitations of the evidence included eligibility for the clinical trials only if other anti-diarrhoeal medicines were not being taken. It had been highlighted that IBS was a disease of relapse and remission and the trial inclusion criteria required that people had pain, loose stools and a moderate IBS-D global symptom score in the week prior to randomisation. A MTRAC review in November 2016 had concluded that the evidence for eluxadoline was relatively weak and a New England Journal of Medicine review in January 2016 had indicated that future studies should be aimed at identifying subpopulations of patients with IBS with diarrhoea who may best benefit from eluxadoline. Mr Dhadli added that advice had been received from Dr W Goddard, DTHFT Consultant Gastroenterologist, that experience was needed at a clinical level and real world use to determine the efficacy of eluxadoline and to define a cohort of patients who could benefit from its use. In addition, its place in therapy should be third line in the event that standard IBS anti-diarrhoeals and amitriptyline had failed in primary care and a referral made to secondary care. **Agreed:** Eluxadoline (Truberzi®) classified as a **RED** drug as per NICE TA471 for treating irritable bowel syndrome with diarrhoea in adults.	**SD**

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b.	**Juxta CURES** Mr Dhadli reported that Juxta CURES, an adjustable wrap-around compression system for use in patients with venous leg ulcers in whom compression therapy was otherwise indicated, was currently unclassified and that JAPC had previously decided that requests to use medical appliances which were prescribed via FP10 should be assessed by the requesting Trust's Drugs and Therapeutics Committee. Juxta CURES had now been discussed and agreed by the DTHFT Drugs and Therapeutic Committee and its inclusion in the formulary was supported by eight vascular surgeons within Royal Derby Hospital. It was noted that GPs were being requested to prescribe Juxta CURES as a compression appliance by the DTHFT vascular department with no traffic light assignment. The NICE Evidence Summary on chronic wounds, advanced wound dressings and antimicrobial dressings had indicated that the use of Juxta CURES would free up GP and practice/district nurse time and was therefore cost effective. Juxta CURES was designed to be easier to apply than standard multi-layer compression bandages, was guaranteed for six months of daily use and could be prescribed using an FP10 prescription. Two papers had been produced on the use and efficacy of Juxta CURES by the Journal Of Community Nursing and this included an evaluation on patient outcomes and overall NHS savings. It had been highlighted that venous leg ulcers (VLU) were a significant burden on NHS resources and the Juxta CURES system provided adjustable compression management of VLUs and was designed to be easier to use, for both clinicians and patients, than standard multi-layer compression bandages. There had been small non-comparative studies which indicated that the use of Juxta CURES was associated with a reduction in wound size, improved healing and improved quality of life. A number of cost savings had been identified from an assessment of twenty-six patients who had used Juxta CURES. There had also been a significant reduction in the use of absorbent dressings which had led to reduced cost. During discussion Dr Mott referred to the need for the place of Juxta CURES to be determined together with the specific cohort of patients who would derive benefit from use. It would also be necessary to establish whether the Tissue Viability Nurses (TVN) or specialist nurses would be responsible for the administration of the Juxta CURES system. Dr Watkins highlighted that Juxta CURES could achieve savings by the release of staff time and its usage could possibly substantially increase when it became more established. Mrs Needham queried whether there was any information on healing rates from the use of Juxta CURES compared to standard multi-4 layer compression bandaging. Mr Dhadli stated that the NICE advice on Juxta CURES had referred to nine studies (all case reports) which had resulted in reduction in wound size, improved healing or improved quality of life in patients. None of the studies were comparative and it was unclear if other compression systems would have achieved similar results. It was also highlighted that patients would need to be trained to use and adjust the Juxta CURES system and therefore any traffic light classification would need to indicate the necessity of specialist initiation and follow up assessments.	

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	It was suggested that DCHSFT consider the production of a business case for much wider use if there was genuine belief that nurse time could be freed up by adopting this product. **Agreed:** Juxta CURES classified as **BROWN** specialist nurse/TVN initiation and training due to its exceptional use in select patients. JAPC also agreed to monitor use within twelve months of its decision.	**JS** **SD**
7.	**CLINICAL GUIDELINES**	
a.	**Management of Dyspepsia and Gastro-oesophageal Reflux Disease (GORD)** Mr Dhadli reported that this guideline was now due for review and had originally been produced in 2015 based on NICE CG 184 'Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management' and NICE NG12 'Suspected cancer: recognition and referral'. The main amendments to the guidance were: • The stool antigen test was now the preferred H.pylori test across Derbyshire. • Inclusion of self-care to include life style changes or use of over the counter antacid and/or alginate therapy. Long-term, frequent dose, continuous antacid therapy was not recommended. • Inclusion of advice in the management strategy for H.pylori when a referral from primary care should be considered and the action to be taken in the event of negative or unclear result. Mr Dhadli highlighted a suggested change in the pathway that H.pylori testing should be done prior to a full dose proton pump inhibitor (PPI) trial in un-investigated dyspepsia or whether this should be done alongside. The NICE guidance had advised that there was currently inadequate evidence to suggest whether full dose PPI or H.pylori testing should be offered first. Mr Dhadli added that the guideline had therefore been amended to indicate that either test or treatment should be offered depending on clinical judgement. Dr Narula referred to the section on the front page of the guideline which referred to hip fractures, hypomagnesaemia and Clostridium difficile associated with long-term use of PPIs and queried why other conditions such as pneumonia had been omitted from this list. Dr Mott commented that the potential risks of PPI prescribing needed to be supported by robust clinical evidence and it was noted that the conditions indicated in the guideline had been given as examples. Mrs Needham requested that the algorithm on page 4 be clarified to make it clear that prescribers had the option of either prescribing a PPI or testing for H pylori infection after lifestyle advice and self-care in the management of un-investigated dyspepsia. **Agreed:** JAPC ratified the Management of Dyspepsia and GORD guidance with the agreed amendments with a two year review date.	**SD** **SD**
8.	**PATIENT GROUP DIRECTIONS**	
	The following PGDs from Public Health England/NHS England were noted and agreed by JAPC:	

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	• Supply and administration of Influenza vaccine nasal spray suspension (Fluenz Tetra®▼), or supply only in well-defined local circumstances, to children and adolescents from two years to under eighteen years of age. • Influenza vaccine in accordance with the national immunisation programme for active immunisation against influenza. • Administration of DTaP/IPV/Hib/HepB) to individuals from six weeks (routinely 8 weeks) to under ten years of age – update of existing PGD • Administration of DTaP/IPV/Hib) to individuals from three years and four months to under ten years of age. Salbutamol for Derbyshire Health United (DHU): Mr Dhadli reported that this was a newly developed PGD for use within DHU which provided practitioners who were unable to prescribe with a means to administer salbutamol nebules in urgent situations whilst summoning assistance from a senior clinician. Mrs Needham highlighted an inconsistency in the indication section, which referred to the relief of acute severe/life threatening bronchospasm in patients over four years of age, and a further reference in the PGD to children aged one to five years - this would be clarified. Dr Mott commented that the dose of the salbutamol nebuliser solution referred to 2.5mg/2.5ml and 5mg/2.5ml but the preferred dose for children should be 2.5mg/2.5ml. Mr Dhadli would check the recommended dose to be used. **Agreed:** JAPC agreed the Derbyshire Health United Patient Group Direction for Salbutamol Nebulising Solution subject to the agreed clarifications. Post meeting note: inclusion criteria pulse > 140 beats/min in children 1-5 years and respirations > 40 beats/minute in children aged 1-5 years have both been amended to 4-5 years, to bring in line with the overall indication -"for the relief of acute severe/life threatening bronchospasm in patients over 4 years of age."	**SD** **SD**
9.	**SHARED CARE GUIDELINES**	
a.	**Azathioprine/Mercaptopurine** Mr Dhadli reported that the shared care guideline had been updated in the light of the 2017 guidance issued by the British Society for Rheumatology (BSR). It had been developed using the standard template previously agreed by JAPC with confirmation that thiopurine methyltransferase (TPMT) monitoring specific to this shared care was done at baseline due to the risk of toxicity at both DTHFT and CRHFT. Mrs Needham highlighted that the monitoring requirements section referred to monitoring to be provided by the consultant when the dosing was increased. However the areas of responsibility section only mentioned dose adjustment by the GP with no reference to monitoring. It was agreed that this would be added to the consultant responsibility section. **Agreed:** JAPC ratified the shared care guideline for Azathioprine/6-mercaptopurine for patients aged 16+ years for a period of two years.	**SD**
b.	**Sodium Auriothiomalate** Mr Dhadli reported that the shared care guideline for sodium aurothiomalate (Myocrisin® Gold Injection) had been updated in the light of the 2017 guidance issued by the British Society for Rheumatology (BSR).	

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	It had been developed using the standard template previously agreed by JAPC with a specific reference to the need to undertake urinalysis before each injection. In addition, the SPC had recommended an annual chest x-ray due to the risk of pulmonary fibrosis. However the BSR guidance had indicated that this was quite rare and made no specific recommendation for x-rays other than a recommendation for this to be done on a case by case basis in all the shared guidelines. In addition, there was no mention of this in the previous shared care guideline for sodium aurothiomalate and was the only one where a requirement for annual x-rays had been stipulated. It was agreed that it would be highly important that patients should report any adverse effects or warning symptoms to the specialist or GP whilst taking the drug and this should be highlighted at point of contact. **Agreed:** JAPC ratified the shared care guideline for sodium aurothiomalate.	**SD**
c.	**<u>Hydroxychloroquine</u>** Mr Dhadli reported that there was currently no shared care agreement for hydroxychloroquine due to a previous decision due to little on-going monitoring required. Hydroxychloroquine was classified as GREEN specialist initiation but required an enquiry about any visual impairment to be undertaken annually by the GP. The 2017 BSR guidance had recommended baseline Ocular Coherence Tomography (OCT) screening within one year of commencing therapy, instead of prior to initiation, and after five years this should be done annually. The prescribing guidance had been sent to consultant ophthalmologists who had indicated that they wanted to wait for updated guidance on this from the Royal College of Ophthalmologists (RCO) whom had closed a draft consultation on this subject in July 2017. This would be included in the action tracker. **Agreed:** JAPC to await the recommendations of the RCO.	**SD**
d.	**<u>Leflunomide</u>** Mr Dhadli reported that the shared care guideline for leflunomide had been updated in the light of the 2017 guidance issued by the British Society for Rheumatology (BSR). The following points were highlighted: • Patients should report any unexplained weight loss of more than 10% to their specialist or GP. • Patients should be advised about the effects of leflunomide on pregnancy and lactation and effective contraception in males. **Agreed:** JAPC ratified the shared care guideline for leflunomide for a period of two years.	**SD**
e.	**<u>Penicillamine</u>** Mr Dhadli reported that the current shared care for penicillamine would need to be updated in December 2017 but the 2017 BSR guidance no longer covered penicillamine as this drug has disappeared from routine use as a DMARD.	

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	However it was noted there was still some local prescribing of this (280 items). Discussion followed on whether the old pencillamine guidance should be extended for a further two years or re-written using the new template which had more and different monitoring requirements. **Agreed:** JAPC agreed that the existing shared care guideline for Penicillamine should be extended for a period of two years if there was no significant differences between this and the SPC.	**SD**
f.	**<u>Dronedarone</u>** Mr Dhadli reported that dronedarone was currently classified as RED following a re-classification from Green in 2011 which had been done in the light of an MHRA alert which recommended new restrictions and monitoring requirements. This had been preceded by the publication by NICE of TA197 dronedarone for the treatment of non-permanent atrial fibrillation in 2010 which had been updated in 2012. It was noted that dronedarone was recommended as an option for the maintenance of sinus rhythm after successful cardioversion in people with paroxysmal or persistent atrial fibrillation (AF). A draft shared care had now been developed by DTHFT for dronedarone which included re-classification from RED to AMBER. Mr Dhadli highlighted the following points: • In the event that the shared care was adopted there would be a need to decide when the responsibility for monitoring would transfer over to primary care as there was significant monitoring up to twelve months. • Should GPs be responsible for providing and interpreting the ECG results that were required every six months • The views of CRHFT cardiologists would need to be obtained. • The contact details for CRHFT would also need to be added. Discussion followed on the monitoring requirements and whether GPs could interpret ECG results to assess QTc intervals and, if patients developed AF, a reason to discontinue treatment. It was also noted that the shared care guideline would also need to indicate how the patient would remain under the shared care of the consultant or whether the intention was to discharge stable patients to primary care supported by a guideline. The views of the CRHFT consultant cardiologists would be required. **Action:** The dronedarone shared care guideline would be brought back for further discussion to the October JAPC meeting. **Action:** The views of the CRHFT consultant cardiologists would be obtained and patient numbers included if supported. **Action:** The views of the DTHFT consultant cardiologists would be sought as to whether they envisaged a full shared care or a discharge mechanism for those patients who were assessed as being very stable. **Action:** Further discussions to be held by the CCG Prescribing Groups.	**SD** **SD** **CN** **SD**

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10.	**MISCELLANEOUS**	
a.	**Category M Savings** JAPC noted that a letter had been sent from NHS England to CCG Accountable Officers, CCG Chief Financial Officers, CCG Audit Chairs and STP Leads concerning the system risk reserve and unplanned drug price reductions in 2017/18. Mr Dhadli highlighted the following items from the letter: • A reduced requirement of 0.5% non-recurrent investment reserves to be held uncommitted by commissioners (£360m). • A contribution from reduced utilisation of commissioner drawdown funding (£200m). • A risk reserve funded by providers from local CQUIN earnings (£270m). • Community Pharmacy Medicine Margin.	
b.	**NOAC in Extreme Weight** Mr Dhadli explained that the International Society on Thrombosis and Haemostasis (ISTH) had issued guidance about the use of the novel oral anticoagulant drugs (NOACs) in patients of extreme weight: • NOACs should not be used in patients with a BMI ≥ 40 kg/m² or weight ≥120kg due to limited data as to their use at extreme weight. • If NOACs were used in a patient with BMI> 40 kg/m2 or weight >120kg, drug-specific peak and trough levels should be monitored to guide continuing use. NOACs should continue to be used if the level was within expected range and change to warfarin if the level was below range. There was currently no dose adjustment for higher weight/BMI advised in the SPC for NOAC use. Mr Dhadli advised JAPC to adopt the principles of caution in patients whose BMI ≥ 40 kg/m² or weight ≥120kg noting the latter of drug monitoring defeats the purpose over warfarin. Local consultant cardiologists and haematologists had agreed to support the recommendation for warfarin to be used in preference to a NOAC in a situation when there was a choice between the two. **Agreed:** The weight guidance for each NOAC indicated by the SPC would be added to the individual drugs section in the local Atrial Fibrillation (AF) guidance together with a reference to the need to seek specialist advice if necessary.	**SD**
c.	**Prescribing Specification** JAPC noted the interface between primary and secondary care - Key messages for NHS clinicians and managers document. Mr Dhadli reported that the prescribing specification 2018 - 2019 had been updated and comments would be requested on this first draft for discussion at the October 2017 JAPC meeting with ratification at the November 2017 meeting. JAPC was advised that two major additions had been made to the specification: Discharge summaries and clinic letters - requirements on provider organisations and the necessity of provider communication with patients and response to queries.	

Item		Action
	Mr Newman highlighted the need for further discussion about the length of gain-share and biosimilars. Dr Mott commented that a biosimilar working group could be advantageous to address the issue of gain share and also ensure that awareness of the opportunities presented by new biosimilars was maximised. It was important that they were appropriately commissioned to ensure better uptake and were clinically owned. **Agreed:** A scoping exercise would be undertaken about the possible formation of a biosimilar task and finish group**.** **Action:** Comments on the prescribing specification to be conveyed to Mr Dhadli within the usual timelines of a JAPC paper submission.	**SD/AM** **All**
11.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
	Dr Mott referred to his circulated notes from the RMOC (Midlands and East) meeting held on 31st August 2017. JAPC noted the following: • RMOC feedback now to be a standing agenda item for each JAPC meeting. • Biosimilars: - Useful to have standard implementation documents. - Share and use early adopters to inform protocols and give assurance from the centre. - Protocols should be biosimilar drug specific. - Await publication and work needed from the 'Biosimilar Commissioning Framework'. • Antimicrobials: - Public Health England AMR 'Fingertips' was the first portal for information and this held a wide range of data down to practice level. - RMOC would look into Point of Care testing and consider funding centrally. - IV broad spectrum antibiotics should be empirically reviewed within three days in order to reduce bed time and nursing and also be monitored at Trust Board level. • Polypharmacy: - Work to be undertaken to bring all the different strands together as there was a need for a whole system approach including pharmacy together.	
12.	**JAPC BULLETIN**	
	The bulletin was noted for information and ratified by JAPC.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for August 2017 was noted. Mr Dhadli highlighted the following MHRA advice: • Corticosteroids: Risk of central serous chorioretinopathy with local as well as systemic administration. The BNF chapter had been updated accordingly where corticosteroids were mentioned to reflect the MHRA advice. • Adrenaline auto-injectors: Updated advice after European review and now recommended that two adrenaline auto-injectors were prescribed which patients should carry at all times.	

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14.	**HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuation: New drug launches in the UK: Brodalumab (Kyntheum®) – Classified as **BLACK** pending NICE TA. New formulation launches in the UK: Dimethyl fumarate (Skilarence®) for treatment of moderate-to-severe plaque psoriasis in adults in need of systemic medicinal therapy. A NICE TA had been published but this would be checked to ascertain whether it was a positive appraisal. Pirfenidone (Esbriet®) – No action needed. Ofatumumab (Arzerra®) – Classified as **RED** as per TAs or NHS England commissioning intentions.	**SQ**
15.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in August 2017. HST6 Asfotase alfa for treating paediatric-onset hypophosphatasia – Classified as **RED** (NHS England). TA463 Cabozantinib for previously treated advanced renal cell carcinoma – Classified as **RED** (NHS England). TA464 Bisphosphonates for treating osteoporosis - This guidance partially replaced TA160 and TA161. Alendronate currently classified as 1st line bisphosphonate with the alternative option of risedronate if alendronate was not tolerated or contra-indicated. The NICE costing template indicated that no significant impact on resource was anticipated as practice was unlikely to change as a result of this guidance. The guidance aligned NICE technology appraisal guidance on the use of bisphosphonates for preventing osteoporotic fragility fractures with the NICE guideline on osteoporosis: assessing the risk of fragility fracture. TA465 Olaratumab in combination with doxorubicin for treating advanced soft tissue sarcoma – Classified as **RED** (NHS England). TA466 Baricitinib for moderate to severe rheumatoid arthritis – Now recommended. Classified as **RED**. CCG commissioned and NICE did not expect this guidance to have a significant impact on resources – Classified as **RED**. TA467 Holoclar for treating limbal stem cell deficiency after eye burns – Classified as **RED** (NHS England). TA468 Methylnaltrexone bromide for treating opioid-induced constipation – Previously classified as BROWN after consultant/specialist recommendation to allow palliative care patients timely access to drug.	

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	Terminated appraisal and no evidence submission received from the company. Mrs Qureshi would look again at the NICE TA and ePACT data to check whether it was being used. TA469 Idelalisib with ofatumumab for treating chronic lymphocytic leukaemia – Classified as **BLACK (**terminated appraisal). TA470 Ofatumumab with chemotherapy for treating chronic lymphocytic leukaemia – Classified as **BLACK** (terminated appraisal). TA471 Eluxadoline for treating irritable bowel syndrome with diarrhoea – Classified as **RED**. TA472 Obinutuzumab with bendamustine for treating follicular lymphoma refractory to rituximab – Classified as **RED** (NHS England). TA160 (updated from October 2008) Alendronate, etidronate, risedronate, raloxifene and strontium ranelate. TA161 (updated from October 2008) Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. TA190 (updated from June 2010) Pemetrexed for the maintenance treatment of nonsmall - cell lung cancer.	**SQ**
16.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in August 2017 was noted. Mr Dhadli highlighted the following: Febuxostat – Classified as **GREEN** 2nd line for use in patients where allopurinol was contraindicated or not tolerated as per NICE TA 164. COPD – Updated with new treatment flowchart. Musculoskeletal and Joint Diseases Chapter updated: • Added in advice oral methotrexate only 2.5mg strength tablets should be prescribed. • Reference to methotrexate spill kits removed as no longer provided. • Gout - added in self-care measures and reference to NICE TA 164 for febuxostat. • Added in reference to BMJ article regarding increased risk of death in long-term use of quinine. Bariatric surgery – It was highlighted that it had not been possible to reach a consensus between the two centres so a decision had now been made to have just one guideline to include a reference to the variation between the two centres.	

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	MHRA August 2017 Corticosteroids: risk of central serous chorioretinopathy with local as well as systemic administration - Rare risk of central serous chorioretinopathy. Advice for patients to report any blurred vision or visual disturbances added to the GI, Respiratory and Eye Chapter. NSTEMI (South) - Awaiting response from DTHFT consultant cardiologist concerning patient numbers and clarity on the position of prasugrel and ticagrelor.	
17.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Eluxadoline – **RED** (as per NICE TA 471) Juxta CURES – **BROWN** specialist nurse and/or TVN initiation and training in select patients Brodalumab – **BLACK** pending NICE guidance Ofatumumab – **BLACK** (terminated appraisal) Asfotase alfa – **RED** (NHS England) Cabozantinib – **RED** (NHS England as per NICE TA 463) Olaratumab with doxorubicin – **RED** (NHS England as per NICE TA 465) Baricitinib – **RED** (as per NICE TA 466) Holoclar – **RED** (NHS England as per NICE TA 467) Idelalisib with ofatumumab – **BLACK** (as per NICE TA 470) Obinutuzumab with bendamustine - **RED** (as per NICE TA 472)	
18.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: DMARDS/Immunomodulating shared care – To be taken off pending feedback on penicillamine. Juxta CURES – To be taken off. Suspected DVTNOAC/D-dimer – A Public Health F2 trainee would be taking the lead on pathway development in primary care to treat suspected DVTs. Mr Jon Vinson from Medicines Management would be meeting with CRHFT to discuss further. NRT and service provision – To be brought to the October JAPC meeting. Rosuvastatin – To be brought to the December JAPC meeting. Rituximab biosimilar – Awaiting contract agreement. ADHD monitoring in adults – To be brought to the October JAPC meeting. (This would be checked by Dr Mott with Mr D Gardner from Hardwick CCG). Biosimilars – Ongoing. Information awaited from both Acute Trusts on cost opportunities and informed decision making.	**SD** **SD** **KN** **SD** **SD** **SD** **AM** **SD**

For agenda items contact Slakahan Dhadli
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Item		Action
19.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Clinical Policy Advisory Group 08/06/17 • DTHFT Drugs and Therapeutic Committee 20/06/17 • JAPC Working Group 13/06/17 • Sheffield Area Prescribing Group 15/06/17 • Burton Drugs and Therapeutic Committee 10/07/17 • DCHSFT Medication Optimisation Safety Team 06/07/17	
20.	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
21.	**DATE OF NEXT MEETING**	
	Tuesday, 10th October 2017 at 1.30pm in the Post Mill Centre, South Normanton.	