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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 14 August 2018

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Actipatch®	BLACK
Anakinra	RED for periodic fever and auto inflammatory disease/BLACK for all other indications
Anakinra and Tocilizumab	RED for the treatment of Adult Onset Still's Disease refractory to second-line therapy (adults)
Lomitapide	RED
Dolutegravir + rilpivirine (Juluca®)	RED
Niraparib	RED (NHS England as per NICE TA 528)
Crizotinib	RED (NHS England as per NICE TA 529)
Nivolumab	BLACK (NHS England as per NICE TA 530)
Pembrolizumab	RED (NHS England as per NICE TA 531)
Cenegermin	BLACK (NHS England as per NICE TA 532)
Ocrelizumab	RED (NHS England as per NICE TA 533)
Ulipristal (Esmya®)	RED
Daclizumab	BLACK

Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
Mometasone (cream/ointment)	GREEN
Mometasone brand (Elocon®)	BLACK
Co-careldopa – To be prescribed generically.	GREEN specialist recommendation
Co-careldopa brand (Sinemet®)	BLACK
Tafamadis	RED as per NHS England commissioning intentions
Autologous Chondrocyte Implantation (ACI)	RED as per NHS England commissioning intentions
Daclizumab	RED as per NHS England commissioning intentions
Paritaprevir	RED as per NHS England commissioning intentions
Albumin Bound Paclitaxel	RED as per NHS England commissioning intentions
Ethinylestradiol and Drospirenone	BROWN

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Clinical Guidelines

Derbyshire commissioning guidance on biologic drugs for the treatment of rheumatoid arthritis with or without methotrexate

Stoma Accessories

Patient Group Directions

Administration of Haemophilus influenzae type b and meningococcal C conjugate vaccine (Hib/MenC) to individuals from their first birthday to under 10 years of age in accordance with the national immunisation programme; and to individuals of any age for the prevention of secondary cases of meningococcal group C (MenC) disease.

Supply and administration of live attenuated influenza vaccine nasal spray suspension (Fluenz Tetra®▼), OR supply only in well-defined local circumstances, to children and adolescents from 2 years to under 18 years of age in accordance with the national flu immunisation programme for active immunisation against influenza.

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Hulme	Director of Medicines Management
Mrs L Hunter	Assistant Chief Finance Officer
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Dr T Narula	GP
Mrs K Needham	Assistant Chief Quality Officer (Medicines Management) (also representing all four Derbyshire CCGs)
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Dr M Henn	GP
Derby City Council	
Derbyshire County Council	
University Hospitals of Derby and Burton NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutic Committee
Mr D Moore	HCD Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Mr S Jones	Acting Chief Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Ms A Braithwaite	Pharmacist
Derby and Derbyshire Local Medical Committee	
Dr K Markus	Chief Executive
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis and Mr S Dhadli.	
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. It was noted that the Register of Interests had now been updated. No conflicts of interest were declared in relation to this agenda; in addition to the existing Register of Interests.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Compression Hosiery • Ulipristal (Esmya®) • Liothyronine • EAMS Scheme	
4.	**MINUTES OF JAPC MEETING HELD ON 10 JULY 2018**	
	The minutes of the meeting held on 10 July 2018 were agreed as a correct record after the following amendment: Management of Type 2 Diabetes – Amend to: Discussion followed and Dr Narula commented that empagliflozin, covered by NICE TAs, had to a large extent replaced usage of the gliptins. However SGLT-2 inhibitors could not be used if the patient's estimated glomerular filtration rate (eGFR) was less than sixty and therefore a gliptin would then be given as second line option. It would seem advantageous that dual therapy of metformin with empagliflozin should move ahead of the dual therapy of metformin with gliptins in the order of drugs to be used in the guideline and, in light of the cardiovascular benefit, as not much cost difference between gliptins and SGLT-2 inhibitors. The combination of metformin + pioglitazone as second line drug should be replaced by metformin + empagliflozin due to the weight of evidence for its efficacy. Dr Narula added that NICE currently recommended the use of GLP-1 agonists after triple therapy but, in the light of the evidence which demonstrated cardiovascular benefit, this could be looked at by the Guideline Group.'	
5.	**MATTERS ARISING**	
a.	**<u>Sequential Use of TNF-alpha Inhibitors in Crohn's Disease and Ulcerative Colitis</u>** Dr Mott reported that the sequential use of TNF-alpha inhibitors had now been approved by the Clinical and Lay Commissioning Committee.	
b.	**<u>Branded Prescribing</u>** In connection with the query about whether generic prescriptions should be issued when eye drops were out of stock Mr Moore would raise this issue at the UHDBFT Drugs and Therapeutic Committee.	**DM**
c.	**<u>Freestyle Libre®</u>** Dr Mott advised that it had been agreed that the Trusts would inform GPs the individual patient's eligibility criteria for their initiation on Freestyle Libre®.	

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Item		Action
	A register would be maintained so that providers would be able to demonstrate compliance when requested. A further update from Derbyshire Hospitals would be provided for JAPC in October 2018.	
d.	**Derbyshire Health United Healthcare Out-of-Hours Drug Formulary** Mrs Needham confirmed that a representative from Derbyshire Health United would attend meetings of JAPC from September onwards.	
6.	**JAPC ACTION SUMMARY**	
	Suspected DVT- NOAC/D-dimer – Ms Braithwaite reported that a DVT pathway paper would be discussed at a meeting of the DCHSFT Patient Safety Group on 17th September. The DVT paper would be brought to the September JAPC meeting. Attention Deficit Hyperactivity Disorder (ADHD) – An update would be brought to the September JAPC meeting. Derbyshire Health United/Healthcare Out-of-Hours Drug Formulary – Mrs Needham would bring the updated formulary to the September JAPC meeting.	**AB** **SJ** **KN**
7.	**NEW DRUG ASSESSMENTS**	
a.	**ActiPatch®** Mrs Qureshi reported that a number of requests for this device had been received from patients. ActiPatch® was a wearable medical device which used electro-magnetic fields to regulate irregular nerve activity and relieve chronic pain. ActiPatch® provided the following benefits: • It could be used for twenty-four hours for seven days a week as there was no skin contact and could be taped directly over bandages or clothing. • There was no sensation when it was used and users could wear it for an extended period. • There were no electrodes or application of gels. However it was highlighted that there had only been two small studies undertaken to provide clinical evidence. The first study had indicated that larger studies were needed to compare pulsed therapy to standard analgesia. The second study, which had signed up subjects via the company's website, had not been randomised or had any of the standards required in the hierarchy of trials. ActiPatch® had been recommended to the Regional Medicines Optimisation Committees (RMOCs) but the topic had been rejected. The RMOC website stated that ActiPatch® had been added to the DNT in April 2018 and there had been requests to prescribe this to GPs. There was no national or CCG guidance for this product and a lack of available evidence with regard to RCTs. The cost was £13.95 for one device and the Guideline Group had recommended a traffic light classification of BLACK be assigned following request from patients. Other neighbouring Area Prescribing Committees has either classified it as BLACK or unclassified. It was confirmed that the product could be purchased over the counter.	

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	Agreed: ActiPatch® classified as a **BLACK** medical device as not recommended or commissioned.	**SQ**
b.	**NHS England New Specialised Treatments** Mrs Qureshi reported that NHS England has published the results of its latest prioritisation exercise which indicated which new specialised treatments and services would be made available to patients. The current local traffic light classifications would therefore need to be adjusted where necessary to meet the NHS England guidance: • Teriparatide – The current traffic light classification was RED so no action was needed. • Anakinra – The current traffic light classification was BLACK but NHS England had now approved Anakinra for periodic fever and auto inflammatory disease. Anakinra and Tocilizumab was currently classified as BLACK and RED respectively. Anakinra would be classified as **RED** for periodic fever and auto inflammatory disease and **BLACK** for all other indications. Anakinra and Tocilizumab classified as **RED** for the treatment of Adult Onset Still's Disease refractory to second-line therapy (adults). • Lomitapide – The current traffic light classification was BLACK. NHS England had approved Lomitapide for treating homozygous familial hypercholesterolaemia in adults and would now be classified as **RED**.	
8.	**CLINICAL GUIDELINES**	
a.	**Commissioning Pathway for Rheumatoid Arthritis** Mrs Qureshi explained that two sets of guidance on biologic drugs for the treatment of rheumatoid arthritis with and without methotrexate had been produced - these included all the new NICE approved treatment options. Mrs Qureshi referred to the local agreements which had been included and Dr S O'Reilly, UHDBFT Consultant Rheumatologist, had recommended the use of oral baricitinib plus methotrexate or oral tofacitinib plus methotrexate instead of abatacept which would achieve a QIPP cost saving of approximately £57,000. A reference had also been included to indicate that the CCGs would only commission five switches per patient and this included treatment failure and contra-indication/tolerance. **Agreed:** JAPC approved the updated Derbyshire commissioning guidance on biologic drugs for the treatment of rheumatoid arthritis with or without methotrexate.	**SQ**
b.	**Derbyshire-wide Stoma Accessories Guideline** Mrs Qureshi reported that a revised Derbyshire-wide formulary of stoma products (which excluded bags, flanges, baseplates and covers) had been agreed in conjunction with the UHDBFT and CRHFT specialist stoma nurses in order to achieve more cost effective prescribing of stoma accessory products. It was highlighted that in 2016/2017 the Derbyshire CCGs had spent £5.5m on stoma items; of which £1.1m had been on stoma accessories such as adhesive remover sprays and deodorisers. The specialist stoma nurses had developed the limited stoma accessories formulary and use of this would enable potential annualised savings of approximately £160,000 to be made.	

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	During discussion Mrs Needham advised that work had commenced in Hardwick CCG on stoma reviews with existing patients across the practices with the advice of the stoma nurses. It had been possible to make savings on stoma prescribing. However it required ongoing close liaison with the Dispensing Appliance Contractors (DACs) to prevent prescribing reverting to the original prescriptions. There would be a need for individual patient conversations and therefore this would need a significant level of input from the Medicines Management Team. However new patients would be discharged in line with the new formulary and this would start the process. **Agreed:** JAPC approved the Derbyshire-wide Stoma Accessories Guideline.	**SQ**
9.	**PATIENT GROUP DIRECTIONS**	
	The following PGDs from Public Health England were noted by JAPC: • Administration of Haemophilus influenzae type b and meningococcal C conjugate vaccine (Hib/MenC) to individuals from their first birthday to under 10 years of age in accordance with the national immunisation programme; and to individuals of any age for the prevention of secondary cases of meningococcal group C (MenC) disease. • Supply and administration of live attenuated influenza vaccine nasal spray suspension (Fluenz Tetra®▼), OR supply only in well-defined local circumstances, to children and adolescents from 2 years to under 18 years of age in accordance with the national flu immunisation programme for active immunisation against influenza.	
10.	**SHARED CARE GUIDELINES**	
a.	**<u>Riluzole</u>** Mrs Qureshi advised that Dr M Knopp, UHDBFT Consultant Neurologist, and Ms S Cole, UHDBFT Nurse Specialist, had proposed changes to the shared care guideline which included the administration of Teglutik 5mg/mL licensed suspension for patients with swallowing difficulties at a cost of £200 per month – this had become available in the UK in 2016. The current shared care guideline currently recommended crushing and dispersing tablets which, if prescribed generically, would cost £14.80p per month and there was therefore a cost differential between the suspension and the tablets. Mrs Qureshi added that patients would not be initiated on suspension although, in the light of any disease progression, it could be appropriate to switch to the suspension. A reference had been included in the shared care guidance to say that, in the cases of swallowing difficulties and enteral tubes, the licensed oral suspension was available, although this was significantly more expensive than the tablets which may be crushed and dispersed. It had also been highlighted that crushed riluzole tablets could block enteral feeding tubes so it was important to ensure that the tube was flushed well after each dose. It was noted that the first choice for swallowing difficulties was the suspension and second choice to crush the tablets and mix with a soft food to aid swallowing. It was noted that there is no information on the use of the suspension with feeding tubes. It was agreed that more information was needed as to the reasons why the suspension was preferred to the tablets, particularly as these could be crushed and used via a fine bore tube, and why a request for the use of the suspension had been submitted two years after introduction to the UK market.	**SQ**

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Item		Action
	The number of patients who were prescribed riluzole would also be determined from ePACT data in order to ascertain the possible cost impact.	**SQ**
11.	**MISCELLANEOUS**	
a.	**Black Position Statement** Mrs Qureshi reported that a meeting had been held to discuss the governance and implications of adopting the policy developed by Stockport CCG for dealing with BLACK drugs via individual patient requests. It had been decided that this could potentially undermine the Individual Funding Request (IFR) policy and instead guidance for dealing with requests had been produced which outlined the IFR process, indicated what should be done with new and existing patients and explained clinical exceptionality. A question and answer section on the IFR process had also been included. Discussion followed and Dr Parkin referred to the necessity for a defined timescale following a clinical review. In connection with the section in the guidance which related to existing patients already on a BLACK drug, Mr Hulme stated that it was not clearly stated that the IFR process should be followed following a patient review and a feeling that the particular drug should be continued. Dr Mott commented that the actions to be undertaken if there were valid reasons why a patient should be on a BLACK drug should be highlighted. The options for this were either the IFR route or for a case to be made to the Guideline Group for a review of the relevant traffic light classification. Dr Mott added that a review timescale for clinical review would be difficult to quantify but there would be a significant role for the Medicines Management Team to work progressively with GP practices in the adoption and adherence to the BLACK drugs policy. JAPC agreed that the guidance was a starting point for practices and could be tightened up in the light of experience and feedback. It was also agreed that the guidance should be re-written as a policy which would strengthen the requirements outlined in the document. It was also noted that the BLACK drugs had recently been robustly reviewed by the JAPC QIPP Working Group and a definitive list confirmed with the exception of nefopam for which further consideration was required. **Action:** The policy and key messages would be promoted at the Prescribing Leads meeting in September. **Action:** Key messages would be added to the black drugs guidance and the question and answer section simplified. The revised guidance would be brought to JAPC members for comment.	**SD** **SQ**
b.	**Derbyshire Recovery Partnership Over the counter, Opiate Based Medication and Benzodiazepine Position Statement and Pathway** Dr Markus highlighted an increasing problem with over the counter (OTC) prescription medication addiction and referred to the position statement of public health in relation to the service provision for use/misuse of OTC medication, opiate based medication and benzodiazepines. The statement indicated that this was an issue which should be dealt with by primary care and had been based on information updates produced by the Royal College of General Practitioners.	

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Item		Action
	This stated that OTC medication addiction could be dealt with in primary care by suitably trained doctors with the right support. However most GPs were not suitably trained to deal with addiction and did not have sufficient capacity - this group of patients did not therefore have a suitable service. The substance misuse service was also unable to provide the necessary support and there was no evidence to show that a gradual reduction in medication such as codeine was effective. This was a national issue but the gap in the commissioning of the local service needed to be urgently addressed. **Action:** Dr Mott would contact the public health directorate to obtain clarification about the gaps in the commissioning of the service to deal with OTC prescription medication addiction.	**AM**
c.	**<u>Pulmonary Rehabilitation in COPD Update</u>** Mrs Qureshi reported that a request had been received from the DCHSFT physiotherapists to change the pulmonary rehabilitation threshold in the COPD guidance concerning the Medical Research Council (MRC) dyspnoea scale for grading the degree of a patient's breathlessness. The current guidance indicated that pulmonary rehabilitation should be made available to patients with a MRC score of 3 (walks slower than contemporaries on the level because of breathlessness or has to stop for breath when walking at own pace), 4 (stops for breath after about 100 metres or after a few minutes on the level) or 5 (too breathless to leave the house or breathless when dressing or undressing). The NICE COPD pulmonary rehabilitation guidance stated that this should be offered to all patients who consider themselves functionally disabled by COPD, usually MRC grade 3 and above, but the British Thoracic Society pulmonary rehabilitation guidelines recommended that patients with a MRC dyspnoea score of 2 or above (short of breath when hurrying or walking up a slight hill) should be referred for pulmonary rehabilitation. In view of the risk that the health outcomes of those patients graded as MRC 2 who do not receive pulmonary rehabilitation could worsen the guideline has been amended to the following: • Pulmonary rehabilitation should be made available to all appropriate patients with COPD (patients who consider themselves functionally disabled by COPD, usually MRC 3, 4 and 5, but may include patients with MRC 2) including those who have had a recent hospitalisation for an acute exacerbation and who are considered a priority to access pulmonary rehabilitation due to its impact on reducing readmission to hospital. **Agreed:** JAPC approved the revised COPD guideline with the agreed amendment. **Action:** Mrs Needham would ascertain whether the change would have any implications for the currently commissioned service in the North of the County.	**SQ** **KN**
d.	**<u>Valproate Update</u>** Mrs Qureshi stated that JAPC had requested the Derbyshire Medicines Safety Network to review all the local actions being undertaken by all organisations to support the implementation of the latest MHRA advice regarding the use of valproate medicines.	

Item		Action
	This included the implementation of the new Pregnancy Prevention Programme (PPP) as valproate medicines were now contraindicated in women or girls of childbearing potential unless this programme had been put in place. The Derbyshire CCGs had now produced a primary care pathway to support prescribers in the prioritisation of patient referrals to specialists for immediate and ongoing review. The pathway reminded GPs that they must identify and recall all women and girls who may be of childbearing potential, provide the patient guide and check that they had been reviewed by the specialist in the last year and were on the highly effective contraception. Patients could be referred to the relevant specialist using the primary care pathway to support this process and an annual review booked by the specialist with women and girls under the PPP and to re-evaluate the treatment as necessary. During discussion a potential issue caused by the refusal of a patient on a valproate medicine to accept highly effective contraception was highlighted and it was noted that these cases would need to be referred back to the specialists. Mr Jones stated that a DHcFT policy had recently been developed which advised specialists that, if there were exceptional circumstances, then these should be agreed with the patient's GP. This would provide clear evidence that a discussion had been held with the patient and any risks shared between the specialist and GP.	
e.	**<u>Prescribing Biosimilars</u>** Mrs Qureshi referred to the British Medical Journal paper on the prescribing of biosimilars and highlighted the reference to the Medicines Optimisation Dashboard which gave information on etanercept, infliximab, and rituximab with the median percentages of these drugs prescribed as biosimilars in January 2018 being 76% (interquartile range 60 - 90%), 90% (85 - 98%), and 60% (42 - 76%) respectively. Mrs Qureshi advised that the local uptake for biosimilars in June 2018 was: • Infliximab – CRHFT: 95% and UHDBFT: 81% • Etanercept – CRHFT: 100% and UHDBFT: 71% • Rituximab – CRHFT: 68% and UHDBFT: 70% Mrs Needham commented that a CCG in Cornwall had achieved a high uptake of Abasaglar® following work by the local District Nursing Services to switch patients. It was noted that primary care had identified the suitable patients but the switch had been undertaken via specialist services.	
12.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
	JAPC noted the following: • Best Value Biologicals: Adalimumab Update 3 - Briefing produced about biosimilar versions of the original biological medicine adalimumab (brand name Humira®) which were due to be introduced in the NHS this year after the patent for Humira® expired in October 2018. This included new patient information materials, toolkit for best value biological implementation, procurement update, product update, best value biologicals and homecare. • Free of charge (FOC) medicines schemes - Advice ratified by the RMOC for adoption as local policy.	

Item		Action
	It was noted that this had already been included in the Derbyshire Prescribing Specification. • North RMOC update from the meeting held in June 2018. • London RMOC update from the meeting held in July 2018. • Midlands and East RMOC Update from the meeting held on 8th August 2018: Items discussed included antimicrobial resistance and sodium oxybate. Sodium oxybate had a local traffic light classification of RED in line with NHS England's commissioning policy for symptom control of narcolepsy with cataplexy in children. In adults a BLACK traffic light classification had been assigned for its use in the treatment of narcolepsy with cataplexy in adults. Dr Mott highlighted that there was great deal of variation in the prescribing of sodium oxybate nationally and the RMOC had formally requested specialist commissioning to formally commission this drug for all ages.	
13.	**JAPC BULLETIN**	
	The bulletin was ratified by JAPC.	
14.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for July 2018 was noted. Mrs Qureshi highlighted the following MHRA advice: • Darunavir boosted with cobicistat: avoid use in pregnancy due to the risk of treatment failure and maternal-to-child transmission of HIV-1. • Pressurised metered dose inhalers (pMDI): risk of airway obstruction from the aspiration of loose objects. • Eltrombopag (Revolade®): reports of interference with bilirubin and creatinine test results. • Parenteral amphotericin B: reminder of the risk of potentially fatal adverse reaction if formulations were confused. • Medicines taken during pregnancy: suspected adverse drug reactions, including in the baby or child, should be reported via the Yellow Card scheme.	
15.	**HORIZON SCAN**	
	Monthly Horizon Scan Mrs Qureshi advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: Dolutegravir + rilpivirine (Juluca®) – Classified as **RED** (NHS England). Insulin lispro biosimilar (Insulin lispro Sanofi®) – To be reviewed when the prices were published. Licence extensions: Osimertinib (Tagrisso®) – Already classified as **RED**. Tofacitinib (Xeljanz®) - Already classified as **RED**. **Quarterly NICE Updates**	

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	Clinical Guidelines: Chronic heart failure in adults: diagnosis and management – September 2018 Chronic heart failure in adults: diagnosis and management – December 2018 Crohns Disease Management (update CG 152) and Ulcerative Colitis (update) (CG166) – April 2019. NICE Technology Appraisals: Ixekizumab for treating active psoriatic arthritis after DMARDs – Due in October 2018. Tofacitinib for treating active psoriatic arthritis after inadequate response to DMARDs – Due in December 2018. Tofacitinib for moderately to severely active ulcerative colitis – Due in January 2019. Certolizumab pegol for treating moderate to severe plaque psoriasis – Due in April 2019. Tildrakizumab for treating moderate to severe plaque psoriasis (Biosimilar) – Due in April 2019.	
16.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance in July 2018: TA 528 Niraparib for maintenance treatment of relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer – Classified as **RED** (NHS England as per NICE TA 528). TA 529 Crizotinib for treating ROS1-positive advanced non-small-cell lung cancer – Classified as **RED** (NHS England as per NICE TA 529). TA 530 Nivolumab for treating locally advanced unresectable or metastatic urothelial cancer after platinum-containing chemotherapy – Classified as **BLACK** (NHS England as per NICE TA 530). TA 531 Pembrolizumab for untreated PDL1-positive metastatic non-small-cell lung cancer – Currently RED as per NICE TA 447. Classified as **RED** (NHS England as per NICE TA 531). TA 532 Cenegermin for treating neurotrophic keratitis – Classified as **BLACK** (NHS England as per NICE TA 532). TA 533 Ocrelizumab for treating relapsing–remitting multiple sclerosis – Classified as **RED** (NHS England as per NICE TA 533). NG100 Rheumatoid arthritis in adults: management. The 2018 recommendations included: • To start with monotherapy and add drugs when the response was inadequate. This was unlikely to have a substantial impact on practice or resources as they aligned with the current approach taken by many healthcare professionals. • The DMARD which should be used at any stage of treatment was not specified.	

Item		Action
	• Dose escalation and reduction not changed substantially from the 2009 guideline and reflected current clinical practice.	
17.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in July 2018 was noted. Mrs Qureshi highlighted the following: Traffic Lights: • Mometasone (cream/ointment) – Classified as **GREEN** to be prescribed generically. The brand (Elocon®) classified as **BLACK**. • Co-careldopa – Classified as **GREEN** specialist recommendation to be prescribed generically. The brand (Sinemet®) classified as **BLACK**. • Tafamadis – Classified as **RED** as per NHS England commissioning intentions. • Autologous Chondrocyte Implantation (ACI) – Classified as **RED** as per NHS England commissioning intentions. • Daclizumab – This has now been withdrawn from the market. Classified as **BLACK**. • Paritaprevir – Classified as **RED** as per NHS England commissioning intentions. • Albumin Bound Paclitaxel – Classified as **RED** as per NHS England commissioning intentions. • Ethinylestradiol and Drospirenone – Classified as **BROWN**. Reserved option. Patients should have tried at least two other combined hormonal contraceptives including a third generation one containing either gestodene or desogestrel. Dretine® was the preferred brand and other brands included Lucette® and Yasmin®. Guideline Group: Formulary update (Chapter 9 - Nutrition and Blood): • Folic acid 400 microgram tablets (self-care) and 400 microgram/5ml syrup (unlicensed) removed from the formulary. • Evacal D3® replaced Natecal D3® as the cost effective calcium + vitamin D chewable tablet. • Brands Galfer® and Sytron® removed and should be prescribed generically. • Prophylaxis with iron preparation section removed and replaced with a link to shared care pathology anaemia guidance. • Statement added that the Derbyshire CCGs did not routinely commission the prescribing of gluten free foods. All gluten free foods have been classified as BLACK. • A link to the patient safety alert on the modification of food and drink added. • A link to the Derbyshire self-care policy and vitamin D PIL added. Clinical/Shared Care Guidelines: • Management of pregnant women and neonates in contact with chickenpox and shingles,	

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	• Management of pregnant women and neonates in contact with measles - Updated with no changes. • Summary of changes in the Public Health England Treatment of Common Infections document produced and distributed via the Medicines Management Team. • Type 2 Diabetes – The appendix on GLP-1 has been merged. The prices for the different insulin preparations had been updated and moved to the endocrine formulary chapter. • Ulipristal acetate for symptomatic fibroids to remain unchanged at present including BLACK traffic light classification. • UTI Diagnosis and Management guideline – a link to useful patient leaflets added to page 2. • COPD - Trelegy® (BROWN) included in the COPD guidance alongside Trimbow®. • Asthma – The inhaled corticosteroids relative potencies table had been amended in line with the NICE recommendations. Miscellaneous: • Freestyle Libre® traffic light classification and JAPC briefing had been updated with the message that practices would be provided with individual patient information to confirm Freestyle Libre® eligibility and removal of the requirement for the ABCD forms to be sent to the GP. • Pioglitazone traffic light classification to remain as **BROWN** due to the existing safety concerns arising from the MHRA warning. No new evidence had been presented to the Guideline Group to warrant a change in classification. It was noted that international diabetes guideline would shortly be published and the place of pioglitazone and other type 2 diabetes drugs would be reviewed and the views of primary care diabetologists obtained. • Quetiapine MR preferred brand changed to Brancico® from Sondate®. Guidelines: • Buprenorphine Shared Care Agreement – To be brought to the September JAPC meeting. • Methadone Shared Care Agreement – To be brought to the September JAPC meeting. • Naltrexone Shared Care Agreement – To be brought to the September JAPC meeting.	**SJ** **SJ** **SJ**
18.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Actipatch® – **BLACK** Anakinra – **RED** for periodic fever and auto inflammatory disease/**BLACK** for all other indications Anakinra and Tocilizumab – **RED** for the treatment of Adult Onset Still's Disease refractory to second-line therapy (adults) Lomitapide – **RED** Dolutegravir + rilpivirine (Juluca®) – **RED** Niraparib – **RED** (NHS England as per NICE TA 528)	

Item		Action
	Crizotinib – **RED** (NHS England as per NICE TA 529) Nivolumab – **BLACK** (NHS England as per NICE TA 530) Pembrolizumab – **RED** (NHS England as per NICE TA 531) Cenegermin – **BLACK** (NHS England as per NICE TA 532) Ocrelizumab – **RED** (NHS England as per NICE TA 533) Ulipristal (Esmya®) – **RED** Daclizumab – **BLACK**	
19.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• DHcFT Drugs and Therapeutic Committee 26/04/2018 • DHcFT Drugs and Therapeutic Committee 24/05/2018 • JAPC Working Group 08/05/2018 • JAPC Working Group 12/06/2018 • DCHSFT Medicines Optimisation Safety Team 05/04/2018 • DCHSFT Medicines Optimisation Safety Team 03/05/2018 • DCHSFT Medicines Optimisation Safety Team 07/06/2018 • Sheffield Area Prescribing Group 17/05/2018 • Sheffield Area Prescribing Committee 21/06/2018 • Regional Medicines Optimisation Committee (South) 03/05/2018	
20.	**ANY OTHER BUSINESS**	
a.	**Compression Hosiery** Dr Markus referred to some queries which had been received by Derbyshire LMC concerning measuring for compression hosiery. In cases where people required class 2 and 3 compression hosiery community nurses would usually undertake a Doppler examination in order to measure for compression stockings. The queries which had been received related to community pharmacies in Ashbourne and class 1 compression hosiery which had been prescribed by a GP. The local community pharmacies had informed the people concerned that they were unable to measure for stockings and had been advised to go back to their GP for this to be done. However Dr Markus highlighted concern about the capacity of primary care to carry out the required measurements and queried whether there had been a change of policy. It was currently uncertain whether measurement by community pharmacists was an optional activity or they had a contractual obligation to do this. Dr Markus would raise this issue with the Derbyshire Local Pharmaceutical Committee in order to obtain a definitive view which would enable the local guidance to be updated or amended as necessary.	**KM**
b.	**Ulipristal (Esmya®)** Mrs Qureshi advised that there was a request for a traffic light classification for ulipristal in the light of the interim MHRA safety measures for the monitoring of liver function before initiation, during treatment and at the end of each treatment course. Ulipristal (Esmya®) had been classified as BLACK pending notification of the restrictions to its use for the symptoms of uterine fibroids following completion of the European Union review to investigate the link between Esmya® and cases of serious liver injury. This had now been published and stated that rare but serious cases of liver injury, including cases of hepatic failure requiring liver transplantation, had been reported worldwide in women treated with Esmya® for the symptoms of uterine fibroids.	

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Item		Action
	It was now only indicated as follows: • Intermittent treatment of moderate to severe symptoms of uterine fibroids in women of reproductive age who were not eligible for surgery. • Each treatment course should not exceed three months and should only be repeated after a break in treatment. • One course of pre-operative treatment of moderate to severe symptoms of uterine fibroids in adult women of reproductive age. • Esmya® treatment to be initiated and supervised by a physician experienced in the diagnosis and treatment of uterine fibroids. • Esmya® contraindicated in women with underlying liver disorders. In addition details of the requirements for liver function testing had been given. **Agreed:** Ulipristal (Esmya®) re-classified as a **RED** drug as it required long term on-going monitoring of efficacy by a specialist and not suitable for shared care.	
c.	**<u>Dupilumab</u>** Mrs Qureshi reported that NICE had just published a positive Technology Appraisal on dupilumab (Dupixent®) for treating moderate to severe atopic dermatitis in adults. This was now a CCG commissioned line rather than NHS England as previously indicated. According to the NICE costing template there would be 5% uptake initially and after five years this would increase to 60%. The cost implication across Derbyshire for year one was £60K and by year five £603K. It was highlighted that there were three patients in UHDBFT who were being treated under the early access to medicines scheme (EAMS) following a clinical trial in Sheffield. The current systemic treatment for moderate to severe atopic dermatitis (eczema) included ciclosporin, methotrexate, azathioprine and mycophenolate mofetil. Dupilumab would be used after these treatments were no longer effective. It was agreed that the EAMS scheme would be brought to the JAPC Biosimilars and High Cost Drugs Working Group and the September JAPC meeting for further discussion.	**SQ**
d.	**<u>Liothyronine</u>** Mr Hulme stated that liothyronine had been classified as a BLACK drug but subsequently re-classified as RED due to the requirement for patients to have specialist reviews and recognition that there were a small cohort of patients who would remain on the treatment. JAPC had agreed that there would be a review of the traffic light classification when all the patients had been reviewed by specialists. UHDBFT had expressed concern about the long term cost risk presented by this residual group of patients and requested assurance that this review would be undertaken. In addition, the RMOC was developing a potential shared care agreement which was due to be published at the end of September. Following discussion it was agreed that there would be a future review of the traffic light status of liothyronine when all the patients had been reviewed and the numbers had been reduced to a residual level within a six month time period. The aim would be to see an 80% reduction in the number of patients who were on liothyronine.	

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Item		Action
21.	**DATE OF NEXT MEETING**	
	Tuesday, 11th September 2018 at 1.30pm in the Coney Green Business Centre, Clay Cross.	