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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 12 June 2018

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Sertraline and Citalopram	BROWN 2nd line after consultant/specialist initiation for children as per NICE guidance
Sucralfate tablets	To remain classified as BROWN
Sucralfate liquid	BLACK (tablets disperse in water)
Sodium valproate	To remain classified as GREEN after consultant/specialist initiation for epilepsy and GREEN after consultant recommendation for mania/mood stabilisation
Sodium valproate (for migraine)	To be removed from the formulary
Rosuvastatin	BROWN 3rd line use in patients who are intolerant of simvastatin, atorvastatin and pravastatin, or unable to tolerate sufficient doses of other statins to achieve target reductions in LDL-C levels (when appropriate)
Liothyronine	RED for all indications
Emicizumab (Hemlibra®)	RED as per NHS England commissioning intentions
Gemtuzumab ozogamicin (Mylotarg®)	RED as per NHS England commissioning intentions
Midostaurin (Rydapt®)	RED as per NHS England commissioning intentions
Ospemifene (Senshio®)	BLACK
Anakinra (Kineret®)	BLACK
Atezolizumab	RED as per NHS commissioning intentions (NICE TA 520) for treating locally advanced or metastatic non-small cell lung cancer

Clinical Guidelines

Management of Hypertension using Ambulatory Blood Pressure Monitoring (ABPM)
Management and Treatment of Common Infections in Primary Care
Diagnosis and Management of Lower UTI
Lipid Modification (FH and Non-FH)

Patient Group Directions

Administration of meningococcal group B vaccine (rDNA, component, adsorbed) to individuals from eight weeks of age eligible for the national routine immunisation programme and to individuals for the prevention of secondary cases of meningococcal group B disease

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Shared Care Guidelines (Greater Manchester Medicines Management Group)
Azathioprine
Ciclosporin
Hydroxychloroquine
Leflunomide
Methotrexate oral
Sodium Aurothiomalate
Sulfasalazine

Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mrs L Hunter	Assistant Chief Finance Officer
Mr S Hulme	Director of Medicines Management (also representing Erewash CCG)
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 all four Derbyshire CCGs)
Ms J Town	Head of Finance
Hardwick CCG	
Erewash CCG	
Dr M Henn	GP
Ms H Murch	Lead Pharmacist
Derby City Council	
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutic Committee
Mr D Moore	HCD 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 A Braithwaite	Pharmacist
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Mr S Dhadli, Dr C Emslie and Dr T Parkin.	
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 in relation to this agenda; in addition to the existing register of interests.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	There were no declarations of any other business.	
4.	**MINUTES OF JAPC MEETING HELD ON 8 MAY 2018**	
	The minutes of the meeting held on 8th May 2018 were agreed as a correct record.	
5.	**MATTERS ARISING**	
a.	**Midazolam** Dr Mott referred to the summary of emails received from specialists at Sheffield Teaching Hospitals NHS Trust following the JAPC decision in May 2018 to classify Epistatus® as a BLACK drug. They had indicated that the BLACK classification would have a significant impact on those Sheffield patients who were prescribed Epistatus®, particularly those who were on care plans which included this drug. The key issue would be implementation and Mrs Needham commented that it would be expected that patients would be swapped to Buccolam® at their next reviews with the specialists and that within a year all patients would have been reviewed and switched by the specialist service. It was noted that the revised JAPC BLACK traffic light classification stated that patients who were already on a drug before the BLACK classification should not have this withdrawn abruptly and treatment continued until the next clinical review. **Agreed:** JAPC agreed that the classification should remain as BLACK and Sheffield Teaching Hospitals NHS Trust specialists informed that the Sheffield service should review patients and swap to Buccolam® at their next review with updated care plans. New patients should be initiated on Buccolam®.	**SD/SQ**
b.	**Chlamydia** Mrs Qureshi advised that the British Association for Sexual Health and HIV (BASHH) chlamydia guidance had referred to the need to re-test for infection in patients who were under twenty-five years of age but the Public Health England (PHE) guidance had stipulated that re-testing should be undertaken for all patients. However, the PHE guidance had now been amended to align with BASHH.	
c.	**JAPC Minutes** Mrs Qureshi stated that a request had been received for an amendment to be made to the liothyronine section of the minutes of the July 2017 JAPC meeting.	

	It was agreed that an addendum be made to this section as follows: 'It had been agreed that levothyroxine (L-T4) was the treatment of choice for hypothyroidism as it was cost-effective, suitable for once daily dosing and provided stable and physiological quantities of thyroid hormone for patients who required replacement'. (Plural thyroid hormones changed to singular thyroid hormone). The liothyronine position statement had also been amended accordingly.	**SD**
6.	**JAPC ACTION SUMMARY**	
	Use of NOAC for Suspected DVT – Ms Braithwaite reported that the pathway used in DCHSFT was currently in the process of being updated and would include consideration of the use of near patient testing for urea and electrolytes and new oral anticoagulant drugs (NOACs) and low-molecular-weight heparin (LMWH). It was also proposed that GP referrals would be accepted to the system if a patient was suspected to have a DVT. It was noted that this GP pathway would require commissioner input. To be brought to the August 2018 JAPC meeting for a further update. Freestyle Libre® – To be brought to the July JAPC meeting. Hydroxychloroquine – Dr Mott referred to the current discussions about the validity and cost effectiveness of the monitoring requirements recommended by the Royal College of Ophthalmologists for the use of hydroxychloroquine. An update would be given to a future JAPC meeting. STEMI (Sheffield) – To be brought to the July or August JAPC meeting. Attention deficit hyperactivity disorder (ADHD) – To be brought to the July or August JAPC meeting.	**SD** **SD** **SD** **SD** **SD**
7.	**NEW DRUG ASSESSMENTS**	
a.	**<u>Citalopram and Sertraline</u>** Mrs Qureshi reported that a request had been received for a traffic light classification of GREEN after consultant/specialist initiation to be assigned for citalopram and sertraline for patients aged eight to eighteen years of age in line with the NICE guidance for the treatment of depression. Citalopram and sertraline would be the second line choice after fluoxetine, which is licensed for use in children from the age of eight and has a robust evidence base, but there is limited evidence as to efficacy of sertraline or citalopram in children. Citalopram and sertraline are not licensed for use in children. However the NICE clinical guideline CG28 recommendations on the treatment of children with depression referred to certain circumstances when citalopram and sertraline could be used as a second line choice in the treatment of depression in children. **Agreed:** Citalopram and sertraline classified as **BROWN** drugs second line for children in line with NICE guidance.	**SD**
b.	**<u>Sucralfate</u>** Mrs Qureshi reported that JAPC had assigned a traffic light classification of BROWN for sucralfate in August 2014.	

	Sucralfate had been available for a long period of time in the UK market as tablets and suspension and requests were being received for its use by primary care for the treatment of gastro-oesophageal reflux disease (GORD)/bile reflux after proton-pump inhibitors (PPIs)/H2 antagonist/antacids had been used. There was a significant disparity in the acquisition cost of sucralfate between primary and secondary care and a total spend of £45,000 in Derbyshire; with the majority usage in the south of the county. A request had therefore been made for the traffic light classification to be changed to RED. It was noted that there was some evidence for its use in the empirical management of patients with severe GORD or post-cholecystectomy, alongside use of PPIs, where there may be bile acid reflux. In addition, there was also some evidence to support the short-term use of sucralfate granules in suspension to speed the healing of endoscopic variceal sclerotherapy/banding induced ulcers. The evidence for sucralfate had remained unchanged and it had not been listed in the NICE guidance on GORD from November 2014. Mr Moore advised that the liquid formulation was available for hospital use only in specialist circumstances but was currently unavailable. However, it was highlighted that the tablets could easily be dispersed in water. Dr Goddard commented that sucralfate was used on short-term basis in secondary care for patients who had undergone banding of their oesophageal varices but otherwise was a long-term drug for GORD/bile acid reflux where other medications had failed. **Agreed:** Sucralfate tablets to remain classified as a **BROWN** drug.	**SD**
	Agreed: Sucralfate suspension classified as a **BLACK** drug and message to be added that the tablets were readily dispersible in water.	**SD**
c.	**<u>Valproate Medicines</u>** MHRA had advised that all valproate containing medicines were contraindicated in women and girls of childbearing potential unless the conditions of the Pregnancy Prevention Programme were met. Mrs Qureshi reported that a guide for healthcare professional had been developed which gave information on the risks of valproate (Epilim®, Depakote®, Convulex®, Episenta®, Epival®, Kentlim®, Orlept®, Sodium Valproate®, Syonell® and Valpal®) use in girls, of any age, and women of childbearing potential. It was noted that the current traffic light classifications were: Valproate semisodium (Depakote®) – BROWN. Sodium valproate for migraine prophylaxis – GREEN. Sodium valproate – GREEN after consultant/specialist initiation for epilepsy. Sodium valproate – GREEN after consultant recommendation for mania/mood stabilisation. Ms Braithwaite requested that GPs should highlight to DCHSFT all the patients who were on sodium valproate under specialist care with DCHSFT so that the required reviews of women and girls of childbearing potential could be undertaken without delay. Dr Mott commented on the need for a consistent approach from primary care with the appropriate assurances and the remit of the Medicines Management Team in this work should be clearly defined to avoid any confusion about responsibility.	

	An implementation plan should also be presented to JAPC in order to provide the necessary assurances. Ms Murch suggested that the Medicines Safety Collaborative would be a suitable mechanism for the development and implementation of such a plan. Dr Taylor referred to the patients with bipolar disorder who may lose capacity to make decisions and the necessity therefore to emphasise that the contraceptive pill alone was not sufficient. In addition, those patients in DHcFT who were taking sodium valproate were being identified and repatriated for review. Discussion followed on whether the current traffic light classifications for the valproate medicines needed to be changed. Dr Mott commented that a change in the traffic light classifications would not be necessary as these were only applicable to a section of people on valproate but queried whether BROWN would be more appropriate. However it was not possible for sodium valproate to be prescribed without a health care professional being alerted to the MHRA warning on the GP clinical system for women of childbearing age. Dr Henn commented that the use for migraine was the biggest risk but, if use for this condition was no longer permitted, then the majority of patients would be removed and therefore the risk in the group much reduced. **Agreed:** Sodium valproate to remain classified as **GREEN after consultant/specialist initiation** for epilepsy and **GREEN after consultant recommendation** for mania/mood stabilisation. **Agreed:** Sodium valproate for migraine to be removed from the formulary. **Action:** The implementation of the Pregnancy Prevention Programme to be picked up by the Medicines Safety Collaborative with an update to a future JAPC meeting.	**SD** **SD** **HM**
8.	**CLINICAL GUIDELINES**	
a.	**<u>Management of Hypertension using Ambulatory Blood Pressure Monitoring (ABPM)</u>** Mrs Qureshi reported that there were no changes to the guideline and the updated NICE Clinical Guideline was not due to be published until August 2019. Dr Narula raised a number of specific queries and it was suggested that these should be sent to Mrs Qureshi and Mr Dhadli for response. **Agreed:** JAPC approved the Management of Hypertension using Ambulatory Blood Pressure Monitoring (ABPM) guideline with a two year review date.	**TN/SQ/SD** **SD**
b.	**<u>Sequential Use of TNF-alpha inhibitors in Crohn's Disease and Ulcerative Colitis</u>** Mr Moore advised that there was a lack of clarity in the current NICE guidance on the use of tumor necrosis factor (TNF)-alpha inhibitors as first line biologic treatment options in the medical management of patients with severe Crohn's disease and severe ulcerative colitis (UC) as to what should happen if a patient experienced failure or intolerance with a first anti-TNF and the possible option to use a second-line anti-TNF before vedolizumab or ustekinumab. During discussion about the commissioning pathway a gastro-enterologist had expressed interest in a sequential switching option, in cases of failure with a first line TNF, to a second line TNF before a move to the more expensive vedolizumab or ustekinumab dependent on the condition.	

	The evidence for a second line TNF had been reviewed by the DTHFT Drugs and Therapeutic Committee and it had been noted that the data had demonstrated that response and remission rates with a second TNF-alpha inhibitor were highest in those patients who had discontinued their first TNF-alpha inhibitor due to intolerance, secondary failure or primary failure. A second line TNF-alpha inhibitor, adalimumab, was more effective in the reduction and maintenance of remission than the two current NICE approved drugs of vedolizumab or ustekinumab. In addition, adalimumab was significantly cheaper than vedolizumab or ustekinumab and a biosimilar for adalimumab would be available later in the year. It was highlighted that this could be a potential cost saving as there would be a reduced need for surgery in people with Crohn's disease who often required multiple surgical interventions. NICE had estimated that the net budget impact of the use of a second TNF-alpha inhibitor, although difficult to estimate, was not anticipated to be substantial. Locally it is felt that this change would be at worst cost-neutral and potentially cost saving if adalimumab was used ahead of vedolizumab or ustekinumab. During discussion Dr Mott stated that the possible switching to adalimumab after infliximab treatment failure had been discussed at the recent meeting of the JAPC HCD and Biosimilar Working Group who had supported this. It was highlighted that this was not anticipated to be a cost pressure and should achieve savings on an individual patient basis. Mr Hulme queried whether there would be a larger cohort of patients on treatment if the switch to adalimumab was successful and there was a consequent reduction in surgery. Dr Mott stated that patients with UC who had undergone a colectomy would not receive a TNF-alpha inhibitor but those with Crohn's disease might continue to have a TNF-alpha inhibitor during or after surgery as there was no cure for the condition. Dr Goddard commented that patients with severe UC who did not respond well to biologic medications would have a colectomy, but many would be keen to avoid this procedure. However if surgery was required their quality of life would be impacted by having a permanent ileostomy or ileo-anal pouch. Patients with Crohn's disease would benefit more from biologic medication due to the need for repeated surgery. Mr Hulme suggested that this could be a QIPP opportunity as the overall treatment was cost effective and there would be a reduction in activity arising from the need for less surgery and provision of blood testing and Stoma bags. Mrs Needham added that it would be useful to ascertain the position of other neighbouring Area Prescribing Committees and whether they had developed any financial models. Mr Moore would follow this up. Dr Mott referred to the need to better demonstrate and define the clinical responses of patients with UC or Crohn's (such as occurred consistently with rheumatoid arthritis) to the TNF-alpha inhibitors but it was acknowledged that this was difficult with IBD patients. **Agreed:** JAPC supported in principle the switch to a second TNF-alpha inhibitor from infliximab to adalimumab for patients with severe Crohn's disease and severe ulcerative colitis. A business case would be developed for presentation to the Joint Clinical and Lay Commissioning Committee meeting on 28th June 2018 and this would include an indication of the estimated cost savings.	**DM** **SD/SQ**

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c.	**Management and Treatment of Common Infections in Primary Care by Public Health England** This national guidance had been produced by Public Health England and the format of this allowed minor changes to be made in order to suit local service delivery and sampling protocols. Accordingly, Dr D Harris, Lead Antimicrobial Pharmacist, had included local messages in this. In addition, 'A Quick Reference Summary for CCGs and Primary Care by Public Health England' had also been included. Mrs Qureshi highlighted the *Varicella zoster*/ chickenpox section where it had now been recommended to remove famciclovir so the first line choices would be aciclovir or valaciclovir. Dr Mott requested that the key changes in the document should be highlighted for ease of reference. Mrs Qureshi would contact Dr Harris to request that this be done. **Agreed:** JAPC approved the Management and Treatment of Common Infections in Primary Care by Public Health England Guidance with a two year review date.	**SQ** **SD**
d.	**Diagnosis and Management of Lower UTI** Mrs Qureshi reported that the guidance on the diagnosis and management of lower urinary tract infections (UTI) had been reviewed and updated by Dr D Harris. The status of methenamine, locally classified as BROWN specialist/consultant recommendation, would be checked in the guideline. **Agreed:** JAPC approved the Guideline for the Diagnosis and Management of Lower UTI with a two year review date.	**SD** **SD**
e.	**Lipid and Familial Hypercholesterolaemia** Mrs Qureshi reported that the price of rosuvastatin, currently classified as BROWN after specialist recommendation, had now decreased significantly as it had become generic. Rosuvastatin had therefore been included in both the Adult Lipid Modification Therapy in Non-familial Hyperlipidaemia (FH) and the Identification and Management of Familial Hypercholesteroleamia guidelines. Dr R Stanworth, DTHFT Consultant in Diabetes and Endocrinology, had proposed that it could be appropriate for GP initiation in patients who had complete intolerance of simvastatin, atorvastatin and pravastatin due to myalgia or partial tolerance of other statins at low-moderate doses (simvastatin 40mg, pravastatin 40mg and atorvastatin 20mg max tolerated dose) but not reaching LDL-C target. Rosuvastatin should therefore be re-classified as BROWN according to these criteria and potential savings achieved as a result of the expiry of the patent. During discussion Mr Hulme commented that rosuvastatin was still more expensive than simvastatin and atorvastatin so, in the event that the specialist recommendation requirement was removed, there would consequently be more use. The position of rosuvastatin would therefore need to be carefully defined, although it was noted that there would be a reduction in the number of referrals. There could be a QIPP opportunity to review those patients who were currently on ezetimibe and possibly switch to rosuvastatin.	

	Dr Narula stated that the 40mg dose of rosuvastatin was contraindicated in the Asian community and this should be highlighted in the LH guidance. It was agreed that it would be advantageous to include this in OptimiseRx together with a reference to specific statin strengths. **Agreed:** Rosuvastatin to be re-classified as **BROWN** third line in patients who had complete intolerance of simvastatin, atorvastatin and pravastatin due to myalgia or for other patients who failed to achieve target lipid reduction with maximum tolerated dose of other generic statins due to lack of data on cost-effectiveness compared with standard therapy. **Agreed:** JAPC approved the Adult Lipid Modification Therapy in Non-familial Hyperlipidaemia (Non-FH) and the Identification and Management of Familial Hypercholesteroleamia (FH) guidelines with a two year review date. **Action:** Prescribing activity to be reviewed in six months in order that the options and evidence could be compared. To be placed on the action tracker.	**SD** **SD** **SD** **SD**
9.	**PATIENT GROUP DIRECTIONS**	
	The following PGD from Public Health England was noted by JAPC: • Administration of meningococcal group B vaccine (rDNA, component, adsorbed) to individuals from eight weeks of age eligible for the national routine immunisation programme and to individuals for the prevention of secondary cases of meningococcal group B disease.	
10.	**SHARED CARE GUIDELINES**	
	DMARD Shared Care Protocols – Stepping Hill Hospital JAPC noted that Stockport CCG, the main commissioner for Stepping Hill Hospital, had developed Disease-modifying anti-rheumatic drugs (DMARDs) shared care protocols which indicated that GPs would be responsible for initiating the DMARD drugs, together with the titration of doses and associated blood tests, during that period. However it was highlighted that this was at variance with the Derbyshire DMARD shared care protocols where the responsibility for initiation and titration was with the specialist. The care would only be transferred to GPs after three months of treatment and once this had been stabilised. This variance in practice caused confusion for both patients and GPs in the High Peak area of the county where referrals were made to Stepping Hill Hospital (SHH) rather than either CRHFT or DTHFT. Greater Manchester Medicines Management Group (GMMMG) had now taken over the responsibility for the development of the shared care protocols and these were now published on their website and they have shared care protocols for GPs initiating, or secondary care initiating, the DMARDs. SHH had therefore agreed the rheumatology shared care protocols for use by Derbyshire GPs with the hospital initiating the DMARD and the GP undertaking the blood tests on behalf of SHH. SHH receive the results until patients are transferred to GP care under the Derbyshire SHH shared care protocols. **Agreed:** The GMMMG shared care protocols to be either published on the Derbyshire Medicines Management website or linked so that they could be easily viewed by GPs in the High Peak area.	**SD**

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11.	MISCELLANEOUS	
a.	**Liothyronine** **JAPC Position Statement** Ms Murch referred to the changes which had been made to the position statement on liothyronine in the light of the JAPC decision to assign a traffic light classification of RED for all indications. Mrs Needham queried an apparent contradiction in the section 'Patients currently receiving liothyronine monotherapy or combination L-T3 and L-T4 for hypothyroidism may continue treatment until their next medication review where their NHS clinician will stop treatment. Continued prescribing of liothyronine would only be supported in exceptional circumstances from an NHS specialist. Continued prescribing will become the responsibility of the specialist.' **Agreed:** JAPC approved the position statement **Update** Ms Murch reported that the Medicines Management Team had been working with the Acute Trusts to ensure that the change in the traffic light status of liothyronine was made as smooth as possible for patients. Some progress had been made although there was further work to be done. However it was now time to implement the new classification of liothyronine by updating the traffic light classifications on the website, changing the position statement as previously discussed and removing the shared care agreement for major depression and commencing the identification of patients to be referred back. A number of guidance documents, including a step-by-step guide, would be produced and made available to support the implementation work. Dr Watkins queried what would happen in the event that a patient who had been referred did not attend. Mr Moore explained that a first appointment would be given and followed up with a second one if necessary. In the event that both appointments were not attended, the patient would be discharged back to primary care at which point a decision would need to be made as to whether the GP would see the patient or the Medicines Management Team would step in to discuss with the individual about any decision to stop liothyronine. Dr Mott commented that there may be external reasons for any non-attendance by a patient and this would necessitate discussions on a case by case basis. **Briefing Paper** The liothyronine briefing paper was noted by JAPC. Dr Taylor expressed some concern about the timescale of 12th June to implement the repatriation of patients currently prescribed liothyronine to secondary care with a view to provision of alternative treatment or continuation of liothyronine by secondary care. Dr Mott stated that there were three cohorts of patients involved: 1. Those currently under the care of secondary care specialists; 2. Those who are not being seen by secondary care and had initially received private prescriptions; and 3. Those known only to primary care and therefore needed to be referred into secondary care. Ms Murch stated that there would need to be a balance to be drawn between the timeframe stipulated by NHS England and to ensure that patients were not caught between primary and secondary care.	**SD**

	The timings for the second and third cohorts above may need to be reviewed and the Trusts had indicated that they did not want this work to run through until later in the year when winter pressures would significantly impact on workload. It was hoped that the work would be completed by September but this relied on the provision of additional endocrinology weekend clinics and the goodwill of specialists. **Implementation Tools** The implementation tools, including a step-by-step guide, were noted by JAPC. It was highlighted that support would be given to primary care by the Medicines Management Team and the Prescribing Leads. At the conclusion of the discussion the following action was agreed: • The JAPC website would be updated with liothyronine classified as RED for all indications. • The shared care agreement for the use of liothyronine in major depression to be removed. • GPs would be advised to refer those patients who were currently prescribed liothyronine to the appropriate endocrine or psychiatric specialist. Referrals would be made via NHS eReferral Service (eRS; previously known as Choose and Book).	**SD** **SD** **SD**
b.	**Self-care Policy** Dr Mott stated that suggested traffic light classifications had been given to the drugs which were part of the Derbyshire self-care policy and already assigned a traffic light classification. In cases where the traffic light classification could not be changed advice had been given to add a self-care message to the traffic light and formularies/guidelines as appropriate. It was highlighted that there were certain traffic light discrepancies in the list and this should go back to the Guideline Group for further discussion.	**SD**
c.	**JAPC Annual Report** The JAPC Annual Report for April 2017 to March 2018 was approved by JAPC. Members were requested to convey any notes or comments to Dr Mott as soon as possible.	**All**
d.	**L-carnitine** Mrs Qureshi advised that L-carnitine had been classified as RED due to requests from Sheffield and was Payment by Results (PbR) excluded with NHS England as the responsible commissioner. It was noted that Sheffield had L-carnitine unclassified.	
e.	**Diamorphine Shortage** Ms Murch reported that information had been received from primary care that 10mg diamorphine was available in the supply chain but not the 5mg dosage.	
12.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC) OUTPUTS**	
	JAPC noted the following: • Position statement on access to pan-regional antidotes and other Rarely Used Medicines (RUMs). • Best value biologicals: Adalimumab – This had been discussed by the JAPC Biosimilar and High Cost Drugs working group.	

	The NHS England Commercial Medicines Unit (CMU) was scheduling the procurement process for adalimumab after the loss of patent exclusivity in October 2018. Current indications were there would be four products available in the UK at this time (the originator and three biosimilars). Further detail was being investigated with regard to the potential products and this would be circulated to the NHS in due course. It was likely that the contract would be in place by December 2018, although NHS England continued to explore the possibility of a contract being in place during October. There was also ongoing work about the provision of patient information and consent to the switch to a biosimilar product.	
13.	**JAPC BULLETIN**	
	It was agreed that a revision would be made to the midazolam and the management of convulsive seizures in the community section about the need for the patients' care plans to be updated by specialists at their next review. The amended bulletin was ratified by JAPC.	**SD** **SD**
14.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for May 2018 was noted. Mrs Qureshi highlighted the following MHRA advice: • Valproate medicines (Epilim®, Depakote®, Convulex®, Episenta®, Epival®, Kentlim®, Orlept®, Sodium Valproate®, Syonell® and Valpal®): Pregnancy Prevention Programme materials were available online. • Braltus® (tiotropium): Risk of inhalation of capsule if placed in the mouthpiece of the inhaler.	
15.	**HORIZON SCAN**	
	Mrs Qureshi advised JAPC of the following new drug launches and licence extensions: New drug launches in the UK: • Emicizumab (Hemlibra®) – Classified as **RED** (NHS England). • Gemtuzumab ozogamicin (Mylotarg®) – Classified as **RED** (NHS England). • Midostaurin (Rydapt®) – Classified as **RED** (NHS England). • Ospemifene (Senshio®) – Classified as **BLACK** awaiting clinician request. • Trastuzumab biosimilar (Herzuma®) – Already has multiple classifications for various NICE TAs. No action needed. Licence extensions: • Anakinra (Kineret®) – The NICE TA had been withdrawn in 2003 and no reference to the responsible commissioner – Classified as **BLACK.** • Denosumab (Xgeva®) – Already dual classified – No action needed.	
16.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in May 2018:	

	TA 520 Atezolizumab for treating locally advanced or metastatic nonsmall-cell lung cancer after chemotherapy – Classified as **RED** (NHS England as per NICE TA 520). ES 17 Chronic obstructive pulmonary disease: beclometasone, formoterol and glycopyrronium (Trimbow®) – This had been previously classified as **BROWN**.	
17.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in May 2018 was noted. Mrs Qureshi highlighted the following: Traffic Lights: • Fludrocortisone – Classified as **GREEN**. As part of steroid replacement therapy. • Fentanyl IR – Classified as **BLACK**. All non-transdermal preparations initiated outside palliative care. • Trimbow® - Additional guidance on use – 'May be suitable for some people with moderate to severe COPD who had found triple therapy beneficial using more than one inhaler and can use a pressurised metered dose inhaler.' Formulary Update: • Preferred brand insulin needle GlucoRx® or consider the purchase of needles less than £6 per 100 • Safety needles should not be used by patients who self-administered insulin. Mylife Clickfine AutoProtect® was the preferred brand for safety needles if indicated. • Preferred brand lancet AgaMatrix® ultra-thin and TRUEplus® or consider lancets less than £3 per 100. Clinical/Shared Care Guidelines: • Treatment for Migraine which was previously based on the British Association for the Study of Headaches (BASH) guideline 2010. This had been updated in line with SIGN 155 (2018). For migraine prophylaxis propranolol replaced atenolol as 1st line; valproate removed from 2nd line option. Guideline Timetable: • *C.difficile* – Review date to be amended pending publication of the Public Health England advice. • ONS for Adults – Review date to be amended.	**SD** **SD**
18.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	<u>Classifications</u> Sertraline and Citalopram – **BROWN 2nd line** for children as per NICE guidance Sucralfate tablets – To remain classified as **BROWN** Sucralfate liquid – **BLACK**	

	Sodium Valproate – To remain classified as **GREEN** after consultant/specialist initiation for epilepsy and **GREEN** after consultant recommendation for mania/mood stabilisation Sodium valproate for migraine – To be removed from the formulary Rosuvastatin – **BROWN 3rd line** Liothyronine – **RED** for all indications Emicizumab (Hemlibra®) – **RED** as per NHS England commissioning intentions Gemtuzumab ozogamicin (Mylotarg®) – **RED** as per NHS England commissioning intentions Midostaurin (Rydapt®) – **RED** as per NHS England commissioning intentions Ospemifene (Senshio®) – **BLACK** Trastuzumab biosimilar (Herzuma®) – Already classified via NICE TAs Anakinra (Kineret®) – **BLACK** Atezolizumab – **RED** as per NHS England commissioning intentions	
19.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Chesterfield Drugs and Therapeutic Committee 15/05/2018 • DHcFT Drugs and Therapeutic Committee 22/02/2018 • DHcFT Drugs and Therapeutic Committee 22/03/2018 • DTHFT Drugs and Therapeutic Committee 17/04/2018 • JAPC QIPP Working Group 13/02/2018 • JAPC QIPP Working Group 13/03/2018 • Nottingham Area Prescribing Committee 18/01/2018 • Sheffield Area Prescribing Group 15/02/2018 • Sheffield Area Prescribing Group 15/03/2018	
20.	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
21.	**DATE OF NEXT MEETING**	
	Tuesday, 10th July 2018 at 1.30pm in the Coney Green Business Centre, Clay Cross.	