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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 13 March 2018

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Onexila® XL (once daily MR oxycodone)	BLACK
MXL® (once daily MR morphine)	BROWN
Fluticasone inhaler	GREEN for children; BROWN for adults
Fluticasone + salmeterol (Seretide®)	GREEN for children; BROWN for adults
Autologous CD34+ enriched cell fraction (Strimvelis®)	RED as per NHS England commissioning intentions (HST7)
Pirfenidone	RED (as per NICE TA 504)
Ixazomib with lenalidomide and dexamethasone	RED (NHS England as per NICE TA 505)
Sofosbuvir + velpatasvir + voxilaprevir (Vosevi®)	RED (NHS England as per NICE TA 507)
Eliglustat (Cerdelga®)	RED as per NHS England commissioning intentions (HST5)
Tilmanocept (Lymphoseek®)	RED as per NHS England commissioning intentions
Glycerol phenylbutyrate (Ravicti®)	RED as per NHS England commissioning intentions
Rilpivirine + emtricitabine + tenofovir alafenamide (Odefsey®)	RED as per NHS England commissioning intentions
Lesinurad	BLACK (as per NICE TA 506)
Dupilumab (Dupixent®)	RED as per NHS England commissioning intentions
Niraparib (Zejula®)	BLACK as per NHS England commissioning intentions
Nusinersen (Spinraza®)	BLACK as per NHS England commissioning intentions
Sodium hyaluronate + triamcinolone hexacetonide (Cingal®)	BLACK

Clinical Guidelines

Asthma management in adults ≥17 years
Asthma management for children and young people aged 5 to16 years and children under 5 years
Chlamydia Testing and Management: A Framework for Derbyshire
Oral fosfomycin for the treatment of multi-resistant UTIs
Acute Coronary Syndrome/NSTEMI guideline
Physical health monitoring in people with serious mental illness: antipsychotic treatment

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Patient Group Directions
Administration of measles, mumps and rubella (MMR) vaccine

Shared Care Guidelines
Naltrexone for the maintenance of alcohol abstinence

Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Professional Secretary)
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Mrs K Needham	Assistant Chief Quality Officer (Medicines Management) (representing all four Derbyshire CCGs)
Ms J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Dr M Henn	GP
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	
Mr S Jones	Acting Chief Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Ms C Duffin	Principal Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Ms A Braithwaite	Chief Pharmacist
Derby and Derbyshire Local Medical Committee	
Dr K Markus	Chief Executive
In Attendance:	
Ms M Hill	HCD Pharmacy Technician, Derbyshire CCGs
Mr A Thorpe	Derby City Council (minutes)
Dr L Zolotas	Paediatric Pharmacology Trainee, DTHFT

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Mr S Hulme, Mrs L Hunter, Dr T Narula, Mr C Newman and Mr M Shepherd.	
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 13 FEBRUARY 2018**	
	The minutes of the meeting held on 13 February 2018 were agreed as a correct record after the following amendments: Traffic Lights on cover page – Addition: Vilanterol and fluticasone and umeclidinium (Trelegy®) – Classified as BROWN. Triple therapy was reserved for exceptional use in severe disease in the presence of persistent exacerbations despite other treatments. NICE Osteoporosis – Amended to read 'Dr Markus referred to those patients who had osteopenia diagnosed via a DEXA scan who were attending the Falls Clinic. It was noted that practices were being requested to prescribe bisphosphonates and it had been queried whether this was a relevant indication.'	
5.	**MATTERS ARISING**	
a.	**<u>Omega 3 and Liothyronine</u>** Mr Jones confirmed that it had been agreed that there was no clinical reason why patients at DHcFT should be initiated on omega-3 fatty acids but consultant psychiatrists had indicated that they wished to continue this with the two patients concerned as they were confident as to its efficacy. However it had been highlighted that no further patients would be initiated on it. In the event that any GPs were asked to prescribe omega-3 for mental health indications they should be advised to refer back to the relevant DHcFT clinician who could either stop the prescribing or continue to prescribe for the patient on an ongoing basis. Mr Dhadli advised that the NHS England commissioners had been contacted about the exceptional use of Omega-3 for the small cohort of patients with severe hypertriglyceridemia and further clarification had been sought from a member of the NHS England joint clinical working group – a response was awaited.	
b.	**<u>NSTEMI (South)</u>** Dr Mott would obtain an update from Mr Hulme about whether agreement had been obtained from the CCGs for investment to change the pathway in the light of the decision at the February JAPC meeting to produce a single Derbyshire-wide ACS NSTEMI dual-antiplatelet policy.	**AM**

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c.	**Co-dydramol** It was reported that the Guideline Group had decided not to assign a traffic light classification to the three strengths of co-dydramol.	
d.	**Age-related Macular Degeneration** Mrs Qureshi would obtain the views of the local ophthalmologists as to whether they were following NG 82 'Age-related Macular Degeneration' and whether this would represent a change in practice.	**SQ**
e.	**Sore Throat (acute): Antimicrobial Prescribing** In response to the request for clarity about the stated course length of antibiotics of five to ten days for adults Dr D Harris, Lead Antimicrobial Pharmacist, had advised that this would be a matter of clinical judgement.	
f.	**Dry Eye Formulary in Chapter 11 Appendix** Mr Dhadli would ascertain whether the optometrists had access to the dry eye formulary and subsequent updates.	**SD**
g.	**Ulipristal acetate (Esmya®)** Ms Duffin and Mr Moore confirmed that there were no outstanding actions in CRHFT and DTHFT in connection with the MHRA warning about Esmya® (ulipristal acetate 5mg tablets).	
6.	**JAPC ACTION SUMMARY**	
	Use of NOAC for suspected DVT – To be brought to the May or June 2018 JAPC meeting.	**SD**
	Rosuvastatin - Pending DT price drop and launch of generics.	**SD**
	Hydroxychloroquine - Guidance from the Royal College of Ophthalmologists was still awaited on optical coherence tomography (OCT) testing and would be brought to a JAPC meeting when available.	**SD**
	Dosulepin – This was included in the list of Items which should not routinely be prescribed in primary care. In connection with the small cohort of patients in DHcFT who had previously benefited from the use of this drug, Mr Jones highlighted that there would be risks involved in taking these patients off a long-term antidepressant. The following patient factors would therefore need to be taken into consideration before any decision was made to withdraw dosulepin and introduce a new drug: • Had the patient had two or more depression episodes and a history of multiple episodes of depression? • Had a patient's depression been severe or prolonged? • Had the patient been hospitalised with suicidal thoughts? • Were there any co-morbidities? • Age of the patient. Dr Markus stated that it would be useful to understand the average age of the patients concerned.	

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	Mr Jones advised that careful consideration would be needed as to whether the risks involved in withdrawal were greater than any benefits. It was agreed that the JAPC working group be requested to discuss further the use of dosulepin for neuropathic pain. Shared care principles – The updated document on shared care principles was awaited from the Department of Health and would be brought to a JAPC meeting when available.	**SD** **SD**
7.	**NEW DRUG ASSESSMENTS**	
a.	**Onexila and MXL** Mr Dhadli reported that Onexila® XL was the first licensed once daily prolonged release oxycodone preparation licensed for the management of severe pain. All the other MR preparations of oxycodone available in the UK were taken twice daily. It was noted that MXL® was the only licensed once daily modified release morphine preparation in the UK. Mr Dhadli highlighted that there may be confusion between the immediate release preparation and the other modified release preparations of oxycodone which were twice daily dosing regimens. Dr Mott advised that Onexila® XL had been discussed by the Southern Derbyshire CCG Prescribing Group and a recommendation made to not recommend its use. A traffic light classification of BLACK was suggested due to the risks of incorrect prescribing at the point of prescribing. **Agreed:** Onexila®XL classified as a **BLACK** drug due to lack of data on safety compared with standard therapy. MXL®, a once daily modified release morphine drug, is not a new product. It was highlighted that there was exceptional use with some patients in the community and it was proposed that a traffic light classification of BROWN would allow exceptionality for this. **Agreed:** MXL® classified as a **BROWN** drug due to exceptionality where a small cohort of patients would benefit from prescribing.	**SD** **SD**
8.	**CLINICAL GUIDELINES**	
a.	**Asthma** Mrs Qureshi reported that the JAPC asthma guidelines for adults and children had been updated in the light of NICE NG 80 Asthma: diagnosis, monitoring and chronic asthma management published in November 2017. It was highlighted that there were differences between the NICE guidance and the guideline on the management of asthma in adults and children produced jointly by SIGN and the British Thoracic Society (BTS). The views of DTHFT and CRHFT respiratory clinicians had also been obtained. The CRHFT clinicians had indicated that they were not in favour of the NICE guidance and the DTHFT clinicians had requested some amendments, which had now been included, but were broadly in agreement. Mrs Qureshi highlighted that the JAPC guidance was primary care facing and referred to the following:	

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Item		Action
	• NICE had recommended the use of short-acting beta-agonists (SABAs) alone at initiation; although this only applied to a small minority of patients. • Enhanced position in the NICE guidance of leukotriene receptor antagonists (LTRAs) and the recommendation that these be used ahead of inhaled corticosteroids (ICS)/long-acting beta agonists (LABAs) as more cost effective therapy. • Removal of the 'step' approach in the NICE guidance. • MART (maintenance and reliever therapy) regimens were recommended by NICE for adults and children. • The pharmacological management of patients under five years old had been included in the JAPC guidance. During discussion Dr Henn commented that the BTS/SIGN guidance was more practice orientated and had looked at aspects such as safety and patient benefit. In addition, the early use of inhaled corticosteroids had been promoted in order to inhibit the inflammatory process involved in asthma. This advice should be highlighted in the JAPC guidelines. Dr Henn added that there were reservations about the recommended use of fractional- exhaled nitric oxide (FeNO) in the diagnosis of asthma and that it was not readily available in primary care. Dr Mott referred to the reference to 'consider inhaled ICS to high dose plus LABA as fixed' in the management of adults aged 17 years and over algorithm and the need to include a combination inhaler in this. It should also be made clear that the drugs listed in the options for the treatment of adult asthma table were the formulary choices – this would be highlighted. Dr Watkins advised that different colours should be used in this table and the ICS doses in order to avoid any confusion that these had been traffic lighted. Mrs Qureshi added that all the products listed in the adult asthma guideline and formulary would be classified as GREEN with the removal of any references to 2nd and 3rd line. In connection with the asthma management guideline for children and young people aged 5 to16 years and children under 5 years, Dr Mott advised that the reference to the need to refer to secondary care, if the event of more than two emergency department attendances or one or more attendances for exacerbation, should be amended to indicate that this should be considered. The reference to consideration of a trial of an additional drug e.g. theophylline in the pharmacological management table was queried as being inappropriate for GPs to initiate in children in primary care. It was agreed that this would be removed and the line which referred to seeking advice from an asthma specialist should have the word 'consider' taken out. Mrs Qureshi also confirmed that the pharmacological management of patients under five years old algorithm had been taken directly from the NICE guidance and had been recommended for inclusion by the Shared Care and Guideline Group. Dr Watkins queried how the new guideline would be advertised to GPs and practice nurses in view of the significant changes which had been made. Mrs Needham advised that information was being given to practice nurses via the prescribing leads and annual prescribing reviews and other ways of supporting implementation would be developed.	**SQ** **SQ** **SQ** **SQ**

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Item		Action
	The CCG Prescribing Groups would need to consider the development of an education programme.	
	Agreed: Fluticasone inhaler classified as **GREEN** for children and **BROWN** for adults as it was not recommended for use other than in children due to the licensing of the drug.	**SD**
	Agreed: Fluticasone + salmeterol (Seretide®) classified as **GREEN** for children and **BROWN** for adults as it was not recommended for use other than in children due to the licensing of the drug.	**SD**
	Agreed: JAPC approved the guideline for asthma management in adults ≥17 years guideline with the agreed amendments with a review date of two years.	**SD**
	Agreed: JAPC approved the guideline for asthma management for children and young people aged 5 to 16 years and children under 5 years with the agreed amendments with a review date of two years.	**SD**
b.	**Chlamydia** Mr Dhadli reported that the chlamydia guidance had been reviewed by Dr Fatima Nathani, Lead Clinician Integrated Sexual Health Services, and Ms B Brown, Derby City Council Public Health Manager, and it was highlighted that the main change concerned test of cure (TOC) and repeat testing. Dr Nathani had referred to the guidance produced by the British Association for Sexual Health and HIV (BASHH) which recommended TOC in pregnancy, poor compliance, persistent symptoms or at least three weeks after completing treatment. However this was at variance with the Public Health England (PHE) guidance on the management and treatment of common infections published in November 2017 which recommended repeat TOC in all at three months. Dr Nathani would contact Public Health England to highlight this discrepancy and request further clarification on re-testing. It was therefore proposed to accept the changes which had been indicated in the guideline but to place it on the action tracker for six months to ascertain whether BASHH and PHE could come to an agreement.	**SD**
	Agreed: JAPC approved the chlamydia guidance with a two year review date but could be reviewed earlier if the above query was resolved.	**SD**
c.	**Oral fosfomycin for the treatment of multi-resistant UTIs** Mr Dhadli reported that the changes to the guideline were the removal of the branded product Monuril®, as this was now available as a generic product at the same price as the brand, and adjustment of the second dose for male patients (unlicensed) to 48 hours after first dose from the previous 72 hours as per Public Health England advice.	
	Agreed: JAPC approved the guideline for oral fosfomycin for the treatment of multi-resistant UTIs with the agreed amendments with a review date of two years.	**SD**
d.	**NSTEMI** Mr Dhadli stated that the South Derbyshire NSTEMI guideline has been updated in line with North Derbyshire in order to produce a single Derbyshire wide acute coronary syndrome (ACS) dual-antiplatelet policy (NSTEMI/ unstable angina) and was fully compliant with the relevant NICE TA.	

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Item		Action
	Mr Dhadli highlighted that the option to continue ticagrelor 60mg BD for up to three years had now been added but was reserved for highly selective patients usually with recurrent events and following advice of a consultant cardiologist. **Agreed:** JAPC approved the use of ticagrelor in patients with possible ACS guideline.	**SD**
e.	**Physical health monitoring in people with serious mental illness: antipsychotic treatment** Mr Jones stated that physical health monitoring in patients who were taking antipsychotic drugs was recommended in the context of serious mental illness. It was noted that patients with serious mental illness had health care needs regardless of whether they were taking antipsychotic drugs or not. The guideline was based on the nationally supported Lester Tool which assisted frontline staff to make assessments of cardiac and metabolic health in order to reduce mortality for people with mental illnesses. It recommended physical monitoring and health check results and outcomes to be shared between healthcare providers but it was highlighted that this only covered a certain cohort of patients in particular circumstances. Mr Jones proposed that the reference to baseline monitoring should be changed to indicate that this would be done by the initiating organisation. For the first twelve months after initiation this monitoring would be via the community-based specialist teams. During discussion Dr Emslie queried point 11 which referred to annual monitoring by primary care section to monitor medication in line with the SPC and what GPs would need to do in terms of blood tests and ECGs. Mr Jones stated that the interpretation of ECGs was not a change made by this guideline from the existing advice and had been taken directly from the commissioning document. Dr Markus commented that it was a generally agreed principle that the person who had initiated the test was responsible for any follow up. Dr Markus also referred to the reference to annual monitoring in primary care for those not in contact with secondary care (discharged or solely under care of primary services). Many of these patients were likely to have been discharged as a result of repeated DNAs, and therefore would be lost to secondary care, but remained on potent antipsychotic drugs. Primary care consequently may be cautious about seeing these patients without input from secondary care and GP registers may not be fully up to date. Dr Watkins highlighted that there was often an inconsistent relationship between psychiatrists and GPs in terms of information requested and provided. Dr Mott referred to the need for consistency in these communications but a challenge remained in determining the long-term mutual shared responsibility. Mr Jones advised that the organisation which had initiated the drug should retain the responsibility for twelve months or until the patient was stable whichever was longest. In the event that the antipsychotic drug was changed then this timescale would restart. It was agreed that point 11 should be taken out of the guideline pending clarification of expectations of health professionals. **Action:** Dr Mott would follow up how the communication channels concerning issues such as responsibility for ECG testing could be improved.	**SJ** **AM**

Item		Action
	Agreed: JAPC approved the physical health monitoring in people with serious mental illness: antipsychotic treatment guideline with the agreed amendment with a review date of two years.	**SD**
9.	**PATIENT GROUP DIRECTIONS**	
	The following PGD from Public Health England was noted by JAPC: • Administration of measles, mumps and rubella (MMR) vaccine to individuals from one year of age for routine immunisation, or from six months of age if early protection is required, in accordance with the national immunisation programme and Public Health England guidelines on post-exposure prophylaxis for measles.	
10.	**SHARED CARE GUIDELINES**	
a.	**Naltrexone** Mr Dhadli reported that the existing shared care agreement for naltrexone for the maintenance of alcohol abstinence had been updated only with revised contact details, consultees and references and there were no other changes. Dr Mott queried the number of patients in Derbyshire who were on naltrexone – this would be checked on ePACT2. **Agreed:** JAPC approved the shared care agreement for naltrexone for the maintenance of alcohol abstinence with a review date of two years.	**SD** **SD**
11.	**MISCELLANEOUS**	
a.	**Prescribing Specification** JAPC noted that the prescribing specification now included the key therapeutic topics which summarised the evidence-base on topics identified to support medicines optimisation. Dr Goddard queried whether self-care, vitamin D and gluten-free foods had been incorporated. Mr Dhadli confirmed that the self-care policy and vitamin D had already been included in the main body of the document.	
b.	**Derbyshire Biosimilar and High Cost Drug Working Group Terms of Reference** The terms of reference for the Derbyshire Biosimilar and High Cost Drug (HCD) working group were approved by JAPC.	
12.	**JAPC BULLETIN**	
	The February 2018 bulletin was ratified by JAPC.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for February 2018 was noted. Mr Dhadli highlighted the following MHRA advice: • Misoprostol vaginal delivery system (Mysodelle®): reports of excessive uterine contractions (tachysystole) unresponsive to colytic treatment. • Mycophenolate mofetil, mycophenolic acid: updated contraception advice for male patients. It was now recommended that either the patient or their female partner used reliable contraception during treatment with mycophenolate medicines and for at least 90 days after stopping.	

Item		Action
	• Gadolinium-containing contrast agents: Omniscan and iv Magnevist no longer authorised; MultiHance and Primovist for use only in liver imaging.	
14.	**HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: • Autologous CD34 + enriched cell fraction (Strimvelis®) – Classified as **RED** as per NHS England commissioning intentions. • Dupilumab (Dupixent®) – Classified as **RED** and await NICE TA expected in August 2018. • Eliglustat (Cerdelga®) – Classified as **RED** as per NHS England commissioning intentions. • Etelcalcetide (Parsabiv®) – Already classified as **RED** as per NICE TA 448. • Glycerol phenylbutyrate (Ravicti®) – Classified as **RED** as per NHS England commissioning intentions. • Ixazomib with lenalidomide and dexamethasone (Ninlaro®) – Classified as **RED** as per NICE TA 505 and NHS England commissioning intentions. • Niraparib (Zejula®) – Classified as **BLACK** and await NICE TA expected in June 2018 as per NHS England commissioning intentions. • Nusinersen (Spinraza®) – Classified as **BLACK** and await NICE TA expected in November 2018 as per NHS England commissioning intentions. • Sodium hyaluronate + triamcinolone hexacetonide (Cingal®) – Classified as **BLACK** and await review or request from clinicians. • Sofosbuvir + velpatasvir + voxilaprevir (Vosevi®) – Classified as **RED** as per NICE TA 507 and NHS England commissioning intentions. • Tilmanocept (Lymphoseek®) – Classified as **RED** as per NHS England commissioning intentions. New formulation launches in the UK: • Rilpivirine + emtricitabine + tenofovir alafenamide (Odefsey®) – Classified as **RED** as per NHS England commissioning intentions.	
15.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in February 2018: HST7 Strimvelis® for treating adenosine deaminase deficiency – severe combined immunodeficiency – Classified as **RED** (NHS England). TA 504 Pirfenidone for treating idiopathic pulmonary fibrosis – Classified as **RED** (as per NICE TA 50 - replaces NICE TA 282). TA 505 Ixazomib with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma – Classified as **RED** (NHS England as per TA 505). TA 506 Lesinurad – Classified as **BLACK** (as per NICE TA 506).	

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Item		Action
	TA 507 Sofosbuvir + velpatasvir + voxilaprevir (Vosevi®) – Classified as **BLACK** (NHS England as per NICE TA 507). TA 160 (updated from October 2008) Raloxifene – The recommendations in this guidance had been updated because strontium ranelate was no longer marketed in the UK. TA 161 (updated from October 2008) Raloxifene and teriparatide – The recommendations in this guidance had been updated because strontium ranelate was no longer marketed in the UK. TA 464 (updated from August 2017) Bisphosphonates for treating osteoporosis – recommendation unchanged. Further clarification of implementation has confirmed that the Derbyshire approach was correct. CG 44 (updated from January 2007) – Heavy menstrual bleeding: assessment and management – The European Medicines Agency temporary safety measures on ulipristal acetate (Esmya®) had been included.	
16.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in February 2018 was noted. Mr Dhadli highlighted the following: Traffic Lights: • HRT formulary preparations classified as GREEN as per local menopause guideline. • Ciprofoxacin ear drops (Cetraxal®) – Classified as GREEN as an alternative option to aminoglycoside ear drops for otitis externa in ages >1year. Guidelines: • Menopause guideline – Mirena® used as a HRT was licensed for four years as opposed to five years when used solely for contraception. • Infant feeding guideline – SMA Gold Prem2 Catch Up discontinued and renamed as SMA PRO Gold Prem 2. Miscellaneous: • Ipinnia XL had been removed as the preferred ropinirole brand due to long-term stock shortage. • CHC formulary choice Lestramyl 20/150 had been discontinued and replaced with Bimizza®. Lestramyl 30/150 had been discontinued and replaced with Gedarel® 30/150. • Humulin R U500 insulin only and KwikPens currently available but not the vials. • The CCG position statement on the supply of multi-compartment compliance aids had been updated with no major changes. • Social care and care homes resources had been updated with no major changes. • COPD detailing aid had been updated with no major changes.	

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Item		Action
17.	**JAPC SUB-GROUPS**	
	Biosimilar and High Cost Drugs (HCD) Working Group Mr Dhadli referred to the tabled paper of the top biosimilar medicines list which gave the target annual savings broken down to DTHFT, CRHFT and Burton Hospitals NHS Foundation Trust for infliximab, etanercept and rituximab. This included the monthly percentage uptake, monthly target saving, monthly savings delivered and cumulative savings for each of the three biosimilars. The working group would review the opportunity costs by Trust, and then the cumulative savings, in order to determine the percentage uptake. Dr Mott highlighted the amount of work which was taking place concerning biosimilars and that the switching rate (patient acceptance) for etanercept was now higher than predicted; although the overall switch rate was below the planned trajectory rate. Mr Dhadli stated that biosimilars offered huge QIPP opportunities and it was therefore highly important that implementation plans were in place when the biosimilars were launched. Dr Mott added that it would also be important to have a robust process in place to enable any problems or concerns to be rapidly escalated from both working groups to the main JAPC meetings.	
18.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Onexila® XL (once daily MR oxycodone) – BLACK MXL® (once daily MR morphine) – BROWN Fluticasone inhaler – GREEN for children; BROWN for adults Fluticasone + salmeterol (Seretide®) – GREEN for children; BROWN for adults Autologous CD34 + enriched cell fraction (Strimvelis®) – RED as per NHS England commissioning intentions Pirfenidone – RED (as per NICE TA 50) Ixazomib with lenalidomide and dexamethasone – RED (NHS England as per NICE TA 505) Sofosbuvir + velpatasvir + voxilaprevir (Vosev®i) – RED (NHS England as per NICE TA 507) Eliglustat (Cerdelga) – RED as per NHS England commissioning intentions Tilmanocept (Lymphoseek®) – RED as per NHS England commissioning intentions Glycerol phenylbutyrate (Ravicti®) – RED as per NHS England commissioning intentions Rilpivirine + emtricitabine + tenofovir alafenamide (Odefsey®) – RED as per NHS England commissioning intentions Lesinurad – BLACK (as per NICE TA 506) Dupilumab (Dupixent®) – RED as per NHS England commissioning intentions Niraparib (Zejula®) – BLACK as per NHS England commissioning intentions Nusinersen (Spinraza®) – BLACK as per NHS England commissioning intentions Sodium hyaluronate + triamcinolone hexacetonide (Cingal®) – BLACK	

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Item		Action
19.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Nottinghamshire Area Prescribing Committee 16/11/2017 • DHcFT Drugs and Therapeutic Committee 23/11/2017 • JAPC QIPP Working Group 12/12/2017 • JAPC QIPP Working Group 09/01/2018	
20.	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
21.	**DATE OF NEXT MEETING**	
	Tuesday, 10th April 2018 at 1.30pm in the Coney Green Business Centre, Clay Cross.	