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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 9th April 2019

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Budesonide (Jorveza®) orodispersable tablets	RED (indicated for treatment of eosinophilic oesophagitis in adults)
Clobetasone, nystatin, oxytetracycline (Trimovate Cream)	BROWN consultant/specialist (including GPs with a Special Interest in Dermatology) recommendation.
Benralizumab	RED (NHS England as per NICE TA 565)
Tisagenlecleucel	RED (NHS England Cancer Drugs Fund as per NICE TA 567)
Abatacept	BLACK (as per NICE TA 568)
Pertuzumab	RED (NHS England as per NICE TA 569)
Pembrolizumab	BLACK (NHS England as per NICE TA 570)
Brigatinib	RED (NHS England as per NICE TA 571)
Ertugliflozin	BROWN (as per NICE TA 572)

Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
N-Acetylcysteine (NACSYS)	Re-classified as GREEN from Brown

Clinical Guidelines

Treatment of Refractory Symptomatic Chronic Constipation in Adults
Gastro-oesophageal reflux disease (GORD) in Children guideline

Patient Group Directions

- Administration of meningococcal group A, C, W, and Y conjugate vaccine (MenACWY) to individuals with an underlying medical condition which puts them at increased risk from Neisseria meningitidis.
- Administration of meningococcal group B vaccine (rDNA, component, adsorbed) to individuals, from two years of age, with an underlying medical condition which puts them at increased risk from Neisseria meningitidis group B.
- 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.
- Administration of low dose diphtheria, tetanus, acellular pertussis and inactivated poliomyelitis vaccine (dTaP/IPV) to women from 16 weeks of pregnancy in accordance with the pertussis vaccination for pregnant women national immunisation programme and to contacts of pertussis, from 10 years of age, in accordance with PHE Guidelines for the Public Health Management of Pertussis in England and/or PHE Guidelines for the Public Health Management of Pertussis Incidents in Healthcare Settings.
- Administration of shingles (herpes zoster, live) vaccine to individuals who are eligible for the national shingles immunisation programme for the prevention of herpes zoster (‘zoster’ or shingles) and herpes zoster-related post-herpetic neuralgia (PHN).

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Present:	
Derby and Derbyshire CCG	
Dr C Emslie	GP (Acting Chair)
Mr S Dhadli	Assistant Director of Clinical Policies and Decisions (Professional Secretary)
Mr S Hulme	Director of Medicines Management and Clinical Policies
Dr T Narula	GP
Mrs K Needham	Assistant Director of Medicine Optimisation and Delivery
Dr T Parkin	GP
Mrs S Qureshi	Head of Medicines Management, Clinical Policies and High Cost Interventions
Dr M Watkins	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	
Dr S Taylor	Chair - Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist (also representing DCHSFT)
Derbyshire Community Health Services NHS Foundation Trust	
Derby and Derbyshire Local Medical Committee	
Dr K Markus	Chief Executive Officer
Derbyshire Health United	
Mr D Graham	Pharmacist
In Attendance:	
Mr A Thorpe	Derby City Council Business Support (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	Dr Emslie reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of JAPC. No conflicts of interest were declared in relation to this agenda; in addition to the existing register of interests.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	Membership of JAPC over the next three months.	
4.	**MINUTES OF JAPC MEETING HELD ON 12 MARCH 2019**	
	The minutes of the meeting held on 12th March 2019 were agreed as a correct record.	
5.	**MATTERS ARISING**	
a.	**Heart Failure** Mr Dhadli referred to the addition of the requirement in the heart failure guideline that all new patients diagnosed with heart failure should be referred to the heart failure specialist service. This had been undertaken in line with the NICE Heart Failure Guideline advice. However, the Guideline Group had subsequently queried whether this would be practical in view of the restricted capacity of the heart failure specialist service in the north of the county. Dr Emslie and Dr Watkins commented that a brain natriuretic peptide (BNP) test and an echocardiogram (echo) would be carried out on those patients with suspected heart failure in primary care in order to confirm the diagnosis. Drug doses would then be titrated by GPs and patients only referred to the heart failure specialist service if there were any concerns or issues. Consultant cardiologists in North Derbyshire had been informed of this proposal to the guidance agreed at JAPC. It was agreed that the guideline be amended to indicate that patients should be referred for echo and referral to the heart failure specialists considered if necessary.	**SD**
b.	**Attention Deficit Hyperactivity Disorder (ADHD)** The section in the GP responsibilities had now been amended by Mr S Jones and uploaded to the website.	
c.	**Shared Care Arrangements for Trans Gender Treatments** The information on the JAPC website had now been updated to include the guidance issued by the British Medical Association.	**SD**
6.	**JAPC ACTION SUMMARY**	
a.	**Hydroxychloroquine** Mr Dhadli reported that updated recommendations issued by the Royal College of Ophthalmologists had been discussed by the CCG Clinical and Lay Commissioning Committee (CLCC) at the meeting held in June 2018. It had been intended to consider hydroxychloroquine again at the September	

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	2018 CLCC meeting but this had not happened and a literature review undertaken by Dr R Dewis, Derby City Council Consultant in Public Health Medicine, had not been included in the original papers submitted to the CLCC. Mr Dhadli would clarify the current position.	**SD**
b.	**Clostridium difficile** Mr Dhadli reported that the C.difficile guideline had last been updated in 2013 and a completely new version had now been produced by Ms D Holland and Ms S Bestwick. Mr Moore advised that one of the antimicrobial drugs, fidaxomicin, was now excluded from tariff. The new guideline would be brought to a future JAPC meeting.	**SD**
c.	**Amiodarone** It was noted that national publication of the Drugs of Limited Clinical Value (DLCV) shared care templates which would assess the need for shared care for amiodarone was awaited.	
d.	**Homely Remedies** Dr Markus reported that Dr D Harris had now taken on responsibility for the review of the homely remedies guidance and a meeting had been held with the Local Pharmaceutical Committee (LPC) to highlight the concerns that GPs should sign off the homely remedies and check for possible interactions. The LPC had indicated their support for the position of Derbyshire Local Medical Committee that community pharmacy should be the first point of contact for this rather than primary care. A revised version of the guidance would be developed by Dr Harris.	
e.	**Atrial Fibrillation (AF) Guidance** Mr Dhadli stated that it had now been established that Derbyshire CCG should advise that edoxaban may not be crushed and this was not included in the SPC or the NEWT guideline for the administration of medication to patients with swallowing problems. In cases where it would be necessary for an oral anticoagulant drug to be crushed then rivaroxaban or apixaban should be used instead.	
f.	**Liothyronine** A review of ePACT data had demonstrated that the prescribing of liothyronine in Derbyshire had decreased by 62.5%; currently short of the anticipated 80% reduction. Mrs Needham reported that the prescribing data had now been reviewed but more detailed information was required, via individual patient audits in each GP practice, as to whether people had been referred, but not yet seen, or whether they were from hospitals outside Derbyshire so could not be referred back. It was agreed that individual audit data would be brought to the June JAPC meeting together with information from UHDBFT and CRHFT on the patients who had been reviewed in each Trust and the outcomes.	**KN/DM/MS**
7.	**NEW DRUG ASSESSMENT**	
a.	**Budesonide oro-dispersible** Mr Moore reported that Jorveza® was a new oral dissolving tablet	

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	formulation of an established glucocorticoid receptor agonist budesonide licensed for the treatment of eosinophilic esophagitis in adults which had been brought to the UHDBFT Drugs and Therapeutic Committee (DTC) for review. The effects of the tablets were studied in a phase III study with 88 patients who were given 1mg budesonide in the oro-dispersible tablet formulation twice daily for six weeks with an option to extend to twelve weeks. The study had ended early due to the positive response rate as a majority of the patients treated with the active product had histological remission (clearance of eosinophils from the oesophagus). Mr Moore added that the DTC had highlighted that the new formulation had not been compared with other forms of medical management strategies currently used such as proton pump inhibitors, dietary modification and topical steroid preparations. These products were unlicensed for this indication but were significantly cheaper than Jorveza®. The trial data had also excluded paediatric patients and there was no indication as to what should be done if the eosinophilic esophagitis returned after six months. A further study was in progress, which included children and further patients, and this would be published at the end of 2019. NICE will also review Jorveza® and publish a TA with an anticipated publication date of October 2019. The DTC had agreed to defer a decision on Jorveza® and prescribe on a concessionary basis, after all other medications such as steroid inhalers and PPIs had been tried, until the publication of the NICE TA. Due to the nature of the condition and the short treatment course of six or twelve weeks Jorveza® would be commenced and continued in secondary care rather than primary care. **Agreed:** Jorveza® oral dissolving budesonide tablet classified as a **RED** drug as considered suitable for a consultant or specialist, usually within secondary or tertiary care services, to initiate and continue prescribing.	**SD**
8.	**CLINICAL GUIDELINES**	
a.	**Vitamin B in Alcohol Misuse** Mr Dhadli referred to the concern which had been expressed at the March JAPC meeting about the recommendation by UHDBFT that on discharge patients on oral vitamins should be prescribed Vitamin B Compound Strong. It had also been noted that there was a wide variance in practice between UHDBFT and CRHFT. Feedback had therefore been requested from the UHDBFT consultant gastroenterologists/hepatologists about the reasons for this recommendation. Mr Moore referred to the response received from Dr A Austin, UHDBFT Consultant Hepatologist, which stated that the use of Vitamin B Compound Strong for alcohol detoxification was not recommended due to the risk of Wernicke's encephalopathy where a high dose of thiamine was required – this was not contained in the vitamin B product. However, the use of Vitamin B Compound Strong was recommended in cases of confirmed nutritional deficiency but there was insufficient evidence to support the use of this product in the management of alcohol withdrawal patients. It was noted that the patients seen by Dr Austin in the hepatology department were those at high risk of nutritional deficiency, due to lack of an adequate diet, and therefore a short course of vitamin B would be appropriate in line with the	

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	NICE guideline. Mr Moore advised that a decision had been made to update the Trust's e-prescribing to indicate that a twenty-eight day course would be supplied by secondary care, together with a note to indicate that this would not be routinely continued in primary care for this group of patients. Mr Dhadli highlighted that the prescribing of thiamine was clearly indicated in the vitamin supplementation in alcohol misuse guideline. This referred to the prescribing of oral thiamine 50 mg per day as a single dose during the maintenance stage following withdrawal and for as long as malnutrition could be present. However, there was uncertainty about the action to be taken concerning the ongoing patients who were on Vitamin B Compound Strong. One option could be to discontinue prescribing, although it would be important to ensure that patients were not disadvantaged by this, or to switch to a significantly cheaper multivitamin product but recognising that this group of patients may not be responsive to self-care advice. It may also be necessary to review each patient on an individual basis. However, it was unlikely that the dietitians would have sufficient capacity to do the reviews. **Action:** An audit would be undertaken in primary care to ascertain why and for how long patients had been initiated and maintained on Vitamin B Strong Compound. The dietitians would also be contacted about the criteria for initiation and further feedback requested from Dr Austin.	**KN/DM**
b.	**<u>Chronic Constipation</u>** Mr Dhadli reported that lubiprostone (Amitiza®) had now been discontinued by the manufacturer and accordingly the treatment of refractory symptomatic constipation algorithm had been amended to remove this drug. The Guideline Group had been requested to review the possible use of prucalopride in men and also whether linaclotide could be included for constipation associated with Irritable Bowel Syndrome constipation (IBS-C). The Guideline Group had concluded that prucalopride could be used in men due to a licence change and a positive evidence summary from NICE based on a twelve week study. Linaclotide is an option for patients with irritable bowel syndrome with constipation and has not been added to the chronic constipation flow chart. It was highlighted that the algorithm referred to the need to stop prucalopride and consider other measures, such as enemas, colonic lavage and surgical options, if there had been no improvement after about four weeks of use. Dr Goddard advised that experience of use has shown that prucalopride can have a tachyphylaxis effect which led to a sudden decrease in response but following a drug 'holiday' it would become effective again. It was agreed that the algorithm would be updated to include a reference to a three month treatment holiday period.	**SD**
	Agreed: JAPC ratified the Algorithm for the Treatment of Refractory Symptomatic Chronic Constipation in Adults with the agreed amendment with a review date of three years.	**SD**
c.	**<u>Gastro-oesophageal reflux disease (GORD) in Children</u>** Mr Dhadli reported that the guideline had been updated with minor updates only.	

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	Agreed: JAPC ratified the Gastro-oesophageal Reflux Disease (GORD) in Children guideline with a review date of three years.	**SD**
9.	**PATIENT GROUP DIRECTIONS**	
a.	The following PGDs from Public Health England effective from 1st March 2019 were noted by JAPC: • Administration of meningococcal group A, C, W, and Y conjugate vaccine (MenACWY) to individuals with an underlying medical condition which puts them at increased risk from *Neisseria meningitidis*. • Administration of meningococcal group B vaccine (rDNA, component, adsorbed) to individuals, from two years of age, with an underlying medical condition which puts them at increased risk from *Neisseria meningitidis* group B. • 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. The following PGDs from Public Health England effective from 1st April 2019 were noted by JAPC: • Administration of low dose diphtheria, tetanus, acellular pertussis and inactivated poliomyelitis vaccine (dTaP/IPV) to women from 16 weeks of pregnancy in accordance with the pertussis vaccination for pregnant women national immunisation programme and to contacts of pertussis, from 10 years of age, in accordance with PHE Guidelines for the Public Health Management of Pertussis in England and/or PHE Guidelines for the Public Health Management of Pertussis Incidents in Healthcare Settings. • Administration of shingles (herpes zoster, live) vaccine to individuals who are eligible for the national shingles immunisation programme for the prevention of herpes zoster ('zoster' or shingles) and herpes zoster-related post-herpetic neuralgia (PHN).	
10.	**MISCELLANEOUS**	
a.	**Freestyle Libre ®** Mr Dhadli reported that NHS England had issued a statement which outlined the funding and commissioning arrangements for the Freestyle Libre® Flash Glucose Monitoring System with effect from 1st April 2019. It was highlighted that the eligibility criteria determined by NHS England was at variance with the Regional Medicines Optimisation Committee (RMOC) criteria currently adopted by JAPC. Mr Dhadli advised that the local policy had now been updated in line with the NHS England criteria and highlighted some of the changes which had been made: • Those patients who had recently developed recurrent severe hypoglycemia or impaired awareness of hypoglycaemia locally defined by use of the Gold score ≥4. • New criteria of diabetes associated with cystic fibrosis on insulin treatment.	

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	• Any form of diabetes on hemodialysis and on insulin treatment. • Previous attendance, or due consideration given to future attendance, at a Type 1 diabetes structured education programme. It was noted that locally for adults the Dose Adjustment For Normal Eating (DAFNE) programme was provided. **Agreed:** JAPC approved the updated JAPC Briefing on the Freestyle Libre® Flash Glucose Monitoring System.	**SD**
b.	**<u>JAPC and Guideline Group Terms of Reference</u>** In the light of the merging of the four Derbyshire CCGs into one new organisation to be known as Derby and Derbyshire CCG from 1st April 2019, Mr Dhadli stated that the terms of reference of functioning for JAPC and the Guideline Group would remain largely unchanged but there would be changes to membership. Mrs Needham advised that the reference to the oversight by JAPC of the work of the Difficult Decision/QIPP Working Group and Biosimilar/High Cost Drug Working Group was now incorrect as they were now sub-groups of the Derbyshire Prescribing Group. In addition, the reference to minutes of meetings to be posted on the Derbyshire Medicines Management website within two weeks of ratification would need to refer to JAPC only. Mr Hulme stated that there would be a need to determine how many GP clinicians should be members of JAPC in order that robust clinical decisions could be made at the meetings and whether these individuals should represent different geographical areas in the county. A communication had recently been sent out to request expressions of interest in a number of clinical roles within the CCG. This included the Prescribing Lead which may operate as a job share. It was anticipated that the Prescribing Lead would be a GP and he/she would chair the JAPC meetings and other meetings such as the Prescribing Group and the Clinical Policies Advisory Group. However, it was currently unclear how many other GPs would need to be included in the membership of JAPC. It was noted that the JAPC Chair would not need to be a member of the CCG Governing Body and a deputy would be required - this would probably be one of the other GPs on the committee. Discussion followed at the conclusion of which the following was agreed: • There should be four GPs as members of JAPC with one to be the Chair and another as deputy. • In order for meetings to be quorate there would be need to be minimum of two GPs in attendance. • The JAPC terms of reference would be amended as previously indicated.	**SD**
c.	**<u>Trimovate® Cream</u>** Mr Dhadli reported that Trimovate® cream, a corticosteroid combination of antibiotic and antifungal compounds (clobetasone butyrate + nystatin + oxytetracycline), had been discontinued in April 2018. It had been classified as a BLACK drug by JAPC in April 2018 as it was available as a special and expensive in comparison to other formulary steroid topical combinations. Mr Dhadli added that Trimovate® cream was now available again as a licensed	

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	product but was more expensive than the other combination corticosteroid products. It was also the only moderate topical corticosteroid preparation with antimicrobials available. It was noted that Dr E Riches, a local GP with a Special Interest (GPSI) in dermatology, had recommended that Trimovate be included in the formulary as none of the other steroid + antibacterial/antifungal combination preparations were of moderate steroid potency strength. **Agreed:** Trimovate® cream classified as **BROWN** consultant/specialist, including GPs with a Special Interest in Dermatology, recommendation. For use after consultant/specialist recommendation, including GPs with a Special Interest in Dermatology, when a moderately potent steroid in combination with an antifungal and antibacterial was required.	**SD**
11.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
	JAPC noted the following: • Compassionate Use/ Free of Charge (FOC) Medicines Scheme Guidance. • Following the publication of the RMOC guidance on liothyronine a variation in practice had been documented in the House of Lords dossier 'Case Details with Clear Evidence that NHS England Guidance on Prescription of Liothyronine is not Being Followed by CCGs'. The RMOC guidance was discussed with key individuals including senior clinical and academic representation from the British Thyroid Association. The reduction in variation of practice as a result of implementing the RMOC guidance was welcomed, but clarification was requested concerning some of the statements in the RMOC document. The document was being considered in light of the House of Lords dossier; with the aim of providing clarification rather than a change in guidance A draft revision of the published RMOC guidance, with clarification of the wording, had been discussed at the South RMOC. This would then be circulated to other RMOCs for comment. • The RMOC considered the work of Bristol, North Somerset and South Gloucester CCG who shared their progress on reviewing the therapeutic uses of botulinum toxin and the issues that have arisen during this process. A short life working group was developing some direction concerning the use of botulinum toxin in a range of unlicensed indications. Evidence reviews and estimated cohort sizes were being produced. • The RMOC considered a proposal for standardised Blueteq templates to be adopted by CCGs in order to provide greater clarity and reduced variation in the system.	
12.	**JAPC BULLETIN**	
	The March 2019 bulletin was ratified.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for March 2019 was noted. Mr Dhadli highlighted the following MHRA advice: • Fluoroquinolone antibiotics: new restrictions and precautions for use due to very rare reports of disabling and potentially long-lasting or irreversible	

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	side effects. At the first sign of tendinitis treatment with the fluoroquinolone should be discontinued and an alternative treatment should be considered. Patients who were older than 60 years, had renal impairment or had had solid-organ transplantation, and those being treated with a corticosteroid are at higher risk of tendon damage. Concomitant treatment with a fluoroquinolone and a corticosteroid should be avoided as the risk of fluoroquinolone-induced tendinitis and tendon rupture may be exacerbated. Fluoroquinolones should not be prescribed for treatment of mild to moderate infections, such as in acute exacerbation of chronic bronchitis and chronic obstructive pulmonary disease, unless other antibiotics that were commonly recommended for these infections were considered inappropriate. The Guideline Group would further discuss the MHRA guidance in conjunction with the Medicines Management Drug Safety Pharmacist. • Onivyde® (irinotecan, liposomal formulations): reports of serious and fatal thromboembolic events. • Medicines with teratogenic potential: what is effective contraception and how often is pregnancy testing needed? Information on pregnancy testing and contraception for pregnancy prevention during treatment with medicines of teratogenic potential had been included in the BNF chapter.	
14.	**HORIZON SCAN**	
	Monthly Horizon Scan Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: • Pegfilgrastim biosimilar (Pelmeg®) – Classified as **RED** as per NHS England commissioning intentions. Licence extensions: • Brentuximab vedotin (Adcetris®) – To remain classified as **RED**. • Dasatinib (Sprycel®) – To remain classified as **RED**.	
15.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCG which had been made for the following NICE guidance in March 2019: TA 565 Benralizumab for treating severe eosinophilic asthma – Classified as **RED** (NHS England as per NICE TA 565). TA 567 Tisagenlecleucel for treating relapsed or refractory diffuse large B-cell lymphoma after two or more systemic therapies – Classified as **RED** (NHS England Cancer Drugs Fund as per NICE TA 567) TA 568 Abatacept for treating psoriatic arthritis after DMARDs (terminated appraisal) – Classified as **BLACK** (as per NICE TA 568). TA 569 Pertuzumab for adjuvant treatment of HER2-positive early stage breast cancer – Classified as **RED** (NHS England as per NICE TA 569).	

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	TA 570 Pembrolizumab for treating recurrent or metastatic squamous cell carcinoma of the head and neck after platinum-based chemotherapy (terminated appraisal) – Classified as **BLACK** (as per NICE TA 570). TA 571 Brigatinib for treating ALK-positive advanced non-small-cell lung cancer after crizotinib – Classified as **RED** (NHS England as per NICE TA 571). TA 572 Ertugliflozin as monotherapy or with metformin for treating type 2 Diabetes – Classified as **BROWN** as per NICE TA 572 - the Guideline Group would determine its place in the local diabetes guidance.	
16.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Shared Care and Guideline Group meeting held in March 2019 was noted. Mr Dhadli highlighted the following: Traffic Lights: • N-Acetylcysteine (NACSYS) – Re-classified as **GREEN** from Brown. Prescribe as brand NACSYS® effervescent tablets. An option for use as a mucolytic in line with the COPD guideline. Formulary Update (Chapter 4 – Central Nervous System): • Mirtazapine orodispersible tabs replaced with tablets. • Morphine suppositories removed as not commonly used. • Zolmitriptan 2.5mg strength included. • Gabapentin and pregabalin re-classified as Schedule 3 Controlled Drugs from 1st April 2019. Clinical Guidelines: • Emollient guideline minor update. The emulsifying ointment was now called Ovelle emulsifying ointment with a higher price. Website Changes/Miscellaneous: • Edoxaban and swallowing difficulties - it had been was decided that there was currently not enough evidence to support crushing and dispersing of edoxaban. An alternative NOAC (rivaroxaban or apixaban) should be used. • A number of patient information leaflets replaced with links to host websites: ➢ Medicines and your kidneys ➢ Treating your infection ➢ Important information about medicines ➢ Buccal patient leaflet ➢ Epistatus ➢ DCHSFT patient information leaflets (anterior knee pain, hip osteoarthritis, knee osteoarthritis, wrist fracture, ankle injuries, acute lower back pain, whiplash, low back pain, neck pain, low back pain during pregnancy and frozen shoulder). • Link to the Faculty of Sexual and Reproductive Healthcare (FSRH)	

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	statement on teratogenic drugs added to the formulary chapter following the MHRA advice issued in March 2019.	
17.	**JAPC SUB-GROUPS**	
	Biosimilar and High Cost Drugs (HCD) Working Group The paper of the top biosimilar medicines list which gave the target annual savings broken down to UHDBFT, CRHFT and Burton Hospitals NHS Foundation Trust was noted by JAPC.	
18.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Budesonide (Jorveza®) – RED Trimovate Cream – BROWN consultant/specialist (including GPs with a Special Interest in Dermatology) recommendation. Benralizumab – RED (NHS England as per NICE TA 565) Tisagenlecleucel – RED (NHS England Cancer Drugs Fund as per NICE TA 567) Abatacept – BLACK (as per NICE TA 568) Pertuzumab – RED (NHS England as per NICE TA 569) Pembrolizumab – BLACK (NHS England as per NICE TA 570) Brigatinib – RED (NHS England as per NICE TA 571) Ertugliflozin – BROWN (as per NICE TA 572)	
19.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Sheffield Area Prescribing Group 17/01/2019 • UHDBFT Drugs and Therapeutic Committee 19/02/2019 • Medication Optimisation Safety Team 07/02/2019	
20.	**ANY OTHER BUSINESS**	
a.	It was agreed that either Dr Henn or Dr Parkin would chair the June JAPC meeting in the absence of Dr Emslie.	
b.	Mrs Qureshi advised that discussion of the COPD guidance by JAPC had been deferred as NICE were currently updating their triple therapy guideline and this was expected in July 2019.	
21.	**DATE OF NEXT MEETING**	
	Tuesday, 14th May 2019 at 1.30pm in the Coney Green Business Centre, Clay Cross.	