For agenda items contact Slakahan Dhadli
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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 8 January 2019

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Insulin glargine biosimilar (Semglee®)	GREEN
Rivaroxaban 2.5mg	BLACK
Decitabine	BLACK (as per NICE TA 548)
Denosumab	BLACK (as per NICE TA 549)
Vandetanib	BLACK (as per NICE TA 550)
Lenvatinib	RED (as per NICE TA 551)
Liposomal Cytarabine-Daunorubicin	RED (as per NICE TA 552)
Pembrolizumab	RED (as per NICE TA 553)
Abemaciclib (Verzenios®)	RED

Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
Co-danthramer	BROWN from GREEN
Co-danthrusate tablets	BROWN from GREEN
Silver Sulfadiazine cream (Flamazine®)	BROWN from GREEN

Clinical Guidelines

Prescribing of Bridging Low Molecular Weight Heparin (enoxaparin and tinzaparin)
Protocol for Non-Vitamin K Antagonist Oral Anti-Coagulant (NOAC) for Suspected DVT in Primary Care
Management of Chronic Rhinosinusitis (CRS) with or without Nasal Polyps

Shared Care Guidelines

Somatostatin analogues (lanreotide and octreotide)
Vigabatrin for children with epilepsy

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

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Mr S Dhadli and Mr S Hulme.	
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 11 DECEMBER 2018**	
	The minutes of the meeting held on 11th December 2018 were agreed as a correct record after the deletion of the following sentence in item 13 MHRA Drug Safety Bulletin concerning hydrochlorothiazide: 'It was noted that there had been only four items prescribed in Hardwick CCG only.' This was removed as it had become clear that there was more use of this medication in the Derbyshire CCGs.	
5.	**MATTERS ARISING**	
a.	**Amiodarone** Mr Moore would send the numbers of patients on amiodarone to be reviewed at UHDBFT to Medicines Management.	**DM**
b.	**Homely Remedies** The homely remedy guidance review had now commenced and would be placed on the action tracker for the updated guidance to be discussed at a future JAPC meeting.	**SQ**
6.	**JAPC ACTION SUMMARY**	
	Hydroxychloroquine – The issues concerning eye screening was still outstanding and was due to be discussed by the CCG Clinical and Lay Commissioning Committee (CLCC) meeting at the end of January. An update would be brought to the February JAPC meeting. Infant Feeding – A review of the choice of infant feeding products would be undertaken when capacity allowed by the UHDBFT and CRHFT dietetic teams with advice to be provided by Dr L Starkey, UHDBFT Consultant Paediatrician and paediatric allergy lead. Clostridium difficile – To be discussed by JAPC at the meeting today. Budesonide – To be discussed at the UHDBFT Drugs and Therapeutic committee in February. An update would be brought to the March JAPC meeting. Amiodarone – This had been discussed earlier in the meeting. To be taken off the list.	**SQ** **SQ** **SQ**

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	Juxta Cures – To be taken off the list. Rosuvastatin – Data on the possible increase in the use of rosuvastatin following the recent change to the lipid guidance to be brought to the February JAPC meeting. Liothyronine – It was noted that patients were still being reviewed at UHDBFT and further information would be brought to a future JAPC meeting.	**SQ** **SQ** **SQ**
7.	**NEW DRUG ASSESSMENT**	
a.	**<u>Rivaroxaban with or without aspirin in people with stable peripheral vascular disease (PVD) or carotid artery disease (CAD)</u>** Mrs Qureshi advised that rivaroxaban 2.5mg had been given a licence extension to be co-administered with aspirin for the prevention of atherothrombotic events in adult patients with CAD or PAD at high risk of ischaemic events. A request had now been received by a GP for its use. It was noted that rivaroxaban 2.5mg currently had a traffic light classification of RED as per NICE TA 335 'Preventing adverse outcomes after acute management of acute coronary syndrome'. The evidence came from a large, multicentre randomised, double-blind control trial in 2018 which had reviewed the use of a combination of low-dose rivaroxaban (2.5mg twice daily) plus aspirin (100mg once daily) in people with stable PAD or CAD. The trial had involved 7,470 people recruited from 558 centres across 33 countries, including the UK. Participants either had a history of PAD of the lower extremities or carotid artery disease or coronary artery disease with an ankle–brachial index (ABI) of less than 0.90. The mean age of the participants was approximately 67 years and 72% were male; 81% of participants met the inclusion criteria for symptomatic PAD including 55% with symptomatic PAD of the lower extremities and 26% with carotid artery disease. Following a thirty day run-in period, during which participants had taken aspirin 100mg daily, the participants were randomised to receive rivaroxaban 2.5mg twice daily plus aspirin 100mg daily, rivaroxaban 5mg twice daily or aspirin 100mg once daily. The participants were also taking lipid lowering drugs, angiotensin II receptor blockers (ARBs), beta blockers and proton pump inhibitors (PPIs). It was noted that 30% of the participants were taking non-study PPIs. The primary outcome was the composite of cardiovascular death, myocardial infarction or stroke which occurred in 5% of the low-dose rivaroxaban plus aspirin group compared with 7% of the aspirin group. Rivaroxaban alone compared with aspirin alone had not significantly reduced the primary composite endpoint. There was no statistically significant difference reported in the individual outcomes of myocardial infarction, cardiovascular death or death when low dose rivaroxaban plus aspirin or rivaroxaban alone had been compared with aspirin. However, a statistically significant difference in the number of people with stroke was found when low-dose rivaroxaban plus aspirin was compared with aspirin alone. In addition, a significant increase in major bleeding had been observed in the low-dose rivaroxaban plus aspirin group compared with the aspirin alone group.	

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	A similar finding had been reported in those participants in the rivaroxaban alone group when compared with aspirin alone. The interpretation of these results indicated that low dose rivaroxaban twice daily with aspirin once a day reduced major adverse cardiovascular and limb events when compared to aspirin alone. However major bleeding was increased with the low dose rivaroxaban rather than aspirin. It was highlighted that the NICE recommended treatment for PAD was clopidogrel and the Caprie study, which the NICE guidance had been based on, demonstrated that long-term administration of clopidogrel to patients with atherosclerotic vascular disease was more effective than aspirin in reducing the combined risk of ischaemic stroke, myocardial infarction, or vascular death. Clopidogrel was the standard antiplatelet used for PAD and cerebrovascular disease and was the current gold standard. However, by not having a comparison with clopidogrel, the relevance of the use of rivaroxaban in combination with aspirin, was currently limited. It was noted that the cost of one month's supply of rivaroxaban 2.5mg was £50.40 compared to one month's supply of clopidogrel 75mg at £1.31. The SMC would publish advice on the new indication in February 2019 and NICE guidance was expected in August 2019. **Agreed:** Rivaroxaban plus aspirin classified as **BLACK** as not recommended or commissioned.	**SQ**
8.	**CLINICAL GUIDELINES**	
a.	**<u>Management of Clostridium Difficile Infection (CDI) in Primary Care</u>** Mrs Qureshi reported that the C.difficile guidance had been reviewed by Dr D Harris, Lead Antimicrobial Pharmacist, and Ms S Bestwick, Lead Nurse - Infection Prevention and Control, Erewash and Southern Derbyshire CCGs. The following changes had been made: • A correction had now been made to Bristol Stool Chart type 5-7 rather than Bristol Stool Chart type 6-7. • On page four a paragraph had been added which referred to the necessity of sending samples on all patients with diarrhoea except where laxatives were believed to be the cause. The Guideline Group had also discussed the guidance and made comments as follows: • On page three the flowchart had been amended to indicate the action to be taken if a test was negative but the patient still had symptoms. Ms Bestwick had advised that, if the patient was toxin negative, it was unlikely that symptoms would not have been resolved so an alternative diagnosis should be considered. In the event of a strong indication of C.difficile vancomycin would be given in acute care as the first line treatment. This has been added to the amended flowchart. • A link to the acute kidney injury (AKI) leaflet had been included on page five. • Confirmation had been requested that Chesterfield, Derby Urgent Care Centre and Derbyshire Health United premises in Buxton routinely maintained stocks of vancomycin.	

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	Ms Bestwick had confirmed that vancomycin was available at all three of the out of hour's locations. • It was recommended that the guidance be reviewed in twelve months pending publication of the national guidance. During discussion Dr Markus expressed concern about the requirement to send stool samples on all patients with any diarrhoea. It was agreed that clarity should be obtained about this. Mrs Needham queried the place of fidaxomicin in the guideline as it was currently classified as RED but the local antimicrobial guidance had included it as a second line option on the advice of a microbiologist. It was highlighted that it was important to have consistency about the prescribing of fidaxomicin across both guidelines and that JAPC would need to consider any re-classification. Mrs Qureshi would raise this with Dr D Harris. Mr Shepherd requested that the guidance be sent to Ms D Holland, Infection Control Nurse, North Derbyshire, for comments. **Action:** Approval of the Management of Clostridium Difficile Infection (CDI) in Primary Care guideline would be deferred pending clarification of the points which had been raised.	**SQ** **SQ** **SQ** **SQ**
b.	**<u>Prescribing of Bridging Low Molecular Weight Heparin (enoxaparin and tinzaparin)</u>** Mrs Qureshi reported that minor changes only had been made to the guidance on the prescribing of Low Molecular Weight Heparin (enoxaparin and tinzaparin). Dr Henn queried the omission of atrial fibrillation (AF) and whether a patient who was out of range and considered lower risk should receive bridging anticoagulation with heparin. A reference that bridging LMWH would not be required in non-valvular AF sub-therapeutic international normalised ratio (INR) would therefore be included. Dr Markus referred to the desirability of including a box in the pro-forma about self-administration of the tinzaparin injection so that it would be clear that this could be done or whether alternative arrangements would be needed in situations when the patient or carer could not administer. It would be important to highlight in the guidance that it would be the responsibility of prescribers to arrange administration in the event that patients or carers could not – this would be included. **Agreed:** JAPC ratified the prescribing of Bridging Low Molecular Weight Heparin (enoxaparin and tinzaparin) guidance with the agreed amendments with a review date of two years.	**SQ** **SQ**
c.	**<u>Non-Vitamin K Antagonist Oral Anti-Coagulant (NOAC) for Suspected DVT in Primary Care</u>** Mrs Qureshi reported that a new protocol had been developed for the use of NOAC for suspected deep vein thrombosis (DVT). This included a pathway to assist primary care with the management of suspected DVT, via the use of the two-level DVT and PE Wells scores, in the event that proximal leg vein ultrasound scan could not be performed on the same day of being requested.	

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Item		Action
	For those patients with a suspected DVT who could not be referred immediately to secondary care for a scan off-licence prescribing of a NOAC (apixaban or rivaroxaban) was recommended until this could be arranged, or LMWH where NOACs were not indicated. The Guideline Group had discussed the pathway in October 2018 and some amendments had subsequently been made as follows: • The flow chart had been updated with 'consider alternative diagnosis, if DVT still suspected take blood for D-dimer to rule out DVT'. • Rivaroxaban should be considered in cancer cases with low bleeding risk and no interaction with the anti-cancer drugs – this should remain on the exclusion list for decision by secondary care. • The weight of <50kg should be included in the dose adjustments for body weight. • The use of NOACs in renal impairment should exclude a creatinine clearance level of <30ml/min. A reference to malabsorption/major drug interactions and valvular atrial fibrillation/antiphospholipid syndrome had been added. • On a patient by patient basis clinical judgement should be used to decide the relevance of undertaking new blood tests and time in delay to treatment. The likelihood of renal dysfunction, previous blood test results and the ability to obtain results in a timely manner together with the need to refer to secondary care if a NOAC could not be started in primary care added. During discussion Dr Markus highlighted the following: • Point of care testing for D-dimers was no longer in the basket of services and not used locally. • There was a requirement in the guideline that, on a patient by patient basis, clinical judgement should be used to decide on the relevance of undertaking new blood tests and time in delay to treatment. There would be a need to determine therefore how long before a blood test should have been undertaken. • In connection with patients with a Wells score of two and above but who could not have a NOAC then GPs would refer to secondary care although sometimes patients would not be seen until the next day. Interim LMWH would be required and, if the patient had been assessed on CDU/EMU, the hospital would initiate but otherwise GPs would prescribe this. In the event that a same day scan was not possible it would be at the discretion/responsibility of the treating GP to initiate treatment with apixaban or rivaroxaban. Dr Mott commented that all DVT patients would require a scan but, if they could not receive a scan until the next day or the day after, then the clinician arranging the scan would need to arrange anticoagulation pending the scan. This included out of hours providers as well as the urgent care settings. The guideline attempted to determine when a NOAC could be used in the treatment of DVT rather than a heparin, but there would always be an element of clinical judgement to be made. Dr Parkin suggested that it would be advantageous to add to the title of the document '…..when an immediate scan was not available' in order to clarify when the pathway should be used.	**SQ**

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	In connection with the flowchart Dr Watkins queried the statement in the box which indicated that a NOAC should be started whilst awaiting scan and initially prescribe for four days. It was agreed that this should be amended to read '….initially prescribe until scan booked'. The word 'no' underneath this box would also be removed.	**SQ**
	Dr Mott queried the sentence in page two 'Refer to secondary care if NOAC cannot be started in primary care'. It was agreed that a reference be included to indicate that, in the event that a patient could not have a NOAC, then a LMWH would be given instead. Dr Mott added that it should also be highlighted in the prescribing information that edoxaban and dabigatran were not appropriate given that they required LMWH doses at initiation.	**SQ**
	Agreed: JAPC ratified the protocol for Non-Vitamin K antagonist Oral Anti-Coagulant (NOAC) for Suspected DVT in Primary Care with the agreed amendments with a review date of two years.	**SQ**
d.	**<u>Management of Chronic Rhinosinusitis (CRS) With or Without Nasal Polyps</u>** Mrs Qureshi reported that the existing guideline had been updated in collaboration with local specialists and highlighted the main changes: • There was no evidence for the efficacy of steam inhalation (reference NICE NG 79 Sinusitis (acute): antimicrobial prescribing October 2017) and this had been included. However patients may choose to use steam inhalation symptomatically as part of self-care. • Antibiotic prescribing was now in line with Public Health England antibiotic guidance. • Advice had been included about the administration of nasal drops in the hanging head position. • Addition of reference to indicate that, due to the fact that beconase/budesonide had high bioavailability compared to other steroid nasal sprays, an alternative product should be considered if the patient was already on an inhaled steroid or had a relative contraindication to a steroid such as glaucoma or diabetes. • The use of nasal drops and oral steroids had been combined as this could lead to an improvement in symptoms. **Agreed:** JAPC ratified the Management of Chronic Rhinosinusitis (CRS) with or without Nasal Polyps guideline with a review date of two years.	**SQ**
9.	**SHARED CARE GUIDELINES**	
a.	**<u>Somatostatin Analogues (Lanreotide/Octreotide)</u>** This was an update of an existing shared care agreement. Mrs Qureshi reported that lanreotide and octreotide were not used by CRHFT and only updated contact details for the UHDBFT consultants in endocrinology had been included. It was agreed that somatostatin analogues should continue to be a shared care. **Agreed:** JAPC approved the shared care agreement for the somatostatin analogues (lanreotide and octreotide) with a review date of two years.	**SQ**

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Item		Action
b.	**Vigabatrin** Mrs Qureshi reported that there were no changes to the shared care guideline for vigabatrin for children with epilepsy. Dr Markus referred to the inclusion in the guideline of an annual primary care review of all patients with epilepsy in the GP responsibilities section. However, there was no defined annual primary care review of patients with epilepsy and the only requirement under the Quality and Outcomes Framework (QOF) was to maintain a register of patients over eighteen years old with epilepsy. Children with epilepsy under the age of eighteen years were closely monitored in secondary care and do not always have annual reviews in primary care. It was highlighted that the consultant responsibilities section referred to the need for paediatricians to make appropriate arrangements for six to twelve monthly visual field checks or, where these are not practical, alternative arrangements for visual screening/monitoring. Following discussion it was agreed that, due to the requirement for visual field checks in the hospital, it should remain as a shared care and the GP responsibilities section be amended to read 'Ensure that the patient has had planned visual field checks.'	**SQ**
	Action: Dr Mott would contact Dr H Faza, UHDBFT Consultant Paediatrician, to obtain assurance that there was a robust process for organising the six to twelve monthly visual field checks.	**AM**
	Agreed: JAPC approved the shared care agreement for the use of vigabatrin for children with epilepsy with the agreed amendment with a review date of two years.	**SQ**
10.	**MISCELLANEOUS**	
a.	**Freestyle Libre®** The notes of the Freestyle Libre® Review meeting held on 11th December 2018 were noted by JAPC. Dr Mott highlighted that future projected activity was to be estimated in the upcoming months and the later this was done the more accurate it was likely to be. It was noted that there may be a plateauing of numbers at UHDBFT.	
b.	**Government's Preparations for a March 2019 'No Deal' Brexit Scenario** JAPC noted the update in the event that the UK left the European Union without an agreement on 29th March 2019. The government was making plans to ensure that, in the event of a no-deal Brexit, the flow of medicines and medical products were not impeded. Work was underway to ensure there was sufficient roll-on, roll-off freight capacity to enable these products to move freely into the UK. Companies were advised to ensure there was a minimum of six weeks additional supply in the UK over and above their business as usual operational buffer stocks. The update also highlighted that additional drugs should not be stockpiled and that there was no need for clinicians to write longer NHS prescriptions.	
c.	**Summary of the 2019 Pharmaceutical Price Regulation Scheme and Updates to the Statutory Pricing Scheme** The summary was noted by JAPC. Mrs Qureshi highlighted that the growth in NHS branded medicines would not exceed 2% per year for the next five years.	

Item		Action
	In addition, the NICE TA appraisal timelines for non-cancer medicines would be speeded up in order to bring them into line with cancer medicines and the standard cost-effectiveness threshold would be retained at £20k - £30k per QALY as the cost effectiveness threshold.	
11.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
	JAPC noted the following: • RMOC London Update December 2018 • Update from RMOC Midlands and the East of England – There had been a lengthy discussion on the GLP-1 receptor agonists and their cardiovascular benefits although there was currently no cost effectiveness analysis. A new GLP-1 receptor agonist, semaglutide, was due to be launched imminently. • RMOC Briefing on Adalimumab – It was noted that switches to the biosimilar product Imraldi® were currently taking place in UHDBFT and CRHFT.	
12.	**JAPC BULLETIN**	
	The December bulletin was ratified.	
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for December 2018 was noted. Mrs Qureshi highlighted the following MHRA advice: • Oral lidocaine-containing products for infant teething: only to be available under the supervision of a pharmacist. • Valproate medicines: compliance with the pregnancy prevention measures. • Emollients: new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients. • Direct-acting antivirals for chronic hepatitis C: risk of hypoglycaemia in patients with diabetes. • Hydrocortisone muco-adhesive buccal tablets: should not be used off-label for adrenal insufficiency in children due to serious risks.	
14.	**HORIZON SCAN**	
	Mrs Qureshi advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: • Abemaciclib (Verzenios®) – Previously classified as **RED** (NHS England). • Insulin glargine biosimilar (Semglee®) – Classified as **GREEN**. • Lutetium-177 (Lutathera®) – Previously classified as **RED** (NHS England). • Ospemifene (Senshio®) – Previously classified as **BLACK**. New formulation launches in the UK: • Fluticasone + salmeterol (Fusacomb®) – To be discussed by RMOC. • Solifenacin (Vesicare®) – Solifenacin tablets classified as **GREEN** third line choice (after a trial of oxybutynin and tolterodine). To be left unclassified and entry to be put into the specials database.	

Item		Action
	Licence extensions: • Cabozantinib (Cabometyx®) • Dexmedetomidine (Dexdor®) • Fluticasone + umeclidinium + vilanterol (Trelegy Ellipta®) • Ivacaftor (Kalydeco®) Drug Discontinuations: • Estradiol/levonorgestrel (FemSeven Conti®).	
15.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance in December 2018: TA 548 Decitabine for untreated acute myeloid leukaemia (terminated appraisal) – Classified as **BLACK** (NHS England as per NICE TA 548) – (terminated appraisal). TA 549 Denosumab for preventing skeletal-related events in multiple myeloma – Classified as **BLACK** (terminated appraisal). TA 550 Vandetanib for treating medullary thyroid cancer – Vandetanib was not recommended, within its marketing authorisation, for the treatment of aggressive and symptomatic medullary thyroid cancer in adults with unresectable, locally advanced or metastatic disease. Classified as **BLACK** (NHS England as per NICE TA 550). TA 551 Lenvatinib for untreated advanced hepatocellular carcinoma – Classified as **RED** (NHS England as per NICE TA 551). TA 552 Liposomal cytarabine–daunorubicin for untreated acute myeloid Leukaemia – Classified as **RED** (NHS England as per NICE TA 552). TA 553 Pembrolizumab for adjuvant treatment of resected melanoma with high risk of recurrence – Classified as **RED** (NHS England as per NICE TA 553). NG 114 Chronic obstructive pulmonary disease (COPD) (acute exacerbation): antimicrobial prescribing – It was confirmed that the local COPD guideline aligned with the NICE recommendations. NG 115 Chronic obstructive pulmonary disease (COPD) in over 16s: diagnosis and management – The local COPD guideline to be updated in line with this NICE guidance. NG 117 Bronchiectasis (non-cystic fibrosis), acute exacerbation: antimicrobial prescribing – It was highlighted that NICE recommended that an antibiotic should be prescribed from ten to fourteen days but the local guidance indicated seven to fourteen days.	
16.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in December 2018 was noted. Mrs Qureshi highlighted the following:	

Item		Action
	Traffic Lights: Co-danthramer – Classified as **BROWN** from GREEN as only used in terminally ill patients. Co-danthrusate tablets – Classified as **BROWN** from GREEN as only used in terminally ill patients Silver Sulfadiazine cream (Flamazine®) – Classified as **BROWN** from GREEN. Not to be used routinely for wound dressing. TVN recommendation only as per wound care formulary. For Information: Formulary update (Chapter 1 – Gastrointestinal system): • Esomeprazole – Classified as BROWN after the use of all formulary choice or PPIs. • Pentasa® and Salofalk® included as brands of mesalazine. • Bisacodyl® and Manevac® granules removed as other cost effective options were available. • Anusol HC Plus available as over the counter OTC but Anusol HC was a prescription only medicine (POM). • Price table updated: Co-danthrusate capsules removed as no longer available. Clinical Guidelines: Atrial fibrillation – The monitoring of renal function in renal impairment had reverted back to the original advice (Creatinine Clearance (CrCl) 30-60ml/min every six months; Creatinine Clearance 15-30ml/min every three months) after practical considerations.	
17.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Insulin glargine biosimilar (Semglee®) – GREEN Rivaroxaban 2.5mg – BLACK Decitabine – BLACK (as per NICE TA 548) Denosumab – BLACK (as per NICE TA 549) Vandetanib – BLACK (as per NICE TA 550) Lenvatinib – RED (as per NICE TA 551) Liposomal Cytarabine-Daunorubicin – RED (as per NICE TA 552) Pembrolizumab – RED (as per NICE TA 553) Abemaciclib (Verzenios®) – RED	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• UHDBFT Drugs and Therapeutic Committee 20/11/2018 • Regional Medicines Optimisation Committee (London) 28/11/2018 • Regional Medicines Optimisation Committee (South) 27/09/2018	
19.	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
20.	**DATE OF NEXT MEETING**	
	Tuesday, 8th February 2019 at 1.30pm in the Coney Green Business Centre, Clay Cross.	