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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 9th July 2019

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Bromocriptine	BROWN specialist initiation 2nd line to cabergoline
Gentamicin (nebules)	RED
Aliskiren	BLACK
Risankizumab	BLACK
Travoprost	GREEN after consultant/specialist initiation 1st line prostaglandin for treatment of glaucoma
Latanoprost	BROWN after consultant/specialist initiation 2nd line prostaglandin for treatment of glaucoma
Brinzolamide	GREEN after consultant/specialist initiation 1st line carbonic anhydrase inhibitor for the treatment of glaucoma
Dorzolamide	BROWN after consultant/specialist initiation 2nd line carbonic anhydrase inhibitor for the treatment of glaucoma
Inotersen	RED (NHS England as per NICE HST9)
Cabozantinib	BLACK (as per NICE TA582)
Ertugliflozin	BROWN (as per NICE TA583)
Atezolizumab	RED (NHS England as per NICE TA584)
Ocrelizumab	RED (NHS England as per NICE TA585)
Lenalidomide	RED (NHS England as per NICE TA586,TA587 and TA171)

Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
Metolazone	GREEN after consultant/specialist recommendation, 2nd line to bendroflumethiazide for heart failure. Combination with loop diuretic should be initiated by specialist only.

Clinical Guidelines

- Primary Care management of Irritable Bowel Syndrome (IBS)
- Management of Emergency Contraception (EC)
- Guidelines for the medical treatment of chronic open angle glaucoma and ocular hypertension
- Hyperprolactinaemia (Cabergoline (Dostinex), quinagolide)
- Guidance on the prevention, diagnosis and management of Vitamin D deficiency in Primary Care
- Position statement of self-care with Vitamin D

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Patient Group Directions

- Administration of rotavirus vaccine (live) to infants aged 6 weeks to 23 weeks and 6 days for active immunisation against rotavirus
- Administration of human papillomavirus vaccine [Types 6, 11, 16, 18] (Recombinant, adsorbed) (HPV) to individuals from 12 years of age or from school year 8 in accordance with the national immunisation programme

Present:	
Derby and Derbyshire CCG	
Dr C Emslie	GP (Chair)
Mr S Dhadli	Assistant Director of Clinical Policies and Decisions (Professional Secretary)
Dr M Henn	GP
Mr S Hulme	Director of Medicines Management and Clinical Policies
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
Ms J Savoury	Assistant Chief Finance Officer
Derby City Council	
Derbyshire County Council	
University Hospitals of Derby and Burton NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutic Committee
Mr R Sutton	Pharmacist
Ms A Brailey	Deputy Chief 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	
Ms A Braithwaite	Pharmacist
Derby and Derbyshire Local Medical Committee	
Dr K Markus	Chief Executive Officer
Derbyshire Health United	
Mr D Graham	Pharmacist
Staffordshire CCG's	
In Attendance:	
Mrs K Rogers	Derby and Derbyshire CCG Senior Administrator (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Dr M Watkins, Ms S Bamford, Dr T Narula, Dr H Hill	
2.	**DECLARATIONS OF CONFLICTS 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**	
	There were no declarations of any other business.	
4.	**MINUTES OF JAPC MEETING HELD ON 11 JUNE 2019**	
	The minutes of the meeting held on 11th June 2019 were agreed as a correct record after minor amendments to the following agenda items: Bariatric surgery Clostridium Difficile Infection (CDI) in Primary Care	
5.	**MATTERS ARISING**	
a.	**Antidepressants in Moderate and Severe Unipolar Depression** Mr Dhadli reported that information on the risk of hyponatraemia, how to manage it and level of evidence has been added to the guideline.	
b.	**Clostridium Difficile** Mrs Needham reported that fidaxomicin within Greater Manchester Medicines Management Group (GMMMG) is classified as Green following specialist advice, Sheffield do not use fidaxomicin and it is not on their formulary.	
c.	**Liothyronine** Mr Dhadli gave an update on liothyronine following on from last months' JAPC meeting. It was recommended to have a co-ordinated audit across the Derbyshire STP and to agree the audit criteria which would include assurance from Primary Care that patients have been reviewed, look at out of area patients reviewed by an endocrinologist and to ensure compliance with exceptional criteria within Regional Medicines Optimisation Committee (RMOC) and the British Thyroid Association (BTA). A discussion took place around the review of patients. Mr Dhadli asked if all patients have been referred to the endocrinologist for review, Mrs Needham replied that there are some patients who are out of area who haven't yet been seen. The exclusion criteria was also discussed, Mr Dhadli referred to the RMOC exclusion criteria, Mr Hulme commented that this was available when a decision was made following NHS England's 'Items which should not be routinely prescribed in primary care' recommendations and that any shared care which may be agreed is likely to follow this. If there isn't assurance that the patient meets the exclusion/exceptionality then GPs could rightfully refuse the patient back into the consultants care. Dr Goddard expressed his concerns on the delay of the decision to repatriate patients back to primary care after it was reported to JAPC that all patients	

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	who had been referred to secondary care for review, have been reviewed. Dr Emslie suggested either to develop a guideline whereby after review with the Endocrinologist and once the patient is stable, they would be discharged back into Primary Care, or to develop a formal Shared Care agreement. It was agreed that reclassification will be considered at the next meeting, with updated data from Chesterfield Royal Hospital Foundation Trust (CRHFT) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT), in regards to how many patients have now been stopped, and an update on those patients that are reducing doses, and assurance on those that remain on liothyronine that they are exceptional in line with RMOC guidance. **Action:** Mr Dhadli to look at developing a clinical guideline and shared care agreement which will be bought back to the August JAPC meeting.	**MS** **SD**
d.	**Psoriasis 3rd biologic** Mrs Qureshi reported that the funding for psoriasis 3rd biologic has been agreed via contracting, this will be assured through Blueteq.	
e.	**Hepatitis B - Renal PGD** Mr Dhadli reported that Administration of Hepatitis B recombinant DNA (rDNA) vaccine (adsorbed) to individuals who are 15 years of age or over and are on haemodialysis, a renal transplantation programme or have chronic renal failure that is likely to require haemodialysis or transplant, has been removed from the Derbyshire Medicines Management website due to new guidance on commissioning responsibilities being released.	
f.	**JAPC/CPAG Terms of Reference** Mr Dhadli confirmed that the Joint Area Prescribing Committee (JAPC) and the Clinical Policy Advisory Group (CPAG) Terms of Reference have been ratified at the last Clinical and Lay Commissioning Committee (CLCC) meeting. In regards to the GP clinical support, GP cover will be in place from September 2019 so this will mean interim cover is needed for the JAPC meeting in August from Dr Narula or Dr Henn.	
6.	**JAPC ACTION SUMMARY**	
a.	**Hydroxychloroquine** Mr Dhadli advised that he was still waiting for an update from CLCC in regards to Hydroxychloroquine. This would be bought back to a future JAPC meeting once he has received further information about this.	**SD**
7.	**NEW DRUG ASSESSMENT**	
a.	**Ibandronate/zoledronic acid for cancer** Mr Dhadli reported that there had been a submission through University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT) Drugs & Therapeutics committee for the use of Ibandronate in breast cancer, which was clinically approved at the meeting in June 2019. The evidence for this is based on NICE Evidence Summary [ES15] (2017) and a large collaborative meta-analysis review (Valachis A, Polyzos NP, Coleman RE, Gnant M, Eidtmann H, Brufsky AM) undertaken to clarify the risks and benefits of adjuvant bisphosphonate treatment in breast cancer. A Cancer Care Ontario	

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	and American Society of Clinical Oncology Clinical Practice Guideline and a European document were also used. The NICE evidence cites meta-analysis of individual participant data from 26 randomised controlled trials including 18,766 women with early breast cancer (the Early Breast Cancer Trialists' Collaborative Group [EBCTCG] meta-analysis 2015). The meta-analysis found that, at 10 years compared with control, adjuvant bisphosphonates (in addition to standard breast cancer treatments) produced small, borderline statistically significant reductions in distant recurrence (recurrence in the bone or elsewhere, not in the breasts or regional lymph nodes), bone recurrence and breast cancer mortality (absolute reductions 1.4%, 1.1% and 1.7% respectively), but not breast cancer recurrence or all-cause mortality. NICE have since published recommendations in their guideline in July 2018. The guideline states 'offer bisphosphonates (zoledronic acid or sodium clodronate) as adjuvant therapy to postmenopausal women with node-positive invasive breast cancer' and 'consider bisphosphonates (zoledronic acid or sodium clodronate) as adjuvant therapy for postmenopausal women with node-negative invasive breast cancer and a high risk[1] of recurrence.' The UHDBFT Drugs and Therapeutics Committee found that there was good evidence that treatment with sodium clodronate and zoledronic acid improved disease-free and overall survival in postmenopausal women with node-positive invasive breast cancer. UDHBFT wish to implement in a similar way to how Sheffield have done this and so they would recommend ibandronate over sodium clodronate. A table to show predicted prescribing of ibandronate and sodium clodronate showed ibandronate to be the most cost effective choice. Since 2016 North Derbyshire and Hardwick have been following Sheffield's protocols. Mr Dhadli made reference to the NICE guideline in that it did not give duration of treatment; it implied that this was an indefinite treatment. If UHDBFT were to go ahead with this they would need to align the guideline to Sheffield or vice versa. A discussion would also need to be had on duration of treatment. The use of bisphosphonates is advocated in NICE NG101; NICE guideline is routinely adopted by the CCGs because of the robust clinical and cost effectiveness review undertaken by NICE. The trial evidence supports clinical efficacy and cost effectiveness in the NICE economic modelling. Mr Dhadli pointed out that NICE would have produced a costing template in situations where financial impact is at a reasonable threshold; however they have instead produced a resource impact statement which states "no significant resource impact is anticipated". Because NICE do not think practice will change substantially as a result of this update to the guideline. A discussion took place around the inequity of access between North Derbyshire and South Derbyshire. Mr Dhadli questioned patient numbers eligible for treatment and the potential budgetary impact, as this has not been reflected in the prescribing in North Derbyshire. Mr Hulme advised that NICE guidelines are not mandatory and questioned whether there is enough information to support this change; Mr Hulme also suggested that it should fit within a local pathway. Ms Braithwaite expressed her concerns of an inequitable service and the delay and impact for patients, whilst waiting for a decision for commissioners. JAPC clinicians supported the NICE guideline (NG101), however recognised	

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	JAPC as non-budgetary holders. **Agreed:** Mr Dhadli suggested that he meet with Ms Urquhart Head of Cancer Commissioning within Derby and Derbyshire CCG, to discuss this further and bring back to a future JAPC meeting. Dr Goddard was also asked if Derby Hospitals could produce a business case for this and submit to JAPC when ready.	**SD** **WG**
b.	**<u>Nebulised Gentamicin</u>** University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT) would like JAPC to consider a request for nebulised gentamicin to be added as a shared care agreement, 2nd line to colomycin. The proposed Shared Care had been discussed at a recent Guideline Group meeting and it was agreed that it could not be accepted in its current format. The reasons included: • unclear how patients will obtain the supply of consumables and how they will be discarded e.g. filter needles/syringes • unclear monitoring (duration of treatment/monitoring requirements) • no recommendation when to refer back and no reference values for risk management • potential risk of prescribing an incorrect brand • Low patient numbers A discussion took place in respect to the above points and there was a general agreement that this could not be accepted as it stands, it would need to be looked at further and then bought back to a future JAPC meeting. Dr Henn made a suggestion that it could be carried out by the respiratory team rather than in Primary Care. JAPC took the decision to classify gentamicin as RED until further notice. **Agreed:** Gentamicin nebules classified as **RED** for treatment of adult non-cystic bronchiectasis	**SD** **SD**
8.	**CLINICAL GUIDELINES**	
a.	**<u>Irritable Bowel Syndrome (IBS)</u>** Mr Dhadli reported that the guideline for Primary Care management of Irritable Bowel Syndrome (IBS) has been reviewed. The guidance is based on NICE CG61 (2017) Irritable bowel syndrome in adults: diagnosis and management. This is still relevant and up to date. Linaclotide has been re-classified from RED to BROWN after gastro-consultant initiation and assessment of efficacy within a 4 week period, a link has also been replaced with NICE endorsed Patient Information Leaflet (PIL) by British Dietetic Association. Mrs Needham asked if 1st and 2nd line pharmacological treatment information on page 3 can all be placed in one box rather than across two. **Agreed:** JAPC ratified the clinical guideline for Primary Care management of Irritable Bowel Syndrome (IBS) with a review date of 3 years.	**SD** **SD**
b.	**<u>Emergency contraception</u>** Mr Dhadli stated that the management of emergency contraception guideline	

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	had been reviewed; this is based on the Faculty of Sexual and Reproductive Healthcare (FSRH) Emergency Contraception Guidance 2017 which is still relevant and up to date. **Agreed:** JAPC ratified the management of emergency contraception guideline with a review date of 3 years.	**SD**
c.	**<u>Glaucoma</u>** Mr Dhadli confirmed that the guidelines for the medical treatment of chronic open angle glaucoma and ocular hypertension has been reviewed. This is based on NICE NG81 Glaucoma: diagnosis and management (Nov 2017). 'Selective Laser Trabeculoplasty' was added under 'Treatment Options' on page 5 following comments from Chesterfield Royal Hospital NHS Foundation Trust (CRHFT). No amendments were made from University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT). Ophthalmologists are to be made aware that changes to first line treatment mean that travoprost is now the most cost effective option. **Agreed:** JAPC ratified the guidelines for the medical treatment of chronic open angle glaucoma and ocular hypertension with a review date of 3 years.	**SD**
d.	**<u>Hyperprolactinaemia</u>** Mr Dhadli advised that bromocriptine is licensed to treat prolactinomas & hyperprolactinaemia. Endocrinologists would prescribe bromocriptine for patients who wish to become pregnant or those who are intolerant of cabergoline. Monitoring is the same between cabergoline & bromocriptine. Cabergoline is preferred, particularly in patients with prolactinoma, due to a greater therapeutic efficiency, a better tolerance and consequently, greater adherence to treatment and finally, because of a more convenient administration regimen. With its long half-life period of 65 hour, cabergoline is administered once or twice weekly, while bromocriptine requires dosing every 8–24 hours. Compared with bromocriptine, cabergoline has a lower affinity for D1 receptors and stimulates 5HT2B receptors stronger. **Agreed:** JAPC classified bromocriptine as **BROWN specialist initiation** for the treatment of hyperprolactinaemia 2nd line to cabergoline.	**SD**
e.	**<u>Vitamin D Guideline/Position Statement</u>** Mr Dhadli informed JAPC that the guidance on the prevention, diagnosis and management of vitamin D deficiency in Primary Care had been updated with comments received from consultants at Chesterfield Royal Hospital NHS Foundation Trust (CRHFT); no further changes/comments were received from University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT). The following changes were noted and accepted at the JAPC meeting: • Recommended brand for adult change from Fultium to Plenachol • Added InVita D3 50,000 IU weekly as an option for adult/>12yrs age (cost effective option) • Added InVita D3 50,000 unit/ml UD weekly as a liquid option for adults • Use of InVita 25,000 unit/ml UD in children at National Osteoporosis Society recommended doses (but as weekly administration), it is not	

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	currently supported due to safety concerns by specialists Mrs Needham asked if Plenachol is readily available for pharmacies, Mr Dhadli replied that he would find out. If Plenachol is not readily available it should remain as Fultium. Mr Dhadli advised that the Position statement of self-care with vitamin D had also been updated with no significant changes. **Agreed:** JAPC ratified the guidance on the prevention, diagnosis and management of vitamin D deficiency in Primary Care and the position statement of self-care with vitamin D with a review date of 3 years. **Post meeting note:** Plenachol not added to formulary due to lack of wide availability.	**SD** **SD**
9.	**PATIENT GROUP DIRECTIONS**	
a.	The following PGDs from Public Health England effective from 1st May 2019 and 1st July 2019 were noted by JAPC: • Administration of rotavirus vaccine (live) to infants aged 6 weeks to 23 weeks and 6 days for active immunisation against rotavirus. • Administration of human papillomavirus vaccine [Types 6, 11, 16, 18] (Recombinant, adsorbed) (HPV) to individuals from 12 years of age or from school year 8 in accordance with the national immunisation programme.	
10.	**SHARED CARE**	
a.	**Lithium** Mr Jones reported that there are only minor amendments in line with committee name change and wording in appendix 1, incorporating reference in the body of the SCA to the lithium 'App' as an alternative option to the purple book. **Agreed:** JAPC ratified the Lithium Shared Care Agreement with a review date of 3 years.	**SD**
11.	**MISCELLANEOUS**	
a.	**Items which should not routinely be prescribed in primary care** Mr Dhadli advised that following a review of the guidance for CCGs on items that should not routinely be prescribed in primary care (first published in November 2017), the NHS England and NHS Improvement board have agreed that the following treatments should be added to the guidance: • Aliskiren – used to treat blood pressure • Amiodarone – used to treat abnormal heart rhythms • Dronedarone – used to treat atrial fibrillation • Minocycline – used to treat acne • Needles for pre-filled and reusable insulin pens for diabetes • Bath and shower emollient preparations • Silk garments A discussion took place and Aliskiren was re-classified from BROWN to BLACK. Patients on Aliskiren will need to be identified and practices will need to review this, specialist advice/review may be needed.	

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	Amiodarone is to be re-classified from GREEN to AMBER and a shared care agreement will be developed and bought to September's JAPC meeting. No change was needed for dronedarone, minocycline, bath and shower emollient preparations and silk garments as they are currently classified as BLACK. There was no change to needles for pre-filled and reusable insulin pens for diabetes as our formulary choices are already below £5 per 100 needles. **Agreed:** Aliskiren classified as **BLACK** **Agreed:** JAPC ratified the amendments to the guidance for CCGs on items that should not routinely be prescribed in primary care.	**SD** **SD** **SD**
12.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
	The RMOC Newsletter 2019 Issue 5 was noted. Mr Dhadli highlighted the following: • Flash glucose monitoring update – The National arrangements and clinical criteria for funding Flash Glucose Monitoring has been published by NHS England, the RMOC position statement was updated in November 2018 and further review of the RMOC statement will take place now that the national arrangements and clinical criteria for funding have been published. • RMOC Position statement – Rarely Used and Urgent Medicines List June 2019. The Regional Medicines Optimisation Committee reviewed the use of Rarely Used and Urgent Medicines (RUUM) lists in November 2018. RUUM lists are useful for hospital pharmacy departments to help them plan storage and supply arrangements for medicines which are not routinely used. A single, national list of potential RUUMs has been developed for use in England by the Specialist Pharmacy Service. The system is able to display which Trusts have issued medicine, this can be used as a proxy for determining which Trusts are likely to stock medicine. It will provide procurement and on-call staff with access to additional data than they would otherwise have had to help them identify which Trust(s) to call to locate stock. The purpose of this list is to indicate to Trusts which medicines it is imperative to stock locally, and which it is likely to be possible to obtain through via other methods when the need arises.	
13.	**JAPC BULLETIN**	
	The June 2019 bulletin was ratified.	**SD**
14.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for June 2019 was noted. Mr Dhadli highlighted the following MHRA advice: • Direct-acting oral anticoagulants (DOACs): A clinical trial has shown an increased risk of recurrent thrombotic events associated with rivaroxaban compared with warfarin, in patients with antiphospholipid syndrome and a history of thrombosis. Rivaroxaban (Xarelto▼) and edoxaban (Lixiana ▼) are subject to additional monitoring, and so any suspected adverse drug reactions should be reported to the Yellow Card Scheme. • GLP-1 receptor agonists: Diabetic ketoacidosis has been reported in	

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	patients with type 2 diabetes on a combination of a GLP-1 receptor agonist and insulin who had doses of concomitant insulin rapidly reduced or discontinued. When GLP-1 receptor agonist therapy is added to existing treatment with insulin, a reduction in the dose of insulin may be considered to reduce the risk of hypoglycaemia. A stepwise approach to insulin dose adjustment is recommended, taking into account a patient's glucose levels and individual insulin requirements. • Lartruvo (olaratumab): withdrawal of the EU marketing authorisation due to lack of efficacy. The ANNOUNCE study failed to show clinical efficacy for olaratumab in its current indication of advanced soft tissue sarcoma and the benefit risk balance is therefore now considered negative. No new patients should be started on olaratumab therapy. • Oral retinoid medicines: revised and simplified pregnancy prevention educational materials for healthcare professionals and women. New prescriber checklists, patient reminder cards, and pharmacy checklists are available to support the Pregnancy Prevention Programme in women taking acitretin, alitretinoin, and isotretinoin. Advice about the risk of neuropsychiatric reactions has been made consistent for all oral retinoid medicines.	
15.	**HORIZON SCAN**	
a.	**<u>Monthly Horizon Scan</u>** Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: • Risankizumab (Skyrizi) – classified as **BLACK**, awaiting NICE TA New formulation launches: Empagliflozin + linagliptin – not classified Licence extensions: • Dupilumab (Dupixent) – to remain classified as **RED** • Lenalidomide (Revlimid) – to remain classified as **RED/BLACK** • Leuprorelin (Prostap DCS) – to remain classified as **GREEN** • Plerixafor (Mozobil) – not classified • Pomalidomide (Imnovid) – to remain classified as **RED** • Tenofovir disoproxil (Viread) not classified	
16.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCG which had been made for the following NICE guidance in June 2019: HST9 Inotersen for treating hereditary transthyretin amyloidosis – classified as **RED** (NHS England) as per HST9 TA582 Cabozantinib for previously treated advanced hepatocellular carcinoma – classified as **BLACK** (as per NICE TA582) TA583 Ertugliflozin with metformin and a dipeptidyl peptidase-4 inhibitor for treating type 2 diabetes – classified as **BROWN** (as per NICE TA583)	

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Item		Action
	TA584 Atezolizumab in combination for treating metastatic non-squamous non-small-cell lung cancer – classified as **RED** (NHS England as per NICE TA584) TA585 Ocrelizumab for treating primary progressive multiple sclerosis – classified as **RED** (NHS England as per NICE TA585) TA586 Lenalidomide plus dexamethasone for multiple myeloma after 1 treatment with bortezomib – classified as **RED** (NHS England as per NICE TA586) TA587 Lenalidomide plus dexamethasone for previously untreated multiple myeloma – classified as **RED** (NHS England as per NICE TA587) TA322 Lenalidomide for treating myelodysplastic syndromes associated with an isolated deletion 5q cytogenetic – no change, currently has a RED classification (as per NICE TA322) TA171 Lenalidomide for the treatment of multiple myeloma in people who have received at least 2 prior therapies – classified as **RED** (NHS England as per NICE TA171) ES20 Doxylamine/pyridoxine (Xonvea) for treating nausea and vomiting of pregnancy – currently has BLACK classification. Going to Guideline Group meeting for review in July 2019	
17.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Shared Care and Guideline Group meeting held in June 2019 was noted. Mr Dhadli highlighted the following: Traffic Lights: Metolazone – **GREEN** after consultant/specialist recommendation, 2nd line to bendroflumethiazide for heart failure. Combination with loop diuretic should be initiated by specialist only. Formulary Update (Chapter 7 – Obstetrics, gynaecology, and urinary tract disorders): • CG171 replaced with NG123 urinary incontinence and pelvic organ prolapse in women: management. Oxybutynin IR not for frail older women (defined as who may be at higher risk of a sudden deterioration in their physical or mental health). • Cost comparison charts for drugs for urinary frequency and drugs for erectile dysfunction updated. Clinical Guidelines: • AF – Edoxaban crushing information (suitable for swallowing difficulty and enteral tube administration) inserted; MHRA warning against using NOAC in antiphospholipid syndrome added.	

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	• Diabetes guideline – insert ertugliflozin prescribing information p.15; insert MHRA warning on GLP-1 receptor agonist risk of diabetic ketoacidosis when concomitant insulin was rapidly reduced or discontinued. P.17 • Allergic rhinitis – flowchart updated to include antihistamine as an option for mod/severe AR as per BASCI rhinitis guidance. • Chlamydia – treatment option updated as per PHE/ NICE antimicrobial prescribing guideline. Doxycycline first line; Azithromycin 2nd line as 3 days course. • UTI – diagnosis & management- replaced with link to PHE UTI diagnosis guideline. Website Changes/Miscellaneous: • Aerivio Spiromax discontinued- remove from TLC/ BNF chapter • Specials & expensive liquid guideline updated to include edoxaban • Signposting substance misuse document removed due to very low usage • Added links for newly updated (simplified) info for Pregnancy Prevention for Isotretinoin, Acitretin and Alitretinion on TLC as per MHRA drug safety update • NOAC in overweight- no change to existing guidance due to limited evidence. Follow specialist advice. Website housekeeping: • Important information about medicines PIL (PCT) replaced with 'Information about Medicines and Medicines Cabinet' leaflet • Other useful guidelines o The North Derbyshire section (Newsletters) removed o AKI/ Vitamin B12 - link to UHDB shared care pathology webpage. Links can be accessed via both Meds man (further resource, local & neighbouring trust websites) and Clinical policies (further information) webpage. o Syringe driver policy moved to clinical guidelines under End of Life pathway Guideline Timetable: • The guideline table action summary and progress was noted by JAPC.	
18.	**BIOSIMILAR REPORT**	
	Mr Dhadli reported that the figures received from the University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT) in relation to the use of etanercept raises concern as it is not what Derby and Derbyshire CCG are expecting to see. Mr Dhadli advised that he has raised these concerns with UHDBFT and asked them to investigate. He has asked that if not resolved it is escalated to the Medical Directors within Derby and Derbyshire CCG. Mr Sutton from UHDBFT reported that the figures are currently being checked. Patients are being contacted via letter; however, it was reported that some patients had not received the original letter and so they are being contacted again.	
19.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Bromocriptine – BROWN specialist initiation 2nd line to cabergoline	

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	Gentamicin (nebules) – RED Aliskiren – BLACK Risankizumab – BLACK Travoprost – GREEN after consultant/specialist initiation 1st line prostaglandin for treatment of glaucoma Latanoprost – BROWN after consultant/specialist initiation 2nd line prostaglandin for treatment of glaucoma Brinzolamide – GREEN after consultant/specialist initiation 1st line carbonic anhydrase inhibitor for the treatment of glaucoma Dorzolamide – BROWN after consultant/specialist initiation 2nd line carbonic anhydrase inhibitor for the treatment of glaucoma Inotersen – RED (NHS England as per NICE HST9) Cabozantinib – BLACK (as per NICE TA582) Ertugliflozin – BROWN (as per NICE TA583) Atezolizumab – RED (NHS England as per NICE TA584) Ocrelizumab – RED (NHS England as per NICE TA585) Lenalidomide – RED (NHS England as per NICE TA586) Lenalidomide – RED (NHS England as per NICE TA587) Lenalidomide – RED (NHS England as per NICE TA171)	
20.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Medicines Optimisation Safety Team 04/04/2019 • UHDBFT Drugs and Therapeutic Committee 21/05/2019	
21.	**ANY OTHER BUSINESS**	
	Lidocaine Plasters Mr Dhadli confirmed that GP's can initiate Lidocaine plasters for symptomatic relief of neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia, PHN) in adults. **Myocrisin discontinuation** Sanofi have issued a letter dated 10th June 2019 to say that manufacture of Myocrisin (sodium aurothiomalate) injection has ceased. Existing stock of Myocrisin Solution for injection (100mg/ml) will last until the end of June 2019 and Myocrisin Solution for injection (20mg/ml) are likely to last until the end of July 2019 (based on projected pattern of use). Mrs Needham advised that patients currently on Myocrisin are being identified so that they can be switched to a suitable alternative with specialist review. Mr Dhadli advised that he would bring the Myocrisin (sodium aurothiomalate) Shared Care Agreement to JAPC following this. **Medicines and Suicide** Mr Jones presented a paper on 'Medicines and Suicide' which has been agreed within Derbyshire Healthcare Foundation Trust (DHcFT) suicide prevention group to support effective conversations with patients, carers and colleagues about medicines management and suicide. The group included GP and Public Health representation. It will be circulated through DHcFT and Public Health over the next few weeks, Mr Dhadli said he would add this information into the JAPC bulletin and include a link to the document once it is available on the DHcFT website.	**SD**

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Item		Action
22.	**DATE OF NEXT MEETING**	
	Tuesday, 13th August 2019 at 1.30pm in the Coney Green Business Centre, Clay Cross.	