For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@nhs.net

# DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

## Minutes of the meeting held on 11 December 2018

# CONFIRMED MINUTES

## Summary Points

### Traffic lights

| Drug | Decision |
|---|---|
| Doxylamine/pyridoxine (Xonvea®) | BLACK |
| Dutasteride/tamsulosin (Combodart®) | BLACK |
| Padeliporfin | BLACK (as per NICE TA 456) |
| Gemtuzumab ozogamicin | RED (as per NICE TA 545 and as per NHS England commissioning intentions) |
| Tofacitinib | RED (as per NICE TA 547) |
| Cannabis-based medicinal products | RED |
| Binimetinib (Mektovi®) | RED |
| Durvalumab (Imfinzi®) | RED |
| Encorafenib | RED |

### Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

| Drug | Decision |
|---|---|
| Aciclovir 5% cream | BROWN from GREEN |
| Malathion 0.5% aqueous liquid | BROWN from GREEN |
| Dimeticone 4% lotion | BROWN from GREEN |
| Aluminium chloride hexahydrate | BROWN from GREEN |

### Clinical Guidelines

Amiodarone Monitoring Protocol
Topical Tacrolimus
Antidepressants in Moderate and Severe Unipolar Depression in Adults and Older Adults Prescribing Specification

### Patient Group Directions

Levonorgestrel (Levonelle®) 1500mcg tablets
Ulipristal Acetate (EllaOne®)

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@nhs.net

| **Present:** | |
|---|---|
| | |
| **Southern Derbyshire CCG** | |
| Dr A Mott | GP (Chair) |
| Mr S Dhadli | Specialist Commissioning Pharmacist (Professional Secretary) |
| Mr S Hulme | Director of Medicines Management and Clinical Policies |
| Mrs L Hunter | Assistant Chief Finance Officer |
| Mrs S Qureshi | NICE Audit Pharmacist |
| | |
| **North Derbyshire CCG** | |
| Dr C Emslie | GP |
| Dr T Narula | GP |
| Mrs K Needham | Assistant Chief Quality Officer (Medicines Management) (representing all four Derbyshire CCGs) |
| | |
| **Hardwick CCG** | |
| | |
| **Erewash CCG** | |
| Dr M Henn | GP |
| | |
| **Derby City Council** | |
| Dr R Dewis | Consultant in Public Health Medicine |
| | |
| **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** | |
| Ms D Railton | Advanced Pharmacist |
| | |
| **Derby and Derbyshire Local Medical Committee** | |
| Dr K Markus | Chief Executive Officer |
| | |
| **Derbyshire Health United** | |
| | |
| **In Attendance:** | |
| Dr G Rouke | FY2 Public Health, Derbyshire County Council |
| Mr A Thorpe | Derby City Council (minutes) |

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@nhs.net

| Item | | Action |
|---|---|---|
| **1.** | **APOLOGIES** | |
| | Dr T Parkin. | |
| **2.** | **DECLARATIONS OF CONFLICT OF INTEREST** | |
| | Dr Mott reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of JAPC.<br><br>No conflicts of interest were declared in relation to this agenda; in addition to the existing register of interests. | |
| **3.** | **DECLARATIONS OF ANY OTHER BUSINESS** | |
| | There were no declarations of any other business. | |
| **4.** | **MINUTES OF JAPC MEETING HELD ON 13 NOVEMBER 2018** | |
| | The minutes of the meeting held on 13th November 2018 were agreed as a correct record after the addition of Dr K Markus to the list of apologies. | |
| **5.** | **MATTERS ARISING** | |
| **a.** | **Low Molecular Weight Heparin**<br>Dr Mott reported that DCHSFT had requested advice from UHDBFT about the BD dosing for enoxaparin. The advice received had indicated an allowable window of two hours either side from the scheduled time of administration - this would be conveyed to Ms J Shaw. | **SD** |
| **b.** | **Cow's Milk Protein Allergy (CMPA)**<br>Dr Mott advised that there was no defined pathway with the CRHFT dietetic service for children with CMPA, but direct referrals were already accepted from primary care. In connection with formulary choice there was currently no further information - this would be followed up. | **SD** |
| **c.** | **Atrial Fibrillation (AF)**<br>It was confirmed that information on the costs of NOACs in AF had been included in the detailed NOAC prescribing information. | |
| **d.** | **Management of Dementia in Primary Care**<br>Dr Mott reported that information on costs had now been included in the guideline but DHcFT had advised that there was no definite way to determine when the cohort of patients who were managed but slowly declining should be referred back for possible use of memantine. In connection with the stopping of medication, Dr Mott stated the default position was to continue the prescribing of an acetylcholinesterase inhibitor in order to reduce the risk of deterioration in clinical condition which can happen on stopping this group of medications. However they could be discontinued if end stage was reached or there was a clinical reason to do this. | |
| **e.** | **Wound Care**<br>Dr Parkin had queried when the use of sterile water would be preferred to tap water. It was noted that tap water was mostly used but there were some circumstances concerning higher risk patients when sterile water would be need instead. | |

| Item | | Action |
|---|---|---|
| | The criteria for the uses of sterile water would be added to the guideline. Mr Dhadli informed JAPC that the specialist advocated had been contacted and that higher risk patients included patients with dehisced surgical wounds, those undergoing NPWT (VAC therapy) and where there was no potable water supply.<br><br>Mr Dhadli advised that information on an alternative product to Bastos Viegas, which was not eligible for prescription on FP10, was still awaited. Mrs Needham added that it had been proposed that a joint DCHSFT/CCG task and finish group be established to review the price of all the wound care products. The guideline may be amended in the light of this. | |
| **f.** | **<u>Cannabis-based Products for Medicinal Use</u>**<br>Mr Dhadli advised that a statement had been proposed by UHDBFT on the use of cannabis-based products and that this had been agreed by CRHFT. JAPC endorsed and adopted the message:<br><br>**Agreed:** Cannabinoid based medicinal products classified as **RED** for the following indications only:<br>• Severe paediatric epilepsy.<br>• Intractable chemotherapy induced nausea and vomiting.<br><br>With the following stipulation:<br>All requests for cannabinoid based medicinal products must be approved by a recognised MDT and approved on an individual concessional basis by the relevant Trust's Drugs and Therapeutic Committee. These products can only be prescribed by a specialist doctor on the General Medical Council Specialist Register (within their own area of practice and training). | |
| **g.** | **<u>NICE Summary</u>**<br>It had been highlighted that NG112 Urinary tract infection (recurrent): antimicrobial prescribing was not consistent with the local antimicrobial guidance. Mrs Qureshi advised that NICE and Public Health England had produced a whole new document which now superseded the original guidance and Dr D Harris, Lead Antimicrobial Pharmacist, and Ms J Dhamrait, were currently looking at these new infections in primary care guidance. The local guidance was due for renewal in March 2019 and would be discussed by the Guideline Group before that time. It was noted that there would be a discrepancy between the national and local guidance until the wider review had been completed. | |
| **6.** | **JAPC ACTION SUMMARY** | |
| | Freestyle Libre® – A meeting to discuss the Freestyle Libre® patient numbers had been held immediately prior to the JAPC meeting. The notes from this would be included with the agenda and papers for the January 2019 meeting.<br><br>Hydroxychloroquine – This would be brought to the January 2019 JAPC meeting.<br><br>C.difficile – It was noted with concern that the guidance was now five months out of date. | **SD** |

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@nhs.net

| Item | | Action |
|---|---|---|
| | Mr Dhadli would contact Mrs S Bestwick, CCG Lead Nurse Infection Prevention and Control, concerning the urgent need for an update to the diagnostic aspects.<br><br>Infant Feeding – An update would be provided for the January 2019 JAPC meeting. | **SD**<br><br>**SD/AM** |
| **7.** | **NEW DRUG ASSESSMENT** | |
| **a.** | **<u>Doxylamine/Pyridoxine (Xonvea®)</u>**<br>Mr Dhadli reported that Xonvea®, a combination product of doxylamine 10mg + pyridoxine 10mg, was the first licensed product for moderate to severe nausea and vomiting in pregnancy (NVP) in women who did not adequately respond to conservative management. Previously unlicensed pharmacological therapies for the treatment of NVP had been used including cyclizine, promethazine, metoclopramide, prochlorperazine and ondansetron.<br>Xonvea® was referenced in the horizon scan, but not currently by NICE in their timetable of work. Clinical data had been obtained from a randomised, double-blind, placebo-controlled trial (n=256) with fourteen days of treatment with doxylamine and pyridoxine. This had resulted in a significantly larger improvement in symptoms of nausea and vomiting of pregnancy compared with placebo based on the Pregnancy Unique Quantification of Emesis (PUQE) score. The PUQE score included the number of daily vomiting episodes, number of daily heaves, and the length of daily nausea in hours, for an overall score of symptoms rated from three (no symptoms) to fifteen (most severe). Doxylamine/pyridoxine had resulted in a larger improvement in the global assessment of well-being score (2.8) versus placebo (1.8).<br><br>However, it was noted that the Royal College of Obstetricians and Gynaecologists (RCOG) did not recommend pyridoxine for treating nausea and vomiting in pregnancy due to the lack of consistent evidence of effectiveness. In addition, high doses of pyridoxine (of up to 80mg daily) were needed to treat nausea and vomiting in pregnancy. CKS also did not recommend pyridoxine for this indication. The trial referred to in the SPC had only involved 261 women and the majority of these had been put on the highest dose of four tablets daily. It was also noted that, in the event that doxylamine/pyridoxine was used instead of off-label cyclizine or promethazine, the additional cost to the Derbyshire CCGs was estimated to be in excess of £130k.<br><br>Mr Moore advised that local obstetricians had not advocated the use of the drug and it had been highlighted that the maximum dose would be needed in order to gain any benefit. Dr Mott commented that the evidence of effectiveness was very limited and there was greater experience of use with the current off label products.<br><br>**Agreed:** Xonvea® classified as a **BLACK** drug due to the lack of data on cost-effectiveness compared with standard therapies. | **SD** |

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@nhs.net

| 8. | CLINICAL GUIDELINES | |
|---|---|---|
| a. | **Amiodarone**<br>Mr Dhadli advised that the amiodarone monitoring protocol had been updated in collaboration with the UHDBFT and CRHFT consultant cardiologists and highlighted some of the main changes:<br>• The long half-life of amiodarone was highlighted and clinical problems could therefore occur or persist for up to a year after stopping the drug. Thyroid function tests should be monitored for up to twelve months after discontinuation.<br>• In the event that optic neuropathy/neuritis was suspected, an urgent referral should be made to an ophthalmologist together with discussions with the patient's cardiologist.<br>• Adverse effects had now been added in terms of frequency, diagnosis and management.<br>• The drugs not included in the British National Formulary or unfamiliar and not used had been deleted and aminophylline/theophylline added.<br>• Further advice included regarding bradycardia and thyrotoxicity added based on comments received from consultants.<br>• The SPS recommended twelve monthly chest x-rays but the specialist view was that this was not routinely required or performed. Therefore no change had been made to the existing guidance.<br>• The SPC had recommended routine electrocardiogram (ECG) testing but the local view was for yearly monitoring due to the progression from paroxysmal atrial fibrillation to persistent and permanent atrial fibrillation.<br><br>During discussion Dr Mott commented that amiodarone should be a shared care drug and this had been indicated in the national second wave of drugs of limited medical value (DLMV) which was out for consultation. Local data for one year had revealed a number of patients who were on amiodarone and this included patients with permanent AF who were no longer under specialist care and therefore should perhaps no longer be on this drug. It was therefore highly important to obtain a better estimate of patient numbers who were prescribed amiodarone in primary care and of those who were under specialist cardiology care. There was also concern that those patients who were on long term amiodarone therapy had not been adequately monitored in line with the guidance and this was particularly important in view of the safety issues associated with the drug. Dr Watkins referred to the desirability of support for GPs concerning the review of their patients taking amiodarone to establish the need for ongoing treatment. Dr Mott suggested that the cardiologists should be informed of the likely forthcoming change to a formal shared care agreement and that there would be cohorts of patients who will be repatriated or perhaps stopped altogether.<br><br>**Agreed:** JAPC gave interim agreement to the amiodarone monitoring protocol with the agreed amendments but with the expectation that there would be a change to shared care following the outcome of the second DLMV consultation. This would be placed on the action tracker with an update to the April 2019 JAPC meeting. | **SD** |
| | **Action:** The likely numbers of patients on amiodarone would be reviewed in order to determine the cohorts which could be stopped in primary care and those who would need to be referred back to secondary care. | **SD** |

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@nhs.net

| | | |
|---|---|---|
| **b.** | **Tacrolimus**<br>Mr Dhadli reported that minor changes only had been made to the protocol for topical tacrolimus in patients being treated with moderate or severe atopic eczema. Dr Watkins advised that it would be advantageous if GPs could be made aware of the risk of prescribing the higher strength of tacrolimus to children. Mrs Needham would arrange for an OptimiseRx message to alert GPs to this.<br><br>**Agreed:** JAPC ratified the protocol for topical tacrolimus with the agreed amendments with a review date of two years. | **KN**<br><br>**SD** |
| **c.** | **Depression and the Use of Antidepressants**<br>The JAPC 'Guidelines for choosing Antidepressants in Moderate and Severe Unipolar Depression in Adults and Older Adults' had been scheduled for review in November 2018. Mr Jones advised that the updates to NICE guideline CG90 'Depression in adults: recognition and management' and CG91 'Depression in adults with a chronic physical health problem: recognition and management' had been expected to be published in 2018. However, there had now been a significant delay with this and totally new guidelines would now be developed, but not expected until the end of 2019. Mr Jones added that the place of esketamine and other novel treatments for treatment-resistant depression may also need to be taken into consideration.<br><br>**Agreed:** JAPC ratified the existing guidelines for choosing Antidepressants in Moderate and Severe Unipolar Depression in Adults and Older Adults for a further six months at which point further information may be available about the progress of the new NICE guideline. | **SD** |
| **9.** | **PATIENT GROUP DIRECTIONS** | |
| | JAPC agreed that the following updated PGDs from DCHSFT should be included on the website:<br>• Levonorgestrel 1500 microgram tablet (Levonelle®) for sexual health clients aged thirteen years and older.<br>• Ulipristal Acetate 30mgs (ellaOne®) for sexual health clients aged thirteen years and older.<br><br>It was highlighted that it would be important for DCHSFT to ensure via its governance processes that the most recent version of these PGDs was on the website and used in view of the implications for the wider health economy. In addition, although DCHSFT commissioned community pharmacy services, it would be important at the time of review to consult with the Derby City Council public health department in order that the PGDs were aligned with their commissioned service of PharmOutcomes. | |

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@nhs.net

| 10. | MISCELLANEOUS | |
|---|---|---|
| a. | **Dutasteride/tamsulosin (Combodart®)**<br>Mr Dhadli advised that Combodart was a combination medicine used to treat men with benign prostatic hyperplasia (BPH) and contained dutasteride and tamsulosin hydrochloride. The Guideline Group had recommended that Combodart be assigned a traffic light classification of BLACK as it was significantly more expensive than its individual constituent products.<br><br>**Agreed:** Combodart classified as a **BLACK** drug as less cost-effective than current standard therapy. | **SD** |
| b. | **Juxta CURES**<br>Mr Dhadli reported that Juxta CURES had been classified as BROWN specialist nurse/TVN initiation and training at the September 2017 JAPC meeting due to its exceptional use in selected patients. JAPC had also agreed to monitor use within twelve months of the decision. It was noted that twenty-nine items had been prescribed in 2016/2017 and thirty-five items in 2017/2018 so there had been no significant increase in prescribing or cost pressures. It was therefore agreed that no further monitoring or action was required. | |
| c. | **Prescribing Outlook 2019-2020**<br>Mrs Qureshi reported that the annual horizon scan for new drugs which would impact on primary and secondary care prescribing budgets for 2019/2020 had been prepared. Five papers had been included which categorised the drugs according to primary or secondary care prescribing and then as whether they were commissioned by CCG or NHS England. The relevant papers for JAPC were:<br>• Primary care drugs<br>• Drugs commenced in secondary care and then transferred to primary care.<br>• CCG commissioned high cost drugs (HCD).<br><br>The following papers were noted for information only:<br>• Fifty-five HCD commissioned by NHS England.<br>• Twenty-six secondary care in-tariff drugs.<br>• Five drugs commissioned by the Local Authorities.<br><br>Mrs Qureshi advised that the drugs which presented a risk to primary care were the SGLT2-inhibitors, dapagliflozin, empagliflozin and a new drug Sotagliflozin, with licence extension for use in type 1 diabetes in combination with insulin. These were currently in the NICE timetable of work and the cost implication for Derbyshire had been estimated at £580k for the 1 million population. Another risk was the drug Xonvea®, the first licensed drug for nausea and vomiting in pregnancy, which had just been assigned a BLACK traffic light classification by JAPC.<br><br>NICE was currently reviewing the following drugs to be initiated in secondary care and then transitioned to primary care:<br>• Budesonide (Joreza®) for eosinophilic oesophagitis. This was the first licensed drug for this indication and JAPC had agreed at the November 2018 meeting to leave unclassified and await review by the Drugs and Therapeutic Committees. | |

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@nhs.net

| | | |
|---|---|---|
| | In the event that NICE gave a positive opinion this drug would have a cost implication of £195k for Derbyshire.<br>• Rivaroxaban for venous thromboembolism (VTE) and VTE related death hospital discharge (licence extension). This was the first NOAC to be licenced for this indication. Rivaroxaban would compete with parenteral options such as enoxaparin if given a NICE positive review. In the event that 50% of eligible patients received rivaroxaban instead of enoxaparin it was highlighted that the additional cost implication would be £1.28m for Derbyshire.<br>• Rivaroxaban for prevention cardio-vascular events (licence extension). There was currently no anticoagulant licenced for this indication so rivaroxaban would be an additional option. The cost implication for Derbyshire would be £486K.<br>• Sodium zirconium cyclosilicate for hyperkalaemia in adults. This was currently being reviewed by NICE and had a 'do not use recommendation'.<br>• Lifitagrast eye drops for dry eyes were being reviewed by NICE but there were no current cost implications.<br><br>In connection with the CCG commissioned HCD the high financial risk drugs included:<br>• Mepolizumab for chronic obstructive pulmonary disease (COPD). Mrs Qureshi advised that it was anticipated that this would be a CCG commissioning responsibility and, if so, the likely cost implication for Derbyshire would be £1.47m but this may change.<br>• Monoclonal antibodies (Fremanezumab and Erenumab) which were the first tranche of new treatments for preventing migraine attacks. Erenumab had very significant financial impact of £2.3m for Derbyshire and could be the first of this class of drugs to be approved by NICE. Fremanezumab will compete with erenumab and, if fremanezumab took a third of market share but the costs were 10% less than erenumab, this would result in an additional cost of £690k for Derbyshire. Galcanezumab is another migraine treatment on the horizon, but this was not currently under review by NICE. It was highlighted that this class of drugs would only be used if all other migraine treatments had failed including botox.<br>• Andexanet alfa for reversal of factor Xa inhibitor in life threatening bleeding. If a positive review was received from NICE the potential cost would be between £715k and 1.43m for Derbyshire.<br>• Canakinumab for secondary prevention of cardio-vascular events in patients with elevated high sensitivity to C-reactive protein (CRP). The assumed cost for Derbyshire was £823k in the event of a NICE positive review.<br><br>Low financial risk drugs included:<br>• Eltrombopag for severe aplastic anaemia.<br>• Upadacitinib for rheumatoid arthritis – This was a Janus Kinase (JAK) inhibitor which was likely to compete with the other JAK inhibitors and oral DMARDs with similar pricing.<br>• Fluocinolone acetonide for uveitis. The additional cost was estimated to be £50k although there would be some savings due to reduced administration costs. | |

For agenda items contact Slakahan Dhadli
Tel: 01332 868781
Email: slakahan.dhadli@nhs.net

| | | |
|---|---|---|
| | • Tildrakizumab, Risankizumab and Certolizumab for psoriasis. These were currently under review by NICE and there was a cost implication of £45k for tildrakizumab and £105k for risankizumab.<br><br>Mr Dhadli reported that the horizon scan process had commenced with UHDBFT and CRHFT and certain drug lines had been agreed. The need for additional resources for the new drugs, particularly the monoclonal antibodies, had been conveyed to finance but there may be a need to highlight these as a risk. | |
| **d.** | **<u>Prescribing Specification 2019-2020</u>**<br>It was reported that comments received from Dr Markus had now been incorporated into the prescribing specification. The prescribing specification 2019-2020 was ratified by JAPC. | **SD** |
| **e.** | **<u>Psoriatic Arthritis Algorithm</u>**<br>It was reported that, following the publication of NICE TA 543 'Tofacitinib for treating active psoriatic arthritis after inadequate response to DMARDs' in November 2018 this JAK inhibitor has been included into the local commissioning algorithm – this was agreed by JAPC. | **SD** |
| **f.** | **<u>NHS England Low Value Medicines – Consultation</u>**<br>Mr Dhadli reported that in 2018 NHS England had published guidance in collaboration with NHS commissioners on eighteen medicines which should no longer be routinely prescribed in primary care. This guidance had now been updated with the inclusion of new indicators. Mr Dhadli outlined the drugs included in the NHS consultation and the current JAPC traffic light classifications for these:<br>• Rubefacients – BLACK (this did not include topical NSAIDs or capsaicin cream for neuropathic pain for which exceptionality was recognised).<br>• Aliskiren – BROWN.<br>• Amiodarone – GREEN at present, but shared care recommended in the consultation.<br>• Bath and shower preparations for dry and pruritic skin conditions – BLACK.<br>• Blood glucose testing strips for type 2 diabetes - All the blood glucose testing strips were under review by the medicines management team.<br>• Dronedarone – AMBER under shared care.<br>• Minocycline for acne – BLACK.<br>• Needles for Pre-Filled and Reusable Insulin Pens – GlucoRx finepoint pen needles were recommended. If unsuitable other brands with needles under £6 per 100 needles to be considered.<br>• Silk garments – BLACK.<br><br>It was noted that JAPC was broadly in line with all of the drugs in the review with the notable exception of amiodarone. | |
| **11.** | **REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)** | |
| | JAPC noted the following:<br>• RMOC South – Position statement on homely remedies for use in care homes by adults. | |

| | | |
|---|---|---|
| | Dr Markus expressed concern about the likely impact on the workload of GPs and potential clinical risk caused by the requirement for primary care and community pharmacies to re-assess patients each time their homely remedies were changed. It was noted that the existing guidance would need to be reviewed and updated in the light of this RMOC position statement. Mr Dhadli would request Ms S Aslam to undertake this review.<br>• RMOC liothyronine position statement and draft shared care. This would need to be taken into consideration when the local position statement was reviewed in early 2019. | **SD** |
| **12.** | **JAPC BULLETIN** | |
| | The November bulletin was ratified. | |
| **13.** | **MHRA DRUG SAFETY UPDATE** | |
| | The MHRA Drug Safety Alert for November 2018 was noted.<br><br>Mr Dhadli highlighted the following MHRA advice:<br>• Hydrochlorothiazide: risk of non-melanoma skin cancer, particularly in long term use.<br>• Systemic and inhaled fluoroquinolones: small increased risk of aortic aneurysm and dissection; advice for prescribing in high-risk patients.<br>• Sildenafil (Revatio® and Viagra®): reports of persistent pulmonary hypertension of the new-born following in-utero exposure in a clinical trial on intrauterine growth restriction.<br>• Support Yellow Card: To help improve the safety of medicines in pregnancy and breastfeeding, and in babies and children.<br>• Letters and drug alerts sent to healthcare professionals in October 2018. | |
| **14.** | **HORIZON SCAN** | |
| | Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations:<br><br>New drug launches in the UK:<br>• Adalimumab biosimilar (Amgevita®) – Classified as **RED**.<br>• Adalimumab biosimilar (Hyrimoz®) – Classified as **RED**.<br>• Adalimumab biosimilar (Imraldi®) – Classified as **RED**.<br>• Axicabtagene ciloleucel (Yescarta®) – Classified as **RED** (NHS England).<br>• Binimetinib (Mektovi®) – Classified as **RED** (NHS England).<br>• Durvalumab (Imfinzi®) – Classified as **RED** (NHS England).<br>• Encorafenib (Braftovi®) – Classified as **RED** (NHS England).<br><br>New formulation launches in the UK:<br>• Doxylamine + pyridoxine (Xonvea®) – Previously classified as **BLACK** by JAPC.<br>• Naloxone (Nyxoid®) – New formulation. Unclassified.<br><br>Licence extensions:<br>• Probiotic (VSL#3).<br>• Benzoyl peroxide (Brevoxyl®) | |

| | | |
|---|---|---|
| **15.** | **NICE SUMMARY** | |
| | Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance in November 2018:<br><br>TA 545 Gemtuzumab ozogamicin for untreated acute myeloid leukaemia – Classified as **RED** (NHS England as per TA 545).<br><br>TA 546 Padeliporfin for untreated localised prostate cancer – Not recommended. Classified as **BLACK** (NHS England as per TA 456).<br><br>TA 547 Tofacitinib for moderately to severely active ulcerative colitis – Classified as **RED** (CCG commissioned). The resource implications for the CCGs over a five year period were noted.<br><br>TA 293 (updated October from July 2013) Eltrombopag for treating chronic immune (idiopathic) thrombocytopenic purpura. It was noted that the marketing authorisation for eltrombopag now included people who had not had a splenectomy.<br><br>TA 221 (updated October from April 2011) Romiplostim for the treatment of chronic immune (idiopathic) thrombocytopenic purpura. It was noted that the marketing authorisation for romiplostim now includes people who had not had a splenectomy.<br><br>NG113 Urinary tract infection (catheter associated): antimicrobial prescribing. This included:<br>• Management of catheter-associated urinary tract infection.<br>• Self care.<br>• Choice of antibiotic.<br>• Prevention of catheter-associated urinary tract infection.<br><br>CG54 (updated October from August 2007): Urinary tract infection in under 16s: diagnosis and management.<br><br>NG88 (updated from March 2018) Heavy menstrual bleeding: assessment and management. | |
| **16.** | **GUIDELINE GROUP ACTION TRACKER** | |
| | The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in November 2018 was noted. Mr Dhadli highlighted the following:<br><br>Traffic Lights:<br>Aciclovir 5% cream – Classified as **BROWN** from GREEN as patients now encouraged to self-care.<br>Malathion 0.5% aqueous liquid – Classified as **BROWN** from GREEN as patients now encouraged to self-care.<br>Dimeticone 4% lotion – Classified as **BROWN** from GREEN as patients now encouraged to self-care.<br>Aluminium chloride hexahydrate – Classified as **BROWN** from GREEN as patients now encouraged to self-care. | |

| | | |
|---|---|---|
| | For information:<br>Formulary update (Chapter 13 – Skin): Medi Derma-S replaced Cutimed protect as barrier preparation for high risk patients.<br>• Polyfax ointment removed (discontinued).<br>• Malathion, dimeticone, and aluminium chloride hexahydrate removed from formulary chapter. Replaced with self-care messages.<br>• Anthlios® sunscreen removed as other brands were available.<br>• CKS advice on treatment of widespread itch added. First line self-care and emollients; menthol and aqueous cream may be trialled if adequate relief not achieved.<br><br>Clinical/Shared Care Guidelines:<br>Over Active Bladder guideline – Pharmacological treatment oxybutynin or tolterodine 1st line; oxybutynin or tolterodine 2nd line. Formulary chapter also updated.<br><br>Website Changes/Miscellaneous:<br>Formulary Chapter Obstetrics and Gynaecology and Urinary Tract – Advice added regarding pill taking without interval. Continuous dosing or extended regimens may be considered in some women (monophasic combined oral contraceptive only). | |
| **17.** | **TRAFFIC LIGHTS – ANY CHANGES?** | |
| | **Classifications**<br>Doxylamine/pyridoxine (Xonvea®) – BLACK<br>Dutasteride/tamsulosin (Combodart®) – BLACK<br>Padeliporfin – BLACK (as per NICE TA 456)<br>Gemtuzumab ozogamicin – RED (as per NICE TA 545 and as per NHS England commissioning intentions)<br>Tofacitinib – RED (as per NICE TA 547)<br>Cannabis-based medicinal products – RED<br>Adalimumab biosimilars: Imraldi®, Amgevita® and Hyrimoz® – RED<br>Binimetinib (Mektovi®) – RED<br>Durvalumab (Imfinzi®) – RED<br>Encorafenib – RED | |
| **18.** | **MINUTES OF OTHER PRESCRIBING GROUPS** | |
| | • DHcFT Drugs and Therapeutic Committee 27/09/2018<br>• Nottingham Area Prescribing Committee 20/09/2018<br>• Sheffield Area Prescribing Group 20/09/2018<br>• UHDBFT Drugs and Therapeutic Committee 16/10/2018<br>• Sheffield Area Prescribing Group 18/10/2018<br>• JAPC Working Group 09/10/2018<br>• CRHFT Drugs and Therapeutic Committee 20/11/2018 | |
| **19.** | **ANY OTHER BUSINESS** | |
| | There were no items of any other business. | |
| **20.** | **DATE OF NEXT MEETING** | |
| | Tuesday, 8th January 2019 at 1.30pm in the Coney Green Business Centre, Clay Cross. | |