Derbyshire JAPC Bulletin

www.derbyshiremedicinesmanagement.nhs.uk

August 2020

Derbyshire Joint Area Prescribing Committee (JAPC)
This is a countywide group covering NHS Derby & Derbyshire Clinical Commissioning Groups, Derbyshire Community Health Service Foundation Trust, Derbyshire Healthcare Foundation Trust, University Hospital of Derby and Burton and Chesterfield Royal Hospital foundation trusts. It provides recommendations on the prescribing and commissioning of drugs. See **http://www.derbyshiremedicinesmanagement.nhs.uk/home**

Due to the current COVID-19 pandemic an interim JAPC ToR has been devised to ensure that there is continuity of JAPC meetings during these extraordinary times. The increased pressures experienced by the CCG and providers necessitated the need to temporarily modify existing arrangements for the running of JAPC meetings and the work-up behind the review/production of clinical guidelines.
See http://www.derbyshiremedicinesmanagement.nhs.uk/medicines-management/joint_area_prescribing_committee

Key Messages From The JAPC August Meeting - Clinical Guidelines

Following the discontinuation of danazol (see CAS alert), JAPC has classified danazol as RED for all licensed and off-label indications. Any remaining patients in primary care should be identified to the responsible specialist in secondary care for review.

Patient Group Directions & Shared Care Agreements (SCA)

None this month

Roflumilast for COPD

Roflumilast (NICE TA461) has been reclassified from RED to BROWN after respiratory consultant/specialist initiation and stabilisation for the first 3 months. Roflumilast a phosphodiesterase type-4 inhibitor with anti-inflammatory properties is used as an add-on to bronchodilator therapy in patients with severe COPD in adults with chronic bronchitis, if:

- the disease is severe, defined as a forced expiratory volume in 1 second (FEV1) after a bronchodilator of less than 50% of predicted normal, and
- the person has had 2 or more exacerbations in the previous 12 months despite triple inhaled therapy is recommended for patients.

Respiratory consultant/specialist initiates treatment in appropriate patients, and monitors the clinical efficacy and adverse effects of the drug initially. At 3 months stable patients will be transferred to the GP for continued treatment. Continued management is based on disease control rather than drug specific monitoring. Ongoing management by GPs can be found in the local COPD guidance.

Overactive bladder

Due to the recent price changes for the anti-muscarinic drugs used for overactive bladder; most notably the price reduction for solifenacin and increase in tolterodine; a partial update of the guidance was undertaken. There are no head-to-head trials, but a Cochrane Review, 2012 and a recent systematic review found small differences between the antimuscarinic's. In particular solifenacin had slightly better efficacy and less risk of dry mouth.
Based on evidence and price differential JAPC has reclassified all OAB drugs with the order of use of OAB drugs now changed to oxybutynin Green 1st line, solifenacin Green 2nd line and trospium and tolterodine immediate release are Green 3rd line. All other drugs have been relegated to Brown alternate options. Prescribers are reminded to remain vigilant of the ACB – anticholinergic burden, classification for this class of drugs.

H2 antagonists shortage

Advice from local specialists with regards to the patients on H2 antagonists- ranitidine treatment is that the majority of patients can be moved to PPI.
However there is a minority of patients who can only be managed with a H2 antagonist including

1. those needing acid suppression who are **genuinely allergic** or intolerant or contraindicated to all PPIs, which is rare
2. those needing acid suppression where low magnesium occurs, which is felt as very rare
3. those who have needed upward titration for reflux symptoms despite high dose PPIs, where addition of H2 blocker (generally at night time) helps.
    - patients suitable for antireflux procedures should be referred at this point, but generally the H2+PPI combination is used for those not suitable for or who would not do well with antireflux surgery (elderly frail etc. + those where there is a functional element to symptoms)
4. small number of patients who claim not to do well on PPI yet symptomatically get better on H2

For all cases, those not responding well to PPIs should be investigated to make sure the diagnosis is correct e.g. to rule out bile reflux, functional pain etc. For groups 1 and 2, if the patient has critical acid related disease (e.g. recurrent oesophageal stricture, severe oesophagitis, persistent ulcer, etc.) then an ongoing H2 blocker is needed as the patient will get further complications/admissions/interventions otherwise. For group 3 the patient would be recommended to go back to PPI + antacids.

Buccal Midazolam - buccolam

Prescribers are reminded the preferred buccal midazolam product across Derbyshire is **Buccolam** for use in children under 18 years and adults. The use in adults is off-label. In May 2018, Epistatus was classified as BLACK, after an extensive consultation with specialists. Also there was a long period of review and negotiation with stakeholders to ensure an appropriate training package was in place before the move to buccolam was undertaken. **Prescribers are reminded of the importance that in order to switch to Buccolam patients and their carers need to be trained and or educated on the new product. Care plans should be updated at next review with specialist.** Further prescribers are reminded to be aware of the volume difference for the 2 products when switching – Buccolam is 10mg/2ml prefilled syringe, whereas epistatus is 10mg/1ml prefilled syringe.

Flu vaccine arrangements with DCHSFT

For the traditional housebound flu cohort patients, DCHS staff will administer the seasonal flu vaccine 20/21. This includes administration to patients 65 years and older against a PSD. The envisioned process includes prescribers in GP practices to individually assess patients for suitability of flu vaccine and to produce a list of names of housebound patients (and their carers if necessary) to receive the specific flu jab the practice has bought. DCHSFT staff will collect vaccine from GP surgery and administer against the list. Further clarification for over 50 year patient's cohort is currently pending from DHSCFT.

Guideline Group key messages

FIASP (Insulin Aspart): GREEN, On specialist recommendation. Now for use in children (>1 year) as well as adult, as per license extension. Note: FIASP and Novorapid are not directly interchangeable.
Ferrous fumarate: GREEN, 322mg tablet/140mg/5 ml oral solution SF solutions are the preferred formulary choices.
Sodium feredetate: GREEN, Oral solution (alternative if unable to tolerate ferrous fumarate)
Strivit D3 replaces Fultium D3 as the cost effective choice of vitamin D treatment choice. Information on suitability for people with nut/soya allergy and special diets added.GORD in children- acidex advance replaces gaviscon advance; lansoprazole is the cost effective choice of PPI (guidance contains prescribing information for both).

MHRA NOTICES

Not relevant for primary care:
Systemically administered VEGF pathway inhibitors: risk of aneurysm and artery dissection
Liposomal and lipid-complex formulations: name change to reduce medication errors

Drug	Date considered	Decision	Details
Danazol	Aug 2020	RED	Discontinuation as per CAS alert. Prescribing for off-label and licenced indications to remain with the specialist.
Rofliumilast	Aug 2020	BROWN after resp con/spec initiation	After Respiratory Consultant/Specialist initiation: NICE TA461: (replaces TA244 - negative appraisal) Roflumilast for treating chronic obstructive pulmonary disease. Patients care to be transferred to primary care after 3 months of roflumilast treatment under the Respiratory Consultant/ Specialist. Further information can be found in the COPD guidance.
Oxybutynin IR/MR	Aug 2020	GREEN / BROWN	**GREEN 1st line:** Standard/immediate release (IR) preparation is first line choice for urinary incontinence. **BROWN:** Modified Release (MR) preparation. The MR preparation should only be used if the IR is unsuitable (i.e. for those who may be at higher risk of sudden deterioration in their physical or mental health).
Solifenacin	Aug 2020	GREEN	**2nd line** option for urinary incontinence
Trospium IR/MR	Aug 2020	GREEN / BROWN	**GREEN 3rd line:** immediate release (IR) preparation is 3rd line choice for urinary incontinence **BROWN:** Modified Release (MR) preparation.
Tolterodine IR/MR	Aug 2020	GREEN / BROWN	**GREEN 3rd line:** Immediate Release (IR) preparation is 3rd line choice for urinary incontinence **BROWN:** Modified Release (MR) preparation, significantly more expensive than IR preparation. (Neditol XL® is the preferred branded generic of tolterodine MR across Derbyshire.)
Propiverine IR/MR	Aug 2020	BROWN	BROWN - immediate release/modified release preparations alternate options for urinary incontinence.
Darifenacin MR	Aug 2020	BROWN	Alternate option for urinary incontinence.
Fesoterodine MR	Aug 2020	BROWN	Alternate option for urinary incontinence
Mirabegron	Aug 2020	BROWN	NICE TA290, an option for treating the symptoms of overactive bladder only for people in whom antimuscarinic drugs are contraindicated or clinically ineffective, or have unacceptable side effects.
Atezolizumab	Aug 2020	RED	TA638: with carboplatin and etoposide for untreated extensive stage small cell lung cancer. NHSE commissioned
Atezolizumab	Aug 2020	RED	TA639: with nabpaclitaxel for untreated PDL1-positive, locally advanced or metastatic, triple-negative breast cancer. NHSE commissioned

Definitions:

RED: drugs are those where prescribing responsibility lies with a hospital consultant or a specialist.

AMBER: drugs are those that although usually initiated within a hospital setting, could appropriately become the responsibility of the GP, under a shared care agreement.

GREEN: drugs are regarded as suitable for primary care prescribing.

BROWN: drugs are those that JAPC does not recommend for use, except in exceptional circumstances, due to lack of data on safety, effectiveness, and/or cost-effectiveness.

BLACK: drugs, treatments or medical devices are **not** recommended or commissioned* (*unless agreed through the individual funding request route)

CONSULTANT/SPECIALIST INITIATION: consultant/specialist issues the first prescription usually following a consultation because:

a. The patient requires specialist assessment before starting treatment and/ or
b. Specialist short term assessment of the response to the drug is necessary.

GPs will be asked to continue prescribing when the patient is stable or predictably stable

CONSULTANT/SPECIALIST RECOMMENDATION: consultant/specialist requests GPs prescribe initial and on-going prescriptions, but ensures:

a. There is no immediate need for the treatment and is line with discharge policies and
b. The patient response to the treatment is predictable and safe

DERBYSHIRE MEDICINES MANAGEMENT, PRESCRIBING AND GUIDELINES WEBSITE

This website is the first port of call for information on local NHS decisions and guidance on medicines use. It includes: local prescribing formularies, JAPC decisions, traffic lights, shared care guidelines, medicines guidelines, newsletters, controlled drug resources, and other medicines management resources. The site improves upon previous sites in several ways. It is faster, more reliable, has its own search engine, and it is easier to find information. Content is constantly being updated and you can sign up for e-mail alerts to keep you up to date.