Derbyshire JAPC Bulletin

www.derbyshiremedicinesmanagement.nhs.uk

December 2022

This is a countywide group covering NHS Derby & Derbyshire Integrated Care Board, 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

Key Messages from December's JAPC meeting

Icosapent ethyl (▼) capsules have been reclassified as **GREY** from **RED.** Indicated as an option to be taken **with** statin therapy, to reduce the risk of cardiovascular events. Relaxation of the traffic lights allows for primary care prescribing for patients with raised triglycerides (1.7 mmol/L or above) and low-density lipoprotein cholesterol >1.04mmol/L and ≤ 2.60mmol/L, in secondary prevention only, as indicated in NICE TA805. Icosapent ethyl has been placed in the local familial hypercholesterolaemia and non-familial hyperlipidaemia guidelines. Statin ± ezetimibe should be optimised to maximal tolerated dose ahead of use of icosapent ethyl. Monitoring requirements can be found in the latest SPC but include baseline ALT & AST and further monitoring at appropriate intervals; ECG if clinically indicated for patients with history of AF/flutter; and periodic monitoring of patients taking concomitant antithrombotics due to increased risk of bleeding.

COPD guidance – routine review of an existing guideline through consultation with local specialists. Amendments include use of reversibility testing as a useful tool to distinguish asthma and COPD, terminology change from smoking cessation to "treatment of tobacco addiction", local contacts for respiratory services updated and link to ARTP added under training information. Treatment options for COPD remain unchanged and are based on presence or absence of asthmatic features.

The following shared care agreements have been updated with minor amendments:

- Acamprosate - removal of specialist responsibility to determine whether the patient is alcohol dependent and arranging a physical assessment as not routine practice and specialist to monitor treatment duration for first 6 months (in line with NICE).
- Disulfiram - removal of specialist responsibility to determine whether the patient is alcohol dependent and arranging a physical assessment as not routine practice and to 'review' patients for first two months.
- Naltrexone - specialist responsibility for initiating reworded to reflect current practice and monitoring requirements section reworded to convey a clearer message.

Type 2 diabetes mellitus guidance (T2DM)

The T2DM guidance has been rewritten in consultation with local specialists and to reflect updated NICE NG28. The new guidance emphases the importance of a managing cardiovascular (CV) risk and stratifying drug treatment based on a person's CV disease and heart failure status. Although metformin remains **first-line** drug treatment of choice, sodium glucose co-transporter- 2 inhibitors (SGLT2i) are placed in a prominent position in the new guidance. The guidance indicates **offering** an SGLT2i to those patients with CHF or established atherosclerotic CVD, and to **consider** SGLT2i for those at high risk of developing cardiovascular disease in addition to metformin. Locally preferred SGLT2i include **empagliflozin and dapagliflozin**. Prescribers are advised to consult the latest SPC and prescribing tables in the T2DM guidance ahead of initiating an SGLT2i to address modifiable risks for diabetic ketoacidosis and to assess the impact of renal and hepatic impairment.

Prescribing recommendations for glucagon-like peptide 1 agonists (GLP1) have been updated to be in line with current NICE guidance. If triple therapy with metformin and 2 other oral drugs is not effective, not tolerated, or contraindicated, the recommendation is to consider triple therapy by switching one drug for a GLP1 agonist. Preferred daily GLP1 agonists include **liraglutide** as first line and lixisenatide 20mcg (for existing patients) - GREEN. Preferred weekly GLP1 agonists include **semaglutide (subcut preparation) and dulaglutide** – GREEN (both evidencing positive CV outcomes).

Dexcom One – GREY
after diabetes consultant/specialist initiation within a Derbyshire diabetes service

JAPC has assigned a GREY con/spec initiation traffic light to Dexcom One, which is an evidence-based real time continuous glucose monitoring (rtCGM) system. Dexcom One will be an additional option for type 1 diabetic patients alongside Freestyle Libre 2 (FSL2). Those patients currently on FSL2, may choose to move to Dexcom One based on their personal preference. Dexcom One is worn on the abdomen and provides continuous real time glucose readings every 5 mins to a compatible smartphone. Dexcom One consists of a 10-day sensor which is water resistant, and a transmitter which fixes on top of the sensor, with a 3-month battery life and an app which is compatible with a smartphone.

Initiation of Dexcom One will be responsibility of the diabetes specialist, who will complete the ABCD forms. GPs will be requested to continue prescribing Dexcom One sensors, on an FP10. The transmitter will be supplied free of charge from the community pharmacy every 3 months. Details of disposal of used sensors can be found in the JAPC briefing for FSL2/Dexcom One.

Testosterone Gel – GREEN

In response to requests from GPs, a local guideline for use of testosterone gel for postmenopausal women with low sexual desire has been developed in collaboration the Shared Care pathology group. The guideline (included as an appendix to the local menopause guidance) enables GPs to consider prescribing testosterone for women as part of their menopause management. Testosterone can be used as an adjunct to traditional HRT (oestrogen plus progesterone) and specifically in those people with low libido. GPs can now prescribe and monitor testosterone gel (off-label) in primary care if deemed clinically appropriate for their patient. The guideline does not however stop GPs referring patients to secondary care for help with menopausal symptom management through Advice & Guidance. The guideline includes recommended products for prescribing, managing adverse effects and further information for clinicians and patients.

UK Health Security Agency recommendations

Group A Steptococcus in children - Interim clinical guidance summary

Developed by the NHS England Group A Streptococcus (GAS) Clinical Reference Group and UKHSA Incident Management Team. It is endorsed by Royal College of General Practitioners (RCGP), Royal Pharmaceutical Society (RPS), Royal College of Paediatrics and Child Health (RCPCH) and the National Institute for Health and Care Excellence (NICE). This interim clinical guidance update is aimed at clinicians involved in the diagnosis and treatment of children up to the age of 18 year. Health care professionals are asked to have a low threshold to consider and empirically prescribe antibiotics to children presenting with features of GAS infection, including when the presentation may be secondary to viral respiratory illness. Clinicians in primary care should maintain a low threshold for prompt referral to secondary care of any children presenting with persistent or worsening symptoms.

Rabies vaccine provision for post-exposure treatment - Stock holding arrangements

- UHDB hold 4 vials
- CRHFT – do not hold vaccine on site
- DHU – do not hold vaccine on site

MHRA NOTICES

Dupilumab (Dupixent▼): risk of ocular adverse reactions and need for prompt management. New onset or worsening ocular symptoms require prompt review.

Influenza season 22/23: use of antiviral medicines. Prescribers working in primary care may now prescribe, and community pharmacists may now supply antiviral medicines (oseltamivir and zanamivir) for the prophylaxis and treatment of influenza at NHS expense.

Guideline Group key messages – traffic light amendments

Parecoxib – RED. Accepted by UHDB DTC as per palliative care guideline

Combodart (dutasteride & tamsulosin) – **DNP.** Combodart is significantly more expensive than the individual components of dutasteride and tamsulosin or the generic combination capsule.

BioMonde Biobag Larval therapy – **RED**. Due to the ordering process and need to ensure viability of the larval therapy a limited list of pharmacies have been agreed to order and supply. Please see www.derbyshirelpc.org for more information.

Beclometasone & formoterol (Luforbec 200/6) inhaler - **GREEN** 1st line for patients requiring an MDI. Luforbec 200/6 MDI is cost effective alternative to Fostair 200/6 MDI for patients requiring an MDI.

Skin chapter - Flexitol 10% added as one of the cost-effective brands for urea 10% cream. Audavate RD replaces Betnovate RD as preferred choice for moderate potency topical steroid. Fluocinolone acetonide 0.00625% (Synalar 1 in 4 dilution) replaces Ultralanum Plain (discontinued) as an alternative when formulary choices unavailable. Audavate replaces Betnovate as preferred choice for potent steroid cream/ ointment. ClobaDerm added as preferred choice for very potent topical steroid. Remove Dovobet as preferred brand for combination calcipotriol/ betamethasone ointment and gel- cost effective to prescribe generally. Sunsense Ultra lotion removed from formulary as discontinued. Reminder- All new drug/ medical devices are not routinely recommended for use within the Derbyshire health economy until either a national (e.g., NICE) or local review via DTC has taken place.

Other minor changes - MSK formulary chapter- Remove Fenbid brand 10% ibuprofen gel as discontinued. Endocrine formulary chapter- under 'Testosterone preparations for male androgen deficiency' add link to shared care pathology guideline on testosterone deficiency in adult males. Crohn's disease high-cost drug algorithm updated to include week 10 dose.

Traffic light changes

Drug	Date considered	Decision	Details
Dexcom One	Dec 22	**GREY after Diabetes con/spec initiation**	GREY after diabetes consultant/specialist initiation within a Derbyshire diabetes service.
Icosapent ethyl	Dec 22	**GREY**	NICE TA805 with statin therapy for reducing the risk of cardiovascular events in people with raised triglycerides (1.7 mmol/L or above) and low-density lipoprotein cholesterol >1.04mmol/L and ≤ 2.60mmol/L.
Testosterone Gel	Dec 22	**GREEN**	For low sexual desire in postmenopausal women. See JAPC menopause guideline for further details
Empagliflozin	Dec 22	**GREEN**	Type 2 Diabetes without CKD Type 2 Diabetes with CKD
Dapagliflozin	Dec 22	**GREEN**	Type 2 Diabetes without CKD Type 2 Diabetes with CKD
Canagliflozin	Dec 22	**GREY**	Type 2 Diabetes without CKD Type 2 Diabetes with CKD
Ertugliflozin	Dec 22	**GREY**	Type 2 Diabetes without CKD
Semaglutide (SC)	Dec 22	**GREEN**	Subcut weekly GLP1
Dulaglutide	Dec 22	**GREEN**	Weekly GLP1
Exenatide	Dec 22	**GREY**	Weekly GLP1
Semaglutide (oral)	Dec 22	**GREY**	Oral daily GLP1
Ziconotide	Dec 22	**RED**	Intrathecal delivery for chronic cancer pain.
Rituximab	Dec 22	**RED**	Idiopathic Membranous Nephropathy in Adults. NHSE commissioned
Estetrol + drospirenone (Drovelis)	Dec 22	**DNP**	Oral contraceptive. Await clinician request
Lidocaine (*Lidbree*)	Dec 22	**DNP**	Topical anaesthesia for moderate acute pain during cervical and intrauterine procedures, in adults and adolescents aged ≥15 years. Await clinician request
Potassium citrate / Potassium bicarbonate (SR)	Dec 22	**DNP**	NICE TA838 - Slow-release potassium bicarbonate–potassium citrate for treating distal renal tubular acidosis. Terminated appraisal
Ruxolitinib	Dec 22	**DNP**	NICE TA839 - Ruxolitinib for treating acute graft versus host disease refractory to corticosteroids. Terminated appraisal

Ruxolitinib	Dec 22	**DNP**	NICE TA840 - Ruxolitinib for treating chronic graft versus host disease refractory to corticosteroids. Terminated appraisal
Carfilzomib	Dec 22	**DNP**	NICE TA841 - Carfilzomib with daratumumab and dexamethasone for treating relapsed or refractory multiple myeloma. Terminated appraisal
Tisagenlecleucel	Dec 22	**DNP**	NICE TA842 - Tisagenlecleucel for treating follicular lymphoma after 2 or more therapies. Terminated appraisal
Luspatercept	Dec 22	**DNP**	NICE TA843 - Luspatercept for treating anaemia caused by beta-thalassaemia. Terminated appraisal
Luspatercept	Dec 22	**DNP**	NICE TA844 - Luspatercept for treating anaemia caused by myelodysplastic syndromes. Terminated appraisal
Mepolizumab	Dec 22	**DNP**	NICE TA845 - Mepolizumab for treating eosinophilic granulomatosis with polyangiitis. Terminated appraisal
Mepolizumab	Dec 22	**DNP**	NICE TA846 - Mepolizumab for treating severe hypereosinophilic syndrome. Terminated appraisal
Mepolizumab	Dec 22	**DNP**	NICE TA847 - Mepolizumab for treating severe chronic rhinosinusitis with nasal polyps. Terminated appraisal

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.

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.
GREY*: 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.
Do Not Prescribe (DNP)*: 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