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

DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 10 December 2013

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Dutasteride	BROWN 2nd Line (intolerant or do not respond to finasteride)
Combodart	BROWN (if dustasteride is indicated and a combination product is needed to aid compliance)
Hux D3	GREEN (preferred cost effective first line in treatment of vitamin D deficiency)
Pro D3	GREEN 2nd line, allows flexible dosing or dosing in dysphagia
Dapoxetine	BLACK (other off-label treatment options available for premature ejaculation)
Indapamide 2.5mg	BROWN – Indapamide 2.5mg should only be continued in stable hypertensive patients. Where indapamide is being used clinicians may consider the cheaper MR formulation. For newly diagnosed hypertensives bendroflumethiazide is the preferred thiazide diuretic
Movocol Paediatric	GREEN as per CG 99
Ranibizumab as per TA298	RED
Bosutinib as per TA299	BLACK
Fluocinolone acetonide intravitreal implant as per TA301	RED
Canakinumab as per TA302	BLACK

Clinical Guideline

Vitamin D Deficiency
Varenicline
Antidepressants in Moderate and Severe Unipolar Depression

Shared Care Guideline

Degarelix for the treatment of adult male patients with advanced hormone dependent prostate cancer

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Email: slakahan.dhadli@southernderbyshireccg.nhs.uk

Disease Modifying Anti-Rheumatic Drugs – Extension of review date to April 2014

Non clinical guidelines
Prescribing specification 2014/15

Present:	
Derbyshire County Council	
Mrs S Qureshi	NICE Audit Pharmacist
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mr S Hulme	Director of Medicines Management
Dr I Tooley	GP
North Derbyshire CCG	
Dr C Emslie	GP
Dr D Fitzsimons	GP
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Hardwick CCG	
Dr T Parkin	GP
Derby Hospitals NHS Foundation Trust	
Mr C Newman	Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Trust	
Ms C Curry	Principal Pharmacist
In attendance	
Ms H Baxter Ms J Lee Mr A Thorpe	Pharmacist, Southern Derbyshire CCG Pharmacist, Southern Derbyshire CCG Derby City Council Public Health

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Item		Action
1.	**APOLOGIES**	
	Dr J Bell, Dr F Game, Dr M Henn, Mrs L Hunter, Dr C Shearer and Mr M Steward.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of conflict of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Jext. • Shared Care Low Molecular Weight Heparin. • JAPC Chair and Administration. • Future Chairing of JAPC.	
4.	**MINUTES OF JAPC MEETING HELD ON 12 NOVEMBER 2013**	
	The following amendments were made to the minutes of the meeting held on 12 November 2013: Traffic lights – Raloxifene – GREEN 2nd line Consultant Initiation for familial breast cancer where tamoxifen is poorly tolerated or considered inappropriate (in line with NICE CG164). Nitrofurantoin – There was some supporting evidence to suggest a creatinine clearance from 60 to 40ml/min may be preferred over the contraindication of 60ml/min creatinine clearance. Mr Shepherd highlighted the potential confusion which could be caused if conflicting advice is given in the British National Formulary and by JAPC. Dutasteride and Combodart - Mr Dhadli reported that prescribing requests to primary care have been received from secondary care to use dutasteride for the treatment of benign prostatic hyperplasia (BPH). RDH has both finasteride and dutasteride in their appropriate formulary chapter but the JAPC Derbyshire wide formulary includes finasteride only. Both dutasteride and Combodart (a combination product containing dutasteride) have not been assigned a traffic light classification. The annual costs in Derbyshire was £194,000 for 51,286 items of dutasteride 500mg, finasteride 5mg £75,000 for 34,875 items and Combodart (a combination treatment of dutasteride plus tamsulosin) £32,980 of 1,338 items. Mr Dhadli investigated the submission at RDH and discovered that the formulary inclusion made in 2007 was at a time when the cost differential between dutasteride and finasteride was small and it had been estimated ten new patients a year, and for use to continue in primary care. The evidence submitted at the time to the RDH Drugs and Therapeutic Committee had come from the SMC and London New Drugs Group who had recommended both dutasteride and finasteride, again at a time when the cost difference was small. A further review by RDH in 2010 then looked at the combination treatment of	

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	Combodart. Neither of these drugs had been submitted to JAPC. Dr Game confirmed that finasteride was also the first line choice in the south. Primary Care Management of Overactive Bladder - During discussion Mr Dhadli advised that NICE had recommended oxybutynin or tolterodine or darifenacin as first line options based on the probability of it being cost effective under the NICE threshold of £20,000- £30,000 per QALY with oxybutynin and tolterodine having the highest probability of clinical effectiveness. Due to the number of changes it was agreed that the revised November JAPC minutes would be circulated to JAPC members in order to be virtually agreed.	**SD**
5.	**MATTERS ARISING**	
a.	**Raloxifene** Mr Dhadli advised that raloxifene was also included in the treatment and prevention of postmenopausal osteoporosis guideline under NICE TA161 and should be classified accordingly as green.	
b.	**Metoclopramide** A statement regarding the use of metoclopramide in palliative care was tabled. JAPC agreed that, as the use of metoclopramide in palliative care was already off licence and previously recognised as standard practice by specialists in palliative care, then its use in palliative care could continue. A statement about this would be included in the bulletin and formulary. Mr Dhadli referred to the comments previously made by Dr Game concerning the use of metoclopramide first line for gastroparesis and informed JAPC that there had subsequently been a UKMI publication to primary care which indicated that domperidone had equivalent efficacy in reducing symptoms of gastroparesis. It was therefore suggested that for this indication domperidone be recommended as first line and metoclopramide second line where domperidone was contraindicated or poorly tolerated. Mr Newman would obtain the views of the RDH consultant gastroenterologists about this.	**CN**
c.	**Aspirin and PPI** Mr Dhadli reported that further feedback had been received from RDH and this would be included in the discussion at the next meeting of the Guidelines Group. The guideline would be brought to the February JAPC meeting.	**SD**
d.	**Dapagliflozin** Mr Hulme referred to the decision which had been made at the November JAPC meeting that dapagliflozin be re-classified from BROWN specialist initiation to Brown after specialist recommendation. Following discussion it was agreed that this decision should be retracted as there was not a valid reason for re-classification. **Agreed:** Dapagliflozin remains **BROWN** after specialist initiation. **Action:** The revised diabetes guidelines would be brought to the March 2014 JAPC meeting.	**SD** **SD**

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e.	**Nitrofurantoin** Mr Dhadli reported that Dr Diane Harris, primary care specialist antimicrobial pharmacist, had discussed the use of nitrofurantoin for urinary tract infections with the RDH and CRH microbiologists in the light of it being contraindicated in patients with <60 ml/min creatinine clearance based on the MHRA warning issued in August 2013. Dr Harris had reported that RDH were using nitrofurantoin in patients with a creatinine clearance of between 40 and 60 ml/min which is outside of the BNF and MHRA alert. Dr Harris had also indicated that eGFR was a poor predictor in the frail and elderly. The RDH Drugs and Therapeutic Antimicrobial Sub Group had agreed that nitrofurantoin could be used in primary care in accordance with the BNF recommendation on renal function. Dr Harris had also referrred to the reservations expressed by the Consultant Nephrologist about the use of trimethoprim compared to cefalexin in renal impaired patients. Mr Newman highlighted that nitrofurantoin was being used in RDH if creatinine clearance was 40-60 ml/min and its efficacy was being carefully monitored. **Agreed:** Nitrofurantoin should continue to be used in primary care for patients with renal impairment as per the BNF guidelines.	
6.	**NEW DRUG ASSESSMENTS/TRAFFIC LIGHT ADDITIONS**	
a.	**Dutasteride and Combodart** Mr Newman reported that Mr Thomas, RDH Consultant Urologist, had indicated that he wanted both agents to be available but with finasteride being the first line drug of choice. It was noted that Combodart was cheaper to use than separate agents if using dutasteride, but finasteride in combination with tamsulosin is cheaper than Combodart. **Agreed:** Finasteride classified as a **GREEN** drug. **Agreed:** Dutasteride classified as a **BROWN** second line drug. **Agreed:** Combodart classified as a **BROWN** drug to be used only if the dutasteride and tamsulosin needed to be used together.	**SD** **SD** **SD**
b.	**Dapoxetine** Mr Dhadli reported that dapoxetine was the first licensed treatment available in the UK to treat premature ejaculation (PE) in 18-64 year olds. Dapoxetine is a rapidly acting Selective Serotonin Re-Uptake Inhibitor (SSRI) which takes effect within one to two hours and can be taken one to three hours prior to sexual intercourse. There were other SSRIs which had been used off-label but these had longer onset of action to reach efficacy and required continuous daily dosing. The prevalence of PE varied due to a lack of an agreed definition, was the major common male dysfunction and could be unreported due to a lack of people who sought professional help or advice. Mr Dhadli outlined the evidence together with the primary endpoint of four of the studies which was average intravaginal ejaculatory latency time (IELT) measured using a stopwatch by participants or partners. One in ten patients had suffered headaches, nausea and dizziness and less than 1% had syncope. Discontinuation rates were 2% to 4% for 30mg and 5% to 10% for 60mg. There are other cheaper SSRIs available such as paroxetine and sertraline and the estimated cost of	

	dapoxetine for one million population in Derbyshire was £222,570. Mr Dhadli highlighted the lack of long term safety data beyond twenty-four weeks, the high prevalence rates which may be underestimated and whether this was a commissioning priority in the light of other PE treatment options being available. Dr Mott queried whether there was any demand for this product from the providers and was informed that there had been no specific requests. There was a planned publicity campaign by the manufacturer scheduled for January 2014. Mr Hulme stated that dapoxetine should be a low priority although GPs may receive requests to prescribe this. Mrs Needham commented that the European Association of Urology did not have dapoxetine as their first choice drug and suggested that this could be a source of information for GPs and that GPS would need prescribing guidance to help them manage requests for treatment. **Agreed:** Dapoxetine classified as a **BLACK** drug and information to be provided for GPs.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**<u>Vitamin D Deficiency</u>** Mr Dhadli stated that the current vitamin D guidance had been updated to reflect the wider range of treatment options available for vitamin D deficiency. The Guideline Group had recommended the use of Hux D3 as the preferred formulary choice for high dose colecalciferol based on the ease of availability, reduction in out of pocket expenses and suitability for special groups. Pro-D3 still remained an option for children and patients with swallowing difficulties. Mr Dhadli indicated the other changes which had been made to the guideline: • Change to the threshold treatment from less that 25 nmol/L to 30 nmol/L. • Addition of box on page 2 for vitamin D level >50 nmol/L. • Change of age groups on page 5 from previously 75s to over 65s. • Addition of Hux D3 and Pro D3 for children or patients with swallowing difficulties. • Inclusion of special groups. It was highlighted that additional costs had been incurred by the use of Pro D3 in the form of out of pocket expenses by some community pharmacies and that more products were coming to market all the time. **Agreed:** Hux D3 classified as a **GREEN** first line drug. **Agreed:** Pro D3 classified as a **GREEN** second line drug. **Agreed:** JAPC ratified the Vitamin D guideline with the agreed amendments.	**SD** **SD** **SD**
b.	**<u>Varenicline</u>** Mr Dhadli reported that the existing guideline for the use of varenicline had been updated in line with the MHRA safety advice. However the information about stopping treatment had been omitted and it was agreed that this should be put back in. **Agreed:** JAPC ratified the varenicline guideline with the inclusion of the	**SD**

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	information about stopping treatment.	**SD**
c.	**Antidepressants in Moderate and Severe Unipolar Depression** Dr Taylor reported that the existing guidelines had been updated to include the key recommendations for choice, cautions in use and strategies for optimising management where treatment had been ineffective. JAPC was informed that the MHRA had issued a warning in 2011 about dose-dependent QT prolongation associated with Citalopram. Post-marketing reports of QT prolongation and a subsequent QT study in 119 patients had assessed the effects of daily doses of 20mg and 60mg of Citalopram on the QT interval in adults. The guidance had been amended to indicate that patients on citalopram at high risk of QT prolongation, congenital long QT syndrome, higher risk of Torsades de Pointes or concomitant QT-prolonging medicines should be offered ECG or alternative treatment considered. Mr Dhadli highlighted the inclusion of a citalopram flow chart with maximum dose recommendations and queried whether this should be retained in the guidance. Discussion followed and it was agreed that the flowchart should be included in the guidance. **Agreed:** JAPC ratified the guidelines for the use of antidepressants in moderate and severe unipolar depresssion with the agreed amendments.	**SD**
8.	**SHARED CARE GUIDELINES**	
a.	**Degarelix** Dr Mott referred to previous consideration by JAPC of the shared care guideline for degarelix in the treatment of adult male patients with advanced hormone-dependent prostate cancer when it had been decided to assign a red classification and postpone a decision on the shared care until the implementation issues had been resolved by the Derbyshire CCGs. Dr Mott added that the main sticking point had been the requirement for monitoring and this has now been altered in the updated guideline. During discussion Mrs Needham commented that the section in the GP responsibilities which referred to when a patient missed his injection by more than two weeks an initiation dose of 240mg degarelix should be given should be clarified to indicate that this should be 2 injections of 120mg. Mr Hulme reported that a GP had queried who was responsible for calling patients in for PSA measuring to be undertaken by primary care. Dr Fitzsimons highlighted that the guidance referred to the monitoring of PSA by GPs but also indicated that patients should be referred back to secondary care if there was an increase in ILP or deterioration in renal impairment. **Action:** Mr Dhadli would amend the shared care guideline to clarify the dosing and remove some of the points section in the action to be taken section. **Agreed:** JAPC ratified the shared care guideline with the agreed amendments.	**SD** **SD**
b.	**Disease Modifying Anti-Rheumatic Drugs (DMARDs)** Mr Dhadli stated that it was proposed to extend the review date of the DMARDs Shared Care Guidelines by six months to April 2014 until the national guidance for rheumatology indications had been updated by the British Society for Rheumatology.	

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	Agreed: JAPC agreed to extend the review date of the DMARDs Shared Care Guidelines to April 2014.	**SD**
9.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of new drug launches, new drug formulations and drug discontinuations: Lubisprostone for chronic idiopathic and opioid induced constipation – It was agreed to wait for the publication of the NICE TA in 2014 or a request for its use by a clinician in secondary care. Drug discontinuations – Anexate (flumazenil), Broflex (trihexyphenidyl), Didronel (etidronate), Ortho-Gynest (estriol) and Pripsen. JAPC was advised that drug discontinuations were included in the newsletter and workplan.	
10.	**MISCELLANEOUS**	
a.	**<u>Indapamide 2.5mg Options Paper</u>** Mr Dhadli stated that JAPC currently endorsed two treatment pathways in the treatment of hypertensive patients: newly diagnosed patients with Ambulatory Blood Pressure Monitoring (ABPM) using NICE CG127 and newly diagnosed patients or continuation of treatment in stable patients diagnosed using Clinic Blood Pressure Monitoring (CBPM) using NICE CG34. The prices of the antihypertensive drugs had been looked at in the light of the updated NICE guidance. A decision had been made to use indapamide 2.5mg as the thiazide type drug and indapamide MR had been classified brown based on the 2011 drug tariff price of £3.17. Mr Dhadli highlighted that the cost per 28 days of indapamide 2.5mg had now increased from £0.96 to £13.98 although the price of indapamide MR had only slightly changed. Three options had therefore been proposed: • Continue with current formulary and treatment regimens. • Review the use of indapamide 2.5mg and allow 1.5mg MR formulation. • Stop indapamide and revert back to previous guidance that recommended bendroflumethiazide. Discussion followed and Mrs Needham advised that most practices continued to use bendroflumethiazide and that many practices had reported issues related to patients electrolytes on indapamide. Mr Hulme commented that it would be advantageous to continue to use bendroflumethiazide due to its effect on blood pressure lowering and highlighted that there was no consistent access in Southern Derbyshire to ABPM. **Agreed:** Bendroflumethiazide would continue to be the first line option for new patients and those who could not be controlled on indapamide. **Agreed:** JAPC agreed that indapamide was no longer a cost effective option. Patients currently on indapamide 2.5mg could continue treatment but for those patients whose blood pressure was stable and well controlled it may be an option to switch to the cheaper thiazide indapamide MR.	**SD**

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	Agreed: Indapamide 2.5mg classified as a **BROWN** drug.	**SD**
b.	**Prescribing Specification** Mrs Needham stated that some clarity had been requested by the North Prescribing Group concerning as to whether secondary care should counsel patients when their medication was recommended in an out-patients department and primary care is asked to initiate the medicine or whether this would need to be done by primary care; which could delay treatment as the patient may need an appointment Mr Hulme commented that it should be the provider's responsibility to ensure that the counselling was done although this would vary according to the type of drug. However ultimately the prescriber would be responsible for counselling the patient unless primary care received documentary evidence that counselling had already been provided. **Agreed:** The existing reference to counselling in the prescribing specification would be retained.	**SD**
c.	**Constipation in Children Guideline** Dr Mott reported that constipation in children was in the top three common reasons for referral from primary to secondary care for children in Southern Derbyshire, so an audit had been undertaken about the prescribing of Movicol Paediatric. A new guideline for the management of idiopathic constipation in children and young people had been developed for use in Southern Derbyshire CCG and the Medicines Management Guideline Group had confirmed its alignment with NICE CG 99 and that the drug recommended in this guideline was in line with the local formulary recommendations. **Agreed:** JAPC agreed that it should be highlighted in the bulletin that movicol paediatric was the drug of choice in the treatment of constipation in children and young people.	**SD**
d.	**Midlands Therapeutic Review and Advisory Committee (MTRAC) Reviews** Mr Dhadli commented on the MTRAC reviews on nalmefene for alcohol dependence and melatonin for the treatment of primary insomnia. Nalmefene – JAPC had classified this as a red drug in July 2013 and MTRAC had referred to studies which had concluded that the evidence for its efficacy was not well established. Mr Dhadli highlighted how this type of advice could be conveyed to public health. Melatonin – This had been discussed by the RDH Drugs and Therapeutic Committee and had been the subject of three randomised placebo trials two of which showed that PR-melatonin shortened sleep latency times by nine and fifteen minutes respectively more than placebo. Mr Dhadli highlighted that some adverse affects of melatonin included loss of consciousness and falls and that it was currently classified as black for adults.	
11.	**JAPC BULLETIN**	
	Mr Dhadli highlighted that the raloxifene and tamoxifen section had been amended to read 'GPs may be requested to continue prescribing these licensed drugs for a small number of patients for a period of up to five years following	

	consultant initiation.' It was agreed that the reference in appendix 2 of the prescribing specification 'Medicines optimisation ensures people obtain the best possible outcomes from their medicines while minimising the risk of harm. Medicines optimisation requires evidence-informed decision making about medicines, involving effective patient engagement and professional collaboration to provide an individualised, person-centred approach to medicines use, within the available resources' be added to the prescribing specification section of the Bulletin.	**SD**
12.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for November 2013 was noted. Mr Dhadli highlighted the following: • Antiepileptic drugs have been divided into three risk-based categories to help healthcare professionals decide whether it is necessary to maintain continuity of supply of a specific manufacturer's product. The three categories based on therapeutic index, solubility and absorption are: Category 1 – Prescribers are advised to maintain their patients on a specific manufacturer's product. This should be prescribed either by specifying a brand name or by using the generic drug name. The two drugs recommended in this category in the local formulary were phenytoin and carbamazepine. Category 2 – The need for continued supply of a particular manufacturer's product should be based on clinical judgement and consultation taking into account facts such as seizure frequency and treatment history. Category 3 – Usually unnecessary to ensure that patients are maintained on a specific manufacturer's product unless there were specific reasons to do so. In addition the MHRA would propose a change of BNF wording and there would be some regulatory changes on product naming own-label suppliers. This would be picked up via the team meetings. • There was a special reminder about sodium valproate and the risk of neurodevelopmental delay in children following maternal use. Sodium valproate should not be used in pregnancy unless there was no effective alternative. • Short-acting agonists: restricted use for tocolysis in premature labour. • Cabazitaxel: risk of medication error resulting in overdose. • Strengthened warnings on risk of neuropsychiatric side effects of mefloquine. • Risperidone and paliperidone: risk of intraoperative floppy iris syndrome in patients undergoing cataract surgery.	
13.	**NICE SUMMARY**	
	Mrs Qureshi and Mr Dhadli informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in November: CG 173 Neuropathic pain – pharmacological management. The pharmacological management of neuropathic pain in adults in non-specialist settings.	

	Mr Dhadli outlined the differences between NICE CG 173 and the local guidance: • Definitions given of non specialist settings and specialist pain services. • NICE had recommended amitripyline, duloxetine, gabapentin or pregabalin as initial treatments for neuropathic pain together with carbamazepine for trigeminal neuralgia. • NICE had stated that tramadol should only be used for short term use if rescue therapy was required and capsaicin cream for people with localised neuropathic pain who wished to avoid or could not tolerate oral treatments. • A list of all the drugs that should not be used in a non-specialist centre such as morphine, topiramate and lamotrigine. • The local guidance recommended tricyclic antidepressants of amitriptyline (nortiptyline if intolerant to amitriptylline) and imipramine (if intolerant to amitriptyline). • The anti-convulsants recommended in the local guidance were gabapentin and carbamazepine. • The economic model had suggested that pregabalin and duloxetine were poor value for money in comparison to gabapentin and amitriptyline. The NICE Guideline Development Group (GDG) could not support either option for the initial treatment of neuropathic pain but when compared to placebo both were a viable option from a health economic point of view. • NICE had indicated that the mean costs per QALY of morphine and tramadol were good value for the NHS but had highlighted the potential for long-term adverse effects and dependency. Tramadol was considered to be a safer option than morphine in a non-specialist setting but estimates may be imprecise due to small numbers, short duration of studies and high withdrawal rates of adverse effects. • A MTRAC review had concluded that lidocaine medicated plaster was poor value for money and had weaker evidence. • Local guidance allowed combination treatments. The GDG had made no recommendation but suggested that this may be more practical and effective than switching to a new treatment and could potentially reduce side effects of a particular drug through using combinations of lower dosages. Mr Dhadli advised JAPC that the local guidance aligned to the NICE CG for the most part although there could be some minor amendments in relation to titration. It was also confirmed that the local guidance also allowed patients to be referred soon after a short course of low dose of tramadol and to initiate patients on morphine. Mr Dhadli would update the local guidance. CG 172 Secondary prevention in primary and secondary care for patients following a myocardial infarction (MI). Mr Dhadli reported that NICE had recommended a review of cardiac rehabilitation services, highlighted the importance of communication between primary and secondary care and offered advice on the management of new patients, management of patients with a history of MI, appropriate titration and use of combined antiplatelets and anticoagulants. The Guideline Group would consider whether there should be a flowchart for the management of patients after MI and report back to JAPC.	**SD**

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	TA 298 Ranibizumab for treating choroidal neovascularisation associated. With pathological myopia. Ranibizumab classified as a **RED** drug. TA 299 Bosutinib for previously treated chronic myeloid leukaemia. Bosutinib classified as a **BLACK** drug. TA 300 Peginterferon alfa and ribavirin for treating chronic hepatitis C in children and young people. Peginterferon alfa and ribavirin classified as a **RED** drug. TA 301 Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema after an inadequate response to prior therapy. Fluocinolone acetonide intravitreal implant re-classified as a **RED** drug. The CCGs would be notified that there is a patient access scheme and the prices would be discounted. TA 302 Canakinumab for treating systemic juvenile idiopathic arthritis (terminated appraisal). Canakinumab classified as a **BLACK** drug.	**SD** **SD** **SD** **SD** **SD** **SQ** **SD**
14.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Dutasteride – BROWN Combodart – BROWN Dapoxetine – BLACK Hux D3 – GREEN 1st line Pro D3 – GREEN 2nd line Indapamide 2.5mg – BROWN Movocol Paediatric – GREEN Ranibizumab – BLACK Bosutinib – BLACK Peginterferon alfa and ribavirin – RED Fluocinolone acetonide intravitreal implant - RED Canakinumab – BLACK	
15.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Shared Care Disulfiram – Guidance currently being updated in line with JAPC recommendations. Actinic Prescribing – Awaiting response from consultant dermatologists. Rivaroxaban – Mrs Needham would be meeting with Mrs Anne Hayes and a DVT pathway would be brought to JAPC when ready. Rifaxamin for HE – NICE guidance expected in January 2014. Diabetes Guidelines – To come to JAPC in March 2014. Lisdexamfetamine – This had been done.	

	Lixisenatide – The review would be completed by October 2014. Metoclopramide – This would be taken off. Nitrofurantoin – To be taken off. NSAID + PPI Protection – A review of recommendations to be presented in January 2014. Myocardial Infarction – Guideline/flowchart to be developed.	**SD** **SD** **SD** **SD**
16.	**GUIDELINE GROUP ACTION TRACKER**	
	The Guideline Group action tracker was ratified by JAPC.	
17.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Burton Drugs and Therapy Committee (draft) – November 2013. • Sheffield Prescribing Group (final) – October 2013.	
18.	**ANY OTHER BUSINESS**	
a.	**<u>Jext</u>** Mr Hulme referred to a CAS alert concerning a Class 2 medicines recall for Jext 150mcg adrenaline solution for injection in pre-filled pen and Jext 300mcg adrenaline solution for injection in pre-filled pen. Mr Hulme added that the alternative temporary option was Epipen which would have some training and financial implications for primary care. The CAS alert would be sent out to GPs by the two Medicines Management Teams. JAPC highlighted concern about the delay in sending out the 48 hours alert by the NHS England Local Area Team and the process for dealing with CAS alerts. Mr Hulme would draft a letter to be sent to the Area Team to be signed by Dr Mott.	**SD/KN** **SH**
b.	**<u>Shared Care Low Molecular Weight Heparin</u>** Mr Dhadli referred to a letter from a GP which had highlighted the importance of the communication that the primary care providers would like from the providers when they recommended shared care.	
c.	**<u>JAPC Chair and Administration</u>** JAPC noted that Dr Bell had now retired as JAPC Chair and expressed formal thanks to her. JAPC also noted that Mr Thorpe would no longer be servicing the meetings and thanks were expressed to him.	
d.	**<u>Future Chairing of JAPC</u>** Dr Mott reported that a paper on the future arrangements, including the future Chair for JAPC, would be discussed by the Derbyshire CCG Chairs/Chief Executives 4 + 4 Group at its meeting next week - this would include future support and chairing of the JAPC. Mr Hulme would be attending this meeting and would report back to the January meeting. JAPC agreed to recommend Dr Mott as JAPC Chair.	**SH**

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Tel: 01332 868781
Email: slakahan.dhadli@southernderbyshireccg.nhs.uk

19.	DATE OF NEXT MEETING	
	Tuesday, 14 January 2014 in the Coney Green Business Centre, South Normanton.	