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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 9 December 2014

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Jaydess	GREEN commissioned in line with advice from Public Health for contraception
DuoResp Spiromax	GREEN 2nd line to Fostair for asthma and COPD
Otovent auto-inflation device	BLACK
Tiotropium Respimat	BROWN specialist initiation following review of effectiveness for asthma
Rivaroxaban	GREEN for VTE treatment in patients with substance misuse (first three weeks supply from hospital)
Alogliptin	GREEN 1st line gliptin choice
Linagliptin	GREEN 1st line choice to alogliptin for patients with renal and hepatic impairment.
Sitagliptin	BROWN exceptionality defined as intolerance to the preferred choices (alogliptin/linagliptin) or restricted by their licensing.
Saxagliptin	BROWN exceptionality defined as intolerance to the preferred choices (alogliptin/ linagliptin) or restricted by their licensing
Vildagliptin	BROWN by exceptionality defined as intolerance to the preferred choices (alogliptin/ linagliptin) or restricted by their licensing
Simoctocog alfa	RED
Triumeq	RED
Imatinib	RED as per NICE TA 326

Clinical Guidelines

Compression Hosiery
Oral Nutrition Supplementation
Oxygen

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Shared Care Guidelines

Denosumab
Substance Misuse (methadone, buprenorphine and naltrexone)
Rivaroxaban (for treating DVT in IV drug users removed from shared care agreement)

Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mr S Hulme	Director of Medicines Management
Mrs Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Mrs K Needham	Head of Medicines Management North (also representing Hardwick CCG)
Ms J Town	Head of Finance Commissioning
Hardwick CCG	
Erewash CCG	
Dr M Henn	GP
Derby City Council	
Derbyshire County Council	
Derby Hospitals NHS Foundation Trust	
Dr W Goddard	Chair - Drugs and Therapeutic Committee
Mr C Newman	Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Ms S Bassi	Chief Pharmacist (Int)
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Trust	
Mr M Steward	Head of Medicines Management
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr R Dewis, Dr D Fitzsimons, Mrs L Hunter and Dr T Parkin.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Meningitis B in asplenia • Pregabalin and aripiprazole – generic prescribing/indications	
4.	**MINUTES OF JAPC MEETING HELD ON 11 NOVEMBER 2014**	
	The minutes of the meeting held on 11 November 2014 were agreed as a correct record after the following amendments: Minutes of JAPC meeting held on 14 October 2014: Clinical Guidelines – 7 (a) Rheumatoid Arthritis Commissioning Algorithm – spelling of toclizumab to 'tocilizumab' Debrisoft – Amend to 'Mr Steward would request the TVNs to undertake this audit. Mr Dhadli made reference to the NICE review recalling that cost effectiveness was demonstrated for not more than ten applications and suggested that this would be advisable to include in the formulary. Agreed: 'Debrisoft re-classified as BROWN specialist recommendation from RED for use by TVNs for the specified wounds to include guidance on treatment length. Not cost effective if more than 10 applications are needed.' Pentosan Polysulfate – Amend to 'Pentosan Polysulfate classified as a **RED** drug because of the need for specialist assessment.'	
5.	**MATTERS ARISING**	
a.	**<u>Gender Dysphoria</u>** Mr Dhadli reported that a letter had been sent to the Nottingham Area Prescribing Committee to ascertain how gender dysphoria clinics were commissioned and the shared role and responsibilities of primary care clinicians. Mr Dhadli had been informed that the service was commissioned by NHS England and been referred to the March 2014 NHS England Specialised Circular on primary care responsibilities in relation to the prescribing and monitoring of hormone therapy for patients undergoing or having undergone gender dysphoria treatments together with Interim Gender Dysphoria Protocol and Service Guideline 2013/14. These documents referred to the take over by GPs of hormone prescribing and the need to follow the protocols contained in these documents. A further document by the Royal College of Psychiatrists 'Good practice guidelines for the assessment and treatment of adults with gender dysphoria ' outlined the off-licence monitoring of drug treatments. Mr Dhadli added that the JAPC cover sheet produced for this item would provide a useful guide for GPs. During discussion Dr Watkins stated that GPs may not feel confident with the prescribing of these drugs but it was acknowledged that the numbers would be small. Dr Henn commented that the guidelines were clear and should	

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	enable GPs to prescribe in a safe way although it was important that sufficient information was made available. Dr Mott highlighted that these were interim guidelines and should be included in the bulletin. However they were for information only and not being adopted by JAPC as these services are commissioned by NHS England. It was however unclear whether the service would continue to be commissioned by NHS England in the future.	
b.	**<u>Travel Vaccinations</u>** Mr Dhadli advised that JAPC had classified vaccines for Hepatitis B (single agent), Meningitis A, C, W and Y (quadrivalent meningococcal meningitis vaccine), Yellow fever, Japanese B encephalitis, tick borne encephalitis and rabies as BLACK when indicated for travel. Queries had been raised about the ambiguity over the combined hepatitis A and B vaccination and whether exemptions applied such as the use of the Meningitis A, C, W and Y vaccine was permitted for Haj. Dr John Grenville, Secretary of Derbyshire Local Medical Committee, had been contacted for advice and a reply was awaited concerning the position regarding Hepatitis A and B. There was BMA guidance which referred to the three categories of travel vaccines - vaccines that must always be given as part of NHS provision through GMS Additional Services; vaccines that could not be given as an NHS service and vaccines that could be given as either NHS or as a private service. Mr Dhadli added that Dr Grenville had highlighted that, if CCGs or NHS England attempted to limit the discretion of practices with a high ethnic minority population to give Meningitis A, C, W and Y, for example people attending Haj, they might be challenged under the Equality Act. Dr Mott stated that if a private service was offered then the patient could be charged for this. However if given under the NHS the practices would be reimbursed for the vaccines but the practice nurse time to administer the vaccines would be included in the core contract. Meningitis A, C, W and Y is not commissioned for travel on the NHS. It was agreed that the decision made by JAPC at the November meeting to classify the specified travel vaccines as BLACK should remain unchanged as per BMA guidance, but decisions about implementation are for the CCG Prescribing Groups to discuss.	
c.	**<u>Phosphate Binders</u>** Mr Dhadli stated that phosphate binders had been re-classified from amber to GREEN specialist initiation at the November JAPC meeting and a prescribing information sheet developed accordingly as a shared care was no longer required. Mrs Needham highlighted that phosphate binders are classified as red in Sheffield and would not usually be prescribed in North Derbyshire. **Agreed:** North Derbyshire Prescribing Group to discuss further. **Agreed**: The information sheet would be amended to reflect the fact that it was not a shared care agreement.	**KN** **SD**
d.	**<u>Clozapine</u>** Dr Mott stated that it had been agreed at the November JAPC meeting that details of patients on clozapine should be conveyed to the relevant GP practices by DHcFT. Ms Bassi queried the timescale for the production of this	

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	list. It was agreed that the list should be produced by 31 March 2015.	**SB/ST**
e.	**Derbyshire Health United (DHU) PGDs – Governance for Updates** Mrs Needham reported that Dr Diane Harris had written a letter to indicate agreement with the use of the antibiotics for the indications of the PGDs and has approved minor adjustments. Mrs Needham would be meeting with Ms Lesley Harris, Senior Nurse Manager and Medicines Lead, to discuss the requirements for ongoing review and monitoring. The PGDs would be signed off shortly by DHU and authorised by the CCGs that commission services from DHU.	
f.	**Jaydess** Mr Dhadli stated that a commissioning guide had just been received from public health and would be placed on the website to assist with GP prescribing.	
g.	**Self-monitoring Anticoagulation** Mrs Qureshi reported that a response had been received from the Clinical Commissioning Policy Group that the use of point of care coagulometers was not encouraged. Mrs Needham advised that the use of patient own CoaguChek was approved for occasional use as part of the monitoring when GPs did the dose adjustment. However NICE had now recommended the use of CoaguChek and another meter when the patient performed the dose adjustment which differed to the current position. Mr Hulme highlighted the need to ascertain access to the use of machines. **Action:** The queries raised by JAPC would be conveyed to Ms Ann Hayes for the attention of the Clinical Commissioning Policy Group.	**SD**
6.	**NEW DRUG ASSESSMENTS**	
a.	**DuoResp Spiromax** Mr Dhadli reported that DuoResp Spiromax was a new formoterol/budesonide inhaler for use in adults with asthma or chronic obstructive pulmonary disease (COPD) where use of an inhaled corticosteroid and a long-acting beta2 agonist was appropriate. The breath-actuated dry powder inhaler was available in two strengths and acted in the same way as Symbicort. Mr Dhadli highlighted that DuoResp Spiromax was significantly cheaper. Dr Henn advised that the delivery of DuoResp Spiromax would be easier to use by some groups of patients such as the elderly. Mrs Needham commented that Fostair (beclomethasone/formoterol) could be administered via a spacer but this could not be done with Symbicort (budesonide/formoterol) or DuoResp Spiromax. **Agreed:** DuoResp Spiromax classified as a **GREEN** drug second line to Fostair. **Agreed:** The asthma guideline to be updated to reflect this decision and the references to Fostair MART and Symbicort SMART regimens to be removed from the algorithm and placed at the back of the guideline.	**SD** **SD/SQ**

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b.	**<u>Otovent</u>** Mr Dhadli stated that it had been agreed that all UKMI devices and drug reviews would be looked at by JAPC. The UKMI had published a review on an autoinflation device Otovent for the treatment of 'glue ear' or otitis media with effusion (OME). A Cochrane systematic review published in 2013 had reviewed trials that used standard treatment with and without autoinflation in children with OME. There had been eight trials, three of which had used the Otovent device, and there was no data on long term outcomes with the device. In addition a reasonable amount of dexterity and co-ordination was required to use it. **Agreed:** Otovent classified as a **BLACK** medical device due to the lack of patient outcome data.	**SD**
c.	**<u>Tiotropium Respimat for Asthma</u>** Mr Dhadli stated that Tiotropium Spiriva Respimat was indicated as an add-on maintenance bronchodilator treatment in stage four of the BTS guidance for adult patients with asthma who were currently treated with the maintenance combination of inhaled corticosteroids (≥800 mcg budesonide/day or equivalent) and long-acting beta-2 agonists and who had experienced one or more severe exacerbations in the previous year. Mr Dhadli referred to the number of treatment options and the evidence which had been given to support these. There was a statement to indicate that long-acting muscarinic antagonists appeared to be as effective as salmeterol in the short term and could be superior to doubling the dose of ICS in fixed airways obstruction. However longer term-studies were required to confirm this evidence. Mr Dhadli advised that a NICE medicines evidence commentary had been published in November 2012, although this was pre-licence and the BTS update. There may be a small and defined cohort of patients who may benefit but this may not apply to patients without airflow obstruction. The MHRA had highlighted cardiovascular safety concerns associated with tiotropium Respimat. Dr Mott commented that it was likely that those patients who had a little obstruction but were mainly asthmatic would be most likely to benefit. Dr Henn stated at step four most asthma patients should be under consultant follow up and that a green classification would create a risk that it could be used in primary care to treat uncontrolled breathlessness in patients who were already on asthma or COPD treatments. **Agreed:** Tiotropium for asthma classified as a **BROWN** drug with specialist/consultant assessment and initiation.	**SD**
d.	**<u>Umeclidinium and Vilanterol Combination Inhaler</u>** Mr Dhadli advised that JAPC had assigned a traffic light classification of BLACK in October 2014 and a NICE New Medicines Evidence Summary had now been published which referred to the limited evidence on patient-orientated outcomes such as shortness of breath, quality of life outcomes or exacerbation rates.	

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7.	**CLINICAL GUIDELINES**	
a.	**Antimicrobial Guidelines** Mr Dhadli stated that Dr Diane Harris had now included new amendments to the antimicrobial guidelines in the light of updated Public Health England guidance, the September 2014 MHRA alert regarding changes to the use of nitrofurantoin in renal impairment and the recently published NICE guidance on pneumonia. These changes included: • Inclusion of C-Reactive Protein (CRP) as an indicator. • Increases to doses of penicillin V and erythromycin in line with BNF doses. • Details have been added about cranberry products. • Duration of co-amoxiclav had changed to seven days for acute pyelonephritis. • Trimethoprim added as a third line treatment option for acute pyelonephritis, if sensitive on report. • Further details added regarding monitoring nitrofurantoin for adverse/side effects. • Choloramphenicol details added and now in line with BNF recommendations. • Addition of topical fusidic acid for very localised impetigo. • Doses of metronidazole for bites. • 'Smiley Faces' on the Public Health England guidance were no longer linked to the BNF details for doses – this is being clarified with Public Health England. • Replacement of erythromycin for adults with clarithromycin due to cost. • Nitrofurantoin considered first line treatment by Public Health England for uncomplicated UTIs in men and non-pregnant women due to increased resistance to trimethoprim. In connection with the guideline for the management of lower UTI in Chronic Kidney Disease it was queried whether the antibiotic dose could be changed, if sensitivities allowed, to go from nitrofurantoin to trimethoprim rather than straight to pivmecillinam. It was noted that more detail was required as to why Dr Harris had indicated that patients with eGFR of 30 to 44 was stated as contraindicated when the MHRA indicated that this was not the case. Dr Mott highlighted the recommendation by Dr Harris to remove doses of erythromycin for adults from the guidelines and only include clarithromycin due to better tolerance although the BNF advised that the latter should be avoided in pregnancy and breast feeding. It had been proposed that doses of erythromycin would be retained in the guidance for children – this was agreed. Dr Henn queried the inconsistency between the inclusion of the immediate release preparation of nitrofurantoin in the guidance for recurrent UTIs and the modified release preparation in the antimicrobial guidelines. **Action:** Mr Dhadli would clarify the queries which had been made with Dr Harris and the guidelines would be brought back to a future JAPC meeting.	**SD**

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b.	**Compression Hosiery** Mr Dhadli advised that this guideline had been produced in May 2014 and subsequently been reviewed by specialists from DCHS, CRH and RDH. Some changes had been requested which mainly concerned when the use of a Doppler was necessary and which types could be used. Dr Mott highlighted the section in the guideline which referred to arterial insufficiency should be investigated further by the vascular team to ensure adequate circulation which may not be clinically appropriate for very old and frail people. It was agreed that this be changed to 'as clinically appropriate.' **Agreed:** JAPC ratified the compression hosiery guideline with the agreed amendment.	**SD**
c.	**Nasal Polyps** Mr Dhadli stated that CRH ENTspecialists had updated an old North Derbyshire GP nasal polyp clinical guideline which now highlighted the position of Flixonase nasules in the treatment of nasal polyps. Mr Shepherd commented that it was intended to introduce Flixonase nasules in CRH in line with the guideline and Dr Goddard would contact relevant specialists about the position at RDH. This guideline will then be discussed again at JAPC.	**WG** **SD**
d.	**Oral Nutritional Supplements (ONS)** Mr Dhadli reported that the existing guidance had been updated in consultation with the dietitians at RDH and CRH. During discussion the following amendments to the guideline were agreed: • Appendix 3 Nutricia Ready-made Products – Amend to 'Ready-made Products' and the products would be listed in order of cost effectiveness. • Add Aymes Shake to the flowchart and Aymes Complete to the ready-made products in Appendix 3. • Appendix 3 'Prescriptions should be for 'mixed flavours' to ensure that patients get flavours they like from the dispensing pharmacist' – Amend to 'variety of flavours'. **Agreed:** JAPC ratified the Oral Nutritional Supplements guideline with the agreed amendments.	**SD**
e.	**Oxygen** Mr Dhadli reported that the existing guidance had been discussed by the Guideline Group who had highlighted that the pathway for patients requiring Home Oxygen Prescription provided most of the information which GPs would need to know. Dr Watkins queried the written consent required and was informed that this was not obligatory. Mr Hulme asked whether there were any assurances that the long term patients were being monitored and was informed that records of these patients were maintained by the Home Oxygen Service and review letters sent out regularly. **Agreed:** JAPC ratified the updated Oxygen guideline.	**SD**

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f.	**Lipids** Dr Dhadli reported that the local lipid modification guidance has been updated to reflect the national recommendations contained in NICE CG 181 issued in July 2014. The guidance has been circulated to both acute trusts and the medicines management teams for comment. The guideline group had also commented on the contents of the guidance. JAPC noted that the guidance would lead to a significant increase in the use of atorvastatin 80mg. Dr Mott queried the timescale for setting up the reporting system for non-HDL-C by both Derbyshire laboratories which was not currently done. Mr Dhadli would check on the progress with this and the proposed replacement suggested by Dr Masters from CRH. Mr Dhadli added that it would be useful to obtain comments on the use of fibrates, nicotinic acid, bile acid sequestrants and omega-3 fatty acid compounds, the recommendation not to use rosuvastatin, except for Familial hypercholesterolaemia, and the inclusion in the local guidance of simvastatin. **Action:** Comments on the guidelines to be conveyed to Mrs Qureshi by 10th January 2015.	**SD** **All members**
9.	**SHARED CARE GUIDELINES**	
a.	**ACHEi and Memantine** Mr Dhadli reported that the shared care agreement for drug treatments in Alzheimer's Disease (AD) had been discussed at DHcFT and changes had been proposed for the two main areas of initiation and continuation of treatment by Dr Mark Whittingham, DHcFT Consultant Psychiatrist/Associate Clinical Director. It had now been suggested that these patients should no longer be the subject of a shared care agreement and instead reviewed at the end of the three month period of initiation and a decision made as to whether on-going specialist monitoring was required. A cognitive function test as recommended by NICE was proposed as no longer being required. A global test could be done in primary care. Mr Dhadli commented that a prescribing guideline should be produced for all the AD drug treatments together with a guideline as to how these patients could be discharged from DHcFT. During discussion Dr Mott advised that there was not a clinical need for shared care, as no specific monitoring is required, and the issue was whether primary care was the correct setting for the care of these patients. However if primary care took on this role a great deal of support and infrastructure would need to be commissioned. The mental health commissioners and DHcFT would need to determine the service required and how this would be funded. Mr Dhadli would convey these comments to Dr Taylor and Beverley Thompson at DHcFT and with the lead commissioners (Hardwick CCG).	**SD**
b.	**Cinacalcet** Mr Shepherd reported that a joint proposal had been developed by the CRH and RDH endocrinologists for the treatment of acute hypocalcaemia due to primary hyperparathyroidism, when parathyroidectomy was contraindicated or not clinically appropriate, in order to avoid the need for further admission to	

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	hospital or the treatment of hypercalcaemia in patients who were significantly symptomatic and awaited surgery. Once the patient was stable and responding a shared care would be initiated either on an on-going basis or when a date had been agreed for surgery. Dr Goddard reported that RDH was undertaking a re-audit and the results of this would be available in January/February. During discussion Mr Dhadli referred to the DTB review which had acknowledged that surgery was the first choice for the vast majority of patients. In the case of the patients who could not undergo surgery cinacalcet and alondronate were the choice of drugs for the reduction of serum calcium levels. The shared care agreement referred to the monitoring of serum calcium to be carried out every two months but the SPC stated that once stabilised after titration the maximum dose this should be periodically monitored. There was an apparent inconsistency in the shared care in that GPs would monitor serum calcium every two months and consultants would make the arrangements for three to four monthly monitoring of PTH and bone profile in secondary care once a stable dose was established. This may depend on the frequency of patient visits. Mrs Needham queried whether advice also needed to given in the GP responsibilities section in the event of an occurrence of hypercalceamia. The inconsistency about dosing in the shared care was also highlighted. Dr Watkins commented on the potential increased workload for GPs despite the small numbers of patients and Mr Steward pointed out the lack of an appendix one. **Agreed:** Mr Dhadli would compile a list of the queries to be resolved prior to reviewing this document at the next JAPC meeting.	**SD**
c.	**<u>Denosumab</u>** Mr Dhadli stated that this was an update to an existing shared care guideline for the prevention of osteoporotic fractures in post-menopausal women. The changes included a change of wording from consultant to specialist to reflect the fact that specialist nurses also administered denosumab. The MHRA advice about monitoring for hypercalcaemia had been added and Chesterfield Royal Hospital included in the shared care agreement. Mr Newman queried the inclusion of men in the shared care agreement. It was agreed that men were not included in the shared care and that it was only for women as per the NICE guidance. A further query concerned the recommendation that risedronate should also be tried before denosumab was considered in the prescribed indications. This would be amended to indicate when practicable unless contrainidicated. **Agreed:** JAPC ratified the denosumab shared care guideline with the agreed amendments.	**SD** **SD**
d.	**<u>Rivaroxaban</u>** Dr Mott referred to the shared care for rivaroxaban for the treatment of VTE in IV drug users which was now obsolete due to the extension of the use of the	

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	drug into other clinical areas together with increased clinical experience. RDH DTC had discussed its use first line for low risk uncomplicated venous thromboembolism (VTE) but this had not yet been assigned a green traffic light classification by JAPC (with exceptions of long term LMWH or IV drug user groups). Dr Henn asked whether there was any intention to undertake county-wide work to allow GPs to use rivaroxaban rather than having to use heparin via injection when DVT was suspected but not yet proven. Dr Henn added that a firmer commitment to patient education would be needed due to poor long-term compliance by patients and referred to the short half-life of the Novel Oral anticoagulant drugs. Dr Mott highlighted the challenge presented by the large variety of health professionals who initiated these drugs and the issue to be addressed of patient compliance. **Agreed:** The shared care agreement for rivaroxaban use in IV drug users for the treatment of VTE would be taken off the list. Paper needed about the use of rivaroxaban/NOACs for uncomplicated DVT. **Agreed:** JAPC classified rivaroxaban as a **GREEN** drug for VTE treatment in substance misuse patients (three weeks supply).	**SD** **SD**
e.	**Substance Misuse** Dr Mott stated that it should be made clear that the shared care for substance misuse should only be used by GPs within the locally enhanced service (LES) and General Practitioners with a special interest (GPSI) in drug misuse. In connection with the methadone shared care agreement, Mr Newman suggested that the section about the need for pharmacists to share relevant information with prescribers and specialist drug services when there were concerns for the safety and welfare of service user and others should be reinforced to include a reference to children in the household due to recent issues concerning safeguarding – this was agreed. **Agreed:** JAPC ratified the substance misuse shared care agreements with the agreed change to the methadone shared care agreement.	**SD**
10.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and licence extensions. Horizon Scan Monthly Action Plan New Drug Launches in the UK: Simoctocog alfa (Nuwiq) – Classified as **RED** Umeclidinium (Incruse) – Evidence summary: new medicine expected from NICE January 2015. New Formulations: Canagliflozin + metformin IR (Vokanamet) – To be classified as BROWN until the black drug review was carried out. Dolutegravir + abacavir + lamivudine (Triumeq) – Classified as **RED** Misoprostol (Mysodelle) - Leave unclassified and await clinician request	

Item		Action
	Licence Extensions: Rivaroxaban (Xarelto) – Await NICE TA which was expected in March 2015.	
11.	**MISCELLANEOUS**	
a.	**Alogliptin** Mr Dhadli advised that JAPC had previously reviewed all the gliptin drugs and concluded that they all had similar efficacy and patient outcomes. The diabetologists had been consulted as to their drug preference and had recommended that sitagliptin should be first line drug of choice followed by linagliptin as an alternative first line gliptin for patients with renal and hepatic impairment. However MTRAC had subsequently produced a review which indicated that all the gliptins had similar efficacy and PRESQiPP had recently published resource on alogliptin. Mr Dhadli highlighted that alogliptin was the cheapest DDP-4 inhibitor and had previously been assigned a GREEN traffic light classification. There was now a need to decide whether alogliptin should be re-positioned in the traffic light formulary. **Agreed:** Alogliptin classified as **GREEN 1st line** glipitin choice. **Agreed:** Linagliptin classified as **GREEN 2nd line** gliptin for patients with renal and hepatic impairment. **Agreed:** Sitagliptin, saxagliptin and vildagliptin classified as **BROWN** drugs when alogliptin and linagliptin are not licensed or tolerated.	**SD** **SD** **SD**
b.	**Prescribing Specification** Mr Dhadli advised JAPC that the amendments had been included in the prescribing specification and that an appendix review would be added by Mr Hulme and Mrs Needham. **Agreed:** JAPC ratified the updated Prescribing Specification.	**SH/KN** **SD**
12.	**JAPC BULLETIN**	
	The following amendments were agreed: Travel vaccines section – Amended to read 'Clarification whether the combination hepatitis A and B vaccine is prescribe-able on the NHS is being determined in consultation with the Local Medical Committee.' Debrisoft – Amended to read: 'Debrisoft re-classified as BROWN specialist recommendation from RED for use by TVNs for the specified wounds to include guidance on treatment length. Not cost effective if more than 10 applications are needed.' The amended JAPC bulletin was ratified.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Update for November 2014 was noted. Mr Dhadli highlighted the following:	

Item		Action
	• Desiccants in blister packs: reminder of risk of ingestion.	
14.	**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 2014. TA323 Erythropoiesis-stimulating agents (epoetin and darbepoetin) for treating anaemia in people with cancer having chemotherapy (including review of TA142) – This was an update of the previous NICE TA 142 and had been assigned a traffic light classification of red. However the agents were now recommended for anaemia in patients receiving chemotherapy and commissioned by CCGs. There was some confusion as to whether the costs of these drugs would be within tariff and therefore picked up by the Acute Trust or by NHS England. Mrs Qureshi would confirm whether these drugs were commissioned by the CCGs or by NHS England. TA324 Dual-chamber pacemakers for symptomatic bradycardia due to sick sinus syndrome without atrioventricular block (part review of technology appraisal guidance 88) – The NICE costing templates stated that this would be commissioned by CCGs but a significant impact on resources was not anticipated. TA325 Nalmefene for reducing alcohol consumption in people with alcohol Dependence – This was commissioned by Public Health. Both City and County public health directorates had been requested to supply details as to how this would be commissioned. Dr Dewis from Derby City Public Health had stated that nalmefene should remain classified as RED for specialist use only to be used alongside behavioural interventions and not routinely available in primary care. TA326 Imatinib for the adjuvant treatment of gastrointestinal stromal tumours (review of NICE technology appraisal guidance 196) – Classified as RED.	**SQ**
15.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Jaydess – GREEN DuoResp Spiromax – GREEN 2nd line for asthma and COPD Otovent – BLACK Tiotropium Respimat – BROWN specialist initiation and review for asthma Rivaroxaban – GREEN for VTE treatment of substance misuse patients (three weeks supply) Alogliptin – GREEN first line Linagliptin – GREEN second line for renal and hepatic impairment Sitagliptin – BROWN Saxagliptin – BROWN Vildagliptin – BROWN Simoctocog alfa – RED Triumeq – RED Imatinib – RED as per NICE TA 326	

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Item		Action
16.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Lipid guidance – To be brought to the January JAPC meeting. Fluticasone propionate nasal drops (nasules) – To be brought to the January JAPC meeting Vigabatrin – To be brought to the January JAPC meeting. Nitrofurantoin – To be removed from the list.	**SD** **SD** **SD** **SD**
17.	**GUIDELINE GROUP**	
	The Guideline Group action progress summary was noted. Mr Dhadli highlighted the following: Insulin guideline – Insulin information had been added to the diabetes Type 2 guidance.	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Nottinghamshire Area Prescribing Committee Draft Minutes 18/09/14 • RDH Drugs and Therapeutic Committee Minutes 21/10/14 • CRH Drugs and Therapeutic Committee Minutes 18/11/14 Mr Dhadli highlighted that the Nottinghamshire APC meeting had discussed the proposed criteria for switching patients from dutasteride to finasteride in primary care which had been endorsed by clinicians. Nottinghamshire APC had also addressed the issue of the availability of medicines for gender dysphoria.	
19.	**ANY OTHER BUSINESS**	
	(a) Mr Dhadli referred to Bexsero vaccine for Meningitis B which JAPC had assigned a traffic light classification of black as it was not part of the routine vaccination schedule. Dr Vanessa McGregor, PHE Consultant in Communicable Disease Control, had been contacted and advice had been given that the vaccine should be GREEN for children and adults with asplenia and complement disorders for use in the management of meningococcal disease. This was included in the Green Book. (b) Mr Dhadli informed JAPC that pregabalin and aripiprazole patents have expired and it is anticipated that cheaper generics are likely to become available. The licenced indications of generics to the respective brands are not always the same. Mr Dhadli noted to JAPC that pregabalin (as Lyrica) has a protected licencing patent for neuropathic pain and that aripriprazole (as Ablify) was additionally licenced for bipolar disorder. Mr Dhadli referenced a National Prescribing Centre statement from 2009 with a similarly related scenario. A number of generic versions of clopidogrel which had been introduced to the UK market in response to Plavix patent expiry and included variation in approved licensing. Within the paper it was cited that if a licensed drug was used the liability rested with the manufacturer and the prescriber. However when prescribed off-licence the liability was with the prescriber and the dispenser. Mr Newman added that a national written	

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Item		Action
	statement had been requested from the Commercial Medicines Unit as the Regional Procurement pharmacist had confirmed that, when they were looking at commercial contracts, they did not look at licensed indications. The views of the Pain and Mental Health Consultants (in relation to aripiprazole) should also be sought if a Derbyshire wide statement was to be drafted.	
20.	**DATE OF NEXT MEETING**	
	Tuesday, 13th January 2015 at 1.30pm in the Post Mill Centre, South Normanton.	