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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on Tuesday 13 January 2015

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Para-aminosalicylic acid (GranuPAS)	RED
Insulin degludec + liraglutide (Xultophy)	BLACK
Peginterferon beta-1a (Plegridy)	RED
Sofosbuvir + ledipasvir (Harvoni)	RED
Darunavir (Prezista)	RED
Idelalisib	BLACK as per NICE TA 328

Clinical Guidelines

Amiodarone Monitoring Protocol
Antimicrobial Treatment
Management of recurrent UTIs in adult females – non pregnant
Management of emergency contraception with ulipristal acetate
Lipids Guideline

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mr S Hulme	Director of Medicines Management
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Dr C Emslie	GP
Dr D Fitzsimons	GP
Mrs K Needham	Head of Medicines Management (also representing Hardwick CCG)
Hardwick CCG	
Dr T Parkin	GP
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	
Dr S Taylor	Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Ms C Duffin	Senior 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**	
	Ms S Bassi, Dr R Dewis, Mrs L Hunter, Mr M Shepherd (sent deputy) and Ms J Town.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Alogliptin and sitagliptin • Denosumab Shared Care • Review of Black Drugs	
4.	**MINUTES OF JAPC MEETING HELD ON 9 DECEMBER 2014**	
	The minutes of the meeting held on 9 December 2014 were agreed as a correct record after the following amendments: Matters Arising: Travel Vaccinations – Delete 'This guidance stated that no charge could be levied to the CCGs for the supply of the vaccine for Meningitis A, C, W and Y but it could be provided privately.' Amend to read: 'Meningitis A, C, W and Y is not commissioned for travel on the NHS.' Otovent: Amend to 'Mr Dhadli stated that it had been agreed that all UKMI devices and drug reviews would be looked at by the JAPC'. Oral Nutritional Support (ONS) – Amend to 'Oral Nutritional Supplements.' ACHEi and Memantine – Amend to 'A cognitive function test as recommended by NICE was also proposed as a global test which 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.' Denosumab – Amend to 'The MHRA advice about monitoring for hypocalcaemia had been added and Chesterfield Royal Hospital included in the shared care agreement.' Rivaroxaban – Amend to: '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 other than for LMWH users and for IV drug users.' Alogliptin: Amend to 'Sitagliptin, saxagliptin and vildagliptin classified as BROWN drugs when alogliptin and linagliptin were not tolerated or due to licence. Any Other Business (b): Amend to: ' Mr Dhadli informed JAPC that pregabalin and aripriprazole 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	

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	pain and that aripriprazole (as Abilify) was additionally licenced for bipolar disorder.	
5.	**MATTERS ARISING**	
a.	**Travel Vaccinations** Dr Mott reported that the issue of payment for travel vaccinations for Hepatitis A and B and Meningitis ACWY had been discussed with Derbyshire Local Medical Committee (LMC). It had been agreed that the combined Hepatitis A and B vaccine could be supplied on the NHS. However Hepatitis B would not be supplied on the NHS if given alone and should therefore be classified as BLACK. The LMC had also agreed that Meningitis ACWY should be classified as black for travel and it had been proposed that the CCGs obtain legal advice about the implications of this from an equality point of view. It was agreed that Mr David Fagg, Equality Adviser from the Greater East Midlands Commissioning Unit be contacted to obtain his views on this and from PrescQIPP.	**SD**
b.	**Derbyshire Health United (DHU) Governance for Updating PGDs** JAPC was informed that DHU had now obtained the services of an external pharmacist and a committee had been established in order to improve their governance processes for PGDs.	
c.	**Self-monitoring Anticoagulation** Dr Mott reported that Ms Anne Hayes had advised that the queries raised by JAPC at the December 2014 meeting concerning point of care coagulometers would be discussed by the Clinical Commissioning Policy Group.	
6.	**NEW DRUG ASSESSMENTS**	
a.	**Evidence Reviews** Mr Dhadli referred JAPC to three new evidence reviews asking JAPC to reflect on past decisions: • DTB Review December 2014 on brimonidine gel for erythema caused by rosacea. JAPC had classified this at the May 2014 meeting as RED for the symptomatic treatment of facial erythema of rosacea in adults where quality of life is severely impaired by the rosacea, and alternative treatments are not suitable. • MTRAC review updated in December 2014 on Flutiform for asthma and this had been found to be of similar efficacy to a fluticasone/salmeterol inhaler in one fully published 12 week trial and at current prices the Flutiform 125 µg/5 µg and 250 µg/10 µg dose formulations were cheaper than the Seretide 125 and 250 Evohaler. JAPC had classified Flutiform as a BROWN drug because 1st and 2nd line steroid inhalers are more cost effective. • RDTC review in December 2014 on glyclopyrronium + indaceterol for the treatment of COPD stated that, until there was longer-term data on safety and evidence of clear patient-oriented advantages over alternatives, fixed-dose LAMA/LABA combination inhalers (including indacaterol/glycopyrronium) should be reserved for those patients who would otherwise be treated with both components given separately.	

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	JAPC reflected that these reviews were useful. No action required about past decisions.	
7.	**CLINICAL GUIDELINES**	
a.	**Amiodarone** Discussions followed and Mr Dhadli referred to the reference in appendix 3 in the light of recent NICE atrial fibrillation guidelines. The general use of amiodarone and its long term use is limited. The appendix offers practical advice to prescribers for reviewing the need for amiodarone, for example any patient who had been completely well for two years with no suggestion of recurrent VT should be referred to a cardiologist for review of the long-term need for amiodarone. Dr Mott commented that he believed that amiodarone should be considered to be under a shared care agreement. Mr Dhadli stated that this was an update of an existing monitoring guideline and referred to the position of other APCs on this. It was noted that many patients on amiodarone are stable and not under specialist care and therefore do not fall within the local definition of shared care. Mrs Needham queried whether the use of the drug and the blood monitoring requirements needed to be re-audited by the North and South Prescribing Groups. Mr Dhadli stated that the guidance had been updated with a few minor amendments and that the Guideline Group had queried whether appendix 1 concerning the amiodarone six monthly monitoring checklist was useful for primary care and should be retained. It was agreed that it should be retained for use in primary care. **Agreed:** JAPC ratified the amiodarone clinical guideline. CCG Prescribing groups to consider formal re-audit of adherence to the guidelines.	**KN/SM**
b.	**Antimicrobial Treatment Guidelines** Mr Dhadli reported that Dr Diane Harris, Southern Derbyshire Lead Antimicrobial Pharmacist, had made a number of amendments to the antimicrobial treatment guidelines following comments made at the December JAPC meeting. The following sections were highlighted: • Community Acquired Pneumonia (CAP) – Following NICE CG 191 pneumonia guideline Dr Harris had suggested that the C-Reactive Protein (CRP) test be used to guide and review patients. It was noted that this point of care test was not readily available in primary care locally and, due to impracticable time lag for the hospital to report, it was agreed that this be removed. There was also a reference to consideration of hospital assessment for scores of 2 or more. • Cranberry products – To be amended to refer to the limited evidence for the use of cranberry juice reflecting its inclusion in Public Health England 2014 Guidance. • Management of Lower UTI in CKD – To be amended to include the use of one drug as first line and others as second and third line options. • Management of Recurrent UTIs – A reference to nitrofurantoin as modified release preparation had been included. JAPC discussed in	

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	detail why local guidance had not included the use of nitrofurantoin in patients with eGFR 30-44ml/min. Consultant microbiologists across Derbyshire had been asked for their views. They saw the use of nitrofurantoin with an eGFR between 30 to 44ml/min by exception and this should not be included in a primary care guideline. The use of nitrofurantoin with an eGFR between 30-44ml/min would be in patients with proven multi-resistant organisms after a discussion with a microbiologist. **Agreed:** JAPC ratified the Antimicrobial Treatment Guidelines with the agreed amendments.	**SD**
c.	**<u>Management of Emergency Contraception with Ulipristal Acetate 30mg (ellaOne)</u>** Mr Dhadli reported that the existing guidance had been updated with comments received from Dr Jackie Abrahams, Dr Stephen Searle and Maureen Whittaker, Derbyshire County Council Associate Director of Public Health. The minor update included a change to the mid-cycle from seven days to six days to bring in line with the PGD. It was also agreed that the references to ellaOne should be replaced by Ulipristal Acetate (generic). **Agreed:** JAPC ratified the ulipristal acetate guideline	
d.	**<u>Lipids</u>** Mrs Qureshi tabled a late paper of the lipid modification guideline and requested comments. • Amend to: JAPC recognise there is marginal benefit of swapping existing patients on simvastatin or pravastatin to atorvastatin. • The switch from simvastatin or pravastatin to atorvastatin is a low priority for the CCGs. • Remove FH reference and signpost to a separate guideline. Mrs Qureshi referred to comments received from Dr Robert Robinson, CRH Consultant Endocrinologist, who had stated that Type 1 diabetic patients should be risk assessed and his practice would not be to always offer a statin to patients that had been diagnosed as type 1 early in life such as childhood. A ten year history would mean potentially putting adolescents on treatment irrespective of other risk factors. Discussion followed about risk assessments and the age that these should be undertaken. It was agreed to look back at the full NICE document and the strength of evidence. It was agreed that the guideline should be circulated to members for comment and confirmation. Comments should be conveyed to Mrs Qureshi or Mr Dhadli by 30 January 2015. If no comments were received the guideline would be agreed virtually by the group.	**SD/SQ All members**
8.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations and drug discontinuations:	

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	New Drug Launches in the UK: Para-aminosalicylic acid (GranuPAS) – Classified as **RED**[5] New Formulation Launches in the UK: Insulin degludec + liraglutide (Xultophy) – Classified as **BLACK**[4,6]Peginterferon beta-1a (Plegridy) – Classified as **RED**.[1,2] Posaconazole (Noxafil) – Drug already classified as **RED**. Sofosbuvir + ledipasvir (Harvoni) – Classified as **RED**[1,2] **(**NHSE) Darunavir (Prezista) – Classified as **RED**. [1,2] **(**NHSE)	
9.	**MISCELLANEOUS**	
a.	**Aspirin in Cancer** Mr Dhadli reported that in November 2014 NICE had published a medicines evidence commentary for "Aspirin: primary prevention of cancer and cardiovascular disease". A summary of the review was given which concluded that long-term prophylaxis with aspirin (five to ten years or longer) had net clinical benefits in the general population and that reduction in risk of fatal and non-fatal cancer and thromboembolic cardiovascular events outweighed the risk of fatal and non-fatal major bleeding. Mr Dhadli summarised that this added to the emerging evidence of a net benefit with aspirin but then highlighted the limitations of the study. JAPC did not advise commissioning on a population level and suggested further studies were needed. There were for example queries about the dosage and which age groups where aspirin therapy might be most efficacious. Mr Dhadli added that the Medicines Evidence Summary had concluded that the best option for healthcare professionals was to present the available evidence in an accessible way to the person seeking advice and encourage and support them to make that choice. This should include visual representation of the absolute risks and benefits as produced by the authors of the review. JAPC agreed that the use of aspirin for the prevention of cancer and cardiovascular disease should not be supported on a population level but that GPs would be able to discuss the risks and benefits with patients on an individual level. **Agreed:** JAPC noted the medicines evidence summary. A reference would be put in the newsletter and bulletin.	**SD**
b.	**Gender Dysphoria Position Statement** Mr Dhadli tabled a JAPC position statement to signpost GPs to resources and references that were relevant to gender dysphoria. The aim was to provide clarity to GPs on the roles and responsibilities of specialist providers within the gender dysphoria care pathway, and to encourage collaboration between GPs and specialists in the delivery of care for trans and gender-variant people. Mrs Needham queried the opening sentence with reference to an inequitable primary care service currently being offered to Derbyshire patients with gender dysphoria. It was agreed that this should be amended to reflect the current lack of clarity about gender dysphoria services.	
c.	**HIV Guidance on Non Anti-retroviral (ARV) Prescribing** Mr Dhadli reported that NHS England had released a Specialised Services Circular which contained advice from the HIV Clinical Reference Group (CRG)	

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	on which non ARV drugs could be reasonably prescribed by HIV specialised services and which should not. The document was noted as a useful reference by JAPC, but non- HIV prescribing was not felt to be an issue in Derbyshire.	
d.	**<u>Off Licence Prescribing of Pregabalin and Aripiprazole</u>** Mr Dhadli updated and reminded JAPC members on the patent expiry of Lyrica (pregabalin) for the indications of generalised anxiety disorder and epilepsy and for Abilify (aripiprazole) for schizophrenia. Mr Dhadli reported that Pfizer had sent a letter to the CCGs to alert them to patent infringement in relation to the generic prescribing of pregabalin for the protected patent of neuropathic pain. This issue had also been highlighted by some community pharmacists. JAPC discussed whether a statement was required to help prescribers understand the issues here. Discussion followed during which Mrs Needham proposed that a holding statement could be helpful. In connection with aripiprazole, which had a licensed indication for the treatment and recurrence prevention of mania, it was agreed that this was less of an urgent issue due to the smaller numbers involved. **Agreed:** Mr Dhadli would consider a position statement in two documents for pregabalin and aripiprazole. The pregabalin document would include a reference to the protected patent and licensed indications and that its place in therapy should be reviewed and stopped if necessary. The two papers would be brought back to the February JAPC meeting.	**SD**
10.	**JAPC BULLETIN**	
	The following amendments were agreed: Oral Nutritional Support (ONS) for adults – Amended to read Oral Nutritional Supplements (ONS) for adults. Denosumab for the prevention of osteoporotic fractures in post-menopausal women – existing shared care had been updated to include recent MHRA monitoring requirements of calcium and vitamin D levels. The denosumab shared care had been updated in the light of the MHRA advice about increased calcium monitoring and vitamin D pre-treatment doses. Mr Dhadli highlighted that the MHRA had only advised calcium levels and vitamin D levels at baseline and only calcium levels to be checked before each injection to ensure that they are within the normal range before administering the denosumab injection. MHRA had made no recommendation to measure vitamin D before each denosumab injection. Mr Dhadli had queried this with the specialist who had updated the shared care agreement. RDH rheumatology stated that many of the patients treated were elderly and often found to have sub-optimal vitamin D levels. In the event that vitamin levels were not at least 45 to 50nmol/L for patients being treated with denosumab there was a risk that they could become hypocalcaemic. JAPC agreed that both vitamin D and calcium monitoring should be included in the shared care guideline for denosumab. The shared care guideline would be updated accordingly.	**SD**

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	Gliptins – Addition to read practices should stop gliptins if HBA1c is not reduced by ≥5.5mmol/mol (0.5% points) in HbA1c in 6 months in line with Derbyshire and NICE diabetes guidance. DuoResp Spiromax – Amended to read that DuoResp is second line choice to Fostair and add that only licensed for adults.	**SD**
11.	**MHRA DRUG SAFETY UPDATE**	
a.	The MHRA Drug Safety Update for December 2014 was noted. Mr Dhadli highlighted the following: • Ivabradine (Procoralan) in the symptomatic treatment of angina: risk of cardiac side effects - new advice to minimise risk. This would be highlighted in the JAPC newsletter.	**SD**
12.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the prescribing implications for the CCGs for the following NICE guidance issued in December 2014. TA 327 Dabigatran etexilate for the treatment and secondary prevention of deep vein thrombosis (DVT) and/or pulmonary embolism (PE) – Dabigatran currently classified as RED for the prevention of VTE (NICE TA 157) and GREEN for the treatment of AF (NICE TA 247). Rivaroxaban for the treatment of VTE was classified GREEN Specialist Initiation. Dabigatran was an alternative option to rivaroxaban for the treatment and prevention of DVT and PE in adults. In the TA treatment with dabigatran required initial treatment with a low molecular weight heparin (LMWH) and the costs were based on nine days of LMWH. Rivaroxaban did not require this initial treatment with a LMWH. The costing template indicated that as it was likely to be given as an alternative to rivaroxaban and the two drugs are similarly priced a significant impact on resources was not anticipated. **Action:** Mr Dhadli would develop a paper to indicate the position of the NOACs. A traffic light classification for dabigatran for the treatment and secondary prevention of DVT as per NICE TA 327 would be assigned at the next JAPC meeting. TA 328 Idelalisib for treating follicular lymphoma that is refractory to two prior treatments - Terminated appraisal. Classified as BLACK as terminated by NICE. CG 189 Obesity: identification, assessment and management of overweight and obesity in children, young people and adults. There were potential cost implications due to increasing the number of referrals to tier 3 services and a likely increase in bariatric surgery procedures involving people with type 2 diabetes with a BMI of 30-34.9kg/m2. There were also potential costs for offering at least annual monitoring of nutritional status and appropriate supplementation according to need following bariatric surgery, as part of a shared care model of chronic disease management. Mrs Qureshi advised that the estimated costs for the treatment of an estimated 55 patients who could go on to bariatric surgery in Southern Derbyshire was £300,000.	**SD** **SD**

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	For North Derbyshire there were an estimated twelve patients who could be treated with bariatric surgery at a cost of £50,000. The costs for 29 patients in Erewash were £150,000 and for 21 patients in Hardwick £100,000. The costs given were queried and Mrs Qureshi undertook to check and inform JAPC if these were incorrect. CG191 Pneumonia: Diagnosis and management of community and hospital acquired pneumonia in adults – Mrs Qureshi advised that Dr Diane Harris would report back on the implications of the additional costs which may be incurred recurrently from implementing the recommendations for C–reactive protein testing in primary care.	**SQ**
13.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Para-aminosalicylic acid (GranuPAS) – RED Insulin degludec + liraglutide (Xultophy) – BLACK Peginterferon beta-1a (Plegridy) – RED Sofosbuvir + ledipasvir (Harvoni) – RED Darunavir (Prezista) – RED Idelalisib – BLACK	
14.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Lipid guidance – To be removed from the list. Fluticasone propionate nasal drops (Nasules) – Dr Goddard would send the information received to Mr Dhadli. Vigabatrin – To be brought to the February JAPC meeting. Nitrofurantoin – To be removed from the list. Cinacalcet – To be brought to the February JAPC meeting. Clozapine – Ongoing. NOACs off licence use – To be brought to the April JAPC meeting.	**WG** **WG** **WG** **SD**
15.	**GUIDELINE GROUP**	
	The Guideline Group action progress summary was noted.	
16.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Sheffield are Prescribing Final Minutes 16/10/14 • South Staffordshire Area Prescribing Group 17/10/14 • RDH Drugs and Therapeutic Committee 18/11/14 Mr Dhadli highlighted the following had been discussed by Sheffield Area Prescribing Group: • NICE Quality Standards in relation to prescribing in order to determine where there were gaps in provision. • Supply of vacuum pumps and the varying cost of these devices to primary care. • Brimonidine – It had been agreed that there should be specialist recommendation to initiate, either by Dermatologists at Sheffield Teaching Hospital or by GPs in primary care.	

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	• Gender Dysphoria - Patients attend Porterbrook Clinic in Sheffield for assessment and initiation of hormone therapy and that draft shared care protocols have been developed to support GPs with prescribing and monitoring. • CG185 Bipolar Disorder – It had been highlighted that monitoring frequency for lithium had changed to twice a year for stable patients and four times a year for unstable patients. DHcFT had been asked to look at this. Mr Dhadli highlighted that the following had been discussed by RDH Drugs and Therapeutic Committee: • Prasugrel in PCI (NICE TA317) – Dr Goddard to amend the flowchart. • Sheila O'Reilly, RDH Consultant Rheumatologist, had attended to present the request to use certolizumab as per NICE guidance for use in radiographic ankylosing spondylitis (AS). Dr O'Reilly would like to use it in non-radiographic ankylosing spondylitis (nr-AS), which is a licensed indication, but not yet NICE supported. An appraisal is underway, but a decision is not imminent. A NICE TA was expected in July 2015 on anti TNFs for AS and nr-AS and this may include the non-radiographic method of diagnosis. The TA could then be extrapolated to the use of certolizumab. It had been estimated that two patients may need this treatment per year but Mr Dhadli requested that the waiting list of patients who would also benefit should be included in the Trust horizon scan.	**WG** **CN**
17.	**ANY OTHER BUSINESS**	
	(a) Dr Mott referred to the discussion at the December JAPC meeting when it had been reported that MTRAC/PrescQIPP had produced a review which indicated that all the gliptin drugs had similar efficacy and suggested using alogliptin as first line as it had a lower acquisition cost. JAPC had assigned a traffic light classification of GREEN 1st line for alogliptin and GREEN 2nd line second line for linagliptin for renal/hepatic failure. The other gliptin drugs had been assigned a traffic light classification of BROWN. Dr Mott advised that some RDH clinicians had expressed concern about this and wished to continue using sitagliptin in addition to querying the licensing. Mrs Needham advised that the CRH clinicians had not expressed as much concern but did not want to switch their patients who were well managed on sitagliptin. The most commonly used position for gliptins was in combination with metformin and sulfonylurea. MTRAC had produced a document which implied that the licensing was essentially the same for sitagliptin and alogliptin. However the SPC had highlighted that there had been no studies on the use of alogliptin with metformin and sulfonylurea. Mr Dhadli stated that it was clear that sitagliptin could be used with metformin and sulfonylurea but alogliptin was also licensed for triple oral therapy. The SPC had stated that the safety and efficacy of alogliptin when used in triple therapy with a metformin and sulfonylurea was not fully established. NICE had issued draft guidance on type 2 diabetes which advised that the gliptin with the lowest acquisition cost could be used.	

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	Mr Dhadli tabled the MTRAC commissioning support document on the use gliptins (DPP- 4 inhibitors) for the treatment of type 2 diabetes which included the licensed indications for the five available gliptin drugs. **Agreed:** JAPC agreed not to change the decision made at the December 2014 meeting due to the lack of concern from the CRH clinicians, the fact that a lot of prescribing was done in primary care and the MTRAC view that alogliptin was licensed for oral triple therapy. This was subject to trying to gain further clarity concerning the licensing issue. **Action:** The MTRAC table of licensed indications for the DDP-4 inhibitors would be referenced in the diabetes guidance. (b) Mr Newman referred to the decision made at the November 2014 JAPC meeting to look at all drugs within the current black traffic light classification. This review would assess whether the original decision of BLACK classification was still valid and would consider whether substantial new evidence had emerged or there had been significant change to the cost effectiveness. A list of black drugs had therefore been sent to JAPC members. Mr Newman highlighted that the turnaround time for replies was very tight and it was agreed that this should be extended to six weeks. Mr Newman also referred to the list of the drugs which were black due to the lack of evidence and lack of cost effectiveness. It had been stated that there was no new evidence against these but each time that cost effectiveness was mentioned in the original decision making it would be necessary to review the costs again in addition to the evidence. Mrs Qureshi explained that the focus had been placed on the drugs which were historically classified as black. JAPC would be able to review the drugs which had reasonable evidence of use on the grounds of cost effectiveness. Mr Dhadli stated that the drugs listed in the two appendices would not need to be looked at as they concerned the negative NICE TAs and the drugs of limited clinical value of which some exceptional use following previous consultation had been allowed.	**SD** **SD** **SQ**
18.	**DATE OF NEXT MEETING**	
	Tuesday, 10th February 2014 at 1.30pm in the Post Mill Centre, South Normanton.	