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 March 2015

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Olodaterol	**BLACK**
Flixonase Nasules	**GREEN** as per local chronic rhinosinusitis guidance
Acetazolamide	**GREEN** after consultant initiation and stabilisation (off-label for idiopathic intracranial hypertension)
Dapagliflozin + metformin (Xigduo)	**BROWN**
Desloratadine, levocetirizine, esomeprazole	**BROWN** after preferred formulary choices
Promixin	**RED**
Clonidine	**BLACK** for hypertension and migraine and **GREEN** for Tourette's and menopausal symptoms
Dasabuvir (Exviera)	**RED**
Nintedanib (Vargatef)	**RED**
Ibrutinib (Imbruvica)	**RED**
Ombitasvir + paritaprevir + ritonavir (Viekirax)	**RED**
Ramucirumab (Cyramza)	**RED**
Sucroferric oxyhydroxide (Velphoro)	**RED**
Tiotropium Respimat	**GREEN**
Infliximab (Remicade, Remsima and Inflectra), adalimumab and golimumab	**RED** (as per NICETA 329)
Sofosbuvir	**RED** (as per NICE TA 330)
Simeprevir in combination with peginterferon alfa and ribavirin	**RED** (as per NICE TA 331)
Sipuleucel –T	**BLACK** (as per NICE TA 332)
Axitinib	**RED** (as per NICE TA 333)
Regorafenib	**BLACK** (as per NICE TA 334)
Silica gels/sheets	**BROWN** specialist recommendation from burns unit

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Clinical Guidelines

Management of chronic rhinosinusitis with or without nasal polyps

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Secretary)
Mrs L Hunter	Assistant Chief Finance Officer
Mr S Hulme	Director of Medicines Management (also representing Erewash CCG)
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 North (also representing Hardwick CCG)
Ms J Town	Head of Finance
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Derby City Council	
Dr R Dewis	Consultant in Public Health Medicine
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
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 M Henn and Dr S Taylor.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	No declarations of interest were made.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	Apart from bimatoprost and oral nutritional supplements no additional declarations of any other business were made.	
4.	**MINUTES OF JAPC MEETING HELD ON 10 FEBRUARY 2015**	
	The minutes of the meeting held on 10th February 2015 were agreed as a correct record after the following amendments: Traffic Lights: Amend to Daranuvir + cobicistat (Rezolsta) Patient Group Directions: Amend to: 'Patient Group Directions agreed for Derby Urgent Care Centre' and 'Amoxicillin capsules and suspension.' Pathology Lipid Reporting: Amend to 'Mr Dhadli would contact Dr Masters directly to ascertain when the non-HDL level would be routinely reported and copy Dr Mott into this email.' Relvar: Amend to: 'In addition, Relvar has a relatively short short shelf-life of six weeks once opened.' Psoriasis: Amend to 'The guideline is now included as an appendix to the psoriasis pathway in the skin formulary which indicated when to prescribe the ointment or gel and the duration that this should be used for.' Cinacalcet: Amend to 'Mr Dhadli informed JAPC that some standard wording in the shared care was missing and asked for these to be added.' Lithium monitoring CG185 Bipolar Disorder: Amend to read 'Ms Beverley Thompson'.	
5.	**MATTERS ARISING**	
a.	**Pathology Lipid Reporting** Mr Dhadli reported that CRH had gone live on 3rd March for the non-HDL cholesterol reporting. RDH would commence shortly but no date had been given.	
b.	**Umeclidinium** Mr Dhadli reported that the guideline group had decided not to adopt the RDH LAMA algorithm in the draft COPD guidance and instead tiotropium would be indicated as first LAMA line choice. The three other LAMAs would be on an equal footing and guidance included to enable GPs to choose on balance which device was most appropriate for the patient. Mr Dhadli supported the views of the guideline group citing the MTRAC and a recent Cochrane review highlighting the lower place of aclidinium which contradicted the prominence in RDHs proposed LAMA pathway.	

Item		Action
	Dr Goddard referred to the decision made by JAPC at the February 2015 meeting that Relvar should remain classified as BLACK. RDH had now included Relvar in the formulary and protocol so the clinicians would need to apply for its use on a concessionary basis. Mr Dhadli stated that the decision had been made due to the lack of evidence for Relvar and concern about some practical issues associated with its use and flexibility to step down treatment. Mr Hulme commented that the RDH respiratory physicians had wanted to use Relvar in a defined cohort of patients and therefore the concessionary route was the appropriate course of action for the time being.	
c.	**Lithium Monitoring** It was reported that the shared care guidance would be updated by DHcFT in line with the NICE guidance when it was reviewed in August 2015.	
d.	**Cinacalcet** Mr Dhadli referred to the query raised at the last meeting as to whether the shared care excluded the use of cinacalcet for renal dialysis (currently funded by NHSE) and confirmed that this was the case.	
e.	**Hyperprolactinaemia** Mr Dhadli advised that Dr Stanworth had indicated that significant changes would be made to the current shared care guideline for hyperprolactinaemia and this would be brought to a future JAPC meeting. No date could be given.	
6.	**NEW DRUG ASSESSMENTS**	
	Olodaterol Mr Dhadli advised that olodaterol was a new once-daily maintenance bronchodilator treatment of airflow obstruction in patients with COPD which had been launched in June 2014 and was administered in a Respimat Soft Mist Inhaler. Olodaterol had been the subject of two reviews from the Scottish Medicines Consortium published in August 2014 and the NICE New Medicine Review in February 2015. Both reviews had looked at two 48 week studies and the reviews had excluded the non-licensed dose. The SMC had originally rejected olodaterol based on a lack of sufficiently robust clinical and economic grounds with economic comparisons made indirectly with indacaterol the other once daily LABA. A re-submission though was successfully made in December 2014 and accepted on cost minimisation grounds versus an indirect comparison against salmeterol. Post meeting information from DTB (April 2015) stated "…at present, we consider that there is insufficient evidence to recommend olodaterol over existing LABAs. NICE had referred to improved lung function compared to placebo over 24 weeks but was not significantly different from formoterol. Statistical significant improvements in health related quality of life compared to placebo had been noted, but the results were less conclusive for dyspnoea and the studies were not designed for exacerbations. Olodaterol appeared to improve lung function as well as formoterol but there was limited evidence to compare directly with other LABAs and LAMAs for COPD.	

Item		Action
	During discussion Mrs Needham queried whether there was any advantage with this particular device compared to other LABAs. Dr Mott commented that indacaterol had previously been assigned a traffic light classification of BROWN and needed to be taken only once a day unlike formoterol and salmeterol. . **Agreed:** Olodaterol classified as a **BLACK** drug due to lack of data on clinical effectiveness compared with standard therapy and cost-effectiveness compared with standard therapy.	**SD**
7.	**CLINICAL GUIDELINES**	
	Fluticasone Nasules Mr Dhadli referred to the decision made by JAPC in September 2014 to assign a traffic light classification of GREEN after consultant/specialist initiation to fluticasone propionate nasal drops for nasal polyps. It had been noted when the decision had been made, that although fluticasone was more expensive than betamethasone nasal drops, it had significant advantages from a safety point of view and therefore had a place in therapy. The draft clinical guideline for the management of chronic rhinosinusitis (CRS) with or without nasal polyps had been sent to ENT consultants at RDH and CRH for comment. The guidance was noted as a useful resource to help GPs manage a commonly presented condition and manage appropriate referrals. During discussion Mrs Needham suggested the following amendments to the guideline: • Self-management - SinuRinse and Sterimar which are available OTC. • Step 1: Drug: beclometasone 50microgram nasal spray 1st line choice/ budesonide 64microgram nasal spray 2nd line choice • Step 1: Drug budesonide spray into each nostril twice daily for up to 3 months and long-term maintenance. • Step 3: When concluded step down to step 1. • Step 4: Take out weight-based dosing for prednisolone tablets (0.5mg/kg for 5 – 10 days) **Action:** The amendments would be made to the guideline. **Agreed:** JAPC ratified the clinical guideline for the management of chronic rhinosinusitis with the agreed amendments. **Agreed:** Fluticasone nasules classified as a **GREEN** drug as per local chronic rhinosinusitis guidance.	**SD** **SD** **SD**
8.	**MONTHLY HORIZON SCAN**	
	Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: Dasabuvir (Exviera) – Classified as **RED** (NHS England high cost drug) Dulaglutide (Trulicity) – Leave unclassified pending NICE diabetes review and/or new NICE evidence summary	

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	Nintedanib (Vargatef) – Classified as **RED** (NHS England high cost drug) Ibrutinib (Imbruvica) – Classified as **RED** until the commissioning intentions were known although it was likely to be by NHS England. Ombitasvir + paritaprevir + ritonavir (Viekirax) – Classified as **RED (**NHS England high cost drug) Ramucirumab (Cyramza) – Classified as **RED** (NHS England high cost drug) Sucroferric oxyhydroxide (Velphoro) – Classified as **RED** (NHS England high cost drug). New formulation launches in the UK: Aclidinium bromide + formoterol fumarate (Duaklir Genuair) – Its place would be discussed in the COPD review. Exenatide (Bydureon Pen device) – Already classified as **BROWN.** Licence extensions: Rivaroxaban (Xarelto) - Prevention of cardiovascular disease in patients with atrial fibrillation undergoing cardioversion. Mrs Needham referred to the possible ease of use for the Exenatide Bydureon pen which was a pre-filled, single use, once-weekly pen injector for adults with type 2 diabetes It was agreed to relook at the exenatide classification as the original product was difficult to manipulate.	**SD**
9.	**MISCELLANEOUS**	
a.	**<u>Acetazolamide</u>** Mr Dhadli reported that RDH had requested the inclusion of acetazolamide for the specific indication of Idiopathic Intracranial Hypertension (IIH). There were currently no nationally recognised clinical guidelines for the treatment of IIH. Evidence was taken from BMJ 'Best practice IIH 2014' the relevant study to this review included the NORDIC Trial. Evidence included recommendations for standard dosing, patient orientated outcomes for efficacy, lack of monitoring requirements and addressing any safety issues. Mr Dhadli highlighted that acetazolamide was not recommended for long-term use and therefore electrolytes may need to be monitored periodically. In addition it was recommended that stable patients were followed up every six months, and recently diagnosed patients every two to four weeks, until the patient showed signs of improvement. **Agreed:** Acetazolamide classified a **GREEN** drug after consultant initiation and stabilisation.	**SD**
b.	**<u>Alprostadil</u>** Mr Dhadli stated that DTB had undertaken a review on alprostadil cream and JAPC had assigned a traffic light classification of BROWN after consultant/specialist initiation second line to a PDE type 5 inhibitors. The review had concluded similarly to JAPC that there was a moderate increase in efficacy compared to placebo and it had some advantages over other forms of alprostadil in terms of pain and ease of administration and should remain a 2nd line option after PDE5 type inhibitors	

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Item		Action
c.	**Biosimilars** Mr Dhadli updated JAPC with the London Medicines Evaluation Network Review (LMENR) on the first biosimilar versions of infliximab which had been approved for use in Europe in October 2014 and were due to be launched in the UK in late February 2015. There would consequently be three brands of infliximab available to prescribers in the UK; (Remicade the reference product; Remsima and Inflectra the two biosimilars) licensed identically to the originator product for use in ankylosing spondylitis, rheumatoid and psoriatic arthritis, psoriasis and inflammatory bowel disease (Crohn's disease and ulcerative colitis). The LMENR was a more re-assuring balanced paper with regards to addressing some safety concerns raised by various relevant organisations. UKMI had also produced an in-use product safety assessment report on the infliximab biosimilars. Mr Dhadli went on to summarise the main points in the LMENR and the UKMI document. Mr Dhadli highlighted to JAPC that for certain conditions when infliximab was indicated then a biosimilar should be used for new patients as the most cost-effective option. Dr Mott commented that it would be necessary to obtain experience in the use of biosimilars locally and also learn from the experience in the other areas if switching had been undertaken.	
d.	**Black List** Mrs Qureshi introduced a paper covering a review of all currently classified BLACK drugs. Mrs Qureshi stated that the original paper had divided the black drugs into three tables of those which had negative or terminated appraisals; those which were not recommended for prescribing locally and all the drugs reviewed by the guideline group that justified further investigation. JAPC then considered in turn the recommendations made by the guideline group and the comments received from GPs, pharmacists and secondary care consultants during the consultation period: *Dapagliflozin + metformin (Xigduo)* - Recommend to change to BROWN status with the proviso that xigduo may be considered if dapagliflozin is indicated and a combination preparation is needed to aid compliance. Mrs Needham pointed out that a note should be included to indicate that the target dose used in the UKPDS of metformin could not be met with this combination. **Agreed:** Dapagliflozin + metformin classified as a **BROWN** drug. *Desloratadine* - Recommend to change to BROWN due to a reduction in price. General consensus was to agree with this recommendation although it had been suggested to change to green or green 3rd line option if cetirizine or loratadine were not tolerated. RDH had queried the need to change the traffic light status. Mr Hulme referred to the desirability of reviewing the hayfever guidance. **Agreed:** Desloratadine classified as a **BROWN** drug after preferred formulary choices *Levocetirizine* – Recommend to change to BROWN due to a reduction in price. **Agreed:** Levocetirizine classified as a **BROWN** drug after preferred formulary choices	

Item		Action
	Esomeprazole - Recommend to change to BROWN due to its price reduction after the use of the other PPIs. **Agreed:** Esomeprazole classified as **BROWN** after preferred formulary choices *Grazax* –A discussion took place to consider a change to BROWN status on recommendation of specialist centre only. Consensus that a brown classification was difficult and therefore it should remain classified as black. Mr Dhadli stated that there was limited evidence for Grazax and that some CCGs had a shared care and others did not commission. Out of area requests from the allergy clinics in Leicester had been received which had gone to the IFR Panel. **Agreed:** Grazax classified as a **BLACK** drug. Paediatricians to make a case if they wished to use this drug. *Escitalopram* - Recommend to change to BROWN status due to price reduction. DHcFT had agreed a change to brown and would agree exceptionality criteria at their next Drugs and Therapeutic Committee. RDH had queried why the classification needed to be changed. **Agreed:** Escitalopram to remain classified as **BLACK** until the exceptionality criteria had been sent to JAPC by DHcFT. *Promixin* – Recommend to change to BROWN after specialist initiation. Mr Dhadli reminded JAPC that the commissioning of cystic fibrosis in relation to drug treatments was less clear. For example the Nottingham APC had classified this as an amber 2 drug for the South of the County only. Furthermore a circular from NHS England had indicated that from April 2014 all post-transplant immuno-suppressants and inhaled antibiotics for cystic fibrosis would be commissioned directly from Trusts. **Agreed:** Promixin classified as a **RED** drug as commissioned by NHS England. *Silica gels/sheets* – Recommend changing to BROWN after recommendation of consultant for burns patients. **Agreed:** Silica gels/sheets classified as **BROWN** after recommendation of consultant for burns patients. *Catapres* (Branded product for clonidine) **Agreed:** Catapres classified as a **BLACK** drug for hypertension and migraine and **GREEN** for Tourette's and menopausal symptoms. *Modafinil* (Dual status with Green after consultant initiation) – RDH had referred to some ex-Nottingham patients already established on modafinil which needed further discussion on what should happen to existing patients on this drug when it was classified as **BLACK**. This had been discussed by the Guideline Group who had concluded as a principle that existing patients on treatment should be allowed to continue pending a discussion and review by the clinicians, but the BLACK drug should not initiated in any new patients. Mr Dhadli would make this clear on the website and put a reference in the bulletin.	

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Item		Action
	Agreed: Modafinil to remain classified as a **BLACK** drug. *Sativex* **Agreed:** Sativex to remain classified as a **BLACK** drug.	
e.	**Cancer Drugs Proposed Transfer** Mr Hulme and Mr Dhadli advised JAPC that there was a briefing paper from the Pharmaceutical Advisers Group to comment on a proposal from NHSE to transfer chemotherapy commissioning from NHS England to the CCGs and an options paper had been developed. Mr Dhadli stated that two options had been given in this paper with strengths, weaknesses, opportunities, threats (SWOT) analysis for each one. Following discussion JAPC agreed to support option 1 'Do nothing – chemotherapy remains nationally commissioned by NHS England'. Mr Hulme would reply to the consultation to indicate the support of Derbyshire JAPC for option 1.	
f.	**Pregabalin** JAPC noted that all CCGs had received a letter from NHS England which contained Pregabalin Guidance and this had been cascaded to all GP practices.	
g.	**Prescribing Specification** Mr Hulme stated that, when JAPC had previously discussed the prescribing specification 2015/16, it had been agreed that appendix 2 would be reviewed in order to make it more quality based as the remainder of the specification was transactional in nature. Following discussions with the Trust Chief Pharmacists and Heads of Medicines Management, the comments made had been included in the specification. Mr Hulme added that Appendix 2 of the specification was proposed to support improvements in Medicines Optimisation between Provider Trusts and Commissioners. Three areas had been proposed with the aim of minimising avoidable medicines harm and improving medicines optimisation and health outcomes. Mr Shepherd queried whether compliance with this Appendix would be monitored. Mr Hulme highlighted that this was not the case as the Appendix aimed to encourage collaborative working and therefore improve medicines safety and quality within the framework of a formal document. **Agreed:** JAPC agreed that Appendix 2 be included to the prescribing specification which would apply across all the Derbyshire Trusts and CCGs.	**SD**
h.	**Primary Care Rebates** Mrs Qureshi informed JAPC of the new and existing primary care rebates. JAPC noted that the following new rebates have been agreed across Derbyshire: • Insuman (insulin) • Zoladex (goserelin) • Fencino (fentanyl) • Firmagon (Degarelix)	

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	In addition an existing rebate for Prostap (leuprorelin) had been extended across Derbyshire. Mr Newman queried whether the agreed rebate for fentanyl patches could incentivise their use. Mr Dhadli confirmed that there was a formulary and pathway for the use of opiates and the place of fentanyl in this had not been changed. Mr Dhadli also highlighted that one of the criteria for rebates was that formularies should not be changed and/or prescribing intentions influenced by a rebate. There was an agreed transparent process for dealing with all aspects of rebates. Dr Parkin queried whether community pharmacists were involved in discussions about rebates. Dr Mott commented that it was not possible to negotiate and that the rebates were offered by pharmaceutical companies via PrescQIPP who would undertake a financial and clinical review of the offers and assist the CCGs in managing the legal implications of entering into presented schemes. In the light of the queries which had been raised it was agreed that the rebate process should be discussed by JAPC at a future meeting.	**SD**
i.	**<u>Tiotropium</u>** Mr Dhadli reported that there had been a recent MHRA update on tiotropium Respimat device and referred back to the New England Journal of Medicine report on the TIOSPIR study in October 2013 which had compared the difference in mortality between tiotropium delivered by the Respimat and tiotropium delivered by an active control the HandiHaler. In the light of this the MHRA had issued clinical advice about the need to take into account the risk of cardiovascular side effects for some patients when using tiotropium delivered via Respimat or Handihaler to treat chronic obstructive pulmonary disease (COPD). The TIOSPIR study would have been better designed to compare tiotropium with a placebo arm. Mr Dhadli highlighted that Tiotropium remained the formulary choice of LAMA inhaler as its efficacy had been demonstrated in the improvement of lung function, quality of life, symptom control and exercise capacity and reduction of exacerbations in patients with COPD. Mr Dhadli also highlighted the SPCs for the three other LAMAs which too included comments of risk in patients with cardiovascular disease. **Agreed:** Tiotropium Respimat classified as a **GREEN** drug with removal of the device.	**SD**
10.	**JAPC BULLETIN**	
	The revised bulletin was tabled for information and ratified by JAPC.	**SD**
11.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for February 2015 was noted. Mr Dhadli highlighted the following MHRA advice:	

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	• Tiotropium delivered via Respimat compared with Handihaler: no significant difference in mortality. • INOmax (nitric oxide) cylinders: valve defect might stop gas delivery early in some cylinders. • Drugs and driving: blood concentration limits set for certain drugs. This information had been circulated to GP practices and highlighted in the bulletin.	
12.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in February 2015: TA329 Infliximab, adalimumab and golimumab for treating moderately to severely active ulcerative colitis after the failure of conventional therapy (including a review of TA140 and TA262) – A costing statement had been included which estimated that for a population of 500,000 132 adults would be eligible for treatment with a biologic and 30 children. In the event that patients would be equally offered all three of the biologics and would be on these for a period of twelve months a cost of £1.1 million had been estimated. These costs could be less if biosimilars were used and the numbers of patients would be subject to clinical discretion. Infliximab, adalimumab and golimumab classified as **RED** drugs. TA330 Sofosbuvir for treating chronic hepatitis C – Classified as a **RED** drug. TA331 Simeprevir in combination with peginterferon alfa and ribavirin for treating genotypes 1 and 4 chronic hepatitis C - Classified as a **RED** drug. TA332 Sipuleucel-T for treating asymptomatic or minimally symptomatic metastatic hormone-relapsed prostate cancer – Not recommended for use or available in the UK. Classified as a **BLACK** drug. TA333 Axitinib for treating advanced renal cell carcinoma after failure of prior systemic treatment. Classified as a **RED** drug. TA334 Regorafenib for metastatic colorectal cancer after treatment for metastatic disease (terminated appraisal). Classified as a **BLACK** drug. CG61 Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care - NICE recommend that tricyclic antidepressants (TCAs) should be considered as second‑line treatment for people with IBS if laxatives, loperamide or antispasmodics have not helped. NICE also recommend linaclotide for people with IBS only if optimal or maximum tolerated doses of previous laxatives from different classes have not helped and they have had constipation for at least twelve months. Patients on linaclotide should be followed up after three months. The recommended use of linaclotide would have a resource implication. The Guideline Group would consider the implications of the clinical guideline.	**SD**

Item		Action
	NG3 Diabetes in pregnancy: management of diabetes and its complications from preconception to the postnatal period – It was highlighted that there could be increased costs arising from new and updated recommendations for testing of women with gestational diabetes with the additional use of testing strips. An increased cost would also be associated with the offer of annual HbA1c tests for post-natal women with gestational diabetes.	
13.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Olodaterol – BLACK Flixonase nasules – GREEN as per local guidance Acetazolamide – GREEN after consultant stabilisation for idiopathic intracranial hypertension Dapagliflozin + metformin - BROWN Desloratadine - BROWN after preferred formulary choices Levocetirizine - BROWN after preferred formulary choices Esomeprazole - BROWN after preferred formulary choices Promixin – RED Catapres - BLACK drug for hypertension and migraine and GREEN for Tourette's and menopausal symptoms Dasabuvir (Exviera) – RED Nintedanib (Vargatef) – RED Ibrutinib (Imbruvica) – RED Ombitasvir + paritaprevir + ritonavir (Viekirax) – RED) Ramucirumab (Cyramza) – RED Sucroferric oxyhydroxide (Velphoro) – RED Tiotropium Respimat – GREEN Infliximab, adalimumab and golimumab RED (as per TA 329) Sofosbuvir for treating chronic hepatitis C –RED (as per TA 330) Simeprevir in combination with peginterferon alfa and ribavirin for treating genotypes 1 and 4 chronic hepatitis C – RED (as per TA 331) Sipuleucel-T for treating asymptomatic or minimally symptomatic metastatic hormone-relapsed prostate cancer - BLACK (as per TA 332) Axitinib for treating advanced renal cell carcinoma after failure of prior systemic treatment RED (as per TA 333) Regorafenib for metastatic colorectal cancer after treatment for metastatic disease (terminated appraisal) – BLACK (as per TA 334)	
14.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: Fluticasone propionate nasal drops (nasules) – Take off. Clozapine – To be brought to the April JAPC meeting. Hyperprolactinaemia - Shared care to be updated by Dr R Stanworth and others. Aripiprazole and pregabalin – To be left on.	
15.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in February 2015 was noted.	

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	Mr Dhadli highlighted it had been agreed that nutilis clear into the formulary as the preferred thickening agent and for vacuum pumps the inclusion of the wording "for new patients" in the traffic light database.	
16.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Burton Drugs and Therapeutic Committee 12/1/15 • DHcFT Drugs and Therapeutic Committee 22/1/15 • DHFT Drugs and Therapeutic Committee 20/1/15 • Sheffield Area Prescribing Group 15/1/15	
17.	**ANY OTHER BUSINESS**	
a.	**Bimatoprost Eye Drops** Mr Dhadli advised JAPC that the manufacturer of Lumigan (bimatoprost) were discontinuing the 300mcg 3ml version of the product with effect from 30th April 2015 and only the 100mcg 3ml would be available. Mrs Needham commented that CRH only use 100mcg for new patients and the views of the consultant ophthalmologists were being sought as to whether patients currently on 300mcg could be switched to 100mcg or another drug such as latanoprost. Mr Newman stated that discussions would be held with the RDH ophthalmologists.	
b.	**Oral Nutritional Supplements (ONS) Supplies on Discharge** Mr Dhadli highlighted that performance indicator 10 in the prescribing specification referred to the supply of medicines on discharge from hospital. This included the supply of ONS products but it was proposed that this should be amended to state that on discharge from hospital patients would receive five to seven days treatment for oral nutritional supplementation. Mr Newman commented that the RDH Chief Dietitian had indicated that the supply of five days ONS was not feasible. In addition the term supply should be amended to ONS be available to them for five or seven days. It was agreed that the prescribing specification be amended to ensure availability for patients to five to seven days supply for ONS.	**SD**
18.	**DATE OF NEXT MEETING**	
	Tuesday 14th April 2015 at 1.30pm in the Post Mill Centre, South Normanton.	