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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 14th February 2017

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Hydromorphone	BROWN after specialist/consultant initiation after other strong opioids had been tried.
Brivaracetam	BROWN after specialist/consultant initiation and stabilisation for three months in patients that have responded to levetiracetam but unable to tolerate the adverse effects.
Doxazosin MR	BLACK
Low Molecular Weight Heparin (Enoxaparin, Tinzaparin)	GREEN after specialist initiation
Ceftriaxone 1g and 2g, Ertapenem 1g, Teicoplanin 800mg, Tazocin 4.5g and meropenum 1g	GREEN only as part of the OPAT service between DCHSFT and CRHFT
Grazoprevir + elbasvir (Zepatier®)	RED (NHS England) already has a RED traffic light classification as TA413
Olaratumab (Lartruvo®)	RED (NHS England)
Palbociclib (Ibrance®)	RED (NHS England)
Pegaspargase (Oncaspar®)	RED (NHS England) already has a RED traffic light classification as per TA408
Venetoclax (Venclexta®)	RED (NHS England)
Pomalidomide for multiple myeloma previously treated with lenalidomide and bortezomib	RED (NHS England) as per NICE TA 427
Pembrolizumab for treating PDL1-positive non-small cell lung cancer after chemotherapy	RED (NHS England) as per NICE TA 428
Ibrutinib for previously treated chronic lymphocytic leukaemia and untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation	RED (NHS England) as per NICE TA 429
Sofosbuvir– velpatasvir for treating chronic hepatitis C	RED (NHS England) as per NICE TA 430
Mepolizumab for treating severe refractory eosinophilic asthma	RED (NHS England) as per NICE TA 431

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Clinical Guidelines
Guidance on prescribing of Low Molecular Weight Heparin (Enoxaparin® and Tinzaparin®) - Guideline agreed and shared care removed.
OPAT (Outpatient and Parenteral Antimicrobial Therapy) Policy for Primary Care (Step-Up Pathway) between DCHSFT and CRHFT.

Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mrs L Hunter	Assistant Chief Finance Officer
Mrs S Qureshi	NICE Audit Pharmacist
Ms Y Soetan	Lead Pharmacist
Dr M Watkins	GP
North Derbyshire CCG	
Mr R Coates	Management Accountant
Dr T Narula	GP
Mr J Vinson	Medicines Management Pharmacist
Hardwick CCG	
Dr T Parkin	GP
Erewash CCG	
Dr M Henn	GP
Derby City Council	
Derbyshire County Council	
Derby Teaching Hospitals NHS Foundation Trust	
Mr C Newman	Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Dr S Taylor	Chair – Drugs and Therapeutic Committee
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Ms J Shaw	Principal Pharmacist
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Ms S Bassi, Dr R Dewis, Mr S Dhadli, Dr C Emslie, Dr W Goddard, Mr S Hulme and Mrs K Needham.	
2.	**DECLARATIONS OF CONFLICT OF INTEREST**	
	Dr Mott reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of JAPC. No additional conflicts of interest were declared in respect to this agenda.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	There were no declarations of any other business. The current register was circulated with the papers.	
4.	**MINUTES OF JAPC MEETING HELD ON 10 JANUARY 2017**	
	The minutes of the meeting held on 10th January 2017 were agreed as a correct record.	
5.	**MATTERS ARISING**	
a.	**Hydromorphone** Mrs Qureshi reported that advice had been received from the pain and palliative consultants that hydromorphone should be used as a last resort. The Guideline Group had discussed the use of hydromorphone and a traffic light classification of BROWN after specialist palliative care initiation and after other strong opioids have been tried – this was ratified by JAPC.	**SD**
b.	**Sayana Press** The protocol for Sayana Press® was currently being developed by the Derby City Council public health department. The protocol will be brought to JAPC when finalised.	**RD**
c.	**Oxygen** It was reported that advice was still awaited on the use of oxygen in palliative care by the consultant.	**SD**
d.	**Osteoporosis** A meeting had been held with Dr Masters and Dr Stanworth and draft guidance developed which would be discussed by the Guideline Group in March 2017.	**SD**
e.	**Bowel Cleansing** It was reported that comments were still awaited from Dr Cole on whether barium enema should be removed from the guideline and replaced with CT colonography.	**SD**
6.	**NEW DRUG ASSESSMENTS**	
a.	**Brivaracetam** Mr Newman reported that brivaracetam was a new drug for the treatment of partial-onset seizures, adjunctive therapy in patients aged 16 years and older and had been discussed by the DTHFT Drugs and Therapeutic Committee.	

Item		Action
	Brivaracetam had been identified for use for those patients who had responded to levetiracetam, which was included in the core formulary for epilepsy, but were unable to tolerate it and therefore could not achieve any benefit from the drug. It was proposed that brivaracetam should only be used for patients who had been given levetiracetam and responded positively to it but had subsequently gone on to develop undesirable side-effects. The consultant and nurse specialist would initiate the patient on brivaracetam and monitor the patient for a three month period and, if successful in reducing the side effects, would be continued on it. A traffic light classification of GREEN specialist initiation had been proposed. Mrs Qureshi advised that brivaracetam was an adjunctive therapy in the treatment of partial-onset seizures with or without secondary generalisation in adult and adolescent patients from 16 years of age with epilepsy. The starting dose was 50mg or 100mg daily in two divided doses and, based on response and tolerability, could be adjusted to a maximum of 200mg daily. NICE CG 137 Epilepsies: Diagnosis and Management had recommended levetiracetam for use in refractory epilepsy patients when first line and adjunctive anti-epileptic drug options as outlined in the NICE CG appendix on pharmacological treatments had failed. Brivaracetam would therefore be prescribed as a third line agent in patients who had responded to levetiracetam but could not tolerate it. The drug would be initiated by secondary specialists to allow response to the treatment to be assessed before transfer to primary care. Mrs Qureshi commented that Nottinghamshire Area Prescribing Committee had recently assigned a traffic light classification of Amber 2 specialist initiation for use in partial-onset seizures and stipulated that prescribing should be transferred to primary care only when a patient had been stabilised on brivaracetam for six months. The evidence arose from three randomised, double-blind and placebo-controlled trials with adults with a history of focal onset seizures. Brivaracetam was used at doses ranging from 25 mg to 200 mg daily and in all the trials there had been an eight week baseline period followed by a twelve week treatment period. 1500 patients had received the study drug; of which 1,099 had been given brivaracetam. The trials had shown that brivaracetam was associated with significantly greater response to treatment to placebo but there that been no head-to-head studies with current anti-epileptic drugs. A pooled analysis of the three trials had shown the proportion of patients who been seizure-free during the entire treatment period: • 50mg dose – 3.5% seizure free • 100mg dose – 5.1% seizure free • 200mg dose – 4% seizure free A MTRAC review on brivaracetam had indicated that the evidence for efficacy for brivaracetam as an adjunctive therapy for epilepsy was considered to be relatively weak. The three randomised controlled trials were associated with a significantly greater response to treatment than placebo, but there had been no trials that directly compared brivaracetam with other adjunctive treatments for epilepsy and evaluated seizure. A traffic light classification of BROWN specialist initiation had therefore been proposed together with a monitoring period of six months.	

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	During discussion Mr Vinson advised that a traffic light classification of BROWN for brivaracetam would be appropriate due its exceptional use for a tightly defined cohort of patients. Dr Mott commented that zonisamide and other related anti-epileptic drugs were classified as GREEN although their use was tightly defined and it would be important to be consistent. However the cohort of patients for whom brivaracetam would be suitable was even more tightly defined. Brivaracetam was significantly more expensive than levetiracetam but comparable with other adjunct antiepileptic agents including zonisamide. **Agreed:** Brivaracetam classified as a **BROWN** specialist initiation drug as a small cohort of patients would benefit from prescribing. The monitoring period would be for a period of three months in order to assess tolerance. It was noted that this time period could be reviewed in the light of experience with its use.	**SD**
b.	**<u>Doxazosin MR</u>** Mrs Qureshi advised that doxazosin modified release (MR) was included in the PrescQIPP Drugs Of low Priority (DROP) List and the Guideline Group had recommended a re-classification of this drug from BROWN to BLACK. Doxazosin is licensed for the treatment of hypertension and benign prostatic hypertrophy and is available in a MR formulation and immediate release (IR) formulation. It was noted that doxazosin had a long half-life of twenty-two hours which made it suitable for once daily dosing. Both the IR and MR versions are both administered once daily and therefore the MR version of doxazosin offered no advantage in terms of patient compliance. In terms of side effects the MR version may have a slightly lower overall incidence of adverse effects, but most adverse effects were mild. The MR version may also have a slightly better tolerability in terms of first dose hypotension, although the SPC referred to first dose hypotension as the most common side effect. It was highlighted that a saving of approximately £100,000 could be achieved in Derbyshire by a 100% switch from doxazosin MR to doxazosin IR. For existing patients there were three potential switch options from doxazosin MR to doxazosin IR, as outlined in the PrescQIPP switching and UKMI documents, and it was agreed that it would be advantageous to highlight these to clinicians to encourage them to switch. **Agreed:** Doxazosin MR classified as a **BLACK** drug as not routinely recommended or commissioned.	**SD**
7.	**CLINICAL GUIDELINES**	
a.	**<u>Low Molecular Weight Heparins (LMWH)</u>** Mrs Qureshi advised that revised prescribing guidance for enoxaparin and tinzaparin to replace the current shared care agreement had been developed and copies were tabled for information. Enoxaparin® and tinzaparin® were both currently classified as AMBER drugs and the current shared care guidance had been due for renewal in July 2016.	

Item		Action
	Mrs Qureshi added that CRHFT had requested the removal of the shared care guidance and that the Guideline Group had highlighted governance issues concerning communication between interfaces and reviewed some examples of inappropriate requests dating from January 2017. This review exercise had revealed that GPs had been requested to prescribe LMWH without adequate information about dosing and length of treatment. The Guideline Group had therefore recommended the use of a proforma for LMWH in order to improve communication and ensure that essential information was conveyed to GPs. In terms of monitoring the British Society for Haematology had recommended that routine platelet monitoring was required for the first fourteen days but after this was not recommended except for cardiopulmonary bypass patients. The Guideline Group had recommended that any necessary monitoring for the first fourteen days should remain the responsibility of secondary care. Dr Mott queried whether there should now be a shared care for LMWH although it was acknowledged that this had previously been a mechanism of ensuring that prescribing was undertaken within a defined range of indications. It would also be necessary to determine whether the pro-forma would be completed in secondary care. Dr Parkin and Dr Henn agreed that the shared care guideline should be removed and advised that enoxaparin and tinzaparin should be classified as GREEN after specialist initiation. In connection with the proposed use of the proforma Mr Newman stated that this would need to be incorporated into the existing electronic discharge system which would take time. In addition, there were a breadth of different specialties/places from which the patients concerned originated including obstetrics, assessment units as well as base wards. However it was considered that the proforma would be a useful aid to safe prescribing. Mr Newman also offered to assist in the review of the inappropriate requests which were previously referred to as they had largely originated in Derby. Mr Shepherd commented that most of the information requested on the proforma was already included on the existing discharge letter. Dr Watkins suggested that the inclusion of patient weight would be advantageous. Dr Parkin referred to the use of LMWH in patients with suspected DVT. It was agreed that details of progress with the DVT diagnostic pathway should be provided for JAPC. **Agreed:** Enoxaparin and tinzaparin classified as **GREEN** specialist initiation drugs. **Action:** The shared care guideline to be taken off and the north and south prescribing sub-groups to take forward implementation of the new guideline and proforma. A report back would be made to JAPC on progress with the implementation.	**KN** **SD** **SH/KN**
b.	**<u>Outpatient and Parenteral Antimicrobial Therapy (OPAT) Policy For Primary Care (Step-Up Pathway)</u>** Mrs Qureshi reported that a request had been made to change the traffic light classifications from RED to GREEN for a limited range IV antibiotics to allow GPs to initiate.	

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Item		Action
	In order to avoid unnecessary hospital admissions the DCHSFT Rapid Response Team had managed patients in the community who required IV medications but were otherwise fit enough to remain in their own homes. The range of IV medications used had historically involved IV antibiotics and, as a consequence of the expansion of the outpatient antibiotic team and pathways, there was now an opportunity to widen the range of IV antibiotics used to help avoid hospital admissions. It would therefore be necessary to re-classify ceftriaxone 1g and 2g, ertapenem 1g, teicoplanin 800mg, tazocin 4.5g and meropenum 1g from RED to GREEN. It was noted that these pathways have been via the group MOST at DCHSFT and the CRHFT Antimicrobial Drugs and Therapeutic Committee in addition to the North Derbyshire CCG prescribing sub-groups and primary care development group. Dr Diane Harris, Lead Antimicrobial Pharmacist, had indicated that the pathways were generic and did not include much clinical detail. The uncomplicated cellulitis pathway for OPAT only included an initial dose of one antibiotic compared to the previous version and this had contained considerably more detail. In addition, the class of cellulitis would need to be specified. On page 2 the formulary did give an indication for the three antibiotics, although the dose for teicoplanin was not clear, and should differ according to the weight of the patient. In addition, it had been highlighted some information in the pathways appeared to be missing or incomplete. **Agreed:** Ceftriaxone 1g and 2g, Ertapenem 1g, Teicoplanin 800mg, Tazocin 4.5g and meropenum 1g classified as GREEN drugs as per the OPAT Step-Up Pathway. **Action:** Clarification on the queries raised by Dr D Harris would be obtained from the DCHSFT Rapid Response Team and conveyed to the North Prescribing Sub-Group for further discussion. A verbal update would be given to the next JAPC meeting.	**SD** **KN/JV**
8.	**PATIENT GROUP DIRECTIONS**	
	<u>Derby Urgent Care Centre Patient Group Directions</u> Mrs Qureshi reported that nine PGDs had originally been received from Derby Urgent Care Centre (DUCC) – One Medical Group in 2015 but these had now expired so revised versions had been re-introduced to be noted and agreed by JAPC. Mrs Qureshi highlighted the following discrepancies in these revised versions of the PGDs: • Amoxicillin 500mg capsules and 250mg/5ml suspension – The indications now included, in addition to otitis media, acute bronchitis, acute exacerbations of COPD, sinusitis and community acquired pneumonia. For acute exacerbations of COPD and sinusitis the first line antibiotic should indicate doxycycline not amoxicillin and it was noted that there was no PGD for the doxycycline. The adverse effects referred to anaphylaxis as common or very common but the SPC had indicated that this was very rare. • Flucloxacillin 500mg capsule and 125mg/5ml and 250mg/5ml suspension for local skin, soft tissue and wound infections, cellulitis and impetigo – The recommendations complied with local guidance but the adverse effects section referred to anaphylaxis as being common or very common but the SPC had indicated that this was very rare.	

Item		Action
	• Phenoxymethylpemcillin 250mg tablets and 125mg/5ml suspension for sore throat, tonsillitis and pharyngitis – This complied with local guidance but in the previous version there had been a specific exclusion criteria of children under one year of age and now children from the age of one month to eleven months had been included. • Codeine phosphate 30mg for moderate to severe pain – In the previous version there had only been a reference to moderate pain and the inclusion criteria referred to codeine licensed to be used in mild pain. However its use was being restricted to at least moderate pain. • Paracetamol 500mg tablets and 120mg/5ml oral suspension and 250mg/5ml oral suspension for mild to moderate pain and pyrexia – There was no reference to impaired renal function in the caution section but the doses were correct. In connection with the antimicrobial PGDs Mr Newman referred to the NICE expert guidance on PGDs which stipulated that all antimicrobial PGDs needed to be approved by a local microbiologist and highlighted the lack of a reference to this and no indication of a clear mechanism for monitoring and auditing. The codeine PGD did not contain a reference to the need to check whether the patients were taking any opiates and the paracetamol PGD was not compliant with the new dosing for light-weight adults (less than 50kg). It was highlighted that the information about this needed to be included in the exclusion section. Mr Vinson queried why sinusitis needed to be treated with amoxicillin via a PGD at a time when attempts were being made to control the volume of antibiotic prescribing. **Action:** All the comments and queries which had been made concerning the PGDs would be conveyed to DUCC with a request that these be addressed in the amended versions to be re-submitted to JAPC.	**SQ**
9.	**MONTHLY HORIZON SCAN**	
a.	**Monthly Horizon Scan** Mrs Qureshi advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: Grazoprevir + elbasvir (Zepatier®) – NHS England. Classified as **RED.** Olaratumab (Lartruvo®) – NHS England. Classified as **RED.** NICE TA expected in August 2017. Palbociclib (Ibrance®) – NHS England. Classified as **RED**. NICE TA expected in October 2017. Pegaspargase (Oncaspar®) – NHS England. Classified as **RED.** Venetoclax (Venclexta®) – NHSD England. Classified as **RED.** NICE TA Expected in June 2017. New formulation launches in the UK: Tiotropium (Braltus Zonda®) - Already on CCG formulary for COPD. Drug Discontinuations: Premique® (conjugated oestrogens/medroxyprogesterone). Due to some continued prescribing in GP practices Dr Mott referred to the need to highlight that this had been discontinued.	

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Item		Action
b.	**Quarterly NICE Update** Mrs Qureshi highlighted the following: Clinical Guidelines: • Type 2 diabetes prevention. Standing Committee update July 2017. • Cataracts in adults: management – July 2017 • Heavy menstrual bleeding (update) – November 2017 • Type 2 diabetes management. Standing Committee update – December 2017 • Depression in adults: recognition and management – November 2017 NICE Technology Appraisals: • Psoriatic arthritis – certolizumab pegol and secukinumab (after DMARDS) • Apremilast for treating active psoriatic arthritis [ID1017]s) – February 2017 • Psoriasis (plaque, moderate, severe): ixekizumab – April 2017 • Obesity, overweight with risk factors: naltrexone, bupropion (prolonged release) – July 2017 • Uveitis (non-infectious): adalimumab and dexamethasone – July 2017	
10.	**MISCELLANEOUS**	
a.	**JAPC Working Group** Mr Vinson outlined the current work areas of the working group which met directly after the meetings of JAPC: • Self-care policies with the aim of encouraging GPs to reduce the amount of prescribing for minor self-limiting conditions and to educate the public to self-care before accessing primary care. Plan developed for public consultation in association with this. • Reduction of prescribing from the PrescQIPP DROP List and amendments to traffic light classifications such as re-classification of doxazosin MR. • Gluten-free prescribing and public consultation to commence on 27th February 2017 for 90 days. • Reduction in unnecessary repeat prescriptions. An agreement between GPs, pharmacies and patients had been developed for use in Nottinghamshire CCGs and this had been sent to Derbyshire Local Pharmaceutical Committee for comment. The Chesterfield Federation of GPs had commenced a project to employ additional staff in practices to look closely at repeat prescribing and liaise with community pharmacies about this. • A national group had been established to look at black drugs and limited prescribing and this would enhance the work being undertaken at a local level. JAPC noted and ratified the terms of reference of the JAPC Working Group. It was noted that the working group was chaired by Dr Parkin and would report directly to JAPC. It was also noted that the working group had a wide membership from the Derbyshire health economy and would include lay representation where feasible.	
b.	**Psoriasis Pathways** Mrs Qureshi advised that there were two pathways which had been updated to include apremilast which NICE had approved for the treatment of moderate to severe plaque psoriasis and secukinumab.	

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	The MHRA warning about apremilast being associated with an increased risk of psychiatric symptoms, including depression, suicidal thoughts and suicidal behaviours, was included for both pathways. The pathways had been seen by both Trusts prior to coming to JAPC. The Derby Hospital agreed pathway allowed switching to a second biologic. This pathway had been developed following a business case from the DTHFT dermatologists to allow for switching in cases of patient failure with a particular biologic thus avoiding best supportive care. The cost of best supportive care was roughly £10k, and the annual cost of a biologic was roughly £10k, therefore switching would be cost neutral. This second pathway was developed because NICE Technology Appraisals do not allow switching to a second biologic. The DTHFT dermatologists had approved the second pathway and it would be necessary to ascertain the views of the CRHFT dermatologists. Both psoriasis pathways have the option of allowing the use of apremilast first and then moving to a biologic; although the clinician could start with a biologic if clinical circumstances deemed this necessary. Dr Mott highlighted that having two separate pathways within Derbyshire was not ideal and asked whether moving to a single pathway would be feasible. Mr Shepherd would take this back to CRHFT dermatologists for their view.	**MS**
c.	**<u>Tariff Watch</u>** This paper was presented for information and discussion as to where best in our system it could be routinely reviewed. Ms Soetan stated that monitoring of drug tariff prices could be a standing agenda item for the South Medicines Management QIPP Co-ordination Group and this had representation from North Derbyshire Medicines Management. Ms Soetan added that any sustained increases in drug tariff prices would be addressed by this group and presented to the north and south prescribing subgroups as necessary. It was agreed that this did not need to be discussed routinely at JAPC meetings.	
11.	**JAPC BULLETIN**	
	It was agreed that a line should be added to the tadalafil once daily – BROWN 2nd line to sildenafil daily dosing post radical prostatectomy section to indicate that sildenafil was the cost effective option. The amended bulletin was ratified by JAPC.	**SD**
12.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for January 2017 was noted. Mrs Qureshi highlighted the following MHRA advice: • Direct-acting antiviral interferon-free regimens to treat chronic hepatitis C: risk of hepatitis B reactivation. • Direct-acting antivirals to treat chronic hepatitis C: risk of interaction with vitamin K antagonists and changes in INR. • Apremilast (Otezla ▼): risk of suicidal thoughts and behaviour. This had been included in the psoriasis pathways. • Intravenous N-acetylcysteine (NAC) for paracetamol overdose: reminder of authorised dose regimen and possible need for continued treatment with intravenous NAC.	

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13.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in January 2017. TA427 Pomalidomide for multiple myeloma previously treated with lenalidomide and bortezomib - This guidance replaced TA338 when a traffic light classification of BLACK had been assigned. Classified as a **RED** drug. TA428 Pembrolizumab for treating PDL1-positive non-small cell lung cancer after chemotherapy – Classified as a **RED** drug (NHS England). TA429 Ibrutinib for previously treated chronic lymphocytic leukaemia and untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation – Classified as a **RED** drug (NHS England). TA430 Sofosbuvir– velpatasvir for treating chronic hepatitis C – Classified as a **RED** drug (NHS England). TA431 Mepolizumab for treating severe refractory eosinophilic asthma – Classified as a **RED** drug (NHS England). NG63 Antimicrobial stewardship: changing risk related behaviours in the general population (Joint NICE and Public Health England guideline) - This was being reviewed by Dr Diane Harris, Lead Antimicrobial Pharmacist.	**SD** **SD** **SD** **SD** **SD** **SD**
14.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Hydromorphone – **BROWN** Brivaracetam – **BROWN** after specialist initiation and stabilisation for three months Doxazosin MR – **BLACK** Low Molecular Weight Heparin – **GREEN** after specialist initiation Ceftriaxone 1g and 2g, Ertapenem 1g, Teicoplanin 800mg, Tazocin 4.5g and meropenum 1g - **GREEN** as per the North Derbyshire Outpatient and Parenteral Antimicrobial Therapy (OPAT) Step-Up Pathway Grazoprevir + elbasvir (Zepatier®) – **RED** (NHS England) Olaratumab (Lartruvo®) – **RED** (NHS England) Palbociclib (Ibrance®) – **RED** (NHS England) Pegaspargase (Oncaspar®) – **RED** (NHS England) Venetoclax (Venclexta®) – **RED** (NHS England) Pomalidomide for multiple myeloma previously treated with lenalidomide and bortezomib – **RED** as per NICE TA 427 Pembrolizumab for treating PDL1-positive non-small cell lung cancer after chemotherapy – **RED** as per NICE TA 428 Ibrutinib for previously treated chronic lymphocytic leukaemia and untreated chronic lymphocytic leukaemia with 17p deletion or TP53 mutation – **RED** as per NICE TA 429 Sofosbuvir– velpatasvir for treating chronic hepatitis C – **RED** as per NICE TA 430 Mepolizumab for treating severe refractory eosinophilic asthma – **RED** as per NICE TA 431	

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15.	**JAPC ACTION SUMMARY**	
	The action summary was noted by JAPC and amendments made: PCSK9 inhibitors and Lipid/Familial Hypercholesterolaemia guidance – To be brought to the April 2017 JAPC meeting. Osteoporosis – To be brought to the April 2017 JAPC meeting. Sacubitril/Valsartan – To be brought to the March 2017 JAPC meeting. Hydromorphone – To be taken off the list.	**SD** **SD** **SD** **SD**
16.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in January 2017 was noted. Dr Mott and Mrs Qureshi highlighted the following: • Tiotroium Braltus classified as GREEN alongside Respimat as 1st line LAMA choice in COPD. • Acidex Advance® had replaced Gaviscon Advance® as a more cost effective option. • Barrier cream products - Cavilon products removed and replaced with Cutimed Protect® as more cost-effective. • Emollients with low paraffin content (ZeroAQS®) highlighted in formulary. Emollient with no paraffin content (Imuderm®) added for use in patients who smoked and/or received oxygen therapy. • Nicotine replacement therapy (NRT) guideline - Mr Vinson would ensure that this was discussed at the next meeting of the Guideline Group. Dr Mott referred to the need to determine future NRT service provision in the south of the county as the future of the Livewell Service was being reviewed by Derby City Council. • Phosphate binders guideline – Mrs Qureshi reported that the guideline had almost been completed but a paper was still awaited about the generic version of sevelamer. • Vitamin supplementation in alcohol misuse – Mrs Qureshi would check whether any comments had been received from DTHFT.	**SQ**
17.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Nottinghamshire Area Prescribing Committee 16/09/16 • Burton Drugs and Therapeutic Committee 14/01/16 • DHcFT Drugs and Therapeutic Committee 24/11/16 • Sheffield Area Prescribing Group 17/11/16 • DTHFT Drugs and Therapeutic Committee 20/12/16 • Chesterfield Drugs and Therapeutic Committee 17/01/17 • DCHSFT Medication Operational Safety Team 05/01/17 Mrs Qureshi highlighted the following items from the minutes: Nottinghamshire Area Prescribing Group - Brivarecetam had been recommended for use in partial-onset epileptic seizures and a proposed Renagel® to Renvela® phosphate binder brand switch had been discussed due to an identified cost saving.	

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18.	**ANY OTHER BUSINESS**	
a.	Dr Mott reported that a meeting was to be held on 16th February in Leicester to discuss progress on the establishment of the four Regional Medicines Optimisation Committees at which he will be attending.	
b.	Dr Narula referred to the decision made by JAPC to classify ibandronic acid 50mg tablets as BROWN for off-licence use in post-menopausal women with breast cancer from Sheffield Teaching Hospital only. Concern had been expressed by Chesterfield GPs about their liability to prescribe this for unlicensed use. Dr Narula was advised to forward the details to Mr Dhadli who would advise.	**TN**
19.	**DATE OF NEXT MEETING**	
	Tuesday, 14th March 2017 at 1.30pm in the Post Mill Centre, South Normanton.	