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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 8 May 2018

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Kyleena® (LNG-IUS)	GREEN
Epistatus® and unlicensed specials	BLACK
Nebulised Colistimethate injection (Colomycin®)	GREEN after consultant/specialist initiation
Dosulepin	BLACK
Benralizumab (Fasenra®)	BLACK
Inotuzumab ozogamicin (Besponsa®)	RED as per NHS England commissioning intentions
Avelumab	RED (NHS England as per NICE TA517)
Pembrolizumab	RED (NHS England as per NICE TA 519)
Tocilizumab	RED (NHS England as per NICE TA518)

Clinical Guidelines

Management of actinic keratosis
Management of emergency rescue medication (buccal/oromucosal midazolam) for children, young people and adults with prolonged or repeated generalised, convulsive (tonic–clonic, tonic or clonic) seizures in the community
Management of UTIs in Older People >65 years Residing in Care Homes
Acute Coronary Syndrome, dual antiplatelet in STEMI patients for North Derbyshire
Use of nebulised Colistimethate injection (Colomycin®) in pseudomonas aeruginosa lung infections in adults with bronchiectasis (non-Cystic Fibrosis)

Patient Group Directions

Administration of human papillomavirus vaccine [Types 6, 11, 16, 18] (Recombinant, adsorbed) (HPV) to females from 12 years of age or from school year 8

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Present:	
Southern Derbyshire CCG	
Dr A Mott	GP (Chair)
Mr S Dhadli	Specialist Commissioning Pharmacist (Professional Secretary)
Mr S Hulme	Director of Medicines Management (also representing Erewash CCG)
Mrs S Qureshi	NICE Audit Pharmacist
North Derbyshire CCG	
Dr C Emslie	GP
Dr T Narula	GP
Mrs K Needham	Assistant Chief Quality Officer (Medicines Management) (also representing all four Derbyshire CCGs)
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 Teaching Hospitals NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutic Committee
Mr D Moore	High Cost Drugs Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Mr S Jones	Acting Chief Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Mr M Shepherd	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Ms A Braithwaite	Chief Pharmacist
Derby and Derbyshire Local Medical Committee	
In Attendance:	
Mr A Hawley	Acting Consultant in Public Health, Derby City Council
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr M Henn, Mrs L Hunter, Dr K Markus and Dr M Watkins.	
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 conflicts of interest were declared in relation to this agenda; in addition to the existing register of interests.	
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Dr Narula: Metformin and prevention of diabetes.	
4.	**MINUTES OF JAPC MEETING HELD ON 10 APRIL 2018**	
	The minutes of the meeting held on 10th April 2018 were agreed as a correct record.	
5.	**MATTERS ARISING**	
a.	**Midodrine** It was reported that the Guideline Group had decided there was no need to assign a traffic light classification to fludrocortisone.	
b.	**Hydoxychloroquine** An assurance had been received from CRHFT that their ophthalmologists were adhering to the new screening process. There were also ongoing discussions between the commissioners with regard to the position at DTHFT.	
c.	**Prioritisation Framework** Mr Hulme reported that the finalised version of the policy framework would be discussed by the newly established Joint Clinical and Lay Commissioning Committee which would hold its inaugural meeting on Friday 18th May 2018. The need to consider delegated authority and thresholds for groups such as JAPC had been highlighted.	
6.	**JAPC ACTION SUMMARY**	
	Use of NOAC for Suspected DVT – To be brought to the June 2018 JAPC meeting. Freestyle Libre® – To be brought to the July 2018 JAPC meeting. Chlamydia – To be brought to the September 2018 JAPC meeting.	**SD** **SD** **SD**
7.	**NEW DRUG ASSESSMENTS**	
a.	**Kyleena®** Mr Dhadli reported that a request had been received for Kyleena®, a levonorgestrel (LNG) intrauterine system (IUS) licensed for contraceptive use for five years, to be added as another option for use in the Derbyshire Integrated Sexual Health Service. Kyleena® was not licensed for management of heavy menstrual bleeding or to provide endometrial protection as part of hormonal replacement therapy.	

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	A review had been undertaken by the Faculty of Sexual and Reproductive Healthcare (FSRH) on the various LNG-IUS products including Kyleena®. The total LNG content was 19.5 mg compared to 52 mg, 52 mg and 13.5 mg for Mirena®, Levosert® and Jaydess® respectively. There was also a difference in size and duration of use and it was noted that Kyleena® was one of the more cost-effective choices for IUS for contraception. There was limited data from phase II and III studies which compared Kyleena® with Jaydess® and Mirena®. However, there was no published study which compared Kyleena® with Levosert®. The phase III trial had indicated an unadjusted Pearl Index of 0.29 for Kyleena® over the five years duration of use which was comparable to the other IUS. Dr Emslie advised that LNG-IUS products should be prescribed by brand. Mr Dhadli highlighted that Kyleena® was a viable alternative to Mirena® for contraceptive use and cost effective over the period of use compared to the other LNG-IUS products. The disadvantage was the slightly higher ectopic rate than Mirena® and that it was not licensed for management of heavy menstrual bleeding or to provide endometrial protection as part of hormonal replacement therapy. **Agreed:** Kyleena® classified as **GREEN** for use in the Integrated Sexual Health Service as suitable for primary care prescribing. **Action:** The table in the FSRH document, which outlined the product characteristics of Kyleena®, Mirena®, Levosert® and Jaydess®, would be included in the formulary chapter.	**SD** **SD**
8.	**PATIENT GROUP DIRECTIONs**	
	The following PGD from Public Health England was noted by JAPC: • Administration of human papillomavirus vaccine [Types 6, 11, 16, 18] (Recombinant, adsorbed) (HPV) to females from twelve years of age or from school year 8 in accordance with the national immunisation programme.	
9.	**CLINICAL GUIDELINES**	
a.	**Actinic Keratosis** Mr Dhadli reported that there had been no need for any significant changes to the actinic keratosis guideline. **Agreed:** JAPC approved the management of actinic keratosis guideline with a review date of two years.	**SD**
b.	**Midazolam** Mr Dhadli reported that buccal/oro-mucosal midazolam was used as emergency rescue for prolonged or repeated generalised, convulsive (tonic–clonic, tonic or clonic) seizures in the community. An information sheet had been produced in 2016 following the discontinuation of the shared care in order to support the prescribing and monitoring of buccal midazolam in primary care. Mr Dhadli highlighted that the main issue had been the choice to use Buccolam® or Epistatus® as the former was then the only licensed preparation.	

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	However Epistatus® now has a licensed 10mg pre-filled oral syringe and an unlicensed 5ml bottle but both remained more expensive than Buccolam®. The DHcFT Drugs and Therapeutic Committee had reviewed the guidance and responses from the DTHFT and CRHFT neurologists were still awaited. It was noted that DTHFT already used Buccolam® as the brand of choice to ensure consistency across the region and it was supported by the epilepsy nurse specialists. The information sheet had been updated in the light of the classifications of the unlicensed buccal midazolam preparations and Epistatus® as BLACK. All references to Epistatus® had been removed and advice given that existing patients should be reviewed by specialist services and then switched to the recommended Buccolam® preparation. During discussion Dr Emslie queried whether there were ongoing problems with the supply of Buccolam®. Mr Dhadli advised that the manufacturer had indicated that the previous quality issue had now been resolved. Mrs Needham commented that the fourth bullet point on page one should be re-worded to highlight that, although Epistatus® did have a licence for the 10mg pre-filled oral syringe, Buccolam® was the most cost effective licensed product. Dr Mott highlighted the training and implementation requirements for the administration of Buccolam®. The guideline referred to the administration of buccal midazolam by trained clinical personnel or, if specified by an individually agreed protocol drawn up with the specialist, by family members or carers with appropriate training. Dr Parkin advised that the majority of learning disability patients had been switched. Mr Jones added that there would be a need for the re-training of the carers due to a residual cohort of these patients. **Agreed:** Epistatus® re-classified as a **BLACK** drug, not routinely recommended or commissioned. **Agreed:** JAPC approved the guideline, with Buccolam® as the drug for the management of emergency rescue medication (buccal/oromucosal midazolam) for children, young people and adults with prolonged or repeated generalised, convulsive (tonic–clonic, tonic or clonic) seizures in the community with a review date of two years.	**SD**
c.	**STEMI (North Derbyshire)** Mr Dhadli reported that the North Derbyshire ST-segment-elevation-myocardial infarction (STEMI) percutaneous coronary intervention (PCI) guideline was due for review and the Guideline Group had been requested to consider whether this could be merged with the South Derbyshire STEMI-PCI guideline. However the Guideline Group had concluded that it was not possible to merge the two guidelines due to the significant differences between them. The current position was that patients in North Derbyshire received ticagrelor unless there were contraindications such as intracranial haemorrhage or advanced sinoatrial disease not yet treated with a permanent pacemaker.	

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	Patients in South Derbyshire received prasugrel unless it was contraindicated or there was an increased risk of bleeding due to age/weight. It was highlighted that the Southern Derbyshire use of prasugrel was significantly cheaper than ticagrelor and, although all the antiplatelet drugs were covered by NICE TAs, a variance in practice could be agreed by the relevant consultant cardiologists. In addition, it was noted that the prasugrel patent had expired and there could consequently be a reduction in price at some stage, although the date remains uncertain due to data patent. Mr Hulme queried whether the North Derbyshire/Sheffield position could be challenged as it appeared that the South Derbyshire STEMI-PCI guideline was more cost effective but still compliant with the NICE TA. **Action:** Mr Dhadli would contact Sheffield Area Prescribing Committee to request that they consider the possible adoption of the South Derbyshire STEMI-PCI guideline.	**SD**
d.	**<u>Management of UTIs in Older People >65 years Residing in Care Homes</u>** Mr Dhadli reported the guidance had been developed in order to provide information and guidance for GP practices to improve the management of urinary tract infections (UTIs) in older people >65 years residing in care homes. This followed on from the ongoing 'To Dip or Not to Dip' project work, a patient centred approach to improve the management of UTIs in the Care Home environment, which was being rolled out across Derbyshire. Mrs Needham highlighted an error in the numbered references in the section 'Treatment choices for Lower UTI' and Dr Narula requested that indications of length of treatment for men and women be added for the use of pivmecillinam and amoxicillin in the section 'Treatment choices for Lower UTI'. Mr Dhadli would clarify the lengths of treatment with Ms J Dhamrait, Southern Derbyshire CCG Medicines Safety and Quality Pharmacist, and include in the guideline. **Agreed:** JAPC approved the guideline for the Management of UTIs in Older People >65 years Residing in Care Homes with the agreed amendments and a review date of two years.	**SD** **SD**
9.	**SHARED CARE GUIDELINES**	
a.	**<u>Colomycin</u>** Mr Dhadli reported that there was an existing shared care guideline for the use of nebulised colistimethate injection (Colomycin®) in pseudomonas aeruginosa lung infections in adults with bronchiectasis (non-cystic fibrosis) and this was now due for review. The shared care guideline had been updated but, in view of the lack of monitoring requirements, it had been queried whether this was still required. Mr Dhadli added that an updated guideline was being prepared by the British Thoracic Society together with a public consultation. **Agreed:** Colomycin® classified as a **GREEN** drug after consultant/specialist initiation with a prescribing guideline to replace the shared care guideline.	**SD**

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Item		Action
10.	**MISCELLANEOUS**	
a.	**Eosinophilia in Immunomodulating Drugs** Mr Dhadli advised that the recommendations from the British Society for Rheumatology (BSR) had been adopted for the prescription and monitoring of non-biologic disease-modifying anti-rheumatic drugs (DMARDs). The shared care agreements had been updated accordingly and circulated for comment. A query had been received from a GP concerning raised eosinophilia counts in DMARD therapy. It was noted that, while the BSR had adopted routine eosinophilia monitoring, this was only an important marker for the identification of toxicity from gold therapy. Following discussion with consultant rheumatologists it had been agreed that eosinophil monitoring should be removed from the DMARD shared care guidelines except for gold therapy. **Agreed:** Eosinophilia monitoring would be taken out of the 'actions to be taken' table of the DMARD shared care guidelines, with the exception of sodium aurothiomalate (gold), and a footnote added to highlight this variance from the BSR guidance.	**SD**
b.	**Self-Care Policy** Mrs Needham reported that the Derbyshire-wide self-care policy, which concentrated only on short-term conditions, had now been updated so that it was in line with the NHS England guidance which included longer term conditions such as hayfever. It was noted that the Derbyshire policy was also disease rather than product specific. Mr Hulme advised that the revised CCG governance structure was still to be finalised but the Derbyshire self-care policy would be discussed by the Joint Clinical and Lay Commissioning Committee at its inaugural meeting on 18th May and then taken to the CCG Governing Bodies if required. **Agreed:** JAPC approved the amended Derbyshire CCGs Self-Care Policy.	**SD**
c.	**Liothyronine** Dr Mott advised that in April 2018 JAPC had re-classified liothyronine as RED in the light of the national position on drugs of low clinical value but agreed that the implementation should be deferred until the necessary referral pathways had been developed. This classification would facilitate the implementation of the NHS England guidance on liothyronine by ensuring that NHS specialist reviews were undertaken. Secondary care had been advised of this traffic light classification for all indications and requested to inform the Derbyshire CCGs of the necessary resources required for implementation. It was highlighted that, with effect from 12th June 2018, patients currently prescribed liothyronine would be referred to secondary care (endocrinology or mental health) by GPs in order to decide whether liothyronine could be stopped, alternative treatments could be offered or for a decision to continue with liothyronine, if appropriate, prescribed by the specialist. It would therefore be necessary to ascertain the numbers of patients affected and then send letters from the practices to them in order to explain the revised position on liothyronine and indicate the reasons for re-referral to secondary care.	

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	These letters, together with the referral templates, would need to be developed and would contain patient specific information to assist the consultants with the review process. This work would be co-ordinated by the JAPC QIPP working group who would also ensure that all the necessary actions had been undertaken in time for the letters to be sent out to patients after the next scheduled JAPC meeting on 12th June 2018. During discussion Mr Moore highlighted the significant work, in terms of additional clinical capacity at DTHFT, which would be needed to carry out this work. It would also need to be determined whether this group of patients would be treated as a separate cohort or as part of the general work of the endocrinology department. Mr Jones referred to those patients in DHcFT who received liothyronine for treatment resistant depression; in some cases for a number of years. Its use for treatment resistant depression had a defined evidence base and would therefore require a separate approach from that to be adopted for the patients with specific endocrine conditions. Mr Jones highlighted a significant problem for DHcFT in effectively communicating to these patients the reasons for a change in medication. Dr Mott commented that the Derbyshire CCGs would have the responsibility to undertake this and inform the DHcFT clinicians accordingly. Mr Hulme added that, in cases where there was genuine exceptionality, the traffic light classification could be re-examined in the future. **Agreed:** JAPC confirmed the previously agreed current traffic light classification of **RED** for liothyronine for all indications.	**SD**
d.	**<u>Omega-3 and Dosulepin</u>** Omega–3: Mr Dhadli advised that a table had been developed which compared the NHS England recommendations about omega-3 fatty acids and dosulepin with the current JAPC traffic light classifications for both drugs. It was noted that exceptionality had been allowed due to the classification by JAPC of omega-3 as BROWN after consultant lipid specialist recommendation in patients with severe hypertriglyceridaemia after a trial of fibrates +/- statins. It had been noted during the decision making process that neighbouring Area Prescribing Committees had allowed similar exceptionality for this cohort of patients. NHS England had indicated that they had not considered this indication in their guidance and any deviation to allow prescribing could be determined locally. Dr Mott commented that an understanding of the number of patients would be advantageous in order to determine whether there was significant usage and an audit would therefore be undertaken. **Agreed:** Omega-3 to remain classified as **BROWN** after consultant lipid specialist recommendation for patients with severe hypertriglyceridaemia (triglycerides>10mmol/L) after trial of fibrates +/- statins. This decision would be reviewed when the audit of patient numbers had been completed by medicines management. Dosulepin: JAPC was advised that dosulepin was classified as BLACK, not recommended or commissioned for new patients and BROWN for continuing use in existing patients only.	**SD**

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	It is considered by the British National Formulary to be less suitable for prescribing but JAPC had acknowledged that it could be used in exceptional circumstances. However, NHS England had indicated that they had not identified any routine exceptionality. During discussion Dr Parkin suggested that dosulepin should be re-classified BLACK, with no exceptionality, and this decision would be reinforced by the proposed new criteria for the JAPC black traffic light classifications. Mr Hulme suggested that an alternative classification of RED may be appropriate as dosulepin was not a safe drug but that there could be a cohort of patients who would require some specialist input in the future. Dr Emslie cautioned that it would be important to ensure that all prescribing was not immediately stopped in the event that dosulepin was classified as BLACK. Mr Dhadli stated that a note about this could be included in the traffic lights and bulletin. Dr Mott added that this would be included in the work being undertaken by the Derbyshire Medicines Management Team on the drugs of limited clinical value. **Agreed:** Dosulepin re-classified as a **BLACK** drug for all patients as not recommended/commissioned.	**SD**
e.	**<u>Low Clinical Value Medicines Policy</u>** Mr Hulme reported that the Derbyshire Low Clinical Value Medicines (LCVM) Policy had been received and supported by the CCG Executives and was now due to be discussed at the Clinical and Lay Commissioning Committee on 18th May. The policy aimed to support the implementation of the NHS England recommendations in Derbyshire and aligned the JAPC traffic light classifications for the eighteen drugs that should not be routinely prescribed in primary care. Mr Hulme highlighted the change in the title of the policy 'Items which should not be routinely prescribed in primary care/Prescribing for Better Value (PBV) Policy' and section six which referred to the actions to be taken by prescribers in the list of the current JAPC traffic light definitions. Mrs Needham commented that the revised policy title did not align with the communications sent to practices about the drugs of limited clinical value. In addition, section 6.4 'Brown drugs' referred to 'no new prescribing should be initiated' and should instead read 'no new prescribing should be initiated outside the exceptionality'. Section four 'Scope and purpose of the policy' referred to the implementation of the policy to be monitored via ePACT data and it was agreed that 'and other activity data' be added to this. **Action:** The amendments to be incorporated into the document which would then be sent to all JAPC members with a request for any further comments to be conveyed to Ms K Stanley, Senior Administration Officer to the Medicines Management Clinical Effectiveness Team.	**SD**
f.	**<u>Black Traffic Light Classification</u>** Dr Mott stated that it was necessary to widen the definitions in the black traffic light classification to cover all items which could be prescribed and strengthen the assurance that there would be no prescribing of any items which had this particular classification.	

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	JAPC was advised that the revised definitions were 'not recommended or commissioned'. This included drugs/treatments/medical devices which: • Were classified by the BNF as 'less suitable for prescribing', and included anti-malarials (where a private prescription may be provided). • Had a lack of data on effectiveness compared with standard therapy. • Had a lack of data on safety compared with standard therapy. • Had a known increase in risk of adverse events compared with standard therapy. • Had a lack of data on cost-effectiveness compared with standard therapy. Less cost-effective than current standard therapy. • Had NICE guidance that recommended they should not be used. • Were deemed by national publications (e.g. by NHS England / NHS Clinical Commissioners) to be of limited value unless agreed by local agreement. 'For patients that were already on the medicine/treatment/medical device prior to the BLACK classification, this should not be withdrawn abruptly from patients, but should be continued until the next medication review where their NHS clinician should consider whether it is appropriate to switch or stop treatment or submit an individual funding request if in exceptional circumstances on-going prescribing was considered clinically appropriate.' Dr Mott referred to the current BLACK traffic light which stated "Not routinely recommended or commissioned' and highlighted that this had been taken out of the revised version. Dr Goddard queried whether there was a defined timescale for medication reviews for the cohort of patients who had been in receipt of a drug for a long period of time. Following discussion, the following amendments were agreed: • '….should consider' to be replaced with '….to decide'. • '….should be continued until the next medication review' to be replaced with '…..should be continued until the next clinical review'. • '….NHS clinician should consider whether it is appropriate to switch or stop treatment….' to be replaced with '…..NHS clinician will decide whether it is appropriate to switch or stop treatment….' It was noted that the retention of the current Individual Funding Request (IFR) Panel, or its replacement/augmentation with another support mechanism, would be discussed by the JAPC QIPP working group at its next meeting. **Agreed:** JAPC supported the revised wording for the BLACK traffic light classifications with the agreed amendments.	**SD**
11.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC) OUTPUTS**	
	JAPC noted the following: • A topics and work programme for London, South, Midlands and East had been developed. • The status of RMOC recommendations and all other outputs were advisory and did not affect the statutory legal responsibilities and duties of NHS organisations.	

Item		Action
	• A consultation document 'Regional Medicines Optimisation Committees – Identifying and assessing medicines optimisation priorities and new medicines' had been issued which referred to the NHS England intention, via the Medicines Value Programme, to address the following priorities through the RMOCs: ➢ Encourage the uptake and use of the best value biological medicines; ➢ Achieve a 50% reduction in antimicrobial resistance; ➢ A sustained reduction in polypharmacy; ➢ Medicines Optimisation in Care Homes. • RMOC North had endorsed the standardisation of strengths of high risk, unlicensed oral liquids for the four drugs which formed the mainstay of anti-TB treatment in children. • A Midlands and East Update April 2018 had been issued following the RMOC meeting and the following were highlighted: ➢ Insulin: safety factors to be considered during local formulary decision-making. An output would be circulated to Area Prescribing Committees when completed. ➢ Guidance on homely remedies in care homes. ➢ There was now a Specialist Pharmacy Services website - RMOC section. • A best value medicines sub-group was to be established in each of the RMOC areas.	
11.	**JAPC BULLETIN**	
	A revision would be made to the last sentence of the omega-3 section. The amended bulletin was ratified by JAPC.	**SD**
12.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for April 2018 was noted. Mr Dhadli highlighted the following MHRA advice: • Valproate medicines (Epilim®▼, Depakote®▼): contraindicated in women and girls of childbearing potential unless the conditions of the Pregnancy Prevention Programme were met. • Obeticholic acid (Ocaliva®▼): risk of serious liver injury in patients with pre-existing moderate or severe hepatic impairment; reminder to adjust dosing according to liver function monitoring. • The Yellow Card Scheme highlighted which was the UK system for monitoring the safety of medicines and healthcare products to ensure that they were acceptably safe for use by patients.	
13.	**HORIZON SCAN**	
	Monthly Horizon Scan Mr Dhadli advised JAPC of the following: New drug launches in the UK: • Benralizumab (Fasenra®) – Classified as **BLACK** awaiting NHS England commissioning intentions.	**SD**

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	• Enoxaparin biosimilar (Enoxaparin Becat®) – Already classified as **GREEN**. • Inotuzumab ozogamicin (Besponsa®) – Classified as **RED** (NHS England). • Trastuzumab biosimilar (Ontruzant®) – Already classified as **RED**. **Quarterly NICE Updates** JAPC noted the NICE horizon scan.	**SD** **SD** **SD**
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance issued in April 2018: TA 517 Avelumab for treating metastatic Merkel cell carcinoma – Classified as **RED** (NHS England as per NICE TA 517). TA 518 Tocilizumab for treating giant cell arteritis – Classified as **RED** (NHS England as per NICE TA 518). TA 519 Pembrolizumab for treating locally advanced or metastatic urothelial carcinoma after platinum-containing chemotherapy – Classified as **RED** (NHS England as per NICE TA 519). CG 90 (updated from October 2009) Depression in adults: recognition and management - Footnotes in the guideline have been amended to link to the latest advice and resources on sodium valproate from the MHRA. CG 137 (updated from January 2012) Epilepsies: diagnosis and management - Footnotes and cautions in the guideline have been added and amended to link to the latest advice and resources on sodium valproate from the MHRA. CG 173 (updated from November 2013) Neuropathic pain in adults: Pharmacological management in non-specialist settings - Cautions in the guideline have been added to link to the latest advice and resources on sodium valproate from the MHRA. CG 185 (updated from September 2014) Bipolar disorder: assessment and Management - Footnotes and cautions in the guideline have been added and amended to link to the latest advice and resources on sodium valproate from the MHRA. CG 192 (updated from December 2014) Antenatal and postnatal mental health: clinical management and service guidance - Footnotes and cautions in the guideline have been added and amended to link to the latest advice and resources on sodium valproate from the MHRA.	
15.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in April 2018 was noted. Mr Dhadli highlighted the following: Formulary Update: • Rivastigmine 4.5mg and 6mg capsules and amisulpride 400mg tablets were significantly more expensive than using combination of lower strengths and preparations had been removed from formulary.	

Item		Action
	Clinical/Shared Care Guidelines: • ICS/LABA step-down guidance - Updated in line with the local asthma/ COPD guideline. • JAPC appeals process document updated. If new national guidance emerged, which was not included in the original decision making process, a review would be defined as a re-submission/update and not an appeal. Traffic Light Amendments: • Fludrocortisone for postural hypotension - unclassified. Very limited evidence, off-label indication. Fludrocortisone licensed for replacement therapy in adrenocortical insufficiency. • Fobumix® (budesonide/formoterol DPI) – unclassified. To be added to 'Summary of common inhalers' document at the next review. Miscellaneous: • EMA March 2018 had recommended a ban on the use of valproate-containing medicines for migraine or bipolar disorder during pregnancy and a ban on treating epilepsy during pregnancy unless there was no other effective treatment available. Valproate containing medicines must not be used in any woman or girl able to have children unless the conditions of a new pregnancy prevention programme were met. Information had been added to the formulary. • Nutilis clear – Mixing instruction updated in the formulary following a change to classification of thickened fluid. The new framework consisted of eight levels and comprised both drink thickness and food texture. • Movelat gel – Following PrescQIPP advice and definition submitted by the manufacturer it was still not defined as an NSAID. Further updates from PrescQIPP were awaited.	
16.	**JAPC SUB-GROUPS**	
	Biosimilar and High Cost Drugs (HCD) Working Group The paper of the top biosimilar medicines list which gave the target annual savings broken down to DTHFT, CRHFT and Burton Hospitals NHS Foundation Trust was received by JAPC. Mr Dhadli advised that total biosimilar culmulative uptake by Trust would be provided for future JAPC meetings.	
17.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Kyleena® – **GREEN** Epistatus® and unlicensed specials – **BLACK** Nebulised colistimethate injection (Colomycin®) – **GREEN** after consultant/specialist initiation Dosulepin – **BLACK** Benralizumab (Fasenra®) – **BLACK** Inotuzumab ozogamicin (Besponsa®) – **RED** as per NHS England commissioning intentions Avelumab – **RED** (NHS England as per NICE TA517) Pembrolizumab – **RED** (NHS England as per NICE TA 519) Tocilizumab - **RED** (NHS England as per NICE TA 518)	

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Item		Action
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• CRHFT Drugs and Therapeutic Committee 20/03/2018 • DTHFT Drugs and Therapeutic Committee 20/03/2018 • Regional Medicines Optimisation Committee (London) 01/03/2018	
19.	**ANY OTHER BUSINESS**	
	Dr Narula queried the status of metformin with pre-diabetes and non-diabetic hyperglycaemia in the support of lifestyle change for people when there had been no improvement in HbA1c or glucose blood test results despite participation in lifestyle-change programmes or alternatively that they could not take part. Mr Dhadli advised that the diabetes guidance had been updated to indicate that any decision to do this would be made on an individual basis. Mr Dhadli would send a reference and further information to Dr Narula.	**SD**
20.	**DATE OF NEXT MEETING**	
	Tuesday, 12th June 2018 at 1.30pm in the Coney Green Business Centre, Clay Cross.	