For agenda items contact Slakahan Dhadli
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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 13 November 2018

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Axicabtagene ciloleucel (Yescarta®)	RED (as per NHS England commissioning intentions)
Cytarabine + daunorubicin liposomal (Vyxeos®)	RED (as per NHS England commissioning intentions)
Alkindi® (Hydrocortisone capsules)	RED as this brand (as per NHS England commissioning intentions for those <18 years of age)
Burosumab	RED as per NICE HST8
Cabozantinib	RED (as per NICE TA 542 and as per NHS England commissioning intentions)
Tofacitinib	RED as per NICE TA 543
Dabrafenib with trametinib	RED as per NICE TA 544 and as per NHS England commissioning intentions)
Fluticasone + formoterol (flutiform® k-haler®)	BROWN
Cariprazine (Reaglia®)	BLACK
Erenumab	BLACK

Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
Olive Oil	BROWN from GREEN
Sodium bicarbonate 5% ear drops	BROWN from GREEN
Ephedrine 0.5% nasal drops	BROWN from GREEN
Sodium chloride 0.9% drops	BROWN from GREEN
Testosterone Gel (Testavan®)	GREEN specialist recommendation

Clinical Guidelines

Management of Non-Valvular Atrial Fibrillation
Compression Hosiery
Management of Dementia in Primary Care
Derbyshire Community Dressing Formulary and Wound Care Guidelines 2018

Patient Group Directions

Administration of Haemophilus influenzae type b and meningococcal C conjugate vaccine (Hib/MenC) to individuals, from their second birthday, with an underlying medical condition which puts them at increased risk from Haemophilus influenzae type b and Neisseria meningitidis capsular group C.

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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 and Clinical Policies
Mrs S Qureshi	NICE Audit Pharmacist
Dr M Watkins	GP
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	
University Hospitals of Derby and Burton NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutic Committee
Mr D Moore	HCD Pharmacist
Mr R Sutton	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	
Derby and Derbyshire Local Medical Committee	
Derbyshire Health United	
Mr D Graham	Pharmacist
In Attendance:	
Mr A Thorpe	Derby City Council (minutes)

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Item		Action
1.	**APOLOGIES**	
	Dr M Henn, Mrs L Hunter and Dr K Markus. It was noted that there was no representation from DCHSFT and it was agreed that any issues relevant to the Trust would be picked up outside the meeting.	
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. Dr Mott highlighted that any outstanding annual declaration of interest forms should be completed and returned as soon as possible to the JAPC Professional Secretary. No conflicts of interest were declared in relation to this agenda; in addition to the existing register of interests.	**All**
3.	**DECLARATIONS OF ANY OTHER BUSINESS**	
	• Derbyshire Health United Patient Group Directions.	
4.	**MINUTES OF JAPC MEETING HELD ON 9 OCTOBER 2018**	
	The minutes of the meeting held on 9th October 2018 were agreed as a correct record.	
5.	**MATTERS ARISING**	
a.	**Low Molecular Weight Heparin** To be placed on the action tracker for an update to the January 2019 JAPC meeting.	**SD**
b.	**Cow's Milk Protein Allergy (CMPA)** An update would be given to the December JAPC meeting following a meeting between the UHDBFT and CRHFT dietetic teams, together with a representative from medicines management, to be held in November. Dr Mott would discuss further the potential development of a direct referral pathway with the CRHFT dietetic service.	**SD** **AM**
c.	**Derbyshire Health United (DHU) Out of Hours Formulary** Mr Dhadli stated that DHU had now responded to the queries which had been raised at the last JAPC meeting. Dihydrocodeine had been removed from the formulary and noted that both morphine and diamorphine were used due to varying practice between the North and South. Dr Mott queried the reasons for the inclusion of diazepam rectal tubes in the DHU formulary. Mr Graham advised that rectal diazepam had been used on three occasions in six months during home visits. There was a significant cost difference between the cost of the alternative product, buccal midazolam pre-filled oral syringes at £6,500, and rectal diazepam at £300 which also had a longer shelf-life. JAPC ratified this variation.	**SD**
d.	**Dupilumab** Mrs Qureshi reported that the NICE template indicated that in year one eight patients had been estimated across Derbyshire increasing to eighty-three by year five.	

Item		Action
	However, UHDBFT had estimated between ten and twenty patients per year, which was higher than predicted due to a cohort waiting for treatment, and CRHFT had estimated up to five patients in the first year. It was noted that the numbers were higher than originally estimated by NICE but should stabilise over time.	
6.	**JAPC ACTION SUMMARY**	
	Freestyle Libre® - A meeting to further discuss the Freestyle Libre® patient numbers would be held immediately before the next JAPC meeting. To be brought to the March 2019 JAPC meeting. Rosuvastatin - Mr Dhadli reported that the prescribing trends following the formulary change from BLACK to BROWN would be reviewed. To be brought to either the January or February 2019 JAPC meeting. Hydroxychloroquine - This would be discussed by the CCG's Clinical and Lay Commissioning Committee in December. A report to JAPC would be made after this; possibly in January 2019. C.Difficile - The prescribing information had been completed but diagnostic aspects were still being reviewed by Ms S Bestwick, CCG Lead Nurse Infection Prevention and Control. The Guideline Group would discuss the updated guideline when this had been completed.	**SD** **SD** **SD** **SD**
7.	**CLINICAL GUIDELINES**	
a.	**<u>Atrial Fibrillation</u>** Mr Dhadli reported that the atrial fibrillation (AF) guideline was due for review in September 2018 and this had been undertaken in line with the European Heart Rhythm Association (EHRA), endorsed by the European Society of Cardiology (ESC), publication on the use of non-vitamin K antagonist oral anticoagulants in patients with atrial fibrillation. The guideline had been updated in collaboration with the acute trust cardiologists and Mr Dhadli highlighted the following: • The definition of valvular AF had been queried by Dr J Baron, UHDBFT Consultant Cardiologist. It was noted that the ESC had referred to the specific underlying valvular heart disease (VHD) but the term 'non-valvular AF' was still contained in the individual summary of product characteristics (SmPCs) of each of the novel anticoagulants (NOACs) due to the original wording used in the exclusion criteria of the clinical trials on which their regulatory approval was based. The AF classifications had been updated and these now indicated where a NOAC could be used but this would be decided by the consultant cardiologists on an individual patient basis. The guideline group had accordingly agreed that the local definition in the guidance should indicate AF in the presence of a mechanical prosthetic heart valve or moderate to severe rheumatic mitral stenosis. • It had been suggested that an echocardiogram should be standard for all patients but the NICE guidance stated this was not necessary unless patients were deemed to be at high risk. This had therefore not been included. • Dr Baron had commented that the NOACs had far fewer interactions but the EHRA paper referred to a wide range of individual interactions.	

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	• Dr Baron had suggested that lipid profile in bloods be included to allow for the assessment of overall cardiac risk profile and that, if patients were needle phobic or difficult to bleed, NOACs were preferred although some blood tests would still be required. It had been agreed that 'consider lipid profile to assess CV risk' be included in page 4 and the wording altered in page 9. • Dr Baron had suggested that, based on pharmacokinetics data, apixaban or edoxaban could be used in patients with renal impairment. However the guideline group had concluded that there was insufficient data to recommend one of these drugs over the other and the SPC guidance concerning renal impairment would therefore be followed. • New key message added in page 1 about the need to check doses at initiation and review at the annual review. • Addition of available 'real world' data to suggest variable adherence to NOAC intake from 38% to 99%, depending on the setting and definition, and patient education on the need for oral anticoagulation therapy and the importance of strict adherence. • Addition of advice that dabigatran capsules must not be opened due to the risk of a substantial increase in drug bioavailability (+75%). • Addition of guidance concerning antithrombotic therapy in AF patients who presented with ACS and/or were undergoing PCI. • Key messages included about repeat renal and liver function tests and full blood count for the four NOACs. • Information on the transition from and to NOAC or warfarin included. During discussion Mrs Needham commented on the need to ensure that the summary guidance/locally adopted detailing aids were updated in line with the full guidance. The latter updated summary guidance would then need to be reviewed by the guidelines group. Mr Hulme highlighted that treatment and acquisition costs of the NOACs had not been included in the guideline and it was important that these were also taken into account when a decision was made about a choice of product. It was agreed that information on costs of NOACs for AF would be included in the detailed prescribing information about the NOACs.	**SD**
	Dr Narula referred to the use of echocardiogram and that consideration of this should be included in the guidance. It was agreed that the reference on page four to echocardiograms should be amended to reflect this.	**SD**
	Agreed: JAPC approved the updated Management of Non-Valvular Atrial Fibrillation with the agreed amendments with a review date of two years.	**SD**
b.	**<u>Compression Hosiery</u>** Mr Dhadli reported that the compression hosiery guideline had been updated in collaboration with the Ms T Townsend, DCHSFT Tissue Viability Matron, Mr G Hicken, CRHFT consultant vascular and general surgeon, Dr G Colver, CRHFT consultant dermatologist, and DCHSFT and CRHFT Heads of Medicine Management and clinical pharmacy. Mr Dhadli highlighted some of the main changes:	

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	• The use of the Ankle Brachial Pressure Index (ABPI), which was not considered to be an absolute test for peripheral arterial disease, and therefore an addition had been made to indicate that its use for diagnosis was a reasonable guide as to the presence of significant peripheral arterial disease but should only be an adjunct to clinical assessment. • The Guideline Group had added a reference to the need for 'made to measure' not to be routinely included on the prescriptions. • Information added from NICE NG 89 'Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism' to indicate the situations when anti-embolism stockings should not be offered. • Removal of the indications table and replacement with information from the NICE Clinical Knowledge Summary on compression stockings. • The Edinburgh Claudication questionnaire had been removed as it was no longer used. **Agreed:** JAPC approved the guidelines for the use of compression hosiery with a review date of two years.	**SD**
c.	**<u>Management of Dementia in Primary Care</u>** Mr Dhadli advised that the guideline for the management of dementia in primary care had been discussed at the October 2018 JAPC meeting. It had been agreed to ascertain the views of DHcFT specialists about a change of practice concerning the withdrawal of an acetylcholinesterase inhibitor (AChEI) and consideration of memantine if patients had moderate Alzheimer's disease or offered if they had severe disease. Comments had subsequently been received from two DHcFT old age specialists, a clinical nurse specialist and the memory assessment service manager. Mr Dhadli highlighted some of the main changes which had been made in the light of these comments: • Amendment made to indicate that patients should only be referred back to the specialist if their cognitive behaviours changes, behavioural and psychological symptoms or risks emerge and specialist support is required. • Information added as to when a patient should be referred back to a specialist. • Memantine should be offered in addition to an AChEI for people with an established diagnosis of moderate/severe Alzheimer's disease. • Most patients would remain on treatment and patients would be reviewed on an individual basis to determine whether the AChEI would be stopped once he or she had been commenced on memantine. Mrs Needham stated that information on costs should be included as all the products and formulations were listed in the prescribing information in the guideline – this would be added.	**SD**
	Dr Watkins queried how it should be determined by primary care when the cohort of patients who were managed but slowly declining should be referred back for assessment for possible use of memantine as the guideline did not seem to offer any guidance about this. Dr Taylor would raise this question within DHcFT.	**ST**

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Item		Action
	Agreed: JAPC approved the guidelines for the management of dementia in primary care with the agreed amendments with a review date of two years.	**SD**
d.	**<u>Wound Care</u>** Mr Dhadli reported that periodically eighteen acute and community Trusts, which included Derbyshire, Leicestershire, Northamptonshire and Nottinghamshire, undertook a procurement exercise to determine the best value wound care products. Arising from this the Derbyshire wound care and dressing formulary has been reviewed and updated to assist clinical staff to use the most clinically effective, appropriate and cost-effective products. During discussion, Mrs Needham commented that one of the new products, Bastos Viegas absorbent pad, which had replaced Zetuvit E, was not eligible for prescription on an FP10, and therefore an alternative product would be required when a prescription was needed. Clarification was also required about the reference in the frequently asked questions section to the need to order dressings through NHS Supplies but also the need to check with relevant commissioners whether the cost of these had been included in the basket of services specification. There was also a lack of clarity about what was supplied via the direct scheme and monitoring and governance issues concerning the off FP10 dressings scheme would also need to be resolved. Dr Parkin queried the occasions when the use of sterile water would be preferred over tap water and why this had been included in the formulary. This would be raised with the tissue viability nurses.	**SD**
	Action: Mr Dhadli would convey the need to include a reference about the unavailability of bastos viegas, the query about water and sterile saline.	**SD**
	Agreed: JAPC approved the Derbyshire Community Dressing Formulary and Wound Care Guidelines 2018 subject to clarification of the issues raised during the discussion and resolution of some formatting/typographical errors.	**SD**
8.	**PATIENT GROUP CLINICAL GUIDELINES**	
	The following addendum to the IM Influenza PGD V06.00, PHE publications gateway number: 2015270, valid from 1 September 2018 to 31 March 2019, page seven, bullet point six, was noted by JAPC: • Have received a complete dose of the recommended influenza vaccine for the current season, unless they are individuals aged 6 months to less than 9 years in a clinical risk group category listed in Chapter 19 of the 'The Green Book' who should, in the first season they are vaccinated against influenza, receive a second dose of an appropriate influenza vaccine at least four weeks after the first dose. The following PGD from Public Health England was noted by JAPC: • Administration of Haemophilus influenzae type b and meningococcal C conjugate vaccine (Hib/MenC) to individuals, from their second birthday, with an underlying medical condition which puts them at increased risk from *Haemophilus influenzae type b* and *Neisseria meningitidis capsular group C*.	

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Item		Action
9.	**MISCELLANEOUS**	
a.	**Horizon Scan** Mrs Qureshi reported that the SPS cost calculator was not yet available to highlight the cost pressures for 2019 to 2020 but the prescribing outlook for 2018, 2019 and 2020 had been published and the drugs now split as follows: • High Cost Drugs (HCD) CCG commissioned. • HCD NHS England commissioned. • Primary care drugs. • Drugs initiated in secondary care, transferred to primary care. • Secondary care in-tariff drugs. • Local Authority commissioned. The horizon scan papers would be brought to the December JAPC meeting for further discussion.	**SQ**
b.	**Cannabis-based Products for Medicinal Use** Mr Dhadli reported that the Home Office had announced that, with effect from 1st November 2018, cannabis-derived medicinal products would move from Schedule 1 to Schedule 2 to allow them to be prescribed. A letter had been published by the Department of Health and Social Care (DHSC) in October 2018 on cannabis-based products for medicinal use. Key points from the letter were: • Synthetic cannabinoids were specifically excluded from this exemption and reserved for further consideration. • Cannabis-based products for medicinal use to Schedule 2 would enable these to be prescribed medicinally where there was an unmet clinical need. • All cannabis-based products for medicinal use, apart from Sativex®, are currently unlicensed medicines. • Due to the limited evidence base and being unlicensed the cannabis-based products for medicinal use could only be prescribed by the clinicians who were listed on the Specialist Register of the General Medical Council and the decision to prescribe should be agreed by the multidisciplinary team. • Anticipated that initial use will be via specialist prescribing only. • NICE would develop more detailed guidelines for clinicians by October 2019. NHS England had requested the British Paediatric Neurology Association (BPNA) to develop clinical advice on the use of cannabis-based products for medicinal use in paediatric patients with certain forms of severe epilepsy. NHS England had also requested the Royal College of Physicians to develop additional guidance concerning the prescribing of cannabis based products for medicinal use in intractable chemotherapy induced nausea and vomiting and chronic pain. It was noted that the commissioning of cannabis-based products for children's epilepsy and multiple sclerosis would likely fall under the remit of NHS England and use for chronic pain would become a CCG responsibility. **Agreed:** The possible assignation of a traffic light classification of RED would be further discussed by JAPC at the December meeting following consideration by the CRHFT and UHDBFT Drug and Therapeutic Committees.	

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Item		Action
	A position statement on its use would also need to be developed.	**SD**
c.	**Pregabalin and Gabapentin – Misuse of Drugs Act** Mr Dhadli reported that the Home Office had issued a consultation on proposals to schedule pregabalin and gabapentin under the Misuse of Drugs Regulations 2001. The likely outcomes were to be safeguards against diversion and a move to schedule 3 with no CD storage.	
d.	**Prescribing Specification** Mr Dhadli reported that the draft 2019/2020 prescribing specification had previously been discussed by JAPC and final sign-off agreed at the December meeting. Mr Dhadli advised that the High Cost Drug part of the specification had now been organised into appropriate sections, including governance, financial, monitoring, incentives/gain sharing and patient monitoring, and outlined the other amendments which had been made to the prescribing specification as referred to in the background paper. Further comments on the specification should be conveyed to Mr Dhadli.	**All**
e.	**Terms of Reference** Dr Mott advised that the terms of reference of JAPC, Shared Care and Guideline Group, Biosimilar/High Cost Drugs and QIPP working groups would need to be amended in the light of the anticipated formation of a single Derbyshire CCG structure with effect from 1st April 2019. It was agreed that the existing terms of reference would be extended for a further six months and finalised when the forthcoming re-structure had been completed.	**SD**
f.	**National Institute for Health Research (NIHR) Signal – Apixaban** Mr Dhadli advised that this NIHR Signal Study had analysed the UK primary care data in two databases with 196,061 people prescribed warfarin or NOACs between 2011 and 2016. It had linked patient-level data to the hospital records to ascertain if complications had been recorded. The researchers had followed patients on warfarin for on average six to eleven months, and on NOACs for three to nine months, but had not looked at patient compliance to the prescribed drugs. The study had found that, for people with atrial fibrillation, major bleeding was less likely with apixaban; intracranial bleeding was less frequent in those on apixaban compared to those on warfarin and risk of death from any cause was higher for patients taking rivaroxaban than warfarin and also higher for those on low-dose apixaban which was of concern. For people on anticoagulation for other reasons apixaban was associated with a lower risk of major bleeding. It was noted that this was an observational study and RCTs would be required to draw definitive conclusions.	
g.	**Eczema in Children BATHE Study** This study had looked at the efficacy of emollient bath additives for the treatment of childhood eczema and had found no evidence of clinical benefit.	
10.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
	JAPC noted the following: • Adalimumab toolkit for commissioners and providers (published July 2018 and updated in August 2018).	

Item		Action
	• Free of Charge (FOC) Medicines Schemes: RMOC Advice for adoption as local policy (July 2018). • Insulin preparations: RMOC recommendations of safety considerations for formulary decision making (June 2018). • RMOC Antidotes and RUMs Position Statement (May 2018). • RMOC FreeStyle Libre® (April 2018). • RMOC Recommendation: Standardising strengths of high risk, unlicensed oral liquids formulations for anti-TB medicines (published in April 2018 and updated in June 2018).	
11.	**JAPC BULLETIN**	
	The bulletin was ratified by JAPC.	
12.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for November 2018 was noted. Mr Dhadli highlighted the following MHRA advice: • Rivaroxaban (Xarelto▼) after transcatheter aortic valve replacement: increase in all-cause mortality, thromboembolic and bleeding events in patients in a clinical trial. The study had been rivaroxaban versus clopidogrel + aspirin. • Ritonavir-containing products: reports of interaction with levothyroxine leading to reduced thyroxine levels. An issue was highlighted concerning practices knowing and recording the antiretroviral (ARV) drugs used to suppress the HIV virus and stop the progression of HIV disease. • Ponatinib (Iclusig▼): reports of posterior reversible encephalopathy syndrome. • Transdermal fentanyl patches: life-threatening and fatal opioid toxicity from accidental exposure; particularly in children. To be highlighted in the bulletin. • Medical Device Alert: CoaguChek Test Strips for Point of Care and Home Use – Risk of false high results.	**SD**
13.	**HORIZON SCAN**	
	Monthly Horizon Scan Mr Dhadli advised JAPC of the following: New drug launches in the UK: • Axicabtagene ciloleucel (Yescarta®) – Classified as **RED** (NHS England). • Cariprazine (Reagila®) – Classified as **BLACK** and await DHcFT clinician request and Drugs and Therapeutic Committee (DTC) review. • Dinutuximab beta (Qarziba®) – Classified as **RED** (NHS England). • Erenumab (Aimovig®) – Classified as **BLACK** and await publication of NICE TA. • Pentosan polysulfate sodium (Elmiron®) – Retain the current traffic light classification of **RED**. New formulation launches in the UK: • Budesonide – To be left unclassified and await review by the DTCs.	

Item		Action
	• Cytarabine + daunorubicin liposomal (Vyxeos®) – Classified as **RED** (NHS England). • Fluticasone + formoterol (Flutiform K-Haler®) – Retain the current traffic light classification of **BROWN**. • Hydrocortisone (Alkindi®) – Classified as **RED** as this brand (NHS England). • Testosterone (Testavan®) – Already classified as **GREEN** by the Shared Care and Guideline Group. **Quarterly NICE Updates** JAPC noted the NICE horizon scan.	
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance in October 2018: HST 8 Burosumab for treating X-linked hypophosphataemia in children and young people – Classified as **RED.** TA 542 Cabozantinib for untreated advanced renal cell carcinoma – Classified as **RED** (NHS England as per NICE TA 542). TA 543 Tofacitinib for treating active psoriatic arthritis after inadequate response to DMARDs – Classified as **RED** (CCG commissioned). TA 544 Dabrafenib with trametinib for adjuvant treatment of resected BRAF V600 mutation – Classified as **RED** (NHS England as per NICE TA 544). NG 109 Urinary tract infection (lower): antimicrobial prescribing – This matched local antimicrobial guidance. NG 110 Prostatitis (acute): antimicrobial prescribing – This matched local antimicrobial guidance. NG 111 Pyelonephritis (acute): antimicrobial prescribing – An additional option cefalexin had been included which was not in the local antimicrobial guidance. NG 112 Urinary tract infection (recurrent): antimicrobial prescribing – This did not match up with local antimicrobial guidance and Dr D Harris, Lead Antimicrobial Pharmacist, was looking further at this.	**DH**
15.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in October 2018 was noted. Mr Dhadli highlighted the following: Traffic Lights: Olive Oil – Classified as **BROWN** from GREEN. Sodium bicarbonate 5% ear drops – Classified as **BROWN** from GREEN.	

Item		Action
	Ephedrine 0.5% nasal drops – Classified as **BROWN** from GREEN. Sodium chloride 0.9% drops – Classified as **BROWN** from GREEN. Testosterone Gel (Testavan®) – Classified as **GREEN** specialist recommendation. Clinical/Shared Care Guidelines: Leflunomide shared care – Pregnancy contraindications affecting both men and women clarified. This had been added to GP, consultant and patient responsibilities section. Irritable Bowel Syndrome (IBS) – Guidance updated to include link to shared care pathology 'Management of Altered Bowel Habit'. Clarified that faecal calprotectin is the marker for inflammatory bowel disease (IBD). Allergic Rhinitis and Grazax – Guidelines updated to include lodoxamide eye drops as per the Derbyshire formulary and recommended that sodium cromoglicate could be purchased over the counter. Website Changes/Miscellaneous: Formulary Chapter 3 Respiratory System – Links added to extra resources for adrenaline auto-injectors. These include educational material produced by the manufacturers and SPS resources.	
16.	**JAPC SUB-GROUPS**	
a.	**Biosimilar and High Cost Drugs (HCD) Working Group** Mr Moore advised that formal notification had now been received that Biogen and the Amgen biosimilar products had been allocated as the adalimumab biosimilar products and the reference prices would be available shortly.	
b.	**Derbyshire Medicines Safety Network** Mr Dhadli reported that a summary of key messages from the meeting of the Derbyshire Medicines Safety Network held on 11th October 2018 had been prepared as follows: • Valproate medicines use in women of childbearing age: ➢ Each provider organisation had individual action plans concerning the Valproate Medicines Pregnancy Prevention Programme (PPP 'Prevent'). ➢ All provider trusts across Derbyshire were ready to receive referrals where required. ➢ Valproate medicines prescribing data from GP practices within Southern Derbyshire CCG, Erewash CCG and the Alfreton area had been shared with UHDBFT to advise about the likely numbers of referrals to neurologists. However it was highlighted that UHDBFT was not receiving as many referrals as anticipated. ➢ GP practices who had not received completed risk acknowledgement forms following a patient appointment with a specialist should follow this up with the relevant specialist in the first instance. ➢ The JAPC Chair, in conjunction with the Derbyshire Medicines Safety Network, had sent a letter to all GP practices to remind them of their responsibilities to take the necessary action to review all women of childbearing potential on valproate medicines and ensure that they were on the PPP where required.	

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Item		Action
17.	**TRAFFIC LIGHTS**	
	Classifications Axicabtagene ciloleucel (Yescarta®) – RED (as per NHS England commissioning intentions) Cytarabine + daunorubicin liposomal (Vyxeos®) – RED (as per NHS England commissioning intentions) Alkindi® (Hydrocortisone capules) – RED as this brand (as per NHS England commissioning intentions for those <18 years of age) Burosumab – RED Cabozantinib – RED (as per NICE TA 542 and as per NHS England commissioning intentions) Tofacitinib – RED Dabrafenib – RED as per NICE TA 542 and as per NHS England commissioning intentions) Fluticasone + formoterol (flutiform® k-inhaler®) – BROWN Cariprazine (Reaglia®) – BLACK Erenumab – BLACK	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• CRHFT Drugs and Therapeutic Committee 18/09/2018 • DHcFT Drugs and Therapeutic Committee 28/06/2018 • DHcFT Drugs and Therapeutic Committee 26/07/2018 • JAPC Working Group 14/08/2018 • JAPC Working Group 11/09/2018 • UHDBFT Drugs and Therapeutic Committee 18/09/2018 The following item was highlighted: • UHDBFT Drugs and Therapeutic Committee – Mr Dhadli referred to the section in the minutes which referred to 'Bath emollients and Mr Moore to chase Dr Starkey regarding paediatric opinion on removing bath emollients from the formulary'. Mr Moore confirmed that these had now been removed from the formulary.	
19.	**ANY OTHER BUSINESS**	
a.	**Derbyshire Health United (DHU) Patient Group Directions** JAPC noted that the DHU Patient Group Directions (PGDs) were due to expire at the end of November 2018 and that a request had been made by DHU to extend the current PGDs by six months. Dr Mott commented that the PGDs needed to be signed off by the CCG and must be valid in order for the service to be effectively provided by DHU. However it was noted that in exceptional circumstances the current PGDs could be extended. Comments on the antimicrobial sections of the PGDs prepared by Dr D Harris were tabled for information. It was agreed that the existing PGDs be extended by six months and the updated versions be brought to the February 2019 JAPC meeting in order that sufficient time could be allowed for their approval. Mr Graham would send through the PGDs and forms for approval.	**SD** **DG**
20.	**DATE OF NEXT MEETING**	
	Tuesday, 11th December 2018 at 1.30pm in the Coney Green Business Centre, Clay Cross.	