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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 10th December 2019

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Debrisoft monofilament debridement pad	BROWN consultant/specialist recommendation NICE MTG17: for use in acute or chronic wounds: Second line product after specialist recommendation from Tissue Viability Nurses for chronic sloughy wounds and hyperkeratotic skin around acute or chronic wounds. A maximum of 5 dressing (1 box) should be prescribed on the advice of the TVN and if further dressings are required, this needs a review by the TVN. All other debridement products are classified as BLACK.
Ibandronate 50mg	GREEN consultant/specialist initiation, 50mg tablets – for use in post-menopausal women with breast cancer as per NICE NG101
ExmaQS, Exmabase Gel, AproDerm Ointment and Epimax paraffin-free Ointment	GREEN as per Emollient Prescribing Guide
Amiodarone	AMBER
Apomorphine	(Apo-go & Dacepton) – AMBER
Andexanet alfa	BLACK pending NICE guidance
Chenodeoxycholic acid	RED
Doravirine	RED
Larotrectinib	RED
Methyl salicylate + levomenthol	BLACK for muscle & joint pain associated with strains and sprains
Naphazoline	BLACK for minor eye irritation and redness
Vonicog alfa	RED
Doravirine + lamivudine + tenofovir disproxil fumarate	RED
Glibenclamide (Amglidia)	RED for treatment of neonatal diabetes mellitus, for use in newborns, infants and children.
Cetomacrogol (Formula A)	BLACK for dry skin conditions
Sodium Chloride (Aeon)	BLACK for corneal oedema
Cerliponase alfa	RED
Ibrutinib	BLACK
Pentosan polysulfate Sodium	RED
Rucaparib	RED
Neratinib	RED
Fluocinolone	BLACK

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Cannabis-based products which include: Nabilone, THC:CBD (Sativex), Dronabinol, THC	BLACK – NICE NG144 Spasticity in adults with multiple sclerosis - currently under review. Further guidance is due once review is complete. (CCG commissioned) BLACK – NICE NG144 intractable nausea and vomiting. (NHS England commissioned) BLACK – NICE NG144 chronic pain (NHS England commissioned) BLACK – NICE NG 144 severe treatment resistant epilepsy (NHS England commissioned) RED – NICE NG144 seizures associated with Lennox-Gastaut syndrome & Dravet syndrome, pending NICE guidance publication (NHS England commissioned)

Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
Diclofenac 2.32% gel	BLACK
Diclofenac 1.16% gel	BROWN after use of GREEN formulary choices – topical ibuprofen and ketoprofen
Ibuprofen (fenbid) 5% gel	GREEN
Ibuprofen (fenbid) 10% gel	BROWN

Clinical Guidelines
Emollient Prescribing Guide
Sodium Oxybate for adults with narcolepsy with cataplexy
Prescribing for oral thrush in babies and prescribing for surface and ductal thrush in lactating women

Patient Group Directions (PHE)
Diphtheria, Tetanus, Acellular Pertussis and Inactivated Poliomyelitis Vaccine

Shared Care Guidelines
Amiodarone
Dacepton (Apomorphine)

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Present:	
Derby and Derbyshire CCG	
Dr C Emslie	GP (Chair)
Mr S Dhadli	Assistant Director of Clinical Policies and Decisions (Professional Secretary)
Mr S Hulme	Director of Medicines Management and Clinical Policies
Mrs K Needham	Assistant Director of Medicine Optimisation and Delivery
Mrs S Qureshi	Head of Medicines Management, Clinical Policies and High Cost Interventions
Ms J Savoury	Assistant Chief Finance Officer
Dr H Hill	GP Prescribing Lead
Ms A Reddish	Clinical Quality Manager – Primary Care
Derby City Council	
Derbyshire County Council	
University Hospitals of Derby and Burton NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutic Committee
Mr R Sutton	Pharmacist
Ms A Brailey	Deputy Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Chesterfield Royal Hospital NHS Foundation Trust	
Ms C Duffin	Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Ms A Braithwaite	Pharmacist
Derby and Derbyshire Local Medical Committee	
Dr K Markus	Chief Executive Officer
Derbyshire Health United	
Staffordshire CCG's	
Ms S Bamford	Senior Medicines Optimisation Pharmacist
Mr K Claire	Medicines Optimisation Pharmacist
In Attendance:	
Ms K Dawidek-Pietryka	Derby and Derbyshire CCG Medicines Optimisation Pharmacist
Mrs K Rogers	Derby and Derbyshire CCG Senior Administrator (minutes)

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Item		Action
1.	**APOLOGIES**	
	Mr M Shepherd, Dr R Dewis, Mr D Graham, Dr S Taylor	
2.	**DECLARATIONS OF CONFLICTS OF INTEREST**	
	Dr Emslie 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**	
	Mr Dhadli reported he would like to discuss the Non-Vitamin K antagonist oral anticoagulants (NOAC) of choice. Dr Markus wished to discuss homely remedies in care homes. Mr Dhadli expressed that due to the forthcoming general election on the 12th December 2019, the meeting was being operated under purdah (Pre Elections Period) guidance.	
4.	**MINUTES OF JAPC MEETING HELD ON 12 November 2019**	
	The minutes of the meeting held on 12th November 2019 were agreed as a correct record after the following amendment: New Drug Assessment item 7b reads 'Agreed: JAPC classified VACOcast diabetic as BLACK pending national review' added: or clinician request via Drugs and Therapeutics Committee.	
5.	**MATTERS ARISING**	
a.	**Bisphosphonates in breast cancer – ibandronic acid 50mg** Mr Dhadli advised that ibandronic acid 50mg as a bisphosphonate in breast cancer has previously been agreed at JAPC. It then went to a Clinical and Lay Commissioning Committee (CLCC) meeting and a Financial Recovery Group (FRG) meeting where the additional cost and funding for this has been agreed. Ibandronic acid 50mg will now be available across the whole of Derbyshire County. **Agreed:** JAPC classified ibandronate 50mg tablets **GREEN consultant/specialist initiation**, for use in post-menopausal women with breast cancer as per NICE NG101.	
b.	**Equality Impact Assessment (EIA)/Quality Impact Assessment (QIA) process** Mr Dhadli reported how he has previously produced an EIA/QIA document which outlines how JAPC makes its decisions, shared cares, clinical guidelines formularies and switches. This explains that JAPC members must have due regard for its decision making. An EIA/QIA section is included in the JAPC front cover sheet and an assessment document has been embedded into this for process purposes. Mr Dhadli has spoken to Mr C Howlett Acute Contract Manager at Derby and Derbyshire CCG (DDCCG), to ask if this paper should be tabled at a Quality and Performance Committee meeting.	

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	Mr Howlett has confirmed that it does not need to go to panel. The EIA/QIA process will continue to be part of all decision making within JAPC and a full EIA and QIA will be undertaken where there is no alternative to a classified BLACK drug and when JAPC considers it necessary.	
c.	**Prescribing specification** Mrs Qureshi confirmed that the prescribing specification has been sent to the contracting team within DDCCG to be included in the contracts with our providers.	
d.	**Gastro-Oesophageal Reflux Disease (GORD) guidance** Mr Dhadli reported that the Gastro-Oesophageal Reflux Disease (GORD) guidance currently remains on the JAPC action summary as a review was scheduled to take place to look at whether NICE (CG184)/BNF guidance has updated the clarithromycin dose to be in line with Public Health England (PHE). Mr Dhadli confirmed the BNF has yet to update. **Action:** BNF guidance to be reviewed in 3 months' time	**SD**
6.	**JAPC ACTION SUMMARY**	
a.	**Hydroxychloroquine** Mr Dhadli advised that there is no further update with the continued work around hydroxychloroquine, currently outreach services are being looked at in regards to ocular monitoring. Mr Hulme expressed his concerns that this has been ongoing for some time and asked if a more specific update could be obtained. Mr Dhadli will ask Dr R Dewis to brief JAPC at the next meeting in January 2020.	**SD/RD**
b.	**GlucoRx safety needles** Ms Braithwaite confirmed that Derbyshire Community Health Services NHS Foundation Trust (DCHSFT) are happy with the training material that is now available for GlucoRx safety needles. Mylife Clickfine should now be declassified.	
7.	**NEW DRUG ASSESSMENT**	
a.	**Debrisoft** Mrs Qureshi reported that a request has been received from Derbyshire Prescribing Group QIPP Working Group, with advice from the tissue viability nurse (TVN) to restrict debrisoft (debridement pad) prescribing and to blacklist other debridement products. Debrisoft monofilament debridement pad is currently classified as BROWN after consultant/specialist recommendation. NICE MTG17 advises that debrisoft is not cost effective if more than 10 applications are needed. Tissue Viability Nurses would like to keep debrisoft products as BROWN, however they have asked that the traffic light classification say a maximum of 5 dressings (1 box) should be prescribed on the TVN's advice and if further dressings are required, this must be reviewed by them. **Agreed:** JAPC agreed debrisoft monofilament debridement pad to remain classified as **BROWN after consultant/specialist recommendation**, with the	

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	addition that a maximum of 5 dressing (1 box) should be prescribed on the advice of the TVN and if further dressings are required, this needs a review by the TVN. All other debridement products are to be classified as **BLACK.**	**SQ**
b.	**<u>Dapagliflozin with insulin for Type 1 Diabetes Monitoring</u>** Mr Dhadli informed the committee that this combination of treatment originates from NICE TA597 published in September 2019. Dapagliflozin with insulin is recommended as an option for treating type 1 diabetes in adults with a body mass index (BMI) of at least 27 kg/m2, when insulin alone does not provide adequate glycaemic control despite optimal insulin therapy. Dapagliflozin is currently classified as RED for this indication. The University Hospital of Derby and Burton NHS Foundation Trust (UHDBFT) clinicians have requested for this to be amended to allow continuing prescribing in primary care. This request has been to the Derbyshire Medicines Management Shared Care and Guideline Group (MMSCGG) where the group asked for at least 6 months of experience and evidence to show the type of patients that would benefit from this. A discussion is being had at the JAPC meeting so that UHDBFT are aware that this has taken place. The committee agreed that the original classification should remain. Dr Goddard asked that this be reviewed again along with patient numbers in 6 months' time. **Agreed:** JAPC recommended that Dapagliflozin with insulin for treating type 1 diabetes remains classified as **RED**. This will be reviewed in 6 months' time.	**SD**
8.	**CLINICAL GUIDELINES**	
a.	**<u>Emollient prescribing</u>** Mr Dhadli advised that the emollient guideline has been updated in line with the most cost effective choices. This was sent to Dr E Riches GP with extended roles (GPwER) Dermatology, Chatsworth Road Medical Centre for comment. Mr Dhadli summarised the changes within the guideline, this includes ExmaQS replacing ZeroAQS cream as it has the same paraffin content, Exmabase Gel replacing MyriBase Gel as it has the same paraffin content, AproDerm ointment is new in the ointment section as another cost effective option, Epimax paraffin free ointment is a new paraffin free ointment option. The following emollients have been removed from the guideline as they have the same or similar ingredients: AproDerm Gel (Exmabase/Isomol Gel is the preferred option), Hydromol ointment (Epimax ointment is the preferred option). Dr Markus asked if all of the recommended products are available. Mr Dhadli responded to say that he's been advised that they are. **Agreed:** JAPC ratified the Emollient Prescribing Guide with a review date of 3 years.	**SD**
b.	**<u>Sodium oxybate</u>** Mr Dhadli reported that at the November 2019 JAPC meeting, committee members were in agreement to produce a guideline for sodium oxybate, following advisory information issued by Midlands and East Regional Medicines Optimisation Committee (RMOC). Sodium oxybate is dual	

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	commissioned by NHS England and CCG's. JAPC has classified this as RED for adults aged nineteen and over, NHS England commissions this for children up to the age of nineteen. Mr Dhadli advised that the guideline includes RMOC clinical criteria, the type of patients eligible for treatment, the ongoing assessments they might need and when to stop treatment. This guideline could also be used as a prior approval form through Blueteq if assurance is required. Dr Goddard asked which specialist sleep centres would be used if a Derby patient fit this criteria and would the sleep centre prescribe sodium oxybate, or would it be prescribed through UHDBFT. Depending on which sleep centre is used some would be classed as out of area. Mr Dhadli responded to say that this should not be an issue and out of area sleep centres would still be able to use Derbyshire Blueteq forms. Mr Hulme asked if patient numbers have been discussed at the previous JAPC meeting and if they will be monitored going forward. Mr Dhadli advised that when the horizon scan is produced next year, the number of Derbyshire patients on sodium oxybate will be based on the RMOC document. The budget will then be set against those numbers and monitoring will be put in place in the same way that other high cost drugs are monitored. Mr Hulme also asked if there would be a review process for patients taking sodium oxybate, it was confirmed that this has been included within the guideline. **Agreed:** JAPC ratified the guideline for Sodium Oxybate for adults with narcolepsy with cataplexy, with a review date of 3 years.	**SD**
c.	**<u>Prescribing for oral thrush in babies and prescribing for surface and ductal thrush in lactating women</u>** Mr Dhadli advised that the guideline for oral thrush in babies and prescribing for surface and ductal thrush in women has been updated. This is an existing guideline which is due for its periodic review. It has been sent for comment to Ms T Twell Acting Matron Midwife and Dr A Foo Consultant Paediatrician at Chesterfield Royal Hospital NHS Foundation Trust (CRHFT). It was also sent to Derbyshire Healthcare NHS Foundation Trust (DHcFT) Medicines Management Committee. There has been no significant change to the guideline, references and contacts have been updated, the miconazole gel dose age reference has been updated as per BNFc. Advice has been added in regards to over the counter paracetamol and ibuprofen and extra resources have been included. Dr Markus queried whether an alternative to miconazole will be provided should a GP not wish to prescribe this due to it being off licence. Dr Emslie referred to the first page of the guideline where it states that 'nystatin suspension is not suitable as first-line treatment because it is not as effective as miconazole', however it is a licensed drug. Mr Dhadli suggested that this be re worded to say that 'nystatin suspension is licenced for oral thrush, however, not as effective as miconazole'.	**SD**
	Agreed: JAPC ratified the guideline Prescribing for oral thrush in babies and prescribing for surface and ductal thrush in lactating women, with a review date of 3 years.	**SD**

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9.	**PATIENT GROUP DIRECTIONS**	
a.	The following PGD from Public Health England effective from 1st December 2019 was noted by JAPC: • Diphtheria, Tetanus, Acellular Pertussis and Inactivated Poliomyelitis Vaccine Patient Group Direction (PGD)	
10.	**SHARED CARE**	
a.	**Amiodarone** Mr Dhadli advised that amiodarone is included in NHS England's 'Items which should not routinely be prescribed in primary care' version two document, which recommends that amiodarone could be a shared care agreement and should not be initiated in primary care. A shared care agreement has been developed largely based on the current guideline and some queries were raised at the JAPC meeting in September 2019. The shared care agreement has now been updated with information surrounding these queries which includes ECG monitoring and duration of treatment. The following has been added under ECG monitoring: 'If there are signs of the following please discuss with the oncall cardiology specialist • If QTc interval ≥ 500 milliseconds (in line with dronedarone shared care) • QRS duration>120 milliseconds • Prolonged PR interval (>240 milliseconds) if previously normal • Morbitz Type II or complete heart block' The following wording was also added under stopping amiodarone/specialist review: 'When PAF goes to permanent AF, amiodarone should be stopped and rate limiting medicines used instead.' The shared care agreement is being tabled at the December 2019 JAPC meeting for any further comments. Ms Bamford added that Mr Sutton has taken this shared care to the Staffordshire Area Prescribing Group meeting where there have been some comments. GP's have expressed that they would like the patient to be stabilised for a minimum of 3 months before taking on responsibility of the prescribing and monitoring, they would also like the patient to be able to report directly to the specialist if they felt unwell. Staffordshire also wanted clarification on whether the annual review should be with the GP or the specialist and for GP's to record on their system the shared care code. Mr Dhadli responded to say that amiodarone has a loading dose which can take several weeks to accumulate; this must be carried out in secondary care before the patient can be monitored by a GP in primary care. All of the Derbyshire shared care agreements also state that a patient's condition must be stable or predictable before prescribing responsibility is transferred a principle agreed and debated previously by JAPC; the committee agreed that this is more suitable than giving a timeframe of 3 months. Dr Markus expressed concerns of monitoring ECG's in primary care. Dr Emslie advised that further information in regards to ECG monitoring has been added into the shared care agreement and Cardiologists were happy to be contacted if GP's needed advice. Ms Brailey asked how existing patients on amiodarone will be managed. Mr Dhadli responded to say that it is likely there will be a reduction of patient numbers taking amiodarone following a review, as there may be some	

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	patients who were discharged on this drug and were given no indication of when it should be stopped. Ms Brailey expressed concerns over the uncertainty of how many patients in Derbyshire are taking amiodarone and can be safely taken off this, or who may need specialist referral. Mr Hulme suggested producing a position statement which would assist in identifying patients against some level of audit, referring to NICE guidance and recommending specialist review. Mrs Needham stated that there should not be any issues identifying patients who are taking amiodarone and it can be highlighted that they need to be reviewed. It will be discussed at the Derbyshire Prescribing Group in January 2019; Mr Hulme suggested that a PCN pharmacist look at this following the meeting. **Agreed:** JAPC classified amiodarone as **AMBER** and ratified the shared care agreement amiodarone with a review date of 3 years.	**KN** **SD**
b.	**Dacepton (Apomorphine)** Mr Dhadli stated that a request has been received from CRHFT to include Dacepton as an apomorphine preparation within the shared care agreement. The device and the cost have been reviewed and it was found that Dacepton cost per ml was the same as APO-Go; it also has a longer shelf life after opening. Dacepton will be in addition to APO-Go products, the two brands are not interchangeable. Mr Dhadli suggested that the title advises to prescribe by brand so there will be no confusion between the two products. There were no further changes to the shared care agreement. The committee agreed to this.	**SD**
11.	**MISCELLANEOUS**	
a.	**Public Health England (PHE) Prescribed medicines review** Mr Dhadli reported that in September 2019, Public Health England (PHE) has completed a public health evidence review of available data and published evidence on the problems of dependence and withdrawal associated with some prescribed medicines. The products looked at include benzodiazepines, z-drugs, gabapentin and pregabalin, opioids for chronic non-cancer pain and antidepressants. The document explains that these drugs are being abused and why they are becoming addictive. The conclusion is that this issue is not down to one provider or commissioner to resolve, all parts of the healthcare system and the general population will need to engage with this complex issue. PHE asks for healthcare systems to look at the concerns that people have with opioids and gabapentinoids and have a collective approach in tackling the abuse and addiction surrounding these. Dr Markus added to include providing addiction services. Mr Dhadli went on to say that the document also talks about NHS England and NHS Improvement ensuring that the work of their Medicines Safety Programme is aligned with, and responds to the findings of this review. NICE is to enhance its focus and place greater emphasis on medicines that can cause dependence or withdrawal when developing or reviewing relevant prescribing recommendations. Local health and social care commissioners should ensure that treatment pathways are available to patients who experience problems with dependence or withdrawal, which meet their support needs in relation to the underlying or related conditions.	

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	Clinicians must have the time and resources to explore these options with patients. Pathways should include pain clinics, mental health teams, IAPT services, support groups, and social prescribing link workers. Primary care services, clinical and community pharmacists, and GPs are encouraged to develop their knowledge of, and competence to identify, assess and respond to, dependence or withdrawal associated with some medicines and to support needs of people experiencing problems with withdrawal or dependence. Dr Goddard advised that clinical psychology would help to give patients the support they need to come off these drugs and there needs to be an alternative way of treating the pain. Mr Hulme advised that there are areas of high prescribing within Derbyshire, he added that although clinical psychology is valuable, there is evidence to show that other areas have changed prescribing behaviour partly through education at both patient and clinician level. Mr Hulme asked how JAPC could assist with this process. Mr Dhadli responded to say that this has been bought to JAPC to raise awareness with providers. DDCCG's guideline around strong opioids for cancer pain is in line with national guidance and all advice is current. Mr Dhadli raised a query in regards to morphine dose. It is currently set at 120mg per day for non-cancer patients who go to specialist pain centres; however SIGN are now recommending a dose of >50mg for annual review and >90mg before referring to pain centres. Mr Dhadli asked if this is something that JAPC would like to re-visit. The committee agreed to look at this during the next JAPC meeting in January 2020.	**SD**
b.	**<u>Teriparatide biosimilars</u>** Mr Dhadli advised that teriparatide has a small volume of use across Derbyshire and biosimilars are now available; it is indicated for osteoporosis in postmenopausal women (CCG) and men (NHSE) at increased risk of fracture. UHDBFT and CRHFT are choosing to use Terossa as a preferred choice of the biosimilar; cost savings of approximately £30,000 are expected.	
c.	**<u>Horizon Scan</u>** Mrs Qureshi reported that costs are now available through the cost calculator for the horizon scan. Two papers were presented, one listed primary care drugs and the other listed secondary care drugs excluded from tariff. The primary care table contained one drug that would potentially have a high impact, ticagrelor for prevention of cardiovascular events in patients with type 2 diabetes. NICE lists this on their timetable however there is not yet a date for its release. The assumption is that 50% of type 2 diabetes patients would need an antiplatelet, if ticagrelor is offered to 5% of these patients instead of clopidogrel this will cost approximately 90k per 100,000 population. Based on Derbyshire it would be a projection of £900k for the population. Dry eye disease and glaucoma are low and medium cost impacts. There will be a cost pressure if patients are moved from an MDI to a DPI this will be influenced by the DPI products chosen for the Derbyshire formulary and by local prescribing. There are some savings to be found through solifenacin tartrate patent expiry and further savings from NHS England 'Items which should not routinely be prescribed in primary care' through areas like liothyronine, pen needles and	

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	lidocaine plasters. There is also potential for more savings through NHS England guidance of over the counter self-care products. Mrs Qureshi went on to say that the second paper which includes high cost drugs excluded from tariff, highlighted solriamfetol oral for narcolepsy and obstructive sleep apnoea as a potentially high impacting drug. This will be a CCG commissioned drug and NICE's timetable suggests that a TA will be released for this in September 2020 and January 2021. Other potentially high impacting drugs included ixekizumab injection and ranibizumab. Andexanet alfa injection for reversal of anticoagulation with apixaban/rivaroxaban was highlighted as a medium risk; the NICE TA is expected in March 2020.	
12.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
	The RMOC Operating Model was noted. Mr Dhadli highlighted the following: • Sustainability and Transformation Partnerships (STPs), initially established to bring local health and care leaders together to plan around the long-term needs of local communities, have begun transitioning to Integrated Care Systems by 2021. • These local partnerships are likely to align with the seven new regions established under the NHS England and NHS Improvement operational model. The number of RMOCs will therefore need to increase from four to potentially seven. • The revised operating model clearly sets out the refined aims and objectives for the RMOCs and their expected ways of working. • RMOCs will focus on regional oversight and implementation of national medicines priorities, with the ability for each RMOC to identify and oversee the implementation of local and regional medicines optimisation priorities. • RMOCs will continue to operate nationally to develop advice that will be of use and relevance to all regions and to coordinate activity between each committee, however, individual RMOCs will be able to review what this advice may mean for their respective region. • Seven RMOCs will be operational by autumn 2020; however, this is subject to agreement within the regions. • Regional oversight of the implementation of national medicines optimisation priorities, including the Medicines Value Programme, Medicines Safety Programme, Public Health England's Prescribed Medicines Review, Antimicrobial Stewardship in line with the Antimicrobial Resistance National Action Plan, Shared Care and uptake of Accelerated Access Collaborative products; • There will be identification and oversight of implementation of local and regional medicines optimisation priorities to support improvements in clinical quality and value and reduction in variation. • The status of RMOC outputs are advisory. • All new medicines and significant new indications would undergo an appropriate NICE appraisal from that point onwards. NICE expects to have achieved full coverage of all such medicines and indications by April 2020. • RMOCs may have a role in reviewing medicines use within pathways of care. • From April 2020, the case is being made for each Integrated Care Systems	

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	(ICS) to appoint a Chief Pharmacist who will be expected to nominate a peer representative to sit on their local RMOC, and all ICS Chief Pharmacists will be expected to have regard to RMOC outputs.	
13.	**JAPC BULLETIN**	
	The November 2019 bulletin was ratified.	**SQ**
14.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for November 2019 was noted. Mr Dhadli highlighted the following MHRA advice: • Yellow fever vaccine: stronger precautions in people with weakened immunity and in those aged 60 years or older. The Commission on Human Medicines has issued a series of recommendations to include new and updated contraindications and strengthened precautions to protect those with a weakened immune systems (including for people aged 60 years or older) and standardised risk benefit evaluation procedures across UK yellow fever vaccination centres • Carfilzomib (Kyprolis▼): risk of reactivation of hepatitis B virus. A recent EU review of clinical studies and cases of suspected adverse drug reactions has identified reports of hepatitis B reactivation associated with carfilzomib. Following the review, changes are being made to the Summary of Product Characteristics to recommend screening for hepatitis B virus before a patient starts carfilzomib treatment. Screening is also recommended for patients already under treatment with carfilzomib with unknown hepatitis B virus serology.	
15.	**HORIZON SCAN**	
a.	**<u>Monthly Horizon Scan</u>** Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK: • Andexanet alfa (Ondexxya) – classified as **BLACK** (awaiting NICE TA) • Chenodeoxycholic acid (Chenodeoxycholic acid Leadiant) – classified as **RED** (as per NHS England commissioning intentions) • Doravirine (Pifeltro) – classified as **RED** (as per NHS England commissioning intentions) • Iloprost – to remain classified as **RED** (as per NHS England commissioning intentions) • Lanadelumab (Takhzyro) – to remain classified as **RED** (as per NHS England commissioning intentions) • Larotrectinib (Vitrakvi) – classified as **RED** (as per NHS England intentions) • Methyl salicylate + levomenthol (Salonpas Pain Relief Patch) – classified as **BLACK** • Naphazoline (Murine Irritation and Redness Relief) – classified as **BLACK** • Neratinib (Nerlynx) – classified as **RED** (as per NHS England commissioning intentions) • Teriparatide biosimilar (Movymia) – to remain classified as **RED** • Vonicog alfa (Veyvondi) – classified as **RED** (as per NHS England	

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	commissioning intentions) New formulation launches in the UK: • Benralizumab (Fasenra) – previously classified as **RED** • Cinacalcet (Mimpara) – previously classified as **AMBER** • Doravirine + lamivudine + tenofovir disoproxil fumarate (Delstrigo) – classified as **RED** (as per NHS England commissioning intentions) • Glibenclamide (Amglidia) – classified as **RED** (as per NHS England commissioning intentions) • Influenza vaccine (Flucelvax Tetra) – previously classified as **GREEN** (as per national immunisation programme) • Mepolizumab (Nucala) – previously classified as **RED** • Mesalazine (Octasa) – previously classified as **GREEN after consultant initiation** • Cetomacrogol (Formula A) (Ovelle) – classified as **BLACK** • Paracetamol (Altridexamol) – previously classified as **BROWN, reserved for patients with swallowing difficulties** • Sodium chloride (Aeon) – classified as **BLACK** Licence extensions: • Atezolizumab (Tecentriq) – previously classified as **RED** • Avelumab (Bavencio) – previously classified as **RED** • Belimumab (Benlysta) – previously classified as **RED** • Ceftolozane + tazobactam (Zerbaxa) – previously classified as **RED** • Dupilumab (Dupixent) – previously classified as **RED** • Ramucirumab (Cyramza) – previously classified as **BLACK** • Secukinumab (Cosentyx) – previously classified as **RED**	
16.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCG which had been made for the following NICE guidance in November 2019: HST12 Cerliponase alfa for treating neuronal ceroid lipofuscinosis type 2 – classified as **RED** (NHS England as per NICE HST12) TA608 Ibrutinib with rituximab for treating Waldenstrom's macroglobulinaemia (terminated appraisal) – classified as **BLACK** (as per NICE TA608) TA610 Pentosan polysulfate sodium for treating bladder pain syndrome – classified as **RED** (as per NICE TA610) TA611 Rucaparib for maintenance treatment of relapsed platinum-sensitive ovarian, fallopian tube or peritoneal cancer – classified as **RED** (NHS England Cancer Drugs Fund as per NICE TA611) TA612 Neratinib for extended adjuvant treatment of hormone receptor-positive, HER2-positive early stage breast cancer after adjuvant trastuzumab – classified as **RED** (NHS England as per NICE TA612) TA613 Fluocinolone acetonide intravitreal implant for treating chronic diabetic	

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	macular oedema in phakic eyes after an inadequate response to previous therapy – classified as **BLACK** (as per NICE TA613) **NG144 Cannabis-based medicinal products** Mrs Qureshi advised that NG144 guideline includes recommendations on prescribing cannabis-based medicinal products for: • Intractable nausea and vomiting • Chronic pain • Spasticity • Severe treatment-resistant epilepsy and prescribing NICE recommend to consider as opposed to offer nabilone as an add-on treatment for adults (18 years and over) with chemotherapy-induced nausea and vomiting which persists with optimised conventional antiemetics. However there is limited evidence to show that nabilone, which is licensed in the UK for adults, resulted in complete or partial reduction in chemotherapy-induced nausea and vomiting. Most of the studies were old, of low quality and used outdated antiemetic regimens that did not reflect current practice. The advice for chronic pain is not to offer Nabilone, Dronabinol, THC (delta-9-tetrahydrocannabinol), a combination of cannabidiol (CBD) with THC. It also states not to offer CBD to manage chronic pain in adults unless as part of a clinical trial. Some evidence showed that CBD reduced chronic pain, but the treatment effect was modest. The evidence did not show a reduction in opioid use in people prescribed medicinal cannabis. The potential benefits offered were small compared with the high and ongoing costs, and the products were not an effective use of NHS resources. NICE has made research recommendations on the use of cannabis-based medicinal products for severe treatment-resistant epilepsy. NICE is developing TA guidance on cannabidiol with clobazam for treating seizures associated with Lennox-Gastaut syndrome and Dravet syndrome (due December 2019). NICE recommendations for moderate to severe spasticity in adults with multiple sclerosis, are to offer a 4-week trial of THC:CBD spray if other pharmacological treatments for spasticity are not effective or the company provides THC:CBD spray according to its pay-for-responders scheme. After the 4-week trial, continue THC:CBD spray if the person has had at least a 20% reduction in spasticity-related symptoms on a 0 to 10 patient-reported numeric rating scale. The evidence showed benefits of THC:CBD spray (licensed product in UK: Sativex) for treating spasticity in people with multiple sclerosis. There were reductions in some measures of patient-reported spasticity and no difference in adverse events in the treatment or placebo groups, although much of the evidence was assessed as low quality. The committee agreed that the longer-term benefits of THC:CBD spray are likely to outweigh any potential harms. As of October 2019 Sativex is the only delta-9-tetrahydrocannibinol and cannabidiol (THC:CBD) spray licensed for use in the UK for treatment for spasticity in multiple sclerosis. Currently, prescribing and monitoring cannabis-based medicinal products takes place in tertiary care.	

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	The recommendations focus on shared care after the initial prescription with the involvement of other healthcare professionals such as non-medical prescribers and GPs. Mrs Qureshi referred to a table with base case results that shows this as being cost effective. Over 5 years there will be a cost implication to the CCG. A discussion took place in regards to the classification of cannabis for spasticity. The committee agreed that further information should be sought from tertiary centres in regards to whether they are would use the drug, clarification on patient numbers and if there would be a virtual shared care agreement set up with secondary care colleagues. **Agreed:** Cannabis for spasticity it is to remain classified as **BLACK** pending further review. Additional guidance is due once the review is complete. The JAPC committee recommended that nabilone for intractable nausea and vomiting be classified as **BLACK** based on the evidence review, pending a positive NICE TA or clinician request via Drugs and Therapeutics Committee. Cannabis is to be classified as **BLACK** for chronic pain and for severe treatment resistant epilepsy. JAPC classified cannabis as **RED** NHS England commissioned for Lennox-Gastaut syndrome and Dravet syndrome, pending NICE guidance publication. **<u>NG145 Thyroid disease assessment and management</u>** Mr Dhadli advised that a question needs to be raised with endocrinologists for NG145 thyroid disease. NICE guidance recommends essentially a loading dose (weight based) for thyroxine which is a change from what the BNF suggests. The MMSCGG will review this.	**SD** **SD**
17.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Shared Care and Guideline Group meeting held in November 2019 was noted. Mr Dhadli highlighted the following: Traffic Lights: • Diclofenac 2.32% gel – classified as BLACK decision based on cost and systemic exposure of 2.32% is equivalent (BD application) to the topical diclofenac 1.16% gel (UKMI query) (QDS application) • Diclofenac 1.16% gel – classified as BROWN after use of GREEN formulary choices – topical ibuprofen and ketoprofen • Ibuprofen (fenbid) 5% gel (clarification of existing) – classified as GREEN • Ibuprofen (fenbid) 10% gel (clarification of existing) – classified as BROWN Formulary Update (Chapter 13 – Skin): • Aproderm and Zerolan included as cost effective alternative barrier preparations to cavilon. • Adapalene added and aknemycin plus removed from the acne section in-line with local acne guidance. • Warts and calluses – self-care link included. • Sunscreens: anthelos added as cost effective choice, link to self-care included and ACBS criteria updated to be in line with the Drug Tariff.	

Item		Action
	• Eflornitine exceptionalities updated to be in-line with a recent traffic light change. Clinical Guidelines: • DMARD quick reference guide – sodium aurothiomalate entry removed. Penicillamine monitoring updated to be in-line with the latest SCA update. • Antipsychotic recommended physical monitoring – review date extended to January 2021, in line with DHCFT/JAPC policy for 3 yearly review cycle. • COPD guidance and respiratory chapter updated to include information on re-usable respimat devices, which replaces the single use disposable respimat devices. Each re-usable respimat device can be used with up to 6 cartridges before replacing. • Type 2 diabetes guidance – hypertension flowchart removed (new NICE hypertension guidance – no separate BP targets for diabetics). Renal dose for saxagliptin amended. • GORD in children guideline updated to include NICE wording: do not offer metoclopramide, domperidone or erthyromycin to treat GOR or GORD unless all of the following conditions are met: the potential benefits outweigh the risk of adverse events, other interventions have been tried, and there is a specialist healthcare professional agreement for its use. Website Changes/Miscellaneous: • Self-care on website – patient information leaflets now linked to the CCG public facing website as Derbyshire Stay Well website has been removed. • Respiratory chapter – all LABA/LAMA inhalers changed to GREEN. Fobumix 1st line DPI. • Formulary CVS chapter blood pressure targets updated as per new hypertension guideline. • A Guide to Managing Medicines Supply and Shortage added to website under other useful guidelines EU exit information. Guideline Timetable: • The guideline table action summary and progress was noted by JAPC.	
18.	**BIOSIMILAR REPORT**	
	Mr Dhadli reported that etanercept figures at UHDBFT have increased to 80% in October 2019.	**SD**
19.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	<u>Classifications</u> • Debrisoft monofilament debridement pad – BROWN consultant/specialist recommendation, NICE MTG17: for use in acute or chronic wounds: Second line product after specialist recommendation from Tissue Viability Nurses for chronic sloughy wounds and hyperkeratotic skin around acute or chronic wounds. A maximum of 5 dressing (1 box) should be prescribed on the advice of the TVN and if further dressings are required, this needs a review by the TVN. All other debridement products are classified as BLACK. • Ibandronate – GREEN consultant/specialist initiation, 50mg tablets – for use in post-menopausal women with breast cancer as per NICE NG101 • ExmaQS, Exmabase Gel, AproDerm Ointment and Epimax paraffin-free	

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	Ointment – GREEN as per Emollient Prescribing Guide • Amiodarone – AMBER (new shared care agreement) • Apomorphine (Apo-go & Dacepton) – AMBER, shared care guideline for Parkinson's Disease. Apo-go and Deception are the preferred clinical and cost effective brands. • Andexanet alfa – BLACK pending NICE guidance • Chenodeoxycholic acid – RED to be used in line with NHSE commissioning intentions • Doravirine – RED to be used in line with NHSE commissioning intentions • Larotrectinib – RED to be used in line with NHSE commissioning intentions • Methyl salicylate + levomenthol – BLACK for muscle & joint pain associated with strains and sprains • Naphazoline – BLACK for minor eye irritation and redness • Vonicog alfa – RED to be used in line with NHSE commissioning intentions • Doravirine + lamivudine + tenofovir disproxil fumarate – RED to be used in line with NHSE commissioning intentions • Glibenclamide (Amglidia) – RED for treatment of neonatal diabetes mellitus, for use in newborns, infants and children. • Cetomacrogol (Formula A) – BLACK for dry skin conditions • Sodium Chloride (Aeon) – BLACK for corneal oedema • Cerliponase alfa – RED • Ibrutinib – BLACK • Pentosan polysulfate Sodium – RED • Rucaparib – RED • Neratinib – RED • Fluocinolone – BLACK • Cannabis-based products which include: Nabilone, THC:CBD (Sativex), Dronabinol, THC – BLACK/RED BLACK – NICE NG144 Spasticity in adults with multiple sclerosis - currently under review. Further guidance is due once review is complete. (CCG commissioned) BLACK – NICE NG144 intractable nausea and vomiting. (NHS England commissioned) BLACK – NICE NG144 chronic pain (NHS England commissioned) BLACK – NICE NG 144 severe treatment resistant epilepsy (NHS England commissioned) RED – NICE NG144 seizures associated with Lennox-Gastaut syndrome & Dravet syndrome, pending NICE guidance publication (NHS England commissioned)	
20.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• Sheffield Area Prescribing Group 19.09.2019 • Nottingham Area Prescribing Committee 19.09.2019 • UHDBFT Drugs and Therapeutics 15.10.2019 • Medicines Optimisation Safety Team 07.10.2019 • Chesterfield Drugs and Therapeutics 19.11.2019 The following items were highlighted in the Sheffield Area Prescribing minutes: • Sheffield APG are seeking clarification around the criteria relating to	

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	patients with psychosocial circumstances that warrant a 6 month trial of FSL. There is currently no further clarity on this statement and it is anticipated this situation will remain. • The committee are looking to update their diabetes guidance in light of new evidence from European Association for the study of Diabetes. • It has been proposed that Glucomen areo 2K be removed from the Sheffield formulary chapter and that CareSens Dual and Fora Advanced pro GD40h will be included in the 'Self-Monitoring of Blood Glucose (SMBG): Guidance on selecting an appropriate test strip for people with type 1 and type 2 diabetes' The following item was highlighted in the Nottingham Area Prescribing minutes: • Nottingham APG discussed naming Edoxaban as the first line (Direct Oral Anticoagulants) DOAC for Non Valvular Atrial Fibrilation.	
21.	**ANY OTHER BUSINESS**	
a.	**<u>Direct Oral Anticoagulants (DOAC) choice</u>** Mr Dhadli advised that a practice pharmacist has raised the use of apixaban from a consultant stroke physician and he wanted to express that edoxaban is the Derbyshire preferred DOAC of choice for Non Valvular Atrial Fibrilation, therefore if the stroke physicians and haematologists can look to use this as a first line option.	
b.	**<u>Homely Remedies in care homes</u>** Dr Markus raised a discussion in regards to homely remedies in care homes. Current CCG/local authority guidelines recommend that care homes have GPs to sign off a list of homely remedies after checking interactions and other criteria, however this is against what the national GPC advice would be. Dr Markus previously met with someone from DDCCG to discuss this, however she has not received any further information as yet and more queries have since been received. Mrs Needham advised that she would follow this up.	**KN**
c.	**<u>Questran</u>** Dr Goddard advised that UHDBFT are receiving a number of letters from GP's in regards to the unavailability of Questran and what alternatives can be recommended. There are currently no alternatives listed in the Derbyshire traffic light classifications, Dr Goddard asked if this can be looked at.	**SD**
22.	**DATE OF NEXT MEETING**	
	Tuesday, 14th January 2020 at 1.30pm in the Coney Green Business Centre, Clay Cross.	