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# DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

## Minutes of the meeting held on 12th March 2019

# CONFIRMED MINUTES

## Summary Points

### Traffic lights

| Drug | Decision |
|---|---|
| Edoxaban | GREEN preferred 1st Line NOAC for NV-AF |
| Apalutamide (Erleada®) | BLACK |
| Brigatinib (Alunbrig®) | RED as per NHS England commissioning intentions |
| Ertugliflozin (Steglatro®) | BLACK |
| Letermovir (Prevymis®) | RED as per NHS England commissioning intentions |
| Tildrakizumab (Ilumetri®) | BLACK |
| Bevacizumab | BLACK (as per NICE TA 560) |
| Venetoclax | RED (NHS England as per NICE TA 561) |
| Encorafenib | RED (NHS England as per NICE TA 562) |
| Abemaciclib | RED (NHS England as per NICE TA 563) |
| Dabrafenib | BLACK (as per NICE TA 564) |

### Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

| Drug | Decision |
|---|---|
| Semaglutide | BROWN intolerance to the preferred 1st line choice (Lixisenatide) or restricted by their licensing. Use in patients who require weekly GLP1 preparation |

### Clinical Guidelines

Clozapine for the treatment of resistant schizophrenia
Identification and management of familial hypercholesterolaemia (extended for a further twelve months)
Management of Non-valvular Atrial Fibrillation
Phosphate binders for the long-term treatment of hyperphosphataemia
Osteoporosis

### Shared Care Guidelines

Denosumab 60mg for the prevention of osteoporotic fractures in men and post-menopausal women
Attention Deficit Hyperactivity Disorder (ADHD)

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| **Present:** | |
|---|---|
| | |
| **Southern Derbyshire CCG** | |
| Dr A Mott | 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 S Qureshi | Head of Medicines Management, Clinical Policies and High Cost Interventions |
| Dr M Watkins | GP |
| | |
| **North Derbyshire CCG** | |
| Dr C Emslie | GP |
| Dr T Narula | GP |
| Mrs K Needham | Assistant Director of Medicine Optimisation and Delivery (also representing all four Derbyshire CCGs) |
| | |
| **Hardwick CCG** | |
| Dr T Parkin | GP |
| | |
| **Erewash CCG** | |
| Dr M Henn | GP |
| | |
| **Derby City Council** | |
| | |
| **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 |
| | |
| **Derbyshire Healthcare NHS Foundation Trust** | |
| Mr S Jones | Chief Pharmacist |
| | |
| **Chesterfield Royal Hospital NHS Foundation Trust** | |
| Mr M Shepherd | Chief Pharmacist (also representing DCHSFT) |
| | |
| **Derbyshire Community Health Services NHS Foundation Trust** | |
| | |
| **Derby and Derbyshire Local Medical Committee** | |
| Dr K Markus | Chief Executive Officer |
| | |
| **Derbyshire Health United** | |
| | |
| **In Attendance:** | |
| Mr A Thorpe | Derby City Council Business Support (minutes) |

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| Item | | Action |
|---|---|---|
| **1.** | **APOLOGIES** | |
| | Ms A Braithwaite, Dr R Dewis, Mr D Graham and Ms J Shaw. | |
| **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.<br><br>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** | |
| | • Freestyle Libre®<br>• Rescheduling of gabapentin and pregabalin. | |
| **4.** | **MINUTES OF JAPC MEETING HELD ON 12 FEBRUARY 2019** | |
| | The minutes of the meeting held on 12th February 2019 were agreed as a correct record after the following amendments:<br>• Addition of Dr M Watkins to the list of members present.<br>• Management of Heart Failure with Reduced Ejection Fraction (HFREF) - Subject to clarification of the echocardiogram diagnostic pathway and funding decision for sacubitril/valsartan. Add: Funding agreed post meeting.<br>• Sacubitril/Valsartan for the treatment of symptomatic chronic heart failure with reduced ejection fracture subject to funding decision. Add: Funding agreed post meeting.<br>• Ketotifen Eye Drops to read 'Following discussion it was agreed that the formulary choices in primary care for allergic conjunctivitis would be updated to include Otrivine Antistin (self-care) together with olopatadine and ketotifen to replace lodoxamide.<br>• Semaglutide to read 'NICE were waiting for the outcome of a number of further diabetes clinical trials, which included GLP-1receptor agonists, to conclude before publication of a TA which was currently under consultation.' | |
| **5.** | **MATTERS ARISING** | |
| **a.** | **Sacubitril/Valsartan**<br>Dr Mott reported that the funding for the additional primary care prescribing for the shared care agreement had now been approved by the CCG Financial Recovery Group. The shared care agreement had also been updated in the light of the feedback received to ensure that the condition of the patient was stable and predictable prior to request to use the shared care agreement and also to ensure patients with repeat prescriptions for ACE or ARBs were stopped. | |
| **b.** | **Derbyshire Health United Antimicrobial Patient Group Directions**<br>Mrs Needham advised that the PGDs had now received antimicrobial approval and would be signed-off by Dr S Lloyd, Derbyshire CCGs Medical Director. | |

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| Item | | Action |
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| c. | **Amiodarone**<br>Mr Moore reported that there had been thirty-five new starters on oral amiodarone in the last twelve months at UHDBFT. This information would be useful should there be a national recommendation for a shared care agreement. | |
| d. | **Enoxaparin**<br>Mrs Needham reported that it was not planned to actively switch patients in primary care to the enoxaparin biosimilar and instead prescribing would be by brand of Clexane for existing patients and Inhixa® for new patients. Mr Moore confirmed that all patients within UHDBFT would have been switched to the biosimilar product by 1st April 2019 and that it would be clearly prescribed by the brand name at discharge. | |
| e. | **Etanercept Biosimilar**<br>Dr Mott referred to the lower than anticipated take up in UHDBFT of the etanercept biosimilar and a joint letter from the DTC and APC Chairs had therefore been developed to be sent to the remaining patients that highlighted the reasons to switch and of our experience to date. The letter was tabled for information and noted by JAPC. | |
| f. | **VSL#3**<br>It was confirmed that the Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) forms had been circulated to JAPC members. | |
| g. | **Heart Failure**<br>Mr Dhadli reported that it had been agreed that all new patients diagnosed with heart failure should be referred to the heart failure specialist service - this had now been added to the key recommendations in the guideline. | |
| h. | **JAPC Quoracy**<br>Mr Jones stated that all the decisions made by JAPC at the February meeting had now been ratified by DHcFT. | |
| **6.** | **JAPC ACTION SUMMARY** | |
| a. | **Hydroxychloroquine**<br>It was reported that this still awaited a decision by the CCG Clinical and Lay Commissioning Committee (CLCC). | |
| b. | **Clostridium difficile**<br>A review was being undertaken by Diane Holland, CRHFT Lead Nurse/Deputy Director Infection Prevention and Control, and would be brought to a future JAPC meeting on completion. | **SD** |
| c. | **Homely Remedies**<br>Dr Markus agreed to make initial contact with the local authority in order to discuss the concern which had been previously expressed about the requirement for GPs to sign off a list of homely remedies and check for possible interactions. | **KM** |

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| Item | | Action |
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| **7.** | **CLINICAL GUIDELINES** | |
| **a.** | **Clozapine**<br>Mr Jones reported that the existing clinical guideline for clozapine for treatment resistant schizophrenia had been updated. The guideline provided important information with respect to the prescribing of clozapine and highlighted the major side effect of constipation which, if untreated, could lead to fatal complications. In addition, the information on smoking cessation had been revised to indicate that smoking tobacco reduced plasma levels of clozapine by up to 50%.<br><br>Dr Markus highlighted the reference at the top of the document to 'Perform annual physical health check (GP) and suggested that this be amended to 'Annual review by GP'. Dr Markus also queried the reference to the requirement that the document must be "filed" prominently in the patient's primary care notes and advised that there was no standardised method in primary care for flagging patient records. Dr Mott stated that it is essential that clozapine was recorded on the system and it should be obvious that a particular patient was on this drug. It was recognised there were different ways of doing this and therefore it was the responsibility of individual GP practices to ensure appropriate visibility. Dr Parkin referred to the prescribing system advice which enabled medicines prescribed elsewhere to be recorded on the GP clinical system to ensure that drug interactions were highlighted to the prescriber.<br><br>**Action:** Amendments would be made to the document to reflect the changes which had been made and then sent for comment to JAPC members.<br><br>**Agreed:** JAPC ratified the clinical guideline for clozapine for the treatment of resistant schizophrenia, subject to approval of the revised wording, with a review date of three years. | **SJ**<br><br>**SD** |
| **b.** | **Familial Hypercholesterolaemia**<br>Mr Dhadli reported that the familial hypercholesterolaemia (FH) guideline had been discussed by JAPC in November 2017. The NICE guideline had always included genetic testing but the service nationally had not been widely available. The guideline was now due for review and had been circulated to Dr R Stanworth, UHDBFT Consultant in Diabetes, Endocrinology and Acute Medicine, Dr P Masters, Consultant Chemical Pathologist, Sheffield Teaching Hospitals NHS Foundation Trust and Mr Shepherd. Mr Dhadli referred to the NHS 10-year Plan which had recommended that genetic testing should be more widely available. The aim is to improve the rate of diagnosis in the next five years via the NHS genomics programme and in Derbyshire there would be a considerable number of newly diagnosed patients in Derbyshire in the next two to three years. The consultants had therefore requested a six-month extension to the guideline pending a review of local service/diagnosis pathways.<br><br>**Agreed:** The current guideline for the identification and management of familial hypercholesterolaemia to be extended for a further twelve months and would be updated in light of local service re-designs. | **SD** |

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| Item | | Action |
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| c. | **Management of Non-Valvular Atrial Fibrillation (NV-AF)**<br>Mr Dhadli reported that the NV-AF guidance had been updated to include edoxaban as the preferred new oral anticoagulant drug (NOAC). It was similarly effective as the other NOAC options but is available at lower cost to the system when using the available rebate scheme. The guidance has therefore been amended to suggest that, if a NOAC was considered to be the most appropriate anticoagulant rather than warfarin, edoxaban is to be used first line for patients with NV-AF unless there was a specific clinical reason not to do so. In response to a query by Dr Watkins concerning the switching of patients to edoxaban in primary care, Mrs Needham advised that a robust process would be developed by medicines management and there would be close liaison with GP practices in order to provide support to undertake the work and also appropriate information and/or training to support new initiations in primary care.<br><br>Mr Dhadli stated that a query had been raised concerning an increase in creatinine clearance with consequent decreasing efficacy of edoxaban compared to well-managed warfarin. Edoxaban should therefore only be used in patients with NV-AF and a high creatinine clearance following a careful evaluation of the risk of individual thromboembolic and bleeding risk. This information had been added to appendix 6: Detailed prescribing information for NOACs.<br><br>Dr Henn commented that the 'considerations when choosing an oral anticoagulation agent' section of the guideline indicated that only rivaroxaban and apixaban could be crushed and it could be therefore assumed that these were the preferred options for patients with swallowing difficulties. However it should be noted that edoxaban could also be crushed and given to patients. Mrs Needham would request Mr J Vinson to clarify the swallowing difficulty and crushing of edoxaban. | **KN** |
| | **Agreed:** JAPC ratified the clinical guideline for the management of NV-AF and the position statement for edoxaban being the preferred choice of NOAC for NVAF with a review date of three years. | **SD** |
| | **Agreed:** Edoxaban classified as the preferred **GREEN** 1st line NOAC for NV-AF as per NICE TA 355. | **SD** |
| d. | **Phosphate Binders**<br>Mr Dhadli reported that the guideline for phosphate binders for the long-term treatment of hyperphosphataemia in patients on dialysis had been circulated for comment and no changes had been made. | |
| | **Agreed:** JAPC ratified the clinical guideline for phosphate binders for the long-term treatment of hyperphosphataemia in patients on dialysis with a review date of three years. | **SD** |
| e. | **Vitamin Supplement in Alcohol Abuse**<br>Mr Dhadli reported that the guidance had been sent to UHDBFT, CRHFT and DCHSFT for comment but it had not been possible to achieve a consensus on when vitamin supplements would be used in alcohol misuse. | |

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| Item | | Action |
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| | The only change had been to indicate that GPs may be asked to continue thiamine in patients with evidence of malnutrition/dietary neglect and/or cognitive impairment and continued until assurance had been obtained that the patient was maintaining a good diet and had not relapsed back to alcohol dependence.<br><br>Mr Hulme expressed concern about the recommendation by UHDBFT that discharge patients on oral vitamins should be prescribed Vitamin B Compound Strong and that GPs may be asked to continue this for three months, with the addition of pyridoxine 20mg OD, if the patient showed signs of peripheral neuropathy. Dr A Austin, UHDBFT Consultant Gastroenterologist, would be requested to provide clarification about this issue. The guideline is to be brought back to the next JAPC meeting for further discussion. | **DM**<br><br>**SD** |
| **f.** | **<u>Osteoporosis</u>**<br>Mr Dhadli reported that the osteoporosis guideline had been re-written in 2017 to incorporate recommendations from NICE CG146, SIGN 143, the National Osteoporosis Guideline Group (NOGG) and local expert opinion. Mr Dhadli highlighted some of the changes which had been made to the guideline:<br>• A change in the high dose oral corticosteroid prednisolone from 15mg to 7.5mg in line with the NOGG guidance 2017 in the Adult Osteoporosis Treatment Pathway.<br>• The significant risk factor of BMI clarified as18.5kg/$m^2$ in line with NICE guidance.<br>• Risk factors: Long-term SSRIs and PPIs removed in line with NICE guidance.<br>• Risk factors: Alcohol intake amended to >14 units/week for women and >21 units per week for men.<br>• DXA and recalculate FRAX® - Addition of 'If age-matched percentage <80% i.e. Z score <-2.0: exclude non-osteoporotic causes and causes of secondary osteoporosis (consider referral).'<br>• Calcium and vitamin D: Addition of 'patients should aim for 1000 mg Calcium daily. Use Calcium calculator – IOF 'International Osteoporosis Foundation' a well-recognised international calculator and no conflict of interest declared.<br>• The 10-year probability of fragility fracture of at least 1% statement included that this is a risk level at which oral bisphosphonates are cost effective and is not an intervention threshold.<br><br>Mr Dhadli advised that a reference to the use of strontium ranelate had been included as a treatment which could be considered by specialists in the event that first and second line treatments were not suitable or not tolerated. However it was noted that strontium ranelate had been discontinued in August 2017 but a brand was available although not listed on clinical systems apart from SystmOne and Emis. It was agreed that this should not be included in the guideline at present as more cost-effective treatments for osteoporosis were now available. However the Guideline Group would consider its future place in treatment. | **SD** |

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| Item | | Action |
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| | **Agreed:** JAPC ratified the clinical guideline for osteoporosis, with the agreed amendments, with a review date of three years. | **SD** |
| **9.** | **SHARED CARE GUIDELINES** | |
| **a.** | **Denosumab**<br>Mr Dhadli reported that the shared care guideline for Denosumab 60mg for the prevention of osteoporotic fractures in men and post-menopausal women had been updated with no major changes following a period of consultation. It had been clarified in the referral criteria that patients with a GFR <30ml/min/1.73m² would be initiated and remain under specialist care. In addition, when to seek specialist advice had been included in the GP responsibilities section as general advice.<br><br>**Agreed:** JAPC approved the shared care guideline for Denosumab 60mg for the prevention of osteoporotic fractures in men and post-menopausal women with a review date of three years. | **SD** |
| **b.** | **Attention Deficit Hyperactivity Disorder (ADHD)**<br>Mr Jones reported that the ADHD guideline had been updated in line with NICE guidance NG 87. The main changes were:<br>• Addition of advice for GPs about switching to preferred brands of methylphenidate.<br>• Clarified that the shared care guideline was for children of five years and over.<br>• Recommendation in the consultant/specialist service responsibilities on the need to undertake a baseline ECG prior to starting atomoxetine or guanfacine.<br>• Recommendation in the consultant/specialist service responsibilities to undertake a baseline evaluation in order to identify patients at risk of sedation and somnolence before starting guanfacine.<br><br>In connection with the switching of brands of methylphenidate Mr Dhadli stated that the Guideline Group had recommended that the wording be amended to 'Patients may be changed in primary care to the preferred recommended brand by their GP for ongoing prescribing providing they have been appropriately informed before the switch takes place.' Mr Jones confirmed that DHcFT accepted this change.<br><br>Dr Markus referred to the section in the GP responsibilities 'If a patient defaults attending clinic do not continue prescription unsupervised' and commented that many of the families concerned were persistent non-attenders at clinic. It would be necessary to determine at which point they would have defaulted appointments in line with the guideline and therefore greater clarity was required.<br><br>**Action:** This section would be amended and then sent for comment to JAPC members.<br><br>**Agreed:** JAPC approved the shared care guideline for Attention Deficit Hyperactivity Disorder (ADHD), subject to approval of the revised wording in the GP responsibilities section, with a review date of three years. | **SJ**<br><br>**SD** |

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| Item | | Action |
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| **10.** | **MISCELLANEOUS** | |
| **a.** | **<u>High Cost Drug (excluded from Tariff) Algorithms</u>**<br>Dr Mott stated the high cost drug algorithms had been updated with the adalimumab biosimilars as the most cost effective first line choice. All the algorithms had been discussed by the High Cost Drug and Biosimilar Working Group at the meeting held in February 2019. Dr S O'Reilly, UHDBFT Consultant Rheumatologist, had confirmed that there was agreement for adalimumab biosimilar to be the first line treatment for ankylosing spondylitis (AS) and psoriatic arthritis (PsA), but would still want to continue to use the etanercept biosimilar for rheumatoid arthritis (RA) due to good clinical results and experience in use. JAPC agreed the updated algorithms. | **SD** |
| **b.** | **<u>Lubriprostone</u>**<br>Mr Dhadli reported that NICE TA 318 Lubiprostone for treating chronic idiopathic constipation had been withdrawn as the manufacturer had discontinued lubiprostone (Amitiza®). The algorithm had been updated for the use of prucalopride in women with a reference included to the action required if this drug had not been effective after four weeks. One of the consultees, Dr K Garsed, UHDBFT Consultant Gastroenterologist, had queried why prucalopride could not be used for men. It was therefore agreed that the Guideline Group should review the possible use of prucalopride in men and also consider whether linaclotide could be included for constipation associated with Irritable Bowel Syndrome. | **SD** |
| **c.** | **<u>Shared Care Arrangements for Trans Gender Treatments</u>**<br>Mr Dhadli reported that queries had been received about the prescribing of hormonal treatment and testing for patients who were undergoing trans-gender treatment. In 2016 NHS England had issued a Specialised Services Circular 'Primary Care Responsibilities in Prescribing and Monitoring Hormone Therapy for Transgender and Non-Binary Adults' which now needed to be replaced. NHS England had accordingly undertaken a consultation on 'specialised gender identity services for adults aged seventeen and above' which had requested views on two proposed service specifications. One of these was how Gender Identity Clinics (GICs) would deliver specialised outpatient services and the other how surgical units would deliver surgical interventions. It was also noted that the General Medical Council (GMC) had published guidance on transgender healthcare. This highlighted that most of the medications used for the treatment of gender dysphoria were not licensed for this specific indication, but the guidance allowed off-licence prescribing where necessary to meet the specific needs of the patient and where there was no suitable licensed medicine.<br><br>A report and service specification had been produced for Specialised Gender Identity Services for Adults and key points from this were noted:<br>• The medical practitioners at the GICs would assess the risks and benefits of the pharmacological interventions.<br>• The medical practitioners would also provide GPs with patient specific prescribing guidance, titration information and additional pharmacological interventions.<br>• The providers should reply promptly to any GP requests or queries. | |

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| Item | | Action |
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| | • The individuals, who were receiving endocrine and other pharmacological interventions recommended by the provider, would have these reviewed by a medical practitioner from the specialist multi-disciplinary team at least once in a twelve month period.<br>• Information on duration of treatments would be conveyed to GPs.<br>• Risk assessments would need to be undertaken in the GICs before off-licence medications were prescribed.<br>• GPs should co-operate with the GICs and gender specialists in the same way as for other specialists. It would not be acceptable just to refuse to treat a patient.<br><br>During discussion Dr Markus highlighted that the NHS England guidance implied that GPs must prescribe on the recommendation of an experienced gender specialist and the GMC guidance, which had been challenged repeatedly, reinforced this message. There was also a lack of a reference to a document published in 2018 concerning the interface between tertiary, secondary and primary care. It would be highly important to take into account whether GPs would feel competent to take on the responsibility for the prescribing for unlicensed indications. Dr Markus added that in other areas of the country MDT Gender Identity Services were being developed and suggested that this was a more efficacious way of delivering a service rather than GPs feeling pressurised to prescribe and monitor outside their knowledge or competence. The implication of this would be that these MDT clinics would undertake the prescribing and monitoring in a broadly similar way to Heart Failure services. Dr Markus also referred to the NHS document 'Responsibility for Prescribing between Primary and Secondary/Tertiary Care' which outlined the circumstances where a shared care could be declined. It should therefore be a decision to be made by individual doctors if they believed there was a valid reason for not prescribing. It was noted that the British Medical Association (BMA) had also produced a statement on gender dysphoria.<br><br>Dr Watkins commented that GPs could not be discriminatory to this group of patients but there would still be concern regarding safety issues resulting from the off-licence use of the drugs for patients; particularly those who had certain risk factors such as a high Body Mass Index (BMI). Mr Hulme advised that the JAPC website on gender dysphoria referred to the 2016 NHS England Specialised Services Circular 2016 'Guidance on Primary Care Responsibilities in Prescribing and Monitoring Hormone Therapy for Transgender and Non-Binary Adults' but this had now been superseded. It would be necessary however to make prescribers aware of the NHS England position, together with that expressed by the General Medical Council and British Medical Association, in order to provide a balanced view. It would also be advantageous if JAPC highlighted that there was a service gap and a reference made to other areas in the country where there were gender dysphoria MDT teams.<br><br>**Action:** The information on the JAPC website would be updated with the position statements expressed by NHS England and the General Medical Council. | **SD** |

| Item | | Action |
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| | Dr K Markus would source and forward, if relevant, the British Medical Association guidance and/or LMC advice which will also be a signposting resource.<br><br>**Action:** The current lack of gender dysphoria service in Derbyshire would be highlighted to the CCG Clinical and Lay Commissioning Committee (CLCC). | **KM**<br><br>**SH** |
| **11.** | **REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)** | |
| **a.** | JAPC noted the following:<br>• Position statement on heparinised saline for central venous catheter lock in adults. | |
| **12.** | **JAPC BULLETIN** | |
| | The February 2019 bulletin was ratified. | |
| **13.** | **MHRA DRUG SAFETY UPDATE** | |
| | The MHRA Drug Safety Alert for February 2019 was noted.<br><br>Mr Dhadli highlighted the following MHRA advice:<br>• Carbimazole: increased risk of congenital malformations; strengthened advice on contraception<br>• Carbimazole: risk of acute pancreatitis.<br>• SGLT2 inhibitors: reports of Fournier's gangrene (necrotising fasciitis of the genitalia or perineum) | |
| **14.** | **HORIZON SCAN** | |
| | **Monthly Horizon Scan**<br>Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations:<br><br>New drug launches in the UK:<br>• Apalutamide (Erleada®) – Classified as **BLACK** pending NICE TA or clinician request.<br>• Brigatinib (Alunbrig®) – Classified as **RED** as per NHS England commissioning intentions.<br>• Burosumab (Crysvita®) – Previously classified as **RED**.<br>• Ertugliflozin (Steglatro®) – Classified as **BLACK** pending NICE TA or clinician request.<br>• Letermovir (Prevymis®) – Classified as **RED** as per NHS England commissioning intentions.<br>• Pegfilgrastim biosimilar (Ziextenzo®) – Previously classified as **RED**.<br>• Tildrakizumab (Ilumetri®) – Classified as **BLACK** pending NICE TA or clinician request.<br>• Tisagenlecleucel-T (Kymriah®) – Previously classified as **RED**. | |
| **15.** | **NICE SUMMARY** | |
| | Mrs Qureshi informed JAPC of the comments for the CCGs which had been made for the following NICE guidance in February 2019:<br>TA 560 Bevacizumab with carboplatin, gemcitabine and paclitaxel for treating the first recurrence of platinum-sensitive advanced ovarian cancer (terminated appraisal) – Classified as **BLACK** (as per NICE TA 560). | |

| Item | | Action |
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| | TA 561 Venetoclax with rituximab for previously treated chronic lymphocytic leukaemia – Classified as **RED** (NHS England as per NICE TA 561).<br><br>TA 562 Encorafenib with binimetinib for unresectable or metastatic BRAF V600 mutation-positive melanoma – Classified as **RED** (NHS England as per NICE TA 562).<br><br>TA 563 Abemaciclib with an aromatase inhibitor for previously untreated, hormone receptor-positive, HER2-negative, locally advanced or metastatic breast cancer – Classified as **RED** (NHS England as per NICE TA 563).<br><br>TA 564 Dabrafenib with trametinib for treating advanced metastatic BRAF V600E mutation-positive non-small-cell lung cancer (terminated appraisal) – Classified as **BLACK** (as per NICE TA 564).<br><br>NG 120 Cough (acute): antimicrobial prescribing – Self-care was recommended. Antibiotics were only indicated for people with an acute cough who were systemically very unwell or at high risk of complications. It was confirmed that the antibiotics were in line with local antimicrobial guidance. | |
| **16.** | **GUIDELINE GROUP ACTION TRACKER** | |
| | The summary of key messages from the Derbyshire Medicines Management Guideline Group meeting held in February 2019 was noted. Mr Dhadli highlighted the following:<br>Traffic Lights:<br>• Semaglutide – Classified as **BROWN.** This was the most cost effective weekly GLP1 preparation and had the added benefit of positive cardiovascular outcomes in clinical trials.<br><br>Formulary Review – Respiratory:<br>• Combisal 50 MDI replaced Seretide 50 Evohaler (Green for children; Brown for adults).<br>• Fusacomb Easyhaler 500 replaced AirFlusal Forspiro 500 (Green 3rd line limited place when a dry powdered inhaler was required for COPD; cost effective alternative to Seretide).<br>• Carbocisteine 750mg/10ml sachets replaced 250mg/5ml oral liquid as cost effective choice if a liquid formulation was required.<br><br>Clinical Guidelines:<br>• Bronchiectasis – Local guideline replaced with link to CKS (BNF Chapter Five. Infections and relevant resources).<br>• UTI recurrent – Local guideline replaced with link to NICE NG 112 (BNF chapter 5 Infections, relevant resources)<br>• Type 2 Diabetes – Updated to include semaglutide.<br><br>Website Changes/Miscellaneous:<br>• Management of UTI in people >65 years residing in care home document replaced with links to Public Health England flowchart for men and women over 65 years with suspected UTI and Older People >65 years with suspected UTI – Guidance for Care Home Staff. | |

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| Item | | Action |
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| | • PPI detailing aid removed as no longer being updated. Refer to PPI guideline and GORD guideline.<br>• Ipinnia XL was the cost effective preferred brand for ropinirole.<br><br>Guidelines:<br>• C.Difficile – The Infection control teams at UHDBFT and CRHFT were working together to update this.<br>• Bisphosphonate holiday – Sent to clinicians for comments and expected to be discussed by the Guideline Group in March.<br>• GORD in children – Sent to clinicians for comments and expected to be discussed by the Guideline Group in March.<br>• STEMI (South) – Sent to clinicians for comments and expected to be discussed by the Guideline Group in April.<br>• Lipid Non familial hypercholesterolaemia (FH) – Sent to clinicians for comments and expected to be discussed by the Guideline Group in April.<br>• Continence formulary – Sent to clinicians for comments and expected to be discussed by the Guideline Group. | |
| **17.** | **JAPC SUB-GROUPS** | |
| | **Biosimilar and High Cost Drugs (HCD) Working Group**<br>The paper of the top biosimilar medicines list which gave the target annual savings broken down to UDBHFT and CRHFT was noted by JAPC.<br><br>JAPC commended the excellent work undertaken by both Trusts to increase the uptake of the adalimumab biosimilars. | |
| **18.** | **TRAFFIC LIGHTS – ANY CHANGES?** | |
| | **Classifications**<br>Edoxaban – GREEN preferred 1st line NOAC in NVAF<br>Apalutamide (Erleada®) – BLACK pending NICE TA or clinician request<br>Brigatinib (Alunbrig®) – RED as per NHS England commissioning intentions<br>Burosumab (Crysvita®) – Previously classified as RED<br>Ertugliflozin (Steglatro®) – BLACK pending NICE TA or clinician request<br>Letermovir (Prevymis®) – RED as per NHS England commissioning intentions<br>Pegfilgrastim biosimilar (Ziextenzo®) – Previously classified as RED.<br>Tildrakizumab (Ilumetri®) – BLACK pending NICE TA or clinician request<br>Tisagenlecleucel-T (Kymriah®) – Previously classified as RED<br>Bevacizumab – BLACK (as per NICE TA 560)<br>Venetoclax – RED (NHS England as per NICE TA 561)<br>Encorafenib – RED (NHS England as per NICE TA 562)<br>Abemaciclib – RED (NHS England as per NICE TA 563)<br>Dabrafenib – BLACK (as per NICE TA 564) | |
| **19.** | **MINUTES OF OTHER PRESCRIBING GROUPS** | |
| | • DHcFT Drugs and Therapeutic Committee 24/01/2019<br>• UHDBFT Drugs and Therapeutic Committee 15/01/2019<br>• Sheffield Area Prescribing Group 15/11/2019 | |

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| Item | | Action |
|---|---|---|
| **20.** | **ANY OTHER BUSINESS** | |
| **a.** | **Freestyle Libre®**<br>Mr Dhadli reported that, with effect from 1st April 2019, the RMOC commissioning criteria for Freestyle Libre® would change and NHS England would fund the device for up to 20% of patients with type 1 diabetes (at a reduced price) for two years. These patients would meet the criteria which had been detailed in Annex A of the NHS England document 'Flash Glucose Monitoring: National Arrangements for Funding of Relevant Diabetes Patients' – this was tabled for information. A paper was also tabled which outlined the key differences between NHS England and the current local position. Mr Dhadli highlighted the following:<br>• NHS England had included a list price of £32.47p<br>• MIMS and the drug tariff had the list price of £35<br>• NHS England then used £26.03p as the reimbursed cost for each sensor prescribed. The reduction in the modelling price was from savings to the CCGs from a reduced requirement to fund testing strips for finger-prick blood glucose monitoring.<br><br>**Action:** The local Freestyle Libre® position statement would be updated and brought to the April 2019 JAPC meeting for further discussion about the funding implications and activity to date. | **SD** |
| **b.** | **Rescheduling of Gabapentin and Pregabalin**<br>JAPC noted that, with effect from 1st April 2019, gabapentin and pregabalin would be re-classified as Schedule 3 controlled drugs under the Misuse of Drug Regulations 2001 and Class C of the Misuse of Drugs Act 1971. This would be included in the bulletin. | **SD** |
| **c.** | **JAPC Chair**<br>Dr Mott reported that he would be leaving the CCGs and therefore would no longer be the JAPC Chair with effect from 1st April 2019. In the interim, Dr Emslie would chair the meetings until a permanent replacement had been appointed. JAPC members expressed their appreciation and best wishes to Dr Mott, both as Chair and a long standing member of the committee for a number of years. | |
| **21.** | **DATE OF NEXT MEETING** | |
| | Tuesday, 9th April 2019 at 1.30pm in the Coney Green Business Centre, Clay Cross. | |