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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 14th July 2020

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Benzathine benzylpenicillin inj	RED specialist use only for short treatment courses
Dorzolamide/timolol (Cosopt) UDV p/f	BROWN 2nd line after consultant/specialist initiation if hypersensitive to silver, or cannot use the alternative eye drop bottle (Eylamdo) with dropper aids/support.
Darolutamide (Nubeqa)	BLACK await national guidance or clinician request
Ropeginterferon alfa-2b (Besremi)	RED (NHS England commissioned)
Avatrombopag	RED (CCG commissioned as per NICE TA626)
Trastuzumab emtansine	RED (NHS England as per NICE TA632)
Ustekinumab	RED (CCG commissioned as per NICE TA633)
Daratumumab with lenalidomide and dexamethasone	BLACK (terminated appraisal as per NICE TA634)
Ramucirumab with erlotinib	BLACK (terminated appraisal as per NICE TA635)
Eculizumab	BLACK (terminated appraisal as per NICE TA636)
Ranbizumab	BLACK (terminated appraisal as per NICE TA637)

Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
Tamsulosin MR capsule	GREEN 2nd line alpha-blocker for treatment of urinary retention.
Tamsulosin MR tablet	BLACK
Timolol tablets	BROWN consultant/specialist initiation Available for a small number of post infarct patients at the discretion of a cardiologist
Nebivolol tablets	BROWN specialist recommendation from GREEN specialist recommendation.
Aciclovir eye ointment	BROWN specialist recommendation only when ganciclovir eye ointment is not suitable.
Olanzapine orodispersible SF tablet	BROWN specialist recommendation from GREEN specialist recommendation, only if an orally dispersible preparation is required.
Olanzapine orodispersible tablets/lyophilisate	BLACK from GREEN specialist recommendation

Clinical Guidelines

Adults with moderately to severely active Ulcerative Colitis

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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
Dr H Hill	GP
Dr R Gooch	GP
Ms J Savoury	Assistant Chief Finance Officer
Ms A Reddish	Clinical Quality Manager – Primary Care
Ms A Cargill	Assistant Director of Quality
Derby City Council	
Derbyshire County Council	
University Hospitals of Derby and Burton NHS Foundation Trust	
Mr D Moore	Lead Pharmacist Commissioning & High Cost Medication
Derbyshire Healthcare NHS Foundation Trust	
Mr S Jones	Chief Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Ms C Duffin	Principal Pharmacist and Medicines Safety Officer
Derbyshire Community Health Services NHS Foundation Trust	
Ms A Braithwaite	Chief Pharmacist
Derby and Derbyshire Local Medical Committee	
Derbyshire Health United	
Staffordshire and Stoke-on-Trent CCG's	
In Attendance:	
Mrs K Rogers	Derby and Derbyshire CCG Senior Administrator (minutes)

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1.	**APOLOGIES**	
	Dr W Goddard, Mr M Shepherd, Dr K Markus, Ms S Bamford, Ms A Brailey, Dr S Lloyd, Ms 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**	
	There were no declarations of any other business.	
4.	**MINUTES OF JAPC MEETING HELD ON 09 JUNE 2020**	
	The minutes of the meeting held on 9th June 2020 were agreed as a correct record.	
5.	**MATTERS ARISING**	
a.	**JAPC Microsoft Teams etiquette** Mr Dhadli advised that during the previous months JAPC meeting, a discussion took place as to how the meeting can be run in the most efficient and effective way through a virtual platform, using Microsoft Teams software. Following this, a survey was circulated to all members and feedback included suggestions for a Microsoft Teams etiquette to be produced. As a result of this, JAPC etiquette guidance has now been developed. Alongside this, Derby and Derbyshire CCG have produced a corporate guide to using Microsoft Teams, some of which has been incorporated into the JAPC etiquette summary. Mr Dhadli discussed some of the main etiquette points which include: JAPC Chair and administrative support to join the meeting 5-10 minutes early and monitor arrivals, attendees to be checked at the start, during and at the end of the meeting to ensure there are no uninvited attendees. Verbally notify participants that the meeting is being recorded for accurate minute taking, once minutes are recorded and ratified they will be deleted from the history. Microphones are to be muted to minimise background noise, members should turn their video cameras on at the start of the meeting if they so wish, however during the meeting unless the member is speaking, cameras should remain switched off as this will help to maintain a good streaming quality. Screen shots of shared documents within Microsoft Teams are forbidden. Members of the committee can ask a question either by adding an asterix to the chat box or by using the hand raiser icon. Conversations are minuted however this will not necessarily be the case for chat box messages. JAPC members were in agreement with this.	
b.	**Summary of feedback from the JAPC survey** Mr Dhadli reported that following last month's JAPC meeting, a survey was circulated to all members and deputies to seek their views and feedback on the frequency of these meetings, which had been reduced to 3 monthly during	

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	the COVID-19 pandemic. If JAPC were to return to a monthly meeting it would rely on whether GP's/clinicians currently have the capacity for this and also whether they would be able to offer clinical engagement to help support guidelines and implementation. The response showed that the majority of members wished to return to a monthly meeting and had the capacity to do so. The survey also asked whether the committee would like to see a more streamlined agenda, to which the majority response was yes. Other positive feedback included how members felt that Microsoft Teams works well and how this encourages good attendance at JAPC meetings. Suggestions for improvement included tabling a shorter agenda and discussing key topics only. It was also acknowledged that there is a reduced capacity within Public Health due to the COVID-19 pandemic. Where Public Health advice needs to be sought in regards to agenda items, it should be done so ahead of the meeting.	
c.	**Summary of feedback for the JAPC agenda** Mr Dhadli advised that after analysing the survey results, feedback was then sought from members to find out what their expectations were of a streamlined agenda and how this might look. Suggestions were made that agenda items 12 onwards be for information only, or a short summary be tabled by exception. Mr Dhadli asked the committee for their thoughts on this; Mr Hulme reminded members that this was an interim arrangement whilst Derby and Derbyshire CCG (DDCCG) remain at Business Continuity Level 3 and agreed with the suggestion, with the exception of the Derbyshire Medicines Management Shared Care and Guideline Group (MMSCGG) key messages which are to be noted at each JAPC meeting. Mrs Needham also acknowledged the importance of minuting the MMSCGG key messages for FOI purposes and to ensure all outputs are captured and actioned where appropriate. Mrs Qureshi highlighted the NICE template and queried how drugs that are assigned a traffic light classification will be noted. Mr Dhadli responded to say that NICE Technology Appraisals do have to be formally acknowledged, therefore prior to the meeting, the template can be arranged so that drugs to be noted by JAPC are at the top and the drugs for information only will be listed beneath those. Mr Dhadli will arrange for the JAPC agenda to be reconfigured so that items for information only will appear greyed out beneath the items tabled for discussion.	**SQ** **SD**
6.	**JAPC ACTION SUMMARY**	
a.	**Continence guidance** Mr Dhadli confirmed that the continence guidance action has currently been put on hold due to the COVID-19 pandemic. When there is capacity to do so, Ms H Greaves Lead Clinical Nurse will plan a meeting with the continence team at UHDBFT, to discuss why continence nurses are not complying with some of the formulary choices.	
b.	**Dapagliflozin and insulin/Sotagliflozin and insulin** Mr Dhadli advised that the committee wait until the trust brings the proposal back with regards to whether dapagliflozin and insulin/sotagliflozin and insulin	

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	are appropriate for primary care prescribing. This does not currently need to be monitored by JAPC; therefore Mr Dhadli recommended that it be removed from the JAPC action summary.	**SD**
c.	**Theoloz Duo** Ms Duffin advised that the ophthalmologists at Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) have agreed that Theoloz Duo does not need to be used and it will be removed from the Trust formulary.	
d.	**RMOC Shared Care Agreement** Mr Dhadli reported that Appendix 1 in the RMOC shared care guidance states that primary care prescribers should reply to specialist colleagues by letter within 14 days so that arrangements can be made for the ongoing provision of prescriptions and monitoring arrangements under shared care. As the Derbyshire local shared care guidelines don't currently have any time restrictions JAPC members were asked if they wished to adopt a 14 day response. Ms Derricott previously advised that she would ask the Enhanced Services Review group if they felt a timeframe would be beneficial for Drugs affecting the Immune Response (DMARDS) and shared care drugs agreements. This work is underway however there are some delays due to the COVID-19 pandemic; therefore Mr Dhadli suggested that this be removed from the JAPC action summary. If in the future the Enhanced Services Review group agree to adopt a response time, this can be bought back to a future JAPC meeting.	**JD/SD**
e.	**H2 antagonists/PPI guidance** At the previous month's JAPC meeting Mr Dhadli reported that he is aware of a supply issue with all H2 antagonists, therefore he advised that if a patient is taking ranitidine then a PPI is recommended, if a PPI is unsuitable then other cost effective H2 antagonists must be considered. The University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT) are in the process of producing a H2 antagonists/PPI guidance, which is due to be tabled at the August 2020 JAPC meeting.	**WG**
7.	**NEW DRUG ASSESSMENT/TRAFFIC LIGHT ADDITION**	
a.	**Benzathine benzylpenicillin** Mr Dhadli advised that benzathine benzylpenicillin is licenced for use in adults, adolescents, children and neonates for treatment of erysipelas, early syphilis (primary and secondary), latent syphilis (except for neurosyphilis and presence of pathological CSF findings), yaws and pinta. It is also used for the prophylaxis of rheumatic fever (chorea, rheumatic carditis), poststreptococcal glomerulonephritis and erysipelas. The administration is strictly for intramuscular injection by a healthcare professional and reactions to treatment must be monitored. Patients must also be warned of the possible reactions which include the Jarisch-Herxheimer reaction, a reaction to penicillin, or both. Benzathine benzylpenicillin is included in the British Association for Sexual Health and HIV (BASHH) guidance where it is listed as a first line treatment for early syphilis, late latent, cardiovascular and gummatous syphilis and syphilis in pregnancy. It has a cost of £9.50 for 1 vial of 1.2 million I.U or 2.4 million I.U and the recommendation is for it to be	

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	classified as RED specialist use only, for short treatment courses. Consultees include Ms A Braithwaite Head of Medicines Management at Derbyshire Community Health Services NHS Foundation Trust (DCHSFT), Dr. R Dewis Public Health Consultant and Dr. F Nathani Sexual Health Consultant DCHSFT. **Agreed:** JAPC classified benzathine benzylpenicillin as **RED specialist use only for short treatment courses.**	**SD**
8.	**CLINICAL GUIDELINES**	
a.	**<u>Ustekinumab Ulcerative Colitis</u>** Mrs Qureshi reported that the NICE Technology Appraisal (TA633) ustekinumab for treating moderately to severely active ulcerative colitis was published on 17th June 2020. The NICE TA states that ustekinumab is recommended as an option for treating moderately to severely active ulcerative colitis in adults when conventional therapy or a biological agent cannot be tolerated, or the disease has responded inadequately or lost response to treatment only if: a tumour necrosis factor-alpha (TNF) inhibitor has failed, or a tumour necrosis factor-alpha inhibitor cannot be tolerated or is not suitable and the company provides ustekinumab at the same price or lower than that agreed with the Commercials Medicines Unit. The TNF inhibitors in the Derbyshire commissioning algorithm currently include infliximab, adalimumab and golimumab. Induction treatment for ustekinumab is administered intravenously (IV) as a weight-based dose using 130mg concentrate for solution for infusion. Maintenance treatment is administered as a subcutaneous injection using solution for injection in a vial or pre-filled syringe. The first subcutaneous administration of 90mg should take place at week 8 after the intravenous dose. Following this, dosing recommendation is every 8 weeks or every 12 weeks according to clinical judgment and how the patient responds to treatment. Consideration should be given to discontinue treatment in patients who show no evidence of therapeutic benefit 16 weeks after the intravenous induction dose or 16 weeks after switching to the 8-weekly maintenance dose. NICE have recommended that ustekinumab is a treatment option after a tumour necrosis factor-alpha inhibitor has failed, therefore the suggestion is that ustekinumab be placed as a second line option in the Derbyshire treatment algorithm. Mrs Qureshi also informed the committee that there is a new subcutaneous preparation for vedolizumab. Induction treatment for this is administered intravenously using 300mg IV doses at weeks 0, 2 and 6. Maintenance treatment is administered as a subcutaneous injection using 108mg solution for injection pre-filled syringe every 2 weeks thereafter. Mrs Qureshi discussed the financial data for both the ustekinumab intravenous dose and the vedolizumab subcutaneous injection, which showed that the vedolizumab was more cost effective. Mr Moore advised that he has contacted NICE for clarity surrounding some of the wording used for ustekinumab and ulcerative colitis, he will update the committee once a response has been received. Mr Hulme asked for approximate patient numbers for those being treated with	

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	vedolizumab, Mr Moore advised that there is currently limited stock of vedolizumab subcutaneous injection; however there is an ongoing review of patients to switch as and when available. **Agreed:** The JAPC committee accepted the positioning of ustekinumab and vedolizumab subcutaneous injection, in the treatment algorithm for Adults with moderately to severely active Ulcerative Colitis. **Agreed:** JAPC classified ustekinumab as **RED NICE TA633: ulcerative colitis CCG commissioned.**	**SQ** **SQ**
9.	**MISCELLANEOUS**	
a.	**DMARD monitoring during COVID-19** Mr Dhadli reported that DMARD monitoring has been discussed during a previous JAPC meeting, where there were discrepancies between what the Specialist Pharmacy Service (SPS) guidance advised and what UHDBFT would like to do. The current position is that DDCCG Clinical Cell agreed for primary care to adopt SPS guidance on the management of drugs requiring monitoring during COVID-19; CRHFT are in agreement with this, however UHDBFT rheumatology department has produced their own guidance and are advising patients of a more stringent monitoring schedule. Mr Dhadli referred to a summary table in paper 11a which highlighted the different suggested monitoring intervals between SPS and UHDBFT. This is causing some confusion between patients and GP's; therefore it is being raised with UHDBFT. Mr Moore advised that a discussion will take place and he will gain consensus as to why the trust has chosen to follow different monitoring guidelines to those set out within the national guidance. Dr Hill added that there needs to be consistency across the whole of Derbyshire. Mrs Needham also highlighted a concern for limited phlebotomy capacity and how this might be affected should UHDBFT choose more frequent monitoring. **Agreed:** Mr Moore to discuss this with UHDBFT and feedback to the JAPC committee at the meeting in August 2020.	**DM** **DM**
b.	**Syringe Driver service change in Nursing Homes during COVID-19** Mr Dhadli advised that this paper has been tabled for information to highlight a change of service. As of 24th May 2020 UHDBFT ceased their long standing service of manufacturing aseptic palliative care syringes for patients in the community. Palliative care syringe drivers are now being mixed by the bedside in the old Southern Derbyshire boundary. Syringes for patients in their own homes are prepared by district nurses, and nursing home nurses are mixing medications for their patients with support from Treetops. The latter was commissioned to host a support service to nursing homes for 12 months. Resources are available for GP's and this information will be circulated in the JAPC bulletin to raise awareness.	**SQ**
c.	**Vitamin D for COVID-19** Mr Dhadli reported that there has been a national review of the vitamin D	

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	evidence during the COVID-19 pandemic and that there are reports that some providers in Derbyshire are supplying their staff with vitamin D supplements. NICE in collaboration with Public Health England undertook a rapid review. It has been hypothesised that vitamin D may have a role in the body's immune response to respiratory viruses, however vitamin D is not specifically licenced for preventing or treating any infection, including COVID-19. The NICE rapid review findings concluded that there is no evidence to support vitamin D supplementation to prevent or treat COVID-19. Evidence was from 5 published studies in peer-reviewed journals: 1 observational cohort study, 3 observational prognostic studies involving published data sets using correlation or regression and 1 case control survey. Four of the studies found an association or correlation between a lower vitamin D status and COVID-19. However, confounders such as body mass index (BMI) or underlying health conditions, which may have independent correlations with vitamin D status or COVID-19, were not adjusted. Importantly, no causal relationship between vitamin D status and COVID-19 was found after adjustment for confounders such as comorbidity, socio-demographics, ethnicity, BMI and other baseline factors. All 5 studies were assessed as being at high risk of bias (very low quality of evidence). None of the studies were intervention studies of vitamin D supplementation (for example randomised controlled trials), so no data on appropriate doses or adverse events was given. The JAPC agreed that vitamin D supplements provided to staff for the prevention and treatment of COVID-19 is not evidence based treatment and should not be recommended. UHDBFT, CRHFT and Derbyshire Healthcare NHS Foundation Trust (DHcFT) all advised that they are currently providing vitamin D to some of their staff on a welfare basis, however they acknowledge that this is not an evidence based treatment and it has been relayed through the trusts that this will not continue to be prescribed in primary care. Mr Dhadli advised that this will also be communicated through the JAPC bulletin.	**SQ**
d.	**<u>Cosopt unit dose eye drops</u>** Mr Moore reported that GPs are receiving requests from UHDBFT consultants to prescribe Cosopt unit dose eye drops which are currently classified as BLACK within primary care. The primary care combination product of choice is Eylamdo. An ophthalmologist at UHDBFT has highlighted that there will be a small group of patients with hypersensitivity reaction to Eylamdo as dispensed drops may contain traces of silver from the container. There are also reports that a number of patients have difficulty using the bottle dropper for Eylamdo. An alternative product for these patients would be the Cosopt unit eye drops. Mr Dhadli advised that there is a large cost difference between Cosopt unit eye drops and Eylamdo, the latter being more cost effective. However, the Summaries of Product Characteristics (SPC) for Eylamdo does state that patients with a history of contact hypersensitivity to silver should not use this product as dispensed drops may contain traces of silver from the container. Therefore it would be reasonable to consider Cosopt as an alternative option if Eylamdo is not suitable. Where a patient is considered to need Cosopt Mr Dhadli queried how this will	

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	be assessed and communicated to GP's, Mr Moore responded to say that the reason for the decision to prescribe Cosopt as the preferred option will be documented on the patient referral to primary care. A discussion took place surrounding the issue of patients having difficulty using the Eylamdo bottle dropper and it was agreed that dropper aids and support must be provided and deemed unsuccessful before prescribing Cosopt. **Agreed:** JAPC classified Dorzolamide/timolol UDV (preservative free) (Cosopt) as **BROWN 2nd line after consultant/specialist initiation if hypersensitive to silver, or cannot use the alternative eye drop bottle (Eylamdo) with dropper aids/support.**	**SD**
e.	**<u>Phenelzine Sulphate supply disruption</u>** Mr Dhadli stated that a supply disruption alert for phenelzine has been received from the Department of Health and Social Care (DHSC). Phenelzine 15mg tablets (Nardil®) have been unavailable since August 2019 and this is now expected to be a long-term supply issue. The alert from the DHSC highlights that it is clinically unsafe to stop or switch this drug abruptly; therefore, any switching or withdrawal will need to be undertaken by a specialist. Unlicensed imports of phenelzine 15mg tablets were being used to manage patients and maintain treatment; however, due to global supply issues these imports have become unreliable. However, supplies of unlicensed phenelzine 15mg capsule specials have become available where it is considered necessary that a patient stay on this drug. The DHSC recommend that no new patients should be initiated on phenelzine, all patients currently prescribed phenelzine should be reviewed by specialist mental health services to determine if this is still the most appropriate treatment and whether gradual withdrawal in order to stop and switch to an alternative agent is a potential management option; and where unlicensed imports of phenelzine 15mg tablets are unavailable, clinicians should consider prescribing specials of phenelzine 15mg capsules to avoid abrupt withdrawal. GP's should identify all patients prescribed phenelzine 15mg tablets and refer these patients for a specialist mental health review regarding ongoing management; and ensure they have a sufficient supply until their review, to avoid abrupt withdrawal. The possible shortage of phenelzine was discussed at the previous month's JAPC meeting and contingency planning for using an alternative was put in place. Mr Jones reported that primary care has so far identified 16 patients currently taking phenelzine, which has allowed DHcFT to make contact with those patients and ensure continuity of treatment.	
10.	**REGIONAL MEDICINES OPTIMISATION COMMITTEE (RMOC)**	
	Mr Dhadli informed the committee that he has attended a recent Medicines Optimisation Oversight Group (MOOG) which oversees how the RMOC is run. The MOOG members confirmed that following the initial onset of the COVID-19 pandemic, they are now in a position to offer previous levels of support for primary care prescribing and medicines optimisation. Mr Dhadli reported that three key areas will be important for Medicines Management teams to address:	

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	• Valproate report – to be considered by Area Prescribing Committees, GP's and secondary care. • Over-prescribing review – a report is expected in September 2020 from the Secretary of State. The DDCCG Medicines Management Team are to note and review when available. • Public Health England report – addiction and opioid prescribing (reducing inappropriate prescribing).	
11.	**JAPC BULLETIN**	
	The June 2020 bulletin was ratified.	**SD**
12.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for June 2020 was noted. Mr Dhadli highlighted the following MHRA advice: • Cyproterone acetate: new advice to minimise risk of meningioma Risk of meningioma with cyproterone acetate increases with increasing cumulative dose, the risk is thought to be rare overall, but is highest for doses of 25mg per day and above. Be vigilant for symptoms and signs of meningioma. Use of cyproterone is contraindicated in patients with previous or current meningioma (for all indications) and should only be considered for control of libido in severe hypersexuality or paraphilias in adult men when other interventions are inappropriate. Advice on use of cyproterone in the management of patients with prostate cancer remains unchanged. • Direct-acting oral anticoagulants (DOACs): reminder of bleeding risk, availability of reversal agents MHRA continue to receive reports of bleeds, often life-threatening or fatal, in association with DOACs in patients in the UK. In many reported cases, patients have underlying factors that suggest they are at increased risk of bleeding events. For this reason, DOACs should be used with caution in patients at increased risk of bleeding such as older people and patients with low body weight or renal impairment. It is important that patients with renal impairment receive an appropriate dose depending on renal function. DOACs interact with a number of medicines, some of which increase bleeding risk, refer to product information for advice on use of DOACs with other medicines. Remain vigilant for signs and symptoms of bleeding complications during treatment with DOACs (apixaban, dabigatran, edoxaban, rivaroxaban), especially in patients with increased bleeding risks. Specific reversal agents are available for dabigatran, apixaban and rivaroxaban but there is currently no specific authorised reversal agent available for edoxaban.	
13.	**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: • Darolutamide (Nubeqa) – classified as **BLACK** await national guidance or	

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	clinician request • Ropeginterferon alfa-2b (Besremi) – classified as **RED** (as per NHS England commissioning intentions) Licence extensions: • Brentuximab vedotin (Adcetris) – previously classified as **RED/BLACK** • Secukinumab (Cosentyx) – previously classified as **RED** Drug discontinuations: • Actonel Once-a-Week (Risedronate) • On Call Advanced • Ultraveen Intensive Balm • Amoxil Paediatric Suspension (Amoxicillin) • Percutol (Glyceryl trinitrate) • Ultraveen Moisturising Cream • Exviera (Dasabuvir) • Viekirax (Ombitasvir/paritaprevir/ritonavir) • Ultraveen Very Dry Skin Cream	
14.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the CCG which had been made for the following NICE guidance in June 2020: TA626 Avatrombopag for treating thrombocytopenia in people with chronic liver disease needing a planned invasive procedure – reclassified as **RED** from BLACK (as per NICE TA626) TA631 Fremanezumab for preventing migraine – to remain classified as **RED** (as per NICE TA631) TA632 Trastuzumab emtansine for adjuvant treatment of HER2-positive early breast cancer – classified as **RED** (NHS England as per NICE TA632) TA633 Ustekinumab for treating moderately to severely active ulcerative colitis – classified as **RED** (as per NICE TA633) TA634 Daratumumab with lenalidomide and dexamethasone for untreated multiple myeloma (terminated appraisal) – classified as **BLACK** (as per NICE TA634) TA635 Ramucirumab with erlotinib for untreated EGFR-positive metastatic non-small-cell lung cancer (terminated appraisal) – classified as **BLACK** (as per NICE TA635) TA636 Eculizumab for treating refractory myasthenia gravis (terminated appraisal) – classified as **BLACK** (as per NICE TA636) TA637 Ranibizumab for treating diabetic retinopathy (terminated appraisal) – classified as **BLACK** (as per NICE TA637)	
15.	**GUIDELINE GROUP ACTION TRACKER**	

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	The summary of key messages from the Derbyshire Medicines Management Shared Care and Guideline Group meeting held in June 2020 was noted. Mr Dhadli highlighted the following: Traffic Lights: • Tamsulosin MR capsule – classified as GREEN 2nd line alpha-blocker for treatment of urinary retention • Tamsulosin MR tablet – classified as BLACK there are potential cost savings across Derbyshire if tablets are switched to capsules (no EIA/QIA concern as alternative available) • Timolol – classified as BROWN consultant/specialist initiation, available for a small number of post infarct patients at the discretion of a cardiologist • Nebivolol – reclassified as BROWN specialist recommendation from GREEN specialist recommendation. Generic 5mg tablets are more cost effective than 2.5mg or 10mg tablets and can be divided into equal halves or quarters. • Aciclovir eye ointment – classified as BROWN specialist recommendation only when ganciclovir eye ointment is not suitable. Higher cost than ganciclovir. • Olanzapine orodispersible SF tablet – reclassified as BROWN specialist recommendation from GREEN specialist recommendation, only if an orally dispersible preparation is required. • Olanzapine orodispersible tablets/lyophilisate – reclassified as BLACK from GREEN specialist recommendation, cost difference between orodispersible tablets/lyophilisate. No EIA/QIA concern as alternative available. Formulary Update (Chapter 7 – Obstetrics, gynaecology, and urinary tract disorders): • Imvagiss pessary (estriol) added to the formulary. Choice of local oestrogen preparation is based on patient preference to maintain compliance. • Fenticonazole pessary removed as discontinued. • CHC containing ethinyloestradiol 30 micrograms – Cimizt moved up to 2nd line; Millinette 30/75 moved down to 3rd line. Alternative equivalent brands Munalea 20/150, Alenvona, and Munalea 30/150 removed as discontinued. • POC – Cerazette/Desmono/Desorex removed as above £5 threshold (Traffic Light Classification BLACK) • Emerres added as an alternate cost effective brand for levonorgestrel 1.5mg. Formulary Update (Chapter 3 – Respiratory): • Ventolin nebules added to formulary as a cost-effective brand of salbutamol nebules. Potential annual saving £47k across CCG. • Kelhale 50 and 100 MDI added to formulary as cost effective beclometasone (extra-fine particle) inhaler. Potential annual saving £195k across CCG. Clinical Guidelines: • GORD in children – partial update as per JAPC. Ranitidine removed; additional PPI prescribing information added; new appendix for alternative	

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	H2RA in children. • Non-malignant chronic pain – advice on opioid tapering/stopping added. Specialist consulted and agreed slower tapering of 10-25% reduction monthly as the preferred option. • Osteoporosis – treatment threshold updated as per NICE TA464, agreed with specialists, removed reference to 1% 10-year fracture risk and replaced with 'assessed as being at higher risk of osteoporotic fragility fracture'. PDA updated as per NICE. • Atrial Fibrilation – dronedarone rivaroxaban interaction updated as per SPC to state concomitant use not recommended due to increased risk of bleeding. Previous advice was caution. Website Changes/Miscellaneous: • 'Supply of items for administration by DCHS staff' statement updated. • Links to DHcFT PIL 'reducing risk of overdose' and 'medicines and Suicide' medication review tool' added to the Derbyshire Medicines Management website CNS chapter under other resources. • Clomipramine MR Hcl (Anafranil SR) Traffic Light Classification removed as it was discontinued in 2015. • Syringe driver protocol removed from the Derbyshire Medicines Management website. From the 24th May UHDBFT ceased service of manufacturing palliative care syringes for patients in the community. • Drugs (propanthelene, oxybutynin) within hyperhidrosis policy reviewed and acknowledged as correct. Guideline Timetable: • The guideline table action summary and progress was noted by JAPC.	
16.	**BIOSIMILAR REPORT**	
	The benchmarking data was noted for information. Mr Dhadli reported that Queen's Hospital Burton is low on the uptake of adalimumab biosimilars, to be discussed at the next UHDBFT finance committee meeting.	**SQ**
17.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	<u>Classifications</u> Benzylpenicillin Benzathine – RED specialist use only for short treatment courses Dorzolamide/timolol (Cosopt) – BROWN 2nd line after consultant/specialist initiation if hypersensitive to silver, or cannot use the alternative eye drop bottle (Eylamdo) with dropper aids/support. Darolutamide (Nubeqa) – BLACK treatment of adult men with non-metastatic castration resistant prostate cancer who are at high risk of developing metastatic disease. Await clinician request. Ropeginterferon alfa-2b (Besremi) – RED monotherapy of polycythaemia vera without symptomatic splenomegaly in adults NHS England commissioned. Avatrombopag – RED NICE TA626: treating thrombocytopenia in people with chronic liver disease needing a planned invasive procedure CCG commissioned Trastuzumab emtansine – RED NICE TA632: adjuvant treatment of HER2-positive early breast cancer	

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Item		Action
	Ustekinumab – RED NICE TA633: ulcerative colitis CCG commissioned Daratumumab with lenalidomide and dexamethasone – BLACK NICE TA634: multiple myeloma (terminated appraisal) Ramucirumab with erlotinib – BLACK NICE TA635: metastatic NSCL (terminated appraisal) Eculizumab – BLACK NICE TA636: refractory myasthenia gravis (terminated appraisal) Ranbizumab – BLACK NICE TA637: diabetic retinopathy (terminated appraisal)	
18.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
	• UHDBFT Drugs and Therapeutics Group 19/05/2020 Mr Dhadli highlighted the following points from the minutes: • Avastin as an alternative to Eylea/Lucentis ○ Bayer/Roche right to appeal the legal decision ○ Launch of biosimilar Avastin in June/July 2020 ○ Suitability of supply chain in Avastin to meet the expected demand. ○ Availability of pharmacy aseptic units to produce a ready to administer product.	
19.	**ANY OTHER BUSINESS**	
	There were no items of any other business.	
20.	**DATE OF NEXT MEETING**	
	Tuesday, 11th August 2020 at 1.30pm to be held virtually via Microsoft Teams	