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DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)

Minutes of the meeting held on 13th December 2022

CONFIRMED MINUTES

Summary Points

Traffic lights

Drug	Decision
Dexcom One	GREY after diabetes consultant/specialist initiation within a Derbyshire diabetes service
Icosapent ethyl	GREY as per NICE TA805 with statin therapy for reducing the risk of cardiovascular events in people with raised triglycerides (1.7 mmol/L or above) and low-density lipoprotein cholesterol >1.04mmol/L and ≤ 2.60mmol/L.
Testosterone Gel	GREEN for low sexual desire in postmenopausal women. See JAPC menopause guideline for further details
Empagliflozin	GREEN: Type 2 Diabetes without CKD Type 2 Diabetes with CKD
Dapagliflozin	GREEN: Type 2 Diabetes without CKD Type 2 Diabetes with CKD
Canagliflozin	GREY: Type 2 Diabetes without CKD Type 2 Diabetes with CKD
Ertugliflozin	GREY - Type 2 Diabetes without CKD
Semaglutide (SC)	GREEN - Subcut weekly GLP1
Dulaglutide	GREEN - Weekly GLP1
Exenatide	GREY - Weekly GLP1
Semaglutide (oral)	GREY - Oral daily GLP1
Ziconotide	RED for Intrathecal delivery for chronic cancer pain
Rituximab	RED for Idiopathic Membranous Nephropathy in Adults. NHSE commissioned
Estetrol + drospirenone (Drovelis)	DNP for Oral contraceptive. Await clinician request
Lidocaine (*Lidbree*)	DNP for Topical anesthesia for moderate acute pain during cervical and intrauterine procedures, in adults and adolescents aged ≥15 years. Await clinician request.
Potassium citrate / Potassium bicarbonate (SR)	DNP as per NICE TA838 for slow-release potassium bicarbonate–potassium citrate for treating distal renal tubular acidosis. Terminated appraisal
Ruxolitinib	DNP as per NICE TA839 for ruxolitinib for treating acute graft versus host disease refractory to corticosteroids. Terminated appraisal
Ruxolitinib	DNP as per NICE TA840 for ruxolitinib for treating

	chronic graft versus host disease refractory to corticosteroids. Terminated appraisal
Carfilzomib	DNP as per NICE TA841 for carfilzomib with daratumumab and dexamethasone for treating relapsed or refractory multiple myeloma. Terminated appraisal
Tisagenlecleucel	DNP as per NICE TA842 for tisagenlecleucel for treating follicular lymphoma after 2 or more therapies. Terminated appraisal
Luspatercept	DNP as per NICE TA843 for luspatercept for treating anaemia caused by beta-thalassaemia. Terminated appraisal
Luspatercept	DNP as per NICE TA844 for luspatercept for treating anaemia caused by myelodysplastic syndromes. Terminated appraisal
Mepolizumab	DNP as per NICE TA845 for mepolizumab for treating eosinophilic granulomatosis with polyangiitis. Terminated appraisal
Mepolizumab	DNP as per NICE TA846 for mepolizumab for treating severe hypereosinophilic syndrome. Terminated appraisal
Mepolizumab	DNP as per NICE TA847 for mepolizumab for treating severe chronic rhinosinusitis with nasal polyps. Terminated appraisal

Derbyshire Medicines Management Shared Care and Guideline Group Traffic Lights

Drug	Decision
Parecoxib	RED - accepted by UHDB DTC as per palliative care guideline
Combodart (dutasteride & tamsulosin)	DNP - combodart is significantly more expensive than the individual components of dutasteride and **tamsulosin** or the generic combination capsule
BioMonde Biobag Larval therapy	RED due to the ordering process and need to ensure viability of the larval therapy a limited list of pharmacies have been agreed to order and supply
Beclometasone & formoterol (Luforbec 200/6) inhaler	GREEN 1st line for patients requiring an MDI, luforbec 200/6 MDI is cost effective alternative to Fostair 200/6 MDI for patients requiring an MDI

Clinical Guidelines
Management of Type 2 Diabetes in adults
JAPC briefing for Freestyle Libre 2/Dexcom One
Chronic Obstructive Pulmonary Disease (COPD) Management

Shared Care Agreements
Acamprosate SCA
Disulfiram SCA
Naltrexone SCA

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Present:	
Derby and Derbyshire ICB	
Dr R Gooch	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 H Hill	GP
Dr R Dills	GP
Dr A Mott	GP
Mrs L G	Assistant Director of Medicines Optimisation and Delivery
Mrs R Monck	Assistant Chief Finance Officer
Derby City Council	
Derbyshire County Council	
University Hospitals of Derby and Burton NHS Foundation Trust	
Dr W Goddard	Chair – Drugs and Therapeutic Committee
Mr M Prior	Deputy Chief Pharmacist
Derbyshire Healthcare NHS Foundation Trust	
Mr S Jones	Chief Pharmacist
Chesterfield Royal Hospital NHS Foundation Trust	
Ms A Brailey	Chief Pharmacist
Derbyshire Community Health Services NHS Foundation Trust	
Mrs K Needham	Chief Pharmacist
Derby and Derbyshire Local Medical Committee	
Derbyshire Health United	
Staffordshire and Stoke-on-Trent CCG's	
Ms S Bamford	Medicines Optimisation Senior Lead Pharmacist
In Attendance:	
Mr A Brownlee	Chief Pharmacy Technician (Interface)
Miss S Greenwell	Senior Administrator, DDCCG (minutes)

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Item		Action
1.	**APOLOGIES**	
	Ms E Kirk	
2.	**DECLARATIONS OF CONFLICTS OF INTEREST**	
	Dr Gooch 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.	**JAPC ACTION SUMMARY**	
a.	**Inclisiran** University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT) are to undertake review of supply and distribution through community pharmacies and develop a business case.	
b.	**Patiromer/Lokelma hyperkalaemia** Remains RED and to review classification in 12 months, to include costs/benefits and the projected increase in patient numbers.	
c.	**Sodium Valproate** Derbyshire Medicines Safety Network (DMSN) to feedback about need for a shared care agreement for sodium valproate.	
d.	**Ranibizumab biosimilar** This is on the agenda to discuss.	
e.	**Mycophenolate** Draft shared care received from Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) in February 2021 and is to be agreed Derbyshire wide. The Guideline Group is to review in line with published RMOC template. This is on the agenda to discuss further.	
f.	**Weekly GLP1** Place in therapy of weekly GLP1's, considered with diabetes guidance update.	
g.	**Icosapent ethyl** Cardiologist/Lipidogist views sought for the managed entry of icosapent ethyl in non-FH/FH guidance. UHDBFT to discuss at Octobers Drugs and Therapeutics Group (DTC). This is also on the agenda to discuss further.	
5.	**NEW DRUG ASSESSMENT/TRAFFIC LIGHT ADDITION**	
a.	**Diabetes glucose monitoring - Dexcom one** Mr Dhadli informed the committee that a request from the Derbyshire Diabetes Group has been received to assign a traffic light classification to the Dexcom One glucose monitoring system. Dexcom One is an evidence based	

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	real time continuous glucose monitoring (rtCGM) system, which can be prescribed on an FP10. Specialists have requested this is available as an additional option for patients who would be eligible for FreeStyle Libre 2. Dexcom One is equivalent in price to FreeStyle Libre 2, so there is no additional cost pressure from prescribing Dexcom One. In line with the existing FreeStyle Libre 2 policy the specialist diabetes team will initiate the device, provide ongoing education, support, and follow up for users. Eligible NHS patients already on FreeStyle Libre 2 may choose to switch to Dexcom One based on their personal preferences and any eligible people living with diabetes who are not already on some form of continuous glucose monitoring, who meet the criteria for access could have access to the FreeStyle Libre 2 or Dexcom One based on individual preference. Mr Dhadli highlighted the Dexcom One sensor specification's, the financial implications and mentioned that Dexcom One sensor is available on System one and Emis Web to prescribe electronically. Dexcom One was discussed previously at JAPC and it was agreed to be discussed at the Derbyshire Prescribing Group (DPG) along with the wastage issues and the implementation. Consensus from DPG was for monthly prescriptions. The recommendation is to assign a GREY consultant/specialist initiation traffic light classification for Dexcom One with a Derbyshire Diabetes service. Ratification of the the JAPC briefing Freestyle Libre 2/Dexcom One and the updated Diabetes glucose monitoring interim position statement is also recommended. **Agreed:** The committee accepted the GREY consultant/specialist initiation traffic light classification for the Dexcom One diabetes glucose monitoring. **Agreed:** The committee agreed to the updated JAPC briefing Freestyle Libre 2/Dexcom One and the Diabetes glucose monitoring interim position statement.	**SD** **SD**
b.	**<u>Icosapent ethyl (Vazkepa) capsules</u>** Mr Dhadli mentioned that the July 22 updated NICE TA805 for icosapent ethyl was discussed at JAPC in August 2022 and was assigned a RED traffic light classification pending specialist recommendation for its place in therapy. NICE TA805 icosapent ethyl is recommended as an option for reducing the risk of cardiovascular events in adults. Icosapent ethyl is recommended as an option for reducing the risk of cardiovascular events in adults. It is recommended if they have raised fasting triglycerides (1.7mmol/L or above) and are taking statins, but only if they have established cardiovascular disease (secondary prevention), defined as a history of any of ACS (such as myocardial infarction or unstable angina needing hospitalisation), coronary or other arterial revascularisation procedures, coronary heart disease, ischaemic stroke, peripheral arterial disease, and low-density lipoprotein cholesterol **(**LDL-C) levels above 1.04 mmol/litre and below or equal to 2.60 mmol/litre. Icosapent ethyl has been discussed at UHDBFT DTC in October 2022 with a recommendation to update the traffic light classification to allow primary care prescribing and insert into the lipid guidelines. Use of icosapent is niche, following end of the pathway after LDL is optimised and a maximally tolerated statin ± ezetimibe. Patients would likely be offered it as part of standard lipid	

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	monitoring rather than actively finding them. The consensus is that this is a treatment which should be initiated in primary care and not as 'specialist recommendation' as no additional screening would be offered in secondary care over NICE criteria and referrals to lipid clinic (including advice & guidance), are usually reserved for patients with more severe dyslipidaemia (than those that fit NICE criteria for icosapent ethyl). The identified risk was of inappropriate referrals for icosapent ethyl, which essentially does not require secondary care specialist input. The cost-effectiveness estimates for icosapent ethyl are uncertain. NICE state icosapent ethyl is unlikely to be cost effective for primary prevention, so it is not recommended for this. But the most likely cost-effectiveness estimates for secondary prevention are within what NICE normally considers an acceptable use of NHS resources. Mr Dhadli presented the clinical evidence. DTC concluded uncertainty in the clinical effectiveness evidence for icosapent ethyl because of the mineral oil placebo in the REDUCE-IT trial. Concerns were also noted about the generalisability of the trial results to the NHS in England. There is concern about the company's modelling approach, including the treatment effect after discontinuation was modelled and the composite outcome. Nevertheless, the most plausible ICER was towards the lower end of the range of what NICE normally considers a cost-effective use of NHS resources. A discussion took place, it was suggested that GPs may not feel comfortable prescribing icosapent ethyl without specialists' advice and roll out could be slow as they may feel they need more experience with the drug. **Action:** DDICB to include icosapent ethyl to the January horizon scan. **Agreed:** The committee agreed a GREY traffic light classification for icosapent ethyl as per NICE TA805. **Agreed:** The committee agreed to the changes in the FH and non-FH guidelines to reflex the icosapent ethyl NICE TA805.	**SD** **SD** **SD**
c.	**<u>Testosterone gel for low sexual desire in menopausal women</u>** Mr Dhadli advised that testosterone gel for low sexual desire in menopausal women guidance has undergone wide consultation and was discussed at Guideline Group. The proposal is to remove the requirement for 'specialist recommendation' for testosterone gel specifically for the off-label indication of low sexual desire in postmenopausal women. Guideline group supported the proposal in principle and recommended guidance was produced to guide primary care prescribing. Mr Dhadli presented the topical testosterone for low sexual desire in menopausal women - prescribing information guidance, which was developed in collaboration with the Shared Care Pathology Group to the committee and highlighted key element which is that testosterone can be used as an adjunct to traditional HRT (oestrogen plus progesterone). JAPC are recommended to update the traffic light classification to remove 'specialist recommendation' for testosterone gel for low sexual desire in menopausal women, and to insert prescribing advice into the JAPC menopause guideline.	

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	Action: DDICB to highlight the traffic light change in Decembers JAPC bulletin. **Agreed:** The committee approved testosterone prescribing advice to be inserted into existing JAPC low sexual desire in menopausal women guideline.	**SD** **SD**
6.	**CLINICAL GUIDELINES**	
a.	**<u>Type 2 diabetes guidance</u>** Mrs Qureshi presented the local Derbyshire Management of Type 2 Diabetes in adults guidance which has been updated based on the NICE NG28 (updated in February 2022). The guidance has undergone wide consultation with Diabetes and Endocrinology specialists at UHDBFT and CRHFT. The latest updated NICE guidance includes cardiovascular and renal protection based on evidence from randomised trials showing that's SGLT2i have both cardiovascular and renal benefits. There is also emphasis on shared decision making in relation to choosing drug treatments, considering the persons preferences, needs and individual clinical circumstances. Mrs Qureshi summarised the changes introduced in the latest NICE guidance and highlighted the updates added to the local Derbyshire Management of Type 2 Diabetes in adults guidance and the treatment algorithms. JAPC were asked to consider several traffic light classification changes; the recommendation for empagliflozin and dapagliflozin is to be classified as GREEN, and canagliflozin and ertugliflozin remain GREY for type 2 diabetes without CKD. UHDBFT renal and cardiac teams are using dapagliflozin as 1st line, canagliflozin is avoided by both sets of consultants. Although canagliflozin demonstrated 14% reduction in MACE, it was associated with unexpected increase in amputations and fractures. This was raised by the MHRA, June 2016. For type 2 diabetes with CKD, the SGLT2i are currently GREEN specialist initiation. Specialists have requested to remove the 'specialist initiation' enabling GPs to start treatment. Mrs Qureshi discussed the GLP1 preferred choices at Guideline Group. The daily GLP1 traffic light classifications remain as is. The weekly GLP1 traffic light classifications have new recommendations; Semaglutide (SC) and Dulaglutide are recommended to be changed to GREEN and Semaglutide (Oral) and Exenatide stay as GREY. With regards to financial implications, implementing NICE recommendations for initiating SGLT2i, may generate savings downstream if it delays the point at which patients are escalated to more expensive drugs. There may be a reduction in hospitalisations for heart failure as a result of people receiving SGLT2 inhibitors. A discussion took place. It was highlighted that a number of GP practices have practice nurses that are responsible for diabetic management and so it is important that those practice nurses receive some form of education on the changes. A further discussion took place regarding affordability and inappropriate use of GLP1s. **Action:** The committee agreed to take this to DPG to discuss the implementation issues for GLP1 and SGLT2i and the spend trends of other	**SD**

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	drugs from the previous 3 years. **Agreed:** The committee approved the several traffic light classification changes as per NICE NG28 guidance and agreed to remove the Pioglitazone prescribing statement from the Derbyshire Medicines Management website.	**SD**
b.	**COPD Guideline** Mr Dhadli advised that the Chronic Obstructive Pulmonary Disease (COPD) Management guidance was due for a routine review. The guidance has undergone consultation with a respiratory consultant at UHDBFT and CRHFT, and an acute and respiratory physician at CRHFT. Mr Dhadli summarised the minor changes within the guideline, which are based on the NICE NG115 (Dec 2018) Chronic obstructive pulmonary disease in over 16s: diagnosis and management. Amendments include use of reversibility testing as a useful tool to distinguish asthma and COPD, terminology change from smoking cessation to "treatment of tobacco addiction", local contacts for respiratory services updated and link to ARTP added under training information. Treatment options for COPD remain unchanged and are based on presence or absence of asthmatic features. **Action:** The committee agreed to add carbon footprint information for each inhaler into the Chronic Obstructive Pulmonary Disease (COPD) Management guidance. **Agreed:** The committee approved the updated Chronic Obstructive Pulmonary Disease (COPD) Management guidance.	**SD** **SD**
7.	**SHARED CARE AGREEMENT**	
a.	**Acamprosate SCA** Mr Dhadli informed the committee that Acamprosate, Disulfiram, Naltrexone shared care agreements for maintenance of alcohol abstinence were all due for routine renewal. NICE CG115 Alcohol-use disorders: diagnosis, assessment, and management of harmful drinking (high-risk drinking) and alcohol dependence is current and up to date. Acamprosate SCA – changes include removal of specialist responsibility to determine whether the patient is alcohol dependent and arranging a physical assessment as not routine practice and specialist to monitor treatment duration for first 6 months (in line with NICE). The minor changes were discussed and agreed at the Derbyshire Healthcare NHS Foundation Trust (DHcFT) Drug and Alcohol Advisory Group and the Medicines Management Committee. **Disulfiram SCA** Minor changes include removal of specialist responsibility to determine whether the patient is alcohol dependent and arranging a physical assessment as not routine practice and to 'review' patients for first two months.	

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	Naltrexone SCA Minor changes include specialist responsibility for initiating reworded to reflect current practice and monitoring requirements section reworded to convey a clearer message. **Agreed:** JAPC approved the updated Acamprosate, Disulfiram, Naltrexone shared care agreements for maintenance of alcohol abstinence and has been ratified for 3 years.	**SD**
b.	**Hydroxychloroquine – RMOC shared care** Mr Dhadli informed the committee that the Hydroxychloroquine prescribing guideline has undergone extensive consultation with Rheumatology and Dermatology at UHDBFT and CRHFT. Hydroxychloroquine did originally have a shared care agreement but was re-classified from AMBER to GREEN specialist initiation in 2011 due to little on-going monitoring required. In 2017/2018 the Royal College of Ophthalmology (RCO) and British Society of Rheumatology (BSR) guidelines both updated the recommendation to advise annual screening for retinopathy, in patients on hydroxychloroquine, after 5 years treatment (or after 1 year for high risk patients). RCO removed the recommendation for baseline OCT (optical coherence tomography) in 2020. UHDBFT and CRHFT both state that they follow national guidance on hydroxychloroquine monitoring, and those patients are actively followed up in secondary care for the underlying condition. Ophthalmology in both acute trusts currently perform SD OCT (spectral-domain optical coherence tomography) in eligible patients on hydroxychloroquine treatment, when they receive referrals from e.g., rheumatology. Reasons for change from current GREEN specialist initiation to AMBER traffic light classification is the significance of potential adverse effects of retinopathy and the national advice for regular ophthalmology monitoring. In 2022, the RMOC's developed a national hydroxychloroquine shared care protocol (2022). However, consultant rheumatologists from UHDBFT and CRHFT have both expressed preference to developing a prescribing guideline rather than a full shared care due to lack of blood monitoring and simple dosing. The Guideline Group has put forward both the shared care agreement and the prescribing guidance for JAPC consideration, with a preference for a prescribing guideline. A discussion took place regarding auditing retinal screening. It was previously agreed following national guidelines that patients would receive annual retinal screening. There are concerns with patients that are taking hydroxychloroquine and are not under Ophthalmology, and therefore are not being referred for annual retinal screening. It was highlighted that within the hydroxychloroquine prescribing guideline the monitoring responsibility sits with Ophthalmology, however GPs also have the responsibility to refer patients for retinal screening. Therefore, the guidance needs to be made clearer on who should be making retinal screening referrals. Rheumatology have confirmed that patient monitoring and referrals are taking place but there is concern that Rheumatology may not be aware of those patients that have been on treatment for a long time. RD highlighted that shared care agreements bring more security, but patients that do not need follow ups cannot be discharged. Annual reviews allow more active management	

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	however, a more robust referral system needs to be in place before joint monitoring is handed over to primary care. **Action:** UHDBFT and CRHFT agree to take the monitoring concern to DTC and determine their referral mechanisms and ensure providers have capacity to manage the estimated 1800 patients. Further to see if the correct number of patients on treatment are known. **Action:** DDICB to collect Epact data on those patients that are on treatment but are not under Rheumatology and distribute to JAPC members. **Agreed:** The committee agreed to defer the decision making on the Hydroxychloroquine prescribing guideline and shared care agreement until the capacity issues with the Ophthalmology monitoring have been addressed.	**SD** **SD** **SD**
c.	**<u>Mycophenolate shared care</u>** Mr Dhadli advised that this has been brought to JAPC again to review the traffic light classification and approve the shared care agreement. The mycophenolate shared care agreement was previously discussed at JAPC and due to the uncertainty in indications the shared care agreement was discarded. Following publication of national shared care protocol for mycophenolate (including non-transplant indications), the contents have been inserted into local shared care template and distributed to specialists for comments. Mr Dhadli summarised the indications added to the mycophenolate shared care agreement. The RMOC shared care include lymphocytes <0.5 $x10^9$ and eosinophil count >0.5$x10^9$ in their templates. JAPC have queried if these monitoring parameters need to be included in the mycophenolate shared care agreement as they are not included in any other JAPC DMARD shared care agreements for immunomodulated drugs. RMOC have not yet confirmed. AM highlighted that as this mycophenolate shared care agreement is new and primary care will be involved in the implementation the Local Medical Committee (LMC) will also need to be made aware before an agreement is made. **Agreed:** The committee agreed to defer the mycophenolate shared care agreement for the specialists to confirm if lymphocytes and eosinophil count need to be included in the mycophenolate shared care agreement, and to get LMC view on this shift of work to primary care.	**SD**
8.	**MISCELLANEOUS**	
a.	**<u>Ranibizumab biosimilar</u>** Mr Dhadli mentioned Ongavia® (Teva) is the first licensed ranibizumab biosimilar to launch in England for use across all indications which will result in a significant reduction in cost. Ongavia is currently only available in a vial and not pre-filled syringe (PFS). With the PFS patent expiry due in June/July 2023, the biosimilar PFS should come to the market shortly after this date. Trusts have been asked to ensure they have plans in place for the uptake of ranibizumab biosimilar thus securing efficiency savings for the system. Although commissioning of these drugs currently resides in block contract	

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	arrangements, JAPC requires oversight of number of patients switching to the biosimilar on a monthly basis. PrescQIPP have informed members during their biosimilar update that Ongavia orders with Teva are currently on hold. Some trusts have been allocated their required stock, whereas some trusts are still awaiting their allocation. Teva has informed trusts that more stock will be available January/February 2023 and will be reviewing who they distribute stock to when more becomes available again. If trusts are yet to show an interest, they must inform their regional procurement specialist as soon as possible to go on the waiting list for when stock is available again from Teva. Mr Dhadli presented slides form PrescQIPP which show the uptake of the biosimilar across various regions. The slides highlight minimal uptake of the biosimilar across the Midlands region. Highlight from CRHFT - engagement with the ophthalmologists has been a challenge, but progress is being made. Engagement and support is being received from the CRHFT improvement team with regards to project management. CRHFT have a plan to implement the ranibizumab biosimilar in two phases, phase one will concentrate on new and existing patients. Phase two will involve reviewing treatment choice for patients. The second phase may be complex as there is a direct impact on clinic capacity for injection frequency. CRHFT suggested connecting their ophthalmologists with UHDBFT ophthalmologists to help with reassurance. UHDBFT advised that from January 2023 new patients will be switched onto the ranibizumab biosimilar. Due to the complications of the switch, a predicted figure will be produced. A discussion took place regarding the importance of providing a figure and the difficulty of doing this. It was highlighted that other providers have previously carried out this switch and it may be useful for CRHFT and UHDBFT to review their costing data. The committee agreed JAPC will review the percentage uptakes and the planning and financial discussions will be discussed at the IPMO board. **Action:** CRHFT and UHDBFT to provide JAPC with an update on percentage figures.	**SD**
b.	**<u>Horizon scan 2023/24</u>** Mrs Qureshi presented the annual horizon scan for new drugs which will impact on primary and secondary care high-cost drugs prescribing budgets for 2022/23/24. Also presented was a summary of the Prescribing Outlook for new medicines for 2023/24, which focuses upon anticipated UK availability of new medicines, licence extensions and new formulations. The committee received a list of drugs to acknowledge those drugs which will have primary care prescribing implications and high-cost drugs which are commissioned by ICB (but currently under block arrangements), that will impact for 2023/24, and the potential cost pressure for drugs on the horizon for the ICBs in 2023/24. High impact drugs for primary care include SGTL2i's for chronic heart failure with preserved ejection fraction, insomnia and unexplained cough. ICB commissioned drugs include a raft of new migraine treatments and very high impact drugs for Alzheimers Disease.	

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c.	**Prescribing specification** Mr Dhadli advised the prescribing specification is due for renewal. The prescribing specification is part of the healthcare services contract commissioners (ICB) has with provider organisations. This document outlines the role and responsibilities of our provider trusts in ensuring a transparent and collaborative approach to the safe and effective management of medicines, seamless care of patients between NHS organisations and ensuring high quality prescribing. It was recommended to extend for another year pending a review as the ICS matures. **Agreed:** The committee agreed to extend the prescribing specification for another year.	**SD**
d.	**Rabies vaccine UKHSA letter** Mr Dhadli reported a letter from a UHDBFT pharmacist has been received to report a requirement for trusts to hold a small number of doses of rabies vaccines or have prompt access to rabies vaccines through the pharmacy emergency process, so that rabies post-exposure treatment can be started as soon as possible. UKHSA will arrange delivery of the rabies vaccines during normal working hours (Monday – Friday), the first dose of vaccine should ideally be given within 24 hours. Vaccines were available for pick up from the UKHSA Colindale site, but as Colindale no longer have a wholesale dealer's licence this will not be possible now. It is also expected for the vaccine to be available to issue to local GPs and walk-in centres to commence treatment whilst procuring further stock from UKHSA. Mr Dhadli highlighted this has been brought to JAPC to notify and help understand the process for how general practice will obtain the vaccines at short notice. UHDBFT confirmed a stock of the rabies vaccines are kept on site. **Action:** CRHFT to confirm acknowledgement of the UKHSA letter. **Action:** DDICB to confirm with out of hours for acknowledgement of the UKHSA letter and if OOH are providing general practice with rabies vaccines, if so, what is this process.	**CRHFT** **SD**
e.	**CMO and Chief Pharmacist antiviral medicine authorisation** Mr Dhadli informed the committee of a notification received from NHS England on 24/11/2022 regarding the use of antiviral medicines. UKHSA surveillance data indicates that influenza is circulating in the community. Prescribers working in primary care may now prescribe, and community pharmacists may now supply antiviral medicines for prophylaxis and treatment of influenza at NHS expense.	
9.	**GLOSSOP TRANSFER GMGG DECISIONS**	
	Mr Dhadli reported that this will be tabled in JAPC for the next 12 months. It was noted that TA832 for Relugolix–estradiol–norethisterone acetate for treating moderate to severe symptoms of uterine fibroids has been recommended by CRH to add to the formulary as a GREEN specialist advice drug in this indication, with links to TA832.	

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10.	**GUIDELINE GROUP ACTION TRACKER**	
	The summary of key messages from the Derbyshire Medicines Management Shared Care and Guideline Group meeting held in November 2022 was noted. Mr Dhadli highlighted the following: Traffic Lights: o Parecoxib – classified as **RED**, accepted by UHDB DTC as per palliative care guideline o Combodart (dutasteride & tamsulosin) – classified as **DNP**, combodart is significantly more expensive than the individual components of dutasteride and tamsulosin or the generic combination capsule o BioMonde Biobag Larval therapy – classified as **RED**, due to the ordering process and need to ensure viability of the larval therapy a limited list of pharmacies have been agreed to order and supply. o Beclometasone & formoterol (Luforbec 200/6) inhaler – classified as **GREEN** 1st line for patients requiring an MDI, luforbec 200/6 MDI is cost effective alternative to Fostair 200/6 MDI for patients requiring an MDI. Formulary Update: Skin: o Flexitol 10% added as one of the cost-effective brands for urea 10% cream. o Audavate RD replaces Betnovate RD as preferred choice for moderate potency topical steroid. Fluocinolone acetonide 0.00625% (Synalar 1 in 4 dilution) replaces Ultralanum Plain (discontinued) as an alternative when formulary choices unavailable. o Audavate replaces Betnovate as preferred choice for potent steroid cream/ ointment. o ClobaDerm added as preferred choice for very potent topical steroid. o Remove Dovobet as preferred brand for combination calcipotriol/ betamethasone ointment and gel- cost effective to prescribe generally. o Sunsense Ultra lotion removed from formulary as discontinued. o Reminder- All new drug/ medical devices are not routinely recommended for use within the Derbyshire health Clinical Guidelines (minor updates): o Freestyle Libra briefing- review date extended to April 23 pending CGM business case. o MSK formulary chapter- Remove Fenbid brand 10% ibuprofen gel as discontinued. o Endocrine formulary chapter- under 'Testosterone preparations for male androgen deficiency' add link to shared care pathology guideline on testosterone deficiency in adult males. o Crohn's disease high cost drug algorithm updated to include week 10 dose.	

Item		Action
	Changes to website: ○ 'Summary of common inhaler' document removed as other resources available. ○ Link to DDICB Adult ADHD assessment guidance (requires intranet access) added under CNS chapter relevant resources ○ Wording for 'contact us' page on MM website updated to remove message relating to service disruption due to covid. ○ Medication and falls- local guideline replaced with link to SPS bulletin ○ Principles to determine JAPC Traffic Light classification for Medical Devices and Appliances- no change, agree for 3 years. Guideline Timetable: ○ The guideline table action summary and progress was noted by JAPC.	
11.	**BIOSIMILAR REPORT**	
	Mr Dhadli advised that the biosimilar report has been tabled for information.	
12.	**JAPC BULLETIN**	
	The November 2022 bulletin was ratified.	**SD**
13.	**MHRA DRUG SAFETY UPDATE**	
	The MHRA Drug Safety Alert for November 2022 was noted. Mr Dhadli highlighted the following MHRA advice: • Dupilumab (Dupixent▼): risk of ocular adverse reactions and need for prompt management. Healthcare professionals prescribing dupilumab should be alert to the risks of ocular reactions. New onset or worsening ocular symptoms require prompt review. Referral for ophthalmological examination should be made as appropriate. • Consultation with healthcare professionals: please complete our consultation to help influence how we communicate with you The MHRA is reviewing its approach to engaging with healthcare professionals on the safety of medicines and medical devices. Through our consultation, you can provide your views and help inform our new approach. • COVID-19 vaccines and medicines: updates for November 2022 ○ MHRA to publish the summaries of the Yellow Card reporting for the COVID-19 vaccines being used in the UK. The report summarises information received via the Yellow Card scheme and includes other data such as usage of COVID-19 vaccines and relevant epidemiological data. The report is updated regularly to include other safety investigations carried out by the MHRA under the COVID-19 Vaccine Surveillance Strategy. • Increase in invasive group A streptococcus (iGAS) infections, including empyema, in children.	

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Item		Action
14.	**HORIZON SCAN**	
a.	**Monthly Horizon Scan** Mr Dhadli advised JAPC of the following new drug launches, new drug formulations, licence extensions and drug discontinuations: New drug launches in the UK which require a traffic light: • Estetrol + drospirenone (*Drovelis*) – classified as **DNP** awaiting clinician request New formulation launches in the UK which require a traffic light: • Lidocaine (*Lidbree*) – classified as **DNP** awaiting clinician request	
15.	**NICE SUMMARY**	
	Mrs Qureshi informed JAPC of the comments for the ICB which had been made for the following NICE guidance in November 2022: TA838 Slow-release potassium bicarbonate–potassium citrate for treating distal renal tubular acidosis – classified as **DNP** (as per NICE TA838) TA839 Ruxolitinib for treating acute graft versus host disease refractory to corticosteroids (terminated appraisal) – classified as **DNP** (as per NICE TA839) TA840 Ruxolitinib for treating chronic graft versus host disease refractory to corticosteroids – classified as **DNP** (as per NICE TA840) TA841 Carfilzomib with daratumumab and dexamethasone for treating relapsed or refractory multiple myeloma – classified as **DNP** (as per NICE TA841) TA842 Tisagenlecleucel for treating follicular lymphoma after 2 or more therapies – classified as **DNP** (as per NICE TA842) TA843 Luspatercept for treating anaemia caused by beta-thalassaemia – classified as **DNP** (as per NICE TA843) TA844 Luspatercept for treating anaemia caused by myelodysplastic syndromes – classified as **DNP** (as per NICE TA844) TA845 Mepolizumab for treating eosinophilic granulomatosis with polyangiitis – classified as **DNP** (as per NICE TA845) TA846 Mepolizumab for treating severe hypereosinophilic syndrome – classified as **DNP** (as per NICE TA846) TA847 Mepolizumab for treating severe chronic rhinosinusitis with nasal polyps – classified as **DNP** (as per NICE TA847)	
16.	**MINUTES OF OTHER PRESCRIBING GROUPS**	
a.	• Medication Optimisation Safety Team 06/10/2022 • Medication Optimisation Safety Team 03/11/2022 • Sheffield Area Prescribing Group 20/10/2022 • Drug and therapeutics committee 15/11/2022	
17.	**TRAFFIC LIGHTS – ANY CHANGES?**	
	Classifications Dexcom One – **GREY** after diabetes consultant/specialist initiation within a Derbyshire diabetes service. Icosapent ethyl – **GREY** as per NICE TA805 with statin therapy for reducing the risk of cardiovascular events in people with raised triglycerides.	GRE

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Item		Action
	Testosterone Gel – **GREEN** For low sexual desire in postmenopausal women. See JAPC menopause guideline for further details. Empagliflozin – **GREEN** for Type 2 Diabetes without CKD AND Type 2 Diabetes with CKD. Dapagliflozin – **GREEN** for Type 2 Diabetes without CKD AND Type 2 Diabetes with CKD. Canagliflozin – **GREY** for Type 2 Diabetes without CKD AND Type 2 Diabetes with CKD. Ertugliflozin – **GREY** for Type 2 Diabetes without CKD. Semaglutide (SC) – **GREEN** for Subcut weekly GLP1. Dulaglutide – **GREEN** - Weekly GLP1. Exenatide - **GREY** - Weekly GLP1. Semaglutide (oral) – **GREY** - Oral daily GLP1. Ziconotide – **RED** for Intrathecal delivery for chronic cancer pain. Rituximab – **RED** for Idiopathic Membranous Nephropathy in Adults. NHSE commissioned. Estetrol + drospirenone (Drovelis) – **DNP** for Oral contraceptive. Await clinician request. Lidocaine (*Lidbree*) – **DNP** for Topical anaesthesia for moderate acute pain during cervical and intrauterine procedures, in adults and adolescents aged ≥15 years. Await clinician request. Potassium citrate / Potassium bicarbonate (SR) – **DNP** as per NICE TA838 for slow-release potassium bicarbonate–potassium citrate for treating distal renal tubular acidosis. Terminated appraisal. Ruxolitinib – **DNP** as per NICE TA839 for ruxolitinib for treating acute graft versus host disease refractory to corticosteroids. Terminated appraisal. Ruxolitinib – **DNP** as per NICE TA840 for ruxolitinib for treating chronic graft versus host disease refractory to corticosteroids. Terminated appraisal. Carfilzomib – **DNP** as per NICE TA841 for carfilzomib with daratumumab and dexamethasone for treating relapsed or refractory multiple myeloma. Terminated appraisal. Tisagenlecleucel – **DNP** as per NICE TA842 for tisagenlecleucel for treating follicular lymphoma after 2 or more therapies. Terminated appraisal. Luspatercept – **DNP** as per NICE TA843 for luspatercept for treating anaemia caused by beta-thalassaemia. Terminated appraisal. Luspatercept – **DNP** as per NICE TA844 for luspatercept for treating anaemia caused by myelodysplastic syndromes. Terminated appraisal. Mepolizumab – **DNP** as per NICE TA845 for mepolizumab for treating eosinophilic granulomatosis with polyangiitis. Terminated appraisal. Mepolizumab – **DNP** as per NICE TA846 for mepolizumab for treating severe hypereosinophilic syndrome. Terminated appraisal Mepolizumab – **DNP** as per NICE TA847 for mepolizumab for treating severe chronic rhinosinusitis with nasal polyps. Terminated appraisal.	
18.	**ANY OTHER BUSINESS**	
a.	There were no items of any other business.	
19.	**DATE OF NEXT MEETING**	
	Tuesday, 10th January 2023, papers are to be circulated and agreed virtually as per JAPC interim Terms of Reference, which is effective during the COVID-19 pandemic.	