

**NHS Portsmouth CCG
South Eastern Hampshire CCG
Fareham and Gosport CCG
Portsmouth Hospitals NHS Trust
Southern Health NHS Foundation Trust
Solent NHS Trust**

**Notes from the Area Prescribing Committee Meeting held on Friday April 28th 2017
Room 6, Education Centre, E level, Queen Alexandra Hospital**

2.17.1	<p>Present: Dr Alastair Bateman (chair), Janet Brember (secretary), Simon Cooper, Jason Peett, Amanda Cooper, Dr Michael Stewart, Paul Bennett, Dr Kevin Vernon, Sarah Nolan (Solent NHS Trust, on behalf of Raj Prakesh), Dr Matthew Puliyl, Dr Jonathan Lake, Vanessa Lawrence (Southern Health NHS Foundation Trust)</p> <p>Apologies for absence: Katie Hovenden, Luke Groves</p> <p>Observers: Mrs Alison Hughes (Respiratory Specialist Nurse currently undertaking the NMP course), Ahmed Zyada (Prescribing Support Pharmacist, Portsmouth CCG)</p> <p>The chair informed the committee that Dr Keith Barnard (lay member) has recently passed away. The committee wished to record their appreciation of Dr Barnard's contribution to the work of the APC</p>	
2.17.1.1	<p>Declarations of Interest:</p>	
2.17.2	<p>DRAFT Notes of last meeting 17th February 2017: Agreed as an accurate record.</p>	
2.17.3	<p>Matters arising:</p> <p>Adjuvant bisphosphonates for postmenopausal breast cancer - the shared care guidance for ibandronic acid tablets and the patient information leaflet on adjuvant bisphosphonates have been finalised.</p> <p>Updated shared care guidance for denosumab (Prolia and Xgeva) has been published.</p> <p>Feedback from the Formulary and Medicines Group meeting held on Friday 17th March. The following hospital-only items were supported for addition to the formulary (classified as RED):</p> <p>Akynzeo (palonosetron/netupitant) capsules for prevention of nausea and vomiting associated with cancer chemotherapy. Akynzeo is on the list of chemotherapy supportive drugs funded by NHS England.</p> <p>Parecoxib injection for analgesia in patients with postoperative ileus as part of colorectal enhanced recovery protocols.</p> <p>Otocomb Otic ointment (unlicensed) for use in ENT clinics only.</p> <p>Hyalase (hyaluronidase) injection for perineal pain/scarring</p>	
2.17.4	<p>Formulary Management – applications for approval</p>	
2.17.4.1	<p>Zeroveen cream: Zeroveen cream is a new addition to the Zero range of emollients and has been formulated to be similar to Aveeno cream. Zeroveen cream can be used as both a wash and a moisturiser for all ages and is SLS, fragrance and paraben free. Zeroveen can be used in dry skin conditions such as eczema, psoriasis, dermatitis, ichthyosis and elderly pruritus. Zeroveen is a Class1 Medical Device and will be listed in Part IXA of the Drug Tariff from June 2017.</p> <p>APC decision: Zeroveen cream will be added to the formulary as an alternative to the current proprietary brand Aveeno®.</p> <p>Financial impact: The cost of Zeroveen is 27% less than Aveeno per 500g. Over the last 12 months the three CCGs have spent over £100,000 on Aveeno cream.</p>	
2.17.4.2	<p>Sayana Press (medroxyprogesterone acetate 104 mg/0.65 ml suspension for injection): Sayana Press is an alternative formulation of medroxyprogesterone acetate injection licensed for long acting reversible</p>	

	<p>contraception and given by subcutaneous injection once every 13 weeks. The Pearl Index (number of pregnancies per 100 woman-years exposure) was 0 over 3 studies including 3565, 5616 and 10,407 woman-cycles. Sayana Press will be an alternative to Depo–Provera intramuscular injection for some adult women. In adolescents (12-18) use of DMPA-SC is indicated only when other contraceptive methods are considered unsuitable or unacceptable, because of unknown long-term effects of bone loss associated with DMPA-SC in the critical period of bone accretion. GP practices are interested in having Sayana Press as an option as it is licenced for self-administration and can therefore potentially save nurse appointments. The patient will be responsible for keeping to the injection schedule and this may relieve pressure on the practice to arrange appointments on specific dates. Subcutaneous injection may be more acceptable than intramuscular administration to some women, including those at risk of haematoma due to bleeding disorders or anticoagulation. Solent NHS Trust are also interested in using Sayana Press in their clinics. Availability of Sayana Press is supported by Public Health in Portsmouth. There was some discussion about the need for sharps disposal. Patients will need a sharps container and to register with the local council for waste collection in the same way as people using other injectable medicines at home.</p> <p>APC decision: Sayana Press was supported for addition to the formulary as an alternative to Depo-Provera in selected adult women. Administration should be initiated under the supervision of a healthcare professional but after training in injection technique and schedule of administration patients may self-inject, if their HCP determines that it is appropriate and with medical follow-up as necessary. The prescriber will need to complete a healthcare waste collection referral form and provide a sharps box.</p> <p>Financial impact: The additional drug cost of Sayana Press compared with Depo-Provera is £1.60 per woman per annum. Sharps containers will be required but it was suggested that these can be obtained from the company.</p>	
2.17.5	Drug therapy and shared care guidance for approval	
2.17.5.1	Shared Care Guidelines for Prescribing Lithium (Sothern Health NHS FT): Item withdrawn for revision – to be presented at the June meeting.	
2.17.5.2	Antipsychotic Guidelines (Southern Health NHS FT): Item withdrawn for revision – to be presented at the June meeting.	
2.17.5.3	Shared Care Guideline for the Management of Patients Receiving Memantine (Southern Health NHS FT): Item withdrawn for revision – to be presented at the June meeting.	
2.17.6	Items for note/consultation	
2.17.6.1	<p>NICE Guidance</p> <p>Guidance published in February 2017:</p> <p>HST 4 Migalastat for treating Fabry disease: Recommended as an option for treating Fabry disease in people over 16 years of age with an amenable mutation, only if migalastat is provided with the discount agreed in the patient access scheme, and only if enzyme replacement therapy (ERT) would otherwise be offered. Noted, no action required.</p> <p>TA 432 Everolimus for advanced renal cell carcinoma after previous treatment: Recommended as an option for treating advanced renal cell carcinoma that has progressed during or after treatment with vascular endothelial growth factor targeted therapy. This TA is a Cancer Drugs Fund reconsideration of everolimus for the second-line treatment of advanced renal cell carcinoma and replaces TA219. NHSE commissioned cancer drug, PAS discount applies. Action: Everolimus tablets will be added to the formulary for prescribing in line with TA 432.</p> <p>TA 433 Apremilast for treating active psoriatic arthritis: This guidance replaces TA 372 where apremilast was not recommended. Apremilast, alone or in combination with DMARDs is recommended as an option for treating active psoriatic arthritis in adults in line with the criteria specified. Apremilast should</p>	

be stopped at 16 weeks if the disease has not shown an adequate response. CCG commissioned high cost drug, PAS discount applies. **Action:** The formulary entry for apremilast tablets will be updated with reference to TA 433. Reminder to be issued that apremilast is for prescribing in secondary care only (RED).

CG 173 Neuropathic pain in adults: pharmacological management in non-specialist settings: Wording added to footnote for recommendation 1.1.8 to clarify use of generic pregabalin and off-label status: The Lyrica (Pfizer) brand of pregabalin has patent protection until July 2017 for its licensed indication of treatment of peripheral and central neuropathic pain; until such time as this patent expires generic pregabalin products will not be licensed for specific indications and their use may be off-label and may infringe the patent, see summaries of product characteristics of pregabalin products for details. **For notin only.**

Guidance published in March 2017:

TA 434 Elotuzumab for previously treated multiple myeloma (terminated appraisal). No evidence submission received by NICE. **No action required**

TA 435 Tenofovir alafenamide for treating chronic hepatitis B (terminated appraisal). No evidence submission received by NICE. **No action required**

TA 436 Bevacizumab for treating EGFR mutation-positive non-small-cell lung cancer (terminated appraisal). No evidence submission received by NICE. **No action required**

TA 437 Ibrutinib with bendamustine and rituximab for treating relapsed or refractory chronic lymphocytic leukaemia after systemic therapy (terminated appraisal). No evidence submission received by NICE. **No action required**

TA 438 Alectinib for previously treated anaplastic lymphoma kinase-positive advanced non-small-cell lung cancer (terminated appraisal). No evidence submission received by NICE. **No action required.**

TA 439 Cetuximab and panitumumab for previously untreated metastatic colorectal cancer: Cetuximab and panitumumab are recommended as options for previously untreated epidermal growth factor receptor (EGFR)-expressing, RAS wild-type metastatic colorectal cancer in adults in combination with FOLFOX or FOLFIRI chemotherapy regimens. NHSE commissioned cancer drugs, PAS discounts apply. Panitumumab was previously available via the CDF. **Action:** The formulary entry for cetuximab will be updated with reference to TA 439. Panitumumab for infusion will be added to the formulary for prescribing in line with TA 439.

TA 340 Ustekinumab for treating active psoriatic arthritis: Patient access scheme withdrawn – company now provides 45mg and 90mg dose at the same cost. **For noting only**

CG 164 Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer: Recommendations about chemoprevention have been revised. Premenopausal women at **high risk** of breast cancer should be offered tamoxifen for 5 years unless they have a past history or may be at increased risk of thromboembolic disease or endometrial cancer. Postmenopausal women at high risk of breast cancer should be offered anastrozole for 5 years unless they have severe osteoporosis. Tamoxifen for 5 years should be considered for premenopausal women at **moderate risk** of breast cancer, unless they have a past history or may be at increased risk of thromboembolic disease or endometrial cancer. Anastrozole for 5 years should be considered for postmenopausal women at moderate risk of breast cancer unless they have severe osteoporosis. Raloxifene is an option for women with a uterus who do not wish to take tamoxifen. All options for chemoprevention are off-licence. Patient decision aids have been published on the NICE website. **Action:** Formulary entries for

	<p>tamoxifen, anastrozole, raloxifene to be updated with reference to CG 164</p> <p>TA 240 Panitumumab in combination with chemotherapy for the treatment of metastatic colorectal cancer (terminated appraisal) No evidence submission received by NICE. No action required.</p> <p>TA 180 Ustekinumab for the treatment of adults with moderate to severe psoriasis: Patient access scheme withdrawn – company now provides 45mg and 90mg dose at the same cost. For noting only</p> <p>CG 68 Stroke and transient ischaemic attack in over 16s: diagnosis and initial management: Updated recommendation 1.4.1.1 Alteplase is recommended within its marketing authorisation for treating acute ischaemic stroke in adults if treatment is started as early as possible within 4.5 hours of onset of stroke symptoms, and intracranial haemorrhage has been excluded by appropriate imaging techniques. Update to recommendation 1.4.2.3 and definition of aspirin intolerance. 1.4.2. Any person with acute ischaemic stroke who is allergic to or genuinely intolerant of aspirin should be given an alternative antiplatelet agent. Aspirin intolerance is defined as either of the following: proven hypersensitivity to aspirin-containing medicines, or history of severe dyspepsia induced by low-dose aspirin. For noting only.</p> <p>Changes to NICE drug appraisals: The changes to the NICE drug appraisal process announced in early April were noted. When the net cost of a new medicine is predicted to cost more than £20m in any of the first three years of use, this will trigger discussions between NHSE and the company to mitigate the impact it will have on the rest of the NHS. If discussions between the company and NHS England cannot manage the budget impact of the drug sufficiently, NHSE can apply to NICE to extend the period over which it is introduced. Drugs that offer exceptional value for money will go through a fast track NICE appraisal process with the aim of becoming available to patients 30 days after the drug has been approved by NICE. Initially this will apply to drugs costing up to £10,000 per QALY. Drugs for very rare diseases will be evaluated against a sliding scale, so that the more additional QALYs a medicine offers, the more generous the cost per QALY level it will need to meet, starting at £100,000 per QALY and rising to a maximum of £300,000 per QALY.</p>	
2.17.6.3	<p>EAMS - dupilumab for atopic dermatitis: Dupilumab is being made available under EAMS to adult patients with severe atopic dermatitis who have failed to respond, or who are intolerant of or ineligible for all approved therapies. Dupilumab can be used with or without topical corticosteroids. Dermatologists at PHT have not expressed an interest in early access to dupilumab to date.</p>	
2.17.6.2	<p>NHS England Commissioning policies: The NHSE Specialised Commissioning Drugs Briefing for Spring 2017 was noted. This includes a useful list of all the Specialised Commissioning Circulars issued since September 2016.</p>	
2.17.6.3	<p>DPC update (February 2017): Safinamide (Xadago®) was not supported for use as an add on therapy to levodopa for Parkinson’s disease due to a lack of long term safety data, lack of evidence demonstrating benefit over current options and greater cost. Safinamide is currently classified as non-formulary in Portsmouth and South East Hampshire.</p> <p>The DPC have agreed (following a detailed appraisal of the current evidence) that previous recommendations on the use of vitamins in age-related macular degeneration will remain in force until the NICE clinical guideline on macular degeneration is published (expected January 2018). It was agreed that APC should take a similar approach and reiterate that specific vitamin products should only be prescribed in primary care on the recommendation of a medical retinal specialist for patients with advanced disease in one eye only. Products prescribed must contain the combination of vitamins and zinc used in the AREDS 2 study (e.g. Viteyes 2 capsules). JP suggested that the LOC should also be asked to remind their members not to refer patients to their GP to</p>	

	<p>obtain these vitamin supplements.</p> <p>It was agreed that the statement on vitamin D supplementation in multiple sclerosis would be useful for local communication. GPs should not be asked to prescribe in this case and people with MS who wish to take vitamin D should be advised by their neurologist that they can purchase OTC.</p>	
2.17.6.4	<p>Hampshire Medicines Safety Group: Notes from the January 2017 were reviewed and a verbal update from the March meeting was given. There are still sporadic incidents due to lack of availability of vitamin K for warfarin reversal in primary care, despite previous guidance issued to practices. It was agreed that the existing guidance should be recirculated to local practices.</p>	
2.17.6.5	<p>Drug Safety Update and Patient Safety Alerts: The MHRA Drug Safety Updates from February and March 2017 were reviewed. The updated advice on the increased risk of lower limb amputation (mainly toes) with canagliflozin was noted. Patients who have risk factors for amputation, such as poor control of diabetes and problems with the heart and blood vessels should be carefully monitored. Prescribers should consider stopping canagliflozin if patients develop foot complications such as infection, skin ulcers, osteomyelitis or gangrene. Patients receiving any SGLT2 inhibitor should be advised of the importance of routine preventive foot care and adequate hydration as it is not clear if the increased risk of amputation is a class effect.</p> <p>Patient Safety Alert (NHS/PSA/RE/2017/002) about resources to support the safety of girls and women who are being treated with valproate was discussed. These resources emphasise the need to avoid the use of valproate in girls and women of childbearing potential; warn women of the very high risks to the unborn child of valproate in pregnancy and emphasise the need for effective contraception planning and specialist oversight of changes to medication when planning a pregnancy. The actions in this alert ask all organisations to undertake systematic identification of girls and women who are taking valproate, and ensure the MHRA resources are used to support them to make informed choices. Practice level data on numbers of women prescribed valproate is available to aid this process.</p>	
2.17.6.6	<p>Regional Medicines Optimisation Committees: JB attended one of the RMOC regional engagement workshops held in Reading on February 20th. A report from the four regional events has since been published. An overview of the work undertaken to date on the establishment of RMOCs was presented and there were discussion groups that focused on the four components of the proposed RMOC Operating Model: Focus and Purpose; Membership; Governance and Medicines Optimisation Priorities. The Operating Model has just been published on the NHSE website and applications are open for membership of the committees. A series of virtual meetings (one for each region) have taken place this month and JB dialled in to the South virtual meeting on 27th April. The operating model was presented and some of the proposed topic areas (biosimilars, polypharmacy, generics, medicines of low value/benefit and antibiotics) were discussed.</p>	
2.17.6.7	<p>CCGs Commissioning intentions for high cost drugs 2017-18: The Portsmouth and south East Hampshire CCGs commissioning intentions for high cost drugs have been updated to include new developments and NICE guidance issued up to the end of March 2017.</p>	
2.17.6.8	<p>Hospital outpatient prescribing and contract changes for 2017-18: There was a discussion about the terms of the NHS standard contract for 2017-18 and the implications for outpatient prescribing arrangements. GPs have been anticipating a change based on the wording in the draft contract. It was agreed that there are problems with inconsistent and inappropriate use of the outpatient prescribing referral forms but if there are to be any changes to the current arrangements these need to be agreed by the Trust and CCGs contracting teams.</p> <p>Post-meeting note: It has been confirmed that the current system for</p>	

	<p>outpatient prescribing at PHT fulfils the terms of the contract as stated in the final published version however dialogue between the Trust and CCGs will continue to look at how the current system can be improved so that it works more effectively for all parties.</p>	
2.17.6.9	<p>Aligned Incentive Contract: Katie Hovenden provided a briefing note to introduce the new aligned incentive contract between PHT and the CCGs. The NHS Standard Contract terms still apply, except for the funding flows which have now been superseded by the new payment arrangements. The approach is designed to deliver the 2017/19 contract on a basis that safeguards service delivery, provides some certainty of income to the Trust within the affordability of the CCG allocations and allows the system to reduce costs accordingly without adversely affecting either party's financial position. Funding has been divided into "buckets" with risks pool funding mechanisms and agreed mechanisms for handling financial risk. The cost reduction incentive "bucket" includes high cost drugs and excluded devices. Payment is based on previous year's spend and PHT will retain benefits if costs fall below this level. If costs rise the CCGs are liable but any overspend in the bucket will be a call on the agreed risk reserve.</p>	
2.17.7	<p>Any other business:</p> <ol style="list-style-type: none"> 1. Adult ADHD service – prescribing arrangements: AB has been in contact with Dr Mukherjee from Surrey and Borders Partnership NHS Trust concerning prescribing of medicines within the new adult ADHD service that Surrey and Borders are providing in Portsmouth and South East Hampshire. It has been agreed that shared care guidance is required and this will be presented for approval at a future meeting. 2. Lucozade change: It was noted that the formulation of Lucozade energy drink is changing so that Lucozade Energy Original will contain approximately 50% less glucose-based carbohydrates. Other flavours will also have significantly less glucose-based carbohydrates. People who have been advised to drink Lucozade Energy Original when their blood glucose is low will need to drink an increased volume. Support materials are available from the company. 	
2.17.8	<p>Dates of future meetings:</p> <p>Dates for 2017:</p> <p>Friday 16th June 2017 Friday 18th August 2017 Friday 20th October 2017 Friday 15th December 2017</p>	