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 August 18th 2017
Room 3, Education Centre, E level, Queen Alexandra Hospital

4.17.1	**Present:** Dr Alastair Bateman (chair), Janet Brember (secretary), Jon Durand, Raj Parekh, Jason Peett, Simon Cooper, Dr Mike Stewart, Amanda Cooper **Apologies for absence:** Sarah Nolan, Dr Kevin Vernon, Dr Jonathan Lake, Paul Bennett, Luke Groves **Observing:** Dr Ian Reid (Dr Reid is considering joining the committee as a lay member) Louise Barker, pharmacist undertaking the non-medical prescriber qualification	
4.17.1.1	**Declarations of Interest:** none	
4.17.2	**DRAFT Notes of last meeting 16th June 2017:** Agreed as an accurate record.	
4.17.3	**Matters arising:** **Nebivolol:** SC has sent recent primary care prescribing data for the three CCGs to MS. MS has agreed to discuss with the cardiology consultants and feedback at the next meeting. **Discharge summary action:** deferred in the absence of LG. **ERD (SC):** the process for managing ERD when patients leave a practice has been clarified and practices will be informed accordingly. **Endocarditis prophylaxis:** scheduled for discussion at Solent NHS Trust Medicines Management Committee when a dental representative is available to attend. Dental and Wessex Cardiac Forum are now in contact. **Local flu outbreaks (SC and JP):** plans for providing antivirals in the case of a local outbreak outside the usual flu season are now in place. **Physical health monitoring guidance:** scheduled for discussion at the next Solent NHS Trust Medicines Management Committee meeting in September.	
4.17.4	**Formulary Management – applications for approval**	
4.17.4.1	**NICE TA 461 Roflumilast for treating chronic obstructive pulmonary disease: Roflumilast** is an orally administered long-acting selective phosphodiesterase-4 enzyme inhibitor licensed for maintenance treatment of severe COPD associated with chronic bronchitis in adult patients with a history of frequent exacerbations as add-on to bronchodilator treatment. Roflumilast is recommended by NICE as an option for treating severe chronic obstructive pulmonary disease in adults with chronic bronchitis if the COPD is severe (FEV1 after a bronchodilator of less than 50% of predicted normal) and the person has had 2 or more exacerbations in the previous 12 months despite triple inhaled therapy with a LAMA, a LABA and an inhaled corticosteroid. Treatment with roflumilast should be started by a specialist in respiratory medicine. It has been confirmed that patients who would be eligible for roflumilast will already be under the care of the hospital respiratory department. **APC decision:** Roflumilast tablets will be added to the formulary for prescribing in line with the recommendations in TA 461. For initiation by respiratory specialists only followed by ongoing prescribing in primary care (AMBER). **Financial impact:** Roflumilast tablets cost £37.71 for 30 tablets and £113.14 for 90 tablets (ex VAT). NICE do not expect this guidance to have a significant impact on resources (less than £9,100 per 100,000 population). This is because the expected uptake of the technology is small and the unit cost for the intervention is low. CCG commissioned, in tariff.	

4.17.4.2	**NICE TA 466 Baricitinib for moderate to severe rheumatoid arthritis:** Baricitinib is a selective and reversible inhibitor of Janus kinase (JAK)1 and JAK2 and is licensed in the UK for the treatment of moderate to severe active rheumatoid arthritis in adult patients who have responded inadequately to, or who are intolerant to one or more disease-modifying anti-rheumatic drugs. Baricitinib can be given as monotherapy or in combination with methotrexate. Baricitinib is recommended as an option for treating active rheumatoid arthritis in adults whose disease has responded inadequately to intensive therapy with a combination of conventional DMARDS if the disease is severe (DAS28 of more than 5.1) Baricitinib is also recommended as an option for treating active rheumatoid arthritis in adults whose disease has responded inadequately to or who cannot have other DMARDs (including at least 1 biological DMARD) if the disease is severe and they cannot have rituximab. NICE concluded that baricitinib is not cost effective for severe disease after biological DMARDs if rituximab is a treatment option. The rheumatology department have stated that uptake of baricitinib is likely to increase rapidly at first because it is the first oral biologic option available. **APC decision:** Baricitinib tablets will be added to the formulary for prescribing in secondary care only (RED) in line with the criteria in NICE TA 466. **Financial impact:** The list price of a 28-tablet pack of 2 mg or 4 mg baricitinib is £805.56. The average cost per patient per year is estimated at £10,501 based on the list price. A PAS discount has been agreed as a condition of the TA recommendation. This guidance is not expected to have a significant impact on resources (less than £9,100 per 100,000 population) because baricitinib is an option alongside current standard treatment options at similar cost. Baricitinib tablets will be supplied to patients via homecare.	
4.17.4.3	**Ulipristal acetate (Esmya) for intermittent treatment of moderate to severe symptoms of uterine fibroids:** Nicky Hill attended to present this item on behalf of the applicants. Ulipristal acetate is a selective progesterone receptor modulator that has previously been approved for pre-operative treatment of moderate to severe symptoms of uterine fibroids. It now has a licence extension for the intermittent treatment of moderate to severe symptoms of uterine fibroids. It is proposed as an alternative to surgical treatment where other medical therapies have failed or are not appropriate and may be particularly useful for younger women who wish to avoid hysterectomy or in other situations where surgery is not advisable. Ulipristal is recommended in NICE CG 44 (Heavy menstrual bleeding: assessment and management) for women with fibroids more than 3cm in diameter) and is accepted by the SMC for use in Scotland. Ulipristal is the only licensed product for long term medical management of the symptoms of uterine fibroids and its use could reduce the number of women having surgical or radiological interventions leading to cost savings overall. The duration of a course of treatment is three months (84 days); subsequent courses should start at the earliest during the second menstruation following completion of the previous treatment course. The course may be repeated up to four treatment courses. Following initiation by a specialist it is suggested that that the ongoing prescribing could be undertaken in primary care (amber). There were a number of questions raised about the costs and practical issues of implementation. Further detail was requested on the patient pathway and the responsibilities of secondary and primary care including decisions on stopping treatment or repeating courses. Arrangements for the annual ultrasound scan need to be clarified. **APC decision:** Mr Sengupta will be invited to attend the October meeting to provide further information to enable the committee to agree the formulary position.	
4.17.4.4	**Magnesium glycerophosphate (Neomag) 4mmol chewable tablets:** Neomag tablets are proposed for addition to the formulary as a replacement for	

	unlicensed magnesium glycerophosphate tablets and capsules. Some use of magnesium glycerophosphate has been replaced by licenced magnesium aspartate sachets but there is still a significant prescribing of unlicensed products in primary care. In addition the formulation of Magnaspartate is not suitable for or acceptable to all patients so it is helpful to have access to a licensed tablet. **APC decision**: Magnesium glycerophosphate (Neomag) 4mmol chewable tablets will be added to the formulary for prescribing in primary or secondary care (GREEN). **Financial impact:** Cost of treatment: £22.77 for 50 tablets (list price). Cost per 28 days at 2 tds = £76.51 Magnaspartate sachets (2 od) cost £50.12 per 28 days and will remain first choice on the formulary based on lower acquisition cost. There may be some cost savings in primary care due to the replacement of variable price special order products with Neomag tablets at a fixed cost.	
4.17.4.5	**Methotrexate pre-filled pen (Nordimet):** Simon Norman attended to present this item. Nordimet is a new presentation of methotrexate for injection in a pre-filled auto-injector pen. The rheumatology department and CCGs have requested that Nordimet is added to the formulary as an alternative to Metoject as the device is very simple to use and the cost is lower than Metoject for the equivalent strength injection. The shared care agreement for methotrexate has been amended so that it no longer specifies the Metoject brand but recommends that methotrexate injections should always be prescribed by brand name to ensure the patient receives the device that they have been trained to use. **APC decision:** Nordimet pen will be added to the formulary as an alternative to Metoject for new initiations and for people who prefer the Nordimet device. AB agreed to review the amended shared care agreement for approval by chair's action. **Financial impact:** Cost saving compared with Metoject for the equivalent weekly dose.	**AB**
4.17.4.6	**Ferric maltol (Feraccru):** Dr Amanda Quine and Sophie Lidstone attended to present this item. Ferric maltol (Feraccru) is indicated for the treatment of iron deficiency anaemia in patients with inflammatory bowel disease. Feraccru is intended for use in patients who have not tolerated other oral iron products (e.g. ferrous sulphate, ferrous gluconate or ferrous fumarate) and for whom IV iron products are being considered. Feraccru offers another option for oral correction of IDA if there is no urgent need to raise haemoglobin levels. Current oral iron supplements are convenient to use but associated with intolerance and non-compliance due to adverse events (e.g. abdominal pain, nausea, bloating, diarrhoea). There may also be impaired absorption due to intestinal inflammation, resection, or severe disease activity. Non-absorbed iron can be toxic and worsen IBD symptoms. Feraccru is just as convenient to take and compliance and reported adverse effects data suggest that Feraccru is a useful and reasonably well-tolerated option in many patients with prior intolerance to oral ferrous salts. Feraccru is also safer, more convenient and less invasive for patients in comparison to IV iron. Use of IV iron is predicted to decrease with the availability of Feraccru and this will release capacity and staff time in the day unit. **APC decision:** Ferric maltol capsules will be added to the formulary as a second-line option for people with IBD who have had an inadequate response or intolerance to oral ferrous salts due to adverse effects. Formulary classification AMBER – for initiation by gastroenterologists only for people with IBD in line with the licensed indication. **Financial impact:** Direct drug cost savings – approximately £60 per patient based on a 12 week oral course of Feraccru (£142.80) compared with a 1.5g dose of IV iron (Ferinject). There will also be savings in terms of IV administration costs avoided.	

4.17.4.7	**Menthol in Aqueous Cream (Menthoderm):** PHT and Solent NHS Trust have requested that Menthoderm is added to the formulary as a replacement for the unlicensed menthol in aqueous cream product currently supplied. Menthoderm has the benefit of being SLS-free and has a longer shelf-life than the unlicensed special. 0.5%, 1% and 2% strengths are available in 100g and 500g pack sizes. **APC decision:** The formulary entry for menthol in aqueous cream will be annotated to state that Menthoderm is the product that will be kept by PHT and Solent pharmacies and may be recommended for prescribing in primary care (formulary classification GREEN). **Financial impact:** There will be cost savings in secondary care from use of Menthoderm to replace the unlicensed special currently used. There will be small cost savings in primary care if Menthoderm is prescribed by brand name (the current Drug Tariff price is based on Dermacool).	
4.17.4.8	**Ciclosporin capsules (Vanquoral):** Vanquoral capsules contain ciclosporin in a microemulsion formulation similar to Neoral and Vanquoral capsules have been shown to be bioequivalent to Neoral in both fasting and fed conditions. This means that Vanquoral can be used as a direct replacement for Neoral capsules at the same dose. Vanquoral is proposed for use instead of Neoral in dermatology for the treatment of severe psoriasis. Vanquoral may replace Neoral for other indications in future. **APC decision:** The formulary entry for ciclosporin will be annotated to state that the Vanquoral brand of ciclosporin will be used for dermatology indications (formulary classification AMBER with shared care). The shared care agreement has been updated to refer to Vanquoral and the amended version is being reviewed by dermatology. JB will send the final draft to AB for approval by chair's action. Vanquoral should be prescribed by brand name in both primary and secondary care. **Financial impact:** Cost-saving in primary and secondary care when prescribed instead of Neoral capsules.	**AB**
4.17.4.9	**Alendronic acid (Binosto) 70 mg effervescent tablets:** Simon Norman attended to present this item and explained that there has been a request from rheumatology to reconsider inclusion on the formulary. The original decision in April 2016 was as follows: Alendronic acid (Binosto) 70 mg effervescent tablets were not supported for addition to the formulary due to lack of evidence that the stated benefits of this formulation justify the additional cost. Rheumatology specialists consider that Binosto may provide an alternative for a small number of patients who are intolerant of alendronate tablets or risedronate tablets and may avoid the need for or inconvenience of more expensive parenteral alternatives. The formulation of Binosto theoretically should make it safer to administer and a post-marketing study has indicated less GI adverse effects (poster presentation only). **APC decision:** The committee members remained unconvinced that the advantages of making Binosto available on the formulary were sufficient to justify the financial risk of increasing usage. There were also patient safety concerns regarding potentially inappropriate use for people unable to remain upright for the required 30 minutes after administration. Alendronic acid effervescent tablets were not supported for addition to the formulary but this position may be reconsidered upon presentation of updated osteoporosis guidelines showing how this product might fit into treatment pathways.	
4.17.4.10	**BAD Specials – proposal for formulary classification:** The BAD first produced a list of preferred unlicensed dermatological preparations in 2008. The list was updated and much abbreviated to forty products in 2014. It is hoped that adherence to the BAD Specials list will allow patients easier access to treatments at less cost to the NHS than if dermatologists prescribe unlimited variations. Although the BAD Specials list has been widely adopted nationally,	

	very few items from the list are currently included on the local formulary. PHT dermatologists have reviewed the BAD list and decided on the preparations they need to prescribe for patients in their care. It is likely that many of these will be used infrequently but do need to be on the formulary for situations when they are thought to be the most appropriate treatment for a particular patient. In addition many of the products on the BAD specials list are now listed in the Drug Tariff and therefore have a fixed price when prescribed on FP10 and dispensed by community pharmacies. **APC decision:** The special products from the BAD list that dermatologists have agreed should be available for prescribing will be listed on the formulary if not already included. Unless otherwise specified, preparations that are listed in the Drug Tariff with a fixed price may be classified as AMBER and all other products will be classified as RED. Dermatologists may ask GPs to continue prescribing those products that are classified as amber but this only applies to the strengths and formulations listed in the Drug Tariff. SC agreed to review local usage data for dermatology specials and there should be further investigation of cost-efficient supply arrangements.	**SC**
4.17.4.11	**Dose escalation of biologics in psoriasis:** Dr Hywel Cooper attended for this discussion of the BAD draft guidelines on biologic therapy for psoriasis and the recommendations for dose escalation strategies. Experience has shown that the licensed dose of biologics may not be as effective as the trial data suggests in some patients due to factors such as obesity. Dermatologists would like to be able to use the dose escalation strategies recommended in the BAD guidelines as part of the treatment pathway without having to apply for individual funding approval in each case. They are particularly interested in reducing the dose interval for ustekinumab. This is already used for some patients and there have been no additional safety concerns reported. Dr Cooper explained that the alternative to dose escalation would be to change to another biologic or add other disease-modifying drugs. Dose escalation may enable the disease to be controlled on a single agent for longer periods and avoid cycling through alternative biologics. There is only a limited amount of evidence to support the dose escalation strategies recommended in the BAD guidelines and this is generally of low quality. There is some registry data but there is unlikely to be any additional data from large RCTs. There were concerns about endorsing use outside the product licences and NICE guidance as well as the increased risk of infection. **APC decision:** Following a detailed discussion of the potential risks and benefits the committee were unable to support dose escalation as described in the draft BAD guidelines at present. It was agreed that this topic would be referred to the SHIP8 Priorities Committee for consideration and AB will approach the Priorities Committee chair in the first instance. Meanwhile if dose escalation is being considered for any new patients it should be through the IFR process.	**AB**
4.17.4.12	**Insulin degludec - request for formulary reclassification:** The diabetes specialists who made the request were not available to attend therefore this item was deferred to the October meeting.	
4.17.5	**Drug therapy and shared care guidance for approval**	
4.17.5.1	**Shared care guidelines for maintenance of abstinence in alcohol dependence (Inclusion):** JD introduced these guidelines that have been prepared for use in the Inclusion Substance Misuse Services provided by South Staffordshire and Shropshire Healthcare NHS FT across Hampshire and are also being reviewed by the DPC. There were a number of queries raised and minor amendments required. The need for a shared care agreement for disulfiram was questioned as this is currently classified as a secondary care only drug on the formulary. Consistency with other shared care agreements used locally needs to be checked. It was felt that the guidelines could not be approved in their current form. JD agreed to feedback to the authors.	**JD**

4.17.5.2	**Guidelines for the use of High Dose Antipsychotics (HDAT):** RP presented this item and explained that it has brought together Solent and Southern Health guidance and has been approved by their internal medicines management committees. There have been some changes in this version including removal of the antipsychotic dosage ready reckoner, addition of a GP letter, changes to the monitoring form and changes to the risk assessment information. Some further minor amendments were suggested including clarification that discharge refers to discharge from inpatient care and that all monitoring will be carried out by the specialist service (CMHT). RP agreed to provide an amended draft for approval by chair's action.	**RP**
4.17.5.3	**Shared care agreement for medicines used in ADHD in Adults (Surrey and Borders Partnership NHS FT):** This draft shared care guidance has been prepared by Surrey and Borders clinicians for use by the adult ADHD service that Surrey and Borders provide across Hampshire. The DPC has also reviewed this draft and have submitted comments to the authors. More specific guidance is required concerning ECGs and who will be responsible for doing these. Currently it is stated that an ECG is "preferable" for methylphenidate, dexamphetamine and lisdexamphetamine but without more explanation there is a concern that ECGs will not be done. It was requested that guanfacine is not included in the shared care arrangements as it is not approved locally for shared care in children and the evidence for use in adults is very limited as well as being unlicensed. Minor amendments and some reformatting are also required. JB to liaise with authors to produce a revised draft.	**JB**
4.17.6	**Items for note/consultation**	
4.17.6.1	**NICE Guidance** **Guidance published in June 2017:** **TA 446 Brentuximab vedotin for treating CD30-positive Hodgkin lymphoma:** Brentuximab vedotin is recommended as an option in adults if they have relapsed or refractory disease after autologous stem cell transplant and if the drug is supplied at the price agreed with NHS England in the commercial access agreement. Brentuximab vedotin is also recommended for use within the Cancer Drugs Fund as an option for adults if they have relapsed or refractory disease after at least 2 previous therapies and they cannot have autologous stem cell transplant or multi-agent chemotherapy. In this case the conditions of the managed access agreement with NHSE must be followed. NHSE commissioned cancer drug, previously only available via CDF. **Action:** Brentuximab vedotin for infusion will be added to the formulary for use in line with TA 446 and CDF criteria. **TA 447 Pembrolizumab for untreated PD-L1-positive metastatic non-small-cell lung cancer:** Recommended for use within the Cancer Drugs Fund as an option for adults if the conditions in the managed access agreement for pembrolizumab are followed. NHSE commissioned high cost drug **Action:** The formulary entry for pembrolizumab will be amended with reference to TA 447 **TA 448 Etelcalcetide for treating secondary hyperparathyroidism:** Recommended as an option for adults with chronic kidney disease on haemodialysis if treatment with a calcimimetic is indicated but cinacalcet is not suitable. NHSE commissioned specialist renal drug, PAS discount applies. Will be prescribed in secondary care only and administered at the end of dialysis. **Action:** Etecalcetide for injection will be added to the formulary for prescribing in line with TA 448. **TA 449 Everolimus and sunitinib for treating unresectable or metastatic neuroendocrine tumours in people with progressive disease:** Everolimus and sunitinib are recommended as options for treating well- or moderately differentiated unresectable or metastatic NETs of pancreatic origin in adults with progressive disease. Everolimus is also recommended as an option for treating well-differentiated (grade 1 or grade 2) non-functional	

	unresectable or metastatic NETs of gastrointestinal or lung origin in adults with progressive disease. NHSE commissioned high cost drugs, PAS discount applies to everolimus. **Action:** The formulary entries for everolimus and sunitinib will be amended with reference to TA 449. **TA 450 Blinatumomab for previously treated Philadelphia-chromosome-negative acute lymphoblastic leukaemia:** Recommended as an option for adults. NHSE commissioned cancer drug, PAS discount applies. **Action:** Blinatumomab for infusion will be added to the formulary for prescribing in line with TA 450 **TA 451 Ponatinib for treating chronic myeloid leukaemia and acute lymphoblastic leukaemia:** Recommended as an option for treating CML and ALL in adults with T3151 mutation, prior treatment criteria apply. NHSE commissioned high cost drug, PAS discount applies. Previously available via CDF. **Action:** Ponatinib tablets will be added to the formulary for prescribing in line with TA 451. **Guidance published in July 2017:** **NG 71 Parkinson's disease in adults:** Includes new and updated recommendations on • information and support • diagnosing Parkinson's disease • pharmacological management of motor symptoms • pharmacological management of non-motor symptoms • non-pharmacological management of symptoms • impulse control disorders • palliative care **Action:** The local Drug Therapy Guideline on drug treatment of Parkinson's disease will be reviewed and updated as necessary. **TA 452 Ibrutinib for untreated chronic lymphocytic leukaemia without a 17p deletion or TP53 mutation (terminated appraisal):** NICE unable to make a recommendation because no evidence submission was received from the manufacturer. **No action required** **TA 453 Bortezomib for treating multiple myeloma after second or subsequent relapse (terminated appraisal):** NICE unable to make a recommendation because no evidence submission was received from the manufacturer. **No action required** **TA 454 Daratumumab with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma (terminated appraisal):** NICE unable to make a recommendation because no evidence submission was received from the manufacturer. **No action required** **TA 455 Adalimumab, etanercept and ustekinumab for treating plaque psoriasis in children and young people:** Adalimumab, etanercept and ustekinumab are recommended as options if the disease is severe and has not responded to systemic therapy, such as ciclosporin, methotrexate or phototherapy, or these options are contraindicated or not tolerated. Biologics for psoriasis in children and young people are commissioned by NHSE. No significant resource impact is anticipated due to small numbers. **Action:** The formulary entries for adalimumab, etanercept and ustekinumab will be updated with links to TA 455. **TA 456 Ustekinumab for moderately to severely active Crohn's disease after previous treatment:** Recommended as an option for adults who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a TNF−alpha inhibitor or have medical contraindications to such therapies. CCG commissioned high cost drug. No significant resource impact is anticipated as this is one of a number of options at similar cost. **Action:** The formulary entry for ustekinumab injection will be	

	updated with a link to TA 456. **TA 457 Carfilzomib for previously treated multiple myeloma:** Recommended as an option in adults if they have had only 1 previous therapy, which did not include bortezomib. NHSE commissioned chemotherapy drug, PAS discount applies. **Action:** Carfilzomib for infusion will be added to the formulary with a link to TA 457. **TA 458 Trastuzumab emtansine for treating HER2-positive advanced breast cancer after trastuzumab and a taxane:** Recommended as an option in adults who previously received trastuzumab and a taxane, separately or in combination and if the drug is supplied in accordance with the commercial access agreement with NHSE. NHSE commissioned chemotherapy drug. Previously available via CDF and numbers are not expected to increase significantly. **Action:** Trastuzumab emtansine for infusion will be added to the formulary with a link to TA 458. **TA 459 Collagenase clostridium histolyticum for treating Dupuytren's contracture:** People who meet the inclusion criteria for the ongoing clinical trial (HTA-15/102/04), comparing collagenase clostridium histolyticum (CCH) with limited fasciectomy, are encouraged to participate in the study. For people not taking part in the ongoing clinical trial CCH is recommended as an option in adults only if specified eligibility criteria apply. One injection is given per treatment session by a hand surgeon in an outpatient setting. CCG commissioned. No significant resource impact is anticipated (less than £9,100 per 100,000) because CCH is an alternative to surgery. **Action:** Xiapex for injection will be added to the formulary with a link to TA 459. **TA 460 Adalimumab and dexamethasone for treating non-infectious uveitis:** Adalimumab is recommended as an option in adults with inadequate response to corticosteroids. Starting and stopping criteria apply. Dexamethasone intravitreal implant is recommended as an option in adults, only if there is active disease and worsening vision with a risk of blindness. No significant resource impact is anticipated because the eligible population is small. Dexamethasone (Ozurdex) is commissioned by CCGs; adalimumab is commissioned by NHS England. **Action:** The formulary entries for Ozurdex and adalimumab injection will be updated with links to TA 460. **TA 461 Roflumilast for treating chronic obstructive pulmonary disease -** see 4.17.4.1 above. **TA 462 Nivolumab for treating relapsed or refractory classical Hodgkin lymphoma:** Recommended as an option in adults after autologous stem cell transplant and treatment with brentuximab vedotin. NHSE commissioned immunotherapy drug, PAS discount applies. **Action:** The formulary entry for nivolumab will be updated with a link to TA 462.	
4.17.6.2	**EAMS:** Idebenone (Raxone) 150 mg film-coated tablets are available under EAMS as treatment for slowing the decline of respiratory function in patients with Duchenne Muscular Dystrophy from the age of 10 years who are currently not taking glucocorticoids. Raxone can be used in patients previously treated with glucocorticoids or in patients in whom glucocorticoid treatment is not tolerated or is considered inadvisable. Unlikely to be used at PHT.	
4.17.6.3	**DPC update (June 2017):** It was noted that the DPC have supported aviptadil with phentolamine (Invicorp) intracavernosal injection for erectile dysfunction. Invicorp is recommended as a third line option for secondary care initiation in patients who have failed oral treatment and either fail treatment with, or experience unacceptable pain with intracavernosal alprostadil. The APC has not been asked to consider Invicorp to date so it will be listed as non-formulary. The DPC did not support the use of desmopressin (Noqdirna) orodispersible tablets for symptomatic treatment of nocturia due to idiopathic nocturnal polyuria in adults, including those over 65 years of age. The DPC recommended that adults with unexplained nocturia should be referred for specialist diagnosis and management. Noqdirna is listed as non-formulary in	

	this area at present as there has been no formulary application to date.	
4.17.6.4	**Hampshire Medicines Safety Group:** The notes of the meeting held on May 22nd were reviewed and there was a verbal update from the July 31st meeting. There were no new issues for the APC to consider. UHS have published an internal patient safety alert on lorazepam in response to recent incidents where a dose of 4mg lorazepam has been prescribed or administered instead of the intended 1mg for agitation in an elderly patient. The alert was passed onto PHT representatives for possible local publication.	
4.17.6.5	**Drug Safety Update and Patient Safety Alerts:** Osteonecrosis of the external auditory canal has been reported with denosumab (Prolia, Zgeva). The possibility of osteonecrosis of the external auditory canal should be considered in patients receiving denosumab who present with ear symptoms including chronic ear infections or in those with suspected cholesteatoma. Possible risk factors include steroid use and chemotherapy, with or without local risk factors such as infection or trauma. Patients should be advised to report any ear pain, discharge from the ear or an ear infection during denosumab treatment. This information is now in the Prolia and Xgeva SPCs and has been added to the shared care agreements.	
4.17.6.6	**Regional Medicines Optimisation Committees:** Monthly meetings will be taking place in rotation around the four regions. Membership lists and meeting details can be found on the SPS website www.sps.nhs.uk	
4.17.6.7	**Diabetes sub-group:** The notes from the meeting held on 27th June were reviewed. The following points were noted: 1. The Freestyle Libre monitoring device will be discussed again when the Drug Tariff price is available. It is likely to be considered for people testing more than 6 times daily and in pregnancy. A statement from Diabetes UK recommending who it should use it will be published soon. 2. Fiasp was supported for specialist recommendation in type 1 diabetes and will be submitted to the DPC for approval. Fiasp is currently undergoing evaluation by the Diabetes Centre at PHT. 3. Philip Newland-Jones is writing a GL-1 information sheet which can be linked to the formulary making suggestions on which product should be used for patient specific requirements. When available it would be useful to publish this locally. Albiglutide is not supported as there are no clear advantages and the reconstitution and administration instructions are complicated. 4. The group recommended that insulin degludec (Tresiba) and Toujeo U300 should remain amber on local formularies.	
4.17.6.8	**NHSE consultations:** The committee members were asked to consider responding to the two consultations below. https://www.engage.england.nhs.uk/consultation/items-routinely-prescribed/ Items which should not be routinely prescribed in primary care. https://www.engage.england.nhs.uk/survey/gender-identity-services-for-adults/ Particularly the service specification on outpatient services including proposed prescribing arrangements.	
4.17.6.9	**NHSE Generic pregabalin guidance:** This guidance replaces that issued in March 2015 and confirms that generic pregabalin can now be prescribed and dispensed for any indication with effect from 17th July 2017.	
4.17.6.10	**APC Annual Report 2016-17:** An annual report summarising the work of the committee from April 2016 to March 2017 has been complied and will be published of the Portsmouth CCG website.	
4.17.7	**Any other business:** **Edoxaban:** SC reported that an enhanced rebate is being offered to CCGs by the manufacturers of edoxaban and asked for views on whether there would be clinical support for making edoxaban the preferred NOAC for AF in order to benefit from the lower cost across the local health economy. The existence of a	

	rebate scheme has not to date been used as a driver to change prescribing practice but if a change was justified on clinical grounds then significant savings could be achieved. Further work is required to scope the savings, develop clinical briefings, consult with stakeholders and agree a communications plan. **Clexane shortage:** AC reported that the impact of the supply shortage was mitigated through management of the supply chain by regional procurement and that to date there has not been a need to switch to alternative LMWH products at PHT.	
4.17.8	**Dates of future meetings:** **Dates for 2017:** **Friday 20th October 2017** **Friday 15th December 2017** **Dates for 2018:** **Friday 16th February 2018** **Friday April 20th 2018** **Friday June 16th 2018** **Friday August 17th 2018** **Friday October 19th 2018** **Friday December 14th 2018**	