Nottinghamshire Area Prescribing Committee

APC meeting 16th July 2020, due to the COVID-19 Pandemic the meeting took place as a web conference using Microsoft Teams.

All attendees should be aware that public authorities are legally required to comply with the Freedom of Information Act 2000. The minutes and papers from this meeting could be published on the Publication Scheme or internet with all names included, unless notified to the Chair before the meeting commences or included in a pre-agreed confidential section due to the sensitive nature of the topic.

Present:

Steve May (SM) Chair	**Chief Pharmacist**	**Sherwood Forest Hospitals NHS Foundation Trust**
Tanya Behrendt (TB)	**Senior Medicines Optimisation Pharmacist**	**NHS Nottingham & Nottinghamshire CCG**
Khalid Butt (KB)	**GP**	**LMC representative**
Laura Catt (LC)	**Prescribing Interface Advisor**	**NHS Nottingham & Nottinghamshire CCG**
Matt Elswood (ME)	**Chief Pharmacist**	**Nottinghamshire Healthcare NHS Foundation Trust**
Esther Gladman (EG)	**GP Prescribing Lead**	**NHS Nottingham & Nottinghamshire CCG**
Tim Hills (TH)	**Interim Assistant Head of Pharmacy**	**Nottingham University Hospitals NHS Trust**
David Kellock (DK)	**Chair SFH Drug and Therapeutics Committee**	**Sherwood Forest Hospitals NHS Foundation Trust**
Gladys Maponese (GM)	**Medicine Management Pharmacist**	**Nottingham CityCare Partnership**
Amanda Roberts (AR)	**Patient representative**	
Jenny Moss-Langfield (JML)	**GP**	**LMC representative**

Interface support:
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist
Jill Theobald (JT), Specialist Interface Efficiencies Pharmacist
Karen Robinson (KR), APC Interface Technician
Hannah Godden (HG), Mental Health Efficiencies Pharmacist
Irina Varlan (IV), Specialist Interface Efficiencies Pharmacist
Shary Walker (SW), Specialist Interface & Formulary Pharmacist

Apologies:
Susan Hume (SH) Advanced Podiatrist Nottinghamshire Healthcare NHS Foundation Trust
David Wicks (DW) GP NHS Nottingham & Nottinghamshire CCG

In attendance Steve Haigh (SH) Medicines Information Pharmacist Sherwood Forest Hospitals NHS Foundation Trust for item 2.
SM welcomed Shary Walker to the team, she will be based at NUH as interface and formulary

pharmacist.

1. **Declarations of interest (DOI)**
None declared.
Annual DOI forms had been sent out to members for completion, a few still required chasing.

ACTION: KR to send out email requests for their return

2. **10 minute learning: Interpreting tests**
The committee expressed thanks to SH for presenting the learning topic 'Interpreting Tests'.
The following links support the 10 minute learning session
- Calculator includes detailed explanation
- Copy of slides (number 14)
- A short cogent summary

JML suggested circulating the message to a wider audience.

ACTION: Interface team to circulate a link with the next APC bulletin.

3. **Minutes of the last meeting/matters arising**
The minutes from the previous meeting were reviewed and agreed as being accurate.

Matters arising:

Adult ADHD shared care
ME provided a welcome update. CCG Mental health commissioning team continues to work with NHCT to develop a full adult ADHD service with shared care; this is expected to be in place by April 2021. Work will continue to ensure the shared care protocol (SCP) and medication information sheets are finalised prior to April 2021. In the interim period, prescribing and monitoring for adults will stay with the provider.
EG and KB raised concern over the paediatric patients transitioning to adults in the interim period.

ACTION: ME will clarify the patient cohort for the new service and update the group via email

Nausea and vomiting in pregnancy (update)
Due to the MHRA warning regarding potential congenital anomalies being reported with ondansetron use in the first trimester of pregnancy, ondansetron was previously changed from AMBER 3 to AMBER 2 specialist recommendation by an obstetrician and removed from the guideline. This was revisited following feedback from a Nottinghamshire GP however the group felt that an AMBER 2 classification was appropriate.

Antimicrobial guideline - Diabetic foot ulcers (update)
Further update required regarding the service provision at SFHT.

ACTION: KR to circulate for approval via email

****All other actions were either complete or on the agenda****

4. FOR RATIFICATION – APC annual report

LC presented the APC annual report for 2019-20. SM commented that the report was thorough and thanked LC for writing it. The committee approved the annual report. The document will be submitted for noting to the various groups within the CCG will be uploaded to the APC website.

ACTION: LC to share with stakeholders and upload to APC website

5. FOR RATIFICATION – Psoriasis Guidelines

JT presented a new primary care psoriasis guideline which had been written by dermatologists at NUH and approved by Dr Joseph at SFHT. It was discussed at JFG as there were a number of formulary amendments required.
The following formulary changes were agreed:

- Clobavate® (clobetasone) – add as GREEN as an alternative to Eumovate®
- Betacap® (betamethasone valerate 0.1%) – add as GREEN to replace Dermovate® scalp application as is more cost effective.
- Psoriderm® shampoo (coal tar 2.5%) – add as GREEN in addition to Capasal® (coal tar 1%) and Alphosyl® (coal tar 5%).
- Polytar® shampoo (coal tar 4%) – currently GREY with a note that it is discontinued, but now available again so agreed to add as GREEN.
- Cocois® (coconut oil compound containing coal tar 12%, salicylic acid 2% and sulphur 4%) - add as GREEN as an less expensive alternative to Sebco® (same active ingredients).

JT had dicussed Tacrolimus (Protopic®) with the specialists as they requested a change to AMBER 3, committee members at JFG felt it should stay as AMBER 2. It will remain as AMBER 2.

Trimovate® had been requested as AMBER 3; JFG recommended AMBER 2 due to risk of resistance. JT discussed with specialists and agreed AMBER 2.

EG noted that the guideline covered both adults and children and asked that this made clear in the guideline title.

JFG had raised reports of non-compliance with the emollient formulary with the dermatologists, In order to work cohesively in future any changes to the emollient formulary will be highlighted to the Dermatologist teams in the acute trusts.

The APC approved the guideline subject to minor amendments.

ACTION: JT to finalise and upload to the APC website

Post meeting note*: Salicylic acid 5% in yellow soft paraffin removed from guidance as only available as an unlicensed special and there is a licensed alternative (Diprosalic® ointment).*

6. FOR RATIFICATION - Phosphate binders SCP

LC presented the SCP update on behalf of Debbie Storer and Ian Hogg (Renal Pharmacist at NUH). Updates to the current version were minimal. Alu-caps® had been removed as a treatment option because this product is no longer licensed or available within the UK and sucroferric oxyhydroxide (Velphoro®) had been added as a 3rd line phosphate binder for patients unable to use/tolerate lanthanum and sevelamer.
Patient and community pharmacy responsibilities will be added as per the usual SCP wording APC approved the updated document subject to these additions.

ACTION: LC to finalise upload to the APC website

7. **FOR RATIFICATION - Rheumatological conditions SCP and information sheets**
The Rheumatology shared care protocol and associated information sheets had reached their review date and had received minor updates. There had been no change to national guidance since the last update and no changes to the monitoring schedules had been made. It was highlighted that sodium aurothiomalate (gold) had been discontinued and the information sheet would be retired once all patients have been reviewed and switched to alternatives.
Patient and community pharmacy responsibilities had been added as per the usual SCP wording.
The updated documents were agreed by the APC.

ACTION: JT to finalise and upload to the APC website

8. **FOR RATIFICATION - Dementia medication information sheets**
HG presented the updated dementia medication information sheets. There had been no change to national guidance (NG97) since the last update, so only minor amendments were required.

TH queried the minimum effective dose for galantamine tablets/oral solution and whether this should be 8mg twice daily rather than 16mg daily as it's twice daily dosing; HG to check and amend if necessary.

JML requested the addition of advice around the de-prescribing of dementia medications. HG explained the specialist view about stopping is that it should not be solely based on disease severity and cognition scores so it is difficult to provide general guidance. JML felt a holistic review and de-prescribing to reduce tablet burden was relevant for some patients.

Subject to clarification on these matters, the APC approved the updated documents.

ACTION: HG to clarify the above points, finalise and upload to APC website

9. **FOR RATIFICATION - Diabetes guideline interim update**
JT gave the background from previous APC discussions (March and May 2020) regarding on-going discussion around the potential cost impact of the requested treatment pathway (using GLP1 agonists and SGLT2 inhibitors earlier in treatment). A local cost impact assessment had proved difficult so it had been agreed with the diabetologists that any major update would be postponed until the updated NICE guidance is published. In the interim, minor updates had been made to the current guidance. The guidance was ratified and it was agreed that it should be given a one year expiry and reviewed again once the updated NICE guidance is published.

ACTION: JT to finalise and upload to APC website

Post meeting note *– Since APC, further minor amendments have been made to the guidance. The licence for canagliflozin has been changed; it can now be used in moderate and severe renal impairment at a reduced dose. However, the glucose lowering effect is reduced in moderate renal impairment (30-45ml/min) and likely non-existent in severe renal impairment (<30 ml/min). It is used as a treatment for diabetic kidney disease rather than for glycaemic control when renal function is poor – a NICE TA is in development to cover this indication. The renal dosing table has been updated to reflect the glucose lowering indication only.*
Black triangles have been removed for medicines that this no longer applies to and the price of canagliflozin has been corrected.

10. FOR RATIFICATION - Stoma Ancillary Items Formulary

LC presented the updated Stoma formulary, which was developed in collaboration with the lead nurse at the Nottinghamshire Appliance Management Service (NAMS) and consulted on with specialist stoma teams at NUH and SFH.
Primary care prescribing is managed by NAMS so it is not expected that GPs will need to prescribe these items, but the formulary is hosted by the APC.
It was noted by the clinicians that the centralisation of this service was beneficial and a similar model could be applied to other areas such as oral nutritional supplements and wound care. LC explained that tracheostomy supplies are currently been reviewed and it is hoped that a similar service will be developed. The committee ratified the updated formulary.

ACTION: LC to finalise and upload to APC website

11. FOR RATIFICATION – Alcohol Dependence Guideline partial update – vitamin B

JT gave a detailed overview of the updated vitamin B guidance and highlighted the main changes for consideration. The Regional Medicines Optimisation Committee (RMOC) had published guidance on the use of oral vitamin B supplementation in alcoholism. The vitamin B section of the local guidance had therefore been updated in response to the RMOC statement. .

It was requested that the wording 'harmful drinker' be revised as it carries negative connotations and that advice on injection technique for Pabrinex be included.

The requirement for a divided daily dose of oral supplements was queried as compliance could be improved by a single dose. JT to check licensed dosing guidance. It was highlighted that current guidance in the acute trusts is different and it would be desirable if the recommendations were aligned.

Members approved the updated guidance subject to clarification of these points.

ACTION: JT to review dosing requirements of oral vitamins
JT to finalise and upload to APC website
JT to liaise with acute trusts to try to align guidance.

12. Formulary amendments and Horizon scanning

Formulary Amendments:

- **Potassium chloride MR tablets (Slow K®) –** Discontinued, but available as parallel import (not licensed in UK), is extremely expensive in primary care with reports of up to £250 per prescription. A GREY classification was agreed pending a review of current primary care prescribing.
  ACTION: JT to facilitate a review of current patients in primary care to ascertain appropriateness of potential GREY classification.
- **Hydrocortisone 10% rectal foam (Colifoam®)** - Supply problems have been in existence for some time and now discontinued. Reclassification to GREY agreed. Budesonide rectal foam to become first choice rectal foam.
- **Zonisamide** - currently AMBER 2 for adults and paediatrics once the patient has been stabilised on treatment by a specialist. A request to remove the requirement for adult patients to have been stabilised on treatment by neurologist had been discussed at the JFG. The views of primary are prescribers had been requested. It was agreed that the titration of adult patients by primary care was appropriate as long as clear direction is provided by secondary care.

ACTION: LK to feed back the request for neurology specialists to provide clear guidance on titration regimens and maximum dose.

- **Aymes Shake Compact**® (powdered food supplement). Agreed as AMBER 2. Will be changed to AMBER 3 once included in the guideline that is currently being updated.
- **Evolve HA**® (eye lubricant) –Classify as GREEN and add to the eye lubricant formulary.
- **Systane Ultra**® **and Optive Plus**® – Re-classify as GREY for new patients (switching of current patients not expected)
- **Danazol** – Re-classify as RED as danazol has been discontinued in the UK and is now only available as unlicensed product. Existing patients may continue obtaining supplies in primary care until reviewed by a specialist.
- **Levetiracetam** – remove restriction that only neurology and paediatrics may initiate and advice about managing patients with swallowing difficulties.

Horizon scanning:

- **Methylphenidate Hydrochloride, Ritalin® XL hard capsules** – GREY as no advantage over current formulary options.
- **Estradiol Hemihydrate, Lenzetto® 1.53 mg/spray, transdermal spray** - Add as GREY (no formal assessment)
- **Oxycodone Hydrochloride and Naloxone Hydrochloride**, **Myloxifin**® prolonged-release tablets - Add as GREY
- **Adapalene & Benzoyl Peroxide, Epiduo® 0.3% / 2.5% gel** - Dermatology approval received regarding the addition of the additional strength. Add as GREEN for severe acne.
- **Peppermint oil, Buscomint® 0.2ml gastro-resistant capsule** - Add as GREY (no formal assessment) and to review when price available
- **Amoxicillin 1000 mg Dispersible Tablets** - Add as GREY (suspension more cost effective)
- **Apremilast tablets (Otezla® 10mg, 20mg, 30mg tablets)** - Deferred to DTC
- **Leuprorelin acetate 10.72mg implant pre-filled syringes (Staladex®)** - Requires further investigation / comparison of other products.

ACTION: KR to review against currently used products

- **Budesonide 500mcg orodispersible tablets, Jorveza**® **-** Deferred to DTC
- **Semaglutide oral, Rybelsus**® - Add as GREY (no formal assessment)
- **Trifarotene cream (selective retinoid acid receptor agonist), Aklief**®**50mcg/g cream** - Add as GREY
- **Insulin lispro 100 units/ml and 200 units/ml, Lyumjev vial, cartridge, pre-filled Kwikpen, Junior KwikPen** - Add as GREY. To highlight importance of prescribing insulin products by brand on the formulary entry as not interchangeable with other insulin lispro products.

ACTION: KR to update the formulary

13. New applications

Ibandronic acid (generic) for adjuvant treatment of breast cancer

A formulary application for ibandronic acid to be used as an adjuvant therapy for women with node-positive invasive breast cancer or node-negative invasive breast cancer and a high risk of recurrence had been discussed at JFG. The JFG recommendation was that this request should be approved clinically, but due to the significant cost associated with the intervention, further

commissioning approval will need to be sought as this request exceeds the threshold for the APC's financial mandate. A business case was being put together but there were no further updates on this. The JFG suggested scoping for a community based IV zoledronic acid service as a future development as this could provide a more cost effective option and aid compliance. Clinically the APC agreed the application.

ACTION: TH to update the finance and contracting team at NUH that clinical approval had been granted by the APC

Utrogestan® (Micronised progesterone, Besins Healthcare (UK) Ltd)

A submission for Utrogestan® 100mg capsules had been discussed at the JFG. Since the meeting the intended patient group had been defined as *patients requiring combined HRT but unsuitable or intolerant of standard combination preparations. These include women at high risk of VTE (eg migraines, BMI >30, PMH of VTE) in whom transdermal oestrogen is recommended, but in whom Evorel Conti is not tolerated or unsuitable because of the need for variable oestrogen dose.*
For women in the high risk patient groups, the oral route for oestrogen is not recommended leaving just patches and gels as an option. Women who still have a uterus are limited to Evorel Conti® which has no flexibility in the oestrogen dose and not all women tolerate norethisterone. Mirena® coil is an option as separate progesterone, but not all women would chose to have a coil fitted. Other progesterones; medroxyprogesterone and norethisterone, are on the formulary but they are not licensed for HRT and they carry more risk for thrombosis and prostogenic side effects. Utrogestan is priced favorably against other HRT options, but a combined preparation would remain first line for patient convenience purposes and to reduce the risk of patients taking unopposed oestrogen if the progesterone component is missed.

APC agreed to add utrogestan to the formulary as a second line option for this patient group with a GREEN classification.

ACTION: LK to update the submitter and the formulary

Methylphenidate (generic) and dexamfetamine (generic) for narcolepsy

A submission for the inclusion of methylphenidate and dexamphetamine on the formulary for narcolepsy, with an AMBER 2 status was discussed at the JFG. These medications have been in use for a significant number of years, but have a limited published evidence base. They are used second line after modafanil, which is currently AMBER 2 on the formulary. Methylphenidate is used in preference to dexamfetamine due to cost and slightly improved evidence base. The monitoring requirements of methylphenidate and dexamfetamine are similar to modafanil. Methylphenidate is currently not listed on the formulary for this indication. Dexamphetamine is currently listed as GREY (awaiting submission and local guidance). However both agents have historically been prescribed by specialists and some patients already receive prescriptions in primary care.
JFG recommended an AMBER 1 classification for methylphenidate, dexamfetamine and modafanil for narcolepsy subject to the approval of an accompanying Shared Care Protocol.
The shared care agreement was not yet available but it is anticipated that it should be by September APC.
The APC members supported the JFG's decision.

ACTION: LK to develop a shared care agreement in conjunction with the submitter. This should be aligned as much as possible to the draft Shared Care Protocol for these medications in Adult ADHD.
LC to pursue commissioning arrangements with the CCG. GP members to facilitate the funding request.

Humalog® 200 (insulin lispro 200 units/ml, Eli Lilly)

The JFG discussed a formulary application from diabetologists at NUH to add the 200 units/ml strength of Humalog (insulin lispro) to the formulary for patients who require higher doses of insulin due to insulin resistance. There is limited published evidence of benefit of the higher strength of insulin, but it is anticipated to be less painful and result in less injection site complications. It is priced comparably to the 100 unit/ml strength and the risks associated with the availability of the higher strength are felt to be minimal as the dose is selected in units via the pen device. As fewer pens will be required it is likely to be more environmentally friendly.
As this was a new insulin product, LK had completed an RMOC risk assessment. Points for local implementation were highlighted such as storage and prescribing.
The APC supported the JFG's recommended of an AMBER 2 classification.

ACTION: LK to inform the submitter and update the formulary

Isocarboxazid

A formulary application for isocarboxazid 10mg tablets had been discussed by the JFG. The current irreversible monoamine oxidase inhibitor (MAOI) of choice is phenelzine 15mg tablets (AMBER 2 classification). However, the global supply situation with unlicensed imports of phenelzine is now unreliable (supply problems with licensed product since July 2019 and no resupply date). Action has been taken to centralise all patients prescribed phenelzine back to NHCT for slow discontinuation in order to avoid abrupt withdrawal and the associated discontinuation symptoms (risk of hypertensive crisis). Isocarboxazid is requested for patients that require continuation of an irreversible MAOI. It is estimated there will be between 20 and 30 patients across Nottinghamshire that may require this medicine. These patients will be individually assessed on a case by case basis within NHCT and only switched to isocarboxazid if appropriate after consideration of other options .
The APC were supportive of this decision to reclassify isocarboxazid as AMBER 2

ACTION: HG to inform the submitter and update the formulary

14. FOR INFORMATION

APC forward work plan – LC explained that although August JFG looked very light the team felt the meeting did need to take place in order to maintain progress and prevent the September APC meeting becoming overwhelmed.

The SIP feed guideline is on the agenda for the September APC. Altrajuce® and Aymes Compact® will be classified as AMBER 2 for the interim and changed to AMBER 3 once they are included within the guideline.

ACTION: KR to update formulary

15. AOB

TB raised an issue with ADHD in children. Not all practices were happy to monitor but they were happy to prescribe. The general consensus was it needs to be all or nothing. KB suggested looking at the PCNs as some within the same federated group might have more confidence to prescribe and monitor. Chatting with peers was suggested in order to tease out any issues.

It was raised that traffic light classifications may need greater clarity as GREY covered a large array of decisions. JT informed the group that one OptimiseRx profile was now being used across the Nottingham and Nottinghamshire CCG so these messages would improve as there was greater capacity within the Medicines Optimisation Teams for the development of messages.

TB provided an update on the RMOC work plan. The meeting for August has been cancelled with no future meeting date set at present.

KB suggested a PowerPoint or a section on the APC website that explained to people how to use it. LC suggested adding something to the bulletin.

ACTION: LC to write a short how to guide for the bulletin

The format of future meetings was raised by SM and members were asked their opinion on virtual meetings. In the most part people felt that these were adequate however there was an onus on members to read the papers prior to the meeting in order to provide comments. The virtual meeting for JFG worked well as the specialists were able to present their submissions and answer questions directly, moving forward this was something that the group felt should continue.

Date of next meeting: 17th September 2020
Meeting ended at: 16:38hrs