Nottinghamshire Area Prescribing Committee

DRAFT Nottinghamshire Joint Formulary Group Meeting Minutes
Thursday 16th September 2021, 2-5 pm
On line Microsoft Teams meeting due to COVID-19

Present:
Tanya Behrendt (TB), Senior Medicines Optimisation Pharmacist NHS Nottingham and Nottinghamshire CCG (Chair)
David Wicks (DW), GP and Local Medical Committee
Steve Haigh (SH), Medicines Information Pharmacist, SFHFT
Asifa Akhtar (AA), GP Prescribing Lead, NHS Nottingham and Nottinghamshire CCG
Tim Hills (TH), Assistant Head of Pharmacy, NUH
Kuljit Nandhara (KN), Deputy Chief Pharmacist, Head of Pharmacy Mental Health Services, NHCT
Laura Catt (LC), Prescribing Interface Advisor, NHS Nottingham and Nottinghamshire CCG
Lynne Kennell (LK), Interface/Formulary Pharmacist, SFHFT
Shary Walker (SW), Interface/Formulary Pharmacist, NUH
Irina Varlan (IV), Specialist Interface Efficiencies Pharmacist, NHS Nottingham and Nottinghamshire CCG

In attendance:
Dr Sue Lim, Consultant Neurologist (joining at 2.15 pm for item 5a)

Apologies:
Karen Robinson (KR), APC/Interface/Formulary Support Technician, NHS Nottingham and Nottinghamshire CCG
Hannah Godden (HG), Mental Health Interface Pharmacist, Nottinghamshire Healthcare Trust
Debbie Storer (DS), Medicines Information Pharmacist, NUH
Matthew Elswood (ME), Chief Pharmacist, Nottinghamshire Healthcare Trust
David Kellock (DK) Consultant, Sexual Health, SFHFT
Steve May (SM), Chief Pharmacist, SFHFT
Esther Gladman (EG), GP Prescribing Lead, NHS Nottingham and Nottinghamshire CCG

Agenda item	Notes
1. Apologies	Noted (see above).
2. Declarations of interest	Nothing was declared by members of the group or submitters.
3. Minutes of previous meeting	The minutes were accepted as an accurate record of the meeting.
4. Matters arising and Action Log	**Matters arising:** **Celecoxib- It had previously been highlighted that new evidence for celecoxib may support its promotion as an NSAID of choice.** **ACTION: Michalina Ogejo (MO), Medicines Optimisation and pain clinic Pharmacist to be asked to review the safety, cost effectiveness and place in therapy of celecoxib with a view to encouraging its use** **Cinacalcet** The traffic light classification was amended to Amber 2 for hyperparathyroidism in June 2020. Recently there has been a significant increase in primary care prescribing and concerns about budget impact had been raised. LK had

	confirmed that current numbers were in line with original predictions by submitters and had discussed future patient numbers with clinicians. It was felt that the increase was due to primary care transfers of existing patients, but numbers were expected to stabilise from now. Any future new patient numbers were expected to be small. **ACTION: LK to monitor prescribing in and feedback at January 2022 JFG.** **Naldemedine** This was Classified as Amber 2 for the treatment of opioid-induced constipation in response to a positive NICE TA in November 2020. There was a recommendation to monitor the prescribing levels in 8 months and report to JFG. There had been only 4 items issued in the last 6 months compared to its alternative naloxegol with 162 items issued according to epact2 data. However, naldemedine is approximately £13 less expensive per month than naloxegol. **ACTION: SW to highlight cost difference to clinicians and encourage prescribing of naldemedene where appropriate.** **Bimatoprost/ timolol UDVs- no progress** **ACTION: LK to pursue discussions with ophthalmology.** **Octasa (mesalazine) suppositories- discussions are underway at NUH regarding implementation.** **ACTION: LK to feedback at next JFG** **Insulin Aspart (Trurapi)- support had been requested from the MO team to assist with the potential adoption of this biosimilar.** **ACTION: LK to feedback at next JFG** ***** All other items were either completed or included on the agenda. ***** **a) Piracetam (Nootropil®, UCB Pharma) – Dr Sue Lim, joined at 2.15 pm** LK presented the piracetam submission from NUH Neurology clinicians to the group. The request was an Amber 2 classification for piracetam for use as an adjunctive treatment of refractory cortical myoclonus, with or without additional epilepsy in adults. Dr Lim joined the meeting and explained that piracetam's place in therapy will be as a adjunctive treatment in patients with refractory myoclonic epilepsy, which is typically considered when at least 2 other first-line medications for myoclonus have failed either due to lack of efficacy or intolerance. Piracetam has a limited evidence base, but individual efficacy can be assessed. It is generally well tolerated, with the most common side effects being GI disturbance, tremors and headaches. These are not different to the other available anti-epileptic medications in the formulary. They also tend to be mild and transient. Renal function monitoring is recommended for elderly patients as dose reduction is required in renal impairment. Piracetam is included in the recommendations in the NICE guidance for epilepsy and is of similar cost to alternative options. The anticipated place in therapy of piracetam is in patients with severe epilepsy and debilitating myoclonus. Patient numbers are expected to be small. If
5. New applications	

	effective, the patient will continue on a maintenance dose indefinitely, otherwise, piracetam treatment will be stopped. It was suggested that patients would remain under secondary care for initial dose titration and demonstration of efficacy and tolerability. Thereafter, prescribing would be transferred to primary care, but patients would remain under the care of the Neurology team. The JFG agreed and recommended an Amber 2 classification. **ACTION: LK to take to APC with a recommendation to include in the formulary with an Amber 2 classification.**
6. Formulary amendments	**FOR INFORMATION - Log of minor amendments carried out** • Trazodone – updated to read: "liquid is expensive: 100mg daily, approximately £42 (50mg/5ml) per month and approximately £270 (100mg/5ml) per month. Capsules are significantly more cost-effective: 100mg daily approximately £2 per month. Only the 150mg tablets are in the formulary as the other tablet strengths are considered less cost-effective than capsules. • Senna – MHRA regulatory changes mean that manufacturers must relabel products to clarify that the active substance is sennosides to improve patient safety – All references in the formulary and guidelines to change from senna to sennosides. • Chlorhexidine gluconate 4% w/v – SPC updated to highlight that Hibiscrub® now contains soya oil – formulary annotated to highlight that Hibiscrub® should be avoided in patients with soya and peanut allergy. • Buprenorphine injection - Buvidal® injection has been approved by NHCT as RED for use in substance misuse service in HMP Leicester. **FOR DECISION - Suggested amendments** • Omega-3 Fatty Acids – currently Amber 3, JFG recommended a change to Amber 2 as prescribing of omega-3 fatty acids has restrictions (e.g. only recommended if the patient has a history or risk of pancreatitis) and therefore, there should be no initiation of prescribing by GPs. • Nifedipine drops – a query had been raised about the appropriateness of a Green classification despite being unlicensed and prescribed under named patients only. NUH confirmed that this is mainly used sublingually in paediatrics for acute treatment of hypertension at NUH and GPs are not expected to prescribe. JFG recommended a red classification for this indication. **ACTION: SW to take to APC**
7. Horizon scanning	**New publications for review** Rosuvastatin capsules- licensed option for patients with swallowing difficulties. The capsules are licensed to be opened and contents sprinkled on soft food. The crushing and dispersing of normal tablets is off-licence **Recommendation:** Add to formulary as an option for patients with swallowing difficulties

	Tiotropium (Tiogiva®) inhaler- more cost-effective option than Spiriva handihaler. **Recommendation**: No further action as new initiations of LABA alone are not recommended. Luforbec® 100/6 (budesonide/ formoteral) inhaler- more cost-effective option than Fostair. This was being considered by MO team. **Recommendation:** No further action by JFG. Wynzora® cream – new brand of calcipotriol and Betamethasone cream. **Recommendation:** No further action as brands no longer stated on formulary Midodrine 10mg tablet. **Recommendation:** Add to formulary alongside other strengths and information sheet at next update. Betula verrucosa wafer melt tablet (Itulazax®). **Recommendation:** Grey no formal assessment. Acarizax® (allergen extract from house dust mites). **Recommendation:** Grey no formal assessment. Drovelis® (drosperinone/estradiol). **Recommendation:** Grey no formal assessment. Ryaltris® (olopatadine/ mometasone) nasal spray. **Recommendation:** Grey no formal assessment. Trimbow NEXThaler ®- **Recommendation:** Confirm price with a view to adding to the formulary as a lower carbon alternative to Trimbow MDI. Roxadustat (Evrenzo®)- **Recommendation:** Grey no formal assessment. Empagliflozin for the treatment of symptomatic chronic heart failure with reduced ejection fraction. NICE TA expected January 2022. Local cardiology pharmacists had agreed with awaiting NICE's recommendations before considering formulary inclusion. **Recommendation:** Grey no formal assessment. Azathioprine 10mg/ml oral suspension (Jayempi®)- **Recommendation:** Confirm price with a view to switching from unlicensed preparation. Add to Shared Care Protocol for patients unable to take azathioprine tablets. Herpes zoster vaccine (Shingrix®)- recommended in National Programme for patients unable to have live vaccine- **Recommendation:** add to formulary with a Green classification. Vericiguat (Verquvo®)- **Recommendation:** Grey no formal assessment **NICE Guidelines, TAs and Evidence summaries** **All Noted**
8. Budesonide Orodispersible (Jordeza®)	LK informed the group that a Red classification had previously been assigned following a formulary application in 2018 due to the expectation of an imminent publication of a NICE TA at that time. A positive TA had recently been published and clinicians had initially expressed a desire for a reclassification to Amber 2.

	Questions were raised at the previous meeting about when transfer to primary care prescribing would be expected to happen as treatment is usually a short courses of 6-12 weeks, with an option of longer-term maintenance treatment if necessary. Clinician opinion differed cross- town, but NUH specialists had since indicated that this would continue to be prescribed from the hospital internally due to the need for specialist review and usual prescriptions of short courses. JFG agreed that as there was no clear need for primary care prescribing at this time, a red classification should remain. This could be reviewed in a year's time if required. **ACTION: LK to update clinicians**
9. NICE NG203 – Chronic kidney disease: assessment and management – Use of SGLT2 inhibitors	NICE published updated CKD guidance in August and recommend that patients with CKD and diabetes with an ACR>30mg/mmol should be offered an SGLT2 inhibitor, in addition to an ARB or an ACE inhibitor. According to the accompanying costing template this recommendation will significantly increase patient numbers taking SGLT2's and is associated with a cost impact of approximately £200k a year to implement this NICE guidance. LK highlighted that the SGLT2 inhibitors licensed for CKD are currently classified as grey no formal assessment but felt that proactive work should be done with clinicians to manage the impact. As the cost implication is likely to exceed the APC's mandate, a business case will also be required, but progress is likely to be complicated by a guideline update expected in November that could increase patient numbers further and the publication of a NICE TA for dapagliflozin in January 2022. **ACTION: LK to seek input from renal clinicians on potential patient numbers and request formulary submission. LK to highlight potential cost impact to Primary Care.**
10. **Dates of next meeting**	18th November 2021 (Via Microsoft Teams). Chair: David Kellock **Chair Rota**
11. AOB	**NUH ophthalmology contact** IV asked the NUH representative to request support from the NUH Ophthalmology team in updating the APC Ophthalmology guidelines. **Diabetes guidelines** LK updated the group with progress on the Diabetes guideline work. NICE had published the draft updated guidance and this was significantly different to the ADA/EASD guidance that clinicians wished to follow locally. Notably, NICE had concluded that GLP-1 agonist use solely for CV risk reduction was not cost effective but had recommended SGLT2 inhibitors for patients with cardiovascular risk as first line therapy alongside metformin. This was on the agenda for the next APC. **Patient Representative** LC announced that the patient representative position had been offered to 2 people. One of the patient representatives had an academic background with a special interest in research and clinical trials and had requested involvement in the JFG. Members agreed that this may be beneficial but suggested initially a trial basis should be offered to enable the patient representative to gain an insight into the workings of the group before a commitment is made.

	Tobacco company takeover of Vectura A company takeover of inhaler manufacturer, Vectura by tobacco company, Philip Morris International is in progress. A statement from the European Respiratory Society had been released and a letter sent to the ministers signed by BTS, UKCPA, ERS, RPS, etc. strongly outlined the objections of the clinical community to any involvement of PMI in healthcare and specifically in respiratory medicines. TH stated that concerns had been raised from NUH and there had been a suggestion that if the takeover goes ahead inhalers manufactured by this company should be removed from the formulary. After discussion the JFG agreed to wait for further developments, with consideration to reviewing guidelines if necessary. **ACTION: TH to provide further feedback at next meeting.** **Low Carbon Inhalers** SH sought interest in the Low carbon inhaler agenda from other organisations. TH will provide NUH contacts outside the meeting. DW expressed a desire to be involved in the workstream and it was highlighted that PCN representatives should be included in any working groups. **ACTION: LC to inform Peter Richards, CCG lead for this work**

The meeting finished at: 15:30 pm