Nottinghamshire Joint Formulary Group Meeting Minutes
Thursday 20th February 2020, 2-5pm
Boardroom, Duncan Macmillan House

Present: David Kellock (DK) Consultant, SFHFT (Chair) Debbie Storer (DS), Medicines Information Pharmacist, NUH Steve Haigh (SH), Medicines Information Pharmacist, SFHFT Laura Catt (LC), Prescribing Interface Advisor, Nottinghamshire County CCGs Shadia Jenner (SJ), Interface/Formulary Pharmacist/ Medicines Management Pharmacist Mansfield and Ashfield CCG Deepa Tailor (DT), Interface/Formulary Pharmacist/ Medicines Management Pharmacist City CCG Esther Gladman (EG), GP Prescribing Lead, Nottingham City CCG
Apologies: Naveen Dosanjh (ND), Deputy Chief Pharmacist, Nottinghamshire Healthcare Trust Jill Theobald (JT), Interface Efficiencies Pharmacist, Greater Nottingham CCP David Wicks (DW), GP and Local Medical Committee. Steve May (SM), Chief Pharmacist, SFHFT Tanya Behrendt (TB) Deputy AD Medicines Management, Nottingham City CCG Karen Robinson (KR), APC/Formulary Support Technician **No Representative from Notts HCT**

Agenda item	Notes
1. Apologies	Noted (see above).
2. Declarations of interest	Nil
3. Minutes of previous meeting	Accepted as accurate
4. Matters arising	**Celecoxib** (Celebrex®) - SH will bring a formal review of the safety of celecoxib to a future JFG. **Eye Lubricants** JT had obtained the ePACT data for those products that have been removed to access any potential impact within Primary Care. It was noted the list is for new patients, it is not designed for existing patients to switch products over. Clinitas® 0.2% UDVs are not listed in the BNF, neither can they be prescribed via SystmOne so these will be removed from the eye lubricant list. **Action: SH will amend to submit to the APC.** **Diabetic foot problems: prevention and management** – updated guidance (NG19). New recommendations on antimicrobial prescribing for adults with a diabetic foot infection. This has been submitted to Dr Weston who in turn has passed it to the Diabetic foot care team to review.

	Action: KR to follow up **Diverticular disease: diagnosis and management** – guidance (NG147) to send to Microbiology for review. **Action: KR to follow up** ***** All other items were either completed or included on the agenda. *****
5. New applications	***A)*** **Betesil Plasters (Betametasone)** Evidence shows equivalence only and the cost impact of £29-£49K based on numbers on original submission for a 30 day course. Shanti Ayob, consultant dermatologist attended to answer questions about place in therapy: *It is thought that the place in therapy would be for isolated thick lesions or localised fixed psoriasis not responding to other options. An alternative to Betesil® could be a steroid cream with an occlusive dressing. For example, dermovate® plus tagaderm® film.* *A cream plus an occlusive dressing does not provide the same consistent delivery. The amount of cream applied could vary and the border of the dressing would need to be considered. All dressings are not equivalent, some are more occlusive, providing inconsistency in treatment depending on what dressing and the amount of cream applied.* *Betesil® is more comparable to tape and would use this as equivalent rather than cream and dressing.* *Haelan® tape is used for similar indications as above, but more useful for fingertip eczema as easier to wrap than a dressing. The tape provides a fixed dose and barrier effect. With a cream and dressing, the amount of cream applied cannot be controlled.* *Betesil® would be an addition to the formulary, rather than a replacement, as Betesil® has not yet been used in clinical practice. It is thought that it would be used when affected patches of skin have not responded to other treatments, before light therapy would be considered.* DK asked why Betesil® plasters rather than cream and dressing? *Unknown, or no control over, quantity of cream used. With Betesil® the dressing helps with reducing scratching and higher reliability and stays on longer. Unless a more adhesive dressing such as Tielle® dressing is used, which is more expensive than other options such as Softpore®.* It was raised that Haelan® tape is more expensive than Betesil® plasters. When the cost is compared to cream plus dressing, Betesil® plasters are up to three times more expensive (dependent on dressing used). Shanti Ayob felt that this additional cost, for use where other treatments have failed, would be appropriate. The next step for this cohort of patients would be light therapy, which is much more costly than the Betesil® plasters.

	Shanti Ayob explained that the plasters can be cut to size and whole dressing is sticky not just the edge, providing treatment to all covered surface area. Betesil® plasters would be used as a step between potent steroids and light therapy/immunosuppression. Making this treatment option more cost effective for selective patients. It is expected that the numbers would be much lower than those stated on the submission. The committee members discussed the option that the Betesil® plasters could be RED, for a period of time. The usage could then be assessed and the formulary status re-evaluated if needed. **ACTION: SJ to liaise with the submitter to establish more specific indications and patient numbers. Request the submitter produce a flow diagram showing place in therapy.** ***B)*** **Apomorphine (Dacepton®)** Apomorphine is currently Amber 1 for the Apo-Go® formulations and delivery devices. Until recently only Apo-Go® products were available. Dacepton® products are now available on the market and potentially offer cost-effective alternatives. NUH have requested an amber 1 classification, which is supported by SFH. Both NUH and SFH are happy with the support offered by Ever Pharma Ltd (Decepton). The use of apomorphine is in line with NICE Guideline 71. The Apo-Go® pen has a 48 hour expiry and can deliver bolus doses up to 10mg daily. The Dacepton® pen has a 15 day expiry and can deliver bolus doses up to 6mg. The stability of Dacepton® cartridges in D-Mine pen means that on average savings of approximately £1800 per patient per year could potentially be released, depending on dosage (generally 6mg-12mg). Apo-Go® must be filled manually, whilst Dacepton® has an auto-filling mechanism. Dacepton® infusion device has an expiry date of 7 days; however any residual apomorphine in the Apo-Go® infusion pre-filled syringes will need to be discarded at the end of 24 hours. Depending on daily dosage (generally 64mg-80mg), Dacepton infusion potentially offers a lower cost to the NHS as the product has longer stability and there may be less waste. Pumps can potentially be filled every 4 days as opposed to daily with Apo-Go®. When doses fall out of the range where savings can be achieved, Dacepton® and Apo-Go® preparations are cost neutral. There was discussion as to whether Dacepton should be first line for new patients, with potential switches from Apo-Go® to Dacepton® following patient consultations or whether to leave choice to consultants and specialist nurses following patient preference discussion. The group recommended Amber 1. **Action: DT to update existing shared care protocol adding Dacepton® as an additional option to Apo-Go®.**

	C) **Chloral Betaine** Submission from NUH for chloral betaine tabs for use in a small cohort of paediatric patients on a ketogenic diet for treating epilepsy. Chloral betaine is converted to chloral hydrate, for which efficacy is well established. The predicted number of patients is small and restricted to patients who would otherwise be on hydrate but are on ketogenic diet. 5 patients at NUH, SFH 1-2 patients (estimated on prescribing in past 12 months). Guidelines on medication in ketogenic diets indicate tablets are preferred as the carbohydrate content is much less. Sugar free doesn't mean carbohydrate free and in a ketogenic diet, carbohydrate content in medication should be less than 1g per dose. Other options to aid sleep in this patient cohort are not suitable; Promethazine caution in epilepsy, alimemazine contraindicated. Unknown risk with melatonin used off label. The submission was for an AMBER 2 status, thus restricting prescribing to this small patient cohort. Open Prescribing data showed no prescriptions issued for Welldorm® tablets in the past 12 months in the county. The group recommended an Amber 2 classification **ACTION: SJ to enquire about the total maximum daily carbohydrate intake, including food for this patient group.** ***D)*** **Verkazia® eye drops** Submission from NUH for ciclosporine 0.1% eye drops (Verkazia®) children from 4 years and adolescents in line with licensed indication of Vernal keratoconjunctivitis (VKC) and off-label for Allergic keratoconjunctivitis (AKC). Ikarvis® (ciclosporin 0.1% eye drops) is currently amber 2 for treatment of severe keratoconjunctivitis in adults with dry eye disease, which has not improved despite treatment with tear substitutes, in line with NICE TA 369. However it is currently being used off-label for VKC and AKC. Both Ikervis® and Verkazia® are manufactured by the same pharmaceutical company and contain the same active and excipient ingredients. The products vary in their product licensing. It was agreed that prescribing should be done by brand to ensure correct product is prescribed for the intended indication. Both products are cost neutral. Scottish Medicines Consortium and All Wales Medicines Management Strategy group have approved the use of Verkazia® for its licensed indication. The committee did raise concerns with use of immunosuppressive ciclosporine in children long-term. There were questions with regards to patient follow-up process and whether the child or adolescent will be discharged from secondary care. The committee agreed that an information sheet to support prescribers would be required and they must detail the questions raised.

	The group recommended Amber 2 with an information sheet sheet/guidance. To remain Red until specialists produce info sheet. **Action: DT to ask submitters to produce an information sheet.** **E) Cinacalcet traffic light update** Cinacalcet is a calcimimetic drug, which can help to reduces calcium levels in primary hyperparathyroidism (PHT). It is currently red for this indication. SFHT have requested a change in classification to amber 2. NUH are in support of shared care. Specialist thyroid conditions and specialist calcium/bone conditions are services commissioned by NHSE, however NHSE recommend shared care and the drug cost is not included. Approximately 30 patients are anticipated to require the medication for this indication. Prescribing of cinacalcet is already exists in primary care, despite red classification. Treatment will be lifelong. SFH state no need for long-term secondary care input required. Once patient is stable on cinacalcet, GPs would be expected to monitor serum Ca^{2+} 2-3 monthly. Questions were raised as to what would be the course of action if levels were above or below those recommended. It was felt that an information sheet would be required to support prescribers. This may include a patient pathway. It was proposed that cinacalcet could be classified Amber 2 with an information sheet **Action: DT to produce information sheet, LC to highlight to commissioners that this may be considered to be included within the shared care LES**
6. Formulary amendments	All suggestions were accepted except Cyclopentolate Ondansetron risk in pregnancy to highlight in the APC bulletin. A consultant at SFH is working to update the nausea and vomiting in pregnancy guideline in light of this highlighted risk.
7. Horizon scanning	Accepted
8. Dates of future meetings	**Next meeting:** Thursday 23rd April 2020, Boardroom, Duncan Macmillan House
9. Any other business	Nil