

**AREA PRESCRIBING COMMITTEE MEETING  
Birmingham, Sandwell, Solihull and environs**

Minutes of the meeting held on  
Thursday 8<sup>th</sup> September 2016

**Venue – Birmingham Research Park, Vincent Drive,  
Birmingham B15 2SQ – Conference Room A**

**PRESENT:**

Dr Paul Dudley	PD	Birmingham CrossCity CCG (Chair)
Dr Neil Bugg	NBu	Birmingham Children's Hospitals NHS FT
Dr Sangeeta Ambegaokar	SA	Birmingham Children's Hospital NHS FT
Mark DasGupta	MD	Birmingham CrossCity CCG
Satnaam Singh Nandra	SSN	Birmingham CrossCity CCG
Alima Batchelor	AB	Birmingham South Central CCG
Jeff Aston	JA	Birmingham Women's Hospital
Nigel Barnes	NBa	BSMHFT
Tania Carruthers	TC	HoE NHS FT
Carol Evans	CE	HoE NHS FT/ Solihull CCG
Kalpesh Patel	KP	Midlands & Lancashire CSU
Jonathan Horgan	JH	Midlands & Lancashire CSU
Isabelle Hipkiss	IH	Midlands & Lancashire CSU
Shabana Ali	SAI	Sandwell & West Birmingham CCG
Peter Cooke	PC	Sandwell & West Birmingham Hospitals NHST
Kate Arnold	KA	Solihull CCG
Dr John Wilkinson	JW	Solihull CCG
Maureen Milligan	MM	The Royal Orthopaedic NHST
Inderjit Singh	IS	UHB NHS FT

**IN ATTENDANCE:**

Dr R. Jainer	RJ	HoE NHS FT for item 0916/05
Dr I. Soryal	ISo	UHB NHS FT for item 0916/06
Ms A-L McDermott	AMcD	BCH NHS FT for item 0916/07
Claire Manzotti	CM	Midlands and Lancashire CSU

No.	Item	Action
0916/01	<p><b>Apologies for absence were received from:</b></p> <ul style="list-style-type: none"> <li>• Dr Timothy Priest</li> <li>• Prof Robin Ferner</li> <li>• Prof Jamie Coleman</li> <li>• Dr Lisa Brownell</li> </ul>	
0916/02	<p><b>Items of business not on agenda</b> (to be discussed under AOB)</p> <ul style="list-style-type: none"> <li>• Metoject<sup>®</sup> injections</li> <li>• Salmeterol inhalers</li> <li>• Update on Esmya<sup>®</sup> appeal</li> </ul>	
0916/03	<p><b>Declaration of Interest (DoI)</b></p> <p>It was noted that they were no outstanding DoI for 2016/17 period.</p> <p>It was also confirmed that DoI forms have been received for all the guest clinicians attending the meeting.</p>	
0916/04	<p><b>Welcome and Introductions</b></p> <p>The chair welcomed everyone to the meeting today. Introductions were not necessary.</p> <p>It was established that the meeting was quorate.</p> <p>The chair reminded members, that the meeting is digitally recorded for the purpose of accurate minute taking and once the minutes are approved, the recording is deleted by the APC secretary.</p>	
0916/05	<p><b>New Drug application - Guanfacine prolonged-release (Intuniv<sup>®</sup>), Shire Pharmaceuticals Ireland Ltd - Dr R Jainer (Consultant Paediatrician, HoEFT)</b></p> <p>It was confirmed they were no Declarations of Interests for Shire Pharmaceuticals Ltd.</p> <p>The chair welcomed Dr Jainer to the meeting and invited her to present the new drug application for guanfacine.</p> <p>Dr Jainer stated that she attended a NICE scoping workshop set up to update NICE guidance CG72 on Attention Deficit Hyperactivity Disorder (ADHD) which was first published in 2008. It is anticipated that the updated NICE guidance will include guanfacine, and will be published in later part of 2018.</p> <p>First-line treatment for ADHD in children would be stimulants. There is a good selection of stimulant therapy available on formulary: short and long- acting methylphenidate, lisdexamfetamine and dexamfetamine. However the only non-stimulant medication currently on formulary is atomoxetine and this offers very limited choice of non-stimulant options. Atomoxetine has been on the market for a long time. Atomoxetine can take up to 13 weeks to show any beneficial effect while side effects are evident early on in treatment course. There is a small risk of suicidal ideation associated with atomoxetine treatment.</p>	

Guanfacine was launched in January 2016 and is recommended for patients in whom first line stimulants are not suitable, not tolerated, ineffective or there is risk of drug diversion or drug misuse. Drug misuse of ADHD drug is a known problem. Guanfacine is not as effective as stimulant therapy, but would provide an alternative licensed non-stimulant option. It is more effective than clonidine (unlicensed for this indication) as it is more specific and has a better safety profile than clonidine.

Sedation, somnolence and fatigue are common side effects. In her clinical experience, guanfacine had to be stopped in one patient because of headaches. No other major issues have been experienced with guanfacine to date.

The chair invited questions and comments from members. Discussion points/concerns raised included:

1. A member asked at what point suicidal ideation became apparent with atomoxetine in relation to it being launched. Dr Jainer stated that mood instability is frequently associated with treatment for neurological conditions, and that the small risk of suicide-related behaviour was noted before atomoxetine was launched and is listed as a special warning and side effect in the summary of product characteristics (SPC).
2. Guanfacine is beneficial in ADHD patients with Autism Spectrum Disorder (ASD). These patients often have anxiety and sleep disorders. Melatonin at night is often prescribed for these patients, but the evidence for melatonin is very weak. Guanfacine can be given at night; the sedation side effect will aid sleep, avoiding the need to prescribe melatonin. Guanfacine is effective for 24 hours.
3. Compliance can be a problem for this group of patients, and this medication has to be taken every single day.
4. Currently guanfacine is prescribed to a very small number of patients at HoEFT in whom other medication has failed; this was made available following one-off non-formulary approval of the Trust's Chair of Drug and Therapeutics Committee.
5. The majority of the evidence for use of guanfacine comes from Germany and Canada. The studies excluded patients with other co-morbidities, except oppositional defiant disorder (ODD), to be referred to in future as ADHD Plus, and it is believed this drug will be useful in this specific group of children.
6. ADHD patients often have other co-morbidities. The only group of patients Dr Jainer would be very careful with is children with epilepsy because the way the treatment works can make a difference.
7. A member enquired on the source of the evidence for the delayed onset of action for atomoxetine (up to 13 weeks) quoted by the applicant. Dr Jainer stated that this was presented at the pre-launch meeting she attended and came from a study, although she could not specifically quote it. She emphasised that guanfacine can show an effect within three weeks of starting treatment.
8. A member enquired on the safety profile of guanfacine compared to atomoxetine as the application form only listed the side effects of the new drug. There is a lot of experience of using atomoxetine, and it was queried at what point guanfacine would be used taking into consideration its significant side effect profile. Would it be used in preference to atomoxetine or would it be used when atomoxetine has failed? Dr Jainer

explained that the time it takes to show an effect is a very important consideration for a child as 13 weeks represent 2 school terms. Evidence for faster onset of effect comes from USA where it has been used for more than 7 years and Canada where it has been used for more than 3 years. But the evidence is not robust as the trials only lasted 8 to 10 weeks and thus did not give atomoxetine enough time to work. Atomoxetine will start to show some effect by weeks 8 to 10 but 13 to 16 weeks should be allowed before evaluating full effectiveness of atomoxetine.

9. A member referred to the independent evidence review (IER) circulated with the application and quoted figures from secondary outcomes analyses which showed that the proportion of patients rated as “improved” at week 10/13 was 68% for guanfacine and 56% for atomoxetine, which suggests that a considerable proportion of patients do respond to atomoxetine within 13 weeks. Dr Jainer repeated her previous statement that an effect would be seen by 8 to 10 weeks, but that clinicians needed to wait for 13 to 16 weeks before seeing the full effect.
10. A member questioned the validity of using Numbers Needed to Treat (NNT) quoted in the application as there is no direct head to head trial comparing atomoxetine with guanfacine. Dr Jainer confirmed that the study used atomoxetine in a reference arm, but no direct head to head comparison was available.
11. A member went back to the IER and quoted the proportion of patients rated as improved at week 10/13 was 44% in the placebo group. Dr Jainer confirmed that the high improvement score in the placebo group is due to the change in interactions with the child following diagnosis of ADHD. Pharmacological treatment is only part of treatment plan that includes psychological and social (behavioural) interventions.
12. A member pointed out the discontinuation rate with guanfacine was double that of atomoxetine. Dr Jainer informed members that experience of using guanfacine in other countries shows that side effects improve with time, particularly sedation. Starting treatment at low doses and slowly increasing the dose improves adherence.
13. A member questioned the safety of guanfacine in view of high drop-out rate and the concern that stopping treatment abruptly would cause ill effects (rebound hypertension, tachycardia etc.). Dr Jainer responded that in her experience most ADHD patients would discuss with the consultant before stopping any ADHD drugs at which point would be advised what to do.
14. Guanfacine would only be required for less than 10-15% of patients who suffer from side effects (including weight gain). It would be most useful in older patients (teenagers) who would need 24hour control.
15. A member requested clarification regarding conflicts of interests. Dr Jainer explained that most ADHD meetings are sponsored by manufacturers and clinicians are free to attend the meetings, funding relates to travel expenses. The meetings are sponsored by a range of manufacturers and not a specific manufacturer.
16. A member highlighted that the patent for atomoxetine is expected to expire in May 2019. What benefit does guanfacine offer over atomoxetine to compensate for the significant price difference between the two products following patent expiry for atomoxetine?
17. The cost of treatment with guanfacine is approximately £1000 a year; currently atomoxetine is not much less but could be significantly less expensive once off patent. When asked if the benefits guanfacine offers will be worth the significant difference in cost between the 2 second-line agents, Dr Jainer was only able to propose that the costs of guanfacine would reduce over time.

18. Dr Jainer informed members that currently compliance in patients taking atomoxetine is an issue. The manufacturer of atomoxetine previously funded an ADHD nurse at the Trust. The nurse would follow-up patients on atomoxetine every two weeks, and this improved compliance. The ADHD team are now preparing a business case to present to the Trust to recruit an ADHD nurse. Dr Jainer also stated that a business case would be presented to the Trust and Shire Pharmaceuticals for a research grant to support long term patient care.

The chair thanked Dr Jainer for her presentation and advised her that the decision would be relayed to her within 7 days, in line with APC policy.

Further discussion points raised in the absence of Dr Jainer included:

- A member clarified the background to the statement regarding funded ADHD nurses: the manufacturers of atomoxetine acknowledged that the drug takes a long time to take effect. They therefore provided ADHD nurses to support patients continue taking atomoxetine while they were waiting for an effect to occur. It takes at least 6 weeks before any effect is noticed. In comparison stimulants work straight away.
- It was stated that Scottish Medicines Consortium (SMC) has accepted guanfacine.
- It was pointed out that the price of atomoxetine has changed since the application was submitted. A pack of 28 capsules now costs £53.09 to £70.79 which translates to a cost per patient per year between £690 and £920. Prices for guanfacine and clonidine remain the same.
- Using the SMC formula which calculated the incidence as 10.8 per 100,000 population, the incidence is expected to be 198 patients across BSSE population (1.84 million across four CCGs). Based on 10% of patients requiring treatment with guanfacine in the first year, this equates to 20 patients costing between £19,800 and £36,840 a year, depending on dose.
- A member expressed concern about balance of efficacy and adverse effects as well as problems with sudden discontinuation; patients treated with guanfacine would require a lot of support to ensure they continue taking the drug. Therefore it is not comparable to atomoxetine.
- Currently guanfacine is licensed in children and adolescents 6 to 17 years. This would create problems in the future when patients transfer to adult services. However specialists would use the drug off label and the manufacturer may apply for licence extension at a later stage.
- It was agreed that guanfacine would be useful to add to the very limited range of non-stimulant drugs available to treat these patients (after atomoxetine has been tried).

The chair directed the members to the Decision Support Tool for completion:

Patient Safety: Lower potential for abuse. Adverse effects such as orthostatic hypotension, bradycardia, hypno-sedation, fatigue and headaches are very common and could limit tolerability. Rebound hypertension and tachycardia may also occur after discontinuation of guanfacine, particularly if abrupt.

Clinical effectiveness: No head to head analysis. Network meta-analysis indicated that guanfacine resulted in a higher response rate versus atomoxetine (55.9% vs. 49.7% respectively), but the results were not statistically significant. No evidence of improved efficacy over atomoxetine.

Strength of evidence: No head to head comparison. Evidence not robust.

Cost-effectiveness or resource impact: This would represent a substantial investment. Extrapolating the figures for Solihull stated in the application it equates to 600 patients across Birmingham and Solihull who would be eligible for non-stimulant treatment. Current price difference between atomoxetine and guanfacine is approx. £500 per year. The number of patients who will require guanfacine instead of atomoxetine is not clear from the application. Therefore the potential absolute increase in costs could be up to £250,000 per year if guanfacine is prescribed instead of atomoxetine.

Place of therapy relative to available treatments: Second tier (stimulants contraindicated or not effective or tolerated)

National guidance and priorities: SMC have approved (February 2016). All Wales Medicines Strategy Group have not approved (June 2016); case for cost-effectiveness not proven. Revision of NICE guidance on ADHD is expected in 2018.

Local health priorities: Cost could be prohibitive in current financial climate. Would only support use as last line resort (after everything else has not worked).

Equity of access: N/A

Stakeholder views: N/A

Implementation requirements: Specialist prescribing only initially because of monitoring requirements. Currently no shared care agreements in place for ADHD drugs, except in Solihull.

**Decision Summary:** RED. Rationale: Monitoring requirements and concerns with side-effect profile. Feedback to applicant that once more clinical experience is gained with this agent and clinicians would consider transferring the prescribing to primary care (i.e. review the RAG rating), the committee will require more information on the population they are aiming to treat with guanfacine and more clarity and assurance on how it would be used in the treatment pathway.

**Actions:**

- Relay decision to Dr Jainer by Thursday 15<sup>th</sup> September 2016
- Add guanfacine to APC formulary as RED

APC sec  
APC sec

**0916/06 New Drug application - Stiripentol (Diacomit®) for adults, Alan Pharmaceuticals Ltd – Dr I. Soryal (Consultant Neurologist, UHB NHS FT)**

It was confirmed they were no Declarations of Interests for Alan Pharmaceuticals Ltd.

The chair welcomed Dr Soryal to the meeting and invited him to present the new drug application for stiripentol.

Dr Soryal stated that he runs transitional clinic for children with epilepsy who have reached a certain age and need to move over to adult services. Over the last three years the number of patients who are coming through his clinic with

this severe form of epilepsy (severe myoclonic epilepsy of infancy or Dravet's syndrome) and are controlled by using stiripentol is increasing. Currently they are no arrangements for prescribing stiripentol in adults. Stiripentol is rarely used in adults; Dr Soryal has initiated stiripentol in one patient in the last 5 years. Patients with this very severe and rare form of epilepsy are now surviving and reaching adulthood. Stiripentol is also used to treat other syndromes (Lennox-Gastaut syndrome and Doose syndrome). These young people are adequately controlled using stiripentol and kept out of hospital. This application is to allow the continued prescribing of stiripentol to the small number of young patients who are transferred to adult services.

The chair invited questions and comments from members. Discussion points/concerns raised included:

- A member commented that the application states stiripentol is very efficacious and that the safety profile is similar to other anti-epileptics. This is based on small trials involving 280 patients and 9 deaths were reported. Side effects with stiripentol are significant. It was explained that the studies involved small number of patients because there is only a finite number of patients suffering from this rare severe form of epilepsy. The first 2 studies were stopped early because stiripentol was so effective. Patients in the trials had previously tried lists of medicines unsuccessfully. Following treatment with stiripentol in the two trials, overall seizure rate was reduced by 80% in 70% of the cases, which was unheard of with previous treatments. Adverse effects are significant and mainly gastro-intestinal. Additive side-effects related to sedative effect of medication are common as stiripentol is often used in combination with other antiepileptics (add-on to valproate and clobazam). So there is an element of sedation and ataxia in relation to the dose. The dose is altered according to the response and to manage the side-effects. Patients tend to discontinue treatment because stiripentol is not efficacious rather than because of adverse effects.
  
- The price for stiripentol treatment was clarified as detailed below:
  - Stiripentol 250mg £284 for 60 capsules/ sachets
  - Stiripentol 500mg £493 for 60 capsules
  
  - Cost of treatment based on recommended adult dose of 1g twice a day:
    - £32.87 per day
    - £986 per month
    - £11,996 per year
  
- A member asked for the rationale behind the amber with shared care status requested on the application form and to clarify the roles of the secondary and primary care clinicians. A question was also raised on the implication if not approved as amber. Members were advised that:
  - Role of GP would be to carry on prescribing under shared-care; it is better for the patient to have all their medicines from one source.
  - The role of the consultant would be to continue monitoring the patient (adjust dose, managing co-existing medication, perform Liver Function Tests, monitor weight loss etc.) Frequency of hospital appointments will depend on the severity of disease; if stable would be 6 monthly, if not then 2 monthly.

- The implications if not approved as AMBER (i.e. RED) would be that arrangements will have to be made to prescribe the drug in secondary care but this may not be the best option for the patient as may not coincide with clinic appointment.
- Members were informed that Professor Rajat Gupta, Consultant Paediatric Neurologist Birmingham Children's Hospital) is in support of this application (application covers both adults and children).

The chair thanked Dr Soryal for his presentation and advised him that the decision would be relayed to him within 7 days, in line with APC policy.

Further discussion points raised in the absence of Dr Soryal included:

- There are currently 12 patients under the care of Birmingham Children's Hospital (BCH) and the Trust has been asked to not refer any more adult patients to UHB as they do not currently have any arrangements to prescribe stiripentol in adult patients.
- NHS policy requires continuation of prescribing of established therapy if initiated elsewhere and still clinically appropriate. The caveat in this case would be that this is continuation of therapy initiated in childhood and needs to be continued in adulthood, not for new initiation in adults. Neurologists would assess the patient to ascertain if prescribed medication is still the most appropriate treatment regime for the patient.
- This is a rare case where the drug is licensed in children, not in adults, as these patients were not expected to reach adulthood.
- Treatment with stiripentol requires close and regular monitoring. GPs are unfamiliar with these very rare forms of epilepsies and treatment regimens are very complex involving multiple drugs. The number of patients is likely to be very small so GPs would not come across this drug regularly and may be reluctant to take on the clinical responsibility. Therefore prescribing responsibility should remain with the specialist in secondary care.
- Secondary care is not funded for long term treatment. BCH clinicians prescribe stiripentol and prescriptions are delivered monthly using home care delivery company. Cost of treatment is recharged to the relevant CCGs. This model is very cost-effective. Discussions to take place between UHB and the CCGs outside this meeting to consider adopting this model and the associated funding.
- It was agreed that completion of the Decision Support Tool is not necessary as this is not a new drug application; the committee is asked to consider if it is clinically appropriate to extend the scope of prescribing this established treatment in a limited group of patients into adults and the transfer of care to another provider. It is currently RED on BCH formulary and the APC is inheriting the formulary status because of the need to continue treatment.

**Decision Summary:** RED (Adults and Children) – Adults: for continuation of therapy started in childhood. Note Off Label use in adults.

**Actions:**

- Relay decision to Dr Soryal by Thursday 15<sup>th</sup> September 2016
- Add stiripentol to APC formulary as RED (Adults and Children) with the annotation Off label in adults

**APC sec**  
**APC sec**

**0916/07 Resubmitted Drug application – Azelastine hydrochloride/fluticasone propionate (Dymista®), Meda Pharmaceuticals Ltd – Miss A-L McDermott (Lead Rhinology Paediatric ENT Consultant, BCH NHS FT)**

It was confirmed they were no Declarations of Interests for Meda Pharmaceuticals Ltd.

The chair welcomed Ms McDermott to the meeting and invited her to present the new drug application for Dymista®.

Dymista® is recommended for treating moderate to severe allergic rhinitis in individuals aged 12 years and above. A total of four phase 3, multicentre, randomised, double-blind, placebo controlled parallel group trials and one long term open label study involving a total of 4,600 patients demonstrated that Dymista® significantly improved all symptoms (nasal and ocular) in patients with moderate to severe allergic rhinitis. These trials also highlighted that improvement in symptoms in patients using Dymista® was much quicker than patients using either intranasal fluticasone (3 days earlier) or intranasal azelastine (5 days earlier).

Results from a non-interventional real life study (Klimek et al) in Germany involving nearly 2000 patients (the type of patients Miss McDermott sees in clinics, who have failed multiple allergic rhinitis therapies in general practice, i.e. tried oral antihistamines, topical nasal sprays) were shared with the members. Two third of patients in this study were being considered for immunotherapy. Use of Dymista® resulted in significant improvement irrespective of age and other co-morbidities.

There are no trials comparing Dymista® with oral antihistamines plus nasal corticosteroids. This is because topical azelastine is more effective than oral antihistamines as advised by NICE accredited British Society for Allergy & Clinical Immunology (BSACI) guidelines. Azelastine has a triple mode of action: antihistamine, anti-inflammatory and mast cell stabiliser. The revised BSACI guidelines due to be published this month will recommend Dymista®.

Compliance is an issue, especially in children, who would otherwise have to take separate devices with a time lag between them, so having a medical management which combines 2 therapies in a single device would improve compliance.

Deposition of medication in the nasal passage is much better with Dymista® compared to sequential administration of either intranasal fluticasone or azelastine due to the improved formulation and device; Dymista® will not run off.

The price of Dymista® has reduced since it was first considered by the APC in May 2014; therefore Dymista® is now more cost-effective than using topical azelastine and topical fluticasone together.

Dymista® would be used third line in young adults who have failed on topical nasal sprays and oral antihistamines.

Members were informed that Pan-Birmingham ENT, Immunology and Respiratory group all strongly believe that there is a place for Dymista® in the management of young adults and adults with allergic rhinitis. Dymista® has

been accepted on local formularies in other areas.

On the application a RED status was requested, but an AMBER status would be better as once initiated in secondary care GPs can carry on prescribing in primary care.

The chair invited questions and comments from members. Discussion points/concerns raised included:

- It was clarified that Dymista® treatment would be continued in patients with severe allergic rhinitis who have good control of symptoms (no step down). Topical azelastine on its own is not well tolerated especially in children, it stings and burns. Stopping Dymista® may adversely affect young adults with exams and GCSEs as they no longer have control of symptoms and this will impact on their quality of life.
- A few members commented that an amber status could result in GPs prescribing Dymista® which is known to be very effective without trying other suitable alternatives that may control the symptoms adequately.
- A member pointed out that the application states that only 1 in 6 patients achieved complete response with Dymista®, which would imply that 5 don't. It was explained that the four main allergic rhinitis symptoms are runny nose, itching, sneezing and blocked nose. Dymista® is very effective in controlling sneezing and blocked nose symptoms. Dymista® controlled the whole range of symptoms in 1 out of 6 patients.
- It was confirmed that the algorithm developed by the Pan-Birmingham group is currently being used in secondary care.
- Use of Dymista® could result in reduction in the number of patients referred for immunotherapy.
- All patients referred to secondary care will have tried topical corticosteroid nasal sprays and/or oral antihistamines.
- It was agreed that reference to brand names Beconase® and Nasonex® should be removed from the algorithm as branded products are considerably more expensive than generic products (generic beclomethasone and mometasone are available).

The chair thanked Miss McDermott for her presentation and advised her that the decision would be relayed to her within 7 days, in line with APC policy.

Further discussion points raised in the absence of Miss McDermott included:

- There was a general concern that GPs will not follow the algorithm and prescribe Dymista® before trialling suitable alternatives that may control the symptoms adequately. Prescribing Dymista® instead of other topical corticosteroid nasal sprays results in doubling of the costs. Prescribing audits are undertaken in primary care to ensure guidelines are being observed and would highlight inappropriate prescribing of third line agents.
- It was accepted that azelastine nasal spray is very poorly tolerated in both adults and children.
- Only a small number of patients are referred to secondary care for allergic rhinitis. It may be more prudent to prescribe Dymista® before referring to secondary care as this is expensive.
- It was agreed that a revision of the algorithm would be appropriate as stopping half way down an escalation in efficacy and referring to secondary care would not be good use of NHS resources. Dymista® could be initiated

in primary care to avoid inappropriate referral to secondary care. Dymista® is suitable for prescribing in primary care.

The chair directed the members to the Decision Support Tool for completion:

Patient Safety: No specific concerns.

Clinical effectiveness: Efficacy demonstrated

Strength of evidence: Strong evidence

Cost-effectiveness or resource impact: Dymista® is cost-effective at the proposed position in the algorithm, but more expensive than nasal corticosteroid and oral antihistamine.

Place of therapy relative to available treatments: Dymista® is a cost-effective third line option for patients with moderate to severe allergic rhinitis who have failed to respond to a steroid nasal spray with the addition of an oral antihistamine.

It must be noted that clinicians cannot currently prescribe topical fluticasone and topical azelastine separately as azelastine is non-formulary.

National guidance and priorities: Recommended by BSACI and SMC. Not reviewed by NICE.

Local health priorities: Supported. This agent would facilitate trialling all options available in primary care before referring to secondary care. Follow algorithm.

Equity of access: N/A

Stakeholder views: N/A.

Implementation requirements: Revise proposed algorithm adding trial of Dymista® (1 month) before referring to secondary care.

**Decision Summary:** Green for adults and children over 12 years– Follow algorithm. It was agreed that the algorithm should be amended (bottom two boxes swapped round and the reference to word 'Specialist initiation only' removed from the Dymista® box. This will allow GPs to prescribe Dymista® in primary care for individuals 12 years and above for a month at least before considering referral to secondary care.

**Actions:**

- Relay decision to Ms McDermott by Thursday 15<sup>th</sup> September 2016 APC sec
- Amend algorithm as agreed APC sec
- Add Dymista® to APC formulary as GREEN (Adults and Children 12 years and above) with the annotation to follow algorithm. APC sec

**0916/08 Minutes of the meeting held on Thursday 14<sup>th</sup> July 2016**

The minutes of the meeting held on Thursday 14<sup>th</sup> July 2016 were discussed for accuracy. The following amendments are required:

Add Jonathan Horgan to attendee list.

Page 5:

First bullet point should be amended to read 'Decline to prescribe rationale that causes concern should be flagged up to the CCGs ....'

Fifth bullet point should be amended to read 'GP members commented .....

It was confirmed that subject to the above amendments, the minutes are approved, can be uploaded to the APC website and the recording deleted.

## 0916/09 Matters arising – Action Table

The Chair moved onto the action table for comments and updates:

(see separate document attachment for updated version – only actions that are not closed were discussed)

- 0716/08 - Practicalities of ESCAs and RICaDs.  
Update: Individuals trusts to work with their IT department to find a solution. Share Solution with other trusts – ongoing.
- 0716/09 – Wound Care Formulary Review. Circulate approved sections of wound care formulary to Trusts.  
Update: Actions from the previous APC meeting were discussed at the Wound Care Sub-group meeting on 05.09.2016. Revised and reformatted document will be circulated to members on receipt.
- 0716/09 – Wound Care Formulary Review.  
Update: Wound Care sub-group to submit application for KytoCel<sup>®</sup>, Urgoclean<sup>®</sup> and UCS<sup>®</sup> Debridement – outstanding.
- 0716/09 – Wound Care Formulary Review.  
Update: Wound Care sub-group to submit application for products evaluated by SWB – outstanding.
- 0716/11 – Enoxaparin – Commissioners Position Statement.  
Update: Draft ESCA for enoxaparin will be circulated on receipt.
- 0716/11 – Enoxaparin – Commissioners Position Statement.  
HEFT to request review of RAG rating of enoxaparin via formal letter-outstanding
- 0716/AOB – Any Other Business.  
Update: Concern regarding letter from manufacturer of Anthelios XL cream has not been reported to ABPI yet-outstanding.
- 0716/AOB – Any Other Business.  
Update: HEFT to submit application for alprostadil urethral sticks – outstanding.
- 0716/AOB – Any Other Business.  
Update: BCH to submit applications for Episanta<sup>®</sup> M/R granules and Desitrend<sup>®</sup> – abbreviated applications received, to be discussed under item 0916/11.
- 0616/09 – Wound formulary review.  
Update: members to email questions/bullet points for consideration at

the APC away day to the APC secretary. Question from a member was forwarded to SWB to address (submit data for evaluation of reducing/limiting the prescribing of antimicrobial dressing). Received admission data; awaiting prescribing data.

- 0616/09 – Wound formulary review.  
Update: Discuss 'declaration of interests' for sub group/clinical network members at the next APC governance sub group meeting – Position of Patient Public Representative is still vacant. An applicant who recently applied withdrew their application as they cannot accommodate APC meetings on Thursday afternoons.

**Action:** Add 'Patient Public Representative (PPR) – Merits and challenges of PPR' to the agenda for the next APC meeting.

**APC sec**

- 0516/10 – Review of decline to prescribe forms.  
Update: Awaiting 'decline to prescribe' form summary from SWB Trust.
- 1115/12 – BNF Chapter 9.  
Update: SWBH to liaise with renal team on iron dextran injection (CosmoFer®) to clarify RAG status and need for supplementary documentation – outstanding.

## 0916/10 NHSE RMOCs Proposal for Establishment-Consultation

Discussion points regarding NHSE RMOCs establishment consultation included:

- Responses were received from five members.
- One member expressed concern that RMOCs will be undertaking a lot of these evaluations and that pharmacists are not in the best position to make these evaluations. A member added that medical input into the evaluations and the steering group is necessary. A member remarked that medical input in evaluations currently is very limited.
- Another member advised that the membership of the committee needs to include more professionals from primary and secondary care. A member commented that the size of the committee needs to take efficiency into consideration; a very large committee cannot produce meaningful results. Secondly the processes need to be concise and not just add another layer of committee.
- Need to submit final response to NHSE before 19<sup>th</sup> September.
- A member emphasised that the proposal of industry representatives as part of the membership is not appropriate due to conflicts of interest, but that ABPI employees should be part of the membership.
- The proposal for establishment implies that industry would be able to make applications to RMOc. Committee members strongly felt that RMOc evaluations should be driven by NHS applications.
- It was acknowledged that based on the responses received the only variations in opinion were over industry representation and conflicts of interests of committee members.
- It was highlighted that RMOc evaluations are advisory. They are not enshrined in legislation but APCs will be expected to either comply or explain why they are not complying. It was proposed that the APC will consider RMOc evaluations like it considers any other evaluations from other trusted sources and make a robust decision clearly documenting

reasons for deviation.

- Some members are questioning the value of RMOCs. A member added that as they will be four regional RMOCs and APCs will interpret their evaluations differently.
- It was agreed that all the responses received will be collated in a single form and then circulated to committee members for approval before submitting to NHSE before 19<sup>th</sup> September 2016.

**Actions:**

- Circulate revised draft collated response to members and submit further comments by return of email. **APC Sec/ALL**
- Submit final collated APC response to NHSE before 19<sup>th</sup> September 2016. **APC sec**

**0916/11 Abbreviated application form**

Following a number of recent queries from clinicians raised under AOB regarding new formulations, new devices or new presentation of drugs already on the formulary; an abbreviated application form has been adopted from Pan-Mersey APC. Currently clinicians are expected to complete a full application to request additional presentations of drugs already on the formulary. Comments received from members following circulation of draft application form have been incorporated in the form.

Discussion points raised about the abbreviated application form:

- It was pointed out that following approval of the abbreviated application form the APC policy will need to be updated.
- It was confirmed that a minimum of 6 weeks consultation period is necessary to allow consultation with several organisations and internal committees.
- It was agreed that the question 'What advantages does this product offer over existing therapy (clinical/financial/patient)?' should be moved to the top after the question 'Indication for which the drug is required'.
- It was also clarified that the clinician is not expected to attend the APC meeting but may attend should they wish to. Secondly the committee members may request a clinician to attend the APC meeting if they identify any ambiguity in the application during the 6 week consultation period.
- Add the question 'Would the current RAG rating need to be reviewed and if yes propose new RAG rating and any guidelines required or need to be reviewed ? (ESCA, RICaDs, pathways, algorithm)' to the application form.

**Action:**

- Amend abbreviated application form as agreed. **APC sec**
- Amend APC policy. **APC sec**

**0916/12 Products update**

1. Insulin degludec – Professor Hanif, chair of the Diabetes MMAG, has written on behalf of the Diabetes network to the APC requesting the committee to reconsider the patient groups insulin degludec can be used for. Currently insulin degludec can only be used for Type 1 diabetic patients in who the next steps would be an insulin pump. The request is following a 30% price reduction in the cost of insulin degludec, as well as the understanding that the soon to be updated NICE guidelines on the management of Type 2 Diabetes in adults will include insulin degludec as an additional long-acting insulin analogue recommended in people who

need assistance from a carer or healthcare professional to inject their insulin, or in people whose lives are restricted by recurrent symptomatic hypoglycaemia. With the 10% reduction in volume required with insulin degludec it is now equivalent in price to insulin glargine (Lantus®). However the insulin glargine biosimilar (Abasaglar®) was recently approved onto the formulary, which was 15% cheaper than Lantus®. Another biosimilar is expected onto the market soon, which is likely to be even cheaper, therefore the cost comparison with Lantus® is not valid.

2. It was highlighted that the wider cohort of patients was not clearly defined in the letter as well as the possible number of additional patients this represented.
3. It was noted that there are already two long acting insulins on the formulary (insulin glargine and insulin detemir) and this is a request to add a third long acting insulin analogue to the formulary. None of the long acting insulin analogues are superior to any other.

**Action:** Inform Diabetes network that they need to submit an abbreviated application form and to clarify the additional cohort of patient for the APC to consider. Committee would recommend Dr Hanif attends the APC meeting on behalf of the Diabetes network to present the case and respond to any queries. **APC sec**

4. Alendronic acid effervescent tablets 70mg (Binosto®) was launched in January 2016. When the BNF chapter was reviewed there were only two formulations of alendronic acid available; alendronic acid 70mg tablets and alendronic acid 70mg/100ml oral solution. Therefore any clinician who would like to use Binosto® needs to submit an abbreviated application form. Binosto® costs £22.80 (4 tablets) and alendronic acid 70mg/100ml oral solution cost £25.08 (4 unit doses). Binosto® is nearly 30 times more expensive than the generic 70mg tablets (77p for 4 tablets).

**Actions:**

- Inform clinician they need to submit an abbreviated application form for Binosto®. **APC sec**
- Amend formulary entry for alendronate to clarify that only plain tablets and oral solution are included. **APC sec**

5. There are currently supply issues with Lestranyl® tablets. It was agreed to add Gedarel® tablets as an alternative. Gedarel® was on the formulary previously.

**Action:** add Gedarel® tablets (both 20/150mcg and 30/150mcg strengths) to the formulary as alternatives to Lestranyl®. **APC sec**

6. Symbicort® pMDI is now available for treatment of COPD.

**Action:** Ask Respiratory network if they would like to include this formulation in the formulary. **APC sec**

## 0916/13 NICE Technology Appraisal (TAs)

It was confirmed that eight new NICE TAs were published during the months of July and August 2016; only one of these is primary care commissioned.

NICE TA404 Degarelix for treating advanced hormone dependent prostate

cancer. Commissioned by CCGs and providers are NHS hospitals trusts and GP practices. .

It was agreed to leave the RAG status as GREY for the interim period, until the place in therapy is clarified. It is a drug that will not be funded from day 1 in primary care; it will be funded from day 90. It will be funded if patient needs it and it is administered in secondary care. Secondary care clinicians recommend amber rating: initiation in secondary care and maintenance in primary care. It was deliberated that they may be concerns from GPs to agreeing to administer this drug in primary care. Existence of an ESCA will have little impact on GPs' willingness to prescribe and administer this drug in primary care. CCGs agreed to explore a solution. In addition CCGs may not be able to benefit from the same discounted drug cost as that available through the Patient Access Scheme as dictated by NICE.

**Action:**

- **Add degarelix to formulary as grey.** **APC sec**
- **CCGs to explore access to discounted price and a solution for prescribing and administration of degarelix in primary care.** **CCGs**

**0916/14 Trust Chairs non-Formulary approvals**

For information only.

**Any Other Business :**

1. Methotrexate injections- Trusts supply Metoject<sup>®</sup> injections as they have a contract with the manufacturer. Metoject<sup>®</sup> injections are designed for patients to self-administer; they are complete units ready to use. Whereas some generic methotrexate injections do not even have a needle; they are not patient friendly ready to use products. It was agreed that Metoject<sup>®</sup> brand should be added to the formulary entry for methotrexate injections. It was also noted that the supporting ESCA will also need to be amended.

**Action:**

- Add Metoject<sup>®</sup> brand to formulary entry for methotrexate injections **APC sec**
- Revise ESCAs for methotrexate injection and add Metoject<sup>®</sup> brand. **APC sec**

2. The current formulary entry for salmeterol is a generic one. There are three brands of salmeterol inhalers on the market; Serevent<sup>®</sup>, Neonent<sup>®</sup> and Vertine<sup>®</sup>. Serevent<sup>®</sup> inhaler does not contain soya lecithin or alcohol. In addition Serevent<sup>®</sup> inhaler is licensed in adults and children aged 4 to 12 years. Neonent<sup>®</sup> and Vertine<sup>®</sup> inhalers both contain soya lecithin and are therefore not suitable for patients with allergies to peanuts or soya. They also contain ethanol which can be a problem for certain groups of patients for religious or cultural reasons. Additionally the SPCs state they "should not be used in children 12 years and younger".

**Action:** Add the following notes to the formulary entry for salmeterol inhaler: **APC sec**

- Prescribe by brand to ensure patients receive the device they are used to.
- Check licensed indication (differences among brands).
- Be aware of differences in excipients among the different brands.

3. Update on Esmya® appeal: Dudley APC has agreed to review the appeal for Esmya® (ulipristal acetate) on 17<sup>th</sup> November 2016. It was acknowledged that NICE are now recommending up to four cycles of treatment with Esmya® in the updated guidance (CG44). This is in line with licensing of Esmya® as it is licensed for use up to four cycles. Members deliberated that in light of updated NICE guidance (CG44) the original application for Esmya® should be re-considered at the December APC meeting (next available slot to discuss drug applications). The appellant should be offered the option of going ahead with appeal process as scheduled on 17<sup>th</sup> November or await outcome of the review by BSSE APC at the December meeting. It was noted that committee will consider Esmya® at the December meeting either way; re-consider the original application or consider the outcome from the appeal process. It was also pointed out that Dudley APC should base their decision on the evidence submitted with the original application to BSSE APC as stated on the appeal form. The appeal is based on ‘any reasonable committee would have come to a different decision’. Committee was also informed that the original application requested re-current cycles and not just 4 cycles.

**Action:**

- Update the appellant Miss Pradhan with the committee discussions and offer her the option of either going ahead with appeal panel as scheduled on 17<sup>th</sup> November or await re-consideration of the original application at the December BSSE APC meeting. **APC sec**
- Advise Dudley APC that they should review the appeal and base their decision on the evidence presented with the original application in line the APC appeals policy. **APC sec**

The chair thanked the members for their input today. The meeting closed at 16:50 pm.

**Date of next meeting: Thursday 13<sup>th</sup> October 2016 14:00 – 16:45**  
**Conference Room A,**  
**Birmingham Research Park,**  
**Vincent Drive.**  
**Birmingham B15 2SQ**