AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 9th March 2017
Venue – Birmingham Research Park, Vincent Drive,
Birmingham B15 2SQ – Conference Room A

PRESENT:

Dr Paul Dudley	PD	Birmingham CrossCity CCG (Chair)
Dr Lisa Brownell	LB	BSMHFT
Nigel Barnes	NBa	BSMHFT
Dr Sangeeta Ambegaokar	SA	Birmingham Women's and Children's NHS FT
Dr Neil Bugg	NBu	Birmingham Children's NHS FT
Mark DasGupta	MD	Birmingham CrossCity CCG
Satnaam Singh Nandra	SSN	Birmingham CrossCity CCG
Elizabeth Walker	EW	Sandwell & West Birmingham CCG
Kate Arnold	KA	Solihull CCG
Alima Batchelor	AB	Birmingham South Central CCG
Dr Waris Ahmad	WA	Birmingham South Central CCG
Dr Timothy Priest	TP	HoE NHS FT
Carol Evans	CE	HoE NHS FT/ Solihull CCG
Prof Robin Ferner	RF	SWB Hospitals NHST
Prof Jamie Coleman	JC	UHB NHS FT
Maureen Milligan	MM	The Royal Orthopaedic NHST
David Harris	DH	Birmingham Community Healthcare NHS FT
Ravinder Kalkat	RK	Midlands & Lancashire CSU
Isabelle Hipkiss	IH	Midlands & Lancashire CSU

IN ATTENDANCE:

Katy Davies	HoE NHS FT on behalf of T. Carruthers
Yusuf Asif	Birmingham Children's NHS FT on behalf of J. Aston
Rebecca Squire	Midlands & Lancashire CSU (observer)

No.	Item	Action

0317/01 Apologies for absence were received from:

- Inderjit Singh UHB NHS FT
- Jeff Aston Birmingham Women's and Children's NHS FT, deputy attended
- Tania Carruthers HoE NHS FT, deputy attended
- Jonathan Horgan MLCSU

It was confirmed that the meeting was quorate.

0317/02 Items of business not on agenda (to be discussed under AOB)

- Decline to prescribe issue for BSMHFT
- Buprenorphine patches- RICaD
- Update on Toujeo® appeal

0317/03 Declaration of Interest (DoI)

It was confirmed that DoI forms have been received for all members attending the meeting.

There were no other interests to declare relating to items on the agenda.

0317/04 Welcome and Introductions

The Chair welcomed everyone to the meeting today. Introductions around the table were carried out for the benefit of the new attendees.

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.

0317/05 New Drug application – paliperidone palmitate (Trevicta®) – 3-monthly injection- Janssen Cilag.

It was established there were no Declarations of Interests for Janssen Cilag.

The Chair invited Dr Lisa Brownell and Nigel Barnes, BSMHFT, to present the application for Trevicta®.

Nigel Barnes began by stating that he was presenting this new drug application on behalf of the DTC at BSMHFT where this 3-monthly injection was discussed and supported at the beginning of the year. There are around 100 psychiatrists at BSMHFT and a few have expressed an interest in this long-acting preparation as it presents some advantages for their patients.

The evidence base for paliperidone long acting depot injection is moderate, but in line with that of other depot injections.
There is a placebo-controlled study which confirmed that it is effective; a non-inferiority study showed that it is broadly similar to the monthly paliperidone injection.

The dosage is not a straightforward three times multiplication of the monthly dosage.

The big advantage is the requirement for only four injections a year, compared

to twelve injections; this is a significant advantage for some patients.

A couple of patients have already been approved under Chair's one-off approval at BSMHFT; one required police involvement to administer monthly depot injection, the other would refuse to cooperate and cause significant disruption in a non-acute patient unit.

In terms of costs, it is comparable to the monthly injection.

With regards to place in therapy, BSMHFT envisage using it, subject to APC approval, in patients who have been stable mentally for at least 12 months on paliperidone monthly injection and have not required a dosage adjustment in the last 6 months.

This is different from the drug company's proposed faster pace which would see a patient moving from monthly paliperidone to 3-monthly paliperidone injections in the space of four to six months as opposed to the Trust's proposed 12-month induction.

BSMHFT believe that their proposed pathway would control access and ensure appropriate use.

There are currently around 200 patients in the Trust on monthly paliperidone injections. They are funded by and administered within the Trust.
A proportion of these patients on paliperidone monthly injection would migrate to 3-monthly injection over a period of time, where they were stable and had been on the injection for at least 12 months.

Dr Brownell added that, in order to get onto the second generation long-acting antipsychotic injections which are substantially more expensive than first generation agents and without much evidence of superiority over these, the clinicians at BSMHFT have to go through a lengthy approval process through the pharmacy department. They have to provide a strong case why a first generation agent is not appropriate, or at least have tried a first generation long-acting depot injection before being able to use paliperidone monthly injections.

Dr Brownell wanted to reassure the committee that the Trust already has a number of internal safety mechanisms in place to ensure that individuals are not put on monthly paliperidone injections without scrutiny. Once the clinicians have got over the internal approval process to initiate paliperidone, the patients can only remain on this expensive treatment if the clinician can demonstrate additional benefits over and above those experienced on the first generation agents. Nigel Barnes added that a number of applications for paliperidone or risperidone long-acting injections within the Trust get turned down.

In summary, patients would only be considered for the 3-monthly long-acting paliperidone injection after getting over the initial hurdle for the monthly injection, have been on it for 12 months, continue to demonstrate benefits over and above those delivered with the first generation agents and have not required a dosage adjustment in the last 6 months.

<u>The Chair invited questions and comments from members. Discussion points/concerns raised included</u>:

- A member commented on the very long half-life of the agent and that it could potentially remain in the body for 12 months afterwards. The member asked if there are any interventions or possible action should the patient experience side-effects, or if a female patient has an unplanned pregnancy. The clinicians confirmed that there wasn't but with regards to use in pregnancy, there is plenty of evidence to suggest that antipsychotics are reasonably safe in pregnancy and comparable to SSRIs. Uncontrolled psychosis could potentially be a worse outcome for a pregnant patient. The proposed delay in initiating the 3-monthly injection would ensure that the patient does not experience any significant side-effects.
- A member requested clarification of the agents classed as first-generation long-acting antipsychotics; it was confirmed these included haloperidol decanoate, flupenthixol and zuclopenthixol.
- The member went on to ask how would one progress from flupenthixol to aripiprazole or paliperidone long-acting injection for example. Dr Brownell outlined the position of the Trust: for individuals who need a long-acting injection, a first-generation agent would be selected between the clinician and the patient. If the patient experiences significant extrapyramidal side effects which are not manageable by using procyclidine, then there would be a move to a second-generation antipsychotic. In the case of aripiprazole, it would only be used if haloperidol or risperidone have caused increased prolactin as well as significant extrapyramidal side effects.
- A member enquired what proportions of patients on long-acting antipsychotics were on first-generation long-acting agents. Dr Brownell noted this was not known precisely as these are issued as stock to the teams, but expected that the vast majority of patients would be on first-generation agents. Nigel Barnes confirmed that the Trust will be able to provide this figure in 12 months' time.
- Dr Brownell stated that the Trust has quarterly reports from Consultants which include the amount spent on long-acting antipsychotic injections, together with the proportional costs between first-generation and second-generation long-acting antipsychotic injections.
- A member enquired on the time course of the neutropenia that is said to occur with paliperidone. It is known that clozapine-associated neutropenia occurs within 6 months, and definitely by 12 months. Nigel Barnes confirmed that BSMHFT has around 10 clozapine-associated neutropenia each year, of which 2 or 3 are frank clozapine-induced neutropenia. It is much rarer with other antipsychotics. He is not aware of any patients on long-acting antipsychotics who have had neutropenia other than those on clozapine.
- A GP member enquired whether it was the intention of the Trust to transfer prescribing of these long-acting antipsychotic injections to Primary Care. It was confirmed that the current annotation on the APC formulary for all antipsychotic depot injections was as follows: "The APC's view is that, on clinical grounds, the status of antipsychotic depot injections should be amber with a framework in place in Primary Care before transfer. HOWEVER, until the commissioning arrangements have been agreed to allow safe transfer of patient care, the status will remain Red." There were no clinical or safety reasons why this 3-monthly paliperidone injection should not be included in this group of agents.
- A member enquired on the frequency of monitoring of these patients. Dr Brownell confirmed that these patients would have an annual review of their general physical health, and that blood tests would not occur more frequently than 3 monthly. Nigel Barnes stated the Trust does not relax the mental state support that these patients receive, and that some patients

remain on the monthly injection because of the regular contact.

- A concern raised by a primary care member was around non-compliance/ non-attendance for their injections. This is the same problem in secondary care and there isn't an infrastructure to address this. Dr Brownell confirmed that around 9 to 10% of patients have a CPN, the rest attend out-patients clinics.

The Chair thanked Dr Brownell and Nigel Barnes for their presentation. They left the meeting while members deliberated and completed the Decision Support Tool.

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

Patient Safety: In line with other long-acting antipsychotic injections, notably the paliperidone monthly injection. The 12x monthly injection period provides some additional reassurance that the patient can tolerate the agent before moving onto the 3-monthly injection.

Clinical effectiveness: Same evidence base as other similar agents on the formulary; better than placebo but no comparative trials.

Strength of evidence: Evidence sufficient to get product licence.

Cost-effectiveness or resource impact: More expensive than first generation long-acting antipsychotic injections, but cost neutral compared to monthly paliperidone injection. Evidence provided during application of scrutiny to ensure cost-effective use.

Place of therapy relative to available treatments: 3rd line therapy, well defined during presentation.

National guidance and priorities: Accepted by SMC for use within NHS Scotland in September 2016.

Local health priorities: CCGs supportive.

Equity of access: Offers a wider choice for patients with psychiatric illness.

Stakeholder views: Psychiatrists at Forward Thinking Birmingham (FTB) are supportive.

Implementation requirements: N/A

Decision Summary: Approved as Red, in line with other long-acting antipsychotic depot injections already on formulary.

Actions:

- **Relay decision to Mental Health colleagues by Thursday 16th March 2017.** **APC sec**
- **Add paliperidone palmitate 3-monthly injection (Trevicta®) to APC formulary as Red.** **APC sec**

0317/06 Primary Care Antimicrobial Guidelines.

The APC secretary informed the members that the Birmingham Antibiotic

Advisory Group (BAAG) is in the process of reviewing the Primary Care Antimicrobial guidelines in line with the latest update from Public Health England (PHE) guidelines on management of infection in Primary Care. The final PHE guidance update is due this month (March 2017) and the group hope to get BAAG approval of their local guidance in April 2017 ready to submit to the APC in May 2017.

A member of BAAG has contacted the APC secretary to seek clarification on the process that needs to be followed in order to implement the changes identified in the PHE final guideline.

For example, the latest PHE guidance (Feb 2017) includes some medicines that are not currently included on the APC formulary or where the formulary RAG rating may need to be changed in line with the guidelines. A number of examples identified so far were quoted:

- Cefixime - currently Black RAG status so may need to be Amber.
- Methenamine hippurate - currently Red RAG status but may need to be Amber.
- Bismuth subsalicylate (Pepto-Bismol®) – not currently on the formulary but will need to be Green RAG status to replace the now discontinued tri-potassium di-citrato bismuthate (De-Noltab®).

The APC secretary had suggested that new drug applications or abbreviated applications be submitted to the APC for consideration, in line with the process recently undertaken by the Respiratory Network to update their COPD guidelines.

The BAAG representative had suggested that it would be favourable not to have to complete applications, and this was the reason for the APC secretary bringing this question to the attention of the APC members.

A CCG member declared an interest as the BAAG representatives are employed by the member, but it was felt odd that a full application would be required for drugs recommended by a national body. The evidence base would have already been discussed at length by Public Health England before making a recommendation in their guideline. However, it was acknowledged that a discussion would be useful to identify any local issues and use the local expertise to address these.

The general consensus was to accept the PHE recommendations but it would be useful to be aware of any alternatives to the recommended drugs, as in the case of cefixime for example.

It was suggested that a paper outlining the main changes be drafted by BAAG to come to APC.

A Trust representative stated that any Chairman's actions approved at the Trust around antimicrobials were based on individual patient's resistance patterns. PHE guidance will be based on a population basis after careful consideration of the antibiograms at CCG level. Therefore their recommendations will reflect local resistance data.

A member was concerned at the mention of methenamine hippurate as the BNF considered this drug as less suitable for prescribing.

A member confirmed that the 3 drugs mentioned by BAAG are second/ third line agents and their usage would therefore by low.

A member sought confirmation that the final RAG rating would be the decision of this committee; however it would welcome BAAG's view on place in therapy.

In summary, it was agreed that full or abbreviated applications would not be required in the first instance; a discussion paper highlighting the main changes in the primary care antimicrobial guidelines would be welcomed from BAAG to aid the discussions at APC.

Action: Relay the APC members' comments to BAAG representatives. **APC sec**

0317/07 Formulary alternatives recommended in Primary Care not approved by APC.

A Secondary Care colleague has contacted the APC secretary to highlight a number of discrepancies between the published formulary and preparations being recommended in Primary Care through Scriptswitch® to achieve their cost improvement plans.

A member reminded the Committee that this issue was discussed in the early days of the APC and that it had been agreed that the choice of branded generics recommended to GPs sat with the CCGs alone.

It was acknowledged that the majority of the formulary was at chemical level, but where deemed necessary by the APC a cost-effective brand would be annotated or brand prescribing would be recommended if it addresses any potential safety issues.

A Trust member clarified that secondary care's concerns were more about potential confusion this may cause to patients where they may have been discharged from hospital on a particular brand of macrogol sachets for example, and being switched to another brand by their GP. In addition, secondary care may be able to benefit from lower acquisition costs if able to do so through their procurement contracts which are decided at regional level.

It was suggested that the CCGs' prescribing newsletter would be a useful source of information for secondary care colleagues and to add the Trusts' formulary teams to the distribution list for CCGs' respective newsletter.

Action: CCGs to add Trusts' formulary teams to their newsletter circulation lists. **CCG leads**

0317/08 TriNovum® discontinued- replacement product for formulary**.**

It has been brought to the attention of the APC secretary that TriNovum® contraceptive pill has been discontinued.

TriNovum® was a triphasic pill; a combination of ethinylestradiol and norethisterone (21 days' supply).

Qlaira® (estradiol/ dienogest) is on the formulary as Amber, only for TriNovum® failure.

In view of TriNovum® discontinuation, the formulary status of Qlaira® may need to be reviewed, however Qlaira® is £25.

It was suggested that the document produced during the harmonisation of this section of the formulary be checked for any further product updates and forwarded to the Umbrella® services (Sexual Health) with suggested cost-effective alternatives for their review and support.

Actions:

- **Contact Umbrella services and confirm they accept the APC's suggestion as a replacement for TriNovum®.** **APC sec**
- **Remove TriNovum® from formulary.** **APC sec**
- **Amend entry for Qlaira® accordingly.** **APC sec**

0317/09 **Urinary incontinence appliance formulary-** RAG status of majority of appliances

Following the APC's approval of the Urinary incontinence appliance formulary, a member had expressed concerns regarding the Green RAG status of the majority of the appliances as it was felt that specialist input would be required from the continence team for GPs to prescribe these, and that an Amber status may be more appropriate.

Following a brief discussion, the members confirmed that, although the GPs would seek advice from the continence nurses or district nurses before prescribing these appliances, a Green RAG status was still appropriate.

Action:

- **Circulate Incontinence appliance formulary document to APC members.** **APC sec**
- **Upload to APC formulary website.** **APC sec**

0317/10 **Minutes of the meeting held on Thursday 9th February 2017**

The minutes of the meeting held on Thursday 9th February 2017 were discussed for accuracy.

Page 4: fourth bullet point, last sentence. To be amended to read "…five to seven years ago".

Page 10: fourth bullet point, first sentence. To be amended to read " …, but others can find it fiddly; .."

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

The following documents were also approved for uploading to the APC website:

DSTs for insulin degludec, Anoro® Ellipta®, Relvar® Ellipta®, Incruse® Ellipta®, Spiolto® Respimat®, Symbicort® pMDI.

0317/11 Matters arising – Action Table

As a matter arising from the minutes, the APC secretary has been contacted by the Respiratory network to confirm the formulary status of a number of inhalers. These included Sirdupla®, Braltus® and DuoResp® Spiromax®.

The members agreed that Sirdupla® was added to the formulary as a cost-effective alternative to Seretide® evohalers, but that in view of the move away from Seretide® Evohaler in general, Sirdupla® should be annotated as "for existing patients only, no new prescribing".
This does not affect the current formulary status of Seretide® Evohaler for use in paediatrics as Sirdupla® is only licensed in adults.

Braltus® is a tiotropium dry powder device, and a cost effective alternative to Spiriva® Handihaler®. As Spiriva® was removed from the formulary during the COPD review in February 2017, it was agreed that Braltus® would remain non-formulary.

Duoresp® Spiromax® would remain on the formulary until the Respiratory network has reviewed the asthma guidelines.

Actions:

- **Relay APC's response to Respiratory network clinicians** **APC sec**
- **Update APC formulary as agreed** **APC sec**

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

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

- 0217/07- High risk drug monitoring following update to the BSR/BHPR guidelines- Review monitoring requirements in ESCAs for DMARDs-
  Update: work in progress.

- 0217/08- Vioform HC cream discontinued- defer decision on replacement product until discussed with BCH representatives.
  Action: **forward information to BCH formulary lead to progress** **APC sec**

- 0117/05- Urinary incontinence appliances review- Investigate issues raised around Instillagel® vs Optilube® Active®-
  Update: BCHC lead to pick up after meeting and respond by end of the week.

- 0117/AOB – Alfentanil use across the interface - APC members to forward contact details of Palliative Care clinicians to APC secretary to form a palliative care sub-group.
  Update: Only received information from HoEFT. Ongoing.

0317/12 NICE Technology Appraisal (TAs)

There were two NICE Technology Appraisals published in February 2017; only one was commissioned by CCGs.

- Apremilast for treating active psoriatic arthritis (TA433). This guidance replaces the previous NICE TA 372. Providers are secondary care and

community care. RED status agreed.

Actions:

- **Update APC formulary with decisions on NICE TAs.** **APC sec**

Any other business:

1. Decline to prescribe forms received at BSMHFT

The BSMHFT representatives informed the committee members of a couple of practices in a local CCG declining to prescribe any oral antipsychotics despite the presence of an ESCA.
It was the view of the committee that it had ensured appropriate governance was in place by providing a shared care document to support the safe transfer of prescribing responsibility.

It was proposed that this issue should be raised with the Clinical Quality Reference Group (CQRG) for further discussion.

Action: BSMHFT to raise issue of blanket decline to prescribe any oral antipsychotics to CQRG. **BSMHFT leads**

2. Buprenorphine patches RICaD

The current formulary entry for buprenorphine patches lists them as Amber with a RICaD (to be developed).
The APC secretary has received an enquiry from a Primary Care colleague on the availability of this document which was confirmed as still in development.

It was requested that the production of this document be prioritised following a joint primary /secondary care Medicines Safety Officers network which has highlighted a potential safety issue regarding the patches, in that different brands need changing at different intervals – currently there are 3-day, 4-day and 7-day brands. A RICaD would go some way towards reducing the risk.

A member suggested that brand name prescribing would address some of these concerns. The indications for which it was approved on the APC formulary were confirmed as for initiation by specialists in pain clinics, palliative care and for patients with swallowing difficulties.

Actions:

- **Add a note recommending brand name prescribing to the formulary entry for buprenorphine patches.** **APC sec**
- **Develop a RICaD for buprenorphine patches.** **CCG/APC sec**

3. Update on Toujeo® appeal

The APC secretary reminded the committee members that the Toujeo® appeal was being heard by the Dudley APC on 23rd March 2017 and that a member of the APC committee, preferably one of the joint chairs, should attend with her to ensure governance was being followed. Unfortunately neither of the chairs was available on that date due to clinical commitments.

A discussion ensued about the documents that had been put forward by the appellant to be considered as part of the appeal but it was felt that these should not be included as they provided new or additional information that had not been considered at the time of the original application to BSSE APC in

April 2016.
As the reason to appeal was that no reasonable committee could have reached the same decision on the evidence presented to APC, it was felt that only the information considered in April 2016 should be considered by the appeal panel.

The members agreed on the way forward:

a) Request a postponement of the appeal panel hearing from Dudley APC so that one of the chairs can attend and proceed with the appeal at a future date but on the clinician's understanding that only the original application and evidence submitted can be considered. Dudley ACE will have to decide if no reasonable committee could have reached the same decision on the evidence presented to BSSE APC.

b) Alternatively, the BSSE APC would consider a resubmission of the original application with the additional information the clinician provided to address the concerns raised in April 2016. This could be done at the next APC meeting, depending on the clinician's availability. However, the clinician would need to withdraw the appeal for this to proceed.

Actions:

- **Request a postponement of the appeal hearing from Dudley APC stating neither of the chairs can attend the original date.** **APC sec**
- **Contact the clinician to confirm the understanding that only the original application and evidence submitted in April 2016 can be considered by the appeal panel.** **APC sec**
- **Or suggest that the clinician withdraws the appeal and resubmits the original application with the additional information provided to address the safety concerns raised by BSSE APC at the next meeting.** **APC sec**

The Chair thanked the members for their input today. The meeting closed at 16:10 pm.

Date of next meeting: Thursday 13th April 2017 14:00 – 16:45
Conference Room A,
Birmingham Research Park,
Vincent Drive.
Birmingham B15 2SQ.