AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 8th October 2015
Birmingham Medical Institute, 36 Harborne Rd, Birmingham, West Midlands B15 3AF.

PRESENT:

Dr Paul Dudley	PD	Birmingham CrossCity CCG (chair)
Dr Lisa Brownell	LB	BSMHFT
Alan Pollard	AP	Birmingham Women's NHS FT
Alima Batchelor	AB	Birmingham South Central CCG
Carol Evans	CE	HEFT NHS FT/Solihull CCG
David Harris	DH	Birmingham Community Healthcare NHST
Dr John Wilkinson	JW	Solihull CCG
Dr Neil Bugg	NBu	Birmingham Children's Hospitals NHSFT
Inderjit Singh	IS	UHB NHS FT
Isabelle Hipkiss	IH	Midlands & Lancashire CSU
Jonathan Horgan	JH	Midlands & Lancashire CSU
Kate Arnold	KA	Solihull CCG
Mandy Matthews	MM	NHS England
Mark DasGupta	MD	Birmingham CrossCity CCG
Nigel Barnes	NBa	BSMHFT
Prof Jamie Coleman	JC	UHB NHS FT
Prof Robin Ferner	RF	Sandwell & West Birmingham Hospitals NHST
Sangeeta Ambegaokar	SA	Birmingham Children's Hospital NHS FT
Satnaam Singh Nandra	SSN	Birmingham CrossCity CCG
Sumaira Tabassum	ST	Sandwell & West Birmingham CCG
Tania Carruthers	TC	HEFT NHS FT
Tony Green	TG	Patient representative

IN ATTENDANCE:

Patricia James	PJ	Minute taker, Midlands & Lancashire CSU

No.	Item	Action

1015/01 **Apologies for absence were received from:**

- Brian Smith, The ROH NHS FT
- Maureen Milligan, The ROH NHS FT
- Elizabeth Walker, Sandwell & West Birmingham CCG

1015/02 **Items of business not on agenda** (to be discussed under AOB)

- Prednisolone solution – IH
- Hydroxychloroquine – IH
- Decline to prescribe form – IH
- Chapter 13- Dermatology – IH
- Dental prescribing – JC
- Silver dressings – Wound management– JC/ ST
- Review RAG ratings of NOACs – KA- agreed to discuss at November meeting when reviewing NOACs
- Rivastigmine (Parkinson's Disease) – DH

1015/03 **Declaration of Interest (DoI)**

The chair reminded members to submit their annual declarations to the APC Secretariat. Members were also asked to declare any interests that may be relevant to the business to be discussed on the agenda.

MD reminded the members of his previous declaration of interest around naloxegol, under item 1015/08, be noted.

MM declared she had been involved in some prostate cancer feedback which involved a drug listed in Chapter 8, item 1015/11 on today's agenda, and asked that it be noted.

1015/04 **Welcome and Introductions**

The chair welcomed those present to the Area Prescribing Committee. Introductions around the table were carried out for the benefit of Dr Neil Bugg.

1015/05 **Minutes of the meeting held on Thursday 10th September 2015**

The minutes of the meeting held on 10th September 2015 were discussed for accuracy.

- MD requested that where reference is made to a person not present at the meeting, their name, title and organisation should be documented in full.
- Kate Arnold requested her apologies be noted
- Page 8, Rakhi's surname should read as Aggarwal.
- Page 8, last paragraph: separate comment about fosfomycin from MD's comment about pivmecillinam.

The minutes were approved subject to these amendments and final sign off from the chair. The recording of the meeting was to be deleted.

1015/06 **Matters arising – Action Table**

The chair turned to the action table for discussion. See appendix 1 for updated action table.

Discussions around action points are detailed below:

0715/06 Matters arising – Action table

- CSU to summarise proposal in an email to enable trust leads to scope out the IT requirements/restrictions of their organisations — ***On-going***

Update: IH advised she had received feedback/comments from a few members. IS has also suggested an alternative Cloud-based system kahootz.com, currently used by Department of Health for the Carter review.

0715/09 Feedback from APC Away Day – 26.06.15 (on-going)

- Trust leads to send prescribing data (PF eye drops) to APC secretary

Update: BMEC already submitted their data, UHB have now sent theirs which suggests 25% of out-patient prescriptions prescribed as PF (data expressed as lines, not items). CE is working through HEFT's data but pointed out that it was difficult to compare single eye drop bottles with boxes of SDU for PF preparations, and that initial calculations suggest 10% usage is PF. **Closed**
RF commented that 25% was a high proportion at UHB and its cost implications, but was satisfied that now the data had been submitted, the item was concluded.

- Draft response to glaucoma specialists informing them of APC's decision to use less expensive agent travoprost. LB will sign off as chair.

Update: IH has emailed glaucoma specialists and Lucy Titcomb (Lead Ophthalmic Pharmacist, Birmingham & Midlands Eye Centre (BMEC); will discuss under item 1015/12 on today's agenda. **Closed**

0915/07 Operational Issues On agenda for discussion

0915/09 NICE Technology Appraisals TAs

- naloxegol – on today's agenda

- Produce draft 0.1 of RICaD for edoxaban

Update: Draft 0.1 was produced by SSN; IH is reviewing to produce draft 0.2 for wide consultation.
ACTION: Circulate draft 0.2 for edoxaban RICaD for wide consultation **IH**

IH highlighted an apparent lack of engagement from cardiology / haematology specialists as she'd had no comments or feedback from them on the draft rivaroxaban post ACS RICaD she'd previously circulated. It was suggested that trust leads on APC should be copied in the consultation process to enable them to chase up specialists' feedback , to state a deadline for comments and that a standard response stating that "as we've not had any feedback, the APC will go ahead with current document" , copied to chair of DTC.

ACTION: Recirculate rivaroxaban document to cardiology /haematology specialists for consultation, copy to APC Trust leads, and state deadline for feedback. **Apply same principles to edoxaban draft RICaD.** **IH**

0915/10 Trust Chairs non formulary approvals

- Email Trust chairs non formulary approvals to APC secretary

Update: PL has submitted the Women's hospital recent non formulary

approvals. No submissions from HEFT or BSMHFT have been received. LB advised that the drug BSMHFT had approved was subsequently discontinued, hence not used.

0915/12 Mycophenolate ESCA

- Seek clarification from Rheumatologists on 3 questions raised by RF, together with clarity on monitoring requirements after 12 months -

Update:
IH summarised the email reply from Dr Ben Rhodes, Consultant Rheumatologist, University Hospitals Birmingham NHS Foundation Trust; this has been circulated to the members for information.

His overarching comment was that mycophenolate is not a special case in terms of its lack of specific licence for connective tissue disease and that methotrexate and azathioprine also fall into this category. The most frequent indication for mycophenolate usage in connective tissue disease would be as the primary treatment of lupus nephritis and as maintenance therapy for various forms of vasculitis when azathioprine is not tolerated. Many of these patients are managed by nephrology so it is suggested that the ESCA should cover all connective tissue disease indications, as these are multisystem disorders that do not fall easily into single speciality management, and to engage other specialities who may do more prescribing than in rheumatology.

How unsafe is the drug: the NICE drug evidence summary (ESUOM36) summarises the incidence of the three commonest side-effects as infection (32%), nausea and vomiting (24%) and diarrhoea (12%). The risk of infection cannot be considered in isolation and needs to be taken in context with patient's health in general and concomitant immunosuppressant therapy.

How does it compare to methotrexate (MTX) which GPs are already prescribing?: stable patients with inactive disease on low dose adjunctive therapy (steroids) are getting no more drug side effects than patients on methotrexate or azathioprine.

Will these patients be seen in hospital anyway for clinical review? : there are going to be groups of stable patients in whom the frequency of required clinical review in secondary care (say 4-6 monthly) is less frequent than the required blood monitoring (say 1-2 monthly) and hence primary care involvement would be to the convenience of the patient.

Can you clarify monitoring requirements after 12 months? : In line with guidance for MTX and other immunosuppressants, he would be happy for monitoring requirements to be more relaxed after 12 months of therapy, providing there is no history of monitoring abnormalities.

Dr Rhodes went on to suggest a compromise in which shared care may be appropriate in low-risk situations such as:
1) Patients who have been on treatment for more than 9 months,
2) Patients on ≤2g/day mycophenolate
3) Patients are taking no more than 10mg Prednisolone
4) Disease activity has been well controlled with no escalation of treatment required in the last 6 months.

RF commented that, with regards to infections, he still wasn't clear if these were life-threatening or minor infections such as sore throats.

JC commented that it depends where these patients go to mycophenolate from and whether this was at adjunctive treatment and patients are already on prednisolone and other immunosupressants. He stated that these connective tissue disease patients are already subject to numerous infections. JC welcomed the pragmatism in relaxing monitoring after 12 months as there was no evidence to suggest how frequently these patients should be monitored. RF questioned whether there have been any controlled trials and if so what is the comparative data around effectiveness safety issues? MD reminded the members that mycophenolate had been previously suggested to come to the APC as a formal drug application so that the evidence could be considered in the process.

ACTION: Circulate NICE ESUOM36 with the draft minutes, then consider if formal drug application is necessary. **IH/PJ**

0915/13 BNF Chapter 5: Infections
Update: all current actions are now closed. The antimicrobials guidelines are uploaded on the APC website and IH is populating Chapter 5. The final version of Chapter 5 harmonised document, together with the supporting primary care guidelines will be circulated to formulary leads on APC shortly.

ACTION: Circulate final version of Chapter 5 and Primary Care Antimicrobial guidelines. **IH**

0915/16 Tapentadol letter from industry

- Draft response to Grunenthal; circulate to members before chairs sign off

IH confirmed that, following comments from both chairs and CCG Leads, the letter in final format has been posted to Grunenthal (5th October 2015). **Closed**

0915/17 Any other business
Midodrine – Chapter 2

- Submit as a new drug application for consideration

UHB has indicated that their team is keen to move this forward as soon as possible, and will be submitting a new drug application once discussed at MMAG. **ongoing**

0715/14 Lidocaine 5% plaster – draft RICaD
IH has confirmed that no comments had been received to date.

ACTION : Add Lidocaine 5% plaster RICaD to the November agenda for ratification and sign off. **IH/PJ**

0615/06 Grazax RICaD
Update: Dr North has submitted draft 0.1 RICaD, which has been reviewed by pharmacist. Draft 0.2 has been circulated to specialist immunologists for a 2 week consultation; deadline for comments is 8th October. IH to incorporate these and circulate draft 0.3 to APC members for 2 week consultation.

ACTION: **Circulate draft 0.3 of Grazax RICaD to APC members for 2 week consultation**. **IH**

1015/07 **Operational Issues**

- Process for ESCAs and RICaDs – for ratification

Version 2 of process for RICaDs and ESCAs paper was discussed. It was felt that in section draft 0.1 – the question "do we need to give heads-up to clinicians at FAD stage" should be moved to the section under TASK. Subject to this amendment, the document was approved for internal use.

- Addition of certain medicines subject to positive NICE TA to the formulary immediately upon publication – for ratification

MD proposed rewording "all primary care commissioned drugs" to read "all CCG commissioned drugs". RF suggested rewording the paragraph relating to drugs that may be prescribed in primary care. To be discussed outside of meeting, forwarded to IH to produce final version.

ACTION: MD/RF/KA to agree final wording and copy to IH. **MD/RF/KA**

1015/08 **NICE Technology Appraisals** (TAs)

IH discussed the formulary adherence checklist for NICE TAs published in September 2015.

Ruxolitinib: NICE unable to make a recommendation, so not applicable.

Edoxaban in AF: Primary care commissioned treatment. IH suggested same RAG rating as other NOACs, however JC pointed out edoxaban was very different in that it needs to be covered with low molecular weight heparin for 5 days (as in the trials), and therefore much less practical to use. It was also highlighted that NOACs may now be referred to as DOACs (Direct Oral AntiCoagulants). It was agreed to leave as grey until discussed at the November meeting.
Further discussion followed regarding the number of DOACs now on formulary to comply with NICE without the option to rationalise them, and possible risks associated with lack of clinical experience. MM noted that it is acceptable to have a hierarchy of preferred options, as long as all options are included on formulary. MM to share NICE statement with IH to circulate to members.
ACTION: **Circulate NICE statement regarding preferred local choice of drug** **IH**

Naloxegol: for opioid-induced constipation. As requested at September meeting, IH circulated TA345 document, together with RDTC new drug evaluation (April 2015). MD reminded the members of his declaration of interest for this drug.
KA was disappointed that NICE has recommended a drug which costs £660 a year for patients who have tried 1 laxative for 4 days. Furthermore, the comparator drug which was used in their economic analysis does not have a NICE TA, but was withdrawn by the manufacturer.
MD noted that NICE's proposed place in therapy did not correspond with the Clinical Knowledge Summary advice.

There was a lengthy discussion around the RAG status. AMBER with specialist initiation supported by a robust RICaD would seem most appropriate. JC can see a place in therapy for palliative care patients on large doses of opioids

where symptomatic constipation is a quality of life issue. NBa agreed but also noted the increased use of opioids in osteoarthritis and back pain, and was concerned with indication creep. MD thought it would not be appropriate to refer a patient back to pain specialist for treatment of constipation. CE suggested an algorithm, placing it as last option but MD reminded the members this was against NICE's TA. NBa proposed contacting Medicines and Prescribing Associates within NICE and seek clarification on their intention with this agent.

It was suggested that the Joint Chairs write to the Chair of NICE, expressing the APC's concerns with their recommendation; the members would only see its place in therapy in end of life care to keep patients comfortable. However it was pointed out that all the trials were carried out in patients with non-cancer pain. The conclusion from RDTC independent drug evaluation (April 2015) was quoted as "there are currently insufficient data to recommend a suitable place in therapy".

It was agreed the best way to proceed would be for the CSU to draft a letter to the Chair of NICE on behalf of the APC Chairs, circulate to members for approval. Leave on the formulary as GREY pending decision.

ACTION: CSU to draft letter to Chair of NICE on behalf of APC Joint Chairs, expressing concerns with their recommendation. **CSU/ Chairs**

1015/09 **Trust Chairs non Formulary approvals**

The chair confirmed that UHB NHS FT has submitted their recent non formulary approvals. For information.

1015/10 **Seretide / Flixotide:** issue raised by BCH re removal of Seretide/ Flixotide inhaler during Chapter 3 harmonisation.

NBu noted that the harmonisation process was fundamentally an adult review and did not include any paediatric views. However, it is his understanding that the formulary is intended to cover both adult and paediatric requirements
NBu. reported an issue raised by paediatric respiratory consultants that fluticasone as a sole ICS agent and Seretide Evohaler may be required for paediatric consideration due to the licensing restrictions of the formulary alternatives.

Of the other formulary combination ICS/LABA combinations, Fostair is not licensed for under 18s, Flutiform is not licensed for under 12s and Symbicort (only one licensed from age 6) is a Turbohaler which is not suitable for all children. There is therefore a gap in licensed ICS/LABA combination MDI (for children) which Seretide would fulfil.

Nbu commented that he was waiting for a response/ feedback from the BCH asthma lead around steroid only inhalers, but advised the committee that clinicians at BCH use a lot of fluticasone as a sole ICS agent and would therefore prefer that this remains a formulary option.

The members agreed to reinstate the licensed preparations of Seretide and fluticasone as GREEN for paediatric use only.

ACTION: Add licensed preparations of Seretide and fluticasone back on formulary as GREEN for paediatric use only. **IH**

There was some discussion around the new branded generic alternative to Seretide and considerably cheaper preparation Sirdupla (fluticasone/ salmeterol) which is only licensed in adults (over 18). MD reminded the members that the formulary is for new prescribing, and that CCGs had the opportunity to switch current patients on Seretide to Sirdupla, which was relatively straightforward, without the need for a full medication review. From a cost effective perspective this would save the health economy over £1m a year. It was agreed to reconsider this agent at a future meeting.

ACTION: MD to summarise issues around Sirdupla to consider at future APC meeting. **MD**

1015/11 **BNF Chapter 8 – for ratification**

Chapter 8 document was discussed.

8.1.3: MM reported that Teysuno capsules (both strengths) are not routinely commissioned by NHSE, policy being drafted which is not supportive. Omit from list.
JW queried the RED rating for methotrexate. It was confirmed that in the context of this chapter, this was correct. MTX was amber with ESCA for use in GI and Rheumatology.

Page 3: Hydroxycarbamide – Amber with an ESCA for myeloproliferative disorders. SSN has drafted 2 ESCAs, one for the licensed preparation, and the other for the unlicensed product. Use in sickle cell is covered in chapter 9. **IH**
ACTION: Circulate draft ESCAs for wide consultation

Tacrolimus: IH requested confirmation regarding the brand to be listed on formulary. It was confirmed that Prograf was the standard release formulation, whereas Advagraf was the modified release presentation. It was agreed to defer decision until clarification was sought from transplant specialists on which brand is used.

ACTION: Trust Leads to seek clarification from transplant specialists on tacrolimus brand used and bring back to APC. **Trust leads**

Buserelin nasal spray: (Page 5): AP enquired on the status of buserelin nasal spray as used at BWH for assisted conception. IH confirmed this is listed in Chapter 6 as RED

Ethinylestradiol: City to clarify usage. MD quoted price as £200/21. RF to come back.

Pages 6 and 7 list agents with positive NICE TA but not currently listed on APC formulary. The trastuzumab emtansine- Is currently included in CDF and MM advised that NHSE have approved so it needs to be on the formulary.

Dimethyl fumarate: Has positive NICE TA for MS so needs to be included on formulary.
Glatiramer injection NHSE approved, so Trusts will need to include in their

formulary.
Pomalidomide is listed in CDF list, as is enzalutamide capsules
Pasireotide: not routinely commissioned so not to be listed on formulary.

IH confirmed that this section would be reviewed regularly, but to check against latest CDF list.
IS requested that the formulary included a link to the CDF list.
It was confirmed that only oral agents would be listed on APC formulary.

1015/12 **BNF Chapter 11 – for ratification**
Under the criteria for PF/ SDU, AP requested the addition of use in neonates. Members agreed.
The chair suggested that the members focus on the shaded cells in the table as these required further clarification.

Section 11.3 anti-infective eye preparations
Fusidic Acid 1% M/R eye drops**:** at the away day it was agreed to remove from formulary to be replaced by azithromycin eye drops as second line to chloramphenicol. However, since the June away day, Lucy Titcomb (Lead Ophthalmic Pharmacist, BMEC) was advised against wider use by microbiologists who were concerned with antimicrobial resistance. This was confirmed by Professor Kaye, ophthalmologist from Liverpool, who has done a lot of work on resistance in ocular isolates: there is greater resistance amongst staphylococcus aureus to azithromycin (10% will be resistant) and less resistance to fucidic acid. AP also confirmed that fusidic acid was the agent of choice in NICU.
The conclusion was as follows:

Chloramphenicol GREEN 1st line
Gentamycin GREEN second line to chloramphenicol
Fusidic acid GREEN second line £££ (as recommended in Antimicrobial Guidelines)
Azithromycin – AMBER 1st line for ophthalmic chlamydia

Levofloxacin- Oftaquix (SDU) – Members had recommended that a new drug application should be considered. BMEC have it on their formulary already. IS commented that, although not listed on UHB's ophthalmic formulary, this has not been reviewed for some time and clinicians may be using it on out – patients' scripts. IS to seek clarification from UHB ophthalmologists.

The following preparations will need new drug applications to be considered for addition to the formulary: moxifloxacin 0.5% eye drops (Moxivig), tobramycin 0.3% eye drops (Tobravisc), propamidine isetionate 0.1% eye drops, dibrompropamidine isetionate eye ointment 0.15%

Section 11.4 Corticosteroids and other anti-inflammatory preps:
Dexamethasone 0.1% eye drops (SDU): 3 brands available, Dexafree currently lowest acquisition cost (32.3p per dose). Rather than specify a preferred brand, APC members agreed to list as generic with note to use one with lowest acquisition cost.

Section 11.6 Treatment of glaucoma
As discussed at the September APC meeting, IH emailed Lucy Titcomb and the glaucoma specialists regarding the APC's decision around the second line prostaglandin analogues. The NICE guidelines (CG85 Aug 2009) for glaucoma recommend the following class of agents for treatment: prostaglandin analogues, beta blockers, carbonic anhydrase inhibitors and sympathomimetics. Prostamides are not mentioned in the guidelines, nor are individual drugs listed.

The APC members believe that these 4 groups of agents are adequately represented on the formulary (bimatoprost was included in the prostaglandin analogues in the proposed guidelines)

Since the specialists were unable to make a decision on the second line prostaglandin analogue agent (with preservative), the APC decided on their behalf and chose the less expensive agent travoprost.
The response was that, with only 2 days' notice of this decision, there has been insufficient time for the ophthalmologists to discuss the issues surrounding potential loss of bimatoprost from the formulary and she disagreed with removing the only prostamide on formulary. Mr Masood (Consultant Ophthalmic Surgeon at BMEC) had commented at the June away day that bimatoprost was an alternative monotherapy for patients who do not respond to a prostaglandin analogue.
TC commented that HEFT ophthalmologists favoured bimatoprost.
Travoprost is due to come off patent in November 2016, bimatoprost in March 2017.
The conclusion was that, having considered the points made, **the members agreed to keep the prostamide bimatoprost on formulary as second line option to latanoprost. This implies that the timolol combination is also on formulary. Travoprost and the combination with timolol are no longer on formulary**. The APC wished to remind the specialists that the formulary would be reviewed in 12 months.
Simbrinza and Tapticom_: DTC application in process at SWB Hospitals

11.8.1 Tear deficiency, ocular lubricants
MD reminded the members that the decisions in this section had been based on the consolidated views of the pan-Birmingham consultants, presented at the away day.
Xailin gel –GREEN

New drug applications required for the following agents: Systane Balance, Systane Ultra SDU, Hylocare, Optive Fusion, Emustil

11.8.2 Ocular diagnostic and peri-operative preps
Nepafenac- new drug application required
Bromfenac- not currently listed on any formulary, would need new drug application.
Aflibercept, ranibizumab and other NICE TA approved drugs to be listed on formulary as RED
Rose Bengal drops are now discontinued- BLACK remove

Miscellaneous:
It was agreed at the Away day to list the following agents as BLACK remove:

- Eyelid wipes for blepharitis

- Antioxidants/vitamins for AMD

ACTIONS:

- **Seek clarification from UHB ophthalmologists on status of levofloxacin (Oftaquix) SDU** **IS**
- **Inform ophthalmologists of revised decision for second line agent- now bimatoprost** **IH**

1015/13 **Biosimilars:** process for inclusion on APC formulary

There was a discussion whether biosimilar agents should go through a formulary application process or whether they should be automatically added to the formulary if their equivalent is already included.
It was established that these are equivalent at therapeutic level, are licensed for the same indications but may still need to be considered as cannot be interchanged with the originator drug.
SSN commented that the insulin glargine biosimilar was being reviewed by the diabetes network. The issue here is that the pen devices are different for the originator and the biosimilar agents, so would need to be prescribed by the brand intended as the patient may end up with a different pen device.

MD suggested the committee invited an expert to attend a future meeting to enable the members to formulate an informed statement regarding biosimilars and add to the APC website.

ACTION: Invite an expert on biosimilars to APC meeting **CSU**

1015/14 **Any other business**:

- Prednisolone oral solution– IH

IH notified the members that there is now a licensed oral solution 5mg/5ml in single dose units, which is more cost effective than the soluble tablets. Soluble tablets are costly at £53.48 for 30 doses (sugar free) compared to £34.23 for 30 X 5mg/5ml unit doses of oral solution. IS referred to BCH guidelines which recommend dispersing 5mg plain tablets. It is unsure if the new oral solution is sugar free. It was also pointed that there is a 10mg/ml oral solution, which could be prescribed in error and lead to dosing error. It was agreed not to add the liquid alternate to the formulary until further clarification was sought.

- Decline to prescribe form – IH

It has been pointed out that not all Trusts have nhs.net email addresses on the decline to prescribe form which may lead to an IG breach. Trust leads need to confirm with their IG lead that the contact details noted on the form are IG safe.
ACTION:

- **Circulate decline to prescribe form to Trust leads** **IH**
- **Trust leads to confirm contact details are IG safe** **Trust leads**

- Hydroxychloroquine - IH

During chapter 10 harmonisation, it was agreed to RAG rate hydroxychloroquine as AMBER , and that an ESCA was no longer required. UHB have received a decline to prescribe form from a practice stating that they were no longer signed up to the DMARD LIS which included a shared care agreement, however the LIS is no longer in place. IH asked the Trust leads present if they had encountered any similar issues. None were reported.
It was suggested that a summary of issues raised in decline to prescribe form

would be useful feedback to come to APC members.

ACTION: Trust leads to send summary of decline to prescribe forms to APC secretary as feedback to members. **Trust leads**

- Dermatology – IH – Chapter 13

It was proposed that dermatology specialists should be invited to the December away day. The members would welcome their input, but their remit would need to be clear: to present a consolidated view. There is a dermatology network which goes under the name of Midlands Derm Soc.

ACTION: Trust leads to contact their respective dermatology directorate and feedback nominated specialist to APC secretary **Trust leads**

- Dental prescribing and Wound dressings – JC

The committee's view was that it would be useful to review these therapeutic areas as part of the harmonisation process.
The wound management section would be informed by the local subgroup currently reviewing this area which includes tissue viability nurses and representatives from local trusts and CCGs, however this group was making slow progress due to lack of engagement. It was proposed to set a deadline for feedback by February 2016.
ST enquired what level of evidence was deemed as good clinical evidence. It was agreed Cochrane reviews and published expert reviews would be acceptable. However this is a therapeutic area where there is very little trial data available.

ACTION:

- **Add dental prescribing to the agenda in January 2016** **IH/PJ**
- **Add wound dressings to the February 2016 agenda** **IH/PJ**

Due to time restraints it was agreed that the following would be added to the November agenda for discussion:

- Review RAG rating of NOACs (DOACs) - KA
- Rivastigmine (Parkinson's Disease) - DH

Members were advised this was the last meeting to be held at the BMI.
The November meeting will be held at the Birmingham Chamber of Commerce. PJ confirmed parking will be free of charge.

The chair thanked the members for their input today. The meeting closed at 17:12 pm

Date of next meeting
Thursday 12th November 14:00 – 16:45
Birmingham Chamber of Commerce
75 Harborne Road
Edgbaston
Birmingham B15 3DH
Rooms: Venture A&B

Appendix 1: ACTION TABLE

Minute number	Description	Action by	Date due	Status at 15/10/15
1015/06	**Matters arising – Action Table**			
	0915/09 NICE Technology Appraisals TAs –			
	• Circulate draft 0.2 for edoxaban RICaD for wide consultation	**IH**	**15/10/15**	**Open**
	• Recirculate rivaroxaban document to cardiology /haematology specialists for consultation, copy to APC Trust leads**.**	**IH**	**15/10/15**	**Open**
	0915/12 Mycophenolate ESCA			
	• Circulate NICE ESUOM36 with the draft minutes, then consider if formal drug application is necessary.	**IH**	**15/10/15**	**Open**
	0915/13 BNF Chapter 5- Antibiotics			
	• Circulate final version of Chapter 5 harmonised document and Primary Care Antimicrobial Guidelines	**IH**	**22/10/15**	**Open**
	0715/14 Lidocaine 5% plaster – draft RICaD			
	• Add Lidocaine 5% RICaD to November meeting agenda.	**IH/PJ**	**05/11/15**	**Open**
	0615/06 Grazax RICaD			
	• Circulate draft 0.3 of Grazax RICaD to APC members for 2 week consultation	**IH/PJ**	**15/10/15**	**Open**
1015/07	**Operational Issues- addition of drugs with positive NICE TA to formulary**			
	• MD/RF/KA to agree final wording and copy to IH	**MD/RF/KA**	**14/10/15**	**Closed**
1015/08	**Nice Technology Appraisals (TAs)**			
	• Circulate NICE statement regarding preferred local choice of drug	**IH**	**14/10/15**	**Closed**
	• Draft letter to Chair of NICE on behalf of APC Joint Chairs, expressing concerns with their recommendation	**CSU**	**15/10/15**	**Open**
1015/10	**Seretide / Flixotide – BCH issue**			
	• Add licensed preparations of Seretide and fluticasone back on formulary as GREEN for paediatric use only	**IH**	**15/10/15**	**Open**
	• Summarise issues around Sirdupla to consider at future APC meeting.	**MD**	**TBC**	**Open**
1015/11	**BNF Chapter 8 – for ratification**			
	• Circulate hydroxycarbamide draft ESCAs for wide consultation	**IH**	**22/10/15**	**Open**
	• Seek clarification from transplant specialists on tacrolimus brand used and bring back to APC.	**Trust leads**	**8/11/15**	**Open**

Minute number	Description	Action by	Date due	Status at 15/10/15
1015/12	**BNF Chapter 11 – for ratification** • Seek clarification from UHB ophthalmologists on status of levofloxacin (Oftaquix) SDU Inform ophthalmologists of revised decision on second line agent- now bimatoprost	**IS** **IH**	**22/10/15** **15/10/15**	**Open** **Open**
1015/13	**Biosimilars** • Invite an expert on biosimilars to APC meeting	**CSU**	**TBC**	**Open**
1015/14	**Any other business** • Circulate decline to prescribe form to Trust leads • Trust leads to confirm contact details are IG safe • Trust leads to send summary of decline to prescribe forms to APC secretary • Trust leads to contact respective dermatology directorate and feedback nominated specialist to APC secretary • Dental prescribing – Add to the January 2016 agenda • Wound dressings - Add to the February 2016 agenda • Rivastigmine (Parkinson's Disease)- Add to November agenda	**IH/PJ** **Trust Leads** **Trust leads** **Trust leads** **IH/PJ** **IH/PJ** **IH/PJ**	**15/10/10** **22/10/15** **5/11/15** **22/10/15** **04/01/16** **01/02/16** **02/11/16**	**Open** **Open** **Open** **Open** **Open** **Open**
	UPDATED ACTION TABLE FROM PREVIOUS MEETING			
0915/06	**0715/06 Matters arising- Action Table -** • CSU to summarise proposal in an email to enable Trust leads to scope out the IT requirements/ restrictions of their organisations. **0715/07 NICE TAs** • Move NOACs review to November APC meeting agenda and email out papers **0715/09 Feedback from APC Away Day – 26.06.15 (on-going)** • Trust leads to send prescribing data (PF eye drops) to APC secretary asap • Move to September Away day agenda • Draft response to glaucoma specialists informing them of APC's decision to use less expensive agent travoprost. LB will sign off as chair.	**CSU** **IH/PJ** **Trust Leads** **IH/PJ** **IH/LB**	**08/10/15**	**Open** **Closed** **Closed** **Closed** **Closed**
0915/07	**Operational Issues** Draft minutes from management/ development meeting • Draft TOR to be drawn up and circulated to members for comments Process for ESCAs ad RICaDs • Amend wording on draft document to reflect agreed changes for ratification at October meeting Addition of certain medicines subject to positive NICE TA to the formulary immediately	**JH/CSU** **IH/CSU**	**01/10/15**	**Open** **Closed – on agenda**

Minute number	Description	Action by	Date due	Status at 15/10/15
	upon publication • Amend wording on draft document to reflect agreed changes for ratification at October meeting	IH/CSU		Closed – on agenda
0915/09	**NICE Technology Appraisals (TAs)** • Add 6 drugs to formulary as per minutes • Add naloxegol to agenda for October meeting and circulate NICE TA345 with meeting papers • Produce draft 0.1 of RICaD for edoxaban see new actions under 1015/06	IH CSU		Closed Closed – on agenda Closed
0915/10	**Trust Chairs non formulary approvals** • Email Trust chairs non formulary approvals to APC secretary	**HEFT outstanding**	**24/09/15**	**Open**
0915/11	**Eslicarbazepine ESCA – revised (final draft for approval)** • Make final amendments to document and publish on APC website	IH		Closed
0915/12	**Mycophenolate ESCA** • Seek clarification from Rheumatologists on 3 questions raised by RF, as well as clarity on monitoring requirements after 12 months Add to chapter 10 as RED status See new actions under 1015/06	IH IH		Closed Closed
0915/13	**BNF Chapter 5: Infections** • Correct typos in guidelines documents. • Insert all green drugs back in RAG rated table and publish on APC website • Link GREEN drugs to Primary Care Antimicrobial guidelines see new actions under 1015/06	IH/RA IH IH		Closed Closed Closed
0915/14	**Utrogestan drug application** • Develop a RICaD and incorporate a revised decision tree • Resubmit evidence around first line use in patients with strong family history of breast cancer. • Bring back to November meeting	**AP/PL** **AP/PL** **IH/PJ**	**25/10/15** **25/10/15** **05/11/15**	**Open** **Open** **Open**
0915/15	**HRT and OC review:** prescribing data analysis and review documents • Collate CCG and family planning clinics prescribing data and add to harmonisation process. • BWH to send details of drugs to remain on formulary for specific indications (other than HRT and OC) • Bring back to December Away day	**IH/CCG/Trust leads** AP/PL **IH/PJ**	**14/10/15** **21/10/15**	**Open** Closed **Open**

Minute number	Description	Action by	Date due	Status at 15/10/15
0915/16	**Tapentadol:** letter from industry • Draft a response to Grunenthal; circulate to members before Chairs sign off.	JH/CSU		Closed
0915/17	**Any other business** Midodrine – Chapter 2 • Submit as a new drug application for consideration Venue for the APC • Email out new venue once confirmed, to all members Chapter 11 Update • Email updated Chapter 11 (Eye) to APC members	HEFT/UHB IH/PJ SSN/ IH	TBC	Open Closed Closed - on the agenda
0715/09	**Feedback from Away Day, 26th June 2015.** • Simbrinza application- in process at SWB- bring to APC once considered • BMEC to investigate suitability of sod. Hyaluronate 4% multidose (Clinitas) and report back to APC • Loteprednol- RICaD to be developed by BMEC • Annotate formulary entry for dexamethasone as SDU • Add statement to formulary regarding antioxidant vitamins and eye lid wipes	BMEC BMEC BMEC IH IH	TBC TBC TBC 31/08/15 31/08/15	Open Open Open Open Open
0715/14	**Lidocaine 5% plasters- draft RICaD** • Comments on draft RICaD to be emailed to APC secretary- see new action under 1015/06	All	27/08/15	Closed
0615/03	**Declaration of Interest** • Members to submit their annual declaration for 2015/16 to APC secretary	ALL	09/07/15	On-going
0615/06	**Matters arising- Action Table** • Once received from Dr North, send copy of draft Grazax RICaD to Col Wilson and Dr Huissoon, Immunology (HEFT) **Update:** Dr North has sent guideline for immunotherapy selection for use in grass allergen policy, rather than RICaD. Resend RICaD template to Dr North and relay comments from APC members See new action under 1015/06	IH	16/07/15	Closed
0615/14	**Stiripentol- transfer from BCH to UHB** • to be followed up in discussions with BCH	Chairs/AB/JH	TBC	Open