AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 8th June 2017
Venue – Birmingham Chamber of Commerce
75 Harborne Rd, Birmingham, B15 3DH

PRESENT:

Dr Paul Dudley	Birmingham CrossCity CCG (Chair)
Prof. Mark DasGupta	Birmingham CrossCity CCG
Alima Batchelor	Birmingham South Central CCG
Elizabeth Walker	Sandwell & West Birmingham CCG
Prof. Robin Ferner	Sandwell &West Birmingham Hospitals NHST
Dr Emma Suggett	UHB NHS FT
Katy Davies	HoE NHS FT
Carol Evans	HoE NHS FT/ Solihull CCG
Maureen Milligan	The ROH NHS FT
Dr Sangeeta Ambegaokar	Birmingham Women's & Children's Hospitals NHS FT
Melanie Dowden	Birmingham Community Healthcare NHS FT
Ravinder Kalkat	Midlands & Lancashire CSU
Isabelle Hipkiss	Midlands & Lancashire CSU
Jasprit Singh	Midlands & Lancashire CSU

IN ATTENDANCE:
No Attendees

No.	Item	Action

0617/01 Apologies for absence were received from:

- Prof Jamie Coleman, UHB NHS FT
- Inderjit Singh, UHB NHS FT, deputy attended
- Marian Smith, Sandwell & West Birmingham Hospitals NHST
- Kate Arnold, Solihull CCG
- Dr John Wilkinson, Solihull CCG
- Dr Lisa Brownell, BSMHFT
- Nigel Barnes, BSMHFT
- Dr Neil Bugg, Birmingham Women's & Children's NHS FT, deputy attended
- Jeff Aston, Birmingham Women's & Children's NHS FT
- Yusuf Asif, Birmingham Women's & Children's NHS FT
- Jonathan Horgan, MLCSU
- Satnaam Singh Nandra Birmingham CrossCity CCG
- Tania Carruthers HoE NHS FT, deputy attended
- Dr Tim Priest, HoE NHS FT
- David Harris, Birmingham Community Healthcare NHS FT, deputy attended
- Mary Johnson, South East Staffordshire & Seisdon Peninsula CCG

It was confirmed that the meeting was quorate.

0617/02 Items of business not on agenda (to be discussed under AOB)

- Dovobet® ointment
- Oral anticoagulants
- Decapeptyl SR (triptorelin)
- Ciprofloxacin Eye Ointment

0617/03 Declaration of Interest (DoI)

It was confirmed that there were no outstanding DoI forms to be received from members attending the meeting. Blank DoI forms were available at the meeting for new deputies to complete.

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

0617/04 Welcome and Introductions

The Chair welcomed everyone to the meeting today. Introductions around the table were carried out for the benefit of new deputies attending for the first time.

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.

0617/05 Pramipexole MR - Abbreviated application – Ethypharm UK Ltd.

It was established there were no Declarations of Interests for Ethypharm or from UHB NHS FT.

As this is an application for a new formulation of a drug already on the APC formulary, the requesting clinician is not expected to attend. The chair

therefore invited the APC secretary to summarise the abbreviated application form on behalf of Dr Saiju Jacob, Neurology Consultant and Clinical Service Lead, UHB NHS FT.

Pramipexole modified-release (MR) was not included in the original Trusts formularies considered during the harmonisation process and was therefore not included in the final joint formulary. The request to add the MR formulation has been made from an acute trust; the current ESCA doesn't cover the modified release preparation.

Pramipexole MR has been shown to be effective and well tolerated for the treatment of Parkinson's disease (PD), either alone or in combination with levodopa; non-inferiority to the immediate-release (IR) formulation has been shown when used alone and no clinically relevant differences in efficacy compared to the IR formulation have been shown in combination with levodopa.

The safety and efficacy of the branded version of pramipexole prolonged-release tablets (Mirapexin®) in the treatment of PD was evaluated in a multinational drug development program consisting of three randomised, controlled trials. Two trials were conducted in patients with early PD and one trial was conducted in patients with advanced PD.

The manufacturer suggests that the MR preparation offers the following advantages compared to the IR formulation:

- Improvements in patient compliance- a study concluded that in PD patients once-daily dosing is associated with significantly higher adherence than more frequent dosing; patients who were more adherent showed significantly better symptom scores.
- Less frequent fluctuations in the pramipexole plasma concentration over 24 hours leading to improved symptom control and fewer 'off' periods.

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

- Members commented that compliance is a relatively trivial argument with once daily preparation, when using alongside drugs such as co-careldopa and co-beneldopa which are all multiple daily doses.
- A question was raised on why was this only raised now and not during the harmonisation process?
- Feedback gathered from other local consultant neurologists during the consultation period was sent to the APC secretary and relayed to the members stating "*Long acting dopamine agonists are now widely accepted as preferable method of administration to address compliance issues, medication on time (i.e. patients may be reliant on carers as unable to get tablet themselves) and maintain 'on' time without motor fluctuations through avoid pulsatile nature of dopamine activity.*

  By having it on the hospital formulary can then replicate patients' drug regime, so avoid unnecessary confusion regarding drug regime in hospital and on discharge i.e. by keeping things the same, more likely to minimise complications and so minimise length of stay"

- A member suggested that monotherapy would be preferable however, as multiple dosing regimens are usually the norm with PD patients, there is little benefit.

- A member stated that the view of their Trust's DTC is that a once daily preparation is not needed, especially when this is significantly more expensive than the IR formulation.
- Patients may need to be converted from modified release to immediate release for varied reasons and doses are not equivalent making this complicated.
- It was noted that the modified release preparation of pramipexole is available within neighbouring trusts and CCGs but not currently within BSSE.
- A question was raised by a member who asked whether another MR dopamine agonist preparation was needed on the joint formulary when ropinirole MR is already included, and has a much lower acquisition cost than pramipexole MR. It was agreed that this is an option on the formulary if a once daily formulation is needed. Ropinirole immediate release is also within the formulary should this be needed.
- A cost-comparison table of pramipexole immediate release and modified release was included in the papers circulated prior to the meeting. The cost of MR in some cases is eight time more expensive than the IR preparation, and could result in as much as an extra £4,000 per patient per year at the maximum dose.
- A member questioned how many patients are currently using MR pramipexole; information from prescribing data analysis indicated that 28 prescriptions were issued within Birmingham CrossCity CCG in February 2017.
- The members were reminded that most PD medicines on the formulary are amber with an ESCA, therefore prescribing is initiated by a specialist only and primary care would not be starting pramipexole MR.
- A member reflected on the trial data which stated the two products were non-inferior drugs to each other so no difference in side effects and no recorded issues on withdrawal. The benefit of both drugs was deemed equal and no difference in clinical efficacy.
- Within the feedback provided for pramipexole, using a modified release preparation would prevent fluctuations in plasma drug state, however this was seen to be anecdotal and no corroborative evidence was available.
- The members agreed that the biggest issue would be its cost; the dilemma being whether it is acceptable to spend almost eight times the amount of an existing formulary drug based solely on improved compliance, with non-inferior efficacy.
- A member suggested that if pramipexole MR was not accepted onto the formulary then the formulary should specify that it is non-formulary (RAG status black). However the applicant would be informed that this decision applies to new prescribing only, and that patients already on this formulation would not be affected by this decision.

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

Patient Safety: Same side effect profile and interactions as the pramipexole immediate release (IR) formulation.

Clinical effectiveness: Non- inferior to IR formulation.

Strength of evidence: Reasonably strong: meta-analysis from 4 trials confirmed MR product was superior to placebo but no better (non-inferior) than its IR counterpart.

Cost-effectiveness or resource impact: Significantly more expensive than IR pramipexole. Pramipexole MR is available as branded Mirapexin® and a couple of branded generics (e.g. Pipexus®) but costs for both are still considerable compared to immediate release, and could result in an additional £2K-4K cost per patient per year compared to IR formulation.

Place of therapy relative to available treatments: Equivalent to IR, marginal benefit for improved compliance. Formulary status would remain amber as with the immediate release formulation. The initiation would be done within secondary or tertiary care.

National guidance and priorities: NICE guidelines are currently being reviewed and updated, but there has been some delay in publishing these. SMC has accepted for use in 2009, when only branded pramipexole IR and MR were available and costs were equivalent.

Local health priorities: CCGs are not supportive in view of high cost, concerns about prescribing creep and with no proven clinical benefit over current formulary option.

Equity of access: N/A

Stakeholder views: N/A

Implementation requirements: Would require ESCA if accepted, in line with current formulary options.

Decision Summary: NOT APPROVED. Rationale: Significant cost impact on health economy with no clinical benefit over current formulary options. There is already a modified–release dopamine agonist on the formulary which is considerably more cost-effective. This is in line with decision reached for opicapone in May 2017.

Actions:

- **Relay decision to clinician at UHB NHS FT.** **APC sec**
- **Annotate pramipexole MR as non-formulary (black)** **APC sec**

0617/06 APC relationship with Diabetologists - feedback from the Diabetes Network meeting

A small number of APC members (primary care and secondary care representatives) attended the Diabetes Network meeting in May 2017 to engage with the network and to receive feedback on their interaction with the APC following a number of applications being considered since its formation in 2014.

The network had two main issues to feedback.

1. The diabetes network felt it was cumbersome for them to be routing their applications through acute Trusts medicines management advisory groups (MMAG) prior to consideration at the APC and wanted to know whether an application can go directly to the APC rather than MMAG.
2. The diabetes network also felt their clinicians had a rough time when attending the APC to submit an application. They felt most issues were to do with the committee members' behaviour during their presentation; they

felt challenged and the behaviour of certain members was perceived as aggressive at times. One clinician stated that it had felt like an interrogation rather than a debate, which was not deemed conducive to good working relationships with the APC. They perceived some members' behaviour as rude as they were being constantly interrupted during their presentation.

The issues were discussed by the members and the chair.
It was accepted that all networks currently go through the DTC/MMAG within their respective trusts before bringing any application to the APC. Originally when the APC was set-up, the members were accepting requests without prior approval or discussion at DTC or MMAG. Individual trusts have since stated that they would want requests to be seen by the trust first rather than going straight to the APC.

The question was raised whether individual clinical networks which comprise of specialists from various Trusts and CCG representatives should be able to make new drug applications directly to the APC and bypassing Trusts' DTC or equivalent decision making bodies.

A member commented that networks are self-appointed bodies which represent the consensus view of that speciality. It was also confirmed that they are made up of NHS staff only, with no sponsorship from pharma industry and network members have to declare any interests.

It was commented that feedback and comments from DTC/MMAG was still useful prior to presenting at the APC. The final decision was to keep the method of approving new medicines at Trusts' DTC/MMAG before being considered at the APC as previously.

The second issue raised at the diabetes network meeting was around the perceived poor behaviour of some APC members.

A number of members stated that the APC process was not about making easy decisions or inviting a debate between applicants and the APC members. There is a case to be made when assessing new drugs and promoting safe, evidence-based and cost effective prescribing within the local community. The APC process is more a question and answer session in which the APC will ensure all aspects are covered. It is important to remember that the decisions made at the APC will influence resources for all healthcare of the BSSE patient population, not just the area of speciality of the applicants.

However it was recognised that this perceived negative image of the APC needed to be addressed.

Going forward, it was agreed that it was the role of the chair to intervene if members became rude or aggressive and to ensure lines are not crossed. The discreet use of a red card divider was suggested.

With regards to constant interruptions, it may be worth asking the applicant if they prefer questions during their presentation or at the end. It was acknowledged that there may be some passionate debate during a presentation and that the APC is seen to be interactive.

It was also reiterated that it was the role of the respective Trust's formulary team to prepare the clinician for the type of questions likely to be asked at the

APC.

It was suggested that when the APC secretary accepts a drug application for consideration at the APC, a template decision support tool (DST) is attached to the acknowledgment email to inform the applicant of the areas considered in reaching a decision.

It was also agreed that when informing the clinician of the outcome of their application, the applicant is provided with the relevant extract of the draft minutes from the meeting, in addition to the completed DST, to outline the discussions that took place and understand the rationale for the decision.

ACTIONS:

- **Chair to use a non-verbal intervention to halt perceived aggressive/ rude behaviour.** **Chair**
- **APC secretary to revise wording of acknowledgement/ acceptance email of drug application to outline process in more detail and attach template DST to inform clinician of criteria considered in reaching decision.** **APC sec**

0617/07 Regional Medicines Optimisation Committees (RMOCs)- update following webinar

A document outlining the feedback from an APC member who participated in the webinar on 11th May was circulated with the papers for the meeting. This was for information.

The RMOCs Operating model, published in April 2017, was also circulated. The document outlined the remit of the four regional RMOCs, which has changed to medicines optimisation rather than assessing new medicines. It has been confirmed that 2 clinical pharmacologists have expressed an interest in sitting on the RMOC panel.

The discussion then turned to whether a Patient and Public representative was still needed as part of the BSSE APC membership. It was agreed that a lay member was still required in view of the decision-making being left with the APC, and not the RMOCs as originally intended. It was suggested to contact chairs of CCGs' Patient Participation Groups who meet bimonthly for suggestions of potential interested parties.

ACTIONS:

- **Consider outputs from RMOCs as a standing agenda item for future meetings.** **APC sec**
- **Recruit new patient and public representative for APC** **APC sec**

0617/08 BSSE APC RICaD Loteprednol etabonate 0.5% eye drops

In June 2015 when BNF chapter 11 was harmonised, Mr Sai Kolli (Consultant ophthalmic surgeon, UHB NHS FT) requested that loteprednol etabonate 0.5% eye drops be included in the formulary as Amber RAG status as opposed to the APC's proposed Red status. The rationale was its niche use as it doesn't increase intraocular pressure as much as other steroid eye drops, and it is used long term in the community. The APC considered this to be an off-label use, and requested that a RICaD be written to support safe transfer of prescribing to GPs after initiation by specialists.

As a draft RICaD was not forthcoming from the Ophthalmology team, an APC member proactively wrote a draft document which was sent on numerous occasions to Ophthalmology specialists requesting their input into the specialist sections. No specialist feedback has been received to date; therefore the members have agreed to keep this agent as Red RAG status as originally decided, until they hear anymore from the ophthalmologists.

ACTION:

- **Change formulary entry for loteprednol etabonate 0.5% eye drops to Red, in the absence of a RICaD to support safe transfer of prescribing to primary care.** **APC sec**

0617/09 Draft consultation document outlining possible options for combined ESCAs for DMARDs

This agenda item is for information purposes only. The APC secretary circulated the consultation document outlining the options for an ESCA for DMARDs.

The secretary has already received positive feedback for consideration. An ophthalmologist has replied stating that they use methotrexate for inflammatory eye disease which is something which wasn't considered.

An inconsistency in the date for reply was highlighted by a member.
A comment was also made that another option should have been leaving the ESCAs in their current format.

ACTIONS:

- **Collate comments and feedback to report at July meeting** **APC sec**

0617/10 Minutes of Meeting held on Thursday 11th May 2017 – for Ratification

The minutes of the meeting held on Thursday 11th May 2017 were discussed for accuracy.

Page 7, third paragraph: Under APC relationship with diabetologists/Clinical network, change the sentence to read "it was perceived as challenging, bordering on rude" instead of "unprofessional" as this could be misinterpreted.

Page 12: Change PhD to DPharm when referring to Dr Emma Suggett's change in title.

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 DST for opicapone (Ongentys®) was also approved for uploading to the APC website.

0617/11 Matters arising- Action Table

The Chair moved onto the action table for comments and updates:
(See separate document attachment for updated version). Consider actions closed if not discussed.

0517/11 HIV-treatment-boosting agents and steroids- MHRA Drug Safety Alert- Update: the APC secretary circulated the response from HoEFT GUM clinic with regards to any counselling given to HIV patients. Patients are not individually counselled regarding this particular potential interaction with steroids. However these patients have regular contacts with pharmacists in the HIV service and the potential for drug interactions is highlighted to all patients when they first start ARVs, and reiterated regularly when seen in clinic. Unfortunately they cannot mitigate these risks if patients do not want to disclose their diagnosis to their GPs. UHB representative stated that this was also the approach of their GUM/HIV clinics.

0117/05 Urinary incontinence appliances review- Provide usage figures in 6 months' time (i.e. June 2017)
Update: it was unclear which organisation was to provide these usage figures, and what purpose these would serve. It was agreed to check the minutes of the January 2017 meeting to clarify the rationale for this action.
ACTION: Check minutes of January 17 meeting for rationale for incontinence appliances usage figures and feedback at next meeting. **APC sec**

1216/11 Enstilar cutaneous foam, feedback from dermatologists regarding removal of Dovobet® ointment from 1st June 2017. Update: this will be discussed under AOB

1016/06 New Drug application - Budesonide MMX (Cortiment®), UHB clinicians to present evidence on admission avoidance in form of case reports to APC in November 2017. Cohort of patients to include those with previous admissions for IV steroids. Update: UHB will keep prescribing of budesonide MMX within their trust for now to collate further data. This will be brought to APC later in the year, but may not be ready for November 2017.

0617/12 NICE Technological Appraisals

There were 2 NICE Technology Appraisals published in May 2017; one is commissioned by CCGs (see below TA445) and the other one was terminated (TA444).

- Certolizumab pegol and secukinumab for treating active psoriatic arthritis after inadequate response to DMARDs (TA445): Technology commissioned by CCGs, providers are secondary care and community care. RED status agreed.

ACTION:

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

Any other business:

1. Dovobet® ointment

Back in November 2016, when Enstilar® foam preparation was accepted on the formulary, it was agreed to automatically remove Dovobet® ointment after a period of 6 months to allow clinical experience with the new foam formulation unless feedback from dermatologists to oppose this. However it has since been argued that the ointment is advantageous for difficult to reach areas, such as the back, and that there are some supply issues with Enstilar® at the moment.
Currently Dovobet® gel is mainly used for the scalp and Dovobet® ointment is primarily recommended for the trunk and limbs. A price comparison confirms

that Dovobet® gel, ointment and Enstilar® foam are all priced similarly. Therefore members have agreed to keep all three products on the formulary. However it was stated that if the pricing changes (i.e. generic alternative available) then it will be reviewed again.

ACTION:

- **Leave Dovobet® ointment on APC formulary following feedback** **APC sec**

2. Oral Anticoagulants

When the Direct Oral Anticoagulants (DOACs) were harmonised on the formulary, there was a discussion with regards to APC preferred agents with input from Trusts' haematologists. Apixaban and rivaroxaban were subsequently annotated as APC preferred agents with the note, "this recommendation must only be taken into account after a patient and prescriber have discussed all treatment options and only if they have no preference about which medicine they want to use."

However it was pointed out that warfarin wasn't really discussed in this context. Although DOACs are NICE approved and licensed for most conditions, there is still a criteria for warfarin and it was believed that it should be mentioned at the start of the anticoagulants in the formulary, and not having to scroll down to the bottom of the list to find its entry.

A unanimous decision was taken to include warfarin as an APC preferred agent and to amend the note for DOACs to read "***APC preferred agent**: this recommendation must only be taken into account **after** a patient and prescriber have discussed **all** treatment options (including warfarin) and **only** if they have **no** preference about which medicine they want to use.*

ACTION:

- **Move warfarin to top of oral anticoagulant section (2.08.02) and annotate as APC preferred agent, in line with apixaban and rivaroxaban.** **APC sec**
- **Amend note for apixaban and rivaroxaban to read "APC preferred agent: this recommendation must only be taken into account after a patient and prescriber have discussed all treatment options (including warfarin) and only if they have no preference about which medicine they want to use."** **APC sec**

3. Decapeptyl® SR

In January 2017 Decapeptyl® SR was accepted for inclusion in the APC formulary. When completing the decision support tool, the members became concerned about needle safety device, stating there was nothing available for this agent. The information used at that time was a PrescQIPP® comparison table for LHRH agonists from April 2015. In November 2016 the company Ipsen Ltd stated they have updated the device to have needle safety included and requested that this information to be corrected on the DST.

4. Ciprofloxacin Eye Ointment

For information purposes only, ciprofloxacin 0.3% w/v eye ointment (Ciloxan®) has been discontinued in May 2017. Only ciprofloxacin 0.3% eye drops formulation is available for ocular use.

ACTION:

- **Remove ciprofloxacin 0.3% eye ointment from formulary, annotate as** **APC sec**

discontinued.

The Chair thanked the members for their input today. The meeting closed at 16:00 pm.

The chair reminded members that the July meeting would be in the same venue as today's meeting. As there is no APC meeting booked for August, the chair suggested having a Developmental Meeting instead.

Date of next meeting: Thursday 13th July 2017 14:00 – 16:45
Birmingham Chamber of Commerce
75 Harborne Rd, Birmingham, B15 3DH