AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 14th December 2017
Venue – Birmingham Research Park
Vincent Drive, Birmingham, B15 2SQ

PRESENT:

Dr Lisa Brownell	BSMHFT (Chair)
Dr Paul Dudley	Birmingham CrossCity CCG
Prof Mark DasGupta	Birmingham CrossCity CCG
Satnaam Singh Nandra	Birmingham CrossCity CCG
Dr Gwyn Harris	Sandwell & West Birmingham CCG
Tania Carruthers	HoE NHS FT
Dr C. Kartsios	HoE NHS FT
Carol Evans	HoE NHS FT
Melanie Dowden	Birmingham Community Healthcare NHS FT
Prof Jamie Coleman	UHB NHS FT
Dr Emma Suggett	UHB NHS FT
Dr Sangeeta Ambegaokar	Birmingham Women's & Children's NHS FT
Jeff Aston	Birmingham Women's & Children's NHS FT
Nigel Barnes	BSMHFT
Maureen Milligan	The ROH NHS FT
Ravinder Kalkat	Midlands & Lancashire CSU
Isabelle Hipkiss	Midlands & Lancashire CSU
Kuldip Soora	Midlands & Lancashire CSU

IN ATTENDANCE:

Prof Tariq Iqbal for item 1217/05	UHB NHS FT
Prof Rajat Gupta for item 1217/06	Birmingham Women's & Children's NHS FT

No.	Item	Action

1217/01 Apologies for absence were received from:

Elizabeth Walker, Sandwell & West Birmingham CCG
Kate Arnold, Solihull CCG
Mary Johnson SES&S Peninsula CCG
Dr Neil Bugg, Birmingham Women's & Children's NHS FT
Inderjit Singh, UHB NHS FT, deputy attended
Yusuf Asif, Birmingham Women's & Children's NHS FT

It was confirmed that the meeting was quorate.

1217/02 Items of business not on agenda (to be discussed under AOB)

- Discontinuation of Accolate® (zafirlukast) 20mg tablets

1217/03 Declaration of Interest (DoI)

There are no outstanding annual declarations of interest from members and there were no interests to declare relating to items on the agenda.

1217/04 Welcome and Introductions

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

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.

1217/05 Feraccru® capsules- new drug application- Shield TX (UK) Limited

It was established that there were no Declarations of Interests for Shield TX.

The Chair welcomed Professor Tariq Iqbal, Gastroenterology Consultant, UHB NHS FT, to the meeting and invited him to present the application for Feraccru®.

Professor Iqbal began by stating that this was a specific request for treating anaemia in inflammatory bowel disease (IBD) only. In IBD, iron deficiency anaemia (IDA) occurs in 30-70% of patients and this used to be overlooked, until the introduction of intravenous (IV) iron preparations such as Ferinject®. Prof Iqbal chaired the European committee on the treatment of IDA in IBD in 2015 at which time it was recommended that, whilst oral iron preparations are still useful, IV iron should be used first line in patients with IBD. In direct comparison RCTs when IV iron has been compared with iron tablets, they have been shown to be equally effective. However, Prof Iqbal went on to say that in real life, patients with IBD are sensitive to iron ingestion and many patients do not tolerate oral ferrous products as their use can be associated with gastrointestinal side effects such as stomach ache and diarrhoea IBD flare up. This can result in reduced patient compliance with therapy or no improvement in iron deficiency anaemia after long term treatment.

Prof. Iqbal's clinic is very busy with 3 to 4 patients a week requiring IV iron; there is currently a six week wait for IV iron.
He also highlighted that administration of IV iron incurs significant costs to the

health economy for day case attendance.

Current formulations of oral iron, e.g. ferrous sulfate, contain a large quantity of elemental iron (65mg in a 200mg tablet) but the gut can only absorb up to 10mg per day after it has been oxidised and bound to molecules in the gut, reducing its bioavailability.

Feraccru® is a novel formulation of oral iron, with 30mg of elemental iron as ferric maltol, and a much lower dose is required. The iron in Feraccru® is complexed with an ester and held in a ferric formulation, therefore being directly available to the duodenum.

Prof Iqbal summarised a Phase III trial which included IBD patients (patients with Crohn's or ulcerative colitis) with iron deficiency that were intolerant of oral iron tablets. The primary end point was a change in haemoglobin (Hb) concentration from baseline to week 12. Statistically significant improvements in Hb were observed in the treatment group (ferric maltol) of 20 grams/litre after 12 weeks compared to placebo. The trial also showed that Feraccru® was largely well tolerated and that the side effect profile was also the same as the placebo group.

There was also a Phase III Open label extension of the original 12-week trial program for up to a year and the iron parameters in the treatment group remained unchanged for up to a year.

There are still some unanswered questions about this treatment; the patients in the trial had mild colitis and mild degree of anaemia but it is not known if similar results would be seen in severe systemic inflammation as it is thought that iron is not absorbed in such cases.

Feraccru® is a 12 week treatment course which would be useful if available for patients who cannot tolerate oral ferrous sulfate. In addition, some IBS patients will ask for IV iron as they won't consider taking oral iron tablets due to previous experience.

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

- A member asked if there was potential for this drug to be used pre operatively in patients with anaemia. Prof Iqbal stated that he has been involved in two pre-op studies and was involved in the pre-op guidelines. He believed there may be potential for its use but that standard iron tablets should work well in these patients as they do not have IBD.
- A member asked if Feraccru® was more expensive than ferrous sulfate or IV iron. Prof Iqbal stated that, at £142.80 per treatment course, Feraccru® is much more expensive than ferrous sulfate but comparable to 1000mg IV iron for drug cost. However considering overall cost in terms of day case attendance for administering IV iron, Feraccru® is a cost-effective alternative to IV iron.
- A member raised the concern that Feraccru® could not be used by certain religious groups as it contains gelatin. Prof Iqbal agreed that as a hard gelatin capsule, you would not be able to use it in this patient cohort.
- A member asked if Prof Iqbal could clarify the proposed treatment algorithm for IDA and what would happen once the patient has had 12 week course of Feraccru®. Prof Iqbal stated that the patient would then have a blood test after 6 months or at the patient's next follow up appointment. This is because it is not severe anaemia that is being

treated. A member asked how then, would the clinician know the treatment has been successful if this was the case. Prof Iqbal stated that the trials show that the treatment works. A member raised concern about what would happen if there was treatment failure; Prof Iqbal stated that IV iron would possibly need to be given however, only mild-moderate anaemia patients are being treated.

- A member highlighted that this treatment option would be cheaper to the health economy compared to IV iron. There was initially some concern about creep but members were reassured now that the patient group/ licensing is clearly defined.
- A member stated that a Green RAG rating would cause them concern due to the product being very expensive. GPs would not necessarily refer IBD patients that are in between clinic visits with anaemia back to secondary care to which Prof Iqbal commented that Ferinject® was administered in Primary Care in Europe. He would recommend an Amber rating as these patients would have a follow up clinic appointment.
- A member thought that Amber with a RICaD would be more appropriate.

The Chair thanked Prof Iqbal for attending the meeting, for answering all the questions from the APC members and advised him that the decision would be relayed within 5 working days, in line with APC policy.

Further discussion points in the absence of the specialist included:

- A member stated that the clinician had made a case for the therapeutic and clinical use and that a valid hypothesis for offsetting costs of IV iron had been presented. However the member questioned the need to involve primary care if the treatment course is only 3 months.
- A member commented that, if Feraccru® was not available in Primary care, it would negate the cost advantages and make it inconvenient for patients to access this treatment if only available from secondary care.
- A member was still unsure of the benefits of GP prescribing when blood tests are not required after a month for ongoing treatment. It would be more efficient for the specialist to prescribe the 3 month-course and for an alternative payment flow to be set up to reimburse the hospital. It was suggested that adding Feraccru® to the PbR exclusion list would be an option to look into, but this involved finance departments.
- There is still a question whether any monitoring is required at end of three month period as GPs would normally monitor Hb after a course of oral iron to establish if the anaemia has been corrected.
- A member commented that IDA is a recurring issue in IBD patients and that the specialist would only pick this up in between follow-up appointments if there was a problem with their disease.

<u>The Chair directed the members to the Decision Support Tool for completion</u>:

<u>Patient Safety</u>: Better tolerated than ferrous sulfate. Side effect profile is comparable to placebo. Black triangle drug so additional monitoring is required and all suspected adverse effects need to be reported to MHRA.

<u>Clinical effectiveness</u>: RCT evidence of effectiveness and licensed product on basis of a phase III trial.

<u>Strength of evidence</u>: Reasonable for cohort of patient identified: IBD patients with mild-moderate anaemia.

Cost-effectiveness or resource impact: More expensive than other oral iron formulations but cost neutral compared to intravenous (IV) iron. Would avoid associated NHS costs with IV iron.

Place of therapy relative to available treatments: As per presented algorithm.

National guidance and priorities: European guidance for treating iron deficiency anaemia in IBD patients, referenced within the application.

Local health priorities: CCGs unsure of benefit in involving primary care for a 3 month treatment course with no monitoring required to establish treatment effectiveness. Also concerned about creep.

Equity of access: Contains gelatin and may therefore prevent access for certain ethnic groups.

Stakeholder views: N/A

Implementation requirements: Some documentation would be needed, but an ESCA is not appropriate for this agent. A RICaD would be more useful.

Decision Summary: The committee agrees that this treatment option is required for the cohort of patients identified within the application (IBD patients with mild-moderate anaemia, unable to tolerate other oral iron formulations) and that it should be initiated in Secondary Care. The debate is whether the specialist prescribes the full 3-month course (this would require a reimbursement process to be agreed and set up) or whether the specialist provides the first month and GP prescribes the remaining 2 months. It was agreed to default to AMBER with RICaD.

ACTIONS:

- **Relay decision to Prof T. Iqbal by Thursday 21st December 2017.** **APC sec**
- **Add Feraccru® to APC formulary as Amber with RICaD (in development).** **APC sec**

1217/06 Sialanar® (glycopyrronium bromide) oral solution. - new drug application – Proveca Limited

It was established that there were no Declarations of Interests for Proveca Limited.

The Chair welcomed Professor Rajat Gupta, Consultant Paediatric Neurologist, Birmingham Women's and Children's NHS FT, to the meeting and invited him to present the application for Sialanar®.

Prof Gupta began by stating that as a paediatric neurologist, he sees a lot of patients with disabilities; they often have bulbar problems which cause difficulties with swallowing of oropharyngeal secretions. This increases the risk of aspiration and can lead to chest infections, but also causes a lot of discomfort.
These patients are already on treatments to reduce the amount of drooling: hyoscine patches are usually used first line, then glycopyrronium if they don't work. The glycopyrronium formulation currently used is an unlicensed preparation; therefore having Sialanar® available on the formulary would support the MHRA recommendation to use a licensed preparation if available.
Prof Gupta does not foresee an increase in prescribing of this medication;

Sialanar® will replace existing prescriptions for the unlicensed product. Children who will be starting on glycopyrronium will be initiated on Sialanar® if it is available on the formulary.

Prof Gupta acknowledged that there are potential risks and side effects with this drug but in his experience, these occur early on in treatment and the drug will be discontinued if this happens. The main side effect is secretions may become too thick and difficult for the child to clear themselves or for oropharyngeal suctioning to clear the airways.

The Chair invited questions or comments from members. Discussion points/concerns raised included:

- A member stated that the cohort of patients in the trials had cerebral palsy. Has this been tried in other neurological conditions? Prof Gupta agreed that most of his patients have cerebral palsy but he also has patients with undiagnosed global developmental delay and these often have some bulbar problems; children with low tone or some form of atrophy but the majority of his patients have developmental problems of some description.
- There may be potential off-licence use of the product; some studies have been carried out in patients with reflex anoxic seizures for example, but this is uncommon.
- A member asked Prof Gupta if he finds hyoscine patches to be effective or if he has to resort to glycopyrronium frequently. Prof Gupta stated that most of his patients, and those in the community, are on hyoscine patches; only patients who don't respond to these or have too great an effect on hyoscine patches will go onto glycopyrronium.
- A member questioned if there is likely to be a lot of adolescent patients on this treatment. Prof Gupta stated that he doesn't anticipate it to be newly prescribed in adolescents but for older children who may still be on glycopyrronium into adolescence.
- A member asked if it is likely to be used in adult patients; i.e. when these patients transition into adult care, and whether there are adults already on glycopyrronium. Prof Gupta stated that these bulbar problems are usually long standing, so they are likely to need this treatment into adulthood. However, these patients are regularly reviewed and the treatment will be stopped if no longer required and he does not anticipate an increase in prescribing.
- A member commented that treatment of sialorrhoea, together with saliva substitute, may also be considered when reviewing the dental formulary. However a dental hospital specialist has confirmed that they would not prescribe Sialanar®.
- Prof Gupta was asked about the use of Botox® injections into the salivary glands as a treatment option for severe sialorrhoea. Prof Gupta commented that the effects of Botox® are transient and it would need to be repeated every 2 to 3 months; the effectiveness of Botox® is also in doubt as only 50% of patients get any benefit from it. Botox® is not routinely used at the Children's Hospital.
- It was confirmed that Sialanar® is not licensed in adults; older children and adults with a reasonable swallow can remain on the tablet preparation.
- Glycopyrronium is on the APC formulary but only in the Dermatology chapter; unlicensed and specialist initiation for hyperhidrosis. It is also in the Respiratory chapter (Seebri® breezhaler).
- A member asked Prof Gupta if GPs would be prepared to take on the prescribing responsibility for this agent as these patients tend to be on polypharmacy such as antispasticity agents and antiepileptics. Prof Gupta explained that it depends on the medication but for glycopyrronium, he

believes most GPs do pick up ongoing prescribing as he doesn't get many requests for repeat prescriptions. However he is concerned that some GPs decline to prescribe any of the child's medication and he may be asked to prescribe drugs that he has not initiated himself. Having a licensed preparation for glycopyrronium on the formulary should reassure GPs about prescribing it.

- A member commented that the tablets cost over £1000 per month.
- A member asked about proposed RAG rating. Prof Gupta commented that Amber is appropriate as children would need regular monitoring, particularly on initiation, and dose adjustment may be necessary. Prof Gupta usually outlines a plan with the child's carer on how to adjust doses depending on side effects. Specialist initiation would be required; antimuscarinic side effects such as urinary retention or constipation don't tend to be seen at the low doses used in these children (1mg/day to 2mg/day).
- A member sought clarification on the length of time required for the dose to be stabilised; Prof Gupta confirmed that this can be done within 2 weeks. The first prescription supplied by the hospital pharmacy is for 2 weeks or a month, depending on the Specialist's request.

The Chair thanked Prof Gupta for attending the meeting, for answering all the questions from the APC members and advised him that the decision would be relayed within 5 working days, in line with APC policy.

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

Patient Safety: Significant side effect profile outlined within the application. Respiratory side effects (thickening of oral secretions) acknowledged during presentation. Anticholinergic side effects considered to be minimal at doses used. However, as a licensed product with known bioavailability profile, Sialanar® will be safer than unlicensed specials. Licensed for use with PEG, nasogastric and G tubes.

Clinical effectiveness: Established therapy for sialorrhoea.

Strength of evidence: Strong, RCTs vs placebo.

Cost-effectiveness or resource impact: Expensive but more cost-effective than current unlicensed products.

Place of therapy relative to available treatments: Second line to hyoscine patches.

National guidance and priorities: NICE evidence summary (ES5, Feb 2017). NICE guideline NG62 (Jan 2017) - Cerebral palsy in under 25s: assessment and management, includes glycopyrronium bromide (oral or by enteral tube) as an option for anticholinergic medication to reduce severity of drooling.

Local health priorities: This treatment is for a well-known condition in small cohort of very poorly patients.

Equity of access: N/A

Stakeholder views: N/A

Implementation requirements: None, RICaD not deemed necessary.

Decision Summary: Approved: Amber with Specialist initiation and stabilisation.

ACTIONS:

- **Relay decision to Prof Gupta by 21st December.** **APC sec**
- **Add Sialanar® to the APC formulary as Amber, specialist initiation and stabilisation.** **APC sec**

1217/07 Invicorp® injection (Aviptadil 25 micrograms / Phentolamine 2 mg) – new drug application – Evolan Pharma AB

It was established that there were no Declarations of Interests for Evolan Pharma AB.

The APC secretary explained that Prof. G Hackett, Consultant Urologist, HoE NHS FT, declined to attend to present the application for Invicorp®. He has already attended the All Wales Medicines Strategy Group and the Scottish Medicines Consortium to present this application. He has however been made aware that should the outcome be unfavourable, he would not be able to lodge an appeal against the decision because he did not attend to support the application, as outlined in the revised APC policy.

Prof Hackett had provided a summary of the application which the APC secretary read out:

- Good Hope hospital has provided this drug for seven years on a named patient basis to about 550 patients.
- Invicorp® will be useful to patients with diabetes or prostate cancer.
- It is the same cost as alprostadil intracavernosal injection so Prof Hackett does not anticipate any new demand.
- There are currently supply issues with alprostadil injection which the APC secretary has confirmed with the manufacturers. The 10microgram vial is out of stock until mid-February 2018. The dual chamber 20 microgram is out of stock until the end of February 2018. Supply of the 20 and 40 microgram vials and the dual chamber 10microgram is not affected.
- Alprostadil injection causes pain. It is a prostaglandin which is a pain mediator. Patients experience a lot of pain on intracavernosal injection of alprostadil.
- The trials have shown equal efficacy (i.e. non-inferiority). The patient selection would have favoured alprostadil as patients with previous use of alprostadil would have only gone through if they had tolerated or responded to alprostadil.
- Prof. Hackett believes Vitaros® (alprostadil cream) is only useful in penile implants.
- MUSE® urethral stick is slightly more useful than Vitaros®. The APC secretary mentioned that MUSE® is not on the formulary.

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

- The secretary explained that All Wales Medicines Strategy Group has accepted the product with restriction: that it is used for patients with erectile dysfunction who have not responded to oral PDE5 inhibitor therapy. Invicorp® is licensed for the symptomatic treatment of erectile

dysfunction in adult males due to neurogenic, vasculogenic, psychogenic, or mixed aetiology.

- A member asked if the APC should take the "one-on, one-off" approach which the APC secretary said had been mentioned to Prof Hackett.
- SMC have also recently approved it. SMC's assessment was published on 11th December. The APC secretary read aloud the SMC statement on Invicorp®: "In an open label crossover study of men with non-psychogenic erectile dysfunction, aviptadil / phentolamine injection was compared with a prostaglandin-based intracavernosal injection. Patients who achieved an erection suitable for sexual intercourse (grade 3) from both treatments were entered into a comparative phase in which similar proportions of injections of each treatment resulted in grade 3 erections. Aviptadil / phentolamine injection was associated with lower incidence of moderate to severe adverse events and pain when compared with the prostaglandin injection".
- A member stated that they were concerned about primary care input. Most patients do not want to consider injectable options. Does the APC formulary need to expand the repertoire to include a second injectable option and wouldn't a one-off one-on approach be more suitable?
- LMMG summary from July 2017 states that alprostadil injection requires a minimum of 3 attendances for titration of dose.
- Dr Hackett has outlined within the application where he sees Invicorp®'s place in therapy: 2nd line when PDE5 inhibitors have failed or when they are contraindicated as per the British Society for Sexual Medicine (BSSM) guidance. The properties of Invicorp® will be discussed with the patient. As alprostadil has been established for over 22 years it will generally be the first option but if pain is a major issue for the patient then Invicorp® might be the first choice. If veno-occlusive ED has been demonstrated previously then Invicorp® might be a more logical option due to the effect of vasoactive intestinal polypeptide (VIP) on the veno-occlusive mechanism.
- The Clinical Director for Urology at HoE FT supports the application.
- It was pointed out that the patent for Caverject® is due to expire.
- LMMG came to the conclusion that it is suitable for prescribing in primary care following recommendation or initiation by a specialist; it should be reserved to patients who are not responding or intolerant to alprostadil as an option before referral for surgical procedure.
- It was pointed out that the product had been available for Good Hope patients for seven years but this was a number of years ago. It has not been recently available at Good Hope.

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

Patient Safety: Similar to alprostadil, claims of less painful injection but evidence provided questionable.

Clinical effectiveness: non-inferior to alprostadil

Strength of evidence: weak comparative evidence against intracavernosal injection.

Cost-effectiveness or resource impact: currently cost neutral vs alprostadil injection but ongoing supply issues with alprostadil.

Place of therapy relative to available treatments: 3rd line after PDE5 inhibitors and alprostadil.

National guidance and priorities: British Society for Sexual Medicine (BSSM) guidelines 2008

Local health priorities: CCGs would support

Equity of access: N/A

Stakeholder views: N/A

Implementation requirements: N/A

Decision Summary: AMBER, Specialist initiation. 3rd line after oral PDE5 inhibitors failed and patient not responding to or intolerant of alprostadil. To be reviewed within 12 months to assess alprostadil injection supply issues and patent expiry. Rationale: supply issues and awaiting the BSSM guidelines.

ACTIONS:

- **Relay decision to Prof Hackett by 21st December.** **APC sec**
- **Add to the APC formulary as Amber, specialist initiation, 3rd line after oral PDE5 inhibitors failure and patient not responding to or intolerant of alprostadil** **APC sec**
- **Request a separate Declaration of Interest form to be filled out by Prof Hackett.** **APC sec**

1217/08 FreeStyle® Libre® Flash Glucose Monitoring system

A verbal update was given by APC representative after attending DMMAG meeting on 30th November regarding FreeStyle® Libre®. The finalised DMMAG recommendation will come to APC in January 2018.

ACTION:

- **Add DMMAG recommendation on FreeStyle® Libre® to APC's agenda for January 2018 meeting.** **APC sec**

1217/09 NOAC RICaDs – For discussion/review

- In the last meeting, it was raised that GPs have been concerned that NOACs may have been initiated in secondary care at creatinine clearance levels that may not have been appropriate. It was agreed that the NOAC RICaD needed reviewing and bought back to the APC.
- NOAC RICaDs are in need of review to ensure that they are fit for purpose and some of the information in them has now changed (e.g. availability of antidotes).
- A member raised the question if RICaDs were still needed as they are so commonly used.
- A member shared a two page document used at HEFT. It includes a section for the HASBLED and CHA_2DS_2-VASC score to be recorded. It does not go into the SPC as extensively as the current RICaDs.
- It was raised that an audit had been done in Birmingham patients and it was found that HASBLED and CHA_2DS_2-VASC scores are not recorded in many of these patients' notes and this creates a medico-legal problem. There is therefore some nervousness about taking on the prescribing of anticoagulant therapy.
- It was raised that more information may be needed in the follow up section

to support GPs with this.
- It was raised that there may be more decline to prescribe from primary care if RICaDs for the NOACs are removed.
- The potential for a merged NOAC RICaD similar to the HEFT document was discussed.

ACTIONS

- **Circulate the 2 page document produced by HEFT with the APC draft minutes.** **APC sec**

1217/10 Minutes of the meeting held on Thursday 9th November 2017 – for ratification

The minutes of the meeting held on Thursday 9th November 2017 were discussed for accuracy.
No comments were made. It was confirmed that the minutes are approved, can be uploaded to the APC website and the recording deleted.

1217/11 Matters Arising

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

The outstanding actions include:

- 1117/05 – Opicapone NDA- PD Specialist to develop ESCA. Update: a draft ESCA has been circulated for consultation; closing date was 20th December. A couple of supportive comments have been received from HoE FT clinicians, but no suggestions to change anything. It was agreed to finalise and publish the ESCA for opicapone.
  ACTION: Finalise and publish ESCA for opicapone **APC sec**

- 1017/07 - Pan-Birmingham Respiratory Clinical Network Asthma Guidelines. Once finalised, upload the guidelines and supporting appendices to the APC website. Update: Still waiting for updated guidelines from Respiratory Network. APC secretary is also aware that NICE have recently reviewed their Asthma Guideline, so the RCN may need to further review these in line with NICE.

- 1017/13 – Matters arising- Write to the Mental Health Commissioners outlining the APC discussions to date and frustrations at the delay in resolving the historical commissioning arrangements for ADHD and dementia services. Update: The letter has been approved by both chairs, is ready to be sent, and just needs contact details for MH Commissioners. It was agreed to copy in Paul Jennings, Interim Chief Executive, NHS Birmingham and Solihull CCGs.

- 0917/16 - NICE Technology Appraisals - Draft a RICaD for eluxadoline for IBS with diarrhoea. Update: Draft document has been circulated for consultation, closing date 20th December 2017. No comments received. In view of the NICE TA being published at the end of August 2017 and the 3 month period allowed to implement, it was agreed to finalise the document and publish.
  ACTION: Finalise and publish RICaD for eluxadoline **APC sec**

- 0717/07 – ESCAs for ADHD- Make agreed changes to atomoxetine and dexamfetamine documents**.** Update: These are now finalised and published. The APC secretary is aware that the ESCA for methylphenidate needed further discussion. The MH representatives thought this has been resolved.
  ACTION: Circulate draft methylphenidate ESCA for consultation. **APC sec**

- 1216/11 – Matters arising- enoxaparin- Trust representatives to go back to their respective departments and relay comments from APC regarding need for business cases. A member sought clarification on the rationale for the need to develop a business case. The chair summarised the previous discussions and the APC's views on clinical grounds. However, in order for the current funding flows to be reviewed, business cases from the Trusts' contract teams need to be brought to the commissioners for consideration and prioritisation. ONGOING.

1217/12 NICE Technological Appraisals (TAs)

In November 2017, there were 9 TAs published; of these, 6 are NHSE commissioned, 2 are CCG commissioned and 1 not recommended. See below.

- Sarilumab for moderate to severe rheumatoid arthritis (TA485): This technology is commissioned by clinical commissioning groups. Providers are NHS hospital trusts. Red status agreed.
- Aflibercept for treating choroidal neovascularisation (TA486): This technology is commissioned by clinical commissioning groups. Providers are NHS hospital trusts. Red status agreed.

ACTION: Update APC formulary with decisions on NICE TAs. **APC sec**

Any other business:

1. AstraZeneca are discontinuing Accolate® (Zafirlukast) on 31st March 2018.

ACTION: Annotate the formulary entry regarding discontinuation. **APC sec**

2. **Prof Ferner stepping down from APC committee**
   Although Professor Ferner was verbally thanked for his valuable contribution to the APC committee since its inception in 2014, it was felt appropriate that a letter from the joint chairs be sent to express this more formally.

   ACTION: Write a letter of thanks to Prof Ferner on behalf of Joint Chair and committee members. **APC sec/Joint chairs**

The Chair thanked the members for their input today. The meeting closed at 16:45.
Date of next meeting: Thursday 11th January 2018 14:00 – 16:45
Birmingham Research Park.