AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 10th January 2019
Venue – Birmingham Research Park
Vincent Drive, Birmingham, B15 2SQ

PRESENT:

Dr Lisa Brownell	BSMHFT
Dr Paul Dudley	Birmingham and Solihull CCG
Prof Mark DasGupta	Birmingham and Solihull CCG
Dr John Wilkinson	Birmingham and Solihull CCG
Dr Nashat Qamar	Birmingham and Solihull CCG
Liz Thomas	Birmingham and Solihull CCG
Carol Evans	Birmingham and Solihull CCG/UHB NHS FT
Dr Sonul Bathla	Sandwell & West Birmingham CCG
Satnaam Singh Naandra	Sandwell & West Birmingham CCG
Dr Angus Mackenzie	Sandwell & West Birmingham Hospitals NHS FT
Prof Jamie Coleman	UHB NHS FT
Dr Mark Pucci	UHB NHS FT
Katy Davies	UHB NHS FT
Alison Tennant	Birmingham Women's & Children's NHS FT
Dr Neil Bugg	Birmingham Women's & Children's NHS FT
Dr Sangeeta Ambegaokar	Forward Thinking Birmingham Partnership
Kalpesh Thakrar	Birmingham Community Healthcare NHS FT
Ravinder Kalkat	Midlands & Lancashire CSU
Kuldip Soora	Midlands & Lancashire CSU
Daya Singh	Midlands & Lancashire CSU

IN ATTENDANCE:

Rajashree Patel (Observer)	Sandwell and West Birmingham CCG

No.	Item	Action

0119/01 Apologies for absence were received from:

Inderjit Singh, UHB NHS FT
Gurjit Kudhail, UHB NHS FT
Nilima Rahman-Lais, Birmingham and Solihull CCG
Dr Dhiraj Tripathi, UHB NHS FT

It was confirmed that the meeting was quorate.

0119/02 Items of business not on agenda (to be discussed under AOB)

- Fiasp® supporting document
- NHS England consultation on items that should not be routinely prescribed in primary care
- Updated guidance on planning for a no-deal Brexit
- Primary Care Clinical Pathway for Atrial Fibrillation Detection and Management - response received from AHSN
- Sodium hyaluronate
- Ketorolac eye drop supply issues
- Naproxen tablets (all strengths) supply issues

0119/03 Declaration of Interest (DoI)

There are some outstanding annual declarations of interest and members were reminded to submit these at the earliest opportunity. There were no interests to declare relating to items on the agenda.

0119/04 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.

0119/05 Tapentadol prolonged-release (Palexia SR®) applicant feedback

It was established that there were no Declarations of Interests for Grunenthal Ltd.

An application for tapentadol prolonged release tablets (Palexia SR®) was considered during the May 2018 APC meeting. The committee decided to retain the RAG status of RED. The chair directed members to the applicant's responses to the minutes of the May 2018 meeting.

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

- A member felt that allowing another preparation with serotonergic and opioid properties prescribable in primary care would be a concern. The member disagreed a licensed ceiling dose would prevent excessive doses being prescribed as doses are often exceeded in pain management if the clinician believes there is a dose response curve. The member has considered the comments however they have not

changed their view.

- A member raised that the evidence discussed in May meeting was anecdotal evidence which was not robust. There is no new evidence shown since the original application. The applicant's reasons for changing the RAG status from RED to AMBER seem to be due to operational issues; i.e. Palexia® is not available at the hospital Trust. This is a matter of funding which should be raised with commissioners.
- Primary care members felt there is limited benefit for shared care agreement with Palexia® and predicted there would be some resistance from primary care clinicians.
- The member quoted from the comments "*If tapentadol continues to be in the red then it can never be prescribed to some very deserving patients I see in the primary care setting. I will also struggle in the hospital because I do not have enough follow up slots to review patients for repeat prescriptions*." The member stated that this appears to be a supply issue. Other mechanisms should be looked at to see how medications can be supplied as opposed to changing the RAG status.
- The Chair highlighted the Decision Support Tool from May 2018, where the applicant was invited to submit a new application with the addition of new evidence.
- Members remain concerned about opioid overprescribing if Palexia® is made Amber.
- Members acknowledged there may be individual patients that require Palexia® hence the approved RED status. This allows pain consultants to use Palexia® within their specialty. This may also help clinicians generate real-world evidence to support their claims.
- A member raised that tapentadol is currently on formulary in a neighboring area and there have been discussions with the consultants over how to control the use of tapentadol. Within this area, 'creep' in prescribing has occurred for patients outside the identified cohort and review of patients is a concern. Analysis was carried out on the opiates used, reviews undertaken, and the potential for harm. As a result, there were attempts to corral the usage of tapentadol within this neighbouring area.
- A member quoted the comment, *"what will happen when doses exceed the ceiling dose of 500mg will still be less dramatic than an equianalgesic dose of a pure opioid".* This is a larger issue of how to deprescribe overuse of opioids and members felt the addition of another medicine onto the formulary would not aid this.
- A member added an effective pain management pathway should be considered, including the expectations of the patient and what benefit they can expect from medicines versus other interventions that can be made.
- A member asked whether there have been any discussions with the palliative care consultants and their views on the potential for abuse of tapentadol. Member responded tapentadol is not on the West Midlands palliative care formulary.
- *"I do Pain Clinics in the hospital and in the Primary Care clinics. I am unable to prescribe any drug in these clinics. I am only able to give the GP my recommendations."* Members acknowledged this is how the clinic is commissioned.
- It was clarified attention deficit hyperactivity disorder (ADHD) medicines are controlled drugs and the mental health Trust does find a way to prescribe theses drugs on an outpatient basis.

- A member felt the use of tapentadol was now being represented as a wider cohort rather than the small cohort discussed originally in May 2018's meeting.
- The APC agreed tapentadol has its role in pain clinics with consultant experience, but the committee are still concerned that changing its status to AMBER will lead to its use expanding outside of the cohort. The committee has noted the comments that tapentadol has fewer addictive properties than tramadol and other agents but felt it would not want it's use to expand out into primary care.
- It was highlighted that the RAG rating does not affect the way the clinic is managed and run. The applicant's concerns are dependent on how the clinic commissioned.
- A member highlighted the comment *'Real World Evidence is due to be published within the next few is months'* Members felt a new application can be submitted if the applicant wishes when this evidence has been published.
- A member raised the MHRA has issued an alert regarding tapentadol; that it may increase seizure risk in patients taking medicines that lower seizure threshold. It also reports of serotonin syndrome when co-administered with other medicines.

Decision summary: Retain RED RAG rating. Rationale: No new evidence outlined, concerns with "creep" in prescribing outside of cohort and opioid over-use.

ACTIONS:

- **Relay decision to applicant** **APC sec**

0119/06 BSSE APC Valproate medicines ESCA – for discussion

A sodium valproate/valproic acid medicines Effective Shared Care Agreement (ESCA) was created for the use in women and girls of childbearing potential as a result of the MHRA update on the Pregnancy Prevention Programme (PPP). The draft ESCA has been sent out for consultation with specialists and comments have been incorporated. The chair directed members to the enclosures and welcomed any comments.

A member Trust has proposed a waiver form to be used in place of the ESCA for those patients who do not wish to be part of the PPP. The draft waiver form produced by the Trust was circulated to the members.

The Trust representative member explained the reason for the waiver form is the Trust has a small number of patients who will never be able to become pregnant, therefore the consultants felt they would rather use a waiver form for these patients.

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

- A member queried in what way can consultants say the patient can never become pregnant if the patient is a woman of childbearing potential.
- A member raised by adopting a waiver form the APC would be making a local decision which is not in line with the MHRA drug safety update.
- A primary care member gave an example of a 10-year-old with severe learning difficulties going into puberty with whom he had a diplomatic

conversation with the patient and family rather than using a waiver form as it will turn out to be a subjective decision to participate.

- It was highlighted the PPP clearly states *'The Pregnancy Prevention Programme applies to women who are not sexually active'*
- A member asked for clarification on Part B of the risk assessment form which states *"I confirm that the above-named patient needs valproate because…"* options being *"her condition does not respond adequately to other treatments"* or *"she does not tolerate other treatments"* and asked whether the patient would need to try an alternative medication if already stable on valproate. A member affirmed this is their understanding of the guidance.
- A member responded that the license for valproate medicines requires patients participate in the PPP if they are of childbearing potential. Clear guidelines have been set out for patients who do not wish to be on the programme which entails them to be switched to an alternative therapy. Prescribers who do carry on prescribing valproate medicines without participating in the PPP are prescribing outside of the product licenses for valproate medicines.
- A member raised in their CCG area there are approximately 1800 people on valproate medicines with an estimated 700-800 of these patients being women of child bearing potential.
- A member asked whether the ESCA will be available in the patient's native language. It was noted the PPP documents are produced in various languages and the patient must sign all the documents. If the patient is not able to understand then an interpreter would be required to attend the clinic appointment.
- A member asked whether there is a definition of the term "effective contraception". A member responded "highly effective contraception" is defined within the PPP materials as user independent methods such as a depot, implant, coil or sterilisation. Members agreed to add these definitions of "highly effective contraception" to the BSSE Valproate medicines ESCA.
- A member raised that there are relatively few known human teratogens and valproate is one of them. It has a risk of somewhere between 1 in 20 and 1 in 10 for every pregnancy, there will be pregnancy potentially occurring with teratogenesis if the PPP is not followed. The member stated that patients' situations change and this is a reason for why the risk acknowledgement form must be completed annually as it is taking every measure possible for risk minimisation.
- Members agreed they were uncomfortable with adopting the drafted waiver form.
- A member highlighted the guidance states the PPP must be followed unless the consultant is certain there is compelling reason not to participate.
- A member stated discussions at their Trust decided that if the consultant feels there are compelling reasons the PPP is not necessary such as the age of the child then the consultant would have to be very explicit of what these compelling reasons are and must document them. The annual review was considered a critical element and must be completed.
- A member highlighted to the committee one of the comments on the draft ESCA is recommending an additional box for clear documentation for what the compelling reasons are. Members agreed to this.
- The member responded that there should be a time line mentioned on the ESCA for when a specialist should see the patient if an unplanned

pregnancy is suspected.

- A member commented an additional Read Code is now available and can be added to the ESCA.
- Primary care colleagues should be very aware of flagging up patients who may be of child bearing potential on valproate medicines and are expected to alert the secondary care clinicians for review.
- A member commented that there should be a CCG approved search criterion for patients of child bearing potential on valproate. It was confirmed that it would be expected for primary care to refer them back to secondary care for review.

ACTIONS:

- **Amend Valproate ESCA as discussed and bring to future meeting** **APC Sec**

0119/07 Ciclesonide RICaD – for ratification

Ciclesonide was approved onto the formulary as AMBER with Rationale for Initiation, Continuation and Discontinuation (RICaD) in December 2018. A draft RICaD was produced by the applicant Colonel Wilson and the UHB NHS FT team. The RICaD was circulated for comments, no comments were received.

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

- A member asked why the term "Shared Care Read Code" was used when RICaDs are not shared care agreements. It was clarified that the term RICaD was created by the BSSE APC so there are no Read Codes for RICaDs.
- A member commented it is not greatly apparent ciclesonide may be used in addition to other inhaled corticosteroids. The RICaD does state the reason ciclesonide has been chosen but has not explicitly made it clear it can be used in conjunction with other inhaled corticosteroids. This could lead to patients existing corticosteroid inhaler being stopped mistakenly during medication use reviews.
- A member raised although initiation and maintenance doses are specified, the RICaD does not allow the patients specific dose to be stated. A member responded the recommended dose for the individual patient should be on the clinical letter from the specialist to the GP. This is common across all RICaDs.
- APC members agreed the following wording should be added to the box for Agreed indication(s) for inclusion in the BSSE APC formulary section: *'Note: often used in addition to other inhalers including those already containing corticosteroids'* in bold.

ACTIONS:

- **Amend Ciclesonide RICaD as discussed and publish** **UHB NHS FT/APC sec**

0119/08 BSSE away day documents – for ratification

An away day was held on Thursday 20th December 2019 covering formulary chapters 1- Gastro-intestinal system, 2- Cardiovascular system and 5- Infections.
The APC secretary directed members to the enclosures for the away day documents. The following proposed changes from the away day were relayed to the members:

Chapter 2 Cardiovascular system:

- The reference to first choice within bendroflumethiazide entry to be removed.
- Propose to withdraw eplerenone RICaD.
- Propose to withdraw dronedarone RICaD.
- In addition, there should be wording to mention dronedarone and other drugs such as amiodarone are part of the NHSE consultation *Items which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs* within their respective formulary entries.
- The reference to first and second choice of beta blockers to be removed.
- Change RAG status of nadolol to non-formulary.
- Propose to withdraw ivabradine RICaD
- Propose to withdraw ranolazine RICaD
- Change RAG status of nimodipine from AMBER to RED due to use by neurosurgeons only.
- Change RAG status of dipyridamole from GREEN to AMBER with specialist initiation.
- Propose to withdraw prasugrel RICaD.
- Propose to withdraw ticagrelor for post MI RICaD

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

- Members agreed there should not be any reference to the NHSE consultation on *Items which should not routinely be prescribed in primary care* within the formulary for the affected drugs until there is an outcome of the consultation. Noting the consultation may imply these medicines should not be prescribed.
- It was clarified the consultation covers both drugs that are deemed to have low clinical effectiveness and drugs that carry risks if prescribed in primary care.
- A member quoted from the consultation '*Advise CCGs that prescribers should not initiate amiodarone in primary care for any new patient. • Advise CCGs that if, in exceptional circumstances, there is a clinical need for amiodarone to be prescribed, this should be undertaken in a cooperation arrangement with a multi-disciplinary team and/or other healthcare professional'* The member made the APC aware this refers to a shared care agreement for amiodarone. This is the same recommendation for dronedarone however dronedarone is RED on the formulary.
- It was agreed that the APC should respond to the consultation stating shared care arrangements should not be required for amiodarone.
- A member questioned why the RICaDs for ivabradine and ranolazine

are being proposed to be withdrawn. A discussion during the away day suggested these agents have been prescribable for a considerable amount of time and primary care clinicians should be familiar with them. APC would monitor the effect of removing these RICaDs in terms of the number of Decline to Prescribe (DtP) forms being received. The decision could be reviewed if it led to an increase in DtP forms.

- A primary care member raised that they had done an audit on ivabradine and found that a number of patients were on it for unlicensed use which is historical. The RICaD provides specific criteria which the secondary care prescriber can tick to specify the condition ivabradine is being prescribed for.
- Primary care members felt they do not have enough experience with ivabradine to warrant the RICaD to be withdrawn, as it is not prescribed very often. It was agreed to retain the RICaDs for ivabradine and ranolazine and to add the RICaDs for discussion as an agenda item at a future APC meeting to discuss whether they are still required.
- A member raised there are a number of RED and Non-formulary BLACK agents that were agreed as such during initial harmonisation of the formulary. The member would share these drugs with the APC secretariat for addition to the formulary.
- There was discussion around Low Molecular Weight Heparins (LMWHs) during the away day in which Dr Lester highlighted patient cases where harm occurred due to patients not being able to receive enoxaparin from their GP. It was suggested at the away day Dr Lester or another clinician should write to the heads of the CCG with examples of patient harm to bring awareness to this ongoing commissioning issue.
- It was confirmed the status for enoxaparin is GREEN for single use in suspected DVT as stated on formulary. A member suggested to amend the wording to 'immediate use in suspected DVT'.
- The away day discussion involved whether non-vitamin K antagonist oral anticoagulants (NOACs) could be used instead of LMWHs for some indications by certain specialties.
- Dr Lester felt there was an immediate need to clarify the APC position on LMWHs. Therefore, a proposal from the away day was to add the wording *'for short term provision (up to 2 weeks) for initial presentation in urgent clinical need whilst secondary care appointment pending'* to the LMWH formulary entries.
- Members recognised the commissioning position around LMWHs should be established as soon as possible.
- A member raised there are many indications where LMWHs will need to be prescribed in primary care such as in palliative care, patients with mechanical heart valves etc.
- A member raised that a draft enoxaparin ESCA had been developed in conjunction with Dr Lester covering all the indications.
- A member added one of the reasons for initial RED rating was partly a patient safety issue to ensure secondary care provides the patient with adequate amounts of LMWH prophylaxis on discharge. Commissioning arrangements at the time were altered to allow this.
- A primary care member added waiting times for GP appointments has lengthened which increases difficulty to obtain urgent prescriptions within primary care.
- A member stated the important element within this discussion is effectively communicating to primary and secondary care regarding where their responsibilities lie. There is a perception that GPs are "not

allowed" to prescribe enoxaparin which is incorrect. Their needs to be education and training regarding appropriate, informed prescribing.

- A member raised many patients cannot self-administer enoxaparin. It costs approximately £63 per district nurse visit for the nurse to administer enoxaparin to the patient. The member felt there should be a piece of work between primary and secondary care to try and limit the amount of enoxaparin prescriptions being issued.
- It was established that there are commissioning pathways for DVT; a community service for single use enoxaparin and diagnosis and there is also a pathway for patients discharged from hospital having had replacement surgery. The difficulty is patients requiring LMWHs for those with long term conditions such as mechanical heart valve or cancer indications.
- Due to limited time, the Chair suggested the discussion is carried over to a future APC meeting where the APC position can be considered fully and the draft enoxaparin ESCA can be reviewed.
- A member raised that there is strong feedback from secondary care the RICaDs for NOACs are no longer useful. It was suggested at the away day to remove the RICaDs and replace by adapting the atrial fibrillation pathway algorithm produced by the West Midlands Academic Health Science Network (AHSN). Primary care colleagues are familiar with the NOAC agents.

Chapter 1 Gastrointestinal disease:
The following proposed changes from the away day were relayed to the members:

- Propose for RICaDs for linaclotide, lubiprostone and prucalopride to be withdrawn.

The following agents are proposed to be added as RED due to use by endoscopy specialty at Sandwell and West Birmingham NHS FT.

- Botulinium toxin 100 units to be added as RED RAG status
- Lugol's iodine to be added as RED RAG status
- 3% acetic acid to be added as RED RAG status
- Gelofusin and indigocarmine to be added as RED RAG status
- Infacol and N acetyl cysteine to be added as RED RAG status
- Histoacryl and lipiodol to be added as RED RAG status

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

- No concerns were raised.

Chapter 5 Infections:
The following proposed changes from the away day were relayed to the members:

- Ceftriaxone and azithromycin to be added as stat doses onto formulary to reflect the BSSE APC primary care guidance on gonorrhea.
- Add Voractiv® and Rifanah® as RED on to formulary under Anti-tuberculosis drugs.

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

- A member questioned the need to add reference to the all strengths of clindamycin injection. It was agreed to remove the additional strengths added. Clindamycin injection has a RAG status of RED.

ACTIONS:

- **Respond to the NHSE consultation on *Items which should not routinely be prescribed in primary care* regarding BSSE APC not supporting shared care for amiodarone.** **APC sec**
- **Ivabradine and ranolazine RICaDs to be reviewed at future APC meeting.** **APC sec**
- **Withdraw eplerenone, dronedarone, prasugrel and ticagrelor RICaDs from the APC formulary** **APC sec**
- **Make agreed changes to the formulary chapters as discussed.** **APC sec**

0119/09 **Regional Medicines Optimisation Committee recommendations –** For information

The Chair directed members to the RMOC recommendations for December 2018.

- RMOC Update London December 2018
- RMOC briefing on adalimumab – December 2018

No comments were made.

0119/10 **Minutes of the meeting held on Thursday 13th December 2018 –** for ratification

- Page 2: 4th paragraph; reword to read "The Chair and members thanked Kate for her valuable contribution to the APC"

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

0119/11 **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:

- 1218/05 – Obtain further clarification from applicant regarding preferred RAG rating and intended use of budesonide MMX Update: March APC meeting.
- 1218/08 – Process for development and review of ESCAs/RICaDs Update: Now available on APC sharepoint for members
- 1218/09 – Publish Feraccru® RICaD on APC website Update: Close action
- 1118/08 – Amend Dermatology ESCAs as per discussion and bring to future APC meeting Update: Ongoing
- 1118/AOB – Sodium clodronate, denosumab, degarelix and apormorphine ESCAs to be reviewed by secondary care Update: Ongoing
- 1018/08 – Finalise and publish Decline to Prescribe form Update: To be

published and circulated via email shortly

- 0418/08 APC membership list to be approved at a later meeting
  Update: Ongoing

0119/12 NICE Technological Appraisals (TAs)

In December 2018, there were 5 TAs published; of these, 4 are NHSE commissioned and 1 is not recommended.

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

Any other business:

1. Fiasp® supporting document

A primary care member who attends Diabetes Medicines Management Group (DMMAG) meetings raised hospital consultants may not be aware patients prescribed Fiasp® for gestational diabetes are to be discharged and their care transferred to primary care. DMMAG are not in favour of discharging these patients to primary care.

It was established this conflicts with the applicants request for AMBER with RICaD. The APC had reviewed the approved RED status when the application was first approved and amended to AMBER with RICaD due to applicant stating patients were going to be seen once by secondary care specialist and then transferred to primary care.

Members agreed to retain Fiasp® as RED until the APC receives further clarification or the RICaD is produced. This is due to the conflicting information being received from the applicant and DMMAG. This was the original APC recommendation due to small patient numbers anticipated in gestational diabetes.

ACTION: RED rating for Fiasp® until clarification from DMMAG **UHB NHS FT/APC sec**

2. NHS England consultation on items that should not be routinely prescribed in primary care

Information surrounding the consultation was circulated to members prior to the meeting.

A member stated that it is important to inform the Trusts who fed back about the *Emollient bath additives for the treatment of childhood eczema* (BATHE) study that this is now part of the NHSE consultation *Items which should not routinely be prescribed in primary care: an update and a consultation on further guidance for CCGs* and feedback regarding bath and shower preparations for dry and pruritic skin conditions should be submitted via the consultation.

3. Updated guidance on planning for a no-deal Brexit

Information surrounding the updated guidance on planning for a no-deal Brexit was circulated to members prior to the meeting.

4. Primary Care Clinical Pathway for Atrial Fibrillation Detection and Management - response from AHSN

An action from the December 2018 APC meeting was to relay comments from the APC to the West Midlands Academic Health Science Network (AHSN) asking for clarification on the inclusion of the section SAMe-TT2R2 algorithm. There was a lack of references on the document and absence of statement regarding authors, their affiliations and a declaration of interests was also a barrier.

The AHSN have responded stating references and declaration of interests can be included. The guideline can be adapted for local implementation if there are components APC would prefer not to take on board.

APC members agreed to ask the AHSN for an editable copy of the document so the SAMe-TT2R2 algorithm section can be removed.

ACTION: Amend editable copy of AHSN algorithm for local use — **UHB NHS FT - HGS/BSOL CCG/APC sec**

5. Ketorolac eye drop supply issue

A trust representative noted there is a supply issue with ketorolac eye drops. Bromfenac eye drops are being used as the alternative option at UHB NHS FT - HGS. However, bromfenac eye drops are currently not on the formulary.

- APC members agreed to add bromfenac eye drops onto the APC formulary as an alternative to ketorolac eyedrops in the interim whilst the supply issue continues.

ACTIONS:

- **Add bromfenac eye drops as AMBER to the formulary** — **APC sec**

6. Sodium hyaluronate eye drops

A Trust representative made the APC secretary aware the ophthalmology department at the Trust has moved to using Evolve HA® as it is a more cost-effective brand of sodium hyaluronate. The formulary makes reference to Hylo-Forte® as the brand for sodium hyaluronate.

APC members agreed to add Evolve HA® to the formulary.

ACTIONS:

- **Add Evolve HA® to the formulary as AMBER** — **APC sec**

7. Naproxen tablets (all strengths) supply issues

Members noted there is a national shortage of naproxen 250mg and 500mg tablets. The brand Naprosyn® is also unavailable.

A member clarified stock shortages could be due to a number of reasons such as a lack of raw ingredient or where people have obtained excessive amount of available stock which has led to price hikes during the period of shortages.

A group at the Department of Health is looking into the implications of supply chain issues. There is a Government proposal for new legislation allowing pharmacists to switch patients' prescriptions without consulting their doctor during a medicines shortage. However, there is still ongoing conversations on

how these switches can be communicated from the community pharmacist to the GP.

The Chair thanked the members for their input today. The meeting closed at 16:45.

Date of next meeting: Thursday 14th February 2019 14:00 – 16:45 Birmingham Research Park.