AREA PRESCRIBING COMMITTEE MEETING
Birmingham, Sandwell, Solihull and environs
Minutes of the meeting held on
Thursday 12th May 2016
Venue – Birmingham Research Park, Vincent Drive,
Birmingham B15 2SQ – Conference Room A

PRESENT:

Dr Lisa Brownell	LB	BSMHFT - (Chair)
Dr Paul Dudley	PD	Birmingham CrossCity CCG
Dr Neil Bugg	NB	Birmingham Children's Hospitals NHS FT
David Harris	DH	Birmingham Community Healthcare NHS FT
Mark DasGupta	MD	Birmingham CrossCity CCG
Satnaam Singh Nandra	SSN	Birmingham CrossCity CCG
Alima Batchelor	AB	Birmingham South Central CCG
Nigel Barnes	NB	BSMHFT
Amanda Berry	ABe	HEFT NHS FT
Carol Evans	CE	HEFT NHS FT/ Solihull CCG
Kalpesh Patel	KP	Midlands & Lancashire CSU
Isabelle Hipkiss	IH	Midlands & Lancashire CSU
Sulthana Begum	SB	ROH NHS FT
Sumaira Tabassum	ST	Sandwell & West Birmingham CCG
Prof Robin Ferner	RF	Sandwell & West Birmingham Hospitals NHS FT
Dr John Wilkinson	JW	Solihull CCG
Prof Jamie Coleman	JC	UHB NHS FT
Emma Suggett	ES	UHB NHS FT

IN ATTENDANCE:

Claire Manzotti	CM	Midlands and Lancashire CSU

No.	Item	Action

0516/01 **Apologies for absence were received from:**

- Tania Carruthers, HEFT NHS FT
- Kate Arnold, Solihull CCG
- Elizabeth Walker, Sandwell & West Birmingham CCG
- Jonathan Horgan, Midlands & Lancashire CSU
- Maureen Milligan, ROH NHS FT
- Inderjit Singh, UHB NHS FT
- Jeff Aston, Birmingham Women's Hospital NHS FT
- Dr Gwyn Harris, Sandwell & West Birmingham CCG
- Dr Sangeeta Ambegaokar, Birmingham Children's' Hospital NHS FT

0516/02 **Items of business not on agenda** (to be discussed under AOB)

- Declaration of Interest – MD
- Entresto® RICaD (sacubitril/valsartan) - CE
- Stiripentol application – IH
- Orphenadrine discontinuation – IH
- Wolverhampton APC – IH

0516/03 **Declaration of Interest (DoI)**

It was noted that they were no outstanding declarations of interests for 2015/16 period.

0516/04 **Welcome and Introductions**

The chair welcomed everyone to the meeting today. Introductions were not necessary.

The chair reminded members, that the meeting is digitally recorded for the purpose of accurate minute taking and once the minutes were approved, the recording is deleted by the APC secretary.

0516/05 **Minutes of the meeting held on Thursday 14th April 2016**

The minutes of the meeting held on Thursday 14th April 2016 were discussed for accuracy. The following amendments are required:

Page 9:

- The first sentence to read '*Making it amber would limit its use by GPs'*
- Under further discussion points/ concerns raised; elaborate on the patient safety concerns to read '*The Committee was concerned that the potential for medication error was high, especially in care settings. The Committee noted the extensive experience of using exclusively 100 units/mL insulin and felt that the introduction of higher strength insulins needs to be supported with a comprehensive risk assessment and assurance given that the risks have been mitigated*.'
- Under Decision Support Tool: reword the patient safety entry to read " *Unacceptably high risk of wrong dose medication errors*"

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

Discussion about the Decision Support Tools:

Decision Support Tool for APCBSSE/00026 Abasaglar® (Insulin glargine biosimilar)

- DST for Abasaglar® (APCBSSE/00026) was approved for publication on the APC website.

Decision Support Tool for APCBSSE/0030 Toujeo® (insulin glargine 300 units/mL)

- Under Patient safety, change the sentence to read "*Unacceptably high risk of wrong dose medication errors."*

- Subject to the above amendment, DST for Toujeo® (APCBBSE/0030) was approved for publication on APC website.

0516/06 Matters arising – Action Table

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

(See separate document attachment for updated version)

Updates and discussions:

- 0416/06 Matter arising: 0316/AOB – Patient & Public Representative recruitment. Gather information/ links for other CCGs to cascade advert through other avenues.
  Update: Have advertised through the links provided by Birmingham CrossCity CCG and Solihull CCG. Advert has not been distributed via Birmingham South Central CCG and Sandwell & West Birmingham CCG as information has not been provided. On-going.
- 0416/06 Matter arising: 0216/06 – Professor Haslam's response. Amend letter as agreed for ratification.
  Update: Amended letter was circulated with the papers for the meeting (removed reference to the NHS Clinical Commissioners and elaborated on the imbalance).
  It was agreed that the fourth paragraph sentence is too long and should be split into two smaller sentences:

  Our Area Prescribing Committee members are pleased that NICE recognises the imbalance between the role primary care commissioning has in making NICE decisions and the costs incurred as a consequence of decisions made. However they would be interested to hear how NICE proposes to resolve this discrepancy and if any measures are being put in place to have a balanced decision that takes into account the financial implications of implementing the NICE TAs in Primary Care.

- 0416/06 Matter arising: 0216/15 – Collaborative review of current ADHD shared care documents between HEFT, Solihull and FTB. Discuss outside the meeting.
  Update: Meeting has not taken place yet. Chair is going to speak to Dr Sangeeta Ambegaokar (Birmingham Children's Hospital NHS FT) and ask her to lead on this project. Several issues need to be addressed: Solihull CCG has different commissioning arrangements for ADHD drugs to other local CCGs and already have a number of shared care documents in place; the specialists need to agree which drugs are

suitable for shared care to be able to move away from current RED formulary status to proposed AMBER with ESCA as well as the fact that both children and adults need to be considered. On-going.

- 0316/07 – Practicalities of ESCAs and RICaDs. Bring back to future meeting to allow further thought/discussion.
  Update: A member recommended that the committee members consider and summarises the key issues during a short session and then take it away for further discussion and consultation within their organisations. It was agreed the short session will be scheduled at the July meeting.

- 0216/AOB – Chairs to draft letter to ophthalmologists outlining the points discussed. Copy to APC members.
  Update: It was pointed out that it is now 12 months since the decision around the glaucoma section was made. Members recalled that previously a group of ophthalmologists presented their recommendations as a consensus view. Then the committee amended their original decision based on the recommendations of another group of ophthalmologists who claimed they represented the consensus view. The committee reverted to the original decision as it transpired this was not the case. The members recognised that this could have been handled better at the time but acknowledged that this occurred in the early stages of harmonisation and the process has become more robust as a result. The aim of the APC review was to harmonise this section but also rationalise the formulary options to a first line and a second line agent for both preservative containing agents and preservative free agents. The option to use a non-formulary agent is available to the specialists via the DTC Chair's non-formulary approval process, but these are intended to be one-off occasions rather than regular requests.
  IH to draft a letter to ophthalmologists from the three Trusts outlining this is an opportune time to reset and review the formulary options and inviting them to provide consensus recommendations for the two preservative containing agents in a letter signed by the 3 heads of departments. The preservative-free options will remain as latanoprost and tafluprost.

- 1115/12 – Liaise with renal team on iron dextran injection (CosmoFer) to clarify RAG status and need for supplementary documentation. To be considered at the next UHB MMAG, defer until reviewed internally.
  Update: It was confirmed that it is on the UHB MMAG meeting agenda and will come back to the June APC meeting.

Summary of drugs incurring out of pocket expenses (OOPE) was circulated with the papers in PDF format for the meeting, but will be recirculated in an excel version to facilitate analysis of the data.

A member drew attention of the committee to the significant out of pocket expenses incurred with cyanocobalamin tablets. This prompted a discussion of appropriateness of prescribing oral cyanocobalamin. The committee was informed that oral cyanocobalamin is increasingly being recommended and used by haematologists for the treatment of non-absorptive vitamin B12 deficiency. Oral cyanocobalamin is not readily available and has to be imported, hence the OOPE.

A member pointed out that the list contains numerous inappropriate gluten-free products e.g. cakes, biscuits etc. that are being prescribed and incurring out of pocket expenses. The coeliac society has produced guidance regarding suitable GF products for prescribing on the NHS.

It was emphasised that the purpose of sharing this document was to make committee members aware that the committee makes decision based on acquisition costs, but there may be hidden costs (e.g. out of pocket expenses) incurred in obtaining the formulary products. The CCGs have been trying to raise these issues with the Department of Health for several years and are also challenging individual contractors who appear to use wholesalers who do not routinely stock these products for commercial advantages.

0516/07 Alogliptin (Vipidia®) – FDA warning regarding heart failure risks

This was brought up under Any Other Business at the last meeting. An email from Jim Glare, Primary Care MI support lead, which summarised the issues and a fact sheet from the manufacturer following the FDA safety alert, were circulated with the papers for this meeting.

The chair asked the members present if the formulary needed to be reviewed in light of this information. It was highlighted that alogliptin is currently first line formulary option for DPP-4 inhibitors (also known as gliptins), however the most commonly prescribed agent is sitagliptin. Sitagliptin and vildagliptin have the shortest remaining patent protection, but both have six years left. Following a discussion about how the APC should deal with this FDA safety alert the committee concurred that this probably is a class effect and, as this was still early days, it would be prudent to wait for further evidence and MHRA guidance and review the situation in a few months. A member advised the committee that the diabetes group is aware of this alert and will be discussing it. The APC members would welcome their recommendation following these internal discussions.

0516/08 Feedback from March 2016 Away Day

Notes from the Away Day on 30th March 2016 were used for reference.

Page 6, section 13.10.4 Parasiticidal preparations: it was decided at the away day to list permethrin 5% as formulary, with no reference made to the cream rinse (Lyclear ® Crème rinse) or dermal cream. Lyclear ® Crème rinse is permethrin 1% used for head lice whereas the dermal cream is permethrin 5% used for scabies. The BNF does not recommend prescribing of the 1% crème rinse due to insufficient contact time.

ACTIONS:

- **List permethrin 1% cream rinse as BLACK** **APC secretary**
- **The formulary entry for permethrin 5% should specify dermal cream.**

Page 11: Note that Epimax® is a cost effective alternative to Zerobase® and not ZeroAQS® as suggested at the away day. Zerobase® was approved on formulary as replacement for Diprobase®. Epimax® is £2.49 for 500g; Zerobase® is £5.26 for 500g whereas Diprobase® is £6.32 for 500g. Epimax® is same lipid formulation and SLS free. As a result of recommendations on appropriate quantities to prescribe, there is considerable wastage with emollients. It was agreed that the product with the lowest acquisition cost

should be used. Epimax® comes in a flexi-dispenser which allows easy application and avoids contamination of the cream but without the waste associated with airless pump mechanisms.
It was agreed that Epimax® is added to the formulary as GREEN. It was also agreed that Zerobase® should remain on the formulary as considerable amount of work has already gone into switching patients to the Zero® range of products.

ACTION: Add Epimax® to APC formulary as GREEN **APC secretary**

The committee was informed that after the emollient section harmonisation was carried out Zerodouble® was launched which offers a low cost alternative to Doublebase®.
A member suggested that, as the range of emollients is continuously evolving the decision on which brand to use in primary care should be left to the commissioners, in the same way the choice of vitamin D was left to local guidance. The CCGs would collaborate on emollient choice and notify the committee regarding their preferred brands.
A secondary care representative pointed out that this was not helpful for the Trusts to decide on which brand to stock.

A member explained that although emollients contain similar ingredients the excipients differ, and some excipients are associated with skin sensitisation. Product choice in secondary care if often based on known allergy or results of skin patch testing and tailored to individuals as a result of these. If such a patient was then switched in primary care to the CCG's preferred brand and this resulted in a reaction, the patient would lose faith in the system.
As a majority of emollients are not licensed medicines but classed as appliances, the information regarding excipients is not readily available and clinicians need to contact the manufacturer. Tables comparing excipients are available from some reference sources (e.g. MIMS).
It was agreed that if a product was indeed chosen as a result of known allergy or sensitisation caused by an excipient, and clearly communicated to the patient's GP, this would not be changed.

Page 12: Under the outstanding areas section there is a list of drugs for which ESCAs are required. Hydroxychloroquine is included in this list. It was noted that there is no ESCA for hydroxychloroquine in Chapter 10 as it was felt prescribers have more experience with this drug. Committee members confirmed that an ESCA for hydroxychloroquine in dermatology is not required.

Members were also informed that colchicine and cyclophosphamide were incorrectly listed in this section and will be removed.

A revised algorithm for Actinic Keratosis was circulated with papers for the meeting. Actikerall® was added as GREEN for hyperkeratotic lesions. Added ££ sign to Zyclara® for field changes with large area>25cm^2. The members approved this algorithm.

With regards to Chapter 14 (immunological products and vaccines), the members supported the proposed statement "Products will be prescribed and used in accordance with the guidance from the Department of Health handbook "Immunisation against infectious diseases" i.e. the Green Book and specialised services circulars" . All vaccines would be GREEN with the exception of cholera vaccine (AMBER as only available from specialised travel clinics) and botulism antitoxin (RED).

Many of the outstanding issues were resolved at the away day. The commissioning discussions around dermatology specials and other issues are scheduled to take place later in the month. UHB representative requested some support with the dutasteride RICaD.

Chapters 13, 14 and 15 were approved and can be uploaded on the formulary.

ACTIONS:

- **Support UHB with draft dutasteride RICaD** — **CSU**
- **Update Chapter 13 with decisions outlined in minutes.** — **SSN**
- **Upload chapters 13, 14 and 15.** — **APC sec**

0516/09 New drug application- Soolantra® (ivermectin 1% cream), Galderma (UK) Ltd

The clinician applying for the addition of ivermectin 1% cream is unable to attend the meeting due to clinical duties but available by phone to answer any questions from the members. Alternatives such as videoconferencing and Skype® had been looked into but the different IT systems did not support this. The chair stated that the APC policy encourages the clinician to come in person to the meeting as it enables the applicant to better understand the process followed, but attendance is not compulsory. This was the first application the APC was considering without the applicant being present.

Discussion points/concerns raised:

- Mirvaso® (brimonidine gel) is RED on the formulary for the treatment of facial erythema in rosacea.
- Standard treatment for rosacea is topical metronidazole / topical azelaic acid or oral tetracyclines.
- Consider antimicrobial stewardship principles of promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness.
- Metronidazole gel is not well tolerated in some patients, a significant number of patients discontinue treatment due to skin reactions.
- On page 3 of the application it states that '*There are few current anti-inflammatory treatment options for rosacea. A recent Cochrane review noted that it is unclear which is the most effective, but some evidence supports the efficacy of topical metronidazole, azelaic acid and subantimicrobial-dose doxycycline in the treatment of moderate to severe rosacea. Ivermectin cream has dual anti-inflammatory and anti-parasitic properties and offers a novel therapeutic option. There is concern about bacterial resistance developing with long term use of topical and systemic antibiotics and ivermectin cream could therefore be very valuable addition in the therapeutic ladder to reduce long-term antibiotic-use in these patients.'*
- If patient has rosacea keratitis they will need oral therapy (topical therapy will not be helpful).
- Current formulary options for acne rosacea include metronidazole 0.75 % topical gel and cream (Rozex® and Acea®) together with azelaic acid 15% gel. Oxytetracycline is the oral antimicrobial option.
- SMC has accepted ivermectin 1% cream for restricted use within NHS

Scotland for treatment of moderate to severe inflammatory lesions of rosacea. AWMSG has recommended this as an option for use within NHS Wales for topical treatment of inflammatory lesions of rosacea in adults.

- Cost comparator is Rozex® gel/ cream costs £6.60 for 30g or £8.01 for 28 days treatment (twice daily application) compared to Soolantra ® cream at ££18.29/30g or £11.95 for 28 days treatment (once daily application). Azelaic acid 15% gel costs £7.48 for 30g but can also cause skin irritation and has a skin drying effect.
- The antibiotic guidelines advice against widespread use of topical antibiotics, especially those agents also available as systemic preparations. The guidelines also recommend topical treatment before oral antibiotics.
- The members supported a move away from topical antibiotics and considered this agent as a welcome addition to the formulary.
- Metronidazole is a useful antibiotic for other indications.

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

Patient safety: No major concerns; this would avoid excessive use of antimicrobials in line with antimicrobial stewardship principles.

Clinical effectiveness: Shown in trials to be at least as effective as metronidazole 0.75% cream.

Strength of evidence: acceptable.

Cost-effectiveness or resource impact: Slightly more expensive than current topical treatment options.

Place of therapy relative to available treatments: Alternative treatment option

National guidance and priorities: None

Local health priorities: N/A

Equity of access: N/A

Stakeholder views: Supported

Implementation requirements: N/A

Decision summary: GREEN, alternative option to metronidazole / azelaic acid gel

ACTIONS:

- **Relay decision to Dr M. Kaur by Thursday 19th May 2016**
- **Add Soolantra® 1% cream to APC formulary as GREEN with the annotation of alternative option to metronidazole / azelaic acid.** **APC sec**

APC sec

0516/10 Review of Decline to Prescribe form

The chair asked the members for comments and feedback on whether the "decline to prescribe " form was useful and whether it met the purposes for which it had been designed.

Points discussed:

- Prescribers are encouraged to have a conversation with secondary care colleagues first to try and resolve the issues before completing the form.
- Secondary care colleagues are reporting a significant disparity between receipt of completed Decline to prescribe forms and GPs stating they are not accepting prescribing responsibility.
- CCG leads confirmed this was one of the most successful implementations and these forms are being used. Practice based pharmacists are frequently asked for advice whether certain drugs should be prescribed in primary care; if the formulary classes the drug as non-formulary, RED, or it is unlicensed and the GP does not want to take on the clinical responsibility, then the pharmacists signpost prescribers to the Decline to Prescribe forms.
- The intention was for the APC members to monitor the Decline to Prescribe Forms to identify trends/ themes and whether a RAG rating needs to be revised or supporting documentation developed. The members need to understand the reasons for declining to prescribe but rely on feedback from the Trusts.
- One benefit of the form is it makes prescribers think why they are declining to prescribe and go through a process to provide a valid rationale.
- It is intended to be a two-way process: if a secondary care clinician repeatedly asks GPs to prescribe RED or non-formulary drugs, the Trust should have an internal discussion. Conversely, if the reason to decline to prescribe is deemed unreasonable, the CCG or practice based pharmacist can have a discussion with the prescriber.
- The form is also useful to inform the secondary care clinician if an alternative medication has been prescribed to support medicine reconciliation.

ACTION: Trust leads to bring summary of "decline to prescribe " forms to June meeting **Trust leads**

0516/11 Pan Mersey Policy on Use of Manufacturers' Free of Charge Medicines Schemes where NICE guidance is pending

- A number of schemes designed to supply medicines that are undergoing NICE Single Technology Appraisal (STA) review free-of-charge prior to publication of the STA have been launched by the respective pharmaceutical manufacturers. The schemes state that the medicine will be supplied free of charge to patients who are anticipated to fit the future NICE STA criteria, prior to its publication, should the drug be approved by NICE in due course. If NICE do not approve the STA then the manufacturer will continue to supply free of charge until the clinician and patient decide the medicine should be stopped. However if NICE approve the STA then the free supply ceases and the commissioner is expected to fund in line with the timescales (up to 3 months after publication).

- This policy, developed by the Pan Mersey APC which MLCSU now supports, was brought to the attention of the APC members following the discussions around apremilast. The manufacturer of apremilast was

providing free of charge stock to local hospitals prior to NICE appraisal for the treatment of psoriatic arthritis in anticipation of a positive NICE TA. CCGs were concerned about a sudden cohort of patients they would be expected to fund from day 91 following NICE TA publication. However NICE appraisal was negative.

- Members were asked if they would consider adopting this policy which recommends CCGs and Trusts do not sign up to these schemes at present.

- UHB NHS FT objected to the adoption of this blanket ban policy as it would like to have the freedom to consider each individual drug and decide, based on the evidence, whether it would benefit from the free of charge scheme.

- They described the case when use of free of charge rifaximin enabled the Trust to gather real world data which supported NICE guidance.

  Concern was raised that secondary care clinicians would make a decision that could have a financial impact on CCGs post NICE approval. In addition CCGs could also incur additional charges under PbR as result of increased activity.

- Some of these drugs could end up being commissioned by NHS England, and therefore not an issue for the APC.

- The provider trusts could decide to incur the costs if NICE does not support the drug, and this would be a risk.

- There is also a risk that, if the drug is licensed but not supported by NICE or this committee, there will be a pool of patients on this treatment.

- A comment was made that the commissioning implications of such schemes were not within the remit of this committee. However the APC would refer such issues to the relevant Commissioning forum, as stated in the policy and advise.

- A member suggested that any of these drugs could come to the APC as a new application, but acknowledged that the outcome may be to wait for NICE.

- The trust leads indicated that they have not had sufficient time to consider this policy and have an internal discussion. It was proposed that members go back to their own organisations and discuss this policy.

- It was suggested that rather than a policy, guiding principles may be more appropriate.
- Discussions on this issue were re-scheduled for the July meeting

Action: Add policy on manufacturers' free of charge medicines schemes where NICE guidance is pending to the July meeting agenda. **APC sec**

0516/12 NICE Technology Appraisal (TAs)

It was confirmed that three NICE TAs were published in April 2016. Only one of the TAs is primary care commissioned.

- Sacubitril valsartan (Entresto®) for treating symptomatic chronic heart failure with reduced ejection fraction (TA388). Primary Care commissioned. Providers are NHS hospital trusts and GPs in primary care. GREY status proposed for the time being. Draft RICaD proposed at March 2016 meeting.
- Sacubitril valsartan is the first drug commissioned by CCGs to be approved under the early access to medicines scheme (EAMS) and this guidance will be implemented 30 days after final publication. Previously, all the other drugs available via EAMS were cancer drugs and commissioned by NHS England.

Other two TAs are NHS England commissioned:

- Topotecan, pegylated liposomal doxorubicin hydrochloride, paclitaxel, trabectedin and gemcitabine for treating recurrent ovarian cancer (TA389) - Secondary Care Prescribing. RED status

- Abiraterone for treating metastatic hormone-relapsed prostate cancer before chemotherapy is indicated (TA387) - This technology is currently available through the Cancer Drugs Fund. Providers are NHS hospital trusts. After the guidance is published, abiraterone will move out of the Cancer Drugs Fund and will be commissioned by NHS England from day 91. RED status.

0516/13 Trust Chairs non-Formulary approvals – For information

None received.

0516/14 Any Other Business :

1. Declaration of interests – a member requested clarification on the timeframe within which a declaration of interest should be made. It was agreed that all although the annual submissions cover the preceding 12 months; any significant or personal interests must be declared beyond 12 months at the member's discretion.
   It was noted that as it is a year since the last annual declaration, the APC secretary will circulate the declaration of interest form for all members to complete.

   ACTION: Circulate the annual declaration of interest form to all members for completion. **APC sec**

2. Sacubitril valsartan (Entresto®) was approved by NICE in April 2016. This is one of the EAMS drugs and therefore needs to be available within 30 days of NICE TA publication instead of usual 90 days. At the March meeting it was agreed to draft a RICaD. This needs to be circulated as soon as possible for consultation. Sign off planned for the next APC meeting.

ACTION: Circulate draft RICaD for Entresto® to all committee members for dissemination within their own organisations for consultation. **APC sec**

3. Stiripentol –Birmingham Children's' Hospital (BCH) currently use stiripentol as add-on therapy for tonic clonic seizures in children with severe myoclonic epilepsy in infancy (SMEI or Dravet syndrome) where other treatment has not worked. There are currently 35 patients under their care. There is a transitional issue for one patient moving into adult services at UHB. A BCH representative attended the UHB MMAG to discuss a way forward. UHB has agreed to supply stiripentol if the patient is admitted but expects BCH to pick up prescribing again once discharged back into the community. It was therefore agreed that BCH would bring an application to the APC for stiripentol for BCH use and consider the clinical aspects. If approved, this may clear the way for commissioners to smooth the transition into the adult sector. Birmingham CrossCity CCG has a commissioning policy that states it will pick up the costs of drugs if inheriting it from another commissioner, in line with the NHS Constitution. Stiripentol is not licensed for use in adults as it was originally intended for use in infancy only, but as a result of better chronic disease management some of these childhood diseases are continuing into adulthood. It is right therefore to bring this to the APC for consideration.

ACTION: BCH to submit an application for stiripentol for consideration at the next available APC meeting. **BCH**

Orphenadrine –orphenadrine tablets were discontinued by the manufacturer in December 2015. It is currently AMBER on the APC formulary. Prescribing data suggests it is still being prescribed. A licensed oral solution is available but expensive. BSMHFT is advising their clinicians to review the small number of patients on this drug and change to an alternative anticholinergic agent.

ACTION: Change orphenadrine to BLACK – discontinued. **APC sec**

4. Wolverhampton APC has expressed an interest to join BSSE APC. This is driven by organisational changes. If agreeable with the members, they will write formally to the chairs. Following a brief discussion, the members' initial thoughts were that they did not want to go through the formulary harmonisation process again; they would expect them to adopt the existing BSSE formulary going-forward.

ACTION: Inform Wolverhampton APC that committee members will consider their request to join BSSE APC. **APC sec**

The chair thanked the members for their input today. The meeting closed at 16:25 pm.

Date of next meeting: Thursday 9th June 2016 14:00 – 16:45
Conference Room A, Birmingham Research Park,
Vincent Drive. Birmingham B15 2SQ