NHS Berkshire West Area Prescribing Committee
Minutes of Meeting held on 5th March 2014
Room G30, 57/59 Bath Road, Reading, RG30 2BA

Attendance:

[redacted]

1. Chairman's Introduction

[redacted] welcomed everyone to the meeting.

2. Apologies

[redacted],

3. Pecuniary Interests

No declarations received.

4. Minutes of the APC meeting held on 8th January 2014

The minutes were agreed.

5. Matters Arising from Meeting on 8th January 2014 not Included in Main Items

11.7 APC 13/11 TA280: Rheumatology Paper, [redacted] will bring to May meeting.

APC 13/31 The Prescribing of Melatonin in Primcary Care; unlicensed vs off-

label – [redacted] is working with BHfT and RBH to look at this and will bring back to the group.

9.5 APC 13/32 Paliperidone Palmitate Prescribing Arrangements – [redacted] to update document. Carry forward to next meeting as [redacted] not present.

9.6 APC 13/33 NOAC DAWN Module – [redacted] and [redacted] had met with RBH as RBH planning a launch event on 26th March. RBH have reduced blood tests to 2 per year instead of 4 and were looking at inappropriate use of NOACS. The proposal for this service had been agreed by the Planned Care Board before APC set up. It was emphasised that all requests for this type of service must come to APC before going to Planned Care Board.

It was agreed that RBH should be advised that the APC recommend no ongoing monitoring is required for NOAC patients as per NICE guidance and therefore this service is not required. The launch event planned for 26th March should be cancelled.

[redacted] to let RBH know that APC and GPs do not support the launch of this service.

[redacted] asked that CCG Representatives take this message back to their CCG members.

9.7 APC 13/24 Lithium Shared Care Guidelines – [redacted] to check ECG requirement under 3.1 and update document. Carried forward as [redacted] not present.

11. Out Patient Prescriptions – [redacted] is arranging to meet with [redacted] to discuss further get a process in place as there was concern about the standard of requests and process.

6. Update on existing and expired EPC topics

Expired policies have now been updated, ratified by GP MOC and published on Netformulary and website.

7. Horizon Scanning / NICE Update

Horizon scanning is being carried out by the lead for the Thames Valley Priorities Committee.

8. Papers

9.1 APC 14/01

What priority should be given to the prescribing of lurasidone (Latuda®)?

- Lurasidone appears to be statistically significantly more effective than placebo and of similar effectiveness to olanzapine and risperidone.
- Lurasidone, olanzapine and risperidone appear to have broadly similar rates of adverse events, although the adverse event profiles of the drugs differ. Meltzer et al. found that in a 6 week study, the proportion of participants experiencing at least 1 adverse event was broadly similar across all groups (around 78%). Akathisia and parkinsonism were more commonly seen with lurasidone, and weight gain and dry mouth were more commonly seen with olanzapine.
- Lurasidone is significantly more expensive than generic olanzapine, risperidone and quetiapine. The average dose of lurasidone costs 30 times more than the average dose of olanzapine.
- This policy has been produced as a guide for GPs. Evidence and information was carefully considered and consulted upon by clinicians who concluded that this treatment is not a cost effective use of scarce NHS resources. There are situations where this policy may not apply to an individual patient due to their clinical exceptionality. This policy statement does not overrule an individual GPs clinical decision making and therefore each GP would be need to make the final decision on whether treatment is a cost-effective use of their CCG budget.

Recommendation
Lurasidone (Latuda®) is not recommended for routine use within Berkshire West for the treatment of schizophrenia.

Action: Policy to be taken to GP's MOC for ratification and then published on Netformulary and websites.

8.2 APC 14/02
Hydroxycarbamide Shared Care
[redacted]at RBH is keen to use this. GPs are not able to prescribe as Red Drug.

[redacted] to ask RBH if number of hospital appointments can be reduced by use of Shared Care and bring back to next meeting.

Action: [redacted] to obtain information from RBH and bring to next meeting.

8.3 APC 14/03
Colomycin and tobramycin shared care
The Committee were happy in principle with these shared care guidelines but felt that the document was not complete as no author or references shown.

Recommendation:
[redacted] to update document and bring to next meeting.

Action: Document to be updated and brought to next meeting.

8.4 APC 14/04

The use of rivaroxaban for the treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) and the prevention of recurrent DVT and PE out of hours

- Warfarin still remains the anticoagulant of choice for VTE.
- Patients presenting out of hours with suspected VTE should be managed with the current standard treatment (low molecular weight heparin) until a 24 hour 7 day service is commissioned.

Recommendation:
The use of rivaroxaban for the treatment of venous thromboembolism (VTE) out of hours is not recommended.

Action: Policy to be taken to GP's MOC for ratification and then published on Netformulary and websites.

8.5 APC 14/05

Drugs for Erectile Dysfunction
The previous EPC policies have expired, but the only change is in the price.

(a) What are the appropriate prescribing frequencies for phosphodiesterase-5 inhibitors (PDE-5 inhibitors)?
DH health service circular recommends:
'one treatment per week will be appropriate for most patients being treated for erectile dysfunction.'
And
'If the GP in exercising his clinical judgement considers that more than one treatment a week is appropriate he should prescribe that amount on the NHS.' (This guidance is only appropriate to those men who are listed as eligible to receive the treatment on the NHS).

Recommendation:
One treatment per week will be appropriate for most patients being treated for erectile dysfunction. Prescribing frequencies above this amount should be **LOW PRIORITY**. Treatment will only be provided on the NHS for patients meeting the SLS criteria.

NB: The first line PDE-5 inhibitor is generic sildenafil.

(b) Is one phosphodiesterase-5 inhibitor (PDE-5 inhibitor) likely to be safer, more effective or more cost effective than another phosphodiesterase inhibitor for treating erectile dysfunction?

- From the limited evidence it appears that these drugs have a similar safety and efficacy profile.
- There are no trials directly comparing these interventions with each other or with other treatments for erectile dysfunction.

- Sildenafil may be marginally more effective and have the lowest dropout rate.

Bearing in mind the current costs and the fact that the price for sildenafil has been reduced significantly since generic sildenafil became available; it would appear sildenafil is likely to be the most cost effective PDE-5 inhibiter for treatment of erectile dysfunction.

Recommendation:
Sildenafil should be the first choice PDE-5 inhibitor for the treatment of erectile dysfunction. Vardenafil and 'on demand' tadalafil may be a treatment option where clinically appropriate when first line sildenafil is contraindicated, not tolerated or has been ineffective. Treatment will only be provided on the NHS for patients meeting the SLS criteria.

(c) What priority should be given to daily tadalafil (Cialis®) for the treatment of erectile dysfunction?

- Trials based on comparison with placebo not 'on demand' treatment which makes it difficult to place in therapy
- More expensive than one tablet per week of any 'on demand' phosphodiesterase-5 inhibitor (PDE5 inhibitor)

Recommendation:
Daily tadalafil should be a **LOW PRIORITY** for patients with erectile dysfunction.

(d) What priority should be given to the combination of daily and 'on demand' tadalafil and doses above 20mg per day?

No studies identified to support the safety or efficacy of combining daily and 'on demand' treatment or doses above 20mg.
Doses above 20mg daily are outside the licence.

Recommendation:
that this combination of daily and 'on demand' tadalafil' or tadalafil at doses above 20mg daily should be a **LOW PRIORITY** for the treatment of patients for erectile dysfunction.

(e) What priority should be given to the treatment of erectile dysfunction to reduce cardiovascular risk?

No studies were identified to provide evidence for treatment of erectile dysfunction with PDE5 inhibitors to improve cardiovascular outcomes.

Recommendation:
Treatment of erectile dysfunction with phosphodiesterase-5 inhibitors (PDE-5 inhibitors) to reduce cardiovascular risk should be a **LOW PRIORITY**.

(f) What priority should be given to the prescribing of generic sildenafil

for the treatment of erectile dysfunction?

The patent on Viagra expired in 2013. Generic sildenafil costs between 12 and 15 times less than Viagra and other brands. This makes generic sildenafil the most cost effective phosphodiesterase inhibitor available.

Recommendation:
Generic sildenafil is recommended as the first line phosphodiesterase inhibitor for the treatment of erectile dysfunction in primary care.

Action: Policy to be taken to GP's MOC for ratification and then published on Netformulary and websites.

8.6 APC 14/06
LUTS Pathway
The flow chart has been produced based on NICE Guidance.

Recommendation:
The flow chart was approved with the addition of the reference of how to find the frequency-volume chart.

Action: [redacted] to add details of where to find frequency-volume chart. Policy to be taken to GP's MOC for ratification and then published on Netformulary and websites.

8.7 APC 14/07
What priority should be given to the prescribing of solifenacin and tamsulosin oral controlled absorption system (TOCAS) (Vesomni®)?

- The fixed dose combination (FDC) of solifenacin 6 mg plus tamsulosin oral controlled absorption system (TOCAS) significantly improved storage and voiding symptoms, as well as QoL parameters, compared with placebo.
- This FDC also improved storage symptoms and QoL compared with TOCAS alone in men with moderate to severe storage symptoms and voiding symptoms, and it was well tolerated.
- The cost of the FDC is currently the same as solifenacin 5mg.
- Adjusting combination products can prove difficult especially in the frail and elderly where anticholinergics can lead to confusion etc.
- Furthermore solifenacin is not recommended as a first or second line antimuscarinic agent where an antimuscarinic is indicated.

Recommendation:
Solifenacin and tamsulosin oral controlled absorption system (Vesomni®) is not recommended for routine use within Berkshire West for the treatment of lower urinary tract symptoms (LUTS)1 and bladder outlet obstruction (BOO).

Action: Policy to be taken to GP's MOC for ratification and then published on Netformulary and websites.

8.8 APC 14/08

Core stepped approach to medical treatment of type 2 diabetes

Current available NICE guidelines are cumbersome and confusing. A pathway was required that was clear and quick to assess for both GPs and practice nurses. This pathway does not preclude the use of the complete pathway and patients falling outside of these recommendations should be referred to the specialists in the usual manner. This has been approved by Diabetes Group.

Recommendation:
Approved.

Action: Policy to be taken to GP's MOC for ratification and then published on Netformulary and websites.

8.9 APC 14/09

Symptom Control Guidelines

These had been produced by [redacted] and it was agreed were very helpful.

[redacted] to check details of 'Liverpool Pathway' and let [redacted] have details.

Action:
[redacted] to check 'Liverpool Pathway' and let [redacted] have details.

8.10 APC 14/10

Re-assess Alogliptin What priority should be given to the prescribing of alogliptin (Vipidia®) as add-on treatment in type 2 diabetes?

Alogliptin as add-on therapy reduces HbA1c by around 5.5mmol/mol (0.5%) compared with placebo

- Alogliptin has been priced 20% lower than sitagliptin.
- Alogliptin appeared well tolerated in the randomised controlled trials with most adverse events reported to be of mild or moderate intensity. The proportions of patients experiencing serious adverse events or adverse events leading to study drug discontinuation were low.

Recommendation:
Alogliptin (Vipidia®) is recommended as the first line dipeptidyl peptidase 4 (DPP-4) inhibitor (DDP-4) in primary care.

Action: Policy to be taken to GP's MOC for ratification and then published on Netformulary and websites.

9. NICE Technology Appraisals

TA303 Multiple sclerosis (relapsing) - teriflunomide (TA303)

Noted by Committee.

10. Any Other Business

None

Dates of Future Meetings

Date of Meeting	Venue
Wed 7th May 2014	Rooms G29/30, 57/59 Bath Road, Reading, RG30 2BA
Wed 2nd July 2014	Rooms G29/30, 57/59 Bath Road, Reading, RG30 2BA
Wed 3rd September 2014	Rooms G29/30, 57/59 Bath Road, Reading, RG30 2BA
Wed 5th November 2014	Rooms G29/30, 57/59 Bath Road, Reading, RG30 2BA

All Meetings 10.00am – 12.00pm