NHS Newbury and District Clinical Commissioning Group | NHS North and West Reading Clinical Commissioning Group | NHS South Reading Clinical Commissioning Group | NHS Wokingham Clinical Commissioning Group

Berkshire West Area Prescribing Committee (BWAPC)

Paper APC16-03

MINUTES of BWAPC Meeting held on 6th July 2016 from 10:00 – 12:00 in Room G29/G30, 57/59 Bath Road, Reading, RG30 2BA

Attendance:	
[redacted]	Commissioning Pharmacist, Wokingham CCG
[redacted]	Clinical Integration Pharmacist (BWCCG)
[redacted]	GP, North & West Reading CCG
[redacted]	GP, Newbury & District CCG
[redacted]	GP, Wokingham CCG
[redacted]	GP, SRCCG
[redacted]	Lay Member
[redacted]	Pharmacist, CIRCLE
[redacted]	Associate Director of Medicines Optimisation
Minutes: [redacted]	PA to Asso. Dir. Of Meds Opts & Admin Support
Apologies:	
[redacted]	Lay Member – Chair
[redacted]	Chief Pharmacist (BHFT)
[redacted]	Pharmaceutical Adviser, BWCCG
[redacted]	CEO, Thames Valley Local Pharma Committee
[redacted]	RBFT
[redacted]	Lay Member, Wokingham CCG
[redacted]	Anaesthetist, RBFT
[redacted]	Interim Medical Director, BHFT
[redacted]	Lay Member
[redacted]	MI Lead Pharmacist, BHFT
[redacted]	Pharmacist, BIH
[redacted]	Lead Contracts Manager, RBFT
[redacted]	Chief Pharmacist, RBFT
[redacted]	Deputy Chief Pharmacist, RBFT
[redacted]	Clinical Pharmacist - SPIRE

1.	**Welcome & apologies:** In the absence of [redacted], [redacted] (interim Chair) welcomed everyone to the meeting. Apologies were noted as above.
2.	**Declaration of Conflicts:** None declared.
3.	**Minutes of the APC meeting held on 4th May 2016:** The minutes were agreed after an amendment; the deletion of a word from page 2. Action Log updated.

4.	**Matters Arising from Meeting not included in Main Items:**
	1) <u>Update on Formulary Appeals:</u> [redacted] reported that following the APC decision to uphold the decision on liothyronine, RBFT has noted that liothyronine is not on their trust formulary for the proposed indication and the appeal was therefore not appropriate. It was suggested that the ToR be updated to include the fact that a trust cannot appeal a drug which is not on their respective formulary. **Action: [redacted] to add the APC Appeals Procedure to the ToR when updating.** **2) <u>Update on NOAC VTE:</u>** [redacted] highlighted the fact that the standard treatment of choice for VTE is Tinzaparin and Warfarin. However, in line with NICE TAs, NOACs can also be used to treat VTE. NOACs are to be used for treating provoked DVTs and the NOACs of choice are rivaroxaban and Apixaban (due to the fact these 2 NOACs do not require initial treatment with a low molecular weight heparin). Further work is ongoing to establish cost effectiveness of the different agents. **Action: [redacted] to bring to September meeting.** **3) <u>Update on Net Formulary:</u>** [redacted] reported that every drug on the net formulary can be prescribed by GPs. BROWN drugs are not advised but ultimately the decision to prescribe rests with the GP. GPs have been reminded that if a drug is not on the RBFT formulary to report it to the Medicines Optimisation Team. [redacted] went on to give an example – unlicensed mexelitine used for pain should be a RED drug. It is currently not on formulary at RBFT and some consultants have been asking GPs to prescribe. **4) <u>Update to OAB Pathway:</u>** [redacted] presented the OAB Pathway being recommended by Dr. [redacted]. After discussion it was decided to provide further clarification on the appendix on anticholinergic burden and link this to step 2: initiate tolterodine immediate release tablets **Action: [redacted] to amend the OAB pathway & send to [redacted] for confirmation before publishing.** **5) <u>Midodrine for Postural Hypotension (PH)/Postural Tachycardia Syndrome (PoTs):</u>** Midodrine was initially a RED drug due to being an unlicensed drug. It now has a license and would be suitable for a shared care agreement. [redacted] presented the shared care guidance and highlighted that it supported by the RBFT cardiologist specialist for PH/PoTs. The document was assessed by the APC who recommended the addition *usually when patient is stable* under 1st line of Specialist responsibilities. **Action: AS to update guidance and publish**
5.	**<u>PAPERS for consultation:</u>** [redacted] presented the 3 Headache Pathways which were requested by Dr. [redacted] & the BW Neurology Steering Group. There was much discussion on all 3 pathways. All agreed to have a separate pathway for the 3 different types of headaches & include Migraines as the 4th Pathway. The following changes were also agreed: **<u>5.1 Cluster Headaches:</u>** Expand the presentation section to say "Extend medication if patient is experiencing it for more than 5 days". Add "Subcut Sumatriptan & Intranasal Triptan" as treatment. **<u>5.2 Medication Overuse Headaches:</u>** [redacted] added that medication overuse could happen with patients having cluster & tension headaches & therefore this should be considered as well. **<u>5.3 Tension Headaches:</u>** It was agreed that although Acupuncture was NICE recognised it should be the last treatment step as this treatment has not been widely commissioned. **Action: [redacted] to redo the 4 pathways with a common cover sheet & bring back to the next meeting.** **Action: [redacted] to check if the Mental Health Commissioning Committee would fund the Medically**

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	Unexplained Symptoms Headaches.
	5.4 Prescribing NOACs in AF: [redacted] presented the NOACs guidelines recommended by the NICE TAs for the safe & cost effective use of NOACs. After much discussion, it was suggested that [redacted] ***bring a one page simple summary to the next meeting. The APC also asked for more clarity on EGFR & highlighting what GPs need to do regarding dosing decisions i.e. choose Creatinine Clearance or not.***
	5.5 Levosert: AS presented Levosert® a levonorgestrel intrauterine system (LNG-IUS) newly launched in the UK for contraception and the management of heavy menstrual bleeding. It was agreed that Levosert® did not appear to confer any additional benefit over Mirena® and was equivalent in terms of safety and side-effect profile. It is anticipated that in the future the license may be extended to 5 years in line with Mirena®, after the conclusion of ongoing studies. *All agreed & chose Option1: Levosert is not routinely recommended.* **Action: [redacted] to formulate a policy. [redacted] was also asked to inform the manufacturing company to stop promoting the product in Berks West CCGs.**
6.	**NICE Updates:** May and June 2016

6	**NICE Updates:**
6.1	TA217: Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzeimhers Disease (May 2016, update on existing)
6.2	TA390: Canagliflozin, dapagliflozin and empagliflozin as monotherapy for treating type 2 diabetes (May 2016)
6.3	TA 391: Cabazitaxel for hormone relapsed metastatic prostate cancer treatment with docetaxel. This is funded by NHS England.
6.4	TA392: Adalimumab for treating moderate to severe hidradenitis suppurative. This is funded by NHS England.
6.5	TA393: Alirocumab for treating hypercholesterolaemia and mixed dyslipidaemia
6.6	TA394: Evolocumab for treating hypercholesterolaemia and mixed dyslipidaemia
6.7	CG 152: Crohn's disease: management (May 2016 update)
6.8	CG42: Dementia: supporting people with dementia and their carers in health and social care (May 2016 update)
6.9	CG 155: Psychosis and schizophrenia in young people; recognition and management (May 2016 update)
6.10	QS12: Breast cancer (June 2016)

7.	**Commissioning Statements:** **1) Sacubitril Valsartan:** [redacted] presented the paper on Sacubitril Valsartan (Entresto®), a NICE recommended option for treating symptomatic chronic heart failure with reduced ejection fraction, only in people: • with New York Heart Association (NYHA) class II to IV symptoms (which is 60% of our HF Patients) and • with a left ventricular ejection fraction of 35% or less and • who are already taking a stable dose of angiotensin-converting enzyme (ACE) inhibitors or angiotensin II receptor-blockers (ARBs). NICE guidelines also stated that the treatment should be started by a heart failure specialist with access to a multidisciplinary heart failure team and dose titration and monitoring should be performed by the most appropriate team member. [redacted] informed the APC that as this drug is not PBR exclusion and the cost is approximately £100 a month per patient. [redacted] also suggested that Hospital HF Nurses should monitor patients for 6 months & therefore the drug should be initiated by Secondary Care. All agreed & recommended the following option: ***OPTION 1:*** *Red drug/hospital only for 1 year: Initiation by specialist in heart failure (in accordance with the NICE TA) with continued prescribing by the specialist* **2) Ciclosporin Eyedrops (Ikervis):** [redacted] presented the paper on Cyclosporin Eyedrops where NICE has recommended it as an option for treating severe keratitis in adult patients with dry eye disease that has not improved despite treatment with tear substitutes. Patients would be reviewed after 3 months by the consultant ophthalmologist who would discontinue treatment if there was no improvement & would transfer them to Primary Care. [redacted] highlighted that each bottle costs £72. AS confirmed discussion with the RBFT Consultant Ophthalmologist who would initiate treatment and be responsible for ongoing monitoring. **3) Adalimumab in HS:** [redacted] presented the paper on Adalimumab, recommended by NICE for treating active moderate to severe hidradenitis suppurativa in adults whose disease has not responded to conventional systemic therapy. This treatment is funded by NHS England who commissions this treatment through specialist centres only. **Action: [redacted] to ensure dermatology at RBH is informed that treatment is through specialist centres only.** **4) Alirocumab for treating hypercholesterolemia & mixed dyslipidaemia:** [redacted] presented the paper on Alirocumab, a treatment option recommended by NICE to be initiated and continued by a consultant biochemist specialising in lipid disorders in a hospital setting. Treatment was designated as a RED drug and should not be continued in primary care. It was reported that RBFT were offered zero cost stock from the Sanofi Pharmaceuticals. [redacted] highlighted the APC's policy on zero cost stock. After some discussion it was agreed that the zero cost scheme should not be supported in this circumstance. **5) Evolocumab for treating hypercholesterolemia & mixed dyslipidaemia:** [redacted] presented the paper on Evolocumab, a treatment option recommended by NICE to be initiated and continued by a consultant biochemist specialising in lipid disorders in a hospital setting. Treatment was designated as a RED drug and should not be continued in primary care.
8.	**Shared Care:** • **Sacubitril Valsartan:** [redacted] presented the shared care prescribing guidance on Sacubitril Valsartan

	for the treatment of symptomatic heart failure. However, most members felt it was inappropriate & have requested [redacted] to challenge NICE. This has been on hold for a year until further info is received from NICE. **Action: [redacted] to challenge NICE on the use of Sacubitril Valsartan** **Action: [redacted] to circulate Top 20 NICE listed drugs**
9.	**Other Committee Updates:** [redacted] presented these papers for information only. **A) RBFT DTC Minutes:** For noting only **B) BHFT DTC Minutes:** For noting only **C) Thames Valley Priorities Committee Minutes:** For noting only
10.	**Expired APC Policies:** AF discussed under 5.4 above.
11.	**Brown Items:** [redacted] informed that [redacted] was currently updating the net formulary which had been prepopulated on the basis of the BNF. [redacted] to then run an epact search & review spend on Brown Drugs. **Action: [redacted] to bring the list of all BROWN Drugs and corresponding spend (from EPACT) to the Sept'16 APC Meeting.**
12.	**Any other Business:** [redacted] informed that Dr [redacted] was looking at the use of Avastin in wet age related macular degeneration (wAMD). [redacted] started a petition online for this to be discussed at the Parliament and has requested as many as possible to sign the petition before December 2016. **Action: [redacted] to send the link**.

ACTION LOG

No.	Action	Lead	Outcome
Actions from 6th July'16 Meeting			
1.	[redacted] to add the APC Formulary Appeals Procedure to the ToR when updating them	[redacted]	
2.	[redacted] to investigate further on RBFT asking GPs to prescribe Apixaban after receiving more info from [redacted].	[redacted]	
3.	[redacted] to redo the OAB pathway & send to [redacted] for confirmation before publishing	[redacted]	
4.	[redacted] to redo the 4 Headache pathways with a common cover sheet & bring back to the next meeting. [redacted] to check if the Mental Health Commissioning Committee would fund the Medically Unexplained Symptoms Headaches	[redacted] [redacted]	
5.	[redacted] to bring a one page simple summary on NOAC for the next meeting. Guidelines amended giving more clarity on EGFR & highlighting what GPs need to do regarding dosing decisions i.e. choose Creatinine Clearance or not.	[redacted]	

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6.	[redacted] to inform the pharma company to stop promoting the product Levosert in Berks West	[redacted]	
7.	[redacted] to challenge NICE on the use of Sacubitril Valsartan & check with contracts if it can be funded in future as it is not PBR exclusive.	[redacted]	
8.	[redacted] to circulate Top 20 NICE listed drugs	[redacted]	
9.	[redacted] to bring the list of all BROWN Drugs and its spend (from EPACT) to the Sept'16 APC Meeting.	[redacted]	

Dates of Future APC Meetings: All Meetings are on Wednesday from 10.00am – 12.00pm

Date of Meeting	Venue
7th September 2016	Rooms G29/30, 57/59 Bath Road, Reading, RG30 2BA
2nd November 2016	Rooms G29/30, 57/59 Bath Road, Reading, RG30 2BA
11th January 2017	Rooms G29/30, 57/59 Bath Road, Reading, RG30 2BA
1st March 2017	Rooms G29/30, 57/59 Bath Road, Reading, RG30 2BA