NHS
Somerset
Clinical Commissioning Group

Minutes of the **Somerset Prescribing Forum** held in **Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset** on **Wednesday 12 March 2014**

Present:	Jon Beard	Chief Pharmacist, Taunton & Somerset NHS Foundation Trust	JB
	Steve Du Bois	Senior Pharmacist Somerset Partnership NHS Foundation Trust	SD
	Dr Joanna Dunn	Consultant in Palliative Care Medicine, St. Margaret's Somerset Hospice	JD
	Dr Steve Edgar	GP, Somerset Local Medical Committee representative	SE
	Shaun Green	Associate Director, Head of Medicines Management, NHS Somerset CCG	SG
	Catherine Henley	Medicines Manager, NHS Somerset CCG	CH
	Gordon Jackson	Patient Representative	GJ
	Helen Kennedy	Prescribing Support Technician, NHS Somerset CCG	HK
	Ann Lee	St Margaret's Hospice	AL
	Jean Perry	Commissioning Manager, NHS Somerset CCG	JP
	Stephanie Wadham	Medicines Information / Formulary Senior Pharmacist, Yeovil NHS Foundation Trust	SW
	Dr Geoff Sharp (Chair)	GP Delegate (Central Mendip Federation),	GS
In Attendance	Vicky Bull	Prescribing Support Technician, NHS Somerset CCG	VB
Apologies:	Dr Clare Barlow	Chair, Drug & Therapeutics Committee, Taunton & Somerset NHS Foundation Trust	CB
	Dr Rosie Benneyworth	GP Delegate (Taunton Deane Federation), Somerset CCG	RB
	Andrew Brown	Head of Medicines Management, Somerset Partnership NHS Foundation Trust	AB
	Lynda Coles	Vice Chair, Local Pharmaceutical Committee	LC
	Dr Andrew Dayani	Medicines Director, Somerset Partnership NHS Foundation Trust	AD
	Dr Orla Dunn	Consultant in Public Health, Somerset County Council	OD
	Dr Ulrike Harrower	Consultant, Public Health, Somerset County Council	UH
	Dr Sally Knights	Chair, Drug & Therapeutics Committee, Yeovil District Hospital	SK
	John Martin	Chief Pharmacist, Yeovil NHS Foundation Trust	JM

Dr Iain Phillips	GP Delegate (South Somerset Healthcare Federation), NHS Somerset CCG	IP

1 WELCOME

1.1 Geoff Sharp welcomed everyone to the meeting and apologies were noted as above and explained that Lynda Coles would be replacing Martin Taylor as a member of SPF going forwards

2 APOLOGIES

2.1 Apologies were provided as detailed above

3 DECLARATIONS of INTEREST

3.1 No new interests were declared

4 MINUTES OF THE MEETING HELD ON 15 January 2014

4.1 The Minutes of the meeting were agreed as an accurate record.

4.2 GS ran through the schedule of actions from the January meeting:

1. **NICE CG159 – Social anxiety disorder**: CH explained that she had contacted Rosemary Brook to follow up she responded that there were no more relevant actions for primary care to note. The formulary has been updated to reflect CG 159.

   SD said that SomPar will ensure that this guidance is fed into the correct 'Best Practice Group'

   It was agreed that this action can now be closed.

2. **NICE PH45** - **Tobacco Harm Reduction** – CH explained that she had contacted Stewart Brock to follow up any actions taken by Public Health. He responded:

   - The Tobacco Products Directive has been passed, with a 2 year implementation period, so we will see licencing of E-cigs soon. I understand some products are well on the way to being licensed.

   - We have agreed that public health prescribing budget will be managed by the CCG as if we still had a single budget, as in PCT days.

   - Regarding wider harm reduction approaches, I have authorised the stop smoking service (specialist service only, not GP, pharmacy, etc.) to support people wishing to use the harm reduction approach with up to 6 months NRT. Beyond 6 months the client will need to fund their own supply.

   - We are currently starting a tendering process for a new contract from April 2015, and we will need to consider to what extent SCC will support the harm reduction approach, including prescribing, both generally but also for specific client groups, such as people with severe mental illnesses such as

schizophrenia. The SPF may wish to offer a view on this.

SG stated that the importance of offering NRT to patients with severe mental illness should be highlighted in the formulary. Otherwise, this action can be closed off. **Action: CH**

- **Ondansetron off license use for non-chemotherapy induced nausea and vomiting**- JM to take forward application to the Forum based on relative risk on behalf of YDH. No application received. **Action JM** – the Forum agreed to carry forward to next meeting as no application submitted. **SW to chase up.** SW has produced an evidence review on off label use of ondansetron to be discussed under 'Matters Arising.'

3. **NICE Guidance on neuropathic pain**– Formulary to be updated to reflect new Guidance **Action CH** – CH confirmed that the formulary has now been updated

4. **NICE guidance on secondary prevention of MI-** Forum members to take guidance beck to own Trusts - **Action All**

   It was agreed that this action can now be closed.

5. **Lojuxta® hard capsules (lomitapide mesylate) as an adjunct to a low-fat diet and other lipid-lowering medicinal products with or without LDL apheresis in adult patients with homozygous familial hypercholesterolaemia (HoFH)** SG to mention this drug with the lipid specialists who would need to seek agreement for treatment on a case-by-case basis. **Action SG-** SG confirmed that this had been done.

6. **Dapoxetine –** Formulary to be updated to include dapoxetine. **Action CH-** CH confirmed that this had been done with max limit of 6 tabs/month.

7. **Canagliflozin–** Formulary to be updated to include canagliflozin. **Action CH-** CH confirmed that this had been done.

5 **MATTERS ARISING** (no otherwise on the agenda)

5.1 Review of SPF Terms of Reference – adapted to include a proposed 'equality statement' under Principles- point 2.3

It was agreed that the proposed statement should be incorporated into the Terms of Reference

5.2 **Trimethoprim for the treatment of acne**- Taunton and Somerset Antimicrobial Prescribing Group meeting in February agreed that trimethoprim could be used off licence as a third line antibiotic option for acne as long as the following criteria are met:

- Dermatologist prescription only on a FP10HP or Blue Outpatient Prescription
- Dose at 200mg bd rather than 300mg bd (Unclear why the latter dose has been used for acne and why it would be better than a standard trimethoprim dose).
- Appropriate monitoring is undertaken which would consist of FBC and U&Es on a monthly basis due to risk of blood dyscrasias and electrolyte imbalance (the same recommendation as for patients on long term Septrin®)
- Patients are informed to keep an eye out for rash developing, particularly within the first month of therapy
- Contraindicated in pregnancy

TSAPG have said that it is difficult to advise on course length and that 6 months is likely to be OK for most patients but there is very little evidence to guide longer term therapy. If there is a potential for longer than this to years of treatment then the benefits vs risks need to weighed up for individuals. Warning given that there is a greater risk of antimicrobial resistance developing with longer courses.

SG and GS commented that GPs are not commissioned to undertake the monitoring. It was agreed that trimethoprim for the third line treatment of acne should go into the Traffic Light Scheme as a RED 'consultant only' drug and that secondary care should be responsible for the monitoring. **Action CH**

5.3 **'Off-label' use of Ondansetron-** SW presented a review of the literature on the use of ondansetron outside its licensed indications where licensed anti-emetics have failed or are not licensed i.e. in intractable nausea and vomiting unresponsive to other anti-emetics, hyperemesis gravidarum, palliative care or drug induced nausea and vomiting.

Key points discussed:

Ondansetron may be considered second-line for the treatment of nausea and vomiting in pregnancy (Nausea/vomiting in Pregnancy NICE CKS June 2013).

The evidence base for many antiemetics in palliative care is poor; the role of ondansetron in palliative care is limited but it may be useful in nausea and vomiting secondary to chemotherapy or radiotherapy, or sometimes in bowel obstruction or renal failure.

There is a lack of published evidence regarding intractable nausea/vomiting unresponsive to other antiemetics.

It was agreed that the group was happy to approve the primary care prescribing of ondansetron 4mg tablets for second line treatment of nausea and vomiting and for non-chemotherapy related nausea that is unresponsive to other treatments (AMBER –specialist initiated). Prescribing of ondansetron for nausea and vomiting associated with chemotherapy should continue to be the responsibility of secondary care.

Formulary and traffic lights to be updated to reflect this. Action CH

5.4. **EMA Review of medicines containing domperidone**- the European Medicines Agency PRAC Committee has reviewed the safety of these products in response to concerns about serious effects on the heart. Their main recommendations are that:

- Domperidone-containing medicines should restricted for the relief of nausea and vomiting only. They should no longer be authorised to treat other conditions such as bloating or heartburn.
- The recommended dose should be reduced to 10mg up to three times daily by mouth for adults
- The medicine should not normally be used for longer than one week.
- Domperidone must not be given to patients with moderate or severe impairment of liver function, or in those who have existing abnormalities of electrical activity in the heart or heart rhythm, or who are at increased risk of such effects.
- It must not be used with other medicines that have similar effects on the heart or reduce the metabolism of domperidone.

SG outlined the debate from PAMM regarding requests made to GPs for prescriptions from midwives for domperidone to increase lactation. JB stated that he was unaware of these requests and that he didn't think this use had been approved via TST D&T committee. The PAMM is still undecided on whether it should approve this indication given the risks outlined above and the fact that the use would be unlicensed. The PAMM had agreed to try to obtain more information from the midwives and paediatricians on the safety of domperidone when used to increase lactation.

Trust representatives to feedback to their organisations on the EMA safety review.

Action All

5.5 Alogliptin (Vipidia®) approved on formulary at February PAMM as 1st line gliptin

SG discussed Alogliptin which is a new Dipeptidyl Peptidase-4 inhibitor (DPP-4) with similar efficacy to other DPP-4s but it is priced 20% cheaper than other 'gliptins'. PAMM agreed in February to approve alogliptin as first line DPP-4 inhibitor on the formulary.

5.6 Relvar Ellipta® (LABA/ICS) inhaler approved on formulary at February PAMM as an option for treatment of asthma at Step 3 and COPD

SG discussed Relvar Ellipta® - this is a new inhaler, available in two strengths containing fluticasone fuorate and vilanterol (a new LABA) 92/22 micrograms or 184/22micrograms. The dose needs to be given just once a day. Trials show that the efficacy of Relvar Ellipta® is not superior to Seretide® but it is less expensive than other ICS/LABA.

It is worth noting that:

- Only the lower strength (92/22 micrograms) is licensed for COPD in adults where FEV_1 is <70% of predicted normal. NICE COPD Guidance divides treatment options into < or >50% so could be confusing. The higher strength is only licensed in asthma.
- Both strengths (92/22 micrograms or 184/22micrograms) are licensed for the treatment of adults and children over 12 years

- The manufacturer states that the product is only licensed for new patients at step 2 who are poorly controlled – i.e. there is no licence for switching well controlled patients from any other ICS/ LABA combinations to Relvar.
- The respiratory group are concerned at the marketing of Relvar, notably: Blue packaging and name Relvar (maybe suggesting reliever) –confusing for patients.
- GSK maintain the 92mcg strength is suitable for mild to moderate asthma at step 3, but the dose equivalent of 92mcg is 500mcg fluticasone/day (1000mcg BDP equivalent) which pushes it into step 4 (described by BTS as persistent poor control!)
- The individual components are not available as separate inhalers which may present problems if a patient needs to be stepped down.

5.7 Melatonin (Circadin®) approved on formulary at Feb PAMM as an option for treatment of primary insomnia

SG explained that at the February PAMM, Circadin® was approved for the treatment of primary insomnia as per license in patients over 55 for up to 13 weeks. This is because it may have a use in patients who are likely to be affected by the proposed driving under the influence of controlled drugs legislation (planned for summer 2014) and frail elderly who may be at increased risk of falls if prescribed benzodiazepines. Melatonin is currently about half the price of temazepam in primary care.

PAMM agreed to add Circadin® to the formulary as an option in primary insomnia for patients aged over 55 years for the shortest period necessary (2-4 weeks). In exceptional circumstances use may be extended to max licensed use of 13 weeks.

The drug may help with improving sleep patterns and it does provide a small improvement in sleep latency.

JB stated that this had been approved at TST D&T committee.

5.8 Prostap® approved on formulary at February PAMM

Approved as 2nd line GnRH analogue for prostate cancer, Decapeptyl® still 1st line and Zoladex® 3rd line. **Prostap®** is given 3monthly rather than 12 weekly compared to Zoladex® meaning that patients need to have one less dose every 3 years. It is also £10 cheaper per dose than Zoladex®.

6 D&TC DECISIONS

6.1 Somerset Partnership MICP

SD gave a verbal report of the most recent March meeting:

- Sompar looking to introduce a 'fall safe' tool across the whole trust to assess risk of falls and introduce measures to reduce the risk of falls in future.

- The development of their discharge notification form development has stalled because SomPar need to upgrade their clinical system which will improve their ability to produce discharge summaries.

- The Trust is currently reviewing how allergy status on MARR charts is

updated and looking at how to improve the use of Patients Own Drugs (PODs)

- The Trust is currently reviewing how their insulin and warfarin to try to get single documents that work across the organisation.

- The Trust is rolling out electronic prescribing but can't roll out to community hospitals yet.

- Sompar is going to review its prescribing of controlled drugs and information they give to patients in the light of the proposed driving under the influence of controlled drugs legislation (planned for summer 2014).

- Aripiprazole Long Acting Injection (Abilify Maintena®) - requesting consultants think that it may reduce admissions and in general, the drug has fewer metabolic side effects that other atypical antipsychotics- less weight gain and lower incidence of hypercholesterolaemia and hyperprolactinaemia. It is also cheaper than paliperidone and Risperdal Consta at some doses.

  SG had expressed concern that the introduction of Abilify Maintena® may increase the number of people being treated with oral aripiprazole. However, Rosemary Brook said that they don't use aripiprazole all that often in a first episode of psychosis because they don't find it all that effective and that it won't necessarily increase the use of the oral product. However, patients do need to be stabilised on the oral drug first before converting to the depot injection.

  MICP agreed that Abilify Maintena® as an option for 'managed entry'. Rosemary Brook will approve all applications. A CGI will be taken at baseline and at intervals and the data will be presented to MICP meetings for approx. 6 months. There will be no Shared Care status yet.

- **Nalmefene** – MICP have received no requests for this drug yet. Rosemary Brook will ask the drug and alcohol best practice groups to feed back to MICP if they want to use it- no requests yet

6.2 TST

Last meeting 14/2/14.

SG and JB gave a verbal update on the most recent meeting:

- Aflibercept accepted for Central Retinal Vein Occlusion as per NICE TAG

- Thromboprophylaxis- elderly care consultants concerned that some patients may be over anticoagulated. GS requested that risks and benefits of anticoagulation be discussed and documented prior to discharge into primary care. **Action: JB to feedback to TST**

- Dexmedetomidine- ITU pharmacist is currently monitoring Trust usage

- Dapoxetine discussed- agreed not for hospital prescribing

- Granisetron transdermal patches approved at TST for limited indications in

patients having highly emetogenic chemotherapy who are unresponsive/ unable to tolerate oral antiemetics. Not for primary care prescribing. **Action: CH to ensure granisitron TD added Traffic Light Scheme as a RED drug**

- Rifaximin agreed for hepatic encephalopathy as a RED hospital only drug under the management of the gastroenterologists. It is cheaper for the health community to obtain this drug via secondary care. **Action: CH to ensure Traffic Light Scheme is updated**

- JB explained that the Trust is having some problems with the outsourcing of services for home delivery. They are moving back towards using FP10 prescriptions for simple products such as growth hormone. **Action: JB to feedback on progress to SG**

6.3 Weston

No new information since last SPF

6.4 YDH

The committee noted that they would like to thank John Martin for all his contributions to SPF.

SW verbally updated the group on the most recent YDH DTC meeting:

Diclofenac- Following the MHRA safety warnings regarding diclofenac, the ED has been asked to review their use of this drug.

Linaclotide- Approved within license for IBS patients with predominant constipation (IBS-C), who have not responded adequately to or cannot tolerate or cannot tolerate antispasmodics and/or laxatives (including prucalopride, if clinically indicated)

It was agreed that linaclotide should be **restricted to consultant gastroenterologist hospital prescribing only** at present until the consultants have enough data to define a patient population and treatment pathway.

The recommendation was to propose this as an amber drug for GPs to initiate on the advice of a consultant – PAMM agreed, this will now be raised at SPF. SG asked JB to take this to TST GI meeting to discuss. **Action:JB**

Seebri Breezhaler®- Approved for use at YDH. Already on CCG Formulary. Contains glycopyrronium and is an alternative inhaled long-acting muscarinic antagonist (LAMA) licensed for use in COPD.

Subcutaneous Trastuzumab- YDH approved the change from currently using IV trastuzumab to the newly licensed s/c presentation. It is cheaper than the IV presentation and involves no dose calculations. NHS England supports its use. This decision will be reviewed once a biosimilar becomes available.

Dabigatran -YDH noted the results of a recent meta-analysis showing an increased risk of MI with the oral direct thrombin inhibitors (dabigatran) when compared with warfarin. It was noted that dabigatran still has good mortality data.

Orthopaedics have decided to change from dabigatran to aspirin for VTE prophylaxis following knee and hip replacement operations, irrespective of this data. This is because they are not entirely happy with the bleeding risks associated with dabigatran.

SG stated that as commissioners, we would expect Trusts to be NICE compliant and requested that YDH come back to SPF with evidence to support the switch back to aspirin. **Action: SW**

6.5 Taunton & Somerset Antimicrobial Prescribing Group (TSAPG)

TSAPG agreed to approve trimethoprim for the third line treatment of acne in a limited group of patients. Already discussed under 'matters arising' -see point 5.2 for more detail.

JB explained that the TST are working to introduce a neutropenic sepsis card. The card will be carried by patients identified to be at risk and will state which antibiotics and dose to administer if a patient presents with suspected neutropenic sepsis. This minimise any delays from when the patient presents to secondary care to the point where they receive the correct antibiotic. JB was asked to update the group on progress at the next SPF. **Action: JB**

6.6 RUH

GS asked that minutes from RUH DTC are included on the SPF agenda in future. **Action: CH**

7 NICE

7.1 A summary of the NICE guidance, including Quality Standards, published in Jan and Feb 2014 was presented to the Forum for information.

7.2 NICE TA303 Teriflunomide for treating Relapsing-Remitting MS (Jan-14)

Noted- funded by specialist commissioning

7.3 NICE TA305: Macular oedema (central retinal vein occlusion) aflibercept solution for injection-

Already agreed for suitable patients at January 14 SPF following positive FAD. It was noted that this decision has now been backed up by NICE.

7.4 NICE TA306: Lymphoma (non-Hodgkin's), relapsed, refractory Pixantrone monotherapy

SG noted that this is not a CCG commissioned drug.

7.5 NICE CG175: Prostate Cancer (Jan 14)

SG asked that this guidance is raised with specific clinical groups within Trusts. **Action: All**

7.6 NICE CG176: Head Injury (Jan 14)

SG asked that this guidance is raised with specific clinical groups within Trusts. **Action: All**

7.7 NICE CG177: Osteoarthritis (Feb-14)

SG noted that:

- There has been no change to recommendations on paracetamol use.
- Hyaluronan injections not recommended.
- Glucosamine and chondroitin products not recommended.

7.8 NICE CG178: Psychosis and Schizophrenia in Adults (Feb-14)

SG commented that the new guidance highlighted the need for psychiatrists to address the issues of premature death in patients with severe mental illness. Specifically, the guidance states that:

- The secondary care team should maintain responsibility for monitoring service users' physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, **whichever is longer**. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.

- Weight, cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia should be regularly monitored.

- If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, interventions should be offered in line with relevant NICE guidance.

- Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential impact of reducing nicotine on the metabolism of other drugs, particularly clozapine and olanzapine.

CH explained that this has been raised with SomPar through MICP. Rosemary Brook has said that they will address the guidance via their best practice group. They are hoping to adapt the system of monitoring that is already in place for clozapine for all antipsychotics. They plan to review shared care guidelines for atypical antipsychotics once this is done.

Evidence Summaries: Quality Standards (noted for information only)

7.9 QS51 Autism

Key points to note:
QS 2: People having a diagnostic assessment for autism are also assessed for coexisting physical health conditions and mental health problems.
QS 3: People with autism have a personalised plan that is developed and implemented in a partnership between them and their family and carers (if appropriate) and the autism team.
QS 5: People with autism have a documented discussion with a member of the autism team about opportunities to take part in age-appropriate psychosocial interventions to help address the core features of autism.
QS 6: People with autism are not prescribed medication to address the core features of autism.

QS 8: People with autism and behaviour that challenges are not offered antipsychotic medication for the behaviour unless it is being considered because psychosocial or other interventions are insufficient or cannot be delivered because of the severity of the behaviour.

7.10 **QS52** **Peripheral Arterial Disease**

Key points to note: QS 2 -People with PAD are offered an assessment for cardiovascular comorbidities and modifiable risk factors.

7.11 **QS53** **Anxiety Disorders**

Key points to note: QS 3 People with an anxiety disorder are not prescribed benzodiazepines or antipsychotics unless specifically indicated.

QS 4 People receiving treatment for an anxiety disorder have their response to treatment recorded at each treatment session.

7.12 **QS54** **Faecal Incontinence**

Key points to note: QS 4- Adults with faecal incontinence have an initial management plan that covers any specific conditions causing the incontinence, and diet, bowel habit, toilet access and medication.

7.13 **QS55** **Children and young people with cancer-** noted

7.14 **QS56** **Metastatic cord compression-** noted

Public Health Guidance- to note

7.15 **PH49** **Behaviour Change: individual approaches-** noted

7.16 **PH50** **Domestic violence and abuse – how services can respond effectively-** noted

Evidence Summaries: New Medicines (noted for information only)

7.17 **ESNM30:** **Prostate Cancer:** Triptorelin (Decapeptyl SR) (Jan 14) – noted

7.18 **ESNM31:** **Long-acting reversible contraception:** subcutaneous depot medroxyprogesterone acetate (DMPA-SC) (Jan 14)- noted

7.19 **ESNM32** **Relapsed and refractory multiple myeloma:** pomalidomide (Feb-14)- noted

7.20 **ESNM33** **Chronic obstructive pulmonary disease**: indacaterol/glycopyrronium (Ultibro Breezhaler) (Feb-14)- noted. Not launched in the UK yet.

7.21 **NICE Consultations**

A list of the current NICE consultations was presented to the Forum for information.

8 **HORIZON SCANNING**

8.2 The following horizon scanning documents were presented to the Forum for

information:

- RDTC Monthly Horizon Scanning document Jan and Feb 14
- UKMi New Drugs Online Newsletter
- A list of forthcoming NICE ESNM and ESUOM

There were no new items to note.

9 FORMULARY APPLICATIONS

9.1 Buprenorphine patches as Hapoctasin®

SG explained that historically Somerset has not recommended. However, prescribing data shows that there is some prescribing. Hapoctasin® patches offer a 40% saving compared with the originator brand (Transtec®). PAMM have agreed that Hapoctasin® should be added to the formulary. **Action: CH**

It was noted that Hapoctasin® patches are available in the same 3 strengths as Transtec® but Hapoctasin® patches need to be changed every 3 days compared with every 4 days for Transtec®. Practices and patients will need to be provided with this information.

9.2 Linaclotide - Linaclotide (Constella®) in patients with moderate to severe IBS with constipation

See point item 6.4 for more detailed information. JB to take back to TST to see where this drug fits in therapy. **Action: JB**

9.3 Certolizumab (Cimzia®)for Psoriatic Arthritis (PsA)

SG explained that certolizumab, hasn't been NICE'd for PsA, but it is licensed for:

Psoriatic arthritis
Cimzia, in combination with MTX, is indicated for the treatment of active psoriatic arthritis in adults when the response to previous DMARD therapy has been inadequate.
Cimzia can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate.

Etanercept, infliximab, adalimumab and golimumab are all approved by NICE for PsA where:

- The person has peripheral arthritis with three or more tender joints and three or more swollen joints, and
- The psoriatic arthritis has not responded to adequate trials of at least two standard disease-modifying antirheumatic drugs (DMARDs), administered either individually or in combination.

The group agreed to approve certolizumab in line with NICE guidance for other biologics for PsA. However, it will be left up to individual clinicians to decide whether or not to choose to use this drug. Traffic lights to be updated to include certolizumab as a RED drug as an option for PsA

Action: CH

9.4 Nalmefene (Selincro®) for alcohol dependence Estimated cost > £1000/yr

Not approved. SG has raised this with turning point and there is no appetite to prescribe nalmefene at the moment due to poor evidence base, high cost and long list of contraindications.

9.5 Aripiprazole Long Acting Injection (Abilify Maintena®)

Not approved because SomPar is currently undertaking managed entry of this product for 6 months to assess efficacy. To come back to SPF in 6 months once data has been reviewed.

10 NHS ENGLAND SPECIALIST COMMISSIONING

SG is awaiting further information from NHS England.

11 PBR EXCLUDED DRUG MONITORING

11.1 CCG PBR Excluded Drugs.

A spreadsheet detailing the CCG-responsible PBR drug spend against budget for TST and YDH was presented and discussed.

SG stated that there has been no confirmation of the budget for next year yet. He is clear that if appropriate uplifts are not given to the non-PBR budget next year, then the budget is likely to be overspent,.

GS discussed the idea that in order to achieve appropriate benchmarking, it would be nice to organise the data into 'drug issues' and 'non-drug issues' for T&S and YDH. JB stated that it may be possible to share local Define data. It was agreed that JP will liaise with JB to try to agree an acceptable format for the data.

Action JP/JB

12 DRUG SAFETY

12.1 **MHRA Drug Safety Update Jan and Feb 2014**

SG asked that trusts review the Drug Safety updates and take appropriate action.

Action All

12 ANY OTHER BUSINESS

No further business was raised.

13 DATE OF NEXT MEETING

- 14 May 2014 **at Wynford House (Meeting Room 2), Yeovil**

Venue: Meeting Room 2, Wynford House, Lufton Way, Yeovil, Somerset BA22 8HR between 2.30pm and 5pm

SCHEDULE OF ACTIONS

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
ACTIONS ARISING FROM THE MEETING HELD ON WEDNESDAY 12 MARCH 2014			
1	**Declarations of interest**	Members were asked to notify the Prescribing Forum secretary of any standing declarations of interest, which could be held on record.	**All** **(on going)**
2	**NICE PH45 Tobacco Harm Reduction**	Importance of offering NRT or support to stop smoking to patients with severe mental illness to be highlighted in the formulary.	**CH** **24-May-14**
3	**Trimethoprim for the treatment of acne**	Update the Traffic Light Scheme to include trimethoprim for the third line treatment of acne as a RED 'consultant only' drug.	**CH** **24-May-14**
4	**Ondansetron off license use for non-chemotherapy induced nausea and vomiting**	Update formulary and Traffic Light Scheme to cover the second line use of Ondansetron 4mg as an AMBER 'specialist initiated' drug to treat nausea and vomiting in pregnancy and other non-chemo related nausea and vomiting that is unresponsive to other treatments.	**CH** **24-May-14**
5	**Domperidone Safety**	Trust representatives to feedback to their organisations on the EMA PRAC committee safety review of domperidone,	**All** **24-May-14**
6	**TST Thromboprophylaxis in elderly patients**	TST has been asked to ensure that risks and benefits of anticoagulation be discussed and documented prior to discharge into primary care.	**JB** **24-May-14**
7	**Granisitron Transdermal Patches**	Update the Traffic Light Scheme to include granisitron TD patches as a RED 'consultant only' drug for patients receiving highly emetogenic chemo who are unresponsive/ intolerant to oral antiemetics	**CH** **24-May-14**
7	**Rifaximin for hepatic encephalopathy as a RED hospital only**	CH to ensure that Traffic Light Scheme is updated.	**CH** **24-May-14**
8	**TST outsourcing of services for home delivery**	TST to update Shaun Green on progress.	**JB** **24-May-14**
9	**Linaclotide for IBS**	TST to take back to their GI group to discuss whether they want to put it on formulary	**JB** **24-May-14**

10	**Certolizumab for Psoriatic Arthritis (PsA)**	Traffic lights to be updated to include certolizumab as a RED drug as an option for PsA in line with NICE guidance	**CH** **24-May-14**
NO.	**SUBJECT**	**OUTSTANDING RESPONSIBILITY**	**ACTION LEAD**
11	**Nalmefene (Selincro®) for alcohol dependence**	Traffic lights to be updated to show nalmefene as a BLACK 'not recommended' drug	**CH** **24-May-14**
12	**Aripiprazole Long Acting Injection (Abilify Maintena®)**	Traffic lights to be updated to show aripiprazole LAI as a BLACK 'not recommended' drug	**CH** **24-May-14**
13	**YDH switch back to aspirin from dabigatran post hip and knee replacement**	YDH to present evidence to SPF to support the switch back to aspirin.	**SW** **24-May-14**
14	**RUH DTC minutes**	Include RUH DTC minutes on SPF agenda in future	**CH** **24-May-14**
15	**Neutropenic Sepsis card**	JB to update on progress at next SPF.	**JB** **24-May-14**
16	**NICE CG175: Prostate Cancer (Jan 14)**	Trust representatives to raise guidance with relevant clinical groups.	**All** **24-May-14**
17	**NICE CG176: Head Injury (Jan 14)**	Trust representatives to raise guidance with relevant clinical groups.	**All** **24-May-14**
18	**Buprenorphine patches as Hapoctasin®**	Ensure that Hapoctasin® patches are added to the formulary.	**CH** **24-May-14**
19	**CCG PBR Excluded Drugs**	JP will liaise with JB to try to agree an acceptable format for the data.	**JP/JB** **24-May-14**
20	**MHRA Drug Safety Updates**	Trusts to review safety updates and take appropriate action	**All** **24-May-14**