NHS
Somerset
Clinical Commissioning Group

Minutes of the **Somerset Prescribing Forum** held in **Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset** on **Wednesday 11 March 2015**

Present:	Dr Clare Barlow	Chair, Drug & Therapeutics Committee, Taunton & Somerset NHS Foundation Trust	CB
	Steve Du Bois	Acting Head of Medicines Management, Somerset Partnership NHS Foundation Trust	SD
	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
	Dr Sally Knights	Chair, Drug & Therapeutics Committee, Yeovil District Hospital	SK
	Dr Geoff Sharp	GP Delegate (Central Mendip Federation), Chair	GS
	Jon Standing	Chief Pharmacist, Yeovil District Hospital	JS
	Donna Yell	Prescribing Support Technician, NHS Somerset CCG	DL
In attendance	Dr Riley	Registrar to Dr Sally Knights	
Apologies:	Jon Beard	Chief Pharmacist, Taunton & Somerset NHS Foundation Trust	JB
	Rosemary Brook	Consultant Psychiatrist Somerset Partnership	RB
	Lynda Coles	Vice Chair, Local Pharmaceutical Committee	LC
	Dr Orla Dunn	Consultant in Public Health, Somerset County Council	OD
	Dr Steve Edgar	GP, Somerset Local Medical Committee representative	SE
	Matt Harvey	Development and Liaison Officer, Somerset LPC	MH
	Jean Perry	Commissioning Manager, NHS Somerset CCG	JP
	Pip Tucker	Public Health Specialist	PT
	Stephanie Wadham	Medicines Information / Formulary Senior Pharmacist, Yeovil NHS Foundation Trust	SW

1 WELCOME

Geoff Sharp welcomed everyone and introduced Donna Yell (Prescribing Support Technician) who will be taking over from HK as secretary to the PAMM when she leaves the CCG at the end of March.

2 APOLOGIES

Apologies were provided as detailed above.

3 DECLARATIONS of INTEREST

GS asked for declarations of interest.

SK declared that she had attended some recent educational meetings sponsored by Leo pharmaceuticals. CH to update the declarations of interests.

Action CH

No other new interests were declared by anyone else at the meeting.

4 MINUTES OF THE MEETING HELD ON 14th January 2015

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

4.2 GS ran through the action points from the last meeting. The following items were specifically noted:

1. **Ulipristal acetate 5mg tablets (Esmya®) for uterine fibroids-** CB updated the group that:

   CB reported that the gynaecologists at TST are not keen to use 2 courses of ulipristal instead of one for uterine fibroids. The license has been extended to allow for up to two courses instead of one. No further action needed.

2. **TA 324: Dual-chamber pacemakers for symptomatic bradycardia due to sick sinus syndrome without AV block**

   SG had highlighted this guidance to the cardiac network.

3. **SIGN 141 British Guidelines on the management of Asthma**

   There had only been minor comments from the Respiratory Network with no major changes relating to prescribing

4. **TA 325: Nalmefene for reducing alcohol consumption in people with alcohol dependence**

   Public health are still looking at how they might commission a service to support the use of nalmefene. CH to find out about progress before next meeting. **Action CH**

5. **PbR Excluded 15/16 budget setting process**

   SG updated the group that the process is ongoing, the data is being tidied up to remove non drug data from the TST report and that at the moment, there is no confirmation of budget allocation.

6. **DEFINE antibiotic benchmarking data-** a review of this data has been

deferred until the May SPF meeting

7. Ophthalmology requests for branded eye drops

SG stated that he is hoping to attend the ophthalmology group meeting tomorrow and will try to ask them to recommend eye drops by generic name.

5 MATTERS ARISING (not otherwise on the agenda)

5.1 Review of SPF Terms of Reference

It was agreed that the following amendments should be made:

- 1.4 should also reference relationships with the antimicrobial group
- 4.6 should state that an SPF application form 'is available' rather than 'should be used' for new medicines to be considered.
- 4.17 should be re-worded to read:
  'Somerset Prescribing Forum will work to ensure appropriate use of NICE approved and non-NICE patient access schemes for high cost drugs.'
- 5.1 Somerset Clinical Commissioning Group Board, should read Somerset CCG Governing Body
- 8.4 should read that agendas and papers will normally be issued 7 working days in advance of the meeting
- Conflicts of interest and declarations should be separate from the governance section

It was also agreed that LPC, LMC and lay members should be observers rather than voting members.

CH to amend the ToRs accordingly and bring back to the next meeting.

Action: CH

5.2 Progress of Drug Monitoring in Primary Care Enhanced Service

A specification has been circulated for comment. GS to update at the next meeting. **Action: GS**

5.3 Guidance on use of supplements and monitoring for bariatric surgery

Recent guidance shared from the bariatric services at TST suggests that blood monitoring is being shifted to general practice before 2 years which would not be consistent with the NHS England (NHSE) policy or NICE.

CB stated that an issue had been raised due to revision of the guidance by the bariatric team without an understanding of the process that should have been followed. In house discussions have not been completed yet but there is an acceptance that bariatrics have responsibility for follow up and monitoring for 2 years after surgery in line with NHS England (NHSE) and NICE guidance.

GS explained that, in some cases, the expectation that GPs will take over the prescribing and monitoring of bariatric patients and other issues are causing

workload problems in primary care.

CB stated that TST are not trying to shirk their responsibilities but it may be difficult to suddenly repatriate the prescribing and monitoring of a lot of bariatric patients back into secondary care. Also, it may not always be possible to arrange for every long distance patient to return to TST for monitoring.

SG stated that the recommendations from the NHSE service spec for bariatric surgery and new NICE CG 189 need to be discussed with Commissioners (currently NHSE) so that any monitoring recommendations from the service and Trust are, as commissioned, and compliant with NICE. TST need to consult with NHSE, as commissioners of the service. If NHSE expect GPs to be responsible for monitoring and prescribing for bariatric patients, the CCG will need to talk to NHSE about how this will be funded.

It was agreed that it is important not to jeopardise patient care and that this would be discussed again at SPF once the guidance has been presented to TST DTC.

Action: CB

5.4 NICE TA 323 Erythropoiesis‐stimulating agents (epoetin and darbepoetin) for treating anaemia in people with cancer having chemotherapy (including review of TA142)

SG stated that CCGs are responsible for paying for epo and darbapoeitin products for this indication.

CB stated that no significant change in practice is anticipated as a result of this guidance. It is just views as an option for treatment.

The oncologists will be monitoring their practice over time and will flag any changes that are likely to happen early on. TST are currently looking to see how many transfusions the use of epo might save but it is unlikely to save many transfusions. The group heard that these views are shared across Somerset.

6 OTHER ISSUES

6.1 Leflunomide Shared Care Guideline

CH explained that the leflunomide SCG had been reviewed in consultation with Teresa Jewell (Rheumatology Nurse Specialist at TST) Dr Sally Knights and Dr Alex Bourne (Rhematologists) at YDH. The main changes were:

- Comment stating that leflunomide is always used third line removed because while this may be most common, it is not the exception.
- Use of leflunomide in Psoriatic Arthritis is now included.
- The loading regime has been removed from the dosing instructions because the rheumatologists don't use it.
- To ensure that prescribers are aware, a statement for appropriate length for treatment discontinuation or wash out for those considering pregnancy has been added in addition to the relevant link in the SPC.

- The monitoring requirements have been changed slightly to bring them into line with British Society of Rheumatologists guidance. This brings the frequency of blood tests down from every 2 weeks in the first 6 months of treatment to every month.

The group agreed that:

- The new SCG is satisfactory
- The SCG should be fed into the 'Drug Monitoring in Primary Care Enhanced Service' **Action: SG**
- The SCG will be brought to PAMM for noting **Action: CH**
- Final version to be published on the website. **Action: Steve Moore**

6.2 Communication on shared care medicines – discussion

There was a discussion around the difficulties that GPs are often having in relation to being asked by the acute trusts to participate in the 'shared care of patients'. Sometimes letters are arriving to GPs with no request to take on shared care or with no mention of the shared care guidelines.

The group asked that Trust DTCs to:

- Ask colleagues to communicate appropriately with GPs and to make it clear that it is not compulsory to enter into shared care arrangements.
- Ensure that the communication letter from secondary care to the GP should ask the GP to let the consultant know within 7 working days of receipt of the letter requesting shared care if they choose not to prescribe.
- Ensure that letter give a date for handover of prescribing and monitoring to the GP.
- Ensure that letters reference any shared care guideline.
- Ensure that letters are clear about the steps involved in any dose titration and the increments that should be used.

Action CB/SK

There have been some changes to the CCG website that have made it difficult for Trusts to access the SCG. CH to share the relevant links. Many of the SCGs need to be updated. **Action CH**

6.3 Low Molecular Weight Heparin bridging therapy- discussion

The wide variation in Trust bridging policies for surgical patients on long term anticoagulation therapy who may require interruption of treatment before a procedure was discussed. This is particularly the case for patients taking warfarin and there is less variation in policy for patient taking NOACs.

CB stated that the perioperative bridging policy for TST recently came to their DTC committee but it had been circulated quite late and it had been difficult to have a proper discussion. She has agreed to meet with the authors next week.

SG stated that there is a large amount of variation between the guidance of each Trust for patients who require interruption of warfarin therapy and that it would be helpful to get some consistency between the policies. The CCG would like some assurances that the evidence base has been reviewed and that this has been used to inform any guidance.

SG stated that there needs to be clarity on what impact a policy will have on primary care. Primary care can't monitor INRs over weekends so we need to ensure that any policy is practical to implement.

CB agreed to feedback on her discussions with the authors at the next meeting. **Action CB**

CB said that it may not be easy to get the consistency that the CCG is looking for because Trusts will want their own policies. However, JS said that we should be able to get consistency between YDH and TST because YDH take their advice from TST. CB agreed to ask relevant haematologists to open discussions with YDH. **Action CB**

CH agreed to circulate a table summarising different Trust protocols prior to the next meeting. **Action CH**

6.4 Outpatient FP10 prescribing – discussion

GS explained that the COG has requested that secondary care look at using more FP10 prescription forms in outpatient clinics. The aim of this would be to attempt to reduce GP workload by minimising the number of patients who have been seen in local outpatient clinics presenting to GPs asking for urgent 'same day' prescriptions. COG are concerned that current arrangements are not working well and that patients often present to surgeries requesting prescriptions after attending hospital OP clinics. This often happens inappropriately early in the belief that the medications have to be started immediately and impacts on GP workload. Sometimes the information regarding the recommended drugs not having been received by practices and the specialist's hand writing is not always legible which presents patient safety issues.

TST, Weston and YDH all have a policy of only supplying an FP10 or dispensing from the hospital pharmacy where an item is needed urgently. In all other cases, patients are asked to request a prescription from their GP. JS was not aware of any dedicated stationary being used for this purpose at YDH

TST and Weston had provided sample outpatient letters which they use to request non urgent medication for GPs. These clearly warn patients that it may take several days for their surgery to generate a prescription. However, these would need to be used consistently and it is probably worth reminding outpatient clinicians that they should also verbally tell the patient that the prescription is not needed urgently.

Data was viewed showing that FP10 use by hospitals is increasing.

It was agreed that the CCG would:

- Try to identify whether particular clinics are poor at communicating prescription information. GS will also approach the discharge group to see how they can help. **Action GS**
- Produce a standardised letter that it would like all outpatient departments to use. There needs to be a clear message stating that it is not urgent to obtain their prescription. **Action CH**

It was also agreed that Trusts would look at:

- Ensuring that stationary is consistently used Ensuring patients are reminded during the consultation that the prescription is not urgent.
- Stating within the outpatient letter that patients don't need a special appointment to see their GP to obtain a prescription.
- Telling patients how long it is likely to be before their GP will receive a letter from the clinic.
- Look at whether an electronic system could be implemented and whether it might be possible to replicate the system used for discharge

Action SK/JS/CB/ JB

6.5 Proposed dry eye treatment pathway

A treatment pathway for dry eyes has been developed outlining the treatments available for mild, moderate and severe dry eyes. It outlines the different drops available on the formulary as well as preservative free options. The guidance is based on best evidence and most cost effective treatment choices.

For people requiring referral to a specialist, the guidance states that, in most cases, it is appropriate to refer to an optometrist first before an ophthalmologist. SG sated that this pathway ensures that the majority of patients are treated for dry eye in primary care. It will hopefully slow down some of the referrals to secondary care by ensuring that they see only the most severe cases.

SG stated that the pathway had been shared through the Ophthalmology Working Group and that ophthalmology have raised no formal comments regarding the choice of eye drops.

SK stated that all patients with suspected Sjorgens Syndrome (SS) should be seen by a rheumatologist and that the pathway should state this. Patients with SS need to be followed up annually because of the significant increased risk of lymphoma. SG to ensure that the wording is amended. **Action SG**

SG stated that if he receives no comments on the pathway in the next 2 weeks, he will share the final document as approved and put into formulary and navigator app. All agreed. **Action SG**

6.6 Discontinuation of Lumigan 0.03% 3ml eye drops

Alcon have discontinued the multidose bottles of Lumigan® (bimatoprost) 0.03% eye drops (nearing the end of patent). The view of the Ophthalmologists is that these patients currently on 0.03% should be switched to Lumigan® 0.01% eye drops.

SG stated that this might have been an opportunity to review patients and potentially switch some to the less costly, latanoprost. However, primary care accept the opthalmologists decision but would like the position to be reviewed again if a generic bimatoprost eye drop 0.03% subsequently becomes available.

Advice to be issued to primary care. **Action SG**

7 D&TC DECISIONS

7.1 Somerset Partnership D&T meeting

There were no minutes available from the last meeting held 5/3/15 so SD updated the group. It was specifically noted that:

- NICE have issued an evidence summary on Lurasidone. This product is more than 10 times more expensive than other antipsychotics but the risks of extrapyramidal side effects were as high as some of the more established (and cheaper drugs). Sompar have therefore decommissioned the use of lurasidone. They had been operating a 'controlled entry process'. Lurasidone will now only be available by individual exception and while they will maintain existing patients, they won't start any new patients on it. It remains a red 'hospital only' drug in the formulary.
- Sompar are concerned that they have growth in the use of melatonin which is being driven by paediatric patients migrating to CAMHs. SG stated that the CCG does not commission Melatonin for unlicensed uses and therefore SomPar need to discuss this with relevant Trusts.

7.2 TST

SG outlined the minutes of the last meeting held on Friday 13/02/14. The following were noted:

- Biosimilar infliximabs (Remcima® and Inflectra®) – Have been launched with no concerns raised. Rheumatology and gastroenterology are the largest users. A 40% cost-saving is anticipated if this replaces current infliximab infusions. There is no wish to change treatment for those self-administering sub-cut injections. This has been added to the SPF agenda as a formulary application.

- Nortriptyline –Due to the high cost, the pain team have agreed to use an alternative TCA. A small usage was agreed for gastroenterology (Emma Greig) as an exception.

- Soluble prednisolone - soluble tablets has are very expensive. The plain tablets will disperse easily in water to form a fine suspension and paediatrics have agreed to use this. The potential saving is 25K/ year by making this change at TST. Soluble tablets have been made non-Formulary and are only available on a 'named-patient basis' via DTC.

- Lumigan® 0.3% eye drops discontinuation –This had already been discussed- agenda item 6.6

- Sastravi® has been accepted by TST as a cost effective alternative to Stalevo®.

- Melatonin has been accepted for: Hemicrania continua – approved as an amber drug to ensure that recommendation is made by secondary care. Also for Parkinson's disease related sleep disorder as a green drug.

  SG stated that we would need to get confirmation from TST on expected treatment duration. In order to approve we would need expect the licensed product, Circadin to be used with a maximum treatment duration for insomnia of 13 weeks. CH to email Nigel Ankcorn. **Action CH**

- Magnaspartate® has been accepted as a licensed magnesium product. SG stated that new patients should be given a licensed product.

- Hyacyst® for painful bladder syndrome. SG has asked that TST to present a review of the evidence to PAMM and SPF if prescribing is to be considered in primary care.

7.3 Taunton & Somerset Antimicrobial Prescribing Group (TSAPG)

The last meeting due on 11/02/15 was cancelled so there were no new minutes.

7.4 YDH

The last meeting due on 27/01/15 was cancelled so there were no new minutes.

7.5 BNSSG Joint Formulary Group

The minutes from the last meeting held 20/01/15 were viewed and noted.

7.6 RUH Bath D&TC

The meeting minutes from Nov 14 were viewed and noted.

8 NICE

8.1 A summary of the NICE guidance published since the last SPF was presented to the Forum for information and noted.

8.2 HST1: Eculizumab for treating atypical haemolytic uraemic syndrome (for noting)

Noted- positive appraisal. Funded by specialist commissioning.

8.3 TA 322: Prostate cancer (metastatic, hormone relapsed) - sipuleucel-T (1st line) (for noting)

Noted- Negative appraisal. Black TLS Status. **Action: Steve Moore**

8.4 TA 329: Infliximab, adalimumab & golimumab for treating moderately to severely active ulcerative colitis after failure of conventional therapy (including review of TA140 & TA262)

NICE are extending the cohort of patients who can be treated with biologic drugs and extending the choice to children too. The potential increased usage had been taken into account in the budget setting process for secondary care in 15/16

SG said that the CCG is hoping that the additional cost pressure will be offset by some of the savings from biosimilars.

8.5 TA 330: Sofosbuvir for treating Hepatitis C (chronic) (for noting)

Noted- positive appraisal. Funded by specialist commissioning. Red Traffic Light status with a note- 'funded by NHS England'. **Action: Steve Moore**

8.6 TA 331: Simeprevir in combination with peginterferon alfa and ribavirin for treating genotypes 1 and 4 chronic hepatitis C (for noting)

Noted- positive appraisal. Funded by specialist commissioning. Red Traffic Light status with a note- 'funded by NHS England'. **Action: Steve Moore**

8.7 **NICE TA333: Axitinib for treating advanced renal cell carcinoma after failure of prior systemic treatment (for noting)**

Noted - positive appraisal. Funded by specialist commissioning. Red Traffic Light status with a note with a note- 'funded by Cancer Drug Fund'. **Action: Steve Moore**

8.8 **NG1 Gastro-oesophageal reflux disease: recognition, diagnosis and management in children and young people**

PAMM have considered this guidance and highlighted it in the latest medicines management newsletter. Trusts were asked to consider the guidance and implement the recommendations as appropriate.

8.9 **NG2 Bladder cancer: diagnosis and management**

Guidance noted

8.10 **CG61 Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care**

Guidance noted:

Low dose tricyclic antidepressants (TCAs) are recommended as second-line treatment for people with IBS if laxatives, loperamide or antispasmodics have not helped.

SSRIs can be considered for people with IBS only if TCAs are ineffective.

Prescribers should take account of the possible side effects when offering TCAs or SSRIs to people with IBS. They should follow up people taking them for the first time at low doses for the treatment of pain or discomfort in IBS after 4 weeks and then every 6–12 months.

This use of TCAs and SSRIs is off label and this will need DTC approval. SG to raise with acute trusts. **Action SG**

8.11 **NG3: Diabetes in pregnancy: management of diabetes and its complications from preconception to the postnatal period**

Guidance noted. SG stated that Trusts should take forward any drug related aspects of the guidance and look to see where there are gaps in provision. Any problems should be raised internally as well as with commissioners.

8.12 **NG4: Safe midwifery staffing for maternity settings**

Guidance noted. Trusts were asked to consider the guidance and implement the recommendations as appropriate.

8.13 **NG 5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes**

Guidance noted. Trusts were asked to consider the guidance and implement the recommendations as appropriate.

Public Health Guidance- None in Jan or Feb 15

NICE Diagnostic Guidance- Nil Noted

9 HORIZON SCANNING

The following horizon scanning documents were made available to SPF members in advance of the meeting. Relevant items had from these had already been added to the agenda:

9.1 • **RDTC Monthly Horizon Scanning document Nov and Dec 14**

9.2 • **UKMI Prescribing Outlook and New Drugs Online**

9.3 • **A list of forthcoming NICE ESNM**

9.4 • **NICE forward planner**

SG that it is important to prioritise issues in the NICE forward planner and to be aware of TAGs and Guidance that is coming so that budget setting discussions can happen early.

SG asked that Trusts don't enter patients into trials without considering how drugs will be funded post trial.

10 FORMULARY APPLICATIONS

10.1 Cosmocol® (Stirling Anglian Pharmaceuticals) line extensions:

Two more Cosmocol® products have been launched.

- Cosmocol Paediatric (£2.99/ 30 sachets)
- Cosmocol Half (£2.99/ 30 sachets)

These are significantly less expensive than their Movicol equivalents. Movicol Paediatric and Movicol Half are both priced at £4.38 per 30 sachets. SG asked the group to note that these had been approved by PAMM and the CCG is looking to use these products in primary care. Agreed. Formulary to be updated.

Action: Steve Moore

10.2 Theical® Calcium and Vitamin D 1000mg/800iu chewable tablets (Stirling Anglian Pharmaceuticals)

Theical® Calcium and Vitamin D 1000mg/800iu chewable tablets are a once daily preparation priced at £2.95 for 30 tablets. This works out to at the same price as Accrete® (which is a solid tablet to be taken twice a day). SG asked the group to note that these had been approved by PAMM for patients who prefer a chewable calcium and vitamin D product. Agreed. Formulary to be updated.

Action: Steve Moore

10.3 Ensure® Shake

This product has marketed at the same price as Aymes Shakes and had been approved by PAMM as another option for patients. Agreed. Formulary to be updated.

Action: Steve Moore

10.4 Modified release methyphenidate branded generic preparation: Xenidate®

Xenidate® is an extended release methylphenidate product which is marketed as being bioequivalent to Concerta XL ® tablets. The product is priced at £20.27 for 30 x 18mg and £27.59 for 30x 36mg which is 35% cheaper than the originator brand. Xenidate had earlier been approved by PAMM. Agreed. Formulary to be updated. **Action: Steve Moore**

10.5 Ultibro® Breezhaler 85 micrograms/43 micrograms inhalation powder hard capsules

A new LABA/ LAMA inhaler containing indacaterol and glycopyrronium.

This was approved at PAMM in February as green drug, as an option for patients taking the individual components. Agreed. Formulary to be updated.
Action: Steve Moore

10.6 Fultium-D3 20,000 IU Capsule

This is a licensed high dose vitamin D preparation. Previously, unlicensed high dose vitamin D preparations have been available as RED 'hospital only' medicines.

The evidence base for use of vitamin D alone is poor but it was agreed at PAMM in February that where there was a clinical need, GPs could prescribe this licensed preparation as a loading dose. Fultium-D3 20,000 IU capsules will appear in the TLS as GREEN. **Action: Steve Moore**

SG recommended that Trusts ensure that they are using licensed products.

10.7 Levodpa/ carbidopa/ entacapone (Sastravi®, Activas) film coated tablets ranging from 50/12.5/200mg to 200/50/200mg £36.44 per 100 tabs

This is a branded generic equivalent licensed product to and is available in the full range of strengths. Sastravi® offers a 50% cost saving compared with Stalevo® and savings of around £3-4k per month across the CCG.

Bioequivalence data from Activas was viewed comparing Sastravi® to Stalevo® . The neurologists at TST have agreed through their DTC that this can be considered a cost effective alternative to Stalevo®

It was agreed that Sastravi® will be added to the formulary and TLS as a cost effective alternative to Stalevo®. SG stated that the CCG will be recommending a switch in primary care. Formulary to be updated. **Action: Steve Moore**

10.8 Dulaglutide (Trulicity®) injection-

This is a new long acting GLP-1 analogue launched by Eli Lilly and licensed to improve glycaemic control in adults with Type 2 diabetes mellitus as monotherapy or add-on therapy. It is available in a prefilled pen device or pre-filled syringe. The dose is once weekly and the product costs £90.95 for 4 doses which is significantly more expensive than modified release exenatide.

At the moment there is no NICE guidance on dulaglutide whereas there is guidance available on the other GLP1 analogues.

SPF therefore agreed with the PAMM recommendation not to approve this product. This will have a black 'not recommended' traffic light status. Formulary to be updated. **Action: Steve Moore**

10.9 Exenatide (Bydureon®) modified release 2mg injection in a prefilled pen –

Bristol Myers Squibb have recently launched modified release exenatide in a prefilled pen, in addition to the pre-existing injection. It costs £73.36 for 4 doses (a one month supply) which is the same price as the injections.

It was agreed that the TLS should be updated to include the use of this product in line with NICE TA248: Exenatide prolonged-release suspension for injection in combination with oral antidiabetic therapy for the treatment of type 2 diabetes. Formulary to be updated. **Action: Steve Moore**

10.10 Rivaroxaban (Xarelto®)- license extension

The SPCs for Rivaroxaban (Xarelto®)- l 15 & 20mg strengths have been updated to state that rivaroxaban can be used for prevention of cardiovascular disease in patients with atrial fibrillation undergoing cardioversion. Noted. Formulary to be updated. **Action: Steve Moore**

10.11 Infliximab Biosimilars

Biosimilar infliximabs (Remcima® and Inflectra®) have been launched and consultants at TST have raised no concerns about using them raised. A 40% cost-saving is anticipated if this replaces current infliximab infusions. Rheumatology and gastroenterology are the largest users with gastroenterology using far more infliximab than rheumatology. TST have accepted these products onto their formulary

SG stated that the CCG would like to see Trusts using biosimilars ahead of the originator brands but patients will have the option to revert to the original brand. The anticipated savings have been taken into account in the budget setting process. He stated that the CCG can't provide more money if Trusts overspend on infliximab.

JS said that he had discussed this issue with the YDH gastroenterologists and that their position is to start all new patients on a biosimilar infliximab until they can start a managed switch programme when they have more experience with the biosimilars.

SK said that rheumatology put very few patients onto infliximab as they prefer to use alternative products that can be administered by subcutaneous injection. Rheumatology patients are usually given infliximab 3rd or 4th line for patients who are unable to have anything else or have failed to respond to alternative products. Although patients are likely to respond to biosimilars, she would like to see some longer experience before switching existing patients. Formulary to be updated. **Action: Steve Moore**

10.9 Branded generic pregabalin prescribing

Branded generic pregabalin products:

- Alzain® (Dr Reddy's) £91.77/ 84 caps all strengths
- Lecaent® (Activas) £86.94/ 84 caps all strengths
- Rewisca® (Consilient) £72.72/ 84 caps- all strengths

The above products have been launched with licences only for the treatment of epilepsy and generalised anxiety disorder (GAD) NOT neuropathic pain. Patent on Lyrica® (pregabalin) neuropathic pain will remain until 2017. Following a court judgement, CCGs have been instructed by NHS England to ensure that pregabalin is explicitly prescribed as Lyrica®, when being used for the treatment of neuropathic pain in order to guarantee that there is no patent infringement.

SG stated that the CCG can't deviate from the guidance issued by NHSE. We may see acute trusts using branded generics for epilepsy and GAD and the CCG will wait to see what Trust DTCs decide and fit in with that. JS, SK ,JB ,CB and SD to discuss at their own organisational DTC meetings.

Action: JS, SK ,JB ,CB and SD

This will be on the SPF agenda in May

11 NHS ENGLAND SPECIALIST COMMISSIONING

No new information has been received.

SG mentioned that:

- the FAD for omalizumab had been published today for previously treated spontaneous urticarial had been published today. NICE are likely to give a positive decision
- the 'not routinely commissioned' list of drugs is constantly changing and we need to keep track of this.

12 PBR EXCLUDED DRUG MONITORING

11.1 CCG PBR Excluded Drugs.

SG gave an overview of the figures. The overspend position against budget of YDH and TST was noted.

SG explained that he'd had no further correspondence from the commissioning team on the budget setting process for next year yet.

13 Medicines Optimisation Prototype Dashboard

Noted. There had been no updates to the dashboard.

14 DRUG SAFETY

14.1 MHRA Drug Safety Update Jan and Feb 2015

These were noted and SG asked that trusts review the Drug Safety updates and take appropriate action. **Action: All**

Specifically, the following items were highlighted:

- **New drug driving legislation came into force on 2nd March 2015.** SG stated that Trusts should ensure that clinicians are aware of the implications in their discussions with patients when initiating drugs.
- **Medicines related to valproate: risk of abnormal pregnancy outcomes.** SD noted that Sompar are reviewing their protocols on the use of valproate in women of childbearing age. SG asked acute Trusts to ensure that they take action.

14.2 Patient safety alert – Harm from using Low Molecular Weight Heparins (LMWH) when contraindicated

SG asked trusts to develop some actions. SDB said that Sompar are reviewing their VTE/ DVT/ PE policy

14.3 NHSE Patient safety alert – Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder

Trusts were asked to review the alert and take appropriate action

14.4 Patient safety alert – Risk of severe harm and death from unintentional interruption of non-invasive ventilation

Trusts were asked to review the alert and take appropriate action

14.5 Acute Kidney Injury

GS stated that it would be positive for the CCG to participate in the national initiative to reduce a number of avoidable admissions acute kidney injury (AKI) across Somerset. This relates usually due to acute fluid loss (often diarrhoea and vomiting) and who continue to take their prescribed ACEIs, ARBs, NSAIDs, diuretics and metformin.

SG said that there will be a national CQIN covering AKI for acute Trusts.

It was agreed that the medicines management team would adapt the “sick day rules” card produced by NHS Highlands. This can be distributed to GPs and pharmacies to allow them to discuss and distribute to patients.

Action: Medicines Management Team

SG stated that it would be good to get assurances from the acute Trusts on whether they had implemented the actions from the NHSE June 2014 Patient Safety Alert on early identification of AKI. **Action CB/ SK/SD**

15 ANY OTHER BUSINESS

15.1 Medicines Optimisation Clinical Reference Group (MOCRG)

SG said that there has been a national re-launch of the MOCRG. The group will produce medicines optimisation guidance which will initially concentrate on secondary care issues.

15.2 Bone morphogenic protein

SG stated that from the non-PbR drugs fund there is a budget line for bone morphogenic protein and TST use it but YDH don't. This product is not nationally commissioned.

SG will be asking TST to provide evidence of efficacy and cost effectiveness.

Action SG

15.3 Treatment of Chronic Stable Angina

SG stated that he is looking to audit the drug treatment of chronic stable angina.

Action SG

He is proposing a reclassification of ranolazine as a green drug due to the contraindications and safety issues with ivabradine. Ranolazine needs no monitoring so it should not be necessary to continue with the shared care protocol. Agreed. This will need to be noted at PAMM. **Action CH**

15 DATE OF NEXT MEETING

- 20th May 2015 **at Wynford House (Meeting Room 1), Yeovil**

Venue: Meeting Room 1, Wynford House, Lufton Way, Yeovil, Somerset BA22 8HR between 2.30pm and 5pm

SCHEDULE OF ACTIONS ARISING FROM THE MEETING HELD ON 11 MARCH 2015

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
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	**TA 325: Nalmefene for reducing alcohol consumption in people with alcohol dependence**	CH to follow up progress with public health.	**CH 20th May 15**
3	**Review Terms of Reference**	Amend ToRs as agreed and bring back to next meeting	**CH 20th May 15**
4	**Enhanced Service for Drug Monitoring in Primary Care**	GS to update the group on progress of the enhanced service at the next meeting	**GS 20th May 15**
5	**Guidance on the use of supplements and monitoring for bariatric patients.**	Review updated guidance at next meeting	**CB 20th May 15**
6	**Leflunomide SCG- upload to website**	Upload to website	**Steve Moore 20th May 15**
7	**Leflunomide SCG- pass on to drug monitoring in primary care group**	GS to pass final SCG to Drug Monitoring in Primary Care group	**GS 20th May 15**
8	**Leflunomide SCG**	Take final SCG for noting at next PAMM meeting	**CH 20th May 15**
9	**Improving communication on Shared Care**	Trust DTCs to look to improve communication on shared care arrangements including outpatient letters	**CB/SK 20th May 15**
10	**Shared Care**	CH to share relevant links to SCGs on CCG website with Trusts and ensure that SCGs are up to date.	**CH 20th May 15**
11	**LMWH perioperative bridging policies**	CB to ask haematologists to open discussions with YDH to improve consistency. CB to feedback on progress with the TST protocol at the next meeting	**CB 20th May 15**
12	**Summary of Trust LMWH perioperative bridging policies**	CH circulate a tabulated summary of different Trust policies prior to the next meeting	**CH 20th May 15**
13	**Standardised outpatient communication letter**	CCG to produce a standardised outpatient letter to ask Trusts to use	**CH 20th May 15**
14	**Outpatient communication letters**	Trusts to look at improving communication with patients on prescriptions they need to obtain in primary care. Investigate whether electronic outpatient clinic letters are possible.	**SK/CB/ JS/JB 20th May 15**

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
15	**Outpatient communication**	CCG to identify whether particular clinics are not communicating as well as others. CH Jo Bird to see whether there has been any feedback from GPs.	**CH 20th May 15**
16	**Proposed Dry Eye Treatment Pathway**	Amend wording in relation to Sjorgens Syndrome. Wait 2 weeks for further comments. If no comments put into formulary and navigator app.	**SG 20th May 15**
17	**Melatonin for Hemicrania Continua and PD related sleep disorder**	CH to contact Nigel Ankcorn at TST to confirm the intended melatonin product and maximum duration of treatment.	**CH 20th May 15**
18	**CG61 Irritable bowel syndrome in adults**	SG to raise the issue of 'off label' use of TCAs and SSRIs in IBS with acute Trusts	**SG 20th May 15**
19	**Generic Pregabalin**	Trusts DTC to consider which products they will use for GAD and epilepsy	**Trust DTCs 20th May 15**
20	**Acute Kidney Injury**	Adapt and distribute the 'Sick Day Rules' card	**Medicines Management Team 20th May 15**
21	**AKI**	Ask local Trusts whether they have implemented the actions from the NHSE June 2014 Patient Safety Alert on early identification of AKI.	**CB/SK/SD**
22	**DEFINE antibiotic benchmarking data**	JB to bring to next meeting	**JB 20th May 15**
23	**Bone morphogenic protein**	SG to ask TST to provide evidence of efficacy and cost effectiveness	**SG 20th May 15**
24	**Treatment of Chronic Stable Angina**	SG to arrange an audit of the treatment of chronic stable angina	**SG 20th May 15**
25	**Removal of ivabradine from pathway for chronic stable angina and consider the reclassification of ranolazine as a green drug**	Bring this item to PAMM for consideration	**CH 20th May 15**

NO.	SUBJECT	OUTSTANDING RESPONSIBILITY	ACTION LEAD
26	**Formulary/ Traffic Light Changes**	• **NICE TA 322: Prostate cancer - sipuleucel-T (1st line) – negative appraisal- BLACK** Traffic Light status • **TA 330: Sofosbuvir for treating Hepatitis C (chronic) -** Red Traffic Light status with a note- 'funded by NHS England'. • **NICE TA333: Axitinib for advanced renal cell carcinoma after failure of prior systemic treatment** Red Traffic Light status with a note with a note- 'funded by Cancer Drug Fund'. • **TA323: Erythropoiesis‑stimulating agents for treating anaemia in people with cancer having chemotherapy –** Ensure noted this is now funded by CCGs not NHSE • **Cosmocol® Paediatric and Cosmocol® Half –** Add to formulary and TLS as GREEN • **Theical®–** Add to formulary and TLS as GREEN • **Ensure Shake–** add to formulary/ TLS as GREEN. Altermative to Aymes Shakes. • **Xenidate®–** add to formulary/TLS as alternative to **Concerta®** • **Ultibro® Breezhaler** add to formulary/ TLS as GREEN. • **Fultium D3® 20,000IU** add to formulary/TLS as GREEN • **Sastravi®** add to formulary/TLS as a cost effective alternative to **Stalevo®** • **Dulaglutide (Trulicity®) injection-** add to TLS as a BLACK – not recocmmended drugbyd • **Exenatide (Bydureon®) modified release 2mg injection in a prefilled pen-**new device to be added to formulary/ TLS • **Xarelto®- license extension- u**pdate formulary • **Remcima® and Inflectra®** include as RED in line with NICE guidance for infliximab	**Steve Moore 20th May 15**