EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST

NEW DRUG AND INTERFACE GROUP

MINUTES OF THE MEETING HELD ON WEDNESDAY 6th December 2017
IN THE BOARDROOM, EPSOM HOSPITAL

Present:
Dr V De Silva (Chair) **VDS**
Anne Davies (Chief Pharmacist) **AD**
Dr S Moodie (Consultant Gastroenterologist) **SMo**
Dr R Shephard (Consultant Neonatologist) **RS**
Sharon Kitkatt (Consultant Nurse, Acute Pain Service) **SK**
Dr R Scott (Joint Medicines Management Lead, GP Sutton CCG) **RSc**
Dr A Pitsiaeli (GP, Surrey Downs CCG) **AP**
Niel Kenny (Representative, Sutton CCG) **NK**
Anne Lowson (Secretary) **AL**

In attendance:
Sumbo Adeyemo (Medicines Management Pharmacist) **SA**
David Babatunde (Medicines Management Pharmacist) **DB**
Kuljit Gata-Aura (Medicines Management Technician) **KGA**
Malar Sutharshan (Clinical Nurse Specialist) **MS**
Dr R Nithiyananthan (Consultant Physician in Endocrinology and Diabetes Mellitus) **RN**

No	Item	Responsible for Action
1.	**Apologies for Absence** Dr A Mahmood (Consultant Gastroenterologist) **AM** Liz Clark (Lead Commissioning Pharmacist, Surrey Downs CCG) **LC** Sarah Taylor (Chief Pharmacist, Sutton CCG) **ST** Susie Mallinder (Lead Renal Nurse) **SM** Dr J Bendig (Consultant Microbiologist) **JB** Dr M Gardner (Consultant Anaesthetist) **MG** Ria John (Medicines Management Administration Coordinator) **RJ**	
2.	**Declarations of Interest** Dr Pitsiaeli declared he has worked with Eli Lilly on advisory boards for dulaglutide.	
3.	**Minutes of the Meeting held on 11 October 2017** The minutes of the meeting held on 11 October 2017 were agreed.	
4.	**Matters Arising** The asthma documents prepared by the respiratory working group will be presented for approval at the next Sutton and Merton MMC. Update at next meeting.	
5.	**New Drug Requests**	
	a) Dulaglutide (Trulicity®) The request for dulaglutide for treatment of adults with type 2 diabetes to improve glycaemic control as monotherapy or add-on therapy was presented by Dr Nithiyananthan. It is one of 6 UK licensed GLP-1 receptor antagonists (RAs). Alternative options are: exenatide daily or weekly, liraglutide, lixisenatide, and albiglutide. The duration of action and hence frequency of administration ranges from twice daily to once weekly. All GLP-1 RAs differ in administration timing and ease of administration effectiveness and tolerability. NICE have supported the use of GLP-1 RAs if triple therapy with metformin or two other oral drugs is not effective, not tolerated, or contraindicated. The evidence for efficacy and safety is from eight phase III trials. These show that, for reducing HbA1c levels in type 2 diabetes, dulaglutide once weekly when added to metformin was statistically superior to	**SA/AL/KGA**

	exenatide twice daily and non-inferior to liraglutide 1.8mg daily. Results from one study indicate that dulaglutide is as effective as a short-acting GLP-1 RA in controlling post-prandial as well as fasting blood glucose levels, and this is not as expected for a long-acting GLP-1 RA. Meta-analysis shows that efficacy of dulaglutide is comparable to other long-acting GLP-1 RAs. Dr Nithiyananthan advised that the benefits of dulaglutide include that it is available as an easy-to-use auto-injector, which avoids the patient handling or seeing the needle, which may improve adherence. The pen is a fixed dose, and there is no need to dial up or select the dose, as with the multi-dose pens such as exenatide and liraglutide, and it is a once-weekly administration. It is thought that, in 2018, exenatide once weekly is being reformatted in a new pen device, which will be easier to mix, and there will be no price increase. Lixisenatide is the cheapest GLP-1 RA, but it is felt, from clinical experience, to be less potent and is not widely used in primary care. Although the Trust currently has the twice daily exenatide on formulary, it is not used widely. Dulaglutide is cost-neutral when compared with exenatide weekly. The SPC advises that injection site reactions are uncommon, but the meta-analysis suggests that dulaglutide is associated with more injection site reactions, and this should be considered. The diabetologists would like to keep the formulary options the same for now, and review product choice once dulaglutide has been trialled and new preparations are on the market next year. **Decision** To add dulaglutide to the Trust formulary for use by the endocrinologists in line with NICE NG28. It will be suitable for transfer to the GP. Review of GLP-1 RAs to be carried out within a year.	
	b) DEKAs Plus The case for adding DEKAs Plus to the formulary for use in cystic fibrosis patients was presented by Malar Sutharshan with support from Dr Handa if needed via phone. Nutritional management is key in the care of children and adults with cystic fibrosis (CF) to achieve normal growth and development. Malabsorption of fat soluble vitamins is likely in most people with CF, particularly those with pancreatic insufficiency. The rationale behind use of multi-vitamin preparations like the DEKAs Plus range is to improve adherence as these children already have a high daily pill burden (e.g. Creon®, antibiotics, proton pump inhibitors and nebulisers between oral medication). The product is manufactured in America as a food supplement, but available from Alliance Healthcare wholesaler in the UK. The manufacturer has submitted an application for inclusion on the ACBS list in the drug tariff, and a decision is expected in January/February 2018. The CF patients are managed initially by the Royal Brompton Hospital (RBH) and initial supplies are given. Maintenance is via the GP or local hospital. The Trust undertakes annual reviews of these patients with more frequent appointments if necessary. The RBH aim to have plasma levels of vitamins A and E at the upper limit of normal, and they have clinical guidelines with empirical recommended dosing for different ages. There are no published trials or studies involving DEKAs Plus in the dietary management of children with CF. Vitamin K may be required in larger amounts than that in DEKAs Plus in patients over 6 years (including pancreatic sufficient) and those with liver disease, with or without clotting abnormalities. It is possible to make up the regimen using separate vitamins, but the pill burden increases. It was also recognised that DEKAs Plus is more expensive than using separate vitamins in children over 8 years old. Patient numbers are small and it was recognised that it may be easier for patients to collect medication from GPs and local pharmacies. The CCG pharmacists will look into whether community pharmacies will be able to order easily through the wholesaler and feedback this information to the Trust Medicines Management Team. An information sheet for GPs would be useful to provide advice around starting and stopping preparations and the monitoring that is required. GPs require	**LC/NK/SA/ Dr Handa/Malar Sutharshan**

	comprehensive communication and then it was thought that, in most cases, they would be happy to maintain prescribing. **Decision** To add DEKAs Plus the formulary for use in children with cystic fibrosis, despite age, in line with the Royal Brompton Hospital guidance to allow continuity of care. CCGs to feedback on community pharmacy availability of product from wholesaler.	
6.	**Six Month New Drug Reviews** Nothing for this meeting.	
7.	**NICE/MHRA Guidance**	
	I. NICE Technology Appraisals Summary	
	Technology Appraisals for Discussion	
	a) Autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee – TA477 Chondrocyte implantation as an option for treating symptomatic articular cartilage defects of the knee can be carried out at a tertiary referral centre. This is not thought to be used in EOC, but response awaited.	**KGA/AL**
	b) Brentuximab vedotin for treating relapsed or refractory systemic anaplastic large call lymphoma – TA478 Brentuximab vedotin will be added to the Trust formulary as an option for treating relapsed or refractory systemic anaplastic large cell lymphoma in adults in line with this TA. The haematologists expect to use it less than once or twice per year. Funding via NHSE/Cancer Drugs Fund.	**KGA**
	c) Reslizumab for treating severe eosinophilic asthma – TA479 Reslizumab will be added to the Trust formulary as an option for treating severe eosinophilic asthma in the patient cohort described. However, patients are expected to be managed via a specialist centre.	**KGA**
	d) Tofacitinib for moderate to severe rheumatoid arthritis – TA480 Tofacitinib will be added to the Trust formulary as an option for treating active rheumatoid arthritis in patients who have responded inadequately to intensive therapy with a combination of DMARDs and if the DAS28 score is in line with the TA guidance. Funding via CCG.	**KGA**
	e) Immunosuppressive therapy for kidney transplant in adults – TA481 VDS advised that these therapies are currently available to the renal clinicians as standard therapy and available on the formulary, The TA will be added to the formulary for information.	**KGA**
	f) Immunosuppressive therapy for kidney transplant in children and young people – TA482 The Trust does not initiate immunosuppressive therapy for kidney transplants in children and young people. Therapy would be continued if the patient was an in-patient.	**KGA**
	g) Nivolumab for previously treated squamous non-small-cell lung cancer – TA483 The Trust does not initiate treatment for squamous non-small-cell lung cancer but treatment would be available if needed. Funding via Cancer Drugs Fund.	**KGA**
	h) Nivolumab for previously treated non-squamous non-small-cell lung cancer – TA484 The Trust does not initiate treatment for non-squamous non-small-cell lung cancer	**KGA**

	but treatment would be available if needed. Funding via Cancer Drugs Fund. **i) Sarilumab for moderate to severe rheumatoid arthritis – TA485** The Trust rheumatologists are interested in using sarilumab for moderate to severe rheumatoid arthritis in line with this TA, and it will be added to the Trust formulary. Funding will be via BlueTeq application to the CCGs. **j) Aflibercept for treating choroidal neovascularisation – TA486** Aflibercept for treating choroidal neovascularisation will be added to the Trust formulary for treatment in line with this TA. Funding will be via BlueTeq application to the CCGs. **k) Venetoclax for treating chronic lymphocytic leukaemia – TA487** Venetoclax for treatment of chronic lymphocytic leukaemia will be added to the Trust formulary for treatment in line with this TA. Funding will be via BlueTeq application to the CCGs. The haematologists have advised it would be used in one or two patients per year. **l) Regorafenib for previously treated unresectable or metastatic gastrointestinal stromal tumours – TA488** The Trust does not initiate treatment for unresectable or metastatic gastrointestinal stromal tumours. Treatment would be available if required. **m) Vesmodegib for treating basal cell carcinoma – TA489** Vesmodegib is not recommended for treating basal cell carcinoma. The Trust would not initiate for this condition. **n) Nivolumab for treating squamous cell carcinoma of the head and neck after platinum-based chemotherapy – TA490** The Trust does not initiate treatment for squamous cell carcinoma of the head and neck. Treatment would be available if required. **o) Ibrutinib for treating Waldenstrom's macroglobulinaemia – TA491** Ibrutinib will be added to the Trust formulary for treatment of Waldenstrom's macroglobulinaemia in line with this TA. Funding via the Cancer Drugs Fund.	**KGA** **KGA** **KGA** **KGA** **KGA**
	Technology Appraisals Terminated	
	None for this meeting.	
	Technology Appraisals for Information	
	p) Nivolumab for previously treated advanced renal cell carcinoma – TA417 Revised to contain details of a commercial access agreement as opposed to a patient access scheme. **q) Trastuzumab emtansine for treating HER2-positive advanced breast cancer after trastuzumab and a taxane – TA458** Revised to contain details of a commercial access agreement as opposed to a patient access scheme. **r) Nivolumab for treating relapsed or refractory classical Hodgkin lymphoma – TA462** Revised to contain details of a commercial access agreement as opposed to a patient access scheme.	
	Technology Appraisals Not Recommended	
	Nothing for this meeting.	

	Clinical Guidelines Updated for Information	
	s) Familial hypercholesterolaemia: identification and management – CG71 The chemical pathologists are aware of this updated guidance. Nicotinic acid is not used and is not on the formulary. Use of PCSK9 inhibitors has already been adopted. **t) Hepatitis B (chronic): diagnosis and management – CG165** A footnote has been changed to update the information on UK marketing authorisations for entecavir. **u) Bipolar disorder: assessment and management – CG185** Some footnotes have been updated, cross-references to other guidelines amended, and some research recommendations stood down. **v) Fractures (complex): assessment and management – NG37** There has been an amendment to the wording from 'administer prophylactic antibiotics' to 'consider administering prophylactic antibiotics'. This guidance will be discussed by the Antibiotic Steering Group (ASG) and Trust guidelines will be amended if required.	**JB/Donna Francis/AL**
	Clinical Guidelines for Discussion	
	w) Cystic fibrosis: diagnosis and management – NG78 This guideline has been circulated to the paediatricians and respiratory consultants. The Trust has on formulary the medications detailed. It was noted that oral gastrografin should be available for distal intestinal obstruction syndrome and reference will be made to the in the formulary. **x) Sinusitis (acute): antimicrobial prescribing – NG79** This guideline will be discussed at the ASG with respect to the antibiotic choices detailed. ENT has been sent this guidance for consideration. **y) Asthma: diagnosis, monitoring and chronic asthma management – NG80** This guidance has been circulated to the paediatricians and respiratory consultants. The formulary has the medications detailed. **z) Glaucoma: diagnosis and management – NG81** This guidance has been circulated to the ophthalmologists. The Trust glaucoma guidelines will be reviewed in line with this TA and brought back for discussion at a future meeting.	**KGA/AL** **KGA/AL**
	Clinical Guidelines for Information	
	aa) Cataracts in adults: management – NG77 This guideline has been circulated to the ophthalmologists. No specific drug-related issues identified.	
	Quality Standard Updated	
	bb) Glaucoma in adults – QS7 This quality standard has been revised to reflect the updated NICE guidelines on glaucoma. **cc) Asthma- QS25** This quality standard has been revised to reflect the updated NICE guidelines on asthma.	
	Quality Standard for Discussion (medicine related issues only)	
	None for this meeting.	
	Quality Standard for Information	
	None for this meeting.	
	Highly Specialised Technologies Guidance	
	None for this meeting.	

	Highly Specialised Technologies for Discussion	
	dd) Provider letters These letters from specialised commissioning NHS England advise on the funding position of these recently published NICE TAs final appraisal determination. **i. NICE Technology Appraisal Final Appraisal Determination: Obinutuzumab with bendamustine for treating rituximab-refractory follicular lymphoma** Funding available via Cancer Drugs Fund from 26.07.17. **ii. NICE Technology Appraisal Final Appraisal Determination: Brentuximab vedotin for treating relapsed or refractory systemic anaplastic large cell lymphoma** Funding available via Cancer Drugs Fund from 24.08.17. **iii. Early Access to Medicines Scheme – Alectinib as monotherapy for the first line treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive advanced non-small cell lung cancer (NSCLC)** The Trust is not a recognised centre for initiating treatment with alectinib for this type of non-small cell lung cancer. **iv. NICE Technology Appraisal 473: Cetuximab for the treatment of metastatic and/or recurrent squamous cell carcinoma of the head and neck (review of TA172)** Funding available from NHS England from 31.08.17. **v. NHS England Policy for Urgent Cases** The policy sets out how NHS England makes decisions around the funding of service developments, including urgent cases. It replaced the critically clinically urgent (CCU) funding request process. CCU requests will no longer be accepted via the individual funding request (IFR) route. Clinicians will be made aware of this change. **vi. NICE Technology Appraisal 446: Brentuximab vedotin for treating CD30-positive Hodgkin lymphoma** Funding available via Cancer Drugs Fund from 26.09.17. **vii. NICE Technology Appraisal 450: Blinatumomab for previously treated Philadelphia-chromosome-negative acute lymphoblastic leukaemia** Funding available via Cancer Drugs Fund from 26.09.17. **viii. NICE Technology Appraisal 451: Ponatinib for treating chronic myeloid leukaemia and acute lymphoblastic leukaemia** Funding available via Cancer Drugs Fund from 26.09.17. **ix. NICE Technology Appraisal 449: Everolimus and sunitinib for treating unresectable or metastatic neuroendocrine tumours in people with progressive disease** Funding available via Cancer Drugs Fund from 26.09.17. **x. NICE Technology Appraisal Final Appraisal Determination: Nivolumab for previously treated locally advanced or metastatic squamous and non-squamous non-small-cell lung cancer** The Trust is not a recognised centre for initiating treatment with nivolumab for non-small-cell lung cancer.	**AD**

	xi. NICE Technology Appraisal Final Appraisal Determination: venetoclax for the treatment of chronic lymphocytic leukaemia Funding available via Cancer Drugs Fund from 05.10.17. **xii. NICE Technology Appraisal Final Appraisal Determination: Ibrutinib for treating Waldenstrom's macroglobulinaemia** Funding available via Cancer Drugs Fund from 28.09.17. **xiii. Abiraterone for hormone-sensitive metastatic prostate cancer** NHS England will not commission the use of abiraterone in this unlicensed indication. This position will be reviewed once the outcome of the NICE assessment of its cost-effectiveness and budget impact is known. The Trust is not a recognised centre for initiating treatment in metastatic prostate cancer. **xiv. NICE Technology Appraisal Final Appraisal Determination: Regorafenib for previously treated unresectable or metastatic gastrointestinal stromal tumours** The Trust is not a recognised centre for initiating treatment in gastrointestinal stromal tumours, but funding will be available from 12.10.17 via the Cancer Drugs Fund. **xv. NICE Technology Appraisal Final Appraisal Determination: palbociclib in combination with an aromatase inhibitor for previously untreated advanced or metastatic hormone receptor-positive, HER2-negative breast cancer** The Trust is not a recognised centre for initiating treatment in advanced or metastatic breast cancer, but funding will be available from 16.11.17 via the Cancer Drugs Fund. **xvi. NICE Technology Appraisal Final Appraisal Determination: ribociclib in combination with an aromatase inhibitor for previously untreated advanced or metastatic hormone receptor-positive, HER2-negative breast cancer** The Trust is not a recognised centre for initiating treatment in advanced or metastatic breast cancer, but funding will be available from 16.11.17 via the Cancer Drugs Fund.	
	Health Technology Assessment	
	For Discussion	
	ee) NHS England funding arrangements for Mavenclad® (cladribine tablets) The manufacturer has advised of the availability of cladribine tablets in England after NICE published its FAD on 03.11.17, supporting its use for treating highly active multiple sclerosis in patients with specific disease criteria. The final guidance is expected in early 2018. Merck has agreed a commercial agreement with the NHS on 03.11.17. Treatment is available after completion via the BlueTeq system. Neurologists to be made aware.	**KGA**
	II. MHRA Guidance – October 2017 These updates will be circulated to the relevant clinicians. This advice includes: - Not to use lactose-containing methyl prednisolone in patients with a known or suspected cow's milk allergy. Stop administration and treat the patient's condition accordingly. - The risk of CNS depression, including severe respiratory depression with gabapentin. When treating patients at risk of these reactions, consider whether dose adjustment is needed. - Rare reports of sexual dysfunction in some patients taking oral isotretinoin for severe acne.	**KGA**

	- Potentially fatal risk of intestinal obstruction during treatment with the antipsychotic clozapine. If constipation occurs during treatment, it should be recognised and treated. Following discussion with Dr Bolton, all patients prescribed clozapine in the hospital will now be emailed to his team to review the reason for admission and advise appropriately if constipation is an issue.	
	III. MHRA Guidance – November 2017 These updates will be circulated to the relevant clinicians. This advice includes: - Some batches of gentamicin may contain higher than expected histamine levels residual from the manufacturing process. A caution in use alert has been issued via the Central Alerting System. A recall is not considered appropriate at this stage. A memo regarding this was circulated on 24 October 2017. - A reminder of the dose-dependent QT prolonging effects of quinine and possible interactions with other medications, e.g. some anticonvulsants. - A reminder to avoid inadvertent switching between oral tacrolimus products following the launch of new products including generic formulations. Prescribe and dispense by brand only. - A request to support the second social media campaign for suspected adverse drug reactions. - Updated advice on switching between different manufacturers' products of anti-epileptic medications.	**KGA**
8.	**Patient Safety Alerts**	
	a) Confirming removal or flushing of lines and cannulae after procedures This patient safety alert advises of the risks of residual anaesthetic or sedative drugs left in IV lines and cannulae unless they are effectively flushed at the end of the procedure. Residual drugs can later be inadvertently introduced into the patient's circulation, causing muscle paralysis, unconsciousness, and respiratory and cardiac arrest. This will be discussed at the next MMCBG meeting for the wider impact on the Trust.	**AL/RJ**
	b) Guidelines for the use of midazolam for conscious sedation in adults Dr Moodie has revised the guidelines for the use of midazolam for conscious sedation in adults to reflect this patient safety alert and agreed. The revised guidelines were updated and the guideline will be added to the Trust intranet. It will also be mentioned at the conscious sedation training programme.	**KGA/RJ**
9.	**Operational Issues**	
	a) Vitamin D including #NOF The Trust guidance on treating vitamin D deficiency in adults was reviewed by Dr Patel. Surrey Downs CCG have advised that some of the treatment regimens for vitamin D deficiency 0-30mmol/L are different to the PCN guidance, and particularly the daily regimens are not cost-effective. However, the committee felt that tolerability may be an issue for some patients, and daily regimens should remain an option. The section on fractured neck of femur was added for clarity, but it was felt to be confusing as it was only one part of the management plan for fractured neck of femur. The CCG had concerns that there was no mention of use of bisphosphonates or levels of vitamin D being taken. The vitamin D dosing in fractured neck of femur will be removed from this document. The GPs did, however, think it would be useful to see the hip fracture pro forma, which includes the need to take vitamin D levels and a bone plan, and discuss options for communicating this to the GPs. GPs requested confirmation that all patients would be vitamin D replete at the time of discharge. Update at next meeting. The Trust guidelines were agreed with the removal of the section on dosing for fractured neck of femur.	**AL**
	b) Regional Medicines Optimisation Area Committees **I. Flash Glucose Monitoring Systems – Positon Statement** The Regional Medicines Optimisation Committee (RMOC) have provided advice to the Area Prescribing Committees that, until further trial data is available, the following is followed:	**LC/ST/NK**

	- Freestyle Libre® should only be used for people with type 1 diabetes, aged 4 and above, attending specialist type 1 care, using multiple daily injections or insulin pump therapy, who have been assessed by the specialist clinician and deemed to meet one or more of the following: ▪ Patients who undertake intensive monitoring ≥8 times daily. ▪ Those who meet the current NICE criteria for insulin pump therapy (HbA1c) >8.5% 69.4mmol/mol) or disabling hypoglycaemia as described in NICE TA151) where a successful trial of Freestyle Libre® may avoid the need for pump therapy. ▪ Those who have recently developed impaired awareness of hypoglycaemia. It is noted that for persistent hypoglycaemia unawareness, NICE recommend continuous glucose monitoring with alarms and Freestyle Libre® does not currently have that function. ▪ Frequent admissions (>2 per year) with DKA or hypoglycaemia. ▪ Those who require third parties to carry out monitoring and where conventional blood testing is not possible. In addition, all patients/carers must be willing to undertake training in the use of the flash glucose monitoring system, and commit to ongoing regular follow-up and monitoring. The limitations of the clinical evidence are discussed and costing information detailed. Surrey PCN are discussing the guidance and will provide feedback to the next NDAIG meeting. The London RMOC has discussed the position statement and feels more detailed implementation guidance is needed, and have recommended that the London Diabetes Clinical Network work in collaboration with NHS London Procurement Partnership develop guidance within the next three months to support implementation. Update at next meeting.	
	c) Patient information leaflet – Supplies of medication The leaflet is still with the Trust Communications team.	**AD**
	d) Feedback from CCGs – IFRs for biologics As Dr Patel has now left the Trust, it was felt that this was best discussed with the clinical networks, as these work across the interface and are speciality focused. Remove from the agenda.	
	e) Carbocisteine sachets Carbocisteine is now available as a single dose sachet containing 750mg in 10ml, and this would currently be a cost-saving in primary and secondary care compared with the current bottles of liquid and capsules. It is not licensed for use in children, and it can only be used for a 750mg dose, so the liquid would remain a formulary option. The pharmacy will ensure the sachets are easy to open and that the respiratory teams are happy with the switch. Subject to this, the Trust will switch appropriate patients. Update at next meeting.	**KGA**
	f) Emollient review (Diprobase® cream switch) The Trust's current emollient formulary options have been reviewed in line with national and local CCG guidance, and the proposal discussed with the dermatologists. The proposal is to: - Replace Diprobase® cream with Epimax® cream - Replace Epaderm® ointment with Hydromol® ointment - Replace aqueous cream with Aquamax® This proposal was agreed and implementation will begin in the new year.	**KGA/AL**
	g) Cow's milk allergy feeds Following feedback from Sutton CCG, the Trust has reviewed the formulary options for cow's milk protein allergy. The proposal to switch: - Neocate® to SMA Alfamino® - Nutramigen® 1 and 2 to Similac Alimentum® 1st line with SMA Althera®2nd line has been discussed with the appropriate paediatricians and raised a few concerns, particularly around the tolerability of Similac Alimentum® and prescribing patterns. These will be raised with the dietician at Sutton CCG and fed back at the next	**Niel Kenny/AL/ KGA**

	meeting.	
	h) NHS England revised individual funding request and standard operating procedure For information. NHS England have revised the Individual Funding Request Policy and SOPs. The documents have been implemented with immediate effect from 17.11.17.	
10.	**Feedback from CCGs and Trust Committees**	
	a) Respiratory Working Group The asthma documents (poster and guidance) discussed at the last meeting await final sign-off by Sutton MMC. The plan is to launch them in January 2018. Final documents will be available for the next meeting.	**SA/NK**
	b) DOACs The cardiologists were unable to meet with CCG colleagues to discuss the preferred option of using edoxaban for AF and stroke prevention. This will be rearranged. It was noted that the manufacturers of edoxaban have pulled out of the CMU contract.	
	c) SWL Sutton & Merton CCGs **I. Minutes September 2017** For information.	
	d) SWL Medicines Optimisation Group Nothing for this meeting.	
	e) SWL Cardiovascular Group for Discussion Nothing for this meeting.	
	f) Surrey Prescribing Clinical Network **I. Minutes October 2017** For information. **II. Minutes November 2017** For information. **III. Surrey Policy Statements** **a. Adapalene 0.1% and Benzyl Peroxide 2.5% gel (Epiduo®) for Acne Vulgaris** The Trust dermatologists support the recommendation. Epiduo® is currently on the Trust formulary. **b. Roflumilast for Chronic Obstructive Pulmonary Disease (NICE TA461)** The Trust respiratory consultants support this recommendation for use of roflumilast in line with NICE TA461. **c. Collagenase clostridium histolyticum (CCH, Xiapex®) for treating Dupuytren's Contracture (NICE TA459)** The Trust hand surgeon supports the use of Xiapex® for treating Dupuytren's Contracture in line with NICE TA459. **d. Intravitreal dexamethasone implant (Ozurdex®) for the treatment of non-infectious Uveitis** The Trust ophthalmologists support the use of intravitreal dexamethasone implant (Ozurdex®) for the treatment of non-infectious Uveitis in line with TA460. **e. Epistatus® 10mg oro-mucosal solution: Midazolam (as maleate) for treatment of prolonged, acute convulsive seizures in children and adolescents from 10 years to less than 18 years** The Trust has currently not agreed to use a second midazolam oro-mucosal solution of midazolam (Epistatus®) for treatment of prolonged acute convulsive seizures in	**KGA**

	children and adolescents from 10-18 years. This is because it is currently a different strength from the formulary option (Buccolam®) and it is only available in one pre-filled syringe size. Epistatus® will remain available as the liquid which is an unlicensed product in a bottle for use if required. **f. Infliximab (biosimilar) for immunotherapy related Colitis** The Trust acknowledges the recommendation for the use of infliximab (biosimilar) for immunotherapy related colitis, which will be used in line with St Luke's Cancer Alliance guidelines. **g. Baricitinib for the treatment of moderate to severe Rheumatoid Arthritis (NICE TA466)** The Trust rheumatologists support the use of baricitinib as a treatment option for moderate to severe rheumatoid arthritis in line with NICE TA466. **IV. Testosterone gel 50mg/5g and Testosterone 2% gel – Information sheet** Dr Jan, Consultant Obstetrician and Gynaecologists, supports the information sheet for use of testosterone gel in post-menopausal women distressed by low libido, who have no other treatable cause and in whom HRT alone is not effective. **V. Testosterone gel for low libido in women – Information for patients** The information sheet for patients was also supported.	**KGA**
	g) Shared Care Prescribing Guidelines **I. Riluzole Shared Care Guidelines** The neurologists support this revised version of the shared care guidelines for riluzole and it will be circulated to them for information	**KGA**
11.	**Medicines Matters Bulletins**	
	I. Safety in Girls and Women Treated with Valproate For information.	
	II. Security and Storage of Medicines For information.	
12.	**Any Other Business**	
	I. Time, dates and venues for next year's meetings For information. **II.** Dr Nithiyananthan sought clarity around the process to add alogliptin to the formulary. This is currently the cheapest gliptin and is used in primary care. The committee agreed to review this drug using a comparative summary style document, rather than an individual evidence review. The formulary currently includes Linagliptin, Saxagliptin and Sitagliptin.	
12.	**Date of Next Meeting:**	
	Wednesday 7th February, 12.30-2.00pm, Boardroom, 5th Floor, Ferguson House, St Helier Hospital.	