EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST

NEW DRUG AND INTERFACE GROUP

MINUTES OF THE MEETING HELD ON WEDNESDAY 7th February 2018
IN THE BOARDROOM, EPSOM HOSPITAL

Present:
Dr V De Silva (Chair) **VDS**
Anne Davies (Chief Pharmacist) **AD**
Sharon Kitkatt (Consultant Nurse, Acute Pain Service) **SK**
Dr R Scott (Joint Medicines Management Lead, GP Sutton CCG) **RSc**
Anne Lowson (Secretary) **AL**
Sarah Taylor (Chief Pharmacist, Sutton CCG) **ST**
Dr M Gardner (Consultant Anaesthetist) **MG**
Dr J Wang (Consultant Medical and Renal) **JW**
Dr Mulleague (Consultant Anaesthetist) **LM**
Sarah Flack (Pharmacist, Surrey Downs CCG) **SF**

In attendance:
Sumbo Adeyemo (Medicines Management Pharmacist) **SA**
David Babatunde (Medicines Management Pharmacist) **DB**
Kuljit Gata-Aura (Medicines Management Technician) **KGA**
Dr A Rodin (Consultant Physician – Endocrinology & Diabetes Mellitus) **AR**
Saba Sheikh (Pre-Registration Pharmacy Student) **SS**
Natalie Stowe (Team Lead Speech & Language Therapist, CSH) **NS**
Georgia Craddock (Specialist Speech & Language Therapist) **GC**
Sarah Jupp (Lead Diabetes Specialist Nurse) **SJ**

No	Item	Responsible for Action
1.	**Apologies for Absence** Dr A Mahmood (Consultant Gastroenterologist) **AM** Liz Clark (Lead Commissioning Pharmacist, Surrey Downs CCG) **LC** Susie Mallinder (Lead Renal Nurse) **SM** Dr J Bendig (Consultant Microbiologist) **JB** Dr S Moodie (Consultant Gastroenterologist) **SM** Dr R Shephard (Consultant Neonatologist) **RS** Dr A Pitsiaeli (GP, Surrey Downs CCG) **AP**	
2.	**Declarations of Interest** Nil declared for this meeting.	
3.	**Minutes of the Meeting held on 6th December 2017** The minutes of the meeting held on 6th December 2017 were agreed.	
4.	**Matters Arising** Nil for this meeting.	
5.	**New Drug Requests**	
	a) Insulin degludec This is a request to review the decision made in 2013 when it was agreed for a specific patient cohort but that prescribing would remain in secondary care. Surrey PCN carried out a review of its decision in 2017 and agreed its use in type 1 and type 2 diabetes in a specified cohort. GPs now maintain supplies post-secondary care initiation. The request from the diabetes team is that GPs in Sutton and Merton also maintain prescribing post-secondary care initiation. The patient cohort in whom insulin degludec is felt to be beneficial is:	

	• Patients whose lifestyle is restricted by recurrent symptomatic hypoglycaemic episodes. • Patients requiring assistance from health carers who are unable to attend at a fixed time each day to administer insulin glargine/ insulin detemir 3rd line after NPH insulin and insulin glargine for patients with frequent A & E attendances/hospital admissions for hyperglycaemic and DKA. • Patients on doses greater than 80 units who would otherwise need to administer two injections. Initiation and stabilisation would be by the diabetes teams in secondary care. Both NICE and SIGN support the use of basal insulin analogues such as insulin degludec in this patient cohort. The price of insulin degludec has reduced but it remains slightly more expensive than the other basal insulin analogues. To date the Trust is maintaining approximately 38 such patients on 100 units/ml and 1 patient on 200 units/ml insulin degludec. However pharmacy dispensing records indicate that 32 patients may have been transferred to GPs. Some GPs in Sutton have also started to prescribe. It was recognised that many patients on insulin degludec are housebound with carers who struggle to get to hospital to collect ongoing prescriptions. SJ described a couple of cases where treatment had been successful but also highlighted the difficulties patients had in collecting supplies from hospital and of the number of appointments needed with the diabetes non-medical prescribers to maintain prescriptions. **Decision** To remove the hospital only status from insulin degludec. Patient cohort to remain as: • Patients whose lifestyle is restricted by recurrent symptomatic hypoglycaemic episodes. • Patients requiring assistance from health carers who are unable to attend at a fixed time each day to administer insulin glargine/ insulin detemir 3rd line after NPH insulin and insulin glargine for patients with frequent A & E attendances/hospital admissions for hyperglycaemic and DKA. • Patients on doses greater than 80 units who would otherwise need to administer two injections. The diabetes team must ensure the patient is stable before requesting the GP takes over the prescribing and that it is clear in the communication to the GP the reason for initiation of this insulin. Feedback from Sutton and Merton regarding GP support at next meeting.	**KGA/AL**
	b) Tiotropium Inhaler (Braltus®) The request to add this branded generic tiotropium inhaler to the formulary has come from the Trust respiratory team. The licensed indication and delivered dose is the same Spriva®. Braltus® has the advantage that it comes in a clear capsule so the patient can see that all the content has been inhaled without the need to open the capsule as with Spiriva®. They come in a bottle rather than blister which may be easier for some patients to remove from and currently Braltus® is cheaper for primary and secondary care. The disadvantages are around ensuring the patient knows not to take the capsule orally and there is a potential risk that if the capsule is inserted into the wrong part of the device then it can be accidentally swallowed during inhalation. The proposal is that the Trust would initiate new patients requiring tiotropium on the Braltus® brand. Sutton CCG is beginning the process of switching appropriate patients from Spiriva® to Braltus®. Surrey PCN have preferred LAMAs and tiotropium is not a first line option, however Braltus® is an unavailable option. **Decision** To add inhaler Braltus® to the Trust formulary for use as an alternative to Spiriva® in	**KGA/AL**

	line with place in therapy in the Trust COPD guidance **c) Citric Acid 0.6mmol/ml sterile solution** The case for adding citric acid solution to the formulary for cough reflex testing (CRT) was presented by Natalie Stowe and Georgina Craddock (Speech and language therapists SALT) but the request is supported by Dr Kakar. It would be used in selected stroke patients for CRT as part of the speech therapy dysphagia assessment and management. CRT has been used to test the cough reflex in stroke patients for many years and is carried out regularly in New Zealand. Following acute stroke up to 25% of patients may aspirate silently and this is associated with pneumonia and mortality. Once the patients are identified they will be placed as nil by mouth and have video fluoroscopy to determine where the breakdown in the cough reflex is. An individual care plan will then be devised. There is evidence that bedside screening is not reliable at identifying silent aspiration and adjuncts like pulse oximetry have high sensitivity but low specificity. The presenters advised levels of community acquired pneumonia have reduced in New Zealand since CRT has been introduced in this cohort. The study by Miles et al however did not show a reduction in pneumonia in post-stroke dysphagic in patients with a strong cough, weak cough or those who failed the CRT; however it did suggest a positive association between 1) failed CRT result and silent aspiration and 2) weak CRT result and weak response to aspiration. It was recognised that development of pneumonia is multifactorial. There is a 10% chance of a false negative. No outcome data from hospitals currently using CRT eg. Northwick Park or Royal Surrey County Hospital have been identified. The proposal at present would be for use at Epsom site only. SALT are employed by Epsom Health and Care. Epsom Health and Care have a different funding stream to the acute trust but the drug costs and governance do sit with the Trust. The speech and language therapists felt that there might be more evidence available and would forward this on to the phamacy team. The committee felt consideration should be given to whether this was a study / trial rather than standard therapy. To be discussed again at the MMCBGM.	**KGA/AL**
6.	**Six Month New Drug Reviews** Nothing for this meeting.	
7.	**NICE/MHRA Guidance**	
	I. NICE Technology Appraisals Summary	
	Technology Appraisals for Discussion	
	a) Atezolizumab for untreated locally advanced or metastatic urothelial cancer when cisplatin is unsuitable – TA492 Atezolizumab will be added to the formulary for this indication. The Trust will not initiate treatment in this patient cohort.	**KGA**
	b) Cladribine tablets for treating relapsing-remitting multiple sclerosis – TA493 Cladribine will be added to the formulary for treating highly active multiple sclerosis in patients with the defined criteria. Funding will be via Bluteq.	**KGA**
	c) Naltrexone-bupropion for managing overweight and obesity – TA494 Naltrexone-bupropion is not recommended for use in this indication.	**KGA**
	d) Palbociclib with an aromatase inhibitor for previously untreated, hormone receptor-positive, HER2-negative, locally advanced or metastatic breast cancer – TA495 Palbociclib will be added to the Trust formulary for use in this indication. The Trust will not initiate treatment in this patient cohort.	**KGA**
	e) Ribociclib with an aromatase inhibitor for previously untreated, hormone receptor-positive, HER2-negative, locally advanced or metastatic breast	**KGA**

	cancer – TA496 Ribociclib will be added to the Trust formulary for use in this indication. The Trust will not initiate treatment in this patient cohort.	
	f) Golimumab for treating non-radiographic axial spondyloarthritis – TA497 This indication will be added to the formulary entry for golimumab. The rheumatologists are interested in using this in line with the guidance. Funding will be via Blueteq application to the CCG.	**KGA**
	g) Lenvatinib with everolimus for previously treated advanced renal cell carcinoma – TA498 Lenvatinib and everolimus will be added to the formulary for this indication. The Trust will not initiate treatment in this patient cohort.	**KGA**
	h) Glecaprevir–pibrentasvir for treating chronic hepatitis C – TA499 Glecaprevir–pibrentasvir will be added to the formulary for this indication. Hepatitis C patients are currently referred to Royal Surrey County Hospital or St Georges for treatment.	**KGA**
	i) Ceritinib for untreated ALK-positive non-small-cell lung cancer – TA500 Ceritinib will be added to the formulary for use in this indication. The Trust will not initiate treatment in this patient cohort.	**KGA**
	j) Intrabeam radiotherapy system for adjuvant treatment of early breast cancer – TA501 This is not recommended for routine commissioning and should only be used in conjunction with NHS England approval.	**KGA**
	k) Ibrutinib for treating relapsed or refractory mantle cell lymphoma – TA502 This indication will be added to the formulary for Ibrutinib. The haematologists will initiate in line with this guidance.	**KGA**
	l) Fulvestrant for untreated locally advanced or metastatic oestrogen-receptor positive breast cancer – TA503 Fulvestrant is not recommended for treatment in this indication.	**KGA**
	Technology Appraisals Terminated	
	None for this meeting.	
	Technology Appraisals for Information	
	None for this meeting.	
	Technology Appraisals Not Recommended	
	None for this meeting.	
	Clinical Guidelines Updated for Information	
	None for this meeting.	
	Clinical Guidelines for Discussion	
	a) Age-related macular degeneration – NG82 This guideline requires discussion with the ophthalmologists to ensure any issues are identified. Post-meeting they have advised that nothing in this guideline would result in a change in practice or service. **b) Oesophago-gastric cancer: assessment and management in adults- NG83** This has been circulated to the gastroenterologists for information. Chemotherapy will not be initiated by the Trust for oesphago-gastric cancer.	**AD**
	Clinical Guidelines for Information	
	a) Cataracts in adults: management – NG77 This guideline has been circulated to the ophthalmologists. No specific drug-related issues identified.	
	Quality Standard Updated	
	a) Suspected cancer – QS124 Definitions have been updated to align with NICE guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care.	

	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	
	a) 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 Final Appraisal Determination: Ixazomib with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma** Ixazomib will be available via Cancer Drugs Fund from 19/12/17 in line with the NICE FAD. **ii. NICE Technology Appraisal 478: Brentuximab vedotin for treating relapsed or refractory systemic anaplastic large cell lymphoma** Brentuximab vedotin will be available via NHSE / CDF in line with TA478 from 02/01/18. **iii. Nivolumab for treatment of adult patients with advanced or recurrent gastric or Gastro-oesophageal Junction (GEJ) cancer** The Trust is not a recognised treatment centre for this treatment. For information only. **iv. Rituximab for chronic inflammatory demyelinating neuropathy, multifocal motor neuropathy, vasculitis of the peripheral nervous system and IgM paraprotein-associated demyelinating neuropathy.** NHSE have advised that currently there is not enough evidence to make Rituximab available for this indication. Neurologists and immunologists will be informed.	**KGA**
	Health Technology Assessment	
	For Discussion	
	None for this meeting.	
8.	**Patient Safety Alerts**	
	a) Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders The Trust medical devices group are considering the necessary actions and developing an action plan next week. Action plan to be discussed at next MMCBGM. Concerns were raised that cylinders may not be being checked for how full they were, and staff may be unaware of how to order. There is a medical gases policy and committee but would be helpful to have nurse involvement.	**KGA**
9.	**Operational Issues**	
	i. Vitamin D Guidelines Final version for information. To be circulated via eUpdate and clinical meetings. SWL guidance is being prepared and this will be considered when available. **ii. Fracture Neck and Femur (Post discharge)** The issues raised at the last meeting regarding fractured neck of femur, bone health and communication to GP have been discussed with the lead clinician. It was felt that the approach was individual and this may not always be transferred to the GP. However it was recognised that the discharge information could be more focused which may improve the detail supplied.	**KGA / AL** **VDS**

	a) Regional Medicines Optimisation Area Committees **I. Flash Glucose Monitoring Systems – Feedback from South West London** Surrey's policy statement is included in 10F 111A and in the process of implementation. SWL have a current position statement on their website. The Regional Medicines Optimisation Committee document is being reviewed by the London-wide diabetes group. Update at future meeting.	**AD / ST**
	b) Patient information leaflet – Supplies of medication This leaflet has been agreed by the Trust Communication team and is ready for circulation. LC has sent comments and these will be reviewed as AD and Sue Wright. Feedback to be given.	**AD / Sue Wright**
	c) Carbocisteine sachets Confirmation has been received that the respiratory teams are happy for adult patients needing a 750mg dose of liquid can use the sachets. Sachets to be added to the formulary. Memo to be devised and stock lists amended. Surrey and Sutton CCG support the switch.	**KGA / AL**
	d) Cow's milk allergy feeds – Feedback from Sutton CCG Feedback from the dieticians at Sutton CCG following the issues raised at the last meeting has been received recently and this will be reviewed. AL and ST to discuss the option that consultants recommend type of feed required. GPs to initiate a suitable brand in-line with Sutton CCG guidelines. Update at next meeting.	**KGA / AL**
	e) Alteplase Theatres Protocol (for information) Following agreement to use alteplase for submacular haemorrhage associated with exudative age-related macular degeneration at NDAIG, the ophthalmologists have devised a guideline for use as requested. This document was approved.	**KGA**
	f) Emollient formulary changes- memo (for information) Memo for information. Surrey emollient choices may be reviewed in future.	
	g) Constipation in adults guidelines This document has been devised by SM and comments are requested to be sent to KGA and AL. ST advised to link with Dr Patel as he is working with the CCG on gastroenterology pathways. Comments received from palliative care will be incorporated and revised version circulated.	**KGA / AL**
	h) Guidelines for prescribing iron in inflammatory bowel disease Following agreement to use Ferracru® at NDAIG, SM has devised guidelines for prescribing iron in inflammatory bowel diseases as requested. Document agreed with the addition of the new Trust logo.	**AL / KGA**
	i) Cilodex® ear drops A request has been made by ENT (Mr Robb has left the Trust but the request is supported by Mr Hehar) to use Cilodex®. This is the first licenced quinolone ear drop and contains ciprofloxacin and dexamethasone. It is licenced for acute otitis media in patients 6 months and older with tympanostomy tubes (AMOT) and acute otitis externa in patients 1 and older (AOE). First line treatment would be aminoglycoside ear drops unless there is a potential risk of ototoxicity. The currently used second line is ofloxacin +/- steroid drop. Ofloxacin is being used off label as they are licensed as eye drops. Microbiology have supported the request and advised that they will be able to provide sensitivities to ciprofloxacin if agreed. Further supply will not be required in primary care. It was recognised that it will be more expensive. **Decision** To agree to the addition of Cilodex® to the formulary for ENT clinicians for acute otitis media in patients 6 months and older with tympanostomy tubes (AMOT) and acute otitis externa in patients 1 year and older (AOE). Microbiology to be informed	

	once funding approval is obtained. Ofloxacin eye drops to remain on formulary for use in the eye and in case the patient is allergic to dexamethasone.	
	j) NHS England- Conditions for which over the counter items should not routinely be prescribed in primary care: A Consultation on guidance for CCGs. The consultation on this document has closed. ST advised that unless consultation locally had highlighted reasons not to, then the guidance should be implemented. Trust should respond to a second document around not prescribing some medicines used for self-care.	**AD / VDS**
10.	**Feedback from CCGs and Trust Committees**	
	a) Respiratory Working Group **i. Asthma poster and guidance** No update for this meeting.	
	b) **ii. DOACs** Comments are invited for the bulletin on DOAC's. **iii. Medicine Matters Bulletin DOAC's** Surrey PCN has supported edoxaban as their preferred DOAC for stroke prevention in AF. The cardiologists have now supported this approach and the stroke team will now be contacted for their views. Contract price will be obtained by the Trust. Sutton CCG still has a rebate scheme for rivaroxaban and will await the outcome of discussion at the cardiac and stroke network.	
	c) SWL Sutton & Merton CCGs **i. Minutes** Minutes for information. **ii. Position Statements** These position statements are in-line with NHS England's national guidance on medicines which should no longer be routinely prescribed. The Trust support all these documents.	
	d) SWL Medicines Optimisation Group Nothing for this meeting.	
	e) SWL Cardiovascular Group for Discussion **a) Midodrine for the treatment of Severe Orthostatic Hypotension due to Autonomic Dysfunction, Postural Orthostatic Tachycardia Syndrome (POTS) or Inappropriate Sinus Tachycardia (IST)** Midodrine is being used in an unlicensed manner for the treatment of POTS. The GP must be notified of initiation after at least 3 months of treatment and when the dose is stable then the hospital doctor can transfer prescribing responsibility to the GP using the transfer of prescribing responsibility form. Awaiting the response of the cardiologists to see if the Trust uses midodrine for treatment of POTS. **b) Prescribing Ivabradine for the treatment of Postural Orthostatic Tachycardia Syndrome (POTS) or Inappropriate Sinus Tachycardia (IST)** Ivabradine is being used in an unlicensed manner for the treatment of POTS or IST. The GP must be notified of initiation using the form. After at least 3 months of treatment and when the dose is stable the hospital doctor can transfer prescribing responsibility to the GP using the transfer of prescribing responsibility form. Awaiting the response of the cardiologists to see if the Trust uses ivabradine for treatment of POTS or IST.	
	f) Surrey Prescribing Clinical Network **I. Minutes December 2017**	

	Minutes for information. **II. Minutes January 2018** Minutes for information. **III. Surrey Policy Statements** **a. Flash Glucose Monitoring System (FreeStyle Libre®) for patients with Type 1 diabetes** Surrey PCN have based their position statement on the NHS England RMOC statement. Patient criteria are clearly stated and the patients must be motivated and educated to respond to the information provided for FreeStyle Libre. Initiation will be by the specialist type 1 diabetes service and they will monitor the response. At 6 months the patient must have demonstrated improvement in the target criteria agreed by the patient and specialist at initiation. After an initial prescribing period of at least 1 month primary care prescribers will be provided with a clinic letter from the diabetes service with baseline criteria detailed. **b. Osteoporosis guideline update** The osteoporosis guideline has been updated to reflect TA464. The Trust support this guideline but do not have all the calcium and vitamin D preparations on formulary. **c. Alimemazine tartrate (trimeprazine tartrate) for the treatment of puritis in eczema (licensed indication)** The Trust is reviewing the usage of alimemazine by dermatology / paediatrics. If clinicians have initiated it they will be asked to review the patient within 12 months, with a view to stopping treatment where possible. Update at next meeting. **d. Alimemazine tartrate (trimeprazine tartrate) for the treatment of sleep disorders in children & adolescents (unlicensed indication)** The Trust is reviewing the usage of alimemazine by paediatrics. If clinicians have initiated it they will be asked to review the patient within 12 months, with a view to stopping treatment where possible. Update at next meeting. **e. Alpha Blockers for men with moderate to severe lower urinary tract symptoms** The Trust supports this statement, and do not have indoramin or doxazosin m/r on formulary or prazosin for this indication. **f. Alfuzosin MR (modified release) for men with recurrent acute retention or acute on chronic urinary retention** The Trust supports this statement and have alfuzosin m/r on formulary. **g. Anticholinergics for the management of over active bladder (OAB) in men** The Trust supports this statement with the exception of solifenacin which has previously been agreed with Surrey Downs CCG. It will only be used in patients unable to have mirabegron or botox and when they have tried and failed treatment with anticholinergic agents. **h. Mirabegron for the treatment of overactive bladder symptoms in men** The Trust supports this statement in-line with NICE TA290. Mirabegron is on formulary. **i. 5-alpha reductase inhibitors for benign prostatic hyperplasia** The Trust supports this statement but currently only have finasteride on formulary.	**KGA / AL** **KGA**

	j. Loop diuretics in nocturnal polyuria in men The Trust supports this statement and have furosemide and bumetanide on formulary. **k. Oral desmopressin for nocturnal polyuria in men (off label use)** The Trust supports this statement. Add to the formulary in-line with NICE clinical guidance CG97. **l. Phosphodiesterase-5 inhibitors for the treament of lower urinary tract symptoms in men** The PCN do not support the use of phosphodiesterase-5 inhibitors for the treatment of lower urinary tract symptoms except as part of a RCT. Urologists will be informed. **m. Combodart® (dutasteride & tamsulosin) for the treatment of lower urinary tract symptoms in men** The Trust supports this statement and do not have the combination product of dutasteride and tamsulosin on formulary. **n. Vesomni® (tamsulosin & solifenacin) for the treatment of lower urinary tract symptoms in men** The Trust supports this statement and do not have the combination product of tamsulosin and solifenacin on formulary. **o. Duloxetine for the treatment of lower urinary tract symptoms in men** The Trust supports this statement and do not have duloxetine on formulary for this indication. **p. Tofacitinib for the treatment of moderate to severe Rheumatoid Arthritis (NICE TA480)** The Trust supports this statement in-line with NICE TA480. **q. Sarilumab for moderate to severe rheumatoid arthritis (NICE TA485)** The Trust supports this statement in-line with NICE TA485. **r. Dimethyl Fumarate (Skilarence) for treating moderate to severe plaque psoriasis (NICE TA475)** The Trust supports this statement in-line with NICE TA475. **s. Botulinum Toxin Type A for the treatment of overactive bladder (men and women)** The Trust supports this statement and have botulinum toxin Type A 'Botox brand' available. **t. Herbal Treatments** These are items which are included in NHS England guidance which should not routinely be prescribed in primary care. The Trust supports these statements. **u. Homeopathy** The Trust supports this statement. **v. Perindopril Arginine** The Trust supports this statement. Perindopril is not on formulary. **w. Trimipramine** The Trust supports this statement. Trimipramine is not on formulary.	**KGA** **KGA / AL**

	x. Co-proxamol The Trust supports this statement. Co-proxamol is not on formulary. **y. Prolonged-release Doxazosin (also known as Doxazosin Modified Release)** The Trust supports this statement and it is not on the formulary. **z. Glucosamine and Chondroitin** The Trust supports this statement and it is not on formulary. **aa. Lutein and antioxidants for the prevention of age related macular degeneration (AMD)** This document will be circulated to the ophthalmologists for information, but the products are not on formulary. **cc. Omega-3 Fatty Acid Compounds (for indications other than raised triglycerides)** The Trust supports this statement. **dd. Paracetamol and Tramadol Combination Product** The Trust supports this statement and the combination product is not on formulary. **ee. Rubefacients (excluding topical NSAIDs)** The Trust supports this statement and rubefacients are not on formulary. **ff. Once Daily Tadalafil** This document will be circulated to the urologists for information. Once a day tadalafil is not on formulary. **gg. Dosulepin** The Trust supports this statement it is on formulary only for patients to admitted on treatment. **hh. Oxycodone and Naloxone Combination Product** The Trust supports this statement and the combination product is not on formulary. **ii. Immediate Release Fentanyl for all indications other than palliative care treatment** The Trust supports this statement. **jj. Lidocaine Plasters for all indications (except symptomatic relief of neuropathic pain associated with previous herpes zoster infection)** As advised at the PCN meeting the Trust have lidocaine patches on the formulary for use by the pain team for post-herpetic neuralgia and localised neuropathic pain when other treatments are ineffective or not tolerated. First month from the Trust and then review by the pain team for efficacy. If further treatment is required the pain team will advise the GP providing all relevant information. The pain team will be made aware of the guidance. Their revised statement is on the Surrey Pad. **kk. Travel vaccines (Hepatitis B, Japanese Encephalitis, Meningitis ACWY, Yellow Fever, Tick-borne encephalitis, rabies & BCG) exclusively for the purposes of travel** The Trust supports this statement and do not supply vaccines for purposes of travel. **ll. Biosimilar enoxaparin (Inhixa®) use for all licensed indications in adults** The Trust supports this statement but do not have enoxaparin on formulary. Dalteparin is the Trust's LMWH of choice.	**KGA / AL** **KGA / AL**

	mm. Opicapone for adjunctive therapy in adult patients with Parkinson's Disease The Trust supports this statement but have yet to receive an application for opicapone for addition to the formulary. **nn. Safinamide as add on therapy to Levodopa alone or in combination to other treatments in adult patients with idiopathic Parkinson's Disease** The Trust supports this statement but have yet to receive an application for safinamide. **oo. Magnesium preparations for the treatment & prevention of magnesium deficiency** The Trust supports this statement but currently only has magnesium aspartate as oral magnesium replacement therapy on formulary. **pp. Aflibercept for treating choroidal neovascularisation (TA486)** The Trust supports this statement in-line with NICE TA486. **qq. Carbocisteine for the reduction of sputum viscosity in respiratory tract disorders** The Trust supports this statement and have agreed to addition to formulary. (see 9c) **rr. Mepilex border dressings for preventing pressure ulcers** The Trust supports this statement and do not have this dressing on formulary. **ss. Naltrexone-bupropion for managing overweight and obesity (NICE TA 494)** The Trust supports this statement in-line with NICE TA494. **tt. Testosterone Gel (Testim & Tostran Gel) for low libido in post-menopausal women (unlicensed indication)** The Trust supports this statement. **IV. FAQ – FreeStyle Libre®** This FAQ document was felt to be practical and useful.	
11.	**Any Other Business**	
	None for this meeting.	
12.	**Date of Next Meeting:**	
	Wednesday 11th April 2018, 12.30-2.00pm, Nightingale Room,2nd Floor, Wells Wing (F Block), Epsom General Hospital.	