**EPSOM AND ST Helier UNIVERSITY HOSPITALS NHS TRUST**

**NEW DRUG AND INTERFACE GROUP**

MINUTES OF THE MEETING HELD ON WEDNESDAY 10th October, 2018 12.30 – 2.00pm
In the Board Room, Ferguson House, St Helier Hospital

**Present:**
Dr V De Silva (Chair) **VDS**
Sarah Taylor (Chief Pharmacist, Sutton CCG) **ST**
Liz Clark (Lead Commissioning Pharmacist, Surrey Downs CCG) **LC**
Lynn Ring (Consultant Nurse Glaucoma) **LR**
Dr J Wang (Consultant Medical and Renal) **JW**
Anne Davies (Chief Pharmacist) **AD**
Anne Lowson (Secretary) **AL**
Dr R Scott (Joint Medicines Management Lead, GP Sutton CCG) **RSc**
Dr S Moodie (Consultant Gastroenterologist) **SM**

**In attendance:**
Dr Rizwan Rajak (Croydon Medicines Management Committee Chair) **RR**
Dr R Nithiyananthan (Consultant endocrinologist) **RN**
Dr P Sharma (Consultant Paediatrician) **PS**
Manjeet Lundh (Deputy Chief Pharmacist Sutton CCG) **ML**
Zahir Hoque (Rotational Pharmacist) **ZH**
Curtis Mansfield (Pre-registration Pharmacist) **CM**
Sumbo Adeyemo (Medicines Management Pharmacist) **SA**
Kuljit Gata-Aura (Medicines Management Technician) **KGA**
Maria D'Sa (Pharmacy and Medicines Management Administrator) **MD**

| No | Item | Responsible for Action |
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| **1.** | **Apologies for Absence**<br>Dr Andreas Pitsiaeli (GP, Surrey Downs CCG) **AP**<br>Dr Justin Bendig (Consultant Microbiologist) **JB**<br>Dr Mulleague (Consultant Anaesthetist) **LM** | |
| **2.** | **Declarations of Interest**<br>Dr Sharma advised that he had attended an international conference on ADHD sponsored by Shire Pharmaceuticals and a Surrey ADHD study day on May 2018. | |
| **3.** | **Minutes of the Meeting held on 7th February 2018**<br>The minutes of the meeting held on 13th June 2018 were agreed. | |
| **4.** | **Matters Arising**<br>**Venous Thromboembolism Prophylaxis Guidelines**<br>EOC have discussed the new NICE guidelines for Prophylaxis of Venous Thromboembolism with the thrombosis committee and have devised guidance for clinicians. This was briefly discussed at the last MMCBGM and the comments made will be fed back to the authors. Update at next meeting. | **VDS** |
| **5.** | **New Drug Requests** | |
| | **a) Guanfacine - ADHD**<br>Dr Sharma presented the case for the addition of guanfacine to the formulary for the treatment of attention deficit hyperactivity disorder (ADHD) or for patients attending Epsom hospital. Guanfacine is licensed for children 6-17yrs old with ADHD or for whom stimulants are not suitable, not tolerated or have been shown to be ineffective as part of an ADHD programme. Guanfacine is a selective alpha 2A adrenergic receptor agonist, and is the second non-stimulant treatment for ADHD | |

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| | licensed in the UK. It is hypothesised that guanfacine modulates signalling in the prefrontal cortex thereby restoring defects in attention and impulse control. It has been compared with atomoxetine as an active control but this study was not powered to test superiority of guanfacine over atomoxetine. NICE have produced an evidence summary and this includes three short terms RCT's showing it was more effective than placebo in improving ADHD symptoms although a beneficial effect on social functioning was not consistently shown. NICE support atomoxetine on guanfacine as a 3rd line agent (after methylphenidate – short or long acting and lisdexamfetamine or dexamfetemine if the longer effect profile of lisdexamfetamine is not tolerated).<br><br>Dr Sharma advised that in his experience patients on the autistic spectrum may do better on guanfacine than atomoxetine as it helps with sleep disorders. Some patients may be able to stop melatonin. Approximately 30% of patients with ADHD will need a third line agent. Guanfacine can cause syncope hypotension and bradycardia. Prior to initiation of treatment patient's cardiovascular status including heart rate, BP and family history of sudden cardiac death should be assessed to identify patients at risk of hypotension bradycardia and QT prolongation/risk of arrhythmia. Dr Sharma advised paediatric cardiologists were available to support these assessments. Shared care for guanfacine has been agreed by Surrey CCG's. Dr Sharma has inputted to these guidelines, and is aware of the monitoring, duration of treatment and communication required with GP's. If agreed then shared care would be supported.<br><br>**Decision**<br>Guanfacine to be added to the formulary for the treatment of ADHD as a 3rd line agent if they cannot tolerate the stimulants methylphenidate or lisdexamfetamine / dexamfetamine. Atomoxetine to remain on formulary as a 3rd line agent in line with NICE guidance for managing ADHD Shared care to be finalised with Surrey CCG and Sutton CCG will support shared care but are currently awaiting guidance from St Georges Hospital.<br><br>**b) Alogliptin- Type 2 diabetes**<br>Dr Nithiyananthan presented the case for the addition of alogliptin to the formulary. It is a dipeptidyl peptidase 4 inhibitor (DPP – 4) and fourth to the market. NICE recommends metformin as an initial drug treatment for glycaemic control in type 2 diabetes. If this is inadequate NICE recommends adding on an additional therapy from a range of options which includes DDP-4 inhibitors. The adverse effects of the DDP-4 inhibitors are broadly similar. In the Examine Study comparing alogliptin with placebo the rate of hospitalisation for heart failure was not a formal outcome, but the data was reviewed by the FDA. Although the difference in rate of admission for heart failure was not statistically significant the FDA added warnings to inform of the potential increased risk of heart failure. The SPC advises using with caution in patients with heart failure (NHYA class III or IV). It is not licensed for monotherapy. Alogliptin requires a dosage reduction in moderate and severe renal impairment. It is currently the cheapest DPP-4 inhibitor and NICE advises that if two drugs in the same class are appropriate use the one with the lowest acquisition cost.<br><br>Currently the formulary has three DPP-4 inhibitors and it was felt that review was necessary if another is to be added. The committee suggested linagliptin should be retained as it is licensed for monotherapy and requires no dose adjustment in renal impairment. Saxagliptin is the least frequently used, requires dose adjustment in renal impairment and is currently more expensive than alogliptin. It carries a caution for use in patients at risk of hospitalisation for heart failure as well as a caution in patients with heart failure (NHYA III or IV). Saxagliptin will be removed | **AL / KGA** |

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| | from the formulary.<br><br>Dr Nithiyananthan also requested if alogliptin was accepted to the formulary and that the combination product of alogliptin / metformin was also considered. The combination product could improve adherence for patients prescribed both drugs particularly as diabetics after need to take multiple medications. The combination product is currently the cheapest DPP-4 inhibitor with metformin although all the DPP-4 inhibitors have a combination product available. The committee did note that combination preparations do not allow flexibility in dosing.<br><br>**Decision**<br>Alogliptin to be added to the formulary for treatment of type 2 diabetes to improve glycaemic control in combination with other glycose lowering medicines including insulin. Saxagliptin to be removed from the formulary.<br><br>Alogliptin and Metformin combination preparation DDP-4: alogliptin and metformin have a clear place in therapy in NICE for management of type 2 diabetes. The advantages of the combination product are that it is the same price as alogliptin alone and may improve adherence as there is a lower pill burden. The drawback is that it does not allow for dose flexibility.<br><br>**Decision**<br>To add the combination of alogliptin and metformin to the formulary for use in line with NICE guidelines.<br><br>**c) Q-Tern®(Saxagliptin and dapagliflozin) – Type 2 diabetes**<br>Dr Nithiyananthan presented the case for Q-Tern® a combination of Saxagliptin (DPP – 4i inhibitor) and dapagliflozin (a SGLT2 inhibitor). This is currently the only DPP-4i /SGLT2 combination product in the UK. The treatment combination of metformin plus DPP-4i plus SGLT2i is not supported by NICE and used in a small number of patients. Currently the combination of saxagliptin and dapagliflozin (as separate components) is not supported by NICE based on cost effectiveness. NICE did not factor in the cost of the combination preparation into the cost effectiveness analysis. The combination dose offers a cost saving compared to prescribing the mono components separately. The committee felt that the fixed dose combination would not allow dose adjustments of the individual components for changes in renal or hepatic function.<br><br>**Decision**<br>To reject the addition of saxagliptin /dapagliflozin Q-tern®. Saxagliptin has been removed from the formulary and replaced with alogliptin (see above). The combination would only be used in a small number of patients as the combination of metformin plus DPP-4i plus SGLT2i is not supported by NICE.<br><br>**d) Mysodelle®- Product withdrawal**<br>Mysodelle® a misoprostal 200mg Vaginal delivery system for induction of labour in women with an unfavourable cervix from 36 weeks gestation in whom induction is clinically indicated was approved for addition to the formulary at the June meeting. However Ferring Pharmaceuticals have decided to voluntarily discontinue the manufacture and distribution of Mysodelle® worldwide. This is a business decision to rationalise the product portfolio. Mysodelle® will be removed from the formulary. | **AL / KGA**<br><br>**KGA** |
| **6.** | **Six Month New Drug Reviews** | |
| | No updates for this meeting. | |

| 7. | NICE/MHRA Guidance | |
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| | **I. MHRA Guidance - June 2018**<br>The new recommendations following cases of neural tube defects in babies born to mothers who become pregnant while taking the HIV medicine dolutegravir has been shared with Dr Estrich. Monitoring advice to minimise the risk of hypercalcaemia following discontinuation of denosumab 120mg when used for giant cell tumour of bone has been circulated to haematology and rheumatology. Study data have shown an increased risk of new primary malignancy with denosumab compared with zolendronic acid when used in prevention of skeletal related events in adults with advanced malignancies involving bone has also been circulated. | **KGA** |
| | **II. MHRA Guidance - July 2018**<br>This update gives advice to healthcare professionals on avoiding the use of darunavir boosted with cobicistat in women who are pregnant, as pharmacokinetic data suggests a risk of treatment failure and potential maternal to child transmission of HIV-1 Dr Estrich has been informed.<br><br>Patients should be reminded to check the mouth piece of their inhalers for loose objects before taking a dose and replace the mouth piece cover securely after use. This has been circulated to respiratory team and pharmacists. The advice on being aware that interference with bilirubin (falsely low/normal results) and creatinine (falsely high/normal results) may occur in patients taking eltrombopag has been circulated to the haematologists. A reminder on possible confusion between preparations of amphotericin and that non lipid based formulation of amphotericin B (Fungizone®) and the lipid based formulation (AmBisome®and Abelcet®) are not interchangeable, has been sent to microbiologists haematologists and pharmacy staff. ePMA to be checked to ensure it is prescribed by brand. | **KGA** |
| | **III. MHRA Guidance - August 2018**<br>Esmya® and the risk of serious liver injury has been discussed previously following the temporary safety measures put in place by the MHRA in March 2018. Following discussion with the gynaecologists. The product was removed from the formulary. The MHRA have now put in new measures to minimise the risk of serious liver injury in women receiving Esmya® for uterine fibroids. Use of more than one treatment course is authorised only in women who are not eligible for surgery and liver function monitoring is to be carried out in all women treated with Esmya®. Dr Jan and Mr Ganapathy have advised they do not wish to add back to the formulary at present, and they are concerned about the monitoring required. | **KGA** |
| | **IV. MHRA Guidance - September 2018**<br>There are now resources available for patients and healthcare professionals to advise on the prevention of serious harms of valproate in pregnancy. Pharmacy have circulated these and prepared a recording sheet to verify female outpatients supplied with valproate are aware of the risks, and amended procedures. Clinicians have been informed about the enrolment of female patients in the Pregnancy Prevention Programme and annual reviews necessary. Sutton CCG is planning to do an audit of female patients on valproate. A Medicines Matters Bulletin is prepared and awaiting final sign off.<br><br>New restrictions are in place on radium 223 dichloride due to the increased risk of fracture and trend for increased mortality seen in trials. The Trust does not currently treat patients with this.<br><br>The updated monitoring recommendations for patients who have been treated for multiple sclerosis with daclizumab have been circulated to the neurologists. The | **KGA** |

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| | Trust did not initiate patients on this treatment, but there is a possibility that they received it elsewhere and require monitoring. Nusinersen is an antisense oligonucleotide for the treatment of 5q spinal muscular atrophy. There have been reports of communicating hydro cephalus and patients/carers should seek urgent medical attention if any signs or symptoms of communicating hydro cephalus develop. | |
| | **Updates** | |
| | None for this meeting | |
| | **Technology Appraisals for Discussion** | |
| | **a) Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma- TA540**<br>Pembrolizumab is not recommended for treating relapsed or refractory classical Hodgkin lymphoma in adults who have had autologous stem cell transplant and brentuximab vedatin. Pembrolizumab is recommended for use within the cancer drugs fund as an option for treating relapsed or refractory classical Hodgkin Lymphoma in adults who have had brentuximab and cannot have autologous stem cell transplant if it was stopped after 2 years of treatment or earlier if the person has a stem cell transplant or the disease progresses and the conditions in the managed access agreement are followed will be added to the Trust formulary in line with the TA.<br><br>**b) Inotuzumab ozogamicin for treating relapsed or refractory B-cell acute lymphoblastic leukaemia- TA541**<br>Inotuzumab ozogamicin is recommended as an option for treating relapsed or refractory CD22 positive B cell precursor acute lymphoblastic leukaemia in adults. People with relapsed or refractory Philadelphia-chromosome – positive disease should have had at least 1 tyrosine kinase inhibitor. Inotuzumab will be added to the formulary in line with the NICE TA. Due to capacity issues this patient cohort is currently being managed by the RMH.<br><br>**c) Cabozantinib for untreated advanced renal cell carcinoma- TA542**<br>Cabozantinib is recommended for adults with untreated advanced renal cell carcinoma that is intermediate or poor risk as defined in the Metastatic Renal Cell Carcinoma Database Consortiums criteria. Cabozantinib will be added to the formulary although not initiated by the Trust.<br><br>**d) Tofacitinib for treating active psoriatic arthritis after inadequate response to DMARDs- TA543**<br>Tofacitinib with methotrexate is recommended as an option for treating active psoriatic arthritis in adults only if it is used as described in NICE. TA on etanercept infliximab and adalimumab for the treatment of psoriatic arthritis or the person has had a TNF alpha inhibitor but their disease has not responded with the first 12 weeks or has stopped responding after 12 weeks or TNF alpha inhibitors are contra indicated. Tofacitinib will be added to the formulary in line with this NICE TA and a Blue Teq application form is being devised by the CCG's. | **AL** |
| | **Technology Appraisals Terminated** | |
| | **e)** None for this meeting. | |
| | **Technology Appraisals for Information** | |
| | **f)** As the August NDAIG meeting was cancelled the following NICE TA's were agreed at MMCBGM. | |

| **Technology Appraisals** | |
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| TA521 | Guselkumab for treating moderate to severe plaque psoriasis |
| TA523 | Midostaurin for untreated acute myeloid leukaemia |
| TA524 | Brentuximab vedotin for treating CD30-postivie Hodgkin Lymphoma |
| TA526 | Arsenic trioxide for treating acute promyelocytic leukaemia |

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| TA527 | Beta interferons and glatiramer acetate for treating multiple sclerosis |
| TA532 | Cenegermin for treating neurotrophic keratitis |
| TA533 | Ocrelizumab for treating relapsing-remitting multiple sclerosis |
| TA534 | Dupilumab for treating moderate to severe atopic dermatitis |
| **For information only** | |
| TA522 | Pembrolizumab for untreated PD-L1- positive locally advanced or metastatic urothelial cancer when cisplatin is unsuitable |
| TA525 | Atezolizumab for treating locally advanced or metastatic urothelial carcinoma after platinum-containing chemotherapy |
| TA528 | Niraparib for maintance treatment of relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer |
| TA529 | Crizotinib for treating ROS-1 positive advanced non-small cell lung cancer |
| TA530 | Nivolumab for treating locally advanced unresectable or metastatic urothelial cancer after platinum-containing chemotherapy |
| TA531 | Pembrolizumab for untreated PD-L1-positive metastatic non- small cell lung cancer |
| TA535 | Lenvatinib and sorafenib for treating differentiated thyroid cancer after radioactive iodine |
| TA536 | Alectinib for untreated ALK-positive advanced non-small cell lung cancer envatinib and sorafenib for treating differentiated thyroid cancer after radioactive iodine |
| TA537 | Ixekizumab for treating active psoriatic arthritis after inadequate response to DMARD |
| TA538 | Dinutuximab beta for treating neuroblastoma |
| TA539 | Lutetium (177Lu) oxodotreotide for treating unresectable or metastatic neuroendocrine tumours |

**Technology Appraisals Not Recommended**

**g)** None for this meeting.

**Clinical Guidelines for Information**

**h) Dementia: assessment, management and support for people living with dementia and their carers (updated)- NG97**

These guidelines have been revised and there is now a place in therapy for using memantine together with anticholinesterases. The Trust is currently not commissioned to provide this service and patients should be referred to the psycho geriatricians.

**i) Brain tumours (primary) and brain metastases in adults- NG99**

For information as the Trust do not treat brain tumours.

**j) Early and locally advanced breast cancer: diagnosis and management- NG101**

For information as the Trust do not initiate treatment for breast cancer.

**k) Flu vaccination: increasing uptake- NG103**

The guideline covers how to increase uptake of the free flu vaccination among people who are eligible. Maternity are currently offering a service for flu vaccination.

**l) Pancreatitis- NG104**

These guidelines cover managing acute and chronic pancreatitis in children young people and adults. No specific drugs are mentioned.

**m) Renal replacement therapy and conservative management- NG107**

This guideline covers renal replacement therapy (dialysis and transplantation) and conservative management for CKD stages 4 and 5. The renal unit are aware of and implementing any changes needed.

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| | **Clinical Guidelines for Discussion** | |
| | **a) Rheumatoid arthritis in adults: management (updated)- NG100**<br>Details are given of initial pharmacological treatment use of glucocorticoids and symptom control e.g. use of NSAID's. The formulary already contains the DMARD's and a range of the other drugs listed.<br><br>**b) Chronic heart failure in adults: diagnosis and management (updated)- NG100**<br>The evidence has been reviewed and the guidelines updated. There are amendments to the monitoring and diagnosis factors. The formulary has the drug choices listed. | **KGA / AL** |
| | **Quality Standard Updated** | |
| | **c) Chronic heart failure in adults- QS9**<br>Minimal changes in terms of medicines. Statement 2 around patients with NT-pro-BNP > 2000 requiring an echo and be seen within 2 weeks has been identified as a resource issue.<br><br>**d) Renal replacement therapy services for adults- QS7**<br>Changes have been made to align the Quality Standard with the NICE guideline. | |
| | **Quality Standard for Discussion (medicine related issues only)** | |
| | **e)** None for this meeting. | |
| | **Quality Standard for Information** | |
| | **f)** None for this meeting. | |
| | **Highly Specialised Technologies Guidance** | |
| | **g)** None for this meeting. | |
| | **Highly Specialised Technologies for Discussion** | |
| | **h) Dinutuximab beta for treating high-risk neuroblastoma**<br>For information as the Trust is not a recognised treatment centre<br><br>**i) Atezolizumab or pembrolizumab as 1st line treatment of locally advanced/metastatic urothelial cancer in patients ineligible for cisplatin-based chemotherapy**<br>For information as the Trust is not a recognised treatment centre<br><br>**j) Atezolizumab for treating locally advanced or metastatic urothelial carcinoma after platinum-containing chemotherapy**<br>For information as the Trust is not a recognised treatment centre<br><br>**k) Avelumab for treating metastatic Merkel cell carcinoma**<br>For information as the Trust is not a recognised treatment centre<br><br>**l) Lutetium (177Lu) oxodotreotide for treating unresectable or metastatic neuroendocrine tumours**<br>For information as the Trust is not a recognised treatment centre<br><br>**m) Pembrolizumab for treating relapsed or refractory classical Hodgkin lymphoma**<br>Pembrolizumab will be available via the Cancer Drugs Fund in patients who meet the criteria in the FAD published 25/07/18.<br><br>**n) Nivolumab for treating relapsed or refractory classical Hodgkin lymphoma**<br>Nivolumab will be available via the Cancer Drugs Fund in patients who meet the criteria in the FAD published 2/06/18<br><br>**o) Guidance to support production of contract monitoring data flows**<br>The document purpose is to provide further guidance to healthcare providers | **AD** |

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| | regarding the content of the 4 core datasets (Aggregate contract monitoring, patient level contract monitoring. Patient level drug and patient level device reporting in order to support delivery of consistent content. This guidance will be followed.<br><br>**p) Tocilizumab for treating giant cell arteritis**<br>The Trust is not one of the specialised rheumatology or ophthalmology centres listed, but it is possible to put in place a hub and spoke model where patients are reviewed virtually. SLA's would be needed. This approach will be discussed with the clinicians. Update at next meeting.<br><br>**q) Glycerol Phenylbutyrate (Ravicti)**<br>For information as the Trust is not a specialist metabolic centre.<br><br>**r) Levofloxacin nebuliser solution for chronic pseudomonas lung infection in cystic fibrosis (adults)**<br>NHSE will commission levofloxacin inhalation solution as a fourth line option for treating chronic pulmonary pseudomonas aeruginosa infection for people with cystic fibrosis (CF) in adults. The Trust are not a recognised centre for adult CF, however a hub and spoke approach model with the Royal Brompton and Harefield NHS Foundation Trust may be viable. AD to discuss with the commissioning team. Update at next meeting. | **AD** |
| | **Health Technology Assessment** | |
| | **s)** None for this meeting. | |
| | **For Discussion** | |
| | **t)** None for this meeting. | |
| **8.** | **Patient Safety Alerts** | |
| | **a) Resources to support safer modification of food and drink**<br>The alert is being reviewed and actioned by the nutrition committee and formulary amendments on the thickeners used in the Trust have been made. Need to ensure that if the product used in community is not the same and that information is provided to the patient/carer on discharge. To be clarified with the dieticians and speech and language therapists.<br><br>**b) Resources to support safer bowel care for patients at risk of autonomic dysreflexia**<br>Daphne Colpman Consultant Nurse in Urology is the lead and an action plan has been devised. Contact to be made to establish if the recommendations include any medicines.<br><br>**c) Resources to support safe and timely management of hyperkalaemia (high level of potassium in the blood)**<br>Dr Johri has been asked to lead on this PSA and it is likely that new guidelines for the management of hyperkalaemia will be written. | **AL/Sonia Moore**<br><br>**AL** |
| **9.** | **Operational Issues** | |
| | **a) Regional Medicines Optimisation Committees**<br>**I. Midlands and East September update**<br>Guidance on homely remedies in care homes in the form of a positon statement is being written. This will align with national policy from CQC NICE and guidance from the National care forum.<br><br>A position statement will be written on access to sodium oxybate for patients suffering from narcolepsy with cataplexy.<br><br>A poly pharmacy sub group for the Midlands and East RMOC will be formed.<br>New CQUINS and Quality Premium Incentive Scheme published for 2018-2019. NICE | **AL/Donna Francis** |

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| | have published 3 common infections guidance and these should be implemented as soon as possible. To be discussed at the next antimicrobial steering group.<br><br>**II. Commissioning intentions: adalimumab**<br>The Commissioning intentions for switching to biosimilar adalimumab have been published. Biosimilars will be available late October and the tendering process will be completed by December 2018, and the Trust informed of the product to use. | |
| | **b) Patient information leaflet – Supplies of Medication - for information**<br>Final version for information | **AD** |
| | **c) NHSE guidance on OTC and self-care prescribing**<br>This guidance is for CCG's to support appropriate use of resources. It relates to conditions for which over the counter items should not routinely be prescribed in primary care. Communications materials are available from NHSE and SWL have their materials in the final stages of preparation. A poster may need to be customised to hospital conditions to provide a consistent message. | **ST/AD** |
| | **d) Free of Charge (FOC) Medicines Schemes**<br>Document discussed at the MMCBGM. Each FOC scheme must be agreed by MMC and shared with local commissioners. The guidance will be included in the Medicines Management Policy and Procedures. | **AD/Jill Stevens** |
| | **e) Discontinuation of Animas® Insulin Pumps**<br>Johnson and Johnson are pulling out of the market for insulin pumps. An agreement has been made with Medtronic and patient data will be transferred once patient consent obtained. Medtronic are offering an upgrade in warranty on Animas patient pumps, but concern has been expressed by the CCG's about appropriateness and ongoing costs/consumables. Discussions will be held with CCG's and Diabetes leads. | **AL** |
| | **f) Freestyle Libre®**<br>The divisions of medicine and paediatrics have agreed to the cost implications of initiating these patients on Freestyle Libre®. Initiation and duration of supply must be in line with the patients CCG recommendations. Sutton CCG and Surrey Downs CCG's have guidance in place, but individuals with GP's outside these CCG's will need to have commissioning considered separately. The adult programme will start at St Helier October / November. | **ALL** |
| | **g) CME Prophylaxis for Cataract Surgery – for information**<br>The protocol has been revised and the duration of dexamethasone with tobramycin eye drops and bromfenac eye drops reduced. This has not impacted on the incidence of Pseudophatic Cystoid Macular Oedema (PCME) in an audit carried out in the eye unit. The full supply of all eye drops must be provided from the eye unit. This revised guideline will provide clarity for GP's protocol agreed. | **KGA/AL** |
| | **h) Referral to Allergy Clinic Adults and Children over 16 years of age- for information**<br>The guidance for referral to Trust allergy clinics has been revised to provide clarity around the usage of some medicines used off label and that GP's to use their formulary options. A request was made to make reference to the MHRA guidance on the quantity of adrenaline auto injectors a patient should hold. Once amended final version to be sent to the CCG's. | **AL/KGA** |
| **10.** | **Feedback from CCGs and Trust Committees** | |
| | **a) Respiratory Working Group**<br>For COPD there are currently two working groups. Sutton CCG working group has completed its guidance for managing COPD and this has been shared with Trust Clinicians and Pharmacists. This work has also been shared with the SWL group who are currently awaiting the publication of the NICE guidance for COPD management due soon. Sutton CCG's working group for asthma is in progress and a request made to utilise the guidance already published by Surry PCN. This was agreed. | |

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| | **b) Sutton & Merton CCGs**<br>**I. Minutes-July 2018**<br>Minutes for information. | |
| | **c) SWL Medicines Optimisation Group**<br>**I. Quick Reference PNS Supplement Guidance for Dietitian Reference**<br>ST to link with Gillian Thorpe (Trust Lead Dietician). | **ST** |
| | **d) SWL Cardiovascular Group for Discussion**<br>Nothing for this meeting. | |
| | **e) Surrey Prescribing Clinical Network**<br>**I. Minutes-June 2018**<br>Minutes for information.<br><br>**II. Minutes-July 2018**<br>Minutes for information.<br><br>**III. Minutes-September 2018**<br>Minutes for information.<br><br>**IV. Surrey Policy Statements**<br>**a. Insulin pumps for all age groups with a non-autoimmune cause for deficiency of beta cells**<br>The PCN supports the use of insulin pump therapy for all age groups with non-autoimmune cause for deficiency of beta cells in patients who meet the NICE TA 151 criteria in every regard other than having Type 1 diabetes e.g. CF, congenital absence of the pancreas, post pancreatitis pancreatic destruction etc. The Trust supports this policy statement.<br><br>**b. (Tiotropium (Spiriva Respimat®) for the treatment of severe asthma in adult patients**<br>The PCN recommends Tiotropium (Spiriva Respimat®) as a treatment option for adult patients with asthma as add-on maintenance treatment in patients treated with maintenance combination of inhaled corticosteroid and LABA and one or more severe exacerbations in the previous year. They also must have had a trial of maintenance and reliever therapy.<br><br>The trust does not have tiotropium on formulary for use in the management of asthma at present. However the Trust is aware of the NICE guidance NG80.<br><br>**c. Oral pentosan polysulfate for the treatment of interstitial cystitis**<br>The PCN recommends Oral pentosan polysulfate for the treatment of interstitial cystitis in patients for whom all other treatment options have been tried. Hospital only.<br><br>**d. RESPeRATE® as a non-pharmacological approach to antihypertensive treatment**<br>The PCN do not recommend the use RESPeRATE® as a non-pharmacological approach to the treatment of hypertension. The Trust supports this policy statement.<br><br>**e. Potassium Hydroxide Treatments (MolluDab® and Molutrex®) for the Management of Molluscum Contagiosum**<br>The PCN does not recommend the prescribing of potassium hydroxide 5% products (MolluDab® and Molutrex®). The Trust supports this policy statement and the products are not on the formulary. | |

**f. Brodalumab for treating moderate to severe plaque psoriasis**

The PCN supports the use of brodalumab for treating moderate to severe plaque psoriasis in line with NICE TA 511. The Trust supports this policy statement.

**g. Alimemazine for the treatment of Urticaria in children (over 2 years of age) & adults**

The PCN does not recommend alimemazine for the treatment of urticaria in children & adults. This has been based on the cost effective use of NHS resources due to the significant list price increase. The paediatricians and dermatologists have been made aware of this and asked to review all current patients. The formulary has been amended to reflect that it should not be newly initiated in hospital.

**h. Guanfacine for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in children and adolescents (*6-17 years old)**

The PCN recommends guanfacine as a treatment option for treatment of Attention Deficit Hyperactivity Disorder (ADHD) in children and adolescents in line with the NICE guidelines NG87. Today's meeting agreed the addition of Guanfacine to the formulary pending financial agreement.

**i. Testosterone Gel (Tostran Gel) for low libido in post-menopausal women**

The policy statement has been amended to advise Testogel® sachets are not used as the testosterone gel to treat low libido in post-menopausal woman. The Trust currently uses Tostran® gel as their treatment option in line with the policy statement.

**j. Relvar Ellipta® (fluticasone furoate / vilanterol) in Asthma**

The PCN supports the use of Relvar Ellipta® in a small group of patients with asthma when all the following apply. A medium or high dose ICS/LABA is indicated. Patient already trialled one or more twice daily. ICS/LABA devices and unable to comply with dosing regimen Patient requires a once daily social package of care.

**k. Cannabis-derived medicinal products (medicinal cannabis), *excluding Sativex®**

The PCN advises clinicians that all cannabis-derived medicinal products with the exception of Sativex® are currently still defined as schedule 1 drugs under the Misuse of Drugs Regulations 2001 and it remains illegal to prescribe or supply cannabis for medical purposes unless a specific licence to do so has been issued by the Home Office. The Trust supports this advice.

**l. Guselkumab for treating moderate to severe plaque psoriasis (TA521**

The PCN recommends guselkumab for treating moderate to severe plaque psoriasis in line with NICE (TA521). The Trust supports this policy statement.

**m. Dupilumab for treating moderate to severe atopic dermatitis (TA534)**

The PCN recommends dupilumab as a treatment option for treating moderate to severe atopic dermatitis in line with NICE (TA534). The Trust supports this policy statement.

**n. Trimbow inhaler (beclomethasone, formoterol & glycopyrronium) for the treatment of Chronic Obstructive Pulmonary Disease (COPD) and Trelegy inhaler (fluticasone, vilanterol & umeclidinium) for the treatment of Chronic Obstructive Pulmonary Disease (COPD)**

The PCN recommends these two triple therapy combination inhalers for the

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| | treatment of COPD in the following patient cohort. On a LABA/LAMA combination inhaler who have an FEVi < 50%predicted and ≥ 2 exacerbations per year or ≥1 exacerbation leading to a hospital admission (i.e. patients at GOLD D classification) or currently stabilised on triple therapy (ICM/LABA and LAMA) in separate devices and there has been a review of the dose of steroids and a 'step down' in treatment is not appropriate. Trimbow® inhaler with a spacer is 1st line triple therapy. Trelegy® inhaler is the 2nd line triple therapy combination inhaler.<br><br>The Trust currently has Trimbow® on formulary with the same place in therapy and it will be reviewing Trelegy® in the next few months.<br><br>**o. Atropine for the treatment of licensed hospital indications ( including Iritis and Uveitis)**<br>The PCN recommends the use of atropine eye drops 1% in a bottle is switched to the minims due to the increase in cost of the 10ml bottles. The Ophthalmologists are aware of this increase in cost and will support its use in patients without dexterity issues.<br>**p. Cyclopentolate eye drops (0.5% or 1%) for the treatment licensed hospital indications ( including Iritis and Uveitis)**<br>The PCN recommends that cyclopentolate eye drops are considered hospital only for Iritis and Uveitis). This is rarely used long term. The Ophthalmologists are aware of this decision. Formulary to be revised.<br><br>**q. Cyclopentolate eye drops (0.5% or 1%) for the treatment of painful ciliary spasm in blind eyes**<br>The PCN recommends the cyclopentolate eye drops for treatment of painful ciliary spasm in blind eyes is transferable to GP's after a minimum of 2 months prescribing by the consultant and the patient is benefiting from treatment. Formulary to be revised.<br><br>**r. Atropine for the treatment of painful ciliary spasm in blind eyes**<br>The PCN recommends that Atropine eye drops for the treatment of painful ciliary spasm in blind eyes is transferable to GP's after a minimum of 2 months prescribing by the consultant and the patient Is benefiting from treatment. The minims should be used unless there are patient dexterity issues. Formulary to be revised.<br><br>**s. Mistletoe extract for the treatment of cancer or palliative care**<br>The PCN does not support the routine use of Mistletoe extract for the treatment of cancer or palliative care. This is not on the Trust formulary.<br><br>**t. Riluzole for the treatment of Motor Neurone Disease**<br>The PCN have revised the statement on the use of Riluzole and still supports its use in line with NICE TA20. Generic Riluzole is on the Trust formulary.<br><br>**u. Febuxostat for the management of chronic hyperuricemia in gout (NICE TA 164)**<br>The PCN have revised their statement on the use febuxostat and still support its use in line with (NICE TA 164). The Trust use febuxostat in line with the policy statement.<br><br>**v. Penicillamine for the treatment of rheumatoid arthritis**<br>The PCN have revised their statement on the use of penicillamine for the treatment of rheumatoid arthritis as it is no longer used routinely. Any new patients initiated on penicillamine will need to have supplies from the hospital only. The rheumatologists have supported this policy statement and confirm it is very rarely | **KGA**<br><br>**KGA**<br><br>**KGA**<br><br>**KGA** |

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| | used now. Formulary to be revised.<br><br>**w. Intramuscular sodium aurothiomalate for the treatment of rheumatoid arthritis**<br>The PCN have revised their statement on the use of intramuscular sodium aurothiomalate for the treatment of rheumatoid arthritis as it is very rarely used now. New patients will need to have injections administered in the hospital. Rheumatologists have supported this policy statement and currently have one patient receiving treatment. Formulary to be revised.<br><br>**x. Racecadotril for acute diarrhoea in children and adult**<br>The PCN does not recommend racecadotril for acute diarrhoea. The Trust does not have this medication on the formulary.<br><br>**y. Finasteride for androgenetic alopecia (male pattern hair loss)**<br>The PCN advises clinicians that finasteride for androgenetic alopecia is not to be prescribed in the NHS. Trust clinicians are aware.<br><br>**z. Pegloticase for treating severe debilitating chronic tophaceous gout**<br>The PCN does not recommend the use of pegloticase for chronic gout as its marketing authorisation has been withdrawn in the UK/EU. This is not on the Trust formulary.<br><br>**aa. Tizanidine for the treatment of spasticity**<br>The PCN recommends the use of tizanidine for the treatment of spasticity and supports its transfer into primary care after a minimum of 2 months treatment and the patient is stable. The PCN have not considered a statement previously. The Trust neurologists support this policy statement.<br><br>**bb. Treatments for Erectile Dysfunction**<br>The Trust urologists have contributed to and support this treatment pathway. | **KGA**<br><br>**KGA** |
| | **f) Shared Care Prescribing Guidelines**<br>**I.** Guanfacine - for the treatment of attention deficit hyperactivity disorder (**ADHD) in children and adolescents 6-17 years old**<br>Dr Sharma has reviewed these shared care guidelines and supports them. The PCN are in support of ESTH NHS Trust using the guidelines. Documents to be customized for the Trust.<br><br>**II. Riluzole - ALS form of motor neurone**<br>This shared care has been updated with minor changes. The Trust supports this shared care and will provide contact details as needed. | **KGA**<br><br>**KGA** |
| **11.** | **Any Other Business** | |
| | AD advised that the outcome of the judicial review on the use of Avastin® for wet AMD is out. There will be an official position from NHSE and the MHRA in due course. The advice currently is to await these, as the law has not changed. The MHRA are the enforcement body and their response to the judicial review is not yet known. There may be appeals. Ophthalmologists are aware of this advice.<br><br>AD advised that as part of the SWL APC (acute partnership collaborative) SWL are looking at having a combined formulary (St Georges, Croydon, Kingston and Epsom and St Helier). Work will start on this soon.<br><br>Meeting dates for 2019 were circulated. | **KGA** |

| 12. | Date of Next Meeting: | |
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| | Wednesday 12th December 2018, 12:30-14:00.<br>Boardroom,5th Floor Ferguson House, St Helier Hospital | |