York and Scarborough
Medicines Commissioning Committee

Minutes of Medicines Commissioning Committee Meeting
Wednesday 10th May 2017
9.30-12pm, West Offices, York

1. Apologies / Attendance

		JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY
Strategic Lead Pharmacist- MMT	Mrs Rachel Ainger (RA)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chair & Vale of York CCG Pharmacist	Mrs Laura Angus (LA)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GP Prescribing Lead – S&RCCG	Dr Greg Black (GB)	✓	✓	A	✓	✓	✓	✓	✓	✓	A	✓	✓
Principal Pharmacist Formulary, Interface and Palliative Care	Mrs Jane Crewe (JEC)	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Consultant Anaesthetist	Dr Peter Hall (PH)	✓	A	A	✓	✓	✓	✓	✓	✓	✓	A	✓
Consultant Physician	Dr Paul Jennings (PJ)	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	A	A
Deputy Chief Pharmacist Tees Esk and Wear Mental Health Trust (TEWV)	Mr Richard Morris (RM)	CW	A	CW	✓	✓	A	✓	✓	A	A	CW	A
GP Vale of York CCG	Dr William Ovenden (WO)	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
GP Prescribing Lead - VoYCCG	Dr Shaun O'Connell (SO'C)	✓	A	✓	A	✓	✓	A	A	A	A	A	✓
Deputy Chief Pharmacist	Mr Stuart Parkes (SP)	✓	A	✓	✓	A	✓	A	A	✓	A	✓	✓
Consultant Psychiatrist (TEWV)	Dr Michelle Beaumont (MB)									✓	A	✓	A
Consultant Psychiatrist (TEWV)	Dr Shona McIlrae (SM)				✓	A	A	A	A	A	A	A	A
Consultant Cardiologist	Dr Chris Hayes										✓	✓	A
Regional Drug & Therapeutics Centre, Newcastle – Professional Secretary (BR & MM alternate)	Ms Bhavana Reddy (BR)/ Mrs Monica Mason (MM)	✓ BR	MM + BR	✓ BR	✓ MM	✓ BR	✓ MM	✓ MM	✓ MM	✓ MM	✓ MM EO	✓ BR EO	✓ MM EO

Item	
1	**General business** Dr Greg Black (GB) chaired the meeting. Apologies were received from Dr Paul Jennings, Dr Chris Hayes, Richard Morris, Chris Williams, Dr Michelle Beaumont and Dr Shona McIlrae for the meeting today.

	Declarations of conflicts of interest relating to the agenda SP declared an interest in ixekizumab following his attendance at a launch event for this product where he was sponsored as a guest speaker. It was agreed that he would not participate in the associated parts of agenda item 5.1 (i.e. the recently published NICE TA442 on ixekizumab for moderate to severe psoriasis within the NICE Guidance monthly update).
2	**Matters arising**
2.1	**Chairs actions to report** VoY CCG declined a request from Seacroft hospital to use ulipristal for pre-operative management of fibroids as the patient had not tried a GnRH analogue which should be tried first. The consultant agreed with the approach and the GP agreed to prescribe a GnRH analogue. **Outcome of VoY SMT/SRCCG Clinical Executive Committee** Recommendations from the April MCC meeting regarding the decommissioning of eflornithine cream for hirsutism and low dose maintenance Vitamin D products (≤ 1,000 IU) for replete patients only was not approved by the SRCCG CE committee as they are awaiting an equality and diversity impact assessment. The asthma pathway was not available for the meeting therefore no decision could be made regarding this. All other recommendations were agreed in full. The VoY CCG CE committee were yet to consider the recommendations from April MCC for approval as the meeting was to be held after the May MCC meeting. However, it was noted that the recommendations regarding decommissioning of eflornithine cream for hirsutism and low dose maintenance Vitamin D products (≤ 1,000 IU) for replete patients only would also not be considered until the equality and diversity impact assessments had been carried out. **Action:** VoY and SR CCGs to carry out equality and diversity impact assessments on recommendations regarding decommissioning of eflornithine cream and low dose maintenance Vitamin D products before being considered by CE committees. **Draft minutes and matters arising from last meeting** The minutes were agreed following some minor amendments. It was noted that the agreement reached from discussions around patients unnecessarily prescribed reduced doses of apixaban was that MMT via RA would gather the data on prescribing for non-valvular AF, for review by MCC at a future meeting. Also, GB asked for clarification on whether the agreement reached regarding off-label use of bupropion for depression for patients on this drug moving to the UK would also apply to children. **Action:** MM/EO to add apixaban to action log and obtain clarification from CW/RM regarding bupropion and feedback at the June meeting. **Action log/long-term matters arising** **Ulipristal pathway** – See agenda item 11.1. Action complete. **T3 prescribing in Y&S** – Primary care are undertaking an audit of T3 prescribing in primary care and will submit this to MCC in due course. **Action**: MMT to submit T3 audit results to June MCC meeting. **COPD guidance** – see agenda item 7.1 **OAB pathway** – The development of this pathway is ongoing with the aim to submit for the June meeting. To consider low dose desmopressin tablets (Noqdirna® 25/50mcg) for idiopathic nocturnal polyuria within this pathway following MCC's approval of its addition to the formulary. **Action:** RA/LA to submit for MCC approval at the June meeting.

	LTHT medicines update – referrals from non-Leeds CCGs – Review of RAG status has commenced beginning with drugs assigned Grey status. See agenda item 7.2. The next items to be looked at will be those which are unclassified. **Action:** MM/JEC to submit required amendments for unclassified drugs for June MCC meeting. **Lisdexamfetamine SCG for treatment by the Tuke Centre** – MMT are still awaiting feedback from mental health regarding issues around commissioning this treatment - the current SCG refers to GPs to initiate treatment due to no facility for prescribing by the Tuke Centre but this arrangement is not truly shared care. It was noted that the same issue also applied to the SCG for methylphenidate. MCC agreed that this item could now be removed from the action log and can be brought back to a future MCC meeting once the feedback has been received. **Methotrexate SCG** – The SCG has now been agreed by GI specialists as well as dermatology and rheumatology specialists. Work is being carried out to include additional indications to the SCG which is hoped should be ready for the June MCC meeting. **Action:** JEC to submit amended SCG for June MCC meeting. **Glaucoma pathway** – JEC still awaiting feedback from Scarborough Trust. **Action:** JEC to submit pathway to MCC once comments received. **RAG criteria for Y&S MCC** – See agenda item 7.2. Action complete. **VoY wound care formulary** – Scarborough representatives have had discussions regarding this however, it is currently not ready to be brought back. MCC agreed that this item could be removed from the action log and brought back to a future MCC meeting when ready. **Botulinum toxin A for facial lines** – Assigned Black status on formulary. Action complete. **Tamsulosin for urolithiasis – formulary assessment** – JEC had received feedback from specialists that they are happy with the approach of developing a referral service (RSS) pathway for management of patients who present to the GP with ureteric stones. LA and WO will work together on this and submit to MCC in due course. Action complete. **Public health formularies** – see agenda item 11.2 **Bivaracetam** – review use of bivaracetam approved by Chair's action (VoY CCG) for refractory epilepsy in 6 months' time (October 2017). MCC agreed to remove this item from the action log. **TEWV: Quick reference formulary and prescribing transfer** – TEWV had produced a reference guide which the group felt was useful, however this related to the CD&D RAG ratings so may be confusing for York and Scarborough prescribers. **Action:** CW/RM to produce a Y&S version of this document with updated RAG colour meanings so that this can be sent out to prescribers. (CM/RM were not in attendance at the May MCC meeting to confirm the status of this.) **TEWV SBARD in relation to prescribing medicines for ADHD** – Cases had been identified of patients being prescribed an ADHD medicine significantly above the maximum recommended dose, or had been prescribed a combination of two products or both. Therefore a SBARD has been written. It was agreed that this should be linked in the Y&S formulary. **Action:** CW to forward link to JEC to add to formulary under the relevant section. (CM/RM were not in attendance at the May MCC meeting to confirm the status of this.)

	Desmopressin tablets (Noqdirna®) 25/50mcg for treatment of idiopathic nocturia – JEC updated the group with feedback on the position in treatment pathway of this drug as requested at the April MCC meeting. Feedback from urology was that low dose desmopressin would be included as a treatment option in the section on nocturnal polyuria in the RSS pathway for LUTS in men which currently only states "consider late afternoon loop diuretic". The urology nurse also noted in general the lack of licensed treatment options specifically indicated for nocturnal polyuria. The group accepted the feedback and approved the addition of this drug to the formulary with an Amber Specialist Recommendation status. It was noted that this drug should be considered within the OAB pathway which is currently in development and expected to be brought to the June MCC meeting. **Action:** JEC to update formulary following CCG approval. MMT to amend LUTS pathway accordingly and consider low dose desmopressin within the OAB pathway currently in development. **FIASP (faster acting insulin aspart)** – see agenda item 6.3 **Nefopam –** JEC has assigned a Black status to nefopam on the formulary. Action complete. **Fulvestrant** – JEC has assigned Black status to fulvestrant for oestrogen-receptor positive metastatic or locally advanced breast cancer in postmenopausal women in whom disease progresses or relapses while on, or after, other anti-oestrogen therapy as per NICE TA. Action complete. **Bisphosphonates in Breast Cancer Patients** – JEC still awaiting feedback from specialists on whether they will be recommending oral or IV infusions and also how this would be implemented. **Action:** JEC to feedback to MCC once comments received from specialists. **RAG status Change of eflornithine cream** – CCGs to carry out equality and diversity impact assessment prior to approval and updating formulary. MCC agreed action to be removed. **Decommissioning of low strength maintenance preparations of vitamin D** – CCGs to carry out equality and diversity impact assessment prior to approval and updating formulary. MCC agreed action to be removed. **CG164 Familial breast cancer (raloxifene)** **Action:** JEC to find out from specialists if they would like to submit a formulary application for use of raloxifene as per updated NICE CG 164 and feedback at June MCC meeting.
3 **3.1**	**Governance** **Formulary – need for Grey and non-formulary categories** The group discussed issues around the Grey and non-formulary categories of the formulary. The Grey category is currently being used for drugs with no formal commissioning position, particularly for NICE TAs that have not yet been discussed at MCC. However, the group considered that this status may not always be helpful given the well-established RAG system which prescribers are familiar with and there is a risk of appearing non-compliant with NICE TAs if this status is not amended within 3 months of the guidance being issued. It was agreed that a better approach would be to wait until the drug/TA has been considered and a RAG status agreed at MCC before adding the drug to the formulary. The group also considered that having a designated non-formulary section would require that all drugs are covered by the formulary which was deemed impractical and defeats the purpose of the formulary. Furthermore, it would not always be appropriate to automatically Black list all drugs that are not a formulary choice, as there are set criteria for Black list inclusion. It was noted that YFT use the non-formulary category for drugs

	prescribed by specialist centres which have a Red status; however MMC considered that an annotation of the restrictions would be sufficient and it was not necessary to assign them as non-formulary. The group agreed that instead of having the non-formulary category, drugs that are not a formulary choice or unsuitable for Black list inclusion would simply not be included in the formulary. This should prompt questions from prescribers who are considering using them. If the MMT notice an increased frequency of requests for drugs not included in the formulary, this should be highlighted to MCC for review. **Action:** JEC to update formulary to remove grey non-formulary categories. Following the above discussion, the formulary status of paroxetine was raised as it is currently included in chapter 4 as a non-formulary Green drug for continuation only. It was agreed that the non-formulary status is removed and it remains as a Green drug for established patients only i.e. not new initiations. **Action:** JEC to update formulary accordingly following CCG approval.
4 **4.1**	**Mental Health Medicines Commissioning** **Tees, Esk and Wear Valley Mental Health Trust:** **D&T confirmed minutes (Jan 17):** The group noted the minutes.
5 **5.1**	**National and Regional Guidance** **Monthly NICE update** It was noted that NICE TAs 180 and 340 were updates regarding withdrawal of the PAS scheme for ustekinumab and TA240 was a terminated appraisal, therefore no further action were required for these items. TA440 – Pegylated liposomal irinotecan for treating pancreatic cancer after gemcitabine was "not recommended. A link to the TA has been added to the formulary and the drug has been assigned a Black status. No further action required. TA441 – Daclizumab for treating relapsing-remitting multiple sclerosis. Currently listed in chapter 8.2.2 as Grey non-formulary pending commissioning position with the NICE TA link included. Grey and non-formulary status to be removed as per previous discussion (item 3.1) and added to formulary in chapter 8.2.4 (MS section) as a Red drug with the NICE TA link. This is an NHS England commissioned drug so there is no cost impact for CCGs. **Action**: JEC to update formulary as above. TA442 – Ixekizumab for treating moderate to severe plaque psoriasis. Currently listed as Grey non-formulary with the NICE TA link included. Grey and non-formulary status to be removed and added to formulary as a Red drug. JEC reported information from the Trust specialists that ixekizumab will be used in very small numbers of patients who fail on other biologics. However, MCC have requested more specific information on patient numbers to inform the cost impact to be included in the recommendations for approval by the CCGs. **Action**: JEC to remove Grey and non-formulary status; and to request information on expected patient numbers for ixekizumab from specialists and feedback to MCC at the June meeting. TA443 – Obeticholic acid for treating primary biliary cholangitis. Currently listed as Grey non-formulary with link included. Grey and non-formulary status to be removed and added to formulary as a Red drug. This is an NHS England commissioned drug so there is no cost impact for CCGs. **Action**: JEC to update formulary. The group noted recently published NICE guidelines (NG68, CG61 & CG100). No further action was required. **NTAG recommendations (March 2017)**

	The group noted that NTAG did not recommend transcutaneous vagus nerve stimulation for cluster headache and migraine, lycra garments for cerebral palsy and other neurological or musculoskeletal conditions, and home iontophoresis for hyperhidrosis. Dimethyl fumarate for moderate to severe plaque psoriasis is recommended by NTAG for patients not suitable for a biologic and in whom other conventional first and second line treatment options have failed and who would otherwise have been given Fumaderm®. It was noted that dimethyl fumarate was yet to be launched and a NICE TA is due in Nov 2017. Therefore it was agreed to await the NICE TA publication before any further action was taken. **Medicines Safety (MHRA drug safety update – April 2017)** Links have been added to the relevant section of the formulary for the MHRA warnings on signal of rebound effect with MS therapies, risk of vascular occlusive events with ponatinib, and valproate and developmental disorders. The valproate and developmental disorders warning was further discussed in item 5.2. Letters sent to healthcare professionals regarding belatacept and carbocisteine were noted but no further action was required. **RDTC monthly horizon scanning** A new fluticasone/salmeterol DPI licensed for asthma and COPD (Aerivio® Spiromax®) was noted, however, this was not deemed to affect the Y&S asthma or COPD pathways. A cheaper lidocaine 5% patch was also noted but it is expected that prescribing of lidocaine patches will stop in view of the upcoming NHS England review on "low value" medicines. The first oral acetylcysteine product (200 mg powder for oral solution) to be licensed was noted which is significantly more expensive than unlicensed acetylcysteine. SP mentioned that a 600 mg capsule formulation was due to launch in about 1 month.
5.2	**Implementation of NHS Improvement Patient safety alert - resources to support the safety of women treated with valproate** The group noted that this alert was to re-emphasise previous advice issued regarding risk of developmental disorders with valproate as evidence had emerged suggesting that a significant proportion of women of childbearing age prescribed valproate remain unaware of the risks associated with valproate in pregnancy. It was agreed that this alert was for MCC to note and for the CCGs to carry out the actions raised in the alert.
6 **6.1**	**Formulary and Managed Entry of New Drugs** **RAG status review: Febuxostat** The group received a request to review the RAG status of febuxostat for treatment of chronic gout which is used as an alternative if allopurinol is contraindicated or not tolerated (NICE TA164). The formulary currently states that febuxostat is restricted for initiation by consultant rheumatologists and renal physicians only but no RAG status is assigned because it was approved prior to the implementation of RAG ratings. This issue came to light during review of an RSS pathway which stated that febuxostat could be initiated by GPs, however, this conflicts with the current formulary status. The rheumatologist involved is of the view that there should be no such restriction as there is nothing to support this position in the NICE TA and febuxostat isn't considered to pose a higher safety risk than allopurinol. On this basis, they conclude that a Green RAG status is appropriate. The group noted evidence from a Cochrane review which did not indicate any particular safety concerns to warrant an Amber or Red status; and that the NICE CKS topic on gout clearly defines febuxostat's place in therapy as per the NICE TA. The higher cost of febuxostat compared to allopurinol was also noted (£24.36 vs £0.75 to £0.85 for 28 days), but was not considered to pose an issue if febuxostat is used according to NICE guidance; febuxostat seems to be prescribed infrequently in practice. The group approved a Green RAG status for febuxostat with the inclusion of links to the relevant RSS guidance and the CKS guideline on gout. **Action:** JEC to update formulary accordingly following CCG approval.

6.2	**Formulary application: Diltiazem 2% ointment for anal fissures** The group reviewed a request to add diltiazem 2% ointment to the formulary for management of anal fissures in preference to diltiazem 2% cream which is currently included as a 2nd choice treatment for anal fissures with a Green status. The group noted that both of the preparations are unlicensed but the ointment costs significantly less than the cream (£35.52 vs £60.50 for 30g). The group approved the addition of diltiazem 2% ointment to the formulary with a Green status. Since there appeared to be no particular reasons to choose one preparation over the other, the group agreed that the diltiazem 2% ointment should replace the diltiazem 2% cream currently on the formulary. **Action:** JEC to update formulary accordingly following CCG approval.
6.3	**Resubmission: Fiasp®** This was a resubmission of the Fiasp® application reviewed at the April MCC meeting. Following discussions at the last meeting, the group requested further information from specialists on whether there were any subgroups of patients who may derive significant benefit from Fiasp over NovoRapid® before a final decision was made. It was noted that Fiasp had already been assigned Black status on the formulary following the April meeting but this position was yet to be finalised by the group or approved by CCGs pending the further information requested. It was agreed that formulary should not include Fiasp until a commissioning position has been finalised and approved as per discussions in item 3.1 The group noted from the resubmission that the patient cohort proposed by the specialists would be pump users and others on basal bolus regimens that have post prandial spikes despite optimisation of insulin to carbohydrate ratios and insulin sensitivity index. They estimate that this would be between 5-10% of existing patients currently using prandial analogue insulins. The group also noted feedback in response to the NICE Do Not Do recommendation in NG17 regarding post-meal insulin, that clinicians do not routinely advise post-meal insulin for T1DM patients. The group queried the clinical significance of an improvement in post prandial glucose (PPG) spikes in terms of actual patient outcomes as this remains unclear. Additionally, the ONSET 1 & 2 trials were primarily designed to demonstrate non-inferiority of Fiasp to NovoRapid in terms of HbA1c; change in PPG was a secondary outcome and a significant difference was only observed in the trial involving T1DM patients (ONSET 1). The applicant's comment regarding unknown impact of biosimilars was questioned by the group as biosimilars have been successfully used in clinical practice for many years now. The EMA's guide on biosimilars for healthcare professionals states: *"The evidence acquired over 10 years of clinical experience shows that biosimilars approved through EMA can be used as safely and effectively in all their approved indications as other biological medicines."* The group also reiterated the Black Triangle status of the drug, and the preference to use more established treatments. The conflict of interest declared by the applicant who is a member of a Novo Nordisk local advisory board was once again noted. Following the discussions, the group did not approve the addition of Fiasp to the formulary at this time and agreed to assign a Black status to the drug on the basis that: • There is a lack of clear evidence of significant benefit from Fiasp over NovoRapid • Fiasp has Black Triangle status and more established treatments with greater clinical experience are generally preferred • Considering the approaching patent expiry of NovoRapid in June 2017, there could potentially be missed opportunities for efficiency savings if a biosimilar becomes available in the near future and patients have already been transferred to, or started on Fiasp, and without any added clinical benefit. The group discussed the rationale for not approving Fiasp® for formulary inclusion on the grounds that there was no associated cost pressure. However, the consensus of the group was that the purpose of the formulary was to rationalise the choices of medicines included and at this time they were unable to identify any benefit of adding this agent to the formulary. **Action:** MM/EO to complete Blacklist inclusion tool, JEC to update formulary as above

and assign Black status to Fiasp following CCG approval.

6.4 **Formulary application: Novorapid FlexTouch device**

The group reviewed an application by the same clinician requesting Fiasp, to add the NovoRapid FlexTouch device to the formulary for patients with dexterity problems. JEC brought placebo pen devices of both NovoRapid FlexPen and FlexTouch for practical comparison by the group. There was doubt that the FlexTouch device offered significant advantages over the FlexPen. The group also questioned who would be responsible for deciding whether patients had dexterity problems to qualify them for the FlexTouch and what criteria would be used. It was noted that the FlexTouch device is slightly more expensive than the FlexPen (£32.13 vs £30.60 for 5x3mL pre-filled pens). Given the considerable financial pressures being faced by the Y&S CCGs and the lack of a proven benefit of the FlexTouch device over the FlexPen, the group did not approve the addition of the FlexTouch device to the formulary.

Action: MM/EO to complete black list assessment tool

7 **Interface: Shared Care Guidelines (SCGs) and Pathways**

7.1 **York and Scarborough COPD Pathway**

The group approved the pathway following a minor formatting adjustment.

Action: LA to fix minor formatting issue and send finalised version to JEC for inclusion in formulary following CCG approval.

7.2 **Review of Grey listed items**

MM presented the review of the Grey listed drugs with suggested actions. The group agreed the following RAG ratings/ formulary status:

Black	**Red**	**Amber**	**Remove from formulary (not used)**
Fosavance®	Apremilast for indications in TA433 & TA419	Flupentixol decanoate (Depixol®); specialist initiation – as per TEWV	Cangrelor
Actonel Combi® (risedronate + calcium and vitamin D)	Daclizumab for indications in TA441 & TA99 (both NHSE commissioned)	Fluphenazine decanoate; specialist initiation – as per TEWV	Histerelin
Olanzapine embonate (ZypAdhera®)	Ivermectin (oral); for specialist dermatologist use	Haloperidol decanoate; specialist initiation – as per TEWV	Pipotiazine palmitate depot (Piportil® Depot) - discontinued
Paliperidone (oral) – as per TEWV	Mepolizumab (TA431) ; specialist centre (NHSE commissioned)	Paliperidone (injection); shared care – as per TEWV	
	Obeticholic acid (NHSE commissioned)	Risperidone LA injection (Risperdal Consta®); specialist initiation – as per TEWV	
		Zulcopenthixol Decanoate (Clopixol®); specialist initiation – as per TEWV	

	It was noted that some links to the TEWV guidance and/or shared care policies were not working. JEC is liaising with RM regarding these. **Action:** JEC to update formulary as above following CCG approval
8 **8.1** **8.2** **8.3**	**Monitoring/reporting** **Twelve month audit data MCC outcomes** The group reviewed the audit reports on cost and activity for recommendations made in January 2016 and February 2016. High spend was noted in both CCGs for VSL#3 which was given a Black status for C.diff in Jan 2016. However, the cost and activity may be explained by its use for pouchitis which is an approved indication. The group requested that MMT review whether the product is being used appropriately for the approved indication. High spend on Pro D3 assigned Black in Feb 16 was also noted. It was requested that the MMT analyse spend on vit D products against formulary choices/ medal ranked oral vitamin D supplements. **Action:** MMT to check appropriate prescribing of VSL#3 and carry out analysis of spend on vitamin D products against formulary choices/ medal ranking, to be brought back to a future MCC meeting. **VoY Red drugs data** This item is discussed quarterly **ScR Red drugs data** This item is discussed quarterly
9	**Patient and clinical communications** Nothing to report.
10 **10.1** **10.2** **10.3**	**Items from other groups** **Hull and East Riding Prescribing Committee (HERPC) minutes (incl Interface minutes) –** not received **Antimicrobial stewardship subgroup update** - no updates **York and Scarborough Drug and Therapeutics Committee minutes –** not received
11 **11.1** **11.2**	**Any urgent business** **Uterine fibroid and ulipristal pathway** RA presented the revised uterine fibroid/ulipristal pathway which has been amended to be more consistent with the NICE guidance on management of heavy menstrual bleeding, and has been agreed by the consultant obstetrician and gynaecologist. The group were generally in support of the pathway but noted a contradiction between the current Black list status of ulipristal for pre-operative treatment and the recommendation in the pathway to use ulipristal pre-operatively if the woman experiences treatment failure or unacceptable side effects with GnRH analogues and reduction in fibroid size is essential. The Black list status was issued on the basis of lack of clinical data on surgical outcomes following ulipristal treatment, and it was not considered a cost-effective alternative to GnRH analogues. It was also noted that this recommendation is not currently in line with NICE guidance. The group were minded to approve the pathway subject to the removal of the recommendation regarding pre-operative use. MCC agreed that the pathway is amended to exclude this recommendation, and be re-sent to the clinicians along with the committee’s comments to seek their agreement and co-operation before approving the drug for pharmacological management of uterine fibroids. The group also noted that once approved, the pathway should be closely followed up and audited to ensure that ulipristal is being used appropriately for the approved indication. **Action:** RA to amend pathway and send to clinicians for comments. Any feedback received to be brought to a future MCC. **Public Health Formularies** RA presented the proposed RAG status of drugs included in the North Yorkshire County Council Public Health Formularies for Shared Care Drug Misuse Treatment and Recovery Service, Pharmacological abstinence supervision service for alcohol misuse, and Targeted Primary Care Sexual Health Service. The group were in support of the RAG ratings as noted below and agreed that the formulary be updated accordingly

clearly specifying that the drugs should only be prescribed within the relevant formally commissioned service.

Alcohol dependence

RAG: Amber Specialist Initiation by North Yorkshire Horizons

Duration: NYH prescribe for initial 12 weeks. GP then prescribes for up to (further) 12 weeks. May be prescribed by GP for longer if structured medicine review at 12 weeks determines this to be clinically appropriate. Structured medicines reviewed required 6 monthly thereafter, if prescribing to continue**.**

- Acamprosate
- Disulfiram
- Naltrexone

Substance misuse

RAG: Green but in conjunction with NYH Recovery co-ordinator

Duration: No fixed duration

- Buprenorphine S/L tabs S/F 2mg, 4mg & 8mg
- Buprenorph/Naloxone S/L tabs S/F 8mg/2mg
- Buprenorphine_Tab Subling 4mg S/F
- Methadone HCl_Mix 1mg/1ml, 1mg/1ml C/F, 1mg/1ml S/F

Sexual health

RAG: Green

Duration: No fixed duration

- Mirena
- Jaydess
- Nexplanon
- Ancora 375 Cu
- Copper T380 A
- Flexi-T 300 & Flexi-T+380
- GyneFix intrauterine contraceptive implant
- Load 375
- Mini TT380 Slimline
- Multiload CU 375
- Multi-Safe 375
- Neo-Safe T380
- Nova-T 380
- Novaplus T 380 Ag (Normal, Mini) & Novaplus T 380 Cu (Normal, Mini)
- Optima TCu380A
- Steriload
- T-Safe 380A QL
- TT380 Slimline
- UT380 Short & UT380 Standard

Action: JEC to update formulary as above following CCG approval.

Date and time of next meeting:
Wednesday 14th June 2017, 9:30am, West Offices, York.