York and Scarborough
Medicines Commissioning Committee

Minutes of Medicines Commissioning Committee Meeting
Wednesday 14th June 2017
9.30-12pm, West Offices, York

1. Apologies / Attendance

		JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
Strategic Lead Pharmacist- MMT	Mrs Rachel Ainger (RA)	✓	✓	✓	✓	✓	CANCELLED	✓	✓	✓	✓	✓	✓
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	A
Deputy Chief Pharmacist Tees Esk and Wear Mental Health Trust (TEWV)	Mr Richard Morris (RM)	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	✓	✓
Deputy Chief Pharmacist	Mr Stuart Parkes (SP)	A	✓	✓	A	✓		A	✓	A	✓	✓	✓
Consultant Psychiatrist (TEWV)	Dr Michelle Beaumont (MB)								✓	A	✓	A	A
Consultant Psychiatrist (TEWV)	Dr Shona McIlrae (SM)			✓	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)	MM + BR	✓ BR	✓ MM	✓ BR	✓ MM		✓ MM	✓ MM	✓ MM EO	✓ BR EO	✓ MM EO	✓ MM EO

Item	
1	**General business** Laura Angus (LA) chaired the meeting. Apologies were received from Dr Paul Jennings and Dr Michelle Beaumont for the meeting today.

	Declarations of conflicts of interest relating to the agenda No interests were declared. Members present submitted their completed DOI forms to LA.
2	**Matters arising**
2.1	**Chairs actions to report** VoY CCG declined a request for Enstillar mousse for scalp psoriasis and approved a request for silk clothing for severe eczema to be reviewed in 6 months' time. There was nothing to report from ScR CCG. **Outcome of VoY SMT/SRCCG Clinical Executive Committee** All recommendations from the May MCC meeting were approved by the ScR CCG CE Committee. The VoY CCG CE Committee were yet to consider the recommendations; their meeting will be held on 22/06/17. It was noted that the asthma pathway approved at the April MCC was yet to be approved by the ScR CCG CE committee and needs to be taken to their next meeting. JEC pointed out a correction relating to the calculation of comparative costs of Noqdirna® 25/50 mcg oral lyophilisate and desmopressin 100 mcg tablets included in the recommendations. The comparison assumed the two formulations are equivalent. However some data from the manufacturer suggests they are not equivalent due to differences in bioavailability, which should be taken into account when comparing their costs. The group noted the correction, but this did not affect the recommendation. **Draft minutes and matters arising from last meeting** The minutes were agreed as a true record. **Action log/long-term matters arising** **T3 prescribing in Y&S** – RA presented some data from an audit of 13 patients across 14 practices. Most of the prescriptions were NHS initiated and 87% of patients were prescribed T3 for hypothyroidism but it was unclear whether T3 was prescribed first or second line. It was recognised that many patients are not reviewed or followed up appropriately. The group agreed that more work is needed on reviewing the appropriateness of the T3 prescriptions and requested that further information be brought back to next month's meeting for discussion. It was noted that PJ had indicated he wanted to participate in the discussions around this item. The group also agreed to assess T3 initiation for new patients for black list status. **Action**: RA to submit further information from theT3 audit for July MCC. RDTC to complete black list assessment for the next meeting. **COPD guidance** – Minor formatting issue has been fixed. It was requested that links to Scarborough's website/pathways be included in the pathway. **Action:** EO to include Scarborough links once provided by MMT. **OAB pathway** – This pathway has been assigned to a member of the MMT and is in progress with the aim of submitting a draft for the July meeting. **Action:** MMT to submit draft pathway for the July meeting. **LTHT medicines update – referrals from non-Leeds CCGs (review of RAG status)** – See agenda item 7.5**.** **Methotrexate SCG** – See agenda item 7.2. **Glaucoma pathway –** JEC reported that several issues have been raised regarding the pathway by Scarborough, therefore submission to MCC put on hold while these are addressed. **Action**: JEC to bring back to MCC once issues raised by Scarborough have been

	addressed. **Public health formularies** – The formulary has been partly updated to reflect the public health formularies. JEC is working with RA on how the information is presented in the formulary for the remaining items. **Action**: JEC to complete updates to formulary once agreed with RA. **TEWV: Quick reference formulary and prescribing transfer** –. **Action:** RM agreed to produce a Y&S version of this document with updated RAG colour meanings so that this can be sent out to prescribers. **TEWV SBARD in relation to prescribing medicines for ADHD** – RM noted that TEWV don't publish their SBARDs on their website so they can't be linked from the Y&S formulary. He indicated that the most relevant information from the SBARD has been included in the recently updated methylphenidate and atomoxetine SCGs which are awaiting final approval. Once approved the SCGs will be linked in the formulary. Action complete. **Desmopressin tablets (Noqdirna®) 25/50 mcg for treatment of idiopathic nocturia** – Formulary has been updated to include Noqdirna for nocturnal polyuria with a RAG status of Amber specialist recommendation. This product will also be incorporated in the LUTS pathway. Action complete. **FIASP (faster acting insulin aspart)** – Formulary has been updated to reflect black status; black list tool has been completed and is held on record by RDTC if required. Action complete. **Bisphosphonates in Breast Cancer Patients** – JEC provided feedback received from the specialist who has been liaising with Sheffield regarding their implementation of the guideline. Sheffield had found it difficult to develop criteria for which patients to treat and had decided to treat all breast cancer patients except those with excellent prognosis. The criteria proposed for implementing this in YFT is for those patients who are node positive, whose breast cancer is grade 2/3, or who have T2 or larger sized tumours. This means that patient numbers are likely to be more than initially proposed. The specialist also indicated that oral treatment with ibandronate would be the preferred choice but an estimated 1 in 5 patients may not tolerate this and will need to be treated with IV zoledronic acid. The group requested that more specific information on numbers of patients who would be eligible be obtained and that this item is included on the agenda for next month. **Action:** JEC to obtain information on patient numbers from specialists and submit this item for the agenda next month. **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 July MCC meeting. **Formulary – removal of Grey and non-formulary categories** – Formulary updated; action complete. **Paroxetine approved for formulary addition (continuation only)** – Formulary updated; action complete. **Formulary amendments agreed in May** – Formulary updated; action complete. **NICE TA442: Ixekizumab for treating moderate to severe plaque psoriasis** – Feedback from YFT was that 2 or 3 patients per year would be treated with ixekizumab. This TA is to be included in the recommendations for CCG approval for June with the

	above information. Action complete. **RAG status review: Febuxostat** – Assigned Green status on formulary. Action complete. **Formulary application: Diltiazem 2% ointment for anal fissures** – Formulary updated, action complete. **Review of Grey listed items** – Formulary updated; action complete. **Twelve month audit data MCC outcomes** – MMT are in the process of obtaining data to analyse appropriateness of VSL#3 prescribing, and spend on vitamin D products against formulary choices/ medal ranking. Findings to be brought back to July meeting. **Action:** MMT to submit findings on analysis of VSL#3 and vitamin D for July meeting. **Apixaban – prescribing data for non-valvular AF** **Action:** MMT to bring data on apixaban prescribing for non-valvular AF to July meeting. CH noted that an SHO at YFT had just started an audit on the appropriateness of apixaban dosing and MMT could liaise with him. SP offered to share data on VTE/ strokes resulting from under-dosing of apixaban to support the audit. **Off-label bupropion for depression for patients moving to the UK –** RM noted there seemed to be no reason why the agreement on managing these patients wouldn't apply to children but the CAMHS team may not be in a position to advise on its appropriateness as they don't use bupropion for their patients. Action complete.
3 **3.1**	**Governance** **Review of processes for formulary and Black list status assessment** MM presented the tool for formulary and black list status assessment which had been reviewed and updated following the changes to formulary categories agreed at the last meeting. The updated tool incorporates criteria for black list status assessment within the formulary assessment tool rather than having two separate tools. The group welcomed the updated tool and agreed to its use for future assessments following a minor amendment to the wording of one of the questions used for black list assessment. **Action:** RDTC to amend wording in the tool as agreed by MCC.
4 **4.1**	**Mental Health Medicines Commissioning** **Tees, Esk and Wear Valley Mental Health Trust:** **D&T confirmed minutes (Mar 17)** The group noted the minutes. **D&T Feedback – summary from May 17 meeting** • Valproate patient safety alert – TEWV have been raising awareness of this alert on the safety of safety of girls and women being treated with valproate. They would like to be kept informed of any work being undertaken in primary care to action this alert. **ADHD Medications Shared Care Guidelines – Methylphenidate and Atomoxetine (update)** These SCGs have combined the separate TEWV SCGs for adults and children & adolescents into one. The maximum doses detailed in the ADHD medications SBARD have been included. They have been approved by their D&T subject to consultation with primary care medicines committees. The group welcomed the documents but sought clarification on a few issues: • Pre-treatment assessment of history of liver impairment/disease and advice on actions to take if patients develop signs/symptoms of liver damage were included in the previous atomoxetine SCG (adults) but not in the updated version. RM stated that he would check whether this was intentional. • The SCGs recommend monitoring cardiovascular status every 3 months whereas the

	SPCs for the medicines suggest every 6 months. RM explained that the SCGs have been brought in line with NICE guidance which recommends 3-monthly monitoring. • It was requested that specialists should measure heart rate and blood pressure when they see patients and this should be documented in the clinic letters sent to GPs so that GPs could easily determine when they were next due and to avoid duplication of work. RM agreed to feed this back. • Many group members were not familiar with the term "dual diagnosis" in the "other information" section. RM clarified that this meant a patient with a mental health disorder alongside substance misuse and agreed to amend the SCGs to specify this. • The dosing section of the methylphenidate SCG does not specify the age of children. It is licensed from the age of 6 years as for atomoxetine. RM agreed that this could be included. **Action**: RM to feedback on issues raised at the next meeting and forward final versions which will replace the atomoxetine and methylphenidate SCGs currently on the formulary following inclusion of the VoY and ScR logos. **Safe lithium prescribing and shared care (update)** Most of the changes to this guideline relate to a serious incident that occurred in the Durham area. The guideline has been updated to include more robust information regarding the management of patients who are more at risk of side effects. RM highlighted a couple of points: • TEWV encourage monitoring lithium levels every 3 months once stable for added safety but it was recognised that the practice in York is to monitor every 6 months in line with NICE guidance. Some criteria for considering 6-monthly monitoring will be added to reflect this. • The layout of the section on action if lithium levels fall outside the target range or features of toxicity occur will be changed to a risk assessment table to include personal target and actual result which then leads to advice on what action to take. The guideline will be taken to the July D&T meeting for approval and will come back to MCC as a final version after this. RM agreed to try and obtain further details on the serious incident in Durham so that this can be shared with prescribers alongside the new guideline as it was felt this would increase the impact of the guideline. **Action:** RM to bring final version of the guideline to July MCC and forward details of the serious incident in Durham if possible.
5 **5.1**	**National and Regional Guidance** **Monthly NICE update** TA444 was a terminated appraisal and no further action was necessary. TA445: Certolizumab pegol and secukinumab for treating active psoriatic arthritis after inadequate response to DMARDs – the drugs are already listed in chapter 10 of the formulary as Red drugs and a link to the TA has been added. SP reported estimated patient numbers for YFT of 6 patients/year for certolizumab and 2 patients/year for secukinumab. NG28**:** Type 2 diabetes in adults: management (update) – it was noted that the guideline has been updated with text on SGLT-2 inhibitors. All of SGLT-2 inhibitors are listed as green drugs in chapter 6. **Action:** JEC to add link to the guideline to the formulary. PH56**:** Vitamin D: increasing supplement use in at-risk groups (update) – this guideline has been updated to reflect Public Health England Scientific Advisory Committee on Nutrition guidelines. It was agreed that the local vitamin D guidance should be updated to refer to Public Health guideline when reviewed.

	NG69 & CG124 were noted for information only and required no further action. **NTAG recommendations** Nothing to consider. Awaiting recommendations from June meeting. **Medicines Safety (MHRA drug safety update – May 2017)** A link to the alert on rare reports of depression and suicidal thoughts in men taking finasteride has been added to the formulary. **RDTC monthly horizon scanning** The group noted that tofacitinib, eluxadoline, rituximab biosimilar (Truxima®) and insulin glargine/lixisenatide (Suliqua®) had been recently licensed, and quetiapine 20 mg/mL oral suspension had been reinstated. The group also noted that metformin *prolonged release* tablets (Glucophage®) had been granted a new licensed indication of reduction in the risk of type 2 diabetes. This conflicts with the current NICE public health guideline on prevention of type 2 diabetes in people at high risk (PH38) which recommends *standard release* metformin for a similar patient group covered in the new license; these are currently not licensed for this indication. **Requested formulary amendment** It was noted that there were two different RAG status assigned to insulin lispro (Humalog®) products on the formulary – Amber for 100 IU/mL products and Green for 200 IU/mL; both were assigned Amber on the Leeds formulary. The group agreed to an Amber status for all the Humalog products. **Action**: JEC to update formulary as above.
5.2	**Yorkshire and Humber commissioning policy on lidocaine patches** This item was not considered, instead MCC requested that the professional secretary contact the group proposing the policy on lidocaine patches to clarify their role and remit. **Action**: MM to produce a response from MCC to the group.
5.3	**Guidelines on appropriate prescribing of specialist infant formulae** This guideline was produced by ScR CCG MMT in response to requests from GPs. The YFT paediatric dietician and allergenist have contributed to the guideline. The guideline was also forwarded to Consultant Paediatrician Dr Thomas Verghese for comment; however, RA noted that there was a potential conflict of interest as Dr Verghese declined to complete a declaration of interest form until he had received feedback on his comments. This was deemed inappropriate by the group and SO'C requested that the correspondence between RA and Dr Verghese be forwarded to him to follow up. The group were generally in support of the guideline. One of the recommendations was to consider mixing lactose free formula with standard formula to improve palatability for infants aged between birth and 6 months. However, a comment was raised that sense of taste is not fully developed in young infants therefore mixing may not be necessary in this age group. There was also an anecdotal report that vanilla essence may help to improve palatability. It could not be confirmed whether health visitors had been consulted on the guideline but the group agreed that this should be done. It is hoped that VoY CCG would also adopt these guidelines and they have been forwarded to a VoY GPSI for comment. YFT already have an arrangement on these products and will check that this is consistent with the guideline. The group agreed that lactose free formulae should be assessed for black list inclusion as they are not recommended for prescribing. **Action:** RA to forward correspondence with Dr Verghese to SO'C, ensure health visitors are involved with the guideline and liaise with local authorities. Feedback received to be reported at the next meeting. RDTC to assess lactose free formulae for black list inclusion for the next meeting.

6	**Formulary and Managed Entry of New Drugs**
6.1	**Formulary application: opicapone** The group reviewed an application requesting the addition of opicapone to the formulary to be used second line after entacapone in patients who are intolerant of it either in a fixed dose combination formulation or alone, or where there is inadequate clinical response. Evidence from two RCTs showed that opicapone was superior to placebo and non-inferior to entacapone in reducing time spent in the OFF state. A potential advantage of opicapone is that it is taken once a day compared to entacapone which has to be taken with every levodopa dose. However, combination preparations of entacapone/levodopa/DDCI are available to reduce pill burden. Opicapone costs significantly more than entacapone. Due to lack of evidence of significant additional benefits over entacapone, and given the current financial status of the CCGs, addition of opicapone to the formulary could not be justified at this time. The group acknowledged that opicapone may be appropriate for a restricted population who have a genuine intolerance to entacapone. However, concerns were raised about what criteria would be used to determine intolerance to entacapone and how opicapone would be monitored and reviewed for clinical benefit over a defined period of time, with a view to switch if no benefits are observed. It was agreed that a restricted population would be considered if specialists could provide the above information. However for the time being, the drug would be assigned a black status based on the criteria that it does not demonstrate greater cost-effectiveness over the existing formulary choice for the majority population. **Action**: JEC to assign black status on formulary following CCG approval and feedback MCC comments to requesting specialists. RDTC to complete black list tool.
7	**Interface: Shared Care Guidelines (SCGs) and Pathways**
7.1	**Fibroids pathway** This pathway was approved following minor formatting amendments. **Action**: RA to forward final version to JEC to be uploaded on the formulary once approved by CCGs.
7.2	**Methotrexate SCG** The group were minded to approve this updated SCG subject to some minor adjustments to wording and clarification on frequency of blood monitoring. It was noted that frequency of blood monitoring recommended in the SCG differs to that recommended in the British Society for Rheumatology (BSR) guidelines on prescribing and monitoring DMARDs (February 2017). SP indicated that he would feed this back at an upcoming rheumatology Away Day and seek views on whether changes should be made. Any changes required will have to be discussed with other specialities involved. **Action**: SP agreed to feedback the outcome of discussions around monitoring requirements from the rheumatology Away Day at the next MCC meeting.
7.3	**Application to include dermatology indications within methotrexate SCG** Further work is required to evaluate the evidence. This item will be brought back to the next meeting. **Action**: RDTC to add to agenda for July meeting.
7.4	**Application to include ophthalmology indications within methotrexate SCG** Further work is required to evaluate the evidence. This item will be brought back to the next meeting. **Action**: RDTC to add to agenda for July meeting.
7.5	**Review of RAG status for unclassified items** The group reviewed the suggested actions for drugs on the formulary with an unclassified RAG and agreed the following RAG ratings/ formulary status:

	<table><tr><th>Black</th><th>Red</th><th>Amber</th></tr><tr><td>Alimemazine tartarate (not a cost-effective use of resources)</td><td>Alfentanyl spray 5mg/5mL</td><td>Parkinson's agents; Specialist recommendation</td></tr><tr><td></td><td>Amikacin</td><td></td></tr><tr><td></td><td>Aprepitant Emend ®</td><td></td></tr><tr><td></td><td>Potassium ascorbate eye drops (unlicensed)</td><td></td></tr></table> Further information was requested regarding penicillamine, pramipexole, sevelamer (Renagel®) and rimexolone (Vexol®). These will be discussed at the next meeting. **Action**: JEC to update formulary above following CCG approval. RDTC to complete black list tool assessment tool for alimemazine and bring further information on outstanding items to next meeting.
8 **8.1** **8.2** **8.3**	**Monitoring/reporting** **Twelve month audit data MCC outcomes for recommendations from March 2016** – to be discussed at the next meeting **VoY Red drugs data (Jan to Mar 17)** – to be discussed at the next meeting. **ScR Red drugs data (Jan to Mar 17)** – to be discussed at the next meeting.
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**	**Any urgent business** **Application for new injectable methotrexate pen – Nordimet®** The YFT rheumatology and dermatology directorates have requested the addition of this product to the formulary to potentially replace Metoject® in some patients. Nordimet costs approximately £1.50 less than Metoject per pen however it is not available in the higher strengths, 27.5mg and 30mg. The group requested further information on the proportion of patients who are prescribed these higher strengths and for this item to be brought back to the next meeting for further discussion. **Action:** MMT have agreed to obtain breakdown of data on proportion of patients prescribed different strengths for the next meeting.
	Date and time of next meeting: **Wednesday 12th July 2017, 9:30am, West Offices, York.**