NHS
Vale of York
Clinical Commissioning Group

Recommendations from York and Scarborough Medicines Commissioning Committee August 2017

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
1	TA455: Adalimumab, etanercept and ustekinumab for treating plaque psoriasis in children and young people		Adalimumab (for children aged ≥4 years), etanercept (≥6 years) & ustekinumab (≥12 years) are recommended for plaque psoriasis in children and young people under specified conditions as detailed in the TA.	All drugs already listed as Red	No cost impact to CCGs as NHS England commissioned.
2	TA456: Ustekinumab for moderately to severely active Crohn's disease after previous treatment Costs saved per patient		Ustekinumab is recommended, within its marketing authorisation, as an option for treating moderately to severely active Crohn's disease, that is, for adults who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a TNF-alpha inhibitor or have medical contraindications to such therapies. Trust specialists intend to continue using adalimumab or infliximab first line but patients would now receive ustekinumab instead of vedolizumab. Ustekinumab has the advantages of being cheaper than vedolizumab, and it can be administered subcutaneously whereas vedolizumab is given via IV infusion currently via the Medical Elective Suite.	Red	Approximate comparative annual costs of vedolizumab and ustekinumab per patient: **Vedolizumab – drug acquisition cost + cost of administration via MES (approx. £400 per visit)**: Year 1 = £19,600 Year 2 onwards = £14,700 to £17,150 **Ustekinumab (based on 70kg adult) – drug acquisition cost** Year 1 = £15,029 Year 2 onwards = £8,588 to £10,735 15 patients (14 from York, 1 from Scarborough) have been changed to vedolizumab since April this year to date, whom it is predicted will be switched to ustekinumab. Potential savings for these 15 patients if switched would be approx. £68,565 in year 1 and £91,680 to £96,225 from year 2 onwards. (NB: A PAS is in place for vedolizumab and a confidential pricing arrangement has been agreed for ustekinumab. The above costs do not take these into consideration)
3	TA457: Carfilzomib for previously treated multiple myeloma		Carfilzomib in combination with dexamethasone is recommended as an option for treating multiple myeloma in adults under specified criteria.	Red	No cost impact to CCGs as NHS England commissioned.

4	TA458: Trastuzumab emtansine for treating HER2-positive advanced breast cancer after trastuzumab and a taxane	Trastuzumab emtansine is recommended, within its marketing authorisation, as an option for treating human epidermal growth factor receptor 2 (HER2) −positive, unresectable, locally advanced or metastatic breast cancer in adults who previously received trastuzumab and a taxane, separately or in combination. Conditions are detailed in the TA.	Red	No cost impact to CCGs as NHS England commissioned.
5	TA459: Collagenase clostridium histolyticum (CCH) for treating Dupuytren's contracture	For people not taking part in the ongoing HTA-15/102/04 clinical trial, CCH is recommended as an option for treating Dupuytren's contracture with a palpable cord in adults only if all of the following apply: • There is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to 2 affected joints. • Percutaneous needle fasciotomy (PNF) is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon. • The choice of treatment (CCH or limited fasciectomy) is made on an individual basis after discussion between the responsible hand surgeon and the patient about the risks and benefits of the treatments available. • One injection is given per treatment session by a hand surgeon in an outpatient setting	Red	Information on estimated number of eligible patients is awaited from YFT. However, NICE state that this guidance is not expected to have a significant impact on resources i.e. it will be less than £9,100 per 100,000 population per year – this equates to less than £26,322 for VoY, and £8,208 for ScR based on the adult population. CCH is marginally less expensive than its comparator options, limited fasciectomy and percutaneous needle fasciotomy. Expert opinion suggests the change in practice is likely to impact a small population because treatment with CCH is only recommended after other options are not considered appropriate. The acquisition cost is £572.00 per injection. Clinical study experience is currently limited to up to 3 injections per cord and up to 8 injections (£4,576) in total.
6	TA460: Adalimumab and dexamethasone for treating non-infectious uveitis	Adalimumab is recommended as an option for treating non-infectious uveitis in the posterior segment of the eye in adults with inadequate response to corticosteroids, only if the criteria specified in the TA are met. Dexamethasone intravitreal implant is recommended as an option for treating non-infectious uveitis in the posterior segment of the eye in adults, only if there is: • active disease (that is, current inflammation in the	Red	NICE state that a significant resource impact is not expected because the eligible population size in England is small (~450 per year for adalimumab and ~380 per year for dexamethasone) in England. This equates to approx. 3 patients per year in VoY and 1 patient per year in ScR. Adalimumab is commissioned by NHS

		eye) and • worsening vision with a risk of blindness.		England therefore there will be no cost impact to CCGs. The acquisition cost of dexamethasone intravitreal implant is £870.00 per implant. The recommended dose is 1 implant into the affected eye. Repeat doses should be considered when a patient experiences a response to treatment followed subsequently by a loss in visual acuity and in the physician's opinion may benefit from retreatment without being exposed to significant risk. There is currently no experience of repeat administrations in posterior segment non-infectious uveitis.
7	TA461: Roflumilast for treating chronic obstructive pulmonary disease	Roflumilast, as an add-on to bronchodilator therapy, is recommended as an option for treating severe chronic obstructive pulmonary disease in adults with chronic bronchitis, only if: • the disease is severe, defined as a forced expiratory volume in 1 second (FEV1) after a bronchodilator of less than 50% of predicted normal, and • the person has had 2 or more exacerbations in the previous 12 months despite triple inhaled therapy with a long-acting muscarinic antagonist, a long-acting beta-2 agonist and an inhaled corticosteroid. Treatment with roflumilast should only be started by a specialist in respiratory medicine YFT specialists have indicated that the target group would be the “frequent exacerbator” phenotype patients who are relatively unusual and identifiable through frequent rises in CRP and WCC. High dose ICS and low dose macrolide prophylaxis would usually be tried first. Expected benefits of roflumilast would include reduction in bronchitic symptoms and some improvement in QoL scores and lung function. However, the main benefit is significant reduction in moderate to severe exacerbations with an expected average reduction of 45% (i.e. 0.5 to 1 exacerbations	Amber specialist Initiation	YFT are currently working on estimated patient numbers but expect this to be low given the restriction of specialist initiation only. NICE do not expect the guidance to have a significant impact on resources (less than £9,100 per 100,000 population per year) – expected uptake is small because the therapy should only be started by specialists in secondary care and the unit cost for the intervention is small. Drug acquisition cost per patient per year = £457.55

		per patient per year). Therefore the drug could be discontinued in patients who have clearly increasing exacerbation rates despite being on the drug. The most common side effects are weight loss and GI disturbance; the drug should be stopped in patients experiencing these to a significant degree.		
8	TEWV shared care guidelines: • Atomoxetine for ADHD • Methylphenidate for ADHD • Lithium	The group approved the use of the updated shared care guidelines on atomoxetine, methylphenidate and lithium which had been approved by the TEWV D&T committee.	Amber shared care	None expected – guidelines updated.
9	Hepatitis A and B combined vaccine for travel	The group were asked to review the current commissioning position of the combined Hep A/Hep B vaccine for travel in light of the current global shortages of the separate vaccines. The VoY travel vaccine guidance currently states that the combined vaccine should not be prescribed on the NHS for travel purposes. Whilst the Hep A vaccine can be given as part of NHS provision, the Hep B vaccine is not remunerated by the NHS when used for travel purposes. The group noted that Public Health England had issued guidance to help mitigate the shortages and the combined vaccine is recommended in certain circumstances. It was agreed that whilst there remains a shortage, the combined vaccine can be used for those patients requiring Hep A for travel in line with PHE guidance. As the Hep B vaccine cannot be given on the NHS, patients requiring it for travel are required to obtain the vaccine privately and this remains applicable when the combined vaccine is used. The travel vaccine guidance will be updated to reflect this temporary position.	N/A	The combined Hep A/Hep B vaccine is more expensive than the single Hep A vaccine - £20.79/£33.31 vs £14.74/£18.10 for the paediatric/adult preparations respectively. Also, the standard primary course of using the combined vaccine consists of three doses while that using the single vaccine consists of just one dose. However, NaTHNac recently updated its Hep A immunisation recommendations and vaccination is no longer recommended for most travellers visiting a number of countries
10	Dicycloverine for gastrointestinal spasm	The group agreed to assign a black status to dicycloverine on the basis that it is not a cost-effective use of NHS resources. The price of dicycloverine has increased considerably over recent months and it now costs significantly more than other antispasmodic drugs. A 28 day supply of dicycloverine 10 mg to 20 mg TDS currently costs around £155 to £197 compared to £4.44 for mebeverine 135 mg TDS. In addition, use of dicycloverine is not advocated by CKS	Black	Cost saving. VoY spent around £271k while ScR spent £38k on dicycloverine between April 16 and March 17.

		or the British Society for Gastroenterology as it is associated with adverse effects, and CKS found little difference in efficacy between different antispasmodics.		
11	Glaucoma pathway and formulary section review	The group approved the glaucoma pathway and the proposed formulary amendments to ensure use of the most cost-effective agents, and to ensure that there is a preservative free (PF) option for each drug group: **Carbonic anhydrase inhibitors – order of choices** Frist line = dorzolamide Second line = brinzolamide **Items to be removed from formulary:** Carteolol 2% Timolol 0.5% Levobunolol PF **Items to be added to formulary (All Amber specialist recommendation)** Bimatoprost PF Dorzolamide PF Dorzolamide + timolol PF	Amber specialist recommendation for items to be added to formulary	Minimal cost impact anticipated as pathway reflects current clinical practice.
12	Guideline for the administration of subcutaneous furosemide in the community setting	The group approved the guideline subject to the removal of the reference to a minor change.	N/A	No cost impact expected as guideline reflects current clinical practice.
13	Atorvastatin as first line statin on Y&S formulary	The group approved a change in the order of choice of statin on the formulary so that atorvastatin would move from 2nd line to 1st line in line with NICE guidance and simvastatin would move from 1st to 2nd line.	Green	Minimal cost impact anticipated.