Oxfordshire Area Prescribing Committee (APCO)
Bullet Points
8th January 2019

Prescribing Points and the Traffic light system are available on the OCCG website. The OCCG Formulary is available online. -links below.
This document summarises the discussions and decisions taken at APCO in January 2019.

Local Guidance: OCCG Formulary

The classifications are:

- Red – Specialist Prescribing Only
- Amber Continuation - Medicines which should be initiated or recommended by a specialist for continuation in primary care. The specialist must notify the GP that the prescribing responsibility has been transferred.
- Amber Shared Care Protocol - Medicines which are appropriate to be initiated and stabilised by a specialist, once stabilised the medicine may be appropriate for responsibility to be transferred from secondary to primary care with the agreement of a GP and a formal 'shared care' agreement. The shared care protocol must be approved by the Area Prescribing Committee Oxfordshire (APCO).
- Green - Medicines which are suitable for initiation and ongoing prescribing within primary care.
- Brown – Prescribe only in restricted circumstances
- Black – Not recommended for use in primary or secondary care
- Holding List – Pending APCO / Priorities Forum decision

Drug	Traffic Light Classification	Rationale
Semaglutide	Brown	Cost equivalent to Dulaglutide, but shows superiority in trials in HbA1c and body weight in comparison to exenatide and dulaglutide. The cardiovascular outcome trial (SUSTAIN 6) showed a statistically significant 26% reduction in risk of a composite of non-fatal stroke, non-fatal MI, cardiovascular death and time to first occurrence of major adverse cardiovascular event in patients treated with semaglutide. Only for patients who would gain significant benefit from once weekly injection, in line with local guidelines. Contraindicated in patients with significant eye disease – see GLP1 guideline
Dulaglutide	Brown	Updated now Semaglutide available. Only for patients who would gain significant benefit from once weekly injection and who are not suitable for treatment with semaglutide, in line with guideline. Patients already treated

Drug	Traffic Light Classification	Rationale
		effectively with dulaglutide do not need to switch. See GLP1 guideline
Instant Carobel Powder	Brown	In line with ACBS conditions
Rivaroxaban for superficial thrombophlebitis	Brown	Second line to dalteparin in patients at intermediate risk (unlicensed)
Tofacitinib for moderately to severely active ulcerative colitis	Red	In line with NICE TA547
Gemtuzumab ozogamicin for untreated acute myeloid leukaemia	Red	In line with NICE TA545. NHS E commissioned
Padeliporfin for untreated localised prostate cancer	Black	In line with NICE TA546
Decitabine for untreated acute myeloid leukaemia	Black	In line with NICE TA548
Denosumab for preventing skeletal-related events in multiple myeloma	Black	In line with NICE TA549
Vandetanib for treating medullary thyroid cancer	Black	In line with NICE TA550
Diltiazem Hydrochloride 1% cream (AnoHeal)	Red	For chronic anal fissure, 2nd line to GTN for use by secondary care only (MMTC Nov 18)
Rituximab for Myasthenia Gravis	Red	NHS E commissioned (MMTC Dec 18)
Levofloxacin nebulised solution (Quinsair)	Red	For adult CF NHS E commissioned (MMTC Dec 18)
Grazex	Red	For use in paediatric patients with severe allergic rhinitis where other treatments have failed. Specialist use only. MMTC Nov 18

Miscellaneous

DN administration of denosumab

Until 2015 densumab was initiated in secondary care, but then changed to G.P initiation. Guidance was produced on responsibilities for prescribing, and the responsibility for checking bloods and issuing prescriptions sat with the GP. Oxford Helath wrote a letter based on this to update all DNs. The letter requires updating. DN would typically administer if the patient is housebound. The debate is for these patients, who should be checking if it is safe for patient to be given denosumab? Should there be a step where the DN checks that the GP has checked the blood results or checks the results themselves? Currently, DNs assume if the prescription has been issued and the direction to administer has been given, then it means that the GP has checked the blood results. It was discussed that the process is quite complicated and when denosumab is on repeat blood checks can be missed. However, it would also be complicated to add the blood results check step in to the DN process. Concern that the more steps involved in the DN process, the more risk there is that something could go wrong. It was agreed that denosumab should not be on repeat, and should only be issued when bloods have been checked by GP. GMC is clear that it's the prescribers responsibility to confirm it is safe to issue a prescription. Noted that it would still be useful for the DN to log in to EMIS and double check that bloods are ok but issue that

not all DNs have access to EMIS. It was highlighted that we need a really robust system where all HCPs are doing the same thing as there seems to be a lot of variety.

The consensus was to keep responsibilities as they are currently, where GPs check the blood results before issuing the prescription. This should be the same for high risk drugs such as methotrexate. We must work to encourage consistency in practices and DNs through joint working.

Gender dysphoria commissioning NHS England update

NHS England's Specialised Commissioning Oversight Group has agreed the final version of the service specifications, after considering a recommendation that was made in July 2018 by the Clinical Priorities Advisory Group in accordance with their established method for agreeing service specifications for specialised services. The service specifications will be used to inform a process of national procurement later in 2018/19 that will identify which organisations are best able to deliver specialised gender dysphoria services in compliance with the new specifications from 2019/20. Ongoing prescribing arrangements appear to remain the same (i.e. GPs asked to prescribe) but it does specifically state that what appears to be an individual SCP should be provided for each patient.

There was concern about the level of training and support available for GPs. There is a suggestion of an MDT approach in local areas, but concern that this will be difficult to procure. There is no specialist centre in Oxfordshire. Committee were asked whether there is something more OCCG can do to help with education e.g. GP update/educational resources, as it is OCCG's responsibility to support GPs through transition period. The guidance that has been published will be shared.

Guidelines

Insulin Lispro Sanofi

Biosimilar insulin lispro is about 15% cheaper than the original reference analogue lispro (Humalog) and therefore offers prescribing cost-saving opportunities for patients being initiated on lispro, and the potential that in the future more patients requiring fast acting insulin would be initiated on this as it is the most cost effective (novorapid is currently most commonly prescribed). Switching Humalog only would save up to £24,000 but if moved to the using it as the first choice fast acting insulin it could save £124,000. There is potential for a county-wide managed switch to release savings from existing Humalog prescribing, however this would only be done in line with a switch protocol. The suggestion for the moment would be to initiate new patients on the biosimilar, which would be the same formulary update currently in place for biosimilar insulin glargine.

There are two points to consider:

- The brand name of the biosimilar 'insulin lispro sanofi' is very similar to the generic 'insulin lispro'. This would require care on the part of the dispenser and patient to ensure they are dispensed the correct product. If mistaken for a generic script, Humalog might be dispensed in error. The pens are different, so if the wrong cartridges were dispensed the patient would not be able to use it. Sanofi were

contacted about this and replied 'it has been approved as a Brand Name by the EMA, MHRA and DH. It follows a brand naming convention for a range of drugs in the UK where continuous use of the same manufacturers drug is required for example within epilepsy treatment (Sodium Valporate Teva) it also follows World Health Organisation guidance -around brand names for biosimilars (drug name + Suffix).

- Insulin Lispro Sanofi does not come in prefilled junior pens, but the cartridges fit in the junior star devices which are Sanofi's half unit pens. This would be necessary for children, those close to diagnosis or very insulin sensitive. But it does offer less choice to those requiring half unit pens.

APCO had concerns about the name, and reasoned that before starting use of the biosimilar, education/information would need to be circulated beforehand and especially some work is needed to promote branded prescribing of all insulins as per safety advice. It was also requested that the paediatric endocrine team were consulted and an application sent to MMTC first.

Approved subject to actions above and MMTC approval

GLP-1 guideline update
Page on Xultophy (lira/degludec fixed combination) has been removed as it was felt it complicated the guidance, is rarely used and is not initiated by GPs. It will be made sure that information is still available.

APCO approved the above mentioned changes to the GLP-1 Guidance

Temporary Lactose Intolerance Patient leaflet
For anyone with a temporary lactose intolerance, aim is to stop patients on lactose free diets/formula when it is not necessary. LG suggested running past communication team to check wording/reading level.
Approved, subject to comms input

Good practice guidelines – Transdermal fentanyl patches
There are numerous "Good Practice Guidelines" relating to medicines, on the OCCG website for use by staff in care homes. All are in need of reviewing and updating, but in view of the recent safety information from the MHRA about transdermal fentanyl patches, this is the first updated guideline. Still similar to previous guidelines. The main changes are a (1)front sheet with clear safety advice with "do" and "don't" sections, (2) advice to keep patches away from children and vulnerable adults (3) advice that patches shouldn't be cut (4) clearer advice re. disposal or used and unused patches and (5) having a recording sheet for patches. It was confirmed that palliative care no longer cutting patches, OH will also update guidance. It is the care home's responsibility to have their own policy, this is good practice guidance for them to use. Also useful to DNs. Another change is that it previously suggested the patch should be dated, but now concerned the pen could pierce patch. It would be beneficial to share guidance so there is clear advice across Oxfordshire. Circulate more widely before finalising, but in principle it is a useful document.

Approved subject to circulation to stakeholders

Management of superficial thrombophlebitis There have been a number of queries as to whether STP should be dealt with by DVT clinic or GP. The DVT clinic will see high risk patients, but have suggested they are not commissioned to treat other groups. Intermediate and low risk should be dealt with by GP to manage. OCCG do have guidance on this in the dalteparin SCP. The DVT clinic produced a flow chart, however it also mentions rivaroxaban which is not licensed and not on formulary for this indication. Do we want to include the flow chart and rivaroxaban in our guidance? It has already been in GP bulletin (without DOAC). It is difficult to estimate how many patients this would be, but potential for a cost impact. Noted that most patients would prefer an oral treatment. However, by adding rivaroxaban we are endorsing it without specific evidence, but suggested that there is a need for an alternative for those who cannot use injections. Would need to be clear on guidance that not licensed and only if dalteparin unsuitable. It was questioned what risk on the flowchart means? Low and intermediate risk seem to apply more to symptoms rather than risk of DVT, this needs to be clarified on document.

Approved subject to above amendments and to be added into dalteparin guidance

Chair's Actions

The Ocular Lubricant Prescribing Guidance (approved July 18) has been amended following feedback that some of the product information was incorrect:

1. Hylo Tears and Hylo Forte contain 300 drops (previously stated contain 200 drops)
2. Xialin Night ointment lasts for 60 days from opening (previously stated 6 months)