Oxfordshire Area Prescribing Committee (APCO)
Bullet Points
10th March 2020

Prescribing Points and the Traffic light system are available on the OCCG website. The OCCG Formulary is available online. - link below. This document summarises the discussions and decisions taken at APCO in March 2020.

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
TA617 Lusutrombopag for treating thrombocytopenia in people with chronic liver disease needing a planned invasive procedure	Red	In line with TA
TA623 Patiromer for treating hyperkalaemia	Red	In line with TA
TA616 Cladribine for treating relapsing–remitting multiple sclerosis	Red	NHSE commissioned
TA619 Palbociclib with fulvestrant for treating hormone receptor-positive, HER2-negative, advanced breast cancer	Red	NHSE commissioned
TA620 Olaparib for maintenance treatment of relapsed platinum-sensitive ovarian, fallopian tube or peritoneal cancer	Red	NHSE commissioned
TA624 Peginterferon beta-1a for treating relapsing–remitting multiple sclerosis	Red	NHSE commissioned
TA622 Sotagliflozin with insulin for treating type 1 diabetes	Amber	
TA618 Atezolizumab with carboplatin and nab-paclitaxel for untreated advanced non-squamous non-small-cell lung cancer	Black	In line with TA

TA621 Osimertinib for untreated EGFR mutation-positive non-small-cell lung cancer	Black	In line with TA
Trimipramine	Black	De-prescribing protocols approved
Glucagon	Brown	can be initiated in primary care but seek specialist support to manage hypoglycaemia (previously non-formulary)
Ingenol mebutate gel	Non-formulary	Actinic keratosis guideline pending update. Marketing authorisation is currently suspended as a precautionary measure due to growing concerns on the possible risk of skin malignancy. The EMA continues to investigate.
Trimovate cream	Green	Licensed product was discontinued and only available as a special in 2018. Classified as Red on the formulary at the time. A licensed product is now available again.
Nadolol - For patients with long QT syndrome	Amber continuation	Licensed product was discontinued in 2016, therefore classified as non-formulary. Licensed product now available and also on OUH formulary.
Collagenase clostridium histolyticum	Non- formulary	Has been discontinued in the UK. NICE TA459 Collagenase clostridium histolyticum for treating Dupuytren's contracture has been withdrawn as a result
Conestat alfa (Ruconest)	Red	For angioedema. NHS E commissioned
Meropenem- vaborbactam	Red	Specialist only. MMTC Feb 20

Miscellaneous

Botulinum Toxin Commissioning Policy

APCO agreed to take 2 conditions off as they weren't being used. TVPC also changed one of the items in the policy.

Approved

RMOC (Regional Medicines Optimisation Committee)

RMOC BlueTeq Principles

This covers Standard Principles for Medicines Prior Approval Forms. This is only for high cost drugs so at APCO for information. Decisions on high cost drugs implementation are made at separate meeting but further policies developed from this statement may be brought back to APCO for approval.

RMOC Sequential Use of Biologic Medicines

Noted at APCO for information, implications will be discussed at Thames Valley Priorities Committee and any changes in commissioning policy statements will be brought back to APCO.

Shared Care Protocols (SCP)

a) Sacubitril Valsartan

Sacubitril Valsartan has been used locally for 3 years. Initially just for hospital initiation only, but now community HF nurses are involved. All patients discussed at joint monthly meeting. About 150 patients have been started in the last 3 years and numbers of prescriptions have been rising. The SCP states it should be initiated by hospital team only, so change in wording to allow community team to be involved. Also clarified wording on monitoring, prescribing etc until patient is stable. National guidance is to discontinue if potassium >6, so have updated this information as well.

The GPs commented that community HF team ask GPs to prescribe, this is because they are not all are prescribers. This will be feedback to the HF team.

On page 1 final sentence cuts off should state 'shared care'. Some GP responsibilities have been crossed out due to feedback. Page 5 information on AKI needs to be broken down in to AKI 1, 2 and 3.

If patient attends the GP for monitoring they must have a card so the results don't come to the practice, this will be made clearer.

Approved subject to amendments

b) Dimethyl Fumarate

The protocol was originally approved at APCO in July 2016, after reviewing they made the following minor changes:

- Responsibilities moved to the front of the document
- Clarified that prolonged lymphopenia is defined as being below the stated level (<0.5 x 109/L) for 6 consecutive months (previously didn't state the number of months)
- Clarification that patient must have completed local immunisation requirements 4-weeks prior to starting treatment for non-live vaccines and 6-weeks prior to treatment for live vaccines (previously 6 weeks for all)
- Clarification that if persistent lymphocyte count is below the stated level (< 0.5x109/L) for more than 6 months, treatment with should be discontinued (previously stated consider stopping).

It was requested that the actions that need to be taken by GPs is made clearer.

Approved subject to changes

Guidelines

a) Maintenance Management of Asthma – Inhaled and oral Therapies (adults)

This is an update of the guidance put together in 2017. The update has involved input from OUH respiratory consultants, OUH pharmacy, OH respiratory nurse, OH respiratory pharmacist, GP and CCG MO. The last version had tables splitting inhalers into MDI or dry powder, the tables now are either MART (maintenance and reliever therapy) or traditional therapy (each

table split into dry powder or MDI) and the guidance is based mainly on GINA and BTS/SIGN. Extra information has been added to include some more info on ICS equivalence, inhaler technique, spacers, add on therapy and when to refer. Most topically, more information has been added about environmental impact of inhalers and how to reduce this as this is now an important factor for patients. A few changes have been made to formulary choices as a result.

It is expected that most patients will remain on the traditional therapy route but may move to the MART section if compliance is an issue or suspected to be an issue. MART therapy discourages overuse of SABA and under use of steroid which causes death in asthma patients.

Note the cost differences, hard to predict how much of an impact MART will make as depends on uptake. Should also have an effect on compliance and control which may reduce admissions and outpatient appointments.
Low carbon could cost extra but can limit this with choice of inhalers. Less inhaler options so will improve compliance and use of correct inhaler when moving up and down the steps.

APCO questioned that although GINA doesn't allow for SABA alone but NICE and BTS do for small cohort – why is there no allowance for that in guidance? It was suggested that a footnote is added which explains why this is and add in small cohort where it would be appropriate e.g. exercise. Fostair is still appropriate for exercise, happy to add a footnote explaining but not appropriate to add additional cohort. How do we make sure we get this message gets out there? Agreed we need an education leaflet to go with this. We also need to be clear it is not for children and why we would choose different inhalers in COPD. Education to support this is very important and also need to include community pharmacists etc. It was stated that we need to be clear that salbutamol needs to be removed from patients medication and the clinician needs to have the confidence to do this. It also needs to be clarified why we are differing from NICE. Would GPs be switching patients? It was answered that this would not be a mass switch, certainly for new patients or anyone getting their regime change. An idea would be recalling overusers of salbutamol. Concerns about supply issues by going to just 2 manufacturers on inhaler choice were noted. The paediatric team want to do their own guidance so children are not covered in this guidance.

Approved subject to amendments

b) Homely Remedies Good Practice Guidelines

In 2018 RMOC produced guidelines on Homely Remedies for Care Homes. The CCG were to review and adopt, however waited until MOCH in place to review. Used RMOC guidance and also added some information from PrescQipp and NICE. The MOCH team will add a section to ClinOx for all new Care Home guidance and documents. How will we engage with care homes to change practice – some of their company won't let them provide homely remedies. The MOCH team will go round and would flag up if they felt there was an issue. Many just have prn meds prescribed, even for indications <48 hour, which is when homely remedies should be used. It was suggested to contact Bucks as they have had implemented for a while. It is beneficial for GPs as it saves time – especially around emollients. CQC clarified that emollients don't need specific directions. Care Home pays for the homely remedies. APCO agreed that the document is suitable; the issues to be considered are around implementation.

Approved

Chair's Actions

Medicines Optimisation Team
APCO Bullet Points March 2020
Recommendations ratified at OCCG Clinical Ratification Group (May 2020)

- Minor updates to SGLT2i checklist and Primary Care Warning to align with Trust advice on stopping SGLT2i 72 hours before surgery and restarting 7 days after discharge
- Formulary entry for sodium valproate to be clarified that patient remains under specialist care and will be reviewed annually in clinic. Questioned if this should be shared care. It is not at the moment, and has been prescribed for years, but now there is extra steps. Hope that formulary update is enough, will clarify in Prescribing Points about review. CQC have it as a high risk medicine.

Action: Clarify information on annual review in Prescribing Points

- Minor update to bone infections SCP to include link to MHRA drug safety update on fluoquinolone antibiotics
- Emollient guidance – addition of new cost effective products; ExCetra (Cetraben equivalent), Epimax ointment (similar to Zeroderm, Epaderm & Hydromol ointments), Epimax oatmeal cream (similar to Aveeno & Aproderm oatmeal), Epimax paraffin free ointment

Approved