Oxfordshire Area Prescribing Committee (APCO)
Bullet Points
10th September 2019

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 July 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
Fluocinolone acetonide intravitreal implant for treating recurrent non-infectious uveitis	Red	In line with NICE TA 590
Risankizumab for treating moderate to severe plaque psoriasis.	Red	In line with NICE TA596
Patisiran for treating hereditary transthyretin amyloidosis	Red	In line with NICE HST10 (NHS E commissioned)
Lenalidomide plus dexamethasone for multiple myeloma after 1 treatment with bortezomib	Red	In line with NICE TA586 (NHS E commissioned)
Lenalidomide plus dexamethasone for previously untreated multiple myeloma	Red	In line with NICE TA587 (NHS E commissioned)
Nusinersen for treating spinal muscular atrophy	Red	In line with NICE TA588 (NHS E commissioned)
Blinatumomab for treating acute lymphoblastic leukaemia in remission with minimal residual disease activity	Red	In line with NICE TA589 (NHS E commissioned)
Letermovir for preventing cytomegalovirus disease after a stem cell transplant	Red	In line with NICE TA 591 (NHS E commissioned)
Cemiplimab for treating metastatic or locally advanced cutaneous	Red	In line with NICE TA592 (NHS E commissioned)

Drug	Traffic Light Classification	Rationale
squamous cell carcinoma		
Dacomitinib for untreated EGFR mutation-positive non-small-cell lung cancer	Red	In line with NICE TA595 (NHS E commissioned)
Brentuximab vedotin for untreated advanced Hodgkin lymphoma	Black	In line with NICE TA594 (terminated appraisal)
Nordimet solution for injection in pre-filled pen (methotrexate)	Amber SCP	Second line to metoject. For use in patients who are unable to use/ have compliance issues with metoject device
Fixpost (timolol/latanoprost PF) for Glaucoma	Amber C	For use if prostaglandin analogue + beta-blocker indicated and preservative free product required. To be included in updated glaucoma pathway
Slenyto (melatonin) 1mg and 5mg prolonged release tablets	Non-formulary	Non formulary until further review in January as part of SCP review. Licensed for a very specific paediatric group but wouldn't cover all the indications in the current SCP.
Melatonin 3mg tablets	Black	Circadin remains formulary option
Melatonin 1mg/ ml oral solution	Black	Not licensed or recommended for use in children (contains Propylene glycol and ethanol at levels that would be not safe). Circadin remains formulary option
Fentanyl (Abstral Tabs), Fentanyl buccal film (Breakyl), Fentanyl sublingual tabs	Black	Previously 'non-formulary'. Updating in line with NHS England Items which should not routinely be prescribed in primary care guidance
Co-proxamol	Black	Previously 'non-formulary'. Updating in line with NHS England Items which should not routinely be prescribed in primary care guidance
Glucosamine and Chondroitin	Black	Currently just glucosamine classified. Updating in line with NHS England Items which should not routinely be prescribed in primary care guidance
Minocycline for acne	Black	Currently amber continuation. Updating in line with NHS England Items which should not routinely be prescribed in primary care guidance
Rubefacients (excluding topical NSAIDs and capsaicin)	Black	Previously 'non-formulary'. Updating in line with NHS England Items which should not routinely be prescribed in primary care guidance
Travel Vaccines (vaccines administered exclusively for the purposes of travel)	Black	BCG requires the 'should not be prescribed on the NHS exclusively for the purposes of travel' caveat
Lixisenatide	Brown	Existing patients only (unless high CV risk) in line with updated GLP1 guidelines
Exenatide	Brown	Existing patients only (unless high CV

Drug	Traffic Light Classification	Rationale
		risk) in line with updated GLP1 guidelines
Dulaglutide	Brown	first line option in line with updated GLP1 guidelines (previously for those who would gain benefit from once weekly and can't have semaglutide)
Semaglutide	Brown	first line option in line with updated GLP1 guidelines (previously for those who would gain benefit from once weekly)
Liraglutide	1.2mg Brown 1.8mg Brown	1.2mg – first line option in line with updated GLP1 guidelines 1.8mg – GP can titrate to 1.8mg if partial response. If no response consider one of the more cost effective options
Lubiprostone	Non formulary (previously brown)	Withdrawn from the market for commercial reasons, NICE has also withdrawn TA318
Cangrelor tetrasodium	Red	Percutaneous Coronary Intervention (PCI). NHS E funded
Fludroxycortide ointment	Red	Agreed at MMTC for Eczema, dermatitis and hypergranulation. Hospital use only

Miscellaneous

Omega 3 and lipid lowering
As per action from the last meeting, an application is in progress for MMTC. Evidence for use of Omega-3 fatty acids will be reviewed by NICE when CG181 is reviewed. Information from the surveillance reports suggests that NICE will be monitoring for further evidence that may or may not impact on the guideline. It was noted patients can continue to purchase Omega 3 if they wish.

RMOC (Regional Medicines Optimisation Committee)

RMOC newsletter

The committee was asked to note the RMOC newsletter. There is work looking at biosimilar insulins which is likely to flag up similar issues that we have found locally. Also work on a Botox statement that will be issued.

RMOC liothyronine updated guidance
New RMOC guidance on liothyronine is now published following the review in the house of lords. Our local guidance will be updated but discussions will need to be had with endocrinology regarding shared care. Otherwise, similar to current OCCG guidance. It was noted that there was no change locally for psychiatrists.

Shared Care Protocols

Rheumatology DMARD shared care protocols – general responsibilities

It was noted that general responsibilities and monitoring for shared care are presented in separate documents which makes it easier to have a general discussion, these can then be copied in to the individual Shared Care Protocols for ease of use.

The responsibilities have been clarified especially around the amount of medication supplied and when to transfer care to the GP. The aim is to improve transition, provide clarity around checking blood results and improved use of the shared care monitoring card. The responsibilities incorporate local and national best practice guidelines. It was stated that the full rheumatology team have agreed to the proposed terms. The handover of prescribing to the GP will be after 56 days unless unstable; it was highlighted that this needs to be clearer as currently it suggests that all patients will be handed over at 56 days.

It was commented on giving GPs 14 days to refuse shared care that it can often take 14 days for a letter to be reviewed. This is from the local guidance on shared care, and GPs will know 8 weeks in advance of that as will be notified at start of treatment. It was asked that the letter is made very clear that it is a shared care handover letter. Agreed that the wording on blood tests is too specific, so can make more general to suit all practices in Oxfordshire.

Approved

Rheumatology DMARD Shared Care Protocols Update – Monitoring

The BSR updated their guidance in 2017, so rheumatology wants to bring all the monitoring in line with the advice. The advice is to initially monitor 2 weekly for 6 weeks, monthly for 3 months then every 3 months, this equates to a decrease in number of tests that are currently happening. The document also contains updated guidance on results which are now standardised. It was noted that having one central document is useful for patients who require two DMARDs, but committee agreed it would also need to be included in each protocol. The document will also be useful for phlebotomy. The document only covers rheumatology monitoring, it would be good to eventually have a document that covers all. It was accepted that there will be some differences in monitoring between specialties.

Approved

Methotrexate SCP (Rheumatology)

The protocols has been simplified to just rheumatology. Updated indications to clarify licensing and updated prescribing information and side effects. It also includes option of Nordimet as a second line product.

Nordimet went to MMTC last month. Examples of Nordimet and Metoject devices were shown. Metoject (current choice) is slightly more bulky and more difficult for those with dexterity issues. It is less discreet and the yellow is anecdotally associated with nausea in children. The Nordimet device is a newer, easier to use device. Cost impact in primary care between all available devices is minimal. It was noted that 60% of prescribing in Oxfordshire is generic, so need to work to reduce generic prescribing for safety reasons. There are two other devices on the market, Methofill which is an unusual device that doesn't fit in sharps bin, and Zlatal which is a syringe rather than the pen which patients don't like as much. It was noted there are risks with having multiple different devices, should we only have one of formulary. CT raised the issue of having only one is when there are stock issues. Need to promote branded prescribing, then it is ok to have two on the formulary. Patients should have shared decision making around the choice of device. The committee decided the safety concerns for two devices are minimal, so

Nordimet was approved as second line. MMTC will mitigate risks once APCO decision is made.

The other specialties in the original protocol (e.g. dermatology) will remain unchanged for the moment. National guidance is for protocols to be separated by speciality. In the future will encourage specialties to align with testing.

Hydroxychloroquine SCP (Rheumatology and dermatology)
Joint dermatology and rheumatology protocol, noted we may have to split the protocol into specialities as per NHS E shared care guidance. This update is part of the actions from July's APCO meeting. Holding statement explains what is happening to current patients, this protocol explains what is happening to new patients. Flow chart is biggest amendment which risk stratifies patients. Recognising risks factors, if high risk explains the screening required. Clarified around community optometrists for names of specific sight tests so it is clear what they need to ask for. Noted that a patient leaflet is in progress via the working group. Optometrists can't do the full retinal screening, but important that patients should continue their annual eye test as this will show if there are changes to vision. MO team currently working with rheumatology to help capture patients to risk stratify. It was queried for the low dose/low risk patients, test at 3 years not baseline so would the review indicate testing? Add loop to potentially stop at that stage if not ok. Questioned if the protocol fully in line with royal college – not all patients will have a baseline but this was low evidence. To make this clear that this is a local decision.

Approved

Ciclosporin SCP (Rheumatology)

It was questioned what type of glucose monitoring is required –to clarify if this is fasting or normal. It was noted that if it is raised, repeat the same test again and do not do an Hba1c.

The family planning and vaccinations document referred to in the protocol doesn't currently exist – to be added in as specialist responsibility. Guidance to be brought to next APCO.

Approved

Azathioprine SCP (Rheumatology)
Leflunamide SCP (Rheumatology)
Mycophenolate SCP (Rheumatology)
Sulfasalazine SCP (Rheumatology)

All approved no further comments

Guidelines

Dalteparin– Guideline and Shared Care Protocol for Prescribing in Primary Care

The dalteparin guideline was updated in line with the Trust guidelines and dose bandings. Used to cap dose at 18,000 units as per the license, now dose band without a cap in line with American Haematology Society Guidelines. This is different to the BNF, so would need to raise awareness around this and make it clearer on the guideline, however current dosing is not in line with BNF either. The new dose banding have been approved by MMTC. In addition there have been a few minor updates such as the superficial thrombophlebitis flow chart. It was noted that most pharmacies won't keep all these strengths in stock, so would need to communicate

with pharmacy the strengths that would be used regularly. Issues around travel and patient paying for medication was questioned, it was agreed to relook at this and allow GP prescribing for very high risk patients who have been recommended it by haematologist for the purposes of travel. If GP cannot complete the D-Dimer outside clinic hours, GP to take blood and give vial to patient to bring in to the service the following day.

Approved

Denosumab duration of treatment holding statement

A holding statement for GPs has been suggested outlining the 5 year review and specialist input. Following NICE guidance and highlighting the risks of stopping that have already been communicated but with some different wording now suggested by a local specialist. Concerns were raised about the statement suggesting that switching to a bisphosphonate may not protect as this wasn't in the original study. It was also noted that it should at least suggest the study did have limitations. It was felt that the risks of staying on treatment need to be clearer. There are different interpretations of the evidence so need to consider carefully. No national guidance on how long to treat for, risks with both stopping and continuing. It was noted that Oxfordshire are one of the highest users of densoumab in the country and no better for fractures and that patients were started at inappropriate place in the pathway (e.g. end of life). GP's responsibility for patients who are lost to follow up was also questioned. Currently, need to remind patients to attend as don't have recall systems in place, some work by a local GP has been shared to assist with this. The statement recommendation is to review periodically which not useful, need to be more specific.

Not approved in current form

GLP-1 Receptor Agonist Guidelines – update

In July 2017 we presented a proposed update to the committee making liraglutide 1.8mg first line in patients at high risk of cardiovascular disease due to the results of the LEADER trial. The committee did not approve this update as they felt the evidence wasn't strong enough and the cost impact was significant. Since then, evidence of cardiovascular benefit in 2 more GLP-1 receptor agonists have been published, dulaglutide and semaglutide. These are both significantly more cost effective than liraglutide 1.8mg. There has also been a lot of focus on cardiovascular benefit of anti-diabetic drugs from organisation the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD) and RMOC.

The suggested guideline removes lixisenatide as an option due to the neutral cardiovascular effects, and gives GPs the choice of dulaglutide, semaglutide or liraglutide 1.8mg. The table provides information for the prescriber to help them identify which GLP-1 would be most appropriate.

Although lixisenatide is cheaper than all other GLP-1s, the cost impact assessment suggests there will be minimal financial impact for OCCG. This is mostly due to the fact that even though it is currently first line, only 20% of GLP-1 prescriptions are for lixi. 55% are for the most expensive liraglutide, so if more patients were to be started on dulaglutide or semaglutide there would actually be a cost saving. There is also the potential for savings to the health economy due to lower rates of cardiovascular events.

OUH would require an MMTC formulary application for dulaglutide and semaglutide. Currently, inpatients would be changed to a once daily for the duration of their stay which isn't ideal. Switching patients and implementing guidelines would be supported through the MDT/PCN meetings. Any patients who are not benefitting should be picked up at their 3 and 6 month

review. It was questioned if the trials are sufficient evidence to switch patients who are meeting target? It was agreed that this would probably be individual patient conversation. RMOC are to review this in the future, and will need to develop to align with BOB ICS. It was questioned if we want to indicate a preference, but it was felt that it is important to give patient choice. Liraglutide 1.8mg (high dose) is significantly more expensive, this needs to be clear to GPs. This can be better tolerated, hence why liraglutide is included, but otherwise once weekly would be a good patient option.

Approved

Chair's Actions

- The Primary Care Respiratory Society UK Guidance 'Evaluation of appropriateness of inhaled corticosteroid (ICS) therapy in COPD and guidance on ICS withdrawal' has been added to Clinox to support the work of the Integrated Respiratory Team (IRT). This will also help give GPs guidance in implementing the updated NICE guidance. https://clinox.info/clinical-support/local-pathways-and-guidelines/Clinical%20Guidelines/OXON%20IRT%20Stepping%20Down%20Steroids%20with%20COPD%20v1.pdf
- The Type 2 Diabetes Blood Glucose Management in Adults – Primary Care Guideline has had all the links updated, the current formulary status for each drug has been updated and the GLP-1 CV trials noted.

Approved