Oxfordshire Area Prescribing Committee (APCO)
Bullet Points
8th September 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 Sept 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
Atezolizumab with carboplatin and etoposide	Red	TA638 Atezolizumab with carboplatin and etoposide for untreated extensive-stage small-cell lung cancer. NHSE commissioning responsibility.
Atezolizumab with nab-paclitaxel	Red	TA639 Atezolizumab with nab-paclitaxel for untreated PD-L1-positive, locally advanced or metastatic, triple-negative breast cancer. NHSE commissioning responsibility.
Treosulfan with fludarabine	Red	TA640 Treosulfan with fludarabine for malignant disease before allogeneic stem cell transplant. NHSE commissioning responsibility.
Brentuximab vedotin	Red	TA641 Brentuximab vedotin in combination for untreated systemic anaplastic large cell lymphoma. NHSE commissioning responsibility.
Gilteritinib	Red	TA642 Gilteritinib for treating relapsed or refractory acute myeloid leukaemia. NHSE commissioning responsibility.

Entrectinib	Red	TA643 Entrectinib for treating ROS1-positive advanced non-small-cell lung cancer. NHSE commissioning responsibility.
Entrectinib	Red	TA644 Entrectinib for treating NTRK fusion-positive solid tumours. NHSE commissioning responsibility.
Daratumumab with lenalidomide and dexamethasone	Black	TA634 Daratumumab with lenalidomide and dexamethasone for untreated multiple myeloma (terminated appraisal)
Ramucirumab with erlotinib	Black	TA635 Ramucirumab with erlotinib for untreated EGFR-positive metastatic non-small-cell lung cancer (terminated appraisal)
Eculizumab	Black	TA636 Eculizumab for treating refractory myasthenia gravis (terminated appraisal)
Ranibizumab	Black	TA637 Ranibizumab for treating diabetic retinopathy (terminated appraisal)
Norditropin	Amb SCP	Second line reserved for unacceptable stinging affecting compliance. See Paediatric SCP.
Sumatriptan 3mg/0.5ml	Black	Due to lack of evidence
Treclin	Green	In line with SCAN guidelines
Daratumumab subcutaneous (Relapsed myeloma)	Red	NHS E commissioned (under CDF) IV already NICE approved
Dolutegravir and Lamivudine (Dovato®) (HIV)	Red	NHS E commissioned
Remdesivir (COVID-19)	Red	In line with current national advice on eligibility

Miscellaneous

a) Ranitidine switch protocol

The updated switch protocol was circulated to members for approval and further comments. Final version included note that PPIs can be used in renal impairment (but not ITN) and linked directly to pdf of CAS alert advice.
The protocol is now available on ClinOx as part of supply issues page.

b) Withdrawal of Priadel

The manufacturers of Priadel (lithium carbonate) have issued notice that the product will be withdrawn with supplies expected to last until April 2021. This has also been confirmed in a supply disruption notification advising about switches. Priadel is the most common brand of lithium prescribed in Oxfordshire (around 1,000 patients) and the rest of the country and the withdrawal is likely to involve a lot of work switching patients (especially as alternatives are not completely equivalent) as well as the worry for

patients and the cost impact. Paper prepared tries to go through these issues (originally produced by Derbyshire CCG) and asks some questions to decide on next steps.

Main issues will be what to recommend switching to, how to do this to ensure supply chain i.e. staggered switch not all at once, how to communicate this to patients and how to plan for additional cost (will be in year) and likely to be somewhere up to £400k.

Lots of discussion at OH but told to hold as potential national guidance. DoH tried to discuss with Essential Pharma, but no progress. Ideally would like a national approach so having been waiting for this, a London Trust has started writing some guidance which could get adopted nationally. Need to stop starting new patients on Priadel from now, need to get guidance out there as soon as possible. Likely to use Camcolit as most similar dosing options. It was noted there has been some stockpiling and shortages, however there has since been a cap on ordering put in place.

Suggested the protocol should cover OUH switching in acute care as well. Noted that lithium is often stopped when people come in from emergency care or planned care anyway, so opportunity to restart on a new brand. Confirmed that Camcolit and Priadel are the same product so could be a direct switch, but some will need to change dose slightly as different strengths available.

Suggested we keep comms team and patient services up to date as patients will be concerned. We will also need to initiate a group to work on this as soon as possible.

c) MicroGuide Update

Genital tract infections section has been reviewed and updated - no significant changes.

Update of foreword to make it clear broad spectrum can be used if indicated but consider CDI risk (reports of previous foreword meaning GPs thought should never use ceph, quin co-amox).

Some data for info on use of the app/web browser across the region - increasing in July from June. However, note that the planned retirement of the pdf version has been postponed due to the survey results suggesting people still not as aware of Microguide as we would like. The results of survey will be shared at the next meeting. No specific date now for full changeover but do APCO have any thoughts? Is there more we can do to promote it? It has been in prescribing points, LPC newsletter and mentioned at prescribing meetings as part of report

RMOC (Regional Medicines Optimisation Committee)

None

Shared Care Protocols (SCP)

Growth Hormone Shared Care Protocol

This is an update to the protocol written in 2012. The indications/doses and responsibilities remain the same. Changes include:

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

- Table of costings has been removed as was out-dated

First line option in omnitrope which has a really good device, but does need to be refrigerated. Other first line is genotropin which doesn't need to be refrigerated so may fit in to lifestyle better.

- Norditropin has been added as an option, reserved for "unacceptable stinging affecting compliance" (it has different additives so doesn't sting like the others). This is current practice, however most patients are fine with Omnitrope so only 1 or 2 a year use this.
- Saizen is much more expensive so really only now justifiable in major compliance issues, as it records when the injection is given. Very rarely started in patients. Add a note to the formulary to say this is rarely used.
- Formatting changes to bring in line with new shared care protocols

Noted that norditropin is not on OUH formulary so would need to add to OUH formulary.

It was noted that the medication is delivered by healthcare at home for Oxfordshire patients, so the GP does the first prescription, this needs to be clarified. Thyroid function test is actually done at 2-3 months by the specialist so this needs to be updated.

It was asked to make sure we can standardise where possible across CCGs. Bucks gets prescribed by specialist, was originally prescribed by GP but moved to specialist as GPs felt it was more appropriate. Huge cost implication to hospital, so shared the cost savings so hospital could increase pharmacy staff.

Guidelines

a) Oseltamivir for prevention of influenza and related morbidity in at-risk patients during outbreaks in care homes and similar settings: evidence summary and review of risk-benefits

GPs have concerned for many years about prescribing antivirals for flu outbreaks in care homes, so MP asked if we could add further information to the formulary.
Noted this year we have the additional pressure of COVID plus flu, which adds 10 percentage points to risk of death if combined. There is an important role for antivirals in treating flu and also huge benefits in transmission interruption as well when used for prophylaxis . The data presented in the paper shows meaningful reductions in morbidity and mortality. Guidance in PHE care home advice suggests going directly to a renal dose for elderly patients when renal function not known and avoids nausea s/e (unlicensed but nationally endorsed).

When there is an outbreak in a care home PHE alerts the CCG and GP practice and then they asses the need for antivirals. GPs have always been resistant to prescribing due to concerns of lack of evidence. This year we have concerns on how do we know whether it is a flu or covid outbreak. Confirmed that there is a pathway for sequential testing but need to question if this would allow them to treat within 48 hours. Need to try to strengthen the pathway for concurrent testing on a one swab one patient model. CW will update CCG with the information when available.

Clarified that majority of care homes do just have one practice. Each care home also gets an MDT meeting which lends itself to one GP per home.

Stated at the moment oseltamivir is brown on the formulary to be used in line with PH/NICE guidance. So this won't change, but can add information as a link to support GPs. Also add pathway when available.

In season and out of season needs to be clarified and differences during COVID. This information refers to in season or confirmed outbreak out of season.

Requested in terms of single swab are they in contact with OUH, a heads up means they can do them locally more easily.

Noted out of hours issues. Confirmed all 25 pharmacies as part of palliative care scheme will hold antivirals. Will all keep 3 boxes of each strength enough to give first dose to all patients. All those pharmacies have dedicated mobile to allow them to be contacted easily as well and some are extended hours.

It was asked what the advice is if no CMO declaration but do need to provide, confirmed we will make it clearer on formulary that it is ok to prescribe if PH declare an out of season outbreak.

Approved

Chair's Actions

As per formulary classifications