Oxfordshire Area Prescribing Committee (APCO)
Bullet Points
9th January 2018

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 decisions taken at APCO in January 2018.

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
Sarilumab for moderate to severe rheumatoid arthritis	Red	In line with NICE TA485
Aflibercept for treating choroidal neovascularisation	Red	In line with NICE TA486
Nivolumab for previously treated squamous non-small-cell lung cancer	Red	In line with NICE TA483 Commissioned by NHS E
Nivolumab for previously treated non-squamous non-small-cell lung cancer	Red	In line with NICE TA484 Commissioned by NHS E
Venetoclax for treating chronic lymphocytic leukaemia	Red	In line with NICE TA487 Commissioned by NHS E
Regorafenib for previously treated unresectable or metastatic gastrointestinal stromal tumours	Red	In line with NICE TA488 Commissioned by NHS E
Nivolumab for treating squamous cell carcinoma of the head and neck after platinum-based chemotherapy	Red	In line with NICE TA490 Commissioned by NHS E
Ibrutinib for treating Waldenstrom's macroglobulinaemia	Red	In line with NICE TA491Commissioned by NHS E
Atezolizumab for untreated locally	Red	In line with NICE TA492 Commissioned by

Drug	Traffic Light Classification	Rationale
advanced or metastatic urothelial cancer when cisplatin is unsuitable		NHS E
Cladribine tablets for treating relapsing–remitting multiple sclerosis	Red	In line with NICE TA493 Commissioned by NHS E
Palbociclib with an aromatase inhibitor for previously untreated, hormone receptor-positive, HER2-negative, locally advanced or metastatic breast cancer	Red	In line with NICE TA495 commissioned by NHS E
Ribociclib with an aromatase inhibitor for previously untreated, hormone receptor-positive, HER2-negative, locally advanced or metastatic breast cancer	Red	In line with NICE TA496 commissioned by NHS E
Vismodegib for treating basal cell carcinoma	Black	In line with NICE TA489
Naltrexone–bupropion for managing overweight and obesity	Black	In line with NICE TA494
Freestyle Libre	Amber continuation	To be initiated by diabetes specialist in line with commissioning policy statement and patient agreement forms (see further information below)
Trelegy Ellipta inhaler	Brown	To be used in line with local COPD prescribing guidance
Pramipexole	Amber continuation	For Parkinson's Disease in line with other Dopamine receptor agonists as per NICE NG71
Modafinil	Red	Excessive daytime sleepiness in people with Parkinson's disease as per NICE NG71
Rivastigmine	Amber continuation	For Parkinson’s disease dementia as per NICE NG71
Perindopril arginine	Black	Recommendation from NHSE as part of Items which should not routinely be prescribed in primary care: Guidance for CCGs. Use equivalent dose of perindopril *erbumine* instead
Fumaderm	Black	Replaced by licensed Skilarence for psoriasis
Rupatadine tablets	Black	In line with discussion APCO November 2017 and Guideline for Spontaneous Urticaria ± Angioedema in Adults
Gemcitabine	Red	pancreatic cancer- NHSE commissioned
Paclitaxel	Red	pancreatic cancer- NHSE commissioned
Sorafenib	Red	Hepatocellular carcinoma- NHSE commissioned
Cetuximab	Red	Squamous cell cancer of the head and neck- NHSE commissioned

Drug	Traffic Light Classification	Rationale
Trastuzumab emtansine	Red	Breast cancer
Human normal immunoglobulin - Cuvitru®	Red	Replaces Subcuvia
Subcuvia	Black	Being discontinued
Etelcalcetide	Red	Hyperparathyroidism - NHS E commissioned

Miscellaneous

Melatonin SCP
Final draft has been approved by CRG. CRG asked if APCO would consider a patient agreement. It was felt that the shared care protocol document should already be shared with patients and this would therefore act as a patient agreement.

Eplerenone
Following the last APCO meeting, where it was agreed to offer this as 1st line MRA to young (under 65) male patients to reduce the risk of cardiovascular mortality and morbidity in stable patients with LVSD and clinical evidence of heart failure after recent MI instead of spironolactone to reduce the risk of side effects, it had been raised whether this should be extended to all relevant patients as this is the licensed product for this indication. This would cost approx. an extra £1500 and would need to go back to MMTC as it was discussed there initially. It was felt that it was difficult to limit this to a particular age group when it is the licensed product unless there is good evidence. APCO would support extending to all relevant patients

Eluxadoline
Gastro have been asked about whether they anticipate using this and for how many patients as is a NICE TA. No current plans to use specifically so numbers likely to be small. Currently classified as amber continuation, but no indication for a guideline associated with this. MHRA alert published in December about risk of pancreatitis and gastro team have agreed to make sure this is in patient discharge or outpatient letters.

Shared Care Protocols (SCP)

Dalteparin (minor review)
Discussed due to confusion caused by dalteparin being classified as amber or red for use in pregnancy depending on VTE risk level. High risk patients need to be prescribed an initial dose by the GP before seeing a specialist and is therefore amber for these patients but red for intermediate risk patients. The committee were asked to consider how this can be made clearer. It was reported that there has been a discussion around the proforma (MMRA) that Kiren Collison has created with the LMC. Noted that this is a 6 page document and felt that it would be better if the proforma was in two parts identifying which parts are essential for the GP to do immediately at the first consultation (i.e. VTE risk) and the rest can be done by the Midwife.

It was agreed that that the formulary classification will remain as amber for high risk and red for intermediate risk, but that there would need to be more clarification of the reasons for this on the formulary and mentioned in the proforma. This would also need to go back to LMC

Sacubitril Valsartan – progress update

An audit has been completed as 1 year since prescribing under shared care began with this drug. The Heart failure team were originally unsure about patient numbers but data has shown that only 60 patients have been referred for consideration, switching from an ACE inhibitor to Sacubitril Valsartan. Around half of these referrals were from Cardiologists and the rest from Community Heart Failure Nurses.12 patients optimised on the highest dose they could tolerate and discharged. 38 were thought to be suitable in the future. 5 patients out of the 60 did not tolerate the switch, 5 patients are under active review currently and in the process of up-titration.

NICE guidelines suggest that this drug can be used for patients with injection fraction of 35% or less. Within the research trial, at a certain point, patients were included with a 40% injection fraction or less and then changed it to 35% to capture the highest risk group for the analysis. Patients with an injection fraction of 40% or less has severe LV diastolic function therefore both Cardiologists at OUH feel that this should be offered to patients with an injection fraction of 40% or less. In this group of 60 that would have meant another 2/3 patients.

It was agreed that APCO would accept the recommendations of the consultant cardiologists and the injection fraction level would be changed to 40% or less on the shared care protocol.

Primary care pathway for foreign visitors (all ages) taking ADHD medication
This paper was originally presented at CRG and APCO have been asked for an opinion before moving forward. LMC have commented '*Not necessarily accepting diagnosis that might be poorly established seems reasonable to me'*.
Noted that this is a specific problem in Oxford and other areas don't appear to require this pathway.
It was asked if anyone in the CCG is linked to the universities. It was confirmed that no one is specifically linked. It was reported that the Oxford University website does state if you are on regular medication you should bring medication with you but this does not cover short stay students or their dependents.

CRG also queried the contact phone number. It was confirmed that this is the number for the co-ordination centre and this should be manned 24/7. On this line you would not speak to a clinician initially but would be triaged to the relevant service/clinician.
The committee agreed that this phone number is sufficient and the document was approved.

Guidelines

Freestyle Libre
This is a flash glucose monitoring system which allows people with diabetes to check interstitial glucose levels and trends without regularly performing capillary (fingerprick)

testing. The sensors were added to the drug tariff in November 2017 and the CCG, GPs and the specialists have received a lot of patient enquiries. There is a potential big cost impact for commissioners. Good evidence of patient outcomes is not available, there are more trials ongoing but nothing published as yet however it is felt that this system will be revolutionary for patients. OCCG had started trying to work up a policy across the Thames Valley for consistency. It went to TVPC who have created a draft protocol. APCO were asked to comment on the draft policy

It was discussed that one of the key items to review were the costings to agree whether funding the sensors will be affordable for the CCG.
If every type 1 patient received this there would be £1.3m – £2.5m potential excess cost. The proposal is that the sensors will be classified as amber continuation with OUH being the gate keepers, assessing patients and deciding if appropriate. Consultants have been asked to give approx. patient numbers.

Based on these numbers, prescribing additional cost impact of £166k - £334k depending on how often the cohort of patients are currently testing. There will be some savings to the system on avoided pump use.

Potential for avoided activity but no evidence of impact on DKA admissions and no evidence on improved HBA1C due to a lack of data. Difficult to know if there will be a benefit in the long term.

The committee was asked to review the draft policy and the patient agreements and approve or suggest any changes In addition to specialist and patient feedback in the submission paper. Feedback from Diabetes UK was also noted.
There were concerns expressed that there is no additional funding available in the prescribing budget and will mean savings on other prescribing items to be able to go ahead as potential costs could be very high. It is acknowledged that patient numbers must reflect specialist estimates to ensure affordability. Acknowledged that there has been good engagement from specialist teams and that draft policy has robust criteria. It was noted that OCCG expect the patient numbers to increase gradually as patients will be initiated at routine appointments only
It felt that children would benefit from the use of this device and the committee were advised that the paediatric consultant would ideally like all children to have access to this but has provided smaller numbers, cost is approx. 150k for children (Freestyle libre is not licensed for children under 4)
It was commented that this has potential to produce whole system savings in the long term if managed correctly. The committee were advised that data would go into a national audit and figures would be provided in the long term. There would be a potential to track savings in the future. It was suggested that numbers should be monitored every 6 months on ePACT.
It was noted that the patient agreement forms set out standards and expectations with the patients that should restrict use to those who need it and only continued if benefit is shown. Committed utilisation of these will ensure managed uptake and discontinuation. It was also felt that this should be incorporated into the wider strategy for diabetes care.

The committee agreed that there were no issues with the policy or the patient agreements and will support their use.

Medicines Optimisation Team
APCO Bullet Points January 2018
Recommendations ratified at OCCG Clinical Ratification Group (February 2018)

Decision made to go ahead with this policy if consultants are advised that data will be reviewed every 6 months and national audit data will be reviewed.

Chair's Actions

All included in traffic light update