**Oxfordshire Area Prescribing Committee (APCO) Bullet Points 10th November 2016**

Prescribing Points and the Traffic light system are available on the OCCG website-link below. These bullet points summarise the decisions taken at APCO in November 2016.

**Local Guidance: Traffic Light Document**

The classifications are:

- Red List – Specialist Prescribing Only
- Yellow (Near Patient Testing LES) – Transfer of prescribing to primary care in line with Shared Care Protocol. Monitoring in Primary Care
- Yellow – Transfer of prescribing to primary care. Monitoring in secondary care
- Yellow Continuation List – Appropriate for continuation in primary care following specialist recommendation
- 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 |
|---|---|---|
| Secukinumab | RED | TA407 for ankylosing spondylitis |
| Aflibercept | RED | TA409 for Branch Retinal Vein Occlusion |
| Certolizumab pegol | RED | TA415 for treating rheumatoid arthritis after inadequate response to a TNF-alpha inhibitor |
| Crizotinib | RED | TA406 for anaplastic lymphoma |
| Pegaspargase | RED | TA408 for acute lymphoblastic anaemia |
| Talimogene laherparepvec | RED | TA410 for unresectable metastatic melanoma |
| Radium 233 dichloride | RED | TA412 for hormone relapsed prostate cancer |
| Elbasvir–grazoprevir | RED | TA413 for treating chronic hepatitis C |
| Osimertinib | RED | TA416 for treating locally advanced or metastatic EGFR T790M mutation-positive non-small-cell lung cancer |
| Necitumumab | BLACK | TA411 for advanced/metastatic squamous NSCLC |
| Cobimetinib | BLACK | TA414 in combination with vemurafenib for treating unresectable or metastatic BRAF V600 mutation-positive melanoma |
| BD Viva pen needles | GREEN | 1st line choice for insulin pen needles along with GlucoRx needles |
| All other insulin pen needles | BROWN | BD Viva and GlucoRx are 1st line choice for insulin pen needles |

**Oral Nutritional Supplements (Sip Feeds)**

A proposal for the reduction of sip feed prescribing was presented to APCO. Two options, which were previously presented at OCCG Savings Taskforce, were discussed:

(1) To work collaboratively with the dietitians (and possibly CCG to employ its own dietitian) to reduce sip feed prescribing both by controlling the requests for sip feeds on hospital discharge prescriptions and reviewing patients currently taking sip feeds in the community

(2) To black list sip feeds in primary care except for very exceptional circumstances.

The two options were discussed in detail. Concerns were raised by OUH regarding the impact of stopping sip feed prescribing in the community on increased hospital admissions and increased length of hospital stay. Option 2 was considered to be very difficult to implement as it was felt that black listing sip feeds would not be appropriate in all patients. All the members of APCO were in agreement that option 1 (i.e. to work with the dietitians) was preferred. It was agreed that a 'Task and Finish' group be set up with representatives from OCCG, OUHFT and OHFT in order to progress this work quickly and collaboratively and that it should be reviewed in 6 months. Until this work is done, APCO did not support an interim statement making sip feeds a low priority for prescribing in primary care. It was therefore recommended that the traffic light status of sip feeds should remain as it is for now (i.e. BLACK for patients in care homes only) but that all sip feeds might be recommended to be traffic lighted as BROWN in future once it has been clarified which patients would fit into the exclusion criteria.

**BD Viva Pen Needles**

A paper was presented to APCO to propose that BD Viva Pen Needles are the 1st line choice of insulin needles along with GlucoRx needles (already 1st line choice in Oxfordshire). The reason for an additional first-line option is that some patients have commented that the GlucoRx needles are painful to use and break more easily than other brands. The cost is £5.36 for 90 i.e. the same price as GlucoRx so there should not be a cost implication. The addition of BD Viva Needles as first-line option was accepted by APCO.

## Shared Care Protocols (SCP)

**Sacubitril Valsartan**

Sacubitril valsartan has been approved by NICE (TA 388) for patients with New York Heart Association class II to IV heart failure symptoms, left ventricular ejection fraction of 35% or less and taking a stable dose of an angiotensin converting enzyme inhibitor (ACEi) or an angiotensin receptor blocker (ARB).

A SCP presented to APCO by OUH outlines a suggested pathway for identifying patients suitable for therapy. The proposal is that sacubitril valsartan therapy would be initiated by the hospital heart failure (HF) team during an out-patient clinic approx. 4 weeks post discharge, if the patient is stable. Treatment would be reviewed at regular intervals by the HF team and the dosage up-titrated as appropriate. It is proposed that once patients are stabilised on the maximum tolerated dose of sacubitril valsartan, the HF team would refer the patient back to the GP for prescribing of on-going treatment under the terms of the SCP. APCO expressed concerns that sacubitril valsartan is a new drug for which there is minimal clinical experience of its use. It was commented that it is currently unclear who will derive benefit from this treatment and that it is essential for GPs to have adequate support when taking on shared care. It was proposed that sacubitril valsartan remains RED (secondary care prescribing only) for 6

months to provide time to gain local experience with this black triangle drug, to collect more information and to allow the new Heart Failure Consultant to come into post. This proposal was agreed

**Action: Continue to traffic light as RED and review in 6 months. OUH to collect information during this time**

## Local guidelines

### Type 2 diabetes blood glucose management in adults

New guidelines to give GPs guidance on prescribing blood glucose lowering medication in type 2 diabetes were presented to APCO. The guideline includes a table with information regarding the advantages and disadvantages of each treatment, long-term safety data, use in renal impairment, OCCG traffic light status and cost. The guideline emphasises the importance of individualisation of treatment and there is guidance regarding proper titration of metformin, typically the first-line choice. There is a section about “Practical Management Points”. The guidelines were accepted by APCO with minor amendments

### Self-monitoring of blood glucose (SMBG)

A paper was presented to APCO concerning SMBG. The table and supporting document are an update of previous guidelines published in Prescribing Points in 2013.The update was completed to take into account the new meters and the variety of cost-effective strips now available. The paper was accepted by APCO

### Gonadotropin-releasing hormone (GnRH) analogues in prostate cancer

A paper was presented to APCO for the use of GnRH analogues in prostate cancer, advising the use of triptorelin SR 22.5mg 6 monthly where appropriate. This is not new advice; it was advocated in Prescribing Points in 2013 and 2014. The guidelines were accepted. The Medicines Optimisation Team will consider how to support practices in switching patients onto triptorelin 22.5mg.

### Migraine: acute therapy guidelines (adult)

Updates to the guidelines written by Dr Richard Wood, CCG lead for neurology in 2015 were presented to APCO. The updates include advice about the restriction of the use of the combined oral contracetive pill in patients suffering from some types of migraine. The updated paper was accepted with some minor amendments.

### Proposal for optimising self-care through appropriate use of over-the-counter medicines (OTC)

A proposal was presented to APCO for optimising self-care through appropriate use of OTC medicines. Two options were presented:

*Option 1:* keep current system (long-standing Lavender Statement in Oxfordshire saying that medicines which can be bought OTC should be considered low priority for prescribing) but need to promote again and further raise awareness.

*Option 2:* update the policy statement in order to promote self-care and reduce unnecessary GP appointments. The message would be linked to the “Choose Well” campaign which encourages self-care where appropriate.

The advantages and disadvantages of the two options were discussed. For option 2, a new policy could include a statement outlining a “Restricted Prescribing List” and recommend that all treatments on this list should be considered a low priority and classify all associated products as BROWN on the Oxfordshire traffic light system i.e.

drugs which should only be prescribed in restricted circumstances. A list of examples for inclusion in Option 2 was provided in the paper. GPs could still use their discretion where they consider there are exceptional circumstances or patient factors (e.g. an unsupported patient with advanced dementia, someone with learning difficulties, extreme hardship) when they would prescribe for these patients. APCO members agreed that Option 2 was preferred with some amendments.

**Guidance on the prescribing of liothyronine**

Guidelines for liothyronine were presented to APCO. Spend on liothyronine was approx. £500k in 2015/16. Discussions with the endocrinologists revealed that liothyronine should be reserved for specific groups of patients, e.g. patients with thyroid cancer whilst they are receiving radioactive iodine post-surgery and the small group of patients who do not tolerate thyroxine replacement. These patients would be expected to be managed by the endocrinologists. The guidelines contain advice about switching patients from liothyronine to levothyroxine. The Medicines Optimisation Team could support practices with switching patients from liothyronine to levothyroxine. The guidelines were accepted with a few amendments.

**Jane Bennett and Odelia Eke (November 2016 APCO recommendations ratified at December OCCG Clinical Ratification Group)**