Oxfordshire Area Prescribing Committee (APCO)
Bullet Points
11th September 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 discussions and decisions taken at APCO in September 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
Ivabradine for Heart Failure	Amber Continuation	Previously amber SCP. To use in line with updated amber continuation guideline
Rifampicin for bone infections	Amber SCP	Bone infections clinic to provide first four weeks of treatment course. Course to be continued by GP for up to 6 months (individual treatment plans will be provided for each patient) To be prescribed in line with SCP
Actipatch electromagnetic pulse therapy patches	Black	Lack of good evidence for effectiveness
Etoricoxib for pain relief in patients with an inherited bleeding disorder	Amber Continuation	Initiated by haemophilia clinic. Prescribe in line with Amber continuation guideline. GP will need to check BP prior to month 2 prescription
Donepezil, galantamine, rivastigmine for the treatment of Alzheimer's disease	Amber continuation	Following recommendation by specialist or clinician with specialist expertise in line with NICE NG97.
Memantine for the treatment of Alzheimer's disease	Amber continuation/brown	AMB C for new patients – Following recommendation by specialist or clinician with specialist expertise in line with NICE NG97. Brown for patients already on AchE

Drug	Traffic Light Classification	Rationale
		inhibitors – Can be started in primary care without the need for specialist advice.
Dalteparin for DVT (out of hours)	Brown	In line with DVT service specification, one off initial dose only if presentation of DVT outside of DVT clinic hours
DOACs (apixaban) for DVT (out of hours)	Brown	In line with DVT service specification, one off initial dose only if presentation of DVT outside of DVT clinic hours
Ixekizumab for treating active psoriatic arthritis after inadequate response to DMARDs	Red	In line with NICE TA537
Atezolizumab for untreated PD-L1-positive locally advanced or metastatic urothelial cancer when cisplatin is unsuitable	Red	NHS E commissioning responsibility. In line with NICE TA492
Pembrolizumab for untreated PD-L1-positive locally advanced or metastatic urothelial cancer when cisplatin is unsuitable	Red	NHS E commissioning responsibility. In line with NICE TA522
Niraparib for maintenance treatment of relapsed, platinum-sensitive ovarian, fallopian tube and peritoneal cancer	Red	NHS E commissioning responsibility. In line with NICE TA528
Crizotinib for treating ROS1-positive advanced non-small-cell lung cancer	Red	NHS E commissioning responsibility. In line with NICE TA529
Pembrolizumab for untreated PD-L1-positive metastatic non-small-cell lung cancer	Red	NHS E commissioning responsibility. In line with NICE TA531
Lenvatinib and sorafenib for treating differentiated thyroid cancer after radioactive iodine	Red	NHS E commissioning responsibility. In line with NICE TA535
Alectinib for untreated ALK-positive advanced non-small-cell lung cancer	Red	NHS E commissioning responsibility. In line with NICE TA536
Nivolumab for treating locally advanced unresectable or metastatic urothelial cancer after platinum-containing chemotherapy	Black	In line with NICE TA530
Cenegermin for treating neurotrophic keratitis	Black	In line with NICE TA532
Human papillomavirus vaccine – MSM	Red	NHS E/PHE funded Specialist Sexual Health Services and HIV clinics.
Letrozole (fertility)	Red	Second line ovulation induction treatment for patients that have unsuccessful clomiphene citrate ovulation induction or are intolerable to the side effects of clomiphene citrate.

Drug	Traffic Light Classification	Rationale
Menotrophin (fertility)	Red	To induce ovulation in women who have not successfully recruited a follicle using other ovulation induction methods, and in male subfertility, to treat hypogonadotrophic hypogonadism to stimulate spermatogenesis.
Tiopronin (for Cystinuria)	Red	Specialist only
Emicizumab (for Haemophilia)	Red	Specialist only
Dupliumab (for Eosinophilic asthma)	Red	FOC medicine following trial use in small group of pts
Dupilumab for treating moderate to severe atopic dermatitis	Red	In line with NICE TA534
Cefazolin (for Staph infections)	Red	Unlicensed. Micro ID use only
Renacet (calcium acetate)	Amber Continuation	Addition to formulary in addition to Phosex. Phosex supply difficulties due to limitation of suppliers to pharmacies.
Oilatum® Scalp Treatment Shampoo and E45® dry scalp shampoo	Brown	Can be purchased over the counter, in line with Clinical Commissioning Policy 88D. No prescribing except where required for a chronic skin condition or for skin care in the elderly who would otherwise be at risk of skin breakdown
CoaguChek INR self testing strips	Brown	Information added to formulary on criteria for use: Restricted to patients who meet the following criteria: • To be on long-term oral anticoagulation. • To have sufficient eye sight to enable them to use the coagulometer. • To be sufficiently dextrous to carry out self-testing. (Training may be considered for patient carers or next of kin who meet the eye sight and dexterity criteria.) • To have GP support for the prescribing of strips. • To already be dosed by the Oxfordshire Anticoagulation Service (JR, Churchill or Horton hospitals).

Drug	Traffic Light Classification	Rationale
		• To be able to afford the coagulometer (about £500 for the CoaguCheks and approximately £20 for enough quality control solutions for approximately one year, not including the training programme). The patient would have to receive suitable training to carry out self-testing and this would normally be provided by the hospital anticoagulation service if self-testing is agreed appropriate.
BD autoshield needles for use by school staff	Brown	Exception to current formulary status of black for small number of primary school age children requiring insulin injections given by school staff and equipment supplied by GP (as per LEA agreement)

Miscellaneous

Heart Failure Guidance

This guidance was discussed at APCO in May, however has been on hold as there is an outstanding query around AKI. It has been requested that this be published as it is and accepted that the AKI advice for HF is different from the general primary care AKI bundle guidance. It is the AKI guidance that is more likely to be changed, not the HF guidance. It would be helpful to get the HF guidance published as soon as possible, as it is relevant to HF audit work being completed in some practices currently. It was agreed that, a line can be added about the difference between the HF AKI advice and other available protocols (due to cohort of pts) to the guidance. Also consider seeing if the pop ups on clinical system can be adjusted. APCO approved for publication subject to amendment.

Shared Care Protocols (SCP)

Ivabradine for Angina SCP

Resubmission with a number of changes; most notable is that titration responsibility will stay with secondary care. The bradycardia section has been clarified and reformatted as agreed in July APCO. Discussed that if patient develops AF ivabradine should be stopped (currently says consider risks of continuing but HF document says stop) Confirmed that ivabradine is not a first line therapy, it is for those who are struggling and the aim is to gain symptom control. Ivabradine has never caused concern or issue, and is safer that beta blockers. APCO approved for publication subject to amendment about AF.

Ivabradine for HF

Resubmission – changed from a SCP to amber continuation protocol. Main change concerns that fact that OUH and OH teams act as one MDT, therefore guidance reflects

that it is one team. Responsibilities section reflects that OH HF team can request initiation of therapy as well as OUH. Bradycardia issue has been addressed and APCO agree this is much clearer. It was requested that CrCl is changed to eGFR (eGFR less than 30). It was queried if this was affected by body weight, however APCO clarified happy with eGFR. It was confirmed a proportion of people with HF or Angina will develop in to AF so would stop in this case. APCO approved for publication subject to amendments above.

Oral antibiotics for the management of Bone and Joint Infections – adult patients SCP

Resubmission from July APCO. Clinically very similar, but is now in a SCP format. Agreement with OUH the specialist will prescribe for the first 28 days and will follow up at 6-8 weeks. Discharge will happen at end of treatment. Now that it is a SCP, GPs will be able to access funding from the NPT LES. Funding will be delayed as will need to be added in to NPT LES. Amoxicillin is included for completeness, but main focus is rifampicin. Wording around shared care to be updated in line with new national guidance. It was suggested a table explaining what to do if blood results are abnormal be added and questioned if the monitoring was to do with drug or disease. Confirmed monitoring was for drug and that table would be added.
Approved by committee via email following addition of above tables

Management of Patients with Essential Thrombocythaemia with hydroxycarbamide SCP

Resubmission from last meeting. Original protocol had a lot of referral/investigation information not normally included in an SCP. Extra info has been removed and will be put in to a guideline. Added in warnings around strengths. It was requested that definition for neutropenia be included –clinicians to be directed to the dose adjustment flowchart. Agreed to update the final page with the list of people involved in developing the protocol as is outdated. APCO approved

Hydroxycarbamide for myeloproliferative disorders SCP

Same as above. Agreed that SCP wording will be updated on both. Approved.

Guidelines

DPP4i Switch Protocol

Alogliptin is the first line DPP4i in Oxfordshire, as it is the most cost effective. It is priced 16-20% lower than the other DPP4i. From ePACT data, we can see that Sitagliptin is the most commonly prescribed, therefore by switching there are savings in the region of £130k to be made. Along with OCDEM and the community diabetes team we have amended the PrescQIPP Switch Protocol for use in Oxfordshire. The switch was mentioned in our annual prescribing report and meetings, and will be supported by a Prescribing Points bulletin.

It was noted that this would be a switch for savings and therefore would need to be carefully explained to the patient as will involve an extra blood test. Suggested could provide patient template letters giving explanation. Noted that alogliptin has been first

line choice for some time. It was also suggested that the new medicines service (NMS) could be used for the initial check of side effects after the switch.
It was also raised that part of this process should also be ensuring the patient is on an effective treatment and this may mean switching to a different drug. It was highlighted that the switch criteria does state that HbA1c should have reduced by 0.5% over 6 months on a DPP4i and if this has not occurred then therapy should be stopped, reviewed and alternative glucose lowering agents should be considered. It was agreed that this area should be made more prominent. It was clarified that an extra drop in HbA1c is not expected on switching between DPP4i agents.
Approved subject to changes noted above.

Migraine – acute treatment and prophylaxis
Resubmission from last meeting which addresses actions. Some of the changes were significant.

- Acute treatment guideline, IM prochlorperazine - APCO agreed wording is an improvement on previous version. Queried use of buccastem, it was confirmed the rapid release formulations can be used and is noted in the guidance.
- Migraine in Pregnancy guideline link has been added to both guidelines.
- Amended that amitriptyline is licensed for migraine but, nortriptyline is not
- Sodium Valproate for women of child bearing age will be traffic lighted as red for migraine prophylaxis in line with the sodium valproate pregnancy prevention programme.

In the lifestyle advice section, it was questioned whether Co-enzyme Q had any evidence. Confirm that either there is evidence from a good source or remove. Also, it was requested that it was made clear that acupuncture is not on NHS. Suggested to change wording to ‘self-help therapies’.
APCO approved subject to amendments.

Migraine in pregnancy
Resubmission from July APCO. Has been rewritten quite extensively taking into the comments from the previous meeting and the table forming the basis of most of the previous version being removed. Still some outstanding comments that require a decision:
Guideline uses expert opinion that NSAIDs can be taken between 12-24 weeks only, which differs from national guidance which states up to 28 weeks. APCO happy that this is expert opinion as it is more cautious.
The prevention therapy section has been changed to say the OUH obstetricians are content for GPs to prescribe prophylaxis without referral but can provide advice if necessary, it was questioned whether caveats were needed around more complex patients. APCO did not feel this was necessary. Queried where advice about aspirin was taken from and it was confirmed that this is expert opinion from Neurology and foetal medicine.
APCO agreed that, in this form, the guideline would be helpful for an area of prescribing where there is limited information. APCO approved.

Ocular Lubricants patient information leaflet
Resubmission from July APCO. Leaflet has been reworked by the comms team with input from Medicines Optimisation.

A change was requested to state patients can get advice on dry eyes from their 'optician, pharmacist or GP' not just GP.
It was queried why the leaflet doesn't explain eye ointments for patients, picture for eye drops only. It was also noted that it doesn't mention that contact lens wearers should be seen by optician as symptoms could be of more serious disease. Can add the patient leaflet to EMIS library once ready, although note that this is a resource for self-care and pharmacy.
Approved subject to amendments

DVT documents update: D-dimer testing in DVT diagnosis
The OUH DVT clinic have raised the issue that D-dimer blood samples are not consistently being sent by GPs with patients who have had interim anticoagulation therapy. This applies to patients who cannot be seen in clinic in time to have ultrasound (US) scan within 4 hours.
The level of omitted blood samples is resulting in additional US scans being carried out at the clinic and therefore reducing clinic capacity.
On review of the associated OCCG resources it was felt that there was some potential confusion about GP responsibilities
Refined some of the wording in the dalteparin and DOACs documents, but doesn't change significantly. Suggesting a Brown formulary status for out of hours. Wording adjusted in guidance and added flow chart. Same was done for DOACs. It was raised that the the flow chart is not clear that the patient has to take the blood to the clinic with them. Agreed to add into flow chart. If phlebotomy service is not running, GP needs to take bloods. It was questioned how long the blood sample lasts, this needs to confirmed outside of the meeting. A number of other questions were raised about when dalteparin should be used and when a DOAC should be used for DVT. It was agreed that there needs to be a bigger piece of work to update and amalgamate current documents. To review both and bring back to a future meeting.
Agreed updates to guidance and formulary change with amendments discussed.

Chair's Actions

1. Tissue Viability dressing request form: There have been instances of delays occurring to patient treatment caused by confusion over certain types of dressings and the reasoning behind requests which have been appropriately made by the TVN and DN teams to GPs, as per the current formulary. A form has been developed to speed up the process of dressing acquisition via the FP10 route to ensure patients receive the treatment they require as soon as possible. This will not result in any change in the formulary or create an increase in spend.
2. Appliance Contractor Requests for Retrospective Prescriptions letter. The template letter for practices to send to appliance contractors who request prescriptions retrospectively has been updated with slightly amended wording to reflect similar letters used by other CCGs. The general message remains the same, that a contractor should not supply a product in advance of receiving a prescription unless it is considered an emergency supply.