Oxfordshire Area Prescribing Committee (APCO)
Bullet Points
13th March 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 March 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
Golimumab for treating non-radiographic axial spondyloarthritis	Red	In line with NICE TA497 (Fast track 30 day implementation)
Lenvatinib with everolimus for previously treated advanced renal cell carcinoma	Red	In line with NICE TA498. NHSE commisioned
Glecaprevir–pibrentasvir for treating chronic hepatitis C	Red	In line with NICE TA499. NHSE commissioned
Ceritinib for untreated ALK-positive non-small-cell lung cancer	Red	In line with NICE TA500. NHSE commissioned
Ibrutinib for treating relapsed or refractory mantle cell lymphoma	Red	In line with NICE TA502 . NHSE commissioned
Pirfenidone for treating idiopathic pulmonary fibrosis	Red	In line with NICE TA504. NHSE commissioned
Ixazomib with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma	Red	In line with NICE TA505. NHSE commissioned
Sofosbuvir–velpatasvir–voxilaprevir for treating chronic hepatitis C	Red	In line with NICE TA507. NHSE commissioned
Pertuzumab with trastuzumab and docetaxel for treating HER2-positive breast cancer	Red	In line with NICE TA509. NHSE commissioned

Drug	Traffic Light Classification	Rationale
Strimvelis for treating adenosine deaminase deficiency–severe combined immunodeficiency	Red	In line with NICE HST7. NHSE commissioned
Fulvestrant for untreated locally advanced or metastatic oestrogen-receptor positive breast cancer	Black	In line with NICE TA503
Lesinurad for treating chronic hyperuricaemia in people with gout	Black	In line with NICE TA506
Abidec oral drops	Green	For pre-term infants (under 34 weeks) until 1 year old. Replaces Dalivit for this indication
Grazax – grass pollen extract	Black	Lack of evidence of efficacy
Olopatadine	Brown	Second line to sodium cromoglycate for allergic conjunctivitis
Nicotine replacement therapy (NRT), varenicline (Champix) and bupropion (Zyban)	Brown	Only to be used as part of the SLA with the new LSSS provider (see notes below)
Levosert	Green	For women requiring contraception for up to four years (see notes below)
Jaydess	Brown	As an alternative to Levosert/ Mirena if • the woman has previously used Mirena IUS and experienced –discomfort –unacceptable symptoms –troublesome (symptomatic) ovarian cysts • Loss of periods is unacceptable to the woman but heavy periods precludes use of copper IUD. • History of breast cancer (for consultation at specialist contraception clinic and following involvement of oncologist) • Woman wishes to avoid hormones because of unacceptable side effects with hormones previously. • Failure at time of fitting to dilate internal os sufficiently for Mirena Jaydess IUS may be fitted because of narrower diameter
Protopic	Amber C	For psoriasis of flexures/genitals in line with local psoriasis treatment pathway and NICE
Actinica lotion	Red	For daylight photodynamic therapy (PDT)
P20 cream (SPF 50)	Red	For daylight photodynamic therapy (PDT)
Sulphur hexafluoride (SonoVue) contrast media	Red	For enhancement of tissues/ blood vessels/ fluid on an ultrasound scan for children. Restricted to radiology

Miscellaneous

Mexiletine

More information was requested from OUH regarding a potential shared care protocol. They have been advised that it would be unlikely to be approved as a very specialist area, with small numbers of patients (around 5) who are seen regularly in clinic. This is also an unlicensed special so the costs are likely to be high. This has been halted.

COPD Guidance update

The committee was advised the joint respiratory prescribing group have requested that the ICS/LABA combination inhalers are kept on the COPD guidance for use in triple therapy following the addition of the single inhalers Trimbow and Trelegy. The single inhalers will, however, be first line and dual inhalers may be used if triple therapy is being trialed.

Shared Care Protocols (SCP)

Methotrexate – amendment to SCP for dermatology indications

It was reported that Dermatology have requested that the methotrexate Shared Care Protocol is updated to formalise what is current practice in Primary Care. This includes adding in some specific dermatology indications that are unlicensed but recommended by the British Association Of Dermatologist Guidelines on the use of methotrexate
Queried whether this was in line with how Methotrexate is currently used and it was confirmed that it was and that this formalises this.
Agreed.

Mycophenolate SCP - update

This has been amended to update the contraceptive information in line with the recent EMA recommendations.
Agreed.

Guidelines

Nicotine replacement therapy (NRT), varenicline (Champix) and bupropion (Zyban)

It was reported that since April 2013 GPs have prescribed NRT and the CCG has recharged this to Public Health.

As of 1st April there will be a new provider who will provide NRT to most patients directly, although some GPs will continue to prescribe. Proposed that all NRT products will be brown on the formulary only to be provided as part of SLA from the new smoking cessation provider
Remaining patients who aren't under the smoking cessation service would no longer have NRT prescribed, and that patients should buy over the counter as per the OCCG policy.

Noted that evidence suggests patients have a better success rate and are more likely to give up smoking with NRT if also receiving behavioural support. This is a change in model taking into account what service users want. It was queried what would happen with prescribing for other patients who want to give up smoking but do not want to attend groups due to location. It was confirmed that patients can access the smoking cessation service virtually either online or by phone.

It was queried the process for peri-operative patients requiring a potentially short term quit in preparation for an operation and whether or not they would still be offered NRT. It was confirmed that Oxfordshire County Council are working with OUH trust regarding peri-operative patients and how they can support as part of the new provider service. Also, that the new provider will help patients who would like to get at least a 4 week quit which will include peri-operative patients. It was agreed that a conversation would be required between OCC and OH as well.

The proposal to change the formulary classification to brown was agreed by the committee. Discussion around how best to communicate this with the GPs. It was also confirmed that smoking cessation service can be accessed by patients directly.

Levonorgenstrel intrauterine systems

The background on GP provision of IUS as part of LARC contract was given. Currently clinicians are free to choose which IUS device to use. OCC have reported that there is a very large amount of Mirena devices currently being used.

OCC would like to limit use of Mirena, and state that the contract is purely for contraceptive use only and not for other gynecological issues. If IUS is being chosen for contraception only the proposal is to use Levosert or Jaydess instead.

Mirena and Levosert are both licensed for heavy menstrual bleeding. Mirena is slightly narrower fit than Levosert (although difference is small) Mirena is licensed to be used for 5 years and Levosert is licensed to be used for 4 years. It is more cost effective to insert Levosert for 4 years and there is view to extending the Levosert license for 5 years. Levosert does not have a license for HRT.
It was discussed that, according to NICE guidance, up to 60% of patients do not keep the device in for the full term of the license length.
There is a £22 difference in cost between the Mirena and Levosert.per device. Cost per year of use (if used for full licensed term) is £16.50 for Levosert and £17.50 for Mirena. If extended to 5 year license the cost will go down to £13.20 per year for the Levosert. There are approximately 2500 devices fitted per year. Suggested that Levosert be added to the formulary and Mirena removed for patients on a contraception only basis.

It was reported that there could be savings of £50,000 per year on a rolling basis if the devices on the formulary are amended. This is purely on device costs.
The committee felt that this was a difficult decision to make due to all of the variables and the wider issues of women's health. It is difficult to separate patients by contraceptive use and gynecological reasons for use as there is often some cross over.

There was some discussion on funding responsibility for women who have Mirena devices fitted for either Heavy Menstrual Bleeding (HMB) or HRT (Hormone Replacement Therapy), with or without contraception. It was noted that the commissioning side of this will be discussed outside of APCO. APCO are asked to make a formulary decision on the available IUS devices.

It was queried how the head to head data on Mirena and Levosert compared as far as patient experience was concerned. It was explained that it was the same and the trials had been conducted mainly in the USA with a large number of patients (although 5 year license in place there)
It was noted that the main issues of concern were the license length and separating contraception from other medical conditions and how the formulary choices can remain to support women across the system
OCC reiterated that their contract is purely for contraceptive use, however it was raised that patients do not tend to present requiring just contraception and that these devices are also used to control periods and that is why a GP may suggest this as a form as contraception
It was noted that Levosert is an equivalent device and should not cause any issues with patient safety. There was concern however that clinicians may be choosing the 'wrong' device for particular patients if feel have to use Levosert. This is because of length of license. Also noted that FSRH guidance does suggest that Mirena (and not Levosert) can be used for longer than 5 years in women over 45
It was suggested that the choice of both devices remain on the formulary and that this be reviewed once more information and data has been obtained including if any of the licences have been extended.

OCC proposed that Mirena is red for gynecological indications but concern that this would not be practical and therefore a funding solution will need to be found to ensure it is still available in primary care for those patients that require it.
It was queried whether there would be a cost for medical staff to be trained on inserting the Levosert device. It was thought that training probably wouldn't be required but could be provided if needed as experienced IUS fitters shouldn't have any problems with inserting Levosert.

It was noted that the proposed deadline for public health funding for fitting of Mirena coils is 4th April. It was noted that patients are being booked in now for fitting of Mirena coils and therefore practices will need information quickly to plan for appointments

The committee agreed to add Levosert to the formulary for women who want contraception for up to four years only. This would be green. Jaydess would be added as brown as an alternative to Levosert with specific criteria.
It was agreed that Mirena would stay on the formulary and OCCG and OCC will discuss funding of Mirena devices.

Psoriasis pathway for primary care
APCO requested that Dermatology put together a psoriasis treatment pathway based on NICE following the addition of Enstilar to the formulary. A comprehensive document has been received and all of information in the pathway is based on NICE and NICE

CKS guidance. A GP who has an interest in Dermatology within OCCG has also reviewed it and thought it was a useful document
There are a couple of issues raised:

- There is a line that states 'choose an emollient that the patient likes'. This needs to be amended to say 'choose an emollient according to current OCGG guidelines'.
- There were a number of products where, according to self-care OTC policy patients would be encouraged to purchase. Reference need to be added to the policy for these products.

In 'flexures and genitals' and 'face' sections the pathway recommends Protopic preparations. Currently the formulary only has this as amber for Atopic Dermatitis. Formulary amendment will be required to include this indication. Also, suggested that this also needs to state not to put protopic on broken skin.

The committee agreed to the above amendments to the pathway as long as this is worded in line with NICE guidance

Lipid Modification Guidance (update)
This is an update of the current guidance. There are a couple of amendments.
The latest recommendations from NICE Clinical Guideline 71 Familial hypercholesterolaemia (FH): identification and management (November 2017), to help identify people at increased risk of coronary heart disease as a result of having FH have been included, the new QRISK3 tool has been taken into account, the new PCSK9 inhibitors have been referenced and Omega-3 fatty acid capsules have been removed from the guideline in line with the NHSE 'Items which should not routinely be prescribed in primary care: Guidance for CCGs and NICE 'do not do''. It was noted that the guideline should still reference that Omega 3 should not be prescribed in the 'do not do' section.
The committee agreed to these amendments

Glaucoma and Ocular Hypertension treatment guidelines (Topical products)
The committee were advised that there have never been any formal guidelines for Glaucoma at OUH.
OUH have produced these guidelines to support decision making. Products on the guidelines have been chosen in line with NICE guidelines in a stepwise approach. It was noted that the products chosen reflects what is currently happening in primary care.

Latanoprost & Timolol combination is not recommended although there is some prescribing in primary care OUH would be happy for an auto switch to be put in place either to separate products or to Duotrav. OCCG GPs confirmed that they would be happy with this if they had sufficient documentation for the switch. This will be added to the guideline

It was suggested it would be helpful to add in trade names of the products as a key at the bottom of the document. It was also noted that Beta-blockers should be listed as contraindicated in asthma rather than caution-

The committee agreed the guideline subject to the amendments above.

Chair's Actions

Rivaroxaban is now licensed for use when extended prevention of recurrent DVT and PE is indicated (following completion of at least 6 months therapy for DVT or PE). The recommended dose is 10 mg once daily (in addition to the old 20mg daily dose). The DOACs for Treatment and Secondary Prevention of DVT and PE guideline has been updated to reflect this. OUHFT has also updated their MIL on VTE