BNSSG Joint Formulary Group
Meeting held on: Tuesday 10th April 2018
Conference Room, Level 5, South Plaza

Minutes

Present:

Shaba Nabi	SN	Public Health Consultant, Bristol City Council GP Clinical Lead for Prescribing
Sasha Beresford	SB	Principal Pharmacist, UHBristol NHS Foundation Trust Deputy HoMM, NHS Bristol CCG
Dan Stephens	DS	GP, North Somerset Medicines Management Pharmacist
Tash Mogford	TM	Rotational Pharmacist (observing), UHBristol NHS Foundation Trust Interface Pharmacist, BNSSG CCG
Angela Stinchcombe	AS	Consultant Neurology Physician, NBT Deputy HoMM, NHS North Somerset CCG
Emily Knight	EK	Formulary and Interface Pharmacist, NBT Interface Pharmacist, BNSSG CCG
Lynn Martin		Rotational Pharmacist (observing), NBT Formulary Pharmacist, AWP Deputy Lead Pharmacist, Weston General Hospital

Apologies:

Helen Wilkinson	HW	Deputy HoMM, NHS South Gloucestershire CCG
Debbie Campbell	DC	Deputy Director of Medicines Optimisation Consultant Renal Physician, and Joint D&TC Chair, NBT

1 Welcome, Apologies and Declaration of Interests

Declarations of Interest

None

2 Minutes of the meeting of 16th January 2018 and Matters arising

The minutes from the Joint Formulary Group (JFG) meeting on the 16th January 2018 had been circulated by EK following the meeting. The minutes were approved.

Matters arising from 16th January 2018 meeting

2.1 Action log

Further information has been supplied by the applicant for TLS change for dymista nasal spray. TM has presented the information in a SBAR.

2.2 Medications of low clinical value

TM presented a briefing paper for medications of low clinical value at BNSSG STP meeting. The paper was then taken to a polypharmacy STP meeting which is acting on the suggestions. MP raised the question regarding RMOC and how RMOC to be fed into the JFG. DC, CD and VH are members of RMOC. The RMOC is reviewing liothyronine.

3 NICE New Technology Appraisals

Published

3.1 Fulvestrant for untreated locally advanced or metastatic oestrogen-receptor positive breast cancer (TA 503) Not approved

3.2 Ibrutinib for treating relapsed or refractory mantle cell lymphoma (TA 502) TLS red

3.3 Intrabeam radiotherapy system for adjuvant treatment of early breast cancer (TA 501) Not approved

3.4 Ceritinib for untreated ALK-positive non-small cell lung cancer (TA 500) TLS red

3.5 Glecaprevir-pibrentasavir for treating chronic hepatitis C (TA 499) TLS red

3.6 Lenvatinib with evorolimus for previously treated advanced renal cell carcinoma (TA 498) TLS red

3.7 Golimumab for treating non-radiographic axial spondyloarthritis (TA 497) TLS red

3.8 Sofosbuvir–velpatasvir–voxilaprevir for treating chronic hepatitis C (TA 507) TLS red

3.9 Lesinurad for treating chronic hyperuricaemia in people with gout (TA 506) Not approved

3.10 Ixazomib with lenalidomide and dexamethasone for treating relapsed or refractory multiple myeloma (TA 505) TLS red

3.11 Pirfenidone for treating idiopathic pulmonary fibrosis (TA 504) TLS red

3.12 Daratumumab monotherapy for treating relapsed and refractory multiple myeloma (TA 510) TLS red

3.13 Pertuzumab with trastuzumab and docetaxel for treating HER2-positive breast cancer (TA 509) TLS red

3.14 Autologous chondrocyte implantation using chondrosphere for treating symptomatic articular cartilage defects of the knee (TA 508) TLS red

Adopted into the BNSSG Joint Formulary – January/February 2017

- Immunosuppressive therapy for kidney transplant in children and young people (TA 482) TLS red
- Immunosuppressive therapy for kidney transplant in adults (TA481) TLS red
- Tofacitinib for moderate to severe rheumatoid arthritis (TA480) TLS red
- Reslizumab for treating severe eosinophilic asthma (TA 479) TLS red

- Brentuximab vedotin for treating relapsed or refractory systemic anaplastic large cell lymphoma (TA478) TLS red
- Autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee (TA477) TLS red
- Regorafenib for previously treated unresectable or metastatic gastrointestinal stromal tumours (TA488) TLS red
- Venetoclax for treating chronic lymphocytic leukaemia (TA487) TLS red
- Aflibercept for treating choroidal neovascularisation (TA486) TLS red
- Sarilumab for moderate to severe rheumatoid arthritis (TA485) TLS red
- Nivolumab for previously treated non-squamous non-small-cell lung cancer (TA484) TLS red
- Nivolumab for previously treated squamous non-small-cell lung cancer (TA483) TLS red

4 New Drug Requests (NDRs)

SUMMARY

4.1 Apixaban-adult patients requiring anticoagulation following mitral valve repair and tissue mitral valve replacements (unlicensed).

The evidence for the unlicensed use of apixaban for mitral valve repair and tissue mitral valve replacements is very limited. Warfarin which is licensed for this indication has more evidence. Apixaban is more expensive than the cost of warfarin. The JFG decided there was insufficient evidence to support the addition onto the formulary.

4.2 Fobumix Easyhaler (budesonide/formoterol) - treatment of asthma.

Fobumix Easyhaler is comparable to DuoResp Spiromax or Symbicort Turbohaler. The group thought the three strengths of Fobumix Easyhaler gave greater flexibility for the management of both asthma and COPD patients. Fobumix Easyhaler is slightly cheaper compared to DuoResp Spiromax and Symbicort Turbohaler. The JFG agreed for inclusion onto the formulary, TLS green, with removal of DuoResp Spiromax.

Decision Criteria used by JFG for NDR

- Patient safety
- Clinical effectiveness
- Cost effectiveness or resource impact
- Strength of evidence
- Place in therapy relative to available treatments
- National guidance and priorities
- Local health priorities
- Equity of access

Full Discussion

4.1 Apixaban for adult patients requiring anticoagulation following mitral valve repair and tissue mitral valve replacements.

Please see application form for full details. TM presented the application.

The application is for the unlicensed use of apixaban for patients undergoing mitral valve repairs and tissue mitral valve replacements. A dose of 5mg twice day for six months in patients with sinus rhythm and long-tem in patients with AF would be prescribed. Apixaban is currently on the formulary for several licensed indications including; AF (non valvular), treatment/prophylaxis of PE/DVT and prophylaxis of VTE post knee/hip replacement surgery. Currently on the formulary for patients undergoing mitral valve repairs and tissue valve replacements there is warfarin, which is licensed.

Apixaban is not on any other formularies for this indication. There is no NICE guidance. In 2017 European and US guidelines all recommend the use of warfarin as anticoagulation to prevent thrombus in patients undergoing bioprosthetic mitral valve replacement.

The applicant states the advantage of apixaban compared to warfarin is that apixaban does not need INR monitoring. This results in a reduction in patient discomfort, hospital stay and hence a reduction in healthcare costs and patient inconvenience.

The evidence submitted by applicant is the ENGAGE-AF TIMI 48 trial. This evidence and other evidence were reviewed by public health. The primary objective of the trial was to determine whether edoxaban is noninferior to warfarin for the prevention of stroke and systemic embolism. A post hoc subgroup analyses of the trial showed that in valvular heart disease, the efficacy and safety of edoxaban compared to warfarin were similar.

The only directly relevant evidence of efficacy comes from a small retrospective observational analysis which investigated 73 patients receiving a range of NOACs for AF after bioprosthetic valve implantation, 4 were taking apixaban. The only other data specifically involving apixaban at the time of surgery comes from animal models and with different valves involved.

The applicant states the evidence for warfarin is not from RCTs, however the evidence available is greater than for any NOAC let alone apixaban in this group of patients.

The main side effect of anticoagulants is bleeding. Apixaban has less incidences compared to warfarin. The cost of a box of apixaban is £53.20, compared to 80p for a box of warfarin. The dose of warfarin varies depending on INR, affecting the cost. Warfarin has the additional cost of INR monitoring. There is no literature available for the cost of INR monitoring.

<u>Discussion</u>

The group discussed why apixaban has been chosen for this indication rather than other NOACs. There are other trials ongoing for use of apixaban for other types of valve but not for mitral valve repairs and tissue valve replacements. KG there was a trial for rivaroxaban which was stopped early because it was found to be inferior to warfarin. SB raised that the use of apixaban for this indication was discussed at a UHB MAG meeting and whether it is being used at UHB. KG apixaban not being prescribed for this indication as far as pharmacy aware.

Based on the evidence provided, there is not sufficient evidence to support the use of apixaban for this cohort of patients. The 2017 US and European guidelines all recommend use of warfarin as anticoagulation to prevent thrombus in patients undergoing bioprosthetic mitral valve replacement.

- **Patient safety** – The main side effect of anticoagulants is bleeding. Apixaban causes less bleeding than warfarin. No long-term safety for this cohort of patients.
- **Clinical effectiveness** – The only directly relevant evidence comes from a small series of patients receiving a range of NOACs.
- **Cost effectiveness or resource impact** – Apixaban tablets are more expensive, compared to warfarin. The impact of warfarin also involves the cost of INR monitoring. No literature is available for the cost of monitoring.
- **Strength of evidence –** Relevant evidence comes from a poor quality, retrospective observational analysis of a small series of patients receiving a range of NOACs. Only four of these received apixaban.
- **Place in therapy relative to available treatments** – Warfarin which is licensed is currently on the formulary for this indication.
- **National guidance and priorities** – No national guidance directly relevant to this specific population. European and US guidelines all recommend use of warfarin as anticoagulation to prevent thrombus in patients undergoing bioprosthetic mitral valve replacement (BPV).
- **Local health priorities** – Low. However would impact on the need for INR monitoring.
- **Equity of access** – No other formularies have apixaban for this indication

The evidence for the unlicensed use of apixaban for mitral valve repair and tissue mitral valve replacements is very limited. Warfarin which is licensed for this indication has more evidence. Apixaban is more expensive than the cost of warfarin. The JFG decided there was insufficient evidence to support the addition onto the formulary.

Action:

1. ***TM*** *to inform applicant.*

4.2 Fobumix Easyhaler (budesonide/formoterol) - treatment of asthma.

Please see application form for full details. AS presented the application.

The application is for the addition Fobumix Easyhaler for the management of asthma. The components of Fobumix Easyhaler, budesonide and formoterol are already on the formulary. The inhaler is a combination of ICS and LABA. Fobumix is comparable to DuoResp Spiromax or Symbicort Turbohaler. The easyinhaler comes in three strengths, compared to the other preparations which have two strengths. This means Fobumix Easyhaler has greater flexibility when stepping patients up and down.

Fobumix Easyhaler is licensed for both asthma and COPD for adults. The application is for use in just asthma to prevent confusion for clinicians. On the formulary there are other easyinhalers for, beclomethasone and salbutamol. Adding Fobumix Easyhaler would mean patients do not need to change device when inhalers are being changed improving compliance.

Fobumix is slightly cheaper than DuoResp Spiromax and Symbicort Turbohaler, £12.60 compared to £13.05 and £13.07.

Discussion

SB raised whether Fobumix Easyhaler should just be added onto the formulary for asthma or to include COPD aswell. Respiratory nurses will probably want to use the inhaler for COPD. The application was for asthma on the request of secondary care clinicians with the view it would be easier for the asthma and COPD guidelines. The group thought that in primary care there is an overlap of asthmatic and COPD patients and therefore difficult to separate the conditions. If it was approved for asthma there would be a demand for COPD. The group agreed Fobumix Easyhaler

should be added onto the formulary for both asthma and COPD.

KG raised if any inhalers could be removed. On the BNSSG Asthma Prescribing Guidelines there is a SABA turbohaler and an ICS turbohaler. There is no ICS only inhaler or reliever inhaler in the spiromax device. The intention is to remove the DuoResp Spiromax from the guidelines leaving the full range of medications as either the Easyhaler or Turbohaler.

- **Patient safety** – Fobumix Easyhaler has the same contra-indications as other fixed dose budesonide/formoterol combinations
- **Clinical effectiveness** – Fobumix is comparable to DuoResp Spiromax or Symbicort Turbohaler.
- **Cost effectiveness or resource impact** – Fobumix Easyhaler is slightly cheaper (£12.60) compared (£13.05 and £13.07) DuoResp Spiromax and Symbicort Turbohaler.
- **Strength of evidence –** Evidence from pharmacokinetic bioequivalence studies and in vitro-in vivo correlation modelling.
- **Place in therapy relative to available treatments** – Fobumix Easyhaler is an alternative fixed combination budesonide and formoterol inhaler, available as an Easyhaler.
- **National guidance and priorities** – NICE inhaled corticosteroids for the treatment of chronic asthma and in children aged 12 years and over.
- **Local health priorities** – Effective management of COPD and asthma is a local priority.
- **Equity of access –** Many other formularies have Fobumix Easyhaler.

Fobumix Easyhaler is comparable to DuoResp Spiromax or Symbicort Turbohaler. The group thought the three strengths of Fobumix Easyhaler gave greater flexibility for the management of both asthma and COPD patients. Fobumix Easyhaler is slightly cheaper compared to DuoResp Spiromax and Symbicort Turbohaler. The JFG agreed for inclusion onto the formulary, TLS green, with removal of DuoResp Spiromax.

Action:

1. ***TM*** *to inform applicant*

2. ***TM*** *to include on the formulary and to remove DuoResp spiromax*

5 Shared Care Protocols/TLS status

5.1 Dymista Nasal Spray SBAR

Application for change of TLS was reviewed at the November JFG meeting. The group thought there was not significant evidence to demonstrate the advantages of the combination product compared to the individual sprays. Further evidence such as how many patients get referred by G.P.s to secondary care and what are the advantages of using the combination product compared to the individual components was needed.

The applicant provided further information to support the TLS change. TM presented the SBAR with the additional information. JFG discussed the extra evidence and felt it did not demonstrate dymista nasal spray to be more effective than other nasal sprays on the formulary or reduce referrals. There was also no evidence to show dymista nasal spray will not be prescribed first line by GP. The group felt a pathway is needed for rhinitis.

Action:

1. ***TM*** *to inform applicant.*

5.2 Quinagolide TLS change from red to amber

JFG felt further information such as monitoring and licensing was required from the applicant to confirm quinagolide is suitable for TLS change.

Forms for change of Traffic Light Status to be amended to include monitoring for primary and secondary care. If known the reason why medication is the current TLS to be added.

Action:

1. ***TM*** *to obtain more information from applicant then change TLS*

2. ***TM*** *to amend TLS form*

5.3 Testosterone undecanoate (Nebido) SCP

The group discussed the issues regarding taking blood tests in primary care. The group felt clarification of timeframe for testosterone monitoring is required.

Action:

1. ***TM*** *to contact the applicant for further information and upload SCP.*

5.4 Testosterone (Sustanon) SCP

As for the SCP for testosterone undecanoate clarification of timeframe for testosterone monitoring is required.

Action:

1. ***TM*** *to contact the applicant for further information and upload SCP.*

5.5 Azathioprine SCP and advise sheet

SCP and advise sheet agreed

Action:

1. ***TM*** *to upload SCP and advise sheet*

5.6 Hydroxychloroquine SCP and advise sheet

SCP and advise sheet agreed

Action:

1. ***TM*** *to upload SCP and advise sheet*

5.7 Riluzole SCP up date

Information regarding liquid riluzole added to SCP. JFG agreed amendment.

Action:

1. ***TM*** *to upload SCP*

5.8 Modafinil TLS from red to amber and SCP

JFG agreed amendment of TLS from red to amber 3 months. The group felt the abuse potential should be added in the cautions or special information. The contraceptive advice

needed to be highlighted and information regarding higher dose contraceptive to be added.

Action:

1. ***EK*** *to change TLS and upload SCP once amendments made*

5.9 Levodopa, carbidopa and entacapone combined tablet SCP up date

JFG agreed amendments

Action:

1. ***TM*** *to upload SCP and advise sheet*

5.10 Entacapone SCP update

JFG agreed amendments

Action:

1. ***TM*** *to upload SCP and advise sheet*

5.11 For information only

- Apixaban dosing error in SCP corrected.
- Sevelamer SCP reviewed by specialist pharmacist. Only update required was the date of references.

6 Individual Funding Requests

Nil

7 Items for Discussion

7.1 Metolazone prescribing in primary care

TM raised that there has been an incidence when a GP has not prescribed a patient metolazone which was started at UHB. On the formulary metolazone is TLS blue, unlicensed for combination of a loop diuretic. The GP involved in the patient's care stated this was a drug that not many GPs will feel comfortable prescribing.

SN patients are normally followed up in the community by heart failure nurses but it would be an issue in areas without the nurses. KG to discuss with heart failure specialist nurse at UHB.

7.2 Fiasp

EK presented a clinical summary by consultant in diabetes and endocrinology, UBH, for fiasp (fast acting insulin aspart) for an additional group of patients. The additional cohort is a small number of type 1 diabetic patients that require multiple injections where post-prandial hyperglycaemia is a particular problem. The JFG felt the evidence for this cohort of patients was similar to the evidence for the cohort of patients already on the formulary such as type 1 diabetics with insulin pumps. The cost of fiasp is comparable with novorapid. The JFG agreed the use of fiasp for patients requiring multiple injections where post-prandial hyperglycaemia is a particular problem.

8 NDRs for October meeting (no papers, for information only)

a. Lecicarbon A suppository for chronic constipation

b. Melatonin for sleep disturbance in lewy body dementia

c. Adex gel for patients with dry skin conditions

9 AOB

RMOC formal minutes to be a standing agenda item.

Natasha Mogford
Interface Pharmacist
April 2018

BNSSG JFG

Action Log for 10th April November 2017

Date of Meeting	Minute No.	Subject	Action Required	Responsible Officer	Deadline	Date of Update	Update
17/9/17	4.2	Alteplase NDR	Ask applicants to bring back local audit data in 1 year for the group to review	EK	October 2018	Done	
16/1/18	5.4	Feraccru SCP	Contact specialist pharmacists to discuss change to amber 3 month	TM	February		Previous minutes of JFG reviewed agreed amber 1 month on Nov 2016. Confirmed GPs happy to review at 3 months.
16/1/18	5.5	Galantamine SCP	Clarify current pathway of reviews in first 3 months for amber 3 month memory drugs and email group with findings	EK	February	Emailed NS and SG GPs	In discussion with dementia leads
16/1/18	5.7	Rotigotine SCP	Convert current SCP to prescribing guidance and amend website	EK	February	Emailed applicant	Prescribing guidance done EK, agreed by neuro pharmacist
10/4/18	4.1	Apixaban NDR	Inform applicant	TM	May	Done	
10/4/18	4.2	Fobumix Easyhaler NDR	Inform applicant, add to website and remove DuoResp Spiromax	TM	May	Done	
10/4/18	5.1	Dymista Nasal	Inform applicant	TM	May	Done	

		Spray					
10/4/18	5.2	Quinagolide SCP	Contact applicant for more information, change TLS	TM	May	Done	
10/4/18	5.3	Nebido SCP	Clarify timeframes for blood tests, upload SCP	TM	May		Emailed consultant
10/4/18	5.4	Sustanon SCP	Clarify timeframes for blood tests, upload SCP	TM	May		Emailed consultant
10/4/18	5.5	Azathioprine SCP	Upload SCP and advise sheet	TM	May	Done	
10/4/18	5.6	Hydroxychloroquine SCP	Upload SCP and advise sheet	TM	May	Done	
10/4/18	5.7	Riluzole SCP	Upload SCP	TM	May	Done	
10/4/18	5.8	Modafinil TLS and SCP	Addition of abuse potential and information regarding higher dose contraception. Contraceptive advice to be highlighted. SCP to be uploaded when amendments made	EK	May		
10/4/18	5.9	Levodopa, carbidopa and entacapone combined tablet SCP	Upload SCP	TM	May	Done	
10/4/18	5.9	Entacapone SCP	Upload SCP	TM	May	Done	
10/4/18	7.1	Metolazone	To discuss with heart failure specialist nurse at UHB	KG	May		
10/4/18	7.2	Fiasp	To add additional indication to formulary website and inform applicant	EK	May	Done	

MEETING DATES 2018

All Tuesday meetings

Date	Cut off for NDRs and SCPs	Time	Venue
~~16th January (AM)~~	~~12th December~~	~~9:30 to 12:30~~	~~South Plaza, Conference room (5th floor)~~
~~27th February (PM)~~	~~16th January~~	~~14:00 to~~	~~Southmead, Pharmacy meeting room~~
~~10th April (AM)~~	~~27th February~~	~~9:30 to 12:30~~	~~South Plaza, Conference room (5th floor)~~
22nd May (PM)	10th April	14:00 to 16:30	Southmead, Pharmacy meeting room
26th June (AM)	22nd May	9:30 to 12:30	South Plaza, Bevan room (6th floor)
4th September (PM)	26th June	14:00 to 16:30	Southmead, Pharmacy meeting room
16th October (AM)	4th September	9:30 to 12:30	South Plaza, Conference room (5th floor)
27th November (PM)	16th October	14:00 to 16:30	Southmead, Pharmacy meeting room