NHS GRAMPIAN
Minute of Formulary Group Meeting held on Tuesday 19th January 2016
in the Aspen Room, Forest Grove House

PRESENT	**APOLOGIES**	**APPROVED**
Dr David Counter	Mr A Duncan	
Dr D Culligan	Mrs L Harper	
Ms A Davie	Mrs L Montgomery	
Ms F Doney	Dr W Moore	
Dr L Elliot	Mr M Paterson	
Dr C Hind	Dr A Sun	
Dr A MacDonald		
Professor J McLay (Chairman)		
Mr C Rore		
Mr R Sivewright		
Professor J Webster		

IN ATTENDANCE
Ms Kate Robertson, Secretary Formulary Team.

OBSERVERS
Ms Dawn Bruce, Specialist Pharmacy Technician, Pharmacy and Medicines Directorate.
Mrs Judith Jordan, Clinical Pharmacist Team Leader (Cancer), Aberdeen Royal Infirmary.
Ms Dayni McConnell, Rotational Pharmacist, Aberdeen Royal Infirmary.

ITEM	**SUBJECT**	**ACTION**

The Chairman opened the meeting and noted that a quorum was present before leading introductions and welcoming members and observers to the meeting.

WELCOME TO NEW MEMBER
Dr Louise Elliot joins the Group as a General Practitioner representative.

THANK YOU AND GOODBYE
Mr Alistair Duncan, in his absence, the Chairman thanked Mr Duncan for all of his work and wished him well in his new role as Specialist Palliative Care Pharmacist. Mrs Jordan will join the Group as the Pharmacy Secondary Care Representative from February.

Note some items were taken out of order.

1. APOLOGIES

Apologies for absence were requested and noted. **FD**

2. DRAFT MINUTE OF THE MEETING HELD ON THE 15TH DECEMBER 2015

The Group accepted the draft note of the meeting held on the 15th December 2015 as an accurate record of the meeting subject to minor typographical changes. **FD**

The approved final minute will be in the public domain within 21 days. **FTeam**

3. PRESENTATION – NONE

It was confirmed that an update regarding HIV medicines is planned for a future meeting. **FTeam**

4. MATTERS ARISING

4.1. DRAFT CODE OF PRACTICE FOR CONFLICTS OF INTEREST

The Grampian Medicines Management Group considered the draft code at its January meeting and an interim position was accepted. Advice regarding how long declarations will be retained and if there is a requirement to publish interests of immediate family and other closely connected people remains unanswered. Pending advice from Information Governance the interim position is that:

- the minimum disclosure period will be 12 months
- disclosures will remain in the public domain for a minimum of three years after the date of disclosure

ITEM	SUBJECT	ACTION

It was confirmed that the code applies to all members of medicines management groups. It is not known if there are plans to extend disclosure to all NHS Grampian clinicians.

5. FORMULARY GROUP DECISIONS DECEMBER 2015 – PUBLISHED 29/12/2015

The Group ratified the advice as published.

6. CMO(2012)1 REPORTING FOR SCOTTISH MEDICINES CONSORTIUM (SMC) ADVICE – 2015/16 YTD

It was confirmed that for the SMC accepted medicines published April 2015 to December 2015 the Formulary Group (FG) audit standard for CMO(2012)1 reporting was achieved for the following criteria:

- Local decision on SMC accepted medicine published within 90 days: 71 of 71 - 100%
- FG decision published within 14 days of the decision being reached: 71 of 71 - 100% (note the December advice was published at 14 days)

7. OTHER BUSINESS

7.1. NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (NICE) (MULTIPLE) TECHNOLOGY APPRAISAL GUIDANCE NO 373 - ABATACEPT, ADALIMUMAB, ETANERCEPT AND TOCILIZUMAB FOR TREATING JUVENILE IDIOPATHIC ARTHRITIS

The Group noted there is no material difference between the recommendations of NICE and SMC, and the local formulary recommendations are in line with the SMC advice. The Group ratified the NICE advice as published. **FTeam**

7.2. NICE (MULTIPLE) TECHNOLOGY APPRAISAL GUIDANCE NO 374 - ERLOTINIB AND GEFITINIB FOR TREATING NON-SMALL-CELL LUNG CANCER THAT HAS PROGRESSED AFTER PRIOR CHEMOTHERAPY

The Group noted the NICE recommendations for erlotinib and gefitinib for treating non-small-cell lung cancer that has progressed after prior chemotherapy. The SMC issued guidance on the use of erlotinib (SMC 220/05) in this indication in 2006. The MTA will be highlighted with the service to confirm that local use is in line with the MTA, and feedback will be brought to a future meeting. **JJ**

The Group ratified the NICE advice as published. **FTeam**

7.3. DISCONTINUATION OF DE-NOLTAB® 120MG - *HELICOBACTER PYLORI* RECOMMENDATIONS

Astellas discontinued De-Noltab® from the UK market at the end of December 2015. De-Noltab® (tri-potassium di-citrato bismuthate 120mg) is a Pharmacy medicine used off label as part of the second-line *Helicobacter pylori* eradication regimen following failure of standard regimens.
The Gastroenterology department wishes to substitute the bismuth content of De-Noltab® by using Pepto-Bismol® (bismuth subsalicylate) in the one-week quadruple therapy *Helicobacter pylori* regimen.

The Group noted that Pepto-Bismol® contains salicylates and the Summary of Product Characteristics recommends that care should be exercised in patients receiving drugs to thin the blood or therapy for diabetes or treatment for gout.

The Medicines Information department reviewed the risks of Pepto-Bismol® interacting with oral anticoagulants and it suggests that the risk of an interaction between bismuth subsalicylate and the new oral anticoagulants is minimal. No increased bleeding risk or direct interaction would be expected. However, there is a bleeding risk when used concomitantly with warfarin. If Pepto-Bismol® is used in these patients, the INR should be closely monitored during and after therapy. Furthermore, on a theoretical basis, the salicylate component of Pepto-Bismol® may interfere with the antiplatelet effects of aspirin, so caution would be required regarding the thrombosis risk of such individuals.

It was reported that Pepto-Bismol® is blacklisted and clarification is required from the Prescription Pricing Bureau if prescriptions issued in Primary Care will be paid. **FTeam**

The Group was minded to accept the off-label use of Pepto-Bismol® as part of a second-line

ITEM	SUBJECT	ACTION

Helicobacter pylori eradication regimen following failure of standard regimens, however the decision was deferred pending clarification regarding Primary Care reimbursement. **FTeam**

7.4. PRAXBIND® ▼ (LICENSED REVERSAL AGENT FOR DABIGATRAN)

There were no declarations of interest recorded in relation to this product.

It was confirmed that in December idarucizumab (Praxbind®) ▼, a specific reversal agent for dabigatran, was licensed and marketed in the UK. SMC advice is not available and it is not known if the company will submit to SMC. Normally Boards would consider licensed medicines not reviewed by SMC using the Individual Patient Treatment Request process, however, this process is not appropriate for drugs to treat medical emergencies.

It was reported, that due to the emergency nature of use, a decision was taken to stock Praxbind® ▼ in every hospital that accepts medical emergencies. It is restricted to hospital use only, limited to patients who have taken dabigatran in the last 48 hours, presenting with life/limb-threatening bleeding or requiring emergency surgery.

The Group supported the decision to stock Praxbind® ▼ noting that it will not be included on the formulary. **FTeam**

8. NEW PRODUCT REQUESTS

Items 8.1 and 8.4 were taken together.

8.1. FG1 SMC 966/14 - FLUTICASONE FUROATE/VILANTEROL 92/22, 184/22 MICROGRAMS INHALATION POWDER (RELVAR® ELLIPTA®) ▼ - ASTHMA

8.4. FGA 008/15 – BUDESONIDE/FORMOTEROL 160/4.5, 320/9 MICROGRAMS OF INHALATION POWDER (DUORESP® SPIROMAX®)

A member declared that a close family member has a personal specific interest in GlaxoSmithKline and took no part in decision-making.

The Group considered the submissions for Relvar® Ellipta® ▼ and DuoResp® Spiromax®, both combination inhalers containing a long-acting $beta_2$ agonist (LABA) and inhaled corticosteroid (ICS).

The Group noted:

- Relvar® Ellipta® ▼:
  - combines fluticasone furoate (ICS) and vilanterol (LABA) in a dry powder inhaler device, Ellipta®
  - is given as one inhalation once a day, which for some patients may improve adherence to treatment, however if a dose is missed the next dose should be taken at the usual time the next day
  - contains a new LABA, vilanterol, that is not available individually so introduction may require patients to change their LABA or ICS
  - the 92/22 strength product is licensed for the treatment of asthma and COPD and it is already included on the formulary for COPD
  - the 184/22 strength product is only licensed for the treatment of asthma
  - has a higher cost than some LABA/ICS combination products but costs less than Seretide® and Symbicort®
- DuoResp® Spiromax®:
  - is considered outwith remit for SMC
  - contains an ICS and LABA that are already included on the formulary - as the individual components and as a combination product
  - has a higher cost than some LABA/ICS combination products but costs less than the reference product Symbicort®
  - is similar to a pressurised metered dose inhaler, so it is a different delivery device to [Symbicort®] Turbohaler®

The Group noted that the introduction of the two LABA/ICS combination inhalers would provide additional cost-minimisation strategies for respiratory physicians and the Respiratory Managed Clinical Network (MCN).

ITEM	SUBJECT	ACTION

The Group accepted the local need for additional cost-effective LABA/ICS combination inhalers, however use is subject to inclusion in the Respiratory MCN framework for inhaled medicines commonly used in asthma and COPD.

SMC 966/14 - Fluticasone furoate/vilanterol 92/22, 184/22 micrograms inhalation powder (Relvar® Ellipta®) ▼ is included on the Grampian Joint Formulary for the indication in question; pending protocol.
Indication under review: the regular treatment of asthma in adults and adolescents aged 12 years and older where use of a combination medicinal product (long-acting beta$_2$ agonist and inhaled corticosteroid) is appropriate in patients not adequately controlled with inhaled corticosteroids and 'as needed' inhaled short acting beta$_2$-agonists.
There was no statistically significant difference between fluticasone furoate/vilanterol 92/22 micrograms daily and another inhaled corticosteroid/long acting beta$_2$ agonist combination (ICS/LABA) inhaler for 0 to 24 hour serial weighted mean forced expiratory volume in one second, at 24 weeks.
Some alternative ICS/LABA combination inhalers are available at a lower daily cost.
It was classified 1a – available for general use and 8e - treatment may be initiated in either hospital or community. Use is subject to inclusion in the Respiratory MCN framework for inhaled medicines. **FTeam**

Budesonide/formoterol 160/4.5, 320/9 micrograms of inhalation powder (DuoResp® Spiromax®) is included on the Grampian Joint Formulary for the indication in question; pending protocol.
Indication under review: adults 18 years of age and older only.

- **in the regular treatment of asthma, where use of a combination (inhaled corticosteroid and long-acting beta$_2$ agonist) is appropriate:**
  - **-in patients not adequately controlled with inhaled corticosteroids and "as needed" inhaled short-acting beta$_2$ agonists.**
    or
  - **-in patients already adequately controlled on both inhaled corticosteroids and long-acting beta$_2$ agonists.**

- **in the symptomatic treatment of patients with severe COPD (FEV$_1$ < 50% predicted normal) and a history of repeated exacerbations, who have significant symptoms despite regular therapy with long-acting bronchodilators.**

For asthma the DuoResp® Spiromax® 160/4.5 strength is licensed for both maintenance therapy and maintenance and reliever therapy regimes (same as Symbicort® SMART regimen).
It was classified 1a – available for general use and 8e - treatment may be initiated in either hospital or community. Use is subject to inclusion in the Respiratory MCN framework for inhaled medicines. **FTeam**

8.2. FG1 392/15 DOCETAXEL CONCENTRATE FOR SOLUTION FOR INFUSION - CASTRATION SENSITIVE METASTATIC PROSTATE CANCER

There were no declarations of interest recorded in relation to this product.

The Group considered the submission and evidence summary for the off-label use of docetaxel in combination with androgen-deprivation therapy for the treatment of castration-sensitive metastatic prostate cancer.

The Group noted:

- prostate cancer is the most common cancer in men and the average 5-year survival rate for men with metastatic prostate cancer is 30%; 10% will survive for at least 10 years
- docetaxel:
  - is an antineoplastic agent, a taxane
  - is licensed in combination with prednisone or prednisolone for the treatment of patients with hormone refractory (castration-resistant) metastatic prostate cancer and use for treating men with castration-sensitive metastatic prostate cancer is off-label use

- is given by infusion at a dose of 75mg/m^2 every three weeks for a total of 6 cycles and patients must have a performance status of 2 or less and no contraindications to docetaxel therapy
- patients with castration-sensitive metastatic prostate cancer are likely to be fitter than those that have progressed to the castration-resistant phase of disease
- androgen-deprivation therapy is continued throughout and after docetaxel therapy

The following points were noted:
Clinical effectiveness: randomised controlled trial data suggest that docetaxel improves overall survival and time to disease progression in men with castration-sensitive metastatic prostate cancer [compared to androgen deprivation therapy alone, docetaxel combined with androgen deprivation therapy improved overall survival by around 10 - 15 months; and time to disease progression was statistically significantly longer].
Cost effectiveness: there is no direct cost-effectiveness data (QALY) however the cost of treatment (cost per course and total cost for all patients) is relatively low. Although this is an additional cost (on top of current therapy) the actual direct medicine cost is low - docetaxel is available as a generic medicine and procurement discounts are available. This relatively low cost coupled with improved overall survival (in a potentially fitter patient group, i.e. more QALY gains) is likely to be within normal QALY thresholds.
Health Gain: based on local estimates approximately forty patients per annum would receive treatment, with the potential to improve overall survival and time to progression in a relatively fit patient group. No additional disbenefits were identified beyond the recognised adverse event profile of docetaxel.
Service impact: the direct drug costs are low but introduction will have a significant service impact [capacity] on the Pharmacy Aseptic unit and day chemotherapy unit. The off-label use of docetaxel will be confined to units specialised in the administration of cytotoxic chemotherapy and only administered under the supervision of a physician qualified in the use of anticancer chemotherapy.
Equity: the overall cost of treatment is low and it is not anticipated that there are any medicines coming to market for this indication in the near future. The off-label use of docetaxel in castration-sensitive metastatic prostate cancer is supported locally, nationally and internationally by uro-oncologists and accepting use within NHS Grampian will bring prescribing in line with other Health Boards in NHS Scotland.
Safety: No additional concerns beyond the recognised adverse events associated with docetaxel were identified.

The Group accepted the restricted local need for the off-label use of docetaxel in combination with androgen depravation therapy for the early treatment of castration-sensitive metastatic prostate cancer.

Docetaxel concentrate for solution for infusion is available for restricted off-label use for the indication in question.
Indication under review: in combination with androgen-deprivation therapy for the early treatment of castration-sensitive metastatic prostate cancer.
Restriction: the off-label use of docetaxel will be confined to units specialised in the administration of cytotoxic chemotherapy and only administered under the supervision of a physician qualified in the use of anticancer chemotherapy. Informed consent should be obtained and documented. It was classified 3b – licensed product requested for off-label use and 8b – recommended for hospital use only. **FTeam**

8.3. FGA SMC 1098/15 – Atazanavir/cobicistat (Evotaz®) ▼ film-coated tablets

There were no declarations of interest recorded in relation to this product.

The Group considered the SMC abbreviated advice document [SMC 1098/15] for Evotaz® ▼ a fixed-dose combination tablet that contains the antiviral agent, atazanavir, boosted by a pharmacokinetic enhancer, cobicistat. It is licensed to be used in combination with other antiretroviral medicinal products for the treatment of HIV-1 infected adults without known mutations associated with resistance to atazanavir.

ITEM **SUBJECT** **ACTION**

The Group noted that:
- cobicistat:
  - has no anti-viral activity
  - is an inhibitor of the cytochrome P450 CYP3A sub-family of metabolic enzymes, and a significant proportion of medicines are metabolised by the P450 enzymes
- the HIV clinicians requested that Evotaz® ▼ is included on the formulary but no stock held
- Evotaz® ▼ is not listed in the new British HIV Association guidelines, but for anyone on other medication which may interact with ritonavir, this combination may be a useful option

The Group accepted the restricted local need for the atazanavir/cobicistat (Evotaz®) ▼ as outlined in SMC 1098/15 without the need for a full submission.

SMC 1098/15 - Atazanavir/cobicistat 300mg/150mg film-coated tablets (Evotaz®) ▼ is included on the Grampian Joint Formulary for the indication in question; restricted use.
Indication under review: in combination with other antiretroviral medicinal products for the treatment of HIV-1 infected adults without known mutations associated with resistance to atazanavir. Pharmacokinetic studies have demonstrated that atazanavir plus cobicistat is bioequivalent (in terms of atazanavir exposure) to ritonavir-boosted atazanavir. For patients in whom atazanavir is an appropriate treatment, atazanavir/cobicistat (Evotaz®) ▼ provides a combination product at a small cost premium compared to ritonavir-boosted atazanavir. It is classified as 1b – available for restricted use under specialist supervision and 8b recommended for hospital use only. Therapy should be initiated by a physician experienced in the management of HIV infection. **FTeam**

9. SCOTTISH MEDICINES CONSORTIUM PROVISIONAL ADVICE – ISSUED JANUARY 2016

The Group noted the SMC provisional advice issued January 2016.

If published next month the negative SMC recommendation for eculizumab (Soliris®) SMC 767/12 and the non-submission statements for pixantrone (Pixuvri®) ▼ SMC 1138/16 and teduglutide (Revestive®) ▼ SMC 1139/16 will not be included on the Grampian Joint Formulary for the indications in question.

10. SCOTTISH MEDICINES CONSORTIUM PRESS STATEMENTS - PUBLISHED JANUARY 2016

The Group noted the SMC advice published January 2016.

The following SMC accepted medicines have not been processed within a 60-day timescale:
- SMC 1024/15 – Albiglutide (Eperzan®) ▼
- SMC 1110/15 – Dulaglutide (Trulicity®) ▼
- SMC 1109/15 – Netupitant/palonosetron (Akynzeo®) ▼
- SMC 482/08 – Sorafenib (Nexavar®)
- SMC 1114/15 – Tolvaptan (Jinarc®) ▼

Local advice for these medicines and indications will be included in the January 2016 decisions as "**not included on the Grampian Joint Formulary because clinicians have not responded to an invitation to apply for formulary inclusion for this medicine for the indication in question**." **FTeam**

SMC 1115/15 – USTEKINUMAB 45MG SOLUTION FOR INJECTION AND PREFILLED SYRINGE (STELARA®)

There were no declarations of interest recorded in relation to this product.

The Group considered the abbreviated SMC advice, SMC 1115/15, for ustekinumab for the treatment of moderate to severe plaque psoriasis. It noted that the licence [for both 45mg and 90mg] now extends to use in children from the age of 12 years, and that including it in the Grampian Joint Formulary, as per SMC 1115/15, will bring formulary approval in line

ITEM	SUBJECT	ACTION

with use in adults (18 years and older). There are no patients currently waiting for treatment but should it be required inclusion on formulary would prevent any delay in treatment.

The Group accepted the restricted local need for ustekinumab without the need for a full submission, noting that use will bring formulary approval in line with use in adults, and continued treatment should be restricted to patients who achieve at least 75% improvement in their Psoriasis Area and Severity Index (PASI 75) within 16 weeks.

SMC 1115/15 – Ustekinumab 45mg solution for injection and prefilled syringe (Stelara®) is included on the Grampian Joint Formulary for the indication in question; restricted use.
Indication under review: treatment of moderate to severe plaque psoriasis in adolescent patients from the age of 12 years and older, who are inadequately controlled by, or are intolerant to, other systemic therapies or phototherapies.
Restriction: continued treatment should be restricted to patients who achieve at least 75% improvement in their Psoriasis Area and Severity Index (PASI 75) within 16 weeks. Ustekinumab has previously been accepted for restricted use in adults for this indication. For the small number of adolescent patients weighing >100kg that require a dose of 90mg, a 90mg prefilled syringe is available at the same price as the 45mg prefilled syringe. It is classified 1b – available for restricted use under specialist supervision and 8b – recommended for hospital use only. Ustekinumab is intended for use under the guidance and supervision of a physician experienced in the diagnosis and treatment of psoriasis. **FTeam**

11. GENERAL INFORMATION FROM SMC JANUARY 2016 – NIL OF NOTE

12. DOCUMENTS FOR INFORMATION

Items 12.1 (Drug Safety Update December 2015) and 12.2 (Scottish Medicines Consortium: update for ADTCs January 2016) were noted.

13. AOCB

A member requested clarification on the formulary status of somatropin preparations on the formulary, this item will be brought to a future meeting. **FTeam**

DATE OF NEXT MEETING

The date of the next meeting was confirmed as Tuesday 16th February 2016 starting at 14.30 in the Aspen Room Forest Grove House.

CHAIRMAN'S SIGNATURE **DATE 16th February 2016**