Prescribing and Formulary Panel

Minutes of meeting held on Tuesday July 9th 2019

Old Board Room PEH

Members

Miss Geraldine O'Riordan, Prescribing Advisor and Chair (GOR)

Mrs Janine Clarke, Pharmacy Manager, HSC (JC)

Dr Julia Rebstein, Island Health Medical Practice (JR)

Dr Douglas Wilson, Queens Road Medical Practice (SW)

Dr Mike McCarthy, Healthcare Group (MMcC)

Dr Hamish Duncan, Medical Specialist Group (GO)

Dr Nikki Brink, Director of Public Health (NB)

Dr Peter Gomes, Medical Specialist Group (PG)

1: Absence/ Apologies for Absence

Drs Brink, Duncan and McCarthy

2: Minutes

The minutes of the previous meeting were approved.

3: Additions to the Prescribing List

- **Methadone**

The reintroduction of methadone has been considered by HSC and has received organisational approval, so now needs to be added to the Prescribing List. The current unsatisfactory arrangement with the use of twice daily unlicensed dihydrocodeine could not continue indefinitely. If approved, methadone would be used as part of a treatment and recovery programme. Prescribing and patient management will be done by the CDAT psychiatrist only. Methadone has an extensive evidence base, with 300 trails reported in the TA. Some pharmacies are now open seven days a week, so increased supervision will be possible and being a liquid the product itself will be far harder to divert.

After a discussion it was agreed that methadone be approved for use.

ACTION: GOR

- **Guanfacine**

This drug has been requested by a Consultant Psychiatrist at CAMHS. There was a suggestion that it is now recommended as first line non-stimulant agent for ADHD. However GOR said that she had been unable to find any evidence that this was the case. The evidence for the drug was not felt to be particularly strong and it is more expensive than atomoxetine. The latter is due to come off patent soon, so costs will fall significantly.

It was agreed, after a discussion, not to recommend it for addition to the prescribing list.

ACTION : GOR

- **Cladribine**

This product was requested by the Visiting Consultant Neurologist for a young female patient with a recent diagnosis of highly active severe relapsing remitting MS. Cladribine's use for her would be in accordance with the NICE TA and NHS England's Commissioning Policies for MS drugs. It is taken as two short (3 or 4 days depending on body weight) courses on two treatment weeks per year for years one and two. It is not required at all in years three and four. The other alternative for this patient would be ocrelizumab, which is infused according to a complex process requiring five and a half hours in secondary care. JC said that because cladribine is a cytotoxic, with an unusual dosing regimen, hospital dispensing would be safer. After a discussion it was agreed to recommend this drug for approval for Consultant Neurologist prescribing only and for PEH pharmacy dispensing only.

ACTION : GOR

- **Avibactam and Ceftazadime**

This product was requested by a Consultant Microbiologist for an inpatient currently being treated with ciprofloxacin for a Carbapenemase-producing Enterobacteria. Should this fail, he would like to use the Avibactam and Ceftazidime combination product (Brand name Zavicefta). Three studies in patients with a range of different severe infections reported that it was at least as effective as best available treatment. After a discussion it was agreed to add it to the Hospital Formulary.

ACTION : GOR

Matters arising

1. **Sildenafil for PAH.**

GOR said that Dr Anees has agreed to use generic Sildenafil 25 mg tablets for Pulmonary Arterial Hypertension (PAH) for cost reasons and in line with very common practice in the UK. The cost of 90 generic 25 mg tablets is £9 compared with £446 for 20mg tablets. GOR said that unlicensed drugs would usually not be approved, but that the Terms of Reference of the

Panel does allow for this when it is overwhelmingly in the public interest to do so. After a discussion it was agreed that the 20mg tablets would be removed from the Prescribing List and that 25mg generic sildenafil tablets be added for PAH.

ACTION : GOR

2. **Anticoagulation in AF**

The draft protocol plus a comparison of DOACs was circulated. The protocol included suggestions from Dr Patterson. The protocol, as discussed in June, involved swapping all patients on rivaroxaban and most on apixaban to edoxaban to part-fund an offer of edoxaban to all warfarin patients. This will only happen if edoxaban is licensed for their condition.

GOR said that experience from the UK was that renal function was a key concern with these drugs. The advice is that creatinine clearance should be calculated using the Cockcroft and Gault formula at the start of treatment and whenever there was reasonable concern that RF might have deteriorated. Dosing data were based on CrCl calculated using C and G in the trials and if another method was used patients could be under- or over-dosed. Primary care representatives felt that eGFR was more practical and that calculating CrCl was not realistic given the volume of patients and their very heavy workload. After a discussion GOR agreed to investigate a simple way of quickly calculating CrCl and to seek the advice of w Dr Mohammed, the Renal Consultant on the preferred method.

There were further concerns expressed about the treatment of DTEs. Edoxaban is licensed only after five days treatment with a LMW heparin. According to the present protocol rivaroxaban can be started on day 1 without the need for a LMW heparin. GOR agreed to investigate further and, if appropriate, to amend the DVT protocol.

ACTION : GOR

3. **EPACT data**

JR asked why EPACT reports were no longer being circulated and why and when this policy had changed. GOR explained that the NHSBSA no longer circulates paper reports on behalf of ESS of any kind, as the EPACT system has undergone a major change. Primary care were asked to advise what data they would like going forward and GOR agreed to accessing the figures directly from the new EPACT2 system and circulating them to the practices.

ACTION : GOR

6: Date of next meeting

Wednesday August 6th at 5pm in the Old Board Room.