NCL Joint Formulary Committee (JFC) Meeting

Minutes from the meeting held on Thursday 28th February 2013
in the Board Room, Floor 3, UCLP Building, Tottenham Court Road

1. Present:	Prof R MacAllister	RM	NCL JFC Chair
	Prof L Smeeth	LS	NCL JFC Vice Chair
	Dr B Coleman	BC	WH Deputy Chief Pharmacist
	Mr A Dutt	AD	NHS Islington, Head of Medicines Management
	Ms P Taylor	PT	NHS Haringey, Head of Medicines Management
	Dr R Urquhart	RU	UCLH Chief Pharmacist
	Ms S Drayan	SD	NMUH Chief Pharmacist
	Mr P Gouldstone	PG	NHS Enfield, Head of Medicines Management
	Dr A Tufail	AT	MEH DTC Chair
	Mr T James	TJ	MEH Chief Pharmacist
	Ms R Clarke	RC	NHS Camden, Deputy Head of Medicines Management
	Ms W Spicer	WS	RFH Chief Pharmacist
	Dr P Ancliff	PA	GOSH, DTC Chair
	Mr A Karr	AK	NCL Procurement Chair
	Dr C Stavrianakis	WZ	NHS Haringey, CCG
	Ms S Beecham	SB	Commissioning Support Unit
	Ms G Kuforiji	GK	BEH Mental Health Trust
	Ms R Dallmeyer	RB	Commissioning Support Unit
	Prof A Jones	AJ	UCLH & RFH Consultant Oncologist
In Attendance:	Ms K Chapman	KC	MEH Formulary Pharmacist
	Dr A Grosso	AG	UCLP Pharmacist
	Mr K Thakrar	KT	UCLH Formulary Pharmacist
	Dr R Yao	RY	Consultant Anaesthetist, BCF
	Mr M Wyke-Joseph	MWJ	NMUH Formulary Pharmacist
	Ms L Luk	LL	BCF Formulary Pharmacist
Apologies:	Mr G Irvine	GI	Lay Member
	Ms L Reeves	JC	C&I Mental Health Trust
	Dr E Boleti	EB	RFH Consultant Oncologist
	Mr TF Chan	TC	BCF Chief Pharmacist
	Dr R Fox	RF	RNOH DTC Chair
	Mr A Shah	AS	RNOH Chief Pharmacist
	Dr L Wagman	RU	NHS Barnet, CCG

2. Minutes of the last meeting

The following corrections were agreed:
Item 3.3. It was noted that membership of the NCLMMC includes the Head of Medicines Management from each PCT/CCG.
Item 5.1, 5.2 & 5.3. The minutes noted that a business case should be unnecessary since these medicines are either already commissioned within NCL or were considered cost neutral. However, it was the feeling of the primary care representatives that the remit of the JFC was to merely make a clinical recommendation concerning PbR-excluded medicines.
Item 12. The "LPC" should be termed "LMC".

3. Matters arising

3.1 NOAC choice

The Committee agreed to re-visit the NOAC issue once the commercial state of play with apixiban was known although it was agreed that this should be placed on the March 2013 agenda regardless.

4. Members & applicants declarations of conflicts of interests

AT has attended advisory boards for Novartis (manufacturer of ranibizumab), Bayer (UK marketer of aflibercept) and was the chief investigator for the non-pharmaceutical sponsored ABC Trial [the first RCT evaluating the role of bevacizumab in wet AMD].

5. New medicine applications

5.1 Hyperbaric prilocaine (Mercury) for spinal anaesthesia

Applicant (Trust)	Presented by	Outcome
Dr Yau (BCF)	AG	Approved under an evaluation

The Committee focused on a single centre, non-industry sponsored, double-blind, randomised study in 88 patients. Eligible patients were aged 18 to 75 years and were undergoing day-case surgery, using spinal anaesthesia, of the lower limbs lasting for a maximum of 45 minutes.

Patients were randomised to receive prilocaine hyperbaric 2% (60mg) or bupivacaine hyperbaric 0.5% (15mg). All could receive additional sedation with midazolam or propofol and supplementary anaesthesia with sufentanil if necessary. The primary outcome was not explicitly defined *a priori* but the general aim of the study was to determine whether using prilocaine hyperbaric 2% rather than bupivacaine hyperbaric 0.5% would improve the scheduling of day case surgery. Patients were suitable for discharge from the recovery room significantly sooner in the prilocaine group (median 91 minutes) compared to the bupivacaine group (150 minutes) and also suitable for discharge home significantly sooner: median 308 minutes versus 407 minutes. In the majority of patients, the last criterion achieved to allow discharge home was voluntary micturition. Secondary outcomes assessed the quality of the block. The success of the block was reported to be comparable in both treatment groups but patients in the bupivacaine 0.5% group achieved a significantly higher level of sensory block than prilocaine (T6 versus T8). Similar analgesic levels of at least T12 were achieved in both groups and block intensity and onset times were also similar. The duration of effect (an analgesic level of T12) was significantly longer in bupivacaine than prilocaine patients (median 120 minutes versus 60 minutes respectively). There were no significant differences between the two groups in pain scores assessed in the operating theatre, recovery ward, surgical ward or after discharge or in the amount of NSAIDs or opioids used. The Committee questioned the significance in terms of a potential for increased throughput based on the recovery times reported. The applicant explained that there is a pressure, particularly within the recovery room setting, which may allow for increased throughput. Moreover, he hypothesized that this will allow them to schedule more patients as a day case without the need for a general anaesthetic and that requirement for overnight admission may reduce. The Committee agreed to approve hyperbaric prilocaine for use at BCF for a period of one year. In one year, the applicant will need to report the number of general anaesthetics and overnight admission avoided and to detail any improvements in day surgery efficiency as a result of the change in spinal anaesthetic.

The Committee noted that the application form stated that patients whose surgery was scheduled for upto 2 hours duration would be indicated for hyperbaric prilocaine. The Committee considered this too long considering the pharmacokinetics of this agent and it was agreed that this should be restricted to procedures of [expected] 60 minutes [or less].

5.2 Aflibercept (Bayer) for wet age-related macular degeneration (AMD)

Applicant (Trust)	Presented by	Outcome
Dr Ockrim (MEH)	AT	Approved pending price evaluations

The Committee reviewed aflibercept, a recombinant fusion protein which binds to and inhibits activation of vascular endothelial growth factor (VEGF-A) and Placental Growth Factor (PIGF) receptors, which has recently been approved for use in the EU to treat adults with wet AMD.

The Committee focused on the two large Phase III studies and the current therapy recommended by NICE, ranibizumab. Essentially, intravitreal aflibercept is non-inferior to monthly ranibizumab at 52 weeks with the possibility that effectiveness continues for up to 2 years with "as needed" dosing.

The safety of aflibercept 2mg (the licensed dose) has been evaluated in 1233 patients and was generally well-tolerated and systemic non-ocular adverse and ocular-related adverse effects were similar to those for monthly ranibizumab.

Aflibercept thus appears to offer a direct alternative treatment option to the existing NICE-approved treatment [ranibizumab]. Clinical evidence in those patients who require frequent re-treatment or have failed previous therapy with ranibizumab is lacking as patients receiving prior treatment for wet AMD were excluded from the licensing trials. However the Committee were informed that such patients would continue to receive ranibizumab to retard the rate of visual decline anyway.

Importantly, there is a reduced frequency of drug administration and monitoring in favour of aflibercept; although this is only clear for the initial year (7 versus 8 injections). A NICE technology appraisal for aflibercept in wet AMD is expected in August 2013. Both products are available at a discount but, like the NOACs, the discount is subject to a confidentiality non-disclosure agreement and could not be discussed in an open forum.

In summary, the Committee considered the two agents comparable in terms of efficacy and safety but noted a slight advantage for aflibercept during the first year in terms of convenience. The Committee therefore agreed that the preferential agent should be based on cost. If both agents are comparably priced, then it was agreed that aflibercept should be the agent of choice.

6. Reviews without applications

6.1 Ocular supplements for AMD

The planned discussion regarding nutrition supplements for patients with AMD was deferred as it has recently been announced that the AREDS II trial data will be presented at a conference during the first week in May which may alter any recommendations made with regards to supplements in AMD.

6.2 Rheumatoid Arthritis (RA) Treatment Pathway

The Committee were presented with a draft pathway compiled by UCLH rheumatologists and pharmacists for the pharmacological treatment of RA. Six deviations from NICE were presented for discussion.

1) Use of SC abatacept as a first-line biologic: NICE has issued draft guidance recommending IV abatacept as another first line option. However, since the NICE review, a SC formulation has become available which is cost neutral to the IV formulation and would save commissioners on paying for infusion costs. The Committee considered this request reasonable.

2) Bypassing rituximab for any patient that does not receive a TNF-inhibitor first line due to an absence of safety data for sequential use of biologics in this manner (due to concerns surrounding the more permanent effects on the immune system associated with B-cell depletion therapy): The Committee were not supportive of this deviation and noted that this was not considered a concern by NICE during their review of tocilizumab or abatacept.

3) Bypassing current first-line biologic options for patients where rituximab may be more appropriate than NICE first-line options e.g. previous malignancy: The Committee noted that this would be a less expensive deviation but requested further clarification regarding this rationale.

4) Use of tocilizumab as a first-line biologic in patients unable to tolerate methotrexate: Dr Leanadro reported that further data has just been released to support this approach therefore it was agreed that this should be discussed again in more detail at the next meeting.

5) Bypassing rituximab in seronegative patients: Dr Leanadro reported that data continues to accumulate to support this approach therefore it was agreed that this should be discussed again in more detail at the next meeting.

6) Use of rituximab as a last-line biologic in patients unable to tolerate methotrexate: Dr Leanadro reported that rituximab is sometimes successfully used as monotherapy (unlicensed – and hence not reviewed by NICE) but it was agreed that this should be discussed again in more detail, along with the other issues, at the next meeting.

6.3 Rasburicase for tumour lysis syndrome

The Committee reviewed the evidence for using rasburicase in preference to allopurinol for patients considered at high risk of tumour lysis syndrome. The evidence supporting rasburicase has been restricted to two open-labelled, randomised, multicentre trials comparing rasburicase to allopurinol, and one retrospective analysis. Although urate oxidase [rasburicase] appears more effective than allopurinol in improving surrogate outcomes such as reducing serum uric acid, this failed to translate into clinical benefits such as a reduction in mortality or renal failure. Considering rasburicase costs between £2-3K per patient (dependent upon patient weight and course length] in comparison to the negligible price of allopurinol, it was agreed that rasburicase should not be used for any adult patient that can tolerate allopurinol. Rasburicase was to be restricted for use in patients unable to tolerate allopurinol. The JFC would consider the case for rasburicase in paediatrics at a later date.

7. Local DTC recommendations

7.1 Selegiline for Parkinson's disease

Selegiline for Parkinson's disease was discussed at the NMUH DTC and a recommendation to include it on the formulary was suggested. The Committee agreed with this decision.

7.2 Rotigotine for Parkinson's disease

Rotigotine patches for Parkinson's disease was discussed at the NMUH DTC and a recommendation to include it on the formulary was suggested. The Committee agreed with this decision.

7.3 Argatroban for heparin-induced thrombocytopenia

Argatroban for heparin-induced thrombocytopenia was discussed at the UCLH DTC and a recommendation to include it on the formulary was suggested for patients with renal failure. The Committee agreed with this decision.

7.4 Fampridine for walking speed in multiple sclerosis

Fampridine for walking speed in multiple sclerosis was discussed at the UCLH DTC and a recommendation to include it on the formulary for a small cohort of significant responders was suggested. However as the NCB have produced draft guidance recommending non-reimbursement for this product it was agreed to await the outcome of the stakeholder appeal.

7.5 Ivacaftor for G551D mutation cystic fibrosis

Ivacaftor for G551D mutation cystic fibrosis was discussed at the GOSH DTC and a recommendation to include it on the formulary was suggested. The Committee agreed with this decision and noted that this product will be reimbursed nationally.

7.6 Hyaluronic acid for osteoarthritis of the knee

Hyaluronic acid for osteoarthritis of the knee was discussed at the RNOH DTC. The RNOH considered that there was insufficient evidence for use of this product for this indication outside of the context of a clinical trial. The Committee agreed with this decision.

8. Date of next meeting

21st March 2013.

9. Any other Business

There was no other business.