North Central London
Joint Formulary Committee

JOINT FORMULARY COMMITTEE (JFC) – MINUTES

Minutes from the meeting held on Thursday 25th February 2016
Room 6LM1, Stephenson House, 75 Hampstead Rd

Present:	Prof R MacAllister	NCL JFC Chair	**(Chair)**
	Ms R Clark	NHS Camden, Head of Medicines Management	
	Prof L Smeeth	NCL JFC Vice-Chair	
	Ms P Taylor	NHS Haringey, Head of Medicines Management	
	Dr A Stuart	NHS Camden, GP Clinical Lead Medicines Management	
	Dr R Fox	RNOH, DTC Chair	
	Mr A Shah	RNOH, Chief Pharmacist	
	Dr R Urquhart	UCLH, Chief Pharmacist	
	Mr T James	MEH, Chief Pharmacist	
	Mr B Sandhu	NEL CSU, Assistant Director Acute Services	
	Mr A Dutt	NHS Islington, Head of Medicines Management	
	Mr C Daff	NHS Barnet, Head of Medicines Management	
	Mr I Man	WH, Deputy Chief Pharmacist	
In attendance:	Mr J Minshull	NCL JFC, Support Pharmacist	
	Ms I Samuel	RFH, Formulary Pharmacist	
	Mr P Bodalia	UCLH, Principal Pharmacist	
	Mr A Barron	NCL JFC, Support Pharmacist	
	Ms S Sanghvi	UCLH, Formulary Pharmacist	
	Mr G Purohit	RNOH, Deputy Chief Pharmacist	
	Ms H Mehta	NMUH, Formulary Pharmacist	
	Ms K Landeryou	Observer	
	Dr D Owen	UCLH, Consultant Clinical Pharmacologist	
	Dr A Shah	UCLH, SpR Clinical Pharmacology	
Apologies:	Dr R Kapoor	UCLH, Consultant Neurologist	
	Dr C McGuiness	JFC Patient Partner	
	Mr TF Chan	BCFH, Deputy Chief Pharmacist	
	Ms W Spicer	RFH, Chief Pharmacist	
	Dr R Sofat	UCLH, Consultant Clinical Pharmacologist	
	Dr A Tufail	MEH, DTC Chair	
	Dr R Breckenridge	UCLH, DTC Chair	
	Mr P Gouldstone	NHS Enfield, Head of Medicines Management	
	Mr G Kotey	NMUH, Chief Pharmacist	

2. Meeting observers

Prof MacAllister welcomed Kelly Landeryou as an observer to the meeting and explained the role of Joint Formulary Committee in NCL.

3. Minutes of the last meeting

Section 8, bullet point one on statin prescribing to be updated to state "lipid profiles should be measured at baseline and 3 months. Consider measuring every 12 months thereafter (or after 6 months if the dose/statin changes)".

Section 9, etanercept biosimilar updated to clarify that Benepali should replace Enbrel where Enbrel is indicated.

4. Matters arising

4.1 Statin Prescribing & Lipid Monitoring

Ms Sanghvi presented the response received from NICE in relation to the Committee's query about the value of using cholesterol levels as a treatment target in primary prevention. NICE has advised that checking non-HDL cholesterol levels should be considered after three months in primary prevention patients on a statin dose with a lower intensity than atorvastatin 80 mg. If there has not been at least a 40% reduction in cholesterol levels, prescribing a higher statin dose can be considered. This however, should be used as an indicator for treatment, not as a hard treatment target and consideration should first be given to adherence and adverse effects.

Action: Ms Sanghvi to update the guideline to reflect this and seek Chair's action for approval.

5. Declarations of relevant conflicts of interest

No conflicts of interest were declared by the Committee members. Dr Roylance declared she had attended an Advisory Board for fulvestrant approximately two years ago.

6. Local DRT recommendations / minutes

Month	DTC site	Drug	Indication	JFC outcome
Nov-15	UCLH	Glatiramer Acetate (Copaxone®)	Relapsing-remitting multiple sclerosis in-line with NHS England Commissioning	Added to NCL Joint Formulary
Nov-15	UCLH	Peginterferon Beta-1a (Plegridy®)	Relapsing-remitting multiple sclerosis in-line with NHS England Commissioning	Added to NCL Joint Formulary

7. New Medicine Reviews

7.1 Bisphosphonates in early breast cancer

An application to use zolendronic acid IV infusion as a first line adjuvant therapy for post-menopausal (including those for whom it is chemically induced) women with breast cancer to prevent bone recurrence and cancer mortality [unlicensed indication] was considered by the Committee. Previous studies have shown it to alter the bone marrow microenvironment, making tumor cell growth less likely.

A large meta-analysis (n=18,766 patients from 26 trials) looking at the benefit of bisphosphonates as adjuvant treatment in early breast cancer to prevent breast cancer recurrence, distant recurrence and breast cancer mortality was reviewed. Included patients had been followed up for a median 5.6 years. When all women were included in the analysis, reductions in recurrence, distant recurrence and breast cancer mortality were of borderline significance. A subgroup analysis was performed specifically on post-menopausal women (n=11,767), which produced more substantial, statistically significant results. There was a reduction in risk of bone recurrence (RR=0.72 95% CI: 0.60 to 0.86, p=0.0002), overall recurrence (RR=0.86, 95% CI: 0.78 to 0.94, p=0.002), and distant recurrence (RR=0.82, 95% CI: 0.74 to 0.92, p=0.0003). It was noted that the 10 year risk of breast cancer mortality reduced from 18% without bisphosphonate to 14.7% with bisphosphonate treatment (RR=0.82, 95% CI 0.73 to 0.93, p=0.002), which was considered to be a substantial reduction in risk of mortality. There was also a reduction in any cause of death with bisphosphonate treatment in the postmenopausal group (RR 0.86, 95% CI: 0.77 to 0.96, p=0.005).

It was questioned whether zolendronic acid is the most appropriate bisphosphonate to use in this indication, therefore Forest plots breaking the population into subgroups based on their treatment type were reviewed. Recurrence in postmenopausal women was reduced most with daily oral clodronate (RR= 0.77, 99% CI: 0.61 to 0.99) and zoledronic acid (RR 0.87, 99% CI: 0.73 to 1.03); pamidronate and

ibandronic acid were not statistically significantly different from control, and no data were available for alendronate or risedronate. A similar pattern was repeated for reduced bone recurrence and reduction in breast cancer mortality. It was agreed that daily treatment with clodronate would not be convenient for the patient as it has very strict administration instructions concerning food. The absence of data for alendronate and risedronate mean that they would not be suitable options. It was agreed that twice yearly zoledronic acid was suitable .

A serious but uncommon side-effect of zoledronic acid infusion is osteonecrosis of the jaw. The Committee acknowledged the results of a 94 month study of zoledronic acid infusions in a similar patient group that reported the infusion was well tolerated and associated with few side-effects, and no cases of osteonecrosis of the jaw were reported.

The Committee agreed that zoledronic acid infusion was a valuable adjuvant treatment for post-menopausal women with early breast cancer, and agreed to add it to the formulary.

Decision: Approved
Prescribing: Hospital only
Tariff status: Included
Funding: Hospital budget only
Fact sheet or shared care required: N/A
Audit required: No

7.2 Fulvestrant for ER+/HER- breast cancer

The Committee reviewed the application in parallel with NICE TA 239 (December 2011) in which fulvestrant was not recommended as an alternative to an aromatase inhibitor (AI) in postmenopausal women with locally advanced or metastatic breast cancer which has returned or worsened after anti-oestrogen therapy (e.g. tamoxifen). It was noted however that the SMC approved fulvestrant in 2016 as part of a patient access scheme (PAS) within its licensed indication. London Cancer guidelines from 2014 recommend fulvestrant following non-steroidal AI and tamoxifen.

The Committee noted that there were no studies exclusively investigating fulvestrant at the 500mg dose as third-line hormone treatment.

Early Phase III studies compared fulvestrant 250mg (unlicensed) to anastrazole 1mg as second-line treatment; the HR for overall survival (OS) was 0.98 (95% CI: 0.84 to 1.15) indicating equivalence between fulvestrant 250mg and non-steroidal AIs. A separate study compared fulvestrant 250mg to exemestane primarily as third-line hormone treatment; the progression-free-survival (PFS) HR was 0.95 (95% CI: 0.79 to 1.14) similarly indicating equivalence between arms. The Phase II FIRST study compared fulvestrant 500mg to anastrazole 1mg as 1st line metastatic treatment; the time-to-progression HR=0.66 (95% CI: 0.47 to 0.92) indicating fulvestrant 500mg superiority to non-steroidal AIs in this setting.

The CONFIRM study compared fulvestrant 500mg to 250mg in postmenopausal women with locally advanced or metastatic ER+ breast cancer who had relapsed or progressed on anti-oestrogen or AI therapy. Patients were randomised 1:1 to fulvestrant 500mg or 250mg until disease progression. The primary endpoint was PFS. The first data cut was taken when 82.0% of patients randomised to fulvestrant 500mg had progressed; median PFS was 6.5m and 5.5m respectively (HR=0.80 [95% CI: 0.64 to 0.94]). A second data cut was taken when 72.1% of patients randomised to fulvestrant 500mg had died; median time to death was 26.4m and 22.3m respectively (HR=0.81 [95% CI: 0.69 to 0.96]). An ad-hoc data cut from those using fulvestrant as third-line therapy (15%) identified the median PFS for fulvestrant 500mg and 250mg was 5.5m and 3.4m respectively (HR=0.69 [95% CI: 0.45-1.06]) and OS was 24.0m and 20.7m respectively (HR = 0.75). It was noted that the P values for overall mortality reduction had not been adjusted for repeat analysis.

Manufacturer submitted real-world data (from Germany) was considered which showed the median TTP as 9.7 months, 6.8 month and 6.7 months for patients treated with fulvestrant as first, second and third line respectively.

The most common adverse events were noted as being nausea, raised LFTs, asthenia and injection site reaction. Fulvestrant requires one appointment for drug administration every 4 weeks, with an additional appointment 2 weeks after the initial dose. The Committee acknowledged that the manufacturer has submitted a confidential PAS price for all Acute Trusts within NCL valid for at least one year.

The Committee heard from Dr Roylance that fulvestrant was the 'best supportive care' (BSC) arm in new trials for IMPs therefore it was unethical for fulvestrant to be unavailable outside of the trial setting. The

Committee disagreed with this view on the basis that trial design does not determine decision-making by the Joint Formulary Committee. The Committee also heard that fulvestrant delayed the time to which systemic chemotherapy was required which was noted to be effective however associated with substantial toxicity and a reduced quality of life.

The substantial price difference between fulvestrant and tamoxifen / anastrazole was discussed however it was agreed that for patients who had relapsed or progressed on both standard treatments currently available, fulvestrant was likely to delay chemotherapy by 5-6 months and may offer a survival benefit of 3-4 months.

In summary, the Committee was satisfied that fulvestrant as a third-line treatment (post non-steroidal AI and tamoxifen) for postmenopausal women with ER+ metastatic breast cancer was cost-effective and should be included for this indication on the NCL Joint Formulary.

Decision: Approved pending funding agreement
Prescribing: Hospital only
Tariff status: In-tariff
Funding: Hospital budget only
Fact sheet or shared care required: N/A
Audit required: No

7.3 Idarucizumab (Praxbind®) for dabigatran reversal

An application for idarucizumab for administration to patients receiving dabigatran who have life/limb threatening bleeding, uncontrolled bleeding, or require emergency surgery was presented. Idarucizumab is a humanized monoclonal antibody that binds with very high affinity to dabigatran to act as a reversal agent. It is active only against dabigatran (i.e. it has no activity against any other oral anticoagulant); there are currently no reversal agents available for apixaban, rivaroxaban or edoxaban, though a factor Xa inhibitor reversal agent (andexanet alpha) is likely to be launched in 2017.

Efficacy of idarucizumab to rapidly reverse anticoagulation is based on an ongoing, prospective, open-label, uncontrolled cohort study (RE-VERSE AD), which included 90 adult patients (mean age 76.5 years). An additional 33 patients were included in the analysis that formed part of the EMA assessment of the drug. RE-VERSE AD study assessed the use of idarucizumab in two separate groups: Group A patients had overt, uncontrollable bleeding, or a life-threatening bleed determined to require a reversal agent and Group B patients required surgery or other invasive procedure where it was decided that a delay of more than 8 hours was not acceptable. The primary efficacy end point for this study was the maximum reversal of dabigatran anticoagulation in the first 4 hours (measured by Ecarin clotting time [ECT] and diluted thrombin time [dTT]). The study determined that the median maximum reversal of dabigatran in the first four hours was 100% for dTT and ECT. Normal clotting was achieved for dTT in 97.5% and 92.9% of patients in groups A and B respectively. For ECT, normalisation was achieved in 89.4% and 88.2% of patients respectively. The EMA commented that the difference in clotting test outcomes may arise from ECT being more sensitive to dabigatran than dTT is. ECT was only below the upper limit of normal in 72% and 54% of patients at 12 hours and 24 hours respectively. These results suggest that, although clotting returned to normal in a high percentage of patients, ECT was less likely to return to normal than was dTT, suggesting there is a limit to the extent of reversal.

The EMA reported that the median onset for dabigatran reversal was five minutes, with median duration of complete reversal of dTT and ECT to be 72 hours. Bleeding status was measured as a secondary clinical outcome, relying on the subjective assessment of the treating physician. From the results reported in the EMA assessment, in group A it was possible to determine that bleeding stopped within 72 hours (median time to stop bleeding 9.8 hours [0.2 hours to 62 days] for 44 of 48 patients. In group B, 48 of 52 patients had normal haemostasis reported by the surgeon. Three patients had mildly abnormal intra-procedural haemostasis. One patient was judged to have moderately abnormal haemostasis, which resulted in 1 GUSTO-mild post-op bleed occurring within 24 hours.

Likelihood of death was considered by the Committee. It was noted that this was not included as either a primary or secondary end-point in the main phase III trial, however data from this ongoing study were analysed as part of the EMA assessment of the drug. Of the 123 patients included in the data, there were 13 deaths in each group (21%), with 11 occurring within 1 day of treatment. These early deaths were likely to be progression of the underlying condition, rather than resulting from drug administration. The only death caused by a thrombotic event was one ischaemic stroke occurring 26 days after treatment in a patient not receiving any antithrombotic treatment. The Committee noted that these data reassuringly suggest that blocking dabigatran is unlikely to have pro-thrombotic effects, though it was agreed that

relatively few people have received idarucizumab so far (224 healthy subjects and 123 patients), therefore it may take a while before rarer side effects manifest themselves. Phase I studies reported that idarucizumab has low immunogenic potential, therefore single dose administration is unlikely to result in anti-idarucizumab antibodies developing.

It was questioned whether the availability of a reversal agent for dabigatran means that JFC should select this drug as the favoured DOAC. The Committee agreed that although idarucizumab is the only DOAC reversal agent available at the moment, it is anticipated that factor Xa inhibitor antidotes will be available by 2017; it would be unreasonable to then expect all patients to switch from dabigatran to apixaban (the preferred DOAC) at this point.

There were a range of views on where would be most appropriate to keep idarucizumab in the hospitals. It was acknowledged that for the most effective control of use to be implemented, it should be kept with the budget holder for the drug. For example, if Haematology holds the budget, it should be kept with them. It is for individual Trusts to determine where to store this drug. This was considered particularly important when considering NHS horizon scanning documents have suggested that up to 4% of DOAC patients may experience a major bleed and a further 1% may require rapid reversal for another reason (e.g. surgery).

The Committee agreed that administration of idarucizumab is likely to be an effective antidote to dabigatran and should be available within Trusts. The applicant was to be asked to define limb-threatening bleeding, given that this complication of anticoagulation seemed rather uncommon, in the collective experience of the Committee members.

Actions: Trusts will have to make local arrangements for appropriate storage and management of this drug.

Decision: Approved
Prescribing: Hospital only
Tariff status: In tariff
Funding: Hospital budget
Fact sheet or shared care required: N/A
Audit required: No

7.4 Ethinylestradiol/drosperinone oral contraception

The Committee reviewed the evidence for Lucette® (drospirenone/ethinylestradiol) a branded generic of Yasmin® for women already taking drospirenone/ethinylestradiol, and for women on a combined hormone contraceptive (COC) who experience acne, bloating and breast tenderness.

Two Phase III, open-label, randomised controlled trials comparing Yasmin to desogestrel/ethinylestradiol (Marvelon®) found equivalent Pearl Index scores (number of pregnancies for every 100 women years) and equivalent intermenstrual bleeding rates for both contraceptives. A Phase IV cohort study of 58,674 women from across Europe including the UK found no significant difference in contraceptive effectiveness between the different progestogen containing oral contraceptive groups.

With regards to the incidence of acne, one Phase III study reported similar incidences for Yasmin and Marvelon (1.1% vs 2.2%) whilst the other reported similar reductions in acne (21.5% to 7.8% vs. 20.1% to 8.2%). A further small RCT comparing Yasmin and Dianette® (cyproterone/ethinylestradiol) specifically in women with acne also found similar improvements in the incidence of acne for both COCs (62.5% vs 58.8%).

Both Phase III studies reported similar incidences of breast-pain for Lucette and Marvelon (12.0% vs 9.2% and 6.4% vs 4.6%).

Bloating was not specifically reported however the Phase III data indicated a small reduction in average differences in weight was with the majority of women not fluctuating ±2Kg from baseline.

Women who use COCs have a two to four-fold increased risk of venous thromboembolism (VTE) when compared to non-users. COCs containing ethinylestradiol plus levonorgestrel, norgestimate or norethisterone have the lowest risk and are therefore first-line agents. COCs containing ethinylestradiol plus gestodene, desogestrel or drospirenone have twice the VTE risk. That was concern raised that some women may use Lucette as their first-line COC thereby putting them at unnecessary risk.

The Committee noted that Lucette was significantly more expensive than other COCs, including Marvelon, and there was no evidence that Lucette would offer any significant advantages over Marvelon in terms of acne, breast-pain or weight gain.

The Committee heard that some CCGs use branded-generics of Yasmin however it was not known if this use was secondary to a formal evaluation of the evidence. The SMC rejected Yasmin in 2011.

In summary, the Committee agreed that Lucette had a similar contraceptive effectiveness to other combined oral contraceptives in routine use, with no significant differences in adverse event profile verses Marvelon. The Committee therefore did not recommend adding drospirenone/ethinylestradiol to the NCL Joint Formulary.

Decision: Not approved

7.5 Levonorgestrel 13.5 mg intrauterine system for contraception

An application from CNWL (provider of community sexual health clinics in Camden) for Jaydess (levonorgestral 13.5mg) intrauterine device was discussed. The application was to add Jaydess device as an alternative Mirena (levonorgestrel 52 mg) intrauterine device where the uterine sounding is less than 6.5 cm, where the internal cervical is tight (resulting in previous failed IUT fitting), where a standard sized device causes pain and discomfort, in women who have previously experienced side effects from levonorgestrel (but wish to use an intrauterine device) or if a woman wants to avoid amenorrhoea. Experience using the Jaydess device is limited, so it is not proposed to make this a first line option.

Jaydess is a long acting reversible contraception inserted for up to three years, its contraceptive action primarily due to its effects on sperm mobility/function and mucosal thickening preventing fertilisation.

This application is to make Jaydess available as an alternative to other methods of long-acting reversible contraception (its main comparator in the UK being Mirena, which is fitted for up to 5 years). The key benefits identified with Jaydess device are that its smaller size (28 mm width compared to 32 mm width) and lower progestogen dose.

A Pearl index score is calculated using the number of pregnancies as numerator and number of patient months treated as denominator. A lower Pearl Index represents a lower risk of becoming pregnant. In a three-arm phase II randomised controlled trial (RCT) comparing 239 women using Jaydess, to 254 women using Mirena®, and 245 women using a third levonorgestrel device, the reported Pearl Indices were 0.17 (95% CI: 0.00 - 0.93); 0 (CI: 0 – 0.59), and 0.82 (95% CI: 0.27 - 1.92) respectively. Thus Mirena was less likely to result in pregnancy than Jaydess. A phase III RCT including 1432 patients using Jaydess showed a Pearl Index of 0.41 (95% CI 0.13 – 0.96) at one year and cumulative Pearl Index after 3 years' use of 0.33 pregnancies per 100 women-years (95% CI 0.16 - 0.60). A similar Pearl score was reported for the higher dose device containing 19.5 mg levonorgestrel. The Kaplan-Meier estimate for the cumulative failure rate of Jaydess over 3 years was 0.9%, and for Mirena is 0.7% at 5 years. Again, Jaydess may be marginally less effective than Mirena.

The application suggested that women who experienced pain and discomfort using Mirena device may be suitable for Jaydess device. However, the Committee noted that evidence suggests that patients were generally satisfied with all device types. Pain was assessed during both trials using an unvalidated measure, with more Jaydess patients reporting no/mild pain (72.3%) than with Mirena (57.9%, $p<0.001$).

Despite lower serum levels of levonorgestrel, current evidence does not suggest any clinically significant advantage in terms of side effect profile, therefore it was questioned what additional benefit this device will provide over Mirena in this respect. All levonorgestrel intrauterine devices result in lower bleeding and spotting days, and an increase in the number of days with spotting only rather than bleeding. Jaydess has a lower rate of amenorrhoea (2.7% of patients 3 to 6 months following insertion, increasing to 12.7% between months 33 to 36) than Mirena (increasing from 5.9% to 23.6% for the same period), but the difference between the two devices was not statistically significant. Whether amenorrhoea is an advantage will depend on the person.

Ectopic pregnancy is a concern in this patient group. Approximately half of the pregnancies that occur in patients using either Jaydess or Mirena are likely to be ectopic. However, because there is far less experience using Jaydess device, it is not possible to compare the absolute ectopic pregnancy rates for these two. Additional data on an inbetween levonorgestrel dose suggest this is not a dose-specific difference.

There was discussion about the difference in price between Jaydess (£69/device or £23 per year of use) and Mirena (£88/device or £17.60 per year of use). The applicant claims that costs will not increase

because women would otherwise have been fitted with a Mirena device, though it should be noted that the cost per year is higher for Jaydess than for Mirena. The Committee noted that when Mirena was first marketed it was also designed for insertion up to 3 years, therefore it is possible that use of Jaydess will be extended when more data are available.

The Committee did not have sufficient information to be certain that the Jaydess device had any advantage over Mirena, therefore could not approve addition of the device to the formulary. Specifically, they had the following questions that needed to be addressed:

1. The Mirena device in use in the UK is smaller than that used in the clinical trials: are there still women who are unsuitable for the Mirenal device who would be better suited to Jaydess?.
2. The application notes that there were fewer reports of pain and discomfort (using an unvalidated score) for placement of Jaydess than for Mirena. However, how does this relate to long term benefit and what about pain/discomfort during use (rather than during placement)
3. If women want to avoid amenorrhoea, what alternative contraception options are available?

Actions: JM to seek clarification on the above points and feedback at the next meeting.

Decision: Not approved

8. Guideline: Calcium and Vitamin D supplementation for the prevention of osteoporotic fragility fractures

The Committee reviewed the calcium and vitamin D guidance and requested that the guideline:

- Does not provide guidance on vitamin D monotherapy for indications other than osteoporotic fragility fractures
- Does not provide guidance on the duration of bisphosphonate treatment
- Includes details of cardiovascular risk with calcium products, especially in the elderly population
- Section 4.3 'Frail elderly women in a residential setting' requires broader consultation with GPs and Care of the Elderly consultants because the monitoring requirements are extensive
- Section 5 'Choice of therapy' should recommend first and second-line agents
- Table 2 'Licensed calcium and vitamin D supplements available on prescription' should not have prices displayed.

The guideline would require an additional round of consultation and should be brought back to JFC for approval.

9. JFC Administration

9.1 Terms of reference

Mr Minshull presented an update to the current terms of reference for approval. The document has been updated and extended to provide more detailed information on a number of areas, including conflicts of interest, the decision making process and relationships with non-member organisations. Information has been sought from other areas outside NCL, including the South East London Area Prescribing Committee. It was agreed that an ABPI representative is not needed on this Committee.

Action: Terms of Reference to be approved following removal of reference to the ABPI.

9.2 JFC membership

Mr Minshull asked the Committee to review the membership list and make any recommendations for change. It was agreed that the Committee does not need LMC, ABPI or procurement representation . Mr Sandhu will act as link between the JFC and NEL CSU, therefore no other members need to be included. A specific post for non-board member GP is not necessary because representation from CCGs already covers non-board members.

There are a number of unfilled posts that we should seek members to fill.

Action: Mr Minshull to ask CCG Heads of Medicines Management and Trust Formulary Pharmacist to seek the following members: nursing representative, Paediatric representative, Psychiatrist, Surgery/Anaesthetics/Pain representative, Respiratory/General Medicine representative.

10. Update on DOACs

Mr Minshull gave a verbal update from a meeting held on 16 February 2016 to discuss the JFC position on DOACs and anticoagulation. The key outcomes from that meeting are as follows:

- DOACs are non-inferior to warfarin and therefore should be considered on a par with warfarin clinically

- A rank order for DOACs was agreed (for stroke prevention in AF and DVT/PE treatment/prophylaxis) based on a network meta-analysis: apixaban, rivaroxaban and dabigatran
- Prescribing support documentation and transfer letters for continuation of DOAC prescribing will be presented to the April 2016 JFC meeting
- Forms for referral into anticoagulation services will be combined into one form
- Prescribing support documentation for initiation of DOACs in AF will be presented to the May 2016 JFC meeting

11. JFC Workplan

This item was included for information only. Any questions should be directed to Mr Barron.

12. Next meeting

Thursday 31 March 2016, Room 6LM1, Stephenson House, 75 Hampstead Rd.

13. Any Other Business

Nil