North Central London
Medicines Optimisation Network

JOINT FORMULARY COMMITTEE (JFC) – MINUTES

Minutes from the meeting held on Monday 22 January 2019
LG01, 222 Euston Road, London, NW1 2DA

Present:	Dr R MacAllister	NCL JFC Chair	**(Chair)**
	Ms P Taylor	Haringey CCG, Head of Medicines Management	
	Mr C Daff	Barnet CCG, Head of Medicines Management	
	Mr A Dutt	Islington CCG, Head of Medicines Management	
	Dr A Stuart	Camden CCG, GP Clinical Lead Medicines Management	
	Ms R Clark	Camden CCG, Head of Medicines Management	
	Dr R Urquhart	UCLH, Chief Pharmacist	
	Mr P Gouldstone	Enfield CCG, Head of Medicines Management	
	Mr S Richardson	WH, Chief Pharmacist	
	Prof D Hughes	RFL, Consultant Haematologist	
	Dr R Woolfson	RFL, DTC Chair	
	Dr S Ishaq	WH, Consultant Anaesthetist	
	Ms W Spicer	RFL, Chief Pharmacist	
	Mr S Tomlin	GOSH, Chief Pharmacist	
	Dr A Sell	RNOH, DTC Chair	
	Ms L Reeves	C&I, Chief Pharmacist	
In attendance:	Mr A Barron	NCL MEP, Lead Pharmacist	
	Ms M Kassam	NCL JFC, Support Pharmacist	
	Mr G Grewal	NCL JFC, Support Pharmacist	
	Ms I Samuel	RFL, Formulary Pharmacist	
	Ms S Sanghvi	UCLH, Formulary Pharmacist	
	Ms H Mehta	NMUH, Formulary Pharmacist	
	Ms Y Al-Hayali	MEH, Formulary Pharmacist	
	Mr S O'callaghan	UCLH, MI and FMM pharmacist	
	Ms R Bharana	Islington CCG, Prescribing Advisor [Observer]	
	Ms Zaynab Furjun	WH, Rotational Pharmacist [Observer]	
Apologies:	Prof L Smeeth	NCL JFC Vice-Chair	
	Dr M Dhavale	Enfield CCG, GP Clinical Lead Medicines Management	
	Mr G Kotey	NMUH, Chief Pharmacist	
	Dr A Bansal	Barnet CCG, GP Clinical Lead Medicines Management	
	Prof A Tufail	MEH, DTC Chair	
	Mr A Shah	RNOH, Chief Pharmacist	
	Dr T Rashid	NHS Haringey, GP Clinical Lead Medicines Management	
	Mr TF Chan	RFL, Deputy Chief Pharmacist	
	Mr S Semple	MEH, Interim Chief Pharmacist	
	Ms A Fakoya	NEL CSU, Senior Prescribing Advisor	
	Mr G Purohit	RNOH, Deputy Chief Pharmacist	
	Ms K Delargy	BEH, Deputy Chief Pharmacist	
	Dr R Sofat	UCLH, DTC Chair	
	Dr M Kelsey	WH, DTC Chair	
	Ms K Davies	NEL CSU, Deputy Director Medicines Management	
	Mr T Dean	Patient Partner	

2. Meeting observers

Dr MacAllister welcomed Ms Bharania (Islington CCG, Prescribing Advisor) and Ms Furjun (WH, Rotational Pharmacist) as observers of the meeting and explained the role of the JFC.

3. Minutes of the last meeting

The minutes were accepted as accurate as accurate reflections of the November meeting.

4. Matters arising

4.1 Audit proposal for Eslicarbazepine in partial epilepsy as an adjunct for partial onset seizure

Item deferred.

4.2 Omega-3 fatty acid ethyl esters (Omacor®, Mylan) for inherited hypertriglyceridaemia (RFL, Dr D Nair) [Appeal]

In October 2018, the Committee reviewed an application for omega-3 fatty acids for the primary and secondary prevention of pancreatitis in patients with inherited hypertriglyceridaemia. The Committee agreed that the uncertainties in the evidence base required omega-3 fatty acids to be limited to those at highest risk of developing a future pancreatitis event. The Committee therefore restricted their approval of omega-3 fatty acids to secondary prevention of pancreatitis only. Dr Nair appealed against this decision on the grounds that patients with inherited hypertriglyceridaemia and severely raised triglycerides were at high risk of pancreatitis irrespective of whether they had a prior episode of pancreatitis. The Committee considered how best to identify patients at highest risk and agreed with Dr Nair that this could be done by identifying patients under the routine care of a lipidologist. The Committee therefore agreed that, provided the patient is under the care of a lipidologist, omega-3 fatty acid could be used for the primary and secondary prevention of pancreatitis in patients with inherited hypertriglyceridaemia when triglycerides levels are ≥10mmol/L despite addressing secondary causes, uptake of lifestyle changes and pharmacological therapy.

It was noted a large number of patients within NCL are already prescribed omega-3 fatty acids, however the Committee was reassured that Dr Nair is developing guidance for GPs to review and withdraw omega-3 fatty acids for appropriate individuals.

Decision: Approved for the management of inherited hypertriglyceridaemia (type 3 hyperlipidaemia, lipoprotein lipase deficiency or in presence of raised chylomicrons and VLDL), when triglycerides levels are ≥10mmol/L despite addressing secondary causes, uptake of lifestyle changes and pharmacological therapy.
Prescribing: Primary and secondary care. Only to be initiated in secondary care lipid clinics, continuation suitable in primary care
Tariff status: in tariff
Funding: Trust/CCG
Fact sheet or shared care required: No
Additional information: GP guidance to be produced to support review of existing patients on treatment

4.3 Erenumab free-of-charge (FoC) scheme

In November 2018, JFC approved a FoC scheme for erenumab to treat chronic migraine for a sub-set of patients who had either failed, or were contraindicated to, botulinum toxin. The Committee restricted their approval of the scheme as these patients were thought to have the greatest unmet need, whilst ensuring the scheme did not contradict existing NICE treatment pathways.

Ms Davies (NEL Commissioning Support Unit, Deputy Director) informed the Committee in writing that several Area Prescribing Committees across London have not approved the erenumab FOC scheme, citing recommendations within the Regional Medicines Optimisation Committee (RMOC) 'Free of charge medicines schemes' policy. The Committee considered whether this policy should influence JFC decision making. The NCL Medicines Optimisation Committee (MOC) had reviewed the RMOC policy and considered it to have internal inconsistencies therefore had not recommended the document for review at JFC. These concerns were escalated to RMOC South who in turn have scheduled a review of the policy. Although the policy's recommendations still remains in force whilst the review is underway, the Committee agreed that the existence of a policy, which has not been approved or adopted locally by the JFC, should not influence their decision making process.

Ms Davies also identified that NICE has recently published a negative ACD for erenumab for chronic and episodic migraine as the £/QALY was too high given the uncertainty in the evidence. The Committee

reflected on their previous approval relating to a cohort with unmet clinical need and balanced this against the modest treatment effects reported in erenumab clinical trials (treatment difference vs. placebo: −2.5 monthly migraine days), the negative ACD as well as the impending FAD. The Committee were in agreement they should not increase the complexity of any price negotiations between NICE, DH and Novartis, and therefore agreed to suspend their approval of the FoC scheme pending publication of a positive FAD. In summary, the Committee agreed to suspend their approval of erenumab FoC scheme for chronic migraine until a positive NICE FAD or TA is available.

Decision: Approval suspended until a positive NICE FAD or TA is available. No prescribing of erenumab should take place until this point.

5. JFC Work Plan & outstanding actions

These items were included for information only. Any questions should be directed to Ms Kassam.

6. Declarations of relevant conflicts of interest

No additional declarations to those noted in the drug application

7. Local DTC recommendations / minutes

7.1 Approved

DTC site	Month	Drug	Indication	JFC outcome
NMUH	Oct -18	Ferric Subsulphate Solution (Monsels)	Haemostatic agent in colposcopy	Decision: Added to the NCL joint formulary Prescribing: Secondary care Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No
RFL	Oct-18	Nivolumab FOC scheme	Adjuvant treatment of melanoma	Decision: RFL only Prescribing: Secondary care Tariff status: N/A Funding: FoC Fact sheet or shared care required: No
RFL	Oct-18	Bezafibrate	Primary Biliary Cholangitis (second line therapy after ursodeoxycholic acid if intolerant to obeticholic acid)	Decision: RFL only Prescribing: Primary and Secondary care Tariff status: In tariff Funding: Trust/CCG Fact sheet or shared care required: TBC
RFL	Nov-18	Levothyroxine oral solution (Tirosint®)	Hypothyroidism (on ITU)	Decision: RFL only Prescribing: Secondary care Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No
RFL/ NMUH	Nov-18	Symtuza® (darunavir/cobi-cistat/emtricita-bine/tenofovir alafenamide)	HIV infection NHSE commisioning policy F03/P/b	Decision: Added to NCL joint formulary Prescribing: Secondary care only Tariff status: Excluded from tariff Funding: NHSE Fact sheet or shared care required: No
UCLH	Nov-18	Ketamine infusion	Postoperative acute pain following complex spinal surgery	Decision: UCLH only Prescribing: Secondary care only Tariff status: in tariff Funding: Trust Fact sheet or shared care required: No
UCLH	Nov-18	Plenvu FoC evaluation	Colonoscopy Bowel Preparation	Decision: UCLH only Tariff status: N/A Funding: FoC Fact sheet or shared care required: No

BEH/C+I	Nov-11 /Nov-12	IM Aripiprazole	Rapid control of agitation and disturbed behaviours in adult patients with schizophrenia or with manic episodes in Bipolar I Disorder when oral therapy is not appropriate and where IM haloperidol is not recommended	Decision: Added to the NCL joint formulary Prescribing: Secondary care only Tariff status: in tariff Funding: Fact sheet or shared care required: No

7.2 **Not approved**

UCLH	Nov - 18	MST Continus® TDS	Acute Pain post Neurosurgery	Decision: Not approved for thrice-daily dosing (remains on Formulary for twice-daily dosing as per SPC)

8. New Medicine Reviews

8.1 Cannabis and Cannabis-related products

8.1.1 Classification of cannabis based medicinal products

The Committee heard an overview of the cannabis and cannabis-related products available for use within the NHS following an amendment to the misuse of drugs regulations which has changed the controlled drug status for some cannabis and cannabis-related products from schedule 1 to schedule 2, allowing their prescription by a clinician on the specialist register. The term 'cannabis based medicinal product' used by NHSE and adopted in the NCL position statement only included cannabinoid containing products which had their controlled drug schedule changed, but not those that did not or remained unscheduled. In order to provide an overview of all products, a draft classification of cannabis based products by their relative cannabinoid content was presented to the Committee for inclusion in the updated position statement. The Committee heard that the DHSC and MHRA are working to import and license products that are licensed in their country of origin; procurement by LPP will be conducted once this is complete. In the interim, if supply is required for an inpatient admitted on cannabis-based therapy, the Trust should contact the lead procurement pharmacist at LPP. Cannabis and cannabis-related products currently available are Sativex®, dronabinol, nabilone and cannabidiol oral solution (Epidiolex®). Sativex® and nabilone are on formulary at some sites within NCL for their licensed indication prior to the change in legislation, and an EAMS for cannabidiol oral solution (Epidiolex®) is undergoing JFC review.

The Committee were supportive of the new classification system, and agreed that the JFC would consider applications for available products not on formulary (i.e. dronabinol and other licensed products being used for an off-label indication). The JFC interim position statement would be updated to reflect this new classification system.

8.1.2 Cannabinoids for the treatment of epilepsies

JFC Support undertook a broad literature search for the use of any cannabinoid for the treatment of epilepsies. The best quality data identified related to cannabidiol oral solution (Epidiolex®) for the treatment of Dravet syndrome and Lennox-Gastaut syndrome (see agenda item 8.3). Other studies of products containing cannabinoids had a small sample size, recruited a mixed population with "intractable epilepsy" (rather than a specific type of epilepsy) or did not examine efficacy as an endpoint therefore were not reviewed further.

8.1.3 Cannabidiol oral solution (Epidiolex®) for the treatment of Dravet syndrome and Lennox-Gastaut syndrome (Applicant: Dr M Sidhu, UCLH)

The Committee considered an evaluation request for cannabidiol oral solution (CBD) (GW Pharmaceuticals) (known as Epidiolex® in the US, and FDA approved) for the treatment of Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS) under an early access medicines scheme (EAMS).

Lattanzi et al performed a meta-analysis of four published randomised, double-blind clinical trials sponsored by GW Pharmaceuticals – two in DS and two in LGS patients. One DS study and the two LGS studies investigated safety and efficacy of Epidiolex®, and these were included in the efficacy analysis (n=516). The remaining study in DS patients investigated safety of Epidiolex® and therefore all four trials were included in the safety analysis (n=550). Participants were given Epidiolex® 2.5mg/kg/day in two divided doses and titrated upward to a target maximum dose. The comparator arm was given an equal

volume of placebo. Most studies used a target maximum dose of 20mg/kg/day, but one study in LGS patients included an additional target maximum dose of 10mg/kg/day. The 10mg CBD group demonstrated an average reduction in change in seizure frequency of 19.5 percentage points versus placebo (95% CI 8.1 to 31.0; p=0.001), though it was noted the 10mg dose was tested in LGS patients only. The 20mg CBD group demonstrated an average reduction in seizure frequency of 19.9 percentage points (95% CI 11.8 to 28.1; p<0.001). The relative risk to achieve ≥50% reduction in frequency of *convulsive seizure* in the 20mg CBD group versus placebo was 1.75 (95% CI 1.23–2.48; p=0.002); however, the relative risk to achieve ≥50% reduction in frequency of *non-convulsive seizure* in the 20mg CBD group versus placebo was 1.42 (95% CI 0.95–2.11; p=0.086) demonstrating a larger treatment effect in reducing convulsive seizures rather than non-convulsive seizures. Strengths of the meta-analysis was the well-structured design, inclusion of high quality evidence and adequate patient numbers for such rare epilepsy syndromes. Weaknesses include the lack of exclusion criteria; the inclusion of only four trials which were all sponsored by the same pharmaceutical company; only two main databases were used for searching; treatment periods were short (up to 14 weeks – though extension trials are ongoing); and the appropriateness of meta-analysing two different syndromes, considering the different baseline criteria (LGS patients characterised as suffering tonic seizures but DS patients did not).

The safety of CBD was demonstrated in the meta-analysis. Adverse events were suffered in 87.9% of CBD patients versus 72.7% placebo patients. The withdrawal rate was 8.9% in CBD patients versus 1.8% of placebo users (RR 5.59, 95% CI 1.87 to 16.73; p=0.002).

CBD oral solution 100mg/mL is available under a national free-of-charge (FoC) scheme with strictly limited patient numbers allowed to enrol from NHNN and GOSH. It is not expected that patients would be treated with the product outside of the scope of the FoC scheme until it is routinely funded (tariff exclusion decision by NHSE expected April 2019). To ensure those patients who could benefit most from the treatment are enrolled, strict criteria would be used by clinicians around the UK; DS patients with a mutation in the SCN1A gene suffering from two or more tonic-clonic seizures per week and LGS patients suffering from two or more drop seizures per week would be enrolled first. Dr Sidhu also highlighted the efforts to be undertaken at the treatment centre to ensure appropriate monitoring such as patient reviews, reporting of adverse effects, gradual titration from 2.5mg/kg/day with an initial reduction in concomitant clobazam if needed, and audits into safety and quality of life. Dr Sidhu gave a summary of some of the individual GWPCARE trials, noting the large reduction of drop seizures in the LGS study, reduced incidence of SUDEP and admissions, and the large improvement in global quality of life found. Dr Sidhu noted that some patients who are refractory to pharmacological therapy eventually need to have a corpus callosotomy procedure, and CBD could preclude the necessity for such palliative surgery.

In camera, the Committee considered the information surmised by Dr Sidhu on the GWPCARE studies and concluded that the information presented showed CBD reduced seizure frequency in these difficult to treat conditions. The Committee approved this novel therapy in accordance with the FoC EAMS criteria on the basis of its therapeutic benefits, including the potential for invasive treatments such as corpus callosotomy to be avoided in some patients.

Decision: Approved (provided patients fulfil EAMS criteria)
Prescribing: Secondary care only
Tariff status: N/A
Funding: FoC
Fact sheet or shared care required: No

Post-meeting note (29/03/2019): NHNN have been allocated 16 patients under the FoC Early Access Scheme. In order to provide a meaningful assessment of clinical response with cannabidiol oral solution, Epilepsy specialists have agreed to restrict the Early Access Scheme to patients with Dravet's syndrome with a proven genetic mutation in the SCN1A gene.

8.2 Proposal to remove bath emollient additives for dry skin conditions from the NCL joint formulary (Haringey CCG, Ms P Taylor)

Bath preparations for dry and pruritic skin conditions have been identified by NHSE as an item which should not routinely be prescribed in primary care due to lack of evidence of efficacy (draft guidance currently under consultation).

The Committee considered a UK multicentre, randomised, pragmatic, open label, superiority trial (n=482) to assess the efficacy, safety and cost-effectiveness of adding emollient bath additives to standard

eczema care for childhood eczema. The primary outcome was adjusted Patient Oriented Eczema Measure (POEM) scores. Results from this trial were negative with no statistically significant difference between 'with' and 'without' emollient bath additive groups at week 16 and 52 (-0.41 points [95% CI: -1.10 to +0.27] and -0.75 [95% CI: −1.55 to +0.05] respectively). Secondary outcomes were also similar between groups; including 'dermatitis family impact', quality of life, number of eczema exacerbations, and type or quantity of topical corticosteroid or topical calcineurin inhibitors prescribed over one year.

A consultation period identified that clinicians at GOSH agree that emollient bath additives could not be justified for childhood eczema however should remain available for ichthyosis and epidermolysis bullosa.

The annual cost of emollient bath additives in the BATHE study was £52 per patient. Dr Santer, author of the BATHE study, provided a comment that because emollient bath additives are relatively inexpensive and children usually outgrow eczema the emphasis should be on not starting emollient bath additives rather than deprescribing for existing patients in order to utilise GP resources effectively. These recommendations do not apply to antiseptic bath emollients or soap substitutes.

The Committee considered the negative results from a high quality trial, the limitations of the study and the GOSH opinion and agreed it was appropriate to remove emollient bath additives from the NCL Joint Formulary for all dry skin conditions (including eczema, atopic dermatitis) except ichthyosis and epidermolysis bullosa.

Indication: Ichthyosis and epidermolysis bullosa
Decision: Added to NCL Joint Formulary
Prescribing: Prescribing in primary and secondary care
Tariff status: In tariff
Funding: Trust/CCG
Fact sheet or shared care required: No

Indication: Dry skin conditions (including eczema, atopic dermatitis) except ichthyosis and epidermolysis bullosa
Decision: Removed from the NCL Joint Formulary

8.3 Lurbinectedin (PM01183, PharmaMar): Relapsed Small Cell Lung Carcinoma & Extrapulmonary Small Cell Carcinoma (UCLH, Dr R Kristeleit)

The Committee considered an application for lurbinectedin (unlicensed) for the treatment of relapsed Small Cell Lung Carcinoma (SCLC) & relapsed Extrapulmonary Small Cell Carcinoma (EPSCC) under a company-sponsored compassionate access scheme. The applicants requested lurbinectedin monotherapy be offered ahead of other currently available treatment options including topotecan, CAV (cyclophosphamide, doxorubicin, vincristine) or re-challenge with previous 1st line platinum containing combination therapy.

The Committee considered a phase 1 dose-finding study reported by *Calvo et al* examining lurbinectedin plus doxorubicin in adult patients with advanced solid tumours of any type, which separately reported tumour response results and median progression free survival (PFS) for the relapsed SCLC population (n=26) and adverse event rates (n=19). Overall response rate (ORR) was 57.7% [n=15, 95% CI 36.9-76.6%] with a higher proportion of responders in patients with sensitive disease (chemotherapy free interval (CTFI) ≥90 days) than patients with resistant disease (CTFI <90 days) of 91.7% [n= 12; 95% CI 61.5-99.8%] and 28.5% [n=4] respectively. Median PFS was reported as 4.7 months [95% CI, 3.5- 8.4] with longer median PFS in sensitive disease (5.8 months; 95% CI, 3.6-10.9) than resistant disease [2nd line: 3.5 months (95% CI 1.1–8.0); 3rd line: 1.2 months (95% CI 0.6–4.1)].

Results from a follow up phase 1 expansion study examining lurbinectedin plus doxorubicin were reported in an abstract by *Forster et al* for relapsed SCLC patients (n=27). ORR was 37% (n=10) with a higher proportion of responders in patients with sensitive disease (CTFI) ≥90 days) than patients with resistant disease (CTFI <90 days) of 53% [n= 9] and 10% [n=1] respectively. PFS was reported as 3.4 months [95% CI, 3.5- 8.4], and somewhat lower than Calvo et a. Median PFS was longer in patients with sensitive disease (5.8 months; 95% CI, 3.6-10.9) and resistant disease [2nd line: 3.5 months (95% CI 1.1–8.0); 3rd line: 1.2 months (95% CI 0.6–4.1)]. Overall survival was also reported as 7.9 months (95% CI, 4.9-11.5), which was proportionally higher in patients with sensitive disease (11.5 months) than those with resistant disease (4.9 months).

The Committee heard preliminary results reported by *Trigo Perez et al* of a phase 2 ongoing clinical trial of lurbinectedin monotherapy in a sub-population of patients with relapsed SCLC (n=50) which has an estimated completion date of January 2020. Partial tumour response was reported in 38% (n=19) patients, and 40% (n=20) had stable disease. Median PFS was 4.2 months (95% CI 2.8-6.3) and was higher in sensitive-disease: 4.7 months (95% CI 3.1-7.4) but not reported for resistant disease. Overall survival was not reportable.

The Committee were presented results from an RCT comparing topotecan and CAV in relapsed SCLC (*Von Pawel et al*) and a meta-analysis of topotecan use in relapsed SCLC (*Horita et al*) to allow an indirect comparison of lurbinectedin response rates to current available treatment options. Substantial variation in both tumour response rates and median PFS between the three lurbinectedin studies was noted. When indirectly compared to topotecan or CAV, there was a high level of uncertainty as to whether any additional advantage was conferred from lurbinectedin.

Safety results from the three lurbinectedin studies was indirectly compared to safety results from *Von Pawel et al* and *Horita et al.* Substantial variation in reported severe toxicities (grade 3/4) were noted between the three lurbinectedin studies and lurbinectedin may result in a higher risk of grade 3/4 anaemia, neutropenia and febrile neutropenia. The safety results reported in a phase 2 study by *Poveda et al* in platinum-resistant ovarian cancer were considered as this was the only published direct comparison study of lurbinectedin (monotherapy) with topotecan. This study reported that patients receiving lurbinectedin had a higher incidence of grade 3/4 neutropenia, febrile neutropenia, thrombocytopenia compared with topotecan.

The Committee highlighted that the early studies reporting on lurbinectedin's efficacy in relapsed SCLC were uncertain and limited by unpowered study design, small sample sizes, and different dosing regimens which likely accounted for the substantial variation between studies and the results being unlikely to reflect the true treatment effect. A phase 3 study (ATLANTIS) comparing lurbinectedin plus doxorubicin with CAV or topotecan is ongoing and expected to complete in early 2020. Parallels were drawn from positive signals initially reported for lurbinectedin efficacy in platinum resistant ovarian cancer from phase 1&2 studies. The recently reported (unpublished) phase 3 [CORAIL] study by *Gaillard et al* which compared lurbinectedin with pegylated doxorubicin or topotecan in platinum resistant ovarian cancer, subsequently reported no difference in tumour response rates, PFS or overall survival between lurbinectedin and topotecan. The presented early safety data for lurbinectedin from small phase 1/2 studies were too limited to conclude any improved safety profile over topotecan or CAV, and there were signals that lurbinectedin may have an increased risk of severe toxicities compared with topotecan.

In summary, the Committee agreed that lurbinectedin demonstrated encouraging tumour response rates but these represented an indirect surrogate marker for efficacy; improvements in PFS were less apparent, overall survival data was limited/not available and quality of life data were not available. The presented early supporting efficacy data was limited, with only preliminary data supporting lurbinectedin without doxorubicin. **Therefore, the Committee were unable to approve lurbinectedin monotherapy for SCLC or EPSCC under a compassionate access scheme ahead of established available treatment options, in particular ahead of a NICE TA approved treatment option (topotecan)**. The Committee encouraged applicants to attend a future meeting to discuss the potential role for lurbinectedin in patients who have failed available treatments options. It was also noted, that as the proposed place in therapy of lurbinectedin under the compassionate access scheme would apply to the entire population of relapsed SCLC or EPSCC, that this would be more suitably offered under an MHRA early access to medicines scheme (EAMS) rather than a company-led compassionate access scheme.

Decision: Not approved

9. **VSL#3 for maintenance of remission of pouchitis**
Item deferred

10. **Denosumab for treatment of osteoporosis in renal impairment**
Item deferred

11. **Sodium Clodronate for Adjuvant Breast Cancer**
Item deferred

12. **Dexmedetomidine for sedation of adult ICU patients: NENCL ACCN recommendations**
Following review of an application for dexmedetomidine at the July 2018 meeting, the Committee concluded that the presented evidence supported the use of dexmedetomidine however noted

differences in the proposed indications and place in therapy across NCL. The Committee agreed that expert opinion from the North East and North Central London (NENCL) ACCN (critical care specialist) would be of value. A summary of the recommendations was presented. The Committee thanked the network for their work and approved the following:

1. Updated indication: Dexmedetomidine should be initiated for light sedation (RASS 0 to -3) in mechanically ventilated adult patients with CAM ICU positive agitated delirium where agitation precludes weaning and extubation only after standard sedative agents (including propofol, clonidine or a benzodiazepine) had been trialled for 48 hours; and used in-line with the following recommendations:
    a. Commence dexmedetomidine at an effective dose (0.5-0.7micrograms/kg/hr) and escalate this dose over a short period to achieve the desired sedation target.
    b. At least 48 hours of treatment at an appropriate dose is needed for full clinical benefits to be observed and if dexmedetomidine had failed to improve agitated delirium after this then treatment discontinuation should be considered.
    c. Treatment duration: between two and five days
2. Removed indication: Dexmedetomidine in NIV patients
3. Removed indication: Adjunct for sedating intubated patients who are difficult to manage (alcohol/drug dependence, combative) where propofol or benzodiazepines have failed to achieve the target sedation level.

The Committee had also asked the Network to consider methods for Trusts to put the following in place for monitoring and limiting to appropriate use of dexmedetomidine. The Committee recommended that dexmedetomidine was subject to the following restrictions:

a. Consultant initiation only
b. Daily authorisation by consultant
c. Supplies to be made to individual patients via pharmacy and clinically screened by pharmacist before supply (with specific criteria to authorise supply)
d. Regular audit and interval reporting to departmental meetings (10, 30, 50 patients)
e. Financial monitoring

The Committee requested that usage was monitored at an NCL level and requested JFC Support to use DEFINE data in 6 and 12 months to identify outliers with particularly high usage.

Decision: Approved for light sedation (RASS 0 to -3) in mechanically ventilated adult patients with CAM ICU positive agitated delirium where agitation precludes weaning and extubation only after standard sedative agents (including propofol, clonidine or a benzodiazepine) had been trialled for 48 hours
Prescribing: Secondary care only
Tariff status: In tariff
Funding: Trust
Fact sheet or shared care required: No
Additional notes: Trusts to put in place methods for limiting and monitoring use of dexmedetomidine, as above, to include regular audits. JFC Support to establish 'dexmedetomidine spend per ITU bed' in 6 and 12 months' time.

13. Melatonin fact sheet [for approval]

Item deferred

14. Rubefacients position statement

Item deferred

15. NCL managing common infections in primary care

Item deferred

16. Next meeting

Monday 18th February 2019, 4.30 – 6.30pm, Venue: LG01, 222 Euston Road, London, NW1 2DA

17. Any other business