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Academic Health Science Partnership

NHS
North Central London
Joint Formulary Committee

JOINT FORMULARY COMMITTEE (JFC) – MINUTES

Minutes from the meeting held on Thursday 26th March 2015
Room 6LM1, Stephenson House, 75 Hampstead Rd

Present:	Prof R MacAllister	NCL JFC Chair	**(Chair)**
	Prof L Smeeth	NCL JFC Vice-Chair	**(Vice-Chair)**
	Dr R Sofat	UCLH, Consultant Clinical Pharmacologist	
	Dr D Bavin	Camden CCG, GP	
	Dr P Bhalla	RNOH, DTC Vice-Chair	
	Mr TF Chan	BCF, Chief Pharmacist	
	Mr A Dutt	NHS Islington, Head of Medicines Management	
	Mr P Gouldstone	NHS Enfield, Head of Medicines Management	
	Mr J Paszkiewicz	NEL CSU, Prescribing Advisor	
	Ms L Reeves	C&I Mental Health Trust, Chief Pharmacist	
	Dr H Taylor	Whittington, Chief Pharmacist	
	Ms P Taylor	NHS Haringey, Head of Medicines Management	
	Mr A Shah	RNOH, Chief Pharmacist	
	Ms N Shah	NHS Camden, Head of Medicines Management	
	Dr L Wagman	Barnet CCG, GP	
In attendance:	Ms U Bhatt	Prescribing Advisor, Camden CCG	
	Mr P Bodalia	NCL JFC, Lead Pharmacist	
	Mr E Hindle	MEH, Formulary Pharmacist	
	Dr D MacDonald	RFH, Consultant Hepatologist	
	Mr G Purohit	RNOH, Deputy Chief Pharmacist	
	Dr S Ragavan	NMUH, Consultant Geriatrician	
	Ms I Samuel	RFH, Formulary Pharmacist	
	Ms S Sanghvi	UCLH, Formulary Pharmacist	
	Dr R Zarnegar	RNOH, Chronic Pain Consultant	
Apologies:	Dr P Ancliff	GOSH, DTC Chair	
	Dr E Boleti	RFH, Consultant Oncologist	
	Dr R Breckenridge	UCLH, DTC Chair	
	Ms J Cope	GOSH, Chief Pharmacist	
	Mr C Daff	NHS Barnet, Head of Medicines Management	
	Ms S Drayan	NMUH, Chief Pharmacist	
	Dr R Fox	RNOH, DTC Chair	
	Dr J Hurst	RFH, Consultant Chest Physician	
	Mr T James	MEH, Chief Pharmacist	
	Mr A Karr	NCL Procurement Consortia Chair	
	Dr R Kapoor	UCLH, Consultant Neurologist	
	Dr M Kelsey	Whittington, DTC Chair	
	Ms W Spicer	RFH, Chief Pharmacist	
	Dr C Stavrianakis	Haringey CCG, GP	
	Dr V Thiagarasah	Enfield CCG, GP	
	Dr A Tufail	MEH, DTC Chair	
	Dr R Urquhart	UCLH, Chief Pharmacist	

2. Minutes of the last meeting

Item 2: It was noted that Dr D Bavin sought clarification regarding the Camden DMARD guideline decision, not Ms N Shah.

Item 5.1: The Committee were informed that within NICE TA 213, aripiprazole is recommended for schizophrenia in people aged 15 to 17 years, and as such would apply to a number of sites within NCL. As aripiprazole prolonged-release injection was approved for patients stabilised and responding to oral aripiprazole, the Committee agreed to remove the restriction limiting prescribing of aripiprazole prolonged-release injection to Camden & Islington Mental Health site only and accept it onto the NCL Joint Formulary across all sites.

3. Matters arising

3.1 NHSE: The Pregabalin Guidance

The Committee noted the guidance issued by NHS England regarding pregabalin. The Committee agreed that brand name prescribing of Lyrica® for neuropathic pain was irrational and detrimental to NHS cost-saving initiatives, however conceded that CCGs would have to comply from a legal standpoint.

3.2 NHSE/PHE: Advice on risk of misuse of pregabalin and gabapentin

The Committee noted the advice for prescribers on the risk of misuse of pregabalin and gabapentin and agreed to disseminate to relevant stakeholders.

4. Declarations of relevant conflicts of interest

None were declared.

5. New Medicine Reviews

5.1 Pregabalin for spinal-cord injury neuropathic pain (Applicant: Dr R Zarnegar (RNOH); Presentation: Mr G Purohit)

The Committee reviewed an application for the use of pregabalin for spinal cord injury (SCI) related neuropathic pain. The Committee heard that SCI pain is often refractory to standard treatments for neuropathic pain and that most RCTs in SCI pain for such agents have yielded negative results. A Cochrane review in 2011 summarised the published RCT data for pregabalin in SCI neuropathic pain and showed a statistically significant reduction in pain compared to placebo (mean difference -1.30 [95% CI -2.11 to -0.16]). There are no comparative studies between pregabalin and gapabentin or other agents, however in general the evidence for pregabalin and gabapentin in neuropathic pain does not favour either agent as being superior. Amitriptyline showed conflicting results for SCI related pain from low-level evidence, and a small study by Vranken et al failed to meet its primary endpoint (reduction in mean pain score at week 8 from baseline) when investigating duloxetine against placebo for neuropathic pain caused by SCI.

Dr Zarnegar proposed a treatment algorithm for the management of SCI related neuropathic pain at RNOH which included tramadol as first line therapy, gabapentin second line and IV lidocaine infusion third line, consistent with the presented evidence. Pregabalin would be used (in combination with tramadol where appropriate) for patients who respond to gabapentin but suffer from intolerable adverse effects, prior to using IV lidocaine infusion. Dr Zarnegar agreed with the Committee that there is no evidence that pregabalin is superior to gabapentin; however for this niche cohort who are difficult to treat it would offer an evidence-based treatment option prior to use of IV lidocaine. Although the Committee felt that the use of tramadol up-front was unconventional, they agreed with Dr Zarnegar's rationale that it was quicker to titrate than amitriptyline (owing to its relatively fast onset of action to therapeutic steady state) and would therefore allow a rapid assessment of response, as well as holding a higher level of evidence for efficacy in SCI neuropathic pain. Dr Zarnegar lastly clarified that although IV lidocaine would initially be used in combination with tramadol and gabapentin / pregabalin, in situations where rapid dose escalation is required the oral medication would be stopped.

Overall, the Committee agreed that the application presented was reasonable, and therefore agreed to include pregabalin on to the NCL Joint Formulary (restricted to the RNOH site only) under Category of Evaluation for 1 year in accordance with the protocol pending minor revisions. The previous position on non-specific neuropathic pain remains i.e. pregabalin may be considered only after the failure of amitriptyline [first-line] and where use of gabapentin [second-line] has provided clinical benefit but resulted in off-target adverse effects on the provision that audit data are collected.

5.2 Buprenorphine patch for chronic pain (Applicants: Dr S Edwards (NMUH), Dr S Ragavan (NMUH), Dr R Edwards (WH); Presentation: Ms S Sanghvi)

The Committee reviewed an application for buprenorphine patches for chronic pain in patients unable to take oral opioids (first-line) or in patients who have not tolerated oral opioids (third-line).

The Committee considered a Cochrane review (2013) by Chaparro et al, which included 2 studies (n=653) which varied in methodology and had several flaws including an enriched design. Overall the evidence was deemed to be of very low quality, however, the meta-analysis showed that transdermal buprenorphine may slightly improve pain compared to placebo with a standardised mean difference of -2.47 for pain intensity (from a scale of 0-10). Interestingly, the Committee noted that there was no improvement compared to placebo for the secondary outcomes, including ≥30% pain relief, ≥50% pain relief and disability.

Five other double-blinded RCTs were considered which demonstrated the efficacy of transdermal buprenorphine in reducing pain compared to placebo although there was a significant placebo response across all trials. In contrast, a double-blind RCT by Bohme & Likar (2003; n=151) in patients with severe chronic pain failed to show a statistically significant improvement in pain relief with transdermal buprenorphine (34-50% responder rate) compared to placebo (31% responder rate).

The Committee considered a network meta-analysis by Wolff et al which concluded non-significant difference between buprenorphine patch and placebo with regards to reduction in pain intensity, however, use of buprenorphine patches was associated with better control of pain intensity compared to morphine (MD -16.20, 95% CI -28.92 to -3.77). There was no significant difference in pain intensity or quality of sleep with buprenorphine patches compared with fentanyl patches.

Overall the Committee agreed that the robustness of the evidence base is limited and assessment is difficult due to the variation in trial design, significant discontinuation rates and the relatively short duration of the studies. Due the nature of conflicting data, clear interpretation was not possible with some data suggesting buprenorphine has comparable efficacy to equivalent doses of oral opioids or fentanyl patches whilst other studies demonstrated no advantage over placebo.

In terms of safety, buprenorphine patches have a typical opioid adverse effect profile, with the most common systemic adverse drug reactions of nausea, vomiting, dizziness, constipation and fatigue. Use of the patch is associated with local site reactions (including erythema, pruritis and rash), although generally well tolerated. The network meta-analysis by Wolff et al found that buprenorphine patches have a favourable tolerability profile compared to fentanyl patches and oral morphine with a lower incidence of nausea, vomiting and treatment discontinuation due to adverse effects.

In terms of cost, the Committee noted that the SMC reviewed BuTrans patches in 2008 and rejected their use across NHS Scotland on an economic basis. The comparative costs for oral and transdermal opioids were considered; in particular that BuTrans® is significantly more expensive than other equivalent opioid doses, but that at low doses of 5mcg/hour (BuTrans '5') and 10mcg/hour (BuTrans '10'), there is no equivalent fentanyl patch. Although availability of the generic Hapoctasin patch (equivalent to Transtec) may offer cost savings in place of fentanyl patches, the Committee felt that the introduction of an unfamiliar agent would increase complexity and confusion around prescribing and was therefore not supported. Therefore, for patients unable to swallow tablets who require a high-dose transdermal opioid it was agreed to remain with fentanyl patches.

The Committee discussed at length the position of BuTrans on the formulary, taking into consideration its favourable tolerability, questionable efficacy, and increased cost compared with fentanyl patch. Dr Bavin acknowledged the poor evidence base for buprenorphine patches but highlighted the practical issues faced in primary care around opioid prescribing in the elderly, particularly, tolerability issues with oral morphine and fentanyl patches even at the lowest doses. Despite the poor quality of data, the Committee conceded that there may be some benefit to patients overall in terms of convenience, compliance and community costs (e.g. district nurses) even by a potential placebo effect.

In conclusion, the Committee agreed to add BuTrans '5' and '10' patches to the NCL Joint Formulary with a restriction to patients unable to take oral opioids due to swallowing difficulties / short bowel AND

requiring a lower dose transdermal opioid than the 12mcg fentanyl patch. All other strengths of BuTrans and preparations of buprenorphine patch (i.e. Transtec and Hapoctasin) remain non-formulary.

6 Pathway for Treatment of Hepatitis C (Early Access Scheme)

The Committee welcomed Dr MacDonald to the meeting to present an update on the early access scheme for the treatment of hepatitis C. NHS England have confirmed that they will expand the selection criteria from April 2015 to treat HCV compensated cirrhotics [in addition to the decompensated and high risk hepatitis C patients already treated]. Within London, patients with hepatitis C are referred to RFH or Bart's Health. In order to facilitate equal and timely access to care with consideration to capacity issues at RFH (approximately 350 patients per annum), it is proposed that all patients within NCL will be reviewed at an MDT at RFH with treatment provided via the local centre.

The Committee reviewed the minutes from the RFH DTC meetings where the relevant drugs were considered and agreed that these approvals should be ratified and included within the NCL Joint Formulary. The regimes approved are detailed below. The NHSE Clinical Reference Group for hepatitis C is in the process of developing a pathway which is due to be published in April 2015 via the British Association for Study of Liver Disease (BASL). The proposed use of simpeprivir was noted as being a last-line therapy (on the basis of lower SVR rates) for patients unable to receive the other oral agents OR for patients who cannot wait for the updated commissioning arrangements and require immediate treatment (RFH site only).

- Sofosbuvir + Ledipisvir (Harvoni®) +/- Ribavirin
- Sofosbuvir (Sovaldi®) + Daclatasvir (Daclinza®) +/- Ribavirin
- Dasabuvir (Exviera®) + Ombitasvir, Paritaprevir and Ritonavir (Viekirax®) +/- Ribavirin
- Sofosbuvir (Sovaldi®) + Ribavirin
- Simeprivir + peginterferon + ribavirin

7 Glaucoma Guidelines Update

The Committee approved the updated glaucoma prescribing guidelines.

8 Fact Sheet: Ciclosporin 0.2% Eye Ointment

The Committee approved the fact sheet for ciclosporin 0.2% eye ointment.

9 Local DTC Recommendations

Site	Drug / Indication	Outcome
BCF / RFH	Eliglustat for Gauchers disease	Interim approval under compassionate use scheme for RFH only
	Lenalidomide for aggressive relapsed refractory DLBCL	Approved as third/last line option under compassionate use scheme
	Rufinamide for refractory epilepsy in children	Approved
	SMOF-lipid for neonatal parenteral nutrition	Approved as a replacement of Intralipid 20%
GOSH	Nil	Nil
MEH	Nil	Nil
NMUH	Nil	Nil
RNOH	Nil	Nil
UCLH	Diltiazem cream for transrectal ultrasound guided prostate biopsy	Approved under evaluation for 1 year
	Pristinomycin for treatment of prosthetic joint infection	Approved pending funding confirmation at each site
	Octenidene wash for MRSA suppression in patients hypersensitive to chlorhexidine	Approved
WH	Nil	Nil

10 Dates/Venues for 2015

These were included for information

11 Next Meeting

30th April 2015, Room 6LM1, Stephenson House, 75 Hampstead Rd

12 Any other business

- Mr Dutt requested that the NCL JFC website be updated to help with signposting GPs. Mr Bodalia agreed to upload recent decisions and minutes.
- Dr Hurst (RFH, Respiratory Consultant) has stepped down from the Committee due to clinical commitments. The Committee thanked him for his contributions
- Ms N Shah requested that Trusts and CCGs invite all relevant stakeholders to contribute to JFC discussions. This followed a complaint from local diabetes consultants who were not kept informed of JFC discussions around NICE guidance on diabetes. Prof MacAllister suggested that it was the responsibility of the representatives from each member site to communicate any relevant information, including invitations