MINUTE of meeting of the Formulary Subgroup (FS) of NHS Highland ADTC
25 August 2015, Board Room, John Dewar Building, Inverness

Present: Okain McLennan, Chair
Evelyn Cromarty, Formulary Pharmacist
Lindsay Barr, Deputy Lead Pharmacist (Primary Care) - Argyll & Bute (by VC)
Susan Caldwell, Senior Pharmacist, Medicines Management & Information
Findlay Hickey, Lead Pharmacist (West)
Dr Robert Peel, Consultant Nephrologist
Johnson Swinton, Patient Representative
Dr Jude Watmough, GP

In attendance: Roberta Kerr, Formulary Assistant
Jack Whitelaw, Pre-registration Trainee Pharmacist

Apologies: Dr Borja Echavarren, GP
Dr Stephen McCabe, GP
Archie Vallance, Raigmore Hospital Patients’ Council Representative

1. WELCOME AND APOLOGIES
   • The chair welcomed members and extended a special welcome to Jack Whitelaw, Pre-Registration Trainee Pharmacist, attending as an observer.
   • The Chair thanked FH for chairing the previous meeting.

2. MINUTES OF MEETING ON 26 MAY 2015
   • Minutes were approved as accurate.

3. FOLLOW-UP REPORT ON ACTIONS AGREED ON 26 MAY 2015
   Item 5e
   • EC has had discussions with LB regarding cross-charging.

   Item 6b: Junior Doctors’ Handbook
   • EC is liaising with Dr Lambie regarding the Junior Doctors’ Handbook.
   • It has been removed from the Intranet. A new version is in production.
   • There have been discussions about linking it to the proposed new Formulary website and making it more accessible.
   • In the meantime information is still available but not all in one place.

4. DECLARATIONS OF INTEREST
   • None.

5. CONSIDER FOR APPROVAL ADDITIONS TO FORMULARY
   a) Apremilast (Otezla®) tablets 10mg, 20mg, 30mg
      • New licensed medicine requested by Dr Harvie for use 3rd or 4th line in rheumatoid arthritis in accordance with SMC advice.
      • Also licensed for use in psoriasis and dermatologists considering its use.
      • Good safety record.
      • Advantage of oral tablets and cost savings over other preparations.
      • FH would like to clarify the numbers of patients to be treated as there appears to be a steep increase over 5 years.
• Patients will be treated for longer therefore costs may increase.
• FH felt that there will be savings in the short term then patients will move onto other drugs so it is not entirely cost saving and may increase costs over time.
• The Chair would also like clarification of patient numbers and long-term costs.
• SC suggested that staff costs also need to be taken into consideration.
• The Chair felt that it is critical to get other associated costs and requested that this information be sought.
• ACCEPTED.

Action:
Seek clarification of apremilast for budget planning

b) Atovaquone suspension 750mg/5mL
• Licensed pre-SMC.
• Requested by Dr Beadles for treatment of mild to moderate Pneumocystis jiroveci pneumonia (PJP) in patients intolerant to co-trimoxazole.
• JS asked if this would be used if other drugs became ineffective.
• RP said that it was used in allergies – co-trimoxazole is prone to causing allergies.
• ACCEPTED.

c) Temocillin sodium 1 gram vial for intravenous injection
• Requested by Dr Mills for treatment of multi-drug resistant urinary-tract infections (UTI).
• The Chair suggested that the wording on submission forms may need to be changed to reflect presence of SMC advice.
• RP suggested that temocillin could be a means to try and avoid prescribing meropenem.
• The Chair requested clarification of costings.
• ACCEPTED.

Action:
Seek clarification of costings for temocillin submission

d) Matoride XL tablets 18mg, 36mg and 54mg
• Requested by Dr Henderson as part of treatment programme for attention deficit hyperactivity disorder (ADHD) in children aged 6 and over when remedial measures alone prove insufficient.
• The ADHD section of the Highland Formulary has 3 brands of methylphenidate, each with different release properties. Branded generics are now coming out with equivalent release properties to one of the brands.
• Dr Henderson is happy to look at other options.
• The Chair felt that there was not enough data on the submission, eg numbers of patients, costs.
• The Chair requested that a decision be deferred pending more information.
• FH suggested asking manufacturers for a commitment on lower prices, ie a guarantee that the price reduction would remain.
• LB asked whether patients would be switched or whether Matoride XL would be initiated in new patients only, and whether there was any guidance.
• It was agreed that guidance on switching would be requested.
• DEFERRED.

Action:
Liaise with Dr Henderson re branded generic choice and guidance for switching

e) Bosutinib (Bosulif®) tablets 100mg, 500mg
Ponatinib (Iclusig®) tablets 15mg, 45mg
• Licensed medicines requested by Dr Craig for treatment of adult patients with leukaemia who have been previously treated with one or more tyrosine kinase inhibitor(s) and for whom imatinib, nilotinib and dasatinib are not considered appropriate treatment options.
• RP felt that the submission lacked sufficient evidence; concerns have been raised with SMC regarding negative responses to drugs not being noted.
• Trials were on a small number of patients - evidence was not submitted to peer review. FH requested that his unease with this submission be put on record.
• These medicines may not be used as they are ultra-orphan. There may only be a few patients in Highland. Evidence is not good but it would be politically hard to refuse.
• The Chair suggested feeding concerns back to ADTC and FH added that ADTC could then refer concerns to SMC.
• FH felt that side-effects had been played down in the impact assessment. There is a major issue around cardiovascular risks.
• There is political pressure to have early access for patients, overriding primary concern for patient safety.
• ACCEPTED.

Action:
Write to ADTC with concerns

FH/RP/EC

f) AquADEKs® paediatric liquid and chewable tablets
• Multivitamin formulated for cystic fibrosis patients who have poor absorption and require higher doses. Easier for children to take the high doses of vitamins they require.
• AquADEKs® are a food supplement listed as ACBS and will therefore be added to unlicensed medicines list.
• Used in leading CF centres in the UK and will be used in a small number of patients in Highland.
• The Subgroup felt that the cost was small for the benefits offered. FH said that it would be covered by Pay & Report in Primary Care.
• EC has been liaising with the distribution company and the CF team.
• ACCEPTED.

g) Umeclidinium 55 microgram/vilanterol 22 microgram (Anoro® Ellipta®) dry powder inhaler
• Requested by Dr Paterson.
• New combined inhaler used in moderate to severe COPD where corticosteroid is not suitable.
• Could minimise use of inhaled corticosteroids in some patients.
• FH supports its inclusion but needs the same consideration to combination drugs. He suggested a link to Section 3.1 and 3.2 and guidance in when this inhaler could be an alternative to steroids.
• Cost-wise, is competitive and FH is positively inclined towards it
• Need to think about cross-referencing Sections 3.1 and 3.2 – SC agreed.
• SC suggested asking respiratory consultants for advice on switching.
• ACCEPTED.

6. UPDATED AND NEW SECTIONS AND GUIDANCE

a) Part of Section 4.10 Drugs used in substance dependence

Nicotine dependence and ‘Smoking cessation interventions’
• Updated with Susan Birse, Sharon Pfleger and Thomas Ross.
• Reflects updated national advice.
• eCigarettes are now accepted as NRT by Public Health England. There was some discussion about this issue.
• If Section/Guidance needs reworked the initiative has to come from Public Health.
• The Chair voiced concerns that the public might start enquiring about e-Cigarettes.
• JW reported that in Primary Care smokers who have switched to e-Cigarettes can be coded as ‘non-smokers’.
• FH felt that it would be good to include a statement from Public Health. And the Chair agreed that some advice needs to be available.

Action:
Confirm e-cigarette wording with Public Health.

EC

b) Part of Chapter 5: Infections

Part of ‘Antibiotic prophylaxis in surgery – general principles’
• Additional text has been added to strengthen advice.
HF will link to new endocarditis policy on intranet.
The online dose calculator is under ‘clinical applications’ on the Intranet. It cannot be published on the Internet as it is classified as a medical device.

**Changes were accepted subjected to correction of a small error in the policy, noted by SC.**

c) Chapter 14: Immunological products and vaccines

- Chapter and guidance have been updated in light of changes to the meningitis vaccination programme.
- Changes were accepted.

7. **MINOR AMENDMENTS TO HIGHLAND FORMULARY**

- Both strengths of co-danthramer will be removed from the Formulary.
- SC enquired whether the electrolyte policy would be reviewed in light of the addition of magnesium aspartate. EC has spoken to Jane Smith and hospital guidance will be updated in due course to reflect this.
- It was suggested that changes to ‘Achieving control in type 2 diabetes’ guidance should be flagged up in the Pink One/Formulary Update.
- EC also thanked LB for her input into these changes.
- Daktacort’s interaction with warfarin was discussed. Patients have come to harm despite warnings, therefore there was a request to remove it from the Formulary.
- JW uses it as an alternative to Canesten HC and feels that it works better.
- Community pharmacies are missing the oral gel now that it is off the Minor Ailments Formulary, as they could offer it over the counter. JW asked if it would be more controlled if it was dispensed in community pharmacies but RP raised concerns that patients might not mention miconazole when being started on warfarin.
- JW asked whether the way that interactions are flagged up on Vision needed looked at so that prescribers don’t overlook interactions.
- There was a discussion about the level of interaction via oral gel and topical ointment. Systemic absorption is noted in the cream and ointment SPCs.
- JW asked whether there had been a recent incident. SC didn’t think that there had been any enquiries in Medicines Information, but Jane Smith has been working on it in Medicines Management and Dermatology have been consulted.
- FH did not want to remove something useful from the Formulary. It has not been been withdrawn by MHRA.
- EC has consulted the podiatrists about miconazole powder spray since the SPC advises caution in patients on warfarin.

**Action:**
Reconsider decision to remove Daktacort

EC

8. **Highland Gluten-free Food Formulary**

- The national Gluten-free Foods scheme is now under review. The review will be published next month.
- The Scottish Government has updated the list of prescribable in accordance with Government circular (PCA(P)(2015)11).
- There are no other changes.
- The patient group have approved the update.
- Changes were accepted.


- Updated with good practice points.
- Only includes items which are included in the Highland Formulary.
- LB pointed out that there was no advice about using isphagula and lactulose in the elderly, or advice on prn use of lactulose. She also asked if the Laxido® brand was still used. Laxido® is included as it is on the national contract.
- LB also asked about eye preparations – there is no preference in the Minor Ailments Formulary, should eye products be listed in the same way as the Formulary?
LB asked whether co-codamol 8/500 should be prescribed in the community?  This has been discussed extensively and was left in MAF as it is still in the Formulary.

LB suggested adding some wording to indicate that it is less suitable.

FH felt that it would be difficult to remove co-codamol 8/500 as it has a perceived benefit over paracetamol.

LB suggested flagging up first-choice drugs so the Formulary is clear, eg drugs for constipation. It was noted that the first choice drugs are already highlighted in bold.

FH commented that the Minor Ailments Service has become a significant part of the Health Service.

The percentage of the budget is small in drug terms, inexpensive items with no delayed access. FH felt that having a Formulary to manage the service is hugely important.

10. Formulary decisions on SMC advice

Information provided for June, July and August. The Subgroup were asked to treat August information as confidential until released to the public on 7/9/15.

There was discussion about PACE (‘patient and clinician engagement’). Some of the Subgroup were not familiar with this term.

HIS is looking at wording for publishing FSG decisions on SMC advice. Health boards are being encouraged to standardise wording to be more ‘patient-friendly’. EC will keep the Subgroup informed.

11. Progress report

The Vision Formulary will be updated.

EC is working on an EMIS formulary for those practices that use it.

12. Any other competent business

EC is liaising with eHealth on a redesign of the electronic Formulary intranet pages. It is hoped that this will host other resources such as the Junior Doctors’ Handbook.

Formulary Update is being redesigned as an emailed newsletter.

A draft will be sent to the Subgroup for approval before it is sent to prescribers. The Chair and FH were happy with this as long as there was a clear deadline and no response would be seen as acceptance.

JW asked if there was another process by which it should be checked. FH explained that the Update reflects facts whereas the Pink One editorialises and this can lead to difficulties.

ADTC will discuss how the Pink One could be relaunched.

FH suggested numbering versions of the Formulary as they are updated, eg 6.1, 6.2 etc.

A closed Formulary will be discussed at a later meeting.

Pharmacy Services Team does not yet have a date for the move to Southside Lodge.

13. Date of next meeting

Tuesday 27 October 2015, 12:00-14:00. Board Room, John Dewar Building.