NCL Joint Formulary Committee (JFC) Meeting

Minutes from the meeting held on Thursday 24th January 2013
in the Board Room, Floor 3, UCLP Building, Tottenham Court Road

Present:	Prof R MacAllister	RM	NCL JFC Chair
	Prof L Smeeth	LS	NCL JFC Vice Chair
	Dr H Taylor	HT	WH Chief Pharmacist
	Mr A Dutt	AD	NHS Islington, Head of Medicines Management
	Ms P Taylor	PT	NHS Haringey, Head of Medicines Management
	Prof A Hingorani	AH	UCLH Clinical Pharmacologist
	Ms S Drayan	SD	NMUH Chief Pharmacist
	Mr A Shah	AS	RNOH Chief Pharmacist
	Dr M Kelsey	MK	WH Consultant Microbiologist
	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 N Shah	NS	NHS Camden, Head of Medicines Management
	Ms W Spicer	WS	RFH Chief Pharmacist
	Mr C Daff	CD	NHS Barnet, Head of Medicines Management
	Mr G Irvine	GI	Lay member
	Dr R Fox	RF	RNOH DTC Chair
	Dr C Stavrianakis	WZ	NHS Haringey, CCG
	Mr TF Chan	TC	BCF Chief Pharmacist
	Ms L Reeves	LV	C&I Mental Health Trust
	Ms B Brese	BB	Commissioning Support Unit
	Dr L Wagman	LW	NHS Barnet, CCG
	Ms R Dallmeyer	RC	NCL Pharmacist
In Attendance:	Ms K Chapman	KC	MEH Formulary Pharmacist
	Mr P Bodalia	PB	RNOH Deputy Chief Pharmacist
	Mr K Thakrar	KT	UCLH Formulary Pharmacist
	Dr R Hamid	RH	Consultant Urologist, RNOH
	Dr D Wood	DW	Consultant Urologist, UCLH
Apologies:	Ms P Shah	PS	NCL Pharmacist
	Ms J Cope	JC	GOSH Chief Pharmacist
	Dr E Boleti	EB	RFH Consultant Oncologist
	Dr P Ancliff	PA	GOSH DTC Chair
	Dr A Jolly	AJ	BMJ Health Economics
	Dr N Trevor	NT	BMJ Health Economics
	Dr P Sardana	PS	NHS Enfield, CCG
	Prof A Jones	AJ	UCLH & RFH Consultant Oncologist
	Dr D Bavin	DB	NHS Camden, CCG
	Dr S Bennett	SB	NHS Islington, CCG
	Dr R Urquhart	RU	UCLH Chief Pharmacist
	Mr A Karr	AK	NCL Procurement Chair
	Dr Penny Hyatt	PH	NMUH DTC chair

1. Members & meeting observers

The chair welcomed the applicants and observers to the meeting. Prof MacAllister welcomed Ms B Brese as the new CSU representative.

2. Minutes of the last meeting

These were accepted as accurate.

3. Matters arising

3.1 NOAC choice

The Committee were informed that there appears to be little difference in the acquisition costs between each of the two NICE-approved drugs. The Committee discussed at length with regards to a potential NOAC of choice on the NCL Formulary, and agreed that considering these drugs have differing profiles, it would seem reasonable to have one preferred agent stated on the formulary to secure familiarity with prescribing. The Committee agreed that rivaroxaban has an advantage in that it need only be taken once a day and it may be less problematic to reverse its anti-coagulant effect.

The Committee were also informed that NICE have recently published draft guidance recommending apixiban as another option for the prevention of stroke and systemic embolism in people with non-valvular atrial fibrillation; however the manufacturer has not yet revealed whether any discounts may follow. The Committee thus agreed to re-visit once the commercial state of play with apixiban was known.

In the meantime the Committee should summarise its view on NOAC for patients with atrial fibrillation, including the sorts of patients that should be offered NOACs and the agent of choice.

3.2 Terms of Reference update: Membership & voting rights

Concerns had been raised with regards to the balance of primary and secondary care membership. The Committee were informed that there are currently 21 secondary care and 19 primary care members therefore the membership was considered satisfactory.

3.3 NCLMMC sub-group

It was suggested that the NCL Medicines Management Committee (NCLMMC) [consisting of Chief Pharmacists from each hospital] be a designated sub-Committee of the JFC. The role of this sub-group will be to review matters that may not be able to reach the JFC directly due to capacity demands. The Committee agreed with the NCLMMC set-up and it was agreed that minutes should be forwarded to the JFC secretariat for circulation with the subsequent JFC agendas.

3.4 Terms of Reference: applicant presentations

The Committee agreed that an independent expert should present applications to the JFC and not the applicants directly.

4. Members declarations of conflicts of interests

None declared.

5. New Medicine Applications

5.1 Dexamethasone (Ozurdex®; Allergan Ltd) for Uveitis

Applicant	Presented by	Outcome
Dr Hameed	AT	Approved
The Committee reviewed the one main single, multicentre, randomised study (Huron study; n = 229) that evaluated the safety and efficacy of dexamethasone intravitreal implant for the treatment of non-infectious ocular inflammation of the posterior segment in patients with uveitis. Patients were randomised to receive dexamethasone 350microgram or 700microgram or sham. The primary end point was the change in vitreous haze score from baseline. The Committee noted that a vitreous haze score of zero [at 8 weeks] was achieved in 47% of patients in the 700microgram group, 36% in the 350microgram group, and only 12% in the sham group ($p < 0.001$). The effects persisted through to week 26. In addition, the proportion of eyes achieving a gain in ≥ 15 letters from baseline BCVA was 2- to 6- fold greater in the dexamethasone implant group compared to the sham group.		

The Committee raised concerns with regards to the administration of the dexamethasone implants in both eyes, as well as the possibility of injecting at a frequency of greater than six monthly as advised. However, the Committee were informed that consultants at Moorfields have had considerable experience in using dexamethasone implants already. In addition, the Committee were satisfied that the patients would be monitored and only injected repeatedly once the effects of the dexamethasone was wearing off. The Committee also discussed the use of triamcinolone, however were informed that the manufacturers have now specifically indicated on the package that it should not be used for intravitreal administration.

There were no major safety concerns reported in the trials. The most frequently reported ocular adverse reactions were conjunctival haemorrhage, raised intra-ocular pressure, cataracts, ocular hypertension, and eye pain.

Dexamethasone implants cost £1,600 per dose (including administration costs). The annual cost impact would vary depending on frequency of administration and whether unilateral or bilateral treatment, however the maximum annual cost per patient would be *circa* £6,600.

In summary, the Committee were satisfied that dexamethasone intravitreal implants are an efficacious and safe option for the treatment of uveitis. The Committee agreed that it should be including on the NCL Formulary and that an NCL business case is not needed and it was agreed that this indication could simply be added to the PbR-excluded list.

5.2 Tisseel fibrin sealant (Tisseel Lyo®; Baxter Ltd) for conjunctival surgery

Applicant	Presented by	Outcome
Dr Tuft	KC	Approved

The Committee reviewed an application for the use of Tisseel Lyo to replace conjunctival sutures in pterygium surgery and in patients with friable conjunctiva where sutures may not hold (e.g laceration, flap surgery).

The Committee reviewed a single meta-analysis by Pan et al (2011) that compared the efficacy of fibrin glue versus sutures for conjunctival autografting in pterygium surgery. The meta-analysis involved seven randomised controlled trials with 336 eyes requiring pterygium surgery. The study outcomes included operating time, complication rates, and recurrence rate. The Committee noted that fibrin glue was associated with a significantly shorter operating time, with a WMD of -17.6 minutes (95% CI -26.0 to -9.2; $p < 0.001$). In addition to this, fibrin glue was more effective in reducing recurrence rates compared to sutures, with no significant differences in complication rates. The Committee also scrutinised the largest randomised trial within the meta analysis (Ratnalingam et al) that showed a 4.4% recurrence rate in the fibrin glue arm versus a 15.9% recurrence rate with sutures. The Committee noted that considering fibrin glue is a protein, hypersensitivity-like reactions are possible and thus should be used with caution.

The incremental cost in switching from sutures to Tisseel Lyo would incur a cost impact of £67 per patient. Moorfields estimates an average of 75 patients a year, resulting in an annual cost impact of £5,000.

In summary, the Committee were persuaded that Tisseel Lyo was preferable to sutures in pterygium surgery in terms of safety, recurrence rates, and operating time. The Committee agreed to include Tisseel Lyo into the NCL Formulary and that an NCL business case is not needed and it was agreed that this indication could simply be added to the PbR-excluded list.

5.3 Botulinum toxin (Botox®; Allergan Ltd) for neurogenic bladder dysfunction

Applicant (Trust)	Presented by	Outcome
Dr Hamid(RNOH)	PB	Approved

The Committee reviewed an application for the use of botulinum toxin (Botox®) for neurogenic detrusor overactivity (NDO).

The Committee were informed that the RNOH DTC have previously approved the use of Dysport® in an off-label capacity as a second-line treatment for adult patients with NDO. However, Botox® subsequently received a Marketing Authorisation for the management of urinary incontinence (UI) in adult patients with NDO who are not adequately

managed with anticholinergics (200 unit dose).

The Committee reviewed the largest study (Cruz et al) investigating the efficacy of Botox in 275 adults with UI due to NDO in a randomised, double-blinded, placebo controlled trial. The primary endpoint was change in UI episodes per week from baseline to week 6 between placebo and Botox® groups (200iu and 300iu). At week 6 and 12, the mean weekly UI episodes were significantly reduced with the use of Botox® compared with placebo, with a 35.9% reduction in placebo compared to a 67.1% reduction in the Botox arm ($p<0.001$ for both dose group). No clinically relevant differences were observed in efficacy between the two Botox® dose groups. In addition, the median duration of effect following the first dose was 42.1 weeks for both Botox® dose groups compared with 13.1 weeks for the placebo group ($p<0.001$).

The Committee discussed at length with regards to using Xeomin® off-label as it is less expensive. The Committee was however informed that the consultants would prefer to use a licensed product in comparison to an off-label preparation for governance and liability reasons.

Although prices may vary at individual hospitals a switch from Dysport to Botox at the RNOH would result in a saving as opposed to any cost impact.

In summary, the Committee were persuaded that botulinum toxin injection into the detrusor appears to be an effective and well tolerated means of managing UI. The Committee agreed that Botox® should be the preparation of choice considering it has obtained a marketing authorisation. The Committee agreed to include Botox® into the NCL formulary for NDO and that an NCL business case is not needed and it was agreed that this indication could simply be added to the PbR-excluded list.

6. Appeals

6.1 Fesoterodine for overactive bladder syndrome (OAB)

An appeal from Dr D Wood regarding the decision not to include fesoterodine into the NCL formulary was presented. The basis of the appeal was that UCLH is a tertiary urology centre and are referred patients from all over the country that have tried and failed all other alternative medicines for OAB. The availability of a new drug such as fesoterodine may restore faith in medicines in this cohort of patients and prevent the need for more expensive invasive treatments. Dr Wood suggested that they would work in collaboration with the JFC to find a way to use fesoterodine in a group of patients that will benefit.

The Committee remained of the view that fesoterodine had little clinical advantage over the formulary alternative tolterodine, and was more expensive. It was agreed that the original decision should stand.

6.2 Ulipristal for uterine fibroids

An appeal from Dr A Fakokunde from NMUH (not present at meeting) regarding the JFCs decision to restrict ulipristal for uterine fibroids as a second-line treatment in patients who do not tolerate the gonadotropin-releasing hormone analogues was presented. The basis of the appeal was that Dr A Fakokunde wanted to use ulipristal as [a more convenient and better tolerated] first line treatment.

The Committee were satisfied that ulipristal appears non-inferior in terms of uterine bleeding to the current standard of treatment, leuprorelin. In addition, it has a quicker onset of action, is more convenient and appears to be better tolerated in the short term. The Committee had made their original restriction based on the proposal by Dr Saridogan (from UCLH) specifically requesting its use as second line. The Committee agreed to include ulipristal into the formulary as first line use pending funding approval from local organisations.

7. Local DTC recommendations

7.1 Busulphan IV for conditioning chemotherapy

Busulphan IV was discussed at the RFH DTC for conditioning chemotherapy and a recommendation to include it on the formulary was suggested. The Committee agreed with this decision.

7.2 Brentuximab for CD30+ lymphomas

Brentuximab was discussed at the RFH DTC for CD30+ lymphomas and a recommendation to include it on the formulary was suggested. The Committee agreed with this decision.

7.3 Anakinra for chronic granulomatous disease

Anakinra was discussed at the RFH DTC for granulomatous disease and a recommendation to include it on the formulary was suggested. The Committee agreed with this decision.

7.4 Ropivicaine for local infiltration analgesia

Ropivicaine was discussed at the RFH DTC for local infiltration analgesia in knee surgery and a recommendation to include it on the formulary was suggested. The Committee agreed with this decision, however restricted its use to RFH only.

7.5 Bendamustine for multiple myeloma

Bendamustine was discussed at the RFH DTC for multiple myeloma and a recommendation to include it on the formulary was suggested. The Committee agreed with this decision.

7.6 Capsaicin patch for neuropathic pain

Capsaicin patch was discussed at the RNOH DTC for neuropathic pain and a recommendation to include it on the formulary was suggested. The Committee agreed with this decision.

8. Probiotic position statement

The Committee were presented an expenditure report on probiotics, macular degeneration supplements and glucosamine. The Committee were informed that these supplements were not included in local formularies; however general practitioners (GPs) are consistently receiving letters from consultants recommending that they should be prescribed on the NHS.

The Committee agreed that the JFC should look into the efficacy of the above mentioned supplements and report back on each in due course.

9. Fingolimod Business Cases

The Committee noted that the business cases submitted for the use of fingolimod for a cohort of MS patients was not in line with the NICE Technology Appraisals. The Committee agreed that this needs to be reviewed at a formulary committee first for efficacy and safety before a business case can be considered.

10. NHS CB draft non-commissioning intentions for consultation

The Committee were informed of the six relevant NCB CB draft statements for information only.

11. Date of next meeting

28th February 2013.

12. Any other Business

The Committee agreed to invite a GP member of the LPC to join the Committee.