Northern, Eastern and Western Devon
Clinical Commissioning Group

Meeting of the Northern and Eastern Devon Formulary Interface Group

Minutes

Thursday, 12 October 2017: 9:00am – 11:00am

Old Heathcoat School, Tiverton

Present:

Tawfique Daneshmend (Chair)	Consultant Gastroenterologist	RD&E
Carol Albury	Locality MO Pharmacist	NEW Devon CCG
Glen Allaway	GP	NEW Devon CCG
Susie Harris	Consultant, Elderly Care	RD&E
Andrew Harrison	GP	NEW Devon CCG
Janice Headon	MO Pharmacist	NEW Devon CCG
Matt Howard	Clinical Evidence Manager	NEW Devon CCG
Simon Kay	GP	NEW Devon CCG
Matt Kaye	Chief Pharmacist	NDHT
Denise Lanyon	MO Pharmacist	NEW Devon CCG
Jess Parker	GP	NEW Devon CCG
Bethan Rogers	Formulary Pharmacist	RD&E
Graham Simpole	Joint Formularies Support Pharmacist	NEW Devon CCG
Darren Wright	Joint Formularies Technician	NEW Devon CCG

In attendance:

Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NEW Devon CCG

1. Welcome and introductions:

Apologies

Beverly Baker	Non-Medical Prescribing Lead	NEW Devon CCG
Carole Knight	Formulary Pharmacists	NDHT
Stuart Kyle	DTC Chair	NDHT

Declaration of Interests

Declaration of Interest forms were collected; there were no Declarations of Interest to report.

2. Minutes of the meeting held on 10th August 2017 and matters/actions arising

The minutes of the meeting held on 10th August 2017 were approved.

Summary of actions

	Action	Lead	Status
17/23	Liothyronine: liaise with Steve Cooke and agree local arrangements with GPs and specialists for reviewing patients.	Carol Albury	Complete
17/29	Fiasp products to be added to the formulary in line with the FIG discussion.	Formulary Team	Complete
17/30	Formulary entry for carbocisteine to be updated.	Formulary Team	Complete
17/31	Guidance to be sought as to whether the dose of Levonorgestrel can continue to be doubled for women with a BMI of more than 30.	Formulary Team	Complete
17/32	Formulary team to update the formulary guidance for emergency contraception subject to clarification regarding use of Levonorgestrel in women with a BMI of more than 30.	Formulary Team	Complete
17/33	If available link to information for patients who have had a seizure to be added to the formulary. No link is currently available.	Formulary Team	Complete
17/34	Subject to clarification of the points raised during the discussion, formulary entry for the management of epilepsy to be updated.	Formulary Team	Complete
17/35	Proposed updates to be added to the formulary migraine guidance and sent to specialists for review.	Formulary Team	Ongoing
17/36	Formulary entry for Catheter patency (maintenance) solutions to be updated in line with the discussion.	Formulary Team	Complete
17/37	On completion of the CCGs' governance processes, approved entry for Tiotropium bromide monohydrate and olodaterol hydrochloride (Spiolto® Respimat®) combination inhaler for COPD to be added to the formulary	Formulary Team	Complete
17/38	Formulary data to be brought to FIG meeting in October.	Formulary Team	Complete

Matters arising

At the August 2017 meeting of the Northern and Eastern Devon Formulary Interface Group it was noted that the Devon Formulary and Referral website and app had been promoted by senior secondary care clinical members of the group at their local acute trusts.

The Clinical Effectiveness team has reviewed data for downloads of the app and use of the website. The data showed that in August 2017 the number of new mobile devices, active mobile devices and the total number of sessions increased over the previous three months. This increase was sustaining into September.

3. Consideration of the inclusion of Budenofalk 2mg/dose rectal foam

The Medicine Optimisation (MO) teams in North and East Devon have requested that Budenofalk® 2mg/dose rectal foam be included in the formulary as a second line alternative for the treatment of active ulcerative colitis, after initially trying Hydrocortisone 10% rectal foam enemas. It is proposed that Budenofalk® 2mg/dose rectal foam be added and Prednisolone rectal foam 20mg/application be removed. The rationale for the move towards Budenofalk® comes from a recent price change; there may be a small cost saving as a result of moving to Budenofalk®. The regulatory authority has concluded that Budenofalk® is non-inferior to other treatments.

A discussion took place about patient preference being based on the device used. Devices are generally interchangeable. The MO team suggested that they include more information in the patient letter. The FIG agreed the proposed formulary entry for Budesonide as an amber (specialist initiated) second line treatment. It was agreed that a note would be added to the entry for Hydrocortisone stating that it was the first line treatment. It was also agreed that Hydrocortisone would appear above Budesonide in the formulary entry. Prednisolone rectal foam 20mg/application will be removed from the formulary entry.

ACTION: Formulary Team to amend formulary entry in line with the discussion.

The MO team will help GPs switch patients.

4. Consideration of AirFluSal MDI for addition to the formularies (including removal of Seretide 125 and 250 Evohalers, and Sirdupla pressurised metered dose inhalers)

It is proposed that AirFluSal® 25microgram/125microgram and 25microgram/250microgram MDIs be added into the formulary, for use in patients aged 18 years and older with asthma, and that Seretide/Evohaler and Sirdupla/MDI products be removed.

A discussion took place about the costs associated with these products; cost savings are likely with the proposed changes. There was also discussion about the licensing of AirFluSal®; a small number of patients are less than 18 years of age, AirFluSal® is not licenced for this group. It was agreed that patients under 18 years of age will not be switched to AirFluSal®. The FIG also agreed that patients should not be switched from one product to another during an acute asthma attack. The FIG requested that supporting information (such as a table) detailing each product, the dose and the patient groups and indication for which it is licenced would be helpful. The FIG also requested that metered dose inhaler be highlighted in the notes of the formulary entry.

The group considered the number of types of devices used by acute trusts and community pharmacies and the difficulties this creates.

It was agreed that Matt Howard and Janice Headon will consider how the formulary and MO website can provide additional supporting information.

ACTION: **Matt Howard and Janice Headon to consider how the formulary and MO website can provide additional support information.**

The FIG accepted the proposed formulary entry subject to the minor amendments agreed during the discussion and the inclusion of new prices.

ACTION: **Formulary team to add AirFluSal MDI and remove Seretide 125 and 250 Evohalers, and Sirdupla pressurised metered dose inhalers from the formulary in line with the discussion.**

The FIG also noted the constant flow of new inhalers and that triple products were expected to become available in the near future. The availability of new medicines in community pharmacies was raised, it was noted that new inhalers are not stocked until the first prescription is received. A discussion took place about the availability of placebo inhalers in GP surgeries. Requests for placebos can be sent to the generic MO inbox.

5. Consideration of AirFluSal Forspiro inhaler for addition to the formularies (including removal of Seretide 500 Accuhaler)

It is proposed that AirFluSal® Forspiro® 50microgram/500microgram DPI be added into the formulary, for use in patients aged 18 years and older with severe asthma, and COPD; and that Seretide® 500 Accuhaler® be removed from the formulary.

There was discussion about doses; the FIG agreed that high doses should be avoided where possible and that this inhaler should not be prescribed for new initiations. A note will be added to the formulary entry stating that AirFluSal® Forspiro® 50microgram/500microgram DPI is not for new initiations.

It was noted that AirFluSal® Forspiro® 50microgram/500microgram DPI is not licensed or used in patients who are less than 18 years of age.

The changes are expected to result in savings of £185,000. It was suggested that this be highlighted in the MO Post.

The FIG also considered whether a strategy was needed for DPIs and the order in which they should be used. It was noted that showing patients how to use devices can be time consuming and changing devices creates waste. The FIG agreed that COPD patients should not be switched during the winter months. It was also noted that the AirFluSal® Forspiro® 50microgram/500microgram DPI is similar to other devices and is easy to use. Empty blister strip shows inside a side chamber when a dose has been taken, however this jams the device if it is not removed after two uses. The FIG agreed that a note will be added to the formulary entry regarding the need to remove this foil strip.

The FIG accepted the proposed formulary entry subject to the minor amendments agreed during the discussion.

ACTION: **Formulary team to update formulary in line with the discussion, including notes that AirFluSal® Forspiro® 50microgram/500microgram**

DPI is not for new initiations and with regard to the foil strip. Seretide® 500 Accuhaler® to be removed from the formulary.

The MO team reported that some work had been done and that placebo devices were available if GP surgeries wanted them. It was agreed that a note would be added to the MO Post to let GPs know that placebo devices are available through the MO team and that they do not have to go through the drug companies. This information will also be added to the formulary inhaler pages.

ACTION: **MO team to add notes to the MO Post regarding availability of placebo inhalers from the MO team and the cost savings to be made if suitable patients are switched to AirFluSal® Forspiro® 50microgram/500microgram DPI**.

Communication lines were also discussed; it was suggested that community pharmacists be utilised to identify patients that they are seeing regularly to GPs.

6. Consideration of reclassification of ondansetron

The formulary status of ondansetron requires clarification. In the North and East Devon Joint formulary ondansetron is listed as green but is described as "first line for hospital use only", an accompanying note states that it is "not to be used first-line in the community". In the South and West Devon joint formulary, ondansetron is classified as red (secondary care only).

The committee was asked to consider which classification is the most appropriate for ondansetron in the North and East Devon formulary.

A discussion took place about other formulary options for the treatment of nausea and vomiting.

The FIG agreed that Ondansetron may be classified as a first line 'blue' treatment and that GPs may initiate treatment.

ACTION: **Formulary team to update formulary entry for Ondansetron in line with the discussion.**

7. Reclassification of rivaroxaban 2.5mg tablets from red to amber

Rivaroxaban is subject to a NICE Technology Appraisal (TA) and is included in the formulary. The 2.5mg tablets had not initially been included. The 2.5mg tablets have recently been added by the formulary team as 'Red' as are all new drugs subject to a TA. It is proposed that rivaroxaban 2.5mg tablets be reclassified from red to amber (specialist use), to indicate that ongoing prescribing by GPs is considered appropriate, following a request from secondary care clinicians.

The FIG discussed and accepted the proposal that rivaroxaban 2.5 mg tablets be reclassified from red to amber. It was also agreed that a note be added to the formulary stating that the 2.5mg tablets are only for use in patients who have had Acute Coronary Syndrome with elevated biomarkers.

ACTION: Formulary team to update formulary status of rivaroxaban from red to amber in line with the discussion.

8. Midazolam oromucosal solution

Buccal midazolam is used in the management of status epilepticus; there are now two buccal midazolam prefilled oral syringe (PFOS) products licensed in the UK (Buccolam® and Epistatus®).

Previously discussions had taken place regarding safety concerns as Buccolam® and Epistatus® contain different strengths of midazolam. A brief summary of the differences between these products was circulated with the meeting papers. In order to prevent confusion and prescribing/dispensing errors, and to ensure the most cost efficient use of NHS resources, it was proposed that the Devon formulary select one licensed product as the local "formulary choice". It was suggested that this single formulary choice could be Buccolam, since it is available in a wide range of licensed doses; has a wider license (specifically relating to age); has a longer shelf life from the date of manufacture; is currently the product with the highest usage locally; and it is available at a lower acquisition cost per dose than the alternatives. It was noted that the volume of Buccolam required is double that of Epistatus to deliver the same dose (2ml vs. 1ml for a 10mg dose).

The FIG was asked to consider routes by which clarification of prescribing quantities can be communicated to prescribers. There was discussion about prescribing; the MO team will let GPs know that Buccolam can be prescribed in individual doses and that it is not necessary to prescribed the product in multiples of four doses, unless required.

ACTION: Carol Albury to let GPs know that Buccolam® can be prescribed in individual doses.

It was also agreed that notes will be added to the formulary for Buccolam stating that:

- Doses can be prescribed individually,
- Epistatus and Buccolam are not interchangeable
- New patients should not be initiated onto Epistatus without careful clinical consideration.

The FIG considered and accepted the proposed formulary entry for Buccolam with the notes agreed.

ACTION: Formulary Team to add proposed formulary entry for Buccolam to the formulary with the notes agreed.

The FIG also considered whether Epistatus should be retained in the formulary and the proposed formulary entry for Epistatus. The FIG did not wish to retain Epistatus in the formulary

ACTION: Formulary Team to remove Epistatus from the formulary.

9. Chronic Obstructive Pulmonary Disease (COPD) treatment recommendations

The revised formulary treatment recommendations have been proposed for patients in category D of the Global Initiative for Chronic Obstructive Lung Disease (GOLD) COPD guidelines. The current N&E Devon formulary COPD guidance is based on the GOLD guidelines.

The formulary section for COPD treatment recommendations has been reviewed following a request from Prof. David Halpin at Royal Devon and Exeter NHS Foundation Trust for the inclusion of an additional treatment option of long-acting β2 agonist (LABA) plus inhaled corticosteroid (ICS). Prof. Halpin indicated that this is particularly suitable for patients who show more day-to-day variability in their symptoms; suggesting that the formulary should include a note to the effect that LABA/ICS should be considered as first choice only if the patient exhibits features suggestive of asthma/COPD overlap syndrome. A note may also be included regarding exacerbations. A response on this is awaited from Prof Halpin.

The FIG discussed and accepted the proposed formulary entry in line with the discussion.

ACTION: Formulary team to update formulary entry for COPD in line with the discussion.

10. Management of low back pain and sciatica

Following publication of the NICE clinical guideline for the management of low back pain and sciatica, the formulary team was asked to consider inclusion of brief guidance in the joint formulary. Work is also being undertaken by Devon Referral Support Services (DRSS) to develop a referral guideline for this condition; it is intended that these documents complement each other. Specialists have been contacted. The FIG was asked if the proposed guidance was useful and clear.

A discussion took place about the clarity of the guidance, the non- pharmacological interventions, including psychological support and guidance on exercise, which is available in the north and east, whether the guidance disadvantaged patients with more serious spinal problems, whether the guidance reinforced that opioids should not be routinely given for back pain and the number of patients.

The FIG approved the proposed formulary entry with no amendments.

ACTION: Formulary Team to add guidance for the management of low back pain and sciatica to the formulary.

11. Recent drug decisions (including NICE)

The recent drug decisions had been noted. All discontinued products have been removed from the formulary.

12. MHRA Drug Safety Updates: August and September

- August 2017
  - The MRHA drug safety updates for Ibrutinib (Imbruvica) and Corticosteriods were noted.
  - Adrenaline – it was noted that work is ongoing to produce guidance on the number of adrenaline auto-injectors to be prescribed to each patient. There should be clear guidance for GPs to give to patients that they are responsible for ensuring that they have their auto-injectors with them. Some work with school nurses will be needed. The Formulary Team will liaise with MO in the East. Louise Greaves will liaise with the formulary team in the North.

ACTION: Formulary Team to liaise with MO in the East.
ACTION: Louise Greaves to liaise with the MO in the North

- September 2017 – The MRHA drug safety updates were noted.

13. Any Other Business

Invita D3 50,000IU tablets and oral solution

A request has been received from Stuart Kyle asking that the formulary reflect that Invita D3 50,000IU tablets and oral solution is the most effective way to administer Vitamin D for deficiency.

The FIG agreed that the MO team would bring a paper to a future meeting.

ACTION: MO team to bring a paper to a future meeting regarding Invita D3 50,000IU tablets and oral solution for vitamin D deficiency.

Bio-similars

NICE states that bio-similar products should be prescribed when available. A discussion took place about highlighting the drugs which have biosimilar options available in the formulary and what these are. This is a complicated issue as some drugs have a number of biosimilar alternatives, brand prescribing is recommended for biosimilars. This is particularly in relation to enoxaparin. Northern Devon Healthcare NHS Trust is using clexane.

It was agreed that Bethan Rogers will let the formulary team know which brands of enoxaparin is used at Royal Devon and Exeter NHS Foundation Trust.

ACTION: Bethan Rogers to let formulary team know which brand of enoxaparin is used at Royal Devon and Exeter NHS Foundation Trust.

It was agreed that biosimilar products should be listed in the formulary by brand.

Summary of actions			
Date	**Action**	**Lead**	**Status**
17/39	Formulary entry for Budesonide, (Budenofalk®), Hydrocortisone and Prednisolone for the treatment of active ulcerative colitis to be amended in line with the discussion.	Formulary Team	
17/40	AirFluSal MDI: consideration to be given to how the formulary and MO website can provide additional support information.	Formulary Team/MO Team	
17/41	AirFluSal MDI to be added to the formulary and Seretide 125 and 250 Evohalers, and Sirdupla pressurised metered dose inhalers to be removed from the formulary in line with the discussion.	Formulary Team	
17/42	AirFluSal® Forspiro® 50microgram/500microgram DPI to be added to the formulary in line with the discussion, including notes that this is not for new initiations and with regard to the blister strip. Seretide® 500 Accuhaler® to be removed from the formulary.	Formulary Team	
17/43	Notes to be added to the MO Post regarding availability of placebo inhalers from the MO team and the cost savings to be made if suitable patients are switched to AirFluSal® Forspiro® 50microgram/500microgram DPI	MO Team	
17/44	Formulary entry for Ondansetron to be update in line with the discussion.	Formulary Team	
17/45	Formulary status of Rivaroxaban to be amended from 'red' to 'amber'.	Formulary Team	
17/46	Midazolam oromucosal solution: GPs to be advised that Buccolam® can be prescribed in single doses.	Carol Albury	
17/47	Midazolam oromucosal solution: Buccolam® – agreed formulary entry and additional notes to be added to the formulary.	Formulary Team	
17/48	Midazolam oromucosal solution: Epistatus® to be removed from the formulary	Formulary Team	
17/49	Agreed formulary entry for COPD to be updated in line with the discussion.	Formulary Team	
17/50	Agreed guidance for the management of low back pain and sciatica to be added to the formulary.	Formulary Team	
17/51	MHRA Drug Updates: Adrenaline – Liaise with MO in East regarding the number of auto-injectors for each patient.	Formulary Team	
17/52	MHRA Drug Updates: Adrenaline – Liaise with MO in North regarding the number of auto-injectors for each patient.	Louise Greaves	
17/53	AOB: Invita D3 50,000IU tablets and oral solution for vitamin D deficiency – paper to be brought to a future meeting.	MO Team	
17/54	AOB: Bio-similars – inform Formulary Team which biosimilar products are used at Royal Devon and Exeter NHS Foundation.	Bethan Rogers	