Milton Keynes NHS Primary Care Trust

Milton Keynes Hospital NHS NHS Foundation Trust

MILTON KEYNES NHS TRUSTS
MEDICINES AND THERAPEUTICS COMMITTEE

Minutes of the meeting held on Tuesday 19th April 2011
At 1p.m. in the Eaglestone Restaurant Function Room

PRESENT:

(Chair)
Dr V Jeevanathan (VJ)

MKH NHS Fdn. Trust	MK NHS PCT
Moez Dungarwalla (MD)	Janet Corbett (JC)
Lakshmi Ragunathan (LR)	Helen Chadwick (HC)
Folake Kufeji (FK)	Sarah Whiteman (SW)
Busola Ade-Ojo (BAO)	

Others in attendance: Oliver Pearce (OP), Rajesh Goel (RG), and Suri Dhanoa (SD).

1. Welcome, apologies for absence and introductions

VJ welcomed SW to the committee.
Apologies received from Dr Essam Hassan (EH), Dr Ahmed Nasiri (AN), Niall Ferguson (NF)

2. Declaration of conflicts of interest

None

3. Minutes of last meeting

Minutes approved as an accurate representation of the meeting.

4. Matters arising from previous minutes

i. New e-Formulary contract update – Contracts have now been agreed. HC/FK to follow up with company with regards to training and population of the formulary with local information. **HC/FK**

5. South Central Priorities Committee decisions

a) SCPC Policy **28** - Palivizumab for the prevention of serious Respiratory Synctial Virus (RSV) disease in at risk pre-term infants
b) SCPC Policy **32** - Immediate release fentanyl for break-through cancer pain
c) SCPC Policy **35** - Pharmaceutical Treatment of Pulmonary Hypertension (primary & secondary)
d) SCPC Policy **38** - Adjuvant gemcitabine in pancreatic cancer
e) SCPC Policy **39** - Pentostatin for hairy cell leukaemia
f) SCPC Policy **40** - Degarelix for tumour flare prevention in prostate cancer
g) SCPC Policy **45** - Biological Disease Modifying Drugs in Rheumatoid Arthritis in adults

JC brought these to the committee to ensure that they were formally noted in the acute trusts committee as there is no representation from the acute trust on the SCPC. VJ suggested that in addition to the committee receiving

the decisions, they should also be sent directly to the consultants. **JC**

6. Drug formulary

Formulary Review:

1. Chapter 11 – Eye

FK reviewed this section of the formulary in consultation with the opthalmologists. Following discussion the committee accepted the following changes to the formulary;

Additions – **FK**

Fluorometholone 0.1% eye drops (FML ®)
Timolol maleate 0.1% (Nyogel®) – second line only in patients who demonstrate non-compliance whilst on twice daily Timolol maleate preparations.

Deletions – **FK**

Adrenaline Eye drops 1%
Betamethasone sodium phosphate Drops 0.1% drops *
Betamethasone sodium phosphate Eye ointment 0.1%
Betaxolol Eye drops 0.5%
Chloramphenicol/Hydrocortisone acetate Eye ointment 1%/0.5%
Clobetasone butyrate Eye drops 0.1%
Dipivefrine hydrochloride Eye drops 0.1%
Framycetin Eye ointment 0.5%
Homatropine Hydrobromide Single Use Eye drops 2%
Pilocarpine Eye drops 0.5%
Pilocarpine Eye drops 3%
Prednisolone acetate Eye drops 1%
Prednisolone sodium phosphate/neomycin sulphate Drops 0.5%/0.5% *
Sofradex Drops *

* Will remain in section 12.1.1 of the formulary for ENT use only

2. Adrenaline auto-injector

FK reviewed this section 3.4.3 of the formulary in consultation with the emergency department and found there was a need for adrenaline auto-injector. The review compared both Epipen® and Anapen®. The emergency consultants would prefer to use Epipen® as they are more familiar with it. HC commented that the Resuscitation council guidelines recommend a dose of 500 micrograms for adults and Epipen® does not come in a 500 micrograms strength. The committee took these points into consideration and approved the following for addition to the formulary;

Additions – **FK**

Epipen® Jr Auto-injector 0.15mg

Epipen® Auto-injector 0.3mg
Anapen® 500

New medicine applications:
a) HYLO-Tear
b) HYLO-Forte
SD presented this application on behalf of Mr Bimal Kumar (BK). There was a need on the formulary for a sodium hyaluronate preservative free tear deficiency/ocular lubricant. The committee considered the evidence and available options and concluded that the most cost effective product should be added on to the formulary. FK to check whether Oxyal is a more cost-effective alternative.
Decision: APPROVAL given for most cost-effective preservative free formulation of sodium hyaluronate, second line to Hypromellose preservative free. Product(s) to be confirmed once checked by FK. **FK/BK**

Post meeting note: FK contacted Kestrel Ophthalmics and obtained the following information from Maria Ponsford (Sales & Marketing Director): The solution is preserved with OXYD® - a newly formulated and patented preserving system, developed in the Research Laboratories of TUBILUX PHARMA, which turns into oxygen, water and sodium chloride on contact with the eye. These substances, which occur naturally in the lachrymal fluids, do not irritate the ocular mucosa and keep healthy the epithelial cells.
Please also find attached an Excel table (HA Table MK) which gives a comparative summary of the available sodium hyaluronate eye drops. Based on this the most cost effective preservative free products are HYLO-Tear and HYLO-Forte which will be added to the formulary.

c) Oxycodone
OP presented this application. Orthopaedics had audited it's practices and identified that they would be part of the trusts enhanced recovery programme. Oxycodone was required for the strict protocol which had already been drawn up and trialled across the trust. The patients would only receive it for 3-4 days. JC expressed concern that the patients would be discharged on this medication. OP assured her that the junior doctor were aware of the protocol and would not be writing oxycodone on TTOs. BAO also confirmed that pharmacists were also aware of the protocol and would not be dispensing any TTO's for oxycodone for this indication. There was also concern raised about the choice of oxycodone over morphine sulphate, OP stated this oxycodone had been used as part of the other drugs in the trial and would be happy to change one parameter at a time after auditing the baseline.
Decision: APPROVED, for inpatient post-operative pain relief only. OP to review and report to the committee in 6 months time. **FK/OP**

d) Nicorette Invisi

HC presented this application from the smoking cessation service. This application was made to expand the nicotine replacement products on the formulary and to improve options for patient choice. There is currently no 16 hour patch on the formulary and this is the recommended product in some patient groups including pregnant and lactating women. NICE guidance on smoking cessation services (PH010) also recommends that the clinician and patient should choose the product that seems most likely to succeed.

Decision: APPROVED. **HC**

e) Metvix

RG presented this application on behalf of Dr Parmjit Duhra. Discussion centred around the current use of the unlicensed product 5-Aminolevulinic acid 20% as part of current commissioned local service and whether the use of Metvix would have to be built into a business case for provision of a commissioned local service for topical photodynamic therapy.

Decision: NOT APPROVED at the present time to be re-submitted. This decision has been made as it was unclear if this medicine was required for a new or as part of an already commissioned service. **FK/PD**

f) Pivmecillinam

LR presented this application. Currently in the trust we use nitrofurantoin or trimethoprim first line for UTI's and co-amoxiclav second line. The use of co-amoxiclav is contributing to the increase in the trusts *Clostridium difficile* (C. diff) infection rates. The trust has been set C. diff targets which it must not exceed; otherwise the trust will incur penalties. The option would then be to use pivmecillinam as a second line drug

Decision: APPROVED, for CONSULTANT MICROBIOLOGIST use only as 2nd line to nitrofurantoin and trimethoprim in UTI's sensitive to pivmecillinam. **FK/LR**

g) Anagrelide

DM presented this application. It was necessary as an option for patients with essential thrombocythaemia who were either refractory to hydroxycarbamide or could not tolerate it. Without treatment, these patients would be at risk for strokes and heart attacks. The number of patients that would require this drug annually would be minimal and our non-formulary usage for the drug last year was in only 10 patients.

Decision: APPROVED, for CONSULTANT HAEMATOLOGIST use only as second line to hydroxycarbamide in the treatment of essential thrombocythaemia. **FK/DM**

7. NICE guidance

a) TA214 – Bevacizumab in combination with a taxane for the first-line treatment of metastatic breast cancer.

- Bevacizumab in combination with a taxane is **NOT RECOMMENDED** for the first-line treatment of metastatic breast cancer.
- Patients currently receiving bevacizumab in combination with a taxane for the first-

line treatment of metastatic breast cancer should have the option to continue therapy until they and their clinicians consider it appropriate to stop.

b) **TA215** – Pazopanib for the first-line treatment of advanced renal cell carcinoma.

1. Pazopanib is **RECOMMENDED** as a first-line treatment option for people with advanced renal cell carcinoma:
• who have not received prior cytokine therapy and have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1 **and**
• if the manufacturer provides pazopanib with a 12.5% discount on the list price, and provides a possible future rebate linked to the outcome of the head-to-head COMPARZ trial, as agreed under the terms of the patient access scheme and to be confirmed when the COMPARZ trial data are made available.
2. When using ECOG performance status, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect ECOG performance status and make any adjustments they consider appropriate.
3. People who are currently being treated with pazopanib for advanced metastatic renal cell carcinoma but who do not meet the criteria in 1 should have the option to continue their therapy until they and their clinicians consider it appropriate to stop.

c) **TA216** – Bendamustine for the first-line treatment of chronic lymphocytic leukaemia

- Bendamustine is **RECOMMENDED** as an option for the first-line treatment of chronic lymphocytic leukaemia (Binet stage B or C) in patients for whom fludarabine combination chemotherapy is not appropriate.

d) **TA217** – Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease (review)

Mental Health team to look at the Alzheimer's protocol

NOTE: This guidance replaces NICE technology appraisal guidance 111 issued in November 2006 (amended September 2007, August 2009).
The review and re-appraisal of donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease has resulted in a change in the guidance. Specifically:
• donepezil, galantamine and rivastigmine are now **RECOMMENDED** as options for managing mild as well asmoderate Alzheimer's disease, **and**
• memantine is now **RECOMMENDED** as an option for managing moderate Alzheimer's disease for people who cannot take AChE inhibitors, and as an option for managing severe Alzheimer's disease.

e) **TA218** – Azacitidine for the treatment of myelodysplastic syndromes, chronic myelomonocytic leukaemia and acute myeloid leukaemia

1. Azacitidine is **RECOMMENDED** as a treatmentoption for adults who are not eligible forhaematopoietic stem cell transplantation and have:
• intermediate-2 and high-risk myelodysplastic syndromes according to the International Prognostic Scoring System (IPSS)
or
• chronic myelomonocytic leukaemia with 10–29% marrow blasts without myeloproliferative disorder
or
• acute myeloid leukaemia with 20–30% blasts and multilineage dysplasia, according to the World Health Organization classification
and
• if the manufacturer provides azacitidine withthe discount agreed as part of the patient access scheme.

8. Guidelines in development

Milton Keynes Neutropenic Policy
MD & LR had worked hard to produce this policy. LR stated that

antibiotics listed had been chosen based on local sensitivity patterns. With regards to the antifungals, MD highlighted that the policy aimed to establish a difference between treatment of haematology and oncology patients. No oncology patients should receive an antifungal. The committee queried the choice antifungals in the policy. Caspofungin first line and AmBisome second line. LR & MD explained that fungizone had not been included as it is quite nephrotoxic and causes hyperkalaemia and the fact that the patient group would also be on a lot of other drugs with similar adverse effects. BAO highlighted that caspofungin was on the PBR exclusion list and would be quite expensive to use as the first line option and amphotericin would be a more cost-effective option. MD said caspofungin would be used in approximately 50 patients per annum with annual costs of £50-60,000 and with the policy in place treatment would be de-escalated as quickly as possible.

Decision: After much debate, the committee was unable to approve the policy as the first line choice of antifungal was not the most clinically and cost-effective option to the trust. BAO to do a review and liaise with MD. **BAO/MD**

9. Hospital ePACT data **FK**

FP10 reports for December 2010, January 2011 and February 2011 were presented to the committee. Following the removal and restriction of use of FP10s across the trust the cost for February 2011 was significantly lower than the two months preceding it. This will be continually monitored to ensure that costs are kept down.

10. Any other business

NIL

11. Confirmation of Dates for 2011

The date of the next meeting was confirmed as
Tuesday 5th July 2011, PCT Boardroom, Time 1.00pm.

M&T Committee Meeting Schedule for 2011

Month	Venue	Day	Time
July	PCT Boardroom	5-Jul	13:00 - 14:00
September	Eaglestone Function Room	20-Sep	13:00 - 14:00
November	Facilities Drawing Room	15-Nov	13:00 - 14:00