MILTON KEYNES NHS TRUSTS
MEDICINES AND THERAPEUTICS COMMITTEE

Minutes of the meeting held on Tuesday 19th June 2012
At 1pm. in the Eaglestone Restaurant Function Room

PRESENT:
(Chair)
Dr V Jeevanathan (VJ)

MKH NHS Fdn. Trust	NHS MK	MK CHS
Busola Ade-Ojo (BAO)	Janet Corbett (JC)	Naomi Fleming (NFle) [For Helen Chadwick (HC)]
Folake Kufeji (FK)	Nigel Fagan (NF)	
Prem Roy (PR)		
Debbie Phillips (DP)		

Other attendance: Packiam Shenbagaraman (PS), Henry Andrews (HA), Terri James (TJ), Mansoor Raza (MR), Sue Ashwell (SA), Dupe Fagbenro (DF), Shanthi Chandran (SC).

1. Welcome, apologies for absence and introductions

Apologies were received from Sheila Begley (SB), Essam Hassan (EH), Sarah Whiteman (SW), Martin Wetherill (MW), Helen Chadwick (HC), and Dushyant Mital (DM) **VJ**

2. Declaration of conflicts of interest

None to report. **All**

3. Minutes of last meeting

The minutes were agreed as an accurate reflection of the meeting. **VJ**

4. Matters arising from previous minutes

a) **Dabigatran** – FK has produced draft shared care guideline (SCG) with Dr Kardos and Dr Duodu. This has been sent round for comments, with a deadline for Friday 22nd June 2012. JC requested a copy of the completed SCG so it can be taken to the prescribing group.

b) **Eviplera** – BHIVA guidelines 2012 have now been approved. FK & JC met with DM to clarify its place in therapy in line with BHIVA guidelines. FK produced a summary showing place in therapy for use in the trust in line with BHIVA guidelines. **FK**

	Preferred	Alternative
NRTI backbone	Tenofovir and emtricitabine (Truvada®)	Abacavir and lamivudine[1,3] (Kivexa®)
Third agent	Efavirenz [Truvada® + efavirenz = Atripla®] – 1st line Atazanavir/ritonavir – 2nd line Darunavir/ritonavir – multiresistant patients Raltegravir – TB patients, pregnancy	Lopinavir/ritonavir - pregnancy Fosamprenavir/ritonavir Nevirapine[2] Rilpivirine[3] [Truvada® + rilpivirine = Eviplera®] – compliance issues, intolerability, pill burden, frequent travellers

Decision: Add Rilpivirine/Eviplera to formulary for use as an alternative 3rd line agent in patients with issues taking current medication.

c) **Ferinject** – FK reviewed the financial savings to nursing time against increased drugs cost. 5 beds are currently being used on ward 14 with the 6th room which is a side room recently converted into an office. On average 5 patients a week are seen and administration is not currently causing any bed blocking. The nursing costs are a fixed cost for the trust but drug cost component represent an increase of £32,126.6.
Cosmofer: Drug cost + Nursing cost = **£46,820 - £54,900.6**
Ferinject: Drug cost + Nursing cost = **£56,824.3 - £57,401.5**
JC noted that the review was very useful in helping the committee reach a decision.

Decision: Cosmofer to remain on formulary as parenteral iron preparation of choice. Ferinject rejected at this time.

5. South Central Priorities Committee Decisions

None to report

6. Drug Formulary
New medicine applications
a) Riamet (Application, Evaluation) **BAO/HA**

MR requested Riamet to be added to the formulary as there is no current alternative treatment option for falciparum malaria. Riamet has been recommended as a first line treatment by WHO, however MR doesn't agree that it should be used as a first line treatment in this case, but the hospital definitely needs an alternative option. He also stated in the past when Riamet has been required, a courier was needed to collect medication from another hospital which stocked it as it would be required quite quickly. This could be avoided if was available on the formulary.
VJ asked how many cases of falciparum malaria we have annually. MR stated that Milton Keynes Hospital sees approximately 25 cases every year. JC noted that the application stated that approximately 2 or 3 patients per year would require Riament, which MR confirmed, most of the patients would be treated with Quinine first line. FK suggested that Pharmacy would hold minimal stock.

Decision: Add Riamet to formulary second line to quinine for treatment of acute falciparum malaria.

b) Tinzaparin (Application, Guideline)
Oxford trust now use Tinzaparin as the parenteral anticoagulant of choice. This was chosen over the other low molecular heparins as it was that had the most experience in use, as well as more cost effective. A protocol for its use in haemodialysis is also available.
JC pointed out that pharmacy has a tendency to standardize anticoagulation medication in order to limit risk, however FK pointed out Tinzaparin would be strictly for use on the renal unit which is part of the Oxford trust in line with their trust policy, not Milton Keynes.

Decision: Approved for use in the Oxford renal unit based on the acute trust site only. Dalteparin remains parenteral anticoagulant of choice at Milton Keynes Hospital.

c) Tamsulosin (Application)
HA presented the application for the unlicensed use of Tamsulosin in treatment of ureteric colic primarily for men. Tamsulosin causes smooth muscle relaxation at the bladder neck thus promoting the passage of water and kidney stones. This ultimately results in a reduction of stone passage time as well as a reduction in pain. Tamsulosin has been adopted by European urology doctors, as well as many British doctors as a treatment for stones which are less than 1cm. Some side effects include low blood pressure and light headedness and advised that patients taking high blood pressure medicines should be warned that these effects can be increased. SA questioned whether it would require patients to have constant clinic visits. HA stated that once patients were used to the treatment, they would actually need less clinic visits. JC asked for clarification on the application as she was confused if it would be a one time course (30 days on application form) or a long term treatment. HA clarified that the vast majority of patients would pass their stone ok within the 30 days, however in a very small amount of patients, 30 day treatment length was unrealistic. They would need a continued course if the stone remains. GPs would be able to continue the treatment if necessary based on discharge notes from the hospital, which would usually be a 6 week treatment time bringing the patient up to the time for their next clinic appointment for review. GPs would not be expected to initiate treatment. BAO stated the flow chart on the guidelines/pathway would be updated for clarity, and HA clarified that all the information would be on the discharge notes for the GP.

Decision: Approved for use for treatment of ureteric colic.
The guideline/pathway would be updated to ensure that it provides clear guidance to GP on what to do if patient has not passed stone within one month.

d) Nebusal (Application, Evaluation)
TJ presented this application for use as a mucolytic in cystic fibrosis patients. It would be used as a more cost-effective alternative to dornase alfa. This compares as £28 per month against £1,200 per month, and is usually well tolerated amongst patients. Some tertiary centres would still use dornase alfa, but most would change to Nebusal. VJ asked if this would require additional costs from purchasing compressors and nebulizers required for its administration. TJ clarified that this would be the case in some patients but most patients already have this equipment in place. JC also pointed out that GPs supported this change.

Decision: Approved for addition to the formulary.

e) Creon Micro (Application, Evaluation)
Creon capsules are currently on the formulary. TJ stated that Creon Micro was required on the formulary for use in babies and infants with pancreatic insufficiency. The creon micro is formulated into gastro-resistant granules, this ensures that it is absorbed in the intestine. TJ also stated it was easier to administer, as parents have to open the creon capsules to administer it to the patients who are unable to swallow capsules. JC questioned if 4 patients was a realistic estimate. TJ stated that most patients are already on Creon and it would purely be the switch to Creon Micro for the youngest patients. FK

stated that the suitable alternative Pancrex V was substantially cheaper. The committee considered this option but concluded that as most patients were currently on creon it would require a switch and would cause disruption to families in stressful circumstances.

Decision: Approved for addition to the formulary

Application form to be circulated post meeting **FK**
Linagliptin – SC requested that Linagliptin be added as a 3rd choice to other DPP-4 inhibitors. SC also clarified that it would be used in a primary setting. FK, however, noted that the general feedback has shown a preference for Linagliptin to replace one of the current options rather than have it as an addition. JC pointed out the advantages Linagliptin would have in some groups, but the lack of advantages in others. NF said the main issue would be educating GPs with regards to changes in current patients and choosing which line of medication to start patients on.

Decision: Add to formulary for use in line with NICE clinical guideline 87 in patients with renal impairment for whom other DPP-4 inhibitors are unsuitable.

7. PBR excluded medicines applications

None

8. NICE guidance

a) **TA 250 – Breast Cancer (advanced) - eribulin**
b) **TA 251 – Leaukaemia (CML, first line) dasatinib, nilotinib and standard-dose imatinib**
c) **TA 254 – Multiple Sclerosis (relapsing-remitting) – fingolimid**
d) **TA 253 – Hepatitis C (genotype 1) – boceprevir**
e) **TA 252 – Hepatitis C (genotype 2) – telaprivir** **FK**
f) **TA 255 – prostate cancer – cabazitaxel**
g) **TA 256 – Atrial fibrillation – (stroke prevention) – rivaroxaban**

The above guidance have been circulated to the relevant specialists. Awaiting their comments for implementation on to the formulary as necessary.

9. Guidelines in Development

a) **Guidelines for the prevention and treatment of infection in patients with an absent of dysfunctional spleen.**
FK stated this was an update to the existing guidelines, the choice of antibiotics and immunisations required are now presented in a tabular form to ensure there is more clarity. NFle stated that clarification should be given on patients carrying emergency supplies of medications as they may require an alternative antibiotic for acute infection. She also questioned what to do with patients who required *H. influenzae* cover who were allergic to penicillin. BAO suggested that LR should be consulted. JC noticed that some sections talk about a lifelong course whereas other parts state 2/3 years. NFle pointed out the reference paper was from 2002, whereas the authors have since released a new paper in 2011. **Wasima Maroof/LR**

Decision: Committee support the guideline with the above comments being incorporated into the final document.

10. Any other business **All**

No other business

11. Confirmation of Date of next meeting

The date of the next meeting was confirmed as
Tuesday 17th July 2012, Facilities Library, Time 1.00pm.