ADTC(M) 13/01
Minutes: 1 - 18

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the**
**Area Drugs and Therapeutics Committee**
**held in the Board Room**
**J B Russell House**
**Gartnavel Royal Hospital**
**on Monday, 18 February 2013 at 2.00 p.m.**

---

**P R E S E N T**

Dr J Gravil (in the Chair)

| | |
|---|---|
| Professor S Bryson | Dr J MacKenzie |
| Mrs J Camp | Dr G J A Macphee |
| Mrs A Campbell | Dr G McKay |
| Mr R Foot | Mrs M Ryan |
| Dr G Forrest | Dr G Simpson |
| Dr R J Hardman | Dr A Taylor |
| Ms L Hillan | Mrs A Thompson |

Mrs J Watt

**I N A T T E N D A N C E**

Dr C Rae .. Lead Clinician, Chronic Pain MCN *[For Minute 4 Only]*
Ms H Harrison .. Senior Prescribing Adviser (Acute Services) *[For Minute 4 Only]*
Mrs E Watt .. Secretariat

ACTION BY

**1. CHAIR'S STATEMENT**

Dr Gravil reminded Members that papers and proceedings relating to SMC advice were, in some cases, confidential and should not be disclosed before the relevant embargo dates stated in the agenda.

She also reminded Members that they should make relevant declarations of interest in line with Board policy as agenda items arose.

Members were advised not to speak with members of the press on ADTC business but to refer such enquiries to the Board press liaison office.

ACTION BY

## 2. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Dr J Burns, Mr A Crawford, Dr S Hood, Dr H Hopkinson, Dr J Larkin, Dr C E McKean, Dr P Moultrie and Dr A Seaton.

The Chair welcomed Dr Colin Rae, Lead Clinician, Chronic Pain MCN, and Ms Heather Harrison, Senior Prescribing Adviser (Acute Services) who were in attendance to present the West of Scotland Chronic Non Malignant Pain Opioid Prescribing Guideline *[Minute 4 refers]*.

## 3. ADTC APPOINTMENTS

Joint Chair - Formulary and New Drugs Sub-Committee

The Chair advised that after the nomination process, Dr Stuart Hood had been appointed as a Joint Chair of the Formulary and New Drugs Sub-Committee. Dr Hood had replaced Dr G J A Macphee.

NOTED

## 4. WEST OF SCOTLAND CHRONIC NON MALIGNANT PAIN OPIOID PRESCRIBING GUIDELINE

Dr Rae outlined the background to producing the above West of Scotland guideline. The guideline had been reviewed by the West of Scotland Prescribing Steering Group and the main West of Scotland Regional Group in December 2012 with the agreement that the guideline should be distributed to local Health Boards for consideration and if in agreement for local implementation. NHSGGC Pain Guideline Group had given its approval to the guideline.

Dr Rae gave an overview of the guideline and outlined that its use would be in the pain clinic setting and in primary care. A monitoring tool would be available for use.

A discussion ensued with Dr Rae and Ms Harrison responding to Members' questions. The following was highlighted.

- A Patient Information Leaflet would be produced.
- How practical would it be for GPs to use the PADT monitoring tool for ongoing assessment? *[The tool would be hyperlinked to the guideline and could be accessed from there. It was pointed out that a template could be produced. Mrs Ryan undertook to see if this could be linked to ScriptSwitch]*.

Mrs Watt advised that the Medicines Utilisation Sub-Committee had reviewed some guidelines in the past with opiates and asked if this guideline would replace these. Dr Rae indicated that it would. He advised that the next guideline to be reviewed by the West of Scotland Group would be Neuropathic guidelines.

It was noted that there was reference to a medicine not recommended by SMC (this status was made clear in the guideline) and the reason it was included was for completeness in terms of ensuring all second line agents were discontinued.

The Chair thanked Dr Rae and Ms Harrison for attending to present the guideline.

DECIDED:

That the Committee give its endorsement to the above guideline.

## 5. WEST OF SCOTLAND GUIDELINES

Dr Simpson asked if West of Scotland Guidelines require to come to ADTC rather than the Medicines Utilisation Sub-Committee. It was agreed that they would be reviewed by the

ACTION BY

Medicines Utilisation Sub-Committee unless there were any key issues which required ADTC input.

NOTED

**6. MINUTES**

The Minutes of the meeting of the Area Drugs and Therapeutics Committee held on 10 December 2012 [ADTC(M) 12/06] were approved as a correct record.

NOTED

**7. MATTERS ARISING**

(a) Ticagrelor Formulary Status – Implementation Plan

At the meeting of the ADTC on 10 December 2012, the Committee agreed to add ticagrelor to the Formulary for patients with NSTeMI and also agreed, in principle to consider adding it for STeMI patients subject to regional advice. In early January 2012 the West of Scotland Regional Planning Group agreed on use in STeMI patients and the Formulary was subsequently updated in response to this.

An abbreviated copy of the regional proposal was attached with the agenda papers. A complete implementation plan would be drawn up which would be in the form of a shared care protocol to reinforce durations of treatment by patient group and supply arrangements.

GPs on the Committee raised concerns about some of the practical arrangements and managing the changeover from clopidogrel to ticagrelor as the preferred agent. They felt that GPs would be reluctant to prescribe ticagrelor before a shared care protocol was in place. They also requested that a separate sheet could be attached with the hospital letter as had been done for clopidogrel and it was thought that this would be the case.

The Chair read out an extract from the ADTC minutes of 10 December 2012 in which the Committee had agreed to add ticagrelor for STeMi patient subject to regional advice [*as mentioned in paragraph 1 above]*.

It was pointed out that the regional statement was only intended for information and the Heart MCN would produce clear advice in the form of a local shared care protocol.

The Heart MCN would be meeting next week and the GP's comments would be passed on to them.

DECIDED:

1. That a prescribing note be put in the Formulary with regard to the above and an article be put in PostScript. **Mr R Foot/ Mrs A Thompson**

2. That the GP's comments above be passed to the Heart MCN. **Mrs A Campbell**

(b) Relative Roles of ADTC and the Hospital Records Committee re Reviewing Prescription Charts

Mrs Watt intimated that a GGC group were reviewing how many charts there were and the range of charts. As the ADTC and the Hospital Records Committee both review prescription charts it was agreed that no change be made until this review was complete.

NOTED

ACTION BY

## 8. FORMULARY AND NEW DRUGS SUB-COMMITTEE

(1) SMC Evaluations / NICE/QIS Guidance

Dr Forrest gave a brief resume of the SMC reviews, and the Formulary and New Drugs Sub-Committee's recommendations. These had been divided into sections for ease of understanding as outlined in the Appendix to this Minute.

Members were asked to consider and, if appropriate, ratify decisions by the Sub-Committee. Recommendations made by the Committee are summarised in an Appendix to these Minutes and would be further publicised in PostScript and in the Formulary update available on the GGC Prescribing website and StaffNet.

Members were asked to declare any interests specific or non-specific, personal or non-personal, on any of the drugs being discussed on an individual basis.

Fourteen interests were declared, three of which were personal, specific, where the person left the room for each of three items.

Professor Bryson gave a brief resume to Members of the declarations of interest and when Members should leave the room or not take part in discussion.

The following was highlighted:-

- Apixaban 2.5mg and 5mg film-coated tablets (Eliquis®) [836/13] ***[Full Submission] [Indication: Prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation (NVAF), with one or more risk factors, such as prior stroke or transient ischaemic attack (TIA); age ≥75 years; hypertension; diabetes mellitus; symptomatic heart failure (NYHA class ≥II)]***

  The SMC decision was "Accepted for use within NHS Scotland".

  This would be discussed at the meeting of the Heart MCN on 26 February 2013. The consensus statement had been developed for dabigatran and then rivaroxaban was included at a later date. It was not clear how apixaban fitted with this statement and national advice was anticipated in due course.

  The Formulary and New Drugs Sub-~Committee's recommendation was that this should be added to the Total Formulary restricted in line with advice for dabigatran and rivaroxaban, ie to patients currently receiving warfarin who have poor INR control despite evidence that they are complying, patients with allergy or intolerable side effects from coumarin anticoagulants or for patients for whom warfarin has been clinically excluded as a therapeutic option but anticoagulation is deemed safe and appropriate. Preference over warfarin for practical rather than clinical reasons remains non-Formulary.

  The ADTC gave its commitment to review these restrictions following further local/national advice.

- Dapagliflozin 5mg and 10mg film-coated tablets (Forxiga®) [799/12] ***[Indication: for use in adults aged 18 years and older with type 2 diabetes mellitus to improve glycaemic control as add-on combination with other glucose-lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control]***

  The SMC decision was "Accepted for restricted use within NHS Scotland".

  The Formulary and New Drugs Sub-Committee had debated whether a local restriction was necessary – but concluded the recommendation of specialist initiation at least until the guideline was updated. It was highlighted that many GP practices have a GP with special interest/experience in diabetes. It was noted that there were

ACTION BY

some potential safety issues and it was thought that some information should be included in PostScript (to be approved by the Diabetes MCN).

The Committee agreed that the decision should be amended from "specialist initiation" to "initiation by clinicians experienced in the treatment of diabetes".

- Ulipristal acetate, 5mg, tablet (Esmya®) [834/13] ***[Indication: Pre-operative treatment of moderate to severe symptoms of uterine fibroids in adult women of reproductive age. The duration of treatment is limited to three months]***

  The SMC decision was "Accepted for use in NHS Scotland".

  The Formulary and New Drugs recommendation was that the medicine should be included in the GGC Total Formulary for the indication in question restricted to specialist initiation. Further information had been received from the advisers who queried the need to add to the Formulary. The Sub-Committee asked if a decision on this medicine could be deferred to the next meeting to allow collation of more views. This was agreed.

- Colecalciferol 800 international units (equivalent to 20 micrograms vitamin $D_3$) tablets (Desunin 800 IU®) [840/13] ***[Indication: Prevention and treatment of vitamin D deficiency in adults and adolescents. In addition to specific osteoporosis treatment of patients who are at risk of vitamin D deficiency, supplemental calcium should be considered]***

  The SMC decision was "Accepted for use within NHS Scotland".

  Fultium D3 tablets had previously been added to the Formulary. It was suggested that the agreed use of Vitamin D supplements be included in a future edition of PostScript. Mrs Watt advised that the Osteoporosis Group were developing a guideline for Vitamin D deficiency for patients at risk of fracture and Medicines Information were developing a guideline for patients with a Vitamin D insufficiency.

- Palonosetron 500 microgram soft capsules (Aloxi®) [838/13] ***[Indication: Prevention of nausea and vomiting associated with moderately emetogenic cancer chemotherapy in adults]***

  The SMC decision was "Accepted for use within NHS Scotland".

  Further to consultation with the Regional Cancer Advisory Group, they had advised that there was no intention to use this medicine and has therefore not been included in the Formulary as it does not represent sufficient added benefit to other comparator medicines (eg ondansetron) to treat the condition in question.

- Vildagliptin 50mg tablets (Galvus®) [826/12] ***[Indication: Treatment of type 2 diabetes mellitus in adults as monotherapy in patients inadequately controlled by diet and exercise alone and for whom metformin is inappropriate due to contraindications or intolerance].***

  The SMC decision was "Accepted for restricted use within NHS Scotland".

  The FND recommendation was to include in the GGC Total Formulary for the indication in question restricted to use in patients for whom both metformin and sulphonylureas are inappropriate due to contraindications or intolerance.

  A member asked if the Formulary required four gliptins. It was pointed out that there had been a section review of this therapeutic area last year. It was agreed that a further section review should take place in 2014. Mr Foot would put this in his timetable of section reviews. **Mr R Foot**

ACTION BY

- Ivacaftor 150mg film-coated tablets (Kalydeco®) [827/12] ***[Indication: Treatment of cystic fibrosis (CF) in patients age 6 years and older who have a G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene].***

  The SMC decision was "Not recommended use within NHS Scotland".

  Professor Bryson advised that the Scottish Government have provided a fund (Rare Conditions Medicines Fund) of £21M (for 13 months) from March 2013 which would fund approved IPTRs for orphan medicines not recommended by SMC. Further advice indicated that ivacaftor patients were to be considered under a Group Patient Request process so that all suitable patients would receive this medicine. It was noted that NHSGGC has 16 eligible patients (some additional patients have been receiving the medicine under a compassionate access programme)

  Further guidance on implementation of the fund was expected from the Scottish Government.

  The ADTC noted this information but concluded that in line with normal process this medicine would not be added to Formulary.

DECIDED:

That recommendations made by the Formulary and New Drugs Sub-Committee at their meeting on 4 February 2013 be ratified by the Committee with the exception of those mentioned above.

(2) Cerelle® 75 microgram Tablets

Mr Foot advised that Cerelle® was a new oral contraceptive with exactly the same hormonal constituents as Cerazette®. The SMC had previously outlined that submissions for new oral contraceptives would not be required unless they contained a new active substance. Decisions for such products would be made by local ADTCs.

The FND recommendation was "Included in the GGC Total Formulary for the indication in question restricted to use in patients in whom oestrogen containing contraceptives are not tolerated or contra-indicated". This was agreed.

NOTED

(3) Appeals

(a) Micafungin (Mycamine®) Powder For Solution For Infusion

Mr Foot advised that an appeal for Micafungin (Mycamine®) powder for solution for infusion had been received from Ms Y Gourlay, Lead Pharmacist, Antimicrobial Management Team (Gartnavel General Hospital) and Dr B Jones, Lead Microbiologist, Antimicrobial Management Team, Glasgow Royal Infirmary. Dr Jones declared personal specific and non specific interests as well as non-personal interests.

This had been an SMC accepted medicine in 2008 but feedback from the AMT indicated that this medicine would be used very infrequently and did not wish it on the Formulary at that time. The AMT would now like this to have this available for the treatment of invasive candidiasis in non haemato-oncology patients.

The important points highlighted by the appellants and the Formulary Team were highlighted in the agenda papers.

The Sub-Committee's recommendation was that this appeal should be upheld and Micafungin (Mycamine®) should be included in the GGC Total Formulary restricted to specialist use in the treatment of invasive candidiasis in adults, elderly, and

ACTION BY

children (including neonates) where other treatment options are unsuccessful of inappropriate.

Use for the treatment of oesophageal candidiasis, or for the prophylaxis of Candida infection in patients undergoing allogeneic haematopoietic stem cell transplantation or patients who are expected to have for 10 or more days is not recommended by SMC and is non-Formulary.

A discussion ensued and it was

DECIDED:

1. That the Committee ratify the Formulary and New Drugs recommendation to uphold this appeal.

2. That a response be sent to the appellants outlining the Committee's decision. **Chair**

(b) Temocillin injection (Negaban®)

Mr Foot advised that an appeal for Temocillin injection (Negaban®) had been received from Ms Y Gourlay, Lead Pharmacist, Dr A Seaton, Lead Physician and Dr B Jones, Lead Microbiologist, Antimicrobial Management Team. Dr Jones declared personal, non specific interest.

This medicine pre-dates SMC advice and the appeal is for use in specific populations of patients with proven ESBL and @AmpCbeta-lactamase bacteraemia. The aim was to use this medicine as an alternative to the carbapenems, thereby reducing the likelihood of a build up of resistance to the carbapenems. It was significantly more costly that meropenem but the anticipated budget impact was fairly small (around £15k per annum) and the long-term strategy was clear. The appeal had the support of the Antimicrobial Management Team who indicated that this would become an "alert antibiotic".

The important points highlighted by the appellants and the Formulary Team were highlighted in the agenda papers.

The Sub-Committee's recommendation was that this appeal should be upheld and Temocillin injection (Negaban®) should be included in the GGC Total Formulary restricted to specialist use only on the advice of a microbiologist or an infectious disease physician as second line therapy in severely-ill patients with confirmed ESBL or AmpC related infections.

DECIDED:

1. That the Committee ratify the Formulary and New Drugs recommendation to uphold this appeal.

2. That a response be sent to the appellants outlining the Committee's decision. **Chair**

(4) Six Monthly Report

(a) General Overview

Dr Forrest gave a brief overview of the work which had been carried out by the Formulary and New Drugs Sub-Committee. A paper had been presented which outlined information on membership, web access for the Formulary, compliance with Scottish Government guidance, pending Formulary status, protocol development, patient access schemes, NICE single technology appraisals, Formulary upkeep, and high priority medicines.

ACTION BY

The Sub-Committee had been compliant with the Scottish Government guidance which outlined that Formulary decisions would be made within 90 days of the Board's receipt of SMC advice and publication of that decision within 14 days.

In 2012, the Sub-Committee requested protocols be developed on six occasions (excluding cancer medicines). Protocols for five of these requests have been finalised (this included one which was approved earlier in the meeting).

The Committee outlined that this was an excellent report, with a GP praising the web access Formulary.

NOTED

(b) Review of Medicines Accepted by the Scottish Medicines Consortium (SMC) but not Added to the NHS Greater Glasgow & Clyde Drug Formulary : 2012

Mrs Campbell gave a summary of the above paper which considered all medicines assessed during the full calendar year of 2012. This included a list of drugs accepted by SMC but not added to the Formulary and a list of drugs accepted by SMC and added to Formulary but with additional local restrictions.

During 2012, out of a total of 50 medicines accepted by SMC, there were six occasions (12%) when NHSGGC ADTC decided, on initial review, not to add to the Formulary. This is similar to the rate observed in the 2011 review (six of 54 occasions; 11%) .

The "acceptance rate" has varied over time with no particular trend. Reasons for accepted medicines not added to the Formulary in 2012 were:-

- 66% no plans to use.
- 17% insufficient benefits.
- 17% combination class not on the Formulary.

On 11 occasions, ADTC added medicines to the Formulary but conferred additional restrictions to the SMC advice to define a more limited place in therapy.

The appeals considered in 2012 did not overturn ay previous decision to exclude SMC accepted medicines from the Formulary.

A number of medicines are currently deferred for further consultation with specialists/MCNs of which some may not be added to the Formulary in due course. Monitoring of drugs in this category will continue. The ongoing low level of appeal suggests that the originally agreed non-Formulary status has largely been appropriate and that Formulary choices meet the requirements for the majority of patients.

NOTED

**9. MEDICINES UTILISATION SUB-COMMITTEE (AUC)**

(a) Six Monthly Report

Dr Simpson gave an brief overview of the work which had been carried out by the Medicines Utilisation Sub-Committee. A paper had been presented which outlined information on membership, guidelines/protocols, utilisation reports, clinical effectiveness projects, GGC Therapeutics Handbook and medicines education.

The following was highlighted:-

- Fourteen guidelines/protocols had been reviewed by the Sub-Committee during the last six months *[A list of the guidelines was attached as Appendix 1 of the paper]*.

ACTION BY

Eleven were approved subject to minor comments being taken on board and three had not been approved (reasons given in the paper).

- Prescribing Information app – A business case had been approved for this app which would facilitate access to the Therapeutics Handbook, the Medicines Formulary and would provide notifications and access to new PostScript bulletins.
- IPTRs for Scottish Government report [*Professor Bryson advised that the numbers of IPTRs submitted and accepted were consistent with other NHS Boards]*.

(b) Guidelines for the Management of Cholesterol

Mrs Watt advised that the above guideline had been received from Dr J Byrne, Consultant Cardiologist, Southern General Hospital, on behalf of the HD MCN Cholesterol Guidelines Revision Group. No declarations of interest had been made.

This was an update of previous guidance. The main changes were the recommendations that the target for cholesterol for secondary prevention is reduced from 5mmol/l to 4mol/l. The MCN working group have advised that this was in line with NICE guidance. They also wish to include atorvastatin 80mg for use after acute myocardial infarction and stroke. This has been partially driven by the drop in price of atorvastatin which had made this treatment option more cost effective. Another proposed change to the guideline was the primary prevention threshold for treatment with a statin which had been reduced from 30% 10 CVD year risk to 20%. This change had already been approved by the NHSGGC Prescribing Management Group.

Attached with the agenda papers were Mrs Watt's comments to Dr Byrne on the Sub-Committee's comments on the guideline and Dr Byrne's response.

A discussion ensued. There were some questions about whether if atorvastatin was to be used after MI or stroke, should there the guideline specify a duration of treatment? It was noted that the QoF target for cholesterol for secondary prevention was 5.0 mmol/L and differing from QoF may present difficulties.

DECIDED:

That a decision on this guideline be deferred for budget impact analysis after which the guideline should be referred to PMG.

(c) Review of Lidocaine Prescribing

A final report of the above audit was submitted with the agenda papers. This outlined the introduction, aim and objectives, methods, results, conclusion and further work.

Mrs Watt outlined that the majority of use appeared to be for an off-label indication. There was some palliative care advice but there was use outwith this too. The Palliative Care Team had reviewed the results of this audit and plan to implement some changes and then re-audit practice. Results to be discussed with the RAD Team regarding suggested areas for improvement, including documentation and use of pain assessment charts. Contact would be made with the Chronic Pain Team to highlight the results and discuss the possibility of developing guidance which might define appropriate off-label use of lidocaine patches, including review and stopping criteria.

An article would be put in PostScript once any further advice was available.

NOTED

The Chair outlined that the Sub-Committee had carried out a substantial amount of work and congratulated them on this

ACTION BY

**10. COMMUNICATIONS SUB-COMMITTEE**

PostScript 73

Issue 73 (January 2013) was attached with the agenda papers for information. This edition included articles on PPIs, PostScript Extra 21: Drug induced QT interval prolongation, patient safety - opiate overdose, ADTC decisions, BNF and BNFC smartphone apps, fingolimod for MS and changes to the home oxygen service.

Mrs Thompson outlined articles which would be in the next edition of PostScript. The Sub-Committee were looking at ways to better market PostScript.

NOTED

**11. POLYPHARMACY SUB-COMMITTEE**

(a) General Update

Dr Macphee gave a brief update on the work of the Polypharmacy Sub-Committee as follows:-

- The Mindful Prescribing Strategy had been signed on by the ADTC on 10 December 2012 and was now on the ADTC website.
- The Polypharmacy LES was in the process of being signed off. Pilot work was being carried out in some GP practices.

A GP asked what was being done in secondary care with regard to polypharmacy. Dr Macphee advised that polypharmacy was being targeted in primary care in the first instance but some specific work had been undertaken in acute admissions at the Southern General Hospital. The importance of ensuring a consistent approach across primary and secondary care was recognised.

Dr Macphee outlined that this was work in progress.

NOTED

(b) Minutes of the meeting held on 30 January 2013

The minutes of the meeting of the Polypharmacy Sub-Committee held on 30 January 2013 were for information.

**12. SAFER USE OF MEDICINES SUB-COMMITTEE**

Dr McKay advised that a report would be given at the next meeting.

NOTED

**13. THERAPEUTICS SUB-COMMITTEE**

Mrs Camp advised that a report would be given at the next meeting.

NOTED

ACTION BY

**14. PRESCRIBING MANAGEMENT GROUP**

Professor Bryson advised that the PMG had not met since the last ADTC. The next meeting would be held on 19 February 2012. He outlined some of the items which would be on the agenda including rare condition medicines fund, and Scottish Government guidance on joint working with the pharmaceutical industry.

NOTED

**15. WOMEN AND CHILDLREN'S DIRECTORATE – ADTC /DTC REVIEW**

Professor Bryson advised that there had been no replacement for Mr J Wallace from the Women and Children's Directorate. He had been in discussions with Dr J Beattie (Associate Medical Director) who was keen to obtain the services of a Clinical Director as a replacement on ADTC. The Committee would be kept advised of developments.

NOTED

**16. ANNUAL DECLARATIONS OF INTEREST**

Professor Bryson gave an overview of the declarations of interest outlining that the ADTC members declare their interests on a meeting by meeting basis. The NHS Board's electronic facility to record declared interests for all employees in the managed service was currently under review. The ADTC Executive had agreed that the ADTC would reinstate the Annual Review which involved completion of a simple proforma which would be sent by the Secretary to all Members. An ADTC register would be established which could be subject to public scrutiny if required. **Secretary Members**

NOTED

**17. ANY OTHER BUSINESS**

(a) SMC – New Members

The Chair advised that the SMC had been looking for new members this year but as NHS GGC was well represented she had not asked for nominations. She outlined that many GGC members' term of office expired in the next few years and asked if anyone would be interested in putting their name forward. If interested and wished to attend as an observer to see how the Committee works, they should make contact with the Chair. **Members**

NOTED

(b) Board Guidance For GPs on Companies Promoting Non-Formulary Medicines

Dr Taylor advised that he had been contacted by a company promoting the use of Souvenaid® and wondered if there was Board guidance against companies promoting non-Formulary medicines. It was pointed out that this was a nutritional supplement and not a medicine.

Professor Bryson advised that the NHS Board Code of Conduct for Staff outlined that there should be no promotion of medicines or other clinical products not on the Formulary. There had been agreement from the NHS Board and the Pharmaceutical Industry outlining that overt publicity on non-Formulary medicines would be discouraged. He asked that Dr Taylor pass the correspondence he received to the Secretary who, in turn, would pass on to Professor Bryson. **Dr A Taylor**

ACTION BY

Mrs Watt advised that Mrs Ryan was preparing a statement for primary care on this topic which would by considered by the Therapeutics Sub-Committee.

NOTED

(c) Isosorbide Mononitrate

Dr Hardman advised that there was significant shortages of isosorbide mononitrate standard release 10, 20 and 40mg and prescribers have very little option but to consider substituting with the more expensive modified release preparations with considerable implications for the medicines budget .

Current information indicated that normal supply was unlikely to resume before the end of April 2013.

A discussion ensued on how best to advise GPs on the proposed actions. This could be sent to GP practices by the GP weekly mailing system sent by the NHS Board and also highlighted in PostScript Primary Care. **Mrs M Ryan**

NOTED

**18. DATE OF NEXT MEETING**

The next meeting of the Area Drugs and Therapeutics Committee would be held on Monday, 8 April 2013 at 2.00 p.m. in Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12.