Hospital Pharmaceuticals Review

PTAC, Hospital Pharmaceuticals Subcommittee, Endocrinology Subcommittee & Reproductive and Sexual Health Subcommittee minutes for web publishing

Hormone Preparations therapeutic group

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This document contains minutes relevant to the consultation document of 19 November 2012 relating to products in the Hormone Preparations therapeutic group.

Note that this document is not a complete record of the relevant PTAC and Subcommittee meetings; only the relevant portions of the minutes relating PTAC and its Subcommittees advice on the review of Hospital Pharmaceuticals are included.

Contents

Hospital Pharmaceuticals Subcommittee – 3 May 2011

1 Calcium Homeostasis

1.1 The Subcommittee reviewed the information from DHB hospitals and PHARMAC in relation to products under the Calcium Homeostasis heading.

1.2 The Subcommittee noted that the following pharmaceuticals are commonly used in DHB hospitals and/or are fully subsidised in the Pharmaceutical Schedule and recommended they be included in a national preferred medicines list (PML) without need for further prioritisation:

- Alendronate sodium
  - Tab 40 mg
  - Tab 70 mg
- Alendronate sodium with cholecalciferol
  - Tab 70 mg with cholecalciferol 5600 iu
- Etidronate disodium
  - Tab 200 mg
- Pamidronate
  - Inj 3 mg per ml, 5 ml
  - Inj 3 mg per ml, 10 ml
  - Inj 6 mg per ml, 10 ml
  - Inj 9 mg per ml, 10 ml
- Zoledronic acid
  - Inj 4 mg in 5 ml
  - Inj 5 mg in 100 ml
- Calcitonin
  - Inj 100 iu per ml, 1 ml

1.3 The Subcommittee recommended that the listing of alendronate and alendronate with cholecalciferol in a national PML be subject to restrictions on their use that are in line with the Special Authority restrictions for them in the Pharmaceutical Schedule.

1.4 The Subcommittee recommended that the listing of zoledronic acid inj 5 mg in 100 ml in a national PML be subject to a restriction on its use that is in line with the Special Authority restriction for it in the Pharmaceutical Schedule. The Subcommittee noted that there were currently issues with administration of community funded zoledronic acid inj 5 mg in 100 ml which was having the effect of limiting its use in hospitals as well.

1.5 The Subcommittee recommended that the listing of zoledronic acid inj 4 mg in 5 ml in a national PML be restricted to use in hypercalcaemia of malignancy.

1.6 The Subcommittee noted that cinacalcet was not in use in a majority of DHBs, and was not subsidised in the Pharmaceutical Schedule. Members noted that PTAC had previously recommended against it being listed in the Pharmaceutical Schedule and that there is a large number of applications made for it to the Exceptional Circumstances Panel, most of which are declined. The Subcommittee recommended that it not be included in a national PML.

1.7 Members noted that strontium ranelate was not used in DHB hospitals, and that was not subsidised in the Pharmaceutical Schedule. The Subcommittee recommended that it not be included in a national PML unless it was listed in the Pharmaceutical Schedule, in which case it should be included subject to restrictions in line with any restrictions in the Pharmaceutical Schedule.

1.8 The Subcommittee noted that PHARMAC was currently consulting on the listing of raloxifene and teriparatide in the Pharmaceutical Schedule. The Subcommittee recommended that these be included in a national PML if they become listed in the Pharmaceutical Schedule, subject to restrictions in line with any restrictions in the Pharmaceutical Schedule.

2 Anabolic Agents

2.1 The Subcommittee reviewed the information from DHB hospitals and PHARMAC in relation to products under the Anabolic Agents heading.

2.2 The Subcommittee noted that nandrolone decanoate (50 mg per ml, 1 ml injection) was not widely used in DHB hospitals, and considered that it did not need to be included in a national PML. However, the Subcommittee requested that the view of endocrinologists and oncologists be sought on its potential exclusion.

2.3 The Subcommittee considered that further advice was required before making a recommendation on the listing of oxandrolone 2.5 mg tablet in a national PML. Members noted that this would likely be used in burns units, and requested the view of plastic surgeons on the need for it in a national PML.

3 Androgen Agonists and Antagonists

3.1 The Subcommittee reviewed the information from DHB hospitals and PHARMAC in relation to products under the Androgen Agonists and Antagonists heading.

3.2 The Subcommittee noted that the following pharmaceuticals are commonly used in DHB hospitals and/or are fully subsidised in the Pharmaceutical Schedule and recommended that they be included in a national preferred medicines list (PML) without need for further prioritisation:

- Cyproterone acetate
  - Tab 50 mg
  - Tab 100 mg
- Testosterone
  - Transdermal patch 2.5 mg per day
- Testosterone cypionate
  - Inj long-acting 100 mg per ml, 10 ml
- Testosterone esters
  - Inj testosterone decanoate 100 mg, testosterone isocarproate 60 mg, testosterone phenylpropionate 60 mg and testosterone propionate 30 mg per ml, 1 ml
- Testosterone undecanoate
  - Cap 40 mg

3.3 The Subcommittee noted that cyproterone acetate injection (100 mg per ml, 3 ml) had previously been discontinued in New Zealand, and was not widely used in DHB hospitals. The Subcommittee recommended that it not be included in a national PML.

3.4 The Subcommittee noted that one DHB had reported using testosterone gel, but considered that this did not need to be included in a national PML.

3.5 The Subcommittee noted that several DHBs had reported using testosterone 200 mg implants, but noted that these were no longer widely used. The Subcommittee recommended that these not be included in a national PML.

3.6 The Subcommittee noted that several DHBs had reported using testosterone undecanoate injection (250 mg per ml, 4 ml). The Subcommittee considered that this was essentially a community treatment, and noted that PTAC had previously recommended that this be listed in the Pharmaceutical Schedule only if it was cost-neutral compared to other testosterone injections. The Subcommittee recommended that this should only be included in a national PML if it became listed in the Pharmaceutical Schedule.

3.7 The Subcommittee noted that the exclusion of these forms of testosterone highlighted a need for existing patients to be permitted to continue on-treatment on non-PML pharmaceuticals when the national PML was implemented.

4 Corticosteroids

4.1 The Subcommittee reviewed the information from DHB hospitals and PHARMAC in relation to products under the Corticosteroids heading.

4.2 The Subcommittee noted that the following pharmaceuticals are commonly used in DHB hospitals and/or are fully subsidised in the Pharmaceutical Schedule and recommended that they be included in a national preferred medicines list (PML) without need for further prioritisation:

- Betamethasone sodium phosphate with betamethasone acetate
  - Inj 3.9 mg with betamethasone acetate 3 mg per ml, 1 ml
- Dexamethasone
  - Oral liq 1 mg per ml
  - Tab 1 mg
  - Tab 4 mg
- Dexamethasone sodium phosphate
  - Inj 4 mg per ml, 1 ml
  - Inj 4 mg per ml, 2 ml
- Fludrocortisone acetate
  - Tab 100 µg
- Hydrocortisone
  - Tab 5 mg
  - Tab 20 mg
  - Inj 50 mg per ml, 2 ml
- Methylprednisolone
  - Tab 4 mg
  - Tab 100 mg
- Methylprednisolone acetate
  - Inj 40 mg per ml, 1 ml
- Methylprednisolone acetate with lignocaine
  - Inj 40 mg per ml with lignocaine 1 ml
- Methylprednisolone sodium succinate
  - Inj 40 mg per ml, 1 ml
  - Inj 62.5 mg per ml, 2 ml
  - Inj 500 mg
  - Inj 1 g
- Prednisolone sodium phosphate
  - Oral liq 5 mg per ml
- Prednisone

- Tab 1 mg
- Tab 2.5 mg
- Tab 5 mg
- Tab 20 mg

- Triamcinolone acetonide
  - Inj 10 mg per ml, 1 ml
  - Inj 40 mg per ml, 1 ml

4.3 The Subcommittee noted that triamcinolone hexacetonide was not widely used, but noted that it was becoming a standard option in paediatric rheumatology. The Subcommittee recommended that it be included in a national PML, but was unsure if just the 20 mg per ml, 1 ml vial should be included, or also the 20 mg per ml, 5 ml vial. Members noted that the 5 ml vial was not a registered medicine in New Zealand. The Subcommittee recommended seeking the views of paediatric rheumatologists on this issue.

4.4 The Subcommittee noted that prednisolone sodium phosphate enema (20 mg in 100 ml) was not used in a majority of DHBs, but noted that it is a useful treatment option for ulcerative colitis, and recommended that it be included in a national PML.

4.5 The Subcommittee considered that further advice was needed before making a recommendation on the listing of betamethasone sodium phosphate injection (4 mg per ml, 1 ml) in a national PML, and requested that the views of obstetricians and gynaecologists be sought on the need for this in place of the more commonly used betamethasone sodium phosphate with betamethasone acetate injection.

4.6 The Subcommittee noted that there was little use of betamethasone sodium phosphate 500 µg tablet in DHB hospitals, and that it is not subsidised in the Pharmaceutical Schedule. The Subcommittee recommended that it not be included in a national PML.

4.7 The Subcommittee noted that there was little use of cortisone acetate 5 mg tablet in DHB hospitals, and that it is not subsidised in the Pharmaceutical Schedule. The Subcommittee recommended that it not be included in a national PML.

4.8 The Subcommittee recommended that, as prednisolone 5 mg tablets are not subsidised in the Pharmaceutical Schedule, and as they do not have a niche use in hospital, they not be included in a national PML. Members noted that there was no need for prednisolone tablets to be included given the availability of prednisone tablets.

5 Hormone Replacement Therapy

5.1 The Subcommittee reviewed the information from DHB hospitals and PHARMAC in relation to products under the Hormone Replacement Therapy heading.

5.2 The Subcommittee noted that the following pharmaceuticals are commonly used in DHB hospitals and/or are fully subsidised in the Pharmaceutical Schedule and recommended that they be included in a national preferred medicines list (PML) without need for further prioritisation:

- Oestradiol valerate
  - Tab 1 mg
  - Tab 2 mg

- Medroxyprogesterone acetate
  - Tab 2.5 mg
  - Tab 5 mg
  - Tab 10 mg

5.3 The Subcommittee noted that the following pharmaceuticals are also listed in the Pharmaceutical Schedule, and recommended that they be included in a national PML:

- Oestradiol
  - Tab 1 mg
  - Tab 2 mg
  - Transdermal patch 25 µg per day
  - Transdermal patch 50 µg per day
  - Transdermal patch 100 µg per day
- Oestrogens
  - Conjugated, equine tab 300 µg
  - Conjugated, equine tab 625 µg
- Oestradiol with norethisterone
  - Tab 1 mg with 0.5 mg norethisterone acetate
  - Tab 2 mg with 1 mg norethisterone acetate
  - Tab 2 mg with 1 mg norethisterone acetate (10), and 2 mg oestradiol tab (12) and 1 mg oestradiol tab (6)
- Oestrogens with medroxyprogesterone
  - Tab 625 µg conjugated equine with 2.5 mg medroxyprogesterone acetate tab
  - Tab 625 µg conjugated equine with 5 mg medroxyprogesterone acetate tab

5.4 The Subcommittee recommended that the listing of oestradiol patches in a national PML be subject to restrictions on their use that are in line with the restrictions for them in the Pharmaceutical Schedule.

5.5 The Subcommittee noted that there was some use of progesterone 100 mg capsules in DHB hospitals, and noted that these were used for the prevention of preterm labour. The Subcommittee recommended that these be included in a national PML. The Subcommittee noted that such use can extend to several months, and as such considered that PHARMAC should consider the listing of these in the Pharmaceutical Schedule for use in the community.

6 Other Endocrine Agents

6.1 The Subcommittee reviewed the information from DHB hospitals and PHARMAC in relation to products under the Other Endocrine Agents heading.

6.2 The Subcommittee noted that the following pharmaceuticals are commonly used in DHB hospitals and/or are fully subsidised in the Pharmaceutical Schedule and recommended that they be included in a national preferred medicines list (PML) without need for further prioritisation:

- Cabergoline
  - Tab 0.5 mg
- Clomiphene citrate
  - Tab 50 mg

- Danazol
  - Cap 100 mg
  - Cap 200 mg
- Gestrinone
  - Cap 2.5 mg
- Metyrapone
  - Cap 250 mg

7 Other Oestrogen Preparations

7.1 The Subcommittee reviewed the information from DHB hospitals and PHARMAC in relation to products under the Other Oestrogen Preparations heading.

7.2 The Subcommittee noted that the following pharmaceuticals are commonly used in DHB hospitals and/or are fully subsidised in the Pharmaceutical Schedule and recommended that they be included in a national preferred medicines list (PML) without need for further prioritisation:

- Ethinyloestradiol
  - Tab 10 µg
- Oestriol
  - Tab 2 mg

7.3 The Subcommittee considered that further advice was required before making a recommendation on the listing of oestradiol 50 mg injection in a national PML, and requested that the view of obstetricians and gynaecologists be sought on this issue.

7.4 The Subcommittee noted that oestradiol 25 µg pessaries pharmaceuticals are not subsidised in the Pharmaceutical Schedule and, as they do not have a niche use in hospitals, recommended that they not be included in a national PML.

8 Other Progestogen Preparations

8.1 The Subcommittee reviewed the information from DHB hospitals and PHARMAC in relation to products under the Other Progestogen Preparations heading.

8.2 The Subcommittee noted that the following pharmaceuticals are commonly used in DHB hospitals and/or are fully subsidised in the Pharmaceutical Schedule and recommended that they be included in a national preferred medicines list (PML) without need for further prioritisation:

- Levonorgestrel
  - IUD - 20 µg / day
- Medroxyprogesterone acetate
  - Tab 100 mg
  - Tab 200 mg
- Norethisterone
  - Tab 5 mg

8.3 The Subcommittee considered that it would be appropriate to restrict use of levonorgestrel-eluting intra-uterine devices, but considered that the current community Special Authority restriction would be too narrow for hospital use. The

Subcommittee noted that it would be appropriate to allow hospital use of this for contraception in specific circumstances, such as following multiple terminations, and in circumstances where it is considered necessary to cause amenorrhoea. The Subcommittee noted that the need for this for contraception has broadly been reduced following the funding of levonorgestrel implants.

8.4 The Subcommittee noted that there is very little use of medroxyprogesterone acetate 200 mg tablets in DHB hospitals and that usage in the community is also very low. Members noted that it is currently more than twice the price of the 100 mg tablet. The Subcommittee considered that PHARMAC should review the listing of this in the Pharmaceutical Schedule.

8.5 The Subcommittee noted that dydrogesterone (10 mg tablet) had been discontinued, and was not in use in any DHB hospital. The Subcommittee considered that this did not need to be included in a national PML.

8.6 The Subcommittee noted that progesterone injection (50 mg per ml, 2 ml) was not in wide use in DHB hospitals, and recommended that it not be included in a national PML.

9 Pituitary and Hypothalamic Hormones and Analogues

9.1 The Subcommittee reviewed the information from DHB hospitals and PHARMAC in relation to products under the Pituitary and Hypothalamic Hormones and Analogues heading.

9.2 The Subcommittee noted that the following pharmaceuticals are commonly used in DHB hospitals and/or are fully subsidised in the Pharmaceutical Schedule and recommended that they be included in a national preferred medicines list (PML) without need for further prioritisation:

- Tetracosactide (tetracosactrin)
  - Inj 1 mg per ml, 1 ml
  - Inj 250 µg
- Goserelin acetate
  - Inj 3.6 mg
  - Inj 10.8 mg
- Leuprorelin
  - Inj 3.75 mg
  - Inj 7.5 mg
  - Inj 11.25 mg
  - Inj 22.5 mg
  - Inj 30 mg
  - Inj 45 mg
- Somatropin
  - Inj 16 iu per vial (5.3 mg)
  - Inj 36 iu per vial (12 mg)

9.3 The Subcommittee recommended that the listing of somatropin in a national PML be subject to restrictions on its use that are in line with the restrictions for it in the Pharmaceutical Schedule.

9.4 The Subcommittee noted that corticotropin releasing hormone (ovine) 100 µg injection was not in common use in DHB hospitals, but noted that it is an important diagnostic tool for endocrinologists, and recommended that it be included in a national PML.

9.5 The Subcommittee noted that buserelin (1 mg per ml, 5.5 ml injection) was no longer listed in the Pharmaceutical Schedule, but noted that it is used in hospitals as a test for gonadotropin deficiency, and recommended that it be included in a national PML.

9.6 The Subcommittee considered that further advice was required before making a recommendation on the listing of thyrotropin alfa (900 µg injection), gonadorelin (100 µg injection) and choriogonadotropin alfa (250 µg injection) in a national PML. Members noted that these are not widely used in DHB hospitals, but that they may be used in a diagnostic setting, and requested the view of endocrinologists, gynaecologists and radiation oncologists on this matter.

9.7 The Subcommittee noted that pegvisomant (15 mg injection) is only in use in one DHB, and that this was approved as a one-off case. The Subcommittee considered that this did not need to be included in a national PML.

9.8 The Subcommittee noted that leuprorelin injection (5 mg per ml, 2.8 ml) is not widely used in DHB hospitals and is not subsidised in the Pharmaceutical Schedule. Members noted that the depot versions of leuprorelin would be used in preference to this presentation. The Subcommittee recommended that this not be included in a national PML.

9.9 The Subcommittee noted that ganirelix had been used in only one DHB, and that it was only used as a fertility treatment. The Subcommittee recommended that it not be included in a national PML.

9.10 The Subcommittee noted that follitropin alfa and follitropin beta were not in use in DHB hospitals, and noted that these are only used as fertility treatments. The Subcommittee recommended that they not be included in a national PML.

10 Thyroid and Antithyroid Preparations

10.1 The Subcommittee reviewed the information from DHB hospitals and PHARMAC in relation to products under the Thyroid and Antithyroid Preparations heading.

10.2 The Subcommittee noted that the following pharmaceuticals are commonly used in DHB hospitals and/or are fully subsidised in the Pharmaceutical Schedule and recommended that they be included in a national preferred medicines list (PML) without need for further prioritisation:

- Carbimazole
  - Tab 5 mg
- Iodine
  - Soln BP 50 mg per ml
- Levothyroxine
  - Tab 25 µg
  - Tab 50 µg
  - Tab 100 µg
- Propylthiouracil
  - Tab 50 mg

10.3 The Subcommittee noted that liothyronine sodium 20 µg injection was not in common use in DHB hospitals, but noted that it is an important treatment option in intensive care units for patients in hypothyroid crisis, and recommended that it be included in a national PML.

10.4 The Subcommittee noted that liothyronine sodium 20 µg tablets are not listed in the Pharmaceutical Schedule, although they are funded under Exceptional Circumstances for many patients. The Subcommittee considered that the need for long-term use of liothyronine was limited, particularly given the availability of three different formulations of levothyroxine. The Subcommittee considered that funding of oral liothyronine should continue to be managed on a case-by-case basis, and recommended that it not be included in a national PML.

10.5 The Subcommittee considered that further advice was required before making a recommendation on the listing of protirelin (0.1 mg per ml, 2 ml injection) in a national PML. The Subcommittee noted that there may be a diagnostic use for this, and recommended that the view of endocrinologists on this issue.

10.6 The Subcommittee noted that potassium perchlorate (200 mg capsule) is not widely used in DHB hospitals and is not subsidised in the Pharmaceutical Schedule. The Subcommittee recommended that it not be included in a national PML.

11 Vasopressin Agents

11.1 The Subcommittee reviewed the information from DHB hospitals and PHARMAC in relation to products under the Vasopressin Agents heading.

11.2 The Subcommittee noted that the following pharmaceuticals are commonly used in DHB hospitals and/or are fully subsidised in the Pharmaceutical Schedule and recommended that they be included in a national preferred medicines list (PML) without need for further prioritisation:

- Desmopressin
  - Inj 15 µg per ml, 1 ml
  - Inj 4 µg per ml, 1 ml
  - Nasal drops 100 µg per ml
  - Nasal spray 10 µg per dose
  - Tab 100 µg
- Terlipressin
  - Inj 1 mg
- Vasopressin
  - Inj 20 u per ml

11.3 The Subcommittee noted that desmopressin 150 µg per dose nasal spray was used in two DHBs, and recommended that this not be included in a national PML. The Subcommittee noted that this presentation is used in von Willebrand disease, and considered that this should not be included in a national PML without undergoing a full evaluation by PTAC.

11.4 The Subcommittee noted that desmopressin 200 µg tablets are not widely used, and considered that these did not need to be included in a national PML.

11.5 The Subcommittee noted that there could be an issue with desmopressin tablets not being funded in the community, and considered that listing in the Pharmaceutical

Schedule would be beneficial. The Subcommittee considered that if desmopressin tablets were to be funded in the community, its use should be targeted, as there would be a risk of significant use for the management of nocturia if it was unrestricted, which would be a significant financial risk.

Endocrinology Subcommittee – 29 May 2012

12 Hospital Pharmaceuticals

12.1 The Subcommittee reviewed a series of recommendations by the Hospital Pharmaceuticals Subcommittee in regards to which pharmaceuticals relevant to endocrinology should be included on a national Preferred Medicines List (PML). The Subcommittee noted that PHARMAC had invited feedback from relevant colleges and professional societies and noted that responses were received.

Anabolic agents

12.2 The Subcommittee noted that the Hospital Pharmaceuticals Subcommittee had deferred making a recommendation in relation to oxandrolone. The Subcommittee noted that oxandrolone can be used as an adjunct to somatropin in the treatment of Turner's syndrome and if it were available would be very useful to have to treat a small number of patients; however the Subcommittee considered that this should only be included in a national PML if it became subsidised in the community.

12.3 The Subcommittee considered that there was no need for nandrolone to be available in DHB hospitals from an endocrinology perspective. Members noted that use of this in the community was very low, and considered that it could be delisted from Section B of the Pharmaceutical Schedule.

Androgen agonists and antagonists

12.4 The Subcommittee considered that a testosterone 5 mg patch, testosterone gel and testosterone undecanoate injection would be useful presentations to have available, but that these would be community-led funding decisions.

Calcium homeostasis

12.5 The Subcommittee noted that zolendronic acid can be used to treat acute bone pain associated with various cancers in particular and other metabolic bone diseases which have the potential for long term, use in the community.

12.6 The Subcommittee noted that the Hospital Pharmaceuticals Subcommittee recommended against including cinacalcet in a national PML, and that PTAC had previously recommended against listing this in the Pharmaceutical Schedule. Members noted that it may be worth reconsidering the evidence for cinacalcet, and considered that the Society of Endocrinology and the Renal Society could be invited to submit evidence for further consideration.

Other oestrogen preparations

12.7 The Subcommittee noted that the Hospital Pharmaceuticals Subcommittee had deferred making a recommendation in relation to oestradiol 50 mg injection. Members noted that this is not used in endocrinology, and considered that obstetricians and gynaecologists would likely have a view on the need for this in a national PML.

12.8 The Subcommittee noted that the Hospital Pharmaceuticals Subcommittee had recommended against the listing of oestradiol pessaries in a national PML. Members noted that it would be useful for these to be available, but that it would be a community-led funding decision.

Other progesterone preparations

12.9 The Subcommittee noted that the Hospital Pharmaceuticals Subcommittee had recommended that progesterone injection not be listed in a national PML. Members noted that this is not used in endocrinology, and considered that obstetricians and gynaecologists would likely have a view on the need for this.

*Pituitary and hypothalamic hormones and analogue*s

12.10 The Subcommittee noted that the Hospital Pharmaceuticals Subcommittee recommended that the community criteria apply to the prescribing of somatropin in a national PML. Members noted that in the case of neonates with hypoglycaemia, it is necessary for commencement of treatment to begin quickly.

12.11 The Subcommittee recommended that thyrotropin alfa, gonadorelin and choriogonadotropin alfa (HCG) all be included in a national PML as they are used in DHB hospitals for diagnostic purposes.

Thyroid and antithyroid preparations

12.12 The Subcommittee recommended that protirelin injection (0.2 mg in 2 ml) be listed in a national PML as it is used in the diagnostic assessment of thyroid function. The Subcommittee noted that as potassium perchlorate (200 mg capsule) is occasionally used as a test for hypothyroidism it should also be included.

12.13 Members noted feedback suggesting that levothyroxine injection be included in a national PML. The Subcommittee considered that there would be no clinical need for this product if liothyronine injection was available.

Other diagnostic agents

12.14 The Subcommittee recommended that pentagastrin (inj 0.5 mg in 2 ml) be included in a national PML as it is used in hospitals for diagnosing medullary thyroid tumours.

Reproductive and Sexual Health Subcommittee – 25 June 2012

13 Hospital Pharmaceuticals

13.1 The Subcommittee reviewed a series of recommendations by the Hospital Pharmaceuticals Subcommittee in regards to which pharmaceuticals relevant to reproduction and sexual health should be included on a national Preferred Medicines List (PML).

Other oestrogen preparations

13.2 The Subcommittee noted that the Hospital Pharmaceuticals Subcommittee had deferred making a recommendation in relation to oestradiol 50 mg injection. The Subcommittee recommended that this be included in a national PML as it is highly effective as a one-off treatment for a small number of patients who have extremely heavy periods.

13.3 The Subcommittee considered that oestradiol pessaries should only be listed in a national PML if they are subsidised in the community. Members noted that these would be used as an alternative to oestriol cream and pessaries.

13.4 The Subcommittee considered that oestradiol implants should be included in a national PML as they are used in hormone replacement therapy and for the treatment of patients who have had a bilateral oophorectomy at 35 years or younger.

Other obstetric and gynaecological preparations

13.5 The Subcommittee recommended that betamethasone sodium phosphate injection not be included in a national PML. Members noted that most centres use betamethasone sodium phosphate with betamethasone acetate, and considered that this was suitable.

14 Review of Hormone Preparations Recommendations

Anabolic Agents

14.1 The Subcommittee noted that it had previously deferred making a recommendation in relation to oxandrolone, and recommended that this be a community-led funding decision.

Corticosteroids

14.2 Members noted that the Reproductive and Sexual Health Subcommittee had recommended that betamethasone sodium phosphate injection not be included in a national PML.

14.3 The Subcommittee noted that it had previously deferred making a recommendation in relation to the 5 ml presentation of triamcinolone hexacetonide. It recommended that this not be included in a national PML.

14.4 The Subcommittee noted feedback indicating some use of betamethasone tablets in neonates. The Subcommittee considered that dexamethasone liquid would generally be used in this situation, and considered that there was not a need for betamethasone tablets to be included in a national PML.

Other Oestrogen Preparations

14.5 Members noted that the Reproductive and Sexual Health Subcommittee had recommended that oestradiol injection be included in a national PML.

14.6 The Subcommittee noted that the Reproductive and Sexual Health Subcommittee had recommended that oestradiol implant be included in a national PML. Members considered that this would require further consideration by PTAC.

14.7 The Subcommittee noted that PTAC has recently recommended that progesterone capsules be listed in the Pharmaceutical Schedule for prevention of preterm birth.

Pituitary and Hypothalamic Hormones and Analogues

14.8 The Subcommittee noted that the Endocrinology Subcommittee had recommended that thyrotropin alfa, gonadaorelin and choriogonadotropin alfa be included in a national PML. The Subcommittee considered that it may be necessary to restrict use of these agents, and recommended that PHARMAC staff seek further advice from endocrinologists on the wording of such restrictions.

Thyroid and Antithyroid Preparations

14.9 Members noted that the Endocrinology Subcommittee had recommended that protirelin and potassium perchlorate be included in a national PML.

Other Diagnostic Agents

14.10 Members noted that the Endocrinology Subcommittee had recommended that pentagastrin be included in a national PML.

Pharmacology and Therapeutics Advisory Committee – 8 & 9 November 2012

15 Hormone Preparations

15.1 The Committee considered a list of pharmaceuticals under consideration for use in DHB hospitals under the Hormone Preparations heading, including advice from the Hospital Pharmaceuticals Subcommittee, the Endocrinology Subcommittee and the Reproductive and Sexual Health Subcommittee. Except where indicated, the Committee agreed with the recommendations by the subcommittees.

15.2 The Committee noted that the Reproductive and Sexual Health Subcommittee had recommended that oestradiol implants be listed in a national PML. The Committee could identify no evidence to support the use of oestradiol implants over alternative options. The Committee recommended that PHARMAC seek a funding application for oestradiol implants.

15.3 The Committee noted that the Hospital Pharmaceuticals Subcommittee had considered that prescribing restrictions may be required for choriogonadotropin alfa, gonadorelin and thyotropin alfa. The Committee considered that limiting their prescribing to diagnostic use under the recommendation of an endocrinologist, would be appropriate.

15.4 The Committee noted that the Endocrinology Subcommittee had commented on the use of somatropin in neonates with hypoglycaemia. The Committee considered that it would be appropriate for such use to be managed under NPPA.