Nottinghamshire Area Prescribing Committee Formulary Meeting Minutes Thursday 28th August 2025: The meeting took place as a web conference using Microsoft Teams.

All attendees should be aware that public authorities are legally required to comply with the Freedom of Information Act 2000. The minutes and papers from this meeting could be published on the Publication Scheme or internet with all names included unless notified to the Chair before the meeting commences or included in a pre-agreed confidential section due to the sensitive nature of the topic.

Present: -

Laura Catt (LC) (Chair)	**Prescribing Interface Advisor**	**NHS Nottingham & Nottinghamshire Integrated Care Board (ICB)**
David Kellock (DK)	**Consultant in Sexual Health and SFHT DTC Chair**	**Sherwood Forest Hospitals NHS Foundation Trust (SFHT)**
Ann Whitfield (AW)	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
Katie Sanderson (KS)	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
Jennifer Moss Langfield (JML)	**GP**	**City Place-Based Partnership (PBP), Nottingham & Nottinghamshire ICB**
Khalid Butt (KB)	**GP**	**Local Medical Committee (LMC) Representative, Nottinghamshire.**
Georgina Dyson (GD)	**Advanced Nurse Practitioner**	**Nottingham CityCare Partnership**
Tim Hills (TH)	**Assistant Head of Pharmacy**	**Nottingham University Hospitals (NUH) NHS Trust**
Steve Haigh (SH)	**Medicines Information and Formulary Pharmacist**	**Sherwood Forest Hospitals NHS Foundation Trust**
Zen Dong Li	**Interim principal pharmacist for Adult Mental Health community teams**	**Nottinghamshire Healthcare NHS Trust (NHCT)**
Nicola Graham (NG)	**Senior Transformation Manager**	**NHS Nottingham & Nottinghamshire ICB**
Nicola Jay (NJ)	**Deputy Medical Director**	**NHS Nottingham & Nottinghamshire ICB**

In Attendance:

There were no guest attendees present.

Observing:

There were no guest observers present.

NHS Nottingham & Nottinghamshire ICB Interface Support in attendance:

Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFHFT.
Karen Robinson (KR), Specialist APC Interface and Formulary Pharmacy Technician.
Lidia Borak (LB) – Specialist Medicines Optimisation, Interface Pharmacist.

1. Welcome and apologies.

APC members were welcomed, and apologies were noted.

2. Declarations of interest

APC members and the APC support team made no declarations of interest.

3. Minutes of the last meeting

The minutes of the previous meeting were accepted as an accurate record.

4. Matters arising and action log.

Matters arising:

Stoma leakage notification system, Heylo®
Heylo® was classified as RED for prescribing only by Nottinghamshire Appliance Management Service (NAMS), and audit criterion has been developed to capture any Heylo® prescribing information. To date, there has not been any prescribing. LB will continue to monitor any product prescribing.

Sodium hyaluronate 0.15% with trehalose 3%, Thealoz Duo®
Thealoz Duo® was previously classified as GREY. This decision was fed back to the submitters, who have not responded to pursue the decision further.
Recently, a post was advertised for an ophthalmology pharmacist or technician to support system wide efficiency work. TH explained that the funding for the post was only for 12 months, so the longevity of the post was in question. NUH are looking at the feasibility of the post, given the funding's short timeframe.

Stoma Formulary
LC explained that due to the time constraints of the formulary meeting in June, the Stoma Formulary had not been discussed. APC members were asked to send any comments to LC, and no further comments had been received. Debbie Storer (DS) had requested an editable version to comment on; however, LC had not received any further feedback. The Stoma Formulary has been uploaded to the APC website.

ACTION: TH will remind DS to send any comments to LC.

NICE Technical Appraisal (TA) 1026 – Tirzepatide for overweight and obesity – update on implementation and price.

LC informed APC members that a Nottinghamshire Primary Care weight loss service will commence on 1st September. Clinicians will then be able to refer patients and consideration for prescribing tirzepatide by the service will be in line with the following criteria;

- must be aged over 18 with a BMI of 40 or more (or 37.5 or more for certain minority ethnic groups) and have at least four out of the five following co-morbidities: Type 2

diabetes, high blood pressure (hypertension), heart disease (cardiovascular disease), obstructive sleep apnoea, and abnormal blood fats (dyslipidaemia).

Additionally, LC explained there isn't a referral pathway from Secondary Care directly to the Primary Care service, therefore Primary Care prescribers may be asked to make this referral instead. Members expressed concern about the expectation for Primary Care prescribers to serve as a gatekeeper and the additional administrative burden this would entail. The concerns raised will be fed back to the Pathway Design team.

It was highlighted that whilst the NHS price of tirzepatide is remaining the same, the price of treatment through private providers will be increasing from September. It had been confirmed at a national level that patients are only eligible for NHS prescription if they meet eligibility at the time of NHS transfer. Communications on this were expected imminently.

ACTION: LC to feedback to the Pathways Design team the concerns raised by APC members. LC to circulate comms on NHS eligibility once available.

Sativex® for Multiple Sclerosis (MS)

LK provided an update on the submission for Sativex for spasticity associated with MS from the Neurology Specialists at NUH. Following the last meeting, discussions about potential funding had taken place within the ICB. Funding had been approved if Sativex® was to be prescribed in Primary Care but with stipulations that tight controls should be maintained along with monitoring of clinical and cost effectiveness. The formulary submission had previously requested an AMBER 2 classification. However, the recommendation in NICE NG144 is felt to be more conducive to a more formal Shared Care agreement in line with an AMBER 1 classification. Primary Care clinicians agreed that although there were no monitoring requirements, in this situation an AMBER 1 classification was more likely to be acceptable to Primary Care.

LK will work with the submitters to develop a Shared Care Protocol (SCP) return this to APC for discussion.

ACTION: LK to work with submitters to develop a SCP and return to APC for final approval.

Linzagolix and Ryeqo® NICE TAs for endometriosis and uterine fibroids

LK provided an update on the Linzagolix and Ryeqo® NICE TAs. This had been discussed at the previous meeting and had been subsequently escalated within the ICB. However it was felt that a clinical decision from the APC was needed on suitability for Primary Care prescribing.

Ryeqo® and linzagolix are currently classified RED for uterine fibroids. This classification was assigned initially for Ryeqo® approximately two years ago at the request of specialists at NUH as they wanted to gain experience using it. Ryeqo and linzagolix are oral treatments; the alternative, triptorelin is given as a monthly or 3-monthly injection. When used for gynaecological uses, it is only licensed for 6-month's treatment and is given via Secondary Care.

TAs have also recently been published for these medications for use in endometriosis and specialists have requested for them to be made available for Primary Care prescribing. Due to the potentially large eligible cohort, NUH Drug and Therapeutics Committee (DTC) discussions have not been supportive of implementing use in endometriosis with a RED classification without funding support, and therefore NICE compliance is not achieved. There is significant

regional and national variation in Traffic light classifications for these medications, and now also locally as SFHT DTC have agreed use in line with the NICE TAs with a RED classification whilst the potential for primary Care prescribing is addressed.

Acceptability for a shared management approach was agreed, but it was felt that there were several issues that needed clarification. Both medications require a Dual-energy X-ray Absorptiometry scan (DEXA) after 1 year of treatment. The responsibilities for arranging and actioning this scan require defining and it was requested that this remain a specialist responsibility. It was suggested that the current pathway for arranging DEXA scans be raised with the trust Interface groups as current practise may be to request the GP to arrange the scan which was not felt appropriate.

Discussions concluded that a working group was likely to be required with representation from the APC, Primary Care, Gynaecologists and ICB commissioners. LMC attendance was also requested. Guidance for Primary Care prescribers would be required to support an Amber classification and this should define requirements such as duration and frequency of Specialist involvement, monitoring responsibilities, contraception planning, de-prescribing plans, management of patients initiated by the Private sector.

ACTION: LK to draft guidance and establish a working group.

Action log:

The action log was noted by members.

Bupivacaine and adrenaline
LK explained that bupivacaine and adrenaline had been made GREEN for use in minor surgical procedures in Primary Care, whilst lidocaine with adrenaline was unavailable. As this was now available, a decision for reclassification was required. Clinicians asked if both bupivacaine and adrenaline, and lidocaine with adrenaline could be made GREEN on the Joint Formulary. LK will investigate the cost difference and provide feedback to APC members for a classification decision.

ACTION: LK to disseminate the prices to members for a classification decision.

All the other items from the previous meeting(s) have been actioned or are on the agenda for further discussion or feedback.

5. New applications

a) Ciclosporin 0.9mg/ml eyedrops (Cequa®) for dry eyes

LB presented the ciclosporin 0.9mg/ml eye drops formulary submission request received from Tariq Mohammad, consultant ophthalmologist at NUH. The new application request was for an AMBER 2 classification for use in patients with severe dry eyes who had failed to respond to ocular lubricants. This request is a cost-effective alternative to the NICE TA369-supported AMBER 2 product, which contains 1 mg/ml of ciclosporin (Ikervis®) and offers a cost-saving of £7.20 per patient per month of treatment. In addition, 0.9 mg/ml ciclosporin eye drops (Cequa®) is a novel formulation of preservative-free solution, which is expected to be more tolerable for

patients and may lead to improved treatment concordance. Currently, steroid eye drops are often required in addition to ease the transient adverse reactions of pain/irritation during/following administration, which is more frequent during the initiation of treatment.

LB noted the 0.9 mg/ml ciclosporin eye drops (Cequa®) require more frequent administration than 1 mg/ml of ciclosporin (Ikervis®), twice daily versus once daily at night. The product also contains phosphates as a buffering agent, which have been linked to corneal calcification with chronic use. Patients with corneal damage may be at an increased risk; however, ophthalmology colleagues do not consider this a significant cause for concern, as many other ocular lubricants also contain phosphates.

The manufacturer recommends that patients using 0.9 mg/ml ciclosporin eye drops (Cequa®) should be reviewed every three months, as opposed to the 6-monthly review recommended with the current product. Specialists confirmed this cohort is normally reviewed with even shorter intervals hence, any signs of deterioration would be recognised by the specialist and the product would be stopped.

The request for ciclosporin 0.9mg/ml eyedrops (Cequa®) is an addition, with a view to eventually replacing the prescribing of the 1 mg/ml of ciclosporin (Ikervis®). The submission is still awaiting sign-off by the ophthalmology head of service.

Members had some concerns regarding the overall benefit of tolerability and safety of the product over the existing drops and the twice-daily dose versus the once-daily dose, and how well patients tolerate the eye drops. It was also noted that the patent for Ikervis® expires in October 2025 with potential for cost-effective generic formulations emerging soon afterwards. APC members agreed that more local ophthalmologists need to be contacted for their professional opinion to support this application before a decision is made, and the submission will be returned for a decision in December, following patent expiry of the current product.

ACTION: LB to discuss the conclusions reached with DS. LB to raise awareness of the patent expiry with the submitter and canvas local ophthalmologists for their opinions on patient product tolerance. LB to ensure the submission is signed off by the NUH ophthalmology head of service before returning for a final APC decision in December.

6. Formulary amendments

LK presented the formulary amendments for discussion and decision:

(a) FOR INFORMATION – Log of minor amendments carried out.

AMBER 2

- Melatonin oral solution 1mg/ml: The Drug Tariff price has decreased significantly and is now similar to other formulations listed; this formulation has been added as AMBER 2.

AMBER 3

- Tiotropium: Traffic light classification amended from AMBER 2 to AMBER 3 for use in asthma >12 years in line with updated guidance.
- WockAir® 160/4.5 (budesonide and formoterol DPI): Added as AMBER 3 alongside other inhalers that are listed in the updated Asthma guidance.

GREY

- Autopen® 24 and Autopen® Classic: The Joint Formulary entry has been made GREY and the information regarding the discontinued products has been linked to the Joint Formulary.
- Haloperidol 0.5mg tablets: GREY as they are significantly more expensive than alternative options.

OTHER

- Insulin detemir (Levemir®) all formulations: Medicine Safety Network (MSN) June 2025, added additional information regarding the switching of medication. National guidance is pending.
- Premique® Low dose, Premarin®, Provera®, and Dalacin® products: Due to the genericising of products, the branded versions have been discontinued and now need to be prescribed generically; the Joint Formulary has been annotated to reflect this.
- Cholera vaccine (Vaxchora®): The vaccine is now listed in the Green Book; this has been reflected on the Joint Formulary.
- Pro-cal® Vitaflo: Additional information added to the Joint Formulary to differentiate between Procal® powder formulary and Procal® shots, which are non-formulary.
- Hypurin® porcine insulin vials: Information about the discontinuation of vial presentations has been added to the formulary and highlighted to the ICS diabetes steering group.
- Humulin® and Humalog® insulin vials: Information about the discontinuation of vial presentations has been added to formulary and highlighted to the ICS diabetes steering group.
- Novofem®, Elleste® duet conti, Progynova®, Estraderm®, FemSeven®, Zumenon®, Progynova®, Sandrena®: Historically listed as GREY, but these are alternative brands of formulary options. Keywords have been added to direct to most cost-effective brand on the formulary.
- Shingrix® vaccine: Expansion in National programme; from 1st September 2025, Shingrix® will be offered to immunocompromised individuals aged 18 years old.

(b) FOR DECISION – Suggested amendments

GREY

- Estriol 0.01% cream: The cost of estriol 0.01% cream has increased significantly and is now much more expensive than the higher-strength 0.1% cream. Both are delivered via an applicator, meaning the delivered dose is the same. Therefore, it was agreed to reclassify the 0.01% strength of estriol cream as GREY.
- Semaglutide (Ozempic®) 2mg dose: although the 2mg preparation is not marketed in the UK, the product license reflects doses upto 2mg for Type 2 diabetes (T2D). The 2mg dose is double the cost of lower doses due to the need for two injections. NICE guidance for T2D is currently being updated and this will be reviewed for dosing recommendations.

GREEN

- Femseven® Conti patch: Offers an alternative patch option to Evorel® Conti (levonorgestrel versus norethisterone).
- Indivina® (estradiol/ medroxyprogesterone): Offers an alternative alongside Kliofem®, Femoston® Conti & conjugated oestrogens/ medroxyprogesterone (medroxyprogesterone versus norethisterone/ dydrogesterone).
- Bijuve® (estradiol, progesterone): Offers an alternative progestogen to Kliofem®, Femoston® Conti & conjugated oestrogens/ medroxyprogesterone.

RED

- Triamcinolone: Kenalog®: Discontinued in June 2025, but Secondary Care intend to continue use in indications where alternatives are unsuitable, eg ophthalmology.

ACTION: LK and KR to update the Joint Formulary.

7. <u>Horizon Scanning</u>

KR presented the horizon scanning for discussion and decision:

GREY

- Rosuvastatin 10mg/5ml Oral Solution: Does not provide a cost-effective option.
- Nalvee (dydrogesterone) 10 mg film-coated tablets: GREY no formal assessment, local HRT guidance is currently under review and this will be reviewed as part of that process.
- Nootropil (piracetam) 33% (333.3mg/mL) Oral Solution: Currently not listed as available from the manufacturer. To be reviewed once the product and price become available.
- Sildenafil (Silandyl) 100mg orodispersible film: GREY less cost-effective than tablets.

GREEN

- Escitalopram (Enalto) 5mg, 10mg, 15mg and 20mg orodispersible tablets: Priced similarly to oral drops in a more convenient dosage form.

Other

- Atenza® (methylphenidate) XL prolonged release tablets (18mg, 27mg, 36mg and 54 mg). It is recommended that all methylphenidate is prescribed by brand. The brand name will be added as a keyword, and the potential cost saving highlighted to authors of the Preferred Prescribing List (PPL) for brand consideration at the next review

ACTION: KR to update the Joint Formulary.

- **(b) New NICE guidelines**

- Betula verrucosa for treating moderate to severe allergic rhinitis or conjunctivitis caused by tree pollen TA1087, Published: 06 August 2025: Highlighted to the Secondary Care Trust representatives for consideration at DTC meetings.

8. Any Other Business

- LK explained to members that Forxiga® (dapagliflozin) has lost its patent earlier than expected, therefore, the price is expected to decrease significantly. Communication will be sent out to all Primary Care prescribers recommending dapagliflozin as the first-line SGLT2 inhibitor in due course.

- AW raised the NHS app for discussion, although beyond the remit of the APC, AW was provided with an appropriate person to contact to raise NHS app issues.

9. Dates of next meeting.

APC Guideline meeting: Thursday 18th September 2025 (2pm to 5pm, Microsoft Teams)
APC Formulary meeting: Thursday 16th October 2025 (2pm to 5pm, Microsoft Teams)

The meeting closed at 16:05