Nottinghamshire Area Prescribing Committee Formulary Meeting Minutes Thursday 17th October 2024: The meeting was held 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 ICB**
Tanya Behrendt (TB)	**Senior Medicines Optimisation Pharmacist**	**NHS Nottingham & Nottinghamshire ICB**
Ann Whitfield (AW)	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
David Kellock (DK)	**Consultant in Sexual Health and SFHT DTC Chair**	**Sherwood Forest Hospitals NHS Foundation Trust**
Jennifer Moss Langfield (JML)	**GP**	**LMC Representative**
Khalid Butt (KB)	**GP**	**LMC Representative**
Asifa Akhtar (AA)	**GP**	**South Notts PBP, Nottingham & Nottinghamshire ICB**
David Wicks (DW)	**GP**	**Mid Notts PBP, Nottingham & Nottinghamshire ICB**
Deborah Storer (DS)	**Medicines Information Manager and D&T Pharmacist**	**Nottingham University Hospitals NHS Trust**
Mark Clymer (MC)	**Assistant Chief Pharmacist**	**Sherwood Forest Hospitals NHS Foundation Trust**
Steve Haigh (SH)	**Medicines Information and Formulary Pharmacist**	**Sherwood Forest Hospitals NHS Foundation Trust**
Hannah Sisson (HS)	**Principal Pharmacist, Adult Mental Health Community Teams**	**Nottinghamshire Healthcare NHS Trust**
Beth Rushton (BR)	**Senior Clinical Pharmacist**	**Nottingham West PCN**
Georgina Dyson (GD)	**Advanced Nurse Practitioner**	**CityCare ICB**

Jacqui Burke (JB)	**Advanced Nurse Practitioner**	**Willowbrook Medical Practice**

Observing:

Paige Edwards, 2nd year Pharmacy Student, University of Nottingham.
Sina Dawit, 2nd year Pharmacy Student, University of Nottingham.

NHS Nottingham & Nottinghamshire ICB Interface Support in attendance:

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

1. Welcome and apologies.

Jessica Waterhouse (JW), Quality Improvement Manager/Trainer – Care Homes, NHS Nottingham & Nottinghamshire ICB, was welcomed and introduced as a new APC member. Pharmacy Students Paige Edwards and Sina Dawit were welcomed as observers.
Apologies from Fatima Malik, PCN pharmacist (Byron PCN), Primary Integrated Community Services Ltd (Beth Rushton in attendance to cover) and from Nicola Graham, Senior Commissioning and Transformation Manager NHS Nottingham & Nottinghamshire ICB, were noted by the Chair.

2. Declarations of interest

Two APC members declared personal health conditions relating to agenda items; no other declarations of interest were raised.

3. 10-minute learning session

SH presented a short learning session on clinical trial statistics and how to interpret the data. A risk calculation crib sheet was provided to show the principles behind Absolute Risk Reduction (ARR), Number Needed to Treat (NNT) and Relative Risk Reduction (RRR).
Members were pleased to have the learning session reinstated.
The recording and slides will be kept for future training purposes.

4. Minutes of the last meeting

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

5. Matters arising and action log.

5(a) NICE TA875 – Semaglutide and draft Technical Appraisal (TA) for Tirzepatide.

LK explained that although there were no updates regarding semaglutide a TA for tirzepatide is expected to be published in December. A funding variation has been submitted that, if approved, would support a phased implementation period against a priority list of cohorts. At present there is no clarity regarding the funding of treatment. However, the impact on the NHS will be unprecedented. The Joint Formulary has been updated to include a statement that tirzepatide should not be prescribed for managing overweight and obesity until NICE has published the TA and a position is reached by the ICB.

ACTION: LK to update further as new developments arise.

5(b) Cytisine for smoking cessation.

A small number of patients were going to be offered cytisine for smoking cessation within Secondary Care as part of a pilot project funded by NHS England; however, this had been delayed.

ACTION: The Secondary Care representatives will update the APC as more information becomes available.

5(c) Patient safety incident – Mesalazine.

APC members were updated on the findings of a mesalazine patient safety incident, where a patient had failed to have some monitoring completed and subsequently went on to develop renal problems. The information sheet contains all the monitoring advice required and no further action was required from the APC.

5(d) Expectations of the formulary.

Due to the increasing number of queries the team were receiving about individual patients, a statement was to be added to the Joint Formulary which outlines the expectations. This is based upon a statement found on North East and North Cumbria ICS and was proposed as follows:

“The formulary is comprehensive but will not cover every medicine in every situation. It is intended to cover the majority of occasions, but it is recognised that individual patients may require medicines which lie outside formulary recommendations. In exceptional circumstances prescribers may agree to work outside APC guidance; Secondary and Primary care prescribers are encouraged to discuss the appropriate management of individual patients personally in these situations.”

APC agreed to the addition of the statement, with a slight adjustment to the wording.
It was felt that some training could be provided for the wider Medicines Optimisation Team to support them in answering formulary queries.

ACTION: LK will add a statement to the Joint Formulary. The APC Support Team will discuss the training needs for the Medicines Optimisation Team.

Action log:

Doxazosin for Post-Traumatic Stress Disorder (PTSD) was previously accepted as AMBER 2. APC had requested an audit of patients following 12 months of prescribing. The findings concluded that doxazosin had been beneficial for the majority of patients with whom it had been used, with any side effects being manageable with dose reduction.

ACTION: LK to remove doxazosin from the action log.

All of the other items listed on the Action Log were noted by the APC members.

6. New applications

a) Antipsychotics for chorea in Huntington's Disease (HD).

LK presented the submission for antipsychotics to be used for chorea in Huntington's Disease. The mainstay of treatment for chorea in HD chorea is with traditional neuroleptic dopamine blockade and off- label use of neuroleptic medication is considered first-line treatment by most specialists. Licenced medication for chorea is limited to tetrabenzine, a pre-synaptic dopamine blocker. However, depression is a common side effect, and in the HD cohort it is often poorly tolerated. It is also contraindicated in those with significant depressive symptoms, which represents a large proportion of patients.

Locally, these medications have previously been prescribed in Primary Care on specialist advice, but recently it has been requested that their use is formalised through the formulary process. A formulary submission had been completed by Dr Sare, Neurologist at NUH, and an AMBER 2 classification had been requested. This is in line with their classification for use in other indications and the classification of tetrabenzine. Most commonly, olanzapine is used (80% of cases), but risperidone, sulpride, amisulpride and haloperidol were also requested as part of the submission. Doses used are generally lower than those used for psychosis.

APC members were asked to consider the formulary classification of antipsychotics for this indication. Monitoring criteria and concerns regarding ongoing prescribing for patients unable to complete the suggested monitoring (e.g., ECG in palliative patients) were discussed. Noting the small patient numbers involved (<10), the predicted use for this indication is low. It was questioned whether it would be more appropriate for a general statement about their usage for this indication to be added to the formulary, as some other areas have done, rather than adopting a formal traffic light classification for each medication.

Various options were discussed. APC members cautiously agreed to an AMBER 2 classification with the addition of supportive information links to the formulary. It was noted that patient management would often be on an individual basis and an individual patient management care plan would be needed.

ACTION: Members agreed to a provisional AMBER 2 classification, subject to confirmation from the specialist about the provision of individualised care plans. This will be brought back to the next APC meeting for continued discussion.

b) Freestyle Libre 3

LC presented the formulary submission for Freestyle Libre 3 sensors for Type 1 diabetes.
A formulary submission had been received from the ICS Diabetes Steering Group for Freestyle Libre 3 sensors for use as part of a hybrid closed loop (HCL) system. These are currently being provided for patients via the NHS supply chain through Secondary Care, although more recently they have been added to the Drug Tariff and were now prescribable on FP10. The cost of the

sensors supplied via FP10 is less than the cost if supplied via Secondary Care so the submission provides an overall system saving.

Freestyle Libre 2+ is more cost-effective and is already prescribed in Primary Care for patients using HCL. Freestyle Libre 3 would offer an alternative for those aged four years and over who were deemed unsuitable for Freestyle Libre 2+. Only Freestyle Libre 3 is compatible with the HCL system licensed for use in pregnancy and once a patient has been initiated on the Freestyle Libre 3 in pregnancy, they may continue with the device post-partum.
Companies offer training and links are available for Primary Care prescribers.
OptimiseRx links will be implemented to prevent errors in switching between the CGM devices and the HCL systems will continue to be initiated only by Secondary Care.
Finance assurance would be sought to ensure the impact on the prescribing budget was offset somehow by the savings made via the current cost and volume invoicing. The Medicines Optimisation Efficiencies Team were investigating this. LC will monitor the prescribing data for years one and two.
Members agreed to an AMBER 2 classification.

ACTION: LC to inform the submitters and update the Joint Formulary for Freestyle Libre 3 to be classified as AMBER 2 for use as part of HCL system only and will ensure OptimiseRx messages are implemented. LC will monitor the prescribing for years one and two.

7. Formulary amendments

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

- The following information was added to the GnRH Joint Formulary entries: “new temporary legislation from 26 June 2024 restricts the use of GnRH analogues as treatment of gender incongruence or dysphoria to children and young people under 18. Prescription endorsement with SLS will be required for prescribing that meets the exemption criteria.”

- Azathioprine 50mg/5ml - The Joint Formulary has been updated to include the licensed liquid with an AMBER 1 classification, as agreed through ratification of the Shared Care Protocol (SCP) for Inflammatory Bowel Disease (IBD) in children and young people; the formulary previously referenced an unlicensed special being available.

- Aymes Complete – the name has changed to Aymes Actagain 1.5. The full and quick reference guidelines have been updated and reloaded onto the APC website.

- Macrogol – the Joint Formulary entry has been amended from “macrogol” to “macrogol compound oral powder" to prevent inadvertent prescribing of the more costly preparation.

- Acetylcysteine effervescent tablets – clarification has been added to the Joint Formulary that Sugar-Free tablets are included in line with Drug Tariff pricing.

- Dapsone tablets - a query had been received regarding the monthly monitoring requirement. Dermatology and Microbiology confirmed 3-monthly monitoring once a patient is stable. This information has been added to the Joint Formulary entry.

- Finasteride tablets – The Joint Formulary entry has been updated to include tablet strength to differentiate between the licenses for benign prostatic hyperplasia and androgenic alopecia.

- Ketone strips - All the products listed in the Blood Glucose Testing Strip formulary have now been added to the Joint Formulary.

- Add Tears Hypromellose 0.3% preservative free – The Joint Formulary has been updated and Add Tears will be added to the Eye Lubricant Formulary. The Medicines Optimisation Team have been notified to amend the SystmOne formularies and implement OptimiseRx messages.

GREEN

- Abryso Respiratory Syncytial Virus vaccination - Added to the Joint Formulary as GREEN in line with the National immunisation programme.

GREY

- Macrogol 3350 - added to the Joint Formulary as GREY, as this is not a cost-effective presentation.

- Risperdal Consta injection – reclassified as GREY, as requested by NottsHC; NottsHC is managing the switch for all patients.

(b) FOR DECISION – Suggested amendments

- Promethazine is now contraindicated in those under 6 years of age, due to a potential for fatal respiratory depression. It is currently still listed in the BNFc for those aged 2-5 years and this has been raised with the BNF publishers. Promethazine currently has a general GREEN classification as an antiemetic and is AMBER 2 for sedation in children. The contraindication has been raised with Paediatric Specialists as there may be a continued requirement for it in this age group. Promethazine is included in APC guidance for management of sleeping difficulties in childhood, which is currently being reviewed.
  OptimiseRx messages will alert if this is prescribed for a child under six years of age.
  Medicine Safety Officers (MSO's) are raising awareness of the contraindications.
  No national safety advice has been issued in the UK, but an equivalent notice was published in New Zealand.

ACTION: Await the outcome of discussions with Specialists.

- Morphine 0.1% in Intrasite gel - Request to clarify the status on the formulary following identification as a high spend item in Primary care.

ACTION: Refer to trust Drug and Therapeutic Committee (DTCs) for potential red classification.

- Sertraline and other antidepressants - A request had been received to clarify the traffic light classification of antidepressants when used in adolescents. The reasons behind the request were questioned as these would generally only be initiated by the Specialists.

ACTION: LK to seek further information.

- Sertraline unlicensed oral solution 50mg/5ml - Listed on the formulary but the 50mg/5ml special has been removed from the Specials tariff so is no longer cost-controlled in Primary Care. During the meeting it was raised that other licensed products were now available. It was agreed to remove the unlicensed special, but LK will investigate the availability of licensed liquids.

ACTION: LK to investigate licensed liquid options further.

- Insulin Levemir will be discontinued across the range from December 2026.NovoRapid Flextouch and Insulatard penfills will be discontinued from March 2025. Insulatard will remain available in vials and Novorapid in Flexpen, vial, pump cartridge and Penfil. Communication about the discontinuation will be delivered to practices via the Hints and Tips. Current patients will need to be reviewed for receiving an alternative product and no new patients are to be started on the discontinuing insulins. Information will be circulated to the ICS Diabetes Strategy Group.

ACTION: LB to add the discontinuation dates to the formulary, inform the ICS Diabetes Strategy Group and advise a management plan for Levemir patients.

GREY

- Torasemide - was reclassified as AMBER 2 to allow use in times of shortages with loop diuretics. As these have now been resolved, torasamide will be reclassified as GREY.

ACTION: LK to amend the formulary.

8. Horizon Scanning

- **(8a) New Horizon Scanning publications for review.**

GREY

- Lyfnua (gefapixant citrate) 45 mg film-coated tablets. Specialist Pharmaceutical Society states Gefapixant (Lyfnua) will only be available on private prescriptions. However, the item is not listed in the XV111A part of the drug tariff for non-NHS products.

ACTION: No further action. It is already listed on the Joint Formulary as GREY; the Primary Care teams will be contacted to ensure it is listed as GREY on Systm1.

Other

- EasyChamber Spacer range - The lead for the ICB respiratory group has been informed for cost-saving efficiency consideration.
- Budesonide (Budenofalk) 4mg suppository – To be considered as a cost-effective formulary alternative to prednisolone suppositories. Gastroenterology Specialists at SFHT and NUH will be contacted for their opinions.

Medications awaiting a price before decision-making:

- Tolak 40 mg/g cream, 5-flurouracil.
- Ciclosporin (Cequa) 0.9mg in 1mL eye drops in single dose container (0.09%).

ACTION: APC members approved the formulary classifications discussed. KR is to update the Joint Formulary and add the items awaiting a price to the Horizon scanning follow-up log.
LK will contact the Gastroenterology Specialists to discuss the feasibility of including budesonide suppositories on the Joint Formulary as a formulary alternative.

- **(8b) New NICE guidelines (LK)**

NICE TA: Vibegron for Overactive Bladder (OAB) syndrome – NICE TA999

LK presented NICE TA999, with the following recommendations.

- Vibegron is recommended as an option for treating the symptoms of OAB in adults. It is only recommended if antimuscarinic medicines are not suitable, do not work well enough or have unacceptable side effects.

- If people with the condition and their healthcare professional consider vibegron to be one of a range of suitable treatments, after discussing the advantages and disadvantages of all the options, the least expensive should be used. Administration costs, dosages, price per dose and commercial arrangements should all be taken into account.

This is the same prescribing positioning as mirabegron. Clinical trial evidence shows that vibegron is more effective than a placebo for treating the symptoms of OAB. The evidence is limited because most people in the trial had not had antimuscarinic medicines. But the reduction in symptoms was similar for people who had had antimuscarinic medicines and people who had not. The licensed dose of vibegron (75 mg) has not been directly compared in a clinical trial with mirabegron, but an indirect treatment comparison suggests it is likely to work just as well. Vibegron is likely to be cost-saving, compared with mirabegron.

Mirabegron and vibegron are both β3-adrenergic agonists, but mirabegron also has some activity at β1 and β2 receptors so this may cause hypertension. Vibegron does not have an appreciable effect on blood pressure, so, unlike mirabegron, it does not require blood pressure monitoring. In addition, it also has fewer drug interactions, does not require dose adjustment, and may be crushed within its license for those with swallowing difficulties.

Mirabegron is available on the formulary locally with an AMBER 3 classification when used in line with Notts APC OAB guidance. Opinion from the author of the guideline has been sought

(Mr Parkinson, Consultant urologist) and it is proposed that vibegron should be made available as an option alongside mirabegron. Vibegron has been added to an amended draft version of the guidance.

APC members agreed to vibegron receiving an AMBER 3 traffic light classification.

ACTION: LK will add vibegron to the Joint Formulary with an AMBER 3 classification. The OAB guideline will be updated and uploaded to the APC website.

NICE TA: latanoprost–netarsudil for previously treated primary open-angle glaucoma or ocular hypertension- NICE TA1009.

LK presented NICE TA 1009. Latanoprost–netarsudil is recommended as an option for reducing intraocular pressure (IOP) in adults with primary open-angle glaucoma or ocular hypertension when a prostaglandin analogue alone has not reduced IOP enough, only if: “they have then tried a fixed-dose combination treatment and it has not reduced IOP enough, or a fixed-dose combination treatment containing beta-blockers is unsuitable.”

The usual treatment for reducing IOP in people with primary open-angle glaucoma or ocular hypertension includes a prostaglandin analogue eye drop (for example, bimatoprost or latanoprost). If this does not work well enough, people usually have a fixed-dose combination treatment eye drop. These include combinations of a prostaglandin analogue with a beta-blocker (for example, bimatoprost–timolol), or a prostaglandin analogue with carbonic anhydrase inhibitors or sympathomimetics.

It was highlighted that latanoprost–netarsudil is a once-daily preparation and may offer a combination product to some patients that would otherwise require separate bottles of eye drops.

APC members agreed an AMBER 2 classification. It was highlighted that clarity was required about implementation dates, due to the current wording in the Prescribing framework about implementation of NICE TAs. This will be discussed further outside the meeting.

ACTION: Formulary to be updated once implementation date has been clarified. LK will provide an update on the decision at the next APC meeting.

9. Barrier Preparations formulary update

KR presented the Barrier preparations formulary, which had been reviewed due to reaching its review date.

The barrier preparations formulary had been widely consulted on and the only product change requested was from LBF to Cavilon. ePACT2 data also indicated this was the prescribing trend. From a care home's perspective, the non-drying time and overuse of barrier products created further issues by preventing the absorbency of continence products. It was agreed that the Barrier Preparations Formulary needed to include more information on how to use barrier preparations as well as offer the estimated monthly quantities to be prescribed, if possible. The number of products and pack sizes available varied and it was questioned whether all of these were required. From a care home's perspective single-use products were beneficial to prevent wastage, but a medium and a large size option could be offered where appropriate.

To make the barrier preparations formulary user-friendly a flow chart was requested as opposed to a table of products. Clinicians also requested a short information leaflet as an appendix.

ACTION: KR to consider requests and formulate a flow chart. This will then be discussed within the Interface Team as to whether ratification can be achieved via email or whether further discussion at the next APC meeting is required.

10. Compression Hosiery and Wrap Formulary Selection Guide

KR informed of a request for links to TeamNet hosted documents to be added to the APC website. The requested links included the Compression Hosiery and Wrap Formulary Selection Guide produced by CityCare, as well as additional guidance on product selection and recommended prescribing quantities.
The Compression Hosiery and Wrap Formulary Selection Guide had been developed to support local Primary Care prescribers in product choice and quantities. It had been brought to the APC at the request of several CityCare GPs and NMPs who had found it to be a useful document but difficult to find on TeamNet.
Several Compression Hosiery and Wraps are appearing in the top 20 spend due to uncontrolled prescribing. It is expected that a similar version of these documents will be produced for the rest of the County in the future.

Some areas had developed prescribing templates for compression hosiery and wraps which offered a safety net to ensure Doppler checking was carried out and prevent over-ordering. Although this was out of the APC's remit the information regarding prescribing templates will be shared with the Medicines Optimisation Team lead for wound care.
Members felt the key messages should be bulleted at the start of the document and this suggestion will be fed back to the author(s).

ACTION: LB to share the information about Prescribing templates with the Medicines Optimisation Team lead for wound care. More consideration will given to the document(s) outside the APC meeting.

11. Any Other Business

- Palliative care medication stocklist – The East Midlands Primary Care Team have updated the community pharmacy stockist and the Service Level Agreement has again been agreed for the Nottinghamshire Pharmacies to hold stocks of vancomycin for C.diff patients.
- Lincolnshire APC have approached the Nottinghamshire APC with a request to share the appeals process in the same way sharing occurs with Derbyshire JAPC. APC agreed but suggested that this should be reviewed every 6 months.
- AW asked about awareness around hypothalamic amenorrhea caused by sudden weight loss; clinicians present shared details with AW.
- It was noted that NUH DTC had agreed a change from branded to generic preparations for dabigatran, oxcarbazepine and eslicarbazepine.

12. <u>Next meeting dates.</u>

APC Formulary meeting: Thursday 12th December 2024 (2pm to 5pm, Microsoft Teams)
APC Guideline meeting: Thursday 21st November 2024 (2pm to 5pm, Microsoft Teams)

The meeting closed at 16:55hrs.