Nottinghamshire Area Prescribing Committee

DRAFT Nottinghamshire Joint Formulary Group Meeting Minutes
Thursday 10th February 2022, 2-5 pm
Online Microsoft Teams meeting due to COVID-19

Present:
Tanya Behrendt (TB), Senior Medicines Optimisation Pharmacist NHS Nottingham & Nottinghamshire CCG (Chair)
Steve Haigh (SH), Medicines Information Pharmacist, SFHFT
Esther Gladman (EG), GP Prescribing Lead, NHS Nottingham and Nottinghamshire CCG
Ann Whitfield (AW), Patient Representative
Tim Hills (TH), Assistant Head of Pharmacy, NUH
Laura Catt (LC), Prescribing Interface Advisor, NHS Nottingham and Nottinghamshire CCG
Lynne Kennell (LK), Interface/Formulary Pharmacist, SFHFT
Shary Walker (SW), Interface/Formulary Pharmacist, NUH
Karen Robinson (KR), APC/Interface/Formulary Support Technician, NHS Nottingham and Nottinghamshire CCG
Hannah Godden (HG), Mental Health Interface Pharmacist, NHS Nottingham and Nottinghamshire CCG/NHCT

In attendance:
Michalina Ogejo (MO), Medicines Optimisation and Pain Management Pharmacist, PICS – joined the meeting at 2.30pm for item 4a.
Dr Milind Sovani, Respiratory Consultant, NUH joined the meeting at 4.15 pm to discuss Trixeo item 5c and Bevespi item 5d.
Joseph Kilgariff - Specialist nurse practitioner joined the meeting at 3 pm for item 6.
Nichola Butcher, Medicines Optimisation and Interface Pharmacist – joined the meeting at 3 pm as an observer.

Apologies:
David Wicks (DW), GP Prescribing Lead, NHS Nottingham and Nottinghamshire CCG
Debbie Storer (DS), Medicines Information Pharmacist, NUH
Jill Theobald (JT), Specialist Interface Pharmacist, NHS Nottingham and Nottinghamshire CCG
Asifa Akhtar (AA), GP Prescribing Lead, NHS Nottingham and Nottinghamshire CCG
Steve May (SM), Chief Pharmacist, SFHFT
Kuljit Nandhara (KN), Deputy Chief Pharmacist, Head of Pharmacy Mental Health Services, NHCT in attendance until 2.30pm, HG provided representation.
David Kellock (DK) Consultant, Sexual Health, SFHFT

Agenda item	Notes
1. Apologies	Noted (see above).
2. Declarations of interest	TB declared a personal interest in Palforzia (included in Horizon Scanning) as a family member has a relevant medical condition. Nothing further was declared by members of the group. Submitter declarations: • Dr Sovani has received speaking fees and educational support grants from Astra Zeneca, Chiesi, Radiometer ResMed and Phillips Respironics. Additionally, payments were also received for attending advisory board meetings from Astra Zeneca and research funding From Radiometer ResMed. Dr Sovani's colleagues in the department have also received funding from AstraZeneca (as well as other companies) towards research, speaking fees and educational travel grants.

3. Minutes of previous meeting	The minutes were accepted as an accurate record of the meeting.
4. Matters arising and Action Log	**Matters arising:** *Post-meeting note:* **Low Carbon Inhalers** Following email discussions, the Joint Formulary had been updated to clarify the 1st, 2nd and 3rd line options for Salbutamol. 1st line = DPI (Easyhaler® Salbutamol) for patients in whom a DPI is appropriate. NB Device expires 6 months after the foil pouch is opened 2nd line = MDI +/- spacer (Salamol® - prescribe by brand) 3rd line = CFC free breath-actuated (Salamol Easi-Breathe® - prescribe by brand) **ACTION: KR will provide an update on the future progress of the greener agenda group** **Action log:** **Cinacalcet** LK presented ePACT graphs showing an increase in patient numbers, but a plateau in usage. **ACTION: LK continue to review for another four months.** **Semaglutide** The committee were informed that the oral Rybelsus® audit is aimed to commence in April 2022. **ACTION: SW to update action log.** **Ketotifen** Costs and patient numbers have remained similar since ketotifen was added to the formulary. Spend approx £100 per month and approx 10 patients. Further monitoring of prescribing was not felt to be necessary. **ACTION: Remove from the action log.** **Opicapone** LK presented prescribing data that showed a small increase in prescribing until opicapone was accepted for first line use in patients that entacapone was not felt to be appropriate for. This will be monitored further alongside safinamide as part of work addressing prescribing of medications for Parkinson's disease. **ACTION: Merge action log entry with safinamide.** **Mesalazine 1G (Octasa® 1G Suppositories)** Discussions ongoing with gastroenterologists. **ACTION: LK will update as progress is made.** **Fentanyl patch switch to Opiodur®** The ICS Medicines Optimisation team do not have the capacity to implement a switch. This has been added to the Integrated Pharmacy and Medicines Optimisation (IPMO) workstream. **ACTION: KR remove from the action log** **NICE NG203 – Chronic kidney disease: assessment and management – Use of SGLT2 inhibitors** LK had attempted to seek input from renal clinicians regarding potential patient numbers and implementation but had not yet received a response. The dapagliflozin NICE TA is expected March 2022 so this will be pursued post

	publication. **ACTION: Remove from the Action log.** **Tobacco company takeover of Vectura** No further action required **ACTION: KR to remove from the action log.** **Oral Nutritional Supplements** Matt Lawson (ML), MO dietitian, has agreed to complete a submission form when requesting ONS changes on the formulary. SW has worked with ML and produced an ONS template to obtain the essential information for an ONS formulary request. **ACTION: SW to update APC on the ONS template.** **WockAIR® 160 micrograms/4.5 micrograms inhaler and 320 micrograms / 9 micrograms inhaler (DPI Budesonide and formoterol fumarate dihydrate)** Notify Peter Richards (PR) of the inhaler for product awareness for the greener inhaler agenda **ACTION: KR to notify PR and remove from the action log, see post-meeting note below** **Post meeting note. Cost comparisons had been made against Fobumix Easyhaler and Symbicort Turbohaler. It offered a small saving against Fobumix so would be considered at next guideline update. *** All other items were either completed or included on the agenda. ******
5. New applications	**a) Myopridin (Mibe Pharma UK)** LK presented the myopridin formulary submission. Myopridin is licensed for the treatment of muscle spasms, lumbar pain, torticollis and general muscle pain in adults and could be an alternative option in the treatment of lower back, neck or sciatica with muscle spasms (acute attack). A green classification had been requested for use in patients in whom NSAIDS have been ineffective or contraindicated. There was a paucity of supporting evidence; no published evidence of efficacy was found and evidence was limited to data on file and these studies were also of poor quality. Side effects appear anticholinergic in nature, with no evidence of potential for dependency or addiction. MO joined for discussion and questions. MO explained that myopridin had been used within Europe for the last 50 years with good effect. Evidence for its use was available, however this was not in English. A trial is currently being carried out in Germany, however it was not known if this was an RCT. MO explained that patients may have chronic pain, but with acute spasms. Currently, NICE CKS suggest a short course of benzodiazepines as an option, but where possible the pain clinic try to avoid prescribing benzodiazepines due to the addictive properties, leaving only baclofen as a short term option. Myopridin has a relatively low side effect profile other than its anticholinergic effects. It was intended that prescribing would be for short term use, i.e. 5 days. Surrey APC has recently approved myopridin for short term use. JFG requested that contact be made in order to determine the reasons for their decision and to ask if they had obtained any further evidence.

ACTION: MO to contact Surrey APC to establish their evidence findings and reasons for positive decision.
MO to seek clarity from manufacturer regarding ongoing trials and potential dates for publication
LK to bring back to April JFG.

b) Trurapi (Insulin aspart biosimilar, Sanofi)

LK presented Trurapi, which is the first insulin aspart biosimilar and offers significant cost savings compared to Novorapid, the originator brand. Preliminary discussions with clinicians have suggested some support for this product as the first-line insulin aspart product for new patients, but further discussions are ongoing. Trurapi is currently available as cartridges, prefilled pens and a 10ml vial. The pre-filled pen device is the Solostar, which is the same device utilised for Lantus (insulin glargine).

Previously uptake of biosimilars has been poor locally, but engagement work with local clinicians and Diabetic Specialist Nurses is underway and they are more supportive of the Sanofi product than other biosimilars due to the devices and product support that the company offers.

Switching existing patients is supported by NICE if done as a shared decision made with the patient and this could be considered once experience with the product had been gained. However, the intention initially was to target new patients.

No safety issues were anticipated, but as device presentation may be different and it is a biosimilar product, patients should be maintained on the same brand so brand prescribing is required.

The JFG agreed with the addition to the formulary of Trurapi with an Amber 2 classification.

ACTION: LK to take to APC.

SW presented the submissions for Trixeo and Bevespi. Dr Milind Sovani, Respiratory Consultant, NUH joined the meeting at 4.15 pm to contribute to discussions and answer questions.

c) Trixeo® Aerosphere (Glycopyrronium/ formoterol/ budesonide, Astra Zeneca)

Trixeo® Aerosphere is a triple fixed-dose LABA/LAMA/ICS combination pressurised metered-dose inhaler (pMDI). This device will be a maintenance treatment option for patients with moderate to severe COPD, who are not adequately treated by a combination of ICS/LABA or LABA/LAMA combination, and for whom a pMDI is clinically appropriate. For example, patients who are unable to use, or unsuitable to receive, other inhaler devices due to the nature of their lung function, breathing technique, or dexterity issues.

Trixeo® Aerosphere is cost neutral. The monthly cost is £44.50, the same cost as the other ICS/LAMA/LABA combination devices recommended in the APC Nottinghamshire COPD guidelines. The triple LAMA/LABA/ICS combination is

NICE and GOLD recommended.

Trimbow® is the alternative LAMA/LABA/ICS MDI combination in the COPD guidelines. Trixeo® does not require fridge storage before use, which is a slight advantage over Trimbow®. However, Trimbow® is already in the formulary and licensed for use in both asthma and COPD.

AZ offer a virtual pulmonary rehab programme for patients on Trixeo®. TB raised concerns and shared the feedback from the ICS-wide respiratory meeting regarding this:

- There is a general caution and this wouldn't be a reason to use Trixeo® because of the pulmonary rehab offer.
- There were no concerns that there is a gap in the local pulmonary rehabilitation services that AZ will be able to fill.
- Caution about who is doing the pulmonary rehab and the education as the local services use respiratory experts.
- Pulmonary rehabilitation services are working towards having accreditation. Not everyone can provide a pulmonary rehabilitation service.
- Virtual rehabilitation is not seen as a gold standard and it should be done face to face.
- A patient could miss out on a better local service if the patient on Trixeo® opts in to the AZ pulmonary rehabilitation service.

Dr Sovani explained that Trixeo® Aerosphere has been demonstrated to provide mortality benefit over dual inhalers and felt it was a better progression from Bevespi® Aerosphere in terms of patient compliance as it is a similar device. Trixeo® can be another triple combination option in the formulary in addition to Trimbow® as it is not inferior to Trimbow® MDI in terms of carbon footprint and cost-effectiveness.

Trimbow® MDI is already available on the formulary for both COPD and asthma and Trixeo® Aerosphere does not have an overwhelming advantage over Trimbow® MDI. As the NHS are trying to move away from using MDIs, JFG felt that it is unnecessary to have two triple MDI options on the formulary and recommended that Trixeo® Aerosphere is classified grey.

ACTION: SW to take to APC.

d) Bevespi® Aerosphere (Glycopyrronium/ formoterol, Astra Zeneca)

Bevespi® Aerosphere (glycopyrronium bromide/formoterol fumarate dihydrate 7.2 µg/5.0 µg) is a dual fixed-dose LAMA/LABA combination that is available in a pMDI device, indicated for the regular maintenance bronchodilator treatment to relieve symptoms of COPD in adult patients, as per its licensed indication. Bevespi® is the first and only LAMA/LABA pMDI combination available in the UK. It provides a device option, that can be used with or without a spacer. The intended place in therapy is in patients receiving their first maintenance treatment, or in patients who require a step up in therapy from SABA or SAMA therapy when limited by symptoms or have exacerbations, who prefer to use a pMDI device due to being unable to use or unsuitable to receive other inhaler devices (due to the nature of their lung function, breathing technique, dexterity

	concerns) Bevespi® Aerosphere is cost neutral. The monthly cost is £32.50, the same cost as the other LAMA/LABA combination devices recommended in the APC Nottinghamshire COPD guidelines. LAMA/LABA combination is recommended by NICE and GOLD guidelines for COPD. The current recommendation is to opt for DPI inhalers due to the lower carbon footprint as part of the greener NHS agenda. Dr Sovani strongly acknowledged the importance of using inhalers that have has a less detrimental impact on the environment such as the DPI formulations. However, some patients are critically unable to manage these inhalers due to frailty, and therefore, there will still be some groups of patients that will need to use an MDI inhaler. Dr Sovani also explained that there will be patients who will prefer Spiolto® Respimat (LAMA/LABA soft mist inhalation, SMI). However, actuation-breathing coordination is an issue in some patients. Moreover, the main issue with respimat inhalers is the dry mouth adverse effects, and the inconsistent distribution of the powder more prominent on the upper airways than the lower part of the lungs. The JFG concluded that as this was the only LAMA/ LABA pMDI device, that this would be appropriate for formulary inclusion for patients unable to use current DPI or SMI choices and were minded to recommend an amber 3 classification. However, opinions of other clinicians should be sought about the need for a pMDI or whether a SMI option is sufficient. **ACTION: SW to seek further clinician opinion about the need for a LABA/LAMA pMDI and take to APC.**
6. Formulary amendment	**Clonidine for TICs in paediatrics** HG presented the clonidine formulary amendment request alongside Joseph Kilgariff (Specialist Nurse Practitioner).Clonidine for Tourette's is classified Amber 2 for adults on the Nottinghamshire Joint formulary. A request has been made to expand this indication to include the treatment of tics and tic disorders in children and young people. This indication is off-label although it is widely used within specialist services and recommended in European clinical guidelines. HG will gain further clarity for expected patient numbers from NUH and SFH but cost impact is extremely unlikely to go over the APC mandate. It was confirmed that the expected age of starting clonidine in children would be 9 to 11-years-old, generally stopping treatment at around 15 years of age. Although sometimes children may need to continue treatment with clonidine for longer. Monitoring of blood pressure and pulse is required every 6 months once stabilised. It was highlighted that this may need to be retained in secondary care due to some reluctance from primary care to undertake this monitoring. However, the monitoring may be possible in primary care for patients who are also receiving ADHD medication via a shared care agreement.

	The JFG agreed with the requested Amber 2 classification with a caveat that some GP practices might not be able to undertake the required monitoring in which case it would remain a secondary care responsibility. **ACTION: HG and Joseph Kilgariff to produce a clonidine prescribing information sheet for March APC.**
7. Formulary amendments	**FOR DISCUSSION** • **Orlistat –** Traffic light reclassification. NICE CG189 states to only prescribe orlistat as part of an overall plan for managing obesity. Nottingham has the Change Point Obesity Prevention and Weight Management Service, which is funded by the Nottinghamshire County Council but not able to supply medication. GPs are not currently commissioned to provide this service. **ACTION: Classify as Grey until appropriate weight loss service available that can supply it. Epact2 data required for APC.** • **Minoxidil 5% w/w (Regaine® 5% Cutaneous Foam)** – New formulation that can be prescribed on the NHS but can also be purchased OTC. **ACTION: Grey as available OTC as part of self-care option.** • **GnRH** – Clarity on which GnRH analogues to classify as Amber 2 for gender dysphoria. Nottingham Gender Identity Centre (GIC) recommends triptorelin as the preferred preparation as it is the most cost-effective. Goserelin is administered as an implant, involving a more complex administration procedure, and leuprorelin is the least cost-effective. **ACTION: Remove the statement on the formulary that "All GnRH analogues are Amber 2 for gender dysphoria". JFG recommends classifying leuprorelin as GREY for gender dysphoria due to being the least cost-effective and also classifying goserelin as GREY for gender dysphoria due to complex administration, Triptorelin Amber 2 as the preferred choice for gender dysphoria, but HG needs to check with the local guidance first.** • **Hydrogen Peroxide and potassium permanganate** - Amber 2 after wound care specialist recommendation • **Venlafaxine 75mg/5mL oral solution sugar-free and 37.5mg/5mL oral solution sugar-free** – Licensed formulation for patients with swallowing difficulties or patients on NG/PEG tubes. It allows accurate measurements of doses less than 37mg when tapering off but is very expensive. **ACTION**: **JFG recommended green if using doses <300mg/day only as a last option where switching to another antidepressant isn't clinically appropriate as it is very expensive**. **HG and SW will work together to include appropriate wording on the formulary update.** • **Erythromycin –** Currently amber 2. Recommended for acne as per NICE/APC Acne guideline. **ACTION: Update all antibiotics for acne as Amber 3 to promote good antimicrobial stewardship and use the dermatological section**

	of the formulary for acne. • **Fexofenadine 30mg film-coated tablets (Telfast®)** – The addition of an additional strength licensed for paediatrics as a third-line agent for allergic rhinitis after cetirizine/loratadine. **ACTION: Add as green** • **Oral Methadone –** currently Amber 2 for initiation by pain team only when used as an analgesic. **ACTION: Amber 2 classification to be expanded to include initiation by the palliative team.** • **Methadone 10mg/ml solution for injection, Physeptone 10mg/ml solution for injection –** Currently not on the formulary. SFH palliative team confirmed its use in patients with difficulty managing pain and requiring subcutaneous administration, and those who were on maintenance methadone from previous addiction who lose their oral route in their last days. Availability on the formulary was requested on an Amber 2 basis. Palliative consultants from Hayward House stated that this will remain an option for them to explore in certain situations but will try not to start a new prescription as an outpatient. It will be initiated, titrated and dose established as an inpatient. Conversely, consultants in the pain medicine do not use methadone injection in the community pain service, and would not recommend its use in the community. It is not in the APC's End of life guideline and will be rarely used by less than 10 patients a year. JFG expressed concerns that this may be difficult to obtain in the community, particularly due to low anticipated usage . Additionally, as it is not included in the APC palliative guideline, GPs are likely to be hesitant to prescribe it. **ACTION: JFG recommended Red based on potential problems in primary care and low frequency of use. LK to find out more information in terms of usage for APC.** • **Atropine 1% eye drops PF Minims for hypersalivation –** NICE recommended for hypersalivation. JFG felt additional information was required for a decision at APC. Specialty input e.g., Parkinson's team, and rationalise the price compared to alternative options. **ACTION: Amber 2, but with some additional work to make the formulary clearer. Add to the work programme.** All other formulary amendments were agreed. **ACTION: SW to take to APC**
8. Horizon scanning	**New publications for review** All horizon scanning suggestions were agreed, with the exception of the following which warranted further discussion: • Paxlovid 150 mg/100 mg film-coated tablets® ▼ - Discussions were continuing between Secondary Care and the Covid Medical Delivery Unit (CMDU). However, there was no expectation for GPs to prescribe and would be delivered via the CMDU. **ACTION: Prescribable only within Secondary Care and CMDU and**

	classified as Red **NICE Guidelines, TAs and Evidence summaries** Noted – no further action required
9.	**Chloral Hydrate- Clarification of traffic light classification and indication** LK informed the JFG that currently, the formulary lists chloral hydrate and chloral betaine with an Amber 2 classification but doesn't define the indication. Both are used in paediatric patients as sedatives and for movement disorders. Chloral betaine is used as a 2nd line agent for patients on a ketogenic diet, but current usage is minimal. The MHRA issued a drug safety update in October 2021 which recommended that these are no longer used long term and following on from this, the NPPG produced guidance which outlines recommendations for discontinuation of chloral hydrate for insomnia (abrupt discontinuation is likely to be harmful) and supports the continued long term off-label use in patients with movement disorders and sleep problems associated with movement disorders. For this patient group, a continued Amber 2 classification was requested. It was highlighted that local patients in this cohort are under specialist supervision and receive regular specialist review. Work is underway with the MSO group to identify current patients in primary care and ensure appropriate review. The JFG was supportive and recommended that the indications be clarified as Red for short term sleep disorders and Amber 2 for patients with movement disorders or sleep problems associated with a movement disorder in line with the NPPG guidance. It was highlighted that appropriate repatriation should take place for any patients identified for review as careful withdrawal of the medication will be required. **ACTION: LK to take to APC**
10.	**Dates of future meetings** - • **Next meeting: 21st April 2022** (Via Microsoft Teams). Chair: Steve Haigh • **Chair rota**
11.	**Any other business** HG raised a query about the process of adding guanfacine for ADHD in adults to the Joint Formulary. JFG felt a submission was required as this is an off-label indication and not currently on the formulary. **ACTION: HG to work with the adult ADHD service to prepare a submission**

The meeting finished at 17:17hrs