These minutes are in draft form until ratified by the committee at the next meeting on 14th December 2023

Nottinghamshire Area Prescribing Committee

Nottinghamshire Area Prescribing Committee Formulary Meeting Minutes

APC Meeting 19th October 2023:

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 ICB**
Tanya Behrendt (TB)	**Senior Medicines Optimisation Pharmacist**	**NHS Nottingham & Nottinghamshire ICB**
David Kellock (DK)	**Consultant in Sexual Health & SFH Drug and Therapeutics Committee Chair**	**Sherwood Forest Hospitals NHS Foundation Trust**
Jennifer Moss Langfield (JML) until 3.20 pm	**GP**	**LMC Representative**
Ann Whitfield (AW)	**Patient Representative**	**Representative for the local Population**
Dr 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) from 14:45	**Assistant Chief Pharmacist**	**Sherwood Forest Hospitals NHS Foundation Trust**
Hannah Godden (HG)	**Principal Pharmacist, Adult Mental Health Community Teams**	**Nottinghamshire Healthcare NHS Trust**
Georgina Dyson (GD)	**Advanced Nurse Practitioner**	**CityCare ICB**
Katie Sanderson (KS)	**Patient Representative**	**Representative for the local population**
Beth Rushton (BR)	**Senior Clinical Pharmacist Nottingham West PCN**	**Primary Integrated Community Services Ltd**

In Attendance:

Dr Amar Mistry, Cardiologist and Helena Shores, Cardiology pharmacist; Nottingham University Hospitals NHS Trust for item 5a.

Kirsten Allen, Consultant Obstetrician – Nottingham University Hospitals NHS Trust for item 5b.

John Lawton (JL) - Lead Pharmacist Clinical Services, Notts Healthcare Trust for item 4e.

Observing:
Ewura-Adjoa Yamoah, 2nd-year University of Nottingham pharmacy student currently on placement with the High-Cost Medicines Optimisation Team at NUH.

Interface Support (NHS Nottingham & Nottinghamshire ICB) in attendance:
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFHFT
Karen Robinson (KR), APC Interface and Formulary Pharmacy Technician

1. Welcome and apologies.

Members' apologies were noted.
To note: the meeting was not GP- quorate from item 5b. A summary of the discussions and decisions was sent to GP members, who have approved them.

2. Declarations of interest.

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

3. Minutes of the last meeting.

The minutes from the previous meeting were reviewed and accepted as an accurate record.

4. Matters arising and action log.

a) NICE TA875 – Semaglutide (LK)

LK explained that concerns regarding potential non-compliance with NICE TA875 had been raised through the ICB. The compliance deadline is December 2023 (90 days post- product launch).

ACTION: No further action at present. LK will feed back on any developments via the APC in due course.

b) Rimegepant NICE TA906

At the August meeting, APC requested an analysis of estimated costings compared to currently used medicines from the High-Cost Medicines team at NUH. These were provided

by TB. Erenumab is currently the most cost-effective product but is an injection and for some patients an oral agent may be preferred. Rimegepant would therefore be an option for this patient group, and it was requested that an AMBER 2 classification be considered, with transfer of care taking place after patients had undergone a review following 12 weeks' treatment. Members agreed but requested that patients are given a further one- month supply from Secondary Care at the 12-week review to cover the period of care transfer.

ACTION: Interface team to update formulary and feed back to Neurology.
UPDATE: Action complete

c) Actimorph – prescription monitoring

LK explained that ePACT prescribing data had been analysed and prescribing levels remained steady and in line with that expected in the submission. It was agreed that the monitoring of Actimorph prescribing could be removed from the action log.

ACTION: LK to remove Actimorph® monitoring from the action log.

d) Vaginal lubricants for post-feminising surgery for transgender patients

LK explained that discussions with Healthwatch had not revealed any additional information to that previously considered so vaginal lubricants will remain GREY for all patients, with a direction to self-care.

ACTION: No further action.

e) Intranasal naloxone for substance misuse

LK provided an update on intranasal naloxone and John Lawton (JL) attended to assist discussions. JL explained that Prenoxad® is currently classified GREEN and a GREEN classification has been requested for intranasal naloxone as it is easy to use and offers less risk than Prenoxad® pre-filled syringes. It is also licensed from 14 years old. The direction of travel nationally is to make naloxone more widely available and restricting it to specialist initiation was felt to be a retrograde step.

The clinicians present explained that as they did not have the training needed to initiate medications for substance misuse, they felt it was a specialised area and substance misuse prescribing should be guided by the specialists. JL explained that online training videos were available. An AMBER 3 classification was suggested, with prescribing guidance to support Primary Care prescribers. This was agreed and felt to be beneficial for those patients who may not be under the substance misuse service but may be identified by other teams. In order to provide a guideline to support the AMBER 3 classification, JL asked clinicians for suggestions about what should be included. It was also suggested that Primary Care education via Protected Learning Time (PLT) events may be of benefit. LK will collate the suggestions and forward them to JL.

ACTION: Clinicians to email LK with suggestions for prescribing guidance. LK to collate the responses to enable JL to produce a guideline.

Intranasal naloxone and Prenoxad to be re-classified as Amber 3 following ratification of prescribing guidance by APC; in the interim an Amber 2 status will be given for intranasal naloxone.
UPDATE: Formulary has been updated, nil received re guideline.

f) Enoxaparin brand of choice

Inhixa is currently the brand of choice for enoxaparin locally; however, following a change to Secondary Care contracts, NUH will be moving to Arovi®. It is understood that SFHFT are not planning to change from Inhixa®. Enoxaparin should be prescribed by brand and the information sheet will require an update to acknowledge the additional brand. It was highlighted that Arovi® offers a cost saving in Primary Care and, ideally, the ICS should try to aim for consistency in brand choice. Arovi® also uses the same delivery system as Inhixa® so requires less education than when switching from Clexane®.

ACTION: LK to feed back to SFHFT.
Interface team to update enoxaparin prescribing information sheet.
UPDATE: LK to feedback at APC meeting

5. New applications

a) **Ivabradine for Postural Orthostatic Tachycardia Syndrome (POTS)**

LK presented the Formulary submission for ivabradine for (POTS). POTS is a chronic condition with multiple proposed pathophysiologic mechanisms. There are currently no "cures" for POTS and the overarching treatment goals should be to provide patient education, reduce symptoms, enhance quality of life, improve physical conditioning, and, if possible, achieve symptom remission. Ivabradine might be an alternative to nonselective beta-blocker therapy, particularly when the patient has prominent symptomatic orthostatic tachycardia and is a non-responder and/or has intolerance because of exacerbation of symptoms of fatigue, comorbid asthma, or a tendency to hypotension. Ivabradine may be teratogenic and adequate contraception is required when used by women of child-bearing potential.
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Although the request is for an off-license indication, it is an established indication and Cardiologists from both trusts favoured its use. Costs in Primary Care vary as to the dose used but would be expected to be between £5K and £30K PA, based on predicted patient numbers, and propranolol will remain the first-line option (also unlicensed for this indication).

Dr Mistry explained that when women of childbearing potential are initiated on ivabradine they are given advice about pregnancy. The need for annual hepatic and renal monitoring was queried by members present and a compelling indication for this was not felt to be necessary.
APC members agreed to an Amber 2 classification but requested clarity on the need for monitoring. It should be highlighted that pre-conception counselling is the responsibility of the initiating clinician.

ACTION: Interface team to investigate the monitoring requirements further and provide feedback to the APC via email.

Interface team to highlight to Medicines Safety team for inclusion in pregnancy prevention work.
UPDATE: Action complete

b) Cyclogest® for the prevention of preterm birth.

LK presented the submission for Cyclogest® pessaries and provided a brief background, explaining that this is an unlicensed indication. However, NICE recommends prophylactic vaginal progesterone to prevent preterm birth in women with a history of spontaneous preterm birth or loss of pregnancy and/or women with a cervical length of 25mm or less. Treatment with vaginal progesterone should start between 16 and 24 weeks and continue until at least 34 weeks. The current dose offered at NUH is one 200mg progesterone pessary inserted PV once daily.

Kirsten Allen (KA), NUH Obstetrician, joined the meeting and gave a quick overview, explaining that it has been used for many years for women at risk of pre-term birth. Initiation would be following a face-to-face appointment and ultrasound. Women were seen frequently until 28 weeks of pregnancy, at which point the GP would be written to and asked to continue the supply.

APC members questioned whether GPs needed to be involved in the prescribing of this medication and whether it was better suited to remain with the specialist. It was suggested that the use of FP10 prescriptions be investigated as a preferable solution.

During the meeting, it was highlighted that Utrogestran® vaginal capsules, an alternative brand of micronised progesterone, were licensed for this indication. Cyclogest® has historically been used by specialists, so there is a large amount of experience of using it and concerns have been raised about the plastic waste associated with Utrogestan® because of it containing individual applicators.

Although APC members supported the use clinically of micronised progesterone for this indication, it was requested that trusts consider alternative options for prescribing.

ACTION: Interface team to liaise with submitters about alternative prescribing routes e.g., FP10s.
Post - meeting update: further views of GP members obtained after the meeting were consistent with an Amber 2 classification being appropriate. Retaining prescribing within NUH is also likely to be problematic therefore micronised progesterone will be given an Amber 2 classification.
UPDATE: Action complete

c) Nitrazepam for epilepsy in children and young people (LK)

LK presented the formulary submission for nitrazepam for the treatment of infantile spasm syndrome and Lennox Gastaut syndrome. This is an unlicensed indication, but one that is recommended as an option in NICE NG217: Epilepsies in children, young people and adults for infantile spasms.

Nitrazepam is not listed in the BNFc, therefore dosing advice for children is not readily available to Primary Care prescribers. It was therefore suggested that Prescribing guidance could be produced if agreed.

LK explained that predicted patient numbers are expected to be low and the tablets may be suitable in most cases. An oral suspension was available, but this was considerably more expensive.

As GPs were absent from the meeting at the time of discussion, a final decision could not be made.

ACTION: LK to summarise the submission and discussions and email GP members for an APC decision.
Post- meeting update: GP members agreed with an Amber 2 classification and with the need for accompanying prescribing guidance. Once this has been ratified by the APC, the Formulary will be updated.
UPDATE: Prescribing guidance in development. To be brought to January APC.

6. Formulary amendments

a) FOR INFORMATION: Log of minor amendments carried out.

- GLP-1s - All entries have had the Red Whale GP Bulletin added to provide additional information during national shortages.
- Vagifem® - Information added that 'Vagifem® can be prescribed in exceptional circumstances where individual applicators are needed'.
- Affenid® XL (methylphenidate) - Added to the list of brands mentioned on the formulary in line with the Narcolepsy information sheet.
- Prednisolone 25mg tablets – The following statement has been added to the entry after an incident in Primary Care when a GP prescribed the 25mg tablets. '25mg tablets are reserved for a very limited number of patients requiring long-term high-dose steroid therapy, to reduce pill-burden. They should not be prescribed for short-term use or as part of a reducing course of steroids'. OptimiseRx will also reflect this statement.
- Healthy Start vitamins – The formulary has been updated with links and additional information, as per NHSBSA.

b) FOR DECISION: Suggested amendments

No traffic light classification change

- Adrenaline Autoinjectors in children: Amend the formulary entry to reflect that parents/ carers may require up to four pens to be renewed if pens have

expired. Primary school-aged children who are unable to carry their own pens at school require two pens for school and two for other times. This should be done by issuing two prescriptions for two pens each rather than having four pens on repeat prescription as this could result in an unnecessary supply. Supporting guidance from The British Society for Allergy and Clinical Immunology (BSACI) link published in June 2023 will be added as a hyperlink: Adrenaline AAI prescription for anaphylaxis guidance for Primary Care

AMBER 2

- Plenvu® powder for oral solution. A pilot scheme is being developed to move the dispensing of Plenvu® bowel preparation from NUH to community pharmacies. An e-referral will be sent, and patients will be directed to a community pharmacy, which will then issue the bowel prep. Reclassified as AMBER 2 to allow supplying by community pharmacies as part of this pilot scheme. There is no expectation that this will be prescribed by GPs.

- St Marks solution – Formulary entry amended to reflect that, although St Marks solution should not be prescribed, in exceptional circumstances, should a patient not be able to purchase the ingredients, glucose powder and sodium bicarbonate could be prescribed.

GREEN

- Bupivacaine and Adrenaline – Reclassified as GREEN as a temporary traffic light change, due to current supply problems with lidocaine and adrenaline, used for minor operations in Primary Care. The amendment will be reviewed at the February APC.

ACTION: KR to add Bupivacaine and Adrenaline to the action log for review in February 2024 and update all the formulary decisions on the Joint Formulary as agreed.

Post-meeting note- pathway for Plenvu® is in development therefore formulary will be updated once confirmed. LK to add to action log.

UPDATE: Action complete.

Formulary traffic light reclassification submissions

- **Ferric maltol traffic light reclassification**

Ferric maltol is currently on the formulary for iron deficiency anaemia in patients with Inflammatory Bowel Disease (IBD), with an AMBER 2 classification. The restriction is in line with its original licensing, but it is now licensed for the treatment of iron deficiency anaemia, regardless of cause. A request has been received to expand the cohort in line with its updated license and to reclassify the medicine to AMBER 3 to allow Primary Care initiation.

Ferric maltol is indicated if standard iron preparations are not tolerated or are ineffective. The alternative is therefore IV iron. Primary Care initiation could potentially reduce Secondary Care referrals and activity costs if effective. Currently there is no IV iron service via the urgent anaemia pathway offered through NUH, but this service is still in place at SFHFT. Concerns about this have been escalated to commissioning and contracting colleagues at the ICB.

LK explained that trial evidence suggests that ferric maltol may not be as effective as IV iron and, although activity costs may be reduced, there will be a cost impact on the Primary Care prescribing budget. The cost impact is difficult to quantify but, based on numbers previously being referred through the urgent anaemia pathway, is predicted to be approximately £64K PA on the basis of patients receiving a 3-month course. Costs will be higher if patients receive longer courses and there is potential for usage to increase, due to increased availability. These costs have been flagged to finance.

Members agreed that an AMBER 3 classification was appropriate, subject to a guideline being produced, with a clear place in therapy for ferric maltol.

ACTION: LK to inform the submitter and develop a prescribing guideline to be brought back to APC at a future date.

UPDATE: Action complete

- **Cenobamate▼ traffic light reclassification**

LK presented the traffic light reclassification request for cenobamate. Cenobamate is recommended in NICE TA753 and its use was approved by NUH DTC following the publication of the TA. At that time the epilepsy team had wanted to gain experience with the medication before requesting Primary Care's involvement in its prescribing, so a RED classification was agreed. The team now feel that there is sufficient experience of the medication and recognise that there are some patients on stable doses who would benefit from receiving their medication in Primary Care.

Members agreed to an AMBER 2 classification, with the caveat that prescribing would be transferred to Primary Care only once the patient's treatment had been stabilised.

LK advised that this would be associated with a cost impact on Primary Care and that this would be highlighted to finance.

ACTION: LK to feed back to submitters, update the formulary and highlight the cost impact to finance.

UPDATE: Action complete

7. Horizon Scanning

New Horizon Scanning publications for review

No traffic light classification

- Levonorgestrel. LoviOne® 1.5 mg Tablet : cost-effective alternatives available; add the brand name as a keyword.

- Progesterone micronised. Gepretix® 100mg soft capsules : add the brand name as a keyword. Highlight to efficiencies team that Gepretix® is a cost-effective comparable medication to Utrogestan® capsules.

ACTION: KR to add Gepretix ® as a keyword and inform the efficiencies team Senior Pharmacist of potential efficiencies.

UPDATE: Action complete

- COVID-19 vaccine entries: the formulary entries have been updated in line with the National Protocol updated on 2nd October 2023.

GREY no formal assessment

- Respiratory syncytial virus (RSV) vaccine (recombinant, adjuvanted). Arexvy powder and suspension for injection solution ® ▼. The vaccine has not yet been added to the Green Book.

- Rivastigmine. Zeyzelf Twice weekly 4.6 mg/24 hr and 9.5mg/24hr transdermal patch delivery applied twice a week. Highlight that this is a twice-weekly application on the Joint Formulary.

- Metaperex® capsule contains RRR-α-tocopherol, 280 mg (equivalent to 400IU of Vitamin E).

GREY

- Azathioprine 75mg and 100mg high-strength tablets: more expensive than currently used strengths and safety concerns about availability of higher strengths. This should be highlighted via SystemOne formularies and Optimiserx.

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- Omeprazole 1 mg/ml Powder for Oral Suspension: 4mg/ml is the preferred regional strength.

New NICE guidelines

- Otitis media with effusion in under 12s - guidance (NG233) The guidelines have been reviewed by the APC team and no further action is required.

ACTION: KR to update the Joint Formulary with the agreed decisions.
UPDATE: Action complete

8. Wound Care Formulary update

KR explained that the wound care section of the Joint Formulary had been updated with the agreed products in the County Wound care Formulary. Some silver dressings and barrier products had been challenged and are still under discussion with the nursing teams.

The CityCare formulary was yet to be finalised. Once complete, it will be brought to a future APC meeting.

ACTION: No further action at present.

9. Any Other Business

- ICS- wide work on melatonin is ongoing. NUH are in the process of switching to a licensed product, due to issues in obtaining the unlicensed product they were using previously.

- Inclisiran- Cardiologists at both acute trusts have expressed interest in initiating inclisiran, due to the low uptake locally. Initially, it was intended by NHS England for Primary Care initiation. Recent communications have raised concerns that GPs may not be prepared to prescribe ongoing treatment, leading to difficulties for patients and pressure on Secondary Care. It was acknowledged that there may be variation in opinion as to whether a GP would prescribe, but Secondary Care initiation may allow experience to be gained.

ACTION: LK to update the Joint Formulary, to remove restrictions on Secondary Care initiation.
UPDATE: Action complete

- There is a national supply problem with bumetanide and the national recommendation is to use furosemide first line. Torasemide is an alternative loop diuretic but is currently classed as GREY. The APC was asked to consider reclassifying torasemide for those patients who were intolerant of furosemide. APC members agreed, but it was highlighted that there have been suggestions for other options circulated by cardiology and this will be investigated further.

ACTION: LK to liaise with BR regarding alternative options

Post meeting note- Guidance for the management of diuretics during bumetanide supply problems has been developed and approved by the APC. Torasemide is included as an option for patients with furosemide allergy. Re-classified as Amber 2 during supply problems. This will be reviewed once the issues are resolved.

- LC will email out for face-to-face attendance at the meeting in December, with an ask for members to give a prompt reply.

ACTION: LC email to members

Date of next APC Formulary meeting - Thursday 14th December 2023 (2pm – 5pm, MS Teams)

Date of next APC Guideline meeting – Thursday 16th November 2023 (2pm – 5pm, MS Teams)

The meeting closed at 16:52.