These minutes are in draft form until ratified by the committee at the next meeting on 18th April 2024.

Nottinghamshire Area Prescribing Committee Formulary Meeting Minutes

29th February 2024: 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**
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**	**LMC Representative**
Asifa Akhtar (AA)	**GP**	**South Notts PBP, Nottingham & Nottinghamshire ICB**
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)	**Assistant Chief Pharmacist**	**Sherwood Forest Hospitals NHS Foundation Trust**
Steve Haigh (SH)	**Medicines Information and Formulary Pharmacist**	**Sherwood Forest Hospitals NHS Foundation Trust**
Hannah Godden (HG)	**Principal Pharmacist, Adult Mental Health Community Teams**	**Nottinghamshire Healthcare NHS Trust**
Beth Rushton (BR)	**Senior Clinical Pharmacist**	**Nottingham West PCN**

In Attendance:

Dr Nicola Jay, Deputy Medical Director, Nottingham and Nottinghamshire ICB.
Dr Harriett Latham-Cork, Contraception lead and Community Sexual & Reproductive Health Consultant, NUH joined the meeting for agenda item 5a.
Jill Theobald, Senior Medicines Optimisation Pharmacist, NHS Nottingham & Nottinghamshire ICB joined the meeting to present agenda item 12.

Observing:

SFHT Trainee pharmacists, Mya Uppal and Iyla Aslam.

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.
Vimbayi Mushayi (VM), Specialist Medicines Optimisation Interface Pharmacist.
Lidia Borak (LB) – Specialist Medicines Optimisation Interface Pharmacist.

1. Welcome and apologies.

Apologies were noted.

2. Declarations of interest

None declared.

3. Minutes of the last meeting

Accepted as an accurate record of the meeting.

4. Matters arising and action log.

4(a) NICE TA875, Semaglutide for weight loss.

LK informed the committee that there had been no further update and the ICB continues to remain non-compliant with NICE TA875. This is on the ICB's risk register.

ACTION: LK to feedback on progress as it becomes available.

4(b) Micronised Vaginal Progesterone (Cyclogest®) for threatened miscarriage.

Following the presentation at the December APC meeting, this had been escalated within the ICB for financial approval, but no decision had been reached with regard to an appropriate process for approval. JML had continued to have discussions with the ICS Women's and Children's forum about the most appropriate prescribing pathway. LK will bring this item back to a future APC meeting for an update once financial sign-off is agreed.

ACTION: JML and LK to continue discussions and return the item to a future APC formulary for an update.

4(c) Ticagrelor for the prevention of ischaemic stroke following Transient Ischaemic Attack (TIA) or minor stroke.

At the December APC meeting, the committee supported the use of ticagrelor for this indication with an AMBER 2 classification. At that time the predicted costs exceeded the APC's threshold for financial approval. However, the threshold has since been increased to £100K PA and the predicted cost impact of this intervention falls below the updated threshold.

ACTION: LK will inform the submitters of the decision and update the formulary with the AMBER 2 classification.

4(d) Riluzole orodispersible film.

At the previous APC meeting, a request for the addition of riluzole orodispersible film was discussed. Concerns were expressed about the significant cost differential between this preparation and the standard tablets and the APC had wished to explore the rationale for prescribing orodispersible film. LK had been in discussion with clinicians, who confirmed that the orodispersible film would be used for a small number of patients who are taking medications orally but are unable to take crushed tablets safely due to the risk of aspiration episodes. Following the APC meeting in December, supply problems have led to the cost of tablets increasing on average from £8 to £300 a month. However, the APC felt that this was likely to be a short-term issue and that any decision to use alternative formulations should be based on clinical circumstances.

The continued benefit of continuing riluzole for these patients was questioned, but APC agreed to riluzole orodispersible film being added to the formulary and classified as AMBER 1, for use in exceptional circumstances and following a multidisciplinary team (MDT) recommendation.
ACTION: LK to inform the submitter of the decision. LK to update the formulary and the Shared Care Protocol.

4(c)NICE TA922: Daridorexant for treating long-term insomnia.

Following discussions about daridorexant at the previous meeting, guidance had been produced and ratified to support prescribers. The lack of access locally to Cognitive Behavioural Therapy for insomnia (CBTi) has been escalated to ICB Mental Health Commissioners. Recently, however, communication had been received about the possibility of a Nationally Commissioned digital CBTi service. Further information was awaited, but, once confirmed, consideration will be given to updating Prescribing information and communications about its availability.
ACTION: LK to provide an update once further information is available.

4(d)Prescribing of RED medications in Primary Care by specialists.

It had been reported previously that queries had been received around the appropriateness of prescribing RED medicines in Primary Care if, for example, a Primary Care specialist prescribes GPwER in the Community Dermatology service. Discussions had taken place by email in order to agree a definition of a specialist.

ACTION: LK to email the final proposed wording to APC members.

Pharmacy First

Pharmacy First had been relaunched nationally. Rebecca Dickinson, ICB Community Pharmacy lead, had produced a number of webinars and LC had provided APC members by email with webinar links.

5. New applications

a) Drospirenone (Slynd®, Exeltis UK Ltd), for contraception- LK.

A formulary submission had been received for drospirenone (Slynd®). Dropsirenone is a Progestogen Only Pill (POP) oral contraceptive. There had been a request for it to be available for use as a second-line POP after desogestrel had been trialled and found to be not suitable and where other methods of contraception, including long-acting reversible methods, are contraindicated declined or are not suitable. The submission request was from the complex contraception service,

but interest in initiating this product had also been shown by the Cripps Medical Centre; the specialist services were in agreement with a GREEN classification when used as a second-line option to desogestrel.
APC members were supportive of an AMBER 3 classification with a guideline, as it was felt that there were important differences between this and other contraceptive pills that prescribers needed to be aware of. While the guideline is being developed, drospirenone will be classified as AMBER 2 to allow Specialists to prescribe it. It was agreed that it should be reserved for women who had undergone a 6-month trial of desogrestrel. Dr Harriet Lantham-Cork was present at the meeting and will work with LK to produce a prescribing information sheet.
AA confirmed to members that, due to the monitoring requirements, drospirenone is unlikely to be included in the pharmacy service PGD.

ACTION: LK to update the formulary with a temporary AMBER 2 classification while a guideline is developed. LK to work on the guideline with the submitter and bring to a subsequent APC for ratification. Once this is published drospirenone will then be reclassified as AMBER 3.

b) ***SimAlvia® (simethicone/ alverine)***

LB presented the formulary submission received for SimAlvia® for the treatment of IBS. A request had been made for a GREEN classification for second-line use after an initial trial of monotherapy with the currently approved antispasmodics/hyoscine butylbromide.
Both active components of SimAlvia®, simethicone and alverine can be purchased separately over-the-counter in pharmacies; however, the licensed dosage is lower than that of SimAlvia®, so a community pharmacist would be unlikely to approve a sale at a like-for-like dose. The cost comparison with mebeverine and low-dose peppermint oil capsules shows SimAlvia® is less cost-effective, whilst when compared to peppermint oil at the maximum dose, SimAlvia® is more cost-effective.
LB explained that the available trial data is of limited quality and a large placebo effect can be seen within the trial data. However, this is similar to the alternative interventions currently used for IBS.
APC members felt further discussion was needed before a decision could be made. LC suggested that the discussion continue outside the meeting and that the findings of these discussions be brought back to the next APC formulary meeting.

To note: The submitting clinician declared that they have been an honorarium for a two-hour lecture to GPs to update the treatment of IBS from Mayoly UK, the manufacturer of SimAlvia.

ACTION: LB will continue discussions with the submitter and the APC formulary team. The findings will be brought back to the next APC formulary meeting for a decision.

6 Formulary amendments

(a) FOR INFORMATION – Log of minor amendments completed.

Metformin 1g tablets have increased significantly in price, Optimise Rx messages are already in place and a reminder will be included in the Hints and Tips publication to prescribe 500mg tablets.

Otigo® : ear drops for the treatment of Otitis Media, the promotion of self-care and advice about the use of simple analgesics (paracetamol and ibuprofen) have been added to the formulary; this course of treatment is first-line, as per NICE.

Tresiba®; : patient safety alert/MSO group information has been added to the Joint Formulary to instruct prescribers not to change the dose if a patient is switched to the 200unit/ml.

Exenatide (Byetta®) will be discontinued in March 2024 and has therefore been made GREY. No new patients are to be initiated and current patients are to be reviewed and switched to Rybelsus® where appropriate. Optimise Rx messages have been actioned and the information has been cascaded via the Hints and Tips publication, the APC bulletin and the ICS diabetes strategy group.

Mirena® IUS : the formulary has been updated to reflect the change in the licensed duration of contraception. Licensed durations for all IUSs have been added to the Joint Formulary. It was suggested that this be cascaded via the Hints and Tips publication.

Insulin Pen Needles: the Joint Formulary has been updated in line with the Blood Glucose Testing Strip (BGTS) and Needles formulary. BD viva, Omnican fine and Tricare have been removed; Greenfine, GlucoRx, Carepoint Ultra and Insupen Original have been added.

Co-careldopa (Sinemet®) : the APC formulary statement regarding brand prescribing being the most cost-effective in Primary Care has been updated to reflect the agreed Preferred Prescribing List (PPL) recommendation for the generic prescribing of 12.5/50 and the 25/100 strengths.

Meflynate XL®, Matoride XL®, Metyrol XL® (Methylphenidate) have previously been agreed for inclusion in the adult and children ADHD Shared Care Protocol (SCP); the Joint Formulary has been updated to reflect their inclusion in the ratified SCP (AMBER 1 classification).

Lecicarbon® C has been changed back to **GREY;** Lecicarbon® C had temporarily been reclassified as GREEN for use during supply problems with bisacodyl suppositories but these supply problems have now been resolved.

Hydrocortisone 5mg/5ml and 10mg/5ml oral solution: the 10mg/5ml has been classified as GREY in line with RCPH recommendations on preferred strengths. The Joint Formulary wording has been updated to reflect the availability of a licensed (5mg/5ml) oral solution; (an unlicensed preparation was listed previously).

(b) FOR DECISION – Suggested amendments

AMBER 2

- Travoprost PF (Visutrax®, VISUfarma UK Ltd): a request had been received from NUH for travoprost PF to be added to the formulary as a second-line option for patients unable to tolerate latanoprost PF and as an alternative PF option, should supply issues arise. Travoprost is a less expensive option, but latanoprost is preferred locally. Bimatoprost PF offers a more cost-effective option but there is no support for using this from local clinicians, due to the increased side-effect profile attributed to bimatoprost.

APC members agreed to the addition of travoprost PF as AMBER 2 on the Joint Formulary.

Ondansetron for Irritable Bowel Syndrome (IBS) traffic light reclassification: Professor Corsetti had requested the reclassification of ondansetron for IBS, due to its inclusion in the British Society of Gastroenterology IBS guideline. Previous discussions had resulted in a RED classification due to it being an unlicensed indication that was not supported by National Guidance. Patient numbers are expected to be low; Professor Corsetti currently has 10 patients under her care. APC members agreed to an AMBER 2 classification but requested a Prescribing Information Sheet to support Primary Care Prescribers.

ACTION: LK will produce a Prescribing Information Sheet in consultation with Professor Corsetti and bring to a subsequent APC meeting. Once ratified, the formulary will be updated with an AMBER 2 classification.

AMBER 3

- Finerenone (Kerendia®, Bayer plc) traffic light reclassification.
VM explained that a traffic light reclassification request had been received from Dr Catherine Byrne, Consultant Nephrologist at NUH. Finerenone was added to the formulary in April 2023 following the publication of NICE TA877: Finerenone for treating chronic kidney disease (CKD) in type 2 diabetes mellitus (T2DM), and it was assigned an AMBER 2 classification. Many patients who qualify under the NICE TA criteria are likely to be under Primary Care only, therefore a request has been made to reclassify finerenone from AMBER 2 to GREEN.
APC clinicians felt that, due to very limited experience of this medication in Primary Care, it was too soon to agree to a GREEN classification but they accepted an AMBER 3 classification with guidance from the renal team. Draft guidance has been produced by the Midlands Kidney Network (MKN) and this was attached as an appendix within the papers. VM highlighted that when the papers were sent out Lincolnshire classification was Green on their website. However, following further clarification, Lincolnshire confirmed that this was an error on their website and the classification should be Amber 2.

ACTION: VM to develop guidance for Primary Care prescribers and bring it to a subsequent APC meeting. Once ratified, the Joint Formulary will be updated with an AMBER 3 classification.

<u>Also</u>

Aripiprazole: currently the formulary restricts aripiprazole to the following:-
Schizophrenia- the treatment of moderate to severe manic episodes in Bipolar I Disorder and the prevention of a new manic episode in patients who experienced predominantly manic episodes and whose manic episodes responded to aripiprazole treatment. NHCT had requested a simplification of the Joint Formulary entry to read as follows:
Initiation on specialist advice only for: Schizophrenia and the treatment and recurrence prevention of manic episodes in bipolar disorders as per NICE CG185.

HG explained that there had been confusion in Primary Care about its use in Bipolar disorder; although off- label for Bipolar II disorder, it is supported by NICE guidance.

ACTION: LK to update the Joint Formulary and antipsychotic guidelines.

Gliptins (sitagliptin, alogliptin, linagliptin): Sitagliptin is now the most cost-effective gliptin, due to a significant price decrease. The Joint Formulary has been updated to reflect this change. Significant savings could potentially be made by the preferential use of sitagliptin, and it was agreed that as alogliptin no longer offers any advantages, this should be made GREY for new patients. There is a historical preference for linagliptin in patients with renal impairment among some clinicians and concerns had been raised that dose reductions may not be carried out if sitagliptin is used with patients with deteriorating renal function. It was suggested that Optimise Rx and SystmOne could be utilised to highlight the cost-effective choice and prompt the need for a dose reduction of sitagliptin if there was a reduced eGFR.
Due to the cost-saving potential of sitagliptin, the APC members were keen to encourage a review of current patients; this will be raised with the Medicines Optimisation Cash Releasing and Savings Hub (CRASH).

ACTION: LK to update the Joint Formulary entry for alogliptin and liaise with Optimise Rx and SystmOne teams about appropriate messages for sitagliptin. Potential savings to be highlighted to the CRASH team for consideration of an active review of patients prescribed other gliptins.

Spironolactone 12.5mg tablets: the evidence base for spironolactone in heart failure is 25-50mg daily. However, patients may be initiated on 12.5mg with the intention to be up-titrated. Local trusts stock 25mg tablets and advise patients to halve the tablets. EPACT data has shown increases in the prescribing of 12.5mg tablets, which are considerably more expensive. The cost differential will be highlighted via Optimise Rx and prescribers will be prompted to review whether the patient should be up-titrated.

ACTION: LK to raise with the Optimise Rx team to enable a SystmOne message to discourage the initiation of 12.5mg tablets and to prompt a review to up-titrate. LK to update the Joint Formulary.

Sulfasalazine for IBD: a query had been received from a PCN pharmacist requesting clarity on monitoring for an existing patient who was being prescribed sulfasalazine for IBD. Members agreed that responsibilities would be expected to be in line with those for rheumatology patients.

ACTION: LK to update the Joint Formulary with appropriate wording.

7 Horizon Scanning

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

GREY

- Omeprazole 10mg/15ml and 20mg/15ml single unit doses, require assembly before administration.
- Levomepromazine 6.25mg tablets- continue to use 25mg tablets

GREY no formal assessment

-Freestyle Libre 3- a Task and Finish group are looking at the implementation of the NICE TA for Hybrid Closed Loop systems. It was pointed out that there was a need to highlight that this is not interchangeable with Freestyle Libre 2.

Classification pending

- STRIGOL® Paediatric 6.86 g powder for oral solution, macrogol 3350, potassium chloride, sodium bicarbonate, sodium chloride. Lemon and orange flavour – add to the action log for consideration when a price becomes available.
- Colextra-D3®, Colecalciferol 20,000 IU Soft Capsules – the Vitamin D guidelines are currently under review and the editing author has been made aware of the new product launch.

ACTION: KR to update the Joint Formulary.

- **(b) New NICE guidelines**

NICE TA924: Tirzepatide (Mounjaro®, Eli Lilly and Company Limited) for Type 2 Diabetes

LK presented NICE TA924. This was published on 25th October 2023, but the UK launch of the medicine had been delayed until February 2024.
The TA recommends the following:
Tirzepatide is a first-in-class dual GLP-1 and GIP (glucose-dependent insulinotropic polypeptide) receptor agonist recommended for treating T2DM together with diet and exercise in adults when it is insufficiently controlled, but only if:
• triple therapy with metformin and two other oral antidiabetic drugs are ineffective, not tolerated or contraindicated, and
• they have a body mass index (BMI) of 35 kg/m2 or more, and specific psychological or other medical problems associated with obesity, or
• they have a BMI of less than 35 kg/m2, and insulin therapy would have significant occupational implications, or weight loss would add to other significant obesity-related complications. Use lower BMI thresholds (usually reduced by 2.5 kg/m2) for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family backgrounds.

This occupies the same place in therapy as what is recommended in NICE NG28 for GLP-1 receptor agonists, except that NICE does not stipulate that treatment with tirzepatide should be stopped if a beneficial metabolic response is not seen, although it does so for GLP-1s as it recognises that this may not happen in clinical practice. GLP-1 agonists are currently classified as AMBER 2 locally but they are subject to ongoing supply issues and only Rybelsus® (oral semaglutide) is available for new patients.
Initially, tirzepatide will be available in a pre-filled pen containing 4 doses currently it is only available in 2.5mg and 5mg strengths. Eventually, it is expected that it will be administered using the single-use device utilised for dulaglutide, but no dates for availability have been confirmed.

APC members agreed an AMBER 2 formulary classification, as per GLP1 agonists for use in line with the NICE TA.

ACTION: LK to update the Joint Formulary and update the Diabetes guidelines.

Post meeting note- it had been highlighted that SystmOne and EMIS had not yet been updated with the Kwikpen formulation and there was potential for confusion if the unavailable autoinjector was prescribed. The Formulary will be updated once the Kwikpen is available on electronic prescribing systems.

- **NICE TA942: Empagliflozin (Jardiance®, Boehringer Ingelheim Limited) for CKD**

The NICE TA942 was published on 20th December 2023 and compliance is required within 90 days of publication (19th March 2024). This TA recommends the following:
Empagliflozin is recommended as an option for treating CKD in adults. It is recommended only if:

- It is an add-on to optimised standard care including the highest tolerated licensed dose of angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs), unless these are contraindicated, and
- Patients have an estimated glomerular filtration rate (eGFR) of :
  20 ml/min/1.73 m_2 to less than 45 ml/min/1.73 m_2 **or**
  45 ml/min/1.73 m_2 to 90 ml/min/1.73 m_2 **and either**:
  a urine albumin-to-creatinine ratio (uACR) of 22.6 mg/mmol or more, **or** T2DM
- If patients with the condition and their clinicians consider empagliflozin to be one of a range of suitable treatments (including dapagliflozin), after discussing the advantages and disadvantages of all the options, use the least expensive. Take into account administration costs, dosage, price per dose and commercial arrangements.

Dapagliflozin is currently available with an AMBER 3 classification for this indication following a positive NICE TA recommendation in March 2022. A prescribing pathway is available to support prescribing and this will be updated to include empagliflozin. The eligibility criteria for empagliflozin is wider than that for dapagliflozin so it is expected that a considerable number of patients locally will meet the criteria outlined in TA942.

APC agreed on an AMBER 3 classification for use, in line with the NICE TA once the prescribing pathway had been updated to include empagliflozin.

ACTION: VM to email updated SGLT2 prescribing pathway to APC members for ratification. Once agreed, the Joint Formulary will be updated with an AMBER 3 classification.

8 Joint Formulary Review

KR presented a report on the interim findings of the Joint Formulary review currently being undertaken. KR will bring a further update to the April APC formulary meeting.

ACTION: KR to present a further update at the April APC formulary meeting.

9 SGLT2i in CKD pathway – update following NICE TA942

This was discussed under item 7b.

10 Insulin chapter review

Work had been carried out to update the insulin section of the formulary.

After the introduction of the diabetes Local Enhanced Service (LES), the Diabetes Specialist Nurses (DSNs) requested a review of the formulary status of some insulins so that initiation can be done in

Primary Care. Work had been conducted, therefore, on reviewing the insulin section of the Formulary.

More details about individual insulin preparations such as durations of action and available devices had been added to the entries and it was proposed that the current layout of the sections be amended to highlight the differences between insulin types. APC agreed to this and also with the traffic light changes of:

Actrapid® - change from GREEN to AMBER 2 due to Actrapid® use in specific conditions which are managed in hospital settings.
Humalog® Mix (25 and 50) and Novomix 30 –Change from AMBER 2 to AMBER 3. Green on the formulary in surrounding areas.

Further discussions about potential changes to eligibility criteria for other insulins are ongoing and they will be brought back to the APC for consideration. For the “Actrapid” entry, there is a plan to link the relevant NUH/SFH hyperkalaemia and DKA guidelines. A question was asked about whether there is any relevant NHCT guidance to be linked as well.

ACTION: VM to consult NHCT regarding the above and update the Joint Formulary. LK to update Diabetes Guidelines.

11 Headache pathway update to include rimegepant

Rimegepant had been discussed at previous APC meetings following positive NICE TA recommendations for both migraine prophylaxis and migraine treatment. An AMBER 2 classification had been agreed upon for both indications. The local Headache Pathway has been updated to reflect the availability of Rimegepant.

Feedback was received about the formatting and usability of the document and it was suggested that a general refresh may be required. Due to capacity within the Interface Team, it was felt that a full review could not be undertaken currently. It was highlighted that there was an intention to review the Traffic light classification of rimegepant in 12-18 months’ time and also it was likely that the guideline would need to be amended following the publication of a TA for atogepant, so this could probably be revisited then. In the meantime, attempts could be made to correct some of the formatting issues highlighted.

ACTION: LB to circulate an amended version of the Headache Pathway by email for ratification. A full guideline review will be considered in due course.

Post-meeting note: Ankish Patel declared an interest in the Pfizer company; he had received the papers, however, he was not present at the meeting(s) for the discussion(s) and has not been involved in the decisions made.

12 Continence formulary update

JT presented an updated continence formulary. Changes included:

- The order of products in the formulary had been changed for ease of use.
- Sections added for body-worn urinals or pouches, sheath fixing strips and adhesives, adhesive remover, lubricant gel (for regular bowel care or insertion of non-lubricated catheters only),
- Updated Indwelling catheter section to add short term catheters and foam/Velcro sheath straps.
- Updated guidelines section– added guidance sections for body-worn urinals, retracted penis pouch, sheath fixing strips & adhesives, adhesive remover, lubricant gel, trans anal irrigation and stress incontinence devices.

The update was reflective of current practice, with the addition of some more cost-effective products. A SystmOne formulary will be created to coincide with this update and to aid the prescribing of these products.

APC approved the updated Continence Formulary.

ACTION: KR/JT to update the Joint Formulary to reflect the updated Continence Formulary.

13 Any Other Business

- Shared care: MC raised the point that, following some instances of GPs declining to take on Shared Care for patients in Mid Notts, there is a possibility that patients may be put at risk from a variability in Shared Care uptake. It was questioned how this should be escalated. It was agreed to discuss the matter further outside the meeting.

ACTION: LC/MC/NJ to discuss further.

- An AOB regarding the liothyronine position statement was deferred to the next meeting due to time constraints.

The meeting finished at 17:10pm.

Date of next APC Formulary meeting - Thursday, 18th April 2024 (2 pm – 5 pm, *MS Teams*)
Date of next APC Guideline meeting – Thursday, 21st March 2024 (2 pm – 5 pm, *MS Teams*)