NHS
North East London

North East London Formulary & Pathways Group (FPG)
Tuesday 8TH October 2024 at 12.30pm via MS Teams

Meeting Chair: Dr Gurvinder Rull

Minutes

Attendance	Name	Initials	Designation	Organisation
Clinical Representatives				
Present	Gurvinder Rull	GR	Consultant Clinical Pharmacology (FPG Chair)	BH
Apologies	Narinderjit Kullar	NK	Clinical Director for Havering	NHS NEL
Present	Mehul Mathukia	MM	Medicines Optimisation Clinical Lead for Redbridge	NHS NEL
Present	Louise Abrams	LA	Clinical Pharmacologist, DTC Chair	HHFT
Absent	John McAuley	JM	Consultant Neurologist, DTC Chair	BHRUT
Apologies	John Booth	JB	Consultant Nephrologist	BH
Trusts' Pharmacy Representatives				
Present	Jaymi Teli	JT	Lead Formulary & Pathways Pharmacist	BH
Present	Farrah Asghar	FA	Lead Clinical Pharmacist, Medicines Commissioning & Pathways	BH
Present	Maruf Ahmed	MA	Formulary Pharmacy Technician	BH
Apologies	Chole Benn	CB	Lead Women's and Children's Consultant Pharmacist and a non- medical prescriber	BH
Absent	Abu Baker Eltayeb	AE	Clinical Pharmacology IMT Resident Doctor	BH
Present	James Steckelmacher	JS	Clinical Pharmacology IMT Resident Doctor	BH
Present	Dawud Masieh	DM	Clinical Pharmacology IMT Resident Doctor	BH
Absent	Emma Magavern	EM	Clinical Pharmacology IMT Resident Doctor	BH
Absent	Dinesh Gupta	DG	Assistant Chief Pharmacist, Clinical Service	BHRUT
Present	Kemi Aregbesola	OA	Medicines Information and Formulary Pharmacist	BHRUT
Apologies	Iola Williams	IW	Chief Pharmacist	HHFT
Absent	Saima Chowdhury	SC	Principal Pharmacist for EMRS and Education & Training	HHFT
Present	Rikesh Patel	RP	Lead Pharmacist for Medicines Information and Formulary Pathways	HHFT
Present	Iffah Salim	IS	CAMHS Directorate Lead, Medicines Information Pharmacist	ELFT

Present	Kiran Dahele	KD	Formulary & Governance Pharmacist	NELFT
Absent	Sibel Ihsan	SI	Lead Directorate Pharmacist for Waltham Forest	NELFT
NEL Pharmacy & Medicines Optimisation Team's Representatives				
Present	Belinda Krishek	BK	Deputy Director of Medicines Optimisation	NHS NEL
Present	Denise Baker	DB	Senior Administrative Officer, Medicines Optimisation	NHS NEL
Present	Ann Chan	AC	Formulary Pharmacist	NHS NEL
Present	Sheetal Patel	SP	Formulary Pharmacist	NHS NEL
Present	Nicola Fox	NF	Commissioning & Contracting Senior Pharmacy Technician	NHS NEL
Other Representatives				
Present	Dalveer Singh Johal	DJ	Pharmacy Services Manager	NEL LPC
Present	Mohammed Kanji	MK	Prescribing Advisor (Representing NEL Primary Care Non-Medical Prescribers)	NHS NEL
Absent	Yasmine Korimbux	YK	Senior Transformation Manager/Lead Medicines Optimisation Pharmacist, NICE Medicine and Prescribing Associate	NHS NEL
Present	Jiten Modha	JMo	Specialised Commissioning Senior Pharmacy Advisor	NHSE
Guests				
Present	Robert Ardley	RA	Lead pharmacist for Stroke and Older People's Services (RLH) (observing)	BH
Present	Natasha Callender	NC	Head of Medicines Optimisation – Safety, Quality of Governance (observing)	NHS NEL
Present	Andrew Stock **(6)**	AS	Health Improvement & Inclusion Manager (Tobacco)	NHS NEL
Present	Martin Lewis **(7)**	ML	INR representative (Post CCT fellow)	BHRUT
Present	Jahid Chowdhury **(7)**	JC	Senior Critical Care and Anaesthetic Pharmacist	BHRUT
Present	Zeeshaan-ul Hasan **(8,9)**	ZH	Dermatology Consultant	BH
Present	Hannah Marrison **(8,9)**	HM	Specialist Pharmacist (Rheumatology & Dermatology)	BH
Present	Sarah Mehrtens **(8,9)**	SM	Dermatology Consultant	BH
Present	Brenton Wait **(10)**	BW	Specialist Doctor, Homerton Anogenital Neoplasia Service/HIV/Sexual Health	HHFT
Present	Raj Nijjar **(14)**	RN	Lead Clinical Cancer Pharmacist	BH
Present	Sophie Broad **(14)**	SB	Lead Renal and Urology Pharmacist	BH
Present	James Green **(14)**	JG	Consultant Urological Surgeon	BH

North East London organisations:

- Barts Health NHS Trust (BH)
- Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
- Homerton Healthcare NHS Foundation Trust (HHFT)
- East London NHS Foundation Trust (ELFT)
- North East London NHS Foundation Trust (NELFT)
- North East London Integrated Care Board (NHS NEL)
- North East London Local Pharmaceutical Committee (NEL LPC)

No.	Agenda item and minute
1.	**Quoracy check**
	The meeting was quorate.
2.	**Welcome, introduction and apologies**
	The Chair welcomed all to the meeting and apologies were noted as above.
3.	**Declarations of interest from members and presenters**
	The Chair reminded members and presenters of their obligation to declare any interests relating to agenda items. It was acknowledged that an email had recently been circulated requesting that all members of the group submit their reviewed DOI as soon as possible to enable an updated register to be available.
4.	**Minutes**
	The minutes of the previous meeting (September 2024) were reviewed and approved. The redacted minutes from July 2024 were also approved.
5.	**Matters Arising**
	FPG action log – the following updates were provided: **202405_04 - Buvidal (buprenorphine) for treatment of opioid dependence** – A Standard Operating Procedure (SOP) had been developed and was awaiting secondary care sign off before a finalised version would be available. The group were advised that the following actions had been completed:

	202409_01 – Review of Declaration of Interest - submissions had been requested for all members via email. **202409_02 – Empagliflozin and dapagliflozin for the treatment of Type 2 Diabetes Mellitus in Children and Young People (CYP) 10 years and over** - the request to produce an NEL patient leaflet for this indication and cohort had been shared with the applicants. **202409_03 –NEL Guidelines on the Identification, Treatment and Management of Malnutrition in Adults, including the appropriate prescribing of Oral Nutritional Supplements (ONS)** - the requested version control had been added to the guidelines and Optimise Rx messages developed to highlight the Aymes Complete reformulation to Actagain. **Noted.**
6.	**Cytisine for smoking cessation across NEL**
	Declarations of interest: Nil declared The request for Cytisine to be added to formulary as an option to support smoking cessation and reduce cravings in adults who were attempting to stop smoking was presented. The reasons to support smoking cessation and the benefits to the NHS when people were able to stop smoking were highlighted to the group. Cytisine is a partial agonist of nicotinic acetylcholine receptors and licensed for use in adults who were over 18 to 65 years. A summary slide was shared with the group which outlined the current smoking cessation options, with a request for Cytisine to be added. It was confirmed that all treatments on the list could be chosen as first line options. The slide also showed evidence for the benefits of Cytisine use. It was highlighted that Cytisine can be a treatment like Varenicline and Zyban for patients who did not wish to use nicotine replacement therapies or nicotine vapes. Cytisine was also the more cost-effective treatment when compared to both Varenicline and Zyban and could be obtained by a single prescription as it has a shorter course duration of 25 days. There was a concern raised regarding the subsequent inequality of access to Cytisine for patients under 18 and over 65 years. It was explained that this was due to the manufacturers licensing of the product and insufficient data to support use outside of the age restriction. A query was raised regarding the hepatic/renal impairment and clarity was sought regarding the cut off definition for eGFR. Clarity was also requested regarding hypersensitivity to active substances. Factsheets to support prescribing were available but they did not provide any clarity regarding eGFR. The group agreed that the factsheet should state that patients with any form of renal/hepatic impairment should not be prescribed this medication. It was confirmed that the pathway and the letter of recommendation were not included in the submission request for approval. **Outcome:** Approved, subject to having a factsheet for all prescribers stating that use in renal and hepatic impairment is to be avoided. Formulary Status: Amber, specialist initiation

	Decision for ratification by the Systems Pharmacy & Medicines Optimisation (SyPMO) Board.
7.	**Tirofiban for the treatment of thrombus formation in intercranial aneurisms and intercranial stent insertion to ensure stent patency**
	Declarations of interest: Nil declared The formulary application for Tirofiban was presented which had been identified as a replacement to Eptifibatide (Integrilin), the current treatment used for endovascular treatment of intercranial aneurysms and secondary prevention of thromboembolism. Eptifibatide has now been withdrawn from the UK market by the manufacturers GlaxosmithKline; unlicensed Eptifibatide is currently being sourced from America. IV Aspirin, another suitable treatment for this indication, is also experiencing intermittent supply and therefore Tirofiban is an available more cost-effective alternative treatment option in the long term and noted to have previously been on the BHRUT formulary. Although the formulary application was presented by BHRUT, the group were advised that BH had already been using Tirofiban which had previously been agreed via Chairs action due to it being a legacy product that had not been added to formulary. It was agreed that Tirofiban should be added to the NEL formulary to harmonise treatment across the areas. **Outcome:** Approved. Formulary Status: Hospital only Decision for ratification by the SyPMO Board.
8.	**Rituximab for the treatment of Pemphigus Vulgaris (PV)**
	Declarations of interest: Nil declared The formulary application for Rituximab as a first line treatment for Pemphigus Vulgaris (PV) which would provide an additional option to the current treatment pathway was presented. Clinical trials had demonstrated that Rituximab had the ability to induce sustained remission in patients with PV with reduced corticosteroid usage, enabling long term risks from prolonged steroid use to be reduced. Therefore, the request was for Rituximab to be a preferred option from the outset of treatment, enabling flexibility to use Rituximab at an earlier stage than the current pathway if clinically appropriate. It was noted that both BHRUT and HHFT did not currently offer Rituximab to patients with PV and referred cases that require treatment to the dermatology team within BH. It was mentioned that Guys and St Thomas' Trust (GSTT) have been known to use Rituximab for this condition. There was concern that this should be considered on a national level rather than locally as there is NHSE guidance and a concern for NHSE to support local nuances varying from the agreed treatment pathway was expressed. Discussion regarding the national process including prioritisation of consideration

	and possible timelines, were difficult to forecast and therefore there was the suggestion for short term actions to be set to support the current need. A case-by-case consideration could be a short-term way forward in the meantime, for exceptional circumstances only. It was acknowledged that the British Association of Dermatologists (BAD) had recommended the use of Rituximab as a first line treatment for this condition, although BAD recommendation does not always enable a drug to be commissioned either by the ICB or NHSE. The group required more clarity regarding the cohort of patients that would be considered for treatment, confirmation of the position of the treatment within the pathway and agreed that discussion at a more national level (e.g. at the CRG) should be considered before any agreement locally. Information relating to treatment availability at GSTT could also enable a wider picture of use to be established including information on their case of patients. **Outcome:** Not approved.
9.	**Adalimumab dose escalation in hidradenitis suppurativa (HS)**
	Declarations of interest: Nil declared The formulary application for dose escalation of Adalimumab to treat patients who were suffering with severe hidradenitis suppurativa or experiencing progression of the condition whilst receiving the current 40mg dose of Adalimumab was outlined. The request for dose escalation was clarified for the following patients: • an inadequate clinical response • blood test showing no antibodies to the 40mg Adalimumab dose The group were advised of the following: • the cost of the Adalimumab 80mg dose pen was cheaper than the 40mg pen due to the 80mg pen initially being used only as an initial loading dose • the dose escalation of Adalimumab would provide an additional step in the treatment pathway before reaching Secukinumab which was the final step before all treatment options were exhausted for this condition • Secukinumab was a more expensive treatment BH had the only HS specialist centre within NEL and therefore only the BH dermatology team would be considering the dose escalation of Adalimumab for this condition. **Outcome:** Approved. Formulary status: Hospital only (BH only) Decision for ratification by the SyPMO Board.

10.	**5-fluorouracil (5-FU) cream for treatment of anogenital intraepithelial neoplasia**
	Presenter: Brenton Wait (BW), Specialist Doctor in Homerton Anogenital Neoplasia Service/HIV/Sexual Health, HHFT **Declarations of interest:** Nil declared The request for 5-FU cream to be added to the formulary to treat anogenital intraepithelial neoplasia which are pre-cancerous lesions due to Human Papillomavirus (HPV) was presented. It was explained that this condition was lifelong for patients and any treatment method was yet to be identified as fully effective, hence the need for alternative treatment options to be available. 5-FU cream would not be suitable for all patients, but evidence (ANCHOR trial) and experience of use elsewhere supported its consideration as a treatment option for this condition. The following cohort of patients would be discussed for potential 5-FU treatment by the High-grade Squamous Intraepithelial Lesions (HSIL) multidisciplinary team (MDT) at BH and HHFT: • patients who were immunosuppressed and not able to mount the immune response necessary for imiquimod treatment • alternative imiquimod treatment due to stock level issues • patients who had failed other topical treatments but were best treated topically (where surgery may not be appropriate) • patients who had severe or recurrent HSIL, to downgrade disease prior to surgery, or to try to reduce recurrence of disease or progression to cancer BHRUT had a Genitourinary Medicine (GUM) clinic and liaison with BHRUT colleagues would take place to establish their interest in using 5-FU for this condition. It was confirmed that 5-FU cream was cheaper that alternative topical treatments and monitoring/follow up would form part of standard care within the specialist units. The group were interested to see the treatment pathway for this indication and it was agreed for this to be shared with relevant NEL colleagues to enable a finalised version of a NEL wide pathway to be shared at the next FPG meeting. **Outcome:** Approved. Formulary Status: Hospital only (subject to finalised pathway) Decision for ratification by the SyPMO Board.
11.	**Formulary Harmonisation - Nil**
12.	**Updated Guidelines - Nil**

13.	NICE TAs and NHSE Commissioned Policies
	NICE TA approval and Horizon Scanning The following updates were provided: **NICE TA approval and Horizon Scanning** **• ICB Commissioned:** **TA991 Abaloparatide for treating osteoporosis after menopause** for patients who have a very high risk of fracture. This was defined by the National Osteoporosis Guideline Group (NOGG) clinical guideline for the prevention and treatment of osteoporosis as a fracture probability (based on the Fracture Risk Assessment Tool [FRAX]) that exceeds the threshold for intervention by 60%. This would be the 2nd parathyroid hormone-related protein available and the 3rd HCD and would be placed in therapy alongside teriparatide and romosozumab. Unlike the other two drugs abaloparatide would be given by daily injection for a maximum period of 18 months. The implementation date will be 5th November 2024. **Outcome:** Agreed for local implementation (decision for ratification by the SyPMO Board) Formulary Status: Hospital only **TA995 Relugolix for treating hormone-sensitive prostate cancer** – refer to item 14 of this document where the discussion regarding this TA was captured. **Outcome:** Agreed for local implementation (decision for ratification by the SyPMO Board) Formulary Status: Amber, specialist initiation. **TA996 Linzagolix for treating moderate to severe symptoms of uterine fibroids** was not a high-cost drug so a NICE TA review or development of Blueteq forms was not required. **Outcome:** Agreed for local implementation (decision for ratification by the SyPMO Board) Formulary Status: Hospital only **TA1004 Faricimab for treating visual impairment caused by macular oedema after retinal vein occlusion.** This would be another anti-VEGF treatment which has already been used to treat both DMO and wetAMD. This would be the 3rd anti-VEGF for this indication and the 4th drug overall. A discounted PAS would enable faricimab to be comparable in price to aflibercept but would remain more expensive than both dexamethasone and the ranibizumab biosimilar. The implementation date will be 11th October 2024 (30days). **Outcome:** Agreed for local implementation (decision for ratification by the SyPMO Board) Formulary Status: Hospital only

	NHSE commissioned: **TA993 Burosumab for treating X-linked hypophosphatemia in adults** — no centres in NEL. **For noting only.** **TA1003 Exagamglogene autotemcel for treating transfusion-dependent beta-thalassaemia in people 12 years and over:** "More evidence on exagamglogene autotemcel is being collected. After this, NICE will decide whether to recommend it for use in the NHS and update the guidance. It will be available with managed access until then within Barts Health which is commissioned for this. Formulary Status: Hospital only **To Note: Re TA981 Voxelotor for treating haemolytic anaemia caused by sickle cell disease -** Pfizer have withdrawn Voxelotor from the global market. Refer to item 15 of this document where further information regarding this TA was captured. **Noted.**
14.	**NICE TAs/ NHSE commissioned policies for discussion**
	TA995 Relugolix for treating hormone-sensitive prostate cancer **Declarations of Interest:** Nil declared Relugolix, an oral GnRH receptor antagonist treatment for treating hormone-sensitive prostate cancer, was an alternative oral treatment to IM injection options such as Leuprolide, Goserelin, Triptorelin and Histrelin and was an equivalent alternative antagonist to Degarelix; all monitoring of these treatments would be completed by secondary care. Current patients would not be switched to Relugolix but continue on their current IM injection treatment. New patients would have the option to discuss and choose their treatment option. There was a concern regarding patient adherence to taking their oral medication in comparison to IM injection. The FP10 prescription software CLEO would eventually support secondary care prescribing directly to community pharmacy but whilst this was still in development, it was requested that Relugolix be considered as an amber drug on the formulary allowing GPs to support prescribing within primary care. A prescribing letter was shared on the screen which would request the GP to continue prescribing the medication after one month; monitoring would continue by the hospital urology team. A named consultant and contact details would be included in the letter should the GP require further information or have any concerns regarding the request; reassurance that these details would be included was provided. The group were advised that all patients would eventually go to a remote monitoring system supported by a Cancer Nurse Specialist (CNS) in BH. It was highlighted that Relugolix was a safer option for patients who had suffered cardiac events and it was estimated that any QT interval concerns raised by the GP would be responded to within 24-48 hours.

	It was requested that a training programme was agreed to support primary care with this fundamental change to previous arrangements and colleagues agreed to support training sessions for GPs. Concern was raised regarding stock issues within primary care as there was only one wholesaler providing access to Relugolix; it was suggested that this could be raised with the manufacturers. A request to ensure that awareness of the drug was raised within primary care and that there was a robust two-way communication system in place to support the interface process was received. The group agreed that a firm commitment to this interface communication was a necessity to support the formulary status approval of amber and it was requested that a contact for each Trust and expectation of turnaround time for responses was provided within the fact sheet. This was to be submitted to the group for consideration under matters arising at the next meeting. **Outcome:** Approved subject to the submission of a fact sheet outlining each NEL Trust's specialist contact details and timeline to respond to primary care patient concerns. Formulary Status: Amber, specialist initiation. Decision for ratification by the SyPMO Board.
15.	**NHSE Circulars:**
	• **SSC2717** Voxelotor (Oxbryta) withdrawal from the UK market in the treatment of Sickle Cell Disorder in people aged 12 years and older. The following update was provided regarding the effect of the removal of Voxelotor from the formulary: • all patients receiving Voxelotor had been spoken to by one of the BH haematology consultants (18 patients) • within the next two weeks all patients would have stopped Voxelotor treatment with this time period to allow for weaning of doses **Noted.**
16.	**Commissioning update**
	- **ICB** **Medicines Value Group Highlight Report** The following update was provided: • Primary care efficiency plans were currently on track to deliver additional savings to the set target (as at month 3) • The generic rivaroxaban price drop is forecast to deliver savings in the financial year with an annual figure quoted within 12 months • The NEL Provider Trust 24/25 Cost Improvement Plans (CIIPs) target was set and assurance was to be provided by each Trust at the MVG meeting later that day including a plan to stay on track

	• The biosimilar switch for dimethyl fumarate (DMT) had been undertaken at both BH and BHRUT • Diabetes Type 1 devices - a discussion would take place at the MVG meeting later that day to discuss next steps **- NHSE** JM provided the following update: • The Medicines Efficiency templates had been received from all Trusts • The statement provided by Pfizer regarding Voxelotor was vague in terms of reason for withdrawal, however it was understood that this was due to mortality concerns **Noted.**
17.	**Formulary Working Group – electronic formulary update**
	The progress tracker was shared and the following update provided: • All chapters highlighted in purple were to part of the soft launch on the 23rd of October • Remaining chapters would be part of the main launch scheduled for December 2024 • Poisoning and Vaccines chapters were to be part of an initial test of the formulary format next week • The landing page to access the formulary had been prepared • An email account has been set up to enable feedback to be received on the electronic formulary once the formulary is 'live' A list of 200 plus drugs had been listed as stage 1 harmonisation and the group agreed to all suggested outcomes. BH clinical pharmacologists who had joined the FPG would be available to support this work area going forward. **Outcome: Approved** Decision for ratification by the SyPMO Board.
18.	**Equality – Monitoring of usage and outcomes (nil at present)**
19.	**BH Antidote Guidelines for use across NEL**
	The 'Guideline on Antidote Availability for BH Emergency Departments' was presented which had been based on RCEM guidance and provided BH information regarding the following:

	• List of drugs that should be immediately available in the ED in a designated storage facility • List of drugs that should be available to treat patients within one hour (usually within the hospital) • List of antidotes that were held supra-regionally and clinicians would be required to discuss use of the antidotes with NPIS and/or clinical toxicologist The guideline was to be shared with the other trusts within NEL to enable a final NEL version to be adopted. It was requested that stock levels at BHRUT and HHFT be shared. It was agreed that NEL Trust colleagues discuss and share a NEL final document. **Outcome: Approved** Decision for ratification by the SyPMO Board.
20.	**Papers from committee reporting into the FPG:** • BH Cancer DTC May Minutes and agenda NIL
21.	**Local Medicines Optimisation group updates:** • BH – Summary of Chairs Actions – September • NELFT MOG Highlight Report - NIL • ELFT medicines committee minutes – NIL • BHRUT MOG Agenda July minutes and September agenda • Homerton – Medicines Committee and Agenda and Minutes - NIL
22.	**NEL FPG recommendations ratified at SyPMO Board July 2024**
	• SyPMO Board September Highlight Report **NEL FPG Outcome Letters:** • Empagliflozin for the treatment of Type 2 Diabetes Mellitus in Children and Young People (first line SGLT2 Inhibitor) • Dapagliflozin for the treatment of Type 2 Diabetes Mellitus in Children and Young People (second line SGLT2 Inhibitor) • Implementation protocol to support the prescribing of the recommended cost-effective generic Sitagliptin tablets • NEL ONS guidelines update (Aymes Complete reformulation to Actagain) • TA986 Lebrikizumab for treating moderate to severe atopic dermatitis in people 12 years and over • TA990 Tenecteplase for treating acute ischaemic stroke • TA998 Risankizumab for treating moderately to severely active ulcerative colitis • TA999 Vibegron for treating symptoms of overactive bladder syndrome

	Noted.
23.	**Finalised Minutes – July 2024**
24.	**Any Other Business -** None
	<u>Time & date of next FPG meeting</u> **12:30 – 15:00 – Tuesday 5th November 2024 via MS Teams**