NHS
North East London

North East London Formulary and Pathways Group (FPG)

Tuesday 3rd March 2026 at 12.30pm via MS Teams

Meeting Chair: Dr Gurvinder Rull

Minutes

Attendance – part 1	Attendance – part 2	Name	Initials	Designation	Organisation
Clinical Representatives					
Present	**Present**	Gurvinder Rull	GR	Consultant Clinical Pharmacology (FPG Chair)	BH
Apologies	Apologies	Narinderjit Kullar	NK	GP, Clinical Director for Havering	NHS NEL
Apologies	Apologies	Ruth Crowley	RC	GP Partner, Avon Road Surgery, Havering	NHS NEL
Present	Apologies	Nishani Jayasooriya	NJ	Consultant Gastroenterologist, Medicines Committee Chair	HHFT
Apologies	Apologies	Mehul Mathukia	MM	GP, Medicines Optimisation Clinical Lead for Redbridge	NHS NEL
Absent	Absent	Jo Howard	JH	Clinical Group Director, Cancer & Clinical Support Division Consultant Haematologist and Responsible Officer	BHRUT
Absent	Absent	John McAuley	JM	Consultant Neurologist, Drugs & Therapeutic Committee Chair	BHRUT
Present	Apologies	John Booth	JB	Consultant Nephrologist	BH
Trust Pharmacist					
Present	**Present**	Jaymi Teli	JT	Lead Formulary & Pathways Pharmacist	BH
Present	**Present**	Farrah Asghar	FA	Lead Clinical Pharmacist, Medicines Commissioning & Pathways	BH
Present	**Present**	Maruf Ahmed	MA	Formulary Pharmacy Technician	BH
Absent	Absent	Chloe Benn	CB	Lead Women's & Children's Consultant Pharmacist and non-medical prescriber	BH
Absent	Absent	Abu Baker Eltayeb	AE	Clinical Pharmacology IMT Resident Doctor	BH
Absent	Absent	James Steckelmacher	JS	Clinical Pharmacology IMT Resident Doctor	BH
Absent	Absent	Dinesh Gupta	DG	Assistant Chief Pharmacist, Clinical Service	BHRUT
Present	**Present**	Tomisin Antwi	TA	Formulary & Medicines Information Pharmacist	BHRUT
Absent	Absent	Iola Williams	IW	Chief Pharmacist	HHFT
Absent	Absent	Silvie Cunderlikova	SC	Pharmacy Digital Solutions Manager (Interim formulary support)	HHFT

Absent	Absent	Nuhu Yaroson	NY	Clinical Commissioning Pharmacist	BH
Absent	Absent	Kamaljit Takhar	KT	Associate Director of Pharmacy - Quality & Safety	NELFT
Absent	Absent	Dupe Fagbenro	DF	Deputy Chief Pharmacist (London Services)	ELFT
Present	**Present**	Jack Ross	JR	Consultant Physician and Clinical Pharmacologist	BH
Present	**Present**	Annabel Ikwuakolam	AI	Lead Community Transformation Mental Health Pharmacist	ELFT
Present	**Present**	Patricia Emumwen	PE	Formulary and Governance Pharmacist	NELFT
NEL Pharmacy & Medicines Optimisation Team's Representatives					
Present	**Present**	Belinda Krishek	BK	Deputy Director of Medicines Optimisation	NHS NEL
Present	**Present**	Denise Baker	DB	Senior Administrative Officer, Medicines Optimisation	NHS NEL
Present	**Present**	Ann Chan	AC	Formulary Pharmacist	NHS NEL
Present	**Present**	Nicola Fox	NF	Commissioning & Contracting Senior Pharmacy Technician	NHS NEL
Present	**Present**	Kalpna Bhudia	KB	Formulary Pharmacist	NHS NEL
Present	**Present**	Anh Vu	AV	Commissioning and Contracting Pharmacist	NHS NEL
Apologies	Apologies	Natalie Whitworth	NW	Head of Medicines Commissioning and Transformation	NHS NEL
Other Representatives					
Apologies	Apologies	Dalveer Singh Johal	DJ	Chief Operating Officer	NEL LPC
Present	**Present**	Mohammed Kanji	MK	Senior Medicines Optimisation Pharmacist (Representing NEL Primary Care Non-Medical Prescribers)	NHS NEL
Present	**Present**	Yasmine Korimbux	YK	Head of Medicines Optimisation – Place Based Partnerships	NHS NEL
Apologies	Apologies	Anudeep Riyat	AR	Deputy Chief Pharmacist, Specialised Commissioning (NEL ICB link pharmacist)	NHSE
Apologies	Apologies	Annett Blochberger	AB	Chief Pharmacist, Specialist Commissioning (London Region)	NHSE
Present	**Present**	Jiten Modha	JM	Specialised Commissioning Senior Pharmacy Advisor	NHSE
Absent	Absent	Andrea Okoloekwe	AO	Lead Pharmacist, Community Mental Health Services	ELFT
Present	Absent	Amina Abdishakur	AA	Highly Specialist Pharmacist, RLH SRIAP (observer)	BH
Guests – part 1 of the meeting only					
Present	Aleksandar Radunovic		ARa	Consultant Neurologist, Director of Barts Motor Neuron Disease (MND) Centre	BH
Absent	Heba Madi		HM	Neurology Registrar ST7	BH
Present	Sharanyhan Suthakaran		SS	Lead Pharmacist for Surgery and Anaesthetics, RLH	BH
Present	Vandita Ralhan		VR	Consultant Anaesthetist, RLH	BH
Present	Chloe MacInnes		CM	ST6 Anaesthetics, RLH	BH

Present	Tiba Hikmat	TH	Specialist Antimicrobial Pharmacist	BH
Present	Nasira Makan	NM	Clinical Service Lead	BH
Present	Zafiat Quadry	ZQ	Head of Medicines Optimisation, Clinical Programmes	NHS NEL
Present	Shoheb Khan	SK	Transformation Pharmacist City & Hackney East London Foundation Trust	ELFT
Present	Uzma Shaikh	US	Lead Medicines Optimisation Pharmacist	NHS NEL
Present	Olapeju Bolarinwa	OB	Neurology Pharmacist	BHRUT
Present	Renato Oliveira	RO	Neurology consultant; lead consultant for migraine services	BHRUT

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)

PART ONE	
No.	Agenda item and minute
1.	**Quoracy check**
	It was noted that GP representation was not available for the meeting and subsequently any decisions would be referred after the meeting to GP members for agreement.
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. A reminder for all members of the group to submit their reviewed DOI, if they have not recently completed their submission to enable an updated register to be available.

4.	**Tofersen (Qalsody®) for the treatment of amyotrophic lateral sclerosis in adults who have a mutation in the superoxide dismutase 1 SOD-1 gene (Motor Neurone Disease)- Early Access Programme (BH only)**
	Declarations of interest: Nil declared. The application was presented for Tofersen, a targeted genetic therapy for Superoxide Dismutase 1 (SOD-1) Motor Neuron Disease (MND) which is caused by an inherited form of ALS due to gene mutation, accounting for 2% of the total number of people with MND. Riluzole is currently the only licensed treatment available and therefore Tofersen would be a beneficial addition to formulary, stabilising disease progression and enabling a significant improvement to quality of life which could include allowing some patients to return to work. The following key points were noted: • Tofersen received approval from the MHRA in July 2025 and currently receiving NICE evaluation • BH is one of 4 centres in London. King's College Hospital and St. Georges Hospital MND centres are currently offering Tofersen to their eligible patients although unable to accept referral from other areas due to lack of clinical capacity. • UCLH are in the process of setting up a service for patients. • Patients in the BH MND centre do not currently have access to Tofersen, creating a disparity in care within London • Tofersen would be administered as a lumbar puncture with protocols aligned to practices already established at other centres such as St Georges • Clinical monitoring for patients would continue as part of their scheduled clinic visits • Standard Operating Procedure (SOP) and Patient Information Leaflet (PIL) produced to support treatment of Tofersen • There is currently a process where staff involved in the intrathecal process from the person who makes the chemotherapy to the person who does the administration to be trained and registered and on the intrathecal register. It is understood that this would apply to this drug, but BH pharmacy team will check and ensure the governance and safety assurance will be in place and regular liaison between pharmacy and clinical teams reporting to a medicines governance and safety group • 1-2 patients per year expected to receive Tofersen within BH There was concern raised regarding an exit strategy for patients should treatment not continue due to NICE guidance criteria not being met or if there is a negative NICE TA outcome. For any early access programmes, there should be a clear documented exit strategy. It was highlighted that the drug itself would be provided by the manufacturer, Biogen, free of charge as part of an Early Access Programme, but the cost of intrathecal administration was estimated to be £100 per dose according to colleagues at King's College Hospital. If NICE approval was received NHSE would commission this as a High-Cost Drug (HCD). The group agreed to approve the application with the additional request for an update to be provided at a future BH Oversight Group meeting. The update would be required from the dedicated clinical governance group reviewing Tofersen use within the BH MND service. **Outcome:** Approved with feedback required back to a future meeting of the BH Oversight Group.

	Formulary status: Red, Hospital only (BH only) Decision for ratification by the NEL System Prescribing and Medicines Optimisation (SyPMO) Board.
5.	**Intravenous dexmedetomidine for anaesthesia/ sedation in adult and paediatric theatres across NEL**
	Declarations of interest: Nil declared The application was presented and it was explained to the group the request for intravenous dexmedetomidine to be added to the NEL formulary for the following proposed uses within RLH; which is a large tertiary centre facilitating renal transplant, neurosurgical services and complex ENT: <u>Procedural sedation</u> IV dexmedetomidine would improve patient outcomes and satisfaction by avoiding general anaesthetic for specific adult and paediatric patient cohorts. It was anticipated that financial savings would be made from shorter hospital stays and reduced theatre time, enabling additional capacity for other clinical activity. Cost savings could also occur for renal transplant cases by reducing the need for post-operative dialysis. A reduction to waiting times for patients would also be seen if IV dexmedetomidine was available for the following: o For MRI scanning in Paediatrics, as is standard in other DGH and tertiary paediatric centres; this could enable twice the number of paediatric MRIs to be performed o Recommended by the Difficult Airway Society for adult awake tracheal intubation, used in both the elective and emergency setting o In interventional radiology to avoid general anaesthetic in a complex, often frail patient cohort e.g. mechanical thrombectomy. <u>As an adjunct to general anaesthesia</u> Extensive research supports the use of dexmedetomidine intraoperatively to improve patient outcomes. Large meta-analyses had shown that patients undergoing renal transplant had lower incidence of delayed graft function with dexmedetomidine. During awake craniotomy, dexmedetomidine is also associated with lower rates of intraoperative seizure compared to alternatives. It was acknowledged that whilst dexmedetomidine was already on formulary for longer term sedation in ITU setting, this application was to support the theatre setting for short term use and would be in line with Trust SOPs developed. Intravenous dexmedetomidine would be monitored by the responsible anaesthetist, with full monitoring as per AAGBI guidelines. It was also confirmed that use of IV dexmedetomidine would not be used within the trauma setting. It was suggested that data is requested from other Trusts already using the treatment, to provide safety assurances. **Outcome:** Approved with the additional request for 12 months usage and outcome data to be presented back at a future FPG meeting.

Formulary status: Red, Hospital Only

Decision for ratification by the SyPMO Board.

6. Outpatient Parenteral Antimicrobial Therapy (OPAT) Elastomeric devices at NUH site (BH)

Declaration of interest: Nil declared

The application to extend the use of pre-filled elastomeric devices within the Newham University Hospital (NUH) OPAT service was presented. The request would be an extension to the already approved use of the devices and proposed changes were highlighted below:

Current	Proposed change	Indication
Piperacillin-tazobactam 4.5g IV Injection TDS/QDS (conventional method)	Piperacillin-tazobactam 18g per day elastomeric	Respiratory (non-cystic fibrosis); diabetic foot infection and Staphylococcus aureus bacteraemia (including infective endocarditis)
Flucloxacillin 2 g IV Injection QDS (conventional method)	Flucloxacillin 8g per day elastomeric	

It was proposed that a maximum threshold for 10 patients would be set, however there were concerns regarding the monitoring of patient numbers. It was acknowledged that additional patients would require 'Chair's action' approval. It was also highlighted that determining actual savings would prove difficult, but the extended use of elastomeric pumps would reduce hospital beds and staff hours needed to administer inpatient care.

The group agreed to approve the use of the device for the above medicines for the specified indication at NUH. However, it was requested that a review of usage over 6-9months period is presented to ensure that the 10-patient treatment threshold was not exceeded and 'Chair's action' approval had been sought for any additional patients. Outcome data and value assessment would be required to the BH Oversight Group from both SBH, where it is already on formulary, and NUH before consideration of wider expansion to other BH hospital sites.

Outcome: Approved with the additional request for 6-9 months' data to be presented by NUH and SBH to the BH Oversight Group.
Formulary status: Red, Hospital Only (BH only at Newham site)

Decision for ratification by the SyPMO Board.

7. ADHD medicines (Methylphenidate, Lisdexamfetamine, Dexamfetamine, Atomoxetine and Guanfacine) - change of formulary status from Amber 3 (historic purple) to Amber 2 in adult patients

	Declaration of interest: Nil declared The request to change the formulary status from Amber 3 to Amber 2 for the following ADHD medicines was presented: • Methylphenidate • Lisdexamfetamine • Dexamfetamine • Atomoxetine • Guanfacine The requested change to formulary status would be supported as part of a local service redesign for adult ADHD treatment services which was required to address the significant local demand pressures and subsequent increase to patient waiting times. It was explained that patients who were clinically stabilised and at low clinical risk could be transferred to primary care for ongoing monitoring and prescribing to enable the limited specialist capacity to be utilised more effectively; protocols and escalation pathways for complex cases would be available to support primary care clinicians. The following was highlighted: • Supports NHSE recommendations outlined in the NHSE Independent ADHD Taskforce (part 2) • Alignment with NICE NG87 which recognises '*the exact balance between primary and secondary care will vary depending on the circumstances of the person with ADHD and the available primary and secondary care services'* • Training to be available for primary care clinicians for ADHD medicines; successful initiative in City and Hackney already implemented • A Locally Enhanced Service (LES) agreement to be introduced for practices who were accepting transfer of care for patients • The stabilisation period would be a minimum of three months before patients were transferred to primary care • The use of guanfacine would require 'off label' use for adults if to be continued; usually having been prescribed throughout childhood and continued into adulthood – documented patient consent would be required • The formulary status change would only apply where a NEL wide commissioned specialist service was available to support GP escalations; NELFT and ELFT would provide this service to support unstable and complex patients within NEL The group agreed to approve the formulary status change from Amber 3 to Amber 2 for the medicines specified above, but only to be implemented once all required supporting paperwork, training and services were available to support primary care. **Outcome:** Approved formulary status change in principle with the caveat that Amber 2 status would only to be implemented once all of the following are in place to support primary care: ADHD LES for Adults Primary Care Service Specification; Specialist Advice and Guidance Plus Service (NELFT & ELFT) and local Right to Choose accreditation in line with local right to choose service specification.

	Formulary status: Amber 2 (with caveat) Decision for ratification by the SyPMO Board
8.	**Positions Statement: Preferred sodium-glucose cotransporter-2 inhibitors (SGLT2i) for the treatment of type 2 diabetes mellitus (T2DM), Chronic Kidney Disease (CKD) and Chronic Heart Failure (CHF)**
	Declaration of interest: Nil declared The position statement had been developed in the response to the UK launch of generic dapagliflozin in September 2025 and NHSE's request for ICBs to optimise SGLT2i prescribing by prioritising the best value agent. Whilst dapagliflozin and empagliflozin are clinical comparable the position statement emphasised the availability of a lower-cost generic which provided an opportunity to improve value, while maintaining clinical effectiveness. It was acknowledged that the position statement advised that generic dapagliflozin was the preferred 1st line choice of treatment for all licensed clinical indications unless contraindicated, not tolerated or clinically unsuitable. It was requested that the position statement is updated with the following: • It was confirmed that the position statement would not include switching. Suggests re-wording of bullet point 3 in the 'Background' section to clarify the expectation of reviewing and switching of medications • The group noted that the generic versions of dapagliflozin have varying licensed indications. Provide clarity for Prescribers regarding prescribing generics and differing licenses • Clarity around the prescribing for patients with CKD without diabetes and highlighting information within the 'Action for HCP' section • Consider including a section which refers to patients that are included/excluded from the position statement advice • Clarity on the recommendations in cases where a generic dapagliflozin cannot be used- specifically, should the branded dapagliflozin be prescribed, or are alternative SGLT2is being recommended in such situations A final version of the updated position statement was to be submitted for information to a future FPG meeting under matters arising. **Outcome:** Approved subject to amendment. Decision for ratification by the SyPMO Board
9.	**Atogepant and Rimegepant for migraine treatment and prophylaxis: proposed formulary status change**
	Declaration of interest: Nil declared

It was explained to the group that both Atogepant and Rimegepant were NICE approved medications for migraine and requested that the formulary status is amended to allow for specialist initiation and then transfer to primary care for prescribing/maintenance which would reduce hospital burden and improve patient access to care.

The following formulary proposals were presented:

Current	Current status	Proposed change	Indication
Atogepant tablets	Red	Amber 2	Prophylaxis of episodic migraine
Rimegepant tablets	Red	Amber 2 then to Green when migraine pathway available	Treatment of acute migraine
Rimegepant tablets	Red	Amber 2	Prophylaxis of episodic migraine

It was acknowledged that the NEL migraine pathway was still in development with an initial draft still awaited. There was a concern regarding prescribing and monitoring within BHRUT who were yet to implement Blueteq; OB would establish the current process and share details. Atogepant and Rimegepant are high-cost drugs with Blueteq requirements for initiation but there is not currently a continuation form - consideration to be given on how such information is captured if transferring to primary care (if needed). Financial implications of the Amber 2 status were also discussed and it was requested that pricing information and possible rebate mechanisms would need to be explored before the transfer of prescribing to primary care.

There was also a discussion on the service arrangements in BH (no current migraine service) and HH (via neurology clinic). Views sought from GP member also mentioned a guidance or supporting fact sheet e.g. on titration would be helpful.

The group agreed that further clarity was required regarding the financial implications (between secondary care acquisition prices and primary care pricing) and the development of the migraine pathway before approval could be considered. It was requested that any future submissions to come back as an agenda item.

Outcome: Not approved.

10. Minutes

The minutes of the previous meeting (February 2025) were reviewed and approved. The redacted minutes from December 2025 were also approved.

11. Matters Arising

FPG action log

An update regarding the following actions was provided:

202602_01 - Del Nido Cardioplegia (DNC) for use in selected cardiac surgical cases at BH – authors informed for the SOP to be updated. **Completed.**

	202602_02 - Items which should not be routinely prescribed in primary care - the positions statement had been updated. **Completed.** 202602_03 - Items which should not be routinely prescribed in primary care - the formulary status of selected drugs had been reviewed. **Completed.** 202507_11 - NICE TA updates - the BHRUT neurology pharmacy team were working to provide a short application form and develop a supporting fact sheet for Cenobamate TA 753. **In progress - Noted.** 202602_04 – Ibuprofen injection formulary harmonisation – BHRUT and BH to submit their respective SOPs for consideration. **In progress – Noted.** Decision for ratification by the SyPMO Board.
Formulary Harmonisation - Nil	
Updated Guidelines - Nil	
12.	**Shared care expiry extensions**
	The following BHRUT Shared Care Guidelines (SCG) were considered for expiry extensions: • Cinacalcet for primary hyperparathyroidism in adults when surgery is inappropriate • Degarelix for treatment of prostate cancer • Enoxaparin for multiple indications – a concern was raised regarding secondary care monitoring and OA will check this within the Trust. The SCG describes on p.4 'H*eparin-induced thrombocytopenia (HIT) is a rare side-effect of heparin including LMWH. Should thrombocytopenia occur, it usually appears between the 5th and the 21st day following the beginning of enoxaparin sodium treatment'*, but p.3 says '*From Day 15 onwards there is no need for routine monitoring'* • Methotrexate in psoriasis, Crohn's disease and ulcerative colitis, pulmonary sarcoidosis, rheumatoid arthritis and psoriatic arthritis • Apomorphine in complex Parkinson's disease – OA to check version of shared care guideline as NELFT said they are no longer involved with shared care for this medication • DMARDs for Rheumatoid Arthritis **Outcome:** Approved for 12 months expiry extension from the date of clinical review. Decision for ratification by the SyPMO Board.
13.	**NICE TA approval and Horizon Scanning** ICB Commissioned:

NICE Technology Appraisal	Outcome	Formulary status

	NICE TA1128 – Targeted release budesonide (Kinpeygo®) for treating primary IgA nephropathy (update to TA937)	Agreed for local implementation	Red, Hospital only (BH and BHRUT)

NHSE commissioned:

NICE Technology Appraisal	Outcome	Formulary status
NICE TA1131 – Obinutuzumab with mycophenolate mofetil for treating lupus nephritis (BH only) – IMF until implementation	Agreed for local implementation	Red, Hospital only (BH only)
NICE TA1134 – Dupilumab for treating severe chronic rhinosinusitis with nasal polyps – IMF until implementation	Agreed for local implementation	Red, Hospital only (BH and HHFT only)

Decision for ratification by the SyPMO Board.

14. NICE TAs/ NHSE commissioned policies for discussion - Nil

15. NHSE Circulars

- SC2926-Specialised Commissioning Update - NICE Appraisals published in December 2025 which are due to be commissioned in March 2026
- SSC2942-NICE summary letter guidance published January 2026

Noted.

16. Commissioning update

- **ICB**

Local Pathways including Medicines – The need for an agreement for a formalised approach to assess medicines within legacy local clinical pathways was outlined. It was requested that any local commissioning arrangements must include the appropriate primary care (place-based team pharmacists) consultation.

It was agreed that the following principles should be followed:

- **Pathways including only Green or Amber 1 formulary status medicines**
  Pathways that include only Green or Amber 1 RAG formulary status medicines may be progressed through local commissioning and approval arrangements, with appropriate involvement of primary care prescribers.

- **Pathways including Amber 2/3 or Red formulary status medicines**
  Pathways that include an Amber 2/3 or Red formulary status medicine that require further review, discussion, and alignment across North East London via the NEL FPG meeting.

	Outcome: The above approved principles were to be referred to SyPMO Board for ratification to ensure consistent and appropriate governance of medicines included within local clinical pathways. Decision for ratification by the SyPMO Board. **Post meeting note**: Additional discussion took place to determine the appropriate process for the local pathways, as following the principles above with a worked example did not arrive at an expected outcome. A process flowchart was subsequently developed and will be brought to the April FPG for approval. • **NHSE** The group were advised that medicines efficiency savings were being maximised at both BH and BHRUT. **Noted.**
17.	**Formulary Working Group – electronic formulary update**
	Amber 1 and Amber 2 alignment as part of the 'Standardisation of RAG rating definitions for formularies across London' The definitions of the RAG rating classification were reiterated for 'Amber 1' & 'Amber 2' to the group and the details of the latest list of amber stated drugs that had re-defined status was shared. Collaboration across NEL had supported the re-classification process which had also included considering other London status positions for the same drug, clinical practice, any available prescribing data and patient access to medications. The spreadsheet outlined the suggested status amendments for the current areas considered and these were agreed by the group. Of note, oral ivermectin for scabies- there was agreement (consultation with trust microbiology teams, specialist pharmacists and also the ICB antimicrobial lead) for this to be made amber 1. **Outcome:** Approved Decision for ratification by the SyPMO Board.
18.	**Equality – Monitoring of usage and outcomes** (Nil at present)
19.	**Papers from committee reporting into the FPG:** • BH Cancer Drugs & Therapeutic Committee – Nil
20.	**Local Medicines Optimisation group updates:** • BH Summary of Chairs Actions – January 2026 • BHRUT MOG Minutes – November 2025 • Homerton Medicines Committee – Nil

	• Homerton Summary of Chairs Actions – Nil • ELFT – Nil • NELFT - Nil **Noted.**
21.	**NEL FPG recommendations ratified at SyPMO Board**
	• SyPMO Board Highlight Report February 2025 **NEL FPG Outcome Letters:** • Remimazolam injection for procedural sedation in adults at Barts Health • Del Nido cardioplegia solution in adults at Barts Health • Ibuprofen injection – formulary harmonisation for BHRUT • Items which should not be routinely prescribed in primary care in North East London: Position statement and patient information leaflets • Ophthalmology pathways: - Medical retina treatment pathway for macular oedema secondary to retinal vein occlusion - Medical retina treatment pathway for visual impairment associated with centre-involving diabetic macular oedema • ELFT Shared care agreement for the treatment of ADHD in Children & Young People (6-18 years): London Localities • NEL Azathioprine and mercaptopurine for patients within adult services (non-transplant indications) expiry extension for 2 years **Noted.**
22.	**Finalised Minutes** – December 2025
23.	**Any Other Business** Tocilizumab biosimilar (Avtozma®) will be available from 1st March as per the framework. There is a shortage of Tocilizumab (Tyenne®) where current patients can be maintained but new patients will not be accepted on Tyenne®. **Noted.** Prevenar20 is a new conjugated pneumococcal vaccination which has replaced PPV23 and Prevenar13 in adults. The Immunoglobulin Clinical Commissioning Policy (IGCCP) had not been updated to reflect this change to vaccines. It was confirmed that information had been shared via Sub Regional Immunoglobulin Assessment Panels (SRIAP) but additional comms may also be circulated. **Noted.** Biosimilars Updates– It was agreed that going forward a standing agenda item would be added for biosimilar updates.
	Time & date of next FPG meeting: **12:30 – 15:00pm, Tuesday 14th April 2026 via MS Teams**