Nottinghamshire Joint Formulary Group Meeting Minutes
Thursday 15th August 2019, 2-5pm
Boardroom, Duncan Macmillan House

Present: David Kellock (DK) Consultant, SFHFT (Chair) Debbie Storer (DS), Medicines Information Pharmacist, NUH Esther Gladman (EG), GP Prescribing Lead, Nottingham City CCG Steve Haigh (SH), Medicines Information Pharmacist, SFHFT Steve May (SM), Chief Pharmacist, SFHFT Laura Catt (LC), Prescribing Interface Advisor, Nottinghamshire County CCGs Karen Robinson (KR), APC/Formulary Support Technician Deepa Tailor (DT), Interface/Formulary Pharmacist/ Medicines Management Pharmacist City CCG Shadia Jenner (SJ), Interface/Formulary Pharmacist/ Medicines Management Pharmacist Mansfield and Ashfield CCG Nicholas Sherwood (NS), Mental Health Interface Pharmacist, Nottinghamshire Healthcare Trust Naveen Dosanjh (ND), Deputy Chief Pharmacist, Nottinghamshire Healthcare Trust
Apologies: Jill Theobald (JT), Interface Efficiencies Pharmacist, Greater Nottingham CCP David Wicks (DW), GP and Local Medical Committee. Tanya Behrendt (TB) Deputy AD Medicines Management, Nottingham City CCG

Agenda item	Notes
1. Apologies	Noted (see above).
2. Declarations of interest	None declared from JFG members.
3. Minutes of previous meeting	The minutes from the last meeting were accepted by the group.
4. Matters arising and action log	**Noqdirna** DT had emailed the BNF to obtain clarity around monitoring and the term "periodic". The response received was inconclusive. **Action: DT to share the BNF response with the group via email and to finalise and upload the documents** **Action log** Degludec annual usage data should be available for the next JFG once the ePACT data is available ***** All other items were either completed or included on the agenda. *****
5. New applications:	**a) Visuxl – Ophthalmology submission (SJ)** A submission was received from the Ophthalmology Department at NUH requesting Amber 2 classification for Visuxl®. Visuxl® (sodium hyaluronate 0.1%, co-enzyme Q10 0.1%, vitamin E 0.5%) is

	not currently classified on the Nottinghamshire Joint Formulary. To be used for any epithelial defect that has not responded to conventional lubricant medication (refractory epithelial defects related to dry eye or other ulcers). These sometimes but not always develop after routine surgery such as cataract and corneal graft surgery. **And** as treatment for moderate or severe dry eye where other treatments have failed and the epithelial defects are persistent. SJ gave an overview of the study evidence. For corneal ulcer the studies offered possible benefit but the trials small and mainly based upon surrogate animal markers. For dry eye Visuxl® appeared to offer no benefit over what is currently available. Moorfields had been contacted and this product is not on their formulary and there was no planned review for Visuxl® to be added. The decision tree was followed and considering the low level evidence and increased cost a grey classification was recommended with the OTC (over the counter) symbol suggested. **Action: SJ to contact Birmingham eye hospital to seek opinion. Current Primary Care prescribing data to be reviewed to assess the reason for initiation in those who are currently being prescribed Visuxl®.** **b) Testosterone – Paediatric submission (DT)** A formulary submission has been received from paediatric endocrinology department at NUH and is supported by SFHT. The submitters are requesting an AMBER 2 classification for the following three formulations of testosterone •Testosterone 250mg/ml (Sustanon-250) solution for injection (mixed esters) •Testosterone 40mg undecanoate capsules (Restandol® 40mg Testocaps) •Testosterone 2% gel (Tostran 2% gel) For use in children and adolescents for the following two indications. •Hypogonadism •Constitutional delay in growth and puberty (CDGP) Sustanon®-250 250mg/ml solution for injection and Restandol® 40mg Testocaps are currently licensed with caution for use in pre-pubertal children. Tostran 2% gel is not indicated for use in children and as not been clinically evaluated in males under 18 years of age (SPC) All three products are licensed for testosterone therapy for male hypogonadism when testosterone deficiency has been confirmed by chemical and biochemical tests. DT presented and gave an overview of the submission, local recommendations and the implications of the submission for patients in primary and secondary care. Up to 25 paediatric patients per annum are anticipated to require testosterone therapy across Nottinghamshire. The majority of patients would not require more than 12 months treatment.

	ePACT2 data showed that prescribing of testosterone for paediatrics is occurring in small numbers within primary care. As testosterone replacement therapy for puberty is rarely prescribed in primary care concerns were raised around specialism required, dosing and administration of the formulations, in particular Sustanon-250 injection. Prescribing may present an issue for clinicians, without specific guidelines to follow. It was considered worthwhile to contact the Local Medical Committee (LMC) in order to gain an overview of opinions amongst clinicians within primary care. It was also highlighted that although Restandol is currently classified grey, there is some prescribing within primary care. **Action: DT to contact APC LMC representatives; Jenny Moss-Langfield and Khalid Butt.**
6. Formulary amendments	All formulary amendments were accepted, except the following which were discussed further: a) FOR DICUSSION - Suggested amendments Clonidine tablets - Further review required for presenting at APC due to the various indications for prescribing. b) FOR INFORMATION – MHRA All recommendations agreed
7. Horizon scanning	Horizon scanning presented. All recommendations were accepted, with the exception of: a) Atomoxetine generic now available NS to review and recommend most cost effective way of prescribing. b) Estriol 50 micrograms/g vaginal gel and applicator (low dose topical oestrogen), JFG recommended as green. c) Botulinum toxin type A. 50, 100 & 200 units powder for injection (Xeomin®), new indication. DS to review the formulary classifications. d) Testavan 20 mg/g Transdermal gel discussed - recommended as grey due to ecological impact of device with no increased clinical benefit.
8. Formulary Submission Form	DS presented the changes to the formulary submission form The suggested changes to the submission form were agreed with the noting of the following: • The use of the word drug amended to medication. • NUH to be made a generically inclusive term. • Declaration of interest to be moved to make clearer. **Action: DS to make the changes and pass to the APC team for final review**
8. Melatonin for discussion	In attendance for this agenda item; Amy Taylor (AT), Pediatrician (neurodisabilities), NUH

	James Sutton (JS), Lead Pharmacist Medicines Finance and Divisional Support (in Tariff Medicines) Saeed Nazir (SN), Consultant Psychiatrist, CAMHS Nottinghamshire Healthcare Trust Sarah Brennan (SB), Senior Pharmacist, Nottinghamshire Healthcare Trust NS gave a brief overview of the current formulary position on melatonin, and introduced the topic; Melatonin is currently classed as RED on the Nottinghamshire Joint Formulary for patients under 18 years old. The medication has been unlicensed in this patient cohort. As a result, the majority of prescribing happens in secondary care where unlicensed preparations are dispensed to patients and the cost is more predictable. NS presented data from the review of melatonin with a view to the JFG/APC addressing two issues: **1.** Evidence review of melatonin in children, it's classification on the formulary and place in therapy **2.** Choice of preparation following launch of several licensed melatonin preparations. Current calculations suggest a significant cost pressure if prescribing was moved to licensed preparations. Therefore it was essential to review the evidence available, make judgement on traffic light status and make a definitive APC stance. It was noted that the funding for the medication is different across SFH, NUH and NHCT – with SFH's costs being passed through to the CCG, while the other organisations bear the cost. Icenia is an imported unlicensed preparation. The group agreed that there are established unlicensed preps being sourced cheaper than this product, so no discernible benefit in swapping identified. Colonis – tablets and liquids. Licensed in adults for jet lag, more expensive than current preparations used. Initially these were advertised by suggesting NHS should use licensed preps if they're available – suggesting that these medications should be used in our cohort. However the MHRA intervened, resulting in withdrawal of advertising material and confirmation that the medication should not be used in children (as per SPC). There were concerns raised regarding the propylene glycol content of the preparations in younger patients (<5y/o) for the liquid preparation (IR prep and liquid both unlicensed in under 18s). NS presented the results of an evidence review. The evidence applies only to children with sleep problems and neurodisorders, and was all published before June 2019. Summary from evidence: • Melatonin can increase **T**otal **S**leep **T**ime by 48 minutes/30 minutes (Abdelgadir et al/Parker et al) • Melatonin can improve **S**leep **O**nset **L**atency by 29minutes/23 minutes (Abdelgadir et al/Parker et al) • Melatonin has no effect on **F**requency of **N**octurnal **A**wakenings (Abdelgadir et al/Parker et al)

- Short-term adverse effect profile is similar between melatonin & placebo Abdelgadir et al/Parker et al)
- Quality data mostly limited to 13 weeks – most long term studies open label, poor quality.
- Some discussion of tolerance – no suggestion from evidence that tolerance is an issue
- Little data on best dose to give – strongest piece suggests "doses over 0.05mg/kg are not necessary and should probably be avoided" (Van Geijlswijk)

There were extensive discussions regarding whether the use of melatonin constitutes a significant intervention and if the additional sleep resulted in significant clinical benefit.

AT (NUH) suggested the extra time afforded by treatment with melatonin is significant and suggested lack of sleep can have impact on child and family members, arguing that treatment improves quality of life for the child and the family. Sleep hygiene always the first line treatment although admitted this was difficult to prove this happens in the current population.

Currently NUH are looking at the cost effectiveness of ongoing treatment and dose reduction over time.
Usual dose used is 2mg, however this can vary with some on 10mg doses/day.
Primarily immediate release used (90% using), children at NUH are reviewed annually.
Suggested other treatments, such as alimemazine, chloral hydrate, promethazine are the alternatives.
Although reduction to every other day or only pre-school evenings can be an option there will always be some children that require constant medication. AT suggested melatonin was needed as an intervention, but did feel that it was possible that prescribing could be reduced.

SN (CAMHS, NHCT) stated that their focus was mainly on inpatients. Melatonin use over the last few years has increased. Stated the 2mg dose was started when Circadin was released, before then there was a history of doses up to 20mg/day. Suggested the medication should be used irregularly, and infrequently. Suggested there is a large placebo effect in treating these patients. If the patient is open to CAMHS, they are reviewed very frequently (weekly/monthly). Stated that these patients should also be going through behavioural programs, but similarly to NUH, could not prove this. The vast majority of this patient population don't see a psychiatrist. When the children leave the service, melatonin treatment is usually stopped.

JS discussed the choice of preparations, and it was agreed that this cost pressure is an inevitability rather than a potential issue. He outlined the estimated £3M cost pressure to the health community and also made reference to work done in NICE CG11. He also drew attention to only licensed preparation in children, Slenyto, which was classified as **GREY** in May 2019 APC.

NICE CG11 suggests medication is an option in challenging behaviour and learning disabilities, provided the patient is under a specialist and non-pharmaceutical interventions have been made. There is a cost effectiveness analysis in this document that JS suggested promotes melatonin as a cost-effective treatment (NS - *post meeting note: NICE costed 3mg melatonin MR,*

	IR and Oral solution for 12 weeks only in 2015 – price of £65 over 3 months for MR tabs). After the guests left the meeting, the group agreed that new options should be explored, with melatonin prescribing being rationalised. This includes starting patients, monitoring and de-prescribing melatonin. JFG agreed medication should remain on formulary in some form. **Actions*:*** • **Need data to inform whether the extra sleep is clinically beneficial – NUH clinicians to share review (NS to chase)** • **Need APC consensus on whether NG11's recommendation should be applied across all age groups on the formulary, as it has been for adults.** • **These minutes to be shared with SFH paediatrics, their opinion on future direction should be sought. And cost analysis done for prescribing from SFH** • **Interface team to develop option paper regarding possible plans for melatonin.** • **LCt and TB to discuss with commissioners the disparity between SFH and NUH/NHCT funding** • **APC need to make a decision, as if this were a new submission, based on;** ◦ Clinical Effectiveness ◦ Safety ◦ Cost effectiveness ◦ NICE approved ◦ Affordability for Nottinghamshire Healthcare Community ◦ Offer significant benefits to patients
9. **Dates of future meetings**	**Next meeting:** Thursday 17th October 2019, Boardroom, Porchester Rd, Nottingham NG3 6AA, 2-5pm
10. Any other business	Dates for future meetings had been emailed

The meeting ended at 1650