Nottinghamshire Area Prescribing Committee

DRAFT Nottinghamshire Joint Formulary Group Meeting Minutes
Thursday 18th November 2021, 2-5 pm
Online Microsoft Teams meeting due to COVID-19

Present:
David Kellock (DK) Consultant, Sexual Health, SFHFT (Chair)
Tanya Behrendt (TB), Senior Medicines Optimisation Pharmacist NHS Nottingham & Nottinghamshire CCG
Steve Haigh (SH), Medicines Information Pharmacist, SFHFT
Asifa Akhtar (AA), GP Prescribing Lead, NHS Nottingham and Nottinghamshire CCG

John Lawton (JL), Clinical Pharmacy Services Manager, NHCT
Laura Catt (LC), Prescribing Interface Advisor, NHS Nottingham and Nottinghamshire CCG
Lynne Kennell (LK), Interface/Formulary Pharmacist, SFHFT
Shary Walker (SW), Interface/Formulary Pharmacist, NUH
Karen Robinson (KR), APC/Interface/Formulary Support Technician, NHS Nottingham and Nottinghamshire CCG
Hannah Godden (HG), Mental Health Interface Pharmacist, NHS Nottingham and Nottinghamshire CCG/NHCT
Debbie Storer (DS), Medicines Information Pharmacist, NUH
Esther Gladman (EG), GP Prescribing Lead, NHS Nottingham and Nottinghamshire CCG
Ann Whitfield (AW), Patient Representative

In attendance:
Michelle Haigh (MH), Medicines Optimisation Pharmacist, NHS Nottingham and Nottinghamshire CCG
Dr Gillian Sare (Neurology) joined the meeting at 14:15hrs for the Safinamide discussion
Dr Sherif Gonem (Respiratory Medicine) joined the meeting for item 5a.
Dr Buddike Mendis (Consultant Diabetes and Endocrinology) joined the meeting for item 5b.

Apologies:
David Wicks (DW), GP and Local Medical Committee
Steve May (SM), Chief Pharmacist, SFHFT
Jill Theobald (JT), Specialist Interface Pharmacist
Kuljit Nandhara (KN), Deputy Chief Pharmacist, Head of Pharmacy Mental Health Services, NHCT
Michalina Ogejo (MO), Medicines Optimisation and pain clinic Pharmacist

Agenda item	Notes
1. Apologies	Noted (see above).
2. Declarations of interest	Nothing was declared by members of the group or submitters.
3. Minutes of previous meeting	The minutes were accepted as an accurate record of the meeting subject to review of some minor amendments highlighted by JT prior to the meeting.

4. Matters arising and Action Log	**Matters arising:** **Celecoxib-** It had previously been highlighted that new evidence for celecoxib may support its promotion as an NSAID of choice. MO had discussed with the Pain team and it was felt that as it was already available for prescribing, there was no need for further work on this at this time. **ACTION: KR to remove from the Action Log.** **Bimatoprost/ timolol preservative free multidose bottle.** More cost-effective than the current UDV's. LK had confirmed support of Ophthalmologists to change to this product and will take it to APC for formulary addition. **ACTION: LK to bring to APC.** **Octasa (mesalazine) suppositories-** discussions are underway at NUH regarding implementation. **ACTION: LK did not have any further feedback will try and provide an update for the next meeting.** **Insulin Aspart (Trurapi)-** Biosimilar to Novorapid. Support had been requested from the Medicines Optimisation team to assist with the potential adoption of this biosimilar. Due to the potential for significant savings, it is imperative that the Diabetic Specialist Nurses (DSNs) are aware and in full support. LK will bring a formulary review of the product to the next JFG. **ACTION: LK to feedback progress at the next JFG.** **NICE NG203 – Chronic kidney disease: assessment and management – Use of SGLT2 inhibitors** LK had attempted to seek input from renal clinicians regarding potential patient numbers, but had not yet received a response. A cross- speciality meeting about implementation of SGLT2 inhibitors had taken place at NUH but no feedback was available. **ACTION: LK to continue to seek input from renal clinicians on potential patient numbers and request formulary submission.** **Tobacco company takeover of Vectura** Concerns had been raised from NUH and there had been a suggestion that if the takeover went ahead inhalers manufactured by this company should be removed from the formulary. After discussion, the JFG agreed to wait for further developments, with consideration to reviewing guidelines if necessary. **ACTION: LC will keep this under surveillance.** **Low Carbon Inhalers** Peter Richards, CCG Senior Medicines Optimisation Pharmacist was leading this work stream and was in the process of forming working groups. **ACTION: KR will provide an update once progress has been made.** **Safinamide- Dr Gillian Sare joined the meeting at 2.15 pm** SW provided the group with a brief update explaining Dr Sare's views that rasagiline was ineffective in clinical practice and selegiline was not well tolerated, particularly in elderly patients. Clinical opinions from other areas agreed that selegiline is often not well tolerated, however, the use of safinamide appeared to be limited and some other trusts use rasagiline routinely. Due to different views from other areas, Dr Sare provided a flowchart, which

	served as a new proposal for patients established on levodopa with off periods without dyskinesia. The flowchart indicated safinamide for use as a 2nd or 3rd line option as an adjunct to levodopa, depending on the patient's circumstance. It indicated that rasagiline is the first-line option for patients over 60 years old and to consider safinamide if rasagiline is ineffective. For patients under 60 years, on the other hand, rasagiline or safinamide can be used if the patient has cognitive impairment or a history of hallucinations. Otherwise, selegiline or rasagiline should be used as first-line choices and if ineffective, then consider using safinamide. Dr Sare explained that her main concerns of using selegiline were cognitive frailty, previous psychosis, and significant cardiac history. EG agreed and suggested modifying the current flowchart to incorporate the above clinical criteria in addition to the age group. The group also noted that the age cut off for initiating safinamide had been reduced to 60 years old. This gave concerns about exceeding the mandate as the patient cohort would be even larger than the previous estimates. SH shared some open prescribing data which showed Nottingham and Nottinghamshire CCG as the 4th highest prescribers of safinamide in England. This was previously explained as due to having a tertiary centre in the area. LK questioned if other clinicians were using safinamide in an unrestricted way and suggested that having a guideline could potentially restrict this. TB shared some practice-based prescribing data from Open Prescribing and most of the prescribing was within the Mid Notts area, suggesting that safinamide was likely initiated by SFHT. **ACTION: SW to amend the algorithm to include clinical criteria in addition to the age group, and to add more detail on trial and review period.** **LK to contact the SFHT Parkinson's team to ascertain current safinamide prescribing patterns.** **SW to take to APC in December with a view to approving the algorithm, but requesting that Dr Sare audits patient numbers from her team at NUH.** ***** All other items were either completed or included on the agenda. ***** **a) Trimbow for asthma**. Dr Sherif Gonem joined the meeting at 3 pm SW presented the Trimbow for asthma submission from Dr Sherif Gonem Respiratory Consultant and Lead Physician for Severe Asthma at NUH. The request was to re-classify Trimbow® as amber 2 for use as a maintenance treatment of asthma, in adults not adequately controlled with a maintenance combination of a long-acting beta2-agonist and medium dose of inhaled corticosteroid, and who experienced one or more asthma exacerbations in the previous year. This is in line with its licensed indication. The use of long-acting muscarinic antagonists (LAMA) is recommended in NICE and BTS/SIGN guidelines for asthma. Spiriva® Respimat is the only LAMA licensed for asthma, which is indicated as an add-on maintenance bronchodilator treatment in patients aged 6 years and older with severe asthma who experienced one or more severe asthma exacerbations in the preceding year.
5. New applications	

Fostair® 100/6 MDI, Symbicort® 200/6 turbohaler, and Fobumix® 160/4.5 easyhaler are the recommended medium-dose ICS/LABA combination treatments, however, Fostair® and Symbicort are the most commonly used in practice. The cost of using Trimbow is more cost-effective (£541.42 annually) compared to using Fostair and Symbicort with Spiriva Respimat (annual cost £632.00 and £616.00 respectively). Fusacomb easyhaler with LAMA is slightly cheaper (annual cost: £538.00) than Trimbow.

Dr Gonem joined the meeting and explained that Trimbow will be particularly useful for patients who are already on MDI particularly Fostair®, who need to step up their treatment due to inadequate control. The current practice is to prescribe Spiriva® respimat (LAMA component) as a separate device in addition to the ICS/LABA device. Spiriva® respimat required a tutorial session with the nurse or pharmacist, but with Trimbow®, this will not be needed due to the similar shape and device mechanism. Having a single inhaler device will also be more convenient for patients and a greener option compared to using two inhaler devices. It was also highlighted that the aim was to control the patient's asthma without having to go to a high dose inhaled steroid, particularly those patients with symptoms of breathlessness on exertion, not exacerbating that often, and who are not particularly eosinophilic. Conversely, Trimbow® cannot be used as a maintenance and reliever therapy for patients on MART. In most cases, patients under MART will be using salbutamol as the reliever, however, in theory, Fostair® could be used as a reliever on top of Trimbow®.

Dr Gonem also highlighted that it is reasonable to stop Trimbow® if the patient has not improved after two months.

JFG felt that it was reasonable to take this forward as Amber 2 for this niche group of patients.

ACTION: SW to take to APC with a recommendation to include in the formulary for asthma with an Amber 2 classification.

b) Lyumjev® (Insulin Lispro). Dr Buddhike Mendis joined the meeting at 4.10pm

LK presented the formulary submission that had been received for Lyumjev®, which is a faster acting version of Humalog®, the current insulin lispro preparation on the formulary. Lyumjev® is available as two strengths but the submitter had confirmed that there is no clinical need for the U200 preparation locally.

Lyumjev® has been shown in trials to be more effective at controlling post-prandial glucose levels and may be particularly useful in patients where tight post-prandial glucose control is desired. It had been suggested that the main patient groups in which this will be considered are pregnant women and patients with an insulin pump.

The benefit in trials were improved post-prandial glucose control, particularly after breakfast as it offers faster control and can be administered just before or during a meal. Trial data however showed that benefits were lost when administration was 20 minutes after the start of a meal. Cost is the same as Humalog®. The safety profile is similar to Humalog®, but trials showed there was

	an increased incidence of injection site reactions. Dr Mendis highlighted that anecdotally from experience in Derby, treatment with Lyumjev® hasn't been terminated in any patients due to injection site pain. Dr Mendis explained international consensus now is that when monitoring patients, total time in range is assessed (blood glucose 3.9- 10 mmol/L). Ideally time in range should be 70%. FreeStyle LIBRE data shows time in range and postprandial blood glucose excursions are more easily identified. DK asked about risk as two insulin lispro formulations would potentially be available on the formulary and one is faster acting. Dr Mendis felt the benefits outweighed any risk and confirmed that their brand names would be used. Cost-effectiveness was discussed, SH pointed out that although Lyumjev is similarly priced to Humalog® and Novorapid®, it is approximately 30% more expensive than the new insulin aspart biosimilar, Trurapi® and the introduction of Lyumjev could prevent uptake of cost saving biosimilars in future. After discussion, it was agreed that this should be approved for the specific cohorts initially where the most benefit is expected to be seen (antenatal patients, patients with an insulin pump and patients with a FreeStyle Libre sensor where time in range can be measured) and for consultant initiation only. Clinicians should be requested to audit results with a view to bringing back audit data in 6 months, but a decision on what needs to be audited required further clarification. The number of patients with Freestyle Libre sensors also needed clarification to determine potential patient numbers in this group. **ACTION: LK to clarify the treatment pathway for Novorapid vs Humalog to determine whether Lyumjev could prevent future uptake of biosimilars. LK to take to APC**
6. Formulary amendments	**FOR INFORMATION - Log of minor amendments carried out** No comments made - no further action required. **FOR DISCUSSION** • Restandol® (testosterone) – these have been discontinued. SW has updated the shared care protocol and information sheet. The relevant specialists have been informed of the discontinuation. • Fluoride enriched toothpaste – a significant amount of toothpaste prescribing was taking place across the CCG; the formulary currently does not give a clear duration of treatment. The maxillofacial team have been contacted and they state that treatment could be lifelong and the patient would need to be registered with a dentist for the prescribing. LK queried how dentists were informed that a patient needs fluoride enriched toothpaste. Currently, dental prescriptions do not fall under the CCG medicines budget; it was thought this was a national budget. The feeling from the group was that long term repeat prescribing by the GP was not the best practice. AW explained Healthwatch was currently

	doing a survey to find out how many people have not been able to see a dentist in the last year (whether this will differentiate between the covid impact was unknown). The Healthwatch survey continues throughout December and the report should be out early in 2022 **ACTION: SW to contact the maxillofacial team to ascertain the pathway for care and clarify what information is relayed to patients and dentists.** • Diazepam rectal tubes 2.5mg – these have been discontinued. Alternative parenteral and non-parenteral preparations remain available. • Diflucortolone valerate (Nerisone®) – had been discontinued a year ago but is now available again. JFG felt as a more cost-effective alternative was available it should remain grey (remove the word discontinued from the formulary). • Potassium citrate with citric acid effervescent tablets - The traffic light query was due to a recommendation made by a urologist to prescribe potassium citrate due to kidney stones. This is also in line with the CKS recommendations. SH clarified that this was used to decrease stone recurrence in patients with calcium nephrolithiasis. **ACTION: Amber 2 for patients with recurrent kidney stones.** • Tacrolimus 0.03% and 0.1% ointment (Protopic®) and Pimecrolimus 1% cream (Elidel®) - A traffic light reclassification request had been made for Amber 3. Currently, this ointment is for specialist initiation only and is usually for short term treatment - to stop if no response after 6 weeks. Unlicensed for use in psoriasis. **ACTION: SW will contact the dermatologists at NUH and SFHT to ascertain their views, gather more information on cancer risk and consider an information sheet.** • Oral Nutritional Supplements - request for several new products from Matthew Lawson, Senior Medicines Optimisation Dietitian. All additions are expected to be Amber 2. LC questioned whether new products should be treated like other new products (i.e., with a submission). Rather than a formal submission, additional information as to the rationale behind the new product request (with the exception of additional flavours) was required alongside confirmation there was no conflict of interest. The next ONS review is September 2023. **ACTION: SW to gather the additional information required.** All other formulary amendments were agreed. **ACTION: SW to take to APC**
7. Horizon scanning	**New publications for review** All horizon scanning suggestions were agreed, with the exception of the following which warranted further discussion: • DPI Budesonide and formoterol fumarate dihydrate (WockAIR® 160 micrograms/4.5 micrograms inhalation powder) - Possibly a cost-effective alternative to Fobumix® and Symbicort®. **ACTION: KR to compare costs of current budesonide/ formoterol options.** • Molnupiravir (Lagevrio® ▼200 mg hard capsules) - Indicated for the treatment of mild to moderate coronavirus disease 2019 (COVID-19) in adults with a positive SARS-COV-2 diagnostic test and who have at least one risk factor for developing severe illness. DS explained this was currently not yet available, however, shipment to the UK was expected

	with a month. Guidance was awaited from the NHS and the Department of Health. **ACTION: To be discussed further once guidance is available** • Berotralstat 150 mg (as dihydrochloride) hard capsule, (Orladeyo® ▼150mg hard capsule). For routine prevention of recurrent attacks of hereditary angioedema (HAE) in adults and adolescents aged 12 years and above. DS noted that grey no formal assessment had been recommended. However, NICE TA 738 has recommended it as a treatment option from October 2021. This was reviewed by NUH DTC and given a red classification. **ACTION: KR to update the formulary** **NICE Guidelines, TAs and Evidence summaries** Noted – no further action required
8. Acamprosate and Pabrinex Traffic light reclassification	**Acamprosate** HG informed the group that a request had been received from Dr Stephen Willott, Clinical Lead for Alcohol & Drug Misuse, to consider a traffic light reclassification of acamprosate from Amber 2 to Amber 3. Currently, Nottinghamshire JF supports GPs/NMPs in primary care, who have received appropriate training, to initiate as per Notts APC alcohol dependence guideline. Implications for Secondary Care: Less referrals to specialist substance misuse services to initiate acamprosate. Improved intervention in primary care may lead to improved outcomes for problematic drinkers as well as reduce the need for acute interventions in secondary care. Implications for Primary Care: Potential increase in prescribing Acamprosate. HG explained that NICE CG115 recommends acamprosate be prescribed alongside appropriate psychological intervention. It is unclear whether a patient could access this if not under the specialist alcohol service. EG queried how a GP would be reassured that a patient had successfully detoxed in primary care if that patient isn't already known to them. The group's consensus opinion was that a traffic light classification probably wouldn't be effective in encouraging reluctant GPs to take up prescribing of acamprosate. The formulary wording was felt to already be sufficient to allow appropriately trained prescribers to initiate acamprosate in primary care. **ACTION: JFG recommend Amber 2 classification, to be discussed further at December APC.** **Intra Muscular (IM) Pabrinex** Alcohol services (CGL) in the City and County administer IM Pabrinex to appropriate patients detoxifying from alcohol in the community. In the County this service is being provided in Mansfield but nowhere else. The City has commissioned GPs with a special interest in substance misuse, so access to IM Pabrinex in the community is better. In the County, however, there is no such commissioned service. There are GPs in the County providing an enhanced service for homeless people but the homelessness nurse has noted some reluctance of GPs in the county to prescribe IM Pabrinex without specialist

	input. It was queried whether the homeless nurse/team is specialist enough to recommend IM Pabrinex and therefore be classed as 'the specialist' for this purpose. GPs who do not have a special interest in substance misuse, may not feel competent to prescribe IM Pabrinex without specialist input. The risk was discussed and IM held a tiny risk of anaphylaxis, but facilities to treat anaphylaxis should be available when IM pabrinex is administered. EG queried whether a PGD for IM pabrinex could be considered. TB queried where the issues are in the County and whether these have been addressed locally with the practices in question. AA queried IM pabrinex availability in the community and whether this can be kept in practice or obtained quickly enough from community pharmacies. The decision was to recommend Amber 3 but liaise with the submitter about the possibility of a PGD. **ACTION: JFG recommends Amber 3 classification, to be discussed further at December APC.** **HG to liaise with the submitter about possible service changes including PGD to improve access.**
9. Dates of next meeting	20th January 2021 (Via Microsoft Teams). Chair: Debbie Storer **Chair Rota**
10. AOB	**Enoxaparin requests from midwives** LC explained that community midwives were requesting prescriptions of enoxaparin from GPs. It was highlighted that they are requesting Clexane rather than Inhixa. Both brands were listed on the formulary, but Inhixa is the preferred brand. Clexane is more cost effective in primary care. There appears to be no primary care guidance for antenatal use and with the traffic light status being Amber 2 – specialist recommendation it was questioned if a midwife would be included in the interpretation of "specialist". **ACTION: Interface team to take forward and feedback if needed.** **Meeting dates and chairs** All happy to continue as a rolling rota. KR will review the dates for potential school holiday clashes and bring them to the next meeting. **ACTION: KR to review and bring forward any potential clashes.**

The meeting finished at 17:10hrs