Nottinghamshire Area Prescribing Committee Formulary Meeting Minutes Thursday 19th June 2025: 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 Integrated Care Board (ICB)**
Tanya Behrendt (TB)	**Senior Medicines Optimisation Pharmacist**	**NHS Nottingham & Nottinghamshire ICB**
Ann Whitfield (AW) until 16:15	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
David Kellock (DK)	**Consultant in Sexual Health and SFHT DTC Chair**	**Sherwood Forest Hospitals NHS Foundation Trust**
Jennifer Moss Langfield (JML)	**GP**	**City Place-Based Partnership (PBP), Nottingham & Nottinghamshire ICB**
Khalid Butt (KB)	**GP**	**Local Medical Committee (LMC) Representative, Nottinghamshire.**
Asifa Akhtar (AA)	**GP**	**South Notts PBP, Nottingham & Nottinghamshire ICB**
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**
Zen Dong Li (ZD) from 14:30	**Interim principal pharmacist for Adult Mental Health community teams**	**Nottinghamshire Healthcare NHS Trust**
Georgina Dyson (GD)	**Advanced Nurse Practitioner**	**Nottingham CityCare Partnership**
Jacqui Burke (JB)	**Advanced Nurse Practitioner**	**Willowbrook Medical Practice Ashfield North Primary Care Network (PCN)**

In Attendance:
Bruno Gran, Consultant Neurologist, NUH, for agenda item 6b
Anna Hill, Specialist Pharmacist, NUH, for agenda item 6b
Nikos Evangelou, Consultant Neurologist, NUH, for agenda item 7b

Observing:
Sue Haria (SH), Medicines Optimisation Pharmacist, NHS Nottingham & Nottinghamshire ICB

NHS Nottingham & Nottinghamshire ICB Interface Support in attendance:

Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFHFT.
Lidia Borak (LB), Specialist Medicines Optimisation Interface Pharmacist.

1. **Welcome and apologies.**

APC members were welcomed, and apologies were noted.

2. **Declarations of interest**

APC members, attendees and the APC support team made no declarations of interest.

3. **10-minute learning session:**

SH presented a short learning session on Misleading Yourself and Letting Go Of Old Knowledge. The recording and slides will be kept for future training purposes.

1. **Minutes of the last meeting**

The minutes of the last meeting were agreed as an accurate record, subject to minor corrections.

2. **Matters arising and action log.**

Matters arising

Cytisine for smoking cessation
An update on the availability of cytisine through community-based smoking cessation services was provided. Thriving Nottingham were finalising arrangements but would be able to prescribe medications imminently. This will harmonise the availability of prescribed medications for smoking cessation via local smoking cessation services.

Heylo submission audit criteria
LB provided an update on the audit criteria for Heylo. There had not been any local prescribing to date.

ACTION: LB to feedback on further developments.

NICE TA1026 – Tirzepatide for overweight & obesity
In line with NICE compliance deadlines, tirzepatide would be available in Primary Care for those eligible patients ie that meet the NHS England clinical criteria. Locally this will be managed via a centralised service that practices refer into. Individual GP practices would not be expected to prescribe for obesity. The ICB would be circulating imminent communications about this with local referral criteria. The process for Secondary Care referrals is being confirmed.

ACTION: LC to confirm arrangements for Secondary Care referrals.

Doxylamine / Pyridoxine (Xonvea) for nausea and vomiting in pregnancy (NVP)
An update was provided following discussions about a formulary submission for doxylamine/ pyridoxine at the previous APC meeting. NUH clinicians had confirmed support for the availability of this medication as a treatment option for NVP; it was suggested that it is an option after cyclizine, promethazine and prochlorperazine have not been effective or not tolerated and before ondansetron or metoclopramide are considered. Although accurate financial predictions were difficult due to variable doses and durations, predicted patient numbers and extrapolation from usage in other areas indicated that this medication may result in a cost implication around the APC's threshold for financial approval.

Concerns were expressed about the poor clinical evidence and potential demand for this medication if it was made available in Primary Care. NICE had confirmed that its inclusion in guidance was driven by it being the only licensed treatment option; supporting evidence was of poor quality and not compelling, but other more evidenced treatment options such as metoclopramide and ondansetron had associated documented risks and restrictions.

The cost of admission for rehydration was highlighted and therefore the potential for this medication to reduce that cost by either preventing or shortening a hospital admission. After discussion, the committee agreed that doxylamine/ pyridoxine should be available as AMBER 2 for Specialist initiation for those patients with severe hyperemesis that had been reviewed in Secondary Care, i.e. on the Early Pregnancy Assessment Unit (EPAU) or during an inpatient admission. Prescribing trends and volume should be monitored after 6 months.

It is anticipated that if use is restricted for initiation by Specialists to patients with severe hyperemesis, the cost implication will be within the APC's mandate and potentially offset by reduced activity costs.

ACTION: LK to update the formulary with an AMBER 2, Specialist initiation classification. LK to add reference to the restriction to the NVP guideline. LK to discuss with Optimise Rx and SystmOne teams regarding configuring systems to encourage only appropriate prescribing. LK to add to action log to review prescribing in 6 months' time.

Action log:

The action log was noted by members.
All the other items from the previous meeting(s) have been actioned or are on the agenda for further discussion or feedback.

3. New applications (LK)

a) Thealoz Duo

Formulary submissions for Thealoz Duo had been discussed twice previously by the APC and in both instances the product had been rejected. A further request had been received for its use in severe dry eye disease with coarse, confluent epithelial erosions; filamentary keratitis; enteral superficial epithelial keratitis; punctate keratitis and severe dry eye syndrome unresponsive to other dry eye lubricating eye drops. An AMBER 2 classification had been requested and it was anticipated that it may be offered as an alternative to Hylo-Forte.

Ocular lubricants are licensed as medical devices and there is a lack of good quality comparative trials. No new evidence had been found since the previous submissions. Although if used in place of Hylo-Forte there would be a small cost saving, these products are more expensive than other products available containing sodium hyaluronate.

The wider use of eye lubricant products was discussed at length, with the considerable spend on products such as Hylo-forte noted. It was suggested that this topic be escalated for consideration of a cost-efficiency programme at ICS-wide level involving ophthalmology and opticians who may recommend these products. It was felt that the current formulary list of products could potentially be rationalised and that there was an opportunity for efficiencies to be achieved from patient reviews and step-downs of treatment.

ACTION: Thealoz Duo to remain GREY. LC/ MC to raise this topic via ICS efficiency groups for prioritisation as a system-wide cost- efficiency project.

b) Sativex for Multiple Sclerosis (MS)

A formulary submission had been received for Sativex for the treatment of spasticity associated with MS. Sativex is recommended in NICE clinical guidance with an “offer” recommendation and proposed usage is in line with the NICE recommendation. An AMBER 2 classification had been requested, with patients being transferred to Primary Care only after stabilisation. NICE guidance supports prescribing in Primary Care but suggests a more defined Shared Care approach. However, there were no specific monitoring requirements asked of Primary Care.

Dr Bruno Gran and Anna Hill were in attendance and confirmed that, prior to initiation, patients would be discussed via an MDT to ensure that appropriate clinical criteria were met. It was highlighted that Sativex is available for Primary Care prescribing in Derbyshire and similar guidance could be developed locally. Assurance was given that there was confidence in the patient numbers proposed.

Some concerns were raised about the suitability of this for Shared Care and the potential for a lack of GP support causing problems over Shared Care refusals. GP members felt that this might be seen as additional workload requiring additional remuneration, but it was highlighted that, prior to trying Sativex, alternative agents would otherwise have been managed in Primary Care.

Although anticipated patient numbers were small, due to the cost of Sativex there was potential for this to reach the APC’s financial threshold so escalation for financial sign-off was required. As this medicine is a High-Cost Medicine commissioned by the ICB*, similar financial approval was required, whether it was to be prescribed in either Primary or Secondary Care.

APC members agreed to clinically approve Sativex for use locally in line with the NICE recommendation, but a Traffic light classification was not agreed. Sativex will be escalated for financial approval and once this had been confirmed, discussions could continue about the most appropriate prescribing arrangements.

ACTION: LK/TB/LC to escalate Sativex for financial approval by the ICB. If financial approval is granted, Sativex will be brought back to APC for a decision on Traffic light classification.

**Post meeting note: it was confirmed following the meeting that Sativex is not classified as a High-Cost Medicine.*

c) Nebivolol

A formulary submission had been received for nebivolol, a cardio-selective beta blocker. It had been requested that this be available as an option as a second line beta blocker for those unable to tolerate bisoprolol due to side effects. Although there are several beta blockers available, pharmacological differences result in different side effect profiles. Nebivolol is specifically licensed for hypertension and Heart Failure in those aged older than 70 years. However, the age restriction for Heart Failure is based on specific trial inclusion criteria; there is no evidence to support clinical superiority over other beta blockers.

When compared to other second-line beta blockers, nebivolol is similar or less expensive than other options when the 5mg tablets are used. Other strengths are significantly more expensive, and there are 5mg tablets that are licensed for halving and quartering. Considerable quantities of nebivolol are already prescribed in Primary Care, and it was suggested that there could be a cost-efficiency opportunity if those patients prescribed more expensive strengths were reviewed and switched to 5mg tablets. The possibility of a payment to community pharmacies for halving or quartering tablets for those unable to do this themselves was raised as an invest-to-save initiative.
The APC agreed that nebivolol should be available with an AMBER 2 classification for those patient's intolerant of other beta blockers but usage should be restricted to the 5mg tablet strength.

ACTION: LK to update the Joint Formulary with an AMBER 2 classification for the 5mg tablet strength. Other strengths are to remain GREY. LK to liaise with Optimise Rx and SystmOne teams regarding appropriate messages; dose titration should be encouraged as part of a clinical review for those patients prescribed low doses.

d) Linzagolix for uterine fibroids

Following a positive recommendation in NICE TA996, NUH had requested that linzagolix be considered for an AMBER 2 classification. However, it had subsequently been suggested that this should be considered alongside the recent TA1067 recommendation for its use for the treatment of endometriosis as well as the use of Ryeqo, which is also recommended in NICE TAs for these indications but was classified RED for the treatment of uterine fibroids.

LK informed the APC that management of this cohort of patients is currently via Secondary Care, either for GnRH injections or Ryeqo but that there was support from both acute trusts for the prescribing of the oral medications to be transferred to Primary Care. Responsibilities for monitoring would require defining as a bone density (DEXA) scan is required after one year of treatment.

GP members were generally supportive of a potential Shared Care approach although it was felt that this was likely to require a larger piece of work with pathway redesign potentially being incorporated. JML offered her support to the project.
Due to NICE compliance deadlines, it was suggested that these TAs be taken to trust DTCs for interim RED classifications whilst this work is carried out. LK confirmed that they are being taken to SFH DTC.

ACTION: LK/ LC to escalate for consideration of pathway redesign. LK to feed back on progress.

4. Formulary amendments

Due to time constraints during the meeting, the Formulary amendments included in the papers were not reviewed; however, following circulation via email, they were confirmed by members.

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

Galantamine tablets – Removed from list of available formulations as discontinued.

Alprostadil vials - Pfizer have launched a generic version of Caverject vials (which are to be discontinued). The formulary has been updated to reflect this and Optimise Rx messages have been requested.

Allevyn non-adhesive foam tracheostomy dressing – formulary annotated to reflect that it is no longer available on FP10. Available via NHS Supplies for community teams.

Permafoam tracheostomy dressing - available in Primary Care on an FP10 but no longer available from NHS Supply Chain. The formulary entry has been updated to include additional information about supplying the dressing.

Survimed® OPD 1.5kcal – changed from GREY to AMBER 3 in line with updated guidance for management of PERT shortage. This is a temporary reclassification in line with Vital 1.5cal and Peptisip Energy HP, to be reviewed once the shortage improves.

Menitorix (Hib/MenC) vaccine - discontinued and from 1st July 2025 will no longer be part of routine immunisation schedule for infants born after 1 July 2024. To be reclassified as GREY once stock is exhausted.

Medihoney CE marked products – most Medihoney wound management products have been discontinued and reclassified as GREY. NB Medihoney barrier cream has not been discontinued and therefore remains available.

(b) FOR DECISION – Suggested amendments

AMBER 2

Activon tube, Algivon, Actilite will be added to the formulary as replacements for the discontinued Medihoney products. Activon tulle will also be added for use if Actilite is not suitable.
ACTION: Interface team to update formulary.

- **Atogepant and Rimegepant traffic light re-classification**

A request had been received from neurology at NUH for a reclassification of rimegepant and atogepant from AMBER 2 to GREEN. This would allow a more cost-effective model of care and

generate capacity within Secondary Care as currently use of these medicines for migraine prevention requires initiation by a Specialist, with a review of treatment after 12 weeks.

Dr Nikos Evangelou was in attendance for this item and explained that it was felt that Specialist initiation was unnecessary and the majority of patients that are referred are given a gepant. Therefore, removing the restriction was unlikely to increase usage. It was also felt that the Specialist review at 12 weeks was unnecessary and may be performed in Primary Care. Others disagreed and felt that referral criteria prevent inappropriate use in patients that have not been fully optimised on treatments recommended earlier in the pathway. GP members were concerned that if the responsibility for treatment review was shifted to Primary Care, it may not be done satisfactorily, leading to increased usage of these medicines.

After discussion, it was agreed that rimpegepant and atogepant would remain classified as Amber 2, but that Specialist recommendation rather than initiation was sufficient, eg via an Advice and Guidance request. Neurology will be asked to produce a standard template letter to accompany the reply, to ensure that the patient has first tried all other options at the optimised dose before starting a gepant. If being used for migraine prophylaxis, advice about the requirement for a 12- week review will be provided. Although this information was already in the APC headache pathway, it was felt that this would help enforce the guideline, given the high cost of these medications.

ACTION: LB to update the formulary with an AMBER 2, A&G - Specialist recommendation classification and APC headache pathway.

5. Horizon Scanning

Due to time constraints during the meeting, the medicines identified as part of the horizon scanning process included in the papers were not reviewed; however, following circulation via email, they were confirmed by members.

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

GREEN

- Supemtek TIVr (influenza vaccine) and Vaxigrip (Influenza virus inactivated split vaccine) – both listed in the Green Book and added to the Joint Formulary as keywords of the influenza vaccine entry.

GREY

- Suvexx (sumatriptan/ naproxen) tablets for the treatment of migraine – not cost-effective when compared with individual constituents sumatriptan and naproxen prescribed separately.
- Rivaroxaban oral suspension 5 mg/ml – an alternative strength (1mg/ml) is currently in use for paediatric patients. Potential risk for medication errors from availability of alternative strength. This has been highlighted to SystmOne and Optimise Rx teams.

GREY no formal assessment

- Estetrol (Donesta) oral tablet – hormone replacement therapy for oestrogen deficiency symptoms in postmenopausal women.

Other

- Roxadin (testosterone undecanoate) 1000mg/4ml injection- a more cost-effective branded generic alternative to Nebido. Drug tariff pricing will be monitored and recommendations for prescribing of testosterone undecanoate reviewed during update of PPL.

ACTION: Interface team to update formulary/ add to action log.

- **(b) New NICE guidelines**

NG249: Falls: assessment and prevention in older people and in people 50 and over at higher risk – was noted; APC falls prevention guideline due to be reviewed January 26.

TA1067:Linzagolix for treating symptoms of endometriosis – this was discussed as part of the linzagolix for uterine fibroids item.

CG150: Headaches in over 12s: diagnosis and management - NICE have changed the strength of recommendations on migraine prevention to make the use of topiramate or propranolol a 'consider' recommendation alongside amitriptyline, to reflect better the balance between the benefits and harms associated with the 3 medicines ; the APC Headache pathway will be updated in due course.

ACTION: LB to work on updating the APC Headache pathway

6. **For Ratification – Antipsychotics Prescribing Guideline- updated to include Treatment Resistant Depression indication**

The use of antipsychotics for Treatment Resistant Depression (TRD) was discussed at the February APC meeting and was accepted with an Amber 2, Specialist Initiation classification, subject to incorporation into the Antipsychotics Prescribing Guideline.

The guidance had been updated by Notts HC and was presented for ratification. It was requested that guidance be added about when treatment reviews should be undertaken, but otherwise APC members were happy to approve the updated guidance. It was suggested that the updated guidance be circulated to GP practices that had queried this use of antipsychotics previously, such as Cripps Health Centre and Radford Medical practice.

ACTION: ZD to liaise with John Lawton about additional information on treatment reviews being added to guideline. LK to upload finalised guidance to APC website and circulate to APC members and the GP practices suggested. LK to update formulary to reflect the agreed AMBER 2, Specialist initiation classification for amisulpride, aripiprazole, olanzapine, risperidone and quetiapine MR for Treatment Resistant Depression.

7. Nottinghamshire Stoma Ancillary Items Formulary (LC)

The Nottinghamshire Stoma Ancillary items formulary had been reviewed and revised with NAMS and input from the acute nursing team and NAMS patient steering group. It was requested that any feedback be forwarded to LC, otherwise APC members supported approving the updated formulary.

ACTION: Interface team to upload the updated formulary to the APC website.

8. Any Other Business

Direction to administer guidance - it was asked whether the APC had insight into the requirement to re-authorise medications monthly as this may be onerous for some medications such as insulin and anticipatory medication. As this was not an APC guideline it was suggested that the Direction to Administer working group be asked.

Transgender Position statement- it was highlighted that some changes were required to this following NHS England changes regarding children. The updated version would be circulated via email. It was asked whether there was any progress on a Locally Enhanced Service (LES) for this and it was confirmed that this is progressing.

ACTION: TB to circulate the updated position statement via email. LC to feed back with progress on LES.

It was highlighted that NUH were changing brands of dorzolamide following contract changes.

ACTION: DS to follow up with LK

APC Guidelines meeting: Thursday 23rd July 2025 (2pm to 5pm, Microsoft Teams)
APC Formulary meeting: Thursday 28th August 2025 (2pm to 5pm, Microsoft Teams)

The meeting closed at: 17:15.