Nottinghamshire Area Prescribing Committee Formulary Meeting Minutes Thursday 18th December 2025: The meeting took place as a hybrid meeting, in the Boardroom, Sir John Robinson House, Sir John Robinson Way, Arnold, Nottingham, NG5 6DA and 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)	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
Katie Sanderson (KS)	**Patient Representative**	**Nottingham & Nottinghamshire ICB local population**
Jennifer Moss Langfield (JML)	**GP**	**City Place-Based Partnership (PBP), Nottingham & Nottinghamshire ICB**
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 Drug and Therapeutics Committee (DTC) Pharmacist**	**Nottingham University Hospitals NHS Trust**
Mark Clymer (MC)	**Assistant Chief Pharmacist**	**Sherwood Forest Hospitals NHS Foundation Trust**
Gladys Maponese (GM)	**Deputy Chief Pharmacist and Head of Community Health Services and Forensic Health**	**Nottinghamshire Healthcare NHS Trust**
Georgina Dyson (GD)	**Advanced Nurse Practitioner**	**Nottingham CityCare Partnership**
Nicola Graham (NG)	**Senior Transformation Manager**	**NHS Nottingham & Nottinghamshire ICB**
Jacqui Burke (JB)	**Advanced Nurse Practitioner**	**Willowbrook Medical Practice, Ashfield North Primary Care Network**

In Attendance:
Dr Mark Fenner Paediatrician, NUH, for agenda Item 5a.
Chris Pudney, Specialist Clinical Pharmacist, Palliative Care, NUH, for agenda item 5c.
Sue Haria, Medicines Optimisation Pharmacist, Nottingham & Nottinghamshire ICB, for agenda item 4.
Nichola Butcher, Interim Senior Medicines Optimisation Pharmacist, Nottingham & Nottinghamshire ICB, for agenda item 9.

Observing:
Naumaan Ahmed and Amy Irvine, Medical students, University of Nottingham.
Alexandro Nlemchi and Bethany Chadwick, Trainee Pharmacists, SFHT.
Nicola Buxton, Medicines Optimisation Technician, Nottingham & Nottinghamshire ICB.

NHS Nottingham & Nottinghamshire ICB Interface Support in attendance:
Lynne Kennell (LK), Specialist Interface & Formulary Pharmacist for SFHFT.
Karen Robinson (KR), Specialist APC Interface and Formulary Pharmacy Technician.
Lidia Borak (LB) – Specialist Medicines Optimisation Interface Pharmacist.
Irina Varlan (IV), 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.

One of the clinicians involved in the enalapril orodispersible (Aquameldi) submission had declared receiving educational support (reduced price conference ticket for the British Congenital Cardiac Association conference meeting).

3. Minutes of the last meeting

The minutes of the previous meeting were accepted as an accurate record.

4. Matters arising and action log

LC provided a brief overview of the future of the APC alongside the NHS 10-year plan. Members were updated on the ongoing ICB restructure and clustering with Derby and Derbyshire, and Lincoln and Lincolnshire ICBs. Significant staffing cuts are expected to take place early in 2026. Therefore, the future of the APC in its current form is uncertain.

Weight management: LC updated the APC on an expansion to eligible cohorts from June 2026 currently being worked on with the service. It had been fed back to the Pathways Design team that the APC is concerned about Secondary Care having no mechanism to refer directly to the service. LC will return any feedback to a future APC meeting.

Sativex: work had begun to develop a Shared Care Protocol following a formulary submission discussed at the August meeting. The first month of treatment is supplied free of charge by the manufacturer and a patient review is then required to confirm suitability for ongoing prescriptions. It had therefore been suggested that Secondary Care provide the first

two months' supply, in line with practice in Derbyshire. However, NUH had indicated that funding was unavailable for the medication to be prescribed internally above the one-month free supply. The MS service had suggested that patients take a one-month treatment gap whilst awaiting transfer to Primary Care. Members felt unable to support this practice and suggested that a request for funding was discussed between the submitter and NUH Drugs and Therapeutics Committee (DTC).

ACTION: SH will inform the submitters of the APC's decision.

FreeStyle Libre 3 prescribing data had been reviewed and it had been noted that there appeared to be more patients being prescribed this product than initially anticipated. This is being investigated further as there were concerns that it may be being prescribed to T2DM patients, and ways to limit this happening were being discussed.

Heylo Coloplast sensor device audit data had initially been requested for review at 6 months; to date, no patients have been initiated. The monitoring of Heylo prescribing will continue, and the findings will be returned to a future APC meeting.

Ciclosporin 0.9 mg/ml eye drops (Cequa) for dry eyes
LB provided a verbal update on ciclosporin 0.9 mg/ml eye drops, explaining that a new product, Vevizye, had now also been launched (although it was not yet listed in the Drug Tariff). LB is awaiting further information on the new product and opinion from the submitters about the use of Cequa or Vevizye.

ACTION: LB to bring ciclosporin eye drops back to APC in February for further discussion and a decision.

5. New applications

5(a) Enalapril orodispersible (Aquameldi)

LK presented a submission for enalapril orodispersible (Aquameldi), with input from Dr Mark Fenner, Paediatrician from NUH.

Enalapril is used in paediatrics for the treatment of heart failure, hypertension and proteinuria in nephritis. When enalapril doses reach 2.5mg, a dispersed regular tablet is the most cost-effective option and this is currently prescribed in Primary care. For children requiring smaller doses, a 1mg/ml liquid formulation has been used at NUH and was classified as RED due to it being unlicensed. There is now a licensed liquid formulation but this is of significant cost. Enalapril orodispersible tablets offer a more cost-effective option as well as other significant benefits, including greater dosing accuracy and a longer expiry date. This is also the product used at the local tertiary centre.

The submitters clarified that patients would not be discharged into Primary Care and confirmed that all monitoring would remain in Secondary Care. GPs requested the blood results in a letter, as the results are not available on the Integrated Clinical Environment (ICE) platform.

The clinicians felt additional discussion was required regarding the availability of blood test results that cannot be seen on the ICE platform. JML will raise this with the Interface groups at NUH and SFHT in her role outside that of being an APC member. Any resulting actions will be brought to a future APC meeting.

ACTION: APC approved the addition of enalapril orodispersible (Aquameldi) to the formulary with an AMBER 2 classification. Relevant blood test results should be provided for Primary Care by letter.
JML to discuss the current issues with ICE and provide the APC with the outcome of the discussions.

5(b) Inhaled levodopa (Inbrija)

LK presented a formulary submission for inhaled levodopa (Inbrija). LK provided an overview of the inhaler device, explaining its intended use during 'OFF periods' of Parkinson's disease. Limitations with the practicalities of the device render it likely to require carer assistance for administration, due to the lack of dexterity which may be experienced during an OFF period. Currently, subcutaneous apomorphine may be used in some patients for the management of 'OFF periods'; however, this is unsuitable for many patients, due to co-morbidities, side-effect profile, need for injection and anti-emetic drug pre-medication. Inhaled levodopa offers an alternative for those patients who are unsuitable for apomorphine.

Clinical trials have compared inhaled levodopa to placebo; there are no active comparator trials. It would be used on an as-required basis and usage is likely to be variable. Based on an average of 2 doses per day seen in trials, the inhaler device costs around £6,000 a year, which is £2,000 more per patient than the equivalent medicine cost of apomorphine. If used in those patients that would not receive apomorphine, this will be an additional cost which could reach the APC's financial mandate, depending on patient numbers. Another new product has recently been launched, a sublingual apomorphine tablet, which, although it requires dose titration and may not be suitable for all patients because of co-morbidities, is less expensive than inhaled levodopa.

APC recognised that the product may have a place in therapy for some patients but deferred a classification decision as it was felt that the inhaled levodopa should be considered alongside sublingual apomorphine. It was requested that a treatment algorithm be presented indicating proposed patient groups for these products. Other questions raised included clarity about the usual frequency of OFF periods and mechanisms for referring patients back to the service if significant numbers of doses/ inhalers are being used.

ACTION: LK to inform the submitters of the decision and return with a treatment algorithm/ pathway to include sublingual apomorphine tablets.

5(c) Parecoxib
LB presented a submission for parecoxib injection which requested consideration for the reclassification from RED to AMBER 2 of subcutaneous parecoxib for pain management in End of Life (EoL) care. Currently, in Nottingham parecoxib is prescribed and supplied for palliative care patients in Secondary Care, except for North Nottinghamshire/Bassetlaw, where it is also prescribed in Primary Care, on the recommendation from the Palliative Care Team or following hospice discharge.

The committee supported the change from RED to AMBER 2, clarifying its use for those patients who lose an oral route for medication administration as they approach EoL and pending its inclusion in the Last Days of Life guideline and/or the provision of a Prescribing Information Sheet.

ACTION: LB to update the submitters with the AMBER 2 classification agreed. The Joint Formulary will be updated once the Last Days of Life guideline or prescribing sheet has been updated and ratified at the January APC meeting.

6. Formulary Amendments

a) For information – Log of minor amendments already completed

GREY

- Exenatide prolonged release (Bydureon Bcise) – Discontinued September 2025.
- Buprenorphine 30 & 40 micrograms patches - Higher strengths of weekly buprenorphine patch classified grey.
- Penicillamine – reclassification from AMBER 1 to GREY for rheumatology use following retirement of SCP in 2023. NB It will remain RED for metabolic conditions.

GREEN

- Buprenorphine patches – The buprenorphine patch preferred brand choice changed from Butrans to Sevodyne for the following strengths: 5, 10, 15, 20 micrograms.

AMBER 2

- Revamil Balm (refined peanut oil, white beeswax, glyceryl oleate, honey, purified water, rose oil) - Added to the Joint Formulary as a temporary replacement for Medihoney Barrier Cream.

RED

- Adcortyl (triamcinolone) injection - Reclassified as RED; due to discontinuation it is now only available as an unlicensed product.

OTHERS

- Atomoxetine 4mg/ 1ml oral solution now requires generic prescribing as the Straterra brand has been discontinued.
- Neocate LCP change to packaging and quantity - formulary annotated to reflect the change from 400g to 420g tins; the overarching Cow's Milk Protein Allergy Guideline has been updated with the new quantity.
- Tadalafil - Formulary annotated to reflect removal of generic tadalafil from SLS list.

APC members noted the completed formulary amendments.

ACTION: No further action required.

b) For decision – Suggested amendments presented by LK.

GREEN

- Metformin 500mg/5ml SF – to be added to the formulary alongside other formulations since cost has decreased to similar or lower cost than sachets.
- Dydrogesterone 10mg tablets (Nalvee) - add to the Joint Formulary alongside other HRT products. Currently available as combination products eg Femoston.

AMBER 2

- Latanoprost eye drops preservative-free - 2.5ml multi-dose preservative-free bottle with a 30-day expiry offers a cost saving and an environmental advantage over Monoprost UDVs.

OTHER

- 128ml Phosphate enemas – significantly more expensive than 133ml enemas. Available as long tube and short tube enemas; long tube enemas may be required if a patient self-administers the enema. This had been highlighted to the CRASH team for consideration as a potential workstream due to significant spend. It was suggested that S1 may need configuring to ensure that the 133ml product is suggested as a search option. LK will discuss this with the Optimise and S1 Teams.
- QV skin lotion has been removed from the Drug Tariff and is therefore no longer prescribable on FP10. This will be discussed with the authors of the emollient formulary to assess if there is a need for an alternative product.

GREY

- Nabumetone – significantly more expensive than other formulary NSAIDs; this decision is supported by SFHT and NUH.
- Aerochamber Plus to be removed from formulary due to formulary rationalisation; currently listed alongside Aerochamber Plus Flow Vu Anti-static. The newer device was added following its previous recommendation in Paediatric asthma guidance and both devices are priced equivalent. It was requested that messages be enabled to encourage Spacer prescribing whenever an MDI is prescribed. This will be discussed with OptimiseRx and SystmOne formulary teams to develop suitable messages if considered appropriate.

ACTION: LK/KR to update the Joint Formulary and liaise with Optimise and S1 teams.

7. Horizon Scanning

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

GREEN

- Estradot Conti 30/95 and 40/130 transdermal patch containing estradiol & norethisterone- lower strength patches compared to products currently available. Price comparable to other HRT formulary brands.
- Measles, mumps, rubella and varicella (MMRV) vaccination - 2 brands of combined MMRV vaccines, Priorix-Tetra and ProQuad - From 1 January 2026 MMRV will replace MMR in the routine childhood schedule.

GREY, no formal assessment

- Tuzulby chewable tablet (methylphenidate), 20mg, 30mg, 40mg – Specialist opinion is being sought.
- Hezkue (sildenafil) 12.5 mg/actuation, white to off-white oromucosal suspension.
- AndroFeme (testosterone)10mg/ml cream.
- Feraccru (ferric maltol) – license change to include adolescents > 12 years. APC guideline available supports use in adults.
- Hylo-dual (Sodium hyaluronate 0.05% / Ectoine 2% eye drops preservative-free) and Hylo-dual intense (Sodium hyaluronate 0.2% / Ectoine 2% eye drops) – more expensive than current sodium hyaluronate formulary products.
- Angeliq (drospirenone/ estradiol) 1 mg/2 mg film-coated tablets.
- Axhidrox (glycopyrronium) cream - NICE TA expected March 26- not recommended in draft guidance.
- Zurzuvae (zuranolone) 20mg,25mg, 30mg capsules– Treatment of moderate or severe postnatal depression in adults following childbirth – high-cost medicine.

Other

- Kixel XL (methylphenidate hydrochloride) 18 mg Prolonged-release tablets - highlighted to the authors of the Preferred Prescribing List (PPL) for consideration as a cost-effective brand.
- Ocular lubricants; Aqualube & Ocufresh (Carmellose) and Lacrigel (carbomer 0.2%) to be considered during update of Eye lubricants formulary.

ACTION: KR to update the Joint Formulary.

- **(b) New NICE guidelines**

  - Pneumonia: diagnosis and management. NG250 – The Antimicrobial guidelines were reviewed against this NICE Guidance in November 2025.
  - Chronic heart failure in adults: diagnosis and management. NG106 – The Heart Failure guidelines were reviewed against this NICE Guidance in November 2025.
  - Atopic eczema in under 12s: diagnosis and management. CG57 – This NICE clinical Guidance has no impact on the current eczema antimicrobial guideline.

8. <u>For Ratification – Relugolix – norethisterone – estradiol & linzagolix Prescribing Information Sheet</u>

LK provided a summary of previous APC discussions which agreed to provisional support for Shared management of these medications when used in line with NICE TA recommendations for Uterine fibroids and Endometriosis. As requested during these discussions, a Task and Finish group had been convened to clarify prescribing responsibilities and agree on the patient's journey. It was proposed that treatment initiation would be by the Specialist, with ongoing prescribing passed to Primary Care under a Shared Care model for the first 12 months. A Dual-energy X-ray Absorptiometry (DEXA) scan is required after 12 months of treatment and the responsibility for arranging and actioning this

would remain with the Specialist. If satisfactory and the patient was taking hormonal add back therapy (as relugolix, estradiol, norethisterone combination therapy or with linzagolix), ongoing management would then be passed to Primary Care. Those patients taking linzagolix without hormonal add back therapy would remain under the care of the Specialist, due to the need for ongoing annual DEXA scans.

It had been suggested that Secondary Care provide an initial three-months supply at the same time as writing to the GP to take over the ongoing care. This proposal was for practical reasons, to allow adequate time for clinic letters to be actioned, but would allow for any patient intolerances to be identified. Patients would be reviewed by the Specialist after six months.

A prescribing information sheet had been developed to support prescribers in Primary Care. Minor amendments were suggested and, subject to these additions, members approved the information sheet, together with the previously agreed AMBER 2 classification for the treatment of moderate to severe symptoms of uterine fibroids and symptomatic treatment of endometriosis.

Potential patient numbers are difficult to predict accurately but, based on NICE estimates, there could be a significant cost implication for the Primary Care prescribing budget. The route for financial sign-off within the ICB is currently unclear. It was noted that the NICE TA implementation dates have passed and, as a system, the ICS is not fully compliant. Members asked for this to be escalated with high priority as patients are currently waiting for treatment, and several patient complaints had been received. Currently NUH clinicians were unable to initiate treatment until there was a patient pathway for ongoing prescriptions.

ACTION: LK to make the minor additions to the prescribing information sheet. LC/LK will escalate the funding issues within the ICB.
LK to update the Joint Formulary, ensuring that the clarity of the shared management plan is noted once financial sign- off has been achieved.

9. For Ratification – Penicillin Allergy awareness Leaflet

NB, attending, presented the updated Penicillin Allergy Awareness Leaflet, which had been updated due to reaching its review date.

The main changes include the following:

- The title of the document has changed to Penicillin Allergy Diagnosis and Documentation in Primary Care, as it is intended to be guidance for clinicians.
- Information about allergy prevalence updated, and NICE CG183 added as a reference source.
- Information added about recording a true penicillin allergy as an allergy in the clinical notes and adding other reactions as either a sensitivity or a side effect.
- Information about reviewing allergy labels during routine patient interactions added.
- Red flag, allergy signs and symptoms updated in line with NICE CG183 definition and World Allergy Organisation recommendations for recognising anaphylaxis.

- Link to the Primary Care Dermatology Society added. This website provides visual aids and photographs to aid diagnosis.
- Information about formal penicillin allergy testing added. The adult service is available across the ICB, provided by NUH. Patients under the age of 18 years can be referred to the paediatric services. Link to e-HealthScope and the full referral pathway added.

Members requested collaboration and oversight with the NUH antimicrobial pharmacist. Primary Care clinicians raised an issue related to allergy recording within SystmOne, noting that when inputting an allergy for penicillin, the rarely prescribed penicillamine appears first on the list, which could lead to the erroneous recording of an allergy. Nationally, there has been a Patient Safety Alert issued regarding mislabelling. Actions include reviewing all patients with a recorded penicillamine allergy label and utilising local digital teams to support appropriate recording.
APC ratified the document.

ACTION: Nichola Butcher will contact the NUH antimicrobial pharmacist to review the document. If no amendments are required, a member of the APC Team will finalise and upload the document to the APC website.

10. Any Other Business

- **Patient query – prescribing post gender reassignment surgery.**
  LC raised a recent query regarding the prescribing of vaginal lubricants post-gender reassignment surgery. The APC had discussed previously the prescribing of vaginal moisturisers for patients who had transitioned from male to female. The decision at that time was for equity, for example, with menopausal women who may also need vaginal moisturisers, vaginal moisturisation should be deemed as self-care.
  Dilatation of a new vagina required short-term lubrication (not moisturisation) and this had been agreed as acceptable for prescribing, although there were considerations about whether this should be supplied by the service as part of the episode of care of the surgery. This will be highlighted to NHS England (NHSE), as lubrication products have not been included within the gender reassignment service specification.
  It was noted that the Joint Formulary could not be expected to cover every prescribing eventuality and that this was an example of it. LC will update the APC if further information is received.

11. Dates of next meeting.

APC Formulary meeting: Thursday 19th February 2026 (2pm to 5pm, Microsoft Teams)
APC Guideline meeting: Thursday 21st January 2026 (2pm to 5pm, Microsoft Teams)
The meeting closed at 17:00hrs