Bedfordshire, Luton and Milton Keynes Area Prescribing Committee – Formulary Subgroup meeting
Final Minutes

Date: 19th April 2022
Time: 12.30- 3.00pm
Venue: Microsoft Teams

The following organisations contribute to and participate in the BLMK APC – Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group; Bedfordshire Hospitals NHS Foundation Trust; Cambridgeshire Community Services NHS Trust; Central and North West London NHS Foundation Trust; East London NHS Foundation Trust; Milton Keynes University Hospital NHS Foundation Trust

Name	Initial	Role	Present	Absent
Dr J Fsadni	JF	GP (Retired), Committee Chairman	✓	
Taiya Large	TL	Professional Secretary/Commissioning Lead Pharmacist, NHS BLMK CCG	✓	
Candy Chow	CC	Hospital Pharmacy Representative, Milton Keynes University Hospital Trust	✓	
Suraiya Chandratillake	SC	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)		✓
Anshu Rayan	AR	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)		✓
Dr Mya Aye	MA	Medical Representative, Milton Keynes University Hospital (12.30-2pm)		✓
Dr Eleanor Tyagi	ET	Medical Representative, Milton Keynes University Hospital (2-3 pm)		✓
Carole Jellicoe	CJ	Nurse and Non Medical Prescribing Representative (Secondary Care)	✓	
Dr M Nisar	MN	Medical Representative, Bedfordshire Hospitals NHS Foundation Trust	✓	
Nikki Woodall	NW	Formulary Lead Pharmacy Technician, BLMK CCG	✓	
Dr Kate Randall	KR	GP Representative, Bedfordshire and Luton	✓	
Reena Pankhania	RP	Pharmacy Representative, Bedfordshire Hospitals NHS Foundation Trust	✓	
Mojisola Adebajo	MA	Place Based Lead Pharmacist	✓	
Matt Davies	MD	Place Based Lead Pharmacist	✓	
Alex Hill	AH	Community Pharmacy Representative	✓	
Dr Dush Mital	DM	Medical Representative, Milton Keynes University Hospital NHS Trust		✓
Yolanda Abunga	YA	Pharmacist Representative, Cambridgeshire Community Health Services	✓	
Richard Simpson	RS	GP representative, Milton Keynes		✓

In attendance:		
Helen McGowan	HM	Pharmacist NHS BLMK CCG
Jacqueline Clayton	JC	Commissioning Lead Pharmacist, NHS BLMK CCG
Anne Graeff	AG	Commissioning Lead Pharmacist, NHS BLMK CCG
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK CCG
Dr Jenny Wilson	JW	Bedfordshire GP
Naomi Scott	NS	Item 5.1
Priya Shah	PS	Item 5.2
Jennis Cain	JC	PA, NHS BLMK CCG
Temitope Sobo	TS	Item 5.3

Apologies:		

Dr Dush Mital		
Amy King		
Nigel Fagan		
Naomi Currie		
Marian Chan		
Katie Newens		

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate.	
2.	**Declarations of Interest** All annual written declarations of interests were up to date. The Chair invited the members to reconfirm their current declarations on the Register of Interests and advise of any new declarations. All members confirmed their declarations were accurate and up to date. The Chair invited members to declare any declarations relating to matters on the Agenda. All members confirmed they had no declarations in relation to matters on the Agenda.	
3.	**Minutes of the previous meeting** The March 2022 combined APC/FSG meeting notes were approved.	
4.	**Matters Arising**	
4.1	**Sanatogen**– Application to switch from Forceval capsules to Sanatogen as a cost-effective choice from Milton Keynes. Beds/Luton consulted regarding change to both Formularies– **awaiting response**	Open TL

No	Agenda Item	Action
4.2	**Kidmel audit –** Review of patients under 5 to ensure appropriate melatonin product is prescribed – **To be completed**	Open MD
4.3	**Testosterone factsheet -** To confirm blood testing between Hospital Pathology Departments. **– awaiting response from Trust** **Update-** Testogel is being discontinued so factsheet will need review. 50mg Testogel is being replaced with a 40.5mg in 2.5mL which has implications for practicality of dosing. Specialists have been contacted for advice.	Open TL
4.4	**SGLT2 inhibitors –** Change to original advice from "all patients on insulin must be referred to specialist for initiation of SGLT2" to "discuss with your Community Diabetes Specialist teams before initiation" **– Close action, message deployed**	Close
4.5	**Phosphate buffers in eye drops –** Concerns expressed with Eyeaze products due to phosphate content - risk of corneal calcification**.** Ophthalmologist opinion sought and for majority of patients deemed not to be a problem. **Add link to EMA review to Formulary, then close action.**	Open TL
4.6	**Cinacalcet Shared Care Guideline & Formulary application** It had been agreed that the SCG would be put onto the new template when available. Community pharmacy responsibilities to be added once the new template is available. As the template had not been ratified (as expected) at the September APC, it was agreed that legacy paperwork could be used with BLMK APC logos added. The following recommendations were made at a previous meeting: • Bedfordshire and Luton – Amber (shared care) • Milton Keynes - Amber (shared care) The Beds and Luton Joint Formulary has been updated. The updates to the MK Joint Formulary will be undertaken when the final Cinacalcet Shared Care Guideline was available, but until then it will be Amber 3.	Open SMc/CC
4.7	**Denosumab SCG -**SCG agreed with the amendments discussed. The suggested wording around acceptance of shared care by GPs is to be discussed and agreed by the BLMK Area Prescribing Committee. **Actions – to update the guideline to reflect the discussion and 'tidy up' typos, punctuation and transfer the guidance onto the BLMK template**	Open SMcG
4.8	**Choice of melatonin bulletin –** To update information on website to reflect Formulary choices **– Update – bulletin now archived. Close action.** NB: More products being launched Autumn 2022 – full review to be undertaken then – added to workplan	Close

No	Agenda Item	Action
4.9	**JPC Legacy – Biosimilar Formulary listings** To be updated to reflect changes to choice of biosimilar and to update entries in line with SPC where necessary. - Adalimumab and etanercept preferred brands to be confirmed for MKUH	Open CC
5	**Items for consideration at meeting**	
5.1	**Hyperhidrosis briefing paper** As part of the update to the 2017 Hyperhidrosis pathway from Priorities Forum, Formulary group reviewed in detail the drug choices to ensure Formulary alignment and selection of cost-effective options for the pathway. **1.** Add Anhydrol Forte and Driclor to both Formularies (GREEN) as 1st line self-care options. It was noted that these preparations are in the NHSE Items which should not be routinely prescribed in primary care document. 2. Add oxybutynin (GREEN) 1st line off label choice and propantheline (GREEN) as alternative 1st line licensed choice of anticholinergic to both Formularies. It was noted that oxybutynin is more effective in (weak) Trials. 3. In place of the pathways current advice to select an "alternative anticholinergic" as 2nd line the proposal is to add trospium 20mg twice daily (GREEN) in this position. Medicines Information completed a search and found no evidence for use of any of the other anticholinergics beyond oxybutynin, glycopyrronium and propantheline therefore a low-cost option was chosen with a favourable side effect profile. This also appears to be the favoured option in this position at other CCGs. 4. Glycopyrronium is listed in NICE CKS guidance as another off label option for Hyperhidrosis. It has a similar weak evidence base to oxybutynin however carries a much higher cost-pressure (£91 for 150mL vs £1.72 for 30 oxybutynin). The group therefore do not support the use of oral glycopyrronium. 5. Glutaraldehyde and formaldehyde were reviewed as they are also listed as options in NICE CKS. Both are older therapies and are considered largely obsolete. They also have unfavourable side effects (formaldehyde up to 20% contact dermatitis and glutaraldehyde stains skin yellow). It was therefore decided not to add these to the Formulary. Methenamine was also considered as a 'slow release' formaldehyde product. NS had completed a literature review and found no good evidence to support its use therefore it was not added to the pathway. 6. Glycopyrronium powder for iontophoresis was not formally discussed within the meeting, however it was circulated for comment and approval following and the proposal to not support its use for the aforementioned indication was supported on the ground of weak evidence to support superiority over tap water and high cost-pressure.	TL TL/CC
5.2	**Rituximab business case** Based on the British Society for Haematology (BSH) guideline on the diagnosis and management of primary autoimmune haemolytic anaemia: • Primary warm AIHA, mixed AIHA and paroxysmal cold haemoglobinuria (off label): rituximab as a second line treatment if no response to prednisolone 1mg/kg/day after three weeks or relapse during or after steroid reduction. • Primary cold haemagglutinin disease (CHAD) (off label): first line treatment with rituximab if symptomatic anaemia, severe circulatory symptoms or transfusion dependence • Dose: 375mg/m^2 IV infusion once a week for four weeks. Usually given as a single course of treatment to induce long-term remission. However, further treatment may be given to patients who relapse following initial response.	PS

	• Patients with AIHA presenting with severe anaemia are likely to require inpatient admission and treatment with red blood cell transfusions and rescue therapy with immunoglobulins (IVIG). The costs associated with hospitalisation and associated emergency interventions could be avoided if rituximab treatment is effective. • It was noted that Truxima is the current biosimilar of choice. MN raised that Rixathon is potentially an even more cost-effective biosimilar being explored by the Trust. • Approximately 2 patients per year expected, with a cost-pressure of £5844.68 – inclusive of 4x activity cost plus 4x administrations of rituximab for the course. **To add rituximab to both Formularies (RED) for AIHA & CHAD**	TL/CC
5.3	**Cobicistat application** Cobicistat as a single agent is licensed as a pharmacokinetic enhancer of atazanavir 300mg once daily (OD) or darunavir 800mg OD, as part of antiretroviral combination therapy in HIV-1 infected adults. In line with NHSE guidance, the constituents of Symtuza, Evotaz and Rezolsta should be supplied to patients separately instead of the combined preparations. According to the guidance, each time a clinical need for switch occurs clinicians should use a clinically appropriate regimen in the lower cost bands in preference to those in higher cost bands. **Both Formulary statuses to be changed for cobicistat from non-formulary to Formulary (RED)**	TS TL/CC
5.4	**Ceyesto application** Ceyesto 3mg tablets are currently on Beds/Luton formulary (Shared Care use) but not on MK formulary – asking to align formularies accordingly. Currently only Circadin MR 2mg on MK formulary. MK doesn't currently have a shared care document for melatonin therefore: **Add Ceyesto to Formulary as Amber 1 in line with other melatonin products**	NW TL/CC
5.5	**Trimbow NEXThaler application (DPI) for COPD** • Trimbow **pMDI** (pressurised Metered Dose Inhaler) for COPD is currently on both Beds/Luton formulary and MK formulary as Green. For asthma indication ,it is Amber on Beds/Luton formulary and Amber 1 on MK formulary. • Recently licensed for maintenance treatment for COPD patients. • Trimbow pMDI has an Annual CO2eq (Kg) of 172kg vs 10.8kg for NEXThaler – this is a lower carbon footprint inhaler option for those patients able to use a DPI. This is in line with national direction for inhaler use and supports the Greener NHS programme. • It would also provide device continuity within a pathway if moving from Fostair NEXThaler and an ICS/LABA/LAMA is required. • Price is the same for pMDI or NEXThaler (£44.50/120 doses) – no financial implications for adding device • Review of COPD guidance on the workplan for Autumn 2022 • Concerns were raised around over-use of inhaled corticosteroids for COPD patients. • Green designation was supported as guidance around the inhalers is robust and concerns raised that an amber status may hinder community specialists from prescribing and switching from two inhalers to one where indicated.	NW

	Add DPI to both formularies (GREEN) for COPD with the following restriction: Triple therapy should be reserved for patients who have failed to achieve or maintain an adequate response to an appropriate course of dual therapy (a combination of an inhaled corticosteroid and a long-acting beta2-agonist).	TL/CC
5.6	**Rosuvastatin capsules** • The addition of the recently launched hard capsules is proposed to give an alternative preparation (2nd line to atorvastatin) for patients with swallowing difficulties or feeding tubes for patient requiring a high intensity statin. • Licensed to be administered via feeding tubes. • Rosuvastatin is the only other statin which offers equivalent percentage reductions in LDL cholesterol at a low or moderate dose. • Would represent a significant cost saving if patients on chewable atorvastatin or simvastatin liquid were switched • Noted that GPs would be happy to prescribe rosuvastatin • Concerns raised around accidental selection of capsule over tablets when prescribing – capsules are higher on the list than tablets – this would add a cost pressure. Need for robust Optimise and Scriptswitch messaging to prevent this. **Add to both Formularies (GREEN) with noted restrictions for use in patient with swallowing difficulties or enteral feeding tubes**	HM TL/CC
5.7	**Rosuvastatin tablets traffic light change** • A change in formulary status is proposed as Rosuvastatin is an alternative high intensity statin to Atorvastatin (at doses of 10mg or more.) • An alternative high intensity statin should be trialled in patients who have an intolerance to 1st line. • It is also now available as a cost-effective generic with similar pricing to atorvastatin • Former amber status was due to the high cost. • Question raised around the status of simvastatin as patients still seem to be prescribed this. 1st line is now high intensity statin. • Formulary adjustment required in line with new guidance which recommends high intensity statins be used – 1st line atorvastatin, 2nd line rosuvastatin, 3rd line simvastatin and remove others due to lack of potency. • Review of Optimise and Scriptswitch messaging needed in line with new ranking and high intensity recommendation. **Change from Amber restricted / Amber 2 to GREEN on both Formularies and re-adjust ranking of preferred statins on the Formularies**	HM TL/CC
5.8	**Emeside application** • Emeside brand of ethosuximide capsule and syrup are about to be launched. This was the original brand that went off market but is being re-launched via a commercial agreement. • Significant savings could be realised if Emeside brand was to be used across BLMK. • Brands can be switched for this particular antiepileptic (tier 3). • Prescribing/monitoring/switching expected to be driven by the specialist with continuation by GPs. • Support required to help GPs switch patients as it was noted that due to the nature of the product GPs would not be happy to change	NW

	antiepileptics as part of patient review • Small patient numbers expected – approx. 136 patients. Cost-pressure ~£220,000 p.a. currently. It was noted that active switching is required if cost-savings were to be realised – added to workplan **Add both products as generic ethosuximide to Milton Keynes Formulary (Amber 3) & add capsules to Beds/Luton (Amber) with wording on both Formularies to specify Emeside is the most cost-effective brand** *NB: ethosuximide syrup already on Beds/Luton as Amber*	TL/CC
6	**Any Other Business –** NICE CKS-anaemia updated Oct 2021 states Iron deficiency anaemia should be treated with one tablet once daily of oral ferrous sulphate, ferrous fumarate or ferrous gluconate. BNF remains unchanged with BD-TDS dosing for therapeutic treatment. It was noted that GPs tend to prescribe longer low dose courses as it leads to fewer side effects, reserving twice daily for severe anaemia. Unclear why BNF has not been updated – possibly lag time/lack of awareness. NICE CKS do not carry the same weight as guidelines therefore proposed to consult with specialists for opinion. Will need to feed back to secondary care clinicians and raise awareness if BLMK endorse once daily dosing. **Action:** Contact haematologists for opinion on the above to be fed back at next meeting. **Traffic light merging** – introductory information	TL TL

Prescribing Spec* **	**Beds/Luton**	**Milton Keynes**
*Prescribing not recommended	BLACK (52)	REDRED (21)
*Consultant only prescribing	RED (756)	RED (588)
Initiated by Specialist, may be continued by GPs	AMBER (268)	
Specialist recommendation followed by GP initiation and continuation		AMBER 1 (190)
Specialist or GP initiation in line with local guideline after 1st line failure followed by GP continuation		AMBER 2 (198)
Specialist initiation and stabilisation followed by GP continuation		AMBER 3 (55)
*Initiated by Specialist, may be continued by GP under a shared care arrangement.	AMBER SCG (49)	AMBER SCG (25)
*May be initiated and continued by GPs	GREEN	GREEN

	• Historical information for Milton Keynes – Formulary started from scratch and was based on Nottinghamshire's Netformulary colour coding. • Black was not selected due to "blacklist" – I.e. product is listed in Part XVIIIA of the Drug Tariff and cannot be prescribed on NHS. REDRED from Notts – to highlight items actively assessed and rejected or not yet assessed but is not currently on the formulary to prescribe. • Amber 1/2/3– aimed to give more flexibility and options to appropriate prescribing of non-green items. • Amber1-e.g. melatonin, no SCG. Specialist can recommend use and GP can initiate. Little ongoing monitoring so SCG not needed. • Amber2-2nd line option. Amber2 asks specialists and GPs to stop and think – look at associated guidance or highlight that its not a first line option (Green). • Amber3-Specialist initiated and stabilised – possibly need for more SCGs here if Amber 3 removed and appropriate. • MK have a "bounceback form" for GPs to send inappropriate prescribing requests back to the hospital pharmacy to investigate e.g. a red drug is requested which should remain with hospital prescriber or a medicine which should be purchased OTC as self-care Similar at beds/Luton "breach form" – same process. • MK hospital do not currently prescribe Amber 1 drugs (make recommendation for GPs to initiate) – if this was to change it would cause increased costs and would need negotiating. • Historical information for Beds/Luton-BLMK adopted hospital Formulary. Amber-ALL meds started by specialist- 28 day prescription initially. • Non-initiation by specialists reduced when Beds/Luton Amber specified that specialist always start the medicine • SCGs – payment for SCGs under review to align payment. Requires consideration. • Working group planned to undertake project – to be fed back into Formulary Subgroup. • Spec for mental health different as not always appropriate to supply 28 days. • Thoughts and ideas to be emailed to TL. • Large project –also need to review Optimise and ScriptSwitch message to align with formularies.	
7	**Dates for BLMK APC Formulary Subgroup 2022 Meetings:** Tuesday 7th June 2022 – 12.30-3pm Tuesday 6th September 2022 - 12.30-3 pm Tuesday 15th November 2022 - 12.30-3 pm	

Approval of minutes:
Chair: Dr John Fsadni

Signed: 

Date: 9th June 2022