

**Bedfordshire, Luton and Milton Keynes Area Prescribing Committee – Formulary Subgroup meeting  
Final Meeting Notes**

Date: 6<sup>th</sup> Sept 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 John Fsadni	JF	GP (Retired), Committee Chair	✓	
Taiya Large	TL	Professional Secretary/Commissioning Lead Pharmacist, NHS BLMK CCG	✓ Until 2pm	
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)		✓
Saema Arain	SA	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton) (deputises Suraiya)		✓
Anshu Rayan	AR	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)		✓
Dr Mya Aye	MA	Medical Representative, Milton Keynes University Hospital		✓
Dr Eleanor Tyagi	ET	Medical Representative, Milton Keynes University Hospital	✓	
Carole Jellicoe	CJ	Nurse and Non Medical Prescribing Representative (Secondary Care)	✓	
Dr Muhammad Nisar	MN	Medical Representative, Bedfordshire Hospitals NHS Foundation Trust	✓	
Nikki Woodhall	NW	Formulary Lead Pharmacy Technician, BLMK CCG	✓	
Dr Kate Randall	KR	GP Representative, Bedfordshire and Luton	✓	
Dr Jenny Wilson	JW	GP Representative, Bedfordshire and Luton	✓	
Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)	✓	
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		✓
Marian Chan	MC	Consultant, Bedfordshire Hospitals NHS Foundation Trust	✓ From 2pm	
Lindsay Mackenzie (deputises Jenny Wilson)	LM	GP Representative		✓
Naomi Currie	NC	Place Based Lead Pharmacist	✓	
Richard Simpson	RS	GP Representative– Milton Keynes		✓
Nigel Fagan (deputises RS)	NF	GP Representative– Milton Keynes		✓
Anne Graeff	AG	Commissioning lead Pharmacist	✓	
Joy Mooring	JM	Primary Care Specialist Pharmacy Technician, BLMK	✓	
Dona Wingfield	DW	Commissioning lead Pharmacist	✓	
Sandra McGroarty	SMc	Commissioning lead Pharmacist	✓	
Karli Hart	KH	Pharmacy Procurement Technician Milton Keynes University Hospital NHS Foundation Trust		✓
Jennis Cain	JC	Luton Place Based Team Coordinator, BLMK	✓	
Iffah Salim	IS	Interim Tower Hamlets Lead Pharmacist CAMHS for Item 5.6		✓
Jacqueline Clayton	JC	Commissioning lead pharmacist	✓	
Jayne Adams	JA		✓	
Nicholas Beason	NB			✓

No	Agenda Item	Action
1.	<p><b>Welcome, Introductions and Apologies</b></p> <p>The Chair welcomed everyone to the meeting.</p> <p>The meeting was confirmed as quorate.</p>	
2.	<p><b>Declarations of Interest</b></p> <p>All annual written declarations of interests – some outstanding – to be sent to Raye Summers please at the earliest opportunity.</p>	

No	Agenda Item	Action
	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.	<p><b>Minutes of the previous meeting</b></p> <p>The June 2022 FSG meeting notes were approved.</p> <p><b>Action</b> JF – To sign the minutes to finalise and send to TL please.</p>	JF
4.	<p><b>Action Log</b></p>  <p>00 BLMK Formulary Subgroup Action log :</p> <ol style="list-style-type: none"> <li>1. Denosumab SCG – under AOB, for approval and close</li> <li>2&amp; 3. Cinacalcet SCG – SCG now finalised, MK Formulary to be updated to Amber SCG</li> <li>4. Kidmel audit – Ongoing. Melatonin to return to FSG towards the end of the year for review. ELFT are looking at melatonin preparations. TL to obtain update from MD</li> <li>5. Testosterone testing– no engagement from secondary care. To close on agenda.</li> </ol> <p>JA – BMS conference July 2022– world leader Prof. Sue Davies stated serum testosterone alone can be used. SHBG and FAI not needed (including at baseline). TL to review testosterone leaflet and BMS statements to reflect updated advice (remove the need for other tests). Issue was that Dr Wassif wasn't performing SHBG at Bedford but now no longer needed.</p> <ol style="list-style-type: none"> <li>6. Sanatogen – Beds/Luton weren't happy to use Sanatogen as insufficient trace elements for bariatric patients (min 2mg copper needed). Forceval does have enough. Sanatogen general use, Forceval 1<sup>st</sup> line bariatric patients (NW-noted routinely bought OTC by the patient). Forceval can be prescribed for bariatric patients in line with NHSE guidance (i.e. surgery resulting in long term malabsorption-prescribe multivitamins.) The type of bariatric surgery undertaken may or may not lead to malabsorption, with some procedures being higher risk for it than others. CC raised that on hospital discharge 2 weeks supply given. GPs would only continue on dietician / specialist advice. It was noted that secondary care should counsel patients on where to get the rest of the supply after the initial 2 weeks has run out. Multivitamins part of the workplan to review for BLMK – estimated November 2022. May also need to re-visit bariatric guidelines and clarify where necessary.</li> <li>7. Iron dosage – consensus now received – once daily dosing for treatment of anaemia. Information on consensus to be disseminated and SS/Orx wording to be added to iron preparations with advice.</li> </ol>	<p>TL</p> <p>CC</p> <p>TL</p> <p>TL</p> <p>TL/CC</p>

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	<p>8. Agomelatine – Remains open for further discussion about the plan. ELFT also have other medications they wish to move to GP prescribing.</p> <p>9. Potassium permanganate – To close</p> <p>10. Buccal midazolam – JPC document now live. To close.</p> <p>11. Progesterone pessaries – To close.</p>	NW/TL/CC
5.	<p><b>Items for consideration</b></p> <p>JF thanked everyone for their engagement with the papers and the comments that were sent.</p>	
5.1	<p><b>Ogluo for severe hypoglycaemia</b></p> <p>Ogluo (GAI) is a pre-filled glucagon pen which is given subcutaneously. The current product in use for the indication is Glucagen Hypokit (GEK), which requires reconstitution.</p> <p>Ogluo is classed as an autoinjector however the administrator requires training on how to administer a subcutaneous injection. It is unlikely that people unfamiliar with subcutaneous injections such as school staff would be willing or able to administer the injection without prior training.</p> <p>Data from the trials indicates that Ogluo is 1 minute faster to administer vs Hypokit but the drug take 4 minutes longer to work, with a slower and less pronounced response vs Hypokit.</p> <p>It was noted that patients are peripherally shut down when hypoglycaemic which could be a possible mechanism for the delay in effect with Ogluo.</p> <p>This slower effect (4-4.5 minutes longer in time to achieve recovery) has been properly reflected in the SmPC. The gain considering no reconstitution is necessary is estimated to be only 1 minute which would mean that there still is a delay of 3 to 3.5 minutes. Moreover, the time to recovery of 14.8 minutes (versus 10.4 minutes for HK) is only a mean value with important variability as the standard deviations were respectively 5.4 and 1.9 minutes. When looking at the responders per time interval for Ogluo (mITT): 18 (14.2%) patients took 15 to 20 minutes, 5 patients (3.9%) took 20 to 25 minutes, 4 patients (3.1%) took 25 to 30 minutes and 1 patient (0.8%) took 30 to 35 minutes to recover. This is in contrast to the HK patients who all took maximum 15 minutes to recover (and 88.6% took only up to 10 minutes, which was the case for merely 37% of Ogluo patients). This means that for more than 20% of Ogluo patients there was a delay of 5 to 20 minutes which can put them at risk of serious consequences.</p> <p>The SmPC of Glucagen HK mentions that if the patient does not respond within 10 minutes, intravenous glucose should be given. If this would be applied to Ogluo patients, this means that 63% of them would need to receive IV glucose.</p>	

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	<p>A subsequent smaller study of 16 individuals focused on the ease of giving GAI vs GEK. The company state: In a simulated human factor study of 16 individuals both trained &amp; untrained, only 31% of participants were successfully able to administer the glucagon solution. The observed causes of failure for included the following: bent needle, injected through clothing (also a problem with Ogluo but fewer cases), injected diluent only, did not fully reconstitute and did not inject entire volume (also a problem with Ogluo but fewer cases).</p> <p>Results from Comparative Study</p> <table border="1" data-bbox="347 712 1155 972"> <thead> <tr> <th><i>Comparative performance measures</i></th> <th><i>GAI</i></th> <th><i>GEK</i></th> </tr> </thead> <tbody> <tr> <td>Successful dose administrations</td> <td>14/16 (88%)</td> <td>5/16 (31%)</td> </tr> <tr> <td>Administered with reduced efficacy</td> <td>0/16 (0%)</td> <td>4/16 (25%)</td> </tr> <tr> <td>Failed administration</td> <td>2/16 (13%)</td> <td>7/16 (44%)</td> </tr> <tr> <td>Error rate</td> <td>3.6%</td> <td>20.1%</td> </tr> <tr> <td>Mean total rescue time (start at entry of room until delivery of dose)</td> <td>47.9 s</td> <td>109.0 s</td> </tr> <tr> <td>Median total rescue time (start at entry of room until delivery of dose)</td> <td>35.0 s</td> <td>96.0 s</td> </tr> </tbody> </table> <p>The group noted that:</p> <ul style="list-style-type: none"> <li>-Often glucagen pens expire and are never used.</li> <li>-Two are issued at a time as per recommendations which increases waste</li> <li>-If dosing is required, the likelihood of needing to give two Ogluo pens is higher (due to reduced effect as detailed above) which potentially doubles the cost pressure</li> </ul> <p>The difference in Subcutaneous (Ogluo) versus intramuscular (Hypokit) administration may cause confusion in secondary care and since nurses are trained to give IM this is familiar to them, compounded by the fact that IV glucose is readily available, the group concluded there is no place for Ogluo in secondary care.</p> <ul style="list-style-type: none"> <li>-High cost pressure – 7 fold more than Hypokit</li> </ul> <p>The group considered issuing Ogluo to patients with dexterity issues however noted that it is unlikely to be self-administered as most patients with severe hypoglycaemia are likely to be unconscious – therefore no place for Ogluo for those with dexterity issues</p> <p>It was noted that National Diabetes Group have not made a decision about the benefits of Ogluo – this will be monitored and reviewed. Action TL</p> <p>The group decision was to place Ogluo in the Non-Formulary section within BLMK.</p> <p><b>Post meeting notes:</b></p> <p>Dear Formulary Subgroup Members,</p> <p>I have some additional information regarding Ogluo to share following on from the meeting. The product is presented as a pre-filled pen in the literature, but on closer inspection it does meet the definition of an auto-injector, working in a similar way to an Epipen.</p>	<i>Comparative performance measures</i>	<i>GAI</i>	<i>GEK</i>	Successful dose administrations	14/16 (88%)	5/16 (31%)	Administered with reduced efficacy	0/16 (0%)	4/16 (25%)	Failed administration	2/16 (13%)	7/16 (44%)	Error rate	3.6%	20.1%	Mean total rescue time (start at entry of room until delivery of dose)	47.9 s	109.0 s	Median total rescue time (start at entry of room until delivery of dose)	35.0 s	96.0 s	
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	<p>Some considerations:-</p> <ul style="list-style-type: none"> <li>• For anaphylaxis the onset is sudden and patients receiving adrenaline are generally not with people that are familiar with injection technique, the adrenaline injection is the only treatment, first line and very time critical.</li> <li>• Hypoglycaemia in diabetes is slower onset with multiple early signs of low blood sugar that people with type one diabetes are trained to be aware of and trained to manage by having a glucose containing snack or drink. The glucose injections are only used if a person is unconscious or very sleepy. The majority of people with type one diabetes do not have hypos that are so severe they lose consciousness and require an injection, however if this is the case family members living with the individual are trained to inject glucose as part of the management of the condition. They are usually familiar with administering insulin injections and injection technique.</li> <li>• The Department for education issued guidance supporting pupils with medical conditions at school in 2014 <a href="https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803956/supporting-pupils-at-school-with-medical-conditions.pdf">https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803956/supporting-pupils-at-school-with-medical-conditions.pdf</a></li> <li>• Schools can administer medication to pupils if it is in their individual healthcare plan</li> <li>• Managing hypoglycaemia should be included in the individual healthcare plan for all pupils with type one diabetes; if administering glucose by injection to an unconscious pupil or pupil that is unable to swallow with hypoglycaemia is part of the care plan and the school staff are trained in the use of the Ogluo autoinjector then prescribing should be considered an option, however it is noted that this is unlikely as pupils with hypoglycaemia should be managed with oral glucose at the onset of symptoms and the likelihood of a pupil being unconscious is low.</li> </ul> <p>A question raised by the group was any difference in storage and expiry. I can confirm the storage and expiry is the same for both products – 2 years at room temperature.</p> <p><b>I am seeking re-confirmation of the decision made in relation to Ogluo in light of the above – which was to list it as a Non-Formulary product for BLMK.</b> <b>I am also proposing a “by exception” message with wording to stipulate that if a child has Ogluo in their individual health care plan AND the appropriate staff are trained to administer Ogluo then it can be supplied under this exception.</b></p> <p>I require a quorate response please for the decision. Please reply directly to me by <b><u>22<sup>nd</sup> September.</u></b></p> <p>Kind regards,</p> <p>Taiya</p>	

No	Agenda Item	Action
	<p><b>Conclusion:</b></p> <p>The information was circulated to the group who maintained support of a negative (Non-Formulary position). The product can be used by exception, if a child has Ogluo in an individual health care plan AND the appropriate staff are trained to administer Ogluo then it can be supplied.</p>	
5.2	<p><b>Hormone Replacement Therapy (HRT) Section Review</b></p> <p>The Formularies have been reviewed with subsequent proposals for update to ensure there is an appropriate range of cost-effective options available for women who require HRT.</p> <p>Key points:</p> <ul style="list-style-type: none"> <li>-Patches are usually the first line option as they do not carry the risks of oral HRT (Stroke, Venous Thromboembolism).</li> <li>-Oestrogen only HRT cause little or no change in the risk of breast cancer, whereas combined HRT can be associated with a small increased risk</li> <li>-Different progestogens carry differing levels of VTE risk</li> <li>-The committee noted the recent difficulties in supply of HRT</li> </ul> <p>Summary of proposals:</p> <ul style="list-style-type: none"> <li>-Femoston tablets – Change from Amber 2 to Green on MK Formulary to align with Bed/Luton</li> <li>-Tridestra tablets – Remove from both Formularies. Low prescribing rate and highest cost tablet with VTE risk being at the higher end</li> <li>-Elleste Duet Conti tablets– Add to Beds/Luton formulary (Green) to align with MK</li> <li>-Femoston conti tablets – Add to Beds/Luton as green and change from Amber 2 to Green at MK</li> <li>-Evorel Conti patches – Change from Amber 2 to Green on MK to align formularies</li> <li>-Premarin – Remove from both Formularies. Less suitable now as the oestrogen is equine based and the body-identical oestrogens are safer</li> <li>-Elleste Solo tablets – currently only listed for gender dysphoria. Add to Beds/Luton (Green) to align with MK and create entry to cover HRT indication</li> <li>-Femseven patches – To be retained on Formularies and change from Amber 2 to Green on MK formulary. To be reserved for patients with compliance issues with twice weekly usage or skin reactions to other patches</li> <li>-Assign Ovestin and estriol cream green designation on MK Formulary</li> <li>-Remove vagifem from the Formularies and replace with Vagirux (Green) (branded generic) as a more cost-effective vaginal tablet. Added benefit of reduced plastic waste as the applicator is re-usable. No active switching to take place – SS/Orx messages to be added to encourage switching. Further discussions on active switching to be taken outside of the meeting. Large numbers of patients are on Vagifem.</li> <li>Noted that some patients complained of the re-usable applicators becoming 'floppy' after a few uses – to be monitored.</li> </ul>	<p>NC/TL</p> <p>TL</p>

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	<p>-The committee noted emergence of an OTC product called Gina (licensed September 2022) which is the same as Vagirux and Vagifem licensed for vaginal atrophy due to oestrogen deficiency in postmenopausal over 50 who haven't have a period in at least 1 year. Not yet available to buy but estimated cost is £2.50 per week for patients when purchased OTC. Dosages are expected to be the same as the drug and strength are the same. JM raised that many OTC products take a long time (up to 1 year) to become available to patients. JW raised that women are already paying high prescription charges as HRT is often charged twice as a combined product. AG – Raised that Gina unlikely to be a replacement for Vagirux/fem as HRT is part of a larger package of care so prescribing likely to continue</p> <p>To add Gina to the action log until such time as more information becomes available for future discussion of prescribing vs purchase of the pessaries.</p>	
5.3	<p><b>Bijuve – Oral Hormone replacement Therapy</b></p> <p>Estradiol 1mg / micronised progesterone indicated for continuous combined HRT in women with an intact uterus and at least 12 months since last menses. Cost is higher vs giving the separate products however Bijuve would be reserved for patients who are non-compliant with progesterone component (if unopposed oestrogen is given to women with a uterus it risks endometrial cancer). Numbers are expected to be very small as Bijuve is an oral HRT (patches are preferred) and the product is restricted to those who are non-compliant.</p>	
5.4	<p><b>Intrarosa pessaries for vulvar and vaginal atrophy</b></p> <p>Schedule 4 part 2 anabolic steroid – active drug is prasterone. Effective treatment however risks include venous thromboembolism and breast/endometrial cancer. A risk benefit should be conducted every 6 months. Numbers are expected to be very low.</p> <ul style="list-style-type: none"> <li>Intrarosa is to be reserved as a last line therapy for symptoms that adversely affect quality of life AND at least two other topical oestrogen preparations have failed / where topical oestrogens are not suitable for the patient. (Amber/Amber 3)</li> </ul>	
5.5	<p><b>Ospemifene for vulvar and vaginal atrophy</b></p> <ul style="list-style-type: none"> <li>Ospemifene is a new product, indicated for the treatment of moderate to severe symptomatic vulvar and vaginal atrophy (VVA) in post-menopausal women who are not candidates for local vaginal oestrogen therapy. Numbers again expected to be very low.</li> <li>Selective oestrogen receptor modulator (SERM). This means that it acts in the same way as oestrogen in some tissues in the body such as the vagina and so helps to reduce symptoms of vulvovaginal atrophy. However, ospemifene does not work in the same way in other tissues such as the breast and womb, where such activity could cause hyperplasia (growth) of tissues which could lead to cancer.</li> <li>Similar efficacy to locally applied vaginal products.</li> </ul>	

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	<ul style="list-style-type: none"> <li>Possible need for shared care arose however the group agreed that a clear monograph would suffice.</li> <li>Amber/Amber3 - restricted to those unwilling or unable to apply local vaginal products or as a last line therapy where all other options have failed.</li> <li>JF raised that this drug will likely sit under the proposed SpIS category (see merging traffic lights document).</li> <li></li> </ul>	
	<b>Change of secretariat at 13:29 – AG</b>	
5.6	<p><b>Updated Formulary Application Form</b></p> <p>EQIA section for future review with the Equality and Diversity lead.</p> <p>Action: TL to upload the new form onto BLMK website following discussion with CC Action: TL to add to action log</p>	TL/CC
5.7	<p><b>Merging traffic Lights</b></p> <ul style="list-style-type: none"> <li>Agreeing a common prescribing traffic-light system across BLMK is considered an essential step towards the longer-term goal of a unified Formulary and supporting prescribing policies</li> <li>Document has already been widely circulated for comment</li> <li>For approval of the plan</li> </ul> <p>Black and RedRed – Moving to DNP with a different colour (purple) to denote entries that have been locally assessed and rejected for use. No additional comments received.</p> <p>Red and Green – entries will remain unchanged with wording to be updated as per the paper.</p> <p>Tools include: Self-care stamp, Discontinued stamp and Existing stamp, to specify the specifics of prescribing (see paper)</p> <p>Amber 2 – Avoids GP prescribing without following the guidelines / drugs that aren't first line. Amber 2 to be audited to ensure suitable category is selected.</p> <p>CC- Raised that some Amber 2's have direct messages on Orx with no associated guideline. Need to keep those messages. TL to explore the possibility of "Green not first line" optimise category.</p> <p>SS/Orx messaging is the cornerstone of information for GPs.</p> <p>Amber 3 to become SpIS <b>confirming specialist initiation and stabilisation before GP takes over prescribing</b></p> <p>Amber 1 – GP only needs a specialist recommendation / specialist input before prescribing.</p> <p>Amber 3 – Specialist also needs to stabilise the patient.</p> <p><b>Whilst Amber and Amber 1 both require specialist recommendation prior to GP prescribing, Amber additionally requires Specialist initiation (with a 28-day prescription) but not</b></p>	

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	<p>stabilisation. Still requiring prior specialist recommendation, a merged SpA aims to provide a future-proof solution whilst allowing for some variation in locally-agreed arrangements.</p> <p>JC: RE contracts to be reviewed in autumn 2022. The two Trusts have different contracts. No plan to align the contracts. Beds/Luton – specialist obliged to supply 1<sup>st</sup> 28 days of medication. This obligation is not applied to Milton Keynes, who can advise by letter that a GP start a medication as recommended by a specialist.</p> <p>SpA wording – “as per contract”. Prescribers may not understand. Wording to be changed to “as per local arrangement/agreement”. (Clarify in each Formulary the definition of this). Futureproofing important.</p> <p>AG- Ultimate goal is to have one BLMK Formulary.</p> <p>CC- Can the contract be linked from the Formularies?</p> <p>JC – Applying to local area but we do get people from outside looking at our Formulary and GPs who are asked to prescribe by secondary care from out of area e.g. Addenbrookes. Local arrangements do not apply here.</p> <p>JC – Historical issues with communication in Beds/Luton which is why the 28 day supply rule is in place. Possibility of relaxing this if a working mechanism for effective communication is put in place. JF raised that GPs may not be happy initially to take on prescribing on advice only in Beds/Luton.</p> <p>Definition of restricted to be clarified.</p>	
5.8	<p><b>Methocarbamol for short term relief of muscle spasm</b></p> <p>Methocarbamol is a drug of limited clinical value and is placed as less suitable for prescribing in the BNF. Pain teams consulted and confirmed they no longer use, preferring to initiate baclofen or short benzodiazepine course with more evidence of efficacy and fewer unpleasant side effects.</p> <p>Already Non-Formulary however there is significant use across BLMK. No messaging currently in place. NW to create.</p> <p>June 2021 to May 2022 – 5000 prescriptions issued costing £57,000. Majority in central beds.</p> <p>Individual review of patients to be taken forward as a separate workstream.</p> <p>JW raised concerns about baclofen ending up on long term repeat when intended for short term use. Addictive and difficult to wean.</p> <p>KR – Used as an alternative to diazepam in central beds, aimed at avoiding giving benzodiazepine. Education needed as perception is methocarbamol is safer than a benzodiazepine.</p> <p>NC- Has observed on repeat in some practices. To include in prescribing lead meetings going forward to raise awareness.</p> <p>Non-Formulary (Do not prescribe) on both Formularies</p>	<p>NW</p> <p>NC</p>

No	Agenda Item	Action
5.9	<p><b>Cacit effervescent tablets for metabolic bone disease of prematurity</b></p> <ul style="list-style-type: none"> <li>• Application from MKUH paediatric team (already on Beds/Luton). Seeing patients referred from Oxford who need this treatment. For use in neonates only.</li> <li>• Lack of consensus in diagnostic criteria and therefore the actual incidence is uncertain</li> <li>• Maximum number needing calcium carbonate would be approx 100 per year assuming the highest estimate</li> <li>• Addition of monograph to MK to align with Beds/Luton</li> </ul>	CC
5.10	<p><b>Ranibizumab biosimilar (Ongavia)</b></p> <p>Already on the formulary and NICE approved for a variety of eye conditions. Recent patent expiry and first biosimilar (Ongavia) licensed for use in the UK.</p> <p>National recommendation to adopt the biosimilar as represents significant cost savings vs originator. NHSE have published commissioning recommendations for the treatment of retinal vascular conditions.</p> <p>Expected that Lucentis patients will be switched. Of note, Ongavia is presented in a vial not a pre-filled syringe as Lucentis is due to the patent protection on the syringes (expires 2023).</p> <p>Expected to be a phased introduction in secondary care.</p> <p>Action: To add to the Formularies (RED).</p>	
5.11	<p><b>Dymista</b></p> <ul style="list-style-type: none"> <li>• Request from ENT consultant at Luton. Change of traffic light from Amber to green for allergic rhinitis. Recommended by NICE and BSACI for adults and adolescents <math>\geq 12</math> years for the relief of symptoms of moderate to severe seasonal and perennial allergic rhinitis if monotherapy with either intranasal antihistamine or glucocorticoid is not considered sufficient.</li> <li>• Specialist referral remains an option where necessary.</li> <li>• NW raised concerns that it may be used earlier on in the pathway by moving Amber 2 to Green.</li> <li>• Switch from Amber/Amber 2 to Green.</li> <li>• Number difficult to quantify due to changes in the ENT service during the pandemic.</li> <li>• RP highlighted the guidance is clear about when to initiate Dymista.</li> <li>• EPACT2 can be tracked for prescribing trends following the change in Dymista designation</li> <li>• SS/Orx messaging a possibility but the group noted that message fatigue could be a problem. JW noted that the messages are helpful and are used.</li> </ul>	

No	Agenda Item	Action
AOB	<p>NW – Freestyle Libre sensors discontinued from December 2022. Still a number of patients prescribed these. Guidance to be sent to practices to help switching to Libre 2. Will also be added to Primary Care Bulletin.</p> <p>AG – Metolazone newly licensed product (Xaquu) – twice the bioavailability of the metolazone that is currently used. Information included in primary care bulletin. Need SS/Orx messages for this.</p> <p>CC – Removal of Anapen from MKF as it has been discontinued. Wording also added for dosing as per patient weight to adrenaline monograph to align with Beds/Luton, along with advice to carry two pens.</p> <p>SMc – Denosumab SCG for approval. Wording around calcium and vitamin D supplementation clarified. MN consulted – requirement to be established by the specialist with GP continuation of prescribing. Baseline tests taken prior to starting denosumab and calcium intake established with a calculator to assess need for medication. Vitamin D is recommended for everyone (as per government advice). GP to reinforce importance of calcium and vitamin D intake to patient and educate on importance of compliance with medication. Every 6 months review– wording added to review need for calcium and vitamin D supplement. Under patient section – to ensure healthy diet and to take prescribed medication. SMC to send to Milton Keynes consultant – link in with CC. The committee are happy in principal with the document.</p> <p><b>Minor Amendments to the Formulary</b></p> <ul style="list-style-type: none"> <li>• New products added to Non-formulary section – See Horizon Scanning document in FSG pack</li> <li>• Cyclogest – Wording added regarding requirement to confirm viable pregnancy via scan prior to initiation</li> <li>• Ceyesto–wording added for paediatrics and adolescents</li> <li>• Anthelios XL suncream – Discontinued product removed</li> <li>• Uvistat suncream– All SPFs included within the monograph</li> <li>• Addition of sharps bin information, where to dispose and when to supply</li> <li>• Adaflex (melatonin) added as a new product (NF)</li> <li>• Sensense Ultra SPF 50+ and Eucerin intensive 10% discontinued</li> <li>• Isotrex, Isotrexin, discontinued</li> <li>• Removal of Arimidex brand from anastrozole monograph (£68 vs £1)</li> <li>• TOR Updated CCG → ICB</li> </ul> <p>CC – Thanked everyone for their hard work and help as this is her last FSG meeting. The chair thanked Candy for her contribution to the group as a valued member of the team and wished her well for the future.</p> <p><b>Future meetings:</b></p>	

No	Agenda Item	Action
	<ul style="list-style-type: none"> <li>• 15<sup>th</sup> November 2022 12:30-3pm</li> <li>• 7<sup>th</sup> February 2023 12:30-3pm</li> <li>• 18<sup>th</sup> April 2023 12:30-3pm</li> <li>• 13<sup>th</sup> June 2023 12:30-3pm</li> <li>• 5<sup>th</sup> September 2023 12:30-3pm</li> <li>• 14<sup>th</sup> November 2023 12:30-3pm</li> </ul>	

**Approval of minutes:**

Chair: Dr John Fsadni

Signed: 

Date: 16<sup>th</sup> November 2022