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

Date: 12th November 2024

Time: 12.30 - 14.00pm

Venue: Microsoft Teams

**The following organisations contribute to and participate in the BLMK APC – Bedfordshire, Luton and Milton Keynes Integrated Care Board; 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**

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| **Name** | **Initial** | **Role** | **Present** | **Absent** |
| Fiona Garnett | FG | Committee Chair |  |  |
| Samina Hassanali | SH | Professional Secretary/Formulary & Medication Safety Pharmacist, NHS BLMK ICB |  |  |
| Janet Corbett | JCo | Pharmacy Programme Manager MKUH |  |  |
| Saema Arain | SA | ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton) |  |  |
| Prabjoth Kaur | PK | Lead Pharmacist Medicines Information and Formulary |  |  |
| 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) |  |  |
| Nikki Woodhall | NW | MK Place lead Medicines Optimisation & digital transformation lead |  |  |
| Dr Kate Randall | KR | GP Representative, Bedfordshire and Luton |  |  |
| Dr Jenny Wilson | JWi | GP Representative, Bedfordshire and Luton |  |  |
| Reginald Akaruese | RA | CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes) |  |  |
| Mojisola Adebajo | MA | Place Based Lead Pharmacist BLMK ICB, Luton |  |  |
| Matt Davies | MD | Head of Pharmacy and Medicines Optimisation and Place Based Lead Pharmacist, C Beds |  |  |
| Alex Hill | AH | Community Pharmacy Representative |  |  |
| Dr Dushyant 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 |  |  |
| Qiratulain Khan | QK | Lead Pharmacist Medicines Information and Formulary |  |  |
| Anne Graeff | AG | Commissioning Lead Pharmacist BLMK ICB |  |  |
| Joy Mooring | JM | Primary Care Specialist Pharmacy Technician, BLMK ICB |  |  |
| Dona Wingfield | DW | Medicines Use and Quality Manager, Bedfordshire Hospitals NHS Foundation Trust |  |  |
| Anila Anwar | AA | Governance and Policies Pharmacist  Bedfordshire Hospitals NHS Foundation Trust |  |  |
| Iffah Salim | IS | Advanced clinical practice CAMHS Pharmacist  Neurodevelopmental Team, ELFT. |  |  |
| Nicholas Beason | NB | Procurement technician MKUH |  |  |
| Candy Chow | CC | Commissioning Lead Pharmacist BLMK ICB |  |  |
| Sandra McGroarty | SMc | Commissioning Pharmacist, BLMK ICB |  |  |
| Jonathan Walter | JWa | Milton Keynes GP representative |  |  |
| Dupe Fagbenro | DF | Deputy Chief Pharmacist (Luton and Bedfordshire)  East London NHS Foundation Trust |  |  |
| Maggie Winter | MW | Milton Keynes GP representative |  |  |
| Aarti Shah | AS | Medicines Optimisation Pharmacist Central Beds |  |  |
| Amjid Hussain | AHu | Bedfordshire Lead for the Community Mental Health Services, ELFT. |  |  |
| Sanil Patel | SP | Associate Director of Pharmacy MKUH |  |  |

**Summary of acronyms used in the document**

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| **Acronym** | **Explanation** |
| MKF | Milton Keynes Formulary |
| B&LF | Bedfordshire and Luton Formulary |
| FSG | Formulary subgroup |
| ORx | Optimise GP messages |
| SCG | Shared care guidance |

| **No** | **Agenda Item** |
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| 1. | **Welcome, Introductions and Apologies**  The chair welcomed everyone to the meeting including Sunny Patel, Associate Director of Pharmacy MKUH and Aarti Shah, Medicines Optimisation Pharmacist, Place based for Central Beds.  Apologies received from Janet Corbett.  The meeting was confirmed as quorate. |
| 2. | **Declarations of Interest**  Annual written declarations of interests – some outstanding, to be sent via email to Harminder Sehmbi.  Members were invited to declare any conflicts of interest relating to matters on the agenda, none declared. |
| 3. | **Minutes of the previous meeting**  The September 2024 FSG meeting notes were approved as accurate. |
| 4. | **Action Log**  Actions were noted in accordance with the action log:   |  |  |  |  | | --- | --- | --- | --- | | **Item** | **Title** | **Action** | **Update** | | 1 | **Adult ADHD shared care and transfer of care agreement -ELFT** | Specialist to include other medications the patient has tried for ADHD in their correspondence.  The guidance states that CAMHS need to inform adult services when a patient needs to be transitioned into their services. This should also include patients under specialists for co-morbid mental health conditions/needs.  Iffah will be taking the guidance to Med. Com. for comments. | Guidance amended and has been uploaded on to the Medicines BLMK ICB and B&L formulary site.  Actioned – To close. | | 2 | **Aymes ActaGain Protein Shot** | Dietitians to request Aymes ActaGain Protein Shots in multiples of 15 in their letters to the GP.  ORx messaging to recommend prescribing in multiples of 15. | Dietitians requested to state correct pack sizes via letters. Pack size messaging doesn’t fall within the intentions of ORx.  To close. | | 3 | **Latanoprost 50mcg/ml preservative free eye drops (multi-dose bottle). Lotacryn®** | ICB to contact consultant, Mr Lobo, at Moorfields Hospital regarding the recommendation of approved multidose preservative free formulations rather than the UDVs. | Dr Lobo is supportive of this and will share with the team. Actioned – To close. | |
| 5. | **Items for consideration** |
| 5.1 | **ADHD children and young people shared care guideline.**  deferred to February meeting. |
| 5.2 | **Apomorphine shared care guideline**  Two separate guidelines are currently available for Bedfordshire and Luton, and Milton Keynes which were due for review in 2021.  An alignment and update of the guidance for use across BLMK ICB was required.  A stakeholder meeting was convened on the 7th of October to discuss the guidance and come to a consensus where disparities between the two SCG occurred.  There is a regional clinical supervision group across BLMK which supports specialists and aims to support alignment. MK have not used apomorphine in the last 4 years, and Luton don’t have any patients on apomorphine currently.  Milton Keynes doesn’t have a Parkinson’s Disease Nurse (PDNS) specialist so referral specifically to a PDNS has been removed and replaced with “specialist”. This therefore excludes application of the flow chart to MK in the appendix which applies to Bedfordshire and Luton only.  The duration of optimisation was agreed to be a *minimum* of 28 days. MK had specified 3 months and BL, 28 days.  It was agreed in the interests of flexibility and choice that both APO-go® and Dacepton® should be included.  Training, educational, and professional support will be provided by the specialists. E.g. for the district nurses that may be administering.  Patients should be pre-treated with domperidone (10mg three time a day) for at least 2 days before starting on apomorphine. Once apomorphine is established, it was agreed that the specialist will gradually reduce and discontinue domperidone.  Bionical nurses are CQC registered and support patients on Dacepton®.  It was agreed that a Coombs test would only be required at initiation and not routinely repeated during maintenance.  The group required confirmation that contact details are accurate and up to date. Only consultant details have been included for MKUH. A typo in the email address of a Luton consultant was noted. It was suggested that wording around taking on shared care by primary care clinicians is amended. Standard GMC wording should be used.  Communication between the specialist, primary care and community pharmacist is included under patient responsibilities but should be under the specialist and primary care responsibilities.  Actions:   * Contact details will be checked and completed. * Communication between care providers to be moved from patient responsibilities to specialist and primary care responsibilities. * Use wording from GMC regarding primary care taking on shared care.   The committee approved the guidance subject to the agreed changes. |
| 5.3 | **Review of formulary choice of standard disposable pen needles.**  This review had been prompted by recent supply disruptions to MyLife pen needles, which is the most prescribed pen needle locally.  There are a wide range of choices costing between£2.40 and £9.24 per pack, lengths ranging from 4mm-12mm and gauge size from 29-32. The Forum for Injection Technique advises use of a shorter length, highest gauge needle to minimise pain on injection. Local specialist teams recommend 4-5mm lengths. NHSE guidance from 2019 recommends using needles costing less than £5/100 needles.  This review has provided an opportunity to align choice across the ICB as there is a wide variation in prescribing from our legacy CCGs and provides an opportunity to realise cost savings. A range of 5 different needles have been selected to mitigate against supply disruptions. They have a universal fit and compatibility with all major pens including insulin and GLP-1 analogues.  Stakeholders, including DSN within the different areas of BLMK ICS, have been consulted and are supportive of the choices.    The recommended choices were approved by the group. |
| 5.4 | **Temazepam and nitrazepam formulary status**  B&L and MK formulary currently designates temazepam as green. B&L designates nitrazepam as green restricted, no new initiations in Primary or Secondary care, exemption to exceptional use by Mental Health Trust. In MK, nitrazepam is green.  Nitrazepam is longer acting and can have next day “hangover” effect.  Risks with benzodiazepines, as included in the NICE CKS for insomnia include, falls and injury in older people due to a greater risk of becoming ataxic and confused. The longer the prescription is continued, the greater the risk of tolerance (within 3 to 14 days of continuous use) which progressively reduces their effectiveness. Dependence may develop, and treatment may serve only to prevent withdrawal symptoms. Preventing long term use avoids experiencing adverse effects (e.g. depression and increased anxiety), the risk of a road traffic accidents, as benzodiazepines can impair driving performance, and minimises the risk of drug interactions (e.g. with alcohol or other drugs with sedative actions).  NICE CKS (Clinical Knowledge Summaries) for insomnia states that pharmacotherapy for insomnia management may be considered if other options such as sleep hygiene measures fail, daytime impairment is severe causing significant distress, and insomnia is likely to resolve soon (for example due to a short-term stressor). BNSSG (Bristol, North Somerset, and South Gloucestershire) ICB advises to always consider alternatives to benzodiazepines, such as non-pharmacological strategies e.g. CBT, mindfulness, social prescribing, Sleepio/Calm/Headspace apps (these would need to be patient funded) and medication with less risk of dependence e.g. SSRIs.  NICE CKS for insomnia June 2024 doesn’t include temazepam or nitrazepam. Recommendation for short-term insomnia, of less than three months’ duration, is a short course (three to seven days) of a non-benzodiazepine hypnotic medication (Z-drug). They are not mentioned in BOB ICB Primary Care Guidance on Managing Insomnia in Adults which was updated in May 2024. PrescQIPP’ s Insomnia Bulletin 352 September 2024 states, not to prescribe benzodiazepines for the treatment of insomnia where Z-drugs would be appropriate. It also states not to switch between hypnotics as there is no evidence to suggest that if a patient does not respond to one of these hypnotic drugs, they are likely to respond to another i.e. there isn’t a need for a choice of hypnotics on the formulary. However, BNSSG ICB, Benzodiazepines and Z-drugs as Hypnotics and Anxiolytics support document August 2023 states that there is no firm evidence of differences in the effect of Z-drugs and shorter-acting benzodiazepines.  The proposal is to remove the green/green restricted formulary options and designate as non-formulary for new patients.  The group was asked if a hypnotic started as an ELFT inpatient would be continued by primary care? The group agreed that secondary care initiation is seen very rarely. Some GPs would not be willing to take over a prescription if started as an inpatient. The group was reminded that NICE CKS recommends benzodiazepines for palliative care patients.  The group agreed status of temazepam and nitrazepam from green to do not prescribe with existing patients to be reviewed with a discontinuation plan.  Action: IS to take proposal to Med. Com. for comments. |
| 5.5 | **Alternative guide to prescribing ‘specials’ update**  Approval is being sought for an update of this support tool created for practices which are prescribing Specials. Recommendations are based on cost, licensing, and local formularies. This document supports the cost saving element of the PIS (Prescribing Incentive Schemes) 24/25 and future PIS. Appropriate messages have been added to ORx to reduce prescribing of specials. This guidance will be regularly reviewed and updated. The drug lines which have been reviewed are those that have been picked up by recent ePACT and ORx data, therefore is relevant to our locality. Whilst completing the review, it has not been requested that expensive licensed liquids should be added to the formulary where there can be off label use (e.g. crushing and dispersing tablets) Otherwise, a lot of high-cost licensed liquids would be added to the formulary. For enalapril, the licensed liquid is £238.00 for 150ml whereas the unlicensed preparations are approximately £30.  The group agreed to the changes to the updated BLMK specials guidance. |
| 5.6 | **Varenicline**  Varenicline has been reintroduced to the market.  It binds with high affinity and selectivity at the α4β2 neuronal nicotinic acetylcholine receptor, where it acts as a partial agonist. Its binding both alleviates symptoms of craving and withdrawal and reduces the rewarding and reinforcing effects of smoking by preventing nicotine binding to α4β2 receptors.  First marketed in the UK by Pfizer in 2006, varenicline (Champix) was an important stop smoking aid until 2021 when it was withdrawn after it was found to contain nitrosamine contaminants above the acceptable level.  Varenicline is currently non-formulary, DNP for both formularies which states:    April 2022: As per MIMS deleted product list - Pfizer have withdrawn product from the market due to possible carcinogen contamination.  There is a NICE TA123 for varenicline which was first published in July 2007 and evidence reviewed in January 2011. Nothing new that affected the recommendations in this guidance was found at the time. This guidance will be reviewed if there is new evidence that is likely to affect the recommendations.  Varenicline was found to be superior to NRT and bupropion in achieving continuous abstinence from direct trials and systematic reviews.  NICE has indicated that it should be a first line treatment and smokers should be routinely offered it as one of the options available to them. It should not be necessary for people to have failed to stop smoking with other medication before using varenicline.  The Committee heard from the clinical specialists and patient experts that the success rates with varenicline made it a useful addition to the variety of interventions available in smoking cessation, particularly because many smokers need to make multiple quit attempts.  The NCSCT (National Centre for Smoking Cessation and Training) is a social enterprise. The NCSCT was initially established at University College London in 2009 via a three-year Department of Health grant. Now a community interest company, the NCSCT is part-funded through a contract with the Office for Health Improvement and Disparities (2023-26) and through licensing its training and assessment programme.  NCSCT states:  “Varenicline is a safe, effective, and cost-effective treatment for smoking cessation in adults. It is a first line stop smoking aid and is recommended by NICE for treatment of tobacco dependence.  Varenicline should be offered as a first line stop smoking aid, including for people with mental health problems. Other first-line stop smoking aids are combination NRT, nicotine-containing vapes and cytisine.  It is certainly more effective than NRT used in single forms (e.g. patch or gum). Its advantage over a combination of more than one NRT product (patch plus a fast-acting form) is likely to be smaller.”  Cytisinicline 1.5mg tablets / cytisine® was approved for use in BLMK in April 2024. NICE exceptional review suggests cytisine is as effective and safe as other treatments available and should be considered for local use. An update to NG209 (Tobacco: preventing uptake, promoting quitting, and treating dependence) is due by 4 February 2025 due to this review. This exceptional review was carried while varenicline was unavailable.  Varenicline treatment course is 12 weeks, but it can be extended to 26 or 52 weeks in abstinent individuals to reduce risk of relapse. Cytisinicline treatment course is 25 days (100 tablets to complete the course). Varenicline (both strengths) cost £23.21 for 28 (£46.42 for 56 tablets). A 12- week course of treatment costs £159.98. A Cytisine course costs £115.00 (100 tablets).  The head-to-head comparisons between cytisine and varenicline found side effects to be less common for cytisine. Cytisine’s main known side effects are gastric symptoms and sleep disturbance. It could remain an option for patients unable to tolerate varenicline. When NICE publish their updated guidance, it is hoped that the place of both varenicline and cytisine will be clarified.  Varenicline typically costs more than other smoking cessation medications. However, it is also more effective, so when examined as cost per quitter, the figures are very similar. Comparisons of cost-effectiveness have found varenicline to be at least as cost-effective as NRT or bupropion.  The proposal is for varenicline to move from non-formulary to green formulary status.  Varenicline is currently not listed in the drug tariff, this creates potential financial risk as pharmacies can dictate the charge. Most will charge the price in the wholesalers, but it may be prudent to wait until it is in the drug tariff. FG has spoken to Susan Greave from the Department of Health who confirmed there has been a delay, but it will go into the drug tariff in due course.  It would need to be added to the formulary due to the NICE TA.  It is now listed on SystmOne.  Smoking cessation counsellors follow a decision aid but cannot prescribe as they are not healthcare professionals. The GP is responsible for clinically checking suitability according to the clinical records.  The group agreed to add varenicline to the formulary as green and review after NICE publishes its updated guidance. |
| 5.7 | **Unlicensed potassium liquids**  Deferred to APC meeting in December. |
| 5.8 | **Glaucoma eye drops review.**  Approval of the rationalisation of the formulary options across MK and B&L has been considered with colleagues at both trusts. Mr Lobo from Bedford Moorfields has seen the paper and agrees to the recommendations.  The recommendations from NICE Clinical Knowledge Summaries for Glaucoma were revised in February 2023 and form the basis for the recommendations along with cost and prescribing data. NICE states that first choice should be a generic PGAs (prostaglandin analogues), then an alternative generic PGA, and thirdly, a beta blocker. A non-generic PGA, carbonic anhydrase inhibitor, sympathomimetic, miotic or a combination of treatments may be prescribed if two different generic PGAs and beta blocker are not tolerated. Topical medicines from different therapeutic classes may be needed at the same time to control IOP (intraocular pressure). For patients with ocular hypertension, offer preservative-free eye drops to people who have an allergy to preservatives or people with clinically significant and symptomatic ocular surface disease, but only if they are at high risk of conversion to COAG (chronic angle closure glaucoma).  These recommendations align with PrescQIPPs Bulletin 344 Eye Preparations published in April 2024. Generic latanoprost was introduced in 2012, followed by generic bimatoprost and travoprost. There is a significant price difference between the branded and generic products which represents considerable savings for the NHS if the generic versions are preferentially prescribed. If a patient with stable glaucoma is tolerating a branded medication well, it may not be appropriate or cost-effective to switch to a generic version of that medication. Switching to a generic medication may prompt extra monitoring visits and there will be costs associated with this. The different appearance of the bottle may cause confusion, especially with the visually impaired, and the bottle may not be as easy for the patient to use. Patients may need different eye drop administration aids if their drops are changed because generic bottles are not necessarily the same size, rigidity nor shape and may not fit their present aid. The need for multiple eye drops may adversely affect adherence, increase exposure to preservatives and if done incorrectly could reduce efficacy through wash-out of the earlier drop with the latter drop. Use of a fixed combination drop can avoid these issues. However, fixed combinations remove the possibility of titrating the individual components both in terms of concentration and timing of administration. Most of the fixed-dose combinations available in the UK contain timolol 0.5%. Furthermore, unnecessary side-effects may arise because of the higher concentration of timolol (0.5%) in all currently available fixed combinations. Some (but not all) fixed combinations also cost more to prescribe than their separate constituents.  The proposal is for the formulary drops to be designated as SpA. Combination drops should only be recommended if patients are unable to manage individual preparations. Levobunolol (Betagan) is recommended as non-formulary due to not being issued by MKUH in the last year.  New cost and carbon saving multidose preservative free drops have been added to the formularies i.e. Bimi®, bimatoprost, Dimaz®, dorzolamide, Codimaz®, dorzolamide and timolol, Lotacryn®, latanoprost.  The group approved the recommendations. |
| 5.9 | **JAC merger and formulary alignment**  This is a new standing agenda item for documentation and governance of formulary alignment in line with work around JAC merger at BHFT.  Amorolfine 5% nail lacquer is non-formulary on B&LF, green on MKF. It has been recommended that this becomes non-formulary as it is considered self-care as per NICE CKS for fungal nail infections. Felodipine 10mg MR tablets are non-formulary on B&LF and green on MKF. It was recommended that this is made non-formulary as it is not included in our recent hypertension guidelines. However, existing patients may remain. Metronidazole (Zidoval) 0.75 % vaginal gel is non-formulary on B&LF but included in the BLMK antimicrobial guidance. It has been added to the formulary as a second line option. Tizanidine 2 mg tablets are SpA on B&LF and SpIS on MKF. It had been agreed that formulary status should be SpIS at FSG in June 2022. Sterile talc has been added as red from non-formulary status at B&LF. Zonisamide is non-formulary on B&LF, SpIS on MKF. As it is recommended in the NICE epilepsy guidance, SpIS status has been advised.  It was clarified that ELFT should be following the BLMK formulary for patients in this ICS.  The group approved the recommendations made from this review. |
| 5.10 | **Retirement of the melatonin shared care guideline**  A shared care guideline for melatonin is in place for the treatment of Insomnia and Sleep Disorders in Children and Adolescents which is applicable for patients within the Bedfordshire & Luton area under the care of a Specialist at East of London NHS Foundation Trust (ELFT). It was published in Dec 2017, and it was due to be reviewed in Nov 2019.  MK formulary designation for melatonin is SpA, specialist to advise medicine prior to initiation in Primary Care.  There are now several licensed melatonin products available as tablets, dispersible tablets, and a liquid formulation with licensing in children and adolescents. This reduces the risk for the patient and primary care prescriber.  There is no specific monitoring that is required for patients on melatonin by primary care other than checking continued benefit (usually via a sleep diary and drug holiday) at the 6-month point between the specialist annual review.  The proposal is for the retirement of the shared care guidance for melatonin and designate it as SpIS for children and young people.  Prescribers will need to ensure this review occurs before the patient is discharged by Childrens’ services:  “It is unusual for a child to continue melatonin into adulthood. It is the responsibility of the referring specialist to decide if it is appropriate to continue for a specific individual. The specialist will then advise the GP on future management.”  A prescribing guidance will replace the SCG, and it is planned that this will go to APC in December.  The community paediatricians’ team are supportive of the retirement of this SCG. Confirmation was required that the GP would review annually if care were transferred when the patient is stable and at 18 years of age the specialist would complete the final review. It was felt that few patients would be on melatonin alone so SCGs would still be in place for the other medication the patient would be taking. However, ELFT is seeing referrals for children that only require melatonin. Utilising/creating a template on SystmOne for melatonin review for primary care could be encouraged. A screen shot for an insomnia template that is available and could be used was shared. It was clarified that this proposal is only for consideration in children and young people and the specialist would still need to initiate.  The group approved retirement of this SCG and to designate melatonin prescribing in children and young people as SpIS. |
| 6 | **Minor amendments log**  Noted. |
| AOB | **Colchicine 500mcg tablets – Serious Incident**  A postmortem toxicology for a patient that died at home showed high levels of colchicine and a probable link to the patient’s death.  Colchicine has a narrow therapeutic window. There has been an MHRA warning regarding [Colchicine: extremely toxic in overdose - GOV.UK](https://www.gov.uk/drug-safety-update/colchicine-extremely-toxic-in-overdose)  These are the recommended doses as per indications:  **For acute gout:**  Prescribe 500 micrograms of colchicine 2-4 times daily, until pain relief is achieved.  The manufacturer recommends a dose of 1 mg to start followed by 500 micrograms after 1 hour, leaving a gap of 12 hours, and resuming treatment with 500 micrograms every 8 hours until symptoms are relieved.  The maximum dose per course is 6 mg (12 tablets) and the course should not be repeated within 3 days.  **For prophylaxis of gout flares (during urate-lowering treatment):**  Give 500 micrograms of colchicine twice daily following initiation of long-term treatment with allopurinol.  Treatment duration should be decided taking into account factors such as flare frequency, gout duration and the presence and size of tophi, but only until the urate has been lowered.  **Acute pericarditis**  An off label unlicensed indication.  It is Red on the MKF, not yet on the B&LF – BHFT are looking to add it.  <https://gmmmg.nhs.uk/wp-content/uploads/2021/08/Colchicine-for-pericarditis-info-sheet-for-GPs-V6-approved.pdf>  BLMK ePACT data    BLMK ICB SystmOne formulary states 12 tablets are issued for an acute course which prevents the prescribing of excess quantities.  However, the TPP formulary defaults to as directed, 100 tablets. The ICB has asked TPP to change this default number.  GP practices will be asked to review prescribing of colchicine via the prescribing leads meetings. This agenda item will be discussed at Medicines Safety Group and Prescribing Committee.  Community pharmacies will be asked to query any prescription written as directed, with high quantities, or prescribed long term, and ensure patients are aware that the therapeutic and toxic dose are very similar.  BHFT are to mirror and align the red indication for pericarditis as seen in MKUH.  Specialists generally do not prescribe more than twice a day for an acute gout flare unless the patient was already on twice daily colchicine, in which case it would be increased to three times a day (due to diarrhoea experienced by some patients). Twice a day dosing is also recommended for patients being treated for pericarditis. Renal patients are prescribed a once daily dose for prophylaxis. Patients can be initiated on an 8-week supply in case there are delays in the patient obtaining colchicine in primary care. A 4-week supply will be provided henceforth. Colchicine can be stopped once the urate has come down. This usually takes 3 months, even sooner if using febuxostat as opposed to allopurinol.  MC offered to support any education or learning around managing patients with gout. |
|  | **Novo Nordisk is planning to discontinue Victoza brand of liraglutide.**  There will be new biosimilar products entering the market and they will be brought to formulary subgroup for approval. |
|  | **Generic prescribing of methylphenidate**  As per recently released NHSE guidance on safe prescribing of methylphenidate the group discussed generic prescribing There is a risk that patients will be switched to a capsule formulation that is not bioequivalent. The methylphenidate formulary entries have been updated recently to help switching to bioequivalent preparations. The ICB will be producing an update of bioequivalent options. |
|  | The group discussed if patients that are HIV positive and not registered with their GP should be issued with medications by the sexual health clinic for other conditions which need to be prescribed. Patients do not have to divulge their HIV status to the GP, and they would need to be registered to access NHS care. There is a need to prevent identity fraud and the diversion of medication by ensuring patients register.  Partner practices deal with homeless patients.  An NHS number is not required for immediate care. |
|  | Meeting dates for 2025 are available on BLMK ICB Website – Formulary Page  <https://medicines.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/> |

Chair Signature: 

Date: 12.03.2025