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

**Meeting Notes**

Date: 22nd of April 2025

Time: 13.00 - 14.30pm

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 |  |  |
| Faisal Khan | FK | Medicines Use & Quality 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 |  |  |
| 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 | Head of Medicines Governance Safety and Quality (cross site)  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 |  |  |
| Amjid Hussain | AHu | Bedfordshire Lead for the Community Mental Health Services, ELFT. |  |  |
| Sanil Patel | SP | Associate Director of Pharmacy MKUH |  |  |
| Dr Matthew Johnson (invited for agenda item 5.4) | MJ | Gastro Consultant BHFT |  |  |
| Dr Maria Mouyis (in attendance for agenda item 5.1) (until 13:35) | MM | Consultant Rheumatologist and Obstetrician |  |  |
| Dr Dushyanthy Jeyanesan (invited for agenda item 5.7) | DJ | Consultant Urogynaecologist, BHFT |  |  |

**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 Faisal Khan, Medicines Use & Quality Manager MKUH and Dr Maria Mouyis.  Apologies received from Dr Dushyant Mital, Dr Mya Aye and Dr Jonathan Walter.  The meeting was confirmed as quorate. |
| 2. | **Declarations of Interest**  Annual written declarations of interests – currently up to date and requests for updates have been sent.  Members were invited to declare any conflicts of interest relating to matters on the agenda, none declared. |
| 3. | **Minutes of the previous meeting**  The February 2025 FSG meeting notes were approved as accurate. |
| 4. | **Action Log**  Actions were noted in accordance with the action log:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Item** | **Title** | **Date added** | **Owner** | **Action** | **Update** | | 1. | **An update of bioequivalent options of methylphenidate.** | November 2024 | ELFT | Update to <https://medicines.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/guideline/table-of-available-brands-for-biphasic-methylphenidate-mr-products/> | The formulary pages will be updated with new methylphenidate preparations and bioequivalent options. Close. | | 2. | **Xonvea formulary decision** | February 2025 | BHFT | To present the results of their local audit at FSG and discuss the consequential formulary status. | Presentation at April meeting. | |
| 5. | **Items for consideration** |
| 5.1 | **BHFT Xonvea audit feedback**  This feedback was presented by Dr Maria Mouyis, Consultant Rheumatologist and Obstetrician BHFT.  In general, 80% of women will experience nausea and vomiting when they're pregnant, and it can persist for most of the pregnancy in 20% of women. 4% will have severe hyperemesis (HG), requiring admission. In 5-10% of women this can lead to termination of the pregnancy. Nausea and vomiting that is not considered hyperemesis can still be quite disabling, and the annual cost can be as high as £62 million.  Side effects of hyperemesis and nausea and vomiting in pregnancy can be a biochemical thyrotoxicosis because HCG can act as a TSH agonist. This will appear biochemically as hyperthyroidism without the clinical symptoms. Oesophagitis, gastritis and reflux s common and treated with a PPI. This can settle when the vomiting is controlled but it also affected by the abdominal pressure from the growing foetus and pregnancy hormones. Liver disturbances can occur such as transaminitis (a concern if five times the upper limit of normal). Women suffering from hyperemesis and nausea and vomiting should have an assessment of their thromboembolic risk (in primary or secondary care). The risk is increased due to dehydration and the pregnancy itself. Wernicke’s encephalopathy is a rarely seen side effect from a deficiency of the nutrient thiamine, but it needs to be monitored for as it can result in the foetus being small for gestational age, a three times increased risk of neurodevelopmental disorders and intrauterine death in 50% of cases. Protracted vomiting may require the prescription of 100mg thiamine three times a day. If electrolytes become deranged, the result could include acute kidney injury, arrhythmias As with the other side effects, treatment would be management of the hyperemesis, nausea and vomiting via hydration and anti-emetics.  The use of antiemetics has not been linked with neurodevelopmental delay. The benefits of treatment outweigh the risks.  The Green-top Guideline No.69 for the Management of Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum was published by the Royal College of Obstetricians and Gynaecologists (RCOG), in February 2024. Information on monitoring and scoring in these patients was defined for the purposes of admission (PUQE Pregnancy-Unique Quantification of Emesis index) score >13 and HELP (HyperEmesis Level Prediction) score >33).  A first line treatment option suggested by RCOG Green-top guideline 69 is doxylamine with pyridoxine (Xonvea®). The usual starting dose is one tablet at night or one tablet twice a day with the potential to increase to a maximum of four tablets daily (in divided doses). Other first line options include cyclizine, prochlorperazine, promethazine, or chlorpromazine. Second line options are metoclopramide and domperidone, but dystonic reactions may occur with prolonged or IV use. With ondansetron there is an insignificantly increased risk of cleft lip. The third line option is hydrocortisone intravenously when the patient needs admission. Xonvea is the only licensed medicine for this indication, however there is a great deal of experience with the alternatives.  The guidelines state that it is important that general practitioners validate the patients’ symptoms, adequately treat and that there may be a need for more than one antiemetic.  The [Bumps website](https://www.medicinesinpregnancy.org/) includes medication summaries with safety profiles which can be referred to and women can be signposted to online support such as the [HER Foundation](https://www.hyperemesis.org/).  Xonvea is being used cautiously in the trust due to the cost implication in relation to other medicines. The audit initially included 12 patients, but complete data was only available for 8 of these patients. The average age was 34.5 years, and average gravida was 2.6 (averaging between 1-4 pregnancies). Onset of symptoms was between 5 and 6 weeks. 6 of the patients were managed as outpatients, and 2 required admission. Most patients had tried 2 antiemetics by the time they were seen with the most common combination being cyclizine and ondansetron or prochlorperazine and ondansetron. Patients were started on a low dose of Xonvea, one tablet twice a day. The PUQE score averaged 12 before treatment with Xonvea and 8 after, so an improvement was seen and a lot of patients felt significantly better. Patients stopped the treatment after 20 weeks or reduced the dose to one tablet at night and stopped the other antiemetics. The prevention in admissions would provide a significant cost saving.  In conclusion, HG and nausea and vomiting are significant health issues for patients in pregnancy and for the foetus. Xonvea is the only licensed anti-emetic for use in pregnancy, is very effective in most patients, reduces the number of antiemetics needed, reduces hospital admission stays and reduced PUQE scores in this audit. It was therefore proposed that formulary status should be changed from Red to SpIS to allow initiation of Xonvea in secondary care, with continuation in primary care.  MM confirmed that patients referred to the maternal medicine clinic will be seen at least twice and depending on the severity, can be seen face to face or virtually. There is a chance that patients admitted to hospital may not be referred post discharge to the maternal medicine clinic and will be managed by their GP.  Patients tend to self-manage their treatment as symptoms improve, and the longest treatment period seen by MM is through to the second trimester. If symptoms are mild, treatment is usually until 20 weeks and if severe, patients are encouraged to gradually reduce their dose to just one tablet daily. By the third trimester only 4-5% of patients may need to stay on treatment.  Women are counselled about Xonvea by secondary care and the way in which to reduce the medications. They tend to have concerns around the risk of congenital malformations and want to minimise the use of medicines as well as genuinely feeling better.  The GPs requested support and guidance when taking over the prescription of Xonvea.  **Action:** A request for a link to the RCOG guidance was suggested via the discharge or outpatient letter and the formulary to support the primary care prescribers with a clear route back if HG or nausea and vomiting persists.  It was agreed for Xonvea to be switched from a red formulary status to SpIS, for secondary care treatment and initiation to prevent delays in obtaining treatment once the patient has been assessed as requiring treatment by secondary care. |
| 5.2 | **Bupropion for treatment resistant depression and prescribing guide**  Patients are classified as having refractory/treatment-resistant depression (TRD) if they haven’t responded to the standard antidepressant pathway and may be on more than one antidepressant or a mood stabiliser or antipsychotic. Bupropion is currently being used off-label for TRD in BLMK by the specialists and has been brought to the subgroup following anticipated resolution of supply issues, with low patient numbers (~3–5/year in ELFT and CNWL). It is considered third or fourth line after licensed options and various combinations have been tried. These patients are likely to remain under specialist care and may eventually require ECT. IS requested the addition of bupropion hydrochloride (150mg modified-release tablets) to the BLMK formulary as an Amber SpIS – Specialist Initiation and Stabilisation, option for TRD in adults. The specialists will initiate and stabilise patients and only if patients are stable, would primary care be asked to take over prescribing. The only specific monitoring required would be blood pressure.  Women that become pregnant, are referred to the perinatal mental health teams for support in assessing the risk to the mother and baby.  It was clarified that sexual side effects are reported less with bupropion, but there are no head-to-head comparisons with SSRIs.  CNWL have received requests for stable patients needing to continue prescribing that have moved from the US or other European countries where it is licensed and used more widely. This prompts a specialist review as it is a non-formulary option and adds to the specialist case load. The group agreed that stable patients should be managed by their GP. Requests from private psychiatrists were noted, but this would not be picked up by the NHS.  It is currently unavailable at the three main wholesalers and is expected back in the middle of May. When there are supply issues, the specialists are requested not to initiate this medication.  **Action:** IS will update the bupropion prescribing guide (can also be found on the ELFT intranet) stating use when licensed options have been explored and that the specialist will provide rationale for choice. A minimum of 6 months stabilisation period will be specified. A link to the MHRA alert on serotonin syndrome will be included. Specialists are requested to check that stock is available before initiating. Changes agreed will be shared with RA for CNWL approval.  Bupropion was approved for addition to the formulary as Amber-SpIS for refractory depression, with a formulary note for use when recommended by the adult mental health team after licensed options have been explored. The associated prescribing support information, with the amendments agreed above, was also approved. |
| 5.3 | **Proxor 100/6 & Proxor 200/6 pMDI**  Current pMDI formulary options for asthma and COPD are Fostair and Luforbec containing beclomethasone and formoterol. A new equivalent pMDI, Proxor has been introduced to the market and it is 66% cheaper than Fostair and cheaper than Luforbec (even with the rebate). The prescribing incentive (PIS) scheme this year is suggesting that practices review patients on Fostair, for consideration of the more cost-effective brand Luforbec. Proxor’s addition to the formulary will provide further savings and options for patients and clinicians. Prescribing has switched to Luforbec following its inclusion in the formulary last year and the team is not suggesting that patients that are stable on Luforbec are switched. The maleic acid in Luforbec resulted in a cough for some patients and some ICBs have removed it from their formulary as a result. However, Proxor is a like for like switch in terms of device and excipients to Fostair. There is no specific benefit in terms of its carbon footprint. The group discussed the preference for a single brand for the benefit of the community pharmacist stock management, prescribers, and the patients. AH confirmed that it is freely available from the wholesalers.  The group agreed to the addition of Proxor to the formulary as the first-choice beclomethasone and formoterol MDI for new patients (unable to use a dry powder inhaler) with the potential to switch patients from Fostair for a cost saving.  **Actions:** NW and trust representatives to consult with specialist respiratory teams informing them of the preferred brand (with the potential to replace Fostair stocks with Proxor). The preference would be for generic prescribing by trusts/respiratory specialists to allow primary care to provide the most cost-effective brand. Optimise Rx messaging will be used to support primary care prescribers to initiate and make appropriate switches. |
| 5.4 | **Pylera -deferred to next meeting.** |
| 5.5 | **Felodipine MR**  This is a request for the addition of felodipine MR to the formulary prescribed as the branded generic, Delofine XL. The first line calcium channel blockers on the formulary are amlodipine and lercanidipine. Even though felodipine MR is not on the formulary, there were 12,000 prescriptions issued in a quarter. There is a potential saving opportunity in prescribing Delofine XL as it is 59% cheaper and has the potential to save up to £130,000/annum. Felodipine MR would still be considered after amlodipine and lercanidipine, but patients could be switched to Delofine XL or new patients initiated on this branded generic. There are no current supply issues. Hospital colleagues are requested to recommend the generic.  The addition of Delofine XL was approved for addition to the formularies as an option after amlodipine and lercanidipine have been considered.  **Action:** Optimise Rx will be utilised to support appropriate initiation and switching. |
| 5.6 | **Tavistock SCG for transmen and women –deferred to next meeting.** |
| 5.7 | **Estring**  This application was initiated by Dr Jeyanesan, consultant urogynaecologist at BHFT. Estring is a vaginal ring releasing 7.5 micrograms estradiol over 24 hours and is licensed for atrophic vaginitis in post-menopausal women. It is an alternative option to the cream and pessary for patients that struggle with administration due to dexterity issues or conditions such as dementia as it only requires insertion every 3 months, The maximum recommended duration of continuous therapy is two years according to the [Summary of Product Characteristics](https://www.medicines.org.uk/emc/product/1083/smpc).It would reduce caregiver burden and improve compliance. An annual review is required. It is included in the NICE HRT CKS and British Menopause Society Tools for clinicians. There is estimated to be an 83% symptom improvement, which is equivalent to vaginal cream, and no endometrial hyperstimulation, which occurs in approx. 11% of patients using the cream. There is improved comfort and ease of use in comparison to the cream. However, it is more costly than the alternative formulations. ePACT Data from 23/24 financial year indicates that 31 patients were prescribed Estring in primary care. Numbers are expected to remain low, as it will be considered as an option for a select patient group, and if 60 patients are prescribed it, the annual cost would be £7,552. As the ring does not require an applicator, like the cream, this avoids plastic waste. The ring should be straightforward to administer.  The recommendation is that Estring is added to the formularies as amber SpA third line option, so it will be recommended/initiated by the specialist, perhaps first insertion by the GP, with continuation in primary care and an annual review.  The group approved the recommendation. |
| 5.8 | **Aminosalicylates review**  As part of the JAC alignment and formularies review, this therapeutic class, with a £2.27M spend annually in primary care, was reviewed to rationalise product choice.  The NICE guidelines for ulcerative colitis and the British Society of Gastroenterology guidelines for inflammatory bowel disease were consulted, but there is no reference to a preferred agent.  Product choices are based on the location of the active disease, cost-effectiveness, and resilience when supply is disrupted.  A summary of the main changes and rationale was provided:   |  |  |  |  | | --- | --- | --- | --- | | **Product** | **Current Status** | **Cost/Tab (Drug Tariff April 2025)** | **Proposal** | | Octasa® MR | 1st-line (BLF/MKF) | 22p (400mg)  45p (800mg) | **Retain** (SpA) | | Octasa® 1600mg MR | Non-formulary | £1.00 | **Add** (SpA) for high dose/once daily | | Mesalazine (Octasa®) 1g suppositories | No entry | 99p | **Add** as cost effective c.f. Pentasa brand. | | Mezavant® XL 1.2g | 3rd-line (BLF) | 72p | **Retain** (SpA); remove "3rd choice" | | Mesalazine (Salofalk®)  (Granules in sachets) | No entry in BLF  Green in MK. | 500mg 29p  1g 57p  1.5g 81p | **Add** to BLF as costs reasonable. | | Mesalazine (Pentasa®) | Green in BLF  No entry in MK | 1g pr sachets 61p  2g pr sachets 123p | **Add** to MK as costs reasonable. | | Mesalazine (Salcrozine®) tabs | No entry | 500mg 22p/tab  1g 43p/tab | No current prescribing.  Don’t add to formulary. | | Balsalazide | Non-formulary | 750mg | Low prescribing. Not added. |   NICE recommends use of once daily maintenance dosing, but patients may experience increased side effects. The high dose formulations can be of value in patients needing to reduce tablet burden.  Most products are currently green on the formulary, but as patients are diagnosed, and treatment initiated by the specialist it is recommended that these products are moved to amber SpA. SpIS status should be retained for the sulfasalazine preparations as there is initial titration and frequent monitoring required.  The recommendations include the following savings opportunities:   * £4,427/year: Switch 50% Pentasa suppositories → Salofalk. * £5,851/year: Switch 50% Asacol → Octasa.   A potential cost pressure from the recommendations includes an estimated £5,208/year from using Octasa 1600mg MR (offset by reduced pill burden) as opposed to the lower strength formulations.  The recommendations support access to different preparations across BLMK. Any switching needs to ensure patients are supported in monitoring for any changes in tolerability and symptom control with specialist review for complex cases.  BHFT gastro team have requested the addition of the mesalazine granules and the 2g in 59ml retention enema for patients unable to tolerate the foam enemas. The retention enema costs £29.92 for 7 enemas which is comparable, gram for gram, to the 1g strength. It was agreed to add this to the formulary.  The recommendations made in the paper were approved including the 2g in 59ml retention enema. |
| 5.9 | **JAC Merger Formulary Alignment 3**  This is a standing agenda item for documentation and governance of formulary alignment in line with work around JAC merger at BHFT.  It was noted that quinine bisulphate is non-formulary on both formularies so would not be added as red as listed on the recommendations.  The addition of fludroxycortide tape was queried as more appropriate for the wound care formulary. However, the green status in MK for use in eczema and keloid scars was felt to be more appropriate for dermatology. In either case, the recommendation should come from a specialist and the group agreed that it was not something primary care would be initiating. It was noted that an application from the stoma nurses is expected forsore/ulcerated peristomal skin and pyoderma gangrenosum.  The group approved the recommendations made from this review with the exclusion of quinine bisulphate, to remain as non-formulary and fludroxycortide tape to move to SpA.  Scheriproct was noted as being POM and cannot be recommended as a self-care item like Anusol Plus HC suppositories. |
| 5.10 | **Ketamine use in palliative care**  Recent queries into the use of ketamine in palliative care in Milton Keynes, Bedfordshire and Luton has led to a review of its status. A shared care guideline has been in place for Bedfordshire and Luton since 2018, but it has a red formulary status in Milton Keynes. However, patient numbers are low with only two patients prescribed it in the last year. The maintenance of shared care guidance is laborious, and the proposal is to retire it considering it is rarely used. St John’s and Keech Hospices (covering Bedfordshire and Luton) have been consulted and agree. They occasionally ask GPs to take over prescribing but often GPs are refusing despite the SCG.  The group agreed to the retirement of the ketamine SCG and that use of ketamine as analgesic in palliative care should be red on both formularies. |
| 5.11 | **Standalone CGM Guidance Update**  Freestyle Libre (FSL) 3+ has recently been launched by Abbott, an upgrade from Freestyle Libre 3, and available on FP10. FSL2+ is the clear market leader with a lower acquisition cost. As a standalone CGM, the only significant advantage of FSL3+ over FSL2+ is that it is smaller and would be better for children under 12 with a small limb size. However, there is a risk that current patients on FSL2+ (5150 patients) could be switched to FSL3+ with a potential cost pressure of £1.6m without any clinical benefit. Therefore, the proposal is for FSL3+ to be recommended as a standalone CGM for type 1 diabetic patients under 12 years, usually in the first 8-12 weeks post diagnosis, before a pump can be introduced. The diabetes teams have been consulted and are supportive of the proposal.  The proposal was approved.  A new standalone CGM has been introduced, CareSens Air, which is comparable but slightly more expensive, in our ICB, than the market leader, FSL2+. It is only licensed in patients over 18. The group were asked to consider its addition as a second line option alongside Dexcom ONE+. The DSNs feel patient numbers are likely to be small, but it offers an alternative. As the current FSL2+ rebate is also based on a prescribing volume, alternatives could reduce the saving.  It was agreed that CareSens Air would not be approved but could, if necessary, be reviewed later. |
| 6 | **Minor amendments log**  Noted. |
| AOB | A self-care symbol Selfhas been added to both formularies for items that should be purchased over the counter but may be prescribed for chronic long-term conditions or on admission to hospital. |
|  | Meeting dates for 2025 are available on BLMK ICB Website – Formulary Page  <https://medicines.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/> |

Chair Signature: 

Date: 24.06.2025