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

Date: 10th of June 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

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	✓ (until 13:24)	
Marian Chan	MC	Consultant, Bedfordshire Hospitals NHS Foundation Trust	✓ (12:29-13:31 and 14:17-14:34)	
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 Timothy Archampong (invited for agenda item 5.1) (13:10 - 13:50)	TA	Gastro Consultant BHFT	✓	
Jo Rayner (in attendance for	JR	Lead Paediatric Dietitian, Nutrition and Dietetic Department (Bedford)	✓	

agenda item 5.2) (until 13:25)				
Dr Susantha Nawaratne Wijayasiri (invited for agenda item 5.4) (12:35 – 13:04)	SNW	Consultant Physician and Geriatrician Specialist and Lead in Parkinson's and Movement Disorders, L&D University Hospital	✓	
Alexa Jumao-as	AJ	Pharmacist from BHFT	✓	
Meagan Maap	MM	Pharmacist from BHFT (observing)	✓	

Summary of acronyms used in the document

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
1.	**Welcome, Introductions and Apologies** The chair welcomed everyone to the meeting including Alexa Jumao-as, Pharmacist, BHFT. Dr Timothy Archampong, Gastroenterology, BHFT, Jo Rayner, Lead Paediatric Dietitian, BHFT, Dr Susantha Nawaratne Wijayasiri, Specialist and Lead in Parkinson's and Movement Disorders, Elderly, L&D University Hospital. Apologies received from Dr Eleanor Tyagi, Dr Kate Randall 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 April 2025 FSG meeting notes were approved as accurate.

<table>
<tr><th>No</th><th>Agenda Item</th></tr>
<tr><td>4.</td><td>Action Log

Actions were noted in accordance with the action log:
<table>
<tr><th>Item</th><th>Title</th><th>Date added</th><th>Owner</th><th>Action</th><th>Update</th></tr>
<tr><td>1.</td><td>To support the primary care prescribers with Xonvea.</td><td>April 2025</td><td>MM, FK and SH</td><td>A link to the RCOG guidance via the discharge or outpatient letter and the formulary</td><td>The formulary pages have been updated with the link. Close.</td></tr>
<tr><td>2.</td><td>Bupropriion for resistant depression prescribing guide</td><td>April 2025</td><td>IS</td><td>Statement on use when licensed options have been explored and the specialist will provide rationale for choice to the primary care prescriber. 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 CNWL for approval.</td><td>IS to complete amendments to the prescribing guide.</td></tr>
<tr><td>3.</td><td>Proxor 100/6 & Proxor 200/6 pMDI</td><td>April 2025</td><td>NW, QK, FK, ORx team.</td><td>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 specialists/in secondary care 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.</td><td>Respiratory pharmacy team at MKUH have been informed, it has been added to the formulary and email comms to the teams associated has been circulated. It will be discussed for implementation at Resp. CIG next week.
ORx now has messaging live for new and existing patients to be switched to Proxor (both strengths).</td></tr>
</table>

The medical rep for Lupin Healthcare which manufacturers Luforbec has highlighted that the level of maleic acid is 340-fold less than would be required to induce a cough and is therefore extremely unlikely due to Luforbec. The newsletter has been amended regarding this information accordingly.</td></tr>
<tr><td>5.</td><td>Items for consideration</td></tr>
<tr><td>5.1</td><td>Pylera®</td></tr>
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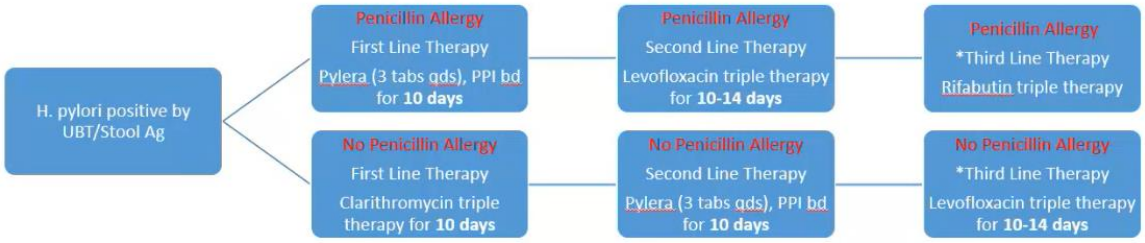
No	Agenda Item
	Dr Timothy Archampong, gastroenterologist at BHFT presented the paper to add Pylera to the formularies for patients requiring Helicobacter Pylori (H.Pylori) eradication treatment. Since the PHE (Public Health England) published guidance on H.Pylori in 2019, resistance patterns have changed and new medication is available. H.Pylori resistance is a significant global problem. There is more than 40% resistance to clarithromycin and 78% to metronidazole in the UK. Clarithromycin resistance of more than 15% significantly impacts on eradication. Resistance to amoxicillin and tetracycline is low at 2% and less than 1% respectively. Levofloxacin resistance is low at 4%, but recent studies suggest it is increasing to 15-20%. Unlike metronidazole, clarithromycin and levofloxacin resistance cannot be overcome by any dose changes. Currently, Pylera is the only combination on the market with more than 90% eradication rate, even with clarithromycin and metronidazole resistance. However, the high pill burden (12 capsules per day) and side effect profile, 35% compared with 25% for other regimens, may limit compliance. Few studies show discontinuation of therapy purely based on side effect profile. Its addition to the formulary would increase treatment options. Pylera could lead to reduced repeat treatments if used in primary care and referrals to gastroenterology. As a first line option, it goes against PHE guidance, but this hasn't been updated since 2019. A 10-day course of Pylera costs £40.14 compared to standard triple therapy which costs £2.91 for a 7-day course. The recommendation is to add it to the formulary as a first line option in patients allergic to penicillin, as they are exposed to clarithromycin and metronidazole, and second line option for all other patients. For patients not allergic to penicillin, regimens containing amoxicillin should prove to be effective. Proposed *H. pylori* treatment algorithm  Bismuth standalone treatment is not licensed for H.Pylori and supplies are difficult to obtain, however, Pylera is a licensed combination. The recommendation for using clarithromycin in patients without a penicillin allergy as a first line option if resistance is significant was queried. This recommendation is based on current PHE guidance.

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	Counselling on the importance of compliance to the Pylera regimen is essential given the greater pill burden and longer duration of treatment. Eradication should be confirmed 2 weeks after stopping the eradication regimen as PPIs reduce sensitivity to testing. A post infective functional dyspepsia can remain for a short period post eradication in some patient as well as a hypersensitivity. This information would be useful for inclusion in the treatment algorithm. Testing is recommended before considering re-treatment. After second failed eradication, patients undergo endoscopy for culture. There are delays due to a backlog at the lab. Pylera may help to alleviate the current issues being faced further down the pathway. TA agreed to support with a short GP education session regarding this change to practice. A local support document can be produced for guidance. The group agreed to add Pylera to the formulary as a green first line option for patients allergic to penicillin and second line for patients without a penicillin allergy.
5.2	**Paediatric Oral Nutritional Supplements** Jo Rayner, paediatric dietitian at BHFT presented a paper on an oral nutritional supplements (ONS) toolkit. The dietetic team across BLMK, have put together guidance to support prescribing decisions. With a growing product range, there is greater choice and the opportunity to be selective. Traditionally, the use of ONS in children has not considered cost and focused on the taste of the product, however this guide considers both as well as the nutritional needs of different age groups. As recommended for adults, the first step is to consider the food first strategy. When fortification of the diet is unsuccessful e.g. due to higher requirements or contribution of a disease state, then ONS is considered. Costs are highlighted in the guidance and consideration of adult products for children over the age of 6 if the weight and height suggest that this may be suitable. Powdered products are included as one of the first line options to consider. The two main products used are Abbot Paediasure Plus (£4.89 each) and Nutricia Fortini (£4.75) (there is an Abbott contract at MKUH and a Nutricia contract at BHFT). These products are more expensive and spend on these two products last year alone was £327,524. If we also account for the prescribing of Fortini Fibre, that will double the spend. A more cost-effective product would be the Nestle Resource Junior at £2.84 each, with a potential saving of £133,739 per annum. Further savings could be made for children 3 and over by using the powdered option Aymes ActaJuni Shake (£1.35 per serving). For children over 6, the cost could be reduced further to 50p/serving by considering adult products. The toolkit has been in place since August last year for use by dietitians, but the impact has been minimal so far. There is a requirement for change in dietetic practice and GP surgeries are pushing back when products on the guidance have been requested as they are not on the formulary and dietitians then revert to the known products. Open Prescribing data on the two cost-effective options, Aymes ActaJuni Shake powder, current spend is approx. £2000/annum, and Resource Junior complete sip feed, current spend is approx. £150/annum, suggest that there are opportunities to make savings and our ICB is below average. Samples can be supplied by the manufacturer free of charge to the child's home and dietetic assistants check if the child will take them and the flavours they prefer. Guidance is available on supporting children to try new products. This practice ensures children are willing to take the products before recommending a prescription.

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	The guidance is for use by the dietitians only so GPs will need to refer to the team if a child is identified as requiring support. These products are not necessarily suitable for fussy or selective children where there may be a requirement for vitamin supplements. Parents can buy products over the counter if they are concerned about their child, but these are ultra-processed, and their inappropriate introduction can create other issues. It is recommended that prescribing the products should fire an alert on the system that the patient should be under the care of a dietitian. None of the products can be classed as non-formulary to account for the hospitals having different contracts and the need for choice to meet a child's individual requirements. JR would not recommend children are switched between products on discharge because a child may not take an alternative product, and as these products are initiated for a clinical need, it is imperative that the child is compliant. Dietitian training has begun to support adoption of the guidance. The spend will be reviewed in August and as part of the Food First project, surgeries across BLMK are being audited. AH stated that not all the products come through the national wholesalers and pharmacies may be required to set up accounts. JR will liaise with AH to ensure the products recommended are readily available for pharmacies to purchase. JR has received a new product, ActaJunior Ready to Drink, which undercuts the current products so she will review the toolkit accordingly. ONS should not be continued indefinitely and, as with adults, there needs to be a discontinuation plan. Children over the age of 10 should not be on a paediatric product. AG requested clarity when adding products to the formulary and confirmed that the toolkit won't be published as it is for dietitian use only. The recommendation from the dietitian will come with a plan which would include information on discontinuation. This may necessitate an acute prescription or adding a stop date. Care needs to be taken in patients that do not attend follow-up appointments. As the dietitians are unable to prescribe, a GP would need to initiate the prescription. The group agreed that the products can be added to the formulary as SpA, recommended by the paediatric dietitians and following trial via the taste test.
5.3	**Cyclogest to help maintain a pregnancy** The current formulary status for Cyclogest is red for threatened miscarriage. A request for review of this status was received from a practice. It was felt that it would be valuable to discuss this at formulary subgroup. The patient was under the care of Oxford and their local formulary states that once the specialist has initiated treatment, primary care can continue. Treatment is normally required for 16 weeks. The proposed status is SpIS, even though titration or monitoring is not required, as the preference would be for specialists to initiate before a GP is asked to take over prescribing. This status would improve access, which is particularly important for women advised bed rest, as it would avoid the need to travel to hospital to obtain a prescription. GPs have overridden the messages that fire via ORx to prevent prescribing. Feedback suggests GPs can be conflicted due to the emotive nature of the request. However, is it clinically appropriate

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	for GPs to take on the responsibility of prescribing Cyclogest for patients, which are high risk and remain under the care of a specialist? The change in status would result in increased primary care prescribing and the figures obtained from the hospital do not differentiate prescribing for this particular indication so the potential impact on primary care is difficult to quantify. This indication is unlicensed and not all GPs may be willing to prescribe which would introduce an inequality. GPs have had pressure to prescribe Cyclogest in the past for women having IVF privately or from a different country or for women that have had miscarriages requesting it without having a confirmed pregnancy. Changing the status to SpIS for this particular indication could add pressure to prescribe Cyclogest for other indications that should remain under the care of a specialist. Secondary care should have an effective process in place for providing patients with the 16 weeks of treatment required and therefore the need to transfer prescribing to the GP was queried by the group. There is a single point of access for midwives when a patient falls pregnant, and prescribing can be taken up immediately. Changing the status of Cyclogest would go against the current enablement of midwives to prescribe via PGDs for treatments such as iron. The decision agreed by the group was to keep Cyclogest as red on the formulary for preventing preterm labour. The relevant specialists at Oxford will be contacted to make them aware that GPs will not take over prescribing for Milton Keynes patients.
5.4	**Safinamide** Alexa Jumao-As, pharmacist from Luton and Dunstable hospital presented the paper requesting addition of safinamide to the formularies for patients with Parkinson's Disease (PD). Safinamide's suggested place in therapy is as an add-on therapy to a stable dose of levodopa, an addition to a combination of other PD medication in mid-to-late-stage PD patients with motor fluctuations or dyskinesia and/or a second line monoamine oxidase B inhibitor (MAOB) where first line MAOB are ineffective or are not tolerated. Addition of safinamide to the formularies has been considered by the Bedfordshire and Luton Joint Prescribing Committee in 2019 but this was declined due to the lack of head-to-head trials with the appropriate comparators, safety issues (e.g. retinopathy) and cost effectiveness. Head-to-head data has been gathered comparing rasagiline with safinamide. Safinamide reduces dopamine agonist dose (LED-DA) better than rasagiline, potentially reducing side effects. Safinamide (100mg) leads to significant reduction in daily "off" time and UPDRS (Unified Parkinson's Disease Rating Scale) motor scores compared to rasagiline. Overnight switch from rasagiline to safinamide is safe and well tolerated; no serotonin syndrome or hypertensive crises have been reported. Safinamide improves motor complications (UPDRS-IV), sleep quality, daytime sleepiness, and non-motor symptoms better than rasagiline. The SYNAPSES trial (Spain) was a large observational study that found that safinamide is effective and safe in real-world use, reducing motor complications and improving quality of life. The XINDI Trial (China) found safinamide significantly reduces off time vs placebo with rapid onset and no serious adverse events. 13 Yellow Card eye disorder reports were recorded for safinamide, including 10 serious cases and 2 involving retinal or vascular eye events, with no fatalities. A total of 225 reports via yellow card are recorded for safinamide. Patient numbers are expected to be low at less than 10 per year across the ICB as this is an option after rasagiline and selegiline. Only 3 patients are currently prescribed safinamide.

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	There is no specific monitoring associated with it, but GPs may require more information due to lack of familiarity. Patients would be under the care of the PD nursing teams and the consultant will prescribe if the PD nurse is unable to. The reporting of eye disorders was queried in terms of actual incidence. Safinamide has been on the market for more than 10 years (no longer a black triangle medicine) and it is contraindicated (as per the BNF) in patients with ocular issues. The company states that retinopathy was discovered in mouse trials, but it has not been reported in human or monkey trials. Dr Susantha Nawaratne Wijayasiri confirmed that patients are screened for ocular disorders. She has experience of using safinamide in 6-7 patients and has only had to stop the prescription in one patient that experienced delirium and hallucinations. She has found safinamide useful as a second- or third-line option when needing to prescribe a tricyclic antidepressants and SSRIs as rasagiline and selegiline interact and this prevents optimisation of motor control. Postural hypotension and off-time is less of an issue with safinamide and its addition allows reduction of dopamine to reduce postural hypotension. Consultants in Northamptonshire use it first line and find it useful for treating non-motor symptoms. For context a primary care prescribing map for safinamide was shared with the group which revealed 5 items in March within BLMK. NHS Northamptonshire did 193 items. There is significant use in Nottinghamshire. There appears to be a wide variation in prescribing across the country. PD nurses can seek support from their colleagues in Northamptonshire in prescribing safinamide. The group agreed that it should be accessible to PD patients, but it also needs to be prescribed safely. The group agreed to add safinamide to the formularies as SpIS.
5.5	**Ketamine oral solution** This request has been brought to the group following MKUH's internal prescribing and medicines governance committee's (PMGC) review of ketamine oral solution for patients who are referred to Willen Hospice for palliative care. Following the retirement of the SCG (shared care guidance) for ketamine, which was in place for Bedfordshire and Luton, but designated as red in Milton Keynes, MKUH's PMGC have requested that the SpIS option is considered due to the impact on their palliative care team. Ketamine, an N-methyl-D-aspartate (NMDA) receptor antagonist, has been shown to be effective in the treatment of opiate-resistant pain syndromes of different aetiologies and is being increasingly used in the palliative care setting due to its opiate-sparing effects. It is used for managing pain that is neuropathic, inflammatory, ischaemic limb-related, or procedure-related when other treatments have failed. Confusion about how to prescribe, order and administer it resulted in a delay in analgesia for an end-of-life patient in severe pain. Consequently, a ketamine usage policy has been formulated for starting patients on the syringe driver, transferring them to Willen Hospice for end-of-life care and consideration of the oral solution. Willen Hospice anticipate ketamine may be used for 1-2 patients per year and less than 10 patients per year in BLMK. The low numbers would not, therefore, pose a great cost burden. There was an agreement that ketamine should be on the formulary for use by the hospices and recognition that the GP may not be involved with the patient as they are often managed entirely by the palliative care team. Some GPs may be reluctant to prescribe ketamine, being less familiar with

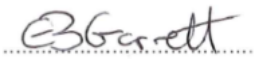
No	Agenda Item
	it and for a group of patients whose condition is altering significantly over a short period of time. Monitoring would not be required for patients rapidly deteriorating, but for those patients with a longer prognosis, week to months, then weekly BP, urinary symptoms and liver function tests and neuropsychiatric symptoms require checking every four weeks. Ongoing consultation with the palliative care physician remains in place. Pharmacies are unlikely to have it in stock but could order in from the main wholesaler, but the patient may still be left without a timely supply Willen Hospice have used ketamine historically and it was queried why they are unable to continue to prescribe and organise a supply as they have been doing. Willen Hospice have been unable to get a timely supply of medication to the patient and there are instances when the palliative consultant is unavailable to provide a prescription. The group decided that ketamine oral solution should remain red but support for the hospices in the prescribing and issuing of this prescription needs to be put in place to avoid the patient supply being delayed.
5.6	**Tavistock SCG for transmen and transwomen** As an organisation, the ICB, and its predecessors, has ratified the Tavistock's shared care guidelines since 2018. The last time this was completed was in 2022, however, our website does state that Tavistock's website should be consulted for the most up-to-date version of the guidance. The new 2025 version includes several changes that have been made throughout the last 3 years which include obvious changes as well as minor tweaks. Due to the number of changes, the committee were asked to review the guidance in its entirety. A summary of the changes include: • New titles of the documents to reflect current terminology • An updated letter from the Clinical Director and Consultant Endocrinologist • Enhanced clarification of the roles of the gender specialists and the role of the GP, with details of who is responsible for blood tests etc… • Inclusion of international guidance from standards of care 8 produced by the World Professional Association for Transgender Health (WPATH) • Inclusion of non-binary clients (as they may elect to take lower doses of hormones, and this will be clarified in communication with the GP) • Inclusion of new evidence base included throughout both documents • Updated information on cardiovascular risk • Updated information on bone health and DEXA scan information • Change in the recommendation for endometrial screening to being symptom based (transmasculine) • Altered target range for Nebido (transmasculine) • Inclusion of a shared care agreement letter (to be completed by the GP) (NB This is different to our normal shared care practice) • The watermark has been added by Tavistock to ensure the document cannot be modified. • Email address for endocrine department Tavistock currently have a long waiting list and may not have the capacity to retain, hence the requirement for the GP to confirm shared care. Due to the potential medicolegal implications, the group agreed that it made sense for shared care not to be assumed in this scenario. It was noted that NHSE are the commissioners and there is a huge amount of work required in this area to move services forward. The group agreed to ratify the new versions of the SCG and add them to our website.
5.7	**Shampoos and scalp preparations**

No	Agenda Item
	This review considers shampoos and treatments for psoriasis of the scalp and seborrhoeic dermatitis in terms of appropriate treatment choices, effective use of products, timely review and the promotion of self-care where appropriate. Consideration needs to be given to patient preference, cosmetic acceptability, practical aspects of application at the site(s) and the extent of psoriasis. This review was conducted using: • BLMK Management of plaque psoriasis in primary care in children • BLMK Management of Plaque Psoriasis in Adult Patients (in Primary Care) • NICE CKS for Psoriasis • NICE CKS Seborrhoeic dermatitis • PrescQIPP Bulletin 312, Shampoos and scalp preparations. A topical vitamin D preparation alone can be useful for patients that are intolerant of or cannot use topical corticosteroids (relatively lower efficacy rank), in mild to moderate scalp psoriasis and to maintain disease control during breaks between corticosteroid courses. Unfortunately, however, there are no topical vitamin D preparations currently available, and this has limited treatment options. Calcitriol and tacalcitol scalp preparations need, therefore, to be removed from the formulary. Coal tar preparations are only slightly more effective than placebo/vehicle scalp solution and are not an appropriate therapy for severe scalp psoriasis. They can maintain disease control during breaks between corticosteroid courses. Self-Care should be added for coal tar over the counter (OTC) products for milder cases where ongoing medical review is not required. However, patients should be counselled to see their doctor for a review if treatment response is poor, symptoms worsen or there are signs of infection. Neutrogena T-Gel will need to be removed from the formularies as it is being discontinued. Ketoconazole 2% shampoo is widely recommended in various resources including in clinical guidance on seborrhoeic dermatitis. For milder cases where ongoing medical review is not required, encourage self-care. Medicated shampoos such as zinc pyrithione, coal tar, or salicylic acid can be used, if ketoconazole is not appropriate or acceptable for seborrhoeic dermatitis in adults. There is little published evidence to support their efficacy, and the recommendation is for self-care in seborrhoeic dermatitis. It was noted that a specialist should be involved in the care of all children and young people with psoriasis and their guidance on treatment should be followed. Deprescribing of 30% (if clinically appropriate) could release savings of almost £54,000. AH informed the group that Cocois is unavailable. Clarity on the formulary site regarding the potential for using products containing vitamin D and a corticosteroid, such as Dovobet gel, on the scalp will be added. The group approved the recommendations made from the shampoos and scalp preparations review of the formulary.

No	Agenda Item
5.8	**Ferric maltol** Ferric maltol is the first oral formulation of a ferric salt licensed in the UK. It is currently not on the B&LF but in MK, it is red, second line for iron deficiency anaemia in adults with mild to moderate IBD (inflammatory bowel disease) who have failed 2 oral ferrous products for consideration prior to administration of IV options. The usual duration is stated as 12 weeks. There could be the potential for primary care to prescribe this treatment for patients and avoid the need for IV iron administration via the hospital. The licensed therapeutic indication has been extended to adults for the treatment of iron deficiency of any cause. The NICE CKS for anaemia – iron deficiency and the British Society of Gastroenterology guidelines for the management of iron deficiency anaemia in adults recommends, for people with significant intolerance to oral iron replacement therapy, alternate day dosing, oral ferric maltol, or parenteral iron preparations. In studies, GI side effects with ferric maltol and overall rates of treatment cessation were comparable to placebo. Due to a relatively low iron content, the rate of iron loading is comparatively slow with ferric maltol, but iron loading and tolerance were maintained during a year of active treatment, with normalisation of haemoglobin (Hb) in 89% of cases. Although more expensive than traditional iron salts, ferric maltol is considerably less expensive than parenteral irons and avoids an invasive procedure, the need for day case admissions, and rare but severe hypersensitivity reactions. For most adults with iron deficiency anaemia (IDA), parenteral iron is not indicated. For example, a course of oral ferrous sulfate 200mg daily is as effective as a single ferric carboxymaltose infusion in restoring Hb after a GI haemorrhage. The Hb response is marginally faster with parenteral iron—for example, 0.7 g/L higher than oral iron after 23 days treatment in postoperative cases. Cambridge and Peterborough ICB currently place ferric maltol as third-line specialist recommendation to the GP for an oral iron product in mild/moderate IBD where there are tolerance issues/failure to at least 2 standard oral iron preparations. They are looking to expand the cohort to non- IBD patients but due to a lot of the evidence being in IBD patients this is proving difficult. Cambridge and Peterborough are considering the introduction of ferric maltol before IV iron to reduce the load on their ambulatory centres due to the large patient numbers being referred via the GPs. The costs associated with a day case admission for 1000mg monofer infusion is estimated by them to be almost £400. BLMK ICB currently has over £9m spend in 24/25 on iron infusions. Hertfordshire and West Essex ICB designated ferric maltol as double red, not recommended due to lack of evidence of clinical effectiveness, cost effectiveness and safety. The Scottish Medicines Committee (SMC) assessed ferric maltol in 2022 and have not recommended it as they stated that there appears to be a lack of robust data with ferric maltol in patients who are representative of a second-line positioning after failure of first-line oral ferrous therapies. Ferric maltol failed to demonstrate non-inferiority to an intravenous (IV) iron preparation but was superior to placebo for correction of IDA in patients with IBD. The submitting company did not present a sufficiently robust clinical and economic analysis to gain acceptance by SMC. Ferric maltol does present a cost pressure, at £285.60 for a 24-week course compared with £3.56 for ferrous sulphate.

No	Agenda Item
	There is support from MKUH with regards to a change in designation, however their policy has only been recently updated to include ferric maltol and clinicians are just becoming more aware of it. 60% of outpatient referrals for IV infusions to MKUH are bounced back to primary care and there is concern around the spend on this procedure. BHFT have not had a response back from their gastroenterology or haematology teams yet, but BHFT are updating their iron deficiency guidelines currently and the decision made at FSG will influence them. There have been non-formulary requests at BHFT for ferric maltol for patients with allergies to oral and parenteral iron. GPs come across many patients that are intolerant to iron, and it can prove difficult to correct their deficiency. There is a potential for many patients to therefore be initiated on ferric maltol and this would have a cost impact. Iron often gets left on repeat, and this would represent a significant cost if prescribed as ferric maltol. The group felt more experience of using it locally is required now that it has been included in MKUH's policy. Review of iron is included in this year's prescribing incentive scheme to improve awareness of taking iron once daily or alternate day dosing when patients experience intolerance. Patients will be provided with an information leaflet which counsels on managing intolerance which was produced by MKUH. IV iron usage for IBD is about half of total usage in Milton Keynes, but only about a fifth in Bedfordshire and Luton, but as MKUH has restricted use to patients with IBD via their policy and this cohort has the most clinical evidence, BLMK will restrict to this cohort initially. The group agreed to align the B&LF with MKF and include ferric maltol as red, second line for iron deficiency anaemia in adults with IBD who have failed two ferrous iron products with the potential to revisit in approximately a year's time (depending on the volume of usage) when the trusts have more experience.
5.9	**Efmody mr capsules containing hydrocortisone -deferred to the next meeting.**
5.10	**Enolio (liothyronine 10mcg/ml oral solution)** The NHS England and NHS Confederation "items which should not routinely be prescribed in primary care" policy guidance recommends that liothyronine should only be initiated by an NHS consultant endocrinologist when being prescribed for the treatment of hypothyroidism. Liothyronine should be prescribed only if no alternative intervention or medicine is clinically appropriate or available for the patient. Patients taking liothyronine for the treatment of hypothyroidism who have not already been reviewed, should be reviewed by an NHS consultant endocrinologist. The group were asked to consider the addition of Enolio® to the formulary as a cost-effective option for new and existing patients. Enolio® liothyronine sodium 10 micrograms/ml oral solution costs £32.23 for a 50ml bottle. 28 liothyronine 10microgram capsules cost £65.00 and 28 liothyronine 10microgram tablets cost £152.44. 28 days equivalent of Enolio® is only £18.05. Assuming a once daily dosing of liothyronine 10mcg tablets, switching to Enolio® could save £1,747/annum.

No	Agenda Item
	A 50% switch from the 20microgram liothyronine tablets to Enolio, would realise savings of almost £12,000 per annum. A 50% switch from 10microgram tablets and capsules to Enolio would make an almost £13,000 per annum saving. There are several issues in using a liquid as opposed to a solid dosage form which would make the switch unsuitable for certain patients. This includes, storage, inconvenience in terms of transport (dosing is usually every 8 hours), difficult for those with dexterity issues or visual impairments to measure, potential increased variability in dosing and loss of entire dosage form if dropped. However, Enolio is ethanol free, contains no gelatine, lactose or starch and is sodium free, but not sugar free. Packaging is 100% recyclable, and it is licensed for use via a gastric, duodenal or nasal feeding tubes. The group felt switching patients from the solid dosage form would be difficult, but as it offered the benefits of savings, it should be added to the formulary as SpA even if uptake is likely to be low.
6	**Minor amendments log** Noted.
AOB	In mid-April 2025, Pfizer Ltd introduced medroxyprogesterone acetate tablets, the new generic alternative to PROVERA® tablets. For a limited transition period, both branded and generic versions will be available. After this phase, the branded product will be phased out from routine availability. ColeKal-D3 Dissolve 400unit/1500mg effervescent tablet were approved when reviewing calcium and vitamin D preparations on the formulary. However, it is classed as a food supplement and contains 161.19mg sodium per tablet. The group were asked if Adcal D3 dissolve could replace this product on the formulary as this is licensed, suitable for vegetarians and patients with soya or peanut allergy and contains only 42.03 mg sodium per tablet. The group approved this amendment to the formulary choice.The BLMK Guideline for the Management of Vitamin D Deficiency in Adults from 18 years of age in Primary Care has been updated as a result of the agreement.
	Meeting dates for 2025 are available on BLMK ICB Website – Formulary Page https://medicines.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/

Chair Signature: 

Date: 11.9.25