BEDFORDSHIRE, LUTON AND MILTON KEYNES AREA PRESCRIBING COMMITTEE

Meeting Notes

Date: 24 September 2025
Time: 12.30- 2.05pm
Venue: Microsoft Teams

Attendees:

Name	Initial	Role
Dr Muhammad Nisar	MN	Chair (Medical Representative, Bedfordshire Hospitals NHS Trust)
Mojisola Adebajo	MA	Place Based Lead Pharmacist – Luton
Nicola Ainsworth	NA	Consultant in Public Health
Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)
Pritesh Bodalia	PB	Bedfordshire Hospitals Trust Pharmacy Representative (Chief Pharmacist, Bedfordshire Hospitals Trust)
Dr Marian Chan (from 13:00)	MC	Medical Representative, Bedfordshire Hospitals NHS Trust
Matt Davies	MD	Head of Medicines Optimisation, BLMK ICB
Dupe Fagbenro	DF	ELFT Pharmacy Representative (Deputy Chief Pharmacist (Luton and Bedfordshire), ELFT)
Fiona Garnett	FG	Associate Director: Pharmacy and Medicines optimisation, BLMK ICB
Anne Graeff	AG	Commissioning Lead Pharmacist, BLMK ICB (Professional Secretary) / Chair of Wound Care Group
Emma Hooton	EH	Practice Pharmacist Representative (Independent Prescriber)
Carole Jellicoe	CJ	Nurse Representative (Independent Prescriber)
Dr Kate Randall	KR	Place Based Lead GP – Central Bedfordshire
Dr Mitan Sarkar	MS	Place Based Lead GP - Luton
Dr Maggie Winter	MW	Place Based Lead GP – Milton Keynes
Dr Jenny Wilson	JW	Place Based Lead GP - Bedford
Dona Wingfield (until 12:45)	DW	Chair of Medicines Safety Group / Bedfordshire Hospitals Trust Pharmacy Representative (Medicines Use and Quality Manager, Bedfordshire Hospitals Trust)

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

In attendance:		
Saema Arain	SA	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)
Samina Hassanali	SH	Medicines Optimisation Pharmacist, BLMK ICB
Qiratulain Khan	QK	Bedfordshire Hospitals Trust Pharmacy Representative
Taiya Large	TL	Formulary and Medicines Safety Pharmacist, BLMK ICB
Sandra McGroarty	SMcG	Commissioning Pharmacist, BLMK ICB
Dr Joy Mutitika	JM	Medical Representative, Keech Hospice
Kike Pinheiro (until 13:40)	KP	Representative, Willen Hospice
Nikki Woodhall	NW	Lead Medicines Optimisation Technician, BLMK ICB
Helen McGowan (for agenda items 5.4 and 11)	HM	Medicines Optimisation Pharmacist, BLMK ICB
Aarti Shah (for agenda item 5.1)	AS	Medicines Optimisation Pharmacist, BLMK ICB

Apologies:		
Rafal Ali	RA	Commissioning Pharmacist, BLMK ICB
Dr Mya Aye	MAy	Medical Representative, Milton Keynes Hospital
Cheryl Green	CG	Patient Representative
Dr Dush Mital	DM	Medical Representative, Milton Keynes Hospital
Takudzwa Shumba	TS	CNWL Pharmacy Representative (Prison Services - HMP Bedford and YarlsWood IRC)
Dr Jonathon Walter	JWa	Place Based Lead GP – Milton Keynes

No	Agenda Item	Action
1.	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting. Apologies were received and noted as above. The meeting was confirmed as quorate.	
2.	**Declarations of Interest** The Chair invited the members to reconfirm their current declarations on the Register of Interests and advise of any new declarations. All members confirmed their declarations were accurate and up-to-date. The Chair invited members to declare any declarations relating to matters on the agenda. All members confirmed they have no declarations in relation to matters on the agenda.	

No	Agenda Item	Action
3.	**Minutes of 02 July 2025 APC meeting** The minutes of the meeting held on 02 July 2025 were approved.	
4.	**Matters Arising**	
4.1	**Feedback on miscellaneous actions not included on the agenda from APC meetings**	
4.1.1	**Bimekizumab first line for Ankylosing Spondylitis and non-radiographic axial spondyloarthritis** - further work to be undertaken to develop the case to support these requests. **Update 11/09/2025** – this is an ongoing action with further assessment being undertaken at BHFT. Further analysis of the data is being undertaken to determine whether the information on Ankylosing Spondylitis and non-radiographic axial spondyloarthritis can be split. It was proposed and agreed that this action is closed and moved to the APC workplan.	Close
4.1.2	**Relugolix–estradiol–norethisterone for endometriosis (TA1057)** – prescribing support document to provide additional information for primary care prescribers to be produced. **Update 11/09/25** – a draft document has been produced and has been circulated to stakeholders for comment. This is an ongoing action.	AG
4.1.3	**Chronic Kidney Disease pathway** – minor update to be made to the pathway to define the uACR thresholds for patients to receive lifestyle advice / standard care, or to follow the CKD treatment pathway. Additionally, wording to be amended slightly to recommend dapagliflozin as first choice for most patients. **Update 28/07/2025** – the amendments have been made, the document finalised, and it has been uploaded onto the Medicines website. It was proposed and agreed that the action could be closed.	Close
4.1.4	**Glucocorticoid-induced Osteoporosis guidelines** – updates to be made as agreed at the meeting: • Additional text to be added to strengthen the message that treatment should be started without delay (as rapid bone loss occurs in the first 3 months). • Additional text to be added to clarify that the management of patients who have stopped steroid treatment should revert back to care/management as described in the main osteoporosis. **Update 24/09/2025** – final comment received from local specialists and some additional changes to the document were outlined to the Committee. It was proposed that, in the section on "Treatment Duration of Bone Protective therapy (for patients with a T score -1.5 or below, or have had a previous fragility fracture): Guidance for GPs", for patients where steroid therapy has been *discontinued*, changes are made to state that bone protective therapy should be continued (this is a change to the previous version of the guidance) and DXA scan repeated after 2-3 years:	Close

No	Agenda Item	Action
	*"**For patients where steroid therapy has been discontinued:*** *Continue bone protective therapy:- repeat DXA after 2-3 yrs and re-assess fracture risk (using Frax®) to decide if continuation of bone protective therapy is still required or if discontinuation can be considered.* *Review other risk factors - refer to the main osteoporosis guideline* ***NB**: If patient receiving denosumab, **seek specialist advice** as denosumab should **not** be stopped without a specialist review (due to increased risk of vertebral fracture) (MHRA advice Aug 2020)".* In the same section, the recommendation in relation to review of treatment / repeat DXA scan, for patients who remain on steroids, has been amended to state: *"<u>For patients on long term steroids / or who have received</u> repeated short-term courses of steroids (e.g. for asthma) with a cumulative dose equivalent to 1.5g per year:* • *Reduce dose of glucocorticoid if / when possible* • *Consider glucocorticoid sparing therapy if appropriate or consider alternative route of administration* • ***Continue bone protective therapy:*** - ***review** treatment +/- DXA scan after 3-5 years, noting that patients on steroids may require longer term bone protective treatment (often at least 10 years)* - *consider repeating DXA every 2-3 years* if treatment to continue beyond 3-5 years* • ***NB**: If patient receiving denosumab, **seek specialist advice** as denosumab should **<u>not</u>** be stopped without a specialist review (due to increased risk of vertebral fracture) (MHRA advice Aug 2020)* **exact frequency will vary depending on present steroid dose / duration of steroids / other risk factors)."* The Committee approved the changes to the guidance tabled at the meeting and agreed that the document could be finalised and uploaded to the Medicines website. It was proposed and agreed that the action could be closed.	
4.1.5	**Osteoporosis guideline** – domnisol to be added as an alternative vitamin D monotherapy option, for selected patients in accordance with the formulary recommendations. **Update 11/09/2025** – the guideline has been updated and uploaded onto the Medicines website. It was proposed and agreed that the action could be closed.	Close
4.1.6	**Shared Care Guideline template** – additional text to be added to clarify that the specialist review (section 7) should be undertaken at least annually; information to be added to the patient responsibilities section regarding accessing blood test results via the NHS app.	Close

No	Agenda Item	Action
	Update 17/07/2025 – the updates have been made and the document finalised. It was proposed and agreed that the action could be closed.	
4.1.7	**Shared Care principles** – amendments to be made as agreed at the meeting: • Removal of reference to primary care prescribers informing the specialist if they adjust doses, as this does not happen in practice. • Addition of text, in the patient responsibilities, regarding accessing blood test results via the NHS app. **Update 10/07/25** – the updates have been made and the document finalised. It was proposed and agreed that the action could be closed.	Close
4.1.8	**Acamprosate shared care** – to liaise with specialists regarding the proposal to retire the existing SCG (applicable for use in Bedfordshire and Luton only). **Update 09/09/2025** – feedback received from all drug and alcohol providers. Providers in Bedfordshire and Luton utilise the current SCG and wish to retain the system with primary care being asked to prescribe after the patient has had 6 months treatment via the drug & alcohol team. The provider in Milton Keynes retains the prescribing of acamprosate. The formulary status of acamprosate was discussed at formulary subgroup on 09/09/25 and it was agreed that a full SCG was no longer required, and this could be replaced with a prescribing support document and Amber SpIS traffic light. Traffic light on the MK formulary to change to red (from Amber SpA) to reflect current prescribing situation. The Committee was advised that Luton Council are reprocuring the drug and alcohol treatment service and this is currently out for tender and the new contract will be in place from the beginning of April next year. Further clarification was provided around the proposed prescribing support document, which will provide a summary of prescribing information and responsibilities. It was proposed and agreed that the action could be closed.	Close
4.1.9	**Linzagolix for the treatment of endometriosis** to be added to the formularies with SpIS traffic light status. **Update 09/09/2025** – both formularies have been updated accordingly. It was proposed and agreed that the action could be closed.	Close
5.	**Items for consideration at meeting**	
5.1	**BLMK Chronic Obstructive Pulmonary Disease (COPD) Primary Care Guidelines** The Committee considered a comprehensive review and update to the BLMK COPD guidelines, with a view to supporting standardised, high-quality COPD care across BLMK. The guideline is aligned to national best practice (GOLD and NICE guidance). Key updates include: • **Service Mapping and Referral Pathways:** Clear guidance on BLMK referral pathways, including current pulmonary rehabilitation provision, to support consistent access to services.	

No	Agenda Item	Action
	• **Integration of Supporting Resources:** Updated hyperlinks to relevant respiratory documents, including the Inhaled Device Decision Aid and guidance on reducing the carbon footprint of respiratory care. • **Inhaler Formulary Update:** An updated inhaler formulary is included, with each inhaler's associated carbon footprint clearly documented to inform environmentally responsible prescribing. Note: the updates relate to the presentation of the information – there are no changes to the inhalers available on the formulary, or the formulary status for any medication within the guidance. • **Content Structure:** The guideline includes both a high-level one-page summary for quick reference and detailed, section-by-section guidance for clinical application. • **Clinical Content:** The guidance encompasses diagnostic criteria, initial assessment and management, pharmacological optimisation, exacerbation management, and ongoing care planning. • **Evidence Base:** The guideline is aligned with the latest GOLD (Global Initiative for Chronic Obstructive Lung Disease) recommendations, with appropriate adaptations and supplementary recommendations from current National Institute for Health and Care Excellence (NICE) guidance. The Committee noted that minor amendments have been made to the circulated document as follows: rationalisation of presentation of contact information in each section; correction of a typo on page 15 (cor pulmonale), and of a non-functioning link in the guidance. **Decision**: the updated COPD guidelines were approved. It was noted that the one-page flow chart was a very useful addition to the document. **EQIA Assessment:** There is no differential impact expected on one or more equality groups differently to others: Age; Disability; Gender reassignment; Marriage & Civil Partnership (in employment only); Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual orientation; carers; other identified groups. **BLMK ICB E and D Lead comment:** No further comments – there is sufficient consideration to show due regard.	
5.2	**Adalimumab dose escalation (severe psoriasis treatment pathway)** Following a request from dermatologists at Bedfordshire Hospital NHS Trust, proposed updates to the severe psoriasis treatment pathway have been made to the severe psoriasis treatment pathway to include the option to escalate the dose of adalimumab prior to considering changing treatment to a different agent available within the pathway. Proposed amendments made to the pathway are: • Inclusion of the option for dose escalation / interval reduction of biosimilar adalimumab for patients who responded initially but subsequently lose response (secondary failure).	

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	• Clarification that adalimumab biosimilar is the usual first choice treatment. • Inclusion of the # symbol to indicate availability of ustekinumab biosimilars and information that ustekinumab biosimilar is the most cost-effective choice when treatment with adalimumab is unsuitable. • Inclusion of wording to clarify that the pathway applies to adults only. • General updating of dates and version number. Adalimumab for the treatment of adults with severe psoriasis was assessed by NICE in June 2008 in NICE TA146. It is a very well-established treatment and, with the availability of biosimilars, a very cost-effective treatment. It is recommended as the first line treatment option in the BLMK pathway, unless contra-indicated or the patient has a preference for oral therapy. At the time of publication of TA146, in June 2008, dose escalation was not included in the license for adalimumab and therefore not included in the evaluation carried out by NICE. This was added subsequently following additional trials being carried out. Information from the trials indicates that 30% of patients may require dose escalation, and information from local specialists indicates that similar numbers are expected locally. The Committee considered the following additional points: • The individual NICE TAs, and the BLMK treatment pathway, advises "If patients and their clinicians consider there to be a range of suitable treatments, the least expensive should be chosen (taking into account availability of biosimilar products, administration costs, dosage, price per dose and commercial arrangements)." • The pathway lists the options by class and advises to choose the most clinically suitable drug (if more than one treatment is suitable, the least expensive should be chosen). • In terms of annual maintenance dose costs, adalimumab is the lowest cost biologic. • Dose escalation may prevent progression to more expensive treatments in the pathway, such as IL-17 or IL-23 inhibitors and is expected to be cost-neutral or cost saving in the overall treatment pathway. • Ustekinumab biosimilar is a cost-effective alternative option (more expensive than the cheapest adalimumab biosimilar option, but less expensive than the more costly adalimumab biosimilar option, at escalated adalimumab doses). • Dose escalation of adalimumab is commissioned by a number of ICBs across the country, including Hertfordshire and West Essex (HWE), Buckinghamshire, Oxfordshire & Berkshire, three London ICBs, and Derbyshire. • The wording proposed for inclusion in the BLMK pathway is based on the HWE pathway with a view to aligning. Agreed wording for inclusion in the pathway:	

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	Adalimumab biosimilar dose escalation or interval reduction (local agreement, September 2025) • Dose escalation or interval reduction (to 40mg weekly or 80mg every other week) can be considered for patients on adalimumab biosimilar whose psoriasis initially responds adequately but subsequently loses response (secondary failure). • Following dose escalation or interval reduction, review within 12 weeks and consider a trial of de-escalation back to standard dose. Patients may be re-escalated and maintained on the escalated / interval reduced dose. • NB: The increased risk of infection and other adverse drug reactions with an escalated dose should be considered. • The dose escalation outlined above is based on the Hertfordshire and West Essex ICB pathway, which is acknowledged with thanks. The proposed pathway update has been shared with local dermatologists, who are in agreement with the wording included. During consultation, a query was received regarding dose escalation following primary failure however, due to the trial information and NICE guidance, it was agreed to apply the recommendations to secondary failure only. The Committee discussed the following additional points: • Dose escalation of adalimumab will not count as an additional line of therapy and therefore will not impact on the future options available to a patient within the treatment pathway. • Blueteq forms for dose escalation will be introduced to allow tracking of usage and management of patients within the pathway. **Decision**: the updated pathway, with the inclusion of dose escalation for adalimumab, was approved. **EQIA Assessment:** There is no differential impact expected on one or more equality groups differently to others: Age; Disability; Gender reassignment; Marriage & Civil Partnership (in employment only); Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual orientation; carers; other identified groups. People with severe psoriasis could be considered disabled under the Equality Act 2010. Inclusion of the option to dose escalate / interval reduce biosimilar adalimumab is anticipated to have a positive impact on the population of patients with severe psoriasis as it will increase the treatment choices for this patient cohort. **BLMK ICB E and D Lead comment:** no further comments. The paper provides sufficient information to be able to show due regard.	
5.3	**Chronic Kidney Disease (CKD) guidance updates** Minor amendments have been made to the CKD pathway agreed at the last APC meeting to reflect recent updates to guidance, and	

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	availability of generic dapagliflozin. The following changes have been made: • Renin–angiotensin system/Renin–angiotensin–aldosterone system (RAS/RAAS) blockade initiation to all patients (with or without diabetes) at a lower uACR threshold (≥3mg/mol). Previous recommendations required initiation at a higher threshold (≥ 22.6mg/mol) in those without diabetes. New advise based on specialist recommendations from KDIGO 2024 Clinical practice guidelines and endorsed by the UK Kidney Association (UKKA) to ensure early intervention and prevention of disease progression / delay of complications. Rapid titration of RAS/RAAS within one month is recommended. • SGLT2 inhibitors – recently updated NICE Technology Appraisals (TA) for dapagliflozin in CKD (TA775 now replaced with TA1075) identified the groups with the most robust evidence for benefit. The estimated glomerular filtration rate (eGFR) threshold for initiation of dapagliflozin in those without diabetes has been widened and mirrors the recommendations for empagliflozin in NICE TA942. • Generic dapagliflozin is now the BLMK preferred 1st choice SGLT2 inhibitor following loss of patent for Forxiga® (dapagliflozin). • Criteria for offering dapagliflozin for CKD with T2DM aligned to SmPC minimum eGFR >15ml/min, noting that loss of glycaemic effect at this eGFR may require adding another agent for blood glucose control. • Addition of notes and references on the same page with updated flow chart. • NG203 referral criteria to renal team included at the request of renal team. • Reformatting of pathway. Additionally, the prescribing support document for SGLT2 inhibitors in CKD has been updated to align with NICE TA1075. **Decision**: the updated CKD pathway and prescribing support document for SGLT2 inhibitors in CKD were approved **EQIA Assessment:** N/A – changes in accordance with national / NICE guidance	

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5.4	**Adult asthma guidelines** The Committee considered an update to the BLMK adult asthma guidelines. This has been undertaken following publication of the NICE / BTS / SIGN guidelines 2024 and updates to the GP contract 2025/26. Updates include: • Changes to diagnostics following the NICE/ BTS / SIGN guidelines update and subsequent April 25 update to the GP contract payments for asthma diagnostics. • Changes on the pharmacological management – particularly the positioning of montelukast and addition of LAMA trial which has changed from the previous BLMK version to reflect the NICE / BTS / SIGN guidelines. • Addition of Proxor as another cost-effective ICS/ LABA Fostair MDI equivalent. • Clear path to switch from the traditional pathway to the SABA-free pathway for patients who have uncontrolled asthma. • Traditional pathway remains in the guidance for use for the large number of existing patients on this pathway who have controlled asthma. Proposed formulary changes are: • Tiotropium (Spiriva Respimat) trial in primary care (SpA to Green) – see further information below. • Theophylline – move to specialist opinion only (Green to SpA). The Committee discussed the positioning of tiotropium (Spiriva Respimat) and montelukast in the updated SABA-free regimen – these are options as add-on therapy with poorly controlled asthma prior to secondary care referral. There is a large cost differential between the two treatment options (£14.40 per year for montelukast versus £276 per year for Spiriva Respimat, at the time of writing) and therefore the possibility of advising use of montelukast first, ahead of tiotropium (Spiriva Respimat) was proposed. It was also noted that in the NICE evaluation on tiotropium, the benefits stated are quite weak and relate to disease orientated outcomes (difference in lung function), rather than patient orientated outcomes (e.g. reduction in exacerbations or admissions). The Committee agreed that it was sensible to place the more cost-effective option (montelukast) as the first line option at this stage in the treatment pathway, provided local specialists are in agreement with this proposal. It was also noted that there is a cost pressure associated with these changes of £97,152/year if all potential untreated patients were switched to tiotropium (£5,069 for montelukast), or £48,576/year if 50% of the patients were switched to tiotropium (£2,534 for montelukast). **Decision**: The updated guidelines, and associated formulary changes, were approved pending input from respiratory specialists regarding the relative positioning of tiotropium and montelukast.	HM

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	EQIA Assessment: The recommendations have been reviewed with regard to equality, inclusion and human rights and no issues have been identified. They are based on national recommendations from NICE. **BLMK ICB E and D Lead comment:** N/A	
5.5	**Proton pump inhibitors guidance (paediatrics)** Item deferred	
5.6	**Crohn's disease pathway update** The Committee was presented with an update to the existing BLMK Crohn's disease pathway. The update has been undertaken to incorporate two newly published NICE technology appraisals, for mirikizumab (TA1080) and guselkumab (TA1095). Mirikizumab and guselkumab have been placed within the pathway alongside risankizumab, as all three medicines belong to the same class (IL-23 inhibitors) and effectively offer the clinicians a choice when selecting an IL-23 agent. As per the routinely commissioned pathway, only one agent per drug class is allowed. An amendment has also been made to the pathway to recommend ustekinumab as the preferred first line alternative to TNF inhibitors, as the biosimilar offers a cost-effective treatment option. Discussions are ongoing with the Gastroenterology leads, around the advantages and disadvantages of the 3 different IL-23 agents as the individual drug costs, induction regimens and frequency of maintenance dosing differ. The pathway states that 'As per NICE, choice of treatment should be made on an individual basis, taking into account individual patient factors such as therapeutic need, co-morbidities and adherence. If more than 1 treatment is suitable, the most appropriate, least expensive should be chosen (taking into account administration costs, dosage and price per dose)'. At standard dosing, guselkumab is the most cost-effective IL-23 agent, but if dose escalation is required then it becomes more expensive than the other options, making preferred treatment options difficult to assess. **Decision**: the updated pathway was approved. **EQIA Assessment:** N/A – addition of NICE approved medicines only.	
5.7	**Ulcerative Colitis pathway update** The Committee considered an update to the moderate to severe ulcerative colitis treatment pathway. The update has been undertaken to incorporate guselkumab, an IL-23 inhibitor which has recently received a positive recommendation from NICE in TA1094. Guselkumab has been placed alongside mirikizumab and Risankizumab on the pathway, as the three medicines belong to the same class (IL-23 inhibitors) and offers clinicians an additional choice of IL-23 agent. As per the routinely commissioned pathway, only one agent per drug class is allowed.	

No	Agenda Item	Action
	Similarly to the Crohn's disease pathway (see item 5.6, above) discussions are ongoing with gastroenterologists regarding preferred choice of IL-23 agent. The considerations in relation to costing, and relative pathway position, as described in agenda item 5.6 also apply to the ulcerative colitis pathway. The document has also been reformatted to allow incorporation of the additional information in relation to guselkumab. The Committee noted the challenges posed by the 30-day implementation period allowed for NICE TA recommendations for new medicines which have been appraised by the cost comparison process, rather than as a full evaluation. From a hospital perspective, there are considerations such organisation of new homecare services which take time to develop and agree. For the ICB, pathway updates and Blueteq funding forms need to be completed. It was agreed that these concerns around 30-day implementation would be fed back to NICE via the BLMK NICE Medicines and Prescribing Associate (PB to support from a hospital perspective). **Decision**: the updated pathway was approved. **EQIA Assessment:** N/A – addition of NICE approved medicines only.	AG / PB
6.0	**NICE Guidance – from 19th June to 10th September 2025** **The following NICE Technology Appraisal Guidance (ICB Commissioned) have been published:** • **Sparsentan for treating primary IgA nephropathy** Technology appraisal guidance Reference number: TA1074 Published: 25 June 2025 https://www.nice.org.uk/guidance/ta1074 **Resource impact:** NICE estimates that the resource impact will be approximately £12k, rising to £156k by year 5. **APC actions:** Created and link added to formularies with RED traffic light • **Nemolizumab for treating moderate to severe atopic dermatitis in people 12 years and over** Technology appraisal guidance Reference number: TA1077 Published: 02 July 2025 https://www.nice.org.uk/guidance/ta1077 **Resource impact:** NICE estimates that the resource impact will be approximately £12k, rising to £156k by year 5. **APC actions:** Created and link added to formularies with RED traffic light. BLMK high cost drug treatment pathway for moderate to severe atopic dermatitis updated (see agenda item 7.2).	

No	Agenda Item	Action
	• **Dapagliflozin for treating chronic kidney disease** Technology appraisal guidance Reference number: TA1075 Published: 02 July 2025 https://www.nice.org.uk/guidance/ta1075 **Resource impact:** NICE estimates that the resource impact will be approximately £88,000 for the BLMK population. This is because the technology is a further treatment option with the same list price as the other main option (empagliflozin). So, the overall cost of treatment will be similar for this population. **APC actions:** dapagliflozin, empagliflozin and canagliflozin formulary entries updated to include a link to TA1075 (replacing link for TA775). BLMK CKD guidance updated (see agenda item 5.3) • **Mirikizumab for treating moderately to severely active Crohn's disease** Technology appraisal guidance Reference number: TA1080 Published: 10 July 2025 https://www.nice.org.uk/guidance/ta1080 **Resource impact:** NICE estimates that the resource impact will be approximately £88,000 for the BLMK population. This is because the technology is a further treatment option and the overall cost of treatment will be similar for this patient group. **APC actions:** link added to formularies. Crohn's disease high cost drug treatment pathway updated (see agenda item 5.6). • **Cenobamate for treating focal onset seizures in epilepsy** Technology appraisal guidance Reference number: TA753 Published: 15 December 2021 Last updated: 24 July 2025 https://www.nice.org.uk/guidance/ta753 **Resource impact:** no substantive change to recommendations; no additional resource impact expected. **APC actions**: none • **Betula verrucosa for treating moderate to severe allergic rhinitis or conjunctivitis caused by tree pollen** Technology appraisal guidance Reference number: TA1087 Published: 06 August 2025 https://www.nice.org.uk/guidance/ta1087 **Resource impact:** NICE estimates that the resource impact of betula verrucosa (Itulazax 12 SQ Bet) will be approximately £26k, rising to £67k by year 3. The Committee discussed the appropriate traffic light status for Betula verrucosa on the formularies, noting the following points: • The NICE costing template assumes specialist initiation and continuation in primary care. • Prescribing support document and commissioning statement in development by the EoE PAC. • There are no local allergy / immunotherapy services within BLMK and therefore patients will be referred out of area to specialist centres for treatment.	

No	Agenda Item	Action
	The Committee agreed RED formulary status, pending availability of the documents in development by PAC, at which time this designation will be reviewed. **APC actions:** to be added to formularies with RED traffic light at the current time. • **Ruxolitinib cream for treating non-segmental vitiligo in people 12 years and over** Technology appraisal guidance Reference number: TA1088 Published: 13 August 2025 https://www.nice.org.uk/guidance/ta1088 **Resource impact:** none – not recommended **APC actions:** added to formularies as non-formulary/DNP • **Guselkumab for treating moderately to severely active ulcerative colitis** Technology appraisal guidance Reference number: TA1094 Published: 28 August 2025 https://www.nice.org.uk/guidance/ta1094 **Resource impact:** NICE estimates that the resource impact will be less than approximately £88,000 for the BLMK population. This is because the technology is a further treatment option, and the overall cost of treatment will be similar for this population. **APC actions:** created and link added to formularies with RED traffic light. Ulcerative colitis high cost drug treatment pathway to be updated (see agenda item 5.7). • **Guselkumab for previously treated moderately to severely active Crohn's disease** Technology appraisal guidance Reference number: TA1095 Published: 28 August 2025 https://www.nice.org.uk/guidance/ta1095 **Resource impact:** NICE estimates that the resource impact will be less than approximately £88,000 for the BLMK population. This is because the technology is a further treatment option, and the overall cost of treatment will be similar for this population. **APC actions:** created and link added to formularies with RED traffic light. Crohn's disease high cost drug treatment pathway to be updated (see agenda item 5.6). • **Tirzepatide for treating type 2 diabetes** Technology appraisal guidance Reference number: TA924 Published: 25 October 2023 Last updated: 01 September 2025 https://www.nice.org.uk/guidance/ta924 **Update information, September 2025:** NICE added the commercial arrangement to the recommendation. NICE also updated the prices and details of the commercial arrangement in the information on tirzepatide section. **Resource impact:** no change to clinical recommendations; commercial arrangement ensures continued cost-effectiveness for the NHS – no additional impact anticipated. **APC actions:** none – no change to the guidance	AG/FK

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	• **Tirzepatide for managing overweight and obesity** Technology appraisal guidance Reference number: TA1026 Published: 23 December 2024 Last updated: 01 September 2025 https://www.nice.org.uk/guidance/ta1026 **Update information, September 2025:** NICE added the commercial arrangement to the recommendation. NICE also updated the prices and details of the commercial arrangement in the information on tirzepatide section. **Resource impact:** no change to clinical recommendations; commercial arrangement ensures continued cost-effectiveness for the NHS – no additional impact anticipated. **APC actions:** none – no change to the guidance **The following NICE Guidelines (NG) (Medicine related and ICB Commissioned) have been published / updated by NICE:** **Bipolar disorder: assessment and management** Clinical guideline Reference number: CG185 Published: 24 September 2014 Last updated: 02 September 2025 https://www.nice.org.uk/guidance/cg185 This guideline covers recognising, assessing and treating bipolar disorder (formerly known as manic depression) in children, young people and adults. The recommendations apply to bipolar I, bipolar II, mixed affective and rapid cycling disorders. It aims to improve access to treatment and quality of life in people with bipolar disorder. **Update information, September 2025:** NICE amended recommendations on using valproate in line with Medicines and Healthcare products Regulatory Agency (MHRA) safety advice that boys and men should be advised to use effective contraception (condoms, plus contraception used by a female sexual partner) throughout the valproate treatment period and for 3 months after stopping valproate. New recommendations are labelled **[2025]**. NICE also updated links to relevant technology appraisal guidance in the sections on electroconvulsive therapy and managing mania in young people. **APC actions:** valproate recommendations are being actioned via the Medicines Safety Group, with regular updates to the Area Prescribing Committee. **Suspected acute respiratory infection in over 16s: assessment at first presentation and initial management** NICE guideline Reference number: NG237 Published: 31 October 2023 Last updated: 02 September 2025 https://www.nice.org.uk/guidance/ng237	

No	Agenda Item	Action
	This guideline covers assessment of people aged 16 and over with symptoms and signs of acute respiratory infection (bacterial or viral) at first remote or in-person contact with NHS services. It also covers the initial management of any infections. It aims to support healthcare practitioners in making sure that people's treatment follows the best care pathway. It forms part of a suite of work on virtual wards being undertaken by NICE. **Update information, September 2025:** NICE removed the section on clinical diagnosis of community-acquired pneumonia in primary care. This information is covered by NICE's guideline on pneumonia: diagnosis and management (see below). **APC actions:** none required. **Pneumonia: diagnosis and management** NICE guideline Reference number: NG250 Published: 02 September 2025 https://www.nice.org.uk/guidance/ng250 This guideline covers diagnosing, assessing, and treating community-acquired and hospital-acquired pneumonia, including bacterial pneumonia secondary to COVID-19, in babies over 1 month (corrected gestational age), children, young people and adults. It aims to optimise antibiotic use and reduce antibiotic resistance. **Update information, September 2025**: This update amalgamates and replaces the NICE antimicrobial prescribing guidelines on community-acquired pneumonia and hospital-acquired pneumonia (both published September 2019), and partially updates and replaces NICE guideline CG191 (published 2014). **APC actions:** update to the BLMK antimicrobial guidelines planned to incorporate the changes **Chronic heart failure in adults: diagnosis and management** NICE guideline Reference number: NG106 Published: 12 September 2018 Last updated: 03 September 2025 https://www.nice.org.uk/guidance/ng106 This guideline covers diagnosing and managing chronic heart failure in people aged 18 and over. It aims to improve diagnosis and treatment to increase the length and quality of life for people with heart failure. **Update information. September 2025:** NICE has reviewed the evidence on treating and monitoring heart failure with reduced ejection fraction, mildly reduced ejection fraction and preserved ejection fraction. NICE amended the recommendations on heart failure with reduced ejection and added new recommendations on heart failure with mildly reduced and preserved ejection fraction. **APC actions:** under review **The following NICE TAs are the commissioning responsibility of NHSE and are listed for information only:** **Tislelizumab for treating advanced non-small-cell lung cancer after platinum-based chemotherapy (terminated appraisal)** Technology appraisal Reference number: TA1072 Published: 19 June 2025 https://www.nice.org.uk/guidance/ta1072 **APC actions**: none – terminated appraisal	

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	Atezolizumab for adjuvant treatment of resected non-small-cell lung cancer Technology appraisal guidance Reference number: TA1071 Published: 19 June 2025 https://www.nice.org.uk/guidance/ta1071 **APC actions:** Link added to formularies (RED traffic light) **Marstacimab for treating severe haemophilia A or B in people 12 years and over without anti-factor antibodies** Technology appraisal guidance Reference number: TA1073 Published: 24 June 2025 https://www.nice.org.uk/guidance/ta1073 **APC actions:** tbc. No local use expected. Information from the TA states that the technology is expected to be used in Haemophilia Comprehensive Care Centres **Fosdenopterin for treating molybdenum cofactor deficiency type A (terminated appraisal)** Technology appraisal Reference number: TA1078 Published: 25 June 2025 https://www.nice.org.uk/guidance/ta1078 **APC actions**: none – terminated appraisal **Adagrasib for previously treated KRAS G12C mutation-positive advanced non-small-cell lung cancer (terminated appraisal)** Technology appraisal Reference number: TA1076 Published: 02 July 2025 https://www.nice.org.uk/guidance/ta1076 **APC actions:** none – terminated appraisal **Zanubrutinib for treating relapsed or refractory mantle cell lymphoma** Technology appraisal guidance Reference number: TA1081 Published: 10 July 2025 https://www.nice.org.uk/guidance/ta1081 **APC actions:** linked added to formularies (RED traffic light) **Fruquintinib for previously treated metastatic colorectal cancer** Technology appraisal guidance Reference number: TA1079 Published: 23 July 2025 https://www.nice.org.uk/guidance/ta1079 **APC actions**: created and link added to formularies (RED traffic light) **Letermovir for preventing cytomegalovirus infection after a kidney transplant (terminated appraisal)** Technology appraisal Reference number: TA1082 Published: 23 July 2025 https://www.nice.org.uk/guidance/ta1082 **APC actions:** none – terminated appraisal **Lisocabtagene maraleucel for treating relapsed or refractory aggressive B-cell non-Hodgkin lymphoma after 1 systemic treatment when a stem cell transplant is unsuitable (terminated appraisal)** Technology appraisal Reference number: TA1083 Published: 23 July 2025 https://www.nice.org.uk/guidance/ta1083 **APC actions:** none – terminated appraisal	

	Idecabtagene vicleucel for treating relapsed or refractory multiple myeloma after 2 to 4 treatments (terminated appraisal) Technology appraisal Reference number: TA1084 Published: 23 July 2025 https://www.nice.org.uk/guidance/ta1084 **APC actions:** none – terminated appraisal **Vanzacaftor-tezacaftor-deutivacaftor for treating cystic fibrosis with 1 or more F508del mutations in the CFTR gene in people 6 years and over** Technology appraisal guidance Reference number: TA1085 Published: 30 July 2025 Last updated: 30 July 2025 https://www.nice.org.uk/guidance/ta1085 **APC actions:** created and link added to formularies (RED traffic light – for prescribing in designated specialist centres only) **Ribociclib with an aromatase inhibitor for adjuvant treatment of hormone receptor-positive HER2-negative early breast cancer at high risk of recurrence** Technology appraisal guidance Reference number: TA1086 Published: 06 August 2025 https://www.nice.org.uk/guidance/ta1086 **APC actions:** linked added to formularies (RED traffic light) **Sacituzumab govitecan for treating hormone receptor-positive HER2-negative metastatic breast cancer after 2 or more treatments (terminated appraisal)** Technology appraisal Reference number: TA1089 Published: 13 August 2025 https://www.nice.org.uk/guidance/ta1089 **APC actions:** linked added to formularies (TERMINATED APPRAISAL) **Durvalumab with tremelimumab for untreated advanced or unresectable hepatocellular carcinoma** Technology appraisal guidance Reference number: TA1090 Published: 19 August 2025 https://www.nice.org.uk/guidance/ta1090 **APC actions:** created and link added to formularies for tremelimumab (RED traffic light); link added for durvalumab. **Tarlatamab for extensive-stage small-cell lung cancer after 2 or more treatments** Technology appraisal guidance Reference number: TA1091 Published: 20 August 2025 https://www.nice.org.uk/guidance/ta1091 **APC actions:** none – not recommended **Pembrolizumab with carboplatin and paclitaxel for untreated primary advanced or recurrent endometrial cancer** Technology appraisal guidance Reference number: TA1092 Published: 27 August 2025 https://www.nice.org.uk/guidance/ta1092 **APC actions:** linked added to formularies (RED traffic light) **Idebenone for treating visual impairment in Leber's hereditary optic neuropathy in people 12 years and over** Technology appraisal guidance Reference number: TA1093 Published: 28 August 2025 https://www.nice.org.uk/guidance/ta1093 **APC actions:** tbc – no local use expected.	

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	Benralizumab for treating relapsing or refractory eosinophilic granulomatosis with polyangiitis Technology appraisal guidance Reference number: TA1096 Published: 03 September 2025 https://www.nice.org.uk/guidance/ta1096 **APC actions:** tbc – no local use expected.	
7.	**Virtual Recommendations/Documents for discussion/ratification**	
7.1	**Tirzepatide Prescribing Guidance for Patients with Type 2 Diabetes** The Committee considered updates to the existing primary care prescribing guidance for tirzepatide for the management of patients with type 2 diabetes (T2DM). The following updates have been made: • Addition of 'formulary choice' to advice to prescribe pen needles. The link to the SPC updated. • Added review at 12 months to determine continuation of therapy. • Addition of advice on co-prescribing with DPP-4 (not recommended). • Updated information on cautions for prescribing – elderly, MHRA warning on risk of pulmonary aspiration with sedation and diabetic retinopathy. • Additional information on blood glucose monitoring and DVLA advice for Group 2 drivers. • References and links all checked and updated. Following receipt of comments received from the circulation of the paper for virtual consideration, additional information has also been added regarding the co-prescription of tirzepatide with other medications, particularly oral contraceptives and hormone replacement therapy. A link has been included to the British Menopause Society guidance on the use of incretin-based therapies in women using hormone replacement therapy (HRT). A quorate response was not received for the virtual consideration of the document and therefore the Committee was asked to approve the changes to the guidance. **Decision**: The updated guidance was approved by the Committee. **EQIA Assessment:** N/A – minor amendments to existing guidance.	
7.2	**Atopic dermatitis pathway update** The Committee reviewed a minor update to the existing atopic dermatitis pathway to incorporate nemolizumab as an additional treatment option. Nemolizumab was recommended by NICE, in TA1077, as an additional treatment option for patients aged 12 years and over with moderate to severe atopic dermatitis. Note: ICBs commission for adults only; NHS England is responsible for funding treatments for children and young people.	

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	The updated pathway has been circulated to local specialists for comment. Feedback was received about the possibility of pathway extension to include an additional line of therapy – this is an additional piece of work which will need to be worked up and costed and therefore looked at separately. A quorate response was not received for the virtual consideration of the document and therefore the Committee was asked to approve the changes to the pathway. **Decision**: The updated pathway was approved by the Committee. **EQIA Assessment:** N/A – addition of NICE approved medicines into the existing pathway only.	
8.	**Medicines Safety update** A Primary Care Medicines Safety Update and a Medicines Safety Group Update was presented to the committee. **<u>Primary Care Medicines Safety Update</u>** This update focussed on the primary care response to the MHRA Drug Safety Updates (July 2025) and CAS alerts (June to September 2025). In particular: **Abrysvo▼ (Pfizer RSV vaccine) and Arexvy▼ (GSK RSV vaccine): be alert to a small risk of Guillain-Barré syndrome following vaccination in older adults (DSU, July 2025)** There is a small increase in the risk of Guillain-Barré syndrome following vaccination with Abrysvo (Pfizer respiratory syncytial virus (RSV) vaccine) and Arexvy (GSK RSV vaccine) in adults aged 60 years and older. Healthcare professionals should advise all recipients of Abrysvo and Arexvy that they should be alert to signs and symptoms of Guillain-Barré syndrome and, if they occur, to seek immediate medical attention as it requires urgent treatment in hospital. **Actions taken:** Added to October MSG agenda for discussion. Included in BHFT's newsletter. **Potential contamination of non-sterile alcohol-free skin cleansing wipes with Burkholderia spp: measures to reduce patient risk (CAS alert, June 2025)** **Actions taken:** For action by trust Infection Prevention Control teams; discussed by the Wound Formulary Management Sterring Group.	

	Bumetanide 1mg tablets are out of stock until mid-August 2025 (CAS alert, July 2025) **Actions taken:** Information included on the Formularies and messaging is live on Optimise Rx to direct prescribers to consider furosemide for new patients to conserve stock. Supply issue no longer appearing on SPS Medicines Supply Tool. Tracked at BHFT Purchasing Medicines for Safety (PMFS) shortages meeting. **Shortage of Antimicrobial Agents Used in Tuberculosis (TB) Treatment (CAS alert, July 2025)** **Actions taken:** Engagement with antimicrobial consultants and TB lead. Ringfencing for TB indications ongoing. Within Primary Care patients have been identified and repatriated +/- de-prescribing where indication is not for TB. Affected practices have been contacted. Optimise Rx messages are in place to flag to prescribers the new red traffic light status. BHFT and MKUH have completed their trust's action plan - to share with the ICB. Memo has been circulated. Patients have been identified and supply limited to one month. Alternatives investigated however sourcing is challenging. (e.g. Voractiv, rifabutin). **Harm from delayed administration of rasburicase for tumour lysis syndrome (CAS alert, September 2025)** **Actions taken:** Red (hospital only) drug on the formularies. Linking in with cancer networks. Actions to be completed by 09 March 2026. Added to October MSG agenda for discussion. **Medicines Safety Group (MSG) Update** Valproate System response update: • Ardens templates in place on SystmOne for referral to specialist and/or sexual health for completion of the ARAF / for support with contraception respectively. • The valproate subgroup was disbanded and valproate taken into MSG as a standing agenda item with a focus on system update every other meeting (last update was August). • ELFT are an exemplar area and have electronic forms and policies all in place. They are also developing a BI dashboard to monitor valproate and form completion. They have widely shared their processes with the system (the main platform being a stakeholder meeting which was held in March). • Optimise Rx messaging is live to highlight the need for form completion. • As of Feb 2025 – approx. 13% of women of childbearing age have a valid ARAF (Annual Risk Acknowledgement Form) or exemption recorded on SystmOne within the last 12 months in BLMK. • BHFT reported their SOPs are in development. Unfortunately, no representative for MKUH was present at the August meeting to update. • The focus is still currently on women but the need to include men is acknowledged. SystmOne searches are set up to	

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	monitor but practices are currently struggling with timely review of the women. <u>Topiramate system response update:</u> • MSG are starting to investigate topiramate and requirements for completion of an ARAF/exemption. The process is less well established but aims to be like valproate. • Ardens searches have been built. • Optimise Rx messaging is in place to flag the need for form completion. • Data suggests larger numbers of patients versus valproate. SystmOne reports 422 women of childbearing age issued topiramate within the last 3 months, not fulfilling the requirements of the PPP (Pregnancy Prevention Programme) in the last 12 months. • There are 501 outstanding an ARAF and 479 not fulfilling the PPP. • Eclipse alerts – These are being upgraded from blue to amber alerts to reflect the risk and actioning amber alerts have been incentivised in this year's prescribing incentive scheme. • Referral to a specialist may present more challenges with topiramate as some prescribing indications do not fall under a specific specialist. This will all be taken forward via MSG. • BHFT are reauditing their baseline and will be presenting at MSG once complete. <u>Do once and share learning topics covered in August MSG:</u> • **GLP-1 medicines for weight loss and diabetes**. The MHRA published "what you need to know" guidance in August 2025 to support clinicians. The desirability of these medications has led to increased GP workload from requests, instances of patients falsifying data to access, the risk of obtaining falsified injections, accessing from unreputable websites, with the potential for misappropriation in healthcare environments. In BLMK, these medicines remain Red on the formularies – for prescribing in specialist weight management services only. • **Oestrogen prescribed without progesterone for HRT in women with an intact uterus.** A small number of incidents were discussed at MSG and learning shared around the risks of prescribing unopposed oestrogen in women with an intact uterus. The patients were identified through audit, which sparked further discussion around development of a suite of audits for high-risk areas of prescribing. This will be added to the MSG workplan and is being considered as a prescribing incentive scheme target. JW offered to support this piece of work. • **Phenytoin – statin interaction.** This interaction was flagged via the ICB regional forum. An initial look at data suggests several patients in Primary Care are co-prescribed phenytoin with simvastatin or atorvastatin, which reduces the effectiveness of lipid lowering, and highlights the need to	

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	raise awareness of the risk. This interaction will be discussed at the BLMK Place Prescribing meetings.
	• **Time critical medicines.** Time critical medicines have been in focus nationally for some time – the group shared learning and resources from a variety of platforms and discussed some future QI projects for BLMK in this area.
	  ○ BHFT have updated their critical medicines list, and it will be shared at the next meeting.
	  ○ Update on Self-administration of Insulin boxes (SAMI): Trusts report ongoing work to embed SAMI boxes, however due to high demand, sourcing stock has been challenging.
	• **End to end processes and interface communication**. The group shared cases of good practice and highlighted the importance of robust processes for the entire patient journey, including at the point of discharge. QI improvement is ongoing in this area and the Trusts have been focusing on improving discharge processes. A systemwide approach is needed to minimise medication errors which arise often at the interface between primary and secondary care. This topic will be added to the MSG workplan and will expand on work currently underway across BLMK.
	
	The following items were noted as being added to the MSG workplan for 2025-26:
	• PSIRF priority mapping
	• Valproate (spotlight every other meeting)
	• Anticoagulation in pregnancy
	• Medicines Safety Improvement Programme 2024-2027 survey (to be reviewed at next MSG)
	• Audits for high-risk areas of prescribing
	• Preventing medication errors at the interface
	
	The Committee noted the medicines safety update.	

9.	**Formulary Update**	
9.1	**Formulary Subgroup Recommendations** The following recommendations were made by the Formulary subgroup at the 09 September 2025 meeting: • **Fresubin Pro Compact** is a new cost-effective product which is equivalent to Fortisip Compact Protein. It was noted that the Trusts have enteral nutrition contracts in place and switching to Fresubin may represent a cost pressure, therefore switch to Fresubin will need to happen upon transfer to Primary Care. *Outcome:* Added to the Formularies as specialist advised (SpA), with development of associated Optimise Rx messaging to support switching of patients in Primary Care. *Cost impact of decision:* 100% switch would realise cost savings of £229k per annum across BLMK. • **Desmopressin for nocturnal enuresis.** Request from Cambridge Community Services (CCS) to add desmopressin sublingual tablets and oral solution to the Formularies for use	

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	in children with nocturnal enuresis. The group discussed swallowing difficulties, the need for social discretion and unpalatability of crushed tablets, all of which are addressed by addition of sublingual tablets and liquid. There is a significant amount of non-formulary prescribing of Desmomelt oral lyophilisates which are high cost. These were placed in Do Not Prescribe, with active switching and support messaging to move patients onto sublingual tablets. *Outcome:* Sublingual tablets and oral solution were added to the Formularies as Green for use in nocturnal enuresis in children. *Cost impact of decision:* Cost saving overall. Moving away from Desmomelts to sublingual tablets will save 50% on current annual spend (Assuming 100% switch) – this represents approximately £68k per annum. • **Desmopressin tidy-up of other indications and products.** The paper reviewed available products on the UK market to clarify which preparations were cost effective and which were licensed for the different indications. The decisions were as follows: ○ Nocturnal enuresis: In alignment with the above item. ○ Diabetes insipidus (DI): Addition of oral solution and sublingual tablets – SpA for DI; Do Not Prescribe stance for lyophilisate preparations; 10microgram nasal spray included also, however information regarding current stock shortage is active. ○ Post-hypophysectomy polyuria/polydipsia (removal of pituitary gland): All licensed preparations (excluding lyophilisates which are DNP) added to Formulary as SpA. ○ A specific product licensed for idiopathic nocturia in adults was also assessed. Noqdirna was found to be in use in small amounts in Primary Care and a mini audit of indication highlighted a possible picking error with this therapy as it was often prescribed outside of its license. The group noted the specialist nature of this product, which was therefore added as Red to the Formularies. Further work will be undertaken to assess Noqdirna use for appropriateness in the few patients prescribed it. *Cost impact of decision:* Cost saving overall – as per desmopressin for nocturnal enuresis (above). • **Oxybutynin Modified Release tablets for nocturnal enuresis.** Request from CCS for addition of oxybutynin Modified Release (MR) for use in paediatric nocturnal enuresis. The usage data shared prompted a wider review of the use of MR oxybutynin across all cohorts. Oxybutynin was acknowledged as being a medication with more unwanted side effects, prompting the question of appropriateness. Currently MR oxybutynin is classified as non-formulary, however there is still significant prescribing across BLMK – in the order of £97k per annum. It was noted that upcoming products such as virabegron may need incorporating into	

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	updated pathways. This option reportedly has fewer blood pressure related side effects. *Outcome:* The application was not approved, noting further work/pathway review and more data is required before taking it forward. *Cost impact of decision:* Neutral – application not approved. • **Arize Infant formula.** This is a new hydrolysed rice infant formula for use in patients with Cow's Milk Protein Allergy (CMPA) which was proposed to be added second line after trial of an extensively hydrolysed formula. The product represents a potential cost saving as its position will reduce the use of amino acid-based formulas (now third line). *Outcome*: The application was approved and Arize was added as Green, second choice to the Formularies. Minor update to be made to the Infant Formula guidelines to reflect this. *Cost impact of decision:* savings of approximately £30k per annum could be realised. • **Independence shower/swim products for protection of lines during bathing/showering position statement.** A position statement has been developed to formalise the recommendations to not prescribe shower/swim patches for patients with lines. The document was developed in response to inappropriate promotion of a non-formulary product and reports of Pharma Reps handing samples out directly to patients on our Trust sites and telling them they are available via GP. This has been raised with the company. The shower pouches are high cost (approximately £12 each) and are a poor use of NHS resources. For patients who wish to purchase shower pouches this option is available via online retailers at a much lower cost vs the pouches that GPs are being requested to prescribe. ○ Renal clinics in BLMK have been consulted and they have confirmed they do not recommend these products. ○ Urology patients in Oxford receive 1 week supply of dressings on discharge from ward and ward orders 1 month supply on discharge through Manfred Sauer Care. The patients are advised that they can then reorder through the company as needed. The team have been notified of the requirement to retain prescribing if they wish to continue them. *Outcome:* The position statement was approved with shower and swim pouches to be placed in Do Not Prescribe (DNP). *Cost impact of decision:* Cost saving – prescribing on the NHS of these products should cease – saving an estimated £160k per annum. • **Updated NHSE recommendations on blood glucose and ketone meters and strips** based upon NHSE Commissioning Recommendations for Blood Glucose and Ketone published June 2025. Update to BLMK formularies: ○ Palmdoc 2 blood glucose meter and testing strips – continues as a BLMK formulary choice. Palmdoc	

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	Smart meter (with connectivity to smartphone as well as existing USB and Bluetooth connectivity) to be available from October 2025. ○ FineTest lite Testing strips price updated. ○ 4 Sure Smart Duo blood glucose testing strips price updated. ○ Greenfine (0.35mm/28G) lancets – new, cost-effective lancets (£1.79/100) compatible with universal lancing devices – add to Formularies. ○ Recycling information now available - will support BLMK sustainability initiative and the NHS net zero target. *Outcome:* The changes were approved. *Cost impact of decision:* Likely cost-saving overall – in line with national guidance for use of cost-effective products. • **Generic dapagliflozin.** Dapagliflozin (Forxiga®) patent has expired and accounts for 70% SGLT2i prescribed in BLMK (others – empagliflozin and canagliflozin). SGLT2 inhibitors are indicated for T2DM, heart failure and CKD. ○ NICE has opened consultation on draft update to NG28 (management of T2DM) - SGLT2i being proposed as 1st line with metformin. This change is anticipated to increase prescribing of dapagliflozin significantly. ○ Cost-effective option providing more opportunity not just for glycaemic control but CVD and renal protection. ○ There are plans for reinvestment of savings locally into hybrid closed loop systems for patients aged 25 and under. *Outcome*: The use of generic dapagliflozin generic as first line SGLT2i was approved. Patients on other SGLT2i will also be actively switched onto dapagliflozin as part of cost-saving incentive schemes and locally commissioned change programme. *Cost impact of decision:* Large cost saving - estimated £223K monthly based on expenditure on dapagliflozin. • **Nirsevimab (Beyfortus®) – Respiratory Syncytial Virus monoclonal antibody immunisation**. RSV vaccination with nirsevimab is being rolled out for infant / selected high risk children up to 24 months of age. The program will start from late September 2025. Around 9,000 babies and infants in the UK are expected to benefit per year, avoiding hospitalisation as per the Green Book (Chapter 27a). RSV vaccine is offered to pregnant women at the recommended time of around 28 weeks. However, babies born before 32 weeks have limited or no protection. Nirsevimab RSV vaccination will replace monthly injections of palivizumab (palivizumab provides around 55% protection while nirsevimab offers more than 80% protection). *Outcome*: Nirsevimab was added to the Formularies as Red – for use within neonates and infants in eligible cohorts. *Cost impact of decision:* Cost neutral – funded by NHSE.	

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	• **Acamprosate – review of formulary status.** Acamprosate was discussed with a view to retiring the current Beds/Luton Shared Care Guidance. Within Beds/Luton, it was agreed to move to SpIS traffic light, with development of a supporting document outlining the key points for prescribing. Milton Keynes representatives raised concerns around extended courses within Primary Care and a preference for specialists to retain prescribing – therefore within Milton Keynes acamprosate was agreed to have a red traffic light status, with review of patients within Primary Care to ascertain prescribing habits. *Outcome*: The SCG was agreed to be retired and the designation moved to SpIS in Beds/Luton. Within Milton Keynes, the designation was amended from SpA to Red. *Cost impact of decision:* Cost neutral – no change. • The formulary **minor amendments log** was noted. • **Jorveza – withdrawn application.** Previous application to assess the use of Jorveza (budesonide orodispersible) for maintenance of eosinophilic oesophagitis was withdrawn due to a NICE TA which is currently in development looking at the same patient population. • **Rybelsus (semaglutide)** – notification of reformulation of the product resulting in increased bioavailability and change to equivalent strengths of product: This is a potential medication safety risk – comms to be developed and shared widely across the system to raise awareness. Estimated 2600 patients, mostly in Central Bedfordshire, are affected. Urgent OptimiseRx messaging is in development to raise awareness when prescribing. **Decision:** The Committee ratified the recommendations of the Formulary Subgroup.	
9.2	**Wound Management Formulary Steering Subgroup Recommendations** A report from the wound management subgroup meetings in July and September 2025 was presented to the Committee: • **Formulary alignment and development:** ○ Suprasorb P foam dressing range is to be extended to incorporate newly available sizes and versions which will accommodate a larger range of wounds. ○ The following like-for-like substitutions will be made shortly to cover dressings that are no longer being produced (financial impact is negligible): ▪ Debrisoft Duo to replace DebriClean pad. ▪ Advancis Honey barrier cream to replace Medihoney barrier cream. ○ A new section for Luton area guidelines has been added to Eolas (online wound management formulary). ○ A contact list for all those who use the formulary online has been put together for dissemination of information from each meeting, to include updates	

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	and notices of temporary products to cover temporary supply issues. • **Financial:** The use of ONPOS (direct procurement) continues to grow as all GP practices in BLMK now have access to the ordering platform. Spend for the first quarter of 2025/26 showed 57% of dressings were ordered via ONPOS use (direct procurement), with the remaining 43% via FP10. This is a 6% increase of ONPOS spend compared to the financial year 2024/25 (51%). • **Additional matters discussed:** o It has been agreed that staff in nursing homes in Bedfordshire and Luton should have access to the formulary on ONPOS so they can order directly, improving quality of patient care by cutting down on time taken to access dressings, and promoting adherence to TVN guidelines. o CAS alert – non-sterile wipes (see also agenda item 8.0). These are not used by TVNs, but members to consider if any action required. o NICE HTE32 – Compression products for treating venous leg ulcers. Members expressed concerns around the quality of the trials used for the evaluation, and whether these expansive enough to give a reasonable demonstration of the advantages afforded by the use of compression wraps. This will be for further consideration and discussed at a future meeting. **Decision:** The Committee ratified the recommendations of the Wound Management Steering group.	
10.	**Patient Group Direction Subgroup Recommendations** The following recommendations were made by the Patient Group Direction (PGD) subgroup:	
10.1	**MK Urgent Care Service PGDs** The following PGD was presented for approval with limited clinical changes: • **Miconazole 2% cream for the treatment of infected nappy rash and skin ringworm:** Change in pack size from 30g to 15g **Decision:** The Committee ratified the PGD, as recommended by the PGD subgroup	
11.	**Antimicrobial Resistance Update** An antimicrobial resistance / infection prevention and control (AMR/IPC) meeting took place recently, in September 2025, and discussed the following ongoing workstreams: • Primary care – antibiotic prescribing in children • Secondary care – IV to oral switch AMR/IPC representatives attended the BLMK ICB Quality & Performance board to give updates on children's antibiotic prescribing, c. difficile, and tuberculosis.	

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	Two recent funding bids have been submitted to NHS England for: • AMS Leadership: Proposal to backfill at Bedfordshire Hospitals NHS Foundation Trust to fund Consultant Pharmacist time (0.2WTE) to drive forward AMR workstreams across the ICS. • Point of Care Tests for paediatric respiratory tract infections at the Milton Keynes Urgent Care Centre (developed with Health Improvement England). The Committee noted the antimicrobial stewardship update.	
All other papers (from this point in the agenda) are for noting/information by the Committee		
12.	**East of England Priorities Advisory Committee (EoEPAC) – items for noting/approval**	
12.1	EoEPAC Meeting Notes – March and May 2025 The committee noted the minutes for information.	
13.	**Bedfordshire, Luton and Milton Keynes Local Prescribing Committee Minutes.** The Committee noted the following minutes for information.	
13.1	Minutes of the Bedfordshire Hospitals Foundation Trust Drug and Therapeutics Committee (DTC) – none available	
13.2	Minutes of the Milton Keynes Hospital Prescribing & Medicines Governance Committee (PMGC) – April, May, June and July 2025	
13.3	Minutes of the BLMK Formulary Subgroup – June 2025	
13.4	Minutes of the BLMK Wound Management Formulary Steering Group – none available	
13.5	Minutes of the BLMK Medicines Safety Group – June 2025	
13.6	Minutes of the ELFT Medicines Management Committee – none available	
13.7	Minutes of the Cambridgeshire Community Services Medication Safety and Governance Group – none available	
13.8	Minutes of the CNWL Trustwide Medicines Optimisation Group (MOG) – none available	
13.9	Minutes of Circle/MSK Medicines Management Committee – July 2025	
14.	**Papers for information / ratification**	
14.1	**Tirzepatide for the management of overweight and obesity / Type 2 Diabetes** The Committee noted the following update regarding tirzepatide: The Department of Health and Social Care (DHSC) has agreed a UK list price increase for tirzepatide (sold under the brand name Mounjaro®) following a request from Eli Lilly reflecting changes in	

No	Agenda Item	Action
	the commercial environment and to ensure continuity of supply for a product that has been subject to systemic long term supply constraints. List price changes are routinely agreed by the DHSC. Through the voluntary scheme for pricing, access, and growth of branded medicines ('VPAG'), DHSC has discretion to approve increased list prices due to company or product commercial viability, risk of discontinuation, withdrawal or non-supply or global supply constraints. The new list prices will apply to all indications of tirzepatide recommended by NICE - currently type 2 diabetes (T2DM) and people living with obesity, and any future indications. NHS England has worked with Eli Lilly to ensure the list price increase will not affect NHS commissioning of tirzepatide in England as a treatment for eligible patients. Tirzepatide will continue to be available for weight loss though the commissioned community weight management service for eligible people with a BMI of 40 or more in addition to four of more qualifying comorbidities in line with the NICE TA. It will continue to be available for type 2 diabetes in line with the NICE TA, noting that the guidelines for type 2 diabetes are currently under review and updated guidelines are anticipated at the end of February 2026 and the place in therapy may change. The Committee discussed that challenges have been presented to the system as a result of the price changes to tirzepatide and noted the following: • For people that have previously accessed tirzepatide through a private provider, the NHS may only continue treatment if, following an assessment by the Integrated Care Board's commissioned weight management service, the individual meets the eligibility criteria at the time they present to the NHS. • Any person presenting to an NHS service with questions about their private tirzepatide prescription, including stopping or tapering off the drug, should be directed to speak with their private provider. • NHS teams, including primary care providers could provide reassurance to the person that stopping tirzepatide, that is being taken for its licensed weight loss indication, is not known to cause withdrawal symptoms, but that they should continue, where appropriate, a reduced-calorie diet and increased physical activity if they want to reduce the risk of weight regain.	
15.	**Any other business** The Committee was informed that access to the current platform used for sharing APC papers (TeamNet) will be lost at the end of this financial year. As a result, options for the sharing of papers are being	

No	Agenda Item	Action
	investigated and the Professional Secretary may contact members, prior to the next meeting, to trial a new platform for this.	
16.	**Future Dates for BLMK APC 2025/26 Meetings (all to be held from 12:30-15:00 via Microsoft Teams):** Wednesday 3rd December 2025 Wednesday 4th March 2026 Wednesday 6th May 2026 Wednesday 1st July 2026 Wednesday 23rd September 2026 Wednesday 2nd December 2026	

Approval of minutes:

Chair: Dr Muhammad Nisar

Signed: 

Date: 22/12/2025

Appendix 1 – Approved 09 September 2025 Formulary Subgroup Minutes:

BLMK ICB FSG
Minutes September 2