

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

Date: 11th November 2025

Time: 12:30

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	✓	
Taiya Large	TL	Professional Secretary/Formulary & Medication Safety Pharmacist, NHS BLMK ICB	✓	
Alex Hill	AH	Community Pharmacy Representative	✓	
Amjid Hussain	AHu	Bedfordshire Lead for the Community Mental Health Services, East London Foundation Trust.		✓
Anne Graeff	AG	Commissioning Lead Pharmacist BLMK ICB	✓	
Carole Jellicoe	CJ	Nurse and Non-Medical Prescribing Representative (Secondary Care)		✓
Dona Wingfield	DW	Head of Medicines Governance Safety and Quality (cross site) Bedfordshire Hospitals NHS Foundation Trust		✓
Dr Dushyant Mital	DM	Medical Representative, Milton Keynes University Hospital NHS Trust		✓
Dr Eleanor Tyagi	ET	Medical Representative, Milton Keynes University Hospital		✓
Dr Jenny Wilson	JWi	GP Representative, Bedfordshire and Luton	✓	

Dr Kate Randall	KR	GP Representative, Bedfordshire and Luton		✓
Dr Mya Aye	MA	Medical Representative, Milton Keynes University Hospital		✓
Dupe Fagbenro	DF	Deputy Chief Pharmacist (Luton and Bedfordshire) - ELFT	✓	
Faisal Khan	FK	Medicines Use & Quality Manager MKUH	✓	
Grace Khoo	GKh	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)		✓
Jonathan Walter	JWa	Milton Keynes GP representative		✓
Joy Mooring	JM	Primary Care Specialist Pharmacy Technician, BLMK ICB	✓	
Maggie Winter	MW	Milton Keynes GP representative	✓	
Marian Chan	MC	Consultant, Bedfordshire Hospitals NHS Foundation Trust	✓	
Matt Davies	MD	Head of Pharmacy and Medicines Optimisation and Place Based Lead Pharmacist, C Beds		✓
Mojisola Adebajo	MA	Place Based Lead Pharmacist BLMK ICB, Luton	✓	
Nicholas Beason	NB	Procurement technician MKUH		✓
Nigel Fagan	NF	GP Local Medical Committee representative	✓	
Nikki Woodhall	NW	MK Place lead Medicines Optimisation & digital transformation lead	✓	
Prabjoth Kaur	PK	Lead Pharmacist Medicines Information and Formulary		✓
Qiratulain Khan	QK	Lead Pharmacist Medicines Information and Formulary	✓	

Reginald Akaruese	RA	CNWL Pharmacy Representative (Community and Mental Health Services Milton Keynes)		✓
Saema Arain	SA	ELFT Pharmacy Representative – Community Services (Beds)/Mental Health Services (Beds and Luton)		✓
Samina Hassanali	SH	Medicines Optimisation Pharmacist	✓	

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.	<p>Welcome, Introductions and Apologies</p> <p>The chair welcomed everyone to the meeting.</p> <p>In Attendance for Specific Items Aarti Shah (For Item 5.6), Hannah Hill (For Item 5.7), Himabindu Gundapudi (On behalf of Reg).</p> <p>Apologies Dush Mital, Kate Randall, Carole Jellicoe.</p> <p>The meeting was confirmed as quorate.</p>
2.	<p>Declarations of Interest</p> <p>Annual written declarations of interests – currently up to date and requests for updates have been sent.</p> <p>Members were invited to declare any conflicts of interest relating to matters on the agenda, none declared.</p>
3.	<p>Minutes of the previous meeting</p> <p>The June 2025 FSG meeting notes were approved as accurate.</p>

No	Agenda Item					
4.	Action Log					
	Item	Title	Date added	Owner	Action	Update
	1.	Bupropion for resistant depression prescribing guide	April 2025	SH	Guidance document is awaiting confirmation of blood pressure monitoring requirement wording. Until such time as the document is finalised, bupropion remains RED on the Formulary.	Awaiting update from ELFT partners.
	2.	Desmopressin – Desmomelt Formulation	Sept 2025	NW	To ensure Desmomelt has been removed from CNWL policy as a DNP item.	Pending confirmation.
	3.	Noqdirna audit	Sept 2025	TL/JM	Investigate via central system reporting the prescribing of Noqdirna in Primary Care.	The MedsOpt team have audited the practices we have access to and submitted review tasks where appropriate. Noqdirna has also moved into Red category on Optimise Rx and this will flag to prescribers going forward. Close action.
	4.	Oxybutynin MR tablets	Sept 2025	PJ	Following on from the last meeting, the request for oxybutynin MR for paediatric nocturnal enuresis was suspended pending further data to define patient numbers/costs and clarity on position in therapy against other preparations such as tolterodine. Stakeholders are working to review the paper and will re-submit to FSG when it is ready. A wider look at MR oxybutynin MR is needed (adult use) as the product is currently Non-Formulary but annual	Close action and add wider look of MR oxybutynin to workplan.

No	Agenda Item					
					spend is significant across BLMK.	
5.	Acamprosate support document	Sept 2025	AG	<p>Prescribing support document due to be ratified at December APC, at which time it will take over the SCG previously in place and traffic light will update to SpIS for Beds/Luton.</p> <p>Within Milton Keynes, traffic light remains Red whilst further investigation into prescribing habits and appropriateness of therapy is undertaken. Work has begun around this, and some patients have as a result had acamprosate discontinued.</p>	<p>Continue audit/review of prescribing in Primary Care and add to workplan future review to align traffic lights for BLMK for equity of access.</p> <p>Action to close.</p>	
6.	Rybelsus change of formulation	Sept 2025	TL	<p>We are currently in the transition period for switching. As of 23.10, the new formulations were not yet included on SystemOne for prescribing – update expected imminently. Optimise Rx messaging is there waiting to be activated once it is listed.</p>	<p>Practice facing team monitoring SystemOne for update on 13/11/25 and will activate messages once they are listed.</p> <p>Close action.</p>	
7.	Xonvea	Sept 2025	SH	<p>Need clarity on the pathway for access to Xonvea – currently SpIS on the Formulary. If a patient presents in Primary Care – where do GPs refer patients to for access to Xonvea?</p>	<p>Following discussion around cost pressure for no additional clinical benefit and GP lack of familiarity of the product at this time the designation is to remain SpIS.</p> <p>Secondary Care have confirmed Maternal Meds clinic is not a referral hub for access and patients should</p>	

No	Agenda Item					
						present to A&E or EPAU/EPC. Close action.
	8.	Fortisip Compact Protein	Sept 2025	NW	Review of prescribing trends across BLMK to identify areas most likely to benefit from targeted switching.	Data analysis suggests Beds/Luton use the most Fortisip Compact Protein. The switch message is now live on Optimise Rx, and we will continue to monitor the acceptance rate of the message. Possible future work to increase engagement with the switch if needed beyond what the message offers.
5.	Items for consideration					
5.1 & 5.2	<p>Compleat 1.1 and Compleat 1.5 HP Enteral Nutrition</p> <ul style="list-style-type: none"> • New to market, nutritionally complete tube-feeding formulas made with real food ingredients, proposed for patients requiring a fibre feed or as an intermediate option when standard feeds are intolerable. It is a more cost-effective option than peptide regimens like Peptamen and a reduction in prescribing of these is expected to realise cost-savings. • Proposal: Add to Formularies as Specialist-initiated and Primary Care Prescribed (SpA). • Decision: The committee was happy to approve a decision outside of the group, pending discussion with procurement leads to ensure it does not upset existing contracts. • Action: Fiona Garnett to consult procurement leads and make a decision, which will be brought back for information at the next meeting. 					
5.3	<p>Dydrogesterone-only hormone replacement therapy (HRT) formulation (Nalvee®), as an option for non-hysterectomised women receiving oestrogen therapy</p> <ul style="list-style-type: none"> • Nalvee marks a return to the market for a dydrogesterone-only product after an absence of 17 years and can be used in combination with any oral/transdermal oestrogen HRT. It is a branded generic version of a product called Duphaston – originally launched in 1961 – that was withdrawn from sale in the UK in 2008 (commercial reasons). • There is strong, long-standing evidence that dydrogesterone given cyclically (commonly 10 mg for 12–14days/month when combined with oestradiol) provides effective endometrial protection. Dose-ranging and randomized studies reported endometrial protection success rates ≈ 97% at typical doses. 					

No	Agenda Item
	<ul style="list-style-type: none"> • It has the same safety profile as micronised progesterone but is better at controlling bleeding. Current practice is to either increase micronised progesterone or fit a Mirena if there are issues with bleeding, or switch to medroxyprogesterone (MPA), which has a less favourable safety profile. • GPs with specialist interest in menopause were consulted and indicate possible usage before MPA but note that its license limits its benefit as most women who need to control problematic bleeding are on continuous HRT for which Nalvee is not licensed. The BMS have no guidance on this and specialists report that prescribers are either using 5mg or 10mg dose in a continuous regime which is not licensed. • There are also concerns about extrapolating the use of Nalvee with a transdermal oestrogen as the pharmacodynamics are different. GPWSI indicate they would not prescribe Nalvee for someone on a patch at equivalent dose to 1mg or 2mg oral oestrogen because of this. • Comment from specialist "you cannot simply guess what dose of progestogen will be enough to provide endometrial protection against a certain dose of oestrogen and of course oral oestrogen is not the same thing as transdermal oestrogen either. Equally you do not want to give more progestogen than you need to as no one in the world knows if the very tiny increased breast cancer risk on it is dose related or not, likewise with micronised progesterone". <p>The decision was taken by the committee to not add Nalvee to the Formularies at this time, due to limitations in licensing making the product too niche and one which specialists would not prescribe.</p>
5.4	<p>Dexamethasone Formulary Amendment (Soluble Tablets)</p> <ul style="list-style-type: none"> • Formulations: Dexamethasone Soluble tablets 2mg, 10mg & 20mg. • Dosing: Mild Croup – Child - 150mcg/kg for 1 dose, Severe croup (or mild croup that might cause complications) Initially 150 micrograms/kg for 1 dose, to be given before transfer to hospital, then (by mouth or by intravenous injection) 150 micrograms/kg for 1 dose, then (by mouth or by intravenous injection) 150 micrograms/kg for 1 dose, to be given 12 hours after previous dose if required.. • Current options (oral solution) is more expensive per dose and requires the pharmacy to decant or dispense a full bottle which the patient will need to discard remaining solution as only one or two doses required for Croup treatment. • Broken Bulk applies to Dexamethasone Soluble tablets 4mg, 8mg & Oral Solution 10mg / 5ml. • Dexamethasone soluble tablets offer a cost-effective alternative to oral solution which will also prevent wasting of excess medication (expiry period for opened dexamethasone oral solution is between 1 month and 90 days (3 months), depending on the specific manufacturer and product formulation). • Proposal: Add the 2mg and 10mg soluble tablets to the formulary as they do not attract a broken bulk prescription claim when only 1-2 doses (e.g., for croup) are prescribed, making them cost-effective. The proposal was to designate them Green. • Rationale: The soluble tablets would allow pharmacies to keep stock for multiple patients and are seen as a move towards sustainability. • Decision: The 2mg and 10mg soluble tablets were approved as Green on the formulary. • 2mg/5mL oral solution designation: Green restricted. • Action: Taiya Large: to ensure Optimise RX messaging is added when the product is listed on the formulary to highlight acute prescription and the need for only a few tablets to be dispensed rather than an original pack.

No	Agenda Item
5.5	<p>Reusable Insulin Pens Guidance</p> <ul style="list-style-type: none"> • Proposal is to add all available re-usable insulin pens to both formularies with attached guide to highlight which cartridges are compatible with the pens. • Guide includes all available options, compatible insulins, lifespan of pens, and cost per annum of each. • Supports clinical decision-making and choice for appropriate patients. • Difference in the cost of using re-usable vs disposable pens is negligible (a small saving if re-usable pens are used > year). • Greater impact is on the environment and aligns with NHS and BLMK sustainability agenda. • Reusable insulin pens to be issued as acute prescriptions only. The group also discussed the need for two pens to be issued in case of loss/failure of one of the pens. • Decision: The use of reusable insulin pens was approved as Green on the formulary. • Action Moji: Develop Orx messages to highlight lifespan of the pens to prevent over prescribing.
5.6	<p>Amiodarone Shared Care Guidance</p> <p>The guidance for Amiodarone has been reviewed and updated, with alignment across BLMK. Currently, Beds/Luton have SCG in place which is due for review and Milton Keynes have amiodarone under SpIS.</p> <p>Concerns were raised regarding annual secondary care review of patients and request for advice from cardiologists on treatment of a low magnesium result were requested to be included in the SCG.</p> <p>Nigel also raised difficulties with requesting T3/T4 assays from the lab.</p> <p>Action: Nigel Fagan to report back on T3/T4 monitoring process to Aarti.</p> <p>Key updates to the guidance were presented and the document was supported, pending finalisation of magnesium and T3/T4 monitoring requirements.</p>
5.7	<p>Estring vaginal ring for atrophic vaginitis in postmenopausal women</p> <p>Review of traffic light designation following addition to the Formulary as SpA, third line in April 2025.</p> <p>Formulary Status</p> <ul style="list-style-type: none"> • Approved as Amber (SpA) third line in April • Initiated by specialist/first insertion by GP; continued in primary care. Including primary care clinicians who have relevant experience and are clinically competent to prescribe <p>However:</p> <ul style="list-style-type: none"> • Green on formularies in other parts of the country

No	Agenda Item
	<ul style="list-style-type: none"> • GPs may be anxious to prescribe a treatment that is safe and effectively manages the symptoms of genitourinary syndrome of menopause, which has a huge impact on quality of life. • Could potentially reduce the amount of antibiotics prescribed for UTIs • Disproportionately disadvantage disabled patients who cannot administer the pessaries • Travel to hospital to a gynae appointment may be difficult. • More frequent administration of a pessary by a community nurse or carer would be unnecessarily inconvenient, undignified and costly when there is this other safe option. <p>Small patient numbers expected, approx. 60 per year.</p> <p>The change to Green, third line was approved.</p>
5.8	<p>Aflibercept biosimilars</p> <p>The originator brand of aflibercept 2mg intravitreal injection, Eylea, loses its patent exclusivity in November 2025. A national procurement process has taken place for the available / soon to be available biosimilars and awarded on a regional basis for use within the NHS. The framework will commence on 1st December 2025. Note: this does not apply to the aflibercept (Eylea)8mg product, which maintains its product exclusivity.</p> <p>At launch, aflibercept biosimilars available on the NHS framework are anticipated to be approved for all reference product (Eylea) indications except retinopathy of prematurity. Retinopathy of prematurity is not a locally approved use for aflibercept.</p> <p>Aflibercept biosimilars: Yesafili® (BHFT) and Afqlir® (MKUH) - Add to respective Formularies with RED traffic light for:</p> <p>Visual impairment (in accordance with NICE criteria) caused by the following conditions:</p> <ul style="list-style-type: none"> • Wet age-related macular degeneration • Retinal vein occlusion (branch & central) • Diabetic macular oedema • Myopic choroidal neovascularisation • <p>Aflibercept biosimilars will produce significant cost savings over the originator brand, Eylea. Prices are commercial in confidence, however the biosimilars represent approximately 75-80% price reduction per dose vs the baseline price for Eylea.</p> <p>The biosimilars were approved. To add respective brands to formularies as RED, and Eylea will change to for “existing patients only”.</p>
6	<p>Minor Amendments Log</p> <p>Noted</p>
AOB	<p>Denosumab Biosimilar (Prolia)</p> <ul style="list-style-type: none"> • Update: Following the patent expiry of Prolia (Denosumab), biosimilars are expected to launch in the UK. Hospitals (MKUH and BHFT) are in different contracting regions and will be allocated different products, and the associated contract prices may not be available in the community. The situation is unique as this is the first biosimilar that is prescribable in Primary Care, therefore careful consideration is needed to ensure value for money across both Primary and Secondary Care and clarity of process systemwide.

No	Agenda Item
	<ul style="list-style-type: none"> • Next Steps: The framework is planned to go live from January 2026. The ICB will add the biosimilar brands as they are assessed and bring updates retrospectively to the Formulary Subgroup, likely at the February 2026 meeting. <p>Sildenafil Oral Spray (Hezkue®) for Erectile Dysfunction</p> <ul style="list-style-type: none"> • Update: A snapshot review was presented for an upcoming product. The oral spray (£2.78/50mg dose) is significantly more expensive than the tablet (£0.14 pence/50mg dose). • Rationale: Evidence suggesting the spray is more effective than tablets is lacking, and its advantages (faster onset, discreetness) are considered cosmetic, not clinical. • Proposal: Place the product in Do Not Prescribe (DNP). • Decision: The product was approved to be placed into the Do Not Prescribe (DNP) category.
	<p>Meeting dates for 2025 are available on BLMK ICB Website – Formulary Page</p> <p>https://medicines.bedfordshirelutonandmiltonkeynes.icb.nhs.uk/</p>