FORMULARY AND MANAGED ENTRY SUBGROUP

Minutes of the meeting held on
24th July 2018
12:30 - 2:30 pm
Pharmacy Dept. CMFT

Present:

Name	Title	Organisation	Jan	Mar	May	July	Sept	Nov
Elizabeth Arkell (EA)	Medicines Management Lead	UHSM	✓	LA	A	✓		
Liz Bailey (LB)	Medicines Optimisation Lead	Stockport CCG	✓	✓	✓	A		
Dr Pete Budden (PB)	GP Prescribing Lead	Salford CCG *(Chair)*	A	✓	✓	✓		
Sarah Boulger (SB)	Senior Medicines Information Pharmacist	The Pennine Acute Hospitals NHS Trust	✓	✓	A	A		
Dr Paul Chadwick (PC)	Consultant Microbiologist and Chair of Meds Management Committee	SRFT	✓	A				
Lorna Hand	Medicines Management and Medicines Information Pharmacist	CMFT	✓	✓	✓	✓		
Claire Foster (CF)	Senior Medicines Optimisation Advisor	SM CCG	✓	✓	✓	✓		
Leigh Lord (LL)	Locality Lead Pharmacist	Trafford CCG	✓	A	A	A		
Rachel Macdonald (RM)	Pharmacist	Community Pharmacy	A	A	A	✓		
Keith Pearson (KP)	Head of Medicines Management	Heywood Middleton and Rochdale CCG	✓	✓	A	✓		
Prof Peter Selby (PS)	Consultant Physician	CMFT	✓	A	✓	A		
Suzanne Schneider	MI Pharmacist	Bolton FT.	A	✓	✓	A		

(SS)								
Dr Hina Siddiqi (HS)	GP	Trafford CCG			✓	A		
Lindsay Harper (LH)	Director of Pharmacy	SRFT	✓	A	A	✓		
Jonathan Peacock (JP)	Deputy Chief Pharmacist	WWL	✓	✓	✓	A		
Zoe Trumper (ZT)	Medicines Management	Pharmacist Wigan Borough CCG	✓	✓	✓	✓		
Andrew Martin (AM)	Strategic Medicines Optimisation Pharmacist	GM Shared Service.	✓	✓	✓	✓		
Monica Mason (MM)	Principal Pharmacist Medicines Management	RDTC *(Professional Secretary)*	✓	✓	✓	✓		
Carol Dolderson (CD)	Lead Pharmacist Medicines Management	RDTC				✓		

1. General Business

1.0 Apologies

Apologies had been received in advance as noted above.

In attendance: Faduma Abukar (FA) (Senior MO Pharmacist, Manchester CCG), Dr Naveed Younis (Consultant Physician/ Endocrinologist MFT) and Jonathan Schofield (Consultant Physician MFT) were present for item 2.1.

1.2 Declarations of Interest:

No declarations of interest were received in advance or made at the meeting. Both endocrinologists expressed an interest in items 2.1, particularly with regards Toujeo®, however as the group had invited them to attend to provide a view on these items that was deemed acceptable, neither clinician was present or involved in any decision-making with regards these items.

1.3 Draft minutes (May and June 2018)

The minutes were agreed as an accurate record, following some minor amendments.

1.4 Matters Arising

1) Consultation feedback:

- Noqdirna® for idiopathic nocturnal polyuria in adults. The group considered consultation feedback for desmopressin 25 mcg oral lyophilisate (Noqdirna®) for symptomatic treatment of nocturia due to idiopathic nocturnal polyuria in adults. Noqdirna® is the only licensed treatment for this indication, and current treatment strategies include lifestyle modifications and trial of medicines such as antimuscarinics, furosemide given in the early afternoon and other formulations/strengths of desmopressin (e.g. 100 microgram tablets); all of which are off-label The group referred to a recent Drug and Therapeutics Bulletin that highlighted a 0.2 to 0.4 reduction in night time voids with Noqdirna®, and that the clinical significance of this outcome was negligible. A routine use for Noqdirna® across GM was not demonstrated from the consultation. The group agreed that

feedback should be sought from the applicant regarding the definition of the improvement expected with Noqdirna® and target population/prescribing figures for GM.

- Naltrexone RAG status review. The group considered consultation feedback on the proposed switch of RAG status for opioid (red) and alcohol dependent patients (amber) to RED for both indications. A paper will be raised with CSB and then AGG/Strat board to challenge the practice of commissioning without considering prescribing provision. It was agreed that the RAG status for both opioid dependence and alcohol disorders should remain unchanged pending these meetings.
- Ciprofloxacin ear drops (Cextraxal®) for otitis externa. The GP members of the group expressed that otitis externa is a common condition that is well managed by GPs, including the need for skin swabs when appropriate. The group agreed that ciprofloxacin ear drops have a place in therapy for acute otitis externa on the basis of microbiological sensitivities, as an alternative for the current off-license use of ciprofloxacin eye drops for this indication. Action: MM will add to formulary with a grey status (green RAG status) for use in cases of proven pseudomonas otitis externa only.

2) Ophthalmology letter for FMESG. The group were asked to agree the proposed changes to the formulary and first draft of the letter for communication across GM ophthalmologists and opticians. The group agreed to the content of the letter following some minor amendments, but asked that the letter highlight the DNP list in addition to formulary compliance, specifically to emphasise unnecessary prescription of preservative-free preparations. Additionally, it was agreed that the GM Primary Eyecare Minor Eye Conditions Service (MECS) should be contacted in regards to reviewing and aligning their formulary to reflect the recent GMMMG update to chapter 11 of the joint formulary. Action: RDTC to contact MECS, then amend letter and distribute as agreed.

2.0 Medicines Optimisation- GM Diabetes Strategy: GMMMG recommendations

2.1 Diabetes Strategy Final Draft

Since FMESG last met the GM Diabetes Strategy has been published- it now states that "The Greater Manchester Medicines Management Group (GMMMG) will be responsible for developing local guidelines for the intensification of medication for the control of diabetes. They will also monitor and report against these guidelines with the aim of reducing unwarranted variation." The group were asked to consider the published GM diabetes strategy.

The group considered that clarification of the terms 'care-planning' and 'FLASH' within the document would be helpful. Additionally, there is ambiguity surrounding the recommended frequency of HbA1c checks (section 5.5) where the first paragraph recommends glycaemic control is checked a minimum of twice a year, however the following paragraph states adults should expect HbA1c testing a minimum of four times per year. The group acknowledged there is a lack of consideration of the roles pharmacists play in optimising the care of patients with diabetes. Some concerns were also raised about the positioning of e-cigarettes in the strategy. However the FMESG welcomed the recognition of GMMMG within this publication and noted the opportunities to work collaboratively to further shape this strategy.

Toujeo® drug addition request (specialist present)

Dr Naveed Younis consultant physician and endocrinologist MFT presented a drug addiction request for Toujeo® 300units/mL insulin glargine solution for injection pre-filled pen which is currently not on formulary/RAG list. Dr Jonathan Schofield also attended to support the application.

NTS had previously recommended (September 2015) that Toujeo® could be considered *as an option in patients who experience painful injections with high volumes of 100units/ml insulin and providing there are adequate measures in place for safe prescribing of higher strength insulin across the health economy.*

The proposed place on formulary would be as an additional choice to existing basal analogue insulins for type 1 and type 2 diabetic patients who are uncontrolled on existing basal analogue insulins, experience problematic hypoglycaemia with established insulins, and/or would otherwise require twice daily dosing of a basal analogue insulin. In a retrospective cohort study, hypoglycaemic events (particularly nocturnal hypoglycaemic events) were considerably lower in insulin-naïve patients starting Toujeo® compared with insulin glargine. Dr Younis explained that Toujeo® can be administered within a 6 hours treatment window which may assist treatment flexibility and patient concordance.

The group noted that prescribing data shows significantly higher than expected prescribing of Toujeo® in primary care. The potential safety concerns related to lack of awareness of the higher strength of the product compared with standard strength glargine, and associated risks if not prescribed by brand were highlighted and discussed. Additionally, the strength of evidence around the reduction in hypoglycaemic episodes with Toujeo® compared with NICE recommendations defining meaningful reductions was questioned. In terms of cost-efficacy, the group agreed that the upcoming release of further biosimilar insulin glargine preparations should be borne in mind as the cost-efficacy of Toujeo® is likely to be less favourable as a result.

In the absence of a defined population for use, the group agreed that there is insufficient evidence to support routine use of Toujeo® over other analogue insulins, and do not recommend formulary inclusion pending further information from the applicant defining target population.

2.2 GLP-1s and CV outcomes review

The evidence base for GLP-1s in prevention of vascular events is developing rapidly and there is not yet any specific clinical guidance on their use in people with established cardiovascular disease or with additional risk factors. The group considered a RDTC review of CV outcomes with GLP-1s. The review highlights that all currently marketed GLP-1s are non-inferior to placebo for the composite outcome of MI, stroke or sudden death in patients with CVD, or with risk factors for CVD. Although there are no published studies of the comparative efficacy of GLP-1s in reducing cardiovascular outcomes, group recommend that liraglutide should replace lixisenatide as the GMMMG first choice GLP-1 agent. This was based on evidence from good quality randomised control trials that liraglutide presents the more cost-effective option for reducing cardiovascular outcomes. It was recognised that this decision will pose a commissioning/financial impact for GM and this will need to highlight via the GM consultation. Based on Drug Tariff April 2018 prices, the cost of one year's treatment of lixisenatide (20mcg OD) is £702.80, for liraglutide (1.2mg OD) is £951.27 (approximately 26% higher cost).

Action: MM to submit this decision to CSB for pre-approval pending GM wide consultation

2.3 SGLT2s and CV outcomes review

The evidence base for SGLT2s in prevention of vascular events is developing rapidly and there is not yet any specific clinical guidance on their use in people with established cardiovascular disease or with additional risk factors. The group considered a RDTC review of CV outcomes with SGLT2s. The review highlights evidence from good quality randomised controlled trials that- compared to placebo- canagliflozin and empagliflozin reduce the risk of the composite outcome of non-fatal stroke, non-fatal MI and cardiovascular death. However, evidence that these drugs are superior to other antidiabetic agents is restricted to observational data and indirect comparisons, and there is no robust evidence supporting the use of any one SGLT2 over the others in people with established cardiovascular disease or with additional risk factors. On the basis of this evidence, the group recommended that no change is required to formulary at present.

2.4 Ertugliflozin review

The group considered a RDTC new drug evaluation of ertugliflozin and noted that two NICE TAs are due in June 2019: Ertugliflozin as monotherapy and in dual therapy for treating type 2 diabetes (TA10283), and Ertugliflozin in a triple therapy regimen for treating type 2 diabetes

(TA10358). The cost of Ertugliflozin is not yet known. The group agreed that pending TA publication there was no reason to assess ertugliflozin for formulary inclusion as it was assumed that in absence of a cost, it would be a less cost effective option than established treatment.

2.5 Semaglutide review

The group considered a RDTC new drug evaluation of semaglutide. The cost of semaglutide and its launch date is not yet known. The group agreed that there was no reason to assess semaglutide for formulary inclusion as it was assumed that in absence of a cost, it would be a less cost effective option than established treatment.

2.6 Diabetes dashboards (x2) and 2.9 Current GMMMG Chapter 6

The FMESG were asked to consider the information presented and the current GMMMG diabetes chapter, and to propose improvements in prescribing that could be undertaken. The group reviewed the dashboard reports showing the number of diabetes mellitus elective and non-elective admissions per CCG over the last 12 months weighted against the prescribing costs per patient on the QOF Diabetes register. The group considered the position of the Greater Manchester area against the rest of the North of England, and also looked at GM CCGs against their "ten most similar" CCGs nationally, as presented within the RDTC® reports.

The group acknowledged that there continues to be a variation in spend across the GM CCGs for drugs in diabetes ranging from 90 (actual cost per patient with diabetes) in Manchester, to 65 in Bury and Salford CCGs. Bury CCG frequently demonstrates a lower spend and better QOF and hospital admission outcome than the England average, and are joined on more than one occasion by Salford, HMR and Bolton CCGs. These results are generally reflected when the aforementioned CCGs are compared to their national top10 most similar CCGs. The group concluded that this data demonstrates significant variance in prescribing practice across GM, and that high spend is not associated with better clinical outcomes as per the QOF Diabetes register. The group noted that a relevant project had been carried out by Bury which aimed to reduce variation in prescribing and had resulted in improved clinical outcomes. The potential for a similar GM-wide project was discussed.

At present, there is no GMMMG diabetes pathway, although there are a number of pieces of relevant guidance from NICE (mainly published in 2015). Following discussion with the diabetologists present, it was agreed that there would be appetite for development of a GM diabetes pathway for the prescribing of insulin, to reduce variation in prescribing and help align prescribing practices between primary and secondary care across GM.

Action: MM to submit paper to CSB proposing outcome targets to tackle the variation in prescribing between CCGs.

2.7 RMOC guidance on insulin safety

The group reviewed the recently published Regional Medicines Optimisation Committee (RMOC) guidance to formulary committees/ Area Prescribing Committees on safety factors to consider when adding a new insulin preparation to a local formulary.

The group agreed that no action was required to the formulary but noted relevance of the tool for upcoming biosimilar insulins to be launched, and the need for adherence to brand prescribing recommendations.

2.8 Horizon scanning diabetes report

The group reviewed anticipated new insulins and other diabetic drugs with expected launch dates within the next 2 years. The group agreed that a review should be undertaken of Suliqua®, a GLP-1 + long-acting insulin analogue for type 2 diabetes, which is due to launch this year.

Action: MM to request production of new drug evaluation for Suliqua® from the RDTC.

3.0 Formulary and RAG

3.1 Formulary amendments July 2018

The following formulary amendments for July 2018 were recommended:

- Tadalafil to replace avanafil as the alternative choice of PDE5 inhibitor for treatment of erectile dysfunction, following recent move to category M (Green RAG status).
- Ulipristal (Esmya®) to be reinstated to formulary following for uterine fibroids following the outcome of a CHMP/ MHRA safety review, with links to CHMP/MHRA advice and information on new restrictions and monitoring.
- Insulin lispro biosimilar- first biosimilar of insulin lispro to launch, with a list price approximately 15% lower than Humalog® (Eli Lilly). To replace Humalog® on formulary as a first choice option in patients requiring a rapid-acting insulin analogue.

The formulary will be updated to reflect recent guidance from NICE and the MHRA. These decisions including their cost impact/commissioning implication where appropriate will be opened for GM wide consultation.

The group considered whether the RAG status of raloxifene for chemoprevention of breast cancer should be reviewed. The group recommended that the RAG status should remain unchanged (Green following specialist initiation) in light of its inclusion in NICE guidance, along with tamoxifen.

The group also considered review of the RAG status of donepezil, galantamine, rivastigmine and memantine following newly published NICE guidance- Dementia: assessment, management and support for people living with dementia and their carers (NG97)- which recommends that treatment with one of these agents may be started on the advice of a clinician who has the necessary knowledge and skills, including GPs if they have a specialist expertise in diagnosing and treating Alzheimer's disease. The group recommended that the RAG status of these medicines should be changed to Green (from Green following specialist initiation).

Action: MM to submit this decision for pre-approval pending GM wide consultation.

The group noted recent MHRA Drug Safety Advice regarding denosumab (Xgeva▼) however it was highlighted that the formulary does not differentiate between brands of denosumab, the licensed indications and RAG status of which differ.

Action: MM to update chapter 6 of formulary to specify different brands of denosumab, align these with RAG status, and to include hyperlink to MHRA Drug Safety Advice.

3.2 Antibiotic formulary chapter update

The FMESG were asked to approve the revised GM antimicrobial guidelines following their quarterly review by the working group, composed of a range of appropriate experts in the field to ensure that they comply with current guidance and are in line with local resistance patterns. There was query as to whether this revised chapter had been opened for GM wide consultation, and that a review by the GM Antimicrobial Stewardship Group should be undertaken prior to approval. It was agreed that the working group be contacted regarding the consultation process undertaken, but otherwise FMESG accepted the revised draft be approved for use and website addition.

Action: MM/AM to contact SW to query consultation process, thereafter chapter to be added to the website when appropriate.

3.3 Triptorelin (Salvacyl®): RAG status review

The group considered a proposal to change the RAG status and application of shared care for triptorelin embonate (Savacyl®) to decrease sexual drive in men with severe sexual deviations. Under the proposed share care agreement, men treated with Salvacyl® would remain under the care of a consultant working in the Sex Offender Treatment Programme (SOTP) who would

oversee treatment. The SOTP service covers the whole of Greater Manchester and at present patients must attend Prestwich for their 3 monthly injections and routine physical health tests. The number of patients being treated for this indication across GM is very small (approx. 5 patients in total). Under the proposed shared care agreement, patients would attend their GP for administration of injection and physical health monitoring.

The group noted the small number of patients and agreed that the indication in question was specialist and forensic in nature, the management of which would fall beyond the scope of primary care. The group recommended that the RAG status should remain unchanged (red).

Action: MM to submit this decision for pre-approval pending GM wide consultation

3.4 Cinacalcet: RAG status review

Cinacalcet for primary hyperparathyroidism- proposed switch from Amber (CCG commissioned) to Red (NHSE commissioned). NHSE commissioning policy document issued for this indication in 2016, however there is currently no mechanism for repatriating existing patients back to NHSE/ secondary care. GMMMG total spend 2017/18 on cinacalcet (all indications) was £400K. The group agreed to defer this item pending further communication from the applicant.

3.5 Formulary inclusion tool: Paravit®

The group considered an application for Paravit-CF® a multivitamin designed for patients with cystic fibrosis (CF) which contains fat soluble vitamins A, D, E, and K. Paravit-CF® is classified as a Food for Special Medical Purposes (rather than a medicinal product) and is available as in a liquid formulation and as capsules. At present, there are a number of fat soluble vitamin containing preparation on the GMMMG formulary, none of which are included for the indication of CF and patients may be supplemented with a number of different individual vitamins/ multivitamin preparations. Compared to existing options, Paravit-CF® reduces the medication burden for patients, offers vitamin supplementation at doses in line with the recommendations made by the CF Trust, and is a cheaper alternative to supplementation of individual vitamins.

The group recommended the inclusion of Paravit-CF® on the Grey List as the first line multivitamin preparation in patients with CF, with a RAG status of green (following CF specialist recommendation).

Action: MM to submit this decision for pre-approval pending GM wide consultation.

3.6 DNP assessment: TheraBite®

TheraBite® was approved for DNP inclusion on the basis of poor evidence base for the management of trismus. TheraBite® is a hand-operated device that is put inside the mouth and its use leads to stretching of the jaw muscles. In a feasibility study with low patient numbers, although use of TheraBite® and wooden spatula did increase mean mouth opening after 6 months, the results were not statistically significant (p=0.39). A health economic analysis demonstrated that TheraBite® is an expensive option with no advantage over wooden spatula.

Action: MM to submit this decision for pre-approval pending GM wide consultation.

3.7 DNP tool: Bath additives

The BATHE RCT published recently by the BMJ found no benefit in using emollient bath additive in the standard management of eczema in children. There are currently a large number of products marketed, of which five are included in the GMMMG formulary. For April 2017 to March 2018, prescribing data for GM CCGs shows that around £630k was spent on bath additives, with a further £250k on shower emollients. The group considered that there were some limitations to the trial: the control group was not blinded and did not receive a placebo, not all patients in the intervention group received the same bath additive, and products containing

antimicrobials were excluded (despite being frequently prescribed in practice). Additionally the relevance to children with infected eczema and to adults has not been studied.

Based on the results of the BATHE RCT, FMESG recommend that bath additives without antimicrobials should be DNP for children, no comments for adults, and those with antimicrobials should be grey for both populations, the criterion being infected eczema.

Action: MM to submit this decision for pre-approval pending GM wide consultation.

4 Horizon scanning and work plan

Monthly horizon scanning documents and work plan

The RDTC monthly horizon scanning documents from June and July were provided to the group, as well as the respiratory horizon scanning report. The group recommended no additional action was required at present on the basis of these documents.

The group noted the need for an implementation consultation paper on the NHSE OTC guide for the next standards, that a paper proposing outcome targets to tackle the variation in diabetes prescribing across GM CCGs to be submitted to CSB and that FMESG would undertake a review of doxylamine and pyridoxine as an option for morning sickness in pregnancy.

The work plan would be updated to consider these items as appropriate.

Action: MM to update the work plan

5 Additional items

There was a very brief discussion around the CURE project, but it was agreed that there was nothing for FMESG to consider at this stage.

The next ordinary meeting will be held on 28th August 2018 12.30-2.30pm, CMFT.