FORMULARY AND MANAGED ENTRY SUBGROUP

Minutes of the meeting held on
Tuesday 27th November 2018
12:30 - 2:30 pm

Pharmacy Dept MFT-ORC (formerly known as CMFT)

Present:

Name	Title	Organisation	Jan	Mar	May	July	Aug	Sept	Oct	Nov
Elizabeth Arkell (EA)	Medicines Management Lead	MFT-WH	✓	LA	A	✓	A	✓	✓	✓
Liz Bailey (LB)	Medicines Optimisation Lead	Stockport CCG	✓	✓	✓	A	✓ (RR)	✓	✓	✓
Dr Pete Budden (PB)	GP Prescribing Lead	Salford CCG *(Chair)*	A	✓	✓	✓	✓	✓	A	✓
Sarah Boulger (SB)	Senior Medicines Information Pharmacist	The Pennine Acute Hospitals NHS Trust	✓	✓	A	A	✓	A	✓	A
Dr Paul Chadwick (PC)	Consultant Microbiologist and Chair of Meds Management Committee	SRFT	✓	A						
Aoidin Cooke (AC)	Medicines Management and Medicines Information Pharmacist	MFT-ORC								✓
Lorna Hand	Medicines Management and Medicines Information Pharmacist	MFT-ORC	✓	✓	✓	✓	✓	✓	✓	
Claire Foster (CF)	Senior Medicines Optimisation Advisor	MHCC	✓	✓	✓	✓	✓ (FA)	✓	✓	✓ (LS)
Leigh Lord (LL)	Locality Lead Pharmacist	Trafford CCG	✓	A	A	A	✓ (AH)	✓	✓	✓

Name	Title	Organisation	Jan	Mar	May	July	Aug	Sept	Oct	Nov
Rachel Macdonald (RM)	Pharmacist	Community pharmacy	A	A	A	✓	✓ (AI)	✓	✓ (AI)	A
Keith Pearson (KP)	Head of Medicines Management	Heywood Middleton and Rochdale CCG	✓	✓	A	✓	✓	✓	✓	A
Prof Peter Selby (PS)	Consultant Physician	MFT-ORC	✓	A	✓	A	A	A	A	A
Suzanne Schneider (SS)	MI Pharmacist	Bolton FT.	A	✓	✓	A	A	✓	A	✓
Dr Hina Siddiqi (HS)	GP	Trafford CCG			✓	A	A	✓	✓	✓
Lindsay Harper (LH)	Director of Pharmacy	SRFT	✓	A	A	✓	A	A	✓	✓
Jonathan Peacock (JP)	Deputy Chief Pharmacist	WWL	✓	✓	✓	A	✓	✓	✓	✓
Zoe Trumper (ZT)	Medicines Management	Pharmacist Wigan Borough CCG	✓	✓	✓	✓	A	✓	✓	✓
Jonathan Schofield (JS)	Consultant Physician	MFT-ORC							✓	✓
Faisal Bokhari (FB)	Deputy Head Medicines Optimisation	T&G CCG							✓	✓
Andrew Martin (AM)	Strategic Medicines Optimisation Pharmacist	GM Shared Service.	✓	✓	✓	✓	✓	✓	✓	✓
Monica Mason (MM)	Principal Pharmacist Medicines Management	RDTC *(Professional Secretary)*	✓	✓	✓	✓	✓	✓	✓	A
Carol Dolderson (CD)	Lead Pharmacist Medicines Management	RDTC				✓	✓	A	✓	✓

1. General Business

1.0 Apologies

Apologies had been received in advance as noted above.

Lara Shah, Medicines Optimisation Pharmacist (Manchester CCG) was in attendance, deputising for Claire Foster.

Petra Brown (PBr), Greater Manchester Mental Health Strategic Lead Pharmacist (GMMH) was in attendance until item 3.5.

Nancy Kane, Senior Medical Information Scientist (RDTC) was also in attendance.

LH chaired the meeting until item 1.3; PB chaired thereafter.

1.2 Declarations of Interest:

No declarations of interest were received in advance or made at the meeting.

1.3 Draft minutes (October 2018)

The minutes were agreed as an accurate record, following a minor grammatical amendment.

PBr raised that the decision taken at the previous meeting to classify haloperidol and chlorpromazine as AMBER was causing difficulties for mental health providers and patients. This was due to patients being referred back to secondary care, which lack capacity. It was proposed that the AMBER listing would be removed, pending a review of these drugs.

Action: RDTC to remove RAG status of haloperidol and chlorpromazine, and liaise with PBr regarding appropriate placing of these drugs.

1.4 Matters Arising

1) Consultation feedback:

All items from the October meeting were out for consultation at time of meeting; closing 21st December. Consultation comments received on actions from the September meeting were discussed.

Xonvea for nausea and vomiting in pregnancy: consultation feedback from the drug manufacturer was noted. RDTC had also sought additional input from specialists, who did not have any significant appetite to prescribe this drug. The group agreed that licensing was a key issue, and there was a discussion around the most appropriate placing. There were concerns around the lack of direct comparative evidence with other currently used options such as cyclizine. It was noted that, if this drug is used, GPs are the most likely prescribers and recognition that every GP and patient population will have different needs. It was highlighted that there has been limited input from primary care prescribers on this decision. It was agreed that GP opinions would be sought via CCG APCs to establish potential positioning of Xonvea, and on whether there is any reluctance around prescribing of current unlicensed options. It was also suggested that the Royal College of Obstetricians and Gynaecologists (RCOG) could be contacted to request input.

Action: CCG leads to seek opinions from GPs, via APCs. RDTC to contact the RCOG.

2) *Action* log: Updates to the action log were noted. It was highlighted that the place in therapy for desmopressin (Noqdirna) is not yet established. Members of the OAB pathway working group had been contacted, but were unable to clarify further the appetite to prescribe.

Action: RDTC to bring summary to future meeting to facilitate a final decision

3) *RMOC guidance – prescribing of liothyronine*: The guidance was considered , and the group agreed that it was in line with current GMMMG positioning. The group noted the RMOC recommendation to consider shared care arrangements for liothyronine; it was acknowledged that monitoring requirements are the same as for levothyroxine, thus it was agreed that no action is required.

2. Medicines Optimisation

2.1 FreeStyle Libre audit

The group considered an audit template submitted by AM to facilitate audit of FreeStyle Libre use by CCGs., in line with FMESG work plan to ensure prescribing is in line with the initial GMMMG recommendations.. The group heard that audits are underway at Salford and MFT, and that there have been reports from primary care that patients are not always being reviewed in a timely manner. It was noted that the ABCD audit is underway, but there were concerns that data will not be available for some time.

Action: AM to approach CCGs and offer the audit template for local use.

3.0 Formulary and RAG

3.1 Formulary amendments November 2018

It was noted that a new insulin glargine biosimilar (Semglee®▼, Mylan) has been launched in the UK. It was noted that, in 2015, the then New Therapies Subgroup published the following statement:

"The group recommends the use of insulin glargine biosimilars, as a first line option in all new patients requiring insulin glargine in line with NICE guidelines on the use of long acting insulin analogues for T1DM and T2DM."

It was therefore agreed that all insulin glargine biosimilars will be named on formulary as first line options. A cost chart will be included to aid prescribers in choosing the most cost-effective option at the time of initiation. There was discussion around whether the formulary choice of insulins needs to be reviewed, but it was agreed that this could be achieved by participating in the consultation on insulin choice which is currently being conducted by the Pathways and Guidelines Development Subgroup (PaGDSG).

It was highlighted that adalimumab biosimilars have now been launched, and that to maintain consistency the formulary should be updated to specify the brand. Formulary currently lists generic name only. The group concluded that the Amgevita®▼ (Amgen) should be named on formulary as the Best Value adalimumab product.

Action: all brands of insulin glargine to remain on formulary, and a cost chart to be added to aid decision-making. Generic adalimumab to be replaced by Amgevita on formulary. RDTC to open these decisions for GM-wide consultation and seek CSB pre-approval.

The remaining suggested formulary amendments for November 2018 were noted and approved by the group.

Action: RDTC to open these decisions for GM-wide consultation and seek CSB pre-approval.

3.2 Cannabis-based products for medicinal use

The group heard that, following communications from the Department of Health, there have been numerous enquiries received by clinicians regarding the prescribing of cannabis-related medicinal products. It was acknowledged that this is a large topic, with potential confusion regarding legal categories, availability of licensed products, and indications.

It was felt that these products should have a RED RAG status, and be restricted to use in specific indications. The group heard that specialists in some areas are choosing not to prescribe at present, and are waiting for guidance from the royal colleges.

Action: Draft statement on positioning to be circulated to the group then opened for GM-wide consultation.

3.5 Cariprazine

PBr requested that this item be discussed early, since she was unable to stay until the end. PBr requested on behalf of GM Mental Health that the group reconsider the positioning of cariprazine, which had been added to the DNP list in May. The group heard that clinicians felt it had some benefits in terms of negative symptoms, and may improve social functioning.

It was agreed that PBr should submit a statement regarding criteria for use and the intended population to the group, with a view to changing cariprazine's RAG status to RED.

Action: PBr to submit a statement for consideration at a future meeting.

3.3 Respiratory chapter update

The group reviewed a copy of chapter 3 (respiratory), which had been updated to bring it in line with the asthma and COPD pathways recently produced by PaGDSG. It was proposed that all drugs not included in those pathways should be removed from formulary. The group expressed concerns regarding whether there was a sufficient variety of drugs and devices represented, and queried whether the proposed changes were too exclusive. The group decided that all drugs recommended in the asthma and COPD pathways should be listed as first choice, with all others currently on formulary rationalised as appropriate and listed as alternatives. The group agreed that terbutaline injection should have a RED RAG status, in line with the existing positioning for salbutamol injection.

Action: RDTC to re-draft chapter 3 and return this item to a future meeting, with appropriate cost-comparison charts to aid decision-making. RDTC to open terbutaline RAG change for GM-wide consultation and seek CSB pre-approval.

3.4 Skin chapter update

The group reviewed a copy of chapter 13 (skin). This chapter was updated and put out for consultation at the end of 2017, but the approved changes were put on hold pending the production of a suite of dermatology pathways and ladders. These documents have recently completed a six week GM-wide consultation and are now nearing completion. The group agreed that the chapter should now be updated accordingly, and all changes which have been previously opened for consultation will be actioned. The following additional points were raised:

Imiquimod: the group heard that the proposed actinic keratosis pathway does not include imiquimod, and recommended that this drug should be removed from formulary and RAG list for this indication only. This will not affect the positioning of imiquimod for treatment of genital warts.

An application had been received to assign a RED RAG status to imiquimod 5% cream (Aldara®, Meda Pharmaceuticals) for the treatment of superficial basal cell carcinoma. The group discussed the issue and concluded that Aldara was suitable for a GREEN (specialist initiation) status. This placing was felt to be appropriate since imiquimod is used in primary care for other indications, and the increased course length was not sufficient to require a RED status. There was also concern that restricting use to hospitals would present a logistical burden for patients in terms of obtaining supplies.

Enstilar foam: the group acknowledged that Enstilar foam is included on the draft psoriasis pathway, but had concerns that this was outside NICE guidance. It was recommended that this product should be added to formulary for use in line with NICE guidance; that is, first choice for use on the scalp and second line in other areas.

Points raised during previous consultation: A request was received to replace Uvistat SPF 50 with Anthelios XL SPF, which has better patient tolerability. The group agreed this change was appropriate and clarified wording around the use of skin camouflage preparations for burns. A further request was received to consider inclusion of silicon sheets/gels for burn scars. The group felt that this was a highly specialist area, and not suitable to inclusion on formulary.

Action: RDTC to open for GM-wide consultation those decisions above which have not had prior consultation, and seek CSB pre-approval for all actions.

3.6 Grey list criteria/GREEN drugs not on formulary

The group heard that there is still some confusion from prescribers as to whether prescription toothpastes can be prescribed by GPs after initiation by a dentist of other specialist. It was proposed that the RAG listing for these products be changed to remove the "specialist initiation" wording, placing them as GREEN for prescribing by dentists only.

Action: RDTC to update RAG list and formulary accordingly.

It was proposed that a fourth criterion for inclusion on the DNP/grey lists should be added: "Criterion 4 (Grey list only): Recommended for use only in a niche indication (as per stated criteria)." The group agreed that this was not necessary, since this information is already conveyed by inclusion on the grey list.

Due to time constraints, the remainder of this item was not fully discussed**.** The chair invited members to make further comment by email.

Action: members to feedback to RDTC via email.

4.0 Horizon Scanning and work plan

4.1 Items for FMESG consideration in 2019

4.2 Monthly horizon scanning document November 2019

4.3 Work plan

Due to time constraints, these items were not discussed. The chair requested that the group review these papers and return comments to the RDTC to allow prioritisation of items for the 2019 workplan.

Action: members to feedback to RDTC via email.

5.0 AOB

No other items were raised.

The next meeting will be held on 22nd January 2019, 12.30-2.30pm, MFT-ORC (formerly known as CMFT).