Minutes of the GM Formulary Subgroup meeting

Date: 3rd November 2016, 12-2pm
Venue: Maternity seminar room, Wythenshawe Hospital
Present: Liz Bailey, Monica Mason, Dev Devapriya, Sarah Jacobs, Helen Burgess, Connie Chen. Jonathan Peacock, Claire Vaughan, Peter Howarth
Apologies: Leigh Lord, Ann Harrison, Danielle Timoney

Declarations of interest:
Nothing declared

Item 3 – Previous minutes
There was no physical FSG meeting or GMMMG meeting in October. The group had submitted comments by email to approve the September formulary amendments which were approved at the October GMMMG meeting as follows:
- the formulary will reflect TA401, TA402, TA403, TA404, TA405, TA406, TA407, TA408, TA409, TA410, TA411, TA412, CG42, CG141, CG126 and CG44 (including update in line with the recent NTS ulipristal for uterine fibroids recommendation.
-the formulary will also reflect the Sept MHRA DSU with the addition of warnings for levonorgesterol-containing emergency contraceptive efficacy with hepatic enzyme inducers, posoconazole tablets vs oral suspension and idelalisib.
- a link to the NTS ticagrelor recommendation, in addition to the NTS ulipristal recommendation, would be added to the formulary; both agents are already listed in formulary.
- the formulary would be updated to reflect RAG recommendations approved by GMMMG in September

Item 4 –Action log
The group considered outstanding actions and agreed the following:

- Anal irrigation systems pathway: a meeting has been arranged with a number of specialists which SJ will attend, this work will be transferred to the new pathways group in January
- Ezetimibe DNP assessment, for uses outside of NICE guidance - deferred to Jan FMESG meeting
- Macular pathway: comments are currently being considered following the GM wide consultation, this work will be transferred to the new pathways group in January
- GM antibiotic guideline: SJ attending AB working group supported by PHE in the coming week and will feedback to CV to agree a way forward. This work should be highlighted to GMMMG.
- Blephasol lotions and wipes for grey list assessment: Awaiting feedback from specialists, FMESG will pick this up in Jan if feedback received.
- IBD pathway: SJ has reviewed comments from the consultation and the final version is in progress, this work will be transferred to the new pathways group in Jan
- Diabetes pathway: as this work has no focus on drug treatment it therefore will not come under FSG remit and has been removed from the work plan. AM is likely to continue to attend this meeting for information.
- GM asthma pathway and COPD supporting information for CCGs: Final draft asthma guidance is nearly completed; this work will be transferred to the new pathways group in January. AM and MM have also submitted first drafts of COPD slides and ADA to CV for comment, this work will remain under the FMESG.

Item 5 – Formulary amendments – Oct 2016

NICE guidance and MHRA warnings: FSG agreed the following formulary amendments: the formulary will be updated to reflect TA413, TA414, TA415 and TA416. A link will be added to the MHRA safety advice for etoricoxib, and retigabine will be removed from the formulary in light of its impending withdrawal from the market.

NTS and IPS recommendations: FSG noted that no formulary action was required from the NTS recommendations recently published (colchicine for pericarditis pain, gabapentin/pregabalin for cough and safinamide for management of Parkinson's disease, as these had all been classes as non-formulary items by NTS. There was nothing published by the Interface group in October for formulary consideration.

Alendronate effervescent tablets application: FSG considered an application for alendronate effervescent tablets; however it was agreed that there was no requirement to add this agent to the formulary. If a patient requires a liquid formulation of alendronate then this would be prescribed off-formulary, as is the case for other agents. The group noted that there was already a liquid preparation available, (which is slightly more costly then the effervescent tablets), but there had been no reason to add this to the formulary previously.

Addition of exenatide weekly preparation to the formulary: The group considered a request that exenatide weekly preparation be reinstated to formulary. The group agreed that dulaglutide would remain the first choice GLP1 weekly agent as per the NTS decision aid submitted to formulary, as clinical data showed it was non inferior to liraglutide, whilst clinical data for exenatide once-weekly did not show non-inferiority to with liraglutide. Reductions in HbA1C from baseline had been shown to be significantly greater in patients taking liraglutide compared with exenatide once weekly. The group considered points raised by GM specialists in support of the reinsertion of exenatide weekly onto the formulary; whilst the group were unable to accept many of the points raised, they did agree that adding exenatide weekly to the formulary would provide an alternative to dulaglutide if required. It would also highlight that exenatide weekly is not the weekly GLP1 preparation of choice and should only be reserved for use in those patients unsuitable for dulaglutide when a weekly GLP1 is required.

EMPA-REG study and position of empagliflozin within the formulary: FSG discussed whether empagliflozin should become the first choice SGLT-2 following publication of the EMPA-REG study. The formulary currently lists all three SGLT2s alongside the relevant TAs (390,315, 288, 336) and the MHRA warnings (ketoacidosis and increased risk of lower extremity amputations). The publication of NG28 (type 2 diabetes, Dec 2015, updated July 2016) did not consider the EMPA REG trial. FSG considered a review of the trial (NICE Medicines Evidence Commentary, Nov 2015) which stated that *"The people in the trial were already at high cardiovascular risk because they had established cardiovascular disease; hence caution should be applied to extrapolating the findings to a wider population of people with type 2 diabetes. It is noteworthy that the reduction in the composite end point was driven by death from cardiovascular causes, but no reduction in myocardial infarction or stroke was seen. It may be important, therefore, to await further studies of SGLT-2 inhibitors before significantly changing prescribing practice."* FSG agreed that there was insufficient evidence to support a change to formulary; however in

those patients with established cardiovascular disease requiring a SGLT-2, empagliflozin may be the preferred choice.
Action: MM to submit proposed amendments to GMMMG update formulary and respond to applicants following GMMMG approval.

Item 6 Liothyronine information from specialists
At the September meeting FSG confirmed that no change was required to the DNP listing and wished to emphasize that the positioning of these agents on the list is due to their poor evidence base, (liothyronine, thyroid extract and Armour thyroid preparations are currently included on the DNP list due to their poor evidence base, the supporting information states that it is not recommended for routine prescribing for the treatment of hypothyroidism and links to CKS hypothyroidism guidance which references statements from The British Thyroid Association and The Royal College of Physicians). The group reviewed the DNP assessment tool that was used during the assessment of these products and references the "Management of primary hypothyroidism: statement by the British Thyroid Association Executive Committee (June 2015)".

Following the meeting query was raised as to whether there were recognised groups of patients who may have a need for T3 and DT contacted Prof S Ball, Clinical Lead Endocrinology at CMFT to gain an understanding as to why T3 may be used in clinical practice. Prof Ball's response highlighted T3 use falling into one of three areas:

1) IV for hypothyroid crisis (a rare indication and would likely be only in an HDU or ITU setting, not involving primary care),
2) for short term (1-2 months) post thyroid surgery in patients with thyroid cancer, prior to iodine scanning/staging and radioactive iodine therapy and thereafter there may be further brief periods on T3 in the run up to staging scans (this practice has been established for many years and has a clear experience and evidence-base).
3) the use of combination thyroxine and T3 therapy.

It is the third area that was noted as an area of concern over recent years following most recent RCP/BTA guidance that proposes this combination should only be used within a clinical trial setting (though the interpretation of 'a clinical trial' is not defined and some interpret as a 'therapeutic trial'). Patient support groups are keen for the access to combination therapy to continue. Prof Ball explained that nationally clinical

colleagues are a little divided on this practice and that the use of thyroid extract is something his department do not support.
FSG agreed that it would be appropriate therefore to assess Armour thyroid and combination thyroxine and T3 therapy for the DNP list separately to liothyronine, which should be assessed for the grey list. The group considered the response from Prof Ball but also the BTA 2016 guideline which states that that both the ETA and ATA guidelines strongly recommend that L-T4 remains the therapy of choice for hypothyroidism, and do not support the routine use of L-T4/L-T3 combination therapy due to insufficient evidence from controlled trials, lack of long-term L-T3 safety data, and unavailability of L-T3 formulations that mirror natural physiology. Therefore armour thyroid and thyroid extract will be placed on the DNP list (due to lack of evidence), whilst liothyronine will be placed on the grey list only for use in hypothyroid crisis and short –term post thyroid surgery, it will also be assessed for a red RAG status.
Action: MM to submit proposed amendments to GMMMG update formulary and respond to applicants following GMMMG approval.

Item 6 b – Flexitol heel balm - DNP assessment
The group discussed this application for the DNP list and noted that although there was a wide range in spend on this agent between GM CCGs, the total GM spend did not warrant this agent being assessed for DNP inclusion. Rather it would be more appropriate for CCGs to highlight via their prescribing software/newsletters that flexitol is a cosmetic product not listed on formulary, and that prescribers should consult the formulary for approved options.
Action: No action

Item 7 – NW urticaria pathway
Following the September FSG meeting MM contacted Dr Marinho and explained that the FSG would not be recommending the proposed NE urticaria pathway for GMMMG approval, as they felt that the pathway did not meet the needs of primary care. In particular it should include guidance on referral criteria and that in order to develop the pathway further the authors would need to engage more fully with primary care and the services currently available.
MM explained to FSG that Dr Marinho was disappointed with this decision, as there are too many unnecessary referrals coming from primary care, and the aim of this pathway is to reduce these referrals by supporting GPs to treat these patients as far as possible within primary care.

MM explained to Dr Marinho that that it would not be FSG that would facilitate the development of the pathway but a working group supported by FSG, and that this will change to the pathways group in due course. FSG agreed that the development of some additional supporting information for primary care to sit under the pathway would be useful; MM explained to FSG that Dr Marinho had also offered training sessions/podcasts to help implement the pathway.
FSG recognised that both primary care and the specialist services are keen to reduce inappropriate referrals of urticaria patients and that patients should be treat as appropriate in the primary care setting. They recognised that the provision of some supporting information for primary care surrounding urticaria and the role of primary care in treatment of this condition would be useful and MM agreed to scope this information and bring it back to the January formulary meeting for discussion.
Action: MM to scope this information and bring it back to the January formulary meeting for discussion. MM to respond to Dr Marinho as per the FSG discussion.

Item 8 – AOB
Nothing raised

Date of next meeting: This was the final physical meeting of the FSG in this format, the group will agree formulary amendments by email in December and the formulary will be maintained under the newly formed GM Formulary and Managed Entry Subgroup from January 2017