SUMMARY OF DECISIONS FOR APPROVAL

Recommendations made by GMMMG subgroups	**August 2026**
Approved by: GMMMG	**10.09.26**
Approved by: CEGC	**29.09.26**
Approved by: SCC	***07.10.26***

The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's technology appraisals. When NICE recommends a treatment 'as an option', the NHS must make sure it is available within 90 days (unless otherwise specified) of its date of publication. This means that, if a patient has a disease or condition and the doctor responsible for their care thinks that the technology is the right treatment, it should be available for use, in line with NICE's recommendations.

DECISIONS WITH A FINANCIAL OR COMMISSIONING IMPACT

Drug and indication	Rationale / criteria	Status and formulary position assigned	Notes on decision	Cost impact and commissioning / service implications	Recommendation from GMMMG
Triptorelin 22.5mg IM injection (generic product) as first choice gonadorelin analogue for the treatment of prostate cancer.	6 monthly injections require fewer healthcare resources to administer each year, and triptorelin 22.5mg has been shown to be effective at controlling PSA levels	Already on formulary as AMBER (shared care medicine) for this indication as 3.75mg dose and as 22.5mg for gender dysphoria. Add 22.5mg product to formulary for prostate cancer and make first line GNRH analogue for this indication. The RAG status will be RED pending addition to the SCP.	Originally proposed as Decapeptyl SR, it was raised that there are other similar products, all of which are likely to be cost-saving vs 3 monthly or more frequent administrations. An update to the SCP is required to facilitate transfer of prescribing to primary care.	Triptorelin 22.5mg is £414 per dose or £828 per year per patient vs £903 for leuprorelin (4 x 3 monthly) and £940 for goserelin (4 x 3 monthly). GM currently spends £3.5m per year on GNRH analogues for prostate cancer, and gives 17,156 doses per year. The cost of administering an injection in primary care is estimated at between £15-30 depending on the grade of staff being used i.e. nurse or GP. If all items in GM were prescribed as triptorelin 22.5mg the savings in drug costs to the GM ICB would be £172k per year and would save the healthcare activity associated with 9010 injections. If 9010 appointments for GNRH injections can be avoided this would save £135k - £270k per year and make these appointments available for other patients.	Note the potential for cost savings and approve addition to formulary.

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TA1152: Semaglutide for reducing the risk of major adverse cardiovascular events in people with cardiovascular disease and overweight or obesity
07/05/26
Commissioning: ICB
	Semaglutide (up to a maintenance dose of 2.4 mg once weekly) can be used, within its marketing authorisation, alongside a reduced-calorie diet and increased physical activity, as an option for reducing the risk of a major adverse cardiovascular event (that is, cardiovascular death, non-fatal myocardial infarction or non-fatal stroke) in adults with both:
	• established cardiovascular disease (CVD), defined as at least 1 of the following:
	  ○ previous myocardial infarction
	  ○ previous ischaemic or haemorrhagic stroke
	  ○ symptomatic peripheral arterial disease (they have intermittent claudication with an ankle-brachial index of less than 0.85 at rest, or have had a peripheral arterial revascularisation procedure or an amputation because of atherosclerotic disease), and
	• a body mass index (BMI) of at least 27 kg/m^2.
	Semaglutide can only be used if the company provides it according to the commercial arrangement.
		Add to formulary add GREEN Specialist Initiation (specialist initiation) pending the production of a prescribing pathway	CRG recognised the scope and scale of the recommendations and that there are potentially 82,284 people eligible for this medicine, 78,000 of which are in primary care (prevalent population) however the NICE TA noted that the highest risk of a CVD event was for those patients who have recently experienced a CVD event (incident population) and Wegovy may be more clinically and cost effective if used earlier. It is proposed that the incident population is prioritised for treatment with Wegovy with an intention to expand access to the prevalent population. A working group is being set up to produce a prescribing pathway to cover prioritisation criteria, initiation, transfer of prescribing and monitoring.	Using estimates of eligible patients from NHS GM Data quality team there are 78,000 people in GM primary care with a BMI> 27 and MI/Stroke/PAD and NICE estimate 4284 new events per year.
				The 78,000 estimate includes overlap with the eligible populations under TA1026: tirzepatide for obesity and recommendations made in NICE NG28: type 2 diabetes management (See GM NG28 interim position) meaning the actual eligible population is likely to be lower.
				Using this population and the NICE resource impact template it is anticipated that 1738 patients would be treated in year 1 rising to 3806 per year by year 3. The estimates of cost impact using NHS list price are: £3m in year 1 and £11m in year 3. However, through the horizon scanning process it was noted that Greater Manchester has a high incidence of CVD, and that uptake is expected to be much higher than that anticipated by NICE.
				NICE estimate that the resource to implement will be 2 x 20minute nursing appointments in addition to the clinical consultation. Further appointments to adjust concomitant medicines e.g. medicines for diabetes and blood pressure are likely to be required following initiation and titration of Wegovy.
				Semaglutide is subject to a commercial arrangement which will result in prescribing and reimbursement at list price and ICBs being charged the discounted price through NHS BSA processes. Central funding from NHSE is expected to be available on a fair share basis for semaglutide for all indications.
					Add to formulary add GREEN Specialist Initiation (specialist initiation) pending the production of a prescribing pathway

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NHS GM position on Metformin in Non-diabetic hyperglycaemia (enc 1)	Proposals to prescribe metformin to people with NDH in line with NICE guidance.	GREEN (all settings)	These recommendations have been agreed previously by GM-DOG and have been used to develop the GMMMG commissioning statement.	Spend on medicines budget is expected to be a maximum of £150k in year 1, rising to £1.36m in year 5 assuming 100% adherence with dosing This is offset by the avoidance of £398k of diabetes-related complications per year. It does not include the prescribing costs of prevention of 1,468 cases of T2DM per year (based on 20,000 NDH patients treated with metformin per year)	Approve position statement noting the financial and workload impact of a preventative intervention.
Ivermectin 3mg tablets for the treatment of human sarcoptic scabies	Second line after topical preparations and where any of the following apply: • Known hypersensitivity to permethrin, its components, or other pyrethroids/pyrethrins, or broken or secondarily infected skin. • Correct topical application is not feasible or is unlikely to be reliable. • Topical treatments are difficult to access or unavailable. • Topical treatment is impractical for coordinated treatment of multiple people, for example in a communal setting. • Dermatology, IPC or HPT advice supports its use.	Alternative second line treatment as GREEN (all settings)	None	Minimal overall change anticipated. Ivermectin 3 mg tablets are already prescribed across Greater Manchester, with expenditure of approximately £1.03 million during the 12 months to April 2026. The application is not expected to generate a significant increase in overall prescribing expenditure, as existing prescribing is already established. There may be a small increase in appropriate prescribing where patients who would previously have received repeated or ineffective topical therapy are appropriately treated with oral ivermectin. Equally, clearer prescribing criteria and antimicrobial stewardship guidance may reduce inappropriate use. Overall, the net financial impact is expected to be cost neutral or minimal.	Approve addition to formulary. Formulary positioning will ensure used appropriately.

Drug and indication	Rationale / criteria	Status and formulary position assigned	Notes on decision	Cost impact and commissioning / service implications	Recommendation from GMMMG
Methenamine Hippurate 1g tablets for the prophylaxis of uncomplicated lower urinary tract infections	For the prevention of recurrent uncomplicated lower urinary tract infection in women and people with a female urinary system aged ≥16 years, in accordance with NICE NG112 and the Greater Manchester Recurrent UTI Guideline. Methenamine hippurate should be considered: • after behavioural and personal hygiene measures have been optimised; • after management of reversible risk factors and triggers (e.g. vaginal atrophy with topical oestrogen where appropriate, post-coital prophylaxis where indicated); • before commencing continuous low-dose antibiotic prophylaxis; as an alternative to daily antibiotic prophylaxis in appropriate patients.	Add to formulary as GREEN (all settings) medicine in line with the recommendations in the antimicrobial guidance document	None	Methenamine hippurate is already widely prescribed within Greater Manchester for the prevention of recurrent urinary tract infections. This application does not seek to introduce widespread new prescribing, but to formalise its place within the Greater Manchester formulary and recurrent UTI pathway in line with NICE NG112. Current prescribing is £554,493 during the 12 months to April 2026 (approximately 26,627 patients). Overall prescribing expenditure is therefore not expected to increase significantly, as prescribing is already established. Improved awareness of NICE guidance may increase appropriate use in patients who would otherwise receive long-term antibiotic prophylaxis; however, this is expected to be offset by reductions in prolonged antibiotic prescribing, associated monitoring requirements, antimicrobial resistance and management of antibiotic-related adverse effects. Overall, the anticipated net financial impact is cost neutral or minimal, with potential longer-term savings through improved antimicrobial stewardship.	Approve addition to formulary

DECISIONS WITHOUT A FINANCIAL OR COMMISSIONING IMPACT

Drug and indication	Rationale / criteria	Status and formulary position assigned	Notes on decision	Cost impact and commissioning / service implications	Recommendation
GM antimicrobial Guidelines – August 2026 update (enc 2)	This paper presents Version 17 of the Greater Manchester Antimicrobial Guidelines, updating the October 2024 (v16) edition.	Various	This paper presents Version 17 of the Greater Manchester Antimicrobial Guidelines, updating the October 2024 (v16) edition. The changes fall into three groups: (1) newly incorporated therapies – Pylera® (restricted bismuth quadruple therapy for H. pylori, per the GMMMG December 2024 decision), oral ivermectin for scabies (second-line), and methenamine hippurate for recurrent UTI; (2) alignment with current national guidance – recurrent UTI definition (NICE NG112), paediatric community-acquired pneumonia course length (NICE NG250), acute prostatitis ciprofloxacin duration (NICE NG110), cellulitis course length (NICE NG141) and gonorrhoea ceftriaxone dosing (BASHH 2025); and (3) safety and housekeeping – correction of the doxycycline maintenance dose in penicillin-allergic patients (cellulitis) and updating PHE references to UKHSA.	No cost impact is expected from the publication of this guidance. Inclusion of new medicines such as methenamine and ivermectin for scabies have been included elsewhere in this decision summary	Approve for publication

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NHS Greater Manchester Incretin Therapies (GLP-1 Receptor Agonists and Tirzepatide): Commissioning Position and Prescribing Guidance (enc 3)	The updated incretin therapy commissioning position (including GLP-1 receptor agonists and tirzepatide) and prescribing guidance consolidates the existing NHS Greater Manchester commissioning position. It aims to support consistent interpretation of nationally approved and locally agreed arrangements, reduce unwarranted variation, and provide practical advice for safe initiation, monitoring and review. The document has also been updated to: • Include a single incretin therapy initiation checklist for use across all NHS GM-approved indications; • Provide specific advice regarding use of incretin therapies in combination with glucose lowering medicines including insulin, Clarify under what circumstances incretin therapies can be used in combination with insulin, including the recommendation that initiation and dose adjustment should be undertaken with oversight from an appropriately trained diabetes specialist.	Various – depending on medicine and indication from GREEN (all settings) to RED (specialist only)	CRG noted the inclusion of oral semaglutide (Wegovy) and orforglipron, the latter of which has been launched in the UK in August 2026. There is a TA expected for the weight loss indication in November 2026, but NICE Have declined to undertake a TA for the T2DM indication, citing NG28 and a class-effect from GLP-1s as the supporting guidance. CRG will be considering an interim position at their September meeting.	This document does not seek approval for additional investment. However, implementation of NICE recommendations and GM approved indications for incretin therapies may have significant financial implications because of the scale of eligible cohorts. The guidance supports mitigation of financial risk by clarifying commissioning arrangements, eligibility criteria, prescribing responsibilities, review requirements and circumstances where prescribing outside agreed pathways is not supported. A paper seeking approval for implementation of NG28 is being considered by CRG in September and a consultation will shortly open for comment. There are implications for NHS resource use for initiating and titrating incretin therapies, supporting patient and carer administration and review and adjustment of treatment. Much of which is already part of routine diabetes therapy, however increased use of injectables will add to the recourse required to obtain best value and outcomes from the medicines.	Approve for publication

Drug and indication	Rationale / criteria	Status and formulary position assigned	Notes on decision	Cost impact and commissioning / service implications	Recommendation
TA1155: Rozanolixizumab for treating antibody-positive generalised myasthenia gravis **20/05/26** **Commissioning: NHSE**	Rozanolixizumab, as an add-on to standard treatment, can be used as an option to treat generalised myasthenia gravis in adults who test positive for anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibodies. It can only be used if: • the condition is classified as Myasthenia Gravis Foundation of America (MGFA) class 2 to 4a • the condition is uncontrolled after 2 or more treatments, excluding acetylcholinesterase inhibitors, and • intravenous immunoglobulin (IVIg) or plasma exchange (PLEX) would otherwise be offered, or has been tried and stopped because of side effects or because it did not work well enough. Rozanolixizumab can only be used if the company provides it according to the commercial arrangement.	Add to formulary as a RED (specialist only) drug in this indication, with links to TA1155.	None	NICE expects around 1,300 people in England to be eligible for treatment, or around 2 per 100,000 population. Rozanolixizumab is administered as a short subcutaneous infusion given weekly, for 6 weeks, equivalent to 1 treatment cycle. As a once-weekly subcutaneous infusion, rozanolixizumab may avoid the need for frequent IV administration and procedures while minimising the treatment burden to patients. Clinical experts estimate 4 cycles for rozanolixizumab per year which incorporates treatment-free intervals. Users can amend the number of cycles to reflect local assumptions.	Approve addition to formulary

Drug and indication	Rationale / criteria	Status and formulary position assigned	Notes on decision	Cost impact and commissioning / service implications	Recommendation
NICE TA1157: Givinostat for treating Duchenne muscular dystrophy in people 6 years and over **28/05/26** **Commissioning: NHSE**	Givinostat can be used as an option to treat Duchenne muscular dystrophy in people 6 years and over who are ambulant (able to walk or stand, with or without support) at the start of treatment. Givinostat can only be used if the company provides it according to the commercial arrangement.	Add to formulary as a RED (specialist only) drug in this indication, with links to TA1157.	None	NICE expects 447 people in England to be eligible for treatment, and 188 (42%) to take up treatment. The key drivers of resource impact are that: • The monitoring requirements and the associated costs for givinostat are greater than comparator treatments. • People on givinostat are expected to have slower disease progression, which may increase the duration and cost of associated care, but this would primarily transact outside of the 3-year resource impact assessment period. Most of the additional capacity requirements associated with using givinostat are already in practice for people having treatment through the early access programme. However, this may vary based on local practice and current uptake.	Approve addition to formulary
Penicillamine Allergy Review SOP (enc 4)	This document represents the Greater Manchester process for identifying, reviewing and correcting penicillamine allergy records that may have been entered in error, in response to National Patient Safety Alert NatPSA/2025/006/NHSPS. The key safety risk is that a true penicillin allergy may be miscoded as penicillamine, potentially preventing prescribing systems from generating appropriate warnings	N/A	The SOP also introduces measures to reduce recurrence, including stronger clinical validation, structured data entry, staff training, system prompts, audit and patient engagement. Completion is expected within four weeks, by the end of October 2026.	NHS GM issued 323 items of penicillamine at a cost of £97,098 during the 12 months to Jun 26.	Approve SOP for GM use

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Single National Formulary comms (enc 5&6)	The document seeks to provide an update on the work done to prepare the GM system for implementation of the Single National Formulary (SNF) and approve the system comms associated with this. The SNF seeks to reduce barriers to uptake of new medicines and facilitate rapid and equitable implementation of NICE guidance and TAs. It aims to do this through standardisation of formulary categories and a number of "digital products for ICB adoption. GM ICB retains decision-making ability for the formulary and medicines.	N/A	GMMMG heard work done to align current RAG statuses with SNF categories and that any changes are being taken through the medicines governance process. No changes apart from a mapping to the new categories will take place without the knowledge of the GM system. The mapping to new categories will be completed by 9th December 2026	None significant expected Some impact on RDTC support but this is expected to be minimal	Note go live date and approve the comms for circulation to the GM system

DECISIONS FOR INFORMATION ONLY

Drug and indication	Rationale / criteria	Status and formulary position assigned	Notes on decision	Cost Impact
NG258: Anaphylaxis: assessment and referral after emergency treatment **20/04/26** **Commissioning: ICB**	This guideline covers assessment and referral for anaphylaxis. It aims to improve the quality of care for people with suspected anaphylaxis by detailing the assessments that are needed and recommending referral to specialist allergy services. This guideline updates and replaces NICE guideline CG134 (December 2011).	Remove links to CG134 and replace with links to NG258.	None	None anticipated. Updates to guidance are based on existing recommendations from the Resuscitation Council UK, MHRA, and British Society for Allergy and Clinical Immunology.
Finasteride and Dutasteride – updated safety warnings for psychiatric side effects and sexual dysfunction	The MHRA has reviewed the evidence for finasteride and dutasteride and the risk of suicidal thoughts and behaviours and has recommended further measures to minimise this risk.	Add links to MHRA advice to formulary.	None	None anticipated
GMMMG Minutes August 2026 (enc 7)	Approved minutes of GMMMG's meeting in August 2026	n/a	None	None
All links to MHRA drug safety updates added to formulary as published. Significant alerts where further action is required are highlighted.				

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