Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Reference: FOI.ICB-2324/457

Subject: Medicines Management; Formularies, Committee's, budgets

*I can confirm that the ICB **does hold the information requested**; please see responses below:*

QUESTION	RESPONSE
Q1. Please can you provide the name and email address of the medicines management team member who led on the Eye Care (Chapter 11) formulary review when it was last reviewed?	All formulary reviews are undertaken as a collaborative team programme of work with clinical representation from BNSSG Integrated Care System to include ICB Interface Pharmacists, Primary Care Prescribing Lead, Specialist Pharmacist and Consultant Team. Formulary review on the Eye chapter of the BNSSG Joint Formulary is undertaken by a small team of Interface Pharmacists within BNSSG ICB Medicines Optimisation Team in collaboration with the specialist teams. Name: Interface Pharmacist Email: bnssg.medicines-optimisation@nhs.net
Q2. Please can you provide the name and email address of the member of the ICS Medicines management team who is currently responsible for overseeing Eye Care formularies?	The BNSSG Joint Formulary is a collaborative team programme of work with clinical representation from BNSSG Integrated Care System to include ICB Interface Pharmacists, Primary Care Prescribing Lead, Specialist Pharmacist and Consultant Team. Work undertaken on the Eye chapter of the BNSSG Joint Formulary is undertaken by a small team of Interface Pharmacists within

	BNSSG ICB Medicines Optimisation Team in collaboration with the specialist teams. Name: Interface Pharmacist Email: bnssg.medicines-optimisation@nhs.net
Q3. Do you have an area prescribing committee/Medicines Optimisation Committees/ Medicines advisory group or similarly named group that manages your drug formulary decisions?	Yes, BNSSG Joint Formulary Group
Q4. Please can you provide the names and email addresses of all members of these formulary groups?	Deputy Director, Medicines Optimisation, BNSSG, ICB Team Administrator & Minute Taker, BNSSG ICB Principal Medicines Optimisation Pharmacist, BNSSG ICB Interface Pharmacist, BNSSG ICB Interface Pharmacist, BNSSG, ICB Medicines Optimisation Pharmacist, BNSSG, ICB Director of Pharmacy, NBT Medicines Information Pharmacist, UHBW High Cost Drugs Pharmacy Technician, BNSSG, ICB Specialist Pharmacist – High Cost Drugs, UHBW Medicines Safety Officer, Sirona Associate Director of Pharmacy - Lead Pharmacist for Women's and Children's Services, UHBW Principal Pharmacist - Pharmacoeconomics, NBT GP and Clinical Lead in Exceptional Funding and Policy Development Head of Medicines Optimisation, Sirona Deputy Chief Medical Officer, BNSSG ICB Neonatal Consultant, NBT Consultant Pharmacist, Rheumatology, NBT

<table>
<tr><td></td><td>Any queries should be directed to bnssg.medicines-optimisation@nhs.net</td></tr>
<tr><td>Q5. Please can you provide copies of the previous two minutes from the Area Prescribing Committee/ Medicines Optimisation Committees/ Medicines advisory group or similarly named groups meetings?</td><td>Please find minutes enclosed.

Please note that FOI requests and responses are publicly available and therefore personal information has been redacted. The ICB considers the names included in the enclosed document(s) to be personal information and therefore has applied a section 40 (Personal Information) exemption to this information.</td></tr>
<tr><td>Q6. I would be grateful if you could confirm for which products within Chapter 11 (Eye) of your formulary, you have a primary care rebate in place, when the agreement commenced, the rebate amount and the end date?</td><td>
<table>
<tr><th>Rebate Product</th><th>Generic name/ product</th><th>Start date</th><th>End date</th></tr>
<tr><td>Vizidor & Vizidor Duo</td><td>Dorzolamide hydrochloride/dorzolamide hydrochloride timolol maleate</td><td>01/09/2023</td><td>31/08/2025</td></tr>
</table>
The level of discount for all rebate agreements are confidential and commercially sensitive information.

The ICB has applied Section 43(2) (Information prejudice to commercial interests) to the question regarding the rebate amount. Section 43(2) is a qualified exemption and subject to the public interest test, outlined below.

<u>Disclosing the information</u>
The public interest arguments in favour of disclosing the rebate amount includes the ICB’s responsibility to be transparent and</td></tr>
</table>

	accountable in its decision making. The ICB policy for Sponsorship of Activities by and Joint Working with the Pharmaceutical Industry outlines the values the ICB adheres to when working with the pharmaceutical industry and this included the principle for the ICB to promote confidence between staff, patients and the public through transparency of NHS activities. The policy also states that information relating to rebate schemes is disclosable under the FOI Act and only information considered commercially sensitive should be redacted. Maintaining the exemption The public interest arguments in favour of maintaining the exemption includes the agreement signed by the ICB which confirms the information is commercially sensitive. Rebate schemes allow organisations to offer financial rebate to the ICB and these schemes are considered on clinical, financial and contractual grounds and will only be considered if the medicines are appropriate and of value to the ICB population. The ICB has considered that disclosure of the information may lead to the contract holder not offering this type of scheme again which may result in the ICB having to spend more public funds on prescribing. The ICB has a responsibility to secure the best use of public resources and provide value for money. Public Interest Test outcome

	The ICB has considered the balance of both disclosing the information and maintaining the exemption and believes it is in the public's best interest to apply the exemption. The ability for organisations to offer rebate schemes to the ICB reduces the amount of public funding used for prescribing and allows for more effective use of resources to ensure the ICB achieves value for money for the local population.
Q7. Does the ICS have a deficit forecast for 2023/2024 financial year? If so, how much is this deficit? And How much is the forecast deficit for 2024/2025 financial year?	There is no deficit forecast for 2023/24. The draft 24/25 plan will be submitted to NHS England on 29 February 2024 and published on the ICB website as part of the May ICB Board papers Events - NHS BNSSG ICB

The information provided in this response is accurate as of 28 February 2024 and has been approved for release by Dr Joanne Medhurst, Chief Medical Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

BNSSG Joint Formulary Group Meeting – Adults and Paediatrics

Meeting Held on: Tuesday 17th October
Time: 09:30 – 13:30
Venue: Virtual – Microsoft Teams

Minutes

Present:

XXXX (Chair)	DC	Deputy Director, Medicines Optimisation, BNSSG, ICB
XXXX (Minutes)	AW	Team Administrator & Minute Taker, BNSSG ICB
XXXX	SBe	Principal Medicines Optimisation Pharmacist, BNSSG ICB
XXXX	AD	Interface Pharmacist, BNSSG ICB
XXXX	HA	Interface Pharmacist, BNSSG, ICB
XXXX	RJ	Medicines Optimisation Pharmacist, BNSSG, ICB
XXXX	MK	Director of Pharmacy, NBT
XXXX	BC	Medicines Information Pharmacist, UHBW
XXXX	ACD	High Cost Drugs Pharmacy Technician, BNSSG, ICB
XXXX	CB	Specialist Pharmacist – High Cost Drugs, UHBW
XXXX	IC	Medicines Safety Officer, Sirona
XXXX	HE	Associate Director of Pharmacy - Lead Pharmacist for Women's and Children's Services, UHBW
XXXX	KJ	Principal Pharmacist - Pharmacoeconomics, NBT
XXXX	PG	GP and Clinical Lead in Exceptional Funding and Policy Development

Apologies:

XXXX	KE	Head of Medicines Optimisation, Sirona
XXXX	GI	Deputy Chief Medical Officer, BNSSG ICB
XXXX	MP	Neonatal Consultant, NBT
XXXX	ERP	Consultant Pharmacist, Rheumatology, NBT

Applicants:

XXXX	SW	ST4 Emergency Medicine, UHBW
XXXX	JJ	Emergency Department Pharmacist, UHBW
XXXX	TLA	Consultant Obstetrician and Gynaecologist, NBT
XXXX	SH	Specialist Dermatology Pharmacist, UHBW
XXXX	SG	Lead Paediatric Pharmacist for Cardiac Services, UHBW

1 Welcome and Apologies

DC opened the meeting as chair. Introductions were made and apologies were noted as above. The meeting was not quorate due to no secondary care representation at the meeting, therefore any decisions made will need to be ratified via email. There were no declarations of interest recorded.

2 Minutes of the Previous Meeting from Tuesday 29th August 2023 and Matters arising

The minutes of the previous Joint Formulary meeting from Tuesday 29th August 2023 were reviewed. These were agreed to be an accurate reflection of the meeting, with no amendments to be made.

3 Joint Formulary Group Adults Action Log

Ref 31.5 - Melatonin – NDR – *The Formulary team to proceed with work required to seek financial approval for option 3 to be added to the adult and paediatric formulary. Option 3 to remain non-formulary until financial approval gained.*

- The formulary team advised there is ongoing work regarding financial sign off. Action ongoing.

Ref 31.6 - Melatonin – NDR – *Formulary team to add to formulary as TLS Amber 3 months once financial approval and SCP protocol including review criteria is agreed.*

- The formulary team advised there is ongoing work regarding financial sign off. Action ongoing.

Ref 35.3 – Discontinuation of Insuman insulin SBAR – *The formulary team to remove all Insuman products from the BNSSG adult and paediatric formulary in May/June 2023 when supplies have been exhausted.*

- The formulary team are awaiting for stock to run out of supplies before updating Remedy. Action ongoing.

Ref 37.2 – Biologics – NDR – *The formulary team to include the biologics (adalimumab, infliximab, etanercept, tildrakizumab, certolizumab, Risankizumab, Guselkumab, Brodalumab, Ixekizumab, Secukinumab, Bimekizumab, Ustekinumab) and apremilast for severe psoriasis at localised, high impact sites onto the BNSSG adult formulary as TLS red for use in line with the BNSSG psoriasis biologics pathway once financial approval has been reached.*

- The formulary team advised this action is ongoing. Blueteq forms are currently being finalised. Action ongoing.

Ref 37.3 – Biologics – NDR – *The formulary team to proceed with work required to seek financial approval for these biologics and apremilast to be added to the adult formulary. These will remain non-formulary until financial approval is gained.*

- The formulary team advised financial approval has been agreed at the ICS MO High Cost Drugs Meeting. Action can close.

Ref 37.4 – Biologics – NDR – *The formulary team to work with the applicant to update the BNSSG psoriasis biologics pathway to include clear criteria for use in this cohort and outcome measures similar to the SE London pathway including that use should only continue in patients where a 50% improvement in disease score is seen.*

- The formulary team advised this action is ongoing. Blueteq forms are currently being finalised. Action ongoing.

Ref 37.5 – Biologics – NDR – *The formulary team to request that ACD/UHBW develop Blueteq forms for Dermatology to use for biologics and apremilast for this patient cohort.*

- The formulary team advised this action is ongoing. Blueteq forms are currently being finalised. Action ongoing.

Ref 38.3 – Dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction – *The formulary team to include Dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction as TLS amber specialist recommended onto the BNSSG adult formulary.*

- The formulary team have included Dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction onto the BNSSG adult formulary as TLS amber specialist recommended. Action can close.

Ref 38.4 – Tadalafil 5mg tablets – NDR – *The formulary team to include tadalafil 5mg tablets for treatment of erectile dysfunction in adult males post robotic laparoscopic prostatectomy (penile rehabilitation) as TLS amber specialist initiation onto the BNSSG adult formulary. The formulary team to include a caveat onto the BNSSG adult formulary to advise 'post robotic laparoscopic prostatectomy treatment up to 12 months only'*

- The formulary team have included Tadalafil once daily 5mg tablets onto the BNSSG adult formulary. Tadalafil which is TLS blue now states weekly. Action can close.

Ref 38.5 – Tadalafil 5mg tablets – NDR – *The formulary team to work with specialist team to clarify the review process for patients and for further specialist input so that this can be incorporated into primary care guidance (Remedy and/or the ED guideline).*

- The formulary team have contacted the applicant to identify point of contact to work with to update guideline/remedy as applicable. This will be picked up as part of the guideline tracker workload as guideline is due for review December 2023. Remedy team have been notified. Action can close.

Ref 38.6 – Methacholine chloride (Provocholine) powder – NDR – *The formulary team to include methacholine chloride (Provocholine) powder for nebuliser solution for diagnostic testing to detect bronchial airway hyperreactivity to assist in the diagnosis of asthma as TLS red onto the BNSSG adult formulary as a second line diagnostic bronchial provocation test, following either a negative mannitol test with a clinical suspicion of asthma or intolerance to mannitol.*

- The formulary team have included onto the BNSSG adult formulary. Action can close.

Ref 38.7 – Uromune sublingual spray vaccine – NDR – *The formulary team to include Uromune vaccine for prevention of recurrent UTIs onto the adult BNSSG Joint Formulary as TLS red, on advice of the Recurrent UTI MDT.*

- The formulary team have included onto the BNSSG adult formulary. Action can close.

Ref 38.8 – Uromune sublingual spray vaccine – NDR – *Applicants to submit outcome data of use in 12-18 months' time so use of Uromune can be evaluated and place in pathway re-considered if appropriate- add to 'action sits with trust' tab on action log.*

- The formulary team will be finalising the outcome data with the applicant. It was agreed to move to 'Actions sit with trust' tab.

Ref 38.9 – Rituximab – NDR – *The formulary team to include rituximab for the treatment of moderate RA in patients for whom TNF inhibitor and JAK inhibitor are clinically contraindicated or not tolerated as TLS red onto the BNSSG adult formulary.*

- The formulary team have included onto the BNSSG adult formulary. Action can close.

Ref 39 – Certolizumab – NDR – *The formulary team to include certolizumab for moderate RA as first line for patients who are actively planning to conceive or pregnant and are due to escalate to bDMARD therapy as TLS red on the BNSSG adult formulary once financial approval has been reached.*

- The formulary team have included onto the BNSSG adult formulary. Action can close.

Ref 39.1 – Certolizumab – NDR – *The formulary team to discuss the additional cost for certolizumab at the ICS High Cost Drugs meeting.*

- The formulary team advised financial approval was agreed at the ICS High Cost Drugs meeting. Action can close.

Ref 39.2 – Estradot transdermal patches – NDR – *The formulary team to include Estradot patches to the formulary as TLS Blue, as a second line brand option for patients where the Evorel patch reported to lack adhesion, be poorly absorbed, or where localized reactions to the glue are reported.*

- The formulary team have included onto the BNSSG adult formulary. Action can close.

Ref 39.3 – Sucroferric oxyhydroxide (Velphoro) – TLS – *The Formulary team to change the TLS for sucroferric oxyhydroxide (Velphoro) from TLS red to TLS amber specialist recommended on the BNSSG adult formulary.*

- The formulary team have updated the BNSSG adult formulary.

Ref 39.4 – Lanthanum – TLS – *The Formulary team to change the TLS for lanthanum from TLS amber 1 month SCP to TLS amber specialist recommended onto the BNSSG adult formulary.*

- The formulary team have updated the BNSSG adult formulary.

Ref 39.5 – Sevalemer – TLS – *The Formulary team to change the TLS for sevalemer carbonate from TLS amber 1 month SCP to TLS amber specialist recommended onto the BNSSG adult formulary.*

- The formulary team have updated the BNSSG adult formulary.

Ref 39.6 – BNSSG Formulary Chapter Review: 2.6 Hyperlipidaemia – *The formulary team to make the agreed recommended changes to the Cardiovascular chapter review for 2.6 Hyperlipidaemia.*

- The formulary team have updated the BNSSG adult formulary. An update will be included within the MO newsletter.

Ref 39.7 – Amiodarone – TLS – *The formulary team to arrange meeting to discuss amiodarone with secondary care Cardiology consultants. Secondary care to support with identifying the appropriate consultants to liaise with.*

- The formulary team advised a meeting will be arranged in due course to discuss the TLS. Action ongoing.
-

Ref 39.8 – SCP Review Update – *The formulary team to update the BNSSG formulary with the agreed recommendations following the Shared Care Review working group.*

- The formulary team have updated the BNSSG adult formulary, except for sodium valproate. Action ongoing.

Joint Formulary Group – Adults Long Term Action log

Ref 7.27 – Subcutaneous Infliximab & Vedolizumab – *To collect data for 6 months to see if subcutaneous preparations do reduce the number of appointments at hospital as suggested*

- ACD will present the data during todays' meeting. Action can close.

Ref 7.43 – Buprenorphine prolonged release injection (Buvidal) – NDR – *The formulary team to include Buvidal on the BNSSG formulary with the restriction that use is part of the pilot only and on the provision of a delivery model for administration. Applicants to return with update from pilot for formulary to re-evaluate*

- The formulary team advised the applicant anticipates the outcome data report will be completed by October. This will be presented at a future Joint Formulary Group meeting. Action ongoing.

Ref 9.2 – Testosterone (Tostran 2% gel) / (Testogel 50mg/5g gel sachets) – *A review of use for the approved cohorts to be completed by applicant after approximately 6 months. This review is required to consider use in wider patient cohorts.*

- The formulary team advised there is currently national research ongoing. The formulary team is awaiting outcome data from UHBW. Action ongoing.

Ref 30 – Tenecteplase - NDR – *NBT to discuss collating evidence outcome data to review in 1 years' time at the Joint Formulary Group and to confirm starting criteria.*

- Tenecteplase is currently still out of stock therefore no outcome data available at the moment. Action ongoing.

Ref 36 Vericiguat tablets – NDR – *NBT/UHBW/ICB team and the applicant to meet outside of the meeting to discuss the expectations of the review in order to support continuation for Vericiguat to be on the BNSSG adult formulary due to lack of experience and evidence.*

- The formulary team have emailed the applicant to request data collection sheet. Action ongoing.

4 NICE New Technology Appraisals

NICE New Technology Appraisals published since August 2023 – For information only. *Will be included in the BNSSG Joint Formulary once Implementation plans have been submitted and agreed within NICE TA Review Group*

NICE TA		Commissioner	TLS Status
TA913	Mavacamten for treating symptomatic obstructive hypertrophic cardiomyopathy	NHSE	Red
TA914	Pembrolizumab for previously treated endometrial, biliary, colorectal, gastric or small intestine cancer with high microsatellite instability or mismatch repair deficiency	NHSE	Red
HST28	Birch bark extract for treating epidermolysis bullosa	NHSE	Red*

*Birch bark extract for treating epidermolysis bullosa
HA advised if acute trusts have been commissioned to deliver birch bark extract for treating epidermolysis bullosa then this would need to be included onto the BNSSG formulary. It was confirmed UHBW and NBT are not commissioned to provide this service, therefore this will not be included onto the BNSSG formulary.

5 New Drugs Request (NDR) – Adults

Droperidol for sedation of patients with acute behavioural disturbance. *XXXX, ST4 Emergency Medicine and XXXX ED Consultant, UHBW*.

Discussion
AD presented the new drug request for droperidol for sedation of patients with acute behavioural disturbance (ABD). Droperidol is an antipsychotic licensed in the UK for treatment of nausea and vomiting. While it is not currently licenced for the treatment of ABD in the UK, it is used extensively for this indication in Australia.

The current BNSSG formulary options are ketamine, lorazepam, midazolam and haloperidol. Droperidol has fewer side effects than lorazepam / midazolam and fewer cases requiring additional sedation than haloperidol or midazolam. Droperidol has a faster onset of action and time to peak effect than haloperidol (reaches peak concentration within 10 minutes).

The Royal College of Emergency Medicine (RCEM) guideline recommends ketamine or droperidol as the first line agent for ABD. The anticipated number of patients likely to receive treatment within BNSSG is 60. The cost of droperidol 2.5mg/ml 10 ampoules is £14.40, 5mg i.m. is £2.88 and 10mg i.m. is £5.76. It is intended that droperidol will be used where ketamine is not appropriate instead of benzodiazepines or haloperidol.

In regard to other ICB formularies, Bath, North East Somerset, Swindon and Wilshire (BSW), Somerset and Devon have not included droperidol on their formularies. Dorset and Oxford have included droperidol for the licensed indication only. Bedfordshire and Luton have included droperidol as TLS red 'approved for off-label intramuscular injection of 5mg dose for the Emergency Department (ED) only. Prescribing to be by ED consultants or registrars'. The applicant advised other trusts / ICSs may be following RCEM guidance but have not yet updated their local guidelines or formularies.

A Cochrane review in 2016 concluded there was high quality evidence supporting the use of droperidol in short term management of psychotic aggressive patients. Studies comparing droperidol to other methods of sedation support its use compared to benzodiazepines and other antipsychotics due to rapid onset, reduced need for additional doses of sedative medication and less risk of respiratory complication. AD advised a double-blind, randomised clinical trial in the emergency department in Australia gave 79 patients either midazolam or droperidol 5mg intravenously every 5 minutes until sedated. There was no difference in time to sedation. Eleven adverse events occurred in the midazolam group and 10 in the droperidol group. Patients sedated with midazolam may have an increased need for active airway management.

JJ and SW joined the meeting to discuss the new drug request application. SW advised in moderate ABD the national RCEM best practice guidance recommends droperidol first-line for rapid tranquilisation over benzodiazepines or haloperidol.

SW advised droperidol was historically used for the management of ABD before concerns over prolonged QT led to its withdrawal in 2001. However, recent evidence has alleviated concerns over prolonged QT.

Droperidol is initially anticipated to be used in 20 patients per year, however this may increase when health care professionals become more confident in its use. SW advised it will be used primarily for a specific sub-group of patients e.g. acutely agitated, autonomic disturbance and patients who are at risk of deteriorating and escalating.

UHBW have developed guidance for the use of droperidol for the management of moderate ABD. NBT have advised they are keen to use droperidol and develop system-wide guidance. SW advised SWAST have also developed guidance that mirrors UHBW guidance and are investigating expansion of out of hospital use. SW is happy to work on system-wide guidance with NBT.

Decision Criteria used by JFG for NDR

- **Patient safety –** Studies demonstrate safe and less adverse effects and need for active airway management than alternative second line agent midazolam.
- **Clinical effectiveness –** RCTs demonstrate efficacy comparable to comparator benzodiazepines.
- **Strength of evidence –** Good- availability of RCTs and included within national guideline.
- **Cost effectiveness or resource impact –** Potentially less need for active airway management than alternatives and less adverse effects which could reduce costs for care, however in terms of comparison of drug costs, droperidol is more expensive than alternative agents.
- **Place in therapy relative to available treatments –** In moderate ABD the national RCEM best practice guidance now recommends droperidol for rapid tranquilisation over benzodiazepines or haloperidol. Second line to ketamine which is included on the formulary.
- **National guidance and priorities –** The Royal College of Emergency Medicine – Acute Behavioural Disturbance (2022) advise that in most cases of ABD requiring parenteral sedation, intramuscular ketamine or droperidol are recommended first-line agents.
- **Local health priorities –** To support Trusts with following national guideline.
- **Equity of access –** Could not see this indication specifically listed on other formularies but use is within nationally recommended guideline for this cohort of patients and applicant advises is being used in other ED departments.
- **Other considerations –** The NBT mental health liaison team and ED team would like to look at whether cross site guidance could be produced for acute behavioural disturbance

Conclusion

The group considered the application, the evidence and the information submitted. The group agreed to include droperidol as an option for the management of acute behavioural disturbance in the Emergency Department onto the BNSSG adult formulary as TLS red. Droperidol will be included onto the BNSSG adult formulary under 4.2.7 Behavioural Disturbance in the Emergency Department for use after ketamine. It was agreed that when system-wide guidance is developed, use in other areas of the system can be revisited and the formulary changed accordingly.

Action

1. The formulary team to include droperidol as an option for the management of acute behavioural disturbance in the Emergency Department onto the BNSSG adult formulary as TLS red.

Bijuve (1mg estradiol / 100mg micronised progesterone) for hormone replacement therapy. *XXXX, Consultant Obstetrician and Gynaecologist, NBT.*

Discussion

AD presented the new drug request for Bijuve (1mg estradiol / 100mg micronised progesterone) for hormone replacement therapy. The intended use for Bijuve is for use within its licensed indication (continuous combined hormone replacement therapy (HRT) for estrogen deficiency symptoms in postmenopausal women with intact uterus and with at least 12 months since last menses).

Bijuve (estradiol 1mg/progesterone 100mg) is the first approved oral continuous combined body-identical estradiol and progesterone formulation in a single capsule.

The evidence base describing risk for breast cancer, heart disease, heart attack, and stroke demonstrates that body-identical hormones are safer forms of HRT than oral synthetic progestogens.

Based on the BNSSG population of 969,256 the anticipated patient numbers in year 1 is 310, then 930 in year 2 and 1240 in year 3. The annual cost for Bijuve is £106.11 (per patient). Bijuve is £56.45/year more expensive than Kliofem (£49.66 – first line option) per patient.

The use of Bijuve should be as an alternative to Femoston-Conti (£106.15 per patient annually, second line option). The next step after Femoston-Conti if not tolerated would be a patch. Formulary patch options include Evorel Conti (£161.29 per patient annually and £55 more than Bijuve per year) and Femseven Conti (£191.19 per patient annually).

There have been significant supply disruptions with many HRT products leading to non-formulary options and different combinations of oral HRT and patches being prescribed. ePACT data between June 2022 – 2023 indicates that £63,000 was spent on Femoston-Conti and £900 on Bijuve (despite non-formulary status). The prescribing of Bijuve would be offset by the reduction in Femoston-Conti and could prevent women needing to try a patch as the next step (with higher associated prescribing costs).

The REPLENISH trial found use of Bijuve was associated with a clinically significant reduction in vaso-motor symptoms compared to placebo.

BSW ICB have included Bijuve as TLS green (second line option if adverse effects experienced with synthetic preparations) on their formulary. Somerset have included Bijuve as TLS green, but Gloucestershire and Cornwall have not included Bijuve on their formulary.

TLA joined the meeting to discuss the application. TLA advised Bijuve is a new continuous combined form of HRT designed to be used by women who are postmenopausal with at least 12 months since their last menses. Bijuve is an option for post-menopausal women with an intact uterus seeking treatment for estrogen deficiency symptoms. This the first body-identical continuous combined treatment for women and prescribers who have concerns regarding the safety of synthetic HRT.

Bijuve has shown a specific benefit regarding sleep, which has previously been reported as a major driver of quality-of-life detriment. This benefit has been attributed to the micronised progesterone component. It is the only HRT with data to demonstrate meaningful improvement on sleep parameters in post-menopausal women.

Decision Criteria used by JFG for NDR

- **Patient safety –** Single combination tablet could improve patient concordance compared to women who were taking an oestrogen and progesterone component separately, reducing the risk of unopposed oestrogen therapy. There may a lower risk of breast cancer compared to non-bioidentical progesterone. Micronised progesterone or dydrogesterone may be preferred in women with Hypertriglyceridaemia due to their neutral effect on lipid profile.
- **Clinical effectiveness –** Evidence from large observational studies and case-controlled studies suggests that micronised progesterone and dydrogesterone are unlikely to increase the risk of venous thrombosis and are associated with a lower risk of breast cancer compared to that noted with synthetic progestogens.
- **Strength of evidence –** A Cochrane review (Bioidentical hormones for women with vasomotor symptoms[4]) found that there was no good evidence of a difference in effectiveness between bioidentical hormone therapy (BHT) and conjugated equine estrogen (CEE), and findings regarding adverse effects were inconsistent. The quality of the evidence was too low to reach any firm conclusions. Bijuve® has not been compared to other HRT products. The REPLENISH study only compared Bijuve® to placebo, however the separate components of Bijuve have been widely used as HRT.
- **Cost effectiveness or resource impact –** Bijuve is more expensive than first line BNSSG choice but is cost-equivalent to the second-line formulary choice (Femoston Conti).
- **Place in therapy relative to available treatments –** Bijuve is a similar cost to Femoston-Conti® which is a second line oral treatment within BNSSG.
- **National guidance and priorities –** NICE recommends prescribing progesterone alongside oestrogen HRT in menopausal women with a uterus.

- Accepted for use in NHS Scotland, however subject to local formulary submission in England and Wales. Has been accepted for use in several ICBs including neighbouring ICBs (Somerset and BSW).
- **Local health priorities –** Priority to the specialist clinic to provide another option but not specific local priority to system.
- **Equity of access –** On menopause PPC list, provides patient choice of continuous combined HRT.
- Utrogestan® 100 mg capsules are currently in short supply and subject to a serious shortages protocol (SSP).

Conclusion

The group considered the application, the evidence and the information submitted. The group agreed to include Bijuve as a second-line treatment option and an alternative to Femoston-Conti when other first line HRT treatments have not been tolerated / are not suitable as TLS green onto the BNSSG adult formulary.

It was agreed that work to review the HRT pathway is required to consider the ongoing place for synthetic combination products, financial impact of a pathway change and TLS status when the HRT guideline is due for review. It was also agreed to review frequency of prescribing of individual components of HRT and whether additional communication is required to highlight risks associated with unopposed oestrogen when individual components are prescribed.

Action

1. The formulary team to include Bijuve as a second line treatment option and an alternative to Femoston-Conti when first line HRT treatments have not been tolerated / are not suitable as TLS green onto the BNSSG adult formulary.

6 Items for Discussion – Adults

SCP Review Working Group Update

HA provided an update from the Shared Care Protocol Review working group. HA discussed the recommendations to the group below.

- **Testosterone oral** (including m/r) is amber 1 month for male hypogonadism. This is no longer used and has not been issued in primary care in the last year. The group agreed to remove from the BNSSG adult formulary.
- **Danazol** for hereditary angioedema is amber (TLS unclear). There is no specific monitoring required. The SCP review working group agreed a SCP is not required and recommended to change the TLS to amber specialist initiated. The group agreed to change the TLS to amber specialist initiated on the BNSSG adult formulary.
- **Rivaroxaban with antiplatelets** the amber indications are TLS amber 1 month for preventing adverse outcomes after acute management of acute coronary syndrome as per NICE TA335 and TLS amber 3 months for preventing atherothrombotic events in people with coronary or peripheral artery disease as per NICE TA607. The SCP review working group agreed a SCP is not required. The SCP review working group felt guidance regarding the use of DOACs in combination with an anti-platelet would be useful. The group agreed to change the TLS to amber specialist recommended and to develop a short guideline including prescribing considerations - risks, benefits and safety concerns on the use of DOACs in combination with antiplatelets (including guidance around bleeding risk).

Action

1. The formulary team to remove testosterone oral (including m/r) for male hypogonadism from the BNSSG adult formulary.

2. The formulary team to change the TLS for danazol for hereditary angioedema from TLS amber to TLS amber specialist initiated on the BNSSG adult formulary.

3. The formulary team to change the TLS for rivaroxaban with antiplatelets from TLS amber 1/3 months to amber specialist recommended on the BNSSG adult formulary and to develop a short guideline including prescribing considerations - risks, benefits and safety concerns on the use of DOACs in combination with antiplatelets.

Subcutaneous infliximab & vedolizumab attendance data

ACD presented subcutaneous infliximab and vedolizumab attendance data to the group. Two years of patient attendance data has been analysed to see if switching patients from intravenous to subcutaneous preparations reduced the number of attendances. The subcutaneous formulation was first available in October 2020. Blueteq was used to identify gastroenterology patients on infliximab and vedolizumab. It is noted that all patients are given intravenous loading doses. ACD presented the data below:

Attendance Savings

Preparation	Number of patients April 2021 – March 2023	Number of attendances April 2021 – March 2023	Average attendances April 2021 – March 2023	Attendances saved April 2021 – March 2023*	Attendance cost saved April 2021 – March 2023
Intravenous	682	5139	8	N/A	N/A
Subcutaneous	77	266	3	385	£179,025

*Based on 5 attendances saved for each patient.
**Based on average BNSSG Gastroenterology attendance cost for an infusion of £465 per attendance.

Yearly Drug Cost – after loading

	Cost of dose	Cost of year treatment	Attendance cost	Attendance cost per year	Homecare cost	Total cost per year (drug & delivery)
Infliximab SC	£150	£3,900	-	-	£80	£3,980
Infliximab IV (based on 70kg adult)	£274	£1,781	£459	£2,984	-	£4,756
Vedolizumab SC	£375	£9,750	-	-	£80	£9,830
Vedolizumab IV	£1,800	£11,700	£459	£2,984	-	£14,684

As anticipated, introduction of infliximab and vedolizumab was associated with fewer attendances per patient. Further data will be presented and discussed at the High Cost Drugs meeting and elsewhere in the system.

7 Shared Care Protocol/TLS Status – Adults

Traffic Light Status Request Change

Nil

New SCPs

Nil

Updated SCPs

Nil

8 Joint Formulary Paediatric Action log

Ref 14.3 – Melatonin – NDR – *The Formulary team to proceed with work required to seek financial approval for option 3 to be added to the adult and paediatric formulary. Option 3 to remain non-formulary until financial approval gained.*

- The formulary team advised there is ongoing work regarding financial sign off. Action ongoing.

Ref 14.4 – Melatonin – NDR – *Formulary team to add to formulary as TLS Amber 3 months once financial approval and SCP protocol including review criteria is agreed.*

- The formulary team advised there is ongoing work regarding financial sign off. Action ongoing.

Ref 16.1 – Discontinuation of Insuman insulin SBAR – *The formulary team remove all Insuman products from the BNSSG adult and paediatric formulary in May/June 2023 when supplies have been exhausted.*

- The formulary team are awaiting for stock to run out of supplies before updating Remedy. Action ongoing.

Ref 16.7 – Itulazax – NDR – *The formulary team to include Itulazax (Standardised allergen extract of pollen from white birch [Betula verrucosa]) for treatment of moderate-to-severe allergic rhinitis and/or conjunctivitis induced by pollen from the birch homologous group on the BNSSG adult and paediatric formulary as TLS red, for the use by the specialist allergy team.*

- The formulary team have updated the BNSSG paediatric formulary. Action can close.

Ref 16.8 – Menthol in aqueous cream – *The formulary team to remove Arjun® cream as the preferred brand of menthol in aqueous cream within the dry skin chapter on the BNSSG adult and paediatric formulary.*

- The formulary team have removed Arjun cream as the preferred brand of menthol in aqueous cream in the BNSSG paediatric formulary. Action can close.

Ref 16.9 – CareSens device request – *The formulary Team to remove MyLife Aveo testing strips from the BNSSG paediatric formulary and replace this with CareSens Pro testing strips.*

- The formulary team have removed MyLife Aveo testing strips and replaced with CareSens Pro testing strips on the BNSSG paediatric formulary. Action can close.

Ref 17 – Flunarizine – *The formulary team to change the TLS of flunarizine for migraine prophylaxis from TLS Amber to TLS Red on the BNSSG paediatric formulary.*

- The formulary team have updated the BNSSG paediatric formulary. Action can close.

Joint Formulary Group – Paediatric Long Term Action log

Ref 1 - Ropivacaine 0.2% solution – *Request for Trust to review following 1 year of usage to the long term outcome data tab on action log.*

- The formulary team have reviewed the previous Joint Formulary Group minutes where ropivacaine was discussed. Long term outcome data was requested as the evidence base for ropivacaine was not specifically for children. XXXX has fed back the use of ropivacaine is working really well in practice and UHBW have raised no concerns. Ropivacaine is already on the BNSSG paediatric formulary and in use. The group agreed to close this action.

9 New Drug Requests (NDRs) – Joint Adult and Paediatrics

Aklief (Trifarotene 50micrograms/g cream) for treatment of acne. *XXXX, Specialist Dermatology Pharmacist and XXXX, Consultant Dermatologist, UHBW.*

Discussion

SH presented the new drug request for Aklief (Trifarotene 50micrograms/g cream) for treatment of acne. Aklief is a topical retinoid which is licensed for the management of acne vulgaris on the face and the trunk for patients 12 years and older. Aklief is the only product which has specifically been trialled on the trunk. Aklief is an additional option to other available retinoids.

Aklief is applied as a thin layer to the affected areas of the face and/or trunk once a day, in the evening, on clean and dry skin. Aklief is an antibiotic free treatment. There is significant antibiotic use in acne, with patients often taking prolonged courses of antibiotic therapy. National and international health authorities are calling for clinicians to limit antibiotic use to reduce antimicrobial resistance.

Trifarotene 50micrograms/g cream 75g (Aklief) annual cost is £248.64 per patient based on daily application to face, trunk and neck. Aklief is a similar cost to other first line formulary options, being cheaper than all but one first line option on the community antimicrobial stewardship guideline. It is therefore likely to be cost neutral or cost saving if used in place of one of the current first line formulary options.

Topical retinoids are recommended in the NICE guidance. Aklief is not included in NICE guidance on management of acne as it was first licensed in the UK after the final guideline scope was agreed.

Gloucestershire have included Aklief onto their formulary as first-line treatment for truncal acne. It has also been accepted for use within NHS Scotland.

The clinical efficacy of Aklief is based on two short-term Phase III, randomised, parallel group and double-blind studies. Patients treated with trifarotene had higher success rates than the vehicle group.

SH agreed to work alongside XXXX (Antimicrobial Stewardship Lead, ICB) to ensure place within the BNSSG Community Antimicrobial Stewardship Guidelines is clearly defined if added to BNSSG Joint Formulary to support primary care prescribing.

Decision Criteria used by JFG for NDR

- **Patient safety –** Appears to be safe.
- **Clinical effectiveness –** Trifarotene cream appears to be an effective option for the treatment of acne vulgaris.
- **Strength of evidence –** Adequate.
- **Cost effectiveness or resource impact –** Trifarotene is of a comparable cost to the other currently available, NICE recommended topical acne therapies.
- **Place in therapy relative to available treatments –** Positioned alongside other topical retinoid products for moderate acne.
- **National guidance and priorities –** Detailed in the management of acne by the Primary Care Dermatology Society https://www.pcds.org.uk/clinical-guidance/acne-vulgaris. Not included in NICE guidance but Aklief first licensed after the final scope of NG198 was agreed.
- **Local health priorities –** Nil found.
- **Equity of access –** Starting to be made available in other areas. Recently added to the Gloucester joint formulary.
- **Other considerations –** Trifarotene cream appears to be an effective and safe option for the treatment of acne vulgaris. Head to head comparison trials are needed in future to establish efficacy against other topical retinoids to identify place in the treatment pathway. The pump dispenser may reduce waste and allow for application of an accurate and consistent amount of product.

Conclusion

The group considered the application, the evidence and the information submitted. The group agreed to include Aklief (trifarotene 50micrograms/g cream) for treatment of acne onto the adult and paediatric formulary as TLS green. The applicant and XXXX to work together to ensure Aklief's place within the pathway is clearly defined on the BNSSG Community Antimicrobial Stewardship Guidelines to support primary care prescribing and to ensure the Remedy Acne page is updated appropriately.

Action

1. The formulary team to include Aklief (Trifarotene 50micrograms/g cream) for treatment of acne onto the adult and paediatric formulary as TLS green.
2. The formulary team to request that the applicant and XXXX update the BNSSG Antimicrobial Stewardship Guideline to include Aklief.
3. The formulary team to request that the applicant and XXXX work with the Remedy Team to update the Remedy Acne page to reflect these changes.

Doublebase Once emollient for treatment of eczema, psoriasis and dermatitis. *XXXX, Consultant Dermatologist, UHBW.*

Discussion

HA presented the new drug request for Doublebase Once emollient for treatment of eczema, psoriasis and dermatitis. It contains isopropyl myristate, liquid paraffin and glycerol. Doublebase Once is used in the management of dry skin conditions such as eczema, psoriasis and ichthyosis. Doublebase Once may be applied once daily, it may be useful for patients who struggle to apply emollients frequently throughout the day.

Doublebase Once is well tolerated in most patients but in rare cases it can cause skin irritation or allergic skin reactions on extremely sensitive skin.

The anticipated number of patients likely to receive treatment within BNSSG is unclear. Doublebase Once is £6.99 for a 500g pump pack. If only used once a day, Doublebase Once gel is slightly more expensive than first line formulary options Epimax Isomol gel or Epimax ointment if these are used twice a day. It is cheaper than AproDerm gel and Balneum Intensiv cream used twice a day. However, if used more than once a day, Doublebase Once gel is significantly more expensive than all other formulary options except Balneum Intensiv cream. If only used once a day where first line formulary options are not effective or if use prevents progression onto a urea containing product this may be cost effective.

The pathway in the application proposes use of Doublebase Once gel after an equivalent to Epimax Isomol gel, Epimax ointment and AproDerm gel but before a urea containing product (e.g. Balneum Intensive cream). Doublebase Once is not included on any local formularies.

There are no specific trials which look at the effect of Doublebase Once other than those that the manufacturer has on file. There are no national guidelines which advise the use of one emollient over another. National guidance advocates use of emollients but does not state a preference for one over another one. A 2017 Cochrane review looked at a variety of emollients and moisturisers which were used for eczema to review if there were differences between products. This did not find reliable evidence that any one emollient is better than another. Canada's Drug and Health Technology Agency also concluded after two systematic reviews that there were no differences between emollients and therefore use should be determined by cost effectiveness and patient choice.

Decision Criteria used by JFG for NDR

- **Patient safety –** Well tolerated, rarely skin reactions on extremely sensitive skin.
- **Clinical effectiveness –** There are no specific trials which look at the effect of Doublebase Once gel other than those that the manufacturer has on file. No robust evidence for use of one emollient over another.
- **Strength of evidence –** Low quality evidence for use over alternatives.
- **Cost effectiveness or resource impact –** More expensive than first line options. May be cost effective if only used once a day where a patient would use an alternative twice a day or if reduces need for a urea containing product.
- **Place in therapy relative to available treatments –** Second line after first line emollient choices and before urea containing products. May be useful where ointments are not practical e.g. hand and foot dermatitis.
- **National guidance and priorities –** National guidelines advocate use of emollients but do not specify a preference for use of one over another.
- **Local health priorities –** Low priority for system to have an additional emollient.
- **Equity of access –** Not included on any local formularies. Not identified on any formulary in other areas.
- **Other considerations –** Licensed as a medical device rather than a medicine.

Conclusion

The group considered the application, the evidence and the information submitted. The group reviewed the strength of evidence alongside the cost effectiveness and agreed there is low quality evidence for use over alterative / current treatment options. On the basis of the low quality of evidence and uncertainty about cost-effectiveness, the group were not able to support inclusion of Doublebase Once emollient for treatment of eczema, psoriasis and dermatitis onto the BNSSG adult and paediatric formulary. The group agreed if the applicant can provide specific evidence that Doublebase Once emollient would be beneficial in a defined cohort of patients the Joint Formulary Group will re-review the application.

Action

1. The formulary team to inform the applicant of the decision to not include Doublebase Once emollient for treatment of eczema, psoriasis and dermatitis onto the BNSSG adult and paediatric formulary.

Adex gel emollient for treatment of eczema, psoriasis and dermatitis. *XXXX, Consultant Dermatologist, UHBW.*

Discussion

HA presented the new drug request for Adex gel emollient for treatment of eczema, psoriasis and dermatitis. Adex gel is an emollient gel containing nicotinamide 4% with glycerol. It is used for the treatment of eczema and psoriasis. It is promoted as an easily absorbed, highly moisturising gel with nicotinamide, included to reduce inflammation and redness.

Adex Gel can help patients with facial dermatoses, where topical steroid sparing is required, topical corticosteroids are not tolerated/effective or reduced topical steroids results in flare. Adex gel may help patients who are looking for an intermediate step in their treatment plan when stepping up from emollients alone or stepping down from steroids and emollients. Adex gel would be used after the current first-line emollient choices where the addition of nicotinamide may be useful for a steroid sparing effect or if a topical steroid is not suitable.

The anticipated number of patients likely to receive treatment within BNSSG is unclear. The only formulary options that are more expensive than Adex gel are Cetraben ointment, urea containing products, products containing antimicrobials and menthol. If the use of Adex gel reduces episodes of disease flare with an associated reduction in topical steroid use, it may reduce some spend on topical steroids. This is dependent on choice of emollient and quantity of emollient/steroid required. Adex gel may be either an additional cost, cost neutral or cost saving. However, if topical steroids continue to be required at the same rate for flares of disease, Adex gel will be more expensive than first line formulary options and most other options with the exception of Cetraben ointment and urea/antimicrobial/menthol containing products. Therefore, use of Adex gel may represent an overall additional cost to the system.

Cornwall have included Adex gel onto their formulary as an option for patients following poor response from other first/second line formulary choices. Hampshire and Isle of Wight have included Adex gel onto their formulary as a potential alternative option to preparations containing an anti-microbial where inflammation is not associated with infection.

There is only one trial which looks at the effects of Adex gel. This was a subjective trial in which subjects rated perceived efficacy of Adex gel compared to the previous product they were using. Patient's responses were very positive, ranging from 81% to 100% agreement with each performance statement in relation to beneficial effects on the skin. When questioned on steroid-sparing effects, more than half reported that they needed to use less of their other anti-inflammatory treatments. It is worth noting that this was a manufacturer sponsored trial. There is no strong evidence which demonstrates the benefit of one emollient over another.

Potential use for facial eczema or as a step-down treatment was discussed. The group considered whether it would be beneficial for the applicant to present some further detail about the proposed pathway before agreement is reached.

Decision Criteria used by JFG for NDR

- **Patient safety –** Adverse effects include mild itching, burning sensation and pruritus.
- **Clinical effectiveness –** Some evidence of benefit from nicotinamide creams with improvement seen in erythema, scaling and papules. Adex gel has been reported to reduce use of other anti-inflammatory treatments e.g. steroids.
- **Strength of evidence –** There is only one trial which looks at the effects of Adex gel. The strength of evidence is low.
- **Cost effectiveness or resource impact –** Adex gel is more expensive than most current formulary emollients. If use reduces topical steroid use, it may be an additional cost, cost neutral or cost saving. If topical steroids continue to be required at the same rate, Adex gel will represent an additional cost.
- **Place in therapy relative to available treatments –** For use after current first line emollient choices where additional anti-inflammatory of nicotinamide might be useful for a steroid sparing effect or if a topical steroid is not suitable.
- **National guidance and priorities –** National guidelines advocate use of emollients but do not specify a preference for use of one over another.
- **Local health priorities –** Low priority for system to have an additional emollient.
- **Equity of access –** Available on Cornwall and Hampshire/Isle of Wight formularies.
- **Other considerations –** Licensed as a medical device rather than a medicine.

Conclusion

The group considered the application, the evidence and the information submitted. The group reviewed the strength of evidence alongside the cost effectiveness and agreed there is low quality of evidence for use over alterative / current treatment options. On the basis of the low quality evidence and cost to the system the group agreed to not include Adex gel emollient for treatment of eczema, psoriasis and dermatitis onto the BNSSG adult and paediatric formulary at this time. The group agreed that if the applicant can provide evidence to suggest Adex gel may be beneficial in a defined cohort of patients the Joint Formulary Group would be happy to re-review the application at a future meeting.

Action

1. The formulary team to inform the applicant of the decision to not include Adex gel emollient for treatment of eczema, psoriasis and dermatitis onto the BNSSG adult and paediatric formulary at the current time and to offer an opportunity present further evidence of benefit in a defined cohort at a later meeting.

10 Shared Care Protocols/TLS Status – Joint Adult and Paediatrics

Traffic Light Status Request Change
Nil

New SCPs
Nil

Updated SCPs
Nil

11 Items for Discussion – Joint Adult and Paediatrics

Nil

12 New Drugs Request (NDR) – Paediatrics

Morphine sulfate orodispersible tablets (Actimorph) for pain relief. *XXX, PICU Pharmacist and Lead Pharmacist for Paediatric Surgery, UHBW. XXXX Associate Director of Pharmacy - Women and Childrens Service, UHBW.*

Discussion

HE presented the new drug request for morphine sulfate orodispersible tablets (Actimorph) for pain relief. Actimorph is licensed for children from 6 months of age. Actimorph would be intended for patients with acute pain, such as post-operative patients, and palliative care patients. Depending on the surgery, duration of treatment could range from 3-14 days, with the maximum being a month. Actimorph is available in a variety of strengths such as 1mg, 2.5mg, 5mg, 10mg, 20mg and 30mg orodispersible tablets.

Morphine is a first-line treatment option on the formulary. Actimorph would be an additional formulation. The application is to include Actimorph as a first line product for morphine for pain for doses that can be rounded to the nearest tablet size.

HE advised morphine sulfate has clear dosing in the BNFC for GPs to prescribe, but there are concerns about supplying a whole bottle of morphine oral solution for patients that only require small doses short-term. Pre-pack bottles of morphine oral solution and smaller volumes have been investigated with no success. As Actimorph is available in a number of strengths, doses can be rounded to the nearest whole tablet to remove the risk of drawing up incorrect doses. Tramadol has been the mainstay of treatment for moderate to severe pain for patients at discharge from Bristol Children's Hospital for many years. Tramadol is supplied as either 50mg soluble tablets to give part doses or 50mg capsules when they can be swallowed whole. Actimorph tablets are generally safer to administer than tramadol soluble tablets as there is a risk that carers will give the incorrect dose of tramadol using the soluble tablets. Tramadol is dosed as per the local acute pain guideline for patients >1 year of age, but there is no dosing in the BNFC for children <12 years.

Actimorph is more expensive (£2 - £4 for 1mg and £3.50 - £7 for 5mg) than morphine oral solution 10mg/5ml (£0.44 - £0.88 for 1mg and £2.20 - £4.40 for 5mg) for most doses. The difference in cost is greater for smaller doses. It is cheaper than Sevredol for doses of 10mg – 50mg. When comparing the cost of tramadol 50mg tablet and a 5mg tablet of Actimorph, tramadol is twice the cost. Switching, or reducing tramadol usage would provide a cost saving. Smaller doses of 1mg and 2.5mg of morphine would have additional cost savings.

Decision Criteria used by JFG for NDR

- **Patient safety –** Safety of active ingredient will be the same as for current formulary preparations. Formulation specific concerns have been raised in relation to use of morphine oral solution and potential for patients to escalate dose / unintentionally take large doses as well as increased risk of diversion due to different CD schedule. It has been proposed that use of solid oral dosage forms may be safer than morphine oral solution for some patients.

For paediatric patients, Actimorph is licensed for use in children from 6 months of age and is also considered safer to administer because whole tablet dosages can be prescribed and administered compared to the current alternative of prescribing tramadol off license and directing patients/parents to dissolve tramadol tablets in solution and administer specific proportions. There is an increased risk of dosing error with tramadol and lack of information on dosing readily available for GPs from the product literature.

- **Clinical effectiveness –** As for current formulary options. Clinical effectiveness has not been assessed as part of the critical appraisal for a new formulation of a medicine already included on the formulary.
- **Strength of evidence –** As for current formulary options. Strength of evidence has not been assessed as part of the critical appraisal for a new formulation of a medicine already included on the formulary.
- **Cost effectiveness or resource impact –** For paediatric patients, it is reported that Actimorph is more cost effective than tramadol soluble tablets and more cost effective than the oral solution.
- **Place in therapy relative to available treatments –** For paediatric patients, Actimorph would be intended for patients with acute pain, such as post-operative patients, and palliative care patients. Depending on the surgery, it could range from 3-14 days, with the maximum being a month. Chronic pain would be a different indication and falls under a different team, so that is not what this application is for. Applicant would like TLS Blue for this specific cohort of patients.
- **National guidance and priorities –** Some concern from coroners about safety of morphine oral solution**.**
- **Local health priorities –** BNSSG Medicines Quality and Safety Group and NHS England Controlled Drugs Accountable Office support use of Actimorph for low doses as an option for patients where morphine oral solution is not tolerated or suitable. The Children's hospital are keen to use a medicine which is licensed for the paediatric cohort and considered a safer option. Dispensing small quantities of oral solution was also not practical for the hospital.
- **Equity of access –** Cannot see that Actimorph is specifically listed on formularies for paediatric use, but product is licensed for this cohort.
- **Other considerations –** Nil.

Conclusion

The group considered the application, the evidence and the information submitted. There is sufficient evidence to support inclusion of Actimorph orodispersible tablets as an alternative to morphine oral solution. Actimorph would be the first line option for short-term use for post-operative pain.

The group agreed to include morphine sulfate orodispersible tablets (Actimorph) for pain relief onto the BNSSG paediatric formulary as TLS amber specialist recommended. The group agreed to review the formulary status for morphine and tramadol on the BNSSG paediatric formulary and to change the TLS to amber specialist recommended. It was agreed to list the individual formulations of morphine approved on the formulary. The formulary team agreed to link in with HE to discuss wording on the formulary outside the meeting but that the formulary should specify that primary care may initiate morphine preparations where there is an urgent clinical need and provide a short supply whilst awaiting specialist advice / investigation.

Action

1. The formulary team to include morphine sulfate orodispersible tablets (Actimorph) for pain relief onto the BNSSG paediatric formulary as TLS amber specialist recommended.

2. The formulary team to change the TLS status of morphine and tramadol on the BNSSG paediatric formulary to amber specialist recommended and to list the individual formulations of morphine approved on the formulary. The formulary team agreed to link in with HE to discuss wording on the formulary outside the meeting.

13 Items for Discussion – Paediatrics

Cardiovascular Paediatric Chapter review

The Cardiovascular chapter of the BNSSG Paediatric Formulary was due for review to ensure the chapter contents are still accurate and relevant (https://remedy.bnssg.icb.nhs.uk/formulary-paediatric/paediatric-chapters/2-cardiovascular-system/). The Paediatric Specialist Team at UHBW provided comments on the chapter. Following the consultation period with Secondary Care, Primary Care colleagues were invited to provide comments on the chapter, along with the proposed changes from Secondary Care. There were 48 suggestions made by the Paediatric Cardiology Team. There are 24 drugs listed as 'TLS amber not specified' or 'TLS amber – SCP needed' but without a SCP. As priority, these drugs were reviewed by the cardiology

team to recommend an appropriate traffic light status that fits within the BNSSG criteria. AD discussed the recommendations which require further discussion, these are summarised below.

TLS Amber (not specified) to TLS Amber 3 or 1 month with Shared Care Protocol

Amiodarone – Change to TLS amber 1 month SCP. In line with national RMOC and safety recommendations and in line with adult formulary (once SCP developed).
Sotalol – Change to TLS amber 1 month SCP. Further information can be provided in a SCP.
Verapamil – Change to TLS amber 1 month SCP. Further information can be provided in a SCP.
Acetazolamide – Change to TLS amber 3 months SCP. BNFC does not cover all the information needed.

The group agreed with the above recommendations.

TLS Amber (not specified) to TLS Amber specialist initiated

Propranolol – Change TLS amber not specified to TLS amber specialist initiated. All relevant information included within BNFC. GPs are familiar with prescribing.
Carvedilol – Change TLS amber not specified to TLS amber specialist initiated. All relevant information is included within the BNFC. Specialists continue to initiate, stabilise and monitor these patients.
Nifedipine – Change TLS amber not specified to TLS amber specialist initiated. All relevant information is included within the BNFC. Specialists continue to initiate, stabilise and monitor these patients.
Diltiazem – Change TLS amber not specified to TLS amber specialist initiated. All relevant information is included within the BNFC. Specialists continue to initiate, stabilise and monitor these patients.
Verapamil – Change TLS amber not specified to TLS amber specialist initiated. All relevant information is included within the BNFC. Specialists continue to initiate, stabilise and monitor these patients.
Enalapril and Lisinopril – Change TLS amber not specified to TLS amber specialist initiated. All relevant information is included within the BNFC. GPs familiar with prescribing. Specialists continue to initiate, stabilise and monitor these patients.
Losartan, irbesartan – Change TLS amber not specified to TLS amber specialist initiated - GPs familiar with prescribing. All relevant information is included within the BNFC. Specialists continue to initiate, stabilise and monitor these patients.
Spironolactone – Change TLS amber not specified to TLS amber specialist initiated. GPs familiar with prescribing. All relevant information is included within the BNFC. Specialists continue to initiate, stabilise and monitor these patients.
Warfarin – Change TLS amber not specified to TLS amber specialist initiated - warfarin is dosed by the nursing team with medic support.

The group agreed with the above recommendations.

TLS Amber - SCP needed to TLS Amber specialist recommended

Colestyramine, ezetimibe, fenofibrate, bezafibrate, atorvastatin, rosuvastatin, simvastatin, pravastatin - Specialists continue to initiate, stabilise and monitor these patients.

The group recommended to change to TLS amber specialist initiated as secondary care are reported to initiate, stabilise and monitor patients. AD to confirm whether all lipid lowering drugs are still needed on the formulary and specific indications for these with the Paediatric Specialist Team at UHBW. SG advised some indications may be for transplant or as part of obesity management which will need clarifying.

Action

1. The formulary team to change colestyramine, ezetimibe, fenofibrate, bezafibrate, atorvastatin, rosuvastatin, simvastatin, pravastatin to TLS amber specialist initiated.
2. AD to confirm whether all lipid lowering drugs are still needed on the formulary and specific indications for each with the Paediatric Specialist Team at UHBW.

TLS Amber 1/3 months with SCP to TLS Amber specialist initiated

The rationale for the following TLS changes is that all relevant information is included within the BNFC or SPC. Specialists continue to initiate, stabilise and monitor these patients.
Digoxin – Change to TLS Amber 3 months with SCP to TLS Amber specialist initiated.
Metoprolol – Change to TLS Amber 3 months with SCP to TLS Amber specialist initiated.
Amlodipine – Change to TLS Amber 3 months with SCP to TLS Amber specialist initiated.
Captopril – Change to TLS Amber 3 months with SCP to TLS Amber specialist initiated.
Furosemide – Change to TLS Amber 1 month with SCP to TLS Amber specialist initiated, update strength specified and move to HF section.

The group agreed with the above recommendations.

Antiplatelets

Aspirin – Currently TLS amber 3 months with SCP change to TLS amber specialist initiated. Information available in BNFC. Secondary care will stabilise patient for first month.

The group agreed to change the TLS for aspirin from TLS amber 3 months with SCP to TLS amber specialist initiated.

Clopidogrel – Currently TLS red – request to change to TLS amber 3 months SCP for PDA stents and TLS amber 1 month SCP for other patient cohorts. Some information included in internal guideline for initiating, further information can be provided in a SCP as doses not documented in BNFC, there are no licensed preparations and two different strengths are used. For PDA stents regular weights and dose increases are needed (would be managed in secondary care) but duration of treatment is short (6-7 months). For other indications (allergy to aspirin, fever on aspirin etc this is considered more straight forward) and would likely be prescribed on a longer-term basis.

The group agreed to keep the TLS of clopidogrel for PDA stents as TLS red as this is considered to be something that is prescribed as part of a tertiary service. The group agreed to change the TLS for clopidogrel for other patient cohorts to TLS amber 1 month SCP, pending a SCP. Clear information should be included in the SCP and clinic letter outlining the responsibilities for the GP and reassurance that any medicine changes will be clearly documented.

Action

1. UHBW to develop SCP to bring back to JFG.

Anticoagulants

Tinzaparin – Currently TLS red – request to change to TLS blue. Second line option after enoxaparin. Rarely used.
Dalteparin – Currently TLS red – request to change to TLS blue. Second line option after enoxaparin. Rarely used.
Enoxaparin – Currently TLS amber not specified for patients over the age of 12; TLS red for under 12s - request to change to TLS amber specialist initiated for patients requiring treatment beyond 3 months.

The group agreed to keep tinzaparin and dalteparin as TLS red and to change enoxaparin to TLS red for all patients. TLS of enoxaparin to be reviewed once the TLS for enoxaparin for adults has been agreed.

Action

1. The formulary team to change enoxaparin to TLS red, which can be reviewed once the TLS for enoxaparin for adults has been agreed.

TLS Red – Proposed changes

Nadolol – Change to TLS amber specialist initiated. All relevant information included within BNFC. Specialists continue to initiate, stabilise and monitor these patients.
Atenolol – Change to TLS amber specialist initiated. All relevant information included within BNFC. Specialists continue to initiate, stabilise and monitor these patients.
Hydralazine – Change to TLS amber 1 month with SCP.

The group agreed with the above recommendations.

Action

1. The formulary team to change nadolol and atenolol to TLS Amber specialist initiated and hydralazine to TLS Amber 1 month (pending shared care protocol).

Requests to add to Paediatric formulary

Taurolock – add onto the BNSSG paediatric formulary as TLS Red.
Alteplase – add onto the BNSSG paediatric formulary as TLS Red. Used in acute trusts.
Streptokinase – add onto the BNSSG paediatric formulary as TLS Red.
Noradrenaline and Adrenaline – add onto the BNSSG paediatric formulary as TLS Red into the inotrope section for heart failure.
Nicardipine – request to add onto the BNSSG paediatric formulary as TLS Red.
Prazosin – request to add onto the BNSSG paediatric formulary as TLS red. Historically has been used.

Rivaroxaban – request to add onto the BNSSG paediatric formulary as TLS red. Currently used within UHBW following venous thrombosis.

The group agreed to include Taurolock, alteplase and streptokinase onto the BNSSG paediatric formulary without the need for a new drug request form due to these medicines already being used within the trusts in line with internal guidelines. The group agreed to include noradrenaline and adrenaline onto the BNSSG paediatric formulary as TLS red into the inotrope section for heart failure. The group agreed a new drug request would be required for the Joint Formulary Group to consider inclusion of nicardipine, prazosin and rivaroxaban for these indications on the BNSSG paediatric formulary.

Action

1. The formulary team to include Taurolock, alteplase and streptokinase onto the BNSSG paediatric formulary as TLS red.

2. The formulary team to include noradrenaline and adrenaline onto the BNSSG paediatric formulary as TLS red into the inotrope section for heart failure.

TLS change form for atenolol

The group agreed to change the TLS for atenolol from TLS red to TLS amber specialist initiated on the BNSSG paediatric formulary.

Action

1. The formulary team to change the TLS for atenolol from TLS red to TLS amber specialist initiated on the BNSSG paediatric formulary.

TLS change form for flecainide

AD presented the TLS change form for flecainide. A shared care protocol is not deemed necessary because specialists will continue to monitor patients and relevant information for this medicine is included within the BNFC. There is also an internal UHBW guideline document for flecainide initiation and monitoring which secondary care follow. The group agreed to include some additional information about monitoring responsibility under the flecainide entry on the formulary e.g. “Patients should contact the cardiac consultant secretary if they are experiencing a breakthrough of symptoms for necessary monitoring. Routine monitoring and review is dependent on the patient’s clinical situation and plan which will be detailed in the clinic letter. GP Practice to ensure a plan is in place before taking over prescribing responsibility.” The group agreed to change the TLS for flecainide from TLS amber (not specified) to TLS amber specialist initiated on the BNSSG paediatric formulary.

Action

1. The formulary team to change the TLS for flecainide from TLS amber (not specified) to TLS amber specialist initiated on the BNSSG paediatric formulary and to include the following words under flecainide on the formulary page “Patients should contact the cardiac consultant secretary if they are experiencing a breakthrough of symptoms for necessary monitoring. Routine monitoring and review is dependent on the patient’s clinical situation and plan which will be detailed in the clinic letter. GP Practice to ensure a plan is in place before taking over prescribing responsibility.”

Responsibility for monitoring

The group discussed whether to include additional information in each section of the cardiac chapter to clarify responsibility for monitoring of amber specialist initiated/recommended medicines. The following suggestion was discussed: “Secondary Care to maintain responsibility for monitoring amber specialist initiated drugs in this section of the formulary. A clear management plan detailed in clinic letter is required to support primary care prescribing. GP Practices should ensure a plan is in place before taking over prescribing responsibility.”

Action

1. Formulary team liaise with SG to agree additional information to add to each section of the formulary to clarify monitoring responsibility for amber specialist initiated/recommended drugs.

14 Shared Care Protocols/TLS Status – Paediatrics

Traffic Light Status Request Change

Folinic acid for metabolic disorders

HA presented the traffic light status request change for folinic acid (calcium folinate) (Vitamin B9) 15mg tablets for metabolic disorders. Folinic acid is TLS red but is currently being prescribed in primary care for some patients. The request is to change from TLS red to amber specialist recommended.

The management of paediatric metabolic disorders requires a comprehensive and proactive approach, with early intervention being critical for improved outcomes. Folinic acid, a derivative of folic acid, has demonstrated potential in treating various metabolic disorders.

Monitoring is usually not required but in some cases cerebrospinal folate concentration will need to be taken; this monitoring will be conducted in secondary care. There are no monitoring requirements for primary care. Secondary care have confirmed they will advise on dose.

There are 7 patients prescribed folinic acid for metabolic disorders in BNSSG. An EMIS search has shown that 5 children have either been issued folinic acid in the last year or it is listed on their current medication list in primary care. Folinic acid is significantly cheaper in secondary care (£10.39) compared to primary care (£46.77). This is based on generic calcium folinate tablets, however, a Pfizer brand is cheaper which could be used within primary care to support cost effective prescribing. The group agreed to change the traffic light status from TLS red to TLS amber specialist recommended. The group agreed to discuss how to manage the TLS change in the most cost-effective way outside the meeting.

Action

1. The formulary team to change the TLS for folinic acid for metabolic disorders from TLS red to TLS amber specialist recommended on the BNSSG paediatric formulary.

New SCPs

Nil

Updated SCPs

Methylphenidate for ADHD

HA presented the updated shared care protocol for methylphenidate for part of a comprehensive treatment programme for attention deficit hyperactivity disorder (ADHD) in children and adolescents of 5 years of age and over where remedial measures alone provide insufficient. HA discussed the updated changes to the SCP to the group, summarised below:

- The previous SCP was for children of 6 years and over. NICE now recommend first line for children aged 5 years and over. SCP has been updated to reflect this.
- There has been a change in use of off-label doses for Concerta brand. This is in line with BNF.
- The use off-label doses have been updated to reflect current practice.
- The dosing for the immediate release tablets differs from the BNFC for 4 – 5 year olds, however reflects local practice not to use immediate release in children under 6 years old.
- The directions around the use at bedtime have been updated to reflect current practice.
- In terms of reviewing treatment and response. The BNF recommends reviewing after 1 month of treatment. However AWP have confirmed current practice is 4 – 6 weeks.
- HA advised there are some contraindications in the BNF and SPC which AWP have moved to cautions e.g. patients with pre-existing cardiovascular disorders, cerebrovascular disorders or history of severe mental health. The group recommended to move these to contraindications and to include a caveat that these can be used “under certain circumstances after a risk benefit consideration by the specialist has been taken into account”.

The group agreed to approve the updated SCP for methylphenidate for ADHD if AWP/Sirona agree with changes to contraindications. The formulary team to include the updated SCP for methylphenidate for ADHD onto the BNSSG paediatric formulary when these changes are made.

Action

1. The formulary team to include the updated SCP for methylphenidate for ADHD onto the BNSSG paediatric formulary when changes to contraindications are made.

Lisdexamfetamine for ADHD

HA presented the updated shared care protocol for lisdexamfetamine dimesylate (Elvanse®) for part of a comprehensive treatment programme for attention deficit hyperactivity disorder (ADHD) in children and adolescents of 5 years of age and over where methylphenidate treatment has been considered to be clinically inadequate, not tolerated, contraindicated or inappropriate. HÀ discussed the updated changes to the SCP to the group, summarised below:

- The previous SCP was for children of 6 years and over. NICE now recommend first line for children aged 5 years and over. SCP has been updated to reflect this.
- The following sentence has been included under indication “methylphenidate treatment has been considered to be; inappropriate (e.g. patient choice and concerns about misappropriation of stimulants)”. The group agreed to remove the words “patient choice” from this section.
- In terms of reviewing treatment and response. The BNF recommend reviewing after 1 month of treatment. However, AWP have confirmed current practice is 4 – 6 weeks.

The group agreed to approve the updated SCP for lisdexamfetamine for ADHD once the recommended change is made. The formulary team to include the updated SCP for lisdexamfetamine for ADHD onto the BNSSG paediatric formulary once recommended change is made.

Action

1. The formulary team to include the updated SCP for Lisdexamfetamine for ADHD onto the BNSSG paediatric formulary once the recommended change is made.

Atomoxetine for ADHD

HA presented the updated shared care protocol for atomoxetine for part of a comprehensive treatment programme for attention deficit hyperactivity disorder (ADHD) in children and adolescents of 5* years of age and over where treatment with methylphenidate or lisdexamfetamine has been considered to be inadequate, not tolerated, contraindicated or inappropriate. HA discussed the updated changes to the SCP to the group, summarised below.

- The previous SCP was for children of 6 years and over. NICE now recommend first line for children aged 5 years and over. SCP has been updated to reflect this.
- In terms of the indication. The following sentence has been included “methylphenidate treatment has been considered to be; inappropriate (e.g. patient choice and concerns about misappropriation of stimulants). The group agreed to remove the words “patient choice” from this section.
- Additional information regarding doses over 1.2mg/kg/daily or 80mg.
- Additional formulations which are on the market have been included under ‘route and formulation’.

The group agreed to approve the updated SCP for atomoxetine for ADHD once the recommended changes are made. The formulary team to include the updated SCP for atomoxetine for ADHD onto the BNSSG paediatric formulary once the recommended changes are made.

Action

1. The formulary team to include the updated SCP for atomoxetine for ADHD onto the BNSSG paediatric formulary once recommended changes are made.

HA advised there are some concerns with private prescribing and primary care taking over responsibility. For adult patients with ADHD there is a Locally Enhanced Service (LES), however for paediatrics there is no LES in place. This is also an issue for other clinical areas. It was agreed this is not directly a medicines issue but relates to problems with service capacity and waiting lists. The group agreed to discuss outside the meeting.

15 Potential NDRs for August / October Meeting (no paperwork, for information only)

- Trixeo Aerosphere for COPD
- Xonvea (doxylamine / pyridoxine) for nausea and vomiting in pregnancy
- Qutenza (capsaicin patch) for pain relief for diabetic neuropathy
- N-acetylcysteine with simethicone to improve visibility during endoscopy
- Ketamine (paeds) for management of acute behavioural disturbance.

16 AOB

Lisdexamfetamine – ADHD Shortages

DC advised there have been concerns from primary care following the National Safety Alert around ADHD medicines shortages. The concerns are regarding primary care being asked to switch patients from lisdexamfetamine to dexamfetamine during this shortage. There is a SCP in place and patients would usually be prescribed 3 months supply by the specialist before the patient is referred to primary care. The group discussed whether the TLS should be changed to allow primary care to switch treatment during the current shortage. The group agreed to not change the TLS but allow primary care to switch adult patients in line with locally agreed guidance without the need for the secondary care to prescribe the first 3 months for existing patients. It was agreed that clear guidance and access to support is required to support primary care to manage this temporary switch safely during this difficult period. It was also agreed that access to advice and guidance / email advice is required to support primary care with any concerns and issues regarding clinical care. The group discussed the need for follow-up to ensure patients are switched back to lisdexamfetamine when the stock shortage is resolved.

The group agreed primary care can complete this short-term switch for adult patients with access to clear guidance and support if required. Further conversations including how to manage switches for children will take place at the ADHD Shortages Safety Working Group.

Post Meeting Note 24/10/2023

ICB Formulary Team have been advised that primary care may also be asked to switch patients from lisdexamfetamine to methylphenidate as a second line option to dexamfetamine where dexamfetamine is not suitable. A BNSSG guideline has been developed and approved by the ADHD Shortages Safety Working Group to support primary care to undertake this switch. The guideline has been made available on the formulary website. Primary care can also access email support from secondary care if any concerns and issues arise.

Ketorolac Injection

AD advised ketorolac injection is TLS amber under the pain chapter and TLS red under general anaesthesia on the paediatric BNSSG formulary. The group agreed to change ketorolac injection to TLS red in all chapters on the BNSSG paediatric formulary.

Action

1. The formulary team to change ketorolac injections from TLS amber to TLS red in all formulary chapters on the BNSSG paediatric formulary.

XXXX/XXXX/XXXX
October 2023

Date of Meeting	Time	Venue
~~Tuesday 31st January Adults only~~	~~13:00-16:00~~	~~Microsoft Teams~~
~~Tuesday 21st March Adult and Paediatrics~~	~~09:30 – 13:30~~	~~Microsoft Teams~~
~~Tuesday 9th May Adults only~~	~~13:00-16:00~~	~~Microsoft Teams~~
~~Tuesday 27th June Adults & Paediatrics~~	~~09:30 – 13:30~~	~~Microsoft Teams~~
~~Tuesday 29th August Adults only~~	~~13:00-16:00~~	~~Microsoft Teams~~
~~Tuesday 17th October Adult & Paediatrics~~	~~09:30 – 13:30~~	~~Microsoft Teams~~
Tuesday 12th December Adults only	13:00-16:00	Microsoft Teams

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

BNSSG Joint Formulary Group Meeting – Adults

Meeting Held on: Tuesday 12th December 2023
Time: 13:00 – 16:00
Venue: Virtual – Microsoft Teams

Minutes

Present:

XXXX	DC	Chief Pharmacist, BNSSG, ICB
XXXX (Minutes)	AW	Team Administrator & Minute Taker, BNSSG, ICB
XXXX	SBe	Principal Medicines Optimisation Pharmacist, BNSSG, ICB
XXXX	AD	Interface Pharmacist, BNSSG ICB
XXXX	HA	Interface Pharmacist, BNSSG, ICB
XXXX	ERP	Consultant Pharmacist, Rheumatology, NBT
XXXX	KJ	Formulary Pharmacist, NBT
XXXX	JW	Clinical Pharmacy Manager, UHBW
XXXX	LC	Consultant Neurologist & Neurophysiologist, NBT
XXXX	RJ	Medicines Optimisation Pharmacist, BNSSG, ICB
XXXX	DR	Medicines Optimisation Pharmacist, BNSSG, ICB
XXXX	LS	GP Trainee, BNSSG, ICB
XXXX	CRN	Pharmacist, NBT
XXXX	BB	GPCB Clinical Lead, BNSSG ICB & OneCare
XXXX	EH	GP trainer, BNSSG ICB
XXXX	GI	Deputy Chief Medical Officer, Primary and Community Care, BNSSG, ICB
XXXX	PG	GP and Clinical Lead in Exceptional Funding and Policy Development

Apologies:

XXXX	ACD	High Cost Drugs Technician, BNSSG, ICB

Applicants:

XXXX	CL	Gynaecology Registrar, NBT
XXXX	CB	Gynaecology Consultant, NBT
XXXX	JD	ST6 in Anaesthetics, NBT
XXXX	HS	Respiratory Specialist Pharmacist, NBT
XXXX	RB	Specialist Nurse Practitioner Respiratory, BNSSG, Pier Health Group
XXXX	ZZ	Consultant Gastroenterologist, NBT
XXXX	SP	Renal and Transplant Specialist Pharmacist, NBT
XXXX	SS	Medicines Optimisation Pharmacist, AWP

1 Welcome and Apologies

DC opened the meeting as chair. Introductions were made and apologies were noted as above. The meeting today was quorate. There were no declarations of interest recorded.

2 Minutes of the Previous Meeting from Tuesday 17th October 2023 and Matters arising

The minutes of the previous Joint Formulary meeting from Tuesday 17th October 2023 were reviewed. These were agreed to be an accurate reflection of the meeting, with no amendments to be made.

3 Joint Formulary Group Adults Action Log –

Ref 31.5 - Melatonin – NDR – *The Formulary team to proceed with work required to seek financial approval for option 3 to be added to the adult and paediatric formulary. Option 3 to remain non-formulary until financial approval gained.*

- The formulary team have received AWPs updated numbers. The finance draft paper is nearly complete. Action ongoing.

Ref 31.6 - Melatonin – NDR – *Formulary team to add to formulary as TLS Amber 3 months once financial approval and SCP protocol including review criteria is agreed.*

- The formulary team have received AWPs updated numbers. The finance draft paper is nearly complete. Action ongoing.

Ref 35.3 – Discontinuation of Insuman insulin SBAR – *The formulary team to remove all Insuman products from the BNSSG adult and paediatric formulary in May/June 2023 when supplies have been exhausted.*

- The formulary team advised one strength is out of stock and will be reviewing other strengths before updating the BNSSG adult formulary. Action ongoing.

Ref 37.2 – Biologics – NDR – *The formulary team to include the biologics (adalimumab, infliximab, etanercept, tildrakizumab, certolizumab, Risankizumab, Guselkumab, Brodalumab, Ixekizumab, Secukinumab, Bimekizumab, Ustekinumab) and apremilast for severe psoriasis at localised, high impact sites onto the BNSSG adult formulary as TLS red for use in line with the BNSSG psoriasis biologics pathway once financial approval has been reached.*

- The formulary team formulary have updated the BNSSG adult formulary. Action can close.

Ref 37.4 – Biologics – NDR – *The formulary team to work with the applicant to update the BNSSG psoriasis biologics pathway to include clear criteria for use in this cohort and outcome measures similar to the SE London pathway including that use should only continue in patients where a 50% improvement in disease score is seen.*

- The formulary team advised the pathway has been developed and is on the BNSSG formulary website. Action can close.

Ref 37.5 – Biologics – NDR – *The formulary team to request that ACD/UHBW develop Blueteq forms for Dermatology to use for biologics and apremilast for this patient cohort.*

- The formulary team confirmed the Blueteq forms have been approved. Action can close.

Ref 39.7 – Amiodarone – TLS – *The formulary team to arrange meeting to discuss amiodarone with secondary care Cardiology consultants. Secondary care to support with identifying the appropriate consultants to liaise with.*

- The formulary team advised a meeting took place with the cardiology consultants and GPs. It was suggested that the delegated phlebotomy LES could support with some of the concerns around monitoring feasibility in secondary care and it was agreed that this issue needs escalating to the

medical directors of the Trusts and Chief Pharmacists. XXXX will discuss further with BNSSG ICB Chief Medical Officer outside the meeting. Action ongoing.

Ref 39.8 – SCP Review Update – *The formulary team to update the BNSSG formulary with the agreed recommendations following the Shared Care Review working group.*

- The formulary team advised the BNSSG adult formulary has been updated, expect Sodium Valproate due to further work required. Action ongoing.

Ref 39.9 – Droperidol – NDR – *The formulary team to include Droperidol as an option for the management of acute behavioural disturbance in the Emergency Department onto the BNSSG adult formulary as TLS red.*

- The formulary team have updated the BNSSG adult formulary. Action can close.

Ref 40 – Bijuve – NDR – *The formulary team to include Bijuve as a second line treatment option and an alternative to Femoston-Conti when first line HRT treatments have not been tolerated / are not suitable as TLS green onto the BNSSG adult formulary.*

- The formulary team have updated the BNSSG adult formulary. Action can close.

Ref 40.1 – SCP Review Working Group Update – *The formulary team to remove testosterone oral (including m/r) for male hypogonadism from the BNSSG adult formulary.*

- The formulary team have updated the BNSSG adult formulary. Action can close.

Ref 40.2 – SCP Review Working Group Update – *The formulary team to change the TLS for danazol for hereditary angioedema from TLS amber to TLS amber specialist initiated on the BNSSG adult formulary.*

- The formulary team have updated the BNSSG adult formulary. Action can close.

Ref 40.3 – SCP Review Working Group Update – *The formulary team to change the TLS for rivaroxaban with antiplatelets from TLS amber 1/3 months to amber specialist recommended on the BNSSG adult formulary and to develop a short guideline including prescribing considerations - risks, benefits and safety concerns on the use of DOACs in combination with antiplatelets.*

- The formulary team are awaiting the development of DOAC with antiplatelet guideline before changing the TLS and removing the SCP from the formulary page. Action ongoing.

Ref 40.4 – Aklief – NDR – *The formulary team to include Aklief (Trifarotene 50micrograms/g cream) for treatment of acne onto the adult and paediatric formulary as TLS green.*

- The formulary team have updated the BNSSG adult formulary. Action can close.

Ref 40.5 – Aklief – NDR – *The formulary team to request that the applicant and XXXX update the BNSSG Antimicrobial Stewardship Guideline to include Aklief.*

- The formulary team have informed XXXX and the applicant the BNSSG Antimicrobial Stewardship Guideline will need updating. Action can close.

Ref 40.6 – Aklief – NDR – *The formulary team to request that the applicant and XXXX work with the Remedy Team to update the Remedy Acne page to reflect these changes.*

- The formulary team have informed XXXX and the applicant to work with the Remedy team regarding the Acne page. Action can close.

Ref 40.7 – Doublebase Once emollient – NDR – *The formulary team to inform the applicant of the decision to not include Doublebase Once emollient for treatment of eczema, psoriasis and dermatitis onto the BNSSG adult and paediatric formulary.*

- The formulary team have updated the decision page and advised the applicant of the Joint Formulary Group decision. Action can close.

Ref 40.8 – Adex gel emollient – NDR – *The formulary team to inform the applicant of the decision to not include Adex gel emollient for treatment of eczema, psoriasis and dermatitis onto the BNSSG adult and paediatric formulary at the current time and to offer an opportunity present further evidence of benefit in a defined cohort at a later meeting.*

- The formulary team have updated the decision page and advised the applicant of the Joint Formulary Group decision. Action can close.

4 NICE New Technology Appraisals

NICE New Technology Appraisals published since October 2023 – For information only. *Will be included in the BNSSG Joint Formulary once Implementation plans have been submitted and agreed within NICE TA Review Group*

NICE TA and HST		Commissioner	TLS
TA915	Pegunigalsidase alfa for treating Fabry disease	NHSE	Red
TA916	Bimekizumab for treating active psoriatic arthritis	ICB	Red
TA918	Bimekizumab for treating axial spondyloarthritis	ICB	Red
TA927	Glofitamab for treating relapsed or refractory diffuse large B-cell lymphoma after 2 or more systemic treatments	NHSE	Red
TA919	Rimegepant for treating migraine	ICB	TBC
TA920	Tofacitinib for treating active ankylosing spondylitis	ICB	Red
TA921	Ruxolitinib for treating polycythaemia vera	NHSE	Red
TA922	Daridorexant for treating long-term insomnia	ICB	TBC
TA923	Tabelecleucel for treating post-transplant lymphoproliferative disorder caused by the Epstein-Barr virus (terminated appraisal)	Terminated appraisal	
TA917	Daratumumab with lenalidomide and dexamethasone for untreated multiple myeloma when a stem cell transplant is unsuitable	NHSE	Red
TA924	Tirzepatide for treating type 2 diabetes	ICB	Green
TA925	Mirikizumab for treating moderately to severely active ulcerative colitis	ICB	Red
TA926	Baricitinib for treating severe alopecia areata (Not recommended)	Not recommended	
TA928	Cabozantinib for previously treated advanced differentiated thyroid cancer unsuitable for or refractory to radioactive iodine (Not recommended)	Not recommended	
TA929	Empagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction	ICB	TLS Amber specialist recommended
TA930	Lutetium-177 vipivotide tetraxetan for treating PSMA-positive hormone-relapsed metastatic prostate cancer after 2 or more treatments (Not recommended)	Not recommended	
TA931	Zanubrutinib for treating chronic lymphocytic leukaemia	NHSE	Red
TA932	Decitabine–cedazuridine for untreated acute myeloid leukaemia when intensive chemotherapy is unsuitable (terminated appraisal)	Terminated appraisal	
TA934	Foslevodopa–foscarbidopa for treating advanced Parkinson's with motor symptoms	NHSE	Red
TA933	Tisagenlecleucel for treating relapsed or refractory diffuse large B-cell lymphoma after 2 or more systemic therapies (terminated appraisal)	Terminated appraisal	
TA936	Idecabtagene vicleucel for treating relapsed and refractory multiple myeloma after 3 or more treatments (terminated appraisal)	Terminated appraisal	

Empagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction

AD advised Empagliflozin has been included onto the BNSSG adult formulary as TLS amber specialist recommended which is in line with Dapagliflozin.

Tirzepatide for treating type 2 diabetes

The Diabetes Specialist Pharmacist, BNSSG, ICB has advised Tirzepatide should be TLS blue. The formulary team confirmed this has been updated on the BNSSG adult formulary website.

5 New Drug Requests (NDRs) – Adults

Doxylamine succinate/pyridoxine hydrochloride (Xonvea) for treatment of nausea and vomiting in women aged 18 years or over who do not respond to conservative management, *XXXX, NBT Gynaecology Registrar and XXXX, Consultant, North Bristol Trust*

Discussion

DR presented the new drug request for Doxylamine succinate/pyridoxine hydrochloride (Xonvea) oral tablet for treatment of nausea and vomiting in pregnant women aged 18 years or over who do not respond to conservative management. The application is to propose Xonvea to be a third-line treatment option after traditional antiemetic therapy has failed.

Xonvea offers an option specifically licensed to treat nausea and vomiting in pregnancy (NVP) where conservative management has failed. Some antihistamines and phenothiazines are licensed for treating nausea and vomiting, but they are not specifically indicated for treating NVP. They also carry warnings about use in pregnancy that may alarm some women if they have not been counselled. As Xonvea has a specific licensed indication for NVP, the MHRA has advised that the use of any other medicine that does not have an indication in NVP over Xonvea would need to be justified. The current RCOG (Royal College of Obstetricians and Gynaecologists) guidelines predate Xonvea availability in the UK but it is included first line alongside other antihistamines in the draft RCOG guidelines. This is based on the safety profile of Xonvea for pregnant women.

In terms of other ICB formularies. Xonvea is non-formulary in all South West ICBs with the exception of BaNES, Swindon & Wiltshire (BSW) formulary, which have recently (November 2023) approved Xonvea as TLS green as a second line option after first line treatments with either/both cyclizine and prochlorperazine. South East London Joint Medicines Formulary approved Xonvea in March 2022 as TLS amber initiation and first prescription from the specialist team (time limited approval for 12 months) as third-line option (after trailing at last 2 regular antiemetics) for the management of NVP. In regards to cost, Xonvea is £28.50 (pack of 20 tablets/vials) which is roughly £159.60 per month if taking 4 tablets a day. The estimated annual cost for 569 anticipated patients likely to receive treatment within UHBW and NT is approximately £68,109 - £136,219 based on a 2-4 tablets daily dose and 6 weeks treatment duration. Conversely, the NICE ES20 budget impact template suggests that introduction of Xonvea in BNSSG would be associated with an annual resource impact of £13,505. This assumption is based on 120 patients prescribed Xonvea at a dose of 2 tablets a day. It is not clear whether the anticipated patient cohort of 569 is an over or underestimate, making estimating resource impact difficult. EPACT2 data shows that in the financial year 2022/2023, Xonvea was prescribed 66 times in BNSSG with treatment periods ranging from 5-22 days (based on a dose of 4 tablets per day). The Xonvea treatment cost is considerably more expensive than other antiemetic options. This additional cost of £68,109 - £136,219 would be considered worthwhile if it is able to offset a minimum of 172 hospital admissions or 470 outpatient appointments (average cost of an in-patient admission for NVP is £793 or £290 for outpatient management). The NICE ES20 for Xonvea and the corresponding budget impact report does not display evidence to support that prescribing Xonvea can offset admissions to secondary care. Additionally, several joint formularies across the UK do not approve of the use of Xonvea due to insufficient cost-effectiveness data.

In terms of safety. The safety profile of doxylamine 10mg/pyridoxine 10mg fixed dose combination is well established. A large amount of data on pregnant women indicates no malformities nor feto/neonatal toxicity of doxylamine/pyridoxine and the previously described trials did not raise new or unexpected safety concerns. Clinical trial experience demonstrated the most common adverse reactions of Xonvea (at least 1 in 100) to be somnolence, dizziness, dry mouth and fatigue. In regards to evidence. The quality of the evidence

is low and although doxylamine/pyridoxine appears to be more effective at relieving symptoms of NVP than placebo, further larger, well-conducted trials are required to test the effectiveness of Xonvea compared with other treatment options.

CL and CB joined the meeting to present the new drug request in further detail. CL advised the current guideline states patients with a PUQE score of >14 on omeprazole and 2 other anti-emetics and 1/300 pregnant women suffer from high premises and the aim is to make an outpatient management a priority. Patients are transferred without any trial of oral agents or on a single agent. The aim is to improve guidance to GPs and patients. There are 288 hyperemesis admissions in NBT per year (2022) and there were 283 in 2021. The average length of stay is just over 1 day. CL advised Xonvea will be third-line treatment and will be initiated in secondary care only and once the patient is on a stable does this can be prescribed/continued in primary care. The dosage is two tablets once daily for 2 days (preferably at bedtime). This can then be increased to 1 tablet OM and 2 tablets ON then if necessary up to 1 tablet OM, 1 tablet lunch and then 2 tablets ON. CL advised a survey of 5000 women with HG 4.9% of women terminated a wanted pregnancy because of suffering from HG, while 52.1% women has considered termination. Hyperemesis effects women with a risk factor of maternal depression and for IUGR (Intrauterine growth restriction) and will be followed up with growth scans in ANC. In terms of patient numbers. CB advised patients who present in hospital will only be on one agent or potentially none. CB advised patients will try either a single or combination trial of cyclizine and stemetil before considering Xonvea.

Decision Criteria used by JFG for NDR

- **Patient safety –** Xonvea is licensed for NVP in women (aged 18 years or older) who do not respond to conservative management. The safety profile of doxylamine 10 mg/pyridoxine 10 mg fixed dose combination is well-established in pregnancy.
- **Clinical effectiveness –** The efficacy of doxylamine/pyridoxine for the treatment of NVP was demonstrated by the Koren et al. (2010) and despite the improvement difference being small compared to the placebo arm, this was still considered statistically significant with a potentially significant impact for pregnant women in clinical settings. In addition, the DESI study provides sufficient evidence to support the clinical contribution of both components in the fixed dose doxylamine/pyridoxine combination. Overall evidence from clinical trials and current clinical use sufficiently supports the efficacy of doxylamine/pyridoxine for the treatment of NVP in women who do not respond to conservative management.
- **Strength of evidence –** The Koren et al. (2010) trial had some limitations for instance a short duration of the trial (15 days), while NVP can last for longer. The PUQE symptom and wellbeing scores were subjective with no indication of what is considered an important difference clinically. The questioned methods and results of the trial were re-analysed by the MHRA during the licensing process using a different method for handling missing data, the results were consistent with the primary results and the MHRA concluded that the difference was small but can be translated in practice to a reduction of symptoms from 3 hours with placebo to 1 hour with doxylamine/pyridoxine, which is considered clinically meaningful for pregnant women. The DESI study had more important limitations as the final results of the study were never published. Besides, the formulation of doxylamine/pyridoxine used in the trial was different to Xonvea. However, this study has clearly shown the important contribution of both components in doxylamine/pyridoxine in the clinical effect in NVP. Both trials had no active treatment comparator arm(s) and there are no other trials available comparing doxylamine/pyridoxine to other currently prescribed treatments for NVP within the scope of this application. Overall, the quality of the evidence is low and although doxylamine/pyridoxine appears to be more effective at relieving symptoms of NVP than placebo, further larger, well-conducted trials are required to test the effectiveness of Xonvea compared with other treatment options.
- **Cost effectiveness or resource impact –** Xonvea is significantly more expensive than currently used antiemetics to treat NVP. Its use should be restricted to a small cohort of patients that do not respond to currently available treatment options. Cost impact of this intervention is difficult to estimate. Impact on admissions may need to be evaluated after a trial period in order to confirm that adding Xonvea to the treatment options will reduce admissions.
- **Place in therapy relative to available treatments –** Antihistamines and phenothiazines are being used as first-line options in clinical practice to treat NVP without a license. Their use is not considered off-label by the MHRA as it is not explicitly contraindicated in pregnancy but rather cautioned. Xonvea is the first drug to be licensed for use specifically for NVP and its delayed action permits the night-time dose to be effective the following morning, when it is most needed. This will make it a favourable option for some patients and prescribers. However, the associated high cost and lack of evidence to compare efficacy with first-line antiemetics can justify reserving Xonvea for patients that have failed other treatment options.

- **National guidance and priorities –** The RCOG guidelines predate Xonvea availability in the UK. Included first line alongside other antihistamines in draft RCOG guidelines.
- **Local health priorities –** Medium priority to system
- **Equity of access –** The use of Xonvea is not recommended in most formularies in England as well as Wales and Scotland. However, it has been approved in a few formularies with a number of statuses ranging from Red to Green.
- **Environmental Impact/Sustainability –** N/A
- **Other considerations –** N/A

Conclusion
The group considered the application, the evidence and the information submitted. The group acknowledged the importance of improving management of NVP in primary care and recommended further work take place to improve existing guidelines available locally on Remedy and promote them to colleagues. It was agreed to approve Xonvea on the formulary as TLS amber specialist initiated as a third line option where patients do not respond to conservative management, with clear criteria for use. It was recommended that the position on the formulary could be re-reviewed in 12 months' time once experience of use is gained and local data collected.

In terms of divisional financial sign off, NBT have confirmed funding for the first month of the patient's treatment and it is anticipated that primary care would cover the remaining costs. JW agreed to check the financial sign off with UHBW Women's and Childrens Divisional Management.

Action
1. The formulary team to include Doxylamine succinate/pyridoxine hydrochloride (Xonvea) for treatment of nausea and vomiting in women aged 18 years or over who do not respond to conservative management as a third line option onto the BNSSG adult formulary as TLS amber specialist initiated in line with clear criteria.
2. Formulary team to request applicants update the pathway for NVP management.
3. Applicants to collect local outcome data for re-review in 12 months.
4. JW to confirm financial sign off with UHBW Women's and Children's Divisional Management.

Capsaicin (Qutenza) 179mg patch for pain relief in diabetic neuropathy, *XXXX, Pain Clinic, Consultant, North Bristol Trust.*

Discussion
JD presented the new drug request application for Capsaicin (Qutenza) 179mg patch for pain relief in diabetic neuropathy. Qutenza is currently used for a range of conditions where allodynia is a feature. When Qutenza was originally included onto the BNSSG adult formulary it was not licensed for Diabetic Neuropathy. However, since then Qutenza is now licensed for pain relief used in Diabetic Neuropathy.

JD advised diabetic neuropathy is difficult to treat. Patients who are referred to the pain clinic would have tried alternative neuropathic agents such as amitriptyline, duloxetine and pregabalin but have gained insufficient benefit or be unable to tolerate side effects. Qutenza patches are a stronger formulation of capsaicin and need to be administered at the pain clinic by a trained member of the nursing team following specific protocols. The patient is referred to the Qutenza Clinic nurses for pre-assessment and a treatment plan. Patients would receive 2-3 treatments before deciding whether treatment is effective. Eight weeks after each treatment, patients receive a follow-up phone call to assess their response to treatment. Pain scores are recorded at each appointment and at the telephone follow-up. Successful treatment is noted when patients report relief of symptoms in their narrative and/or in their pain scores. If, after 2-3 initial treatments, pain symptoms are not relieved, patients stop treatment.

Qutenza treatments may be repeated every 90 days, as warranted by the persistence or return of pain. The anticipated number of patients likely to receive treatment within BNSSG is 22 (12 UHBW and 10 NBT). The figures from UHBW are based on the previous 12 months which also include non-diabetic patients as UHBW are already using for this indication. In regards to cost, Qutenza is £252 per patch. The cost for 5 patients having one patch per treatment 4 times a year would be £5,040.00. The cost for 5 patients having two patches per treatment 4 times a year would be £10,080.00. Compared to other formulary options, Qutenza patches are more expensive. However, Qutenza is being used as a last resort. The applicant suggests the use of Qutenza patches might enable a reduction of other oral treatment options.

In regards to other ICB formularies. NHS Somerset classify Qutenza (capsaicin cutaneous patch) as TLS red for the treatment of peripheral neuropathic pain in adults either alone or in combination with other medicinal products for the treatment of pain and black (not recommended) for other indications as per traffic light guidance. Devon have included as TLS ref only for non-diabetic patients. Hampshire and Isle of Wight have included only for post herpetic neuralgia where other pain relief is inadequate. Oxford do not recommend for use in peripheral neuropathic pain in non-diabetic patients due to the lack of clinical and cost effectiveness data.

In terms of efficacy and clinical effectiveness. A meta-analysis considered 25 randomised controlled trials. The meta-analysis suggests that the efficacy observed with the capsaicin 8% patch is similar to that observed with oral agents (i.e. pregabalin, duloxetine, gabapentin) in patients with painful diabetic peripheral neuropathy. The oral agents were associated with a significantly elevated risk of somnolence, dizziness, fatigue, and discontinuation because of adverse effects compared with placebo (none of these events was reported in association with the capsaicin 8% patch). Qutenza is recommended by NICE within the Neuropathic pain in adults: pharmacological management in non-specialist settings clinical guideline as an option to be prescribed by a specialist.

Decision Criteria used by JFG for NDR

- **Patient safety –** Patients can experience burning pain and localized redness when a capsaicin-containing patch is topically applied (from Qutenza SPC). Large studies have shown that no loss of sensory perception, testing of sharp, warm, cold and vibration stimuli was found with capsaicin applied topically (Vinek et al. 2016). There is a lower risk of systemic side effects compared with oral agents for neuropathy such as pregabalin or duloxetine.
- **Clinical effectiveness –** High-concentration topical capsaicin works well in a small proportion of people with various forms of neuropathic pain, although the evidence is not of the highest quality due to use of subjective outcomes for pain reduction. The problem is that there is no way of knowing in whom the therapy will work before using it, and there is little evidence about efficacy in repeated dosing, which is needed in chronic pain conditions.
  The meta-analysis suggests that the efficacy observed with the capsaicin 8% patch is similar to that observed with oral agents (i.e., pregabalin, duloxetine, gabapentin) in patients with painful diabetic peripheral neuropathy. This therapy would probably be tried only after other therapies had been shown not to work. Ongoing use is only worthwhile in people with demonstrably high levels of pain intensity reduction. Applicants advised that patients would be regularly reviewed and the treatment will be stopped if ineffective.
- **Strength of evidence –** Two large meta-analyses (including Cochrane) show that capsaicin 8% is as effective as oral treatments for the management of painful diabetic neuropathy.
- **Cost effectiveness or resource impact –** Capsaicin 8% are more expensive than first line options but this is for patients who not respond adequately to these treatments. If pain controlled and patient quality of life improved could reduce need for systemic agents (anti neuropathics, NSAIDs, opioids) and would be expected to reduce GP and other health care professional contact/ appointments.
- **Place in therapy relative to available treatments** – As this is used within Pain Clinic, patients would have tried other first-line agents
- **National guidance and priorities –** Listed as an option for recommendation for neuropathic pain (NICE CG173)
- **Local health priorities –** Pain Clinic would like this as an option for their diabetic patients
- **Equity of access –** On formulary for non-diabetic indications locally
- **Environmental Impact/Sustainability - The** active substance of this medicinal product, capsaicin is a natural substance (found in chilli peppers), the CHMP agreed that an update to the environmental risk assessment is not necessary.
- **Other considerations –** Only used in Pain Clinic

Conclusion

The group considered the application, the evidence and the information submitted. The group agreed to include Capsaicin (Qutenza) 179mg patch onto the BNSSG adult formulary for pain relief in diabetic neuropathy as TLS red.

Action

1. The formulary team to include Capsaicin (Qutenza) 179mg patch onto the BNSSG adult formulary for pain relief in diabetic neuropathy for use in pain clinic only as TLS red.

Trixeo Aerosphere (formoterol, budesonide, glycopyrronium) pressurised inhalation suspension for adults with moderate to severe COPD, *XXXX, CNS Respiratory, North Bristol Trust.*

Discussion

HS and RB presented the new drug request for Trixeo Aerosphere (formoterol, budesonide, glycopyrronium) pressurised inhalation suspension for adults with moderate to severe COPD. Trixeo Aerosphere is indicated as a maintenance treatment in adult patients with moderate-to-severe COPD who are not adequately treated by a combination of an ICS and a LABA or combination of a LABA and a LAMA.

The addition of Trixeo will provide an additional triple therapy MDI option for patients and clinicians, where a DPI or Trimbow is not tolerated/clinically appropriate. Unlike the currently listed other triple pMDI device (Trimbow), the Aerosphere Co-suspension delivery technology is also available in a dual bronchodilator inhaler, Bevespi (already on BNSSG formulary) and therefore provides device consistency for step up and step down between LABA/LAMA and ICS/LABA/LAMA therapy.

The anticipated number of patients likely to receive treatment within BNSSG are 250 (year 1), 500 (year 2), 700 (year 3), and 1000 (year 4 and 5). In terms of cost. Trixeo is £44.50 for 120 actuations (30 days). Trixeo is identically priced to the other triple therapy inhalers already included on the BNSSG formulary. Trixeo offers cost-benefits of approx. £15/month, compared with separate prescribing, for those patients for whom LABA/LAMA/ICS is indicated.

In terms of other ICB formularies. BSW have approved Trixeo as TLS green, Gloucester has approved as an alternative to Trelegy and Trimbow and Somerset ICB have included as TLS green. Trixeo is not included on Devon ICBs formulary. In regards to environmental impact and sustainability. Compared to Trimbow MDI, the carbon impact of Trixeo Aerosphere is 703 gCO_2e less per inhaler. Trixeo Aerosphere does not require refrigeration storage/refrigerated transportation.

Decision Criteria used by JFG for NDR

- **Patient safety –** Safety profile consistent with the individual components of the triple inhaler.
- **Clinical effectiveness – Trixeo** shown to be effective compared to dual therapies for moderate to severe COPD.
- **Strength of evidence – Good** RCTs, multicentre, active comparators, 24-52 week duration, however no studies available to compare efficacy between other triple inhalers. A network meta-analysis was conducted to compare the relative efficacy, safety and tolerability of Trixeo to comparator triple inhaler therapies and Trixeo was deemed comparable.
- **Cost effectiveness or resource impact –** Cost neutral. Same price as other triple inhalers. In line with the other triple inhalers, Trixeo offers cost-benefits of approx. £15/month, compared with separate prescribing, for those patients for whom LABA/LAMA/ICS is indicated.
- **Place in therapy relative to available treatments –** Available as an alternative triple inhaler, in particular for those patients who are unable to use a DPI or where it is clinically inappropriate.
- **National guidance and priorities –** National guideline does not specify inhaler device or brand
- **Local health priorities –** Provide another device option for patients
- **Equity of access –** Included on other formularies (and within the region).
- **Environmental impact/Sustainability –** A DPI triple inhaler remains the preferred more carbon efficient inhaler, but Trixeo could be a suitable option for patients prescribed alternatives. Compared to Trimbow MDI, the carbon impact of Trixeo Aerosphere is 703 gCO_2e less per inhaler.
- **Other considerations –** Applicant requesting TLS Green. Bevespi aerosphere is included on the formulary, trixeo could provide a step up option for these patients to aid consistency with inhaler devices.

Conclusion

The group considered the application, the evidence and the information submitted. The group agreed to include Trixeo Aerosphere (formoterol, budesonide, glycopyrronium) pressurised inhalation suspension for adults with moderate to severe COPD onto the BNSSG adult formulary as TLS green in line with the traffic light status of other triple inhalers on the BNSSG adult formulary for COPD.

Action

1. The formulary team to include Trixeo Aerosphere (formoterol, budesonide, glycopyrronium) pressurised inhalation suspension for adults with moderate to severe COPD onto the BNSSG adult formulary as TLS green.

Aerochamber Plus Flow-Vu anti-static chamber, *XXXX, CNS Respiratory, North Bristol Trust.*

Discussion
HS and RB presented the new drug request for Aerochamber Plus Flow-Vu anti-static chamber. AeroChamber Plus Flow-Vu is a new version of the AeroChamber Plus spacer which is currently TLS green on the BNSSG formulary. The difference between formulation is that the Flow-Vu has a feedback mechanism that provides a visual indicator whose movement confirms correct inhalation technique. The Flow-Vu inspiratory flow indication only moves if a good seal is created between the lips and the mouthpiece (or between the facemask and the face).

The cost difference with the original Aerochamber plus is 1p without a mask and 3p with a mask. The additional cost of the AeroChamber Plus® Flow-Vu can be offset by health outcomes from the improved inhalation technique.

In terms of other ICB formularies. Dorset and Buckinghamshire formulary have included AeroChamber Plus Flow-Vu onto the formulary in addition to AeroChamber Plus. Berkshire West formulary, Hampshire and Isle of Wight, East Berkshire/Frimley formulary and Bedfordshire & Luton formulary have included AeroChamber Plus Flow-Vu onto their formulary as a replacement option.

Conclusion
The group considered the application, the evidence and the information submitted. The group agreed with the proposal to include Aerochamber Plus Flow-Vu anti-static onto the BNSSG adult formulary as TLS green. Following this decision, a wider discussion took place on how to list spacers on the formulary and agreed to include spacer devices generically, rather than maintaining an exhaustive list onto the BNSSG adult formulary. Instead, clinicians will be directed to prescribe the most appropriate and cost effective spacer for the patient.

Action
1. The formulary team to amend the BNSSG adult formulary to refer to spacers generically and direct clinicians to prescribe the most appropriate and cost effective spacer for the patient.

N-acetylcisteine (NAC) mixed with simeticone to improve mucosal visibility during upper GI endoscopy, *XXXX, Consultant Gastroenterologist, North Bristol Trust.*

Discussion
ZZ presented the new drug request application for N-acetylcisteine (NAC) mixed with simeticone to improve mucosal visibility during upper GI endoscopy. ZZ advised early detection of upper GI cancers is key to improving patient outcomes in those presenting with malignancies. There is a well-established miss rate for esophageal and gastric cancer in upper GI endoscopy. It is common for GI visualization to be reduced by the presence of mucus, hampering the identification of subtle abnormalities essential for diagnosis of GI conditions. The use of a mucolytic, such as N-acetylcysteine, and an anti-foaming agent e.g. simeticone, pre-procedure has been shown in studies to improve mucosal visibility during gastroscopy and is already being used in endoscopy centres within the UK, including Portsmouth University Hospitals NHS Trust. N-acetylcisteine would provide increased detection and management of upper GI conditions, including upper GI cancer, through improved image quality and lesion detectability.

There is currently no alternative treatment option on the BNSSG formulary. N-acetylcisteine would be used in all patients receiving an upper GI endoscopy to aid visualization. N-acetylcisteine is a stat drink to be given pre-upper GI endoscopy (50mls of water with 5ml NAC 1g and 60mg simeticone 1.5ml Infacol). There are no subsequent or baseline tests required.

The use of acetylcysteine injection orally in combination with simeticone during endoscopy is included on a number of formularies in England. BSW have included simeticone for use during endoscopic procedures as a defoaming agent and acetylcysteine injection (indication not specified). Hampshire and Isle of Wight have included simeticone for use during endoscopy and acetylcysteine injection (indication not specified). Sandwell Area have included Infacol and N acetylcysteine for mucosal cleansing (for use by endoscopy speciality). Cambridgeshire and Peterborough have included simethicone for restricted use in endoscopy only and acetylcysteine injection given orally for gastrointestinal endoscopy.

The anticipated number of patients likely to receive treatment within BNSSG is 6,000 per year. In regards to cost. Acetylcysteine 200mg/ml (10ml) x 10 is £15,300 for 6,000 patients per year. Simeticone 40mg/ml oral suspension sugar free (55ml) is £600 for 6,000 patents per year. The applicant advised the off-set costs include reduced number of patients needing repeat endoscopy as visualization would be improved. The chances of catching potentially cancerous tissue would be increased with better visualisation leading to earlier intervention and the associated benefits of that. In terms of efficacy and clinical effectiveness.

Decision Criteria used by JFG for NDR

- **Patient safety –** Safe use demonstrated in published literature. Has been associated with nausea, vomiting, bloating and abdominal pain. Acetylcysteine injection can be given orally.
- **Clinical effectiveness –** Premedication with simethicone plus N-acetylcysteine has been shown to improve mucosal visualisation, increase rate of findings, reduce need for flushing and lower flush volume required. In one study, improved visualisation was not replicated in post-procedure analysis of still images.
- **Strength of evidence –** Evidence from meta-analysis and RCTs. There is limited medium strength evidence to support use to improve visualisation of mucosa.
- **Cost effectiveness or resource impact – Additional** small cost to system.
- **Place in therapy relative to available treatments –** Add on to current endoscopy protocol to improve mucosal visibility.
- **National guidance and priorities –** Nil.
- **Local health priorities –** High priority to local clinicians to improve mucosal visibility and reduce cancer miss rate in upper GI endoscopy. Medium priority to system.
- **Equity of access –** Included on a number of formularies nationally including BSW.
- **Environmental Impact/Sustainability –** Nil.
- **Other considerations –** Off-label use of two medicines. Requires mixing of medicines prior to administration to create an unlicensed product. Protocol for use within endoscopy department is required.

Conclusion

The group considered the application, the evidence and the information submitted. The group agreed a protocol/guidance is required to support use within the Endoscopy department and should be shared across Trusts to ensure preparation is safe, consistent and appropriate. The group agreed to include N-acetylcisteine (NAC) mixed with simeticone onto the BNSSG adult formulary to improve mucosal visibility during upper GI endoscopy as TLS red, pending a protocol to support use.

Action

1. The formulary team to include N-acetylcisteine (NAC) mixed with simeticone onto the BNSSG adult formulary to improve mucosal visibility during upper GI endoscopy as TLS red, pending notification of development of protocol/guidance.
2. Formulary team to notify BNSSG ICB Cancer lead for information.

6 Shared Care Protocols/TLS Status – Adults

Traffic Light Status Request Change

Potassium binders for patients on a stable dose of potassium binder and RAASI drug: Sodium Zirconium TLS Change request form and Patiromer TLS Change request form

AD advised the sodium zirconium and Patiromer TLS change request form were discussed at a Joint Formulary Group meeting in April 2022. It was agreed for acute trusts to confirm specific monitoring recommendations and current patient numbers. The patient numbers provided were large as this included the potential cohort that may be in primary care that could benefit from being initiated on potassium binders.

The updated TLS change forms only contain patient numbers for the cohort of patients who are currently prescribed potassium binders by secondary care with an aim to transfer the stable patients to primary care with a TLS amber specialist initiated status, along with a guideline to support primary care. In terms of the revised patient numbers for this specific cohort, there are 20 patients within NBT renal clinic, 13 patients within NBT cardiology and 2 patients within UHBW cardiology for sodium zirconium. For patiromer there is 1 patient and they are not within the BNSSG area. The annual cost for sodium zirconium is £71,531.20 for this current patient cohort.

In terms of other ICB formularies, Gloucestershire have sodium zirconium as TLS amber specialist initiated with a shared care guideline and ongoing monitoring to be undertaken by primary care once the patient is on a stable dose. Pan Mersey and York and Scarborough also have sodium zirconium as TLS amber specialist initiated with a shared care guideline.

SP joined the meeting to discuss the TLS change request forms. SP advised patients being treated for the management of emergency hyperkalaemia (initial potassium above 6) will remain under the care of secondary care. Sodium zirconium cyclosilicate may allow people to stay on RAAS inhibitors (drugs used to treat heart failure and kidney disease) whom otherwise hyperkalaemia would have prevented this. Staying on these drugs may extend life and improve quality of life. Considering the benefit from more people being able to stay on RAAS inhibitors, the cost-effectiveness estimates for sodium zirconium cyclosilicate suggest that it is a good use of NHS resources. Therefore, it is recommended for treating confirmed persistent hyperkalaemia in outpatient care, for people who are not taking an optimised dose of RAAS inhibitors because of hyperkalaemia (NICE TA599). Patients are seen between 2-6 months at the renal or heart failure clinics meaning that it can take several years for a RASSi to reach maximum titration. The future aim is for primary care to either be able to initiate or titrate to enable quicker dose optimisation of RAASI therapies which is important for these patients to improve their renal and cardiovascular outcomes.

The group acknowledged the lack of familiarity with these drugs in primary care and potential risk without guidance. The group agreed clear guidance would be required to allow primary care to gain confidence in prescribing, monitoring and managing these drugs appropriately in primary care. The group felt that gaining familiarity with the specific cohort of patients already initiated and stabilised by secondary care would allow experience of use. The group acknowledged the longer-term ambition of the applicants and noted the potential wider cohort across BNSSG in primary care who may benefit from these drugs and recommended a phased approach to addressing this. At present, the group agreed an Amber Specialist Initiated status for patients who are already stabilised on treatment with potassium binder and RAASi drug, pending development of a system-wide guideline to support this. The group agreed the importance of clearly defining ‘stabilised’ to avoid ambiguity. Once the guideline is developed this would need to be approved at the Area Prescribing Medicines Optimisation Committee (APMOC). Once prescribing practice is established, the formulary position could be re-reviewed to explore primary care involvement in titrating and stabilising and potentially initiating these drugs in the future.

The group suggested further discussion take place to see whether the transfer of budget could take place from secondary care to primary care due to the financial impact on prescribing spend to primary care.

Action

1. The formulary team to work with applicants to facilitate development of guideline
2. DC to discuss transfer of budget from secondary care to primary care for potassium binders spend with Finance team

New SCPs
Nil

Updated SCPs.
Nil

7 Items for Discussion

Gepretix brand micronised progesterone capsules – request to add brand to formulary – verbal update
HA advised Gepretix is a new brand of micronised progesterone capsules which are equivalent to Utrogestan. Gepretix is £2 cheaper per box than Utrogestan and is a significant cost saving for primary care. The aim is to switch patients with ScriptSwitch to avoid supply issues. The group agreed to include Gepretix as the suggested brand of micronised progesterone capsules onto the BNSSG adult formulary.

Action

1. The formulary team to include Gepretix as the suggested brand of micronised progesterone capsules onto the BNSSG adult formulary.

BNSSG Formulary Chapter Review: Heart Failure and Vascular Disease (Adults)
AD presented the BNSSG formulary chapter review for Heart Failure and Vascular Disease (adults). The 'Cardiovascular chapter of the BNSSG Adult Formulary was due for review to ensure the chapter contents are still accurate and relevant. Due to the chapter size, the review process has taken place in smaller subsections. 2.5 Heart Failure and 2.9 Vascular disease have been reviewed. Secondary Care Specialists from UHBW and NBT provided comments on the chapter. Following the consultation period with Secondary Care, Primary Care colleagues were invited to provide comments on the chapter, along with the proposed changes from Secondary Care. There were 8 suggestions received as feedback from Secondary care and Primary care regarding the heart failure page. There were no changes suggested for the vascular disease page. The group discussed the changes below:

Spironolactone – There was a request to change from TLS blue to TLS green as this is a key medication for heart failure. The group agreed TLS blue is more appropriate as Spironolactone is not a first-line treatment option for heart failure. It was also felt to remain as TLS blue as it is available for prescribing in primary care for a specific cohort of patients. If a TLS change form was submitted the Joint Formulary Group agreed to review in further detail at a future meeting.

Eplerenone – There was a request to change from TLS amber specialist recommended to TLS blue for patients with heart failure who have had gynaecomastia or side effect such as taste disturbance with spironolactone. Eplerenone is more expensive therefore further information would be required to avoid clinicians prescribing as first-line. Comments from primary care also echoed the concern for clear guidance to avoid this being more widely prescribed first-line. The group agreed a TLS change form request would be required to review the cost implications and pathway of use.

Dapagliflozin and **Empagliflozin** – for heart failure patients with reduced ejection fraction. There was a request to change from TLS amber specialist recommended to TLS blue for this cohort. It was felt this would reduce delay for patients being referred to specialist services. The group agreed that although the drugs themselves do not present concerns, there are some factors to consider, such as support for GPs for this cohort of patients and NICE TA guidance which recommends dapagliflozin and empagliflozin should be initiated on advice of a heart failure specialist. The group agreed a TLS change form request would be required to review the benefits and concerns and to consider whether deviation from national guidance is justified locally.

Formulary website feedback – There was a request to review the formulary website and to link

dapagliflozin and empagliflozin in the heart failure guidelines under the drug entries so this is easier for GPs to locate all relevant guidelines.

Further discussions amongst the group took place regarding how to manage patients in primary care with suspected heart failure. This feedback will be shared with the team involved with updating the heart failure guidance.

NICE TA919 Rimegepant for treating migraine (Final Appraisal Document ID1539)

HA discussed the NICE TA919 for Rimegepant for treating migraine. Patients will not be seen in Secondary care. The recommended TLS is blue for a specific cohort of patients who have received two courses of triptans with failed treatment response. The group agreed a guideline will be required to support primary care. The group agreed to include Rimegepant for treating migraine as TLS blue onto the BNSSG adult formulary.

Action

1. The formulary team to include Rimegepant for treating migraine as TLS blue onto the BNSSG adult formulary.

NICE TA922 Daridorexant for treating long-term insomnia

HA discussed the NICE TA922 for Daridorexant for treating long-term insomnia. This is a new treatment option for long-term insomnia. NICE have positioned this after CBTI (Cognitive Behavioural Therapy for Insomnia). Patients will only be seen in Primary care. The recommended TLS is blue for a specific cohort of patients. The group agreed further work will be required to develop a pathway guidance to support Primary care. CBTI is not commissioned by BNSSG therefore the formulary team have provided feedback to Mental Health Teams regarding the commissioning aspect. The group agreed to include Daridorexant for treating long-term insomnia as TLS blue onto the BNSSG adult formulary for a specific cohort of patients.

Action

1. The formulary team to include Daridorexant for treating long-term insomnia as TLS blue onto the BNSSG adult formulary for a specific cohort of patients.

TLS Formulary changes- ketorolac injection and bupivacaine injections

Following a review of this page, the following changes were recommended:

Current TLS	Recommendation
TLS BLUE in Chapter 10.4. States 'For use by anaesthetic staff only' 10.4 Pain and inflammation in musculoskeletal disorders (Remedy BNSSG ICB)	Change to TLS Red as only to be used in hospital setting
TLS GREEN for periop analgesia 15.1 General Anaesthesia (Remedy BNSSG ICB)	Change to TLS Red as only to be used in hospital setting
TLS RED for palliative care 16.1 Pain due to cancer in adults- Palliative Care (Remedy BNSSG ICB) but says under specialist advice only	Consider change to TLS Amber specialist recommended (for rare cases)

Bupivacaine 0.1%/fentanyl 5 micrograms/ml infusion is TLS red on the BNSSG paediatric formulary but TLS green on the BNSSG adult formulary. It was recommended changing to TLS red on the BNSSG adult formulary for consistency. The group agreed to change the below bupivacaine treatment options on the BNSSG adult formulary from TLS green to TLS red for local anaesthesia:

- Bupivacaine 0.25% & 0.5% injection
- Bupivacaine 5mg / Glucose 80mg/mL injection
- Bupivacaine 0.25% / Adrenaline 1 in 200,000 injection
- Bupivacaine 0.5% / Adrenaline 1 in 200,000 injection
- Bupivacaine 0.1% for epidural infusion
- Bupivacaine 0.1% / Fentanyl 2micrograms/mL

Post JFG Meeting note: The group discussed whether this changes affected any PGDs and it has been confirmed this would not.

Action

1. The formulary team to change the recommended TLS for Ketorolac injection and Bupivacaine injections on the BNSSG adult formulary.

SCP template for mental health drugs

HA presented the SCP template for mental health drugs to the group. BNSSG use two different SCP templates which are a BNSSG only template and a BNSSG/BSW combined template for two mental health drugs to align practice across both ICS areas covered by AWP. NHS England have published national SCPs however the Joint Formulary Group have previously agreed not to use these as they were lengthy documents.

The SCP review working group is currently reviewing all SCPs and will look at the NHS England SCPs on a case-by-case basis to agree if suitable for use. It is hoped where possible to use the content of the NHS England SCPs even if the template is not used. The group reviewed the options to ensure there is a consistent approach for SCPs use across BNSSG.

For sodium valproate, naltrexone, typical antipsychotic depot injections and melatonin where there is not an NHS England template available, the group agreed to use the BNSSG template.

When SCPs are due for review the Joint Formulary Group agreed to consider use of the NHS England template for guanfacine and lithium to facilitate continued collaboration with BSW. The group agreed to use the current combined BNSSG/BSW template for the ADHD stimulant/atomoxetine SCP and to use the content of the NHS England SCP when possible.

8 AOB

Change iron isomaltoside 1000 to ferric derisomaltose

HA advised Iron Isomaltoside 1000 has changed its name to ferric derisomaltose. The formulary team have changed the name on the BNSSG formulary website.

Removal of Cilest brand off formulary (discontinued)

The formulary team have removed Cilest brand from the BNSSG formulary as this is now discontinued. The formulary team advised in February 2024 a review will take place to list new options for recommended brands, in the meantime the formulary website recommends a generic brand.

9 Potential NDRs for October Meeting (no paperwork, for information only)

- Flupentixol (oral tablets)- depression (with or without anxiety)- adults
- Flupentixol (oral tablets)- schizophrenia and other psychoses- adults
- Aerobika mucus clearance device- adults
- Ketamine- acute behavioural disturbance- paediatrics

XXXX/XXXX/XXXX
December 2023

Date of Meeting	Time	Venue
Tuesday 12th December Adults only	13:00-16:00	Microsoft Teams
Tuesday 6th February Adult and Paediatrics	09:30 – 13:30	Microsoft Teams
Tuesday 26th March Adults only	13:00-16:00	Microsoft Teams
Tuesday 21st May Adult and Paediatrics	09:30 – 13:30	Microsoft Teams
Tuesday 9th July Adults only	13:00-16:00	Microsoft Teams
Tuesday 3rd September Adult and Paediatrics	09:30 – 13:30	Microsoft Teams
Tuesday 22nd October Adults only	13:00-16:00	Microsoft Teams
Tuesday 10th December Adult and Paediatrics	09:30 – 13:30	Microsoft Teams