NHS GRAMPIAN
Minute of Formulary Group Meeting
Tuesday 18 June 2024 at 14:30 via Microsoft Teams

PRESENT	APOLOGIES	APPROVED
Ms L Cameron	Dr V Chieng	
Ms A Davie	Dr D Culligan	
Ms F Doney (Vice-Chair)		
Dr L Elliot (Chair)		
Mrs G McKerron (from item 3.2)		
Mrs E Milne		
Mrs S O'Beirne		
Mr M Paterson		
Dr K Simpson		
Mr R Sivewright		

IN ATTENDANCE

Ms Dawn Bruce, Specialist Pharmacy Technician, Formulary Team.
Dr Susan McGeoch, Consultant Physician, Diabetes, Endocrine and General Medicine, for item 4.
Mrs Elaine Sheridan, Child and Adolescent Mental Health Services Pharmacist, for item 3.3.

Note some items were taken outwith agenda order.

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WELCOME

The Chair welcomed members, opened the meeting, and noted that a quorum was present.

1. APOLOGIES

Apologies for absence were requested and noted.

4. PRESENTATION/DISCUSSION

The Chair welcomed Dr Susan McGeoch, Consultant Physician, Diabetes, Endocrine and General Medicine, to the meeting to talk about the pharmacological management of Type 2 diabetes mellitus (T2DM), including the request for tirzepatide (item 5.1), formulary choice glucagon-like peptide-1 receptor agonists (GLP-1 RAs) and other antidiabetic medicines for T2DM (item 6.1).

Dr McGeoch shared the local updated draft guidance for the pharmacological management of T2DM, that included tirzepatide. Dr McGeoch noted that over time the pharmacological management of T2DM has become more complicated with more drugs involved.

Dr McGeoch confirmed that:

- the specialist service supports colleagues in Primary Care across Grampian to deliver regional diabetes care
- there are ~33,000 people with diabetes in NHS Grampian, and 87-89% have T2DM and the majority of these people have their diabetes care provided in General Practice
- the local guidance is based on the NICE guidance (2022), SIGN guidance is currently out of date with updated guidance expected
- locally tirzepatide would be considered a fourth-line alternative, after the injectable GLP-1 RAs
- there have been significant problems with shortages of GLP-1 RAs
- NICE has positioned the GLP-1 RAs further down the pathway as they are one of the more expensive agents
- [injectable] liraglutide and semaglutide have good cardiovascular data

- the local guidance has a flowchart on page 1, with practice points on page 2 that highlight when to consider the different agents
- the Scottish Diabetes Group issued a position statement for the use of tirzepatide
- tirzepatide:
  - is a combined glucose-dependent insulinotropic polypeptide (GIP) and GLP-1 receptor agonist (GLP-1/GIP RA). Studies suggest that this dual receptor antagonism will effect glycaemic control and weight loss by similar mechanisms but at a greater effect [than we would expect [from GLP-1 RAs]]
  - has no cardiovascular outcome data
  - is positioned locally as a fourth-line agent, considered for glycaemic control for adults with T2DM who have a BMI >30kg/m^2 (adjust for ethnicity). Generally a GLP-1 RA should be used first. A GLP-1/GIP RA could potentially be considered if suboptimal glycaemia with GLP-1 RA use or in context of supply issues with GLP-1 RAs. Treatment should be withdrawn if there is no clinical benefit (under 5% weight loss and/or HbA1c reduction under 5mmoL/moL at 6 months).

Mindful that there is a responsibility with the formulary to keep the choices straightforward Dr McGeoch moved on to discuss some suggested changes to the formulary.

Ms Doney shared the Primary care prescribing data for the antidiabetic medicines used in T2DM, which showed exceptionally small prescribing for acarbose, repaglinide and fixed-dose combination products.

Dr McGeoch suggested:
- for the GLP-1 RAs offering a daily and weekly preparation with good cardiovascular data, the preferred agents being liraglutide and semaglutide (injectable and oral). Oral semaglutide has no cardiovascular data but is useful and has efficacy in terms of glycaemic control and weight loss.
- noting the following GLP-1 RAs as not preferred, dulaglutide injection (weekly preparation with little experience locally), Xultophy® injection (fixed dose combination insulin degludec plus liraglutide), fixed-dose combination products are not routinely supported locally
- noting acarbose and repaglinide as not preferred as they do not form part of the diabetes guidance
- noting ertugliflozin as not preferred, as currently the formulary choice sodium-glucose cotransporter-2 (SGLT2) inhibitors provide a good spread of agents covering multiple indications

The Chair thanked Dr McGeoch for attending the meeting to clarify the local guidance for the pharmacological management of T2DM, and the proposed use of tirzepatide.

Dr McGeoch left the meeting before decision-making.

5.1 SMC 2633 - TIRZEPATIDE (TYPE 2 DIABETES MELLITUS)

There were no declarations of interest recorded in relation to this product.

The Group considered the request for tirzepatide for adults with T2DM.

The Group noted that:
- tirzepatide:
  - is a first-in-class long-acting dual glucose-dependent insulinotropic polypeptide (GIP) and GLP-1 receptor agonist.
  - shows evidence that it is effective at controlling blood glucose in five main studies involving more than 6,000 adults with T2DM (measure of effectiveness was HbA1c)
- the main evidence considered by SMC included three large, well-conducted, phase III

studies versus active comparators, one of which compared tirzepatide with semaglutide demonstrated statistically significant and clinically meaningful:
  - (excluding 5mg tirzepatide) reductions from baseline in HbA1c compared with semaglutide 1mg once weekly and basal insulin (insulin degludec and insulin glargine) at week 40 and week 52, respectively
  - reductions in body weight compared with semaglutide 1mg and basal insulin
- limitations in the data, there is:
  - a lack of long-term data, which is important for a chronic disease (data to 104 weeks)
  - limited data for tirzepatide in combination with two other anti-diabetic medications (relevant for place in pathway). It is uncertain if the number of prior anti-diabetic medications impacts the relative treatment effect of tirzepatide.
  - a lack of direct evidence for tirzepatide versus some of the relevant comparators. An indirect treatment comparison showed positive results for tirzepatide but had limitations in terms of substantial heterogeneity in baseline characteristics and in assessment time-points; most studies included only had background treatment of metformin; sparse evidence of relative efficacy of GLP-1 RAs versus tirzepatide as part of triple therapy regimens; some inconsistencies between direct and indirect evidence suggesting uncertainty in the results
- cost-offset will be available from offset of GLP-1 RAs

The Group accepted the restricted local need for tirzepatide used in addition to other oral anti-diabetic medicines, for adults with T2DM, used in line with local guidance.

SMC 2633 - Tirzepatide 2.5mg, 5mg, 7.5mg, 10mg, 12.5mg, 15mg solution for injection in pre-filled pen (Mounjaro®)▼ is routinely available in line with local guidance.
Indication under review: in addition to other oral anti-diabetic medicines, for adults with type 2 diabetes mellitus, where glycaemia is insufficiently controlled, as an adjunct to a reduced-calorie diet and increased physical activity and who have a BMI >30kg/m^2 (adjust for ethnicity):
- **generally after a trial of GLP-1 RA**
- **or as an alternative to GLP-1 RAs in the following instances:**
  - **where there are supply issue with existing GLP-1 RAs**
  - **high-risk individuals in where greater weight loss will have a positive benefit on obesity related complications e.g. young onset, Obstructive Sleep Apnoea etc.**

It was classified 1b - available for restricted use under specialist supervision and 8d - treatment may be initiated in community on the recommendation of a consultant/specialist (specialist to include GPs/independent prescribers with a specialist interest in diabetes). **FTEAM**

6.1 MEDICINES FOR TYPE 2 DIABETES MELLITUS; INCLUDING GLP-1 RAS

Mr Paterson declared a personal, non-specific interest in relation to AstraZeneca UK Limited, and took part in decision-making.

Members noted the lack of cardiovascular outcome data for oral semaglutide and the very small usage of acarbose, repaglinide and fixed-dose combination products.

The Group accepted the suggested changes to the formulary GLP-1 RA choices:
- include semaglutide as Ozempic® and Rybelsus® for restricted use in line with the local guidance 'Pharmacological management of Type 2 Diabetes':
  - Ozempic® as an alternative injectable GLP-1 RA to liraglutide
  - Rybelsus® if an oral GLP-1 RA is preferred, i.e., injectable GLP-1 RA not possible/patient choice. Members noted the lack of cardiovascular data for oral

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semaglutide and that the maximum daily dose 14mg orally should be taken as a single tablet Taking two 7mg tablets to achieve the effect of a 14mg dose has not been studied and is therefore not recommended [ref SmPC], and would also double the cost.
    - classification in line with previous decisions for GLP-1 RAs
- record as non-formulary – 'not routinely available as there is a local preference for alternative medicines. People currently established on treatment may continue to receive treatment until they and their clinician consider it appropriate to stop':
    - exenatide extended release weekly injection as Bydureon®
    - dulaglutide injection weekly preparation, little experience locally
    - Xultophy® injection (fixed dose combination insulin degludec plus liraglutide), fixed-dose combination products are not routinely supported locally
- no change to liraglutide injection (Victoza®), remains on formulary (max 1.2mg daily)

Members discussed if there was a need to prescribe the preferred GLP-1 RAs by brand. NHS Grampian supports generic prescribing unless there was a clear reason to prescribe by brand. The Formulary Team will check the cost, at different doses, of the products licensed for T2DM and weight management and report back at a future meeting. **FTEAM**

SMC 2092 - Semaglutide 0.25mg, 0.5mg, 1mg solution for injection in pre-filled pen (Ozempic®) is routinely available in line with local guidance.
Indication under review: in addition to other oral anti-diabetic medicines, for adults with type 2 diabetes mellitus, where glycaemia is insufficiently controlled, as an adjunct to a reduced-calorie diet and increased physical activity and who have a BMI >30kg/m^2 (adjust for ethnicity).
Restriction: as a fourth-line choice. Consider if triple therapy with metformin and two other drugs not effective/not tolerated/contraindicated.
It was classified 1b - available for restricted use under specialist supervision and 8d - treatment may be initiated in community on the recommendation of a consultant/specialist (specialist to include GPs/independent prescribers with a specialist interest in diabetes). **FTEAM**

SMC 2287 - Semaglutide 3mg, 7mg, 14mg tablets (Rybelsus®)▼ is routinely available in line with local guidance.
Indication under review: in addition to other oral anti-diabetic medicines, for adults with type 2 diabetes mellitus, where glycaemia is insufficiently controlled, as an adjunct to a reduced-calorie diet and increased physical activity and who have a BMI >30kg/m^2 (adjust for ethnicity).
Restriction: as a fourth-line choice, generally after a trial of an injectable GLP-1 RA. Consider if triple therapy with metformin and two other drugs not effective/not tolerated/contraindicated.
It was classified 1b - available for restricted use under specialist supervision and 8d - treatment may be initiated in community on the recommendation of a consultant/specialist (specialist to include GPs/independent prescribers with a specialist interest in diabetes). **FTEAM**

SMC 585/09 - Liraglutide 6mg/mL solution for injection in pre-filled pen (Victoza®) is routinely available in line with local guidance.
Indication under review: in addition to other oral anti-diabetic medicines, for adults with type 2 diabetes mellitus, where glycaemia is insufficiently controlled, as an adjunct to a reduced-calorie diet and increased physical activity and who have a BMI >30kg/m^2 (adjust for ethnicity).
Restriction: as a fourth-line choice. Consider if triple therapy with metformin and two other drugs not effective/not tolerated/contraindicated.
Maximum dose 1.2mg daily.
It was classified 1b - available for restricted use under specialist supervision and

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	8d - treatment may be initiated in community on the recommendation of a consultant/specialist (specialist to include GPs/independent prescribers with a specialist interest in diabetes).	**FTEAM**
	SMC 748/11 - Exenatide 2mg powder and solvent for prolonged-release suspension for injection (Bydureon®) is not routinely available as there is a local preference for alternative medicines. **Indication under review: in adults, adolescents and children aged 10-years and above with type 2 diabetes mellitus to improve glycaemic control in combination with other glucose-lowering medicinal products including basal insulin, when the therapy in use, together with diet and exercise, does not provide adequate glycaemic control.** **Not routinely available as there is a local preference for alternative medicines.**	**FTEAM**
	SMC 1110/15 - Dulaglutide 0.75mg, 1.5mg, 3mg, 4.5mg solution for injection in pre-filled pen (Trulicity®) is not routinely available as there is a local preference for alternative medicines. **Indication under review: for the treatment of patients 10 years and above with insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise:** • **as monotherapy when metformin is considered inappropriate due to intolerance or contraindications.** • **in addition to other medicinal products for the treatment of diabetes.** **Not routinely available as there is a local preference for alternative medicines.**	**FTEAM**
	SMC 1088/15 - Xultophy 100units/mL / 3.6mg/mL (insulin degludec/liraglutide) solution for injection is not routinely available as there is a local preference for alternative medicines. **Indication under review: for the treatment of adults with insufficiently controlled type 2 diabetes mellitus to improve glycaemic control as an adjunct to diet and exercise in addition to other oral medicinal products for the treatment of diabetes.** **Not routinely available as there is a local preference for alternative medicines.**	**FTEAM**
	The Group accepted the suggested changes to the formulary for some other oral antidiabetic drugs: • record as non-formulary – 'not routinely available as there is a local preference for alternative medicines. People currently established on treatment may continue to receive treatment until they and their clinician consider it appropriate to stop': ▪ acarbose tablets ▪ repaglinide tablets ▪ ertugliflozin tablets	
	Acarbose 50mg, 100mg tablets is not routinely available as there is a local preference for alternative medicines. **Indication under review: for the treatment of type 2 diabetes (non-insulin dependent) in patients inadequately controlled on diet alone, or on diet and (i) metformin and / or (ii) a sulphonylurea.** **Not routinely available as there is a local preference for alternative medicines.**	**FTEAM**
	Repaglinide 0.5mg, 1mg, 2mg tablets is not routinely available as there is a local preference for alternative medicines. **Indication under review: adults with type 2 diabetes mellitus whose hyperglycaemia can no longer be controlled satisfactorily by diet, weight reduction and exercise. Repaglinide is also indicated in combination with metformin in adults with type 2 diabetes mellitus who are not satisfactorily controlled on metformin alone.** **Treatment should be initiated as an adjunct to diet and exercise to lower the blood**	

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	glucose in relation to meals. **Not routinely available as there is a local preference for alternative medicines.**	**FTEAM**
	SMC 2102 - Ertugliflozin L-pyroglutamic acid 5mg, 15mg tablets (Steglatro®)▼ is not routinely available as there is a local preference for alternative medicines. **Indication under review: for the treatment of adults with insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise:** • **as monotherapy when metformin is considered inappropriate due to intolerance or contraindications** • **in addition to other medicinal products for the treatment of diabetes** **Not routinely available as there is a local preference for alternative medicines.**	**FTEAM**

2. MINUTE AND DECISIONS

2.1. DRAFT MINUTE OF THE MEETING HELD 21 MAY 2024

Members accepted the draft note of the meeting subject to minor typographical changes.

The corrected final approved minute will be in the public domain within 21 days of final approval. **FD**

2.2. FORMULARY GROUP DECISIONS MAY 2024 - PUBLISHED 03/06/2024

Members ratified the decisions of the May 2024 meeting as published.

3. MATTERS ARISING

3.1. Action LOG

The action log was noted.

ADDITIONAL ITEMS NOT INCLUDED ON THE AGENDA.

DUPILUMAB FOR MODERATE-TO-SEVERE PRURIGO NODULARIS

At the May meeting a member questioned why in the 12-week follow-up period the proportion of patients in the dupilumab group with an improvement decreased and the number of responders in the placebo group increased.

The Marketing Authorisation Holder (MAH) has confirmed that:
- after 24 weeks at the end of treatment, administration of dupilumab or placebo was stopped for all participants
- in the 12-week follow-up period, dupilumab or placebo was not administered
- during the 12-week follow-up period, only background therapy, low to medium potency of topical corticosteroids or topical calcineurin inhibitors and moisturisers, were allowed. Participants could change the dose of their background therapy during the 12-week follow-up period.

HYDROGEN PEROXIDE (CYSTACIDE®) FOR IMPETIGO

Ms Doney confirmed that the Antibiotic Pharmacists have released a news item regarding changes to antimicrobial empirical guideline.
More detailed information regarding hydrogen peroxide 1% cream (now recommended first-line for treatment of non-bullous impetigo) will be included in the Primary Care bulletin.

The formulary entry was updated at the end of May.
Item closed. **FTEAM**

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3.2. SCRIPTSWITCH (UPDATE)

At a previous meeting there was request to investigate if ScriptSwitch could be used to support directing prescribing for topical acne preparations away from single-agent topical products to combination topical products.

Ms Davie confirmed that ScriptSwitch will not be able facilitate this change, because there are multiple choices to change from, and the dose regimens are not the same. Additionally, this was moving away from the principles of ScriptSwitch as it is not a decision-support system but a cost saving tool.

Item closed. **FTEAM**

5. NEW PRODUCT REQUESTS

5.2. SMC 2573 - SELPERCATINIB (ADVANCED RET FUSION-POSITIVE NSCLC IN TREATMENT-NAÏVE PATIENTS)

There were no declarations of interest recorded in relation to this product.

The Group considered the request for selpercatinib as monotherapy for the treatment of adults with advanced rearranged during transfection (RET) fusion-positive non-small cell lung cancer (NSCLC) not previously treated with a RET inhibitor.

The Group noted that:

- RET fusions are rare (estimated ~ 1% to 2% of NSCLC)
- compared with the general NSCLC population, patients with RET fusion-positive NSCLC tend to be younger and never have smoked
- selpercatinib:
  - [for this indication] meets SMC end of life and orphan equivalent criteria, and was accepted for restricted use on an interim basis following a full submission assessed under the end of life and orphan equivalent medicine process, the output from the PACE process, and application of SMC decision modifiers that can be applied when encountering high cost-effectiveness ratios
  - [for this indication] was granted a Conditional Marketing Authorisation*
  - is an inhibitor of the RET receptor tyrosine kinase, and changes in the RET gene can produce abnormal proteins that encourage growth of cancers. Selpercatinib blocks the activity of these abnormal proteins, preventing the growth and spread of the cancer cells.
  - the recommended dose is based on body weight - 120mg twice daily for those weighing <50kg and 160mg twice daily for those weighing ≥50kg
  - treatment should be continued until disease progression or unacceptable toxicity
  - the presence of a RET gene fusion should be confirmed by a validated test prior to initiation of treatment
- evidence comes from a cohort of LIBRETTO-001, an open-label, single-arm phase I/II multi-cohort study:
  - included patients with RET fusion-positive NSCLC who had received no prior therapy and an ECOG performance status ≤2. In phase I, patients received selpercatinib 20mg once daily to 240mg twice daily and in phase II, all patients (n=69) received selpercatinib 160mg twice daily (note this differs from the licensed dose for patients weighing <50kg where the recommended dose is 120mg twice a day).
  - the primary outcome was objective response rate (ORR) defined as the proportion

* The approval of a medicine that addresses unmet medical needs of patients on the basis of less comprehensive data than normally required. The available data must indicate that the medicine's benefits outweigh its risks and the applicant should be in a position to provide the comprehensive clinical data in the future. [ref EMA]

of patients with best overall response of confirmed complete response (CR) or confirmed partial response (PR). After a median duration of follow-up of 20.3 months, the ORR was 84% (n=58); CR 5.8% (n=4), PR 78% (n=54).
    - secondary outcomes included median PFS which was 22 months and overall survival which was not reached
- the lack of direct evidence against alternative therapies and that an indirect treatment comparison, comparing selpercatinib with pemetrexed plus platinum chemotherapy and pembrolizumab in combination with chemotherapy, suggested that selpercatinib was associated with greater odds of a response and lower risk of progression or death compared with the comparators
- evidence for selpercatinib in treatment-naïve RET fusion-positive NSCLC comes from a small number of patients (n=69) in a single-arm, open-label study which lacked a control group
- the licensed dose is different to the study, in phase II of LIBRETTO-001, all patients received selpercatinib 160mg twice daily, unless reduced due to toxicity
- the median duration of treatment for treatment-naïve RET fusion positive NSCLC patients in the LIBRETTO-001 trial was 18.5 months
- the service confirmed that selpercatinib will become the first-line treatment [for RET fusion-positive NSCLC] before considering combination chemotherapy in the second line as per Scottish guidance
- patient numbers will be small, with cost-offset expected from displacement of other first-line therapies
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of selpercatinib

The Group accepted the restricted local need for selpercatinib as monotherapy for the treatment of adults with advanced RET fusion-positive NSCLC not previously treated with a RET inhibitor or any other systemic treatments for their advanced stage of disease, as outlined in SMC 2573.

SMC 2573 - Selpercatinib 40mg, 80mg hard capsules (Retsevmo®)▼ is routinely available in line with national guidance, on an interim basis subject to ongoing evaluation and future reassessment (SMC 2573).
Indication under review: monotherapy for the treatment of treatment-naïve adults with advanced rearranged during transfection (RET) fusion-positive non-small cell lung cancer (NSCLC) who have not previously received a RET-inhibitor or any other systemic treatments for their advanced stage of disease.
In a phase I/II study, in treatment-naive patients with RET fusion-positive NSCLC, selpercatinib was associated with an objective response rate (ORR) of 84%. Final study results and comparative study results are awaited.
This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/list price that is equivalent or lower.
This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting.
It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Therapy should be initiated and supervised by physicians experienced in the use of anti-cancer therapies.
The presence of a RET gene fusion should be confirmed by a validated test prior to initiation of treatment. FTEAM

5.3. SMC 2574 - PRODUODOPA® (FOR ADVANCED LEVODOPA-RESPONSIVE PARKINSON'S DISEASE)

There were no declarations of interest recorded in relation to AbbVie Ltd.

The Group considered the request for Produodopa® for the treatment of advanced

levodopa-responsive Parkinson's disease with severe motor fluctuations and hyperkinesia or dyskinesia when available combinations of Parkinson medicinal products have not given satisfactory results.

The Group noted that:

- the symptoms of Parkinson's disease impact physical health and people struggle to perform day to day chores or activities. This decline in physical health results in a significant impact on quality of life [for patients and family members/caregivers].
- Produodopa®:
  - is administered as a continuous subcutaneous infusion, 24 hours per day
  - [for this indication] was accepted for restricted use in NHS Scotland following an abbreviated submission
- evidence comes from two Phase 3 studies (12 and 52 weeks) with small patient numbers (n = 145 and 244 respectively). The 12 week study assessed the effect of Produodopa®, and the 52 week study evaluate the safety and tolerability of 24-hour daily exposure of continuous subcutaneous infusion of Produodopa®.
- there are uncertainties in the clinical data:
  - both studies had a significant drop-out rate, with 110/145 and 137/244 completing the studies
  - there is no direct evidence against the most relevant comparator Duodopa® intestinal gel. However, Produodopa® subcutaneous administration and Duodopa® intestinal administration were shown to have comparable levodopa maximum concentration (Cmax), area under the curve (AUC), and degree of fluctuation, which supports a comparable efficacy profile. [ref SmPC]
- the MAH for both Duodopa® intestinal gel and Produodopa® is AbbVie Ltd.
- the Service supports restricting use to those for whom apomorphine (or DBS) is not appropriate or ineffective, i.e., in line with NICE recommendations
- NICE concluded that even when considering the uncertainty, the most likely incremental cost-effectiveness ratios for Produodopa® were within the range that NICE usually considers an acceptable use of NHS resources
- patient numbers are expected to be very small, and cost-offset is available from displacement of other therapies
- Duodopa® and Produodopa® are subject to PASs that improve the cost-effectiveness of treatment
- AbbVie has commissioned and funds a homecare clinical and technical support service for patients prescribed Produodopa®
- NHS Grampian will sign up to the homecare arrangement if Produodopa® is accepted to formulary

The Group accepted the restricted local need for Produodopa® for a group of adults with advanced levodopa-responsive Parkinson's disease with severe motor fluctuations and hyperkinesia or dyskinesia.

The Group supported the service's place in therapy and considered that treatment with Duodopa® or Produodopa® should be restricted to the same patient group, i.e., for use in patients that cannot have apomorphine or deep brain stimulation, or these treatments no longer control symptoms.

SMC 2574 - Produodopa® 240mg/mL/12mg/mL solution for infusion (foslevodopa/foscarbidopa) is routinely available in line with local guidance.
Indication under review: treatment of advanced levodopa-responsive Parkinson's disease with severe motor fluctuations and hyperkinesia or dyskinesia when available combinations of Parkinson medicinal products have not given satisfactory results.
Restriction: for use in patients that cannot have apomorphine or deep brain stimulation, or these treatments no longer control symptoms.

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	Foslevodopa-foscarbidopa offers an additional treatment choice in the therapeutic class of dopa and dopa derivatives for this indication. Another medicine within this therapeutic class has been accepted via the orphan medicine process for this indication. This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/list price that is equivalent or lower. **It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only.**	**FTEAM**
	SMC 316/06 - Duodopa® 20mg/mL/5mg/mL intestinal gel (levodopa/carbidopa monohydrate) is routinely available in line with local guidance. **Indication under review: treatment of advanced levodopa-responsive Parkinson's disease with severe motor fluctuations and hyperkinesia or dyskinesia when available combinations of Parkinson medicinal products have not given satisfactory results.** **Restriction: for use in patients that cannot have apomorphine or deep brain stimulation, or these treatments no longer control symptoms.** **This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/list price that is equivalent or lower.** **It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only.**	**FTEAM**

5.4. SMC 2288 - SODIUM ZIRCONIUM CYCLOSILICATE (CHRONIC HYPERKALAEMIA IN PATIENTS WITH HEART FAILURE) - DRAFT REVIEW

Members discussed the draft review of sodium zirconium cyclosilicate (SZC) for adults with hyperkalaemia (defined as a serum potassium of >6.0mmol/L) with heart failure who would otherwise need to down-titrate or discontinue their renin-angiotensin-aldosterone system inhibitor (RAASi) therapy to maintain a clinically acceptable serum potassium level.

The Chair confirmed that SZC is currently included on the formulary for the same indication in renal patients, however, it is classified as a 'hospital-only product' and this request seeks to include heart failure patients coupled with reclassification to allow supply from Primary Care.
The requestor will attend the August meeting and the Chair requested that members consider the questions in the review and if additional questions should be posed to allow decision-making at the August meeting.

Members requested that additional questions are included in the review:

- is there evidence that up-titrating renin-angiotensin-aldosterone system inhibitor (RAASi) therapy provides better cardiovascular benefits than not up-titrating therapy? Also does up-titration outweigh the risks of using SZC in a way that may disguise a potentially serious adverse drug event that requires investigation?
- do all patients have access to a community heart failure nurses? Is the service consistent across NHS Grampian, including Moray and Aberdeenshire? If not consistent across NHS Grampian how is the discrepancy handled?
- what is the suggested monitoring protocol?
- who is responsible for the monitoring, community heart failure nurses, community hubs, Community Treatment and Care (CTAC)? **FTEAM**

Members considered that this is potentially a group of patients with complex medical conditions, that already have a significant drug burden and the monitoring for many patients is already complicated.
There were concerns that the patient numbers may be underestimated.

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3. 3.3. CLONIDINE REQUEST FOR RECLASSIFICATION

The Chair welcomed Mrs Sheridan, Child and Adolescent Mental Health Services (CAMHS) Pharmacist, to the meeting to talk about the request for reclassification of clonidine for attention deficit hyperactivity disorder (ADHD) in children and adolescents.

At previous meetings members raised various concerns particularly that Primary Care may be prescribing without having access to the relevant monitoring information.

Mrs Sheridan confirmed:

- clonidine is used off-label as a fourth-line treatment for ADHD
- only used in the population that have other comorbidities that may benefit from treatment, so rages, tics, sleep disturbances
- a significant proportion of patients on clonidine also have a learning disability
- generally stimulants and non-stimulants have been tried and are not tolerated or have not been effective
- currently the majority of prescribing is already in Primary Care, and there is a wish for consistency of prescription ordering and supply, which will allow patients/carers to collect all of their medicines from Community Pharmacy - less risk of delay in access to medicines
- in the interests of treatment continuity the service is requesting a change in formulary classification to Amber 1 - *Available for restricted use under specialist supervision. Treatment may be initiated in Primary Care on the recommendation of a consultant/specialist*
- the CAMHS clinicians would undertake all of the monitoring, answers questions about common side-effects and make adjustments to doses. The monitoring and any dose adjustments or continuation of therapy would be communicated to Primary Care with a request to continue the prescription, as is done with other ADHD medications.
- currently monitoring is done in clinic for face-to-face appointments, if not seen face-to-face, e.g., patient preference or for geographic reasons, then patients are referred to Secondary Care community-hubs for blood pressure and pulse checks.
  Questioning regarding side-effects is followed up with a telephone or Near Me video appointment.
  The outcomes are communicated to Primary Care by letter or clinical contact note.

Mrs Sheridan answered questions from members and confirmed that:

- CAMHS has agreement with the Secondary Care community hubs (Aberdeen and Aberdeenshire) to undertake bloods and physical monitoring for all ADHD patients
- her experience in CAMHS is that clinicians are emailed if patients fail to attend community hub monitoring appointments
- clonidine titration is not usually a quick titration, as children often need time to regulate for any changes in blood pressure and the side-effects that can happen earlier in treatment but usually dissipate with time, e.g., sedation. In this period the clinician would telephone or see the patient and advise Primary Care to continue at the current dose or issue a prescription for a revised dose.
- Community Pharmacy Prescription (CoPPr) is being considered for the Mental Health Directorate but is not available yet, and when it does become available it will only be for emergency prescriptions where the appointment is taking place off-site

The Chair raised concerns about communication, as Primary Care colleagues can cite issues with clinical information not arriving in a timely manner, meaning that prescription turnaround times are very short.
The Chair thanked Mrs Sheridan for attending the meeting to discuss the reclassification request.

Mrs Sheridan left the meeting before decision-making.

ITEM	SUBJECT	ACTION

Questions remained about the consistency and equity of communication across NHS Grampian, and members questioned if appointments for ADHD patients were always available in Secondary Care community hubs.

Members accepted that clonidine was required for a small group of patients but did not feel that there was sufficient assurance to allow reclassification at this time.
Members queried if the service could provide audit results/clear evidence that the communication pathways, including fail-safe processes for non-attendance, are working well across the whole of NHS Grampian. Can the service provide audit results, taken over a period of time, for Aberdeen City, Aberdeenshire and Moray?

The Group agreed that it was not in a position to reclassify clonidine, and that more evidence would be needed to consider a change in classification. **FTEAM**

6. FORMULARY REVIEW

6.2. GIP/GLP-1 RAS FOR WEIGHT MANAGEMENT

There were no declarations of interest recorded in relation to these products.

Ms Doney confirmed that SMC advice for tirzepatide for weight management was published earlier this month, and that there is work ongoing in NHS Grampian to consider implementation of these 'new' weight management drugs.
A local expert group is discussing how these medicines can be implemented safely and sustainably, and while this work continues the request is to record these medicines as non-formulary – 'Not routinely available as local implementation plans are being developed'.

The Group supported the request to record these medicines as 'not routinely available as local implementation plans are being developed'.

SMC 2455 - Liraglutide 6mg/mL solution for injection in pre-filled pen (Saxenda®) is not routinely available as local implementation plans are being developed.
Indication under review: as an adjunct to a reduced-calorie diet and increased physical activity for weight management in adult patients with an initial Body Mass Index (BMI) ≥35kg/m^2* (obesity class II and above) with:

- **non-diabetic hyperglycaemia (prediabetes) at high risk of type 2 diabetes which is defined as having either:**
  - **fasting plasma glucose level of 5.5 to 6.9mmol/L or**
  - **HbA1c of 6.0 to 6.4% (42 to 47mmol/mol), and**
- **high risk of cardiovascular disease (CVD):**
  - **total cholesterol >5mmol/L, or**
  - **high-density lipoprotein (HDL) <1.0mmol/L for men and <1.3mmol/L for women, or**
  - **systolic blood pressure (SBP) >140mmHg.**

Patients should be treated in a specialist weight management service.
a lower BMI cut-off may be more appropriate for members of minority ethnic groups known to be at equivalent risk of the consequences of obesity at a lower BMI than the white population.
In a phase III study, liraglutide, as an adjunct to diet and exercise, was associated with significant reduction in body weight compared with placebo in patients with BMI ≥30kg/m^2 or ≥27kg/m^2 if they had dyslipidaemia or hypertension.
This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/list price that is equivalent or lower.
Not routinely available as local implementation plans are being developed. **FTEAM**

ITEM	SUBJECT	ACTION
	SMC 2497 - Semaglutide, 0.25mg, 0.5mg, 1mg, 1.7mg, 2.4mg FlexTouch solution for injection in pre-filled pen (Wegovy®)▼ is not routinely available as local implementation plans are being developed. **Indication under review: as an adjunct to a reduced-calorie diet and increased physical activity for weight management, including weight loss and weight maintenance, in adults with an initial Body Mass Index (BMI) of ≥30kg/m²* in the presence of at least one weight-related comorbidity.** **Patients should be treated in a specialist weight management service.** ***a lower BMI cut-off may be more appropriate for members of minority ethnic groups known to be at equivalent risk of the consequences of obesity at a lower BMI than the white population.*** **In a phase III study, semaglutide, as an adjunct to diet and exercise, was associated with significant reduction in body weight compared with placebo in patients with a BMI ≥30kg/m² or ≥ 27kg/m² if they had at least one weight-related comorbidity.** **This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/list price that is equivalent or lower.** **Not routinely available as local implementation plans are being developed.**	**FTEAM**
	SMC 2653 - Tirzepatide 2.5mg, 5mg, 7.5mg, 10mg, 12.5mg, 15mg solution for injection in pre-filled pen (Mounjaro®)▼ is not routinely available as local implementation plans are being developed. **Indication under review: for weight management, including weight loss and weight maintenance, as an adjunct to a reduced-calorie diet and increased physical activity in adults with an initial Body Mass Index (BMI) of ≥30 kg/m² (obesity) or ≥27 kg/m² to <30 kg/m² (overweight) in the presence of at least one weight-related comorbid condition (e.g., hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease, prediabetes, or type 2 diabetes mellitus).** **SMC restriction: for use in adults with BMI ≥30 kg/m²* and at least one weight-related comorbidity.** ***a lower BMI cut-off may be more appropriate for members of minority ethnic groups known to be at equivalent risk of the consequences of obesity at a lower BMI than the white population.*** **In phase III studies, tirzepatide, as an adjunct to diet and exercise, was associated with significant reduction in body weight compared with placebo in patients with BMI ≥30 kg/m² (obesity) or ≥27 kg/m² to <30 kg/m² (overweight) in the presence of at least one weight-related comorbid condition.** **Not routinely available as local implementation plans are being developed.**	**FTEAM**
	6.3. FORMULARY UPDATES The Chair reported that Teva UK Limited has confirmed that it plans to discontinue GoResp® Digihaler® (budesonide and formoterol fumarate dihydrate). GoResp® Digihaler® is currently noted as 'non-formulary not routinely available for use in NHS Grampian' [costs £75.63 for 90 doses], the formulary entry will be updated to note the withdrawal.	**FTEAM**
	Members supported updating the formulary noting the discontinuation.	
	6.4. SIMPLE LINCTUS ON PHARMACY FIRST The Chair reported that Simple Linctus has been removed from the latest version of the NHS Pharmacy First Scotland Approved list. This has no effect on the formulary, as Simple Linctus is not included on the formulary.	

ITEM	SUBJECT	ACTION

7. PUBLISHED ADVICE

7.1. SCOTTISH MEDICINES CONSORTIUM ADVICE PUBLISHED JUNE 2024

The Group noted the SMC advice published June 2024.

Following publication of the non-submission statements, for clostridium botulinum neurotoxin type A (Xeomin®) SMC 2680, dupilumab (Dupixent®) SMC 2682, Inaqovi® ▼ (decitabine/cedazuridine) SMC 2681 and pembrolizumab (Keytruda®) SMC 2683, these medicines will not be included on the Grampian Joint Formulary for the indications in question.

The following SMC accepted medicines have not been processed within a 60-day timescale:

- SMC 2626 voxelotor (Oxbryta®)▼
- SMC 2632 epcoritamab (Tepkinly®)▼
- SMC 2655 etrasimod (Velsipity®)▼ (submission expected)
- SMC 2614 glofitamab (Columvi®)▼ (submission expected)
- SMC 2636 momelotinib (Omjjara®)▼ (submission expected)

Local advice for these medicines and indications will be included in the June 2024 decisions as 'Not routinely available as the ADTC is waiting for further advice from local clinical experts'. **FTEAM**

8. PROVISIONAL ADVICE

8.1. SCOTTISH MEDICINES CONSORTIUM ADVICE ISSUED JUNE 2024

The Group noted the SMC provisional advice issued June 2024.

If the negative SMC recommendation and non-submission statements are published next month, these medicines will not be included on the formulary for the indications in question.

9. OTHER BUSINESS

9.1. DRAFT FORMULARY GROUP ANNUAL REPORT

Members noted the content of the draft Formulary Group annual report for 2023/24.

The Chair requests members review the report and feedback any comments by the 24th June. **ALL**

Item 9.1.1 (CMO 2023/24 report (SMC advice published 2023/24)), item 9.1.2 (NCMAG report (NCMAG advice published since April 2022)) and 9.1.3. 93-day report (2023/24) were noted and will be included in the final annual report.

10. DOCUMENTS FOR INFORMATION

The Chair highlighted item 10.1 (Drug Safety Update May 2024), noting that over the coming year, topical steroids will be labelled with information on their potency to assist with counselling patients.

Items 10.2 and 10.3 (Antimicrobial Management Team (AMT) minutes March and April 2024), 10.4 (Acute and Mental Health Medicines Safety Group minute March 2024), 10.5 (Grampian Primary Care Prescribing Group minute March 2024), and 10.6 (Medicine Guidelines and Policies Group (MGPG) minute April 2024) were noted.

ITEM	SUBJECT	ACTION

11. AOCB

The Chair reminded members that there is not a meeting in July, and wished everyone a good summer break.

DATE OF NEXT MEETING

Tuesday 20 August 2024 starting at 14.30 via Microsoft Teams

Dr Louise Elliot

CHAIR'S SIGNATURE **Signature on file** **DATE 20 AUGUST 2024**