NHS GRAMPIAN
Minute of Formulary Group Meeting
Tuesday 20 May 2025 at 14:30 via Microsoft Teams

PRESENT	APOLOGIES	APPROVED
Ms L Cameron	Dr V Chieng	
Dr D Culligan	Ms A Davie	
Ms F Doney		
Dr L Elliot (Chair)		
Mrs M Galvin		
Mrs G McKerron		
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.
Mrs Christine Standen, Formulary and Medicines Management Pharmacist.

ITEM	SUBJECT	ACTION

WELCOME

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

1. APOLOGIES

Apologies for absence were requested and noted.

2. MINUTE AND DECISIONS

2.1. DRAFT MINUTE OF THE MEETING HELD 15 APRIL 2025

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 APRIL 2025 - PUBLISHED 28/04/2025

Members ratified the decisions of the April 2025 meeting as published.

3. MATTERS ARISING

3.1. ACTION LOG

The Action log was noted.

4. PRESENTATION/DISCUSSION

None.

5. NEW PRODUCT REQUESTS

5.1. FG1SMC 2707 - LEBRIKIZUMAB (MODERATE TO SEVERE ATOPIC DERMATITIS)

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

ITEM	SUBJECT	ACTION

The Group considered the request for lebrikizumab for the treatment of moderate-to-severe atopic dermatitis in adults and adolescents, 12 years and older with a body weight of at least 40kg, who are candidates for systemic therapy and who have had an inadequate response to an existing systemic immunosuppressant such as ciclosporin, or in whom such treatment is considered unsuitable and where a biologic would otherwise be offered.

The Group noted that:

- lebrikizumab:
  - selectively inhibits interleukin (IL)-13 signalling
  - is available as a 250mg subcutaneous injection which can be self-administered
  - is given as 500mg (two 250mg injections) at weeks 0 and 2, followed by 250mg administered subcutaneously every other week up to week 16. The recommended maintenance dose is 250mg every 4 weeks.
- the service plans to supply lebrikizumab using a homecare arrangement, so costs will not include VAT
- current treatments for moderate to severe atopic dermatitis are the biologics (dupilumab and tralokinumab) and the Janus kinase (JAK) inhibitors (abrocitinib, baricitinib and upadacitinib)
- evidence comes from ADvocate 1 and 2, ADhere and ADvantage which compared lebrikizumab against placebo
  - the primary outcomes were Eczema Area and Severity Index (EASI) 75 (≥75% reduction from baseline in EASI score) at week 16 (all trials), and Investigator's Global Assessment (IGA) score of 0 or 1 with a reduction (indicating improvement) of ≥2 points from baseline at week 16 (ADvocate 1 and 2 and ADhere)
  - lebrikizumab, as monotherapy or in combination with topical corticosteroids, was associated with improved outcomes compared with placebo
- cost-offset is available from displacement of alternative biologic agents
- compared to the alternative biologic agents [licensed for atopic dermatitis] lebrikizumab offers a less frequent dosing regimen
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of lebrikizumab

The Group accepted the restricted local need for lebrikizumab as an additional IL-13 inhibitor for the treatment of moderate-to-severe atopic dermatitis, as outlined in SMC 2707.

SMC 2707 - Lebrikizumab 250mg solution for injection in pre-filled syringe or pen (Ebglyss®)▼ is routinely available in line with national guidance (SMC 2707).
Indication under review: for the treatment of moderate-to-severe atopic dermatitis in adults and adolescents 12 years and older with a body weight of at least 40kg who have had an inadequate response to an existing systemic immunosuppressant such as ciclosporin, or in whom such treatment is considered unsuitable and where a biologic would otherwise be offered.
Four phase III studies demonstrated superiority of lebrikizumab in improving signs and symptoms of atopic dermatitis when compared with placebo, as monotherapy or in combination with topical corticosteroids in patients with moderate to severe atopic dermatitis.
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.
Treatment should be initiated by healthcare professionals experienced in the diagnosis and treatment of atopic dermatitis. **FTEAM**

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5.2. FG1SMC 2410 - BIMEKIZUMAB AND FG1SMC 2581 - DEUCRAVACITINIB (MODERATE TO SEVERE PLAQUE PSORIASIS)

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

The Group considered the requests for bimekizumab injection and deucravacitinib film-coated tablets for the treatment of moderate to severe plaque psoriasis in adults who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments.

The Group noted that:

- bimekizumab
  - inhibits interleukins IL-17A, IL-17F and IL-17AF
  - is given by subcutaneous injection at a dose of 320mg at week 0, 4, 8, 12, 16 and every 8 weeks thereafter. For some patients with a body weight ≥120kg who do not achieve complete skin clearance at week 16, treatment response may improve if the dose frequency is reduced to 320mg every 4 weeks.
- the formulary already includes two other IL17 inhibitors, secukinumab and ixekizumab, however bimekizumab is the first monoclonal antibody targeting both IL-17A and IL-17F
- the service plans to supply bimekizumab using a homecare arrangement, so costs will not include VAT
- the 4-week regimen will double the cost of treatment
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of bimekizumab
- evidence for efficacy and safety of bimekizumab were evaluated versus placebo and ustekinumab (BE VIVID - PS0009), versus placebo (BE READY - PS0013) and versus adalimumab (BE SURE - PS0008)
  - treatment with bimekizumab resulted in significant improvement across efficacy endpoints compared to placebo, ustekinumab or adalimumab at week 16
  - BE RADIANT a phase 3b direct comparative study provides data versus secukinumab. Bimekizumab-treated patients achieved significantly higher response rates compared to secukinumab for the primary endpoint of *PASI 100 (complete skin clearance) at week 16.
- deucravacitinib:
  - selectively inhibits the tyrosine kinase 2 (TYK2) enzyme, which belongs to the JAK family
  - is the first TYK2 inhibitor licensed for treatment in plaque psoriasis, offering a novel mechanism of action compared with other treatment options
  - is an oral treatment option, which is convenient for patients and the service, and additionally it does not require refrigeration
  - is taken orally at a dose of 6mg once daily
- evidence for efficacy and safety comes from international, multi-centre, randomised, double-blind, phase III studies POETYK-PSO-1 (n = 666) and POETYK-PSO-2 (n = 1020)
  - deucravacitinib demonstrated statistically significant benefits over apremilast and placebo for both co-primary outcomes at week 16 (PASI 75 and †sPGA 0/1 response)
  - data for the use of deucravacitinib in patients aged 75 years or older are limited, and its Major Adverse Cardiac Event risk is not yet known
- the service plans to supply deucravacitinib using a homecare arrangement, so costs will not include VAT
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of deucravacitinib

* Psoriasis Area and Severity Index (PASI) score

† Static Physician's Global Assessment (sPGA)

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	Members acknowledged the advantage of an 8-weekly dosing regimen but deferred decision-making for bimekizumab pending replies to the questions posed in the review.	FTEAM
	SMC 2410 - Bimekizumab 160mg, 320mg solution for injection in pre-filled syringe and pre-filled pen (Bimzelx®)▼ decision deferred to future meeting. **Indication under review: treatment of moderate to severe plaque psoriasis in adults who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments.** **Bimekizumab provides an additional treatment choice in the therapeutic class of interleukin inhibitors.** **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.** **Decision deferred to future meeting.**	FTEAM
	The Group recognised that deucravacitinib provided the advantage of an oral treatment option with a novel mechanism of action. The Group accepted the restricted local need for deucravacitinib film-coated tablets for the treatment of moderate to severe plaque psoriasis in adults who have failed to respond to standard systemic therapies, are intolerant to, or have a contra-indication to these treatments, as outlined in line SMC 2581.	
	SMC 2581 - Deucravacitinib 6mg film-coated tablets (Sotyktu®)▼ is routinely available in line with national guidance (SMC 2581). **Indication under review: for the treatment of moderate to severe plaque psoriasis in adults who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments.** **In two phase III studies, deucravacitinib was superior to a phosphodiesterase type-4 inhibitor and placebo in improving the signs and symptoms of psoriasis in adults with moderate to severe plaque psoriasis, who were candidates for systemic therapy.** **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. Treatment should be initiated under the guidance and supervision of a physician experienced in the diagnosis and treatment of psoriasis.**	FTEAM
	Items 5.3 and 5.4 were taken together.	
	5.3. FG1SMC 2669 - ELRANATAMAB (RELAPSED AND REFRACTORY MULTIPLE MYELOMA)	
	5.4. FG1SMC 2668 - TECLISTAMAB (RELAPSED AND REFRACTORY MULTIPLE MYELOMA)	
	There were no declarations of interest recorded in relation to these products.	
	The Group considered the requests for elranatamab and teclistamab used as monotherapy for the treatment of adults with relapsed and refractory multiple myeloma, who have received at least three prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody and have demonstrated disease progression on the last therapy.	

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The Group noted that:

- elranatamab and teclistamab:
  - [for this indication] meet SMC end of life and orphan equivalent criteria
  - [for this indication] were accepted for use in NHS Scotland only in the context of the SMC decision modifiers that can be applied when encountering high cost-effectiveness ratios and the output from the PACE process
  - are bispecific antibodies that target the CD3 receptors expressed on the surface of T cells and B-cell maturation antigen (BCMA), by binding to both sites, they are able to draw the T cells closer to the BCMA-expressing cells, which leads to lysis of these cells
- multiple myeloma is an incurable and progressive condition that has a substantial impact on survival and quality of life
- the relapsing-remitting nature of the condition has a psychological impact on patients, as people are aware that treatment options and life expectancy reduce with each relapse
- drug resistance to prior regimens in patients with relapsed or refractory multiple myeloma is due to continuous changes in the disease biology, in which a higher proportion of malignant cells are expressing a more aggressive, highly proliferative phenotype over time
- treatment choice is influenced by many factors such as patient preference, age, cytogenetic profile, comorbidities, performance status, and most importantly the type of therapies previously received and response to these
- patients with multiple myeloma have a poor prognosis; median overall survival in patients who have received at least three prior lines of therapy and are refractory to both an immunomodulatory agent and a proteasome inhibitor is 13 months [ref SMC]
- patients earlier in the treatment pathway may receive combinations of immunomodulatory agents (such as lenalidomide or thalidomide), proteasome inhibitors (such as bortezomib) or anti-CD38 antibodies (such as daratumumab) in conjunction with dexamethasone
- efficacy and safety data for elranatamab comes from cohort A of MagnetisMM-3 (n = 123), an open-label, multicentre, non-randomised, phase II study:
  - the Primary outcome was Objective response rate (ORR); after a median follow-up of 17.6 months, the objective response rate was 61%, the median progression-free survival (PFS) was 17.2 months and median overall survival (OS) was 21.9 months
  - at data cut-off 14 March 2023, the median duration of treatment in cohort A was 5.6 months.
- supportive studies include, cohort B of MagnetisMM-3, where patients that had received prior BCMA-directed treatment, either licensed or investigational (n=64). After a median follow-up of 13.4 months, the confirmed ORR was 34%; 33% achieved very good partial response or better and 11% achieved complete response or better.
- indirect treatment comparisons suggested elranatamab had superior efficacy versus physician's choice of therapy in terms of PFS in both analyses [unanchored matching adjusted indirect comparison (MAIC) and adjusted direct comparison], and OS in the MAIC adjusted analysis only
- efficacy and safety data for teclistamab comes from MajesTEC-1 (n = 165), an open-label, single arm, multicentre, non-randomised, phase I/II study:
  - the Primary outcome was overall response rate; after a median follow-up of 30.4 months (August 2023 data-cut off), the overall response rate was 63%, median PFS was 11.4 months and median OS 22.2 months.
  - in MajesTEC-1 study at data-cut March 2022, the median duration of treatment was 8.5 (range: 0.2 to 24.4) months
- supportive studies had different baseline characteristics than in MajesTEC-1; patients were older (median age 67 years versus 64 years), had a higher median number of lines of prior therapy (6 versus 5), and a higher proportion were triple-class refractory (93% versus 78%). Despite these differences, teclistamab appeared to exhibit similar efficacy in the real-world analyses compared with MajesTEC-1 (overall response rate

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in 59% of patients).
- an indirect treatment comparison versus pomalidomide plus dexamethasone suggested teclistamab resulted in a statistically significant improvement in time to next treatment (HR 0.56, 95% CI 0.40 to 0.79) and OS (HR 0.52, 95% CI 0.36 to 0.74).
- for both agents treatment should be continued until disease progression or unacceptable toxicity
- the SMC advice take account of the benefits of PASs that improve the cost-effectiveness of elranatamab and teclistamab
- introduction will incur additional costs; in-patient stays, monitoring, management of adverse events, premedication, intravenous immunoglobulin to prevent infection
- the fixed-dose regimen for elranatamab would allow delivery closer to the patient's home

The Group accepted the restricted local need for the two new bispecific agents, elranatamab and teclistamab, used as monotherapy for the treatment of adults with relapsed and refractory multiple myeloma, who have received at least three prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody and have demonstrated disease progression on the last therapy.

SMC 2669 – Elranatamab 40mg/mL solution for injection (Elrexfio®)▼ is routinely available in line with national guidance on an interim basis subject to ongoing evaluation and future reassessment (SMC 2669)
Indication under review: as monotherapy for the treatment of adults with relapsed and refractory multiple myeloma, who have received at least three prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody and have demonstrated disease progression on the last therapy.
In a single-arm, phase II study, in patients with relapsed and refractory multiple myeloma, elranatamab was associated with an objective response rate of 61%.
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.
Treatment should be initiated and supervised by physicians experienced in the treatment of multiple myeloma. — **FTEAM**

SMC 2668 - Teclistamab 10mg/mL, 90mg/mL solution for injection (Tecvayli®)▼ is routinely available in line with national guidance (SMC 2668)
Indication under review: as monotherapy for the treatment of adults with relapsed and refractory multiple myeloma, who have received at least three prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody and have demonstrated disease progression on the last therapy.
In a single-arm, phase I/II study in patients with relapsed and refractory multiple myeloma, teclistamab was associated with an overall response rate of 63%.
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.
Treatment should be initiated and supervised by physicians experienced in the treatment of multiple myeloma. — **FTEAM**

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6. FORMULARY REVIEW

6.1. FORMULARY UPDATES MAY 2025

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

DEBRANDING

Ms Doney reported that Ennogen Heathcare International Ltd has debranded Otomize® and it now known by its generic name - dexamethasone 0.1%w/w /neomycin sulfate 0.5%w/w /acetic acid 2%w/w ear spray.

The Group supported update of the current entry to the generic name. **FTEAM**

DISCONTINUATIONS

Ms Doney reported that:

- Pharmacosmos UK Limited has discontinued calcium acetate 1,000mg tablets (Phosex®). Patients currently established on Phosex® will be transferred to Renacet®.
- Zambon UK Ltd has discontinued colistimethate 1million unit powder for nebuliser solution (Promixin®), alternative products are available
- Sanofi has discontinued two strengths of Epilim® Chronosphere MR 750mg, 1,000mg modified release granules. The discontinuation is part of Sanofi's ongoing strategy to improve supply stability to the UK by removing products where alternatives are available to patients.
- AstraZeneca UK Limited has discontinued the non-formulary medicine Evusheld® solution for injection (tixagevimab 150mg/mL and cilgavimab 150mg/mL), discontinuation is due to commercial reasons
- Theramex has withdrawn the licence for FemSeven® Sequi patches, this follows the product being out of stock
- galantamine 8mg, 16mg, 24mg tablets are withdrawn; the capsules remain available
- Zambon UK Ltd has discontinued Otrivine-Antistin® Eye drops (xylometazoline/antazoline), the withdrawal was not due to any safety concerns
- Sanofi has discontinued the non-formulary product Suliqua® pre-filled SoloStar pens (insulin glargine /lixisenatide)
- Bristol Myers Squibb Pharmaceuticals limited is discontinuing the triamcinolone acetonide injections Adcortyl® and Kenalog®. Bristol Myers Squibb confirmed that the discontinuation is not due to any quality, safety or efficacy concerns. The availability of Adcortyl® and Kenalog® will continue until existing stock is depleted, with discontinuation effective on 02 June 2025.
- Vygoris Ltd has discontinued the branded product Nystan® and introduced a generic nystatin oral suspension. Prescribers should prescribe as generic nystatin suspension, not Nystan®.

Apart from triamcinolone these were considered low impact discontinuations.

Members supported update of the formulary entries to note the discontinuations. **FTEAM**

6.2. TOPIRAMATE (REQUEST TO REVIEW CLASSIFICATION)

The Group considered the request to review the classification of topiramate for the prophylaxis of migraine in women of childbearing age.

The Group noted that:

- topiramate (Topamax®):
  - is licensed for the prophylaxis of migraine [adults only] and for the treatment of epilepsy [children, adolescents and adults] and locally the formulary classification is 'Amber 1' for epilepsy but 'Green' for migraine prophylaxis
  - is subject to new safety measures, including a Pregnancy Prevention Programme,

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for women of childbearing potential
  - is contraindicated in pregnancy for the prophylaxis of migraine
- clinicians in the Headache Service attended the Clinical Interface Group to discuss a topiramate pathway including options for new patients going forward. The pathway ensures clarity regarding the roles and responsibilities for those prescribing and initiating topiramate for migraine and compliance with Medicines and Healthcare products Regulatory Agency (MHRA) Pregnancy Prevention Programme annual Risk Awareness Form requirements.
- as part of this process the formulary status of topiramate requires review, for women of child bearing age topiramate would now only be initiated if deemed appropriate and at the request of the Headache Clinic, i.e., Amber 1
- the Headache Service clinicians would prefer that the change in classification only applied to women of childbearing age, i.e., remains GREEN for men and women over 55 years of age

Noting that a pathway will now support the prescribing of topiramate for migraine prophylaxis in women, and mindful of the potential for an increase in Headache Clinic waiting times if men were referred for consideration of topiramate for migraine prophylaxis, members supported the proposal to have a different classification for migraine prophylaxis only for adults of childbearing potential.

Topiramate 25mg, 50mg, 100mg, 200mg film-coated tablets, 10mg/mL, 20mg/mL oral suspension, 15mg, 25mg, 50mg sprinkle hard capsules is routinely available in line with local guidance.
Indication under review: in women of childbearing potential for the prophylaxis of migraine headache after careful evaluation of possible alternative treatment options. Topiramate is not intended for acute treatment.
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. **FTEAM**

6.3. REVIEW OF FORMULARY SECTION – OPIOID DEPENDENCE

Members reviewed the proposed revised formulary layout suggested by the Substance Use Service.

The Group noted that:
- no significant changes were proposed to the entries for methadone, Espranor® and Buvidal®
- buprenorphine sublingual moves from second- to first-line, with the comment that 'Where methadone and buprenorphine are both equally suitable methadone should be prescribed'
- at previous meetings it was confirmed that the addition of naloxone to buprenorphine as a safety measure was no longer supported. However, the service has suggest that the fixed-dose combination buprenorphine/naloxone remains on formulary with a restriction.

The Group supported the proposed formulary changes, apart from buprenorphine/naloxone, which the Group requested should be noted as non-formulary alternatives preferred.

Buprenorphine/naloxone 2mg/0.5mg, 8mg/2mg, 16mg/4mg sublingual tablets is not routinely available as there is a local preference for alternative medicines.
Indication under review: substitution treatment for opioid drug dependence, within a framework of medical, social and psychological treatment. The intention of the naloxone component is to deter intravenous misuse. Treatment is indicated in adults and adolescents over 15 years of age who have agreed to be treated for addiction.
Not routinely available as there is a local preference for alternative medicines. **FTEAM**

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People currently established on buprenorphine/naloxone for substitution treatment for opioid drug dependence may continue to receive treatment until they and their clinician consider it appropriate to stop.

7. PUBLISHED ADVICE

7.1. SCOTTISH MEDICINES CONSORTIUM ADVICE PUBLISHED MAY 2025

The Group noted the SMC advice published May 2025.

Following publication of the negative SMC recommendations, for donanemab (Kisunla®)▼ SMC 2687 and fruquintinib (Fruzaqla®)▼ SMC 2748, and the non-submission statements for Genvoya® (cobicistat/elvitegravir/emtricitabine/tenofovir alafenamide fumarate) SMC 2809 and sarilumab (Kevzara®) SMC 2810, 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 2738 erdafitinib (Balversa®)▼ (submission expected)
- SMC 2765 mepolizumab (Nucala®)
- SMC 2556 molnupiravir (Lagevrio®)▼
- SMC 2557 Paxlovid®▼ (nirmatrelvir and ritonavir)
- SMC 2730 sodium thiosulfate (Pedmarqsi®) (submission expected)

Local advice for these medicines and indications will be included in the May 2025 decisions as 'Not routinely available as the ADTC is waiting for further advice from local clinical experts'. **FTEAM**

7.2. UMAR SMC 2709 - EXAGAMGLOGENE AUTOTEMCEL

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

In line with local processes, and pending confirmation that this medicine is available for prescribing within the ultra-orphan pathway, the Formulary Group recorded exagamglogene autotemcel (exa-cel) (Casgevy®) as 'not routinely available in NHS Grampian. If local need identified contact the Pharmacist Team Leader/Principal Pharmacist – Supply (ARI).'

UMAR SMC 2709 - Exagamglogene autotemcel 4-13 x 10^6 cells/mL dispersion for infusion (Casgevy®)▼ is not routinely available in NHS Grampian.
Indication under review: for the treatment of transfusion-dependent beta-thalassemia in patients 12 years of age and older for whom haematopoietic stem cell transplantation is appropriate and a human leukocyte antigen matched related haematopoietic stem cell donor is not available.
Not routinely available in NHS Grampian. If local need identified contact the Pharmacist Team Leader/Principal Pharmacist – Supply (ARI). **FTEAM**

7.3. NATIONAL CANCER MEDICINES ADVISORY GROUP (NCMAG) ADVICE PUBLISHED APRIL 2025

The Group noted the NCMAG advice published April 2025.

The following NCMAG supported medicines and indications have not been processed within a 60-day timescale:

- NCMAG 121 nivolumab (submission expected)
- NCMAG 122 pembrolizumab (submission expected)

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	Local advice for these medicines and indications will be included in the May 2025 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 MAY 2025

The Group noted the SMC provisional advice issued May 2025.

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

9. OTHER BUSINESS

9.1. NEW BMS TOOL FOR CLINICIANS - USE OF INCRETIN-BASED THERAPIES IN WOMEN USING HRT

The Chair highlighted the new British Menopause Society tool for clinicians regarding the use of incretin-based therapies in women using hormone replacement therapy (HRT). The tool provides general guidance and considerations when prescribing incretin-based therapies in women using HRT during the menopause transition and post-menopause.

Members touched on the issues of incretin-based therapies being provided outwith the NHS and the lack of clarity about what, if any, counselling is being provided to women on contraceptives, HRT etc.

10. DOCUMENTS FOR INFORMATION

Items 10.1 (MHRA Safety Roundup April 2025), 10.2 (Antimicrobial Management Team meeting minute March 2025), 10.3 (Grampian Area Drug and Therapeutic Committee meeting minute January 2025), 10.4 (Grampian Primary Care Prescribing Group meeting minute November 2024) and 10.5 (Acute and Mental Health Medicines Safety Group meeting minute February 2025) were noted.

11. AOCB

None.

DATE OF NEXT MEETING

Tuesday 17 June 2025 starting at 14.30 via Microsoft Teams.

Signature on file

CHAIR'S SIGNATURE **Dr Louise Elliot** **DATE 17 JUNE 2025**