NHS GRAMPIAN
Minute of Formulary Group Meeting
Tuesday 18 November 2025 at 14:30 via Microsoft Teams

PRESENT	APOLOGIES	APPROVED
Mr Y Al-Obaidi	Dr V Chieng	
Ms E Bruce	Mrs M Galvin	
Mr G Burt (from item 3.1)	Dr K Simpson	
Ms L Cameron		
Ms F Doney		
Dr L Elliot (Chair)		
Mrs G McKerron (from item 2.1)		
Mrs E Milne		
Mrs S O'Beirne (from item 3)		
Mr M Paterson (from item 3)		

IN ATTENDANCE

Ms Dawn Bruce, Specialist Pharmacy Technician, Formulary Team.
Mrs Christine Standen, Formulary and Medicines Management Pharmacist.

IN ATTENDANCE FOR PRESENTATION

Dr Petrus I. Elofuke, Consultant and Honorary Senior Clinical Lecturer (Stroke & Acute Medicine), Clinical Lead-Acute Stroke Service, for item 4.1.

NOTE ON AGENDA ORDER

To accommodate availability and time constraints, some items were taken out of order during the meeting. For clarity and consistency, these minutes are recorded in the original agenda sequence, with annotations where applicable.

ITEM	SUBJECT	ACTION

WELCOME

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

Note: This was taken later than scheduled, after item 3.1, to accommodate members' availability.

The Chair led introductions and formally welcomed Mr Grant Burt, Senior Finance Manager, as the new finance representative on the Group.

1. APOLOGIES

Apologies for absence were requested and noted.

2. MINUTE AND DECISIONS

2.1. DRAFT MINUTE OF THE MEETING HELD 21 OCTOBER 2025

Ms Doney reported that an error was identified and will be corrected before publication.
Members endorsed the draft note of the meeting, subject to this amendment.
The final approved minute will be made publicly available within 21 days of formal approval. **FD**

2.2. FORMULARY GROUP DECISIONS OCTOBER 2025 - PUBLISHED 03/11/2025

Members formally ratified the October 2025 decisions document as published.

ITEM	SUBJECT	ACTION

3. MATTERS ARISING

3.1. ACTION LOG

Ms Doney reported that the current action log will be reviewed and retired, and a new action log developed for implementation at the January meeting. **FTEAM**

NON-AGENDA ITEMS
Ms Doney presented the responses to queries identified in the reviews for bevacizumab (NCMAG 123 and 124) and Pylera® (SMC 2701).

4. DISCUSSION/PRESENTATION DR PETRUS I. ELOFUKE

4.1. DR PETRUS I. ELOFUKE, CONSULTANT AND HONORARY SENIOR CLINICAL LECTURER (STROKE & ACUTE MEDICINE), CLINICAL LEAD-ACUTE STROKE SERVICE FOR FG1 481/15 TICAGRELOR

Note: This item was taken later than scheduled, after item 5.3, to accommodate presenter availability.

The Chair welcomed Dr Elofuke, Consultant and Honorary Senior Clinical Lecturer (Stroke & Acute Medicine), Clinical Lead-Acute Stroke Service to discuss the request for the off-label use of ticagrelor in stroke secondary prevention.

Dr Elofuke confirmed that:

- in 2022 NHS Tayside developed a genetic test to identify alleles associated with reduced metabolism of clopidogrel, meaning some people will not activate the drug effectively
- people with one of these variants are unlikely to benefit from clopidogrel as stroke secondary prevention, and therefore require consideration of alternative antiplatelet strategies
- historically, aspirin plus dipyridamole modified-release was used for stroke secondary prevention, although this regimen was associated with adverse effects such as headaches and gastrointestinal symptoms. Clopidogrel offered a single daily medication with better tolerability and compliance.
- evidence suggests that approximately one-third of patients have reduced clopidogrel metabolism due to genetic variants
- clinically, recurrent strokes in patients taking clopidogrel raise the possibility of pharmacogenetic non-response. This underpins the Scottish Government's decision, through the Accelerated National Innovation Adoption (ANIA) programme, to implement pharmacogenomic testing across Scotland.
- the test is a simple blood test sent via a EDTA purple top tube to the Tayside genetic laboratory. Results are available in about seven days. These results allow clinicians to reassess antiplatelet therapy to reduce the risk of further stroke or transient ischemic attacks (TIAs).
- a clinical pathway has been established to guide treatment based on clopidogrel metabolism status. Broadly, patients are categorised as either clopidogrel metabolisers (for whom the drug is effective) or non-metabolisers
- evidence from the POINT and CHANCE trials supports dual antiplatelet therapy (DAPT) for selected patients - specifically those with minor strokes, mild strokes, or high-risk TIAs. DAPT significantly reduces early recurrent stroke risk in this group.
- the benefit of DAPT is limited to the first 10–30 days; beyond 30 days the bleeding risk outweighs benefit. Therefore, for eligible patients, the recommended regimen begins with loading doses of high-dose aspirin and 300mg clopidogrel, followed by 75mg of each from day two for up to three weeks.
- locally, a three-week DAPT duration is used, reflecting the CHANCE-2 trial protocol, whereas the 2023 national clinical guideline recommends 30 days of ticagrelor-based DAPT. The CHANCE study directly compared ticagrelor-DAPT with clopidogrel-DAPT

and used a 21-day treatment period, informing local practice.
- for patients who do not meet criteria for DAPT, such as those with severe stroke or low-risk TIA, the traditional approach remains: aspirin 300mg for two weeks, followed by clopidogrel for normal metabolisers, or aspirin plus dipyridamole modified-release (MR) for non-metabolisers
- a subset of high-risk patients may not tolerate aspirin plus dipyridamole MR after the initial three-week DAPT course. In these cases, ticagrelor monotherapy for up to 90 days is used, based on the CHANCE-2 trial. Beyond 90 days, clopidogrel and ticagrelor provide similar protection against recurrent stroke, though ticagrelor carries a slightly increased risk of all forms of bleeding.

Members' questions were addressed, and the following points were confirmed:
- ideally, clopidogrel metaboliser status would be known before initiating treatment. However, in the acute setting, clinicians will start clopidogrel plus aspirin, and if required, change to ticagrelor plus aspirin to complete the 21-day DAPT course.
- when switching acute antiplatelet agents there is no need to reload with aspirin. The group noted an outstanding query regarding whether ticagrelor requires a reload dose or whether patients should move directly to the maintenance regimen.
- a GP representative emphasised the importance of receiving clear, step-by-step instructions on required actions, subsequent steps, and additional prescribing considerations such as PPI cover, given that primary care teams will initially be unfamiliar with initiating or adjusting these regimens. Clear communication with practices was highlighted as essential.
- as part of the project, template letters will be issued to primary care. These will outline the patient's test result, its clinical implications, and the recommended treatment plan.
- the risk of recurrent stroke is greatest in the early phase and declines over time. If patients are unable to tolerate dipyridamole MR plus aspirin, they will be offered ticagrelor monotherapy for 90 days. After 90 days, patients will be retried on dipyridamole MR plus aspirin; if still not tolerated, they will move to aspirin monotherapy.
- a patient information leaflet has been produced. Staff taking the blood sample will explain the purpose and implications of the genetic test and provide the leaflet for the patient to read.

A member noted that the dispensary routinely supplies two weeks of medication on discharge, which may not cover the full 21-day treatment course for some patients depending on their length of stay.

The Chair thanked Dr Elofuke for attending the meeting to discuss the request.
Dr Elofuke left the meeting prior to the decision-making process.

5. NEW PRODUCT REQUESTS

5.1. FG1 474/25 - ACTIMORPH® (SEVERE PAIN WHICH REQUIRES OPIOIDS)

Note: This item was taken earlier than scheduled, after item 3.1, to accommodate presenter availability.

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

The Group considered the request for morphine sulfate orodispersible tablets as the brand Actimorph®.

The Group noted:
- Actimorph® is an orodispersible immediate-release tablet available as 1mg, 2.5mg, 5mg, 10mg, 20mg and 30mg strengths
- it is a Schedule 2 controlled drug, subject to the full Controlled Drug requirements

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relating to prescriptions, safe custody and the need to keep a Controlled Drug register
- morphine sulfate is currently included on the formulary as GREEN in various formulations including immediate-release tablets, modified-release tablets, modified-release capsules, oral solution and injection
- Actimorph® is included in the East Region Formulary for severe pain which can be managed adequately only by opioids, restricted to use as an alternative for patients unable to swallow morphine sulphate 'Sevredol' tablets, or where a lower dose is required and unable to measure morphine sulphate oral solution due to dexterity issues or visual impairment
- the Scottish Palliative Care Guidelines note that Actimorph® 1mg is the lowest dose immediate-release preparation available and is cost-neutral compared to oral morphine. It also allows limited supply if there are concerns about errors in drawing up the correct dose, misuse or diversion.
- the request is for palliative care use, but benefits may apply to other specialties where immediate-release morphine is indicated
- the paediatric service has confirmed that Actimorph® would be a useful addition to its armamentarium
- the Palliative Care Service plans to:
  - use Actimorph® for a small number of patients (in preference to existing formulations) where the orodispersible formulation offers an advantage in terms of patient acceptability and patient safety
  - continue to use morphine sulfate oral solution or Sevredol® as the first-line immediate-release morphine preparation but they would like to include Actimorph® on the formulary as an option for patients requiring low doses of morphine but are unable to use the oral solution, e.g., patients who can't draw it up, or where the oral solution is felt to be inappropriate or unsafe.
- that the use of Actimorph® as an alternative immediate-release oral morphine preparation is expected to be cost neutral

Members did not support limiting use to palliative care, noting that the benefits could extend to other service areas, such as paediatrics. A member recommended highlighting that Actimorph® is an orodispersible tablet rather than a standard immediate-release tablet, to ensure correct use.

The Group accepted the restricted local need for morphine sulfate orodispersible tablets (Actimorph®).

FG1 474/25 - Morphine sulfate (Actimorph®) 1mg, 2.5mg, 5mg, 10mg, 20mg, 30mg orodispersible tablets is routinely available in line with local guidance.
Indication under review: for patients aged 6 months and older with severe pain which can be adequately managed only with opioids.
It was classified 1a - available for general use and 8e - treatment may be initiated in either Primary or Secondary care. **FTEAM**

5.2. FG1SMC 2659 - REZAFUNGIN (INVASIVE CANDIDIASIS IN ADULTS)

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

The Group considered the request for rezafungin for the treatment of invasive candidiasis in adults.

The Group noted:
- rezafungin meets SMC orphan criteria for this indication, and was accepted for use in NHS Scotland following a full submission assessed under the orphan medicine process, the output from the PACE process, and application of SMC decision modifiers that can be applied when encountering high cost-effectiveness ratios
- rezafungin is an antifungal medicine used to treat adults with invasive candidiasis. It is

administered as a single 400mg loading dose on Day 1, followed by 200mg on Day 8 and once weekly. Clinical trials treated patients for up to 28 days; safety data beyond four weeks is limited.
- evidence comes from the ReSTORE study, a phase III, multicentre, randomised, double-blind study comparing rezafungin and caspofungin. The primary outcome of Global cure at day 14 was 59% for rezafungin versus 61% for caspofungin. Secondary outcomes included global cure at day 5 (56% versus 52% for rezafungin versus caspofungin respectively) and global cure at day 30 (50% versus 49% for rezafungin versus caspofungin respectively)
- if accepted, rezafungin will be included on the formulary as an Alert (protected) antimicrobial
- treatment duration will be dependent on clinical presentation and response, typically estimated as two to six weeks, but may extend to 12 weeks for conditions like endocarditis or infected prosthesis
- patient numbers are expected to be small, and supplies will be via the outpatient parenteral antimicrobial therapy (OPAT) service based on referrals from the Infectious Diseases service
- cost offset is anticipated from the displacement of alternative antifungal agents
- rezafungin offers an additional treatment option with the advantage of once-weekly administration, reducing nurse/chair time compared to daily infusions
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of rezafungin

The Group accepted the restricted local need for rezafungin acetate for the treatment of invasive candidiasis in adults. Formulary acceptance is subject to inclusion in the alert (restricted) antimicrobials list, with treatment only available in the managed service after authorisation by a medical microbiologist or infectious disease specialist.

FG1SMC 2659 - Rezafungin acetate 200mg powder for concentrate for solution for infusion (Rezzayo®)▼ is routinely available in line with national guidance (SMC 2659).
Indication under review: for the treatment of invasive candidiasis in adults.
Restriction: use should be on the advice of local microbiologists or specialists in infectious disease.
In a randomised, double-blind, phase III study, rezafungin was non-inferior to another echinocandin for global cure at day 14 in patients with candidaemia and/or invasive candidiasis and one or more systemic signs attributable to these conditions.
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. Consideration should be given to official guidance on the appropriate use of antifungal agents. **FTEAM**

5.3. FG1 475/25 - INFLIXIMAB (INFLAMMATORY BOWEL DISEASE IN PAEDIATRIC PATIENTS)

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

The Group considered the request for the off-label use of infliximab subcutaneous injection as a maintenance treatment option for young people with inflammatory bowel disease.

The Group noted that:
- intravenous infliximab is licensed and included on formulary for the treatment of active

Crohn's disease (6 years and over) in line with NICE TA187 and for the treatment of moderately to severely active ulcerative colitis after the failure of conventional therapy (6 years and over) in line with NICE TA329

- infliximab subcutaneous injection is included on formulary for the treatment of Crohn's disease and ulcerative colitis but only for adults in line with the licensing for the subcutaneous injection. Remsima® is the preferred biosimilar of infliximab subcutaneous injection.
- infliximab subcutaneous injection for young people (12 years to <18 years) with Crohn's disease or ulcerative colitis would be of 'off-label' use
- the service has defined eligibility and exclusion criteria [for people to switch to subcutaneous injection]
- infliximab is administered subcutaneously as 120mg every 2 weeks. Before initiating the subcutaneous injection, two intravenous infusions should be given two weeks apart.
- patients will receive the first injection in hospital and subsequent injections will be administered by the community nursing team until the patient/carer is competent in self-administration
- the service plans to supply the first two doses from the hospital then continue the supply from homecare. Supplies from homecare will exclude VAT.
- there is limited evidence for the use of subcutaneous infliximab in young people under 18 years
- real world data which included patients aged 13 to 18 years, weighing >50kg and receiving intravenous infliximab 10mg/kg every 4 to 8 weeks suggests patients remained in clinical remission and experienced no serious adverse events after switching
- patient numbers switching annually are expected to be low
- subcutaneous infliximab would replace intravenous infliximab for patients in remission that choose the subcutaneous route as their maintenance treatment option
- cost offset is available from displacement of intravenous infliximab, and switching to the subcutaneous injection would reduce chair time and ancillaries associated with intravenous infusions

The Group accepted the restricted local need for infliximab subcutaneous injection as an off-label maintenance treatment option for young people with severely active Crohn's disease or ulcerative colitis.

FG1 475/25 - Infliximab 120mg/1mL solution for injection in pre-filled pens (Remsima®) is routinely available in line with local guidance.
Indication under review: [off-label use] for the maintenance treatment of young people aged 12 to 17 years with:

- **severely active Crohn's disease**
- **severely active ulcerative colitis**

It was classified 3b - licensed product available for restricted off-label use and 8b - recommended for hospital use only. Treatment should to be initiated and supervised by qualified physicians experienced in the diagnosis and treatment of conditions for which Remsima® is indicated. Patients should be given the package leaflet and the patient reminder card. **FTEAM**

5.4. FG1 479/25 - DROSPIRENONE (CONTRACEPTION)

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

Note: This item was taken later than scheduled, after Item 5.5, to accommodate presenter availability.

The Group considered the request for drospirenone as an additional progestogen-only contraceptive.

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The Group noted that:

- drospirenone is a progestogen-only pill (POP) derived from spironolactone that has antiandrogenic and antimineralocorticoid properties
- the recommended dose is one tablet daily for 28 consecutive doses; one white active tablet daily during the first 24 days and one green inactive tablet daily during the 4 following days
- in October 2024, drospirenone was not recommended for use in NHS Scotland as contraception due to the absence of a submission from the holder of the marketing authorisation
- the College of Sexual and Reproductive Healthcare advice on POPs includes:
  - the available evidence is too limited to inform whether there is a significant difference in contraceptive effectiveness between traditional POP and desogestrel/drospirenone POPs
  - individuals with significant risk factors for chronic kidney disease, measurement of urea and electrolytes and blood pressure should be considered prior to prescription of the drospirenone, particularly in those aged over 50 years
- the requestor has stated that it will be recommended for use as a second-line alternative to other contraceptive options and used only by specialists or GPs with an interest in contraception and/or women's healthcare
- the service plans to use drospirenone as a second-line POP after desogestrel. Whilst there are other oral POP available, these options have a 3-hour 'missed pill' window compared to drospirenone's 24-hour window. These alternatives may pose an unacceptable risk of unplanned pregnancy for many women of reproductive age.
- although the cost of drospirenone is higher than alternative POPs, the service has stated that when compared to the cost of an unintended pregnancy in women for whom they have not been able to find a suitable method, drospirenone POP would provide a cost-effective [public health] intervention

Members raised queries about the risk of thromboembolism with drospirenone, and if there is evidence that the 24-hour window provides a significant advantage in terms of effectiveness compared to other POPs.
Members noted that, as a derivative of spironolactone, monitoring is different to other contraceptives and questioned how this difference would be highlighted to prescribers.

The Group was minded to support the request but had concerns about the safety of introduction. Without sufficient information, would prescribers consider this as just another POP with a 24-hour window and not consider the additional monitoring that may be required.

Decision deferred to a future meeting. **FTEAM**

5.5. FG1 481/15 - TICAGRELOR (OFF-LABEL USE IN PATIENTS WITH LOW RISK OF BLEEDING: FOR TRANSIENT ISCHAEMIC ATTACK OR MINOR ISCHAEMIC STOKE)

Note: This item was taken earlier than scheduled, following the presentation of Item 4.

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

The Group considered the requests for the off-label use of ticagrelor [in combination with aspirin] for TIA or minor ischaemic stroke in patients with a low risk of bleeding.

The Group noted that:

- ticagrelor is an inhibitor of platelet aggregation, reducing the risk of a blood clot forming and helping to prevent a stroke or another heart attack
- the use of ticagrelor for TIA [in patients with low risk of bleeding] and for minor ischaemic stroke [in patients with low risk of bleeding] is off-label. However, the British

National Formulary lists a dose for this indication - initially 180mg for one dose, to be started within 24 hours of onset of symptoms, then 90mg twice daily, to be combined with aspirin for the first 30 days.

- ticagrelor is already included on formulary [for its licensed indication] in combination with aspirin for the prevention of atherothrombotic events in adults with acute coronary syndromes in line with SMC 699/11
- the current NHS Grampian guidance for Secondary Prevention for Stroke/TIA states that patients with recurrent TIA or stroke whilst taking clopidogrel, consideration should be given to clopidogrel resistance. In such cases consider using ticagrelor (initial dose 180mg followed by 90mg twice daily) plus aspirin (300mg followed by 75mg daily for 30 days) followed by antiplatelet monotherapy with ticagrelor 90mg twice daily or clopidogrel 75mg once daily at the discretion of the prescriber.
- NHS Tayside already carries out clopidogrel genotype testing and has included ticagrelor on its formulary for TIA and minor ischaemic stroke [in patients with a low risk of bleeding] combined with aspirin for the first 30 days after the ischaemic event.
- National Clinical Guideline for Stroke, 2023 edition states - *Patients with TIA or minor ischaemic stroke should be given antiplatelet therapy provided there is neither a contraindication nor a high risk of bleeding. The following regimens should be considered as soon as possible:*
  - *For patients within 24 hours of onset of TIA or minor ischaemic stroke and with a low risk of bleeding, the following dual antiplatelet therapy should be given: Clopidogrel (initial dose 300mg followed by 75mg per day) plus aspirin (initial dose 300mg followed by 75mg per day for 21 days) followed by monotherapy with clopidogrel 75mg once daily*
    OR
  - *Ticagrelor (initial dose 180mg followed by 90mg twice daily) plus aspirin (300mg followed by 75mg daily for 30 days) followed by antiplatelet monotherapy with ticagrelor 90mg twice daily or clopidogrel 75mg once daily at the discretion of the prescriber*
- one of the key messages from the Scottish Health Technologies Group (SHTG) - Genotype testing to guide clopidogrel use after an ischaemic stroke or transient ischaemic attack (TIA) assessment was that people who are clopidogrel resistant should be prescribed an alternative antiplatelet
- a meta-analysis of two randomised controlled trials (n=7,087) showed that ticagrelor is more effective at reducing the risk of ischaemic stroke recurrence compared with clopidogrel in people who are clopidogrel resistant: Hazard Ratio (HR) 0.77, 95% Confidence Interval (CI) 0.65 to 0.93. Ticagrelor was associated with a statistically significant increase in the risk of bleeding: HR 1.85, 95% CI 1.45 to 2.23.
- ticagrelor is already included in the local guidance for those with recurrent TIA or stroke whilst taking clopidogrel, so some costs will already be in the system, but with the introduction of genotype testing this will mainly be a new cost. The higher drug costs do not include cost offset gains related to TIA or stroke prevention.
- the SHTG Assessment included a cost analysis for NHS Scotland, and found that genotype-guided antiplatelet therapy was resource-saving compared with no testing, resulting from a reduction in hospital and rehabilitation costs associated with fewer people having a recurrent stroke
- these are medicines that primary care is familiar with, although the requested use is slightly different

Members recognised the need for an alternative antiplatelet regimen for people who are resistant to clopidogrel. Some concerns remained about the practical aspects of implementation, and the potential for confusion or miscommunication, emphasising the importance of clear communication.
It was noted that communications should clearly specify the stop date for the 21-day DAPT regimen, and where applicable, the stop date for long-term ticagrelor therapy. Members also queried who would be responsible for reviewing treatment in cases where

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patients are intolerant of aspirin plus dipyridamole MR, and whether such patients should directly contact the acute service or primary care for further management. **FTEAM**

The Group requested assurance that appropriate measures are being implemented to ensure clear and consistent communication with both primary care and patients. **FTEAM**

The Group accepted the restricted local need for the off-label use of ticagrelor, in combination with aspirin as dual antiplatelet therapy, for a 21-day course in adults with TIA or minor ischaemic stroke who are assessed as having a low risk of bleeding.

FG1 481/25 - Ticagrelor 90mg tablets, 90mg orodispersible tablets is routinely available in line with local guidance.
Indication under review: [off-label use] in combination with aspirin for the first 21 days after an ischaemic event in adults with a low risk of bleeding for:
- **transient ischaemic attack (TIA)**
- **minor ischaemic stroke**

It was classified 3b - licensed product available for restricted off-label use and 8d - treatment may be initiated in community on the recommendation of a consultant/specialist. **FTEAM**

6. FORMULARY REVIEW

6.1. FORMULARY UPDATES NOVEMBER 2025

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

DISCONTINUATIONS

Ms Doney reported that:
- three medicines were noted as being discontinued:
  - econazole nitrate 1% vaginal cream (Gyno-Pevaryl®),
  - exenatide 2mg/0.85mL prolonged-release suspension for injection pre-filled pen (Bydureon® BCise)
  - mometasone 200microgram/dose, 400microgram/dose dry powder inhaler (Asmanex® Twisthaler®)
- the changes are considered low impact discontinuations

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

6.2. SGLT2 INHIBITORS (RECLASSIFICATION REQUEST)

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

The Group considered the request to reclassify the current formulary choice sodium-glucose cotransporter-2 (SGLT2) inhibitors to allow treatment to be initiated in either Primary or Secondary care.

Ms Doney confirmed that:
- SGLT2 inhibitors have been prescribed for many years, and were initially licensed as glucose lowering agents for Type II diabetes mellitus
- dapagliflozin and empagliflozin are now licensed for heart failure and chronic kidney disease
- the SGLT2 inhibitors have proven cardiovascular benefits particularly in Type II diabetes mellitus and heart failure, and have demonstrated renoprotection in those with chronic kidney disease

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- increasingly SGLT2 inhibitors are being considered as an additional first-line agent for people with a high risk of cardiovascular disease
- dapagliflozin is now off patent
- the change in classification is supported by the specialist services

The Group accepted that it was important to remove any perceived barriers to prescribing, and supported the proposal to reclassify the current formulary SGLT2 inhibitors to allow treatment initiation in either Primary or Secondary care. **FTEAM**

6.3. TRIXEO AEROSPHERE® (BUDESONIDE/FORMOTEROL FUMARATE DIHYDRATE/GLYCOPYRRONIUM BROMIDE)

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

Ms Doney summarised information from the Respiratory Managed Clinical Network (MCN) requesting that the fixed-dose triple-combination therapy, Trixeo® Aerosphere®, is considered for inclusion on the formulary.

Ms Doney confirmed that:

- Trixeo® Aerosphere®:
  - is accepted by SMC for use in adults with severe COPD (forced expiratory volume in one second [FEV_1] less than 50% predicted normal)
  - is a fixed-dose triple-combination therapy
  - was previously considered for formulary inclusion, but alternative fixed-dose triple-combination therapy devices were preferred at that time
- inclusion would be cost-neutral
- in 2025, Trixeo® Aerosphere® was approved [for use in the UK] with a new next-generation propellant with near-zero global warming potential. It is the first medicine delivered by a pressurised metered-dose inhaler (pMDI) approved with a new greener propellant.
- to support greener prescribing initiatives, the MCN has requested formulary inclusion

Members noted that addition would be cost neutral and acknowledged the potential environmental benefits of the new formulation.

The Group accepted the restricted local need for Trixeo® Aerosphere® without the need for a full submission.

SMC 2321 - Trixeo® Aerosphere® 5micrograms/7.2micrograms/160micrograms pressurised inhalation, suspension (formoterol fumarate dihydrate/glycopyrronium bromide/budesonide) is routinely available in line with local guidance.
Indication under review: maintenance treatment in adults with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist or combination of a long-acting beta2-agonist and a long-acting muscarinic antagonist.
Restriction: in adults with severe COPD (forced expiratory volume in one second [FEV1] less than 50% predicted normal).
Formoterol fumarate dihydrate/glycopyrronium / budesonide (Trixeo® Aerosphere®) offers an additional treatment choice of long-acting beta2-agonist (LABA), long-acting muscarinic antagonist (LAMA) and inhaled corticosteroid (ICS) in a single inhaler.
It was classified 1a - available for general use and 8e - treatment may be initiated in either Primary or Secondary care. **FTEAM**

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6.4. PROTECTED ANTIMICROBIALS (FOR DISCUSSION)

The Group reviewed the SBAR from the Antimicrobial Management Team (AMT) requesting support to move the current 'alert list' of antimicrobials from a guidance document to maintaining the list within the Right Decision platform.

Members accepted that maintaining the alert list within a web-based application would allow timely update of entries and would be beneficial from a workload perspective.
The Group offered qualified support for the proposal to retire the document and maintain the alert list within the Right Decision Service (RDS), subject to confirmation:

- that long-term funding for the RDS has been secured
- of the AMT's contingency plans if RDS is not fully funded going forward

FTEAM

6.5. UPDATE TO THE SHARED CARE ARRANGEMENTS FOR METHOTREXATE AND MYCOPHENOLATE

Ms Doney reported that the shared care arrangements for methotrexate and mycophenolate have recently had minor amendments to include the respiratory specialist service as one of the specialties that may recommend the use of these drugs for patients. These medicines will be used off-label in a small cohort of patients for interstitial lung diseases, such as sarcoidosis. This is in line with longstanding practice but explicit inclusion in the shared care arrangement ensures appropriate management of these patients and inclusion in the High Risk Medicines Locally Enhanced Service.

FTEAM

The formulary will be updated appropriately.

NON-AGENDA ITEM: SERTRALINE TABLETS

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

Ms Doney reported that:

- the local Medicines Management Team has highlighted a potential cost-efficiency for sertraline tablets
- sertraline is available as a tablet formulation in strengths of 25mg, 50mg, 100mg, 150mg and 200mg
- the 150mg and 200mg strengths are not included in the Scottish Drug Tariff, and at current costs it is more cost-effective to use multiple lower strength tablets that use the 150mg or 200mg tablets
- there is a request to note the 150mg and 200mg tablets as non-formulary and utilise ScriptSwitch to support the change to prescribing
- the Principal Pharmacist for Mental Health and Learning Disability Services has not raised any concerns regarding the requested change

To support a cost-avoidance opportunity the Group supported noting the non-tariff strengths of sertraline, 150mg and 200mg, as non-formulary, not preferred.

Sertraline 150mg, 200mg tablets is not routinely available as there is a local preference for alternative medicines.
Indications under review: in line with the current formulary acceptance, including any restrictions.
Not routinely available as there is a local preference for alternative medicines.

FTEAM

ITEM	SUBJECT	ACTION

7. PUBLISHED ADVICE

7.1. SCOTTISH MEDICINES CONSORTIUM ADVICE PUBLISHED NOVEMBER 2025

The Group noted the SMC advice published November 2025.
Following publication of the negative SMC recommendations for elacestrant (Korserdu®▼ - SMC 2807) and tarlatamab (Imdylltra®▼ - SMC 2816), and the non-submission statement for melatonin (Slenyto® - SMC 2882), these medicines will not be included on the Grampian Joint Formulary for the respective indications.

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

- SMC 2855 budesonide (Budenofalk®) (submission expected)
- SMC 2857 durvalumab (Imfinzi®) (submission expected)
- SMC 2848 guselkumab (Tremfya®) (submission expected)
- SMC 2850 guselkumab (Tremfya®) (submission expected)
- SMC 2804 isatuximab (Sarclisa®) (submission expected)
- SMC 2824 mercaptamine (Procysbi®) (submission expected)
- SMC 2803 ribociclib (Kisqali®) (submission received)

Local advice for these medicines and indications will be included in the November 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 NOVEMBER 2025

The Group noted the SMC provisional advice issued November 2025.

If the SMC issues negative recommendations or non-submission statements next month, these medicines will not be included on the formulary for the specified indications. **FTEAM**

9. OTHER BUSINESS

None.

10. DOCUMENTS FOR INFORMATION

Items 10.1 (MHRA Safety Round-up October 2025), 10.2 (MedWatch Vol.6:Issue 5 November 2025), 10.3 (Grampian Primary Care Prescribing Group meeting minute July 2025), 10.4 (Acute and Mental Health Medicines Safety Group meeting minute August 2025), 10.5 (Antimicrobial Management Team meeting minute September 2025), were noted.

11. AOCB

None.

DATE OF NEXT MEETING

Tuesday 20 January 2026 starting at 14.30 via Microsoft Teams.

Signature on file

CHAIR'S SIGNATURE **Dr Louise Elliot** **DATE** **20 January 2026**