# NHS GRAMPIAN
## Minute of Formulary Group Meeting
## Tuesday 20 January 2026 at 14:30 via Microsoft Teams

| PRESENT | APOLOGIES | APPROVED |
|---|---|---|
| Mr Y Al-Obaidi | | |
| Ms L Cameron (until item 5.7) | | |
| Dr V Chieng (from item 3.1) | | |
| Ms F Doney | | |
| Dr L Elliot (Chair) | | |
| Mrs M Galvin | | |
| Mrs G McKerron | | |
| Mrs E Milne | | |
| Mrs S O'Beirne | | |
| Mr M Paterson (from item 5.6) | | |

**IN ATTENDANCE**

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

| ITEM | SUBJECT | ACTION |
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WELCOME

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

GOODBYE AND THANK YOU

The Chair reported that due to a change in responsibilities Dr Simpson has resigned from the Group. The Group expressed its sincere thanks to Dr Simpson for her commitment, professionalism and valuable contributions to the work of the Group. Members extended their best wishes for the future.

**1. APOLOGIES**

Apologies for absence were requested and noted.

**2. MINUTE AND DECISIONS**

**2.1. DRAFT MINUTE OF THE MEETING HELD 18 NOVEMBER 2025**

Members endorsed the draft note of the meeting, pending minor typographical amendments.
The final approved minute will be made publicly available within 21 days of formal approval. **FD**

**2.2. FORMULARY GROUP DECISIONS NOVEMBER 2025 - PUBLISHED 02/12/2025**

Members formally ratified the November 2025 decisions document as published.

**3. MATTERS ARISING**

**3.1. ACTION LOG**

The Group noted the item.

**4. DISCUSSION/PRESENTATION**

None.

| ITEM | SUBJECT | ACTION |
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**5. NEW PRODUCT REQUESTS**

**5.1. FG1SMC 2736 – OSIMERTINIB (ADVANCED NON-SMALL CELL LUNG CANCER)**

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

The Group considered the request for osimertinib, used in combination with pemetrexed and platinum-based chemotherapy, for the first-line treatment of adults with advanced non-small cell lung cancer (NSCLC) whose tumours have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations.

The Group noted:

- osimertinib:
  - is a tyrosine kinase inhibitor (TKI) that inhibits EGFR harbouring sensitising-mutations and TKI-resistance mutation T790M
  - [for this indication] the recommended dose is 80mg once a day taken with pemetrexed and platinum-based chemotherapy every 21 days
  - [for this indication] meets SMC orphan equivalent criteria, and was accepted for use in NHS Scotland following a full submission assessed under the 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
- current treatment for this patient group is osimertinib monotherapy, in line with SMC 2382
- the Scottish Cancer Network update from July 2025 includes osimertinib in combination with pemetrexed and platinum-based chemotherapy as an option for this patient group
- evidence comes from FLAURA-2:
  - compared osimertinib monotherapy and osimertinib in combination with intravenous (IV) pemetrexed and IV cisplatin or carboplatin
  - the primary outcome was progression-free survival (PFS); median PFS of 25.5 months for osimertinib plus chemotherapy and 16.7 months for osimertinib monotherapy
- patient numbers are expected to be small, but increasing in year two
- cost offset is available from osimertinib monotherapy however the treatment duration is likely to be longer with osimertinib plus chemotherapy
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of osimertinib

The Group accepted the restricted local need for osimertinib, in combination with pemetrexed and platinum-based chemotherapy, for the first-line treatment of adults with advanced NSCLC as outlined in SMC 2736.

**FG1SMC 2736 - Osimertinib 40mg, 80mg tablets (Tagrisso®) is routinely available in line with national guidance (SMC 2736).**
**Indication under review: in combination with pemetrexed and platinum-based chemotherapy for the first-line treatment of adults with advanced non-small cell lung cancer (NSCLC) whose tumours have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations.**
**In an open-label, phase III study, addition of pemetrexed and platinum-based chemotherapy to osimertinib significantly improved progression-free survival in adults with NSCLC whose tumours have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations.**
**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**

| ITEM | SUBJECT | ACTION |
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| | **(PACE) meeting.**<br>**It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only.**<br>**Treatment should be initiated by a physician experienced in the use of anticancer therapies.**<br>**When considering the use of osimertinib, EGFR mutation status (in tumour specimens for adjuvant treatment or for locally advanced, unresectable tumours and tumour or plasma specimens for locally advanced or metastatic setting) should be determined using a validated test method.** | **FTEAM** |

Items 5.2 and 5.3 were taken together.

**5.2. FG1SMC 2767 – PEMBROLIZUMAB (ADVANCED OR RECURRENT ENDOMETRIAL CARCINOMA)**

**5.3. FG1SMC 2797 – DURVALUMAB (ADVANCED OR RECURRENT ENDOMETRIAL CARCINOMA)**

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

The Group considered the requests for two immunotherapies, pembrolizumab and durvalumab, both used in combination with carboplatin and paclitaxel, for the first-line treatment of primary advanced or recurrent endometrial carcinoma in adults.

The Group noted:

- pembrolizumab and durvalumab are immunotherapies which are already included on formulary for multiple other indications
- for this indication:
  - the recommended dose of pembrolizumab is 200mg every three weeks in combination with carboplatin and paclitaxel for 6 cycles and then 400mg every six weeks for up to 14 cycles as monotherapy
  - the recommended dose of durvalumab is 1,120mg in combination with carboplatin and paclitaxel every three weeks for 4 to 6 cycles then 1,500mg every four weeks as monotherapy for the mismatch repair deficient (dMMR) population or in combination with olaparib 300mg twice daily for the mismatch repair proficient (pMMR) population
- dostarlimab, another immunotherapy agent is currently included on formulary for adults with dMMR, microsatellite instability-high (MSI-H) recurrent or advanced endometrial cancer that has progressed on or following prior treatment with a platinum-containing regimen
- the maximum duration of treatment with pembrolizumab is shorter than with dostarlimab: 2 years compared to (up to) 3 years respectively

*Pembrolizumab*

- the evidence for pembrolizumab comes from KEYNOTE-868 which compared pembrolizumab plus chemotherapy to placebo plus chemotherapy
- the primary outcome was PFS (pembrolizumab versus placebo):
  - pMMR: PFS 13.1 months versus 8.7 months
  - dMMR: PFS not reached versus 8.3 months
- an indirect treatment comparison comparing pembrolizumab and dostarlimab suggested similar PFS

*Durvalumab*

- the evidence for durvalumab comes from DUO-E study
- patients were randomised to durvalumab plus chemotherapy followed by durvalumab monotherapy (licensed treatment for dMMR tumours), durvalumab plus chemotherapy followed by durvalumab plus olaparib (licensed treatment for pMMR tumours) or placebo plus chemotherapy followed by placebo
- the primary outcome was PFS (overall cohort):

| ITEM | SUBJECT | ACTION |
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- PFS 10.2 months for durvalumab plus chemotherapy
- PFS 15.1 months for durvalumab plus chemotherapy, then plus olaparib
- PFS 9.6 months for placebo plus chemotherapy

- PFS subgroup analyses:
  - dMMR: PFS not reached for durvalumab plus chemotherapy versus 7 months for placebo plus chemotherapy
  - pMMR: PFS 15 months for durvalumab plus chemotherapy then plus olaparib versus 9.7 months for placebo plus chemotherapy
- an indirect treatment comparison comparing durvalumab and dostarlimab showed no difference in efficacy but durvalumab may perform better in terms of grade 3 or higher adverse events
- patient numbers for the different sub-groups are expected to be small, and the duration of treatment will vary depending on the treatment used
- pembrolizumab plus chemotherapy will be given as an alternative to chemotherapy alone in pMMR patients and as an alternative to dostarlimab in dMMR patients
- durvalumab offers an alternative treatment option to dostarlimab for dMMR patients. For pMMR patients the addition of durvalumab and olaparib to standard chemotherapy improves PFS but this needs to be balanced against the toxicities of maintenance doublet treatment.
- the service anticipates that patients who receive pembrolizumab or durvalumab in the first-line setting will then not receive pembrolizumab plus lenvatinib in the second-line setting
- the SMC advice documents take account of the benefits of PASs that improve the cost-effectiveness of pembrolizumab and durvalumab for this indication
- the service wishes to have all three immunotherapies available for different subgroups of patients

The Group accepted the restricted local need for both pembrolizumab and durvalumab for the first-line treatment of primary advanced or recurrent endometrial carcinoma in adults as outlined in SMC 2767 and SMC 2797 respectively.

**FG1SMC 2767 - Pembrolizumab 25mg/mL concentrate for solution for infusion (Keytruda®) is routinely available in line with national guidance (SMC 2767).**
**Indication under review: in combination with carboplatin and paclitaxel, for the first-line treatment of primary advanced or recurrent endometrial carcinoma in adults.**
**In a double-blind, phase III study, addition of pembrolizumab to carboplatin plus paclitaxel chemotherapy significantly improved progression-free survival in adults undergoing first-line treatment of primary advanced or recurrent endometrial carcinoma.**
**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. Therapy must be initiated and supervised by specialist physicians experienced in the treatment of cancer.** **FTEAM**

**FG1SMC 2797 - Durvalumab 50mg/mL concentrate for solution for infusion (Imfinzi®) is routinely available in line with national guidance (SMC 2797).**
**Indication under review: in combination with carboplatin and paclitaxel for the first-line treatment of adults with primary advanced or recurrent endometrial cancer who are candidates for systemic therapy, followed by maintenance treatment with:**

- **durvalumab as monotherapy in endometrial cancer that is mismatch repair deficient (dMMR)**
- **durvalumab in combination with olaparib in endometrial cancer that is mismatch repair proficient (pMMR).**

| ITEM | SUBJECT | ACTION |
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| | **In a double-blind, randomised, phase III study, progression-free survival was significantly improved with the addition of durvalumab to chemotherapy followed by durvalumab maintenance with or without olaparib compared with chemotherapy alone in patients with primary advanced or recurrent endometrial cancer.<br>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.<br>This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting.<br>It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Treatment must be initiated and supervised by a physician experienced in the treatment of cancer.** | **FTEAM** |

Items 5.4 and 5.5 were taken together.

**5.4. FG1SMC 2822 - MIRIKIZUMAB (MODERATELY TO SEVERELY ACTIVE CROHN'S DISEASE)**

**5.5. FG1SMC 2850 - GUSELKUMAB (MODERATELY TO SEVERELY ACTIVE CROHN'S DISEASE)**

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

The Group considered the request for the use of two biologic agents licensed for the treatment of adults with moderately to severely active Crohn's disease who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a biologic treatment.

The Group noted that:

- mirikizumab and guselkumab are interleukin-23 (IL-23) antagonists
- another IL-23 antagonist, risankizumab, is already included on formulary for Crohn's disease
- mirikizumab is already included on formulary for adults with moderate to severely active ulcerative colitis however, the dosing used for Crohn's disease differs from the ulcerative colitis dose
- mirikizumab is administered at an induction dose of 900mg IV at weeks 0, 4 and 8, then maintenance dose is 300mg every 4 weeks by subcutaneous (SC) injection
- guselkumab induction is administered 200mg by IV or 400mg SC at weeks 0, 4 and 8, then maintenance is 100mg SC every 8 weeks. A higher maintenance dose of 200mg SC every 4 weeks can be considered for patients who do not show adequate therapeutic benefit to induction treatment.
- the service plans to use IV or SC guselkumab for induction depending on the patients symptoms

*Mirikizumab*

- the safety and efficacy comes from VIVID-1, a randomised, double-blind, placebo- and active-controlled treat-through, phase III study
- patients were randomised to mirikizumab (n=579), ustekinumab (n=287) or placebo (n=199)
- the co-primary endpoints assessing superiority of mirikizumab over placebo were:
  - patient-reported outcome (PRO) clinical response at week 12 and endoscopic response at week 52 (38% versus 9%)
  - PRO clinical response at week 12 and Crohn's Disease Activity Index (CDAI) clinical remission at week 52 (45.4% versus 19.6%)
  - at week 52, mirikizumab demonstrated non-inferiority to ustekinumab on clinical remission by CDAI (mirikizumab 54%; ustekinumab 48 %). Superiority over ustekinumab in week 52 endoscopic response was not achieved (mirikizumab 48%, ustekinumab 46%).

| ITEM | SUBJECT | ACTION |
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*Guselkumab*

- the safety and efficacy data comes from GALAXI-2/-3 and GRAVITI, double-blind, treat-through, phase III studies
- in GALAXI-2/-3 patients were randomised to receive guselkumab IV induction followed by guselkumab 100mg SC every 8 weeks (n=143), guselkumab IV induction followed by guselkumab 200mg SC every 4 weeks (n=146), ustekinumab IV induction followed by ustekinumab 90mg SC every 8 weeks (n=143) or placebo (n=76)
- the co-primary efficacy endpoints at week 12 (placebo versus guselkumab):
  - clinical remission: GALAXI-2 – 22% versus 47%; GALAXI-3 – 15% versus 47%
  - endoscopic response: GALAXI-2 – 15% versus 47%; GALAXI-3 – 14% versus 36%
  - secondary outcomes included clinical remission and endoscopic response at week 48 which was 39% versus 42% versus 49% for ustekinumab versus guselkumab 100mg SC every 8 weeks versus guselkumab 200mg SC every 4 weeks respectively
  - guselkumab (100mg SC every 8 weeks and 200mg SC every 4 weeks) was superior to ustekinumab for the objective endpoints at week 48 of endoscopic response (52.7% versus 47.9% versus 37.1%) and endoscopic remission (37.2% versus 33.2% versus 24.7%)
- in GRAVITI patients were randomised to receive guselkumab SC induction followed by guselkumab 100mg SC every 8 weeks (n=115), guselkumab SC induction followed by guselkumab 200mg SC every 4 weeks (n=115) or placebo (n=117)
- the co-primary efficacy endpoints were (placebo versus guselkumab):
  - clinical remission at week 12: 21% versus 56%
  - endoscopic response at week 12: 21% versus 41%
- the service plans to supply maintenance mirikizumab and guselkumab via homecare, so costs will exclude VAT
- cost offset will be available from the displacement of other biologic agents
- the service would like risankizumab, mirikizumab and guselkumab included on formulary. They have experience using risankizumab and mirikizumab and guselkumab would be used as an alternative if risankizumab/mirikizumab are ineffective.
- generally, these agents would be used later in the pathway, when most of the other biologics have been tried. The inclusion of these agents would provide additional options for patients that could be tried and potentially prevent surgery.

The Group accepted the restricted local need for mirikizumab and guselkumab as licensed for the treatment of adults with moderately to severely active Crohn's disease who have had an inadequate response with, lost response to, or were intolerant to either conventional therapy or a biologic treatment.

**FG1SMC 2822 - Mirikizumab 300mg concentrate for solution for infusion, 100mg, 200mg solution for injection in pre-filled pen (Omvoh®)▼ is routinely available in line with national guidance (SMC 2822).**
**Indication under review: for the treatment of adults with moderately to severely active Crohn's disease who have had an inadequate response, lost response, or were intolerant to either conventional therapy or a biologic treatment.**
**Mirikizumab offers an additional treatment choice in the therapeutic class of interleukin inhibitors in this setting.**
**This advice applies only in the context of approved NHS Scotland Patient Access Scheme (PAS) arrangements delivering the cost-effectiveness results upon which the decision was based, or PAS/list prices that are equivalent or lower.**
**It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. This medicinal product is intended for use under the guidance and supervision of a physician experienced in the diagnosis and treatment of ulcerative colitis or Crohn' disease.** — **FTEAM**

| ITEM | SUBJECT | ACTION |
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| | **FG1SMC 2850 - Guselkumab 200mg/2mL concentrate for solution for infusion, 100mg/1mL, 200mg/2mL solution for injection pre-filled pen (Tremfya®) is routinely available in line with national guidance (SMC 2850).**<br>**Indication under review: for the treatment of adults with moderately to severely active Crohn's disease who have had an inadequate response, lost response, or were intolerant to either conventional therapy or a biologic treatment.**<br>**Guselkumab offers an additional treatment choice in the therapeutic class of interleukin inhibitors in this setting.**<br>**This advice applies only in the context of approved NHS Scotland Patient Access Scheme (PAS) arrangements delivering the cost-effectiveness results upon which the decision was based, or PAS/list prices that are equivalent or lower.**<br>**It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. This medicinal product is intended for use under the guidance and supervision of a physician experienced in the diagnosis and treatment of conditions for which it is indicated.** | **FTEAM** |

Items 5.6 and 5.7 were taken together.

### 5.6. FG1SMC 2497 - SEMAGLUTIDE (WEIGHT MANAGEMENT)

### 5.7. FG1SMC 2653 - TIRZEPATIDE (WEIGHT MANAGEMENT)

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

The Group considered the requests from the bariatric service for the weight loss drugs semaglutide, as the brand Wegovy®, and tirzepatide.

The Group noted that:

- the formulary request is for use in a subpopulation of the SMC acceptance - in patients in the bariatric surgical service during their time in the service. It is anticipated that the main use will be before bariatric surgery, with treatment usually ending before the patient undergoes bariatric surgery.
- semaglutide is administered SC as a 2.4mg once-weekly maintenance dose. The maintenance dose is reached by starting with a 0.25mg dose and escalating treatment over a 16-week period to reduce gastrointestinal symptoms.
  A 7.2mg weekly dose (given as 3 x 2.4mg injections) has recently been included in the Summary of Product Characteristic (SmPC) but this dose has not been assessed by SMC so it is not known if this is a cost-effective dose regimen.
- tirzepatide is administered SC as 5mg, 10mg or 15mg maintenance. The starting dose is 2.5mg once weekly and increased by 2.5mg increments after a minimum of 4 weeks.
- people on the bariatric surgery waiting list will be offered treatment. If patients receive surgery before commencing drug treatment, treatment will be offered to new patients on the list. The numbers treated will be capped, with patients receiving up to 2 years treatment.

*Semaglutide*

- the key evidence comes from STEP1, an international, randomised, double-blind, parallel group, phase III study comparing semaglutide and placebo in adults with obesity or overweight with at least one weight-related comorbidity and without diabetes
- patients were randomised to receive 2.4mg semaglutide SC once a week for 68 weeks (n=1,306) or matching placebo (n=655), both were in addition to lifestyle interventions including a reduced-calorie diet and increased physical activity
- the co-primary outcomes were change from baseline to week 68 (semaglutide versus placebo)
  - body weight: -15% versus -2.4%
  - proportion of patients who achieve ≥5% body weight reduction: 86% versus 32%

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*Tirzepatide*

- evidence comes from SURMOUNT-1, -2 and -3 double-blind, phase III studies
- patients were recruited with a BMI ≥30kg/m$^2$ or ≥27kg/m$^2$ plus ≥1 co-morbidity
- patients were treated with tirzepatide or placebo
- the co-primary outcomes at week 72 were percent change in body weight and body weight reduction ≥5% [tirzepatide showed a greater percentage change in body weight and body weight reduction than semaglutide]
- treatment duration will be up to 2 years, as the service are currently only planning to treat patients on the bariatric waiting list until their bariatric surgery
- this will be a new cost as semaglutide and tirzepatide do not replace any current treatments, however successful reduction in obesity due to a reduction in associated comorbidities and complications could lead to future cost avoidance
- prescribing and support monitoring is requested via primary care
- tirzepatide would be preferred as the first-line agent due to its superior efficacy, with semaglutide as second-choice if tirzepatide is not tolerated

Members discussed the requests noting the lack of data regarding potential long-term effects and that the significant weight regain observed when treatment is stopped. Members also highlighted the importance of appropriate education and educational support for patients.

Members did not support inclusion of the new 7.2mg weekly maintenance dose, as there is currently no health technology assessment (HTA) to confirm cost-effectiveness. The Group also questioned patients' ability to tolerate this higher dose.

Members noted the need for a phased approach to implementation and were supportive of the request for use in patients on the bariatric waiting list. This support is subject to clarification of any monitoring requirements for the agents themselves and/or monitoring required in relation to bariatric surgery.

The Group acknowledged that these agents are recognised as a public health measure in the management of obesity and accepted the restricted local need for the weight loss drugs semaglutide, as the brand Wegovy®, and tirzepatide. Use is restricted to patients within the bariatric surgical service until their bariatric surgery, with the maximum maintenance dose of Wegovy® limited to 2.4mg weekly.

**FG1SMC 2497 - Semaglutide 0.25mg, 0.5mg, 1mg, 1.7mg, 2.4mg FlexTouch solution for injection in pre-filled pen (Wegovy®) is routinely available in line with local guidance.**
**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/m$^2$ * (obesity) in the presence of at least one weight-related comorbidity.**
**Restrictions:**

- **as a second-line choice if tirzepatide is not tolerated and,**
- **for patients in the bariatric surgical service until their bariatric surgery and,**
- **at a maximum maintenance dose of 2.4mg once per week**

**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

**FG1SMC 2653 - Tirzepatide 2.5mg, 5mg, 7.5mg, 10mg, 12.5mg, 15mg, solution for injection in pre-filled pen (Mounjaro® KwikPen®)▼ is routinely available in line with local guidance.**

* A lower BMI cut-off may be more appropriate for members of minority ethnic groups known to be equivalent risk of the consequences of obesity at a lower BMI than the white population.

| ITEM | SUBJECT | ACTION |
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| | **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 † (obesity) in the presence of at least one weight-related comorbidity.**<br>**Restriction: for patients in the bariatric surgical service until their bariatric surgery. 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. FORMULARY REVIEW

### 6.1. FORMULARY UPDATES JANUARY 2026

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

DEBRANDING

Ms Bruce reported that Tavneos® has been de-branded and will now be known as Avacopan Vifor®. The PAS agreement has been updated to novate the current agreements for Tavneos®.
The formulary entry will be updated to remove the brand name, and the name change will be highlighted to the local and regional Hospital Electronic Prescribing and Medicines Administration (HEPMA) Teams.

**Members supported update of the formulary entry to note the debranding.** **FTEAM**

DISCONTINUATIONS

Ms Bruce reported that the following six medicines were noted as being discontinued:
- buprenorphine sublingual tablets (Subutex®)
- Suboxone® sublingual tablets (buprenorphine/naloxone)
- diclofenac 75mg/mL solution for injection (Akis®)
- Kaletra® 100mg/25mg, 200mg/50mg tablets (lopinavir/ritanovir)
- lopinavir/ritonavir 200mg/50mg tablets
- sotrovimab 500mg/8mL solution for infusion vials (Xevudy®)

Work is ongoing to manage the Subutex® and Suboxone® discontinuations, otherwise the changes are considered low impact discontinuations.

Ms Bruce reported that the following formulations/presentations were being discontinued:
- epoetin beta 20,000 units/0.6mL solution for injection pre-filled syringes (NeoRecormon®)
- hydrocortisone butyrate 0.1% ointment (Locoid®)
- the FlexTouch® pre-filled pen for insulin aspart (Fiasp® FlexTouch®) and insulin degludec (Tresiba® FlexTouch®)
- terbutaline 0.5mg/mL solution for injection ampoules (Bricanyl®)

The changes are considered low risk discontinuations.

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

† A lower BMI cut-off may be more appropriate for members of minority ethnic groups known to be equivalent risk of the consequences of obesity at a lower BMI than the white population.

## 7. PUBLISHED ADVICE

### 7.1. SCOTTISH MEDICINES CONSORTIUM ADVICE PUBLISHED DECEMBER 2025

The Group noted the SMC advice published December 2025.
Following publication of the non-submission statements for iptacopan (Fabhalta®▼ - SMC 2889) and trastuzumab deruxtecan (Enhertu®▼ - SMC 2888) 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 2878 amivantamab (Rybrevant®▼)
- SMC 2817 delgocitinib (Anzupgo®▼) (submission received)
- SMC 2856 givinostat (Duvyzat®▼) (submission received)
- SMC 2806 maralixibat (Livmarli®▼) (submission expected)
- SMC 2869 progesterone (Prometrium®)

Local advice for these medicines and indications will be included in the January 2026 decisions as 'Not routinely available as the ADTC is waiting for further advice from local clinical experts'. **FTEAM**

### 7.2. UMAR PUBLISHED DECEMBER 2025

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 leniolisib (Joenja®▼) as 'not routinely available in NHS Grampian. If local need identified contact the Pharmacist Team Leader/Principal Pharmacist – Supply (ARI).'

**UMAR SMC 2836 - Leniolisib 70mg film-coated tablet (Joenja®)▼ is not routinely available in NHS Grampian.**
**Indication under review: for the treatment activated phosphoinositide 3-kinase delta (PI3K-delta) syndrome (APDS) in adult and paediatric patients 12 years of age and older.**
**Not routinely available in NHS Grampian. If local need identified contact the Pharmacist Team Leader/Principal Pharmacist – Supply (ARI).** **FTEAM**

### 7.3. SCOTTISH MEDICINES CONSORTIUM ADVICE PUBLISHED JANUARY 2026

The Group noted the SMC advice published January 2026.

Following publication of the negative SMC recommendation, for serplulimab (Hetronifly®▼ - SMC 2840) and the non-submission statements, for clascoterone (Winlevi®▼ - SMC 2894), daratumumab (Darzalex® - SMC 2895), dupilumab (Dupixent® - SMC 2896) and pirtobrutinib (Jaypirca®▼ - SMC 2897) 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 2873 ciclosporin (Vevizye®)
- SMC 2852 exagamglogene autotemcel (Casgevy®▼)
- SMC 2759 marstacimab (Hympavzi®▼) (submission expected)
- SMC 2820 nivolumab (Opdivo®)
- SMC 2839 zolbetuximab (Vyloy®▼) (submission expected)

Local advice for these medicines and indications will be included in the January 2026 decisions as 'Not routinely available as the ADTC is waiting for further advice from local clinical experts'. **FTEAM**

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### 7.4. NATIONAL CANCER MEDICINES ADVISORY GROUP PUBLISHED JANUARY 2026

The Group noted the NCMAG advice published January 2026.

The following NCMAG supported medicine has not been processed within a 60-day timescale:

- NCMAG 125 paclitaxel (submission expected)

Local advice for this medicine and indication will be included in the January 2026 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 JANUARY 2026

The Group noted the SMC provisional advice issued January 2026.

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 November 2025), 10.2 (MHRA Safety Round-up December 2025), 10.3 (MedWatch Vol.6:Issue 6 December 2025), 10.4 (Grampian Primary Care Prescribing Group meeting minute September 2025), 10.5 (Antimicrobial Management Team meeting minute October 2025), were noted.

## 11. AOCB

None.

### DATE OF NEXT MEETING

Tuesday 17 February 2026 starting at 14.30 via Microsoft Teams.

**Signature on file**

**CHAIR'S SIGNATURE** **Dr Louise Elliot** **DATE** **17 February 2026**