NHS GRAMPIAN
Minute of Formulary Group Meeting
Tuesday 17 February 2026 at 14:30 via Microsoft Teams

PRESENT	APOLOGIES	APPROVED
Mr Y Al-Obaidi	Dr V Chieng	
Ms L Cameron (from item 4.1)	Mr G Burt	
Ms F Doney	Mrs M Galvin	
Ms C Douglas	Mrs E Milne	
Dr L Elliot (Chair)	Mr M Paterson	
Mrs S O'Beirne		

IN ATTENDANCE

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

IN ATTENDANCE FOR PRESENTATIONS

Dr Sinead Cook, Sexual and Reproductive Health Consultant for items 4.1 and 4.2.
Dr Sarah Wallage, Sexual and Reproductive Health Consultant for items 4.1 and 4.2.

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.

1. APOLOGIES

Note: This item was taken later than scheduled, after item 5.1, to accommodate presenter availability.

Apologies for absence were requested and noted.

2. MINUTE AND DECISIONS

2.1. DRAFT MINUTE OF THE MEETING HELD 20 JANUARY 2026

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 JANUARY 2026 - PUBLISHED 02/02/2026

Members formally ratified the January 2026 decisions document as published.

3. MATTERS ARISING

3.1. ACTION LOG

The Group noted the item.

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3.2. FG1 479/25 – DROSPIRENONE (CONTRACEPTION)

Note: This item was taken later than scheduled, after item 4.2, to accommodate presenter availability.

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

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

The Group noted that:
- drospirenone is derived from spironolactone that has antiandrogenic and antimineralocorticoid properties
- prescribers should be aware of the additional considerations for use including caution in users at risk of hyperkalaemia
- the SRH Service considers drospirenone a second-line alternative progestogen-only pill that should only be prescribed if people are aware of and following the additional considerations for use including caution in users at risk of hyperkalaemia

The Group accepted the restricted local need for drospirenone as an additional progestogen-only pill. Drospirenone has a longer missed-pill window, and may provide an alternative bleeding pattern and side-effect profile for those who cannot tolerate desogestrel.

The proposed formulary entry will be presented at a future meeting for formal approval. **FTEAM**

FG1 479/25 - Drospirenone 4mg film-coated tablets (Slynd®) is routinely available in line with local guidance.
Indication under review: contraception in adults as a second-line alternative progestogen-only pill for use when desogestrel is not tolerated or is unsuitable.
Restriction: use is restricted to specialists in Sexual and Reproductive Health (SRH) or GPs and Independent prescribers with SRH competence.
It was classified 1a - available for general use and 8e - treatment may be initiated in either Primary or Secondary care. **FTEAM**

4. DISCUSSION/PRESENTATION

Note: These items were taken earlier than scheduled, before item 1, to accommodate presenter availability.

4.1. DR SARAH WALLAGE, SEXUAL AND REPRODUCTIVE HEALTH CONSULTANT, TO DISCUSS THE REQUEST TO EXTEND THE USE OF PENTHROX®

The Chair welcomed Dr Wallage, Sexual and Reproductive Health (SRH) Consultant to discuss the request to extend the off-label use of Penthrox® in the SRH Service.

Dr Wallage confirmed that:
- the service has been using Penthrox®, in combination with local anaesthetic, in the operating theatre for people having surgical termination or evacuation of retained products since June 2025. It has been transformative for some patients and has provided staff with a valuable addition to the analgesic armamentarium to support patients during these procedures.
- training has been straightforward, with in-house training supported by the manufacturer's patient information leaflets. It is not a complicated device to learn to use or to teach patients to use.
- the service is being more cautious than other units and advises patients not to drive [for 24 hours] post procedure
- patients report that it is easy to use, and they appear to have no lasting effects. It also

appears to clear the system quickly with normal coordination, writing, steadiness of gait returning promptly.
- experience to date has been very positive, with Penthrox® proving to be a safe and useful additional analgesic
- this request seeks to extend the use of Penthrox® to the SRH Clinic in fixed sites, the Health Village and Dr Gray's Main Outpatients, both of which have adequate air changes in clinic rooms
- the indication requested is for difficult/complex intrauterine device insertion and removal, only by senior medical SRH staff
- Consultant Anaesthetist colleagues have confirmed that ten air changes an hour is suggested as adequate room ventilation when using Penthrox®, and overall, the risk of occupational exposure if used as directed and in a well-ventilated space is low
- the Aberdeen Maternity Hospital and the Women's Day Clinic do not have sufficient airflow in clinic rooms but when the Baird Family Hospital opens the procedure rooms will have sufficient airflow, and a further roll-out to obstetrics and gynaecological conditions may be progressed
- the anaesthetic form has worked well and would be uploaded to TRAK from the clinic setting
- Penthrox® will be held in locked drug cupboards, with disposal using the supplied bags into blue-lidded clinical waste bins

Members' questions were addressed.

4.2. DR SINEAD COOK, SEXUAL AND REPRODUCTIVE HEALTH CONSULTANT, TO DISCUSS DROSPIRENONE

The Chair welcomed Dr Cook, SRH Consultant to discuss the request for drospirenone as an alternative second-line progestogen-only pill.

Dr Cook confirmed that:
- the drospirenone-only progestogen-only pill has been available in the UK for a while now and is being used quite routinely in other parts of the UK
- was not accepted for use by SMC based on a non-submission by the manufacturer
- there is some off-formulary use within the SRH Service for select cases
- currently there are a few progestogen-only pill options for women. There are many more combined pills but these have a relatively large number of contraindications, particularly compared with progestogen-only pills.
- some people do not tolerate the desogestrel progestogen-only pill, which is the main progestogen-only pill used. The other/traditional progestogen-only pills only have a 3-hour window, and for many people this limits their acceptability.
- the drospirenone-only pill has 24 active pills and four inactive pills; it has a 24-hour window for pill taking which is slightly easier than desogestrel at 12-hours
- there is no evidence of a statistically significant difference in venous thromboembolism (VTE) risk between the drospirenone-only pill and other progestogen-only pills. The College of Sexual and Reproductive Healthcare (CoSRH) gives the same recommendations to other progestogen-only pills regarding VTE in the UKMEC, i.e., UKMEC 2 if personal previous history of VTE or known thrombogenic mutation.
- there is no evidence that a 24-hour window for pill taking provides increased contraceptive effectiveness compared with other progestogen-only pills. However, from practical clinical experience the 3-hour window can be very off-putting for many women, and can be particularly difficult if for example they change time zones often.
- compared with other progestogen-only pills the only difference in monitoring is for those at risk of renal impairment/hyperkalaemia (including those aged over 50), for whom baseline and subsequent urea and electrolytes monitoring is advised
- if drospirenone is accepted for use locally the SRH Service 'Contraceptive Counselling - Progestogen Only Pill' guidance will be updated to include a statement about urea and electrolyte monitoring at initiation and continuation

- a 'specialist' for prescribing drospirenone, would be any prescriber with a special interest in contraception/women's health/sexual health, e.g., GPs who have completed a Career Start programme in sexual health, those who hold the Diploma in the College of Sexual Health or Letter of Competence in LARC fitting or other relevant qualifications, those who has considerable clinical experience in providing contraception
- the SRH Service considers that the drospirenone-only pill would be a useful addition to the formulary. It would be positioned as a second-line alternative progestogen-only pill used after desogestrel as it costs significantly more than desogestrel, however many women do not tolerate desogestrel.

Members' questions were addressed and it was confirmed that:
- it is important to highlight, in local guidance and on the formulary, that the drospirenone-only pill is not just another progestogen-only pill it is different
- the SRH Service will highlight the differences, in local guidance and at engagement sessions. The SRH Service will emphasise that drospirenone is a second-line alternative progestogen-only pill that should only be prescribed if people are aware of and following the additional considerations for use including caution in users at risk of hyperkalaemia.
- if drospirenone is accepted for use locally, there are no plans to include drospirenone in the progestogen-only pill patient group direction
- drospirenone is included in the Family Planning Association progestogen-only pill leaflet

The Chair thanked Dr Cook and Dr Wallage for attending the meeting to discuss the requests.
Dr Cook and Dr Wallage left the meeting prior to the decision-making process.

5. NEW PRODUCT REQUESTS

5.1. SBAR – PENTHROX (OFF-LABEL)

Note: This item was taken earlier than scheduled, after item 3.2, to accommodate presenter availability.

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

The Group considered the request to extend the off-label use of Penthrox® to the SRH Service.

The Group noted that:
- Penthrox® is licensed for the emergency relief of moderate to severe pain in conscious adults with trauma and associated pain, this request would be off-label use
- *Clinical effectiveness*: there is evidence of efficacy as an analgesic when used for moderate to severe pain in conscious adults
- *Cost effectiveness*: there are no QALY estimates, but the expected patient numbers are not significant and Penthrox® is not a high-cost item [one bottle 3mL inhalation vapour liquid costs £18.46 (£22.15 including VAT)]
- *Health gain*: there are potential health gains for patients and the Health Board; health gains related to improved analgesia, and the potential for fewer failed procedures
- *Service impact*: for this indication there were no service impacts identified, no impact on current infrastructure; small financial cost with cost-offset available from the potential to prevent failed coil insertion or removal
- *Equity*: Penthrox® is used off-label for this (and other indications) in other areas of the UK
- *Safety*: no new or unexpected safety issues identified; with administration in specific clinic rooms with sufficient ventilation and a low risk of occupational exposure.

Locally patients will be advised not to drive for 24 hours post procedure.
- *Green prescribing*: Penthrox® is a volatile anaesthetic in a single-use delivery device, some of the environmental impact is offset by some users avoiding a general anaesthetic and all the disposable equipment used for general anaesthesia.

The Group accepted the restricted local off-label need for Penthrox® as an additional method of pain relief for difficult coil insertion and removal, with use limited to senior medical staff within the SRH Service.

SBAR - Methoxyflurane 99.9% inhalation vapour, liquid (Penthrox®) is routinely available in line with local guidance.
Indication under review: [off-label use] in adults for difficult coil insertion/removal.
Restriction: to use by senior medical staff within the Sexual and Reproductive Health Service.
It was classified 3b - licensed product available for restricted off-label use and 8b - recommended for hospital use only.
Penthrox® should be self-administered under supervision of a person trained in its administration, using the hand held Penthrox® Inhaler. It is inhaled through the Penthrox® inhaler. **FTEAM**

5.2. FG1SMC 2819 – ZANUBRUTINIB (MANTEL CELL LYMPHOMA)

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

The Group considered the request for an additional Bruton's tyrosine kinase (BTK) inhibitor for adults with mantle cell lymphoma (MCL) who have received at least one prior therapy.

The Group noted:
- zanubrutinib is a highly selective, irreversible inhibitor of BTK, which blocks B-cell receptor-induced BTK activation thereby inhibiting proliferation and survival of malignant B-cells
- ibrutinib is another oral BTK inhibitor which is already included on formulary for the same indication. Ibrutinib was accepted by SMC under the end of life and ultra-orphan medicine process.
- the recommended daily dose of zanubrutinib is 320mg orally, either once-daily (four 80mg capsules) or divided into two doses of 160mg twice daily
- evidence comes from two open-label, multicentre, single-arm studies, BGB-3111-206 (n=86) and BGB-3111-AU-003 (n=32)
  - the primary outcome in both studies was objective response rate (ORR)
  - in BGB-3111-206 the ORR was 84% at a median follow up of 18.4 months
  - in BGB-3111-AU-003 the ORR was 84% at a median follow up of 18.8 months
- patient numbers are expected to be small
- the service stated that zanubrutinib will be used as an alternative to ibrutinib as it has been shown to have less cardiac toxicity than ibrutinib, particularly less arrhythmias
- the service requested that ibrutinib remains on formulary for patients who are unable to tolerant zanubrutinib
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of zanubrutinib

The Group accepted the restricted local need for zanubrutinib, as monotherapy for the treatment of adults with MCL who have received at least one prior therapy, as outlined in SMC 2819.

FG1SMC 2819 - Zanubrutinib 80mg capsules (Brukinsa®)▼ is routinely available in line with national guidance (SMC 2819).
Indication under review: as monotherapy for the treatment of adults with mantle

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cell lymphoma (MCL) who have received at least one prior therapy.
Zanubrutinib offers an additional treatment choice in the therapeutic class of Bruton's tyrosine kinase inhibitors (BTKi).
Another BTKi was accepted for use under the end of life and ultra-orphan process.
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. Treatment with this medicinal product should be initiated and supervised by a physician experienced in the use of anticancer medicinal products. **FTEAM**

5.3. FG1SMC 2762 – BRENTUXIMAB (PREVIOUSLY UNTREATED CD30+ STAGE III OR IV HODGKIN LYMPHOMA)

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

The Group considered the request for brentuximab used in combination with doxorubicin, vinblastine and dacarbazine (AVD) for adults with previously untreated CD30+ Stage III or IV Hodgkin lymphoma (HL).

The Group noted:

- brentuximab vedotin:
  - is the first medicine that is an antibody drug conjugate licensed for first-line treatment of advanced Stage III or IV HL
  - [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
- the recommended dose in combination with chemotherapy (doxorubicin [A], vinblastine [V] and dacarbazine [D] [AVD]) is 1.2mg/kg administered as an intravenous infusion over 30 minutes on days 1 and 15 of each 28-day cycle for 6 cycles
- primary prophylaxis with growth factor support (G-CSF), beginning with the first dose, is recommended for all patients with previously untreated HL receiving combination therapy
- brentuximab is already included on formulary for relapsed or refractory CD30 positive HL
- evidence comes from the ECHELON-1 study, an international, open-label, phase III study. Patients were randomised to six cycles of IV treatment on day 1 and day 15 with A+AVD (brentuximab plus AVD (doxorubicin, vinblastine and dacarbazine)) (n=664) or ABVD (Bleomycin plus AVD) (n=670)
  - the primary outcome was modified progression-free survival (mPFS)
  - at the primary analysis (20 April 2017), mPFS significantly improved with A+AVD compared with ABVD
  - mPFS events was 117 with A+AVD and 146 with ABVD (hazard ratio (95% CI) 0.77 (0.60 to 0.98), p=0.035), Kaplan-Meier estimated mPFS at 3 years was 79% vs 75% for A+AVD vs ABVD respectively
  - for overall survival (at the 11 March 2023 cut-off), the number of deaths were 46 vs 69 (Hazard ratio (95% CI) 0.62 (0.42 to 0.90)), KM estimated OS at 8 years 93% vs 88% for A+AVD vs ABVD respectively.
- the service has experience using brentuximab for this indication as the service participated in the ECHELON-1 study
- patient numbers are expected to be small
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of brentuximab
- the service has stated that brentuximab plus AVD:

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- will be offered to patients not fit enough for eBEACOPDac as per HD18 protocol which would be the standard choice for most younger patients with advanced stage HL, who are still fit for ABVD intensity therapy
- would be favoured where there are specific concerns about bleomycin toxicity (e.g., concurrent lung disease) or where fertility preservation were considered important

The Group accepted the restricted local need for brentuximab used in combination with AVD for adults with previously untreated CD30+ Stage III or IV HL.

FG1SMC 2762 - Brentuximab vedotin 50mg powder for concentrate for solution for infusion (Adcetris®) is routinely available in line with national guidance (SMC 2762).
Indication under review: for adults with previously untreated CD30+ Stage III or IV Hodgkin lymphoma (HL) in combination with doxorubicin, vinblastine and dacarbazine (AVD).
In an open-label, phase III study, six cycles of brentuximab vedotin (in combination with AVD) compared with six cycles of ABVD (doxorubicin, bleomycin, vinblastine and dacarbazine), significantly improved modified progression-free survival in adults with previously untreated CD30+ Stage III or IV HL.
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. Brentuximab should be administered under the supervision of a physician experienced in the use of anti-cancer agents. FTEAM

5.4. FG1SMC 2803 – RIBOCICLIB (HR POSITIVE, HER2-NEGATIVE EARLY BREAST CANCER)

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

The Group considered the request for ribociclib, used in combination with an aromatase inhibitor, for the adjuvant treatment of patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative early breast cancer at high risk of recurrence.

The Group noted that:

- ribociclib:
  - is an inhibitor of CDK4/6 (cyclin-dependent kinases 4 and 6), which play an important role in signalling pathways and lead to cell cycle progression and proliferation
  - is licensed and accepted by SMC to treat patients with node-positive and node-negative disease
  - [for this indication] the recommended dose is 400mg once daily for 21 days followed by 7 days off treatment. In patients with early breast cancer, ribociclib should be taken until completion of 3 years treatment or until disease recurrence or unacceptable toxicity.
  - [for this indication] should be used in combination with an aromatase inhibitor and in pre- or perimenopausal women, or in men, the aromatase inhibitor should be combined with a luteinising hormone-releasing hormone (LHRH) agonist
- monitoring of liver function, QT interval with electrocardiogram (ECG) plus serum electrolytes, pulmonary symptoms, and complete blood counts is required prior to initiation of ribociclib and at regular intervals during treatment. The service confirmed ECG monitoring is done in-house, and no capacity issues are anticipated.
- abemaciclib, another CDK4/6 inhibitor, is already included on formulary for the adjuvant treatment of adults with HR-positive, HER2-negative, node-positive early breast cancer at high risk of recurrence

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- the Scottish Clinical Management Pathway includes a statement that – "For patients that meet the eligibility criteria for both abemaciclib and ribociclib, then abemaciclib is the preferred choice"
- evidence comes from NATALEE, an international, open-label, randomised, phase III study:
  - patients were treated with ribociclib 400mg daily for 21 days followed by 7 days off treatment for 36 months, plus an aromatase inhibitor for at least 60 months or aromatase inhibitor alone taken for at least 60 months. Men and premenopausal patients in both groups also received goserelin.
  - the primary outcome was invasive disease-free survival
  - there are no direct data comparing ribociclib and abemaciclib, however an indirect treatment comparison concluded comparable efficacy between the two CDK4/6 inhibitors
  - this will be a new cost for patients that are not eligible for treatment with abemaciclib
  - in early breast cancer the treatment duration of abemaciclib is shorter than ribociclib (two years versus three years)
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of ribociclib

The Group accepted the restricted local need for ribociclib, used in combination with an aromatase inhibitor, as outlined in SMC for the adjuvant treatment of adults with HR-positive, HER2-negative early breast cancer at high risk of recurrence.

FG1SMC 2803 - Ribociclib 200mg tablets (Kisqali®) is routinely available in line with national guidance (SMC 2803).
Indication under review: in combination with an aromatase inhibitor for the adjuvant treatment of adults with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative early breast cancer at high risk of recurrence. In pre- or perimenopausal women, or in men, the aromatase inhibitor should be combined with a luteinising hormone-releasing hormone (LHRH) agonist.
In an open-label phase III study in patients with HR-positive, HER2-negative early breast cancer, ribociclib in combination with an aromatase inhibitor was associated with a statistically significant improvement in invasive disease-free survival when compared with aromatase inhibitor monotherapy.
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 with ribociclib should be initiated by a physician experienced in the use of anticancer therapies. **FTEAM**

5.5. FG1SMC 2858 - FRUQUINTINIB (METASTATIC COLORECTAL CANCER)

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

The Group considered the request for fruquintinib for the treatment of adults with metastatic colorectal cancer (mCRC) who have been previously treated with available therapies, including fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, with or without an anti-VEGF (vascular endothelial growth factor) therapy, and if RAS wildtype and medically appropriate, an anti-EGFR therapy.

The Group noted that:

- fruquintinib:
  - is a tyrosine kinase inhibitor (TKI) of VEGF receptors-1, -2, and -3 with antitumor effects
  - [for this indication] meets SMC end of life and orphan equivalent criteria, and was accepted for use in NHS Scotland following a resubmission assessed under the end of life and orphan equivalent medicine process, the output from the PACE process, and application of SMC decision modifiers that can be applied when encountering high cost-effectiveness ratios
- the recommended dose of fruquintinib is 5mg once daily at approximately the same time each day for 21 consecutive days, followed by a 7-day rest period
- evidence comes from FRESCO and FRESCO-2, double-blind, phase III trials
- patients were randomised to receive fruquintinib 5mg once daily for 21 days of a 28-day cycle or placebo
- in FRESCO-2 the median overall survival was 7.4 months for fruquintinib versus 4.8 months for placebo
- in FRESCO the median overall survival was 9.3 months for fruquintinib versus 6.6 months for placebo
- an indirect treatment comparison comparing fruquintinib and regorafenib showed there was no substantial difference between the groups for overall survival
- in FRESCO-2 the median PFS was 3.7 months for fruquintinib
- the service has stated that fruquintinib will likely take the place of regorafenib in the fourth line setting. The pill burden with fruquintinib is less than regorafenib.
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of fruquintinib

The Group accepted the restricted local need for fruquintinib for the treatment of adults with mCRC who have been previously treated with available therapies, as outlined in SMC 2858.

FG1SMC 2858 - Fruquintinib 1mg, 5mg capsules (Fruzaqla®)▼ is routinely available in line with national guidance (SMC 2858).
Indication under review: treatment of adults with metastatic colorectal cancer (mCRC) who have been previously treated with available therapies, including fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, with or without an anti-VEGF therapy, and if RAS wildtype and medically appropriate, an anti-EGFR therapy.
Fruquintinib, compared with placebo, significantly improved overall survival in adults with mCRC who had been previously treated with available therapies
This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting.
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. Fruquintinib should be initiated by a physician experienced in the administration of anticancer therapy. FTEAM

5.6. FG1SMC 2852 – EXAGAMGLOGENE AUTOTEMCEL (SICKLE CELL DISEASE)

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

The Haematology Service confirmed that, at least initially, the plan is to have one centre in Scotland performing gene therapy. This is to be a centre accredited to do allografts, i.e., Glasgow, and at this time, there is not a local need for this medicine.

This medicine will not be included on the Grampian Joint Formulary for this indication.

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	FG1SMC 2852 - Exagamglogene autotemcel 4-13 x 10Exp6 cells/mL dispersion for infusion dispersion for infusion (Casgevy®)▼ is routinely available from a specialist centre in another health board. **Indication under review: for the treatment of sickle cell disease in patients 12 years of age and older with recurrent vaso-occlusive crises who have the βS/βS, βS/β+ or βS/β0 genotype, for whom haematopoietic stem cell transplantation is appropriate and a human leukocyte antigen matched related haematopoietic stem cell donor is not available.** **In a single-arm open-label study, 97% (28/29) of patients remained free from severe vaso-occlusive crises for at least 12 consecutive months after receiving an exagamglogene autotemcel (exa-cel) infusion.** **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.** **Not routinely available in NHS Grampian. If local need identified treatment is available from a specialist centre in another health board.** **Treatment must be administered in an authorised treatment centre by a physician(s) with experience in both haematopoietic stem cell transplantation and in the treatment of patients with β-haemoglobinopathies.**	**FTEAM**

6. FORMULARY REVIEW

6.1. FORMULARY UPDATES

None.

7. PUBLISHED ADVICE

7.1. SCOTTISH MEDICINES CONSORTIUM ADVICE PUBLISHED FEBRUARY 2026

The Group noted the SMC advice published February 2026.

Following publication of the negative SMC recommendations for donanemab (Kisunla® - SMC 2871), sotatercept (Winrevair®▼ SMC 2831) and zuranolone (Zurzuvae®▼- SMC 2862) these medicines will not be included on the Grampian Joint Formulary for the indications in question. **FTEAM**

8. PROVISIONAL ADVICE

8.1. SCOTTISH MEDICINES CONSORTIUM ADVICE ISSUED FEBRUARY 2026

The Group noted the SMC provisional advice issued February 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.

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10. DOCUMENTS FOR INFORMATION

Items 10.1 (MHRA Safety Round-up January 2026), 10.2 (Grampian Primary Care Prescribing Group meeting November 2025), 10.3 (Grampian Acute and Mental Health Medicines Safety Group meeting minute October 2025), 10.4 (Grampian Medicines Guidelines and Policies Group meeting minute September 2025), 10.5 (Antimicrobial Management Team meeting minute November 2025), 10.6 (Grampian Area Drug and Therapeutics Committee meeting minute September 2025), were noted.

11. AOCB

SEMAGLUTIDE (WEGOVY, OZEMPIC AND RYBELSUS): RISK OF NON-ARTERITIC ANTERIOR ISCHEMIC OPTIC NEUROPATHY (NAION)

The Chair flagged the Drug Safety Updated issued 05 February which highlighted that semaglutide treatment may be very rarely associated with non-arteritic anterior ischemic optic neuropathy (NAION).

DATE OF NEXT MEETING

Tuesday 17 March 2026 starting at 14.30 via Microsoft Teams.

Signature on file

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