

NHS GRAMPIAN
Minute of Formulary Group Meeting
Tuesday 18 August 2026 at 14:30 via Microsoft Teams

APPROVED

ITEM SUBJECT

ACTION

WELCOME

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

1. ATTENDANCE, APOLOGIES AND DEPUTIES

1.1. CHAIR

Dr Louise Elliot.

1.2. MEMBERS PRESENT

Present

Apologies

Deputies

Mr Y Al-Obaidi

Mr G Burt

Ms L Cameron

Dr V Chieng

Ms F Doney

Dr L Elliot

Mrs M Galvin

Mrs E Milne

Mrs B Teismann (from item 4)

Mrs S O'Beirne (from item 3)

Mr M Paterson

1.3. IN ATTENDANCE

Ms D Bruce, Specialist Pharmacy Technician, Formulary Team.

Mrs C Standen, Formulary and Medicines Management Pharmacist.

1.4. NOTES

Members who sent apologies were recorded.

2. MINUTE AND DECISIONS

2.1. DRAFT MINUTES OF THE MEETING HELD 16 JUNE 2026

Members approved the minutes of the previous meeting, subject to minor typographical amendments.

The approved minutes will be made publicly available within 21 days of approval.

FD

2.2. FORMULARY GROUP DECISIONS JUNE 2026 - PUBLISHED 29/06/2026

Members formally ratified the June 2026 decisions document as published.

3. MATTERS ARISING

3.1. ACTION LOG

The Group noted this item.

ITEM	SUBJECT	ACTION
	3.2. PATIENT RECORD ALERT/FLAG (PRIMARY CARE) - FEEDBACK Ms Doney provided members with an update on the outcome of discussions with Health and Social Care Partnership Lead Pharmacists regarding processes for flagging secondary care prescribed medicines in primary care records. Ms Doney advised that local guidance (Guidance for recording medicines origination in Secondary Care by General Practices) has recently been refreshed, and that the responsibility to action discharge letters and highlight drugs on prescribing systems as supplied by secondary care lies with General Practices. Members considered it would be helpful if the refreshed guidance was shared via the primary care brief to remind General Practices that it is good practice to record secondary care prescribed medicines in patient records. Action closed: The Group agreed that the action regarding flagging secondary care medicines in primary care records is considered closed, pending sharing of the refreshed guidance document.	FD FTEAM
4.	DISCUSSION/PRESENTATION 4.1. PHARMACY FIRST APPROVED LIST REVIEW Ms Doney led a review of the Pharmacy First Scotland Approved List, discussing requests for addition and removal, with input from the local Pharmaceutical Services Development Manager and sought group consensus on support or rejection for specific items. Six items were requested for addition to the Approved List. Ms Doney summarised the Formulary Team and local Pharmaceutical Services Development Manager's comments, recommending rejection of mebendazole (due to audit and safety concerns), naproxen (due to independent prescriber availability and cost-effectiveness), omeprazole (due to risk of repeat supply and previous support under PGD) and Infacol® suspension (due to lack of evidence). Conditional support was suggested for Epimax® eyelid ointment and Xailin® Plus/Xailin® Tears, pending advice from ophthalmology and formulary update. The Group supported the recommendations. Items with weak evidence or safety concerns were rejected, while those with potential benefit and appropriate specialist advice were conditionally supported. Two items, Mucogel® liquid and hydrocortisone buccal tablets, were noted as discontinued and will be requested for removal from the list The Group discussed Iglu® sugar-free pastilles, suggested as a replacement for hydrocortisone buccal tablets, but rejected it due to weak evidence. Ms Doney will collated NHS Grampian's feedback and submit to the national group for consideration.	FD
5.	NEW PRODUCT REQUESTS 5.1. FG1 476/25 – SYMBICORT® 100/3 PMDI (ASTHMA MANAGEMENT IN CHILDREN) There were no declarations of interest recorded in relation to this product. The Group considered the request from the paediatric service for Symbicort® 100/3	

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	pressurised metered-dose inhaler (pMDI) for the management of asthma in children aged 5 to 11 years. The Group noted that: - Symbicort® 100/3 pMDI is a combination inhaler (inhaled corticosteroid (ICS) and long-acting beta₂ adrenoceptor agonist (LABA)) which can be used for the treatment of asthma either as maintenance therapy or as maintenance and reliever therapy (MART) - Symbicort® 100/3 pMDI is licensed in adults and adolescents (12 years and older) for the regular treatment of asthma, where use of a combination is appropriate: - patients not adequately controlled with inhaled corticosteroids and “as needed” inhaled short-acting beta₂ adrenoceptor agonists - or - patients already adequately controlled on both inhaled corticosteroids and long-acting beta₂ adrenoceptor agonists - Symbicort® as the pMDI formulation is not included on the formulary for its licensed indications - the Respiratory Managed Clinical Network (MCN) supports the application for the pMDI for paediatric use, but for use in adults the Turbohaler® should remain the only Symbicort® presentation on formulary - Symbicort® 100/6 Turbohaler® is a dry powder inhaler (DPI) that is included on the formulary for the management of asthma as the AIR (anti-inflammatory reliever) and MART regimens for people aged 12 years and older - Symbicort® 100/6 Turbohaler® is now licensed from 6 years and the BTS/NICE/SIGN asthma guideline recommends using it for MART in children aged 5 to 11 years. The service has stated that if children aged 5 (and older) will be prescribed a Turbohaler® if they can use one. - the BTS/NICE/SIGN Joint Guideline on Asthma: diagnosis, monitoring and chronic asthma management recommends: - consider paediatric low-dose MART for children with asthma that is not controlled on paediatric low-dose ICS plus short-acting beta₂ agonist (SABA) as needed, as long as they are assessed to have the ability to manage a MART regimen - Symbicort® Turbohaler® 100/6 (licensed from age 6) - Symbicort® 100/3 (off-label, licensed from age 12) - the propellant used in Symbicort® pMDI has higher greenhouse gases than other pMDIs. However with the MART regimen people only use one inhaler rather than a multiple inhalers, e.g., salbutamol pMDI plus a low dose ICS. - the service plan to give patients and families clear guidance about administration dosing and advice to contact healthcare practitioner if close to the maximum doses are being used. The service also plans to monitor patients on treatment after three months to ensure that education is understood and the medication is being given appropriately with no side effects. - the service could not estimate patient numbers, and planned for treatment to be initiated in either hospital or community - cost off-set will be available as Symbicort® will be used as an alternative to salbutamol as multi-dosing plus an ICS pMDI Members discussed the licensing of Symbicort® and accepted the potential local need for the off-label and licensed use of Symbicort® Turbohaler® 100/6 and off-label use of Symbicort® 100/3 pMDI in children aged 5 to less than 12 years. Following the meeting, consideration of this item was deferred pending further information. The item will be brought back to a future meeting. Decisions deferred to future meeting.	FTEAM FTEAM

ITEM	SUBJECT	ACTION
5.2.	FG1SMC 2814 – BUDESONIDE 4MG MR HARD CAPSULES (KINPEYGO®) (IgAN) There were no declarations of interest recorded in relation to this product. The Group considered the request for budesonide 4mg modified-release capsules for the treatment of adults with primary immunoglobulin A nephropathy (IgAN). The Group noted: - budesonide as Kinpeygo® is: - a corticosteroid that has been formulated to be locally acting in the ileum, where it suppresses mucosal B-cells located in the Peyer's patches that produce the majority of galactose-deficient IgA1 antibodies (Gd-IgA1) in IgAN - one of the first disease modifying treatments licensed for primary IgAN - administered at a recommended dose of 16mg once daily in the morning for an initial duration of 9 months. When treatment is to be discontinued, the dose should be reduced to 8mg once daily for two weeks of therapy; the dose may be reduced to 4mg once daily for an additional two weeks, at the discretion of the treating physician. Re-treatment may be considered at the discretion of the treating physician. - the KDIGO (Kidney Disease: Improving Global Outcomes) 2025 Clinical Practice Guideline recommends a 9-month course of Kinpeygo® in patients who are at risk of progressive loss of kidney function with IgAN - the service only plan to initiate Kinpeygo® in patients with an eGFR ≥ 35 mL/min per 1.73m^2 which is in line with the NeflgARD trial - evidence comes from NeflgARD, an international, double-blind, randomised, phase III study. Patients were randomised equally to budesonide modified release 16mg orally once daily or placebo for 9 months (Part A) then observed for a further 12 months (Part B). - the primary outcomes were: - Part A: ratio of change in Urine Protein-Creatinine Ratio (UPCR) from baseline to 9 months - % reduction versus placebo was 27% - Part B: time weighted average estimated glomerular filtration rate (eGFR) over 2 years - $-2.5\text{mL/min/1.73m}^2$ for budesonide and $-7.5\text{mL/min/1.73m}^2$ for placebo - there is a lack of long term data (over 2 years) and there are uncertainties relating to the duration and magnitude of benefit on renal function - there is a cohort of people eligible to start treatment, with a smaller number of new patients expected annually - the service plans to supply Kinpeygo® from the hospital but may consider homecare supply in the future - this will be a new cost to the service, with minimal offset, as the service has stated that Kinpeygo® could be added in if proteinuria targets are not achieved on combination of angiotensin-converting enzyme inhibitor (ACEi)/angiotensin ii receptor blocker (ARB) plus sodium-glucose co-transporter 2 inhibitor (SGLT2i) - the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of Kinpeygo® Members requested clarification of the service's arrangements for issuing Steroid Emergency Cards and providing appropriate patient counselling, including how this information will be communicated to colleagues in Primary Care. Clarification was also requested on whether treatment with budesonide (Kinpeygo®) should be recorded in the Emergency Care Summary (ECS) as a hospital-prescribed medicine. The Group accepted the restricted local need for Kinpeygo® for the treatment of adults with primary IgAN, in line with SMC 2814.	FTEAM

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	FG1SMC 2814 - Budesonide 4mg modified-release capsules (Kinpeygo®)▼ is routinely available in line with national guidance (SMC 2814). Indication under review: treatment of adults with primary immunoglobulin A nephropathy (IgAN) with a urine protein excretion ≥ 1.0 g/day (or urine protein-to-creatinine ratio ≥ 0.8 g/g*). *equivalent to ≥ 90 mg/mmol In a phase III study of patients with primary IgAN with a urine protein excretion ≥ 1.0 g/day (urine protein-to-creatinine ratio ≥ 0.8 g/g [equivalent to ≥ 90 mg/mmol]) and on renin angiotensin system (RAS) inhibition, budesonide modified-release treatment was associated with a statistically significant reduction in the decline of estimated glomerular filtration rate (eGFR) over 2 years compared with placebo. This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/list price that is equivalent or lower. It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only.	FTEAM

5.3. FG1SMC 2847 - SPARSENTAN FILM-COATED TABLETS (IGAN)

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

The Group considered the request for sparsentan for the treatment of adults with primary IgAN.

The Group noted:

- sparsentan:
 - is a dual endothelin angiotensin receptor antagonist that reduces proteinuria and slows the progression of kidney disease
 - is administered at a recommended dose of 200mg orally once daily for 14 days increasing to a maintenance dose of 400mg once daily
 - [for this indication] meets SMC orphan criteria, 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
- KDIGO 2025 Clinical Practice Guideline recommends sparsentan as an option for patients who are at risk of progressive loss of kidney function with IgAN
- the service plan to:
 - check sparsentan efficacy at 24 weeks and only continue treatment if UPCR < 199 mg/mmol AND UPCR decreased $> 20\%$ from baseline
 - discuss sick day rules with patients when prescribing sparsentan and when it is supplied from outpatient areas. Patients will be advised to contact the Chronic Kidney Disease nurses if they have any side effects.
 - communicate with GPs via patient letters and may include a clinical contact note if needed
- evidence comes from the PROTECT trial, an international, double-blind, phase III study:
 - patients were randomised to sparsentan (target dose 400mg) or irbesartan (target dose 300mg)
 - the primary outcome was the geometric least square mean change from baseline to 36 weeks in UPCR based on 24-hour urine sampling (-49.8 for sparsentan and -15.1 for irbesartan)
- there is a cohort of people eligible to start treatment with a smaller number of new patients expected annually
- the service would treat patients with both budesonide (Kinpeygo®) and sparsentan, with budesonide started first and initiate sparsentan a few weeks later if budesonide has been tolerated

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	- the service plan to supply sparsentan from the hospital but may consider homecare supply in the future - minimal cost off-set will be available as sparsentan will be used instead of an ACEi or ARB - the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of sparsentan Members highlighted the importance of clear communication with Primary Care regarding sparsentan's place in therapy and key prescribing considerations, including contraindications and adverse effects. Clarification was also requested on whether sparsentan should be recorded in the ECS as a hospital-prescribed medicine. The Group accepted the restricted local need for sparsentan for the treatment of adults with primary IgAN, in line with SMC 2847. FG1SMC 2847 - Sparsentan 200mg, 400mg film-coated tablets (Filspari®)▼ is routinely available in line with national guidance (SMC 2847). Indication under review: for the treatment of adults with primary immunoglobulin A nephropathy (IgAN) with a urine protein excretion $\geq 1.0\text{g/day}$ (or urine protein-to-creatinine ratio $\geq 0.75\text{ g/g}^*$) whose condition has not responded adequately to current standard of care that is; maximally tolerated angiotensin converting enzyme inhibitor or angiotensin receptor blocker and sodium-glucose cotransporter-2 inhibitor, as appropriate. Patients should stop sparsentan at week 24 if no response to treatment. *equivalent to $\geq 85\text{ mg/mmol}$ In a double-blind phase III study, sparsentan, compared with an angiotensin receptor blocker, significantly reduced proteinuria and decline in renal function measured via annualised slope of estimated glomerular filtration rate (eGFR). 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.	FTEAM FTEAM
5.4.	FG1SMC 2842 - ENFORTUMAB VEDOTIN (UROTHELIAL CANCER)	
	There were no declarations of interest recorded in relation to this product. The Group considered the request for enfortumab vedotin in combination with pembrolizumab for the first-line treatment of adults with unresectable or metastatic urothelial cancer who are eligible for platinum-containing chemotherapy. The Group noted: - enfortumab vedotin: - is an antibody drug conjugate that targets and binds to the Nectin-4 protein expressed on the surface of urothelial cancer cells [when given in combination with pembrolizumab] is administered at a recommended dose of 1.25mg/kg (up to a maximum of 125mg for patients $\geq 100\text{kg}$) - is administered as an intravenous infusion over 30 minutes on Days 1 and 8 of every 3-week (21-day) cycle until disease progression or unacceptable toxicity - is given in combination with pembrolizumab. SMC has restricted the treatment duration for pembrolizumab to 2 years, as there is limited evidence of efficacy and safety beyond this treatment duration. [for this indication] meets SMC end of life and orphan equivalent criteria, and was	

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	accepted for use in NHS Scotland following a full submission assessed under the end of life and orphan equivalent medicine process, the output from the PACE process, and application of SMC decision modifiers that can be applied when encountering high cost-effectiveness ratios - the service plan to administer pembrolizumab subcutaneously - evidence comes from EV-302, an international, randomised, open-label, phase III trial. Patients were recruited with an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2, and were randomised to enfortumab plus pembrolizumab, or gemcitabine plus cisplatin or carboplatin (chemotherapy was given for a maximum of six cycles). Avelumab maintenance was permitted. - the primary outcomes were progression free survival (PFS) and overall survival (OS) - at the primary analysis, after a median follow-up of 17.2 months, the median PFS was 12.5 months for enfortumab vedotin plus pembrolizumab and 6.3 months for chemotherapy. The median OS was 31.5 months for enfortumab vedotin plus pembrolizumab and 16.1 months for chemotherapy. - an ad-hoc analysis supported the primary analysis; after a median follow-up of 29.1 months and the median PFS was 12.5 months and 6.3 months and OS was 33.8 months and 15.9 months for enfortumab vedotin plus pembrolizumab and chemotherapy respectively - the median duration of treatment with enfortumab vedotin was 7 months (~9 cycles, range 0.3 to 31.9 months) and the median duration of treatment with pembrolizumab was 8.5 months (11 cycles) - enfortumab vedotin plus pembrolizumab will become the first-line treatment for metastatic/unresectable urothelial cancer as an alternative to six cycles of platinum based chemotherapy - minimal off-set is available from displacement of platinum based chemotherapy, however cost offset will be available from displacement of avelumab maintenance after platinum-based chemotherapy, and second-line pembrolizumab will not be required in patients who receive enfortumab plus pembrolizumab in the first-line setting. - the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of enfortumab vedotin A member reported that patients have received this treatment combination as individual requests and local experience has been positive, with treatment well tolerated by patients. Members were supportive of the request noting the positive trial data, and the limited treatment options for a disease with poor outcomes. The Group accepted the restricted local need for enfortumab vedotin in combination with pembrolizumab for the first-line treatment of adults with unresectable or metastatic urothelial cancer who are eligible for platinum-containing chemotherapy. FG1SMC 2842 - Enfortumab vedotin 20mg, 30mg powder for concentrate for solution for infusion (Padcev®)▼ is routinely available in line with national guidance (SMC 2842). Indication under review: in combination with pembrolizumab, for the first-line treatment of adults with unresectable or metastatic urothelial cancer who are eligible for platinum-containing chemotherapy. Treatment with pembrolizumab is subject to a two-year clinical stopping rule. In a phase III, open-label study, enfortumab vedotin in combination with pembrolizumab was associated with statistically significant improvements in progression-free survival and overall survival compared with platinum-based chemotherapy in patients with untreated locally advanced or metastatic urothelial carcinoma.	

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	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. This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting. It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Treatment should be initiated and supervised by a physician experienced in the use of anti-cancer therapies. Ensure good venous access prior to starting treatment.	FTEAM

5.5. FG1SMC 2833 - NEMOLIZUMAB (ATOPIC DERMATITIS)

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

The Group considered the request for nemolizumab for the treatment of moderate-to-severe atopic dermatitis for use in those who have had an inadequate response to an existing systemic immunosuppressant such as ciclosporin, or in whom such treatment is considered unsuitable and where a biologic would otherwise be offered.

The Group noted:

- nemolizumab:
 - is a humanised immunoglobulin G2 (IgG2) monoclonal antibody that selectively binds to interleukin-31 receptor alpha (IL-31RA) and inhibits IL-31 signalling
 - is the first immunotherapy licensed for atopic dermatitis that targets IL-31 receptor alpha
 - the recommended dose is an initial dose of 60mg (two 30mg injections), followed by 30mg given every 4 weeks. After 16 weeks of treatment, for patients who achieve clinical response, the recommended maintenance dose of nemolizumab is 30mg every 8 weeks. Consideration should be given to discontinuing treatment with nemolizumab in patients who have shown no response after 16 weeks.
 - is administered by subcutaneous injection which patients can be taught how to self-administer
 - is administered less frequently than other biologics for atopic dermatitis, which may be beneficial for some patients
- evidence comes from ARCADIA 1, ARCADIA 2 and ARCADIA-CYCLO trials which were international, double blind, randomised, phase III studies (phase IIIb for ARCADIA-CYCLO). Patients with moderate to severe atopic dermatitis were randomised to nemolizumab 60mg SC followed by 30mg SC every 4 weeks or placebo until week 16.
- in ARCADIA 1 and ARCADIA 2, the primary outcomes were Investigator Global Assessment (IGA) score 0 or 1 with ≥ 2 point improvement from baseline at week 16 and $\geq 75\%$ improvement from baseline in Eczema Area and Severity Index (EASI-75) at week 16
 - ARCADIA 1:
 - IGA score improvement – 36% for nemolizumab and 25% for placebo
 - EASI-75 – 44% for nemolizumab and 29% for placebo
 - ARCADIA 2:
 - IGA score improvement – 38% for nemolizumab and 26% for placebo
 - EASI-75 – 42% for nemolizumab and 30% for placebo
- in ARCADIA-CYCLO the primary outcomes were EASI-75 at week 16 and Peak Pruritus Numerical Rating Scale (PP-NRS) ≥ 4 -point improvement from baseline at week 16
 - ARCADIA-CYCLO:
 - EASI-75 – 47% for nemolizumab and 35% for placebo
 - PP-NRS improvement – 39% for nemolizumab and 17% for placebo
- the service plan to supply nemolizumab by a homecare arrangement so costs will

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	exclude VAT - the service has stated that nemolizumab provides an alternative option for patients who have not achieved adequate control with dupilumab, tralokinumab, lebrikizumab or Janus Kinase inhibitors, or for whom these treatments are unsuitable and it offers a unique mechanism of action by blocking the IL-31 receptor - cost offset is available from displacement of alternative biologic treatments - the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of nemolizumab The Group accepted the restricted local need for nemolizumab as an additional biologic treatment option for the management of moderate-to-severe atopic dermatitis in adults and adolescents, as outlined in SMC 2833. FG1SMC 2833 - Nemolizumab 30mg powder and solvent for solution for injection in pre-filled pen (Nemluvio®)▼ is routinely available in line with national guidance (SMC 2833). Indication under review: for the treatment of moderate-to-severe atopic dermatitis in combination with topical corticosteroids and/or calcineurin inhibitors in adults and adolescents 12 years and older with a body weight of at least 30kg, who have had an inadequate response to an existing systemic immunosuppressant such as ciclosporin, or in whom such treatment is considered unsuitable and where a biologic would otherwise be offered. Three phase III studies demonstrated superiority of nemolizumab in improving signs and symptoms of atopic dermatitis when compared with placebo, in combination with topical corticosteroids with or without topical calcineurin inhibitors, in patients with moderate-to-severe dermatitis. This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/list price that is equivalent or lower. It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only.	FTEAM

6. FORMULARY REVIEW

6.1. FORMULARY UPDATES

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

The Group supported the proposed formulary updates, including generic naming changes following product de-branding or discontinuation, adoption of preferred biosimilar products for subcutaneous tocilizumab and denosumab 120mg in line with current contracting arrangements, and the removal of discontinued medicines from the formulary. Relevant communications will be issued to prescribers and local and regional HEPMA teams as appropriate.

FTEAM

6.2. WEGOVY® TABLETS (WEIGHT MANAGEMENT)

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

Ms Doney reported that semaglutide tablets (Wegovy®) are now licensed and available for weight management. It was proposed that semaglutide 1.5mg, 4mg, 9mg and 25mg tablets (Wegovy®) be recorded as non-formulary pending publication of SMC advice. Members supported the proposal.

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	Semaglutide 1.5mg, 4mg, 9mg, 25mg tablets (Wegovy®)▼ is not routinely available in NHS Grampian. 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: • ≥30 kg/m² (obesity), or • ≥27 kg/m² to <30 kg/m² (overweight) in the presence of at least one weight-related comorbidity. Not routinely available in NHS Grampian.	FTEAM
	6.3. PHARMACOLOGICAL MANAGEMENT OF TYPE 2 DIABETES MELLITUS Ms Doney reported that the Diabetic Service has updated its local pathway for the pharmacological management of type 2 diabetes mellitus in line with NICE guidance. The main changes include promoting modified-release metformin and sodium-glucose cotransporter-2 (SGLT2) inhibitors to first-line treatment options. The Group supported updating the formulary in line with the changes to the revised local guidance for the pharmacological management of type 2 diabetes mellitus.	FTEAM
7.	PUBLISHED ADVICE 7.1. SCOTTISH MEDICINES CONSORTIUM ADVICE PUBLISHED JULY 2026 The Group noted the SMC advice published July 2026. Following publication of the negative SMC recommendation for avapritinib (Ayvakyt®▼-SMC 2849) this medicine will not be included on the Grampian Joint Formulary for the indication in question. The following SMC accepted medicines have not been processed within a 60-day timescale: • SMC 2870 benralizumab (Fasenra®) (submission expected) • SMC 2880 durvalumab (Imfinzi®) (submission received) • SMC 2898 fezolinetant (Veoza®▼) (submission expected) • SMC 2846 glofitamab (Columvi®▼) (submission expected) • SMC 2910 tebentafusp (Kimmtrak®) (submission expected) Local advice for these medicines and indications will be included in the August 2026 decisions as 'Not routinely available as the ADTC is waiting for further advice from local clinical experts'. 7.2. NATIONAL CANCER MEDICINES ADVISORY GROUP ADVICE PUBLISHED – JULY 2026 The Group noted the NCMAG advice published July 2026. The following NCMAG supported medicine has not been processed within a 60-day timescale: • NCMAG 127 arsenic trioxide (submission expected) • NCMAG 128 pazopanib (submission expected) Local advice for this medicine and indication will be included in the August 2026 decisions as 'Not routinely available as the ADTC is waiting for further advice from local clinical experts'. 7.3. SCOTTISH MEDICINES CONSORTIUM ADVICE PUBLISHED – AUGUST 2026 The Group noted the SMC advice published August 2026.	FTEAM

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	Following publication of the non-submission statements for efgartigimod alfa (Vyvgart[®]▼ - SMC 2964), elinzanetant (Lynkuet[®]▼ - SMC 2965) and lutetium (177Lu) vipivotide tetraxetan (Pluvicto[®]▼ - SMC 2966) 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 2885 standardised allergen extract from the house dust mites Dermatophagoides pteronyssinus and Dermatophagoides farinae sublingual lyophilisate (Acarizax[®]) (submission expected) • SMC 2967 cabozantinib (Cabozantinib Ipsen[®]) • SMC 2953 dostarlimab (Jemperli[®]▼) • SMC 2876 Lecigon[®] (levodopa/carbidopa/entacapone) • SMC 2884 sodium zirconium cyclosilicate (Lokelma[®]▼) • SMC 2879 upadacitinib (Rinvoq[®]) (submission expected) • SMC 2955 zilucoplan (Zilbrysq[®]▼) (submission expected) Local advice for these medicines and indications will be included in the August 2026 decisions as 'Not routinely available as the ADTC is waiting for further advice from local clinical experts'.	
8.	PROVISIONAL ADVICE 8.1. SCOTTISH MEDICINES CONSORTIUM ADVICE ISSUED AUGUST 2026 The Group noted the SMC provisional advice issued August 2026. If the SMC publishes 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 9.1. CONFLICTS OF INTEREST AND MEMBERSHIP Ms Doney apologised for delays in maintaining the conflicts of interest register and outlined plans to update records and improve group membership resilience, with future suggestions to be brought to the group.	FD
10.	DOCUMENTS FOR INFORMATION Items 10.1 and 10.8 (MHRA Safety Round-up June 2026 and July 2026), 10.2 (Acute and Mental Health Medicines Safety Group meeting minutes – December 2025), 10.3 (Acute and Mental Health Medicines Safety Group meeting minutes – February 2026), 10.4 (Grampian Primary Care Prescribing Group meeting minutes – March 2026), and 10.5 (Antimicrobial Management Team meeting minutes – March 2026) were noted without further comment.	
11.	AOCB ANNUAL REPORT FEEDBACK AND GROUP SURVEY RESULTS Ms Doney presented the results of the Formulary Group annual report feedback survey, highlighting the sections considered most valuable, areas for future focus, and suggestions for improvement. Feedback will be used to inform future reports and to improve stakeholder engagement and communication regarding formulary decisions. The annual report received an average rating of 4.8 out of 5. Risks and governance, monitoring and compliance, widening access, patient safety, communication, and	

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	performance indicators were identified as the most valuable sections. Respondents suggested future priorities of improving engagement and providing greater visibility of formulary decision timelines, including when SMC advice is published and when local teams are contacted regarding implementation. Overall, the report was considered clear and appropriately presented, with charts and tables regarded as particularly helpful. Ms Doney thanked Ms Bruce and Mrs Standen for their significant contribution to supporting Formulary Group meetings and maintaining the formulary.	
	Ms Doney to circulate a link to the summary of feedback for members to review.	FD
DATE OF NEXT MEETING		
Tuesday 15 September 2026 starting at 14.30 via Microsoft Teams.		

Signature on file

CHAIR'S SIGNATURE	Dr Louise Elliot	DATE	15 September 2026
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