NHS GRAMPIAN
Minute of Formulary Group Meeting
Tuesday 15 September 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 G McKerron	
Mrs E Milne		
Mrs S O'Beirne (from item 4)		
Mr M Paterson		

1.3. IN ATTENDANCE

Professor P Forget, Clinical Chair in Anaesthesia University of Aberdeen, and Honorary Consultant NHS Grampian, for item 4.
Ms D Bruce, Specialist Pharmacy Technician, Formulary Team.

1.4. NOTES

Members who sent apologies were recorded.

2. MINUTE AND DECISIONS

2.1. DRAFT MINUTES OF THE MEETING HELD 18 AUGUST 2026

Due to the delayed circulation of the draft minutes, the review period was extended until 28 September 2026 to allow members additional time to submit comments prior to approval.

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

2.2. FORMULARY GROUP DECISIONS AUGUST 2026 - PUBLISHED 01/09/2026

Members formally ratified the August 2026 decisions document as published.

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3. MATTERS ARISING

3.1. ACTION LOG

The Group noted this item. NHS Grampian's Pharmacy First feedback had been submitted to the national group for consideration, and the link to the Annual Report feedback summary had been circulated to members following the August meeting. Both actions were closed. **FTEAM**

3.2. SYMBICORT MART – AGE 5 TO <12 YEARS (UPDATE)

The Group noted that publication of the Symbicort® decision had been deferred following identification of queries requiring further clarification after the previous meeting. The item will be brought back to a future meeting for further consideration. **FTEAM**

4. DISCUSSION/PRESENTATION – CLONIDINE (OFF-LABEL USE)

Professor Patrice Forget, Clinical Chair in Anaesthesia University of Aberdeen and Honorary Consultant NHS Grampian, discussed the request for the off-label use of clonidine for acute pain associated with high opioid requirements or intolerance, short-term sedation in critically ill patients, and assistance with withdrawal syndromes.

Professor Forget outlined the established clinical experience with clonidine and advised that its haemodynamic effects, including effects on blood pressure, required appropriate caution. He explained that, in his experience, clonidine was generally used as a third-line treatment to provide a short-term bridge in complex clinical situations, for a relatively small patient population where other approaches had not been effective or appropriate.

The proposed protocol was intended to provide a framework to support safe and appropriate prescribing. Professor Forget favoured a cautious approach, highlighting the recognised risk of rebound hypertension following abrupt discontinuation and the additional complexity associated with longer-term treatment and safe withdrawal. A short course, with a clear discontinuation date and consultant-led approach, was considered appropriate to maintain suitable safeguards while experience with the protocol developed.

Restricting prescribing to a very small number of clinicians had been considered, however, a protocol-based approach would provide appropriate safeguards while recognising that patients may receive care from different clinical teams.

The Chair thanked Professor Forget for attending the meeting and for his contribution to the discussion. Professor Forget then left the meeting prior to the Group's consideration and decision on the formulary request.

5. NEW PRODUCT REQUESTS

5.1. FG1 487/26 – CLONIDINE (OFF-LABEL USE)

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

The Group considered the supporting information for the proposed off-label use of clonidine for acute pain associated with high opioid requirements or intolerance, short-term sedation in critically ill patients, and assistance with withdrawal syndromes.

The Group noted:

- that clonidine is an established medicine that is already included in the formulary, including for an alternative off-label indication
- the clinical evidence supporting the requested off-label uses. Supporting evidence

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included guidance on perioperative pain management recommending multimodal analgesia, including alpha-2 adrenergic agonists, and guidance supporting clonidine in the management of some opioid withdrawal symptoms. The British National Formulary also references off-label use of clonidine for sedation where adequate sedation cannot be achieved with standard treatment. Guidance for clonidine in acute pain management within another NHS Board was also considered.

- that the proposed use was for a limited patient population where other approaches had not been effective or were not appropriate. Treatment would normally be limited to three days, with inpatient pain team oversight required for extended use.
- that costs were not considered problematic, given the short duration of treatment and the expectation that patients would predominantly receive oral treatment. Some costs were already within the system and no additional service implications were identified.
- the haemodynamic effects of clonidine, particularly its effect on blood pressure and the risk of rebound hypertension following abrupt discontinuation, with particular consideration required for longer-term treatment

Members considered the proposed restrictions important safeguards; short-duration treatment, consultant-led use within the acute hospital setting, in line with the proposed guidance. It was agreed that patients should not be discharged on clonidine under the proposed arrangements. Longer-term use could be considered separately if a future need was identified.

Members considered that the proposed restrictions provide important safeguards, including the short-duration of treatment, consultant-led use within the acute hospital setting, in accordance with the proposed guidance.
Members agreed that patients should not be discharged on clonidine under the proposed arrangements. Longer-term use could be considered separately if a future need was identified.

The Group accepted the restricted local need for the short-term, off-label use of clonidine as an adjunct to treatment for acute pain associated with high opioid requirements or intolerance, for sedation in critically ill patients, and to assist with withdrawal syndromes. Formulary acceptance is conditional on approval and publication of associated guidance by the Medicines Guidelines and Policies Group (MGPG).

FG1SMC 487/26 - Clonidine 25microgram, 100microgram tablets, 150micrograms solution for injection is routinely available in line with local guidance.
Indication under review: [off-label use] in adults for:

- **adjunctive treatment of acute pain in cases of high opioid requirement or intolerance**
- **short-term sedation in critically ill patients when adequate sedation cannot be achieved with standard treatment**
- **management of selected cases of acute opioid and/or alcohol withdrawal**

Restriction: short-term use only, on the advice of an anaesthetist, the Critical Care Team, or the Inpatient/Acute Pain Team.
It was classified 3b - licensed product request for unlicensed use and 8b - recommended for hospital use only. **FTEAM**

5.2. FG1SMC 2863 – TALQUETAMAB (TALVEY®) (RELAPSED AND REFRACTORY MULTIPLE MYELOMA)

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

The Group considered the request for talquetamab as monotherapy for the treatment of adults with relapsed and refractory multiple myeloma, who have received at least three prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an

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anti-CD38 antibody and have demonstrated disease progression on the last therapy.

The Group noted:

- talquetamab
  - is an immunoglobulin G4 (IgG4) bispecific antibody that targets the CD3 receptor complex expressed on T cells and the G protein-coupled receptor class 5D (GPRC5D) expressed on multiple myeloma cells
  - should be administered subcutaneously on a weekly or every two week dosing schedule
  - has conditional marketing authorisation from the Medicines and Healthcare products Regulatory Agency (MHRA) and meets SMC end of life and orphan equivalent criteria for this indication
- patients should be instructed to remain within proximity of a healthcare facility and monitored for 48 hours after administration of all doses within the talquetamab step-up phase for signs and symptoms of cytokine release syndrome (CRS) and immune effector cell-associated neurotoxicity syndrome (ICANS)
- pre-treatment with a corticosteroid, antihistamine and antipyretic should be administered 1 to 3 hours before each dose
- evidence comes from the MonumenTAL-1 study - a multicentre, open-label single-arm, phase I/II study
- the primary outcome was overall response rate (ORR) and secondary outcomes included duration of response (DOR), progression free survival (PFS) and overall survival (OS)
- an indirect treatment comparison suggested that talquetamab is superior to teclistamab for OS but there was no evidence of a difference for PFS and that talquetamab is superior to selinexor plus dexamethasone for PFS and OS
- it was estimated that patient numbers would be low and remain relatively static
- in the MonumenTAL-1 trial, the median PFS was 11.2 months in the cohort taking talquetamab 0.8mg/kg every 2 weeks and 7.5 months in the cohort taking talquetamab 0.4mg/kg every week
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of talquetamab

The Group accepted the restricted local need for talquetamab monotherapy for the treatment of adults with relapsed and refractory multiple myeloma, in line with SMC 2863.

FG1SMC 2863 - Talquetamab 2mg/mL, 40mg/mL solution for injection (Talvey®)▼ is routinely available in line with national guidance (SMC 2863).
Indication under review: as monotherapy for the treatment of adults with relapsed and refractory multiple myeloma, who have received at least three prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody and have demonstrated disease progression on the last therapy.
In an uncontrolled phase I/II study, patients with relapsed and refractory multiple myeloma who had at least three prior therapies (including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody), and received talquetamab 0.8mg/kg every two weeks, achieved an objective response rate of 70%.
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 talquetamab should be initiated and supervised by physicians experienced in the treatment of multiple myeloma. Talquetamab should be administered by a healthcare professional with adequately-trained medical personnel and appropriate medical equipment to manage severe reactions, including cytokine release syndrome (CRS) and

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	neurologic toxicity, including immune effector cell-associated neurotoxicity syndrome (ICANS).	FTEAM

5.3. FG1SMC 2699 – QUIZARTINIB (ACUTE MYELOID LEUKAEMIA)

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

The Group considered the request for quizartinib used in combination with standard cytarabine and anthracycline induction and standard cytarabine consolidation chemotherapy, followed by quizartinib single-agent maintenance therapy for adult patients with newly diagnosed acute myeloid leukaemia (AML) that is FLT3-ITD positive.

The Group noted:

- quizartinib:
  - is a selective type II tyrosine kinase FMS-like tyrosine kinase 3 (FLT3) receptor inhibitor
  - should be administered in combination with standard chemotherapy at a dose of 35.4mg once daily for two weeks in each cycle of induction. For patients who achieve complete remission (CR) quizartinib should be administered at 35.4mg once daily for two weeks in each cycle of consolidation chemotherapy followed by quizartinib single-agent maintenance therapy initiated at 26.5mg once daily. After two weeks the maintenance dose should be increased to 53mg once daily if the QT interval is ≤450ms. Single-agent maintenance therapy may be continued for up to 36 cycles.
  - [for this indication] meets SMC orphan criteria
- during induction and consolidation, electrocardiograms (ECGs) should be performed prior to initiation and then once weekly during quizartinib treatment. During maintenance, ECGs should be performed prior to initiation and then once weekly for the first month following dose initiation and escalation.
- FLT3 testing is required before starting quizartinib treatment and this is already standard in AML patients
- evidence comes from the QuANTUM-First study – an international, randomised, double-blind, phase III study
- patients were randomised to quizartinib 35.4mg (n=268) or placebo (n=271) once daily for 14 days of each induction and consolidation cycle, followed by maintenance phase with quizartinib 26.5mg (which could be increased to 53mg daily) or placebo orally daily for up to thirty six 28-day cycles
- the primary outcome was overall survival (OS)
- after a median follow-up of 39.2 months, the median OS was 31.9 months for quizartinib and 15.1 months for placebo
- the company presented SMC with an indirect treatment comparison comparing quizartinib with midostaurin. There was no evidence of a difference found for OS and complete remission but the comparison of cumulative incidence of relapse suggested that the risk of relapse was lower with quizartinib than midostaurin.
- patient numbers are expected to be low, but there is a clinical trial open for this patient cohort currently which may reduce this number
- in QuANTUM-First, the median duration of treatment was 10.7 weeks with quizartinib. The median duration of maintenance treatment was 1.3 years.
- cost offset is available as quizartinib will be used as an alternative to midostaurin, gastrointestinal adverse effects are less frequent with quizartinib. The maximum duration of treatment with midostaurin is 12 cycles of maintenance, whereas quizartinib can be continued for up to 36 cycles of maintenance.
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of quizartinib

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The Group accepted the restricted local need for quizartinib, in combination with standard cytarabine and anthracycline induction and standard cytarabine consolidation chemotherapy, for the treatment of adults with newly diagnosed AML that is FLT3-ITD positive, in line with SMC 2699.

FG1SMC 2699 - Quizartinib 17.7mg, 26.5mg tablets (Vanflyta®)▼ is routinely available in line with national guidance (SMC 2699).
Indication under review: in combination with standard cytarabine and anthracycline induction and standard cytarabine consolidation chemotherapy, followed by quizartinib single-agent maintenance therapy for adults with newly diagnosed acute myeloid leukaemia (AML) that is FLT3-ITD positive.
In a randomised, double-blind, phase III study, the addition of quizartinib compared with placebo to standard chemotherapy significantly improved overall survival in newly diagnosed patients with AML with FLT3-ITD mutation.
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 quizartinib should be initiated by a physician experienced in the use of anti-cancer therapies. Before taking quizartinib, AML patients must have confirmation of FLT3-ITD positive AML using a CE-marked in vitro diagnostic (IVD) medical device with the corresponding intended purpose. If a CE-marked IVD is not available, confirmation of FLT3-ITD positive AML should be assessed by an alternate validated test. ECGs should be performed, and electrolyte abnormalities should be corrected prior to initiation of treatment. FTEAM

5.4. FG1SMC 2818 - DURVALUMAB (LIMITED-STAGE SMALL CELL LUNG CANCER)

Mr Paterson declared a non-specific personal interest in AstraZeneca UK Limited and remained present for, and participated in, decision-making.

The Group considered the request for durvalumab as monotherapy for the treatment of adults with limited-stage small cell lung cancer (LS-SCLC) whose disease has not progressed following platinum-based chemoradiation therapy.

The Group noted:

- durvalumab:
  - is a monoclonal antibody that inhibits the protein PD-L1 (Programmed Death-Ligand 1)
  - [for this indication] the recommended dose is 1,500mg administered intravenously every 4 weeks (patients with a body weight of 30kg or less must receive weight-based dosing, equivalent to durvalumab 10mg/kg every 2 weeks or 20mg/kg every 4 weeks as monotherapy until weight increases to greater than 30kg).
    It is recommended to continue treatment until disease progression, unacceptable toxicity, or a maximum of 24 months.
  - [for this indication] represents the first consolidation option in this setting, and is included in the national Clinical Management Pathway for LS-SCLC
  - meets SMC end of life and orphan equivalent criteria for this indication
- evidence comes from the ADRIATIC study, an international, randomised, double-blind, phase III study
- patients had an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 1
- patients were randomised to durvalumab 1,500mg or placebo every 4 weeks
- the co-primary outcomes were overall survival (OS) and progression-free survival (PFS)

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- at the January 2024 cut off:
  - the median OS was 55.9 months for durvalumab and 33.4 months for placebo
  - the median PFS was 16.6 months for durvalumab and 9.2 months for placebo
- patient numbers are expected to be low
- the median duration of treatment with durvalumab in the ADRIATIC study was 40 weeks
- this will be a new cost, as there are currently no consolidation therapies recommended for this patient group
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of durvalumab

The Group accepted the restricted local need for durvalumab as monotherapy for the treatment of adults with LS-SCLC whose disease has not progressed following platinum-based chemoradiation therapy, in line with SMC 2818.

FG1SMC 2818 - Durvalumab 50mg/mL concentrate for solution for infusion (Imfinzi®) is routinely available in line with national guidance (SMC 2818).
Indication under review: as monotherapy for the treatment of adults with limited-stage small cell lung cancer (LS-SCLC) whose disease has not progressed following platinum-based chemoradiation therapy.
In a randomised, double-blind phase III study, durvalumab significantly improved progression-free and overall survival compared with placebo in patients with LS-SCLC who had not progressed following concurrent chemoradiotherapy.
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.
Suggested classification: RED; 1b - Available for restricted use under specialist supervision, 8b - Recommended for hospital use only. Treatment must be initiated and supervised by a physician experienced in the treatment of cancer. FTEAM

5.5. FG1SMC 2880 - DURVALUMAB (MUSCLE INVASIVE BLADDER CANCER)

Mr Paterson declared a non-specific personal interest in AstraZeneca UK Limited and remained present for, and participated in, decision-making.

The Group considered the request for durvalumab in combination with gemcitabine and cisplatin as neoadjuvant treatment, followed by durvalumab as monotherapy adjuvant treatment after radical cystectomy, for the treatment of adults with resectable muscle invasive bladder cancer (MIBC).

The Group noted:

- durvalumab:
  - is the first treatment licensed for perioperative (neoadjuvant and adjuvant) treatment of MIBC, and looking for curative intent
  - [for this indication] the recommended daily dose in patients with a body weight greater than 30kg is 1,500mg as an intravenous infusion in combination with chemotherapy every 3 weeks for four cycles prior to surgery, followed by 1,500mg every 4 weeks as monotherapy for up to eight cycles after surgery.
    Patients with a body weight of 30kg or less must receive weight-based dosing of durvalumab at 20mg/kg.
- evidence comes from NIAGRA, an international randomised, open-label, phase III trial
- patients were randomised to receive neoadjuvant durvalumab plus gemcitabine and cisplatin followed by radical cystectomy and adjuvant durvalumab, or neoadjuvant gemcitabine and cisplatin followed by radical cystectomy alone
- the co-primary outcomes were pathological complete response (pCR) and event-free survival (EFS)

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- at the April 2024 data-cut off, perioperative durvalumab plus neoadjuvant gemcitabine and cisplatin resulted in statically significant improvements in EFS (median EFS not reached versus 46.1 months; HR 0.68) and OS (median OS not reached in either arm but Kaplan-Meier OS rate at 24 months 82% versus 75%); pCR was not significantly different between treatment groups, although pCR rates were numerically higher with durvalumab
- an indirect treatment comparison suggested that durvalumab improved OS and EFS compared with the counterfactual control group (that is, eligible patients in the NIAGARA control group who were simulated to receive adjuvant nivolumab)
- patient numbers annually are expected to be low
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of durvalumab
- cost offset is expected because the use of adjuvant nivolumab post-operatively would not be indicated in patients treated with durvalumab

The Group accepted the restricted local need for durvalumab for the treatment of adults with resectable MIBC, in line with SMC 2880.

FG1SMC 2880 - Durvalumab 50mg/mL concentrate for solution for infusion (Imfinzi®) is routinely available in line with national guidance (SMC 2880). Indication under review: in combination with gemcitabine and cisplatin as neoadjuvant treatment, followed by durvalumab as monotherapy adjuvant treatment after radical cystectomy, for the treatment of adults with resectable muscle invasive bladder cancer (MIBC).
Evidence from an open-label, phase III study demonstrated that the addition of perioperative durvalumab to neoadjuvant gemcitabine plus cisplatin significantly improved event-free survival and overall survival. Neoadjuvant gemcitabine plus cisplatin is the most relevant comparator in this setting
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 must be initiated and supervised by a physician experienced in the treatment of cancer. **FTEAM**

6. FORMULARY REVIEW

6.1. FORMULARY UPDATES

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

The Group supported the formulary updates presented, including generic naming changes following product de-branding or patent expiry, and the alignment of arsenic trioxide prescribing to the preferred 1mg/mL concentration for solution for infusion in line with current contracting arrangements.
Relevant communications will be issued to prescribers and local and regional HEPMA teams as appropriate. **FTEAM**

6.2. SOPROBEC® INHALERS (BECLOMETASONE, ASTHMA)

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

Ms Doney reported the planned discontinuation of Clenil® 50microgram and 250microgram inhalers. The Group noted that Soprobec® is the closest like-for-like alternative to Clenil®, although it does not include a dose counter.

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The Group supported the inclusion of Soprobec® inhalers on the formulary as a cost-minimising option to maintain access to all strengths of beclometasone pMDI therapy and support patients transferring from other Health Boards.

The Group accepted the restricted local need for Soprobec® inhalers.

Soprobec® 50micrograms, 100micrograms, 200micrograms, 250micrograms inhaler (beclometasone dipropionate) is routinely available in line with local guidance.
Indication under review: for the maintenance treatment of asthma, when the use of pressurised metered dose inhaler is appropriate.
It was classified 1a - available for general use and 8e - treatment may be initiated in either Primary or Secondary care. **FTEAM**

6.3. BEVESPI® AEROSPHERE® 7.2MICROGRAMS/ 5MICROGRAMS PRESSURISED INHALATION, SUSPENSION (GLYCOPYRRONIUM/ FORMOTEROL FUMARATE)

Mr Paterson declared a non-specific personal interest in AstraZeneca UK Limited and remained present for, and participated in, decision-making.

The Group considered the request from the Respiratory Managed Clinical Network (MCN) to add Bevespi® Aerosphere® to the formulary.

The Group noted:
- Bevespi® Aerosphere®:
  - is licensed as a maintenance bronchodilator treatment to relieve symptoms in adult patients with COPD
  - is a fixed-dose combination therapy containing formoterol fumarate and glycopyrronium
  - would offer an additional treatment choice of long-acting $beta_2$-agonist (LABA) and long-acting muscarinic antagonist (LAMA) in a single inhaler
  - was previously noted on the formulary as not-preferred
- November 2025, Trixeo® in the Aerosphere® device was accepted to formulary due to inhaler being available with a 'greener' propellant
- accepting Bevespi® Aerosphere® to formulary would support device consistency across the COPD pathway, particularly following the formulary inclusion of Trixeo® Aerosphere®, and may support patients moving between Health Boards

The Group accepted the restricted local need for Bevespi® Aerosphere® as an additional fixed-dose combination LABA/LAMA inhaler to support device consistency within the COPD pathway and facilitate prescribing for patients transferring from other Health Boards.

SMC 2652 - Bevespi® Aerosphere® 7.2micrograms/5micrograms pressurised inhalation, suspension (glycopyrronium/formoterol fumarate) is routinely available in line with local guidance.
Indication under review: as a maintenance bronchodilator treatment to relieve symptoms in adults with chronic obstructive pulmonary disease (COPD).
Glycopyrronium/formoterol fumarate (Bevespi® Aerosphere® offers an additional treatment choice in the therapeutic class of a long-acting muscarinic antagonist (LAMA) in combination with a long-acting $beta_2$-adrenergic agonist (LABA).
It was classified 1a - available for general use and 8e - treatment may be initiated in either Primary or Secondary care. **FTEAM**

6.4. SBAR PILOT REQUEST

Ms Doney presented a proposal to pilot the use of recommendations from the NHS Scotland Cancer Collaborative Lung Clinical Management Pathway (CMP) to inform the

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local formulary assessment of SMC and NCMAG accepted oncology medicines. The Group noted that the proposed approach aimed to reduce duplication between national and local review processes whilst maintaining existing local formulary, financial and clinical governance arrangements. Members noted the continued requirement for Formulary Group approval of medicines and indications, consideration of budget impact, service implications and patient numbers, and the retention of local accountability for implementation.

The Group supported the development of a standardised governance checklist and approved the proposed pilot, with a formal review to be undertaken after approximately six months. **FTEAM**

7. PUBLISHED ADVICE

7.1. SCOTTISH MEDICINES CONSORTIUM ADVICE PUBLISHED SEPTEMBER 2026

The Group noted the SMC advice published September 2026.

Following publication of the non-submission statements for depemokimab (Exdensur®▼ - SMC 2970), hydrocortisone (Efmody® - SMC 2971), lisocabtagene maraleucel (Breyanzi®▼ - SMC 2972), sotatercept (Winrevair®▼ - SMC 2973) and toripalimab (Loqtorzi®▼ - SMC 2974) 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 2930 capivasertib (Truqap®▼)
- SMC 2933 elacestrant (Korserdu®▼)
- SMC 2881 epcoritamab (Tepkinly®▼) (submission received)
- SMC 2867 lorlatinib (Lorviqua®)
- SMC 2877 nusinersen (Spinraza®) (submission expected)
- SMC 2907 pembrolizumab (Keytruda®)
- SMC 2946 seladelpar (Livdelzi® ▼) (submission expected)

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

7.2. SMC 2867 – LORLATINIB (NSCLC)

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

Updated SMC advice for lorlatinib (SMC 2867) was presented. The Group was asked to ratify the current Formulary position.

The Group noted:

- lorlatinib is currently included on the formulary for anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC) in adults whose disease has progressed after alectinib or ceritinib as first ALK tyrosine kinase inhibitor therapy, or after crizotinib and at least one other ALK inhibitor
- SMC 2867 supersedes the previous advice and has broader license wording, allowing use following brigatinib
- the national CMP is being updated to incorporate the new SMC advice

The Group ratified the current formulary position and supported consideration of the current non-formulary subgroups through the lung cancer pilot process following publication of the updated CMP. **MG/ FTEAM**

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8. PROVISIONAL ADVICE

8.1. SCOTTISH MEDICINES CONSORTIUM ADVICE ISSUED SEPTEMBER 2026

The Group noted the SMC provisional advice issued September 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.

9. OTHER BUSINESS

9.1. MHRA CONCLUDES REVIEW OF AVACOPAN VIFOR FOLLOWING REASSESSMENT OF BENEFIT-RISK BALANCE

The Group noted the MHRA decision to suspend the use of avacopan (Avacopan Vifor) in new patients from 1 September 2026. A six-month managed withdrawal period has been established for existing patients, with UK marketing authorisation expected to be revoked on 1 March 2027. Relevant renal and rheumatology services are aware, and only a small number of patients are affected within NHS Grampian.

It was noted that avacopan will be recorded as non-formulary, with reference to the MHRA decision. **FTEAM**

10. DOCUMENTS FOR INFORMATION

Items 10.1 (MHRA Safety Round-up August 2026), 10.2 (Medicines Guidelines and Policies Group meeting minute June 2026), 10.3 (Grampian Area Drug and Therapeutics Committee meeting minute May 2026), 10.4 (Grampian Area Drug and Therapeutics Committee meeting minute July 2026), were noted.

11. AOCB

CHAIRING ARRANGEMENTS

The Chair advised that Dr Chieng and Mr Paterson had agreed to support chairing duties when the Chair or Vice-Chair were unavailable, to support continuity of meetings and ensure business could proceed as scheduled.

DATE OF NEXT MEETING

Tuesday 20 October 2026 starting at 14.30 via Microsoft Teams.

Signature on file

CHAIR'S SIGNATURE **Fiona Doney** **DATE** **20 October 2026**