http://www.devonformularyguidance.nhs.uk/

Meeting of the Devon Formulary Interface Group

Minutes

Wednesday 27th September 2023

Via Microsoft Teams

Present:

Name	Job Title	Organisation
Susie Harris (Chair)	Consultant Physician/Geriatrician	RDUH NHS FT
Ailene Barclay	Pharmacist	UHP NHS Trust
Heidi Campbell	Pharmacist	NHS Kernow ICB
Matt Howard	Clinical Evidence Manager	NHS Devon ICB
Nick Keysell	GP	NHS Devon ICB
Carole Knight	Medicines Information Pharmacist	RDUH NHS FT
Rebecca Lowe	Joint Formulary Technician	NHS Devon ICB
Sarah Marner	Senior MO Pharmacist	NHS Devon ICB
Jess Parker	GP	NHS Devon ICB
Hilary Pearce	Clinical Effectiveness Pharmacist	NHS Devon ICB
Chris Sullivan	Deputy Chief Pharmacist	Devon Partnership NHS Trust
Larissa Sullivan	Pharmacist	T&SD NHS FT
Darren Wright	Joint Formulary Specialist Pharmacy Technician	NHS Devon ICB

Guests:

Anh Nguyen	Specialist Dermatology Pharmacist	RDUH NHS FT
Nic Perrem	Healthcare Evidence Reviewer	NHS Devon ICB
Amy Rice	Clinical Effectiveness Pharmacist – (commissioning projects lead)	NHS Devon ICB
Rebecca Stuckey	Clinical Nurse Specialist Headache	UHP NHS Trust

Observers:

Dr Lucy McGavin	Consultant Neuroradiologist	UHP NHS Trust
Amy Hughes	Trainee Pharmacist	RDUH NHS FT

In attendance:

Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NHS Devon ICB

1. Welcome and announcements

Meeting etiquette

Susie Harris explained the meeting etiquette.

Chairman's welcome

Susie Harris welcomed attendees to the meeting of the Devon Formulary Interface Group.

Apologies

NAME	JOB TITLE	ORGANISATION
Glen Allaway	GP	NHS Devon ICB
Beverley Baker	Non-Medical Prescribing Lead	NHS Devon ICB
Andy Craig	GP	NHS Devon ICB
Emma Gitsham	Clinical Effectiveness Pharmacist – Specialised Medicines Service (SMS) Guidelines Lead	NHS Devon ICB
James Leavy	Medicines Information Pharmacist	RDUH NHS FT

Emma Gitsham had been due to present the paper on Guanfacine for attention deficit disorder (ADHD) in children and young people, however Emma was unable to attend the meeting. The Chair expressed thanks to Emma for putting the paper together which was subsequently presented by Matt Howard, Clinical Evidence Manager.

Declarations of Interest

The Declarations made did not result in anyone being excluded from the meeting or from the discussion of any item.

DRUG TO BE CONSIDERED	PHARMACEUTICAL COMPANY/ MANUFACTURER
Lurasidone in adults and children: • Lurasidone (Latuda) **Alternative Treatments:** • Amisulpride • Aripiprazole • Chlorpromazine • Clozapine (Clozaril, Denzapine) • Haloperidol • Olanzapine • Quetiapine (Immediate release) • Quetiapine (Modified release) • Risperidone • Sulpiride	CNX Therapeutics Ltd (formerly Sunovion Pharmaceuticals Europe) Various manufacturers Various manufacturers Various manufacturers Mylan, Britannia Pharmaceuticals Ltd Various manufacturers Various manufacturers Various manufacturers Various manufacturers Various manufacturers Various manufacturers
TA906 Rimegepant for preventing migraine: • Rimegepant (Vydura) **Alternative treatments:** • Eptinezumab (Vyepti) • Erenumab (Aimovig) • Fremanezumab (Ajovy)	Pfizer Ltd Lundback Ltd Novartis Pharmaceuticals UK Ltd Teva UK Ltd

DRUG TO BE CONSIDERED	PHARMACEUTICAL COMPANY/ MANUFACTURER
• Galcanezumab (Emgality)	Eli Lilly and Company Ltd
NICE TA Tirzepatide for type 2 diabetes: • Tirzepatide (Moujaro) **Alternative treatments:** • Dulaglutide (Trulicity) • Exenatide (Byetta, Bydureon) • Liraglutide (Victoza) • Lixisenatide (Lyxumia) • Semaglutide (Ozempic and Rybelsus)	Eli Lilly and Company Ltd Eli Lilly and Company Ltd AstraZeneca UK Ltd Novo Nordisk Limited Sanofi Novo Nordisk Limited
Negative Pressure Wound Therapy (NPWT): **Traditional Negative Pressure Wound Therapy (tNPWT):** • ActiV.A.C / INFOV.A.C Therapy Unit • Renasys Touch / Renasys GO • Venturi Avanti / Venturi MiNO **Alternatives:** • Other tNPWT **Single-use Negative Pressure Wound Therapy (sNPWT):** • Avelle • PICO / PICO 7 Multisite / PICO 14 Multisite **Alternatives:** • Other sNPWT **NPWT dressings:** • Renasys-AB / Renasys-F / Renasys-G / Renasys-G Drain • V.A.C Granufoam / V.A.C Simplace EX / V.A.C Veraflo • Venturi Gauze / Venturi MiNO Gauze – • Kerlix AMD **Alternatives:** • Other NPWT dressings	 KCI Medical Ltd Smith + Nephew Healthcare Ltd Talley Group Ltd Various manufacturers ConvaTec Ltd Smith + Nephew Healthcare Ltd Various manufacturers Smith + Nephew Healthcare Ltd KCI Medical Ltd Talley Group Ltd H&R Healthcare Various manufacturers
Doublebase Once: • Doublebase Once **Alternatives:** • Doublebase / Doublebase Dayleve • Epimax Isomol • Zerodouble	Dermal Dermal Epimax Zeroderma

DRUG TO BE CONSIDERED	PHARMACEUTICAL COMPANY/ MANUFACTURER
• Other emollients	Various manufacturers
Glucagon 500micrograms and 1mg pre-filled pens (Ogluo) for adults: • Glucagon (Ogluo) pre-filled pens **Alternative treatments:** • GlucaGen HypoKit	 Tetris Pharma Ltd Novo Nordisk Ltd
Allevyn Gentle Border / Gentle Border Lite / Allevyn Life / Allevyn Life Non-Bordered dressings: • Allevyn Gentle Border / Gentle Border Lite / Allevyn Life / Allevyn Life Non-Bordered **Alternatives:** • ActivHeal Silicone Foam Border • Biatain Silicone / Silicone Lite • Other soft silicone dressings	 Smith + Nephew Healthcare Ltd ActivHeal Coloplast Various manufacturers
Sodium zirconium cyclosilicate (Lokelma): • Sodium zirconium cyclosilicate (Lokelma) **Treatment modification:** Renin-angiotensin-aldosterone system (RAAS) inhibitors**:** • ACE inhibitors (e.g. enalapril, lisinopril, ramipril etc.) • ARBs (e.g. candesartan, losartan, irbesartan, valsartan etc. and sacubitril / valsartan (Entresto) • Aldosterone antagonists / mineralocorticoid receptor antagonists (e.g. eplerenone and spironolactone) **Alternative treatments**: • Patiromer calcium (Veltassa) • Calcium resonium	 AstraZeneca UK Limited Various manufacturers Various manufacturers (including Novartis Pharmaceuticals UK Ltd for Entresto) Various manufacturers Vifor Fresenius Medical Care Renal Pharma UK Ltd Sanofi
Reclassification of sildenafil for secondary Raynaud's phenomenon / digital ulceration in systemic sclerosis: • Sildenafil **Alternative treatments:** • Bosentan • Intravenous iloprost	 Various manufacturers Various manufacturers Various manufacturers

DRUG TO BE CONSIDERED	PHARMACEUTICAL COMPANY/ MANUFACTURER
Melatonin for use in adult patients • Melatonin **Alternative treatments for insomnia:** • Non-benzodiazepine hypnotics (z-drugs) i.e. zopiclone & zolpidem • Cognitive behavioural therapy for insomnia (CBT-I) **Alternative treatments for RBD in Parkinson's disease:** • Clonazepam	Various manufacturers Various manufacturers Various providers Various manufacturers
Guanfacine for attention deficit hyperactivity disorder (ADHD) in children and young people aged 6 – 17 years: • Guanfacine (Intuniv) **Alternative treatments:** • Dexamfetamine • Lisdexamfetamine (Elvanse, Elvanse Adult) • Methylphenidate, Atomoxetine	Takeda UK Ltd Various manufacturers Takeda UK Ltd Various manufacturers

Name	Job Title	Declaration
Rebeca Lowe	Joint Formulary Pharmacy Technician	Devon Secondary employment including locum dispenser at various community pharmacies and bank pharmacy technician at HMP Channings Wood.
Rebecca Stuckey	Clinical Nurse Specialist Headache	The initial DOI indicated that Ms Stuckey had "no material interest to declare", however subsequent to the meeting, a potential conflict of interest was identified, that should have been reported. An updated DOI has been received which declared: 'I presented two posters and gave a talk to other headache specialists and received £2,074.70 as an honorarium for Teva in 2022'.

2. Minutes of the meeting held on 19th July 2023 and Actions/Matters Arising

Minutes of the meeting held on 19th July 2023

The minutes of the meeting held on 19th July 2023 were approved.

Summary of actions			
	Action	**Lead**	**Status**
21/23	Thyroid disorders: Update – redraft final guidance in line with the discussion and discuss with specialists.	Formulary Team	Ongoing
21/24	Thyroid disorders: Update – circulate the final draft via e-FIG for agreement.	Formulary Team	Ongoing
22/61	Formulary team to liaise with the Chair on writing to the Pathology Optimisation Group to ask the group to discuss the MHRA recommendations for vitamin B12 testing for patients receiving metformin.	Formulary Team	Ongoing
22/62	Update formulary with a link to MHRA Drug Safety Update and note regarding Pathology Optimisation Group after correspondence is sent to the group.	Formulary Team	Ongoing
22/80	Pharmacological treatment for type 2 diabetes (NICE NG28): bring the formulary guidance for the pharmacological treatment of Type 2 diabetes to a future meeting.	Formulary Team	Ongoing
22/92	Report of e-FIG decisions: November 2022: Treatment of vaginal candidiasis - seek the views of specialists on the use of vaginal creams which require insertion using an applicator during pregnancy and bring revised guidance back to the FIG via the appropriate route.	Formulary Team	Ongoing
22/98	Undertake further work on Ryeqo SmPC recommendation for DXA scan at 12 months for all patients.	Formulary Team	Ongoing
23/02	Hyperhidrosis management and the use of systemic oral anticholinergic drugs (propantheline bromide and oxybutynin – Proposed Formulary Entry to be amended in line with the discussion and added to the local formulary.	Formulary Team	Ongoing
23/04	4.10.2 Nicotine dependence – undertake further consultation and bring the proposed formulary entry back to FIG via an appropriate route.	Formulary Team	Ongoing
23/13	NICE guidance NG196: Atrial fibrillation – If accepted by specialists, publish formulary guidance for Atrial Fibrillation.	Formulary Team	Complete
23/27	Bevespi Aerosphere and Trixeo Aerosphere – ascertain from specialists which patient groups would benefit from a LABA/LAMA pMDI in preference to a LABA/LAMA SMI.	Formulary Team	Complete

23/28	Bevespi Aerosphere and Trixeo Aerosphere – bring back to FIG when specialists can attend.	Formulary Team	Ongoing
23/29	Metolazone 5mg tablets (Xaqua) – consult with heart failure and renal teams for metolazone 5mg tablets (Xaqua).	Formulary Team	Ongoing
23/41	Management of Hypertension (Update) – consult with specialist on proposed guidance.	Formulary team	Ongoing
23/42	Management of Hypertension (Update) – following consultation with specialists, bring draft guidance back to the FIG via the e-FIG process.	Formulary team	Ongoing
23/46	Sodium zirconium cyclosilicate for treating hyperkalaemia: consideration of reclassification – work with specialists on the prescribing guidance.	Formulary team	Ongoing
23/47	Sodium zirconium cyclosilicate for treating hyperkalaemia: bring SZC back to FIG via the appropriate route.	Formulary team	On agenda
23/48	MHRA Drug Safety Updates – April 2023: update the relevant formulary sections with recommendations from the MHRA Drug Safety Updates March 2023 and April 2023.	Formulary team	Ongoing
23/49	MHRA Drug Safety Updates – April 2023: write to MHRA to ask for clarification on frequency of monitoring for hepatic adverse reactions for patients receiving nitrofurantoin.	Formulary team	Ongoing
23/50	Devon FIG Annual Report to be submitted to the Clinical Policy Recommendation Committee	Formulary team	Complete
23/51	Drug Interactions with Hormonal Contraceptives – publish the updated formulary guidance.	Formulary team	Complete
23/52	Insulins – amend proposed formulary entry for insulins in line with the discussion.	Formulary team	Complete
23/53	Insulins undertake consultation with adult and paediatric specialists. Any significant changes will be brought back to the FIG via an appropriate route.	Formulary team	Ongoing
23/54	Glucagon 500micrograms and 1mg pre-filled pens (Ogluo) – make minor amendments to the proposed formulary entry and proceed with consultation with adult specialists.	Formulary team	On agenda
23/55	Chronic heart failure (including NICE TA902) - Consult with heart failure specialists.	Formulary team	Ongoing
23/56	Avenor (fluticasone propionate & salmeterol, pMDI) and Tiogiva (Tiotropium, DPI) - Update the Devon Formulary entry for inhalers in line with the agreement and discussion of Avenor (pMDI) and Tiogiva (DPI) together with additional relevant pages.	Formulary team	Complete
23/57	Priadel (lithium) update - update the SMS guidance as agreed by the FIG.	SMS Guidelines Lead	Complete
23/58	Priadel (lithium) update – present the lithium guideline to the LMC for negotiation of remuneration.	SMS Guidelines Lead	Ongoing
23/59	Update the relevant formulary sections with recommendations from MHRA Drug Safety Updates May and June 2023.	Formulary team	Ongoing

3. Papers for information only

Recent Drug Decisions

The FIG received a report of recent drug decisions.

The Devon Wound Formulary Group (DWFG): Who and What

At the May 2023 FIG meeting, a paper including a detailed review of a wound care product recommended by the DWFG was considered. This led to discussion regarding the role of the FIG in considering a recommendation from an expert group, the level of wound care expertise in the core FIG membership, and the required level of detail in respect of wound care product application papers. As a result, the Formulary team provided additional information on the DWFG and reviewed the format of papers on wound care products.

The DWFG is not a decision-making group, it is an expert working group that makes recommendations to the FIG. A paper outlining the membership and work of the DWFG was presented to the FIG.

The DWFG is a multi-stakeholder group with the breadth of skills and experience to make recommendations on products for use in general practice, and to recognise when products are only suitable for use on the recommendation of a specialist team member. The group's purpose is to supporting safe, evidence based, cost-effective prescribing to make the best use of valuable health resources. It provides a forum for NHS Devon Integrated Care Board (ICB) and the provider organisations it commissions to discuss national and/or local wound management guidance and associated wound management products. National and/or local guidance relevant to wound management are discussed in detail at this forum, and following appropriate product evaluation/audit cycle by the representatives from relevant specialities, wound management product recommendations are made via application to the FIG.

Clinical specialists and other stakeholders can be invited to attend meetings as needed to discuss specific agenda items. Pharmaceutical representatives do not attend meetings but may be asked to provide research and or further information upon request to aid in discussions.

The DWFG monitors the use of formulary products across the NHS in Devon and provides feedback where appropriate to locality leads and GP practices, with the intention of promoting effective wound healing, managing financial expenditure on wound management products across health communities, and to ensure practice reflects formulary recommendations.

Wound chapter harmonisation task:

The DWFG has been working to harmonise the N&E Devon and S&W Devon wound formulary recommendations, to reduce variation and ensure that where differences remain, these are explicitly considered and borne of necessity. The group has agreed recommendations for over 50 wound products across the chapter, which includes additions as well as removals of discontinued or less desirable products. The group wishes to submit these recommendations to the FIG for approval but is conscious of FIG time. A proportionate approach to these recommendations was proposed.

The FIG agreed that:

- Where the DWFG has made a recommendation for a product already listed in either the N&E or S&W presentation of the Devon Formulary to be included Devon-wide, this can be done without individual consideration by the FIG.
- Where the DWFG wishes to remove a product that is currently included in either (or both) the N&E or S&W presentations of the Devon Formulary, this can be removed without formal consideration by the FIG.
- The FIG will be informed of these changes but will not be asked to take a decision on them.
- DWFG requests for new products which do not currently appear in either presentation of the Devon Formulary will be considered for inclusion once the harmonisation task has been completed.

Wound product applications:

A proportional approach to wound product application papers was proposed. A detailed review of available evidence of effectiveness, safety and cost will be considered by DWFG but not submitted to the FIG. Instead, a summary paper will be presented to FIG to provide assurance that the DWFG has considered these areas and identified a clear rationale for product inclusion. The summary paper will include the proposed formulary classification and formulary entry, the estimated financial impact, the rationale for the recommendation and any proposed actions for the DWFG to support implementation. The FIG will be asked to take a decision based on this information and may request additional detail if necessary.

The new approach to papers for product applications was trialled on the Allevyn dressings paper discussed later in the meeting.

4. Lurasidone in adults and children

On 6th September 2023 the Clinical Policy Committee (CPRC) made a recommendation to accept the routine commissioning of lurasidone in Devon for schizophrenia in adults, children and adolescents who meet specific clinical criteria. This recommendation has been accepted by NHS Devon ICB.

For adults, lurasidone is commissioned for patients who have not responded to or not tolerated separate trials of amisulpride or aripiprazole, or, for patients with QTc prolongation who have not responded to or not tolerated aripiprazole.

For children and adolescents, lurasidone is commissioned for patients aged 13 years and above who have not responded to or not tolerated aripiprazole. In addition, for children and adolescents initiated on treatment who later transition to adult mental health services and require continued treatment, lurasidone will continue to be commissioned for that individual.

These policies replace a prior policy in which the routine commissioning of lurasidone was not accepted. They differ however in that the new position restricts the use of lurasidone to a more specific population and places it as a later option in the treatment pathway.

Classification of lurasidone as an amber drug in the Devon formulary was proposed. This is in line with other antipsychotics. A draft formulary entry was presented which specialists at relevant providers had agreed prior to the meeting.

The FIG considered and accepted without amendment the amber classification and the proposed formulary entry for lurasidone in line with the criteria of the commissioning policies.

ACTION: Formulary Team to add the accepted formulary entry for lurasidone in adults and children to the Devon Formulary.

5. TA906 Rimegepant for preventing migraine

Rimegepant is a new oral preparation licensed as an acute treatment and as a prophylactic treatment for episodic migraine in adults who have at least four migraine attacks per month. It has a similar mechanism of action to injectable monoclonal antibodies which have been available for the prevention of migraine for several years. NICE has separated the indications for rimegepant into two technology appraisals (TAs). TA906 for preventive treatment was published on 5th July and is due to be added to the formulary by 5th October. The TA for acute treatment is due to be published by NICE on 18th October.

Rimegepant is an oral lyophilisate which is administered every other day. Its licensing is supported by randomised placebo-controlled trials. The European Medicines Agency described its treatment effect as modest.

NICE TA906 recommends rimegepant as an option for episodic migraine if there are at least four and fewer than 15 attacks per month and only if at least three preventative treatments have not worked. Rimegepant should be stopped after 12 weeks of treatment if the frequency of migraine attacks does not reduce by at least 50%. Where there is more than one option, the least expensive option should be used. The injectable monoclonal antibodies were the comparators for the NICE TA.

A request for an amber (specialist input) formulary classification for rimegepant for the prophylaxis of migraine was received from the Clinical Lead at the Exeter Headache Clinic. The Formulary Team undertook a consultation with the local headache teams. This highlighted differences in service provision and significant issues with capacity to see patients with episodic migraine. The Formulary Team has explained to headache teams that funding of services is outside of the FIG remit and has offered to provide contact details for the ICB commissioning team to the UHP service. Two services (Exeter and UHP) do not currently prescribe the monoclonal antibodies for capacity reasons, and in the Torbay service only a small number of patients with episodic migraine are seen.

The term ‘specialist’ does not refer solely to a neurologist. It also encompasses specialist nurses and specialist pharmacists who are members of a headache team. This can be clarified in the drug entry.

A headache specialist nurse from UHP NHS Trust joined the meeting for the discussion of this item.

The financial impact is difficult to estimate. For an individual patient, the price of a 12-week treatment initiation is £619.20. The results from study 305 indicate that 49% of patients will meet the criteria for continuation of treatment. The annual cost for patients who receive rimegepant on a long-term basis is £2,347.80 per patient.

The FIG considered the proposed formulary entry for TA906 rimegepant for preventing migraine. Specifically, the FIG:

- accepted the amber (specialist-input) classification for rimegepant for prophylaxis of migraine,
- agreed that rimegepant be prescribed by the headache specialist during the first 12 weeks, with long-term prescribing to be continued in primary care, for those who meet the TA continuation criteria,
- agreed that the review of rimegepant efficacy at 12 weeks of treatment should be undertaken by the headache specialist (this represents a more favourable patient pathway, allowing consideration of alternative specialist options at the same time if required),
- accepted the formulary entry for rimegepant for the prophylaxis of migraine, with the removal of note 2 as the current draft recommendations from NICE indicate a positive TA for acute treatment of migraine.

The FIG also considered and accepted the proposed update to the formulary guidance for prophylaxis of migraine.

The discussion noted that:

- Specialist “advice and guidance” is not available Devon wide.
- The specialist nurse present noted that patients with episodic migraine are not usually seen at UHP. The introduction of rimegepant for this patient group would have a significant impact on the waiting list.
- The FIG acknowledged the significant issues with capacity for headache services, however, the funding of services is outside the remit of the FIG whose role is to agree a formulary entry for rimegepant in line with the NICE TA.

ACTION: Formulary Team to publish the agreed formulary entry for rimegepant

Post meeting note: It has been recommended to the headache services that they discuss the impact of the NICE TAs on service capacity with the ICB elective care lead, who has been informed of the concerns of the headache services in Devon. The ICB has a statutory obligation to include NICE TAs in the Devon Formulary and cannot agree positions which conflict with their statutory obligation.

6. NICE TA Tirzepatide for type 2 diabetes and treatment pathway

NICE TA Tirzepatide for type 2 diabetes

NICE is developing a technology appraisal (TA) for tirzepatide, a new drug for treating type 2 diabetes (T2DM). Tirzepatide has a similar mechanism of action to the GLP-1 agonists which have not been available since 2022, resulting in a significant interruption to the management of patients with type 2 diabetes and a national shortage of some insulin products.

The NICE website indicates that the TA for tirzepatide is due to be issued on 11th October 2023. The final appraisal document (FAD) for tirzepatide has been published; the recommendations are subject to change until the TA is issued.

Tirzepatide is a dual glucose-dependent insulinotropic polypeptide (GIP) and glucagon-like peptide-1 (GLP-1) receptor agonist. Both pathways increase the sensitivity of pancreas beta-cells to glucose and increase insulin secretion under hyperglycaemic conditions. GLP-1 receptor agonists are expected to decrease glucagon levels at high blood glucose concentrations, whereas GIP

agonists increase glucagon levels at low glucose concentrations counterbalancing the risk for hypoglycaemia. GIP mediated effects on adipose tissue may complement GLP-1 mediated effects on GI mobility, a decrease in appetite and an increase in satiety to contribute to weight reduction in overweight patients with T2DM.

Tirzepatide is available as a solution for injection in a pre-filled auto-injector containing 2.5mg, 5mg, 7.5mg, 10mg, 12.5mg and 15 mg of tirzepatide to be administered subcutaneously into the abdomen, thigh or upper arm. The starting dose is 2.5 mg once weekly. After 4 weeks, the dose should be increased to 5 mg once weekly. If needed, dose increases can be made in 2.5 mg increments after a minimum of 4 weeks on the current dose. The recommended maintenance doses are 5mg, 10mg and 15 mg. The maximum dose is 15 mg once weekly.

NICE considered clinical evidence from four of the five phase 3 global trials (SURPASS 2-5) including the three trials with active comparators (s/c semaglutide; insulin degludec; insulin glargine) and the placebo-controlled comparison with insulin glargine as a background treatment. The TA indicates that tirzepatide reduces blood glucose levels (measured by HbA1c) and body weight compared with semaglutide, insulin therapy or placebo. There is only an indirect comparison of tirzepatide with other GLP-1 agonists, which suggests similar benefits, although these results are less certain.

The TA discussion of the company's economic model notes that no comparative data on micro- and macrovascular complications of diabetes, including cardiovascular outcomes, were available. Instead, these outcomes needed to be modelled. A scenario analysis showed that there was a limited impact on cost effectiveness of adding insulin to tirzepatide and to the GLP-1 agonist comparator when HbA1c targets were not met. All ICERs for the base case and scenario analyses were less than £20,000 per QALY gained for tirzepatide (all doses) against all comparators. The committee considered tirzepatide to be a cost-effective use of NHS resources. The final recommendations for tirzepatide do not include the NG28 continuation criteria applied to GLP-1 agonists.

The FIG considered and accepted in principle the proposed formulary entry and the blue (second line) classification for tirzepatide based on the NICE TA final appraisal document. If there is a significant change to the recommendations for tirzepatide on publication of the final TA, the Formulary team will progress an update to the draft formulary entry through the appropriate route.

The discussion included that:

- Concern was expressed by the Medicines Optimisation team regarding costs if all patients on GLP-1 agonists are prescribed tirzepatide.
- GPs present noted that the lack of GLP-1 agonists has caused a lot of work and concern regarding weight management.

Type 2 diabetes treatment pathway

The FIG has discussed the approach to the NG28 treatment pathway for T2DM and agreed that a single pathway is the preferred option. The draft pathway discussed at the October 2022 FIG meeting has been updated to incorporate the NICE TA final appraisal document recommendations for tirzepatide. Formulary guidance on SGLT2 inhibitors is under development to support prescribing for the management of T2DM, heart failure, and CKD.

The section on pharmacological treatment has been updated to bring the advice in line with the NG28 recommendations and to improve readability.

It is intended that the pathway is published following consultation with specialists. The pathway would be updated with the agreed text on tirzepatide when the NICE TA for tirzepatide is published in the formulary.

The FIG considered and accepted in principle the Type 2 diabetes mellitus pathway including the subsection on pharmacological management. No areas of concern were raised.

It was agreed that if any significant comments are received from specialists they will be brought back to the FIG via the e-FIG process if appropriate.

ACTION: Formulary team to consult with specialists on the formulary entry for tirzepatide and type 2 diabetes pathway.

7. Negative Pressure Wound Therapy (NPWT)

Negative Pressure Wound Therapy (NPWT) is a controlled negative pressure (sub-atmospheric) system that is applied topically onto the wound. The wound is filled with a porous material (wound filler) and hermetically sealed with an airtight adhesive polyurethane drape. A drain connects the wound filler to the vacuum source that delivers a negative pressure. The suction is propagated from the vacuum source to the wound bed, leading to a negative pressure in the filler and removal of exudate. It is widely used in the management of complex wounds in inpatient care.

There are differences in the existing NPWT guidance provided in the two presentations of the Devon Formulary. For both presentations, excluding small changes to formatting etc., the information relating to NPWT has been largely unchanged since the merger of the predecessor formularies in 2013/14.

Clarity had been sought regarding the appropriateness of requests for primary care prescribing in one part of the County. System wide discussions have taken place with providers and teams within NHS Devon ICB (including the Formulary Team, Medicines Optimisation Team, Nursing and Quality Assurance Team, and Commissioning Team) regarding this issue. The Deputy Director of Integrated Care (UHP), the Head of Nursing and Quality Assurance (NHS Devon), and the Patient Safety and Quality Lead for Primary Care (NHS Devon) consider NPWT to be a specialist product, which should be provided only by those who have undergone additional training in its use. Assessment and application of dressings should not be undertaken in primary care, as this requires a skillset that a practice nurse or GP would not usually be expected to have.

A revised section was proposed, to provide clarity and consistency regarding the responsibility for prescribing NPWT and associated products. A refined list of recommended NPWT systems (supported by the DWFG) was included to aid electronic systems in the trusts and support identification of inappropriate NPWT product requests in primary care.

The FIG considered and accepted the proposed formulary entry without amendment. The discussion noted that this is a highly specialised area.

ACTION: Formulary Team to publish the updated formulary guidance for Negative Pressure Wound Therapy.

8. Doublebase Once

A consultant dermatologist at Royal Devon University Healthcare NHS Foundation Trust has proposed the inclusion of Doublebase Once gel as a blue, second line, option for those who have failed on cheaper emollient gels. It was proposed as a replacement for Doublebase Dayleve gel (currently in N&E Devon only, a second line option recommended for twice daily application). A Specialist Dermatology Pharmacist from RDUH attended the meeting for discussion of this item.

Doublebase Once gel is a topical paraffin-containing emollient that can be used from birth. It is indicated for use with dry skin conditions such as eczema and psoriasis. Product literature recommends it is applied once daily or as often as needed, and as a soap substitute; the once daily recommendation is intended to aid compliance. It is available in a 100g tube and a 500g pump dispenser.

There are nine emollient gels listed in the Directory of Medicines and Devices (dm+d), Doublebase Once gel is the most expensive per gram. There is no comparative evidence between the use of Doublebase Once gel and the current Devon formulary recommended emollient gels.

In support of their application, the applicant submitted extracts of unpublished manufacturer data and poster presentations of corneometry results in skin samples. These data were not considered sufficient to inform a decision on formulary inclusion because of significant concerns regarding quality and associated risk of bias, and concerns regarding relevance.

Guidance on dry skin conditions by NICE, the British Association of Dermatologists, and the Primary Care Dermatology Society, all recommend frequent application of emollients. This recommendation is reflected in current formulary guidance, which recommends application of emollient gels at least three or four times a day. It has not been possible to accurately ascertain how often patients are applying emollients in practice.

Specialist consultation was in support of the proposal, though it was noted that one respondent was unconvinced that changing a preparation will necessarily alter patient behaviour and believed the gains between the different preparations are small.

If Doublebase Once gel is applied once a day, there is a potential for cost savings compared with more frequent application of alternative emollient gels. However, due to a lack of published evidence, it is not known whether once daily application of Doublebase Once gel is at least as effective as more frequent application of alternative emollient gels. If Doublebase Once gel is applied more frequently than once daily, it would likely remain more expensive than alternative emollient gels.

The FIG considered the Formulary Application for the inclusion of Doublebase Once gel and the removal of Doublebase Dayleve gel. There was discussion about:

- The efficacy of Doublebase Once gel. There is no evidence that Doublebase Once gel is equivalent, or superior, to other emollients (applied once daily or more frequently).
- The specialist pharmacist present acknowledged the lack of evidence but noted that the opinion of the specialist team is that this could be beneficial to patients who do apply the product once a day. It was suggested that school children and elderly people with carers visiting once a day may benefit. GPs present noted that it is difficult to change people's behaviour, and that current guidance regarding emollients is that they are applied frequently. Ensuring once daily use of Doublebase Once may be difficult.

- Doublebase Once gel is more expensive than the alternative options. There is a risk that the use of Doublebase Once results in increased costs, with no clear clinical benefit.

The FIG did not accept the addition of Doublebase Once gel to the Devon Formulary

9. Glucagon 500micrograms and 1mg pre-filled pens (Ogluo) for adults

At the last meeting, the FIG took a decision in principle to add Ogluo auto-injector pens to the Devon Formulary as a green (first-line) option for paediatric and adolescent patients pending a consultation with the adult diabetes specialist teams on its suitability for their patients. Advice has now been sought from several adult diabetes specialists before consulting with the wider teams as there may be different considerations for adult patients.

Adult patients account for approximately 70% of prescribing of GlucaGen Hypokit in primary care. Given the potential impact on the primary care drug budget of prescribing Ogluo in place of GlucaGen Hypokit for adults with diabetes, the Formulary team consulted with the Medicines Optimisation Response Group over the proposed formulary classification and place in therapy for Ogluo for adults before consulting with the adult diabetes specialist teams. The formulary entry proposed to the teams included Ogluo as a blue (second line) option for adult patients with the following note:

- Adults 18 years and older: Ogluo is significantly more expensive than GlucaGen Hypokit (above). If GlucaGen Hypokit is acceptable for the patient's circumstances, consider prescribing it in preference to Ogluo.

The annualised increase in the cost of prescribing Ogluo in place of GlucaGen Hypokit, considering differences in shelf life for the two products, ranges from £44,000 to £52,000 a year. The trust formulary pharmacists have confirmed that the inclusion of Ogluo as a second line formulary option for adults would not be a significant financial concern for the trusts.

Consultation with the specialist teams has identified a difference in views on the proposed place in therapy for Ogluo for adult patients. Based on feedback received, a strengthened place in therapy was proposed for Ogluo for adults which is likely to restrict use and accommodate the range in responses received: that Ogluo would be second line for adults and only if GlucaGen Hypokit is not available or is unsuitable for a patient's circumstances.

The FIG considered and accepted the proposal for Ogluo (glucagon) prefilled pens to be added to the Devon Formulary as a blue (second line) option for adults with diabetes. The FIG accepted the proposed formulary entry for Ogluo subject to an amendment to note 3 to reflect that it should be prescribed for adults only if GlucaGen Hypokit is not available or if GlucaGen Hypokit is unsuitable for the patient's circumstances.

The FIG considered and accepted an updated formulary entry for GlucaGen Hypokit subject to the removal of note 3 ("Adults 18 years and older: GlucaGen Hypokit is significantly less expensive than Ogluo (Below). If GlucaGen Hypokit is acceptable for the patient's circumstances, consider prescribing it in preference to Ogluo").

ACTION: **Formulary Team to add Glucagon 500micrograms and 1mg pre-filled pens (Ogluo) for adults to the formulary and update the GlucaGen HypoKit entry in line with the discussion.**

10. Allevyn Gentle Border, Allevyn Gentle Border Lite, and Allevyn Life Dressings

Following a proposal by the tissue viability clinical matron at RDUH, a recommendation from the Devon Wound Formulary Group (DWFG) for the addition of the following contact wound dressings to the Devon Formulary:

- Allevyn Gentle Border and Allevyn Gentle Border Lite as green (first line)
- Allevyn Life and Allevyn Life Non-Bordered as amber (specialist input)

The DWFG recommendation also proposed removal of ActivHeal Silicone Foam Border from the Devon Formulary (currently N&E Devon only); Allevyn Gentle Border is proposed as a direct replacement.

The dressings are indicated for use on fragile skin areas for the management of granulating, exuding, and full- and partial-thickness wounds and can be worn for up to 7 days.

Prescribing data show that Allevyn Gentle and Life products are already in use in Devon and are used more widely than ActivHeal. Although the individual dressings are more expensive than ActivHeal, evaluations made by the RDUH team found that the proposed dressings have superior absorption and adhesion which reduced the frequency of dressing changes and the quantity of dressings used during treatment. RDUH estimated a saving of approximately £10,000 during the 24-month trial.

The FIG considered and accepted the proposed formulary entry without amendment, including:

- the inclusion of Allevyn Gentle Border and Gentle Border Lite as green options
- the inclusion of Allevyn Life and Allevyn Life Border as amber options
- the removal of ActivHeal Silicone Foam Border dressings

ACTION: **Formulary Team to remove ActivHeal Silicone Foam Border from the Formulary and publish the agreed Formulary entries for the Allevyn Gentle and Allevyn Life products**

As indicated during the presentation of the work being undertaken by the DWFG, FIG members were asked if they were happy with the approach taken to the papers for new wound dressings. The FIG confirmed that this approach was appropriate.

11. NICE TA599: Sodium zirconium cyclosilicate (SZC) for treating hyperkalaemia (consideration of reclassification from red to amber)

At the May 2023 meeting, the FIG agreed the reclassification of SZC to an amber (specialist-input) formulary option for persistent hyperkalaemia in line with NICE TA599 pending the development of supporting guidance for the formulary. The Formulary Team has developed prescribing guidance based on the SmPC for Lokelma and guidance from other areas.

Feedback was received from the renal and heart failure teams, except those from North Devon District Hospital. The feedback identified a sentence under “Management by secondary care” which supported initiation in primary care on the advice of a renal specialist in individual cases, to avoid a hospital admission. The sentence had originated from a consultant nephrologist from RDUH at the start of the discussions on SZC. The statement appeared to suggest that there is more than one position on the initiation of SZC. The Formulary Team proposed that if the statement is left in, it should be strengthened to make it clear that it is the exception and not routine practice. Suggested wording was: “In exceptional circumstances, a specialist may ask a GP whether it would be possible to initiate sodium zirconium cyclosilicate in primary care. The practical implications of monitoring the effect of treatment should be considered".

Any change to the formulary classification and publishing of the supporting guidance will not occur until the MO team notify the formulary team that the funding arrangements for the primary care prescribing of SZC have been established.

The FIG considered the proposed formulary entry. It was discussed that:

- at the May 2023 meeting, it was agreed for specialists to start treatment with SZC, optimise the dose, and prescribe SZC for 3 months before requesting continuation of long-term prescribing by GPs. Having two positions on the initiation of treatment is confusing.
- a serum sodium of 150mmol/L or greater is acceptable as a threshold to seek advice for cases of hypernatraemia,
- the section on serum potassium results should be made more prominent and placed under the dose section.
- regular monitoring of serum potassium levels is required and the dose of SZC adjusted accordingly. The FIG GPs noted that changes in the dose of SZC are required for serum potassium levels in the normal range which could result in the need for action being overlooked. The daily checking of laboratory test results in primary care may not be undertaken by the patient’s usual GP, and ordinarily a serum potassium result in the normal range would not be highlighted for review/action. A possible approach was raised during the discussion to be explored with trust laboratories in Devon.

ACTION: Formulary team to liaise with trust laboratories over a method of identifying serum potassium results for patients receiving SZC via the FIG GP representative for the Devon Pathology Optimisation Group.

12. Reclassification of sildenafil for secondary Raynaud’s phenomenon /digital ulceration in systematic sclerosis

A request has been received from a consultant rheumatologist, South Devon and Torbay NHS Foundation Trust for reclassification of sildenafil for the treatment of secondary Raynaud’s phenomenon (RP) and digital ulceration (DU) in systemic sclerosis (SSc) in adults. The request is supported by consultant rheumatologists from RDUH and UHP. It was proposed that sildenafil is reclassified from red (hospital only) to amber (specialist input) for these indications.

Secondary RP (vasospasm of the peripheral arteries associated with an underlying cause) represents around 10-20% of cases of RP; underlying causes include connective tissue disorders such as systemic sclerosis. SSc is an uncommon systemic autoimmune disease that can cause a wide range of tissue damage. The most common vascular manifestation of SSc is Raynaud’s

phenomenon due to excessive vasoconstriction (RP occurs in over 90% of people with systemic sclerosis). However, more marked vascular involvement, resulting in digital ulceration, occurs at some point in up to 55% of SSc patients. The use of sildenafil for secondary RP and digital ulceration in SSc is supported by guidelines from BSR & BHPR, and EULAR. There is an NHS England commissioning policy in respect of sildenafil for digital ulceration in SSc.

The FIG considered and accepted the reclassification of sildenafil from red to an amber for secondary RP / DU in SSc. The FIG also agreed the harmonisation of the N&E Devon and S&W Devon formulary entries to include sildenafil 20mg tablets and 10mg sugar free oral suspension 10mg/ml as red (hospital only) options for the treatment of pulmonary arterial hypertension (as per NHS England policy).

The discussion noted that:

- GPs are familiar with sildenafil however the doses are higher than those usually prescribed by GPs for erectile dysfunction. Specialists should prescribe and monitor until the patient is stabilised on the required dose.
- Formal "Shared Care" guidelines are not required as there is no need for regular drug safety monitoring.
- Sildenafil may cause hypotension. The Formulary Team will amend the note section to make it clear that there is no need for regular blood pressure monitoring however GPs should reduce dose and/or seek specialist advice if symptomatic hypotension develops.

ACTION: Formulary Team to publish the formulary entry for Sildenafil in line with the discussion.

13. Melatonin for use in adult patients

Currently the formulary only recommends the use of melatonin in children. Prescribing data indicates that a significant proportion of existing melatonin use is in adults. The annual spend on various melatonin products in primary care in Devon is approximately £2.1 million. Several melatonin products are available with a range of licenced indications. Following a clinical audit by the NHS Devon Medicines Optimisation team, and individual applications for melatonin from specialist teams, a review of formulary melatonin recommendations is underway to support use in adults where appropriate. Two indications, insomnia in adults and rapid eye movement behaviour disorder in patients with Parkinson's disease were presented to the FIG for consideration.

Insomnia

Insomnia may cause difficulty with getting to or maintaining sleep, or non-restorative sleep, and may also result in early wakening. It may be classified as short term (<3 months in duration), or long term (>3 months). Guidance from NICE CKS (in line with guidelines from the British Association of Psychopharmacology) recommends that for short term insomnia in patients aged 55 and above, melatonin may be considered as an adjunct to cognitive behavioural therapy for insomnia (CBTi), when sleep hygiene measures have failed, daytime impairment is severe causing significant distress, and insomnia is not likely to resolve soon. In patients with long term insomnia NICE CKS recommends that primary management should involve CBTi and that pharmacological management should be avoided unless a patient is experiencing severe symptoms from an acute exacerbation. In such cases usually a z-drug should be considered, however in patients aged 55 and over melatonin may also be considered.

An evidence review identified seven systematic reviews with some form of quantitative analysis. These reviews suggest that melatonin likely improves sleep latency better than placebo, but not as well as zopiclone. Melatonin may improve wakefulness after the initial onset of sleep greater than placebo with a comparable effect to zolpidem and potentially better than zopiclone. However, these findings should be interpreted with caution as it is not clear whether the effect sizes represent clinically meaningful outcomes for patients. Also, the original trials included use a wide variety of dosing regimens and release profiles which are pooled in the various meta-analyses. At present the only UK licensed product for adults with insomnia is 2mg modified release tablets once daily in patients aged 55 and above.

Six trials comparing 2mg modified release melatonin with placebo were identified. These suggest that melatonin may improve objective measurements of sleep latency, and wakefulness after sleep onset better than placebo. A correction to the briefing paper was noted; the paper had stated that there was no significant difference between melatonin and placebo for wakefulness after sleep onset, when in fact a significant difference was found. Furthermore, secondary outcomes also suggest improvement in some patient reported outcomes relating to sleep quality and quality of life for patients with insomnia who were treated with 2mg modified release melatonin.

Subgroup analyses from two studies found that patients aged 55 and older taking 2mg modified release melatonin reported significant improvements in sleep latency, sleep quality, and quality of life which were not observed in patients receiving placebo; this difference was not observed in those under 55 years old.

Rapid Eye Movement Behaviour Disorder (RBD) in Parkinson's disease

An application for the use of melatonin in the management of RBD in Parkinson's disease was received from the movement disorder team at Torbay and South Devon NHS Foundation Trust. In RBD, muscle atonia (which is usually present in the rapid eye movement phase of sleep) is not present, meaning that dream enactment behaviours may occur. This can be concerning for patients and their bed partners and may also result in injury. No melatonin products are currently licenced for this indication in the UK. The applicants indicated that the usual approach to management with melatonin is the off-label use of 2mg modified release tablets at a dose of between 2mg and 12mg daily.

NICE guideline NG71 (Parkinson's disease in adults) suggests that clonazepam or melatonin may be considered for the managing of RBD when a medicines review has ruled out other possible pharmacological causes.

An evidence review identified a single RCT which examined the use of modified release melatonin in patients with RBD with Parkinson's. In this trial 15 participants received 4mg modified release melatonin daily for 4 weeks with a control group of 15 participants receiving placebo. The results demonstrated no significant difference in the frequency of RBD related events, however some benefit in general sleep outcomes was observed. The review also identified additional articles in which melatonin was used in cohorts that included some individuals with RBD who also had Parkinson's disease. These trials suggest that melatonin may improve sleep latency, and quality, and other non-motor aspects of Parkinson's disease. The articles used a range of dosing regimens (2mg to 12mg daily), the inconsistency in dosing likely confounds some of the published results.

It is challenging to assess the likely resource impact of these proposals as total patient numbers for each indication are unknown and it is not known if the inclusion of these indications in the

formulary will alter current prescribing trends. It is understood that locally, melatonin is already used to some extent in both these patient groups.

Cost comparisons suggest that melatonin is likely a more expensive treatment option than zolpidem or zopiclone for the management of insomnia, and clonazepam for RBD. However, any increases in cost may be acceptable if melatonin is deemed to be a more suitable treatment option due to risks associated with use of the alternatives.

The FIG accepted in principle the proposal to include melatonin as a blue (second line) treatment for insomnia in adults aged 55 and over together with the proposed wording for the drug entry, subject to development of revised formulary guidance on the management of insomnia.

The discussion noted that:

- Where possible insomnia should not be managed with drugs and that the first line option should be CBTi. However, there may not be enough capacity in local CBTi provision for all patients to be seen. On-line alternatives to CBTi such as Sleep Station and Sleepio were noted. In addition, there is uncertainty around the commissioning of CBTi services in Devon. The Formulary Team is seeking to understand the available services. The FIG felt that CBTi should be routinely available in Devon.
- Patients are sometimes discharged by specialist services whilst on melatonin, often with insufficient information on treatment duration etc. It was agreed that guidance on deprescribing melatonin would be beneficial.
- NICE is expected to publish a Technology Appraisal for daridorexant for the treatment of insomnia disorder. This will be brought to the FIG alongside revised insomnia guidance.

The Formulary Team will revise the formulary guidance on insomnia and bring to a future meeting.

ACTION: Formulary Team to bring revised formulary guidance on insomnia to a future meeting.

The FIG accepted the proposal to include melatonin as an amber (specialist input) drug for the treatment of RBD for patients living with Parkinson's disease.

The discussion noted that:

- Clinical evidence is limited, but use of melatonin for this indication is supported by the NICE guideline.
- Treatment will be initiated and supervised by the specialist team, who will continue to oversee the ongoing management of the patient. The specialist will establish the patient on a stable dose of melatonin prior to asking the GP to take on long-term prescribing.

ACTION: Formulary Team to add RBD in Parkinson's disease as an indication to the melatonin entry, in line with the discussion.

14. Guanfacine for attention deficit hyperactivity disorder (ADHD) in children and young people aged 6 - 17 years

NHS Devon has a commissioning policy accepting the routine commissioning of guanfacine for the management of ADHD in children and adolescents aged 6 to 17 years, where previous treatment with stimulants AND previous treatment with atomoxetine, is ineffective OR not tolerated OR these

treatments are not suitable. This position acknowledges NICE guidance and makes guanfacine available as a treatment option for patients in Devon, but it clarifies that it should only be used after previous treatment with atomoxetine to reflect that guanfacine is now substantially more expensive than atomoxetine and is considered poor value for money in comparison.

Guanfacine is currently included in the Devon formulary as a red hospital only treatment for ADHD in children and adolescents aged 6 to 17 years, where previous treatment with stimulants and previous treatment with atomoxetine, is ineffective, or not tolerated, or these treatments are not suitable. Introduction of an SMS guideline will enable and support prescribing in primary care and formulary reclassification from a red (hospital only) treatment to an amber (specialist input) treatment.

Use of guanfacine in adults has not been considered for routine commissioning in Devon. Guanfacine is not licensed for this age group; the SmPC states that "the safety and efficacy of guanfacine in adult and the elderly with ADHD has not been established. Therefore, guanfacine should not be used in this group." The patient-facing NHS website (nhs.uk) states that "guanfacine should not be offered to adults with ADHD." NICE found no evidence specifically supporting its use in adults, resulting in a recommendation in the NICE guideline that guanfacine should not be offered to adults without advice from a tertiary ADHD service. This service arrangement has not been defined in Devon. Children being treated with guanfacine should normally have this withdrawn prior to transition to adult services unless an individual request has been submitted and approved by the relevant adult specialist service provider Drug and Therapeutics Committee (or equivalent) for continuation within a secondary care setting.

An SMS guideline for guanfacine in children and adolescents has been developed in consultation with local specialists. Consideration has been given to information in the SmPC, the BNF for children, and the NHS England template shared care protocols. The overall content of the guideline is based on NICE Guideline NG97 (2018) and follows the same principles and format as the recently agreed methylphenidate, lisdexamfetamine, atomoxetine and dexamfetamine paediatric SMS guidelines.

The FIG considered and accepted the proposed guideline for Devon wide implementation with minor amendment.

There was discussion about:

- Feeding back to specialists that it would be useful if they could provide patients with a chart for recording height and weight rather than this being recorded in two separate places.
- The pressure on local adult ADHD specialist service providers, and in particular issues relating to guanfacine and the need for this to be discontinued in children approaching 18 years of age prior to transition to adult services unless an individual request has been submitted and approved by the relevant adult specialist service provider DTC for continuation in secondary care.
- The FIG recognised that specialist services are under extreme pressure, however the FIG is not able to extend the approved formulary indication or SMS guidelines for guanfacine to adults without a specific commissioning decision from the ICB.
- There was discussion about adverse events including that some patients report significant somnolence and sedation. It was agreed that somnolence and sedation be moved to the adverse event section of the monitoring table (so that clinicians are "alert to the possibility" of these adverse effects. It was also agreed that the action to be taken by the GP should be amended to

apply to somnolence or sedation that are clinically concerning or persistent (in line with the SmPC).

ACTION: Formulary Team to feedback to specialists that it would be useful if they could provide a patient-held chart for recording height and weight rather than this being recorded in two separate places.

ACTION: Formulary Team to update the SMS guideline in line with the discussion.

ACTION: Clinical Effectiveness Pharmacist – SMS Guidelines Lead to submit guideline to LMC for negotiation of remuneration with ICB Primary Care Team.

15. MHRA Drug Safety Updates (July 23-Aug 23)

July 2023

Hyoscine hydrobromide patches (Scopoderm 1.5mg Patch or Scopoderm TTS Patch): risk of anticholinergic side effects, including hyperthermia: There have been a small number of reports of serious and life-threatening anticholinergic side effects associated with hyoscine hydrobromide patches, particularly when used outside the licence, including the unexpected death of a child due to hyperthermia caused by a hyoscine hydrobromide patch.

Hyoscine hydrobromide patches are included in the formulary for their licensed indication and for use in palliative care. Use in Meniere's disease is also referred to in S&W Devon. The formulary entry for Sialanar (glycopyrronium bromide oral solution) refers to NICE NG62 recommendations for glycopyrronium bromide oral solution and hyoscine hydrobromide transdermal patches (off-label) as options to reduce the severity and frequency of drooling in children and young people with cerebral palsy. The formulary entry for hyoscine hydrobromide will be updated to include the key points and a weblink to the Drug Safety Update.

Codeine linctus: public consultation on the proposal to reclassify to prescription-only: The proposal is to reclassify codeine linctus from a pharmacy-only medicine to a prescription-only medicine due to it being used recreationally for its opioid effects.

Letters sent to healthcare professionals and drug alerts in June 2023

Tresiba FlexTouch 100 units/mL solution for injection (insulin degludec): Supply Shortage in the UK: The formulary entry for Tresiba FlexTouch has been updated with key points from the Medicines Shortage Notice.

GAVRETO (pralsetinib): Increased risk for tuberculosis and measures to minimise this risk: Pralsetinib was the subject of a NICE technology assessment and is not recommended for use within its marketing authorisation. In line with the ICB's statutory obligations, NICE TA812 has been published on the formulary website.

August 2023

Fluoroquinolone antibiotics: reminder of the risk of disabling and potentially long-lasting or irreversible side effects: This is a reminder for healthcare professionals of the Drug Safety Update

issued on this subject in 2019. The advice for healthcare professionals has not changed. The 2023 article includes a new section on advice to provide to patients, parents and carers, including signs and symptoms where the advice is for the patient to stop treatment and to contact a doctor immediately. The Devon Formulary includes extensive information from the 2019 Drug Safety Update article under the formulary section for fluoroquinolones and where a fluoroquinolone is recommended under guidance on the management of infections. Fluoroquinolones are recommended in the Devon Formulary in line with NICE guidance, or guidance from professional societies, or on the recommendation of a specialist. A weblink to the 2023 article including a reference to the advice for patients will be added to the formulary guidance and the section on fluoroquinolones alongside the existing information from the 2019 Drug Safety Update.

Methotrexate advise patients to take precautions in the sun to avoid photosensitivity reactions: Photosensitivity reactions are known side effects of methotrexate treatment and can be severe. The MHRA has recently received a Coroner's report following a case of a photosensitivity reaction in a patient on methotrexate. Prescribers and pharmacists are reminded to inform patients of the risk of photosensitivity reactions and to advise them to use a product with a high sun protection factor and clothing that covers the skin when in the sun.

The Devon Formulary entry for methotrexate will be updated with key points from the Drug Safety Update and a weblink to the update. A link to the formulary section on sunscreen products which can be prescribed will be included.

Valproate re-analysis of study on risks in children of men taking valproate: An article published in the Drug Safety Update issued in December 2022 advised that the Commission on Human Medicines (CHM) had recommended new safety measures for valproate-containing medicines. This followed a review of prescribing data for valproate medicines in females, including some use in pregnancy, as well as evolving information about potential risks in male patients.

These measures were to be introduced over the coming months according to patient priorities so they could be introduced safely. Advice on the timing of introduction was to be provided once the CHM's implementation group had finalised plans and after full engagement with stakeholders. This is the first update on the subject from the MHRA since December 2022. NICE had scheduled an extraordinary update to their guidance for epilepsy and bipolar disorder to be issued in May 2023. This has been delayed and the date for publication is to be confirmed.

The December 2022 article indicated that the current product information states that valproate may impair male fertility, and there is some evidence that this is reversible upon discontinuation. The CHM considered data from studies reporting adverse effects to the male reproductive system in animals receiving valproate, as well as non-clinical studies on the potential for epigenetic effects of valproate and transgenerational risks. It was reported that there are currently limited data available on these risks in humans and further studies are planned. There was also an ongoing retrospective study on the outcomes of babies exposed to valproate via paternal use.

The July 2023 article indicates that the MHRA has kept under close review the possibility of risks to children associated with paternal exposure to valproate, however, a re-analysis of study results is required before conclusions can be drawn. As soon as the revised study analysis is available, it will be re-assessed by the MHRA and any further guidance will be communicated to patients and healthcare professionals as soon as possible.

GPs and pharmacists are advised to continue to provide repeat prescriptions for valproate; patients currently taking valproate must be advised not to stop taking it unless they are advised by a

specialist to do so. The article includes a reminder of the conditions of the Valproate Pregnancy Prevention Programme. No update to the formulary is proposed as a result of this communication.

Letters sent to healthcare professionals and drug alerts in July 2023

Systemic and inhaled fluoroquinolone antibiotics: reminder on restrictions of use. This communication is the subject of the article on fluoroquinolones in the Drug Safety Update which is reviewed above.

ACTION: Formulary Team to update the relevant formulary sections with recommendations for the MHRA Drug Safety Updates July and August 2023.

Summary of actions			
	Action	**Lead**	**Status**
21/23	Thyroid disorders: Update – redraft final guidance in line with the discussion and discuss with specialists.	Formulary Team	Ongoing
21/24	Thyroid disorders: Update – circulate the final draft via e-FIG for agreement.	Formulary Team	Ongoing
22/61	Formulary team to liaise with the Chair on writing to the Pathology Optimisation Group to ask the group to discuss the MHRA recommendations for vitamin B12 testing for patients receiving metformin.	Formulary team	Ongoing
22/62	Update formulary with a link to MHRA Drug Safety Update and note regarding Pathology Optimisation Group after correspondence is sent to the group.	Formulary team	Ongoing
22/80	Pharmacological treatment for type 2 diabetes (NICE NG28): bring the formulary guidance for the pharmacological treatment of Type 2 diabetes to a future meeting.	Formulary Team	Complete
22/92	Report of e-FIG decisions: November 2022: Treatment of vaginal candidiasis - seek the views of specialists on the use of vaginal creams which require insertion using an applicator during pregnancy and bring revised guidance back to the FIG via the appropriate route. ***Post meeting note****: to be included under a wider review including recurrence of vaginal candidiasis*	Formulary Team	Closed
22/98	Undertake further work on Ryeqo SmPC recommendation for DXA scan at 12 months for all patients.	Formulary Team	On agenda
23/02	Hyperhidrosis management and the use of systemic oral anticholinergic drugs (propantheline bromide and oxybutynin – Proposed Formulary Entry to be amended in line with the discussion and added to the local formulary.	Formulary Team	Complete
23/04	4.10.2 Nicotine dependence – undertake further consultation and bring the proposed formulary entry back to FIG via an appropriate route.	Formulary Team	On agenda
23/28	Bevespi Aerosphere and Trixeo Aerosphere – bring back to FIG when specialists can attend. ***Post meeting note****: Formulary team are consulting with primary care respiratory champions.*	Formulary Team	Closed
23/29	Metolazone 5mg tablets (Xaqua) – consult with heart failure and renal teams for metolazone 5mg tablets (Xaqua). ***Post meeting note****: included under the review of chronic heart failure*	Formulary Team	Closed
23/41	Management of Hypertension (Update) – consult with specialist on proposed guidance.	Formulary Team	Complete

23/42	Management of Hypertension (Update) – following consultation with specialists, bring draft guidance back to the FIG via the e-FIG process if required.	Formulary Team	Ongoing
23/46	Sodium zirconium cyclosilicate for treating hyperkalaemia: consideration of reclassification – work with specialists on the prescribing guidance.	Formulary Team	Complete
23/48	MHRA Drug Safety Updates – April 2023: update the relevant formulary sections with recommendations from the MHRA Drug Safety Updates March 2023 and April 2023.	Formulary Team	Ongoing
23/49	MHRA Drug Safety Updates – April 2023: write to MHRA to ask for clarification on frequency of monitoring for hepatic adverse reactions for patients receiving nitrofurantoin.	Formulary Team	Ongoing
23/53	Insulins undertake consultation with adult and paediatric specialists. Any significant changes will be brought back to the FIG via an appropriate route.	Formulary Team	Complete
23/55	Chronic heart failure (including NICE TA902) - Consult with heart failure specialists.	Formulary Team	Complete
23/58	Priadel (lithium) update – present the lithium guideline to the LMC for negotiation of remuneration.	SMS Guidelines Lead	Complete
23/59	Update the relevant formulary sections with recommendations from MHRA Drug Safety Updates May and June 2023.	Formulary team	Ongoing
23/60	Lurasidone in adults and children – accepted formulary entry for lurasidone in adults and children to the Devon Formulary.	Formulary Team	Complete
23/61	TA906 Rimegepant for preventing migraine - publish the agreed formulary entry for rimegepant	Formulary Team	Complete
23/62	NICE TA Tirzepatide for type 2 diabetes and treatment pathway - consult with specialists on the formulary entry for tirzepatide and type 2 diabetes pathway.	Formulary Team	Ongoing
23/63	Negative Pressure Wound Therapy (NPWT) – publish updated guidance.	Formulary Team	Complete
23/64	Add Glucagon 500micrograms and 1mg pre-filled pens (Ogluo) for adults to the formulary and update the GlucaGen HypoKit entry in line with the discussion	Formulary Team	Complete
23/65	Remove ActivHeal Silicone Foam Border from the Formulary and publish the agreed Formulary entries for the Allevyn Gentle and Allevyn Life products	Formulary Team	Complete
23/66	NICE TA599: Sodium zirconium cyclosilicate (SZC) for treating hyperkalaemia (consideration of reclassification from red to amber) - liaise with trust laboratories over a method of identifying serum potassium results for patients receiving SZC via the FIG GP representative for the Devon Pathology Optimisation Group.	Formulary team	Ongoing
23/67	Reclassification of sildenafil for secondary Raynaud's phenomenon/digital ulceration in systemic sclerosis – publish the formulary entry for Sildenafil in line with the discussion.	Formulary Team	Complete

23/68	Melatonin for use in adult patients – bring revised formulary guidance on insomnia to a future meeting.	Formulary Team	On agenda
23/69	Melatonin for use in adult patients – add RBD in Parkinson's disease as an indication to the melatonin entry, in line with the discussion	Formulary Team	Ongoing
23/70	Guanfacine for attention deficient hyperactivity disorder (ADHD) in children and young people aged 6 – 17 years – Feedback to specialists that it would be useful if they could provide a patient-held chart for recording height and weight rather than this being recorded in two separate places.	Formulary Team	Ongoing
23/71	Guanfacine for attention deficient hyperactivity disorder (ADHD) in children and young people aged 6 – 17 years – Update the SMS Guidelines in line with the discussion.	Formulary Team	Ongoing
23/72	Guanfacine for attention deficient hyperactivity disorder (ADHD) in children and young people aged 6 – 17 years – submit guideline to LMC for negotiation of remuneration with ICB Primary Care Team	Clinical Effectiveness Pharmacist – SMS Guidelines Lead	Ongoing
23/73	Update relevant formulary sections with recommendations for the MHRA drug safety Updates July and August 2023.	Formulary Team	Ongoing