South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
14 December 2023 (Hybrid meeting)
FINAL Minutes

1. **Welcome, introductions and apologies**
   The Chair welcomed attendees to the meeting. Apologies were noted and observers welcomed

2. **Conflict of interests – declarations and DOI refresh**
   The Chair asked that any conflicts of interest with the meeting agenda be declared and that any outstanding declarations be returned. No conflicts were raised.

3. **Minutes of the last two meetings, and action log:**
   The minutes were accepted as an accurate record of the last two meetings subject to minor formatting and typographical corrections. Members were provided with an update on progress against actions due for this month, these were noted, and items closed were agreed.

4. **Updated sleep pathways:**
   - **Pharmacological management of excessive daytime sleepiness due to narcolepsy**
   - **Pharmacological management of restless legs syndrome (RLS) or periodic limb movement disorder (PLMD)**

   The authors were in attendance to present this item.

   Excessive daytime sleepiness due to narcolepsy (with or without cataplexy) pathway
   The treatment pathway has been updated to include solriamfetol following the publication of a technology appraisal (TA) from the National Institute for Health and Care Excellence (NICE). The presenter explained that there are two elements to treatment depending on the symptomology of the patient: the narcolepsy element and the cataplexy element. Both elements are part of the same condition, however they have different symptomatic profiles and the treatment therefore covers the symptoms experienced. Solriamfetol is an option alongside pitolisant, however, solriamfetol has only a modest effect on sleep paralysis. The presenters outlined that the intention will be for the sleep centre to use solriamfetol in combination with sodium oxybate to address daytime sleepiness in patients with type 1 narcolepsy. Solriamfetol alone would be effective in treating narcolepsy, however it has no anti-cataplexic activity and no significant effect on rapid eye movement (REM) intrusion symptoms associated with type 1 narcolepsy patients. Conversely, sodium oxybate which is licensed to treat narcolepsy associated with cataplexy, has no stimulant effect and does not reduce daytime sleepiness but has good suppression of REM intrusion symptoms such as cataplexy. The combination of drugs would address both narcolepsy and cataplexy symptoms, where these both existed.

   Members noted that the request to use solriamfetol in combination with sodium oxybate to treat narcolepsy associated with cataplexy would need to be clarified within the pathway and submitted using a formulary request, given this use is not covered by the NICE TA. Additionally the pathway needs to be clear in relation to the departure from the NICE recommendations covering solriamfetol monotherapy. The pathway was not approved and will require re-submission to the Committee at a later date.

   ***Post meeting note**: A meeting has been held with the author and separate formulary request with confirmation of any evidence base for combination use will be progressed and presented to the Committee.*

   ACTION: Formulary request for combination use to be progressed and narcolepsy pathway to be updated to reflect combination use for re-presentation to the Committee at a future date.

   Pharmacological management of restless legs syndrome or periodic limb movement disorder
   The main changes to the updated RLS were provided in the agenda paperwork. The updates include a formulary request to increase the maximum daily dose for rotigotine patch to 4mg daily, which is an off-label dose (licensed dose in RLS is up to 3mg daily).It was clarified that this dose would be reserved for patients where sufficient control of symptoms had not been achieved, to delay or avoid adding another

agent, including escalating to benzodiazepines or opioids (2nd and 3rd line treatments).The evidence suggests a small improvement and the 4mg dose would be used in a limited number of cases. Members noted that the resource impact of including the rotigotine patch dose of 4mg daily is within the financial threshold that the Committee is authorised to approve.

Reductions in the dosing regimens for clonazepam and oxycodone/naloxone were also presented and will limit the risk of adverse effects. Members requested the off-label use of up to 4mg daily for rotigotine patches is separated out as an option for resistant cases, making clear it is off-label use. In response to a query, the authors clarified that opioids and benzodiazepines would not be used simultaneously for safety reasons. Additionally, when a patient moves to an opioid the dopamine agonist is stopped. This will be clarified within the pathway. Typographical errors will also be corrected. Committee members approved the RLS pathway and the formulary inclusion of the 4mg daily dose of the rotigotine patch by consensus pending amendments and clarifications to the pathway in line with the discussions.

ACTION: Pathway to be updated by authors and progressed for ratification via Chair's action

5. Pitolisant for the treatment of cataplexy in adult patients with type 1 narcolepsy – review of the time limited approval

The presenters for the sleep pathways remained to present this item, which provides feedback as requested by the Committee following approval to use pitolisant in this setting. Overall, two patients were treated with pitolisant in this setting since approval was granted in November 2022. Both patients demonstrated improvement marked with a reduction in the frequency and severity of episodes of cataplexy, which ultimately led to less or no occurrences of cataplexy related injuries. Secondary benefits in both patients were also seen, for instance reduction in antidepressant doses and quality of life improvements. It was also noted that actual numbers treated were significantly lower than the original estimated patient numbers of 15 – 20 per year. The presenters confirmed that the original numbers are likely to have been an overestimate.

Committee members agreed by consensus to remove the time limit for pitolisant in this setting. Members agreed further updates could be requested in the future on patient numbers, if required.

ACTION: Formulary recommendation to be updated to remove time-limit and presented at a future meeting

6. Daridorexant for treating long-term insomnia - NICE technology appraisal

The presenters for the sleep guidelines and the lead Pharmacist provided an overview of NICE TA 922 – daridorexant for treating long-term insomnia, published on 18th October 2023. The TA recommends use of daridorexant (QUVIVIQ™) for treating insomnia in adults with symptoms lasting for 3 nights or more per week for at least 3 months and whose daytime functioning is considerably affected, only if:

- cognitive behavioural therapy for insomnia (CBTi) has been tried but not worked, or
- CBTi is not available or is unsuitable

The NICE TA also makes recommendations on the treatment duration being as short as possible, a review after the first 3 months of treatment and review at regular intervals in those continuing treatment to determine ongoing effectiveness. The summary of product characteristics (SmPC) for daridorexant notes that clinical data are available for up to 12 months of use. The NICE TA and the resource impact modelling, indicate that daridorexant is a medicine that can be initiated in primary care. Feedback from local acute and mental health Trusts also suggest primary care would initially manage chronic insomnia. Therefore the desired Red, Amber, Green, Grey (RAGG) category is Green in SEL.
Cost modelling for SEL included in the agenda pack is based on the impact estimated by NICE, which local sleep centre experts agree with. The modelling suggests a 2% uptake of daridorexant in Year 1 (23/24) rising to 11.7% by year 5 (27/28 - steady state). By Year 5, the cost impact for SEL will exceed the financial threshold the IMOC has delegated authority to approve. The cost impact will therefore need to be escalated to the SEL Executive Committee for information only (as this relates to a NICE TA). Members noted the estimated cost impact is based on certain assumptions, and any deviations

from this would impact on the local cost impact. NICE notes that there is potential for savings in GP appointments if treatment is effective for patients, meaning less visits to their GP to treat insomnia. Communication from the Integrated Care Board's (ICB) mental health planning team has confirmed that CBTi is available in each SEL borough.

A draft fact sheet aimed at providing information about daridorexant to primary care clinicians has been prepared, however, has not yet been consulted on as it is pending discussions at this meeting. This or alternative educational tools, such as NICE Clinical Knowledge Summaries (CKS) will be important for primary care training on the use of this medicine. Members suggested the information covered in any education resource such as a treatment pathway or factsheet should also expand on the information provided in the NICE TA to explain the practical aspects such as use of daridorexant in patients already prescribed other hypnotics or melatonin or those self-medicating. The presenters noted that acute insomnia medications such as z-drugs should not be used for longer than four weeks and are not licensed for chronic use. In practice patients will likely continue acute medications whilst going through CBTi before daridorexant is started. CBTi is the first line option and lasts for around 6 weeks. With respect to safety, the presenters noted that many of the warnings listed in the SmPC would mainly affect narcoleptic patients, and daridorexant should be avoided in these patients. This can be reflected within any educational resource.

Members agreed that developing a general insomnia pathway or use of the NICE Clinical Knowledge Summary (CKS) topic would be helpful to clinicians across SEL. At the present time, the NICE CKS topic on insomnia has not been updated with information on daridorexant but is likely to be and may suffice. The presenter agreed to consider both options and update the Committee on the decided approach. The importance of enabling management of long-term insomnia in primary care was acknowledged by Committee members, in particular due to the impact of sleep deprivation on physical and mental health. Committee members discussed the proposed RAGG category for daridorexant, noting the information contained within the NICE guidance and supporting NICE documentation. A RAGG category of Green means initiation can occur in primary or secondary care. Members acknowledged that where primary care practitioners feel they need support in determining whether daridorexant would be an appropriate option, they could seek advice from the specialist sleep service or mental health services.

The Committee agreed by consensus a RAGG category of Green for daridorexant with signposting to available CBTi services in SEL. Consideration will also be given to use of either the NICE CKS topic or development of a suitable factsheet/ general insomnia pathway to support primary care prescribing. The approach will be agreed once it is clear if the NICE CKS topic is being updated.

ACTION: Daridorexant to be added to the SEL formulary with a Green category by the NICE implementation date with supporting signposting
ACTION: Presenters to confirm approach for guidance on insomnia management in primary care - NICE CKS or local pathway - once CKS updates their insomnia topic
ACTION: Cost modelling for daridorexant to be escalated to the Executive Committee for information

7. **Primary and Secondary care adult osteoporosis treatment pathway and associated formulary requests:**
   - **Alendronic acid 70mg weekly in men as Green (off-label)**
   - **Categorise alendronic acid and risedronate as Green and note risedronate as joint first line oral bisphosphonate**
   - **Alendronic acid and risedronate as Green for the management of glucocorticoid induced osteoporosis (off-label)**
   - **Denosumab as Red for the management of glucocorticoid induced osteoporosis**
   - **Intravenous zoledronic acid for the management of osteoporosis using extended dosing interval of up to 18 months as Red (off-label)**

Representatives from the short life working group set up to develop the treatment pathway presented this new pathway to the Committee, which forms one of the workstreams in the 23/24 Committee work plan. Along with the borough lead, the presenters included an acute Trust consultant geriatrician and

specialist pharmacists. Five formulary requests are also included as these were identified as part of the pathway development. The treatment pathway covers adults with osteoporosis and incorporates recommendations from the Scottish Intercollegiate Guideline Network (SIGN), NICE, the National Osteoporosis Guideline Group (NOGG) and local expert opinion and consensus. It adopts a pragmatic approach to assess patients' risk of fracture in conjunction with the use of bone mineral density (BMD) measurement. The presenters noted that some minor changes had been made to the treatment pathway after the meeting agenda pack had been circulated and these were shared on screen. The changes included the introduction of wording to support a change in cultural practice so that patients being treated in specialist clinics where a risk of osteoporosis is identified can be started on preventative therapy without the need for a DEXA scan. Additionally, wording has been included to note that patients on long term glucocorticoid therapy should receive a review at 5 years in line with non-glucocorticoid patients for consistency and the terminology of "pauses in treatment" has been included to replace 'break in treatment' or 'treatment holiday'. A reminder has also been added regarding the opportunity to use patient encounters for potential deprescribing. Further context has also been given to help clinicians provide patient centred care and wording to note decisions are at clinical discretion of the clinician has been included.

Members welcomed development of the guidance and thanked the presenters for the work undertaken to establish it. Queries responded to by the presenters included clarifying that whilst it is no longer common practice to use raloxifene, it is included in the additional treatment options section rather than in the main pathway and should remain on the formulary. The presenters also clarified that the treatment pathway attempts to transform the culture of regular DEXA scans where scan results would not change treatment plans. Patients would still be followed up and the need to have scans should be decided on an individualised basis. Committee members were also taken through each formulary request, all of which are within the financial threshold delegated to the Committee because all form established historical practice and therefore a significant additional cost impact is not expected from them. The requests were all approved by consensus.

Committee members agreed by consensus to approve the pathway and associated formulary requests (including RAGG categories where requested) pending minor updates in line with discussions.

ACTION: Authors to share the updated pathway for IMOC Chair's ratification
ACTION: SEL Joint Medicines Formulary to be updated to reflect approved formulary requests once the pathway is approved.

8. **Updated denosumab shared care guideline (SCG) and associated formulary request:**
   - **Recategorisation of denosumab for men with osteoporosis and creatine clearance <30ml/min from Red to Amber 3**

The author was in attendance to present this item alongside the borough lead. A formulary request to recategorise denosumab for osteoporosis in men accompanied the shared care guideline (SCG). Denosumab is licensed for use in men and a recategorisation to Amber 3 would align the arrangements to those for post-menopausal women. A significant additional cost impact is not expected from this recategorisation request and is within the financial threshold the Committee has delegation to approve. The amendments were summarised within the meeting paperwork and include moving the SCG to the new template and inclusion of additional clinical experience and long-term safety data, which are available since the original approval in 2018. The formulary request is to remove the requirement for renal impairment to be present in male patients over 50 years old with osteoporosis to align this with the use of denosumab in postmenopausal women at all levels of renal impairment. Denosumab is licensed for men for in this setting at all levels of renal function, thus the request will bring denosumab in SEL in line with national best practice guidance.

Members requested some minor amendments to the SCG, including clarification that men with glucocorticoid induced osteoporosis are excluded from the SCG given use in this cohort will have a RAGG category of Red from earlier discussions on the osteoporosis treatment pathway.

The Committee agreed by consensus to approve the updated denosumab shared care guideline and also agreed by consensus the associated formulary request pending amendments to the SCG in line with discussions.

ACTION: Authors to update shared care guideline and return to the IMOC team to progress for ratification via Chair's action

9. Formulary Submission: Carvedilol for the prophylaxis of variceal bleeding in children with portal hypertension

This formulary submission originates from a paediatric hepatology consultant at KCH. The application requests to use oral carvedilol, after endoscopy, for primary or secondary prophylaxis of variceal bleeding in children with portal hypertension (PHT), where endoscopic band ligation and/or sclerotherapy are ineffective/unsuitable or not tolerated (off-label use). Carvedilol is proposed to be used in a cohort of children at higher risk of variceal bleeding or who have failed propranolol (currently the only beta blocker treatment for this indication in children), as assessed on an individual basis by a consultant hepatologist. The application notes the choice of agent will be decided on clinical status of the patient and risk benefits of side effects (such as higher risk of hypotension with carvedilol). The duration of therapy is intended to be until the patient receives a liver transplant. The use of carvedilol in this setting is off-label and the desired RAGG category is Amber 2, following a period of stabilisation, with ongoing monitoring through the specialist team.

- **Evidence Review**

The formulary pharmacist provided an overview of the evidence base for the use of carvedilol in this setting. A detailed evidence review was provided within the meeting agenda pack covering background to the condition, a review of the evidence base with strengths and limitations and rationale for use of carvedilol. The information presented also included the estimated resource impact for carvedilol in this setting. The resource impact of the submission is within the financial threshold that the Committee is authorised to approve. It was noted that carvedilol is on the adult formulary with a RAGG category of Amber 2 for use in the prophylaxis of variceal haemorrhage in adults (off-label use) as an alternative to propranolol for primary and secondary prophylaxis of variceal haemorrhage in cirrhosis. Propranolol is included in the paediatric formulary with a RAGG category of Green, although members noted that the Green category is under review.

- **Applicant's presentation**

The applicant was in attendance to present the submission and field any questions along with a specialist paediatric pharmacist. The applicant's declaration of interest was noted. The applicant outlined that use of carvedilol is intended for a small group of patients with PHT and that their Trust is a tertiary centre for the hepatology service. Endoscopy with a band ligation is the first line treatment option in this setting and if it is deemed unsuitable, propranolol has traditionally been used as the first line drug therapy in this setting. The applicant noted that in adult medicine it is now common to use carvedilol as a fist line option in this setting. Historically there is experience of carvedilol use in paediatrics in other settings, for example in children with heart failure. Specialist transplant nurses within secondary care will follow up patients closely and monitoring would be consultant led and include blood monitoring, liver function and cardiac monitoring. The request is for an Amber 2 category for carvedilol in this setting which would enable primary care clinicians to prescribe carvedilol once dose stabilisation has occurred. The service has a database to record experience of using carvedilol in this setting.

In response to a query requesting clarification regarding when prescribing would be transferred to primary care, the applicant explained that initially children would be placed on a starting dose and reach final dose stabilisation within a month and further dose increases after a month are not anticipated. The presenter also clarified that treatment with carvedilol would be limited to pre-transplant patients who would not typically be prescribed other medications and if they are, these are usually via the GP. The risk from use of carvedilol is not expected to exceed that of propranolol, which is already provided in primary care in children. The applicant stressed that requesting prescribing of carvedilol in

paediatrics in primary care is not novel as it is already widely prescribed for other indications. Treatment with carvedilol would be stopped after the liver transplant

Members requested that the comparative costings for propranolol are updated to include the tablet formulation as in the current costings, liquid propranolol is compared to carvedilol tablets. It was also highlighted that the paediatric SEL formulary notes propranolol as RAGG category Green, however, it is unclear how this decision was reached. This will be revised to match whichever RAGG category is decided for carvedilol.

- **IMOC discussion after departure of the applicant**

Members discussed the application and noted concern regarding crushing and dispersing of carvedilol tablets as this would be an unlicensed use of the preparation, which is also being used in an off-label way in this setting. The paediatric formulary pharmacist noted that patients will have been stabilised first and parents/carers shown how to manipulate the dose. Clear instructions would also be provided on how this should be done as part of the letter to the GP. A point around dosing was also highlighted - the lowest available tablet strength of carvedilol is 3.125mg and the starting dose is 50 micrograms/kg. Clarity is needed on how the dose will be achieved from the tablet formulation as patients would require carvedilol tablets to be crushed and dispersed to make the correct dose before using them. Members also queried if this would constantly change based on the child's weight. Clarity will be required on this point. Committee members agreed that clear guidance would need to be offered to the primary care clinician taking on the responsibility of prescribing. This could be in the form of a patient information leaflet (PIL) to support the parents/carers crushing and dispersing the tablets. This would also benefit the primary care clinician when taking over prescribing. It was noted that there is an existing PIL available for cardiac paediatric patients that could be adapted and used in this setting.

Committee members agreed by consensus that the formulary inclusion of carvedilol in this setting is acceptable and should not be delayed whilst a PIL is developed, given the additional option it provides to these patients. In view of this, in terms of the RAGG category, members agreed by consensus that until supporting information is developed for parents/carers, the interim position would be a category of Red. This will be reviewed once the supporting information has been developed and approved by the Committee. Members also agreed by consensus that as an interim category was being agreed, a formal formulary recommendation would not need to be drafted at this stage. However the paediatric formulary entry should detail the setting that carvedilol is approved in – i.e. the criteria for use in line with the formulary application.

ACTION: Formulary pharmacist to feedback from Committee discussion to applicant and applicant to follow up development of PIL for consideration at a future meeting
ACTION: Carvedilol to be added to paediatric formulary with interim Red RAGG category and detail on criteria for use

10. **Formulary Recommendation 148 rivaroxaban for post deep vein arterialisation with posterior tibial vein stenting in peripheral arterial disease**

This formulary recommendation has been drafted following the formulary application approval for rivaroxaban in this setting under a Red RAGG category at the November IMOC meeting. A comment from the Triage Panel review of the draft recommendation has requested that information around the ongoing review of patients when rivaroxaban treatment is needed beyond one year is added. The applicant has confirmed that patients remain under the ongoing review of the specialist team and this will be added to the recommendation.

The Committee approved by consensus Formulary Recommendation 148 pending minor amendments in line with discussions.

ACTION: Formulary recommendation 148 to be updated and progressed for ratification via Chair's action

11. Primary care antimicrobial guidelines - genital tract infections

The Borough lead for the primary care antibiotic guidelines and lead author for this section, presented this item. As presented at the November IMOC meeting, a process is underway through the Primary Care Antimicrobial Stewardship Group to harmonise antimicrobial prescribing guidelines across the 6 SEL boroughs. This is being taken forward in a cyclical way, section by section and the current section being presented is for genital tract infections. The section covers: bacterial vaginosis, Chlamydia trachomatis/urethritis, gonorrhoea, genital herpes/herpes simplex, pelvic inflammatory disease, trichomoniasis and vaginal candidiasis. The oversight for this work is through the SEL Forum for Antimicrobial Stewardship (SEL FAS); the primary care group is a sub-group of the SEL FAS. Once approved, the guidance in this section (genital tract infections) will be added to the online platform MicroGuide for primary care to access (launch pending).

The presenters took Committee members through the recommendations for the genital tract infection section. To a query requesting that treatment duration is more definitive in some areas of the guidance, for example where a range of 5 -7 days treatment is given, the presenters responded that course length recommendations were reduced to 5 days where possible but 5-7 reflected NICE guidance in some instances. Members also noted that there is a national steer to moving to 5 day prescribing of amoxicillin. The presenters agreed that an overarching statement will be added to the guidance to indicate that a shorter treatment duration is preferred. The presenters also agreed to include the link to the formulary recommendation for dequalinium chloride and the Joint Medicines Formulary entry in the bacterial vaginosis section.

Members also queried if the Committee was being requested to recategorise the RAGG category for metronidazole 2 grams single dose, which is noted as suitable for prescribing in the primary care guidance for bacterial vaginosis and trichomoniasis but is categorised as Red currently on the formulary. The presenters confirmed this was the desired outcome and GP members present confirmed this was a reasonable request as the single 2 gram dose is prescribed in primary care. It was not felt that this would carry a significant financial impact, given it is established practice. The Committee agreed by consensus a RAGG recategorisation from Red to Green for the 2 gram single oral metronidazole single dose in bacterial vaginosis and trichomoniasis. The presenters also agreed to make clear that reference to intramuscular ceftriaxone in the pelvic inflammatory disease and gonorrhoea sections is under a Red RAGG category. A hyperlink to the British Association for Sexual Health and HIV (BASHH) guidance will be added to the gonorrhoea section to signpost users to alternative advice on treatment in primary care.

The Committee agreed by consensus to approve the genital tract infection section of the primary care antibiotic guidelines pending amendments in line with the discussions.

ACTION: Guideline to be updated by authors and returned to the IMOC team to progress for ratification via Chair's action
ACTION: Metronidazole 2 gram single dose to be categorised as Green for use in bacterial vaginosis and trichomoniasis (with caveats as per the guidance) in the SEL Joint medicines Formulary following guideline ratification

12. Standing items

- Formulary submissions tracker
  Noted.
- NICE Technology Appraisal (TA) Guidance Summary - ICS & NHSE/I attributed medicines:
  - The summary was noted and Red, Amber, Green, Grey (RAGG) categories were agreed by consensus.
- For information and noting:
  - Adult and paediatric formulary updates
  - Updated pan-London Interface Policy- to be circulated for a second consultation

These were noted by Committee members.

13. Formulary recategorisation of Duraphat™ toothpaste and pilocarpine tablets/4% eyedrops post radiotherapy for head and neck cancer from Red to Amber 2.

The applicant (a consultant oral surgeon) was in attendance to present this abridged formulary request. Radiotherapy for head and neck cancer causes dryness of the mouth which has the potential to lead to dental decay, deterioration of dental orientation and subsequent further head and neck complications. The request is for Duraphat™ toothpaste and pilocarpine tablets and 4% pilocarpine eye-drops to be recategorised from Red to Amber 2 to allow for primary care prescribing in a small, niche cohort of patients. Members discussed the request with the applicant and GP members raised concerns regarding patients receiving toothpaste from a GP without specialist dental input and review. The presenter responded that in practice there is currently limited access to NHS dentistry for patients to obtain the toothpaste at repeating frequencies and this has been an ongoing barrier for patients in obtaining supplies. Additionally, the inequity in access to NHS dentistry will force some patients to private care, where charges may vary and affordability will be an issue. The applicant confirmed that patients would be under continued surveillance by the head and neck service and stressed that not all patients will require Duraphat™. Some patients will be successfully managed with regular treatment options, such as artificial saliva or pilocarpine 4% eyedrops (used off-label orally).

Members acknowledged that access to dentistry across London is poor but whilst the ideal is access via a dentist, currently this is challenging to achieve. However, GP members emphasised that requesting GPs to prescribe would not be the solution to addressing challenges to accessing NHS dentistry. GP members felt that it would be inappropriate for Duraphat™ to be categorised as Amber 2, even on an interim basis until access to NHS dentistry is resolved. Members agreed by consensus that the category should remain as red for Duraphat™ toothpaste. However, members also agreed by consensus that the wording in the Joint Medicines Formulary could be updated to indicate that under exceptional circumstances, primary care could be requested to take on prescribing of Duraphat™ for dry mouth post radiotherapy in head and neck cancer patients. Members agreed that the applicant could feedback any continuing challenges despite this arrangement being in place via their formulary lead.

With respect to pilocarpine 5 milligram tablets and the 4% eyedrops (to be used orally – off-label – in situations where there is a pilocarpine tablet shortage), members noted the formulary request form and that there is historic use of pilocarpine in this setting. The tablets are not on the formulary for use in dry mouth post radiotherapy for head and neck cancer (they are formulary included as red for Sjogren's syndrome). The eye drops are on the formulary in this setting but categorised as Red. The financial impact of the request is negligible and within the financial threshold the Committee is authorised to approve. The Committee agreed by consensus to approve the inclusion of the indication of "dry mouth following radiotherapy for head and neck cancer" for pilocarpine 5mg tablets and to recategorise both the tablets and 4% eye drops to Amber 2 in this setting.

ACTION: Duraphat™ formulary entry to be updated with caveat wording enabling requests for primary care prescribing post radiotherapy for head and neck cancer in exceptional circumstances in line with discussions
ACTION: Indication of "dry mouth following radiotherapy for head and neck cancer" to be added to formulary entry for pilocarpine tablets. Both pilocarpine tablets and 4% eye drops to be updated to an Amber 2 category on the formulary in this setting.

14. Any Other Business
Nil items raised.

IMOC dates for next 3 months

Date	Time	Venue
18th January 2024	2:00pm – 4:30pm	MS Teams
15th February 2024	2:00pm – 4:30pm	MS Teams
21st March 2024	2:00pm – 4:30pm	MS Teams