South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
Thursday 18th April 2024, 2pm to 4:30pm (Meeting held via MS Teams)
FINAL Minutes

1. **Welcome, introductions and apologies**

The Chair welcomed attendees to the meeting. Apologies and observers were noted.

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. **Detailed action notes of the last meeting, minutes, and action log:**

The notes were accepted as an accurate record of the meeting subject to the correction of minor typographical errors. In relation to the updated GLP-1 pathway for Type 2 diabetes, a sentence will be added in relation to tirzepatide cost impact to clarify that after year one, the cost is estimated to fall within the Committee's financial delegation. Members were provided with an update on progress against actions due for this month, these were noted, and items closed were agreed.

4. **Formulary application for prazosin for nightmare disorder with disturbed sleep initiation in adult patients and associated formulary amendments**

This formulary submission originates from a consultant psychiatrist based in the tertiary Sleep service at GSTT. The application requests the use of prazosin as a first line treatment for post-traumatic stress disorder (PTSD) related nightmare disorder with disturbed sleep initiation in adult patients aged over 18 years. The application notes that prazosin should be trialled after non-pharmacological interventions, including image rehearsal therapy (IRT) and psychological therapies. The application requests an Amber 2 "Red, Amber, Green, Grey" (RAGG) category. In line with this request the Committee is also being asked to consider the following formulary request:

- Request to amend the use of trazadone and agomelatine to first/second line options in nightmare disorder associated with PTSD instead of melatonin.

➢ **Evidence Review**

The formulary pharmacist provided an overview of the evidence base and background to the condition. 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 prazosin in this setting. The information presented also included the estimated resource impact for use of prazosin in this setting. The resource impact of the submission is within the financial threshold that the Committee has delegated authority to approve.

Nightmares in PTSD have been associated with significant distress, functional impairment, poor health outcomes, and decreased quality of life. International guidance such as from the American Academy of Sleep Medicine, and The Anxiety Disorders Association of Canada recommend prazosin as first-line treatment for PTSD-associated nightmares. Current UK guidance is limited to a consensus statement published in 2019 from the British Association for Psychopharmacology on the treatment of insomnia, parasomnias, and circadian rhythm disorders. For parasomnias, it is noted that prazosin has good evidence of beneficial effects in reducing nightmares related to PTSD in both military and civilian settings. Prazosin is licensed in the UK for various conditions; however, use in nightmare disorders associated with PTSD is off label. In this setting the starting dose of prazosin noted in the application is 1mg daily at bedtime, titrating up to a maximum of 10mg daily at bedtime over a period of three months.

With respect to the evidence base, one RCT in 2018 included 304 veterans found no difference between prazosin and placebo in nightmare severity, sleep quality, and improvement in change scores and found greater blood pressure changes with prazosin. A meta-analysis in 2019 compared IRT to prazosin for treating trauma-related nightmares and found no difference between the two for nightmare frequency, PTSD symptoms, and sleep quality. However, it demonstrated the superiority of prazosin over placebo. Finally, two meta-analyses published in 2020 included the large RCT to assess impact of prazosin on nightmares and PTSD. One found prazosin improved overall PTSD symptoms, and the other one did not. Both found improvements in nightmare symptoms with prazosin. Overall, prazosin is well tolerated, with the main side effects being hypotension and dry mouth.

- **Applicants' presentation**

A Consultant in Sleep and Respiratory Medicine was in attendance to present the application and field any questions on behalf of the applicant and was supported by the specialist sleep pharmacist. The applicant's and presenter's declaration of interest were noted and in response to clarification on their DoI, the presenter confirmed they did not have any declarations to make. The presenter outlined that evidence suggests that prazosin is effective in treating nightmare disorder that is related to post traumatic stress disorder. Prazosin in this setting is not expected to be prescribed in a large number of patients and prescribing would be restricted to the Sleep service.

The presenters also noted the accompanying formulary request asks for a change to the co-morbid insomnia pathway to amend trazodone and agomelatine from 2nd and 3rd line to 1st and 2nd line options respectively, specifically in people with PTSD associated nightmare disorder. It was confirmed that these two agents are used as insomnia treatments, not as treatments for PTSD associated nightmares. Melatonin is not a suitable 1st line option in these patients as it can increase time spent in the rapid eye movement (REM) phase, potentially leading to an increased risk of nightmares. Committee members agreed that the co-morbid insomnia pathway would need to make clear that trazodone and agomelatine are being used to treat insomnia and not the nightmare disorder. It was noted that the cost impact associated with this formulary change is negligible and within the Committee's delegated financial threshold.

In response to a query from a member, the presenter confirmed that the response to treatment will be measured using patient feedback questionnaires to review nightmare intensity. With respect to current use, the presenter informed the Committee that in the last year, seven patients have been treated with prazosin, four of which have had complete resolution. The numbers are low, and it was noted that IRT is an important non-pharmacological therapy that is used first-line, before medication. The application notes that prazosin has also been used at the South London and Maudsley (SLaM) Trust in this setting. The SLaM representative confirmed that prazosin is a third line option in this setting after psychological therapies, followed by selective serotonin reuptake inhibitors (SSRIs) or serotonin norepinephrine reuptake inhibitors (SNRIs), which are specifically for the PTSD element of treatment. Prescribing has historically been kept in-house and there are ~10 patients treated per year.

After the initial reviews, will there be a review at 1 year and members queried what criteria are applied for stopping/deprescribing prazosin in this setting. The presenter confirmed that the patient will remain under the consultant that initiated treatment and after the initial reviews, there are consultant reviews at 6 and 12 months. If treatment is not efficacious at the 3-month mark it would be stopped and if treatment is not tolerated due to side effects, for instance hypotension, then this could also warrant stopping treatment. Members also queried how potential compliance issues with the large number of tablets required for the higher doses would be managed (at the upper dose, 20 tablets daily would be needed). It was clarified that it is rare for patients to reach those higher doses; most are maintained on much lower doses. The desired RAGG category would be Amber 2, and prescribing would be transferred to primary care once patients are on a stable dose and after a minimum of 3 months

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

Members discussed the application and noted that whilst the evidence base is limited, prazosin is being used in a small number of people with very distressing nightmares that disrupt the individual's quality of life. As there is good experience of its use in other indications in primary care an Amber 2 arrangement seems reasonable. Committee members agreed by consensus to a time limited approval for the addition of prazosin to the formulary with an Amber 2 category. However, this approval is pending the presentation and approval of the nightmare disorder pathway and the updated co-morbid insomnia pathway. Until the pathways have been updated and reviewed/approved through the Committee, prazosin remains non-formulary in this setting. Members agreed that it was beneficial patients would remain under specialist care and have regular reviews with the initiating consultant. It was agreed by consensus that once the pathway was finalised, the approval would be time limited to one year. A report will be requested after one year to summarise the numbers of patients treated and the outcomes to support ongoing formulary inclusion.

ACTION: Authors to update the proposed draft nightmare disorder pathway for consultation with the Committee
ACTION: Authors to update the co-morbid insomnia pathway to reflect changes to the use of agomelatine and trazadone

5. Formulary recommendations for approval:

- **New formulary recommendation 149 - Ospemifene for moderate to severe symptomatic vulvar and vaginal atrophy in a select cohort of post-menopausal women**
- **Updated formulary recommendation 122- Rivaroxaban for the treatment of left ventricular thrombus (LVT) in adults (off label use)**

- Formulary recommendation 149: Following discussions at the March IMOC meeting, the decision regarding formulary approval was deferred pending discussions with the applicant on the criteria for use, which has been completed and the criteria are reflected in the recommendation. The approval is time limited to a year to enable experience of use, with a request that an outcomes report is presented to the Committee in a years' time. The Committee agreed by consensus to approve ospemifene for formulary inclusion in this setting and approved the formulary recommendation with a 1-year time limited approval under an Amber 2 category.

- Recommendation 122 has been updated following discussions at the March IMOC meeting to approve recategorisation of rivaroxaban and apixaban from red to Amber 2 in LVT. Minor amendments have been made following comments returned via the Triage Panel review and these were shared on screen. It was noted that currently the formulary recommendation only covers rivaroxaban. Apixaban in this setting was originally discussed and approved through the hospital only Joint Formulary Committee (JFC). As the criteria use of rivaroxaban and apixaban in this setting are identical, it is proposed that apixaban is added to the formulary recommendation. The JFC Chair has confirmed their support for this approach. Committee members agreed by consensus it was reasonable to add apixaban to the recommendation for completeness. Members agreed by consensus that the recommendation could be updated to incorporate apixaban and the amended version approved via IMOC Chair's action.

ACTION: Outcome data for ospemifene in line with recommendation 149 to be presented back to the Committee in a years' time
ACTION: Recommendation 122 to be updated to include apixaban and the IMOC team to progress for ratification via Chair's action

6. Outcome data for the use of Alkindi® granules in capsules (for opening) for replacement therapy of adrenal insufficiency in paediatric patients

The lead formulary pharmacist presented this item. Alkindi® in this setting was approved by the Committee as a time limited approval in 2022, with a request to present outcome data after one year. Due to capacity challenges within the Trusts, the data is being presented later than requested. The data captured over a year

and a half note that there have been 13 patients treated with Alkindi® by the SEL acute Trusts, which is in line with the original estimate of 10-20 patients. Two of these patients were initiated on Alkindi® outside of the recommendation criteria by non-endocrine specialties and those initiating have been reminded of the local arrangements. All patients were switched to Alkindi® from hydrocortisone tablets due to risks with inaccurate dosing through crushing tablets and majority of these patients experienced good control with Alkindi®. There were no safety issues reported by patients whilst using Alkindi® and the majority of patients stopped treatment with Alkindi® because they no longer required steroid treatment, or they were switched from Alkindi® to hydrocortisone due to dose and age. The Committee agreed by consensus to remove the time limit on the recommendation.

ACTION: Formulary recommendation 130 to be updated to remove the time limit and presented at a future meeting

7. Guidance and resources for the use of Continuous Glucose Monitoring (CGM) in Children and Young People (CYP) living with Type 1 diabetes in SEL and associated formulary requests

The Paediatric Formulary Lead alongside the Diabetes Consultant Pharmacist, Paediatric Diabetes Consultant and the children and young people Programme Director were in attendance to present this item. A declaration of interest was noted for the Consultant Diabetes Pharmacist.

In response to the updated NICE guidance NG18- Diabetes (Type 1 and Type 2) in children and young people (CYP), the NHS England (London region) Babies, Children and Young People (BCYP) Transformation Programme has supported development of pan-London resources (implementation guide, implementation flowchart and device list) to support the implementation of NG18 across London to help minimise variation in implementation. The implementation guide, device list and implementation flowchart were approved by the London Clinical Executive Group (LCEG) in December 2023. These new documents have undergone consultation through the SEL IMOC. The comments received were mainly in relation to the practical application of the pathway rather than the clinical detail within the pathway and these comments will be shared with the London leads, who authored these resources for consideration in future updates. Resultantly the documents being presented to the Committee remain unchanged.

The presenters noted that it is recognised that the NHS supply chain (hospital only) devices are not within the remit of the SEL IMOC as they are not prescribable on FP10. However, in the interest of a consistent approach to this work and in line with the approach taken with the CGM guidance for adults with Type 1 diabetes, the request is for the Committee to consider review and approval of the guidance as a whole, considering the hospital only devices too. No objections were raised by Committee members to this.

The Committee is also being requested to consider two formulary requests for CYP with Type 1 diabetes:
(i) Formulary inclusion of Dexcom One™ device as Amber 1 and
(ii) Recategorisation of Freestyle Libre 2 from Amber 3 to Amber 1

It was noted that in CYP, even with an Amber 1 category, the specialist would be responsible for providing training of new devices and providing an initial prescription, removing this responsibility from primary care clinicians.

Five updated SEL documents – primary care information sheet/community pharmacy information sheet/ initiation letter/patient & prescriber transfer agreement/ Flash glucose 6-9 month review form) were also presented to the Committee. A summary of the updates were included within the agenda paperwork and highlighted for the attention of Committee members.

With respect to the cost impact, the presenters outlined that the estimated costs are based on the NICE cost assumptions model and across London consistent calculations were used. Based on the year on year current and future costs provided by presenters it was noted that the implementation of CGM in this setting exceeds

the IMOC's delegated financial threshold for approval. In view of the estimated cost impact, escalation of the costs associated with implementing this guidance to the SEL Executive Committee will be required for financial approval. The presenters noted the longer term clinical and value benefits of implementing CGM in this setting, including a reduction in HbA1c for patients on CGM, a reduction in emergency admissions and associated costs and greater patient empowerment to self-manage blood glucose

Members discussed the guidance and the presenters noted that the three new pan-London documents would be hosted on the relevant NHSE London webpages, which the SEL IMOC website and formulary could signpost to. Members fed back that an Amber 2 category would be more appropriate from a primary care perspective because specialists are initiating and training patients on the use of these devices, which is in line with the Amber 2 definition. In response to a query about patient training the presenters clarified that patients who are given CGM devices from diagnosis or earlier in their treatment seem to have better outcomes. Diabetes psychologists work with patients who are transferred to CGM at a later stage because this helps with their understanding. It was confirmed that training is adapted to the individual patient for the best results. Additionally, patients are seen every 3 months by specialists in the multi-disciplinary clinics, for patients who need more extensive support, they are seen more frequently than 3 months. Responding to a query about how long-term outcomes would be measured, the presenters outlined that every paediatric diabetes unit is mandated to report into the national paediatric diabetes audit with patient admission numbers. It is expected that as HbA1c reduces, patient admissions also reduce, and this could be measured through the national audit.

Committee members agreed by consensus to approve all the requested new/updated resources. Members also agreed by consensus to approve the two formulary requests as Amber 2 rather than the Amber 1 requested in line with earlier discussions. Members noted that the Committee had provided clinical sign off. The guidance will only be considered final for publication once it has received financial approval through the Executive Committee.

ACTION: SEL resources to be updated to reflect the agreed Amber 2 category and shared with the IMOC team for Chair's action
ACTION: Guidance and the cost impact modelling to be presented to the Executive Committee for financial review and approval

8. Updated South East London Interface Prescribing Policy for 2024/25

The leads for this policy presented the updated version for 2024/25. The main updates to the policy were highlighted within the agenda paperwork and include:

- an update to the terminology to reflect Integrated Care Systems
- Inclusion of information on virtual wards, adapted from the draft pan-London policy
- Inclusion of information that relates to recent guideline publications and priorities such as the Discharge Medicines Service and overprescribing information.

The policy was also presented and approved at the Integrated Pharmacy Stakeholder Group meeting in March 2024.

The Committee approved the updated interface prescribing policy by consensus.

9. Branded generics guidance for South East London

The author presented the branded generic guidance which has been developed by the Primary Care Medicines Value group (MVG) with the input of acute Trust colleagues. The guide aims to provide principles around the prescribing of branded generic medications as well as clarity around the various types of generic medications available. The guidance was approved by the SEL Medicines Value Group in February 2024.

The Committee agreed by consensus to approve the guidance.

10. Guideline for Medicines Optimisation in Bariatric and Metabolic Surgery

The author was in attendance to present this item alongside the borough lead and the Lead Formulary Pharmacist. The guideline is based on guidance from the British Obesity & Metabolic Surgery Society (BOMSS) and aims to provide GPs with information about managing patients with respect to their medicines post-surgery. The guideline highlights the responsibilities of both primary and secondary care clinicians and incorporates information relevant to both parties. Medication prescribing and monitoring information for the relevant drugs and procedures are all available within the guidance. The guidance advises that vitamin and mineral supplementation begins two weeks post operatively when patients have progressed from a free fluid diet. The expectation is for GPs to take over prescribing at this two-week mark. Malabsorptive bariatric surgery, such as bypass procedures leave patients at high risk of malabsorption, therefore lifelong vitamin supplementation is essential to avoid adverse effects and complications in these patients. Restrictive bariatric surgery is less likely to cause malabsorption. Most procedures are malabsorptive in nature with less than 2% of the planned workload being restrictive.

A member query was raised regarding the guidance supporting prescribing of vitamin supplements on the NHS without a deficiency being present, which seems at odds with national guidance on over the counter (OTC) medicines. The presenters noted that patients requiring vitamins post-bariatric surgery are exempt from NHSE OTC guidance meaning these patients could be prescribed the supplements by their GP. Without supplementation 100% of patients would become malnourished leading to side effects and complications and a greater burden on the NHS. Forceval™ is preferred over Sanatogen A-Z™ because of the trace element supplementation within it, if patients prefer Sanatogen A-Z™ they could purchase this OTC. It was also clarified that most patients already have the supplementation at home as pre-operative information gives advice on the vitamins needed and most GPs often prescribe prior to the procedure, supplies would be given to patients if they had not already received medications from their GP.

To avoid any confusion, it was agreed that clear messaging will be included on the first page of the guide distinguishing between information and responsibilities for primary care and secondary care clinicians as on first glance it appears that the guide is oriented more towards hospital clinicians. The author also agreed that the document will include a refined cohort of eligible patients that is in line with the PrescQIPP guidance (making a distinction between malabsorptive procedures and restrictive procedures). Members noted that cost modelling associated with this guideline would be required given the financial thresholds the Committee works to and as this is a new guideline. The author responded that it is anticipated that the majority of patients are already prescribed treatment so it is estimated that there will not be significant cost implications. As a follow up, it was noted that costs over time would be helpful to understand and also if patient numbers being treated are likely to increase. It was agreed that cost modelling will be prepared and presented to the Committee.

The guideline was not approved – it will be updated and re-presented to the Committee at a future date along with cost modelling.

ACTION: Guideline to be updated in line with discussions and presented at a future meeting
ACTION: Cost modelling associated with guideline to be presented at a future meeting alongside the guideline

11. SEL IMOC workplan 23/24 - Q4 closing update

The final report for the 23/24 work plan highlights that all of the 23/24 IMOC workstreams are completed or near completion. It was proposed that as the Integrated Care Board (ICB) is in the last stages of its restructure, the development of a 24/25 IMOC work plan is paused to enable the ICB Medicines Optimisation

team to establish in the new structures. A 6-month workplan starting later in the year will be considered once there is more stability. Members agreed and were supportive of this approach.

12. Standing items/Items for information only

- Formulary submissions tracker

Noted.

- NICE TA Guidance Summary - ICS & NHS England attributed medicines:

The summary was noted, and RAGG categories were agreed by consensus, where it was possible to confirm the RAGG status.

- For information and noting:

- RMOC update – Nil for this meeting
- Adult and paediatric formulary updates - noted by Committee members.

13. AOB

- SEL IMOC Terms of Reference (ToR) – extension to review date: Members agreed by consensus to extend the existing ToR by 6 months to October 2024 to allow new ICB structures to embed and resulting Committee membership to be determined.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 16th May	2pm-4:30pm	MS Teams
Thursday 20th June	2pm-4:30pm	MS Teams
Thursday 18th July	2pm-4:30pm	MS Teams