South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
18th July 2024 (Meeting held via MS Teams)
Final Minutes

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

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, detailed action notes of the last meeting, and action log:**
   The minutes and detailed action notes were accepted as an accurate record of the meeting subject to the correction of typographical errors. 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 pyridostigmine in adults for the treatment of postural tachycardia syndrome (PoTS)**

   This formulary submission originates from a specialist consultant cardiologist at KCH, where a tertiary service for the management of postural tachycardia syndrome (PoTS) is provided. Pyridostigmine is licensed for use in myasthenia gravis. The application requests the off-label use of pyridostigmine as a third line option in PoTS after beta-blockers and fludrocortisone in line with specified criteria. The dose range is between 30mg once a day up to 60mg three times a day. The application requests an Amber 3 category for pyridostigmine in this setting, with the first 3 months of treatment proposed from the hospital and then primary care would be requested to take over under shared care /transfer of prescribing arrangements. This is line with existing guidance for the use of midodrine in PoTS.

   - **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 pyridostigmine in PoTS. The information presented also included the estimated resource impact for use of pyridostigmine in this setting. The resource impact of the submission is within the financial threshold that the Committee has delegated authority to approve. PoTS is a disorder characterised by orthostatic intolerance, accompanied by excessive tachycardia without arterial hypertension. There are currently no United Kingdon (UK) or European guidelines for the treatment of PoTS, but in some United States (US) and Canadian consensus statements and guidelines, lifestyle interventions such as exercise and increased fluid and salt consumption are recommended first, followed by pharmacological interventions if required.

   The South East London Joint Medicines Formulary (JMF) includes approved symptom treatment options for PoTS, which follow a similar treatment strategy to the US/Canada and includes beta blockers (for tachycardia/palpitations), off-label use of fludrocortisone (for boosting sodium retention and plasma volume), midodrine (for increasing venous return) and ivabradine (for tachycardia and palpitations). Pyridostigmine bromide, a reversible acetylcholinesterase inhibitor, would be an alternative pharmacological approach, theoretically increasing parasympathetic nervous system activity and peripheral vascular resistance as well as reducing heart rate. Its use in treating PoTS would be off label, at lower than licensed doses (for myasthenia gravis), in cases where beta-blocker protocols were contraindicated, had failed or were not tolerated.

   With respect to the evidence base, the specific evidence for use for pyridostigmine for PoTS is low quality and limited to a single dose placebo cross-over randomised controlled trial (RCT), and a single centre retrospective study in 203 patients. The single-dose study crossover RCT compared single-dose 30mg pyridostigmine versus placebo with the alternate treatment taken on a separate day in 17 patients. The study found a statistically significant reduction in heart rate difference between sitting and

standing for patients taking pyridostigmine compared to placebo at two hours. There did not appear to be an effect on blood pressure but mainly an impact on tachycardia. The single-centre retrospective, observational study of 203 patients over 12 months trialled pyridostigmine as a rescue treatment following failure of alternative drug therapies. It suggested that orthostatic intolerance was improved in 43% of patients mostly in relation to fatigue, palpitations, and syncope, as well as a statistically significant reduction in standing heart rate. With respect to safety, due to its mechanism of action, pyridostigmine results in a number of side effects particularly gastrointestinal symptoms and bladder dysfunction. The side effect profile will be similar to those reported by myasthenia gravis patients taking the medicine, although for PoTS the doses would be lower (up to 180mg daily) suggesting less incidence of side effects. Pyridostigmine does not have a Red, Amber, Green, Grey (RAGG) category assigned within the JMF at present, although it is historically used by neurology for its licensed use and is transferred to primary care in this setting.

- **Applicant's presentation**

The applicant was in attendance to present the submission and answer questions. The applicant's declaration of interest was noted. In response to a query about monitoring arrangements in primary care, it was clarified that this would be three monthly blood pressure and heart rate checks and an annual blood test for standard kidney and liver function. Patients are educated to largely self-monitor and manage their heart rate. Deprescribing would be determined on a case-by-case basis; there may be some patients who gradually improve and eventually stop the medication, but also others with a persistent problem may stay on the medication lifelong. Other medication such as propranolol would be deprescribed if possible, although the exertion of different pharmacological effects means patients sometimes require these medications simultaneously. With respect to the review process at 3 months and how this would work in practice, the applicant noted that the initial medication supply will be provided by the hospital and titrated over three months before the GPs take over the patient care. The patients would receive information about heart rate and blood pressure monitoring and how to titrate the dose at initiation from the arrythmia nurses. Patients remain in contact with the arrhythmia nurses who could arrange for additional prescriptions from the service if needed. Members queried whether the patient numbers estimated in the submission were accurate they appeared higher than anticipated for SEL. The applicant responded that exact numbers are challenging to define and there may be fewer. The high percentage of patients in SEL is likely due to the availability of the expertise locally and increasing awareness in local clinicians rather than prevalence.

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

Members discussed the application and whether the use of pyridostigmine in this setting would be more suited as red (hospital only). Whilst GPs would be familiar with prescribing in the licensed indication, these patients would be quite complex and towards the end of the treatment pathway. Some members fed back that amber 3 would be acceptable with the shorter Transfer of Prescribing guidance, as for midodrine. Members also discussed if a treatment pathway would be necessary and it was noted that these patients are quite nuanced and it would be difficult to cover this in a single pathway. It was acknowledged that midodrine and ivabradine were Amber 3 for the same indication outside of their licences, and to vary for pyridostigmine could be confusing. Pyridostigmine is prescribed in higher doses for other indications with no specialist support. The cardiovascular disease sub-group had supported an Amber 3 rating when providing their expert view on this application.

Whilst minded to agree an Amber 3 position for pyridostigmine in this setting, the Committee deferred a final decision until there was further clarity regarding primary care monitoring and blood test requirements, review of patients at 3 months and further supply of medication at that point, ongoing review and further details of the role of GPs in the shared care, including in the context of ongoing nurse support. The precise requirement for blood pressure checks every 3 months was also requested (whether the practice would need to undertake these). It was also important to clarify how the shared care agreement would be operationalised and how contact would be maintained between the patient and specialist team.

ACTION: Applicant to advise on the detail requested by the Committee in line with the discussions to further support the decision-making process

5. Formulary application for pyridostigmine in adults for the treatment of orthostatic hypotension

This formulary submission originates from a general and elderly medicine consultant with a specialist interest in movement disorders at KCH. The application requests the off-label use of pyridostigmine as a third line treatment (after fludrocortisone and midodrine) in orthostatic hypotension (OH) in line with specified criteria. All three acute Trusts in SEL have confirmed an interest in utilising pyridostigmine in this setting, with low patient numbers anticipated. The intended dose range is 15mg three times a day to 60mg three times a day. The application requests an Amber 3 category for pyridostigmine in this setting, with the first 3 months of treatment proposed from the hospital and then primary care would be requested to take over under shared care/transfer of prescribing arrangements. This is line with existing guidance for the use of midodrine in OH.

- **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 pyridostigmine in OH. The information presented also included the estimated resource impact for use of pyridostigmine in this setting. The resource impact of the submission is within the financial threshold that the Committee has delegated authority to approve. Orthostatic hypotension is another orthostatic intolerance identified where there is a blood pressure drop within 3 minutes of the person standing resulting in light-headedness, dizziness, weakness, difficulty thinking and feeling faint. This typically presents in older people due to gradual impairment of the baroreflex sensitivity. European guidelines for the management of syncope address OH management and recommend midodrine as first line therapy followed by fludrocortisone, which are already formulary included treatment options in SEL. Other potential treatments include pyridostigmine, octreotide and erythropoietin, however no recommendations are specified.

The evidence base is limited and low quality, with three RCTs describing the use of pyridostigmine in OH. A cross over study in 58 patients compared single doses of pyridostigmine 60mg, pyridostigmine 60mg with midodrine 2.5mg, pyridostigmine 60mg with midodrine 5mg and placebo. No significant difference in blood pressure was found in either treatment but pair-wise analysis of pyridostigmine and a placebo showed a statistically significant improvement in blood pressure and symptom scores. A separate RCT (n = 13) found pyridostigmine was statistically inferior to fludrocortisone for improving standing blood pressure. A further RCT compared midodrine, pyridostigmine and a combination of midodrine and pyridostigmine finding all three treatments significantly improved supine to standing blood pressure drop from the baseline measurement, with no significant difference between treatments.

Adverse effects are as described for the previous application covering use of pyridostigmine in PoTS.

- **Applicant's presentation**

The applicant was in attendance to present and respond to questions from the Committee. The applicant's declaration of interest was noted. The applicant outlined that it would be very rare for pyridostigmine to be used in this setting. It is usually a last line option and, in their service, it is usually considered for people with OH who are admitted due to falls. The applicant has some limited experience in using pyridostigmine for OH, it is usually started when the patient is an inpatient and its effect determined during their hospital stay.

In response to a query regarding the rationale for using a dosing regimen outside of the RCTs, the applicant acknowledged that there is little evidence to guide treatment but OH is a serious issue with varied expertise. Doses being use in OH are smaller compared to those used to treat myasthenia gravis. At the point this drug would be considered, it would be a last line option and clinicians would be keen to achieve a result. With respect to other treatment options noted in European guidelines (desmopressin, octreotide and erythropoietin), the applicant confirmed there is no intention to use these in OH at the current time. It was clarified by the applicant that pyridostigmine is rarely used in OH, it is a last resort therapy in patients who are often approaching the end of life and have multiple co-morbidities. Typically, these are hospital inpatients in whom OH is an incidental find and who do not

respond to any other pharmacological/non-pharmacological treatments. In severe cases, these patients remain bedbound as a result of their OH and the treatment aims are to support improved mobility and discharge. A positive treatment effect may prevent consequences such as the patient becoming bed-bound and requiring a nursing home. If the patient remained bedbound after initiation, there would be no rationale to continue the treatment. Members queried how the clinical effect would be determined during the hospital stay and how prescribing would occur before transfer to GP. The applicant advised that discharge supplies could be arranged for 3 months, with additional Parkinson's Disease (PD) nurse checks during the initial 3 month period to support planning for transfer to GP prescribing. Patients are reviewed every 6 months by the service (consultant or PD nurse), usually lifelong.

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

The discussions were similar to those for the previous application covering the use of pyridostigmine in PoTS. Members questioned whether a red category would be more appropriate in this setting, given use appears to be intended in a specific group of patients at the end stage before a nursing home would be considered. Additionally patients are monitored lifelong and the numbers anticipated are low. Given the cohort of patients are elderly and frail, the medication side effects such as diarrhoea and bladder dysfunction could present serious problems. It was noted that as medications for this condition are already prescribed by GPs, making this rating red may complicate the process. It was also recognised appointment attendance within this group was a challenge, making a Red RAGG category unfavourable.

Members queried the patient numbers provided in the application as the applicant indicated patients in their service are initiated as inpatients and only anticipated 1 or 2 patients a year. The Formulary Pharmacist noted that the application was made as there have been a number of non-formulary requests for use of pyridostigmine in OH. Whilst the applicant is referring to their experience of use in people with PD, the application is broader than this cohort. Other clinicians who initiate pyridostigmine may not have the same follow up processes, however the prescribing process would be the same as midodrine for OH which is being proposed as Amber 3. Members requested clarity on which specialties intend to use pyridostigmine in this setting, their estimated patient numbers and whether there would be any outpatient initiation. It would also be helpful to understand if the initiation and review processes for pyridostigmine in OH would be consistent across all specialties and across all Trusts. Members also requested clarity on the duration of treatment/review arrangements and the arrangements for deprescribing. The Committee deferred a final decision on the application until this further information is available for the Committee to review.

ACTION: Applicant to provide further detail in line with the Committee's discussions to support the Committee's decision-making

6. Formulary recommendations for approval

- **Updated formulary recommendation 116 – safinamide for the management of Parkinson's disease in adults**

This recommendation has been updated following the presentation of the outcome report at the last meeting. No comments were received from the virtual Triage Panel review and there were no comments from members. The updated recommendation was approved by consensus.

- **Formulary recommendations for moderate to severe seasonal and perennial allergic rhinitis in adults and children 12 years and over:**
  - New formulary recommendation 150 – Ryaltris™
  - Updated formulary recommendation 067 – Dymista™

The Committee were informed that there had been no comments made on these two recommendations as part of the virtual Triage Panel review. The APC paediatric ENT guidance is expected to be approved shortly and the intention is to publish these decisions at the same time as the APC guidance is published. The Committee approved by consensus formulary recommendations 150 (Ryaltris™) and 067 (Dymista™).

7. Multivitamin formulary inclusions for approval:

(i) Paravit-CF™ capsules and liquid as Amber 1 for adults with cystic fibrosis

The inclusion of Paravit- CF™ capsules and liquid, which contains several different vitamins, was requested for both adult and paediatric cystic fibrosis (CF) patients. Due to ongoing menadiol formulation shortages, there is a need to find alternatives as the shortages cause significant issues in both primary and secondary care. The use of mostly unlicensed food supplements has also been explored but patients may not obtain these easily and GPs are, understandably, reluctant to prescribe. The alternative would be to prescribe the vitamins separately or to use DEKAS plus – which is already formulary included. Paravit-CF™ could help improve adherence as the alternative requires four separate vitamin components to be prescribed, or DEKAS Plus™ (on formulary) which had a less favourable vitamin profile. Paravit- CF™ is more suitable in pregnancy (unlike DEKAS Plus™) and was cheaper than the sum of the individual vitamin components and DEKAS Plus™. Formulary inclusion of Paravit-CF in this setting is not expected to result in significant cost impact and will be a substitute against the cost of the separate vitamin prescriptions. The estimated cost impact is therefore within the threshold delegated to the Committee.

The Committee approved, by consensus, the addition of Paravit- CF™ capsules and liquid as Amber 1 for adults and children with CF.

ACTION: Adult and paediatric formulary to be updated to include Paravit- CF™ capsules and liquid in people with CF

(ii) DEKAS Essentials as Amber 1 for adults and children with liver disease

DEKAS Essentials, a new product, is requested for adult and paediatric patients who require vitamin supplementation due to cholestasis and chronic liver disease. The rationale for the request includes the shortage of menadiol formulations and the adherence advantages of a multi-component preparation, as well as reduced cost compared to the sum of individual components. The estimated cost impact is likely to be a substitution against existing formulary options and could be cost saving compared to individual components being prescribed. The estimated cost impact is therefore within the threshold delegated to the Committee.

Members requested clarity on the intended patient cohort as a large number of patients can be included within the cohort of cholestasis or chronic liver disease but would not automatically be offered this supplementation. The Formulary Pharmacist will follow this up with the requesting teams, although the intention is mainly for paediatric patients with cholestasis. The place of DEKAS Essentials within the Drug Tariff was queried as DEKAS Essentials is classified as a borderline substance by the national Advisory Committee on Borderline Substances (ACBS) and is therefore only recommended for prescribing in CF in primary care. It was noted that the if the indication for DEKAS Essentials didn't fit the drug tariff ACBS criteria, it would be difficult to prescribe in primary care, suggesting a red categorisation.

Committee members agreed to defer a final decision on DEKAS Essentials pending clarity on the cohort for whom it is intended and the consequences of the ACBS criteria outlined in the Drug Tariff.

ACTION: Formulary pharmacist to clarify the specific patient cohort and the application of the ACBS criteria in line with discussions to support the final decision on DEKAS Essentials

8. Proposed formulary entry wording for octreotide and lanreotide long and short acting injections for palliative care and gastroenterology indications

Following discussions at the last meeting regarding inclusion of long acting octreotide and lanreotide for palliative care, wording has been drafted for the formulary entries for approval by the Committee. The proposed wording covers new entries for the long-acting formulations of octreotide and lanreotide and updated wording for the existing entries for octreotide short-acting injection. Wording has also been drafted for new formulary entries related to the use of the long-acting formulations of octreotide and lanreotide in gastroenterology indications (short-bowel syndrome and high output stoma), following discussions at the last meeting.

Members provided feedback on the entries and requested that examples of “intractable diarrhoea” are included for clarity and that the entry notes that clear instructions on dosing must also be provided to the GP. For the new entries relating to the use of the long acting formulations in palliative care, an amendment was requested to clarify that the first prescription for depot means the first month’s prescription from palliative care specialists. A request was made to distinguish the neuroendocrine tumours indication as this fell outside ICB commissioning responsibilities and to include instead a palliative care indication. It was noted that use of for octreotide and lanreotide for primitive neuro-ectodermal tumours was typically symptomatic rather than curative and therefore palliative care should be rated the same as treatment indication.

With respect to the new gastroenterology entries, the Committee agreed that further detail was required for these before they could be approved. This includes criteria for starting/stopping and whether the short-acting formulation would be trialled first. Criteria used to apply for individual funding requests could be used to provide this detail. Additionally there needs to be confirmation of gastroenterology engagement in these entries. These should be presented back to the Committee once updated.

The Committee agreed by consensus to approve the wording for the formulary entries (new and updated) for the palliative care indications pending the amendments discussed. Once updated, this can be progressed for approval via IMOC Chair’s action.

ACTION: Formulary entries for palliative care (new and updated) to be amended in line with discussions and shared with IMOC team for Chair’s action. Once approved, formulary to be updated
ACTION: Formulary entries for specific gastroenterology indications to be discussed with gastroenterology teams and updated in line with discussions for re-presentation to Committee

9. Paediatric formulary re-categorisation of morphine 500 mcg/5ml oral liquid from Green to Red

This request is to recategorise morphine 500 mcg/5mg oral liquid, an unlicenced special used predominantly in paediatrics, from the current green to red (hospital only) RAGG category. This approach is endorsed by NHS England (NHSE), The Royal College of Paediatrics and the Child Health (RCPCH) and the Neonatal and Paediatric Pharmacy Group (NPPG) following adverse incidents involving this preparation nationally. There is no evidence that GPs in SEL had prescribed such a treatment in the absence of specialist advice. The change in category is in response to some serious incidents nationally where the dose had not been clear to primary care or parents and an infant had received an overdose. Morphine 10mg/5ml oral liquid preparation would remain on the formulary as a RAGG category Green medicine for other uses. It was clarified that although a national patient safety alert has not currently been issued, the potential for confusion evidenced from the incidents nationally warranted the change. Committee members supported the change but requested that the Medicines Safety Network is sighted. The need for clear messaging via the OptimiseRx system for primary care was strongly emphasised and this should be further planned through the Medicines Safety Network.

The Committee agreed by consensus formulary re-categorisation of morphine 500 mcg/5ml oral liquid from a Green to Red RAGG category.

ACTION: Paediatric formulary entry for morphine 500mcg/ml oral liquid to be re-categorised as red
ACTION: Medication Safety Network to be briefed on the recategorisation

10. Updated psoriasis biologic drug treatment pathway

The author was in attendance to present the update with the Borough lead for dermatology supporting. The psoriasis pathway has been updated to include deucravacitinib, in line with recommendations made by the National Institute for Health and Care Excellence (NICE) in technology appraisal (TA) 907. As deucravacitinib is an oral formulation, it is noted as a first line option for needle-phobic patients. The efficacy data are similar to that for adalimumab, and it has a reasonable side effect profile. Approximately 50 patients are anticipated annually in SEL. Separately, further updates had been made to the pathway to include licenced dose escalations for bimekizumab, secukinumab and guselkumab. It

was noted that no significant resource impact is anticipated from deucravacitinib as other advanced treatments are comparably priced. In response to a query regarding the process for de-escalating patients once their doses are escalated, the presenter confirmed that a16 week review would be undertaken in all escalations to determine any improvements. In practice, escalations were rare and often only resorted to for a short period before switching to another drug. Members noted that the associated outcomes monitoring framework associated with this guideline in planned for review.

The Committee noted that in terms of resource impact, this fell within the threshold delegated to the Committee as a significant cost pressure was not anticipated. The Committee approved the updated pathway by consensus.
Post meeting note: *The IMOC team advised the author of some minor formatting amendments required within the document, which the author will address.*

ACTION: Author to make post meeting minor formatting amendments and share final version with IMOC team

11. Formulary request for FreeStyle Libre 2 Plus flash glucose monitoring sensor as Amber 1 for Type 1 Diabetes (adults, children and young people)

The Consultant Pharmacist for diabetes and a consultant diabetologist were in attendance to present this item. A declaration of interest was noted for the Consultant Diabetes Pharmacist. The Committee heard that Freestyle Libre 2 (FSL-2) devices are now being extensively used in people with type 1 diabetes (T1DM) for glucose monitoring. A new Freestyle Libre 2 Plus (FSL-2 Plus) device is now available at the same cost but slightly better accuracy, which lasts for 15 days rather than 14 days. It is also compatible with Omnipod® closed loop pumps. and has a cost advantage other compatible devices. Freestyle Libre 2 Plus is an easy switch for patients already on FSL-2 and this will be carried out in a phased way. With respect to the resource impact, the cost is a substitute cost for those currently on Freestyle Libre 2 sensors so no additional impact is expected. There may also be some cost savings in those on the Omnipod® 5 hybrid closed loop. The resource impact is therefore within the financial threshold delegated to the Committee.

Members requested the authors to consider how the new devices could best be accommodated within the overarching guidance for continuous glucose monitoring (CGM), whilst minimising the need to revise the guidance with each new device. In the interim, it was suggested that the formulary entry makes clear the position for use and that the local guidance is under review. It was noted that the application is for adults and paediatrics and that the summary document in the agenda pack states that “Freestyle Libre 2 continuous glucose monitoring (CGM) sensors are currently on the SEL joint medicines formulary in line with previous IMOC applications”. It was clarified that current approval only covers adults with Type 1 diabetes. Guidance on the use of CGM in children and young people with Type 1 diabetes has not yet been approved as the amended documents are awaited from the authors post discussion at the April 2024 IMOC meeting. Once received they are to be progressed to the Executive Committee for financial sign off. The presenters advised that paediatrics had less utilisation of FSL-2 due to the functionality but paediatrics would be made aware of this.

The Committee agreed by consensus the inclusion of Freestyle Libre 2 Plus flash glucose monitoring sensor as Amber 1 for T1DM in adults. Paediatric inclusion is also supported but pending sign-off of the CYP CGM guidance.

ACTION: Authors to determine wording within the CGM guidance/resources to address future iterations of devices and update guidance accordingly
ACTION: Freestyle Libre 2 plus to be added to the SEL adult formulary with information included that the CGM guidance documentation is under review to incorporate this new device. Paediatric formulary inclusion to be completed one the paediatric CGM guidance is signed off

12. Updated guidance for self-monitoring of blood glucose (SMBG) in adults

The Consultant Diabetes Pharmacist presented this updated guidance. The amendments made are highlighted throughout the document. NHS England (NHSE) published a list of preferred blood glucose

test strips, ketone test strips and lancets for the NHS to implement to ensure that there is value for money from these devices nationally. Discussions through the diabetes sub-group of the IMOC and discussions with primary care colleagues found that a further streamlined list of preferred test strips and meters would simplify education for staff, patients and increase consistency across SEL. Companies listed in the NHSE recommended list were invited to present to local nurse and pharmacist specialist diabetes colleagues from across SEL. After testing the devices, a condensed, preferred list for SEL was agreed through the diabetes sub-group. The existing blood glucose testing guidance for adults has been updated to include this "SEL preferred list" as an appendix. The guidance covers adults only at this stage due to potential changes in national guidance for children and young people. Information reflecting the use of CGM has also been added to the guidance, including that those on CGM will still require some blood glucose testing. As part of the consultation on the draft guidance, there is a request to update the IMOC webpage title from 'flash glucose monitoring' to 'continuous glucose monitoring'.

The presenter noted that a correction to the introduction section of the guidance had been requested since the papers had been circulated, where reference to "hypoglycaemia" should be "hyperglycaemia". This change will be made post meeting. Members recommended that in view of a national preferred list from NHSE, the author ensures they have recorded a clear rationale and process for the condensed list being recommended in SEL. The author noted that for some patients, other devices may be more suitable and could be selected from the NHSE recommended list. The authors were requested to make the wording in the guidance clear that the NHSE list is available to use and select from and that the SEL condensed preferred list aims to simplify choice locally.

The Committee approved the updated guidance by consensus pending the changes discussed.

ACTION: Authors to ensure their processes in agreeing the SEL list are documented and available to share for information
ACTION: Authors to update the guidance in line with discussions and share back with IMOC team for Chair's ratification
ACTION: IMOC webpage title to be updated 'flash glucose monitoring' to 'continuous glucose monitoring'

13. Standing items – items for information

- *Formulary submissions tracker*

Noted.

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

The summary was noted, and RAGG categories were agreed by consensus.

- *For information and noting:*

- RMOC update – nil for this meeting, RMOC meetings are paused.
- Adult and paediatric formulary updates – noted by Committee members.
- Interim medicines monitoring guidance during reduced pathology capacity – noted by Committee members.

14. Any other business

The Chair informed members that the GP Clinical Leads for Medicines Optimisation in Greenwich and Lambeth were changing and thanked the current leads for their contributions to the Committee's work.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 15th August	2pm-4:30pm	Hybrid - MS Teams and face-to-face
Thursday 19th September	2pm-4:30pm	MS Teams
Thursday 17th October	2pm-4:30pm	MS Teams