South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
15th August 2024 (Hybrid meeting held in person and 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 noted to be 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.

Matter arising: DEKAS® Essentials in liver disease - Advisory Committee on Borderline Substances (ACBS)

The Formulary Pharmacist presented this item following discussions at the previous IMOC meeting in July 2024 and the request for clarifications on the specific cohort and the ACBS position for use in liver disease. The cohort has been clarified as predominantly children and adolescent patients with cholestasis and chronic liver disease. Vitamin supplementation is important for this cohort as they are growing and at high risk of complications. An updated version of the formulary request form was also shared on screen, which includes reference to the European Society for Paediatric Gastroenterology Hepatology and Nutrition guidelines on supplementation. Adults had been included in the original request to support the transition from paediatric to adult liver care services. It has been confirmed that multi-vitamin supplementation is not routinely continued in adult liver patients. The ACBS has been contacted regarding prescribing outside of ACBS criteria and they have advised that the ACBS list is advisory; clinicians could prescribe outside the list if felt to be in the patient's best interest with a rationale to support such use. DEKAS® Essentials liquid is not currently listed within the Drug Tariff. Pending the addition of DEKAS® Essentials liquid to the ACBS list, and the outcome of further enquiries with local and specialist dieticians, the Committee were asked to consider the inclusion of DEKAS® Essentials capsules with a "red, amber, green, grey" (RAGG) category of Red in the paediatric formulary.

Committee members agreed that for primary care prescribing, further consideration should be given to robust initiation and stopping criteria, the patient cohort and indications. If there remains a desire to request prescribing in primary care, the Trust should take these factors into consideration as part of any resubmission to the Committee. It was agreed that DEKAS® Essentials capsules only will be included at present and only within the paediatric formulary. The Committee approved by consensus the addition of DEKAS® Essentials capsules as Red to the paediatric formulary.

ACTION: Paediatric formulary to be updated with DEKAS® Essentials capsules entry

4. **Updated position statement for direct oral anticoagulants (DOACs)**

The author was in attendance to present this item with support from the Lead Medicines Optimisation Pharmacist. Changes in the direct oral anti-coagulant (DOAC) market have resulted in the introduction of generic apixaban and rivaroxaban and the existing position statement for DOACs has been updated to reflect this. These generic products present a significant potential cost saving to the NHS. With the Drug Tariff expected to reflect these changes early in September 2024, the proposal was to recommend the use of apixaban and rivaroxaban as first line DOAC agents within SEL. The Lead Pharmacist also tabled a slide (shared on screen) outlining that a number of DOAC guidelines with specific reference to particular DOACs have been identified and will require minor updates to reflect the new recommendations. The Clinical Effectiveness South East London (CESEL) Guide for

Atrial Fibrillation may also need a review through the CESEL team. The position statement has also been reviewed and discussed through the Medicines Value Group.

In relation to a query regarding updates to existing DOAC guidelines, the Committee were requested to consider, in view of the relatively minor changes to be made, whether the amended documents could be approved through IMOC Chair's action, without broader consultation. The Committee agreed that the updated DOAC guidelines could be approved by Chair's action, given the changes were minor and the resources need to align to the position statement. Members noted that there is an increased focus on the use of best value DOACs, with a specific indicator included in the national Medicines Optimisation opportunities. Some minor amendments were requested by Committee members to the positioning and formatting of wording – including signposting to the general link for the Summary of Product Characteristics (SmPC) rather than a specific generic product.

The Committee approved by consensus the updated DOAC position statement pending the agreed changes.

ACTION: Author to update Position Statement and relevant DOAC guidelines in line with discussions and share back with the IMOC team to progress for IMOC Chair's ratification.

5. Low molecular weight heparins choice of product and updated guidance
(i) Formulary request for Inhixa® (biosimilar enoxaparin)
(ii) Updated SEL guidance for prescribing enoxaparin in primary care

The lead author (main presenter) and supporting presenters were in attendance to present this item.

(i) Formulary request for Inhixa® (biosimilar enoxaparin)

The main presenter noted that Guy's and St Thomas' NHS Trust (GSTT) and King's College Hospital NHS Trust (KCH) will be transitioning to biosimilar enoxaparin (Inhixa®) as their preferred low molecular weight heparin (LMWH) in adults. Lewisham & Greenwich NHS Trust (LGT) implemented biosimilar enoxaparin a few years ago and this change will unify the choice of LMWHs across SEL for adults. Whilst enoxaparin is the preferred LMWH at KCH and LGT, dalteparin (Fragmin®) is currently the preferred LMWH at GSTT and is assigned a red RAGG category (hospital prescribing only), following a unilateral switch to dalteparin at GSTT over a decade ago. Biosimilar enoxaparin would remain as an Amber 2 RAGG category in the SEL adult Joint Medicines Formulary (JMF) with no changes to the approved indications. However, there will be an impact on primary care prescribing when switching from dalteparin to biosimilar enoxaparin as there will be patients on long term treatment with dalteparin who will have their prescribing moved to primary care under the Amber 2 category indications. The presenters outlined that it is estimated there are a number of patients prescribed dalteparin at GSTT for the long term indications, essentially:

- Patients requiring anticoagulation but unable to take oral anticoagulant therapies
- Treatment and secondary prevention of deep vein thrombosis (DVT)/pulmonary embolism (PE) in patients with cancer

New patients requiring LMWH treatment would be prescribed Inhixa® if suitable and patients already established on other LMWH therapies would gradually be switched to Inhixa®. All transitions from other LMWH to Inhixa® would be led by the specialist secondary care teams on a rolling clinic appointment basis, with three months' supply of Inhixa® issued by the specialist before maintenance prescribing is requested in primary care. Robust internal processes and comprehensive training programmes have been planned by the acute trusts to mitigate risks. These will undergo approval through the Trust Drug and Therapeutics Committees. Inhixa® is a biosimilar of enoxaparin, therefore brand prescribing is recommended.

The switch to biosimilar enoxaparin will result in significant savings to the Trusts. The cost impact to primary care from switching dalteparin to biosimilar enoxaparin is estimated to be within the financial threshold delegated to the committee. It was acknowledged that the overall savings reflect system wide savings for the local health economy. The presenter confirmed that the switch will be completed between September and December 2024. No cost impact is expected in primary care when switching from Clexane® to Inhixa®, as the list prices are the same, therefore this switch will be cost-neutral.

Transitioning to Inhixa® as the preferred LMWH in SEL may also benefit from a more robust supply chain given historical supply difficulties with LMWH.

(ii) Updated SEL guidance for prescribing enoxaparin in primary care

The existing guidance for prescribing enoxaparin has been updated to reflect the change to Inhixa® across SEL. Overall, other changes to the guideline are minimal and highlighted within the document, the main changes include:

- Key messages at the start of the document regarding Inhixa® and brand prescribing.
- Signposting to a training video demonstrating administration of Inhixa®
- Clarification under the indication of "Treatment and secondary prevention of DVT/PE in patients with cancer" that DOACs are usually used first line.

It was noted that whilst training and education for hospital and community teams will be progressed, the plans for communications to primary care or patients seem less clear. Members queried what the communication plan was for primary care, community pharmacy and patients. The presenters confirmed that patient training would occur during specialist clinics, where suitability of switching to Inhixa® can be assessed. Discharge/clinic letters would provide the main patient and primary care communications and the primary care newsletter will be used to communicate the changes to choice of LMWH to primary care. Communications will also be shared with the Local Pharmaceutical Committee to keep community pharmacists informed to these changes, along with borough based community anticoagulation clinics. The communication plan for KCH also requires confirmation. A comment was made that communications to primary care, community pharmacies and anticoagulation clinics would need to be clear when recommending brand prescribing for Inhixa® as generic prescribing is emphasised during medical training. It was noted that primary care prescribing data, included in the meeting paperwork, shows there is some dalteparin prescribing in primary care and there is substantial generic (non-brand) prescribing of enoxaparin, which would need to be reviewed. The applicant agreed these patients would need a future review and this will be discussed through the CVD sub-group.

Members welcomed the proposal that the clinic would make the switch. In response to a query about how monitoring of community prescribed enoxaparin would be undertaken, the applicant advised prescribing numbers would be monitored and if significant changes were noted, they would advise if additional audits were required. Committee members agreed this should be managed through the CVD sub-group. It was noted that the wording in the guideline under the treatment and secondary prevention of DVT/PE in patients with cancer needed a minor amendment.

The Committee approved by consensus the proposal to switch to Inhixa® as the LMWH of choice in SEL, pending the agreed amendments and follow up as discussed.

ACTION: Leads to confirm communication plans as discussed
ACTION: Author to update enoxaparin guideline with amendment discussed and share with the IMOC team to progress for ratification by Chair's action

6. Formulary application for insulin lispro (Lyumjev™) in adults with diabetes mellitus

This formulary submission originates from a Consultant Diabetologist at GSTT. The application requests the inclusion of an insulin lispro (Lyumjev®) as an additional second line, ultra-fast acting insulin (after Humalog®) for the treatment of diabetes mellitus in adults. Lyumjev® would be an alternative to Fiasp® within the treatment pathway and be subject to the same criteria for use as Fiasp® where the first line fast-acting insulin does not provide adequate post-prandial plasma glucose (PPG) control.

- Adults with Type 1 diabetes mellitus or cystic fibrosis related diabetes
- Pregnant women with diabetes (Type 1 or Type 2) or gestational diabetes where post prandial control is of particular importance for foetal health
- Where a post-meal insulin injection would be of benefit to PPG control due to social, physiological or psychological reasons

The diabetes sub-group, which includes representation from all three acute Trusts, primary and intermediate care teams, has reviewed and supported the application. The application requests a RAGG category of Amber 2 for Lyumjev®, with initiation by specialist diabetes teams before primary care continue maintenance prescribing, in line with current criteria for use of Fiasp® (rapid acting insulin aspart).

- **Evidence review**

The formulary pharmacist provided an overview of the evidence base - 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 Lyumjev in this setting. The information presented also included the estimated resource impact for Lyumjev in this setting. The resource impact of the submission is within the financial threshold that the Committee has delegated authority to approve. Limiting postprandial plasma glucose (PPG) excursions in diabetes is one of the most challenging aspects in achieving adequate glycaemic control. Rapid-acting insulin analogues such as insulin aspart (NovoRapid®), and insulin lispro (Humalog®) aim to control PPG excursions via a faster onset and shorter duration of action. Guidelines from the National Institute of Health and Care Excellence (NICE) for Type 1 and Type 2 diabetes set out the positioning of different insulin regimens.

Lyumjev® is mealtime insulin and a novel formulation of insulin lispro classed as ultra rapid lispro (URLi) that is licensed for the treatment of diabetes mellitus in adults, adolescents and children aged 1 year and above. It is recommended to be administered up to 2 minutes before the start of the meal, with the option to administer up to 20 minutes after starting the meal.

With respect to the evidence base, no head-to-head data exist comparing URLi formulations and studies aim to show non-inferiority with lispro. One RCT in adults with type 1 diabetes showed that mealtime and post-meal URLi demonstrated non-inferiority to lispro for HbA1c and glycaemic control, with mealtime URLi demonstrating a 37% lower rate of severe, documented and postprandial hypoglycaemia in the period less than four hours after a meal. Similar noninferiority was confirmed in another RCT in patients with type 2 diabetes where significantly lower PPG excursions were evident from 0.5 to 4.0 hours post meal with URLi treatment. Safety studies of URLi have demonstrated a safety profile similar to lispro. It was highlighted that biosimilars are available for Humalog® and offer savings on the current usage of insulin lispro, although it was noted that the application restricts Lyumjev® to 2nd line.

The completed insulin safety checklist enclosed in the agenda pack as part of the submission was noted by Committee members.

- **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 presenter outlined the rationale for the application was based on a strong, SEL-wide clinical need to treat patients who required better post-meal glycaemic control. The addition of Lyumjev® would also provide an alternative supply of insulin during ongoing shortages of Fiasp® (rapid acting insulin aspart) and provide an alternative insulin analogue in patients experiencing adverse skin reactions with other formulary included ultra-fast acting insulins as the additives in Lyumjev® are different.

In response to a query regarding the evidence base and the tighter control of PPG being a secondary outcome measure in the studies, the presenter noted that the impact on HbA1c was found to be non-inferior. The non-inferiority of Lyumjev® was outlined in subsequent studies which showed reduction in postprandial glucose excursions, as well as less hypoglycaemic episodes in the late postprandial period. Lyumjev® was designed to be rapid in the onset and cessation of action, unlike standard analogues which remain active up to six hours post dose. Improved postprandial glycaemic control could improve cardiovascular risk in intensively managed patients. It was also confirmed that in practice the use of Lyumjev® 20 minutes post meal would generally not be recommended in clinical practice, which advocates taking insulin at least 7-10 minutes before the meal. A very small cohort of

patients would take insulin after eating, for example where severe anxiety about hypoglycaemia exists.

With respect to the availability of head-to head studies between Lyumjev® and Fiasp®, the applicant confirmed that no studies are planned. In terms of safe prescribing, it was confirmed that Lyumjev® would be subject to hospital or specialist initiation only, with clear communication to primary care after a period of supervision, specific communications to primary care would be developed. Only the 100 unit/mL formulations have been included in the application and based on the intended clinical need, only a small proportion of patients will require Lyumjev®. The presenter also noted that where biosimilars already exist they would remain first line with ultra rapid acting insulins remaining as the second line therapy. The diabetes sub-group has recognised biosimilars as a focus area, however there are complexities involved with introducing biosimilars to patients already established on insulin. The main opportunity for biosimilars would be those using insulin for the first time.

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

Members discussed the application and no additional concerns were noted. The Committee felt that the rationale for inclusion in the formulary for a specific patient cohort was justified by the applicant. It was noted that the criteria quoted in the formulary application were identical to Fiasp® and the Committee agreed by consensus that an Amber 2 categorisation was appropriate.

The Committee approved by consensus the formulary application for Lyumjev® 100 units/mL in adults with diabetes mellitus.

ACTION: Formulary recommendation to be drafted and presented at a future meeting
ACTION: Adult formulary to be updated to include Lyumjev® insulin as Amber 2 once formulary recommendation is approved

7. Annual review of the Terms of Reference (ToR) for the SEL IMOC (2024/25)

The Committee's Terms of Reference (ToR) had been extended to October 2024 to enable the re-organisation of the Integrated Care Board (ICB) to be completed and new organisational structures established. As the process is now completed, a review of the ToR has been progressed, as highlighted in the paperwork enclosed in the agenda pack. The main changes made to the ToR include:

- Changes in membership to reflect the changes in the ICB structure and reduced capacity. This now includes two borough Assistant Directors for Medicines Optimisation attending the meetings instead of six (previously one from each SEL borough), attendance will be on a rotational basis between the borough medicines optimisation leads. The six borough GP representatives would continue to represent their respective boroughs. Two Associate Chief Pharmacists will also form part of the core membership.
- It is proposed that the reporting arrangements for the Committee are revised and the Committee will now report to the Executive Committee. There will be informal reporting to the Quality and Safeguarding Committee on issues relating to quality, including medicines safety and antimicrobial stewardship.
- Votes allocated per organisation have been included for clarity.
- In line with information added to the guideline development and formulary application processes last year in relation to overprescribing, references to learning disability and autism (LDA) have similarly been added to the ToR following a request from the LDA Medicines Optimisation team. This includes consideration of reasonable adjustments for people with LDA, such alternative formulations.
- The LDA, sustainability and overprescribing aspects have also been included within the item to discuss abridged formulary request form.
- The urgent triage panel process used in emergency situations has been formally included as an appendix.

- Other changes are minor/formatting related and include removal of references to the Regional Medicines Optimisation Committee (RMOC), replaced with references to NHS England.

Members discussed the updated ToR and there was a suggestion that it would be helpful to reconsider a lay /public member in the membership of the Committee as they could bring an additional perspective to the discussions. It was noted that when the Committee was originally set up the lay/public member representation was included but attendance was poor. Additionally previous discussions at the Committee had concluded the patient engagement would be best achieved through the subgroups of the committee. Members supported the potential value that a broader patient perspective and independent challenge could offer but agreed that to work well, the public membership would need to be well managed and well informed to ensure full engagement with the meeting. It was agreed that lay / public member representation would be explored with the SEL patient engagement team and added to the optional membership of the Committee. A minor amendment was also requested to the items to discuss form to include anticipated SEL patient numbers when a formulary request is made.

It was noted that the reporting arrangements described for the committee require confirmation.

The Committee approved the revised ToR by consensus, pending amendments in line with discussions, to be approved via Chair's action. Consideration will be given to including more general information on reducing health inequalities in the next scheduled review of the ToR.

ACTION: Author to amend the ToR in line with discussions before progressing for ratification via Chair's action and then to the Executive Committee for approval

8. Updated oral nutritional supplement (ONS) guidelines

The authors were in attendance to present this item. The main presenter advised that there were no major clinical changes to the guidelines since IMOC approval was last obtained, but two new documents had been added to the adult ONS resources and one new document added to the paediatric cow's milk allergy (CMA) resources.

(i) Adult ONS prescribing guideline and associated resources

To complement the main adult ONS guideline, a new summary guideline has been developed for simplicity and ease of use. Both the main and summary guidelines have been updated to clarify they are not for use in enterally fed patients. A new 300 calorie booster diet sheet has been developed to support the transition from supplements to food based interventions. Evidence based sustainability elements have been introduced throughout the documents, including a sustainability statement and plant-based food recommendations. Guidance to support the nutritional management of bariatric and obese patients has been added and minor updates made to the ready reckoner and dietetic contact lists. Other updates mainly reflect formatting changes.

(ii) CMA prescribing guideline and associated resources

The main paediatric CMA guideline title has been changed to provide clarity of use to "Prescribing of Hypoallergenic Formula" and associated forms have been aligned to ensure correct allergy service referrals. Information relating to non-validated allergy testing, age to cease formula guidance and step down from amino acid formula guidance have been updated in line with national and European guidelines. A new standard operating procedure (SOP) has been produced to support GPs and pharmacists who receive prescriptions from private healthcare providers requesting products that are not in line with SEL guidance.

With respect to the 300 calorie booster diet sheet, the presenters clarified that the examples of foods do not always amount to 300 calories and the form does include a caveat statement that examples vary from 200-400 calories. The examples reflect achievable portions, for example a handful of nuts rather than a specific number. It was also confirmed that a tablespoon measurement is a standard flat measure rather than a heaped tablespoon. Members requested that a signposting link is included in

the new bariatric /obese patients section within the adult ONS guidelines to the adult bariatric surgery medicines optimisation guideline, which covers vitamin supplementation.

Members queried the reasoning for the different review dates across the documents. The authors suggested three yearly reviews for the main documents, which were unlikely to change clinically and annual reviews for other resources to ensure prices, RAG ratings and contact details were up to date. Committee members agreed that a three year review date for the main documents would be acceptable with more regular review for the associated resources.

The Committee approved by consensus the new guidance resources and updated guidelines pending the agreed changes.

ACTION: Authors to include reference to the IMOC adult bariatric surgery medicines optimisation guideline within the relevant section of the adult ONS guideline
ACTION: Authors to update the documents in line with the meeting discussion before sharing with the IMOC team to progress for ratification via Chair's action

9. Formulary request for inclusion of the 2-monthly formulation of aripiprazole long-acting injection (LAI)

For this request, the applicant outlined that aripiprazole long-acting injection (LAI; Abilify™ Maintena™) monthly preparation is RAGG categorised as Amber 3 (shared care) in the adult JMF. This formulary request is to include a new two-monthly aripiprazole LAI to the formulary, also as Amber 3.

Patients who are stable on one-monthly injections may be switched to the two-monthly preparation. The two-monthly LAI presents a cost saving due to the need for fewer appointments for administration. Additionally there are savings for the Trusts due to reduced acquisition costs for specialist providers (discounts are commercial in confidence). The transition is anticipated to be cost-neutral in primary care and therefore within the financial threshold delegated to the Committee. The presenter also described several patient benefits including fewer painful injections per year which result in time, travel and financial savings to patients. In response to a query regarding where the switching process would occur, the presenter confirmed that all switching would be completed by the mental health teams, primary care would not be expected to change suitable patients over. Members noted that the existing shared care guideline for aripiprazole monthly LAI will need to be updated to reflect the inclusion of the two-monthly reparation.

The Committee approved the formulary request for inclusion of the 2-monthly formulation of aripiprazole long-acting injection by consensus. The shared care guideline update will need to be progressed by the presenter.

ACTION: Applicant to update shared care guideline for aripiprazole LAI for review and approval by the Committee
ACTION: Adult formulary to be updated to include aripiprazole two-monthly long-acting injection

10. Decline to prescribe patient notification letter

The author was in attendance to present this template letter, which was requested by the Committee following the update to the SEL formulary feedback letter in February 2024. The patient letter has been developed for practices to notify patients of the status of their prescribing transfer request. The letter has been developed and designed to reflect the format of the practice feedback letter to the referring specialist. The language has been modified to reduce jargon and increase recipient readability and understanding. Community champions also reviewed the letter and their recommendations to remove reference to RAGG colours and unnecessary information have been actioned. Borough teams have also provided feedback and many of the comments had been incorporated.

Following comments from members, it was agreed that the sentence referring to “IMOC” would be re-worded to “‘in line with arrangements in South East London for medicines’ to maintain document simplicity. The phrase ‘mark and delete as appropriate’ seemed unnecessary and would leave the final letter with a single ticked box which may be confusing. The author agreed to rephrase the statement to ‘please delete as appropriate’ and use bullet points rather than tick boxes.

The Committee approved the decline to prescribe patient notification letter by consensus subject to the amendments discussed followed by IMOC Chair’s approval.

ACTION: Author to update the documents in line with the meeting discussion and share with the IMOC team to progress for IMOC Chair’s ratification

11. 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, where it was possible to confirm the RAGG status.
- For information and noting:
  - RMOC update – nil for this meeting, RMOC meetings are paused.
  - Interim medicines monitoring guidance during reduced pathology capacity – noted by Committee members.
  - Updated ICB medicines optimisation staff structure – noted by Committee members.

12. Any other business

Members were advised that declarations of interest information would be shared to support committee members when updating their declarations.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 19th September	2pm-4:30pm	MS Teams
Thursday 17th October	2pm-4:30pm	MS Teams
Thursday 21st November	2pm-4:30pm	MS Teams