South East London Integrated Medicines Optimisation Committee Meeting
16 June 2022 (Meeting held via MS Teams)
Final Minutes

1. Welcome, introductions and apologies

The Chair welcomed attendees to the meeting followed by a round of introductions. 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 annual declarations be returned. No conflicts were raised.

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

The action notes and minutes were accepted and approved as an accurate record pending corrections to minor grammatical errors and the following additions:

- Agenda item 6 – inclusion of the sentence "The form has been updated following advice from NHS England and Improvement."
- Agenda item 9 - inclusion of "and outcomes and monitoring framework**"** to documents approved by the Committee.

Members were provided with an update on progress against actions due for this month, these were noted, and items closed were agreed.

4. Updated lipid management pathways

Further updates to the lipid management pathways are required. In line with this, the agenda item has been deferred to a future IMOC meeting.

5. Re-presentation of updated guideline for the use of sodium glucose co-transporter 2 inhibitors (SGLT2i) in patients with heart failure with reduced ejection fraction (HFrEF) without diabetes mellitus

The author was in attendance to re-present this item which has been updated in line with discussions from the last meeting.

To support the Amber 1 recategorisation of SGLT2i's (dapagliflozin and empagliflozin) in HFrEF without diabetes mellitus (DM) discussed at the last meeting, a request was made for patient information leaflets (PIL) available to support the safe and appropriate prescribing of SGLT2i in primary care to be presented to the Committee. The SGLT2i in heart failure (HF) PIL from KCH and HF medicines PIL from GSTT was shared. LGT do not have a specific trust PIL, however provide patients with a generic manufacturer leaflet; LGT have fed back they would be happy to adopt the KCH and GSTT PIL.

Committee members agreed there was merit in promoting the use of both PILs across SEL with permission from the Trusts.

The Committee agreed by consensus the updated guideline for the use of SGLT2i in patients with HFrEF without DM and the recategorisation of SGLT2i's in this patient cohort from Amber 2 to Amber 1.

ACTION: Dapagliflozin and empagliflozin for the management of HFrEF without DM to be categorised as Amber 1 within the SEL JMF.
ACTION: GSTT formulary pharmacist to confirm if GSTT PIL is the final version and available via the GSTT website.

6. Updated neuropathic pain guideline and associated resources

The authors were in attendance to present the following updated documents:

- Pharmacological management of neuropathic pain in adults in primary care guideline
- Guide to deprescribing lidocaine 5% plasters in primary care
- Lidocaine plasters for the treatment of post-herpetic neuralgia and focal neuropathic pain with allodynia position statement

The updates to the guideline and associated resources are highlighted and provided within a summary document in the agenda pack. The guideline and associated resources have been updated in line with clinical expertise from local pain specialists, the neuropathic pain subgroup and a SEL wide consultation.

Comments were raised regarding the availability of an OptimiseRx message to support the brand prescribing of Ralvo™ in primary care to support implementation. The authors confirmed there isn't an OptimiseRx message currently available, however this will be fed back and developed via the local OptimiseRx group. Minor updates to the guideline and supporting template patient letters within the lidocaine plaster deprescribing guide were fed back to the authors which included the creation of template text messages which could be used instead of patient letters.

The Committee approved the neuropathic pain guideline and associated resources by consensus pending updates in line with the discussion.

ACTION: Updated neuropathic pain guideline and associated resources to be updated in line with the discussion and progressed for ratification via Chair's action.

7. Re-presentation of SEL good practice guidance for the safe use of 'When required' (PRN) medicines in care homes

The Bromley Assistant Director of Medicines Optimisation team presented this item following updates to the guidance in line with discussions from the April IMOC meeting, where consultation with the Local Pharmaceutical Committee (LPC) was requested.

A comment was raised regarding the recommendation for care homes to contact emergency services out of hours for patients who take PRN medication continuously for 3 days or more and whether this would cause increased pressure on out of hours/emergency services. The presenter confirmed this is the safest option for specific high risk patients, however the urgent care centres monitor the groups of patients they see and if the number of care home patients seen increases significantly, this will be fed back.

The Committee approved the guidance by consensus.

8. Revised estimated cost impact for implementing NICE recommendations on the use of SGLT2i in people with Type 2 diabetes with cardiovascular risk

The author was in attendance to present this item via a presentation slide deck provided at the meeting. In line with the updated Type 2 diabetes mellitus (T2DM) glycaemic control management guideline presented at the last IMOC meeting, further information was provided regarding the factors which affect the costings for SGLT2i in T2DM. The next steps for financial approval for the use of SGLT2i in T2DM locally was outlined to the Committee

The Lead IMOC Pharmacist noted the complexity of the estimated cost impact for implementing SGLT2i in patients with T2DM with cardiovascular risk and that this should be seen as an investment in medicines which in the long term would result in savings in other areas of the healthcare system (such as reduced complications and hospitalisations). The Committee thanked the SEL Consultant Pharmacist for diabetes and Lead SEL IMOC pharmacist for all their hard work and efforts on the estimated cost impact.

ACTION: T2DM glycaemic control management guideline to be presented back at a future SEL IMOC meeting following financial approval from the SEL Finance and Planning Committee.

9. Formulary submissions relating to off-label use of apixaban in haemodialysis patients:

(i) Apixaban (Eliquis™) 2.5mg tablets for the prevention of recurrent venous thromboembolism (VTE) in adults undergoing haemodialysis where vitamin K antagonist (VKA) therapy has been considered or previously used and is determined to be inappropriate

(ii) Apixaban (Eliquis™) 2.5mg tablets for the prevention of stroke and systemic embolism in adult patients with non-valvular atrial fibrillation (NVAF), with one or more risk factors,

undergoing haemodialysis where VKA therapy has been considered or previously used and is determined to be inappropriate

These formulary submissions originate from GSTT - led by a Consultant Haematologist & Clinical Lead for Haemostasis and Thrombosis, Principal Pharmacist for Haemostasis and Thrombosis and Highly Specialist Renal Pharmacist. The applications were not originally supported by KCH as the Trust tends not to anticoagulate this patient cohort unless the patient is at high risk of a stroke or has had a previous stroke. However the Lead formulary Pharmacist for KCH informed the Committee that the KCH renal team have today confirmed they would like to use apixaban in these indications.

The application requests the off-label use of apixaban (Eliquis™) 2.5mg tablets twice daily as a second line option where VKA therapy is inappropriate in adults undergoing haemodialysis for:

i. the prevention of recurrent VTE
ii. the prevention of stroke and systemic embolism (SSE) in patients with NVAF, with one or more risk factors

- **Evidence review**

The Formulary Pharmacist presented an overview of the efficacy evidence for the use of apixaban in the two settings, the detailed review was provided within the meeting agenda pack. The information presented also included the estimated resource impact for apixaban, the resource impact of the submission is within the financial threshold that the Committee is authorised to approve

Post meeting note: The resource impact provided within the evidence review has been updated to include the additional patients identified by KCH.

- **Applicant's presentation**

One of the applicants (Principal Pharmacist for Haemostasis and Thrombosis) and a Haematology Consultant for GSTT (not an applicant) were in attendance to present the submission and field any questions. The applicants and presenters DoI's were noted. The applicant and presenter confirmed that apixaban is considered as a second line option when VKA therapy is determined to be inappropriate in haemodialysis patients at risk of recurrent VTE and SSE. The intended criteria for use were also clarified by the presenters.

- **IMOC discussion after departure of presenters**

Committee members discussed the application and acknowledged that whilst apixaban provides a 2nd line option for patients in this cohort where warfarin is not appropriate, due to the specialist nature, off-label indication and limited evidence, it would be considered unsuitable for prescribing in primary care, in particular from a patient safety perspective.

Committee members ratified by consensus the formulary inclusion of apixaban (Eliquis™) as a second line option when VKA therapy is determined to be inappropriate in haemodialysis patients at risk of recurrent VTE and SSE; categorised as Red (specialist or hospital prescribing only) alongside outcome data to be presented back to the Committee in 12 months.

ACTION: Formulary recommendation to be drafted.

10. Updated dermatology guidelines for primary care

The authors were in attendance to present the updated guideline, which has been reviewed via the dermatology subgroup. The updates to the guideline are highlighted within the agenda pack and incorporate key changes from the National Institute for Health and Care Excellence (NICE), British Association of Dermatologists (BAD) and the Primary Care Dermatology Society(PCDS) as well updates to local services.

In January 2020 the Committee received a request for the use of spironolactone in acne and had deferred a decision pending inclusion of spironolactone to the acne section of the guideline. This has now been included within the updated guideline.

The Committee noted that a wider dermatology network has been set up in SEL and as a result it has been agreed that the referral information will be taken out from these treatment guidelines. As a result

there will be two pathways, a primary care dermatology referral pathway and a primary care dermatology treatment pathway. In line with this the Committee is requested to approve the clinical content of the guideline being presented today only.

The authors responded to queries from Committee members which focused on the initiating clinicians and the desired Red, Amber, Green, Grey (RAGG) for specialist treatments such as betamethasone, fluticasone and tacrolimus for the management of lichen planus and spironolactone for acne. As tacrolimus is not on the local formulary for the management of lichen planus, the Committee agreed tacrolimus should be removed from the guideline until an abridged application form is submitted and discussed at a future SEL IMOC meeting.

A comment was raised regarding the importance of including the need for effective contraception with spironolactone within the guideline and whether spironolactone will primarily be used in adolescent female patients. The author confirmed spironolactone will be indicated for patients with hormonally mediated acne e.g. acne caused by PCOS and peri-menopausal women, who have tried all other treatment options and isotretinoin is not suitable.

The Committee agreed by consensus the categorisation of spironolactone for the management of acne in females and betamethasone and fluticasone used as mouthwash for the management of lichen planus as Amber 2 (*specialist initiation followed by maintenance prescribing in primary care)*. This detail will be added to the guideline in the relevant sections. Final approval is pending the updates to the guideline in line with discussions and re-presentation of the guideline at a future IMOC meeting.

ACTION: Guideline to be updated in line with discussions and feedback from the SEL Dermatology Network and presented at a future IMOC meeting for ratification.

11. Formulary inclusion of subcutaneous vedolizumab for the management of inflammatory bowel disease (IBD) following interim approval during COVID-19

The GSTT specialist pharmacist for gastroenterology was in attendance and presented the outcome data following the interim formulary approval via the urgent Triage Panel process for the use of subcutaneous (SC) vedolizumab for the management of IBD (ulcerative colitis and Crohn's disease) during the COVID-19 pandemic.

The outcomes data presented demonstrates variable use of SC vedolizumab across the SEL Trusts which is due to the different cohorts of patients across SEL i.e. more complex patients at particular Trusts. The use of SC vedolizumab has provided an advantage of home administration for patients, cheaper drug cost in comparison to IV vedolizumab and reduction in IV infusion suite costs.

Based on the outcome data and the recommendation from the IBD subgroup that formulary inclusion of SC vedolizumab should be formalised, the Committee agreed by consensus the formal inclusion in the SEL formulary of SC vedolizumab for the management of IBD (RAGG category of red).

12. Pan-London ophthalmology formulary implementation in SEL

The GSTT Formulary Pharmacist presented an update on the Pan-London ophthalmology formulary project which began last year through the London Procurement Partnership (LPP) with endorsement and oversight from the Regional Medicines Optimisation Committee (RMOC). A summary of the discussions with the local ophthalmology leads and CCG representative is provided within the agenda pack.

The resultant Pan-London ophthalmology formulary contains ophthalmology medicines not within the ophthalmology chapter of the SEL JMF, these items were not recommended for adoption locally as local ophthalmologists have confirmed that there is no clinical interest in their use. A few specialist antimicrobial eye drops (majority unlicensed, list provided in the agenda pack) from the project were included in the ophthalmology chapter of the SEL JMF following discussion at the hospital Joint Formulary Committee. Their use will be at an individual basis, and they are all categorised as Red. The Committee noted that the Pan-London ophthalmology formulary is useful as a reference point however in SEL the current ophthalmology chapter of the SEL JMF will be retained. If there is interest to prescribe a medicine within the Pan-London ophthalmology formulary in the future, this can be discussed and ratified through the Committee.

The Committee agreed by consensus to retain the current SEL ophthalmology chapter of the SEL JMF.

13. Establishing an Overprescribing subgroup of the SEL IMOC

The SEL Chief Pharmacist presented this item to request development of an overprescribing subgroup of the SEL IMOC to support the delivery of the national overprescribing review report. The overprescribing subgroup will aim to implement the actions from the national overprescribing review report. The list of proposed members of the overprescribing subgroup is provided within the agenda pack, however additional members have been identified for example, a learning disability representative and links to Age UK.

The Committee agreed by consensus the development of an overprescribing subgroup of the SEL IMOC.

14. Standing items

- Formulary submissions tracker

Noted.

- NICE Technology Appraisal Guidance Summary:

The summary was noted and Red, Amber, Green, Grey (RAGG) categories were agreed by consensus for NICE TAs published since the last meeting.

- British Hepatology Pharmacy Group prescribing weight adjusted oral paracetamol in adults position statement:
  - The position statement has been developed by the British Hepatology Pharmacy Group. The position statement aims to support clinicians identify patients who may require weight adjusted oral paracetamol dosing due to their risk factors for hepatotoxicity.
  - Committee members discussed the feasibility of implementing the position statement in primary care. Various factors were highlighted as barriers to implementation such as inconsistent recommendations within the position statement in comparison to the SPC for paracetamol and the lack of endorsement from the MHRA and/or other national medical organisations for this advice, covering oral paracetamol. This has the potential to cause confusion for prescribers in relation to which guidance they should be following. The issue of over the counter use of paracetamol was also identified as a challenge. Additionally, the British National Formulary (BNF) already advises clinical judgement in adjusting the dose for those with risk factors for hepatotoxicity.
  - Committee members agreed by consensus the position statement was not appropriate for implementation in primary care currently. However the SEL medicines safety group will be a good forum to discuss possible future implementation if more robust recommendations are issued nationally.
- The Committee noted the extensions approved by Chair's action to expiry dates of the SEL interface prescribing policy, NHS and private interface prescribing guide and the interim arrangement for prescribing, monitoring and administration of denosumab (Prolia®) in primary care for the prevention of osteoporotic fractures during the COVID-19 pandemic. No comments were raised.

15. Any other business

No items raised.

IMOC dates for next 3 months

Date	Time	Venue
21st July 2022	2:00pm – 4:30pm	MS Teams
18th August 2022	2:00pm – 4:30pm	MS Teams
15th September 2022	2:00pm – 4:30pm	MS Teams