South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
16th February 2023 (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 action notes and minutes were accepted and approved as an accurate record pending the amendments of minor typographical errors and an update to the content under the isotretinoin discussion. Members were provided with an update on progress against actions due for this month, these were noted, and items closed were agreed.

4. **Re-categorisation of agomelatine for the treatment of depression from Red to Amber 2 supporting guidance for primary care**

   The author presented this item following the approval to recategorise agomelatine from Red to Amber 2 for the treatment of depression, pending the development of supporting guidance for primary care at the November 2021 MPRG meeting.

   A two week supply of agomelatine will be provided on discharge where agomelatine is initiated via the psychiatric liaison service in acute Trusts and GPs will be requested to continue. Where agomelatine is initiated by the local mental health service, transfer of care to the GP will be after a minimum of 6 weeks.

   Comments were raised regarding the difference in time to transfer prescribing to primary care after initiation of agomelatine depending on whether treatment was initiated by the psychiatric liaison service (2 week supply of medication) or the local mental health service (6 week supply and monitoring). Members raised that transfer of prescribing to primary care following a 2 week supply poses a safety risk to patients, given agomelatine requires frequent monitoring in the initial period. The author clarified there is currently no pathway to transfer inpatients who are initiated on agomelatine via the psychiatric liaison service to the Community Mental Health team (CMHT) for continual prescribing and monitoring for 6 weeks.

   A view from Committee members was requested in regard to whether members would be happy to consider approval of this guidance pending updates in line with the discussions at this meeting or whether the guidance requires a SEL wide consultation prior to approval. Committee members agreed by consensus they would be happy for the guidance to be considered for approval by the Committee without wider consultation. However in agreement with the author, as given the concerns raised regarding the 2 week transfer to primary care in situations where the psychiatric liaison service initiates, this section will be removed from the guidance for the current time.

   Committee members recommended further discussions between the author and the psychiatric liaison service to scope out alternative routes for the prescribing and monitoring of agomelatine in this situation and did not approve recategorisation from Red to Amber 2 in this cohort of patients.

   Committee members approved the guidance by consensus pending the requested amendments. For patients initiated on agomelatine by their local mental health service for depression, Committee members also confirmed approval for the recategorisation of agomelatine from red (hospital only) to Amber 2 - a minimum of 6 weeks supply and a minimum of the first 6 weeks monitoring for patients initiated by their local mental health services only.

   ACTION: Author to update the guidance in line with discussions and progress for IMOC Chair's ratification

ACTION: Author to discuss with psychiatric liaison service alternative routes for the prescribing and monitoring of agomelatine as Amber 2 for a minimum of 6 weeks following initiation

5. Formulary re-categorisation of rivaroxaban and apixaban for left ventricular thrombus (LVT) from Red to Amber 2

The applicants were in attendance to present this item with support from the Formulary Pharmacist. The use of rivaroxaban in this setting was discussed and approved as Red by the Committee in 2021 and apixaban was subsequently approved for the same indication as Red via the Joint Formulary Committee processes. Use in this setting is off label.

When the formulary application for rivaroxaban in this setting was presented to the Committee in 2021, it was predicted that a small proportion of patients would require long term anticoagulation. However a recent local Trust audit demonstrated that 80% of patients required long term anticoagulation with rivaroxaban for the management of left ventricular thrombus (LVT) post myocardial infarction (MI) and continual prescribing via the hospital is often an issue, for example patient convenience in accessing their medication via their GP.

Committee members were requested to consider a recategorisation from Red to Amber 2 for rivaroxaban and apixaban in this setting to enable transfer of prescribing to GP practices after 5 months for post MI patients and after 3 months for HF patients, when the need for long term anticoagulation has been determined.

Concerns were raised regarding the use of apixaban and rivaroxaban in this setting where there is limited evidence for use and that the indication is off-label. It was clarified that the evidence review which supported the original formulary application demonstrated a reasonable amount of good quality evidence for the use of rivaroxaban in LVT including a large cohort study. In addition to this, the use of direct oral anticoagulants (DOACs) in this setting is similar to the management of the licensed indication (secondary prevention of a DVT) as the acute management is carried out in a specialist setting and then transferred to primary care if it is to be continued longer term.

A comment was also raised regarding whether a consensus on the use of a single DOAC choice in this setting could be agreed i.e. rivaroxaban, as this is one of the nationally preferred DOACs in primary care and transferring apixaban to primary care could cause confusion in the messages being given to primary care regarding preferred DOACs. The applicants confirmed that it would be useful to have both DOAC choices to enable the most appropriate DOAC to be selected based on patient factors. Additionally, a consensus is lacking between clinicians at the different acute Trusts on the choice of DOAC in this setting.

Committee members agreed by consensus there is currently insufficient evidence and supporting information to support approval of this recategorisation request. Committee members agreed they would be willing to reconsider the recategorisation request in the future if the presenters can provide supporting outcome and safety data from their experience of use thus far to provide reassurances on the concerns raised by Committee members.

6. Updated formulary recommendations

- Withdrawal of clofazimine in combination with clarithromycin and rifabutin as anti-MAP therapy for the treatment of Crohn's disease in adults

The withdrawal formulary recommendation has been drafted following the approval at the December IMOC meeting to withdraw the previous formular approval in this setting on the recommendation of the Inflammatory Bowel Disease (IBD) subgroup.

- Ferric maltol capsules for the treatment of iron deficiency anaemia in adults with inflammatory bowel disease (IBD)

This formulary recommendation has been updated following the approval of the updated treatment pathway for iron deficiency in people with IBD at the December IMOC meeting. Minor amendments have been requested through the Triage Panel review. The presenter clarified that in line with the already existing Amber 2 categorisation, initiation and the supply of the first prescription is via the specialist gastroenterology team.

- Insulin degludec (Tresiba™) for Type 1 and Type 2 diabetes in adults and Type 1 diabetes in children aged 1 – 11

This formulary recommendation has been updated following the approval of the formulary application discussed at the January IMOC meeting to extend the use of insulin degludec to an extended Type 1 patient cohort and Type 2 diabetes patients as well as the recategorisation approval for insulin degludec from Amber 3 to Amber 2.

- Dulaglutide (Trulicity™), semaglutide (Ozempic™) and oral semaglutide (Rybelsus™) for Type 2 diabetes in adults

These three formulary recommendations have been updated following the recategorisation approval at the January 2023 IMOC meeting for GLP-1's from Amber 3 to Amber 2 with the initiation and minimum supply of one month by the diabetes specialist. Minor comments were received regarding the inclusion of a link to the GLP-1 information sheet.

Committee members approved the updated formulary recommendations by consensus pending updates to the ferric maltol and GLP-1 formulary recommendations in line with the comments received.

ACTION: Ferric maltol capsules for the treatment of iron deficiency anaemia in adults with IBD formulary recommendation to be updated and ratified via Chair's action
ACTION: Dulaglutide (Trulicity™), semaglutide (Ozempic™) and oral semaglutide (Rybelsus™) for Type 2 diabetes in adults formulary recommendations to be updated and ratified via Chair's action alongside the supporting GLP-1 guidance documents

7. Apixaban for thromboprophylaxis following deep venous stent insertion post thrombolysis for deep vein thrombosis

This formulary submission originates from GSTT and requests the use of apixaban to reduce and prevent extension of clot burden around deep venous stent inserted post-catheter directed thrombolysis (CDT) as part of first line treatment for acute subclavian and ileofemoral deep vein thrombosis (DVT). GSTT is a tertiary, national specialised centre for the management of these patients.

➢ **Evidence review**

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

➢ **Applicant's presentation**

The applicant was in attendance to present the submission and field any questions. The applicant's DoI was noted. The applicant clarified that the formulary application for the use of apixaban first line in this setting formalises the current practice at GSTT as the national centre for CDT to treat symptomatic iliofemoral DVT. The applicant explained to the Committee that the service at GSTT receives referrals from across the UK. The formulary application also requests a categorisation of Amber 2 (specialist initiation followed by transfer of care to primary care) for the use of apixaban in this setting, which has also been discussed with the CVD subgroup.

Comments were raised regarding the rationale of recommending apixaban as first line treatment in this setting despite the limited evidence for use and the available evidence supporting the use of warfarin or rivaroxaban, where a DOAC was used. The applicant clarified that the choice of apixaban is based on local experience where apixaban has demonstrated better bioavailability and stent patency rates in comparison to rivaroxaban. In addition to this, as this patient cohort is young, the use of apixaban provides better compliance in comparison to warfarin.

Another comment was raised in relation to the Trust being a national centre for this procedure and whether the centre is collating data for the use of apixaban in this setting and whether the centre has explored running a clinical trial to generate evidence. The applicant clarified that the team currently has an extensive database for this patient cohort which demonstrates an improvement in stent patency over the past 5 years. The centre also has a pilot study underway with the hope of the study being a multicentre study across the country, however the timescales for completing this study are long term as patients will be followed up for at least 2 – 5 years.

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

Committee members discussed the application and members acknowledged currently there is not sufficient published evidence to support the use of apixaban as first line treatment in this setting. However, Committee members also appreciated the expertise of the specialist team as the national centre for the management of iliofemoral DVT via CDT and their experience to date of using apixaban in this patient cohort. Committee members agreed by consensus that a decision on the approval for the use of apixaban as first line treatment in this setting could not be agreed in the meeting and would be deferred. Members requested the submission of the additional supporting data collated by the Trust to be presented to the Committee at a future IMOC meeting for review.

ACTION: Additional supporting data collated by the GSTT vascular team for the use of apixaban in this setting to be presented at a future IMOC meeting

8. Update from the overprescribing subgroup of the IMOC

The Lead Pharmacist was in attendance to present this item and shared a presentation at the meeting which highlighted the workplan for the subgroup, including priorities and actions.

In SEL, the overprescribing subgroup has been formed as a subgroup of the IMOC to help tackle overprescribing locally with the aim to address all the complex and interdependent factors and barriers in the local health system which impact on overprescribing. The overprescribing group also aims to consider health inequalities linked to overprescribing as well as improving the impact of medicines on the environment. Data currently demonstrates that overprescribing in more common in older people, certain ethnicities and in areas of high deprivation. This data will help to focus and target specific cohorts of patients across SEL in which tackling overprescribing is a priority.

The two primary areas of focus for the overprescribing subgroup are working with secondary care to improve the transfer of care process following discharge and structured medication reviews in primary care for people over the age of 65 on 10 or more medicines. In relation to the IMOC specifically, the workplan includes agreeing standard wording for IMOC guidelines regarding overprescribing and signposting to non-drug options and deprescribing considerations. The subgroup will also be engaging with patients to help support a shift in culture towards addressing overprescribing.

The Committee welcomed and noted the overprescribing workplan and thanked the presenter for their ongoing work in this area.

9. Formulary inclusion of Espranor™ (buprenorphine oral lyophilisate) at GSTT for use by GSTT addiction treatment service

The Formulary Pharmacist presented this item which requests the use of Espranor™ (buprenorphine oral lyophilisate) as a Red medication by the GSTT addiction treatment service. Espranor™ is an orodispersible buprenorphine formulation which disperses quicker in comparison to sublingual

buprenorphine and is currently on the formulary as Red for use by SLaM addiction services only. The GSTT addiction treatment service would like to use Espranor™ within the service as the quicker dispersion properties may be of benefit for certain patient cohorts, the service estimates use in 1 – 2 patients per month. Committee members approved by consensus the formulary inclusion of Espranor™ as Red for use by the GSTT addiction treatment service.

ACTION: Espranor™ for use by the GSTT addiction treatment service to be added to the SEL JMF with a red category

10. Annual review for the IMOC Terms of Reference

The IMOC Terms of Reference (ToR) annual review is due for April 2023, in line with this, the current IMOC ToR will be circulated to Committee members via email for review and comments.

11. Standing items/Items for information only

- Formulary Submissions tracker

Noted

- NICE Technology Appraisal Guidance Summary – ICS attributed medicines & NHSE/I:
- The summary was noted and Red, Amber, Green, Grey (RAGG) categories were agreed by consensus.
- Committee members noted that the place in therapy for somatrogon requires further consideration

ACTION: Trust formulary leads to report back on somatrogon place in therapy

- RMOC update – the Committee noted an update from the February RMOC meeting, including an update provided at the RMOC meeting on the national genomics services.

ACTION: Genomics presentation from February 2023 London RMOC meeting to be shared with IMOC members

12. Any Other Business:

Committee members were congratulated on the SEL IMOC's 10th birthday following its establishment in February 2013.

IMOC dates for next 3 months

Date	Time	Venue
16th March 2023	2:00pm – 4:30pm	MS Teams
20th April 2023	2:00pm – 4:30pm	MS Teams
18th May 2023	2:00pm – 4:30pm	MS Teams