South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
21 September 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 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. **i. Updated pharmacological management of heart failure guidance**
   ii. Recategorisation request for sacubitril/valsartan from Amber 3 to Amber 2 for the management of heart failure:
   - **Sacubitril/valsartan patient pathway**
   - **Sacubitril/valsartan FAQ**

   The authors were attendance to re-present this item following the discussion at the August IMOC meeting. The pharmacological management of HF guidance, sacubitril/valsartan patient pathway and frequently asked questions (FAQ) have been updated in relation to the comments raised at the previous IMOC meeting. At the August IMOC meeting, there was no clear consensus reached on the 4 weeks transfer of prescribing to primary care for sacubitril/valsartan under the Amber 2 arrangements (regardless of whether the patient had reached a maintenance dose). The presenters clarified the HF team would like to seek approval for the transfer of care to primary care to occur at 4 weeks following specialist initiation.

   The transfer of care at 4 weeks aims to prevent the concurrent prescribing of ACEi's or ARB's with sacubitril/valsartan and enables patients who may miss their follow up with the specialist HF team to obtain a continual supply of sacubitril/valsartan. In response to this, Committee members fed back that there needs to be a clear pathway with the specialist heart failure services for managing patients who are initiated on sacubitril/valsartan and do not attend their follow up appointments at 4 weeks. GP members also highlighted that patients not attending their appointments is a risk with any medication. There is also a potential risk to patients who continue to receive sacubitril/valsartan by their GP without the necessary follow up and monitoring by the specialist HF team.

   A comment was raised in relation to the "Red, Amber, Green, Grey" (RAGG) category for ivabradine which is used for the management of HF and also categorised as Amber 2 and transferred to primary care once the patient has reached stable maintenance dose. It was suggested that the transfer of care for sacubitril/valsartan should be aligned to this for consistency. The consensus of the borough GP clinical leads present at the meeting supported an Amber 2 recategorisation with a transfer of care at maintenance dose, rather than specifically at 4 weeks, in line with the Amber 2 RAGG definition.

   Committee members agreed to approve the recategorisation request for sacubitril/valsartan from Amber 3 (shared care) to Amber 2 (specialist initiation followed by transfer of care at maintenance dose) by consensus. The amendments to the pharmacological management of heart failure guidance, sacubitril/valsartan patient pathway and FAQ will be approved through Chair's action.

   ACTION: Pharmacological management of heart failure guidance, sacubitril/valsartan patient pathway and FAQ to be updated by authors and progressed for ratification via Chair's action
   ACTION: Recategorisation of sacubitril/valsartan to Amber 2 (specialist initiation followed by transfer of care at maintenance dose) to be added to the SEL JMF

5. **Updated adult vitamin D guideline**

The lead borough representative presented this item, which has been updated following comments raised at the June IMOC meeting. Updates to the guideline include the removal of the vitamin D management in patients with CKD 4 and above and inclusion of a link to the NHS vitamin D patient information. Additional comments were also shared prior to the meeting with the author which are to be actioned.

A comment was raised as to whether it is possible to continue exploring engagement with the secondary care renal specialists to enable inclusion of vitamin D insufficiency and deficiency in patients with CKD 4 and above. The presenter clarified the team has endeavoured to engage with secondary care renal specialists, unfortunately support is not currently available due to other priorities and pressures at the Trusts. The authors will continue to explore engagement with the secondary care renal specialists. To prevent any further delay in the approval of the guideline, the authors recommended the guideline is progressed without the inclusion of this patient cohort, as they are predominately managed by the specialist renal team. In line with this, it was also recommended to remove patients with CKD 4 and above from the vitamin D monitoring table. A note will also be included that specialists may recommend specific vitamin D treatments outside of the guideline for specific patient cohorts e.g. patients with CKD stage 4 and above.

Committee members approve the updated adult vitamin D guideline by consensus pending updates to the guideline in line with the discussion.

ACTION: Authors to update adult vitamin D guideline for progression to ratification via Chair's action

6. SEL Forum for Antimicrobial Stewardship workplan

A representative of the SEL Forum for Antimicrobial Stewardship - (SEL FAS) was in attendance to present the Forum's workplan. The SEL FAS reports to the SEL ICB Infection Prevention and Control Committee and to the IMOC for approval of medicines related aspects. Committee members were requested to note the items on the SEL FAS workplan in relation to medicines optimisation, for example optimising the duration of antimicrobial prescribing with a particular focus on amoxicillin prescribing in primary care as well as Covid medications and their usage.

The Committee noted the workplan and thanked the presenter for sharing an overview of the SEL FAS workplan. Updates on progress with the workplan will be arranged in the future.

7. Primary care migraine treatment pathway and headache diary for adults

- **Formulary inclusion of various triptan agents for the acute treatment of migraine**
- **Formulary inclusion of nortriptyline as Green for migraine prophylaxis**
- **Formulary recategorisation of topiramate from Amber 2 to Green and candesartan from Amber 1 to Green for migraine prophylaxis**

Members of the IMOC headache and migraine sub-group were in attendance to present these items. The treatment pathway and formulary requests have been reviewed and recommended via the IMOC's Headache and Migraine sub-group. The primary care migraine treatment pathway provides concise guidance on the diagnosis, acute and preventative treatments for the management of migraine in primary care.

To support the request to add zolmitriptan (orodispersible tablets and nasal spray), naratriptan, eletriptan, almotriptan and frovatriptan to the formulary for the management of acute migraine, the pathway also includes a triptan decision tree. The pathway also proposes the initiation of preventive migraine treatment in primary care (Green) which is currently recommended as initiation by a specialist (Amber 2) - topiramate or on the recommendation of a specialist (Amber 1) – candesartan (off-label).

The Formulary Pharmacist presented an overview of the efficacy evidence for the use of the various new triptans noted above in this setting. A detailed evidence review was provided within the meeting

agenda pack. The resource impact of the various triptan agents for the acute treatment of migraine is within the financial threshold that the Committee is authorised to approve.

A comment was raised regarding the choice of preventative treatments and whether this would be in line with the NICE Guideline (No. 150). The presenters explained that migraine has a high disease burden and is not optimally treated in primary care. The NICE recommendations are from 2012 and there is conflict with more up to date recommendations from the British Association for the Study of Headache (BASH) resulting in an underuse of preventative agents in primary care. Additionally, whilst topiramate and propranolol are first line within the NICE guideline, the existing Amber 2 RAGG category for topiramate makes this challenging for primary care initiation. Candesartan is not in the existing NICE guideline but is recommended by BASH. In reality, the choice of preventative treatment should be individualised based on patient factors. Early treatment in primary care is also desired to decrease the risk of the patient progressing to a chronic migraine state. Members suggested that as the choice of preventative treatment is individualised, the statement within the preventative treatment box which notes this information should be bolded to make this clearer.

A comment was also raised requesting the addition of information in relation to the review of on-going preventative migraine treatment 6 months after initiation to enable deprescribing where clinically appropriate. Comments were also raised in regard to adding which triptans are categorised as Green and Amber 1 within the triptan decision tree. Members also requested that, in line with NICE, the triptan with the lowest acquisition cost should be recommended first line, in this case sumatriptan tablets should be noted clearly as the first line option within the triptan decision tree.

GP clinical leads present at the meeting shared that the safety risks associated with topiramate such as the congenital malformations in pregnancy makes the initiation of topiramate in primary care challenging. As many GPs will not feel comfortable initiating topiramate without the advice of a specialist, an Amber 1 category would be more favourable in this setting, with detailed information in the clinic letter.

Committee members approved the following by consensus:

- Primary care migraine treatment pathway and headache diary pending updates to the guideline in line with the discussion.
- Formulary inclusion of the following triptans, in line with the triptan decision tree and formulary request:
  - Zolmitriptan (orodispersible tablets and nasal spray), naratriptan, and frovatriptan under a RAGG category of Green
  - Eletriptan and almotriptan under a RAGG category of Amber 1
- Formulary inclusion of nortriptyline as Green (primary care or specialist initiation) for migraine prevention, 2nd line to amitriptyline where a patient is unable to tolerate amitriptyline
- Candesartan RAGG recategorisation from Amber 1 to Green for migraine prevention

Members also agreed by consensus that a category of Green could not be supported for the recategorisation of topiramate from its current Amber 2 category (specialist initiation). Instead, Committee members agreed by consensus a recategorisation from Amber 2 to Amber 1.

ACTION: Primary care migraine treatment pathway and headache diary to be updated and progressed for ratification via Chair's action
ACTION: Zolmitriptan (orodispersible tablets and nasal spray), naratriptan, eletriptan, almotriptan and frovatriptan to be added to the SEL JMF in line with the triptan decision tree and agreed RAGG categories
ACTION: Nortriptyline to be added to the SEL JMF as Green for migraine prevention, 2nd line to amitriptyline, where a patient is unable to tolerate amitriptyline
ACTION: Candesartan to be recategorised as Green for migraine prevention in the SEL JMF
ACTION: Topiramate to be recategorised as Amber 1 for migraine prevention in the SEL JMF

8. Alimemazine for the management of dystonia particularly with poor sleep and/or vomiting in paediatrics

This formulary submission originates from a Consultant at the Evelina Children's hospital. The application requests the use of alimemazine for the management of dystonia particularly with poor sleep and/or vomiting in paediatrics. Treatment with alimemazine in this setting will usually be for one month, but long term use may be helpful in certain children and a RAGG category of Amber 2 is desired.

- **Evidence review**

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

- **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 request for alimemazine in this setting is for children with dystonia particularly where poor sleep and/or vomiting is the predominate issue. Alimemazine is currently used in practice at small doses to help with gastroenterology side effects such as vomiting and as adjunct therapy to help reduce the dose of treatments such as chloral hydrate.

A comment was raised in relation to whether the pharmacokinetics of alimemazine in dystonia is known and whether an alternative antihistamine in the same class such as promethazine can be used in this setting. The applicant clarified this is not completely known, however the sedative effect of alimemazine may be the main effect for the management of dystonia and the safety profile of alimemazine may be better in comparison to other sedative antihistamine. Comments were also raised in regard to what proportion of children will need long term treatment and whether children transition from the liquid formulation to the tablet formulation as they become older. The applicant clarified that in their experience of use (~5 patients), the majority of patients who have experienced benefit from treatment tend to be kept on long term treatment. It was also noted that most children will be tube fed and as a result tend to remain on the liquid formulation.

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

Committee members discussed the application and members acknowledged there is an existing patient cohort benefiting from treatment with alimemazine in this setting, despite the low quality evidence. Members also appreciated due to the rarity of the condition and resulting small patient numbers, it is challenging to obtain high quality, randomised control trial evidence. However it would be useful for the Committee to review patient outcome data.

Committee members agreed by consensus a time limited approval under a RAGG category of Red (hospital only) with a caveat for outcome data to be presented back to the Committee in 12 months.

ACTION: Formulary recommendation to be drafted and presented at a future meeting
ACTION: Outcome data to be presented back to the Committee in 12 months

9. **Updated rheumatology treatment pathway and associated resources:**
   i. **seronegative spondyloarthropathy treatment pathway**
   ii. **rheumatology pathways cost tool**
   iii. **rheumatology pathways outcomes and monitoring framework**

The author was in attendance to present this item, which has been updated and recommended via the rheumatology sub-group. The seronegative spondyloarthropathy (SpA) treatment pathway has been updated to include NICE TA 861 upadacitinib for treating active non-radiographic axial spondyloarthritis (AS). The NICE resource impact statement summarises that upadacitinib in this setting is not anticipated to be significant resource impact as it is a further treatment option for this patient cohort and the cost is likely to be a substitution. The SpA cost tool has been updated to incorporate upadacitinib in

non- radiographic axial AS, dose escalated guselkumab and updated wording for biosimilar adalimumab in line with the new framework. The rheumatoid arthritis (RA) cost tool has also been updated to include the updated wording for biosimilar adalimumab. The rheumatology pathways outcomes and monitoring framework has also been updated to include new locally commissioned elements of the pathway.

The Committee approved the updated rheumatology treatment pathway and associated resources by consensus.

10. Acne vulgaris related formulary requests:

i. Formulary inclusion of Treclin™ 1%/0.025% gel as Green

ii. Formulary inclusion of Epiduo™ 0.3%/2.5% gel and categorisation request of green

The applicant was in attendance to present these requests, which have been reviewed and approved via the dermatology sub-group. Treclin™ 1%/0.025% gel (clindamycin/tretinoin) and Epiduo™ 0.3%/2.5% gel (adapalene/benzoyl peroxide) are both licensed for the topical treatment of acne vulgaris when comedones, papules and pustules are present in patients 12 years or old. NICE recommends a fixed combination of topical tretinoin with topical clindamycin for the management of acne of any acne severity. Epiduo™ is currently on the local formulary at the lower strength, the request to include the higher Epiduo™ strength aims to reduce the number of patients needing oral antibiotics if their acne symptoms have not sufficiently reduced with the lower strength product.

Committee members were requested to consider a RAGG categorisation of green for Treclin™ and Epiduo™ (lower and higher strength) in line with the proposed updated draft acne section of the dermatology primary care guideline.

The Committee approved the formulary inclusion of Treclin™ 1%/0.025% and Epiduo™ 0.3%/2.5% gel as Green and categorisation of Epiduo™ 0.1%2.5% as Green by consensus, pending the updated primary care guidelines being presented for approval. Committee members noted the formulary will be updated once the updated dermatology primary care guideline has been discussed and approved by the Committee.

ACTION: Primary care dermatology guidelines to be updated with the inclusion of Treclin™ 1%/0.025% and Epiduo™ 0.3%/2.5% gel
ACTION: Treclin™ 1%/0.025% and Epiduo™ 0.3%/2.5% gel to be added to the SEL JMF once the guideline is updated and approved

11. Updated SEL Acute Provider Collaborative adult urology guidelines for primary care – approval of the medicines content

The author was in attendance to present this item which has been updated following initial comments from the July IMOC meeting and further comments via the SEL FAS. Committee members were informed that following the discussion at the July IMOC meeting, an area on the SEL ICB website has also been set up for SEL APC clinical guidelines to be uploaded, once approved.

A minor amendment was requested in regard to the erectile dysfunction section, to clarify that patients will also be trained on the use of second line treatments and vacuum devices by the initiating specialist team before transfer to primary care.

The Committee approved the medicines sections of the guidelines by consensus pending updates as discussed.

ACTION: Guideline to be updated by authors and progressed for ratification via Chair's action

12. Updated formulary recommendation 133 - apixaban 2.5mg tablets as a second line option where vitamin K antagonist therapy is inappropriate in adults undergoing haemodialysis

The formulary recommendation has been updated following presentation of the outcome data at the August IMOC meeting. No comments were raised by Committee members and the updated formulary recommendation was approved by consensus.

13. Standing items

- Formulary submissions tracker

Noted.

- NICE Technology Appraisal (TA) Guidance Summary – ICS & NHSE/I attributed medicines:

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

- Quarter 1 & 2 update on progress with the SEL IMOC workplan – noted – all workstream areas are progressing with some amendments to timescales.

14. AOB

The Chair informed the Committee that this was the last meeting for a borough GP Clinical Lead member for Medicines Optimisation, who is retiring. Committee members thanked them for their contributions and wished them well for the future.

IMOC dates for next 3 months

Date	Time	Venue
19th October 2023	2:00pm – 4:30pm	MS Teams
16th November 2023	2:00pm – 4:30pm	MS Teams
14th December 2023	2:00pm – 4:30pm	Hybrid – MS Teams/in person