North Central London
Medicines Optimisation Network

JOINT FORMULARY COMMITTEE (JFC) – MINUTES

Minutes from the meeting held on 18 February 2020
G12 Council Room, South Wing, UCL, Gower Street, WC1E 6BT

Present:	Dr R Sofat	NCL JFC Chair	(Chair)
	Mr S Semple	MEH, Chief Pharmacist	
	Dr R Urquhart	UCLH, Chief Pharmacist	
	Mr P Gouldstone	Enfield CCG, Head of Medicines Management	
	Mr A Dutt	Islington CCG, Head of Medicines Management	
	Ms K Delargy	BEH, Deputy Chief Pharmacist*	
	Dr K Tasopoulos	NMUH, DTC Chair	
	Ms L Reeves	C&I, Chief Pharmacist	
	Dr S Ishaq	WH, Consultant Anaesthetist	
	Dr A Stuart	NHS Camden, GP Clinical Lead Medicines Management	
	Ms G Smith	RFL, DTC Chair	
	Mr G Kitson	WH, Deputy Chief Pharmacist*	
	Ms E Mortty	NHS Haringey, Deputy Head of Medicines Management*	
	Ms I Samuel	RFL, Formulary Pharmacist*	
In attendance:	Mr A Barron	NCL MEP, Project Lead	
	Ms M Kassam	NCL JFC, Support Pharmacist	
	Mr G Grewal	NCL JFC, Support Pharmacist	
	Ms A Fakoya	NEL CSU, Senior Prescribing Advisor	
	Ms J Wrobel	UCLH, Medical Student	
	Mr F Master	RFL, Formulary Pharmacist	
	Mr D Abdulla	NMUH, Critical Care and Formulary Pharmacist	
	Ms P McCormick	WH, Lead Pharmacist Integrated Medicine	
	Mr S O'Callaghan	UCLH, Medicines Information and Governance Pharmacist	
	Ms C Gates	UCLH, Specialist Pharmacist	
	Dr A Drebes	RFL, Consultant Haematologist	
Apologies:	Mr C Daff	Barnet CCG, Head of Medicines Management	
	Mr S Richardson	WH, Chief Pharmacist	
	Dr A Bansal	Barnet CCG, GP Clinical Lead Medicines Management	
	Prof A Tufail	MEH, DTC Chair	
	Mr S Tomlin	GOSH, Chief Pharmacist	
	Mr A Shah	RNOH, Chief Pharmacist	
	Mr T Dean	Patient Partner	
	Dr M Kelsey	WH, DTC Chair	
	Ms R Clark	Camden CCG, Head of Medicines Management	
	Ms P Taylor	Haringey CCG, Head of Medicines Management	
	Ms W Spicer	RFL, Chief Pharmacist	
	Dr A Sell	RNOH, DTC Chair	

**Deputising for Committee member*

2. Meeting observers

The Committee welcomed Ms Wrobel (UCLH, Medical Student) as an observer of the meeting and Ms Smith (RFL, DTC Chair) as a new member of the Committee.

3. Minutes of the last meeting

The minutes were accepted as an accurate reflection of the meeting.

4. Matters arising

Nil

4.1 Chronic Spontaneous Urticaria

JFC Support has spoken with Dr Leslie (RFL) who was supportive of removing routine montelukast from the adult treatment pathway prior to omalizumab, although in their personal experience they note clinically relevant improvement in a few patients. The Committee approved the removal of montelukast from the NCL Joint Formulary for chronic spontaneous urticaria (CsU), noting that any 'one-off' requests could be approved via Trust DTCs.

The Committee approved the updated NCL guidance for treatment of CsU in adult patients.

Action: JFC Support to submit the rationale for the change in the treatment pathway to NICE and RMOC, and refer the necessary changes to the omalizumab BlueTeq form to NEL.

4.2 Rivaroxaban and aspirin for peripheral arterial disease/coronary artery disease

NCL Provider Trusts are working together to harmonise implementation of NICE TA609 in a phased manner by prioritising patients who would benefit most. It was noted that a proportion of eligible patients are not actively managed by secondary care therefore consideration should be given as to how patients are identified and who should be responsible for initiation.

Action: To consult with NCL specialists and update the NCL antiplatelet guideline accordingly

5. JFC Work Plan & outstanding actions

These items were included for information only. Any questions should be directed to Ms Kassam.

5.1 Patient information leaflet and consent form – Letrozole for ovulation induction (verbal update)

In November 2019, JFC approved letrozole (off-label) for ovulation induction on the provision that a Patient Information Leaflet (PIL) and Patient Consent Form were developed to appropriately inform potential patients of the risks and benefits from this treatment.

The Committee reviewed and approved both documents subject to resolving queries received from Mr Dean (Patient Partner).

6. Declarations of relevant conflicts of interest

No additional declarations were noted for the new medicine applications.

7. Local DTC recommendations / minutes

7.1 Approved

DTC site	Month	Drug	Indication	JFC outcome
UCLH	Jan 20	Gabapentin	Part of a multimodal analgesic regimen during the perioperative period in patients undergoing for complex major neurosurgery	Decision: UCLH only Approved in line with 'NHNN Acute Pain Management Prescribing Guidelines' Prescribing: Secondary care Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No
RFL	Apr 18	Anagrelide	Treatment of essential thrombocythaemia when first-line agent hydroxycarbamide is not considered suitable according to the London Cancer essential thrombocythaemia guidelines.	Decision: Added to the NCL Joint Formulary Prescribing: Secondary care Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No

RFL	Dec 19	Ruxolitinib	STAT1 GOF mutations in PID	Decision: Added to the NCL Joint Formulary Prescribing: Secondary care Tariff status: Not routinely commissioned Funding: Trust Fact sheet or shared care required: No
RFL	Dec 19	Leuprorelin (Prostap®)	In combination with tamoxifen or aromatase inhibitor to manipulate oestrogen levels in women with breast cancer, as an alternative to goserelin	Decision: Added to the NCL Joint Formulary Prescribing: Secondary care Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No

7.2 Approved under evaluation

DTC site	Month	Drug	Indication	JFC outcome
UCLH	Jan 20	Piperacillin/Tazobactam	Continuous infusion in the treatment of febrile neutropenia	Decision: UCLH only - approved under evaluation Prescribing: Secondary care Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No
RFL	Dec 19	Imatinib	Pulmonary veno-occlusive disease in pulmonary hypertension	Decision: RFL only - approved under evaluation Prescribing: Secondary care Tariff status: Not routinely commissioned Funding: Trust Fact sheet or shared care required: No

7.3 Not approved

DTC site	Month	Drug	Indication	JFC outcome
UCLH	Jan 20	Belantamab mafodotin	FoC scheme: Treatment of relapsed/refractory multiple myeloma	Decision: Not approved

8. New Medicine Reviews

8.1 Appeal: Botulinum toxin for urinary retention due to a disorder of the urethral sphincter (Dr Panicker, NHNN)

The Committee considered an appeal to inject botulinum toxin A into the urethral sphincter for patients with urinary retention secondary to Fowler's Syndrome. Dr Panicker presented separate audits in patients with Fowlers Syndrome conducted at National Hospital for Neurology and Neurosurgery (NHNN) and Westmoreland Street Hospital (WMS).

Between 2010 and 2019, 28 women received botulinum toxin injected into the urethral sphincter at NHNN; in total 125 injections were administered. A response was defined as catheter free or <50% need for a catheter. Changes in bladder symptoms were measured using the International Prostate Symptom Score (IPSS) and the Urinary Symptom Profile (USP). Patients received a mean of 6.6 injections (range 1 to 22), the mean interval between injections was 4.5 months (range 1 to 22 months). In terms of outcomes, 15 of the 28 patients (54%) were defined as responders, 8 of which (29%) continue to return for repeat injections. The mean IPSS score reduced from 21/35 at baseline to 14/35 after botulinum toxin. Similarly

the 'low stream' questions of the USP reduced from a mean of 4/9 at baseline to 2.7/9 (an improvement of >1 was considered clinically meaningful). In terms of safety, 6% of injections resulted in side effects of oozing, soreness, urinary retention, or transient stress incontinence (3% of injection sessions).

The WMS audit evaluated a 5 year period and included 34 women. Use of botulinum toxin reduced the number of women requiring clean intermittent self-catheterisation (CISC) and suprapubic catheters from 71% to 53%, and from 8% to 6% respectively. Overall, 35% reported 'good improvement' and 35% reported 'some improvement' as measured by the Patient Global Improvement (PGI) score at 3 months. In terms of safety, 6% experienced transient stress urinary incontinence.

The Committee heard from Mr Panicker that women with urinary retention due to Fowler's syndrome are initially considered for sacral nerve stimulation (SNS). Whilst there are no absolute contraindications to SNS, certain comorbidities are known to reduce its effectiveness e.g. mental health disorders or joint hypermobility. Botulinum toxin is reserved for patients unsuitable for SNS. The number of women continuing botulinum toxin long-term is low as most women become eligible for SNS once psychological comorbidities resolve or they are able to manage their bladder with CISC.

With regards to safety of long-term injections, Dr Panicker cited studies reporting no permanent histological changes in the detrusor of humans and animals following repeat injections. In addition, the audit data, which includes one patient who received 23 injections, showed a low risk of adverse effects including stress urinary incontinence.

The Committee noted several limitations of the data presented; the use of means rather than medians for symptom scores (given non-normally distributed data); the use of IPSS score which has not been validated in women (IPSS is a score for prostate disease and related symptoms); the lack of a comparator arm; and the lack of statistical testing of a patients pre- and post- score (i.e. Wilcoxon non-parametric test). As with all audit data, it was impossible to determine whether use of botulinum toxin was effective as the placebo-effect is unknown. Dr Panicker explained that NHNN explored the feasibility of running an RCT however believed it was unfeasible due to low patient numbers, ethical concerns and that patients with Fowlers Syndrome often have high levels of psychological and medical co-morbidities which makes them unsuitable for clinical trials. As an alternative, a framework was proposed to ensure consistency between NHNN and WMS which would require an MDT decision to initiate injections, standardised injection protocol, patient questionnaire to monitor improvement at 1 month from baseline, discontinuation in patients who have not observed a ≥50% improvement and annual review of safety and efficacy data.

In camera, the Committee considered an 'N-of-1' RCT design would overcome the challenge of low patient numbers and considered that a placebo-controlled study would be accepted by an ethics committee as the effectiveness of the intervention remained unproven, as there are precedents of sham procedure randomised studies. The committee accepted that there may be features of the condition that did not lend itself to such an 'N-of-1' trial design; the condition was not stable over a long period (as demonstrated by the large number of treatment discontinuing for various reasons) and there was variability in the duration of action of the botulinum toxin injection (audit range: 1 to 22 months).. The Committee accepted the audit data demonstrated safety of botulinum toxin and the overall cost of the intervention was low owing to low patient numbers. The Committee took reassurance from the proposed governance framework.

In summary, the Committee agreed that whilst the submitted data did not prove effectiveness of botulinum toxin, the required RCT maybe unfeasible and unlikely to be pursued. The available data suggested the risk to patients and the health-economy was small. The Committee therefore agreed to the continued use of botulinum toxin for urinary retention in Fowlers Syndrome conditional on the improved governance arrangements being put into place.

Decision: Approved for urinary retention secondary to Fowlers Syndrome
Prescribing: Secondary care
Tariff status: Excluded from tariff but not routinely commissioned
Funding: TBC; NHNN/WMS to submit a business case to CCG or apply for divisional funding
Fact sheet or shared care required: No

Action: Dr Panicker to submit the prospective data collection form to JFC Support for approval.

8.2 Botulinum toxin for complex abdominal hernia

As the applicants were unable to attend, this item was deferred.

9. DOAC treatment hierarchy within NCL – VTE

The Committee undertook an extensive review of the primary literature of DOACs for the treatment and secondary prevention of venous thromboembolism (VTE), including deep vein thrombosis (DVT) and pulmonary embolism (PE). The Committee took into consideration the cost-effectiveness analysis and recommendations from the draft NICE guideline for VTE and concluded rivaroxaban was the preferred DOAC for VTE management because it does not require prior loading with low molecular weight heparin, has a low acquisition cost (patent expiry in 2023) and is a once-daily dose. This recommendation was consistent with current practice across NCL. The Committee heard from Ms Gate (UCLH) and Dr Drebes (RFL) that for some patients, rivaroxaban might not be the optimal choice. The Committee asked that these cohorts be defined for discussion at the next meeting.

10. RMOC Advisory Statement: Sequential use of biologics

The Committee reviewed the RMOC recommendations for the sequential use of biologics. The Committee considered it important to not recommend medicines with no added benefit therefore adopted the following position for high-cost therapies: '*One drug per mechanism of action ± a second biosimilar anti-TNF for patients who develop anti-drug-antibodies to their first anti-TNF*'. Whilst the statement was considered equitable and cost-effective, the Committee noted the affordability challenge with adding new mechanisms of action sequentially and referred this to the NCL Commissioners for broad consideration amongst other priorities for funding.

Action: NCL Commissioners to provide an update on achieving the agreed positon for high-cost therapies at JFC meetings

11. Pre-NICE FoC scheme: Upadacitinib (3rd to market JAK inhibitor) for RA after failure of rituximab

The Committee agreed there was no unmet need addressed by the introduction of a third-to-market JAK inhibitor for Rheumatoid Arthrosis and declined to review the FOC scheme in full. In terms of clinical approval for existing JAKis (baricitinib and tofacitinib); upadacitinib appears similarly effective therefore, given the NICE ACD recommendation for upadacitinib as a 3rd line agent, baricitinib and tofacitinib are also considered cost-effective 3rd line agents. Further, JFC have already recommended the use of JAKis in the 5th line setting therefore by extension, JAKis are recommended as 3rd and 4th line treatments. JAKis offer an oral and less costly alternative to IL-6 inhibitors therefore JFC recommended the NCL RA Working Group updated their draft pathway to include all JAKi as a 3rd, 4th and 5th line options (provided 5th line therapies are commissioned and all JAKis are similarly priced). The Committee requested NEL write to Trusts to explain which medicines are currently commissioned as 3rd, 4th and 5th line agents. It was noted the pathway approved in July 2015 went beyond strict interpretation of NICE pathways by recommending either IL-6 inhibitors or abatacept as 3rd and 4th line treatments. The guideline should be updated as a priority as the review date was July 2017.

Action: NCL RA working group to update the RA pathway

12. Octasa® MR 400mg and 800mg for UC and CD (displacing Asacol® MR and Mezavant XL®)

This item was deferred

13. Cannabis-based medicinal products: Position Statement and Patient Information

This item was deferred.

Post meeting note: The NCL position statement and patient information documents were approved via Chair's action.

14. JFC membership

This item was deferred

15. Next meeting

Monday 16th March 2020

16. Any other business

Nil