North Central London
Medicines Optimisation Network

JOINT FORMULARY COMMITTEE (JFC) – MINUTES

Minutes from the meeting held on 8th December 2020

Present:	Dr P Taylor	NCL JFC Vice Chair	(Chair)
	Prof R Sofat	NCL JFC Chair	
	Dr A Sell	RNOH, DTC Chair	
	Dr M Kelsey	WH, DTC Chair	
	Ms W Spicer	RFL, Chief Pharmacist	
	Mr S Richardson	WH, Chief Pharmacist	
	Dr R Urquhart	UCLH, Chief Pharmacist	
	Mr P Gouldstone	NCL CCG, Head of Medicines Management (Enfield)	
	Ms S Stern	NMUH, Chief Pharmacist	
	Ms G Smith	RFL, DTC Chair	
	Mr A Dutt	NCL CCG, Head of Medicines Management (Islington)	
	Mr T Dean	Patient Partner	
	Dr K Tasopoulos	NMUH, DTC Chair	
	Mr A Shah	RNOH, Chief Pharmacist	
	Ms P Taylor	NCL CCG, Head of Medicines Management (Haringey)	
In attendance:	Dr P Bodalia	UCLH, Principal Pharmacist	
	Mr A Barron	North London Partners, MEP Project Lead	
	Mr G Grewal	North London Partners, JFC Support Pharmacist	
	Ms M Kassam	North London Partners, JFC Support Pharmacist	
	Ms H Thoong	GOSH, Formulary Pharmacist	
	Mr G Purohit	RNOH, Formulary Pharmacist	
	Mr H Weaver	NHSE, Specialised Commissioning Pharmacist	
	Ms I Samuel	RFL, Formulary Pharmacist	
	Mr F Master	RFL, Formulary Pharmacist	
	Dr J Kimpton	UCL, Clinical Research Fellow	
	Ms S Amin	UCLH, Formulary Pharmacist	
	Dr A Lambarth	UCL, Clinical Research Fellow	
	Dr A Scourfield	UCLH, Clinical Pharmacology Consultant	
	Dr M George	UCLH, Specialist Registrar Clinical Pharmacology	
	Dr A Hosin	UCLH, Specialist Registrar Clinical Pharmacology	
	Dr S Huq	UCLH, Consultant in Clinical Pharmacology	
	Ms A Fakoya	NEL CSU, Senior Prescribing Advisor High Cost Drugs	
	Ms SY Tan	NEL CSU, Contracting and Commissioning Pharmacist	
	Ms N Kubah	RFL, Formulary Pharmacist	
	Ms P McCormick	WH, Lead Pharmacist Integrated Medicine	
	Dr D Thompson	UCLH, Specialist Registrar Clinical Pharmacology	
	Mr S O'Callaghan	UCLH, Formulary Pharmacist	
	Ms N Kubah	RFL, Rotational Pharmacist	
	Dr R Samir	Parliament Hill Medical Centre, GP registrar	
	Ms J Hadi	WH, Specialist Pharmacist- Oncology & Rheumatology	
	Dr A Nuttall	WH, Consultant Rheumatologist	
	Dr M Leandro	UCLH, Consultant Rheumatologist	
	Dr P Harrow	UCLH, Consultant Gastroenterologist	
	Dr N Halliday	RFL, Specialist Registrar	

	Prof D Thorburn	RFL, Consultant Hepatologist
Apologies:	Ms S Lever	NCL CCG, Head of Medicines Management (Barnet)
	Ms L Reeves	C&I, Chief Pharmacist
	Mr S Semple	MEH, Chief Pharmacist
	Mr A Tufail	MEH, DTC Chair
	Ms R Clark	NCL CCG, Head of Medicines Management (Camden)
	Mr S Tomlin	GOSH, Chief Pharmacist
	Dr S Ishaq	WH, Consultant Anaesthetist
	Ms K Delargy	BEH, Deputy Chief Pharmacist
	Dr D Burrage	WH, Consultant in Emergency Medicine

2. Meeting observers

Ms Weaver (NHSE, Specialised Commissioning Pharmacist) and Dr Samir (Parliament Hill Medical Centre, GP registrar) were welcomed as observers of the meeting.

3. Minutes of the last meeting

The minutes and abbreviated minutes of the 19 November 2020 meeting will be available in the January JFC meeting agenda.

4. Matters arising

Nil

5. JFC Outstanding Items & Work Plan

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

6. Members declarations of conflicts of interest

Nil

7. Local DTC recommendations / minutes

7.1 Approved

DTC site	Month	Drug	Indication	JFC outcome
UCLH	November 2020	Aripiprazole IM	Rapid tranquilisation in children and young people (>12 years)	Decision: Added to the NCL joint formulary Prescribing: Secondary care Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No
UCLH	November 2020	Olanzapine IM	Rapid tranquilisation in children and young people (>12 years)	Decision: Added to the NCL joint formulary Prescribing: Secondary care Tariff status: In tariff Funding: Trust Fact sheet or shared care required: No

8. New Medicine Reviews

8.1 Ferric maltol (Feraccru®) for iron deficiency anaemia in Inflammatory Bowel Disease (Applicant: Dr Harrow, UCLH)

In July 2020 the Committee heard an application for ferric maltol in patients with iron deficiency anaemia in Inflammatory Bowel Disease (IDA-IBD) who have failed 2 prior oral ferrous products and have either an allergy to IV iron or the oral route is preferred. The Committee deferred their decision pending publication of the AEGIS H2H study and recommended that the applicant submit proposed IDA-IBD treatment pathway.

The Committee considered the reanalysed AEGIS-H2H data which demonstrated ferric maltol is inferior to IV iron. AEGIS H2H was a 12-week, Phase 3b, open-label, active-comparator controlled study to compare the efficacy and safety of oral ferric maltol (Feraccru®) and intravenous ferric carboxymaltose (Ferinject®) for IDA-IBD in adults (Hb 8.0-11.0 g/dL for women, 8.0-12.0 g/dL for men; n=250). Importantly, the study did not require patients to have previously failed treatment with prior ferrous products. Patients were randomised to ferric maltol 30mg twice daily or ferric carboxymaltose dosed according to the SPC. The

primary endpoint was the 'Hb responder rate', defined as the proportion of patients achieving either ≥2 g/dL increase in Hb or normalisation of Hb. The study was powered to detect non-inferiority with a non-inferiority margin of 20%. Results show that non-inferiority was not demonstrated (67% vs. 84%; estimated treatment difference -17% [95% CI: -28% to -6%]). Study limitations include the differences in inclusion criteria to the propose use and the absence of results being published in a peer reviewed journal.

With regards to safety, ferric maltol was associated with an increase in treatment-emergent adverse events compared to ferric carboxymaltose (TEAE; 59% vs. 36%) and serious TEAE (10% vs. 3%).

In terms of budget impact, ferric maltol is less costly than intravenous iron and may save £24,000 per annum excluding activity (assuming ferric maltol is discontinued after 12 weeks). SEL have approved the use of ferric maltol for IDA-IBD, NWL approved an evaluation of ferric maltol.

The Committee heard from Dr Harrow that the eligibility criteria for the proposed treatment pathway is as follows: haemoglobin level ≥8g/dL and a diagnosis of IBD and failed 2 oral ferrous products due to intolerance or inefficacy and eligible for further oral iron. Ferric maltol will be stopped when haemoglobin levels normalise or if a significant improvement in haemoglobin is not observed (<2g/dL). Dr Harrow suggested that the treatment pathway will reduce the likelihood of prescribing creep. It was recognised that ferric maltol was inferior to IV iron however it was felt that a proportion of patients would respond. This was considered advantageous because the UCLH IBD infusion clinic has an extensive waiting list.

In camera the Committee agreed an effective and well-tolerated oral iron alternative would fulfil an unmet need and reduce the pressure on infusion clinics. Regarding efficacy; the case had not been made as (i) there was no comparative data with oral ferrous products, (ii) ferric maltol is inferior to IV iron and (iii) the head-to-head study did not require patients to have been pre-treated with oral ferrous products therefore does not reflect current practice in NCL. Regarding safety; the case has not been made as (i) there was no comparative data with oral ferrous products and (ii) ferric maltol has a seemingly worse adverse effect profile than IV iron. With the above considered, it was unknown how many patients treated with ferric maltol in line with the proposed NCL pathway would eventually require an IV infusion. Prescribing creep of ferric maltol remained a concern and the budget impact was correspondingly unknown.

In summary, the Committee were unable to support of the full approval of ferric maltol. The Committee agreed ferric maltol could be only offered to patients who are actively following PHE advice to shield, provided they meet the criteria 'mild-moderate anaemia i.e. haemoglobin level ≥8g/dL and a diagnosis of IBD and failed 2 oral iron ferrous products due to intolerance or inefficacy and eligible for further oral iron.' This decision will be reviewed in July 2021.

Decision: Short-term approval only (see above)
Prescribing: Secondary care only
Tariff status: In tariff
Funding: Trust
Primary and secondary care Fact sheet or shared care required: No

8.2 Delayed use of biosimilar rituximab for rheumatoid arthritis during COVID-19 pandemic (Applicant: Dr Leandro, UCLH)

The Committee considered an application to pause or delay biosimilar rituximab as 2nd line therapy for rheumatoid arthritis during the current pandemic, and replace with an alternative active treatment. Scope included patients eligible to commence rituximab (rituximab naïve) and patients requiring rituximab re-dosing (rituximab pre-treated). The basis for the application was that rituximab is immunosuppressive, is an independent risk factor for severe COVID-19 and may reduce the effectiveness of any SARS-CoV-2 vaccine. Rituximab is currently the only second-line treatment option recommended by NICE for those who "can have" rituximab.

There were no RCTs comparing rituximab to alternative active therapies with 'incidence of severe COVID-19' as the outcome of interest. The Committee therefore reviewed the available observational data to establish whether caution with rituximab was warranted during the current pandemic.

The COVID-19 Global Rheumatology Alliance [poster] analysed registry data for rheumatology patients with COVID-19 (March to July 2020; n=3,729). Primary outcome of interest was 'death from COVID-19' and a multivariate analysis was used to identify independent risk factors. Results showed that in addition to well documented risk factors (age, male sex etc.) rituximab (and sulfasalazine) was an independent risk factor

for mortality (OR=4). This finding is supported by Sormani et al [preprint, not peer reviewed] which also found rituximab/ocrelizumab was an independent risk factor for COVID-19 death in patients with multiple sclerosis (MS) in Italy (OR=2.59).

MS Global Data Sharing Initiative [abstract] analysed registry data for patients with MS with COVID-19 (N=1,252). Outcomes of interest were admission to hospital, admission to ITU, need for artificial ventilation, and death from COVID-19. Prevalence for each outcome was adjusted for age, sex, MS type and disease severity. Results found that the prevalence of death from COVID-19 was not increased with rituximab however the prevalence of other COVID-19 related adverse outcomes were increased.

The Committee heard that none of the studies had been subject to peer-review, however from the information available, the methodological approach appeared appropriate. NICE/EULAR/ACR had not updated their guidance to reflect this new information; however ACR recommends "consider the use of drugs with the shortest half-life (eg etanercept, JAKi)" and NICE recommends "assess whether maintenance treatment with rituximab can be reduced to 1 pulse or the duration between treatments increased".

In terms of budget impact, the proposal is expected to be a short-term cost-pressure as JAKi (the most likely third-line agent) is more expensive than biosimilar rituximab however in the long-term, no cost-pressure was expected (2nd line JAKi followed by 3rd line rituximab, is as costly as 2nd line rituximab followed by 3rd line JAKi).

The Committee heard from Dr Leandro (UCLH) that rheumatologists had approached NEL in June with the same request which had been rejected due to insufficient evidence. Evidence now indicates increased rates of severe COVID-19 with rituximab, and because there are licensed and effective alternatives, the Rheumatology community would like to have the option to offer other treatments during the pandemic. The request is supported by colleagues at RFL, NMUH, RNOH and WH. Whilst there was no data to suggest patients with rituximab would have a lower response to a SARS-CoV-2 vaccine, it remained a theoretical concern due to B-cell depletion. If patients decline rituximab treatment, the only currently available options are high-dose steroids or no treatment, both of which are clinically undesirable.

In camera, the Committee acknowledged the individual study limitations however were reassured that multiple registries had reached similar conclusions. The Committee agreed the pandemic was effectively a 'caution for use' for rituximab and consequentially it was appropriate for patients to be offered other treatment options in the 2nd line setting. It was agreed that where a patient chooses to pause/delay rituximab, they should remain on their new treatment until failure. It was considered essential that biosimilar rituximab was not lost from the treatment pathway, therefore patients who delay rituximab use must use rituximab as their 3rd line agent (unless contraindicated).

In summary, the Committee agreed rituximab could be paused or delayed during the current pandemic, and alternative active agents (e.g. JAKi) should be made available. Where a patient delays rituximab treatment, they should remain on the new treatment until treatment failure before (re)starting rituximab.

Decision: Approved for 6 months only
Prescribing: Secondary care
Tariff status: Excluded from tariff
Funding: Trusts are receiving block payment from CCGs therefore the short-term cost-pressure will be borne by the Trust (not the commissioner) and will require individual Trust funding approval
Primary and secondary care Fact sheet or shared care required: No

8.3 Etoricoxib for rheumatological indications (e.g. RA, OA, acute gout, ankylosing spondylitis) (Applicant: Dr Leandro, UCLH)

The Committee considered a request to use etoricoxib, a selective COX-2 inhibitor, for osteoarthritis, rheumatoid arthritis, ankylosing spondylitis and acute gout. It is on formulary at RFL, but currently non-formulary at other NCL Acute Trusts.

The Committee considered the evidence for each of the indications applied for. Da Costa et al conducted a network meta-analysis of 76 RCTs (n=58,556) to compare seven NSAIDs and paracetamol for use in osteoarthritis (OA), which found etoricoxib 60mg to be amongst the most effective for treatment of pain in knee or hip OA (effect size -0.58 [95% CrI -0.74 to -0.43]). Li et al conducted a meta-analysis of 24 RCTs (n=2,513) to compare five NSAIDs for use in acute gout, and found etoricoxib 120mg OD to be comparable to indomethacin 150mg TDS but better than diclofenac 50mg TDS on a five-point Likert pain scale (standard

mean difference = -0.53 [95% CI: -0.98 to 0.09]). Fan et al conducted a Bayesian network meta-analysis of 9 RCTs (n=3,647) to compare six NSAIDs for use in ankylosing spondylitis (AS); a probability analysis suggested etoricoxib remained the most effective option for outcomes which include total pain score and patient's global assessment of disease activity. Two RCTs conducted in patients with rheumatoid arthritis (RA) were discussed. Collantes et al (n=891) compared etoricoxib 90mg OD, naproxen 500mg BD and placebo, and found etoricoxib and naproxen to both be superior to placebo and without significant differences between the two active treatments. Bickham et al (n=1,404) compared etoricoxib 60mg, 90mg and placebo in patients with RA and found superiority for both 60mg and 90mg doses of etoricoxib versus placebo [p=0.004 and p=0.034 respectively].

In terms of safety, the Committee also considered evidence from the Multinational Etoricoxib and Diclofenac Arthritis Long-term (MEDAL) study. Data was pooled from 3 RCTs (n=34,701), which included 23,913 patients with OA and 9,787 patients with RA. Patients had been randomised to receive diclofenac (either 50mg TDS or 75mg BD) or etoricoxib (either 60mg OD or 90mg OD) for a mean duration of 17.9 months. The primary endpoint, a composite of fatal and non-fatal thrombotic cardiovascular events (including myocardial infarction, unstable angina, thrombotic stroke etc), was not significantly different with etoricoxib compared to diclofenac (event rate per 100 patient years 1.24 vs. 1.30; HR: 0.95 [95% CI: 0.81 to 1.11])). Incidence of discontinuation due to hypertension related adverse events was statistically higher for etoricoxib, and oedema related adverse events was significantly higher for etoricoxib 90mg vs. diclofenac 150mg. A meta-analysis of 639 RCTs by the COXIB and traditional NSAID triallists collaboration investigating several NSAIDs and placebo (n= >350,000) found coxibs or diclofenac cause around three additional major vascular events (non-fatal myocardial infarction, stroke or vascular death) per 1,000 patients per year compared with placebo, independent of baseline risk. A nested case-control study by Arfe et al of five electronic databases found current use of any NSAID was associated with a 19% increase of hospital admission for heart failure (OR = 1.19 [95% CI: 1.17 to 1.22]) compared with past use of NSAIDs; a dose-response analysis found current use of etoricoxib >120mg/day and diclofenac >200mg/day were associated with at least double the risk of heart failure compared with past use. The MEDAL study also offered information on gastrointestinal adverse effects that demonstrated upper gastrointestinal adverse effects were significantly less common with etoricoxib than diclofenac (HR = 0.69 [95% CI: 0.57 to 0.83]). A risk assessment concluded that patients with significant risk factors for cardiovascular events should only be treated with etoricoxib after careful consideration, that the shortest duration possible and the lowest effective dose should be used, and that etoricoxib contraindications should be followed closely.

In terms of budget impact, etoricoxib is expected to cost up to £9,000 per annum, though is similar in cost to alternative NSAIDs and may reduce or delay progression to more intensive treatments such as biologic DMARDs.

The Committee heard from Dr Leandro that NSAIDs in general can increase the risk of cardiovascular events, and therefore regular NSAID use is generally avoided wherever possible, although for some patients it is required for optimal management of symptoms. Two conventional NSAIDs (such as ibuprofen and naproxen) would be used prior to considering etoricoxib. Rheumatoid patients with RA and AS would normally have annual review with the consultant, and acute gout and OA is managed in primary care. Some patients given NSAIDs at optimal doses will respond to any NSAID; however, there are some patients that respond better to specific NSAIDs.

In camera, the Committee heard that RNOH consultants had patients who moved on to biologic options quicker as they had run out of conventional NSAID formulary options, and would welcome the addition of an additional option on formulary. The Committee had concerns surrounding cardiovascular safety and appropriate initiation which was likely to be linked to patients' pre-existing baseline risk of CVD. The Committee heard that both Dr Leandro and Dr Mukerjee supported the adaption of a South-East London statement on use of etoricoxib in RA and AS, which effectively excluded patient with high baseline CVD risk. The Committee were reassured that the safety concerns would be addressed if the position statement could be adapted for NCL use.

In summary, the Committee agreed to add etoricoxib to the NCL Joint Formulary for RA, AS, OA and acute gout on the provision that a position statement is created to support safe prescribing practice.

Decision: Approved (pending the creation of an NCL position statement for etoricoxib prescribing practice)
Prescribing: Secondary care initiation and primary care continuation

Tariff status: In tariff
Funding: Hospital and CCG
Primary and secondary care Fact sheet or shared care required: No

8.4 Bezafibrate for treatment of persistent pruritis secondary to primary sclerosing cholangitis, primary biliary cirrhosis or secondary sclerosing cholangitis (Applicants: Dr Halliday and Prof Thorburn, RFL)

The Committee considered an application for bezafibrate, a peroxisome proliferator activator receptor (PARP) agonist for treatment of persistent pruritus with primary sclerosing cholangitis (PSC), primary biliary cirrhosis (PBC) or secondary sclerosing cholangitis (SSC) (cholestatic itch) as an adjunct in patients with inadequate response, intolerance or contraindication to current treatment options including cholestyramine, rifampicin, naltrexone and sertraline.

FITCH was a 21-day, placebo-controlled trial to assess the efficacy and safety of bezafibrate in patients with moderate to severe pruritus (≥5 of 10 on VAS) due to PSC, PBC, or SSC (n=74). The study was stopped after 3 years due to slow recruitment. The median baseline VAS score in each group was 7. The primary end point, >50% reduction of pruritus, was greater in the bezafibrate group (45% vs. 11%; p=0.003). An improvement in pruritis and quality of life, assessed by the 5D itch questionnaire, was observed in the bezafibrate arm compared with placebo (p=0.002 for total score and disability subscore). The median VAS score was lower in the bezafibrate group at 21 days (4 vs.7) and was higher than the reported minimally meaningful difference. Key limitations of the study were the short duration of the study, early termination, and the publication is available as an uncorrected format.

Results from an earlier study (BEZURO) support the finding of bezafibrate reducing pruritis intensity however this outcome was a secondary endpoint (hypothesis generating) and there was an imbalance of the number of patients reporting clinically significant pruritis at baseline. A small observational study of patients with PSC (n=20) found 65% discontinued fibrates after a median time of 1.4 years. At baseline, 8 had pruritis and during treatment with fibrates 7 patients (88%) described improvement of pruritus.

In terms of safety, no serious adverse events were reported in the 35 days of follow-up of the FITCH study. In the BEZURSO study, serious adverse events were reported in 28% in the bezafibrate group and 24% in the placebo group.

In terms of budget impact, bezafibrate is estimated to cost £5,520 to £7,360 per annum.

The Committee heard from Professor Thornburn and Dr Halliday that a large placebo effect is observed with pruritis treatments and it is a difficult symptom to study. Following the BEZURSO study, bezafibrate has been used in 20-25 RFL patients with PBC. Local experience has demonstrated a favourable improvement in itch, significant toxicity has not been observed in these patients. An RCT in PSC patients is planned to begin recruitment (NCT04309773) with pruritis being evaluated as a secondary endpoint.

In camera, the Committee agreed the limited, short-term efficacy data supported the use of bezafibrate for this rare condition. The Committee recommended monitoring FBC, LFTs and Creatinine Kinase in line with established practice for hyperlipidaemia. In term of place in therapy, the 2019 European Association for the Study of the Liver guideline suggests the following sequential order of medicines: 1st cholestyramine, 2nd rifampicin, 3rd naltrexone, 4th sertraline. In 2016, JFC reviewed naltrexone for cholestatic itch, the committee recommended the sequential order of treatments should be: 1st cholestyramine, 2nd antihistamine, 3rd naltrexone, and 4th rifampicin; due to concerns with the adverse liver effects of rifampicin and support of antimicrobial stewardship. The Committee asked for clarification on where bezafibrate would be used in the treatment pathway.

In summary, the Committee were supportive for the use of bezafibrate of cholestatic itch and requested clarification on the proposed place in therapy and monitoring requirements (to include monitoring of FBC, LFTs and creatinine kinase).

Decision: Deferred
Action: Clarification on the proposed place in therapy and monitoring requirements (to include monitoring of FBC, LFTs and creatinine kinase)

8.5 Pfizer/BioNTech vaccine to prevent symptomatic COVID-19

The Committee considered an application for the Pfizer/BioNTech COVID-19 vaccine (BNT162b2).

NCT00001955 was a Phase II/III, placebo-controlled study to assess the safety and efficacy of BNT162b2 in the general population (n=43,448). The primary endpoint, symptomatic COVID-19, was significantly less frequency with BNT162b2 compared to placebo (8 vs. 162; relative efficacy was 95.0% [95% CI: 90.3 to 97.6%]). The result was robust across multiple subgroups and sensitivity analyses.

In terms of safety, the most frequency adverse effects were usually mild or moderate in intensity and resolved within a few days after vaccination.

The Committee agreed that the size of the trial was typical for paediatric vaccination programmes however the follow-up period was shorter than would usually be expected. The shorter follow up time reflects the urgent public health need for a vaccine to reduce COVID-19 associated death in the general population. The Committee considered the implications of this short follow-up period; in terms of efficacy, it was unknown whether the treatment effect will be retained over time, however data on this will continue to be collected prospectively. In terms of safety, it is known the vaccine did not cause serious adverse effects within 2 months. Other vaccine trials show that uncommon serious side effects materialise within 6 weeks (e.g. Guillain-Barré Syndrome after influenza vaccine) therefore the 2-month follow-up is acceptable. Rare and very rare (<0.1% and <0.01%) adverse effects will not be identified pre-approval however this true for all medicines.

In summary, the Committee agreed to add BNT162b2 to the NCL Joint Formulary to prevent COVID-19 in line with guidance from DHSC.

Decision: Approved
Prescribing: Primary and secondary care
Tariff status: NA
Funding: NA
Primary and secondary care Fact sheet or shared care required: No

9. Tocilizumab for patients admitted to ICU with COVID-19 pneumonia (off-label)

NHS England published an interim position statement for the off-label use of tocilizumab for patients admitted to ICU with COVID-19 pneumonia. The statement follows a press-release from REMAP-CAP outlining that tocilizumab reduces the composite outcome of 'death or length of time receiving organ support in ICU' compared to no immunomodulation. The position statement outlines eligibility criteria for when off-label tocilizumab may be considered.

REMAP-CAP remains active for patient enrolment into all arms of active immunomodulator treatment (only the no immunomodulation arm was discontinued).

Responding to the interim position statement, JFC Support wrote to DTCs encouraging continued enrolment into trials rather than off-label use of tocilizumab. This sentiment was subsequently supported by a joint statement from the 'Faculty of Intensive Care Medicine' and the 'Intensive Care Society', and the 'COVID-19 Therapeutics Support and advice Group' (CTAG). JFC Support also encouraged Trusts to register interest in accessing stock of tocilizumab. Ms Weaver reiterated the recommendation for Trusts to register their interest as it protects access to tocilizumab which could be used for patients as part of a clinical trial.

10. GnRH analogues for prostate cancer: update of STP workstream

This item was deferred to the January JFC meeting

11. Cannabis-based medicinal products: minor update

This item was deferred to the January JFC meeting

12. Next meeting

Tuesday 21st January 2021