Joint Formulary Committee (JFC): Minutes

Minutes from the meeting held on 20th July 2023

		Present	Apologies
Members			
Prof A Hingorani	NCL JFC Chair	✓	
Dr B Subel	NCL JFC Vice Chair	✓	
Ms W Spicer	RFL, Chief Pharmacist	✓	
Dr P Jasani	RFL, DTC Chair		✓
Dr K Boleti	RFL, DTC Chair		✓
Dr A Scourfield	UCLH, DTC Chair		✓
Mr J Harchowal	UCLH, Chief Pharmacist; NCL ICS, Interim Chief Pharmacist	✓	
Ms L Coughlan	NCL ICS, ICS Chief Pharmacist	✓	
Dr R Urquhart	UCLH, Divisional Clinical Director	✓	
Dr K Tasopoulos	NMUH, DTC Chair	✓	
Ms S Stern	NMUH, Chief Pharmacist		✓
Dr M Kelsey	WH, DTC Chair		✓
Mr S Richardson	WH, Chief Pharmacist	✓	
Dr S Ishaq	WH, Consultant Anaesthetist		✓
Dr A Worth	GOSH, DTC Chair		✓
Ms J Ballinger	GOSH, Chief Pharmacist		✓
Mr V Raman	RNOH, DTC Chair	✓	
Mr A Shah	RNOH, Chief Pharmacist	✓	
Prof A Tufail	MEH, DTC Chair		✓
Ms N Phul	MEH, Chief Pharmacist		✓
Ms K Delargy	BEH, Chief Pharmacist	✓	
Ms L Reeves	C&I, Chief Pharmacist		✓
Dr L Waters	CNWL, Consultant Physician in HIV		✓
Ms R Clark	NCL ICB, Head of Medicines Management (Camden)	✓	
Mr P Gouldstone	NCL ICB, Head of Medicines Management (Enfield)	✓	
Ms E Mortty	NCL ICB, Interim Head of Medicines Management (Haringey)	✓	
Ms M Singh	NCL ICB, Head of Medicines Management (Barnet)	✓	
Mr A Dutt	NCL ICB, Head of Medicines Management (Islington)	✓	
Dr D Roberts	NCL ICB, Clinical Director (Islington)		✓
Attendees			
Ms S Amin	IPMO Programme Team, JFC Principal Pharmacist	✓	
Ms S Maru	JFC Support Pharmacist	✓	
Ms P Varu	JFC Support Pharmacist	✓	
Ms S Sanghvi	IPMO Programme Team, JFC Principal Pharmacist	✓	
Ms I Samuel	RFL, Formulary Pharmacist	✓	
Mr H Shahbakhti	RFL, Formulary Pharmacist		✓
Ms H Bouattia	RFL, Formulary Pharmacist		✓
Mr A Barron	UCLH, Principal Pharmacist	✓	
Mr S O'Callaghan	UCLH, Formulary Pharmacist	✓	
Ms A Gabriela	UCLH, Formulary Pharmacist		✓
Ms A Sehmi	NMUH, Formulary Pharmacist	✓	
Ms H Thoong	GOSH, Formulary Pharmacist	✓	
Mr D Sergian	MEH, Formulary Pharmacist	✓	
Ms H Weaver	NHSE, Specialised Commissioning Pharmacist (Observer)	✓	

Ms A Fakoya	NCL ICB, Contracts & Commissioning Pharmacist		✓
Ms EY Cheung	NCL ICB, Deputy Head of Medicines Management (Camden)		✓
Ms K Mistry	RNOH, Formulary Pharmacist	✓	
Ms S Ahmed	WH, Formulary Pharmacist	✓	
Ms R Pointon	WH, Rotational Pharmacist	✓	
Ms H Muhammed	WH, Specialist Pharmacist	✓	
Mr J Flor	WH, Finance, Business and Performance Pharmacist		✓
Ms M Thacker	RFL, Clinical Lead Pharmacist		✓
Mr G Purohit	RNOH, Formulary Pharmacist		✓
Ms J Bloom	MEH, Associate Chief Pharmacist	✓	
Dr D McLornan	UCLH, Consultant Haematologist	✓	
Mr A Tailor	UCLH, Lead Haematology Pharmacist	✓	
Ms R Burgoyne	UCLH, Haematology Pharmacist	✓	
Ms N Patel	Prescribing Advisor, NCL ICB (Barnet)	✓	

1. Meeting apologies

Prof Hingorani welcomed members and applicants to the meeting (see above). The Committee welcomed Louise Coughlan (NCL Deputy Chief Clinical Officer and ICS Chief Pharmacist) as a new Committee member. The Committee also welcomed back Sonali Sanghvi into her role as JFC Principal Pharmacist.

2. Meeting observers

Prof Hingorani welcomed observers to the meeting (see above).

3. Members' declaration of interests

The Declarations of Interests register for Committee members was included for information.

4. Minutes of the last meeting

Minutes and abbreviated minutes were accepted as an accurate reflection of the June 2023 meeting.

5. Matters arising

Nil.

6. Review of action tracker

Action tracker included for information.

7. JFC outstanding items & work plan

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

7.1 NCL High Cost Drugs Crohn's Disease Pathway (regarding Upadacitinib action)

In February 2023, JFC reviewed a pre-NICE FOC scheme application to use upadacitinib for Crohn's disease. At the time, due to the FOC scheme, it was approved in a last-line position after all available NICE TA therapies. The Committee agreed that the place in therapy and NCL IBD pathway would need to be reviewed following publication of the NICE TA. A positive NICE TA recommendation for upadacitinib for Crohn's disease was published on 21st June 2023 with a fast-track 30-day implementation process. There is a statutory responsibility for Trusts and Commissioners to make NICE TA approved treatments available by the end of the recommended implementation period. The Committee were informed that this deadline has not been met due to reduced capacity within the ICB to support high-cost drug pathways (previously managed by the Commissioning Support Unit (CSU)/London Shared Services (LSS) on behalf of NCL). This issue similarly applies to other ICB-commissioned high-cost drugs and NCL pathways.

The Committee were made aware of discussions underway with Trust CFOs and the ICB to recognise the current issues regarding NICE approved ICB-commissioned high-cost drugs, estimated costs and potential opportunities to offset costs. Once funding has been approved for these medicines, existing pathways will need to be updated and approved via the NCL JFC. The mechanism for delivering these updated pathways is yet to be determined. The Committee recommended that Trusts and the ICB add the delay in implementation of NICE approved ICB-commissioned high-cost drugs to their risk registers.

8. Local DTC recommendations / minutes

DTC site	Month	Drug	Indication	JFC outcome
UCLH	June 2023	Talquetamab (FOC scheme))	Relapsed/refractory multiple myeloma	**Decision**: Added to the NCL Joint Formulary **Prescribing**: Secondary care only **Tariff status**: N/A **Funding**: FOC scheme **Fact sheet or shared care required**: N/A
UCLH	June 2023	Recombinant ADAMTS13 (FOC scheme)	Prophylaxis and treatment of patients with severe congenital thrombotic thrombocytopenic purpura	**Decision**: Added to the NCL Joint Formulary **Prescribing**: Secondary care only **Tariff status**: N/A **Funding**: FOC scheme **Fact sheet or shared care required**: N/A
UCLH	June 2023	IV milrinone	Refractory vasospasm following subarachnoid haemorrhage [Off-label review]	**Decision**: Conditionally approved – UCLH only **Prescribing**: Secondary care only **Tariff status**: In tariff **Funding**: Trust **Fact sheet or shared care required**: N/A **Additional information**: Conditionally approved with use restricted to NHNN ICU and pending development of a local protocol
UCLH	June 2023	Sumatriptan	Acute management of trigeminal neuralgia [Off-label review]	**Decision**: Conditionally approved – UCLH only **Prescribing**: Secondary care only **Tariff status**: In tariff **Funding**: Trust **Fact sheet or shared care required**: N/A **Additional information**: Approved pending development of a guideline
UCLH	June 2023	Phenytoin		
UCLH	June 2023	Lidocaine		

8.1 Talc for pleurodesis

The Committee was informed of a request to use talc for pleurodesis from Whittington Hospital. The Committee ratified the use of talc for pleurodesis for addition to the NCL Joint Formulary, given the availability of a local guideline (RFL, December 2016) and the long-term historical use of this at two NCL Trusts (UCLH and RFL), pending the development of local guidelines at each interested site.

Medication: Talc for pleurodesis
Decision: Added to the NCL Joint Formulary
Prescribing: Secondary care only
Tariff status: In tariff
Funding: Trust
Fact sheet or shared care required: N/A
Additional information: Approved pending the development of local guidelines at each interested site

8.2 Bempedoic acid prescribing status

In July 2022, the JFC approved the NCL Lipid Pathway and proposed green prescribing status (suitable for initiation in primary and secondary care) for the use of bempedoic acid with ezetimibe in patients with primary hypercholesterolaemia or mixed dyslipidaemia. In February 2023, JFC approved an application for the use of bempedoic acid monotherapy for treating hypercholesterolaemia or mixed dyslipidaemia in patients in whom ezetimibe was not tolerated or not effective. At the time, the prescribing was restricted to secondary care initiation and primary care continuation (amber prescribing status). This was to ensure restricted prescribing of bempedoic acid monotherapy, which is not included within current NICE TA recommendations. The Committee was informed that queries have been received from primary care colleagues clarifying the difference in prescribing status between bempedoic acid monotherapy and bempedoic acid with ezetimibe. The Committee was asked to consider harmonising the prescribing status for bempedoic acid monotherapy

and bempedoic acid with ezetimibe to be suitable for initiation in primary or secondary care (green prescribing status).

The Committee noted that West Essex and Hertfordshire APCs are undergoing similar discussions. The Committee suggested seeking clarification of the consensus view from clinicians involved in developing the NCL Lipid Pathway. Therefore, this item will be brought back to a future meeting.

9. New medicine reviews

9.1 Ferracru Audit Evaluation

This item was deferred to the next available JFC meeting.

9.2 Momelotinib for myelofibrosis (Free of Charge Scheme)

The Committee considered a revised application for unlicensed momelotinib (as 200mg tablets daily), a JAK-inhibitor, to be used in a narrower cohort of patients compared to the original application presented to the JFC in April 2023. In April 2023, the Committee did not approve the use of momelotinib in anaemic myelofibrosis patients with symptoms and splenomegaly i) in a first-line setting based on the SIMPLIFY-1 study because of insufficient evidence to place ahead of licensed NICE TA approved therapies, ii) in a second- or third-line setting based on the SIMPLIFY-2 because the primary outcome was not met, the secondary outcomes were subsequently exploratory and momelotinib had a worse adverse effect profile compared to best available therapy (BAT), iii) in a second- or third-line setting based on the MOMENTUM study because of the choice of danazol monotherapy as a comparator, which only targets anaemia – therefore comparisons of momelotinib with danazol on other aspects of the disease does not represent a fair test.

In line with recommendations arising from the April meeting, the Committee was presented with a flowchart proposing the use of momelotinib in a narrower more clearly defined cohort of myelofibrosis patients, via the Free of Charge Scheme. Momelotinib was proposed for use as a last-line option, i.e. in patients in whom JAK-inhibitor use is limited by anaemia despite existing standard of care adjunctive therapies for anaemia being used (such as epoietin and danazol). The Committee reviewed efficacy data from two studies: SIMPLIFY-2 and MOMENTUM.

SIMPLIFY-2 (2018; n=156) was a 24-week phase III, randomised, open-label, active-comparator controlled superiority trial to compare the efficacy and safety of momelotinib to best available therapy (BAT) in JAKi pre-treated patients with myelofibrosis. In the BAT arm, 89% of patients were on ruxolitinib. The primary endpoint, spleen response rate at week 24 (SRR24) was not significantly better than BAT (7% vs 6%; proportion difference (PD): 0.01 (95% CI: -0.09–0.10, p=0.90). As the primary outcome was not achieved, the authors reported that "statistical significance could not be claimed for further multiplicity testing of secondary endpoints per the sequential testing procedure". Therefore, nominal values were reported for all secondary outcomes. For the secondary outcome, symptom response rate at week 24 (SyRR24), momelotinib was nominally better than BAT (26% vs 6%, p=0.0006). For the secondary endpoint, transfusion independence rate at week 24 (TIR24), 12% of patients gained transfusion independence in the momelotinib arm compared to 16% that lost transfusion independence in the BAT arm. Key limitations of the study were the open-label study design, subtherapeutic doses of ruxolitinib used in the BAT arm, and lack of wash-out period prior to study enrolment. Additionally, the study did not report on whether any adjunctive treatments were used for anaemia in the control arm, but the applicant states that to his knowledge anaemia adjunctive therapies were not used. The study design did not allow for statistical analysis of other secondary endpoints if the key secondary endpoint was not met.

MOMENTUM (2023; n=195) was a phase III, double-blind, double-dummy, randomised, active-comparator controlled study to compare the efficacy and safety of momelotinib to danazol in JAKi-treated patients with myelofibrosis. The primary endpoint, symptom response rate at week 24 (SyRR24), defined as the proportion of patients with a 50% or more reduction in mean MFSAF TSS over the 28 days immediately before the end of week 24 compared with baseline, was significantly superior to danazol (25% vs 9%; proportion difference: 16% [95% CI: 6-26]; p=0.0095). As per the study design, the key secondary endpoints were to be evaluated in hierarchical order only if the primary outcome showed significance in favour of momelotinib. The key secondary endpoint, transfusion independence rate at week 24 (TIR24) was tested by non-inferiority testing. TIR24 for momelotinib was non-inferior to danazol (+17% vs +5%; non-inferiority proportion difference: 15% [95% CI: 3-26]; p=0.0064). As momelotinib was non-inferior for this endpoint, a superiority test was conducted. Momelotinib was not statistically significantly superior to danazol for transfusion independence rate (superiority proportion difference: 11% [95% CI: -1 – 23], p=0.086). The next secondary endpoint, splenic response rate (SRR24), was significantly superior for momelotinib compared to danazol (23% vs 3%, p<0.0006). A key limitation of this study was that danazol was used as an active comparator. However, in real-

world practice, danazol is often used either alone or as an adjunct with ruxolitinib for treating anaemia associated with myelofibrosis, and not splenomegaly or splenic symptoms. Additionally, discontinuation of previous JAK-inhibitors was not required for study enrolment.

In terms of safety, from the SIMPLIFY-1 and SIMPLIFY-2 studies, momelotinib had a higher risk of i) side effects that led to discontinuation (SIMPLIFY 1: 13.1% vs 5.6%; SIMPLIFY-2: 21% vs 2%) ii) grade 3 ≥ thrombocytopenia (SIMPLIFY-1: 7% vs 4.6%; SIMPLIFY-2: 7% vs 6%) and iii) peripheral neuropathy (SIMPLIFY-1: 10.3% vs 4.6%; SIMPLIFY-2: 11% vs 0%) compared to ruxolitinib, respectively. Momelotinib had fewer dose reductions due to adverse effects compared to ruxolitinib (17.3% vs 35.6%) in the SIMPLIFY-1 study. From the MOMENTUM study, the side effect profile of momelotinib was generally similar to danazol.

In terms of budget impact, momelotinib is being provided via a free of charge scheme until commissioned by the NHS or deemed clinically unsuitable as determined by the treating clinician.

The Committee heard from Dr McLornan that only 15% of patients with myelofibrosis are eligible for curative treatment with allogeneic transplant. The most difficult patients to treat are those who are transfusion dependent or have Hb<100g/L. Momelotinib offers patients a chance for transfusion independence whilst also offering spleen and symptom response. The Committee heard that exploratory analysis from SIMPLIFY-2 and MOMENTUM studies in JAK-inhibitor experienced patients suggests that patients with transfusion independence have a better chance of overall survival. Additionally, majority of patients receiving momelotinib are able to receive the maximum dose density. On the other hand, a greater number of patients on ruxolitinib are unable to receive the full dose density due to anaemia, despite the use of adjunctive anaemia treatments, resulting in sub-optimal spleen and symptom responses. The Committee questioned whether the benefits of momelotinib for anaemia related responses were greater than the comparator arm for SIMPLIFY-2 as adjunctive treatments for adjuncts were not permitted as part of the trial protocol. The applicant confirmed that adjuncts for managing anaemia have generally been excluded from all the clinical trials as not all treatment centres may have access to these adjuncts and therefore use of these adjunctive treatments may be heterogeneous. The Committee were informed that GSK are likely to propose momelotinib in a second- or higher-line of therapy in their submission to NICE.

In camera, the Committee agreed that despite the limitations of the momelotinib studies, there was sufficient evidence of an effect on splenic size and disease symptoms, such that momelotinib could be used in a narrow cohort of myelofibrosis patients as a pre-NICE Free of Charge Scheme: i.e., in a last-line setting in patients in whom JAK-inhibitor use is limited by anaemia despite existing standard of care adjunctive therapies for anaemia being used, *pending clarification of the stopping criteria for momelotinib*. Patients enrolled to the FOC scheme should complete the NCL FOC consent form, and the JFC approval would be reconsidered if there was a negative MHRA licensing or NICE TA decision.

Decision: Added to the NCL Joint Formulary
Prescribing: Secondary care only
Tariff status: Not applicable – Free of Charge Scheme
Funding: Not applicable – Free of Charge Scheme
Fact sheet or shared care required: N/A
Additional information: Approved pending clarification of the stopping criteria for momelotinib and subject to completion of NCL FOC consent form for each patient. JFC approval to be reviewed following MHRA licensing and NICE TA decision.

10. Luforbec (Generic Fostair switch)

The Committee considered availability of a new generic version of Fostair pMDI inhaler, Luforbec 100/6 and 200/6. Adoption of generic medicines does not routinely require approval by JFC however the Committee noted that the potential implementation into pathways, cost savings and sustainability impact required specific consideration before adding Luforbec to the NCL Joint Formulary.

The Committee noted that Luforbec was considered equivalent to Fostair in terms of efficacy (albeit no direct comparison data), safety, shelf life and licensing. In terms of sustainability, Luforbec has a higher carbon footprint compared to Fostair (data from PrescQIPP), however Lupin Healthcare (manufacturers of Luforbec) claim that Luforbec is the first inhaler to be carbon neutral. This is stated to be via purchase of 'carbon credits', by investing in a renewable energy wind farm in China. The credits were purchased after assessment by an organisation named "Carbon Footprint Ltd"; the assessment is valid for 2 years or until the formulation of the

product changes. If the company ceases to buy carbon credits after this time, it will no longer be carbon neutral.

The Committee noted that approximately 6000 NCL patients are estimated to be on Fostair 100/6 pMDI (from 2021 data) and that blanket switching would result in cost savings of approximately £628,000, but also come with a significant local carbon impact of 779,425,920g of CO2e. The Committee has previously considered lower carbon footprint inhalers and endorsed the use of dry powder inhalers where possible and avoiding blanket switching. The Committee discussed concerns regarding the sustainability impact if a cost-saving switch was pursued, particularly in view of the broader green agenda in NCL. It was noted that there is currently no nationally defined mechanism for assessing the sustainability impact of medicines or threshold for cost per carbon emission reduction. The Committee agreed that this issue is complex and should be escalated to the NCL Green Board, London ICS Pharmacy Network, LPP and the NHSE Medicines Sustainability Committee for input.

11. Addition of Yuflyma (biosimilar adalimumab) to formulary

The Committee reviewed the evidence and approved the addition of Yuflyma as an additional biosimilar adalimumab on the NCL Joint Formulary, for implementation in local Trusts. Yuflyma should be added to the BlueTeq form for NCL. The Committee also agreed that the wording of the Q&A document on the NCL MON website should be updated to support biosimilar switching (the previous version refers to "originator to biosimilar" switches, whereas now a more generic term of "biosimilar switches" is preferable to include a biosimilar-to-biosimilar switch). This will be updated and brought to a future JFC meeting for ratification.

12. Update on COVID-19 therapies

In May 2023, JFC considered the use of three COVID treatments in immunocompromised patients (paxlovid, sotrovimab and remdesivir irrespective of time from symptom onset or oxygenation status) and remdesivir in patients who are hospitalised with COVID pneumonitis. The treatments, protocol and treatment algorithm have now been clinically approved by JFC; however, the funding decision is pending from the ICB finance team. Therefore, any use of treatments before a funding decision may be at Trust risk, and so should be considered on a case-by-case basis.

13. Shortages

13.1 Testosterone supply disruption – for use in women with low libido

The NCL JFC has previously approved testosterone for low libido in women. The Committee reviewed a table of suggested alternative testosterone formulations and doses, which was produced by JFC support and the UCLH specialist team, to support primary care clinicians during current supply disruptions for Tostran®and Testim®. The table was approved pending minor amendments and the Committee agreed that this should be shared with primary care clinicians.

13.2 GLP-1s and use of insulin

13.3 The Specialist Pharmacy Service (SPS) have made recommendations on the insulins to be used during the GLP-1 receptor agonist shortage. They recommend Toujeo (insulin glargine 300units/mL) first-line, and Abasaglar (insulin glargine 100units/mL) second-line. However, In October 2015, the JFC recommended against the use of Toujeo and the NCL insulin T2DM guideline does not recommend the use of Toujeo. Abasaglar is approved on the NCL Joint Formulary and therefore formulary teams were reminded that Abasaglar is the preferred option locally for patients with T2DM requiring insulin during the GLP-1 receptor agonist shortage. Following the meeting, clarification from SPS was sought regarding the placement of Toujeo first-line in the recommendation. The first-line recommendation was based on initial concerns regarding the Abasaglar supply chain which have since been resolved, with the Abasaglar manufacturer confirming that they are able to support supply for increased Abasaglar use.

14. Paediatric Primary Care Pathways

14.1 Acute wheeze and acute asthma attacks

14.2 Bronchiolitis

The risk assessments for the medicines included in the; i) Acute Wheeze and Acute Asthma Attacks and ii) Bronchiolitis Paediatric Primary Care Pathways were presented to the Committee for consideration and approval as part of the JFC support for the pathways transformation work. The risk assessment undertaken involved a review of the place in the pathway and the evidence base for each medicine including safety, efficacy, costs and prescribing and formulary position. The medicines in the pathways were discussed with the JFC clinical pathways sub-group prior to the meeting with no issues identified. The Committee agreed that it was preferable for paediatric dosing calculations to be weight-based as opposed to age-based.

In summary, the medicines-related elements in the; i) Acute Wheeze and Acute Asthma Attacks and ii) Bronchiolitis Paediatric Primary Care Pathways were approved; other elements of the pathway (e.g., clinical and operational aspects) will be approved by other ICB groups as per the ICB primary care pathways' governance process.

15. Next meeting

Thursday 17th August 2023

16. Any other business

Nil