Joint Formulary Committee (JFC): Minutes

Minutes from the meeting held on 16th May 2024

		Present	Apologies
Members			
Prof A Hingorani	NCL JFC Chair		✓
Dr B Subel (Chair)	NCL JFC Vice Chair	✓	
Ms L Coughlan	NCL ICB, Deputy Chief Clinical Officer & ICS Chief Pharmacist	✓	
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	✓	
Dr R Urquhart	UCLH, Divisional Clinical Director		✓
Dr K Tasopoulos	NMUH, DTC Chair	✓	
Ms A Stein	NMUH, Interim 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, Assistant Director of Medicines Optimisation	✓	
Ms M Kaur-Singh	NCL ICB, Head of Medicines Planning & Operations	✓	
Dr D Roberts	NCL ICB, Clinical Director (Islington)		✓
Attendees			
Ms S Sanghvi	IPMO Programme Team, JFC Principal Pharmacist	✓	
Ms S Amin	IPMO Programme Team, Lead Pharmacist		✓
Ms S Maru	IPMO Programme Team, JFC Support Pharmacist	✓	
Ms K Leung	IPMO Programme Team, JFC Support Pharmacist	✓	
Ms M Butt	IPMO Programme Team, Director		✓
Ms T Shah	RFL, Deputy Chief Pharmacist		✓
Ms I Samuel	RFL, Formulary Pharmacist	✓	
Mr H Shahbakhti	RFL, Formulary Pharmacist	✓	
Mr G Grewal	RFL, Deputy Chief Pharmacist	✓	
Mr A Barron	UCLH, Principal Pharmacist	✓	
Mr S O'Callaghan	UCLH, Formulary Pharmacist	✓	
Ms C OBeirne	UCLH, Formulary Pharmacist		✓
Ms H Matthews	UCLH, Medicines Optimisation and Governance Pharmacist	✓	
Ms H Thoong	GOSH, Formulary Pharmacist		✓
Mr D Sergian	MEH, Formulary Pharmacist	✓	
Ms A Bathia	RNOH, Formulary Pharmacist		✓
Ms S Ahmed	WH, Formulary Pharmacist	✓	

Ms A Lim	WH, Antimicrobial Pharmacist	✓	
Ms N Patel	NMUH, Formulary Pharmacist		✓
Ms M Thacker	GOSH, Deputy Chief Pharmacist	✓	
Ms H Weaver	NHSE, Specialised Commissioning Pharmacist (Observer)	✓	
Ms P Hayre	NHSE, Specialised Commissioning Pharmacist	✓	
Ms EY Cheung	NCL ICB, Head of Medicines Quality & Improvement		✓
Ms C Weaver	NCL ICB, Senior Prescribing Advisor	✓	
Mr A Fazal	RFL, Principal Pharmacist	✓	
Ms J Pang	IPMO Programme Team	✓	
Dr A Patel	RFL, Consultant Respiratory Physician	✓	
Ms H Logan	NCL ICB, Public Health Consultant	✓	
Ms N Pandya	NMUH, Pharmacist	✓	
Dr M Brown	RFL, Infectious Disease Consultant	✓	
Dr E Sanchez	RFL, Infectious Disease Consultant	✓	
Ms M Lanzman	RFL, Antimicrobial Pharmacist	✓	
Ms P Panesar	UCLH, Antimicrobial Pharmacist	✓	
Dr S Kinra	NCL ICB, Deputy Medical Director (Observer)	✓	
Ms H Shah	NCL ICB, Prescribing Advisor (Observer)	✓	
Mr Z Nunns	NCL ICB IPMO Team (Observer)	✓	

2. Meeting attendees

Dr Subel welcomed members, observers, and applicants to the meeting (see above). The JFC, in consultation with ICB colleagues, accepted an amended primary care quoracy of three for this meeting, noting that work is underway to review primary care membership.

3. Members' declaration of interests

The Declarations of Interests register for Committee members was included for information. No further interests relevant to the agenda were raised.

4. Minutes of the last meeting

Minutes and abbreviated minutes of the April 2024 meeting were ratified.

5. Review of action tracker

Action tracker included for isecukinnformation. Closed actions have been updated on the tracker.

6. JFC Outstanding items and workplan

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

7. Local DTC recommendations/minutes

DTC site	Month	Drug	Indication	JFC outcome
RFL	March 2024	Abatacept*	CTLA-4 Insufficiency and Lipopolysaccharide LRBA Deficiency	**Decision**: Approved – RFL only **Prescribing status**: Secondary care only **Funding source**: Trust **Additional information**: Approved pending consideration of CD80/CD86 ligand binding activity monitoring and internal funding consideration **Fact sheet or shared care required**: N/A
RFL	March 2024	[FOC Scheme] Maralixibat†	Cholestatic itch	**Decision**: Approved – RFL only **Prescribing**: Secondary care only **Funding source**: FOC Scheme **Additional information**: N/A

				Fact sheet or shared care required: N/A
RFL	March 2024	[Pharma-funded EAMS] Lebrikizumab†	Atopic dermatitis	**Decision**: Approved **Prescribing status**: Secondary care only **Funding source**: EAMS **Additional information**: N/A **Fact sheet or shared care required**: N/A
RFL	March 2024	[FOC Scheme] Fruquitinib†	Refractory metastatic colorectal cancer as a fifth-line agent	**Decision**: Approved **Prescribing status**: Secondary care only **Funding source**: EAMS **Additional information**: N/A **Fact sheet or shared care required**: N/A
UCLH	March 2024	[FOC Scheme] Elranatamab†	Relapsed refractory multiple myeloma in patients who have received at least 3 prior therapies (including an immunomodulatory agent, proteasome inhibitor, and anti-CD38 antibody) • 4th line: as an option for patients with a good performance status and who cannot access isatuximab (TA658) or ixazomib (TA870) • 5th line onwards: as an option for patients with a good performance status	**Decision**: Approved **Prescribing status**: Restricted to haematology team (hospital only) **Funding source**: Free of Charge Scheme **Additional information**: Decision to be reviewed following publication of NICE TA **Fact sheet or shared care required**: N/A
UCLH	March 2024	Amitriptyline	First-line management option for prophylaxis of Cyclic Vomiting Syndrome and Cannabinoid Hyperemesis Syndrome (CVS/ CHS)	**Decision**: Approved **Prescribing status**: Suitable for secondary care initiation, primary care continuation **Funding source**: In-tariff **Additional information**: N/A **Fact sheet or shared care required**: Deferred to the NCL Shared Care Group for review
UCLH	March 2024	Topiramate	Second-line management option for prophylaxis of CVS/CHS	**Decision**: Approved **Prescribing status**: Suitable for secondary care initiation, primary care continuation **Funding source**: In-tariff **Additional information**: N/A

				Fact sheet or shared care required: Deferred to the NCL Shared Care Group for review
UCLH	March 2024	Haloperidol	Acute management of CHS	**Decision**: Approved **Prescribing status**: Restricted to secondary care only **Funding source**: In-tariff **Additional information**: Acute CVS/CHS management guideline to be developed with acute medical service **Fact sheet or shared care required**: N/A
UCLH	March 2024	Venlafaxine MR	Menopausal hot flushes	**Decision**: Approved **Prescribing status**: Suitable for initiation in primary and secondary care **Funding source**: In-tariff **Additional information**: N/A **Fact sheet or shared care required**: Deferred to the NCL Shared Care Group for review
UCLH	December 2024	Paxlovid	Off-label renal dosing in line with the dosing regimen suggested by the University of Liverpool	**Decision**: Approved **Prescribing status**: Primary and secondary care initiation **Funding source**: ICB commissioned High Cost Drug (but currently at zero cost via DHSC purchased stock) **Additional information**: Primary care prescribing via NCL COVID-19 GP hub only **Fact sheet or shared care required**: N/A
UCLH	March 2024	Aprepitant	Prophylaxis of CVS/CHS	**Decision:** Not approved **Additional information:** Continuation permitted when patients transition to adult services, with the aim to reduce to the lowest effective dose or stop

*Subject to funding consideration; †The relevant commissioner should be notified in line with NCL Free of Charge scheme guidance. Approval is conditional on the provision of a free of charge scheme agreement and funding statement.

7.1 Melatonin Factsheet: Formulations Update

The melatonin factsheet was updated and approved via the Shared Care Group in May 2024. The Committee noted that updates to the factsheet include additional indications and recommendations on the brand and formulation that should be prescribed, as several products have become available since the first version of this document. The recommendations consider the formulation characteristics (standard vs modified release), tablet size and swallowing difficulties, and cost. Trust formulary teams should ensure local formularies, prescribing systems and procurement align with the factsheet recommendations.

8. Matters arising

8.1. Antivirals for COVID-19 (Applicants: Dr Brown, Dr Sanchez, Marisa Lanzman; RFL)

The Treatment Algorithm for Adults in Hospital with COVID-19 was updated by the UCLH and RFL ID and virology teams. The new treatment algorithm reflects the updated NICE TAs that have been published, previous JFC decisions, and a pragmatic proposal on the use of combination therapy in severely immunocompromised patients:

- NICE TA878 (updated 13/03/24) - Expanded access criteria for Paxlovid (nirmatrelvir/ ritonavir) in patients without an oxygen requirement.
- NICE TA971 (published 08/05/24) – Revised place in therapy for remdesivir for patients with and without an oxygen requirement.
- In severely immunocompromised patients on advice of ID/Virology MDT an option to offer an antiviral in combination with sotrovimab, particularly in treatment refractory/ recurrent infection patients. This is a pragmatic UCLH proposal not covered by NICE, licensing, or pivotal studies.

The Committee were informed that the COVID Medicines Delivery Unit (CMDU) have also updated their practice in line with NICE TA recommendations for the expanded access criteria for Paxlovid. The Committee also noted that off-label dosing for Paxlovid in severe renal impairment (eGFR <30mL/min) was previously discussed at UMC in December 2023. The Committee clinically approved the updated COVID-19 treatment algorithm, noting that the ICB are reviewing commissioning implications and financial sign-off. The pathway will be circulated for adaptation by other NCL Trusts where relevant to local practice.

9. Medicine reviews

9.1. Cytisine for smoking cessation (Applicants: Ms Logan, Dr Patel; NCL ICB and RFL)

The Committee considered an application for cytisine (also known as cytisinicline), a partial agonist of nicotinic acetylcholine receptors, for licensed use, in adult smokers for smoking cessation. Varenicline, which has the same mechanism of action, was initially recommended under NICE TA123 but was withdrawn from the market in 2021 due to unsafe levels of nitrosamines. In January 2024, unlicensed varenicline (Apotex®) was approved by the Committee for use in secondary care only due to limited supplies and it being unlicensed. This has resulted in increased interest in licensed cytisine, which would be suitable for initiation and continuation in primary and secondary care.

A NICE exceptional surveillance report for NICE guideline NG 209 was published in February 2024 which reviewed a Cochrane review on nicotine receptor partial agonists for smoking cessation (Livingstone-Banks et al, 2023) and a Cochrane component network meta-analyses on pharmacological and e-cigarette interventions for smoking cessation in adults (Lindson et al, 2023). Following consideration of the evidence, NICE plans to add cytisine to the recommended options within the guideline, noting it has comparable effect, safety, and cost to currently recommended products.

Lindson et al (2023; n= 151,179) was a component network meta-analysis (CNWA) that investigated the comparative benefits, harms, and tolerability of smoking cessation pharmacotherapies and e-cigarettes. The primary outcome of interest was smoking cessation at six months or longer and number of people reporting serious adverse events (SAEs). The study found high-certainty evidence that cytisine was associated with higher quit rates than control (OR 2.21 [95% CrI 1.66 to 2.97]).

Livingstone-Banks et al (2023; n= 45,049) was a Cochrane review that assessed the effectiveness of nicotine receptor partial agonists for smoking cessation. The review included 75 trials and found moderate-certainty evidence (limited by heterogeneity) that cytisine helps more people quit smoking than placebo (RR 1.30 [95% CI 0.78 to 1.37]). Pooled results from studies that randomised participants to receive varenicline or cytisine found no evidence of a difference in quit rates (RR 1.00 [95% CI 0.79 to 1.26]).

In terms of safety, Lindson et al found rates of SAEs were lower in the cytisine arm when compared to placebo or no intervention (0.94 [95% CrI 0.58 to 1.50]). However, the credibility intervals also incorporated potential harm and crossed the line of no effect. Livingstone-Banks et al found similar adverse event profile between cytisine and varenicline. However, the study found participants randomised to cytisine were less likely to experience nausea (RR 0.41 [95% CI 0.33 to 0.50]) and abnormal dreams (RR 0.60 [95% CI 0.50 to 0.73]) than those who received varenicline.

In terms of budget impact, the anticipated spend for cytisine is approximately £350,000 per annum for 3000 patients per annum. However, the budget impact is expected to be lower than this, as patients who receive cytisine would have otherwise been eligible for varenicline, which was previously approved within drug budgets but is not currently available to prescribe in primary care settings.

The Committee heard from Dr Patel and Ms Logan that tobacco is a major risk factor for mortality and disease and a leading cause of health inequalities in the UK. Dr Patel highlighted that there is compelling cost-effectiveness data to support smoking cessation as a public health intervention, and that the cost-effectiveness of cytisine specifically can be inferred from varenicline data and has been proven in specific sub-groups. Dr Patel emphasised that despite cytisine and varenicline having the same mechanism of action, there is a role for both

drugs on the NCL formulary, as cytisine is only licensed for use in adults aged 18 to 65 years, and a large proportion of the smoking population is above 65 years of age. Moreover, cytisine and varenicline have different dosing regimens, which may account for different patient preferences. Ms Logan responded that cytisine in primary care would primarily be initiated by stop smoking services, and in some cases by the GP e.g. in Enfield where smoking cessation services are still being set up. The Committee questioned whether a repeat course of cytisine would be considered if a patient was not successful in quitting on the first course. The applicants stated clinicians would first need to investigate why the relapse occurred and decide whether a re-trial was appropriate, and that from experience with varenicline the number of patients warranting a repeated course would be extremely low (<5/year).

In camera, the Committee acknowledged the rationale for having cytisine and varenicline on the NCL formulary. The Committee noted that cytisine and varenicline have the same mechanism of action and similar efficacy and safety profiles but varenicline is currently only available as an unlicensed product at a higher cost compared to cytisine, a licensed product. Therefore, the Committee requested clarity on the criteria for prescribing unlicensed varenicline instead of cytisine.

In summary, the Committee agreed to add cytisine to the NCL Joint Formulary for smoking cessation in adult smokers, subject to clarity on the criteria for unlicensed varenicline use in preference to cytisine.

Drug: Cytisine; licensed use
Indication: Smoking cessation in adult smokers (18 to 65 years)
Decision: Approved
Prescribing status: Suitable for initiation in primary and secondary care
Funding source: In tariff
Fact sheet or shared care required: No – to be primarily initiated by smoking cessation services.
Additional Information: Subject to clarity on the criteria for when unlicensed varenicline would be prescribed instead of licensed cytisine.

9.2. Dalteparin for VTE treatment and prophylaxis (Applicants: Dr Nair (in absentia), Ms Pandya; NMUH)

The Committee reviewed the use of dalteparin for:

- The treatment of symptomatic VTE in patients < 1 month old and ≥ 1 month old, and,
- VTE prophylaxis post-orthopaedic surgery in non-weight bearing patients ≥ 13 years old.

The Committee was informed that the use of low-molecular weight heparins (LMWHs) for these indications is established practice across some NCL Trusts historically, and that a rapid review was conducted to assess safety before addition to the NCL formulary.

i. Treatment of symptomatic VTE in patients ≥ 1 month old:

Evidence of dalteparin as an established standard of care for the treatment of symptomatic VTE in patients < 1 month old was identified in standard resources including the product license, BNFc, UpToDate, Martindale, Micromedex and GOSH/Evelina/OUH guidelines. The Committee were reassured that dalteparin in the paediatric population had an established safety profile in the adult population and licensing documentation stated that the frequency, type and severity of adverse reactions in paediatrics is expected to be the same as in adults. Additionally, as this was already routinely used in practice for this cohort with only 5 patients per annum estimated to require this treatment across NMUH and UCLH, the cost pressure of introducing this indication was minimal. The Committee noted that recommendations on treatment initiation, duration and dose changes are recommended by the GOSH haematology team, and other centres (currently UCLH and NMUH) will prescribe and supply dalteparin and monitor anti-Xa levels. GOSH and Evelina guidelines advising on anti-Xa target range, monitoring and dose changes are available.

ii. Treatment of symptomatic VTE in patients < 1month old:

Evidence of dalteparin as an established standard of care for the treatment of symptomatic VTE in patients < 1 month old was identified in standard resources including the BNFc, UpToDate, Martindale and Evelina/OUH guidelines. However, it is not licensed for this age group and no national guidelines were available for this indication. While there were no GOSH guidelines available in this age range, the Committee noted that recommendations on treatment initiation, duration and dose changes are recommended by the GOSH haematology team, and other centres (currently UCLH and NMUH) will prescribe and supply dalteparin and monitor anti-Xa levels. The Committee were reassured that dalteparin in the paediatric population had an

established safety profile in the adult population and licensing documentation stated that the frequency, type and severity of adverse reactions in paediatrics is expected to be the same as in adults. Additionally, as this was already routinely used in practice for this cohort with only 5 patients per annum estimated to require this treatment across NMUH and UCLH, the cost pressure of introducing this indication was minimal.

iii. **VTE prophylaxis post-orthopaedic surgery in non-weight bearing patients ≥ 13 years old:**

Evidence of dalteparin as an established standard of care for the VTE prophylaxis post-orthopaedic surgery in non-weight bearing patients ≥ 13 years old was identified in standard resources including the BNFc, UpToDate, Martindale, Micromedex and Association of Paediatric Anaesthetists of Great Britain/Evelina/OUH guidelines. RNOH guidelines recommend the use of tinzaparin for this cohort. The Committee were reassured that dalteparin in the paediatric population had an established safety profile in the adult population and licensing documentation stated that the frequency, type and severity of adverse reactions in paediatrics is expected to be the same as in adults. Additionally, as this was already routinely used in practice for this cohort with approximately 20 patients per annum estimated to require this treatment at NMUH, the cost pressure of introducing this treatment was minimal. The Committee noted that the NMUH orthopaedic team would recommend treatment initiation following VTE risk assessment.

The Committee heard from Ms Pandya that dalteparin was the LMWH of choice for NMUH for consistency across paediatric indications and because the available strengths of dalteparin pre-filled syringes facilitated safe administration of doses across varying body weights. The use of vials may be necessary to achieve similar doses for tinzaparin. Patient's carers would be taught and accredited to safely administer LMWHs to their children for all indications. The Committee recommended that Trusts complete individual risk assessments to ensure appropriate formulations are available to support safe dosing of LMWH for paediatrics, particularly for low body weight, and to ensure processes are in place to support safe administration, particularly on discharge from hospital.

In summary, the Committee were supportive of approving the use of:

- Dalteparin for the treatment of symptomatic VTE in patients < 1 month old and ≥ 1 month old
- LMWHs (with the choice of LMWH to be decided by each Trust) for VTE prophylaxis post-orthopaedic surgery in non-weight bearing patients ≥ 13 years old.

Drug: Dalteparin
Indication: Treatment of symptomatic VTE in patients < 1 month old and ≥ 1 month old
Decision: Approved
Prescribing status: Restricted to secondary care only
Funding source: Trust
Fact sheet or shared care required: N/A
Additional Information: Trusts to complete risk assessments to ensure appropriate formulations are available to support safe dosing of LMWH for paediatrics, particularly for low body weight, and to ensure processes are in place to support safe administration, particularly on discharge from hospital

Drug: LMWHs (with the choice of LMWH to be decided by each Trust)
Indication: VTE prophylaxis post-orthopaedic surgery in non-weight bearing patients ≥ 13 years old.
Decision: Approved
Prescribing status: Restricted to secondary care only
Funding source: Trust
Fact sheet or shared care required: N/A
Additional Information: N/A

9.3. Latanoprost-netarsudil drops for glaucoma

Deferred.

10. Position Statements and Guidelines

10.1. NCL Glaucoma Guideline

Deferred.

10.2. High Cost Drug Pathway Updates

The Committee reviewed updates to four high cost drug (HCD) prescribing pathways, which were previously approved by JFC in November 2023:

- Rheumatoid Arthritis
- Anklyosing Spondylitis (AS) and Non-radiographic axial spondyloarthritis (nr-AxSpA)
- Crohn's Disease
- Ulcerative Colitis (UC)

The following significant changes were noted:

In the Anklyosing Spondylitis Pathway, reference to secukinumab dose escalation (including 'temporary dose escalation') was removed as funding for this has not been approved, and further treatment options (e.g., JAK inhibitors) are now available on the pathway. Clinical teams have been informed and any future proposal for secukinumab dose escalation (e.g. FOC scheme or business case) would require review via JFC and the HCD team.

In the Crohn's Disease and Ulcerative Colitis pathways, vedolizumab IV maintenance was added back in as a treatment option, noting a preference for SC maintenance which is lower cost. This interim position was agreed with commissioners as further work is required to support clinical teams with the switch to SC maintenance as part of the Cost Improvement Plan (CIP) programme.

In the Ulcerative Colitis Pathway, etrasimod was added as an option in line with NICE TA956 recommendations. Etrasimod, a sphingosine-1-phosphate (S1P) receptor modulator, is now preferred over ozanimod in line with NCL commissioning principles (equivalent efficacy and safety, lower cost). Ozanimod was updated to 'available but not preferred' treatment option. Discussions with clinical teams indicate that etrasimod will not routinely be used ahead of more expensive treatments such as vedolizumab and ustekinumab at the present time due to lack of clinical experience and practical implementation challenges (e.g. cardiac monitoring). This should be reviewed by the HCD team in 12 months, to consider whether a clinical audit standard could then be set to encourage prescribing of etrasimod as a cheaper option.

11. NHSE Updates

11.1. NHSE Specialised Commissioning NICE Appraisals Update

The Committee noted an NHSE Circular (SSC2650) providing an update on Specialised Commissioning from April 2024. This was included for information only.

12. Next meeting

Thursday 19th June 2024

13. Any other business

Nil