Joint Formulary Committee (JFC): Minutes

Minutes from the meeting held on 17th October 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 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		✓
Dr M Henley	RNOH, DTC Chair	✓	
Mr A Shah	RNOH, Chief Pharmacist		✓
Prof A Tufail	MEH, DTC Chair		✓
Ms N Phul	MEH, Chief Pharmacist		✓
Ms K Delargy	NLMHP, Partnership Deputy Chief Pharmacist	✓	
Ms L Reeves	NLMHP, 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)	✓	
Ms EY Cheung	NCL ICB, Head of Quality and Improvement	✓	
Ms K Petrou	NCL ICB, Community Pharmacy Clinical Lead		✓
Dr S Ghosh	Enfield Unity PCN, Clinical Director; Enfield GP Federation, Co-Chair	✓	
Dr D Heaney	UCLH, Consultant Neurologist		✓
Mr S Jenkinson	RFL, Lead Pharmacist Cancer Services	✓	
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 Senior Pharmacist	✓	
Ms K Leung	IPMO Programme Team, JFC Senior Pharmacist	✓	
Ms M Darjee	IPMO Programme Team, JFC Senior Pharmacist	✓	
Ms M Butt	IPMO Programme Team, Director	✓	
Ms I Samuel	RFL, Formulary Pharmacist	✓	
Mr H Shahbakhti	RFL, Formulary Pharmacist	✓	
Mr A Barron	UCLH, Principal Pharmacist		✓
Mr S O'Callaghan	UCLH, Formulary Pharmacist	✓	
Ms H Thoong	GOSH, Formulary Pharmacist	✓	
Mr D Sergian	MEH, Formulary Pharmacist		✓

Mr W Li	MEH, Formulary Pharmacist	✓	
Ms J Bloom	MEH, Associate Chief Pharmacist	✓	
Ms A Bathia	RNOH, Formulary Pharmacist	✓	
Ms S Ahmed	WH, Formulary Pharmacist	✓	
Ms S Shah	NMUH, Formulary Pharmacist	✓	
Ms Y Lam	UCLH, Formulary Pharmacist	✓	
Ms M Thacker	GOSH, Deputy Chief Pharmacist	✓	
Mr J Modha	NHSE, Specialised Commissioning Pharmacist	✓	
Mr J Flor	WH, Lead Pharmacist		✓
Ms R Allen	UCLH, Commissioning Pharmacist	✓	
Mr A Fazal	RFL, Principal Pharmacist	✓	
Mr G Grewal	RFL, Deputy Chief Pharmacist		✓
Ms C Tse	LNWH, Lead Formulary Pharmacist (Observer)	✓	
Ms J Collins	WH Rotational Pharmacist (Observer)	✓	
Ms K Stringaris	UCLH Consultant Haematologist	✓	
Ms C Weaver	NCL ICB, Senior Prescribing Advisor – Quality and Improvement	✓	
Ms N Patel	NCL ICB, Senior Prescribing Advisor – High cost Drugs	✓	
Ms H Wilson	UCLH, Consultant Neurologist	✓	
Ms A Shields	UCLH, Neurology Pharmacist	✓	
Ms B Bharkhada	UCLH, Neurology Pharmacist	✓	

2. Meeting attendees

Dr Subel welcomed members, observers, and applicants to the meeting (see above). The Committee thanked Ms Saloni Maru (IPMO Programme Team, JFC Support Pharmacist) for her contributions to the Committee and wished her luck during her maternity leave. The Committee welcomed Ms Madhuri Darjee who has been appointed to cover the role of JFC Senior Pharmacist.

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 declared by members or attendees present.

4. Minutes of the last meeting

Deferred.

Review of action tracker

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

5.1 Eltrombopag for Aplastic Anaemia (Applicant: Dr K Stringaris, UCLH)

In February 2024, the NCL JFC considered an application for the use of eltrombopag for severe to very severe aplastic anaemia and deferred a decision on approval pending further review of cost-effectiveness and weaning protocol for eltrombopag treatment and a ceiling of treatment duration.

Following a review of the above information provided by the clinical team, the JFC recommend eltrombopag for severe to very severe aplastic anaemia to be clinically- and cost-saving for the following patient cohorts, on the basis of the proposed 3-6 month prescribing protocols (plus weaning where appropriate) :

- as first-line adjunctive therapy in patients ≥12 years old and <60 years old who will receive immunosuppressive therapy [IST (anti-thymocyte globulin; horse ATG + ciclosporin; CSA)],
- as first-line adjunctive therapy in patients ≥60 years old who will receive immunosuppressive therapy [IST (anti-thymocyte globulin; horse ATG + ciclosporin; CSA)], provided ATG or CSA was not cautioned or contraindicated,
- as second-line adjunctive therapy with IST (rabbit ATG + CSA) in patients ≥12 years old and <60 years old, who have relapsed following complete remission (CR) or partial remission (PR) in first-line setting and are unfit for transplant or have no suitable donor.

The ICB, as commissioners, will need to review affordability and make a funding decision before this is added to the formulary. If eltrombopag were to be funded for the above scenarios, the JFC recommends that:

- The ICB implements Blueteq forms (or equivalent assurance process) to ensure compliance with the agreed initiation criteria and prescribing protocol.
- The ICB review cost-effectiveness if there are significant changes in price of eltrombopag (noting that the patent for eltrombopag is due to expire in September 2025 and there are currently 4 generic manufacturers with an MHRA license to develop generics but no information on the level of discount currently).
- Applicants ensure that patients sign a consent form prior to starting treatment, which clearly outlines the approved treatment duration and that treatment may be stopped even if patients are responding.

Long-term use of eltrombopag (due to relapse on weaning) affects a small proportion of patients (<10%) but represents a high drug cost, and the cost-analysis of this cohort remains uncertain. The complex cost-analysis modelling for this cohort is beyond the scope of local modelling. JFC recommends that this cohort is not routinely commissioned and that the ICB considers these patients on an individual basis, and considers setting thresholds for transfusion savings that would deem the treatment cost-saving and affordable.

In summary, the Committee clinically approved the use of eltrombopag for the first- and second-line cohort and deferred a decision on funding approval to the ICB. Ms Coughlan agreed to take this forward for financial consideration and also to work with ICB and UCLH colleagues to consider commissioning options for individual funding consideration for the long-term cohort.

Drug: Eltrombopag tablets
Indication: Severe or very severe aplastic anaemia
Decision: Clinically approved, deferred to the ICB for funding consideration

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

Date	Drug and Indication	DTC Decision and Details
August 2024	[EAMS FOC scheme] Elafibranor for primary biliary cholangitis*†	**Reviewed by**: RFL **Drug**: Elafibranor, 80mg once daily **Indication**: Treatment of PBC in combination with UDCA in adults who have had an inadequate response to UDCA, or as monotherapy in patients unable to tolerate UDCA. **Decision**: Clinically approved **Funding source**: EAMS FOC scheme **Prescribing status**: Secondary care prescribing only **Additional information**: Subject to written letter of guarantee from Ipsen that supply will continue FOC to patients in the event Elafibranor is not recommended by NICE for the treatment of PBC. To be referred to the LEC(s) for funding consideration. **Fact sheet or Shared Care required**: N/A
August 2024	Upadacitinib (Rinvoq®) for inflammatory myositis including dermatomyositis*	**Reviewed by**: RFL **Drug**: Upadacitinib **Indication**: Inflammatory myositis including dermatomyositis. 15mg once daily **Decision**: Clinically approved **Funding source**: Divisional **Prescribing status**: Secondary care only **Additional information**: Provide update to DTC on clinical efficacy and safety in 8-10 months' time. To be referred to the LEC(s) for funding consideration. **Fact sheet or Shared Care required**: N/A

September 2024	Propranolol & Timolol for infantile haemangioma (off-label historical review)	**Reviewed by**: UCLH **Drug**: Propranolol oral solution (as per BNFC) **Indication**: Infantile haemangioma **Decision**: Approved **Prescribing status**: Proposed as suitable for secondary care initiation, primary care continuation – for further consideration via Shared Care Group **Funding source**: In tariff **Fact sheet or Shared Care required**: For review via Shared Care Group **Reviewed by**: UCLH **Drug**: Timolol 0.5% LA gel-forming eye drops (1-3 drops topically to the affected area BD to TDS) **Indication**: Infantile haemangioma **Decision**: Approved **Prescribing status**: Proposed as suitable for secondary care initiation, primary care continuation – for further consideration via Shared Care Group **Funding source**: In tariff **Fact sheet or Shared Care required**: For review via Shared Care Group
September 2024	Tamoxifen for prevention of bicalutamide-induced gynaecomastia (off-label historical review)	**Reviewed by**: UCLH **Drug**: Tamoxifen tablets 20mg weekly **Indication**: Prevention of gynaecomastia in men with prostate cancer requiring long-term bicalutamide treatment **Decision**: Approved **Prescribing status**: Proposed as suitable for secondary care initiation, primary care continuation – for further consideration via Shared Care Group **Funding source**: In tariff **Fact sheet or Shared Care required**: For review via Shared Care Group

*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.

The Committee noted that the UCLH DTC (UMC) is supporting the review of historical off-label prescribing decisions via rapid review. In some cases, existing practice is for prescribing to be transferred to primary care. The Committee recommended that these cases are reviewed via the Shared Care Group, and that the existing rapid review by UMC plus data on patient numbers forms the basis of this decision-making. This should avoid duplication while ensuring that any primary care implications (e.g. requirement for interface prescribing support) are considered before confirming the prescribing status.

The Committee deferred ratification of the following decision regarding methoxyflurane to the next meeting pending clarification of queries raised by the Committee. Mr O'Callaghan agreed to circulate details of the UCLH DTC discussion to check applicability for other Trusts.

September 2024	Methoxyflurane (Penthrox®) for management of pain during colonoscopy in patients where IV sedation is preferred but an escort cannot be arranged	**Reviewed by**: UCLH **Drug**: Methoxyflurane (Penthrox®) **Indication**: Management of pain during colonoscopy in patients where IV sedation is preferred but an escort cannot be arranged

	(**Deferred**)	**Decision**: Conditionally approved pending development of local SOP. Data to be reported back to Committee 6 months (or 20 patients) after implementation. **Prescribing status**: Secondary care only **Funding source**: In-tariff **Fact sheet or Shared Care required**: N/A

Matters arising

8.1. Mitapivat FOC Scheme

Deferred.

8 Medicine reviews

8.1 [FOC Scheme] Cladribine for multiple sclerosis (Year 3 onwards) (Applicant: Dr H Wilson, UCLH; Ms A Shields, UCLH)

The Committee considered an application for a free-of-charge (FOC) scheme for cladribine, a nucleoside analogue of deoxyadenosine, for the treatment of highly active or rapidly evolving severe relapsing-remitting multiple sclerosis (RRMS) in years 3 and beyond. To date, cladribine was available for initiation in patients with RRMS for 2 years only as per NICE TA616. In May 2022, the NCL JFC agreed to add cladribine to the NCL Joint Formulary for use in patients who are eligible under the terms of the FOC scheme, for a further 'top-up' course of cladribine in years 3 or 4 of treatment for RRMS. At the time, the Committee considered evidence from the CLARITY trial (2010, n= 1,326) and CLARITY extension trial (2018, n= 806). Additionally, the Committee requested applicants to collect data on efficacy and safety in patients treated locally and attempt to collaborate with other UK centres to produce a preliminary policy proposition (PPP) for NHSE. The Committee were informed that there was a PPP in progress (submitted by St George's Hospital) but there is no confirmed timeline, and the current JFC application cohort is not covered by the PPP.

The current application seeks to remove the time restriction for the 'top-up' course of cladribine to allow patients to receive this in year 3 and beyond (i.e., not be restricted to just year 3 and 4). In terms of new evidence, Giovannoni et al (2023; n= 435) is an exploratory, low-interventional, multicentre, ambispective, phase IV study which reported long-term mobility and disability of patients who participated in CLARITY with or without subsequent enrolment to CLARITY extension. The median follow-up after CLARITY/ CLARITY extension was 10.9 years (range: 9.3-14.9 years). Of the patients who were not using a wheelchair in the 3 months prior to the first study visit of this study, patients who were exposed to cladribine were less likely to require a wheelchair or be bedridden compared to patients who received placebo (OR 0.39 [95% CI 0.167 to 09.31). However, limitations of the study include the exploratory nature of the study with no pre-planned protocol, therefore, sample size calculations were not undertaken, and formal statistical analysis could not be conducted.

In terms of safety, the Committee were informed that there was a recent MHRA safety alert recommending liver monitoring prior to each treatment course of cladribine to reduce the risk of serious liver injury. It was highlighted that cladribine was associated with transient lymphopenia, however, its safety profile is superior compared to alternative treatment options which may lead to long-term immune suppression. Alternative RRMS treatment options as per the NHSE Treatment Algorithm for Multiple Sclerosis Disease-Modifying Therapies include: natalizumab, ocrelizumab, ofatumumab, S1P receptor modulators (e.g., fingolimod), and haematopoietic stem cell transplant (HSCT). These are associated with serious adverse effects such as progressive multifocal leukoencephalopathy (PML), malignancies (e.g., basal cell carcinoma), rebound syndrome following missed doses or discontinuation, herpes meningoencephalitis, and significant bradycardia or heart block. These adverse events have also been highlighted by MHRA Safety Alerts.

In terms of convenience, cladribine is a short course of oral tablets compared to other treatments options that are administered parenterally (via IV or SC injections) or continuous oral therapies. The Committee also heard that there was fewer monitoring requirements associated with cladribine treatment compared to other treatment options.

The Committee heard from Dr Wilson and Ms Shields that approximately 25% of patients at year 5 or 6 may present with new MRI and/or clinical activity. These patients may therefore require a second course of treatment to prevent accumulating disabilities related to relapse activity. Dr Wilson mentioned that the NICE eligibility criteria of Cladribine is currently under review and it is expected that recommendations may change to allow treatment to be initiated following one relapse instead of two relapses within 12 months.

In camera, the Committee acknowledged that the initial restriction of a repeated course of treatment with Cladribine at year 3 or 4 was to align with the access criteria within the FOC scheme and this scheme has since been updated. There is limited new evidence for long-term efficacy or safety. The Committee discussed the long half-life of cladribine and concerns that this may delay use of another effective treatment if the second course of cladribine was not tolerated or not effective. The applicants outlined selection criteria for patients, for example avoiding use in very highly active MS, and also outlined that different alternative treatment options would be available depending on the rate of lymphocyte recovery. The Committee noted that treatment with Cladribine will be considered as a one-off course at any time following the initial treatment (Year 1 and 2) and will not be an annual course each year, and that this reduced financial risk associated with the terms of the FOC scheme.

In summary, the Committee agreed to approve the use of Cladribine in patients with highly active or rapidly evolving severe relapsing-remitting multiple sclerosis (RRMS) in years 3 and beyond in line with the terms of the FOC scheme.

Drug: Cladribine tablets
Indication: Highly active or rapidly evolving severe relapsing-remitting multiple sclerosis (RRMS) in years 3 and beyond
Decision: Approved
Prescribing status: Restricted to secondary care only
Funding source: FOC scheme
Fact sheet or shared care required: N/A
Additional information: N/A

9 Position Statements and Guidelines

9.1 NCL JFC Terms of Reference (Draft)

The Committee reviewed changes made to the NCL JFC Terms of Reference, and agreed to send any comments back to the JFC secretariat team within 2 weeks.

9.2 Ulcerative colitis pathway update: Risankizumab NICE TA

The Committee noted that a new NICE technology appraisal for risankizumab for the treatment of moderate to severe active UC was published in August 2024.

Risankizumab (and other p19 IL23 receptor antagonists) are considered to have a different mechanism of action to ustekinumab (p40 IL12 and IL23 receptor antagonist) on the following basis:

- Different target specificity (p19 subunit is exclusive to the IL23 receptor whereas the p40 subunit is shared by IL12 and IL23 receptors),
- Superioritiy of risankizumab to ustekinumab in head-to-head comparison in two other therapeutic areas (psoriasis and CD).

The Committee also noted that there was no clinical evidence to compare ustekinumab to IL23 inhibitors in UC (as per the INSPIRE, COMMAND, LUCENT-1 and –2, and QUASAR trials), but were supportive of extrapolating the efficacy data from the ADVANCE and MOTIVATE studies reporting CD patients pre-treated with ustekinumab derive a greater benefit from treatment with risankizumab (with a greater proportion achieving CDAI clinical remission) compared to placebo.

The Committee approved the use of risankizumab alongside mirikizumab as an alternative option for patients who fail to respond to ustekinumab. Mirkizumab is listed as the preferred IL23 inhibitor and risankizumab as available but not preferred as there is no clinical evidence to suggest a difference in efficacy or safety, but there is a substantial cost differential between the two. Due to infusion site capacity concerns at some Trusts, the High Cost Drug Team will work with Trusts to help build this capacity.

9.3 NCL Hypertriglyceridaemia Pathway

The Committee approved the updated NCL Hypertriglyceridaemia pathway which included NICE TA 805 for icosapent ethyl.

9.4 NCL Use of Gastroprotective Agents: PPIs and H2RAs

The Committee acknowledged comments received from the NCL-wide consultation of the updated position statement for NCL Use of Gastroprotective Agents and were supportive of JFC responses to these comments. The Committee agreed that due to equivalent efficacy and safety across H2RAs (within drug class), the choice of H2RA in NCL should be based on lowest drug acquisition cost in primary care, which is currently famotidine.

Trust formulary teams were asked to ensure that this was implemented locally. The Committee approved the position statement for the NCL Use of Gastroprotective Agents: PPIs and H2RAs pending clarification on the use of unlicensed versus licensed omeprazole suspension in primary care.

10 Sub-Group Updates

10.1 NICE TA Implementation Group

The Committee approved the NICE TA Implementation Group Terms of Reference and noted the report template which will be shared with JFC on a monthly basis to highlight the NICE TAs with complex implementation issues that are being actioned at an ICS level, and to support any clinical issues with implementation that are escalated by the NICE TA Implementation Group to JFC.

10.2 Shared Care Group Update – Options Appraisal

Ms Sanghvi presented an update from the NCL Shared Care Group (SCG), a sub-group of JFC, outlining current interface prescribing challenges which threaten the Group's ability to successfully deliver interface support documents. It is recognised that many of these challenges are national, particularly in relation to capacity across primary and secondary care to take on prescribing, and challenges for tertiary services of dealing with out-of-sector variation in prescribing status. Although the challenges are not limited to NCL, the SCG considered it important to review options for continued delivery and assess whether its current processes and scope were appropriate. The Committee heard a summary of the options appraisal considered by the SCG.

Overall, it was concluded that the outcomes of the SCG are valued across the system, and the group should continue to deliver these. The SCG agreed that a combination of option 2 (promoting collective responsibility and reducing administrative burden) and option 4 (addressing commissioning concerns raised during document development to support uptake of documents) would be the preferred route forward. The Committee were supportive of the following actions proposed by the SCG:

- Louise Coughlan and ICB Medicines Optimisation Team to explore commissioning options with ICB primary care leads and feasibility of a commissioning triage step.
- Current challenges and options to be shared with NCL ICB Medicines Clinical Reference Group for further discussion.
- JFC Team to work with Shared Care Group members to support delegated responsibility for document development and ensure appropriate membership of the group.

11 NHSE Updates

Nil

12 Next meeting

Thursday 21st November 2024

13 Any other business

Nil