Joint Formulary Committee (JFC): Minutes

Minutes from the meeting held on 15th May 2025

		Present	Apologies
Members			
Prof A Hingorani (Chair)	NCL JFC Chair	✓	
Dr B Subel	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 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	✓	
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 C Tse	IPMO Programme Team, JFC Principal 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 S Amin	IPMO Programme Team, Lead Pharmacist	✓	
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		✓
M A Sehmi	NMUH, Formulary Pharmacist		✓
Ms Y Lam	UCLH, Formulary Pharmacist		✓
Ms M Thacker	GOSH, Deputy Chief Pharmacist	✓	
Mr J Modha	NHSE, Specialised Commissioning Pharmacist		✓
Ms A Blochberger	NHSE, Chief Pharmacist – Specialised Commissioning	✓	
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 Weaver	NCL ICB, Senior Prescribing Advisor – Quality and Improvement		✓
Dr B Powell	UCLH, Clinical Pharmacology Specialist Registrar	✓	
Mr L Nicholson	MEH, Consultant Ophthalmologist	✓	
Mr D Hanumunthadu	RFL, Consultant Ophthalmologist	✓	
Dr P Harrow	UCLH, Consultant Gastroenterologist	✓	
Ms J Pang	IPMO Programme Team, Lead Pharmacist (Observer)	✓	
Mr K Simpson	IPMO Programme Team, Principal Population Health Analyst (Observer)	✓	
Ms H Shah	NCL ICB, Prescribing Adviser - High Cost Drugs (Observer)	✓	
Ms A Fakoya	NCL ICB, Contracting & Commissioning Support Pharmacist (Observer)	✓	
Ms A Farook	NCL ICB, Prescribing Support Pharmacist (Observer)	✓	
Ms S Ghartey	MEH, Lead Pharmacist for EPR and Transformation (Observer)	✓	
Ms R Nassar	RNOH, Pharmacist (Observer)	✓	
Ms S Shah	UCLH, Lead Pharmacist for A&E and Same Day Emergency Care (Observer)	✓	

2. Meeting attendees

Prof Hingorani welcomed members, observers, and applicants to the meeting (see above).

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. Mr Nicholson and Mr Hanumunthadu declared interests from the manufacturer for Eylea® (aflibercept) (Bayer) and Vabysmo® (faricimab) (Roche).

4. Minutes and abbreviated minutes of meetings on 24th April 2025

Minutes and abbreviated minutes of the 24th April 2025 meeting were ratified.

5. Review of action tracker

Action tracker included for information. 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 Tse.

7. Local DTC recommendations/minutes

Date	Drug and Indication	DTC Decision and Details	JFC recommendation
March 2025	Rituximab for chronic inflammatory demyelinating polyneuropathy*	**Reviewed by:** UCLH **Drug:** Rituximab; Dose: Initially 2x1g doses 2 weeks apart, followed by 1g up to every 6 months **Indication:** Antibody-negative Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP) **Decision:** Approved under evaluation **Prescribing status:** Restricted to secondary care only **Funding source:** Internal funding of high-cost drug	**Conditionally approved for UCLH**

		Additional information: Approved under evaluation, rituximab for antibody negative treatment refractory CIDP patients pending development of a formal treatment protocol. The Committee requested that applicants collect and submit the results of the first 10 patients treated with rituximab for treatment refractory CIDP. **Fact sheet or Shared Care required:** N/A	
March 2025	Clonidine transdermal patches for childhood onset severe generalised dystonia; continuation of therapy in patients transferring to adult services*	**Reviewed by:** UCLH **Drug:** Clonidine transdermal patch (0.1mg, 0.2mg, or 0.3mg) **Dose:** Variable based on dose established at GOSH prior to transfer; administered weekly **Indication:** Continuation for treatment for patients with childhood onset severe generalised dystonia transferring from GOSH to adult services at NHNN **Decision:** Approved **Prescribing status:** Restricted to secondary care only **Funding source:** Internal funding **Additional information:** Pending further cost estimates and divisional approval for internal funding. **Fact sheet or Shared Care required:** N/A	**Approved for UCLH only**
March 2025	Metoprolol IV for CT angiography (off-label historical review)	**Reviewed by:** UCLH **Drug:** Metoprolol IV **Dose:** 5mg every 2-3 minutes until the heart rate falls below 60 bpm (total maximum 30mg) **Indication:** Minimisation of motion artefacts prior to CT angiography **Decision:** Approved **Prescribing status:** Restricted to secondary care only **Funding source:** In tariff **Additional information:** Approval in principle for the development of a metoprolol IV PGD up to a maximum dose of 15mg. **Fact sheet or Shared Care required:** N/A	**To add to the NCL Joint Formulary**
March 2025	GTN spray for CT angiography and CT pelvis (off-label historical review)	**Reviewed by:** UCLH **Drug:** GTN spray 400mcg/dose **Dose:** 1-2 sprays sublingually **Indication:** Arterial dilation prior to a CT angiography and CT pelvis scan **Decision:** Approved **Prescribing status:** Restricted to secondary care only **Funding source:** In tariff **Additional information:** Approval in principle for the development of a GTN PGD. **Fact sheet or Shared Care required:** N/A	**To add to the NCL Joint Formulary**
March 2025	Losartan for Raynaud's Phenomenon (off-label historical review)	**Reviewed by:** UCLH **Drug:** Losartan tablets **Dose:** 25mg to 100mg daily **Indication:** Symptomatic management of Raynaud's phenomenon **Decision:** Approved **Prescribing status:** Suitable for secondary care initiation, primary care continuation – referred to NCL JFC for review **Funding source:** In tariff	**To add to the NCL Joint Formulary**

		Additional information: Nil **Fact sheet or Shared Care required:** N/A	

*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.

8. Matters arising

8.1. JFC Terms of Reference – Voting procedure

Deferred.

9. Medicine Reviews

9.1 High-dose thiamine for fatigue in inflammatory bowel disease (Applicant: Dr P Harrow, UCLH)

The committee considered an off-label application for use of high-dose thiamine for managing fatigue in patients with inflammatory bowel disease (IBD), including ulcerative colitis (UC) and Crohn's disease (CD). Thiamine is a water-soluble B vitamin and an essential micronutrient. Due to chronic diarrhoea, inflammation, and malabsorption, IBD patients are at risk of thiamine deficiency and often experience fatigue even when in remission and even when thiamine replete. Although thiamine is licensed for treating vitamin B deficiency at doses up to 300mg daily and is used off-label for Wernicke-Korsakoff syndrome, there are currently no approved therapies for managing fatigue in patients with IBD. Furthermore, no national, international, or societal guidelines recommend thiamine for this indication. The applicant proposed a high-dose oral thiamine regimen (600–1800mg/day, adjusted for gender and weight) over eight weeks for the treatment of fatigue in patients with inflammatory bowel disease in remission even if thiamine replete.

The TARIF study (by Bager et al 2021, n=40) was a single centre, randomised, double-blinded, placebo-controlled crossover trial designed to investigate the effect and safety of high-dose oral thiamine (600-1800 mg/day) on chronic fatigue in thiamine replete patients with quiescent IBD. The study included patients who had a diagnosis of CD or UC for more than 3 months, with disease in remission, a faecal calprotectin <200 mg/kg and normal-range clinical scores (measured using the Harvey–Bradshaw Activity Index (HBAI) for CD and the Simple Clinical Colitis Activity Index (SCCAI) for UC). Participants were randomised in a 1:1 ratio and received either oral thiamine or placebo for an initial 4-week treatment period, followed by a 4-week washout phase, after which they crossed over to the alternate treatment for another 4 weeks. Fatigue was measured using the Inflammatory Bowel Disease-Fatigue (IBD-F) Questionnaire. A clinically relevant improvement was defined as an increase of ≥3 points on Section I of the IBD-F scale. The pre-specified primary efficacy endpoint was the improvement in fatigue after 4 weeks of thiamine treatment compared with placebo measured using Section I of the IBD-F scale. There was no statistically significant difference in baseline characteristics between study group 1 (thiamine-followed by placebo) and group 2 (placebo followed by thiamine). The endpoint reported by the study authors, *which was different from the pre-specified primary efficacy end point*, was the week 12 mean fatigue difference for the combined group 1 and group 2, which was a reduction of 4.7 points in IBD-F (95% CI 3.4-6.0; P < 0.0001). However, the pre-specified primary efficacy endpoint of the difference in fatigue after 4 weeks of thiamine treatment compared with placebo, was 2 points (12.9 vs 10.9 in the placebo and thiamine treated groups respectively, p=0.07). 55% of group 1 and 75% of group 2 showed an improvement ≥ 3 points while on thiamine compared with 25% of group 1 and 35% of group 2 while on placebo. The crossover analysis reported a mean reduction of 4.5 points (95% CI 2.6-6.2) in fatigue after thiamine compared with a mean increase of 0.75 point (95% CI −1.3-2.8; P = 0.0003) after placebo.

In terms of safety, there were no significant safety concerns reported in the study. Only mild side effects were reported, suggesting that thiamine is a safe medication.

In terms of convenience, oral thiamine presents challenges, with tablets available in various strengths up to 100 mg. High-dose regimens can require 6–18 tablets daily, potentially impacting adherence.

In terms of budget impact, minimal to no cost pressure expected as thiamine has low drug acquisition cost. It is expected that the estimate budget impact for NCL is approximately £2000.

The Committee heard from Dr Harrow that although thiamine is a readily available over-the-counter medication, financial barriers may limit access for certain patients. The rationale for prescribing thiamine to this cohort is based on the possibility of thiamine deficiency; however, confirming this may be challenging, as thiamine levels are not routinely measured in clinical practice. Fatigue is a highly multifactorial symptom, and

while evidence base suggests that there are no sustained benefits from long term thiamine treatment, short-term use may offer some benefits. Dr Harrow confirmed that other potential causes of fatigue would be ruled out prior to considering thiamine as a treatment option. The proposed course of treatment will be limited to 8 weeks, with the possibility of additional courses being prescribed for up to a year.

In camera, the Committee discussed several concerns regarding the reported efficacy of thiamine. The IBD-F scale was not fully displayed in the trial results; instead, a magnified segment was used, which overstated the difference between the thiamine and placebo groups. When interpreted on the full 0–20 scale, the difference was notably smaller. The trial primary endpoint was defined as a ≥3-point improvement in fatigue on Section I of the IBD-F scale after 4 weeks of treatment. However, this threshold was not met, and the p-value for the comparison was not statistically significant. The authors did not report this outcome. Instead, they highlighted a different, statistically significant endpoint measured at week 12, which combined results from both groups—diverging from the stated primary outcome. Additionally, at the end of the washout period, the IBD-F score difference between the two groups was approximately 2 points, similar to the difference observed at the claimed efficacy timepoint. Although the authors argued that the washout was complete and the difference was not meaningful, this raised concerns about the reliability of the efficacy claims.

The Committee acknowledged that oral thiamine is low cost and generally safe and also noted concerns regarding inequity of access, highlighting that some individuals can afford to purchase thiamine supplementation over the counter and others not, but in the absence of reliable evidence of efficacy, the committee concluded that equity arguments did not apply here.

In summary, the Committee elected not to approve the use of thiamine for fatigue in IBD patients. It was recommended that thiamine should not be prescribed in the secondary care or be recommended for purchase over the counter for this indication.

Drug: Thiamine tablets; off-label; 600-1800mg daily (depending on gender and weight)
Indication: Fatigue in inflammatory bowel disease
Decision: Not approved
Additional information: Clinicians must not prescribe or recommend thiamine over the counter for this indication.

9.2 nAMD HCD Pathway – Aflibercept 8mg versus faricimab as the first-line treatment option for patients requiring reduced treatment burden for patients with best-corrected visual acuity (BCVA) 6/12 to 6/96; sequential use of anti-VEGF treatments as second-line therapies in patients with BCVA 6/12 to 6/96; and Business Case for aflibercept 2mg for the treatment of patients with BCVA better than 6/12 (Applicants: Mr Nicholson, MEH; Mr Hanumunthadu, RFL; Mr Haris Papanikolaou (in absentia), RFL)

In April 2025, the Committee reviewed the rationale and evidence underpinning the proposed changes to first- and third-line treatments of the NCL High-Cost Drug pathway for neovascular age-related macular degeneration (nAMD). At the time, the Committee agreed to defer their decision pending a full review of evidence across all treatment lines. The Committee considered the evidence for the following proposed changes:

- Aflibercept 8mg (Eylea®) versus faricimab as the first-line treatment option for patients requiring reduced treatment burden for patients with best-corrected visual acuity (BCVA) 6/12 to 6/96;
- The sequential use of anti-VEGF treatments as second-line therapies in patients with BCVA 6/12 to 6/96;
- The business case for aflibercept 2mg for the treatment of patients with BCVA better than 6/12.

The evidence indicates that NICE-recommended treatments (aflibercept 2mg, ranibizumab, brolucizumab, faricimab, and bevacizumab gamma) are broadly equivalent in efficacy. Therefore, positioning and sequencing of anti-VEGF agents should be guided by cost, frequency of dosing, and safety profiles.

9.2.1 Aflibercept 8mg versus faricimab as the first-line treatment option for patients requiring reduced treatment burden for patients with best-corrected visual acuity (BCVA) 6/12 to 6/96

Aflibercept 8mg, a high-dose formulation of aflibercept was approved by the Medicines and Healthcare products Regulatory Agency (MHRA) in January 2024. Aflibercept 8mg was not the subject of a NICE Technology Appraisal, therefore, there is no statutory requirement for its routine commissioning. However, NICE has

acknowledged that aflibercept 8mg is "*clinically equivalent and of at least equal cost-effectiveness to the NICE recommended 2mg formulation*". Aflibercept 8 mg eases treatment burden of nAMD through extended dosing and fewer injections. This regimen may be particularly beneficial for patients with complex care needs such as those who require hospital transport, patients with advanced dementia, learning difficulties, and co-morbidities requiring frequent hospital appointments or inpatient admissions, and those requiring treatment under sedation or general anaesthesia in theatre. Therefore, aflibercept 8mg is currently under consideration as a first-line treatment option for patients with BCVA 6/12 to 6/96 requiring reduced treatment burden, in place of faricimab.

PULSAR (2024; n= 1,011), a phase III, randomised, three-group, double-masked, non-inferiority trial aimed to demonstrate that patients treated with intravitreal aflibercept 8mg achieved non-inferior visual acuity gains compared with aflibercept 2mg. Adults with nAMD were randomised 1:1:1 to aflibercept 8mg every 12 weeks (8q12), aflibercept 8mg every 16 weeks (8q16), or aflibercept 2mg every 8 weeks (2q8), following three initial monthly doses in all groups. The primary outcome of interest was change from baseline in BCVA (ETDRS letter score) at week 48. The study reported that patients that received 8mg 12- and 16-weekly (8q12 and 8q16) showed non-inferior BCVA gains versus aflibercept 2mg every 8-weekly (2q8) (mean BCVA change from baseline +6.7 [SD 12.6] and +6.2 [11.7] vs +7.6 [12.2] letters). The least squares mean differences between aflibercept 8q12 versus 2q8 and 8q16 versus 2q8, respectively, were −0.97 (95% CI −2.87 to 0.92) and −1.14 (−2.97 to 0.69) letters (non-inferiority margin at 4 letters). The authors concluded that aflibercept 8mg showed efficacy and safety with extended dosing intervals.

In terms of safety, the study also found similar rates of ocular adverse events across the three study groups suggesting the adverse events profile of aflibercept 8mg and aflibercept 2mg were comparable.

In terms of convenience, aflibercept 8mg at 12-weekly and 16-weekly dosing interval requires 11 and 14 injections over a 3-year period, respectively. In the PULSAR trial (2024; n= 1,011), study authors reported that most patients in the aflibercept 8q12 (79%) and 8q16 (77%) groups maintained their assigned dosing regimens up to week 48; overall, 83% of patients who received aflibercept 8mg maintained at least 12-week dosing intervals up to week 48. The Committee were informed that real-world data on aflibercept 8mg remain limited due to its recent licensing. However, there was potential for fewer injections with aflibercept 8mg compared to faricimab which requires an average of 17 injections (based on an audit conducted by the MEH/ Kingston Hospital) over a 3-year period.

In terms of cost, aflibercept 8mg has a lower acquisition cost compared to faricimab (prices redacted due to confidentiality). The use of aflibercept 8mg represents cost savings of between £3800-5600 per patient (based on 12-weekly and 16-weekly dosing interval) over three years, including appointment costs.

9.2.2 Sequential use of anti-VEGF treatments as second-line therapies in patients with BCVA 6/12 to 6/96

The Committee reviewed the potential sequential use of anti-VEGF treatments as second line therapies in patients with BCVA 6/12 to 6/96. In patients who respond to aflibercept 2 mg but are unable to extend the treatment interval to ≥8 weeks, consideration may be given to second-line treatment with faricimab or aflibercept 8 mg.

The Committee were proposed with two pathway options and supporting evidence for their associated sequential switches were presented. While no randomised controlled trials were available, several real-world retrospective studies demonstrated the efficacy and safety of switching anti-VEGF treatments.

Sim et al (abstract only 2025, n=117) a retrospective, multicentre cohort investigated the outcomes of patients with treatment-intensive neovascular age-related macular degeneration (nAMD) switched to faricimab from aflibercept 2mg. Patients with nAMD switched to faricimab were identified from electronic medical records and those who met criteria of high treatment burden were included. The primary endpoint was to measure the outcome of visual acuity, central subfield thickness (CST), presence of intraretinal fluid, subretinal fluid, and injection intervals over 1 year after switch to faricimab. The study reported that there was no statistical difference in the mean visual acuity following the switch to faricimab from aflibercept, however there was statistical significance reported in the mean CST which reduced after the third faricimab injection and at 12 months by 20.0µm (P = 0.035) and 22.1µm (P = 0.041) respectively. Furthermore, the mean treatment intervals increased to 6.9 ± 2.3 weeks (P < 0.005) at 12 months with 42.9% and 11.4% of patients being on ≥8-weekly and ≥12-weekly treatment intervals, respectively. The authors concluded that, after one year, patients with nAMD who had previously experienced a high treatment burden maintained visual acuity and showed improved anatomic outcomes when switched to faricimab, with extended treatment intervals.

Szigiato et al (2024, n=106) a short term, retrospective, non-comparative cohort study investigated the effect of switching to faricimab in nAMD patients who have previously been treated with an anti-VEGF treatment. The study involved 106 patients (126 eyes) of which 110 eyes had previously been treated with aflibercept 2mg. The study aimed to investigate effect of switching to faricimab on the central subfield thickness and presence of intraretinal fluid (IRF) or presence of subretinal fluid (SRF) after ≥ 3 faricimab injections. The study reported the mean visual acuity (62.9 vs. 62.7 approximate ETDRS letters, P = 0.42) and interval between injections (6.3 vs. 5.7 weeks, P = 0.16) was similar after the third dose of faricimab compared with baseline. Furthermore, the central subfield thickness was reduced from baseline after the first faricimab dose (266.8 ± 64.7 vs. 249.8 ± 58.6 µm, P = 0.02) and was sustained over 3 faricimab injections (P = 0.01). The study concluded that following the switch to faricimab, visual acuity remained stable and treatment intervals were similar to those with prior anti-VEGF treatments. Additionally, a reduction in mean CST was observed, and no other adverse drug events were reported following the switch.

Bala et al (2025, n=184, 209 eyes) a single centre, retrospective, noncomparative cohort study investigated the outcomes of patients with nAMD treated with high dose aflibercept (HDA) 8mg following treatment with prior Anti-VEGF treatment. Within the study cohort, 125 eyes had previously been treated with aflibercept 2mg. The primary end point was the proportion of eyes able to sustain an 8 ± 1-week or longer treatment interval without anatomical deterioration which were measured by best-corrected visual acuity (BCVA) and macular OCT parameters at baseline and after HDA. The study reported that the treatment interval of HDA after 3 initial injections significantly increased to 7.4 ± 2.2 weeks compared with the last pre-switch interval of 5.8 ± 2.5 weeks (P <0.0001). Furthermore, the mean BCVA at baseline was 65.8 ± 18.5 ETDRS letters and 64.3 ± 21.0 ETDRS letters at the final visit (P = 0.559), signifying it was maintained following switch to HDA. There was no statistically significant change observed in the mean baseline CST at baseline 59.2 ± 58.0 compared to the final visit 258.1 ± 64.4 µm (P = 0.892). The authors concluded that aflibercept 8mg maintained anatomical stability with no major adverse events reported.

In summary, switching from aflibercept 2 mg to faricimab maintains BCVA, reduces CSF, and may allow for longer injection intervals with faricimab. Similarly, switching from aflibercept 2mg to aflibercept 8mg supports extended dosing without compromising BCVA or safety, and with no notable CSF changes.

The Committee reviewed two proposed NCL nAMD pathways options, based on whether faricimab or aflibercept 8mg was preferred as the first-line option in patients requiring reduced treatment burden with BCVA 6/12 to 6/96.

Pathway option 1 places faricimab as the first-line treatment in patients requiring reduced treatment burden with BCVA 6/12 to 6/96, with a potential switch to aflibercept 8mg as second-line treatment option for patients requiring a reduced treatment burden. Momenaei et al (2025, n=85) a retrospective study assessed the efficacy of switching to aflibercept 8mg in nAMD patient treated with faricimab with suboptimal response. Switching from faricimab to aflibercept 8 mg did not result in extension of injection interval or improvement in the visual acuity. The study reported there was an increase in incidence of intraretinal fluid and subretinal haemorrhage following switch to aflibercept 8mg. The study reported that patients who received an average of 7.4 (4) faricimab injections with a mean interval of 53 days, decreased to 48 days by the 5th aflibercept 8 mg injection (P = 0.056). The mean visual acuity at the time of switch was 63.9 (14.4) letters and was 65 (13.5) letters after four aflibercept 8 mg injections (P = 0.726) and the mean central foveal thickness (CFT) at switch was 325 (104) µm which decreased to 272 (65) after four aflibercept 8 mg injections (P < 0.001). The study concluded that switching from faricimab to aflibercept 8mg maintained visual acuity and injection interval, demonstrated improvement in the central foveal thickness, but was associated with an increased incidence of adverse ocular events.

Pathway option 2 places aflibercept 8mg as the first-line treatment in patients requiring reduced treatment burden with BCVA 6/12 to 6/96, with a potential switch to faricimab as second-line treatment option for patients requiring reduced treatment burden. There are limited evidence supporting the switch from aflibercept 8mg to alternative anti- VEGF treatments. Bala et al (2025, n=184, 209 eyes) reported that treatment with aflibercept 8mg (HAD) was discontinued in several cases due to inability to extend the treatment interval to the minimum 8 ± 1 weeks' duration (22 eyes, 91.6%), the higher cost associated with HDA despite persistent macular fluid (1 eye, 4.1%) or a reversion to previous treatment (1 eye, 4.1%). Following discontinuation with HDA, 16 eyes were switched to faricimab. The study reported that a switch to faricimab maintained anatomical stability with the mean visual acuity (ETDRS letters) maintained from 63.8 to 63.6 and no significant changes were observed in the central subfield thickness following the switch.

In summary, the evidence supporting a switch from faricimab to aflibercept 8mg indicates that anatomical outcomes were maintained; however, there may be potential increase in adverse drug events associated with

aflibercept 8mg. Although data on switching from aflibercept 8mg to faricimab are limited, the anatomical stability is maintained without additional safety concerns. Based on the current evidence, the committee decided to adopt nAMD Pathway Option 2, recommending aflibercept 8 mg as the first-line therapy and faricimab as the second-line treatment for patients who respond to aflibercept 2 mg but are unable to extend the treatment interval to ≥8 weeks.

9.2.3 Business Case for aflibercept 2mg for the treatment of patients with BCVA better than 6/12

In July 2021, the Committee clinically approved the inclusion of off-label bevacizumab 1.25mg intravitreal injection to the NCL joint Formulary for patients with nAMD and visual acuity better than 6/12 (pre-NICE thresholds). Observational studies suggested that initiating treatment for nAMD when visual acuity is better than 6/12 helps to maintain good visual acuity for longer and may reduce the overall number of intravitreal injections required. NICE guidelines support this approach, stating that "*anti-VEGF treatment for eyes with late AMD and visual acuity better than 6/12 is clinically effective and may be cost effective depending on the regimen used*". The Committee were also informed that maintaining visual acuity of at least 6/12 was important, as this represents the minimum eyesight standard for driving eligibility. Therefore, it was critical to delay any deterioration in patient's vision below this threshold for as long as possible. The current proposal recommends aflibercept 2mg as the preferred treatment option in place of off-label bevacizumab, thereby aligning with the main treatment pathway for patient with a BCVA between 6/12 and 6/96.

In terms of cost, the Committee was informed that the Medicines and Healthcare products Regulatory Agency approved bevacizumab gamma (Lytenava®) in July 2024, marking it as the first licensed formulation of bevacizumab for nAMD. However, with the patent for aflibercept 2 mg anticipated to expire in November 2025 and biosimilars expected to follow in December 2025, aflibercept is anticipated to more cost-effective than the licensed bevacizumab gamma.

At the previous NCL JFC meeting, the Committee discussed concerns regarding the potential unwarranted variation in practice between the NCL nAMD pathway, the pan-London pathway (published by the NHS London Procurement Partnership, LPP in March 2025), and the forthcoming NHS England pathway (anticipated to be published by the end of May 2025). The Committee heard that there were several key justifications for maintaining a distinct NCL nAMD pathway:

i) To support robust clinical and financial governance, the NCL JFC undertook a thorough evaluation of the available evidence to ensure that all recommendations are evidence-based,

ii) It remains unclear whether the forthcoming NHS England pathway would provide the necessary level of specificity,

iii) While the pan-London pathway incorporates valuable insights, certain elements hold less relevance to NCL (e.g., service capacity).

The Committee heard from Mr Nicholson and Mr Hanumunthadu that experience with aflibercept 8mg remains limited, as it was only recently approved by the MHRA. Although trial data suggested patients could be maintained on extended treatment intervals, it is uncertain how these outcomes would translate into real-world practice. Despite that, Mr Nicholson and Mr Hanumunthadu advised that aflibercept 8mg is unlikely to result in more annual injections than faricimab. The Committee noted the minimum post-loading treatment intervals are: 8 weeks for aflibercept 8mg, and 3 weeks for faricimab.

Initiating treatment with aflibercept 8mg in patients with BCVA between 6/12 and 6/96 who require less frequent dosing supports a reduced treatment burden. For those who cannot maintain the 8-week interval, faricimab provides an escalation option with more frequent dosing flexibility.

The Committee requested the NCL nAMD pathway to be reviewed following the publication of the NHS England nAMD pathway.

In summary, the Committee approved the following changes to the NCL nAMD pathway:

i) For patients with BCVA between 6/12 and 6/96:

   a) Aflibercept 2mg as the first-line treatment,

   b) Ranibizumab biosimilar as an alternative first-line treatment in patients at risk of retinal pigment epithelium tears,

   c) Aflibercept 8mg and faricimab as second-line treatment,

   d) Bevacizumab gamma and brolucizumab as third-line treatment options.

ii) For patients requiring reduced treatment burden with BCVA between 6/12 to 6/96:

a) Aflibercept 8mg as the first-line treatment option, and

b) Faricimb as the second-line treatment option.

iii) Aflibercept 2mg for the treatment patients with BCVA better than 6/12 (non-NICE commissioned).

10. Position statements and guidelines

11. Sub-Group Updates

11.1 NICE TA Implementation Group Report

The Committee heard from Ms Cheung who provided a summary of updates from the NICE TA Implementation Group. The Committee noted the current workplan, which was included in the agenda pack for information. This workplan covers:

- Implementation of atogepant for migraine prevention (NICE TA973) is underway, including the development of a high cost drugs migraine pathway for NCL,
- Implementation of Relugolix-estradiol-norethisterone for treating symptoms of endometriosis (NICE TA1057) and SQ-HDM SLIT for treating allergic rhinitis and allergic asthma caused by house dust mites (TA1045) are awaiting advice from specialists,
- Implementation of Molnupiravir for treating COVID-19 (NICE TA1056) is being reviewed.

The NCL JFC formulary will be updated accordingly to reflect NICE recommendations.

11.2 NCL Pathways Group

Nil

11.3 Shared Care Group Updates

Nil

12 Next meeting

Thursday 19th June 2025

13 Any other business

Nil