North Central London Integrated Care System

NHS
North Central London
Medicines Optimisation Network

Joint Formulary Committee (JFC): Minutes

Minutes from the meeting held on 19th June 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		✓
Mr O Odejide	NCL ICB, Prescribing Advisor	✓	
Ms T Shah	RFL, Deputy Chief Pharmacist	✓	
Mr S Lee	RFL, Infectious Disease Doctor	✓	
Mr D Fink	RFL, Consultant in Infectious Diseases and Virology	✓	
Ms A Connolly	NLFT, Interim Associate Chief Pharmacist	✓	
Ms A Coker	NLFT, Lead Pharmacist for Clinical Services	✓	
Dr J Norman	UCLH, Inclusion Health Consultant	✓	
Dr D Lambo	UCLH, Consultant in Maternal-Foetal Medicine	✓	
Dr C Kortsalioudaki	UCLH, Neonatal Consultant	✓	
Ms A Husain	UCLH, Lead Women's Health and Neonates Pharmacist	✓	
Ms P Stepney	UCLH, Senior Specialist Neonatal Dietitian	✓	
Dr M Brown	UCLH, Consultant in Infectious Diseases	✓	
Dr E Sanchez	UCLH, Consultant Virologist	✓	
Ms P Panesar	UCLH, Lead Antimicrobial Pharmacist	✓	
Ms M Lanzman	RFL, Lead Antimicrobial Pharmacist	✓	
Dr S Bhagani	RFL, Consultant in Infectious Diseases and HIV Medicine	✓	
Ms J Pang	IPMO Programme Team, Lead Pharmacist (Observer)	✓	
Ms W Adelusi	IPMO Programme Team, Clinical Pharmacist (Observer)	✓	
Ms S Ladd	NCL ICB, Prescribing Advisor (Observer)	✓	

2. Meeting attendees

Prof Hingorani welcomed members, observers, and applicants to the meeting (see above). Mr Odejide deputised for Ms EY Cheung at this meeting.

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 and abbreviated minutes of meetings on 15th May 2025

Minutes and abbreviated minutes of the 15th May 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
October	Morphine sulphate orodispersible immediate release	**Reviewed by**: RNOH **Drug**: Morphine Sulphate orodispersible immediate release tablets (Actimorph®)	**To add to the NCL Joint Formulary**

2024	tablets (Actimorph®) for acute post-operative pain management, palliative pain management and chronic pain management	**Indication**: Acute post-operative pain management, palliative pain management and chronic pain management **Decision**: Approved **Prescribing status**: Suitable for secondary care initiation, primary care continuation – referred to NCL JFC for review **Funding source**: In-tariff **Additional information**: Nil **Fact sheet or Shared Care required**: N/A	
February 2025	Estradiol gel for HRT for oestrogen deficiency symptoms in postmenopausal women and premature ovarian insufficiency	**Reviewed by**: RFL **Drug**: Estradiol gel (Oestrogel®) **Indication**: HRT for oestrogen deficiency symptoms in postmenopausal women and premature ovarian insufficiency **Decision**: Approved **Prescribing status**: Suitable for initiation in primary and secondary care – referred to NCL JFC for review **Funding source**: In-tariff **Additional information**: Nil **Fact sheet or Shared Care required**: N/A	**To add to the NCL Joint Formulary**
April 2025	[FOC Scheme] Seladelpar (Livdelzi®) for primary biliary cholangitis *†	**Reviewed by**: RFL **Drug**: Seladelpar (Livdelzi®) **Indication**: Primary biliary cholangitis **Decision**: Approved **Prescribing status**: Restricted to secondary care only **Funding source**: Free of Charge Scheme **Additional information**: N/A **Fact sheet or Shared Care required**: N/A	**Approved for RFL only**
April 2025	Elacestrant (Korserdu®) for metastatic breast cancer [Private patients only]	**Reviewed by**: RFL **Drug**: Elacestrant (Korserdu®) **Indication**: Primary biliary cholangitis **Decision**: Approved **Prescribing status**: Restricted to secondary care only **Funding source**: Private funding **Additional information**: N/A **Fact sheet or Shared Care required**: N/A	**Approved for RFL only**
April 2025	Lumasiran (Oxumo®) for primary hyper-oxaluria-1	**Reviewed by**: RFL **Drug**: Lumasiran (Oxumo®) **Indication**: Primary hyper-oxaluria-1 **Decision**: Approved **Prescribing status**: Restricted to secondary care only **Funding source**: NHSE or private funding **Additional information**: Clarification of specific adolescent treatment age in the Clinical Commissioning Policy for use of Lumasiran at RFL. **Fact sheet or Shared Care required**: N/A	**Approved for RFL only**
March 2025	Aripiprazole depot injections for maintenance treatment of schizophrenia in adult patients stabilised with aripiprazole	**Reviewed by:** NLFT **Drug**: Aripiprazole depot – 2 monthly **Indication**: Maintenance treatment of schizophrenia in adult patients stabilised with aripiprazole **Decision**: Approved **Prescribing status**: Restricted to secondary care only **Funding source**: In tariff **Additional information**: Consultant psychiatrist initiation. Fact sheet or Shared Care required: N/A	**Approved for NLFT only**

May 2025	[FOC Scheme] Mirvetuximab for folate receptor alpha-positive platinum-resistant advanced epithelial ovarian, fallopian tube or primary peritoneal cancer *†	**Reviewed by**: UCLH **Drug**: Mirvetuximab IV **Dose**: IV infusion 6mg/kg once every 21 days until disease progression or intolerable toxicity **Indication**: Adult female patients (≥18yrs) with platinum-resistant disease, high-grade serous ovarian cancer, primary peritoneal cancer, or fallopian tube cancer who have previously received one but no more than three lines of therapy, have positive FRα tumour expression, adequate performance status (ECOG PS 0-1), adequate haematological, hepatic, and renal functions **Decision**: Approved pending service impact assessment **Prescribing status**: Restricted to secondary care only **Funding source**: Free of charge scheme **Additional information**: N/A **Fact sheet or Shared Care required**: N/A	**Approved for UCLH only**
May 2025	[FOC Scheme] Brentuximab plus nivolumab for relapsed/refractory classical Hodgkin's Lymphoma in paediatrics*†	**Reviewed by**: UCLH **Drug**: Brentuximab plus nivolumab **Dose**: Brentuximab 1.8 mg/kg every 3 weeks and nivolumab 3 mg/kg every 3 weeks up to 6 cycles (18 weeks) **Indication**: Relapsed/refractory classical Hodgkin's lymphoma in paediatrics **Decision**: Approved for (i) private patients as a first-line salvage and (ii) NHS patients as a third-line salvage (response must be achieved by 2 cycles) **Prescribing status**: Restricted to secondary care only **Funding source**: (i) Privately funded for private patients (ii) brentuximab is NHS-funded for up to 16 cycles (if response is observed after 4 cycles), and nivolumab is provided free of charge for NHS patients. **Additional information**: N/A **Fact sheet or Shared Care required**: N/A	**Approved for UCLH only**

May 2025	Zoledronic acid for secondary prevention of osteoporotic fractures post-acute hip fracture surgery (off-label use)	**Reviewed by**: UCLH
		Drug: Zoledronic acid 5mg pre-filled bags
		Indication: Prevention of osteoporotic fractures following hip fracture repair surgery for acute hip fracture patients admitted through the Emergency Department (ED)
		Doses: 5mg single infusion
		Decision: Approved off-label uses to facilitate inpatient administration
		• Administration after at least 1 week post hip fracture repair surgery
		• Pre-existing dental issues not an absolute contraindication but require:
		  ○ Clinical examination of dental health and history check
		  ○ An orthogeriatric consultant risk benefit discussion with patients with dental risk factors
		  ○ A patient information leaflet on risks of zoledronic acid administration
		  ○ Documented informed consent if decision to proceed prior to dental referral
			To add to the NCL Joint Formulary for Trust with this model of care

		Prescribing status: Restricted to secondary care only **Funding source**: In-tariff **Additional information**: N/A **Fact sheet or Shared Care required**: N/A	
May 2025	Colecalciferol for rapid vitamin D loading to facilitate inpatient administration of zoledronic acid post hip fracture repair surgery	**Reviewed by**: UCLH **Drug**: Colecalciferol (oral) **Indication**: Rapid vitamin D loading to facilitate inpatient administration of zoledronic acid post hip fracture repair surgery **Dose**: 20,000 units twice daily for 7 days **Decision**: Approved **Prescribing status**: Restricted to secondary care only **Funding source**: In-tariff **Additional information**: N/A **Fact sheet or Shared Care required**: N/A	**To add to the NCL Joint Formulary**
May 2025	Olanzapine for prevention and treatment of highly emetogenic chemotherapy-induced nausea & vomiting	**Reviewed by**: UCLH **Drug**: Olanzapine **Dose**: 2.5-10mg/day pre- or post- highly emetogenic chemotherapy in line with NCL CINV guideline **Indication**: Prevention and treatment of highly emetogenic chemotherapy-induced nausea & vomiting **Decision**: Approved **Prescribing status**: Restricted to secondary care only **Funding source**: In tariff **Additional information**: N/A **Fact sheet or Shared Care required**: N/A	**To add to the NCL Joint Formulary**

*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. ProPrems for the prevention of necrotising enterocolitis in preterm infants – Evaluation Results (Applicants: Dr C Kortsalioudaki, UCLH)

In January 2023, following an appeal, ProPrems® was approved under evaluation for the prevention of necrotising enterocolitis (NEC) in preterm infants at the UCLH level 3 neonatal unit only. The Committee requested for an audit to be conducted and results to presented before a decision was made regarding the application to add ProPrems® to the NCL Joint Formulary. In April 2024, an update was brought to JFC where the neonatal team discussed proposed mitigations as part of the implementation of ProPrems® following an FDA alert on the risk of invasive, potentially fatal disease caused by bacteria or fungi contained in unlicensed probiotics. The Committee were satisfied that the neonatal team had taken sufficient precautions and requested that the results are reported back to the JFC in one year's time.

The Committee heard from Dr Kortsalioudaki that the neonatal team conducted a retrospective audit from 24th April 2024 for a 12-month period. The inclusion criteria were very pre-term neonates with gestational age (GA) at birth less than 32 weeks, or GA at birth between 32-36 weeks with very low birth weight less than 1.5kg. Out of 111 eligible babies, 101 babies received probiotics and were included in the final analysis. Dr Kortsalioudaki reported the following results:

- All eligible babies received probiotics and no parents declined administration of probiotics.
- All babies who received probiotics met the eligibility criteria to receive probiotics.
- Babies were on at least 10ml/kg enteral feeds.
- Mean duration of probiotics was 22 days and recommended treatment durations (12 weeks) were not exceeded for any babies; probiotics was stopped for all babies who were transferred to a different hospital.

- There were no cases of probiotic sepsis reported. However, 12 babies had a positive blood culture with pathogens that were not contained in ProPrems®.
- Two babies (2%) developed NEC that was medically treated, and both recovered following administration of antibiotics, probiotics were restarted once feeds were introduced and tolerated well. No cases of NEC required surgical intervention.

Dr Kortsalioudaki was in favour of ProPrems® being used in Level 2 neonatal units due to the high incidence of NEC reported. The Committee agreed that if Level 2 neonatal units were able to provide reassurance that they could deliver probiotics treatment with the same degree of rigour as at UCLH, the approval could be extended to include Level 2 units. Dr Kortsalioudaki informed the Committee that the UCLH neonatal team work collaboratively with other Trusts and would be willing to share the UCLH protocol and guidelines to support Trusts with local implementation.

In summary, the Committee agreed to approve the addition of ProPrems® for the prevention of NEC in very pre-term neonates (<32 weeks GA) and/or very low birthweight (<1.5kg) neonates and continued until 34 weeks gestational age. The use of ProPrems® has been approved for level 2 and level 3 neonatal units in accordance with the protocol established as part of the UCLH audit.

Drug: ProPrems®
Indication: For the prevention of necrotising enterocolitis (NEC) in very pre-term neonates (<32 weeks GA) and/or very low birthweight (<1.5kg) neonates
Decision: Approved
Prescribing status: Restricted to secondary care only (level 2 and 3 neonatal units)
Funding source: In tariff
Additional information: Approved for level 2 and level 3 NICUs in accordance with the protocol established as part of the UCLH audit. The Committee also advised that other NICUs implementing the use of ProPrems® to audit their outcomes for at least one year following implementation.
Fact sheet or Shared Care required: N/A

8.2. UCLH COVID-19 algorithm (Adult) - Results on the use of Paxlovid on the local extended cohort and pathway updates following NICE TA878 (Applicants: Dr M Brown, UCLH; Dr E Sanchez, UCLH; Ms P Panesar, UCLH)

In May 2023, the JFC approved the use of Paxlovid (nirmatrelvir/ ritonavir), sotrovimab and remdesivir in severely immunocompromised hospitalised adult patients, irrespective of oxygen requirement or days since symptom onset.

In May 2024, the JFC approved the use of remdesivir for patients with and without an oxygen requirement, and the option to offer an antiviral in combination with sotrovimab, particularly in treatment refractory/ recurrent infection in severely immunocompromised patients, based on the advice of ID/ virology multi-disciplinary team (MDT).

At present, severely immunocompromised patients with recurrent SARS-CoV-2 infection requiring combination treatment that exceeds licensed doses are discussed on a case-by-case at the UCLH Use of Medicines Committee (UMC). The UCLH ID/ virology team aimed to define a standardised approach for this patient cohort, and to collect data to justify a treatment pathway as a standard of care moving forward for both inpatient and outpatient settings. The Committee noted that practices vary considerably across the UK. The pathway was informed by published studies, local experience, and audit data to provide reassurance on outcomes and safety for this cohort.

The Committee heard the key findings from several recent studies from Dr Brown and Dr Sanchez:

- The LUNAR study (2025; n= 217), a prospective, observational, descriptive study assessed outcomes in sotrovimab-treated immunocompromised patients in the UK reported that standard dose sotrovimab (500mg) was associated with clearance of SARS-CoV-2 infection in immunocompromised patients with 83.5% of participants experiencing substantial viral load reductions by day 28.
- Dowgier et al (2025; n= 71), a prospective observational cohort study, designed to investigate the longitudinal immunity to the SARS-CoV-2 variant JN.1. The results indicated that sotrovimab marginally maintained neutralisation of JN.1 at clinically relevant concentrations. Additionally, this study was part of

The Legacy Study developed by the Crick COVID Surveillance Unit, contributing broader insights into immune responses to COVID-19 vaccines and infections.

- The RECOVERY trial (pre-print; n= 1,723), a randomised, controlled, open-label platform trial in patients admitted to hospital with COVID reported that high-dose sotrovimab (1g) was associated with reduction in 28-day mortality in 'high-antigen' patients (according to their baseline serum SARS-CoV-2 nucleocapsid antigen concentration) [RR 0.75, 95% CI 0.56 to 0.99; p= 0.046], but no-significant difference reported in the low/unknown antigen groups (RR 0.95; 95% CI 0.77-1.16; p=0.60). The Committee heard from Dr Brown that it is reasonable to assume that the severely immunosuppressed inpatient cohort of patients will exhibit high antigen levels, as their level of immunosuppression prevents a sufficient immune response.

The Committee heard from Dr Brown and Dr Sanchez that the UCLH team conducted a retrospective audit (October 2023 to January 2025) on 15 patients who were severely immunocompromised and received treatment for refractory SARS-CoV-2. 14 patients had significant lymphomas or leukaemia; 1 patient had severe rheumatoid arthritis treated with rituximab. The cohort received various refractory SARS-CoV-2 treatment regimens based on their prior history of antiviral treatment and total immunoglobulin G levels. Four patients received 5 days of Paxlovid only; five patients received 5 days of Paxlovid in combination with sotrovimab (500mg or 1g) or intravenous immunoglobulin (IVIg); one patient received IVIg alone; and five patients ultimately were treated with a 10-day course of Paxlovid in combination with 1g of sotrovimab. All patients reported symptomatic improvement following their refractory treatments. The findings of this audit support the conclusion that in cases where licensed doses and durations were ineffective, escalated dosing and duration may be curative.

In terms of cost, there are changes to the funding arrangements for Paxlovid and sotrovimab. The national free of charge (FOC) stock of Paxlovid expired on 31st May 2025. All Paxlovid stock purchased after this will be priced at £994.80 (including VAT) per 5-day course. The national FOC stock of Sotrovimab expires in August 2025. It is unclear whether the expiry will be extended or how much FOC stock will remain. To note, the list price of Sotrovimab is £3,180 (including VAT) per 500mg dose. The Committee heard that the audit data from UCLH indicates that the proposed initiatives will impose an annual cost pressure of approximately £43,000 (inclusive of VAT) on NCL ICB.

The Committee heard the proposed treatments for three cohorts of severely immunocompromised patients (all with ID/ virology MDT support):

- For outpatients with no oxygen requirement, a stepwise intensification of treatment if failure to single-agent and combination (standard dose/ duration), to offer intensified combination of prolonged course Paxlovid (10 days) and high-dose sotrovimab (1g)
- For inpatients with no oxygen requirement, a stepwise intensification of treatment if failure to single-agent and combination (standard dose/ duration), to offer intensified combination of prolonged course Paxlovid (10 days) and high-dose sotrovimab (1g)
- For inpatients with oxygen requirements or COVID pneumonitis, upfront treatment with high dose sotrovimab (1g) and either: (1) Paxlovid (5-10 days course) or (2) remdesivir (10 days) (licensed treatment, NICE TA878)

The Committee heard that the UCLH Haematology service, the largest in Europe, manages a cohort of severely immunocompromised patients with persistent infections. The proposed pathway adopts a pragmatic approach to treating these patients, balancing the acquisition cost of treatments with optimal outcomes. Each patient eligible for treatment would still require approval from the infectious disease/ virology/ haematology multidisciplinary team to ensure clinical governance.

The Committee were informed that whilst the proposed algorithm was formulated by UCLH and informed by recent trials and the local audit, other NCL Trusts may also have eligible patients. It was acknowledged that RFL has a large cohort of solid organ transplant patients on immunosuppressive therapy such as calcineurin inhibitors which interacts with the ritonavir portion of Paxlovid. Therefore, the algorithm may require updates and reconsideration to account for this cohort of patients.

In summary, the Committee agreed to defer a decision on the proposed treatment algorithm for severely immunocompromised patients with recurrent SARS-CoV-2 infection. The Committee requested that UCLH engage with other Trusts and relevant stakeholders and work together to collaboratively reach a consensus and produce a treatment algorithm that could then be adopted by other Trusts across NCL. The Committee welcomed the applicants to bring an updated version of the algorithm to the NCL JFC for review.

8.3. Drospirenone (Slynd®) off-label use for menstrual dysfunction and androgen excess in adolescents, patient information leaflet (PIL) for final sign-off (Applicants: Dr H Learner (in absentia), UCLH; Dr T Davidson (in absentia), UCLH)

In April 2025, the Committee conditionally approved the use of drospirenone (Slynd®) for adolescents for the treatment of menstrual dysfunction and androgen excess as a third-line alternative to Mirena® or depo-medroxyprogesterone for contraception; and as a second-line treatment option for androgen excess, replacing spironolactone. The approval was subject to the development of a patient information leaflet (PIL) to highlight the off-label use and any additional monitoring requirements for primary care.

The Committee were presented with the proposed PIL, developed by Dr Learner, and approved by the UCLH Gynaecology Guideline Governance Group. The Committee discussed whether it provided sufficient information to patients to make an informed decision. The Committee requests that the following details are included:

- The available treatment options for this condition;
- A short but clear explanation of a licensed medicine and off-label use;
- Which of the treatment options is licensed and which is licensed for other indications but used off-label for menstrual dysfunction and androgen excess;
- Statement of the evidence of efficacy and safety for drospirenone in this indication;

In summary, the Committee requests that the applicants provide greater clarity on the off-label use of drospirenone in the PIL. The Committee agreed that following this, the PIL will be approved offline via Chairman's action.

8.4. Neovascular age-related macular degeneration (nAMD) NCL Pathway – Feedback on NHSE Ophthalmology Pathway

In April and May 2025, the Committee clinically approved updates to the NCL nAMD high-cost drug pathway. The also Committee requested that the NCL nAMD pathway was to be reviewed following the publication of the NHS England (NHSE) nAMD pathway.

The Committee heard from Ms Pang who provided an update on key variations between the NCL and NHSE pathways. In summary, the position of drugs is the same in both pathways with slight differences in visual presentation and no modifications were required to be made to the NCL nAMD high-cost drugs pathway.

9. Medicine Reviews

9.1. Rapid Review: Intranasal naloxone (Nyxoid®) for known or suspected opioid overdose for inclusion health patients who are street drug users and/ or on methadone (Applicant: Dr J Norman, UCLH)

The committee considered an application for intranasal naloxone (Nyxoid®), a competitive opioid antagonist, for known or suspected opioid overdose for inclusion health patients who are street drug users and/ or on methadone. The licensed dose is one spray, equivalent to 1.8mg, administered into one nostril. Patients may require further doses after 2-3 minutes if they do not respond or relapse into respiratory depression. Nyxoid® is licensed for adults and adolescents aged 14 years and over.

The intended patient cohort is inclusion health patients, individuals who are socially excluded and typically face multiple overlapping risk factors for poor health, such as poverty, violence, and complex trauma. These patients often also experience homelessness, drug, and alcohol dependence which contribute to worse health outcomes and increasing health inequalities. Homeless individuals often live with or near others in homeless communities, where more experienced members are informed about accessing local health services. The UK experiences higher than expected rates of mortality and morbidity from opioids and synthetic opioids, such as

nitazenes, which are increasingly detected in the street drug market. Synthetic opioids are extremely dangerous and can be over 200 times more potent than heroin. Most drug users do not expect to die from an overdose; however, the high potency of synthetic opioids can lead to accidental overdoses and deaths. This application aims to provide inclusion health patients, who are street drug users and/or on methadone with to-take-away (TTA) packs of Nyxoid®. These packs can be used by the patients themselves or on others within their community in cases of suspected opioid overdose. It was noted that Nyxoid® is not a substitute for emergency medical care and patients should seek medical attention after administering it. The intranasal naloxone acts as a 'buffer', temporarily reversing the effects of opioids whilst waiting for or seeking emergency medical attention. After using a nasal spray, individuals are encouraged to replace it via drug treatment services, or, in some cases, their GP. The overall aim is to ensure inclusion health patients have access to intranasal naloxone to reduce rates of drug-related deaths.

Evidence of naloxone for the reversal of opioid overdose was identified in standard resources including the product license, BNF, Toxbase, Micromedex, and Martindale. Intranasal naloxone was also included in the NICE Clinical Knowledge Summary (CKS) on opioid dependence. Recent updates to the Human Medicines Regulations permit the supply of injectable and intranasal naloxone to individuals by drug treatment services and specific groups of healthcare professionals without a prescription to save life in an emergency.

In terms of efficacy, naloxone is an established treatment for opioid overdose and is widely used in medical and non-medical settings. The bioavailability of intranasal naloxone is lower compared to parenteral (intramuscular or intravenous) naloxone; therefore, it is possible that the proportion of patients responding to the first dose may be lower with the intranasal route.

In terms of safety, the adverse event profile of naloxone is well understood and is generally considered to be well-tolerated. The Committee were informed about an NHS England Patient Safety Alert (NHS/PSA/W/2014/016) regarding the risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid or opiate treatment. The alert highlights the significance of ensuring appropriate doses of naloxone are given to this patient cohort, as larger than recommended doses can cause rapid reversal of the physiological effects for pain control, resulting in pain, distress, an increase in sympathetic nervous stimulation and cytokine release precipitating an acute withdrawal syndrome.

In terms of convenience, the nasal spray is more convenient than intramuscular injection. The nasal spray is easier to use and store since no needles required, making it the preferred choice for needle-phobic patients. The Committee were also informed that the training required for patients to administer intranasal naloxone is simpler compared to intramuscular naloxone, which posed a barrier to the implementing the issuance of TTA intramuscular naloxone to this patient cohort.

In terms of budget impact, each nasal spray costs £26 as per the Drug Tariff. The anticipated annual expenditure is difficult to predict due to uncertainty around how often nasal sprays will need to be replaced. However, the anticipated budget impact is expected to be minimal.

The Committee heard from Dr Norman who shared his experience, highlighting the benefits of intranasal naloxone for patients. Dr Norman emphasised the short half-life of naloxone and noted that whilst there is no perfect solution, Nyxoid® provides a crucial grace period for patients to seek medical attention. The Committee heard that Nyxoid® is intended to be issued only at the point of discharge, with eligible patients being trained and provided with the nasal spray to take away. Parenteral naloxone will remain the treatment of choice for suspected opioid overdose in hospital and other medical settings. Dr Norman acknowledged that if Nyxoid® is to be approved at the NCL JFC, the inclusion health team will engage with other relevant stakeholders such as the local authority and community services to ensure maintenance and replacement of Nyxoid® is arranged.

In camera, the Committee considered the possibility that the introduction of intranasal naloxone could reduce mortality from drug overdoses in the community; and discussed whether each nasal spray would deliver a sufficient dose to reverse opioid effects long enough for patients to seek medical attention, given the reported potency of synthetic opioids and increasing wait times at Emergency Departments. However, it was recognised that intranasal naloxone provides a pragmatic solution to opioid overdose in the community. The Committee discussed the importance of the Inclusion Health team engaging with other relevant stakeholders to implement the use of intranasal naloxone following its approval by the JFC, ensuring it is adopted NCL-wide.

In summary, the Committee agreed to approve the addition of intranasal naloxone to the NCL Joint Formulary for known or suspected opioid overdose in the community among inclusion health patients who are street drug users and/ or on methadone, subject to clarification on how the Inclusion Health Team will coordinate with community services and the local authority to ensure appropriate training and procedures are in place for

the supply and replacement of Nyxoid®. This approval does **not** cover use of intranasal naloxone for opioid overdose in the emergency department where other routes of administration are available.

Drug: Intranasal naloxone; as per licensed dose
Indication: Known or suspected opioid overdose for inclusion health patients who are street drug users and/or on methadone
Decision: Conditional approval, pending further details on how the Inclusion Health Team will coordinate with community services (including specialist centres) that have prescribing rights to serve the inclusion health patients; the Committee requested that details are brought back to JFC for discussion.
Prescribing status: Secondary care initiation (by the Inclusion Health Team), primary care continuation
Funding source: In tariff
Additional information: To be initiated only at the point of discharge for the specified patient group; not to be used for reversal of opioid overdose in hospital or other healthcare settings.
Fact sheet or Shared Care required: N/A

9.2. Xonvea® (pyridoxine hydrochloride/ doxylamine succinate) for treating nausea and vomiting in pregnancy (Applicant: Dr D Lambo, UCLH)

In September 2022, the Committee reviewed an application for (Xonvea®), a combination of doxylamine 10mg (a first-generation antihistamine) and pyridoxine 10mg (vitamin B6), which is licensed for management of nausea and vomiting (NVP) in pregnancy for women who do not respond to conservative management. At the time, the Committee noted that there was insufficient evidence of superiority of Xonvea® over other available antiemetics and acknowledged a relatively large budget impact. However, it was noted that Xonvea® had a good safety profile and is the only licensed product for nausea and vomiting in pregnancy. The Committee requested the development of a pathway to support implementation of Xonvea® onto the NCL Joint Formulary

In November 2022, the Committee were supportive of the addition of Xonvea® to the NCL Joint Formulary following the development of the NCL pathway. The Committee approved the use of Xonvea® as second line therapy after ondansetron and agreed for it to be initiated in secondary care and continued by primary care.

The Committee considered a new proposal from the applicant, Dr Lambo, requesting that Xonvea® be promoted to a first line option for NVP alongside cyclizine, promethazine and prochlorperazine, with initiation permitted in both primary and secondary care settings. The proposal was driven by four reasons:

- Clinical Guidance: alignment with RCOG and NICE CKS guidance recommending Xonvea® as first-line for NVP,
- Tolerability: claims of better tolerability, particularly less sedation compared to other antihistamine antiemetics,
- Licensed product: benefit of using a licensed product for NVP,
- Equitable access: promotion of equitable access following NMUH's adoption of Xonvea® as first line option.

Although, the Royal College of Gynaecology (RCOG) updated their guideline on the management of nausea and vomiting in pregnancy and hyperemesis gravidarum in 2024, recommending Xonvea® as a first line agent amongst other first line treatments and stated that 'clinicians should use antiemetics with which they are familiar and should use drugs from different classes if the first drug is not effective or only partially effective'. These recommendations are based more on expert opinions than on evidenced-based findings.

In terms of efficacy, there are no new randomised clinical trials or studies indicating that the use of Xonvea® within this patient cohort is superior to alternative antihistamine antiemetics or other options. The Committee reconsidered Koren et al (2010), a randomised multi-centre, Phase III, placebo-controlled, double-blind study, as the only available RCT that assessed the safety and efficacy of doxylamine-pyridoxine (10mg-10mg) delayed-release for the managing nausea and vomiting in women with a single pregnancy. The primary endpoint, symptoms of nausea and vomiting as measured by the validated PUQE score, showed improvement with doxylamine-pyridoxine compared to placebo (a reduction in 4.8 points ± 2.7 vs. a reduction in 3.9 points ± 2.6; p=0.006). The Committee noted that the difference in the PUQE score from baseline to day 15 was approximately one point in the doxylamine-pyridoxine group compared to placebo. This change was not deemed substantial enough to be clinically significant or to reflect a meaningful improvement in daily functioning and quality of life.

In terms of safety, there are no randomised clinical trials or studies indicating any new concerns regarding the use of Xonvea®. Regarding tolerability, there are limited studies suggesting that Xonvea® is less sedative than other antihistamine antiemetics.

In terms of convenience, Xonvea® is the only licensed treatment for nausea and vomiting in pregnancy. While the applicant suggested that this offers greater reassurance to patients and prescribers compared to off-label alternatives, NICE has highlighted that these alternatives are safe, effective, and have extensive use experience.

In terms of cost, the drug acquisition cost remains the same resulting in an addition cost of approximately £40,000 - £80,000 per annum. Since the approval of Xonvea® onto the NCL Joint Formulary, the prescribing cost pressure within secondary and primary care has significantly increased.

The Committee heard from Dr Lambo that the proposal is to promote Xonvea® from second line therapy (secondary care only initiation) to first line therapy (primary care or secondary care initiation) along with the other antihistamine antiemetics. Dr Lambo added that cyclizine, being the most common well tolerated antihistamine antiemetic for nausea and vomiting in pregnancy, will remain the first option prescribed this cohort of patients. Additionally, not all patients will be prescribed Xonvea® at first presentation to their GP or Accident & Emergency (A&E) and other antiemetic options may be explored. Offering Xonvea® as a first line therapy in all care settings will allow patients with previous positive experience to access it through their GP or A&E, significantly impacting their quality of life.

In camera, the Committee discussed that, in the absence of new evidence to supporting the superiority of Xonvea® compared to other antihistamine antiemetics, the alternatives, although off-label for this indication, are well established treatment options with supporting trials and studies. While there are no new grounds to consider Xonvea® as first line therapy, the Committee agreed it has a place as a first-line option for patients who have used it in a previous pregnancy.

In summary, the Committee agreed to add Xonvea® as a first-line treatment option, among other alternatives, for initiation in both primary and secondary care. This is subject to the applicant developing an information leaflet for patients, detailing all the evidence-based treatment options for nausea and vomiting in pregnancy, including those that are widely used but off-label. The Committee required the applicants, in conjunction with various teams in NCL, produce this leaflet, highlighting that the widely used off-label medicines are safe, effective, and have extensive use experience for this indication and that, while Xonvea® has marketing approval specifically for this indication, there is no evidence to suggest that it is safer or more effective than the off-label alternatives. Therefore, the decision on choice of agent should be left to prescribers and pregnant mothers, based on the available evidence. Patients who have used Xonvea® successfully in a previous pregnancy may obtain prescription directly from their GP.

Drug: Xonvea® (pyridoxine hydrochloride 10mg/ doxylamine succinate 10mg); as per licensed dose
Indication: Management of nausea and vomiting in pregnancy
Decision: Conditionally approved pending development an information leaflet for patients, detailing the evidence-based treatment options for nausea and vomiting in pregnancy.
Prescribing status: Secondary care initiation and primary care continuation
Funding source: In-Tariff
Additional information: Xonvea® can be prescribed by all care settings as first line antiemetic in patient who have been treated successfully in a previous pregnancy.
Fact sheet or Shared Care required: N/A

10. Position statements and guidelines

10.1. NCL Use of gastroprotective agents: PPIs and H2RAs

The Committee were informed that the NCL position statement on the use of gastroprotective agents has been updated. Key updates include:

- The adult enteral feeding section now includes licensed omeprazole liquids.
- The paediatric section is still under review and will be updated in due course.

The Committee were asked to approve the updated section on adult enteral administration. The Committee agreed to circulate the updated position statement for consultation and comments to be submitted to the NCL ICB within 2 weeks.

11. Sub-Group Updates

11.1 NICE TA Implementation Group Report

The Committee noted the current workplan for the NICE TA Implementation Group, which was included in the agenda pack for information.

11.2 NCL Pathways Group

Nil

11.3 Shared Care Group Updates

Nil

12 Next meeting

Thursday 17th July 2025

13 Any other business

Nil