North Central London Integrated Care System

NHS
North Central London
Medicines Optimisation Network

Joint Formulary Committee (JFC): Minutes

Minutes from the meeting held on 18th September 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 Deputy Chair		✓
Dr K Boleti	RFL, DTC Deputy Chair		✓
Dr A Scourfield	UCLH, DTC Chair		✓
Mr J Harchowal	UCLH, Chief Pharmacist		✓
Dr K Tasopoulos	RFL, DTC Deputy Chair	✓	
Ms S Stern	RFL, Deputy 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	✓	
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	✓	

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 O Odejide	NCL ICB, Prescribing Advisor	✓	
Ms C Weaver	NCL ICB, Senior Prescribing Advisor – Quality and Improvement	✓	
Mr S Mahal	GOSH, Lead Pharmacist – Clinical Services	✓	
Ms A Coker	NLFT, Lead Pharmacist – Clinical Services	✓	
Ms A Connolly	NLFT, Interim Associate Chief Pharmacist (Observer)	✓	
Ms E Ward	IPMO Programme Team, Lead Pharmacist (Observer)	✓	
Mr K Simpson	IPMO Programme Team, Principal Population Health Analyst (Observer)	✓	
Ms Jessica Chen	MEH, Rotational Clinical Pharmacist	✓	

2. Meeting attendees

Prof Hingorani welcomed members, observers, and applicants to the meeting (see above). Mr Barron and Mr Flor deputised for Mr Harchowal and Mr Richardson respectively 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 21st August 2025

Minutes and abbreviated minutes of the 21st August 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
July 2025	[FOC Scheme] Sebetralstat for Hereditary Angioedema Type 1 and 2*†	**Reviewed by:** RFL **Drug:** Sebetralstat **Indication:** Hereditary Angioedema Type 1 and 2 **Decision:** Approved **Prescribing status:** Restricted to secondary care only **Funding source:** Free of charge via an early access to medicines scheme **Additional information:** Nil **Fact sheet or Shared care required:** N/A	**Approved for RFL only**
July 2025	Parecoxib for perioperative analgesia	**Reviewed by:** RFL **Drug:** Parecoxib **Indication:** Perioperative analgesia **Decision:** Approved **Prescribing status:** Restricted to secondary care only **Funding source:** Divisional Budget **Additional information:** Discuss with other specialists Trust in London to gauge efficacy and safety of the use of Parecoxib	**To add to the NCL Joint Formulary**

		Fact sheet or Shared care required: N/A	
July 2025	[FOC Scheme] Tafasitamab for Relapsed/refractory follicular lymphoma*†	**Reviewed by:** UCLH **Drug:** Tafasitamab (in combination with rituximab and lenalidomide) **Dose:** 12mg/kg for up to 12 cycles (days 1, 8, 15, 22 in cycle 1 to 3; days 1 and 15 for cycle 4 to 12) Indication: Relapsed/refractory follicular lymphoma (grade 1, 2, 3a) in adult patients after previous treatment with systemic anti-CD20 immunotherapy or chemo-immunotherapy, to be offered to patients where intensive chemotherapy required for autologous stem cell transplant was not suitable, or after second-line chemo-immunotherapy had failed. **Decision:** Approved **Prescribing status:** Restricted to secondary care only **Funding source**: Free of Charge Scheme **Additional information:** Nil **Fact sheet or Shared care required:** N/A	**Approved for UCLH only**
July 2025	[FOC Scheme] Mezigdomide: Relapsed/refractory multiple myeloma*†	**Reviewed by:** UCLH **Drug:** Mezigdomide capsules (unlicensed) **Dose:** Mezigdomide 1mg daily for 21 days (as part of a 28-day cycle) plus dexamethasone 40mg weekly until disease progression or intolerance Indication: 5th line (and beyond) treatment option for adult patients with relapsed or refractory multiple myeloma who had received (or not suitable for) anti-BCMA therapy, and there were no other suitable alternatives or clinical trials available **Decision:** Approved (pending assurances regarding implementation of pregnancy prevention programme) **Prescribing status:** Restricted to secondary care only **Funding source:** Free of charge scheme **Additional information:** Nil	**Conditionally approved for UCLH only**

*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 Doxylamine succinate and pyridoxine hydrochloride (Xonvea®) for nausea and vomiting in pregnancy - Patient information leaflet sign-off (Applicant: Dr Diane Lambo,)

In June 2025, the Committee considered and conditionally approved the addition of doxylamine with pyridoxine (Xonvea®) as a first-line antiemetic, suitable for initiation in both primary and secondary care for patients successfully treated in a previous pregnancy. This was subject to the applicant developing a patient information leaflet (PIL) outlining all the evidence-based treatment options for NVP, including the commonly used off-label treatments.

The Committee considered the locally developed PIL, which outlines the causes of NVP, home management strategies, available treatment options and guidance on when to seek medical attention. The leaflet also includes a tiered treatment framework, incorporating off-label medications were justified by evidence and clinical familiarity. The Committee agreed that the information provided meets the requirements set out in June.

The Committee recommended some minor revisions to the PIL to improve clarity around discharge information, specifically guidance on accessing hospital-only medications, including repeated courses. It was also agreed that the PIL should be reviewed by the Trust's Communications Department to ensure it is patient-

friendly and meets accessibility standards. Subject to these changes, the PIL will be approved offline via Chairman's action.

8.2 NCL Psoriasis Pathway – Spesolimab (NICE TA 1070)

The Committee heard from Ms Tse that the NCL Psoriasis Pathway was updated following the publication of NICE TA 1070 which recommends the use of spesolimab, a humanised anti-interleukin-36 receptor monoclonal antibody, for the treatment of generalised pustular psoriasis (GPP) flares in adults. GPP is a rare, severe form of psoriasis characterised by recurrent flares of widespread sterile pustules with erythematous, painful skin.

Prior to the approval of spesolimab, there were no licensed treatment options in the UK for this patient cohort. Standard care consists of systemic non-biological therapies such as ciclosporin or methotrexate which were not approved for prescribing in primary care for this indication. In line with NICE TA 1070, spesolimab is recommended as an option for GPP in adults with moderate to severe flares, with up to two doses per flare permitted.

The Committee were informed that NCL ICB High-Cost Drugs (HCD) Pathway Group oversaw the updates of the pathway and spesolimab will be assigned a red RAG formulary status, indicating that it is for secondary care prescribing only. The updated Psoriasis pathway was circulated for consultation with relevant stakeholders, including dermatologists, dermatology pharmacists, and formulary pharmacists by the NCL ICB psoriasis working group.

In summary, the Committee approved the updated NCL Psoriasis pathway with the inclusion of spesolimab, the only licensed NICE-approved treatment for GPP flares in adults.

8.3 Drospirenone for contraception – Patient information leaflet sign-off (Applicant: Dr J Bignall, RFL) (in absentia))

In November 2024, the Committee considered an application for drospirenone, a fourth-generation progestin and spironolactone analogue, for contraception. The Committee deferred its decision pending further information regarding its proposed place in therapy; definition of the eligible patient cohort; itemisation on operating procedure for initiation and monitoring; and clear itemisation of responsibilities (if any) to be assigned to primary care for ongoing prescribing and monitoring. In February 2025, the Committee heard from Dr Bignall, who provided clarification on the intended place in therapy, outlined the eligible patient cohort, and addressed mitigation strategies for potential side effects.

The JFC secretariats have been informed by the National Pharmacy Lead for Primary Care, Community, Vaccinations and Screening (PCVS) that a national Patient Group Direction (PGD) for drospirenone will be introduced from October 2025, enabling both initiation and continuation in primary care by community pharmacies. However, this national arrangement does not align with the local formulary decision made by the NCL JFC. As such, the Committee upheld its original position:

- Drospirenone should only be initiated in secondary care, specifically by specialists in Sexual and Reproductive Health or Gynaecology clinics, for women aged from menarche to 49 years who cannot use LARC or COCs. It is a second-line option after a 3–6-month trial of desogestrel and may be considered as an alternative to levonorgestrel.
- NCL community pharmacies and GPs must not initiate drospirenone independently but may continue maintenance prescribing for patients who meet the approved criteria and do not present any exclusion factors.

The Committee considered the locally developed Patient Information Leaflet (PIL) for drospirenone for contraception, which outlines the prescribing framework, safety profile, and potential adverse effects. The leaflet is intended to support patient education and guide GPs in the safe and appropriate maintenance prescribing of drospirenone. To ensure alignment with local governance, the NCL ICB team will work with the National Pharmacy Lead for PCVS to update the PGD addendum, reflecting the decision by the NCL JFC.

The Committee recommended minor revisions to the PIL to improve patient understanding and simpler wording to support accessibility.

In summary, the Committee requested improvements to the PIL to provide greater clarity around repeat prescriptions for hospital-only medicines and recommended a review by the Trust's Communications Department to ensure it meets patient accessibility standards. The Committee agreed that, following these amendments, the PIL will be approved offline via Chairman's action.

8.4 Child and Adolescent Mental Health (CAMHS) Formulary

Deferred.

8.5 Intranasal naloxone (Nyxoid®) for known or suspected opioid overdose for inclusion health patients who are street drug users and/ or on methadone

Deferred.

9 Medicine Reviews

9.1 Rapid Review: Donepezil, memantine, rivastigmine, galantamine for severe dementia; Behavioural and psychological symptoms in dementia (BPSD) with Lewy Bodies (Applicant: Audrey Coker, Lead Pharmacist for Formulary, NLFT)

The Committee considered a review of the off-label use of donepezil, rivastigmine, galantamine and memantine in adult patients with severe dementia and behavioural and psychological symptoms associated with Lewy body dementia. Following the merger of Barnet, Enfield and Haringey Mental Health Trust with Camden and Islington NHS Foundation Trust, the JFC secretariats collaborated with the pharmacist at the newly formed North London Foundation Trust (NLFT) to align the mental health formulary. It was confirmed that the use of acetylcholinesterase inhibitors and memantine in this patient cohort reflects historical clinical practice, with no documented evidence of a formal review being conducted by the legacy Trusts.

The Committee considered the clinical context surrounding Lewy Body Dementia (LBD), a progressive neurological disorder where treatment focuses on managing core symptoms. Behavioural and Psychological Symptoms of Dementia (BPSD) are characterised by cognitive and motor fluctuations, hallucinations, anxiety and depression and REM sleep behaviour disorders.

The use of donepezil, rivastigmine, galantamine, and memantine in this cohort is supported by NICE Technology Appraisal (NICE TA217) and NICE Clinical Guideline (NICE NG97), which recommend these agents as off-label options for non-Alzheimer's dementia, depending on disease severity. Further evidence supporting the use of use of acetylcholinesterase inhibitors and memantine was identified in Martindale, Micromedex, and UpToDate, with additional endorsement from the British Association for Psychopharmacology (BAP) and the Maudsley Prescribing Guidelines, which recommend their use in this patient cohort.

The Committee considered the current treatment pathway for LBD, which aligns with NICE guideline recommendations, where donepezil or rivastigmine are considered as first line treatment options. In clinical practice rivastigmine is often preferred due to its availability in a transdermal formulation and flexible dosing. Galantamine may be considered if donepezil and rivastigmine are not tolerated, although it is not routinely prescribed. Memantine is reserved for cases where acetylcholinesterase inhibitors are contraindicated or not tolerated; however, it is rarely used as monotherapy due to limited evidence supporting its efficacy. Patients are typically assessed for treatment response 4-8 weeks after initiation, with the focus on tolerability rather than efficacy. Treatment is discontinued if the patient experiences serious adverse drug reactions or fails to show meaningful improvement in symptoms.

In terms of efficacy, the evidence for the use of acetylcholinesterase inhibitors and memantine in LBD remains mixed. A 2012 Cochrane review conducted by Rolinski et al found no strong evidence to support effectiveness of acetylcholinesterase inhibitors such as donepezil and rivastigmine in managing BPSD in LBD. However, more recent meta-analyses suggest potential benefit. In 2016, Matsunaga et al reviewed 17 randomised controlled trials and reported that acetylcholinesterase inhibitors were superior to placebo in improving cognitive function, activities of daily living and overall function in patients with LBD. Similarly, Meng et al in 2019 reviewed 15 randomised controlled trials and found that both acetylcholinesterase inhibitors and memantine improved global cognitive function and motor symptoms. It is important to note that all studies included were placebo-controlled, with no head-to-head comparisons between agents or drug classes. As a result, the evidence for significant differences in efficacy and safety between individuals remains limited.

In terms of safety, galantamine is associated with more contraindications and cautions compared to donepezil and rivastigmine. Acetylcholinesterase inhibitors require dose adjustments in cases of renal and hepatic impairment, and are contraindicated in patients with hypersensitivity, pregnancy or breastfeeding. Caution is advised when prescribing to patients with known cardiac conditions, including QT prolongation as well as those with a history of asthma, COPD, or seizures. Additionally, both acetylcholinesterase inhibitors and memantine are subject to interactions with other classes of medication, including antimuscarinic agents, antipsychotics and others. Therefore, careful consideration is required when used concurrently with other treatments to avoid adverse effects or reduced efficacy.

In terms of cost, the drug acquisition cost for galantamine modified-release tablets range from £50-80 per pack, while rivastigmine patches are priced at £77.97 for 4.6mg/24hours and 13.3mg/24hours strengths. Within the NCL population, an estimated 9,247 patients are diagnosed with dementia. However, a caveat of this data is the inability to accurately differentiate the number of patients specifically diagnosed with LBD. Current prescribing data indicates that donepezil and rivastigmine are the most prescribed medications with 89% of rivastigmine being prescribed as patches rather than capsules. It should be noted that the reported cost impact reflects prescribing across all dementia subtypes, which may include conditions such as dementia associated with Parkinson's disease and not exclusively LBD.

In terms of convenience, treatment is suitable for initiation by a specialist or under the recommendation of the Services for Ageing Mental Health (SAMH) or memory clinic, ensuring appropriate oversight and alignment with clinical pathways.

The Committee heard from Ms Coker that patients with Lewy body dementia (LBD) are particularly vulnerable to side effects from acetylcholinesterase inhibitors and memantine. As a result, antipsychotics are sometimes considered as alternative treatment options. However, due to their heightened sensitivity to these agents, antipsychotics are generally avoided in this population because of the risk of severe adverse effects. This sensitivity also limits the robustness of clinical trial data, as studies often compare treatments to placebo rather than to other active agents. Regarding the use of rivastigmine patches, Ms Coker highlighted practical challenges in this patient group, particularly around adherence. In some cases, the Mental Capacity Act may need to be applied, or medication administered covertly, reflecting the complexities of managing treatment in patients with impaired capacity.

The Committee heard that while the treatment effects observed in clinical trials are modest, the use of acetylcholinesterase inhibitors and memantine remains an established clinical practice. All agents are supported by positive NICE TAs, especially for Alzheimer's disease, with additional indications references in NICE Clinical Guideline NG97. Given this context, the Committee agreed on the need to bring these longstanding practices under formal governance.

The Committee discussed the value of establishing the incidence of LBD within NCL population, and assessing the specific cost impact, particularly in relation to rivastigmine patches, which play a key role in patients unable to tolerate oral formulations. Clarifying and defining prescribing criteria for these agents would help to ensure clinical benefits is maintained while avoiding unnecessary cost inflation within the system. The Committee also highlighted the importance of considering the risk of side effects, such as extrapyramidal symptoms and cholinergic burden, when determining the appropriate place in therapy.

In summary, the Committee agreed that donepezil, memantine, rivastigmine, galantamine should be made available on the NCL Joint Formulary for severe dementia and Behavioural and psychological symptoms in dementia (BPSD) with Lewy Bodies. However, a clear and refined treatment pathway should be established, outlining the place in therapy and prescribing status (RAG rating) for each agent. Emphasis should be placed on defining clear prescribing criteria for rivastigmine patches and galantamine. The Committee will consider the proposed pathway before final ratification.

10 Position statements and guidelines

10.1 New High-Cost Drugs commissioning proposal process

The Committee heard an update to the NCL ICB high-cost drug commissioning proposal (business case) process. This proposal aims to clarify which proposals constitute a formal 'business case' and to establish a consistent

and transparent framework for reviewing new high-cost drugs (HCDs) requests to the NCL Joint Formulary. The proposed framework is outlined as follows:

- Where the proposed drug is recommended within a positive NICE Technology Appraisal (TA) and is intended to be used in line with the NCL principles for commissioning high-cost drug pathways, the proposal will require a cost impact assessment by the NCL HCD Team.
- Where the proposed drug is recommended within a positive NICE TA but its use does not align with the NCL principles for commissioning high-cost drug pathways, the proposal will require both a cost impact assessment by the NCL HCD Team and an evaluation by the NCL JFC.
- Where the proposed drug is not recommended within a NICE TA and is anticipated to create cost pressure to the ICB high-cost drugs budget, the proposal will undergo a cost impact assessment by the NCL HCD Team, an evaluation by the NCL JFC, and will require a full commissioning proposal (business case) to be submitted to the NCL ICB Strategic Commissioning Team.

Where the proposed drug is not recommended within a NICE TA but is not anticipated to create a cost pressure to the ICB high-cost drugs budget, the proposal will require a cost impact assessment by the NCL HCD Team and an evaluation by the NCL JFC.

It is important to note that:

- This process does not extend to HCDs governed by specialised commissioning (spec comm) delegation. When delegation arrangements evolve, the process will be reviewed to ensure continued relevance and alignment.
- Adherence to the host commissioner's rule is central to this process. This requirement will be referenced in the NCL ICB NHS Payment Scheme policy as well as in the guidance for commissioning high-cost drug pathways.
- It is proposed that the ICB consider adopting a multi-year funding approach for horizon scanning, rather than limiting financial planning to single-year costs. To support this, the ICB would need to establish funding applications that span longer durations (such as three to four years). This approach would be subject to discussion and approval by the Medicines Finance and Value Group (MFVG) and is intended to improve financial forecasting, prioritisation, and system-wide planning.

The intention is to integrate this draft process into the existing NCL guidance and contractual policy for ICB-commissioned HCDs. This integration aims to support a consistent approach to contractual, budgetary, and funding considerations, while ensuring alignment between operational processes, rules, and principles. The JFC and HCD teams will use this process to advance business cases for assessment. The effectiveness of the new process will be demonstrated through its application to the renewal of the next four HCD pathways, with its impact on consistency, prioritisation, and system-wide collaboration assessed as part of this pilot phase.

The Committee heard that the HCD Team would consistently conduct a cost impact assessment prior to submitting any HCD proposal to the JFC. It was also noted that the same process would be followed by the NICE Technology Appraisal (TA) Implementation Group which is responsible for implementing NICE TAs with positive recommendations. Further operational details of the process will require greater clarity following the presentation of the proposed commissioning approach to the NCL MFVG. The Committee requested that the HCD team report back to the NCL JFC once the finer details have been confirmed.

In summary, the Committee approved the updated high-cost drugs commissioning proposal process in advance of it being presented to the MVG in October.

11 Sub-Group Updates

11.1 Shared Care Group Updates

Nil

11.2 NICE TA Implementation Group Report

The Committee were provided an update by Ms Odejide on the current workplan for the NICE TA Implementation Group, which was included in the agenda pack for information. The following were highlighted to the Committee:

- Atogepant for preventing migraine [NICE TA973] – Implementation is underway. The primary care pathway is being updated to include atogepant. Once approved by the Medicines Clinical Reference Group, further webinars will be arranged, and primary care support materials will be updated on ScriptSwitch and NCL NetFormulary to assist primary care clinicians.
- SQ-HDM SLIT (Acarizax®) for treating allergic rhinitis and allergic asthma caused by house dust mites [NICE TA1045] – Implementation is progressing, with the treatment already available through some NCL allergy services. UCLH allergists support continuation of prescribing to be continued in primary care following 6-12 months following specialist initiation. Feedback form other NCL allergy services, however, as most prescribing currently originates from the UCLH allergy service. Therefore, the Group has taken a pragmatic decision to adopt the UCLH Allergy Team's recommendations on interface prescribing if no further feedback is received by end of September 2025.
- Relugolix-estradiol-norethisterone (Ryeqo®) for treating symptoms of endometriosis [NICE TA 1057] – Implementation is progressing. The Shared Care Group has assigned a RAG status of Amber-2, as reflected on the NCL NetFormulary. The proposed transfer period of 2 months aligns with the current arrangement for uterine fibroids.
- Betula verrucosa for treating moderate to severe allergic rhinitis or conjunctivitis caused by tree pollen [NICE TA 1087] – Already available on the NCL Joint Formulary following the allergen immunotherapies review (JFC June 2023). NICE TA supports continuation of prescribing in primary care following specialist initiation. Consultation with allergists is ongoing to determine the appropriate timing for transfer of care and interface prescribing arrangements.

11.3 NCL Pathways Group

12 Next meeting

Thursday 16th October 2025

13 Any other business

Nil