NHS GRAMPIAN
Minute of Formulary Group Meeting
Tuesday 18 October 2022 at 14:30 via Microsoft Teams

PRESENT	APOLOGIES	APPROVED
Ms L Cameron	Dr D Culligan	
Dr V Chieng	Ms A Davie	
Ms F Doney (Vice-Chair)	Dr L Elliot	
Dr E Elias	Dr J Newmark	
Ms M Galvin		
Mrs G McKerron		
Dr M Metcalfe (Chair)		
Mrs K Neave		
Mrs S O'Beirne		
Mr M Paterson		
Mr R Sivewright		

IN ATTENDANCE

Miss Valerie Dick, Pharmacist Team Leader Women and Children's Service, for item 3.
Dr Elma Stephen, Consultant Paediatric Neurologist, Joint Clinical Lead - NESCANN (North East Scotland Child and Adolescent Neurology Network), for item 3.

Note some items were taken outwith agenda order.

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WELCOME AND GOODBYE

The Chair welcomed members, opened the meeting and noted that a quorum was present.

The Chair confirmed that Mrs Montgomery has retired from the group. The Chair led members in thanking Mrs Montgomery for the valuable contribution she has provided supporting this and other groups/work streams in the organisation and NHS Scotland.

1. APOLOGIES

Apologies for absence were requested and noted.

3. PRESENTATION - INTRANASAL DEXMEDETOMIDINE (PAEDIATRICS)

The Chair welcomed Miss Valerie Dick, Pharmacist Team Leader Women and Children's Service, and Dr Elma Stephen, Consultant Paediatric Neurologist, Joint Clinical Lead – NESCANN, to discuss the request for the extension of use for intranasal dexmedetomidine in paediatrics.

Miss Dick and Dr Stephen confirmed that:

- intranasal dexmedetomidine is included on the formulary for the sedation of paediatric patients undergoing neuroimaging (to reduce the need for intravenous sedation or anaesthesia)
- over the past few years, the NHS Grampian paediatric anaesthetic team have expanded their use of intranasal dexmedetomidine within the Royal Aberdeen Children's Hospital (RACH) to include pre-operative anxiolysis where the oral route is not available
- the paediatric neurology team wish to introduce the use of intranasal dexmedetomidine for sedation prior to electroencephalography (EEG) and selected inpatient neuroimaging (magnetic resonance imaging (MRI), Computed tomography (CT) scans).
- dexmedetomidine is a selective alpha-2 receptor agonist with sympatholytic, sedative, analgesic and anaesthetic/analgesic-sparing properties. It is licensed for intravenous use for sedation of adult intensive care unit patients and or sedation of non-intubated

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adult patients prior to and/or during diagnostic or surgical procedures requiring sedation.

- intranasal dexmedetomidine is routinely used for sedation for non-painful procedures in children in a number of centres in the UK (Leeds, London) and is a useful alternative if a child refuses oral pre-medication, e.g., lorazepam, midazolam
- the sedation provided by dexmedetomidine resembles natural sleep, it has a quick onset of action and a favourable safety profile, and has similar effects to midazolam [in terms of efficacy]
- there are some concerns with use, and dexmedetomidine is contraindicated in hypersensitivity to the active substance, advanced heart block unless paced, uncontrolled hypotension and acute cerebrovascular conditions. It should be avoided in children with prolonged QT interval or being treated with medication likely to prolong the QT interval, those with bradyarrythmias, severe renal/liver insufficiency, difficult airway or obstructive sleep apnoea.
- unlike other conventional sedatives, dexmedetomidine interferes little with brain waves, and patients sedated with dexmedetomidine remain arousable, enabling clinicians to assess a child's cognitive status after the completion of an EEG examination
- the RACH Paediatric Anxiolytic Premedication local guidance document has recently been updated to include the use of intranasal dexmedetomidine for preoperative anxiolysis, and prior to MRI, CT, and EEG
- dexmedetomidine is odourless and tasteless, and may be administered intranasally without discomfort to the patient via a mucosal atomizer device (MAD) or by drops
- children do not require to be continuously monitored after administration, but fifteen-minute pulse checks should be performed. Consideration can be given to monitoring oxygen saturation with sound off. Following completion of the procedure, there is no requirement for extended recovery, which should increase the turnover of cases.
- patient numbers are expected to be small (n=20) and the impact on spend is not expected to be substantial. Additionally the alternative medicines can have variable acceptability resulting in re-dosing with other agents.
- intranasal dexmedetomidine will only be prescribed by an anaesthetist or consultant neurologist familiar with the use of this drug. Prescribing will be closely monitored by the paediatric anaesthetic, neurology and pharmacy teams.
- when sedating children for EEGs the agent used needs to reliably induce sleep, it should be safe to use and not affect the EEG, and it should be quickly reversible to allow discharge home
- intranasal dexmedetomidine:
  - has a short half-life and high bioavailability
  - only acts on the central nervous system and has little influence on haemodynamics or respiration
  - has little interference with background brain wave activity (may increase slightly theta, alpha and beta) but no effect on epileptiform discharges
  - produces a state similar to natural sleep (i.e., easily reversible)
- recent evidence supports the safe and effective used of intranasal dexmedetomidine for sedation in children, including those with Autistic Spectrum Disorder
- there will be nursing input (epilepsy nurse) throughout the procedure
- a care pathway has been developed to support the introduction [of intranasal dexmedetomidine] to RACH for sleep EEGs
- a prospective data collection and analysis is planned (after use in ~20-30 patients)
- intranasal dexmedetomidine is a recognised treatment option in a number of paediatric centres across the UK and it represents a useful addition to the paediatric sedation armamentarium. It offers a reliable level of non-invasive sedation, with a high success rate. There is experience within RACH of successfully and safely using this agent in paediatric patients.

The Chairman thanked Miss Dick and Dr Stephen for attending the meeting and providing a clear informative presentation. Miss Dick and Dr Stephen left before decision-making.

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The Group discussed the request from the paediatric neurology team to use intranasal dexmedetomidine for sedation prior to EEG and selected inpatient neuroimaging.

The following points were noted:
Clinical-effectiveness: unlicensed use noted (licensing and administration). Intranasal use provides the potential for high efficacy (sedation effect) and an easier route of administration compared to some alternatives. Evidence presented for efficacy in relevant patient group, with high first dose success rate. Study showing high efficacy in autistic patients, and no degradation of the EEG.
Cost-effectiveness: no QALY data; this is a new cost to the Board, but small patient numbers and cost offset available from displacement of other medicines.
Health gain for NHSG: potential benefits for patients and the service. Orally administered and acceptable to patients, potential to preventing delays to procedures.
Service impact: patient numbers small, and budget impact expected to be manageable. Potential positive service impact on capacity if delayed procedures reduced.
Equity: intranasal dexmedetomidine is a recognised treatment option in a number of paediatric centres across the UK.
Safety: no new or additional concerns noted. Local experience successfully and safely using this agent in paediatric patients.

The Group acknowledged that the proposed off-label use is available in other parts of the country, and use is supported by the local specialist services. The Group agreed that the off-label use of intranasal dexmedetomidine provided the opportunity for benefits to paediatric patients and the paediatric service.

The Group accepted the restricted local need for the off-label use of dexmedetomidine used by the intranasal route in a group of paediatric patients.

SBAR - Dexmedetomidine hydrochloride 100micrograms/mL concentrate for solution for infusion is routinely available in line with local guidance.
Indications under review: [off-label use] for the sedation of paediatric patients prior to electroencephalography (EEG) and selected inpatient neuroimaging (magnetic resonance imaging (MRI), computed tomography (CT) scans).
Restriction: intranasal use where the oral route is not available and cannulation or venepuncture is not required.
Dexmedetomidine should be administered only by health care professionals skilled in the anaesthetic management of patients in the operating room or during diagnostic procedures.
It was classified 3b - licensed product request for unlicensed use and 8a - licensed for hospital use only. Informed consent should be obtained and documented. **FTEAM**

2. DRAFT MINUTE OF THE MEETING HELD 20 SEPTEMBER 2022

The Group accepted the draft note of the meeting subject to minor typographical changes.

The corrected final approved minute will be in the public domain within 21 days of approval. **FD**

4. MATTERS ARISING

4.1. Action Log

The action log was noted.
No additional items were identified that should have been included on the agenda.

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4.2. Potassium permanganate

At a previous meeting, members discussed the National Patient Safety Alert regarding the inadvertent oral administration of potassium permanganate, and agreed to host information on the formulary, as the benefits for patient safety and staff education outweighed any issues regarding product licensing.

Ms Cameron provided an update to members and confirmed that:

- a guidance document that encompasses everything that is included in the National Patient Safety Alert has been produced and will be sent to the relevant service(s) as part of the final consultation
- the final draft document will be reviewed and signed off by the Medication Safety Group before uploading to the Medication Safety intranet pages **LC**

When the final document is available on the intranet, it will be linked to a potassium permanganate entry on the formulary. **LC/ FTEAM**

4.3. Abiraterone

Ms Galvin updated the Group with significant cost-avoidance initiatives related to two medicines that have recently come off patent, and the plans to implement the switch to generics by the end of the year.

Ms Galvin confirmed that:

- abiraterone, as the brand Zytiga®, is now off patent and generic products are available
- for the majority of patients the current supply arrangement is dispensing from Community Pharmacies (via hospital-based prescription), however this is not viable with the availability of generic abiraterone products
- there are supply options under discussion and they have yet to be appraised
- a favoured option is to bring dispensing back into Aberdeen Royal Infirmary (ARI) and distribute via Community Pharmacy collection hubs to continue supporting patients getting their medicines closer to home
- once agreed the service plans to move quickly

Ms Galvin confirmed that:

- lenalidomide, as the brand Revlimid®, is now off patent and generics are available
- there are strict prescribing and dispensing regulations regarding pregnancy prevention for lenalidomide [pomalidomide and thalidomide], and at the moment an electronic system for undertaking/recording the relevant checks is only available for Revlimid®
- an electronic recording system is in process for the generics but is not available yet
- the service will move from the reference product when the electronic recording system is available for generic products

5. FORMULARY GROUP DECISIONS SEPTEMBER 2022 - PUBLISHED 03/10/2022

Members ratified the decisions of the September 2022 meeting as published. **FTEAM**

6. NETFORMULARY/FORMULARY REVIEW

6.1. Highlight Pharmacy First Scotland Approved List medicines on the formulary

Ms Doney presented a proposal to add a new traffic light icon on the formulary to highlight the sub-group of ‘general use’ formulary items that are also available via the NHS Pharmacy First Scotland service.

It was confirmed that:

- NHS Pharmacy First Scotland allows community pharmacies to give people expert help for treating conditions such as sore throats, earache and cold sores, along with

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common clinical conditions such as urinary tract infections
- Community Pharmacy teams offers advice, treatment or referral to other healthcare teams if required

The Group supported the proposal to add a new formulary icon [GREEN+] to the current traffic light choices on the formulary so that Pharmacy First Approved List items are easier to find on the formulary website. **FTEAM**

6.2. Formulary updates October 2022

There were no declarations of interest recorded in relation to these products.

The Group reviewed the Formulary Team's proposed decisions and actions for the recent SMC advice for imlifidase, and some discontinued medicines/indications.

Ms Doney reported that the local specialists have confirmed that imlifidase is not required locally as treatment is given immediately pre-transplant in Edinburgh so it will not be administered in NHS Grampian.

The Group accepted the position presented by the local specialists and categorised imlifidase as 'non-formulary - routinely available from a specialist centre in another health board'.

SMC 2445 - Imlifidase 11mg powder for concentrate for solution for infusion (Idefirix®) ▼ is routinely available from a specialist centre in another health board.
Indication under review: for desensitisation treatment of highly sensitised adult kidney transplant patients with positive crossmatch against an available deceased donor. The use of imlifidase should be reserved for patients unlikely to be transplanted under the available kidney allocation system including prioritisation programmes for highly sensitised patients.
In a phase II study, imlifidase reduced donor specific antibodies and converted positive crossmatch to negative in highly sensitised patients awaiting kidney transplantation from a deceased donor.
This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/ list price that is equivalent or lower.
This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting.
Routinely available from a specialist centre in another health board. **FTEAM**

The Group supported the changes proposed by the Formulary Team:
- the current website entries for the formulary medicines, loperamide 1mg/5mL oral solution sugar free, Daktacort® ointment and Dithrocream®, will be amended to note that these products are now (or are being) discontinued/withdrawn from use
- the current website entry for the non-formulary medicine, vinflunine (Javlor®), will be amended to note the product is discontinued
- no action required for the withdrawal of the third-line treatment indication for rucaparib as this indication is not included on the formulary **FTEAM**

7. OTHER BUSINESS

7.1. NICE and SMC/HIS collaboration on health technology appraisal of therapeutics for COVID-19

Dr Metcalfe reported the positive news that the collaborative approach between NICE and SMC will continue post COVID.

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7.2. FreeStyle Libre 1 discontinued

The Group noted that Abbott has taken the decision to discontinue the original FreeStyle Libre sensors by 31 December 2022, and that FreeStyle Libre 2 and FreeStyle Libre 3 sensors remain available.

7.3. Yellow Card Scotland Annual Report 2021/22

Ms Cameron discussed the results of the Yellow Card Centre for Scotland Annual Report for 2021/22. She highlighted that there was a significant increase in reporting in NHS Grampian (up by 76%) and the majority of reports are from patients.

Ms Cameron will share a one-page breakdown of the NHS Grampian data with members. **LC**

8. NEW PRODUCT REQUESTS

8.1. FG1SMC 2412 - Venetoclax (acute myeloid leukaemia (AML))

There were no declarations of interest recorded in relation to this product.

The Group considered the request for venetoclax used in combination with azacitidine for the treatment of adults with newly diagnosed acute myeloid leukaemia (AML) who are ineligible for intensive chemotherapy.

The Group noted that:

- April 2022, venetoclax was accepted for use within NHS Scotland in combination with a hypomethylating agent for the treatment of adults with newly diagnosed AML who are ineligible for intensive chemotherapy. However, only data for venetoclax used in combination with azacitidine injection was presented to support the clinical case.
- venetoclax meets SMC end of life and orphan equivalent criteria for this indication and was accepted for use within NHS Scotland following a full submission assessed under the end of life and orphan equivalent medicine process, the output from the PACE process, and application of the appropriate SMC modifiers that can be applied when encountering high cost-effectiveness ratios
- evidence comes from VIALE-A (n = 431) which evaluated the efficacy and safety of venetoclax in combination with azacitidine versus azacitidine alone
- the co-primary outcomes were overall survival (OS) and the percentage of patients with complete remission (CR) and complete remission with incomplete blood count recovery rate (CRi), CR/CRi, as assessed by investigator
- interim analysis (data cut-off 04/01/2020) showed venetoclax plus azacitidine significantly improved OS and CR/CRi rate compared with azacitidine, [median follow-up 20.5 months – OS 14.7 versus 9.6 months (hazard ratio 0.66, p-value <0.001), and CR/CRi rate, 66% versus 28%]
- the licensed dose is 400mg daily however, in the UK, azole antifungals are given as standard with this regimen, and the venetoclax dose is maintained at 100mg daily, and for some patients, from cycle 2 venetoclax is only given for 14 days per 28 day cycle to limit toxicity
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of venetoclax
- there are some costs in the system as during the COVID pandemic venetoclax-based regimens were used in place of intensive chemotherapy

Members noted that azacitidine monotherapy, given by injection, for AML will be replaced by combination therapy with venetoclax. There may be occasional patients where a step-down from venetoclax/azacitidine combination therapy is required. Members felt that it was too early to remove azacitidine monotherapy for AML from the formulary, but requested review of this position in 6 to 9 months. **FTEAM**

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The Group accepted the restricted local need for venetoclax, used in combination with azacitidine injection, for the treatment of adults with newly diagnosed AML who are ineligible for intensive chemotherapy, as outlined in SMC 2412.

SMC 2412 - Venetoclax 10mg, 50mg, 100mg film-coated tablets (Venclyxto®) ▼ is routinely available in line with national guidance (SMC 2412).
Indication under review: in combination with azacitidine injection for the treatment of adults with newly diagnosed acute myeloid leukaemia (AML) who are ineligible for intensive chemotherapy.
In a phase III study, treatment with venetoclax in combination with azacitidine significantly improved overall survival and remission rate when compared with azacitidine alone.
This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/ list price that is equivalent or lower.
This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting. It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Treatment with venetoclax should be initiated and supervised by a physician experienced in the use of anticancer medicinal products. FTEAM

8.2. FG1SMC 2443 - Sotorasib (non-small cell lung cancer (NSCLC))

Ms Galvin declared a personal, non-specific interest in Amgen Limited.

The Group considered the request for sotorasib monotherapy for the treatment of adults with KRAS G12C-mutated, locally advanced or metastatic, non-small cell lung cancer (NSCLC), who have progressed on, or are intolerant to platinum-based chemotherapy and/or anti PD-1/PD-L1 immunotherapy (SMC 2443).

The Group noted that:

- sotorasib:
  - received a Conditional Marketing Authorisation from the Medicines and Healthcare Products Regulatory Agency
  - was accepted for use within NHS Scotland, on an interim basis subject to ongoing evaluation and future reassessment, following a full submission assessed under the end of life and orphan equivalent medicine process, the output from the PACE process, and application of the appropriate SMC modifiers that can be applied when encountering high cost-effectiveness ratios
  - is the first KRAS G12C inhibitor licensed, and therapy options for patients with KRAS p.G12C-mutation NSCLC are currently limited to non-targeted therapies
- evidence for efficacy and safety comes from CodeBreaK 100 (n = 126), an ongoing, open-label, single-arm, phase I (dose escalation and expansion) and phase II study in patients with KRAS G12C-mutated advanced solid tumours, including NSCLC
- major efficacy outcome measures were objective response rate (ORR) and duration of response (DOR)
- ORR response to treatment was assessed using body scans (~ 37% (46 out of 124, 95% CI: 29, 46) of the patients showed partial (34%) or complete (3.2%) cancer shrinkage after treatment with sotorasib)
- among the 46 responders:
  - the median time to response was 1.35 months (1.2, 10.1) with 70% of responses occurring within the first 7 weeks
  - on average responses lasted for ~ 11 months (11.1 months, March 2021 cut-off)
  - the median duration of treatment was 5.5 months (range: 0 to 15) with 48% of patients treated for ≥6 months and 33% of patients treated for ≥9 months
  - progression free survival (PFS), median PFS was 6.8 (5.1 to 8.2) months
- the most common severe side effect was hepatotoxicity, which may lead to drug-

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induced liver injury and hepatitis
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of sotorasib
- as a new targeted agent sotorasib represents a new cost, but cost offset will be available from the displacement of non-targeted treatments
- the requestor confirmed that:
  - KRAS p.G12C testing is routinely included in the panel testing at diagnosis
  - the inclusion/exclusion criteria for CodeBreak 100 will be used to direct treatment, including patients having received no more than three prior lines of therapy

The Group accepted the restricted local need for sotorasib monotherapy for the treatment of adults with KRAS G12C-mutated, locally advanced or metastatic NSCLC, as outlined in SMC 2443.

SMC 2443 - Sotorasib 120mg film-coated tablets (Lumykras®) ▼ is routinely available in line with national guidance, on an interim basis subject to ongoing evaluation and future reassessment (SMC 2443).
Indication under review: as monotherapy for the treatment of adults with KRAS G12C-mutated, locally advanced or metastatic, non-small cell lung cancer (NSCLC), who have progressed on, or are intolerant to platinum-based chemotherapy and/or anti PD-1/PD-L1 immunotherapy.
In a single-arm, phase II study, 37% of previously treated patients with advanced or metastatic, KRAS G12C-mutated NSCLC who received sotorasib achieved an objective response. This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting.
This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/ list price that is equivalent or lower.
It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Treatment with sotorasib must be initiated by a physician experienced in the use of anticancer medicinal products.

FTEAM

8.3. FG1SMC 2429 - Nivolumab (oesophageal or gastro-oesophageal junction cancer)

There were no declarations of interest recorded in relation to this product.

The Group considered the request for nivolumab monotherapy for the adjuvant treatment of adults with completely resected oesophageal or gastro-oesophageal junction cancer who have residual pathologic disease following prior neoadjuvant chemoradiotherapy.

The Group noted that:
- [for this indication] nivolumab meets SMC orphan equivalent and end of life criteria and was accepted for use in NHS Scotland following a full submission
- evidence comes from a randomised, double-blind, placebo-controlled study, CheckMate 577 (n = 794; nivolumab 532, placebo 262)
- the relevant comparator is surveillance and treatment was continued until disease recurrence, unacceptable toxicity, or for up to one year in total duration. The primary outcome was disease-free survival, the secondary end points were OS and survival at 1, 2, and 3 years (OS data are not available yet).
- in the interim analysis (July 2020) patients receiving adjuvant nivolumab lived on average for 22 months before disease recurrence compared to 11 months for those on placebo (22.4 versus 11, HR 0.69, p<0.001). This difference was maintained in the updated ad hoc analysis (Feb 2021, median follow-up 32.2 months, 22.4 versus 10.4, HR 0.67).
- in CheckMate 577:
  - patients received neoadjuvant chemoradiotherapy followed by complete resection,

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which potentially does not reflect current practice for adenocarcinoma, and it is unclear if the pathway will change for this patient group
    - adjuvant treatment with nivolumab was given 4 to 16 weeks after surgery, there are no data to support use of adjuvant nivolumab outwith this timescale
- the service confirmed that inclusion criteria for Checkmate 577 would be used to direct treatment
- this is a new line of therapy and represents a new cost to the service, however costs will not be cumulative as [for adjuvant therapy] the maximum treatment duration with nivolumab is 12 months
- introduction will have service implications - staffing, aseptic preparation, chair time, and for monitoring/imaging, and costs related to managing adverse events

The Group accepted the restricted local need for nivolumab monotherapy for the adjuvant treatment of adults with completely resected oesophageal or gastro-oesophageal junction cancer who have residual pathologic disease following prior neoadjuvant chemoradiotherapy, as outlined in SMC 2429.

SMC 2429 - Nivolumab 10mg/mL concentrate for solution for infusion (Opdivo®) is routinely available in line with national guidance (SMC 2429).
Indication under review: as monotherapy for the adjuvant treatment of adults with completely resected oesophageal or gastro-oesophageal junction cancer who have residual pathologic disease following prior neoadjuvant chemoradiotherapy.
Restriction: for adjuvant therapy, the maximum treatment duration with nivolumab is 12 months.
In one randomised, double-blind, phase III study, nivolumab significantly improved disease-free survival compared with placebo in patients with oesophageal or gastro-oesophageal junction cancer who had complete resection and residual pathologic disease after neoadjuvant chemoradiotherapy.
This advice applies only in the context of approved NHS Scotland Patient Access Scheme (PAS) arrangements delivering the cost-effectiveness results upon which the decision was based, or PAS/ list prices that are equivalent or lower.
It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Treatment must be initiated and supervised by physicians experienced in the treatment of cancer. FTEAM

8.4. SBAR - Paliperidone Palmitate (Byannli®) six-monthly long-acting injection (schizophrenia)

There were no declarations of interest recorded in relation to this product.

The Group considered the request to include a new six-monthly formulation of paliperidone palmitate long-acting injection on the formulary.

The Group noted that:
- paliperidone palmitate long-acting injection is included on the formulary as one-monthly and three-monthly injections
- Byannli® is a new six-monthly formulation, and specialists within the Mental Health Service have confirmed that there is a restricted local need for the six-monthly injection
- if available, patients will require fewer injections per year, and there will be reduced nursing time and costs for administration
- the time window for giving injections either side of the due date is longer [than the other presentations] so may benefit patients who default from attendance on time
- there are only two strengths available, so Byannli® is only suitable for patients stabilised on the higher doses of one-monthly (i.e., 100mg or 150mg) and three-monthly (i.e. 350mg or 525mg) paliperidone palmitate long-acting injections
- at the medicine cost, introduction is cost-neutral

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- specialists in the Mental Health Service have confirmed that there is a restricted local need for the six-monthly formulation

The Group accepted the restricted local need for Byannli® without the need for a full submission.

SBAR - Paliperidone palmitate 700mg, 1000mg prolonged-release suspension for injection in pre-filled syringe (Byannli®) is routinely available in line with local guidance.
Indication under review: for the maintenance treatment of schizophrenia in adults who are clinically stable on one-monthly or three-monthly paliperidone palmitate injectable products.
It was classified 1b - available for restricted use under specialist supervision and 8d - treatment may be initiated in community on the recommendation of a consultant/specialist. **FTEAM**

8.5. SBAR Trimbow® NEXThaler® (DPI) 88/5/9 and Trimbow® 172/5/9 pMDI

There were no declarations of interest recorded in relation to these products.

The Group considered the request to include two new presentations of Trimbow® on the formulary. The new formulations of Trimbow® are new dry powder inhaler (DPI) presentation of the current medium-dose inhaled corticosteroid (ICS) pMDI and a new high-dose ICS pMDI.

The Group noted that:

- Trimbow®:
  - is a fixed-dose combination inhaler that contains three ingredients - an ICS (beclometasone) plus a long-acting beta$_2$ agonist (LABA - formoterol) plus a long-acting muscarinic antagonist (LAMA - glycopyrronium)
  - as the 87/5/9 pressurised metered-dose inhaler (pMDI) contains a medium dose of ICS, and is included in the NHS Grampian Respiratory Managed Clinical Network's prescribing guidance for both asthma and chronic obstructive pulmonary disease (COPD)
- evidence for high-dose ICS Trimbow® in asthma showed Trimbow® (medium- and high-dose ICS pMDI) was found to have a beneficial effect on the rate of severe exacerbations
- evidence for the new DPI in COPD demonstrated non-inferiority of the new DPI formulation administered via the NEXThaler® device to the Trimbow® pMDI product already licensed for the treatment of adults with moderate to severe COPD
- there were no new or unexpected adverse drug reactions identified with these products
- the Respiratory Managed Clinical Networks (MCN):
  - wishes to include Trimbow® NEXThaler® 88/5/9 and Trimbow® pMDI 172/5/9 on the formulary pending release of the NHS Scotland Respiratory Prescribing Strategy
  - the Respiratory MCN plans to review its prescribing guidance early 2023, and there is a local need for both inhalers
- the NEXThaler® device is a DPI, and the availability of more DPI devices will support 'green-prescribing' initiatives
- the propellants used in pMDIs are powerful greenhouse gases with global warming potentials. Trimbow® pMDI ustilises HFA 134a (tetrafluoroethane; Norflurane) which is preferable to HFA227ea.
- triple inhalers are beneficial for patients as they remove the need to use separate inhalers, which has the potential to improve compliance with therapy and disease control, and reduce the risk of inadvertent duplication of therapy
- improved disease control, will reduce waste and the use of 'rescue' therapies

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The Group accepted the restricted local need for Trimbow® as a new high-dose ICS pMDI and medium-dose ICS DPI, without the need for full submissions.

SMC 2334 - Trimbow® 172micrograms/5micrograms/9micrograms metered dose inhaler (beclometasone dipropionate/formoterol fumarate dihydrate/ glycopyrronium) is routinely available in line with local guidance.
Indication under review: maintenance treatment of asthma, in adults not adequately controlled with a maintenance combination of a long-acting beta$_2$-agonist and high dose of inhaled corticosteroid, and who experienced one or more asthma exacerbations in the previous year.
It was classified 1a - available for general use and 8e - treatment may be initiated in either hospital or community. **FTEAM**

SBAR - Trimbow® NEXThaler® (DPI) 88micrograms/5micrograms/9micrograms per actuation inhalation powder (beclometasone dipropionate/formoterol fumarate dihydrate/glycopyrronium) is routinely available in line with local guidance.
Indication under review: maintenance treatment in adults with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist or a combination of a long-acting beta2-agonist and a long-acting muscarinic antagonist.
Restriction: severe COPD (forced expiratory volume in one second less than 50% predicted normal).
It was classified 1a - available for general use and 8e - treatment may be initiated in either hospital or community. **FTEAM**

9. SCOTTISH MEDICINES CONSORTIUM PROVISIONAL ADVICE - ISSUED OCTOBER 2022

The Group noted the SMC provisional advice issued October 2022.

If the non-submission statements are published next month, these medicines will not be included on the formulary for the indications in question.

10. SCOTTISH MEDICINES CONSORTIUM PRESS STATEMENTS PUBLISHED SEPTEMBER 2022

The Group noted the SMC advice published October 2022.

Following publication of the negative SMC recommendation for Palforzia® ▼ (defatted powder of Arachis hypogaea L., semen (peanuts)) SMC 2487, this medicine will not be included on the Grampian Joint Formulary for the indication in question.

The following SMC accepted medicines have not been processed within a 60-day timescale:

- SMC 2508 brolucizumab (Beovu®) ▼ (clinicians not responded)
- SMC 2475 filgotinib (Jyseleca®) ▼ (submission expected)
- SMC 2478 ozanimod (Zeposia®) ▼ (submission received)
- SMC 2460 pembrolizumab (Keytruda®) (submission received)
- SMC 2474 pembrolizumab (Keytruda®) (clinicians not responded)
- SMC 2479 pembrolizumab (Keytruda®) (submission received)
- SMC 2510 upadacitinib (Rinvoq®) ▼ (submission expected)

Local advice for these medicines and indications will be included in the October 2022 decisions as 'Not routinely available as the ADTC is waiting for further advice from local clinical experts'. **FTEAM**

11. GENERAL INFORMATION FROM SCOTTISH MEDICINES CONSORTIUM - OCTOBER 2022

None.

ITEM	SUBJECT	ACTION

12. DOCUMENTS FOR INFORMATION

Items 12.1 (Drug Safety Update September 2022), 12.2 (Grampian Area and Drug Therapeutics Committee (GADTC) minute June 2022) and 12.3 (National Cancer Medicines Advisory Group (NCMAG) Newsletter, October 2022) were noted.

13. AOCB

UMAR SMC 2413 – ATIDARSAGENE AUTOTEMCEL (LIBMELDY®)

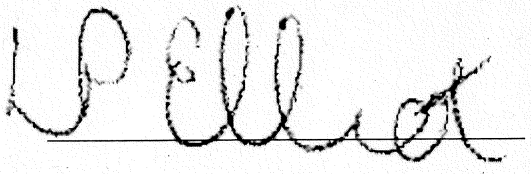
There were no declarations of interest recorded in relation to this product.

October 2022, the Scottish Government notified Health Boards that the pharmaceutical company, Orchard Therapeutics, had met all the conditions of the ultra orphan pathway, including providing a data collection plan and a PAS. Atidarsagene autotemcel (Libmeldy®) will be available on the NHS for up to three years, via the Ultra Orphan pathway, while further evidence on its effectiveness is generated. After the three year period, the SMC will review the available evidence and make a decision on its routine use in this patient group in NHS Scotland.

UMAR SMC 2413 - Atidarsagene autotemcel 2 to 10 x 10^6 cells/mL dispersion for infusion (Libmeldy®) ▼ is not routinely available in NHS Grampian.
Indication under review: for the treatment of metachromatic leukodystrophy (MLD) characterized by biallelic mutations in the arylsulfatase A (ARSA) gene leading to a reduction of the ARSA enzymatic activity:
- in children with late infantile or early juvenile forms, without clinical manifestations of the disease or
- in children with the early juvenile form, with early clinical manifestations of the disease, who still have the ability to walk independently and before the onset of cognitive decline.
Not routinely available in NHS Grampian. If local need identified treatment is available through the National Services Scotland Ultra orphan medicines Risk Share Scheme. **FTEAM**

DATE OF NEXT MEETING

Tuesday 15 November 2022 starting at 14.30 via Microsoft Teams

CHAIR'S SIGNATURE  **DATE 15 NOVEMBER 2022**