TAM SUBGROUP OF THE NHS HIGHLAND AREA DRUG AND THERAPEUTICS COMMITTEE

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MINUTE of meeting of the TAM Subgroup of NHS Highland ADTC
29 February 2024, via Microsoft TEAMS

Present:	Alasdair Lawton, Chair Findlay Hickey, Principal Pharmacist (Medicines Management and Prescribing Advice) Patricia Hannam, Formulary Pharmacist Dr Jude Watmough, GP Dr Robert Peel, Consultant Nephrologist Claire Wright, Acute Pain Nurse Specialist Dr Antonia Reid, GP Dr Stephen McCabe, Clinical Director Wendy Laing, Primary Care Clinical Pharmacist Linda Burgin, Patient Representative Lauren Stevenson, Pharmacist, Medicines Information Service Emma King-Venables, Lead AHP, A&B
In attendance:	Wendy Anderson, Formulary Assistant Damon Horn, Clinical Lead Pharmacist
Apologies:	Jenny Munro, AHP Physiotherapist Continence and Independent Prescriber Dr Alan Miles, GP (comments submitted via email) Joanne McCoy, MySelf-Management Manager

1. WELCOME AND APOLOGIES

The Chair welcomed the group.

2. REGISTER OF INTEREST

No register of interests were declared.

3. MINUTES OF MEETING HELD ON 7 DECEMBER 2023

Minutes accepted as accurate.

4. ACTIONS FROM PREVIOUS MEETING

Of particular note: the next edition of the Pink One is due to be sent out week commencing 04/03/24 so the wound formulary action point will also be complete.

Actions from meeting				
ITEM	ACTION POINT	ACTION	STATUS	COMMENTS
Aviptadil/phentolamine (Invicorp®) 25 micrograms/2mg in 0.35ml solution for injection (SMC1284/17)	Suggest secondary care provide patient education and training to the patient on how to administer, prescribe initial dose, and provide full advice to primary care when a recommendation to prescribe is made.	**PH**	Complete	Confirmed and monograph updated
Formoterol fumarate dihydrate/glycopyrronium/budesonide (Trixeo® Aerosphere) 5mcg/7.2mcg/160mcg pressurised inhalation, suspension (SMC2321)	Collate environmental impact evidence and email the Subgroup.	**PH**	Complete	GMMMG-COPD-Inhaler-Guide-update-Mar-2023.pdf

Dupilumab (Dupixent®) 300mg solution for injection in pre-filled pen (non SMC)	Is there robust evidence that it reduces further surgery?	**PH**	Complete	No response. Remains off Formulary
	In NHS Highland how much FESS surgery is done, how many repeat surgeries are done and what is the opportunity to displace surgery in Highland?	**PH**	Complete	No response. Remains off Formulary
	Is this being used elsewhere in Scotland or the UK?	**PH**	Complete	Only GGC mentions it: Non-formulary indication as per SMC2324
Lidocaine (Ralvo®) plaster 700mg (SMC224/06: NB advice is for Versatis brand)	Evidence required showing effectiveness, ideally randomised, doubling blind controlled trial data for the submission indication.	**PH**	Complete	Requestor has rescinded the submission.
Emollin aerosol spray (non SMC)	Needs to be stated clearly on the monograph that it is only for this specific indication.	**PH**	Complete	
Anastrozole 1mg tablets (non SMC)	Will there be an impact on patients if this is not approved in the interim? Agreed that a statement for patients will be developed.	**PH**	Complete	
Semaglutide (Wegovy®) 0.25mg, 0.5mg, 1mg, 1.7mg, 2.4mg Flextouch solution for injection in pre-filled pen (SMC2497)	A statement about NHS Highland stance on GLP1 -RA's be provided to primary care and the weight management team.	**PH**	Complete	National statement made. Given to dietetic team to take forward.
Wound Formulary – update to Formulary Product List	Article to go into the Pink One.	**PH**	Outstanding	
	Contact details for Tracy Sutherland, the Primary Care Medicines Management Nurse to be provided to JW.	**PH**	Complete	
Neonatal formulary – Propofol	Change 60s to 60 seconds.	**PH**	Complete	
Haematology guideline suite	Move to February 2024 agenda.	**PH**	Complete	
Multiple sclerosis guidance	Who is it aimed at? Information that is needed includes: What does the neurologist want the GP to do before they make the referral? In the event of a relapse what should the GP do? There are three blood tests to do, but doesn't provide detail on who to phone, what to prescribe or how to monitor. Needs to be more user friendly and succinct.	**PH**	Actioned	Author to review the guidance and resubmit.
Bronchiectasis	This guidance states 7 to 14 days, clarification required.	**PH**	Complete	To be amended to: **7 days** if mild bronchiectasis, non-severe symptoms of infection, not known/suspected Pseudomonas infection and satisfactory response by day 7. **14 days** if moderate to severe bronchiectasis, more severe symptoms of infection, known/suspected Pseudomonas.
Environment	The presentation which National Procurement gave to the ADTC Forum will be circulated to the Subgroup.	**FH**	Complete	

5. FOLLOW UP REPORT

The follow up report was noted. Work was ongoing to see what was still outstanding.

6. SUBMISSIONS FOR ADDITION TO HIGHLAND FORMULARY FOR APPROVAL

6.1. Haematology Chemotherapy formulary submissions

No submission made.

6.2. Oncology Chemotherapy formulary submissions

Pembrolizumab 25mg/ml concentrate for solution for infusion (SMC2589)
ACCEPTED

Trastuzumab deruxtecan 100mg powder for concentrate for solution for infusion (SMC2608)
ACCEPTED

Nivolumab 10mg/ml concentrate for solution for infusion (SMC2619)
ACCEPTED

6.3. Atogepant (Aquipta®) 60mg and 10mg tablets (SMC2599)

Submitted by: Francisco Javier Carod Artal, Consultant Neurologist

Indication: Prophylaxis of migraine in adults who have at least four migraine days per month.

SMC restriction: for patients with chronic and episodic migraine who have had prior failure on three or more migraine preventive treatments.

Comments: An expensive, specialist medicine with 3 monthly monitoring to be done by GPs was felt not to be appropriate, as patients could be lost to follow up in Primary Care and remain unintentionally on treatment. Place in therapy for migraine drugs in the Formulary is as per SIGN guidance, but atogepant and rimegepant are not currently incorporated. They are an alternative more cost effective option to other therapies eg Botox. Request to change to specialist initiation only with initial review done by Secondary Care and only when patient is on maintenance treatment should prescribing fall to Primary Care. Request an up to date algorithm for the treatment of migraine (acute and prophylaxis) with these medicines placed accordingly. To ask for clarification why two prophylactic medications are required; atogepant and rimegepant.

ACCEPTED pending

Action

6.4. Rimegepant (Vydura®) oral lyophilisate (SMC2521)

Submitted by: Francisco Javier Carod Artal, Consultant Neurologist

Indication: for the acute treatment of migraine with or without aura in adults.

SMC restriction: for patients who have had inadequate symptom relief after trials of at least two triptans or in whom triptans are contraindicated or not tolerated; and have inadequate pain relief with non-steroidal anti-inflammatory drugs (NSAIDs) and paracetamol.

Comments: Comment was made that the anticipated numbers seemed low as patients were already asking GPs about it. Clarity is required for Primary Care on the intended use of these medicines, ie which patients and why. Financial risk that patients will slide on to this medicine for a long period of time. Agreed to be changed to specialist initiation only with first review done by Secondary Care and only when patient is on maintenance treatment should prescribing fall to Primary Care. Request an up to date algorithm for the treatment of migraine (acute and prophylaxis) with these medicines placed accordingly.

ACCEPTED pending

Action

6.5. Rimegepant (Vydura®) oral lyophilisate 75mg (SMC2603)

Submitted by: Francisco Javier Carod Artal, Consultant Neurologist

Indication: for the preventive treatment of episodic migraine in adults who have at least four migraine attacks per month.

SMC restriction: for patients with episodic migraine who have at least 4 migraine attacks per month, but fewer than 15 headache days per month and who have had prior failure on three or more migraine preventive treatments.

Comments: as per item 6.3.

ACCEPTED pending

Action

6.6. Vortioxetine (Brintellix®) 5mg, 10mg, 20mg film-coated tablet (SMC1158/16)

Submitted by: Lesley Hansen, Clinical Pharmacist, New Craigs Hospital

Indication: the treatment of major depressive episodes in adults.

Comments: Evidence showed this medicine was no better than existing serotonin noradrenaline reuptake inhibitors. Is it appropriate to add this medicine, which is no more effective to what is currently on the Formulary? Benefit noted that it can be stopped abruptly and better patient tolerability. It is toxic and bio accumulative in the water supply. Comments received that this is already being used, so this would be normalising what is already occurring in practice, eg for patients who have not tolerated other therapy due to failure of therapy or unacceptable side effects. Decision to be made between having multiple drugs on

the formulary that are of equal benefit or limiting patient choice. Felt it was not unreasonable to have as another option for those patients when it looks to be cost neutral. Request that it is resubmitted with further information on its place in therapy justified.

REJECTED – to be resubmitted

Action

6.7. Lurasidone (Latuda®) 18.5mg, 37mg, 74mg film-coated tablets (SMC994/14)

Submitted by: Lesley Hansen, Clinical Pharmacist, New Craigs Hospital

Indication 1: Treatment of schizophrenia in adults in patients in whom it is important to avoid weight gain and metabolic adverse effects.

Indication 2: Bipolar affective disorder depression.

Comments: Evidence-base is good and it has a better metabolic profile than alternatives.

ACCEPTED

6.8. Prucalopride 1mg, 2mg tablets (SMC653/10)

Submitted by: Catriona Wheelan, Lead Pharmacist Respiratory and Gastroenterology

Indication: for symptomatic treatment of chronic constipation in women in whom laxatives fail to provide adequate relief.

Comments: This was not accepted by SMC in 2011 therefore evidence of a change in either the clinical or the cost-effectiveness case needs to be given. Prucalopride has come off patent and is now available as a generic. NICE have approved this for this indication. This is being used in practice in Secondary Care. The 1mg tablets remain at a similar price as per the SMC submission, however the 2mg tablets are about half the price at time of SMC submission. If 2mg is prescribed, then it needs to be noted on the Formulary monograph that 2 x 1mg should not be prescribed, as this is less cost-effective. Clarity needs to be provided for place in therapy, eg the NICE recommendation to be added to the monograph. Will be noted in the Formulary as specialist recommendation only.

ACCEPTED pending

Action

6.9. FreeStyle Libre 3 rt-CGM (real time continuous glucose monitoring) system

Submitted by: David MacFarlane, Consultant Physician

Indication: it is recommended that flash glucose monitoring with Freestyle Libre® is available for individuals with diabetes who are actively engaged in the management of their diabetes and who intensively manage their condition with multiple daily insulin injections or insulin pump therapy.

Comments: FreeStyle Libre 2 is currently on the Formulary and will remain first choice with FreeStyle Libre 3 only to be used in patients in whom FreeStyle Libre 2 is not suitable. It is very well thought out submission. Great to see the recycling scheme as the plastic waste associated with these is huge. The lack of detail about the recycling scheme is a bit concerning given plastic can only really be recycled once or twice maximum.

ACCEPTED

6.10.Tafamidis (Vyndaqel®) 62mg soft capsules (SMC2585)

Submitted by: Stephen Leslie, Consultant Cardiologist

Indication: treatment of ATTR Cardiac Amyloid (symptoms and mortality).

Comments: Expensive but numbers are very small and it is shown to be effective. Patient use is being limited with specific exclusions for patients with frailty and less than one year of life. Ensure appropriate contraception warning to be included on monograph. The medicine will be specialist initiation only. Clarification on when to stop the drug required, is this to be done in the cardiology clinic or in primary care as well? The criteria states period of review is 6 monthly in cardiology clinic. Confirm that this continues throughout the length of treatment. To be clarified if there are there any discounts, eg contract pricing agreed with National Procurement that can be taken advantage of.

ACCEPTED

Action

7. Formulary review

7.1. Immunological products and vaccines

- Wording to be clarified: Green book chapter 18 has two different wordings. For Fendrix it is patients with renal insufficiency aged 15 and over. For HBvaxPRO it is adult dialysis patients and predialysis patients; it is not limited to haemodialysis patients as stated in the guidance.
- How do patients throughout Highland access travel vaccines? Feedback to Vaccine Transformation Service.

ACCEPTED pending

Action

8. FORMULARY MINOR ADDITIONS/DELETIONS/AMENDMENTS

Noted and approved.

9. FORMULARY REPORT

Noted and approved. The Formulary Working Group met and focus is being made on several items including omeprazole suspension, melatonin, lidocaine patches and co-proxamol. These will also be taken to the Prescribing Sufficiency Working Group.

10. SMC ADVICE

Noted.

11. NEW TAM GUIDANCE FOR APPROVAL

11.1. Bariatric surgery suite

- This is very helpful, welcome guidance and it would be good to be highlighted via a Pink One article.
- At the recent Area Drug and Therapeutics Committee Collaborative a presentation was given on private clinics and about private healthcare and NHS interface. There is a list of clinics that are regulated by Health Improvement Scotland and a request was put to ADTCC asking could there be a policy 'Once for Scotland' approach for private/NHS interface?
- The Scottish Government official advice is that if a patient has had a treatment done privately in the UK, it is up to the UK provider to provide the follow up and pay for the follow up assessment and treatment of that patient.

ACCEPTED

Action

11.2. Raynaud's phenomenon

ACCEPTED

11.3. Anaemia in CKD

- Roxadustat not in the Formulary so is currently classed as a non-formulary drug; however a submission will be made to the April Subgroup.

ACCEPTED

12. GUIDELINE UPDATES

12.1. TAM139 Statins for the prevention of atherosclerosis (now: Lipid lowering therapy in the prevention/treatment of atherosclerosis)

ACCEPTED

12.2. Haematology

- Very appreciative of the guidance. It was recognised that a lot of work has gone into review and it was very helpful to have them up-to-date.

ACCEPTED

12.3. Psychotic disorders

- Interim guidance linking to NICE CKS – psychosis and schizophrenia, a decision would be made as to whether local guidance to support this needs to be developed.

ACCEPTED

12.4. ADHD

- Note: This guidance will be not be published until a letter has been sent out to primary care to update them of the change of practice.

ACCEPTED

12.5. Long COVID

- Amendment to the guidance may be needed. Labs will now only do vitamin D levels for specific criteria.
- Clarify 'assess as you normally would'.
- What is this hoping to achieve? What is the service that sits behind this guidance? These patients will need is a proper long COVID service with a Long COVID clinic consisting of physiotherapists, occupational therapists and clinical psychologists etc. Is this feasible given the anticipated patient numbers? Further information for the service itself to be tabled at the next Subgroup meeting.

ACCEPTED pending

Action

12.6. Frank Haematuria
ACCEPTED

12.7. Occult or non-visible haematuria
ACCEPTED

12.8. Urology referral criteria
ACCEPTED

13. GUIDELINE MINOR AMENDMENTS

Noted and approved pending removal of any Latin abbreviations.
Action

14. GUIDANCE FOR NOTING ONLY (REVIEWED AND NO CHANGES MADE)

Noted and approved:
Female urinary incontinence.

15. GUIDANCE REMOVED

Noted:
Treatment of low electrolytes introduction.

16. TAM REPORT

Report noted as below:

Work is ongoing with sending out annual departmental reports to the clinical leads and service managers and this is very much trying to engage with departments so that they have revised and ownership of the full suite of guidance that they own. Forty-one reports have been sent out and to date 8 responses have been received.

Authority to recruit has been approved to cover the TAM Project Support Manager post from June until January. A bid is being made to the additional cost of teaching fund which gets released in April, June and September to look to get a TAM Manager, which would be in addition to the Tam Project Support Manager, and to be able to drive things forward with TAM.

RDS have tightened up their governance process they are under Health Improvement Scotland now. All toolkits now have to complete an audit of their governance processes. As there is a lack of governance process about development of toolkits within NHS Highland, the implementation leads for NHS Highland agreed to develop a process as to who within NHS Highland decides which toolkits can be developed. The issue raised was that TAM was set up because of the lack of governance and structure with guidance on the intranet and potentially with RDS, if clinicians are able to develop toolkits on RDS without a governance process, then we could have the same situation but on a wider scale. So it has been agreed that any toolkit that has therapeutic guidance within it will come to TAM Subgroup.

PM is involved in developing a strategy or service level agreement between NHS Highland and the University of Highlands and Islands regarding the library service. Interested as a stakeholder from the point of view of Pharmacy and TAM in that how could knowledge manager support (librarians) aid in the review and development and maintenance and governance of therapeutic guidance which would support clinicians.

Further comments

Top 10 out of date:

- The anticoagulant recommendations are being addressed as part of a review of DOACs.
- The DVT guidance still works in practice but perhaps change fax number to email address. Feed back to author.
- It was hoped that diabetes guidance would be tabled at the April Subgroup meeting.
- Can Primary Care guidelines be written by Primary Care rather than Secondary Care? This is being taken forward by the TAM team.

17. ENVIRONMENT

Community Pharmacy Services are looking to support Community Pharmacies in doing a waste amnesty of patients medicines.

18. NHS WESTERN ISLES

Nothing to note. PH will liaise with DoP for WI to clarify engagement with the Highland formulary and TAM guideline process.

19. ANY OTHER COMPETENT BUSINESS

- Articles have been included in the next Pink One newsletter regarding the National Patient Safety Alert about GLP1-RAs and valproate.
- **Director of Pharmacy**
  The new Director of Pharmacy, Sarah Buchan, has started in post and we welcome her to NHS Highland and look forward her contribution to the organisation.

20. DATE OF NEXT MEETING

Next meeting to take place on Thursday 25 April 2024, 14:00-16:00 via TEAMS.

Actions agreed at TAM Subgroup meeting

Minute Ref	Action Point	Action by
Atogepant (Aquipta®) 60mg and 10mg tablets (SMC2599) *Back to minutes*	• Request to change to specialist initiation only with initial review done by Secondary Care and only when patient is on maintenance treatment should prescribing fall to Primary Care. • Request an up to date algorithm for the treatment of migraine (acute and prophylaxis) with these medicines placed accordingly. • Ask for clarification why two prophylactic medications are required; atogepant and rimegepant.	**PH**
Rimegepant (Vydura®) oral lyophilisate (SMC2521) *Back to minutes*	• Clarity is required for Primary Care on the intended use of these medicines, ie which patients and why? • To be changed to specialist initiation only with first review done by Secondary Care and only when patient is on maintenance treatment should prescribing fall to Primary Care. • Request an up to date algorithm for the treatment of migraine (acute and prophylaxis) with these medicines placed accordingly.	**PH**
Rimegepant (Vydura®) oral lyophilisate 75mg (SMC2603) *Back to minutes*	• Request to change to specialist initiation only with initial review done by Secondary Care and only when patient is on maintenance treatment should prescribing fall to Primary Care. • Request an up to date algorithm for the treatment of migraine (acute and prophylaxis) with these medicines placed accordingly. • Ask for clarification why two prophylactic medications are required; atogepant and rimegepant.	**PH**
Vortioxetine (Brintellix®) 5mg, 10mg, 20mg film-coated tablet (SMC1158/16) *Back to minutes*	• Request that it is resubmitted with further information on its place in therapy justified.	**PH**
Prucalopride 1mg, 2mg tablets (SMC653/10) *Back to minutes*	• If 2mg is prescribed, then it needs to be noted on the Formulary monograph that 2 x 1mg should not be prescribed, as this is less cost-effective. • Clarity needs to be provided for place in therapy, eg the NICE recommendation to be added to the	**PH**

	monograph. • Will be noted in the Formulary as specialist recommendation only.	
Tafamidis (Vyndaqel®) 62mg soft capsules (SMC2585) *Back to minutes*	• Ensure appropriate contraception warning to be included on monograph. • Clarification on when to stop the drug required, is this to be done in the cardiology clinic or in primary care as well? • The criteria states period of review is 6 monthly in cardiology clinic. Confirm that this continues throughout the length of treatment. • To be clarified if there are there any discounts, eg contract pricing agreed with National Procurement that can be taken advantage of.	**PH**
Immunological products and vaccines *Back to minutes*	• Wording to be clarified: Green book chapter 18 has two different wordings. For Fendrix it is patients with renal insufficiency aged 15 and over. For HBvaxPRO it is adult dialysis patients and predialysis patients; it is not limited to haemodialysis patients as stated in the guidance. • How do patients throughout Highland access travel vaccines? Feedback to Vaccine Transformation Service.	**PH**
Bariatric surgery suite *Back to minutes*	Pink One article to be written.	**PH**
Long COVID *Back to minutes*	• Amendment to the guidance may be needed. Labs will now only do vitamin D levels for specific criteria. • Clarify 'assess as you normally would'. • Further information for the service itself to be tabled at the next Subgroup meeting.	**PH**
Guideline minor amendments *Back to minutes*	Remove any Latin abbreviations.	**PH**