NHS GRAMPIAN
Minute of Formulary Group Meeting
Tuesday 17 August 2021 at 14:30 via Microsoft Teams

PRESENT	APOLOGIES	APPROVED
Ms A Davie	Ms M Galvin	
Ms F Doney	Mr R Sivewright	
Dr L Elliot		
Dr J Fitton		
Professor J McLay (Chairman)		
Dr M Metcalfe		
Mrs L Montgomery		
Mrs K Neave		
Dr J Newmark		
Mrs S O'Beirne		
Mr M Paterson		

IN ATTENDANCE
Ms Christine Hay, Formulary and Medicines Management Pharmacist
Mrs Grace McKerron, Chief Nurse, Corporate (observer)

ITEM	SUBJECT	ACTION
	The Chairman welcomed members, opened the meeting and noted that a quorum was present. The Chairman welcomed Mrs Grace McKerron to the meeting. Mrs McKerron was attending the meeting as an observer with a view to either joining the Formulary Group as a nursing representative or identifying a peer to join the Group in the near future.	
1.	**APOLOGIES** Apologies for absence were requested and noted.	
2.	**DRAFT MINUTE OF THE MEETING HELD 15 JULY 2021** Ms Doney confirmed that Dr Hannah has requested clarity over the dapagliflozin restriction, amending the wording to include cardiologists, i.e., Restriction: start treatment on the advice of a heart failure specialist/cardiologist. The Group accepted the draft note of the July meeting subject to minor typographical changes, and inclusion of the amendment requested by Dr Hannah. The July decisions document will be updated and re-issued. The corrected final approved minute will be in the public domain within 21 days of approval.	**FTEAM** **FD**
3.	**PRESENTATION** None.	
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.	
5.	**FORMULARY GROUP DECISIONS JULY 2021 - PUBLISHED 03/08/2021** Members ratified the decisions of the July 2021 meeting, subject to update of the dapagliflozin heart failure entry as outlined in item 2.	

ITEM	SUBJECT	ACTION

6. NETFORMULARY/FORMULARY REVIEW

6.1. THE RESUSCITATION COUNCIL UK GUIDELINES ON THE EMERGENCY TREATMENT OF ANAPHYLAXIS UPDATED AND PUBLISHED MAY 2021

The Group discussed the update of the Resuscitation Council Emergency treatment of anaphylactic reactions: Guidelines for healthcare providers.

Ms Doney confirmed that the formulary has been updated and that the resuscitation nurses are updating the e-anaphylaxis package and resus kits.

The Group noted that:

- antihistamines are considered a third-line intervention and should not be used to treat Airway/Breathing/Circulation problems during initial emergency treatment
- non-sedating oral antihistamines, in preference to chlorphenamine, may be given following initial stabilisation especially in patients with persisting skin symptoms (urticaria and/or angioedema)
- corticosteroids, e.g., hydrocortisone are no longer advised for the routine emergency treatment of anaphylaxis
- the adrenaline intramuscular dosing in the anaphylaxis algorithm differs from the doses for self-administration
- patients should carry two auto-injectors with them at all times

Members requested Dr Herriot attend a future meeting to discuss the use and dosing requirements of adrenaline auto-injectors. **FTEAM**

7. OTHER BUSINESS

7.1. FORMULARY GROUP REPORT 2020/21

The Chairman confirmed that the draft Formulary Group annual report for 2020/21 was sent by email just prior to the meeting. He requested members review the report and provide feedback to Ms Doney within seven working days. **ALL**

8. NEW PRODUCT REQUESTS

8.1. FG1SMC 2267 - ATEZOLIZUMAB (TECENTRIQ®) AND NAB-PACLITAXEL (ABRAXANE®) (TRIPLE-NEGATIVE BREAST CANCER)

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

The Group reviewed the request for atezolizumab in combination with nab-paclitaxel for the treatment of adults with unresectable locally advanced or metastatic triple-negative breast cancer (TNBC) whose tumours have programmed death-ligand 1 [PD-L1] expression ≥1% and who have not received prior chemotherapy for metastatic disease.

The Group noted that:

- nab-paclitaxel is currently included on the formulary as a second-line treatment for metastatic breast cancer, so if this regimen is accepted for use it will move treatment to first-line for this patient group
- atezolizumab [in combination with nab-paclitaxel] is the first immunotherapy licensed for adults with TNBC
- the service already has significant experience using atezolizumab for other indications, and only the 840mg vial is licensed for TNBC
- the service estimates the length of treatment to be 8 months for atezolizumab and 6 cycles for nab-paclitaxel. Dose limiting toxicities (myelosuppression/neuropathy) limit the duration of nab-paclitaxel.
- this will mainly be a new cost as this treatment regimen will replace various chemotherapy regimens (capecitibine, vinorelbine, paclitaxel), and these medicines will now be available later in the treatment pathway

ITEM	SUBJECT	ACTION

The Group accepted the restricted local need for the combination regimen atezolizumab and nab-paclitaxel used for the treatment of adult patients with unresectable locally advanced or metastatic TNBC as outlined in SMC 2267.

SMC 2267 - Atezolizumab 840mg concentrate for solution for infusion (Tecentriq®) ▼ is routinely available in line with national guidance (SMC 2267).
Indication under review: in combination with nab-paclitaxel for the treatment of adults with unresectable locally advanced or metastatic triple-negative breast cancer (TNBC) whose tumours have programmed death-ligand 1 [PD-L1] expression ≥1% and who have not received prior chemotherapy for metastatic disease.
In a randomised, double-blind, phase III study, the addition of atezolizumab to nab-paclitaxel significantly improved progression-free survival and numerically improved overall survival in patients with locally advanced or metastatic triple-negative breast cancer with PD-L1 expression ≥1% who had not received prior chemotherapy for metastatic disease.
It was classified 1b - available for restricted use under specialist supervision and 8b – recommended for hospital use only. Atezolizumab must be initiated and supervised by physicians experienced in the treatment of cancer. Patients with previously untreated triple-negative breast cancer should be selected for treatment based on the tumour expression of PD-L1 confirmed by a validated test (see SmPC 5.1). **FTEAM**

8.2. FG1SMC 2338 - NIRAPARIB (OVARIAN, FALLOPIAN AND PRIMARY PERITONEAL CANCER)

Dr Fitton declared a personal, non-specific interest in GlaxoSmithKline UK, and took part in decision-making.

The Group reviewed the request for niraparib monotherapy for the maintenance treatment of adults with advanced epithelial (FIGO Stages III or IV) high-grade ovarian, fallopian tube or primary peritoneal cancer who are in response (complete or partial) following completion of first-line platinum-based chemotherapy.

The Group noted that:

- niraparib:
  - is a poly (adenosine diphosphate-ribose) polymerase (PARP) -1 and -2 inhibitor
  - is included on the formulary in this patient group as maintenance for relapsed platinum sensitive ovarian cancer for adults who do not have a germline BReast CAncer gene (BRCA) mutation
  - is an oral treatment option, and in the trial [PRIMA] progression-free survival (PFS) with niraparib was 13.8 months for the intention to treat population and 21.9 months in the homologous recombination deficiency (HRD) population
- olaparib (another PARP inhibitor) is included on the formulary for this indication, however it is limited to adults with a BRCA mutation [mutation in either of the BRCA1 and BRCA2 genes, germline and/or somatic]
- unlike olaparib, niraparib is licensed for patients with or without a BRCA mutation
- niraparib is a new maintenance treatment option for patients with no BRCA mutation, but would compete with olaparib as maintenance for patients with a BRCA mutation
- the service suggested that for patients with a BRCA mutation, olaparib will continue to be the preferred choice as there are more mature data available
- the service would not consider re-challenging patients with a second-line PARP inhibitor
- where niraparib is used [as maintenance after first-line platinum-based chemotherapy] in adults with no BRCA mutation this represents a new cost to the service
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of niraparib

ITEM	SUBJECT	ACTION

Members were unclear why niraparib would not compete with olaparib for BRCA positive adults. Accepting that there is no direct head-to-head data and unaware of the comparative outcome data, the group asked for confirmation of the reasoning for only considering olaparib in BRCA positive patients. Is olaparib more effective or does it have a better side-effect profile?

The Group accepted the restricted local need for niraparib 100mg hard capsules as monotherapy for the maintenance treatment of adults with advanced epithelial high-grade ovarian, fallopian tube or primary peritoneal cancer who are in response following completion of first-line platinum-based chemotherapy as outlined in SMC 2338.

SMC 2338 - Niraparib 100mg hard capsules (Zejula®) ▼ is routinely available in line with national guidance (SMC 2338).
Indication under review: as monotherapy for the maintenance treatment of adults with advanced epithelial (FIGO Stages III or IV) high-grade ovarian, fallopian tube or primary peritoneal cancer who are in response (complete or partial) following completion of first-line platinum-based chemotherapy.
In a randomised, double-blind, phase III study, niraparib significantly improved progression-free survival compared with placebo.
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 niraparib should be initiated and supervised by a physician experienced in the use of anticancer medicinal products. **FTEAM**

8.3. FG1SMC 2298 - TRASTUZUMAB EMTANSINE (KADCYLA®) (BREAST CANCER)

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

The Group considered the request for trastuzumab emtansine (Kadcyla®) as a single agent for the adjuvant treatment of adults with human epidermal growth factor-2 (HER2) positive early breast cancer who have residual invasive disease, in the breast and/or lymph nodes, after neoadjuvant taxane-based and HER2 targeted therapy.

The Group noted that:

- trastuzumab emtansine:
  - is an antibody-drug conjugate containing trastuzumab and the microtubule inhibitor DM1
  - [for this indication] is given as an intravenous infusion administered every three weeks. Patients should receive treatment for a total of 14 cycles unless there is disease recurrence or unmanageable toxicity.
  - [for this indication] meets SMC orphan equivalent criteria
  - will replace trastuzumab alone in oestrogen receptor (ER)-negative patients, and will compete with neratinib plus trastuzumab in ER-positive patients.
    In ER-positive patients' the preference will be for adjuvant trastuzumab emtansine. Neratinib will be considered in those who are unable to tolerate trastuzumab emtansine and withdraw early or those who opt not to have trastuzumab emtansine.
- the service has experience using trastuzumab emtansine in advanced breast cancer
- to prevent medicinal product errors it is important to check the vial labels to ensure that the medicinal product being prepared and administered is Kadcyla® (trastuzumab emtansine) and not Herceptin® (trastuzumab) or other trastuzumab biosimilars
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of trastuzumab emtansine

ITEM	SUBJECT	ACTION

The Group accepted the restricted local need for trastuzumab emtansine as a single agent for the adjuvant treatment of adults with HER2 positive early breast cancer, as outlined in SMC 2298.

SMC 2298 - Trastuzumab emtansine 100mg, 160mg powder for concentrate for solution for infusion (Kadcyla®) is routinely available in line with national guidance (SMC 2298).
Indication under review: as a single agent, for the adjuvant treatment of adult patients with human epidermal growth factor-2 (HER2) positive early breast cancer who have residual invasive disease, in the breast and/or lymph nodes, after neoadjuvant taxane-based and HER2 targeted therapy.
Trastuzumab emtansine was associated with a statistically significant improvement in invasive disease-free survival compared with a HER2 targeted agent in patients with HER2 positive early breast cancer with residual invasive disease in the breast and/or axillary lymph nodes after completion of neoadjuvant treatment containing a HER2 targeted agent.
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.
Trastuzumab emtansine should only be prescribed by a physician and administered as an intravenous infusion under the supervision of a healthcare professional who is experienced in the treatment of cancer patients (i.e. prepared to manage allergic/anaphylactic infusion reactions and in an environment where full resuscitation facilities are immediately available).
In order to prevent medicinal product errors it is important to check the vial labels to ensure that the medicinal product being prepared and administered is Kadcyla® (trastuzumab emtansine) and not Herceptin® (trastuzumab) or biosimilar trastuzumab. FTEAM

8.4. FG1SMC 2336 - MOGAMULIZUMAB (MYCOSIS FUNGOIDES AND SÉZARY SYNDROME)

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

The Group considered the request for mogamulizumab for the treatment of adults with advanced mycosis fungoides or Sézary syndrome, as outlined in SMC 2336.

The Group noted that:

- the Marketing Authorisation Holder requested the SMC only consider use in adults with advanced Sézary syndrome following at least one prior systemic therapy, who are clinically ineligible for or refractory to treatment with brentuximab vedotin
- mogamulizumab:
  - is administered as an intravenous infusion every week on days 1, 8, 15 and 22 of the first 28 day cycle, followed by fortnightly infusion on days 1 and 15 of subsequent cycles until disease progression or unacceptable toxicity
  - [for this indication] meets SMC orphan equivalent criteria, was accepted for restricted use in NHS Scotland following a full submission considered under the orphan medicine process, the output from the PACE process, and application of the appropriate SMC modifiers
  - represents a new cost to the service, as mogamulizumab is largely fulfilling an unmet need although it may replace brentuximab in some cases, e.g., patients with pre-existing peripheral neuropathy
- the median treatment exposure in MAVORIC was 170 days, but this ranged from 71 to 348 days
- patient numbers are expected to be very small

ITEM	SUBJECT	ACTION

- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of mogamulizumab

The Group accepted the restricted local need for mogamulizumab for the treatment of adults with advanced mycosis fungoides or Sézary syndrome following at least one prior systemic therapy, who are clinically ineligible for or refractory to treatment with brentuximab vedotin, as outlined in SMC 2336.

SMC 2336 - Mogamulizumab 4mg/mL concentrate for solution for infusion (Poteligeo®) ▼ is routinely available in line with national guidance (SMC 2336). Indication under review: for the treatment of adults with advanced mycosis fungoides or Sézary syndrome (Stage ≥IIB and all SS) following at least one prior systemic therapy, who are clinically ineligible for or refractory to treatment with brentuximab vedotin.
In an open-label phase III study, mogamulizumab, compared with a histone deacetylase inhibitor, was associated with a significant improvement in progression-free survival.
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, and should only be administered by healthcare professionals in an environment where resuscitation equipment is available. **FTEAM**

9. SCOTTISH MEDICINES CONSORTIUM PROVISIONAL ADVICE - AUGUST 2021

The Group noted the SMC provisional advice issued August 2021.

If the negative SMC recommendations are published next month, these medicines will not be included on the formulary for the indications in question.

10. SCOTTISH MEDICINES CONSORTIUM PRESS STATEMENTS - AUGUST 2021

The Group noted the SMC advice published August 2021.

Following publication of the SMC non-submission statement for elotuzumab (Empliciti®) (SMC 2407) this medicine will not be included on the Grampian Joint Formulary for the indication in question. **FTEAM**

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

- SMC 2345 avatrombopag (Doptelet®) ▼ (submission expected)
- SMC 2358 inclisiran (Leqvio®) ▼ (submission received)
- SMC 2359 avelumab (Bavencio®) ▼ (submission expected)
- SMC 2362 nivolumab (Opdivo®) (submission expected)
- SMC 2367 olaparib (Lynparza®) (submission expected)
- SMC 2381 patiromer sorbitex calcium (Veltassa®) ▼

Local advice for these medicines and indications will be included in the August 2021 decisions as 'Not routinely available as the ADTC is waiting for further advice from local clinical experts'. **FTEAM**

SMC 2360 - GUSELKUMAB (TREMFYA®) ▼ (PSORIATIC ARTHRITIS)

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

It was confirmed that the Rheumatology Service does not anticipate using guselkumab very often as the interleukin-23 inhibitors seem to be more effective for skin disease than the associated arthritis.

ITEM	SUBJECT	ACTION

The Group agreed that guselkumab would not be added to the formulary for psoriatic arthritis as there is preference for other agents. If guselkumab is required for an adult with psoriatic arthritis it can be accessed on an individual patient basis.

SMC 2360 - Guselkumab 100mg solution for injection (Tremfya®) ▼ is not routinely available as there is a local preference for alternative medicines.
Indication under review: alone or in combination with methotrexate (MTX) for the treatment of active psoriatic arthritis in adult patients who have had an inadequate response or who have been intolerant to a prior disease-modifying antirheumatic drug (DMARD) therapy.
Restriction: (i) patients whose disease has not responded adequately or who have been intolerant to two previous conventional disease-modifying antirheumatic drug (DMARD) therapies but have not received biologic DMARD therapy (biologic-naïve population);
(ii) patients whose disease has not responded adequately to conventional DMARDs and one or more tumour necrosis factor (TNF) inhibitors (biologic-experienced population); and
(iii) patients in whom TNF inhibitors are contraindicated or not tolerated.
Three phase III studies demonstrated superiority of guselkumab when compared with placebo in reducing signs and symptoms of psoriatic arthritis in patients who had not previously received a tumour necrosis factor (TNF) inhibitor medication and in those with an inadequate response or intolerance to TNF inhibitors.
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.
Not routinely available as there is a local preference for alternative medicines. **FTEAM**

SMC 2351 - AUTOLOGOUS ANTI-CD19-TRANSDUCED CD3+ CELLS (KTE-X19) (TECARTUS®) ▼ (MANTLE CELL LYMPHOMA)

Dr Fitton declared a personal, non-specific interest in Gilead Sciences Ltd and took part in decision-making.

The Group noted that:

- autologous anti-CD19-transduced CD3+ cells (KTE-X19) (Tecartus®):
  - is an advanced therapy medicinal product (ATMP) that must be administered in a qualified treatment centre by a physician with experience in the treatment of haematological malignancies and trained for administration and management of patients treated with autologous anti-CD19-transduced CD3+ cells
  - should be noted as non-formulary because treatment is currently only available from a specialist centre in another Health Board. If a local need is identified patients are discussed at a national multidisciplinary team meeting and if appropriate allotted treatment in a qualified treatment centre.

The Group agreed that autologous anti-CD19-transduced CD3+ cells (KTE-X19) should be recorded as non-formulary, routinely available from a specialist centre in another health board.

SMC 2351 - Autologous anti-CD19-transduced CD3+ cells (KTE-X19) (Tecartus®) ▼ is routinely available from a specialist centre in another Health Board.
Indication under review: the treatment of adult patients with relapsed or refractory mantle cell lymphoma (MCL) after two or more lines of systemic therapy including a Bruton's tyrosine kinase (BTK) inhibitor.
In a single-arm, open-label, phase II study in patients with relapsed or refractory MCL, autologous anti-CD19-transduced CD3+ cells (KTE-X19) (Tecartus®) ▼ improved overall response rate compared with historical controls.

ITEM	SUBJECT	ACTION
	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**

11. GENERAL INFORMATION FROM SCOTTISH MEDICINES CONSORTIUM

None.

12. DOCUMENTS FOR INFORMATION

The Group noted items 12.1 (MEDwatch August 2021) and 12.2 (Antimicrobial Management Team Meeting 26 November 2020) were noted.

13. AOCB

UPDATE - SODIUM-GLUCOSE CO-TRANSPORTER-2 (SGLT2) INHIBITOR LICENSING

Ms Doney confirmed that since the last meeting:

- dapagliflozin has been granted a licence for adults for the treatment of chronic kidney disease
- empagliflozin has been granted a licence for adults for the treatment of symptomatic chronic heart failure with reduced ejection fraction, and, as expected, the dose is 10mg daily

WELCOME

The Chairman welcomed Dr Newmark to the Group, noting that this was his first meeting as a member of the Formulary Group.

DATE OF NEXT MEETING

Tuesday 21 September 2021 starting at 14.30 via Microsoft Teams.

CHAIRMAN'S SIGNATURE **DATE 21 SEPTEMBER 2021**