NHS GRAMPIAN
Minute of Formulary Group Meeting
Tuesday 21 June 2022 at 14:30 via Microsoft Teams

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

IN ATTENDANCE

Dr Alison Black, Consultant Rheumatologist, for item 3.1
Mrs Sarah Irvine, Senior Finance Manager, for item 3.2
Dr Erwan Elias, General Practitioner, Kemnay Medical Practice, observer

Note some items were taken outwith the agenda running order.

ITEM	SUBJECT	ACTION

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

3. PRESENTATION

3.1. DR ALISON BLACK – ZOLEDRONIC ACID FOR LOW-IMPACT HIP FRACTURE - LINKS WITH ITEM 8.1 (OFF-LABEL REQUEST)

Dr Black provided members with an overview of the request for the off-label use of zoledronic acid infusion for the treatment of osteoporosis in adults with a recent low-trauma hip fracture.

Dr Black confirmed that:

- it is clear that there is scope to improve future osteoporosis prevention within the hip fracture setting, as studies show a third of all patients break a second hip within 21 months of the first hip
- there is an urgency to change care as hip fracture can be a devastating event for patients and preventing a second hip fracture would significantly improve care for patients and provide a significant cost-avoidance for the Health Board
- the only thing that will truly make a difference to preventing a second hip fracture is zoledronic 5mg infusion, because it is preventing future fracture within one month of infusion. Oral bisphosphonates are difficult to manage for patients with studies showing that only about a third are still taking medication one year after starting. Oral bisphosphonates are slower to start working and are difficult for patients to comply with therapy.
- the International Osteoporosis Foundation advocates the use of intravenous (IV) zoledronic in patients immediately post hip fracture in an orthopaedic or orthogeriatrian setting
- those suitable would have fracture prevention for about the next two years, and for many older people they would not need any further treatment
- for the more able patients the full treatment course would be an annual 5mg infusion for three years [with first infusion administered as an in-patient]
- the request is coming to formulary as although zoledronic acid has a licence for use post hip fracture (in men and women) the SmPC recommends the infusion is given at least two weeks after hip fracture. This is because the licensing studies did not include patients treated in this time window, but smaller studies have shown that treatment is efficacious and there is no impairment in fracture healing.
- as long as patients are selected correctly there are no concerns about giving the

infusion 'early'
- 'early' use is accepted by the Hip Fracture Audit Scotland Group. This Group includes orthopaedic surgeons, anaesthetists and orthogeriatricians. It is also supported by the Osteoporosis Specialist Network.
- the local specialist services [Orthopaedic, Orthogeriatric, Metabolic Bone Service] are advocating use and seeking formulary approval so that zoledronic acid infusion can be given in the orthopaedic ward, usually under the care of orthogeriatricians, from 48 hours after hip fracture
- the 48-hour window is to allow time for an initial loading dose of vitamin D to be administered before giving the zoledronic infusion - vitamin D administered as soon as possible after admission or surgery, whatever is available for the patient
- patients will have a quick turnaround, the more able patients will get vitamin D on admission and their infusion 48 hours later and then they will go home. The frailer person who has had a hip fracture is often in hospital longer, sometimes 7 to 10 days, and it is envisaged that the infusion would be given 5 or 6 days post hip fracture although it could be given sooner.
- the infusion should not be considered for those at end-of-life care, and it cannot be given to people whose estimated glomerular filtration rate (eGFR) is <35. If eGFR borderline (~40) patients will get IV fluids before and after the zoledronic acid infusion, but these patients will be under the care of an orthogeriatrician.

Dr Black answered questions from members:
- for the initial in-patient infusion, the service implications [including impacts on nursing staff] have been considered and discussed at ward level and services have accepted this is appropriate to take forward
- for those assessed as appropriate for repeat infusion, subsequent infusions will be given in the Rheumatology Department and the day-case unit considers it can cope with the increased numbers. For patients unable to attend the clinic alternative treatment options will be considered.
- patients will have been covered within that initial period immediately post-fracture where falls risk are higher and patients are frailer
- patient numbers are an estimate, assuming those with adequate renal function that consent to treatment
- a formal dental review is not planned (or required), this is accepted policy in other units. The patients are bisphosphate-naïve and will have their teeth checked on admission (including by an anaesthetist when under anaesthetic), also this is a one-off infusion and all patients will be recommended to see a dentist before any subsequent infusions.
- patients will be bisphosphate-naïve so a one-off zoledronic acid infusion is unlikely to have much effect on either atypical femoral fracture or osteonecrosis of the jaw
- the Osteoporosis Service will arrange follow-up for those requiring subsequent infusions, including liaison with GPs and if appropriate making arrangements for the next infusion

The Chair thanked Dr Black for attending the meeting, and Dr Black left the meeting before decision-making.

8.1. FG1 429/20 - Zoledronic acid (monohydrate) 5mg/100mL solution for infusion (osteoporosis – off-label low trauma hip fracture)

The Group discussed the request for the early (from 48 hours to <14 days post hip fracture), off-label, use of zoledronic acid 5mg for the treatment of osteoporosis in a subgroup of bisphosphonate-naïve adults with a recent low-trauma hip fracture.

The following points were noted:
Clinical-effectiveness: proven efficacy (increased bone mineral density and reduce re-fracture rates); benefit is seen early in treatment with a long duration of action so benefit

ITEM	SUBJECT	ACTION

for patients expected even if only one infusion is administered.
Cost-effectiveness: no QALY data; this is a new cost to the Board, but costs are manageable as zoledronic acid is subject to confidential contract pricing.
Treatment provides the potential to reduce hospital admission due to reduced re-fracture rates; potential for improved outcomes versus oral bisphosphonates (better adherence to therapy vs oral agents). Annual infusion given for a maximum treatment period of three years (three infusions).
Health gain for NHSG: benefits for patients and the Board – potential for improved quality of life and reduced morbidity and mortality. Provides the opportunity for reduced hospitalisation for re-fractures.
Service impact: impact from (in-patient) first infusion minimised and relevant processes agreed with the service(s), including nursing staff in these areas.
Potential significant impact for nursing staff, outpatient clinics and Community Hospitals in years two and three minimised as the Rheumatology Service will administer repeat infusions or alternative treatment options will be considered for those that cannot attend the outpatient clinic.
Equity: 'early infusion' is used in other areas in the UK; it is recommended internationally, and by the Scottish Osteoporosis Specialist Network and the Hip Fracture Audit Group.
Safety: no new or additional concerns; no evidence of harm if administered 'early'; no evidence that 'early' administration affects fracture healing.

The Group agreed that the early off-label use of zoledronic acid infusion provided the opportunity for significant benefits to patients, and the proposed use is supported by local specialist services.

The Group accepted the restricted local need for the early off-label use of zoledronic acid infusion for the treatment of osteoporosis in a subgroup of bisphosphonate-naïve adults with a recent low-trauma hip fracture.

FG1 429/20 - Zoledronic acid (monohydrate) 5mg/100mL solution for infusion is routinely available in line with local guidance.
Indication: [off-label use] for the treatment of osteoporosis in adults with a recent low-trauma hip fracture.
It was classified 3b - licensed product request for unlicensed use and 8b - recommended for hospital use only. Informed consent should be obtained and documented. **FTEAM**

3.2. FINANCE UPDATE

Mrs Sarah Irvine, Senior Finance Manager NHS Grampian, briefed members on the budget setting process, how the secondary care budget is set, how the costs of 'new medicines fund (NMF)' drugs and any new drugs approved by the Formulary Group are managed.

Mrs Irvine confirmed that:
- during 21/22 the spend on NMF drugs exceeded the funding available to support NMF drugs, and there has been a significant increase in spend on NMF drugs in the last few years
- NHS Grampian continues to require prioritisation and managed entry of new medicines via the Formulary Group
- at the beginning of a financial year it is difficult to predict the likely cost pressures that will occur as a result of new medicine introductions
- the greatest risks to the budget will most likely be related to the widening access of medicines for rare conditions, and for use in end-of-life situations
- the funding received from Scottish Government is lower than the cost of NMF drugs, and the gap between NMF drug costs and funding is widening

ITEM	SUBJECT	ACTION

Members accepted that as the Formulary Group has no budget and it has no indication of departmental budgets, it would be beneficial for decision-making if clinicians attended meetings to present requests for new medicines. As the presentations would be additional workload requests for attendance would need to be balanced against the pressure that services/clinicians are already under.

The Formulary Team will continue to liaise with colleagues in finance to highlight cost pressures/implications related to formulary requests.

1. APOLOGIES

Apologies for absence were requested and noted.

The Chair led introductions to Dr Erwan Elias, GP in Kemnay Medical Practice, who was attending the meeting as an observer with a view to joining the Group in the future.

2. DRAFT MINUTE OF THE MEETING HELD 17 MAY 2022

The Group accepted the draft note of the meeting subject to typographical changes and classification changes. [Correction of the formulary classification from '1b' to '3b - licensed product request for unlicensed use' for micronised progesterone, and from '1b' to '3a' - unlicensed product/request for unlicensed use for L-Ornithine-L-Aspartate (LOLA) 3g granules for oral solution].

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

4. MATTERS ARISING

4.1. ACTION LOG

Ms Doney apologised that the action log was not issued with the papers, and confirmed that an updated action log would be issued with the draft minute. **FD**

5. FORMULARY GROUP DECISIONS MAY 2022 – PUBLISHED – 30/05/2022

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

6. NETFORMULARY/FORMULARY REVIEW

6.1. MICONAZOLE 2% CREAM

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

Ms Doney confirmed that:

- despite being used for several years, there has never been a submission to include miconazole topical cream on the formulary
- topical miconazole 2% (including in combination with hydrocortisone) is the preferred topical antifungal cream for proven nipple candidiasis, as noted in national and local guidance
- miconazole oral gel should not be used because it is not formulated to penetrate the breast tissue

The Group acknowledged there was an established local need for topical miconazole (including in combination with hydrocortisone) for the management of fungal skin infections, and that miconazole 2% cream is the preferred topical agent for proven nipple candidiasis.

ITEM	SUBJECT	ACTION

The Group accepted topical miconazole (including in combination with hydrocortisone) to the formulary without the need for a full submission.

Miconazole nitrate 2% w/w cream is routinely available in line with local guidance.
Indication: for the topical treatment of mycotic infections of the skin and nails and superinfections due to Gram-positive bacteria.
First-line topical treatment for proven nipple candidiasis.
It was classified 1a - available for general use and 8e - treatment may be initiated in either Primary or Secondary care. **FTEAM**

Miconazole nitrate/hydrocortisone 2%/1% w/w cream, ointment is routinely available in line with local guidance.
Indication: for the topical treatment of inflamed dermatoses where infection by susceptible organisms and inflammation co-exist, e.g., intertrigo and infected eczema.
It was classified 1a - available for general use and 8e - treatment may be initiated in either Primary or Secondary care. **FTEAM**

6.2. DESCOVY® FOR PRE-EXPOSURE PROPHYLAXIS

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

The Group considered the request from the Sexual Health Service for the licence extension of Descovy® 200/25mg tablets prescribed on a daily-dosing basis for HIV Pre-exposure Prophylaxis (PrEP) therapy.

The Group noted:

- PrEP is only prescribed by the Grampian Sexual Health Service
- SMC considers the licence extension for Descovy® 200/25mg outwith remit
- Descovy® 200/25mg:
  - [for this indication] would be an alternative to the generic combination emtricitabine/tenofovir disoproxil (FTC/TDF) 245mg tablet
  - only differs from FTC/TDF in the tenofovir salt (alfenamide versus disoproxil), and the alfenamide salt has a more favourable effect on bone mineral density and renal function
  - costs significantly more than generic FTC/TDF
  - [for this indication] is licensed from 12 years but formulary acceptance would be limited to adults and adolescents from 16 years of age. Adolescents 12 to <16 years would be considered on an individual basis, following a child protection assessment as per Fraser Guidelines and as per BHIVA Guidelines for under 16 years of age.
- in terms of licensing for PrEP, Descovy® and FTC/TDF differ in the populations and regimens available. Both are licensed for 12 years and older, with Descovy® only licensed as a daily-dosing regimen for at-risk men who have sex with men. FTC/TDF is also available for daily-dosing and event-based dosing (intermittent), in high-risk groups (i.e., not limited to men who have sex with men).
- the licensing trial showed Descovy® was non-inferior to FTC/TDF in reducing the risk of acquiring HIV-1 infection
- NHS Scotland has PrEP eligibility criteria for FTC/TDF, however due to the cost differential between the two preparations, FTC/TDF would be considered the first-choice agent with Descovy® limited to use in a subgroup of patients
- that the availability of PrEP provides the opportunity to reduce the risk of acquiring HIV-1 infection, and formulary acceptance of Descovy® would support local and national initiatives

The Group accepted the restricted local need for daily-dosing Descovy® 200mg/25mg film coated tablets, used in combination with safer sex practices, for PrEP in a group of at-risk

adolescents and men aged 16 years and older.

SBAR - Descovy® 200mg/25mg film coated tablets (emtricitabine/tenofovir alafenamide fumarate) is routinely available in line with local guidance.
Indication: in combination with safer sex practices for pre-exposure prophylaxis to reduce the risk of sexually acquired HIV-1 infection in at-risk men who have sex with men, including adolescents (with body weight at least 35kg).
Restriction: second-line choice in adolescents and adult men from 16 years of age, who:
- **are unable to take emtricitabine/tenofovir disoproxil (due to contraindication or intolerance), and**
- **meet pre-exposure prophylaxis (PrEP) eligibility criteria**

It was classified 1b - available for restricted use under specialist supervision and 8b – recommended for hospital use only. Treatment should be initiated by a physician experienced in the management of HIV infection – prescribing and supply restricted to the Sexual Health Service. **FTEAM**

Note: The classification 'recommended for hospital use only' does not prevent supply of medicines by Primary Care, e.g. use of hospital-based prescription (HBP) stationery.

6.3. MELATONIN 2MG MR TABLETS

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

Ms Doney confirmed that:
- melatonin 2mg prolonged-release tablets, as the brand Circadin®, is included on the formulary
- generic products are now marketed and this strength and formulation was recently included in the Scottish Drug Tariff (SDT)
- prescribing generically provides a cost-avoidance opportunity for the Health Board
- the change to generic has been highlighted with colleagues, including the team that will take forward any efficiency work

The Group noted the cost-minimising opportunity provided by generic prescribing and ratified changing the current formulary entry from branded Circadin® to generic naming.

SBAR - Melatonin 2mg MR tablets is routinely available in line with local guidance.
Indication: [off-label use] second-line treatment in conjunction with other therapies and/or behavioural strategies, in children over 3 years of age and adults with learning difficulties with neuro-developmental disorders (including ADHD), autism spectrum disorders (ASDs), visual impairment, or other neuropsychiatric disorders, and chronic sleep disturbance where:
- **sleep hygiene measures have not been effective**
- **symptoms of sleep disturbance have been present for at least six months**
- **sleep disturbance is associated with significant interference with daily functioning**

It was classified 3b - licensed product request for unlicensed use and 8d - treatment may be initiated in community on the recommendation of a consultant/specialist. Informed consent should be obtained and documented. **FTEAM**

Circadin® will be noted as 'Not routinely available as there is a local preference for alternative medicines'. **FTEAM**

6.4. SMC ACCEPTED ADVICE NOT REQUESTED LOCALLY

Dr Culligan declared a personal, non-specific interest in Takeda and took part in the decision-making.

ITEM	SUBJECT	ACTION

Ms Doney reported that following a review of outstanding applications for SMC accepted medicines:

- requests for five medicines will not be progressed, four oncological medicines and one antifungal medicine
- the Oncology Service has confirmed that there is a local preference for alternative medicines
- the Antimicrobial Management Team does not wish to apply for formulary inclusion for oritavancin as there is not a local need at this time
- where there is confirmation that services do not wish to apply for formulary inclusion these medicines are recorded as non-formulary - not routinely available. This position does not preclude use of these medicines (for the relevant indications) on an individual-patient basis and if the situation changes the services can apply for formulary inclusion in the future.

The Group supported recording the medicines for the relevant indications as non-formulary - 'not routinely available'.

SMC 2314 - Brigatinib 30mg, 90mg, 180mg film-coated tablets (Alunbrig®) is not routinely available as there is a local preference for alternative medicines.
Indication under review: as monotherapy for the treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive advanced non-small cell lung cancer (NSCLC) previously not treated with an ALK inhibitor.
Brigatinib offers an additional treatment choice in the therapeutic class of tyrosine kinase inhibitors for this indication.
Medicines within this therapeutic class have been accepted via the orphan process for this indication.
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 2386 - Cabozantinib 20mg, 40mg, 60mg film-coated tablets (Cabometyx®) is not routinely available as there is a local preference for alternative medicines.
Indication under review: in combination with nivolumab for the first-line treatment of advanced renal cell carcinoma in adults.
Cabozantinib offers an additional treatment choice in the therapeutic class of tyrosine kinase inhibitors given in combination with a PD-1 inhibitor for this indication.
Medicines within this therapeutic class have been accepted under the end of life process for this indication.
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 2199 - Lenvatinib 4mg, 10mg hard capsules (Kisplyx®) is not routinely available as there is a local preference for alternative medicines.
Indication under review: in combination with everolimus for the treatment of adult patients with advanced renal cell carcinoma (RCC) following one prior vascular endothelial growth factor (VEGF)-targeted therapy.
In a phase II study, the addition of lenvatinib to everolimus significantly improved progression-free survival in patients with advanced renal cell carcinoma who had received one previous VEGF-targeted therapy.
This SMC advice takes account of the benefit of Patient Access Schemes (PAS) that improve the cost effectiveness of lenvatinib and everolimus. This advice is contingent upon the continuing availability of these PAS in NHS Scotland or list prices that are equivalent or lower. This advice takes account of views from a

ITEM	SUBJECT	ACTION
	Patient and Clinician Engagement (PACE) meeting. **Not routinely available as there is a local preference for alternative medicines.**	**FTEAM**
	SMC 2285 - Oritavancin 400mg powder for concentrate for solution for infusion (Tenkasi®) is not routinely available as local clinical experts do not wish to add the medicine to the formulary at this time. **Indication under review: treatment of acute bacterial skin and skin structure infections (ABSSSI) in adults.** **SMC restriction: patients with confirmed or suspected methicillin-resistant Staphylococcus aureus (MRSA) infection who are eligible for early discharge. Use should be on the advice of local microbiologists or specialists in infectious disease.** **In two randomised, phase III, double-blind studies of patients with ABSSSI, oritavancin was non-inferior to a glycopeptide antibiotic for clinical cure at the end of treatment in the clinically evaluable population.** **Not routinely available as local clinical experts do not wish to add the medicine to the formulary at this time.**	**FTEAM**
	SMC 2328 - Trametinib 0.5mg, 2mg film-coated tablets (Mekinist®) is not routinely available as there is a local preference for alternative medicines. **Indication under review: in combination with dabrafenib for the treatment of adult patients with unresectable or metastatic melanoma with a BRAF V600 mutation.** **SMC restriction: after first line treatment.** **Trametinib in combination with dabrafenib offers an additional treatment choice in the therapeutic class of BRAF/ mitogen-activated extracellular signal-regulated kinase (MEK) inhibitors.** **Another medicine combination within this therapeutic class has been accepted via the end of life and orphan medicine process.** **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.** **SMC has previously accepted trametinib for restricted use in combination with dabrafenib for first-line treatment of adult patients with unresectable or metastatic melanoma with a BRAF V600 mutation (SMC 1161/16). The current advice now extends use after first line treatment.** **Trametinib is also licensed as monotherapy. As the company submission related only to combination therapy, SMC cannot recommend use as monotherapy.** **Not routinely available as there is a local preference for alternative medicines.**	**FTEAM**

6.5. FAMPRIDINE 10MG PROLONGED RELEASE TABLETS (FAMPRYA®)

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

The Chair confirmed that the service issues regarding the introduction of fampridine have been resolved and the service is now running for all regions that NHS Grampian covers. The formulary entry has been updated from 'Not routinely available as local implementation plans are being developed' to '1b - available for restricted use under specialist supervision and 8b – recommended for hospital use only'.

The Group ratified the updated formulary classification.

SMC 2253 - Fampridine 10mg prolonged-release tablets (Fampyra®) is routinely available in line with national guidance (SMC 2253).
Indication: for the improvement of walking in adult patients with multiple sclerosis with walking disability (EDSS [expanded disability status scale] 4-7).
In double-blind phase III studies fampridine, compared with placebo, improved walking ability in adults with multiple sclerosis and walking impairment.

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. It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Treatment is restricted to prescription and supervision by physicians experienced in the management of multiple sclerosis. **FTEAM**

6.6. NALOXEGOL AND NALDEMEDINE

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

Ms Doney confirmed that:

- naloxegol and naldemedine were accepted to formulary for the treatment of refractory opioid-induced constipation in adults but prescribing was limited to the managed service until local prescribing protocols were published
- the relevant protocols are in final checks, due to be published at the end of the month, and the formulary classification requires to be updated to allow prescribing in Primary Care
- the Scottish Palliative Care Guidelines advise that both naloxegol and naldemedine are '*For administration under specialist palliative care guidance only'*. So when used in the palliative setting the formulary classification should be '*1b - available for restricted use under specialist supervision and 8d - treatment may be initiated in community on the recommendation of a consultant/specialist'*.

The Group supported updating the formulary classification of both naloxegol and naldemedine to allow prescribing in primary care in line with local guidance.

Naldemedine 200micrograms film-coated tablets (Rizmoic®) ▼ is routinely available in line with local guidance.
Indication: for the treatment of refractory opioid-induced constipation in adults with chronic cancer pain whose constipation has not adequately responded to at least two laxatives. 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**

Naldemedine 200micrograms film-coated tablets (Rizmoic®) ▼ is routinely available in line with local guidance.
Indication: for the treatment of refractory opioid-induced constipation in adults with chronic non-cancer pain whose constipation has not adequately responded to at least two laxatives. It was classified 1a - available for general use and 8e - treatment may be initiated in either hospital or community. **FTEAM**

Naloxegol 12.5mg, 25mg film-coated tablets (Moventig®) is routinely available in line with local guidance.
Indication: for the treatment of refractory opioid-induced constipation in adults with chronic cancer pain whose constipation has not adequately responded to at least two laxatives. 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**

Naloxegol 12.5mg, 25mg film-coated tablets (Moventig®) is routinely available in line with local guidance.
Indication: for the treatment of refractory opioid-induced constipation in adults with chronic non-cancer pain whose constipation has not adequately responded to at least two laxatives. It was classified 1a - available for general use and 8e - treatment may be initiated in either hospital or community. **FTEAM**

ITEM	SUBJECT	ACTION

7. OTHER BUSINESS

7.1. ANNUAL REPORT

Ms Doney confirmed that due to staffing issues the annual report was delayed but would be issued with a 10-day consultation period. **FD**

8. NEW PRODUCT REQUESTS

8.2. FG1SMC 2404 - DOSTARLIMAB (ENDOMETRIAL CANCER)

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

The Group considered the request for dostarlimab infusion for the treatment of adults with mismatch repair deficient (dMMR)/microsatellite instability-high (MSI-H) recurrent or advanced endometrial cancer that has progressed on or following prior treatment with a platinum-containing regimen.

The Group noted:

- endometrial cancer is the sixth most common cancer in women worldwide. It has one of the highest observed rates of mismatch repair deficient (dMMR)/microsatellite instability-high (MSI-H).
- dostarlimab:
  - is a monoclonal antibody which blocks the Programmed Cell Death Protein 1 (PD-1) receptor
  - is the first treatment licensed for dMMR/MSI-H recurrent or advanced endometrial cancer
  - is given as monotherapy at a recommended dose of 500mg every 3 weeks for 4 cycles followed by 1000mg every 6 weeks for subsequent cycles. Treatment is continued until disease progression or unacceptable toxicity.
  - [for this indication] received a conditional marketing authorisation from the Medicines and Healthcare products Regulatory Agency
  - meets SMC end of life and orphan equivalent criteria for this indication, and was accepted for use in NHS Scotland on an interim basis subject to ongoing evaluation and future assessment
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of dostarlimab
- patient numbers are expected to be small but this will be a new cost to the service with minimal offset from cisplatin/doxorubicin/paclitaxel. Additional service impacts are expected - clinic pressures (staff, consumables, chair-time etc.); pharmacy aseptic unit preparation; cost of supportive therapies/care, e.g. for management of adverse drug reactions, including management of infusion related reactions.
- evidence comes from a cohort (cohort A1) of GARNET, an ongoing multicentre, open-label, single-group, phase I study. The study only included patients with an ECOG Performance Status of 0 or 1. The two co-primary outcomes were 1) objective response rate (ORR) and 2) duration of response (DOR). Interim analysis after a median follow-up of 16.3 months showed the ORR was 44% (n=47; 95% CI 34% to 53%) and the median DOR (months) was not reached (range 2.6 to 28.1+ months). Subgroup analysis by ECOG Performance Status showed considerable difference in ORR; ORR was 67% in patients with a performance status of 0 (n=42) and 29% in patients with a performance status of 1 (n=63)
- in GARNET cohort A1, the median duration of treatment with dostarlimab was 26 weeks. The service expect treatment to be up to 2 years, however this may be continued longer if the patient was felt to continue to receive benefit.

The Group accepted the restricted local need for dostarlimab for advanced endometrial cancer, as outlined in SMC 2404.

ITEM	SUBJECT	ACTION
	SMC 2404 - Dostarlimab 500mg concentrate for solution for infusion (Jemperli®) ▼ is routinely available in line with national guidance on an interim basis subject to ongoing evaluation and future reassessment (SMC 2404). **Indication under review: as monotherapy for the treatment of adults with mismatch repair deficient (dMMR)/microsatellite instability-high (MSI-H) recurrent or advanced endometrial cancer (EC) that has progressed on or following prior treatment with a platinum-containing regimen.** **In a single-arm cohort of a phase I study in patients with dMMR/MSI-H recurrent or advanced endometrial cancer who had progressed following treatment with platinum doublet chemotherapy, dostarlimab was associated with an objective response rate (ORR) of 44%, median duration of response has not been reached.** **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. Therapy must be initiated and supervised by specialist physicians experienced in the treatment of cancer. The identification of dMMR/MSI-H tumour status should be determined using a validated testing method such as immunohistochemistry, polymerase chain reaction or next-generation sequencing.**	FTEAM

8.3. FG1SMC 2400 - ENZALUTAMIDE (MHSPC)

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

The Group considered the request for enzalutamide in combination with androgen deprivation therapy (ADT) for the treatment of adults with metastatic hormone-sensitive prostate cancer (mHSPC).

The Group noted:

- mHSPC is incurable and the aims of treatment are to prevent disease progression and prolong overall survival
- standard of care in newly diagnosed mHSPC is anti-testosterone therapy (surgically or medically induced (LHRH analogue)) alone or with chemotherapy (docetaxel) or hormone therapy (abiraterone plus prednisolone)
- enzalutamide:
  - [for this indication] was accepted for use within NHS Scotland following a full submission under the orphan equivalent medicine process, the output from the PACE process, and application of SMC modifiers [that can be applied when encountering high cost-effectiveness ratios]
  - plus ADT offers patients with newly diagnosed mHSPC an additional licensed treatment option that may be useful where the alternatives are contraindicated
  - [for this indication] provides the opportunity to delay disease progression and subsequent chemotherapy/antineoplastic therapy, and extend overall survival
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of enzalutamide
- October 2020, abiraterone plus prednisolone was accepted to formulary for high-risk mHSPC patients [SMC 2215]. During COVID, abiraterone was accepted for off-label use in NHS Scotland by NCMAG as an alternative to docetaxel for use in the low-risk mHSPC population [NCMAG 001].
- enzalutamide has a lower monitoring burden (blood pressure, bloods) than abiraterone-steroid-ADT, and patients do not have to take low dose oral prednisolone for several years (5mg daily for mHSPC)
- for patients with newly diagnosed mHSPC who are unfit for chemotherapy, enzalutamide-ADT offers an alternative to abiraterone-steroid-ADT
- the trials for enzalutamide (and abiraterone) only included fitter patients so there is a lack of data for patients with an ECOG Performance Status of 2 or more

ITEM	SUBJECT	ACTION

- abiraterone is due to come off patent this year (October). Generic competition is expected and there is a potential that the cost of generic abiraterone will fall below that of enzalutamide.

The Group accepted the restricted local need for enzalutamide for mHSPC as outlined in SMC 2400.

SMC 2400 - Enzalutamide 40mg film-coated tablets (Xtandi®) is routinely available in line with national guidance (SMC 2400).
Indication under review: treatment of adults with metastatic hormone-sensitive prostate cancer (mHSPC) in combination with androgen deprivation therapy (ADT).
Enzalutamide improved radiographic progression-free survival compared with placebo and it improved overall survival compared with placebo and an older non-steroidal anti-androgen (NSAA) in adults with mHSPC who were receiving ADT.
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 should be initiated and supervised by specialist physicians experienced in the medical treatment of prostate cancer. **FTEAM**

9. SCOTTISH MEDICINES CONSORTIUM PROVISIONAL ADVICE – ISSUED JUNE 2022

The Group noted the SMC provisional advice issued June 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 JUNE 2022

The Group noted the SMC advice published June 2022.

Following publication of the negative SMC recommendations, for ixekizumab (Taltz®) SMC 2440 and tepotinib (Tepmetko®)▼ SMC 2457, and the non-submission statement for ruxolitinib (Jakavi®) SMC 2498, these medicines will not be included on the Grampian Joint Formulary for the indications in question.

The following SMC accepted medicines have not been processed within a 60-day timescale:
- SMC 2431 abrocitinib (Cibinqo®)▼ (clinicians not responded)
- SMC 2442 Ryeqo® (relugolix/estradiol/norethisterone acetate)▼ (submission expected)
- SMC 2476 lenvatinib (Kisplyx®) (clinicians not responded)

Local advice for these medicines and indications will be included in the June 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 - JUNE 2022

None.

ITEM	SUBJECT	ACTION

12. DOCUMENTS FOR INFORMATION

Items 12.1 (Drug Safety Update May 2022), 12.2 (MedWatch Newsletter May 2022), 12.3 (Medicine Guidelines and Policy Group (MGPG) minute April 2022), 12.4 (Antimicrobial Management Team (AMT) minute April 2022) and 12.5 (Primary Care Prescribing Group (PCPG) March 2022) were noted.

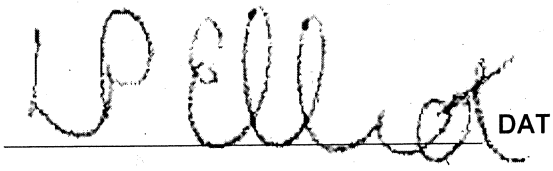
13. AOCB

JULY MEETING

With the summer holidays immanent members agreed to cancel the July meeting. **FTEAM**

DATE OF NEXT MEETING

Tuesday 16 August 2022 starting at 14.30 via Microsoft Teams

CHAIR'S SIGNATURE  **DATE 16 AUGUST 2022**