Surrey Heartlands Integrated Care System
Area Prescribing Committee (APC)

MINUTES

Date	5th March 2025	Time	1430 - 1600
Venue	Microsoft teams invitation		

nName (Initials)	Role	Attendance /apologies											
APC voting members		**Jan** Virtual	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Dr Stephen Cookson (SC)	RSFT – Consultant Cardiologist (Chair)		√	√									
Sarah Watkin (SWa)	Head of Medicines Resource Unit – Surrey Heartlands Integrated Care Board (Deputy Chair)		√	√									
Linda Honey (LH)	Director of Pharmacy - Surrey Heartlands Integrated Care System		√ **(left at 4pm)**	√									
Tara Bahri	Deputy Chief Pharmacist Out of Hospital, Surrey Downs Place		√	√									
Tim Dowdall	Deputy Chief Pharmacist Out of Hospital - Guildford & Waverley		√	√									
Lis Stanford	Deputy Chief Pharmacist Out of Hospital – North-West Surrey		**A**	√									
Monika Cunjamalay	Deputy Chief Pharmacist Out of Hospital – East Surrey		√	**A**									
Nikki Smith (NS)	Head of Medicines Safety / Patient Safety Specialist		√	√									
Veronica Davis	RSFT – Formulary Pharmacist		√	√									
Jemma Hives	Clinical Lead Pharmacist - ASPH		√	**X**									
Asad Qureshi	Formulary Pharmacist - ASPH		**A**	√									
Nicky Leitch (NL)	SASH – Formulary Development Pharmacist		√	√									
Amy Fox or Kanwal Sheikh	ESHUT – Formulary and Medicines Optimisation Pharmacist		√	**X**									
Alison Marshall (AM)	SABPFT - Formulary Pharmacist		√	√									

Simon Whitfield	Chief Pharmacist – Surrey & Borders Partnership NHS Foundation Trust		**A**	**X**									
	CSH - Lead Pharmacist		√	**X**									
Temitope Odetunde (TO)	FCH&C - Lead Pharmacist		**X**	√									
	ASPH - Medical Director		**X**	**X**									
Dr James Clark (JC)	SASH – Consultant Endocrinology & Diabetes Mellitus		**X**	**X**									
	ESHUT - Medical Director / Chair of DTC or nominated Consultant		**X**	**X**									
Dr Raja Badrakalimuthu	SABPFT – Chair of Medicines Optimisation Committee		√ **(left at 3.23pm)**	√									
Dr Andreas Pitsiaeli	GP prescribing Lead (SD place) & LMC representative)		√	√									
Dr Darren Watts	GP prescribing Lead (Guildford & Waverley place)		√	√									
Dr Rebecca Rogers	GP prescribing Lead (North West Surrey place)		√	√									
Dr Claire Badawi	GP prescribing Lead (East Surrey place)		√	**X**									
Sunita Duggal (SD)	NMP representative – Advanced Nurse Practitioner		√	√									
Julia Powell (JP)	Chief Executive, Community Pharmacy Surrey & Sussex, on behalf of Sussex and Surrey Local Pharmaceutical Committees		√	√									
Dr Janice Kirby- Smith (JK-S)	Patient representative		√	√									
Mohamed Kharbouch	Patient representative		√	√									
Shani Corb (SC)	Chief Pharmacist - SECAMB		**A**	**A**									
Andy Law (AL)	Surrey Heartlands ICS finance representative		**X**	**X**									
Dr Ruchika Gupta (RG)	Surrey Heartlands ICS Clinical Director for Long Term Planning Delivery		√	√									

Richard Barnett (RB)	Surrey Heartlands ICS quality directorate representative		√	√									
Liz Saunders (LS)	Surrey County Council - Public Health Consultant		**X**	**X**									
Non-voting members													
Catrin Thomas (CT)	Medicines Management Pharmacist Kingston Hospital NHS Foundation Trust		**X**	X									
Judith Foy (JF)	Chief Pharmacist, Kingston Hospital NHS Foundation Trust		**A**	**A**									
	Senior Medicines Optimisation Pharmacist - NHS Sussex ICB		**X**	**X**									
Phillipa Blatchford (PB)	Principal pharmacist Commissioning (Croydon) – Interim professional secretariat of SWL IMOC		**X**	**X**									
	Representative from QVFH		**X**	**X**									
Gillian Ells (GE)	Acute/Interface Specialist Pharmacist NHS Sussex Commissioners		**X**	**X**									
Mohammed Asghar (MA)	Formulary Pharmacist Frimley Park Hospital NHS Foundation Trust		**X**	**X**									
	Public Health Consultant, West Sussex County Council		**X**	**X**									
	Pharmacy Lead Practice Plus Group		**X**	**X**									
	Surrey Heartlands Clinical Academy Representative		**X**	**X**									
Clare Johns (CJ)	Pharmacy Technician – Medicines Resource Unit (MRU) – NHS Surrey Heartlands APC Secretariat		√	√									
Carina Joanes (CJo)	Lead Pharmacist - MRU (Clinical)		√	√									
Tejinder Bahra	Lead Pharmacist (MRU) Operational		√	√									
Georgina Randall	Senior Pharmacy Technician - MRU		√	√									
In attendance													

Rachel Claridge	Lead primary care Pharmacy Technician – Surrey Heartlands		√	√									
Rumaan Aslam	Rotational Pharmacist (North West Surrey Place)			√									
Sam Lane	Tissue Viability Nurse (Surrey Heartlands ICB)			√									
Grainne Conway	Lead Antimicrobial Specialist Pharmacist		√	√									
Perminder Oberai	Lead Diabetes Specialist Pharmacist (for Joint Formulary items)		√	√									

Item No.	Discussions and New Actions
1	**Introduction** The chair welcomed members, presenters and all observers to the APC.
2	**Quorum** The chair noted that the meeting was quorate
3	**Declarations of Interest** Members were asked if there were any declarations of interest for the agenda items that had not already been declared.
4	**Minutes from previous meeting** The final minutes from the APC held in February 2025 were noted by the members **Matters Arising** Adrenal Insufficiency Place in therapy and traffic light status were confirmed at the APC in February, however, there some clarifications were required in relation to the PAD narrative and the traffic light status of steroid formulations for prednisolone, dexamethasone and fludrocortisone to support joint formulary. The following narrative was agreed

The Surrey Heartlands Integrated Care System Area Prescribing Committee (APC) agrees the following place in therapy for glucocorticoids in line with NG243 (Adrenal insufficiency: identification and management)

Adrenal Insufficiency

First choice glucocorticoid or 1st line BLUE (ON INITIATION).

- Hydrocortisone immediate release **TABLETS**
  - 10mg should be used first line for doses of 5mg and above
- Hydrocortisone immediate release **GRANULES (in a capsule for opening)**
  - For use in infants & children on doses below 5mg.
  - 5mg granules (in a capsule for opening) are not a cost-effective treatment option
- Hydrocortisone immediate release **SOLUBLE TABLETS**
  - Restricted to patients on dose of 10mg AND unable to swallow solid dosage form

Transfer to primary care after initiation and stabilisation of treatment with a minimum of 1 months' supply from the specialist endocrinology team

- Hydrocortisone oral solution – **RED traffic light status**
  - For use in infants and children where smaller doses may be required
- Hydrocortisone Buccal Tables **– NON-FORMULARY**
  - MHRA drug safety update December 2018

ALTERNATIVE 1st Line BLUE (ON INITIATION)

- Prednisolone tablets
  - if multiple daily doses are not appropriate
- Prednisolone oral solution
  - If difficulty swallowing tablets
- Prednisolone soluble tablets
  - If difficulty swallowing tablets

Transfer to primary care after initiation and stabilisation of treatment with a minimum of 1 months' supply from the specialist endocrinology team

- Prednisolone Enteric Coated tablets – **NON-FORMULARY**

2nd line BLUE (ON RECOMMENDATION) by the specialist endocrinology team

- Hydrocortisone modified release tablets
- Fludrocortisone tablets for mineralocorticoid replacement

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	o if needed (to normalise serum electrolytes and plasma renin, and reduce postural symptoms and salt craving) **Dosing of glucocorticoids during acute illness** It is important for people with adrenal insufficiency to increase their corticosteroid doses at times of illness in order to reduce the risk of adrenal crisis. As a guide, for any moderate intercurrent illness (such as illness with fever, requiring bedrest, or requiring antibiotics), they should double their usual doses of Hydrocortisone until recovered, or if on Prednisolone, they should increase to a minimum dose of 10 mg daily (or follow specific advice as recommended by their specialist). In order to allow patients to promptly increase their corticosteroid dose at times of need, and to avoid any risk from unexpected supply shortages, patients should ideally retain 2 months reserve supply at all times and should be reminded to renew their prescription in good time.
	The Surrey Heartlands Integrated Care System Area Prescribing Committee (APC) agrees the following place in therapy for glucocorticoids in line with NG243 (Adrenal insufficiency: identification and management) **<u>Congenital Adrenal Hyperplasia</u>** **First choice glucocorticoid or 1st line BLUE (ON INITIATION).** • Hydrocortisone immediate release **TABLETS** o 10mg should be used first line for doses of 5mg and above • Hydrocortisone immediate release **GRANULES (in a capsule for opening)** o For use in infants & children on doses below 5mg. o 5mg granules (in a capsule for opening) are not a cost-effective treatment option • Hydrocortisone immediate release **SOLUBLE TABLETS** o Restricted to patients on dose of 10mg AND unable to swallow solid dosage form Transfer to primary care after initiation and stabilisation of treatment with a minimum of 1 months' supply from the specialist endocrinology team • Hydrocortisone oral solution – **RED traffic light status** o For use in infants and children where smaller doses may be required • Hydrocortisone Buccal Tables **– NON-FORMULARY** o MHRA drug safety update December 2018 **ALTERNATIVE 1st Line BLUE (ON INITIATION)** • Prednisolone tablets o if multiple daily doses are not appropriate • Prednisolone oral solution o If difficulty swallowing tablets • Prednisolone soluble tablets o If difficulty swallowing tablets Transfer to primary care after initiation and stabilisation of treatment with a minimum of 1 months' supply from the specialist endocrinology team • Prednisolone Enteric Coated tablets – **NON-FORMULARY** **2nd line - BLUE (ON RECOMMENDATION) by the specialist endocrinology team** • Hydrocortisone modified release capsules • Dexamethasone tablets • Dexamethasone oral solution o If difficulty swallowing tablets • Fludrocortisone tablets for mineralocorticoid replacement

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	○ if needed (to normalise serum electrolytes and plasma renin, and reduce postural symptoms and salt craving) **Dosing of glucocorticoids during acute illness** It is important for people with adrenal insufficiency to increase their corticosteroid doses at times of illness in order to reduce the risk of adrenal crisis. As a guide, for any moderate intercurrent illness (such as illness with fever, requiring bedrest, or requiring antibiotics), they should double their usual doses of Hydrocortisone until recovered, or if on Prednisolone, they should increase to a minimum dose of 10 mg daily (or follow specific advice as recommended by their specialist). In order to allow patients to promptly increase their corticosteroid dose at times of need, and to avoid any risk from unexpected supply shortages, patients should ideally retain 2 months reserve supply at all times and should be reminded to renew their prescription in good time. **ACTION:** • **Add narrative to PAD and Joint Formulary (PAD admin)**
5	**Action Log:** The members were asked to consider the following actions: **1. Melatonin - Clinical review of documents on PAD and update on SWL & Sussex full clinical review of melatonin** • A paper is scheduled for discussion at the APC in April 2025. This action will remain open until the paper is ready for discussion. **ACTION TO REMAIN OPEN – Date changed to April 2025** **2. Covid 19 NICE guidance review** • It was noted that the initial phase was completed in June 2024 and consideration for the second phase will is due in June 25. The APC will be kept updated on progress. This action is recommended for closure. **ACTION CLOSED** **3. LHRH for breast cancer** • Information from Royal Surrey in terms of patient numbers has been provided. This information will be discussed with finance colleagues before potential transfer of funding to support change in traffic light status. The action will remain open with an update expected in April 2025 APC. **ACTION TO REMAIN OPEN – Date changed to April 2025** **4. Joint formulary – Review Tapentadol place in therapy** • Add to APC work programme. APC agreed to close action **ACTION CLOSED** **5. Esomeprazole 10mg < 1year** • On agenda for APC. APC agreed to close action **ACTION CLOSED**
6	**Urgent AOB:** No urgent AOB for March APC
7	**Standing Agenda item - Medicines Safety Committee (MSC)** Head of Medicines Safety shared a highlight report with the members, prior to the meeting. Points to note were as follows: • Review of all patients on promazine to ensure they were not meant to be prescribed promethazine. Look alike sound alike errors have been identified. Audits have been

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	completed in practices locally and they show a 50% prescribing error rate for prescribing of promazine instead of promethazine. All patients are being reviewed.
8	**NICE Guidance** The APC noted the NICE guidance published since the last APC
9	**Chapter Review – Antidiabetic medicines** The lead presented the proposed traffic light status for antidiabetic medicines, and these were all agreed as presented. The lead had some queries for the APC, and these were considered as follows: **Acarbose:** • Agreed as **GREEN** with a specific indication for use in Diabetes **Exenatide** • Agreed as **GREEN (see narrative),** noting that exenatide isn't a preferred treatment option but that patients currently on treatment can remain on therapy. **Repaglinide** • Agreed as **GREEN** **Diazoxide** • Tablets & capsules were being proposed as **NON-FORMULARY** and a **RED** status (in combination with Chlorothiazide) for the oral solution. However, it was noted that it would be helpful to have a solid dose formulation available for use. The tablet formulation is licenced and has been used locally but is now unavailable. The APC agreed a **RED** status for the capsules, alongside the **RED** status for the oral solution. **ACTION:** • **Upload decisions to PAD and JF (PAD admin)**
10	**Chapter Review - Insulins** The lead presented the proposed traffic light status for insulin, and these were all agreed as presented **ACTION:** • **Upload decision to PAD and JF (PAD admin)**
11	**Aflibercept 8mg intravitreal injection for use in Wet Age-Related Macular Degeneration (wet AMD) and Diabetic Macular Oedema (DMO) – Evidence review.** The lead author presented an evidence review proposing a **RED** traffic light status for aflibercept 8mg for these indications. Aflibercept 8mg is considered to be clinically equivalent and cost effective compared to the 2mg formulation and so NICE is not undertaking a Health Technology Evaluation. Aflibercept is an anti VEGF treatment with a higher concentration of aflibercept compared to the 2mg preparation which is currently NICE approved and available for use for wet AMD & DMO indications. The higher concentration of aflibercept means that fewer injections will be needed, which is beneficial for patients and will free up capacity in clinics. It is proposed that aflibercept 8mg is only offered where treat and extend protocols are in place, to enable extension of dosing intervals as clinically indicated and for patients who have failed to extend treatment intervals beyond 8 weeks with aflibercept 2mg (see wet AMD pathway agenda item for consultation consideration) The prices of both the aflibercept preparations are currently competitive and aflibercept 2mg biosimilar expected in November 2025 will bring with it significant savings for the NHS.

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12	There are some specialists that would like to use faricimab earlier in the pathway, but it was noted that the published evidence of benefit is considered to be low. The APC members agreed that aflibercept should be given a RED traffic light status to be used by Ophthalmology specialist teams in wet AMD and in DMO, for use in patients who have not responded sufficiently to the aflibercept 2mg treat and extend protocols and that aflibercept 8mg will be used no more frequently than every 8 weeks in line with the licence. The Surrey Heartlands Integrated Care System Area Prescribing Committee agreed the place in therapy for aflibercept 8mg intravitreal injection in Diabetic Macular Oedema The Surrey Heartlands Integrated Care System Area Prescribing Committee agreed the place in therapy for aflibercept 8mg intravitreal injection within the wet AMD treatment pathway. **ACTION:** • **Add information to JF & PAD for reference (PAD admin)** • **Develop Blueteq forms for use by specialist teams (CJ)**
13	**Wet AMD treatment pathway** Following the previous decision in January 2025 to implement the NICE guidance for bevacizumab gamma the APC were asked to consider place in therapy for that treatment and for the addition of aflibercept 8mg into the wet AMD treatment pathway. Each additional proposal was discussed in turn by the APC members **Bevacizumab Gamma** There was agreement from Ophthalmology medicines Network members that bevacizumab gamma should be placed as a 2nd choice. There is continued concerns about capacity issues within clinics that will impact on the use of this treatment option **Aflibercept 8mg** At consultation Ophthalmology specialist teams had highlighted that if longer dosing intervals could not be achieved with a switch to aflibercept 8mg, there should be an option to switch to faricimab or brolucizumab in wet AMD, and it was agreed by APC, where there is a realistic expectation that this would further increase dosage intervals. The wet AMD pathway was amended to reflect this change. During the consultation had also highlighted that if a patient did not respond to aflibercept 2mg then there would be no benefit in switching that patient to aflibercept 8mg and so for those patients a switch to faricimab or brolucizumab could be indicated. Safety concerns were also raised during consultation about switching to aflibercept 8mg in preference to faricimab for specific groups of patients (e.g. patients with a diagnosis of glaucoma or ocular hypertension) but the evidence to support this was not provided with the comments received. It was agreed that evidence regarding safety concerns in specific groups of patients could be taken into consideration along with the national retinal pathway evaluation when received. **<u>Pathway discussion</u>** **Re-Loading after switching** APC agreed that after a switch reloading is not required. This was proposed by members of the Ophthalmology Medicines Network and is expected to free up capacity in clinics.

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	Free Switch The APC members agreed that switching to a biosimilar anti-VEGF will be considered a free switch (currently only ranibizumab biosimilar but aflibercept expected later this year) **Treatment use outside NICE thresholds** During consultation the Ophthalmology Medicines Network agreed to offer biosimilar anti-VEGF treatment or bevacizumab gamma outside of NICE guidance. However, the APC had previously agreed ONLY to offer off label bevacizumab (Avastin) in this cohort of patients. The members noted that the publication of national retinal pathways is in development and are expected to be published very soon. With that in mind the members agreed that off label bevacizumab should continue to be offered, outside of NICE thresholds until publication of the national retinal pathways, and after evaluation and consideration for adoption at APC. The APC members agreed the wet AMD pathway as presented and noted that there would be consideration for the national pathways at a future APC. The Surrey Heartlands Integrated Care System Area Prescribing Committee agrees the Wet AMD pathway **ACTION:** • **Add wet AMD pathway to JF & PAD for reference (PAD admin)** • **Review wet AMD Blueteq forms to ensure in line with revised pathway (CJ)** **Diabetic Macular Oedema** The APC members agreed that aflibercept 8mg should be added to the DMO pathway at 2nd or 3rd choice but after aflibercept 2mg and the pathway will be brought to the APC for agreement. At consultation the Ophthalmology medicines network members highlighted that if longer dosing intervals could not be achieved with a switch to aflibercept 8mg, there should be an option to switch to faricimab or dexamethasone in DMO, and it was agreed by APC, where there is a realistic expectation that this would further increase dosage intervals. The DMO pathway will be amended to reflect this change. **ACTION:** • **Amend DMO pathway in line with APC decision and consideration at next APC (CJ)**
14	**Wound Management - Cavilon advance barrier cream for severe unmanageable moisture skin damage** The addition to the wound management formulary for this cream was agreed at the wound management formulary group (WMFG). It was noted that then used appropriately it is cost effective in terms of drug costs, but to ensure appropriate application it was agreed by the WMFG that it should only be used on advice from a Tissue Viability Nurse (TVN). There was a concern raised by the APC that there could be a delay in accessing a TVN in some areas, but the lead author highlighted that emails and photos could be used to speed up access and obtain advice from a TVN prior to use. A RED traffic light status was proposed and was agreed by the APC and the wound management formulary will be updated for upload to the PAD The Surrey Heartlands Integrated Care System Area Prescribing Committee agrees Cavilon advance Skin Protectant is approved for addition to the Surrey Heartlands Wound Formulary for use on recommendation by Tissue Viability Nurses only when the first line

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	treatments: Derma-protect plus and Medi-derma S together with enhanced hygiene regime are insufficient to treat Moisture Associated Skin Damage. A **RED** traffic light status was agreed. **ACTION:** • **Upload information to JF & PAD for reference (PAD admin)** • **Update wound management formulary for PAD upload (KM/SL)**
15	**Position statement on prescribing of shower protection pouches (wound drainage bags)** The lead highlighted the overuse of these bags for other indications other than for the intended purpose. APC were asked to agree to adopt the policy statement from South-West London. This was agreed by the APC It was also noted that dispensing appliance contractors (DACs) are contributing to the bags being inappropriately used and so a letter to the DACs was presented to the APC for agreement. The letter had been amended from a previously agreed stoma DAC letter from last year. This was also agreed by the APC members. The Surrey Heartlands Integrated Care System Area Prescribing Committee agree to adopt the SWL position statement for wound drainage bags. The following PAD/JF narrative was agreed **Wound management** – Wound drainage bags are for chronic non-healing and highly exuding wounds, which are unmanageable with standard formulary dressings, only on recommendation from Tissue Viability nurse (TVN). The preferred product is the 'Eakin wound drainage bag with fold and tuck closure, small.' **Renal dialysis –** Primary care prescribers are asked not to prescribe any wound drainage bag shower protection pouches and auxiliary products for dialysis patients. E.g. Cath Dry Dressing, Independence easy access / wound protection /collection pouches, LINC catheter shower pouches or independence No Sting Barrier Film wipes. Ensure that new and further prescriptions are not issued on a dispensing appliance company's (DAC) recommendation on behalf of a patient. If required, patients can be asked to seek further advice from their dialysis clinician or dialysis nurse at their regular appointments. **ACTION:** • **Upload resources (including DAC letter & SWL position statement) to PAD/JF for reference (PAD admin)**

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16	**Tirzepatide for managing overweight and obesity (NICE TA1026)** A NICE Technology Appraisal was published for tirzepatide for this indication in December 2024 and the ICB has a requirement to implement within 3 months in secondary care. The briefing paper presented proposed a RED traffic light status with access through the weight management service at Ashford & St Peters Hospital NHS Foundation Trust. The second phase of implementation will be to consider access for tirzepatide within 6 months of NICE publication within primary care. A working group has been established, and this group is looking at pathways for primary care implementation. NHS England commissioning guidance is pending, and that guidance will provide further information to support the wider roll out of tirzepatide for use in weight management, to include the initial cohorts of patients to be treated within the first 3 years. The patient cohort for this initial phase will be the same as was agreed for semaglutide (Wegovy). Communications are being prepared to inform primary & secondary care about the implementation and the phased approach for access to treatment. The members asked for clarity about access to treatment for patients that may have purchased treatment privately and at implementation (in primary care) are seeking to access continued treatment through the NHS. It was noted that the working group had discussed this and will be providing that clarification at implementation. Also noted was a request to include information on the financial implications for implementation of the NICE guidance. It was agreed this information would be included in the communications piece that is being prepared. A RED traffic light status was agreed as proposed for this phase of implementation The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed tirzepatide for obesity and weight management in line with NICE TA1026. A **RED** traffic light status has been agreed, and access will be through the specialist weight management service (SWMS) at Ashford & St Peters NHS Foundation Trust **ONLY.** Tirzepatide will be added to the existing SWMS medical pathway alongside semaglutide and in line with the Guidance issued by the Society for Endocrinology and Obesity Management Collaborative UK. Initially patients who meet the eligibility criteria listed in phase 1 of the guidance will be prioritised for referral to the specialist weight management service to allow those with the combination of highest and most urgent clinical need to be assessed). **ACTION:** • **Upload briefing and other resources to PAD for reference (PAD admin)** • **Update PAD page for tirzepatide to reflect APC decision (PAD admin)**
17	**PPI Support tools – Patient information Leaflets** The members were presented with support tools which have been developed following previous decisions made by the APC. The tools have had wide consultation with stakeholders and comments have been made by an APC patient representative.

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	There were some adverse events included which were questioned by the membership and it was agreed that the tools would be further reviewed before circulating to the members for agreement **ACTION:** • **Review support tools (CJo)** • **Circulate to APC post meeting for agreement (CJ)** • **Upload to PAD for reference (PAD admin)**
18	**Teriparatide - Secondary Care Pathway** The lead author has worked with the local rheumatology medicines network members to propose that teriparatide is used in line with its product licence in post-menopausal women, as the most cost-effective treatment option compared to abaloparatide or romosozumab. Teriparatide was the first of these three treatments to have a NICE TA published in 2008 (updated 2018) with strict criteria for its use. In August 2024 NICE TA991 (abaloparatide for treating osteoporosis after menopause) recommended that the least expensive suitable treatment (romosozumab, teriparatide or abaloparatide) was used, but restrictions on teriparatide mean the specialist teams are not able to use teriparatide as the least expensive preparation. It was highlighted by the lead author that enabling the specialist teams to use teriparatide earlier in the treatment pathway, could represent a considerable saving for the ICS. It was noted that the APC had previously agreed to the use of teriparatide for an 18-month course of treatment in 2008, but the licence has since changed, to a 24-month course. The paper also noted that teriparatide also lost its patent in 2019 and has been available as a biosimilar for some time. The members agreed with the proposals requested by the Rheumatology Medicines Network members and noted the current proposed treatment pathway (for treatments used in secondary care) in the presented papers. It was agreed that the MRU members would finalise that pathway for upload to the PAD without the need for the pathway to be further discussed at the APC. Also agreed was for the APC to adopt the updated definitions for use and severity in the national guidance for osteoporosis treatment from the NOGG/ROC (which has been previously accepted by the APC when the romosozumab NICE guidance was implemented). It was noted in the presented paper, that the guidance also included a newer definition of very high-risk patients, which was proposed was applied to access criteria for teriparatide, romosozumab and abaloparatide, moving forward. The members discussed if the Osteoporosis assessment and treatment guidelines on the PAD should be removed given that the secondary care treatments included in the guidelines have now been reviewed and updated. It was agreed that there is still a lot of information related to primary care treatment, included in the guidelines and so they will stay on the PAD, but the PAD narrative should highlight that a review is pending. The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the use of teriparatide for osteoporosis in postmenopausal women in line with its licence. Teriparatide will continue to have **RED** traffic light status for use in this patient cohort.

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	The updated definitions for use and severity in the national guidance for osteoporosis treatment from the NOGG/ROC was agreed to enable access to teriparatide, romosozumab and abaloparatide at patients at high risk. **ACTION** • **Amend secondary care pathway for upload to PAD (MRU)** • **Add narrative to PAD to highlight Osteoporosis assessment and treatment guidelines are pending a review (PAD admin)** • **Add information agreed to PAD/JF for reference (PAD Admin)**
19	**Juvenile Idiopathic Arthritis – South-East Regional Medicines Optimisation Group (SERMOG)** A policy recommendation from SERMOG was presented to the APC members. The MRU has compared the recommendation to current policy at Surrey Heartlands APC. The policy recommendation clarifies the arrangements for patients transitioning from paediatric to adult services. NHS England is the responsible commissioner for patients treated in the paediatric service and when the patient moves into the adult service, the responsible commissioner would be Surrey Heartlands (for local patients). The APC members accepted the policy recommendations and the PAD, Joint Formulary and Blueteq will be updated to reflect the recommendations made. The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed to adopt the policy recommendation from the South East Regional Medicines Optimisation Group (SERMOG-05), high-cost drugs for adults with juvenile idiopathic arthritis (JIA). **ACTION:** • **Upload information to PAD for reference (PAD admin)** • **Update Blueteq forms (MRU)**
20	**South-West London Migraine Pathway** APC were asked to consider adoption of the South-West London (SWL) migraine pathway, which had been updated to include atogepant which had been appraised by NICE in August 2024. It was noted that SERMOG are in the process of developing a migraine pathway which will be considered for adoption by the APC when it is published. The members agreed to adopt the SWL pathway as presented The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed to adopt the SWL migraine pathway. **ACTION:** • **Upload information to PAD for reference (PAD admin)**
21	**APC work programme for 2025-2026 year** The APC were presented with the APC work programme for the coming year for noting. The programme will be uploaded to the PAD for reference

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	ACTION: • **Upload information to PAD for reference (PAD admin)**
23	**PAD holding statements** The PAD holding statements were agreed as presented. The lead author had also requested a number of deletions to the PAD/JF because of product discontinuations. These were also agreed as presented **ACTION:** • **Update PAD with deletions as agreed (PAD admin)**
23	**AOB** **National Shared Care documents – Expiry extension** In 2022, the RMOC North published a number of national shared care documents for consideration for local adoption. These adopted shared care are available for access on the PAD. The shared care were given a 3 year expiry date and are now in the process of being reviewed by the Medicines Value Programme at NHS England. At a recent PrescQIPP update, the timelines for that publication have not been provided to date. In view of this review, the APC is asked to agree to a 12-month expiry extension on the national shared care that have been adopted. It was requested that this extension would be made clear for each of the shared care. **ACTION:** • **12-month extension on each national shared care adopted by Surrey Heartlands (MRU)**

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	Summary of recommendations to follow (when minutes agreed

MATTERS ARISING – ADRENAL INSUFFICIENCY

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  - For use in infants & children on doses below 5mg.
  - 5mg granules (in a capsule for opening) are not a cost-effective treatment option
- Hydrocortisone immediate release **SOLUBLE TABLETS**
  - Restricted to patients on dose of 10mg AND unable to swallow solid dosage form

Transfer to primary care after initiation and stabilisation of treatment with a minimum of 1 months' supply from the specialist endocrinology team

- Hydrocortisone oral solution – **RED traffic light status**
  - For use in infants and children where smaller doses may be required
- Hydrocortisone Buccal Tables **– NON-FORMULARY**
  - MHRA drug safety update December 2018

ALTERNATIVE 1st Line BLUE (ON INITIATION)

- Prednisolone tablets
  - if multiple daily doses are not appropriate
- Prednisolone oral solution
  - If difficulty swallowing tablets
- Prednisolone soluble tablets
  - If difficulty swallowing tablets

Transfer to primary care after initiation and stabilisation of treatment with a minimum of 1 months' supply from the specialist endocrinology team

- Prednisolone Enteric Coated tablets – **NON-FORMULARY**

2nd line BLUE (ON RECOMMENDATION) by the specialist endocrinology team

- Hydrocortisone modified release tablets
- Fludrocortisone tablets for mineralocorticoid replacement
  - if needed (to normalise serum electrolytes and plasma renin, and reduce postural symptoms and salt craving)

Dosing of glucocorticoids during acute illness

It is important for people with adrenal insufficiency to increase their corticosteroid doses at times of illness in order to reduce the risk of adrenal crisis. As a guide, for any moderate intercurrent illness (such as illness with fever, requiring bedrest, or requiring antibiotics), they should double their usual doses of Hydrocortisone until recovered, or if on Prednisolone, they should increase to a minimum dose of 10 mg daily (or follow specific advice as recommended by their specialist).

In order to allow patients to promptly increase their corticosteroid dose at times of need, and to avoid any risk from unexpected supply shortages, patients should ideally retain 2 months reserve supply at all times and should be reminded to renew their prescription in good time.

Item No.	Discussions and New Actions

	The Surrey Heartlands Integrated Care System Area Prescribing Committee (APC) agrees the following place in therapy for glucocorticoids in line with NG243 (Adrenal insufficiency: identification and management)
	
	<u>Congenital Adrenal Hyperplasia</u>
	First choice glucocorticoid or 1st line BLUE (ON INITIATION).
	• Hydrocortisone immediate release **TABLETS**
	  ○ 10mg should be used first line for doses of 5mg and above
	• Hydrocortisone immediate release **GRANULES (in a capsule for opening)**
	  ○ For use in infants & children on doses below 5mg.
	  ○ 5mg granules (in a capsule for opening) are not a cost-effective treatment option
	• Hydrocortisone immediate release **SOLUBLE TABLETS**
	  ○ Restricted to patients on dose of 10mg AND unable to swallow solid dosage form
	Transfer to primary care after initiation and stabilisation of treatment with a minimum of 1 months' supply from the specialist endocrinology team
	
	• Hydrocortisone oral solution – **RED traffic light status**
	  ○ For use in infants and children where smaller doses may be required
	• Hydrocortisone Buccal Tables **– NON-FORMULARY**
	  ○ MHRA drug safety update December 2018
	
	ALTERNATIVE 1st Line BLUE (ON INITIATION)
	• Prednisolone tablets
	  ○ if multiple daily doses are not appropriate
	• Prednisolone oral solution
	  ○ If difficulty swallowing tablets
	• Prednisolone soluble tablets
	  ○ If difficulty swallowing tablets
	
	Transfer to primary care after initiation and stabilisation of treatment with a minimum of 1 months' supply from the specialist endocrinology team
	
	• Prednisolone Enteric Coated tablets – **NON-FORMULARY**
	
	2nd line - BLUE (ON RECOMMENDATION) by the specialist endocrinology team
	• Hydrocortisone modified release capsules
	• Dexamethasone tablets
	• Dexamethasone oral solution
	  ○ If difficulty swallowing tablets
	• Fludrocortisone tablets for mineralocorticoid replacement
	  ○ if needed (to normalise serum electrolytes and plasma renin, and reduce postural symptoms and salt craving)
	
	Dosing of glucocorticoids during acute illness
	It is important for people with adrenal insufficiency to increase their corticosteroid doses at times of illness in order to reduce the risk of adrenal crisis. As a guide, for any moderate intercurrent illness (such as illness with fever, requiring bedrest, or requiring antibiotics), they should double their usual doses of Hydrocortisone until recovered, or if on Prednisolone, they should increase to a minimum dose of 10 mg daily (or follow specific advice as recommended by their specialist).
	
	In order to allow patients to promptly increase their corticosteroid dose at times of need, and to avoid any risk from unexpected supply shortages, patients should ideally retain 2 months reserve supply at all times and should be reminded to renew their prescription in good time.

Item No.	Discussions and New Actions
	AGENDA ITEM 12 – AFLIBERCEPT 8MG EVIDENCE REVIEW
	The Surrey Heartlands Integrated Care System Area Prescribing Committee the place in therapy for aflibercept 8mg intravitreal injection within the Diabetic Macular Oedema treatment pathway.
	The Surrey Heartlands Integrated Care System Area Prescribing Committee agreed the place in therapy for aflibercept 8mg intravitreal injection within the wet AMD treatment pathway.
	AGENDA ITEM 13 – WET AMD PATHWAY
	The Surrey Heartlands Integrated Care System Area Prescribing Committee agrees the Wet AMD pathway
	AGENDA ITEM 15 – CAVILON ADVANCE SKIN PROTECTANT
	The Surrey Heartlands Integrated Care System Area Prescribing Committee agrees Cavilon advance Skin Protectant is approved for addition to the Surrey Heartlands Wound Formulary for use on recommendation by Tissue Viability Nurses only when the first line treatments: Derma-protect plus and Medi-derma S together with enhanced hygiene regime are insufficient to treat Moisture Associated Skin Damage. A **RED** traffic light status was agreed.
	AGENDA ITEM 15 – WOUND DRAINAGE BAGS
	The Surrey Heartlands Integrated Care System Area Prescribing Committee agree to adopt the SWL position statement for wound drainage bags. The following PAD/JF narrative was agreed **Wound management** – Wound drainage bags are for chronic non-healing and highly exuding wounds, which are unmanageable with standard formulary dressings, only on recommendation from Tissue Viability nurse (TVN). The preferred product is the 'Eakin wound drainage bag with fold and tuck closure, small.' **Renal dialysis –** Primary care prescribers are asked not to prescribe any wound drainage bag shower protection pouches and auxiliary products for dialysis patients. E.g. Cath Dry Dressing, Independence easy access / wound protection /collection pouches, LINC catheter shower pouches or independence No Sting Barrier Film wipes. Ensure that new and further prescriptions are not issued on a dispensing appliance company's (DAC) recommendation on behalf of a patient. If required, patients can be asked to seek further advice from their dialysis clinician or dialysis nurse at their regular appointments.

Item No.	Discussions and New Actions
	AGENDA ITEM 16 – TIRZEPATIDE NICE TA1026 PHASED IMPLEMENTATION

The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed tirzepatide for obesity and weight management in line with NICE TA1026.

A **RED** traffic light status has been agreed, and access will be through the specialist weight management service (SWMS) at Ashford & St Peters NHS Foundation Trust **ONLY.**

Tirzepatide will be added to the existing SWMS medical pathway alongside semaglutide and in line with the Guidance issued by the Society for Endocrinology and Obesity Management Collaborative UK. Initially patients who meet the eligibility criteria listed in phase 1 of the guidance will be prioritised for referral to the specialist weight management service to allow those with the combination of highest and most urgent clinical need to be assessed).

AGENDA ITEM 18 – TERIPARATIDE SECONDARY CARE PATHWAY

The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the use of teriparatide for osteoporosis in postmenopausal women in line with its licence.

Teriparatide will continue to have **RED** traffic light status for use in this patient cohort.

The updated definitions for use and severity in the national guidance for osteoporosis treatment from the NOGG/ROC was agreed to enable access to teriparatide, romosozumab and abaloparatide at patients at high risk.

AGENDA ITEM 19 – SERMOG HIGH-COST DRUGS FOR ADULTS WITH JIA POLICY RECOMMENDATION

The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed to adopt the policy recommendation from the South East Regional Medicines Optimisation Group (SERMOG-05), high-cost drugs for adults with juvenile idiopathic arthritis (JIA).

AGENDA ITEM 20 – SOUTH WEST LONDON MIGRAINE PATHWAY

The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed to adopt the SWL migraine pathway.

Item No.	Discussions and New Actions
Future meeting dates: (2.30pm to 5pm) via Microsoft teams calls • Wednesday 2nd April 2025	
Signed and agreed by: **Date: DD MMM YYYY** **Chair Name, Chair Title (Chair)**	
Minutes agreed for publication by: **Date: DD MMM YYYY** **Exec Lead name, Exec Lead Title (Exec Lead)**	