Surrey Heartlands Integrated Care System
Area Prescribing Committee (APC)

MINUTES

Date	2nd July 2025	Time	1430 - 1634
Venue	Microsoft teams invitation		

Name (Initials)	Role		Attendance /apologies											
APC voting members		**Jan** Virtual	**Feb**	**Mar**	**Apr**	**May**	**May 14th**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Dr Stephen Cookson (SC)	RSFT – Consultant Cardiologist (Chair)		√	√	**A**	√	√	√ **left at 1512**	√					
Sarah Watkin (SWa)	Head of Medicines Resource Unit – Surrey Heartlands Integrated Care Board (Deputy Chair)		√	√	√	**A**	√	√	**A**					
Linda Honey (LH)	Director of Pharmacy - Surrey Heartlands Integrated Care System		√ **(left at 4pm)**	√	**A**	√	√	√	√					
Sarah Flack	Primary Care Pharmacist, Surrey Downs Place representative								√ **(from 3pm)**					
Tara Bahri	Deputy Chief Pharmacist Out of Hospital, Surrey Downs Place		√	√	√	√	√	**A**	**A**					
Tim Dowdall	Deputy Chief Pharmacist Out of Hospital - Guildford & Waverley		√	√	√	√	√	**A**	√					
Lis Stanford	Deputy Chief Pharmacist Out of Hospital – North-West Surrey		**A**	√	√	√	√	√	√					
Monika Cunjamalay	Deputy Chief Pharmacist Out of Hospital – East Surrey		√	**A**	√	√	**A**	√	√					
Nikki Smith (NS)	Head of Medicines Safety / Patient Safety Specialist		√	√	√ **(left at 15:43**	√	√	√	√					
Veronica Davis	RSFT – Formulary Pharmacist		√	√	√	√	√	√	**A**					
Jemma Hives	Clinical Lead Pharmacist - ASPH		√	**X**	**X**	**X**	**A**	**X**	**X**					
Asad Qureshi	Formulary Pharmacist - ASPH		**A**	√	√	√	√	√	√					

Nicky Leitch (NL)	SASH – Formulary Development Pharmacist		√	√	√	√	√	**A**	√					
Amy Fox or Kanwal Sheikh	ESHUT – Formulary and Medicines Optimisation Pharmacist		√	**X**	√	**X**	**X**	√	√					
Alison Marshall (AM)	SABPFT - Formulary Pharmacist		√	√	√	**A**	**A**	√	√					
Simon Whitfield	Chief Pharmacist – Surrey & Borders Partnership NHS Foundation Trust		**A**	**X**	**X**	**X**	√	√ **left at 4pm**	√					
	CSH - Lead Pharmacist		√	**X**	√	√	**X**	√	√					
Temitope Odetunde (TO)	FCH&C - Lead Pharmacist		**X**	√	**X**	**X**	**X**	**X**	**X**					
	ASPH - Medical Director		**X**	**X**	**X**	**X**	**X**	**X**	**X**					
Dr James Clark (JC)	SASH – Consultant Endocrinology & Diabetes Mellitus		**X**	**X**	√	√	√	√	√					
	ESHUT - Medical Director / Chair of DTC or nominated Consultant		**X**	**X**	**X**	**X**	**X**	**X**	**X**					
Dr Raja Badrakalimuthu	SABPFT – Chair of Medicines Optimisation Committee		√ **(left at 3.23pm)**	√	√	√	**X**	**X**	√					
	GP prescribing Lead (SD place) vacant position from July 2025		√	√	√	√	√	√						
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**	√	√	**A**	√	√					
Sunita Duggal (SD)	NMP representative – Advanced Nurse Practitioner		√	√	√	√	√	**X**	√					
Julia Powell (JP)	Chief Executive, Community Pharmacy Surrey & Sussex, on behalf of Sussex and Surrey Local Pharmaceutical Committees		√	√	√	√	**A**	**A**	**A**					
Dr Janice Kirby- Smith (JK-S)	Patient representative		√	√	√	√	**A**	√	√					

Mohamed Kharbouch	Patient representative		√	√	√	√	**X**	**A**	√					
Shani Corb (SC)	Chief Pharmacist - SECAMB		**A**	**A**	**A**	**A**	**A**	**A**	**A**					
Andy Law (AL)	Surrey Heartlands ICS finance representative		**X**	**X**	**X**	**X**	**X**	**X**	**X**					
Dr Ruchika Gupta (RG)	Surrey Heartlands ICS Clinical Director for Long Term Planning Delivery		√	√	**A**	**A**	**X**	√ from 1544	√					
Richard Barnett (RB)	Surrey Heartlands ICS quality directorate representative		√	√	√	√	**X**	√	√					
Liz Saunders (LS)	Surrey County Council - Public Health Consultant		**X**	**X**	**X**	**X**	**X**	**X**	**X**					
	Non-voting members													
Dr Andreas Pitsiael	LMC representative								**A**					
Catrin Thomas (CT)	Medicines Management Pharmacist Kingston Hospital NHS Foundation Trust		**X**	X	**X**	**X**	**X**	**X**	**X**					
Judith Foy (JF)	Chief Pharmacist, Kingston Hospital NHS Foundation Trust		**A**	**A**	**A**	**X**	**X**	**X**	**A**					
	Senior Medicines Optimisation Pharmacist - NHS Sussex ICB		**X**	**X**	**X**	**X**	**X**	**X**	**X**					
Phillipa Blatchford (PB)	Principal pharmacist Commissioning (Croydon) – Interim professional secretariat of SWL IMOC		**X**	**X**	√	√	**X**	**X**	**X**					
	Representative from QVFH		**X**	**X**	**X**	**X**	**X**	**X**	**X**					
Gillian Ells (GE)	Acute/Interface Specialist Pharmacist NHS Sussex Commissioners		**X**	**X**	**X**	**X**	**X**	**X**	**X**					
Mohammed Asghar (MA)	Formulary Pharmacist Frimley Park Hospital NHS Foundation Trust		**X**	**X**	**X**	**X**	**X**	**X**	**X**					
	Public Health Consultant, West Sussex County Council		**X**	**X**	**X**	**X**	**X**	**X**	**X**					
	Pharmacy Lead Practice Plus Group		**X**	**X**	**X**		**X**	**X**	**X**					
	Surrey Heartlands Clinical Academy Representative		**X**	**X**	**X**	**X**	**X**	**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		√	√	√	√	**X**	√	√					
Georgina Randall	Senior Pharmacy Technician - MRU		√	√	√	√	**X**	√	√					
	In attendance													
Jayesh Shah	Lead Primary Care Pharmacist for Mental Health Surrey Heartlands ICB								√					
Rachel Claridge	Lead Pharmacy Technician (Primary Care) Surrey Heartlands ICB								√					
Parmvir Jutla	Pharmacy Business manager (ASPH)								√					
Anna Larkham	Lead Community Nutritional Management Specialist Dietitian							√	√					

Item No.	Discussions and New Actions
1	**Introduction** The chair welcomed members, presenters and all observers to the APC and confirmed with members that during discussions, any member that does not agree with a proposed decision, should make their objection known to the chair. It was noted that the APC makes all decisions by consensus and not through a voting process unless there are objections to a proposed decision.
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. None were declared.
4	**Minutes from previous meeting** The final minutes from June APC were noted by the members. One update since circulation was in relation to the SERMOG OTC guidance, where it was noted that the SERMOG provide a policy recommendation and not a policy statement. The recommendation is then considered by APC for adoption.
5	**Action log** The members were informed of updates to the following actions: **ADHD in adults shared care** • Flow chart has been developed which will be considered by the MOOG. **ACTION TO REMAIN OPEN – Date changed to October 2025 for update.**
6	**Medicines safety highlight report** Head of Medicines Safety shared a highlight report with the members, prior to the meeting. Points to note were as follows: • Medicines waste campaign progressing well with phase 2 campaign taking place over June and July with associated communications
7	**NICE Guidance** The APC noted the NICE guidance published since the last APC. The author highlighted that there had also been a NICE guidance published for Linzagolix for treating the symptoms of endometriosis (TA1067). The responsible commissioner is ICBs and a briefing will be brought to the APC in due course.
8	**Urgent AOB:** None to note
9	**Biosimilar Policy update** The current Biosimilar Policy was developed and launched in June 2024. The policy is now due for review and has been amended to take into account the updated NHS England Commissioning framework for best value biological medicines (NHSE, April 2025), and alignment with South-East Regional Medicines Optimisation Group: Overarching policy on switching between biosimilars (SERMOG, September 2024). Amendments to the current policy were made following the updated national commissioning framework and following comments received during consultation with stakeholders. As proposed a 3-year review date was agreed by the APC members. The Surrey Heartlands Integrated Care System Area Prescribing Committee have agreed the reviewed Biologicals and biosimilar of best value policy. **ACTION:** • **Upload to PAD/JF for reference (PAD admin)**
10	**Joint Formulary: Acute hypotension and shock**

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	The lead presented the proposed traffic light status for this chapter review. All were accepted as presented but the lead pointed out that some indications had been changed to acute hypotension following consultation with a critical care lead Pharmacist at Royal Surrey NHS Foundation Trust **ACTION:** • **Upload to JF for reference (PAD admin)**

11	**Joint Formulary: Antimuscarinic medication for drug induced extrapyramidal symptoms**
	The lead presented the proposed traffic light status for this chapter review. The lead asked the APC to agree to the proposed traffic light statuses as follows:
	• **Procyclidine (tablets & oral solution) & Trihexyphenidyl (tablets and oral solution)**
	  ○ The APC members considered that specialist initiation and subsequent stabilisation would be safer for patients. It is considered a complex area that primary care clinicians may not be familiar with.
	  ○ Agreed as **BLUE (with specialist initiation)** and stabilisation for at least 1 month prior to transfer of care.
	  ○ Procyclidine tablets will be considered as the preferred first line treatment option
	• **Orphenadrine solution**
	  ○ Agreed as **NON-FORMULARY** on the traffic light system
	  ○ It was noted that this treatment is rarely prescribed, however there are patients currently on treatment and those patients should continue on treatment until they and their prescriber or specialist consider it appropriate to stop.
	ACTION:
	• **Upload to JF for reference (PAD admin)**

12	**Joint Formulary: Mental Health medication – Adult ADHD** The lead presented the proposed traffic light status for this chapter review. The lead asked the APC to confirm that atomoxetine, dexamfetamine, lisdexamfetamine and methylphenidate will continue as AMBER with shared care. It was noted that there is shared care already on the PAD for these treatments and the APC will be presented with updated shared care later this year following discussion and agreement with the LMC about implementation of the national shared care documents for these treatments. **Guanfacine** ○ There is currently no traffic light status on the JF for adult patients (that have not transferred from children's service on the medication) and use of guanfacine for adults over the age of 17 years is off label. ○ It was highlighted that there is prescribing in primary care of guanfacine in adults and prescribing from other providers and also from private prescribers. ○ The APC members were asked if an AMBER traffic light status would be supported for adults. The members noted that without a shared care document to consider they were unable to agree an appropriate traffic light status ○ It was therefore agreed that a holding statement would be added to the PAD to note that a proposal will be considered at the APC in due course and that adult patients should remain on treatment as prescribed.

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	Holding statement Guanfacine for use in adult patients with ADHD (that have not transferred from children's service on the medication), has not yet been assessed for formulary status. National shared care documents are being considered by Surrey & Borders Partnership NHS Foundation Trust for implementation over the next few months through APC. Adult patients currently being prescribed guanfacine in primary care can continue on treatment until they and their prescriber or specialist consider it appropriate to stop. **ACTION:** ○ **Add holding statement to PAD re guanfacine treatment for adult patients with ADHD (PAD admin)**
13	**Joint Formulary: Mental Health medication – Anti-Psychotics** The lead presented the proposed traffic light status for this chapter review. Traffic light status of items approved prior to APC have not been included below and these will be added to the JF as proposed. The lead asked the APC to consider the proposed traffic light statuses as follows: **Promazine (tablets and oral solution)** • Agreed as **NON-FORMULARY** to reduce errors of this medication being prescribed or dispensed when promethazine should have been prescribed (look alike, sound alike medicines). There are alternative options available for use for the short-term management of agitation. **Risperidone oro dispersible tablets** • Agreed as **RED** traffic light status as the oral solution is considered to be more cost effective but there will potentially be cases where compliance with medication is poor and the solution is refused, and supervised administration of the orodispersible can be facilitated in an inpatient unit **Quetiapine Modified Release (MR) tablets** • It was noted that this will be a decision based purely on cost effectiveness and not clinical effectiveness. • Agreed as **RED** traffic light status (see caveat) as the IR tablets are more cost effective. • However, on rare occasions where the use of IR would risk destabilizing the persons condition a patient's treatment may be transferred to primary care on the MR tablets, after stabilisation. • It was noted that moving forward patients will be discharged on the Immediate release preparation after stabilisation. • There was a discussion about those patients currently on MR treatment and those patients should continue on treatment until they and their prescriber or specialist consider it appropriate to stop. It was noted that where appropriate patients had already been switched to the IR preparation by their specialist, but there are a small number of patients on the MR preparation, who need to be maintained on that treatment. **Chlorpromazine Intramuscular injection and suppositories** • Agreed as **NON-FORMULARY.** These preparations are not used locally and suppositories appear to have been discontinued. **GPs prescribing as requested by the crisis team** • The APC members considered requests to initiate treatment in primary care by crisis teams. The primary care lead GPs on the committee had medicolegal concerns about prescribing in this situation. • It was agreed that in the majority of circumstances the prescription should be written by the clinician proposing the treatment. The APC and SABPFT colleagues on the call noted that a process to enable initiation by crisis teams would need to be considered internally.

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	• The members agreed that it is important to try and avoid unnecessary admission into an acute setting so discussion with the acute trusts and other key stakeholders would be useful too. • The APC members were asked to provide examples of requests from the crisis teams which will be used for the development of internal processes at SABPFT. **Blue Information sheets for oral antipsychotics** • The APC members agreed that these are not required as the SPCs provide all information required on dosing and associated monitoring. • These will be removed from the PAD **Chlorpromazine tablets and oral solution** • The APC agreed that these preparations would be BLUE (with specialist initiation) for a minimum of 3 months prior to transfer of care. • It was noted that chlorpromazine tablets used for anxiety may be for short term use but the SABPFT specialist on the call highlighted that chlorpromazine for this indication is very rarely used. **Oral antipsychotics in mania** • The APC agreed that these treatments would be BLUE (with specialist initiation) for a minimum of 3 months prior to transfer of care. • The members considered that the specialist should be used rather than a consultant as prescribing may be initiated by other qualified healthcare professionals. The APC noted that when treatment is initiated by a non-medical prescriber, there needs to be documentation of the supervising clinician. **ACTIONS:** • **Take off AMBER* Information leaflets from PAD as proposed (PAD admin)** • **Primary care to forward examples of queries from crisis teams (JS/Primary care leads)** • **Upload traffic light status to JF as proposed and agreed (PAD admin)**
14	**Joint Formulary – Nutrition Borderline substances** The lead presented the proposed traffic light status for this chapter review. The lead asked the APC to agree to the proposed traffic light statuses as follows: a. Paediatric oral nutritional supplements should be given a traffic light status of BLUE (on advice from specialist) b. Enteral feeds which have ACBS approval should be given the traffic light status of “BLUE (on advice from specialist)”. c. Enteral feeds without ACBS approval should be given the traffic light status of RED The APC members agreed with the traffic light statuses as proposed **ACTION:** • **Upload agreed traffic light statuses to JF for reference (PAD admin)**
15	**Joint Formulary – Nutrition Micronutrients** The lead presented the proposed traffic light status for this chapter review. The lead asked the APC to agree to the proposed traffic light statuses as follows:

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	Calcium Acetate for hyperphosphatemia secondary to Pemgatinib ○ As part of the Joint Formulary harmonisation process a traffic light status will not be given to this treatment until the renal chapter has been completed and brought to APC for consideration. ○ MRU are liaising with St Helier and other renal units bordering Surrey Heartlands to bring this chapter review to APC. **Slow sodium** ○ The APC members considered that a **GREEN** traffic light status for this treatment would be appropriate. Slow sodium is used in primary care **Phosphate Sandoz (effervescent phosphate)** ○ The APC members considered that a **GREEN** traffic light status for this treatment would be appropriate. **LABiNiC Probiotic Drops** ○ The APC members considered that a **RED** traffic light status for this treatment would be appropriate It was noted that treatments used for the correction of electrolyte imbalances will be brought to the APC at a later date. **ACTION:** • **Upload agreed traffic light statuses to JF for reference (PAD admin)**
16	**Cenobamate for treating focal onset seizures in epilepsy in Adults – Change in traffic light status** In May 2025 a review of the NICE guidance for Cenobamate for this indication was published (previously published in December 2021). The reviewed guidance states that 'treatment is started by a healthcare professional with expertise in epilepsy, after which treatment can be continued in primary care'. The APC were asked to agree a change in traffic light status from RED to Blue (with specialist initiation), with at least 12 weeks prescribing by the specialist prior to transfer of care. The lead author also requested a NON-FORMULARY traffic light status for children & Young People (CYP) under the age of 18 because Cenobamate is not licensed for that age group. The APC members considered that information from the specialist teams on the monitoring requirements for Cenobamate and also information on the timeframes if dose adjustment is suggested. It was agreed that the lead author would liaise with the specialist teams and would bring the information back to the APC under matters arising at the APC in August 2025. In the meantime the **NON-FORMULARY** status for use in CYP was agreed as proposed. The Surrey Heartlands Integrated Care System Area Prescribing Committee agrees that Cenobamate for treating focal onset seizures in epilepsy in children and young people under the age of 18 will be given a **NON-FORMULARY** traffic light status. **ACTION:** ○ **Liaise with specialists re monitoring and dose titration timeframes (GR)**

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17	**Somapacitan for treating growth hormone deficiency in people 3 to 17 years (NICE TA1066)** The lead author presented a briefing paper for implementation of this NICE TA which had been published with a mandatory 30-day implementation time frame. The briefing paper had been prepared using the Decision-Making Framework which ensures consistent decision making by the APC. Somapacitan is a once weekly growth hormone and is another option for patients with growth hormone deficiency in people aged 3 to 17 years. An AMBER traffic light status with at least 3 months' prescribing by the specialist teams prior to requesting shared care with the patient's primary care clinician, was proposed and accepted by the APC members. The current shared care documents will be updated and brought to APC for consideration. The APC were also asked to agree a NON-FORMULARY status for those patients initiated on treatment as adults (18 years and over). Although Somapacitan is licensed for use in adults, NICE have not made a recommendation for this age group. The APC noted that there may be children and young people initiated on treatment and continued on treatment in adulthood where final growth height has not been achieved. The proposed status was agreed by the APC members. The Surrey Heartlands Integrated Care System Area Prescribing Committee (APC) approves somapacitan for the treatment of growth hormone deficiency in people 3 to 17 years as recommended by NICE TA1066. Somapacitan for this indication will be considered as AMBER - Prescribing initiated and stabilised by specialist team but has potential to transfer to primary care under a formal shared care agreement after 3 months of treatment. The Surrey Heartlands Integrated Care System Area Prescribing Committee (APC) agrees a NON-FORMULARY status for those patients initiated on somapacitan treatment as adults (18 years and over). **ACTION:** • **Growth Hormone shared care document to be reviewed for APC consideration (GR)** • **Upload to PAD/JF for reference (PAD admin)**
18	**Relugolix-estradiol-norethisterone for the treatment of endometriosis (NICE TA implementation)** The lead author presented a briefing paper for implementation of this NICE TA, there had been wide consultation with specialist teams. The briefing paper had been prepared using the Decision-Making Framework which ensures consistent decision making by the APC. Ryeqo® is an oral tablet and is a combination of relugolix (GnRH antagonist), estradiol (oestrogen hormone) and norethisterone (progestogen). It is licensed to be used as an option or treating symptoms of endometriosis in adults of reproductive age who have had medical or surgical treatment for endometriosis. Patients on treatment would be required to have a DXA scan after 12 months because of the potential decrease in Bone Mineral Density (BMD) during treatment. The NICE cost template makes an assumption that treatment would be initiated by a specialist and would then transfer to primary care after at least 1 months prescribing by the specialist team.

<table>
<tr><th>Item No.</th><th>Discussions and New Actions</th></tr>
<tr><td></td><td>A BLUE (with specialist initiation) was agreed by the APC members

The Surrey Heartlands Integrated Care System Area Prescribing Committee (APC) approves relugolix-estradiol-norethisterone for the treating symptoms of endometriosis as recommended by NICE TA1057

Relugolix-estradiol-norethisterone for this indication will be considered as BLUE (with specialist initiation), with at least 1 month prescribing by the specialist prior to transfer of care.

A DXA scan is recommended after the first 52 weeks of treatment to verify that the patient does not have an unwanted degree of BMD loss, that exceeds the benefit of treatment. This DXA scan will be organised & performed by the specialist team responsible for the ongoing care of the patient.

ACTION:
• Upload to PAD/JF for reference (PAD admin)</td></tr>
<tr><td>19</td><td>Joint Formulary – Endometriosis chapter review
Members were presented with a chapter review for all treatments used for the management of symptoms in patients with endometriosis. Traffic light status of items previously approved at APC have not been included below as they are already included on the Joint Formulary.

Combined Hormonal Contraception:
• The APC members agreed that the use of Combined Hormonal Contraceptives for endometriosis related symptoms, would be in line with already agreed preferred choices for contraception.

GnRH agonists (leuprorelin, triptorelin & gonadorelin)
No traffic light status has previously been agreed for these treatments. To ascertain prescribing in primary care an epact search was run which showed prescribing for women in primary care. Information from specialist teams also confirmed that primary care are prescribing for this patient cohort.
A subsequent audit of one practice in each place highlighted that practices are claiming for administration and all associated monitoring of these preparations through the Locally Commissioned Service.
The lead proposed a BLUE (with specialist initiation) with the first injection being given by the specialist team. From a clinical perspective this was agreed by the APC members, however from a finance perspective, the information that has been gathered needs to be discussed with the finance leads and primary care leads administering the LCS.
There are discussions taking place with regards treatment of patients with breast cancer in primary care and so both discussions need to be considered and hopefully moved forward, noting that prescribing and subsequent claiming is already happening locally.
Following discussions with finance and the LCS administrators this will be brought back to APC as a matter arising to finalise the traffic light status for GnRH agonists used in women.
ACTIONS:
• Leads to discuss financial implications for GnRH agonists with finance and administrators of the LCS (LH/MRU)</td></tr>
<tr><td>20</td><td>PAD holding statements
The PAD holding statements were noted and agreed as presented</td></tr>
</table>

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21	**APC terms of reference – review** The APC TOR has been updated to reflect the changes in membership of the committee in that a GP prescribing lead OR an Out of Hospital deputy chief pharmacist is included in the membership. Previously both were included as members. The APC was accepted as presented and the updated TOR will be ratified at MOB and uploaded to PAD for reference **ACTIONS:** • **Take to MOB for ratification (TB/SWa)** • **Upload to PAD for reference (PAD admin)**
22	**AOB** **Shared care principles and update to APPENDIX A – accompanying shared care documentation.** A paper detailing the principles around shared care were presented to the MOB recently and on the back of that meeting some minor amendments were requested by the membership to Appendix A. The amendments were in regard to delegated responsibilities as below: • Appendix A accompanying the shared care document can be sent to the primary care prescriber by a delegated non-medical prescriber (NMP) with their registration details requesting participation in shared care. The name of the consultant with overall responsibility should also be included in appendix A. • Highlighting that an agreed shared care document should be used. • Agreement that the primary care prescriber if they agree to undertake monitoring and prescribe treatment from at least 1 month from the date of the letter requesting shared care The APC members agree with the update and Appendix A will replace all copies available on the PAD
23	**Summary of decisions made:** **AGENDA ITEM 9 – Biosimilar Policy** The Surrey Heartlands Integrated Care System Area Prescribing Committee have agreed the reviewed Biologicals and biosimilar of best value policy. **AGENDA ITEM 16 – Cenobamate for treating focal onset seizures in epilepsy** The Surrey Heartlands Integrated Care System Area Prescribing Committee agrees that Cenobamate for treating focal onset seizures in epilepsy in children and young people under the age of 18 will be given a **NON-FORMULARY** traffic light status. **AGENDA ITEM 17 – Somapacitan for treatment of growth hormone deficiency NICE TA 1066)** The Surrey Heartlands Integrated Care System Area Prescribing Committee (APC) approves somapacitan for the treatment of growth hormone deficiency in people 3 to 17 years as recommended by NICE TA1066.

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	Somapacitan for this indication will be considered as AMBER - Prescribing initiated and stabilised by specialist team but has potential to transfer to primary care under a formal shared care agreement after 3 months of treatment. The Surrey Heartlands Integrated Care System Area Prescribing Committee (APC) agrees a NON-FORMULARY status for those patients initiated on somapacitan treatment as adults (18 years and over). **AGENDA ITEM 18 – Relugolix CT for treating symptoms of endometriosis (NICE TA1057)** The Surrey Heartlands Integrated Care System Area Prescribing Committee (APC) approves relugolix-estradiol-norethisterone for the treating symptoms of endometriosis as recommended by NICE TA1057 Relugolix-estradiol-norethisterone for this indication will be considered as BLUE (with specialist initiation), with at least 1 month prescribing by the specialist prior to transfer of care. **A DXA scan is recommended after the first 52 weeks of treatment to verify that the patient does not have an unwanted degree of BMD loss, that exceeds the benefit of treatment. This DXA scan will be organised & performed by the specialist team responsible for the ongoing care of the patient.**
Future meeting dates: (2.30pm to 5pm) via Microsoft teams calls • Wednesday 6th August 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)**	