

## Surrey Heartlands Integrated Care System Area Prescribing Committee (APC)

### MINUTES



|       |                            |      |             |
|-------|----------------------------|------|-------------|
| Date  | 04 <sup>th</sup> June 2025 | Time | 1430 - 1633 |
| Venue | Microsoft teams invitation |      |             |

| Name (Initials)           | Role   | Attendance /apologies |                 |     |                   |     |          |                |     |     |     |     |     |     |
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|                           |  | Jan Virtual           | Feb             | Mar | Apr               | May | May 14th | Jun            | Jul | Aug | Sep | Oct | Nov | Dec |
| <b>APC voting members</b> |  |                       |                 |     |                   |     |          |                |     |     |     |     |     |     |
| 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   | √        | √              |     |     |     |     |     |     |
| Linda Honey (LH)          | Director of Pharmacy - Surrey Heartlands Integrated Care System                          |                       | √ (left at 4pm) | √   | A                 | √   | √        | √              |     |     |     |     |     |     |
| Tara Bahri                | Deputy Chief Pharmacist Out of Hospital, Surrey Downs Place                              |                       | √               | √   | √                 | √   | √        | 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  |                       | √               | √   | √                 | √   | √        | √              |     |     |     |     |     |     |
| Jemma Hives               | Clinical Lead Pharmacist - ASPH  |                       | √               | X   | X                 | X   | A        | X              |     |     |     |     |     |     |
| Asad Qureshi              | Formulary Pharmacist - ASPH  |                       | A               | √   | √                 | √   | √        | √              |     |     |     |     |     |     |
| Nicky Leitch (NL)         | SASH – Formulary Development Pharmacist  |                       | √               | √   | √                 | √   | √        | A              |     |     |     |     |     |     |

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| 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             |  |  |  |  |  |  |  |
|                               | ASPH - Medical Director   |  | 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             |  |  |  |  |  |  |  |
| Dr Raja Badrakalimuthu        | SABPFT – Chair of Medicines Optimisation Committee  |  | √ (left at 3.23pm) | √ | √ | √ | X | X             |  |  |  |  |  |  |  |
| 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 | √ | √ | 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             |  |  |  |  |  |  |  |
| Dr Janice Kirby- Smith (JK-S) | Patient representative  |  | √                  | √ | √ | √ | A | √             |  |  |  |  |  |  |  |
| Mohamed Kharbouch             | Patient representative  |  | √                  | √ | √ | √ | X | A             |  |  |  |  |  |  |  |

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| Shani Corb (SC)           | Chief Pharmacist - SECAMB   |  | A | A | A | A | A | A           |  |  |  |  |  |  |
| Andy Law (AL)             | Surrey Heartlands ICS finance representative  |  | 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           |  |  |  |  |  |  |
| <b>Non-voting members</b> |   |  |   |   |   |   |   |             |  |  |  |  |  |  |
| Catrin Thomas (CT)        | Medicines Management Pharmacist Kingston Hospital NHS Foundation Trust                      |  | X | X | X | X | X | X           |  |  |  |  |  |  |
| Judith Foy (JF)           | Chief Pharmacist, Kingston Hospital NHS Foundation Trust                                    |  | A | A | A | X | X | X           |  |  |  |  |  |  |
|                           | Senior Medicines Optimisation Pharmacist - NHS Sussex ICB                                   |  | X | X | X | X | X | X           |  |  |  |  |  |  |
| Phillipa Blatchford (PB)  | Principal pharmacist Commissioning (Croydon) – Interim professional secretariat of SWL IMOC |  | X | X | √ | √ | X | X           |  |  |  |  |  |  |
|                           | Representative from QV FH   |  | X | X | X | X | X | X           |  |  |  |  |  |  |
| Gillian Ells (GE)         | Acute/Interface Specialist Pharmacist NHS Sussex Commissioners                              |  | X | X | X | X | X | X           |  |  |  |  |  |  |
| Mohammed Asghar (MA)      | Formulary Pharmacist Frimley Park Hospital NHS Foundation Trust                             |  | X | X | X | X | X | X           |  |  |  |  |  |  |
|                           | Public Health Consultant, West Sussex County Council  |  | X | X | X | X | X | X           |  |  |  |  |  |  |
|                           | Pharmacy Lead Practice Plus Group   |  | X | X | X |   | X | X           |  |  |  |  |  |  |
|                           | Surrey Heartlands Clinical Academy Representative   |  | 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)  |  | √ | √ |   |   |   |             |  |  |  |  |  |  |

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| Tejinder Bahra   | Lead Pharmacist (MRU) Operational   |  | √ | √ | √ | √ | X | √ |   |  |  |  |  |  |  |
| Georgina Randall | Senior Pharmacy Technician - MRU  |  | √ | √ | √ | √ | X | √ |   |  |  |  |  |  |  |
|                  | In attendance   |  |   |   |   |   |   |   |   |  |  |  |  |  |  |
| Carina Joanes    | Cardiovascular lead Surrey Heartlands ICS   |  |   |   |   |   |   |   | √ |  |  |  |  |  |  |
| Dr Rania Ward    | Principal Pharmacist for Sleep Medicine Queen Victoria Hospital                           |  |   |   |   |   |   |   | √ |  |  |  |  |  |  |
| Louise Berger    | Occupational Therapist specialising in Sleep (Sleep Clinic Royal Surrey Foundation Trust) |  |   |   |   |   |   |   | √ |  |  |  |  |  |  |
| Rumaan Aslam     | Rotational Pharmacist from Ashford & St Peters NHS Foundation Trust                       |  |   |   |   |   |   |   | √ |  |  |  |  |  |  |
| Anna Larkham     | Lead Community Nutritional Management Specialist Dietitian                                |  |   |   |   |   |   |   | √ |  |  |  |  |  |  |

| Item No. | Discussions and New Actions  |
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| 1        | <p><b>Introduction</b><br/>The chair welcomed members, presenters and all observers to the APC.</p>  |
| 2        | <p><b>Quorum</b><br/>The chair noted that the meeting was quorate</p>  |
| 3        | <p><b>Declarations of Interest</b><br/>Members were asked if there were any declarations of interest for the agenda items that had not already been declared. None were declared.</p>  |
| 4        | <p><b>Minutes from previous meeting</b><br/>The final minutes from the two APCs held in May 2025 were noted by the members</p>   |
| 5        | <p><b>NICE Guidance</b><br/>The APC noted the NICE guidance published since the last APC.</p>  |
| 6        | <p><b>Daridorexant for chronic insomnia – Change in traffic light status</b><br/>The members were presented with a proposal to change the traffic light status of daridorexant, from BLUE (with initiation) to either BLUE (on recommendation from a specialist) or GREEN. The Chair highlighted the comments made during consultation which were in support of a BLUE (on recommendation traffic light status and the APC members were asked for their comments on this proposal. The members did have some areas of clarification for the specialists who attended to provide support</p> <p><b>Place in Therapy</b><br/>Cognitive Behavioural Therapy for insomnia (CBT-I) is the primary intervention for chronic insomnia that can be provided by a therapist in secondary care, in primary care, or via app-based technology. It was noted that there is a cost to some of the more common apps (Sleepio &amp; Sleep Station) but that other free apps are available. The lead author highlighted the need to use non-pharmacological interventions first. It was noted that zolpidem and zopiclone are for short-term insomnia or where the patient is distressed suggesting immediate need for treatment. Chronic insomnia is classified as insomnia that occurs at least 3 times a week for at least 3 months, with daytime dysfunction. Without daytime dysfunction it is not an insomnia that requires medical intervention. The lead author highlighted that chronic insomnia should be treated in primary care using the guidelines for insomnia treatment. It was noted that after non-pharmacological interventions, CBTi and daridorexant, a patient could then be referred to the specialist team for consideration of other pharmacological interventions</p> <p><b>Length of treatment with daridorexant</b><br/>The APC agreed a BLUE (with initiation) traffic light status in February 2024 and since then, 120 patients from Surrey Heartlands were prescribed daridorexant in the sleep service at Queen Victoria Hospital. The specialist highlighted that it could take up to 8 weeks for daridorexant to take effect and patients should be made aware at initiation. It was also noted that if a patient has been suffering from chronic insomnia for many years, it could take a long time for the patient to get back into a normal sleep pattern and at that point (potentially 12 months) there could be consideration for the gradual withdrawal of treatment.</p> <p><b>Safety concerns</b><br/>The specialist highlighted that experience shows that initiating treatment at 25mg would be recommended to reduce the potential for side effects, but the dose must be increased to 50mg if the patient tolerates the starting dose after 2 weeks, as maximal benefit is obtained at 50mg. APC</p> |

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|          | <p>members also considered the use of daridorexant in specific patient cohorts and the specialist advised as follows:</p> <p><b>Over 75s</b></p> <ul style="list-style-type: none"> <li>• Start with a low dose to ensure tolerance and up titrate slowly.</li> <li>• No clinical data for patients over 85 and there has been little benefit to treatment in this age group</li> </ul> <p><b>History of Obstructive Sleep Apnoea</b></p> <ul style="list-style-type: none"> <li>• The specialist noted that this cohort of patients would not have been considered in the clinical trials but there would be no reason why the cohort should not be treated with daridorexant.</li> </ul> <p><b>Excessive alcohol consumption</b></p> <ul style="list-style-type: none"> <li>• The specialist highlighted the need to be cautious at initiation and up titrate slowly</li> </ul> <p><b>Patients with severe hepatic impairment</b></p> <ul style="list-style-type: none"> <li>• Contraindicated in patients with severe hepatic impairment</li> <li>• Moderate hepatic impairment – use 25mg maximum dose</li> </ul> <p>In line with NICE guidance, daridorexant is recommended for treating insomnia only if CBTi has been tried but not worked or CBTi is unavailable or is unsuitable. It was noted that there is a CBTi service offered in Surrey in the sleep clinic at Royal Surrey and so a BLUE (on recommendation) should be agreed until there is more experience with daridorexant.</p> <p>Taking all the above information into consideration, the APC members agreed with a <b>BLUE (on specialist recommendation)</b> for daridorexant for chronic insomnia.</p> <div style="border: 1px solid black; padding: 10px; background-color: #f9e79f;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed a change in traffic light status to <b>BLUE (on specialist recommendation)</b> for daridorexant for chronic insomnia.</p> <p>It is important to reach the therapeutic dose of 50mg daily, however, experience shows that initiation at 25mg would be recommended to reduce the potential for side effects, but the dose must be increased to 50mg if the patient tolerates the starting dose after 2 weeks, as maximal benefit is obtained at 50mg.</p> <p>Patients should be advised that the treatment with daridorexant should be used alongside the learning from CBTi and that it may take several months to reach optimum benefit.</p> <p>During the use of Daridorexant, patients should be encouraged to continue implementing the taught strategies of CBTi.</p> <p>Treatment may continue beyond 1 year if the patient was experiencing significant benefit, and stopping treatment gradually meant that this benefit was lost.</p> <p>Discontinuation should be carried out slowly, reducing to 25mg before stopping.</p> </div> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li>• <b>Upload briefing to PAD/JF for reference (PAD admin)</b></li> </ul> |

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| 7        | <p><b>Action log</b><br/> The members were informed of updates to the following actions:<br/> <b>GnRH agonists use in Breast Cancer – transfer of prescribing budget</b></p> <ul style="list-style-type: none"> <li>The finance team at Surrey Heartlands ICB are picking the transfer of budget up with the contracting negotiations for this year (25/26)</li> </ul> <p><b>ACTION TO REMAIN OPEN – Date changed to July 2025 for update.</b></p> <p><b>ADHD in adults shared care</b></p> <ul style="list-style-type: none"> <li>Internal discussions at SABPFT are taking place to ensure appropriate communication processes are in place.</li> </ul> <p><b>ACTION TO REMAIN OPEN – Date changed to July 2025 for update.</b></p>  |
| 8        | <p><b>Urgent AOB:</b><br/> On behalf of the APC members, Linda Honey (Director of Pharmacy) thanked Dr Andreas Pitsaeli who has taken the decision to step down from his role as the prescribing lead for Surrey Downs Health &amp; Care Partnership, after many years in post.<br/> Andreas will continue to attend the APC as an associate member and as a Local Medical Committee representative</p>  |
| 9        | <p><b>Medicines safety highlight report</b><br/> Head of Medicines Safety shared a highlight report with the members, prior to the meeting. Points to note were as follows:</p> <ul style="list-style-type: none"> <li>To continue to support the implementation of the Valproate MHRA alert and Drug Safety Update. The valproate and topiramate primary care audit has been completed which focused on females with childbearing potential. The audit results were discussed at the Medicines Safety Committee and further discussion will take place at the valproate implementation group in July 2025</li> </ul>  |
| 10       | <p><b>Acarizax (12 SQ-HDM SLIT) for treating allergic rhinitis and allergic asthma caused by house dust mites (NICE TA1045)</b><br/> The lead author presented a NICE briefing paper to consider implementation of this NICE technology appraisal.<br/> It was noted that NICE do not recommend the use of Acarizax (12 SQ-HDM SLIT) in allergic asthma and a NON-FORMULARY traffic light status has already been agreed for that indication.</p> <p>The members considered a RED or BLUE (with specialist initiation) traffic light status. The APC members considered that a BLUE (with specialist initiation) would be appropriate as long as the patient showed signs of clinical benefit prior to transfer of care to a primary care.</p> <p>It was noted that there are contraindications in the SPC about severe asthma exacerbations and patients experiencing an acute respiratory tract infection. The APC asked what the process would be for those patients that may have been initiated on treatment and present to their primary care clinician with an asthma exacerbation or respiratory tract infection. It was agreed that the process to potentially refer back to the immunology teams would be confirmed and information provided in the PAD narrative for prescribers.</p> <p>The APC agreed a BLUE (with specialist initiation) with at least 3 months prescribing by the specialist team to enable review and confirmation of clinical benefit, prior to transfer of care to Primary Care</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee (APC) approves Acarizax (12 SQ-HDM SLIT) for treating allergic rhinitis caused by house dust mites in line with NICE TA1045</p> |

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|          | <p>A <b>BLUE (with specialist initiation)</b> traffic light status has been agreed with at least 3 months prescribing by the specialist team to enable review and confirmation of clinical benefit, prior to transfer of care to Primary Care</p> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li>• <b>Check process for referral back to specialist for asthma exacerbation or respiratory tract infection (VD)</b></li> <li>• <b>Upload information to PAD/JF (include reference to referral process) (PAD admin)</b></li> </ul>   |
| 11       | <p><b>Covid Medicines Delivery Unit – Update</b></p> <p>Since Dec 2021 Surrey Heartlands have provided a COVID medicines delivery service. The service is jointly commissioned with the Frimley system initially in line with the pandemic specific arrangements for non-hospitalised patients with COVID-19 at highest risk.</p> <p>In March 2023 NICE guidance was published for Nirmatrelvir plus ritonavir, sotrovimab and tocilizumab for treating COVID-19. This guidance recommended treatment only for the highest risk cohort of patients and in Surrey Heartlands an estimated 75K of the population fall into the highest risk cohort. NICE TA878 updated criteria issued March 2024 expanded the cohort of eligible patients and a funding variation was applied which meant that further cohorts of Surrey Heartlands patients would be eligible for treatment if they tested positive for COVID-19.</p> <p>The lead highlighted that from 1st of May 2025 the free of charge supply of Paxlovid (nirmatrelvir plus ritonavir) procured centrally during the pandemic ran out which meant from Paxlovid costs for the service are in line with the drug tariff price. NICE reviewed NICE TA878 following this change and updated guidance was issued 1st May 2025. The updated guidance now only recommends Paxlovid as an option for treating COVID 19 in adults with the highest risk, only if they.</p> <ul style="list-style-type: none"> <li>• do not need supplemental oxygen for COVID 19 and</li> <li>• have an increased risk for progression to severe COVID 19</li> </ul> <p>The APC members supported the use of treatment options for treating COVID-19 in adults in line with the updated NICE criteria. Updated narrative has been provided in the briefing paper</p> <p>The lead also highlighted that the community pharmacy Locally Commissioned Service (LCS) had been updated and 3 community pharmacies in Surrey Heartlands are commissioned to supply the treatments in NICE TA878. It was noted that only one pharmacy (in Dorking) is commissioned to dispense intravenous sotrovimab or molnupiravir. It was noted that this information has already been added to PAD/JF for reference</p> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee agreed the updated LCS for community pharmacies to supply COVID-19 treatments in Surrey Heartlands</p> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li>• <b>Upload information to PAD/JF for reference (PAD admin)</b></li> </ul> |
| 12       | <p><b>Molnupiravir for treating COVID-19 in adults (NICE TA1056)</b></p> <p>The lead author presented a NICE briefing paper to consider implementation of this NICE technology appraisal. Treatment will be available through the Covid Medicines Delivery Unit</p>   |

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|          | <p>(CMDU) and only for patients at the highest risk in line with the NICE guidance and only if nirmatrelvir plus ritonavir and sotrovimab are contraindicated or unsuitable</p> <p>The lead again highlighted It was noted that only one pharmacy (in Dorking) is commissioned to dispense intravenous sotrovimab or molnupiravir.</p> <p>Very small numbers of patients are expected to need this treatment and a RED traffic light status through the CMDU service was agreed.</p> <p>It was highlighted that if a patient who falls into one of the high-risk cohorts, is in hospital and gets COVID-19 (not admitted due to COVID) then these individuals should be treated with molnupiravir if nirmatrelvir plus ritonavir and sotrovimab are contraindicated or unsuitable. This is reflected in the narrative provided in the briefing paper.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee agree implementation of Molnupiravir for treating COVID-19 in adults in line with NICE TA1056</p> <p>Molnupiravir is agreed as <b>RED</b> for prescribing only by the commissioned CMDU service (not for prescribing through A&amp;E / hospital clinics)</p> <p>*if a patient who falls into one of the high-risk cohorts, is in hospital and gets COVID-19 (not admitted due to COVID) then these individuals should be treated with molnupiravir if nirmatrelvir plus ritonavir and sotrovimab are contraindicated or unsuitable</p> </div> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li>• <b>Upload information to PAD/JF for reference (PAD admin)</b></li> </ul>  |
| 13       | <p><b>Pizotifen for migraine – Change in Traffic Light Status</b></p> <p>The APC members were asked to consider a proposal to change the traffic light status of pizotifen for migraine to BLUE (on recommendation) from GREEN. The reason for the proposal is because pizotifen use may result in undesirable side effects including weight gain.</p> <p>Dr Jan Coebergh, consultant neurologist and specialist lead has proposed that all new initiations would be following a recommendation made by the specialist service i.e. BLUE.</p> <p>There are other treatment options available for the prophylaxis of migraine and the specialist would be considering those other treatments prior to pizotifen.</p> <p>South-West London have recently approved a change in traffic light too and this proposal would bring Surrey Heartlands in line with them.</p> <p>The APC members considered the place in therapy and asked if pizotifen had a place in the migraine pathway. It was noted that there is a niche group of patients that would benefit from this treatment and so NON-FORMULARY would not be an appropriate traffic light status.</p> <p>The APC were not in agreement, at this point in time, with the proposed BLUE traffic light status. The members considered that the patient cohort that would be referred into the specialist service for consideration of migraine prophylaxis, would be in a difficult to treat cohort.</p> <p>Pizotifen may be considered much later in the pathway and potentially as a last line therapy and therefore by definition these patients will have significant drug-resistant migraine.</p> <p>The APC members agreed that the specialist service should potentially start treatment and check for benefit and tolerance prior to a transfer of care to primary care. It was noted that the specialist service has proposed a trial withdrawal after 9 months and so the APC members considered that</p> |

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|          | <p>may be an appropriate point to transfer care to primary care if the patient is continuing on treatment and the side effects are being tolerated.<br/>The APC members agreed that the lead author should contact the specialist service to discuss the APC members concerns for initiation for new patients.</p> <p>For those patients currently on treatment in primary care, it was agreed to promote a review of those patients and consider a trial withdrawal. The proposed narrative is agreed as follows:</p> <p><b>‘Long term use of pizotifen (like most migraine prophylactic medication) is rarely indicated and withdrawal should normally be attempted after 9 months.</b></p> <p><b>If, after 2-months of withdrawal, migraine frequency increases to warrant prophylactic medication again options to consider in discussion with the patient would be:</b></p> <ul style="list-style-type: none"> <li>• <b>Alternative prophylactic medication as per the Surrey Headache Pathway</b></li> <li>• <b>Re-start pizotifen only if there were no previous major side effects of low mood, weight gain and cognitive symptoms.’</b></li> </ul> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee agreed a PAD narrative message for patients currently on treatment with pizotifen for migraine prophylaxis in primary care, as follows:</p> <p>Long term use of pizotifen (like most migraine prophylactic medication) is rarely indicated and withdrawal should normally be attempted after 9 months.<br/>If, after 2-months of withdrawal, migraine frequency increases to warrant prophylactic medication again options to consider in discussion with the patient would be:</p> <ul style="list-style-type: none"> <li>• Alternative prophylactic medication as per the Surrey Headache Pathway</li> <li>• Re-start pizotifen only if there were no previous major side effects of low mood, weight gain and cognitive symptoms.</li> </ul> </div> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li>• <b>Prescribing support message to be uploaded to PAD/JF</b></li> <li>• <b>Discussion with specialist lead re concerns from APC members (TB)</b></li> </ul> |
| 14       | <p><b>Pancreatic Enzyme Replacement Therapy – PERT update</b></p> <p>The dietetic lead highlighted 2 key points in relation to this APC update.</p> <ul style="list-style-type: none"> <li>• As of April 2025 the identified imported products (Pangrol 10,000 and Pangrol 25,000) are now listed on GP electronic systems so electronic prescriptions can be generated.</li> <li>• The distribution of Creon to community pharmacy has been streamlined to one wholesaler, with monthly stock allocations for individual community pharmacies.</li> </ul> <p>Liaison with Community Pharmacy colleagues highlighted that for some patients with high volumes of medication on their repeat prescriptions, may need to have their monthly prescriptions split across separate prescriptions.</p> <p>The APC members agreed that this was not an ideal situation and would be a challenge for primary care. Also noted was that previously the hospitals were able to help with rescue prescriptions, but they are no longer being prioritised for stock.</p> <p>The APC agreed the updated guidance to support prescribers with PERT stock shortages and this will be added to the PAD/JF for reference.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the updated guidance to support prescribers with PERT stock shortages</p> </div>  |

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|          | <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li>• <b>Upload information to PAD/JF for reference (PAD admin)</b></li> </ul>   |
| 15       | <p><b>Sacubitril valsartan for Heart Failure – Change in traffic light status</b></p> <p>The members were presented with a paper proposing a change in traffic light from Amber to BLUE (with specialist initiation) for patients meeting NICE guidance for the use of sacubitril valsartan for the treatment of heart failure.</p> <p>An AMBER traffic light status was agreed by the APC when the original NICE guidance was published in 2016 and there has now been more experience of using this treatment by the specialist teams and in primary care.</p> <p>South-West London have recently agreed to a change in traffic light status to AMBER2 which is equivalent to the traffic light status being proposed to APC.</p> <p>It was noted that this proposal does not include the use of sacubitril valsartan in HF rEF in patients that do not meet the NICE criteria specification such as an ejection fraction above 35% but below 40% meeting the European society of cardiology (ESC) criteria.</p> <p>If specialists deem it necessary in such a population, a request can be made for an addition to the workplan by the local specialist teams and the MRU team would support the specialists in writing a paper for APC consideration.</p> <p>Currently there is no new compelling evidence to suggest sacubitril valsartan use other than how it has been outlined in the NICE TA388 (2016).</p> <p>The APC members agreed with the proposal to change the traffic light status to BLUE (with specialist initiation) with prescribing by the specialist team to initiate, up titrate and stabilise on the maximum tolerated dose (for a minimum of 4 weeks), prior to transfer of care to primary care.</p> <p>The members also agreed that a BLUE information sheet would not be required as this information is available</p> <div data-bbox="264 1267 1544 1464" style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed a change in traffic light status to <b>BLUE (with specialist initiation)</b> for sacubitril valsartan for the treatment of Heart Failure, with prescribing by the specialist team to initiate, up titrate and stabilise onto the maximum tolerated dose (for a minimum of 4 weeks), prior to transfer of care to primary care.</p> </div> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li>• <b>Upload information to PAD/JF for reference (PAD admin)</b></li> </ul> |
| 16       | <p><b>Tirzepatide for obesity and weight management – Primary Care implementation of NICE TA1026</b></p> <p>The NICE guidance for tirzepatide for obesity and weight management was published in December 2024. In March 2025 the APC members supported the use of tirzepatide via the Surrey Weight Management Service (SWMS) at Ashford &amp; St Peters Hospitals NHS Foundation Trust. Criteria for initiation of treatment was based on criteria from the Society of Endocrinology &amp; Obesity Management Collaborative UK (Phase 1) and was the same criteria in place for semaglutide for obesity and weight management.</p> <p>ICBs were given an extended period, through a funding variation, to develop coordinated and sustainable service models in primary care.</p>   |

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|          | <p>The leads proposed a GREEN traffic light status for tirzepatide use in primary care for weight management under a Locally Commissioned Service (LCS) for patients who meet the funding variation criteria (Cohort 1)</p> <ul style="list-style-type: none"> <li>• BMI <math>\geq</math> 40 kg/m<sup>2</sup> (BMI should be adjusted by -2.5 kg/m<sup>2</sup> for individuals of South Asian, Chinese, other Asian, Middle Eastern, Black African or African–Caribbean ethnic backgrounds, due to increased cardiometabolic risk at lower BMI levels)</li> </ul> <p>AND at least four of the five following comorbidities:</p> <ul style="list-style-type: none"> <li>• Type 2 diabetes (T2DM)</li> <li>• Hypertension</li> <li>• Dyslipidaemia</li> <li>• Cardiovascular disease (CVD)</li> <li>• Obstructive sleep apnoea (OSA) Access period: 12 months</li> </ul> <p>It was agreed that tirzepatide should not be used in primary care for weight management other than via the LCS for patients meeting the funding criteria.</p> <p>It was also noted that primary care should not be taking on prescribing of tirzepatide for patients who have been initiated privately and do not meet the funding variation criteria.</p> <p>It was also highlighted that the use of tirzepatide for diabetes should be in line with the previous Area Prescribing Committee recommendation and that tirzepatide is 3rd line where dulaglutide / semaglutide are unsuitable or unavailable. It should not be used outside of the recommendation and should only be used when the primary indication is diabetic control to allow for equity of access to tirzepatide for weight management in line with the national funding variation cohorts.</p> <p>Members noted that the Traffic Light Status remains RED for tirzepatide use via the SWMS (with wrap around support) in line with the current criteria (phase 1 of Guidance issued by the Society for Endocrinology and Obesity Management Collaborative UK agreed in March 2025). It was noted that a 'wrap around' support is mandated by the NICE guidance and ensures that patients are provided with nutritional and dietetic advice as a minimum. Patients treated in primary care will have access to 'wrap around' support through the LCS.</p> |

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|          | <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed tirzepatide in primary care for obesity and weight management in line with NICE TA1026.</p> <p>Tirzepatide in Surrey Heartlands will be available via primary care for patients who fall within the Funding Variation criteria detailed within the <a href="#">NHS England Commissioning Guidance</a> as a <b>GREEN</b> traffic light status via a Locally Commissioned Service (which will include wrap around support).</p> <ul style="list-style-type: none"> <li>BMI <math>\geq 40</math> kg/m<sup>2</sup> (BMI should be adjusted by -2.5 kg/m<sup>2</sup> for individuals of South Asian, Chinese, other Asian, Middle Eastern, Black African or African–Caribbean ethnic backgrounds, due to increased cardiometabolic risk at lower BMI levels)</li> </ul> <p>AND at least four of the five following comorbidities:</p> <ul style="list-style-type: none"> <li>Type 2 diabetes (T2DM)</li> <li>Hypertension</li> <li>Dyslipidaemia</li> <li>Cardiovascular disease (CVD)</li> <li>Obstructive sleep apnoea (OSA)</li> </ul> <p><b>NB:</b><br/> <b>Tirzepatide weekly injection for use in Type 2 Diabetes should ONLY be used when the primary indication is diabetic control to allow for equity of access to tirzepatide for weight management in line with the national funding variation cohorts. The agreement made in March 2024 by the APC is available here for patients with Type 2 Diabetes:</b><br/> <a href="https://surrey.res.services/PAD/Profile/Index/6604">https://surrey.res.services/PAD/Profile/Index/6604</a></p> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li><b>Upload information to PAD/JF for reference when LCS has been agreed (PAD admin)</b></li> </ul> |
| 17       | <p><b>SERMOG-07</b><br/> <b>Over the counter (OTC) guidance</b></p> <p>The members were presented with the regional policy recommendation SRMOG-07, promoting regional wide promotion of the NHS England guidance on those treatments that should not be prescribing in primary care before their limited clinical effectiveness.</p> <p>It was noted that the prescriber still has some responsibilities for individual patients if they feel that they are not able to self-care and exceptions do apply.</p> <p>There is a self-care patient information leaflet available from PrescQIPP which the APC are asked to adopt on behalf of Surrey Heartlands.</p> <p>The APC members agreed to adopt the SERMOG-07 policy statement and the PIL leaflet from PrescQIPP. Both documents will be added to PAD/JF for reference</p> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee have agreed to adopt SERMOG-07 policy recommendation and the PIL leaflet from PrescQIPP.</p> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li><b>Upload statement and PIL to PAD/JF for reference (PAD admin)</b></li> </ul>   |
| 18       | <p><b>SERMOG -06</b><br/> <b>Inflammatory Bowel Disease pathway for patients within the adult service.</b></p> <p>The members were presented with the first of a region wide high-cost drugs pathway for IBD. The regional pathway has had extensive consultation with all stakeholders and gastroenterology specialist teams and has been developed using original pathways from across the region.</p>  |

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|          | <p>The key differences to the Surrey Heartlands ICB pathway are that there are</p> <ul style="list-style-type: none"> <li>• more dose escalations available (licensed and unlicensed) but these are already commonly used in IBD.</li> <li>• Use of dose escalations for greater than a 12-week treatment limit before returning to standard dosing.</li> </ul> <p>The APC members agreed the pathway as presented and the pathway will be added to the PAD/JF for reference. It was noted that the Blueteq forms have also been updated, and these will be enabled for use by the specialist teams, as soon as the APC minutes have been signed off.</p> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee have agreed the SERMOG Inflammatory Bowel Disease high-cost drugs pathway.</p> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li>• <b>Upload information to PAD/JF for reference (PAD admin)</b></li> </ul> |
| 19       | <p><b>PAD holding statements</b></p> <p>The members agreed with the holding statements that have already been added to the PAD/JF by PAD admin.</p>  |
| 20       | <p><b>Gender Identity Services – Update</b></p> <p>The lead author highlighted guidance from NHS England in May 2025 advising primary care prescribers against shared care agreements with unregulated providers in relation to hormone medication for children and young people under 18.</p> <p>It was noted that the Surrey Heartlands primary care guidance has been updated and will be uploaded to PAD for reference</p> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee have agreed the updated Surrey Heartlands Primary Care guidance for Gender Identity Services</p> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li>• <b>Upload information to PAD/JF for reference (PAD admin)</b></li> </ul>  |
| 21       | <p><b>AOB</b></p> <p><b>Guidelines for Micronutrient Monitoring and Supplementation post Bariatric Surgery</b></p> <ul style="list-style-type: none"> <li>• Following a query a missing footnote related to the tables on pages 5-7 has been added and the guidelines will be re-uploaded to the PAD/JF for reference</li> </ul> <p><b>ACTION:</b></p> <ul style="list-style-type: none"> <li>• <b>Upload information to PAD/JF for reference (PAD admin)</b></li> </ul>   |
|          | <p><b>Summary of decisions made:</b></p> <p><b>AGENDA ITEM 6: Daridorexant for Chronic Insomnia – Change in traffic light status</b></p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed a change in traffic light status to <b>BLUE (on specialist recommendation)</b> for daridorexant for chronic insomnia.</p> <p>It is important to reach the therapeutic dose of 50mg daily, however, experience shows that initiation at 25mg would be recommended to reduce the potential for side effects, but the dose must be increased to 50mg if the patient tolerates the starting dose after 2 weeks, as maximal benefit is obtained at 50mg.</p>   |

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|          | <p>Patients should be advised that the treatment with daridorexant should be used alongside the learning from CBTi and that it may take several months to reach optimum benefit.</p> <p>During the use of Daridorexant, patients should be encouraged to continue implementing the taught strategies of CBTi.</p> <p>Treatment may continue beyond 1 year if the patient was experiencing significant benefit, and stopping treatment gradually meant that this benefit was lost.</p> <p>Discontinuation should be carried out slowly, reducing to 25mg before stopping.</p> <p><b>AGENDA ITEM 11: Acarizax for treating Allergic Rhinitis caused by house dust mites (NICE TA implementation)</b></p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee (APC) approves Acarizax (12 SQ-HDM SLIT) for treating allergic rhinitis caused by house dust mites in line with NICE TA1045</p> <p>A <b>BLUE (with specialist initiation)</b> traffic light status has been agreed with at least 3 months prescribing by the specialist team to enable review and confirmation of clinical benefit, prior to transfer of care to Primary Care</p> <p><b>AGENDA ITEM 12: Community Pharmacy LCS for supply of COVID-19 treatments</b></p> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee agreed the updated LCS for community pharmacies to supply COVID-19 treatments in Surrey Heartlands</p> <p><b>AGENDA ITEM 13: Molnupiravir for COVID-19 (NICE TA IMPLEMENTATION)</b></p> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee agree implementation of Molnupiravir for treating COVID-19 in adults in line with NICE TA1056</p> <p>Molnupiravir is agreed as <b>RED</b> for prescribing only by the commissioned CMDU service (not for prescribing through A&amp;E / hospital clinics)</p> <p>*if a patient who falls into one of the high-risk cohorts, is in hospital and gets COVID-19 (not admitted due to COVID) then these individuals should be treated with molnupiravir if nirmatrelvir plus ritonavir and sotrovimab are contraindicated or unsuitable</p> <p><b>AGENDA ITEM 14: Pizotifen for Migraine (People currently on treatment)</b></p> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee agreed a PAD narrative message for patients currently on treatment with pizotifen for migraine prophylaxis in primary care, as follows:</p> |

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|          | <p>Long term use of pizotifen (like most migraine prophylactic medication) is rarely indicated and withdrawal should normally be attempted after 9 months.<br/>           If, after 2-months of withdrawal, migraine frequency increases to warrant prophylactic medication again options to consider in discussion with the patient would be:</p> <ul style="list-style-type: none"> <li>• Alternative prophylactic medication as per the Surrey Headache Pathway</li> <li>• Re-start pizotifen only if there were no previous major side effects of low mood, weight gain and cognitive symptoms.</li> </ul> <p><b>AGENDA ITEM 14: PERT stock shortages update</b></p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the updated guidance to support prescribers with PERT stock shortages</p> <p><b>AGENDA ITEM 15: Sacubitril valsartan for Heart Failure -Change in traffic light status</b></p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed a change in traffic light status to <b>BLUE (with specialist initiation)</b> for sacubitril valsartan for the treatment of Heart Failure, with prescribing by the specialist team to initiate, up titrate and stabilise onto the maximum tolerated dose (for a minimum of 4 weeks), prior to transfer of care to primary care.</p> <p><b>AGENDA ITEM 16: Tirzepatide in overweight and obesity management primary care implementation:</b></p> |

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|  | <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed tirzepatide in primary care for obesity and weight management in line with NICE TA1026.</p> <p>Tirzepatide in Surrey Heartlands will be available via primary care for patients who fall within the Funding Variation criteria detailed within the <a href="#">NHS England Commissioning Guidance</a> as a <b>GREEN</b> traffic light status via a Locally Commissioned Service (which will include wrap around support).</p> <ul style="list-style-type: none"> <li>BMI <math>\geq 40</math> kg/m<sup>2</sup> (BMI should be adjusted by -2.5 kg/m<sup>2</sup> for individuals of South Asian, Chinese, other Asian, Middle Eastern, Black African or African–Caribbean ethnic backgrounds, due to increased cardiometabolic risk at lower BMI levels)</li> </ul> <p>AND at least four of the five following comorbidities:</p> <ul style="list-style-type: none"> <li>Type 2 diabetes (T2DM)</li> <li>Hypertension</li> <li>Dyslipidaemia</li> <li>Cardiovascular disease (CVD)</li> <li>Obstructive sleep apnoea (OSA)</li> </ul> <p><b>NB:</b><br/> <b>Tirzepatide weekly injection for use in Type 2 Diabetes should ONLY be used when the primary indication is diabetic control to allow for equity of access to tirzepatide for weight management in line with the national funding variation cohorts. The agreement made in March 2024 by the APC is available here for patients with Type 2 Diabetes:</b><br/> <a href="https://surrey.res.services/PAD/Profile/Index/6604">https://surrey.res.services/PAD/Profile/Index/6604</a></p> <p><b>AGENDA ITEM 17: SERMOG OTC policy statement</b></p> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee have agreed to adopt SERMOG-07 policy recommendation and the PIL leaflet from PrescQIPP.</p> <p><b>AGENDA ITEM 18: SERMOG IBD pathway</b></p> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee have agreed the SERMOG Inflammatory Bowel Disease high-cost drugs pathway.</p> <p><b>AGENDA ITEM 20: Gender Identity Services</b></p> <p>The Surrey Heartland Integrated Care System Area Prescribing Committee have agreed the updated Surrey Heartlands Primary Care guidance for Gender Identity Services</p> |
| <p><b>Future meeting dates: (2.30pm to 5pm) via Microsoft teams calls</b></p> <ul style="list-style-type: none"> <li>Wednesday 2<sup>nd</sup> July 2025</li> </ul> |   |
| <p><b>Signed and agreed by:</b></p> <p><b>Date: DD MMM YYYY</b><br/> <b>Chair Name, Chair Title (Chair)</b></p>  |   |
| <p><b>Minutes agreed for publication by:</b></p> <p><b>Date: DD MMM YYYY</b><br/> <b>Exec Lead name, Exec Lead Title (Exec Lead)</b></p>                           |   |