

Surrey Heartlands Integrated Care System Area Prescribing Committee (APC)



MINUTES

Date	3 rd September 2025	Time	1430 -1609
Venue	Microsoft teams invitation		

Name (Initials)	Role	Attendance /apologies												
		Jan Virtual	Feb	Mar	Apr	May	May 14th	Jun	Jul	Aug	Sep	Oct	Nov	Dec
APC voting members														
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)	X	X			
Tara Bahri	Deputy Chief Pharmacist Out of Hospital, Surrey Downs Place		√	√	√	√	√	A	A	√	√			
Tim Dowdall	Deputy Chief Pharmacist Out of Hospital - Guildford & Waverley		√	√	√	√	√	A	√	√ (left at 1622)	√			
Lis Stanford	Deputy Chief Pharmacist Out of Hospital – North-West Surrey		A	√	√	√	√	√	√	√	√			
Monika Cunjamalay	Deputy Chief Pharmacist Out of Hospital – East Surrey		√	A	√	√	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	X	x			

Asad Qureshi	Formulary Pharmacist - ASPH		A	√	√	√	√	√	√	X	√			
Nicky Leitch (NL)	SASH – Formulary Development Pharmacist		√	√	√	√	√	A	√	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	√	X	√ (left at 1450)			
	CSH - Lead Pharmacist		√	X	√	√	X	√	√	√	√			
Temitope Odetunde (TO)	FCH&C - Lead Pharmacist		X	√	X	X	X	X	X	√	X			
	ASPH - Medical Director or nominated representative		X	X	X	X	X	X	X	X	X			
Dr James Clark (JC)	SASH – Consultant Endocrinology & Diabetes Mellitus		X	X	√	√	√	√	√	√	√ (from 1517)			
	ESHUT - Medical Director / Chair of DTC or nominated Consultant		X	X	X	X	X	X	X	X	X			
Dr Raja Badrakalimuthu	SABPFT – Chair of Medicines Optimisation Committee		√ (left at 3.23pm)	√	√	√	X	X	√	X	√			
	GP prescribing Lead (SD place) vacant position from July 2025		√	√	√	√	√	√	X	X	X			
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)	Multiprofessional prescribing representative – Advanced Nurse Practitioner		√	√	√	√	√	X	√	A	A			
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	A	A			
Andy Law (AL)	Surrey Heartlands ICS finance representative		X	X	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	√	A	√ from 1515			
Richard Barnett (RB)	Surrey Heartlands ICS quality directorate representative		√	√	√	√	X	√	√	√	A			
Liz Saunders (LS)	Surrey County Council - Public Health Consultant		X	X	X	X	X	X	X	X	X			
Non-voting members														
Dr Andreas Pitsiaeli	LMC representative								A	√	A			
Catrin Thomas (CT)	Medicines Management Pharmacist Kingston Hospital NHS Foundation Trust		X	X	X	X	X	X	X	X	X			
Judith Foy (JF)	Chief Pharmacist, Kingston Hospital NHS Foundation Trust		A	A	A	X	X	X	A	X	X			
TakHo Cheung or Amy Herbert	Medicines Governance and Value Pharmacy Representative - NHS Sussex ICB		X	X	X	X	X	X	X	√ from 1504	A			
Phillipa Blatchford (PB)	Principal pharmacist Commissioning (Croydon) – Interim professional secretariat of SWL IMOC		X	X	√	√	X	X	X	X	A			
	Representative from QVFH		X	X	X	X	X	X	X	X	X			
Gillian Ells (GE)	Acute/Interface Specialist Pharmacist NHS Sussex Commissioners		X	X	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	X	X			
	Public Health Consultant, West Sussex County Council		X	X	X	X	X	X	X	X	X			
	Pharmacy Lead Practice Plus Group		X	X	X		X	X	X	X	X			

	Surrey Heartlands Clinical Academy Representative		X	X	X	X	X	X	X	X	X			
Clare Johns (CJ)	Lead Pharmacy Technician – Medicines Resource Unit (MRU) – NHS Surrey Heartlands APC Secretariat		√	√	√	√	√	√	√	√	√			
Carina Joanes (CJo)	Lead Pharmacist - MRU (Clinical)		√	√										
Tejinder Bahra (TB)	Lead Pharmacist (MRU) Operational		√	√	√	√	X	√	√	√	A			
Georgina Randall (GR)	Senior Pharmacy Technician - MRU		√	√	√	√	X	√	√	√	√			
	In attendance													
Ozma Tahir	Deputy Chief Pharmacist – Surrey & Borders Partnership NHS Foundation Trust (for matters arising)										√			
Rachel Claridge	Lead Pharmacy Technician – Primary Care – Surrey Heartlands										√			
Jayesh Shah	Lead Primary Care Pharmacist for Mental Health – Surrey Heartlands										√			
Jesny Babu	Pharmacist Surrey & Sussex Healthcare NHS Trust										√			

Item No.	Discussions and New Actions
1	<p>Introduction The chair welcomed members, presenters and all observers to the APC</p>
2	<p>Quorum The chair noted that the meeting was quorate</p>
3	<p>Declarations of Interest Members were asked if there were any declarations of interest for the agenda items that had not already been declared. One member declared a non-financial personal interest as a member of the National Eczema Society for the emollient guidelines.</p>
4	<p>Minutes from previous meeting The APC secretary did not have a quorate response from the APC membership to check the accuracy of the APC minutes from August and so the final draft minutes from August needed to be ratified by the members at the meeting. These were all agreed as presented.</p> <p>Matters Arising Anti-Psychotics – Impact of decision to change length of prescribing by SABPFT prescribers from 1 month to 3 months. At the July 2025 APC the formulary status of oral antipsychotics was changed from BLUE on specialist initiation with stabilisation by a SABP specialist for a minimum of 1 month transfer of prescribing responsibility to stabilisation by a SABP specialist for a minimum of 3 months before transfer of prescribing responsibility At the time of the decision the impact of this change had not been fully assessed by SABP colleagues and therefore did not inform the decision-making process. The SABPFT leads have since received feedback from operational colleagues that this change is causing significant financial and operational pressure within community teams. The members considered the proposed change and agreed with SABPFT colleagues that there should be at least 1 month prescribing by the specialist team and that the patient should be stabilised on treatment prior to transfer of care. it was noted that GPs must be notified of stabilisation when the request is made. Primary Care colleagues were in agreement that where a stabilised patient requires a simple, non-complex and non-urgent dose adjustment this can be managed in primary care on recommendation by the specialist team. The JF will be amended to reflect the new decision, and this change will be communicated through the APC webinar and in the new additions page on the Joint Formulary.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed to change the length of prescribing of anti-psychotics by the specialist team at Surrey & Borders Partnership NHS Foundation Trust to:</p> <ul style="list-style-type: none"> • BLUE (on specialist initiation) with specialists prescribing anti-psychotics for at least 1 month and until the patient is stabilised on treatment prior to transfer of care to primary care. <p>Where a stabilised patient requires a simple, non-complex and non-urgent dose adjustment can be managed in primary care on recommendation by the specialist team.</p> </div> <p>ACTION:</p> <ul style="list-style-type: none"> • Amend JF to reflect new decision made (PAD admin)
5	<p>Action log The members were informed of updates to the following actions:</p> <p>Somapacitan treatment for Growth Failure – Shared Care</p> <ul style="list-style-type: none"> • On agenda for discussion at September APC

Item No.	Discussions and New Actions
	<p>ACTION CLOSED</p> <p>GnRH agonists discussions with Primary Care</p> <ul style="list-style-type: none"> Discussions are ongoing and a potential solution will be communicated to the APC post meeting. <p>ACTIONS TO REMAIN OPEN</p> <p>POST MEETING NOTE:</p> <p>A potential solution has been discussed and agreed. The LCS is being updated to reflect the agreement and the JF will be updated accordingly, when arrangements are finalised, in accordance with previously agreed traffic light status.</p> <ul style="list-style-type: none"> GnRH agonists use in Breast Cancer (agreed in principle in September 2023) <ul style="list-style-type: none"> BLUE (with specialist initiation) Specialists will prescribe and administer the first injection prior to transfer of care. GnRH agonists use in Endometriosis (agreed in principle in July 2025) <ul style="list-style-type: none"> BLUE (with specialist initiation) Specialists will prescribe and administer the first injection prior to transfer of care.
6	<p>Medicines safety highlight report</p> <p>Head of Medicines Safety shared a highlight report with the members, prior to the meeting and this was noted by the membership</p> <p>Aide Memoire – Adrenaline auto-injector (review)</p> <p>The APC members were presented with a reviewed aide memoir with the following amendments made</p> <ul style="list-style-type: none"> Emerade has been discontinued so has been removed from the aide memoire. The dosing advice for Jext has been updated in the British National Formulary (BNF) stating that the dose for patients over 25kg is 300micrograms. This is different to the licensed dose in the Specific Product Characteristics (SPC) which states that patients over 30kg should use the 300microgram autoinjector. But is in line with other adrenaline autoinjectors. <p>It was agreed after consultation with GP prescribing leads that the BNF dosing advice should be followed for Jext in line with national guidance. This will in turn reduce the confusion around the dosing for the adrenaline autoinjectors for prescribers.</p> <p>It was noted that these are unlicensed doses and so there would need to be a conversation with the patient and that conversation should be clearly documented in patients notes.</p> <p>A minor amendment was requested in the labelling instructions on the aide memoir which made reference to 30kg rather than 25kg. It was agreed this would be amended prior to PAD upload.</p> <div data-bbox="264 1473 1544 1541" style="border: 1px solid black; background-color: #f9e79f; padding: 5px;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the updated Aide Memoire for adrenaline auto-injectors</p> </div> <p>ACTION:</p> <ul style="list-style-type: none"> Upload to PAD for reference (PAD admin) Remove old aide memoire (PAD admin)
7	<p>NICE Guidance</p> <p>The APC noted the NICE guidance published since the last APC.</p>
8	<p>Urgent AOB: None to note</p>
9	<p>Horizon scanning and formulary updates</p> <p>A new standing agenda item for the APC will be to update members on recent new formulations that maybe considered more cost effective than current agreed formulations on the Joint formulary. These are discussed at the MOOG prior to APC as part of a horizon scanning process.</p> <p>The following treatments were presented for agreement as follows:</p>

Item No.	Discussions and New Actions
	<p>Rosuvastatin</p> <ul style="list-style-type: none"> • Tablets already on the formulary with a green traffic light status • Capsules now available that are more costly. • A NON-FORMULARY traffic light status was proposed and agreed for the capsule formulation. <p>Estradiol gel</p> <ul style="list-style-type: none"> • New indication for the prevention of postmenopausal osteoporosis. APC were asked to agree to add the gel as an option for this indication now that it has been licensed. • It was proposed that the same restriction be applied to the gel for this indication as for menopausal symptoms where the gel would be an option if estradiol tablets are not suitable. • Members considered the place in therapy for estradiol (all formulations) for the prevention of postmenopausal osteoporosis, and it was agreed that they would need to be reviewed for consideration by APC. • It was noted, that at the MOOG, the decision had been made to remove the osteoporosis guidance from the PAD and link prescribers to the Clinical Knowledge Summaries (CKS) for osteoporosis and the National Osteoporosis Guideline Group (NOGG). It was agreed that the place in therapy for estradiol within CKS & NOGG should also be considered as part of the review process • Also agreed was the need for some training and guidance for prescribers in relation to the use of HRT for the prevention of postmenopausal osteoporosis. • It was agreed by APC that the estradiol gel would be added to the JF alongside the tablets and patches whilst the place in therapy for estradiol was reviewed <p>ACTION:</p> <ul style="list-style-type: none"> • Upload formulations to JF as proposed (PAD admin) • Place in therapy of estradiol for prevention postmenopausal osteoporosis to be reviewed and discussed at MOOG for next steps to include consideration for training and comms strategy (MRU)
10	<p>Dapagliflozin patent expiry.</p> <p>Members were informed that now dapagliflozin has lost its patent to capitalise on the potential savings it is proposed to make dapagliflozin the preferred SGLT-2 inhibitor in Surrey Heartlands for type 2 diabetes, heart failure and chronic kidney disease.</p> <p>As a consequence of this proposal the APC were asked to agree to remove the type 2 diabetes guidance from the PAD as new guidance from NICE is expected soon and the guidance on the PAD is now out of date. Also proposed was the removal of a preferred product choice document from PAD which is not needed now that the Joint Formulary has been launched.</p> <p>The members noted that there will be engagement with secondary care re the opportunity for switching patients to dapagliflozin and there is a potential for a payment for work done scheme in primary care.</p> <p>There are significant savings to be made from the agreement to use dapagliflozin as the preferred SGLT-2 treatment and no evidence to suggest any treatment is superior to another and so the APC agreed with the proposals as presented.</p> <div data-bbox="264 1848 1544 1951" style="border: 1px solid black; padding: 5px;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed that dapagliflozin will be the preferred SGLT-2 inhibitor in type 2 diabetes, Chronic Kidney Disease and Heart Failure.</p> </div> <p>ACTION:</p>

Item No.	Discussions and New Actions
	<ul style="list-style-type: none"> • Update JF with preferred option (PAD admin) • Remove type 2 diabetes guidance from PAD (PAD admin) • Remove preferred choice paper from PAD (PAD admin)
11	<p>Melatonin (Slenyto®) – modified release tablets for sleep disorders in children and adolescents</p> <p>The APC were asked to agree to publish the profile on the Joint Formulary for this treatment for this indication. A NON-FORMULARY decision had been made in 2019 for sleep disorders in children and adolescents, by the APC but the profile had not been published because of the review of melatonin prescribing as a whole, and this was causing some confusion in primary care. It was noted that Slenyto® has some new licensed indications and the review for those indications will continue</p> <p>The APC agreed to publish the profile as proposed</p> <p>ACTION</p> <ul style="list-style-type: none"> • Publish melatonin (Slenyto®) profile on JF (PAD admin)
12	<p>Emollient formulary & prescribing guidance</p> <p>A review has taken place of the emollient treatments in the Surrey Heartlands emollient prescribing guidance. All treatments (except aqueous cream) will be GREEN in primary care, on the JF with narrative/restrictions where appropriate. The formulary will give advice to prescribers on 1st and 2nd line treatment choices and the indication will be dry skin conditions. Optimise RX will be utilised to promote the 1st line preferred choices and the cost-effective options, at the point of prescribing</p> <p>It was noted that the local trusts will be unable to stock all items but they are all undertaking a review of products to consider alignment with the formulary.</p> <p>The prescribing guidance will be uploaded to the PAD to provide prescribers with information on using emollients and product choices.</p> <p>A review of products containing cetostearyl alcohol will be undertaken prior to JF upload and a link to the MHRA/Aspire safety alert will be added as appropriate</p> <p>The APC members agreed the traffic light statuses for the emollients as presented and they also agreed to amend the review date of the cost-effective prescribing recommendations, the emollient guidance and the summary guidance as proposed</p> <p>ACTION</p> <ul style="list-style-type: none"> • Upload emollients to JF as proposed (PAD admin) • Review products containing cetostearyl alcohol and upload MHRA/aspire link to JF (PAD admin) • Upload prescribing recommendations, guidance and summary to PAD (PAD admin) • Remove current prescribing recommendations, guideline and summary from PAD (PAD admin)
13	<p>Cinacalcet in Primary Hyperparathyroidism</p> <p>In 2016 NHS England published a commissioning policy for cinacalcet use in complex primary hyperparathyroidism. At that time cinacalcet was a medicine that was excluded from the national tariff.</p> <p>In 2019 the price of cinacalcet dropped and NICE published a guideline: Hyperparathyroidism (primary): diagnosis, assessment and initial management. In April 2019, cinacalcet was removed from the excluded medicines list and went back into the medicines tariff.</p> <p>The NHS England commissioning policy highlighted, in a pathway, that cinacalcet should only be initiated with approval by a nominated lead clinician at a specialised endocrinology centre. In</p>

Item No.	Discussions and New Actions
	<p>Surrey Heartlands that centre is Royal Surrey NHS Foundation Trust. On a review of the prescribing data from the local trusts in Surrey, it was clear that patients were being seen across Surrey in all local hospitals.</p> <p>Earlier this year in discussion with NHS England colleagues, the 2016 NHS England commissioning policy was withdrawn and with the support of colleagues in endocrinology across Surrey a paper was presented to the APC to propose a BLUE (on specialist initiation) traffic light status with prescribing of cinacalcet being transferred to primary care after dose optimisation (which can take up to 16 weeks).</p> <p>An information sheet was presented to give prescribers information on their responsibilities for monitoring and particularly the monitoring of serum calcium.</p> <p>It was agreed that the reference ranges from local laboratories would be used as parameters for further advice from specialists because there may be local differences in adjusted serum calcium levels.</p> <p>A DXA scan is recommended every 2 years dependant on specialist advice, in line with the CKS for Hypercalcaemia, and that will be added to the information sheet for reference</p> <p>It was highlighted by APC that there will be patients being prescribed cinacalcet for primary hyperparathyroidism in local hospitals and that as the prescribing is transferred to primary care there should be clear information about the dose to be prescribed and the frequency of monitoring of serum calcium and patients should be transferred with at least 1 month supply of cinacalcet to enable the smooth transfer of prescribing.</p> <p>The APC members agreed the traffic light status as proposed. The BLUE information sheet will be circulated as a final draft to members for any further comments prior to PAD upload</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed a BLUE (on specialist team initiation) traffic light status for cinacalcet prescribing for Primary Hyperparathyroidism. Cinacalcet will be initiated by the specialists and prescribing will be transferred to primary care after dose optimisation.</p> <p>Patients already established on cinacalcet treatment can be transferred to primary care following their next routine clinic appointment with at least 1 month supply of cinacalcet to enable a smooth transfer. The primary care prescriber should be provided with the dose to be prescribed and the frequency of serum calcium monitoring in all cases.</p> </div> <p>ACTION:</p> <ul style="list-style-type: none"> • Circulate BLUE information sheet to APC members for final comments (CJ) • Add briefing and BLUE information sheet to PAD for reference (PAD admin)
14	<p>Sparsentan for treating primary IgA nephropathy NICE TA1074</p> <p>The APC members considered the implementation of this NICE guidance with reference to the APC decision making framework.</p> <p>NICE recommend that sparsentan should be used as a 1st line therapy for this indication, with targeted release budesonide an alternative option after sparsentan has failed.</p> <p>It was noted that sparsentan will be on formulary at hospitals providing renal services only, which in this area would likely be Epsom, Frimley & Brighton hospitals.</p>

Item No.	Discussions and New Actions
	<p>Sparsentan is a treatment this is excluded from the national tariff and therefore blueteq will be used by the renal teams to notify the ICBs of initiation in line with NICE guidance.</p> <p>With the level of discount against list price made available to the NHS and the limited patients numbers expected, the cost of this medicine in Surrey Heartlands is not expected to exceed the threshold of £100,000 within each individual Place.</p> <p>A RED traffic light status was proposed and agreed by the APC members for this treatment for primary IgA nephropathy in line with NICE TA1074</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed implementation of sparsentan for treating primary IgA nephropathy in line with NICE TA 1074</p> <p>Sparsentan for this indication will be considered as RED on the Joint Formulary with treatment initiation and continued prescribing by specialists in renal services</p> <p>Primary care prescribers should be aware that their patient is receiving this medicine and ensure that this is recorded on the patient's medication screen as a hospital-only drug in line with guidance on the PAD.</p> <p>This will also alert the prescriber to potential side effects and interactions with other medicines prescribed in primary care. It will also ensure that GP records, which are accessed by other healthcare providers, are a true and accurate reflection of the patient's medication.</p> <p>ACTION:</p> <ul style="list-style-type: none"> • Upload briefing and weblink to NICE guidance to the PAD for reference (PAD admin) • Add sparsentan for this indication to JF for reference (PAD admin)
15	<p>Review of Human Growth Hormone use in Paediatrics - shared care document</p> <p>In July 2025, the APC agreed the implementation of NICE TA1066 for somapacitan for treating growth hormone deficiency. An AMBER traffic light status was agreed, and the current shared care documents were reviewed to include somapacitan.</p> <p>The APC agreed the reviewed shared care document as presented.</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed the reviewed and updated Shared Care document for Growth Hormone treatment for Growth Failure in paediatric patients.</p> <p>ACTION:</p> <ul style="list-style-type: none"> • Add reviewed shared care to PAD (PAD admin) • Remove current shared care from PAD (PAD admin)
16	<p>Linzagolix for endometriosis (NICE TA1067)</p> <p>The APC members considered the implementation of this NICE guidance with reference to the APC decision making framework.</p> <p>Linzagolix is another GnRH antagonist which is only recommended by NICE when used with hormonal Add Back Therapy (ABT). Its comparator is Ryeqo®, which contains relugolix, estradiol and norethisterone acetate as a combined oral treatment). Comments received during consultation had highlighted that this treatment would be useful for patients unable to take oral estradiol, and other formulations of estradiol could be used for the ABT.</p>

Item No.	Discussions and New Actions
	<p>It was noted that a DXA scan is needed at 52 weeks and that this would be organised by the specialist teams. Information would be added to the JF to remind prescribers of this recommendation from the SPC.</p> <p>The of linzagolix (combined with ABT) is not expected to exceed the threshold of £100,000 within each individual Place.</p> <p>A BLUE (following specialist team initiation) traffic light status was proposed with specialists expected to prescribe a minimum of 1 month of linzagolix before requesting transfer of care to the primary care prescriber. This proposal was agreed by the APC members in line with NICE TA1067</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed implementation of linzagolix for treating the symptoms of endometriosis in line with NICE TA1067.</p> <p>Linzagolix for this indication will be considered as BLUE (following specialist team initiation) on the traffic light system. Specialist will be expected to prescribe a minimum of 1 month of linzagolix before requesting transfer of care to the primary care prescriber.</p> <p>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</p> </div> <p>ACTION:</p> <ul style="list-style-type: none"> • Upload briefing and weblink to NICE guidance to the PAD for reference (PAD admin) • Add linzagolix for this indication to JF for reference (PAD admin)
17	<p>Nemolizumab for treating severe atopic dermatitis (NICE TA1077)</p> <p>The APC members considered the implementation of this NICE guidance with reference to the APC decision making framework.</p> <p>Nemolizumab is a new mode of action for this treatment pathway which would add another line of treatment available to patients. It was noted that treatment with nemolizumab for treating severe atopic dermatitis in adolescents (12 to 17 years) would be commissioned by NHS England.</p> <p>It was highlighted by the lead author that patients would need training on preparation and administration prior to initiation. The device requires the users to dissolve the nemolizumab in water prior to initiation which could cause issues for patients with dexterity issues.</p> <p>With the PAS price the financial impact of nemolizumab is not expected to exceed £100,000 per place.</p> <p>An Atopic Dermatitis treatment pathway is being developed by SERMOG and will be presented to the APC in due course</p> <p>Nemolizumab is a treatment this is excluded from the national tariff and therefore blueteq will be used by the dermatology teams to notify the ICBs of initiation in line with NICE guidance.</p> <p>A RED traffic light status was proposed and agreed by the APC members for treating severe atopic dermatitis in line with NICE TA1077</p>

Item No.	Discussions and New Actions
	<p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed implementation of nemolizumab for treating severe atopic dermatitis in adults (18 years and over) in line with NICE TA1077</p> <p>Nemolizumab for this indication will be considered as RED on the Joint Formulary with treatment initiation and continued prescribing by specialists in dermatology</p> <p>Primary care prescribers should be aware that their patient is receiving this medicine and ensure that this is recorded on the patient's medication screen as a hospital-only drug in line with guidance on the PAD.</p> <p>This will also alert the prescriber to potential side effects and interactions with other medicines prescribed in primary care. It will also ensure that GP records, which are accessed by other healthcare providers, are a true and accurate reflection of the patient's medication.</p> <p>ACTION:</p> <ul style="list-style-type: none"> • Upload briefing and weblink to NICE guidance to the PAD for reference (PAD admin) • Add nemolizumab for this indication to JF for reference (PAD admin)
18	<p>Mirkizumab for treating Crohn's Disease (NICE TA1080)</p> <p>The APC members considered the implementation of this NICE guidance with reference to the APC decision making framework.</p> <p>It was noted that mirikizumab is already recommended by NICE for use in Ulcerative Colitis and is another IL23 alongside risankizumab for use in treating Crohn's Disease.</p> <p>It was highlighted that with the discounted price the financial impact of mirikizumab is not expected to exceed £100,000 per place.</p> <p>Mirikizumab is a treatment that is excluded from the national tariff and therefore blueteq will be used by the gastroenterology teams to notify the ICBs of initiation in line with NICE guidance.</p> <p>A RED traffic light status was proposed and agreed by the APC members for treating Crohn's Disease in line with NICE TA1080</p> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed implementation of mirikizumab for treating Crohn's Disease in line with NICE TA1080</p> <p>Mirikizumab for this indication will be considered as RED on the Joint Formulary with treatment initiation and continued prescribing by specialists in gastroenterology.</p> <p>Primary care prescribers should be aware that their patient is receiving this medicine and ensure that this is recorded on the patient's medication screen as a hospital-only drug in line with guidance on the PAD.</p> <p>This will also alert the prescriber to potential side effects and interactions with other medicines prescribed in primary care. It will also ensure that GP records, which are accessed by other healthcare providers, are a true and accurate reflection of the patient's medication.</p> <p>ACTION:</p> <ul style="list-style-type: none"> • Upload briefing and weblink to NICE guidance to the PAD for reference (PAD admin) • Add mirikizumab for this indication to JF for reference (PAD admin)

Item No.	Discussions and New Actions
19	<p>SERMOG Migraine pathway</p> <p>The South-East Regional Medicines Optimisation Group (SERMOG) have developed a regional Migraine pathway for the use of anti-CGRP and botulinum toxin type A for migraine prevention. The most significant differences between the current Surrey Heartlands Migraine pathway and the new regional pathway were noted by the members. These include:</p> <ul style="list-style-type: none"> • Extending the NICE recommendation for erenumab, allowing the use of the lower dose (70mg) when the clinician feels it would be beneficial for the patient as this gives an additional treatment option without cost pressure. • One switch is now recommended between the NICE recommended anti-CGRP treatments (6 treatments in total - 2 different mechanisms of action) where a switch is recommended for inadequate response. <p>The APC approved SERMOG 08 Migraine pathway for use by local specialists. It was noted that all anti-CGRP medications have a RED traffic light status on the JF already, for migraine prevention.</p> <div data-bbox="264 819 1544 922" style="border: 1px solid black; background-color: #f4b084; padding: 5px;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed SERMOG-08 Migraine pathway</p> </div> <p>ACTION:</p> <ul style="list-style-type: none"> • Upload SERMOG-08 to Migraine prevention guidelines page (PAD admin) • Remove current migraine pathway from guidelines page (PAD admin)
20	<p>SERMOG Psoriatic Arthritis pathway</p> <p>The South-East Regional Medicines Optimisation Group (SERMOG) have developed a regional Psoriatic Arthritis high cost immunomodulator treatment pathway. The pathway has been developed based on the current Surrey Heartlands pathway as it includes all NICE recommended treatments and there is not considerable variation from the NICE recommended treatments and the dosing schedules. The APC approved SERMOG 09 Psoriatic Arthritis high cost Immunomodulator pathway for use by local specialists. It was noted that all high cost immunomodulators have a RED traffic light status on the JF already, for Psoriatic Arthritis</p> <div data-bbox="264 1435 1544 1538" style="border: 1px solid black; background-color: #f4b084; padding: 5px;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed SERMOG-09 high-cost immunomodulatory drugs for psoriatic arthritis.</p> </div> <p>ACTION:</p> <ul style="list-style-type: none"> • Develop a guidelines page for Psoriatic Arthritis on PAD (PAD admin) • Upload SERMOG-09 to Psoriatic Arthritis guidelines page (PAD admin) • Remove current Psoriatic Arthritis pathway from all individual drug profile pages (PAD admin)

Item No.	Discussions and New Actions
21	<p>Spesolimab for Generalised Pustular Psoriasis flares (NICE TA1070) The APC members considered the implementation of this NICE guidance with reference to the APC decision making framework. It was noted by APC that there are no licensed treatments and no specific guidelines in the UK for GPP flares. Spesolimab is licensed for use in adolescents, but NICE have not made a recommendation for that age group. With the PAS price the financial impact of spesolimab is not expected to exceed £100,000 per place.</p> <p>Spesolimab is a treatment that is excluded from the national tariff and therefore blueteq will be used by the dermatology teams to notify the ICBs of initiation in line with NICE guidance.</p> <p>A RED traffic light status was proposed and agreed by the APC members for treating GPP in line with NICE TA1070</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>The Surrey Heartlands Integrated Care System Area Prescribing Committee has agreed implementation of spesolimab for Generalised Pustular Psoriasis in line with NICE TA1070</p> <p>Spesolimab for this indication will be considered as RED on the Joint Formulary with treatment initiation and continued prescribing by specialists in dermatology.</p> <p>Primary care prescribers should be aware that their patient is receiving this medicine and ensure that this is recorded on the patient's medication screen as a hospital-only drug in line with guidance on the PAD.</p> <p>This will also alert the prescriber to potential side effects and interactions with other medicines prescribed in primary care. It will also ensure that GP records, which are accessed by other healthcare providers, are a true and accurate reflection of the patient's medication.</p> </div> <p>ACTION:</p> <ul style="list-style-type: none"> • Upload briefing and weblink to NICE guidance to the PAD for reference (PAD admin) • Add spesolimab for this indication to JF for reference (PAD admin)
22	<p>PAD holding statements The PAD holding statements were noted and agreed as presented. Also agreed was the proposal to remove items from the joint formulary because of product discontinuations. The Joint Formulary lead requested confirmation from the APC to remove Freestyle Libre 2 from the joint formulary because it has been or will be discontinued imminently. It was also proposed to add a newsfeed article to the JF to provide information to users about the product discontinuation. This was agreed as proposed.</p>
23	<p>AOB</p> <p>Appeal for daridorexant was not upheld</p> <ul style="list-style-type: none"> • APC noted that appeal for daridorexant had been held, as per process in August 2025 • Appeal was not upheld and lead authors had been contacted <p>Genomic testing – Clopidogrel</p> <ul style="list-style-type: none"> • APC secretary shared a communication from NHS England providing an update on CYP2C19-clopidogrel testing.

Item No.	Discussions and New Actions
	<ul style="list-style-type: none"> NHS England confirmed that information from the pilot has informed the implementation of routine commissioning and setting out an approach to national testing for the future remains a priority. However, within the current financial year, it has not been possible to identify the necessary recurrent headroom in revenue budgets to support the funding of this testing for the indicated population. This position is being kept under active review and takes into account the need to maintain all existing services for patients across the specialised commissioning portfolio, such as the delivery of all other routinely delivered genomic tests by the NHS Genomic Medicine Service.
	Summary of decisions made:
Future meeting dates: (2.30pm to 5pm) via Microsoft teams calls <ul style="list-style-type: none"> Wednesday 1st October 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)	