MINUTE of meeting of the Formulary Subgroup (FS) of NHS Highland ADTC  
24 March 2015, Board Room, John Dewar Building, Inverness

Present:  
Okain McLennan, Chair  
Evelyn Cromarty, Formulary Pharmacist  
Lindsay Barr, Locality Pharmacist, Lorn & the Isles (by VC)  
Susan Caldwell, Senior Pharmacist, Medicines Management & Information  
Dr Borja Echavarren, GP  
Findlay Hickey, Lead Pharmacist (West) (by VC)  
Dr Stephen McCabe, GP (by VC, until 13:25)  
Dr Robert Peel, Consultant Nephrologist (by VC)  
Johnson Swinton, Patient Representative  
Archie Vallance, Raigmore Hospital Patients’ Council Representative  
Dr Jude Watmough, GP  
Dr Jason Davies, Consultant Anaesthetist (by VC for Item 7)  
Dr John Macleod, Consultant Anaesthetist (by VC for Item 7)

In attendance:  
Roberta Kerr, Formulary Assistant  
Nicola Bett, Pre-registration Pharmacist, Raigmore Hospital (Observing)  
Amy Brotherton, Pharmacy Student (Observing)  
Spenser Harris, Pharmacy Student (Observing)

Apologies:  

1. WELCOME AND APOLOGIES  
   • Introductions were made for the benefit of observers Nicola Bett, Amy Brotherton and Spenser Harris.

2. MINUTES OF MEETING ON 27 JANUARY 2015  
   • Minutes were approved as accurate subject to the correction of a typographical error.

3. FOLLOW-UP REPORT ON ACTIONS AGREED ON 27 JANUARY 2015  

   Stoma Formulary  
   • Implementation of a Stoma Formulary for Argyll & Bute (A&B) needs to be taken forward.  
   • There are no stoma nurses in A&B therefore there is a question of how to progress this.  
   • A service is provided by Greater Glasgow & Clyde (GGC) which has a wider range of products.  
   • EC suggested taking this issue back to the North Highland stoma nurses and asking them to liaise with GGC stoma nurses. The Chair agreed.

   Progressive bone disease  
   • There has been no response from the Cancer Centre. It was agreed that EC would follow this up.

   Diazepam  
   • Information has come back from New Craigs hospital. Their first choice benzodiazepine is chlordiazepoxide.  
   • New Craigs only use diazepam in the hospital setting, not in the community.  
   • SM was concerned about use of 2 drugs for the same indication and could not see the logic of using diazepam.  
   • SC said that it has better efficacy in use for seizures, but SM felt that an anticonvulsant should be used in those cases. The Chair felt that this was a valid point and that the question had not been answered yet.  
   • SC said that evidence still needed to be examined and that there were also cost issues to be considered—chlordiazepoxide is twice as expensive as diazepam.
• RP felt that diazepam use in Raigmore was confined to patients more at risk of seizures but shared SM's concerns. He felt that it was not a drug of abuse in the secondary care setting.
• SM did not have a problem with its use solely in secondary care but would be happy if there were clear restrictions. RP and SC would support this.
• The Chair suggested covering this issue in a Pink One article.

Action:
Follow up enquiry with Cancer Centre EC
Amend benzodiazepine guidance EC
Pink One article on benzodiazepines EC

4. DECLARATIONS OF INTEREST
• FH declared a personal interest in Eli Lilly and Company Ltd (pemetrexed).

5. CONSIDER FOR APPROVAL ADDITIONS TO FORMULARY

a) Perampanel tablets 2mg, 4mg, 6mg, 8mg, 10mg, 12mg (Fycompa®)
• New licensed medicine accepted by SMC with a Patient Access Scheme (PAS) therefore cost-effectiveness is within acceptable limits.
• Requested by Consultant Neurologist Dr Carod Artal as part of chapter review.
• For specialist use only in a small number of patients within PAS scheme.
• ACCEPTED.

b) Eslicarbazepine tablets 800mg (Zebinex®)
• New licensed medicine accepted by SMC with a Patient Access Scheme (PAS) therefore cost-effectiveness is within acceptable limits.
• Requested by Consultant Neurologist Dr Carod Artal as part of chapter review.
• For specialist use only in a small number of patients within PAS scheme, specialist use only.
• ACCEPTED.

c) Insuman® Basal, Insuman® Rapid, Insuman® Comb
• Licensed medicines, have been available for many years, pre-SMC.
• Cost-effective alternative to newer insulins.
• Diabetes review group agreed to move to Insuman® for patients with type 2 diabetes.
• Guidance on insulins in Type 1 diabetes is deferred until NICE guidance is published in August 2015.
• The Chair was concerned that the submission forms were not fully completed and would like to ensure that this is done in future.
• RP asked whether there was a way to emphasise Insuman® within the text of the chapter, eg a first choice box? EC said that the chapter introduction covered this but that a first choice box could be added.
• ACCEPTED.

Action:
Add first choice box for Insuman® EC

d) Stribild® tablets (elvitegravir 150mg, cobicistat 150mg, emtricitabine 200mg, tenofovir disproxil (as fumarate) 235mg)
• New licensed product.
• Combination of 2 antiretrovirals already on the Formulary.
• Accepted with a PAS for use in line with SMC advice.
• Will be used on 2 to 3 patients per year, small cost saving.
• FH was not convinced of the advantages as it was not shown to be any better and was more expensive than Atripla® at face value. The sole reason for its license is for use in treatment-naive patients, he could not see any benefit otherwise.
• The Chair added that the submission form shows a cost saving. FH said that it did not specify the PAS details. RP explained that this is because they are commercially sensitive and cannot be included in the detailed advice document (DAD), however IR had included the figures on the submission form.
• The Chair would be mindful to accept it, but that FH's concerns would be recorded.
• ACCEPTED.
e) Ulipristal tablets 5mg (Esmya®)
• Licensed medicine. 30mg tablet already on Formulary in section 7.3.
• 5mg tablet will be for specialist use only in moderate to severe symptoms of uterine fibroids and will avoid
  the necessity for injections at clinics.
• Approximately 700 patients per year.
• ACCEPTED subject to receipt of signed submission form and Declaration of Interest.

Action:
Follow up signed submission form EC

f) Vesomni® (tamsulosin 400 micrograms, solifenacine 6mg)
• New licensed product – combination of solifenacine and tamsulosin.
• Cost-effective alternative for patients who are stable on both.
• Not all urologists support its inclusion as adjusting dosage can be harder with a combination drug and
  solifenacine goes off-patent in 2018.
• SM felt that it should not be included in the Formulary without unanimous support. RP agreed and said
  that he would not support it as he had concerns about side-effects of solifenacin.
• It was agreed to reject the submission.

g) Adalimumab (Humira®)
• Unlicensed indication for licensed Formulary medicine (off-label use).
• For inclusion in Highland Unlicensed/Off-label Medicines List.
• Already on the Formulary for inflammatory bowel disease and rheumatic disease.
• Use off-label in eye disease within national guidelines and requires approval via non-Formulary process.
• Dr David Knight has requested addition to Unlicensed Medicines list to reduce paperwork.
• Risk of reactivation of latent tuberculosis noted.
• Currently in specialist use for 4 patients.
• RP felt that it was an expensive drug for off-label use.
• FH said that there were problems with licensing issues. The IPTR process is time consuming for 4
  patients.
• ACCEPTED.

h) Dexamethasone intravitreal implant (Ozurdex®)
• New indication for licensed Formulary medicine.
• Indication not recommended by SMC due to non-submission.
• Formulary inclusion for this indication requested by IPTR panel, for use in a small sub-set of patients in
  Highland.
• SC pointed out that this was similar to the previous IPTR submissions – it has gone through the IPTR
  process a few times with positive evidence.
• AV felt that the numbers were not good and asked whether the IPTR process was difficult for patients.
• SC confirmed that IPTR process is time consuming and involves delays and a lot of senior staff time.
• AV replied that he was in favour of patients getting drugs as soon as possible.
• The Chair commented that he would prefer a proper submission process from a protocol point of view.
• ACCEPTED.

Action:
Request a signed submission form from Dr Knight and circulate to Subgroup EC

i) Everolimus (Afinitor®)
• New licensed medicine approved by SMC for renal cell carcinoma.
• Signed form and Declaration of Interest has been received from Dr Neil McPhail.
• ACCEPTED.

j) Cetuximab (Erbitux®)
• New indication for licensed Formulary medicine, already on the Formulary for use in colorectal cancer.
• Accepted by SMC.
• The Chair felt that if it has been accepted by SMC then the Subgroup cannot turn it down, despite cost.
• JS asked about the cost – the drug would be used in 5 to 7 patients yearly.
k) Pemetrexed (Alimta®)
- New indication for licensed Formulary medicine. Accepted by SMC.
- ACCEPTED.

Formulary submission forms
- The Chair expressed concern about financial information not being given in submission forms.
- He felt that it was in NHS Highland’s best interests to show that displaced costs were being saved.
- EC reported that discussions are underway with the Finance Department and will follow this up.

Action:
Follow up on discussions with Finance Department

EC

6. UPDATED AND NEW SECTIONS AND GUIDANCE

a) Chapter 2, Cardiovascular guidance

Anticoagulant switching
- Apixaban was added to the Formulary in January 2015.
- Anticoagulant guidance has been updated – EC thanked SC for her input.
- There is draft guidance for different indications.
- Guidance has been approved by Dr Joanne Craig, Consultant Haematologist.
- RP suggested that headings on the table should be carried over to the following page.

Action:
Adjust table headings

RK

b) Part of Section 4.2 Drugs used in bipolar disorder
- Updated following a suggestion at the neurology chapter review that advice on bipolar disorder should also be updated.
- Approved by Dr Nikki Thomson, Consultant Psychiatrist.
- There was a discussion about side-effects of lithium in pregnancy but SC suggested that there was no point in flagging this up as the same cautions applied to all drugs in pregnancy.

c) Neurology review

Part of Section 4.7 Antimigraine drugs

Section 4.8 Antiepileptics
- GP input was provided by Dr Malcolm MacRae and Consultant input from Dr Francisco Javier Carod Artal.
- Dr Carod Artal requested addition of retigabine and rufinamide but submission forms are outstanding.
- EC is also waiting for a submission form for flunarizine.
- In section 4.8 the MHRA box needs to be updated in line with BNF information.
- There was a discussion about evidence for propranolol in migraine. It is licensed for migraine prophylaxis at a low dose.

Action:
Follow up retigabine/rufinamide submission forms
Remove reference to flunarizine from section in meantime
Check BNF for information on propranolol in migraine prophylaxis

EC
EC/RK
EC

d) Chapter 5 Infections
- Gentamicin and vancomycin policies are on the intranet only, and have been updated in line with national guidance.
- Small changes have been made to the Skin/soft-tissue infections section of ‘Management of infection’ guidance.
- Changes to the Urinary-tract infections section have been approved by urologists.
• SC highlighted an error in the ‘Vancomycin concentration’ section of the vancomycin flow diagram (>20mg/L not >15mg/L).
• RP was concerned about gentamicin side-effects and suggested rounding down doses to the nearest 40mg as it comes in 40mg ampoules. He was also concerned about the potential for nephrotoxicity and pointed out that oliguria is not a sign of gentamicin toxicity.
• Other than these suggested changes the amendments were approved.

Action:
Clarity suggested revisions with RP

---

**e) Part of Section 6 Drugs used in diabetes**

**Section 6.1 Blood monitoring test strips**

- Some test strips are significantly cheaper.
- Diabetes specialist nurses have identified preferred meters for testing patients with type 2 diabetes who need to test blood glucose. There are savings to be made by changing meters.
- Meters for Type 1 diabetes have also been identified.
- Strips were removed from the text because they are already listed in the table.
- JW suggested listing ‘preferred choice’ for Type 2.
- SM said that people with Type 2 diabetes should not regularly test, unless they are unwell. FH added that some may be affected by DVLA legislation but the majority of Type 2 patients should not need to test. JW suggested that this might be worth highlighting.

- The section amendments were accepted.

---

**7. PROPOSAL TO REVIEW INCLUSION OF PREGABALIN IN THE HIGHLAND FORMULARY FOR USE IN NEUROPATHIC PAIN**

- Previous discussion included Dr John MacLeod (Consultant Anaesthetist, Caithness General Hospital), SM and FH.
- SM has an interest in drug/alcohol issues and is aware of increased misuse of pregabalin.
- He feels that Formulary drugs should be better, cheaper, and safer than existing medicines for a particular condition, and that pregabalin does not tick any of these boxes. He also has concerns about overdose.
- Pregabalin is no more effective than other drugs, giving minimal benefit to only one in seven patients. Gabapentin works in a similar way. There is little human research.
- SM suggested that the Subgroup should consider whether to keep pregabalin in the Formulary for this indication, but would accept the majority view.
- Pregabalin costs £1.6m for a 12-month period: average prescription £81 compared to £10 for gabapentin.
- Number Needed to Treat (NNT) is 5 to 7 for both drugs. Neither has good evidence.
- There are no comparative trials and both are made by the same manufacturer.
- Both have similar side-effects and similar efficacy. Pregabalin allows twice-daily dosing.
- There are public health concerns with pregabalin and to a lesser extent gabapentin: significant euphoric effects and particular risk if used with opioids.
- Removal of pregabalin from the Formulary for neuropathic pain was suggested. There have been inappropriate recommendations from clinicians who are not pain specialists. It should be reserved for patients who have responded to gabapentin but cannot tolerate it due to side-effects. Prescribers are obliged to prescribe it by brand name (Lyrica®) for this indication due to legal requirements of its patent.
- JD said that he did not disagree however many Formulary drugs have diversion potential and have to be prescribed responsibly. Pregabalin in this indication was accepted by SMC for 3rd line use; there is a lack of support for primary care in the form of protocols for its use. A detailed protocol would be useful.
- JM agreed. He felt that there was a confusion of issues. Many agents that are used in pain can be diverted. Many uses of drugs, for example opioids, are unhelpful but clinicians need some tools of pharmacological intervention and pregabalin is helpful. A lot of issues relate to education and training in primary care.
- The Chair asked whether JM would agree with prescribing by pain specialists only. JM replied that this would be difficult as there are only two pain specialists in Highland.
- JW agreed that a protocol would support and guide prescribers.
- The Chair suggested that the Subgroup should think about a protocol for prescribing in primary care and suggested a working group with JM, JD and a couple of GPs. JW suggested including a representative from psychiatry.
• There is a protocol in development based on guidance from Glasgow. FH felt that it would be pharmacologically illogical to give pregabalin to patients unresponsive to gabapentin. He would like stronger limitations and would be comfortable not to have it on the Formulary for this indication.
• JD said that patients who cannot attain a therapeutic dose on gabapentin can tolerate pregabalin.
• FH said that there is a need for clear guidance on how to assess the success of other lines of therapy.
• BE only uses it when gabapentin is not tolerated. His patients seem to tolerate pregabalin better and he felt it was useful to have a third-line.
• JS asked whether discussions include cost aspects. The Chair replied that the main concern is to ensure the best therapy.
• RP suggested that a protocol should emphasise how to stop pregabalin.
• The Chair thanked JM and JD and they left the VC.
• SM asked for it to be recorded that he also requested removal of tramadol from the Formulary.

8. UPDATED AND NEW SECTIONS AND GUIDANCE – Continued

a) Part of Section 9.1 Anaemias and some other blood disorders
• Higher-strength Ferinject® has been added to the Formulary.
• Medicines Information at Raigmore Hospital have had calls seeking advice and a link has been added to the SPC.
• There is information rationalising the range of parenteral irons. The review did not reach consensus on removing any.
• RP suggested additional text to the note box. Iron sucrose is needed but others may be superfluous.
• EC added that use might change, and SC said that it would be good to rationalise options as it is difficult for staff to know which is preferred.
• The Chair indicated that he would like to revisit this item for consensus.

Action:
Review Section 9.1 to reach consensus

b) Part of Chapter 10 Musculoskeletal and joint disease
• Changes have been approved by Dr John Harvie, Consultant Rheumatologist.

‘Non-steroidal anti-inflammatory drugs’ (NSAIDs) guidance
• Advice on NSAIDs was updated in line with Scottish Patient Safety Programme guidance on non-steroidal anti-inflammatory drugs (NSAIDs).
• SC felt that advice on gastroprotection on p2 should not include age over 75 years as this contradicts advice relating to *C. difficile*. JW asked about using ranitidine instead.
• RP noticed an increase in patients with GI bleeds from NSAIDs without gastroprotection and felt that ranitidine has a modest effect.
• RP felt that the risk depends on frailty rather than age, and dose/length of time on NSAID.
• FH suggested that the key issue was not use of PPIs but to try to diminish the use of NSAIDs particularly in elderly/frail patients.
• The Chair requested that this section be reviewed and then circulated round the Subgroup for ratification.

Action:
Review criteria for gastroprotection with NSAIDs

EC

c) Part of Chapter 11 Eye: Section 11.8 Tear deficiency, ocular lubricants and astringents
• Lacrilube® is the most frequently used liquid paraffin preparation but cheaper ones are available that could save £8k annually.
• Dry eye guidance has been updated by Dr Steve Thomson to include lower-cost brands. Dr Thomson would like these included in both sections (preservative and preservative-free) although they are both preservative-free.
• JW commented that there is a lot of choice on the page. Dr Thomson's guidance gives first and second choices and also cost implications of different preparations.
• The Chair asked whether it would be possible to replicate this information in the chapter and EC thought that the table in the guidance could be added.
JW asked why so many devices were listed and SC explained that this is to allow for patient preference and also that there are differences in delivery devices. JW said that some droppers are easier to use than others and EC added that the range of devices is increasing.

**Action:**
Section 11.8 to be reviewed to include guidance on selection  
EC

### 9. MINOR AMENDMENTS TO HIGHLAND FORMULARY

- It is proposed to change oxycodone brands to Shortec® and Longtec® as these new brands are much cheaper but have the same release characteristics and exactly mimic Oxynorm® and Oxycontin®. They come on to the market on 1st April 2015.
- Palliative Care are already moving to branded generics
- JW suggested highlighting this in a Pink One article.
- FH said that this would create significant savings.
- FH also suggested highlighting changes in colecalciferol. Vitamin D guidance is out for consultation with Dr Harvie and EC suggested liaising with Jane Smith (Principal Pharmacist, Medicines Management & Information) on a Pink One article.
- All recommended minor amendments were agreed.

**Action:**
Pink One feature on oxycodone branded generics  
EC/FH
Liaise with Jane Smith re Pink One feature colicalciferol  
EC

### 10. PRINTING OF 6TH EDITION OF HIGHLAND FORMULARY

- The Subgroup needs to decide whether to print the 6th Edition of the Highland Formulary as a hard copy now that the 2-year review of the 5th Edition is complete.
- The 5th Edition was not distributed to junior doctors due to issues with accessing out-of-date editions
- There are some issues with access to the electronic version, but use is increasing.
- JW felt that moving to an electronic-only Formulary seems logical but RP felt that it should be a more user-friendly version and until this was possible then a user-friendly print version might as well be produced.
- LB said that there were access issues around machines and suggested trialling tablets in hospitals.
- FH felt that in light of out-of-date advice being followed, the paper version may need to be sacrificed, but if the Formulary is printed this year, then it should be the last time.
- SC suggested reducing the print run and seeing who wanted a paper copy before printing.
- BE said that he preferred a paper copy.
- The Chair reported that there are still high numbers using the print copy and that this is supported in comments in the User Survey. He is in favour of printing reduced numbers.
- He agreed with looking into the use of tablets in some areas and agreed with FH’s suggested of making the 6th Edition the final paper copy.
- JW felt that if the paper copy was to be discontinued then a user-friendly alternative must be offered.
- EC explained the process with the electronic version. A quote from the company that produced the Glasgow Formulary was at the top end of the Formulary budget but perhaps costs could be reduced this year.
- JW suggested approaching the Endowments Fund and the Chair agreed to seek advice from the Endowments Committee.
- The Chair summarised that the Formulary needs to be printed again in light of comments in the User Survey but that this should be the last paper edition.

**Action:**
Investigate endowment funding  
OM

### 11. Formulary User Survey 2015

- EC is starting to identify issues from the comments received.
- FH suggested that the statistics on Vision would be more useful presented as a percentage of GPs.
- LB suggested doing an electronic survey next time as some users were not happy posting replies. EC confirmed that the next survey will be emailed to users.
- Further discussion was deferred to the May Subgroup meeting.

### 12. NHS Highland Formulary: Formulary Report
EC thanked Tracy Beauchamp, Data Analyst, for an enormous amount of work on the report which is based on quarterly data on primary care prescribing.
Data is also available to practice pharmacists on the PRISMS website.
Further discussion was deferred to the May Subgroup meeting.

13. **Formulary decisions on SMC advice**
- March SMC advice is confidential until 13/04/2015 therefore decisions will not be published until then.

14. **Progress report**
- The Pink One is back in production and the latest issue will be published in 2 to 3 weeks’ time.
- Agreement has been reached with the Central Legal Office.

15. **Matters arising from minute and action plan of previous meeting**
- None.

16. **Any other competent business**
- None.

17. **Date of next meeting**
- Tuesday 26 May 2015, 12:00-14:00. Board Room, John Dewar Building (FH to chair).