South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
19th December, 2pm to 4:30pm (Hybrid meeting, in per via MS Teams)
Final Minutes

1. Welcome, introductions and apologies

The Chair welcomed attendees to the meeting. Apologies and observers were noted. The meeting was noted to be quorate.

2. Conflict of interests – declarations and DOI refresh

The Chair asked that any conflicts of interest with the meeting agenda be declared and that any outstanding declarations be returned. No conflicts were raised.

3. Detailed action notes of the last meeting, minutes, and action log:

The minutes and detailed action notes were accepted as an accurate record of the meeting subject to correction of minor typographical errors. Members were provided with an update on progress against actions due for this month, these were noted, and items closed were agreed.

4. Formulary recommendations:

- **New recommendation: Nephrotrans™ (sodium hydrogen carbonate) gastro-resistant capsules for the treatment and maintenance treatment against recurrence of metabolic acidosis in adults with chronic renal impairment**

Nephrotrans™ was approved as Amber 1 at the last IMOC meeting and this formulary recommendation sets out the agreed criteria for use. No comments have been feedback via the virtual Triage Panel review. An amendment to the wording in the costing section will be made clear that the side effects should be "intolerable". There were no comments from members and the recommendation was approved by consensus.

- **New recommendation: Cytisine (cytisinicline) 1.5mg tablets for smoking cessation in adults**

Cytisine was approved as Green in this setting at the last IMOC meeting and the recommendation sets out the agreed criteria for use. This includes consideration of linking in with local authority commissioned smoking cessation services when primary care practitioners prescribe. Review through the virtual Triage Panel recommended some minor changing to the wording on use in populations aged 65 years and over. A comment was raised to clarify if there would be support for primary care prescribers initiating cytisine and the smoking cessation pathway in general. It was noted at the November IMOC meeting that the respiratory leads were developing an educational programme. Additionally, the borough Medicines Optimisation teams would be available to support queries in primary care. The recommendation was approved by consensus.

- **New recommendation: Apixaban for thromboprophylaxis following deep venous stent insertion post thrombolysis for deep vein thrombosis**

This formulary recommendation outlines the approval of apixaban 5mg tablets in this setting as Amber 2, agreed at the November IMOC meeting. The criteria for use are in line with discussions at the meeting. No feedback has been received through the virtual Triage Panel review process. There were no comments from members and the recommendation was approved by consensus.

ACTION: Adult formulary to be updated to include Nephrotrans™, cytisine and apixaban in line with agreed criteria

5. Updated guideline for the off-label use of nebulised antibiotics in the management of pseudomonas aeruginosa in non-cystic fibrosis (CF) bronchiectasis and associated formulary request (for nebulised tobramycin as a third line treatment option)

The authors were in attendance to present the updated guidance on behalf of the respiratory sub-group. The update includes a formulary request to formalise the use of nebulised tobramycin as a third

line option for the off-label treatment (eradication and suppression) of *pseudomonas aeruginosa* infection in adults. Tobramycin is currently the third line option for a small number of patients in this setting who are unable to use gentamicin. Gentamicin is the second line treatment for patients unable to tolerate first line Colomycin® therapy and is only available as a glass ampoule. Occasionally patients are unable to tolerate gentamicin and some patients find the reconstitution process challenging. Nebulised tobramycin is available as pre-filled syringes and are more suitable for this cohort. The British Thoracic Society (BTS) non-CF bronchiectasis guideline also supports the use of tobramycin as eradication therapy (a 3-month course). The formulary request also includes use of tobramycin in suppression therapy (28-day continuous cycle of on/off treatment). Use of nebulised tobramycin in is not expected to have a significant cost impact and is within the financial threshold delegated to the committee. A commercial in confidence discount is in place for tobramycin, which reduces its acquisition cost. Tobramycin is classified as a high cost drug when nebulised and use in non-CF bronchiectasis falls under Integrated Care Board commissioning. If approved, this would be a commissioned indication for nebulised tobramycin.

Other updates made to the guideline were detailed within the agenda pack and included:

- Under “Aims, diagnosis and treatment” - *check allergy status* added after IV antipseudomonal beta-lactam
- Addition of COVID-19 vaccination under the “Considerations and Initial management” section
- Addition of the 1-million-unit dose for colomycin as an option
- Changes to include more than one brand of nebuliser equipment

The updated guidance has had oversight from the SEL Forum for Antimicrobial Stewardship (SEL FAS) at its August 2024 meeting and through the consultation process. The formulary request for tobramycin was presented at the December 2024 SEL FAS meeting where SEL FAS members confirmed support for the formulary request. Committee members were requested to note that the proposed dosing for tobramycin in the suppression regimen (continuous 28 days on treatment and 28 days off) is outside the BTS guideline, which only includes the recommendation for 84 days of continuous treatment before stopping with the potential to restart if needed. The SEL FAS acknowledged that there may be concerns about resistance, however the proposed use would be in a small cohort of patients, thus limiting resistance risks. SEL FAS members had also noted that the availability of tobramycin could potentially keep patients out of hospital. The presenter confirmed that the initial eradication regimen would be in line with the BTS guidance. Only a small group of patients who remain unwell due to colonising pseudomonas would require monthly dosing as suppression therapy. The SEL FAS requested an audit to be reported back to the SEL FAS in twelve months’ time to monitor patient numbers and outcomes for use of nebulised tobramycin in this setting. In response to a query, the presenter agreed to update the pathway to detail and provide clarity on the rationale for progressing treatment from first line to second- or third-line options, as well as specifying the formulations, concentrations and strengths of each diluent being used. The committee were informed that this pathway update has been consulted through colleagues at all of the Trust sites. In relation to a comment about tobramycin being second-line therapy in the future, members were advised that the cost difference between gentamicin and tobramycin is negligible and tobramycin is currently being used as a third line treatment option due to the limited evidence available for its use in the second-line setting.

The committee approved by consensus the updated guideline and the formulary inclusion of nebulised tobramycin as a third line option pending amendments to the guidance in line with discussions.

ACTION: Author to amend guidance in line with meeting discussions and share with the IMOC team to progress for IMOC Chair’s ratification.

6. Updated primary care and private interface prescribing guide:

The author was in attendance to present this item. The current guide has been updated following a scheduled review and undergone SEL-wide consultation. The main updates relate to language changes (e.g. changing ‘drugs’ to ‘medications’) and inclusion of more information about shared care with NHS and private providers. The majority of additional information has been adopted from national

resources provided by PrescQIPP. Following feedback from Healthwatch, the patient letter included as part of the consultation within the appendices has been removed and will be reviewed independently and submitted for approval in the future. In response to a discussion by members, the author agreed to include more information to support practices in verifying the suitability of private providers. Methods on how to contact the CQC for advice and other relevant guidance/signposting will also be added as a separate bullet point. It was noted that support around implementation of this guide at borough level would be useful especially private prescribing/transfer of patients with ADHD and gender dysphoria.

In response to a comment, the author agreed to amend the policy wording to reflect situations where the primary care provider will not be able to continue privately provided treatment and help manage patient expectations. The committee were informed that a statement noting that a private provider should only be selected under the Right to Choose arrangement if they can meet the service requirements set out by the NHS would be added to the guide. A query was raised regarding patients under private practitioners who are not based in the UK presenting to primary care NHS providers in the UK for ongoing prescribing, members agreed that patients seeing private practitioners abroad should be referred back into NHS pathways for treatment. The British Medical Association (BMA) has relevant guidance which will be hyperlinked within the guide.

The committee approved by consensus the updates to the primary care and private interface prescribing guide pending amendments to the guide in line with discussions.

ACTION: Author to amend guidance in line with meeting discussions and share with the IMOC team to progress for IMOC Chair's ratification.

7. Updated shared care guideline for aripiprazole long-acting injection (LAI) for the treatment of schizophrenia in adults- inclusion of 2 months aripiprazole LAI:

The author presented the updated shared care guidance. The inclusion of 2-monthly formulation of aripiprazole long-acting injection to the SEL adult formulary was previously approved at the August 2024 meeting. As requested at the August meeting, the SEL shared care guideline (SCG) for the treatment of schizophrenia has been updated to include the 2-monthly preparation. The SCG has also been transferred into the new SCG template. The committee were advised that minor rephrasing and corrections of typos would be corrected by the applicant. Members discussed the financial implications to community pharmacy/primary care if patients miss their administration appointment or do not collect medication supplies. The committee were advised that various mechanisms are employed by community pharmacists to manage stock, however there are many variables to consider (e.g. the patient cohort, individual supplier arrangements). The query will be fed back to the SEL Clinical and Care Professional Lead for mental health, who is leading on programme of work involving access to LAI's antipsychotics across SEL. Following a query, the applicant confirmed that patients who are already established and stabilised on monthly LAI would not require a further stabilisation of 12 months when switching to 2-monthly dosing intervals. The applicant also agreed to include clearer information for clinicians in primary care indicating the dose and preparation they are being requested to take on prescribing for. In response to a suggestion that ECG monitoring for patients on LAI should be the responsibility of secondary care services, the majority of members discussed and agreed that it is more suitable for ECG monitoring of this patient cohort to remain with primary care. It was noted that additional advice clarifying when to seek advice (e.g. for abnormal ECG/QT interval) may be useful to support primary care clinicians.

The committee approved by consensus the updated shared cared guidance pending the amendments discussed.

ACTION: Author to amend document in line with meeting discussions and return to IMOC team to progress for Chair's ratification

8. Formulary re-categorisation of spironolactone from Amber 2 to Amber 1 for the treatment of hormonal acne in women and updated associated pathway

The applicants (Consultant Dermatologist and specialist dermatology Pharmacist) were in attendance to present this item on behalf of the dermatology sub-group. The request is for the recategorisation of spironolactone following the impact of changes to the MHRA guidance for isotretinoin has had on women being able to access treatment in secondary care for hormone related acne. Given the waiting times for dermatology referrals, recategorising spironolactone to a RAGG category of Amber 1 would improve patient access to treatment whilst waiting for specialist assessment after referral. This proposal, in line with British Association of Dermatologist (BAD) recommendations, will empower GPs to prescribe interim treatment following a specialist recommendation and will help patients access a viable treatment option when isotretinoin is not suitable. No additional cost impact is anticipated with this request, however, the reduced referrals and associated costs of these may offer potential savings.

Members discussed the requirement for contraception whilst on spironolactone and how clinicians would ensure the prescribing of adequate contraception. It was noted that a patient's sexual activity could change without their GP being informed or sexual health advice sought from other providers. The committee were advised that counselling on the risks of pregnancy whilst on spironolactone should be given to all patients and contraceptive/sexual health advice will be determined on a case-by-case basis when advice and guidance is given. Patients are routinely signposted to the patient information leaflet (PIL) during consultations. Similar to methotrexate and other high-risk medications, there is no national pregnancy prevention program or consent form required for spironolactone. However, this medication is routinely prescribed in dermatology and primary care for other conditions. Additionally, as an Amber drug, there will always be an opportunity for specialist input via advice and guidance. The presenters confirmed that patients are routinely signposted to the PIL during consultations to minimise the burden for clinicians. Members agreed that an alert should be added to OptimiseRx to remind prescribers to check a women's contraception status when prescribing spironolactone. In response to a query regarding spironolactone being contraindicated in pregnancy, the presenters advised that pregnancy is not formally contraindicated in the product licence and the results of the spironolactone for women with acne vulgaris (SAFA) trial published in the British Medical Journal (2023), highlight that spironolactone is an effective treatment, cost effective and relatively easy to manage. The presenters noted that evidence of harm to foetus is limited and occurred at higher doses than proposed in the pathway. In response to a query seeking clarification of the RAGG category request, the Committee were advised that the request for Amber 1 is to prevent treatment delay whilst patients are awaiting referral, if there are concerns about dose titration or monitoring, advice and guidance can be sought. Spironolactone should only be initiated in primary care after advice and guidance from a specialist and this will be clarified within the pathway. Following comments from members, the presenters agreed to amend the flowchart to clarify Amber 1 RAGG category request for spironolactone in this setting. In response to a query, the presenters clarified that spironolactone is only used for patients with hormonal acne and the pathway will be updated to reflect this.

The committee approved by consensus this recategorisation of spironolactone from Amber 2 to Amber 1, in the treatment of hormonal acne in women. The updated treatment pathway was also approved by consensus pending amendments in line with discussions.

ACTION: Author to update pathway in line with meeting discussions and share with IMOC team to progress for IMOC Chair's ratification

9. Updated pathway and cost tool for the management of atopic dermatitis (AD) and associated formulary request - olopatadine for managing ocular side effects from dupilumab (Amber 2, off-label use).

The applicants (specialist dermatology Pharmacists) were in attendance to present this item on behalf of the dermatology sub-group. The Consultant Dermatologist involved in the pathway development was unable to attend the meeting. The pathway has been updated in response to the National Institute for Health and Care Excellence (NICE) technology appraisal (TA) recommending lebrikizumab for treatment of atopic dermatitis (TA986). The updated pathway also includes recommendations from the BAD guidance on the management of ocular surface disease, including prescribing olopatadine eye drops for patients with moderate to severe ocular side effects resulting from interleukin-4 (IL-4) inhibitors. Whilst olopatadine eye drops are not on the formulary for this indication, they have been

prescribed prophylactically to all patients being treated with the IL-4 inhibitors dupilumab, tralokinumab and lebrikizumab. Patients are reviewed at 16 weeks and a decision is made whether to continue olopatadine. Recent recommendations in the BAD guidance suggest that olopatadine eye drops should only be considered for patients with pre-existing or current corneal or conjunctival eye disease. Patients with severe eye disease will be referred to ophthalmology for support with disease management. The request is for the formulary inclusion of olopatadine eye drops as Amber 2 for patients with a history of, or current, conjunctival eye disease resulting from IL-4 inhibitor treatment. This is off-label use of olopatadine eye drops. These patients will be regularly reviewed in the eczema clinic at 6 months then annually. The associated cost tool for the pathway has also been updated to include lebrikizumab. The updated pathway has undergone SEL-wide consultation and has been approved by the SEL Dermatology subgroup.

No additional cost impact is expected from the NICE TA for lebrikizumab in comparison to existing agents as there is a commercial in confidence discounted price and its inclusion would be a substitution against other NICE approved treatment options. The cost impact from lebrikizumab is therefore within the financial threshold delegated to the committee. With respect to olopatadine, it is estimated that up to two-thirds of patients being treated with IL-4 inhibitors may require olopatadine eye drops. This cost impact is negligible and therefore within the financial threshold delegated to the committee.

In response to a query the committee were advised that because olopatadine is being requested for use off-label and use will be long-term, self-care would not apply as this is not a self-limiting, acute condition. Members confirmed olopatadine was not on the self-care list as it is a prescription only medicine. The presenters confirmed that a certain percentage of AD patients will have pre-existing eye conditions, however dupilumab has revolutionised eczema therapy. Patients with a prior history or a current ocular side effect would qualify for olopatadine.

In response to a comment, the applicants agreed to add a statement to the AD pathway that olopatadine eye drops are an Amber 2, off-label treatment within the pathway algorithm once approved. Members were also advised that the intention is for tacrolimus 0.1% ointment to only be prescribed by the hospital (Red RAGG category) in severe eye disease caused by IL-4 inhibitors. Approval for this is to be sought from the SEL Joint Formulary Committee (JFC). Members agreed that in order to approve a final version of the pathway, approval for the use of tacrolimus 0.1% ointment would need to be completed through the JFC. Once approved by JFC, the applicants agreed to note the Red category within the pathway so that it is clear that primary care would not be expected to prescribe. Following a query about male conception whilst on this treatment, the committee were informed that technically there is no contraindication for men to use these biologic treatments whilst trying to conceive. This section is to enable a conversation between the patient and clinician in light of the lack of evidence, but these are the preferred drugs in this case and this section can be rephrased. The committee requested that within the next iteration of the document a clearer expression of how clinicians cycle through sequential use of specialist treatments is included, for example criteria for multidisciplinary team review and consideration of clinical trials. It was noted that the NHS England (NHSE) London Pharmacy Specialised Commissioning team have confirmed that the paediatric cohort for lebrikizumab in atopic dermatitis falls under NHSE commissioning responsibility.

The committee approved the updated pathway, cost tool and the addition of olopatadine to the SEL formulary as Amber 2 by consensus pending amendments to the pathway in line with discussions.

ACTION: Authors to obtain JFC approval for tacrolimus 0.1% ointment and update pathway in line with meeting discussions
ACTION: Authors to share updated pathway with IMOC team to progress for IMOC Chair's ratification

10. Updated rheumatology pathways, monitoring framework and associated cost tools

The applicant was in attendance to present this item, which also includes a formulary request for the use of dose escalated adalimumab in psoriatic arthritis (off-label use). The updated documents and formulary request have been approved by the rheumatology sub-group. It was highlighted that the main

change to both the existing treatment pathways for seronegative spondyloarthropathy (SpA) and rheumatoid arthritis (RA) is an update in line with recent revised recommendations from the British Society of Rheumatology (BSR) on the use of biologic medications in pregnancy. Previously it was recommended that certolizumab should be used for all women planning pregnancy, when pregnant and in breastfeeding. However, the BSR guidance now states that anti-TNF inhibitors can also be used if patients have low risk of disease flare, and also includes advice on when to stop and restart medications after giving birth and infant vaccinations. This has been reflected using the same wording in both the RA and SpA treatment pathways. Other updates to both pathways were also highlighted:

(i) SpA treatment pathway and cost tool:
The SpA pathway also includes the following updates:

- Inclusion of medicines approved through the NICE TAs: tofacitinib in ankylosing spondylitis (NICE TA920), bimekizumab in axial spondyloarthritis (NICE TA918), and bimekizumab in psoriatic arthritis (NICE TA916). These treatments are not expected to have an additional financial impact because they will substitute against other specialist therapies within the existing pathway. Commercial in confidence discounts are also available for these medicines. The cost impact for these TAs is therefore within the committee's delegated financial threshold.
- The cost tool has been updated to include bimekizumab and the tocilizumab biosimilar preparation.

(ii) RA treatment pathway and cost tool:
The treatment pathway and cost tool have been updated to reflect the availability of biosimilar ustekinumab. Tocilizumab biosimilar for sub-cutaneous and intravenous formulations have been included in the RA cost tool.

In response to a query, the presenter confirmed that in the case of spontaneous or unplanned delivery, patients should stop anti-TNF's immediately and restart once fully healed. The infant vaccination schedule would depend upon when the patient stopped treatment. Members were also informed that these patients are monitored in a joint obstetrics and rheumatology maternity clinic. This information should be clearly documented in the patient's clinic letters throughout their pregnancy and has been routine practice across SEL for some time. It was clarified that breastfeeding has been included more for consideration during planning pregnancy rather than specific advice. As the document signposts the reader to information, members agreed that the section doesn't require a title change. In response to a query, the presenters confirmed there is very limited published data on male conception and most studies are in animals and the BSR also have never published any official guidance on this.

(iii) Proposal for the use of dose escalated adalimumab for use in psoriatic arthritis (PsA)
This item was presented on behalf of the rheumatology sub-group, who have discussed and approved it. Adalimumab is used first line in psoriatic arthritis patients at a standard dose of 40mg on alternate weeks. Some patients develop secondary failure, where treatment failure occurs despite an initial response to adalimumab. This request proposes increasing dosing to 40mg weekly in this setting as an alternative to escalating to the next stage of treatment as per the SEL pathway. The inclusion of dose escalated adalimumab in PsA has been reflected in the notes of section 14.1 of the SpA pathway. With respect to the financial impact, it is estimated that patient numbers will stabilise by year five, and the cost of treating these patients is within the financial threshold delegated to the committee. There are also potential savings from fewer patients needing to transition to more costly treatments, such as upadacitinib or risankizumab. Patients meeting the criteria for dose escalated adalimumab will be assessed by a biologics multidisciplinary team (MDT) who will measure their response to treatment at 12 weeks, 6-months and 12-months, with continued monitoring every 6-12 months. An inadequate response to treatment at 6-months would result in a change in biologic therapy. Implementation of the dose escalated regimen (including patient outcomes and de-escalation of therapy) will be audited through the rheumatology sub-group. Members requested that the new wording added to the pathway makes clear this is an off-label use of adalimumab.

(iv) Outcomes and monitoring framework for 24/25

The outcomes monitoring framework has been updated to include an audit on the sequential use of biologics/advanced treatments following multiple treatment failures in RA and SpA.

The committee approved by consensus the updated rheumatology pathways, monitoring framework and associated cost tools. The committee also approved by consensus the proposal for use of dose escalated adalimumab in psoriatic arthritis pending amendment to the SpA pathway.

ACTION: Authors to update the pathways in line with meeting discussions and share with IMOC team to progress for IMOC Chair's ratification
ACTION: Formulary to be amended once pathway signed off to include dose escalated adalimumab

11. Updated primary care antimicrobial guidelines for SEL - sections on Skin and Soft Tissue, parts 1 & 2

The authors were in attendance to present this item on behalf of the SEL FAS. A process is underway through the Primary Care sub-group of SEL FAS to harmonise antimicrobial prescribing guidelines across the 6 SEL boroughs. This is being taken forward in a cyclical way, section by section and the current sections being presented are Skin and Soft Tissue, parts 1 & 2. These sections have been reviewed and agreed by the SEL FAS and the SEL FAS primary care sub-group. Each segment of the Skin and Soft Tissue parts 1 & 2 updates were presented, with the key points noted as follows:

Skin & soft tissue infections - Part 1: The original guidance being used in Bexley, Lewisham, Oxleas and Greenwich (BLOG) has been updated for SEL. The guidance reflects updates from NICE, SEL expert groups, consultations, MHRA recommendations, self-care guidance, and the National Medicines Optimisation Opportunities. A table detailing all the changes was included in the agenda pack and the presenters took the committee through these.

Skin & soft tissue infections - Part 2: This is new guidance – historically some SEL boroughs included information on these skin infections and others did not. The sub-sections covered by this new chapter are: Acne vulgaris, chickenpox, insect bites & stings, leg ulcer infection, tick bites, Lymes disease, mastitis and breast abscess and shingles. Links have been included to signpost to the SEL primary care dermatology guideline throughout the document, where applicable. For acne, the advice aligns to the primary care dermatology guideline. Where self-care is referenced, links signposting to self-care resources have been added. Treatments suggested through the consultation process but not on the SEL adult formulary have not been included in the guidance and links signposting to the SEL adult formulary have been added. In the tick bites section, it was noted that the use of doxycycline in children aged 9 -12 years is off-label but is supported by NICE. The chickenpox pregnancy section is awaiting confirmation of the GSTT obstetrics contact. There were no questions and comments from members regarding the sections presented. Some minor formatting changes were shared with the authors before the meeting and will be updated post meeting within the guidelines. The GSTT obstetrics contact will also be included.

The committee approved by consensus the sections presented for the SEL primary care antimicrobial guidelines pending amendments in line with discussions.

ACTION: Authors to update guidance in line with meeting discussions and share with IMOC team to progress for IMOC Chair's ratification.

12. Formulary inclusion and categorisation (proposed Amber 1) of the following as approved off-label treatments and associated evidence review:
i. Lorazepam and oxycodone for the relief of refractory breathlessness in advanced chronic obstructive pulmonary disease (COPD)
ii. Morphine sulphate orodispersible tablets (Actimorph®) for cough and breathlessness in palliative care

The applicant, also the chair of the respiratory sub-group, was in attendance to present this item on behalf of the respiratory subgroup. The broader COPD guideline has been updated via the SEL respiratory sub-group following changes in the specific inhaler pathway earlier this year. The pathway

was discussed at the October 2024 IMOC meeting and is awaiting to be finalised pending amendments.

(i) Lorazepam and oxycodone for the relief of refractory breathlessness in advanced COPD
As part of the guideline update, a new section on management of COPD-related breathlessness has been included. This proposes to use oxycodone oral solution, and lorazepam tablets and oral solution for the relief of refractory breathlessness in advanced COPD, despite optimised inhaled therapies and non-pharmacological treatments for breathlessness. The presenter outlined that morphine would be first line in this setting, then lorazepam. Oxycodone will be reserved as an alternative for patients being considered for morphine but with severe renal impairment. The Formulary Pharmacist provided a brief overview of the evidence base, background to the condition and its management. Use of both these medicines for this indication is off-label, though recognised practice in the UK. The Global Initiative for Obstructive Lung Disease (GOLD) global strategy for prevention, diagnosis and management of COPD 2024 report lists opiates, amongst other interventions, that can relieve breathlessness as part of palliative treatment, with specific reference to morphine.

With respect to the evidence base, no head-to-head studies were found comparing oxycodone with morphine for relieving breathlessness. In studies assessing outcomes of breathlessness, opioids did not reduce breathlessness intensity measured in daily life compared to the comparator. The GOLD recommendation is based on a systematic review and meta-analysis which included 16 randomised controlled trials (RCT) (n=271, 95% with severe COPD; 8 crossover trials using systemic opioids). For the effect on breathlessness (12 studies, 8 of systemic and 4 of nebulised opioids), pooled analysis of all studies found that opioids reduced breathlessness. However, in a meta-analysis of five trials examining breathlessness, breathlessness intensity was lower following opioids compared with placebo which suggested clinically significant treatment. Oxycodone was not trialled in any of the 8 studies that used systemic opioids. Lorazepam is recommended in national and local resources for palliative medicine, where breathlessness is usually linked to anxiety. It's believed that relieving dysphoria by depressing hypoxic or hypercapnic ventilatory responses and altering the emotional response dyspnoea may have an effect that's potentiated by diazepam. NICE advises to consider short term uses of benzodiazepines if shortness of breath is associated with acute anxiety and opioids have been insufficient. The GOLD guidance concluded there was no evidence for a beneficial effect of benzodiazepines as suggested by a Cochrane review.

With respect to the safety, study data suggest that using opioids for refractory breathlessness has an increased adverse effect profile to comparators, however no new safety concerns were identified as the proposed doses are significantly lower than standard dosing. Similarly, the studies found that when using benzodiazepines there was a higher rate of adverse events, particularly drowsiness and somnolence versus placebo.

The application requests that lorazepam and oxycodone are initiated in primary care on recommendation of a respiratory specialist and continued in primary care (Amber 1). Both treatments are already established in practice in SEL and therefore significant additional costs are not expected. The estimated cost impact falls within the financial threshold delegated to the committee.
The committee were informed that GSTT and KCH have integrated respiratory teams that undertake home visits, and these patients fall into this category. Patients are regularly reviewed by specialists and 6- or 12-monthly reviews for this cohort are unlikely. Community respiratory patients under the service have regular telephone reviews plus home visits with close review. In response to a query regarding the service prescribing instead of primary care, the presenter advised that this request also aims to increase access to medicines and promoting patient preference in that regard. It may not always be possible to visit patients or deliver medicines and this increases patient options for access to their medicines. The presenter also confirmed that although lorazepam isn't mentioned specifically in the NICE end of life care guidelines, there is reference to benzodiazepines. Therefore, the clinical decision would reside with the individual clinical teams responsible for the patient. Members were informed that the risk of these medications are well understood, especially in complex and severe COPD patients. With respect to polypharmacy and deprescribing, these patients are regularly discussed at the respiratory multidisciplinary meetings and decisions are not made in isolation to prescribe opioids and benzodiazepines. Specialists explain to patients the importance of interactions and regular blood tests

for their renal function. The applicant clarified that the oxycodone request only covers the liquid formulation as this allows clinicians to manage administration of lower doses which is not an option with capsules. It is very rare to require use of the modified release oxycodone capsules. The committee were informed that the application reflects historical, established practice, and the current process varies depending on the patient's locality; recommendations to the GP can be made by the home visit teams or prescribing can be started during a clinic appointment.

(ii) Morphine sulphate orodispersible tablets (Actimorph®) for cough and breathlessness in palliative care
In line with discussions under any other business at the last IMOC meeting, morphine sulphate orodispersible tablets currently have no RAGG category assigned for cough and breathlessness in palliative care. Given the palliative nature, an Amber 1 category would be desirable.

Members discussed the requests and agreed that prescribing requests for these medications in primary care from palliative care specialists were routine and familiar to most GPs. However, initiation of lorazepam or oxycodone for non-palliative patients with COPD would be a concern given the potential risks and consequences for patients. Therefore, an Amber 2 category would be preferable in this setting. It was clarified by the presenter that the oxycodone and lorazepam request is for patients who are not end of life care patients – these patients have a longer prognosis but the COPD is sufficiently severe to warrant these treatments. It was noted that there was disparity across SEL regarding the provision of care for this COPD cohort and the adult formulary would need to reflect the different categorisation between the long-term COPD patients and end of life (palliative) patients.

The committee agreed by consensus to approve lorazepam and oxycodone as Amber 1 for palliative COPD patients and Amber 2 for breathlessness in non-palliative COPD patients, pending amendments to the SEL COPD guideline in line with discussions. Similarly, the committee also agreed by consensus to a RAGG category of Amber 1 for morphine orodispersible tablets if being used in cough and breathlessness in palliative care. A category of Amber 2 was agreed by consensus for use in breathlessness in non-palliative COPD patients.

ACTION: Author to update the COPD guideline in line with meeting discussions and share with IMOC team to progress for IMOC Chair's ratification.

13. Standing items/Items for information only

- Formulary submissions tracker

Noted.

- NICE Technology Appraisal (TA) Guidance Summary - ICS & NHS England attributed medicines:

The summary was noted, and RAGG categories were agreed by consensus, where it was possible to confirm the RAGG status.

- For information and noting:
  - Adult and paediatric formulary update – noted by Committee members.

14. AOB:

This is the last meeting of the current Lambeth borough GP representative and the committee thanked them for their contributions. The Chair noted that this would be the last meeting of the current IMOC vice-Chair from South London and Maudsley NHS Trust (SLaM) and expressed thanks to them for their valued input over the years. Members thanked the vice-chair for supporting the committee and expressed their well wishes. A process to identify a replacement vice-chair is underway at SLaM.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 16th January 2025	2pm – 4:30pm	MS Teams
Thursday 20th February 2025	2pm – 4:30pm	MS Teams
Thursday 20th March 2025	2pm – 4:30pm	MS Teams