South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
19th June 2025 (Online via MS Teams)
Final Minutes

1. Welcome, introductions and apologies

The Chair welcomed attendees to the meeting. Apologies and observers were noted, and 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. A declaration was noted from a committee member in relation to agenda item 5 - primary care implementation of tirzepatide (Mounjaro®) for managing overweight and obesity in SEL. No further conflicts were raised by members.

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 the correction of minor typographical errors. Members were provided with an update on the progress against actions due for this month, these were noted, and items closed were agreed. In relation to the action on the guidance for the use of continuous glucose monitoring (CGM) in Type 2 diabetes mellitus (T2DM), formulary requests and associated cost modelling, committee members were informed a revision to the cost modelling originally presented in May 2025 had been made. The cost modelling previously presented in May 2025 was updated due to an error identified in the national costing template. The revised cost estimates are still above the financial threshold delegated to the committee; however, lower than previously estimated. The revised cost estimates were escalated to and approved by the Executive Committee.

4. Formulary request for the first line use of desogestrel as a progesterone only contraceptive

The applicant was in attendance to present this item, which requests to remove the restrictions associated with desogestrel as a progesterone only contraceptive. Desogestrel is currently recommended locally as a second line progesterone only contraceptive in the adult joint medicines formulary (JMF). This is a historical arrangement that pre-dates the IMOC.

Both NICE Clinical Knowledge Summaries (CKS) and the Faculty of Sexual & Reproductive Healthcare guidance recommend that any progesterone-only pill (POP) should be offered as a first-line option for contraception, with no requirement for restriction as second line options. Desogestrel is available generically and has a longer missed pill window in comparison to other POPs currently recommended first line within the JMF, thus, reducing the likelihood of missed pill episodes and unwanted pregnancy or the need for repeat emergency hormonal contraception.

A comment was raised regarding some generic versions of desogestrel containing soya or arachis oil which is not suitable for patients who have a soya or nut allergy. Committee members noted there is an alert on EMIS which highlights this information, but it will also be useful to note this information within the local adult JMF. A suggestion was made for the local memo which supports the NHS Pharmacy Contraception Service to be updated and recirculated to local Community Pharmacies to reflect the change in place of therapy for desogestrel as a first line POP if approved and the potential allergy risk associated with generic versions of desogestrel containing soya or arachis oil.

Committee members approved by consensus for the restrictions placing desogestrel as a 2nd line option to be removed so that desogestrel can also be considered as a first line POP option.

ACTION: Desogestrel to be updated within the SEL JMF to remove the 2nd line and include information regarding the potential allergy risk associated with the generic versions of desogestrel containing soya or arachis oil

ACTION: Local NHS Pharmacy Contraception Service memo to be updated to reflect desogestrel as a first line POP option and the potential allergy risk associated with the generic versions of desogestrel

5. Primary care implementation of tirzepatide (Mounjaro®) for managing overweight and obesity in SEL

The authors were in attendance to present this item, outlining the primary care implementation of tirzepatide (Mounjaro®) for managing overweight and obesity in line with NICE Technology Appraisal (TA) 1026 and commissioning guidance from NHS England (NHSE). NICE TA 1026 recommends tirzepatide as an option for managing overweight and obesity, alongside a reduced-calorie diet and increased physical activity (referred to as 'wrap around care') in adults, if they have:

- an initial body mass index (BMI) of at least 35 kg/m² and
- at least 1 weight-related comorbidity

As per NICE TA 1026, tirzepatide is recommended for prescribing within specialist weight management services (SWMS) and primary care settings. Due to the large eligible population, associated drug costs and the need for provision of 'wrap around care', which does not exist in settings outside of SWMS, NHSE agreed a funding variation with NICE for the implementation period of the NICE TA.A phased implementation is in place beginning in SWMS from March 2025 and in primary care from June 2025.

The NHSE interim commissioning policy, outlines the phasing patient cohort for primary care settings over the initial 3 years of implementation. The primary care service to support the use of tirzepatide for managing overweight and obesity is still under development and therefore the financial implications in primary care over the next 3-year period cannot be accurately predicted as this will depend on specifics such as capacity and timing of implementation of the service. The system wide cost modelling for implementing NICE TA 1026 in SEL was presented at the March IMOC meeting and in line with the committee's terms of reference, the cost modelling has already been escalated to the Executive Committee for information.

In line with the proposed primary care implementation of tirzepatide, committee members were requested to approve the recategorisation of tirzepatide from Red *(hospital only)* to Amber 2 *(specialist initiation)*, indicating initiation by specialist (tier 3 and tier 4 bariatric teams only) followed by continuation in primary care for the Year 1 NHSE phased patient cohort. The other eligible cohorts for tirzepatide in this setting will remain categorised as Red. All other GLP-1 receptor agonists approved locally in this setting will also remain categorised as Red in accordance with their NICE TAs.

An information sheet has been developed for approval by the committee to support primary care clinicians manage patients prescribed tirzepatide in this setting appropriately and safely. As the information sheet is based on the existing GLP-1 information sheet for the management of Type 2 diabetes, the information sheet was consulted on through local key stakeholders rather than a wider consultation.

Members discussed the information and a query was raised in relation to the provision of 'wrap around care' for primary care, and if this will continue once the prescribing of tirzepatide has been transferred to primary care. The presenter explained that the SWMS are expected to provide wrap around care for a set number of sessions, noting that this may finish at different times, but primary care prescribers will be informed. Members queried whether prescribing of tirzepatide in primary care will be carried out by selected GPs as part of the phased implementation. The presenter clarified that currently all patients will access treatment with tirzepatide via the SWMS until there is a primary care service. There will be a separate pathway which enables initiation of tirzepatide via primary care i.e. via a centrally commissioned primary care pathway and this will be made clear in the communications to primary care.

It was queried whether the number of SEL patients currently accessing tirzepatide privately who may be eligible for tirzepatide in line with the NHSE eligibility criteria is known. The presenter

explained that as the documentation of tirzepatide private prescriptions on EMIS has been carried out in different ways by the GP practices it has been difficult to quantify. However, ~15% of the NHSE year 1 patient cohort are already prescribed a GLP-1 agonist, although the breakdown in terms of private and non-private prescribing is not available. Members requested that if the recategorisation of tirzepatide is approved as Amber 2 for the Year 1 NHSE phased patient cohort, the local adult JMF will need to be clear in terms of the eligibility criteria,

Committee members approved by consensus the recategorisation of tirzepatide (Mounjaro®) for managing overweight and obesity from Red to Amber 2 for the Year 1 NHSE phased patient cohort and the tirzepatide for managing overweight and obesity information sheet, pending updates in line with the discussion.

ACTION: Tirzepatide (Mounjaro®) information sheet to be updated in line with discussions and progressed for ratification via IMOC Chair's ratification
ACTION: SEL JMF to be updated to include Mounjaro® as Amber 2 for the management of obesity and overweight in line with discussions

6. Updated Clinical Effectiveness South East London (CESEL) asthma guides and associated formulary request

The authors were in attendance to present this item, which is being presented to the IMOC for approval of the medicine's elements. The presenters outlined the work to update the guides including the development of a working group which included representatives from the respiratory sub-group of the IMOC, SEL respiratory network, acute Trust clinicians, and respiratory community teams.

The CESEL adult and CYP asthma guides have been updated to align with the recently published joint NICE/SIGN (Scottish Intercollegiate Guidelines Network)/BTS (British Thoracic Society) asthma guideline (NG245), resulting in significant general updates (e.g. diagnosis) in addition to updates to the medicines section. The guides have been through IMOC consultation and members were provided with the main updates to the guides within the agenda pack.

- The following formulary considerations were also included as part of the updated guides: Categorising montelukast with a green RAG category for adults and paediatrics
- Removal of Atectura® Breezhaler (indacaterol/mometasone) and Enerzair® Breezhaler (glycopyrronium/indacaterol/mometasone) from the local adult JMF as these inhalers have been discontinued

Vivaire® formulary request
Alongside the request to approve the updated CESEL adult and CYP asthma guides, there is a formulary request on behalf of the respiratory sub-group for the formulary inclusion of Vivaire® (beclometasone/formoterol) 100/6 and 200/6 metered doses inhaler (MDI) as a cost-effective alternative to Fostair® MDI. Vivaire® MDI is a hybrid generic beclomethasone/formoterol MDI, equivalent to Fostair MDI in terms of active ingredients, efficacy, product licensing, and dosing.

- A green RAG category is being requested for Vivaire® 100/6 MDI for the management of asthma and COPD and
- An Amber 1 RAG category is being requested for Vivaire® 200/6 MDI for the management of asthma which aligns with the categorisation for Fostair® MDI

For the management of asthma, Vivaire® MDI is being recommended for MART and as an anti-inflammatory reliver (AIR) which is off label but aligns with Fostair® and is supported by the NICE/BTS/SIGN asthma guideline. From a cost impact perspective, the formulary inclusion of Vivaire® MDI is within the delegated financial threshold for the committee and there is a cost saving associated with prescribing Vivaire® MDI in comparison to Fostair® MDI in this setting.

A request was made to clarify within the adult guide that Vivaire® is the preferred MDI over Fostair®. The presenter clarified that some patients are well established on Fostair® MDI and will not be

switching to Vivaire® MDI, in line with this the guide will be updated to highlight that Vivaire ® MDI is the preferred option in new patients.

For children aged 5 – 11 years old, the recommended treatment regimens are a balance of alignment across NICE/BTS/SIGN guidance, an expert consensus recommendation on maintenance and reliever (MART) therapy and the local paediatric formulary. Members queried the origin of the consensus recommendations for the practical application of the NICE/BTS/SIGN asthma guideline on MART therapy in CYP and whether the statement is from a reputable professional group and has been published online. The presenters outlined that development of the consensus recommendation was led by NHS England (NHSE) via the paediatric asthma lead for NHSE following many primary and secondary care clinicians requesting clarification on the management on asthma in paediatrics based on the new NICE/BTS/SIGN asthma guideline. A link for the document via NHSE is not currently available online, but this can be investigated further, or the document can be uploaded to the CESEL webpage. In response, members noted that it is important for a source link to be identified not only to provide assurances around the legitimacy of the recommendations but also so that it can be signposted to ensure any version control is maintained.

Clarification was requested regarding the off-label dosing for Seretide® 100 Accuhaler in the asthma CYP guide, and why this was selected instead of opting for the licensed preparation, Seretide Accuhaler 250, which allows for one puff twice daily to achieve the desired dosing in accordance with NICE. The presenter explained that the use of Seretide 100 Accuhaler® enables a pragmatic approach to support dose adjustments, without requiring a different device or additional training.

Committee members approved the following by consensus:

- Updated medicines sections of the CESEL asthma adult and CYP guides pending updates in line with the discussion
- Formulary inclusion of Vivaire® 100/6 MDI as Green for the management of asthma and COPD and 200/6 MDI as Amber 1 for the management of asthma
- Categorisation of montelukast as Green in adults and paediatrics for the management of asthma
- Removal of Atectura® Breezhaler and Enerzair® Breezhaler from the local adult JMF

ACTION: CESEL adult and CYP guides to be updated in line with discussions and progressed for ratification via Chair's action
ACTION: Vivaire® MDI 100/6 for asthma and COPD to be added as Green and Vivaire® 200/6 MDI for asthma to be added as Amber 1 to the SEL JMF
ACTION: Atectura® and Enerzair® to be removed from the SEL JMF
ACTION: Montelukast to be added as Green to the SEL JMF and paediatric formulary

Post meeting note: The formulary inclusion of Vivaire® as green for the management of COPD will be implemented once the SEL IMOC COPD guideline has been updated to include Vivaire®.

7. i. Request to expand the use of apixaban for thromboprophylaxis following catheter directed post-thrombolysis (CDT) to all deep venous stenting procedures in SEL

The applicant presented this item which is a request to expand the formulary approved use of apixaban as Amber 2 for post deep venous stenting after catheter directed post-thrombolysis (CDT) for acute venous thromboembolism (VTE) treatment to all deep venous stenting procedures, i.e. including stent insertion cases for compression syndrome where there was no prior thrombolysis or an acute VTE event. Examples of compression syndrome include May Thurner syndrome, and renal vein entrapment. The original formulary application for the use of apixaban after CDT presented at the Feb 2023 IMOC meeting and re-presented at the November 2024 IMOC meeting, requested the use of apixaban for thromboprophylaxis and maintenance of stent patency following stent insertion after CDT for acute VTE treatment. However, the intention of the formulary application was for the use of apixaban in all stenting cases as stents are also inserted for the treatment of vascular compression syndrome and for cases of acute deep vein thrombosis (DVT) or prior DVT with post-thrombotic syndrome where thrombolysis was not required. The current request has also been shared with the cardiovascular disease sub-group of the IMOC, with no comments or objections received.

The evidence presented to the committee for the original application also included data for patients who received stents for reasons such as thromboprophylaxis post stent and the audit data that was presented in November 2024 also included non-CDT cases. From a cost perspective, the figures detailed in the original formulary application covered all intended use for apixaban in this setting, therefore no extra costs are anticipated with this request.

A comment was raised in relation to whether there are any changes in the information shared with GPs when prescribing is transferred to primary care in line the with the Amber 2 prescribing arrangements. The presenter clarified there are no changes in the information provided to GPs upon transfer of prescribing, this will remain as the standard communications sent to GPs post stent from vascular surgery.

ii. Updated formulary recommendation 155 – apixaban for thromboprophylaxis in this setting

The associated formulary recommendation has been updated in line with the request to expand the formulary approved use of apixaban as Amber 2 for post deep venous stenting after CDT for acute VTE treatment to all deep venous stenting procedures. The updated formulary recommendation has been shared with the IMOC virtual Triage Panel with no comments received.

Committee members approved by consensus the request to expand the formulary approved use of apixaban as Amber 2 for post deep venous stenting after CDT for acute VTE treatment to all deep venous stenting procedures and the updated formulary recommendation.

ACTION: SEL JMF to be updated to expand use of apixaban for thromboprophylaxis post CDT to all deep venous stenting procedures as Amber 2

8. Primary prevention of breast cancer in women at moderate or high risk

The authors were in attendance to present this item, which is a request to approve a new treatment pathway for the primary prevention of breast cancer in women at high or moderate risk, in line with guidance from NICE. The treatment pathway aims to support a new referral pathway under the GSTT service. The treatment pathway has been consulted through IMOC and is accompanied by an abridged formulary request for the formulary inclusion of the following risk reducing endocrine treatments in this setting as Amber 2:

- Tamoxifen
- Anastrozole
- Raloxifene (off-label)

A slide deck summarising the background to the GSTT clinical genetics service and the detail of the referral pathway was presented on screen; the main highlights include:

- NICE guideline CG164 recommends chemoprevention for women over 35 years old at moderate/high risk of breast cancer due to family history, with the option of treatment with tamoxifen, anastrozole or raloxifene for 5 years. Tamoxifen and anastrozole are licensed, while raloxifene is off label.
- Patients personal and family history and suitability for risk-reducing endocrine treatment is assessed within the risk-reducing endocrine clinic as well as a discussion in relation to the advantages and disadvantages of treatment.
- Where prophylaxis is appropriate, the clinic will initiate treatment and provide 3 months' supply of treatment. If patients do not wish to consider treatment, they will be discharged from the clinic.
- Risk reducing endocrine treatments should not exceed 5 years, and prescribing information sheets to support GPs have been produced for tamoxifen, anastrozole and raloxifene, which includes information on contraindications, side effects, monitoring and follow up.
- The NICE patient decision aids for tamoxifen and anastrozole were presented to showcase the benefit of risk reducing endocrine treatments.

Committee members noted the service is currently funded for a minimum of 12 months. The presenters explained that long term commissioning of the service will be decided following an evaluation of the service and outcomes. The aim is to ensure the service can be sustainably commissioned in the future and ongoing sustainable commissioning will be managed through contracts as part of the annual commissioning intentions process. From a cost impact perspective, the formulary inclusion of tamoxifen, anastrozole and raloxifene is within the delegated financial threshold for the committee. It was noted that from a value perspective, there would be associated benefits not only to the NHS and social care from a reduction in breast cancer cases but also personally to individuals prescribed prophylaxis.

A request was made for a standardised clinic letter from the service to GPs, to ensure that all critical information is effectively communicated including the roles and responsibilities of GPs. The presenter confirmed this can be developed. Committee members agreed the draft standardised clinical letter should be shared with a primary care committee members for review, prior to IMOC Chair's approval.

A query was raised on how primary care clinicians should manage BMI increases to ≥35 kg/m^2 during treatment with tamoxifen and whether treatment should be stopped due to the risk of DVT? The presenter clarified that for patients who develop new risk factors for DVT/ pulmonary embolism (PE) it would be appropriate to re-refer to the clinic. However, the presenter agreed to seek clarity from the clinical lead for service and will incorporate guidance on this in the pathway where appropriate. A query was raised in relation to the annual monitoring of cholesterol associated with anastrozole, with a request for clarification on the type of cholesterol monitoring required (e.g. total cholesterol or fasting lipid profile) and the action required if there are changes or an abnormal result. The presenter agreed to seek clarity from the clinical lead for this service and will incorporate guidance on this within the pathway where appropriate.

Committee members approved by consensus the pathway for the use of risk-reducing endocrine treatment in the primary prevention of breast cancer in women at high or moderate risk, pending amendments to the pathway in line with the discussions, and the formulary inclusion of tamoxifen, anastrozole and raloxifene as Amber 2 in this setting once the pathway is approved.

ACTION: Pathway to be updated in line with the discussions and progressed for ratification via Chair's action
ACTION: Tamoxifen, anastrozole and raloxifene to be added to the SEL JMF as Amber 2 for the primary prevention of breast cancer in women at moderate or high risk once pathway approved

9. Formulary request for the off-label use of aripiprazole in autistic spectrum disorder (ASD) and tics and Tourette's in children.

The applicants were in attendance to present this item which is an off-label formulary request for the use of aripiprazole in autistic spectrum disorder (ASD) and tics and Tourette's syndrome (TS) in children aged 6 years old and over as Amber 2 based on historical use. The formulary request was originally presented in March 2023, a decision on the request was deferred until additional supporting data could be provided as well as the development a GP factsheet to support prescribing in primary care in line with the proposed Amber 2 categorisation.

The Formulary Pharmacist provided a brief overview of the evidence to support the formulary inclusion request. Aripiprazole in ASD and tics and TS is licensed in the United States (US) and recommended locally within the Maudsley Prescribing Guidelines, supported by a 2016 Cochrane review. NICE guidance recommends atypical antipsychotics can be used for treatment of irritability in ASD, where psychosocial interventions are insufficient or ineffective. NICE do not make recommendations on specific antipsychotics. The European clinical guidelines for TS and other tic disorders also supports the use of aripiprazole in this setting.

The recommended starting dose in the US is 2mg, titrating up to 15mg for ASD or 10-20mg for tics based on weight. In the UK, treatment typically begins at a lower dose of 0.5mg per day, with a

maximum of 5mg per day to mitigate adverse effects, a practice supported by various clinical trials. In clinical practice, lower doses of aripiprazole are typically prescribed for children with TS and autism, despite higher doses suggested by research and guidelines. The presenter clarified that the lower doses of aripiprazole used in this setting is also common among colleagues in the UK and internationally. The rationale for the lower dosages is that children often respond sufficiently well at these levels with fewer side effects. While there is a notable gap between clinical practice and established evidence, efforts are underway to publish data supporting the efficacy of lower doses of aripiprazole in this setting. To date, GPs have generally agreed to take on the monitoring and prescribing of aripiprazole in this setting following specialist initiation and continued review by the specialist team.

The evidence base for the off-label use of aripiprazole in this setting is primarily based on data from two pivotal randomised controlled trials (RCTs), described in the agenda papers. A phase 3 multicentre RCT in patients aged 7 to 17 years old with a diagnosis of TS were randomised patients to low-dose aripiprazole, high-dose aripiprazole, or placebo for 8 weeks. The study found statistically significant improvements in tic symptoms versus placebo after 8 weeks, with both doses of aripiprazole leading to reductions in points on the Yale Global Tic Severity Scale Total Tic Score (YGTSS-TTS). Only those receiving high dose aripiprazole had a statistically significant response rate vs. placebo. However, higher discontinuation rates were noted for the high dose aripiprazole. The most common adverse events were sedation, somnolence, and fatigue.

A RCT in the US randomised 218 children with autism aged 6-17 to aripiprazole 5mg, 10mg, 15mg (gradually titrated to dose) or placebo daily, for 8 weeks of treatment, with the Aberrant Behaviour Checklist – Irritability [ABC-I] score as the primary endpoint reviewed. All doses of aripiprazole demonstrated a statistically significant improvement in ABC-I vs placebo. Sedation, tremor, drooling, extrapyramidal disorders and hypersalivation among other adverse effects, appeared more common with aripiprazole.

From a cost impact perspective, the formulary inclusion of aripiprazole in this setting is within the delegated financial threshold for the committee. The treatment is licensed in the US and regarded as a preferred option in European and American guidelines for ASD and the request is for lower dosing than the FDA-approved levels, which will help with side effect management.

In discussions about the request, GP Committee members expressed concerns about taking on prescribing of aripiprazole for an off-label indication in a very young patient cohort. As these patients will continue to be reviewed regularly by the specialist team, a Red (hospital only) categorisation was suggested as more appropriate. Committee members noted that aripiprazole's licensed uses in paediatrics start at age 13 years (bipolar disorder) and 15 years (schizophrenia). Members queried how old patients are generally with these conditions. The presenter confirmed that the cohort with tic's tends to be under 13 years old as this starts at a younger age and patients grow out of this condition as they grow older. The cohort with TS has varying ages.

A comment was raised in relation to whether an Amber 3 categorisation (shared care) could be considered in this setting, for example for older age groups as opposed to a Red categorisation. GP committee members expressed that while shared care allows patients to remain under continued supervision with a specialist, the off-label use, age-related considerations, and complexities of individual cases would be difficult for a GP to manage in primary care.

Committee members agreed that the desired Amber 2 category would not be appropriate for the reasons discussed and did not approve the request. The committee approved by consensus the formulary inclusion of aripiprazole in ASD and tics and Tourette's in children as Red (hospital only).

ACTION: Aripiprazole in ASD and tics and Tourette's syndrome in children to be added to the paediatric formulary as Red

10. Updated primary care antimicrobial guideline for SEL – stoma section (addition to Skin and Soft Tissue Infections section)

The authors were in attendance to present this item on behalf of the SEL Forum for Antimicrobial Stewardship (SELFAS) Primary Care working group and SEL FAS. The local primary care antimicrobial guideline has been updated to include a section on the management of stoma infections and consulted on locally. This guideline is intended to complement, rather than replace, existing protocols from the nutrition team on the management of stoma infection. A query was raised regarding a comment received during the consultation which recommended removing the reference to purchasing treatments OTC, however it was noted that the treatment of fungal infections recommended are primarily available OTC and this is referenced in other parts of the existing primary care antimicrobial guidance. Committee members agreed the recommendation to purchase fungal treatments OTC is appropriate as it is forms part of self-care.

A concern was raised about the lack of guidance for patients using OTC medications, querying how patients will know when to seek medical advice from their GP after self-treating mild infections, in the case of worsening conditions if proper counselling is not provided. The presenter explained that as patients are regularly monitored by stoma nurses, this allows for any changes in the patient's condition to be promptly identified, facilitating timely interventions and necessary treatments. Clarification was requested to confirm the frequency of reviews with the stoma nurses and whether education is provided on how patients should manage potential stoma infections in between appointments. The presented agreed to confirm this with the clinical team.

Committee members approved by consensus the updated primary care antimicrobial guideline for SEL – stoma section (addition to Skin and Soft Tissue Infections section) pending updates in line with the discussion.

ACTION: SEL primary care antimicrobial guideline stoma section to be updated in line with discussions and progressed for IMOC Chair's ratification

11. Updated formulary recommendation 145 - rituximab for the treatment of refractory autoimmune hepatitis in adults.

This formulary recommendation has been updated following a presentation on the outcome data for the use of rituximab for the treatment of refractory autoimmune hepatitis in adults. The updated formulary recommendation has been shared with the virtual Triage panel with no comments received. A minor amendment to the recommendation was noted in relation to the title of the specialist group collating data across the UK and Europe. It was agreed longer term outcome data from this database should be reported to the committee in the future with an update on patient numbers to be presented back to the committee in 2 years.

Committee members approved by consensus the updated formulary recommendation 145.

ACTION: An update on patient numbers to be presented back to the committee in two years.

12. Standing Items

- Formulary submission tracker

Noted.

- NICE Technology Appraisal Guidance Summary – ICS & NHSE attributed medicines:

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

- For information and noting:
  - Adult and paediatric formulary updates
  - Categorisation of glaucoma medications as Amber 2 in line with the updated chronic open angle glaucoma and ocular hypertension pharmacological treatment pathway approved via IMOC Chair's action

Committee members noted these updates.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 17th July 2025	2pm - 4:30pm	MS Teams

Thursday 21st August 2025	2pm – 4:30pm	Hybrid in person/MS Teams
September 18th September 2025	2pm – 4:30pm	MS Teams