South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
18th December 2025 (Hybrid meeting)
Final Minutes

1. Welcome, introductions and apologies

The Chair welcomed attendees to the meeting. Apologies and observers were noted, and the meeting was confirmed 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.

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 grammatical and 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.

4. Formulary inclusion of DEKAs® Essential multivitamin for patients with cholestasis and chronic liver disease as Amber 1

The applicants were in attendance to present this request, with support from the Trust formulary pharmacist. The formulary inclusion of DEKAs® Essential multivitamin capsule and liquid for adults and children and young people (CYP) in the management of chronic liver disease and cholestasis, was originally presented at the July 2024 meeting. The committee agreed by consensus to defer a final decision on the formulary request pending clarity on the intended patient cohort and the consequences of prescribing DEKAs® Essential multivitamin outside of the Advisory Committee on Borderline Substances (ACBS) criteria. Subsequently, at the August 2024 meeting, the desired patient cohort was clarified and confirmation provided that prescribing outside of the ACBS criteria can be considered if there is clinically rationale to support use. Committee members also noted that the liquid formulation of DEKAS® Essentials multivitamin is not listed within the Drug Tariff and that the ACBS were unable to advise if the liquid formulation would be considered for inclusion. In line with this, the committee agreed by consensus a “Red, Amber, Green” (RAG) category of Red (hospital only) for DEKAS® Essentials multivitamin capsules only in this setting. For consideration of primary care prescribing, the request would require further detail outlining robust initiation and stopping criteria, a clear patient cohort and indication at a future IMOC meeting.

DEKAs® Essential multivitamin will be initiated for children and young people (CYP) aged 0 -17 years old identified as having fat soluble vitamin malabsorption due to underlying liver disease and cholestasis, as diagnosed by a paediatric consultant hepatologist. As the preparation is a combined preparation which can be administered in a smaller volume, it has the potential to significantly improve adherence. In line with the European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) guidelines, fat soluble vitamins will be monitored every 3-6 months by the specialist team. In line with this, committee members were requested to consider the formulary inclusion of DEKAs® Essential vitamins liquid as Amber 1 and recategorisation of DEKAs® Essential vitamins capsule from Red to Amber 1.

As noted at the July 2024 meeting, the estimated cost impact is within the threshold delegated to the Committee. The estimated cost impact is likely to be a substitution against existing formulary options and could be cost saving compared to individual vitamins being prescribed.

Clarification was requested regarding the eligible patient cohort and if the use of DEKAs® Essential multivitamin in adults is for new initiations or patients transitioning to adult services. The presenter noted DEKAs® Essential multivitamin is initiated for CYP and is not for initiation in adult patients. CYP may require multivitamins in this setting as they transition into adulthood, as these patients

have chronic liver disease which does not usually resolve unless a liver transplant has occurred. However, the preparation and dose of the multivitamin should be reviewed and adjusted where necessary when patients transition into adult services.

A query was raised regarding the monitoring requirements as well as whether DEKAs® Essential multivitamin is readily available via community pharmacies. The presenter highlighted that monitoring will be carried out by the specialist team and noted that community pharmacies are able to readily obtain DEKAs® Essential multivitamin capsules and liquid. A comment was raised requesting an enhanced formulary entry to note the initiation and stopping criteria for DEKAs® Essential multivitamin and that use is outside of the ACBS criteria in this setting if approved. The presenter agreed with this request.

Committee members approved by consensus the formulary inclusion of DEKAs® Essential multivitamin liquid as Amber 1 and the recategorisation of DEKAs® Essential multivitamin capsule from Red to Amber 1, with an enhanced formulary entry in line with the discussions. Members noted that for adults the inclusion is for those transitioning to adult services, in adults who have been reviewed and deemed as still requiring the DEKAs® Essential preparation. New initiations in adulthood would not be expected.

ACTION: The SEL paediatric formulary to be updated to include DEKAs® Essential multivitamin liquid as Amber 1 and DEKAs® Essential multivitamin capsule recategorised from Red to Amber 1 in this setting detailing the initiation and stopping criteria, monitoring arrangements and a clear statement that use is outside of the ACBS criteria
ACTION: DEKAs® Essential multivitamin capsule and liquid to be added to the SEL adult JMF as amber 1 for adults in this setting transitioning to adult services who have been reviewed and still require this preparation. Entry to include initiation and stopping criteria, monitoring arrangements and a clear statement that use is outside of the ACBS criteria

5. Primary care information factsheet for CYP2C19 testing

The authors were in attendance to present this item and the background was provided, noting that one SEL Trust is implementing CYP2C19 genetic testing to support medicines optimisation and guide clopidogrel use in patients following acute ischaemic stroke or Transient Ischemic Attack (TIA), in line with the National Institute for Health and Care Excellence (NICE) HealthTech guidance 724 (HTG724). The presenter noted long term the aim is to implement CYP2C19 genetic testing across SEL Trusts to limit inequity of access to the test for the local population, however timelines for implementation across SEL acute Trusts are to be confirmed.

At the August 2025 SEL Joint Formulary Committee (JFC) meeting, the committee reviewed an application for the use of ticagrelor (off-label) in this setting for 28 days for patients with an unknown CYP2C19 genetic status or are poor or intermediate CYP2C19 metaboliser. This was approved as Red, pending the development of internal Trust guidance (for approval via the Trust Drugs and Therapeutic committee) and support information for primary care (for approval via SEL IMOC).

In line with this, a primary care information sheet has been developed by the acute Trust and approved via the Cardiovascular sub-group following IMOC consultation. The information sheet aims to support healthcare professionals in primary care who may be requested to continue the prescribing of long-term antiplatelet treatment in patients with either a poor or intermediate CYP2C19 metaboliser status following ischaemic stroke or TIA. The presenter outlined the pathway, highlighting the two key actions for primary care following the receipt of a patient's CYP2C19 metaboliser status - to continue long-term antiplatelet prescribing as per the recommendation from the specialist stroke team and code the genetic status in the patient's primary care electronic records using SNOMED codes.

To support best patient care and medicines optimisation, the Trust stroke team will be reviewing patient's existing medicines based on the CYP2C19 genetic testing result and adjusting medications, if necessary, which will also be communicated to primary care via a clinic or discharge letter. The Royal College of General Practitioners (RCGP) have developed a position statement

which highlights that GPs are not obliged to utilise CYP2C19 metaboliser status to guide prescribing of other medications. Local implementation plans include a patient information leaflet (PIL) as well as an educational webinar for primary care.

Concerns were raised around the SNOMED code appearing when clopidogrel is being prescribed for a different indication outside of acute ischaemic stroke or TIA. The presenter explained that currently the GP electronic system does not flag drug-gene interactions and highlighted there is no expectation at present to use the genetic status code to guide treatment outside of acute ischaemic stroke or TIA which aligns with the RCGP position statement and will be reiterated at the educational webinar.

Members requested the primary care information sheet is presented as a SEL wide document rather than a Trust specific document with a statement included to clarify that currently there is only one SEL Trust offering this service. A query was raised regarding the long term availability of funding for the service at the Trust and if there are any imminent plans at the other SEL Trusts to implement CYP2C19 genetic testing, as availability of the test at one SEL Trust introduces inequity to the local population. The presenter explained the funding should be long-term as support for use is aligned to the availability of NICE HTG 724. The presenter appreciated the concerns around inequity for the local population, whilst highlighting the current local inequalities between ethnicities for stroke outcomes and the potential for access to genetic testing, even at one Trust currently to help improve this, as well as the benefit in the overall reduction of strokes.

In response to a query about the management of patients who decline genetic testing, the presenter confirmed patients would follow the existing treatment pathway and be offered treatment with clopidogrel. This will be clarified in the primary care information sheet. Committee members were requested to note that the primary care information sheet will be an appendix to the local antithrombotic summary of options in cardiovascular disease (CVD) guideline.

Committee members approved by consensus the primary care information sheet for CYP2C19 testing at GSTT, pending amendments in line with the discussion.

ACTION: Primary care information sheet to be amended in line with the discussion and progressed for ratification via IMOC Chair's action

6. **SEL Acute Provider Collaborative (APC) primary and secondary care gynaecology guidelines and associated formulary request:**
    - **Formulary requests**
    - **Guidelines for approval (medicines content only):**
        - **Dysmenorrhea**
        - **Post-Menopausal Ovarian Cyst**
        - **Pre-Menopausal Ovarian Cyst**
        - **Premenstrual Syndrome**
        - **Premature ovarian insufficiency**

The lead authors from the APC were in attendance to present the item with support from the Trust formulary pharmacist and SEL ICB Lead Pharmacist. The presenters outlined the work to develop the guideline which supports the diagnosis and management of various gynaecological sub-conditions. The guidelines were circulated for consultation with the IMOC as well as a broader consultation including the Local Medical Committee (LMC). Post IMOC consultation, five guidelines (dysmenorrhea, post-menopausal ovarian cyst, pre-menopausal ovarian cyst, premenstrual syndrome (PMS) and premature ovarian insufficiency) have been reviewed, updated and approved by the APC board and are being requested for approval (medicines content only) by the committee. The outstanding guidelines are currently under review and will be presented at a future IMOC meeting for approval of the medicines content.

Committee members were also requested to consider the approval of the associated formulary requests for the various gynaecological sub-conditions as detailed in the agenda pack. All the formulary requests are in line with national guidelines including recommendations from NICE and

the Royal College of Obstetricians and Gynaecologists and represent established practice. In summary, this included the following formulary requests summarised in a table format:

- Combined oral contraceptives as Green used off-label for - dysmenorrhoea, inter-menstrual bleeding (IMB), heavy menstrual bleeding (HMB), chronic pelvic pain (CPP), endometriosis, pre-menstrual syndrome (PMS), polycystic ovary syndrome, prevention of endometrial hyperplasia and acne/hirsutism in polycystic ovary syndrome (PCOS)
- Levonorgestrel intrauterine system (IUS) as Green used for HMB (licensed) and off-label for dysmenorrhoea, endometriosis and PMS
- Progestogen-only pills (POPs) as Green used off-label for - IMB, HMB, CPP and endometriosis
- Medroxyprogesterone & norethisterone as Green used off-label for the prevention of endometrial hyperplasia (oligomenorrhea & amenorrhoea) in PCOS
- Etonogestrel implant as Green used off-label for endometriosis
- Transdermal estradiol and oestradiol gel as Green, micronised progesterone and continuous combined hormone replacement therapy as Amber 1 and gonadotropin-releasing hormone analogues as Amber 2 used off label for PMS
- Lidocaine 5% ointment and oral amitriptyline as Green used off-label for vulval symptoms

The formulary requests outline the estimated patient numbers and costings for each indication. An update to the formulary requests for approval was presented on screen at the meeting, which included an update to the estimated patient numbers and associated costings for progesterone only pills and the inclusion of levonorgestrel intrauterine systems for PMS. The presenter clarified that the formulary requests are historical practice and established across primary and secondary care. Therefore, from a cost perspective, the formulary requests are within the financial threshold delegated to the committee as an additional cost impact is not expected for SEL.

A query was raised regarding consultation with Trust radiology teams as part of the development of the guidelines, as there are often requests following radiology advice to refer patients to gynaecology for further review. The presenter noted engagement with radiology is ongoing, with plans to align scanning pathways and address the increase in gynaecology referrals. A comment was raised in relation to whether the guidelines will prevent referrals to secondary care where patients have specifically requested referral. The presenter explained the guidelines are intended to empower GPs to manage more patients in primary care, but referral remains appropriate for patients who do not respond to first-line management or who request specialist input. A request was made to update the guidelines to include where pharmacological treatments are being used off-label in the guidelines and signpost to the SEL adult JMF.

Committee members approved by consensus the SEL APC gynaecology guidelines formulary requests and the following guidelines (medicines content only) pending the amendments requested:

- Dysmenorrhea
- Post-menopausal ovarian cyst
- Pre-menopausal ovarian cyst
- Premenstrual syndrome
- Premature ovarian insufficiency

ACTION: Authors to return amended guidelines in line with discussions for progression for IMOC Chair's approval
ACTION: SEL adult JMF to be updated in line with the formulary request for dysmenorrhea, inter-menstrual bleeding, heavy menstrual bleeding, chronic pelvic pain, endometriosis, polycystic ovary syndrome, premenstrual syndrome (PMS) and vulval symptoms

7. **Updated SEL antithrombotic summary of options in cardiovascular disease (CVD) guideline and associated formulary request:**
    - **Updated guideline**
    - **Recategorisation of rivaroxaban in preventing atherothrombotic events after acute coronary syndrome (ACS) from Amber 3 to Amber 2**
    - **Retirement of the following SEL IMOC guidance and resources:**

- **Rivaroxaban for preventing atherothrombotic events after acute ACS guidance, notification of initiation and transfer of care**
- **Rivaroxaban for preventing atherothrombotic events in coronary and/or peripheral artery disease guidance**

The authors were in attendance to present this item, which updates the previous summary of antiplatelet options and has been approved via the CVD sub-group following IMOC consultation. The presenter outlined the main updates to the summary of antiplatelet options in CVD guideline which includes:

- Broader range of treatments, covering both antiplatelets and anticoagulants and a new structure by indication (cardiac, stroke, peripheral arterial disease (PAD)).
- Expanded triple therapy section
- Detailed stroke section, including CYP2C19 genotype testing and clear differentiation between minor and major stroke management
- Updated recommendations for clopidogrel and rivaroxaban in the management of PAD
- Inclusion of rivaroxaban for the management of coronary artery disease (CAD)

In line with the inclusion of PAD and CAD with rivaroxaban within the updated guideline, committee members were requested to consider the retirement of the local rivaroxaban for preventing atherothrombotic events in CAD and/or PAD guidance.

As part of the guideline update, the RAG category of medicines used in this setting were also reviewed. The following uncategorised medicines used in this setting are being proposed with the following RAG category - aspirin, clopidogrel and dipyridamole as Green and prasugrel as Amber 1. Recategorisation of rivaroxaban for the prevention of atherothrombotic events after ACS from Amber 3 (shared care) to Amber 2 (specialist initiation) is also being requested. The shared care arrangements for rivaroxaban in this setting no longer reflect current practice and an amber 2 categorisation would align with the use of rivaroxaban in other CVD indications covered by NICE technology appraisals. From a cost perspective, this formulary request is within the financial threshold delegated to the committee as there is no anticipated cost impact expected from the recategorisation. Alongside the recategorisation request, if approved, committee members were also requested to consider the retirement of the rivaroxaban for preventing atherothrombotic events after acute ACS guidance, notification of initiation and transfer of care document.

Post consultation, the thrombotic myocardial infarction (MI) section was updated and renamed as MI with non-obstructive coronary arteries (MINOCA), noting the difference in pathophysiology for this group of myocardial infarctions. Treatment will be tailored to the individual patient depending on the underlying cause. The management of MINOCA is not covered by NICE guidance, however the use of antiplatelets and anticoagulants for the management of MINOCA is established practice and patient numbers are relatively small. A significant additional cost impact is not expected locally with the inclusion of MINOCA within the guideline. The presenter shared an amended version of the document on screen with the wording for the MINOCA section made clearer.

A comment was raised highlighting the importance of clear discharge communication, especially for dual or triple antiplatelet therapy, with explicit instructions on duration and stopping criteria. The presenter provided reassurance that secondary care teams aim to provide clear communications on clinic letters and discharge summaries which outlines the intended duration of treatment of antiplatelet and anticoagulant treatments.

It was noted that the information sheet for CYP2C19 testing post stroke or TIA discussed earlier in the meeting will be added as an appendix to this document.

Committee members approved the following by consensus:

- Updated SEL antithrombotic summary of options in CVD guideline
- Categorisation of aspirin, clopidogrel and dipyridamole as Green and prasugrel as Amber 1
- Recategorisation of rivaroxaban for the prevention of atherothrombotic events after ACS from Amber 3 to Amber 2

- Retirement of rivaroxaban for preventing atherothrombotic events after acute ACS guidance, notification of initiation and transfer of care documents
- Retirement of rivaroxaban for preventing atherothrombotic events in CAS and/or PAD guidance
- Inclusion of MINOCA as a new section (added post IMOC consultation)

ACTION: Rivaroxaban for preventing atherothrombotic events after acute ACS to be recategorised from Amber 3 to Amber 2 in the SEL adult JMF
ACTION: Aspirin, clopidogrel and dipyridamole to be categorised as Green and prasugrel to be categorised as Amber 1 in the SEL adult JMF
ACTION: Authors to share amended summary of antithrombotic options for approval via IMOC chair's action

8. Updated SEL inclisiran initiation checklist and retirement of inclisiran frequently asked questions (FAQs)

The authors were in attendance to present this item; the updated inclisiran initiation checklist and request to retire the inclisiran FAQ has been discussed and approved via the CVD sub-group. Main updates to the inclisiran checklist include the following:

- Clarifying statement that submitting the inclisiran checklist for advice and guidance implies willingness to initiate inclisiran in primary care if appropriate
- Updated statin therapy questions and new resource section to support implementation in primary care

A comment was raised regarding the retirement of the inclisiran FAQ resource, particularly the information in relation to how primary care procure inclisiran which is often a query received by secondary care. The presenter clarified there is information available online nationally via NHS England, which primary care clinicians can be signposted to.

In response to a query about the black triangle status of inclisiran, the presenter advised that the black triangle was removed in November 2025 and no longer appears within the Summary of Product Characteristics. However, this is yet to be updated in the British National Formulary (BNF). Concerns were raised about the implications for GPs following the new statement within the inclisiran initiation checklist which implies GPs are now obliged to prescribe inclisiran following a request for advice and guidance. The presenter explained the existing inclisiran initiation checklist included a similar statement however the statement has been clarified to streamline the process. GPs who do not feel comfortable initiating inclisiran in primary care should refer patients to the lipid clinics. In line with this, committee members agreed the statement should be updated to clarify that referral to the lipid clinic is the most appropriate option for patients who would like to be considered for inclisiran but the GP is not comfortable to take on prescribing in primary care.

Committee members approved by consensus the inclisiran initiation checklist, pending amendments in line with the discussion and the retirement of inclisiran FAQs.

ACTION: SEL inclisiran initiation checklist to be updated in line with discussion and progressed for ratification via IMOC Chair's approval

9. Good news story – SEL osteoporosis treatment pathway recognition by the Royal Osteoporosis Society

The Lead Pharmacist for the osteoporosis treatment pathway task and finish group provided an update on the recognition and commendation received from the Royal Osteoporosis Society (ROS) for the SEL osteoporosis treatment pathway. The ROS support the All-Party Parliamentary group (APPG) for the management of osteoporosis and bone health, and together they conduct an annual inquiry into osteoporosis care nationally, with a focus this year on how patients are supported and empowered to manage their condition over the long term. As part of the inquiry, a report is being published in January 2026, and the ROS will feature the SEL Osteoporosis Treatment Pathway as being an exemplary example.

Members from the SEL osteoporosis treatment pathway task and finish group were invited to represent SEL ICS at the APPG to discuss the rationale and principles behind the development of the SEL Osteoporosis Treatment Pathway, key successes, learning points, and opportunities for national improvement in osteoporosis care.

Committee members noted the good news story and commended the ongoing excellent work of the committee, which is also being recognised nationally.

10. Updated SEL paediatric melatonin prescribing pathway

The author presented this item, which has undergone a minor amendment following feedback from colleagues regarding patients initiated on melatonin in childhood and transferred to adult services. There have been instances where GPs have been reluctant to continue prescribing melatonin in primary care once the patient becomes an adult as melatonin is not licensed in people under the age of 55. The section in the paediatric melatonin prescribing pathway on transition of CYP to adult services has been updated with additional detail noting that GPs can continue treatment if the treatment has been effective, well tolerated and there is a clear management plan documented by the paediatric/specialist team. GPs should seek advice from the relevant adult service or the originating specialist team where required.

Committee members approved by consensus the updated SEL melatonin prescribing pathway.

11. Formulary recommendation: Metformin for the prevention and treatment of weight gain associated with antipsychotics

This formulary recommendation has been drafted following the approval of metformin in this setting at the September IMOC meeting. There has been a time lag whilst patient numbers were confirmed by both mental health trusts. No comments were received from triage panel review. Committee members approved the formulary recommendation for metformin in this setting by consensus.

12. Standing Items:

- Formulary submissions tracker

Noted.

- *NICE Technology Appraisal (TA) Guidance Summary – Integrated Care Board and NHSE attributed medicines:*

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

- For information – committee members noted the adult and paediatric formulary updates for November 2025

13. i. Re-presentation of cariprazine outcome data for the treatment of schizophrenia in adults

The supporting presenter outlined this item following a request from the May 2025 IMOC meeting for updated outcome data to be presented to the committee to demonstrate whether cariprazine was continued or discontinued in practice following a review of Scale for the Assessment of Negative Symptoms (SANS) score. The updated outcomes data demonstrated that the majority of patients continued with treatment at 12 months irrespective of a 6 month and/or 12-month SANS score. A reduction in the average duration of inpatient hospital admission following treatment with cariprazine was also observed. In terms of adverse drug reactions, overall cariprazine is generally well tolerated and no ECG changes were observed.

ii. Request to remove the restrictions associated with prescribing cariprazine in SEL for schizophrenia in adults

The applicant was in attendance to present this item which requests the use of cariprazine in line with its licensed indication without the following restrictions associated with its use:

- Patients who continue to have prominent and debilitating negative symptoms on their current antipsychotic regimen **and** have a SANS score of ≥50
- Treatment with cariprazine should only be continued if there is a ≥50% improvement in the SANS score

Cariprazine is licensed in the UK for the treatment of schizophrenia in adults, covering both positive and negative symptoms. Using cariprazine more widely would be beneficial to patients with early psychosis or first-episode psychosis were treatment options are limited, particularly for negative symptoms. The benefits of cariprazine in comparison to other antipsychotics include cardiac neutrality making it a safer option for patients with CVD risk factors, and minimal side effects which may improve tolerability (which is often experienced with other antipsychotics). Cariprazine is also a partial dopamine agonist, therefore initiating cariprazine early may reduce the risk of dopamine receptor supersensitivity, which can occur with prolonged exposure to full antagonists. Cariprazine would be positioned as a first-line option primarily for patients presenting with first-episode psychosis, especially those with negative symptoms, CVD risk factors and have expressed concerns about side effects with other antipsychotics.

From a cost perspective, this formulary request is within the financial threshold delegated to the committee.

A query was raised regarding the use of best value antipsychotics and in which clinical scenario would cariprazine be initiated over alternative antipsychotics such as aripiprazole, which is available generically. The presenter noted the place in therapy would be dependent on the individual patient, noting the benefit of cariprazine is particularly for first time psychosis with prominent negative symptoms, if the patient has CVD risk factors and antipsychotic tolerability is a concern. A follow up query was raised whether cariprazine will be restricted to patients at risk of cardiovascular side effects and if the formulary recommendation should still refer to negative symptoms as an initiating criterion. The presenter noted there is currently no established process locally for selecting one antipsychotic over another, however this can be considered as a broader piece of work across SEL. The presenter agreed the formulary recommendation should still include the benefit of cariprazine in managing negative symptoms without making this a prerequisite for initiation, to enable patient choice.

Committee members approved by consensus the request to remove the restrictions associated with prescribing cariprazine in SEL for schizophrenia in adults.

ACTION: Formulary recommendation to be updated in line with the discussion and presented at a future meeting
ACTION: SEL adult JMF entry to be updated in line with updated formulary recommendation once approved

14. Updated SEL methylphenidate shared care guidelines (SCG) and template letter:

- **Summary of changes**
- **Narcolepsy and idiopathic hypersomnia SCG**
- **Adult (complex) attention deficit hyperactivity disorder (ADHD) SCG**
- **Adult (non-complex) ADHD discharge to GP template letter**
- **Paediatric ADHD SCG**

The supporting author was in attendance to present this item. At the November 2025 IMOC meeting, committee members agreed by consensus for methylphenidate modified release (M/R) tablet and capsule to be noted generically within the SEL adult JMF and SEL joint paediatric formulary. The SCGs which contain methylphenidate M/R tablet and capsule have been updated to reflect this formulary change.

The presenter highlighted there have been no clinical changes to the SCGs, however as a clinical review is due for the adult and paediatric ADHD SCGs, committee members were requested to approve the ADHD SCGs with a review date of one year. As the narcolepsy and idiopathic

hypersomnia SCG was recently clinically reviewed and approved by the committee in September 2025, the current 3 year review date will remain for this SCG.

A comment was raised in relation to appendix 1 of the SCGs to move the dose and treatment start date information to the same sentence which notes the medication to be prescribed by the GP and the indication. As appendix 1 is part of the IMOC approved SCG template, committee members agreed appendix 1 should be amended to reflect this change in the SCGs as well as within the IMOC SCG template.

Committee members approved by consensus the following updated methylphenidate M/R containing SEL shared care guidelines and template letter pending updates to appendix 1 as per the discussion:

- Narcolepsy and idiopathic hypersomnia SCG
- Adult (complex) attention deficit hyperactivity disorder (ADHD) SCG
- Adult (non-complex) ADHD discharge to GP template letter
- Paediatric ADHD SCG

ACTION: Appendix 1 of the methylphenidate M/R containing SCGs and IMOC SCG template to be updated in line with discussion and progressed for ratification via IMOC Chair's approval

15. Any Other Business

Committee members offered congratulations to the Senior Pharmacist on the safe delivery of their baby.

IMOC dates for the next 3 months

Date	Time	Venue
Thursday 15th January 2026	2pm – 4:30pm	MS Teams
Thursday 19th February 2026	2pm – 4:30pm	MS Teams
Thursday 19th March 2026	2pm – 4:30pm	MS Teams