

**South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
15th January 2026 (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 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. A declaration was noted from one of the presenters of agenda item 15 - updated position statement for generic dapagliflozin in SEL. No further conflicts were raised by members.

3. Minutes, detailed action notes of the last meeting, and action log

The minutes and action notes were accepted as an accurate record of the meeting subject to the correction of typographical errors and the following amendment below for the minutes:

- Agenda Item 8 – Updated SEL inclisiran initiation checklist and retirement of inclisiran frequently asked questions (FAQs): as reported at the December 2025 meeting, sentence on the removal of the black triangle status for inclisiran to be added.

Members were provided with an update on the progress against actions due for this month, these were noted, and items closed were agreed.

4. Update to formulary request for the re-categorisation of sevelamer carbonate for hyperphosphataemia in chronic kidney disease (CKD) from Red to Amber 2

The applicant was in attendance to present this item which provides an update to the approval at the November 2025 IMOC meeting to recategorise sevelamer carbonate from Red to Amber 2. The request specifically covered sevelamer tablets and sachets to be noted as sevelamer carbonate on the SEL adult Joint Medicines Formulary (JMF). Following the November 2025 meeting, a subsequent request was received to include sevelamer on the adult JMF without noting the salt form, which is now being presented. This is because the hydrochloride salt form of sevelamer is also now available generically. The presenter clarified sevelamer is noted generically without the salt (carbonate or hydrochloride) within the drug tariff, British National Formulary (BNF) and within the secondary care prescribing system. The summary of product characteristics (SPCs) do refer to the salt.

At the November 2025 IMOC meeting, concerns were raised regarding metabolic acidosis in relation to the use of sevelamer hydrochloride, however the presenter clarified this has not been observed in practice locally or other renal centres nationally.

A query was raised regarding the patient cohort for which sevelamer is being requested, noting the licensing differences between sevelamer carbonate and sevelamer hydrochloride. Sevelamer hydrochloride is licensed for use in CKD patients in dialysis only, whereas sevelamer carbonate is licensed for use in both dialysis and non-dialysis CKD patients. In line with this, clarification was sought as to whether the proposed use of sevelamer hydrochloride in this setting would be off-label. The presenter clarified that the National Institute for Health and Care Excellence (NICE) guidance for CKD (NG203) acknowledges the off-label use of sevelamer hydrochloride with no efficacy concerns. The presenter agreed that the off-label nature will be explicitly noted in the adult JMF along with reference to the NICE guideline.

The committee approved by consensus for the wording in the adult JMF to refer to sevelamer in this setting without the salt (and in line with the previous discussions in November 2025, the “Red, Amber, Green” (RAG) category is Amber 2).

ACTION: Generic sevelamer tablets to be added to the SEL adult JMF for hyperphosphataemia in CKD as Amber 2 in line with the discussions at the November 2025 and January 2026 IMOC meetings

5. Formulary inclusion of carvedilol as Amber 1 in the following setting:

- **Primary prevention of decompensated cirrhosis in adults with clinically significant portal hypertension**
- **Recategorisation from Amber 2 to Amber 1 for prevention of bleeding from medium or large oesophageal varices in adults with cirrhosis**

The applicant was in attendance to present this item; the presenter summarised the request and provided the following background and context:

- Propranolol is traditionally used in this setting, however there is evidence which demonstrates carvedilol provides superior efficacy and tolerability in comparison to propranolol.
- NICE guideline (NG50) cirrhosis in over 16s recommends carvedilol as first-line therapy for the primary prevention of decompensation in patients with confirmed liver cirrhosis and clinically significant portal hypertension. Propranolol is recommended as a second-line option where carvedilol is contraindicated.
- NG50 recommends carvedilol as an alternative to propranolol for the prophylactic management of medium or large oesophageal varices.
- Locally, carvedilol is used as first line treatment for both indications. However, use is off-label in this setting but is recognised as standard treatment in the BNF.
- Monitoring requirements for carvedilol in this setting are consistent with standard beta-blocker use (heart rate and blood pressure).

Committee members were also requested to consider a request to categorise propranolol as Amber 1, as propranolol is currently uncategorised in the SEL adult JMF in this setting. Propranolol is licensed for the prevention of bleeding from medium or large oesophageal varices in adults with cirrhosis. However, use of propranolol is off-label for the primary prevention of decompensated cirrhosis in patients with clinically significant portal hypertension. From a cost perspective, this request is within the financial threshold delegated to the committee. As carvedilol is primarily being initiated instead of propranolol, this will be a substitute cost, however as this is established practice, the cost is likely to be stable.

A query was raised regarding the potential delay in treatment with carvedilol if categorised as Amber 1 in high risk patients diagnosed with large varices at endoscopy. The presenter clarified inpatients, who tend to be high risk with large varices, will be initiated on treatment whilst in hospital. However, the Amber 1 category is useful for low risk patients i.e. diagnosed with medium varices and have their endoscopy as an outpatient closer to home. Clarification was sought in relation to whether patients will remain under the care of the specialist team or discharged to the care of their GP following diagnosis. The presenter confirmed patients will remain under the care of the specialist team. Specialist follow-up includes regular surveillance scans, typically every six months, or annually for low risk patients.

A request was made to include a link to NG50 and the section within NG50 on “safe prescribing and use of carvedilol and propranolol in people with cirrhosis” within the SEL adult JMF entry for carvedilol and propranolol. A query was also raised regarding patients with medium or large oesophageal varices and whether carvedilol is always used as first line followed by propranolol as a second line option. The presenter clarified carvedilol is usually used first line in this setting as the evidence demonstrates that carvedilol is more efficacious on the portal vein pressure in comparison to propranolol.

Committee members approved the following by consensus for the use of carvedilol and propranolol in adults with liver cirrhosis as Amber 1:

- Carvedilol as first line for the primary prevention of decompensated cirrhosis in adults with clinically significant portal hypertension (*off-label*)

- Propranolol as second line for the primary prevention of decompensated cirrhosis in adults with clinically significant portal hypertension (*off-label*)
- Carvedilol (*off-label*) and propranolol (licensed) for the prevention of bleeding from medium or large oesophageal varices in adults with cirrhosis

The off-label nature will be noted in the formulary entries as appropriate.

ACTION: SEL adult JMF to be updated to include carvedilol as first line treatment and propranolol as second line treatment for the primary prevention of decompensated cirrhosis in adults with clinically significant portal hypertension as Amber 1

ACTION: Carvedilol to be recategorised from Amber 2 to Amber 1 in the SEL adult JMF for the prevention of bleeding from medium or large oesophageal varices in adults with cirrhosis

ACTION: Propranolol to be categorised as Amber 1 in the SEL adult JMF for the prevention of bleeding from medium or large oesophageal varices in adults with cirrhosis

ACTION: SEL adult JMF entries for carvedilol and propranolol for liver cirrhosis to include the link to NG50 and the section within NG50 on “safe prescribing and use of carvedilol and propranolol in people with cirrhosis”

6. Recategorisation of propranolol and carvedilol for children and young people (CYP) with portal hypertension to Amber 2 (previously presented in December 2023 & October 2024)

The applicant was in attendance to present this item; the background to the request was provided in line with the proposal as per the agenda pack. Carvedilol has been used off-label in this setting locally for the past two years ahead of propranolol in line with the strong evidence base in adults. A retrospective review has been conducted alongside two paediatric liver centres to review patient outcomes from the use of carvedilol in this setting. The review concluded that carvedilol reduced bleeding events and reduced the number interventions that CYP needed per year, demonstrating that carvedilol is effective at managing the risks associated with portal hypertension in this patient cohort.

Historically, propranolol has been used as first-line treatment in this setting followed by carvedilol as a second line option. However, based on the outcomes observed with carvedilol in this setting, which has also been demonstrated in the adult population, carvedilol is now the preferred first-line treatment. Propranolol is reserved for CYP unable to tolerate carvedilol. The team has a multi-disciplinary specialist service which manages the initiation, stabilisation, monitoring, and prescribing of carvedilol for this patient cohort, once a patient is stable on treatment, a request would be made to GPs to take over prescribing. At the October 2024 IMOC meeting, updates were requested to the Trust patient information leaflet (PIL), which are still underway. Once complete, the PIL will be shared with the committee for information.

In line with the proposal outlined by the presenter, committee members were requested to consider the recategorisation of carvedilol and propranolol to Amber 2 in this setting, supported by the emerging evidence of efficacy and safety in CYP. Clarification was sought regarding the responsibility of GPs when they take on the prescribing of carvedilol or propranolol in this setting. The presenter clarified GPs will only be responsible for prescribing carvedilol and propranolol, and all monitoring, dose titration, and clinical management will be conducted by the specialist team. Children and young people in this setting typically receive blood tests every three months; for very stable CYP who are older without recent bleeds, monitoring may be extended to six months or annually

Members requested that the GP responsibility and monitoring requirements outlined in the request are included in the carvedilol and propranolol formulary monograph if approved. The formulary entry should also make clear which clinician is responsible for carrying out the monitoring and titration requirements and in which setting. Clarification was also requested regarding the minimum period of prescribing by the specialist team. The presenter confirmed the Trust will issue a minimum of one month supply as the dose usually stabilises during this period.

Committee members approved by consensus the recategorisation of propranolol and carvedilol for children and young people with portal hypertension to Amber 2.

ACTION: Carvedilol formulary recommendation to be drafted and presented at a future IMOC meeting for approval

ACTION: Propranolol and carvedilol to be recategorised to Amber 2 within the paediatric joint formulary alongside the inclusion of information on GP responsibility, monitoring and titration requirements

ACTION: Updated carvedilol PIL to be shared with the committee for information

7. SEL Acute Provider Collaborative (APC) primary and secondary care gynaecology guidelines and associated formulary request

- **Levonorgestrel 52mg intrauterine device (IUD) formulary request in Polycystic Ovarian Syndrome (PCOS)**
- **Guidelines for approval (medicines content only):**
 - **Recurrent Inter- menstrual bleeding and break through bleeding**
 - **Cervical polyps**
 - **Lichen sclerosus**
 - **Heavy menstrual bleeding**
 - **Oligomenorrhoea and secondary amenorrhoea**
 - **Suspected polycystic ovarian syndrome (PCOS)**
 - **Primary amenorrhoea**
 - **Subfertility**
 - **Endometriosis**

The lead authors were in attendance to present the item, which covers nine SEL APC guidelines that support the diagnosis and management of 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 and associated formulary requests were discussed and approved (pending amendments to the guidelines) at the December 2025 IMOC meeting.

An additional nine guidelines post IMOC consultation have been reviewed, updated and approved by the APC board and are being requested for approval (medicines content only) by the committee.

Committee members were also requested to consider a formulary request for the use of levonorgestrel 52mg intrauterine device (IUD) in PCOS. The use of levonorgestrel 52mg IUD in this setting is in line with guidance in the NICE Clinical Knowledge Summaries (CKS) topic on the management of PCOS. The use of levonorgestrel 52mg IUD in this setting is historical practice and established across primary and secondary care. Therefore, from a cost perspective, the formulary request is within the financial threshold delegated to the committee as the estimated cost is not expected to have an additional impact in SEL.

The aim of the guidelines is to improve care, reduce variation, and provide consistent advice to GPs across a range of gynaecology conditions. The last set of outstanding guidelines are currently under review and will be presented at a future IMOC meeting for approval of the medicines content.

A query was raised regarding the heavy menstrual bleeding guideline; post-IMOC consultation, for patients with fibroids above 3 cm, the guideline has been amended to recommend the initiation of hormonal or non-hormonal treatment in primary care. Clarification was requested on which hormonal or non-hormonal treatments are being recommended. The presenter clarified reference to hormonal and non-hormonal treatments refers to the treatment options noted earlier in the guideline such as combined and progesterone only contraceptive pills. The presenter agreed to amend the guideline to clarify the treatment options for patients with fibroids above 3 cm and that treatment should be trialled for 6 months in primary care before referral to specialist services. In relation to the inclusion of metformin (off-label) as a treatment option within the PCOS guideline, members reported that metformin is prescribed in primary care on the recommendation of a specialist and the guideline requires updating to reflect this. A follow up comment was raised regarding the Red, Amber, Green (RAG) category for metformin in the management of PCOS on the SEL adult JMF. As metformin is uncategorised, committee members were requested to formally consider a categorisation of Amber 1 in line with its place in therapy.

Committee members approved the following by consensus:

- Formulary inclusion of levonorgestrel 52mg IUD in PCOS
- Categorisation of metformin (off-label) as Amber 1 in PCOS
- The nine guidelines presented (medicines content only), pending the amendments discussed

ACTION: SEL adult JMF to be updated in line with the formulary request for levonorgestrel 52mg IUD in PCOS

ACTION: Metformin (off-label) as Amber 1 in PCOS to be updated within the SEL adult JMF

ACTON: Authors to return amended guidelines in line with discussions for approval via IMOC Chair's action

8. Updated SEL Medical Retinal Treatment Pathway in Wet Age-Related Macular Degeneration (wet AMD)

The lead author was in attendance to present this item with support from members of the Ophthalmology Medical Retinal Therapies sub-group. The wet AMD guideline has undergone minor updates in line with recent updates to NHS England's (NHSE) national treatment pathway which includes:

- Removal of the word "preferred" for aflibercept 8mg
- Off-label dosing details for aflibercept 8mg and faricimab added

Committee members noted NHSE had removed the "preferred" second line option recommendation for aflibercept 8mg in the national pathway and the second line choice is now equally between aflibercept 8mg and faricimab. This change has been made by NHSE in line with their recent proposed reference pricing for intravitreal therapies (which is under discussion in SEL). However, in the event NHSE reference pricing is withdrawn, the sub-group has committed to reviewing the wet AMD guidance and consideration of re-adding the "preferred" recommendation.

Committee members approved by consensus the updated SEL medical retinal treatment pathway in wet AMD.

9. Re-presentation of formulary application for zoledronic acid 4mg for osteoporosis in men and postmenopausal women with impaired renal function (off-label)

The supporting applicants were in attendance to present this item on behalf of the original co-applicant who is currently unable to attend IMOC to present. This formulary application was originally presented at the October 2025 IMOC meeting. However, the use of intravenous (IV) zoledronic acid 4mg (off-label) as a single dose in patients with a creatinine clearance (CrCl) between 30-35 ml/min, or estimated glomerular filtration rate (eGFR) >30ml/min/1.73 m² in patients post-fracture with limited life expectancy (6 -12 months) could only be considered and was approved as Red.

The presenter outlined that the current presentation to the committee is for the cohort of patients in the formulary application with impaired renal function where IV zoledronic acid is being proposed as a single dose or annual infusion for 3 years or longer in certain patients or 18 monthly infusions based on individual cases for the following indications noted within the original formulary application:

- First line treatment for secondary prevention of a fragility fracture in line with guidance from the National Osteoporosis Guideline Group (NOGG) or
- Primary and secondary prevention of a fragility fracture as per the SEL osteoporosis treatment pathway

The presenter clarified that the majority of patients in this setting will receive a single dose of IV zoledronic acid 4mg due to their frailty. However, in some cases it may be suitable for patients to receive IV zoledronic acid 4mg 18-monthly. Current practice at the Trust is to use IV zoledronic acid 4mg 18-monthly for frail patients with reduced renal function, and not as an annual infusion. The presenter acknowledged that this isn't completely in line with the original formulary application presented to the committee in October 2025 as it's not the practice at the centre they are based in.

Denosumab would be the preferred as an alternative for those with longer life expectancy (e.g. at least 3 years).

A query was raised regarding whether denosumab is an alternative treatment option for patients who require 18 monthly IV zoledronic acid 4mg in this setting and how treatment choice is determined. The presenter clarified that frail patients with reduced renal function are typically treated with 18-monthly zoledronic acid rather than denosumab due to barriers such as the need to travel every 6 months to receive a dose and the monitoring requirements associated with denosumab treatment. Committee members noted, if approved, the local osteoporosis guideline will need be updated to reflect the use of the IV zoledronic acid 4mg in this setting.

Committee members noted that they could not make a decision about the request in the original formulary application for the use of a yearly infusion of IV zoledronic acid for 3 years or longer given it is not implemented by the service the presenter is based in. The Formulary Lead for the original application added their support for the 18 month regimen in view of the experience at the local Trust supporting the application and agreed to feed this back to the clinicians at their Trust, who had originally requested the yearly infusion.

Committee members approved by consensus the use of IV zoledronic acid 4mg (off-label) as a single dose or 18 monthly infusions in patients with a CrCl between 30-35 ml/min, or eGFR >30ml/min/1.73 m² in the following setting:

- First line treatment for secondary prevention of a fragility fracture in line with guidance from the National Osteoporosis Guideline Group (NOGG) or
- Primary and secondary prevention of a fragility fracture as per the SEL osteoporosis treatment pathway

ACTION: Formulary recommendation to be drafted and presented at a future IMOC meeting for approval

ACTION: SEL osteoporosis treatment pathway to be updated to include the use of IV zoledronic acid 4mg (off-label) 18 monthly in patients with impaired renal function once formulary recommendation is approved

ACTION: IV zoledronic acid 4mg (off-label) 18 monthly in patients with impaired renal function to be added to the SEL adult JMF once formulary recommendation is approved

10. Updated shared care guideline for denosumab 60mg subcutaneous injection for the treatment of osteoporosis

The author was in attendance to present this item; the denosumab shared care guideline (SCG) has been reviewed and updated with the following main updates:

- Addition of biosimilar denosumab and removal of reference product - Prolia[®] throughout the document
- Inclusion of the preferred denosumab biosimilar brand for use in SEL - Osyrti[®]
- Removal of Prolia[®] specific materials (self-injection training and patient website)
- Updated Trust contact details

Committee members noted that the SPC is not available for Osyrti[®], and this will be added to the SCG once this is available.

A request was made to state the strength of denosumab biosimilar injection (60mg) throughout the SCG as there are two biosimilar strengths available (60mg and 120mg) with differences in licensing. A comment was also raised to note that specialist advice should be sought in the event of a shortage and that Osyrti[®] is the “preferred” biosimilar of choice in SEL. An update to the SEL adult JMF was requested to note denosumab 60mg is available as a biosimilar and the preferred brand in SEL is Osyrti[®].

Committee members approved by consensus the updated shared care guideline for denosumab 60mg subcutaneous injection for the treatment of osteoporosis pending amendments as per the meeting discussion.

ACTION: SCG for denosumab 60mg injection to be updated in line with discussions for approval via IMOC Chair's action

11. Updated nutrition guidelines

- Adult oral nutrition supplement (ONS) guides and resources
- Paediatric Cow's Milk Protein Allergy (CMPA) guides and resources

The author was in attendance to present this item which has been primarily updated to note ONS and CMPA product changes, price updates, and the teams contact information.

Committee members noted the ONS extended product reference guide and the hypoallergenic formula and volume guide have had some minor additional updates since circulation of the meeting agenda pack, which were shared on screen. The ONS extended product reference guide now includes an updated RAG rating for Ensure Plus Juice. The hypoallergenic formula and volume guide has been updated to include the new tin sizes for Neocate LCP in line with product repackaging.

The committee approved by consensus the updated nutrition guidelines.

12. Updated shared care prescribing guideline for recombinant growth hormones (somatropin, somapacitan, somatrogen) in paediatric growth hormone deficiency

A member of the Trust Paediatric Pharmacy team was in attendance to present this item on behalf of the author who was unable to attend the meeting. The SCG has been reviewed, and updated with the following main updates:

- Formatted into the updated shared care template
- Inclusion of two new weekly growth hormone products in line with NICE technology appraisal (TA) guidance – somapacitan (NICE TA1066) and somatrogen (NICE TA 863)
- Removal of discontinued brand (Zomacton®)
- Refined wording and updated doses to align with the British National Formulary for Children (BNFc) and national guidance

The committee approved by consensus the updated shared care prescribing guideline for recombinant growth hormones (somatropin, somapacitan, somatrogen) in paediatric growth hormone deficiency, pending a minor formatting change.

13. Updated “Red, Amber, Green” (RAG) category definition list for SEL

The existing definition list for “RAG” categories has been updated to reflect the adoption of the Pan-London RAG list definitions in SEL (approved over summer 2025). Over the last few months, the SEL adult JMF, paediatric joint formulary and the primary care prescribing decision support tool (OptimiseRx) have been updated to reflect the Pan-London RAG list definitions.

Committee members noted the RAG category definition list for SEL includes reference to the outdated list of NHSE specialist medicines which are not listed in the SEL adult JMF. Committee members were requested to consider the retirement of this list, as alternative mechanisms exist for the verification of NHSE-commissioned specialist medicines. Committee members agreed by consensus for the list of non-formulary medicines under NHSE commissioning to be retired. The presenter also noted a minor amendment to the “*non-formulary - not recommended for prescribing*” category within the document to include a statement that this category is not assigned a colour.

Next steps included as part of the implementation of the Pan-London RAG list definitions in SEL, includes updating the grey formulary recommendations to align with the non-formulary - not

recommended for prescribing category and sending communication to local stakeholders in primary and secondary care regarding the adoption of the Pan-London RAG list definitions in SEL. Committee members agreed by consensus that the updated grey formulary recommendations can be approved via IMOC Chair's action, as the amendments are considered minor.

The committee approved by consensus the updated RAG category definition list for SEL.

14. Standing items for information only

- Formulary submission 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.

15. Updated position statement for generic dapagliflozin in SEL

The lead authors presented this item, which is an updated version of a previously presented (but not published) position statement on the choice of sodium-glucose co-transporter 2 (SGLT2) inhibitor for the treatment of:

- type 2 diabetes (with or without chronic kidney disease [CKD])
- symptomatic chronic heart failure

The position statement aims to support implementation of generic dapagliflozin in SEL as a preferred SGLT2 inhibitor and has been revised to align to the current licensing for generic dapagliflozin (as per the cohorts above). Significant savings are estimated for the NHS from implementation of generic dapagliflozin in the currently licensed patient cohorts. Recent communication from NHSE notes that a second medical use patent has been granted for the use of dapagliflozin in the treatment of CKD in patients without T2DM. In line with this, brand prescribing of dapagliflozin is required for patients with CKD who do not have diabetes.

The second medical use patent creates implementation challenges for generic dapagliflozin despite no clinical issues with the use of generic dapagliflozin in CKD. However generic dapagliflozin offers significant cost savings for use in patients with T2DM (with or without CKD) and patients with symptomatic chronic heart failure. A member comment noted that a pilot in some SEL boroughs is proactively identifying patients with CKD, hypertension, hypercholesterolemia, or diabetes and optimising their risk factors. Anecdotally a significant cohort of patients with CKD but no diabetes is being started on SGLT2 inhibitors, therefore it is possible that the proportion of such cases in SEL may rise over time.

Committee members discussed the complexity of implementation for generic dapagliflozin locally due to the new second medical use patent in CKD and the need for clear communication to primary care.

Committee members approved by consensus the revised position statement for generic dapagliflozin in SEL, which supports the licensed uses for generic dapagliflozin.

16. Any Other Business

Committee members congratulated the IMOC vice Chair on their appointment as new Chair of the Advisory Council on Misuse of Drugs. Committee members also shared well wishes to a member of the SEL IMO Team as they embark on their three month sabbatical travelling around South east Asia.

IMOC dates for the next 3 months

Date	Time	Venue
Thursday 19th February 2026	2pm – 4:30pm	MS Teams
Thursday 19th March 2026	2pm – 4:30pm	MS Teams
Thursday 16th April 2026	2pm – 4:30pm	MS Teams