South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
19th February 2026 (Online via MS Teams)
Final Minutes

Microsoft Copilot (artificial intelligence) was used to support the initial drafting of these meeting notes. The accuracy and content have been reviewed, edited and finalised by the meeting leads.

1. Welcome, introductions and apologies

The Chair welcomed attendees to the meeting. Apologies were noted 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 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. Guideline for the treatment of acute multiple sclerosis (MS) relapse

The authors were in attendance to present this item with support from the primary care borough lead. The guideline has undergone SEL wide consultation and aims to provide a clear approach for the management of acute MS relapse across primary and secondary care settings in line with the National Institute for Health and Care Excellence (NICE) guideline (NG) 220 – management of MS in adults. The presenter outlined the key recommendations within the guideline, including treatment options, dosing considerations, and monitoring requirements. The guideline emphasises that not every relapse requires steroid treatment and supports the use of oral methylprednisolone 500mg once daily for five days where treatment is indicated under the existing Amber 1 “Red, Amber, Green” (RAG) category.

An update to the flowchart within the pathway was requested to make clear that the initiation of oral methylprednisolone should occur on the advice of the specialist MS team, to ensure primary care prescribing is supported by specialist confirmation. A comment was raised regarding the use of night sedation for steroid-induced insomnia and the inclusion of night sedation treatment examples consistent with the SEL adult JMF and the treatment duration within the guideline. The presenter agreed to include this information.

Committee members approved the guideline for the treatment of acute MS relapse by consensus, pending amendments to the guideline in line with the meeting discussion.

ACTION: Acute MS relapse guideline to be updated in line with the discussion and progressed for approval via IMOC Chair’s action

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

- **Formulary request for aspirin 75mg daily in women with recurrent miscarriage diagnosed with anti-phospholipid syndrome**
- **Guidelines for approval (medicines content only):**
  - **Persistent Vaginal Discharge**
  - **Recurrent First Trimester Miscarriage and/or one or more second trimester miscarriage**
  - **Post-coital bleeding**
  - **Chronic Pelvic Pain**
  - **Management of Lost IUD**
  - **Vulval symptoms**
  - **Management of Pelvic Inflammatory Disease**

The APC Programme Lead was in attendance to present this item which covers seven SEL APC guidelines (third tranche of 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 across South East London. Following IMOC consultation, the first tranche of guidelines (five guidelines) and associated formulary requests were presented and approved at the December 2025 IMOC meeting. At the January 2025 IMOC meeting, the second tranche of guidelines (nine guidelines) with an associated formulary request were presented and approved. Both the first tranche and second tranche of guidelines were approved subject to amendments.

As part of this submission, committee members were also requested to consider a formulary request for the use of aspirin 75mg daily in women with recurrent miscarriage diagnosed with antiphospholipid syndrome (APS). The use of aspirin 75mg in this setting is in line with guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) and the proposed RAG category is Amber 1 *(initiation in primary care on specialist advice).* From a cost impact perspective, the formulary request is within the financial threshold delegated to the committee.

It was noted that following IMOC consultation, the "recurrent first trimester miscarriage and/or one or more second trimester miscarriage" guideline was updated to include enoxaparin for thromboprophylaxis in APS, which remains hospital-only (Red) in line with local guidance and the SEL adult JMF. Micronised vaginal progesterone was also included in line with RCOG guidance for women with early pregnancy bleeding and a history of miscarriage; however, its use in this setting is off-label and not currently included within the SEL adult JMF. As a result, the committee agreed that the guideline could not be approved until a formulary request is submitted for consideration at a future IMOC meeting via the established governance processes. Committee members also noted that the off-label use of oral amitriptyline and lidocaine 5% gel within the vulva symptoms guideline was discussed and approved as part of the formulary requests presented at the December IMOC meeting.

A query was raised whether daily low dose aspirin could be initiated in primary care prior to specialist review in certain circumstances, noting delays to specialist review could delay beneficial treatment. GP members expressed differing views with some supporting primary care initiation prior to specialist review due to the low risk associated with aspirin and experience in prescribing aspirin for obstetric indications while others preferred initiation in primary care following specialist advice due to variable primary care familiarity with APS management in pregnancy. A suggestion was made for the guideline to note the use of advice and guidance (rather than referral only) for this patient cohort to expedite specialist input and reduce delays. It was further proposed that a statement be included to clarify that, for patients with established APS and subsequent pregnancies, GPs may initiate aspirin without the need for advice and guidance or referral. Members fed back that it would be helpful to signpost to NICE Clinical Knowledge Summaries (CKS) within relevant sections of the guidelines, where CKS summaries exist. The presenter agreed to update the guideline accordingly.

A comment was also raised in relation to whether aspirin can be initiated before a patient is seen in secondary care for the initiation of enoxaparin or whether both treatments need to be initiated simultaneously. The presenter agreed to confirm this with the lead specialist clinician for the guideline.

Committee members approved the following by consensus:

- Formulary inclusion of aspirin 75mg daily in women with recurrent miscarriage diagnosed with APS
- The following guidelines (medicines content only), pending the amendments discussed:
  - Persistent Vaginal Discharge
  - Recurrent First Trimester Miscarriage and/or one or more second trimester miscarriage
  - Post-coital bleeding
  - Chronic Pelvic Pain
  - Management of Lost IUD
  - Vulval symptoms
  - Management of Pelvic Inflammatory Disease

ACTION: SEL adult JMF to be updated in line with the formulary request for aspirin 75mg daily in women with recurrent miscarriage diagnosed with APS

ACTION: Authors to progress formulary request for micronised vaginal progesterone for women with early pregnancy bleeding and a history of miscarriage
ACTION: Authors to return amended guidelines in line with discussions to be progressed for approval via IMOC Chair's action

6. Formulary recommendations

I. New recommendations

- Carvedilol tablets for the treatment of portal hypertension in children and young people
- Zoledronic acid solution for infusion for osteoporosis in men and postmenopausal women with reduced renal function

These formulary recommendations have been drafted following the approval of carvedilol in this setting as Amber 2 (specialist initiation) at the January 2026 IMOC meeting and approval of zoledronic acid in this setting at the October 2025 and January 2026 meeting. The draft formulary recommendations were shared with the triage panel for comments, minor comments were noted.

Committee members approved the new formulary recommendations by consensus.

II. Updated recommendations

- 097 - cariprazine hydrochloride for the treatment of schizophrenia in adults
- 133 - apixaban 2.5mg tablets as a second line option where vitamin K antagonist therapy is inappropriate in adults undergoing haemodialysis

The cariprazine recommendation has been updated following the presentation of outcome data and approval to amend the criteria for use at the December 2025 IMOC meeting. The apixaban formulary recommendation has been updated to reflect revised UK Kidney Association guidance, including anti-factor Xa monitoring considerations. The draft formulary recommendations were shared with the triage panel for comments, no comments were received.

Committee members approved the updated formulary recommendations by consensus.

7. Formulary inclusion of pyridostigmine in adults for the treatment of orthostatic hypotension as Amber 3 (previously presented in July 2024)

- **Responses to queries raised at July 2024 IMOC meeting**
- **Draft updated transfer of prescribing guidance**

The Formulary Lead Pharmacist presented this item on behalf of the applicants; committee members were requested to reconsider the formulary application for the use of pyridostigmine for orthostatic hypotension as Amber 3 (shared cared), previously presented at the July 2024 meeting. A decision on the formulary application was deferred at the July 2024 IMOC meeting pending responses to queries raised at the meeting. The presenter provided a summary of the responses to the queries raised as outlined within the agenda pack, confirming the main initiating specialties, initiation settings (inpatient and outpatient), follow-up arrangements, and criteria for review and discontinuation.

Committee members noted that the use of pyridostigmine in this setting is expected to be small patient numbers and is typically reserved for patients who have failed standard therapies for example fludrocortisone and midodrine. Committee members were requested to consider an Amber 3 categorisation for pyridostigmine in this setting. In line with the Amber 3 recommendation, the existing transfer of prescribing document available for midodrine in OH has been updated to include pyridostigmine in OH and is also being presented for approval by the committee.

A comment was raised in relation to the use of fludrocortisone in this setting to note that fludrocortisone is off-label for OH and is not included within the SEL adult JMF for this indication. However, this is established practice. The presenter informed the committee that GPs have been accepting requests to continue the prescribing of fludrocortisone in primary care for OH and as such there is no immediate need to submit a formulary request, however, agreed to note this for future work.

Committee members approved the formulary inclusion of pyridostigmine in adults for orthostatic hypotension as Amber 3 and the updated transfer of prescribing document by consensus.

ACTION: Formulary recommendation to be drafted and presented at a future IMOC meeting for approval
ACTION: Pyridostigmine in OH as Amber 3 to be added to the SEL adult JMF following approval of the formulary recommendation

8. Reflections on patient experience and feedback related to access to pyridostigmine for postural orthostatic tachycardia syndrome (POTS)

Members considered reflections on patient experience relating to access to pyridostigmine for POTS, following a complaint to a Trust that was multi-factorial. One aspect of the complaint concerned the time taken to approve a formulary application for pyridostigmine for the use for POTs. A timeline was reviewed highlighting the time the formulary application was submitted to IMOC for consideration to formulary inclusion, and the administrative and governance steps that may have created a delay in the approval process. Members discussed system learning, including the importance of applicants being aware of non-formulary request processes to enable access for individual patients while the formulary process is ongoing. For this particular application, the applicant was not aware of the Trust's non-formulary process. Members also suggested that a prompt be added within the IMOC formulary application form regarding using the Trust non-formulary process in the interim for access to medicines whilst a formulary application is being considered. Members noted that delays in progressing the pyridostigmine for POTS formulary application were partly due to organisational restructuring under the SEL Integrated Care board (ICB) change programme, including the temporary stand-down of the cardiovascular disease (CVD) sub-group, which was supporting the application and the development of the POTS pathway. The committee acknowledged the impact of these changes and noted the importance of clear escalation routes when sub-groups are stood down or responses are delayed.

The committee discussed potential process improvements including consideration of:

- parallel submission to sub-groups groups and IMOC for meeting scheduling purposes
- Clearer process expectations for applicants. This would include an update to the formulary application form at the next iteration of the committee Terms of Reference to signpost that non-formulary processes exist and should be initiated where treatment is necessary before the formulary application is considered and approved.

The Chair also suggested that for existing formulary applications where progress is delayed pending further actions (such as follow up data or pathway development), the overarching committee Chair writes to the applicant to confirm that patients have access to the treatment concerned via the non-formulary route.

Committee members noted the learnings and reflections following the patient experience and feedback.

9. Updated guideline for medicines optimisation in bariatric and metabolic surgery

The author was in attendance to present this item, which has been updated following the withdrawal of a multivitamin product previously recommended (Sanatogen®), alongside other minor safety and medicine optimisation updates based on service experience.

A comment was raised regarding the on-going monitoring requirements for patients, noting that the PIVKA-II test is not available in primary care. The presenter clarified that PIVKA-II is a blood test carried out by the specialist team only and GPs would not be required to carry out this testing and this can be clarified within the guideline. A comment was also raised in relation to the availability of contact details for bariatric dietetic advice which would be useful in the guideline to support the management of vitamin and mineral deficiencies. The presenter confirmed the contact details for the bariatric dietetic team can be included in the guideline.

Committee members approved the updated guideline by consensus pending amendments in line with the meeting discussions.

ACTION: Guideline to be updated in line with IMOC discussion and progressed for approval via IMOC Chair's action

10. Updated guidance on optimising prescribing for chronic stable angina

The author presented this item which has been updated and approved via CVD sub-group. The update focused on refreshing hyperlinks, clarifying first-line and second-line anti-anginal therapy, and the inclusion of a section on the de-prescribing of anti-anginals in patients with severe frailty or limited life expectancy. The guidance reaffirms the role of prognostic medicines alongside symptom control with anti-anginals. A comment was raised requesting signposting to the SEL adult JMF for ranolazine and ivabradine which require specialist initiation and noting the Amber 2 category for these treatments within the guideline. Further clarification was requested on the population referred to in statements regarding lack of mortality benefit of anti-anginals. The presenter confirmed the reference was to those approaching end of life and/or severe frailty and agreed to add further clarification within the guideline.

Committee members approved the updated guidance consensus pending amendments in line with the meeting discussions.

ACTION: Guidance to be updated in line with IMOC discussion and progressed for approval via IMOC Chair's action

11. Updated guidance on omega 3 fatty acid compounds and fish oil supplements

The author was in attendance to present this item which has been updated and approved via the CVD sub-group, following a request from the self-care and low priority products sub-group to update the resource. The guidance has been updated to include the place in therapy of icosapent ethyl in line with NICE TA 805 and alignment with the existing NHS England (NHSE) "Items which should not routinely be prescribed in primary care policy guidance" for omega-3 supplements. The document has also been simplified to a visual summary and includes signposting to supporting resources. A comment was raised requesting the addition of a link to the NHSE "items which should not routinely be prescribed" policy. The presenter agreed to this addition.

Committee members approved the updated guidance pending amendments in line with the meeting discussion.

ACTION: Guidance to be updated in line with IMOC discussion and progressed for approval via IMOC Chair's action

12. Amendment to place in therapy for Tostran® (testosterone) 2% gel in male hypogonadism due to androgen deficiency

The applicant presented this item which is a request to amend the SEL adult JMF entry to note Tostran® as the preferred first line testosterone 2% gel preparation in this setting to improve consistency, reduce prescribing variation, and deliver system savings. This formulary amendment will align with the use of Tostran® as the first line testosterone 2% gel preparation in the off-label indication in women with decreased libido due to the menopause. The presenter confirmed stock availability assurances and no current intention to change pricing by the manufactures. Trust Formulary pharmacists have also confirmed support for the use of Tostran® first line in this setting.

Committee members approved the amendment to the place in therapy for Tostran® 2% gel in male hypogonadism due to androgen deficiency by consensus.

ACTION: SEL adult JMF to be updated to reflect Tostran® 2% gel as first-line in male hypogonadism due to androgen deficiency

13. Formulary inclusion of omalizumab biosimilar

The Formulary Pharmacist presented this item which is a request to update the formulary entries for omalizumab to note the availability of biosimilars, consistent with wording used for other biosimilar entries within the SEL adult JMF. Committee members noted omalizumab is ICB commissioned for the management of chronic spontaneous urticaria, while use in asthma is commissioned by NHSE. There is currently no stock available of omalizumab biosimilar with a stock update anticipated in March 2026.

The committee approved the formulary inclusion of omalizumab biosimilar by consensus.

ACTION: SEL adult JMF and SEL paediatric formulary to be updated to include omalizumab biosimilar

14. Update on progress with IMOC workplan 25–26 quarter 3

The author presented this item, which notes the progress to date on the IMOC workplan for 2025/26 including a review of responses received from authors on whether existing IMOC guidelines and resources should be retired, reviewed or retained. Members also noted progress with the enhanced formulary entry approach as an alternative to developing full guidelines where appropriate and the on-going exploration of digital solutions to support the production of IMOC minutes and committee consultation processes.

Members noted the update.

15. Paediatric formulary 'Red, Amber, Green' (RAG) rating review - Phase 6 Miscellaneous

The SEL Paediatric Formulary lead presented this item, which aims to update the formulary RAG categories for a range of paediatric medicines in line with their actual use in practice. This forms part of a wider programme of work to undertake a comprehensive review of paediatric medicines to determine the appropriate RAG category. This process does not include the down categorisation of Red or Amber 3 medicines, which will remain unchanged. A number of Green, Amber 1 and Amber 2 medicines have also been identified as appropriate with no proposed change. The table within the agenda pack summarises the drug class, indications, and current and proposed RAG categories. In most cases, a reclassification from Green to Amber 1 or Amber 2 is proposed, reflecting hospital initiation of the first prescription.

Members discussed practical implications for primary care and noted that for the entry for ibuprofen, routine analgesic use (for example for mild to moderate pain or as an antipyretic) should not be impeded by indication-specific categorisation, such as the Amber 1 categorisation for ibuprofen in juvenile arthritis.

Committee members approved by consensus the proposed RAG category changes identified through the Phase 6 miscellaneous paediatric medicines RAG rating review.

ACTION: Paediatric formulary to be updated with approved RAG category changes for paediatric medicines identified through the Phase 6 miscellaneous RAG rating review

16. Standing items/Items for information only

- Formulary submission tracker
  - Noted
  - Members noted an application routed to the hospital only SEL Joint Formulary Committee (JFC) regarding enoxaparin. Members agreed that JFC should consider removing the item from the work queue until the service is operational, to avoid perceived delays attributable to governance.

- NICE Technology Appraisal 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 and noting
  - Adult and paediatric formulary update December 2025 and January 2026
  - Items approved via IMOC Chair's action
    - The Levemir® discontinuation implementation plan was approved via the urgent triage panel process due to time-sensitive discontinuation requirements
    - The updated lipid management pathway has been updated to clarify how to manage patients in primary care who do not have a baseline non-HDL cholesterol level

17. Any Other Business

Members noted changes in committee membership, including an update that a member will be moving roles and transitioning to a new SEL Trust, with a planned handover period. Members congratulated the colleague on their role change.

The Chair reminded members that the March 2026 meeting will be held as a hybrid meeting and will be the final meeting chaired by the committee Chair. Committee members were encouraged to attend in person where possible.

Members were reminded that the process for the election of a new committee Chair is currently underway and expressions of interest for the role are due by 27th February 2026.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 19th March 2026	2pm – 4:30pm	Hybrid (MS Teams/in person)
Thursday 16th April 2026	2pm – 4:30pm	MS Teams
Thursday 21st May 2026	2pm – 4:30pm	MS Teams