South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
16th April 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 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. No conflicts were raised.

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

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

4. Updated SEL osteoporosis treatment pathway and associated formulary request:

- **Amendment to the criteria for use of teriparatide in the management of osteoporosis**
- **Combination denosumab and teriparatide therapy for post-menopausal women at high risk of fracture established on denosumab treatment**

- **Updated SEL osteoporosis treatment pathway**

The authors and leads were in attendance to present this item on behalf of the osteoporosis treatment pathway task and finish group. The osteoporosis treatment pathway has been updated and approved via the task and finish group to reflect changes in national guidance, National Institute for Health and Care Excellence technology appraisals (NICE TAs), National Osteoporosis Guideline Group (NOGG) recommendations, and emerging real-world evidence from specialist osteoporosis services. The overarching objectives of the updated guideline is to improve consistency of practice in osteoporosis management across SEL, reduce unwarranted variation in access to treatment, and ensure earlier identification and treatment of individuals at high and very high fracture risk.

The presenter highlighted the key amendments made to the updated pathway, including the following:

- Addition of an executive summary
- An emphasis on earlier consideration of anabolic therapy as first-line treatment in selected patients at very high fracture risk
- Updates to the primary and secondary prevention flow charts to include Fracture Risk Assessment Tool (FRAX) for risk stratification
- Inclusion of abaloparatide for treating osteoporosis after menopause in line with NICE TA991
- Inclusion of zoledronic acid 4mg for the management of osteoporosis in patients with renal impairment (in line with recent formulary approvals)
- Use of biosimilar denosumab and strengthened advice regarding the discontinuation risks associated with denosumab

An update to the draft osteoporosis pathway was presented on screen at the meeting. It was noted that minor amendments to the pathway have been made since circulation of the April meeting paperwork, including typographical errors.

- **Formulary request for the amendment to the criteria for use of teriparatide in the management of osteoporosis**

In line with NICE TA161 published in 2008, teriparatide is recommended for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. NHS England (NHSE) clinical commissioning policy: teriparatide for osteoporosis, also recommends teriparatide as an alternative

treatment option for the secondary prevention of osteoporotic fragility fractures in men as per the criteria outlined. in NICE TA 161.

Since the publication of NICE TA161, two more anabolic therapies have been approved for use by NICE in this setting (romosozumab and abaloparatide), with less strict criteria. As a result, romosozumab and abaloparatide are often used ahead of teriparatide, however teriparatide is more cost effective, given biosimilar availability and is the only anabolic treatment licensed for the management of glucocorticoid induced osteoporosis (GIOP).

In line with this, the osteoporosis treatment pathway task and finish group is requesting committee members to consider a formulary request to amend the criteria for use for teriparatide to enable use outside of the criteria set by NICE but in line with the licenced indication for teriparatide as follows:

- Management of primary and secondary prevention of osteoporosis in post-menopausal women at very high risk of fracture (using FRAX)
- Adult men with osteoporosis at very high risk of fracture (using FRAX)
- GIOP in men and women at very high risk of fracture (using FRAX)

The use of teriparatide outside of NICE criteria is consistent with established clinical practice and has also been adopted by other local ICBs.

From cost perspective, this formulary request is within the financial threshold delegated to the committee and provides opportunities for savings.

- **Formulary request for combination denosumab and teriparatide therapy for post-menopausal women at high risk of fracture established on denosumab treatment**

Denosumab (an anti-resorptive treatment), is approved for the treatment of osteoporosis in post-menopausal women and men with an increased risk of fracture and for the treatment of GIOP in adult patients at increased risk of fracture. Post-menopausal women on denosumab treatment identified as having a very high risk of fracture may be eligible for treatment with an anabolic such as teriparatide instead of denosumab. However, cessation of denosumab treatment leads to rapid reductions in bone mineral density (BMD) and elevations in bone turnover to levels above those seen before treatment initiation of denosumab.

In line with this, usual practice post denosumab cessation in this setting is the initiation of a bisphosphonate i.e. intravenous (IV) zoledronic acid, followed by anabolic treatment i.e. teriparatide (24 month course) followed by treatment with zoledronic acid as on-going anti-resorptive treatment.
To prevent the high-risk transition period between denosumab and teriparatide, this is a formulary request for the combination treatment of denosumab and teriparatide therapy for post-menopausal women at high risk of fracture established on denosumab therapy (off-label use). Post teriparatide treatment, denosumab will be continued as the monotherapy antiresorptive treatment instead of IV zoledronic acid.

The Formulary Pharmacist provided a brief overview of the evidence to support this request. According to the SPC for denosumab, stopping denosumab treatment lowers BMD and may raise fracture risk, and regular BMD monitoring and alternative therapies should be considered in line with clinical guidance. This is also supported by recommendations from the Medicines and Healthcare products Regulatory Agency (MHRA) and NOGG guidance.

The DATA study, an open-label randomised controlled trial involving 100 postmenopausal women at very high fracture risk, compared teriparatide monotherapy, denosumab monotherapy, and combination therapy. Combination therapy produced greater increases in lumbar spine bone mineral density than either monotherapy, with no treatment-related serious adverse effects reported. The DATA-Switch study, a pre-planned extension of the DATA study, demonstrated that switching from denosumab to teriparatide resulted in initial BMD loss, whereas denosumab following teriparatide or combination therapy stabilised and further increased BMD. Over 48 months, all groups showed net BMD increases, but treatment sequencing significantly influenced outcomes. It was emphasised that

while BMD outcomes are informative, fracture outcome data remain limited and definitive fracture reduction benefit cannot be quantified from the available evidence.

From a safety perspective, no serious adverse events related to the DATA study treatments were reported. In the DATA-Switch study, minimal serious adverse events were reported across the patient cohorts. One adverse event (nephrolithiasis) was related to teriparatide treatment.

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

Updates to the osteoporosis treatment pathway were noted, including the incorporation of a link within the secondary prevention flowchart to the GIOP section of the pathway. Clarification was also requester regarding the duration of steroid treatment in patients aged ≥70 years that requires initiation of bone-protective treatment.
A comment was raised regarding whether teriparatide would be considered as first-line treatment in post-menopausal women at very high risk of fracture to prevent the need for combination treatment. The presenter clarified that post-menopausal women in this setting naive to treatment, and eligible, should be prioritised for first-line anabolic therapy such as teriparatide instead of antiresorptive treatment such as denosumab. A comment was also raised regarding any additional risks associated with the combination therapy of denosumab and teriparatide. The presenter advised as per the DATA-switch study, no additional safety risks are anticipated from the use of the combination treatment beyond those expected for each agent individually.

Clarification was requested regarding whether the parameters of the DATA-switch study would be the same in practice in terms of excluding patients with prior bisphosphonate therapy. The presenter advised they would not advocate for this as an exclusion criteria given the number of patients who experience bisphosphonate intolerance or failure and are currently on denosumab. It is considered best practice to add in teriparatide for these patients also.

Considering the request to use teriparatide and densoumab combination therapy is outside of national guidance, a request for outcome data was raised. The presenters agreed to collate outcome data and present this back to the committee in 18 months.

Committee members approved the following by consensus:

- Updated SEL osteoporosis treatment pathway pending amendments in line with the meeting discussion
- Amendment to the criteria for use of teriparatide in the management of osteoporosis in line with locally agreed criteria
- Combination denosumab and teriparatide therapy for post-menopausal women at high risk of fracture established on denosumab treatment

ACTION: Guideline to be updated in line with the discussion and progressed for approval via IMOC Chair's action
ACTION: Outcome data for the use of teriparatide and denosumab combination therapy to be presented in 18 months at a future IMOC meeting
ACTION: Amended criteria for use of teriparatide in the management of osteoporosis to be added to the SEL adult JMF following approval of the updated guideline

5. Updated guidance on the off-label use of medicines in Oral Medicine and associated formulary requests

i. Pentoxifylline 400mg modified release tablets for use in recurrent aphthous stomatitis (off-label)

This formulary submission originates from the acute Trust oral medicine clinicians. The application requests the off-label use of pentoxifylline 400mg modified release (M/R) tablets in patients with a confirmed diagnosis of recurrent aphthous stomatitis (RAS), having excluded any other secondary causes. The application requests an Amber 2 "Red, Amber, Green" (RAG) category for the use of

pentoxifylline in this setting, noting prescribing will be transferred from the specialist team to GPs after a period of 3 months.

- **Evidence Review**

The Formulary Pharmacist provided an overview of the evidence base, background to the condition and its management. RAS is a chronic condition characterised by recurrent, painful ulceration of the oral mucosa in the absence of systemic disease. Management follows a stepwise escalation, beginning with topical treatments in line with NICE Clinical Knowledge Summaries (CKS) guidance, including topical anaesthetics, analgesics and antimicrobial agents. Where these are ineffective, topical corticosteroids can be used. Patients who fail these approaches require referral to specialist oral medicine services, where systemic therapies such as colchicine or short courses of systemic corticosteroids may be considered alongside concomitant topical corticosteroids following no or limited response to topical treatment only. For severe refractory disease, thalidomide may be considered, although this carries significant toxicity and monitoring burden.

Pentoxifylline 400mg M/R tablets twice a day to three times a day is being proposed as a third-line systemic option in this setting, following failure or intolerance of topical therapies and at least three months of systemic colchicine, and before escalation to thalidomide. Pentoxifylline is also described as an alternative for patients who are unable to tolerate thalidomide. Prescribing would be restricted to recommendation by an oral medicine consultant. The application notes pentoxifylline does not require close blood monitoring as with other immunosuppressants. Patients will be reviewed every 3 months for the first 6 months, followed by 6 monthly outpatient reviews.

The available evidence base for the use of pentoxifylline is limited. One randomised controlled trial (RCT) was identified, involving 26 patients assigned to either pentoxifylline 400mg three times daily or placebo. The RCT reported a slight improvement in disease severity score for the pentoxifylline group and a slight deterioration in the placebo group, though no statistically significant difference was observed. Pentoxifylline produced a statistically significant reduction in median ulcer size, but there were no significant differences detected in pain, number of ulcers, or ulcer-free days. Other studies reviewed were small, non-controlled or open-label and demonstrated variable benefit, but none included robust statistical analysis.

From a safety perspective, pentoxifylline is generally well tolerated, with common adverse effects including gastrointestinal upset, dizziness and headache. More serious adverse effects, such as cardiac, haematological or hepatic abnormalities and transient hypertension, are rare.

From a cost impact perspective, this formulary request is within the financial threshold delegated to the committee. It was noted that the use of pentoxifylline is already established in this setting within the Oral Medicine clinic.

- **Applicants' presentation**

The applicants were in attendance to present the submission and field any questions. The applicant's declaration of interest was noted. It was highlighted that the management of RAS can be challenging for patients. First line systemic therapy, colchicine, can be limited by adverse effects, that prevent dose escalation. Despite the evidence for thalidomide in this setting, the oral medicine team are transitioning patients off thalidomide either as patients no longer require treatment as frequently or patients experience an adverse effect, particularly peripheral neuropathy.

Local clinical experience was described, relating to patients who have been treated with pentoxifylline in this setting. Patients were described as carefully selected, systemically well adults with refractory disease. Treatment was initiated by consultants only, with baseline blood tests and blood pressure monitoring, followed by close follow-up. From local experience, some patients were reported to experience meaningful clinical improvement, often evident within the first three months of treatment. Adverse effects were described as uncommon, with treatment more often discontinued due to lack of efficacy rather than intolerance.

A question was raised relating to any published outcome data by the specialist team for patients currently prescribed pentoxifylline in this setting. The applicant explained they have not published any outcome data, however the team have been monitoring patients and the data is being audited closely. In response to a comment regarding the current prescribing arrangements and associated monitoring for pentoxifylline, the applicant clarified that the Oral Medicine service is responsible for prescribing the first 3 months of treatment and advise patients to keep an ulcer diary. Blood tests and blood pressure are taken initially and at each appointment following initiation. Patients are also followed up within 4 weeks on initiation via a virtual telephone appointment.

A query was raised regarding how quickly adverse reactions occur and whether these are usually within the first 3 months whilst prescribing is under the specialist team. The applicant explained most patients tend not to experience many adverse reactions and treatment with pentoxifylline is not usually limited by adverse reactions but efficacy. Clarification was requested relating to the average age for the patient cohort who experience RAS and require specialist treatment and if the patient cohort is generally clinically well. The applicant confirmed the average age is 18-40 years old and patients are generally clinically well.

- **IMOC discussion after departure of the applicant**

Committee members raised concerns regarding the limited quality of published evidence for the use of pentoxifylline in this setting. Conversely, committee members acknowledged the specialist experience and the role of pentoxifylline as a potential step prior to escalation to thalidomide, which carries significant toxicity. After balancing the lack of robust evidence whilst noting the benefit of pentoxifylline in delaying or preventing the need for thalidomide, committee members approved by consensus pentoxifylline 400mg M/R tablets for use in RAS (off-label) as Red (hospital only).

ACTION: Formulary recommendation to be drafted and presented at a future IMOC meeting
ACTION: Pentoxifylline 400mg M/R tablets for recurrent aphthous stomatitis (off-label) to be added to the SEL adult JMF following approval of the formulary recommendation

ii. **Formulary inclusion of tacrolimus ointment 0.03% and 0.1% for oral lichen planus (lip involvement) and exfoliative cheilitis as Amber 2 (off-label)**

Tacrolimus 0.03% and 0.1% ointment is widely used in dermatology and in oral medicine and is included within the SEL adult JMF for orofacial granulomatosis (OFG) as Amber 2 and for dermatological indications including facial lichen planus as Amber 1. The use of tacrolimus ointment for oral lichen planus (lip involvement) is already established practice locally and this request aims to formalise use in lichen planus of the lips but as Amber 2 in line with the OFG indication.

Exfoliative cheilitis is a chronic superficial inflammatory disorder of the lips characterised by scaling, desquamation, and crusting. There are no local, national or international guidelines for exfoliative cheilitis, and that therapeutic options are limited and include topical corticosteroids. However the use of topical corticosteroids on the lips is associated with mucosal atrophy and worsening disease and the use of tacrolimus in this setting can be useful as a steroid-sparing option. Tacrolimus ointment 0.03% and 0.1% formulations are being requested as some patients do not tolerate 0.1%. The 0.03% formulation may be better tolerated and supports treatment de-escalation in long-term use (e.g. exfoliative cheilitis), allowing continued daily application where reduced frequency dosing with 0.1% is not tolerated.

The Formulary Pharmacist provided a brief overview of the evidence to support the use of tacrolimus for the management of exfoliative cheilitis. The condition predominantly affects young adults and is often triggered by a stressful event in a patient's life as well as risk factors such as poor oral hygiene and/or vitamin deficiencies. Evidence was presented from small, randomised studies demonstrating benefit in healing and relapse reduction, albeit with acknowledged limitations. The risks associated with prolonged topical steroid use on lip and oral mucosa were emphasised, positioning tacrolimus as a key steroid-sparing option.

. Limitations included small sample sizes, short treatment durations and lack of placebo-controlled trials.

From a safety perspective, adverse effects are mainly local irritation at the site of application, which is generally mild and resolved with dose reduction or cessation.

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

Clarity was requested regarding the treatment duration. The applicant explained for oral lichen planus of the lips, it is usually a 2-6 week course for flares and is not used on a long-term basis. For exfoliative cheilitis, treatment is usually long term, patients are advised to use tacrolimus ointment once to twice daily for at least six weeks and then tapered to a maintenance dose. Patients with exfoliative cheilitis are reviewed regularly in clinic. Clarification was sought on whether overprescribing of tacrolimus ointment is observed in practice, noting the application states patients are reviewed every 3–6 months to mitigate this risk. The applicant explained that oral lichen planus has premalignant potential; therefore, patients with active disease are reviewed regularly for ongoing surveillance, irrespective of treatment. Patients with exfoliative cheilitis often require regular review due to complex clinical needs, including overlap with low mood and input from linked psychology services.

GP committee members commented that they felt more confident in taking on prescribing of tacrolimus ointment vs. pentoxifylline discussed previously. Tacrolimus ointment is commonly prescribed in primary care for its licensed indications and other off-label indications included in the adult JMF. Committee members approved by consensus the formulary inclusion of tacrolimus ointment 0.03% and 0.1% for oral lichen planus of the lips and exfoliative cheilitis (off-label) as Amber 2.

ACTION: Tacrolimus ointment 0.03% and 0.1% for oral lichen planus (lip involvement) and exfoliative cheilitis (off-label) to be added to the SEL adult JMF following approval of the updated guideline

iii. Formulary inclusion of dexamethasone 2mg/5ml solution for inflammation of the oral mucosa as Amber 2 (off-label)

Dexamethasone 2mg/5ml solution (off-label) as a mouthwash for inflammation of the oral mucosa has been historically used locally in response to national shortages of alternative steroid mouthwash preparations (fluticasone and betamethasone) and intolerance of crushed prednisolone tablet suspensions in patients with ulcerated mucosa. Dexamethasone solution was described as better tolerated, mixing easily with water to form a clear mouthwash that coats the oral mucosa effectively. Additionally it is easier to use for patients with dexterity issues, and more acceptable for those with widespread mucosal disease. Local experience indicates a good patient acceptability and continued use once initiated. Betamethasone soluble tablets will be used first line, followed by fluticasone nasules (used as a mouth wash) as second line and dexamethasone solution as the third line option.

Committee members were asked to consider the removal of budesonide 0.5 mg nebules (off-label) for oral ulceration and inflammation from the SEL adult JMF, as it is no longer routinely used and is the least cost-effective option. Although currently the highest-strength steroid mouthwash available for this indication, dexamethasone 2 mg/5 ml solution would replace budesonide as the higher-strength steroid mouthwash alternative.

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

A comment was raised whether most patients in this setting experience dexterity issues hence the request to add dexamethasone solution instead of dexamethasone soluble tablets to the local formulary in light of the cost difference. The applicant noted that many patients in this cohort have pemphigoid linked with their oral condition and are often frail, with multiple comorbidities and dexterity issues. Generic fluticasone nasal preparations can be difficult to open, and dexamethasone solution has been an alternative option for this group. Additionally, dexamethasone soluble tablets has not been

used by the oral medicine service. The applicant also noted that patients typically cycle through betamethasone, fluticasone, and prednisolone in the interim before initiating dexamethasone. Once commenced, patients generally remain on dexamethasone, which is reflective of a patient cohort with a higher flare burden.

Committee members agreed by consensus to defer the decision on the formulary inclusion of dexamethasone 2mg/5ml solution for inflammation of the oral mucosa as Amber 2 (off-label). Members acknowledged the benefits of dexamethasone 2mg/5ml solution in this setting. However due to the cost difference between the dexamethasone formulations and its use for a specific patient cohort, committee members requested that the draft primary care oral medicine guideline be updated to include the intended use for dexamethasone solution with a clearly defined patient cohort and be presented to the Committee at a future IMOC meeting for review.

ACTION: Draft primary care oral medicine guideline to be updated in line with discussions and presented at a future meeting

iv. Updated guide for primary care on the off-label use of medicines in the oral medicine clinics

Given the update required to the guideline in line with the formulary request for dexamethasone 2mg/5ml solution for inflammation of the oral mucosa as Amber 2 (off-label), committee members agreed to defer this to a future IMOC meeting.

6. Updated self-testing of INR guidance and patient information leaflet (with summary of changes)

The authors were in attendance to present this item which has been reviewed and updated via the cardiovascular sub-group. The original guideline and patient information leaflet (PIL) were developed by the London Stroke Clinical Network. However as this network is no longer in existence, the guidance and PIL have been updated for local use. The main updates to the guideline and PIL include the following:

- Updated coagulometer device to current device available - CoaguChek INRange
- Clarified patient acquisition responsibilities for the coagulometer device
- Requirement for six-monthly venous INR calibration checks
- Out-of-range INR lower limit updated
- Addition of GP responsibility to prescribe test strips and lancets after initiation from secondary care

A question was raised relating to the out-of-range INR lower limit threshold, as for patients with a normal valve the INR lower limit is usually below 2. The presenters confirmed some patients will need to repeat their INR if below 2 as opposed to below 1.5 and will amend the guideline to reflect this. A comment was raised regarding amendments to statements throughout the guideline and PIL relating to the supply of the coagulometer. Members requested it is made clearer that patients will need to buy their own meter. An additional section under patient responsibilities was also requested to advise that patients will need to comply with the quality assurance programme.

Committee members approved by consensus the updated self-testing of INR guidance and PIL pending amendments in line with the meeting discussion

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

7. Re-categorisation of liothyronine for the management of hypothyroidism and resistant depression to amber 2

Members of the self-care and low priority prescribing sub-group were in attendance to present this item. In line with updated NHSE guidance in 2023 and the Joint British Thyroid Association (BTA) and

Society of Endocrinologist consensus statement 2023, it is now recommended that liothyronine can be prescribed in primary care for the management of hypothyroidism in certain circumstances for patients who are on long term treatment. It was noted that the initiation of liothyronine would remain the responsibility of an NHS endocrinologist and patients would require confirmation of diagnosis, trial of levothyroxine for at least six months, and exclusion of co-morbidities before liothyronine treatment.

For existing patients on liothyronine or new patients (after 3-months or longer), if the decision after a review by an NHS consultant endocrinologist is to continue liothyronine as monotherapy or in combination with levothyroxine, transfer of prescribing to primary care would be reasonable in line with any local shared care arrangements as recommended by NHSE (Amber 3 RAG category in SEL). However due to the small eligible patient cohort in SEL for liothyronine in this setting, committee members were requested to consider a re-categorisation of liothyronine for hypothyroidism from non-formulary (not recommended for prescribing) to Amber 2 as opposed to shared care (Amber 3).

Committee members were also requested to consider a re-categorisation request for liothyronine in the management of resistant depression (off-label) from Red to Amber 2. In addition to this, there is also a request to update the locally approved indication for liothyronine in depression as add on therapy for the treatment of resistant depression in line with NICE guideline (NG 222) – depression in adults: treatment and management. In line with the updated NHSE guidance (2023) for liothyronine, existing patients with resistant depression who have not been reviewed and are established on liothyronine should have a review by an NHS Psychiatrist. For new patients, the prescribing responsibility of liothyronine should remain with the NHS Psychiatrist for at least 3 months. If after completion of a 3-month or longer review, transfer of prescribing for liothyronine in this setting to primary care would be reasonable under a shared care arrangement (Amber 3). However, the request being presented to the committee is for Amber 2 in view of the small patient numbers.

From a cost perspective the formulary inclusion of liothyronine for the management of hypothyroidism and resistant depression is within the delegated financial threshold for the committee.

Concerns were raised by members regarding the ongoing clinical responsibility for the use of liothyronine in hypothyroidism. It was emphasised that while monitoring requirements are relatively non-complex, the patients themselves are often clinically complex. In line with this, a Red or Amber 3 category would be more appropriate for liothyronine in this setting. Committee members also stressed the importance of ensuring that patients remain under specialist endocrinologist review regularly, even if prescribing transfers to primary care. Regarding liothyronine for resistant depression, members raised concerns that this represented a different clinical context, described as particularly complex, with overlapping physical and mental health symptoms and long-term engagement with secondary mental health services. In line with this and other ICBs regionally and nationally, maintaining the Red category would be most appropriate.

The committee reflected on the previous national directive to deprescribe liothyronine and the significant professional, patient, and reputational impact of the change in the national stance in 2023. Committee members agreed that the desired Amber 2 category would not be appropriate for the reasons discussed and did not approve the Amber 2 recategorisation request. The committee approved the following by consensus:

- Recategorisation of liothyronine for the management of hypothyroidism from non-formulary, not recommended for prescribing to Amber 3 (shared care) with agreement that the abridged transfer of prescribing document can be used to develop the shared care.
- Maintain the current formulary category of Red for the management of resistant depression
- Update the locally approved indication for liothyronine in resistant depression (off-label) as add on therapy only in line with the NICE guideline

ACTION: Development of a transfer of prescribing document for liothyronine in the management hypothyroidism to be progressed and presented at a future IMOC meeting
ACTION: Position statement for liothyronine in the management hypothyroidism to be updated and presented at a future IMOC meeting

ACTION: Position statement for liothyronine in the management resistant depression to be updated to reflect use as add-on treatment only and presented at a future IMOC meeting

8. Formulary inclusion of enalapril orodispersible (Aqumeldi®) for the management of heart failure in paediatrics as Amber 2

The applicant was in attendance to present this item with support from the Lead Paediatric Formulary Pharmacist, enalapril orodispersible tablets (Aqumeldi®) was recently licensed in the UK, offering a stable formulation that can disperse in water or be given via feeding tubes for the management of heart failure in children. Paediatric studies supporting the licence included acceptability and palatability assessments, demonstrating good tolerability and positive impact on adherence. Enalapril orodispersible tablets (ODT) replaces the need for special-order enalapril liquid and captopril liquid which requires thrice daily dosing. The ease of administration and reduced dosing schedule aims to improve adherence and efficacy for patients.

The application proposes the use of enalapril ODT in the following setting:

- Patients under 10kg whose doses are not achievable via conventional tablets (these patients are normally prescribed captopril liquid)
- Patients over 10kg (under 18 years) that cannot swallow tablets or have feeding tubes (these patients are normally prescribed captopril or lisinopril liquid).

The request is not seeking to replace the use of standard tablets where appropriate, but instead to replace the prescribing of liquid preparations.

From a cost impact perspective the formulary inclusion of enalapril ODT in this setting is within the delegated financial threshold for the committee. Switching patients from lisinopril or captopril liquid to enalapril ODT is also predicted to confer potential savings in SEL.

A query was raised regarding the estimated patient numbers for SEL, noting that the application suggests approximately 60–70% of the eligible patient cohort would be SEL patients. Clarification was requested given the Trust is a tertiary centre and whether this SEL proportion might be an overestimate. The presenter agreed that the estimate was likely an overestimate. The Trust serves a wide tertiary population, including referrals beyond SEL, and in practice the SEL proportion may be lower. The higher estimate was used to avoid underestimating the potential cost impact.

Committee members approved by consensus the formulary inclusion of enalapril orodispersible (Aqumeldi®) tablets for the management of heart failure in paediatrics as Amber 2.

ACTION: Enalapril orodispersible (Aqumeldi®) tablets for the management of heart failure to be included in the SEL paediatric formulary as Amber 2

9. Update on the review of IMOC guidelines and resources – IMOC workplan 2025/26

The lead for this item explained that as part of the committee's workplan for 25/26, an stocktake of all IMOC guidelines and resources was undertaken to determine which guidelines and resources require retaining, updating, or retiring, (with signposting to national or alternative local sources if available). This project has been carried out to ensure proportionality, reduce duplication with national guidance and prioritise capacity for high-value resources in view of capacity constraints across the system. In addition, impending national changes such as the Single National Formulary, is also likely to result in less need for local resources. In summary:

- A total of 212 IMOC guidelines and resources were identified through the stocktake
- 65 guidelines or resources were deemed duplicative or obsolete and can be retired
- 70 guidelines or resources have been identified for review
- 68 guidelines or resources are up-to-date and will be retained.
- The final 9 guidelines or resources have outstanding queries which are being actively followed up with the lead authors

The next steps include liaising with lead authors to take forward a prioritised review process for the guidelines and resources identified as requiring review. A process will also be progressed for removing the 65 guidelines and resources identified as suitable for retiring.

Committee members approved by consensus the identified IMOC guidelines and resources to be retired and noted the update on the review of IMOC guidelines and resources including the next steps.

10. Standing items/Items for information only

- 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 and noting:
- Adult formulary update March 2026 - noted by committee members
- Updated Trust carvedilol for prevention of variceal bleeding in children with portal hypertension PIL - noted by committee members

11. AOB

Committee members acknowledged this was the last meeting for the Senior Pharmacist for Integrated Medicines Optimisation. Committee members thanked them for all their contributions and support with the committee and wished them well.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 21st May 2026	2pm – 4:30pm	MS Teams
Thursday 18th June 2026	2pm – 4:30pm	MS Teams
Thursday 16th July 2026	2pm – 4:30pm	MS Teams