South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
21st May 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 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. Updated once daily basal insulin titration patient information leaflet (PIL)

The author was in attendance to present the updated once daily basal insulin titration PIL on behalf of the diabetes sub-group. The PIL is intended as an optional tool for healthcare professionals to use when teaching patients how to self-titrate insulin. The leaflet was originally introduced as a temporary resource in 2023 in response to the Glucagon-Like Peptide-1 (GLP-1) receptor agonist shortage. Although that shortage has resolved, it was agreed through the diabetes sub-group that the leaflet remains beneficial. The key changes were highlighted to the committee for review including a section describing when to reduce the dose and a requirement for patients to highlight episodes of blood glucose below 4 mmol/L.

Clarification was requested around the rationale for the wording at the top of the leaflet regarding the dose. The presenter confirmed this wording reflected feedback from the local health content team. A question was raised whether the leaflet should include a timeframe for patients to contact a healthcare professional should their blood glucose levels fall below 4mmol/L and it was agreed that the leaflet would be updated to include this information to prompt timely review. A query was raised around the intent of providing an editable electronic version and whether organisations would use the leaflet in its current form or adapt it. The presenter clarified that making the leaflet available in Word format would allow organisations to upload it more easily to their systems and was not for the intention of local adaption.

Committee members approved by consensus the updated once daily basal insulin titration PIL pending amendments in line with the meeting discussion.

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

5. Local response to discontinuation of Levemir® (insulin detemir):

- **Levemir® discontinuation plan update (previously approved via the urgent triage panel process)**
- **Trurapi® (insulin aspart) factsheet**

The author was in attendance to present the items on behalf of the diabetes sub-group and their declaration of interest was noted.

- **Levemir® discontinuation plan update**

An update on the SEL system-wide response to the discontinuation of Levemir® (insulin detemir) was shared and approval was sought from the committee to extend the review date of the discontinuation plan. The plan had previously been approved via the urgent triage panel process, which provides a

time limited approval. The presenter informed the committee that since circulation of the meeting paperwork, a further Medicines Supply Notification (MSN) had been issued indicating that progress nationally has been slower than anticipated. South East London is a high prescriber of Levemir® reflecting prescribing in line with guidance from the National Institute for Health and Care Excellence (NICE) historically but now resulting in a large cohort requiring switching.

NHS England has requested reassurance on local progress, which has been provided through established reporting and governance arrangements. Since January, a reduction in Levemir® prescribing against baseline was noted, with updates reported through various SEL working groups, networks and to NHS England as required. Implementation is continuing through provider follow-up, weekly Ardens reviews, targeted contact with practices with higher numbers of affected patients, use of referral pathways where specialist support is required, updated SELnet guidance, and engagement with primary care teams and community pharmacy neighbourhood leads to support consistent messaging. Challenges discussed included previous shortage of an alternative basal insulin, difficulty accessing reusable pens, variable implementation across primary care, and the need for clearer clinic letters on alternative treatment options. It was emphasised that searches remain necessary to identify all affected patients, including those seen outside SEL.

Members also noted that expected manufacturer stickers had not appeared in local pharmacies and that no additional resources were available. The diabetes sub-group will consider whether a local pharmacy poster or leaflet should be developed. A London-wide webinar is planned, and a proposed offer of support from Novo Nordisk and IQVIA remains under consideration pending clarification on indemnity, protocols, and responsibilities.

A question was raised regarding the wording in the implementation plan stating that all patients will be safely transitioned by the end of September 2026, given the likelihood that some patients may still require transition beyond this date. The presenter advised that the ambition remains end of September 2026 and that searches and specialist team actions are designed to achieve this, while acknowledging a small cohort may still need to be captured between September 2026 and December 2026.
The presenter clarified that the main ask for primary care is to run searches to identify patients and to check whether patients have a specialist appointment before September 2026. If not, practices or patients are asked to contact the specialist team so appointments can be brought forward. For patients not under a service, a GP referral is required to ensure switching is done safely, with specialist teams providing support as primary care would not be expected to make insulin change decisions.

A query from the group was raised to determine if there is scope to include this work in an incentive scheme to support workload. The presenter advised that as this is a shortage, it should be considered as routine practice. Additionally, there have been many shortages in diabetes in recent years and incentivising one shortage may lead to further requests for other shortages which would not be feasible. Further clarification was provided by committee members that compliance with safety alerts is a regulatory expectation rather than an incentivised activity.

In response to a query on the process for expediting the referral process for patients not under a diabetes service, the presenter advised that these patients should be referred by GPs with referrals flagged for Levemir® discontinuation to enable prompt triage and clinic scheduling.

The committee discussed the appropriate duration for extending the review date of the discontinuation plan and it was agreed that the review date should be extended until December 2026, with a specific progress update to return to IMOC in September 2026 to assess transition completion.

The committee approved by consensus the extension of the Levemir® discontinuation plan.

ACTION: Levemir® discontinuation implementation plan review date to be extended until December 2026, with a progress update to be brought back to IMOC in September 2026

- **Trurapi® (insulin aspart) factsheet**

A prescriber-facing factsheet for Trurapi® has been developed to support safe implementation as the locally preferred insulin aspart product for adults. The factsheet states that Trurapi® is a biosimilar of NovoRapid® and is therapeutically equivalent within its licensed indications. It also sets out the local formulary position that Trurapi® is the preferred first-line insulin aspart product for adults and routine blanket switching between insulin aspart preparations is not supported. The factsheet includes practical switching advice and key product differences, highlighting that Trurapi® is not available as a PumpCart® device. The factsheet has been approved by the diabetes sub-group and the SEL Medicines Safety Network. A recent Department of Health and Social Care (DHSC) MSN noted a shortage of Trurapi®; however, given current usage in SEL, this is not expected to significantly affect roll out as the shortage relates to only one listed device.

A request was made by the committee to remove detailed acquisition cost figures and acquisition-cost based wording to reduce the risk of the document becoming quickly outdated, and to keep the factsheet focused on safe use and practical decision-making. The committee also requested that abbreviations are expanded for clarity and that references to the adult and paediatric formulary are consistently worded. A question was raised as to whether the manufacturers of Trurapi® are planning to make a PumpCart® device. The presenters informed the committee that they are not aware of any plans underway by the company. Clarification was requested regarding the Tresiba® FlexPen listed in the plan and whether it has been discontinued. The presenter confirmed that Tresiba® FlexPen 100 units/mL had been discontinued but the 200 units/mL FlexPen remains available, and this aligns with the list in the document.

Committee members approved by consensus the Trurapi® factsheet pending amendments in line with the meeting discussion.

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

6. Acetazolamide immediate release tablets and topiramate tablets for the management of idiopathic intracranial hypertension in adults

This formulary submission originates from acute Trust neuro-ophthalmology clinicians and requests the off-label use of acetazolamide immediate-release tablets as first line treatment and topiramate tablets as second line treatment in patients with a confirmed diagnosis of IIH. Use of these agents in IIH is established practice and this formulary application aims to formalise these existing arrangements. The application requests an Amber 2 "Red, Amber, Green" (RAG) category in this setting, noting prescribing will be transferred from the specialist team to GPs after a period of 1 month.

- **Evidence Review**

The Formulary Pharmacist presented an overview of the evidence base - a detailed evidence review was provided within the meeting agenda pack, covering background to the condition, a review of the evidence base with strengths and limitations and rationale for use. The information presented also included the estimated resource impact for use of acetazolamide and topiramate in this setting. IIH is a neurological condition characterised by raised intracranial pressure (ICP) with normal cerebrospinal fluid (CSF) and no identifiable cause after imaging and examination, with patients experiencing neuro-ophthalmological symptoms such as papilloedema, diplopia, headaches accompanied with nausea and vomiting and reduced visual acuity. It was emphasised that untreated disease can result in permanent visual loss due to optic disc oedema and ischemia, and that symptom control and prevention of complications are essential in IIH management.

Evidence for IIH treatment is limited and it was noted that large-scale randomised controlled trials (RCTs) are unlikely given historical use and off-patent status. A RCT comparing medical and surgical treatment was stopped early due to poor recruitment. The available evidence is constrained by subjective patient-reported outcomes, use of unvalidated assessment tools, and incomplete reporting in some studies. To support practice, an international multidisciplinary special interest group, with input from the Association of British Neurologists, Society of British Neurological Surgeons and Royal College of Ophthalmologists, developed a consensus treatment guideline. This guideline broadly

divides management into surgical and non-surgical approaches. Surgery is often reserved for the most severe cases and/or for patients whose condition does not respond to non-surgical treatment. Non-surgical management includes pharmacological treatment alongside lifestyle measures, such as weight loss. There are no medicines licensed for the treatment of IIH, however the consensus guideline states that acetazolamide and topiramate can be used as off-label treatment options for IIH, with acetazolamide having the most evidence. Both medicines inhibit carbonic anhydrase, which reduces CSF production and ICP.

For acetazolamide, an initial dose of 250-500mg twice daily, titrated up to 4g daily is proposed, and if papilloedema resolves then a maintenance dose of less than 4g per day can be prescribed. For topiramate, an initial dose of 50mg once a day to 100mg twice a day is proposed. Lifelong treatment is intended for both treatments with the aim to induce remission prior to this. A treatment pathway has been developed internally at the Trust to guide the use of acetazolamide and topiramate.

Evidence for acetazolamide is based mainly on two trials involving 215 participants. In the first, a 12-month open-label study of 50 participants, acetazolamide (250–1500 mg daily) was compared with placebo. Although completion rates were poor and some placebo patients later received acetazolamide because of deterioration, no acetazolamide-treated participants were classified as deteriorating at study end, whereas visual loss occurred in two placebo participants. In the second, a double-blind RCT of 165 participants, acetazolamide plus a supervised low-sodium weight-reduction diet was compared with placebo over six months. The primary outcome showed a greater, but not statistically significant, improvement with acetazolamide, while cerebrospinal fluid opening pressure and weight loss improved significantly. Adverse effects were consistent with the known safety profile, although serious adverse effects were more frequent in the acetazolamide arm. Overall, a Cochrane review concluded that evidence for acetazolamide remains inconclusive despite some modest benefits.

Evidence for topiramate is more limited. In a 12-month open-label comparative study of 41 patients, topiramate and acetazolamide both improved visual field grade, papilloedema, headaches and diplopia, with no statistically significant difference between groups; weight loss was greater with topiramate and no treatment discontinuations due to adverse effects were reported. A retrospective review of 17 female patients treated over approximately 8.5 years found that topiramate, used either alone or after inadequate response to other agents, was associated with significant improvement in optic disc oedema, with recurrence in one patient.

From a safety perspective, acetazolamide has already been historically used with consistently positive outcomes in reducing ICP, improvement in visual acuity and preservation. Treatment is generally well tolerated with side effects including lethargy and paraesthesia being mild and largely dose dependent. Topiramate has also been historically used for this indication with most patients experiencing improved visual function and headaches and minimal reports of severe side effects including paraesthesia, however with the additional benefit of weight loss, especially in obese patients.

From a cost impact perspective, this formulary request is within the financial threshold delegated to the committee. It was noted that the use of these medicines is likely to be lower than the cost of surgical intervention. Treatment can be stopped if a patient achieves remission through weight loss, plans to be pregnant, or becomes pregnant.

- **Applicants' presentation**

The applicants were in attendance to present the submission and field any questions. The applicant's declaration of interest was noted. Local experience was described and it was noted that acetazolamide has been used for IIH for over 50 years globally and is established in use locally. Committee members noted that there is established historical prescribing for this indication, and it would be unlikely to significantly change the workload or responsibility in primary care.

A query was raised concerning the transfer of medicines for an unlicensed indication to primary care, including whether the patient has been informed the indication is unlicensed, and what reassurance and safeguards would be considered to protect clinicians if adverse events occur. The applicant explained that continuation in primary care would be on specialist advice at the recommended dose. It

was also noted that the indication is unlikely to become licensed, and the unlicensed use should be explained to the patient by the initiating prescriber at initiation and, where available, a PIL on the use of unlicensed medicines could be shared with the patient. With regards to the patient initiation and follow-up pathway and communication with primary care, the applicant clarified that a graduated approach to dose escalation was used proportionate to pressure and with an aim to control symptoms without extensive up-titration. The applicant stated the IIH service reviews optic nerve swelling and would write to the GP following each visit with the current dose and clinical status, including requesting repeat prescribing, routine monitoring of bloods and advising step-down if appropriate with a subsequent review date. It was explained that some patients may require only short-term treatment whereas others may need longer term treatment.

Clarity was sought by the committee regarding primary care expectations to up-titrate doses or make clinical decisions on escalation. The applicant stated GPs are not expected to titrate upwards; if escalation is needed, primary care should contact the specialist team as clinical correlation and specialist assessment are required to judge disease control. In response to a query regarding the service's footprint, the applicant confirmed a wide catchment area, whilst noting most patients are from SEL. The applicant confirmed that acetazolamide remains preferred first-line, with topiramate second-line due to teratogenicity/pregnancy prevention requirements for topiramate and potential low mood side effects, despite the weight loss and migraine benefits. It was also confirmed that the individual acute trusts in SEL essentially follow a similar clinical pathway, with some minor differences.

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

Committee members reflected that acetazolamide and topiramate use in IIH is long-established in practice and a discussion was held around establishing a clear formulary position and clarifying responsibilities for safe continuation in primary care. Members agreed that an Amber 2 categorisation provides a proportionate approach, supporting continuity of prescribing in primary care following specialist initiation, with specialist letters clearly outlining monitoring, contact points and follow up intervals. After balancing the lack of robust evidence whilst noting the longstanding use in practice, committee members approved by consensus acetazolamide immediate release tablets and topiramate tablets for the management of IIH (off-label) in adults as Amber 2 (specialist initiation).

ACTION: Formulary recommendation to be drafted and presented at a future IMOC meeting
ACTION: Acetazolamide immediate release tablets and topiramate tablets for the management of idiopathic intracranial hypertension in adults to be added to the SEL adult JMF following approval of the formulary recommendation

7. Updated rheumatology guidelines and associated proposals:

The lead authors were in attendance to present these items on behalf of the rheumatology sub-group.

i. Rheumatoid arthritis (RA) guideline with cost tool and proposal for the use of dose escalated adalimumab for the management of RA as combination therapy with disease modifying antirheumatic drugs (DMARDs)

The updated RA treatment pathway and cost tool were presented, alongside a proposal to enable dose escalated adalimumab for a defined cohort of patients with RA receiving adalimumab as combination therapy with DMARDs (off-label use). The pathway has been updated to include an addendum stating that anti-TNF inhibitors are the preferred treatment option for patients with a history of solid tumours, reflecting updated European guidance.

The pathway has also been updated to include a dedicated section on adalimumab dose escalation, which is in line with the proposal for the use of dose escalated adalimumab in combination with DMARDs to treat RA (off-label). Use of dose escalated adalimumab was noted to be established in practice and licensed in other relevant inflammatory conditions, and a small cohort study was referenced in the proposal indicating no additional safety concerns when weekly dosing is used with concomitant DMARDs. The proposal sets out that response to dose escalation should be reviewed at 24 weeks and treatment stopped if an adequate response is not achieved. The intention of the pathway

update was to clarify that weekly adalimumab dosing can be considered locally for patients who initially respond to standard fortnightly dosing at six months but subsequently experience reduced response or a “tapering effect” where symptoms recur before the next dose is due.

When presented at the rheumatology sub-group meeting, the pathway was approved, pending further detail being included, in line with the proposal, on how the decision to escalate is made and how response will be measured. The presenters shared on screen updated wording (compared to the circulated meeting paperwork), which set out that the decision to escalate should be made through the biologics multidisciplinary team (MDT), when to review and measure a response and that use will be audited to monitor outcomes and usage. The cost tool has also been updated to highlight medicines removed from the NHS high-cost drugs list, in line with the 2026/27 NHS payment scheme.

Clarity was requested regarding the scope of “combination therapy” within the proposal and pathway wording, noting that the written proposal refers to combination therapy with DMARDs while the pathway wording was interpreted by some as being specific to methotrexate. The presenters clarified that the proposal is intended to apply to patients receiving adalimumab with methotrexate and/or other DMARDs. It was explained that adalimumab monotherapy is defined as not being on methotrexate and previously patients on methotrexate were excluded in the pathway whereas those on other DMARDs have been able to receive escalation.

From a cost perspective, the proposal in this setting is within the delegated financial threshold for the committee.

Committee members approved the guideline, cost tool, and proposal by consensus.

ii. Axial spondyloarthritis (SpA) guideline with cost tool and proposal for the use of dose escalated adalimumab for the management of axial SpA

The updated axial SpA treatment pathway and cost tool were presented, alongside a proposal to enable dose escalated adalimumab (weekly dosing) for a defined cohort of patients. Similar to the RA pathway, the axial SpA pathway has been updated to state that anti-TNF inhibitors are the preferred treatment option for patients with a history of solid tumours, in line with European guidance and local practice. Additionally, updates have been made to clarify eligibility for dose escalation, including patients with secondary failure or those experiencing a tapering effect before the next dose is due.

A correction was made to the timing of assessment as the pathway previously referenced a 16-week assessment point, but this was corrected to 12 weeks for axial SpA and psoriatic arthritis in the dose escalation section, with stopping criteria added directly to the pathway segment. The cost tool has been updated to reflect medicines removed from the NHS high-cost drugs list for 2026/27 and to note that apremilast is now available as a generic.

The proposal for the use of dose escalated adalimumab in axial SpA (off-label) recognised that the licensed adalimumab dose remains 40 mg every other week however the proposal requests approval for weekly dosing in a small cohort who experience reduced response/secondary failure and would otherwise be progressed to the next stage of the pathway. Weekly dosing was stated to be established in other indications without increased adverse event rates, and this has been reflected within the pathway. As per the RA pathway, when presented at the rheumatology sub-group meeting, the AS pathway was approved, pending further detail being included on how the decision to escalate is made and how response will be measured. The presenters shared on screen updated wording (compared to the circulated meeting paperwork) within the pathway. It was confirmed that use will be audited through the relevant pathway governance processes to monitor compliance, patient numbers, and outcomes.

No additional questions were raised during the meeting discussion on the axial SpA pathway update or the associated proposal. It was noted that dose escalated adalimumab would reduce the incidence of pathway escalation to more costly therapies.

From a cost perspective the proposal in this setting is within the delegated financial threshold for the committee.

Committee members approved the guideline, cost tool, and proposal by consensus.

8. **Updated Heart Failure (HF) medicines optimisation pathway and associated formulary requests:**
   - **HF pathway**
   - **Dapagliflozin and empagliflozin recategorisation from Amber 1 to Green**
   - **Sacubitril/valsartan (Entresto®) recategorisation from Amber 2 to Amber 1 (with cost modelling)**
   - **Metolazone recategorisation from Red to Amber 1**

The authors and leads were in attendance to present this item on behalf of the cardiovascular disease (CVD) sub-group. The updated guideline and associated formulary requests aim to support implementation of the updated NICE guideline for HF, which supports the four pillar approach to treatment.

- **HF pathway**

The updated HF medicines optimisation pathway was presented to the committee, which has been developed as a more succinct primary care tailored guide. This has been adapted from the previous guideline, in response to feedback from primary care requesting a shorter, more practical resource and aligns to the updated NICE guideline in terms of the place in therapy of the treatments concerned. The updated version incorporates post-consultation amendments to align with the updated NICE HF guideline and to improve clarity for primary care use. It was noted that the diagnostic pathway, not included in the agenda pack (but shared on screen), will be progressed for approval via the Care and Clinical Professional Committee (CCPC), once IMOC approval is complete.

Key amendments post consultation included:
- Angiotensin II Receptor Blockers (ARBs) are now positioned as third line for HF with reduced ejection fraction (HFrEF).
- Intravenous iron has been added to the pathway. Further advice has been included on switching Angiotensin-Converting Enzyme inhibitors (ACEi) to Angiotensin Receptor-Neprilysin Inhibitors (ARNI), including the washout period.
- Clarification that temporary withholding or dose reduction of prognostic medicines during decompensation (including sick day rules) should not be interpreted as long-term cessation.
- Clearer signposting and linking throughout the document including stronger palliative care and end-of-life references.
- Updated preferred medicines sections to clarify long-term monitoring once patients are at targeted or tolerated doses and potassium thresholds at initiation versus during treatment.
- Dapagliflozin stated as preferred first line and empagliflozin as a second line sodium glucose co-transporter 2 (SGLT2) inhibitor option where dapagliflozin is not tolerated. Additional cautions and safety advice also included.

The committee discussed the “specialist medicines not initiated in primary care” section and noted that some medicines listed may be initiated in primary care for other indications; it was agreed that the intent is to support appropriate escalation and prescribing responsibilities specifically in the context of heart failure management. A comment was raised around the breastfeeding wording within the ACE inhibitor section to clarify specifically which medications are safe. The presenters agreed to amend the breastfeeding statement to be more explicit and to reduce scope for misinterpretation, including specifying the relevant ACE inhibitor.

Committee members noted that several medicines referenced in the pathway do not have heart failure-specific RAG categories within the SEL adult formulary and requested that the pathway and formulary wording should avoid implying any restrictions for non-heart failure indications. The presenters suggested that the correct wording would be “not for initiation in primary care for heart failure indications,” recognising that a medicine may be initiated in primary care for other common indications while still requiring specialist input when used as part of escalation in heart failure. The committee

agreed an Amber 2 categorisation for hydralazine, noting that the initial prescription would need to be provided by the secondary care provider before continuation by the GP.

Committee members approved the HF pathway pending amendments in line with the meeting discussion by consensus.

ACTION: HF pathway to be updated in line with the discussion and progressed for approval via IMOC Chair's action
ACTION: Hydralazine to be categorised to Amber 2 in the SEL adult JMF for heart failure

- **Formulary request for dapagliflozin and empagliflozin recategorisation from Amber 1 to Green**

The committee considered a request to recategorise dapagliflozin and empagliflozin for HF from a RAG rating of Amber 1 to Green. It was shared that these medicines are already categorised as Green for other indications (chronic kidney disease and glycaemic control in type 2 diabetes). In the context of the updated NICE guidance and the "four pillars" approach making these medicines Green for HF supports timely initiation and optimisation in primary care enabling eligible patients to be established on the recommended disease-modifying therapies.

No comments or queries were raised from members regarding this recategorisation. It was noted that a significant majority of this spend is already occurring within the system. From a cost perspective, the formulary inclusion of dapagliflozin and empagliflozin in this setting is within the delegated financial threshold for the committee. Committee members approved by consensus the recategorisation of dapagliflozin and empagliflozin from Amber 1 to Green in this setting.

ACTION: Dapagliflozin and empagliflozin for HF to be recategorised from Amber 1 to Green in the SEL adult JMF.

- **Formulary request for sacubitril/valsartan (Entresto®) recategorisation from Amber 2 to Amber 1**

The committee considered a request to recategorise Entresto® from Amber 2 to Amber 1 for HF. This would support alignment with updated NICE guidance, which positions ARNIs early in therapy and supports initiation in primary care on specialist recommendation, rather than requiring secondary care initiation and titration in all cases. It was noted that community heart failure services will continue to support optimisation and up-titration where required, but an Amber 1 category better reflects the intended pathway and removes avoidable delays to patient access. A comment was raised regarding cost modelling and governance thresholds, noting that the specific modelling presented may not fully capture all relevant cohorts and may require escalation through the appropriate governance route. The presenters and committee members agreed to review the costings post meeting and escalate if the financial threshold delegated to the committee is exceeded.

Committee members supported the recategorisation in principle, while noting the need for cost modelling refinement and escalation through the appropriate governance route where required.

ACTION: Cost modelling for the use of sacubitril/valsartan (Entresto®) to be revised and progressed via the appropriate governance route in line with the committee's delegated financial threshold
ACTION: Sacubitril/valsartan (Entresto®) to be recategorised from Amber 2 to Amber 1 in the SEL adult JMF following revision of cost modelling and approval of the guideline

- **Formulary request for metolazone recategorisation from Red to Amber 1**

The committee considered a request for metolazone recategorisation in HF. It was flagged by the committee at the outset that the paperwork indicated Red to Amber 1, but clarified that this should be Red to Amber 2. Metolazone is used in combination with loop diuretics for severe fluid overload in heart failure and patients often require either short intermittent courses or, in a smaller cohort, longer-term

low-frequency dosing to maintain fluid balance and prevent recurrent admissions. It was emphasised that timely access to metolazone can reduce escalation to hospital based intravenous diuresis, and while some patients only require one or two doses, there is a defined cohort in whom ongoing prescribing in primary care is helpful once stabilised, under specialist guidance and monitoring.

The committee discussed the practicalities and safety considerations for primary care prescribing, including GP concerns about potency and unfamiliarity. It was noted that the risk of significant diuresis and renal impairment is greatest when these agents are used in combination with loop diuretics with similar risks for bendroflumethiazide.

From a cost perspective, the formulary inclusion of metolazone in this setting is within the delegated financial threshold for the committee.

Following discussion, the committee agreed by consensus to a recategorisation of metolazone use in HF from Red to Amber 2 with clear guidance on the adult formulary for GPs, specifying continuation of prescribing after specialist initiation and guidance on the monitoring requirements for long-term treatment. The committee also agreed by consensus to categorise bendroflumethiazide as Amber 2 for heart failure.

In response to a query about the plans to support implementation of the updated HF guidance once launched, the presenters confirmed plans for webinars with the workforce development hub and educational events to support coding and implementation of the new guidance in primary care.

ACTION: Metolazone to be re-categorised from Red to Amber 2 with clear guidance included in the formulary entry for GPs outlining patient monitoring for long-term prescribing and bendroflumethiazide to be categorised as Amber 2 in the SEL adult JMF

9. Formulary recommendations:

- **Intranasal adrenaline (EURneffy®) for the emergency treatment of severe allergic reactions (anaphylaxis) with updated cost modelling**

This formulary recommendation has been drafted following the approval of intranasal adrenaline (EURneffy®) in this setting as Amber 1 (initiation in primary care on advice of a specialist) at the March 2026 IMOC meeting. No feedback or comments have been received through the Triage Panel review. The costings have been updated since presentation of the formulary application to include estimates reflecting patients who might be prescribed more than two devices. The revised cost modelling was noted by committee members.

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

This formulary recommendation has been drafted following the approval of pentoxifylline tablets in this setting as Red (hospital only) at the April 2026 IMOC meeting. Minor comments were received through the Triage Panel review, including clarification on required blood tests and timeframes for initial specialist review, and these have been actioned.

Committee members approved both formulary recommendations by consensus.

10. IMOC Workplan:

- **2025/26 quarter 4 update**
- **2026/27 workplan**

- **2025/26 quarter 4 update**

The lead for this item summarised progress to date and closed the 2025/26 IMOC workplan, including a stocktake of existing IMOC guidelines and resources. The team is now progressing implementation actions including consulting with the communications team to remove items and contacting lead

authors regarding the documents marked for review to confirm timescales for review completion. The team is continuing to explore the use of enhanced formulary entries as an alternative to developing full treatment guidelines and pathways, including signposting to national guidance and other established sources rather than duplicating content locally. Digital options for hosting IMOC consultations on SELnet have also been explored and the next step is to pilot a consultation on SELnet.

Members noted the update.

- **2026/27 workplan**

The lead also presented the proposed workstreams for the SEL IMOC workplan in 2026/27. The committee was informed that, in line with the ongoing NHS organisational changes including within the ICB, the workplan for 2026/27 would continue with the same key areas from 2025/26. It was highlighted that the workplan would have a particular focus on:

- Review of IMOC guidelines and resources identified for review as part of the 25/26 stocktake
- Progressing a digital solution for IMOC consultations

Committee members approved the SEL IMOC workplan for 2026/27 by consensus.

11. 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 and Paediatric Formulary updates for April 2026 - noted by committee members

12. AOB

Committee members acknowledged this was the last meeting for a while for the Lead Pharmacist as they start maternity leave. Committee members thanked them for all their contributions and support with the committee and wished them well during maternity leave.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 18th June 2026	2pm – 4:30pm	MS Teams
Thursday 16th July 2026	2pm – 4:30pm	MS Teams
Thursday 20th August 2026	2pm – 4:30pm	Hybrid (MS Teams/in person)