http://www.devonformularyguidance.nhs.uk/

Meeting of the Devon Formulary Interface Group

Minutes

Wednesday 17th August 2022

Via Microsoft Teams

Present:

NAME	JOB TITLE	ORGANISATION
Tawfique Daneshmend (Chair)	Consultant Gastroenterologist	RDUH NHS FT
Glen Allaway	GP	NHS Devon ICB
Ailene Barclay	Pharmacist	UHP NHS Trust
Andy Craig	GP	NHS Devon ICB
Susie Harris	Consultant Physician/Geriatrician	RDUH NHS FT
Matt Howard	Clinical Evidence Manager	NHS Devon ICB
Carole Knight	Medicines Information Pharmacist	RDUH NHS FT
James Leavy	Medicines Information Pharmacist	RDUH NHS FT
Hilary Pearce	Clinical Effectiveness Pharmacist	NHS Devon ICB
Graham Simpole	Medicines Optimisation Pharmacist	NHS Devon ICB
Darren Wright	Joint Formulary Specialist Pharmacy Technician	NHS Devon ICB

Guests:

Emma Gitsham	Clinical Evidence Pharmacist – Specialist Medicines Service (SMS) Guidelines Lead	NHS Devon ICB
Chris Price	Consultant Neurologist	RDUH NHS FT
Mr Nathanial Knox Cartwright	Consultant Ophthalmologist	RDUH NHS FT
Dr Stuart Kyle	Consultant Rheumatologist	RDUH NHS FT

Observers:

Catherine Burdett	Pharmacist	UHP NHS Trust
Nic Perrem	Healthcare Evidence Reviewer	NHS Devon ICB
Claudia Oliveira	Medicines Optimisation Pharmacist	NHS Devon ICB

In attendance:

Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NHS Devon ICB

1. Welcome and announcements

Meeting etiquette

Tawfique Daneshmend explained the meeting etiquette.

Chairman's welcome

Tawfique Daneshmend welcomed attendees to the meeting of the Devon Formulary Interface Group.

Apologies

NAME	JOB TITLE	ORGANISATION
Beverley Baker	Non-Medical Prescribing Lead	NHS Devon ICB
Nicola Diffey	Principal Clinical Pharmacist	Livewell Southwest
Nick Keysell	GP	NHS Devon ICB
Bill Nolan	GP	NHS Devon ICB
Jess Parker	GP	NHS Devon ICB
Chris Sullivan	Deputy Chief Pharmacist	Devon Partnership NHS Trust
Larissa Sullivan	Pharmacist	T&SD NHS FT

Declarations of Interest

Declarations of Interest were collected. No attendees reported an interest.

DRUG INCLUDED ON AGENDA	PHARMACEUTICAL COMPANY / MANUFACTURER
Solriamfetol (Sunosi®) for the treatment of excessive daytime sleepiness ***Alternative treatments*:** • Pitolisant (Wakix®) • Sodium oxybate (Xyrem)	Jazz Pharmaceuticals Bioprojet UK Limited UCB Pharma Limited
Osteoporosis • Various medicines including oral and intravenous bisphosphonates and biosimilar teriparatide • Denosumab (Prolia) • Romosuzumab (Evenity)	Various manufacturers Amgen Ltd UCB Pharma Ltd
Hydrocortisone sodium phosphate eye drops: Softacort ***Alternative treatments*:** • Minims prednisolone 0.5% single-dose units	Thea Laboratories Ltd Bausch and Lomb UK Ltd

DRUG INCLUDED ON AGENDA	PHARMACEUTICAL COMPANY / MANUFACTURER
Solifenacin oral suspension • Vesicare oral suspension 1mg/1ml *Alternatives*: • Vesicare tablets 5mg and 10mg • Solifenacin tablets 5mg and 10mg • Solifenacin oral suspension 10mg/5ml • Solifenacin oral solution sugar free 5mg/5ml • Oxybutynin 2.5mg and 5mg tablets • Oxybutynin oral solution sugar free 2.5mg/5ml • Oxybutynin oral solution sugar free 5mg/5ml • Kentera patches 3.9mg/24 hours	 Astellas Pharma Ltd Astellas Pharma Ltd Various manufacturers Various manufacturers Various manufacturers Various manufacturers Various manufacturers Various manufacturers Accord Healthcare Ltd
Asymptomatic bacteriuria screening in pregnancy • Nitrofurantoin modified release capsules 100mg • Nitrofurantoin oral suspension sugar fee 25mg/5ml • Amoxicillin capsules 250mg and 500mg • Amoxicillin oral suspension 125mg/5ml and 250mg/5ml • Cefalexin capsules 250mg • Cefalexin suspension 125mg/5ml and 250mg/5ml	 Various manufacturers Various manufacturers Various manufacturers Various manufacturers Various manufacturers Various manufacturers
Potassium permanganate **Permitabs for cutaneous solution** *Alternative treatments:* • Hydrogen peroxide solution • Various antiseptic products	Alliance Pharmaceuticals Ltd Various manufacturers Various manufacturers
Iron deficiency anaemia • Ferrous fumarate tablets 210mg • Ferrous sulfate tablets 200mg • Ferrous gluconate tablets 300mg • Sodium feredetate elixir 190mg/5ml Alternatives: • Ferric maltol capsules 30mg • Parenteral iron	 Various manufacturers Various manufacturers Various manufacturers Various manufacturers Various manufacturers Various manufacturers

e-FIG ITEM	PHARMACEUTICAL COMPANY / MANUFACTURER
Edoxaban (Lixiana)	Daiichi Sanko UK Limited
Alternative direct-acting oral anticoagulants:	
Rivaroxaban (Xarelto)	Bayer plc
Apixaban (Eliquis)	Bristo-Myers Squibb-Pfizer
Dabigatran (Pradaxa)	Boehringer Ingelheim Limited

2. Minutes of the meeting held on 22nd June 2022 and Actions/Matters Arising

Minutes of the meeting held on 22nd June 2022

The minutes of the meeting held on 22nd June 2022 were approved.

Summary of actions			
	Action	**Lead**	**Status**
21/23	Thyroid disorders: Update – redraft final guidance in line with the discussion and discuss with specialists.	Formulary Team	Ongoing
21/24	Thyroid disorders: Update – circulate the final draft via e-FIG for agreement.	Formulary Team	Ongoing
21/54	Methotrexate/folic acid dose scheduling clarification – Folic acid recommendations in the gastroenterology Shared Care prescribing guideline for west Devon to be reviewed following contact with gastroenterology specialists at UHP to discuss a more specific definitive statement. *Post meeting note: RD&E gastroenterologists have requested updates to the N&E methotrexate guidelines. A Devon-wide review is proposed and the folic acid prescribing notes in the west Devon gastroenterology guideline will be considered as part of this review.*	Formulary Team	Ongoing
21/72	Osteoporosis – liaise with specialists and bring final draft to a future FIG meeting. *Post-meeting note: The National Osteoporosis Guideline Group (NOGG) issued updated guidance for osteoporosis in April 2021. A draft update to the formulary guidance based on the new guidance from NOGG has been sent to specialists for review and will be scheduled for discussion at a future FIG meeting.*	Formulary Team	On agenda
22/17	Sacubitril Valsartan: partial review – work with heart failure teams to develop draft prescribing guidance for sacubitril valsartan and submit to FIG for discussion.	Formulary Team	Ongoing
22/18	Lipid guidance – Confirm that the necessary financial arrangements have been agreed.	Medicines Optimisation	Complete
22/19	Circulate the final changes to the formulary guidance for the management of lipids to FIG members for agreement via the e-FIG process. This was added to the agenda of the meeting held on 22nd June 2022.	Formulary Team	Complete

22/25	NICE TA599: Sodium zirconium cyclosilicate for treating hyperkalaemia (update to TA599 and consideration of reclassification from red to amber) – Feedback to specialists on the discussion to understand the frequency of potassium monitoring required.	Formulary Team	Ongoing
22/26	NICE TA599: Sodium zirconium cyclosilicate for treating hyperkalaemia (update to TA599 and consideration of reclassification from red to amber) look at TA599 evaluations to determine if potassium threshold of 5.5mmol/L has been considered for patients with heart failure.	Formulary Team	Ongoing
22/27	NICE TA599: Sodium zirconium cyclosilicate for treating hyperkalaemia (update to TA599 and consideration of reclassification from red to amber) - update the proposed formulary entry and bring back to a future FIG meeting.	Formulary Team	Ongoing
22/31	Octasa (mesalazine) 1g suppositories - consider Scriptswitch message to remind clinicians to prescribe mesalazine enemas and suppositories by brand.	MO Team	Ongoing
22/38	Following further consultation with specialists. Progress the formulary entry for Amiodarone (Cordarone X): via the e-FIG process, or a short discussion at the next FIG meeting.	Formulary Team	On agenda
22/39	Add accepted formulary entry for Tirbanibulin to the formulary. (Pending publication of the policy)	Formulary Team	Ongoing
22/40	Tirbanibulin for actinic keratosis – Update guidance for AK and entries for Actikerall and fluorouracil 5% cream in line with the discussion.	Formulary Team	Ongoing
22/41	Tirbanibulin for actinic keratosis - consult with specialists in SW Devon to see if a Devon wide harmonisation of the classification for imiquimod 5% cream (Aldara) is acceptable.	Formulary Team	Ongoing
22/42	Seek specialist advice from dermatologists regarding the interval between first and second treatment courses using 5-fluorouracil cream.	Formulary Team	Ongoing
22/43	Submit Devon FIG Annual Report for CPRC of the ICB.	Formulary Team	Complete
22/44	Terms of Reference of the Devon FIG to be reviewed following the establishment of the ICB.	Formulary Team	On agenda
22/45	Lipid guidance – Update the guidance on the Management of blood lipids in line with the discussion.	Formulary Team	Complete
22/46	Lipid Guidance - add a Scriptswitch message to atorvastatin chewable tablets to advise recommending rosuvastatin hard capsules.	MO Team	Complete
22/47	Lipid Guidance update section 2.12 Lipid-regulating drugs in line with the discussion.	Formulary Team	Complete
22/48	NICE guidance NG196 – Atrial fibrillation: consult with specialists on the anticoagulation guidance.	Formulary Team	Ongoing
22/49	Intermittent Catheters: Update the formulary with the accepted formulary guidance.	Formulary Team	Complete

22/50	Ciclosporin eye drops (Verkazia for vernal Keratoconjunctivitis - Contact trust pharmacies to ascertain the level of prescribing for Ikervis for children and adolescents.	Formulary Team	Complete
22/51	Ciclosporin eye drops (Verkazia for vernal Keratoconjunctivitis – discuss the impact of the amber classification on prescribing in primary care with the Head of Medicines Optimisation	Formulary Team	Ongoing
22/52	Ciclosporin eye drops (Verkazia for vernal Keratoconjunctivitis – Update Devon formulary as agreed by the Devon FIG.	Formulary Team	Ongoing
22/53	Reclassification of Ilube (acetylcysteine) 5% w/v eye drops from red to amber – update the formulary entry in line with the discussion.	Formulary Team	Complete
22/54	Transdermal oestrogens for HRT – update the formulary with the agreed formulary entry.	Formulary Team	Complete
22/55	Serviced transitions for young people with an existing ADHD diagnosis - update the Devon Formulary with the accepted Specialised Medicines Service (SMS) adult ADHD prescribing guidelines for methylphenidate, lisdexamfetamine and atomoxetine without amendment.	Formulary Team	Complete
22/56	MHRA Drug Safety Update – May 2022: Formulary entry for Prolia to be updated to include weblink to the Drug Safety Update.	Formulary Team	Complete

Report of e-FIG decisions: Edoxaban for atrial fibrillation

In July 2022 the FIG was asked to consider Edoxaban for atrial fibrillation (AF) in patients with high creatinine clearance via the e-FIG process. Thirteen responses were received.

One response requested that additional text be added to the proposed amendment for the edoxaban entry and the references to the NHS England commissioning recommendations to further highlight the need to consider the clinical appropriateness of edoxaban for these patients, and to consider whether an alternative DOAC which is less dependent on renal excretion may be appropriate. Other FIG members supported these proposals.

Subsequently, the FIG was asked to consider additional amendments to address this request. A second e-FIG paper presenting amendments to the formulary entry for edoxaban, references to the NHS commissioning recommendations and the guidance for AF was sent to FIG members.

This e-FIG closed on Friday 12th August 2022. Twelve responses were received, all respondents were happy with the proposals for edoxaban.

ACTION: Formulary Team to update the formulary entry for Edoxaban for AF and the guidance for AF.

3. Consideration of hydrocortisone sodium phosphate 3.35mg/ml eye drops (Softacort)

An application was received from a consultant ophthalmologist at the RD&E Hospital for the inclusion of Softacort (hydrocortisone sodium phosphate 3.35mg/ml) eye drops to the Devon Formulary as an amber (specialist-input) option for its licensed indication (mild non-infectious allergic or inflammatory conjunctival diseases). The application was supported by a second consultant ophthalmologist from the RD&E Hospital and a consultant ophthalmologist from Torbay and South Devon NHS Trust. The applicant joined the meeting for the discussion. Support from other consultant ophthalmologists in Devon was noted.

The eye drops are preservative free and are available in single dose containers. Hydrocortisone sodium phosphate is a well established low potency topical corticosteroid for ocular conditions. The SmPC for Softacort indicates that corticoid class effects, including cataract and glaucoma, have not been observed with hydrocortisone, but are known with other topical corticosteroids.

The only formulary preservative free corticosteroid eye drop, prednisolone 0.5%, is a medium potency corticosteroid. Softacort is cost saving compared with prednisolone single dose unit eye drops and is available in a larger pack size.

The FIG considered and accepted the inclusion of Softacort eye drops to the Devon Formulary as an amber (specialist-input) treatment.

ACTION: Formulary team to add the formulary entry for Softacort to the Devon Formulary in line with the discussion.

4. Consideration of solifenacin succinate oral suspension 1mg/ml

An application was received from the Lead Paediatric Bladder and Bowel Care Nurse Specialist, at University Hospitals Plymouth NHS Trust, for the inclusion of Vesicare (solifenacin succinate) oral suspension 1mg/ml in the Devon Formulary as an amber (specialist input) option, for the treatment of NDO in paediatric patients aged 2 to 18 years.

Vesicare oral suspension is an antimuscarinic containing 1mg/ml solifenacin succinate. It is indicated for symptomatic treatment of urge incontinence and/or increased urinary frequency and urgency as may occur in patients with overactive bladder (OAB) syndrome in adults, and for the treatment of neurogenic detrusor overactivity (NDO) in paediatric patients aged 2 to 18 years.

An alternative liquid form of solifenacin is also available (1mg/1ml oral *solution* sugar free), however this is not licensed for use in children and is available at a higher acquisition cost compared with the oral suspension. The oral *solution* was *not* considered for inclusion in the formulary.

Solifenacin 5mg and 10mg tablets are currently listed in the Devon Formulary as blue (second line) options for urinary frequency, urgency and urge incontinence.

It was identified that the use of a liquid antimuscarinic may also have benefits for adults with swallowing difficulties who require an antimuscarinic for urinary incontinence, frequency and urgency. The only alternative licensed products for adult patients are oxybutynin oral solution or transdermal patch. For paediatric patients who are unable to swallow tablets and require an antimuscarinic for symptoms of OAB / NDO, the only alternative licensed product is oxybutynin oral solution (licensed for children over 5 years

of age). Of these options, only oxybutynin patches 3.9mg/24h are currently recommended in the Devon Formulary.

Local bladder and bowel specialists and consultant urologists, both paediatric and adult specialities, were asked whether they supported the inclusion of Vesicare (solifenacin succinate) oral suspension 1mg/ml in the Devon Formulary for use in line with its licensed indications. Responses from local specialists generally indicated a positive response for the product.

The FIG considered and accepted the inclusion of Solifenacin oral suspension 1mg/ml in the Devon Formulary as blue (second line) for adult patients with swallowing difficulties and amber (specialist input) for the treatment of NDO in paediatric patients.

It was agreed the Medicines Optimisation Team would put a Scriptswitch message in place to suggest a switch from solifenacin *solution* to solifenacin *suspension*.

ACTION: Medicines Optimisation Team to put a Scriptswitch message in place to suggest a switch from solifenacin solution to solifenacin suspension.

ACTION: Formulary Team to update the formulary with the accepted formulary entry for solifenacin succinate oral suspension 1mg/ml.

5. MHRA Drug Safety Updates (June 22 to July 22)

Two MHRA Drug Safety Updates have been issued since the last meeting.

June 2022

Metformin and reduced vitamin B12 levels: new monitoring advice for patients at risk

New advice is issued on checking and monitoring vitamin B12 levels in patients receiving metformin following a European review, with input from the MHRA. The regulatory agency assessment report supporting amendments to the SmPCs of metformin-containing medicines was not available to view at the time of writing the meeting paper. The recommendations from the MHRA include specific advice for metformin-treated patients on the testing of vitamin B12 serum levels if deficiency is suspected (for example in patients presenting with megaloblastic anaemia or new-onset neuropathy), to follow current clinical guidelines on the investigation and management of vitamin B12 deficiency, and to consider periodic vitamin B12 monitoring in patients with risk factors for vitamin B12 deficiency.

The British Society for Haematology (BSH) issued guidance for vitamin B12 deficiency in 2014 which included recommendations for patients receiving metformin. The MHRA recommendations are in line with the BSH recommendations with the exception of giving consideration to periodic monitoring of patients with risk factors for vitamin B12 deficiency. The BSH guidance states that no definitive advice can be given on the desirable frequency of monitoring of serum cobalamin in patients with type 2 diabetes mellitus on metformin therapy and recommends that serum cobalamin is checked in the presence of strong clinical suspicion of deficiency.

The Drug Safety Update includes references for three papers which were published after the BSH guidance was issued. The Formulary team reviewed these papers and reported on the methodology of the two studies and gave an overview of the third paper, which was a review of drugs associated with vitamin B12 deficiency.

The local clinical referral guidance (CRG) for investigations and monitoring for type 2 diabetes states 'Although some GPs measure FBC, LFTs, B12 and folate there is not a good evidence base for doing this routinely' and 'Vitamin B12 levels may be reduced in patients on metformin. However the clinical significance is uncertain and we do not advocate screening for this'. This guidance was developed by the Pathology Optimisation Group and does not fall under the remit of the FIG.

The discussion of the MHRA recommendations included the following points:

- The Chair, a consultant gastroenterologist, discussed the complexity of investigating the cause of a low vitamin B12 level.
- GPs are aware that metformin is associated with vitamin B12 deficiency. They investigate if the patient is symptomatic or an abnormal test result is identified during the routine care of the patient. The MHRA recommendation for periodic testing for patients with risk factors could result in unnecessary testing and unnecessary follow-up for patients.
- The reference to 'periodic' monitoring for patients with risk factors is unhelpful, the MHRA should have provided specific advice on the frequency of monitoring.
- There were approximately 440,000 prescriptions for metformin over 12 months in Devon. Periodic monitoring for patients with a risk factor listed in the Drug Safety Update could potentially result in the testing of large numbers of patients in Devon.
- The list of risk factors for vitamin B12 deficiency includes elderly patients. An elderly care consultant reported that a vitamin B12 test is conducted for every frail patient seen by the elderly care team and that abnormal test results are extremely rare.
- A decision will need to be taken on whether vitamin B12 should be added to the test order set for type 2 diabetes.

It was agreed that as the CRG recommendations are not in line with the Drug Safety Update, and due to the complexity of the subject and the potential significant impact of these recommendations on the number of tests conducted in Devon, the FIG would ask the Pathology Optimisation Group to discuss the MHRA recommendations and take a decision on whether these should be implemented in full in Devon.

The Formulary team was asked to write to the Pathology Optimisation Group to inform them of the FIG's decision. When the Pathology Optimisation Group has been contacted, the formulary will be updated with a link to the entry and a note to indicate that the MHRA recommendations will be discussed by the Pathology Optimisation Group.

ACTION: **Formulary team to liaise with the Chair on writing to the Pathology Optimisation Group to ask them to discuss the MHRA recommendations for vitamin B12 testing for patients receiving metformin**

ACTION: Formulary team to update formulary with a link to MHRA Drug Safety Update and note regarding Pathology Optimisation Group after correspondence is sent to the group

<u>Roche Accu-chek Insight insulin pump and Novorapid Pumpcart insulin cartridges: alert following cases of insulin leakage</u>

Following reports of serious harm, a National Patient Safety Alert has been issued on insulin leakage during use of the Accu-Chek Insight Insulin pump with NovoRapid PumpCart prefilled insulin cartridges.

The fault lies with the Accu-Chek Insight insulin pump. The company ceased marketing the Insight insulin pump in December 2021. Patients are being moved to alternative pumps. The Accu-Chek Insight insulin pump is not listed in the Devon Formulary.

The NovoRapid PumpCart is listed in the Devon Formulary. The formulary team will add a time limited link from the formulary entry for NovoRapid PumpCart to the safety alert.

ACTION: Formulary Team to add a time-limited link from the formulary entry for Novorapid Pumpcart to the NPSA alert.

July 2022

Topiramate (Topamax): start of safety review triggered by a study reporting an increased risk of neurodevelopmental disabilities in children with prenatal exposure

The Commission on Human Medicines considers that a new large observational study provides robust evidence of an increased risk of neurodevelopmental disabilities in children with prenatal exposure to topiramate. A new safety review will be conducted to evaluate the findings of the study in the context of the accumulating data relating to the benefits and risks of use of topiramate, with a particular focus on women of childbearing potential and during pregnancy.

The article reiterates advice on the prescribing of valproate to girls and women of childbearing age and the current advice for topiramate in epilepsy and migraine.

The article notes that the latest data show that whilst there has been substantial decline in the prescribing of valproate in girls and women of childbearing age, the total prescribing of topiramate across indications is increasing. Topiramate is now one of the more commonly prescribed antiepileptics in women.

The Formulary team will update the formulary section on migraine, epilepsy and the topiramate entry as the result of this safety update.

ACTION: Formulary Team to update the formulary section on migraine, epilepsy and the topiramate entry.

6. Asymptomatic bacteriuria screening in pregnancy

Asymptomatic bacteriuria (ASB) can suggest that a person may have a urinary tract infection. It may also cause complications for pregnant mothers and their babies.

In 2019 the predecessor FIGs agreed formulary guidance, supported by antimicrobial specialists in Devon, to recommend routine screening for ASB early in pregnancy. The recommendation was based on several NICE publications.

A review of the antenatal screening programme by the UK National Screening Committee (UK NSC) in November 2020 reported that there is currently a lack of available data to inform population screening strategies for ASB in pregnancy in the UK and that population screening may not be useful in reducing the negative effects of ASB. Subsequently NICE has updated their antenatal care guidance and no longer include a recommendation on routine testing for ASB. NICE has also removed the recommendation for routine screening of pregnant women from their antimicrobial guidance for lower urinary tract infections

(NG109). However, the recommendation for antibiotic treatment of ASB in pregnancy, which indicates that ASB is “a risk factor for pyelonephritis and premature delivery”, remains in NG109. It is unclear how ASB would be identified in pregnant women, in order to be treated, without routine testing.

The Formulary team contacted specialists to gather feedback on the UK NSC statement and whether the formulary guidance should be amended in line with the UK NSC position. Early feedback suggested there is a still a place for screening for ASB in pregnancy in current practice. However, further discussion via the Local Maternity Network is required. Feedback from the Local Maternity Network suggests differing opinions between the specialists, a more detailed discussion is planned at the next workstream meeting.

When feedback has been received the Formulary team will bring the formulary guidance on asymptomatic bacteriuria screening in pregnancy back to the FIG for either a decision by e-FIG or for discussion at a FIG meeting.

The FIG was asked for their views on this topic. The discussion noted that:

- GPs value specialist opinion,
- any decision needs to be Devon wide,
- decisions will be taken via the specialists/Local Maternity Network,
- the GPs reported that it is not clear who undertakes the tests and whether positive results have been acted upon,
- the Formulary team will liaise with local specialists/Local Maternity Network and bring their views to the FIG either via the e-FIG process or to a FIG meeting.

ACTION: Formulary Team to liaise with local specialists/Local Maternity Network and bring their views and formulary guidance for ASB back to the FIG either via the e-FIG process or to a meeting.

7. FIG Terms of Reference

The Devon FIG Terms of Reference (ToR) has been reviewed in line with the group’s governance processes and to reflect organisational change. The Devon FIG received the updated ToR.

Several minor changes had been made, including that:

- the names of the local decision-making groups have been updated to reflect the groups currently in place;
- following the merger of Northern Devon Healthcare NHS Trust (NDHT) and Royal Devon and Exeter (RD&E) NHS Foundation Trust to form the Royal Devon University Healthcare (RDUH) NHS Foundation Trust, pharmacy representatives were asked how they wished to be represented. It has been agreed that the pharmacy departments of the two hospitals will be represented by Carole Knight (North Devon District Hospital) and James Leavy (RD&E Hospital);
- it was also noted that Rebecca Lowe will be joining the Formulary Team and the Devon FIG as Joint Formulary Pharmacy Technician, the ToR will be updated to reflect this.

ACTION: FIG ToR to be updated to reflect organisational and membership changes.

8. Solriamfetol for the treatment of excessive daytime sleepiness

A Consultant Neurologist from RDUH joined the meeting for discussion of this item.

Narcolepsy is a chronic sleep disorder which causes excessive daytime sleepiness (EDS). The condition may also result in sufferers experiencing sudden periods of loss in muscle tone whilst awake. Other symptoms of narcolepsy include hallucinatory experiences occurring in sleep–wake transitions, disturbed night-time sleep, and sleep paralysis. The condition is characterised as either narcolepsy with or without cataplexy. Type 1 narcolepsy is the predominant type, with 60-80% of patients experiencing cataplexy as well as EDS and other symptoms.

Solriamfetol is a centrally acting sympathomimetic that inhibits reuptake of dopamine and noradrenaline, thereby improving wakefulness. Solriamfetol only treats EDS; it may be necessary to prescribe additional medicines to treat other symptoms.

NICE Technology Appraisal Guidance (TA758) was issued for solriamfetol in January for treating EDS in adults caused by narcolepsy with or without cataplexy only if modafinil and either dexamfetamine or methylphenidate have not worked well enough or are not suitable.

The Devon Formulary does not contain any specific guidance on the management of narcolepsy in adults. Three drugs are recommended in the Devon Formulary as amber (specialist input) options with one other drug classified as amber for north, east and west Devon patients, but remains red (secondary care only) for south Devon patients.

Solriamfetol was added to the Devon Formulary as a red hospital only drug to meet the mandatory timeline for implementation of the NICE Technology Appraisal. In line with other narcolepsy treatments, it is proposed that solriamfetol is reclassified to amber (specialist input). In addition, an SMS prescribing guideline has been drawn up to support safe and effective prescribing in primary care.

An accurate local dataset is not available to inform on the number of narcolepsy patients in Devon. It is expected that the number of patients progressing onto solriamfetol as a third line agent the number of existing patients offered treatment in the future will be low.

The FIG considered and accepted the reclassification of solriamfetol from red (hospital only) treatment to an amber (specialist) treatment, and the proposed SMS prescribing guideline.

There was discussion about:

- Access to secondary care services for the treatment of excessive daytime sleepiness. Including patient follow-up, treatment and side effects.
- Blood pressure monitoring. Home blood pressure monitoring is supported. Other routes whereby patients may have their blood pressure checked include community pharmacies and GPs surgeries.
- Prescribing and monitoring responsibilities: it was agreed that a six month period of prescribing and monitoring responsibilities should remain with the specialist following initiation of solriamfetol due to the newness of the treatment and local specialists' lack of familiarity with its use in practice. The specialist present felt that 6 months enabled him to oversee the titration period, complete the necessary monitoring and then assess benefit to the patient before sharing responsibilities with the GP. Patient numbers are expected to be low for solriamfetol as it is not a first line treatment.
- Monitoring requirements: If home blood pressure and pulse monitoring is considered appropriate on an individual patient basis during the first six months of treatment, the specialist should agree the requirements and expectations directly with the patient and/or patient's carer. Specialist to advise the

patient on suitable equipment to facilitate this and how to submit results for review. It was agreed that the information in the table 'Monitoring to be completed by the GP once the shared agreement is in place:' be amended to read six months following treatment initiation, then six monthly thereafter.

ACTION: SMS pharmacist to circulate the proposed formulary entry and amended guideline to specialists for comment.

ACTION: SMS pharmacist to bring SMS prescribing guideline for Solriamfetol back to the FIG via the appropriate route.

9. Management of osteoporosis

A Consultant Rheumatologist from RDUH joined the meeting for discussion of this item.

Draft guidance on osteoporosis was originally produced by a speciality doctor for the RD&E rheumatology team. The draft guidance, which incorporated NICE CG146, was briefly reviewed by the FIG in 2021 with a view to a more in-depth discussion at a later meeting. Subsequently, the UK National Osteoporosis Guidelines Group (NOGG) issued an update to their guidance. The Formulary team updated the RD&E team's guidance to incorporate the updated NOGG guidance.

The draft guidance has been circulated to and is supported by specialists at NDDH and UHP. Comments are awaited from specialists based at Torbay hospital. It is intended that the final guidance will replace the current formulary guidance for osteoporosis in its entirety.

The FIG was asked to undertake an initial discussion to confirm clarity of the guidance and to consider any further information that may be required.

It was noted that NICE CG146 and the NOGG guidance differs in approach to recommending fracture risk assessment for a patient receiving a glucocorticoid with respect to whether both oral and systemic steroids are considered and the dosing threshold for the assessment of fracture risk. The FIG considered and accepted in principle the approach proposed by the specialists which is for fracture risk assessment for patients receiving oral glucocorticoids only, at a threshold dose equivalent to 7.5mg/day of prednisolone or higher for three months, and that this would apply to current use of glucocorticoids only.

The Formulary team will review comments received from specialists at Torbay hospital and update the current draft for review by specialists across Devon. The formulary entries for drugs for osteoporosis are under review.

There was discussion about:

- Which fractures should be classed as a fragility fracture and specifically whether a report of an incidental vertebral fracture should trigger a FRAX assessment.
- How often patients should be reassessed for fracture risk. It was suggested that a link to the section addressing re-assessment of fracture risk should be included in the first section.
- The link to the assessment tool, FRAX, should be included in other sections of the guidance for easy access.
- It can be difficult to determine whether patients receiving corticosteroids meet the threshold for fracture risk assessment as some patients receive short tapering courses. The specialist present offered to write a clinical vignette to include in the section on patients receiving corticosteroids.

- The NOGG recommendation to consider referral of very high risk patients to a specialist for assessment and consideration of parenteral treatments. It was noted by the specialist present for the discussion that the majority of patients referred recently were at very high risk and that this recommendation is to 'consider' referral. The Formulary team will look further into the NOGG recommendation.
- Feedback from specialists on the route of referral for parenteral treatment. It was noted that the development of referral pathways falls outside the remit of the Formulary team / FIG. The team will send the feedback received from specialists to the DRSS GP representative who will be developing clinical referral guidance for osteoporosis.
- Add wording to the section on vertebral fractures regarding access to the vertebroplasty service and that patients should always be discussed with the relevant specialist.

The FIG accepted in principle the draft proposed update to the formulary guidance, subject to amendment in line with the discussion, and on the understanding the draft would be updated with feedback from the Torbay specialists, and there would be a further consultation with specialists in Devon. The FIG indicated it would be acceptable to provide any further changes to the draft guidance as highlighted text. The formulary entries for drugs for osteoporosis are under review.

ACTION: Formulary Team to update the proposed formulary guidance for osteoporosis in line with the discussion and undertake further consultation with specialists.

Following further consultation with specialists the Formulary team will bring the guidance and any proposed amendments to drug entries back to the FIG for approval via the e-FIG process or discussion at a meeting.

ACTION: Following further consultation with specialists the Formulary Team to bring the osteoporosis guidance and any proposed amendments to drug entries back to the FIG via appropriate route.

10. Potassium permanganate (Permitabs): National Patient Safety Alert

A Patient Safety Alert was issued in 2014 which highlighted incidents where patients had inadvertently ingested the concentrated form of potassium permanganate, which is available as a tablet or solution for dilution for external use. Ingestion can be fatal, even dilute solutions can be toxic if swallowed. Reports of incidents continued to be received prompting the publication of a new National Patient Safety Alert (NPSA) issued on 5th April 2022 accompanied by guidance issued by the British Association of Dermatology (BAD). The alert indicates that actions must be completed by 4th October 2022.

Implementation of the NPSA alert by trusts in Devon falls outside the remit of the FIG and the Formulary team.

The FIG meeting papers included the NPSA alert, the BAD guidance for potassium permanganate and a discussion paper which included the following information: proposals for the FIG to consider; key points from the guidance on potassium permanganate from the BAD; review of relevant NICE guidelines and guidelines for primary care for recommendations for potassium permanganate; prescribing data for primary care; overview of the formulary position of potassium permanganate in formularies in southwest England; consultation with the Devon Antimicrobial Stewardship Group, Devon Wound Management Group, Dermatology teams, acute trust formulary representatives and NHS Devon Medicines Optimisation team; and the draft formulary entry for potassium permanganate.

The BAD guidance makes recommendations on prescribing in primary and secondary care, including who can prescribe and on areas such as repeat prescribing, and also recommends a risk assessment before each prescription for potassium permanganate to be used in the home to ensure the patient (or carer) can manage potassium permanganate safely and it can be stored and disposed of safely.

The Devon Formulary includes potassium permanganate Permitabs currently as a blue (second-line) entry. An updated entry was proposed with a reference to the 2022 NPSA alert, a link to the BAD guidance and highlighting the requirement for a risk assessment if potassium permanganate is to be used in the patient's own home. The initial proposal to the dermatology specialists was for a red (hospital-only) traffic light classification. Subsequently, clarification was sought from the BAD on prescribing of potassium permanganate in the community setting. The BAD have clarified that non-specialist GPs and non-medical prescribers may prescribe potassium permanganate in the community setting if they have experience in dermatological conditions and the use of potassium permanganate. In light of this and responses received during the consultation, the formulary classifications of amber (specialist input) and blue (second-line) were also discussed. The proposal for an amber classification was that a specialist may prescribe or recommend potassium permanganate for a GP to prescribe, in which case an alternative treatment option should also be given to the GP.

The FIG heard that the Devon Wound Formulary Group were presented with a briefing paper on the NPSA alert and the guidance from the BAD. The group includes representatives from the following specialities: tissue viability teams from NDDH, RD&E hospital, UHP, and T&SD NHS Trust; healthcare professionals with expertise in leg ulcers, vascular ulcers and podiatry; ICB non-medical nurse prescriber, Medicines Optimisation team pharmacist and pharmacy technician, Devon Formulary specialist pharmacy technician, and the lead for the Livewell Community services.

It was reported that the tissue viability teams noted there is limited evidence for prescribing potassium permanganate and do not see a benefit over the current risks, and that there are other more appropriate antimicrobial soaks available. It was reported that patients have experienced burns in the community setting as a result of inappropriate administration and dilution of potassium permanganate. There is occasional use by the vascular teams and the podiatry teams, although this varied between areas; some teams are no longer using potassium permanganate.

The consensus of the Wound Management Group was that the formulary should have an entry to highlight safety advice and that the proposed draft entry was clear and made sense. The group noted that responsibility lies with the prescriber and that they should assess a patient's risk. When offered a statement to suggest when potassium permanganate is recommended, an alternative option should be offered as well, the group agreed this would enable those less comfortable with prescribing potassium permanganate to utilise other treatment options.

Specialists were invited to join the FIG discussion but this offer was not taken up.

There was wide-ranging discussion, including the following points:

- An entry for potassium permanganate should be included in the Devon Formulary for safety reasons to draw attention to the NPSA alert and BAD guidance.
- It was reported during the Wound Management Group discussion that there has been a fatality in Devon as a result of oral ingestion of potassium permanganate prescribed for the patient to use in their home.
- There were 219 prescriptions for potassium permanganate in primary care in Devon over the most recent 12 month period. It was too early to determine whether the NPSA alert has resulted in a reduction in prescribing.

- An e-mail received from the lead dermatologist at the RD&E hospital after the meeting paper was finalised lists a number of conditions for which potassium permanganate is considered to be clinically appropriate.
- Feedback was received from FIG members who are members of the Devon Wound Management Group and were present for the discussion of potassium permanganate.
- The GPs considered that there may be some GPs and practice nurses who prescribe potassium permanganate but it is not widely seen as a treatment option.
- There was debate about the appropriate traffic light classification. It was noted that there was a difference in opinion between specialities over the appropriate classification. The Wound Management Group supported amber (specialist-input) whereas the dermatologists were concerned that the amber classification would result in advice and guidance requests for areas that fall outside of their expertise (e.g. wound care). The FIG considered that patient safety was the overriding factor for consideration.
- The FIG was supportive of the proposal that an alternative treatment option is offered if a specialist recommends potassium permanganate to a GP for prescribing. This was considered to be a pragmatic approach which would give GPs an alternative option if they were uncomfortable with prescribing potassium permanganate or a risk assessment indicated that potassium permanganate should not be prescribed. Providing an alternative option with the initial recommendation would mean the GP would not have to contact the specialist again for advice, would save time on the part of the GP and the specialist, and would prevent delays in treatment.
- A specialist would need to be clearly defined in the formulary entry to recognise that potassium permanganate may occasionally be recommended by specialist community team members who are non-medical prescribers.
- The formulary entry should indicate that potassium permanganate is less suitable for prescribing.
- It was noted the proposed formulary entry includes the points which are required to be covered by a risk assessment in the patient's home and that the formulary entry indicates the risk assessment should be documented in the patient's record.
- The consultation with the Wound Management Group included several suggestions for alternatives to potassium permanganate. It would be helpful to highlight these in the formulary.
- Potassium permanganate is listed as an option in the South & West Devon guidance for infected eczema. NICE has issued antimicrobial guidance for infected eczema which does not include potassium permanganate. The FIG accepted the removal of potassium permanganate from the South & West Devon guidance for infected eczema. The Formulary team will review the formulary guidance for infected eczema with a view to updating it and will consult with specialists.
- The LPC should be made aware of the update to formulary entry for potassium permanganate when it is published.
- The formulary entry to be scheduled for discussion again at an appropriate time in the future to discuss the impact of the new formulary entry.

The FIG accepted the amber classification on the understanding that if a specialist requests that a GP prescribes potassium permanganate, an alternative option is recommended to the GP at the same time.

The FIG accepted the proposed formulary entry subject to minor amendments in line with the discussion and to replace the current North & East Devon and South & West Devon entries for Permitabs in their entirety. The revised entry to be brought back to the FIG for a final decision using the e-FIG process.

ACTION: Formulary team to update the proposed entry for potassium permanganate in line with the discussion and bring back to the FIG via e-FIG process.

ACTION: Formulary team to publish formulary entry before NPSA timeline (04 October 22)

ACTION: Formulary team to communicate publication of new formulary entry for potassium permanganate to specialist teams and primary care

ACTION: Formulary team to notify LPC (via MOCC LPC representative) of new formulary entry for potassium permanganate when published

ACTION: Formulary team to schedule the formulary entry for potassium permanganate for review by the FIG at an appropriate time in the future

ACTION: Formulary team to remove potassium permanganate from the South & West Devon guidance for infected eczema and review formulary guidance for infected eczema and bring to FIG for discussion following specialist consultation

ACTION: Formulary team to liaise with Wound Management Group over alternatives to potassium permanganate for highlighting in the formulary

11. Iron deficiency anaemia: dose of oral iron preparations

Investigations to establish the underlying cause of iron deficiency anaemia (IDA) were outside the scope of this review. The Devon Formulary currently does not have specific management guidelines for the treatment of IDA.

The N&E Devon and S&W Devon presentations of the formulary differ slightly in the supporting information included alongside the oral iron preparations recommended. In N&E Devon this includes reference to the British Society of Gastroenterology (BSG) guidelines for the management of IDA in adults, which have subsequently been updated. Clinical referral guidelines (CRGs) for anaemia in adults are available for both N&E and S&W Devon, these were last updated in July 2016. Clinical referral guidance is outside the remit of the FIG. The British Society of Gastroenterology (BSG) published revised guidelines for the management of IDA in adults in September 2021. The revised BSG guidelines prompted an update to the NICE Clinical Knowledge Summary Anaemia - iron deficiency.

Two recommendations from the BSG on the treatment of IDA are of relevance to the Devon Formulary guidance. These are that:

- the initial treatment of IDA should be with one tablet per day of ferrous sulphate, fumarate or gluconate. If not tolerated, a reduced dose of one tablet every other day, alternative oral preparations or parenteral iron should be considered.
- parenteral iron should be considered when oral iron is contraindicated, ineffective or not tolerated. This consideration should be at any early stage if oral iron replacement therapy is judged unlikely to be effective and/or the correction of IDA is particularly urgent.

It is noted that once daily/alternate day dosing of ferrous sulfate, ferrous fumarate and ferrous gluconate for the treatment of IDA is not in line with the various product SmPCs, or the BNF. It was reported during the discussion that the BSG has contacted the BNF committee to request the BNF dosing recommendations for the relevant iron preparations are updated from three times a day to once daily dosing, however, this update will not be published until later this year.

Local specialists were consulted and generally indicated support for alternate day dosing.

The review of the formulary entry provided an opportunity to harmonise the formulary drug entries and supporting information. A revised draft was presented to the group for discussion prior to circulation to local specialists for any final comments.

There are currently some ongoing discussions regarding the number of tablets required for a once daily dose of ferrous gluconate and the volume of sodium feredetate elixir required for a once daily dose. The BSG guidelines does not offer a clear explanation, clarity has therefore been sought from local specialists.

Niferex, which is listed in South & West Devon, has been discontinued and will be removed from the formulary.

Following consultation with the specialists and considering the updates from national bodies, the FIG was asked to consider the proposed formulary entry for IDA, including amendments to sub-section "9.1.1.1 Oral Iron" of the Devon Formulary.

The FIG considered and accepted the proposed Devon Formulary entry for 'Iron deficiency anaemia: dose of oral iron preparations'. It was agreed that the proposed formulary entry be circulated to specialists in line with the discussion. If no significant changes are made to the entry on consultation with specialists, the FIG agreed to accept the proposed formulary entry.

The FIG accepted the Devon-wide formulary classification of green (first-line) for ferrous fumarate, ferrous sulfate, and ferrous gluconate oral iron preparations and blue (second-line) for sodium feredetate as an alternative oral iron preparation.

There was discussion about the number of doses to be given per day and on emphasising that iron preparations should be taken on an empty stomach to improve absorption.

ACTION: Formulary Team to forward the draft formulary entry to specialists for final comment.

ACTION: After further consultation with specialists the formulary team to update the formulary with the accepted entry or bring the entry back to a future FIG meeting for discussion or pursue through the e-FIG process.

12. Recent drug decisions (including NICE updates)

The FIG received a report of recent drug decisions, these include:

- the discontinuation and removal of haloperidol 20mg tablets,
- the addition of two meningitis vaccines,
- the addition of Byannli (paliperidone) 6-monthly prolonged release injections as a red (hospital only) drug for maintenance in schizophrenia.

Summary of actions			
	Action	**Lead**	**Status**
21/23	Thyroid disorders: Update – redraft final guidance in line with the discussion and discuss with specialists.	Formulary Team	Ongoing
21/24	Thyroid disorders: Update – circulate the final draft via e-FIG for agreement.	Formulary Team	Ongoing
21/54	Methotrexate/folic acid dose scheduling clarification – Folic acid recommendations in the gastroenterology Shared Care prescribing guideline for west Devon to be reviewed following contact with gastroenterology specialists at UHP to discuss a more specific definitive statement. *Post meeting note: RD&E gastroenterologists have requested updates to the N&E methotrexate guidelines. A Devon-wide review is proposed and the folic acid prescribing notes in the west Devon gastroenterology guideline will be considered as part of this review.*	Formulary Team	Ongoing
21/72	Osteoporosis – liaise with specialists and bring final draft to a future FIG meeting. *Post-meeting note: The National Osteoporosis Guideline Group (NOGG) issued updated guidance for osteoporosis in April 2021. A draft update to the formulary guidance based on the new guidance from NOGG has been sent to specialists for review and will be scheduled for discussion at a future FIG meeting.*	Formulary Team	Complete

22/17	Sacubitril Valsartan: partial review – work with heart failure teams to develop draft prescribing guidance for sacubitril valsartan and submit to FIG for discussion. *Post meeting note: A UHP cardiologist and West Devon Community Heart Failure team manager submitted a proposed protocol for consideration by the FIG GPs. The GPs gave the proposal careful consideration and concluded that the protocol was not supportable and should not be progressed.* *The proposed protocol was considered to be broadly the same as the proposals previously considered by the FIG and included GP prescribing from start of treatment on the advice of a heart failure specialist.* *It was agreed that the specialist heart failure teams are best placed to optimise treatment (including dose titration, prescribing and monitoring) until the patient is on a stable dose, at which point it is appropriate to request continued prescribing and monitoring in primary care, with ongoing specialist support. It was felt that the changes already made to the formulary entry support this approach.* *The specific difficulties arising from the service configuration of the teams in Plymouth were recognised, particularly a lack of prescribing clinicians within the Livewell community heart failure team. Passing prescribing responsibility to GPs was not considered to be the appropriate solution to this particular issue.*	Formulary Team	Closed
22/25	NICE TA599: Sodium zirconium cyclosilicate for treating hyperkalaemia (update to TA599 and consideration of reclassification from red to amber) – Feedback to specialists on the discussion to understand the frequency of potassium monitoring required.	Formulary Team	Ongoing
22/26	NICE TA599: Sodium zirconium cyclosilicate for treating hyperkalaemia (update to TA599 and consideration of reclassification from red to amber) look at TA599 evaluations to determine if potassium threshold of 5.5mmol/L has been considered for patients with heart failure.	Formulary Team	Ongoing
22/27	NICE TA599: Sodium zirconium cyclosilicate for treating hyperkalaemia (update to TA599 and consideration of reclassification from red to amber) - update the proposed formulary entry and bring back to a future FIG meeting.	Formulary Team	Ongoing
22/31	Octasa (mesalazine) 1g suppositories - consider Scriptswitch message to remind clinicians to prescribe mesalazine enemas and suppositories by brand.	MO Team	Complete
22/38	Following further consultation with specialists. Progress the formulary entry for Amiodarone (Cordarone X): via the e-FIG process, or a short discussion at the next FIG meeting.	Formulary Team	Complete
22/39	Add accepted formulary entry for Tirbanibulin to the formulary. (Pending publication of the policy)	Formulary Team	Complete

22/40	Tirbanibulin for actinic keratosis – Update guidance for AK and entries for Actikerall and fluorouracil 5% cream in line with the discussion.	Formulary Team	Ongoing
22/41	Tirbanibulin for actinic keratosis - consult with specialists in SW Devon to see if a Devon wide harmonisation of the classification for imiquimod 5% cream (Aldara) is acceptable.	Formulary Team	Ongoing
22/42	Seek specialist advice from dermatologists regarding the interval between first and second treatment courses using 5-fluorouracil cream.	Formulary Team	Complete
22/44	Terms of Reference of the Devon FIG to be reviewed following the establishment of the ICB.	Formulary Team	Complete
22/48	NICE guidance NG196 – Atrial fibrillation: consult with specialists on the anticoagulation guidance.	Formulary Team	Ongoing
22/51	Ciclosporin eye drops (Verkazia for vernal Keratoconjunctivitis – discuss the impact of the amber classification on prescribing in primary care with the Head of Medicines Optimisation.	Formulary Team	Ongoing
22/52	Ciclosporin eye drops (Verkazia for vernal Keratoconjunctivitis – Update Devon formulary as agreed by the Devon FIG.	Formulary Team	Ongoing
22/57	Update the Devon Formulary entry for edoxaban for atrial fibrillation and the guidance for atrial fibrillation.	Formulary Team	Complete
22/58	Add the formulary entry for Softacort to the Devon Formulary in line with the discussion.	Formulary Team	Complete
22/59	Consideration of solifenacin succinate oral suspension 1mg/ml – put a Scriptswitch message in place to suggest a switch from solifenacin solution to solifenacin suspension	Medicines Optimisation	Complete
22/60	Update the Devon Formulary with the accepted formulary entry for Solifenacin succinate oral suspension 1mg/ml	Formulary Team	Complete
22/61	Formulary team to liaise with the Chair on writing to the Pathology Optimisation Group to ask the group to discuss the MHRA recommendations for vitamin B12 testing for patients receiving metformin	Formulary team	Ongoing
22/62	Update formulary with a link to MHRA Drug Safety Update and note regarding Pathology Optimisation Group after correspondence is sent to the group	Formulary team	Ongoing
22/63	MHRA Drug Safety Update: June 2022 – add a time-limited link from the formulary entry for Novorapid Pumpcart to the NPSA alert	Formulary Team	Ongoing
22/64	MHRA Drug Safety Update: July 2022 – update the formulary section on migraine, epilepsy and the topiramate entry.	Formulary Team	Ongoing
22/65	Asymptomatic bacteriuria screening in pregnancy – liaise with local specialists/Local Maternity Network and bring views and formulary guidance back to the FIG either via the e-FIG process or to a meeting.	Formulary Team	Ongoing
22/66	FIG Terms of Reference to be updated to reflect organisational and membership changes.	Formulary Team	Ongoing

22/67	Solriamfetol for the treatment of excessive daytime sleepiness – circulate the proposed formulary entry and amended guideline to specialists for comment.	SMS pharmacist	Ongoing
22/68	Solriamfetol for the treatment of excessive daytime sleepiness – bring SMS prescribing guideline back to the FIG via the appropriate route.	SMS pharmacist	Ongoing
22/69	Update the proposed formulary guidance for osteoporosis and undertake further consultation with specialists.	Formulary Team	Ongoing
22/70	Following further consultation with specialists bring formulary guidance for osteoporosis and drug entries back to the FIG via the appropriate route	Formulary Team	Ongoing
22/71	Update the proposed entry for potassium permanganate in line with the discussion and bring back to the FIG via e-FIG process	Formulary Team	Complete
22/72	Potassium permanganate – publish formulary entry before NPSA timeline (04 October 22)	Formulary Team	Complete
22/73	Potassium permanganate – communicate publication of new formulary entry for potassium permanganate to specialist teams and primary care	Formulary Team	Ongoing
22/74	Potassium permanganate – notify LPC (via MOCC LPC representative) of new formulary entry for potassium permanganate when published	Formulary Team	Ongoing
22/75	Schedule the formulary entry for potassium permanganate for review by the FIG at an appropriate time in the future	Formulary Team	Ongoing
22/76	Remove potassium permanganate from the South & West Devon guidance for infected eczema and review formulary guidance for infected eczema and bring to FIG for discussion following specialist consultation	Formulary Team	Ongoing
22/77	Liaise with Wound Management Group over alternatives to potassium permanganate for highlighting in the formulary	Formulary Team	Ongoing
22/78	Iron deficiency anaemia – Forward draft formulary entry to specialists for final comment.	Formulary Team	Ongoing
22/79	Iron deficiency anaemia – following consultation with specialists update the formulary entry with the accepted entry or bring back to a future FIG meeting for discussion or pursue through the e-FIG process.	Formulary Team	Ongoing