**NHS GRAMPIAN**
**Minute of Formulary Group Meeting**
**Tuesday 21 February 2023 at 14:30 via Microsoft Teams**

| PRESENT | APOLOGIES | APPROVED |
|---|---|---|
| Ms L Cameron | Miss R Anderson | |
| Dr V Chieng | Dr D Culligan | |
| Ms A Davie | Mrs G McKerron | |
| Ms F Doney (Vice-Chair) | Mr M Paterson | |
| Dr E Elias | | |
| Dr L Elliot (Chair) | | |
| Mrs S Howlett | | |
| Dr M Metcalfe (Vice-Chair) | | |
| Mrs K Neave | | |
| Dr J Newmark (from item 4.2) | | |
| Mr R Sivewright | | |

**IN ATTENDANCE**
Dr Gordon Urquhart, Consultant Medical Oncologist, for items 3.
Mrs Sarah Irvine, Senior Finance Manager (observer for item 3).
Ms Keira Watson, Oncology Pharmacist (observer for item 3).

Note some items were taken outwith agenda order.

| ITEM | SUBJECT | ACTION |
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| | WELCOME | |
| | The Chair welcomed observers and members, opened the meeting, and noted that a quorum was present. | |
| | The Chair welcomed Mrs Sarah Howlett to the Group as the Acute Pharmacy representative while Ms Galvin is off. | |
| **1.** | **APOLOGIES** | |
| | Apologies for absence were requested and noted. | |
| **2.** | **DRAFT MINUTE OF THE MEETING HELD 17 JANUARY 2023** | |
| | The Group accepted the draft note of the meeting subject to minor typographical changes. | |
| | The corrected final approved minute will be in the public domain within 21 days of final approval. | **FD** |
| **4.** | **MATTERS ARISING** | |
| | **4.1. ACTION LOG** | |
| | The action log was noted.<br>No additional items were identified for discussion at the meeting. | |
| **3.** | **PRESENTATION** | |
| | The Chair welcomed Dr Urquhart to the meeting to discuss stage matched therapeutic strategies for prostate cancer, including the formulary requests for abiraterone (off-label use), olaparib and apalutamide (items 8.1, 8.2 and 8.3). | |

| ITEM | SUBJECT | ACTION |
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Dr Urquhart confirmed that:

- there are not a lot of systemic therapies in prostate cancer, the four main drug groups used are:
  - traditional androgen deprivation therapy (ADT), with a luteinizing hormone-releasing hormone (LHRH) agonist or antagonist, remains a mainstay treatment for prostate cancer with indications in both the local and advanced settings.
  - newer hormonal agents - abiraterone, enzalutamide, apalutamide, darolutamide. They target androgen receptors with slightly different mechanism of action. There are no cross-trial evaluations of one drug against another, and they have been evaluated in both metastatic and early prostate cancer treatment settings.
  - traditional chemotherapy drugs have been the backbone of prostate cancer management for decades (docetaxel, cabazitaxel)
  - biomarker treatments, currently limited to olaparib which is available for patients with BRCA* mutations (somatic and germ line). Within prostate cancer, most of the BRCA mutations are somatic.
- many patients presenting with localised low- or intermediate-risk disease will be cured with local therapy (e.g., radiotherapy, brachytherapy, surgery), very few have a significant need for systemic therapies to reduce the risk of metastatic disease
- in patients presenting with localised high-risk disease the risk of metastatic disease increases. In a subgroup of these patients, evidence from STAMPEDE showed that off-label use of abiraterone (for 2 years) plus radiotherapy plus ADT (for 3 years) improved survival and delayed the time to metastatic disease.
- patients with metastatic disease will either present with do-novo disease or at relapse. Metastatic disease generally first presents as a hormone-sensitive disease progressing to a castrate-refractory/resistant disease.
- metastatic disease in the hormone-sensitive setting:
  - there are a number of existing treatments, combining ADT and one of the newer hormonal agents to improve overall survival. There are separate data of overall survival benefit for abiraterone, enzalutamide and apalutamide, but no head-to-head comparison data. The hazard ratios for improvement in overall survival are broadly similar.
  - enzalutamide and apalutamide are licensed for patients with any stage of metastatic prostate cancer. Abiraterone is licensed for a narrower group of patients based on the LATITUDE study - *newly diagnosed high-risk metastatic hormone-sensitive prostate cancer*.
  - the role of chemotherapy with ADT has now passed with the availability, better tolerability, and better results of the newer hormonal drugs
  - there is some benefit (improvements in overall survival) in patients who present with low metastatic volume disease having radiotherapy to their primary, but not in more advanced disease
  - there is a small group of patients who will just be treated with ADT alone
- for the majority of people metastatic prostate cancer will be a life-limiting illness, and will see progression to castrate-refractory disease
- metastatic disease in the castrate-refractory setting:
  - the majority of patients now progressing to castrate-refractory disease will have already had exposure to abiraterone, enzalutamide or apalutamide, and this is where chemotherapy is introduced, generally initially docetaxel followed by cabazitaxel
  - only a small number of patients have a BRCA mutation (~5%), so olaparib will only be a meaningful treatment for a small number of patients. Following progression of one of the newer hormonal agents there is an OS benefit for olaparib.

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* "BRCA" is an abbreviation for "BReast CAncer gene"

| ITEM | SUBJECT | ACTION |
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Responding to questions from members Dr Urquhart confirmed that:

- there are no head-to-head data comparing abiraterone, enzalutamide and apalutamide
- abiraterone is generally symptomatically well tolerated, the main time it is withdrawn relates to concerns about liver dysfunction
- cognitive change can be a limiting effect of enzalutamide
- apalutamide would be a useful addition where there is intolerance to the other agents
- there is no evidence for sequencing of the newer hormonal agents, patients would be treated once in the pathway and not re-challenged
- the role of immunotherapies in prostate cancer is limited, and although there are some medicines coming to market, the treatment pathway is likely to remain relatively stable

Dr Urquhart also provided members with some additional information for the formulary request for pembrolizumab for unresectable or metastatic triple-negative breast cancer, item 8.6.

He confirmed that:

- the national pathway for breast cancer is immanent and will be shared as soon as possible
- pembrolizumab or atezolizumab would be relevant immunotherapies for this indication. The licensing trials used different tests for a biomarker, PDL1, and these tests have significant limitations.
- the role of immunotherapies in metastatic breast cancer is likely to change to use, in combination with chemotherapy, as neo-adjuvant therapy for early breast cancer. Trials are seeing incrementally better benefit combining immunotherapy with chemotherapy in an early stage rather than in the metastatic setting, and the trials treated all patients regardless of biomarker status.
- relatively few patients present with de-novo metastatic disease
- the tests for immunotherapy are immunohistochemical, and do not add much over the diagnostic work done on biopsy [for this patient group]

The Chair thanked Dr Urquhart for attending the meeting and providing a clear informative presentation that confirmed the proposed therapeutic strategies for the management of prostate cancer.

Dr Urquhart, Mrs Irvine and Ms Watson left before decision-making.

Items 8.1, 8.2 and 8.3 were taken together.

**8.1. NCMAG 102 - ABIRATERONE (OFF-LABEL USE, HIGH-RISK HORMONE-SENSITIVE NON-METASTATIC PROSTATE CANCER)**

**8.2. SMC 2366 - OLAPARIB (METASTATIC CASTRATION-RESISTANT PROSTATE CANCER)**

**8.3. SMC 2472 - APALUTAMIDE (METASTATIC HORMONE-SENSITIVE PROSTATE CANCER)**

There were no declarations of interest recorded in relation to these products.

The Group accepted the restricted local need for the off-label use of abiraterone for the treatment of high-risk hormone-sensitive prostate cancer in line with NCMAG 102.

**NCMAG 102 - Abiraterone acetate 500mg film-coated tablets is routinely available in line with national guidance (NCMAG 102).**
**Indication under review: [off-label use] in combination with prednisolone and androgen deprivation therapy (ADT) for the treatment of high-risk hormone-sensitive non-metastatic prostate cancer.**
**Restriction: treatment is subject to a two-year clinical stopping rule.**
**It was classified 3b - licensed product requested for unlicensed use and 8b - recommended for hospital use only.**

ITEM SUBJECT ACTION

**Informed consent should be obtained and documented.**
**This medicinal product should be prescribed by an appropriate healthcare professional.**

The Group accepted the restricted local need for olaparib monotherapy for the treatment of adults with metastatic castration-resistant prostate cancer and BRCA1/2-mutations, as outlined in SMC 2366.

**SMC 2366 - Olaparib 100mg, 150mg film-coated tablets (Lynparza®) is routinely available in line with national guidance (SMC 2366).**
**Indication under review: as monotherapy for the treatment of adults with metastatic castration-resistant prostate cancer and BRCA1/2-mutations (germline and/or somatic) who have progressed following prior therapy that included a new hormonal agent.**
**In a phase III study in men with metastatic castration-resistant prostate cancer who had disease progression while receiving a new hormonal agent and had a BRCA1, BRCA2 or ATM mutation, olaparib was superior to treatment with a new hormonal agent measured by progression free survival.**
**This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/ list price that is equivalent or lower.**
**This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting.**
**It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only.**
**Treatment should be initiated and supervised by a physician experienced in the use of anticancer medicinal products.**
**BRCA1/2 mutation status should be determined by an experienced laboratory using a validated test method.**

The Group accepted the restricted local need for apalutamide, used in combination with ADT, as an alternative treatment option for men with metastatic hormone-sensitive prostate cancer, as outlined in SMC 2472.

**SMC 2472 - Apalutamide 60mg film-coated tablets (Erleada®) ▼ is routinely available in line with national guidance (SMC 2472).**
**Indication under review: in combination with androgen deprivation therapy (ADT) for the treatment of adults with metastatic hormone-sensitive prostate cancer (mHSPC).**
**Apalutamide plus ADT significantly improved radiographic progression-free survival (rPFS) and overall survival compared with placebo plus ADT in adults with mHSPC.**
**This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results upon which the decision was based, or a PAS/ list price that is equivalent or lower.**
**It was classified 1b - Available for restricted use under specialist supervision and 8b - recommended for hospital use only. Treatment with apalutamide should be initiated and supervised by specialist physicians experienced in the medical treatment of prostate cancer.**

**4. MATTERS ARISING (CONTINUED)**

**4.2. SMC 2493 - Somatrogon (responses from requestor)**

There were no declarations of interest recorded in relation to this product.

At the January meeting members were minded to accept somatrogon to formulary but

| ITEM | SUBJECT | ACTION |
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requested additional information to support decision-making and to clarify the formulary classification.

The Group noted the replies from the requestor:

- patients on growth hormone treatment attend the clinic for monitoring and measurements every 6 months. There are extra visits in the first 6 months after initiation of treatment.
- the endocrine consultants carry out all these in the routine clinic visit. Any dose changes are communicated to the patient in the clinic and confirmed in the clinic letter which is copied to the patient and the GP. Ad hoc changes might be communicated either by letter or via 'Clinical contact note' to the GP. Any device change is communicated to the practice by our endocrine nurse. She also provides all the required patient education. Systems are already in place for prescribing and monitoring Growth Hormone treatment for our patient population and the same arrangements would continue with the introduction of the long acting growth hormone.
- IGF-1 is readily available in general practice and goes to Biochemistry in the same tube as all general biochemistry requests. IGF-1 is already part of the routine monitoring of growth hormone treatment which is done when the patient comes to clinic. In the case of somatrogon there are timing issues with the testing which we would plan to fit around clinic visits. When tests cannot be done in clinic there is access to Day Case Unit testing in RACH, Elgin and several community paediatric hubs. There are rare occasions when the patient prefers to have bloods done at the GP practice in which case we would communicate with the practice and give clear instructions on tests to be done and timing. We would not expect the GP to act on the results. When we use this arrangement we ask the patient to mail us when the test is done so results can be chased by us and acted upon.
- patients/carers have access to specialist nurses via a team email address which is regularly monitored and actioned by our endocrine nurse or other team members. Patients regularly mail with any issues. All clinic letters are copied to families and include team and secretarial numbers and email addresses.
- the specialist nurse provides all device training. This can be done in the hospital or the patients home depending on individual circumstances. As this is a once-weekly injection only parents/carer needs to be trained with no need to involve anybody else in the community.

Members discussed the proposal to transfer prescribing to Primary Care. With the small patient numbers, there was a concern about how familiar General Practice would become with the drug.

Members accepted that existing preparations are being prescribed in Primary Care, and that we are coming into a changing culture. There is a general understanding that individuals are responsible for what they prescribe, and this becomes more difficult when the request is for highly specialist drugs that are rarely used

Members noted the clear suggestion from GP representatives that growth hormone is not something that should automatically be coming out to General Practice to prescribe.

The Group accepted the restricted local need for somatrogon. Due to the small patient numbers, the highly specialist nature of disease management, and concerns with dose changes/prescribing in Primary Care, members supported an initial classification of '8b - hospital only' pending discussion regarding the development of a prescribing arrangement, e.g., a shared care arrangement for growth hormones.

**SMC 2493 - Somatrogon 24mg, 60mg solution for injection in pre-filled pen (Ngenla®) ▼ is routinely available in line with national guidance (SMC 2493). Indication under review: for the treatment of children and adolescents from 3 years of age with growth disturbance due to insufficient secretion of growth hormone.**

| ITEM | SUBJECT | ACTION |
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| | **Somatrogon offers an additional treatment choice in the therapeutic class of recombinant human growth hormones for this indication.<br>It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only.** | **FTEAM** |

**5. FORMULARY GROUP DECISIONS JANUARY 2023 - PUBLISHED 01/02/2023**

Members ratified the decisions of the January 2023 meeting as published. **FTEAM**

**6. NETFORMULARY/FORMULARY REVIEW**

**6.1. SBAR – Review of traffic light classifications**

Ms Doney confirmed that the Formulary Team undertook a review of the current formulary decision-making codes and traffic lights used.

It was confirmed that:

- for the traffic lights used:
  - no changes are suggested for the icons and descriptions for 'RED', 'AMB 1', 'AMB 2', 'GREEN', 'GREEN+', 'GREY', 'BLUE' and 'NF'
  - a minor change is suggested for the 'not recommended/not routinely available' 'BLACK' traffic light, changing the icon to 'NR' bringing it in line with the other 'non-formulary/not routinely available' icon used. The description remains unchanged.
- for the classifications used:
  - a new decision classification of '8f' is suggested to support items that are also available on the NHS Pharmacy First Scotland Approved List. The description for the classification was suggested as 'May be initiated in either hospital or community, including Community Pharmacies for minor illnesses included in the NHS Pharmacy First Scotland Approved List'.'

The Group supported the suggested changes to the traffic lights and decision-making, classifications. **FTEAM**

**7. OTHER BUSINESS**

**7.1. EMA review of crizanlizumab**

Ms Doney reported that the European Medicines Agency (EMA) has started a review of crizanlizumab - prompted by preliminary results from an ongoing study (STAND) in patients with sickle cell disease which indicate that, after one year of treatment, crizanlizumab did not reduce the number of painful crises leading to a healthcare visit compared with placebo.
Crizanlizumab was recently included on the formulary (December 2022), and the EMA information was highlighted to the requestor. Further information will be brought to the Group when available. **FTEAM**

**7.2. NHS Pharmacy First Scotland – 2023 Review of Approved List**

Ms Doney reported that the review of the NHS Pharmacy First Scotland Approved List is expected in the next few months with the finalised list due for publication by October.

**8. NEW PRODUCT REQUESTS**

**8.4. SMC 2473 - Sativex® (moderate to severe spasticity due to multiple sclerosis)**

There were no declarations of interest recorded in relation to this product.

The Group considered the request for Sativex® for symptom improvement in adults with moderate to severe spasticity due to multiple sclerosis (MS).

| ITEM | SUBJECT | ACTION |
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The Group noted that:

- MS is a chronic condition that affects the central nervous system
- Sativex® Oromucosal Spray:
  - was licensed in 2010, previously it was not recommended for use in NHS Scotland, SMC 703/11. Additionally a local request for off-label use, for neuropathic pain in association with MS resistant to currently available standard treatments and atypical analgesics, was not supported by the Formulary Group (November 2011).
  - September 2022, it was accepted for use within NHS Scotland as licensed (SMC 2473) - *as treatment for symptom improvement in adult patients with moderate to severe spasticity due to multiple sclerosis (MS) who have not responded adequately to other anti-spasticity medication and who demonstrate clinically significant improvement in spasticity related symptoms during an initial trial of therapy*
  - is a Controlled Drug (Schedule 4 Part I), so has some CD prescription requirements but no CD storage or register requirements
  - requires refrigeration (2° to 8°C) prior to dispensing
  - is used in addition to the person's current anti-spasticity medicine(s)
- current oral treatment options for spasticity management include baclofen, tinazinidine, dantrolene and benzodiazepines
- evidence comes from trials against placebo, the primary outcome was the change from baseline to the end of randomised treatment in mean NRS spasticity score (patient-reported outcome ranging from 0 to 10, with 0 = no spasticity and 10 = worst possible spasticity)
- in two studies Sativex® was associated with a statistically significant reduction in spasticity NRS score over the randomised treatment periods versus placebo. In another the difference in mean change in spasticity NRS score over the randomised treatment period numerically favoured Sativex® but did not reach statistical significance compared with placebo.
- additional costs expected are the additional pressure on clinics for the initial assessment and 4-week reassessment process, and ongoing review of therapy
- costs will depend on the number of sprays used per day. The median dose in the studies was eight sprays, and the maximum number of sprays per day is 12.
- there will be initial pressure on specialist clinics to assess patients, initiate a trial of treatment in relevant patients, titrate and reassess patients
- both the Rehabilitation Medicine and Neurology departments will be assessing patients for eligibility for Sativex® and treatment will only be continued in those who show an adequate response
- the services support the transfer of prescribing to Primary Care, in line with the prescribing for other anti-spasticity medicines. Patients will be under the supervision of physicians with expertise in treating people with MS.
- patients will be reviewed at clinics, approximately annually, as part of their MS care
- this will be an additional cost as Sativex® is used in addition to the patient's current anti-spasticity medication

Members discussed:

- the potential for there to be a cohort of patients receiving Sativex® on private prescriptions. Members agreed that automatically transfer of prescribing from private to the NHS cannot be assumed, and a referral pathway will be needed for assessment [of these patients] by local specialists to ensure the use of Sativex® is in line with the local/national guidance.
- the importance of having clear dosing instructions to support the handover of prescribing, (including highlighting the maximum dose, and how long a spray is expected to last at a particular dose)

The Group accepted the restricted local need for Sativex® Oromucosal Spray as a treatment for symptom improvement in adults with moderate to severe spasticity due to

| ITEM | SUBJECT | ACTION |
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MS who have not responded adequately to other anti-spasticity medication and who demonstrate clinically significant improvement in spasticity related symptoms during an initial trial of therapy, as outlined in SMC 2473.
The initial trial and assessment of benefit will be managed by the specialist services.

**SMC 2473 - Sativex® Oromucosal Spray 2.7mg/2.5mg per 100microlitre spray (delta-9-tetrahydrocannabinol/cannabidiol) is routinely available in line with national guidance (SMC 2473).**
**Indication under review: as treatment for symptom improvement in adults with moderate to severe spasticity due to multiple sclerosis (MS) who have not responded adequately to other anti-spasticity medication and who demonstrate clinically significant improvement in spasticity related symptoms during an initial trial of therapy.**
**In four phase III/IV studies, Sativex® was associated with greater improvements in patient reported spasticity symptom numerical rating score (NRS) and response rate compared with placebo.**
**It was classified 1b - available for restricted use under specialist supervision and 8c - treatment to be initiated in hospital prior to handover. Sativex® is for oromucosal use only. Sativex® is intended to be used in addition to the patient's current anti-spasticity medication. Treatment must be initiated and supervised by a physician with specialist expertise in treating this patient population.** FTEAM

### 8.5. SMC 2479 - PEMBROLIZUMAB (RENAL CELL CARCINOMA)

There were no declarations of interest recorded in relation to this product.

The Group considered the request to include pembrolizumab on the formulary, as licensed, for the adjuvant treatment of adults with renal cell carcinoma (RCC).

The Group noted that:

- October 2022, following a full submission, pembrolizumab was accepted for use within NHS Scotland as licensed - as monotherapy for the adjuvant treatment of adults with renal cell carcinoma (RCC) at increased risk of recurrence following nephrectomy, or following nephrectomy and resection of metastatic lesions (SMC 2479)
- evidence comes from KEYNOTE-564; a multicentre, randomised, double-blind, phase III study
- KEYNOTE-564 (n = 994):
  - patients received intravenous (IV) pembrolizumab 200mg (n=496) or placebo (n=498) every three weeks for 17 cycles (approximately 1 year)
  - the primary outcome was investigator-assessed disease-free survival (DFS)
  - at the first interim analysis, pembrolizumab increased investigator-assessed DFS compared with placebo. Hazard ratio (95% CI) 0.68 (p=0.001) with 109 events and 151 events for pembrolizumab group and placebo group respectively.
  - no new or unexpected safety issues were identified
- results from an updated efficacy analysis are consistent with the first interim analysis. The median number of treatment cycles administered was 17 (interquartile range 9 – 17) in the pembrolizumab group and 17 (16 – 17) in the placebo group.
- patients should be treated [with pembrolizumab] until disease progression or unacceptable toxicity or a maximum of 1 year
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of pembrolizumab
- patient numbers are expected to be small, and this will be a new cost to the service
- a six-weekly treatment regimen is now licensed and the service wishes to have both three-weekly and six-weekly regimens available locally

The Group accepted the restricted local need for pembrolizumab, as adjuvant treatment for RCC, as outlined in SMC 2479.

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| | **SMC 2479 - Pembrolizumab 25mg/mL concentrate for solution for infusion (Keytruda®) is routinely available in line with national guidance (SMC 2479). Indication under review: as monotherapy for the adjuvant treatment of adults with renal cell carcinoma (RCC) at increased risk of recurrence following nephrectomy, or following nephrectomy and resection of metastatic lesions. In a phase III study, pembrolizumab significantly improved investigator-assessed disease-free survival (DFS) when compared with placebo. This advice applies only in the context of an approved NHS Scotland Patient Access Scheme (PAS) arrangement delivering the cost-effectiveness results. It was classified 1b - Available for restricted use under specialist supervision and 8b - recommended for hospital use only. Therapy must be initiated and supervised by specialist physicians experienced in the treatment of cancer.** | **FTEAM** |

### 8.6. SMC 2460 - PEMBROLIZUMAB (TRIPLE NEGATIVE BREAST CANCER)

There were no declarations of interest recorded in relation to this product.

The Group considered the request to include pembrolizumab, used in combination with chemotherapy, on the formulary for the treatment of locally recurrent unresectable or metastatic triple-negative breast cancer (mTNBC) in line with SMC 2460.

The Group noted that:

- October 2022, pembrolizumab, in combination with paclitaxel or nab-paclitaxel, was accepted for restricted use in NHS Scotland following a full submission assessed under the end of life and orphan equivalent medicine process, the output from the PACE process, and application of the appropriate SMC modifiers. Treatment was restricted to a two-year clinical stopping rule.
- evidence comes from KEYNOTE-355; an international, randomised, double-blind, phase III study
- KEYNOTE-355:
  - compared pembrolizumab plus chemotherapy with placebo plus chemotherapy in patients with previously untreated triple-negative breast cancer that could not be removed surgically or had spread
  - showed that for patients with high levels of PD-L1, those in the pembrolizumab group lived longer without their disease getting worse compared to those in the placebo group [9.7 months compared with 5.6 months]
  - showed that overall survival was longer in the pembrolizumab group [23 months compared with 16.1 months]
  - used a 3-weekly pembrolizumab regimen, and pembrolizumab could be given for a maximum of 35 cycles, however the median duration of treatment was 24.6 weeks
- the SMC advice takes account of the benefits of a PAS that improves the cost-effectiveness of pembrolizumab
- patient numbers are expected to be small
- a six-weekly pembrolizumab treatment regimen is now licensed
- cost offset is available from the displacement of atezolizumab (also used in combination with nab-paclitaxel, with treatment administered two-weekly) for people with triple-negative breast cancer and a PD-L1 ≥1%

The Group accepted the restricted local need for pembrolizumab, in combination with paclitaxel or nab-paclitaxel, for the treatment adults with locally recurrent unresectable or metastatic triple-negative breast cancer, as outlined in SMC 2460.

**SMC 2460 - Pembrolizumab 25mg/mL concentrate for solution for infusion (Keytruda®) is routinely available in line with national guidance (SMC 2460). Indication under review: in combination with paclitaxel or nab-paclitaxel, for the treatment of locally recurrent unresectable or metastatic triple-negative breast cancer in adults whose tumours express PD-L1 with a CPS ≥ 10 and who have not**

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**received prior chemotherapy for metastatic disease.**
**Restriction: treatment with pembrolizumab is subject to a two-year clinical stopping rule.**
**In one randomised, double-blind, phase III study, pembrolizumab plus chemotherapy significantly improved progression free survival and overall survival compared with chemotherapy alone.**
**This advice applies only in the context of approved NHS Scotland Patient Access Scheme (PAS) arrangements delivering the cost-effectiveness results upon which the decision was based, or PAS/ list prices that are equivalent or lower.**
**This advice takes account of the views from a Patient and Clinician Engagement (PACE) meeting.**
**It was classified 1b - Available for restricted use under specialist supervision and 8b - recommended for hospital use only. Therapy must be initiated and supervised by specialist physicians experienced in the treatment of cancer.** **FTEAM**

### 8.7. SMC 2453 - DELAFLOXACIN (ACUTE BACTERIAL SKIN AND SKIN STRUCTURE INFECTIONS)

There were no declarations of interest recorded in relation to this product.

The Group considered the request for delafloxacin for the treatment of acute bacterial skin and skin structure infections (ABSSSI) in adults.

The Group noted that:

- delafloxacin:
  - is a fluoroquinolone antibacterial that is available as two formulations, an oral tablet and an IV infusion
  - is licensed for the treatment of 1) ABSSSI, and 2) community-acquired pneumonia (CAP), when it is considered inappropriate to use other antibacterial agents that are commonly recommended for the initial treatment of these infections
  - only the ABSSSI indication is included in the SMC advice
  - [for ABSSSI] is administered every 12 hours for a total duration of 5 to 14 days
  - was shown to be as effective as alternative antibiotics in two main studies of adults with ABSSSI. The main measure of effectiveness was whether the infection was cured.
  - is not available for supply from Primary Care as it is a 'hospital-only' medicine
- treatment would only be recommended by Medical Microbiologists or Infectious Disease Specialists, and patients would have suspected or confirmed polymicrobial infection having failed or not be suitable for standard antibacterial therapies
- patient numbers are expected to be small
- IV to oral switch may be possible, which may be beneficial for patients and the Health Board

The Group accepted the restricted local need for delafloxacin, as an additional treatment option for adults with ABSSSI, as outlined in SMC 2453. Formulary acceptance is subject to inclusion in the 'NHS Grampian staff guidance for optimising use of alert (restricted) antimicrobials', with delafloxacin only available in the managed service after authorisation by a Medical Microbiologist or Infectious Disease Specialist.

**SMC 2453 - Delafloxacin 450mg tablets, 300mg powder for concentrate for solution for infusion (Quofenix®) ▼ is routinely available in line with national guidance (SMC 2453).**
**Indication under review: treatment of acute bacterial skin and skin structure infections (ABSSSI) in adults when it is considered inappropriate to use other antibacterial agents that are commonly recommended for the initial treatment of this infection.**
**Restriction: adults with suspected or confirmed polymicrobial infection following treatment failure or when standard antibacterial therapies are not suitable.**

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| | **Delafloxacin should be used on the advice of local microbiologists or specialists in infectious disease.**<br>**In two randomised, phase III, double-blind studies in patients with ABSSSI, delafloxacin was non-inferior to a glycopeptide antibacterial plus a monocyclic beta-lactam antibiotic for clinical cure at the follow-up visit in the intention to treat population.**<br>**It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Consideration should be given to official guidance on the appropriate use of antibacterial agents.** | **FTEAM** |

**9. SCOTTISH MEDICINES CONSORTIUM PROVISIONAL ADVICE ISSUED - FEBRUARY 2023**

The Group noted the SMC provisional advice issued February 2023.

**10. SCOTTISH MEDICINES CONSORTIUM ADVICE PUBLISHED - FEBRUARY 2023**

**10.1. SCOTTISH MEDICINES CONSORTIUM PRESS STATEMENTS PUBLISHED FEBRUARY 2023**

The Group noted the SMC advice published February 2023.

The following SMC accepted medicines have not been processed within a 60-day timescale:

- SMC 2547 - eptinezumab (Vyepti®)▼ (submission expected)
- SMC 2503 - nivolumab (Opdivo®) (clinicians not responded)
- SMC 2501 - pembrolizumab (Keytruda®) (clinicians not responded)
- SMC 2532 - upadacitinib (Rinvoq®)▼ (clinicians not responded)

Local advice for these medicines and indications will be included in the February 2023 decisions as 'Not routinely available as the ADTC is waiting for further advice from local clinical experts'. **FTEAM**

**10.2. UMAR SMC 2514 - BUROSUMAB (CRYSVITA®)**

There were no declarations of interest recorded in relation to this product.

Members noted the content of the summary document for the ultra-orphan medicines assessment report (UMAR) for burosumab (Crysvita®).

Ms Doney confirmed that:

- ultra-orphan medicines undergo an initial assessment of evidence by the SMC and are considered outwith remit for the Formulary Group
- burosumab is available for prescribing within the ultra-orphan pathway for the treatment of X-linked hypophosphataemia with radiographic evidence of bone disease in children 1 year of age and older and adolescents with growing skeletons (SMC 2240)
- the latest assessment, UMAR SMC 2514, extends use to include adults (≥18 years old) with a confirmed diagnosis of X-linked hypophosphataemia who have evidence of progressive disease due to chronic hypophosphataemia and are experiencing persistent and debilitating symptoms
- SMC 2514, was published 13 February 2023, but the SMC subsequently revised a comment on its website, and has confirmed that burosumab for this indication is not currently included in the ultra-orphan pathway. The Scottish Government Medicines Policy Branch will notify Health Boards when it is available for prescribing, and meantime any requests to access treatment should be considered through local non-formulary processes.

In line with local processes, the Group recorded burosumab (Crysvita®) for adults as 'not routinely available in NHS Grampian'.

| ITEM | SUBJECT | ACTION |
|---|---|---|
| | **UMAR SMC 2514 - Burosumab 10mg, 20mg, 30mg solution for injection (Crysvita®) ▼ is not routinely available in NHS Grampian. Indication under review: treatment of X-linked hypophosphataemia in adults. Not routinely available in NHS Grampian. If local need identified contact the Pharmacist Team Leader/Principal Pharmacist – Supply (ARI).** | FTEAM |

**11. GENERAL INFORMATION FROM SCOTTISH MEDICINES CONSORTIUM - FEBRUARY 2023**

None.

**12. DOCUMENTS FOR INFORMATION**

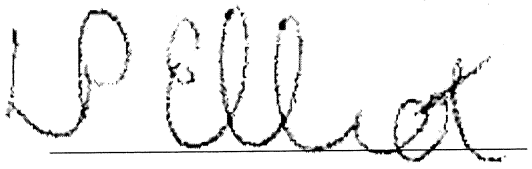
Items 12.1 (Drug Safety Update January 2023), 12.2 (AMT minute December 2022), 12.3 (MSG minute November 2022), 12.4 (NHSG Shared learning points fentanyl conversion January 2023) and 12.5 (Scottish Health Technologies Group (SHTG) quarterly bulletin January 2023) were noted.

**13. AOCB**

None.

**DATE OF NEXT MEETING**

Tuesday 21 March 2023 starting at 14.30 via Microsoft Teams

**CHAIR'S SIGNATURE**  **DATE 21 MARCH 2023**