NHS GRAMPIAN
Minute of Formulary Group Meeting held on Tuesday 17th March 2015
in the Aspen Room, Forest Grove House

PRESENT	**APOLOGIES**	**APPROVED**
Ms A Davie	Dr D Counter	
Ms F Doney	Dr D Culligan	
Mr A Duncan	Mrs L Harper	
Dr C Hind	Dr D Hood	
Dr A MacDonald		
Professor J McLay (Chairman)		
Mrs L Montgomery		
Dr W Moore		
Mr M Paterson		
Mr C Rore		
Mr R Sivewright		
Professor J Webster		

IN ATTENDANCE
Dr Robert Caslake, Consultant Geriatrician, for the talk on the pharmacological management of Parkinson's disease.
Ms Kate Robertson, Secretary Formulary Team.

OBSERVER
Mr Bruce Wilkie, Principal Pharmacist (Supply).

ITEM	**SUBJECT**	**ACTION**

1. APOLOGIES

The Chairman welcomed members to the meeting and apologies for absence were requested and noted. **FD**

The Chairman welcomed Mr Wilkie, Principal Pharmacist (Supply), to the meeting as an observer.

2. DRAFT MINUTE OF THE MEETING HELD ON THE 17TH FEBRUARY 2015

The Group accepted the draft note of the meeting held on the 17th February 2015 as an accurate record of the meeting subject to minor typographical changes. **FD**

PRESENTATION

Dr Caslake provided the Group with an overview of the treatment of Parkinson's disease.

3. MATTERS ARISING

3.1. NEW MEDICINES FUND ALLOCATION 2014/15

It was confirmed that for 2014/15 Boards will receive an allocation from the New Medicines Fund for medicines that have been accepted by the SMC under its new process for orphan, ultra-orphan and end of life medicines. Monies will be allocated to Boards based on an NHSScotland Resource Allocation Committee (NRAC) basis not actual spend.
NHS Grampian is awaiting further details from Scottish Government on the process for allocation of New Medicines Fund monies for 2015/16.

3.2. FORMULARY GROUP FINANCIAL RISKS 2014/15

It was reported that to date £925,000 of the 2014/15 Formulary Group budget has been allocated and drawn down to the relevant service budgets, with £625,000 allocated for hepatitis C medicines. £75,000 of the Formulary Group budget remains unallocated but several medicines remain under- or un-funded.

A document summarising the current 2014/15 formulary accepted medicines (excluding hepatitis C medicines) that remain under- or un-funded was tabled. [*Current list of active risks: epoetins TA323 (awaiting advice from oncology); everolimus (renal cell carcinoma, costs not realised for axitinib in 14/15 so introduction of everolimus may prove a stress as there is a lower than expected offset cost in the system and everolimus may be better*

ITEM **SUBJECT** **ACTION**

tolerated); aflibercept (diabetic macular oedema – proving difficult to cost potential prevalent peak); pomalidomide (multiple myeloma – new line of treatment). Plus medicines included on March agenda, biologics TA329 (use of biologics extended in patients with ulcerative colitis); ipilimumab (malignant melanoma, moves to first-line); dabrafenib (malignant melanoma will complete with vemurafenib but may be better tolerated).
Uplift requests for ipilimumab (first-line) and Mysodelle® were included in the Drug Budget Prediction Paper 2015/16.]

The Group noted the content of the tabled document and deferred allocation of the remaining Formulary Group budget until the end of the meeting.

3.3. CLARIFICATION OF COST ESTIMATE FOR RITUXIMAB SUBCUTANEOUS INJECTION

Mr Rore confirmed that the savings presented in the submission for rituximab subcutaneous (SC) injection were wrong, an over-estimate of savings. However the introduction is expected to be cost-saving because the SC injection includes a patient access scheme. Also the introduction of the SC preparation moves dosing from a body surface area (BSA) to flat-dosing basis, which means that for patients with higher BSA the flat-dose SC preparation will cost less than the required IV dose (opposite for lower BSA patients).

3.4. KENALOG INJECTION (CLARIFICATION OF INTRAOCULAR PRESSURE (IOP) MONITORING)

This item was deferred, advice awaited from the service. **FD**

3.5. STATUS OF MOORFIELDS PHARMACEUTICALS (AS A SOURCING AGENT)

Moorfields Pharmaceuticals central London production facility has closed. The closure of the manufacturing unit does not affect Moorfields ability to provide products sourced from elsewhere. In addition, products manufactured at different Moorfields facilities are not affected by the closure of the London production facility.
Moorfields Pharmaceuticals will continue with its range of licensed medicines (e.g. Ilube®) as well as the smaller range of outsourced ophthalmic specials, which are not available from other suppliers.

4. FORMULARY GROUP DECISIONS FEBRUARY 2015 – PUBLISHED 27/02/2015

The Group ratified the advice as published.

5. CMO(2012)1 REPORTING FOR SCOTTISH MEDICINES CONSORTIUM (SMC) ADVICE - 2014/15 YTD

It was confirmed that for the SMC accepted medicines published April 2014 to February 2015 the Formulary Group (FG) audit standard for CMO(2012)1 reporting was achieved for the following criteria:

- Local decision on SMC accepted medicine published within 90 days: 65 of 65 - 100%
- FG decision published within 14 days of the decision being reached: 65 of 65 - 100%

6. OTHER BUSINESS

6.1. NICE (M)TA329 INFLIXIMAB, ADALIMUMAB AND GOLIMUMAB FOR TREATING MODERATELY TO SEVERELY ACTIVE ULCERATIVE COLITIS AFTER THE FAILURE OF CONVENTIONAL THERAPY (INCLUDING A REVIEW OF TA140 AND TA262)

The Group considered NICE TA329 - Infliximab, adalimumab and golimumab for treating moderately to severely active ulcerative colitis after the failure of conventional therapy (including a review of TA140 and TA262). It noted the material difference between the NICE and SMC advice and that Healthcare Improvement Scotland advises that the recommendations are as valid for Scotland as for England and Wales.

The adult Gastroenterology service is reviewing the implications of the NICE appraisal guidance with a departmental meeting planned towards the end of March. Full submissions are anticipated and the service will be invited to speak at the meeting when the NICE appraisal guidance is discussed. **FTeam**

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6.2. DRAFT NHSSCOTLAND BIOSIMILAR MEDICINES PRESCRIBING FRAMEWORK

The Group considered the draft NHSScotland biosimilar medicines prescribing framework document. The aim of the framework is to inform clinical decision-making and support safe, effective and consistent use of biosimilar medicines. It was confirmed that the Grampian Medicines Management Group is currently reviewing the framework and a short-life working group will be convened to discuss the draft framework/implications for NHS Grampian.

The Group noted:

- a biosimilar medicine is not a generic medicine but is a biological medicine that is similar to another biological medicine that is already licensed for use (the original reference product)
- biosimilar medicines can be small molecules (human insulin or erythropoietin) or complex molecules (monoclonal antibodies)
- there are no safety or efficacy concerns identified for biosimilar medicines, the safety and efficacy has been established through the medicines' regulatory process
- the standard approach to licensing a generic medicine is not appropriate for a biosimilar medicine
- small changes to the manufacturing process of biological medicines (of the reference medicine or the biosimilar medicine) may modify the medicine and theoretically produce small changes in efficacy and safety
- the recommendation that biological and biosimilar medicines should be prescribed by brand name, with the brand name and batch number recorded at the time of administration
- the recommendation that current registries are expanded to include biosimilar medicines
- the potential development of a national Scotland-wide registry, although the requirements for a national registry remain to be determined

Members expressed concern that development of another registry if not adequately scoped and linked with existing resources could complicate the prescribing process, and make the required data entry more onerous.

As the efficacy and safety of biosimilar medicines is established through the medicines' regulatory processes the Group considered that biosimilar medicines should be available for prescribing within NHS Grampian without the need for individual formulary submissions if the original reference product is already on formulary. This position is subject to compliance with the relevant monitoring and governance requirements of a biosimilar medicines prescribing framework.
The Group supported the restricted use of biosimilar medicines as a treatment option within treatment pathways for appropriate patients as identified by treating clinicians and subject to compliance with a biosimilar medicines prescribing framework.

The outcome of the Formulary Group discussion will be shared with the Chairman of the Grampian Medicines Management Group. **JMcL/FD**

6.3. MENTAL HEALTH PHARMACY STRATEGY GROUP – SBAR - POSITION STATEMENT: MAXIMUM DOSE OF HALOPERIDOL FORMULATIONS

The Group reviewed the SBAR produced by the Mental Health Pharmacy Strategy Group (MHPSG) detailing the current lack of clarity of the maximum dose of the different haloperidol brands and formulations.

The Group noted:

- the position statement was developed to provide a unified approach across NHS Scotland and takes account of the views of the Mental Welfare Commission
- the situation will not be fully resolved until the European Union (EU) harmonisation process for haloperidol summary of product characteristics is completed
- the NHS Grampian Mental Health Service supports the recommendations of the MHPSG position statement

The Formulary Group endorsed the Mental Health Service's stance to adopt the MHPSG position statement until the EU harmonisation process is concluded. **FD**

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6.4. MINIMS® POVIDONE IODINE 5% W/V EYE DROPS

The Group noted the content of the briefing document from an English Commissioning Group regarding the use of Minims® Povidone iodine 5% eye drops for ocular antisepsis.

The Group noted:

- Minims® Povidone Iodine 5% w/v eye drops:
  - is indicated for cutaneous peri-ocular and conjunctival antisepsis prior to ocular surgery to support postoperative infection control
  - is an ophthalmic use only product, restricted to pre-operative ocular antisepsis only
- there are concerns about the use of non-sterile products because they are susceptible to contamination, and use of these products would not be considered best practice

It was confirmed that current practice uses large bottles of higher strength povidone iodine diluted to 5% w/v, and used for multiple patients. Local ophthalmic consultants support a change to the ophthalmic Minims® preparation for pre-operative ocular antisepsis. The exact cost of the change is not known but it is anticipated to be lower than the Formulary Group budget threshold.

The Group accepted the local need for a single-use product without the need for a full formulary submission.

Minims® Povidone Iodine 5% w/v eye drops solution is included on the Grampian Joint Formulary for the indication in question; restricted use.
Indication under review: for cutaneous peri-ocular and conjunctival antisepsis prior to ocular surgery to support post-operative infection control.
Restriction: the use of Minims® Povidone Iodine 5% w/v eye drops solution is restricted to pre-operative ocular antisepsis only. It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. **FTeam**

7. NEW PRODUCT REQUESTS

7.1. FG1 SMC 917/13 – NALMEFENE 18MG FILM-COATED TABLETS (SELINCRO®) ▼ - ALCOHOL DEPENDENCE

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

The Group considered the submission for nalmefene for the reduction of alcohol consumption in adult patients with alcohol dependence who have a high drinking risk level (DRL), without physical withdrawal symptoms and who do not require immediate detoxification.

The Group noted that:

- nalmefene:
  - is taken as-needed, on each day the patient perceives a risk of drinking alcohol; maximum dose one tablet per day
  - should only be prescribed in conjunction with continuous psychosocial support focused on treatment adherence and reducing alcohol consumption
  - should be initiated only in patients who continue to have a high DRL two weeks after initial assessment
- the use of nalmefene is a harm reduction strategy, and abstinence is not the goal of therapy
- the majority of patients will be identified in Primary Care, and nalmefene would not be appropriate for inclusion on a patients repeat prescription list
- it is not clear:
  - what constitutes the appropriate level of psychosocial support
  - if psychosocial intervention, such as extended brief intervention or motivational interviewing, would be appropriate and could be delivered by Primary Care

The Group queried if the assessment and ongoing monitoring required to support the prescribing of nalmefene are part of core General Medical Services. The Group requested that the specialist alcohol service liaise with the Primary Care Integrated Management

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Group (PCIMG) to clarify the requirements for the introduction of nalmefene in Primary Care, particularly the implications for General Practice in terms of time/resource to provide psychosocial support.

The Group accepted the local need for nalmefene noting the licensing requirement that nalmefene should only be prescribed in conjunction with continuous psychosocial support and should be initiated only in patients who continue to have a high DRL two weeks after initial assessment. Due to the uncertainties for implementation in Primary Care the Group restricted use to the specialist alcohol service with all follow-up provided by the specialist alcohol service.

SMC 917/13 - Nalmefene 18mg film-coated tablets (Selincro®) ▼ is included on the Grampian Joint Formulary for the indication in question; restricted use.
Indication under review: the reduction of alcohol consumption in adult patients with alcohol dependence who have a high drinking risk level (DRL), without physical withdrawal symptoms and who do not require immediate detoxification. Nalmefene should only be prescribed in conjunction with continuous psychosocial support focused on treatment adherence and reducing alcohol consumption. Nalmefene should be initiated only in patients who continue to have a high DRL two weeks after initial assessment.
Restriction: prescribing is limited to the specialist alcohol service with follow-up/continuous psychosocial support provided by the specialist alcohol service.
In a post hoc analysis of two pivotal phase III studies representing the licensed population, nalmefene was shown to significantly reduce alcohol intake compared with placebo, measured as a reduction in heavy drinking days and total alcohol consumption over a six month period. It was classified 1b – available for restricted use under specialist supervision and 8b – recommended for hospital use only restricted to the specialist alcohol service. **FTeam**

7.2. FG1 SMC 997/14 - IPILIMUMAB - ADVANCED MELANOMA AND

7.3. FG1 SMC 1023/15 - DABRAFENIB – ADVANCED MELANOMA

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

Items 7.2 and 7.3 were considered together. Before the submissions were reviewed Ms Doney provided the Group with an overview of the possible treatment pathways for patients with advanced melanoma, taking account of a patient's BRAF mutant status and tumour load.

The Group considered the submissions for ipilimumab and dabrafenib for the treatment of advanced (unresectable or metastatic) melanoma in adults.

FG1 SMC 997/14 IPILIMUMAB FIRST-LINE

The Group noted:

- the poor prognosis for advanced melanoma (12 to 18 months)
- Ipilimumab:
  - is given as an induction regimen consisting of four doses. Ipilimumab 3mg/kg is given by intravenous infusion over a 90-minute period every three weeks for a total of four doses. Patients should receive the entire induction regimen as tolerated, regardless of the appearance of new lesions or growth of existing lesions.
  - is an immunotherapy that stimulates the body's immune system to target and destroy the tumour
  - is already included on the formulary for the treatment of advanced melanoma in adults who have received prior therapy
  - meets SMC end of life criteria and orphan-equivalent criteria and was accepted for use within NHS Scotland in the context of SMC decision modifiers
- dacarbazine is the current first-line choice for BRAF wild-type melanoma. Patients are treated first-line with dacarbazine, generally with no survival advantage, in order to access ipilimumab second-line.
- vemurafenib is the current first-line agent for BRAF positive advanced melanoma

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- the current submission moves ipilimumab to first-line use for all patients regardless of BRAF mutant status
- that patients with BRAF mutated melanoma may also benefit from first-line ipilimumab - as a response may be seen in patients regardless of BRAF status

It was confirmed that:
- no patients are waiting for first-line ipilimumab treatment and there are some costs already in the system
- the 2015/16 budget paper included an uplift request for ipilimumab

The Group accepted the local need for ipilimumab for the treatment of adult patients with advanced (unresectable or metastatic) melanoma. The Group noted the additional costs related to ipilimumab moving to a first-line therapy option. The costs will be highlighted to finance within the context of the 2015/16 budget request and costs already included in the system.

SMC 997/14 - Ipilimumab 5mg/mL concentrate for solution for infusion (Yervoy®) ▼ is included on the Grampian Joint Formulary for the indication in question; restricted use.
Indication under review: treatment of advanced (unresectable or metastatic) melanoma in adults (first-line use).
In a phase III, randomised study median overall survival was extended by 2.1 months in patients treated with ipilimumab plus dacarbazine (an unlicensed dose regimen) compared with dacarbazine alone. Efficacy data for the licensed dose of ipilimumab are limited to two retrospective single-arm observational studies where median overall survival was 11.5 to 14.3 months.
This advice takes account of the benefits of a Patient Access Scheme (PAS) that improves the cost-effectiveness of ipilimumab and is contingent upon the continuing availability of the PAS in NHS Scotland or a 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 must be initiated and supervised by specialist physicians experienced in the treatment of cancer. **FTeam**

FG1 SMC 1023/15 DABRAFENIB – NO PRIOR THERAPY

The Group noted:
- the poor prognosis for advanced melanoma (12 to 18 months)
- dabrafenib:
  - is the second oral monotherapy (protein kinase inhibitor) licensed for the treatment of adult patients advanced melanoma with a BRAF V600 mutation. Vemurafenib is already included on the formulary, restricted to first-line treatment of BRAF V600 mutation-positive unresectable or metastatic melanoma.
  - will compete directly with vemurafenib as an alternative first-line treatment option for BRAF V600 mutation-positive patients
  - meets SMC end of life criteria
- the submitting company requested that SMC consider dabrafenib when positioned for use in patients with unresectable or metastatic BRAF V600 mutation-positive melanoma who have received no prior therapy
- both dabrafenib and vemurafenib are restricted to use as first-line agents

The Group noted that the protein kinase inhibitors, dabrafenib and vemurafenib, used as a second-line treatment option would be outwith the SMC restriction. The possibility of a Group Treatment Request was discussed but not supported at this time. If eligible patients are identified treatment requests should be progressed on an Individual Patient Treatment Request (IPTR) basis.

The Group accepted the local need for dabrafenib for the treatment of adult patients with advanced (unresectable or metastatic) melanoma as per SMC 1023/15.

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SMC 1023/15 - Dabrafenib 50mg and 75mg hard capsules (Tafinlar®) ▼ is included on the Grampian Joint Formulary for the indication in question; restricted use.
Indication under review: monotherapy treatment of adult patients with unresectable or metastatic melanoma with a BRAF V600 mutation.
Restriction: for use in patients with unresectable or metastatic BRAF V600 mutation-positive metastatic melanoma who have received no prior therapy.
In a phase III randomised open-label study, treatment with dabrafenib extended median progression free survival by 4.2 months compared with chemotherapy.
This advice takes account of the benefits of a Patient Access Scheme (PAS) that improves the cost-effectiveness of dabrafenib and is contingent upon the continuing availability of the PAS in NHS Scotland or a 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 with dabrafenib should be initiated and supervised by a qualified physician experienced in the use of anticancer medicinal products. Before taking dabrafenib, patients must have confirmation of tumour BRAF V600 mutation using a validated test. **FTeam**

7.4. FG1 SMC 1018/14 - PEGINTERFERON-BETA-1A (PLEGRIDY®) ▼ – RELAPSING REMITTING MULTIPLE SCLEROSIS

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

The Group considered the submission for a new pegylated form of interferon-beta licensed for relapsing remitting multiple sclerosis (RRMS).

The Group noted that:

- multiple sclerosis is a chronic progressive neurodegenerative disorder. Relapses are unpredictable in onset, severity, type of symptoms, and duration. Recovery is often incomplete, leading to accumulation of disability with each successive relapse.
- peginterferon-beta-1a (Plegridy®) ▼:
  - is the first pegylated form of interferon-beta licensed for RRMS
  - has a reduced dosing frequency, every 2 weeks, compared with current standard interferon-beta treatments, which are administered every other day to every week.
- there are no direct comparative data with other beta-interferons
- the reduced dosing frequency would be advantageous to some patients

The Group accepted the local need for peginterferon-beta-1a (Plegridy®) ▼ for the treatment of relapsing remitting multiple sclerosis in adult patients.

SMC 1018/14 - Peginterferon-beta-1a (63, 94 and 125microgram solution for injection in pre-filled syringe, Plegridy®) ▼ is included on the Grampian Joint Formulary for the indication in question; restricted use.
Indication under review: in adult patients for the treatment of relapsing remitting multiple sclerosis.
Peginterferon-beta-1a, compared with placebo, improved annualised relapse rate in adults with relapsing remitting multiple sclerosis. It was classified 1b – available for restricted use under specialist supervision and 8b – recommended for hospital use only. Treatment should be initiated under the supervision of a physician experienced in the treatment of multiple sclerosis. **FTeam**

8. SCOTTISH MEDICINES CONSORTIUM PROVISIONAL ADVICE – ISSUED MARCH 2015

The Group noted the SMC provisional advice issued March 2015. There were no negative SMC recommendations issued in March 2015.

Jaydess® ▼ was accepted to formulary in July 2014 with use restricted to the Specialist Service, as a second-line contraceptive option when Mirena® is not appropriate. The service has confirmed that the wider SMC recommendation (without restriction) will be requested locally. **FTeam**

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9. SCOTTISH MEDICINES CONSORTIUM PRESS STATEMENTS - PUBLISHED MARCH 2015

The Group noted the SMC advice published March 2015.

Following publication of the negative SMC recommendation for cabozantinib (Cometriq®) ▼ SMC 1022/15 it will not be included on the Grampian Joint Formulary for the indication in question. **FTeam**

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

- ruxolitinib (Jakavi®) ▼ SMC 867/13 (in process)
- idelalisib (Zydelig®) ▼ SMC 1026/15 (in process)
- apixaban (Eliquis®) ▼ SMC 1029/15
- fosfomycin (Fomicyt®) SMC 1033/15 (in process)

Local advice for these medicines and indications will be included in the March 2015 decisions as: "**not included on the Grampian Joint Formulary because clinicians have not responded to an invitation to apply for formulary inclusion for this medicine for the indication in question**." **FTeam**

INFLIXIMAB BIOSIMILAR MEDICINES - SMC 1006/14 (REMSIMA®) ▼ AND SMC 1007/14 (INFLECTRA®) ▼

Following the discussions for items 6.1 and 6.2 (TA329 and NHSScotland biosimilar medicines prescribing framework. The infliximab biosimilar medicines Remsima® ▼ SMC 1006/14 and Inflectra® ▼ SMC 1007/14 are included on the Grampian Joint Formulary for the indication in question; restricted use. Restriction: as a treatment option within treatment pathways for appropriate patients as identified by treating clinicians and subject to compliance with a biosimilar medicines prescribing framework. The SMC Advice is superseded by NICE TA329 - Infliximab, adalimumab and golimumab for treating moderately to severely active ulcerative colitis after the failure of conventional therapy (including a review of TA140 and TA262). **FTeam**

SMC 1030/15 HARVONI® ▼

The Group noted publication of SMC 1030/15 for ledipasvir/sofosbuvir (Harvoni®) ▼. The advice limits treatment to genotype 1 and 4 chronic hepatitis C (CHC), however the submitting company requested that SMC considers ledipasvir/sofosbuvir when positioned for use in patients with genotype 1 and 4 CHC only.

The Group considered that the benefits previously identified to support the use of Harvoni® ▼ remain valid. It noted that no data was provided to SMC for genotype 3 but was reminded that the service:

- supports the use of Harvoni® ▼, alone or in combination with ribavirin as licensed, on the basis that it will provide high sustained virological response (SVR) rates with additional benefits to patients, clinicians and the Board:
  - reduced treatment burden in terms of side effects, treatment duration, and pill burden
  - simplification of the CHC treatment regimens will reduce the risk of prescription errors
  - the low pill burden and simple treatment regimens will facilitate community dispensing which is more convenient for patients

The Group accepted the SMC advice as published and ratified its previous position regarding the treatment of genotype 3 CHC with appropriate prioritisation of treatment. The advice for genotype 3 CHC remains extant and will be reviewed on publication of a health technology appraisal that takes account of the evidence for genotype 3 CHC patients.

SMC 1030/15 - Harvoni® ▼ 90mg/400mg film-coated tablet (ledipasvir/sofosbuvir) is included on the Grampian Joint Formulary for the indication in question; restricted use.
Indication under review: treatment of chronic hepatitis C (CHC) in adults.

ITEM	SUBJECT	ACTION
	Restriction: genotype 1 and 4 CHC only. **In three, uncontrolled phase III studies conducted in treatment-naïve and treatment-experienced non-cirrhotic and cirrhotic patients with genotype 1 CHC, ledipasvir/sofosbuvir ± ribavirin achieved sustained virological response (at 12 weeks post treatment) rates of 93% to 99%, which were significantly superior to historical control rates.** **No clinical or economic data were presented for genotype 3 patients with cirrhosis and/or prior treatment failure. It was classified 1b - available for restricted use under specialist supervision and 8b - recommended for hospital use only. Harvoni® ▼ treatment should be initiated and monitored by a physician experienced in the management of patients with CHC.**	**FTeam**

10. GENERAL INFORMATION FROM SMC MARCH 2015

This item was noted.

11. DOCUMENTS FOR INFORMATION

Items 11.1 (Drug Safety Update February 2015), 11.2 (NHS Grampian generic pregabalin letter dated 3rd March 2015), 11.3 (Grampian Medicine Management Group minute 7th January 2015) and 11.4 (Area Drug and Therapeutics Committee Collaborative, and SMC report) were noted.

12. AOCB

HEALTH ECONOMICS LECTURE – HOLD THE DATE

The Chairman advised members that on the 29th April Dr Andrew Walker, Health Economist, University of Glasgow, will be in Aberdeen to give a student lecture. Extra places are anticipated and will be allocated on a first-come first-served basis. Details will be sent to members when available. **FD**

FORMULARY GROUP ACTION LOG

The 2015 action log was presented to members and from April the Formulary Group action log will be reviewed at each meeting. **FD**

FORMULARY GROUP BUDGET ALLOCATION

The Group considered the £75,000 remaining unallocated from the Formulary Group budget. As highlighted in the Formulary Group 2014/15 risk document several medicines are potentially under-funded. As service budgets are re-based at year end the monies will be allocated to everolimus (and axitinib) in renal cell carcinoma. **RS**

DATE OF NEXT MEETING

The date of the next meeting was confirmed as Tuesday 21st April 2015 starting at 14.30 in the Aspen Room Forest Grove House.

CHAIRMAN'S SIGNATURE **DATE 21st April 2015**