



## East Region Formulary Committee

### Minutes

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Date: 02 September 2026

Time: 2.00pm – 4:00pm

Location: MS Teams

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#### Present:

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|---------------------|---------------------------------------------------------------------|
| Farrah Al-Ghita     | Senior Pharmacist - Renal, NHS Fife                                 |
| Malcolm Clubb       | Director of Pharmacy (Co-Chair), NHS Borders – in the Chair         |
| Dr Grace Ding       | Consultant Oncologist, NHS Lothian                                  |
| Dr Joan Egerton     | GP, NHS Fife                                                        |
| Dr Tariq Farrah     | Consultant – Renal, NHS Lothian                                     |
| Carol Holmes        | Pharmacist – Primary Care, NHS Lothian                              |
| Dr Elliot Longworth | GP, NHS Borders                                                     |
| Lesley Macher       | Lead Pharmacist – Medicines Governance and Guidance, NHS Lothian    |
| Dr Iain Macintyre   | Consultant – Renal (Co-Chair), NHS Lothian                          |
| Joanne Miskelly     | Formulary Support Pharmacist, NHS Lothian                           |
| Fraser Notman       | Senior Pharmacist – Medicines Management, NHS Fife                  |
| Dr Jo Rose          | GP, NHS Lothian                                                     |
| Claire Stoddart     | Lead Formulary Pharmacy Technician, NHS Lothian                     |
| Mandy Wilson        | Advanced Cancer Care Pharmacist - Medicines Governance, NHS Lothian |

**In attendance:** Caitlin Satti, Information Officer, NHS Lothian (minutes)

#### Apologies:

Mona Boriceanu, Advanced Nurse Practitioner, NHS Fife  
Jane Browning, Associate Director of Pharmacy, NHS Lothian  
Dr David Griffith, Consultant – Microbiologist, NHS Fife  
Dr Alice Klauser, Consultant Haematologist and Head of Laboratory Haematology, NHS Lothian  
Noreen Mohammed, Senior Practice Pharmacist, NHS Fife  
Diane Murray, Formulary Pharmacist, NHS Lothian  
Dr Monica Szabo, Consultant Oncologist, NHS Lothian  
Sarah Tait, Lead Advanced Practitioner, NHS Borders

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## 1 Welcome and Apologies

The Chair welcomed those present to the East Region Formulary Committee (ERFC).

- ERFC noted that the meeting is being recorded

### 1.2 Matters arising

- 1.2.1** ERFC March 2026 Item 3.1.10 FAF3 DoxyPEP was reviewed at the ERFC March meeting. The ERFC received a verbal update regarding the learning from other UK centres regarding surveillance associated with Doxycycline post exposure prophylaxis, noting that antimicrobial teams across the region are aware of the issue and it is now on the Scottish Antimicrobial Prescribing Group agenda for discussion.

- 1.2.2** ERFC June 2026 Item 3.1.1 FAF1 Dupilumab: Dupixent (SMC2851) was reviewed at the ERFC June meeting. The ERFC requested a submission of the draft prescribing guidance to ensure the queries raised have been addressed. Additionally, the ERFC requests a revised application with corrected NHS Fife Clinical Director support to ensure awareness of budgetary implications.

It was noted that whilst some initial concerns have been addressed, several service delivery, governance, and clinical implementation issues remain unresolved. Further clarification is requested regarding patient selection criteria beyond the high-level SMC criteria, arrangements for treatment monitoring, and how clinical teams intend to assess treatment response. Additional information is also required regarding responsibility for ongoing patient care, including the criteria and processes for discontinuing treatment after 24 weeks where no clinical benefit has been demonstrated.

The ERFC acknowledged that the local treatment protocol provided is for NHS Lothian only and requested confirmation as to whether NHS Fife and NHS Borders intend to adopt the NHS Lothian protocol or develop their own local protocol. Corrected Clinical Director sign-off from NHS Fife is also still required.

Outstanding information is awaited regarding the potential use of Omalizumab, including pricing across all relevant strengths, as well as SMC advice on Tezepelumab. It was noted that approval of the remaining actions could potentially proceed before this information is received.

The ERFC requested the applicants are requested to respond with information on the recommended actions by 06 October 2026 (or a future paper deadline, see [East Region Formulary](#) for dates).

**ACTION: East Region Formulary Team**

- 1.2.3** ERFC June 2026 Item 3.1.9 FAF2 Gadopichlenol (Elucirem) was reviewed at the ERFC June meeting. The ERFC requested the submission of a revised application to include explicit renal inclusion/exclusion criteria (e.g. avoidance in severe renal impairment and acute kidney injury), confirm mandatory pre-scan renal function assessment, and clarify that Gadopichlenol will follow existing GBCA safety guidance.

As part of the resubmission, the committee also requested corrected costings, updated Clinical Director support to ensure awareness of budgetary implications, and revised formulary flagging. Action complete.

The ERFC agreed to classify FAF2 Gadopichlenol (Elucirem) as Routinely available in line with local or regional guidance. Included on the ERF for Specialist Use Only. The formulary website will be updated.

**ACTION: East Region Formulary Team**

## **2 Governance**

### **2.1 East Region Formulary Committee (ERFC) meeting minutes 24 June 2026**

The minutes of the previous meeting were approved as an accurate record with no changes to note.

### **2.2 East Region Working Group (ERWG) meeting minutes 29 July 2026**

The ERFC received a verbal update from the East Region Working Group meeting on July 29<sup>th</sup>.

It was noted that there are emerging concerns regarding the potential association between Depo-Provera, progesterone-containing medicines and meningioma risk; however, there remains uncertainty regarding any formulary implications until national guidance is available. The Scottish Government has advised that the MHRA is expected to issue guidance within the coming weeks. The ERWG agreed not to make any immediate changes to formulary status, prescribing pathways, or treatment priorities pending MHRA advice, with future action dependent on the nature of the MHRA communication. No actions were required from the East Region Formulary Committee at this stage.

A FAF3 application for Pneumococcal vaccine was discussed. It was noted that whilst vaccines do not usually fall within the remit of formulary review, the application relates to the diagnosis of antibody deficiency in specialist immunology services provided by NHS Lothian on behalf of the region and was linked to a shortage of a licensed alternative product. Further clarification has been sought from the applicants regarding whether formulary inclusion is required for this purpose, and the likelihood of future product changes or supply issues. As a result, the application will remain under review by the Working Group and will not proceed to the Formulary Committee at this stage.

Additionally, NHS Borders colleagues requested clarification on whether medicines mentioned within prescribing notes should be considered formulary approved. The ERWG agreed that medicines referenced in prescribing notes should currently be regarded as formulary-approved medicines, however, there was consensus that this practice should be phased out. The current situation was recognised as a legacy issue arising from the integration of the three regional formularies. Future ambition is for medicines to be clearly included either within formal formulary decisions or within approved clinical pathways. Future chapter reviews or amendment requests for urgent items should address this issue and ensure formulary status is clearly documented.

## **2.3 East Region Formulary (ERF) sections/amendments for review**

None.

## **3 New Medicines**

### **3.1 Formulary Application Forms (FAF)**

#### **3.1.1 FAF1 Budesonide: Budenofalk ([SMC2855](#))**

The ERFC noted and discussed the previously circulated FAF1 submission. No declarations of interest were received. Named CD support received from all three Boards.

Indication: Short-term treatment of mild to moderate acute ulcerative colitis limited to the rectum (ulcerative proctitis) in adult patients.

The ERFC reviewed the submission, noting the proposed inclusion of Budesonide suppository as second-line treatment option within the 'Mild to moderate exacerbation of ulcerative proctitis' pathway following Mesalazine, with Prednisolone moved to third line.

The ERFC agreed to classify FAF1 Budesonide suppository (SMC2855) as Routinely available in line with national guidance. Included on the ERF for Specialist Initiation. The formulary website will be updated.

**Post-meeting note:** The product Budenofalk is now discontinued and replaced with a debranded product. This will be reflected in the formulary decision and pathway, the link to original SMC advice for Budenofalk will remain.

**ACTION: NHS Lothian Admin Team**

#### **3.1.2 FAF1 Fezolinetant: Veoza ([SMC2898](#))**

The ERFC noted and discussed the previously circulated FAF1 submission. No declarations of interest were received. Named CD support received from all three Boards.

Indication: For the treatment of moderate to severe vasomotor symptoms (VMS) associated with menopause. **SMC restriction:** for use in patients for whom hormone replacement therapy (HRT) is not deemed suitable.

A 'Once for Scotland' clinical management guideline and local treatment protocol were included with the FAF.

The ERFC reviewed the proposed inclusion of Fezolinetant, noting that the evidence presented is largely based on comparisons with placebo, with no direct comparative studies against HRT or other non-hormonal alternatives such as SSRIs, SNRIs or gabapentin.

Significant concern was expressed that the application and associated draft Once for Scotland guidance appeared to broaden the eligible population beyond the SMC detailed advice statement in full. Whilst the SMC approval is restricted to patients for whom HRT is not suitable, the draft guidance was reported to include patients who decline HRT because of personal preference, perceived safety concerns or side effects, and the potential inclusion of perimenopausal women and those with less severe symptoms. People recruited to the DAYLIGHT and SKYLIGHT 1 and 2 studies had at least 7 moderate to severe daily vasomotor symptoms (VMS) events; however, in practice, people with fewer or more persistent VMS may also request treatment, and there is no evidence for fezolinetant in these populations. The studies did not include perimenopausal women, and, therefore, evidence is in those who are postmenopausal only. Formulary approval aligns to the group defined in the supporting clinical studies in the full SMC advice statement where cost-effectiveness is proven.

The committee discussed the relationship between the Once for Scotland guidance and local formulary governance, with members agreeing that decisions on approval and implementation of medicines remain the responsibility of individual NHS Boards.

The application proposed primary care prescribing with specialist initiation arrangements and transfer to GP prescribing following initial monitoring. Concerns were raised regarding whether specialist initiation was deliverable consistently across all Boards, as well as the additional pressure on GP services and menopause clinics. Following discussion, members agreed that specialist initiation remains appropriate, recognising that local interpretation of "specialist initiation" may vary between Boards and could include appropriately experienced GPs with a specialist interest in menopause.

The ERFC agreed to classify FAF1 Fezolinetant: Veoza (SMC2898) as Routinely available in line with national guidance. Included on the ERF for Specialist Initiation. The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.1.3 FAF1 Isatuximab: Sarclisa (SMC2804)**

The ERFC noted and discussed the previously circulated FAF1 submission. No declarations of interest were received. Named CD support received from all three Boards.

Indication: In combination with bortezomib, lenalidomide, and dexamethasone, for the treatment of adult patients with newly diagnosed multiple myeloma who are ineligible for autologous stem cell transplant.

The clinical management guideline and local treatment protocol were included with the FAF.

The ERFC reviewed the submission. It was noted that isatuximab, bortezomib, lenalidomide, and dexamethasone (IBLd) will partially replace daratumumab, lenalidomide and dexamethasone (DLd), but only for fitter patients but who are not transplant fit. DLd will remain an option for older, frailer patients who are not suitable for quadruplet therapy.

The ERFC discussed whether the projected patient numbers may underestimate actual activity, with members highlighting that several non-formulary requests have already been received and local clinical experience suggested uptake could exceed the projected estimates. It was recognised that the application's figures were based on historical treatment data and estimates of the proportion of patients expected to receive the regimen rather than real-world utilisation data.

The ERFC requested the revision of predicted patient numbers per annum utilising recent Chemocare prescribing data to provide a more accurate estimate of actual treatment numbers. The applicants are requested to respond with information on the recommended actions by 06 October 2026 (or a future paper deadline, see [East Region Formulary](#) for dates).

**ACTION: East Region Formulary Team**

The ERFC agreed to classify FAF1 Isatuximab: Sarclisa (SMC2804) as Routinely available in line with national guidance. Included on the ERF for Specialist Use Only. The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.1.4 FAF1 Talquetamab: Talvey ([SMC2863](#))**

The ERFC noted and discussed the previously circulated FAF1 submission. No declarations of interest were received. Named CD support received from all three Boards.

Indication: As monotherapy for the treatment of adult patients with relapsed and refractory multiple myeloma, who have received at least 3 prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 antibody and have demonstrated disease progression on the last therapy.

The clinical management guideline and local treatment protocol were included with the FAF.

The ERFC noted that Talquetamab offers an additional choice of Bispecific T-cell engager (BiTE) therapy with a different target (GPC5D), in the fourth-line treatment setting. Talquetamab will be used for patients previously exposed to B-cell maturation antigen (BCMA) directed treatment e.g. belantamab. Elranatamab (BCMA targeted) will remain the preferred choice for patients who have not received prior BCMA targeted therapy.

The ERFC agreed to classify FAF1 Talquetamab: Talvey (SMC2863) as Routinely available in line with national guidance. Included on the ERF for Specialist Use Only. The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.1.5 FAF1 Zanubrutinib: Brukinsa ([SMC2528](#))**

The ERFC noted and discussed the previously circulated FAF1 submission. One personal non-specific declaration of interest was received. Named CD support received from all three Boards.

Indication: As monotherapy for the treatment of adult patients with Waldenström's macroglobulinaemia (WM) who have received at least one prior therapy, or in first line treatment for patients unsuitable for chemo-immunotherapy.

The clinical management guideline and local treatment protocol were included with the FAF.

The ERFC reviewed the submission, noting the proposed use of zanubrutinib in patients with Waldenström's macroglobulinaemia who have received at least one prior therapy and are under the care of haematology outpatient services, or as first-line treatment in patients unsuitable for chemo-immunotherapy. Zanubrutinib provides an alternative oral BTK inhibitor to ibrutinib, with greater selectivity and a more favourable adverse effect profile, including lower rates of atrial fibrillation, hypertension and haemorrhagic complications. Ibrutinib should remain on formulary as an alternative; however, where a BTK inhibitor is indicated, zanubrutinib will be preferred.

Treatment will be delivered to an existing patient cohort who otherwise would have received ibrutinib. There are established consultant clinics where oral SACT is prescribed. Members noted that patients have been receiving zanubrutinib for this indication with approval from the Cancer Medicines Management Committee since the SMC approval, and, therefore, there will be no service implications with addition of zanubrutinib to formulary.

The ERFC agreed to classify FAF1 Zanubrutinib: Brukinsa (SMC2528) as Routinely available in line with national guidance. Included on the ERF for Specialist Use Only. The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.1.6 FAF1 Zanubrutinib: Brukinsa ([SMC2600](#))**

The ERFC noted and discussed the previously circulated FAF1 submission. One personal non-specific declaration of interest was received. Named CD support received from all three Boards.

Indication: As monotherapy for the treatment of adult patients with chronic lymphocytic leukaemia (CLL). **SMC restriction:** For adults with CLL in whom chemo-immunotherapy is unsuitable.

The clinical management guideline and local treatment protocol were included with the FAF.

The ERFC noted the proposed inclusion of zanubrutinib for patients with CLL who are unsuitable for chemo-immunotherapy and are under the care of outpatient haematology services. Zanubrutinib offers an alternative oral treatment option to ibrutinib, with a more favourable adverse effect profile.

The ERFC agreed to classify FAF1 Zanubrutinib: Brukinsa (SMC2600) as Routinely available in line with national guidance. Included on the ERF for Specialist Use Only. The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.1.7 FAF2 Dydrogesterone: Nalvee**

The ERFC noted and discussed the previously circulated FAF2 submission. No declarations of interest were received. Named CD support received from all three Boards.

Indication: For Hormone Replacement Therapy (HRT). Used to supplement oestrogen treatment in non-hysterectomised women with symptoms due to natural onset of or surgically induced menopause. In the context of HRT, it counteracts the oestrogen influence on the endometrium.

The committee reviewed the submission, with Dydrogesterone: Nalvee proposed for inclusion on the formulary as an additional progestogen option alongside levonorgestrel IUD, medroxyprogesterone acetate and micronised progesterone for use with systemic oestrogen. Inclusion would provide greater choice and allow HRT regimens to be tailored to individual patient tolerability, particularly for those unable to tolerate other progestogens who may otherwise discontinue treatment and be at increased risk of unscheduled bleeding and potential endometrial pathology.

The application included evidence suggesting dydrogesterone is an effective option for endometrial protection within HRT regimens, and members noted that whilst the evidence base is not extensive, its use is supported within recognised menopause guidance and specialist clinical practice. There was broad agreement that providing an additional progesterone option was clinically reasonable, with additional support for the inclusion of dydrogesterone provided by The British Menopause Society.

Members recognised that introducing another progesterone option has the potential to increase complexity within HRT prescribing. It was acknowledged that the current HRT sections of the formulary

and associated pathways may benefit from review and updating, with discussions highlighting the need to establish where dydrogesterone should sit within treatment pathways; the circumstances in which it should be considered over the other progesterone options; and how prescribers should navigate available choices. There was consensus that this work should form part of a wider review of HRT guidance and formulary content.

**ACTION: East Region Formulary Team**

The ERFC agreed to classify FAF2 Dydrogesterone: Nalvee as Routinely available in line with national guidance. The formulary website will be updated.

**ACTION: East Region Formulary Team**

**Post-meeting note:** It was noted that continuous therapy of dydrogesterone constitutes off-label use this approach is referenced within British Menopause Society guidance. This was noted and will be considered further as part of future chapter review work.

**ACTION: NHS Lothian Admin Team**

### **3.1.8 FAF3 Nivolumab + ipilimumab: Opdivo + Yervoy ([NCMAG121](#))**

The ERFC noted and discussed the previously circulated FAF3 submission. No declarations of interest were received. Named CD support received from all three Boards.

Indication: Nivolumab in combination with ipilimumab for the neoadjuvant treatment of resectable stage III melanoma.

The ERFC reviewed the submission, with key evidence supporting the proposed inclusion of Nivolumab + ipilimumab: Opdivo + Yervoy provided by the NADINA study which demonstrated that a major pathological response was reported in 59% of patients with 47% achieving a complete response and 12% a near complete response. Additionally, the American Society of Clinical Oncology (ASCO), the National Comprehensive Cancer Network (NCCN), the European Association of Dermato-Oncology (EADO), and the European Society for Medical Oncology (ESMO) support the use of neoadjuvant nivolumab plus ipilimumab for patients with resectable Stage III melanoma, with neoadjuvant therapy preferable to adjuvant therapy.

The ERFC agreed to classify FAF3 Nivolumab + ipilimumab: Opdivo + Yervoy (NCMAG121) as Routinely available in line with national. Included on the ERF for Specialist Use Only. Classified for use under policy for the use of unlicensed medicines. The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.1.9 FAF3 Nivolumab + ipilimumab: Opdivo + Yervoy ([NCMAG126](#))**

The ERFC noted and discussed the previously circulated FAF3 submission. No declarations of interest were received. Named CD support received from all three Boards.

Indication: Nivolumab in combination with ipilimumab for the neoadjuvant treatment of adults with mismatch repair deficient or microsatellite instability-high locally advanced colon cancer classified as T4 or borderline resectable.

The ERFC reviewed the submission, noting that patients who receive this neo-adjuvant treatment will no longer receive current standard of care adjuvant treatment (CAPOX or FOLFOX). The addition of nivolumab and ipilimumab will result in a decreased aseptic, dispensary, and clinical pharmacy

workload as treatment will reduce from six or four cycles to only one cycle. Overall, nivolumab and ipilimumab will have a positive impact on the wider service with a reduction in the number of blood tests, treatment days and cycles.

The ERFC agreed to classify FAF3 Nivolumab + ipilimumab: Opdivo + Yervoy (NCMAG126) as Routinely available in line with local or regional guidance. Included on the ERF for Specialist Use Only. Classified for use under policy for the use of unlicensed medicines. The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.1.10 FAF3 Spironolactone**

The ERFC noted and discussed the previously circulated FAF3 submission. One personal non-specific declaration of interest was received. Named CD support received from all three Boards.

Indication: Acne – adult female patients who have failed to respond to 2 courses of antibiotics, at least 3 months in duration.

The proposed inclusion of spironolactone is as a third-line treatment option in the 'Acne: Treatment of moderate to severe acne' pathway alongside co-cyprindiol, for female patients who have not responded adequately to topical treatments and extended courses of oral antibiotics. Spironolactone may be used alone or in combination with topical treatments. Local prescribing information will be developed/updated by board clinical teams pending formulary approval. Additional supporting information for Spironolactone is provided by the Primary Care Dermatology Society, British Association of Dermatologists, and the NHS GGC Clinical Guideline – 'Spironolactone for Persistent Acne in Women in Primary Care'.

Spironolactone provides a useful non-antimicrobial treatment option due to its anti-androgenic effects and established safety profile. Its use may also help reduce antibiotic prescribing in primary care, where acne contributes significantly to the high volume of antibiotics prescribed by dermatology.

The ERFC agreed to classify FAF3 Spironolactone as Routinely available in line with local or regional guidance. Included on the ERF for Specialist Initiation. Classified for use under policy for the use of unlicensed medicines. The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.1.11 FAF3 Blinatumomab (Blincyto)**

The ERFC noted and discussed the previously circulated FAF3 submission. No declarations of interest were received. Named CD support received from all three Boards.

Indication: First line with chemotherapy for children and young adults up to 18 years with B-cell acute lymphoblastic leukaemia.

The ERFC reviewed the submission, acknowledging the proposed inclusion as part of first-line consolidation therapy, replacing part of the standard chemotherapy regimen in patients who achieve remission after induction. It was noted that patients with high-risk disease may still receive partial consolidation chemotherapy before Blinatumomab to further reduce disease burden and minimise the risk of treatment-related adverse effects, including cytokine release syndrome.

The application is supported by national UK clinical guidelines and evidence from published studies demonstrating improvements in MRD negativity, disease-free survival, and overall survival and relapse rates, with an acceptable safety profile.

The committee queried whether the proposed use of blinatumomab should be restricted to Philadelphia chromosome-negative ALL, as this is specified across the licensed indications, including the paediatric indication following first relapse. The evidence and cited CCLG/CLCN guidance did not clearly confirm the Philadelphia status requirement.

The ERFC requested clarification from the applicants on whether the indication is intended to be restricted to Philadelphia chromosome-negative patients only, as this would narrow the eligible patient population. The applicants are requested to respond with information on the recommended actions by 06 October 2026 (or a future paper deadline, see [East Region Formulary](#) for dates).

**ACTION: East Region Formulary Team**

Pending clarification on the intended indication restrictions, the ERFC agreed to classify FAF3 Blinatumomab (Blincyto) as Routinely available in line with local or regional guidance. Included on the ERF for Specialist Use Only. Classified for use under policy for the use of unlicensed medicines. The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.1.12 FAF3 Cefazolin**

The ERFC noted and discussed the previously circulated FAF3 submission. No declarations of interest were received. Named CD support received from all three Boards.

Indication: Treatment of methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia (SABs).

The ERFC noted the proposed inclusion of IV Cefazolin as first-line treatment for patients with MSSA SAB. IV Flucloxacillin will be a second-line alternative in patients with normal renal function, or if Cefazolin is not available. All patients with MSSA bacteraemia should be discussed with an infection specialist (ID physician or microbiologist) as per the SAPG pathway, and treatment should be advised/initiated by the infection specialist and used within secondary care only.

In response to concerns raised upon review at East Region Working Group, the applicants provided reassurance that there are limited concerns about the increased risk of *C. difficile* infection with Cefazolin, considering its risk to be comparable to current therapy. Cefazolin is a first-generation cephalosporin classified under the WHO and national AWaRe (Access, Watch, Reserve) system as an Access category antibiotic, which is associated with a lower *C. difficile* infection risk than third- or fourth-generation cephalosporins. Evidence from the *Staphylococcus aureus* Network Adaptive Platform (SNAP) Trial also showed no statistically significant difference in *C. difficile* infection risk between Cefazolin and Flucloxacillin/Cloxacillin.

It was additionally noted that all *C. difficile* infection cases in NHS Lothian are subjected to routine surveillance and reviewed by the IPC team. If there are concerns related to antimicrobial use, these will be flagged to the clinical team. No other specialties have requested Cefazolin for additional indications. While Cefazolin may have potential wider applications, current supplier assurances relate only to the anticipated increase in use for *Staphylococcus aureus* bacteraemia. Any proposal to use Cefazolin for other indications would require a separate formulary application.

The ERFC agreed to classify FAF3 Cefazolin as Routinely available in line with local or regional guidance. Included on the ERF for Specialist Use Only. Classified for use under policy for the use of unlicensed medicines. The formulary website will be updated.

**ACTION: East Region Formulary Team**

### 3.1.13 FAF3 Methoxyflurane (Penthrox)

The ERFC noted and discussed the previously circulated FAF3 submission. No declarations of interest were received. Named CD support received from all three Boards.

Indication: Short-term inhaled analgesic for women undergoing outpatient hysteroscopy (diagnostic and operative) and selected ambulatory gynaecological procedures.

The ERFC reviewed the submission, recognising that there is an unmet need to improve pain management during outpatient hysteroscopy as current local anaesthetic techniques may not adequately control procedural pain or anxiety, leading to some procedures being abandoned. Methoxyflurane is proposed as an adjunct to, rather than a replacement for, local anaesthetic and as an alternative to nitrous oxide (Entonox) where infrastructure or governance concerns exist.

It was noted that there is a relatively limited evidence base. However, the evidence that was provided demonstrated a reduction in procedural pain compared with placebo, improved procedure completion rates, and high patient satisfaction, with no evidence of increased serious adverse effects.

Concerns were raised regarding cumulative exposure and patient tracking across services as there is no electronic safety system currently identified that would automatically alert clinicians if a patient had recently received Penthrox at another service. Existing risk mitigation measures include Patient Alert Cards and documentation in clinical records, as well as the consideration of wristbands. Members recognised that while these safeguards exist, they rely heavily on patient reporting and local processes. Further concerns centred around effective staff training and occupational exposure. However, it was acknowledged that many of these considerations sit outside formulary governance and involve individual Board Clinical Directorates and Health and Safety teams, and respective Medical Gas Committees.

The committee were supportive of the inclusion of Methoxyflurane (Penthrox) on the ERF for the proposed indication, with assurance from the applicants that appropriate local governance arrangements are being established in each Board to manage occupational exposure, ensure appropriate documentation and audit, and monitoring of cumulative patient exposure.

The ERFC agreed to classify FAF3 Methoxyflurane (Penthrox) as Routinely available in line with local or regional guidance. Included on the ERF for Specialist Use Only. Classified for use under policy for the use of unlicensed medicines. The formulary website will be updated.

**ACTION: East Region Formulary Team**

## 3.2 Formulary Amendment Form

### 3.2.1 Esomeprazole GR tablets

The ERFC noted and discussed the previously circulated Formulary Amendment form. No declarations of interest were received. Clinical team support received from all three Boards.

Indication:

- Adult: Dyspepsia: NSAID-associated ulcers
- Child: Dyspepsia
- Adult & Child: Gastro-oesophageal reflux disease (GORD): 'Treatment of Gastro-oesophageal reflux disease (GORD)'

Application for amendment to include 20mg and 40mg tablets on the ERF alongside the existing capsules, for adults and children. This allows for the selection of the most cost-effective formulation (20mg capsules are more cost-effective, while 40mg tablets are more cost-effective than capsules). In

regard to paediatrics, use is relatively limited due to availability of sachets; however, tablets are preferred over capsules where a solid formulation is required, as they can be cut or dispersed for part dosing.

The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.2.2 Dexmedetomidine**

The ERFC noted and discussed the previously circulated Formulary Amendment form. No declarations of interest were received. Clinical team support received from all three Boards.

Indication: Maintenance of sedation in ITU.

Application for amendment to switch to replace the currently listed vial formulation with ampoules following a change in the contracted product. There will be no change to the approved indications or place in therapy, with dexmedetomidine remaining first choice for maintenance of sedation in ITU.

The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.2.3 Aripiprazole**

The ERFC noted and discussed the Formulary Amendment form. No declarations of interest were received. Clinical team support received from all three Boards.

Indication: Schizophrenia.

Application for amendment to include the 720mg strength to the 'Oral treatment of schizophrenia' and 'Injectable treatment of schizophrenia' pathways where the 960mg strength is already included. The lower strength is required for patients unable to tolerate the higher dose, those taking interacting medicines, or where dose reduction is needed due to adverse effects. It is consistent with licensed dosing and supports individualised treatment. A minor amendment to chlorpromazine dosing has also been made to align with current BNF recommendations.

The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.2.4 Ferric Carboxymaltose-Feristark**

The ERFC noted and discussed the Formulary Amendment form. No declarations of interest were received. Clinical team support received from all three Boards.

Indication: Anaemia.

Application for amendment to switch from Ferrinject to Ferristark. Paediatric services are currently reviewing use of IV iron preparations and will report back on proposed formulary updates at a later date. It was noted that other iron preparation brands may continue to be prescribed where clinically appropriate.

The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.3 Ultra Orphan Medicines Initial Assessment**

None noted.

### **3.4 SMC not recommended advice**

The ERFC noted the SMC not recommended advice for information.

- 3.4.1** Avapritinib: Ayvakyt ([SMC2849](#))
- 3.4.2** Efgartigimod alfa: Vyvgart ([SMC2964](#))
- 3.4.3** Elinzanetant: Lynkuet ([SMC2965](#))
- 3.4.4** Lutetium (177Lu) vipivotide tetraxetan: Pluvicto ([SMC2966](#))

The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.5 Abbreviated submissions**

None noted.

### **3.6 Paediatric licence extensions**

- 3.6.1** None noted.

### **3.7 Non-submissions within 90 days of SMC publishing**

The ERFC noted the non-submissions within 90 days of SMC publishing.

- 3.7.1** Glofitamab: Columvi ([SMC2846](#))
- 3.7.2** Benralizumab: Fasenra ([SMC2870](#))
- 3.7.3** Durvalumab: Imfinzi ([SMC2880](#))
- 3.7.4** Tebentafusp: Kimmtrak ([SMC2910](#))
- 3.7.5** Upadacitinib: Rinvoq ([SMC2879](#))
- 3.7.6** D. pteronyssinus & D. farinae allergen extracts: Acarizax ([SMC2885](#))
- 3.7.7** Sodium zirconium cyclosilicate: Lokelma ([SMC2884](#))
- 3.7.8** Levodopa + carbidopa monohydrate + entacapone: Lecigon ([SMC2876](#))
- 3.7.9** Zilucoplan: Zilbrysq ([SMC2955](#))
- 3.7.10** Dostarlimab: Jemperli ([SMC2953](#))
- 3.7.11** Cabozantinib: Cabozantinib Ipsen ([SMC2967](#))

The ERFC agreed to classify item 3.7.1, 3.7.2, 3.7.3, 3.7.4, 3.7.5, 3.7.6, 3.7.7, 3.7.8, 3.7.9, 3.7.10, and 3.7.11 as Not Routinely available as local clinical experts do not wish to add the medicine to the formulary at this time or there is a local preference for alternative medicines. The formulary website will be updated.

**ACTION: East Region Formulary Team**

### **3.8 National Cancer Medicines Advisory Group**

- 3.8.1** None.

### **3.9 Scottish Medicines Consortium**

- 3.9.1** None.

## **4 Board specific information**

### **4.1 NHS Borders**

None raised.

**4.2 NHS Fife**

None raised.

**4.3 NHS Lothian**

None raised.

**5 Any other competent business**

None raised.

**6**

Date of next meeting

The next ERFC meeting is scheduled for Wednesday 28th October 2026 at 1400 - 1630 hours via MS Teams. NHS Borders will be hosting the meeting.

FAF3s should be submitted by 27 October 2026 (for discussion at the ERWG meeting on 11 November 2026).

FAF1s and FAF2s should be submitted by 06 October 2026.

All FAFs need to include information on proposed use and confirmation of Clinical Director (or equivalent medical manager) support from all three Boards (including names), to be added to the agenda. In the case where the service is only provided by one of the Boards, this should be clearly stated in the application. Confirmation of Clinical Director (or equivalent medical manager) support from all three boards is required where cross-Board charging applies.

Apologies for the meeting to be sent to [eos.prescribing@nhs.scot](mailto:eos.prescribing@nhs.scot).