

OPT-OUT SHARED CARE GUIDELINE

It is assumed that shared care **will** be accepted unless the specialist is informed otherwise within 28 days of receipt of the request at the end of this document.

MEDICATION NAME: MEDICATIONS FOR ADHD

INDICATION/S COVERED:

Attention Deficit Hyperactivity Disorder (ADHD) in Adults

Crawley CCG and Horsham and Mid-Sussex CCG Traffic Light System Classification: Amber

NOTES to the general practitioner (GP) or primary care prescriber

For medicines which require specialist initiation and/or dose titration and specific on-going monitoring. For initiation, dose stabilisation and prescribing (including monitoring) by a specialist until the patient is stabilised (usually for 3 months) after which the GP may be asked to work under shared care through the use of approved shared care guidelines.

The expectation is that these guidelines should provide sufficient information to enable GPs or primary care prescribers to be confident to take clinical and legal responsibility for prescribing these medicines.

The questions below will help you confirm this:

- Is the patient currently under your care (e.g. shared care should not be agreed if the patient is currently in intermediate care following hospital discharge)?
- Do you have the relevant knowledge, skills and access to equipment to allow you to monitor treatment as indicated in this shared care guideline?
- Have you been provided with relevant clinical details including monitoring data?

If you can answer YES to all these questions (after reading this shared care guideline), then it is appropriate for you to accept prescribing responsibility. It is assumed that shared care will be accepted unless the specialist is informed otherwise within 28 days of receipt of this request.

If the answer is NO to any of these questions, you should not accept prescribing responsibility. You should inform the consultant or specialist within 28 days, outlining your reasons for NOT prescribing. If you do not have the confidence to prescribe, we suggest you discuss this with your local Trust or specialist service, who will be willing to provide training and support. If you still lack the confidence to accept clinical responsibility, you still have the right to decline. Your CCG medicines management pharmacist will assist you in making decisions about shared care if you are unsure.

Prescribing unlicensed medicines or medicines outside the recommendations of their marketing authorisation alters (and probably increases) the prescriber's professional responsibility and potential liability. The prescriber should be able to justify and feel competent in using such medicines.

The GP or primary care prescriber has the right to refuse to agree to shared care, in such an event the total clinical responsibility will remain with the consultant or specialist.

Reason for update: N/A	Prepared by: Gus Fernandez	Updated by: N/A
Approved by (Specialist or Consultant): Dr Sanjay Jain, Consultant Psychiatrist		
Approved by (Chief Trust Pharmacist): Ray Lyon, Chief Pharmacist - Strategy		
Approved by (CCG Medicines Management Pharmacist): Fiona Brown, Pharmaceutical Advisor		
Approved by Crawley CCG, Horsham and Mid-Sussex CCG on: 29 th May 2018		

Information

This information sheet does not replace the Summary of Product Characteristics (SPC), which should be read in conjunction with this guidance. Prescribers should also refer to the appropriate paragraph in the current edition of the BNF.

1. Link to the relevant SPC website:

Methylphenidate:

Concerta XL® Tablets:

<https://www.medicines.org.uk/emc/product/6872>

Matoride XL® Tablets:

<http://www.medicines.org.uk/emc/medicine/29870>

Equasym XL® Capsules:

<http://www.medicines.org.uk/emc/medicine/15804>

Medikinet® Tablets:

<http://www.medicines.org.uk/emc/medicine/19664>

Medikinet XL® Capsules:

<https://www.medicines.org.uk/emc/product/313>

Ritalin® Tablets:

<http://www.medicines.org.uk/emc/medicine/1316>

Xaggitin XL

<https://www.medicines.org.uk/emc/product/2704>

Atomoxetine:

<http://www.medicines.org.uk/emc/medicine/14482>

Dexamfetamine:

Solution (only link available), but generic tablets prescribable:

<http://www.medicines.org.uk/emc/medicine/29014>

Lisdexamfetamine

<http://www.medicines.org.uk/emc/medicine/27442>

2. Background to use for the indication/s, including licence status

For adults over the age of 18 years of age, previously treated as a child and/or adolescent transferring from CAMHS, adults newly diagnosed with ADHD or adults previously treated as children and/or adolescents discontinuing treatment which to recommence treatment at a later stage in life.

Methylphenidate, dexamfetamine & lisdexamfetamine:

Methylphenidate, dexamfetamine and lisdexamfetamine are stimulant drugs used in the treatment of severe attention deficit hyperactivity disorder (ADHD) as part of a comprehensive treatment approach when remedial measures alone prove insufficient. Methylphenidate is not licensed for adults, only in children of 6 years old and over, though widely used first-line 'off label' in-line with NICE guidance. Dexamfetamine is not licensed for adult use but doses are quoted in the BNF, again 'off label'.

Lisdexamfetamine is licensed in adults when response to previous methylphenidate treatment is considered clinically inadequate; after the trial of at least two preparations of modified release methylphenidate, unless a previous adverse reaction to methylphenidate has ruled out further use.

Atomoxetine:

Atomoxetine is licensed for the treatment of attention deficit hyperactivity disorder (ADHD) in children aged 6 years and over and adults as part of a comprehensive treatment plan. (Comprehensive treatment programme – defined to include psychological, education & social measures).

3. Adult Dose & administration

Drug Name	Starting Dose	Frequency	Titration Information	Time of day	Maximum dose*
Methylphenidate (unlicensed in adults)					
Ritalin®	5mg	3 times a day	Increasing at weekly intervals, according to response over 4-6 weeks	Divided doses	100mg total daily dose
Matoride XL®, Xenidate XL®, Concerta XL®, Xaggitin XL®	18mg	Once daily	Increasing at weekly intervals, according to response over 4-6 weeks	Morning	108mg total daily dose
Equasym XL®	10mg	Once daily	Increasing at weekly intervals, according to	Morning (before breakfast)	100mg total daily dose

			response over 4-6 weeks		
Medikinet XL®	10mg	Once daily	Increasing at weekly intervals	Morning (with breakfast)	100mg total daily dose
Atomoxetine					
Strattera®	Body weight: - up to 70kg, 0.5mg per kg daily - more than 70kg, 40mg daily	Once daily	- Increasing after 7 days to approximately 1.2mg per kg daily - Increasing after 7 days to 100mg daily	Morning	Maintenance dose of 80mg-100mg total daily dose. Allowing 6 weeks at maintenance dose to evaluate effectiveness
Dexamfetamine (unlicensed in adults)					
	5mg	Twice daily	Increasing by 10mg at weekly intervals, according to response over 4-6 weeks	Divided dose between 2-4 times a day	60mg total daily dose
Lisdexamfetamine					
Lisdexamfetamine is a pro-drug formulation of dexamfetamine, which is converted to free dexamfetamine by enzymes present on red blood cells.					
Elvanse®	30mg	Once daily	Increasing by 20mg at weekly intervals, according to response over 4-6 weeks	Morning	70mg total daily dose, discontinuing if response insufficient after one month.

*NICE recommended maximum doses.

4. Cautions (Including for pregnancy and lactation where relevant)

Methylphenidate, dexamfetamine, lisdexamfetamine and atomoxetine:

- Underlying medical conditions which may be compromised by increases in blood pressure or heart rate.
- Sudden cardiac or unexplained death or malignant arrhythmia (family history)
- Cardiac disease (physical examination to assess) or suggestive symptoms of including palpitations, exertional chest pain, unexplained syncope, dyspnoea
- Unstable blood pressure, including abrupt heart rate or blood pressure changes
- Cardiovascular disorders that are pre-existing **unless specialist cardiac advice has been obtained.**
- Structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, or other serious cardiac problems
- Cerebrovascular conditions, including patients with additional risk factors (such as a history of cardiovascular disease, concomitant medications that elevate blood pressure)
- Psychiatric disorders of any degree, exacerbation of pre-existing and or the emergence of new symptoms
- Epilepsy / history of seizure
- Stimulant treatment abuse, misuse or diversion (not atomoxetine)
- Withdrawal (which may unmask depression as well as chronic over-activity)

Concerta XL, Matoride XL and Xaggitin XL

- Gastro intestinal narrowing, tablets are non-deformable and do not appreciably change in shape
- Dysphagia, tablets needing to be swallowed whole

Atomoxetine

- QT prolongation congenital, acquired or a family history of QT prolongation (only in)
- Anaphylactic or allergic reactions
- Suicide-related behaviour (suicide attempts and suicidal ideation) has been reported, but more frequently observed among children and adolescents treated compared to those treated with placebo, where there were no events.
- Hepatic dysfunction

5. Contraindications

This list is not exhaustive; refer to the Summary of Product Characteristics (SPC) or BNF for further guidance.

Methylphenidate, dexamfetamine & lisdexamfetamine and atomoxetine:

- Known sensitivity to methylphenidate, dexamfetamine, lisdexamfetamine, other amphetamine derivatives or any of the excipients
- Patients with porphyria, hyperexcitability, glaucoma or phaeochromocytoma
- During treatment with non-selective, irreversible monoamine oxidase inhibitors (MAOIs), or within a minimum of 14 days of discontinuing those drugs, due to risk of hypertensive crisis

Pre-existing severe cardiovascular or cerebrovascular disorders cerebral aneurysm, vascular abnormalities including vasculitis or stroke, advanced arteriosclerosis

Methylphenidate, dexamfetamine & lisdexamfetamine (not applicable to atomoxetine):

- Hyperthyroidism or Thyrotoxicosis
- Diagnosis or history of severe depression, anorexia nervosa/anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, psychopathic/borderline personality disorder.
- Diagnosis or history of severe and episodic (Type I) Bipolar (affective) Disorder (that is not well-controlled)
- Pre-existing cardiovascular disorders including severe hypertension, heart failure, arterial occlusive disease, angina, haemodynamically significant congenital heart disease, cardiomyopathies, myocardial infarction, potentially life-threatening arrhythmias and channelopathies (disorders caused by the dysfunction of ion channels),
- Patients with a history of drug abuse or alcohol abuse.
- Patients with Gilles de la Tourette syndrome or similar dystonias.
- Pregnancy and lactation.

Atomoxetine (not applicable to methylphenidate, dexamfetamine & lisdexamfetamine):

If the patient develops jaundice and/or other signs of liver injury, then atomoxetine should be immediately discontinued and not restarted.

6. Side effects

This list is not exhaustive; refer to the Summary of Product Characteristics (SPC) or BNF for further guidance and uncommon, rare and very rare side-effects.

Methylphenidate, dexamfetamine & lisdexamfetamine:

Very Common (frequency estimate >10%) side effects include:

- Insomnia, nervousness and headache

Common (frequency estimate 1% to 10%) side effects include:

- Abdominal pain, nausea, dry mouth, appetite suppression (usually transient), moderately reduced height and weight gain in long term use in children
- Drowsiness, dizziness, dyskinesia, psychomotor hyperactivity, somnolence
- Tachycardia, palpitations, arrhythmias, changes in BP and heart rate
- Rash, pruritis, urticaria, fever, alopecia, arthralgia and muscle tightness
- Anorexia, affect lability, aggression, agitation, anxiety, depression, irritability, abnormal behaviour, bruxism, tics, libido decreased, panic attack
- Cough, pharyngolaryngeal pain, nasopharyngitis, URTI, sinusitis

Atomoxetine:

Very Common (frequency estimate >10%) side effects include:

- Decreased appetite (usually transient), headache, somnolence, abdominal pain, nausea and vomiting (usually transient), increased blood pressure and heart rate.

Common (frequency estimate 1% to 10%) side effects include:

- Anorexia (loss of appetite), irritability, mood swings, insomnia, agitation, anxiety, depression and depressed mood, tics, dizziness, mydriasis, constipation, dyspepsia, dermatitis, pruritus, rash, fatigue, lethargy, chest pain, weight loss.

7. Notable drug interactions

This list is not exhaustive; refer to the Summary of Product Characteristics (SPC) or BNF for further guidance.

Methylphenidate, dexamfetamine, lisdexamfetamine and atomoxetine:

- MAOIs

Methylphenidate, dexamfetamine & lisdexamfetamine:

- Isoflurane
- Moclobemide
- Rasagiline

Dexamfetamine & lisdexamfetamine:

- Guanethide

Methylphenidate

- Adrenergic neurone blockers

- Anaesthetics general (volatile liquid)
- Clonidine
- Coumarins

Atomoxetine:

- Amiodarone
- Antidepressants tricyclics
- Antipsychotics

- CYP2D6 inhibitors, e.g. SSRIs
- Disopyramide
- Diuretics
- Erythromycin

- Mefloquine

- Methadone
- Moxifloxacin

- Sotalol

8. Criteria for use (to be read in conjunction with *Clinical guidelines for the treatment of ADHD in adult*)

Drug treatment is the first-line treatment for adults with ADHD with either moderate or severe levels of impairment. Psychological interventions without medication may be effective for some adults with moderate impairment, but there are insufficient data to support this recommendation. Methylphenidate is the first-line drug. If methylphenidate is ineffective or unacceptable, lisdexamfetamine, atomoxetine or dexamfetamine can be tried. If there is residual impairment despite some benefit from drug treatment, or there is no response to drug treatment, CBT may be considered.

Lisdexamfetamine, atomoxetine or dexamfetamine should be considered in adults unresponsive or intolerant to an adequate trial of methylphenidate (this should usually be about 6 weeks). Caution should be exercised when prescribing dexamfetamine to those likely to be at risk of stimulant misuse or diversion. Atomoxetine is considered first-line treatment in patients with substance use disorders.

Methylphenidate, dexamfetamine and lisdexamfetamine are stimulant drugs used in the treatment of severe attention deficit hyperactivity disorder (ADHD) as part of a comprehensive treatment approach when remedial measures alone prove insufficient. Methylphenidate is not licensed for adults, only in children of 6 years old and over, though widely used first-line. Dexamfetamine is not licensed for adult use but does are quoted in the BNF.

Lisdexamfetamine is licensed in adults when response to previous methylphenidate treatment is considered clinically inadequate. Lisdexamfetamine therapy is indicated by Sussex Partnership Trust after the trial of at least two preparations of modified release methylphenidate, unless a previous adverse reaction to methylphenidate has ruled out further use.

Atomoxetine is licensed for the treatment of attention deficit hyperactivity disorder (ADHD) in children aged 6 years and over and adults as part of a comprehensive treatment plan.
(Comprehensive treatment programme – defined to include psychological, education & social measures).

9. Any further information (e.g. supporting therapies)

Methylphenidate, Dexamfetamine & Lisdexamfetamine:

Methylphenidate, dexamfetamine and lisdexamfetamine are controlled drugs that need monitoring for potential abuse or diversion. Prescriptions should usually be restricted to 28 or 30 days, depending on pack size.

If improvement of symptoms is not observed after the appropriate dosage adjustment over one month, it should be discontinued.

Following updated MHRA guidance on the use of methylphenidate in ADHD, issued in March 2009, treatment with stimulant medication should be interrupted at least once a year to determine whether continuation is needed (e.g. by stopping the drug for up to two weeks each year).

Due to the short half-life of stimulants and their immediate effect, they are sometimes used only on days when the patient needs them, e.g. when studying.

Lisdexamfetamine at oral doses up to 100mg has been shown in one abuse liability study to have less 'drug liking effects' than immediate release dexamfetamine 40mg. However oral doses of 150mg and above had comparable 'drug liking effects' to immediate release dexamfetamine 40mg. Another study on IV administration witnessed doses of up to 50mg producing drug liking effects greater than placebo, but less than IV administration of immediate release dexamfetamine 20mg.

Prescriptions should be written in accordance with the Misuse of Drugs Act.

Modified-release preparations of methylphenidate pose less risk of abuse and improve adherence. It is worth noting that the various brands of modified-release methylphenidate available differ in proportions of immediate release and delayed release, and are not bioequivalent

Atomoxetine:

ADHD symptoms can show an improvement by the first week of commencing atomoxetine and the maximum therapeutic effect can be seen from four weeks.

In response to adverse effects, atomoxetine can be discontinued without titrating down the dose otherwise it should be tapered off over a suitable time period.

Following updated MHRA guidance on the use of atomoxetine in ADHD, issued in January 2012, patients taking atomoxetine for extended periods (i.e. >1 year) should have their treatment reviewed at least once a year by a specialist to determine whether continuation is needed.

If a treatment break is deemed appropriate, consideration should be given to the length of any break. It may take up to five days for atomoxetine to be eliminated. Following any treatment break it may take four weeks before the full benefit from atomoxetine is again observed.

Pregnancy and breastfeeding

With regards to pregnancy, both continuing and stopping drug treatment carries risk. While discontinuation of drugs removes the risk of medication harming the child, there may be an increase in harmful behaviours related to the mother's mental state. These may include poor risk management, such as dangerous driving or the use of illicit drugs, alcohol or tobacco during the pregnancy; increased stress levels; and self-injurious behaviour.

The latest information about the teratogenic potential of psychotropic drugs can be obtained in the UK by contacting the National Teratology Information Service

Little is known of the effects of ADHD medications reaching the child through breastfeeding; however, drugs that are licensed for use in children are in general less risky than those that have not been used in this population. A recent systematic review supports the idea that very little methylphenidate reaches the infant during breastfeeding (Bolea-Alamanac et al., 2013)

INFORMATION TO PATIENTS

A pharmaceutical company patient information leaflet (PIL) will be provided with each supply.

INFORMATION TO BE RECEIVED BY THE GP FROM THE SPECIALIST TEAM

The Specialist Team's review letter will be sent after initial assessment and following each further appointment. It is assumed that the GP agrees to the shared care arrangements

INFORMATION TO BE RECEIVED BY THE CONSULTANT FROM THE GP

The NICE Guidance^j suggests shared care between the specialist clinic and GP. In the rare event that the GP is unwilling to assume prescribing responsibility for the patient the specialist should be informed promptly on receipt of the specialist's letter. In such cases the GP must inform the specialist of all relevant medical information regarding the patient and any changes to the patient's medication regime irrespective of indication.

THE GP SHOULD INFORM THE SPECIALIST OF ANY ADVERSE EFFECTS EXPERIENCED BY THE PATIENT.

Information websites

- Choice and medication website: <http://www.choiceandmedication.org/sussex>

10. References

- a. Strattera 10mg, 18mg, 25mg, 40mg, 60mg or 80mg hard capsules [atomoxetine – Eli Lilly]. *Electronic Medicines Compendium*. (8th June 2015). Available from: <http://www.emc.medicines.org.uk> (accessed 27th April 2018).
- b. Ritalin [methylphenidate – Novartis Pharmaceuticals]. *Electronic Medicines Compendium*. (26th April 2018). Available from: <http://www.emc.medicines.org.uk> (accessed 27th April 2018)
- c. Equasym XL 10mg, 20mg or 30mg Capsules [methylphenidate – Shire Pharmaceuticals]. *Electronic Medicines Compendium*. (27th March 2018). Available from: <http://www.emc.medicines.org.uk> (accessed 27th April 2018).
- d. Medikinet Tablets [methylphenidate – Flynn Pharma]. *Electronic Medicines Compendium*. (20th March 2017). Available from: <http://www.emc.medicines.org.uk> (accessed 27th April 2017).
- e. Medikinet XL [methylphenidate – Flynn Pharma]. *Electronic Medicines Compendium*. (9th February 2018). Available from: <http://www.emc.medicines.org.uk> (accessed 6th May 2015).
- f. Concerta XL 18-36mg Prolonged-Release Tablets [methylphenidate – Janssen-Cilag]. *Electronic Medicines Compendium*. (24th March 2015). Available from: <http://www.emc.medicines.org.uk> (accessed 6th May 2015).
- g. Matoride XL[methylphenidate – Sandoz Ltd]. *Electronic Medicines Compendium*. (28 June 2017). Available from: <http://www.emc.medicines.org.uk> (accessed 27th April 2017).
- h. Xaggitin XL [methylphenidate – Ethypharm UL Ltd]. *Electronic Medicines Compendium*. (17 May 2017). Available from: <http://www.emc.medicines.org.uk> (accessed 27th April 2017).
- i. Dexedrine 5mg tablets [dexamfetamine – UCB Pharma]. *Electronic Medicines Compendium*. (24 September 2008)(not available in Apr 2018).
- j. Dexamfetamine Sulfate 1mg/ml Oral Solution – [Martindale Pharma]. *Electronic Medicines Compendium* (14th November 2014). Available from: <http://www.emc.medicines.org.uk>. (accessed 27th April 2018)
- k. Elvanse 30mg, 50mg or 70mg hard capsules [lisdexamfetamine – Shire]. *Electronic Medicines Compendium* (21st April 2015). Available from <http://www.emc.medicines.org.uk> (3rd April 2018)
- l. NICE Guidelines: Attention Deficit Hyperactivity Disorder: Diagnosis and Management (NG87). March 2018. Available from: <https://www.nice.org.uk/guidance/NG87> (accessed 27th April 2018).
- m. British National Formulary. Online Edition. London: BMJ Publishing Group Ltd and RPS Publishing; September 2017. Available from <https://www.medicinescomplete.com/mc/bnf/current/> (accessed 27th April 2018)

RESPONSIBILITIES and ROLES

Consultant or specialist responsibilities

- 1 Confirm diagnosis and indication for treatment with ADHD medication.
- 2 To discuss fully the aims, benefits, risks and side effects of treatment and a treatment plan with the patient and/or carer and for written information to be supplied to the patient and/or carer.
- 3 Inform GP when initiating treatment so the GP is aware what is being prescribed and can add to GP clinical record.
- 4 Undertake baseline monitoring as required (specific to the medication).
- 5 Record other medications and address potential medicine interactions before starting therapy.
- 6 To discuss the potential implications of pregnancy and breastfeeding in women of child bearing potential and agree a risk minimisation strategy where appropriate.
- 7 To initiate treatment by prescribing and monitoring usually for a minimum of 3 months.
- 8 Undertake monitoring if dose changed.
- 9 Monitor and prescribe according to guidelines until handover is appropriate (including when dose changes are made).
- 10 Discuss the possibility of shared care with the patient and/or carer and ensure that they understand the plan for their subsequent treatment.
- 11 Supply GP with a summary of the patient's review (including anticipated length of treatment) and a link to, or a copy of, the shared care guideline when requesting transfer of prescribing to GP or primary care prescribers.
- 12 Advise GP if treatment dose changes or treatment is discontinued.
- 13 Inform GP if patient does not attend planned follow-up.

GP or primary care prescriber responsibilities

- 1 Continue prescribing of the ADHD medication at the dose recommended and undertake monitoring requirements..
- 2 Monitor for adverse effects throughout treatment and check for medicine interactions on initiating new treatments.
- 3 Add information about the medicine to the patient record, initially as "hospital prescribed", and highlight the importance that this medicine is only to be prescribed under a shared care guideline in primary care.
- 4 Inform the consultant or specialist of any issues that may arise.
- 5 Prescriptions for stimulants should be restricted to a 30 day supply and are only valid for 28 days from the date of signature, as stimulant medications are controlled drugs subject to safe custody and specific regulations for prescribing.
- 6 Refer patient back to the Consultant/Specialist if any concerns.
- 7 Ensure that if care of the patient is transferred to another prescriber, that the new prescriber is made aware of the shared care guideline (e.g. ensuring the patient record is correct in the event of a patient moving surgery).

Monitoring requirements (if relevant to specific medication)

1. Weight and appetite, recorded at baseline, following dosage adjustments and 6 monthly – Specialist
2. Blood pressure and pulse, recorded at baseline, following dosage adjustments and at 6 monthly - Specialist
3. Blood and platelet counts at discretion of supervising clinician(s) (e.g. if recurrent nose bleeds, bruising or infections occur). Baseline, then when clinically indicated. – Specialist at baseline, but if clinically indicated later, by the GP or specialist as appropriate.
4. Liver function tests if prescribing atomoxetine if clinically indicated - Specialist
5. To refer patients who develop symptoms such as palpitations, exertional chest pain, unexplained syncope, dyspnoea, or other symptoms suggestive of heart disease for prompt specialist cardiac evaluation - Specialist at baseline, but if clinically indicated later, by the GP or specialist as appropriate.
6. The development of new or worsening of pre-existing, psychiatric symptoms (also following dose adjustments and at every visit) - Specialist
7. Neurological signs and symptoms after initiating treatment, in particular the possibility of cerebral vasculitis should be assessed at every visit - Specialist

Patient and/or carer role

- 1 Make sure that you understand the treatment and ask for more information, if needed.
- 2 Share any concerns in relation to treatment with whoever is prescribing this medicine for you.
- 3 Tell the prescriber of this medication about any other medication being taken, including over-the-counter products.
- 4 Read the patient information leaflet included with your medication and report any side effects or concerns you have to whoever is prescribing this medicine for you.
- 5 Attend any follow up appointments with the consultant or specialist.
- 6 Attend any monitoring appointments.

SHARED CARE GUIDELINE

MEDICATION NAME:

INDICATION:

DATE OF REQUEST:

Agreement to transfer prescribing to general practice or primary care prescriber:

Patient details:

Name:

Address:

DoB:

NHS No:

Hospital No:

Medication name, form and strength:

The following tests and investigations have been carried out:

Date treatment initiated:

At the last patient review the medication appeared to be effectively controlling symptoms or providing benefit:

Yes/No

The patient has now been stabilised on a dose of:

The patient has been given written information about their medication:

Yes/No

The patient understands that this medication is being prescribed under a shared care agreement between their GP and specialist and that they have responsibilities under the agreement to ensure they attend their GP to be regularly monitored.

Yes/No

The patient has been informed that the GP can opt-out of taking on prescribing responsibility if they do not feel clinically able to prescribe or if the patient persistently does not attend for monitoring:

Yes/No

Date of next clinic appointment:

If the practice declines shared care, then the named consultant or specialist should be informed within 28 days of receipt of this request. Forms used to decline prescribing can be found here:

Crawley CCG, Horsham and Mid Sussex CCG:

<http://www.horshamandmidsussexccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?allId=415216>

BACK-UP ADVICE AND SUPPORT

	Name / position	Telephone	Email
Specialist / Consultant:			
Alternative specialist (e.g. departmental contact):			
Hospital Pharmacy:	Worthing Hospital St Richards Hospital	01903 205 111, ext 5698 01243 788 122, ext	pharmacy@wsht.nhs.uk
Out of hours (e.g. medical team on call):	On call physicians	N/A	N/A

Link to full SCG: <http://>