Specialised Medicines Service (SMS) Guideline ~
Oral amisulpride for patients within adult mental health services (Devon wide)

Specialist: Please complete the shared care agreement letter at the end of this document and send together with the guideline to the GP.

GP: GPs are invited to participate. Please indicate whether you agree to share patient's care by completing the relevant letter at the end of this document and returning to the specialist.

Responsibilities remain with the specialist service until formally accepted by the GP. If a GP is not confident to undertake these roles, then they are under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist.

If the GP agrees to share the care of the patient, the patient should not be discharged from the care of their specialist, but rather the care of the patient is shared between the patient, GP and specialist in accordance with the responsibilities outlined in this guideline.

The prescriber has the clinical and legal responsibility for the drug and the consequences of its use. Responsibility for drug monitoring and acting on results remains with the prescriber.

This guideline applies to the use of **oral amisulpride in adults aged 18 years and over** and details the responsibilities for the ongoing prescribing and monitoring required to enable a shared care agreement to be arranged between the primary and secondary care interface. Refer to the online British National Formulary (BNF), Summary of Product Characteristics (SmPCs), Medicines and Healthcare products Regulatory Agency (MHRA) or the National Institute for Health and Care Excellence (NICE) website for up-to-date information on any medicine.

Introduction and aims of treatment

Amisulpride is a second-generation atypical antipsychotic which should only be initiated by specialists who have a full understanding of the characteristics of the drug, its mode of action and risks of therapy.

The specialist must specify the indication for each patient when initiating shared care. It is the specialist's responsibility to determine the place of amisulpride in the treatment pathway for the indication being managed, and its use alongside concomitant pharmacological treatments and psychological therapies.

Licensed indications vary between different medicines containing the same drug. The following **licensed** indications for amisulpride are included within this guideline:

- Chronic schizophrenic disorders, in which positive symptoms (such as delusions, hallucinations, thought disorders) and/or negative symptoms (such as blunted affect, emotional and social withdrawal) are prominent, including patients characterised by predominant negative symptoms.
- Secondary negative symptoms in productive state, as well as affective disorders such as depressive mood.

The following **unlicensed** indications for amisulpride are well established and supported by local specialists and therefore included within this guideline:

- Depression
- Obsessive compulsive disorder (OCD)
- Behaviour that challenges in autism spectrum disorder (ASD)
- Behaviour that challenges in adults with a learning disability
- Post traumatic stress disorder (PTSD)

Use of amisulpride for other indications, high dose antipsychotic prescribing* and instances whereby the GP has commenced amisulpride in the absence of specialist oversight and a shared care agreement, falls outside the scope of this guideline.

***High Dose Antipsychotic Therapy** is defined as either:

- A total daily dose of a single antipsychotic which exceeds the upper limit stated in the BNF **or**
- A total daily dose of two or more antipsychotics which exceeds the BNF maximum as calculated by percentage. A cumulative dose of more than 100% is a high dose.

Stopping over medication of people with a learning disability and autistic people (STOMP)

STOMP is a national NHS England work programme to stop the inappropriate prescribing of psychotropic medications, an identified priority in the NHS Long Term Plan.

People should only be given psychotropic medication for the right reasons, in the lowest dose, for the shortest time.

Certain psychotropic medications can be prescribed for behaviour that is thought to be challenging. This is an unlicensed indication and the medication should be initiated, monitored, reviewed and stopped in line with NICE guidance. Specialist oversight is required, particularly for initiation.

The use of antipsychotics in the management of behaviour that challenges in adults with a learning disability should be reserved for use in exceptional cases only.

Service transition for young people currently receiving antipsychotics

- Refer also to: NICE Guideline NG43 Transition from children's to adults' services for young people using health or social care services (2016).
- Young people transferring from child/adolescent services to adult services should be offered a transition appointment jointly with the child/adolescent and adult specialist providers (contact details are provided later in the guideline).
- During the appointment drug treatment should be discussed with consideration of whether continuation into adulthood will continue to provide therapeutic benefit, or in some circumstances whether a change of medication is required. A treatment plan should be formulated collaboratively with the young person.
- Precise timing of transition arrangements may vary according to the needs and preferences of the individual patient but should usually be completed by the time the young person is 18 years old.

Specialist responsibilities

The specialist may decide to delegate some of these tasks to members of their team, however the responsibility for ensuring the following are undertaken remains with the named specialist overseeing the care of the individual patient:

- Assess the patient, establish diagnosis and the need for treatment with amisulpride. Ensure the diagnosis is within scope of this SMS guideline.
- Assess the patient's capacity to make a decision regarding this treatment and their understanding of associated patient responsibilities.
    - **If patient has capacity**: Document their decision, consent and agreement to associated patient responsibilities (see below).
    - **If patient lacks capacity**: Follow Best Interest decision making processes, in line with the Mental Capacity Act (2005), taking into account the views of the patient, carers and significant others. Document the Best Interests discussion and decision
- Use a shared decision-making approach; provide appropriate counselling to ensure the patient and/ or the patient's carer is involved in making an informed choice about their treatment.
- Provide the patient and/ or the patient's carer with suitable written and verbal information about the medication prior to starting treatment, including benefits and risks, side effects, cautions, frequency of dosing, monitoring requirements and treatment reviews (timing and by whom). Resources may include use of the Choice and Medication website; refer to relevant provider: Devon Partnership NHS Trust / Livewell

Southwest. It is acknowledged that it may not be possible to provide detailed written and verbal information prior to commencing treatment in people who are extremely distressed. In these circumstances clinical judgement should be used, and this should be provided at the earliest opportunity thereafter.

- Inform the patient and/or the patient's carer if the indication being treated is unlicensed.
- Update records with list of existing drugs from available resources and ensure there are no drug interactions of clinical significance with current medication.
- Discuss the use of alcohol, tobacco, recreational drugs, over the counter (OTC) drugs, herbal remedies and other complementary therapies; discuss the safety, efficacy and possible interaction with prescribed medication. Recommend the patient and/ or the patient's carer consults a pharmacist before using any new over the counter (OTC) drugs or herbal remedies.
- Provide advice on the need for contraception, and the risks of pregnancy to individuals on initiation and at each review; the ongoing responsibility for providing this advice rests with both the specialist and the GP.
- Ensure the patient and/ or the patient's carer understands that treatment may be stopped if they do not attend for monitoring & treatment review.
- Undertake pre-treatment screening and required baseline monitoring before initiating amisulpride.
- Initiate, prescribe and optimise amisulpride. Continue to prescribe and monitor the patient for at least the first 12 months or until the patient's condition has stabilised whichever is longer. Monitoring during this period will include drug specific monitoring and physical health monitoring as defined within this guideline. Review the patient regularly during this period in line with relevant NICE guidelines.
    - Any deviation from this timeframe, e.g. in exceptional clinical circumstances, must only occur where the GP has agreed to take on shared care in advance of any change of arrangements.
- The condition should be stable with satisfactory monitoring results (see below) for at least 4 weeks and the dose optimised with no anticipated further changes expected in the immediate future, before the responsibility for prescribing and monitoring may be transferred to primary care under shared-care arrangements.
- It will remain the specialist's ongoing responsibility to monitor the continued efficacy of amisulpride.
- After this time ask the GP in writing whether they are willing to participate in shared care for a particular patient using the shared care agreement letter below. Include all relevant test results (GPs may not have access to these results in primary care). Prescribing and monitoring will remain in secondary care until the GP agrees to share care.
- Ensure that the patient has an adequate supply of medication (usually 28 days) until shared care arrangements are in place. Further prescriptions will be issued by the specialist if, for unforeseen reasons, arrangements for shared care are not in place at the end of this period.
- Continue to review the patient at GP and specialist mutually agreed and clinically appropriate intervals. Specialist review should assess response to antipsychotic treatment and the need to continue therapy. For most patients NICE recommends that a review of antipsychotic medication should take place annually.
    - **Behaviour that challenges in adults with a learning disability:** NICE recommends a review at least every 6 months.
- Ensure prompt written summary is sent to the GP whenever the patient is reviewed including any changes in treatment or monitoring requirements, results of monitoring undertaken, assessment of adverse events, or guidance on when to stop treatment if indicated. Confirm ongoing dose.
- Urgent changes to treatment should be communicated electronically and directly to the GP surgery (and followed up by telephone as required) to ensure prompt and immediate update.
- Provide the GP with relevant contact information and clear arrangements for back-up advice and support.
- Where the named specialist overseeing the care of the individual patient within the same service provider changes the GP should be notified in writing and updated contact details provided.
- Where patient care is transferred from one mental health service provider to another, and/or the patient is initiated on a different antipsychotic with associated SMS guidelines a new shared care agreement must be completed between the specialist, the GP and the patient (this excludes brand / formulation / dose changes for the same drug).
- Respond promptly to GP or patient queries and advise on action required when abnormal monitoring results are identified or adverse effects signs or symptoms are detected and flagged.
- If the patient wishes to become pregnant, where appropriate seek advice from perinatal mental health team (see contact details in supporting information below). Notify GP.

- If the patient becomes pregnant the specialist will reassume prescribing responsibility, ending the shared care agreement.
- Report suspected side effects to MHRA via yellow card scheme.

General practitioner responsibilities

GPs may decide to delegate some of these tasks to members of their team; however, the responsibility for ensuring the following are undertaken remains with the named GP overseeing the care of the individual patient:

- Ensure a timely reply is sent to the specialist in response to the request for shared care using the shared care agreement letters below. Where possible this should be undertaken within 14 days of the request being made.

If GP has agreed to share care:

- Continue to prescribe amisulpride as requested by the specialist.
- Continue to monitor treatment in accordance with these guidelines. Review monitoring results and take any necessary action, communicating any results of concern to the specialist (see monitoring requirements below).
- Be alert to the possibility of interactions when initiating new medicines, recommending over the counter (OTC) treatments or herbal remedies, or disclosure of the use of recreational drugs.
- Provide ongoing advice on the need for contraception where clinically appropriate.
- Be alert to the possibility of adverse effects at every contact. Manage patient in accordance with guidance below. Ensure prompt action in the case of a severe adverse effect or signs or symptoms.
- Contact the specialist urgently if any of the following are suspected:
  - Suspected relapse in medical condition being treated
  - Significant increase in the use of alcohol or substance misuse
  - Non-adherence to medication
- Ensure advice sought promptly from the specialist if there is a change in the patient's physical or mental health status which is of concern to the GP and may affect treatment.
- If the patient wishes to become pregnant, seek advice from perinatal mental health team (see contact details in supporting information below). The perinatal mental health team will be responsible for ensuring the initiating specialist and GP are notified of the outcome.
- If the patient becomes pregnant the specialist will reassume prescribing responsibility, ending the shared care agreement.
- Respond promptly to advice from specialist regarding any changes in treatment or monitoring requirements.
- Ensure that the specialist is informed in writing of any changes to the patient's GP or their contact details.
- Where patient care is transferred from one GP practice to another a new shared care agreement must be completed.
- Report suspected side effects to specialist and to MHRA via yellow card scheme.

Patient and/ or carer responsibilities

- Take amisulpride as directed by the prescriber. Patients wishing to reduce their dose or stop amisulpride should discuss with their specialist before doing so. Avoid abrupt withdrawal unless advised by the GP or specialist.
- Understand the importance of monitoring treatment and attend specialist and GP appointments to ensure timely monitoring and reviews can be completed in accordance with the guideline. Understand that treatment will be stopped if they do not attend.
- Ensure contact details are kept up to date with both the GP and the specialist.
- Read the amisulpride patient information leaflet and any other resources which the specialist may recommend. Request information in different format(s) if required to aid understanding. Understand treatment, expected benefits and potential side effects.
- Tell anyone who prescribes them a medicine that they are taking amisulpride.
- Seek guidance from a pharmacist, GP or specialist on medication safety and potential interaction with amisulpride if engaging in over the counter (OTC) treatments, recreational drug use, or herbal remedies. Report the use of any regular items to the GP.

- Report any adverse effects or newly presenting signs or symptoms to the GP and/or specialist in a timely way for assessment.
- Ensure adequate hydration and continued mobility where possible to reduce the risk of certain side effects
- Avoid direct sunlight exposure; take appropriate precautions when outside (photosensitisation may occur with higher dosages).
- The patient should take a pregnancy test if they think there is a possibility they may be pregnant, and inform the GP or specialist immediately if they become pregnant or wish to become pregnant.
- Store medicines safely and securely; it must not be shared with anyone else. Dispose of any unused medication appropriately.
- Report suspected side effects to the GP or specialist and the MHRA via yellow card scheme.

Monitoring requirements

Baseline assessment to be undertaken and recorded by the specialist prior to commencing antipsychotic treatment:

- Weight (plotted on a chart) and BMI
- Waist circumference
- Pulse and blood pressure
- Fasting blood glucose or HbA1c
- Blood lipid profile
- U&Es (including creatinine and eGFR)
- LFTs
- Prolactin
- ECG
- Assessment of any movement disorders
- Assessment of nutritional status, diet and level of physical activity

Consideration should also be given to baseline measurement of FBC and creatinine phosphokinase.

Any baseline measurement results outside of the reference range should be managed accordingly prior to commencing treatment. Alternative antipsychotic may be required in some cases.

Specialist should copy all results to GP.

Ongoing drug monitoring requirements once stable:

The requirements outlined in the table below will be completed by the specialist until the GP takes over prescribing and monitoring.

The exact frequency of monitoring to be communicated by the specialist in all cases. Where abnormal results are identified during routine monitoring consider the actions in the table below, seeking advice from specialist for further support and guidance where required. As well as responding to absolute values, a rapid change or a consistent trend in any value should prompt caution and extra vigilance. If monitoring results are forwarded to the specialist team, include clear clinical information on the reason for sending, to inform action to be taken by secondary care.

Given the observed risk for worsening metabolic profile (weight gain, hyperglycaemia, dyslipidaemia) in patients with severe mental illness, changes in patients' metabolic parameters should be regularly monitored during treatment. The table below includes recommendations based on NICE and Maudsley Prescribing Guidance for such monitoring and any manufacturer highlighted drug specific safety monitoring requirements. In patients considered to be at higher risk, more frequent monitoring may be required (particularly during the first 12 months).

Physical health monitoring is the subject of a separately commissioned local enhanced service (LES): “Annual Physical Health Checks for People with Severe Mental Illness”. Primary Care Teams should consider any additional blood monitoring required as part of the LES and may wish to undertake this at the same time as the monitoring outlined below to streamline appointments wherever possible.

Tests	Association with amisulpride*	Minimum frequency of monitoring†	Threshold for action and action to be taken by GP
U&Es (including creatinine and eGFR)	Amisulpride is renally excreted.	Monitoring frequency during dose titration varies according to individual patient need – this will be undertaken by the specialist. Once stabilised measure at 12 weeks, then at 12 months and then annually. Additional measurement may be considered if there are specific clinical concerns (e.g. dehydration), ECG changes, or if concomitant medicines that may cause electrolyte disturbances are prescribed.	If renal function deteriorating or creatinine clearance below 60ml/min seek advice from initiating specialist (dose reduction may be required). See supporting information for further details.
Prolactin	Amisulpride is associated with a moderate - high incidence/severity of prolactin elevation. Refer to table below for examples of long-term adverse consequences of raised prolactin.	Measure at 6 months, then at 12 months and then annually. Early morning sample should be obtained and stress during venepuncture minimised. If the patient presents with symptoms outside the annual monitoring period refer to table below.	If elevated compared to handover baseline (with / without symptoms), consider other causes e.g. stress (physical or psychological, including venepuncture), exercise, pregnancy, lactation, seizures, renal impairment, hypothyroidism, prolactinoma and other medical conditions or medicines. This is particularly important if the patient has been taking a stable dose of amisulpride for a long time without prolactin level changes. Consider taking a repeat measurement; if exercise is the cause, repeat test after rested for 2-3 days. Seek advice from initiating specialist as required.

Table continued overleaf

Tests	Association with amisulpride*	Minimum frequency of monitoring†	Threshold for action and action to be taken by GP
ECG	Risk of sudden death is increased with most antipsychotics. Amisulpride is associated with low - moderate incidence/severity of QTc prolongation.	Repeat ECG once dose stabilised. Specialist will advise the GP on the necessity (and frequency) for ECG monitoring for each individual patient. GPs may wish to consider additional ECG measurement if change in clinical picture (e.g. renal function) or new medicines initiated which are associated with QT prolongation.	If QTc >440msec (men) or >460msec (women) or change from baseline >20msec, check potassium, magnesium and calcium levels and consider other causes / medication. Repeat ECG (consider checking the QTc calculation manually in case of machine error). If prolongation confirmed seek advice from initiating specialist. **If QTc exceeds 500msec stop amisulpride and seek same day cardiology advice.** Notify initiating specialist who will follow up patient directly. If other abnormalities are identified seek advice from initiating specialist and consider seeking advice from cardiology. Refer to interactions section below for linked resources which identify medicines that affect the QT interval.
Adverse effects	Be alert to the possibility of side effects at every contact. Refer to table below and contact specialist for advice as required.		

* Modifiable lifestyle factors are likely to impact weight, pulse, blood pressure, blood glucose and blood lipids.
† In patients considered to be at higher risk, more frequent monitoring may be required (particularly during the first 12 months). Specialist will confirm.

Important safety information

MHRA Drug Safety Update (December 2014): Atypical (second-generation) antipsychotics

Reminder to monitor and manage weight, glucose, and lipid levels. **See table above for local monitoring requirements.**

Presentation of the following adverse effects, signs or symptoms and associated actions should be noted. Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. See also adverse effects in supporting information below.

Adverse effects, signs and symptoms	Action to be taken by GP
Risk to self or others; suicidal behaviour or thoughts; unusual changes in behaviour	Refer to appropriate mental health team according to severity. Contact initiating specialist who will determine whether amisulpride should be withdrawn.
Hyperglycaemia Symptoms include polydipsia, polyuria, polyphagia and weakness Hyperglycaemia is reported to be an uncommon adverse effect.	Investigate for hyperglycaemia. Prediabetes: HbA1c: 42-47mmol/mol (6.0% - 6.4%), fasting: 5.5 - 6.9mmol/l. Diabetes: HbA1c: ≥48 mmol/mol (≥6.5%), fasting ≥7.0mmol/l, random ≥11.1mmol/l. Follow Devon Formulary Guidance on the management of T2DM (see here N&E / S&W). Seek further advice from initiating specialist as required.
Extrapyramidal side effects (EPSEs)	Contact initiating specialist for advice as required.
Somnolence and related symptoms, such as sedation	Advise patients not to drive/operate machinery if affected. If symptoms are judged to be clinically concerning or persistent, a dose decrease or treatment discontinuation should be considered; seek specialist advice.
Orthostatic (postural) hypotension: usually defined as ≥ 20mmHg fall in systolic blood pressure and/or a ≥ 10mmHg fall in diastolic blood pressure within 3 minutes of standing. Symptoms include dizziness, light-headedness, asthenia, headache and visual disturbance	Check blood pressure in suspected cases. Offer practical advice to patient and contact initiating specialist for further advice where required.
Neuroleptic malignant syndrome Clinical manifestations include hyperthermia, altered mental status, muscular rigidity, autonomic instability, and increased creatine phosphokinase.	This is a **medical emergency** where early recognition and treatment is essential. In an emergency call 999. Hyperthermia is often an early sign of this syndrome. **Antipsychotic treatment must be withdrawn immediately** and appropriate supportive therapy and careful monitoring instituted. Inform initiating specialist who will follow up patient directly.

Table continued overleaf

Adverse effects, signs and symptoms	Action to be taken by GP
Weight changes Weight gain has been reported with amisulpride.	If BMI >25 and/or weight gain >5kg from baseline provide exercise & dietary advice. Consider referral to dietician. Seek further advice from initiating specialist as required.
Neutropenia or agranulocytosis Signs/symptoms include infection, fever, weakness, lethargy, sore throat, mouth ulcers	Exclude other causes, including adjunctive treatments; in the case of concomitant chemotherapy a multidisciplinary review of medication must be undertaken. Measure white blood cell (WBC) count and an absolute neutrophil count (ANC) promptly. **If Neutrophils < 1.5 x 10^9/L*:** • **Stop amisulpride.** Inform initiating specialist who will follow up patient directly. • Repeat FBC in one week (48 hours if neutrophils <1 x 10^9/L) • Advise patient to seek urgent medical attention if they become unwell or febrile **Arrange urgent medical assessment if:** • patient is unwell or febrile, **or** • neutrophils < 0.5 x 10^9/L ** If the patient has benign ethnic neutropenia (BEN), use a threshold of <1 x 10^9/L.*
Hyperprolactinemia Symptoms may include: unexplained headaches or visual impairment, breast enlargement, galactorrhoea, reduced libido, erectile dysfunction, amenorrhoea, anorgasmia, delusions of pregnancy. Long term adverse consequences may include reduced fertility in women, reductions in bone mineral density and a possible increase in the risk of breast cancer.	If hyperprolactinaemia is suspected obtain prolactin level. Early morning sample should be obtained and stress during venepuncture minimised. Refer to monitoring table above for action to be taken when reviewing results.
Hepatic impairment Symptoms may include: fatigue, pain in the upper right abdomen, jaundice, swelling, and confusion. Hepatocellular injury and elevations of hepatic enzymes, mainly transaminases are uncommon adverse effects. Severe liver toxicity has been reported with amisulpride.	Measure LFTs. Investigate any abnormalities detected. If elevated compared to handover baseline but < 3xULN consider alternative causes of hepatic dysfunction such as alcohol history and drug interactions, including over the counter (OTC) treatments or complementary medication. **Stop amisulpride** if transaminases ≥3xULN or functional damage (PT/albumin change). Seek further advice from initiating specialist as required.

Important safety information

MHRA Drug Safety Update (August 2020): Clozapine and other antipsychotics: monitoring blood concentrations for toxicity

This update reminds healthcare professionals that following fatal cases involving toxicity of clozapine and other antipsychotic medicines, the MHRA advises that monitoring blood concentration of amisulpride may be helpful in certain circumstances.

For antipsychotics other than clozapine, drug level monitoring for toxicity is not routine practice. This service is not provided by local trust laboratories. **Local advice is that clinicians who have concerns about a patient receiving an antipsychotic should in the first instance contact the mental health specialist team for advice. This applies to patients with symptoms suggestive of toxicity, or when concomitant medicines may interact to increase antipsychotic drug levels, and also when non-adherence or poor response to treatment is suspected.**

MHRA Drug Safety Update (December 2014): Antipsychotics: risk of venous thromboembolic events (VTE)

Use of Antipsychotic may be associated with an **increased risk of venous thromboembolic events.**

Supporting Information

This section provides additional information regarding amisulpride. Refer to the online BNF, SmPCs, the MHRA or NICE websites for up-to-date information on any medicine.

Formulation

Refer to Devon formulary for list of preparations approved for use locally.

Dosage and administration

Dosing titration schedules and maintenance doses vary depending on indication and individual patient factors including concomitant medication, co-morbidities, and response to treatment. Patients must receive clear information on the appropriate dose for their condition.

The specialist retains responsibility for initiating amisulpride and optimising the dose in accordance with tolerability and efficacy; the maximum daily dose should not exceed 1200mg.

For further information, refer to the BNF, SmPC, and specialist advice.

High dose antipsychotic prescribing falls outside the scope of this guideline.

Elderly

Lower starting dose and slower / smaller titration steps may be required.

Renal impairment

The dose should be reduced to half in patients with creatinine clearance between 30-60 ml/min and to a third in patients with creatinine clearance between 10-30 ml/min. As there is no experience in patients with severe renal impairment (creatinine clearance < 10 ml/min) particular care is recommended in these patients.

Treatment withdrawal

Treatment duration will be determined by the specialist. Termination of treatment will be the responsibility of the specialist with exceptions due to adverse effects detailed in the table above. The specialist will determine the rate of withdrawal and continue to oversee the patient during this time to avoid the risk of acute withdrawal syndromes or rapid relapse. Antipsychotic withdrawal effects can be delayed in onset for weeks and sometimes months.

Shared care prescribing arrangements can continue during the treatment withdrawal period if felt to be clinically appropriate.

Contraindications

- Hypersensitivity to the active substance or to other ingredients of the medicinal product; amisulpride contains lactose monohydrate therefore patients with rare hereditary problems of galactose intolerance, the total lactase deficiency or glucose-galactose malabsorption should not take this medicine
- Concomitant prolactin-dependent tumours e.g. pituitary gland prolactinomas or breast cancer
- Phaeochromocytoma
- Children up to puberty
- Combination with levodopa
- Some SmPCs also state that amisulpride is contraindicated in combination with the following medicinal products which could induce torsade de pointes (class Ia antiarrhythmics such as quinidine and disopyramide; class III antiarrhythmics such as amiodarone and sotalol; other medicinal products such as bepridil, cisapride, sultopride, thioridazine, methadone, erythromycin (intravenous application), vincamine (intravenous application), halofantrine, pentamidine, sparfloxacin, azole antifungals)

The BNF also includes CNS depression and comatose states in the list of contraindications.

Precautions and special warnings

In addition to the points listed below, refer to the monitoring section above for further cautions to be noted during and / or prior to treatment depending on patient medical history, and actions to take in the case of a severe adverse effect or patient reported signs or symptoms.

As amisulpride has several indications, the safety profile should be considered in the context of the individual patient's diagnosis and the dose being administered.

Blood dyscrasias; breast cancer; cardiovascular disease; conditions predisposing to seizures; dementia; depression; diabetes (may raise blood glucose); elderly (e.g. stroke risk, parkinsonism, Lewy Body Disease, falls risk, hyperprolactinaemia; hypotension, prostatism, urinary retention); epilepsy; history of jaundice or liver disease/impairment; myasthenia gravis; Parkinson's disease (may be exacerbated); photosensitisation (may occur with higher dosages); prolongation of QT interval; prostatic hypertrophy; renal insufficiency; severe respiratory disease; susceptibility to angle-closure glaucoma; VTE risk factors

Adverse effects

The data below has been taken from the online BNF. **The list is not exhaustive.** Refer to the online BNF and SmPCs for full prescribing data. Seek specialist advice where necessary. See also adverse effects, signs and symptoms in monitoring requirements section above.

Very common (≥1/10) or common (≥1/100 to <1/10): Agitation; amenorrhoea; anxiety; arrhythmias; breast pain; constipation; dizziness; drowsiness; dry mouth; erectile dysfunction; fatigue; galactorrhoea; gynaecomastia; hyperglycaemia; hyperprolactinaemia; hypersalivation; hypotension (dose-related); insomnia; leucopenia; movement disorders; muscle rigidity; nausea; neutropenia; oculogyric crisis; orgasm abnormal; parkinsonism; postural hypotension (dose-related); QT interval prolongation; rash; seizure; tremor; trismus; urinary retention; vision blurred; vomiting; weight increased

Uncommon (≥1/1000 to <1/100): Agranulocytosis; bone disorders; dyslipidaemia; confusion; hepatic disorders; nasal congestion; neuroleptic malignant syndrome (discontinue—potentially fatal); pneumonia aspiration

Rare (≥1/10,000 to <1/1,000) or very rare (<1/10,000): Angioedema; embolism and thrombosis; hyponatraemia; neoplasms; SIADH; sudden death; urticaria; withdrawal syndrome neonatal

Frequency not known: Photosensitivity reaction

Interactions

The following list is not exhaustive; where an extensive list of interacting medicines exists those more commonly prescribed in primary care are highlighted as examples below. The lists are intended to alert the reader and prompt further consideration before prescribing. Refer to the online BNF and SmPCs for full prescribing data. Seek specialist advice where necessary and / or refer to specialist Medicines Information services for additional support (and reference to Stockley's Drug Interactions where paid subscription available) if concomitant administration of interacting medicines clinically indicated.

The following interactions are classified in the online BNF as **severe** (the result may be a life-threatening event or have a permanent detrimental effect):

- **Medicines which prolong QT interval or increase the risk of QT prolongation (e.g. amiodarone and other anti-arrythmics, antipsychotics, citalopram, domperidone, erythromycin, escitalopram, fluconazole, hydroxychloroquine, hydroxyzine, methadone, ondansetron, quinine, tramadol*):** Avoid using two or more drugs that are associated with QT prolongation. Increasing age, female sex, cardiac disease, and some metabolic disturbances (notably hypokalaemia) predispose to QT prolongation.
  - *The following resources can identify medicines which can affect the QT interval: CredibleMeds (access is free but users must be registered); BNF; SmPCs; MHRA; Stockley's Drug Interactions (subscription required); Specialist Pharmacy Service (SPS)*

  **Tramadol not listed in the BNF or SmPC for this side effect but noted as a potential interaction by local specialists and cited by CredibleMeds as being associated with QT prolongation when taken at clinically recommended doses*
- **Medicines which are predicted to cause hypokalaemia (e.g. antibiotics, diuretics, corticosteroids and mineralocorticoids, beta$_2$-agonists (e.g. salbutamol), xanthines (e.g. theophylline), chemotherapy agents** – refer to BNF / product literature for full list**):** potentially increasing the risk of torsade de pointes. Consideration should be given to other medicines which cause hypokalaemia but not listed in the BNF as a severe interaction such as insulin, laxatives and enemas.
- **Active metabolite of foslevodopa:** Amisulpride might decrease the effects (monitor).
- **Ivabradine:** Predicted to increase the risk of torsade de pointes (avoid).
- **Levodopa:** Amisulpride is predicted to decrease the effects (avoid). Contraindicated.

The following interactions are classified in the online BNF as **moderate** (the result could cause considerable distress or partially incapacitate a patient; they are unlikely to be life-threatening or result in long-term effects.):

- **Dopamine receptor agonists (e.g. amantadine, apomorphine, cabergoline, pramipexole, rotigotine)**: amisulpride is predicted to decrease the effects (avoid).

The BNF and SmPCs also highlight the following interactions:

- **Medicines which increase the risk of hyponatraemia**
- **Alcohol and medicines which effect the CNS and can cause sedation**. Use of two or more drugs that have effects on the CNS might also increase the risk of CNS depressant effects (which could range from sedation to unconsciousness, coma, respiratory depression, and/or cardiovascular depression).
- **Antihypertensive drugs** and other **hypotensive medications**
- **Clozapine**: may lead to an increase in plasma levels of amisulpride
- **Bradycardia-inducing medicinal products** (e.g. beta-blockers, calcium channel blockers, clonidine, guanfacine, digitalis)

Pregnancy and lactation

No psychotropic medication has a UK marketing authorisation specifically for women who are pregnant or breastfeeding.

If the patient becomes pregnant, the specialist will reassume prescribing responsibility, ending the shared care agreement.

Before prescribing in this area seek specialist advice and check up-to-date sources of information.

Pregnancy (Maternal exposure)

The UK Teratology Information Service (UKTIS) provides a national service on all aspects of the toxicity of drugs and chemicals in pregnancy (Tel: 0344 892 0909), and provides the 'best use of medicines in pregnancy' (bumps) website for supportive patient information relating to individual treatments.

A summary of the UKTIS monograph for amisulpride can be accessed here.

Amisulpride crosses the placenta. SmPCs state that the use of amisulpride is not recommended during pregnancy and in women of childbearing potential not using effective contraception, unless the benefits justify the potential risks. Devon Formulary signposts to resources for contraception for drugs with teratogenic potential, and prescribing in pregnancy and lactation including MHRA Drug Safety Update (March 2019): Medicines with teratogenic potential: what is effective contraception and how often is pregnancy testing needed?

The BNF and SmPCs report for all antipsychotics that extrapyramidal effects and withdrawal syndrome have been reported occasionally in the neonate when antipsychotic drugs are taken during the third trimester of pregnancy. Following maternal use of antipsychotic drugs in the third trimester, neonates should be monitored for symptoms including agitation, hypertonia, hypotonia, tremor, drowsiness, feeding problems, and respiratory distress.

Important Safety Information

MHRA Drug Safety Update (December 2014): Antipsychotics: risk of extrapyramidal effects or withdrawal symptoms in newborns

Risk of extrapyramidal effects or withdrawal symptoms (or both) in newborns after maternal use of antipsychotics during the third trimester of pregnancy.

Lactation

UK Drugs in Lactation Advisory Service (UKDILAS) provides evidence based information on the use of drugs during the breastfeeding period to all UK healthcare professionals.

The Specialist Pharmacy Service (SPS) also has guidance on the use of antipsychotics during breastfeeding produced by the UKDILAS here.

SmPCs state that amisulpride is excreted into breastmilk in rather large amounts above the accepted value of 10% of the maternal weight-adjusted dosage in some cases, but blood concentrations in breastfed infants have not been evaluated. There is insufficient information on the effects of amisulpride in newborns/infants. A decision must be made whether to discontinue breast-feeding or to abstain from amisulpride therapy taking into account the benefit of breastfeeding for the child and the benefit of therapy for the woman. The BNF states “avoid”.

Further resources

National Institute for Health and Care Excellence (NICE)

- Clinical Guideline 31: Obsessive-compulsive disorder and body dysmorphic disorder: treatment, 2005
- Clinical Guideline 142: Autism spectrum disorder in adults: diagnosis and management, 2012
- Clinical Guideline 178: Psychosis and schizophrenia in adults: prevention and management, 2014
- NICE Guideline 11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, 2015
- NICE Guideline 54: Mental health problems in people with learning disabilities: prevention, assessment and management, 2016
- NICE Guideline 116: Post-traumatic stress disorder, 2018
- NICE Guideline 222: Depression in adults: treatment and management, 2022

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Support

Adult mental health service providers	
Devon Partnership Trust See website for community teams contact details: https://www.dpt.nhs.uk/locations Trust HQ (Wonford House reception): 01392 208866 Medicines Helpline: 01392 674900 Email: dpt.medsquery@nhs.net (Available 10am - 4pm, Monday to Friday, excluding Bank Holidays)	**Livewell Southwest** Email: livewell.antipsychoticadviceguidance@nhs.net (Available 10:00am – 4:00pm, Monday to Friday, excluding Bank Holidays. Response within 2 working days) **Urgent advice / support requiring a same day response** Please contact switchboard: 01752-435502 and ask to be directed to the relevant team / specialist (Mon-Fri 9am-5pm) or the on-call consultant psychiatrist after-hours. **Non-urgent enquiries** Please email the relevant medical secretary team: • Avon House livewell.cmhsmedsecs.avon@nhs.net • Cumberland Centre livewell.cmhsmedsecs.cumberland@nhs.net • OPMH livewell.OPMHSMedicalSecretaries@nhs.net
Learning disabilities and autism service providers	
Devon Partnership Trust See website for learning difficulties service contact details: https://www.dpt.nhs.uk/service-details/service/learning-disability-intensive-assessment-and-treatment-service-75/ See website for autism service contact details (various depending on support required): https://www.dpt.nhs.uk/services	**Livewell Southwest** Community Learning Disability Team: livewell.cldtreferrals@nhs.net Autism queries to be emailed to the Community Mental Health Teams (Avon House and Cumberland Centre – see above).
Perinatal mental health teams	
Exeter Email: dpn-tr.PerinatalTeamExeter@nhs.net Telephone: 01392 674964	**North Devon** Email: dpn-tr.perinatalNorth@nhs.net Telephone: 01271 322772
Plymouth Email: livewell.perinatalmht@nhs.net Telephone: 01752 431607	**South Hams and West Devon** Email: dpt.perinatalteamwestdevon@nhs.net Telephone: 01822 813 070
Torbay Email: dpn-tr.PerinatalTeamTorbay@nhs.net Telephone: 01803 396590	
For further support and information in relation to individual shared care agreements please contact your practice pharmacist or alternatively please contact the Medicines Optimisation Team. Email: D-ICB.medicinesoptimisation@nhs.net	

Version 1 **Date ratified: 20th May 2026**
This guideline has been reviewed by stakeholders across Devon and is intended for use in accordance with locally commissioned services.

Shared Care Agreement Letter - Specialist Request to GP (New initiations)

To	**GP name**	
	Practice address	
Patient name		
Hospital number		
NHS number		
Date of birth		
Address		

GPs are invited to participate in shared care agreements, but if the GP is not confident to undertake these roles then they are under no obligation to do so. If so, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. If asked to prescribe this drug the GP should reply to this request as soon as practical. Continuing the care assumes communication between the specialist, GP and patient; the intention should be explained to the patient and accepted by them.

The prescriber has the clinical and legal responsibility for the drug and the consequences of its use. Responsibility for drug monitoring and acting on results remains with the prescriber.

NHS England 'Responsibility for prescribing between Primary & Secondary/Tertiary care' guidance (2018) states that "when decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. It is therefore essential that a transfer involving medicines with which GPs would not normally be familiar should not take place without full local agreement, and the dissemination of sufficient, up-to-date information to individual GPs."

This patient is now suitable for prescribing to move to primary care. The patient fulfils criteria for shared care therefore I am writing to request your agreement to continue the care of this patient according to the Specialised Medicines Service (SMS) Guideline.

In accordance with the SMS Guideline the transfer of monitoring and prescribing to the GP is normally after the patient has been treated for 12 months or until the patient's condition has stabilised whichever is longer. The condition should be stable with satisfactory blood results for at least 4 weeks and the dose optimised with no anticipated further changes expected in the immediate future, before the responsibility for prescribing and monitoring may be transferred to primary care under shared-care arrangements.

I have discussed and agreed the following treatment with the patient:

	Specialist to complete
ORAL ANTIPSYCHOTIC *(Specify formulation and dose to be administered)*	
Indication *(Indicate licensing status)*	
Treatment start date	
Patient has been on the optimised dose stated for	
Sufficient medication has been provided to last until	
GP to undertake prescribing and monitoring in line with the SMS Guideline from	
Next monitoring due date	
Next medication review planned for *(Expected timeframe if exact date not known)*	

I can confirm that the following have occurred with regard to this treatment:

	Specialist to complete (YES/NO)
The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care	
The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments	
The roles of the Specialist / GP / Patient have been explained and agreed	
The risks and benefits of treatment have been explained to the patient	
Baseline investigation and monitoring as set out in the SMS Guideline have been completed and were satisfactory	
I have enclosed a copy of the SMS Guideline which covers this treatment. The guideline can also be found here	
I have included with this letter copies of the information the patient has received	

The results of baseline tests or monitoring performed by the specialist, and any additional supportive information is included below and/or attached.

GP please sign response letter and return promptly (where possible this should be within 14 days of the request being made).

Specialist signature		**Date**	
Specialist name, role, speciality			
Daytime telephone number			
Email address			
Alternative contact e.g. clinic or specialist nurse			
Out of hours contact details e.g. duty doctor			

Remember to keep a copy of this letter for the patient's records.

Shared Care Agreement Letter - Specialist Request to GP (Patients in primary care, already established on treatment)

To	**GP name**	
	Practice address	
Patient name		
Hospital number		
NHS number		
Date of birth		
Address		

GPs are invited to participate in shared care agreements, but if the GP is not confident to undertake these roles then they are under no obligation to do so. If so, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. If asked to continue prescribing this drug the GP should reply to this request as soon as practical. Continuing the care assumes communication between the specialist, GP and patient; the intention should be explained to the patient and accepted by them.

The prescriber has the clinical and legal responsibility for the drug and the consequences of its use. Responsibility for drug monitoring and acting on results remains with the prescriber.

NHS England 'Responsibility for prescribing between Primary & Secondary/Tertiary care' guidance (2018) states that "when decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. It is therefore essential that a transfer involving medicines with which GPs would not normally be familiar should not take place without full local agreement, and the dissemination of sufficient, up-to-date information to individual GPs."

This patient is already established on oral antipsychotic treatment and fulfils criteria for shared care therefore I am writing to request your agreement to continue the care of this patient according to the Specialised Medicines Service (SMS) Guideline.

Please continue to prescribe and perform ongoing drug safety monitoring in accordance with the SMS Guideline.

	Specialist to complete
ORAL ANTIPSYCHOTIC *(Specify formulation and dose to be administered)*	
Indication *(Indicate licensing status)*	
Next medication review planned for *(Expected timeframe if exact date not known)*	

I can confirm that the following have occurred with regard to this treatment:

	Specialist to complete (YES/NO)
The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care	
The roles of the Specialist / GP / Patient have been explained and agreed	
The risks and benefits of treatment have been explained to the patient	
Patient is optimised on treatment with no anticipated further changes expected in the immediate future	
I have enclosed a copy of the SMS Guideline which covers this treatment. The guideline can also be found here	

The results of any recent monitoring performed by the specialist and any additional supportive information are included below and/or attached.

GP please sign response letter and return promptly (where possible this should be within 14 days of the request being made).

Specialist signature		**Date**	
Specialist name, role, speciality			
Daytime telephone number			
Email address			
Alternative contact **e.g. clinic or specialist nurse**			
Out of hours contact details **e.g. duty doctor**			

Remember to keep a copy of this letter for the patient's records.

Shared Care Agreement Letter – GP Acceptance Letter to Specialist

To	Specialist name	

Patient name	
Hospital number	
NHS number	
Date of birth	
Address	

GPs are invited to participate in shared care agreements, but if the GP is not confident to undertake these roles then they are under no obligation to do so. If so, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. If asked to prescribe this drug the GP should reply to this request as soon as practical. Continuing the care assumes communication between the specialist, GP and patient; the intention should be explained to the patient and accepted by them.

The prescriber has the clinical and legal responsibility for the drug and the consequences of its use. Responsibility for drug monitoring and acting on results remains with the prescriber.

NHS England 'Responsibility for prescribing between Primary & Secondary/Tertiary care' guidance (2018) states that "when decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. It is therefore essential that a transfer involving medicines with which GPs would not normally be familiar should not take place without full local agreement, and the dissemination of sufficient, up-to-date information to individual GPs."

Thank you for your request for me to accept prescribing responsibility for this patient under a shared care agreement and to provide the following treatment:

<*State oral antipsychotic, formulation and dose to be administered*>

……

I can confirm that **I am willing to take on this responsibility** from …….. and will maintain the prescribing and monitoring responsibilities as set out in the Specialised Medicines Service (SMS) Guideline.

GP signature		**Date**	
GP name			
Practice address			
Telephone number			
Email address			

Remember to keep a copy of this letter for the patient's records. If this letter is not returned sharing of the care for this patient will not commence.

Shared Care Agreement Letter – GP Refusal Letter to Specialist

To	Specialist name	

Patient name	
Hospital number	
NHS number	
Date of birth	
Address	

GPs are invited to participate in shared care agreements, but if the GP is not confident to undertake these roles then they are under no obligation to do so. If so, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. If asked to prescribe this drug the GP should reply to this request as soon as practical. Continuing the care assumes communication between the specialist, GP and patient; the intention should be explained to the patient and accepted by them.

The prescriber has the clinical and legal responsibility for the drug and the consequences of its use. Responsibility for drug monitoring and acting on results remains with the prescriber.

NHS England 'Responsibility for prescribing between Primary & Secondary/Tertiary care' guidance (2018) states that "when decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. It is therefore essential that a transfer involving medicines with which GPs would not normally be familiar should not take place without full local agreement, and the dissemination of sufficient, up-to-date information to individual GPs."

In the interest of patient safety NHS Devon, in conjunction with local acute trusts have classified a number of oral antipsychotics as "shared care" drugs which require a number of conditions to be met before transfer can be made to primary care.

Thank you for your request for me to accept prescribing responsibility for this patient. I regret to inform you that in this instance **I am unable to take on responsibility** due to the following:	**Tick all applicable**
The prescriber does not feel clinically confident in managing this individual patient's condition, and there is a sound clinical basis for refusing to accept shared care. As the patients GP I do not feel clinically confident to manage this patient's condition. I have consulted with other GPs in my practice who support my decision. This is not an issue which would be resolved through adequate and appropriate training of prescribers within my practice. **I have discussed my decision with the patient and request that prescribing for this individual remain with you as the specialist, due to the sound clinical basis given below.**	

The condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement. As the condition requested to be treated is not included on the locally recognised list of indications for shared care I am unable to accept clinical responsibility for prescribing this medication at this time. **Until this condition is identified locally as requiring shared care the responsibility for providing this patient with their medication remains with you.**	
A minimum duration of supply by the initiating specialist. As the patient has not had the minimum supply of medication to be provided by the initiating specialist (28 days) I am unable to take clinical responsibility for prescribing this medication at this time. Therefore can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. **Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.**	
Initiation and optimisation by the initiating specialist. The transfer of monitoring and prescribing to the GP is normally after the patient has been treated for 12 months or until the patient's condition has stabilised whichever is longer. The condition should be stable with satisfactory blood results for at least 4 weeks and the dose optimised with no anticipated further changes expected in the immediate future, before the responsibility for prescribing and monitoring may be transferred to primary care under shared-care arrangements. As the patient has not been optimised on this medication I am unable to take clinical responsibility for prescribing this medication at this time. Therefore can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. **Until the patient is optimised on this medication the responsibility for providing the patient with their medication remains with you.**	
Other (GP to complete if there are other reasons why shared care cannot be accepted):	

I would be willing to consider prescribing for this patient once the above criteria have been met for this treatment.

Please do not hesitate to contact me if you wish to discuss any aspect of my letter in more detail and I hope to receive more information regarding this shared care agreement as soon as possible.

GP signature		**Date**	
GP name			
Practice address			
Telephone number			
Email address			

Remember to keep a copy of this letter for the patient's records.