# Shared Care Guidelines



***Some of the guidelines previously included in this document have been reviewed and replaced. Where this is the case, information has been redacted from this document and clinicians are redirected to the relevant standalone guidelines which may be found on the NHS Devon website:***
https://onedevon.org.uk/our-work/services-and-support/medicines-and-treatments/clinical-guidance-for-prescribers/

# Introduction to Shared Care Guidelines

Developed: November 2005
Updated: April 2008

| IMPORTANT | In its guidance on responsibility for prescribing between hospital and general practitioners, the Department of Health has advised that the legal responsibility for prescribing lies with the doctor who signs the prescription.<br>See Shared Care, Prescription Writing. BNF |
|---|---|

**Background**
Shared Care Guidelines are intended to provide GPs with sufficient information to undertake prescribing responsibility for specialist therapies where:

- Treatment is complex
- Monitoring is required
- Communication between primary and secondary care is vital
- GPs are unfamiliar with the therapy, particularly new treatments.
- GPs will usually be asked to assume prescribing responsibility by an appropriate specialist

Treatment with these drugs will be initiated by the specialist, who is responsible for prescribing until shared care is agreed. Any GP who does not wish to undertake the clinical and legal responsibility for a shared care drug is not obliged to undertake the prescribing.

***These Shared Care Guidelines are clinical guidelines only. Please contact your PCT GP contract lead to discuss funding issues.***

**Initiating Therapy**
Having assessed the patient and discussed with them the benefits, side effects, frequency of dosing and monitoring requirements of the drug the specialist team will send a letter to the GP asking whether the GP will agree to share care for the patient. The GP will notify the specialist, in writing, whether or not he/she agrees to share care and prescribe for the patient.

A Shared Care Agreement Letter is included in Appendix 1 to facilitate this process.

**The Guidelines**
The information is derived from relevant references and expert advice and is intended to be sufficient to empower a non-specialist prescriber to undertake the prescribing responsibility for the drug. However, in order to keep the guidelines concise there may be occasions when prescribers need to contact the specialist team for further information.

Each guideline contains the following information:

- Indications
- Dosage, including target/maintenance range and titration details, if any
- GP Monitoring required, including appropriate actions to abnormal results
- References and sources of additional information.
- Side effects
- Drug interactions
- Other relevant clinical information may be included, such as usage in pregnancy, additional vaccination requirements etc.
- Specialist team responsibilities, including those required to initiate therapy as well as ongoing responsibilities.
- GP responsibilities
- Patient's responsibilities
- Contact details of the specialist teams concerned

Please note, new guidelines will only be written when it has been agreed that shared care is an appropriate option.

**Individualised Management Plan for Exceptional Prescribing by GPs**

There may be occasions where a specialist, following discussion with and agreement by the GP, feels that an individualised management plan for an exceptional drug should be produced. An individualised management plan may be appropriate where

- The therapy being proposed is used exceptionally and it would not be appropriate to agree a formal shared care guideline. There should be no reason why a GP cannot prescribe the drug.
- A GP would need further information about the drug in order to prescribe it.
- The South Devon Joint Formulary does not specify that the drug should only be prescribed by a hospital specialist.
- The GP is happy to prescribe the drug, under an individualised management plan, but needs information to support him / her to take the legal responsibility for the prescribing.

Where a hospital specialist wishes the GP to prescribe a drug under an individualised management plan arrangement he / she should make personal contact with the GP to discuss whether such an arrangement would be appropriate.

If the GP is in agreement then the hospital specialist should write to the GP using the agreement letter (Appendix 2) and should produce an individualised management plan for exceptional prescribing, including sufficient information to enable the GP to prescribe the drug. A template for an individualised management plan is included as Appendix 2.

Where a GP is not happy to prescribe under an individualised management plan for exceptional prescribing then prescribing responsibility will remain with the hospital specialist.

# Appendix 1 Shared Care Agreement Letter

**Consultant Request**

To Dr ……..

Practice Address:

| |
|---|
| Patient Name |
| Hospital number |
| Date of birth |
| Address |

Diagnosed condition:…….

I recommend treatment with the following drug: ……

I am requesting your agreement to sharing the care of this patient according to the South Devon Shared Care Guideline for this drug. If you agree, I will send you, in writing, any additional information required for you to undertake prescribing responsibility, as laid down in the Shared Care Guideline.

Signed:…….. Date……

Consultant name:……..

Department:……..……

Contact telephone number: …….

**GP Response**

**I agree / do not agree*** to share the care of this patient in accordance with the Shared Care Guideline.

Signed:…….. Date……

GP name:……...

*Delete as appropriate

# Appendix 2 Individualised Management Plan for Exceptional Prescribing

a) Request letter

| | |
|---|---|
| Consultant Request<br><br>To Dr ……..<br><br>Practice Address: | Patient Name<br>Hospital number<br>Date of birth<br>Address |

Diagnosed condition:…….

I recommend treatment with the following drug: …….

Following our telephone conversation, I am writing to request your agreement to sharing the care of this patient according to the enclosed individualised management plan. If you agree, I will send you, in writing, any patient specific information required for you to undertake prescribing responsibility as laid down in the management plan, for example, results of blood tests.

Signed:…….. Date……

Consultant name:…….. Contact number: …….

Department:……..……..……

Enclosed: Completed Individualised Management Plan for Exceptional Prescribing

GP Response

I agree / do not agree* to share the care of this patient in accordance with the Individualised management plan.

Signed:…….. Date……

GP name:……...
*Delete as appropriate

## b) Template Individualised Management Plan for Exceptional Prescribing

| | | | |
|---|---|---|---|
| **Drug** | | **Patient** | |
| **Hospital Specialist** | | **GP** | |

This is an individualised management plan specific for the above named drug and patient.

| | |
|---|---|
| Indication(s) | |
| Dose | |
| Likely duration of treatment | |
| Formulation and strengths available | |
| Is the drug licensed for this indication? | |
| Side effects | |
| Drug interactions | |
| Other relevant clinical information, such as<br>Special precautions / warnings<br>Use in pregnancy<br>Renal / hepatic impairment<br>Additional vaccination requirements | |
| GP Monitoring required, including appropriate actions to abnormal results | |
| Specialist team responsibilities (initial and ongoing) | |
| GP responsibilities | |
| Patient's responsibilities | |
| Contact details of the specialist teams concerned | |
| References and sources of additional information. | |

## Appendix 3 List of Shared Care Guidelines with indications

| Guideline | Speciality | Indications |
|---|---|---|
| Ciclosporin | Rheumatology | Connective tissue disease (unlicensed) and rheumatoid arthritis. |

## Indications for this guideline

**Rheumatology**
Connective tissue disease (unlicensed) and rheumatoid arthritis.

## Dosage

- Patients will be stabilized by the specialist team before GPs will be asked to prescribe under this shared care agreement.
- Usual dosage is 1.25mg – 2.5mg per kg BD
- Preparations
- Capsules 10mg, 25mg, 50mg, 100mg.
- Oral solution 100mg per ml

| IMPORTANT | Prescribe as Neoral®. Different brands are not bioequivalent. |
|---|---|

## GP Monitoring

**Infection (e.g. persistent sore throat, fever) or easy bruising should be reported to specialist team.**

- Please copy all results to secondary care team.
- **Blood pressure and U&E every fortnight until dose stable for 3 months then every month.**
- **LFT & FBC monthly until dose stable for 3 months, then every 3 months.**
- **Please include CRP with LFT for Rheumatology.**
- **Serum lipids every 6 months.**

Seek advice from specialist team and consider stopping ciclosporin if any of the following occur:

- Creatinine rises by 30% of baseline.
- Potassium rises above normal range.
- Significant rise in lipids.
- Platelet count < 150
- ALT or AST > 120
- Alk Phos > 300

If blood pressure rises above normal range discuss with specialist team.

## Side effects (not covered by specific monitoring requirements)

- Some patients feel a burning sensation in their hands and feet during the first weeks of therapy. This may disappear with continued therapy, if not discuss this with specialist team.
- All patients put on this medication will be warned of the theoretical but as yet unquantifiable risk of lymphoproliferative disorders and other malignancies.

**Very common / common:**

- Hyperlipidaemia, hyperuricaemia, hyperkalaemia, hypomagnesaemia
- Tremor, headache, fatigue
- Paraesthesia, muscle cramps, myalgia
- Hypertension
- Gingival hypertrophy, gastro-intestinal disturbance
- Hepatic dysfunction
- Hypertrichosis

**Uncommon:**

- Anaemia, thrombocytopenia
- Rashes, oedema, weight gain

## Drug interactions: (refer to BNF, Appendix 1 for full list of interactions)

Drugs that activate or inhibit the hepatic microsomal p450 oxidation system will alter the elimination of ciclosporin. Concurrent administration of ciclosporin and interacting drugs is not precluded but requires close monitoring (e.g. when starting or stopping the interacting drug).

The following is a **GUIDE** to some of the interactions that may occur with ciclosporin therapy

| **Drugs that may Reduce blood levels** | **Drugs that may Increase blood levels** |
|---|---|
| Rifampicin | Erythromycin and other macrolides |
| Carbamazepine | Ketoconazole, fluconazole and itraconazole |
| Phenobarbitone/Primidone | Allopurinol |
| Phenytoin | Danazol |
| Octreotide | Doxycycline |
| Orlistat | Diltiazem, nicardipine, verapamil Methylprednisolone (high doses) |
| St John's Wort | Oral contraceptives and progestogens |
| | Propafenone |
| | Chloroquine |
| | Metoclopramide |
| | Amiodarone |
| | Ursodeoxycholic acid |
| | Protease inhibitors |
| | Grapefruit juice |

Care should also be taken using ciclosporin with:

- **Nephrotoxic drugs: NSAIDS** (including adjusting dosage), aminoglycoside antibiotics, ciprofloxacin (and other quinolones), aciclovir, trimethoprim, co-trimoxazole, amphotericin, melphalan and colchicine
- **Potassium-sparing agents**: Amiloride, spironolactone, ACE inhibitors.
- **Digoxin**: May increase digoxin levels. Monitor for digoxin toxicity.
- **Statins**: Increased risk of myopathy. Max. dose of Simvastatin

## Pregnancy and breastfeeding

May sometimes be used in pregnancy. Discuss with specialist team.
Breastfeeding is contraindicated. Ciclosporin passes into breast milk.

## Vaccinations and infectious illness

- Live attenuated vaccines are contraindicated in patients taking immunosuppressants unless stopped at least 3 months beforehand. Live vaccines include MMR, BCG, varicella-zoster and yellow fever vaccines.
- Where a patient has received a live vaccine allow at least 2, preferably 4, weeks before starting immunosuppressive therapy.
- Patients should be advised to avoid contact with anyone with active chickenpox and shingles.
- If a patient is vaccinated (with 'killed' vaccines) while taking immunosuppressants they may not mount the appropriate immune response. Consider repeating 3 months after therapy has ceased if antibody titres are low.
- If contact risk is significant (e.g. Varicella, Measles) discuss with specialist team and consider using specific immunoglobulin.
- Vaccinate against influenza annually and with Pneumovax® II every five years.

For additional information refer to the British Society of Rheumatology guidance on vaccinations for immunosuppressed patients at www.rheumatology.org.uk

## Initiating therapy

Having assessed the patient and discussed with them the benefits, side effects, frequency of dosing and monitoring requirements of ciclosporin treatment the specialist team will:-

- **Communicate with the patient's GP, in writing, and confirm that the GP agrees to share care, as described in the Introduction to Shared Care Guidelines.**
- Record the patient's confirmation of understanding of the risks, benefits and consent.
- Undertake baseline investigations, initiate and stabilise therapy.
- Specify dose, monitoring and review dates at clinically relevant time intervals for both the GP and specialist team and any other patient specific information.
- Ensure that full information is sent to the GP without undue delay and recommend that the GP continues treatment in accordance with this shared care guideline.

### Baseline investigations

Prior to therapy, FBC, LFT serum lipids and repeated measurements of U&Es including serum creatinine and blood pressure to establish baseline.

**Information given to patient**

A. Patient information leaflets may be available from some specialities.

## GP Responsibilities

**The GP will notify the specialist, in writing, whether or not he/she agrees to share care and prescribe for the patient, according to this guideline.**

B. Monitor for adverse effects and drug interactions and report adverse events to the CSM and specialist team.
C. Conduct blood tests, review results and undertake any necessary action as specified in GP Monitoring section above.
D. Report to and seek advice from the specialist team on any aspect of patient care which is of concern to the GP and may affect treatment.
E. Prescribe further supplies of ciclosporin according to the recomendations specified in this guideline.
F. Inform specialist team if treatment is stopped for any reason.

## Ongoing Specialist Team Responsibilities

- Review the patient at agreed intervals.
- Provide advice as requested by the GP.
- Assess patients referred back by GPs as soon as is practical.

## Patient's Responsibilities

- Report any adverse effects to their GP and / or specialist team.
- Ensure that they have a clear understanding of their treatment.
- Ensure they attend for monitoring requirements as specified in this shared care guideline.
- Be aware that treatment will be stopped it they do not attend for monitoring.

## Contact details for the Specialist Teams

**Rheumatology:**
Rheumatology Nurse Specialist: 01803 654 939
Rheumatology secretary: 01803 654 832
e-mail: rheumatology.sdhct@nhs.net

Out of Hours:
Medical SHO on-call via SDHCT switchboard (01803 614 567)

**Full Prescribing Information**
For full prescribing information please consult summaries of product characteristics and the current BNF.

## References


- eSPC for Neoral®, February 2005
- BNF 50, September 2005
- British Society for Rheumatology. National Guidelines for the Monitoring of Second Line Drugs, July 2000


The information contained in these shared care guidelines is issued on the understanding that it is the best available from the resources at our disposal at the time of issue. Please see Chapter 20 – Introduction to Shared Care Guidelines for more information.