Working in Partnership

SHARED CARE PRESCRIBING GUIDELINE

Drugs for the Treatment of Dementia – Shared and Transfer of Care, dementia with Lewy bodies, vascular dementia & Parkinson's disease dementia. This guideline applies to Bedfordshire, Luton and Milton Keynes

General Shared Care Guideline (SCG) Principles

- Medicines considered suitable for shared care are those which should be initiated by a Specialist, but where prescribing and monitoring responsibility may be transferred to Primary Care. Due to their potential side effects, shared care medicines usually require significant regular monitoring, and regular review by the Specialist is needed to determine whether the medicines should be continued. The best interest, agreement and preferences of the patient should be at the centre of any shared care agreement.

- The transfer of prescribing responsibility from the Specialist to the patient's General Practitioner (GP) or Primary Care prescriber should occur when both parties are in agreement that the patient's condition is stable or predictable, and that the Primary Care prescriber has the relevant knowledge, skills and access to equipment to allow them to monitor treatment as indicated in this shared care prescribing guideline.

- The aim of this guideline is to equip Primary Care prescribers with the information to confidently take on clinical and legal responsibility for prescribing the medication under a shared care agreement within their own level of competence.

- Within the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS), shared care guidelines are produced and updated through a robust governance process, following consultation with a wide range of key stakeholders. On this basis for BLMK ICS approved shared care guidelines, it is anticipated that Primary Care prescribers, upon individual assessment, will accept shared care for the patient if they felt it was clinically appropriate to do so and seek patient consent.

- If the Primary Care prescriber feels that a request for shared care cannot be accepted, i.e. falls outside of their own level of competence, they should initially seek further information or advice from the clinician who is sharing care responsibilities or from another experienced colleague in line with the General Medical Council (GMC) guidance.

- If the Primary Care prescriber is still not satisfied clinically to accept shared care, they should make appropriate arrangements for the patient's continuing care where possible. This may include asking another colleague in their practice to undertake the shared care. In the event that other colleagues in the practice also decline to share care, the Primary Care prescriber could seek assistance and advice from their Primary Care Network (PCN) (e.g. PCN Pharmacist).

- If the decision, after discussion with the PCN, is to decline shared care, the Primary Care prescriber must notify the Specialist clinician of their decision and reason (See annex 8) to decline as soon as they can and in a timely manner (within a maximum of 14 to 21 days upon receipt of request) in writing and ensure the patient is aware of the change. In this scenario, the prescribing responsibility for the patient remains entirely with the Specialist. This principle also applies where shared care needs to be terminated in primary care e.g. due to lack of patient engagement. It is anticipated that these would be very rare events.

- The requirement for the Primary Care prescriber to send confirmation in writing via letter or approved electronic communication to the Specialist team for acceptance of shared care is NOT mandated.

- Where the hospital or Specialist clinician retains responsibility for monitoring drug therapy and/or making dosage adjustments, the Primary Care prescriber must be informed of any dose changes made as soon as possible to avoid medication errors. Similarly, if the Primary Care prescriber makes changes to the

The following organisations contribute to and participate in the BLMK APC – Bedfordshire, Luton and Milton Keynes Integrated Care Board; Bedfordshire Hospitals NHS Foundation Trust; Cambridgeshire Community Services NHS Trust; Central and North West London NHS Foundation Trust; East London NHS Foundation Trust; Milton Keynes University Hospital NHS Foundation Trust.

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patient's medication regimen, the Primary Care prescriber must inform the Specialist in a timely manner. Primary Care prescribers can contact the Specialist team for advice, training and support as required.

- An agreed method of communication of blood test results and results of investigations between the Specialist, the Primary Care prescriber, the Community Pharmacist and the patient should be agreed at the onset of shared care and documented in the patient's notes in both Secondary care and Primary Care. Blood test results can usually be accessed electronically by both Secondary Care and Primary Care prescribers in the majority of cases. For some medications and in certain cases, the patient may elect to have a patient-held monitoring booklet, e.g. those on warfarin and lithium therapy.

- The principles above apply to shared care arrangements that involve the Specialist service sharing care with GPs and/or other Primary Care prescribers, e.g. Community Nursing Services. Where patient care is transferred from one Specialist service or GP practice to another, a new shared care agreement request must be commenced.

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Drugs for the Treatment of Dementia – Shared and Transfer of Care, dementia with Lewy bodies, vasculardementia & Parkinson's disease dementia)

Introduction and Aims of Shared Care (including a brief overview of the condition being treated for):

To outline the prescribing responsibilities between primary and secondary care to enable primary care to safely take over prescribing after initiation and stabilisation by the specialist team.

The recommendations for prescribing follow national (NICE) guidance as outlined below:-

NICE guidance

Prescribing of cognitive enhancing drugs for the management of Dementia should bein accordance with:-

- NICE TA 217 (Mar 2011) (Donepezil, galantamine, rivastigmine and memantine forthe treatment of Alzheimer's disease) updated as a result of NICE NG 97 (Dementia: assessment, management and support for people living with dementia and their carers) for the treatment of Alzheimer's Disease
- NICE NG 97 (June 2018) for Non-Alzheimer's Dementia
- NICE NG 71 (July 2017) (Parkinson's Disease in Adults) for Parkinson's Disease Dementia

A summary of the recommendations is outlined below:

Alzheimer's Disease

As per NICE NG 97 (Dementia: assessment, management and support for people living withdementia and their carers) & NICE TA 217 (Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease):

- The three acetylcholinesterase (AChE) inhibitors donepezil, galantamine and rivastigmine as monotherapies are recommended as options for managing mild tomoderate Alzheimer's disease.
- Memantine monotherapy is recommended as an option for managing Alzheimer's disease for people with moderate Alzheimer's disease who are intolerant of or have acontraindication to AChE inhibitors.
- Memantine monotherapy is also recommended as an option for managing severeAlzheimer's disease.
- For people with an established diagnosis of Alzheimer's disease who are already takingan AChE inhibitor, clinicians can:

    - **consider memantine in addition to an AChE inhibitor in moderate disease, as well as**
    - **offer memantine in addition to an AChE inhibitor in severe disease.**

- For people who are not taking an AChE inhibitor or memantine, prescribers should onlystart treatment on the advice of a clinician who has the necessary knowledge and skills.
- Following discussions at locality level as to when prescribing of cognitive enhancing drugs (CEDs) should move to primary care, and a decision has been made that GPs wish to maintain the status quo (i.e.. AChE inhibitors and memantine are initiated by the Specialist team and shared care can be requested once the patient is on a stabilised dose (usually after 3 months). **The only change to this shared care guideline is to allow GPs the ability to initiate memantine when used as an adjunct to AChE inhibitors in moderate and severe Alzheimer's disease if considered appropriate. This only applies to clinicians who have received training and are comfortable to manage this addition.**
- Treatment should be continued only when it is considered to be having a worthwhileeffect on cognitive, global, functional or behavioural symptoms.
- Patients who continue on treatment should be reviewed regularly using cognitive, global,functional and behavioural assessment. Carer's views on the patient's condition on follow-up should be sought.
- AChE inhibitor treatment should normally be started with the drug with the lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started). However, an alternative AChE inhibitor could be prescribed ifconsidered appropriate taking into account adverse event profile, expectations about adherence, medical comorbidity, possibility of drug interactions and dosing profiles.

  Following a review of the NICE guidance (outlined above), the mental health lead GP has had discussions at locality level as to when prescribing of CEDs should move to primary care, and a decision has been made that GPs wish to maintain the status quo (i.e. AChE inhibitors and memantine are initiated by the Specialist team and shared care can be requested once the patient is on a stabilised dose [usually after 3 months]). GPs can, however initiate memantine when used as an adjunct to acetylcholinesterase (AChE) inhibitors in moderate and severe Alzheimer's disease if considered appropriate. This only applies to clinicians who have received training and are comfortable to manage this addition.

Dementia with Lewy Bodies (DLB)

As per NICE NG 97 (Dementia: assessment, management and support for people living withdementia and their carers):

- Donepezil or rivastigmine can be offered to people with a diagnosis of mild tomoderate DLB. (The use of these drugs for this indication is off-label.)
- Only consider galantamine for people with mild to moderate DLB if donepezil and rivastigmine are not tolerated. (The use of galantamine for this indication is off-label.)
- Donepezil or rivastigmine can be considered for people with severe DLB. (The use ofdonepezil or rivastigmine for this indication is off-label.)
- Memantine may be considered for people with DLB if AChE inhibitors are not tolerated or are

contraindicated. (The use of memantine for this indication is off-label.)

Dementia in Parkinson's Disease

As per NICE Guideline 71 (Parkinson's disease in adults):

- AChE inhibitors can be offered to people with mild to moderate Parkinson's diseasedementia. (The use of these drugs for this indication is off-label.) Rivastigmine has a license for use in mild to moderate dementia in patients with idiopathic Parkinson's Disease.
- AChE inhibitors can be considered for people with severe Parkinson's diseasedementia. (The use of these drugs for this indication is off-label.)
- Only consider memantine for people with Parkinson's disease dementia if AChEinhibitors are not tolerated or contraindicated. (Off-label.)

Vascular Dementia

As per NICE NG 97 (Dementia: assessment, management and support for people living withdementia and their carers):

- AChE inhibitors or memantine should only be considered if the person also has suspected comorbid Alzheimer's disease, DLB or Parkinson's disease dementia.(The use of these drugs for this indication is off-label.)
- Do not offer AChE inhibitors or memantine to people with frontotemporal dementia.
- Do not offer AChE inhibitors or memantine to people with cognitive impairmentcaused by multiple sclerosis.

1. AREAS OF RESPONSIBILITY

Summary of Specialist / Memory Assessment Service (MAS) / Community Mental Health Team (CMHT) Responsibilities:

- Obtain patient informed consent for sharing of care between the Specialist, Primary Care prescriber and patient. Consenting parties must have sufficient, accurate, timely information in an understandable form. Consent must be given voluntarily and must be documented in the patient's notes.
- Confirm the diagnosis of Dementia, including subtype where possible.
- Assess the likelihood of patient/carer compliance.
- Counsel carers as to the likely benefits and risks of treatment, including theconsequence of poor compliance.
- Offer advice as to the limited effectiveness of treatment over time as the illnessprogresses.
- Clear documentation of mental capacity assessments/power of attorney in patient notes.
- For the majority of patients, the Specialist will accept referral without an ECG, however in exceptional cases an ECG may be required. In these exceptional cases the Specialist clinician will discuss with the patient's GP. If the GP is unable to facilitate an ECG, the responsibility for undertaking the ECG remains with the specialist service. NB – responsibility for interpretation of the ECG remains with the Specialist Service.
- Offer an initial trial period of treatment for approximately 3 months of cognitive enhancingdrug (CED), and assess response during, and at the end of the trial period. The dose should be titrated according to response and tolerance.
- On initiation, provide the GP and patient with information about treatment; particularly with regard to stopping treatment, the conditions/circumstances when treatment may be stopped; and the benefits that might be expected from a successful trial period for that patient in accordance with NICE TA 217, NICE Guideline 97 and NICE Guideline 71, as appropriate.
- Provide the GP, in the form of a detailed report, information relating to the initial memory clinic assessment. The memory assessment Clinic will inform the GP of progress with dose titration at weeks 4 or 8, 12 or 16 (depending on the cognitive enhancing drug prescribed) during the medication titration phase.
- On discontinuing /adjusting treatment, consider restarting/switching treatment if the patient

experiences a dramatic deterioration of cognitive function or unacceptable side effects. Inform GP/ and patient/carer of rationale.

- Prior to transfer of prescribing, the Specialist will:
  - Ensure that patients (and their caregivers, where appropriate) are aware of and understand their responsibilities to attend appointments and the need for continued monitoring arrangements.

Shared Care

- Contact the GP to request shared care. The Specialist will document the decision to transfer prescribing of the treatment to the Primary Care prescriber via the shared care guideline in the patient's hospital medical notes. If the Primary Care prescriber declines the request for shared care and the Specialist is therefore responsible for the prescribing of the medication for the patient, the Specialist will document this also in the patient's hospital medical notes.
- Shared care to be started once patient has been stabilised on CED medication - typically at around 3 months.
- Following the request to the patient's Primary Care prescriber to initiate shared care; to ensure that the patient has an adequate supply of medication until shared care arrangements are in place. Further prescriptions will be issued if, for unforeseen reasons, arrangements for shared care are not in place by the anticipated start date of the shared care.
- ***Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme.***

Transfer of Care

- When a requisite response has been achieved at a dose commensurate with patient tolerability (usually up to 6 months) consideration can be given to transferring the ongoing monitoring of the CED to the GP. Thus, the request for the transfer of care will usually be made when the patient has been stable up to 6 months of treatment.
- The GP practice need to confirm the acceptance of the transfer of care and if the GP practice is happy to accept, the following information (as a minimum) has to be provided by the memory assessment service to the GP in order that the ongoing prescribing and monitoring can be taken on by the primary care:
  - Transfer of care guidelines. (Annex 6 and 7)
  - Clear diagnosis and care plan
  - Confirmation that the patient has undergone the appropriate assessments and shown a beneficial response to treatment and is now stable on a maintenance dose of dementia drug.
  - Specialist team contact details must be provided so that GPs can obtain advice and support, especially in the case of adverse events noted by the GP or the patient which require specialist intervention. **An initial response should be received within 24 – 48 hours.**
  - That patient has been fully informed with regards to their treatment and consenthas been discussed and documented including the change in where their futureprescriptions will be issued from
- Patients with a diagnosis of mild cognitive impairment along with chronic disease (e.g. diabetes mellitus, hypertension, previous cerebrovascular accident) need to have a follow-up appointment at the memory clinic after 12 months.
- Prescriptions should always be generated in the generic form.

Summary of GP responsibilities:

Pre-Assessment and Diagnosis

- Provide a full drug/medical history (preferably as recorded on the GP computerised records) using the relevant Specialist dementia referral template to the Memory Assessment Service as per referral pathway.
- Prior to referral to the Memory Assessment Service, perform an initial blood screen to rule out possible causes for cognitive impairment (FBC, ESR, U&E, LFT, eGFR measurement, calcium profile, blood glucose, TFT, B12 and red cell folate).
- For the majority of patients, the Specialist will accept referral without an ECG, however in exceptional cases an ECG may be required. In these exceptional cases the Specialist clinician will discuss with the patient's GP. If the GP is unable to facilitate an ECG, the responsibility for undertaking the ECG

remains with the Specialist Service.

- At the time of referral, inform the specialist clinician regarding the availability of a carer orcare-worker in order to ensure compliance with treatment. Ensure that carer contact details are included within the referral.

Post-Assessment, Diagnosis, Agreement to Accept Shared Care and ultimately, Transfer of Care

- Once the patient has been adequately stabilised and benefit from cognitive enhancing drug therapy has been demonstrated, the GP will accept prescribing responsibility for the relevant CED drug, usually after 3 months (shared care).
- Review the request from the specialist to take on the transfer of prescribing andmonitoring of the patient. (up to 6 months).
- Once the patient has been adequately stabilised (psychologically, behaviourally and medication optimised) and benefit from cognitive enhancing drug therapy has been demonstrated, the GP will accept prescribing and monitoring responsibility for the relevant drug, usually after 6 - 8 months (transfer of care).
- If prescribing responsibility is not accepted, GP should inform the memory clinic (within 2 weeks), using the transfer of care template letter, providing a clinical reason for not accepting the transfer of care. (Annex 6 and 7)
- Transfer of care can be refused by GP if information provided from the memory assessment service is insufficient.
- Monitor the patient's overall health and wellbeing during the normal consultation process and monitor progression annually. Refer back to Older Peoples CMHT if there is deterioration in cognitive function which requires further investigation or emergence of Behavioural and Psychological Symptoms of Dementia.
- Undertake minor dosage adjustments if necessary, in accordance with specialist advice.
- Check for possible drug interactions when newly prescribing or stopping concurrent medication.
- Report any suspected adverse event to the specialist clinician and, if appropriate, to the MHRA.
- Deal with any concomitant illness, with specialist clinic support if appropriate.
- Inform the specialist clinic of life situation changes which may require revaluation in thesuitability of cognitive enhancing drugs for the patient.
- For people with an established diagnosis of moderate Alzheimer's disease who are already taking an AChE inhibitor, GPs can consider the addition of memantine therapy tothe AChE inhibitor.
- For people with an established diagnosis of severe Alzheimer's disease who are alreadytaking an AChE inhibitor, GPs should offer the addition of memantine therapy to the AChE inhibitor.

Patients should be referred back to the Specialist Service in the following circumstances:

- When discontinuation of treatment is being considered.
- Difference of opinion between primary care team and carer about stoppingmedication.
- Uncertainty about side effects or benefits.
- Behavioural problems that would require the community team whether or not the patient is taking anti-dementia medication.
- If the GP would prefer a specialist opinion before initiating memantine as an adjunct therapy in patients with moderate to severe Alzheimer's disease. (See above)

On discontinuation / amendment of treatment by secondary care, refer back to a specialistclinician if the patient is observed to experience a dramatic deterioration in cognitive function. Monitor and if necessary refer back to secondary care, any patients with behavioural/physiological symptoms which require further investigation, assessment and management.

Ongoing Monitoring Requirements in Primary Care

Annual Monitoring Review in Primary Care

For QOF there should be an annual review done. An Ardens Template is available for use across BLMK.

The review should encompass the following aspects (see below for further detail):

- Physical health monitoring.
- Impact on global functioning.
- Monitoring for adverse effects and drug interactions.
- Checking compliance (including information on missed doses).
- Checking whether the medication is still of overall benefit and info re stopping medication.

Physical Health Monitoring

Physical Health Monitoring	Rationale for Required Monitoring
Weight	If weight loss has started or accelerated after starting an AChE inhibitor medication, this may be the cause.
Pulse	If <60, or irregular carry out an ECG. If PR interval > 200ms, stop drug or discuss with mental health specialist.
U+Es with eGFR and LFTs	Donepezil, Galantamine and Rivastigmine- avoid in severe hepatic impairment. Caution in mild to moderate impairment. Clinical benefit needs to be weighed before plan is made to continue anti dementia medications in patients with mild to moderate hepatic impairment. If concerns, then refer to secondarycare. Memantine should be avoided in severe hepatic impairment. Galantamine- avoid if eGFR is less than 9ml/min/1.73 m2 Avoid in severe hepatic impairment (Child-Pugh score >9), and maximum daily dose of 16mg for moderate impairment (Child-Pugh score 7-9). Rivastigmine- titrates according to individual tolerability. Memantine- Reduce dose to 10mg if eGFR 30-49 ml/min/1.73 m2.If well tolerated after at least 7 days dose than can be increased insteps of 5mg up to 20mg daily. Reduce dose to 10mg if eGFR 5-29 ML/min/1.73 m2, avoid if eGFR less than 5ml/min/1.73 m2. **For further information – see relevant drug fact sheet below (annex 2-5)**
Overall tolerance to medication	GI symptoms - anorexia, nausea, vomiting and diarrhoea Neurological symptoms – headaches, dizziness, drowsiness, syncope

Impact on Global Functioning

Functional and Behavioural Assessment. This is best made via a discussion with the patient and carer. Please note it might be important to see the carer alone to elicit behavioural problems.

Functional Assessment	Impact on daily living. Is there declining function?
Carer Impact	Does the carer value the effect / impact of the medication?
Behavioural Assessment	Any new behavioural problems / issues? Is the service user displaying behavioural and physiological symptoms of dementia (BPSD)?
Cognitive Assessment	Some patients distressed by repeated use of formal cognitive scoring tests. Thus, it is not always necessary to repeatedly to use a formal scale to measure cognition as this can also be assessed via the patient and carer interview. It is also important to consider the global functioning of the patient by discussion with the carer / relatives. When the use of a formal cognitive scoring test is appropriate (e.g. when there has been a significant deterioration in the global functioning) consider using either of the following open access primary care validated scales – 6CIT (six item cognitive impairment test) or GPCOG (General Practitioner Assessment of Cognition).

Monitor for adverse effects and drug interactions, the most relevant are:

- Exacerbation of asthma and COPD
- Anorexia and weight loss
- GI ulcer or bleed
- AV node block as a possible cause of collapse
- Potential additive effects with other drugs that share the same side effects (e.g. beta- blockers and bradycardia; SSRIs and anorexia)

Compliance

- Is the medication being taken properly?

Missed Doses

If medication doses have been missed, refer to *Table 1* below for appropriate action.

Table 1: Re-titration following AChE inhibitor missed doses or planned treatment breaks.

Medicine	Treatment break	Action
Donepezil	7 days or less	Resume at the same dose
	>7 days	Re-titrate from 5mg daily
Rivastigmine (capsules and oral solution)	3 days or less	Resume at the same dose
	>3 days	Re-titrate from a dose of 1.5mg twice a day
Rivastigmine patch	3 days or less	Resume at the same dose
	>3 days	Re-titrate from 4.5mg/24 hours
Galantamine (oral solution, tablets or XL capsules)	7 days or less	Resume at the same dose
	>7 days	Re-titrate from a dose of 8mg daily (4mg twice a day if oral solution or tablets, 8mg once a day if XL capsules

<u>Is the medication still of overall beneficial to the patient?</u>

Stopping Medication

Medication should be stopped if:

1. There is no cognitive, behavioural, functional or global benefit.
For GP management it is anticipated that if there is still an overall benefit and providing thepatient is tolerating the treatment and there are no contraindications, the treatment will be maintained until such a time as it becomes inappropriate such as in extreme frailty.

2. If the patient cannot tolerate side effects
It is advisable to give reducing doses – e.g. donepezil 5 mg od for a month if the patient hasbeen taking 10mg. Similar gradual reduction with other drugs may be used.

If there are concerns about response to treatment or if the patient develops adverse effects, referback to the specialist for a review of treatment and discontinuation if necessary. If adverse effects are significant, the GP should stop treatment in advance of the specialist's review.

Factors that need to be taken into account when/if considering stopping acetylcholinesterase inhibitor:

- A subacute decline in cognitive performance, in the absence of other causes, mayindicate that the AChE inhibitor is no longer effective.

- Family/patient views and expectations need to be taken into account.
- Medical complications? For patients with increasing physical problems, the risks ofstopping AChE inhibitors need to be weighed against the likelihood of developing new complications on continuing AChE inhibitors.
- To what extent is the AChE inhibitor contributing the patient's quality of life if they are increasingly physical frail?
- For patients at risk of entering care home, stopping an AChE inhibitor may disrupt care and hasten admission.
- Once a patient is in a care home individual patient factors need to be taken into account when deciding if memory-enhancing medication is right for them.

There is no firm evidence on how to stop AChE inhibitors however it is recommended that discontinuation should be by gradual dose reduction (*see table 2 below*). The patient should be closelymonitored for any subsequent deterioration and consideration given to the need to reinstate treatment.

Table 2: Stopping AChE inhibitors

Donepezil	Long half-life, so can be stopped without the need for tapering, however it may be advisable to reduce to 5mg daily for a month and monitor for deterioration before stopping altogether.
Rivastigmine	Short half-life, reverse titration recommended (i.e. a reduction of 1.5 to 3mg every two to four weeks.
Galantamine	Long half-life, so can be stopped with the need for tapering. However, it may be advisable to gradually reduce the dose over a month and monitor for deterioration before stopping altogether.

Patient and/or carer

- To provide their informed consent for sharing of their care with the Specialist and Primary Care prescriber. Consenting parties must have sufficient, accurate, timely information in an understandable and accessible format. Consent must be given voluntarily and must be documented in the patient's notes. Supporting information is available from NICE "Making decisions about your care".
- To take their medication as agreed, unless otherwise instructed by an appropriate healthcare professional.
- To meet all necessary monitoring arrangements to ensure the safe prescribing of their medication, and to alert the prescriber where these arrangements are not met.
- To attend all follow-up appointments with the Primary Care prescriber and Specialist. If the patient is unable to attend any appointments, they should inform the relevant practitioner as soon as possible and arrange an alternative appointment.
- Inform healthcare professionals of their current medications prior to receiving any new prescribed or over-the-counter medication.
- Report all suspected adverse reactions to medicines to their Primary Care prescriber.
- Store their medication securely away from children and according to the medication instructions.
- Read the information supplied by their Primary Care prescriber, Specialist and Pharmacist and contact the relevant practitioner if they do not understand any of the information given.
- An agreed method of communication of results of investigations between the Specialist, the Primary Care prescriber, the Community Pharmacist and the patient should be agreed at the onset of therapy.
-

Community Pharmacist

Aid in the monitoring for adverse effects and drug interactions. The most relevant of these are also listed in the GP section above:

- Exacerbation of asthma and COPD
- Anorexia and weight loss
- GI ulcer or bleed

- AV node block as a possible cause of collapse
- Potential additive effects with other drugs that share the same side effects (e.g. beta-blockers and bradycardia; SSRIs and anorexia)

- Know where to access locally agreed shared care guidelines to aid professional clinical check of prescription prior to dispensing.
- Professionally check prescriptions to ensure they are safe for the patient and contact the Primary Care prescriber if necessary to clarify their intentions.
- Fulfil legal prescriptions for medication for the patient unless they are considered unsafe.
- Counsel the patient on the proper use of their medication.
- Advise patients suspected of experiencing an adverse reaction to their medicines to contact their Primary Care prescriber or Specialist/Specialist nurse team.

2. COMMUNICATION AND SUPPORT

Hospital / Specialist contact information *(The referral letter will indicate named consultant)*	**Out-of-hours contact details & procedures as well as specialist support / resources available to Primary Care Prescribers (including patient information):**
ELFT: **Bedford Memory Assessment Centre** Whitbread House Twinwoods Health Resource Centre Telephone Number: 01234 275 464 Email: elft.bedfordmascmht@nhs.net **Luton Memory Service** Bungalow 2 Beech Close Dunstable Telephone: 01582 656 528 Email: elft.Lutonmas@nhs.net **Mid Beds Memory Assessment Service** The Lawns Resource Centre Biggleswade Telephone: 01767 223 314 Email: elft.mbmas@nhs.net **South Bedford MAS Team** Bungalow 2 Beech Close Dunstable Telephone: 01582 707 557 Email: elft.bedfordshiremas@nhs.net **CNWL:** **MK Healthy Ageing Team** Stantonbury Health Centre Stantonbury Milton Keynes MK14 6BL Telephone: 01908 801020 Email: cnw-tr.miltonkeynes.sms.referrals@nhs.net	**ELFT:** **For Bedfordshire**: The Dementia Intensive Support Service (DISS) provides specialist support to those living dementia, as well as family, carers, and professionals caring for those with the condition. DISS operates 9am – 8pm 24/7 year-round and provides an urgent response to people living with dementia in their own homes and care settings. The team provides: - A response within four hours. - Timely and effective assessment and excellent care planning strategies. - Advice and support to enable people to stay in their own homes with reduced levels of distress and a better quality of life. - Specialist training to those working in care homes, domiciliary care as well as family members who want to keep their loved ones in their own homes for longer. The service is ONLY open to anyone registered with a Bedfordshire GP (excludes Luton) and is commissioned by Bedfordshire, Luton and Milton Keynes ICB. Telephone: 07880 078 843 Email: elft.diss@nhs.net **For Luton**: GPs can contact the second on-call doctor via the Duty Senior Nurse (DSN) for out of hours support. Telephone: 07930 445215 **CNWL (for Milton Keynes):** Out of hours (urgent advice line for family and carers of Older Adults with dementia): 0800 0234 650 Out of hours procedure (Crisis team support for prescribers and other professionals): 01908 724501 A specific crisis team support pathway for dementia patients is unavailable: patients/carers to call the above number or present at A&E.

This shared care guideline is to be read in conjunction with the following documents:

- **RMOC Shared Care Guidance – link here**
- **NHSE/NHSCC guidance – items which should not be routinely prescribed in Primary Care: guidance for CCGs – link here**
- **NHSE policy – Responsibility for prescribing between Primary & Secondary/Tertiary Care – link here**

Annex 1 – Definitions

Severity of Dementia

(from ICD -11)

- Mild – New learning mainly affected. Impaired performance in daily living but not to adegree it makes the individual dependent on others.
- Moderate – Degree of memory loss represents a serious handicap to independent living.Unable to function without assistance of another in daily living.
- Severe – Complete inability to retain new information, failure to recognise close relatives. Absence of intelligible ideation.

In clinical trials staging of dementia has tended to be defined by Mini Mental State score.

- Scores above 18/30 defined as “mild”,
- 10 to 18 defined as “moderate”
- And below 10 “severe”

Specialist Clinicians

Specialist clinicians (for the purpose of starting and monitoring treatment with acetylcholinesterase inhibitors and memantine) are those with the appropriate knowledge and skills and include secondary care medical specialists (for example psychiatrists, geriatricians and neurologists)and other healthcare professionals (for example GPs, nurse consultants and advanced nursepractitioners) with specialist expertise in diagnosing and treating dementia**.**

Annex 2 – Donepezil Drug Fact Sheet[1,2]

(*For full information consult the latest Summary of Product Characteristics and the BNF)*

Formulation

Tablets / Oro-dispersible tablets / Oral solution. Please note that the use of any pharmaceutical form other than solid oral tablets should be clinically justified by concordance issues or sensitivity to side effects. Oro-dispersible tablets and liquid preparations may be considerably more expensive, and should only be used where it is clinically indicated (e.g. patients with established swallowing difficulties).

Dosage and Administration

Following a one-month clinical assessment of treatment at 5mg/day, the dose may be increased to 10mg once a day, which is the maximum recommended daily dose.
For patients with renal impairment, the dosage schedule is the same. Due to possible increased exposure in mild to moderate hepatic impairment, dose escalation should be performed according to individual tolerability. No data is available for patients with severe hepatic impairment.

Precautions and Warnings

- Reports of syncope and seizures. In investigating such patients, the possibility of heartblock or long sinus pauses should be considered.
- Not recommended for use in children and adolescents below 18 years of age.
- May affect the heart rate (e.g. bradycardia) which may be of particular importance in patients with sick sinus syndrome or other supraventricular cardiac conduction conditions e.g. sinoatrial or A-V block. Cases of QTc interval prolongation have also been reported.
- Patients at increased risk for developing ulcers e.g. those with a history of ulcer disease or those receiving nonsteroidal anti-inflammatory drugs (NSAIDs) should be monitored for symptoms.
- May cause Neuroleptic Malignant Syndrome (rarely). If patient develops hyperthermia, muscle rigidity, fever or unexplained weight loss, discontinue treatment.
- Drugs of this class may cause bladder outflow obstruction, and are also believed to have some

potential to cause generalised convulsions and may have the potential to exacerbate or induce extrapyramidal symptoms.
- Prescribe with care to patients with a history of asthma or chronic obstructive pulmonary disease.
- Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiencyor glucose-galactose malabsorption should not take tablet formulations.
- Do not use in pregnancy unless clearly indicated.

Contraindications

- Patients with a known hypersensitivity to donepezil, piperidines (e.g. terfenadine, azatadine, cyproheptadine, astemizole, loratadine) or any excipients used in theformulation. (e.g. lactose, maize, starch, cellulose, hyprolose, magnesium stearate
- Breast feeding mothers.

Interactions

- Avoid concomitant administration of donepezil with other acetylcholinesterase inhibitors or agonists/antagonists of the cholinergic system.
- In vitro studies suggest that some enzyme inhibitors such as ketoconazole, quinidine, itraconazole, erythromycin and fluoxetine could inhibit the metabolism of donepezil, resulting in increased donepezil levels.
- Enzyme inducers such as rifampicin, phenytoin, carbamazepine and alcohol may reduce the levels of donepezil. Synergy may occur with concomitant treatment with succinylcholine, other neuro-muscular blockers or cholinergic agonists or beta blocking agents, which have effects on cardiac conduction.
- The above drug combinations should be used with care.

Side effects

Common or very common nausea, vomiting, anorexia, diarrhoea, fatigue, insomnia, headache, dizziness, syncope, psychiatric disturbances, muscle cramps, urinary incontinence, rash, pruritus; **less commonly** bradycardia, seizures, gastric and duodenal ulcers, gastro-intestinal haemorrhage; **rarely** sino-atrial block, AV block, liver dysfunction including hepatitis, potential for bladder outflow obstruction, extrapyramidal symptoms; **very rare** neurolepticmalignant syndrome, rhabdomyolysis.

Effects on ability to drive and use machines

Alzheimer's Dementia may cause impairment of driving performance or compromise the ability to use machinery. Furthermore, donepezil can induce fatigue, dizziness and muscle cramps, mainly when initiating or increasing the dose. The ability of Alzheimer patients on donepezil to continue driving or operating complex machines should be routinely evaluated by the treating physician.

References

1. *Donepezil 5mg film-coated tablets SPC, updated Jan 2023, Accessed Aug 2023*
2. *Electronic BNF accessed Aug 2023*

Annex 3 – Galantamine Drug Fact Sheet[1,2,3]

(*For full information consult the latest Summary of Product Characteristics and the BNF*)

Formulation

Tablets / Prolonged Release Capsules / Oral solution. Please note that the use of any pharmaceutical form other than solid oral tablets should be clinically justified by concordance issues or sensitivity to side effects. Prolonged Release Capsules and liquid preparations may be considerably more expensive, and should only be used where it is clinically indicated (e.g. patients with established swallowing difficulties).

Dosage and Administration

Galantamine tablets and oral solution should be administered twice a day, preferably with morning and evening meals. Galantamine prolonged release capsules should be administered once-daily in the morning, preferably with food. The capsules should be swallowed whole with some liquid. The capsules must not be chewed or crushed. Ensure adequate fluid intake during treatment.

- *Initial dose – 8mg/day (4mg twice daily for normal release tablets) for at least 4 weeks.*
- *Maintenance dose – 16mg/day (8mg twice daily for normal release tablets) for at least 4 weeks. An increase to the maintenance dose of 24mg/day (12mg twice daily for normal release tablets) should be considered on an individual basis depending on response to drug and tolerability.*
- *In individual patients not showing an increased response or not tolerating 24mg/day, a dose reduction to 16mg/day should be considered.*

In Mild to Moderate Renal impairment (contra-indicated in severe renal impairment) the normal dosing schedule applies. In Mild to Moderate hepatic impairment (contra-indicated in severe hepatic impairment) using the tablets/oral solution initiate at 4mg daily for 1 week then 4mg twice daily for at least 4 weeks. If using the prolonged release capsules initiate at 8mg every other day for one week then 8mg once-daily for 4 weeks. Daily doses in these patients should not exceed 16mg.

Precautions and Warnings

- Weight loss during therapy has been reported – monitor patient's weight.
- May cause bradycardia – particularly important in patients who have sick sinus syndrome, or other supraventricular cardiac conduction disturbances or who are already receiving drugs which significantly reduce the heart rate e.g. digoxin, beta blockers, or for patients with uncorrected electrolyte disturbance.
- Caution should be exercised when administering galantamine to patients with cardiovascular diseases e.g. immediate post-myocardial infarction period, new-onset atrial fibrillation, second degree heart block or greater, unstable angina pectoris, or congestive heart failure, especially NYHA group III – IV.
- In a pooled analysis of placebo-controlled studies in patients with Alzheimer dementia treated with galantamine an increased incidence of certain cardiovascular adverse events were observed (supraventricular extrasystoles, AV block, sinus bradycardia).
- Serious skin reactions (Stevens – Johnson syndrome) has been associated with galantamine. Discontinue treatment at the first appearance of a skin rash.
- Patients at increased risk of developing peptic ulcers e.g. those with a history of ulcer disease or predisposed to these conditions should be monitored for symptoms. Not recommended in patients with gastro-intestinal obstruction or recovering from gastro- intestinal surgery.
- Drugs of this class are believed to have some potential to cause generalised convulsions.
- Cerebrovascular events were uncommonly observed in pooled placebo studies with galantamine. This should be considered when administering galantamine to patients with cerebrovascular disease.
- Prescribe with care in patients with a history of severe asthma or obstructive pulmonary disease or active pulmonary infections.
- Not recommended in patients with urinary outflow obstruction or recovering from bladder surgery.
- Use with caution in a pregnant patient.

Contraindications

- Known hypersensitivity to galantamine, or any excipients in the formulation.
- Severe hepatic (Child-Pugh score greater than 9) and/or renal (creatinine clearance lessthan 9 ml/min) impairment.
- Breastfeeding women.

Interactions

- Should not be given concomitantly with other drugs of this class.
- May interfere with the activity of anticholinergic medication.
- May interact with drugs which significantly reduce the heart rate e.g. digoxin, beta blockers, certain calcium-channel blocking agents and amiodarone. Caution should be taken with medicinal products that have potential to cause torsade de pointes.
- May exaggerate effect of succinylcholine (and related) muscle relaxants.
- Drug interaction studies indicated that some enzyme inhibitors reduced the metabolism of galantamine resulting in higher bioavailability. Therefore, during initiation of treatment with potent enzyme inhibitors (e.g. quinidine, paroxetine, fluoxetine, fluvoxamine, ketoconazole, ritonavir, erythromycin) patients may experience an increase in cholinergic side-effects, predominantly nausea and vomiting. A reduction in galantamine maintenance dose (based on tolerability) may be considered.

Side-effects

Common and very common nausea, vomiting, diarrhoea, abdominal pain, dyspepsia, syncope, rhinitis, sleep disturbances, dizziness, confusion, depression, headache, fatigue, anorexia, tremor, fever, weight loss; **less commonly** arrhythmias, blurred vision, hyperhidrosis, palpitations, myocardialinfarction, cerebrovascular disease, paraesthesia, tinnitus, and leg cramps; **rarely** atrioventricular block, bradycardia,hallucinations (auditory and visual) agitation, aggression, dehydration, hypokalaemia and rash; **very rarely** hepatitis, gastrointestinal bleeding, dysphagia, hypotension, exacerbation of Parkinson's disease, and Steven's Johnson syndrome.

Effects on ability to drive and use machines

Galantamine may cause dizziness and somnolence, which could affect the ability to drive or use machines, especially during the first weeks after initiation of treatment.

References

1. *Galantamine 4mg/mL oral solution SPC, updated Aug 2021. Accessed Aug 2023*
2. *Galantamine 8mg Prolonged Release Capsules (Reminyl XL) SPC, updated May 2022. Accessed Aug 2023*
3. *Electronic BNF accessed Aug 2023*

Annex 4 – Rivastigmine Drug Fact Sheet[1,2,3,4]

(*For full information consult the latest Summary of Product Characteristics and the BNF)*

Formulation

Capsules / Oral solution / Transdermal Patches. Please note that the use of any pharmaceutical form other than solid oral capsules should be clinically justified by concordance issues or sensitivity to side effects. Oral solution and transdermal patches may be considerably more expensive, and should only be used where it is clinically indicated (e.g. patients with established swallowing difficulties).

Dosage and Administration

Rivastigmine should be administered twice a day, with morning and evening meals. Capsules should be swallowed whole. The prescribed dose of the oral solution should be administered via the oral dosing syringe supplied.

- *Initial dose is 1.5mg twice daily for a minimum of two weeks treatment.*
- *Subsequent dose increases to 3mg bd, then 4.5mg bd and finally 6mg bd should be undertaken at a minimum of fortnightly intervals, only if the patient is tolerating the current dose.*
- *Maintenance dose: the effective dose is 3 to 6mg twice a day. 6mg twice a day is the recommended maximum daily dose.*
- *Re-initiation of therapy – if treatment is interrupted for more than three days, it should be re-initiated at 1.5mg twice daily. Dose titration should then be carried out as described above.*
- *Renal impairment: titrate dose according to individual tolerability.*
- *Hepatic impairment: Avoid in severe hepatic impairment. In mild to moderate impairment titrate dose cautiously according to individual tolerability.*
- *Treatment with rivastigmine patch starts with 4.6 mg/24 hours. Apply 4.6 mg/24 hours daily for at least 4 weeks, increased if tolerated to 9.5 mg/24 hours daily for a further 6 months, then increased if necessary to 13.3 mg/24 hours daily, increase to 13.3 mg/24 hours patch if well tolerated and cognitive deterioration or functional decline demonstrated. If treatment interrupted for more than 3 days, re-titrate from 4.6 mg/24 hours patch.*

- ***When switching from oral to transdermal rivastigmine:***
    - *Patients taking 3–6 mg by mouth daily should initially switch to 4.6 mg/24 hours patch, then titrate as above.*
    - *Patients taking 9 mg by mouth daily should switch to 9.5 mg/24 hours patch if oral dose stable and well tolerated*
    - *Patients taking 12 mg by mouth daily should switch to 9.5 mg/24 hours patch*
    - *In those patients in which the oral dose is not stable or well tolerated, should switch to 4.6 mg/24 hours patch, then titrate as above.*
    - *The first patch should be applied on the day following the last oral dose.*

- Transdermal patches should be applied once a day to clean, dry, hairless, intact healthy skin on the upper or lower back, upper arm or chest, in a place which will not be rubbed by tight clothing. It is **not** recommended to apply the transdermal patch to the thigh or to the abdomen due to decreased bioavailability of rivastigmine observed when the transdermal patch is applied to these areas of the body. Please note there is a risk of fatal overdose with patch administration errors.

Precautions and Warnings

- Pregnancy – should not be used unless clearly necessary.
- Patients with body weight below 50 kg may experience more adverse reactions and maybe more likely to discontinue due to adverse reactions.
- Gastrointestinal disorders (e.g. nausea and vomiting) may occur particularly when initiating treatment and/or increasing the dose. More common in women.
- Monitor patient's weight.
- In case of severe vomiting, it may be necessary to temporarily reduce the dose ordiscontinue treatment (consult SPC for further information).

- Use with care in patients with sick sinus syndrome or conduction defects (e.g. sino-atrial or A-V block).
- May increase gastric acid secretions; use with care in patients with active gastric or duodenal ulcers or those predisposed to these conditions.
- Use with care in patients with a history of asthma or obstructive pulmonary disease.
- Drugs in this class may induce or exacerbate urinary obstruction and seizures. Cautionis recommended in treating patients pre-disposed to these diseases.
- Rivastigmine may exacerbate or induce extrapyramidal symptoms; including worsening in patients with dementia associated Parkinson's disease.
- Skin application site reactions may occur with rivastigmine patch and are usually mild or moderate in intensity. Patients and caregivers should be instructed accordingly.

Contraindications

- Not recommended for use in children.
- Known hypersensitivity to rivastigmine, or other carbamate derivatives (e.g. physostigmine, pyridostigmine) or any excipients in the formulation.
- Severe hepatic impairment
- Women on rivastigime should not breast-feed
- Previous history of application site reactions suggestive of allergic contact dermatitis with rivastigmine patch

Interactions

- Should not be given concomitantly with other drugs in this group.
- May interfere with the activity of anticholinergic medication.
- Metabolic drug interactions appear unlikely, although rivastigmine may inhibit the butyrylcholinesterase mediated metabolism of other drugs (e.g. neuromuscular blockers).
- Rivastigmine may exaggerate the effects of succinylcholine type muscle relaxants during anaesthesia.
- Combined use of various beta blockers and rivastigmine may lead to bradycardia, and potential fainting.

Side-effects

Common and very common nausea, vomiting, diarrhoea, dyspepsia, anorexia, abdominal pain, dizziness, headache, drowsiness, tremor, asthenia, malaise, agitation, confusion, sweating, weight loss and rash (with patches); **less commonly** syncope, depression, insomnia; **rarely** gastric or duodenal ulceration, angina pectoris, seizures; **very rarely** gastro-intestinal haemorrhage, pancreatitis, cardiac arrhythmias, bradycardia, hypertension, hallucinations, extrapyramidal symptoms (including worsening of Parkinson's disease), and rash. (**Note** – Gastro-intestinal side-effects more common in women).

Effects on ability to drive and use machines

Alzheimer's disease may cause gradual impairment of driving performance or compromise the ability to use machinery. Furthermore, rivastigmine can induce dizziness and somnolence, mainly when initiating treatment or increasing the dose. Therefore, the ability of Alzheimer's patients on rivastigmine to continue driving or operating complex machines should be routinelyevaluated by the treating physician.

References

1. Rivastigmine 2mg/mL oral solution (Rosemont) SPC, updated June 2019 accessed Aug 2023
2. Rivastigmine 1.5mg hard capsules (Sandoz) SPC updated Jan 2021 accessed Aug 2023
3. Rivastigmine 4.6mg / 24 hours transdermal patches (Exelon) SPC updated Nov 2020 accessed Aug 2023
4. Electronic BNF accessed August 2023

Annex 5 – Memantine Drug Fact Sheet[1,2,3]

(*For full information consult the latest Summary of Product Characteristics and the BNF*)

Formulation

Tablets / Oral solution / Oro-dispersible tablets. Please note that the use of any pharmaceutical form other than solid oral capsules should be clinically justified by concordance issues or sensitivity to side effects. Oral solution and Oro-dispersible tablets may be considerably more expensive, and should only be used where it is clinically indicated (e.g. patients with established swallowing difficulties).

Dosage and Administration

The Oral solution or Oro-dispersible tablet or film-coated tablet can be taken with or without food. The solution must not be poured or pumped into the mouth or directly from the bottle or pump, but should be dosed onto a spoon or into a glass of water.

- *Initial dose is 5mg (orally) once a day. This initial dose should be continued for 1 week.*
- *In order to reduce the risk of undesirable effects the maintenance dose is achieved by upward titration of 5 mg per week over the next 3 weeks.*
- *The recommended maintenance dose is 20 mg per day.*
- *Memantine should be taken orally once daily at the same time each day.*
- *In patients with eGFR of 30-49 ml/min/1.73 m2 (moderate renal impairment) the daily dose should be reduced to 10mg. If well tolerated after at least 7 days, dose can be increased in steps of 5mg up to 20mg daily. Reduce dose to 10mg if eGFR 5-29 ml/min/1.73 m2. Avoid if eGFR is less than 5ml/min/1.73m2. Memantine is not recommended in patients with severe hepatic impairment.* ***It is advised that renal function is checked prior to commencing Memantine.***

Precautions and Warnings

- Caution is recommended in patients with epilepsy.
- Concomitant use of N-methyl-D-aspartate (NMDA)-antagonists such as amantadine, ketamine or dextromethorphan should be avoided.
- Memantine should not be used during pregnancy unless clearly necessary.

Contraindications

- Women taking memantine should not breastfeed.

Interactions

- The mode of action suggests that the effects of L-dopa, dopaminergic agonists, and anticholinergics may be enhanced by concomitant treatment with memantine.
- Concomitant use of memantine and amantadine should be avoided, owing to the risk of pharmatoxic psychosis.
- Memantine is predicted to increase the risk of CNS side-effects when given with ketamine. Manufacturer advises avoid.
- *In post-marketing experience isolated cases with international normalized ratio (INR) increases have been reported in patients concomitantly treated with warfarin, although no causal relationship has been established.*

Side-Effects

Common balance disorders, elevated LFTs, somnolence, drug hypersensitivity, dizziness, hypertension, dyspnoea, constipation and headache; l**ess common** fungal infection, confusion, hallucinations, cardiac failure, VTE, abnormal gait, vomiting and fatigue; r**arely** seizures.

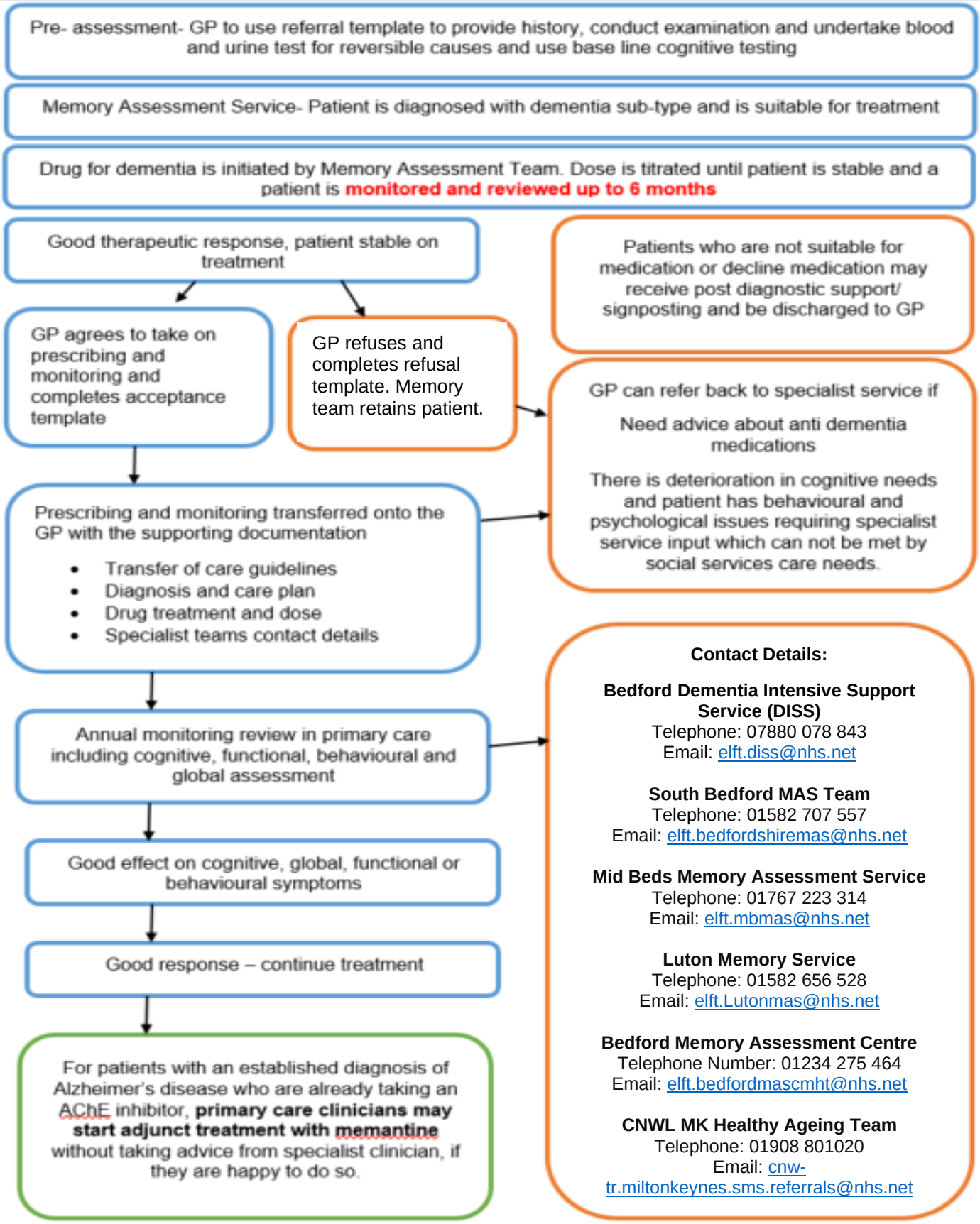
Effects on ability to drive and use machines

Moderate to severe Alzheimer's disease usually causes impairment of driving performanceand compromises the ability to use machinery. Furthermore, memantine has minor or moderate influence on the ability to drive and use machines, such that outpatients should take special care.

References

1. *Memantine 10mg film-coated tablets (Mylan) SPC updated Oct 2021 accessed Aug 2023*
2. *Memantine 5mg/mL pump actuation oral solution (Ebixa) SPC updated Jan 2021 accessed Aug 2023*
3. *Memantine 10mg Orodispersible Tablets (Valios) SPC updated Oct 2019 accessed Aug 2023*
4. *Electronic BNF accessed Aug 2023*

Annex 6: Management of Dementia – Transfer of Care Guidance



Annex 7: Transfer of care agreement

GP Practice details:
Name……
Address……
……
Tel no……
Email……

Patient details:
Name……
Address……..
……..
D.O.B……
NHS Number……..

Consultant name……
Clinic name……
Contact details……
Address……
……
Tel no……..**Email**……

Diagnosis

Current medication and dose

The patient has been reviewed on……. /……. /……. and they are considered acceptable for transfer of care.

Dear GP,

Mr / Mrs /Ms----------has been prescribed dementia treatment for the above diagnosis. He/she has been on the treatment under shared care and is now stable and benefiting from this treatment.
We would like to transfer the care of this patient and would like to request your agreement to receive the care of this patient from …./……/…..... in accordance with the transfer of care guidelines (approval date----------) enclosed.
Patient information has been given outlining potential aims and side effects of this treatment. The patient has given me consent to treatment under this transfer of care(with your agreement) and has agreed to comply with instructions and follow up requirements. We have also informed the patient that the medication may be discontinued if not proving effective.

Memory Nurse Name:
Consultant Name:
Signature:
Date:

Annex 8 – Possible Reasons for a Primary Care Prescriber to decline to accept shared care:

1	I do not feel clinically confident in managing this individual patient's condition, and there is a sound clinical basis for refusing to accept shared care. I have consulted with other Primary Care prescribers in my practice who support my decision. I have discussed my decision with the patient and request that prescribing for this individual remains with you due to the sound clinical basis given above.
2	The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement (medicine not included on the national list of shared care drugs as identified by RMOC or is not a locally agreed shared care medicine).
3	The patient has not had the minimum duration of supply of medication to be provided by the initiating Specialist. Therefore, please contact the patient as soon as possible in order to provide them with the appropriate length of supply of the medication before transferring the prescribing responsibility to the Primary Care prescriber.
4	The patient has not been optimised/stabilised on this medication. Therefore, please contact the patient as soon as possible in order to provide them with the medication until the patient is optimised on this medication before transferring the prescribing responsibility to the Primary Care prescriber.
5	Shared Care Guideline and/or relevant clinical information as stipulated in the guideline not received. Therefore, please contact the patient as soon as possible in order to provide them with the medication until I receive the appropriate Shared Care Guideline before transferring the prescribing responsibility.
6	Other (Primary Care prescriber to complete if there are other reasons why shared care cannot be accepted or why shared care is to be discontinued if already started, e.g. adverse effects): ……