Shared care prescribing guideline:

Amiodarone for patients within adult services

November 2025, Version 1

Approved by the BLMK Area Prescribing Committee: March 2026

Review date – March 2029

The content of this shared care guideline was correct as of November 2025. As well as this document, please ensure that summaries of product characteristics (SPCs), British National Formulary (BNF) or the Medicines and Healthcare products Regulatory Agency (MHRA) or NICE websites are reviewed for up-to-date information on any medicine.

This guideline should also be read in conjunction with the BLMK Shared Care Principles which provide additional detail to support prescribers.

Contents

Adapted from Specialist Pharmacy Service National shared care protocol – Amiodarone for patents within adult services, 04/07/2022, version 1.

Specialist responsibilities

- Assess the patient and provide diagnosis; ensure that this diagnosis is within scope of this shared care guideline (section 2) and communicated to primary care.
- Use a shared decision-making approach; discuss the benefits and risks of the treatment with the patient and/or their carer and provide the appropriate counselling (see section 10) to enable the patient to reach an informed decision. Obtain and document patient consent. Provide an appropriate patient information leaflet.
- Assess for contraindications and cautions (see section 3) and interactions (see section 6).
- Conduct required baseline investigations and initial monitoring (see section 7).
- Initiate and optimise treatment as outlined in section 4.
- Transfer to primary care is normally after the patient has been treated for 3 months and stabilised on treatment, with satisfactory investigation results for at least 4 weeks.
- Once treatment is optimised, contact the patient's GP practice to initiate shared care, detailing the diagnosis, current and ongoing dose of amiodarone, any relevant test results, and when the next monitoring is required. Include contact information (section 12).
- Prescribe sufficient medication to enable transfer to primary care (minimum 84 days' supply), including where there are unforeseen delays to transfer of care.
- Conduct the required monitoring in section 7 and communicate the results to primary care. After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in section 8 remains appropriate.
- Review treatment and reassume prescribing responsibility if a patient becomes or wishes to become pregnant.
- Provide advice to primary care on the management of adverse effects if required.

Primary care responsibilities

- To confirm that the patient or carer consents to sharing of care between the specialist, primary care prescriber and patient.
- If shared care is **accepted**, commencement of shared care must be clearly documented in the patient's primary care medical notes. 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.
- If **declining** the request for shared care, the decision and rationale should be explained to the specialist in writing as soon as is possible and in a timely manner, within a maximum of 14 to 21 calendar days upon receipt of request. The patient should also be informed of the decision. See Appendix 1 of the BLMK Shared Care Principles for supporting information.
- If accepted, prescribe the maintenance therapy as detailed in the specialist's request and as per section 4, taking into any account potential drug interactions in section 6.
- Adjust the dose of amiodarone prescribed as advised by the specialist.
- Conduct the required monitoring as outlined in section 8. Communicate any abnormal results to the specialist.
- Manage adverse effects as detailed in section 9 and discuss with specialist team when required.
- Stop amiodarone and make an urgent referral to the specialist if hyperthyroidism, thyrotoxicosis, new or worsening arrhythmia or heart block, ophthalmological effects, hepatotoxicity, pulmonary toxicity or bullous skin reactions are suspected.
- Refer the management back to the specialist if the patient becomes or plans to become pregnant.
- Stop treatment as advised by the specialist.

Summary Table

Frequency	Action	Responsibility
Initiation	Review contraindications Counsel around risks and give patient information Conduct baseline investigations: • Bloods: TFT, LFT, U&E • Lung assessment including chest X-Ray • ECG	Secondary Care
Initiation	Prescribe loading course Prescribe 12 weeks of amiodarone including the loading dose and maintenance dose. Inform patient that they should let secondary care know if there are any problems in the first 12 weeks Inform primary care of amiodarone initiation, and request takeover of prescription at 12 weeks	Secondary Care
3 months	Take over continued maintenance prescription of amiodarone	Primary Care
At 6 months and then every 6 months thereafter	6-monthly bloods: TFT, LFT, U&E Act as per advice below if abnormalities	Primary Care
Every 12 months	ECG Act as per advice below if abnormalities	Primary Care
Every 12 months	Clinical review	Secondary Care

Patient and/or carer responsibilities

- Take amiodarone as prescribed and do not stop taking it without speaking to their primary care prescriber or specialist.
- Tell anyone who prescribes them a medicine that they are taking amiodarone.
- Attend regularly for monitoring and review appointments with primary care and specialist and keep contact details up to date with both prescribers. Be aware that medicines may be stopped if they do not attend appointments. Test results from the GP surgery, and hospital test results which have been sent to the GP surgery, may be reviewed via the NHS app.
- Report adverse effects to their primary care prescriber. Seek immediate medical attention if they develop any symptoms as detailed in section 10.

- Report the use of any over the counter (OTC) medications to primary care and specialist and be aware they should discuss the use of amiodarone with their pharmacist before purchasing any OTC medicines.
- Avoid grapefruit juice while taking amiodarone and for several months after discontinuation.
- Moderate their alcohol intake to no more than 14 units per week to reduce the risk of hepatotoxicity.
- Inform the specialist or primary care prescriber as soon as possible if they become pregnant or wish to become pregnant.

1. Background

Back to top

Amiodarone is used in the treatment of arrhythmias, as detailed in **section 2**. It has an important place in the treatment of severe cardiac rhythm disorders where other treatments either cannot be used or have failed. Amiodarone has potentially serious adverse effects and its use requires regular monitoring.

Due to the significant safety concerns, NHS England (NHSE) and NHS Clinical Commissioners' (NHSCC) guidance advises that prescribers should not initiate amiodarone in primary care for any new patients. In exceptional circumstances, if there is a clinical need for amiodarone to be prescribed, this must be initiated by a specialist and only continued under a shared care arrangement in line with NICE clinical guidance Atrial fibrillation: NG 196. NICE defines the place in therapy of amiodarone in NG196 and has made a "Do not do" recommendation: "**Do not offer amiodarone for long-term rate control**".

Amiodarone may also be suitable in patients prior and post cardioversion or in specific patients who have heart failure or left ventricular impairment.

Where there is an existing cohort of patients taking amiodarone who are not currently under shared care, it is recommended that these patients be reviewed to ensure that prescribing remains safe and appropriate, and a shared care arrangement is introduced.

This shared care guideline does not cover treatment of people less than 18 years old

2. Indications

Back to top

Licensed indications:

- Tachyarrhythmias associated with Wolff-Parkinson-White Syndrome.
- Atrial flutter fibrillation / atrial fibrillation when other drugs cannot be used.
- All types of tachyarrhythmias of paroxysmal nature including supraventricular, nodal and ventricular tachycardias and ventricular fibrillation when other drugs cannot be used.

The specialist **must specify the indication for each patient** when initiating shared care.
No national or locally agreed off label use.

3. Contraindications and cautions

Back to top

This information does not replace the Summary of Product Characteristics (SPC) and should be read in conjunction with it. Please see eBNF & SmPC for comprehensive information.

Contraindications:

- Sinus bradycardia and sino-atrial heart block/severe conduction disturbances (high grade AV block, bifascicular or trifascicular block) or sinus node disease (unless pacemaker fitted)
- History of thyroid dysfunction. Use of amiodarone may be considered in patients who are euthyroid, after case-by-case assessment of the risks and benefits and with appropriate monitoring.
- Known hypersensitivity to iodine or amiodarone, or any of the excipients (including patients with galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption)
- Concurrent use with medicines that may prolong the QT interval or increase the risk of Torsades de Pointes
- Pregnancy - except in exceptional circumstances (see Section 11)
- Breastfeeding

Cautions:

Amiodarone can cause serious adverse reactions affecting the eyes, heart, lung, liver, thyroid gland, skin and peripheral nervous system; it is subject to several cautions. Because these reactions may be delayed, patients on long-term treatment should be carefully supervised. As undesirable effects are usually dose-related, the minimum effective maintenance dose should be given.

4. Initiation and ongoing dose regimen

Back to top

- Transfer of monitoring and prescribing to primary care is normally after the patient has been treated for at least 12 weeks and when the patient's dose has been optimised and with satisfactory investigation results for at least 4 weeks
- The duration of treatment & frequency of review will be determined by the specialist, based on clinical response and tolerability.
- All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care clinician
- Termination of treatment will be the responsibility of the specialist.

Initial stabilisation:

200mg three times per day for one week, then reduce to 200mg twice per day for one week.
Amiodarone is initiated with a loading dose to achieve adequate tissue levels rapidly. Rarely, the specialist team may use an alternative loading regimen.

The loading period must be prescribed by the initiating specialist.

Maintenance dose (following initial stabilisation):

200mg per day, or less if appropriate. The minimum dose required to control the arrhythmia should be used.
Rarely, a higher maintenance dose may be required. The maintenance dose should be reviewed regularly, particularly if it exceeds 200mg per day.

The initial maintenance dose must be prescribed by the initiating specialist.

Transfer of monitoring and prescribing to primary care is usually after 12 weeks. The duration of treatment will be determined by the specialist based on clinical response and tolerability.

Conditions requiring dose adjustment:

Although there is no evidence that dose requirements for elderly patients are lower, they may be more susceptible to bradycardia and conduction defects if too high a dose is prescribed. The minimum effective dose should be used. Particular attention should be paid to monitoring thyroid function.

5. Pharmaceutical aspects

Back to top

Route of administration:	Oral
Formulation:	100mg and 200mg tablets
Administration details:	For oral administration. Maintenance dose can be given once daily, however doses >200 mg daily (including loading period) may be given as split doses to minimise nausea. If necessary, tablets may be crushed and dispersed in water but have a bitter taste (unlicensed). Different brands may disperse in water at notably different rates. The solution for injection is irritant and should not be given orally.
Other important information:	The half-life of amiodarone is very long, with an average of 50 days (range 20-100 days). Side effects slowly disappear as tissue levels fall. Following drug withdrawal, residual tissue bound amiodarone may protect the patient for up to a month. However, the likelihood of recurrence of arrhythmia during this period should be considered. Grapefruit juice should be avoided during treatment with oral amiodarone and for several months after discontinuation (see section 7).

6. Significant medicine interactions

Back to top

The following list is not exhaustive. Please see eBNF or SmPC for comprehensive information and recommended management.

Amiodarone is associated with a large number of interactions, some of which are significant enough to contraindicate concurrent use, require dose adjustment and/or additional monitoring (see section 4).
Amiodarone is an enzyme inhibitor and can increase exposure to a number of medicines including:

- P-glycoprotein (PgP) substrates (e.g. digoxin, dabigatran)
- CYP2C9 substrates (e.g. warfarin, phenytoin)
- CYP3A4 substrates (e.g. ciclosporin, statins, fentanyl, sildenafil, colchicine)
- CYP2D6 substrates (e.g. flecainide)

Amiodarone interacts with other medicines that:

- induce Torsade de Points or prolong QT (e.g. other anti-arrhythmics, antipsychotics, antidepressants, clarithromycin, erythromycin)

- lower heart rate (e.g. beta-blockers, calcium channel blockers)
- induce hypokalaemia (e.g. diuretics, stimulant laxatives)
- induce hypomagnesaemia (e.g. diuretics, systemic corticosteroids)

Other interactions include:

- CYP3A4 and CYP2C8 inhibitors: may increase exposure to amiodarone (e.g. cimetidine, letermovir, ritonavir, darunavir, grapefruit juice)
- Sofosbuvir with daclatasvir; sofosbuvir and ledipasvir; simeprevir with sofosbuvir: risk of severe bradycardia and heart block (mechanism unknown) see MHRA advice

Due to the long half-life of amiodarone, there is potential for drug interactions to occur for several weeks/months after treatment has been discontinued.
See SPC for information on managing interactions.

7. Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist

Back to top

Monitoring at baseline and during initiation is the responsibility of the specialist; only once the patient is optimised on the chosen medication with no anticipated further changes expected in immediate future will prescribing and monitoring be transferred to primary care.

Baseline investigations:

- Thyroid function tests (TSH & T4)
- Liver function tests (LFTs, particularly transaminases)
- Urea and electrolytes (U&Es, including magnesium and potassium)
- Electrocardiogram (ECG)
- Chest X-ray
- For patients taking warfarin: monitor international normalised ratio (INR) at baseline and during dose stabilisation period
- For patients taking digoxin: clinical monitoring is recommended, and the digoxin dose should be halved. Digoxin levels should be monitored appropriately.

Initial monitoring and at dose change:

None specifically recommended by manufacturer.

Ongoing monitoring to be taken under secondary care:

The specialist will retain the responsibility for monitoring the patient's ongoing response to treatment and advise if a dose change or treatment cessation is appropriate. This should be undertaken on at least an annual basis.

Chest X-ray and pulmonary function tests, if respiratory symptoms or toxicity suspected

After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in section 8 remains appropriate.

8. Ongoing monitoring requirements to be undertaken by primary care

Back to top

See section 9 for further guidance on management of adverse effects/responding to monitoring results.

Monitoring	Frequency
• Thyroid function tests free T4 and TSH (T3 will automatically be measured as per Lab guidelines depending on TSH results) • LFTs (particularly transaminases) • U&Es (including magnesium and potassium)	**Perform all tests every 6 months during treatment, and 6 months after discontinuation. See schedule of monitoring for primary care below:** **Primary care** - Bloods at 6 months, then every 6 months thereafter Thyroid function should continue to be monitored for up to 12 months after discontinuation, in the same pattern as above or with frequency determined clinically.
• ECG (monitoring may be conducted in primary care where this service is available)	At least annually, in primary care unless specifically agreed otherwise.
(If relevant) If monitoring results are forwarded to the specialist team, please include clear clinical information on the reason for sending, to inform action to be taken by secondary care.	

9. Adverse effects and other management

Back to top

Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit https://yellowcard.mhra.gov.uk/.

For information on incidence of ADRs see relevant summaries of product characteristics.

Result	Action for primary care
As well as responding to absolute values in laboratory tests, a rapid change or a consistent trend in any value should prompt caution and extra vigilance	
The most serious toxicity with amiodarone is seen with long-term use and patients may therefore present first to primary care. Due to the long half-life of amiodarone there is potential for adverse effects to occur for several weeks/months after treatment has been discontinued.	
Electrolyte deficiency	
Hypokalaemia / hypomagnesaemia	Continue amiodarone. Correct deficiency as per local guideline or in the absence of a local guideline refer to SPS guideline – Link below. Review other medicines that may be contributing to a deficiency See below SPS guideline for treating hypomagnesaemia:

	Treating acute hypomagnesaemia in adults – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
Cardiovascular effects	
Bradycardia: Heart rate 50 - 60bpm without symptoms	Continue amiodarone. Repeat monitoring. No action required unless symptoms develop, or heart rate decreases further
Bradycardia: Heart rate ≤ 50bpm, or ≤ 60bpm with symptoms	Discuss with specialist team; dose reduction may be required
Worsening of arrhythmia, new arrhythmia	**Stop amiodarone**. Urgent referral to initiating specialist. Urgent advice request to discuss stopping amiodarone.
Second or third degree Heart block	**Urgent hospital referral for consideration of pacemaker. Emergency admission required.**
Thyroid dysfunction	
Borderline results according to local reference range	Continue amiodarone. Repeat test after 6 weeks.
Hyperthyroidism / thyrotoxicity: high T4, normal/high T3, low TSH	**Stop amiodarone**. Urgent referral to initiating specialist and endocrinologist.
Hypothyroidism: low/normal T4, low/normal T3, high TSH	Continue amiodarone. Inform initiating specialist. Consider starting levothyroxine based on initiating specialist's advice. Monitor levothyroxine according to local pathways.
Subclinical hypothyroidism normal T4, raised TSH; clinical features not overtly manifest	Contact specialist team for advice, which may include input from endocrinology services. Anticipate the need for additional monitoring, investigations and potentially thyroid hormone replacement based on specialist recommendations.
Ophthalmological effects	
Optic neuropathy/neuritis. blurred or decreased vision	**Stop amiodarone**. Urgent referral to initiating specialist and ophthalmology.
Corneal micro-deposits: blueish halos when looking at bright lights, with no blurred or decreased vision	Continue amiodarone: reversible on discontinuation. The deposits are considered essentially benign and do not require discontinuation of amiodarone.
GI disturbance	
Nausea, anorexia, vomiting, taste disturbance	Continue amiodarone. May require dose reduction; discuss with specialist if persistent.
Hepatotoxicity	

Abnormal LFTs +/- symptoms of hepatic injury (e.g. hepatomegaly, weakness, ascites, jaundice)	If serum transaminases elevated >3xULN but no symptoms of hepatic injury continue amiodarone and – repeat LFTs in 2 weeks. If still elevated may require dose reduction; discuss with specialist. If serum transaminases >5xULN or any symptoms of hepatic injury**- stop amiodarone**. Urgent referral to initiating specialist and hepatologist.
Neurological symptoms	
Extrapyramidal tremor, ataxia, peripheral neuropathy, myopathy	Continue amiodarone. May require dose reduction; discuss with specialist.
Pulmonary toxicity	
Including pneumonitis or fibrosis new/worsening cough, shortness of breath or deterioration in general health (e.g. fatigue, weight loss, fever)	**Stop amiodarone**. Urgent referral to initiating specialist and respiratory specialist. Admission may be required.
Skin reactions	
Bullous skin reactions Life threatening or even fatal cutaneous reactions Stevens-Johnson Syndrome (SJS), Toxic Epidermal Necrolysis (TEN)	**Stop amiodarone**. Urgent referral to dermatology, inform initiating specialist.
Photosensitivity	Continue amiodarone. Reinforce appropriate self-care e.g. sun avoidance and purchasing of a broad-spectrum sunscreen (at least SPF30).
Skin discolouration (blue/grey): occurs in unprotected, light exposed skin	Continue amiodarone. May require dose reduction; discuss with specialist.

10. Advice to patients and carers

Back to top

The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.

The patient should be advised to report any of the following signs or symptoms to their primary care prescriber without delay:

- Breathlessness, non-productive cough or deterioration in general health (e.g. fatigue, weight loss, fever)
- New or worsening visual disturbances
- Progressive skin rash +/- blisters or mucosal lesions
- Signs and symptoms of bradycardia or heart block, e.g. dizziness, fatigue, fainting, shortness of breath, chest pain or palpitations, confusion or trouble concentrating

The patient and/or carer should be advised:

- What shared care means for their treatment, what to expect, and their responsibilities under shared care.

- Tell anyone who prescribes them a medicine that they are taking amiodarone. Always ask a pharmacist before purchasing any medicines over the counter, including herbal remedies, and ask if they are safe.
- To use appropriate self-care against the possibility of phototoxic reactions: e.g. sun avoidance, protective clothing, avoiding tanning (including tanning beds) and to purchase and use a broad-spectrum sunscreen (at least SPF30). These measures to be continued for the duration of therapy and for several months after discontinuation.
- If taking a statin and amiodarone, to report any signs of unexplained muscle pain, tenderness, weakness or dark coloured urine.
- Avoid grapefruit and grapefruit juice while taking amiodarone and for several months after discontinuation.
- Although there have been no case reports on enhanced hepatoxicity with alcohol, patients should be advised to moderate their alcohol intake to no more than 14 units per week while taking amiodarone.
- Advise patient to attend optician annually and report any ophthalmological effects to primary care provider.

Example of Patient information signposting:

British Heart Foundation – anti-arrhythmics: Drug cabinet: Anti-arrhythmics - BHF

11. Pregnancy, paternal exposure and breast feeding

Back to top

It is the responsibility of the specialist to provide advice on the need for contraception to male and female patients on initiation and at each review, but the ongoing responsibility for providing this advice rests with both the primary care prescriber and the specialist.

Pregnancy:

Due to the risk of neonatal goitre, amiodarone should only be prescribed in pregnancy if there is no alternative. Under these circumstances prescribing and monitoring will be the responsibility of the initiating specialist.

Breastfeeding:

Amiodarone is excreted into the breast milk in significant quantities; breast feeding is considered contraindicated due to the potential risk of iodine-associated adverse effects in the infant.

Information for healthcare professionals: https://www.sps.nhs.uk/medicines/amiodarone/

12. Specialist contact information

Back to top

Cardiology team contact details for information and advice

Advice and Guidance (part of the E-RS booking system)

GPs can contact Consultant Specialists from Cardiology and a range of other Specialities for advice via the 'Advice & Guidance' facility in the E-RS booking system.

Urgent calls contact:

Bedford Hospital cardiology department on 01234 792119

Luton & Dunstable Hospital via switchboard on 01582 491166

Milton Keynes University hospital on 01908 997050

13. Additional information

Back to top

Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be initiated. Ensure that the specialist is informed in writing of any changes to the patient's GP or their contact details.

There will be a cohort of patients already on amiodarone who will have been initiated on the medication under different arrangements to those now accepted on this shared care protocol. In some cases, shared care arrangements were not robust and did not include requirement for long-term follow-up and monitoring in secondary care.

Accordingly, it is likely that there are patients taking amiodarone in whom arrangements for continuing monitoring in secondary care have not been made, and that this monitoring is occurring in primary care only.

Primary care: In patients who are taking amiodarone and have not been seen in secondary care cardiology within the last year, please refer back to cardiology for ongoing review via the standard mechanism for your area.

Primary care: Please continue 6 monthly blood tests as per section 8 whilst awaiting review.

Secondary care: Such referrals should be accepted and ongoing review initiated as described.

14. References

Back to top

Adapted from Specialist Pharmacy Service National shared care protocol – Amiodarone for patents within adult services, 04/07/2022, version 1.

1) SPS (2022). Amiodarone for patients within adult services. [online] Available at: https://www.england.nhs.uk/publication/shared-care-protocols [Accessed 30 Sep. 2025].
2) eBNF British National Formulary (n.d.). Amiodarone hydrochloride. [online] NICE. Available at: https://bnf.nice.org.uk/drugs/amiodarone-hydrochloride/ [Accessed 30 Sep. 2025].
3) England, N. (2023). NHS England» Items which should not routinely be prescribed in primary care: policy guidance. [online] www.england.nhs.uk. Available at: https://www.england.nhs.uk/long-read/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance/ [Accessed 30 Sep. 2025].
4) National Institute for Health and Care Excellence (2021). Overview | Atrial fibrillation: diagnosis and management | Guidance | NICE. [online] www.nice.org.uk. Available at: https://www.nice.org.uk/guidance/ng196 [Accessed 30 Sep. 2025].
5) Specialist Pharmacy Service (2021). Amiodarone monitoring. [online] SPS - Specialist Pharmacy Service. Available at: https://www.sps.nhs.uk/monitorings/amiodarone-monitoring/ [Accessed 30 Sep. 2025].

15. Other relevant national guidance

Back to top

- Shared Care for Medicines Guidance: A Standard Approach, Regional Medicines Optimisation Committee (RMOC), February 2021.
- NHSE guidance – Responsibility for prescribing between primary & secondary/tertiary care. Available from https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/
- General Medical Council. Good practice in prescribing and managing medicines and devices. Shared care. Available from https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care
- NICE NG197: Shared decision making. Last updated June 2021. https://www.nice.org.uk/guidance/ng197/.