DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE
SHARED CARE AGREEMENT

AMIODARONE

1. REFERRAL CRITERIA

- Shared Care is only appropriate if it provides the optimum solution for the patient.
- Prescribing responsibility will only be transferred when it is agreed by the consultant and the patient's GP that the patient's condition is stable or predictable.
- When transferred, the patient will be given a supply of amiodarone sufficient for 4 weeks maintenance therapy by the specialist.

2. AREAS OF RESPONSIBILITY

GP responsibilities	Consultant/specialist responsibilities
1. If NOT participating in shared care reply to the request from the consultant/specialist as soon as practicable. **2.** Prescribe amiodarone at the dose determined by the secondary care specialist and clearly document indication/ anticipated treatment duration in patient's notes. **3.** Refer to secondary care physician if the patient's condition deteriorates. **4.** Perform monitoring tests as outlined in section VI, including annual ECG monitoring. **5.** Manage adverse effects as detailed in section v and discuss with specialist team when required. **6.** Check for drugs not recommended or should be avoided with amiodarone; or where concomitant use with amiodarone are cautioned. **7.** Stop treatment on the advice of the specialist or immediately if any urgent need to stop treatment arise. (see section v & vi) **8.** Continue to perform 6 monthly TFT for 12 month after treatment completed. **9.** Refer the management back to the specialist if the patient becomes or plans to become pregnant. **10.** Report any adverse effects to the referring specialist and the MHRA yellow card scheme	**1.** Assess the patient and provide diagnosis; ensure that this diagnosis is within scope of this shared care protocol and communicated to primary care. **2.** To confirm the patient has no contra-indications to treatment and consider the relevance of any cautions. **3.** 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 to enable the patient to reach an informed decision. Counsel patient to report side effects from amiodarone treatment and to protect skin from sunlight. **4.** To initiate amiodarone (loading*) for the licensed indication in accordance with the manufacturer's Summary of Product Characteristics (SPC). **5.** Perform monitoring tests as outlined in section VI. **6.** To discuss the possibility of sharing prescribing and monitoring of amiodarone with the patient's GP; to provide a copy of this shared care agreement for their consideration and not to transfer prescribing responsibility until the GP has formally agreed to share care in this way. Clearly communicate to GP the indication, dose and anticipated treatment duration. **7.** To advise on the clinical relevance of concomitant medication after initiation of amiodarone, as well as potential drug interactions (e.g. with anticoagulants, digoxin, beta-blockers etc). see section vii **8.** Annual reviews are unnecessary, however, consultants are asked to provide advice remotely when needed and review patients in cases of difficulty. **9.** To ensure that arrangements are in place for GPs to obtain advice and support where needed. **10.** To communicate promptly with the GP the results of any monitoring undertaken in secondary care and any changes to treatment made by the specialist. **11.** Reassume prescribing responsibilities if a patient becomes or wishes to become pregnant
Patient responsibilities **1.** Report to the specialist or GP if he/she does not have a clear understanding of the treatment. Share any concerns in relation to treatment with amiodarone. **2.** Take amiodarone as prescribed and avoid abrupt withdrawal unless advised by the primary care prescriber or specialist.	

3. 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.
4. Seek urgent medical attention should their condition significantly worsen.
5. The patient must notify the GP or secondary care specialist if they develop any of the following:
   - Breathlessness and non-productive cough or deterioration in general health (e.g. fatigue, weight loss, fever)
   - New or worsening visual symptoms
   - Progressive skin rash +/- blisters or mucosal lesions
   - Signs and symptoms of bradycardia (slow heartbeat) or heart block e.g. Dizziness or fainting, fainting, shortness of breath, palpitations/ chest pain, confusion or trouble concentrating
   - symptoms of potential thyroid or liver injury (such as rapid weight loss; sustained new-onset abdominal pain, anorexia, nausea, vomiting, fever, malaise, fatigue, jaundice, dark urine or itching)
6. Report any other adverse effects to the specialist or GP whilst taking amiodarone
7. Report the use of any over the counter medications to their primary care prescriber and be aware they should discuss the use of amiodarone with their pharmacist before purchasing any OTC medicines.
8. Avoid grapefruit juice while taking amiodarone and for several months after discontinuation.
9. Moderate alcohol intake to no more than 14 units per week to reduce the risk of hepatotoxicity.
10. Patients of childbearing potential should take a pregnancy test if they think they could be pregnant, and inform the specialist or GP immediately if they become pregnant or wish to become pregnant.

3. COMMUNICATION AND SUPPORT

i. **Hospital contact:**	ii. **out of hours contact and procedures:**
University Hospitals of Derby & Burton Foundation Trust Consultant/nurse via switchboard:01332 340131 **Chesterfield Royal Hospital Foundation Trust** Consultant via switchboard: 01246 277271	Pharmacy, UHDB ask for on-call pharmacist via switchboard: 01332 340131 Cardiology UHDB, ask for on-call Cardiology Consultant via switchboard: 01332 340131 Contact the CRH on-call Medic for the relevant speciality via switchboard: 01246 277271

iii. Patient information

British Heart Foundation – anti-arrhythmics: https://www.bhf.org.uk/informationsupport/heart-matters-magazine/medical/drug-cabinet/anti-arrhythmics
https://www.bhf.org.uk/informationsupport/publications/heart-conditions/medicines-for-your-heart
https://patient.info/medicine/amiodarone-for-irregular-heartbeats-cordarone-x
http://www.heartrhythmalliance.org/files/files/afa/For%20Patients/Factsheet%20-%20Amiodarone%20Advice%20(160201).pdf

4. CLINICAL INFORMATION

i. Prescribed indications	Treatment of severe heart rhythm disorder not responding to other therapies or when other treatments cannot be used. • Prior and post cardioversion • In patients who also have heart failure or left ventricular impairment **<u>Licensed indications</u>** • Tachyarrhythmias associated with Wolff-Parkinson-White syndrome. • Atrial flutter and fibrillation when other drugs cannot be used. • Tachyarrhythmias of paroxysmal nature including: supraventricular, nodal and ventricular tachycardias. Ventricular fibrillation; when other drugs cannot be used. Patients should NOT be on amiodarone for palpitation unless there is a clearly defined electrophysiological diagnosis. Do not offer amiodarone for long-term rate control
ii. Therapeutic summary	Amiodarone is a class III antiarrhythmic drug (Vaughan-Williams classification) that reduces the incidence of arrhythmias by increasing the duration and refractory period of the cardiac action potential prolonging the QT interval. It also slows heart rate and cardiac action potential conduction through inhibition of beta receptors and ion channels in a similar manner to antiarrhythmic drugs from classes IA, II and IV
iii. Dose & Route	<u>Oral loading*</u> (by consultant/ specialist)

<table>
<tr><td>of administration</td><td>200mg 3 times daily for 1 week, reduced to 200mg twice daily for a further week.
<u>Maintenance</u>
Usually 200mg daily or the minimum dose required to control the arrhythmia.
The minimum effective maintenance dose should be given because undesirable effects are usually dose related.

Do not take with grapefruit juice during treatment and for several months after discontinuation of amiodarone.</td></tr>
<tr><td>iv. Duration of treatment</td><td>For use after electrical cardioversion starting 4 weeks prior and continue for up to 12 months.

Duration of treatment and review should be specified by cardiologist/specialist.
For example
1. When PAF goes to permanent AF, amiodarone should be stopped and rate limiting medicines used instead.
2. Permanent AF/ Ventricular tachycardia- requires a 2 year prompt for consideration of stopping treatment
3. WPW- historic patients should be given opportunity to discuss treatment options

The half-life of amiodarone is very long, with an average of 50 days (range 20-100 days). 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.</td></tr>
<tr><td>v. Adverse effects

Refer to the SPC for a full list of adverse effects & further information
<u>http://www.medicines.org.uk</u></td><td>Amiodarone can cause serious adverse reactions affecting the eyes, heart, lung, liver, thyroid gland, skin and peripheral nervous system. Patients on long term treatment should be carefully supervised because these reactions may be delayed. Because of long half-life of amiodarone, clinical problems may occur up to a year (e.g. photosensitivity) after stopping the drug (hyperthyroidism may occur up to several months after discontinuation).
<table>
<tr><td>Adverse effects</td><td>Action for primary care</td></tr>
<tr><td>Hypokalaemia / hypomagnesaemia</td><td rowspan="6">See monitoring section below</td></tr>
<tr><td>Cardiovascular effects- bradycardia; Worsening of arrhythmia, new arrhythmia, or heart block</td></tr>
<tr><td>Thyroid dysfunction</td></tr>
<tr><td>Hepatotoxicity</td></tr>
<tr><td>Pulmonary toxicity: pneumonitis or fibrosis</td></tr>
<tr><td>Ophthalmological effects: Optic neuropathy/neuritis; blurred or decreased vision</td></tr>
<tr><td>Corneal micro-deposits: blueish halos when looking at bright lights, with no blurred or decreased vision</td><td>Continue amiodarone;. The deposits are considered essentially benign and reversible on discontinuation</td></tr>
<tr><td>GI disturbance: nausea, anorexia, vomiting, taste disturbance</td><td>Continue amiodarone. May require dose reduction; discuss with specialist if persistent.</td></tr>
<tr><td>Neurological symptoms (e.g. extrapyramidal tremor, ataxia, peripheral neuropathy, myopathy)</td><td>Continue amiodarone. A reduced dosage may be required- discuss with specialist</td></tr>
<tr><td>Bullous skin reactions: life threatening or even fatal cutaneous reactions Stevens-Johnson Syndrome (SJS), Toxic Epidermal Necrolysis (TEN)</td><td>Stop amiodarone. Urgent referral to dermatology, inform initiating specialist.</td></tr>
<tr><td>Photosensitivity</td><td>Continue amiodarone. Reinforce appropriate self-care e.g. sun avoidance and purchasing of a broad spectrum sunscreen (at least SPF30).</td></tr>
</table></td></tr>
</table>

	Skin discolouration (blue/grey): occurs in unprotected, light exposed skin	Continue amiodarone. A reduced dosage may be required- discuss with specialist. Reinforce self-care measures (as for photosensitivity above). Pigmentation slowly disappears following treatment discontinuation.

vi. Monitoring Requirements

<u>Consultant/specialist responsibility</u>

Baseline investigations:

- Thyroid function tests
- Liver function tests (LFTs, particularly transaminases)
- Urea and electrolytes (U&Es, including magnesium)
- 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.
- PFT inc DLCO (as per local specialists)

Ongoing monitoring:

- ECG (at least annually- this may be done in primary care)
- 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 remains appropriate.

<u>GP responsibility</u>

Every 6 months

- Assess compliance, ask patient about adverse effects (breathlessness, non-productive cough) and review possible interactions
- TFTs[$] (**and for up to 12 months after discontinuation**)
- LFTs (and for 6m after discontinuation)
- U&Es (including magnesium ; and for 6m after discontinuation)

[$] Locally only TSH is routinely reported. T3/T4 only reported if TSH is abnormal or there is suspicion of pituitary disease- this is to reduce unnecessary investigations (amiodarone reduces T4 to T3 conversion thus T4 may be benignly raised).

Annually

- ECG

Other monitoring if applicable

- Digoxin level- assess serum digoxin levels if dose increased or toxicity is suspected
- INR- more frequent monitoring of INR both during and after amiodarone treatment (initially weekly for first 7 weeks)
- Chest X-ray if clinically indicated (suspected pulmonary toxicity)
- Eye exam- Assess if new or worsening visual symptoms occur.
- Check for drug interactions if new agents added to patient's usual prescription

<u>GP Actions</u>

Parameter	Action
Thyroid function tests (see appendix 1)	An increase of up to 40% above the baseline T4 is a normal effect of amiodarone. This occurs approximately 2 months after initiation and does not require discontinuation if there is no clinical or further biological evidence (TSH) of thyroid disease.

	If TFTs are borderline repeat test in 6 weeks. In the event of thyrotoxosis seek the urgent advice of an endocrinologist.
Liver function tests (See appendix 2)	Normal results - continue treatment and reassess in 6 months If ALT increase within five times the normal range and patient is not jaundiced, continue amiodarone and repeat LFTs in 2 weeks. If still raised, discuss with initiating hospital specialist urgently. If ALT increase exceeds five times the normal range or jaundiced- Stop amiodarone & refer to initiating specialist urgently.
U&E's Hypokalaemia / hypomagnesaemia	Continue amiodarone. Correct deficiency as per local guidelines (See SCP guideline). Review other medicines that may be contributing to a deficiency
Bradycardia HR <50bpm or symptoms present) HR 50 - 60bpm without symptoms	Check for symptoms and arrange an ECG urgently. If the patient has syncope or second or third degree heart block, admission is advised. Mild sinus bradycardia is common but if the patient has symptoms such as increased breathlessness or presyncope which you feel may be due to this- stop amiodarone and discuss with the specialist or arrange review. Continue amiodarone. Repeat monitoring. No action required unless symptoms develop or heart rate decreases further.
Proarrhythmia	Stop amiodarone and arrange urgent specialist appointment. Acute admission may be required.
ECG	If there are signs of the following discuss with the oncall cardiology specialist: • QTc interval ≥ 500 milliseconds • QRS duration>120 milliseconds • prolonged PR interval (>240 milliseconds) if previously normal • Morbitz Type II or complete heart block GPs can also contact cardiologist for advice on • Interpretation of ECG • Consideration for stopping treatment e.g. if patient develop permanent AF/ ventricular tachycardia.
Symptoms of pulmonary toxicity (new/ worsened cough or shortness of breath or deterioration in general health e.g. fatigue, weight loss, fever)	Perform prompt ECG and CXR to exclude alternative diagnoses. If pulmonary toxicity remains a possibility, stop amiodarone and contact cardiologist/specialist or a respiratory physician **urgently** for confirmation of diagnosis and consideration of alternative anti-arrhythmics. Acute admission may be required. Early investigation with HRCT chest scan is important.
Visual disturbances (new onset/ worsening)	Perform eye examination, make urgent ophthalmology referral to exclude optic neuropathy; stop amiodarone and discuss alternative anti-arrhythmics with initiating cardiologist/specialist

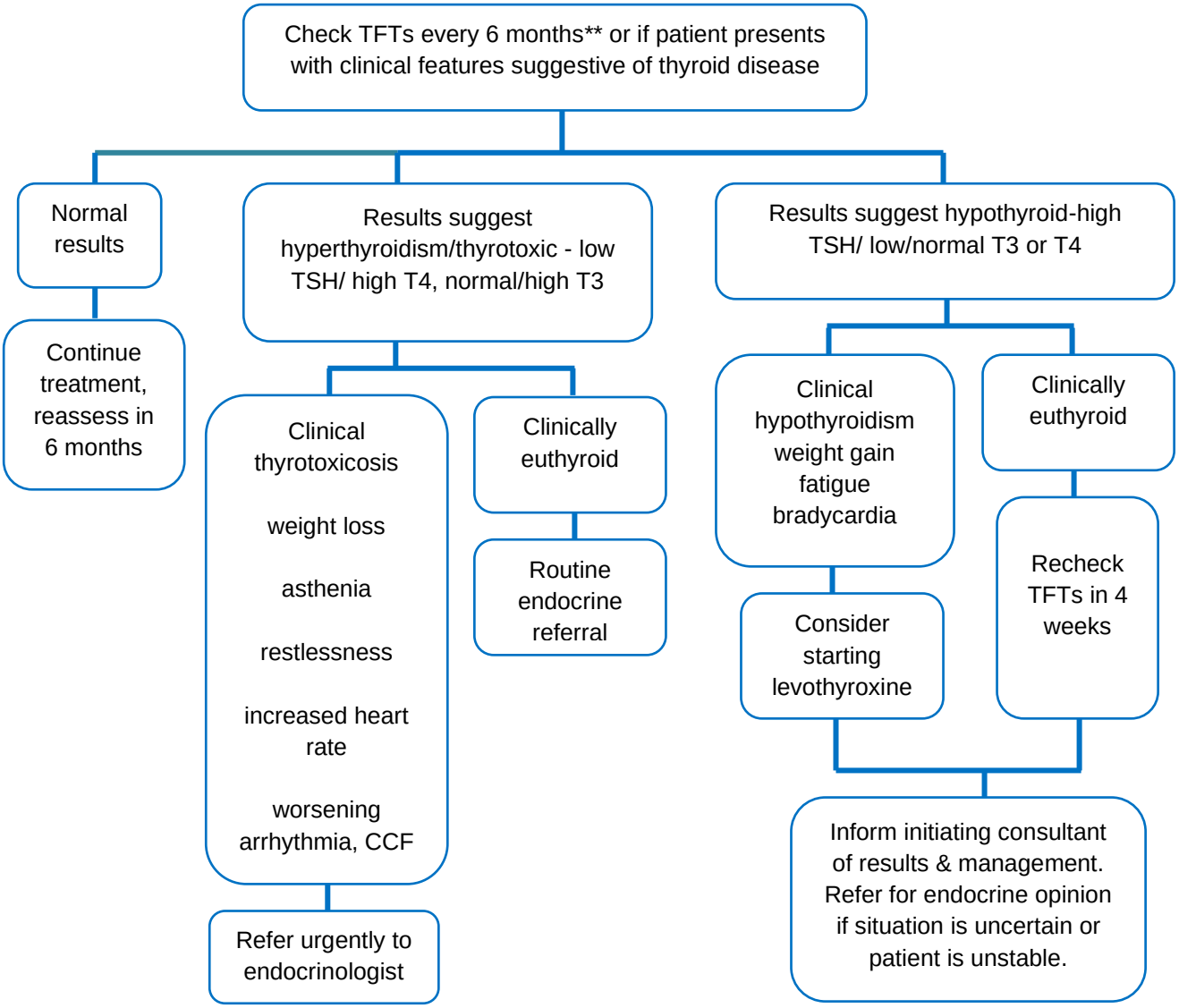
vii. Contra-indications Refer to the SPC for more detailed information	• Sinus bradycardia and sino-atrial heart block/ severe conduction disturbances (high grade AV block, bifascicular or trifascicular block) or sinus node disease (unless pacemaker fitted) • History of thyroid dysfunction: Thyroid function tests should be performed prior to therapy in all patients. 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 to 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 (see viii interaction) • Pregnancy - except in exceptional circumstances • Breastfeeding
viii. Clinically relevant drug interactions Refer to the SPC for more detailed information on drug interactions http://www.medicines.org.uk.	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
ix. Pregnancy, paternal exposure and breastfeeding	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/
x. Additional information	Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed **To be read in conjunction with the following documents** • RMOC Shared Care Guidance • NHSE/NHSCC guidance – items which should not be routinely prescribed in primary care: guidance for CCGs • NHSE policy- Responsibility for prescribing between Primary & Secondary/Tertiary Care
xi. Supply of ancillary equipment; Supply, storage instructions	Not applicable

xii. Prepared by	Derbyshire shared care and guideline group In consultation with: Dr. Julia Baron consultant cardiologist UHDB Dr. J Cooke consultant cardiologist CRHFT
Reviewed (2023)	Derbyshire guideline group in consultation with Dr. J Baron consultant cardiologist UHDB Dr. R Stanworth, consultant endocrinologist UHDB Dr. P Sheridan, consultant cardiologist CRHFT In line with National shared care protocol: Amiodarone for patients within adult services. 4 July 2022, Version 1 https://www.england.nhs.uk/publication/shared-care-protocols/

This does not replace the SPC, which should be read in conjunction with it.

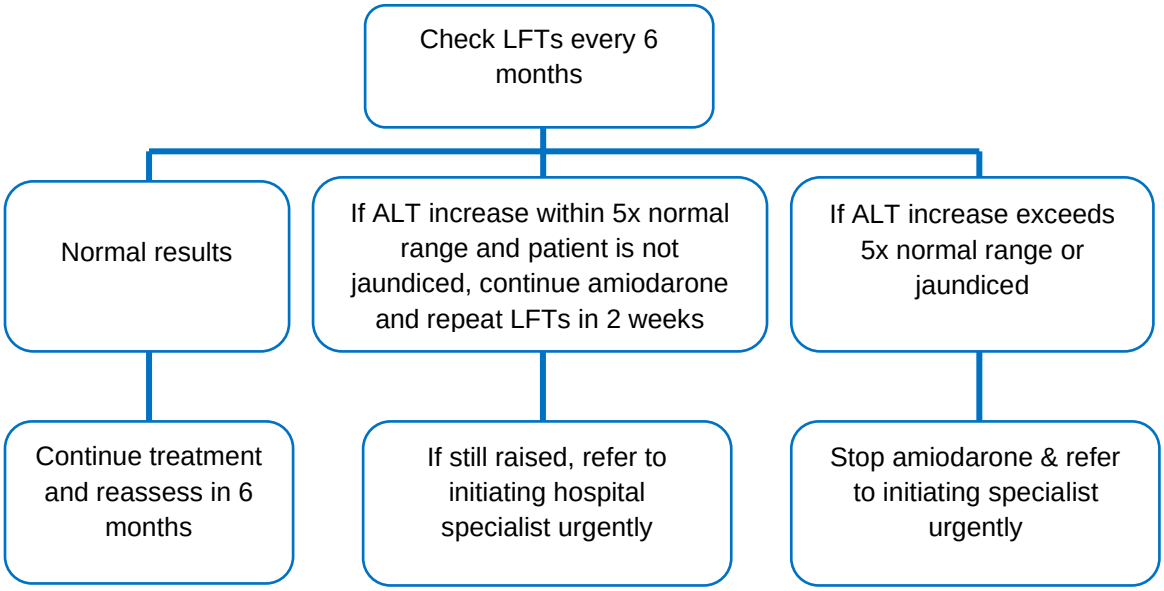
Date Prepared: November 2019 **Reviewed**: August 2023 **Next Review**: July 2026

Appendix 1 Thyroid function test algorithm



** and for up to 12months after discontinuation of amiodarone as hyperthyroidism may occur up to several month after discontinuation.

Appendix 2 Liver function test algorithm



Appendix 3. Amiodarone Patient Advice

Many people take Amiodarone for a long period to maintain a regular heart rhythm without experiencing any problems.

However, unwanted effects can occur as a result of taking Amiodarone including:

- dizziness or fainting:
- unexplained dry cough and/or shortness of breath
- rapid weight loss
- new or worsening visual symptoms

If you experience any of the above symptoms while taking Amiodarone please make an appointment to see your GP.

You will require regular (every six months) blood tests to check your thyroid and liver function during treatment with amiodarone and for up to 12 months after, due to potential adverse effects.

Protect your skin from sunlight
Keep out of direct sunlight while taking this medicine and for a few months after you have finished taking it. This is because your skin may become more sensitive to the sun. Use high factor, wide-spectrum sunscreen to protect against both long-wave ultraviolet and visible light, and/or wear a hat and clothes which cover your arms and legs.

Amiodarone can also affect the action of other medications taken for other medical conditions including:

Warfarin: Amiodarone increases the blood thinning effect of Warfarin. If you notice increased bruising, nose bleeds or difficulty stopping bleeding from cuts please make an appointment to see your GP immediately to adjust your dose of Warfarin.

Digoxin: Amiodarone increases the effect of Digoxin. Your GP will halve your dose of Digoxin when you start taking Amiodarone. If you notice any unexplained dizziness, nausea or vomiting, loss of appetite or visual disturbances see your GP immediately, as the level of Digoxin in your blood could be too high.

Antidepressants: Certain medications such as Lithium and Amitriptyline can increase the risk of irregular electrical activity in the heart if taken together with Amiodarone.

Please inform your GP about any other medications you take when you first see them after starting Amiodarone.

Sample transfer letter

{Insert Hospital Logo here}

Hospital No: «HOSPITAL_NUMBER» NHS
No: «NHS_NUMBER»

{Insert date}

PRIVATE & CONFIDENTIAL
«GP_TITLE» «GP_INITIALS» «GP_SURNAME»
«GP_ADDRESS_1»
«GP_ADDRESS_2»
«GP_POSTCODE»

DERBYSHIRE JAPC SHARED CARE AGREEMENT LETTER

Dear «GP_TITLE» «GP_SURNAME»

«FORENAME_1» «SURNAME» «DATE_OF_BIRTH»
«CURRENT_ADDRESS_1» «CURRENT_ADDRESS_2» «CURRENT_POSTCODE»

Your patient was seen on ***{Insert date}*** with a diagnosis of ***{Insert diagnosis}***. I have initiated the following medication ***{Insert drug name}*** and am writing to ask you to participate in the shared care for this patient.

This medication has been accepted as suitable for shared care by the Derbyshire Joint Area Prescribing Committee (JAPC). I agree to the secondary care responsibilities set out in the shared care agreement for this medication (available from www.derbyshiremedicinesmanagement.nhs.uk/clinical_guidelines/shared_care_guidelines). I am therefore requesting your agreement to share the care of this patient. Where preliminary tests are set out in the agreement I have carried these out and results are below.

Dose Regimen	Date ***{Insert medicine name}*** started	Date for GP to start prescribing ***{Insert medicine name}*** from
The baseline test results are (if applicable):		

I can confirm that the following has happened with regard to this treatment:

	Specialist to complete
The patient has been initiated on this therapy and has been on an optimised dose for the following period of time:	
Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory	*Yes / No*
The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care	*Yes / No*
The risks and benefits of treatment have been explained to the patient	*Yes / No*
The roles of the specialist/specialist team/ Primary Care Prescriber / Patient and pharmacist have been explained and agreed	*Yes / No*
The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments	*Yes / No*
I have enclosed a copy of the shared care protocol which covers this treatment/the SCP can be found here (insert electronic/ web link)	*Yes / No*
I have included with the letter copies of the information the patient has received	*Yes / No*
I have provided the patient with sufficient medication to last until	
I have arranged a follow up with this patient in the following timescale	

If you do **NOT** wish to participate in shared care for this patient, usually under clinical grounds, please complete the attached form.

Yours sincerely

{Consultant name}

GP RESPONSE TO SHARED CARE (only complete & send if **NOT** participating in shared care*)

* For completeness please record medication on GP clinical system as per guidance- 'Recording medicines prescribed and issued by other Healthcare Providers'

Shared care is produced by GPs and specialists knowledgeable in the field of that drug usage. The shared care has been approved by the JAPC. This allows a more convenient service to the patient and cost effective use of NHS resources.

Patient:	NHS No:
Consultant:	Medicine requested for shared care:

I will **NOT** be undertaking the GP responsibilities as described in the agreed shared care guideline. My clinical reasons for declining shared care for this patient are listed in the box below:

		Tick which apply
1.	**The prescriber does not feel clinically confident in managing this individual patient's condition, and there is a sound clinical basis for refusing to accept shared care** As the patients primary care prescriber I do not feel clinically confident to manage this patient's condition because *[insert reason]*. I have consulted with other primary care prescribers in my practice who support my decision. This is not an issue which would be resolved through adequate and appropriate training of prescribers within my practice. **I have discussed my decision with the patient and request that prescribing for this individual remain with you as the specialist, due to the sound clinical basis given above.**	
2.	**The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement** As the medicine requested to be prescribed is not included on the national list of shared care drugs as identified by RMOC or is not a locally agreed shared care medicine I am unable to accept clinical responsibility for prescribing this medication at this time. **Until this medicine is identified either nationally or locally as requiring shared care the responsibility for providing this patient with their medication remains with you**	
3.	**A minimum duration of supply by the initiating clinician** As the patient has not had the minimum supply of medication to be provided by the initiating specialist I am unable to take clinical responsibility for prescribing this medication at this time. Therefore can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. ***Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.***	
4.	**Initiation and optimisation by the initiating specialist** As the patient has not been optimised on this medication I am unable to take clinical responsibility for prescribing this medication at this time. Therefore can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. ***Until the patient is optimised on this medication the responsibility for providing the patient with their medication remains with you.***	
5.	**Shared Care Protocol not received** As legal responsibility for clinical care lies with the clinician who signs the prescription, I need to ensure that I am in possession of sufficient clinical information for me to be confident to prescribe this treatment for my patient and it is clear where each of our responsibilities lie to ensure the patient is safely managed**.** For this reason I am unable to take clinical responsibility for prescribing this medication at this time, therefore would you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.	

	Until I receive the appropriate SCP, responsibility for providing the patient with their medication remains with you.	
6.	**Other (Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted)**	

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

Yours sincerely

{GP name}
{Surgery}

Please send a copy of this response to the specialist/consultant requesting shared care