DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE
(JAPC) and DHCFT MEDICINES MANAGEMENT COMMITTEE

SHARED CARE AGREEMENT

Lithium

Appendix 1 – Assurance framework for the management of initiation, monitoring and shared care responsibilities with primary care

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.
- The patient will be given a supply of Lithium Carbonate or Citrate sufficient for 4 weeks maintenance therapy except where the patient's risk assessment indicates a smaller quantity would be more appropriate.

2. AREAS OF RESPONSIBILITY

GP responsibilities	Consultant/specialist responsibilities
• Upon request, share relevant patient information to aid consultant in optimising patient care such as cardiac risk status, psoriasis, list of current medication, ensuring adequate contraceptive precautions in women. • Ensure medical record updated to clearly indicate secondary care co-prescribing whilst consultant stabilises dose. • Respond to shared care request and if agreed, prescribe lithium by brand name, noting any risk concerns, restrictions to supply quantity and target serum lithium level as advised by consultant. • Undertake monitoring of serum lithium levels and other parameters (see 4 vi below) such as renal & thyroid function and calcium levels. • Monitor for signs/symptoms of change in cardiac function & consult with psychiatrist to arrange ECG & to consider other potential causes if new signs of dysfunction arise. • Copy reports of any monitoring to consultant & discuss how to manage any aberrant results. • Take serum lithium levels 12 to 14 hours after the last dose. Ensure full documentation on the request form of time & date of last dose and blood sampling time to assure validity of results. • Have a system in place to ensure blood test results are reviewed before prescribing and that these and any changes to treatment are recorded in the patient's 'purple book' or can be uploaded to the 'App' by the patient. • Report unacceptable adverse effects promptlyto consultant. • Be aware of potential for drug interactions and monitor serum levels as appropriate (see 4 vii) • Avoid abrupt discontinuation unless indicated by toxicity or severe side effects. If patient does not attend for routine screening please seek support from mental health team to facilitate.	• Provide diagnosis. • Perform baseline tests as indicated below, copy results to GP. Seek information from GP regarding any cardiac risk, psoriasis and list of current medication. • Discuss treatment with patient including benefits, side-effects, blood tests, likely duration, increased relapse risk in bipolar disorder after rapid discontinuation or due to poor adherence. • Provide patient with lithium information, alert card and record book, ensuring details are recorded. Advise on the availability of a smartphone 'App' if the patient prefers. • Counsel women on necessary contraceptive precautions; liaise with GP/family planning. Advise women to discuss with consultant as soon as possible if becomes pregnant or planning pregnancy. • Consider potential drug interactions. Ensure patient is asked about medication use including herbal and OTC at each review and check medicines using the Summary Care Record/MIG and SystmOne records. • Risk-assess patient, seeking cardiology opinion if ECG abnormal (see 4 vi below). Risk-assess appropriate supply quantity (see referral criteria). • Start lithium; arrange for serum level 5-7 days post initation and dose changes and weight monitoring; titrate and stabilise dose, based on serum levels. Inform and copy GP test & weight results during dose stabilisation period. • Ask GP if willing to share care. If agreed, transfer prescribing (by brand name) and monitoring of serum levels and other parameters (see 4 vi below) such as renal & thyroid function, calcium levels and new clinical signs/symptoms of cardiac dysfunction. • Indicate to GP the individual's target serum lithium level and any restrictions to supply quantity. Advise GP of any risk assessment judgements made e.g. cardiac, overdose or medication interaction risks. • If care is not to be shared, undertake all monitoring, as indicated below, and prescribing and copy GP in reports • Assess response in conjunction with adherence.

• Respond to any discontinuation plan advised by consultant. • Discontinue shared care and refer back to Consultant and to Perinatal psychiatrist if informed of pregnancy by patient. Inform midwife and ensure the woman is received in consultant-led maternity care. • Report any adverse effects to the referring specialist and the MHRA yellow card scheme.	• Evaluate and advise on adverse events noted by GP or patient. • Promptly communicate any changes to GP and update electronic patient records. Where there is a purple booklet or lithium app ensure these are also updated. • Advise GP on when and how to discontinue treatment (see 4 iv below). • Undertake individual review on a case by case basis according to clinical need • Report any adverse effects to the MHRA yellow card scheme

Patient responsibilities

- Attend appointments and have recommended tests at recommended intervals; Be aware that medicines may be stopped if they do not attend.
- Moderate their alcohol intake to no more than 14 units per week. Avoid recreational drugs.
- Not to drive or operate heavy machinery if lithium affects their ability to do so safely.
- Use an appropriate form of contraception, as agreed with their doctor/nurse/sexual health service.
- Seek medical attention if they develop diarrhoea or vomiting or become acutely ill for any reason. Be aware of possible side-effects, especially signs of high lithium level and report promptly to professional involved with their care
- Share any other concerns regarding lithium such as an incomplete understanding of their treatment, with professional involved with their care
- Maintain their fluid intake, particularly after sweating (e.g. after exercise, in hot climates or if they have a fever), if they are immobile for long periods or if they develop a chest infection or pneumonia.
- Women should talk to their doctor as soon as possible if they become pregnant or are planning a pregnancy
- Seek advice before self-medicating with over the counter preparations.
- Carry the lithium alert card. Keep the lithium record book (purple book in a safe place and show the alert card to healthcare professionals involved in their care. Take the record book with them to their GP, clinic appointments and to pharmacies when collecting lithium medication (or use the 'App' if patient prefers).

3. COMMUNICATION AND SUPPORT

i. Hospital contacts: Consultant psychiatrist caring for patient	**ii. Out of hours contacts and procedures:** Duty doctor via switchboard: South :01332 623700 North: 01246 277271 (CRH) - bleep 291

iii Specialist support/resources available to GP including patient information:

Mental health team/consultant caring for patient (Individual CMHT contact details corresponded to patient and primary care by DHCFT)

www.medicines.org.uk

Patient information on this medicine can be found at the following links:

- NHS: https://www.nhs.uk/medicines/lithium/
- MIND: https://www.mind.org.uk/information-support/drugs-and-treatments/lithium-and-other-mood-stabilisers/lithium/

4. CLINICAL INFORMATION (continued overleaf)

i. Prescribed indications	Treatment and prophylaxis of mania, hypomania and bipolar disorder. Augmentation of antidepressants in treatment resistant depression. Control of aggressive behaviour and intentional self-harm.
ii. Therapeutic summary	Mode of action not fully understood, competes with sodium at various sites in the body and used in the indications described in (i) above.
iii. Dose & Route of administration	Lithium carbonate Starting dose typically 400 mg once daily, then adjusted according to patient response and 12-hour plasma levels. In some scenarios, such as acute mania, a higher starting dose may be preferable. Doses may initially be divided throughout the day but once-daily administration is preferred when plasma lithium concentration is stabilised in the target range (specified by specialist team).

Lithium carbonate tablets should be prescribed unless there is a specific problem with swallowing difficulties.

Lithium citrate
Starting dose typically 509 mg or 520 mg twice daily (depending on brand), in the morning and evening, then adjusted according to patient response and 12-hour plasma levels.

Dosing is by slow upwards titration to achieve a target serum level usually between 0.4 – 0.8mmol/L.
In bipolar disorder target level should be 0.6 – 0.8mmol/L but consider maintaining target level 0.8 – 1.0mmol/L for a trial of at least 6 months in those who have relapsed whilst taking lithium previously or who have subthreshold symptoms with functional impairment.
Levels at the lower end of the therapeutic range 0.4 – 0.8mmol/L may be advisable in older adults or those at risk of renal impairment, heart disease or interacting concomitant medicine
The specialist service will determine the target plasma range for each patient and advise the primary care prescriber accordingly.

Brands of lithium are **not** interchangeable due to considerable differences in product bioavailability, inter-individual variability and narrow therapeutic index and should be **prescribed by brand name**.

Lithium is available as lithium carbonate (tablet formulations) and lithium citrate (liquid formulations). The patient should be maintained on the same brand and formulation of lithium. If a switch in brand or formulation is considered, refer to the specialist team.

Lithium tablets and liquids are not interchangeable. Liquid formulations contain lithium citrate and doses are not equivalent to lithium carbonate; bioavailability is significantly different. If a switch in formulation is considered, discuss with the specialist team.

Extra care must be taken when prescribing lithium in liquid form, as some offer different strengths under the same brand names, and some brands are used for the liquid and tablet forms. Lack of clarity may lead to the patient receiving a sub-therapeutic or toxic dose.

iv. Duration of treatment and discontinuation

Duration of treatment will be determined by the indication and the individual's previous history. According to the indication, assessment of response can take from 3 months or longer. Prophylaxis can sometimes be for many years.
Unless adverse effects dictate otherwise, when discontinuing in bipolar disorder this should be done gradually over at least 4 weeks and preferably over 3 months. Monitor closely for early signs of mania or depression during dose reduction and for 3 months after stopping.

v. Adverse effects

Serum lithium levels > 1.3mmol/L are generally associated with acute toxicity, signs & symptoms include: coarse tremor, nausea & vomiting, dysarthria, drowsiness, ataxia, blurred vision, muscle weakness, tinnitus, confusion, convulsions, ECG changes – STOP lithium immediately, urgently measure serum Lithium, U & Es and refer to hospital as necessary.

Other adverse effects include: weight gain (avoid sugary drinks), oedema, mild GI disturbances e.g. nausea, diarrhoea, (but see acute toxicity above), fine tremor, polydipsia, polyuria, exacerbation of psoriasis, acne.

Longer term - hypothyroidism (see monitoring vi), hypercalcaemia & hyperparathyroidism (see vi - serum calcium check), renal impairment & diabetes insipidus (see vi - regular eGFR & U&Es & avoid episodes of acute toxicity), bradycardia, arrhythmias (see vi – ECG if risk)

vi. Monitoring requirements

Consultant/ specialist responsibility

Baseline	Weekly after starting until parameter stable
Exclude pregnancy where appropriate U & Es **including Calcium,** eGfR TFTs FBC ECG if risk factors for or existing CVD Weight/BMI **Additional baseline investigations (bipolar disorder):** • Cardiovascular status including pulse and blood pressure • Metabolic status including fasting blood glucose, glycosylated haemoglobin (HbA_{1c}) and blood lipid profile. • Liver function tests (LFTs).	Serum lithium (including after dose changes) Weight/BMI

<table>
<tr><td></td><td>
Ongoing Monitoring- GP responsibility (once taken prescribing)
<table>
<tr><td colspan="3">All patients to have lithium monitoring every 3 months for first year and then:</td></tr>
<tr><td>Every 3 months</td><td>Every 6 months
(or more often if abnormal)</td><td>Annual</td></tr>
<tr><td rowspan="2">serum Lithium (12-16 hr level) in these patients During the first year of treatment with lithium and for:
• Older adults or
• Serum Lithium ≥0.8mmol/L
• Impaired renal function
• Impaired thyroid function
• Hypercalcaemia
• Lithium-interacting drugs
• Poor adherence
• Poor symptom control</td><td rowspan="2">• Serum lithium (after the first year) for those with stable level and not in the 3 monthly category recommendations
• U & Es <u>including Calcium, eGFR</u>
• TFTs
• Weight/BMI</td><td>• Physical health check i.e. blood glucose, BP, lipids smoking/alcohol
• ECG if cardiac risk factors continue or new concerns</td></tr>
<tr><td>At each appointment
• Ask about polyuria or polydipsia symptoms (diabetes insipidus signs)
• Ask about tremor, ataxia, paraesthesia, memory (neurotoxic signs)</td></tr>
</table>
</td></tr>
<tr><td>vii. Contraindications and cautions</td><td>
Contraindications:
• Hypersensitivity to lithium or any of the excipients
• Addison’s disease
• Cardiac disease associated with rhythm disorder
• Cardiac insufficiency
• Family or personal history of Brugada syndrome
• Patients with abnormal sodium levels, including dehydrated patients or those on low sodium diets
• Untreated hypothyroidism
• Severe renal impairment
• Pregnancy (especially the first trimester), unless considered essential
• Breastfeeding

Cautions:
• Mild to moderate renal impairment
• Use in elderly patients
• Adequate and stable sodium and fluid intake should be maintained. This may be of special importance in hot weather, or during infectious diseases, including influenza, gastro-enteritis or urinary infections, when dose reduction may be required.
• Review lithium dose if diarrhoea and/or vomiting present and in cases where the patient has an infection and/or profuse sweating. Adjustments may be required.
• Risk of seizures may be increased if co-administered with drugs that lower the seizure threshold, or in patients with epilepsy.
• Cardiac disease
• May exacerbate psoriasis
• Surgery: discontinue 24 hours prior to major surgery and re-commence post-operatively once kidney function and fluid-electrolyte balance is normalised. Discontinuation is not required prior to minor surgery, providing fluids and electrolytes are carefully monitored.
</td></tr>
<tr><td>viii. Clinically relevant drug interactions</td><td>
Check lithium levels after interacting meds are started (at 1 week) or stopped (within 4 weeks)

<u>Risk of lithium toxicity</u> in sodium depletion or reduced renal clearance so avoid concurrent diuretics, NSAIDs, ACE inhibitors and Angiotensin II antagonists.
<u>Risk of potentially serious serotonergic syndrome</u> with concurrent serotonergics including SSRIs, triptan migraine products, certain opioids e.g. tramadol, which resolves rapidly on stopping serotonergic agent.
<u>Risk of neurotoxicity</u> due to concurrent diltiazem, verapamil, methyldopa, carbamazepine, phenytoin, haloperidol, phenothiazines or SSRIs
<u>Theophylline</u> increases lithium excretion therefore stopping concurrent theophylline can increase lithium levels, whilst adding it can lower lithium.
</td></tr>
<tr><td>ix. Pregnancy, paternal exposure and breast feeding</td><td>
All patients should be informed of the risks and benefits of taking this medicine during pregnancy and breastfeeding.
<u>Pregnancy</u>:
If a patient becomes pregnant whilst on lithium, the specialist team should be informed immediately (but do not stop the lithium).
</td></tr>
</table>

	Lithium should not be used during pregnancy where possible, especially in the first trimester (risk of teratogenicity, including cardiac abnormalities). In certain cases where a severe risk to the patient could exist if treatment were stopped, lithium has been continued during pregnancy; under these circumstances prescribing is the responsibility of the specialist team. There is a risk of relapse of bipolar disorder if lithium is withdrawn, particularly in the postnatal period. **Patients of child-bearing potential should be advised to use a reliable form of contraception.** It is the responsibility of the specialist to provide advice on the need for contraception to patients on initiation of lithium, and at each review. Under shared care agreements, the ongoing responsibility for providing this advice rests with both the GP and the specialist. Information for healthcare professionals: https://www.medicinesinpregnancy.org/bumps/monographs/USE-OF-LITHIUM-IN-PREGNANCY/ Information for patients and carers: https://www.medicinesinpregnancy.org/Medicine--pregnancy/Lithium/ **Breastfeeding:** Lithium is secreted in breast milk and there have been case reports of neonates showing signs of lithium toxicity. Breastfeeding should be avoided during treatment with lithium. Information for healthcare professionals: https://www.sps.nhs.uk/medicines/lithium/ **Paternal exposure**: Animal studies have reported spermatogenesis abnormalities that may lead to impairment of fertility. It is unknown if this risk applies to humans.
x. Supply of ancillary equipment	Replacement / new Patient-held lithium treatment alert/reminder cards are available from Primary Care Support England (PCSE) through the following link http://pcse.england.nhs.uk/ using your practice log in details.
xi. Supply, storage and reconstitution instructions	N/A
xii. 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
Prepared by	Reviewed and updated by Michelle Lad – Deputy Chief Pharmacist Medicine Safety and Governance, DHCFT Medicines management committee DHCFT Derbyshire Guideline group Adapted from NHSE National shared care protocol- Lithium for patients within adult services. 4 July 2022, Version1. https://www.england.nhs.uk/medicines-2/regional-medicines-optimisation-committees-advice/shared-care-protocols/ (accessed March 2023)

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

Date approved: June 2023
Review Date: May 2026

Appendix 1: Assurance framework for the management of initiation, monitoring and shared care responsibilities with primary care

Lithium initiation

Service user commenced on lithium

Prescriber discusses lithium, monitoring, etc
Document in the electronic patient record any baseline blood test results and the target lithium plasma level

Lithium is titrated to the target plasma level by the team. Prescriber documents doses and blood test results in the electronic patient record and purple book/app (if used by the service user).

The team assesses when treatment has been stablised. Document this and any change to the target lithium plasma level

Patients may download an application to use on their iOS or Android smartphone.
Where available DHCFT will issue purple lithium booklets and alert cards at the point of initation.

If the service user is using their purple book or smartphone application then document doses and blood tests in the book or on the application.

Baseline	Weekly after starting until parameter stable
Exclude pregnancy where appropriate U & Es **including Calcium** eGfR TFTs FBC ECG if risk factors for or existing CVD Weight/BMI	Serum lithium (including after dose changes) Weight/BMI

Unstable or shared care not viable

Mental health team responsible for further prescribing and monitoring of lithium

A

Stable. Shared care with GP.

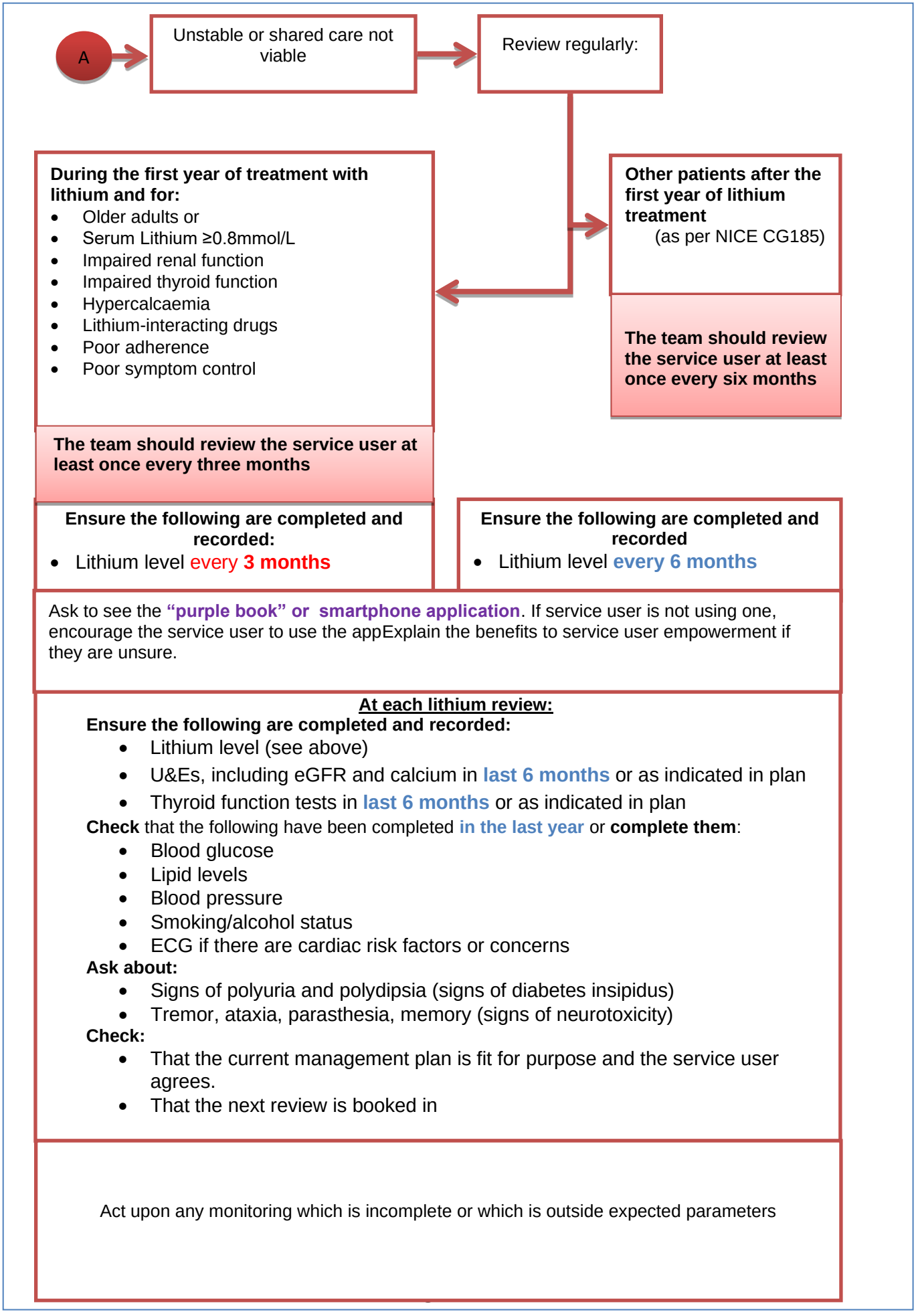
GP can prescribe and monitor lithium under **"shared-care guideline"**. Mental health team will review monitoring

B

Stable and discharged

GP is responsible for further prescribing and monitoring of lithium

At present these are a pre-existing group of patients who were established on lithium a long time ago.
We do not currently discharge such service users from care, but we do try to encourage shared-care


A
Unstable or shared care not viable
Review regularly:
During the first year of treatment with lithium and for:
Older adults or
Serum Lithium ≥0.8mmol/L
Impaired renal function
Impaired thyroid function
Hypercalcaemia
Lithium-interacting drugs
Poor adherence
Poor symptom control
Other patients after the first year of lithium treatment
(as per NICE CG185)
The team should review the service user at least once every six months
The team should review the service user at least once every three months
Ensure the following are completed and recorded:
Lithium level every 3 months
Ensure the following are completed and recorded
Lithium level every 6 months
Ask to see the "purple book" or smartphone application. If service user is not using one, encourage the service user to use the appExplain the benefits to service user empowerment if they are unsure.
At each lithium review:
Ensure the following are completed and recorded:
Lithium level (see above)
U&Es, including eGFR and calcium in last 6 months or as indicated in plan
Thyroid function tests in last 6 months or as indicated in plan
Check that the following have been completed in the last year or complete them:
Blood glucose
Lipid levels
Blood pressure
Smoking/alcohol status
ECG if there are cardiac risk factors or concerns
Ask about:
Signs of polyuria and polydipsia (signs of diabetes insipidus)
Tremor, ataxia, parasthesia, memory (signs of neurotoxicity)
Check:
That the current management plan is fit for purpose and the service user agrees.
That the next review is booked in
Act upon any monitoring which is incomplete or which is outside expected parameters

B

Stable but kept on mental health team caseload under **"shared-care"** alongside the GP

Lithium review (as below) at least once every 12-months depending upon clinical needs

Ask to see the **"purple book" or app**. If service user is not using one, encourage use of the appExplain the benefits to service user empowerment if they are unsure.

During the first year of treatment with lithium and also long term maintenance for:

- All Older adults

or those with:

- Serum Lithium ≥0.8mmol/L
- Impaired renal function
- Impaired thyroid function
- Hypercalcaemia
- Lithium-interacting drugs
- Poor adherence
- Poor symptom control

Check pathology results for:

- Lithium level in the **last 3 months**
- U&Es, including eGFR and calcium in **last 6 months**
- Thyroid function tests in **last 6 months**

Patients after the first year of lithium treatment (where the criteria in the box to the left do not apply)
(as per NICE CG185)

Check pathology results for:

- Lithium level in the **last 6 months**
- U&Es, including eGFR and calcium in **last 6 months**
- Thyroid function tests in **last 6 months**

At each lithium review:

Check that the following have been completed **in the last year**:

- Blood glucose
- Lipid levels
- Blood pressure
- Smoking/alcohol status
- ECG if there are cardiac risk factors or concerns

Ask about:

- Signs of polyuria and polydipsia (signs of diabetes insipidus)
- Tremor, ataxia, parasthesia, memory (signs of neurotoxicity)

Check:

- That the current management plan is fit for purpose and the service user agrees.
- That the next review is booked in

Act upon any monitoring which is incomplete or which is outside expected parameters

Sample Transfer Letter

Derbyshire Healthcare
NHS Foundation Trust

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): **See overleaf for initiation criteria.**		

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	

The next blood monitoring is due on [insert date] and should be continued in line with the shared care guideline.
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}

Making a positive difference

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

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 applies
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 patient's 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