DRUGS USED IN THE MANAGEMENT OF ADHD IN CHILDREN AND ADULTS

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 reasonably predictable and the treatment regime has been specified.
   • Patients will only be referred to the GP once the GP has agreed in each individual case, subject to receiving the relevant clinical information.
   • The patient will be given a supply of the relevant drug sufficient for 4 weeks maintenance therapy.

2. AREAS OF RESPONSIBILITY

<table>
<thead>
<tr>
<th>GP responsibilities</th>
<th>Consultant/Specialist Service’s responsibilities</th>
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</thead>
<tbody>
<tr>
<td>• Initial referral to specialist raising possibility of ADHD</td>
<td>• Inform patient about unlicensed status (adults)</td>
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</tbody>
</table>
| • Provide information re medical history and perform physical examination if requested. | • Discuss the benefits and side effects of treatment with the patient/carer. In particular ensure awareness of: how to recognise symptoms of hepatic disorder (stomach pain, nausea, dark urine, jaundice); need to report promptly suicidal thoughts & self-harming behaviour; possible teratogenicity in pregnancy (as appropriate).
| • Report to the request for shared care as soon as practicable.                    | • Risk assess for diversion and misuse.            |
| • Once dose has been stabilised, prescribe repeat prescriptions – maximum of 30 days recommended (NB.CD requirements for all except atomoxetine) | • Assess full medical history including history of convulsive disorders, exercise syncope, undue breathlessness, other cardiovascular symptoms and family history of cardiac disease or history of sudden death in young family members. Ensure examination of cardiovascular system and undertake ECG if abnormal findings. Patient should be referred for specialist cardiac evaluation if initial findings suggest such history or presence of cardiac disease. |
| • Adjust the dose as advised by the specialist.                                    | • Ensure baseline monitoring of height (under 18 only) weight, pulse and BP are performed plus any additional relevant investigations (e.g. specialist cardiac evaluation) |
| • Refer if patient develops palpitations, exertional chest pain, unexplained syncope or other symptoms suggestive of heart disease. | • Initiate treatment taking into account contra-indications, cautions, side-effects, compliance/diversion issues and cost. |
| • Monitor for onset or exacerbation of motor and verbal tics                        | • Initiate prescriptions, titrating the dose against symptoms and side effects until dose optimisation is achieved. |
| • Monitor for the development or worsening of psychiatric disorders.                | • Prescribe by brand name for MR preparations      |
| • Report to and seek advice from the specialist on any aspect of patient care that is of concern and may affect treatment. | • Ask the GP whether he or she is willing to participate in shared care once the dose is stable (informing of unlicensed status where applicable). Do not continue to prescribe once responsibility is transferred without communication with the GP (risk of misuse). |
| • Refer patient to the specialist if his or her condition deteriorates.             | • Communicate promptly with the GP when treatment is changed or the patient defaults attending clinic. |
| • Stop treatment on the advice of the specialist or immediately if an urgent need to stop treatment arises. | • Review patient regularly, with an annual review of medications. Communicate the results of the review to the GP and provide advice on stopping treatment as appropriate. |
| • If patient defaults attending clinic do not continue prescription unsupervised    | • Agree monitoring schedule with GP for adults every 6 months and ensure sharing of these results. Patients who develop symptoms that suggest heart disease should undergo a prompt specialist cardiac evaluation. |
| • Report any adverse events to the referring specialist and MHRA yellow card scheme. | • Monitor BP/ HR/ weight and Height in children and young people |
| • Undertake shared monitoring requirements for adults in agreement with consultant/specialist. | • Monitor for onset or exacerbation of motor and verbal tics |
| • Monitor patients in line with the physical monitoring guidance provided on page 6 of this SCA. | • Have a mechanism in place to receive rapid referral of a patient from the GP in the event of deteriorating clinical condition. |
| • Monitor for signs of diversion and misuse (e.g. by checking prescribing intervals of prescriptions) | • Report adverse events to the MHRA yellow card scheme. |
| • Prescribe by brand name for MR preparations                                        | • Ensure that clear backup arrangements exist for GPs to obtain advice and support. |

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### Patient / carer responsibilities:
- Report any adverse effects
- Maintain handheld records
- Complete any monitoring forms requested by the specialist
- Order repeat prescriptions and supplies and store safely
- Attend all medical / other appointments as necessary

### 3. COMMUNICATION AND SUPPORT

#### i. Contacts
If necessary contact the consultant who is supervising care – refer to assessment letter for details.

**Pharmacy departments:**
- Derbyshire Healthcare NHS Foundation Trust: 01332 623700 ext 33268
- Royal Derby Hospital: 01332 340131 Pharmacy via switchboard
- Chesterfield Royal Hospital: 01246 512157

#### ii. Out of hours:
- On call psychiatrist/paediatrician/CAMHS via CRH switchboard 01246 277271
- On call psychiatrist/paediatrician/CAMHS via DHCFT switchboard 01332 623700
- On call paediatrician RDH via switchboard 01332 340131

#### iii. Specialist support/resources available to GP including patient information
Information on treatment for ADHD is available at [http://www.choiceandmedication.org/derbyshcft/](http://www.choiceandmedication.org/derbyshcft/)
The local Parent Support Group contact is: FLARE, Derbyshire ADHD Support Service.
Telephone: 01246 569012    E-mail flareadhd@aol.com

### 4. CLINICAL INFORMATION
Please note cautions and contraindications in cardiac disease, cerebrovascular disease, glaucoma, phaeochromocytoma and hyperthyroidism.

Caution in patients whose underlying medical condition might be compromised by increases in blood pressure or heart rate. *Caution in epilepsy or history of seizures.*

Methylphenidate is contraindicated in patients with a diagnosis or history of severe depression, anorexia nervosa/anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, and personality disorder.

For full prescribing information please see the relevant Summary of Product Characteristics.

### Information Sources Used:

  - Ritalin, Equasym XL, Concerta XL and Medikinet XL
  - Strattera
  - Elvanse
  - Dexamfetamine


- BNF accessed on-line September 2016
- BNF for Children accessed on-line September 2016
- Stockley’s Drug Interactions accessed September 2016 at [www.medicinescomplete.com](http://www.medicinescomplete.com)
Further information:


Shared care ADHD guideline:

<table>
<thead>
<tr>
<th>Reviewed and Reformatted by:</th>
<th>Beverley Thompson Deputy Chief Pharmacist Derbyshire Healthcare NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lisa Taylor Senior Pharmacist Derby Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td></td>
<td>Dr Morton Consultant Paediatrician Derby Hospitals NHS Foundation Trust</td>
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<tr>
<td></td>
<td>Dr J Thomas, Chesterfield hospital</td>
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<tr>
<td></td>
<td>Dr S Banta, Derbyshire Healthcare NHS Foundation Trust</td>
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<tr>
<td></td>
<td>Dr S Taylor, Derbyshire Healthcare NHS Foundation Trust</td>
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<tr>
<td>In consultation with:</td>
<td>The Shared Care Guidelines Group Derby Hospitals NHS Foundation Trust</td>
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<tr>
<td></td>
<td>Child and Adolescent Mental Health Services (CAMHS) Derbyshire</td>
</tr>
</tbody>
</table>

Shared care ADHD guideline for adults:

| Written by:                 | Simon Taylor, Consultant Psychiatrist, Derbyshire Mental Health Services NHS Trust |
|                            | Beverley Thompson, Pharmacist, Derbyshire Mental Health Services NHS Trust         |
|                            | Updated by Sally Jordan, Pharmacist, Derbyshire Healthcare Foundation Trust May 2012 |

Shared Care ADHD guideline for adults & children:

| Amalgamated and reviewed by: | Beverley Thompson, Pharmacist, Derbyshire Healthcare Foundation Trust               |
| In consultation with:        | Dr Walters, Chesterfield Royal Hospital                                              |
|                             | Dr McIntyre, Derby Hospitals NHS Foundation Trust                                  |
|                             | Drs Banta & Taylor, Derbyshire Healthcare Foundation Trust                         |

This does not replace the SPC, which should be read in conjunction with it.
<table>
<thead>
<tr>
<th>Drug</th>
<th>Controlled Drug</th>
<th>Dose in children</th>
<th>Place in Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methylphenidate (Ritalin, Medikinet) 5mg, 10mg, 20mg tablets</td>
<td>Yes</td>
<td>BNFc 4-5 years unlicensed: 2.5mg twice a day, increased by 2.5mg at weekly intervals. Max 1.4mg/kg in 2-3 doses. 6 years and over Initial: As per plain tablets, using an equivalent dose. If initiating treatment with Equasym XL use 10mg daily, (before breakfast). Max: 60mg once a day</td>
<td>First line, if once daily dosing and 8-hour action is required or there are concerns about diversion. (30% immediate release and 70% extended)</td>
</tr>
<tr>
<td>Equasym XL* (Methylphenidate LA) 10mg, 20mg, 30mg capsules</td>
<td>Yes</td>
<td>6 years and over Initial: As per plain tablets, using an equivalent dose. Not usually for initiation of treatment - use 18mg in the morning if required. Max: 54mg once a day.</td>
<td>First line, if once daily dosing and 12-hour action is required or there are concerns about diversion. (22% immediate release and 78% extended)</td>
</tr>
<tr>
<td>Delmosart SR 18mg, 27mg, 36mg, 54mg tablets</td>
<td>Yes</td>
<td>6 years and over Initial: As per plain tablets, using an equivalent dose. If initiating treatment with Medikinet XL use 10mg daily, (with breakfast). Max: 60mg once a day.</td>
<td>First line, if once daily dosing and 8-hour action is required or there are concerns about diversion. (50% immediate release and 50% extended)</td>
</tr>
<tr>
<td>Medikinet XL* (Methylphenidate LA) 10mg, 20mg, 30mg, 40mg capsules</td>
<td>Yes</td>
<td>6 years and over Initial: Once a day dose in the morning or 2 evenly divided doses (morning &amp; late afternoon/early evening), if not tolerated/inadequate response &lt;70kg: initially 0.5mg/kg/day minimum of 7 days, then titrated. Max: 70mg once a day.</td>
<td>Second line if stimulant ADHD treatment is required and there is concern of diversion</td>
</tr>
<tr>
<td>Xaggitin SR (Methylphenidate LA) 18mg, 27mg, 36mg, 54mg tablets (Previously matoride XL and concerta XL were the preferred brands)</td>
<td>No</td>
<td>6 years and over Initial: 30mg once daily in the morning or 20mg if appropriate. Titrate according to response/tolerability. May be increased at weekly intervals by 10-20mg increments. Max: 70mg once a day.</td>
<td>Second line if stimulant ADHD treatment is required and there is concern of diversion</td>
</tr>
<tr>
<td>Atomoxetine (Strattera) 10mg, 18mg, 25mg, 40mg, 60mg capsules and 4mg/ml oral solution</td>
<td>Yes</td>
<td>6 years and over: 5-10mg a day, increasing if necessary by 5mg daily at weekly intervals. Usual max: 20mg daily. (40mg or more in some older children).</td>
<td>Second line</td>
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<tr>
<td>Lisdexamfetamine (Elvanse) 20mg, 30mg, 40mg, 50mg, 60mg 70mg caps (Elvanse Adult) 30mg, 50mg, 70mg</td>
<td>Yes</td>
<td>Cost effective choice compared to atomoxetine and lisdexamfetamine. where there are no concerns of diversion.</td>
<td>Second line</td>
</tr>
<tr>
<td>Dexamfetamine (Dexedrine) 5mg tablets</td>
<td>Yes</td>
<td>Refractory hyperkinetic states under the supervision of a physician specialising in child psychiatry.</td>
<td>Unlicensed: Treatment of ADHD in adults</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Dose in Adults</th>
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<tbody>
<tr>
<td><strong>Unlicensed:</strong></td>
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<td>Initial:</td>
<td><em>Initial:</em></td>
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<tr>
<td>5mg 2 or 3 times a day. Titrate against symptoms and side effects at weekly intervals. Max: 100mg/day in up to 4 divided doses.</td>
<td>As per plain tablets, using an equivalent dose. If initiating treatment with Equasym XL use 10mg daily, (before breakfast). Max: 100mg daily Usually given once daily, but not more than twice daily.</td>
<td>As per plain tablets, using an equivalent dose. If initiating treatment with Delmosart or Xaggitin use 18mg daily, adjusted at weekly intervals. Max 108mg daily Usually given once daily, but not more than twice daily</td>
<td>40mg/day minimum of 7 days, then titrate as required. BNF suggests start at 0.5mg/Kg if &lt;70kg Usually maintenance dose 80-100mg/day. Max dose 120mg (unlicensed). Once a day dose in the morning or 2 evenly divided doses (morning &amp; late afternoon/early evening), if not tolerated/inadequate response</td>
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<td><strong>Unlicensed:</strong></td>
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<td>Initial:</td>
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<td>40mg/day minimum of 7 days, then titrate as required. BNF suggests start at 0.5mg/Kg if &lt;70kg Usually maintenance dose 80-100mg/day. Max dose 120mg (unlicensed). Once a day dose in the morning or 2 evenly divided doses (morning &amp; late afternoon/early evening), if not tolerated/inadequate response</td>
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<td><strong>Unlicensed:</strong></td>
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<td>Initial:</td>
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<td>30mg once daily in the morning. Titrate according to response/tolerability. May be increased at weekly intervals by 20mg increments. Max: 70mg daily</td>
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<td><strong>Unlicensed:</strong></td>
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<td>Initial:</td>
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<td>5mg twice a day. Titrate against symptoms and side effects, increasing at weekly intervals as required. Max: 60mg/day in 2 - 4 divided doses.</td>
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<td><strong>Physical Monitoring</strong></td>
<td>Agree monitoring schedule with GP and consultant/specialist for adults</td>
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<tr>
<td>Pulse &amp; BP before and after dose changes and then every 3 months (GPs to monitor in adults. Children will continue to be monitored by specialists) Weight every 6 months in adults</td>
<td>Weight and height every 6 months for children and adolescents and recorded on growth chart- specialist to monitor</td>
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<tr>
<td>Management of ADHD in adults and children</td>
<td><strong>Updated:</strong> October 2016</td>
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<td>Page 5 of 8</td>
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<tr>
<td>Drug Interactions</td>
<td>Methylphenidate:</td>
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<td></td>
<td>Warfarin.</td>
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<td>Phenytioin.</td>
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<td>Valproate.</td>
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<td>Carbamazepine</td>
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<td>MAOls.</td>
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<td>Tricyclic antidepressants.</td>
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<td>SSRIs</td>
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<td>Clonidine</td>
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<td>Tricyclic antidepressants.</td>
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<td>Drugs that cause electrolyte imbalance</td>
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<td>Clonidine</td>
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<td>Atomoxetine:</td>
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<td>CYP2D6 inhibitors eg Fluoxetine &amp; Paroxetine</td>
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<td>Drugs that increase the QT interval.</td>
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<td>Drugs that lower the convulsive threshold.</td>
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<td>Drugs that cause electrolyte imbalance</td>
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<td>MAOls</td>
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<td>Methadone, Tramadol</td>
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<td>MAOIs.</td>
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<td>SNRIs</td>
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<td>Lithium</td>
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<td>Haloperidol</td>
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<td>HIV protease inhibitors</td>
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<td></td>
<td><strong>Drug Interactions</strong></td>
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<td></td>
<td>At the beginning of treatment: Nervousness, insomnia, decreased appetite</td>
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<tr>
<td></td>
<td>CNS – headache, drowsiness, dizziness, dyskinesia, psychomotor hyperactivity</td>
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<td>GI – abdominal pain, nausea/vomiting, dry mouth, weight loss, diarrhoea</td>
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<td>CVS – tachycardia, palpitations, arrhythmias, changes in heart rate and BP (usually an increase).</td>
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<td>Heart disease: Symptoms require prompt specialist cardiac evaluation.</td>
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<td>Skin – rash, pruritus, urticaria, arthralgia, hair loss.</td>
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<td>Blood – very rarely leucopenia, anaemia, thrombocytopenia</td>
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<td>Psychiatric disorders: associated with causing or worsening e.g. depression, suicidal thoughts, hostility, anxiety, agitation, psychosis and mania.</td>
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<td>Motor and verbal tics: associated with exacerbation or onset.</td>
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<td>Other – fever, cough.</td>
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<td>In children- moderately reduced weight gain and growth retardation</td>
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<td></td>
<td>CNS – headache, somnolence, dizziness, insomnia.</td>
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<td></td>
<td>GI - abdominal pain, nausea, vomiting, constipation, dyspepsia, dry mouth, weight loss</td>
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<td></td>
<td>CVS- increased BP and pulse rates, QT prolongation, orthostatic hypotension</td>
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<td>Skin – rash, dermatitis</td>
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<td></td>
<td>Psychiatric disorders:</td>
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<td></td>
<td>Rare - psychotic or manic symptoms, suicidal behaviour</td>
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<td>Common- Hostility, mood swings, irritability</td>
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<td>Motor and verbal tics: associated with exacerbation or onset.</td>
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<td>Liver toxicity: very rare. Other- decreased appetite, fatigue, lethargy, dysmenorrhoea, urinary retention, sexual dysfunction.</td>
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<td></td>
<td>CNS- restlessness, irritability, tremor, dizziness, insomnia, headache.</td>
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<td>GI - dry mouth, anorexia, abdominal pain, nausea, vomiting, diarrhoea, weight loss.</td>
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<td></td>
<td>CVS - tachycardia, palpitations, and increased blood pressure</td>
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<td></td>
<td>Psychiatric disorders:</td>
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<td></td>
<td>Aggression, anxiety emotional lability, psychosis, euphoria</td>
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<td></td>
<td>Motor and verbal tics: associated with exacerbation or onset</td>
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<td></td>
<td>Others: dyspnoea, rash, fever.</td>
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</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Dose Regimen</th>
<th>Date {Insert medicine name} started</th>
<th>Date for GP to start prescribing {Insert medicine name} from</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

The baseline test results are (if applicable): 
See overleaf for initiation criteria.

I confirm I have explained to the patient: the risks and benefits of treatment, the baseline tests conducted, the need for monitoring, how monitoring will be arranged, and the roles of the consultant / nurse specialist, GP and the patient in shared care. I confirm the patient has understood and is satisfied with this shared care arrangement at this time. 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)

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.

<table>
<thead>
<tr>
<th>Patient:</th>
<th>NHS No:</th>
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<table>
<thead>
<tr>
<th>Consultant:</th>
<th>Medicine requested for shared care:</th>
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</tbody>
</table>

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:

Yours sincerely

{GP name}

{Surgery}

**Please send a copy of this response to:**

1. The specialist/consultant requesting shared care
2. **AN ANONYMISED COPY OF THIS FORM ONLY** to the Medicines Management Clinical Effectiveness Team, 1st Floor East Point, Cardinal Square, 10 Nottingham Road, Derby, DE1 3QT or E-MAIL: sderccg.derbyshiredomedicinesmanagement@nhs.net

*(Sending a copy of this form to the Clinical Effectiveness Team will help to identify any inappropriate requests for shared care e.g. indication not covered, hospital monitoring requirements not fulfilled. It will also help to inform the CCG prescribing group of the reasons shared care is not being undertaken allowing for changes to be made in future updates to improve patient care).*