DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE
SHARED CARE AGREEMENT

Somatostatin Analogues (LANREOTIDE and OCTREOTIDE)

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.
- Safe prescribing must be accompanied by effective monitoring
- Patients will only be referred to the GP once the GP has agreed in each individual case, subject to receiving the relevant clinical information.
- Once stable the patient will be given a supply of lanreotide/octreotide sufficient for 4 weeks maintenance therapy.

2. AREAS OF RESPONSIBILITY

GP responsibilities	Consultant responsibilities
1) Reply to the request for shared care as soon as practicable. 2) Prescribe lanreotide/octreotide by brand and at the dose recommended by the specialist 3) Report to and seek advice from the specialist on any aspect of patient care that is of concern to the GP and may affect treatment. 4) Report any adverse effects to the referring specialist and the MHRA yellow card scheme 5) Stop treatment on advice of specialist	1) Discuss the possible benefits and side effects of treatment with the patient. 2) Perform baseline tests GH and IGF-1 levels (Acromegaly patients only) 3) Provide results of baseline tests. Discuss potential side effect of gallstone disease with patient. Ultrasonic examination of the abdomen particularly the gall bladder should be undertaken before initiation of treatment and at intervals of 6 – 12 months by specialist 4) Perform baseline measurements of LFT & blood glucose 5) Prescribe the lanreotide/octreotide for the first 3 months to exclude any adverse effects. 6) Recommend dose of the drug. 7) Review the patient's condition and monitor response to treatment regularly (3 monthly). 8) Ensure that clear backup arrangements exist for GPs to obtain advice and support. 9) To report any adverse effects to the MHRA yellow card scheme and GP

Patient responsibilities

- Report any adverse effects to the specialist or GP whilst taking lanreotide/octreotide
- Share any concerns in relation to treatment with lanreotide/octreotide
- Report to the specialist or GP if they do not have a clear understanding of their treatment

3. COMMUNICATION AND SUPPORT

i. Hospital contacts:	ii. Out of hours contacts and procedures:
Adults **Consultants in Endocrinology** Dr Roger Stanworth - 01332 783283 Dr Hisham Ali - 01332 783284 Dr Paru King - 01332 783284 Dr Suma Sugunendran - 01332 783286 Dr David Hughes - 01332 787696 Dr Antonia Uger – 01332 783283 Dr Luckni Sellahewa – 01332 783283 Dr Supreeth Rudrappa – 01332783283 Dr Sunita Sandhu – 01332 787696 Dr Is Idris Dr Agnieszkca Swiecicka Dr Anjan Lenkalapally **Consultant in Oncology** Dr R Vijayan – 01332 786452	Pharmacy, UHDB, ask for on-call pharmacist via switchboard – 01332 340131

4. CLINICAL INFORMATION

i. Prescribed indications	• Treatment of individuals with acromegaly when the circulating levels of Growth Hormone (GH) and/or Insulin-like Growth Factor-1 (IGF-1) remain abnormal after surgery and/or radiotherapy, or in patients who otherwise require medical treatment) • Treatment of symptoms associated with neuroendocrine (particularly carcinoid) tumours.
ii. Dose & Route of administration	**<u>Lanreotide should be used as the 1st line treatment. Octreotide is reserved for use if Lanreotide has been stopped due to adverse effects or lack of efficacy.</u>** <u>Administration</u> Lanreotide should be injected via the deep sub-cutaneous route in the superior external quadrant of the buttock. The skin should not be folded. The needle should be inserted rapidly to its full length, perpendicularly to the skin. Octreotide is administered by either subcutaneous injection or depot (deep intragluteal) IM injection**.** <u>Dose</u> ***Acromegaly****:* In patients receiving a somatostatin analogue for the first time, the recommended starting dose of lanreotide is 60 mg administered every 28 days. Patients being treated with octreotide will have had an initial treatment with subcutaneous octreotide and then move to Sandostatin LAR® at a dose of 20mg every 4 weeks. The LAR preparation can be started the 1st day after completing the subcutaneous preparation. Thereafter, for all patients, the dose should be individualised according to the response of the patient (as judged by a reduction in symptoms and/or a reduction in GH and/or IGF1 levels). If the desired response is not obtained, the dose may be increased. If complete control is obtained (based on GH levels under 1 ng/ml, normalised IGF1 levels and/or disappearance of symptoms), the dose may be decreased. ***Neuroendocrine tumours:*** The recommended starting dose of lanreotide is 60 to 120 mg administered every 28 days. Patients being treated with octreotide will have had an initial treatment with subcutaneous octreotide and then move to Sandostatin LAR® at a dose of 20mg every 4 weeks. The subcutaneous preparation should be continued for 2 weeks after starting the LAR preparation. The dose should be adjusted according to the degree of symptomatic relief obtained.
iii. Duration of treatment	Indefinite
iv. Adverse effects	The adverse reactions related to somatostatin analogues are predominantly gastrointestinal and common effects include diarrhoea or constipation, abdominal pain, nausea, flatulence, cholelithiasis, gall bladder sludge. Less common side effects may include: asthenia, fatigue, increased bilirubin, hot flushes, leg pain, malaise, headache, tenesmus, vomiting, abnormal glucose tolerance, hyperglycaemia, decreased libido, somnolence, pruritus, increased sweating. <u>Local skin reactions may occur at injection sites.</u>
v. Monitoring Requirements	Long term monitoring of symptoms, GH and IGF1 levels should be undertaken as clinically indicated (for patients being treated for acromegaly). Ultrasonic examination of the abdomen particularly the gall bladder should be undertaken before initiation of treatment and at intervals of 6 – 12 months by specialist. Baseline measurements of LFT and blood glucose.
vi. Clinically relevant drug interactions	The gastrointestinal effects of lanreotide/octreotide may reduce the intestinal absorption of co-administered drugs. <u>Concomitant administration of lanreotide/octreotide injection with ciclosporin may decrease blood levels of ciclosporin, hence blood levels of ciclosporin should be monitored.</u>
vii. Contraindications	Hypersensitivity to lanreotide/octreotide or related peptides.
viii. How to obtain in primary care	**Lanreotide:** • Only available through AAH – 0844 6518 899

		• May need to fax a copy of the prescription if not ordered before or if volumes change **Octreotide:** • Only available directly through Novartis – 01276 692370 • An anonymised (omitting patient details only) copy of the FP10 to be faxed to 08457 419443 (or 01276 698794) • Community pharmacy must provide their postcode, contact name and telephone number • Novartis will issue the amount requested on the FP10; this should arrive at the pharmacy within 2 working days
ix.	**Supply of ancillary equipment**	Supplied through homecare arrangements
x.	**Supply, storage and reconstitution instructions**	Lanreotide/octreotide should be stored in a refrigerator between 2 and 8ºC out of the reach of children.
xi.	**Prepared by** **Reviewed by** **Reviewed 2021**	Colin Ward Cancer Network Pharmacist and Directorate Pharmacist Cancer and Rehab Duane McLean Directorate Pharmacists Derbyshire Medicines Management & Guideline Group Dr R Stanworth, Consultant Physician, University Hospitals of Derby and Burton NHS Foundation Trust Dr R Vijayan, Consultant Oncologist, University Hospitals of Derby and Burton NHS Foundation Trust Dr R Stanworth, Consultant Physician UHDB Dr Hisham E Ali, Consultant Physician Diabetes & Endocrinology UHDB

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

Date Prepared: September 2012 **Reviewed:** January 2021 **Review Date:** December 2023

Sample Transfer Letter

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_ADDRESS_3»
«GP_ADDRESS_4»
«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_ADDRESS_3»
«CURRENT_ADDRESS_4» «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 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.

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:

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 and Clinical Policies and Decisions Team, 1st Floor East Point, Cardinal Square, 10 Nottingham Road, Derby, DE1 3QT or E-MAIL: ddccg.medicinesmanagement@nhs.net

(Sending a copy of this form to the Medicines Management and Clinical Policies and Decisions 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).