1. REFFERAL 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>
</tr>
</thead>
<tbody>
<tr>
<td>- Initial referral to specialist raising possibility of ADHD</td>
<td>- Inform patient about unlicensed status (adults)</td>
</tr>
<tr>
<td>- Provide information re medical history and perform physical examination if requested.</td>
<td>- Discuss the benefits and side effects of treatment with the patient/carer and the importance of adherence. In particular ensure awareness of: how to recognise symptoms of hepatic disorder (stomach pain, nausea, dark urine, jaundice); need to report promptly suicidal thoughts &amp; self-harming behaviour; possible teratogenicity in pregnancy (as appropriate).</td>
</tr>
<tr>
<td>- Report to and seek advice from the specialist.</td>
<td>- Risk assess for diversion and misuse.</td>
</tr>
<tr>
<td>- Once dose has been stabilised, prescribe repeat prescriptions – maximum of 30 days recommended (NB:CD requirements for all except atomoxetine)</td>
<td>- Assess full medical history including history of cardiac disease, convulsive disorders, thyroid disorders, mental health problems and current medication.</td>
</tr>
<tr>
<td>- Confirm adherence to treatment and support as appropriate. Monitor for signs of diversion and misuse (e.g. by checking prescribing intervals of prescriptions)</td>
<td>- Initiate treatment taking into account contra-indications, cautions, side-effects, compliance/diversion issues and cost.</td>
</tr>
<tr>
<td>- Report to and seek advice from the specialist on any aspect of patient care that is of concern and may affect treatment.</td>
<td>- Initiate prescriptions, titrating the dose against symptoms and side effects until dose optimisation is achieved. Titrate cautiously where indicated e.g. in neurodevelopmental disorders, mental health conditions and physical health conditions such as epilepsy or cardiac disease.</td>
</tr>
<tr>
<td>- Refer patient to the specialist if his or her condition deteriorates.</td>
<td>- Prescribe by brand name for MR preparations</td>
</tr>
<tr>
<td>- Stop treatment on the advice of the specialist if he or her condition deteriorates.</td>
<td>- Prescribe by brand name for MR preparations</td>
</tr>
<tr>
<td>- If informed by the consultant or specialist clinic that the patient has defaulted from attending clinic do not continue prescription unsupervised</td>
<td>- 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.</td>
</tr>
<tr>
<td>- Report any adverse events to the referring specialist and MHRA yellow card scheme.</td>
<td>- Agree monitoring schedule with GP for adults every 6 months and ensure sharing of these results.</td>
</tr>
</tbody>
</table>

Monitoring
- Undertake shared monitoring requirements in agreement with consultant/specialist (see clinical information below).
- Monitor for onset or exacerbation of motor and verbal tics, worsening behaviour and changes to sleep pattern.
- Monitor for the development or worsening of psychiatric disorders.

Adults
- Monitor HR and BP. Liaise with specialist and reduce the dose if:
  - sustained tachycardia, arrhythmia or
  - a clinically significant increase in

Baseline
- Height (under 18 only), weight, pulse and BP
- Examination of cardiovascular system.
  - Refer for specialist cardiac evaluation if there is
    - a history of congenital heart disease or cardiac surgery
    - history of sudden death in a first degree relative under 40 years
    - undue breathlessness
    - fainting on exertion or in response to fright or noise
systolic BP measured on two occasions.

Atomoxetine
- Monitor for sexual dysfunction with Atomoxetine and refer back to specialist if a problem.

Guanfacine
- If a person taking guanfacine has sustained orthostatic hypotension or fainting episodes reduce the dose and refer back to the specialist for review.

Switching brands of methylphenidate
Switching between brands is supported if bioequivalent and recommended by Derbyshire medicines management team. Patients may be changed in primary care to the preferred recommended brand by their GP for ongoing prescribing, providing they have been appropriately informed before the switch takes place.

Currently the recommended methylphenidate modified release brands are Delmosart SR and Xaggitin XL, which are both bioequivalent to the brand Concerta XL.

see MHRA drug safety warning on switching between products (detailed below)

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/
The local Parent Support Group contact is: FLARE, Derbyshire ADHD Support Service.
Telephone: 01246 569012 E-mail: flareadhd@aol.com

4. CLINICAL INFORMATION
See Summary table below
Cautions and contraindications in cardiac disorder, cerebrovascular disorder, 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.

**MHRA Sept 2022** Methylphenidate long-acting (modified-release) preparations: caution if switching patients between different long-acting formulations of methylphenidate.

- **Prescribe by brand name**
- caution if long-acting formulations of methylphenidate are to be used interchangeably due to the differences between formulations in dosing frequency, administration with food, amount and timing of the modified-release component, and overall clinical effect. Follow specific dosage recommendations for each formulation.

If considering a switch to another long-acting preparation:

- consult with the patient (and their parent or caregiver if relevant) to discuss the reasons for this and the possible changes they may experience in symptom management and side effects (and what to do if these occur)
- consider patient preferences such as their individual needs, dose frequency, possible side effects, or other issues related to the patient’s condition
- reiterate the instructions for use for the newly prescribed formulation, whether it should be taken with or without food

**Information Sources Used:**

- **NICE clinical guideline 87**: Attention Deficit Hyperactivity Disorder – Diagnosis and Management of ADHD in children, young people and adults. March 2018 (accessed July 2018)
- SPCs accessed July 2018 at [www.emc.medicines.org.uk](http://www.emc.medicines.org.uk)
  - Ritalin, Equasym XL, Delmosart SR, Xaggitin SR and Medikinet XL
  - Strattera
  - Elvanse
  - Intuniv
- MHRA Drug Safety Update Volume 5 Issue 6 January 2012 Atomoxetine (Strattera▼): increases in blood pressure and heart rate—new contraindications, warnings, and advice for monitoring
- BNF accessed on-line July 2018
- BNF for Children accessed on-line July 2018
- Stockley’s Drug Interactions accessed July 2018 at [www.new.medicinescomplete.com](http://www.new.medicinescomplete.com)

**Further information:**


Clinical Knowledge Summaries. Attention deficit hyperactivity disorder. ([https://cks.nice.org.uk/attention-deficit-hyperactivity-disorder](https://cks.nice.org.uk/attention-deficit-hyperactivity-disorder))

**Acknowledgement**

### Shared care ADHD guideline for children:

**Reviewed and Reformatted by:**
- Beverley Thompson Deputy Chief Pharmacist Derbyshire Healthcare NHS Foundation Trust
- Lisa Taylor Senior Pharmacist Derby Hospitals NHS Foundation Trust
- Dr Morton Consultant Paediatrician Derby Hospitals NHS Foundation Trust
- Dr J Thomas, Chesterfield hospital
- Dr S Banta, Derbyshire Healthcare NHS Foundation Trust
- Dr S Taylor, Derbyshire Healthcare NHS Foundation Trust
- The Shared Care Guidelines Group Derby Hospitals NHS Foundation Trust
- Child and Adolescent Mental Health Services (CAMHS) Derbyshire

**In consultation with:**
- Child and Adolescent Mental Health Services (CAMHS) Derbyshire

### 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
- 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.

**Reviewed: September 2018**

**Next Review Date: March 2023 (Extended to September 2023)**
<table>
<thead>
<tr>
<th>Brand name</th>
<th>Methylenidate</th>
<th>Methylenidate modified release (see MHRA drug safety warning on switching between products- prescribe by brand)</th>
</tr>
</thead>
</table>

### Place in Therapy

**First line**

- As part of a comprehensive treatment programme for ADHD in children aged 6 and over. Treatment of ADHD in adults is **unlicensed**. NICE: Offer medication for ADHD only if symptoms are still causing a persistent significant impairment in at least one domain after environmental modifications have been implemented and reviewed.

### Controlled Drug

**Yes**

### Dose in children 6 years and over

- **5mg** once or twice a day. Titrator by weekly increments of 5-10mg/day against symptoms and side effects. **Max:** 60mg/day in divided doses.
- **4-5 years (unlicensed):**
  - 2.5mg twice a day, increased by 2.5mg at weekly intervals. **Max:** 14mg/kg in 2-3 doses.

### Unlicensed dose in children

Can be increased to 2.1mg/kg daily in divided doses up to a maximum of 90mg under specialist supervision. Discontinue after 1 month if no response. **(Note BNFc only includes this under Concerta XL, not Delmosart or Xaggitin)**

### Dose in adults (unlicensed)

- **5mg** 2 or 3 times a day. Titrator against symptoms and side effects at weekly intervals.
  - **Max:** 100mg/day in up to 4 divided doses.

### Adult Physical Monitoring by GP

**Agree monitoring schedule with GP and consultant/specialist**

- Pulse & BP before and after dose changes and then every 6 months; Weight every 6 months.
- Reduce the dose and liaise with specialist if: sustained tachycardia, arrhythmia or a clinically significant increase in systolic BP measured on two occasions.

### Monitoring in children by specialist

- **Monitor BP/HR**
  - Monitor Weight: every 3 months in children aged 10 years and under; at 3 months & 6 months in young people and children over 10 years and every 6 months thereafter
  - Monitor Height every 6 months for children and adolescents and recorded on growth chart

### Drug Interactions

- **Warfarin; Phenytoin; Valproate; Carbamazepine; MAOIs; Tricyclic antidepressants; SSRIs; Clonidine; Risperidone**

### Side effects (common or significant)

- **CNS – headache, drowsiness, dizziness, dyskinesia, psychomotor hyperactivity**
- **GI – abdominal pain, nausea/vomiting, dry mouth, weight loss, diarrhoea**
- **CVS – tachycardia, palpitations, arrhythmias, changes in heart rate and BP (usually increase).** **Heart disease: Symptoms require prompt specialist cardiac evaluation.**
- **Psychiatric disorders: associated with causing or worsening e.g. depression, suicidal thoughts, hostility, anxiety, agitation, psychosis and mania.**
- **Motor and verbal tics: associated with exacerbation or onset.**

### Other – fever, cough.**
<table>
<thead>
<tr>
<th>Brand name</th>
<th>Lisdexamfetamine</th>
<th>Dexamfetamine</th>
<th>Atomoxetine</th>
<th>Guanfacine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength</td>
<td>20mg, 30mg, 40mg, 50mg, 60mg, 70mg caps</td>
<td>5mg, 10mg, 20mg tablets</td>
<td>10mg, 18mg, 25mg, 40mg, 60mg caps and 4mg/ml oral solution</td>
<td>1mg, 2mg, 3mg, 4mg prolonged release tablets</td>
</tr>
<tr>
<td>Indication</td>
<td>As part of a comprehensive treatment programme for ADHD in children aged 6 and over, when response to previous methylphenidate is considered clinically inadequate. Treatment of ADHD in adults.</td>
<td>Refractory hyperkinetic states under the supervision of a physician specialising in child psychiatry. Treatment of ADHD in adults (unlicensed).</td>
<td>As part of a comprehensive treatment programme for ADHD in children aged 6 and older, in adolescents and in adults.</td>
<td>As part of a comprehensive treatment programme for ADHD in children and adolescents 6-17 years old for whom stimulants are not suitable, not tolerated or have been shown to be ineffective.</td>
</tr>
<tr>
<td>Place in Therapy</td>
<td>Second line: For those who have not derived enough benefit from an adequate (NICE suggest 6 weeks) trial of methylphenidate.</td>
<td>Third line: For those whose symptoms respond to lisdexamfetamine but who cannot tolerate the longer effect profile.</td>
<td>Third line: If methylphenidate and lisdexamfetamine have not been tolerated or if symptoms have not responded to adequate trials of each.</td>
<td>Third line for children aged 5 years and over and young adults. If methylphenidate and lisdexamfetamine have not been tolerated or if symptoms have not responded to adequate trials of each.</td>
</tr>
<tr>
<td>Controlled Drug</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Dose in children 6 years and over</td>
<td>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>2.5mg 2 or 3 times a day, increasing if necessary by 5mg daily at weekly intervals up to 1mg/kg in 2-4 divided doses up to 20mg daily (40mg or more in some children).</td>
<td>&lt;70kg: initially 0.5mg/kg/day minimum of 7 days, then titrate according to response and tolerability. Recommended maintenance dose is approx. 1.2mg/kg/day. Unlicensed: 1.8mg/kg/day (up to 120mg). &gt;70kg: initially 40mg/day minimum of 7 days titrated according to response and tolerability. Recommended maintenance dose is 80mg. Max dose 100mg Unlicensed max: 120mg. Once a day in the morning or 2 evenly divided doses (morning &amp; late afternoon/ early evening) if not tolerated/inadequate response</td>
<td>1mg once a day, adjusted in increments of not more than 1 mg per week then titrated according to response and tolerability. Recommended maintenance dose range is 0.05-0.12 mg/kg/day.</td>
</tr>
<tr>
<td>Dose in adults</td>
<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>
<td>Initial: 5mg twice a day. Titrate against symptoms and side effects, increasing at weekly intervals as required. (Unlicensed) Max: 60mg/day in 2 - 4 divided doses.</td>
<td>40mg/day minimum of 7 days, then titrate as required. BNF: start at 0.5mg/Kg if &lt;70kg Usual maintenance dose 80-100mg/day. Unlicensed max dose 120mg. Once a day in the morning or 2 evenly divided doses (morning &amp; late afternoon/ early evening). if not tolerated/inadequate response</td>
<td>Unlicensed NICE: do not offer guanfacine for adults without advice from a tertiary ADHD service.</td>
</tr>
<tr>
<td>Adult Physical Monitoring by GP</td>
<td>Agree monitoring schedule with GP and consultant/specialist. Pulse &amp; BP before and after dose changes and then every 6 months; Weight every 6 months. Reduce the dose and liaise with specialist if: sustained tachycardia, arrhythmia or a clinically significant increase in systolic BP measured on two occasions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring in children by specialist</td>
<td>Monitor BP/ HR. Monitor Weight: every 3 months in children aged 10 years and under; at 3 months and 6 months in young people and children over 10 years and every 6 months thereafter Monitor Height every 6 months for children and adolescents and recorded on growth chart. Guanfacine: weekly monitoring (for somnolence, sedation, hypotension and bradycardia) during dose titration; 3 monthly monitoring during first year of treatment.</td>
<td>Monitor for sexual dysfunction with and refer back to specialist if a problem.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other monitoring</td>
<td></td>
<td></td>
<td></td>
<td>If orthostatic hypotension or fainting episodes reduce the dose and refer back to the specialist for review.</td>
</tr>
</tbody>
</table>
## Drug Interactions

<table>
<thead>
<tr>
<th>Drug Interactions</th>
<th>Lisdexamfetamine &amp; dexamfetamine</th>
<th>Atomoxeine</th>
<th>Guanfacine</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAOIs &amp; Moclobemide</td>
<td>CYP2D6 inhibitors eg Fluoxetine &amp; Paroxetine</td>
<td>CYP3A4/5 inhibitors or inducers</td>
<td></td>
</tr>
<tr>
<td>Tricyclic antidepressants</td>
<td>Drugs that increase the QT interval</td>
<td>Drugs that increase the QT interval</td>
<td></td>
</tr>
<tr>
<td>SSRIs</td>
<td>Tricyclic antidepressants</td>
<td>Grapefruit juice</td>
<td></td>
</tr>
<tr>
<td>SNRIs</td>
<td>Carbamazepine</td>
<td>Clarithromycin,</td>
<td></td>
</tr>
<tr>
<td>Lithium</td>
<td>Valproate</td>
<td>Erythromycin</td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Phenytoin</td>
<td>Tricyclic antidepressants</td>
<td></td>
</tr>
<tr>
<td>HIV protease inhibitors</td>
<td></td>
<td>Carbamazepine</td>
<td></td>
</tr>
<tr>
<td>Opioids</td>
<td></td>
<td>Valproate</td>
<td></td>
</tr>
</tbody>
</table>

## Side effects (common or significant)

<table>
<thead>
<tr>
<th>Side effects (common or significant)</th>
<th>Lisdexamfetamine &amp; dexamfetamine</th>
<th>Atomoxeine</th>
<th>Guanfacine</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNS: restlessness, irritability, tremor, dizziness, insomnia, headache.</td>
<td>CNS – headache, somnolence, dizziness, insomnia.</td>
<td>CNS – headache, somnolence, dizziness, insomnia, nightmares</td>
<td></td>
</tr>
<tr>
<td>GI: dry mouth, anorexia, abdominal pain, nausea, vomiting, diarrhoea, weight loss.</td>
<td>GI: abdominal pain, nausea, vomiting, constipation, dyspepsia, dry mouth, weight loss</td>
<td>GI: abdominal pain/discomfort, nausea, vomiting, constipation, diarrhoea, dry mouth, decreased appetite</td>
<td></td>
</tr>
<tr>
<td>CVS: tachycardia, palpitations, and increased blood pressure</td>
<td>CVS: increased BP and pulse rates, QT prolongation, orthostatic hypotension</td>
<td>CVS: bradycardia, hypotension</td>
<td></td>
</tr>
<tr>
<td>Psychiatric disorders: Aggression, anxiety emotional lability, psychosis, euphoria</td>
<td>Psychiatric disorders: Rare - psychotic or manic symptoms, suicidal behaviour</td>
<td>Psychiatric disorders: depression, anxiety, affect lability</td>
<td></td>
</tr>
<tr>
<td>Motor and verbal tics: associated with exacerbation or onset</td>
<td>Motor and verbal tics: associated with exacerbation or onset.</td>
<td>Others: lethargy, fatigue, irritability</td>
<td></td>
</tr>
<tr>
<td>Others: dyspnoea, rash, fever.</td>
<td>Liver toxicity: very rare.</td>
<td>sedation, enuresis,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other: decreased appetite, fatigue, lethargy, dysmenorrhoea, urinary retention, sexual dysfunction.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Summary of NICE NG87 recommended on medication choice

Medication choice - children aged 5 years and over and young people
Recommendations 1.7.7 to 1.7.10

Offer
• Methylphenidate

Switch
• Lisdexamfetamine
  • If after 6-week trial of methylphenidate at an adequate dose not derived enough benefit in terms of reduced ADHD symptoms and associated impairment

Consider
• Dexamfetamine
  • If ADHD symptoms are responding to lisdexamfetamine but cannot tolerate the longer effect profile

Offer
• Atomoxetine or guanfacine
  • if they cannot tolerate methylphenidate or lisdexamfetamine or
  • their symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate

Medication choice - adults
Recommendations 1.7.11 to 1.7.15

Offer
• Lisdexamfetamine or methylphenidate

Switch
• Lisdexamfetamine or methylphenidate
  • If after 6-week trial of initial treatment at an adequate dose not derived enough benefit in terms of reduced ADHD symptoms and associated impairment

Consider
• Dexamfetamine
  • If ADHD symptoms are responding to lisdexamfetamine but cannot tolerate the longer effect profile

Offer
• Atomoxetine
  • if they cannot tolerate methylphenidate or lisdexamfetamine or
  • their symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate
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}. Following out discussion of (date) and your agreement to continue the prescribing when we discharge him/her, 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>
</table>

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:

- The patient has been initiated on this therapy and has been on an optimised dose for the following period of time: [Yes / No]
- 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]
<table>
<thead>
<tr>
<th>The roles of the specialist/specialist team/ Primary Care Prescriber / Patient and pharmacist have been explained and agreed</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments</td>
<td>Yes / No</td>
</tr>
<tr>
<td>I have enclosed a copy of the shared care protocol which covers this treatment/the SCP can be found here (insert electronic/ web link)</td>
<td>Yes / No</td>
</tr>
<tr>
<td>I have included with the letter copies of the information the patient has received</td>
<td>Yes / No</td>
</tr>
<tr>
<td>I have provided the patient with sufficient medication to last until</td>
<td></td>
</tr>
<tr>
<td>I have arranged a follow up with this patient in the following timescale</td>
<td></td>
</tr>
</tbody>
</table>

I confirm I have explained to the patient: the risks and benefits of treatment and have given them the relevant patient information leaflet. The relevant baseline tests have been conducted and the need for monitoring, how monitoring will be arranged, and the roles of the consultant / nurse specialist, GP and the patient in shared care have been explained. 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.

I will write to you prior to the discharge in 3 months with regards to continued prescribing.

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.

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

| 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. |
| 6. | Other (Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted) |

Yours sincerely

{GP name}
(Surgery)

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