

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 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 can be considered 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 <ul style="list-style-type: none"> • 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: Adults Consultants in Endocrinology Consultants in Endocrinology Dr Roger Stanworth, Dr Iskandar Idris, Dr Luckni Sellahewa - Secretary Wendy 01332 783283/01332 258268 Dr David Hughes, Dr Supreeth Rudrappa, Dr Suma Sugunendran - Secretary Michael - 01332 783286/01332 258269 Dr Antonia Ugur, Dr Hisham Ali - Secretary Chloe 01332 783284/01332 258260 Consultant in Oncology Dr R Vijayan – 01332 786452	ii. Out of hours contacts and procedures: Pharmacy, UHDB, ask for on-call pharmacist via switchboard – 01332 340131
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4. CLINICAL INFORMATION

i. Prescribed indications	<ul style="list-style-type: none"> 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	<p><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></p> <p><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.</p> <p>Octreotide is administered by either subcutaneous injection or depot (deep intragluteal) IM injection.</p> <p><u>Dose</u> <u>Acromegaly:</u> In patients receiving a somatostatin analogue for the first time, the recommended starting dose of lanreotide is 60 mg administered every 28 days.</p> <p>Patients being treated with octreotide may 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.</p> <p>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).</p> <p>If the desired response is not obtained, the dose may be increased.</p> <p>If complete control is obtained (based on GH levels under 0.4 ng/ml, normalised IGF1 levels and/or disappearance of symptoms), the dose may be decreased.</p> <p><u>Neuroendocrine tumours:</u> The recommended starting dose of lanreotide is 60 to 120 mg administered every 28 days.</p> <p>Patients being treated with octreotide may 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.</p> <p>The dose should be adjusted according to the degree of symptomatic relief obtained.</p>
iii. Duration of treatment	Indefinite
iv. Adverse effects	<p>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.</p> <p>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.</p> <p>Local skin reactions may occur at injection sites.</p>
v. Monitoring Requirements	<p>Long term monitoring of symptoms, GH and IGF1 levels should be undertaken as clinically indicated (for patients being treated for acromegaly).</p> <p>Ultrasonic examination of the abdomen particularly the gall bladder can be considered before initiation of treatment and at intervals of 6 – 12 months by specialist.</p> <p>Baseline measurements of LFT and blood glucose.</p>
vi. Clinically relevant drug interactions	<p>The gastrointestinal effects of lanreotide/octreotide may reduce the intestinal absorption of co-administered drugs.</p> <p><u>Concomitant administration of lanreotide/octreotide injection with ciclosporin may decrease blood levels of ciclosporin, hence blood levels of ciclosporin should be monitored.</u></p>
vii. Contraindications	Hypersensitivity to lanreotide/octreotide or related peptides.
viii. How to obtain in primary care	<p><u>Lanreotide:</u></p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> • 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 8°C out of the reach of children.
xi. Prepared by	Colin Ward Cancer Network Pharmacist and Directorate Pharmacist Cancer and Rehab Duane McLean Directorate Pharmacists
Reviewed by	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
Reviewed 2021	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:** December 2024 **Review Date:** November 2024

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

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

<i>I have included with the letter copies of the information the patient has received</i>	<i>Yes / No</i>
<i>I have provided the patient with sufficient medication to last until</i>	
<i>I have arranged a follow up with this patient in the following timescale</i>	

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

Yours sincerely

{Consultant name}

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

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

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

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

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

		Tick which apply
1.	<p>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</p> <p>As the patients primary care prescriber I do not feel clinically confident to manage this patient's condition because <i>[insert reason]</i>. 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.</p> <p>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.</p>	
2.	<p>The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement</p> <p>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.</p> <p>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</p>	
3.	<p>A minimum duration of supply by the initiating clinician</p> <p>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.</p> <p>Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.</p>	
4.	<p>Initiation and optimisation by the initiating specialist</p> <p>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.</p> <p>Until the patient is optimised on this medication the responsibility for providing the patient with their medication remains with you.</p>	
5.	<p>Shared Care Protocol not received</p> <p>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.</p> <p>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.</p> <p>Until I receive the appropriate SCP, responsibility for providing the patient with their medication remains with you.</p>	
6.	<p>Other (Primary Care Prescriber to complete if there are other reasons why shared care cannot be</p>	

	accepted)	
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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