Policy for the Transfer of Prescribing Responsibilities between Primary and Secondary Care

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Policy for the Transfer of Prescribing Responsibilities between Primary and Secondary Care

Aims of this Document

The aim of this document is to support the transfer of prescribing responsibilities between Primary and Secondary care. To ensure that treatments are prescribed for patients in a way that maximises effectiveness, maintains patient safety, and reduces risk to prescribers in both primary and secondary care.

Additional supporting documents

Additional supporting documents are available to support this policy which includes:

- Shared-care protocols to support the shared care arrangements for each drug.
- An A to Z list of all drugs which have shared-care implications.

Objectives

- Define principles of shared care arrangements.
- Define drug categories – **RED**, **AMBER**, **GREEN +**, **GREEN**
- Describe process for assigning drugs to specific categories.
- Describe information to be included within a shared care protocol.
- Describe criteria under which exceptions should be made.
- Procedures for prescribing categories of drugs.
- List of **RED** drugs.
- List of **AMBER** drugs.
- List of **GREEN +** drugs.
- Implementation policy for delivering goals of this document.
- Process for agreeing shared-care status for new drugs or altering status for existing drugs.

Definitions

1. Prescribing Responsibility
It is the responsibility of the clinician signing a prescription to ensure the details on the prescription are entirely correct and that the medication is appropriate for the patient. Prescribing of drugs that are contra-indicated or will interact with other drugs being taken by the patient are common causes of adverse events and litigation. Failing to ensure the appropriate doses and directions are given or to ensure that appropriate monitoring and dosage adjustment takes place are also common errors.

Primary care clinicians who are asked to prescribe drugs by a Primary or Secondary care specialist prescriber have a duty to ensure the treatment is appropriate and in line with current accepted practice. **The key determinant is the safe and effective care of each individual patient.** The issue of finance will be addressed as part of the commissioning process either additional outpatient attendances to maintain clinical responsibility in secondary care or prescribing budgets/services in primary care. Financial arrangements should not be an impediment to appropriate delivery of care in the appropriate location by the appropriate clinician. The cost of prescribing should not be used as an excuse for refusing to prescribe a shared care drug.

2. Shared Care
In the context of this document, shared care is defined as "both the Primary Care or Secondary care specialist prescriber and GP having an active role in the management of a patient's condition, which would include Primary or Secondary Care Specialist Prescribers (including Consultant, GPSi, Registrar, Advance Nurse Practitioner with special interest and Pharmacist Practitioner with special interest) having responsibility for starting and may also be involved in stopping a medication". After discussion with the specialist prescriber a GP may decide to stop medication if required.

- The best interests of the patient should always be centre of any shared care agreement. Arrangements should never be detrimental or inconvenient to the patient.
- Each shared care guideline should have clearly define the responsibilities of all parties and be patient specific.
- All parties must have sufficient information and there must be a joint agreement between prescribers.

3. Shared Care Drug
A shared care drug can be defined as follows:

- Medicines initiated by a specialist for potentially serious conditions which may have a relatively high adverse-effect profile and may require specific monitoring and dose titration.
- A drug which has a significant pharmacological complexity and/or rarity of use to make the prescribing of the medicine relatively uncommon in the community.
- Patients for whom complex medicines are prescribed, may have a particular complex monitoring requirements, which may require specialist knowledge for the appropriate interpretation of results.
- The patient may require monitoring for response to the drug treatment.

4. Transfer of Prescribing Responsibility

In the context of this document this is defined as the transfer of prescribing responsibility from a Primary or Secondary care specialist prescriber to a GP. There have been critical incidents as a result of therapy being initiated and maintained in by specialist prescribers without the knowledge of the primary care practitioner. It is accepted for safety reasons that where possible there should be a single prescriber, which would normally be the General Practitioner. It is recognized that in some circumstances (e.g., palliative care) prescribing responsibility may be transferred from a Primary or Secondary care specialist prescriber to a non-medical prescriber, in these circumstances where prescribing is undertaken by a prescriber other than the GP, the shared care agreement should still take place between Primary or Secondary care specialist prescriber and GP and any changes to medication must be notified to the GP. Requests to a GP for a non formulary drug should not occur unless formal written notification is provided on the rationale for not choosing the normal formulary drug.

5. Shared Care Drug Categories

Drug Category	Definition
RED Drugs	Drugs that should remain under the total responsibility of the Primary or Secondary care specialist prescriber (i.e. consultant) should only be prescribed under the direct supervision of that clinician and are not suitable for shared care arrangements (e.g., HIV and chemotherapy drugs). • Drugs that require frequent, specialist, long-term, monitoring of efficacy by the Primary Care or Secondary Care Specialist Prescribers. • Drugs that require frequent, specialist, long-term, monitoring of toxicity by the Primary Care or Secondary Care Specialist Prescribers. • Drugs requiring Secondary Care or specialist facilities or high-cost environment for preparation or reconstitution. • Drugs specified as hospital only by product license or DoH legislation. • Drugs with no UK product license. • Drugs with unlicensed indications without recommendation from local or national guidance e.g. NICE. • Drugs without substantial wholesale body of support unless in the BNF or Children's BNF.
AMBER Drugs	These are specialist drugs which must be initiated by Primary Care or Secondary Care Specialist Prescribers, but with the potential to transfer to primary care within written and agreed shared care protocols and according to the agreed process for transfer of care. The patient's condition and/or treatment should normally be stabilised before the GP should be asked to participate in shared care. This time period can be variable dependent on the condition being treated and the individual patient's response to the treatment. A minimum of one months stabilised dose would be expected to be

	provided by the Primary or Secondary Care Specialist Prescriber before considering transfer of prescribing. Criteria for an Amber drug are as follows: • A Primary or Secondary Care Specialist is required to start the medication. • Both the Primary Care or Secondary Care Specialist and GP have a shared responsibility in maintaining the patient progress and prescribing (details will be defined in a Shared Care Protocol). • Both the Primary Care and Secondary Care Specialist and GP may share the responsibility for stopping the medication.
GREEN+ Drugs	It is accepted that some drugs should be initiated by a Primary Care or Secondary Care Specialist but can be safely maintained in primary care without on-going specialist monitoring and will be classified as **GREEN+** rather than **AMBER**. A minimum of one month supply should be given to patients with their first prescription by the Primary Care or Secondary Care Specialist Prescriber before transferring responsibility to primary care. If a patient uses compliance aids, consider the best interests of the patient when deciding the length of the first supply.
GREEN Drugs	These are defined as new and established drugs, which may be prescribed, initiated, changed or maintained on FP10 by the GP and if appropriate discontinued without recourse to secondary care.

General Principles

These guidelines have been prepared in accordance with guidance previously issued by the NHS executive on shared care prescribing:

Responsibility for prescribing between hospitals and GPs, EL(91)127. This set out the following principles:

> ***"When clinical, and therefore prescribing, responsibility for a patient is transferred from hospital to GP, it is of the utmost importance that the GP has the full confidence to prescribe the necessary drugs. It is therefore essential that a transfer involving drug therapies with which the GP would not normally be familiar should not take place without full local agreement and dissemination of sufficient information to individual GP's".***

It would be normal practice for all prescribing for on-going care to be undertaken by the General Practitioner and it is clear that prescribing for hospital initiated clinical trials, hospital only drugs, chemotherapy drugs and those drugs where monitoring can only be undertaken by a Hospital specialist should be the responsibility of and remain with the consultant. This document is designed to improve the transfer of prescribing between secondary to primary care and to address areas of concern relating to new or rarely prescribed medication, unlicensed or off-label use of medication and non-formulary prescribing. The objective is to enhance the safe and effective use of medicines ensuring "seamless" continuity of treatment without inconvenience or distress to the patients involved.

When drawing up protocols or where there is a professional disagreement over who should prescribe, it may be necessary for local discussion to take place between, trust managers and medical staff (from the Secondary Care trust), Clinical Commissioning Group Leads and the Local Medical Committee as a prelude to establishing agreement with individual practitioners. The service heads, usually the Heads of Medicines Management & Chief Pharmacists, who have overall accountability for safe and effective medicines are responsible for maintaining the safe, consistent and seamless transfer of prescribing responsibilities between secondary and primary care (and vice-versa).

Shared-Care Approval Processes

Shared Care should not be seen as an opportunity to circumvent existing Drug Approval processes within either Secondary or Primary Care. Unlicensed Drugs not approved by the Secondary Care approval process should never be referred to a primary care practitioner. Similarly licensed drugs that have failed to obtain approval in the host Trust D&T should normally not be referred to primary care and the General Practitioner receiving a request would normally refuse to accept prescribing responsibility for that treatment without a specific agreement. Primary Care Medicines Management Committees should liaise closely with their equivalent secondary care group to agree pathways and processes for altering the shared-care status of existing drugs and for assigning a status for new drugs. Clinical Commissioning Groups and Primary Care or Secondary Care Specialist Prescribers should liaise closely together to agree pathways.

Equality and Diversity Statement

This policy will aim to be accessible to everyone regardless of age, disability, gender, race sexual orientation, religion/belief or any other factor which may result in unfair treatment or inequalities in health / employment.

Specific Principles

Patient Health and Safety

Prescribing and dispensing of medication must always be in the interest of patient health and safety. Transfer of prescribing should only be considered if there are advantages to the patient and no potential unmanaged hazards to the patient or GP.

Certain drugs (classified under the process as **RED**) are deemed unsuitable for transfer of prescribing responsibility to primary care. Primary Care or Secondary Care Specialists must continue to prescribe these treatments and not request transfer of prescribing responsibility. If asked to do so GPs should refuse both verbally and in writing and inform the Clinical Commissioning Group (CCG) of the request.

Patient choice should also be considered when deciding whether to transfer prescribing responsibility to a GP. However, the overriding concern should be that the most appropriate doctor does the prescribing to ensure the patient gets the best possible standard of care.

Individual patients should not be used as 'messengers' or 'levers' to influence prescribing decisions by either primary or secondary care clinicians.

Requests to transfer prescribing responsibility for **AMBER** Drugs must only be made when the patients **condition and treatment is stable**. Unless otherwise agreed, a notice of one month should be provided in writing to the GP before the transfer of prescribing responsibility is envisaged. This will allow the GP to either decline or under go training as necessary whilst ensure the patient's care continues. Patients should be informed of the nature of the process and participate in the implementation of the shared care arrangement. GP or prescriber should confirm either agreement or declining the shared care arrangement in writing using either a shared care returns slip or if this is not available a letter.

Clinical and Legal Prescribing Responsibility

GPs must be free to accept prescribing responsibility for both shared care drugs and other drugs without prejudice to present and future budgets.

Primary Care or Secondary Specialists must be free to best meet the identified needs of the patient without financial restraint, provided treatments are evidence based.

In order to accept legal prescribing responsibility the GP or prescriber should ensure a full understanding of the following:

Pharmacology of the drug, its contraindications and any potential drug interactions.

Monitoring of treatment and the ability to amend treatment if necessary.

Expected outcome measures of treatment.

Nature and frequency of adverse reactions and appropriate action in such an event.

CCG Responsibilities

1. The CCG will facilitate the training and support to enable GPs to accept prescribing responsibility where desirable and appropriate.

2. The CCG will address any individual practice financial issues regarding the transfer of prescribing responsibility with individual practice budgets. These will be addressed when individual concerns are raised.

3. The CCG will be responsible for commissioning any local services deemed appropriate e.g., Local Enhanced Services to support transfer of prescribing.

4. The CCG may include the requirement to produce prescribing guidelines, in specific circumstances, in contracts and SLA's with secondary care providers.

5. The decision to assign a drug to a specific category will be taken with the approval and consultation of both the Clinical Commissioning Group Prescribing Lead, Primary Care Medicines Management or Prescribing Group and Secondary Care Trust Drug and Therapeutics Committee or any group that is given the responsibility for Shared Care by the CCG. It is important that all groups with responsibility for prescribing within a locality agree to any changes or new approvals.

6. This guidance and the status of drugs listed will be reviewed at least annually and will be updated regularly on the CCG website. New drugs and any significant changes to licensed indications will be reviewed by the relevant Committee(s) and assigned to a category regarding prescribing responsibility as highlighted in 5.

7. The Service Leads for Medicines Management and CCG Prescribing Leads are jointly responsible for the resolution of any disputes relating to the transfer of prescribing of **AMBER** drugs. It is hoped that any difficulties can be resolved informally between the hospital clinician and the relevant GP. Any dispute that cannot be resolved in this way to the satisfaction of all parties will be taken up jointly by the respective service leads for resolution with the support of the respective drug approval or prescribing committees if required.

Responsibilities of the Primary Care or Secondary Care Specialist Prescriber

The Primary Care or Secondary Care Specialist Prescriber is responsible for the following:-

1. It is the responsibility of Specialist Primary Care Services or Secondary Care directorates to ensure that all medical, nursing, pharmaceutical and other appropriate staff are kept up to date on shared care and how drugs should be managed through this policy.
2. The Primary Care or Secondary Care Specialist Prescriber should not try to transfer the prescribing responsibility for any drugs that are classed as **RED** drugs. This should be treated as an on-going clinical commitment with an appropriate outpatient review appointment. The GP should be informed of any **RED** drugs initiated and dose changes made with clear instructions not to supply in primary care.
3. The initial comprehensive assessment of the patient, including any baseline assessments prior to initiating prescribing.
4. For initiating Amber drugs along with any subsequent dose titration is required.
5. Notifying the GP of any decision to initiate or change drug regimen following the initial consultation.
6. Any patient information leaflet provided to the patient by the clinician at the time of the initiating consultation should be copied to the prescribing GP for inclusion in the patient medical records. (The patient information leaflet must be part of the shared care protocol)
7. Supply **AMBER** medication during titration and until shared care and/or transfer of prescribing is formally accepted by the patients GP.
8. Reviewing and monitoring during therapy titration and stabilisation, where responsibility is retained.
9. The Primary Care or Secondary Care Specialist Prescriber will ensure that individual patients are stabilised on the named **AMBER** medication prior to transfer to the GP under this proposal, unless other arrangements have been agreed between the commissioners and the Secondary care Trust. For most drugs this will be a minimum of one month. Patients will have been stabilised on optimal doses with no adverse events and monitoring is within acceptable parameters.
10. Formally requesting a GP to share care on an individual patient basis via an opt-in and opt-out (opting in or opting out needs to be confirmed by the medicines management groups) form (see Appendix 2). The GP will be expected to respond within two weeks whether they decide to accept or decline the shared care agreement. Specialist prescribers are required to keep an accurate record of patients receiving shared care (**RED** or **AMBER**) under their care.
11. Ensuring that all patients have at least one month's supply of **AMBER** medication at the time of making the shared care request to the GP.
12. The letter requesting the transfer of prescribing and or shared care agreement from Primary Care or Secondary Care Specialist Prescriber must allow the future responsible GP to decline to enter into the shared care process based on his / her own clinical judgement.
13. The initial shared-care protocol or if not available a letter must be sent with each request to a GP from the Primary Care or Secondary Care Specialist Prescriber initiating Clinician and must include drug name, dose form, strength of drug and dosing instructions. Other information that must also be included are the prescribed indication of the named drug, duration of use,

monitoring requirements and information on resulting dosage adjustments, a contact source in case of problems, and the date of next review appointment with the initiating Clinician. Most of this information relating to the **AMBER** drug itself is contained within the agreed shared care protocol, which should be made available to the GP as a hard copy.

14. Any special instructions on drug use or patient education should be provided with the initial letter requesting shared care arrangements (e.g., folate supplementation with Methotrexate).

15. The Primary Care or Secondary Care Specialist Prescriber will review the patient at appropriate intervals. For new shared care patients this will normally be 3-6 months after transfer of care, or a shorter interval if clinically indicated, and then as guided by the Primary Care or Secondary Care Specialist Prescriber.

16. The Primary Care or Secondary Care Specialist Prescriber will review all shared care patients according to each individual protocol.

17. Review letters sent to the GP under shared care agreements by a Primary Care or Secondary Care Specialist Prescriber should include disease diagnosis, the name, form and strength of the drug, information on drug dosing and next review appointment date.

18. The Primary Care or Secondary Care Specialist Prescriber will forward information following the review appointment within 4 weeks of the appointment, although the Primary Care or Secondary Care Specialist Prescriber will aim to have this information to the GP within 2 weeks subject to continued current administration arrangements.

19. The Primary Care or Secondary Care Specialist Prescriber will inform the GP when a patient defaults review appointments.

20. The GP must be informed where there are changes following a review to allow continuity of supply. The Primary Care or Secondary Care Specialist Prescriber will only supply new medication if there is an immediate need. i.e. changes required in the next 28 days.

21. The Primary Care or Secondary Care Specialist Prescriber will provide a point of contact during working hours for any queries related to the prescribing and monitoring of the shared care drugs.

22. Should a Service or Pathway be developed that has specific shared care (transfer of prescribing) related issues it may then affect all parties involved in the care of the patient. Therefore if other parties are involved in a patients care (e.g., a commissioned provider of near patient testing) then in this situation a copy of all relevant shared care information should be supplied to all parties.

23. It is recognised that overall outpatient activity especially in terms of outpatient reviews will be decreased if this process is successfully implemented.

24. The Primary Care or Secondary Care Specialist Prescriber will ensure that patients started on a **GREEN+** drug receive a minimum of one months treatment (see table on page 27) and meet the clinical criteria set for the patient prior to transferring care to a GP.

25. The letter requesting the transfer of care of a **GREEN+** drug must allow for sufficient time for the GP to accept prescribing and to arrange for a FP10.

Responsibilities of the GP

1. It is the responsibility of primary care and its clinicians to ensure that all medical, nursing, pharmaceutical and other appropriate staff are kept up to date on shared care and how drugs should be managed using this document.
2. GPs should not accept prescribing responsibility for **RED** drugs. There should however be a system of recording all medication under the on-going responsibility of a Primary Care or Secondary Care Specialist Prescriber with safe and effective procedures in the GP practice to ensure prescriptions cannot be issued or supplies obtained inadvertently in primary care.
3. The GP will be required to respond to the formal shared care request from the Primary Care or Secondary Care Specialist Prescriber within 2 weeks from date of receipt stating if they wish to decline or accept the transfer. GPs may refuse to accept prescribing responsibility for an **AMBER** drug if they do not have adequate knowledge, facilities or capacity to do so. **In refusing to prescribe the GP should inform both the** Primary Care or Secondary Care Specialist Prescriber **and separately the medicines management link.** Secondary care clinicians should normally seek advice from the Chief Pharmacist.
4. The GP should set up a call and recall system to identify patients prescribed drugs by Primary Care or Secondary Care Specialist Prescribers. An accurate record of all **RED** and **AMBER** drugs should be kept within a patients medical record, including where patients get this medicine from.
5. The GP should ensure that all appropriate monitoring required of the GP under the shared care protocol is undertaken in line with the shared care protocol.
6. The GPs should expect shared care protocols to accompany any request for transfer of any **AMBER** drugs.
7. The GP should review the results of monitoring and seek appropriate advice from the appropriate Primary Care or Secondary Care Specialist Prescriber regarding adverse monitoring results (as specified in the shared care protocols).
8. The GP should inform the Primary Care or Secondary Care Specialist Prescriber when a patient defaults review appointments in primary care.
9. The GP should be aware of potential side effects and inform the Primary Care or Secondary Care Specialist Prescriber of suspected side effects (as specified in the shared care protocols).
10. The GP should stop issuing prescriptions if advised by the Primary Care or Secondary Care Specialist Prescriber. Advice will be issued on an individual patient basis and unstable patients may be referred back to secondary care for complete review.
11. The GP should provide regular prescriptions for medication used within their licensed indications, and/or off label use only for indications supported by research and a body of evidence or **exceptionally** by specific agreement an unlicensed drug under the shared care protocol at the dosage recommended by the Primary Care or Secondary Care Specialist Prescriber for stable shared care patients.
12. The GPs should expect at least 4 weeks notice of the need to accept a request to prescribe a **GREEN+** drug from a Primary Care or Secondary Care Specialist Prescriber.
13. GPs should follow local and national guidance for appropriate monitoring of **GREEN+** drugs.

Additional information

1. New drug(s) may be added to the transfer of prescribing document by approval from the Clinical Commissioning Group (via the local prescribing group) in consultation with the Secondary Care Trust (e.g. via the Drug & Therapeutics Committee) – usually one cycle of meetings is required for this approval. It is expected this role will be carried out by a group that is authorised to do so by the CCG and Secondary Care Trusts.
2. New drug(s) should be presented (by the Primary Care and Secondary Care Specialist Prescriber) with full correspondence for scrutiny to both the CCG and the Secondary Care Trust.
3. In the event of a shared care agreement breakdown, the following are suggested appropriate actions:

   Patient – in the event of the patient defaulting from any given appointment, the patient will be re-invited to attend via a letter or documented telephone call from the responsible Primary Care and Secondary Care Specialist Prescriber reminding the patient of the importance of medication/disease reviews and the potential consequences of defaulting from such reviews. In the event of persistent defaulting, a firmer styled letter should be sent to the patient detailing the adverse consequences on the disease process of not taking the named medication and also the potential ultimate adverse consequences of failing to attend for monitoring of the named drug. If the patient continues to default the Shared Care Drug will be withdrawn. Parties to the Shared care agreement should inform each other when a patient defaults his/her review appointment.

   Specialist Service or Trust – in the event of an appointment being changed by the Primary Care and Secondary Care Specialist Prescriber by more than 3 months, or shorter time if clinically appropriate, the shared care agreement will cease and responsibility for future prescribing of the named drug will pass to the Primary Care and Secondary Care Specialist Prescriber.

   CCG – a review will be carried out by the CCG prescribing lead. Any GP providing services of less than the agreed quality may be invited to provide an explanation to the CCG Board.

   CCG/NECS – a performance review will be carried out by the CCG or NECS on behalf of the CCG.
   Any GP providing services of less than the agreed quality baseline will be invited to provide an explanation to the Medical Director.

Unlicensed Use of Medicines

Unlicensed Medicines – The position in relation to unlicensed medicines and the use of licensed medicines used outside their license – the so called off label use - is the subject of advice from numerous professional regulatory and representative bodies. The GMC advice on unlicensed medicines is as follows

Prescribers can prescribe unlicensed medicines but, if they decide to do so, they must:

> Be satisfied that an alternative, licensed medicine would not meet the patient's needs
>
> Be satisfied that there is a sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy
>
> Take responsibility for prescribing the unlicensed medicine and for overseeing the patient's care, including monitoring and any follow up treatment
>
> Record the medicine prescribed and, where you are not following common practice, the reasons for choosing this medicine in the patient's notes.

Hence it is normally expected that all unlicensed drugs will be automatically classified as **RED.** There may be an exception for a defined group of patients with a defined condition when a Primary Care and Secondary Care Specialist Prescriber may request the GP to undertake clinical responsibility for an unlicensed drug, but this must only be within the confines of a formally agreed shared care protocol **and with** specific GP agreement.

Off-Label –There is also GMC advice for prescribing medicines for use outside the terms of their licence (off-label). It notes there are a number of circumstances when off-label prescribing occurs and that it is likely to occur most frequently in prescribing for children. The criteria for accepting prescribing are identical to those listed above.

Unless there is a specific risk that requires consultant intervention or the off-label use is not innovative or the Primary Care and Secondary Care Specialist Prescriber is using the drug outside the scope of its license where there is little research or other evidence of current practice to support its use this use would be considered **GREEN**. Off label use that is either innovative and or not supported by research or clinical practice would be considered **RED**. The Primary Care and Secondary Care Specialist Prescriber should be willing to meet requests from primary care clinicians for evidence in support of any off-label use.

Patients, or those authorising treatment on their behalf must be given sufficient information about the proposed course of treatment including any known serious or common side effects or adverse reactions. This is to enable them to make an informed decision and this included unlicensed and off label use of medicines.

Where current practice supports the use of a medicine outside the scope of their licence it may not be necessary to draw attention to the licence when seeking consent. However, it is good practice to give as much information as patients, or those authorising treatment on their behalf, require or which they may see as significant. Where patients or their carers express concern an explanation, in broad terms, as to the reasons why medicines are not licensed for their proposed

use should be provided. Such explanations may be supported by written information, including the leaflets on the use of unlicensed medicines or licensed medicines for unlicensed applications in paediatric practice produced by the Royal College of Paediatrics and Child Health/Neonatal and Paediatric Pharmacists Group Standing Committee on Medicines.

The reasons for prescribing a medicine that is unlicensed or being used outside the scope of its licence where there is little research or other evidence of current practice to support its use, or the use of the medicine is innovative must always be explained to the patient.

For specific information on prescribing medicines for children see the websites of the Royal College of Paediatrics and Child Health and the British National Formulary for Children.

Definition of Drug Categories

The CCG, local Trust D&T and/or the CCG Prescribing Group are currently responsible for classifying drugs into either the **RED** or **AMBER**, **GREEN+** or **GREEN** categories.

Implementation Plan

Current prescribing may not be consistent with these standards; drugs that have been categorised as unsuitable for primary care prescribing may already be being prescribed. It is vital that patient safety is not jeopardised by any move to shift prescribing back into secondary care. It is therefore necessary to adopt a staged approach to this process. This may take several months or years, but is necessary to ensure that standards of care are maintained.

Existing Prescribing

Arrangements for existing prescribing of **RED** and **AMBER** drugs will be reviewed on a drug by drug basis. If deemed desirable the CCG will work with all parties to transfer prescribing responsibility back into secondary care and as a result resource issues may need to be addressed. Drugs will be prioritised according to prescribing volume and the potential hazards of continued prescribing arrangements.

New Prescribing

These guidelines will be submitted for approval by the Gateshead MMC, South Tyneside MMC and Sunderland Primary Care Prescribing Group and the appropriate local Drug and Therapeutics Committees. The guidelines will also be sent to local LMCs for comment. When approved they will be made available to all GPs and Prescribers by the CCG and to secondary care clinicians as well as managers of individual directorates.

Record Keeping

Specialist prescribers responsibilities

- Specialist prescribers are required to keep an accurate record of all **RED** and **AMBER** drugs within a patients medical record, including where patients get this medicine from and be able to audit the process if required.
- To ensure that a shared-care agreement is sent with each new request to transfer prescribing

GP responsibilities

- GPs are required to keep an accurate record of patients receiving **RED** and **AMBER** drugs under their care and be able to audit the process if required.
- To ensure all shared care agreements are scanned into the individual patient records.

Review of Guidelines

These guidelines will be reviewed at least annually or sooner as identified by the committees.

Specialist only (RED) drugs

Drugs that should remain under the total responsibility of the Primary or Secondary care specialist prescriber (i.e. consultant) should only be prescribed under the direct supervision of that clinician (e.g., HIV and chemotherapy drugs).

*It is recognised that a exceptionally small number of regularly prescribed drugs for groups of defined patients especially within paediatrics are prescribed that have no UK product license but are used in accordance with current practice defined in accredited guidance documents e.g. Medicines for Children or the Paediatric BNF and are therefore designated **AMBER**.

Specific categories

- Drugs used in conjunction with a clinical trial
- Antiviral drugs used in the treatment of HIV/AIDS
- All hormonal drugs used for IVF treatment
- Drugs available for prescribing by a hospital Secondary Care Trust Clinician only as a condition of their licence (***Including Acitretin, Isotretinoin, Phenylbutazone)***
- Drugs prescribed out with the product licence unless approved by the appropriate bodies
- All cytotoxic drugs used as part of a cancer chemotherapy regime ***(Including, Anti-emetics):***

  The 2011 Department of Health Chemotherapy Measures contain a measure for PCTs, 11-6A-101s, which states 'The measure 11-6A-101s requires that the PCT has a policy stating General practitioners (GPs) should not prescribe systemic, including oral, cytotoxic chemotherapy or intracavitary cytotoxic chemotherapy for the treatment of malignant disease, under the contract each General Practice has with the PCT. **Reference** http://www.cquins.nhs.uk/?menu=resources.

  For the purposes of compliance CCG are advised that the measures use the terms chemotherapy and anticancer medicines to refer to all drugs with direct anti-tumour activity, administered to cancer patients, including traditional cytotoxic chemotherapy such as carboplatin, capecitabine, hydroxycarbamide, paclitaxel and newer targeted therapies such as imatinib, sunitinib, rituximab and other agents such as thalidomide. It does not include hormonal or anti-hormonal agents such as octreotide, tamoxifen and anastrazole.

Specific RED drugs

- Amber drugs for indications not covered by shared care agreements are considered to be red

Drug	Indication / Restriction
Abacivir	HIV infection
Abatacept	Cytokine modulator
Acitretin	Psoriasis
Adalimumab	Cytokine modulator
Adefovir	Hepatitis B
Adenosine injections & infusions	Anti-arrhythmic Drug
Ajmaline	Unlicensed - used in the diagnostic testing of Brugada syndrome.
Alemtuzumab	Cancer treatment
Alitretinoin	Recommended for use by NICE as a treatment option for severe chronic hand eczema.
Ambrisentan	Treatment for pulmonary hypertension
Amifostine	Cancer treatment
Amprenovir	HIV infection
Amsacrine	Cancer treatment
Anagrelide	2nd line treatment for essential thrombocythaemia in at risk patients
Anakinra	Cytokine modulator
Anti-D (Rho) Immunoglobulin	Prevention of RhD immunisation in RhD negative women
Anti-lymphocyte immunoglobulin	Prevention & treatment of transplant graft rejection
Anti-thymocyte immunoglobulin	Prevention & treatment of transplant graft rejection
Aprepitant	limited use in patients receiving highly emetic cancer chemotherapy
Arsenic	Cancer treatment
Ascorbic acid (potassium ascorbate) eye drops	Unlicensed
Atazanivir	HIV infection
Atosiban	Treatment for premature labour
Atripla	Combination of efavirenz, emtricitabine and tenofovir for treating HIV infection
Azacitidine	Cancer treatment
Azathioprine	Cancer treatment (**AMBER** for other indications)
Basiliximab	Used for prevention of transplant rejection
BCG (Connaught)	Bladder cancer
Bendamustine hydrochloride	Cancer treatment
Benzylpenicillin eye drops	Unlicensed
Beriplex B	Specialist use for prevention and treatment of bleeding caused by warfarin overdose
Bevacizumab	Cancer treatment
Bexarotene	Cancer treatment
Bleomycin	Cancer treatment
Bortezomib	Cancer treatment

Drug	Indication / Restriction
Bosentan	Treatment for pulmonary hypertension
Botulinum toxin A & B	All indications
Busulfan	Cancer treatment
Capecitabine	Cancer treatment
Capecitabine with Irinotecan	Metastatic colorectal cancer
Carboplatin	Cancer treatment
Carboprost	All indications
Carmustine	Cancer treatment
Carnitine	Treatment of carnitine deficiency
Caspofungin	Antifungal
Cefuroxime eye drops	Unlicensed
Certolizumab	Anti TNF-α drug used for the treatment of rheumatoid arthritis in accordance with NICE guidelines
Cetrorelix acetate 3mg injection	Used for the inhibition of premature LH surges in women undergoing controlled ovarian stimulation.
Cetuximab	Cancer treatment
Chlorambucil	Unlicensed
Chronic gonadotrophin	Red when used for treating infertility
Ciclosporin eye drops & eye ointment	Unlicensed
Ciclosporin IV infusion	Transplant patients
Cidofovir	For prevention/treatment of cytomegalovirus infection
Cilostazol	Intermittent claudication
Cisplatin	Cancer treatment
Cladribine	Cancer treatment
Clofarabine	Cancer treatment
Clozapine	Antipsychotic
Cocaine 4% eye drops	Unlicensed
Combivir	HIV infection
Crisantaspase	Cancer treatment
Cyclophosphamide	Cancer treatment
Cytarabine	Cancer treatment
Dacarbazine	Cancer treatment
Daclinomycin	Cytotoxic antibiotic
Daclizumab	For prophylaxis of acute transplant rejection
Dactinomycin	Cancer treatment
Daptomycin	Antibiotic for restricted use
Darunavir	HIV infection
Dasatinib	Cancer treatment
Daunorubicin	Cancer treatment
Desferrioxamine	Chronic iron overload
Dibotermin Alfa (Inductos)	Bone Morphogenic Protein used in spinal fusion procedures.
Didanosine	HIV infection
Digoxin specific antibody (Digibind)	Digoxin toxicity

Drug	Indication / Restriction
Disodium Pamidronate	Treatment of conditions associated with increased osteoclast activity
Dobutamine	Inotropic sympathomimetic
Docetaxel	Cancer treatment
Dopamine	Inotropic sympathomimetic
Dopexamine	Inotropic sympathomimetic
Doripenem	Antibiotic for restricted use
Doxapram	Respiratory stimulant
Doxorubicin	Cancer treatment
Drotrecogin Alfa (Xigris)	Adjunctive treatment of severe sepsis with multiple organ failure
Duolube ophthalmic ointment	Unlicensed
Efavirenz	HIV infection
Emtricitabine	HIV infection
Enfuvirtide	HIV infection
Entecavir	Hepatitis B
Epirubicin	Cancer treatment
Epoprostenol	Treatment for pulmonary hypertension
Eptotermin Alfa (Osigraft)	Bone Morphogenic Protein used in tibia surgery
Eribulin	Cancer treatment
Everolimus	Cancer treatment
Erlotinib	Cancer treatment
Erythromycin 5% eye ointment	Unlicensed
Esmolol	Short-term treatment of supraventricular arrhythmias
Estramustine	Cancer treatment
Etanercept	Cytokine modulator
Etoposide	Cancer treatment
Etravirine	HIV infection
Ferric carboxymaltose injection (Ferinject®)	All indications
Fentanyl lozenges	Analgesia
Filgrastim	Neutropenia
Fludarabine	Cancer treatment
Fluorouracil injection	Cancer treatment
Fosamprenavir	HIV infection
Foscarnet	Intravenous anti-viral agent
Fosfomycin	Unlicensed
Fulvestrant	Cancer treatment
Fumaric acid esters	Unlicensed treatment for psoriasis
Ganciclovir	Antiviral injection
Gefitinib	Cancer treatment
Gemcitabine	Cancer treatment
Gemeprost	Induction of termination
Gentamicin 1.5% preservative-free eye drops	Unlicensed
Gentamicin injection	Antibiotic for restricted use

Drug	Indication / Restriction
Glatiramer	Antiviral injection
Glycerol 10% & 50% eye drops	Unlicensed
Grazax	For sublingual immunotherapy
Hyaluronic acid derivatives	Osteoarthritis of the knee
Hyaluronidase	Enhance permeation of subcutaneous or intramuscular injections
Hydroxycarbamide	Cancer treatment
Idarubicin	Cancer treatment
Ifosfamide	Cancer treatment
Iloprost	Treatment for pulmonary hypertension
Imatinib	Cancer treatment
Indinavir	HIV infection
Infliximab	Cytokine modulator
Interferon Alfa 2a and 2b	Immunodulating drug
Interferon Beta (all types)	Treatment for multiple sclerosis
Irinotecan	Cancer treatment
Isoprenaline injections	Unlicensed
Isotretanoin	Unlicensed
Kivexa (abacavir + lamivudine)	HIV infection
Lamivudine	HIV infection
Lapatinib	Cancer treatment
Lenograstim	Neutropenia
Levosimendan	Unlicensed
Lidocaine Plasters	For use in the treatment of neuropathic pain on the advice of pain specialists only
Linezolid	Restricted antibiotic
Lomustine	Cancer treatment
Lopinavir with ritonavir (Kaletra)	HIV infection
Maraviroc	HIV infection
Melatonin	Approved for use in some other sleep disorders (unlicensed indication)
Melphalan	Cancer treatment
Menotrophin	Infertility treatment
Mercaptopurine	Cancer treatment
Methotrexate	Cancer treatment
Micafungin	Antifungal
Miconazole buccal tablets (Loramyc®)	Only approved for second-line use in the treatment of severe oropharyngeal candidiasis. Not considered appropriate for GP prescribing
Mifepristone	Induction of termination
Mitomycin	Cancer treatment
Mitomycin C eye drop	Unlicensed
Mitoxantrone	Cancer treatment
Mitobronitol	Cancer treatment
Mitotane	Cancer treatment
Nabilone	Includes use of nabilone for pain relief (unlicensed indication)

Drug	Indication / Restriction
Natalizumab	Treatment for multiple sclerosis
Nelarabine	Cancer treatment
Nelfinavir	HIV infection
Neomycin	Aminoglycoside
Neviripine	HIV infection
Nilotinib	Cancer treatment
Omalizumab	Monoclonal antibody for specialist use in patients with severe IgE mediated asthma, in accordance with NICE guideline
Oxaliplatin	Cancer treatment
Paraldehyde	Status epilepticus
Paclitaxel	Cancer treatment
Palonosetron	Limited use in patients receiving highly emetic cancer chemotherapy
Palifermin	Cancer treatment
Panitumumab	Cancer treatment
Pazopanib	Cancer treatment
Pegfilgrastim	Neutropenia
Peginterferon Alfa 2a and 2b	Immunodulating drug
Pemetrexed	Cancer treatment
Pentosan polysulphate	All indications
Phenylbutane	For status epilepsy
Pentostatin	Cancer treatment
Picibanil	Unlicensed
Plerixafor (Mozobil®)	Used for stem cell mobilisation.
Polyhexamethylene biguanide (PHMB) eye drops (unlicensed)	Unlicensed
Poractant Alfa	Respiratory distress syndrome
Porfimer Sod	Cancer treatment
Posaconazole	Orally administered systemic antifungal agent
Povidone-Iodine eye drops	Unlicensed
Procarbazine	Cancer treatment
Raltegravir	HIV infection
Raltitrexed	Cancer treatment
Ranibizumab	Treatment for ‘wet’ macular degeneration
Raspuricase	Prophylaxis and treatment of hyperuricaemia associated with cytotoxic drugs
Ribavarin	Antiviral for restricted use
Riluzole	Treatment to extend life or the time to mechanical ventilation for patients with amyotrophic lateral sclerosis
Ritonavir	HIV infection
Rituximab	Cytokine modulator
Rufinamide	Anti-epileptic for use in treatment of Lennox - Gastaut syndrome
Saquinavir	HIV infection
Sativex	Treatment for multiple sclerosis
Sildenafil (Revatio®)	Treatment of pulmonary hypertension and secondary Raynaud’s disease. Sildenafil (Viagra) used for erectile dysfunction is Green

Drug	Indication / Restriction
Sitaxentan	Treatment for pulmonary hypertension
Sodium citrate (citrate 6.5%) eye drops	Unlicensed
Sodium Clodronate IV	Hypercalaemia associated with cancer
Sodium Phenylbutyrate	Treatment of urea cycle disorders
Somatropin	Growth Hormone
Sorafenib	Cancer treatment
Stavudine	HIV infection
Streptozocin	Cancer treatment
Sumatinib	Cancer treatment
Sunitinib	Cancer treatment
Telbivudine	Hepatitis B
Temozolamide	Cancer treatment
Tenofovir	HIV infection
Temoporfin	Cancer treatment
Temsirolimus	Cancer treatment
Thalidomide	Unlicensed
Thiotepa	Cancer treatment
Tigecycline	Antibiotic for restricted use
Tioguanine	Cancer treatment
Tiopronin	Unlicensed
Tipranavir	HIV infection
Tocilizumab	For use in patients with moderate to severe active rheumatoid arthritis, Poly-Articular and Systemic-Onset Juvenile Idiopathic arthritis [Unlicensed indication]
Tolcapone	Treatment for Parkinson's disease.
Topotecan	Cancer treatment
Total Parenteral Nutrition	Nutrition
Trabectedin	Cancer treatment
Trastuzumab	Cancer treatment
Treosulfan	Cancer treatment
Tresprostinil	For pulmonary hypertension
Tretinoin	Cancer treatment
Tretinoin (retinoic acid) eye drops	Unlicensed
Trifluorothymidine eye drops	Unlicensed
Trizivir (abacavir + lamivudine + zidovudine)	HIV infection
Truvada (emtricitabine + tenofovir)	HIV infection
Uftoral (Tegafur/uracil)	Cancer treatment
Urofollitropin	Infertility treatment
Ustekinumab	Restricted use in patients with plaque psoriasis
Valganciclovir	Antiviral for restricted use
Verteporfin (Visudyne)	Treatment for 'wet' macular degeneration
Vinblastine	Cancer treatment
Vincristine	Cancer treatment

Drug	Indication / Restriction
Vindesine	Cancer treatment
Vinorelbine	Cancer treatment
Voriconazole	Systemic antifungal
Xelma	Limited use in difficult to heal leg ulcers
Zalcitabine	HIV infection
Ziconotide	Intrathecal analgesic, rarely used
Zidovudine	HIV infection
Zoledronic acid injection	For hypercalcaemia, bone lesions in metastatic breast cancer and osteoporosis

AMBER

These are specialist drugs which must be initiated by a Primary Care or Secondary Care Specialist Prescriber, but with the potential to transfer to primary care within written and agreed shared care protocols and according to the agreed process for transfer of care. The patient's condition and/or treatment should normally be stabilised before the GP should be asked to participate in shared care. This time period can be variable dependent on the condition being treated and the individual patient's response to the treatment. A minimum of one months stabilised dose would be expected to be provided by the Primary Care or Secondary Care Specialist Prescriber before considering transfer.

These include:

- Rarely prescribed drugs
- Drugs requiring infrequent monitoring by a Primary Care or Secondary Care Specialist Prescriber
- Drugs for which specialist monitoring is vital to the efficacy of therapy

It is recognised that many drugs prescribed for patients although especially within paediatrics are prescribed off label in accordance with routine current practice and evidence as defined in accredited guidance e.g., Medicines for Children or the Paediatric BNF and are therefore designated **GREEN** *

Specific AMBER drugs

Note: atypical antipsychotics are being discussed by NTW and CCG leads at a separate meeting and the shared-care documents will be updated and made available in due course.

Drug	Indication / Restriction	Shared Care Document available ?
Amisulpride	Atypical antipsychotic	
Apomorphine	Treatment for Parkinson's disease.	
Aripiprazole	Atypical antipsychotic	
Atomoxetine	Attention deficit hyperactivity disorder	✓
Auranofin	Musculo-skeletal disorders	
Azathioprine	Non cancer indications (Red for cancer indications)	✓
Bicalutamide	Prostate cancer	
Chlorothiazide/Spironolactone capsules (unlicensed)	Unlicensed, RVI specialists only	
Ciclosporin	Rheumatological, gastro-intestinal & dermatological conditions and transplant patients	✓
Cinacalcet	Hyperparathyroidism	
Colistin	Antimicrobial	
Cyclophosphamide	Non cancer indications (Red for cancer indications)	
Darbepoetin	Anaemia	
Dapsone	Antileprotic - dermatology	
Degarelix	Advanced hormone dependent prostate cancer	✓
Dexamfetamine	Attention deficit hyperactivity disorder	
Dornase alfa	Can be taken over by GPs only in exceptional circumstances for patients with cystic fibrosis	
Dronaderone	Class II antiarrhythmic drug used by electrophysiologists for use in patients who are unsuitable for or not tolerant to	

Drug	Indication / Restriction	Shared Care Document available ?
	amiodarone	
Erythropoietins • Epoetin alfa • Epoetin Beta • Epoetin Theta • Epoetin Zeta • Methoxy Polyethylene Glycol-epoetin Beta	Anaemia	
Flupentixol Decanoate	Antipsychotic	
Fluphenazine Decanoate	Antipsychotic	
Glycopyrolate	Anti-secretory	
Goserelin	Advanced hormone dependent prostate cancer	In draft
Goserelin	Endometriosis	
Hydroxycarbamide	Non cancer indications (already agreed as Red for cancer)	
Haloperidol depot	Antipsychotic	
Hydroxychloroquine	Rheumatoid arthritis	✓
Ketamine	Used in palliative care and chronic pain	✓
L tryptophan	Treatment-resistant depression after trials of standard antidepressant drug treatments	
Lanreotide	Somatostatin analogue	
Leflunomide	Monitoring in rheumatological patients	
Leuprorelin	Advanced hormone dependent prostate cancer	In draft
Lithium	Antimanic drug	✓
Melatonin (UK specials)	Approved for use in some other sleep disorders (unlicensed indication)	✓
Mepacrine	Dermatology	
Mercaptopurine	Non cancer indications (already agreed as Red for cancer)	
Methotrexate	Non cancer indications (already agreed as Red for cancer)	✓
Methylphenidate	Attention deficit hyperactivity disorder	✓
Mycophenolate	Rheumatological, gastro-intestinal & dermatological conditions and transplant patients	
n-Acetylcysteine	Unlicensed – used in pulmonary fibrosis in accordance with British Thoracic Society Guidelines	
Naltrexone	self-injurious behaviour in people with learning difficulties	✓
Octreotide	Somatostatin analogue - all indications other than acromegaly at Gateshead, very rare used in South Tyneside	
Olanzapine	Atypical antipsychotic	
Penicillamine	Rheumatoid arthritis	✓
Pimozide	Antipsychotic	
Pipotiazine Palmitate	Antipsychotic	
Quetiapine	Antipsychotic	
Risperidone (oral and depot)	Atypical antipsychotic	
Sirolimus	Prophylaxis of organ rejection	
Sodium Aurothiomalate	Rheumatoid arthritis	✓
Sulphasalazine	Rheumatoid arthritis	✓
Tacrolimus (oral)	Prophylaxis of organ rejection	
Triptorelin	Prostate Cancer	
Zuclopenthixol Decanoate	Antipsychotic	

Green

For completeness **GREEN** drugs are defined as new and established drugs which may be prescribed on FP10 without recourse to secondary care.

- Independent prescribers should accept clinical responsibility and be able to deal with all aspects of regimes, without further advice or instruction.
- In certain circumstances GPs may wish to share prescribing of this group of drugs with consultants in the best interests of patients (e.g. if the patient is attending hospital regularly for treatment or follow-up).

Green +

It is accepted that some drugs should be initiated by a Primary Care or Secondary Care Specialist Prescriber, but can be safely maintained in primary care without on-going specialist monitoring are classified as **GREEN+** rather than **AMBER**. All **GREEN+** drugs should be supplied to patients with a patient information leaflet. These include:

Specific GREEN+ drugs

Drug	Indication / Restriction	Prescription length for initial prescription	Monitoring
Acamprosate	Alcohol withdrawal	4 weeks	
Agomelatine	Antidepressant for limited use, initiated by specialist mental health physicians only	4 weeks	Liver function tests
Amiodarone	Atrial fibrillation	4 weeks	6mthly Liver function and Thyroid tests ECG Opthamological examination annually Lung function tests Ensure patient is reduced to maintenance dose
Bemiparin	Low molecular weight heparin (**not agreed** as GREEN + for post operative use)	At the discretion of the prescriber	Baseline platelets then 3 -5 days after initiation
Bromocriptine	Treatment for Parkinson's disease.	4 weeks	
Buprenorphine (Subutex®)	Opioid dependence	4 weeks	Liver function tests in patients who are positive for viral hepatitis, and/or have liver dysfunction.
Cabergoline	Treatment for Parkinson's disease.	4 weeks	

Drug	Indication / Restriction	Prescription length for initial prescription	Monitoring
Caphosol	Topical oral agent to be used in patients having chemo & radiotherapy or radiotherapy alone for malignancies of the oral cavity, hypopharynx and oro-pharynx.	4 weeks	
Clomiphene	Ovulatory failure	2 cycles	Ovulation absence
Dalteparin	Oral anticoagulation treatment (**not agreed** as GREEN + for post operative use)	At the discretion of the prescriber	Baseline platelets then 3 -5 days after initiation
Dekristol (Colecalciferol)	Unlicensed product used for treatment of severe vitamin D deficiency	4 weeks	
Denosumab	For the treatment of postmenopausal osteoporosis in accordance with NICE guidance.	1 injection	
Donepezil	Management of Dementia	4 weeks	
Enoxaparin	Oral anticoagulation treatment (**not agreed** as GREEN + for post operative use)	At the discretion of the prescriber	Baseline platelets then 3 -5 days after initiation
Entacapone	Treatment for Parkinson's disease.	4 weeks	Monitor adverse effects, if necessary reduce levodopa dosage
Eslicarbazepine	For use in the adjunctive treatment of partial epilepsy in patients who have shown side effects to carbamazepine and who have shown failure to respond to alternative first line antiepileptic medication	4 weeks	
Exenatide	Hypoglycaemic drug for treatment of very obese patients with type-2 diabetes in accordance with NICE guidance	4 weeks	
Fesoterodine	Selective muscarinic antagonist for second line use in the management of overactive bladder	4 weeks	Re-evaluate efficacy after 8 weeks
Galantamine	Management of Dementia	4 weeks	
Ibandronic acid	Metastatic breast cancer	4 weeks	
Levatiracetam	Epilepsy	4 weeks	
Liraglutide	Type-2 diabetes in accordance with NICE guidance	4 weeks	
Lofexidine	Opioid dependence		
Melatonin (Circadin®)	Approved for use in some other sleep disorders	4 weeks	
Memantine	Management of Dementia	4 weeks	
Methadone	Pain management	4 weeks	
Midazolam buccal solution	Unlicensed formulation	4 weeks	
Modafinil	Narcolepsy	4 weeks	Clinical assessment of the need for treatment performed periodically
Pergolide	Treatment for Parkinson's disease.	4 weeks	
Pramipexole	Treatment for Parkinson's disease.	4 weeks	

Drug	Indication / Restriction	Prescription length for initial prescription	Monitoring
Pregabalin	Neuropathic pain/ epilepsy	4 weeks	
Rasagiline	Treatment for Parkinson's disease	4 weeks	
Rifaxamin	Restricted antibiotic	4 – 6 weeks	
Rivastigmine	Management of Dementia	4 weeks	
Ropinirole	Treatment for Parkinson's disease.	4 weeks	Evaluate after 12 weeks of treatment
Rosuvastatin	Treatment of familial hypercholesterolaemia in patients who do not respond adequately or do not tolerate maximal doses of other statins.	4 weeks	
Rotigotine	Treatment for Parkinson's disease and Restless Legs Syndrome	4 weeks	
Stalevo	Treatment for Parkinson's disease.	4 weeks	
Suboxone ® (buprenorphine / naloxone)	Opioid dependence	4 weeks	Liver function tests in patients who are positive for viral hepatitis, and/or have liver dysfunction.
Tacrolimus ointment	Dermatitis	4 weeks	
Tiagabine	Epilepsy	4 weeks	
Ticagrelor	Acute coronary syndromes	4 weeks	
Tinzaparin	Oral anticoagulation treatment (**not agreed** as GREEN + for post operative use)	At the discretion of the prescriber	Baseline platelets then 3 -5 days after initiation
Topiramate	Epilepsy	4 weeks	
Triptorelin	Treatment of precocious puberty	1 injection	
Venlafaxine (high dose)	Patients taking a daily dose of 300mg venlafaxine or more.	4 weeks	
Vigabatrin	Epilepsy	4 weeks	

SHARED CARE GUIDELINE

For

Insert Name of Drug(s) and Condition

Implementation Date:

Review Date:

This guidance has been prepared and approved for use within Gateshead, South Tyneside and Sunderland in consultation with CCGs and Secondary Care Trusts, primary care medicines management committees and Local Medical Committees. The guideline sets out the details of the transfer of prescribing and respective responsibilities of GPs and specialist services within shared care prescribing arrangements. It is intended to provide sufficient information to allow GPs to prescribe these treatments within a shared care setting.

Further copies are available from

Approved by:

Committee	Date

Name of drug:	**Template**	Form and strength:	
Brand name:		BNF Chapter & sub-section (e.g., : 4.4)	
Conditions(s) to be treated:		Aim of treatment:	

Excluded patients	**Unstable disease state**	
Eligibility criteria for shared care	**Following dose and drug stabilisation for at least 1 month**	
Initiation		
Duration of treatment		
Usual Maintenance Dose		
Usual Dose Range		
Maximum Dose		
Available Strengths (Colours)		
Preparations	Film coated tablets Liquid mg/ml	
Cost 28 days (Drug Tariff)	£ / month	
Adverse effects Incidence and actions to be taken		
Contra-indications	Known hypersensitivity to the product	
Renal impairment and liver disease		
Pregnancy and breast feeding		
Monitoring	e.g., Monitor blood glucose at 6 monthly review	
Administration requirements (if appropriate).	e.g., community nurse or practice nurse required to administer an injectable medication	
Responsibilities	Primary Care or Secondary Care Specialist Prescriber	e.g., annual review of disease state and appropriateness of shared care.
	G.P.	e.g., monthly blood test and review of physical health. Prescribe FP10
Communications	Primary Care or Secondary Care Specialist Prescriber	Consultant annual review letter within 3 weeks Notification of FTA within 3 weeks
	G.P.	Relevant referrals Notification of FTA for monitoring
Re- referral criteria	Failure to attend for monitoring review Intolerance of drugs Monitoring parameters of acceptable range	

	Communications failure
Contact details	Primary Care or Secondary Care Specialist Prescriber
Agreed Date	**Expiry date**

Reference to full prescribing information e.g. SPC

Appendix 2: Shared Care Request Form

PRIMARY / SECONDARY CARE SPECIALIST PRESCRIBER TO COMPLETE

Name of Specialist	
Address of Specialist	
Contact phone no	

Patient's name		
Patient's address		
Patient's DOB		
Patient's NHS No		
This patient has been stabilised on:	**DRUG**	**DOSE**

Pharmacy		Compliance Aid	☐ YES	☐ NO

Administration by: (if appropriate)	e.g. community nurse
Monitored by:	

Prescription for 28 days given on:	
This treatment has been explained to the patient and a review arranged for:	
Appointments to continue every **……..** months	

GP TO COMPLETE ONE SECTION THEN RETURN FORM WITHIN 14 DAYS TO <u>ACCEPT</u> OR <u>DECLINE</u> TRANSFER OF PRESCRIBING

I **ACCEPT** the proposed Shared-Care Agreement for this patient		
Name of GP		DATE
Signature		

I **DECLINE** the proposed Shared-Care Agreement for this patient		
Name of GP		DATE
Signature		
My reasons for declining are:		

Appendix 3: Protocol for Adding Drugs Prescribed Outside GP Practice or prescribed by a practice on a non standard prescription form

Procedure to add medicines that are only prescribed by a hospital or prescribed by a practice on a non standard prescription form to a Primary care medical record

Background to Procedure

- It is essential that a record of all patient medications is readily available on medical systems in primary care.
- Many patients receive regular medication from hospital (e.g., antipsychotics, injections, selective antidementia drugs, selective DMARDs, DEPOT injections, yearly bisphosphonate injections).
- Some specialist medications (e.g., methotrexate S/C injection, oxygen) are prescribed by a practice on specialist forms and are not automatically recorded on the EMIS.
- It is important that practices adopt a system to ensure that an accessible record of these regular hospital and specialist medications is made in a patients electronic medical record
- It is not appropriate to assume that by recording a hospital issued or specialist medication in a consultation (e.g., scanning a hospital letter or scanning a prescription copy) that all future clinicians will be aware that a patient is taking this drug.
- Practices should, where possible, record a patient's regular medications in the repeat medication section of a patient's medical record.
    - This will mean that when a patients medications are sent to other agencies or clinicians that a comprehensive list is provided – as the item appears ion the 'B' side / list of drugs attached to a letter.
    - The hospital issued or specialist drug will also then be included in any drug interaction check that is run by the primary care medical system.
    - By adding the drug as a repeat rather than acute, the drug will not move to past drugs and so it will be seen by all necessary parties.
    - An extension of this is that care must be taken to update/remove this drug(s) as and when a hospital letter indicates a change has occurred.
    - Practices should ensure they are aware of how to add details of drugs prescribed outside of their GP practice onto their own clinical system such as EMIS web, Vision, System one etc.

Example: How to add to an EMIS LV Record

(i) Add drug in usual way

(ii) Pick drug from pick-list

(iii) Enter dose in usual way, need to put in here where patient is getting their drug in capitals (e.g., **PATIENT GETS FROM HOSPITAL, Hospital ONLY ITEM or PATIENT GETS FROM THIRD PARTY SUPPLIER (*insert name of supplier)***)

(iv) Enter quantity as follows:

0*0

By entering the quantity in this way means that if a prescription is accidentally printed then pharmacy will see 0*0 and there will be a note in the dose saying that the patient gets their medication from the hospital or third party supplier. The pharmacy would then contact the practice to check if this was therefore an incorrect prescription request

(v) If you want to add the drug on the date it was administered in the hospital or tertiary service (e.g., zolendronic acid IV infusion, anti-TNF drugs, biologics), you will need to change the date via the consultation mode:-

- ***In consultation mode – A to add a consultation***
- ***Select D – change the date to the date the drug was issued***
- ***Select M – add the medication issued (as above with a 0*0 quantity and annotate as above depending on where the drug was administered) and do not issue a prescription***
- ***Press F1 to go out of consultation mode, then F1 again. You will be prompted to cancel the consultation, press Y for yes (this will NOT cancel the medication added but will not register this entry as a consultation).***