**SHARED CARE GUIDELINE**

**Hydroxychloroquine sulfate for use in Rheumatology**

**Implementation Date: 1st December 2019 Review Date: 1st December 2022**

***This guidance has been prepared and approved for use within Sunderland and South Tyneside in consultation within the CCGs, and Secondary Care Trust.***

***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 this treatment within a shared care setting***

**Approved by:**

|  |  |
| --- | --- |
| **Committee** | **Date** |
|  |  |
|  |  |

**Instructions for completion:**

## Consultant to counsel patient on medication and ensure patient has been provided with information leaflet

## Consultant to ensure all clinical details completed on this document

## Consultant to ensure patient understands proposed monitoring and prescribing arrangements if a shared care agreement is entered into

## GP to complete final section of form and return to specialist prescriber within 28 days

## GP to retain copy of document on patient record within surgery

**Clinical details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SHARED CARE GUIDELINE | | | | | |
| Non-proprietary name | Hydroxychloroquine sulfate | Licensed  Y/N? | Y | | |
| Dosage form and strength | 200mg tablets | | | BNF class | 10.1.3 |

|  |  |
| --- | --- |
| Indication | Inflammatory arthritis, SLE, Sjogren’s syndrome |
| Dosage and Administration | Routinely commence treatment at a dose of 200mg bd, reducing dose to 200mg od after three months of treatment. |
| Eligibility criteria for shared care | Patients must be under the care of a consultant rheumatologist  Must have a diagnosis of inflammatory arthritis  Patients who have been stabilised and have been treated by specialist for at least three months.  Patients who are not stable should not be transferred to primary care for monitoring. |
| Excluded patients | Any patient in whom hydroxychloroquine sulfate is contraindicated or not tolerated.  Not for patients under the age of 16 years |
| Initiation | Shared care to be initiated once patient has been stable on maintenance dose for three months |
| Monitoring | The consultant rheumatologist will retain responsibility for referring patients for ophthalmological assessments. These include:   * Baseline ophthalmic examination, ideally including objective retinal assessment using optical coherence tomography within 12 months of commencing treatment   Annual eye assessments to screen for retinal toxicity, ideally including optical coherence tomography, for patients remaining on hydroxychloroquine sulfate for >5 years. |
| Pregnancy and breastfeeding | If the patient becomes pregnant, contact the specialist. |
| Perioperative use | Steroid exposure should be minimised prior to surgical procedures and increases in steroid doses to prevent adrenal insufficiency are not routinely required.  Hydroxychloroquine sulfate is generally thought to be safe to continue in low risk patients. For **high risk** patients, it may be appropriate to consider stopping hydroxychloroquine sulfate on the day of surgery. Please contact the consultant rheumatologist for advice. |
| Specialist Responsibilities | * The decision to initiate hydroxychloroquine sulfate must be made in conjunction with the patient/carer and be supervised by an expert in the condition in question * Patients must be provided with education about their treatment * Patient will be provided with a hydroxychloroquine sulfate patient information leaflet * Patients must be assessed for contra-indications and co-morbidities * Where appropriate, patients should be advised about the impact of the medication on fertility, pregnancy and breastfeeding * Vaccinations against pneumococcus and influenza are recommended * Interactions between hydroxychloroquine sulfate and current medication should be identified and actioned * Direct the patient to report any sign of infection or side effect to their GP or hospital clinic * Conduct baseline monitoring * Prescribe medication until responsibility agreed to be transferred to patients GP * Supply general background information regarding hydroxychloroquine sulfate to GP as per this guidance * Request GP participate in shared care in writing no sooner than **3 months after initiation** and patient **is stable** * At least 4 weeks of medication supplied at point of transfer * The secondary care specialist will communicate with the patient and GP when treatment is changed and/or needs to be changed by GP on future prescriptions, and/or when any changes to the monitoring are required, usually within 24 hrs * Conduct routine monitoring as per schedule while prescribing responsibility with specialist – this could be during initiation or at any point in time where the responsibility has been transferred back to the specialist * Observe advice relating to vaccination, perioperative use, infections etc. contained in this document * Specialist responsible for ongoing **disease** monitoring – clinical response to therapy will be assessed by the hospital physician in all cases and communicated to the GP * Specialist responsible for assessing if a patient is defined as ‘high risk’ and communicating this to the GP * The specialist will retain responsibility for referring patients for ophthalmological assessments. |
| GP Responsibilities | * The GP should reply to the request for shared care as soon as possible, but always within 14 days, either accepting shared care or informing the specialist why shared care is not felt appropriate in this case. * If GP declines shared care responsibilities it is still the GP’s responsibility to record on the primary care record that the drug is being prescribed by secondary care * Shared care to be initiated once patient is stable and at least 3 months after initiation * Prescribe medication as per document * Observe advice relating to vaccination, perioperative use, etc. contained in this document |
| Contraindications,  Precautions and Adverse Effects | **Contra-indications**  Known hypersensitivity to the product or 4-aminoquinoline compounds (e.g. chloroquine)  Pre-existing maculopathy of the eye  Pregnancy and breast feeding  **Precautions**  *Chronic kidney disease (CKD)*  In renal disease, immunosuppressant agents (IAs) that are renally excreted accumulate, and some IAs are nephrotoxic. Patients with CKD should be graded as per NICE definition of CKD (table 1) and have IA dose reductions as per recommendations by the British Society of Rheumatology (BSR) (table 2).  **Table 1: NICE Definitions of CKD**   |  |  | | --- | --- | | **Degree of Impairment** | **Calculated GFR ml/min/1.73m2** | | Normal, Stage I | >90 (other evidence of kidney damage) | | Mild, Stage II | 60-89 (other evidence of kidney damage) | | Moderate, Stage III | 30-59 | | Severe, Stage IV | 15-29 | | Established renal failure, Stage V | <15 |   **Table 2: Recommended dose adjustment in CKD by the BSR**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | | | Recommended adjustment  (% of standard dose) | | | | Drug | Accumulates in renal failure | Nephrotoxic | CKD III | CKD IV | CKD V | | Hydroxychloroquine  sulfate | Yes | No | 75 | 25-50 | 25 |   **Adverse Effects**  **N.B. Hydroxychloroquine sulfate is extremely toxic in overdose and urgent advice from the National Poisons Information Service (0344 892 0111) is essential. Life-threatening features include arrhythmias and convulsions.**   * Abdominal pain, diarrhoea, nausea, vomiting, decreased appetite, headache, skin reactions. * Vision disorders:   + Blurring of vision due to a disturbance of accommodation; this is dose dependent and reversible   + Corneal changes including oedema and opacities. They may be transient and are reversible on stopping treatment.   + Retinopathy with changes in pigmentation and visual field defects can occur. This may be permanent; however the occurrence of retinopathy is rare if the recommended daily dose is not exceeded. * Alopecia * Tinnitus, vertigo, hearing loss * Dizziness * Cardiomyopathy   **For a full list of adverse effects please consult either the current BNF or SPC:**  [**https://bnf.nice.org.uk/**](https://bnf.nice.org.uk/)  [**https://www.medicines.org.uk/emc**](https://www.medicines.org.uk/emc) |
| Common Drug Interactions | **Interactions:**   * Digoxin – hydroxychloroquine sulfate has been reported to increase the plasma level of digoxin. Serum digoxin levels should be closely monitored in patients receiving concomitant treatment with hydroxychloroquine sulfate and digoxin. * Cimetidine – inhibits the metabolism of hydroxychloroquine sulfate, resulting in a possible increase in plasma hydroxychloroquine sulfate concentration. * Antacids reduce absorption of hydroxychloroquine sulfate. An interval of at least 4 hours should be observed between dosing of hydroxychloroquine sulfate and an antacid. * Effects of hypoglycaemic treatments may be enhanced by hydroxychloroquine sulfate. A reduction in the dose of insulin or other antidiabetic drugs may be required. * There is the possibility of an increased risk of inducing ventricular arrhythmias if hydroxychloroquine is used concomitantly with other arrhythmogenic drugs, such as amiodarone and moxifloxacin. * Hydroxychloroquine sulfate can lower the convulsive threshold. There may be an increased risk of convulsions if hydroxychloroquine sulfate is co-administered with other antimalarials known to lower the convulsion threshold (e.g. mefloquine). * Ciclosporin – increased plasma ciclosporin levels. * Penicillamine - increased risk of haematological toxicity; manufacturers advises avoid co-administration.   **For a full list of interactions please consult either the current BNF or SPC:**  [**https://bnf.nice.org.uk/**](https://bnf.nice.org.uk/)  [**https://www.medicines.org.uk/emc**](https://www.medicines.org.uk/emc) |
| Communication/ Contact Details | * For acute advice:   + Monday to Friday, 9.00 am to 5.00 pm, phone the on-call monitoring nurse, rheumatology registrar or rheumatology consultant on call via the switchboard on **(0191) 565 6256**. Please use the bleep number **53546** in order to contact the rheumatology monitoring nurse for all routine queries.   + Out of hours, phone the on-call medical registrar on **(0191) 565 6256**. * For non-acute advice, send a letter to the consultant in charge of the patient’s care. |

***This information is not inclusive of all prescribing information and potential adverse effects. Please refer to full prescribing data in the SPC or the BNF.***

## Shared Care Request/Confirmation Private and Confidential

**Patient information:  
*To be completed by specialist prescriber:***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **Patient details (use hospital label if preferred)** | | | | |
| **Consultant** | …………………………………… | **Name** | …………………………………………… | | | |
| **Department** | …………………………………… | **Address** | …………………………………………… | | | |
| **Hospital** | …………………………………… |  | …………………………………………… | | | |
|  |  | **Postcode** | ................................. | | **Sex** | ………... |
|  |  | **NHS or Hosp. Reg. No.** | | ………………… | **DoB** | ………... |

**Treatment Requested for Prescribing in Accordance with Shared Care Arrangement:**

***To be completed by specialist prescriber:***

|  |  |
| --- | --- |
| **Drug name** |  |
| **Dose** |  |
| **Frequency** |  |
| **Indication** |  |
| **Other information** |  |

Name (print)……………………….… Signature (of specialist prescriber)…………………..……….. Date……..

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**Acceptance/rejection of treatment under Shared Care Agreement:  
*To be completed by GP:***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | Please tick one box | | |
| ***I ACCEPT the proposed shared care arrangement for this patient*** | | | **❑** | |
| or |  | |  | |
| ***I ACCEPT the proposed shared care arrangement with the caveats below*** | | | **❑** | |
| or |  | |  | |
| ***I DO NOT ACCEPT the proposed shared care arrangement for this patient*** | | | **❑** | |
| My caveats / reason(s) for not accepting include: …………………………………………………………………………………… ………………………………………………………………………………………………………………………………………  Name (print)…………………………..… Signature (of GP)………………………………..………….... Date……… | | | | . |

**N.B. Participation in this shared care arrangement implies that prescribing responsibility is shared between the specialist prescriber and the patient’s GP**