THE SOUTH YORKSHIRE & BASSETLAW

Shared Care Guideline

For

The Management of Epilepsies in Children

Shared care guideline developed by:
Sheffield Children's NHS Foundation Trust;

Dr P Baxter	**Consultant Paediatric Neurologist**
Dr S Mordekar	**Consultant Paediatric Neurologist**
Dr C Rittey	**Consultant Paediatric Neurologist**
Barbara Warden	**Epilepsy Specialist Nurse**
Sally Hartley	**Epilepsy Specialist Nurse**
Laura Godden	**Senior Pharmacist**

With support from
Heidi Taylor Clinical Effectiveness Pharmacist, NHS Sheffield CCG

Date approved: September 2018 (interim update re clobazam monograph April 2019)

Interim update (valproate): June 2024 (Approved by SY IMOC)
Interim update (topiramate and valproate in boys): November 2024 (Approved by SY IMOC)

Review Date: 3 years from approval or on update of NICE guideline

The Management of Epilepsy in Children

Statement of Purpose

This shared care guideline (SCG) has been written to enable the continuation of care by primary care clinicians of patients initiated on antiepileptic medication by the paediatric neurologists and/or the specialist epilepsy nurses at Sheffield Children's NHS Foundation Trust. Primary care will only be requested to take over prescribing of antiepileptic medication within its licensed indication unless specifically detailed otherwise in writing by the neurology team.

Responsibilities of consultant clinician

- To discuss benefits and side effects of treatment with the patient/carer and obtain informed consent. This is particularly important for unlicensed products or preparations being used off-label.
- To initiate anti-epileptic medication in appropriate patients
- To monitor seizure control by telephone assessment and/or clinic assessment with epilepsy nurse specialists/consultant neurologists
- To prescribe the first month's supply or until patient stable
- To contact patient's GP to request prescribing under shared care and send a link to or copy of the shared care guideline.
- To advise the GP regarding continuation of treatment, including the length of treatment and any monitoring required.
- To monitor growth, seizure control and side effects and advise GP of any dose changes and monitor response.
- To discuss any concerns with the GP regarding the patient's therapy
- The patient to remain under the consultants care whilst ever the patient is being prescribed anti-epileptic medication

Special considerations that apply to valproate

From January 2024, valproate must not be initiated in new patients (male or female) younger than 55 years, unless two specialists* independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply. This decision must be documented, and a Risk Acknowledgement Form (female or male) completed and shared with the GP, epilepsy nursing service and patient.

See below for the additional responsibilities required for female patients.

Note: Male patients only require a Risk Acknowledgement form at initiation, NOT annually. Male patients established on valproate prior to January 2024 should be informed about a possible increased risk of neurodevelopmental disorders in children born to men treated with valproate in the 3 months prior to conception. As a precaution, male patients should be advised to use effective contraception throughout the valproate treatment period and for 3 months after stopping valproate.
The MHRA visual risk communication diagram and PIL can be used to support discussions. More details can be found in the MHRA alert and educational materials (Valproate Patient Guide, Healthcare Professional Guide and Patient Card). [Add links when available]

*A specialist prescriber, who initiates treatment, is a consultant neurologist, psychiatrist or paediatrician who regularly manages complex epilepsy or bipolar disorder.
The second specialist signatory could include the following:

- Consultant adult or paediatric neurologists
- Consultant psychiatrists
- Speciality and associate specialist doctors in psychiatry and neurology
- Speciality doctors in psychiatry

- Paediatrician with special interest in epilepsy
- Paediatrician who regularly manages complex epilepsy or bipolar disorder
- Epilepsy Nurse Consultant
- Specialist Nurses in relevant disciplines
- Specialist Pharmacists in relevant disciplines

Special considerations for female patients

At initiation, and where relevant during follow up appointments, discuss with females patients (or their parent/carers), the risks associated with anti-epileptic drugs and untreated epilepsy in pregnancy (See MHRA drug safety update and safety information leaflet to assist discussion), and any interactions that treatment may have with hormonal contraception. See Contraception section below.

- **Valproate**
  - From January 2024, at their next annual specialist review, women of childbearing potential and girls receiving valproate should be reviewed using the revised valproate Annual Risk Acknowledgement Form. A second specialist signature will be needed if the patient is to continue on valproate. Subsequent annual reviews only require one specialist signature.
  - The valproate decision support tool can be used to support discussions: **Is valproate the right epilepsy treatment for me?**
  - Female children receiving valproate who have not yet reached menarche DO NOT need to fulfil the conditions of the Pregnancy Prevention Programme (PPP), but they and their responsible person (parent/caregivers) need to be aware of the importance of the risks relating to exposure to valproate during pregnancy.
  - For patients who have reached menarche the conditions of the Pregnancy Prevention Programme (PPP) must be fulfilled, as applicable, ensuring:
    - Pregnancy is excluded, where necessary, before treatment initiation.
    - The patient (or their carer) is made aware of, and understands, the risks and is supplied with the Patient Guide
    - The patient understands the need to comply with effective contraception throughout treatment (if necessary) and undergo pregnancy testing when required. See the Contraception section below and the MHRA aide-memoir table.
    - All patients are reviewed at least annually to re-evaluate treatment, contraception (if necessary), discuss risks and sign an updated Annual Risk Acknowledgement Form. Copies must be forwarded to the patient's GP and epilepsy nursing service.
    - If the PPP is not required*, the reason is documented in Step 1 of the Annual Risk Acknowledgement Form and shared with the patient and GP.
  - Further details on the responsibilities of the specialist are given in the Guide for Healthcare professionals.

* **PPP not required**

If the reason is **permanent,** Step 1 of the updated ARAF only needs to be completed on one occasion.

Where the **absence of risk may change** (e.g. pre-menarche, same sex relationship and not planning pregnancy, intellectual disability), the position should be reviewed at least annually in case of changes in circumstances and at least Step 1 of the ARAF completed annually.

The decision around the absence of risk of pregnancy can be made by the specialist prescriber alone on consideration of the patient's individual circumstances (without the need for countersignature). [This has been confirmed by the MHRA]

- **Topiramate**
  - From June 2024, an Annual Risk Awareness Form for Epilepsy must be completed with all female patients of childbearing potential receiving topiramate (or their responsible person).
  - If topiramate is being used, the conditions of the Pregnancy Prevention Programme (PPP) must be fulfilled, as applicable, ensuring:
    - Pregnancy is excluded before treatment initiation.
    - The patient (or their carer) is made aware of, and understands, the risks and is supplied with the Topiramate Patient Guide - Epilepsy.
    - The patient understands the need to comply with highly effective contraception throughout treatment (if necessary) and undergo pregnancy testing when required. See the Contraception section below and the MHRA aide-memoir table.
      NOTE: Topiramate can potentially reduce the efficacy of hormonal contraception. Acceptable forms of contraception include an intrauterine method (Cu-ICD or LNG-IUS), or the medroxyprogesterone acetate depot (MDPA) injection PLUS a barrier method.
    - All patients are reviewed at least annually to re-evaluate treatment, contraception (if necessary), discuss risks and sign an Annual Risk Awareness Form. Copies must be forwarded to the patient's GP and epilepsy nursing service.
    - If the PPP is not required, the reason is documented in Step 1 of the Annual Risk Awareness Form and shared with the patient and GP.
  - Further details on the responsibilities of the specialist are given in the Guide for Healthcare professionals.

Responsibilities of the primary care clinician

- To refer appropriate patients to secondary care for assessment
- To agree to prescribe for patients in line with the shared care agreement
- To report any adverse reaction to the MHRA and the referring consultant
- To continue to prescribe for the patient as advised by the consultant
- To undertake monitoring as per shared care guideline
- To inform the consultant if the patient discontinues treatment for any reason
- To seek the advice of the consultant if any concerns with the patient's therapy
- To conduct an annual face to face medication review or more frequent if required
- In the event that the GP is not able to prescribe, or where shared care is agreed but the consultant is still prescribing certain items e.g. Hospital only product; the GP will provide the consultant with full details of existing therapy promptly by fax on request.
- For medication supplied from another provider GPs are advised to follow recommendations for Recording Specialist Issued Drugs on Clinical Practice Systems

Special considerations that apply to valproate

From January 2024, **all new requests** to prescribe valproate should be accompanied by a completed Risk Acknowledgement Form (female or male), signed by two specialists. See above for the definition of appropriate specialists.

See below for additional responsibilities required for female patients.

Note: Male patients only require a Risk Acknowledgement form at initiation, NOT annually.

Male patients established on valproate prior to January 2024 should be informed about a possible increased risk of neurodevelopmental disorders in children born to men treated with valproate in the 3 months prior to conception. As a precaution, male patients should be advised to use effective contraception[1] throughout the valproate treatment period and for 3 months after stopping valproate.

Patients only require referral to the specialist if they are planning a family in the next 12 months or if they wish to discuss alternative treatment options.

The MHRA visual risk communication diagram and PIL can be used to support discussions. More details can be found in the MHRA alert and educational materials (Valproate Patient Guide, Healthcare Professional Guide and Patient Card). [Add links when available]

Special considerations for female patients

- Ensure that female patients taking antiseizure medication are given appropriate contraceptive advice, taking into account the considerations detailed in the contraception section below.
- Urgently refer female patients who are pregnant or planning to become pregnant for specialist advice on their anti-seizure treatment if they have not previously been counselled about this.
- All female patients using seizure medication who are planning to become pregnant should be offered 5mg per day of folic acid (Note. 5mg strength is prescription only - POM) before any possibility of pregnancy.

- **Valproate**
  - Ensure that all women of childbearing potential and girls, who are taking sodium valproate for the treatment of epilepsy, have been reviewed by a specialist in the last year, and a valid Annual Risk Acknowledgement Form has been received and uploaded to the patient record. If they have not been reviewed, refer them urgently for assessment. An appropriate SNOMED code should be assigned – see Valproate Guidance for Primary Care for more information.
  - Ensure all women of childbearing potential and girls receiving valproate who are reviewed by a specialist after January 2024 have been reviewed using the revised valproate Annual Risk Acknowledgement Form. A second specialist signature will be needed if the patient is to continue on valproate. Subsequent annual reviews only require one specialist signature.
  - Put in place a robust mechanism to ensure that the ARAF is in date when prescriptions are issued and to ensure that patients are recalled or referred back to secondary care before the expiry date. However, a prescription for sodium valproate should not be stopped, simply due to a delay in specialist review/ ARAF completion, as this may put the patient at risk.
  - For female children using valproate, remind the patient's responsible person to contact their specialist or GP once the patient using valproate experiences their first period (menarche) for referral back to the specialist.

[1] Effective contraception is classed as condoms, plus contraception used by the female sexual partner. If there is no pregnancy risk or if the woman is already using highly effective contraception, then condom use is not required to prevent pregnancy.

- Ensure women and girls of childbearing potential who are taking valproate are complying with the pregnancy prevention programme (where applicable) and:
  - Have a copy of the Patient Guide.
  - Are using effective contraception and understand the need to comply with effective contraception throughout treatment with valproate. For patients not using highly effective contraception, the risk of pregnancy should be assessed prior to issuing each valproate prescription; pregnancy testing may be required. See the contraception section below and the MHRA aide-memoir table for details on contraceptive efficacy and pregnancy testing requirements.
  - Remind the patient to contact you immediately if they suspect there has been a problem with their contraception or if they may be pregnant.
- Further details on the responsibilities of the GP are given in the Guide for Healthcare professionals. See BPNA / RCPCH Prescribing valproate to female patients under 18 years of age in individual cases for more information. Seek specialist advice if concerned.
- Ensure appropriate PPP SNOMED codes are assigned to all patients – see Valproate Guidance for Primary Care for more information.

- **Topiramate**
  - Ensure all women of childbearing potential and girls receiving topiramate who have been reviewed by a specialist after June 2024 are being treated in line with the new topiramate Pregnancy Prevention Programme, and a valid Annual Risk Awareness Form (ARAF) has been received and uploaded to the patient record.
  - Put in place a robust mechanism to ensure the ARAF is in date when prescriptions are issued and to ensure that patients are recalled or referred back to secondary care before the expiry date. However, a prescription for topiramate should not be stopped, simply due to a delay in specialist review/ ARAF completion, as this may put the patient at risk.
  - Ensure women and girls of childbearing potential who are taking topiramate are complying with the pregnancy prevention programme (where applicable) and:
    - Have a copy of the Topiramate Patient Guide - Epilepsy
    - Are using highly effective contraception and understand the need to comply with this throughout treatment with topiramate and for 4 weeks after stopping. For patients not using highly effective contraception, the risk of pregnancy should be assessed prior to issuing each topiramate prescription; pregnancy testing may be required. See the contraception section below and the MHRA aide-memoir table for details on contraceptive efficacy and pregnancy testing requirements.

      NOTE: Topiramate can potentially reduce the efficacy of hormonal contraception. Acceptable forms of contraception include an intrauterine method (Cu-ICD or LNG-IUS), or the medroxyprogesterone acetate depot injection PLUS a barrier method.
    - Remind the patient to contact you immediately if they suspect there has been a problem with their contraception or if they may be pregnant.
  - Further details on the responsibilities of the GP are given in the Topiramate Healthcare Professional Guide - Epilepsy. Seek specialist advice if concerned.
  - Ensure appropriate PPP SNOMED codes are assigned to all patients.

Responsibilities of Patients or Carers

- To attend hospital and GP clinic appointments and to bring monitoring booklet (if applicable). Failure to attend will potentially result in the medication being stopped.
- Present rapidly to the GP or specialist should their clinical condition significantly worsen.
- Report any suspected adverse effects to their specialist or GP whilst taking anti-epileptic medication.
- To read the drug information given to them, including, if relevant, Valproate patient guide or Topiramate Patient Guide - Epilepsy for the details of pregnancy prevention programmes.
- To take anti-epileptic medication as prescribed
- Inform the specialist, GP or community pharmacist dispensing their prescriptions of any other medication being taken – including over-the-counter medication.

Indication

Children with a diagnosis of epilepsy who have continuing uncontrolled seizures. This shared care guideline follows NICE Guidance CG137 The Epilepsies: the diagnosis and management of epilepsies in adults and children in primary and secondary care (Jan 2012 updated April 2018). Please refer to this guideline for further information.

At a consultant's discretion and where expected benefits exceed the risks, the dose may be increased beyond the maximum recommended in the BNFc if tolerated by the patient. The consultant will be responsible for discussing unlicensed use of these agents with patients and their carers.

Formulation switching of antiepileptics

Concerns about switching between different manufacturers' products of antiepileptic drugs (AEDs) have been raised by patients and prescribers. These include switching between branded original and generic products, and between different generic products of a particular drug.
Different AEDs vary considerably in their characteristics, which influence the risk of whether or not switching between different manufacturers' products of a particular drug may cause adverse effects or loss of seizure control.
Following a review of the available evidence, the UK Commission on Human Medicines (CHM) considered the characteristics of AEDs and advised that they could be classified into three categories, based on therapeutic index (a comparison of the amount of a therapeutic agent that causes the therapeutic effect to the amount that causes or toxicity), solubility and absorption, to help prescribers and patients decide whether it is necessary to keep using a supply of a specific manufacturer's product. See MHRA Drug Safety Update for details.

Category 1 – Phenytoin, carbamazepine, phenobarbital, primidone

For these drugs, doctors are advised to ensure that their patient is maintained on a specific manufacturer's product.

Category 2 – Valproate, lamotrigine, perampanel, retigabine, rufinamide, clobazam, clonazepam, oxcarbazepine, eslicarbazepine, zonisamide, topiramate

For these drugs the need for continued supply of a particular manufacturer's product should be based on clinical judgement and consultation with patient and/or carer taking into account factors such as seizure frequency and treatment history. Take into account patient/carer-related factors such as their negative perceptions about alternative products and/or other issues related to the patient.

Category 3 - Levetiracetam, lacosamide, tiagabine, gabapentin, pregabalin, ethosuximide, vigabatrin, brivaracetam

For these drugs it is usually unnecessary to ensure that patients are maintained on a specific manufacturer's product unless there are specific concerns such as patient anxiety, and risk of

confusion or dosing errors. Take into account patient/carer-related factors such as their negative perceptions about alternative products and/or other issues related to the patient should also be taken into account.

Dosage

For information regarding dosing, side-effects, contra-indications, precautions, drug interactions and monitoring, please refer to the BNFc or manufacturer's Summary of Product Characteristics available from www.emc.medicines.org.uk

Information for parents, carers and patients on the individual drugs included can be found at - https://www.medicinesforchildren.org.uk/

Drug	Licensing information	Off label use	Other information
Brivaracetam	Over 16 years - Adjunctive therapy of partial-onset seizures with or without secondary generalisation		
Carbamazepine	Children. Monotherapy for focal seizures and tonic-clonic seizures secondary to a focal discharge.		When possible tablet formulation is preferable to liquid.
Clobazam	6 years and over - As adjunctive therapy	Children 1 months to 6 years in exceptional circumstances. Monotherapy under specialist supervision for catamenial seizures.	
Clonazepam	Over 1 month of age - All types of epilepsy over 1 month of age		
Ethosuximide	Children. Monotherapy for absence seizures, atypical absences (adjunct) and myoclonic seizures.		

Drug	Licensing information	Off label use	Other information
Gabapentin	Children over 6 years - Adjunctive treatment of focal seizures with or without secondary generalisation. Can be used as monotherapy in children aged over 12 years.		
Lacosamide	Children aged over 4 years Monotherapy and adjunctive treatment of focal seizures with or without secondary generalisation.		
Lamotrigine	2- 12 years -Adjunctive treatment of partial seizures and generalised seizures, including tonic clonic seizures and the seizures associated with Lennox Gastaut syndrome. Monotherapy of typical absence seizures. 13 years and over; Adjunctive or monotherapy treatment of partial seizures and generalised seizures, including tonic clonic seizures. Seizures associated with Lennox Gastaut syndrome.		
Levetiracetam	From 1 month - Adjunctive treatment of focal seizures with or without secondary generalisation. Aged over 16 years - Monotherapy of focal seizures with or without secondary generalisation. From 12 years - Adjunctive therapy of myoclonic seizures and tonic-clonic seizures		

Drug	Licensing information	Off label use	Other information
Oxcarbazepine	Children aged over 6 years Monotherapy and adjunctive treatment for focal seizures with or without secondary generalisation.		
Perampanel	Children aged over 12 years - Adjunctive treatment of focal onset seizures with or without secondary generalisation and primary generalised tonic-clonic seizures.		
Phenytoin	All forms except for absence seizures in childhood (age not specified by manufacturer). Licensed for status epilepticus or acute symptomatic seizures following neurosurgery, head injury.		
Phenobarital	Neonate onwards - All forms of epilepsy except for typical absence seizures		
Rufinamide	Patients over 4 years - Adjunctive treatment for Lennox Gastaut syndrome.		
Sodium valproate	All ages - All forms of epilepsy.		*See additional safety information above (for specialists and primary care)
**Stiripentol	Children over 3 years - Adjunctive therapy of refractory generalized tonic-clonic seizures in patients with severe myoclonic epilepsy in infancy (Dravet Syndrome).		BNFc and SPC recommends 6 monthly FBC and LFTs, however, based on expert opinion at SCH, routine monitoring not generally done unless clinically needed. The consultant should discuss and agree this with the patient / carer on a case by case basis

Drug	Licensing information	Off label use	Other information
Tiagabine	Children over 12 years - Adjunctive treatment for focal seizures with or without secondary generalisation.		
Topiramate	Children over 6 years - Monotherapy of generalised tonic-clonic or focal seizures with or without secondary generalisation Children 2 years and over - Adjunctive therapy with partial onset seizures with or without secondary generalization or primary generalized tonic-clonic seizures and for the treatment of seizures associated with Lennox-Gastaut syndrome.		*See additional safety information above (for specialists and primary care)
Vigabatrin	Adjunctive therapy for focal epilepsy with or without secondary generalisation in which other combinations are unsuccessful or not tolerated. Monotherapy for the management of infantile spasms (West's syndrome).		
Zonisamide	Aged 6 years and over - Adjunct therapy for refractory focal seizures with or without secondary generalisation.		
Rectal diazepam	Children over 1 year - Rescue medication for prolonged seizures / clusters of seizures.		

Drug	Licensing information	Off label use	Other information
Buccal midazolam	Buccolam® 5mg/ml Licensed for children 3 months and over. Rescue medication for prolonged seizures / clusters of seizures.		See additional safety advice regarding Buccolam® - Link
**Rectal paraldehyde In equal parts olive oil		Rescue medication for status epilepticus	Available from Stockport Pharmaceuticals

****Subject to Traffic Light Drug status in receiving CCG

Monitoring

Regular blood test monitoring in children and young people is not recommended as routine and should be done only if clinically indicated and recommended by the specialist. Children will be regularly reviewed in the specialist epilepsy consultant led clinics and in epilepsy nurse review clinics.

Medications will be commenced or withdrawn on the written instructions of the consultant neurologists or epilepsy nurse specialists.
Use the Yellow Card System to report adverse drug reactions directly to the MHRA. Yellow Cards and guidance on its use are available at the back of the BNF. Alternatively report online at www.mhra.gov.uk/yellowcard

Contraception

The effectiveness of *combined* oral contraceptives, *progestogen-only* oral contraceptives, contraceptive patches, vaginal rings, progestogen implants, and emergency hormonal contraception can be considerably reduced by interaction with antiseizure drugs that induce hepatic enzyme activity, including: carbamazepine, eslicarbazepine, felbamate, lamotrigine*, oxcarbazepine, perampanel, phenytoin, phenobarbital, primidone, rufinamide and topiramate. The Faculty of Sexual and Reproductive Health (FSRH) gives detailed advice: Drug Interactions with Hormonal Contraception

* Lamotrigine interacts to a limited degree, and it is recommended patients are warned that contraceptive efficacy might be affected. Lamotrigine concentrations can also be affected by contraceptives, with the risk of reduced seizure control or lamotrigine toxicity. Combined hormonal contraceptives (CHC) can reduce the blood level of lamotrigine; progestogen-only contraceptives may increase lamotrigine concentrations. See the BNF for more information.

During use of a teratogen that is NOT an enzyme inducer (and no other enzyme-inducing drug being taken) use of the progestogen implant, the copper IUD or a levonorgestrel-releasing IUS is recommended. If CHC, a progestogen-only pill or depot medroxyprogesterone acetate is used, condoms should be used reliably in addition.

During use of a teratogen that is an enzyme inducer or a potential enzyme inducer (or if an enzyme-inducing drug is also being taken) use of the copper IUD, a levonorgestrel-releasing IUS, or depot medroxyprogesterone acetate PLUS condoms is recommended. Use of CHC, progestogen-only pills and the progestogen implant is not recommended.
See FSRH CEU guidance (Contraception for women using known teratogenic drugs or drugs with potential teratogenic effects**)** and MHRA guidance (Medicines with teratogenic potential) for more information.

During use of an enzyme-inducer (and no teratogenic medications) use of a contraceptive method that is unaffected by the enzyme inducer is recommended. Intrauterine contraception and depot medroxyprogesterone acetate (either intramuscular or subcutaneous) are appropriate options. In exceptional circumstances, where alternative effective contraception is not acceptable, consider the use of two ethinylestradiol (EE) monophasic combined oral contraceptive pills together containing a total of 50µg of EE (30µg + 20µg). These should be used in a continuous regimen (or tricycled with a shortened hormone-free interval of 4 days).

Re-Referral guidelines

- If the patient discontinues treatment for any reason
- If any concerns with the patient's therapy
- If the patients clinical condition significantly worsens.

Financial implications

Reduced outpatient appointments
Reduced emergency and hospital admissions

Support, education and information

Epilepsy Nurse Advice Line: 0114 2717620 Monday- Friday 9am-5pm

The on-call paediatric neurologist can be contacted via Sheffield Children's NHS Foundation Trust switchboard 0114 2717000

www.medicinesforchildren.org.uk

www.emc.medicines.org.uk

References

1. NICE CG137. Jan 2012 (updated April 2018) - https://www.nice.org.uk/guidance/cg137
2. MHRA. Antiepileptic drugs: updated advice on switching between different manufacturers' products. Nov 2017 - https://www.gov.uk/drug-safety-update/antiepileptic-drugs-new-advice-on-switching-between-different-manufacturers-products-for-a-particular-drug
3. Valproate safety measures – https://www.gov.uk/government/collections/valproate-safety-measures
4. Topiramate (Topamax): introduction of new safety measures, including a Pregnancy Prevention Programme – https://www.gov.uk/drug-safety-update/topiramate-topamax-introduction-of-new-safety-measures-including-a-pregnancy-prevention-programme

5. Electronic Medicines Compendium - https://www.medicines.org.uk/emc/
6. BNFc – https://www.medicinescomplete.com/#/browse/bnfc

(Template letter to GP)

Dear Doctor

RE: ……. DOB: …… NHS No. ……..

Address: ……

Your patient is being started on treatment with (enter Medication).

This treatment can be prescribed by GPs under the Traffic Light System under the "shared care" arrangements. This shared care guideline has been approved by the Sheffield, Rotherham, Barnsley and Doncaster and Bassetlaw Area Prescribing Committees /Groups.

http://www.intranet.sheffieldccg.nhs.uk/medicines-prescribing/shared-care-protocols.htm

We have chosen to use …..…… because ……

As part of shared care arrangements please can you monitor xxxxxxx (e.g. FBC, eGFR), adherence, response and side effects to therapy every XX months. Will you also please undertake to prescribe for your patient?

Please acknowledge you are happy to take on shared care by completing and returning the slip below to above address or by faxing to …….

Do not hesitate to contact us if you have any concerns.

Yours sincerely

Clinician's Name

Clinician's Title

IMPORTANT REMINDER

The prescribing doctor is responsible for monitoring the patient on the medication being prescribed

_____*please tear here, return to address or fax*

_____

RE: …… DOB: …… NHS:……..

Address: ……...

☐ I AGREE to take on shared care of this patient

☐ I DO NOT AGREE to take on shared care of this patient

Signed …… GP Practice……

Date……