

# Ciclosporin

For up to date version of Shared Care Agreement contact specialist team or latest version on website <https://westessexccg.nhs.uk/your-health/medicines-optimisation-and-pharmacy/shared-care-medicines>

## Referral Criteria

- These guidelines are for patients over 16 years of age.
- Shared Care is only appropriate if it provides the optimum solution for the patient.
- Prescribing responsibility will only be transferred when it is agreed by the consultant and the patients' GP
- Safe prescribing must be accompanied by effective monitoring
- When transfer is agreed, the patient will be given a supply of ciclosporin sufficient for 4 week maintenance therapy
- **The doctor who prescribes the medication has the clinical responsibility for the drug and the consequences of its use.**

From April 2019 West Essex patients under the care of Princess Alexandra Hospital Rheumatology Consultant will be assessed and those patients with stable disease markers and DAS<3.2 after 6 months of consultant led care will be transferred for ongoing case management to a West Essex General Practitioner with Specialist Interest (GPSI) in Rheumatology. Thereafter shared care for the management of DMARD will be between the Consultant/GPSI (further referred to as Specialist) and the GP.

## SHARED CARE RESPONSIBILITIES

### Consultant

- Undertake the necessary testing to confirm a diagnosis for which ciclosporin treatment is recommended.
- Ensure the patient's concurrent drug therapy is stabilised and there are no contra-indications to treatment with ciclosporin
- Discussion with the patient regarding benefits and side effects of treatment. Ensure patient understands their treatment regime, monitoring and follow up. Provide appropriate patient information leaflet.
- Ensure the patient understands the shared care agreement and has signed the Patient Agreement Letter (page 7-8)
- Perform pre-treatment screening (see Monitoring section) and provide results to GP.
- Ensure documented normal cervical smear within recommendations of the national programme.
- Check skin for pre-existing skin malignancy
- Initiate treatment and prescribe until the patient has been on a stable dose for minimum of SIX weeks
- To send a letter to the GP requesting shared care and enclose shared care agreement
- Review the patient in outpatients as clinically appropriate and advise the GP promptly after these reviews on when to adjust the dose, stop treatment or consult with the specialist.
- To send a letter/ result notification after each clinic attendance including current dose, most recent blood results and frequency of monitoring or advise GP of non-attendance.
- To evaluate any reported adverse effects by GP or patient. To report any adverse events to the CHM and GP.  
<https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency>
- Ensure that backup advice is available at all times. (see Contacts section) and respond to any GP queries as soon as practicable.
- For patients under the care of Princess Alexandra Hospital Rheumatology Consultant refer patients with stable disease markers and DAS<3.2 for ongoing case management after 6 months of consultant led care to General Practitioner with Specialist Interest in Rheumatology; inform the GP.

### General Practitioner with Specialist Interest in Rheumatology (for West Essex patients under the care of Princess Alexandra Hospital)

- Accept patients with stable disease markers and DAS<3.2 for ongoing case management after 6 months of consultant led care.
- Provide ongoing patient education
- Annual review of all patients as per NICE guidance
- Review the patient annually or as clinically appropriate and advise the GP promptly after these reviews on when to adjust the dose, stop treatment or consult with the Specialist.
- Inform GP, by letter, of each clinic attendance and action taken for the management of the patient ensuring current dose, most recent blood results and frequency of monitoring are stated.
- Evaluate any reported adverse effects by GP or patient.
- Inform GP of patients who do not attend clinic appointments and contact patient to rearrange.

### General Practitioner

- Consider request to prescribe under shared care arrangements and reply only if you do not agree to share care, in a timely manner within 14 days as outlined on page 6 with clinical reasons and return to Consultant and Pharmacy department.
- Monitor patient's overall health and well-being.
- Ensure compatibility with other concomitant medication
- Prescribe ciclosporin, by brand, at the dose recommended.
- Monitor U&E, creatinine, blood pressure, FBC and LFTs at recommended frequencies (see Monitoring section) and refer if abnormal.
- Adjust the dose as advised by the specialist
- Stop treatment on advice of specialist or immediately if any urgent need to stop treatment arises (see monitoring section)
- Report any adverse events to the specialist and CHM.
- <https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency>
- Inform specialist of any change in the medical condition of patient which may have effect on disease / medications.
- Ensure patient is offered an annual flu vaccination and a one off pneumococcal vaccination

## Patient

- Report to specialist or GP if there is not a clear understanding of their treatment and discuss any concerns in relation to treatment.
- Report any adverse effects to their Specialist whilst taking ciclosporin, especially unexplained bruising/bleeding, unexplained rash which should be reported immediately.
- Report any changes in disease symptoms to Specialist whilst taking ciclosporin.
- Alert GP and/or specialist of any changes of circumstance which could affect management of disease e.g. plans for pregnancy whilst taking ciclosporin.
- Try to avoid contact with chickenpox and shingles if no definite history of chickenpox, and report any such contact to urgently to their GP and/or consultant
- Inform GP or specialist of any other medicines being taken including over-the-counter products.
- Attend for regular reviews and blood monitoring tests.

### CONTACT NUMBERS FOR ADVICE AND SUPPORT

**Advice and guidance:** Access Advice & Guidance tool via e-RS referral system selecting the relevant specialty for non-urgent queries

Princess Alexandra Hospital NHS Trust - Gastroenterology	
Consultant	<b>For GPs only:</b> contact Gastroenterologist of the week via switchboard if urgent <b>Email for GPs only:</b> <a href="mailto:tpa-tr.gastroadminclinicalcorrespondence@nhs.net">tpa-tr.gastroadminclinicalcorrespondence@nhs.net</a>
Specialist Gastroenterology Pharmacist: Clare Macpherson	Bleep 272 Direct dial: 01279 278224 (voicemail if not answered) <a href="mailto:Claremacpherson@nhs.net">Claremacpherson@nhs.net</a> for medication issues
IBD Specialist Nurse	Direct dial:01279 278223 (voice mail only) usual response within 48 hours <a href="mailto:Paht.ibd@nhs.net">Paht.ibd@nhs.net</a>

Princess Alexandra Hospital NHS Trust - Rheumatology	
Consultant:	<b>For GPs only:</b> contact Rheumatologist via switchboard if urgent <a href="mailto:tpa-tr.rheumatologyadminclinicalcorrespondence@nhs.net">tpa-tr.rheumatologyadminclinicalcorrespondence@nhs.net</a> for non-urgent queries.
Rheumatology Specialist Nurse DMARDs	01279827434 helpline (voice mail only) for non-urgent queries only Lily Robinson
Rheumatology Specialist Nurse / Pharmacist - Biologics	01279827819 helpline (voice mail only) for non-urgent queries only Mona Kamal Zou / Sachini Amarasekera
	<b>Patients can email</b> <a href="mailto:tpa-tr.rheumatologyadminclinicalcorrespondence@nhs.net">tpa-tr.rheumatologyadminclinicalcorrespondence@nhs.net</a> for non-urgent queries.

Princess Alexandra Hospital NHS Trust - Dermatology	
Consultant:	<b>For GPs only:</b> contact Dermatologist via switchboard if urgent 01279 444455 Ext 7431 / 7421 for non-urgent queries only <a href="mailto:tpa-tr.dermatologyclinicalcorrespondence@nhs.net">tpa-tr.dermatologyclinicalcorrespondence@nhs.net</a>
Specialist Pharmacist Dermatology	<a href="mailto:Noemi.corrao@nhs.net">Noemi.corrao@nhs.net</a>

#### Licensed indications

Rheumatoid arthritis  
Psoriasis  
Atopic dermatitis

#### Unlicensed Indications

Psoriatic arthritis <sup>1</sup>  
Bullous pemphigoid <sup>2</sup>  
Pyoderma gangrenosum <sup>3</sup>  
Connective tissue disorders <sup>4</sup>  
Chronic actinic dermatitis <sup>5</sup>  
Cutaneous vasculitis <sup>6</sup>  
Systemic lupus erythematosus <sup>5</sup>  
Scleroderma <sup>7</sup>  
Ulcerative Colitis <sup>8</sup>

## Therapeutic Summary

Ciclosporin, a calcineurin inhibitor, is a potent immunosuppressant which is virtually non-myelotoxic but markedly nephrotoxic. Ciclosporin blocks the amplification of certain T cell immune responses and suppresses IL-2 synthesis and release. The time to response is usually 3 months  
See SPC for full details <http://www.medicines.org.uk/emc/medicine/1307>

## Dose and Route of Administration

### Rheumatology

Starting dose: 2.5 mg/kg/day in two divided doses for 6 weeks, and then may be increased every 2-4 weeks by incremental dose of 25 mg until clinically effective or the maximum dose of 4mg/kg is reached. Maintenance Dose: Often effective between 2.5 – 3.2 mg/kg/day. Adjust to patients' tolerance and benefit. Constantly evaluate *before increasing* to the maximum dose which may be 4mg/kg/day

### Dermatology

2.5 mg/kg/day in two divided doses if good response is not seen within 2 weeks then increase to 5mg/kg is reached. A starting dose of 5mg/kg may be used if rapid control is required.

### Gastroenterology

Ulcerative Colitis - ciclosporin is only for those steroid refractory UC who are Azathioprine or 6MP naïve. Ciclosporin is given orally in a microemulsion formula (Neoral) in doses starting at 2-4mg/kg/day administered every 12 hours. Treatment is usually for 3 - 6 months only. Dose adjustments are made during therapy based on clinical response and blood levels. Dose is reduced by half every month, starting from 3 months from discharge

## Adverse Effects and Management

**Benign Gingival hyperplasia:** not uncommonly seen and patients are advised on good oral hygiene. If hyperplasia persists it is advisable to consider stopping but discuss with the specialist team.

**Hirsutism:** may be a cause for stopping therapy in some. May try bleaches and depilatory creams that are often safe.

**Tremor, headache & paraesthesia:** are common and if persistent or severe, discuss with the specialist team.

**Hypertension:** B.P (Diastolic) over 95 mm of Hg – Consider reducing the dose of Ciclosporin by 25-50%. If the BP still remains elevated, may like to follow the British Hypertension Society treatment regimen. Usually a beta-blocker or calcium channel blocker is used but Diltiazem, Nifedipine and Verapamil should NOT be used as they may increase the plasma ciclosporin levels. STOP Ciclosporin if BP remains uncontrolled. Diuretics frequently increase serum creatinine and best avoided, if possible.

**Hyperlipidaemia:** Statin therapy can be used if necessary but the dose should not exceed 10mg/day.

**Nephrotoxicity:** Increases in serum creatinine and urea during first few weeks of treatment are generally dose dependent and reversible on dose reduction.

**Electrolyte Disturbances:** hyperkalaemia (may occur by concurrent use of potassium sparing diuretics), hyperuricaemia, hypomagnesaemia.

**Commonly:** hepatotoxicity- bilirubinaemia, elevation of liver enzymes nausea, vomiting, diarrhoea, abdominal pain, pancreatitis muscle cramp, myalgia, fatigue

Lymphadenopathy – if patient develops a single swollen lymph node (not related to inflamed skin in dermatology patients) fast track referral of patient to specialist for review.

**Less Commonly:** Anaemia, thrombocytopenia, Allergic rash, Increased risk of benign intracranial hypertension

## Cautions

- **Vaccination:** Avoid use of all LIVE vaccines – administration should be postponed until at least 6 months after stopping ciclosporin
- **Cancer risk:** Due to increased risk of lymphomas and malignancies of the skin, patients should be advised to avoid excessive exposure to the sun and to use high factor sunscreens.
- **Immunosuppression:** For patients who have not had chicken pox and are in contact with anyone with the virus follow guidance from Public Health England June 2019 <https://www.gov.uk/government/publications/varicella-zoster-immunoglobulin>
- **Prescribing: Important** Patients should be stabilised on a particular brand of oral ciclosporin because switching between formulations without close monitoring may lead to clinically important changes in blood-ciclosporin concentration. Prescribing and dispensing of ciclosporin should be by brand name to avoid inadvertent switching. If it is necessary to switch a patient to a different brand of ciclosporin, the patient should be monitored closely for changes in blood-ciclosporin concentration, serum creatinine and blood pressure.

## Contraindications

Renal and liver failure (unless advised otherwise by a specialist)  
Uncontrolled hypertension  
Suspected systemic infection or sepsis  
Severe electrolyte imbalance i.e. hyperkalaemia  
Malignancy  
Known hypersensitivity to Ciclosporin  
Concomitant use of rosuvastatin, dabigatran or oral tacrolimus

## Pregnancy and Lactation

Careful assessment of risks vs benefit to be considered before use in women of childbearing potential, during pregnancy and breast-feeding. Patients discovered or planning to become pregnant should be referred to the initiating specialist at the earliest opportunity without stopping ciclosporin.

The drug may be excreted in milk and patients should be advised against breast-feeding.

### Monitoring Standards for Ciclosporin based on BSR BHPR Standards 2017

The following standards have been agreed for the monitoring of ciclosporin in all patients at Princess Alexandra Hospital NHS Trust.

<b>Pre-treatment by Specialist</b>	Height, weight, blood pressure, FBC, U&Es, LFTs, calculated GFR and albumin	
<b>Initial monitoring by Specialist</b>	FBC Creatinine / calculated GFR ALT +/- AST Albumin	Every 2 weeks until on stable dose for 6 weeks.
<b>Ongoing monitoring by GP</b>	FBC Creatinine / calculated GFR ALT +/- AST Albumin	Then once on stable dose monitor monthly.
	FBC Creatinine / calculated GFR ALT +/- AST Albumin	Patients who have been stable for 12 months can be considered for reduced frequency monitoring on an individual patient basis, Specialist to advise.
<b>Dose increase</b>	FBC Creatinine / calculated GFR ALT +/- AST Albumin	Every 2 weeks until on stable dose for 6 weeks, then revert to previous schedule
<b>Specialist and GP</b>	BP and Glucose	At every visit

Ciclosporin levels	<p><b>Gastroenterology Patients only:</b>  <b>In hospital</b> during initiation to avoid a colectomy- first drug level should be send on Day 2 (before the 3<sup>rd</sup> dose) and then biweekly until the level is therapeutic (if not increase the dose by 25%) and stable (in two consecutive levels).            Then check the level weekly for the first month before patient can be transferred to shared care.</p> <p><b>In community:</b>            Once a month, take 12 hour trough ciclosporin levels prior to administration of morning dose (aim for 150-250ng/ml). <b>Ensure patient is advised to withhold ciclosporin until blood taken.</b></p>
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## Action and Advice

If a GP has taken blood tests for the general medical management of a patient and blood test results fall into the categories below or the patient reports one of the adverse events below, these are recommendations for considering the withdrawal of Ciclosporin therapy:

Blood Test Results	
Creatinine increased by >30% of baseline in two consecutive readings one week apart (even if creatinine values still lies within laboratory's normal range)	Withhold until discussed with specialist team
eGFR $\leq$ 55ml/min	Withhold until discussed with specialist team
Potassium rises above reference range	Withhold until discussed with specialist team
Platelets $<$ $150 \times 10^9/l$	Withhold until discussed with specialist team
> 2-fold rise in AST, ALT, alkaline phosphatase (from upper limit of reference)	Withhold until discussed with specialist team
Blood pressure > 140/90 on two consecutive readings to weeks apart	Treat blood pressure before stopping the ciclosporin (note interactions with several anti- hypertensives). If BP cannot be controlled, stop ciclosporin and obtain BP control before restarting ciclosporin. Discuss with the specialist team.
Unexplained reduction in albumin <30 g/l	Discuss with specialist team
Ciclosporin levels (Gastroenterology patients only)	Ciclosporin levels of 500ng/ml then stop for 2 consecutive days and discuss with specialist team Ciclosporin levels between 300-500ng/ml, reduce dose by 25% and discuss with specialist team.
Symptoms	
Unexplained Rash	Withhold until FBC results available & discuss with specialist team
Abnormal bruising or bleeding	Withhold until FBC results available & discuss with specialist team

## Clinically relevant Drug interactions

Please note that ciclosporin interact with many drugs and prescribers should refer to the BNF and SPC for full information. This list is not comprehensive.

**Drugs that decrease ciclosporin levels:** barbiturates, carbamazepine, phenytoin, orlistat, terbinafine and rifampicin

**Drugs that increase ciclosporin levels:** azole anti-fungals, diltiazem, nicardipine, verapamil, amiodarone, metoclopramide, oral contraceptives, high dose methylprednisolone, allopurinol, tacrolimus, some anti-retrovirals.

**Nephrotoxic Drugs:** Use ciclosporin with caution with other nephrotoxic drugs. Monitor renal function closely.

**NSAIDs and Diclofenac:** close monitoring of renal function is essential. Reduce dose of diclofenac by 50% when given with Ciclosporin

**Colchicine:** ciclosporin may increase the level of colchicine – **avoid concomitant use**

**Statins:** use lower doses to reduce the risk of muscular toxicity. Refer to relevant statin SPC. Rosuvastatin is specifically contraindicated.

**Nifedipine:** use with caution due to increased risk of gingival hypertrophy.

**Digoxin:** Ciclosporin may increase serum levels of digoxin

**St John's Wort:** decreases level and clinical effect of ciclosporin – **avoid concomitant use.**

**Potassium sparing drugs:** (potassium sparing diuretics, ACE inhibitors, Angiotensin II antagonists) use with **extreme caution** as may lead to significant increase in potassium.

**Grapefruit or grapefruit juice:** grapefruit increases the bio-availability of ciclosporin and should be avoided.

**Macrolides:** marked increase in ciclosporin levels. **Avoid if possible.** If use is unavoidable, monitor ciclosporin levels closely and reduce dose as necessary.

**Quinolones and Trimethoprim:** increased risk of nephrotoxicity

**Cimetidine:** increased risk of nephrotoxicity

**Herbal / Complimentary medications are not recommended when taking this medication as interactions may occur.**

## Further Information and references

1). Etanercept, infliximab and adalimumab for the treatment of psoriatic arthritis NICE TA 199

<https://www.nice.org.uk/guidance/ta199/resources/etanercept-infliximab-and-adalimumab-for-the-treatment-of-psoriatic-arthritis-pdf-82598565006277>

2). British Association of Dermatologists' guidelines for the management of bullous pemphigoid 2012

<http://www.bad.org.uk/shared/get-file.ashx?id=47&itemtype=document>

3). Ciclosporin compared with prednisolone therapy for patients with pyoderma gangrenosum: cost-effectiveness analysis of the STOP GAP trial. <https://www.ncbi.nlm.nih.gov/pubmed/28391619> Br J Dermatol. 2017 Apr 9

4). An audit of cyclosporin for systemic lupus erythematosus and related overlap syndromes: limitations of its use <http://ard.bmi.com/content/59/6/487> Annals of the Rheumatic Disease Volume 59 Issue 6

5). Long-term Follow-up of Eczema Patients Treated with Cyclosporine Acta Derm Venereol (Stockh) 1998; 78: 40–43



Chronic actinic dermatitis.pdf

6). Cyclosporin A in the treatment of cutaneous vasculitis. Clinical and cellular effects Journal of the European Academy of Dermatology and Venereology Volume 6, Issue 2, March 1996, Pages 135-141

<http://www.sciencedirect.com/science/article/pii/092699599400000X>

7). Cyclosporin and tacrolimus: their use in a routine clinical setting for scleroderma Rheumatology, Volume 39, Issue 8, 1 August 2000, Pages 865–869 <https://academic.oup.com/rheumatology/article/39/8/865/1784039/Cyclosporin-and-tacrolimus-their-use-in-a-routine>

8). Ulcerative colitis: management CG 166 <https://www.nice.org.uk/guidance/cg166/resources/ulcerative-colitis-management-pdf-35109695126725>

This document does not replace the SPC and BNF and should be read in conjunction with it.

BSR and BHPR guideline for the prescription and monitoring of non-biologic disease-modifying anti-rheumatic drugs 2017 <https://academic.oup.com/rheumatology/article/3053478/BSR-and-BHPR-guideline-for-the-prescription-and?searchresult=1>

BSG guidelines for management of inflammatory bowel disease in adults:

<https://www.bsg.org.uk/clinical/bsg-guidelines.html?section=inflammatory-bowel-disease>

CKS

<http://cks.nice.org.uk/dmards#!scenario:3>

Arthritis Research UK

<http://www.arthritisresearchuk.org/arthritis-information/drugs/ciclosporin.aspx>

West Essex Shared Care Guidelines

[Shared Care Letter - West Essex CCG](#)

GMC Prescribing Guidance: Shared Care

<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/shared-care>

Approved MOPB Oct 2017 Review Oct 2019

**GP response to Shared Care Agreement**  
(only complete & send if NOT participating in shared care)

**This shared care agreement has been approved by the Medicines Management Optimisation Programme Board**

Patient Name:	NHS No:
Consultant:	Medicine requested for shared care: <b>Ciclosporin</b>

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

Yours sincerely

{GP name}

{Surgery}

**Please send a copy of this response to:**

1. The Specialist/consultant requesting shared care
2. **ANONYMISED COPY OF THIS FORM ONLY** to the E-MAIL: [tpa-tr.ClinicalPharmacy@nhs.net](mailto:tpa-tr.ClinicalPharmacy@nhs.net)

(sending a copy of this form to the PAH pharmacy will help to identify any inappropriate requests for shared care e.g. indication not covered, hospital monitoring requirements not fulfilled. It will also help to inform the CCG Medicines Optimisation Team of the reasons shared care is not being undertaken by GPs allowing for changes to be made in future updates to improve patient safety)



Information for patients:

## SHARED CARE:

### Agreement information and confirmation

**Patient name:**

.....

**Medicine:**

.....

**We would be grateful if you would take time to read this information as it will help us work with you to manage your condition and ensure safe prescribing of the specific medicine listed above.**

### What is a Shared Care Agreement (SCA)?

A Shared Care Agreement (SCA) enables the care you have for a specific condition to be shared between the hospital and your GP.

The agreement means that the medicine the hospital has started, can be continued by your GP, so you won't have to visit the hospital to collect your medicine.

The SCA gives information on your medicine, guidance on the prescribing and monitoring responsibilities for your consultant (in the hospital), your GP and you. For an SCA, to work everyone involved must understand it and communicate effectively.

Your consultant and your GP will need to sign the agreement and if you agree to this approach, we would ask you to sign this letter, to indicate your agreement to have your care managed in this way.

### How does shared care work?

#### Your consultant and GP share responsibility for your care.

The consultant is a specialist in your condition and will start prescribing your medicine, making sure it is suitable for you. There will come a point in your treatment when you may not need to be monitored by the consultant as often and this monitoring can be done by your GP.

Once your GP has agreed to the SCA, they will be able to prescribe the same medicine for you at the dose recommended by the consultant.

The organisation which regulates GPs, the General Medical Council, says that 'when a GP prescribes a medicine, the GP needs to satisfy themselves that the prescription is needed, appropriate for the patient and within the limits of their competence'.

So, your GP can only issue a prescription if the consultant and you keep to the responsibilities you have agreed (see below). If responsibilities are not kept or if the GP no longer feels it is safe to prescribe the medicine, he/she will explain the reasons to you and your consultant, then prescribing responsibilities will be transferred back to the hospital.

### What do I need to do to ensure the SCA can continue?

#### Attend hospital outpatients

You must still attend the hospital for regular reviews as directed by your consultant (these may be less frequent than before and you may be seen by a specialist pharmacist or a specialist nurse). If you do not attend your hospital appointments, your GP will not be able to continue issuing prescriptions for this medication.

#### Attend GP appointments

You must attend any appointments you have with your GP in relation to this medicine, so they can look after you effectively

▶ **Have blood tests as you have been**

**advised to:** Your consultant should have informed you if and how often you need to have blood monitoring tests. You can usually have your blood taken at an appropriate clinic and not need to go to the hospital.

- ▶ If you do not have the blood monitoring tests as advised by your consultant, your GP will no longer be able to issue you with prescriptions as it would not be safe to do so.

## What do I do if I am having side-effects to the medicine?

Your consultant should have informed you of the common side-effects to expect and what to do if you experience them. If you think you may be having side-effects from a medicine report these directly to your consultant. Your GP may need to seek advice from your consultant before issuing you with another prescription; this is to ensure it is safe for you to continue on the medication.

## What if my disease symptoms change or get worse?

Report any changes in disease symptoms or circumstances that could affect management of your disease to your consultant.

## What about the other medicines I take?

Inform your GP and the consultant of all other medicines you are taking, including those you may have bought yourself. Do not take new medicines (including those you could buy) until you have discussed this with your pharmacist, GP or consultant.

If you would like to go ahead with a shared care agreement for the specific medication identified on page 1, please sign below to confirm that you:

- ▶ Understand the shared care agreement.
- ▶ Are happy to have your care for this aspect of your health managed by a shared care agreement.
- ▶ You agree to attend regular review appointments as requested.
- ▶ You agree to have blood tests as required.

## What happens if I change GP Practice?

If you register at a new GP Practice a new agreement needs to be put in place between your new GP and the specialist team.

The specialist team can start this process if you provide them with information before you move to make sure there is a smooth handover.

Patient's signature .....

Date .....

Print name .....

If at any point in time you would like this shared care agreement to stop, please talk to your GP.