**Patient Agreement Form**

**Lixisenatide, liraglutide, dulaglutide or exenatide for type 2 diabetes**

At your appointment today we have agreed to start treatment with one of the following medicines to help manage your type 2 diabetes:

* Lixisenatide (Lyxumia)
* Liraglutide (Victoza)
* Dulaglutide (Trulicity)
* Exenatide (Byetta or Bydureon)

These medicines all work in a very similar way and are sometimes known as GLP-1 agonists. Further information on how to use the device and any side-effects you should be aware of is included in the patient information provided with your medicine supply.

Although these medicines are given as an injection, they work in a different way to insulin. However they should help reduce your blood glucose levels and may also help you lose weight, especially if you follow a healthy diet and take regular exercise.

Please ask your nurse or GP if you would like further information on the use of these medicines to treat type 2 diabetes or help and support with losing weight.

These injections do not work for everyone, we therefore need to regularly monitor whether they are being effective. The National Institute of Health and Care Excellence (NICE) have advised that treatment with these medicines should only be continued for patients who have a reasonable benefit. This means after 6 months a patient sees a reduction in their HbA1c (measurement of long term blood sugar control) of 11mmol/mol (in the old number system that is about 1% HbA1c) and a reduction in their weight of 3% or more.

**Patient Agreement:**

The information overleaf has been explained to me and I understand that treatment with:

 (Insert name of medicine)

will be stopped and alternative options considered if the beneficial effects on my weight and HbA1c are not achieved after 6 months, or continued long-term.

|  |  |  |
| --- | --- | --- |
|  | **Today** | **6 month’s target** |
| Weight (3% loss needed by 6 months) |  |  |
| HbA1c (11mmol/mol (1%) reduction needed by 6 months) |  |  |
| eGFR (to check your kidney function) |  | To be measured in 6 months |

Patient name …………………………………………………………………….

Patient signature …………………………………………………………………

Clinician name ……………………………………………………………………

Date…………………………………… Date of 6-month review ……………………………..........

If you have any questions or problems with your treatment, please contact:

Name:…………………………………… Contact number ……………………………..........

(Adapted from Derbyshire Joint Area Prescribing Committee type 2 diabetes guidelines)