**AMBER** shared care protocol:

|  |
| --- |
| **Apomorphine hydrochloride** for the treatment of motor fluctuations ('on-off' phenomena) in patients with Parkinson's disease which are not sufficiently controlled by oral anti-Parkinson medication. |

Review date – May 2026

|  |
| --- |
| Specialist responsibilities* Assess the patient and provide diagnosis; ensure that this diagnosis is within scope of this shared care protocol ([section 2](#Three_local_indications)) and communicated to primary care.
* Ensure compliance with NICE NG71 [Overview | Parkinson’s disease in adults | Guidance | NICE](https://www.nice.org.uk/guidance/ng71)
* Use a shared decision-making approach; discuss the benefits and risks of the treatment with the patient and provide the appropriate counselling (see [section 11](#Eleven_advice_to_patients)) to enable the patient to reach an informed decision. Obtain and document patient consent. Provide an appropriate patient information leaflet.
* Assess for contraindications and cautions (see [section 4](#Four_cx_and_cautions)) and interactions (see [section 7](#Seven_interactions)).
* Conduct required baseline investigations and initial monitoring (see [section 8](#Eight_specialist_monitoring)).
* Initiate and optimise treatment as outlined in [section 5](#Five_dosing).
* Initiate therapy (either intermittent apomorphine injection or continuous infusion) and optimise anti-parkinsonian drug therapy. Ensure prescribing for at least 3 months, titrating dose accordingly over this initial treatment period. Prescribe sufficient medication to enable transfer to primary care, including where there are unforeseen delays to transfer of care.
* Transfer to primary care is normally after the patient has been treated for 3 months and with satisfactory investigation results for at least 4 weeks.
* Monitor and evaluate response to apomorphine hydrochloride therapy, including adverse drug reactions, with the patient and continue/discontinue treatment in line with agreed treatment plan.
* Once treatment is optimised, complete the shared care documentation and send to patient’s GP practice detailing the diagnosis, current and ongoing dose, baseline and most recent test results, confirm the monitoring schedule and when the next monitoring is required. Include contact information ([section 13](#Thirteen_specialist_contact)).
* Conduct the required monitoring in [section 8](#Eight_specialist_monitoring) and communicate the results to primary care. After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in [section 9](#Nine_primary_care_monitoring) remains appropriate.
* Give advice to primary care on continuing treatment if a woman becomes or wishes to become pregnant or breastfeed.
* Clarify the roles of the Parkinson’s Disease Nurse Specialist (PDNS) and/or the Specialist Britannia/Ever Pharma nurse
* Inform GP if patient does not attend planned follow-up appointment.
* Provide advice to primary care on the management of adverse effects if required.

Primary care responsibilities* Respond to the request from the specialist for shared care in writing. It is asked that this be undertaken within 14 days of the request being made, where possible.
* If accepted, prescribe ongoing treatment as detailed in the specialists request and as per [section 5](#Five_dosing) taking into any account potential drug interactions in [section 7](#Seven_interactions).
* Adjust the dose, or stop or change treatment prescribed as advised by the specialist.
* Inform the specialist team of any significant developments, or deterioration, such as the occurrence of side effects or an inability to administer apomorphine.
* Conduct the required monitoring as outlined in [section 9](#Nine_primary_care_monitoring).
* Assess for possible interactions with apomorphine when starting new medicines (see [section 7](#Seven_interactions)).
* Consult promptly with the specialist or PDNS if the patient deteriorates, has problems administering apomorphine or when test results are abnormal, or patient defaults from blood test appointments.
* Manage any adverse effects as detailed in [section 10](#Ten_ADRs_and_Management) and discuss with specialist team when required.
* Facilitate the co-ordination of on-going patient care within the community and home environment, liaising with the Specialist Team when necessary.
* Be aware of the MHRA advice (see [section 4](#Four_cx_and_cautions)) regarding the use of domperidone. Most patients will have been able to discontinue domperidone prior to the shared care transfer to the General Practitioner.
* Discuss other adverse effects with the specialist team as clinically appropriate (see [section 10](#Ten_ADRs_and_Management)).
* Contact the specialist team for advice if the patient becomes or plans to become pregnant.
* Stop treatment as advised by the specialist.

Britannia/Ever Pharma nurse responsibilities* Assess patient’s suitability for apomorphine in conjunction with specialist team.
* Discuss the aims, benefits and side effects of treatment with the patient/spouse/carer as well as their role.
* Carry out [response test](#_Baseline_investigations,_initial) in conjunction with specialist team.
* Provide training and support to patient/carer, and other healthcare professionals as required.
* Inform the GP and specialist team (consultant, PDNS and community PDNS) promptly (within 48 hours) of changes in treatment or dose. Nurse will be working within written titration guidance of hospital specialist team.
* Report significant adverse effects to specialist, GP and MHRA.
* Have a mechanism in place to deal with mechanical failure of an apomorphine pump (Britannia 24hour hotline: 0844 8801327), D-mine pen and D-mine pump (EVER Pharma 24hour hotline: 0800 2540175)
* Carry out ongoing monitoring of PD symptoms, drug response and blood pressure as requested by specialist team

Patient and/or carer responsibilities* Use apomorphine as prescribed and do not stop taking it without speaking to their primary care prescriber or specialist.
* Tell anyone who prescribes them a medicine that they are having apomorphine.
* Read the patient information leaflet included with your medication and report any side effects or concerns you have to the specialist or GP. Report any symptoms including unexplained bruising or bleeding, tiredness, jaundice or shortness of breath.
* Attend regularly for monitoring and review appointments with primary care and specialist. Be aware that medicines may be stopped if they do not attend appointments.
* Report issues with the administration device/equipment (e.g., pump failure) to the relevant company nurse or contact company hotline for advice/urgent replacement as required.
* Report adverse effects to their primary care prescriber. Seek immediate medical attention if they develop any symptoms as detailed in [section 11](#Eleven_advice_to_patients).
* Report the use of any over the counter medications to their prescriber and be aware they should discuss the use of apomorphine with their pharmacist before purchasing any OTC medicines.
* Inform the specialist or primary care prescriber as soon as possible if they become pregnant or wish to become pregnant.
 |
| Background [Back to top](#Responsibilities) |
| Parkinson’s disease (PD) is a common neurodegenerative disorder with a prevalence of about 120/100,000; typical age of onset is between 50-65 years. Motor symptoms (bradykinesia, rigidity and tremor) dominate the clinical picture. The aetiology of PD is unknown, but motor symptoms are believed to be caused by a dopamine deficit in the striatum due to progressive loss of dopaminergic neurons that project to the striatum from the substantia nigra.Drug therapy with levodopa (a precursor to dopamine) and oral dopamine agonists usually provide good symptomatic relief without significant side effects in early disease. However, after some years of treatment many patients develop motor complications which include fluctuations in motor control and dyskinesias. As the disease progresses, the motor fluctuations often cause increasing disability.Disabling motor fluctuations include unpleasant “off” periods. “Off” periods can be associated with dystonia, depression, pain, sleep dysfunction, bladder dysfunction and swallowing difficulties. With disease progression ‘off’ periods can occur suddenly rendering someone immobile in a matter of minutes. Apomorphine is a dopamine agonist, which acts directly on D1 and D2 receptors, stimulating areas of the brain where dopamine works. It produces a similar effect to levodopa, that is, the ability to prevent and reverse disabling “off” periods. However, optimising treatment can be difficult and complex for many patients. Despite its name it has no opiate or additive properties. Apomorphine cannot be used orally because it undergoes extensive first pass metabolism (in the liver) to an inactive metabolite; for this reason, it is administered subcutaneously.Patients selected for treatment with apomorphine should be able to recognise the onset of their “off” symptoms and be capable of injecting themselves or else have a responsible carer able to inject for them when required. Apomorphine can be administered by intermittent subcutaneous injection or continuous subcutaneous infusion. A response test is required prior to initiation to monitor response to treatment and determine the correct starting dose. Apomorphine is brand specific. Infusion pumps and pens are not interchangeable between different brands. Patients must be maintained on the same brand, unless a decision is made to switch (with patient retraining).  |
| 2 Indications [Back to top](#Responsibilities) |
| Motor fluctuations ('on-off' phenomena) in patients with Parkinson's disease which are not sufficiently controlled by oral anti-Parkinson medication. |
| 3 Locally agreed off-label use [Back to top](#Responsibilities) |
| The Surrey Heartlands Integrated Care System Area Prescribing Committee recommended the use of this document for the indications as outlined above.The following information should be provided in correspondence to support prescribing in line with this shared care.* Dosing specific to the indication
* Relevant interaction information
* Any additional monitoring requirements over and above the shared care.
* Duration of treatment
* Frequency of review.
* Specific features of adverse effects or deterioration pertinent to the specific indication for which it is used
 |
| Contraindications and cautions [Back to top](#Responsibilities)This information does not replace the Summary of Product Characteristics (SPC), and should be read in conjunction with it. Please see [BNF](https://bnf.nice.org.uk/drugs/) & [SPC](https://www.medicines.org.uk/emc/) for comprehensive information. |
| PREVENTION OF NAUSEA AND VOMITING – DOMPERIDONEBoth apomorphine and domperidone may prolong QT interval. Before the decision to initiate domperidone and apomorphine treatment, risk factors for QT interval prolongation in the individual patient should be carefully assessed to ensure that the benefit outweighs the risk. Discuss the benefits and risks of apomorphine with patients and carers and advise them to contact their doctor immediately if they develop palpitations or syncopal symptoms during treatment. Check the QT-interval before starting domperidone, during the apomorphine initiation phase and if clinically indicated thereafter (e.g., if a QT-prolonging or interacting drug is started or if symptoms of cardiac side effects are reported). Regularly review domperidone treatment to ensure patients take the lowest effective dose for the shortest duration. It can be weaned off if no nausea. If nausea persists or returns on reducing the dose, domperidone can be reinstated. Advise patients to inform their doctor of any changes that could increase their risk of arrhythmia, such as: symptoms of cardiac or hepatic disorders conditions that could cause electrolyte disturbances (e.g., gastroenteritis or starting a diuretic) starting any other medicines. Patients should not be given domperidone whilst on medications known to prolong the QT interval or strongly inhibit CYP3A4 (e.g., ketoconazole or erythromycin). Domperidone should not be prescribed in patients with specific contraindications, including known QTc prolongation (e.g., on baseline ECG). Refer to the MHRA drug safety alerts for apomorphine and domperidone: [**https://www.gov.uk/drug-safety-update/apomorphine-with-domperidone-minimising-risk-of-cardiac-side-effects**](https://www.gov.uk/drug-safety-update/apomorphine-with-domperidone-minimising-risk-of-cardiac-side-effects)[**https://www.gov.uk/drug-safety-update/domperidone-for-nausea-and-vomiting-lack-of-efficacy-in-children-reminder-of-contraindications-in-adults-and-adolescents**](https://www.gov.uk/drug-safety-update/domperidone-for-nausea-and-vomiting-lack-of-efficacy-in-children-reminder-of-contraindications-in-adults-and-adolescents)**CAUTIONS*** Patients with renal, pulmonary or cardiovascular disease
* Elderly and/or debilitated patients
* Patients with neuropsychiatric disturbances – may be exacerbated by apomorphine
* Prone to nausea and vomiting, or with pre-existing postural hypotension;
* pregnant women and women of child-bearing age.
* Patients at risk of torsades de points arrythmias – potential for QT prolongation at high doses

**CONTRA-INDICATIONS** * Apomorphine is contra-indicated in: patients with respiratory depression, dementia, psychotic diseases or hepatic insufficiency; children and adolescents under 18.
* Apomorphine should not be administered to patients who have a hypersensitivity to apomorphine or any excipients of the medicinal product.

**SIDE EFECTS*** Nausea, vomiting, drowsiness (including sudden onset of sleep), confusion, hallucinations, injection-site reactions (including nodule formation and ulceration) – change injection sites in rotation; less commonly postural hypotension, breathing difficulties, dyskinesias during ‘on’ periods (may require discontinuation), haemolytic anaemia with levodopa (haematology monitoring required), and rash; rarely peripheral oedema, eosinophilia
* Impulse control disorders - patients should be regularly monitored for the development of impulse control disorders. Patients and carers should be made aware that behavioural symptoms of impulse control disorders including pathological gambling, increased libido, hypersexuality, compulsive spending or buying, binge eating and compulsive eating can occur in patients treated with dopamine agonists including apomorphine. Dose reduction/tapered discontinuation should be considered if such symptoms develop.
* Dopamine dysregulation Syndrome (DDS) is an addictive disorder resulting in excessive use of the product seen in some patients treated with apomorphine. Before initiation of treatment, patients and caregivers should be warned of the potential risk of developing DDS.

Positive Coombs’ tests have been reported for patients receiving apomorphine and levodopa |
| Initiation and ongoing dose regimen [Back to top](#Responsibilities) |
| * Transfer of monitoring and prescribing to primary care is normally after at least 12 weeks, and when the patient’s dose has been optimised and with satisfactory investigation results for at least 4 weeks.The duration of treatment & frequency of review will be determined by the specialist, based on clinical response and tolerability.
* All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care clinician.
* Termination of treatment will be the responsibility of the specialist.
 |
| Pharmaceutical aspects [Back to top](#Responsibilities) |
| Route of administration: | 1. **Intermittent subcutaneous injection**
* Apo-go pen 10mg/ml solution for injection [APO-go Pen 10mg/ml Solution for Injection - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)](https://www.medicines.org.uk/emc/product/2232)
* Dacepton 10mg/ml solution for injection in a cartridge [Dacepton 10 mg/ml solution for injection in cartridge - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)](https://www.medicines.org.uk/emc/product/9650)
1. **Continuous subcutaneous infusion**
* Apo-go PFS 5mg/ml solution for infusion in pre-filled syringe (for use with Crono APO-go 111 Pump): [APO-go PFS 5mg/ml Solution for Infusion in Pre-filled Syringe - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)](https://www.medicines.org.uk/emc/product/3908)
* APO-go POD 5 mg/ml solution for infusion in cartridge (for use with Crono PAR4 20 pump: [APO-go POD 5 mg/ml solution for infusion in cartridge - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)](https://www.medicines.org.uk/emc/product/13993/smpc)
* Dacepton 5mg/ml solution for infusion: [Dacepton 5 mg/ml solution for infusion - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)](https://www.medicines.org.uk/emc/product/9632)
 |
| Formulation: | * Solution for injection in a pen or cartridge
* Solution for infusion in a pre-filled syringe or cartridge
 |
| Administration details: | **Intermittent subcutaneous injection** The optimal dosage of apomorphine has to be determined on an individual patient basis and the threshold dose is determined by the specialist using incremental dosing schedules. Once the optimal dose for an individual patient has been determined and the patient is stable, the dose is likely to remain relatively constant.The daily dose of Apomorphine varies widely between patients. Typically, 1-10 injections per day, each dose no more than 10mg **The total daily dose should not exceed 100mg****Continuous subcutaneous infusion**Typically, 1–6 mg per hour (but may be higher, dependent upon individual response), mostly during waking hours but may be necessary for overnight infusion according to patient’s needs. Considered if the patient experiences so many “off” periods that repeated bolus injections are inappropriate, or for patients who experience more complex motor fluctuations including dyskinesia. **The total daily dose should not exceed 100mg**. Any doses prescribed over 100mg are with documented consultant consent and the GP will be informed |
| Other important information: | **APO-go (Britannia):**Apomorphine pre-filled syringes (APO-go® PFS), apomorphine intermittent injection pens (APO-go® PEN and apomorphine cartridges can be prescribed on FP10.* Community pharmacists can obtain supplies direct from Britannia Pharmaceuticals: 0118 892 9534
* Novofine needles are supplied free of charge and should be ordered at the same time as the pens.
* Neria infusion lines can be prescribed on FP10
* A Crono APO-go® 111 pump is loaned to the hospital for each patient, free of charge, by Britannia Pharmaceuticals. Crono® PAR4 20 infusion pump will be available from 2023. Dedicated syringes and connectors are supplied free of charge for use with the Crono APO-go® 111 pump and APO-go® PFS
* An APO-go® Helpline is available for patients and healthcare professionals 24/7, 365 days a year: 0808 196 4242. Replacement pumps can be dispatched for delivery within hours in the event of an emergency
* APO-go® information is available for both patients and healthcare professionals: <http://www.apo-go.co.uk>
* Training on the use of the Crono APO-go® 111 pump can be provided to community nurses and other healthcare professionals by Britannia Pharmaceuticals. Please call Britannia Customer Services on 0118 892 9534 to arrange contact with your local Key Account Manager.

**Dacepton (Ever Pharma):*** Ever Pharma technical support: 0800 254 0175 for patients and healthcare professionals (24 hours/day. During peak times, out of hours and weekend, leave a message and you will be called back)
* Initial reusable D-mine® Pen supplied free of charge (has a warranty). Further supplies to be prescribed on FP10
* Pen Cartridges require BD Micro-Fine Ultra™ needles 29 to 31 gauge (diameter 0.25 – 0.33 mm) and 5 - 12.7 mm length or Pen needles from other manufacturers can be used according to their stated compatibility details
* D-mine Pump provided by Ever Pharma on a permanent loan for infusion. Full replacement service for the pump available. Infusion line 28G to 31G required.
 |
| Significant medicine interactions [Back to top](#Responsibilities)The following list is not exhaustive. Please see [BNF](https://bnf.nice.org.uk/drugs/) or [SPC](https://www.medicines.org.uk/emc/) for comprehensive information and recommended management. |
| Patients should be monitored for potential interactions during initial stages of apomorphine therapy. Particular caution should be given in patients with pre-existing cardiac disease or in patients taking vasoactive medicinal products such as antihypertensives, and especially in patients with pre-existing postural hypotension.* Patients taking concomitant medications for their Parkinson's disease should be monitored for unusual side effects or signs of potentiation of effect.
* Neuroleptic medicinal products may have an antagonistic effect if used with apomorphine.
* It is recommended to avoid apomorphine together with other drugs known to prolong QT interval
* Caution with medicines with a narrow therapeutic index – the effects of apomorphine on the plasma concentration of other medicinal products has not been studied.
 |
| Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist [Back to top](#Responsibilities)Monitoring at baseline and during initiation is the responsibility of the specialist; only once the patient is optimised on the chosen medication with no anticipated further changes expected in immediate future will prescribing and monitoring be transferred to primary care. |
| **Apomorphine response test:** Baseline ECG monitoring prior to commencing domperidone 10mg oral TDS daily, 48 hours prior to initiation of apomorphine response test and arrange apomorphine response test. For patients the domperidone dose can be gradually reduced and then discontinued. Repeat ECG after two weeks of treatment if the patient is receiving >30mg daily of domperidone maintenance therapy.**Apomorphine response test:*** The challenge may take place in an outpatient clinic/day case, in community by an appropriate specialist or as an inpatient.
* **Patients require pre-treatment with domperidone 10mg three times at least 48 hours prior to starting apomorphine.** The dose can be increased to 20mg TDS (unlicensed dose) by specialist if nausea is still severe after careful consideration provided ECG shows no QT prolongation.
* Avoid domperidone in patients taking concomitant medication known to cause QT prolongation.
* Routine ECG is required to exclude cardiac conduction problems or significant cardiac disease. If these are present, the challenge will not take place and the patient will be referred to a cardiologist.
* The patient must be in an ‘off’ state prior to starting the challenge so their morning PD medication is usually omitted; however, the patient’s mobility needs to be considered if the challenge is to be performed as a day case.
* A baseline motor function examination using a clinical assessment tool is performed to provide an assessment of the patient’s response to consecutive doses of apomorphine.
* Single injections of increasing doses of apomorphine are administered (e.g. 1mg, 3mg, 5mg, 6mg and 7mg) at intervals with subsequent recordings using the clinical assessment tool until a response is seen (the patient switches ‘on’). If 7mg is administered without any positive effect, the patient is usually considered to be a non-responder. However, in rare cases the specialist team may consider administering a slightly higher dose (max 10mg).
* The patient is closely observed and monitored throughout for any side effects.
* Lying and standing BP is monitored.
* The challenge will be stopped if the patient experiences any side effects.
* The results of the test are communicated to the GP

**Baseline assessment (by hospital specialist team):** * ECG
* BP
* FBC
* Reticulocyte count
* Coombs
* Renal function test
* LFTs

**Follow-up assessment (usually within first 2 months by hospital specialist team)*** Lying and standing blood pressure
* FBC
* Reticulocyte count
* ECG

ECG Interpretation: (carried out by hospital specialist team)ECG carried out to check the QTc interval prior to the use of domperidone - If the QTc is greater than 450 milliseconds in a male or more than 470 milliseconds in a female then domperidone should not be prescribed and a cardiology opinion obtained. If a second QT prolonging drug or a strong CYP3A4 inhibitor is added then the ECG should be repeated (e.g., ketoconazole or erythromycin). The ECG should be repeated once at 2 weeks if the prescribed dose is maintained at more than 30mg daily. The second ECG is to be conducted by secondary care if required. |
| Ongoing monitoring requirements to be undertaken by primary care [Back to top](#Responsibilities)See [section 10](#Ten_ADRs_and_Management) for further guidance on management of adverse effects/responding to monitoring results. |
| **Monitoring and actions** | **Frequency** |
| * FBCs (reticulocyte/Coombs if needed),
* LFTs
* U+Es

(Coombs tests only required if patient is anaemic) | **6 monthly intervals** |
| **(If relevant) If monitoring results are forwarded to the specialist team, please include clear clinical information on the reason for sending, to inform action to be taken by secondary care.** |
| Adverse effects and other management [Back to top](#Responsibilities)**Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit** [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard)For information on incidence of ADRs see relevant summaries of product characteristics |
| **Result** | **Action for primary care** |
| **As well as responding to absolute values in laboratory tests, a rapid change or a consistent trend in any value should prompt caution and extra vigilance** |
| If WCC < 3.9 x 109/lOr if Neutrophils <2.0 x 109/lOr if platelets <150 x 109/l x 2 separate testsIf creatinine >150 (used with caution in renal impairment) If potassium >6mmol/l (cardiac side-effects)If ALT raised x 2 above normal limits (extensively metabolised by liver) |  GP will continue treatment but seek immediate specialist advice  |
|  In the event of a hypersensitivity reaction |  GP will STOP treatment and seek advice |
| Advice to patients and carers [Back to top](#Responsibilities)The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines. |
| Advise patient to report side-effects including nodule formation, ulceration, somnolence and persistent side-effects to GP without delay. Explain to the patient their treatment plan including the dosing schedule. |
| Pregnancy, paternal exposure, and breast feeding [Back to top](#Responsibilities)It is the responsibility of the specialist to provide advice on the need for contraception to male and female patients on initiation and at each review, but the ongoing responsibility for providing this advice rests with both the primary care prescriber and the specialist. |
| **Pregnancy:** [**www.medicines.org.uk**](http://www.medicines.org.uk)There is no experience of apomorphine usage in pregnant women.Animal reproduction studies do not indicate any teratogenic effects, but doses given to rats which are toxic to the mother can lead to failure to breathe in the newborn. The potential risk for humans is unknown. See Section 5.3.APO-go should not be used during pregnancy unless clearly necessary**Breastfeeding:** [**www.medicines.org.uk**](http://www.medicines.org.uk)It is not known whether apomorphine is excreted in breast milk. A decision on whether to continue/discontinue breastfeeding or to continue/discontinue therapy with APO-go should be made taking into account the benefit of breast-feeding to the child and the benefit of APO-go to the woman.**Paternal exposure**:No data is available on the risks associated with paternal exposure to apomorphine.  |

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| Specialist contact information [Back to top](#Responsibilities) |
| Name: *[insert name]*Role and specialty: *[insert role and specialty]*Daytime telephone number: *[insert daytime telephone number]*Email address: *[insert email address]*Alternative contact: *[insert contact information, e.g. for clinic or specialist nurse]*Out of hours contact details: *[insert contact information, e.g. for duty doctor]* |
|  Additional information [Back to top](#Responsibilities) |
| Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed. Ensure that the specialist is informed in writing of any changes to the patient’s GP or their contact details. |
| References [Back to top](#Responsibilities) |
| 1. MHRA safety alert – Apomorphine with domperidone: minimising risk of cardiac side-effects, accessed via <https://www.gov.uk/drug-safety-update/apomorphine-with-domperidone-minimising-risk-of-cardiac-side-effects>
2. MHRA safety alert – Domperidone for nausea and vomiting: lack of efficacy in children; reminder of contraindications in adults and adolescents

<https://www.gov.uk/drug-safety-update/domperidone-for-nausea-and-vomiting-lack-of-efficacy-in-children-reminder-of-contraindications-in-adults-and-adolescents>1. SPC APO-go pen 10mg/ml Solution for Injection

<https://www.medicines.org.uk/emc/product/2232/smpc> (last updated 02/22)1. SPC APO-go PFS 5mg/ml Solution for Infusion in Pre-filled Syringe

<https://www.medicines.org.uk/emc/product/3908/smpc> (last updated 07/18)1. SPC APO-go POD 5 mg/ml solution for infusion in cartridge

<https://www.medicines.org.uk/emc/product/13993/smpc> (09/22)1. BNF app V3.1.2 updated 26th May 2022
2. SPC Dacepton 10mg/ml solution for injection in a cartridge

[Dacepton 10 mg/ml solution for injection in cartridge - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)](https://www.medicines.org.uk/emc/product/9650) (last updated 6/1/23)1. SPC Dacepton 5mg/ml solution for infusion

[Dacepton 5 mg/ml solution for infusion - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)](https://www.medicines.org.uk/emc/product/9632) last updated 6/1/23)1. Email correspondence with Dr Peter Brash, Medical Consultant for Ever Pharma
 |
| Other relevant national guidance [Back to top](#Responsibilities) |
|  |
| Local arrangements for referral [Back to top](#Responsibilities)Define the referral procedure from hospital to primary care prescriber & route of return should the patient’s condition change. |
| **To be agreed and completed locally**  |

APC board date:

Last updated:

# Appendix 1: Shared Care Request letter (Specialist to Primary Care Prescriber)

Dear *[insert Primary Care Prescriber's name]*

Patient name: *[insert patient's name]*

Date of birth: *[insert date of birth]*

NHS Number*: [insert NHS Number]*

Diagnosis: *[insert diagnosis]*

As per the agreed *[insert APC name]*shared care protocol for *[insert medicine name]* for the treatment of *[insert indication],* this patient is now suitable for prescribing to move to primary care.

The patient fulfils criteria for shared care and I am therefore requesting your agreement to participate in shared care. Where baseline investigations are set out in the shared care protocol, I have carried these out.

I can confirm that the following has happened with regard to this treatment:

|  |  |
| --- | --- |
|  | **Specialist to complete** |
| *The patient has been initiated on this therapy and has been on an optimised dose for the following period of time:* |  |
| *Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory* | *Yes / No* |
| *The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care* | *Yes / No* |
| *The risks and benefits of treatment have been explained to the patient* | *Yes / No* |
| *The roles of the specialist/specialist team/* *Primary Care Prescriber / Patient and pharmacist have been explained and agreed* | *Yes / No* |
| *The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments* | *Yes / No* |
| *I have enclosed a copy of the shared care protocol which covers this treatment/the SCP can be found here (insert electronic/ web link)* | *Yes / No* |
| *I have included with the letter copies of the information the patient has received* | *Yes / No* |
| *I have provided the patient with sufficient medication to last until* |  |
| *I have arranged a follow up with this patient in the following timescale* |  |

Treatment was started on *[insert date started]* and the current dose is *[insert dose and frequency]*.

If you are in agreement, please undertake monitoring and treatment from *[insert date]* NB: date must be at least 1 month from initiation of treatment.

The next blood monitoring is due on *[insert date]* and should be continued in line with the shared care guideline.

Please respond to this request for shared care, in writing, within 14 days of the request being made where possible.

# Appendix 2: Shared Care Agreement Letter (Primary Care Prescriber to Specialist)

**Primary Care Prescriber Response**

Dear *[insert Doctor's name]*

Patient *[insert Patient's name]*

NHS Number *[insert NHS Number]*

Identifier *[insert patient's date of birth and/oraddress]*

Thank you for your request for me to accept prescribing responsibility for this patient under a shared care agreement and to provide the following treatment

|  |  |  |
| --- | --- | --- |
| Medicine | Route | Dose & frequency |
|  |  |  |

I can confirm that I am willing to take on this responsibility from *[insert date]* and will complete the monitoring as set out in the shared care protocol for this medicine/condition.

Primary Care Prescriber signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Prescriber address/practice stamp

# Appendix 3: Shared Care Refusal Letter (Primary Care Prescriber to Specialist)

**Re:**

Patient *[insert Patient's name]*

NHS Number *[insert NHS Number]*

Identifier *[insert patient's date of birth and/oraddress]*

Thank you for your request for me to accept prescribing responsibility for this patient.

In the interest of patient safety NHS *[insert CCG name]***,** in conjunction with local acute trusts have classified *[insert medicine name]*as a Shared Care drug, and requires a number of conditions to be met before transfer can be made to primary care.

**I regret to inform you that in this instance I am unable to take on responsibility due to the following:**

|  |  |  |
| --- | --- | --- |
|  |  | **Tick which apply** |
| **1.** | **The prescriber does not feel clinically confident in managing this individual patient’s condition, and there is a sound clinical basis for refusing to accept shared care**As the patients primary care prescriber I do not feel clinically confident to manage this patient’s condition because *[insert reason]*. I have consulted with other primary care prescribers in my practice who support my decision. This is not an issue which would be resolved through adequate and appropriate training of prescribers within my practice.**I have discussed my decision with the patient and request that prescribing for this individual remain with you as the specialist, due to the sound clinical basis given above.** |  |
| **2.** | **The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement**As the medicine requested to be prescribed is not included on the national list of shared care drugs as identified by RMOC or is not a locally agreed shared care medicine I am unable to accept clinical responsibility for prescribing this medication at this time. **Until this medicine is identified either nationally or locally as requiring shared care the responsibility for providing this patient with their medication remains with you**  |  |
| **3.** | **A minimum duration of supply by the initiating clinician**As the patient has not had the minimum supply of medication to be provided by the initiating specialist I am unable to take clinical responsibility for prescribing this medication at this time. Therefore can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.***Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.*** |  |
| **4.** | **Initiation and optimisation by the initiating specialist**As the patient has not been optimised on this medication I am unable to take clinical responsibility for prescribing this medication at this time. Therefore can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.***Until the patient is optimised on this medication the responsibility for providing the patient with their medication remains with you.*** |  |
| **5.** | **Shared Care Protocol not received**As legal responsibility for clinical care lies with the clinician who signs the prescription, I need to ensure that I am in possession of sufficient clinical information for me to be confident to prescribe this treatment for my patient and it is clear where each of our responsibilities lie to ensure the patient is safely managed***.***For this reason I am unable to take clinical responsibility for prescribing this medication at this time, therefore would you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.***Until I receive the appropriate SCP, responsibility for providing the patient with their medication remains with you.*** |  |
| **6.** | **Other (Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted)** |  |

I would be willing to consider prescribing for this patient once the above criteria have been met for this treatment.

NHS England ‘Responsibility for prescribing between Primary & Secondary/Tertiary care’ guidance (2018) states that “when decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. It is therefore essential that a transfer involving medicines with which GPs would not normally be familiar should not take place without full local agreement, and the dissemination of sufficient, up-to-date information to individual GPs.” In this case we would also see the term GP being interchangeable with the term Primary Care Prescriber.

Please do not hesitate to contact me if you wish to discuss any aspect of my letter in more detail and I hope to receive more information regarding this shared care agreement as soon as possible

Yours sincerely

**Primary Care Prescriber signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Prescriber address/practice stamp**