Prescribing Clinical Network

Application for change in colour classification

GREEN - Non-Specialist Drugs GPs (or non-medical prescribers in primary care) are able to take full responsibility for initiation and continuation of prescribing
BLUE - Specialist Input WITHOUT Formal Shared Care Agreement Prescribing initiated and stabilised by specialist but has potential to transfer to primary care WITHOUT a formal shared care agreement
AMBER - Specialist Initiation WITH Shared Care Guidelines Prescribing initiated and stabilised by specialist but has potential to transfer to primary care under a formal shared care agreement
RED - Specialist ONLY drugs Treatment initiated and continued by specialist clinicians
BLACK – NOT recommended Not recommended for use in any health setting across Surrey and NW Sussex health economy

Medicine details

Name, brand name and manufacturer	**Hydroxychloroquine**	
Licensed indication, formulation and usual dosage	Oral tablets 200mg **Licensed indications** Adults: Treatment of rheumatoid arthritis, discoid and systemic lupus erythematosus, and dermatological conditions caused or aggravated by sunlight. Paediatric Population: Treatment of juvenile idiopathic arthritis (in combination with other therapies), discoid and systemic lupus erythematosus. **Usual dosage** Adults (including the elderly) The minimum effective dose should be employed. This dose should not exceed 6.5 mg/kg/day (calculated from ideal body weight and not actual body weight) and will be either 200 mg or 400 mg per day. In patients able to receive 400mg daily: Initially 400 mg daily in divided doses. The dose can be reduced to 200 mg when no further improvement is evident. The maintenance dose should be increased to 400 mg daily if the response lessens. Paediatric Population The minimum effective dose should be employed and should not exceed 6.5 mg/kg/day based on ideal body weight. The 200 mg tablet is therefore not suitable for use in children with an ideal body weight of less than 31kg. Hydroxychloroquine is cumulative in action and will require several weeks to exert its beneficial effects, whereas minor side effects may occur relatively early. For rheumatic disease treatment should be discontinued if there is no improvement by 6 months. In light-sensitive diseases, treatment should only be given during periods of maximum exposure to light.	
Traffic Light Status	**Current status**	**Proposed status**
	AMBER	**BLUE – no info leaflet Minimum one month from specialist**

Reason for requested change

Please use PCN decision making criteria to inform reasons for change

20160526_colour classification guideline

The Rheumatology Network met on the 2nd March 2016 and considers that this drug is suitable to be prescribed in primary care without the a formal shared care agreement because of the following reasons –

1. Monitoring of efficacy can be undertaken in primary care without specialist support
2. Monitoring of toxicity can be undertaken in primary care without specialist support
3. No on-going requirement for specialist support but opportunity for advice

Key Considerations

Cost implications to the local health economy

Annual cost per patient:

Availability of patient access scheme and details (if appropriate): not applicable

Availability of homecare service (if appropriate): not applicable

Impact to current prescriber or medication initiator

Current responsibilities (secondary care prescriber)

1. Review FBC, LFTs and U&Es prior to initiating treatment and subsequently thereafter once a year.
2. Ask about visual impairment not corrected by glasses
3. Initiate treatment and prescribe until GP agrees to share care.
4. Explain to the patient / carer their roles (if a drug specific additional role required then this responsibility will change to 'give a copy of the information sheet to the patient / carer and explain to them their roles')
5. Send letter to GP requesting shared care for the patient.
6. Routine clinic follow-up on a regular basis.
7. Send a letter to the GP after each clinic attendance ensuring correct dose, most recent blood results and frequency of monitoring are stated.
8. Evaluation of any reported adverse effects by GP or patient
9. Advise GP on review, duration or discontinuation of treatment where necessary.
10. Inform GP of patients who do not attend clinic
11. Annual evaluation of the following at secondary care level:
    - Ask about visual symptomatology
    - Recheck acuity and assess for blurred vision using a reading chart
    - Refer to Ophthalmologist if patient has any visual impairment or eye disease detected at baseline or develops changes in acuity or blurred vision
    - ESR or C-reactive protein (CRP) tests annually
    - FBC, LFTs and U&Es

Maintenance of prescribing and monitoring will completely transfer to primary care, without the need for a formal shared care agreement, as the consultant Rheumatologists have all agreed at the Rheumatology Network that these are no significant special monitoring requirements or prescription arrangements necessary for patients on this drug.

Impact to proposed prescriber or medication initiator

Prescribing will continue to be initiated by a specialist in a secondary care setting.

Primary care prescribers are (currently, and will continue to be) responsible for:
1. Subsequent prescribing of hydroxychloroquine at the dose recommended.
2. Monitor patient's overall health and well being
3. Report adverse effects to the hospital consultant.
4. Assist with monitoring the progression of disease

Impact to patients

No changes from status quo

Additional comments

Currently, there is a formal shared care agreement in place for the treatment of patients with hydroxychloroquine.

The Rheumatology Network considers that a formal shared care agreement is no longer necessary due to the low requirement for monitoring of patients whilst on this drug, the risk of complications and primary care experience of prescribing this drug.

The normal expectations of communication between secondary and primary care with regards to regular clinic letters and advice on dose changes and blood results, i.e. an informal shared care agreement, remain unchanged.
No special requirements for prescribing of this drug in primary care are necessary, although it is important that patients continue to attend regular clinic appointments with their specialist.

Identified lead for development of necessary documents e.g. shared care agreement

Name: n/a
Designation:
Organisation:
Estimated date of preparation:

Declaration of interest

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Declaration of interest: none
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Declaration of interest: None
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