Surrey Heartlands Integrated Care System
Area Prescribing Committee (APC)

Integrated Care Partnership - Surrey Downs, Guildford & Waverley, North-West Surrey, and East Surrey Places & associated partner organisations.

AMBER shared care protocol:

Recombinant human growth hormone for Paediatric Patients

Somatropin/somatrogon is classified as a Controlled Drug Schedule 4 (Part II [CD Anab POM]).
In summary, this means that:
- the prescription is valid for 28 days after appropriate date on the prescription
- controlled drug prescription requirements do not apply
- somatropin/somatrogon is not subject to safe custody requirements.

Somatropin/somatrogon is a biological medicine. Biological medicines must be prescribed and dispensed by brand name.
Automatic substitution of brands at the point of dispensing is not appropriate for biological medicines.

Review date – 3 years from date of development

Specialist responsibilities

- Assess the patient and provide diagnosis; ensure that this diagnosis is within scope of this shared care protocol (section 2) and communicated to primary care.
- 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) 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) and interactions (see section 7).
- Conduct required baseline investigations and initial monitoring (see section 8).
- Initiate therapy as indicated by NICE guidance (NICE TA188) and supervise training and education of patients and families and optimise treatment as outlined in section 5. Liaise with GP about local arrangements necessary for instigation of therapy and identify any possible barriers to treatment.

- Transfer to primary care is normally after the patient has been treated for 4 months and with satisfactory investigation results for at least 4 weeks. Prescribe sufficient medication to enable transfer to primary care, including where there are unforeseen delays to transfer of care.
- Once treatment is optimised, complete the shared care documentation and send to patient's GP practice detailing the diagnosis, indication, current and ongoing dose (and preparation), baseline and most recent test results, confirm the monitoring schedule and when the next monitoring is required. Include contact information (section 13).
- Conduct the required monitoring in section 8 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 remains appropriate.
- Give advice to primary care on continuing treatment if a woman becomes or wishes to become pregnant or breastfeed.
- 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 taking into any account potential drug interactions in section 7.
- Adjust the dose of human growth hormone prescribed as advised by the specialist.
- Conduct the required monitoring as outlined in section 9.
- Assess for possible interactions with human growth hormone when starting new medicines (see section 7).
- Manage any adverse effects as detailed in section 10 and discuss with specialist team when required.
- Stop human growth hormone and discuss urgently with the specialist if bone marrow suppression is suspected.
- Discuss other adverse effects with the specialist team as clinically appropriate (see section 10).
- To monitor patient's overall health and wellbeing.
- Contact the specialist team for advice if the patient becomes or plans to become pregnant.
- Stop treatment as advised by the specialist.

Patient and/or carer responsibilities

- Take human growth hormone 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 taking human growth hormone.
- 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.
- To share any concerns in relation to treatment with the supervising Consultant and/or GP.
- Report adverse effects to their primary care prescriber. Seek immediate medical attention if they develop any symptoms as detailed in section 11.
- Report the use of any over the counter medications to their prescriber and be aware they should discuss the use of human growth hormone 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.

1. Background

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This document is based upon the British Society for Paediatric Endocrinology and Diabetes (BSPED) growth hormone therapy shared care guidelines which were produced by the BSPED Clinical Committee in August 2015. These guidelines were updated by the BSPED Growth Disorders Special Interest Group (SIG) in December 2023.

Recombinant human GH (r-hGH) is available as a daily (somatropin) or as long-acting growth hormone (LAGH) preparations. Currently somatrogon is the only LAGH preparation available but other LAGH preparations are likely to be licenced.

There are separate BSPED guidance/clinical standards available for the use of r-hGH:

- Standards for GH treatment for GHD https://www.bsped.org.uk/media/iczlv32f/clinical-standards-for-gh-treatment-of-ghd-in-childhood-and-adolescence-v1.pdf
- Standards for GH treatment for other growth disorders excluding GHD https://www.bsped.org.uk/media/kfnh1unq/clinical-standards-for-gh-treatment-of-growth-disorders-excluding-ghd-19122023.pdf
- Use of once-weekly long-acting growth hormone therapy in children with growth hormone deficiency https://www.bsped.org.uk/media/2xdjdr0g/lagh-guideline-24-04-2024.pdf

Recombinant growth hormone (r-hGH) use in children and young people

Somatropin, also known as daily recombinant human growth hormone (r-hGH) is used to treat short stature secondary to several conditions and optimise body composition in Prader-Willi syndrome. **Somatropin** is recommended and approved by NICE as a treatment option for children with growth failure associated with the [1-6] conditions listed below.

LAGH (weekly injections) is now available in the UK and approved by NICE (2023) as an option for the treatment of growth hormone deficiency for children and young people aged three years and over.

2. Indications

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Somatropin is used in the UK for the treatment in children for the following conditions:

1. Growth hormone deficiency (GHD)
2. Turner syndrome (TS)
3. Chronic renal insufficiency (CRI)
4. Prader-Willi syndrome (PWS)
5. Short stature secondary to being born small for gestational age (SGA)
6. SHOX deficiency (SHOX) note; off-label use.

BRAND	Licensing of product					
	GHD	TS	CRI	PWS	SGA	SHOX
Genotropin	✅	✅	✅	✅	✅	❌
Norditropin	✅	✅	✅	❌	✅	❌
NutropinAQ	✅	✅	✅	❌	❌	❌
Omnitrope	✅	✅	✅	✅	✅	❌
Saizen	✅	✅	✅	❌	✅	❌
Zomacton	✅	✅	❌	❌	❌	❌
Ngenla (Somatrogon)	✅	❌	❌	❌	❌	❌

Somatrogon is a LAGH (weekly) preparation licenced in the UK for use in children for: Growth hormone deficiency for children over the age of 3 years up until adult height has been reached.

Please note; different brands of growth hormone have different licensing agreements. A licensed preparation should always be used where possible.

3. Locally agreed off-label use

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Treatment of SHOX deficiency is an off-label use of human growth hormone.

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

4. Contraindications and cautions

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Please see BNF & SPC for comprehensive information.

5. Initiation and ongoing dose regimen

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- 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.

Typical dose ranges are included in the table below (as per BNFc). Note; licensed dosage ranges vary between preparations; refer to individual product information for full details.

Diagnosis	Dose (micrograms/kg/day)	Dose (mg/m^2/day)
GH deficiency	23 to 39 (or 660 once weekly)	0.7 to 1.0
Turner Syndrome (TS)	45 to 50	1.4

Chronic renal insufficiency (CRI)	45 to 50	1.4
Prader-Willi syndrome (PWS)	35 (maximum dose 2.7mg/day)	1
Small for gestational age (GSA)	35	1
SHOX deficiency	45 to 50	n/a

6. Pharmaceutical aspects

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Route of administration:	Subcutaneous injection
Formulation:	• **Genotropin**, MiniQuick syringe (0.2mg, 0.4mg, 0.6mg, 0.8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 20mg) and GoQuick cartidge (5.3mg and 12mg) • **Norditropin**, FlexPro pre-filled pens (5mg, 10mg, 15mg) and Nordiflex pre-filled pens (5mg, 10mg and 15mg) • **NutropinAq**, Cartidge (10mg) • **Omnitrope**, Cartridge (5mg, 10mg and 15mg) • **Saizen**, Cartridge (6mg, 12mg and 20mg) • **Ngenla (somatrogon)**, pre-filled pens (24mg and 60mg)
Administration details:	**Somatropin** is self-administered or given to the child by an adult at home, usually as a subcutaneous injection, 6-7 times a week. **Somatrogon** is self-administered or given to the child by an adult at home, usually as a subcutaneous injection, ONCE a week.
Other important information:	**Usual response time:** A noticeable linear growth response is expected 3-6 months after starting treatment. Most products require storage in a refrigerator (2°C to 8°C) and to be kept in the outer carton in order to protect from light. There are exceptions; refer to SPC for each individual product.

	Growth hormone should be **prescribed by brand** to avoid substitution of similar products during dispensing. Not all products have marketing authorisations in the UK for all indications approved by NICE. The choice of product should be made on an individual basis after informed discussion between the consultant and the patient and/or their carer about the advantages and disadvantages of the product available, taking into consideration therapeutic need and the likelihood of adherence to treatment. If, after that discussion, more than one product is suitable, the least costly product should be chosen.

7. Significant medicine interactions

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The following list is not exhaustive. Please see BNF or SPC for comprehensive information and recommended management.

Clinically relevant medicine interactions and their management	
Corticosteroids	Growth-promoting effect of somatropin may be inhibited by corticosteroids – discuss with specialist team prior to initiation
Oestrogens	Increased doses of somatropin may be needed when given with oestrogens (when used as oral replacement therapy) – discuss with specialist team prior to initiation
Drugs metabolised by cytochrome P 450 enzymes, particularly 3A4 (e.g. sex steroids, corticosteroids, anticonvulsants and ciclosporin)	Metabolism may be increased by growth hormone treatment, leading to lower plasma levels, clinical significance unknown – discuss with specialist team prior to initiation
Antidiabetic agents including insulin	Growth hormone treatment may cause hyperglycaemia and increase the risk of insulin resistance. – discuss with specialist team prior to initiation or dose adjustment

8. Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist

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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.

1. To undertake necessary testing to confirm a diagnosis that requires r-hGH treatment, as indicated above.
2. To provide the GP with written information regarding the diagnosis and indication for r-hGH therapy along with dosage and preparation to be used.
3. To initiate therapy and supervise training and education of patients and families with r-hGH injections, liaise with GP about local arrangements necessary for instigation of therapy and identify any possible barriers to treatment.

4. Strict adherence to published NICE guidance for initial prescription of r-hGH and monitor ongoing r-hGH therapy.
5. The ongoing care by the specialist/ consultant will include the following:
    - To advise about dose changes, preparation changes, drug interactions, contra-indications, assess medicine adherence and inform GP of any changes
    - To monitor for side effects from r-hGH therapy
    - To monitor patient's growth and response to r-hGH, assess pubertal development,
    - To institute biochemical surveillance during r-hGH treatment
    - Assess ongoing or evolving endocrinopathy and general condition at 4-6 monthly intervals following instigation of therapy
    - Communicate with the GP after each clinic attendance including stating the current r-hGH dose
    - Blood results are communicated to patient, family and GP
    - To supervise the timing of cessation of treatment at final height and reassessment of the GH axis and where necessary other hormone status in those with a pituitary problem, according to Consensus guidelines.
    - Transition to adult endocrine care where necessary.

9. Ongoing monitoring requirements to be undertaken by primary care

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No specific monitoring required by primary care.

Prescribers should remain vigilant to unusual symptoms and possible adverse effects to treatment and to treat, seek advice or refer to secondary care as appropriate.

See section 10 for further guidance on management of adverse effects/responding to monitoring results.

(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.

10. Adverse effects and other management

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Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit www.mhra.gov.uk/yellowcard

For information on incidence of ADRs see relevant summaries of product characteristics.

Circumstances requiring discussion with specialist team and local arrangements for contacting specialist team

- If pregnancy occurs or if the patient is planning to become pregnant or breastfeed.
- If non-compliance is suspected or the patient fails to attend monitoring appointments and the primary care prescriber considers it is no longer safe to continue prescribing.

- The patients' clinical condition deteriorates such that the primary care prescriber feels a dose change is required / the patient no longer appears to be benefitting from therapy.
- Dose reduction may be required if the patient develops: fluid retention, arthralgia and symptoms of carpal tunnel syndrome.
- Somatropin is metabolised within the liver and kidneys and excreted in bile however there are no data to suggest the need to reduce the dose in reduced hepatic and/or renal function.

Result	Action for primary care
Local discomfort at the site of injection / lipoatrophy	Advise patient/parent/carer to rotate injection site
Headache – dose dependant • May be noted transiently in patients on higher dosage regimens. • Benign intracranial hypertension has been rarely reported	Consider reducing dose or stop awaiting specialist advice. If nature of the symptoms suggests raised intracranial pressure (e.g. severe headache with nausea, vomiting, vision disturbance), or symptoms are persistent, treatment to be stopped while awaiting further advice from the paediatric endocrine team.
Peripheral oedema / signs of fluid retention • This is not serious and is generally mild and transient. May cause discomfort but rarely requires treatment discontinuation. • Occurs especially in girls with Turner Syndrome who have a history of lymphoedema.	If persistent, discuss with specialist.
Slipped upper femoral epiphyses (SUFE)	Stop therapy
Hyperglycaemia or ketosis	GP to inform paediatric endocrine team. In children with existing diabetes, glycaemic control and insulin therapy may require readjustment.

Sleep apnoea / upper airway obstruction	Stop therapy until a new ENT assessment has been performed.
Visual problems, nausea and vomiting, athralgia / myalgia / paraesthesia, carpal tunnel syndrome (rare), hypothyroidism or antibody formation (very rare)	If visual problems, nausea and vomiting are accompanied by headache consider reducing dose or stop awaiting specialist advice (As above). Severe paraesthesia may require dose reduction
Abdominal pain	Although rare, pancreatitis should be considered in somatropin-treated pateints, especially children who develop abdominal pain.
Respiratory disease / infection	Suspected respiratory infections should be diagnosed as early as possible and treated aggressively according to local antimicrobial guidelines.
Patient using illicit drugs, or develops any other contraindication to treatment	GP to inform specialist team responsible for chared care agreement.

11. Advice to patients and carers

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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.

Information will be provide to the patient on an individual basis, depending on the indication for the use of growth hormone and the brand of growth hormone selected.

12. Pregnancy, paternal exposure and breast feeding

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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: Refer back to supervising Consultant for advice

Breastfeeding: Refer back to supervising Consultant for advice

Paternal exposure: Refer back to supervising Consultant for advice

13. Specialist contact information

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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]*

14. Additional information

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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.

15. References

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1. BSPED recommendations for the initial clinical assessment, investigation and genetic testing of children with growth failure and/or short stature: https://www.bsped.org.uk/media/1ylhw1qk/assessment-of-short-stature-final.pdf
2. BSPED clinical standards for growth assessment and referral criteria for children with a suspected growth disorder: https://www.bsped.org.uk/media/oo1hsxet/clinical-standards-for-growth-assessment and-referral-criteria-for-children-with-a-suspected-growth-disorder.pdf

3. Standards for GH treatment for GHD https://www.bsped.org.uk/media/iczlv32f/clinical standards-for-gh-treatment-of-ghd-in-childhood-and-adolescence-v1.pdf
4. Standards for GH treatment for other growth disorders excluding GHD https://www.bsped.org.uk/media/kfnh1unq/clinical-standards-for-gh-treatment-of growth-disorders-excluding-ghd-19122023.pdf
5. Use of once-weekly long-acting growth hormone therapy in children with growth hormone deficiency https://www.bsped.org.uk/media/2xdjdr0q/lagh-guideline-24-04-2024.pdf
6. Shared Care Protocol for Growth Hormone (Somatropin) v2.1, Greater Manchester Medicine Management Group, March 2023
7. Information sheet for primary care prescribers - Growth Hormone (Somatropin) in children and young people v4, Nottinghamshire Area Prescribing Committee, February 2022

16. Other relevant national guidance

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1. Human growth hormone (somatropin) for the treatment of growth failure in children. National Institute for Health and Care Excellence. Technology appraisal guidance 26 May 2010. Overview | Human growth hormone (somatropin) for the treatment of growth failure in children | Guidance | NICE
2. Somatropin. British National Formulary for Children 2023. https://bnfc.nice.org.uk/drugs/somatropin/
3. NICE recommends a weekly injection for treating growth failure in children | News | News | NICE
4. Institute for Health and Care Excellence. Somatrogon for treating growth disturbance in children and young people aged 3 and over: https://www.nice.org.uk/guidance/ta863

17. Local arrangements for referral

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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