**PYRIDOSTIGMINE, IVABRADINE & MIDODRINE**

**Transfer of Prescribing Responsibility**

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| **Section A: To be completed by the initiating organisation / clinician INITATING ORGANISATIONS TO ADD LOCAL CONTACT DETAILS FOR SPECIALIST SERVICE (TEL / EMAIL) FOR QUERIES** |
| **Patient Details:** **Name:........................................ DOB: …./.…/.… Hospital No: …………………….. NHS No: ………………………..**  |
| **GP Practice Details:**Name: ………………………………………Address: ……………………………………Tel no: ………………………………………NHS.net e-mail: …………………………… | **Consultant Details:**Consultant Name:.......................................................Organisation Name:...........................................................Clinic Name:……………………………………………Tel no: …...................... NHS.net email: ………………………… |
| Dear Dr…………**This patient is on:**

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| **Drug** | **Indication** |
| Pyridostigmine [ ]  | Postural Orthostatic Tachycardia Syndrome (POTS) [ ]  |
| Ivabradine [ ]  | Postural Orthostatic Tachycardia Syndrome (POTS) [ ]  |
| Inappropriate Sinus Tachycardia (IST) [ ]  |
| Midodrine [ ]  | Postural Orthostatic Tachycardia Syndrome (POTS) [ ]  |
| Inappropriate Sinus Tachycardia (IST) [ ]  |
| Severe orthostatic hypotension due to autonomic dysfunction [ ]  |

**I have supplied the first three months of therapy for this patient and the dose is now stable. I am requesting your agreement to transfer the prescribing responsibility for this patient’s on-going treatment from …/…/… in accordance with the South East London Integrated Medicines Optimisation Committee (IMOC) formulary recommendations.**I will review the patient at least annually throughout treatment. The following investigations have been performed and are acceptable for transfer of care.

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| **Test** | **Result** | **Date of test** | **Please repeat test in:** |
| Supine Blood Pressure |  |  | Months  |
| Standing Blood Pressure |  |  | Months  |
| Sitting Blood Pressure |  |  | Months  |
| Heat Rate |  |  |  |
| Serum Creatinine  |  |  |  Months |
| Creatinine Clearance\* |  |
| Aspartate Transaminase (AST) or Alanine Transaminase (ALT) |  |  |  Months |

\*Estimate creatinine clearance (CrCl) using the Cockcroft-Gault equation**Contact details of specialist nurse for GPs to access:**Name: ………………………….. Tel no:……………………………. NHS.net email: …………………………**Other relevant information**: ………………………………………………………………………………………………………………..

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| * I confirm that I have prescribed in accordance with the SEL IMOC guidelines
* I confirm the patient has consented to treatment
* I confirm that the patient understand that this is an off-licence use and consents to treatment
* I confirm that the patient has been made aware of the benefits and risks of therapy, and

that they know how to seek medical help should symptoms occur.* I confirm that patient and/or carer is able to monitor their BP while lying, sitting and standing at home
* I confirm patient has access to specialist nursing support (including contact numbers)

**Signed:……………………………………. Name of Clinician:…………………………… Date: …………….** |
| **Roles and responsibilties:**

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| **Initiating clinician / organisation** | **Patient’s GP** |
| * To initiate medicines in line with SEL formulary recommendations
* To ensure patients has consented to treatment and is aware this specific use is unlicensed
* To provide counselling to improve adherence and address any adverse effects (including advice on dosage, frequency and the risks and benefits of treatment).
* As part of self-monitoring, patient should be recommended to use BP monitors approved by the British & Irish Hypertension Society (BIHS).
* Perform baseline monitoring tests: BP (supine, sitting and standing), heart rate, ECG, baseline renal and liver function.
* Patient is provided with contact information for specialist nurse advice during normal working hours.
* To supply the medicines for at least the first 3 months of treatment and until the dose is stable.
* Following the initial three months of treatment and when the dose is stable, transfer care to the GP using this document
* Provide the GP with relevant specialist contact information should further assistance be required during working hours.
* To review the patient at the request of GP should any problems arise (side-effects / lack of efficacy).
* To review the patient at least annually and communicate promptly with the GP if treatment is changed.
* To report any suspected adverse effects to the MHRA:https://yellowcard.mhra.gov.uk/
 | * To ensure use of medicines in line with SEL formulary recommendations
* To agree to take over prescribing responsibility when the patient is stable on therapy (at least 3 months after initiation and in line with the transfer of care guidance).
* To provide on-going prescriptions after 3 months.
* For patients on ivabradine:
	+ To seek advice from the specialist if resting ventricular rate falls below 50bpm for patients on ivabradine.
	+ Manual pulse rhythm check should be performed at every annual review to check for AF.
	+ Patients should be advised not to consume grapefruit juice during treatment
* For patients on midodrine :
	+ To seek advice from the specialist if BP rises consistently more than 20mmHg or where symptoms of orthostatic hypotension return.
* Review renal and liver function at least annually and more frequently if clinically indicated.
* To monitor patient for adverse effects and control of symptoms.
* To report and seek advice regarding any concerns, for example: side-effects, co-morbidities, pregnancy, or lack of efficacy to the specialist team.
* To advise the specialist if non-adherence is suspected.
* To refer back to specialist if the patient's condition deteriorates or treatment failure.
* To stop treatment on the advice of the specialist or immediately if an urgent need to stop treatment arises.
* To report any suspected adverse effects to the MHRA via the Yellow Card scheme: https://yellowcard.mhra.gov.uk/
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| **Section B: To be completed and signed by the GP if NOT willing to take on prescribing responsibility and returned to the specialist clinician as detailed in Section A above.**  |
| This is to confirm that I am not willing to accept the transfer of care of prescribing for this patient ***for the following reason***:……………………………………………………………………………………………………………….**GP name: ………………………………GP signature: ………………………………………………Date: ……/….…/…....** |