**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:**   |  |  | | --- | --- | | **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.   |  |  |  |  | | --- | --- | --- | --- | | **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**: ………………………………………………………………………………………………………………..   |  | | --- | | * 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:**   |  |  | | --- | --- | | **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: ……/….…/…....** |