PYRIDOSTIGMINE, IVABRADINE & MIDODRINE

Transfer of Prescribing Responsibility

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:	**Consultant Details:**
Name: ……	Consultant Name:.....
Address: ……	Organisation Name:.....
Tel no: ……	Clinic Name:……
NHS.net e-mail: ……	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			
Creatinine Clearance*			Months
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/

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: ……/……./…...