

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:

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 <input type="checkbox"/>	Postural Orthostatic Tachycardia Syndrome (POTS) <input type="checkbox"/>
	Orthostatic hypotension <input type="checkbox"/>
Ivabradine <input type="checkbox"/>	Postural Orthostatic Tachycardia Syndrome (POTS) <input type="checkbox"/>
	Inappropriate Sinus Tachycardia (IST) <input type="checkbox"/>
Midodrine <input type="checkbox"/>	Postural Orthostatic Tachycardia Syndrome (POTS) <input type="checkbox"/>
	Inappropriate Sinus Tachycardia (IST) <input type="checkbox"/>
	Severe orthostatic hypotension due to autonomic dysfunction <input type="checkbox"/>

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
Heart 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	<input type="checkbox"/>
• I confirm the patient has consented to treatment	<input type="checkbox"/>
• I confirm that the patient understand that this is an off-licence use and consents to treatment	<input type="checkbox"/>
• 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.	<input type="checkbox"/>
• I confirm that patient and/or carer is able to monitor their BP while lying, sitting and standing at home	<input type="checkbox"/>
• I confirm patient has access to specialist nursing support (including contact numbers)	<input type="checkbox"/>

Signed:..... **Name of Clinician:**..... **Date:**

Roles and responsibilities:

Initiating clinician / organisation	Patient's GP
<ul style="list-style-type: none"> 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/ 	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 : <ul style="list-style-type: none"> 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:/...../.....