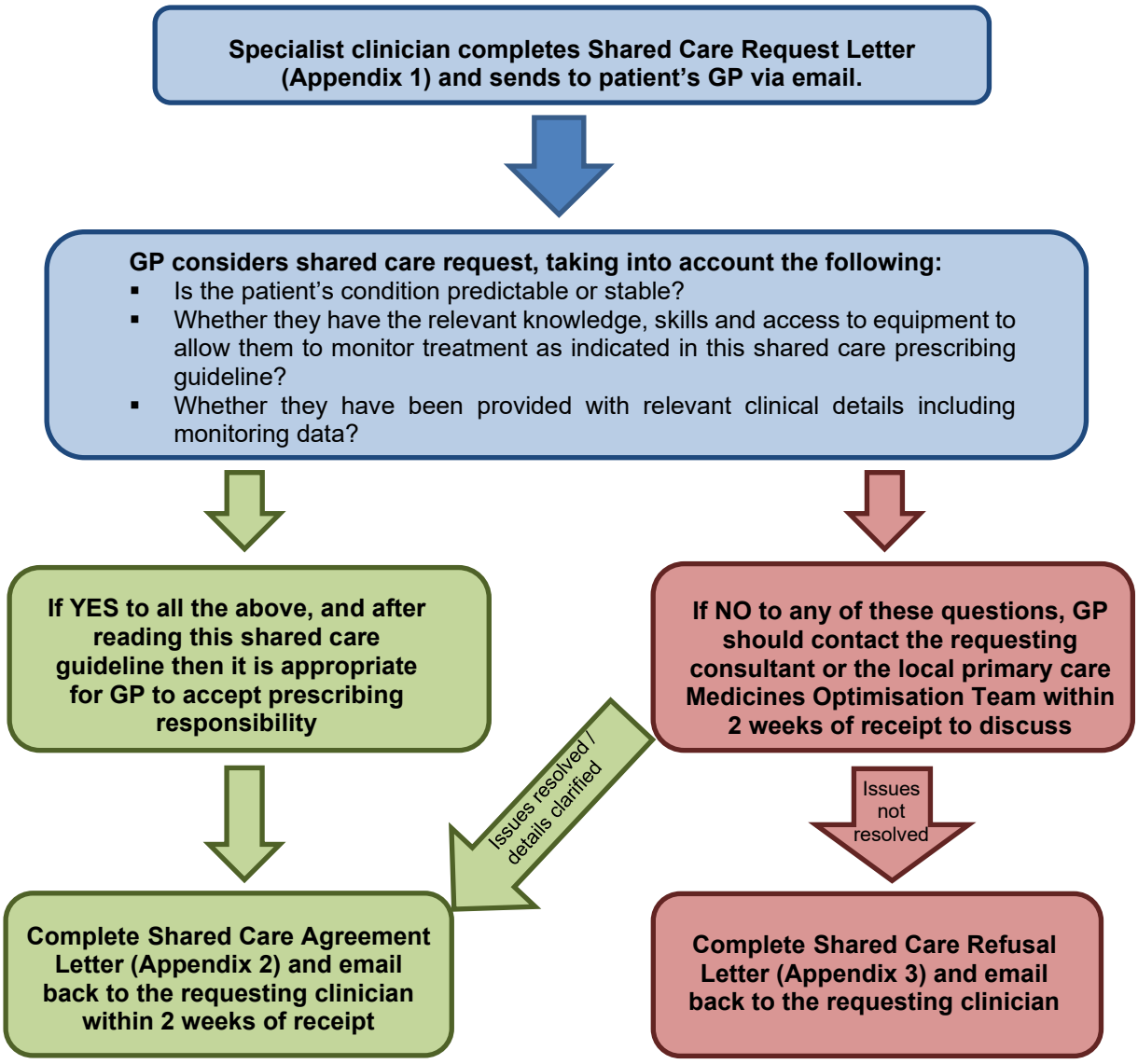
Ref: IMOCSCG010
South East London Shared Care Prescribing Guideline for Human Growth Hormones for treatment of Growth hormone deficiency disorders in paediatrics.
Original Approval Date: Date approved: October 2016 **Last reviewed and updated:** January 2026 **Document review date:** January 2028 (or sooner if evidence or practice changes)

SHARED CARE PRESCRIBING GUIDELINE

Recombinant Growth Hormones (Somatropin, Somapacitan, and Somatrogon) for the treatment of Growth Hormone deficiency disorders in PAEDIATRICS

SHARED CARE PROCESS FLOWCHART



NOTES

There may be implications for the patient where invitation to share care is declined. For example, the patient may need to be changed to an alternative treatment regimen. It would not normally be expected that shared care prescribing would be declined on the basis of cost.

Sharing of care assumes communication between the specialist, GP and patient. The intention to share care should be explained to the patient by the doctor initiating treatment. **It is important that patients are consulted about treatment and are in agreement with it**.

Prescribing should follow requirements in the South East London Interface Prescribing Policy.
The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use. The patient's best interests are always paramount.

If the GP is not confident to undertake these roles, then they are under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. If a specialist asks the GP to prescribe this drug, the GP should reply to this request as soon as practicable (within 2 weeks).

1. AREAS OF RESPONSIBILITY

It is the responsibility of the specialist team to work with the Primary Care Lead to support GPs with drug monitoring, including consideration of patient recall systems where appropriate, and to advise on long-term stock issues where these become apparent.

Consultant / Specialist team responsibilities

- Establish or confirm diagnosis and assess patient suitability for treatment in line with NICE guidance.
- Baseline monitoring and assessment: growth parameters, thyroid function, bone age.
- To initiate and supply treatment for the **first month.**
- To inform GP that they are expected to take on prescribing after the first month.
- To inform GP of the brand of somatropin/somapacitan/somatrogon the patient is on. **Note:** Somatropin/somapacitan/somatrogon must be prescribed by the **brand name** (BNF).
- To inform patients of practical issues related to the use of somatropin/somapacitan/somatrogon such as administration, storage and maximum dose – see “Clinical Information” section on page 6.
- Discuss treatment with patient and ensure they have a clear understanding of it. A specialist nurse carries out training for the administration of the growth hormone (GH). The carer/child is involved with the choice of administration device. The specialist nurse provides ongoing telephone support for any problems with treatment. The consultant makes all decisions about the GH treatment e.g. dose, continuing and stopping treatment and managing side effects.
- Email a signed shared care guideline with patient details completed to GP for consideration of shared care treatment.
- To report any suspected adverse effects to the MHRA: http://www.yellowcard.gov.uk.
- If somatropin, somapacitan, or somatrogon is supplied via a homecare company, this must be always be prescribed by the hospital.
- Where prescribing of GH is transferred to the GP, the community pharmacy will be dispensing (should not be via homecare as this must be retained by the hospital) and the hospital must ensure that the patient is supplied with the reusable pen devices where required, as they are not prescribable on the NHS. Where compatible needles required for reusable pen devices, these are prescribable on the NHS.

After agreement to shared care

- Inform GP that they are expected to take on prescribing from one month onwards
- Inform GP of monitoring results and any changes in therapy
- Evaluate adverse events reported by GP or patient
- Recommend the prescribed brand, dose and monitor treatment as below:
    - Regular assessment of growth response by a specialist in child growth at intervals: usually every 3-4 months during the first year.
    - If the response to treatment is satisfactory, the interval between assessments may be extended to six months.
    - Thyroid function annually or when indicated.
    - Bone age assessment annually or when indicated.
    - Assessment of pituitary status as other deficiencies may evolve.
    - Sex hormone replacement to induce puberty at the normal timing if indicated.
    - Examining patients with growth hormone deficiency (GHD) secondary to an intracranial lesion for evidence of progression or recurrence of underlying disease.
- Regular communication with the GP to update about response, developments and any change in treatment.

General Practitioner responsibilities

- To consider shared care proposal within 2 weeks of receipt. If agree to request to continue prescribing as detailed in shared care guideline. Confirmation to the requesting consultant is required **within 2 weeks** of receipt of this guideline by completing and returning the agreement on page 3
- If do not agree to shared care discuss with requesting consultant or local primary care Medicines Optimisation Team within 2 weeks of receipt of shared care request
- To provide ongoing prescriptions for recommended growth hormone after 1 month of initiation by specialist
- To adjust the dose as advised by the specialist
- To agree monitoring requirements with specialist – see page 8 of this document for GP monitoring requirements
- To comment on the results of any monitoring undertaken in primary care to make the results and any impact of these clear to the patient
- 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-compliance is suspected
- To refer back to specialist if the patient's condition deteriorates
- 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: http://www.yellowcard.gov.uk

Patient's / Carer's responsibilities

- To contact the specialist or GP if they do not have a clear understanding of any aspect of the treatment.
- To inform prescribing specialist, GP and other healthcare professionals of any other medication being taken, including over the counter products, alternative therapies or recreational drugs.
- To inform community pharmacists that they are using growth hormones before purchasing medication over-the-counter
- To attend all hospital and GP appointments
- To take medicines as agreed and take steps to ensure that no doses are missed and not to share medicines with others
- To arrange and attend all regular monitoring required and to confirm with the specialist or GP team that the results of these are satisfactory to continue the medication (contact can be via telephone to the admin team or patient having online access to their results in cases where confirmation is provided alongside the results that they are satisfactory).
- To read the patient information leaflet included with the medication.
- To report any adverse effects or warning symptoms to GP or hospital specialist
- To report to GP and maternity services team if pregnant or breastfeeding.
- To inform GP and hospital of any changes in addresses or telephone contact numbers.

2. CLINICAL INFORMATION

NOTE: The information here is not exhaustive. Please also consult the current **brand specific** Summary of Product Characteristics (SPC) for **Somatropin, Somapacitan, or Somatrogon** prior to prescribing for up to date prescribing information, including detailed information on adverse effects, drug interactions, cautions and contraindications (available via www.medicines.org.uk)

Background and Place in Therapy Indicate what drugs should have been tried before this drug is considered	Human growth hormone is produced by the anterior pituitary gland. The synthetic form, recombinant human growth hormone is available as somatropin, somapacitan, or somatrogon. Human growth hormone is essential for normal growth in children. It increases growth by a direct action on the growth plates and by production of insulin-like growth factors (especially IGF-1), mainly in the liver. Human growth hormone also has important effects on the metabolism of proteins, lipids and carbohydrates, not only during childhood, but also throughout adult life. Growth failure in children can be a result of growth hormone deficiency, but also occurs in children with Turner syndrome, chronic renal insufficiency (CRI), short stature homeobox-containing gene (SHOX) deficiency, and in children born small for gestational age. **Growth hormone deficiency** (**GHD**) occurs when the pituitary gland does not produce enough human growth hormone, which is the most common endocrine cause of short stature. Growth hormone deficiency may occur as an isolated hormonal deficiency or in combination with deficiencies in several pituitary hormones arising from hypopituitarism, tumours in the central nervous system, cranial irradiation or other physiological causes. **Turner syndrome** is a chromosomal disorder characterised by the complete or partial lack of one X chromosome in girls. The two most common clinical features are short stature and ovarian failure. Girls with Turner syndrome do not have a deficiency in human growth hormone, although they may have a relative lack of sensitivity to human growth hormone because of haploinsufficiency of the short stature homeobox-containing gene. **Prader–Willi syndrome (PWS)** is a genetic disorder caused by an abnormality of chromosome 15. Common clinical characteristics include hypogonadism, short stature, hypotonia, dysmorphic features, hypoventilation, changes in body composition, obesity and obesity-related diseases, and behavioural problems. **Chronic renal insufficiency (CRI)** which may include end-stage renal disease, is defined as a persistent elevation of serum creatinine and/or urea. It can be caused by a variety of conditions, including congenital disorders, glomerular disorders and infections. Growth failure associated with CRI usually begins when the glomerular filtration rate falls to 50% of normal. **Small for gestational age (SGA)** can be defined as: • a height at birth that is 2 standard deviations or more below the population average, or • a weight at birth that is 2 standard deviations or more below the population average, or • a weight at birth below the 10th percentile. The diagnosis of small for gestational age requires accurate assessment of gestational age and valid data from a reference population **Short stature homeobox-containing gene (SHOX) deficiency**: The short stature homeobox-containing gene (SHOX) is located on the distal ends of X and Y chromosomes and plays a role in long bone growth. Normal growth requires two functional copies of the gene. Consequently, growth impairment can occur if one copy of the SHOX gene has been inactivated by mutation or deleted (haploinsufficiency). SHOX deficiency can cause short stature in people with conditions such as Turner syndrome, Leri–Weil syndrome and dyschondrosteosis. Human growth hormones are recommended as a treatment option for children with growth failure associated with the following conditions: Somatropin - Growth hormone deficiency - Turner syndrome - Prader-Willi syndrome - Chronic renal insufficiency

- Born small for gestational age with subsequent growth failure at 4 years of age or later
- Short stature homeobox-containing gene (SHOX) deficiency

Somapacitan
- Growth hormone deficiency

Somatrogon
- Growth hormone deficiency

Where multiple brands and agents are available for the treatment of growth hormone deficiency disorders, the choice of product should be made on an individual basis after informed discussion between the responsible clinician and the patient and/or their carer about the advantages and disadvantages of the products available, taking into consideration therapeutic need and the likelihood of adherence to treatment.

Place in Therapy

- **Growth Hormone Deficiency** – Somatropin, somapacitan or somatrogon should be started as clinically indicated
- **Turner Syndrome** - Somatropin should be considered from 2 years of age
- **Chronic Renal Impairment** - nutritional support and metabolic abnormalities have to be optimised and steroid therapy has to be reduced to minimum before starting somatropin.
- **Prader-Willi Syndrome** - Somatropin should be considered from 18 months onwards until bones fused, in combination with an energy restricted diet.
- **Small for Gestational Age** – Somatropin can be considered in short children with growth disturbance who were born Small for their gestational age, whose growth has not caught up by the age of 4 years or later.
- **Short stature homeobox-containing gene (SHOX) deficiency**- Somatropin should be prescribed for patients who have growth failure associated with SHOX deficiency, as confirmed by DNA analysis

Indications

Note if indication is unlicensed or not

Somatropin
- Growth hormone deficiency
- Turner syndrome
- Prader-Willi syndrome
- Chronic renal insufficiency
- Born small for gestational age with subsequent growth failure at 4 years of age or later
- Short stature homeobox-containing gene (SHOX) deficiency

Somapacitan
- Growth hormone deficiency

Somatrogon
- Growth hormone deficiency

Initiation and ongoing dose regime

Somatropin

THIS MEDICATION MUST BE PRESCRIBED AND DISPENSED BY BRAND NAME

The product license and approved indication for treatment in SEL is as follows:

Product –Manufacturer	GHD	TS	CRI	PWS	SGA	SHOX
NutropinAq- Ipsen	√	√	√			
Humatrope- Lilly	√	√	√		√	√
Norditropin- Novo	√	√	√		√	
Genotropin- Pfizer	√	√	√	√	√	
Saizen- MerckSerono	√	√	√		√	

Omnitrope – Sandoz	√	√	√	√	√	

The choice of product should be made on an individual basis after informed discussion between the responsible clinician and the patient and/or their carer about the advantages and disadvantages of the products available, taking into consideration therapeutic need and the likelihood of adherence to treatment.

Note:

- 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

Growth Hormone is usually given as a subcutaneous injection at night to mimic the child's natural fluctuations in growth hormone. Doses can be adjusted based on response.

Growth Hormone Deficiency

23-39 micrograms/kg daily, or 0.7-1 mg/m^2 daily

Turner Syndrome

45-50 micrograms/kg daily, or 1.4 mg/m^2 daily

Chronic Renal Impairment

45-50 micrograms/kg daily, or 1.4 mg/m^2 daily.

Prader-Willi Syndrome

35 micrograms/kg daily or 1 mg/m^2 daily; max 2.7 mg daily

Small for Gestational Age

Ages 4 – 17 years: 35 micrograms/kg daily or 1mg/m^2 daily

Short stature homeobox-containing gene (SHOX)

45-50 microgram/kg daily or 1.4 mg/m^2 daily

Somapacitan

Growth Hormone Deficiency

Age 3-17 years: Initially 160 micrograms/kg ONCE weekly, dose to be given same day each week.

Somatrogon

Growth Hormone Deficiency

Age 3-17 years: Initially 660 micrograms/kg ONCE weekly, dose to be given same day each week.

<table>
<tr><td></td><td colspan="2">Duration of treatment

Growth Hormone therapy should be discontinued in children with Turner Syndrome, SHOX, SGA and PWS by the consultant in consultation with the patient and/or carer, giving due consideration to likely final height and other clinical issues. The consultant will make the final decision to stop therapy and will inform the GP.

Patients with Childhood onset growth hormone deficiency can continue GH treatment in accordance with NICE technology appraisal.

In children with PWS, evaluation of response to therapy should also consider body composition (NICE).

In children with CRI, GH treatment should be stopped after renal transplantation, subject to restoration of normal renal function.</td></tr>
<tr><td>Pharmaceutical aspects – refer to the SEL paediatric formulary for further details</td><td>Route of administration
Formulation
Administration details</td><td>Subcutaneous injection
Pre-filled injection/Solution for injection
Inject into the thigh or abdomen, or upper arm or buttocks (if not self-administered); rotate injection site.

If more than one injection is required to deliver a complete dose, each injection should be administered at a different injection site.</td></tr>
<tr><td>Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist</td><td colspan="2">Regular assessment of growth response by a specialist in child growth at intervals: usually every 3-4 months during the first year.

If the response to treatment is satisfactory, the interval between assessments may be extended to six months.

Thyroid function annually or when indicated.

Bone age assessment when indicated.

Assessment of pituitary status as other deficiencies may evolve.

Sex hormone replacement to induce puberty at the normal timing if indicated.

Examining patients with GHD secondary to an intracranial lesion for evidence of progression or recurrence of underlying disease</td></tr>
<tr><td>Ongoing monitoring requirements to be undertaken by primary care</td><td>Monitoring

Report to the specialist centre any adverse events or significant medical conditions presented by the patient.

Reporting of changes or additions to patient's other medication (if any).</td><td>Frequency

As required</td></tr>
<tr><td>Adverse effects and management

Any serious adverse reactions should be reported</td><td>Result

GH therapy is safe and adverse effects are uncommon with recommended dosages, but include these listed below.

Local discomfort at the site of injection has</td><td>Action for GP

Advise the family to withhold growth hormone (if any doubt) until specific instructions from the paediatric endocrine specialist team.</td></tr>
</table>

to the MHRA via the Yellow Care scheme www.mhra.gov.uk/yellowcard	been reported and frequent subcutaneous injection into the same site may result in tissue atrophy. This can be avoided by varying the injection site. Headache may be noted transiently in some patients on higher dosage regimens. Rarely benign intracranial hypertension has been reported but this can be detected by fundoscopy. Oedema may be exacerbated in Turner's syndrome but is rare in other patients. Hypothyroidism has been reported in 5-10% of patients undergoing treatment with GH. This may be a result of the natural history of hypopituitarism due to the associated deficiency of TSH. It is essential to correct any deficiency with levothyroxine if the optimal response to GH treatment is to be achieved. GH exerts effects on both carbohydrate and lipid metabolism. It is both anabolic and diabetogenic and, in theory, hyperglycaemia and ketosis may occur but is rarely seen in practice. In children with existing diabetes mellitus, glycaemic control and insulin therapy may need readjustment; the induction of insulin resistance is also a rare occurrence. Antibody development has been observed in some patients. It rarely affects the clinical response to treatment. Acute leukaemia has been reported both in untreated GHD children and GH treated children. Studies show that there is no increased incidence over standard population data so these reports are chance associations. The incidence in treated children is not higher even in children who have had leukaemia previously or a bone marrow transplant. **Interaction with other medications** Corticosteroids in supraphysiological doses may interfere with the growth promoting actions of GH. Children with co-existing adrenocorticotropic hormone (ACTH) deficiency should have their glucocorticoid replacement dose carefully adjusted to avoid an inhibitory effect on growth. Titration of doses should be managed by a specialist Consultant. Oral hypoglycaemics and insulin therapy. Diabetic patients may require their glycaemic control measures reviewed to take account of the hyperglycaemic effects	Inform the paediatric endocrine specialist team Families usually have contact details for the paediatric endocrine specialist team and will usually reach out directly. They are given clear instructions at the start of growth hormone.

	of GH.
Advice to patients and carers 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.	**The patient should be advised to report any of the following signs or symptoms to their GP without delay:** • Headache, change in vision or behaviour • Curvature in the spine • Pain in the hip and knees, Walking with a limp • Excessive thirst and frequent urination particularly if at night
Criteria for stopping treatment e.g. poor response, adverse effects requiring cessation	In patients with Turner syndrome, SHOX, SGA or idiopathic isolated GH deficiency treatment should be reviewed after the first year. In any of the indications, if there is a poor response, i.e. < 50% increase in growth rate, or if compliance or growth rate remains poor despite optimisation of GH treatment dose, then GH should be discontinued in line with NICE guidance. Treatment can otherwise continue until height velocity is < 2cm/year, assessed over 6-12 months, or once final height has been achieved. The Consultant will make this The decision regarding continuation of treatment will be made by the consultant in consultation with patient and/or carers.
Follow up arrangements e.g. frequency of specialist clinic attendance	4-6 monthly review in specialist endocrine clinic while on growth hormone treatment
Pregnancy, paternal exposure and breast feeding 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 GP and the specialist.	**Pregnancy and breastfeeding:** If pregnant or breastfeeding refer back to specialist as limited information in this patient group, risk/benefit ratio needs to be assessed
Additional information	Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed.
Evidence base for treatment and key references Include hyperlinks to original sources and access dates	Summary of Product Characteristics – available via https://www.medicines.org.uk/emc/ British National Formulary for Children (BNFc) Accessed online August 2025, via MedicinesComplete — Dashboard National Institute for Clinical Excellence (NICE) Technology Appraisal TA188 (2010) Full guidance on the use of human growth hormone (somatropin) in children with growth failure. Overview | Human growth hormone (somatropin) for the treatment of growth failure in children | Guidance | NICE National Institute for Clinical Excellence (NICE) Technology Appraisal TA863 (2023) Somatrogon for treating growth disturbance in children and young people aged 3 years and over. Overview | Somatrogon for treating growth disturbance in children and young people aged 3 years and over | Guidance | NICE National Institute for Clinical Excellence (NICE) Technology Appraisal TA1066 (2025)

	Somapacitan for treating growth hormone deficiency in people 3 to 17 years Overview | Somapacitan for treating growth hormone deficiency in people 3 to 17 years | Guidance | NICE British Society for Paediatric Endocrinology and Diabetes (BSPED). Shared Care Guidelines 2015/2023. Treatment of Children with Recombinant Human Growth Hormone (r-hGH) Shared Care Guidelines: BSPED GH gh-shared-care-guidelines-20240206.pdf Van Pareren 2003 Journal of Clinical Endocrinology & Metabolism 88:3584–3590. De Zegher 2000 Journal of Clinical Endocrinology & Metabolism 85:2816–2821.
To be read in conjunction with the following documents	South East London Paediatric Formulary. Available online at **https://www.clinibee.com/**
Local arrangements for referral Define the referral procedure from hospital to primary care prescriber & route of return should the patient's condition change.	Clinic letter/email request to GP for shared care consideration. Practice letter/email from GP to secondary care

3. COMMUNICATION AND SUPPORT

King's College and Princess Royal Hospitals switchboard: 0203 299 9000	
King's College Hospital contacts: **Consultant Paediatric Endocrinologists** **Dr Ved Arya** **Dr Ritika Kapoor** Kings College Hospital Denmark Hill, London, SE5 9RS **Tel :0203-299-9000 ext 3**	**Tel :0203-299-9000 ext 33431** **Email: ritikakapoor@nhs.net or vedarya@nhs.net**
Medication – Prescribing advice, interactions, availability of medicines **Bansri Bharania** W&C Pharmacy Team Leader King's College Hospital Denmark Hill, London, SE5 9RS	**Tel: 0203-299-9000 ext 39656** **Email: kch-tr.WomenandChildrenPharmacyTeam@nhs.net**

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 South East London shared care prescribing guideline for [insert medicine name] for the treatment of [insert indication]. Treatment was started on [insert date started] and the current dose is [insert dose and frequency]. 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 prescribing guideline, I have carried these out.

I can confirm that the following has happened with regard to this treatment:

[Shared care can only be considered if the following requirements have been met. Please complete all parts of the right hand column to confirm this]	**Specialist to complete:**
The patient has been initiated on this therapy and has been on an optimised dose for the following period of time:	..... *weeks/months*
Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory	*Yes* ☐
The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care	*Yes* ☐
The risks and benefits of treatment have been explained to the patient	*Yes* ☐
The roles of the specialist/specialist team/ Primary Care Prescriber / Patient and pharmacist have been explained and agreed	*Yes* ☐
The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments	*Yes* ☐
I have enclosed a copy of the shared care prescribing guideline which covers this treatment/the SCPG can be found here (insert electronic/ web link)	*Yes* ☐
I have included with the letter copies of the information the patient has received	*Yes* ☐
I have provided the patient with sufficient medication to last until:	.....
I have arranged a follow up with this patient in the following timeframe e.g. within 3 months / 6 months (please specify)	.....

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 could you reply to this request for shared care and initiation of the suggested medication to either accept or decline within 14 days.

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 prescribing guidance and 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 prescribing guideline 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 South East London ICS**,** 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 patient's 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 (Regional Medicines Optimisation Committees) 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 by the initiating specialist**	

	As the patient has not been initiated 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 initiated on this medication the responsibility for providing the patient with their medication remains with you.***	
5.	**Shared Care Prescribing Guideline 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 SCPG, 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. NB: Capacity issues to be discussed with local primary care Medicines Optimisation Team prior to returning this form)**	

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: