**Request to continue prescribing of danazol in primary care**

**Information for the GP Practice**

|  |  |  |
| --- | --- | --- |
| **Urticaria Clinic specialist details** | **GP Details** | **Patient details** |
| Name: | Name: | Surname: |
| Site/clinic initiating: | Address: | Forename: DOB: |
| Tel: | Tel: | Address: |
| Fax: | Fax: | Postcode: |
| Nhs.net email | Nhs.net email: | NHS no: |

**Dear Dr** …………………..

Your patient has been started on danazol for the management of cholinergic urticaria (off-label use).

The patient has completed 3 months of treatment under Specialist care and as per South East London Integrated Medicines Optimisation Committee (SEL IMOC) recommendations, we now request you to take over prescribing and management of this medicine.

**I confirm that the patient: -**

|  |  |  |
| --- | --- | --- |
| 1. | Has been initiated on danazol in line with SEL IMOC recommendations for this drug | 🞏 YES (tick box) |
| 2. | Has tolerated the treatment well and there are no concerns about adverse effects  | 🞏 YES (tick box) |
| 3. | Has shown a suitable clinical response to treatment, appropriate for continued prescribing in primary care | 🞏 YES (tick box) |

**Note: The specialist completing this form MUST answer the 3 questions above before sending this request to the practice**

**Further information:**

|  |  |  |
| --- | --- | --- |
| **Patient parameters** | **Date of test** | **Result** |
| Renal function prior to treatment  |  |  |
| Liver function test (and ultrasound if indicated) prior to treatment * \* Liver ultrasound will occur every 2 years in urticaria clinic as appropriate
 |  |  |
| Full Blood Count prior to treatment  |  |  |
| Lipid function prior to treatment  |  |  |

**Recommended on-going monitoring by the practice**:

* 6 monthly monitoring of FBC, LFTs & renal function.

Markedly impaired hepatic, renal or cardiac function or any state which may be exacerbated by fluid retention is a contraindication to treatment.

* Annual lipids

Discuss any abnormalities with the referring Consultant using the contact details outlined above. Treatment should be stopped if any clinically significant adverse event arises particularly if evidence of papilloedema, headache, visual disturbance (or other signs of raised intracranial pressure), jaundice or other indications of significant hepatic disturbance, thrombosis or thromboembolism.

**Other Notes**

* Patients should preferably continue a non-sedating H1 antihistamine throughout treatment
* Starting dose of danazol is 200mg-400mg (titration to a final dose of 200-600mg once a day as tolerated). All dose alterations will be advised by the specialist team.
* Please refer to the [Summary of Product Characteristics](https://mhraproducts4853.blob.core.windows.net/docs/a693f6af06f2e835cb965700c0bffbfc1f1f1f50) (SPC) and [BNF](https://bnf.nice.org.uk/treatment-summaries/gonadotrophins/#gonadotrophin-affecting-drugs) for full list of cautions, contraindications, drug interactions or further drug specific information

Please contact the specialist **Urticaria** team via the contact details above if you have any questions about the treatment of this patient or the information contained in this letter.

Yours sincerely

**Print Name:**

**References**

1. SEL Urticaria Treatment Pathway – 2025. Available online via SEL IMOC website
2. Danazol Capsules 100mg, Summary of Product Characteristics. Accessed online via MHRA products <https://products.mhra.gov.uk/> (last updated 03/05/2018)

**Request to continue prescribing of danazol in primary care**

**GP PRACTICE RESPONSE: to be completed and signed by the GP if NOT willing to take on prescribing**

**responsibility and returned to the Urticaria specialist:**

This is to confirm that I am not willing to accept prescribing responsibility for danazol in Cholinergic Urticaria for this patient for the following reason:

…………………………………………………………………………………………………………………………..

**GP name: ………………………………GP signature: ………………………………………………Date: ……/….…/…....**