LINCOLNSHIRE CLINICAL COMMISSIONING GROUPS in association with UNITED LINCOLNSHIRE HOSPITALS TRUST AND LINCOLNSHIRE PARTNERSHIP FOUNDATION TRUST

SHARED CARE GUIDELINE: Donepezil, galantamine, rivastigmine and Memantine for the treatment of Alzheimer's disease
Sixth edition (2015)

This shared care guidance replaces the Lincolnshire protocol for the initiation of cholinesterase inhibitors for the treatment of Alzheimer's disease issued May 2009.

General Principles

Shared Care Responsibilities:

In its guidelines on responsibility for prescribing (circular EL (91) 127) between hospitals and general practitioners, the Department of Health has advised that legal responsibility for prescribing lies with the doctor who signs the prescription. (*BNF* 61, March 2011, p. 4)

Aims:

(1) The aim of shared care guidelines is to provide information and/or guidance to GPs and hospital staff relating to the potentially complex implications of sharing patient care for a specific drug between primary and secondary/tertiary care.

(2) Specific shared care guidance should be available for any high cost or high-risk drug therapy or device that may be prescribed for a patient following specialist referral. Such guidance will only be produced where shared care is considered an appropriate option.

(3) Each guideline will include a clear statement of the responsibilities of both the GP and the specialist unit within the overall provision of the treatment to the patient.

(4) Shared care guidelines will ensure that the GP has sufficient information available to undertake to prescribe a specialist treatment if s/he so wishes. It is not the intention of these guidelines to insist that GPs prescribe such treatment and any doctor who does not wish to accept clinical or legal responsibility to prescribe such a drug is under no obligation to do so. Nonetheless the development of a shared care guideline will only be undertaken within the context of a broad acceptance between Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF) and secondary/tertiary care that GP prescribing of such a treatment is appropriate within the constraints of formal shared care. Any drug approved for the development of a shared care guideline will automatically be classified as amber on the Lincolnshire Traffic Lights List and, if high-cost, will be supported financially through the High Cost Drugs Reserve. Thus there should be no financial reason why a GP should be deterred from prescribing a high cost drug under a shared care guideline.

Further copies

Further copies of any guideline in this series are available from NHS Lincolnshire Prescribing Advisers.

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SCA Dementia drugs 03/14
Lincolnshire East CCG
Lincolnshire West CCG
South Lincolnshire CCG
South West Lincolnshire CCG
Lincolnshire Partnership Foundation Trust
United Lincolnshire Hospitals Trust
Greater East Midlands Commissioning Support Unit

Principles of shared care

The General Medical Council published their Good Practice In Prescribing And Managing Medicines and which came into effect 25th February 20. A section of the guidance provides recommendations for the sharing of care which applies to any instance when care is shared between different services.

Good practice recommendation 35.

- Decisions about who and who should take responsibility for continuing care or treatment after initial diagnosis or assessment should be based on patients best interest rather than on convenience or the cost of the medicine and associated monitoring or follow-up

Good practice recommendation 36.

- Shared care requires the agreement of all parties including the patient. Effective communication and continuing liaison between all parties to a shared care agreement is essential.

Good practice recommendation 37.

- If you prescribe at the recommendation of another doctor, nurse or other healthcare professional, you must satisfy yourself that the prescription is needed, appropriate for the patient and within the limits of your competence.

Good practice recommendation 38.

- If you delegate assessment of a patients' suitability for a medicine, you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to make the assessment. You must give them enough information about the patient to carry out the assessment required

Good practice recommendation 39.

- In both cases, you will be responsible for any prescription you sign.

Good practice recommendation 40.

- If you recommend that a colleague, for example a junior doctor or general practitioner, prescribes a particular medicine for a patient, you must consider their competence to do so. You must satisfy yourself that they have sufficient knowledge of the patient and the medicine, experience (especially in the case of junior doctors) and information to prescribe. You should be willing to answer their questions and otherwise assist them in caring for the patient, as required

Good practice recommendation 41

- If you share responsibility for a patient's care with a colleague, you must be competent to exercise your share of clinical responsibility.

You should:

a) Keep yourself informed about the medicines that are to be prescribed for the patient

b) Be able to recognise serious and frequently occurring adverse side effects
c) Make sure appropriate clinical monitoring arrangements are in pace and that the patient and the healthcare professionals involved understand them
d) Keep up to date with relevance guidance on the use of the medicines and on the management of the patient's condition

Good practice recommendation 42

- In proposing a shared care arrangement, specialists may advise the patient's general practitioner which medicine to prescribe. If you are recommending a new or rarely prescribed medicine you should specify the dosage and means of administration and agree a protocol for treatment. You should explain the use of unlicensed medicines and departures from authoritative guidance or recommended treatments and provide both the general practitioner and the patient with sufficient information to permit the safe management of the patient's condition.

Good practice recommendation 43

- If you are uncertain about your competence to take responsibility for the patients continuing care you should seek further information or advice from the clinician with whom the patient's care is shared or from another experienced colleague. If you are still not satisfied you should explain this to the other clinician and to the patient and make appropriate arrangements for their continuing care.

Introduction

In March 2011 the National Institute for Health and Clinical Excellence (NICE) published Technology Appraisal 217 (TA 217), which reviewed the use of donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease. There are significant changes from the recommendations made in the previous NICE technology appraisal NICE TA 111.

- The three acetylcholinesterase (AChE) inhibitors donepezil, galantamine and rivastigmine are now recommended as options for managing mild as well as moderate Alzheimer's disease.
- Memantine is now recommended as an option for managing moderate Alzheimer's disease for people who cannot tolerate AChE inhibitors, and as an option for managing severe Alzheimer's disease.
- NICE has removed the stipulation that treatment should normally only be provided for those patients who satisfied a set clinical criteria based on their Mini Mental State Examination (MMSE) scores.
- NICE has removed the recommendation for a six monthly review by a mental health specialist assessing response to treatment by using MMSE and other assessment tools.

The main recommendations from TA217 are:

- The three acetylcholinesterase inhibitors (AChE) inhibitors donepezil, galantamine and rivastigmine are recommended as options in the management of people with Alzheimer's disease of mild to moderate severity.
- Memantine is recommended as an option for managing Alzheimer's disease for people with moderate disease who are intolerant to or have a contraindication to AChE inhibitors or those with severe disease.
- Treatment should only be initiated by specialists in the care of patients with dementia i.e. psychiatrists including those in learning disabilities, neurologists and physicians specialising in the care of the older people. The carer's view on the patient's condition at baseline should be sought.
- The option to share care is an 'invitation' to the all parties, not an 'expectation' hence the GP retains the right to refuse to prescribe. The consultant also retains the right not to continue prescribing and in this status quo the GP will be solely responsible for the prescribing and monitoring of an alternative medicine.
- Treatment should only be continued if it is considered to be having a worthwhile effect on cognitive, global, functional or behavioural symptoms.
- Patients who continue on treatment should be reviewed regularly using cognitive, global, functional or behavioural assessment. Treatment should be reviewed by a specialist team unless there are locally agreed protocols for shared care. Carers view on the patient's condition at follow-up should be sought.
- If prescribing an AChE inhibitor treatment should be started with the drug of lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started. **Following the introduction of generic products donepezil standard release 5 & 10mg tablets have the lowest acquisition cost and therefore should be the preferred first line AChE inhibitor.**
- However an alternative AChE could be prescribed if considered appropriate when taking into account adverse event profile, expectations about adherence, medical co morbidity, possibility of drug interactions and dosing profiles.
- When using assessment scales for determining the severity of Alzheimer's disease , healthcare professionals should take into account any physical, sensory, learning, communication difficulties (including linguistic) and level of education that could affect the results.
- When assessing the severity of the condition if cognition scores are not an appropriate tool then healthcare professionals should determine the need for initiation or continuation of treatment by using another appropriate method of assessment.

Drug Details

Acetylcholinesesterase inhibitors

Approved name - **Donepezil**
Form and strength: 5mg, 10mg tablets, 5mg, 10mg orodispersible tablets

Approved name - **Galantamine**
Form and strength: 8mg, 12mg tablets; 4mg/ml oral solution;
8mg, 16mg, 24mg modified release capsules
If modified release is require advised to prescribe low cost brands such as Galantex XL or Gatalin XL (please refer to formulary for more detail).

Approved name - **Rivastigmine**
Form and strength: 1.5mg, 3mg, 4.5mg, 6mg capsules: 2mg/ml oral solution; 4.6mg/24hr transdermal patch, 9.5mg/24hr transdermal patch. (Exelon)

NMDA antagonists

Approved name - **Memantine**
Brand Name - Ebixa
Form and strength: 10mg, 20mg tablets, 10mg/ml oral solution

Specialist Responsibilities

The specialist secondary/tertiary care service will:

1. Assess the patient, establish the diagnosis, determine a management strategy and devise a care plan in conjunction with the GP, other healthcare professionals and appropriate support agencies.
2. Interpret or arrange interpretation of electrocardiogram (ECG) if applicable.
3. Seek carer's views as appropriate on the condition of the person with dementia at baseline.
4. Initiate therapy with an acetylcholinesterase inhibitor – donepezil standard release formulations should be used first-line if clinically indicated. **The decision as to which is the most appropriate product to use is the responsibility of the specialist, if a product other than donepezil 5mg or 10mg is to be used, the reason why an alternative agent or formulation is preferred should be detailed in the request for the GP to prescribe**
5. Send a letter to the GP requesting that the GP participates in shared care. As part of the communication the GP should be signposted to where they can find a copy of the shared care protocol e.g. the PACEF website http://lincolnshire-pacef.nhs.uk/lincolnshire-prescribing-and-clinical-effectiveness-forum-pacef

6. There may be occasions when the consultant may initiate treatment but then require the GP to continue to titrate the dose according to response. Alternatively there may be some circumstances when the consultant in agreement with the patient's GP requires the GP to initiate treatment. In these circumstances a written invitation to share the care should still be sent to the GP along with a copy of the shared care protocol along with clear instructions as to the drug and dose required.
7. Send a care plan letter to the GP, detailing the diagnosis, results of baseline assessments, name and dose of the prescribed drug treatment, clear schedule for any further dose titrations and review. This will be shared with the service user.
8. All patients who have been initiated on cognitive enhancers will be followed up for review and on-going management by the CMHT for older adults on a needs led basis.
9. Notify the GP as soon as practical of any changes to drug treatment to ensure that the supply of the patient's medication is maintained. This will include when potentially a patients treatment may change from an acetylcholinesterase inhibitor to memantine.
10. At the point when the treatment is considered not to be providing any further benefit in terms of its effect on cognitive, global, functional or behavioural functions, provide the GP with alternative suggestions on the future management of the patient.

GP Responsibilities

The GP will:

1. Refer patients with suspected dementia to the specialist service after completing basic dementia screening as recommended in the NICE clinical guideline on dementia. Screening should include routine haematology, electrolytes, renal and liver function, thyroid function tests, serum $B_{12,}$ folate levels, mid stream urine and chest X-ray and ECG if deemed necessary.
2. **Notify the consultant in writing, within two weeks, if they do or do not agree to share care.**
3. Monitor the patients overall health, global well-being and functioning including clinical response and side-effects.
4. Prescribe the acetyl cholinesterase inhibitor –usually generic donepezil unless otherwise directed/ memantine for the patient on the written instruction (GP letter or fax) of the specialist team.
5. Liaise with the consultant/ specialist team regarding any complications of treatment.
6. Involve the specialist team if the GP considers discontinuation of treatment is necessary.

Licensed Indications
(Ref: Aricept Summary of Product Characteristics

Donepezil is licensed for the symptomatic treatment of mild to moderately severe Alzheimer's dementia.

(Ref: Reminyl/ Reminyl XL & Reminyl Oral Solution Summary of Product Characteristics

Galantamine is licensed for the symptomatic treatment of mild to moderately severe dementia of the Alzheimer type.

(Ref: Exelon Summary of Product Characteristics

Rivastigmine is licensed for the symptomatic treatment of mild to moderately severe Alzheimer's dementia and for the symptomatic treatment of mild to moderately severe dementia in patients with idiopathic Parkinson's disease.

(Ref: Ebixa Summary of Product Characteristics

Memantine is licensed for the moderate to severe dementia in Alzheimer's disease.

Recommended Dosage and Administration

Donepezil

Initially 5mg once daily at bedtime increased if necessary at one month to 10mg daily. Maximum daily dose is 10mg.

The 5mg daily dose should be maintained for at least one month to allow for the earliest clinical response to treatment to be assessed and to allow for the steady-state concentrations of donepezil to be achieved.

Galantamine

Galantamine tablets and oral solution

Initially 4mg twice daily (preferably with morning and evening meals) for four weeks increasing then to 8mg twice daily. The initial maintenance dose is 8mg twice daily (16mg a day) and patients should be maintained on this dose for at least four weeks. An increase to a maintenance dose of 12mg twice daily (24 mg a day) should be considered after appropriate assessment including evaluation of clinical benefit and tolerability. In patients not showing an increased response to this dose, a reduction back to 8mg twice daily should be considered.

Galantamine modified release capsules (Reminyl XL).

Initially 8mg daily (preferably with morning meals) for four weeks increasing then to 16mg daily. The initial maintenance dose is 16mg daily and patients should be maintained on this dose for at least four weeks.

An increase to a maintenance dose of 24mg daily should be considered after appropriate assessment including evaluation of clinical benefit and tolerability. In patients not showing an increased response to this dose, a reduction back to 16mg a day should be considered.

Galantamine doses will need to be reduced in patients with moderately impaired hepatic function.

Rivastigmine

Initially 1.5mg twice daily, with morning and evening meals, increased in steps of 1.5mg twice daily at intervals of at least 2 weeks according to response and tolerance. Usual dose range 3 -6mg twice daily. Maximum dose 6mg twice daily. The capsules should be swallowed whole. Rivastigmine oral solution and capsules may be interchanged at equal doses.

If treatment is interrupted for more than several days it should be re-initiated at 1.5mg twice daily and dose titration carried out as described above.

Transdermal

Treatment should be initiated with the 4.6mg/24hr patch. After a minimum of four weeks and if well tolerated the dose should be increased to the 9.5mg/24hour patch, which is the recommended effective dose. Maintenance treatment should be temporarily interrupted if gastrointestinal adverse effects are observed until these adverse effects resolve. Transdermal treatment can be resumed at the same dose if treatment is not interrupted for more than several days, otherwise treatment should be re-initiated with 4.6mg/24hr patches.

Switching: Patients on oral doses of not more than 6mg/day can be switched to 4.6mg/24hr patches. Those on 9mg/day in whom the dose has not been stable or well tolerated can be switched to the 4.6mg/24hr patch. Those on an oral dose of 9mg/day in whom the dose is well tolerated, or those on 12mg/day can be switched to the 9.5mg/24hr patch. After a minimum of four weeks of treatment with the

4.6mg/24hr patch, if well tolerated, the dose should be increased to the 9.5mg/24hr patch which is the recommended effective dose. It is recommended to apply the first transdermal patch on the day after the last oral dose

Memantine

Initially 5mg daily increased in steps of 5mg at weekly intervals to a maximum daily dose of 20mg.

Background Pharmacology

Donepezil, galantamine and rivastigmine are all reversible inhibitors of acetylcholinesterase and galantamine also has nicotinic receptor agonist properties. Neurochemical studies in Alzheimer's disease has shown a wide spread loss of several neurotransmitters associated within the cerebral cortex and hippocampus. Studies have shown that the cognitive impairment that is associated with Alzheimer's disease is due to a disorder affecting cholinergic neurones. Whilst the widespread nature of the neurotransmitters deficits suggests it is difficult to devise a replacement therapy, studies have shown that increasing acetylcholine function may benefit cognitive function in some patients.

Memantine is a glutamate receptor antagonist which can prevent the pathological stimulation of NMDA receptors.

The glutamatergic neurotransmitter system plays a crucial role in memory formation and information processing. Disturbances in the system contribute to the manifestations of the symptoms of Alzheimer's disease.

Memantine blocks the effect of excessive glutamate thus restoring physiological signal transmission.

Adverse Effects

Donepezil

Most commonly: nausea, vomiting, anorexia, diarrhoea, fatigue, insomnia, headache, dizziness, syncope, hallucinations, agitation, aggressive behaviour, muscle cramps, urinary incontinence, susceptibility to the common cold, rash and pruritis.

Less frequently: bradycardia, convulsions, gastric and duodenal ulcers and gastro-intestinal haemorrhage.

Rarely: sino-atrial block, AV block, liver dysfunction including hepatitis and potential for bladder outflow obstruction.

Galantamine

Most commonly: nausea, vomiting, diarrhoea, abdominal pain, dyspepsia, syncope, rhinitis, susceptibility to urinary tract infections, sleep disturbance, dizziness, confusion, depression, headache, fatigue, malaise, tremor, asthenia, fever, anorexia and weight loss.

Less frequently: arrhythmias, palpitations, myocardial infarction, myocardial ischaemia, cerebrovascular disease, transient ischaemic attacks, paraesthesia, tinnitus and leg cramps.

Rarely: bradycardia, seizures, hallucinations, agitation, aggression, dehydration, hypokalaemia, and rash.

Very rarely: gastrointestinal bleeding, dysphagia, hypotension, AV block, sweating and exacerbation of Parkinson's disease.

Rivastigmine

Adverse effects may occur particularly when initiating therapy or increasing the dose.
Most commonly: nausea, vomiting, diarrhoea, dyspepsia, anorexia, abdominal pain, dizziness, headache, fatigue, drowsiness, tremor, asthenia, malaise, agitation, confusion, sweating and weight loss.
Less frequently: syncope, depression and insomnia
Rarely: gastric or duodenal ulceration, rashes, angina pectoris and seizures
Very rarely: gastrointestinal haemorrhage, pancreatitis, elevated liver function tests, cardiac arrhythmias, bradycardia, hypertension, hallucinations, extrapyramidal symptoms (including worsening of Parkinson's disease).

Memantine

Common adverse effects are constipation, hypertension, dyspnoea, headache, dizziness and drowsiness. Less commonly vomiting, thrombosis, heart failure, confusion, fatigue, hallucinations and abnormal gait. Very rarely seizures, pancreatitis, psychosis, depression and suicidal ideation.

Drug Interactions

All anticholinesterase inhibitors will act additively with other anticholinesterase and cholinergic drugs and oppose the actions of anticholinergic drugs.

Donepezil

Muscle Relaxants -possibly enhances the effects of suxamethonium and possibly antagonises effects of non-depolarising muscle relaxants.

Galantamine

May cause bradycardia and therefore may enhance effects of other medication that reduce the heart rate including digoxin and beta blockers.
Muscle relaxants - enhances the effects of suxamethonium.
Paroxetine increases bioavailability of galantamine by about 40% because it inhibits CYP2D6 increasing risk of galantamine side effects particularly nausea and vomiting. Manufactures advise a dose reduction of galantamine if this should occur. There is also a potential for similar interactions with other CYP2D6 inhibitors such as fluoxetine, fluvoxamine and quinidine.
Ketoconazole & erythromycin increase plasma concentration of galantamine due to CYP3A4 inhibition. Manufacturers warn of potential similar interactions with other CYP3A4 inhibitors such as ritonavir.

Rivastigmine

Muscle relaxants - enhances the effects of suxamethonium and antagonises effects of non-depolarising muscle relaxants.
Should not be used with other cholinomimetic drugs such as tacrine because of possible additive effects.
As an anticholinesterase it is expected to oppose the activity of anticholinergic drugs.

Memantine

General anaesthetics - memantine increases risk of CNS toxicity.
Ketamine – avoid concomitant use.
Analgesics – increased risk of CNS toxicity, manufacturer advises avoid concomitant use with dextromethorpan.

Dopaminergics. Memantine enhances the effect of dopaminergics and selegiline. There is also increased risk of CNS toxicity if used with amantadine.
The BNF also advises caution if prescribed with the following:
Warfarin – memantine possibly enhances its anticoagulant effect
Antiepileptic - memantine possibly reduces the effect of primidone.
Antimuscarinics – memantine possibly enhances the effect.
Antipsychotics – memantine possibly reduces the effect.
Barbiturates - reduces the effects.
Muscle relaxants – possibly modifies the effect of baclofen and dantrolene.

Precautions

Donepezil

Sick sinus syndrome and other supraventricular conduction abnormalities, susceptibility to peptic ulcers including those on concurrent NSAIDs, asthma, chronic obstructive pulmonary disease, hepatic impairment, may exacerbate extrapyramidal symptoms, history of seizures.

Galantamine

Cardiac disease (including sick sinus syndrome or other supraventricular conduction abnormalities, unstable angina, congestive heart failure), electrolyte disturbances, susceptibility to peptic ulcers, asthma, chronic obstructive pulmonary disease, pulmonary infection, hepatic impairment, pregnancy, avoid in urinary retention, gastro-intestinal obstruction and those recovering from gastrointestinal or bladder surgery, may worsen Parkinsonian symptoms.

Rivastigmine

Gastric or duodenal ulcers (or susceptibility to ulcers), monitor body-weight, sick sinus syndrome, conduction abnormalities, history of asthma or chronic obstructive pulmonary disease, history of seizures, bladder outflow obstruction, hepatic impairment avoid if severe, renal impairment, pregnancy, may worsen Parkinsonian symptoms.

Memantine

Should be used with caution if history of convulsions.

Contraindications

All - A known hypersensitivity to the named acetylcholinesterase inhibitor or any of the excipients used in the formulation.

Donepezil

Pregnancy and breast- feeding.

Galantamine

Severe hepatic and renal impairment; breast-feeding.

Rivastigmine

Breast-feeding, severe hepatic impairment.

Memantine

Severe hepatic impairment

Monitoring

Response to treatment needs to be periodically reviewed by assessing effectiveness on cognitive, global, functional or behavioural symptoms.

All assessments measuring response to treatment are the responsibility of the consultant/ specialist team.

Treatment will be monitored on a needs led basis by the older adult CMHT.

It is the responsibility of the specialist services to advice regarding discontinuation of medication.

Details are provided on page 9 of this protocol of the contact details of the specialist teams and the approximate geographical areas that they cover.

It is also recommended that the view of the carers is sought prior to the patient commencing treatment and at each follow-up review with the specialist.

Indication of Likely Cost of Therapy in Primary Care (28 days)

Donepezil tabs 5mg once daily	£1.33
Donepezil tabs 10mg once daily	£1.70
Donepezil orodispersible 5mg once daily	£6.84
Donepezil orodispersible 10mg once daily	£9.14
Galantamine tabs 8mg twice daily	£60.40
Galantamine tabs 12mg twice daily	£74.10
Galantamine oral solution (Reminyl) 4mg/ml 100ml	£120.00
Galantamine caps (Reminyl XL) 8mg once daily	£51.88
Galantamine caps (Reminyl XL) 16mg once daily	£64.90
Galantamine caps (Reminyl XL) 24mg once daily	£79.80
Galatamine cap (Gatalin XL) 8mg once daily	£25.94
Galatamine cap (Gatalin XL) 16mg once daily	£32.45
Galantamine cap (Gatalin XL) 24mg once daily	£39.90
Galatamine cap (Galantex XL) 8mg once daily	£25.42
Galatamine cap (Galantex XL) 16mg once daily	£31.80
Galantamine cap (Galantex XL) 24mg once daily	£39.10
Rivastigmine caps 1.5mg twice daily	£6.14
Rivastigmine caps 3mg twice daily	£6.22
Rivastigmine caps 4.5mg twice daily	£34.66
Rivastigmine caps 6mg twice daily	£32.76
Rivastigmine oral solution (Exelon) 2mg/ml 120ml	£96.85
Rivastigmine transdermal patch 4.6mg/24hr	£77.97
Rivastigmine transdermal patch 9.5mg/24hr	£42.39
Memantine 10mg tablets 10mg daily	£2.48
Memantine tablets 20mg daily	£3.72
Memantine 10mg/ml oral solution 50ml	£62.67

(Taken from March 2015 Drug Tariff)

Appendix A Invitation to Shared Care.
Agreement for Transfer of Prescribing to GP for the Treatment with Acetylcholinesterase Inhibitors or Memantine

Patient details / addressograph label

Name ……

Address ……

……

DOB …… NHS Number ……

Date seen / last follow up: _____

Follow up arrangements: _____

Diagnosis: _____

Assessments, investigations and tests that have been carried out:

Presenting Problems:

Personal History:

Past Psychiatric History:

Past Medical History:

Family History:

Current Medication:

Investigations and tests:

Test 1: _____ Date:
Test 2: _____ Date:
Test 3: _____ Date:
Test 4: _____ Date:

Summary of Test Results: _____

_____

_____

_____

_____

Management Plan:

Impression: _____

Drug name: _____

Drug dose: _____

Date medication to initiate: _____

Titration Regime: _____

Side-effects expected and advice on their management _____

_____

_____

Consultant: Address: Contact Number:	**Agreement to shared care, to be signed by GP and Consultant before transfer of care to GP.** **Consultant Signature:** **……** **Date:**
GP: Address: Contact Number:	
Main Carer / parent / guardian: Name: Contact Number:	**GP Signature:** **……** **Date:**
Key worker if appropriate: Name: Contact Number:	

The GP has the right to refuse to agree to shared care, in such an event the total clinical responsibility will remain with the consultant. The GP should then discuss alternative arrangements with the responsible consultant.

Contact details

For support to patients (Care Coordinators)

Lincoln - Angie Spencer
Team Coordinator
Witham Court
Tel 01522 508332

Grantham/Sleaford – Gail Harvey
Team Coordinator
Manthorpe Centre
Grantham Hospital
Tel 01476 591676

Boston/Skegness – Jason Ingamells
Team Coordinator
Skegness Resource Centre
Tel 01754 769859

Spalding – Rob Van Duyn
Team Coordinator
Johnson Community Hospital
Tel 01775 652000

Louth – Christopher Rooney
Team Coordinator
Windsor House
Louth
Tel 01507 6083109

For advice regarding medication

Specialist Mental Health Pharmacy Service
Gervas House
Long Leys Road
Lincoln
LN1 1EJ
Tel No 01522 577000 ext. 7563

Lincoln – Dr C Esiwe
Consultant Psychiatrist & Interim Clinical Director
Lincolnshire Partnership NHS Foundation Trust
Witham court
Tel no 01522 500690

Grantham – Dr B Al-Kaissy
Consultant Psychiatrist
Lincolnshire Partnership NHS Foundation Trust
Manthorpe Centre
Tel 01476 591544

Boston – Dr M Sharma
Consultant Psychiatrist
Lincolnshire Partnership NHS Foundation Trust
Department of Psychiatry at Pilgrim Hospital
Tel 01205 446510

Skegness – Dr V Waykar
Consultant Psychiatrist
Lincolnshire Partnership NHS Foundation Trust
Skegness Resource Centre
Tel 01754 769859

References:

British National Formulary Number 66, September 2013 - March 2014.
SPC Aricept®, Eisai Limited. eMC website. Updated 27/07/10
SPC Aricept Evess ®, Eisai Limited. eMC website. Updated 27/07/10
SPC Reminyl®,Shire Pharmaceuticals Limited. eMC website. Updated 08/06/10.
SPC Reminyl XL® Shire Pharmaceuticals Limited. eMC website. Updated 06/09/10.
SPC Exelon®, Novartis Pharmaceuticals UK Limited eMC website. Updated 02/06/10.
SPC Ebixa® ,Lundbeck Ltd. eMC website
NICE Clinical Guideline 42 - Dementia – supporting people with dementia and their carers in health and social care. Issued November 2006.
NICE Technology Appraisal Guidance 217 – Donepezil, galantamine, rivastigmine and memantine (review) for the treatment of Alzheimer's disease.

Compiled on behalf of Lincolnshire Partnership Trust Medicines Management Committee, United Lincolnshire Hospital Trust and NHS Lincolnshire by:

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