NORTH DERBYSHIRE HEALTH PRESCRIBING AND NEW TECHNOLOGIES STRATEGY GROUP (PANTS) AND SHARED CARE GROUPS

SHARED CARE AGREEMENT

Drug Treatment of Alzheimer's Disease (NICE Guidance No. 19)

1. REFERRAL CRITERIA

- Shared Care is only appropriate if it provides the optimum solution for the patient.
- Prescribing responsibility will only be transferred when it is agreed by the consultant and the patient's GP that the patient's condition is stable or predictable.
- Patients will only be referred to the GP once the GP has agreed in each individual case.
- The patient will be given a supply of ____________________ sufficient for 4 weeks maintenance therapy.

2. AREAS OF RESPONSIBILITY

GP responsibilities	Consultants responsibilities
ONLY reasonable to refer for consideration of prescribing if : • patient has mild to moderate dementia (MMSE score >12) • exclude if possible vascular dementia/ reversible causes of confusion (Appendix 1) • a carer or care-worker is available to ensure compliance with treatment • patient/carer realises treatment will be stopped if no convincing evidence of benefit at 12 weeks • willing to continue prescribing after intitial 12 weeks • a GP who has discussed the benefits of the drug with the patient/carer and has agreed with them that pursuing such treatment is <u>not</u> appropriate should make this clear in any referral letter requesting other psychogeriatric help. # prescribing following stabilisation of patient # monitoring patient's overall health and well-being. # monitoring adverse effects and interactions	• only initiate prescribing in mild to moderate AD,usually in those with a MMSE score above 12. • obtain views of patient and carer on treatment and evaluate likely compliance • total prescribing and assessment for the first 12 weeks • prescribing to continue after 12 weeks only where there has been an improvement or no deterioration in MMSE score, together with evidence of global improvement on the basis of behavioural and/or functional assessment • transfer prescribing to GP ensuring patient has a minimum of 4 weeks supply of drug • review patient every 6 months – drug should normally only be continued if MMSE remains above 12 and where global, functional and behavioural condition remains at a level where drug is having a worthwhile effect • if MMSE score falls below 12, drug should normally be stopped and patient reassessed

3. COMMUNICATION AND SUPPORT

i. Hospital contacts: Name: Dr. J. R. Sykes (Chesterfield) Dr. M. Whittingham (Clay Cross/The Dales) Dr. T. De (N.E. Derbyshire & Bolsover)	Dr. Kate Hayden (High Peak) Dr. B. B. Dhomma
Telephone No: 01246-552864	01298-212840
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ii Specialist support/resources available : Alzheimer's Society Telephone – 020 7306 0606 E-mail – info@alzheimers.org.uk Web site – www.alzheimers.org.uk

4. CLINICAL INFORMATION

i. Prescribed indications	Mild to moderate Alzheimer's Disease
ii. Therapeutic summary	Compared with placebo, typical average improvements in ADAS-cog of 2-3 points (out of 70) and of 1-2 in MMSE (out of 30), over 6 months are usual.
iii. Dose & Route of administration	Oral: Donepezil 5mg (£891 pa) or 10mg (£1248 pa) daily Galantamine 8mg (£876 pa) or 12mg (£1049 pa) twice daily Rivastigmine 3-6mg twice daily (all doses £821 pa)
iv. Duration of treatment	For as long as effective – see first page
v. Adverse effects	Possible vagotonic effects on heart rate Diarrhoea, muscle cramps, fatigue, nausea/vomiting, insomnia, abdominal pain
vi. Monitoring Requirements	See first page Caution in patients at risk of developing peptic ulcers; history of asthma or COAD; heart block
vii. Clinically relevant drug interactions	Should not be given with other cholinomimetic drugs. Might interfere with activity of anticholinergics. See individual SPCs for specific drugs.
viii. Supply of ancillary equipment eg. syringe drivers, tubing	N/A
ix. Supply, storage and reconstitution instructions	Store below 30°C
x. Prepared by Peter Burrill, Senior Pharmaceutical Adviser, North Derbyshire Health Authority, in conjunction with Consultants listed in contact details. **Date Prepared: May 2001 Review Date: May 2002**	

This does not replace the SPC, which should be read in conjunction with it.

__Appendix 1__ Reversible causes of confusion: depression; effects of medication; physical disease – so do : FBC, ESR, B12, U & Es, Thyroid function, LFT including calcium, syphilis serology, urine examination, BP, ECG, RBC folate.