NOTTINGHAMSHIRE AREA PRESCRIBING COMMITTEE
SHARED CARE PROTOCOL AGREEMENT

MANAGEMENT OF DERMATOLOGICAL CONDITIONS WITH DISEASE-MODIFYING ANTI-RHEUMATIC MEDICATIONS IN ADULTS

OBJECTIVES

- **Provide a summary of information on DMARDs for refractory eczema, severe psoriasis, connective tissue disease and lichen planus to GPs**
- **Define the patient's referral procedure from hospital to GP and vice versa**
- **Define the back-up care available from the Dermatology department**

REFERRAL CRITERIA

- Prescribing responsibility will only be transferred when it is agreed by the specialist and the patient's primary care prescriber that the patient's condition is stable.

REFERRAL PROCESS

- The request for shared care should be accompanied by individual patient information, outlining all relevant aspects of the patients' care including:
  - Diagnosis of the patient's condition with the relevant clinical details
  - Details of treatment to be undertaken by the GP.*

  **Including reasons for choice of treatment, medicine or medicine combination, frequency of treatment (including day of the week if weekly treatment), number of months of treatment to be given before review by the consultant.*
  - Details of the patient's treatment to date (if relevant).
  - Date that treatment was started for each medicine being transferred to shared care.
  - Details of any recent dose changes (in the past 6 months).
  - Details of all other treatments being received by the patients that are not included iin the shared care – e.g. steroid, analgesics etc.
  - Details of monitoring arrangements.
  - Allergies
  - Identified interactions and any action undertaken.
  - Details of medication supplied and when the patient is due to need a new supply.
  - Details of influenza and/or pneumococcal vaccines given (to ensure that vaccinations are not duplicated).
  - Direction to the information sheets at www.nottsapc.nhs.uk.
- If the GP does not agree to the shared care for the patient then he/she will inform the Specialist of this decision in writing within 14 days.
- In the interim, the clinical responsibility and supply of the medicine under issue to the patient will be retained by the prescriber who initiated the treatment.
- In cases where shared care arrangements are not in place or where problems have arisen within the agreement and patient care may be affected, the responsibility for the patient's management including prescribing reverts back to the specialist.

BACKGROUND INFORMATION

Methotrexate and azathioprine may be used to treat severe or troublesome psoriasis and eczema, where other treatments are ineffective or inappropriate. Improvement usually occurs within 6-8 weeks.
Hydroxychloroquine may be used to treat connective tissue diseases and lichen planus/lichen planopilaris. Stabilisation, and sometimes improvement of the condition may occur within three months. Patients will usually be advised to continue with topical treatment while awaiting full benefit.

CONDITION TO BE TREATED

Chronic plaque psoriasis and refractory eczema
Connective tissue disease, lichen planus and lichen planopilaris

AREAS OF RESPONSIBILITY

The Dermatologist will be responsible for:-

- Investigations before starting therapy. Enquire about any history of varicella zoster. If no known history then the patient should be tested for this. If there is a previous history of varicella zoster, then there is no need for a test. If no antibodies, patients should be offered vaccination. Offer HIV and Hepatitis B and C testing for patients commencing methotrexate and azathioprine.
- Confirming the working diagnosis, initial dosing and monitoring of DMARD.
- When a satisfactory response is obtained, the patient is referred to the Clinical Nurse Specialist.
- Ensure that the patient has an adequate supply of medication (usually 28 days) until the shared care arrangements are in place. Further prescriptions will be issued if, for unseen reasons, the arrangements for the shared care are not in place at the end of 28 days. Patients should not be put in a position where they are unsure where to obtain supplies of their medication.
- Review patients annually including reviewing the blood results from the previous 12 months and send a written summary within 14 days to the patient's GP.
- The specialist team will be able to provide training for primary care prescribers if necessary to support the shared care agreement.

The dermatology clinical nurse specialist will be responsible for:

For methotrexate and azathioprine:

- Monthly review for up to three months.
- Monitoring of therapy for the first three months of treatment.
- At three-monthly review if the patient is stable, arrange a shared care with the GP, highlighting the relevant patient information and the necessary monitoring.
- Send direction to Shared Care Protocol at www.nottsapc.nhs.uk to GP with patient's clinical and medicine history.
- Dose increases/decreases if required.
- For patients taking methotrexate, documenting dose and blood results in the patient's monitoring book.
- Arranging patient's yearly appointment with the Dermatology Consultant.
- Contact details for primary care prescribers for during working and non-working hours will be made available.
- Details for fast track referral will be supplied.
- Provide the patient with details of their treatment, follow-up appointments, and monitoring requirements.

For hydroxychloroquine, nurse review not required.

Primary care prescribers' roles and responsibilities

The GP will be responsible for:

1. Ensuring that he/she has the information and knowledge to understand the therapeutic issues relating to the patient's clinical condition.
2. Undergoing any additional training necessary in order to carry out a practice based service.
3. Agreeing that in his/her opinion the patient should receive shared care for the diagnosed condition unless good reasons exist for the management to remain within secondary care. If the GP does not agree to the shared care for the patient then he/she will inform the specialist of his/her decision in writing within 14 days.
4. Prescribing the maintenance therapy in accordance with the written instructions contained within the GP information sheets, and communicating any changes of dosage to the patient.
5. It is the responsibility of the clinician actioning the results from monitoring, in accordance with this shared care guideline, and thereby prescribing for the patient to complete the patient's record with the necessary information.
6. Provide to patients taking methotrexate, who do not attend dermatology clinics at the hospital on a regular basis, a patient information leaflet and monitoring document in line with the National Patient Safety Agency Patient Safety Alert 13, 1 June 2006 'Making sure you take oral methotrexate safely'.
7. Liaison with dermatologist or clinical nurse specialist over any concerns or need to stop treatment.
8. Monitoring the patient according to the Nottinghamshire Area Prescribing Committee Shared Care Agreement for DMARDs for dermatological conditions and take the advice of the referring

consultant if there are any amendments to the suggested monitoring schedule.

9. Ensuring that the patient is given the appropriate appointments for follow up and monitoring (including a yearly appointment with the patient's consultant) and those defaulters from follow up are contacted to arrange alternative appointments. It is the GP's responsibility to decide whether to continue treatment in a patient who does not attend appointments required for follow up and monitoring. A script note may be added to the prescription to remind the patient of the monitoring schedule.
10. For methotrexate: Be aware of patients who attend with symptoms such as breathlessness, dry persistent cough, vomiting or diarrhoea, as these can be signs of toxicity or intolerance. Refer them back to the prescriber for further investigation.
11. It is good practice to maintain a record of any over-the-counter items supplied to the patient.
12. Administration of influenza, pneumococcal and any other vaccines recommended in the national schedules/advice as appropriate.

Community pharmacist roles and responsibilities

The community pharmacist will:

1. Professionally check prescriptions to ensure they are safe for the patient and contact the GP if necessary to clarify their intentions.
2. Fulfill legal prescriptions for medication for the patient unless they are considered unsafe.
3. Counsel the patient on the proper use of their medication.
4. Advise patients suspected of experiencing an adverse reaction to their medicines to contact their GP.

Patient's roles and responsibilities

1. The patient will: Take their medication as agreed, unless otherwise instructed by an appropriate healthcare professional.
2. Attend regular blood tests, routine influenza, pneumococcal and other appropriate recommended vaccinations, and all follow-up appointments with the GP and the specialist. If they are unable to attend any appointments they should inform the relevant practitioner as soon as possible and arrange an alternative appointment.
3. Inform all healthcare professionals, involved in the care, of their current medication prior to receiving any new prescribed or over-the-counter medication.
4. Report all suspected adverse reactions to medicines to their GP.
5. Ensure not to run out of their medications, request supply of maintenance therapy in a timely manner, and store their medication securely away from children.
6. Read the information supplied by their GP, specialist and pharmacist, and contact the relevant practitioner if they do not understand any of the information given.

COMMUNICATION

BACK-UP ADVICE ON ANY ASPECT OF DMARD THERAPY IS AVAILABLE AT ALL TIMES

Primary care practitioners should contact the consultant's secretary/specialist nurse's secretary during working hours

Nottingham Treatment Centre (0115 9194477)
Secretaries for Dermatology Consultants and Nurse Specialists. Ext 78941

Sherwood Forest NHS Foundation Trust Contacts (Kings Mill Hospital 01623 622515)
Consultant Dermatologist and Clinical Nurse Specialists. **01623 672310**

Specialist and primary care prescribers are encouraged to communicate directly where questions arise around the shared care for a particular patient. If issues remain, after these discussions, the Chief/Senior Pharmacist at the CCG or hospital Trust should be contacted for advice.

REFERENCES

- NPSA Patient Safety Alert No 13. Available from www.npsa.nhs.uk
- Chakravarty, K., McDonald, H., Pullar, T. et al. (2008) BSR/BHPR guideline for disease-modifying anti-rheumatic drug (DMARD) therapy in consultation with the British Association of Dermatologists. *Rheumatology* **47**(6), 924-925.
- R.B. Warren, S.C. Weatherhead, C.H. Smith, L.S. Exton, M.F. Mohd Mustapa, B. Kirby and P.D. Yesudian. (2016) British Association of Dermatologists' guidelines for the safe and effective prescribing of methotrexate for skin disease 2016. British Journal of Dermatology (2016) 175, pp23–44

IN CONSULTATION WITH

Dermatological Consultants from SFHT, NUH and NUH Treatment Centre including Consultant Dermatology Nurses

Version Control- **Management of Dermatological Conditions with DMARDs in Adults**			
Version	Author(s)	Date	Changes
2.1	Shary Walker		1. The referral process, area of responsibility and nurse specialist responsibilities have been updated to get it in line with the other APC shared care protocol format. 2. Community pharmacist roles and responsibilities added and also added more responsibilities for the patient. 3. Contact details updated.