SHARED PRESCRIBING GUIDELINE

Amisulpride, Aripiprazole, Olanzapine, Quetiapine, Oral Risperidone

Introduction

This shared prescribing guideline for the second generation antipsychotic medications listed above has been developed with due consideration to the appropriate NICE Clinical Guidelines (CG) e.g. Bipolar Disorder (CG185), Psychosis and Schizophrenia in Children and Young People (CG155), Psychosis and Schizophrenia in Adults (CG178), Schizophrenia- Aripiprazole (TA213), Bipolar Disorder- Adolescents (TA292).

Due to the range of licensed indications for the individual antipsychotics, they may be prescribed to treat a number of different conditions

Dose & Administration

Drug	Licensed Indication/s	Dose
Amisulpride	Schizophrenia	Max daily dose of 1200mg
Aripiprazole	Schizophrenia in adults and in adolescents 15 years and older, moderate to severe manic episodes of Bipolar I Disorder in adults and adolescents aged 13 and over (up to 12 weeks treatment in adolescents), prevention of a new manic episode in patients who experienced predominantly manic episodes and whose manic episodes respond to aripiprazole treatment	Max daily dose of 30mg, although limited evidence of benefit above 15mg
Olanzapine	Treatment and prophylaxis of schizophrenia and moderate to severe manic episodes	Max daily dose of 20mg
Quetiapine	Schizophrenia, manic episodes associated with bipolar disorder, major depressive episodes in bipolar disorder, preventing recurrence in bipolar disorder in patients whose manic or depressive episode has responded to quetiapine treatment. XL only: Add on treatment of major depressive episodes	Dependent on indication. Max daily dose of 800mg
Risperidone	Schizophrenia, moderate to severe manic episodes associated with bipolar disorders, short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others, short-term symptomatic treatment (up to 6 weeks) of persistent aggression in conduct disorder in children from the age of 5 years and adolescents with subaverage intellectual functioning or mental retardation diagnosed according to DSM-IV criteria in whom the severity of aggressive or other disruptive behaviours require pharmacologic treatment	2mg to 16mg depending on the indication

LCFT Responsibilities

- Choice of antipsychotic drug will be made with due consideration to the principles in the relevant NICE clinical guidelines.
- The choice of antipsychotic drug will be made jointly by the patient and clinician, following an informed discussion of relative benefits and side effect profiles of both first and second generation antipsychotic drugs and giving due consideration to these likely benefit, side effects, licensed indications and cost effectiveness. Advocates or carers will be consulted where appropriate. If an advance directive has been previously agreed, drug treatment will be in line with this wherever possible.
- Physical health monitoring will be conducted according to Lancashire Care NHS Foundation Trust Monitoring guidelines (see appendix). The responsibility for monitoring rests with LCFT for the first twelve months. Thereafter a request can be made to pass monitoring to the GP as part of a shared care arrangement. When this is in place patients will be told about the need to attend for an annual physical health check at their GP surgery. Where a need is identified, patients will be supported to attend GP surgeries for the purposes of an annual physical health check by LCFT staff
- LCFT will share the results of any blood monitoring with primary care.
- Following instigation of the drug the patient will be maintained on the second generation antipsychotic for a minimum of three months to establish response and tolerability. During this period existing antipsychotic therapy will be rationalised, to ensure that first and second generation antipsychotic drugs are not co-prescribed for extended periods.
- During this assessment period medication will be supplied by the hospital.
- After this period the patient will be reassessed in secondary care and a shared prescribing arrangement between primary and secondary care will be facilitated if
  - the illness has stabilised and
  - side effects of the medication are manageable and
  - concordance to the regime is established then

The shared prescribing arrangement between primary and secondary care to manage the patient will be adopted as follows: -

- The Shared Care template letter will be completed by mental health services and sent to the GP
- The patient will be prescribed a further 28 days of medication by secondary care during this process to allow continuity of treatment and the GP will be advised of this.
- The patient will be informed of the process.
- GPs will respond to the request within 28 days. Should responses from GPs persistently not be received within this time frame, LCFT pharmacy team will contact the CCG practice pharmacists to request their support in ensuring a prompt reply.

Once all the above is in place and the GP has agreed to participate in the shared prescribing arrangements a record will be made in the patient's clinical record and the patient will be informed that their next supply of medication will be obtained from their GP.

If an alternative second generation antipsychotic medication is commenced in secondary care following referral back to the consultant, dose stabilisation, monitoring and shared prescribing arrangements should be followed as outlined above for the new drug.

<table>
<tr><td>Primary Care Responsibilities</td><td colspan="3">

The repeat prescription arrangements employed by the practice must be made clear to the patient in order to avoid any disruption in continuity of supply.
Consider referral back to secondary care (using the contact details provided) in the following circumstances:

Suspected relapse
Poor response to treatment
Non-adherence to medication
Intolerable side effects from medication
Co-morbid substance misuse
Risk to self or others

Identify those service users at increased risk of developing cardiovascular disease and/or diabetes and manage them using the appropriate NICE guidance for the prevention of these conditions.
Monitor the physical health of the service user on treatment at least annually, from month 24 onwards, focusing on cardiovascular disease risk assessment as described in ‘Lipid Modification’ (NICE Clinical Guideline 67). Clinicians should also be mindful of other general health conditions and at their discretion consider other physical health checks such as full blood count, renal and liver function tests
Treat those diagnosed with diabetes and/or cardiovascular disease in primary care according to the appropriate NICE guidance

To send a copy of any physical health results to the care coordinator and/or psychiatrist as required in the NICE guideline e.g. by completion of the ‘copy to….’ section on the blood test forms
</td></tr>
<tr><td>Monitoring Required in Primary Care</td><td colspan="3">Annual monitoring of pulse, blood pressure, weight, waist circumference, fasting blood glucose, HbA1c or lipid profile and prolactin. Enquire about any side effects and assess adherence with medication. Clinicians should also be mindful of other general health conditions and at their discretion consider other physical health checks such as full blood count, renal and liver function tests</td></tr>
<tr><td>Adverse Effects & contraindications</td><td><u>Drug</u></td><td><u>Common side effects</u></td><td><u>Contraindications</u></td></tr>
<tr><td></td><td>Amisulpride</td><td>Insomnia, anxiety, agitation, hyperprolactinaemia displayed as gynaecomastia, amenorrhoea, galactorrhoea or sexual dysfunction
EPSE’s, hypotension, constipation, nausea, vomiting, dry mouth, weight gain</td><td>Hypersensitivity to ingredients, prolactin-dependent tumours, phaeochromocytoma
children under 15 years old, lactation, woman of childbearing age unless using adequate contraception, concomitant medication which could induce torsade de pointes, combination with levodopa</td></tr>
<tr><td></td><td>Aripiprazole</td><td>Insomnia, restlessness, headache, dizziness, anxiety, EPSEs, akathisia, somnolence/sedation, tremor, blurred vision, nausea, vomiting, constipation, dyspepsia, hypersalivation</td><td>Hypersensitivity to Aripiprazole or any excipients</td></tr>
<tr><td></td><td>Olanzapine</td><td>Somnolence, oedema, dizziness, fatigue,
weight gain, increased appetite, eosinophilia, elevated glucose, elevated triglycerides, elevated cholesterol, glycosuria, akathisia, parkinsonism, dyskinesia, rash, sexual dysfunction,
orthostatic hypotension, anticholinergic effects, elevation in liver enzymes, asthenia and oedema, increased prolactin levels</td><td>Hypersensitivity to any ingredient

Known risk of narrow-angle glaucoma</td></tr>
<tr><td></td><td>Quetiapine</td><td>Somnolence, dizziness, constipation, headache, dyspnea, dyspepsia, vomiting, weight gain, nightmares, orthostatic hypotension, tachycardia, palpitations, peripheral oedema. dry mouth, blurred vision, liver enzyme abnormalities, increases in blood glucose, decreased haemogolobin, eosinophilia, leucopenia, decreased neutrophil count,
thyroid function test abnormalities, elevated plasma tri-glyceride and cholesterol concentrations, decreased HDL cholesterol, hyperprolactinaemia, irritability, suicidal ideation</td><td>Hypersensitivity to any ingredient

Concomitant administration of cytochrome P450 3A4 inhibitors, such as HIV-protease inhibitors, azole-antifungal agents, erythromycin, clarithromycin</td></tr>
<tr><td></td><td>Risperidone</td><td>Insomnia, agitation, anxiety, headache, sedation, blurred vision, weight gain, tachycardia, hypertension, abdominal pain, gastrointestinal effects, dry mouth, rash, musculoskeletal pain, urinary incontinence, oedema, pyrexia,respiratory tract infections, urinary tract infections, sinusitis, nasal congestion,dyspnoea, cough, epistaxis, depression, hyperprolactinaemia displayed as gynaecomastia, galactorrhea or sexual dysfunction, extra pyramidal side effects</td><td>Hypersensitivity to any ingredient</td></tr>
<tr><td>Drug Interactions</td><td colspan="3">Caution is needed with medication that may cause electrolyte imbalance or prolong the QTc interval
Dose adjustments of some antipsychotics may be necessary if co-prescribed with significant hepatic enzyme inducers or inhibitors e.g. carbamazepine, fluvoxamine, fluoxetine, paroxetine, ketoconazole, itraconazole</td></tr>
<tr><td>Contact Details</td><td colspan="3">See letter to GP</td></tr>
<tr><td colspan="4">This guidance does not replace the SPC’s, which should be read in conjunction with this guidance.</td></tr>
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Appendix 1: Physical Health Monitoring Requirements

Time Period	Responsibility	Monitoring Required
Prior to Initiation Blood tests and ECG conducted within the previous three months can be considered baseline tests	LCFT	Weight* Waist Circumference* Pulse and blood pressure Fasting blood glucose or glycosylated haemoglobin (HbA1c), blood lipid profile and prolactin levels Assessment of any movement disorders Assessment of nutritional status, diet and level of physical activity. An electrocardiogram (ECG) if any of the following apply: • It is a requirement of the summary of product characteristics (SPC). The SPC can be accessed via the website http://www.medicines.org.uk/emc/ • A physical examination has identified specific cardiovascular risk (such as diagnosis of high blood pressure) • There is a personal history of cardiovascular disease or • The service user is being admitted as an inpatient.
First three months on treatment (Titration Phase)	LCFT	Weight*, weekly for the first 6 weeks Routinely and systematically assess side effects to treatment, emergence of movement disorders and overall physical health particularly during the titration phase At twelve weeks: Weight* Pulse and blood pressure Fasting blood glucose, HbA1c Blood lipid levels
At 12 months	LCFT	Weight* Waist circumference* Pulse and blood pressure Fasting blood glucose or HbA1c, blood lipid and prolactin levels Side effects to treatment, emergence of movement disorders and overall physical health
At 24 months and annually thereafter	GP	Weight* Waist circumference* Pulse and blood pressure Fasting blood glucose or HbA1c, blood lipid and prolactin levels Side effects to treatment, emergence of movement disorders and overall physical health

***Weight and waist circumference must be plotted on a chart or in an electronic system that can generate graphs to facilitate monitoring of trends**

This monitoring does not negate the need for additional health checks at the professional discretion of the clinician e.g. checks for renal and liver function