**Request to Share Care and Agreement Form**

**Sulfasalazine use in adults with multisystem autoimmune disease:**

**Gastroenterology / Rheumatology**

**Shared Care Protocol: Guideline Number 8; Version 1.2**

This request to share care provides key primary care information on responsibilities and monitoring. The aim is to support the GP to agree to share care arrangements. Refer to full shared care protocol for further information.

**GP to review and must respond to provider Trust request to share care within 2 weeks**. **This form is used to agree shared care between the specialist, patient and GP and a copy of the form to be retained in 1.Patients’ hospital records, 2. Given to patient, and 3. Retained in GP notes.**

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| **Patient Information or Addressograph label** | | **Drug information** | |
| Patient name: |  | Drug(s) and Dose at handover: |  |
| DOB: |  | Indication: |  |
| NHS number: |  | Estimated date for prescribing to be continued by the GP: |  |
| Patient weight (kg): |  | Date of first prescription by specialist |  |
| Next monitoring tests due and dates: | |  | |
| Specialist additional comments/advice: | |  | |

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| **Specialist and patient agreement**  **By signing below we accept:**   * The Herts and West Essex Area Prescribing Committee [shared care principles](https://www.hweclinicalguidance.nhs.uk/all-clinical-areas-documents/download?cid=1739&checksum=752d25a1f8dbfb2d656bac3094bfb81c) (HWE APC) and * The requirements and responsibilities defined in this drug specific shared care protocol | | |
| Specialist name: | Specialist signature: | |
| Designation: | Date: | |
| Direct telephone: | Patient signature or specialist confirmation of patient agreement to shared care arrangement: | |
| Provider trust: |
| Email/ Shared care email for use by GP: | Date: | |
| **GP response to shared care**  **Please return to specialist within two weeks of receipt of request to share care.**  ***This form is to be completed by the GP who is requested to share care.***  I agree to accept shared care for this patient as set out in this shared care protocol and APC [shared care](https://www.hweclinicalguidance.nhs.uk/all-clinical-areas-documents/download?cid=1739&checksum=752d25a1f8dbfb2d656bac3094bfb81c) principles  I do not accept shared care for this patient  My reason(s) for not prescribing are given below (refer to GP considerations for shared care at end of protocol): | | |
| GP name: | | Practice Address/Stamp: |
| Direct telephone number: | |
| Email: | |
| Date: | | GP Signature: |

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| **Key Primary Care Information (refer to Full Shared Care Protocol for further information)**  **GP RESPONSIBILITIES**   * Consider request to shared care arrangements and prompt completion and emailed return of signed response to the specialist using the Shared Care Agreement Form within 14 days of its receipt. * If shared care accepted, prescribe sulfasalazine once patient is clinically stable in line with protocol. * Arrange, record, and share ongoing monitoring and take appropriate action as per protocol and advised by specialist (see monitoring table), ensuring GP practice systems are in place to recall patients for monitoring blood tests. * Re-iterating with the patient that non-attendance for blood testing may lead to withdrawal of the medication. Further help and advice can be sought from the hospital specialist team. * Ascertaining the reason for non-completion of routine blood testing, if one test is missed. * Appropriately prompt notification to the hospital specialist of any significant and relevant changes in the patient’s condition, medication dose, or of an adverse reaction, according to the protocol and if the patient fails to attend for blood monitoring. * Ensure no drug interactions with other medicines. * Administer inactivated influenza vaccine and other recommended seasonal vaccines (e.g. coronavirus) annually unless otherwise advised by the initiating specialist. * Check patient has had ONE DOSE of pneumococcal vaccine (revaccination is not recommended except every five years in patients whose antibody levels are likely to have declined more rapidly e.g. asplenia), see BNF or Green Book. * For susceptible immunosuppressed individuals with significant exposure to chickenpox (varicella) or shingles (zoster), follow latest national guidance on post exposure prophylaxis and use of anti-virals and varicella zoster immunoglobulin (VZIG) [Post exposure prophylaxis for chickenpox and shingles - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/post-exposure-prophylaxis-for-chickenpox-and-shingles) * Ask about oral ulceration, sore throat, unexplained rash or unusual bruising/bleeding at every consultation. * Change dose or stop treatment in line with protocol and as advised by specialist. * Organisation of urgent referral to the specialist team or A&E if severe side effects or potential overdose is apparent. * Liaising with the initiating clinician if the medicine becomes less effective and patient complains of symptoms.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **MONITORING AND ACTIONS TO BE TAKEN**  **Monitoring Table – see GP monitoring highlighted in grey**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Monitoring table** | | **Hospital specialist** | **Hospital specialist** | **Hospital specialist / GP** | **GP** | **Hospital specialist** | | **Test** | **Indication** | Pre-treatment baseline | During TreatmentInitiation | Following Treatment  Initiation | Ongoing | Annual review | | FBC | Baseline and ongoing assessment, including dose adjustment | ✔ | **Phase I monitoring\*** Every 2 weeks until stable dose for 6 weeks | **Phase II monitoring\***  Every 4 weeks for next 12 weeks  *Hospital specialist will undertake the first 4-week test*  *GP will undertake the second and third 4-week test* | **Phase III monitoring\*†**  Every 12 weeks | As part of annual review or as clinically indicated | | LFTs, Albumin | | U&Es, eGFR | | ESR/CRP (Rheumatology patients) | Disease activity scoring | ✔ | Every 12 weeks | Not routinely required | Every 12 weeks on advice of specialist | | Height & Weight  Blood pressure | Baseline assessment | ✔ | Not routinely required | | | If clinically indicated | | Hepatitis B, C & HIV | Baseline assessment, viral, respiratory and TB screening | If clinically indicated | | Chest X-ray | | TB screening if indicated | | Urinalysis | To assess for or monitor renal disease (proteinuria) or infection | ✔ | | Ask about oral ulceration, sore throat, unexplained rash or unusual bruising/bleeding | | ✔ | At every consultation | | At every consultation | At every consultation | | **\***If a further DMARD is added as combination therapy, or the dose is increased, the initial starting schedule should be reinstated. **For dose increases monitoring should start back with Phase I monitoring and be every 2 weeks until dose is stable for 6 weeks, then revert to previous schedule.** There may be clinical circumstances where the frequency of monitoring may vary and this should be specified by the initiating specialist.  **†Routine monitoring beyond 12 months post-initiation is not usually required**. Extended monitoring beyond 12 months may be considered on a case-by-case basis, including for patients with impaired renal/liver function at baseline. If extended monitoring beyond 12 months is required, this should be specified by the initiating specialist. | | | | | | |   **Action to be taken if abnormal result**  Normal reference range may vary slightly between labs. Results should be recorded in the patient’s shared care monitoring record booklet (where in use). Please note an unusual fall or rise or a consistent downward or upward trend in any value should prompt review of the patient and extra vigilance. Some patients may have abnormal baseline values, specialist will advise.   |  |  | | --- | --- | | **Result** | **Action for primary care** | | **As well as responding to absolute values in laboratory tests, a rapid change or a consistent trend in any value should prompt caution and extra vigilance** | | | **Full blood count**   * WCC less than 3.5 x109/L * Lymphocytes less than 0.5 x109/L * Neutrophils less than 1.6 x109/L * Platelets less than 140 x109/L * Unexplained eosinophilia; greater than 0.5 x109/L * Unexplained fall in albumin; less than 30g/L | Withhold treatment and discuss with specialist. | | MCV >105 fL | Consider interruption in treatment.  Check serum folate, B12, alcohol history and TSH and treat any underlying abnormality. If results of these additional investigations are normal discuss with specialist team urgently. | | **Liver function tests:**  ALT and/or AST greater than 100units/L  And/or a sudden increase (e.g. doubling of baseline)  Jaundice | Withhold and discuss with specialist team.  Check any other reason for risk of hepatic dysfunction such as alcohol history and drug interactions, including OTC or complementary medication. | | **Renal function**  Creatinine increase of greater than 30% from baseline in the last 12 months or CrCl reduces to less than 60mL/min | Use clinical judgement and repeat in 1 week  If still more than 30% from baseline, withhold and discuss with specialist. | | |

* The expectation is that this information along with the full protocol provides sufficient information to enable GPs to be confident to take on the clinical & legal responsibility for prescribing and monitoring.
* Prescribing and monitoring responsibility will only be transferred under this shared care protocol when:
* Specialist has initiated treatment and prescribed/monitored treatment for initial stabilisation period.
* Specialist has provided pre-treatment counselling and discussed patient responsibilities, preferences and obtained consent to shared care arrangements.
* Specialist and patient have completed and signed the shared care agreement form (page 1).

**Full Shared Care Protocol**

**Sulfasalazine use in adults with multisystem autoimmune disease:**

**Gastroenterology / Rheumatology**

**Shared Care Protocol: Guideline 8; Version 1.2**

**This full protocol provides prescribing and monitoring guidance. It should be read in conjunction with** [**local shared care principles**](https://www.hweclinicalguidance.nhs.uk/all-clinical-areas-documents/download?cid=1739&checksum=752d25a1f8dbfb2d656bac3094bfb81c)**,** [**Summary of Product Characteristics (SPC)**](https://www.medicines.org.uk/emc) **and the** [**BNF**](http://www.bnf.org/bnf/index.htm)**.**

**BACKGROUND AND INDICATION(S) FOR USE**

Sulfasalazine is a disease modifying antirheumatic drug (DMARD) used to treat a number of rheumatological conditions, and to induce and maintain remission in certain inflammatory gastrointestinal diseases.

The licensed indications for sulfasalazine are rheumatoid arthritis, ulcerative colitis, and Crohn’s disease.

Sulfasalazine is also used off-label for other chronic inflammatory disorders including seronegative spondyloarthropathies such as psoriatic arthritis and psoriasis.

**DOSAGE, ROUTE OF ADMINISTRATION AND TREATMENT REGIMEN**

**Route of administration:** Oral

**Preparations:** 500mg tablets, 500mg enteric coated tablets, 250mg/5mL oral suspension (contains ethanol).

**Initial stabilisation**

Treatment of acute attacks of ulcerative colitis and Crohn’s disease:

Oral: 1-2g four times daily until remission. The night-time interval between doses should not exceed 8 hours.

Rheumatoid arthritis:

Oral (using enteric coated tablets): 500mg daily, increasing by 500mg each week until 2-3g per day in divided doses is reached according to response. Only the enteric coated tablets are licensed in rheumatoid arthritis; use of other formulations is off-label.

For other indications take specialist advice.

**Maintenance dose (following initial stabilisation)**

Ulcerative colitis and Crohn’s disease:

By mouth: Usual maintenance dose 500mg four times daily.

Rheumatoid arthritis and other indications:

By mouth (using enteric coated tablets): 2-3g daily in 3-4 divided doses.

**Conditions requiring dose adjustment**

In patients with GFR <10 mL/min, start at very low dose and monitor.

Swallowing difficulties

Please refer to the [‘specials’ alternative guidance](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.hweclinicalguidance.nhs.uk%2Fall-clinical-areas-documents%2Fdownload%3Fcid%3D2274%26checksum%3D95f8d9901ca8878e291552f001f67692&data=05%7C02%7Cheernamehta%40nhs.net%7Ccba67ac584344a90298108dcafcc3bcd%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638578538908037976%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=drWPIVzT4RkMn0VJJa96%2F2dIm19xPNtqcc0yghL%2FsEA%3D&reserved=0) for a list of commonly prescribed medicines and alternative methods of administration for patients with swallowing difficulties, feeding tubes or for patients prescribed unlicensed ‘specials’ medication. Each entry takes into account alternative medicines, formulations, cost and licensing. This list is not exhaustive. As not all medicines are listed, please contact the initiating specialist if required for individual patient advice if a patient has a swallowing difficulty.

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| **SPECIALIST RESPONSIBILITIES INCLUDING PRE-TREATMENT ASSESSMENT**   * Assess if patient is suitable for treatment with sulfasalazine and initiate treatment. * Where treatment is off-label advise patient. * Undertake pre-treatment counselling and document discussion in patient’s records. Provide patient/carer with relevant (preferably written) information on use, side effects, need for monitoring of medication and precautions including that no new medicines are started (including over the counter preparations) unless this has been discussed with the GP, specialist or pharmacist. * Obtain agreement and consent to share care. Complete and sign specialist and patient agreement section of Shared Care Agreement form. Document in patient’s notes and transfer once patient stabilised. * Request for GP confirmation of acceptance of shared care by secure emailing of request to share care, protocol and completed agreement form, allowing 2 weeks for response. * Receipt and recording in patient records/notes that GP has / has not accepted shared care and ensuring appropriate action if not (specialist to continue to prescribe/monitor). * Prescribe and monitor for initial stabilisation period. This is usually 12 weeks. * Undertake baseline and ongoing tests as indicated in the monitoring table. Review results of safety monitoring and request additional tests as required. * Continue to review the patient at agreed specified intervals, sending a written summary to the GP whenever the patient is reviewed. * Monitor response and adverse effects to treatment and need to continue therapy. Notify the GP of any changes to dose or cessation of therapy. * Notify GP if patient does not attend clinic repeatedly and advise on action to take. * Provide any other advice, information or support for the GP if required. Communicate any clinically important issues and action to be taken and ensure clear back-up arrangements exist for GPs to obtain advice and support. |

**GP RESPONSIBILITIES**

Refer to page 1/2 and GP Considerations for Shared Care page 10.

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| **PATIENT RESPONSIBILITIES IN COOPERATION WITH SPECIALIST AND GP**   * Confirm their agreement with the decision to move to a shared care model for their ongoing care and their understanding of the shared care agreement. * Consent to share care and complete/sign Specialist and patient agreement section of Shared Care Agreement form. * Take sulfasalazine as prescribed and avoid abrupt withdrawal unless advised by the primary care prescriber or specialist. * Confirm their understanding of the treatment and agreeing to contact the specialist/GP if they subsequently do not have a clear understanding of the treatment (patient to be provided with relevant contact details for GP/specialist in and out of hours). * Attending for blood monitoring and follow up hospital or GP appointments. * Ensuring a list of all medications are brought to all GP surgery, outpatient and A&E consultations. * Reporting any change in symptoms and adverse effects promptly to the clinician who is currently prescribing. * Confirm that no new medicines are started (including over the counter preparations) unless this has been discussed with the GP, specialist or pharmacist. * Share any concerns in relation to treatment with sulfasalazine with the Specialist or GP. * Alert GP and/or specialist of any changes of circumstance which could affect management of disease e.g. if they become/wish to become pregnant; plans to move/change GP practice. |

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| **DISPENSING PHARMACIST RESPONSIBILITIES**   * Confirming that the patient has received verbal and written patient counselling / information and provide additional counselling should this be required. |

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| **MONITORING AND ACTIONS TO BE TAKEN**   * Refer to page 2/3. |

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| **SIDE EFFECTS AND ACTIONS TO BE TAKEN (REFER TO** [**BNF**](http://www.bnf.org/bnf/index.htm) **AND** [**SPC**](http://www.medicines.org.uk/emc) **for full details)**   * GP to liaise with specialist if any side effects are a cause for concern. * Patients should be instructed to report immediately any evidence of infection, unexpected bruising or bleeding or other manifestations of bone marrow depression - also refer to monitoring section. * Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard)  |  |  | | --- | --- | | **SIDE EFFECTS** | **Action to be taken by GP** | | Signs or symptoms of bone marrow suppression, e.g. unexplained bleeding or bruising with or without sore throat, purpura, mouth ulcers. | Check FBC immediately, withhold treatment while awaiting results, and discuss with the specialist team. See haematological monitoring above. | | Nausea, vomiting, diarrhoea or unintentional weight loss | Review for reversible causes. Advise patient to take with food. If no improvement contact specialist team. | | **Other side effects**   * Skin/mucosal reaction, e.g. serious rash * Diffuse alopecia * Breathlessness or cough * Peripheral neuropathy | Consider withholding treatment and discussing with specialist.  For widespread rash, discontinue and discuss with specialist urgently. | |

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| **CONTRAINDICATIONS AND PRECAUTIONS (REFER TO** [**BNF**](https://bnf.nice.org.uk/) **AND** [**SPC**](http://www.medicines.org.uk/emc) **for full details)**  **Contraindications:**   * Known hypersensitivity to sulfasalazine, its metabolites or any of the excipients as well as sulfonamides or salicylates. * Porphyria.   **Cautions:**   * Hepatic or renal impairment. * Pre-existing blood dyscrasias. * Severe allergy or bronchial asthma. * Glucose-6-phosphate dehydrogenase (G6PD) deficiency due to risk of haemolytic anaemia. * Folic acid deficiency. * Adequate fluid intake should be maintained during treatment to avoid crystalluria and kidney stone formation. * Slow acetylator status increases the risk of sulfapyridine-related adverse drug reactions (ADRs) which can present as a drug-induced lupus-like syndrome.   **Pregnancy, breastfeeding and paternal exposure**  All patients should be informed of the risks and benefits of taking sulfasalazine during pregnancy and breastfeeding. The specialist team should be contacted if a patient becomes pregnant or is planning to become pregnant or breastfeed.  **Pregnancy:**   * Sulfasalazine can be prescribed during pregnancy, but it should only after careful consideration of risk and benefit. * Adequate folic acid supplements (5 mg/day) should be provided as there is a theoretical risk of neonatal haemolysis in the third trimester due to inhibition of folate absorption.   **Breastfeeding:**   * Sulfasalazine is compatible with breastfeeding in healthy, full-term infants. * There have been reports of bloody stools or diarrhoea in infants who were breastfeeding from mothers on sulfasalazine. In cases where the outcome was reported, bloody stools or diarrhoea resolved in the infant after discontinuation of sulfasalazine in the mother.   **Paternal exposure:**   * Men taking sulfasalazine may have reduced fertility, due to oligospermia and impaired mobility, which may take 2-3 months to return to normal following treatment cessation. |

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| **NOTABLE DRUG INTERACTIONS (REFER TO** [**BNF**](https://bnf.nice.org.uk/) **AND** [**SPC**](http://www.medicines.org.uk/emc) **for full details)**   * **Digoxin:** Reduced absorption may be seen when used concomitantly with sulfasalazine. * Sulfonamides are chemically similar to some **oral** **hypoglycaemic agents** and may causehypoglycaemia. Patients receiving sulfasalazine and hypoglycaemic drugs should closely monitor blood glucose. * **Azathioprine and 6-mercaptopurine:** Possible risk of bone marrow suppression and leucopenia * **Folate** absorption and metabolism may be reduced by sulfasalazine**.** * **Darolutamide and voxilaprevir** may increase exposure to sulfasalazine, manufacturer advises avoid. |

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| **ADVICE TO PATIENTS AND CARERS**  The specialist will counsel the patient on the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.  **The patient should be advised to report any of the following signs or symptoms to the prescribing clinician without delay:**   * Sore throat, mouth ulcers, fever, malaise, swollen lymph nodes, or unexplained bleeding or bruising * Progressive skin rash with blisters or oral ulcerations – see below * Nausea, vomiting, diarrhoea, jaundice, dark urine and unintentional weight loss. * Hair loss * Breathlessness, infection or cough * Symptoms of peripheral neuropathy e.g. pins and needles, numbness or burning pain in extremities   **The patient should be advised:**   * Life-threatening skin reactions Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) have been reported with the use of sulfasalazine. The highest risk for occurrence is within the first weeks of treatment. Patients should be advised to report a progressive skin rash often with blisters or mucosal lesions, or any other sign of hypersensitivity. * During a serious infection, sulfasalazine should be temporarily discontinued until the patient has recovered from the infection. * Tell anyone who prescribes them a medicine that they are taking sulfasalazine. Always ask a pharmacist before purchasing any medicines over the counter, including herbal remedies, and ask if they are safe. * That vaccination in line with current national advice (e.g. for COVID-19, influenza) is safe and recommended. * Sulfasalazine may cause a harmless yellow-orange discolouration of body fluids and skin. Certain types of extended wear soft-contact lenses may be permanently stained. * To maintain adequate fluid intake during treatment to reduce the risk of crystalluria and kidney stones. * Enteric coated tablets should be swallowed whole and not crushed or broken. * Sulfasalazine oral suspension contains 4.7 mg of alcohol (ethanol) in each 5ml, equivalent to less than 1ml of beer or wine. The small amount of alcohol in this medicine will not have any noticeable effects.   Patient information:   * General information: <https://www.nhs.uk/medicines/sulfasalazine/> * General information: <https://patient.info/medicine/sulfasalazine-salazopyrin-sulazine> * Rheumatology: <https://www.versusarthritis.org/about-arthritis/treatments/drugs/sulfasalazine/> |

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| **CONTACT DETAILS for BACK-UP INFORMATION / ADVICE**  **East and North Hertfordshire NHS Trust**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Department** | **Contact number** | **Specialist Team designated nhs.net email** | **Pharmacy Team shared care admin contact** | **Out of hours contact / switchboard** | | **Gastroenterology** | 01438 285767 | [ibdhelpline.enh-tr@nhs.net](mailto:ibdhelpline.enh-tr@nhs.net) | [sharedcare.enh-tr@nhs.net](mailto:sharedcare.enh-tr@nhs.net)  01438 284032 | 01438 314333 | | **Rheumatology** | 01438 285624 | [rheumsecretariesenh-tr@nhs.net](mailto:rheumsecretariesenh-tr@nhs.net) |   **West Hertfordshire Hospitals NHS Trust**   |  |  |  | | --- | --- | --- | | **Contact Details**  *(provide details of different sites where applicable)* | **Rheumatology**  **Specialist Nurse Helpline (non-urgent queries, may take up to 48 hours to respond)**  Watford General:  01923 217798  St Albans City:  01727 897912 | **Gastroenterology**    **Specialist Nurse Helpline (non-urgent queries, may take up to 48 hours to respond)**    **01442 287485**  (All sites) | | **Direct dials for clinicians** *(and nhs.net e-mail where available)* | Watford General:  01923 217520  St Albans City:  01727 897859  Hemel Hempstead:  01442 287049 |  | | **Specialist Team designated nhs.net email** | [wherts-tr.rheumatology@nhs.net](mailto:wherts-tr.rheumatology@nhs.net) | [westherts.ibd@nhs.net](mailto:westherts.ibd@nhs.net) | | **Out of hours contact** | Call medical on call team | Call medical on call team | | **Pharmacy Team shared care admin nhs.net email** | [wherts-tr.medinfowatford@nhs.net](mailto:wherts-tr.medinfowatford@nhs.net) | [wherts-tr.medinfowatford@nhs.net](mailto:wherts-tr.medinfowatford@nhs.net) | | **Switchboard** | Watford General:  01923 244366  St Albans City:  01727  866122  Hemel Hempstead:  01442 213141 | Watford General:  01923 244366  St Albans City:  01727  866122  Hemel Hempstead:  01442 213141 |   **Princess Alexandra Hospital NHS trust**   |  |  |  |  | | --- | --- | --- | --- | | **Department** | **Contact number** | **Specialist Team designated nhs.net email** | **Out of hours contact / switchboard** | | **Gastroenterology** | 01279 278224 | [Tpa-tr.gastroadminclinicalcorrespondence@nhs.net](mailto:Tpa-tr.gastroadminclinicalcorrespondence@nhs.net)  [Paht.ibd@nhs.net](mailto:Paht.ibd@nhs.net) - IBD Specialist Nurse | 01279 444455 | | **Rheumatology** | 01279827434 – DMARD helpline  01279827819- Nurse helpline | [tpa-tr.rheumatologyadminclinicalcorrespondence@nhs.net](mailto:tpa-tr.rheumatologyadminclinicalcorrespondence@nhs.net) | 01279 444455 |   **Communication**  For any queries relating to a patient’s treatment with sulfasalazine, please contact the specialist as documented at the top of this document. Read in conjunction with [HWE APC shared care principles](https://www.hweclinicalguidance.nhs.uk/all-clinical-areas-documents/download?cid=1739&checksum=752d25a1f8dbfb2d656bac3094bfb81c) document.  For advice if you have any concerns contact the specialist team. If unable to contact specialist team or out of hours, contact medical registrar on call. |

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| **REFERENCES**   * British National Formulary (BNF) – accessed via <https://bnf.nice.org.uk/> on 29/12/23 * Electronic Medicines Compendium (EMC) –accessed via [https://www.medicines.org.uk/emc](https://www.medicines.org.uk/emc%20on%2024.08.23) on 29/12/23 * NICE CKS DMARDs: Last revised in December 2021; <https://cks.nice.org.uk/topics/dmards/> * BSR and BHPR guideline for the prescription and monitoring of non-biologic disease-modifying anti-rheumatic drugs, Rheumatology 2017;56:865868 <https://academic.oup.com/rheumatology/article/56/6/865/3053478> * NHS England shared care protocol - Sulfasalazine for patients within adult services: Last updated July 2022; <https://www.england.nhs.uk/publication/shared-care-protocols/> * The Green Book Immunisation against infectious disease <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book> |

**GP Considerations for Shared Care**

This shared care agreement outlines suggested management for the prescribing of the specified drug(s) and indication(s) when the responsibility is shared between the specialist and general practitioner (GP). Sharing of care assumes communication between the specialist, GP and patient. It is important that patients are consulted about treatment and are in agreement with it. The intention to share care should be explained to the patient by the doctor initiating treatment and consent obtained.

Prescribing is to be initiated in secondary care by a provider Trust specialist and will usually be prescribed for 12 weeks unless otherwise stated within the agreed individual shared care protocol**. The expectation is that these shared care guidelines should provide sufficient information to enable GPs to be confident to take on the clinical and legal responsibility for the prescribing and the monitoring of this / these drug(s) in stable patients.** The questions below will help you confirm this:

* Is the patient’s condition predictable or stable?
* Do you have the relevant knowledge, skills and access to equipment to allow you to monitor treatment as indicated in this shared care document?
* Have you been provided with relevant clinical details including monitoring data?
* Have this document and BNF/SPC provided sufficient information for you to feel confident in accepting clinical and legal responsibility for prescribing?

**If you can answer YES to all of these questions (after reading this shared care guideline), then it is appropriate for you to accept the prescribing responsibility. GPs need to formally accept shared care by completing and returning the form provided within this protocol to the specialist within two weeks of receipt of request to share care.**

If the answer is NO to any of these questions, you should not accept prescribing responsibility. You should respond back to the consultant outlining your reasons for NOT prescribing on the agreement form within two weeks of receiving the request to share care. If you do not have the confidence to prescribe, you still have the right to decline. In such an event, the total clinical responsibility for prescribing the medication and any monitoring required remains with the specialist. Please note that medication cost is not an acceptable reason for refusal to take on shared care.

The prescribing doctor legally assumes clinical responsibility for the drug and the consequences of its useas well as responsibility of monitoring (securing and reviewing blood test results).

Prescribing and monitoring responsibility will only be transferred when the consultant and the GP agree that the patient’s condition is stable or predictable. This will usually be 12 weeks of treatment unless otherwise stated within the agreed individual shared care protocol.

**Approval Information**

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| Version | 1.2 Updated in line with new shared care protocol template May 2025  1.1 Updated with wording on swallowing difficulties and patient consent to shared care. September 2024 |
| Developed by | Pharmacy and Medicines Optimisation Team, Hertfordshire and West Essex (HWE) ICB with relevant HWE ICS stakeholders. |
| Approved by | Hertfordshire & West Essex Area Prescribing Committee |
| Date approved/updated | February 2024 |
| Review date: | This HWE APC recommendation is based upon the evidence available at the time of publication. This recommendation will be reviewed upon request in the light of new evidence becoming available. |
| Superseded version | DMARDs in Adult Rheumatology - Sulfasalazine Shared Care Information – Herts Valleys CCG & WHHT, July 2014  Sulfasalazine Shared Care Agreement – West Essex CCG, MOPB, October 2017  1.0 February 2024 |