South West Yorkshire Area Prescribing Committee

HYDROXYCHLOROQUINE – Shared Care Guideline

Introduction	
General Statements	• The patient will receive supplies of the drug from the hospital until the transfer of shared care is agreed between the Consultant and GP • The GP must reply in writing to the request for shared care as soon as practicable if unwilling to participate. • Responsibility for prescribing and monitoring must be clearly documented in the patient's hospital and GP notes • The agreement to consider the use of a shared care guideline is only considered when the patient's clinical condition is stable or predictable
Indication	**Licensed indications** - Rheumatoid arthritis, systemic and discoid lupus erythematosus (and related connective tissue diseases – unlicensed)

Individual's Responsibilities	
Hospital Specialist's Responsibilities	➢ Baseline monitoring and initial prescribing until the patient is established on treatment. ➢ Monitoring disease progression and response to treatment ➢ Supporting and advising GPs ➢ Monitoring booklets are available and may be beneficial in certain circumstances, for example if the patient receives blood monitoring at a location where results are inaccessible to the clinician. In these situations the Hospital Specialist will communicate this fact to the GP at the point when prescribing and monitoring is transferred. ➢ Ensure that the patient has an adequate supply of medication until GP supply can be arranged. ➢ Continue to monitor and supervise the patient according to this protocol, while the patient remains on this drug, and agree to review the patient promptly if contacted by the GP. ➢ Provide patient with rheumatology nurse helpline contact number.
General Practitioner's Responsibilities	➢ Ensure hospital is notified if unwilling to undertake prescribing and monitoring when requested ➢ Prescribing following written request from specialist care ➢ Monitoring to be undertaken as per shared care guideline and only continue prescription if compliance with monitoring and results satisfactory. ➢ Follow guidance in the event of reaction or abnormality, record it and report back to the specialist ➢ Encourage influenza vaccination as per Green Book ➢ Ensure no drug interactions with concomitant medicines ➢ To inform Rheumatology Team if patient repeatedly does not attend routine blood monitoring.
Monitoring Required	**Baseline** ➢ FBC, U&E and creatinine, LFTs ➢ Ask about visual impairment not corrected by glasses. ➢ Record visual acuity in each eye using a test type or reading chart. If abnormal refer to an optometrist.

	➢ Ophthalmic screening recommended if pre-existing ocular pathology or visual disturbance, impaired renal function or over the age of 60. The patient will be advised by the Hospital Specialist to have this testing performed by their Optician annually. The Hospital Specialist must confirm to the GP which stages of the maintenance monitoring have already been completed at the point when prescribing and monitoring are transferred to the GP **Maintenance** ➢ Repeat U&E and creatinine annually in those over 70 years of age, or if pre-existing renal impairment or if known hypertension/diabetes. ➢ Annual visual acuity/fundoscopy and enquire about visual symptoms. Amsler charting may occasionally be required – this will be organised by the Hospital Specialist ➢ Formal ophthalmological screening if doses of **>6.5mg/kg/day** used or when a **cumulative dose of 500grams** reached (equivalent to 3.4 years of 400mg/day or 6.8 years of 200mg/day) or when treatment has continued in excess of five years (whichever occurs first)
When and How to Discontinue Treatment	Stop if photophobia, haloes, field defects, reduced visual acuity, abnormal colour vision, pigmentary abnormality, muscle weakness; and contact rheumatology specialist.
Information given to the patient	Patient information leaflet
Contact Details	Specialist care details as documented in letter to GP

Product Information	
The information in this Shared Care Guideline should be used in conjunction with the latest edition of the BNF and Summary of Product Characteristics	
Dosage	Usually started at a dose of 200mg twice daily for up to 3 months, maintenance dose 200-400mg daily. **Maximum dose 6.5mg/kg/day ideal body weight.** Tablets should be taken with a meal or glass of milk.
Adverse Effects	**Mucocutaneous** – rash, skin pigmentation **Gastrointestinal** – nausea, diarrhoea **Ocular** – reversible keratopathy, irreversible maculopathy with high dose long term use, photophobia **CNS**- headache, rarely proximal myopathy, peripheral neuropathy. Refer to the current BNF and www.medicines.org.uk/emc/ for complete and up to date information
Precautions and Contra-indications	**Contraindications** ➢ Pre-existing maculopathy ➢ Pregnancy **Precautions** ➢ Epilepsy, severe gastrointestinal disorders, hepatic and renal impairment, G6PD deficiency ➢ Known hypersensitivity to 4-aminoquinoline compounds ➢ Psoriasis

Clinically relevant Drug Interactions and their management	Avoid **antacids** within 4 hours – reduced absorption Avoid concomitant use with **amiodarone, moxifloxacin** – increased risk of arrhythmias **Antiepileptics** – increased risk of convulsions Increases **digoxin** and **ciclosporin** levels Refer to the current BNF and www.medicines.org.uk/emc/ for complete and up to date information