Name: Attach Banda Label here
Address:
Date of Birth:
NHS number:

Coventry & Warwickshire Area Prescribing Committee

Shared Care Agreemer

Sertraline: *For treatment of children and adolescents of 6 years of age and above in the treatment of anxiety, depression, obsessive compulsive disorder (OCD), Post-Traumatic Stress Disorder (PTSD)*

AREAS OF RESPONSIBILITY FOR THE SHARING OF CARE

This shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of sertraline can be shared between the specialist and general practitioner (GP). The recent introduction of a licensed product, advice for the MHRA regarding imported products and Area Prescribing Committee support has facilitated the participation of GPs in shared care. GPs are **invited** to participate. GPs should not be asked to initially prescribe but may be asked to continue prescribing for those patients in whom sertraline has proved successful. Prescribers should familiarise themselves with the guidelines and the monitoring requirements before agreeing to undertake prescribing. If the GP is not confident to undertake these roles, then he/she is under no obligation to do so. In such an event, the total clinical responsibility for the patient, including issuing prescriptions, remains with the specialist. **If a specialist asks the GP to prescribe this drug, the GP should reply to the request as soon as practicable.**

Sharing of care assumes communication between the specialist, GP and patient. The intention to share care is usually explained to the patient by the specialist initiating treatment. It is important that patients are consulted about treatment & are in agreement with it
The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.

Specialist Responsibilities
1. Discuss the benefits and side effects of treatment with the patient & parents/carers, including possible emergence of suicide related behaviours, gain consent for unlicensed use of licensed medicine if applicable. 2. Initiate and stabilise treatment with sertraline. 3. Ask the GP whether he or she is willing to participate in shared care by emailing the shared care request letter, (continue to prescribe until GP has agreed to take over prescribing). 4. Continue to prescribe until GP has agreed to take over prescribing. 5. Communicate to the GP re-established regimen; follow up arrangements and when to refer back. 6. Communicate promptly with the GP when treatment is changed. 7. Monitor treatment as stated overleaf. 8. Have a mechanism in place to receive rapid referral of a patient from the GP in the event of adverse effects or deteriorating clinical condition. 9. Notify GP of review date (three to four monthly) and give advice on stopping treatment. 10. Ensure that clear backup arrangements exist for GPs to obtain advice and support. Report adverse events to the MHRA on a Yellow Card www.mhra.gov.uk/yellowcard (If in Coventry & Warwickshire Partnership Trust via the Clinical Governance Pharmacist – see Medicines Policy section 20) and GP.

General Practitioner responsibilities
1. Reply to the request for shared care as soon as practicable, preferably within 2 weeks, by emailing back the shared care letter. If declining the request please indicate the reason for declining. 2. Prescribe the sertraline at the dose recommended, from the agreed date. 3. Adjust the dose as advised by the specialist. 4. Monitor treatment as stated overleaf. 5. Report to & seek advice from the specialist on any aspect of patient care of concern to the GP that may affect treatment. 6. Refer back to specialist if the patient's condition deteriorates, or if there are concerns over patient compliance. 7. Stop treatment on the advice of the specialist or immediately if an urgent need to stop treatment arises. Report adverse events to the MHRA on a yellow Card, the Specialist, & the appropriate Medicines Optimisation team.

Patient/carer's role
1. Report to the specialist or GP if he or she does not have a clear understanding of the treatment. 2. Share any concerns in relation to treatment with sertraline. 3. Inform specialist or GP of any other medication being taken, including over-the-counter products. 4. Report any adverse effects or warning symptoms to the specialist or GP whilst taking sertraline. 5. The patient may also choose to report any adverse drug reaction direct to the MHRA on a Yellow Card form, available at pharmacies, GP surgeries or from the Yellow Card hotline (freephone 0808 100 3352 during business hours). The form can also be downloaded from www.mhra.gov.uk/yellowcard

BACK-UP ADVICE AND SUPPORT: See patient letter and/or other supporting information for contact details of clinician(s) initiating and stabilising patient prior to request for shared care

SUPPORTING INFORMATION (see SPC for complete details/specific guidance http://emc.medicines.org.uk)

Licensed indications: Sertraline is licensed for the treatment of obsessive compulsive disorder (OCD) in paediatric patients aged 6-17 years. The use of sertraline for other indications in this population is unlicensed, but is recommended by NICE as one of the second line treatment options for the treatment of depression if fluoxetine is unsuccessful or not tolerated because of side effects.

Dosage and administration: OCD[1]: Age 13-17 years*:* Initially 50 mg once daily.
Age 6-12 years: Initially 25 mg once daily. The dosage may be increased to 50 mg once daily after one week.
Subsequent doses may be increased in case of less than desired response in 50 mg increments over a period of some weeks, as needed. The maximum dosage is 200 mg daily. The generally lower body weights of children compared to those of adults should be taken into consideration when increasing the dose from 50 mg. Dose changes should not occur at intervals of less than one week.
Depression[2]: Initially 25 mg, gradually increased if clinically necessary to 200 mg over the next 2 to 4 weeks. Lower doses should be considered in children with lower body weight. There is little evidence regarding the effectiveness of the upper daily doses for adults in children and young people, but these may be considered in older children of higher body weight and/or when, in severe illness, an early clinical response is considered a priority. When a child or young person responds to treatment, the sertraline should be continued for at least 6 months after remission (defined as no symptoms and full functioning for at least 8 weeks).
Anxiety or PTSD[3]: Initially 12.5 mg to 25 mg; increase as clinically necessary to within the dose range of 25 mg to 200 mg daily.
Administration tips: Many 50 mg tablets are scored; and they can be split on the score line to enable a 25 mg dose[4]. Wherever possible the child/adolescent should be encouraged to use tablet formulations rather than prescribing a liquid "special" which may cost upwards of £1,000 per year (see cost information below).
Crushing the tablets should be avoided as the tablets have a bitter taste and an anaesthetic effect on the tongue[5].
Enteral tubes: the crushed tablets can be dispersed in water before administering via the tube[5]. (May take 1 to 5 minutes to disperse).
Discontinuation: The dose should be gradually reduced over a period of at least 6 weeks[3] to minimise withdrawal effects.

Monitoring:
Consultant Baseline and at regular intervals: Suicidal symptoms, self-harm and hostility; mental state and general progress; emergence of mania/hypomania; height, weight, TANNER staging (where appropriate)
GP: no specific monitoring; to review and act on adverse physical reactions which emerge between consultant appointments

Cautions[1] - Suicide-related behaviours (suicide attempt and suicidal thoughts), and hostility (predominantly aggression, oppositional behaviour and anger) were more frequently observed in clinical trials among children and adolescents treated with antidepressants compared to those treated with placebo. The patient should be carefully monitored for appearance of suicidal symptoms. A few cases of **retarded growth** and **delayed puberty** have been reported post-marketing. The clinical relevance and causality are yet unclear. Physicians must monitor paediatric patients on long term treatment for abnormalities in growth and development. Co-administration of sertraline with other drugs which enhance the effects of serotonergic neurotransmission e.g. tryptophan, fenfluramine, 5-HT agonists, St John's Wort should be undertaken with caution and avoided whenever possible. Patients should be monitored for the emergence of signs and symptoms of **serotonin syndrome** or **neuroleptic malignant syndrom**e. May cause **QTc prolongation**; sertraline should be used with caution in patients with risk factors for QTc prolongation. Should only be used with caution in patients with a history of **mania/hypomania**. Sertraline should be discontinued in any patient entering a manic phase. **Psychotic symptoms** may be exacerbated in patients with schizophrenia. Sertraline should be avoided in patients with **unstable epilepsy**; patients with **controlled epilepsy** should be carefully monitored. Sertraline should be discontinued in any patient who develops **seizures**. There have been reports of **bleeding abnormalities** with SSRIs including cutaneous bleeding (ecchymoses and purpura) and other haemorrhagic events such as gastrointestinal or gynaecological bleeding, including fatal haemorrhages. Caution is advised in patients taking SSRIs, particularly in concomitant use with drugs known to affect platelet function (e.g. anticoagulants, atypical antipsychotics and phenothiazines, most tricyclic antidepressants, acetylsalicylic acid and non-steroidal anti-inflammatory drugs (NSAIDs)) as well as in patients with a history of bleeding disorders. **Hyponatraemia** may occur with sertraline. **Withdrawal symptoms** when treatment is discontinued are common, particularly if discontinuation is abrupt. Generally these are mild to moderate. It is advised that sertraline should be gradually tapered over a period of several weeks or months when discontinuing. The use of sertraline has been associated with the development of **akathisia**. Cautioned in patients with risk factors for **QTc prolongation**. Cautioned in patients with **angle-closure glaucoma** or history of **glaucoma**. False-positive urine immunoassay screening tests for benzodiazepines have been reported in patients taking sertraline. May affect **glycaemic control** in patients with diabetes. If sertraline is administered to patients with **hepatic impairment**, a lower/less frequent dose should be considered; should not be used in patients with **severe** hepatic impairment.
Contra-indications[1]: Hypersensitivity to the active substance or any of the excipients. Concomitant treatment with irreversible monoamine oxidase inhibitors (MAOIs) (risk of serotonin syndrome) Sertraline must not be initiated for ≥14 days after discontinuation of treatment with an irreversible MAOI. Sertraline must be discontinued for ≥7 days before starting treatment with an irreversible MAOI. Concomitant intake of pimozide or linezolid.

Side effects[1]: In over 600 paediatric patients treated with sertraline, the overall profile of adverse reactions was generally similar to that seen in adult studies. Adverse reactions reported from controlled trials (n=281 patients treated with sertraline): *Very common (≥1/10)*: headache (22%), insomnia (21%), diarrhoea (11%) and nausea (15%). *Common (≥1/100 to <1/10)*: chest pain, mania, pyrexia, vomiting, anorexia, affect lability, aggression, agitation, nervousness, disturbance in attention, dizziness, hyperkinesia, migraine, somnolence, tremor, visual disturbance, dry mouth, dyspepsia, nightmare, fatigue, urinary incontinence, rash, acne, epistaxis, flatulence. *Uncommon (≥1/1000 to <1/100)*: ECG QT prolonged, suicide attempt, convulsion, extrapyramidal disorder, paraesthesia, depression, hallucination, purpura, hyperventilation, anaemia, hepatic function abnormal, alanine aminotransferase increased, cystitis, herpes simplex, otitis externa, ear pain, eye pain, mydriasis, malaise, haematuria, rash pustular, rhinitis, injury, weight decreased, muscle twitching, abnormal dreams, apathy, albuminuria, pollakiuria, polyuria, breast pain, menstrual disorder, alopecia, dermatitis, skin disorder, skin odour abnormal, urticaria, bruxism, flushing. *Frequency not known*: enuresis. *See SPC for full list.*

Drug interactions[1]**:** with drugs that have **serotonergic effect** (e.g. serotonergic antidepressants, triptans) or affect **platelet function** (see cautions); with irreversible **MAOIs** (see contra-indications). Following treatment with a **reversible MAOI-**, a shorter withdrawal period than 14 days may be used before sertraline initiation. It is recommended that sertraline should be discontinued for ≥ 7 days before starting treatment with a reversible MAOI. Interacts with CYP 2D6 substrates with a narrow therapeutic index e.g. **class 1C antiarrhythmics** such as **propafenone** and **flecainide, tricyclic antidepressants** and **typical antipsychotics**, especially at higher sertraline dose levels. Interacts with **grapefruit** (increased levels of sertraline). Administration with potent or moderate CYP3A4 inhibitors, e.g. **protease inhibitors, ketoconazole, itraconazole, posaconazole, voriconazole, clarithromycin, telithromycin** and **nefazodone, aprepitant, erythromycin, fluconazole, verapamil** and **diltiazem** may result in increased sertraline levels. Possible interaction with strong inhibitors of CYP2C19, e.g. **omeprazole**, **lansoprazole, pantoprazole, rabeprazole, fluoxetine, fluvoxamine**. May cause prolongation of action of **mivacurium** or other **neuromuscular blockers**. Co-administration with **cimetidine** may cause a substantial decrease in sertraline clearance. Co-administration with **warfarin** may result in an increase in prothrombin time (may in rare cases unbalance the INR value). Co-administration of phenytoin may cause a reduction in plasma levels of sertraline. Monitor plasma **phenytoin** levels if starting sertraline. Other CYP3A4 inducers, e.g. **phenobarbital**, **carbamazepine**, **St John´s Wort**, **rifampicin** may cause a reduction of sertraline plasma levels. Use with **alcohol or grapefruit juice** is not recommended. When prescribing selective serotonin reuptake inhibitors (SSRIs), the MHRA[6] have reminded prescribers to enquire about cocaine use when considering drug–drug interactions and the need to avoid concurrent use of multiple serotonergic drugs.

Cost: (Drug Tariff July 2016): At current prices, one year's treatment at 100 mg per day costs £17.76 (tablets) £3068.74. (suspension)

References:

1. SPC Lustral accessed 14/7/16 *http://www.medicines.org.uk/emc/medicine/27116*
2. Depression in children and young people: identification and management (CG28) www.nice.org.uk
3. The Maudsley Prescribing Guidelines in Psychiatry 12th Edition 2015
4. Lustral Patient information leaflet accessed 18/7/16 http://www.medicines.org.uk/emc/medicine/2362
5. The NEWT Guidelines 3rd Edition 2015
6. MHRA. Drug Safety Update Volume 9 Issue 12, July 2016: 2.

See patient letter and/or other supporting information for contact details of clinician(s) initiating and stabilising patient prior to request for shared care.