Basingstoke, Winchester & Southampton District Prescribing Committee

Shared Care Guideline for Ciclosporin (GP Summary)

It is essential that a transfer of care only takes place with agreement of the GP and when sufficient information has been received. If the GP does not agree to share care they will inform the Consultant responsible for the patient's care.

Specialist Contact Details	Patient ID Label
Name: _____	Surname: _____
Location: _____	Forename: _____
Date: _____	NHS Number: _____
Tel: _____	Date of Birth: _____

Indications	**Licensed:** Rheumatoid arthritis, psoriasis, atopic dermatitis
Dose & Response	**Dose:** **NB: Different brands of ciclosporin are not interchangeable and patients must remain on the same brand.** **Rheumatoid arthritis:** Start at 2.5mg/kg/day in two divided doses for 6 weeks and then may be incrementally increased by 25mg at 2-4 weekly intervals until clinically effective. Often effective between 2.5–3.2mg/kg/ day. Adjust to patient's tolerance and benefit. Constantly evaluate response and toxicity before increasing to the maximum dose. Maximum dose: 4mg/kg/day. **Duration:** If the response is maintained then doses are usually given daily indefinitely. Treatment may be withdrawn after a prolonged period of disease remission in selected cases. **Psoriasis and atopic dermatitis (BAD):** starting dose 2.5–5mg/kg/day in two divided doses depending on disease severity and then treated according to response; maximum dose 5mg/ kg/day. **Duration:** If the response is maintained then doses are usually given daily for up to 12 months unless otherwise directed by a dermatologist. Note that BNF states maximum duration of treatment for psoriasis usually 1 year unless other treatments cannot be used. **"Off-label use – Uveitis:** Start at 2.5mg/kg/day in two divided doses for 6 weeks and then may be incrementally increased by 25mg at 2-4 weekly intervals until clinically effective. Often effective between 2.5–3.2mg/kg/ day. Adjust to patient's tolerance and benefit. Constantly evaluate response and toxicity before increasing to the maximum dose. Maximum dose: 4mg/kg/day. **Duration:** If the response is maintained then doses are usually given daily indefinitely. Treatment may be withdrawn after a prolonged period of disease remission in selected cases
Secondary Care responsibilities	• Prescribing initial doses of ciclosporin, stating the brand to be used • Requesting and monitoring of blood results until dose stable - usually 6-12 weeks
GP responsibilities	• Prescribing maintenance dose of ciclosporin according to the dose regimen suggested by the Rheumatologist or Dermatologist. • Request blood tests once dose is stable and requested by hospital to take over shared care • Review blood test results before prescribing and, in cases where blood tests have not been performed in secondary care, ensure copy of blood test results is provided to relevant secondary care physician in Dermatology and/or Rheumatology • Ensure the patient understands their treatment and which warning signs to report. Advise patients to report symptoms of bone marrow suppression, such as inexplicable bruising, bleeding or severe sore throat/oral ulceration, immediately • Communicate with Rheumatologist and/or Dermatologist regarding any problems/compliance issues **Recommended monitoring for new DMARDs; note that recommended monitoring may be modified to more frequently if patient has comorbidities.** • **FBC,Creatinine (or GFR), ALT, albumin every 2 weeks until stable dose for 6 weeks** • **Then monthly FBC, Cr (or GFR), ALT, albumin for 3 months** • **Then FBC, Cr (or GFR), ALT, albumin at least every 12 weeks** • **For dose increases - FBC, Cr (or GFR), ALT, albumin every 2 weeks until stable dose for 6 weeks then back to previous schedule**

Reviewed November 2017
Next review due May 2019
Uveitis added as an indication – January 2022

	Monitoring specific to ciclosporin ○ **Check Blood Pressure and glucose at each monitoring visit** ○ **Patients who have been stable for 12 months can be considered for reduced frequency of monitoring on an individual patient basis, in consultation with the relevant specialist** • Communicate with specialist regarding any problems/compliance issues • Pneumococcal vaccination every 10 years and annual influenza vaccinations are recommended for patients with inflammatory arthritis • Although the shingles (Zostavax) vaccine is a live attenuated vaccine, treatment with ciclosporin is not considered sufficiently immunosuppressive and is not a contraindication to administering the vaccine (British Society for Rheumatology guideline 2017) • The British Association of Dermatologists recommends that the shingles (Zostavax) vaccine should not be administered to patients treated with ciclosporin
Actions to be taken in response to monitoring	**Thresholds at which to discontinue treatment and contact Rheumatology or Dermatology for urgent advice:** • **WCC<3.5 x10^9/L** • **Neutrophils<1.6 x10^9/L** • **Unexplained eosinophilia>0.5 x10^9/L** • **Platelets<140 x10^9/L** • **MCV>105** • **ALT>100 units/L** • **Unexplained fall in albumin** • **Creatinine>30% above baseline +/- GFR<60**
Contra-indications	• **Uncontrolled hypertension** • **Severe electrolyte imbalance** i.e. hyperkalaemia • **Suspected systemic infection or sepsis** • **Malignancy** – see BNF for details
Cautions	• **Pregnancy and lactation** • **Reduction in liver and/or renal function**, especially where patient is taking other medications that may also cause these issues. Communicate with rheumatologist/dermatologist regarding dose adjustments • **Grapefruit** including grapefruit juice must be avoided for 1 h before or after taking ciclosporin tablets as bioavailability is increased • **Malignancy** such as lymphomas • **Live vaccines** - patients receiving ciclosporin must not receive immunisation with live vaccines. Inactivated polio is available although suboptimal response may be seen
Important adverse effects & management	• **Abnormal bruising** - Check FBC immediately and withhold until discussed with the specialist team
Important drug Interactions	• **Diclofenac:** Avoid or use alternative NSAID • **Colchicine:** Avoid • **Simvastatin:** Avoid or use alternative • **Nifedipine:** Use with caution • **Digoxin:** May increase the serum levels of digoxin • **St. John's Wort:** Decreases ciclosporin activity • **Potassium sparing diuretics**

This guidance should be read in conjunction with the BNF

Contact numbers for urgent GP advice:
Southampton –Dermatology: On-call SpR (Mon-Fri 9-5), Out of hours - on-call SpR or consultant. All can be contacted via hospital switchboard; 023 8077 7222

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Southampton - Rheumatology: Nurse specialist advice line 023 8120 5352 or bleep SpR 1801 (Mon-Fri 9-5). Out of hours – on-call consultant via hospital switchboard
Basingstoke - Administration team 01256 312768, fax 01256 313653, advice line (answerphone) 01256 313117 or on-call consultant via switchboard
Winchester – Administration team 01964 824150, advice line 01962 824256, on-call SpR bleep 3425 via switchboard

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