In partnership with Hampshire, Southampton and Isle of Wight Clinical Commissioning Group

Essential Shared Care Agreement
Acamprosate

Please complete the following details:
Patient's name, address, date of birth
Consultant's contact details (p.3)
And send One copy to:

1. ***The patient's GP***
2. ***Put one copy in care plan***
3. ***Give one copy to the patient***

Patient's name:	
NHS Number:	
Patient's address:	
Patient's Date of Birth:	
Patient ILLY no:	
As of this date: **Please add to repeat prescription**	
Medication prescribed: **Dose:**	

The aim of this shared care agreement is to provide information on the responsibilities of the General Practitioner and the Consultant while sharing the care of patients prescribed medicines covered by the shared care agreement.
Guidelines will only be written when it has been agreed that shared care is an appropriate option, and will include a statement of Specialist Unit /GP responsibilities.
Shared Care Guidelines will ensure that all GPs have sufficient information to enable them to undertake responsibility for specialist therapies and other therapies which may affect/interact with specialist therapies.
It is not the intention to insist that GPs prescribe such a therapy and any doctor who does not wish to undertake the clinical and legal responsibility for a Shared Care Drug is not so obliged. (It should be noted that it is inappropriate to decline the invitation to shared care on the grounds of cost alone).Acceptance of the Shared Care Guidelines will be endorsed by the Medicines Management Teams of the CCGs.
The information contained in this guideline is issued on the understanding that it is the best available from the resources at our disposal at the time of issue.
For further information please refer to the relevant Summary of Product Characteristics and NICE guidance or contact your local Specialist or Drug Information Centre.

Further copies of this guideline may be obtained from:

- Midlands Partnership NHS Foundation Trust
- CCG's Prescribing Advisers.

Produced: Dr R. Turner
Review date: Jan 2025

Shared Care Guideline		Reference Number
Version: 3	**Replaces: 2**	**Issue date: 28/01/2022**
Author(s)/Originator(s): (please state author name and department) *Dr Rachel Turner GPwSI Inclusion Substance Misuse Services Hampshire*		**To be read in conjunction with the following documents:** Current Summary of Product characteristics (http://www.medicines.org.uk) BNF

Date approved by Trust Governance Group: 28/01/2022	**Date approved by MPFT Medicines Management Group: 28/01/2022**
Date approved by CCG: 28/01/2022	**Review Date: Jan 2025**

PLEASE COMPLETE ALL SECTIONS

1. Licensed Indications	Maintenance of abstinence in alcohol dependence
2. Background and therapeutic use:	Acamprosate is licensed for maintenance of abstinence in alcohol dependent patients aged 18-65 years as an adjunct to appropriate psychosocial interventions and support. Acamprosate is thought to act as a GABA mimic, enhancing the inhibitory neurotransmission and antagonising glutamic acid (the excitatory pathways). It may be neuro-protective and reduce the kindling effect observed in repeated alcohol withdrawals and many patients report reduced physical cravings to drink although the mechanism of this is not fully understood. Large series of placebo controlled trials across Europe have demonstrated efficacy and a dose-related effect (abstinence rates increased by approximately 10-40% compared with placebo). NICE have therefore recommended as first line treatment after successful withdrawal from alcohol for relapse prevention (NICE Clinical Practise Guideline 115 Feb 2011).
3. Contraindications (see also the BNF and the SPC):	Established hypersensitivity to Acamprosate, Renal impairment (creatinine >120mmol), severe hepatic failure (Childs-Pugh Classification C), Pregnancy, Breastfeeding, Children.
4. Pregnancy and Lactation:	Acamprosate should not be prescribed in pregnant or breastfeeding patients and should be discontinued if pregnancy occurs.
5.Dose/Administration	Acamprosate is available as 333mg enteric-coated tablets (Campral EC). Oral administration. Taking Acamprosate with food may reduce its bioavailability but reduce side-effects. Treatment should be initiated as soon as possible after detoxification and can be started during a chlordiazepoxide detoxification. There is some evidence to suggest that starting it before the detoxification may reduce the risk of kindling and worsening subsequent withdrawals. It should be prescribed in combination with adjunctive psychosocial interventions. Treatment can be continued for up to 12 months but in practice this is usually 3-6 months. Acamprosate should be stopped in the event of a full relapse, lack of efficacy or intolerable side-effects. It works best in those who are abstinent but may be effective in reducing the risk of a minor lapse becoming a full relapse (return to heavy drinking for 4-6 weeks) so it should be continued in these patients until a full relapse becomes obvious. • Adult >60kg: 666mg (2 tablets) three times a day • Adult <60kg:666mg mane, 333mg midday and 333mg 6pm **Please note that in all cases the specialist service will prescribe the first 2-4 weeks prior to asking the GP to continue prescribing.**

6.Drug Interactions (see also BNF and SPC):	There are no significant drug interactions and Acamprosate can be prescribed safely with benzodiazepines in a detoxification regimen.
7.Side-effects (see also BNF and SPC):	• Very common (>10%): diarrhoea, headaches. **Action:** reassure as usually mild and self-limiting, advise to drink plenty of water and try simple analgesia for headaches. Discontinue Acamprosate if severe and persistent. • Common (<10%): stomach pain, nausea and vomiting, skin rash and pruritus, fluctuation of libido and anorgasmia. **Action:** taking the tablets with or after food can help gastrointestinal side-effects but it may reduce the bioavailability, alternatively reduce the dose to the lower dose level (666mg, 333mg, 333mg). In the event of a rash discontinue Acamprosate. Otherwise reassure and discontinue Acamprosate if symptoms severe or persistent. Rare (<0.1%): Allergy, Bullous rash and palpitations. **Action:** Stop Acamprosate in the event of allergic reaction and in the event of bullous rash (and consult a dermatologist). Palpitations are usually mild and self-limiting but may require discontinuation of Acamprosate.
8. Baseline Investigations and Advice	• Baseline blood tests are not required unless severe renal impairment or end-stage liver disease is suspected (Childs-Pugh C). In practice most patients will have a recent set of LFTs done prior to detox. The patient should be weighed to establish correct dosage (if <60kg use the lower dose regimen). The patient should be advised of the potential side-effects.
9. Monitoring:	No blood test monitoring required. 2-4 weekly review by keyworker in specialist service initially and then 6-8 weekly review thereafter by the GP. The purpose of the review is to monitor side-effects and efficacy and ensure engagement in the psychosocial support programme. GPs will be advised by Inclusion of the level of engagement of the patient with the specialist service.
10. Criteria for Shared Care:	Prescribing responsibility will only be transferred when: • Treatment is for a specified indication and duration • Treatment has been initiated and established by the specialist (Inclusion Services or detoxification unit under an Inclusion care plan, i.e. not if privately arranged) • The patient's general physical, mental and social circumstances allow for shared care arrangements
11. Responsibilities of initiating specialist	• Initiate treatment or advise the GP regarding initiating treatment as appropriate • Monitor initial reaction and progress • Prescribe enough medication until the GP supply can be arranged (minimum 1 month) • Continue to review the patient according to this protocol and agree to review promptly if contacted by the GP • Provide GP with adequate information on the diagnosis, treatment plan, drug information and baseline results. Letters detailing outpatient consultations should be sent within 14 days of the date of the consultation • Provide the patient with relevant information (preferably written) on the drug to include potential side-effects and appropriate action

12. Responsibilities of the GP	• Continue treatment as directed by the specialist • Monitor and prescribe in collaboration with the specialist according to this protocol • Discontinue medication if lack of efficacy, full relapse of unacceptable or severe side-effects • Communicate with secondary care as necessary and promptly
13. Responsibilities of the patient	• Take medication as prescribed and inform clinician if not taking medication • Attend primary and secondary care appointments • Report adverse effects to their keyworker, GP or specialist
14. Supporting documentation:	The SCG must be accompanied by a patient information leaflet. (Available from http://www.medicines.org.uk/emc OR http://www.mhra.gov.uk/spc-pil/)
15. Shared care agreement form:	**See Annex 1** **Note: This agreement would last for a maximum of 3 months duration. Responsibility for continuing prescribing following this period, if felt appropriate, would be at the responsibility of the Primary Care prescriber and any associated costs.**
16. Substance Misuse Contact numbers:	**Hampshire Inclusion Recovery Teams - Tel : 0300 124 0103 and choose from the following options:** **Option 1 = Aldershot** **Option 4 = Fareham** **Option 7 = Winchester** **Option 2 = Basingstoke** **Option 5 = Havant** **Option 8 = Andover** **Option 3 = Eastleigh** **Option 6 = New Forest**

Annex 1

as part of

In partnership with

Shared Care Agreement for Acamprosate

Name of Prescriber:

Specialist Area:

Telephone Number:

Fax Number:……

Signature: Date:

Patient's Name:

Address:

ILLY No:

Drug and dose:

Name of GP:

Signature: Date:

Practice Address

- ***This form will be required for invoicing purposes to the Inclusion (Midlands Partnership NHS Foundation Trust)***