THE Doncaster and Bassetlaw

Guidance

for

Management of Prescribing for Dementia (Doncaster and Bassetlaw APC)

Initially developed - September 2008
Rotherham, Doncaster & South Humber NHSFT (RDaSH)
Doncaster and Bassetlaw Area Prescribing Committee

Most recent review – October 2019
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NHS Bassetlaw Clinical Commissioning Group

NHS Doncaster Clinical Commissioning Group

NHS Rotherham Doncaster and South Humber NHS Foundation Trust

Management of Prescribing for Dementia (Doncaster and Bassetlaw APC)

Statement of purpose

This guidance has been written to enable the continuation of care by primary care clinicians of patients initiated on anti-dementia drugs (acetylcholine esterase inhibitors (AChEIs) and/or memantine) by:

- Secondary care medical specialists such as psychiatrists, geriatricians and neurologists
- Other healthcare professionals (such as GPs, nurse consultants and advanced nurse practitioners), if they have specialist expertise in diagnosing and treating Alzheimer's disease.

Where this is appropriate and in the patients' best interests. Primary care will only be requested to take over prescribing of anti-dementia drugs within their licensed indication unless specifically detailed otherwise below.

Responsibilities of specialist clinician

- To discuss benefits and side effects of treatment with the patient/carer and obtain informed consent, in line with national guidance. This is particularly important for unlicensed products.
- To provide patient/carer with contact details for support and help if required; both in and out of hours
- To initiate anti-dementia drugs in appropriate patients
- To prescribe the first month's supply and titrate to maintenance dose or until patient stable
- Assess effectiveness of treatment at minimum of one month after reaching maintenance dose
- Reassess on a regular basis to ensure continuing benefit, minimum annually using appropriate scales
- To contact patient's primary care prescriber to request prescribing
- To advise the primary care prescriber regarding continuation or discontinuation of treatment, including the duration of treatment
- To discuss any concerns with the primary care prescriber regarding the patient's therapy
- The patient to normally remain under the specialists' care, but if on-going specialist co-ordination of the patient's care is not required, an individual care plan should be agreed on a case by case basis. This may include depending on the CCG, access to advice and intervention of that specialist in a timelier manner than via a new referral, and may fall outside shared care arrangements. CCG approval may be required.

Responsibilities of the primary care clinician

- To refer appropriate patients to secondary care for assessment
- Confirm the acceptance of the ongoing prescribing arrangement.
- To report any serious adverse reaction to the appropriate bodies eg: MHRA and the referring specialist

- Ensure monitoring as indicated in monitoring section below
- Consider discontinuation, in line with guidance below and to inform the specialist if the patient discontinues treatment for any reason
- To seek the advice of the specialist if any concerns with the patient's therapy
- To conduct an annual medication review or more frequent if required.

Responsibilities of patients or carers

- To be fully involved in, and in agreement with, the decision to move to primary care prescribing.
- To attend primary care clinic appointments and to bring monitoring information eg: booklet (if required). Failure to attend will potentially result in the medication being stopped.
- Present rapidly to the primary care prescriber should the clinical condition significantly worsen.
- Report any suspected adverse effects to their primary care prescriber whilst taking anti-dementia drugs
- To read the product information given to them
- To take anti-dementia drugs as prescribed
- Inform the specialist, primary care prescriber or community pharmacist dispensing their prescriptions of any other medication being taken – including over-the-counter medication.

Indication

This guidance applies to any patient with a neurodegenerative dementing process that could respond favourably to cognitive enhancers. In practice this means patients with Alzheimer's disease, but also could include similar presentations (such as Pick's Disease and Lewy Body Dementia (LBD)). Mixed vascular and Alzheimer's dementia can respond to medication, patients with pure vascular dementia are excluded from this guidance.

This guidance only covers the pharmacological management of Alzheimer's disease and non-Alzheimer's dementia. For guidance on managing behavioural and psychological symptoms of patients with dementia (BPSD) please refer to: BPSD Guidance on the Doncaster CCG medicines management website.

THERAPEUTIC USE

1.1. ALZHEIMER'S DEMENTIA

1.1.1. Initiation of treatment

For people who are not taking an AChE inhibitor or memantine, prescribers should only start treatment with these on the advice of a clinician who has the necessary knowledge and skills. This could include:

- Secondary care medical specialists such as psychiatrists, geriatricians and neurologists

- Other healthcare professionals (such as GPs, nurse consultants and advanced nurse practitioners), if they have specialist expertise in diagnosing and treating Alzheimer's disease.

1.1.2. Acetylcholinesterase (AChE) inhibitors

Donepezil, galantamine and rivastigmine are recommended as monotherapy options for the treatment of mild to moderate Alzheimer's disease. AChE Inhibitors may form part of combined treatment with memantine.

When the decision has been made to prescribe an acetylcholinesterase inhibitor, it is recommended that therapy should be initiated with a drug with the lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started). However, an alternative acetylcholinesterase inhibitor could be prescribed where it is considered appropriate having regard to adverse event profile, expectations around concordance, medical co-morbidity, possibility of drug interactions, and dosing profiles.

1.1.3. Memantine

Memantine monotherapy is recommended as an option for managing Alzheimer's disease for people with:

- Moderate Alzheimer's disease who are intolerant of or have a contraindication to AChE inhibitors **or**
- Severe Alzheimer's disease

Memantine may be part of combined treatment with AChE inhibitors.

1.1.4. Combination of AChE Inhibitor and Memantine

For people with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor:

- Consider memantine in addition to an AChE inhibitor if they have moderate disease
- Offer memantine in addition to an AChE inhibitor if they have severe disease

1.2. NON- ALZHEIMER'S DEMENTIA

1.2.1. Dementia with Lewy bodies

- Donepezil or rivastigmine will be considered for people with mild to moderate and severe dementia with Lewy bodies
- Galantamine will only be considered for people with mild to moderate dementia with Lewy bodies if donepezil and rivastigmine are not tolerated.
- Memantine will be considered for people with dementia with Lewy bodies if AChE inhibitors are not tolerated or are contraindicated

Vascular dementia, frontotemporal dementia and cognitive impairment caused by multiple sclerosis are not indications covered within this guidance.

For guidance on pharmacological management of Parkinson's disease dementia, see Parkinson's disease dementia in the NICE guideline on Parkinson's disease

This guidance has been updated in line with

- NICE guideline [NG97] Dementia: assessment, management and support for people living with dementia and their carers. June 2018
- Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease (TA217)

NICE recognise that suitably experienced GPs may wish to initiate anti-dementia treatment in primary care for patients with an established diagnosis of dementia. While this initiation is outside of agreed shared care arrangements, such GPs should use this document guide as part of their decision making.

Prescribing of anti-dementia drugs in primary care

AChE inhibitors are Amber-G on the Doncaster traffic light system
Memantine is Green-G on the Doncaster traffic light system

Where a patient has a diagnosis of dementia

- RDaSH services will initiate AChE inhibitors and will be actively involved in patient care while establishing an appropriate management plan. Prescribing may be passed to primary care during this period when a medication has been determined to be effective and stable.
- Memantine initiation may occur in primary care
    - by suitably experienced GPs or
    - following discussion with RDaSH OPMH specialist or commissioned dementia expert (eg Admiralty Nursing)

Dosage

For dosage and other prescribing information please see current BNF:
http://www.bnf.org.uk/bnf/bnf/current/index.htm

For more detailed dosing and prescribing information the summary of product characteristics for the individual drug: http://www.medicines.org.uk/

Contra-indications

For contra-indications please see individual monographs as indicated in “Dosage.”

Side –effects

For side-effects information please see individual monographs as indicated in “Dosage.”

Monitoring

Monitoring of effectiveness, side effects and continued benefit should be conducted ad hoc, but annually as a minimum.

This will be done by RDaSH where the patient is actively under their treatment, otherwise it is the responsibility of primary care.
There is no specific physical health monitoring required for use of these medicines.

Appropriate scales should be used to help judge effectiveness, such as

- Montreal Cognitive Assessment (MOCA)
- Severe Impairment Battery (SIB)
- The Neuropsychiatric Inventory (NPI)
- The Bristol Activities of Daily Living (BADL) scale
- Six Item Cognitive Impairment Test (6CIT)
- Mini-Mental State Examination (MMSE)
- Mini-Addenbrooke's Cognitive Examination (MACE)

Interactions

For drug interaction information please see individual monographs as indicated in "Dosage."

Additional information

Guidance on Continuation of anti-dementia medication

Treatment should be maintained where

- The patient meets the criteria in the initiation and monitoring in mild to severe Alzheimer's disease by response in at least one domain which is clinically relevant. Improvement/ stabilisation of cognitive function better than expected natural decline e.g. less than expected decline in MOCA score of >5 points in 12 months in moderate disease or 5 points on the SIB over 6 months in severe disease.
- Meaningful improvement/ stabilisation of functional ability as evidenced by improvement, stabilisation or reduction in expected decline (<10/60 in 12 months) on clinically relevant items or total score on the BADL in moderate disease or improvement or stabilisation in severe disease.
- Reduction in aggressive behaviour that challenges and/or psychosis as evidenced by NPI improved scores of 2 or more in the relevant subscale over 6 months.
- An overall clinical global impression of stabilisation or improvement must be stated.

Where there has been demonstrable further decline treatment escalation should be considered as highlighted in the table below.

Severity	MOCA	Drug options	Comment
Mild	>20	• Initiate AChEI	• If annual drop ≤5 pts – continue • If drop >5 pts consider a swap of AChEI
Moderate	10-20	• AChEI +/- memantine • Memantine alone if AChEI ineffective or not tolerated	Continued decline - consider adding memantine
Severe	<10	• AChE + memantine • Memantine alone if AChEI ineffective or not tolerated	If MOCA <9 pts consider drug holiday for 2 weeks, removing AChEI first

Guidance on consideration for discontinuation of anti-dementia medication

Discontinuation must be discussed first with the Consultant, carers, family, and with the patient wherever possible. Consider discontinuation of treatment in situations where

- Adverse reaction to the medication or
- Lack of compliance with the medication lack of evidence of efficacy i.e. the patient does not fulfil the criteria for continuation stated above or
- Patient is on an end of life care pathway or
- If the treatment is for cognitive problems predominantly a MOCA of <5/30 or SIB score of <30/100. GPs may wish to use any recognised cognitive tests (eg 6 item CIT) to determine cognitive decline and likely continued benefit of anti dementia drug or
- An irreversible deterioration in the patients global clinical presentation since the last review e.g., a CVA

An overall clinical global impression must state the treatment is no longer effective

Do not stop AChE inhibitors in people with Alzheimer's disease because of disease severity alone.

Re-Referral guidelines

Patients who are being treated on the advice of the secondary care team, but are no longer being seen in that setting, may still need review should problems arise. The appropriate level of care and/or advice should be available from the secondary care team in a timely manner without requiring a new referral. Include route of return' should their condition change (such as a return of symptoms, or a development of adverse effects).

Ordering information

There are no special ordering requirements.

Contacts for support, education and information

Office Hours – Specialist Locality based Older Person's CMHT:

Doncaster Central OP CMHT : 01302 566555
Doncaster East OP CMHT : 01302 566505
Doncaster North OP CMHT : 01302 566500
Doncaster South OP CMHT : 01302 796104

Out of hours – On-call **The Single Point of Access** Tel: 01302 566999

References

- NICE guideline [NG97] Dementia: assessment, management and support for people living with dementia and their carers. June 2018
- Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease (TA217)
- British National Formulary: http://www.bnf.org.uk/bnf/bnf/current/index.htm
- Electronic Medicines Compendium: http://www.medicines.org.uk/

https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf

It will be presumed by the referring specialist that the primary care team is operating under this guidance. Should the primary care prescriber feel unable to act under this prescribing guidance they should discuss with the specialist requesting the care in the first instance and explain to their patient why they are declining to provide this care. If after discussion they still feel unable to prescribe then the primary care clinician must notify the specialist in writing.

As stated under primary care responsibilities, they should communicate with the specialist to confirm the transfer of prescribing.