

# **Somatropin in Adults Shared Care Guideline**

**V5.1**

**March 2026**

## 1. Aim/Purpose of this Guideline

- 1.1. This Shared Care Guideline has been approved whilst the system-wide approach with the Local Medical Committee to shared care is under review. Hence this guideline may be altered sooner than its review date.
- 1.2. This guideline applies to medical, nursing and pharmacy staff in the safe and appropriate prescription and administration of Somatropin (growth hormone) when used in adults.
- 1.3. The Society for Endocrinology estimates that the prevalence of adult-onset GH deficiency is approximately 1 in 10,000 of the adult UK population.
- 1.4. Growth hormone is produced by the anterior pituitary gland. It has a role in the regulation of protein, lipid and carbohydrate metabolism, as well as in increasing growth in children. GH deficiency in adults may be associated with the following adverse features to a variable degree in any individual: reduced quality of life (QoL) especially reduced energy levels; altered body composition (reduced lean mass and increased fat mass, especially in the trunk); osteopenia/osteoporosis (reduced bone mineral density); dry skin (reduced sweating); reduced muscle strength and exercise capacity; lipid abnormalities (especially elevated LDL cholesterol); insulin resistance; increased levels of fibrinogen and plasminogen activator inhibitor; reduced extracellular fluid volume; increased thickness of the intima media of blood vessels; and impaired cardiac function.
- 1.5. Clinical studies have shown that growth hormone replacement therapy in such patients produces modest though significant improvements in these clinical features. However, they do not yet provide evidence that, for example, cardiac events or fracture rates are reduced as a consequence.
- 1.6. This shared care guideline sets out details for the sharing of care of adults with growth hormone deficiency prescribed somatropin. These guidelines provide additional limited information necessary to aid in the treatment of these patients. As with all shared care guidelines they highlight relevant prescribing issues but should be used in conjunction with relevant NICE guidance, the BNF, ABPI summary of product characteristics and do not replace them.
- 1.7. This version supersedes any previous versions of this document.

## **Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.**

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust      [rch-tr.infogov@nhs.net](mailto:rch-tr.infogov@nhs.net)

## **2. The Guidance**

2.1. Recombinant human growth hormone (somatropin) treatment is recommended for the treatment of adults with GH deficiency only if they fulfil all three of the following criteria:

- They have severe GH deficiency, defined as a peak GH response of less than 9 mU/litre (3 ng/ml) during an insulin tolerance test or a cross-validated GH threshold in an equivalent test.
- They have a perceived impairment of quality of life (QoL), as demonstrated by a reported score of at least 11 in the disease-specific 'Quality of life assessment of growth hormone deficiency in adults' (QoL-AGHDA) questionnaire.
- They are already receiving treatment for any other pituitary hormone deficiencies as required and these therapies have been optimised.
- NICE state the QoL status of people who are given GH treatment should be reassessed 9 months after initiation of therapy.

2.2. Patients who develop GH deficiency in early adulthood, after linear growth is completed but before the age of 25 years, should be given GH treatment until adult peak bone mass has been achieved, provided they satisfy the biochemical criteria for severe GH deficiency (defined as a peak GH response of less than 9 mU/litre (3 ng/ml) during an insulin tolerance test or a cross-validated GH threshold in an equivalent test). After adult peak bone mass has been achieved, the decision to continue GH treatment should be reassessed based on the three criteria.

2.3. When an insulin stress test is contraindicated (e.g. epilepsy, ischaemic heart disease) the use of a glucagon (or arginine) test alone will be appropriate.

### **2.4. Preparations and Dosage**

2.4.1. Somatropin is human growth hormone produced by recombinant DNA technology. Its amino acid sequence is identical to that of natural human GH.

- 2.4.2. The Specialist Team will advise on the preparation to be used, with Omnitrope® as the first line growth hormone for adult patients.
- 2.4.3. Treatment is self-administered by a daily subcutaneous injection at bed-time. The initial dose is 150 micrograms (0.15mg) to 300 micrograms (0.3mg) daily [typically 270 micrograms (0.27mg) daily]. For the first 2-3 months the consultant/specialist nurse makes adjustments based on monthly assessments of serum IGF-I and appearance of adverse effects, until maintenance dose is achieved. The currently used median dose is 400 micrograms daily. Maximum daily dose is 1mg. GH requirements may decrease with age.
- 2.4.4. Somatropin 1mg  $\equiv$  3 units (dose formerly expressed as units).

## 2.5. Contraindications

- Hypersensitivity to somatropin or any excipient of the formulation chosen.
- Evidence of tumour activity (complete any antitumour therapy and ensure that intracranial lesions are inactive before starting).
- After renal transplantation in seriously ill patients.
- Somatropin is not recommended during pregnancy and in women of childbearing potential not using contraception.
- Patients with acute critical illness (critically ill adult patients suffering complications following open heart surgery, abdominal surgery, multiple accidental trauma or acute respiratory failure).

## 2.6. Precautions:

- Diabetes mellitus (adjustment of antidiabetic therapy may be necessary).
- Papilloedema.
- History of malignant disease.
- Resolved intracranial hypertension (monitor closely).
- Rotate subcutaneous injection sites to prevent lipoatrophy.
- Breast-feeding.
- Disorders of the epiphysis of the hip - monitor for limping.
- Pancreatitis should be considered in somatropin-treated patients who develop abdominal pain.
- Deficiencies of other pituitary hormones:
  - ACTH deficiency – treatment with steroid replacement should precede other hormone replacement.

- Hypothyroidism – manufacturers recommend periodic <yearly> thyroid function tests but limited evidence of clinical value.

## 2.6. Monitoring

### 2.6.1. Specialist Team:

- 2.6.1.1. The consultant/specialist nurse is responsible for initial and ongoing assessment of the patient.
- 2.6.1.2. Adrenal deficiency should be assessed in the initial investigation and replacement therapy should be initiated before somatropin is considered.
- 2.6.1.3. Somatropin dose should be adjusted according to clinical response. The lowest effective dose should be used. Patients should initially receive treatment on the basis of a dose titration and stabilisation for 3 months followed by a 6 months trial of therapy at a maintenance dose. GH treatment should be discontinued for those patients who demonstrate a QoL improvement of less than 7 points in QoL-AGHDA score at this time.
- 2.6.1.4. The consultant will carry out regular annual checks on haemoglobin A1c, blood glucose, insulin-like growth hormone (IGH-1) and thyroid function tests. Testing of luteinising hormone/follicle stimulating hormone will be patient dependent.
- 2.6.1.5. Insulin treated diabetes patients may require adjustment of their insulin dose on initiation of therapy. If necessary insulin dosage alteration will be the responsibility of the consultant based on the above monitoring.

### 2.6.2. General Practice:

There are no specific biochemical monitoring requirements for the GP to undertake.

A non-urgent referral should be made to the consultant if hypothyroidism is suspected or identified.

### 2.6.3. Side Effects

Most common adverse effects reported are

- Sodium retention (oedema, carpal tunnel syndrome) is only common with higher doses and can usually be relieved by a reduction in dose.
- Arthralgia and myalgia can occur but are also dose dependent and usually transient.
- Overtreatment with somatropin results in acromegaly.
- Other side effects include:

- Skin reactions at the injection site.
- Hypothyroidism.
- Hypertension.
- Insomnia.
- Headache (fundoscopy for papilloedema recommended if severe or recurrent).
- Visual problems.
- Nausea and vomiting: if papilloedema is confirmed consider benign intracranial hypertension (rare cases reported).
- Paraesthesia.
- Antibody formation.
- Hyperglycaemia.
- Hypoglycaemia (causal link has not been established).

#### 2.6.4. Significant Drug Interactions

- 2.6.4.1. **Corticosteroids** – Growth promoting effect may be inhibited. Interactions do not generally apply to corticosteroids used for topical action (including inhalers).
- 2.6.4.2. **Oestrogens** – Higher doses of somatropin may be needed with oral oestrogen replacement therapy. Interaction with combined oral contraceptives may also apply to combined contraceptive patches. In the case of HRT, low doses are unlikely to induce interactions.
- 2.6.4.3. **Anticonvulsants and ciclosporin** – clearance of these compounds may be increased by somatropin resulting in lower plasma levels of these compounds.

#### 2.7. Areas of Responsibility for the Sharing of Care

- 2.7.1. These are suggested ways in which the responsibilities for the management of adult patients with growth hormone deficiency who are prescribed **somatropin** can be shared between the specialist and the general practitioners. The expectation is that these guidelines should provide sufficient information to enable GPs to be confident to take clinical and legal responsibility for prescribing these drugs. If a specialist asks the GP to prescribe this drug the GP should reply to this request as soon as practical. Sharing of care assumes communication between the specialist, GP and patient. The intention to share care should be explained to the patient and be accepted by them.

2.7.2. **In the NHS E guidelines on responsibility for prescribing (January 2018) between hospitals and GPs, it is advised that legal responsibility for prescribing lies with the doctor who signs the prescription.**

2.7.3. **Specialist:**

- Confirmation that GH treatment is appropriate.
- Selection of appropriate preparation and to teach the patient self-injection technique and how to dispose safely of any sharps / yellow bins.
- Initiation of drug treatment and stabilisation of patient's condition over 3 months for dose stabilisation.
- After the stabilisation period ask the GP whether they are willing to participate in shared care using the suggested wording template (Appendix 3).
- A decision on continuing therapy will be taken by the consultant/specialist nurse after a further 6 months of prescribing in primary care.
- Provide the patient or patient's carer with suitable written and verbal information about the drug prior to starting medication and discuss the benefits and side effects of treatment.
- Ensure that training on reconstitution, administration and storage of GH is provided for the patient or carer.
- Prescribing the drug until the patient's condition/dose is stabilised and the GP agrees to take over responsibility for prescribing (usually 3 months).
- Specify review dates at clinically relevant time intervals. The first review should be at 6 months after dose stabilisation and thereafter at 12 monthly intervals for continued therapy.
- Undertake monitoring as described in the shared care guideline including annual thyroid function test.
- Prompt communication with GP of any changes in treatment, results of monitoring undertaken and assessment of adverse events.
- Advice to GP on when to stop treatment.
- Provide the GP with relevant contact information with clear arrangements for back-up advice and support should further assistance be required relating to this drug.
- Reporting adverse events to the MHRA.

#### 2.7.4. General Practitioner:

- To respond to the shared care request from the consultant in writing without undue delay (Appendix 4 or Appendix 5).
- Prescribing somatropin BY BRAND after communication with specialists regarding the need for treatment (this will usually take place after the first 3 months of dose stabilisation).
- GP prescribing of somatropin for a further 6 months after dose stabilisation. At this point the consultant will review the patient to assess whether there is any benefit from continued treatment.
- Prompt referral to a specialist if there is symptomatic change in the patient's expected response to treatment.
- Reporting to, and seeking advice from, a specialist on any aspect of patient care which of concern to the GP and may affect treatment.
- Reporting adverse events to the specialist and MHRA.
- Stopping treatment in the case of severe adverse event or as per shared care guideline.

#### 2.7.5. Patient: and parent / carer responsibilities

- Report any adverse effects to their GP and/or specialist regarding their treatment.
- Ensure that they have a clear understanding of their treatment.
- Ensure they attend for monitoring requirements as per shared care guideline.
- Aware that treatment will be stopped if patient does not attend for monitoring.

#### 2.7.6. Back-up advice and support is available from the relevant clinical team.

Endocrinology Team:

Email: [rcht.endocrinenurses@nhs.net](mailto:rcht.endocrinenurses@nhs.net)

Tel: 01872 253014.

### 3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance with prescribing and administration in accordance with this guideline (or other safe practice).

<b>Information Category</b>	<b>Detail of process and methodology for monitoring compliance</b>
<b>Lead</b>	Head of Prescribing Support Unit.
<b>Tool</b>	Audit and review tool using patient documentation.
<b>Frequency</b>	As required according to clinical incident reports.
<b>Reporting arrangements</b>	Via Cornwall Area Prescribing Committee / Medication Practice Committee.
<b>Acting on recommendations and Lead(s)</b>	Relevant Clinical Staff.
<b>Change in practice and lessons to be shared</b>	Lessons and changes in practice will be communicated through various channels to relevant staff.

## **4. Equality and Diversity**

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ['Equality, Inclusion and Human Rights Policy'](#) or the [Equality and Diversity website](#).

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

## Appendix 1. Governance Information

Information Category	Detailed Information
<b>Document Title:</b>	Somatropin in Adults Shared Care Guideline V5.1
<b>This document replaces (exact title of previous version):</b>	Shared Care Guideline For Somatropin In Adults V5.0
<b>Date Issued/Approved:</b>	March 2026
<b>Date Valid From:</b>	March 2026
<b>Date Valid To:</b>	December 2028
<b>Directorate / Department responsible (author/owner):</b>	Endocrinology Team / Pharmacy - Head of Prescribing Support Unit
<b>Contact details:</b>	01872 253548
<b>Brief summary of contents:</b>	Some clinical issues and details of prescribing responsibilities for GP and specialists.
<b>Suggested Keywords:</b>	Somatropin, Shared Care.
<b>Target Audience:</b>	<b>RCHT:</b> Yes <b>CFT:</b> No <b>CIOB ICB:</b> Yes
<b>Executive Director responsible for Policy:</b>	Chief Medical Officer
<b>Approval route for consultation and ratification:</b>	Cornwall Area Prescribing Committee
<b>General Manager confirming approval processes:</b>	Richard Andrzejuk
<b>Name of Governance Lead confirming approval by specialty and care group management meetings:</b>	Michele Reed
<b>Links to key external standards:</b>	None
<b>Related Documents:</b>	Resource for Doctors and Patients: <a href="http://www.pituitary.org.uk">http://www.pituitary.org.uk</a> . Summary of Product Characteristics.

Information Category	Detailed Information
	NICE Technology Appraisal 64: Human growth hormone (somatropin) in adults with growth hormone deficiency - August 2003.
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Pharmacy

### Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
19 September 2012	V1.0	Initial Version.	M Wilcock, Head of Prescribing Support Unit
23 September 2015	V2.0	New style Appendix and minor text alterations.	M Wilcock, Head of Prescribing Support Unit
November 2018	V3.0	New format and slight text amendments 2.4, 2.7, 2.9 and inclusion of shared care agreement letter.	M Wilcock, Head of Prescribing Support Unit
March 2020	V3.1	Appendix 3 added following FRG approval - CHA4215 Shared Care Agreement Letter Consultant Request.	Demi Louise Kent, Corporate records Manager
September 2021	V3.2	Replacement of shared care agreement letter with suggested wording template (Appendix 3).	M Wilcock, Head of Prescribing Support Unit
March 2022	V4.0	Correction of minor typos.	M Wilcock, Head of Prescribing Support Unit
Nov 2025	V5.0	New statement at 1.1. Removal of second mention of myalgia at 2.7.3. New wording at Appendix 3.	M Wilcock, Head of Prescribing Support Unit
March 2026	V5.1	Addition of Appendix 4 and Appendix 5 and mentioned at 2.8.4	Mike Wilcock, Head of Prescribing Support Unit

**All or part of this document can be released under the Freedom of Information Act 2000.**

**All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.**

**This document is only valid on the day of printing.**

**Controlled Document.**

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

## Appendix 2. Quality and Equality Impact Assessment (QEIA) Guidance Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

For guidance, please contact the Equality, Diversity and Inclusion Team at [rcht.inclusion@nhs.net](mailto:rcht.inclusion@nhs.net)

### 1. About the Policy / Service Change:

Information Category	Detailed Information
<b>Individual completing QEIA:</b> (Name, Role, Email)	Mike Wilcock, Head of Prescribing Support Unit. 01872 253548.
<b>Service Area:</b> (Department, Division)	Pharmacy, Clinical Support and Cancer Division
<b>Name of document:</b>	Somatropin in Adults Shared Care Guideline V5.1
<b>Type of document:</b> (Policy, Strategy, Service Change)	Shared Care Guideline
<b>Policy / Service Change Objective(s):</b> (What should it achieve, and for whom?)	To provide information on prescribing of somatropin to enable General Practitioners to take over prescribing responsibility from secondary care.  To promote a consistent level of shared care between primary and secondary care (in relation to RCHT catchment area).
<b>Does this Policy / Service Change:</b> (Select all that apply)	Eliminate Discrimination? Yes Advance Equal Opportunity? Yes Foster Good Relations? Yes
<b>Which Groups are impacted by this policy?</b> (Select all that apply)	Yes – Workforce. Yes – Patients. No – Visitors. Yes - System Partners. No - External Organisations. No – Contractors.

### 2. About the impact:

For each characteristic, please indicate whether you think the impact will be positive, negative or unknown, and provide a brief explanation:

**Note:** Stating 'This document has no impact on this group' for all characteristics will result in the document not being approved.

Characteristic	Impact	Explanation
Age	Positive	
Sex	Positive	
Gender Reassignment	Positive	
Race, Ethnicity, Culture	Positive	
Disability or Long-term Health Condition	Positive	
Religion or Belief	Positive	
Marriage and Civil Partnership	Positive	
Pregnancy and Maternity	Positive	
Sexual Orientation	Positive	
Armed Forces Community	Positive	
Low Income Households	Positive	

A consultation must take place with appropriate groups to clarify unknown impacts and recommend mitigation of negative impacts.

### 3. About the Consultation

Information Category	Detailed Information
<p><b>Which bodies have been consulted?</b> (Not all will be required)</p>	<p>Yes Service Employees. No Employee Network Groups. No Union Representatives. No EDI Team. No Patient / Service Users. No Patient Advisory Group. No Patient Representatives. No Local / National Charities. No System Partners. No External Organisations. No Other.</p>

<b>Information Category</b>	<b>Detailed Information</b>
<b>Please list the individuals / groups who have been consulted:</b> (Role, Organisation, Email. Avoid using individual names)	Cornwall Area Prescribing Committee.
<b>Consultation Outcomes:</b> (Positive feedback, new negative impacts, recommendations)	Positive.
<b>What action will you now take?</b>	Continue without Amendments
<b>Provide Details:</b>	Agreed.
<b>Do any negative impacts remain?</b>	No
<b>Explain rationale for proceeding with negative impacts:</b>	None

I am confident that this QEIA is an honest reflection of my efforts to comply with the Public Sector Equality Duty, and that all appropriate, necessary actions have been taken to mitigate any negative impacts as far as practicable.

Name:	Mike Wilcock	Role:	Head of Prescribing Support Unit.
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## Appendix 3. Suggested wording for Specialist communication re commencement of shared care

**Medication:** [Insert Name].

**Indication:** [Insert Indication].

**Date treatment started:** [Date].

**Current dose:** [Insert Dose] mg.

**Time on treatment:** [Insert Number of Months] months.

**Prescription provided for:** [Insert Number of Weeks] weeks.

NB: It is expected that the specialist team will prescribe sufficient medication to provide at least 4 (four) weeks of treatment.

**GP practice to monitor and prescribe from:** [Insert Date].

**Next blood monitoring due:** [Insert Date].

**Next follow up:** [Insert Date (if known) or Timescale].

As per the agreed Cornwall Area Prescribing Committee shared care guideline, this patient is now suitable for prescribing to move to primary care.

The patient fulfils the criteria for shared care and I am therefore requesting your agreement to participate in shared care. Where baseline investigations are set out in the shared care protocol, I have carried these out.

I can confirm that the following has happened with regard to this treatment:

- The patient has been initiated on this therapy and on a stable dose for the following period of time stated above.
- Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory.
- The condition being treated has a reasonably predictable course of progression and the patient can be suitably maintained by primary care.
- The risks and benefits of treatment have been explained to the patient.
- The roles of the specialist, specialist team, primary care prescriber, patient and pharmacist have been explained and agreed.
- The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments.

- A copy of the shared care document is either attached or can be found on the [RCHT](#) or [CPFT](#) document library or via the [Cornwall Joint Formulary website](#).
- I have provided the patient with sufficient medication to last for the period of time specified above. (NB: there is an expectation that the specialist will prescribe sufficient medication to provide at least 4 (four) weeks treatment).
- I have arranged a follow up with this patient as specified above.

If you are in agreement, please undertake monitoring and treatment the date specified above (NB: date must be at least 1 month from initiation of treatment).

## Appendix 4. Suggested wording for Primary care accept shared care letter

Thank you for your request for me to accept prescribing responsibility for this patient under a shared care agreement and to provide the following treatment:

Medicine: **[Insert Medicine Name]**

Route: **[Insert Medicine Route]**

Dose and frequency: **[Insert medicine dose and frequency]**

I can confirm that I am willing to take on this responsibility from **[Insert Date]** and will complete the monitoring as set out in the shared care protocol for this medicine/condition.

## Appendix 5. Suggested wording for Primary care refuse shared care letter

Thank you for your request for me to accept prescribing responsibility for this patient.

In the interest of patient safety NHS Cornwall and Isles of Scilly Integrated Care Board in conjunction with local acute trusts have classified **[Insert Medicine Name]** as a Shared Care drug and requires a number of conditions to be met before transfer can be made to primary care.

I regret to inform you that in this instance I am unable to take on responsibility due to the following:

- **The prescriber does not feel clinically confident in managing this individual patient's condition, and there is a sound clinical basis for refusing to accept shared care**

As the patient's primary care prescriber, I do not feel clinically confident to manage this patient's condition because **[Insert Reason]**. I have consulted with other primary care prescribers in my practice who support my decision. This is not an issue which would be resolved through adequate and appropriate training of prescribers within my practice.

I have discussed my decision with the patient and request that prescribing for this individual remain with you as the specialist, due to the sound clinical basis given above.

- **The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement**

As the medicine requested to be prescribed is not a locally agreed shared care medicine, I am unable to accept clinical responsibility for prescribing this medication at this time.

Until this medicine is identified locally as requiring shared care the responsibility for providing this patient with their medication remains with you.

- **A minimum duration of supply by the initiating clinician**

As the patient has not had the minimum supply of medication to be provided by the initiating specialist, I am unable to take clinical responsibility for prescribing this medication at this time. Therefore, can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.

Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.

- **Initiation and optimisation by the initiating specialist**

As the patient has not been optimised on this medication, I am unable to take clinical responsibility for prescribing this medication at this time. Therefore, can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.

Until the patient is optimised on this medication the responsibility for providing the patient with their medication remains with you.

- **Shared Care Guidance not received**

As legal responsibility for clinical care lies with the clinician who signs the prescription, I need to ensure that I am in possession of sufficient clinical information for me to be confident to prescribe this treatment for my patient and it is clear where each of our responsibilities lie to ensure the patient is safely managed.

For this reason, I am unable to take clinical responsibility for prescribing this medication at this time, therefore would you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.

Until I receive the appropriate shared care guidance, responsibility for providing the patient with their medication remains with you.

- **Other:**

**[Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted].**