Royal Cornwall Hospitals
NHS Trust

Sulfasalazine for Adults in Rheumatology and Gastroenterology Shared Care Guideline

V2.0

November 2026

1. Aim/Purpose of this Guideline

1.1. This guideline supports medical, nursing and pharmacy staff to provide safe and appropriate prescribing, monitoring, and administration of sulfasalazine when used in adults to treat several rheumatological and gastroenterological conditions.

1.2. This SCG covers the treatment of adults with inflammatory bowel disease (IBD), rheumatoid arthritis, and other forms of inflammatory arthritis including spondyloarthropathy. This guideline is based on the NHS England shared care protocol for sulfasalazine. As with all shared care guidelines they highlight relevant prescribing issues but should be used in conjunction with relevant NICE guidance, the BNF, Summaries of Product Characteristics and do not replace them.

1.3. This version supersedes any previous versions of this document.

Data Protection Legislation

The Trust must comply with the UK GDPR, Data Protection Act 2018, and Data (Use and Access) Act 2025 by ensuring all personal data is processed lawfully, fairly, transparently, and for a defined purpose.

Before processing personal data, an appropriate Article 6 UK GDPR lawful basis must be identified and recorded. Where special category data is involved, a relevant Article 9 condition must also be documented.

All staff, contractors, students, volunteers, agency workers, and third parties working on behalf of the Trust are responsible for complying with data protection legislation.

Further guidance is available in the Trust's Information Use Framework and Information Governance policies. Advice can also be obtained from the Information Governance Team.

2. The Guidance

2.1. Sulfasalazine is a disease modifying antirheumatic drug (DMARD) used to treat several rheumatological conditions. The licensed indications for sulfasalazine include the management of active Crohn’s disease and ulcerative colitis as well as active rheumatoid arthritis (GR tablets only), though sulfasalazine is also used off-label for other chronic inflammatory disorders including seronegative spondyloarthropathies such as psoriatic arthritis, and sarcoidosis.

2.2. The guideline is for the treatment of adults.

2.3. **Preparations and Dosage**

2.3.1. Sulfasalazine is available as 500mg tablets, 500mg gastro-resistant (GR) tablets, and 250mg/5mL oral suspension (contains ethanol, see below).

2.3.2. GR tablets should be swallowed whole and not crushed or broken. Plain tablets are only licensed for use in ulcerative colitis or active Crohn's disease. The oral suspension contains 4.7mg of ethanol (alcohol) in each 5ml, equivalent to less than 1ml of beer or wine. The small amount of ethanol in this medicine will not have any noticeable effect.

2.3.3. Initially the dose is titrated upwards in rheumatoid arthritis (using the licensed GR tablets) starting at 500mg once daily, increasing by 500mg each week a dose of 2g per day in divided doses is reached, according to response. Only the GR tablets are licensed in rheumatoid arthritis; use of other formulations is off-label. Higher doses may sometimes be recommended by the specialist team.

2.3.4. For other rheumatological indications take specialist advice. Sulfasalazine is generally up-titrated in line with 2.3.3 for all indications.

2.3.5. **The initial stabilisation period must be prescribed by the initiating specialist team.**

2.3.6. Maintenance dose (following initial stabilisation) in rheumatoid arthritis and other indications (using GR tablets): 2 to 3g daily in 1 to 2 divided doses. The maximum daily dose is 40mg/kg/day (not exceeding 4g/day) in divided doses.

2.3.7. **The initial maintenance period must be prescribed by the initiating specialist.**

2.3.8. In IBD the dose is usually 1 to 2g orally four times a day until remission occurs, reducing to a maintenance dose of 500mg four times a day

2.3.9. Conditions requiring dose adjustment: In patients with GFR <10 mL/min, start at very low dose and monitor.

2.4. Contraindications and Precautions

2.4.1. Contraindications are:

- Known hypersensitivity to sulfasalazine, its metabolites or any of the excipients as well as sulfonamides or salicylates.
- Porphyria.

2.4.2. Precautions are:

- Hepatic or renal impairment.
- Pre-existing blood dyscrasias.
- Severe allergy or bronchial asthma.
- Glucose-6-phosphate dehydrogenase (G6PD) deficiency due to risk of haemolytic anaemia.

- Folic acid deficiency.
- Adequate fluid intake should be maintained during treatment to avoid crystalluria and kidney stone formation.
- Slow acetylator status increases the risk of sulfapyridine-related adverse drug reactions (ADRs) which can present as a drug-induced lupus-like syndrome.

2.5. Pregnancy and breastfeeding

2.5.1. The British Society for Rheumatology and British Health Professionals in Rheumatology guideline on prescribing DMARDs in pregnancy and breastfeeding advises the following:

2.5.2. Pregnancy: Sulfasalazine, with folate supplementation (5 mg/day), is compatible with all trimesters of pregnancy.

2.5.3. Breastfeeding: Sulfasalazine is compatible with breastfeeding in healthy, full-term infants. There have been reports of bloody stools or diarrhoea in infants who were breastfeeding from mothers on sulfasalazine. In cases where the outcome was reported, bloody stools or diarrhoea resolved in the infant after discontinuation of sulfasalazine in the mother.

2.5.4. Paternal exposure: Men taking sulfasalazine may have reduced fertility, due to oligospermia and impaired mobility, which may take 2-3 months to return to normal following treatment cessation.

2.6. Monitoring

2.6.1. Specialist Team

- Monitoring at baseline and during initiation is the responsibility of the specialist team; only once the patient is optimised on the chosen medication with no anticipated further changes expected in immediate future will prescribing and monitoring be transferred to primary care.

Baseline investigations are:

- Urea and electrolytes (U&Es) including creatinine and eGFR.
- Alanine aminotransferase (ALT), bilirubin, and albumin.
- Full blood count (FBC).
- Weight.
- Height and blood pressure.
- Assess for co-morbidities which may influence DMARD choice.
- Screening for HIV and hepatitis B and C.

- Screening for lung disease, including tuberculosis, should be undertaken at clinician discretion on a case by case basis.

- Provide or request appropriate vaccination prior to treatment initiation, according to local arrangements (e.g. pneumococcal, influenza, COVID-19).

Initial monitoring and at dose change:

- Repeat every 2 weeks until the dose has been stable for 6 weeks, then monthly for three months. The transfer of prescribing to primary care should normally only take place when the patient has received a stable dose for at least 4 weeks and their blood and physical tests results have been satisfactory. It is anticipated that this will take place around 12 weeks after initiating the medicine, but may be sooner in some circumstances, for example when patients have moved into area already on treatment”

- Until the transfer of prescribing to primary care has taken place, the specialist team are responsible for requesting and reviewing the results of monitoring blood tests. If blood samples are being taken at the GP surgery during this stage the requests should be placed on ICE by the specialist team.

- BP.

- FBC.

- U&Es, including creatinine and eGFR.

- AST, bilirubin, and albumin.

- C-reactive protein (CRP).

- Following a dose change, repeat monitoring bloods every 2 weeks until the dose has been stable for 6 weeks, then revert to previous schedule.

Ongoing monitoring: The specialist will retain the responsibility for monitoring the patient’s ongoing response to treatment and advise if a dose change or treatment cessation is appropriate. This should usually be undertaken at least annually.

- After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in 2.6.2 remains appropriate.

2.6.2. General Practice

- Once the dose of sulfasalazine has been stable for six weeks, the frequency of blood monitoring can reduce to monthly for three months and then once every three months. After 12 months no routine monitoring is required for the majority of patients. Annual

serum creatinine or eGFR may be considered. **The decision to discontinue monitoring should be following advice from the specialist for the individual patient.**

- FBC.
- U&Es including creatinine and eGFR.
- ALT, bilirubin, and albumin
- CRP
- Note that vaccines are safe and recommended for this patient group and should be offered in line with the standard schedule. Refer to Green Book Chapter 6 for further details. Shingles vaccination: one course. Other vaccinations as per national schedule. Influenza vaccination: annual. It is advisable to add the patient to the influenza vaccine list.

2.6.3. **If any of the following occur, repeat the test to confirm the result, consider interrupting treatment, and if required contact the Specialist Team for advice (see contact details later in this document):**

- WCC less than 3.5 $x10^9$/L.
- Lymphocytes less than 0.5 $x10^9$/L.
- Neutrophils less than 1.6 $x10^9$/L.
- Platelets less than 140 $x10^9$/L.
- Unexplained eosinophilia; greater than 0.5 $x10^9$/L.
- Unexplained fall in albumin; less than 30g/L.
- MCV >105 fL - Consider interruption in treatment. Check serum folate, B12, alcohol history and TSH and treat any underlying abnormality. If results of these additional investigations are normal discuss with specialist team urgently.
- Signs or symptoms of bone marrow suppression, e.g. unexplained bleeding or bruising with or without sore throat, purpura, mouth ulcers. Check FBC immediately, withhold treatment while awaiting results, and discuss with the specialist team. See haematological monitoring above.
- Acute infection. During serious infections (e.g. requiring intravenous antibiotics or hospitalisation) temporarily withhold sulfasalazine until the patient has recovered. Consider additional investigations (e.g. FBC), if clinically appropriate.

- **Liver function tests below:** Withhold and discuss with specialist team. Check any other reason for risk of hepatic dysfunction such as alcohol history and drug interactions, including OTC or complementary medication.
    - ALT and/or AST greater than 100units/mL and/or a sudden increase (e.g. doubling of baseline).
    - Jaundice.
- **Renal function tests below:** Use clinical judgement and repeat in 1 week. If still more than 30% from baseline, withhold and discuss with specialist.
- Creatinine increase of greater than 30% from baseline in the last 12 months or eGFR reduces to less than 60mL/min.

2.7. **Side Effects**

Side effects include:

- Gastrointestinal disorders - Nausea, vomiting, diarrhoea or unintentional weight loss. Review for reversible causes. Advise patient to take with food. If no improvement contact specialist team.
- Skin/mucosal reaction, e.g. serious rash; diffuse alopecia ; breathlessness or cough; peripheral neuropathy - consider withholding treatment and discussing with specialist. For widespread rash, discontinue and discuss with specialist urgently.

2.8. **Advice to patients and carers**

2.8.1. The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.

2.8.2. **The patient should be advised to report any of the following signs or symptoms to their primary care team without delay:**

- Sore throat, mouth ulcers, fever, malaise, swollen lymph nodes, or unexplained bleeding or bruising.
- Progressive skin rash with blisters or oral ulcerations – see below.
- Nausea, vomiting, diarrhoea, jaundice, dark urine and unintentional weight loss.
- Hair loss.
- Breathlessness, infection or cough.
- Symptoms of peripheral neuropathy e.g. pins and needles, numbness or burning pain in extremities.

2.8.3. **The patient should be advised:**

- Life-threatening skin reactions Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) have been reported with the use of sulfasalazine. The highest risk for occurrence is within the first weeks of treatment. Patients should be advised to report a progressive skin rash often with blisters or mucosal lesions, or any other sign of hypersensitivity.

- During a serious infection (requiring hospitalisation or intravenous antibiotics) sulfasalazine should be temporarily discontinued until the patient has recovered from the infection.

- Tell anyone who prescribes them a medicine that they are taking sulfasalazine. Always ask a pharmacist before purchasing any over-the-counter (OTC) medicines, including herbal remedies, and ask if they are safe.

- Vaccination in line with current national advice (e.g. for COVID-19, influenza) is safe and strongly recommended.

- Sulfasalazine may cause a harmless yellow-orange discolouration of body fluids and skin. This can be particularly noticeable in urine. Certain types of extended wear soft-contact lenses may be permanently stained.

- To maintain adequate fluid intake during treatment to reduce the risk of crystalluria and kidney stones.

- Sulfasalazine oral suspension contains 4.7 mg of alcohol (ethanol) in each 5ml, equivalent to less than 1ml of beer or wine. The small amount of alcohol in this medicine will not have any noticeable effects.

2.9. **Significant Drug Interactions**

- Digoxin: Reduced absorption may be seen when used concomitantly with sulfasalazine.

- Sulfonamides are chemically similar to some oral hypoglycaemic agents and may cause hypoglycaemia. Patients receiving sulfasalazine and hypoglycaemic drugs should closely monitor blood glucose.

- Azathioprine and 6-mercaptopurine: Possible risk of bone marrow suppression and leucopenia

- Folate absorption and metabolism may be reduced by sulfasalazine.

- Darolutamide and voxilaprevir may increase exposure to sulfasalazine, manufacturer advises avoid.

2.10. Areas of Responsibility for the Sharing of Care

2.10.1. These are suggested ways in which the responsibilities for the management of patients who are prescribed sulfasalazine can be shared between the specialist team and the general practice. 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.

2.10.2. **In the NHS England 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.**

2.10.3. **Specialist Team:**

- Assess the patient and provide diagnosis; ensure that this diagnosis is within scope of this shared care guideline and communicated to primary care.
- Use a shared decision-making approach; discuss the benefits and risks of the treatment with the patient and/or their carer and provide the appropriate counselling to enable the patient to reach an informed decision. Obtain and document patient consent. Provide an appropriate patient information leaflet.
- Assess for contraindications, cautions, and potential interactions.
- Conduct required baseline investigations and initial monitoring.
- Initiate and optimise treatment as outlined. Transfer to primary care normally occurs once the patient has been treated for 3 months and has had satisfactory investigation results for at least 4 weeks. Prescribe sufficient medication to enable transfer to primary care, including where there are unforeseen delays to transfer of care.
- Once treatment is optimised, complete the shared care documentation and send to patient's GP practice detailing the diagnosis, current and ongoing dose and formulation, baseline and most recent test results, confirm the monitoring schedule and when the next monitoring is required. Include contact details. (Appendix 3)
- Conduct the required annual reviews and monitoring and communicate the results to primary care. After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined remains appropriate.

- Give advice to primary care on continuing treatment if a woman becomes or wishes to become pregnant.

- Provide advice to primary care on the management of adverse effects if required.

2.10.4. **General Practitioner:**

- Respond to the request from the specialist for shared care in writing (Appendices 4 and 5). It is asked that this be undertaken within 14 days of the request being made, where possible.

- If accepted, prescribe ongoing treatment as detailed in the specialists request, taking into account any potential drug interactions.

- Adjust the dose of sulfasalazine as advised by the specialist.

- Conduct the required monitoring as outlined. Communicate any abnormal results to the specialist.

- Manage adverse effects as detailed and discuss with specialist team when required.

- Stop sulfasalazine and make an urgent referral to the specialist if signs of myelosuppression, hepatic or renal dysfunction develop or a serious skin reaction or oral ulceration is observed.

- Seek advice from the specialist if the patient becomes or plans to become pregnant.

- Stop treatment as advised by the specialist.

2.10.5. **Patient / carer:**

- Take sulfasalazine as prescribed and avoid abrupt withdrawal unless advised by the primary care prescriber or specialist.

- Attend regularly for monitoring and review appointments with primary care and the specialist team, and keep contact details up to date with both prescribers. Be aware that medicines may be stopped if they do not attend.

- Report adverse effects to their primary care prescriber. Seek immediate medical attention if they develop any symptoms as detailed in 2.8.2 and 2.8.3.

- Report the use of any OTC medicines to their primary care prescriber and be aware they should discuss the use of sulfasalazine with their pharmacist before purchasing any OTC medicines.

- Patients of childbearing potential should take a pregnancy test if they think they could be pregnant, and inform the specialist or GP immediately if they become pregnant or wish to become pregnant.

2.10.6. **Contact Details**

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

- Patients can contact the Rheumatology department via the Advice Line on 01872 252202. This service is available between 13:00 and 15:30 Monday to Friday, excluding Bank Holidays.
- Healthcare Professionals with routine queries should submit these through the Advice and Guidance service. This is reviewed daily by the on-call consultant. Please do not send letters or emails.
- Healthcare Professionals with urgent queries should contact the on-call Rheumatology Consultant/SpR via the RCHT switchboard, 01872 252000. Please note there is no out-of-hours on-call service for Rheumatology.
    - **Inflammatory Bowel Disease Nurse Specialist:**
    - Email rch-tr.IBDnurse@nhs.net
    - Tel 01872 2521783.

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).
Lead	Head of Prescribing Support Unit.
Tool	Audit and review tool using patient documentation.
Frequency	As required according to clinical incident reports.
Reporting arrangements	Via Cornwall Area Prescribing Committee / Medication Practice Committee.
Acting on recommendations and Lead(s)	Relevant Clinical Staff.
Change in practice and lessons to be shared	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 Diversity and Inclusion Policy or the Equality and Diversity website.

4.2. Quality and Equality Impact Assessment (QEIA)

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged. The Quality and Equality Impact Assessment (QEIA) Form is available via the link in Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Sulfasalazine for Adults in Rheumatology and Gastroenterology Shared Care Guideline V2.0
This document replaces (exact title of previous version):	Sulfasalazine for Adults in Rheumatology Shared Care Guideline V1.1
Date Issued/Approved:	October 2026
Date Valid From:	November 2026
Date Valid To:	November 2029
Directorate / Department responsible (author/owner):	Rheumatology Team / Gastroenterology Team / Pharmacy - Head of Prescribing Support Unit
Contact details:	01872 253548
Brief summary of contents:	Some clinical issues and details of prescribing responsibilities for GP and specialists.
Suggested Keywords:	Sulfasalazine.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** Yes
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Cornwall Area Prescribing Committee. Local Medical Committee.
General Manager confirming approval processes:	Richard Andrzejuk
Name of Governance Lead confirming approval by specialty and care group management meetings:	Jemma Moore
Links to key external standards:	None required
Related Documents:	Summary of Product Characteristics
Training Need Identified?	No

Information Category	Detailed Information
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
Nov 2023	V1.0	Original document.	Mike Wilcock, Head of Prescribing Support Unit
March 2026	V1.1	New Appendices 4,5 and 6 and mentioned at 2.10.3 and 2.10.4.	Mike Wilcock, Head of Prescribing Support Unit
October 2026	V2.0	Minor amendment to 1.2 and 2.6 and to (correctly renamed) Appendix 3 and following Appendices. Relevant text to include Gastroenterology and IBD indication.	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 6 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.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

E11 QEIA Policy

For guidance, please see the QEIA Essentials – Quick Reference Guide or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net

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].