# Powys Shared Care Protocol

## MEMANTINE

for the treatment of moderate to severe dementia in Alzheimer's Disease

| | ✶PLEASE CHECK http://howis.wales.nhs.uk/sitesplus/867/page/42689 FOR THE LATEST VERSION OF THIS PROTOCOL✶ |
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| **General guidance** | The Powys Primary Care Drugs and Therapeutics Committee has endorsed this protocol.<br>It outlines the shared care arrangements for patients initiated on ***memantine*** and should be read in conjunction with the:<br>1. *Shared Care Agreement Form – Memantine*<br>2. Summary of Product Characteristics (SPC or Data Sheet) for ***Ebixa*** ® – available at: http://www.medicines.org.uk/EMC/medicine/10175/SPC/Ebixa+5mg+pump+oral+solution%2c+20mg+and+10+mg+Tablets+and+Treatment+Initiation+Pack/<br>3. NICE Technology Appraisal Guidance 217 (March 2011): http://guidance.nice.org.uk/TA217<br>4. NICE Dementia Guidelines: http://www.nice.org.uk/CG42 |
| **1. Licensed indication** | The treatment of **moderate to severe** dementia in Alzheimer's Disease |
| **2. Therapeutic use & Background information** | Memantine is a glutamate receptor antagonist.<br>Use of memantine is recommended by NICE in Technical Appraisal 111 (2011), within its licensed indication, as an option for managing Alzheimers disease for people with:<br>**Moderate or severe dementia:**<br>○ With intolerance of acetycholinesterases (cognitive symptoms) or where neuroleptics are contraindicated (behavioural symptoms)<br>**Severe dementia (behavioural symptoms):**<br>○ With moderate or severe behavioural problems such as agitation ( including driven behaviour), delusions or hallucinations<br>○ With a clinical profile of challenging behaviour and 'frontal features'<br>○ Non-pharmacological measures are inadequate<br><br>Treatment should be under the following conditions:<br>• Carers' views on the patient's condition at baseline should be sought.<br>• Treatment should be continued only when it is considered to be having a worthwhile effect on cognitive, global, functional and behavioural symptoms.<br>• Patients who continue on the drug should be reviewed at least every 6 months using cognitive, global, functional and behavioural assessment. Treatment should be reviewed by an appropriate specialist team.<br>• Carers' views on the patient's condition at follow-up should be sought.<br>• Combination treatment with memantine and AchE inhibitors is not recommended – NICE conclude there was a lack of evidence for the additional clinical efficacy with the combination compared with memantine monotherapy. A transition (cross-titration) period from AChE inhibitor treatment to Memantine treatment may take up to 3 months, to allow gradual withdrawal of the previous AChE inhibitor.<br>• There may be clinical situations where longer-term combination treatment might be indicated, such as Severe Behavioural and Psychological Symptoms of Dementia (BPSD), on recommendation of a Secondary Care specialist. **However, long term combination treatment is not covered by the shared-care protocols for AChE inhibitors and memantine.** |
| **3. Contra-indications and Cautions** | Hypersensitivity to the active substance or to any of the excipients.<br><br>History of convulsions: caution. |

Hepatic impairment: avoid in severe impairment

Renal impairment:
Reduce dose to 10mg daily if eGFR 30-49mL/minute/1.73m$^2$, if well tolerated after at least 7 days dose can be increased in steps to 20mg daily.
Reduce dose to 10mg daily if eGFR 5–29mL/minute/1.73m$^2$.
Avoid if eGFR less than 5mL/minute/1.73m$^2$

**4. Typical dosage regimen (adults)**

**Initiation and dose adjustment will be the responsibility of the Specialist Centre.**

**Starting dose (adult):** Memantine is initially given as 5mg once daily and then increased in steps of 5mg at weekly intervals to a maximum of 20mg daily.

**Usual maintenance dose (adult):** 20mg once daily

**Maximum dose:** 20mg once daily

Duration of treatment: Treatment should be continued only when it is considered to be having a worthwhile effect on cognitive, global, functional and behavioural symptoms. Evidence of continued benefit may be demonstrated through clinical assessment, use of rating scales (eg NPI, CMAI) or through use of timely drug-holidays.

**5. Drug interactions**
For a comprehensive list consult the BNF or SPC.

| Interacting drugs | Interaction | Action |
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| **Amantidine** | Risk of pharmatoxic psychosis due to action on same receptor site | Avoid concomitant use |
| **Levo dopa, dopminergic agonists, anti-cholinergics, warfarin** | Mode of action may be enhanced by memantine | Avoid concomitant administration- dose adjustment may be necessary |
| **Barbiturates, neuroleptics** | Effects may be reduced by memantine | |
| **Cimetidine, ranitidine, procainamide, quinine, quinidine, nicotine** | Possible increased plasma levels due to competition for renal cationic transport system | Avoid concomitant use, be vigilant for adverse effects. |

**6. Adverse drug reactions**

**Most serious toxicity is seen with long-term use and may therefore present first to GPs.**
Adverse reaction frequency are classified using the following convention.

| **Common (≥1% & <10%)** | **Less common (≥0.1%&<1%)** | **Rarely(<0.001%)** |
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| Constipation, headache, hypertension, dyspnoea, dizziness, drowsiness, hypersensitivity | Vomiting, thrombosis, heart failure, confusion, fatigue, hallucinations, abnormal gait. | Seizures |

**All serious adverse events should be reported to MHRA/CHM via the Yellow Card scheme.**

**7. Baseline investigations**

**To be undertaken by GP, prior to referral for memory or psychiatric assessment:**
Physical examination
FBC, U&Es, creatinine, eGFR measurement, LFTs, TFTs, B12/Folate, calcium and phosphate.
ECG if history of cardiac disease and arrhythmia
Chest X-ray if history of severe lung disease. Only if none available in last 12 months.
Baseline brief cognitive examination – carers' views on the patient's condition at baseline

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| | should be sought.<br><br>The Quality and Outcomes Framework for the nGMS contract 2011-12 includes indicator DEM3 for the ongoing monitoring of dementia patients:<br>**DEM3**: The percentage of patients with a new diagnosis of dementia (from 1 April 2011) with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels **recorded 6 months before or after** entering on to the register.<br><br>The purpose here is to exclude a potentially reversible or modifying cause for the dementia and to help exclude other diagnoses (e.g. delirium). Reversible or modifying causes include metabolic and endocrine abnormalities (e.g. vitamin B12 and folate deficiency, hypothyroidism, diabetes and disorders of calcium metabolism). |
| **8. Ongoing monitoring** | **Specialist**: review at 2 - 3 months, once on stable dose – thereafter specialist review at least every 6 months, through older adult mental health team. All patients prescribed Memantine will remain under Secondary care for monitoring of cognition and mental health. All patients are subject to CPA review, which includes review of carer needs.<br>Decisions to discontinue treatment due to lack of effectiveness or deterioration of dementia should be undertaken by Secondary care.<br><br>**Primary Care:** ongoing review and monitoring of patient's physical health and well being.<br><br>The Quality and Outcomes Framework for the nGMS contract 2011-12 includes indicator DEM2 for the ongoing monitoring of dementia patients:<br>**DEM2**. The percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 15 months.<br>The review should address four key issues:<br>i. An appropriate physical and mental health review for the patient.<br>ii. If applicable, the carer's needs for information commensurate with the stage of the illness and his or her and the patient's health and social care needs.<br>iii. If applicable, the impact of caring on the care-giver.<br>iv. Communication and co-ordination arrangements with secondary care (if applicable) |
| **9. Pharmaceutical aspects** | *N/A* |
| **10. Specialist centre contact information** | **If stopping the medication or needing advice please contact:**<br>Dr Marianne James (BCHB) tel: 01686 617240<br>Dr Mahmoud Ahmed (ABHB) tel: 01874 712472<br>Dr Cathryn Jani (ABHB) tel: 01874 712472<br>Dr Chineze Ivenso (ABM UHB) tel : 01267 237481 |
| **11. Criteria for shared care** | **Only specialists in the care of patients with dementia** (that is, psychiatrists including those specialising in learning disability, neurologists, and physicians specialising in the care of older people) **should initiate treatment**<br>Prescribing responsibility will only be transferred when:<br>➢ Treatment has been initiated and established by the specialist centre.<br>➢ Treatment is for a specified indication.<br>➢ The patient's initial reaction to and progress on the drug is satisfactory.<br>➢ The patient's general physical, mental and social circumstances are such that he/she would benefit from shared care arrangements. |
| **12. Responsibilities of initiating consultant** | 1. To undertake memory and psychiatric assessment and confirm a likely diagnosis of Alzheimer's disease.<br>2. To advise the patient and carer on potential side effects and the action to be taken should they occur.<br>3. To confirm the patient's understanding and consent to treatment or to discuss with carer(s) where patient lacks capacity. |

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| | 4. To identify a suitable person or process to ensure adherence/compliance with treatment where the patient cannot manage on their own.<br>5. To ensure the patient and carer understands that treatment needs monitoring and may be discontinued if no objective evidence of improvement occurs.<br>6. To initiate prescribing & monitor patient's initial reaction to treatment and ongoing progress, making any dose adjustments as necessary.<br>7. Once the patient has reached a stable dose of the memantine, to send the Shared Care Agreement Form (*copy below*) to the GP.<br>8. To provide GP with:<br>• Diagnosis, relevant clinical information and baseline results, treatment to date and treatment plan, duration of treatment before consultant review.<br>• Provide GP with details of outpatient consultations, ideally within 14 days of seeing the patient *or* inform GP if the patient does not attend appointment<br>• Advice on when to stop the medication.<br>9. At point of transfer of prescribing to the GP, to ensure the patient has a minimum of 4 weeks supply of medication.<br>10. To undertake ongoing monitoring in respect of continued efficacy of memantine**.** Initial review at **3 months or sooner** to make continuation decision. Once on stable dose, thereafter regular specialist review **every 6 months** (maximum 12 months gap) in accordance with NICE guidance (i.e. using cognitive, global, functional and behavioural assessment and seeking carers' views on the patient's condition).<br>11. To communicate any information on changes to the GP.<br>12. To provide advice to the GP at any time when needed.<br>13. To discontinue memantine if it is unsuitable for the patient for reasons of efficacy (based on an appropriate method of assessment) or tolerability. Medication should be withdrawn gradually on discontinuation. |
| **13. Responsibilities of Primary Care** | 1. To undertake baseline physical health monitoring (as outlined in Section 7) and brief cognitive examination prior to referral. Ensure test results are sent with referral.<br>2. To refer any patient on memantine transferred to the area to the specialist team.<br>3. To respond to the shared prescribing request within 7 days if unable to accept shared care.<br>4. Once the patient is on stable dose, to prescribe and monitor memantine in accordance with this protocol, subject to ongoing specialist review (as above).<br>Patient monitoring is an option in The Quality and Outcomes Framework for the nGMS contract 2011-12 (*see section 8 above*).<br>5. To be vigilant for potential drug interactions and adverse drug reactions.<br>6. To notify the responsible clinician of any problems or concerns, or any circumstances that question the need for continued treatment.<br>a. Sudden deterioration in cognitive function.<br>b. Patient intolerance or adverse effects to medication.<br>c. Non-compliance.<br>d. Signs or symptoms of toxicity<br>7. To discontinue memantine based on the advice from the specialist service.<br>8. To undertake ongoing physical health monitoring and management. |
| **14. Responsibilities of patients/carer** | ➢ To attend hospital and GP clinic appointments.<br>➢ Failure to attend will result in medication being reviewed and possibly stopped on specialist advice.<br>➢ To report adverse effects to their specialist or GP |
| **15. Responsibilities of all prescribers** | **Any suspected serious adverse reaction to an established drug should be reported to MHRA via the "yellow card scheme." http://yellowcard.mhra.gov.uk/** |
| **16. Responsibilities of pharmacists** | ➢ Whenever practicable, to reaffirm with the patient the importance of reporting any unexplained side-effects |

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| **17. Supporting documentation / information** | **Information**<br>**http://www.medicines.org.uk/EMC/searchresults.aspx?term=memantine&searchtype=QuickSearch**<br>**Memantine Patient Information Leaflet:**<br>http://www.medicines.org.uk/EMC/medicine/10122/XPIL/Ebixa+10+mg+Film-Coated+Tablets/<br><br>**Other information:**<br>NICE technology appraisal guidance 217 (March 2011): Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease: http://guidance.nice.org.uk/TA217<br><br>NICE Clinical Guideline 42 (November 2006 amended to incorporate the updated TA217) Dementia: Supporting people with dementia and their carers in health and social care: **http://www.nice.org.uk/CG42** |
| **18. GP request letter** | **Shared Care Agreement Form – Attached below** |

# Shared Care Agreement Form

**CONSULTANT REQUEST**

**To: Dr.**

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| **Your patient:** | **NHS No. (10digit):** |
| **was seen on:** | |
| **with a diagnosis of:** | |
| **I recommend that the following drug is initiated:** | |

This drug has been accepted as suitable for shared care by the Powys *PCD&T* Commitee. I agree to the responsibilities set out in the Memantine Shared care protocol. This should be read in conjunction with the definition of shared care at: **http://www.wales.nhs.uk/sites3/Documents/371/Doc%202%20Defining%20shared%20care.pdf**

I am requesting your agreement to sharing the care of this patient. The preliminary tests set out in the protocol have been carried out. I am currently prescribing the stabilising treatment.

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| **I would like you to undertake treatment from:** |
| **The initial treatment will be:** |
| **The baseline tests are:** |

If you undertake treatment I will reassess the patient in ____ weeks. You will be sent a written summary within 14 days. I will accept referral for reassessment at your request.

The medical staff of the department are available at all times to give you advice.

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| **Consultant Name:** | **Signature and date:** |
| **Department:** | |
| **Contact Telephone Nos:** | |

**GP RESPONSE** (*Please circle the appropriate number below detailing your response*)

1. I am willing to undertake shared care for this patient, as set out in the Shared Care Protocol.
2. I would like further information. Please contact me on: _____
3. I am unable to undertake shared care for this patient because: (*Please state*)

_____

G.P. Signature _____ Date _____

Practice Address/Stamp _____

**PLEASE RETURN WHOLE COMPLETED FORM OR A COPY TO THE REQUESTING CONSULTANT WITHIN 2 WEEKS**