Prescribing Framework for Donepezil in the Treatment and Management of Dementia

Patients Name: ................................................................. NHS Number: .................

Patients Address: ..............................................................(Use addressograph sticker)

GP’s Name: ..............................................................................

Communication

We agree to treat this patient within this Prescribing Framework.

Specialist Prescriber’s Name ...............................................................

Specialist Prescriber’s Signature..................................................Date: ..............

GP’s Signature: ............................................................................Date: ..............

The front page of this form should be completed by the specialist and the form sent to the patient’s general practitioner.

The patient’s GP should sign and send back to specialist, to confirm agreement to enter into shared care arrangement. If the General Practitioner is unwilling to accept prescribing responsibility for the above patient the specialist should be informed within two weeks of receipt of this framework and specialist’s letter.

Full copy of framework can also be found at: http://www.hey.nhs.uk/content/prescribingCommittee/amber.aspx

APPROVAL PROCESS

| Written by: | Jackie Stark, Medicines Management Pharmacist, HFT Dr David Lawley, Consultant Psychiatrist, HFT |
| Consultation process: | Drug Therapeutics Committee HFT (Nov 2009) Dr Alec Ming, Consultant Neurologist, HEY |
| Approved by: | MMIG March 2012 |
| Ratified by: | HERPC May 2012 |
| Review date: | May 2013 |
1. Background

Donepezil is one of three acetylcholinesterase inhibitors (ACHEIs), licensed for the treatment of people with mild to moderate Alzheimer’s Disease (the others being rivastigmine and galantamine). Evidence is also beginning to emerge that these drugs have some benefit in patients with mixed Alzheimer’s/vascular dementia (i.e. Alzheimer’s Disease with concomitant vascular dementia), as well as in patients with mild, moderate or severe Alzheimer’s Disease, dementia associated with Parkinson’s Disease and Lewy Body Dementia with non cognitive symptoms and/or behaviour that challenges.

The National Institute of Clinical Excellence (NICE) in TAG 217 produced guidance for the use of the ACHEIs in March 2011, recommending that they should be used in the management of people with Alzheimer’s disease of mild to moderate severity. NICE Clinical Guideline 42, published in November 2006, clarified the use of ACHEI's in mild, moderate and severe Alzheimer’s Disease (AD), as well as Lewy Body Dementia (DLB) in patients who have non cognitive symptoms causing significant distress or behaviour that challenges. This advice has become increasingly pertinent as the evidence base surrounding the risks associated with the use of antipsychotic drugs in such patients, has strengthened. N.B. The evidence base for dementia in Parkinson’s disease (PDD) was not examined specifically in NICE CG 42. However, the guideline suggested that the recommendations for DLB may be useful when considering treatments for dementia in Parkinson’s disease.

This framework aims to provide guidelines for the prescribing of donepezil in the management of people with Alzheimer’s disease, mixed Alzheimer’s Disease/vascular dementia (i.e. Alzheimer’s Disease with concomitant vascular dementia), dementia associated with Parkinsons Disease and Lewy Body Dementia by GPs and to set out the associated responsibilities of GPs and hospital specialists who enter into the shared care arrangements.

The guidelines should be read in conjunction with the general guidance on prescribing matters given in EL (91) 127 “Responsibility for prescribing between hospitals and GPs”.

2. Indication

This prescribing framework applies to the prescribing of Donepezil in the treatment of Alzheimer’s Disease of mild to moderate severity, as well as it’s use in the treatment of patients with mild, moderate or severe Alzheimer’s Disease, mixed Alzheimer’s Disease/vascular dementia (i.e. Alzheimer’s Disease with concomitant vascular dementia associated with Parkinsons Disease or Lewy Body Dementia who have non cognitive symptoms causing significant distress or leading to behaviour that challenges.

3. Dose

Please consult the most up to date BNF for detailed information.
The starting dose is 5mg of donepezil daily, increasing, if necessary, after a minimum of one month to a maximum of 10mg daily. Donepezil is available as tablets or as an orodispersible preparation.

*Doses above 10mg may be clinically appropriate in individual patients under specific circumstances, but would be ‘off licence’ and should only be undertaken under the direct supervision of a specialist team for the management of dementia, after a thorough consideration of the possible benefits and risks of such a course of action.*

4. Duration of treatment

The specialist team will provide the GP with clear directions about treatment end points, together with the offer of support and advice when necessary. Treatment should be continued while it is considered to be having a worthwhile effect on cognitive, global, functional or behavioural symptoms, or where it is clinically judged that the withdrawal of treatment would not be in the patient’s best interests (for example due to the risk of an adverse clinical outcome, such as triggering behaviour that challenges).

A sudden withdrawal of treatment should be avoided, as this can precipitate a withdrawal reaction which can lead to an increased level of confusion.

In circumstances where there is a loss of treatment effect, after several months or years of donepezil, the following options should be considered by the specialist team on an individual patient basis, when clinically appropriate:

a) Increasing the dose of donepezil to the BNF maximum recommended dose (i.e. 10mg)

b) Considering the appropriateness of ‘off licence’ prescribing by increasing the dose to above the BNF maximum recommended dose by or under the direct supervision of a specialist team for the management of dementia

c) Considering prescribing an alternative ACHEI (i.e. rivastigmine or galantamine)

d) Considering the appropriateness of the prescription of memantine

5. Contraindications and cautions

- Known hypersensitivity to donepezil, or any other component of the product.
- Donepezil is contraindicated in breast feeding
- Susceptibility to peptic ulcers
- Asthma or Chronic Obstructive Pulmonary Disease (COPD)
- Patients with hepatic impairment
- Sick sinus syndrome or cardiac conduction disorders, including bradycardia
- History of falls/syncope
- Pregnancy
- Donepezil may exacerbate extrapyramidal symptoms
6. Adverse effects

Specific information should be sought from the current BNF (electronically www.bnf.org/bnf/) or Data Sheet (electronically www.medicines.org.uk).
Prescribers should be aware of emerging evidence suggesting that ACHEI’s may lead to an increased risk of falls, possibly through the mechanism of bradycardia. It is therefore important to consider this possibility, particularly in patients with pre-existing cardiovascular disease, or in receipt of β–blockers.

Should the patient be unable to tolerate donepezil, consideration should be given to the following:-
   a) Prescribing an alternative ACHEI
   b) Prescribing memantine as an alternative

7. Interactions

Specific information should be sought from the current BNF (electronically www.bnf.org/bnf/) or Data Sheet (electronically www.medicines.org.uk).

NB. Anaesthetists need to be advised of use of these drugs if surgery is required

Details of contraindications, cautions, drug interactions and adverse effects listed above are not exhaustive. For further information always check with BNF www.bnf.org.uk or SPC (www.medicines.org.uk).

8. Monitoring

   a. Drug Monitoring

There is no need to monitor any biochemical markers during treatment with donepezil

Routine pulse checks should be carried out at baseline, after each dose increase during titration and then 6 monthly, with the following advice:-

   a) Pulse under 50 bpm
      • Withhold or stop treatment with cholinesterase inhibitor
      • Consider withdrawal of co-prescribed β–blockers and reassessment
      • Carry out ECG monitoring
      • GP or cardiologist review as appropriate
      • If cause found unrelated to drug, or if pacemaker fitted, consider retrial of medication, with monitoring of pulse.

   b) Pulse between 50 and 60 bpm and asymptomatic
      • Carry out ECG monitoring if has cardiovascular risk factors, history of falls or ‘funny turns’ or irregular pulse
      • Start/continue treatment dependent on ECG finding
      • Review pulse and symptoms after one week
      • If patient remains asymptomatic, continue drug and check pulse one week after each dose increase.
c) Pulse 50-60 bpm and symptomatic of syncope or ‘funny turns’
   - Withhold or stop treatment with cholinesterase inhibitor
   - Consider withdrawal of co-prescribed β-blockers and reassessment
   - Carry out ECG monitoring
   - GP or cardiologist review, as appropriate
   - If cause found unrelated to drug, or if pacemaker fitted, consider retrial of medication, with monitoring of pulse.

d) Pulse over 60bpm
   - Start/continue treatment
   - Routine pulse checks at baseline, after each dose increase during titration and then 6 monthly.

**Routine ECG monitoring** should be carried out in patients with the following history or symptoms:
- Cardiac disease, or significant cardiovascular risk factors (e.g. diabetes, hypertension etc)
- Falls or ‘funny turns’
- Irregular pulse

**Routine compliance and side effects** should be monitored by patients, carers, members of the specialist team (when appropriate) and the prescriber.

b. **Disease Monitoring**

This may be provided by either the primary care team or specialist team, depending on individual patient and carer needs.

When assessing the severity of Alzheimer’s disease and the need for treatment, healthcare professionals should not rely solely on cognition scores in circumstances in which it would be inappropriate to do so. These include:
- if the cognition score is not, or is not by itself, a clinically appropriate tool for assessing the severity of that patient’s dementia because of the patient’s learning difficulties or other disabilities (for example, sensory impairments), linguistic or other communication difficulties or level of education or
- if it is not possible to apply the tool in a language in which the patient is sufficiently fluent for it to be appropriate for assessing the severity of dementia or
- if there are other similar reasons why using a cognition score, or the score alone, would be inappropriate for assessing the severity of dementia.

In such cases healthcare professionals should determine the need for initiation or continuation of treatment by using clinical judgement, taking into account information provided by the patient and carers and after conducting a Mental State Examination (including appropriate assessment of cognition).

The management of patients with dementia should involve partnership working to provide psycho-social and pharmacological interventions as outlined in the locally developed stepped care model for patients with dementia, based on the recommendations of the national Dementia Strategy.
9. Information to patient

The specialist team will be responsible for informing the patient and their carer about likely benefits and risks (including possible side effects) from the treatment prior to starting the drug. In situations where the patient is unable to give informed consent due to a lack of mental capacity, the patient’s ‘best interests’ should be determined as outlined in the Capacity Act, by liaising with the patients relatives and carers, as well as other professionals involved in their care, prior to starting any possible treatment.

10. Responsibilities of clinicians involved

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<th>Stage of Treatment</th>
<th>Specialist team</th>
<th>General Practitioner</th>
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| Initiation         | • Selection of suitable patients  
                    | • To develop and co-ordinate the implementation of a comprehensive care plan for the patient and their carer  
                    | • To initiate treatment, assess the patient 2-4 months after reaching the maintenance dose and determine whether treatment should be continued or not at this assessment.  
                    | • Provide verbal and written treatment information to patient and their carer  
                    | • To provide appropriate monitoring of the patient for treatment side effects during the initiation phase, in liaison with the patient’s GP | • Liaise and seek advice from the specialist team, when appropriate  
                    | | • Take over prescribing of medication after the first month of treatment and provide ongoing clinical care |
| Monitoring         | • Liaise and provide support to GP  
<pre><code>                | • Ensure clear guidance is provided to the General Practitioner about treatment end points | Seek advice from specialist if necessary |
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<p>| Discontinuation    | • Advising the GP when medication should be | • Co-operate with the specialist during discontinuation |</p>
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<td>• Provide any necessary supervision, support or advice during the discontinuation phase</td>
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<td>• To initiate alternative treatment, should this be clinically appropriate.</td>
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**Contact Details:**

**Humber NHS Foundation Trust:** contact as advised in clinic letter.

**Hull and East Yorkshire Hospitals NHS Trust**

During office hours: Neurology secretaries 01482 675592

Out of hours: Contact on-call Physician for Neurology via Switchboard: 01482 875875