HERPC
Hull & East Riding Prescribing Committee

Prescribing Framework for Acamprosate tablets 333mg in alcohol relapse prevention

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…… Prof Reg. No. ……

Specialist Prescriber's Signature…… Date:……

Where prescriber is <u>not</u> a consultant:

Consultant's Name: …… GMC No ……..

Consultant's Signature ……... ……. Date:……

GP's Signature:…… Date:……..

GP's Name (if different from listed above)……..

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 **<u>send back to specialist</u>**, to confirm agreement to enter into shared care arrangement. If the General Practitioner is **<u>unwilling</u>** 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/amber.htm

SHARED CARE FRAMEWORK FOR CLINICAL INFORMATION ONLY.
Drug and alcohol treatment services in Hull and East Riding are directly commissioned by Public Health with specialists and GPs, who prescribe treatment for opioid/ alcohol dependence as part of this locally commissioned Public Health service. GPs prescribing outside of these arrangements using this framework should do so in accordance with NICE guidance.

Background

Alcohol dependence affects 4% of people aged between 16 and 65 in England (6% of men and 2% of women), and over 24% of the English population (33% of men and 16% of women) consume alcohol in a way that is potentially or actually harmful to their health or well-being. Alcohol misuse is also an increasing problem in children and young people.

Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. In the longer term, harmful drinkers may go on to develop high blood pressure, cirrhosis, heart disease and some types of cancer, such as mouth, liver, bowel or breast cancer.

Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Alcohol dependence is also associated with increased criminal activity and domestic violence, and an increased rate of significant mental and physical disorders.

People with moderate dependence (with a SADQ score of between 15 and 30) usually need assisted alcohol withdrawal, which can typically be managed in a community setting unless there are other risks. People who are severely alcohol dependent (with a SADQ score of more than 30) will need assisted alcohol withdrawal, typically in an inpatient or residential setting

Chronic alcohol intake alters the balance of excitatory (e.g. glutamate) and inhibitory (e.g. gamma amino butyric acid) amino acids within the brain. Acamprosate crosses the blood brain barrier and is thought to act by complex neuromodulatory processes to restore the balance, especially the inhibition of glutamate which is thought to have an important role in dependency. It reduces craving and therefore the risk of relapse.

Acamprosate is an effective and generally well tolerated treatment for relapse prevention in patients with alcohol dependence.

After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol misuse.

For harmful drinkers and people with mild alcohol dependence, offer a psychological intervention (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social networks.

For harmful drinkers and people with mild alcohol dependence who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention, consider offering acamprosate or oral naltrexone in combination with an individual psychological intervention (cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) or behavioural couple's therapy

For children and young people aged 10–17 years who misuse alcohol offer:

- individual cognitive behavioural therapy for those with limited comorbidities and good social support

- multicomponent programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy or multisystemic therapy) for those with significant comorbidities and/or limited social support.

After a careful review of the risks and benefits, specialists may consider offering acamprosate or oral naltrexone in combination with cognitive behavioural therapy to young people aged 16 and 17 years who have not engaged with or benefited from a multicomponent treatment programme. The prescribing of acamprosate in these patients should remain with the specialist and is considered RED.

These guidelines aim to provide a framework for the prescribing of acamprosate by GPs and to set out the associated responsibilities of GPs and hospital specialists who enter into the shared care arrangements.

This document should be read in conjunction with the guidance "Responsibility for prescribing between Primary & Secondary/Tertiary Care" https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf

1. Indication

Acamprosate is indicated for maintenance of abstinence in alcohol-dependent patients. It should only be used as part of an integrated programme including psychotherapy and counselling during rehabilitation, when it is considered by the specialist to be beneficial to the patient.

Before starting treatment with acamprosate conduct a comprehensive medical assessment (baseline urea and electrolytes and liver function tests including gamma glutamyl transferase [GGT]). In particular, consider any contraindications or cautions (see the SPC), and discuss these with the service user.

Acamprosate does not prevent the harmful effects of continuous alcohol abuse. Continued alcohol abuse negates the therapeutic benefit; therefore acamprosate treatment should only be initiated after weaning therapy, once the patient is abstinent from alcohol

3. Dose

Adults (18 to 65 yrs) weighing 60kg or more: 666mg three times a day
Adults (18 to 65 yrs) weighing under 60kg: 666mg in the morning, 333mg at noon and 333mg at night

Acamprosate should be taken with or after food and the tablets should be swallowed whole.

Acamprosate should not be administered to children and the elderly. Refer to the latest BNF for more information.

4. Duration of treatment

Treatment should be commenced as soon as possible after alcohol withdrawal and should continue for 6 months to one year. Although treatment should be maintained if the patient relapses (SPC recommendation), it should be discontinued if the drinking persists 4-6 weeks after starting medication.
Service users taking acamprosate should stay under supervision, at least monthly, for 6 months, and at reduced but regular intervals if the drug is continued after 6 months. Do not

use blood tests routinely, but consider them to monitor for recovery of liver function and as a motivational aid for service users to show improvement.

5. Contraindications and cautions

Acamprosate is contraindicated in patient known to be hypersensitive to the drug, pregnancy, lactation, renal insufficiency (serum creatinine >120 micromol/L) and **severe** hepatic impairment.

6. Adverse effects

The most common side effect (> 1 in 10) is diarrhoea. Other side effects occurring in between 1 in 10 and 1 in 100 patients include abdominal pain, nausea, vomiting, flatulence pruritis, maculopapular rash, decreased libido, frigidity and impotence. Very rarely (less than 1 in 10,000 patients) hypersensitivity reactions including urticaria, angio oedema or anaphylactic reaction can occur.

7. Interactions

No significant interactions have been associated with the use of acamprosate. Concomitant intake of alcohol does not affect the pharmacokinetics of acamprosate.

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

There is no necessity for biochemical or other monitoring, although biochemical monitoring may be considered to monitor for recovery of liver function and as a motivational aid to show improvement. The specialist who initiated the treatment will review the patient at least monthly for 6 months, and at reduced but regular intervals if the drug is continued after 6 months.

9. Information to patient

Patients will be provided with verbal information and the written product information leaflet by the specialist team

10. Responsibilities of clinicians involved

Stage of Treatment	Specialist	General Practitioner
Initiation	• Specialist initiation and monitoring for the first month • Perform baseline renal function and liver function tests. • Assess and recommend appropriate treatment to GP, including the duration of treatment and other forms of aftercare.	
Monitoring	• Available for advice. • Review patient every month for the first 6 months. • After 6 months review at a	• Take over prescribing from specialist after the first month. • Monitor response to treatment and adverse effects every 3 months.

	reduced but regular interval. • Patient must be in receipt of continuing therapeutic intervention from a specialist team	(Psychiatric and mental co-morbidity may occur in patients with a history of alcohol abuse). • Monitor alcohol intake. • Refer to specialist where necessary.
Review and discharge	• Review patient after 1 year and discharge from service or stop treatment. • Advise GP of when and how treatment should be discontinued	• Continue treatment as recommended. • • Co-operate with the specialist during discontinuation

Contact Details:

Contact Specialist as per clinic letter

During office hours:	Out of hours:
Humber Teaching NHS Foundation (HTFT) Baker Street (01482 336562	Victoria House and ask for the on-call consultant 01482 223191
CGL ReNEW Hull Trafalgar House, 41-45 Beverley Road Hull, HU3 1XH 01482 620013 earlyhelp.hull@cgl.org.uk	

APPROVAL PROCESS

Written by:	***Jackie Stark, Specialist Pharmacist, HFT***
Consultation process:	***Addictions Service, Dr Bassey CGL Hull***
Approved by:	***Humber DTC, MMIG***
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