HERPC

Hull & East Riding Prescribing Committee

Prescribing Framework for Verapamil in Cluster Headache

Patient's Name:……..… NHS Number: ……

Patient's 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

1. Background

Cluster headache is a type of headache causing patients intense pain and incapacity. In episodic cluster headache, bouts of headache are, typically, experienced daily over 6 -12 weeks, once or twice a year. Prophylactic drugs are the mainstay of treatment and verapamil is recommended as first line prophylaxis for cluster headache[1]. This is an unlicensed indication but is recommended by NICE CG 150[2]

This shared care agreement outlines how the responsibilities for managing the prescribing of verapamil for cluster headache can be shared between the secondary care specialist and general practitioner (GP) / primary care prescriber.

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

Cluster headache

3. Dose

Initial dose 80mg tds Increasing by 80mg every 2 weeks. Doses of up to 960mg daily in divided doses may be required.

Lower doses may be required in hepatic impairment.

Modified release preparations are used for doses above 80mg tds.

4. Duration of treatment

As advised by specialist.

For some patient’s treatment may be withdrawn gradually following 14 symptom-free days. In others, treatment may be required long term.

5. Contraindications/cautions

Due to negative inotropic effect, verapamil is contraindicated (or should be used with caution) in patients with any form of reduced cardiac output, heart failure or conduction disorders. See BNF/SPC for further details.

Verapamil is contraindicated in pregnancy.

6. Adverse effects

Verapamil is usually well tolerated, constipation (which may be severe) and flushing are common side effects.

Gingival hyperplasia heralded by gum bleeding that should trigger referral for medical review.

At high doses may cause hypotension, heart failure, bradycardia, heart block, and asystole (see section on Monitoring).

7. Interactions

Increased risk of asystole, severe hypotension and heart failure when verapamil given with beta-blockers and other antiarrythmics e.g. digoxin, amiodarone, dronedarone. Verapamil should not be given to patients on beta-blockers as it may increase risk of AV block, bradycardia, hypotension, heart failure

Verapamil is metabolized by cytochrome CYP3A4. Clinically significant interactions occur with other drugs which are inhibitors or inducers of CYP3A4 enzymes including macrolides, antiepileptics, digoxin, ciclosporin, simvastatin, theophylline, St John's Wort and grapefruit juice.

Increased exposure to direct acting oral anticoagulants (apixaban, dabigatran, edoxaban and rivaroxaban).

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. Information to patient

Patient should be advised of risks and benefits of treatment and supply arrangements.

9. Responsibilities of clinicians involved

Stage of Treatment	Hospital Specialist	General Practitioner
Initiation	Select patients appropriate for treatment. Inform patient of risks and benefits of treatment and supply arrangements. Prescribe and assess patient's response until dose stabilised. Contact the GP to invite shared care for the patient and provide information on treatment.	
Maintenance	Assess clinical response and inform GP of any changes to treatment. Arrange ECG for patient before dose reaches 480mg daily and for any subsequent dose increases. Provide adequate advice and support for the GP	Prescribe treatment once stabilised. Monitor patient for efficacy and adverse effects. Refer to specialist where appropriate

Contact details

During office hours:

Neurology specialist pharmacist

Priscilla Kanyoka (01482) 674043

Consultant neurologist

As per clinic letter Via switchboard

Out of hours: contact on call registrar for neurology via switchboard

References

1. British Association for the Study of Headache. (2019). National Headache Management System for Adults. http://www.bash.org.uk/downloads/guidelines2019/01_BASHNationalHeadache_Management_SystemforAdults_2019_guideline_versi.pdf
2. NICE CG150 (Updated Nov 2015) Headaches in over 12s: diagnosis and management. https://www.nice.org.uk/Guidance/CG150

APPROVAL PROCESS

Written by:	**Marie Miller, Interface Pharmacist** **Jane Morgan, Interface Pharmacist** ***Jan 2014. Reviewed March 2018 and December 2020***
Consultation process:	**Prof F Ahmed, Consultant Neurologist, Dr M Khalil, Consultant Neurologist**
Approved by:	***MMIG, LMC***
Ratified by:	***HERPC Jan 2021***
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