RIFAXIMIN-α (Targaxan®) for preventing episodes of overt hepatic encephalopathy in adults

Screening Checklist and Notification of Initiation to GP

The checklist must be completed and returned to pharmacy department **prior** to the initiation of **RIFAXIMIN-α** for the above indication.

Hospital clinicians should be aware that, if a drug is prescribed for patients / indications that do not meet the agreed criteria, prescribing responsibility will remain with the initiating team

- **This completed checklist (pages 1-2) should be sent to the GP when RIFAXIMIN-α is initiated**
- **Following a 6 month period, prescribing responsibility may be transferred to the GP (subject to GP agreement). The transfer of care / prescribing agreement should be completed and sent directly to the GP (page 3).**

Important information for GPs:
This is notification that RIFAXIMIN-α has been started. If appropriate, after the hospital has prescribed and supplied RIFAXIMIN-α for 6 months, we will send a transfer of care document requesting that you take over prescribing responsibility.

Patient Details	GP Details
Surname	Name
Forename	Address
Address	
	Tel
Postcode	Fax
NHS No:	NHS.net email
DOB: SEX: Male / Female	

Eligibility criteria - Note: ALL criteria below must be met*

Criteria set out in the NICE technology appraisal guidance TA337 [Published: March 2015]: Rifaximin for preventing episodes of overt hepatic encephalopathy[1]. (Refer to the Summary of Product Characteristics [SPC[2]] for full details of licensed indications)	Yes	No
Patient has been diagnosed with hepatic encephalopathy		
Adult patient 18 years or over		
Rifaximin- α has been initiated by consultant gastroenterologist or hepatologist		
The following criteria must also be met:		
The patient has had 2 or more hospital admissions secondary to the development of overt hepatic encephalopathy or has persistent or chronic hepatic encephalopathy which does not respond to lactulose therapy.		
The prescribing physician must have subjective and/or objective evidence of an improvement in neurocognitive function following 3 months of rifaximin-α therapy. This may include a reduction in overt encephalopathy episodes, a reduction in hospital admissions, improved neuropsychometry (Number Connection Test A & B) or an improved quality of life/reduced carer burden.		
The patient is not actively consuming alcohol in excess (>2.5units/day in women and >5units alcohol/day in men).		
There is no history in the previous 6 months of clostridium difficile infection.		

***NOTE: Must be yes for all statements for transfer to primary care**

Contraindications (Refer to the SPC for full details of drug interactions)

Tick all boxes – **NOTE: all answers must be No to proceed**	Yes	No
Any contraindication to rifaximin-α?		
Allergy to rifamycin based antibiotics e.g rifampicin		

Patient Information ***- NOTE: Must be yes for all statements for transfer to primary care after 6 months***

Patient Information[2] (circle yes or no as appropriate)		
Patient is aware/has been informed:		
1) Of the importance of maintaining compliance with their hepatic encephalopathy treatment (lactulose/laxatives) in addition to regular rifaximin therapy.	**Yes**	**No**
2) That the first 6 months of treatment will be prescribed **and** supplied by the hospital pharmacy. They should not take their prescription to their GP practice until after this 6 month period.	**Yes**	**No**

Dosing recommendations
Rifaximin-α (Targaxan) 550mg to be taken orally twice daily 12 hours apart.

AUTHORISATION (medical practitioner undertaking assessment)	
Signature:	**Print name:**
Position:	**Contact number:**
Date:	

HOSPITAL OUTPATIENT PHARMACY DEPT
Approved Yes / No / Not applicable (circle as appropriate)
If 'No' include reason :

References:
1. Rifaximin for preventing episodes of overt hepatic encephalopathy NICE technology appraisal guidance [TA337] Published date: March 2015. Available at: https://www.nice.org.uk/guidance/ta337
2. Summary of Product Characteristics for rifaximin (Targaxan) 550mg film coated tablets, available at: http://www.medicines.org.uk/emc/medicine/27427

RIFAXIMIN-α (Targaxan) 550mg for preventing episodes of overt hepatic encephalopathy in adults

Transfer of Care / Prescribing Agreement

Following a 6 month period, prescribing responsibility may be transferred to the GP (subject to GP agreement). This transfer of care / prescribing agreement should be completed and sent directly to the GP. The original checklist should also be re-attached for information.

Section A: To be completed by the initiating organisation

Patient Details:
Name..... DOB: ……/……/…… NHS No: ……

GP Practice Details:	**Consultant Details:**
Name: …… Address: …… Tel no: …… Fax no: …… NHS.net e-mail: ……	Consultant Name: Trust: Tel no: Fax no: Email:

Next hospital appointment: ……/……/……..

Dear Dr. …… , your patient was seen on …../…../…….

and was initiated on **rifaximin-α** delivered as **Targaxan 550mg twice daily**

for ……..months on ……./……/……..

I am requesting your agreement to the transfer of the care of this patient from …../…../……. in accordance with arrangements agreed by the South East London Area Prescribing Committee (i.e. after at least 6 months treatment by the hospital).

The following investigations have been performed on ……/……/……. and confirm the patient is acceptable for transfer of care:

If there are any concerns or advice is required regarding the ongoing prescription of rifaximin-α, please do not hesitate to contact Dr Debbie Shawcross for King's College Hospital NHS Foundation Trust (debbie.shawcross@nhs.net) or Dr.Philip Berry (Philip.Berry@gstt.nhs.uk) for Guy's and St. Thomas' NHS Foundation Trust or Dr Alistair McNair for Lewisham and Greenwich Trust (a.mcnair@nhs.net)

Other relevant information: ……
……

- I confirm that I have prescribed in accordance with the NICE guidance [1] and criteria set out in the Screening Checklist and Notification of Initiation to GP form (previously sent to the GP) ☐
- I confirm that the patient has been given the information required as described in the Screening Checklist and Notification of Initiation to GP form (previously sent to the GP) ☐
- I confirm the patient has consented to treatment ☐

Signed:…… Name of Clinician:…… Date: ……..

Section B: To be completed and signed by the GP if NOT willing to take on prescribing responsibility and returned to the prescribing specialist as detailed in Section A above.

This is to confirm that I am not willing to accept the transfer of care of Rifaximin-α (Targaxan®) for this patient ***for the following reason***:

……

GP name: ……GPsignature: ……Date: ……/……./…....

(This transfer of care document should be reviewed in-conjunction with the drug screening checklist sent previously by the initiating clinician - this should be re-attached with this request. If not, please contact consultant named above for details)