

Ref:

Please attach patient addressograph here

# GP Name

Address 1

Address 2

Address 3 City Postcode

Date Dear

# Patient name…………………………….

Please could you initiate prescribing of hydroxychloroquine 200mg tablets for the above patient?

Hydroxychloroquine 200mg tablets Dose…………………………………....

Date patient will be reviewed again on …………………………………………………………….

As per Pan-Mersey Area Prescribing Committee recommendation, this medicine is categorised as Amber Patient Retained. The Pan Mersey Prescribing Support Information for hydroxychloroquine can be found [here.](https://www.panmerseyapc.nhs.uk/media/2181/hydroxychloroquine_prescribing.pdf)

**Please note that it has been agreed that the GP will initiate the drug for patients under Wirral Health and Care Commissioning** and we would be grateful if you would agree to prescribe and administer this treatment**.**

Routine monitoring is not required for hydroxychloroquine but your patient will require eye screening if they are taking this medication for more than 5 years. The specialist is responsible for this monitoring and any relevant information will be communicated to you on the proforma within the prescribing support information. The patient has been informed that eye screening will be necessary.

To acknowledge whether you agree to prescribe hydroxychloroquine to your patient, please could you sign and send this letter back to the department on (insert secure mail address) within

14 days? Please retain a copy for your records.

# Name

Position

# To be completed by GP(\*delete as applicable)

I agree/do not\* agree to prescribe hydroxychloroquine to the above patient in accordance with Wirral Health Care and Commissioning Prescribing Support Information.

GP Signature……………………………………Print………………………………..Date…………………….

**Adapted with permission from Pan Mersey APC**

**Review date: March 2022 Review date extended to September 2023**

**v.1.1 July 2023 Amendments approved at Wirral MMC**