

**[Insert Trust name  
and address here]**

Clinic Date:                      Date dictated:                      Date Typed:

**Dr [insert name here]  
Consultant Neurologist**

GP Name  
Address line 1  
Address line 2  
Address line 3  
City  
Postcode

Our Reference:  
NHS Number:

Dear Dr **[insert name here]**

**Re: *insert Patient name***

**DOB: \_\_/\_\_/\_\_**

This letter is to inform you that the above patient has been assessed and deemed suitable for apomorphine therapy for the treatment of Parkinson's disease.

Patients on apomorphine remain under the care of our specialist team and will be regularly monitored whilst receiving this medication. We will initiate and monitor apomorphine therapy until the patient is established on therapy and prescribe and supply apomorphine for the first month of treatment. We intend on initiating the APO-go/Dacepton brand for this patient (*please delete as appropriate*). Patients may be signed up to homecare to receive Dacepton, although this is not a requirement for initiation. If you would like to proceed with homecare, this is for local implementation and the pharmaceutical company (EVER Pharma) should be contacted directly. Please note that brands of apomorphine are **not** interchangeable due to the different devices used.

As per Pan Mersey Area Prescribing Committee recommendation, this medicine is categorised as Amber Retained and we would be grateful if you would agree to continue to prescribe this.

A copy of the Prescribing Support Information for apomorphine can be found here:

[https://www.panmerseyapc.nhs.uk/media/1218/apomorphine\\_support.pdf](https://www.panmerseyapc.nhs.uk/media/1218/apomorphine_support.pdf)

Any changes in the dose will be conducted by the neurology team and this will be communicated to you in writing.

To acknowledge whether you agree to prescribe apomorphine for your patient, please could you sign and return the following documentation within 10 working days to the Parkinson's Disease Nurse Specialists at The Walton Centre for Neurology and Neurosurgery NHS Trust, Lower Lane, Liverpool L9 7LJ, retaining a copy for your records.

Yours Sincerely,

**Dr [insert name here]**  
**Consultant Neurologist**

**To be completed by GP:**

Patient Name:

NHS Number:

I agree/do not agree (*delete as appropriate*) to prescribe apomorphine treatment to the above patient in accordance with Pan Mersey Prescribing Committee/Prescribing Support Information.

GP signature\*: .....

Print name: .....

Date: .... / .... / .....

*\*This could be signed electronically by entering the GP's name, if this is possible.*