Ref:

Please attach patient addressograph here

**GP Name**

Address 1

Address 2

Address 3

City Postcode

Date

Dear

**Patient name…………………………….**

This letter is to inform you that the above patient has been commenced on hydroxychloroquine tablets:

Hydroxychloroquine tablets Dose…………………………………....

Date commenced………………………………………………………………………………………………

Dose of…………………………………..next due on the …………………………………………………

As per Pan-Mersey Area Prescribing Committee recommendation, this medicine is categorised as Amber Patient Retained and we would be grateful if you would agree to continue to prescribe and administer this treatment. A copy of the Prescribing Support Information for hydroxychloroquine can be found here [Link](https://www.panmerseyapc.nhs.uk/media/2181/hydroxychloroquine_prescribing.pdf)

Your patient will require eye screening if they are taking this medication for more than 5 years. However, monitoring may be started after 1 year of therapy if there are additional risk factors for hydroxychloroquine retinopathy eg tamoxifen, renal impairment, high dose hydroxychloroquine. The specialist is responsible for this monitoring and your patient will first require eye screening after one/five years (delete as applicable).

The patient has been informed that eye screening will be necessary.

We will assume that you have agreed to prescribe hydroxychloroquine for your patient.

If you do not agree to do so, please could you sign and return this letter with your reasons to the rheumatology department at (insert contact details) within 14 days? Please retain a copy for your records

Thank you

Yours sincerely

**Name**

Position

**To be completed by GP if prescribing is declined**

I do not agree to prescribe hydroxychloroquine to the above patient in accordance with Pan Mersey Area Prescribing Support Information for the following reason…………………………………….

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