**SACUBITRIL VALSARTAN** (Entresto®) for the treatment of symptomatic chronic heart failure with reduced ejection fraction (HFrEF)

**Transfer of Prescribing Responsibility**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sacubitril valsartan should always be prescribed using the generic name to avoid concomitant prescribing of ACE-I or additional ARB therapy** | | | | | | |
| ***Patient Details*** | | | | | | |
| **Name:..................................................... …. DOB: ……/………/…………**  **Hospital Number: ……………………………… Address:……………………………………………………………………..**  **NHS Number: …………………………………….. ……………………………………………………………………...................** | | | | | | |
| **GP Practice Details:**  Name: ………………………………………  Address: ……………………………………  Tel no: ………………………………………  Fax no: ………………………………………  NHS.net e-mail: …………………………… | | | **Heart Failure Specialist Details:**  Name:.......................................................  Organisation:...........................................................  Clinic :……………………………………………  Address: ……………………………………………  Tel no: …................................................………  Fax no:: …………………… NHS.net email:: ………………………… | | | |
| Dear Dr………….  This patient has been initiated on sacubitril valsartan (*notification of initiation form previously sent*) in accordance withthe [South West London guidance on Pharmacological Management of heart failure](https://swlimo.swlondonccg.nhs.uk/clinical-guidance/cardiovascular/). | | | | | | |
| ***Details of treatment plan on transfer*** | | | | | | |
|  | | **Date initiated** | | **Dose on transfer**  **(=maximum tolerated dose)** | **Date of next review** | |
| **Sacubitril Valsartan (ENTRESTO®)** | |  | |  |  | |
| I am writing to transfer the prescribing responsibility for this patient’s on-going treatment from ….. /…../……  **The patient has been uptitrated, monitored and stabilised on the maximum tolerated dose** (stated above) for at least one month.  This transfer of care document should be reviewed in conjunction with the screening checklist and notification sent previously by the initiating clinician. If this has not been received, please contact the HF specialist named above for details.  All patients receiving sacubitril valsartan therapy should be reviewed throughout their treatment. Please refer to the HF guidance for more details. | | | | | | |
| ***Monitoring following last dose titration*** | | | | | | |
| **Test** | **Result** | | | **Date of test** | | **Please repeat test in:** |
| Serum Creatinine |  | | |  | | ………….………..months |
| Estimated GFR (renal function) |  | | |
| Potassium |  | | |  | | ………….………..months |
| Blood pressure |  | | |  | | ………….………..months |
| Other relevant information: ……………………………………………………………………………………………………………  This patient has a blister pack or is housebound? Yes □ No □  Community pharmacy contact details (and consider New Medicines Service referral): …………………………………………………………………………………………………………………………………………… | | | | | | |
| * I confirm that I have prescribed in accordance with SWL heart failure guidelines * I confirm the patient has been made aware of the benefits and risks of sacubitril valsartan and that they   know how to seek medical help   * I confirm that the patient has consented to treatment   **Signed:……………………………………. Name of Prescriber:…………………………… Date: …………….**  **(Heart Failure Specialist ……………………………… Contact details…………………………………….)** | | | | | | |

(In the event that there are any concerns regarding the acceptance of the prescribing responsibility for this medication please contact the initiating prescriber or heart failure team)