**A Pharmacist and Nurse-led Repatriation with Tacrolimus Brand Switch**

**Introduction:**

A pharmacist independent prescriber and a specialist nurse were seconded for 12 months from July 2016 to manage the repatriation to secondary care of immunosuppressant prescribing for all renal transplant recipients attending the renal department for follow up. This was in response to an NHS England directive to improve patient safety. We decided to change our preferred tacrolimus brand from Prograf® to Adoport® alongside repatriation in line with local guidelines.

**Objectives:**

To transfer the prescribing of post-transplant immunosuppressant drugs from primary to secondary care.

To switch tacrolimus brand from Prograf® to Adoport® where appropriate.

**Method:**

Each renal transplant patient was offered an appointment, in conjunction with their routine clinic attendance, to see the pharmacist and/or specialist nurse to discuss repatriation of immunosuppressant prescribing and brand switch if relevant.

Patients taking Prograf® were asked to switch to Adoport® a week before their next routine transplant clinic appointment so that a post-switch blood sample was obtained without the need to attend for extra tests. Pre- and post-switch tacrolimus and creatinine levels were reviewed by the pharmacist or nurse.

**Results:**

Between July 2016 and June 2017, the repatriation team saw 601 transplant recipients.

Prescribing was repatriated for 415 patients (69%). The remainder either already received prescriptions from the clinic (25%) or were considered unsuitable for repatriation (6%), predominantly due to having immunosuppressants dispensed into a weekly multicompartment compliance aid (MCA) in primary care.

A planned switch from Prograf® to Adoport® was made in 263 patients (44%) whilst 37 patients (6%) chose to remain on Prograf®. The remaining 301 (50%) were on a regimen not including Prograf®.

The median pre-switch level was 6.2 micromol/L (interquartile range 5.2-7.1), the median post-switch level was 6.0 (interquartile range 5.0-7.5). There was no statistically significant difference between the two groups (Wilcoxon signed rank test).

The majority of patients (218, 89%) were able to switch from Prograf® to Adoport® without needing a dose adjustment. Of the patients who did require a dose adjustment, 16 had their dose decreased and 11 had their dose increased.

Twenty patients requested to switch back to Prograf® having experienced a range of symptoms they attributed to Adoport®. These included headaches, diarrhoea and muscle cramps.

One patient misunderstood the instructions and took Prograf® and Adoport® simultaneously resulting in a high tacrolimus level. We didn’t identify any other patients who had problems with the switch.

**Discussion:**

Prescribing was successfully repatriated to secondary care for most patients. A shared care agreement was put in place for patients who have their medicines in a MCA. A small proportion of patients refused repatriation on the grounds of convenience; shared care was requested in these cases although GPs did not always agree to participate.

The majority of patients agreed to change their brand of tacrolimus. We respected the choice of patients who preferred to remain on Prograf®. Patients safely switched brand of tacrolimus with appropriate monitoring and in general the switch was well tolerated. It did not result in a significant change in plasma tacrolimus level, and in most cases a dose adjustment was not required. Patients were accepting of discussing a change to both the provider of their immunosuppressant medicines and tacrolimus brand at the same appointment.

One patient took both Prograf® and Adoport® together in error, resulting in transient increases in creatinine and tacrolimus levels. We reported this incident through the Trust incident reporting system and reflected on our consultation process with the aim of preventing a similar event occurring again.