## Dronedarone for patients within adult services

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| Version: | HNY v1.0 | Replaces version: | RDTC v1.0 |
| Clinical content last reviewed: | October 2023 | Next review date: | October 2025 |

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| **Version** | **Date published** | **Changes since previous version** |
| RDTC v1.0 | 7th December 2023 | Hyperlinks updated to link to current resources.  Bepridil removed as an interacting drug (no longer marketed)  Section 10: Cross reference added to contraindication if HR <50bpm |
| HNY v1.0 | April 2025 | * HNY logos added * Section 4: Transfer of monitoring and prescribing updated as per NHSE document - <https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf> and following wording added: To transfer from the specialist to primary care, the patient must be a) stable, i.e. the condition/indication is 'managed' appropriately, monitoring is within normal parameters, and b) the patient remains on the same dose that the specialist recommended. * Section 5: Baseline investigations – added "Confirm that women of childbearing potential are not pregnant" * Section 5: Ongoing monitoring – removed ECG, at least every six months * Section 5: Ongoing monitoring – added " At initiation of shared care, communication to primary care should include current and ongoing dose, any relevant test results, and date the next monitoring is required." * Section 6: Magnesium now listed separately as not part of routine U&E's * Section 6: ECG – removed "Monitoring may be conducted in primary care where this service is available" * Section 9: added quetiapine, citalopram, escitalopram to other medicines that prolong the QT interval * Section 10: Hypokalaemia / Hypomagnesaemia – added "or SPS" and hyperlink to SPS guidelines * Section 12: Pregnancy – added " Women of childbearing potential should use effective methods of contraception during treatment with dronedarone and for 7 days after the final dose". * Section 13: Contact information updated to "Detailsfor contacting specialist must be included on clinic letter" * Section 16: Hyperlink to Shared Care for Medicines Guidance updated |

**Local review and adoption**

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| **Local approval** | **Date** |
| Local content added | March 2025 |
| Approved for use by Humber and North Yorkshire ICB | 2nd April 2025 |

Clinical content has been reviewed and updated by the RDTC on the date indicated above. Every effort is made to keep the content up to date. These templates are provided to the North West and North East and Yorkshire ICBs for localisation and approval through standard ICB processes. The most recent version is available on the RDTC website at <https://rdtc.nhs.uk/publication-type/shared-care/>.

This document is intended for use by NHS healthcare professionals and cannot be used for commercial or marketing purposes.

**Shared Care Protocol**

**Dronedarone for patients within adult services**

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| Background | Dronedarone is used in the treatment of severe cardiac rhythm disorders, as a second line option when other drugs are ineffective or contraindicated. It has potentially serious adverse effects and its use requires monitoring both clinically and via laboratory testing.  Due to the significant safety concerns, NHS England (NHSE) and NHS Improvement’s [guidance](https://www.england.nhs.uk/long-read/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance/) advises that prescribers should not initiate dronedarone in primary care for any new patients. In exceptional circumstances, if there is a clinical need for dronedarone to be prescribed, this must be initiated by a specialist and only continued under a shared care arrangement in line with NICE clinical guidance ([Atrial fibrillation: NG 196](https://www.nice.org.uk/guidance/ng196/chapter/Recommendations)). Dronedarone should be used as recommended in NICE [TA 197 Dronedarone for the treatment of non-permanent atrial fibrillation](https://www.nice.org.uk/guidance/ta197).  Where there is an existing cohort taking dronedarone, it is recommended that these patients be reviewed to ensure that prescribing remains safe and appropriate.  This document applies to adults aged 18 and over. |
| Licensed and agreed off-label indications | Licensed indication: maintenance of sinus rhythm after successful cardioversion in adult clinically stable patients with paroxysmal or persistent atrial fibrillation.  [NICE TA 197](https://www.nice.org.uk/guidance/ta197) recommends dronedarone as an option in patients:   * whose atrial fibrillation is not controlled by first-line therapy (usually including beta-blockers), that is, as a second-line treatment option and after alternative options have been considered **and** * who have at least 1 of the following cardiovascular risk factors:   + hypertension requiring drugs of at least 2 different classes   + diabetes mellitus   + previous transient ischaemic attack, stroke or systemic embolism   + left atrial diameter of 50 mm or greater **or**   + age 70 years or older and * who do not have left ventricular systolic dysfunction **and**   who do not have a history of, or current, heart failure |
| Locally agreed indications | National scoping did not identify any additional appropriate off-label indications. |
| Initiation and ongoing dose regime | Transfer of monitoring and prescribing to primary care is normally after at least 12 weeks, and when the patient’s dose has been optimised and with satisfactory investigation results for at least 12 weeks. To transfer from the specialist to primary care, the patient must be a) stable, i.e. the condition/indication is 'managed' appropriately, monitoring is within normal parameters, and b) the patient remains on the same dose that the specialist recommended.  The duration of treatment & frequency of review will be determined by the specialist, based on clinical response and tolerability.  All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care clinician.  Termination of treatment will be the responsibility of the specialist. Initial stabilisation and maintenance dose: Initial stabilisation and maintenance dose:  400mg twice daily, with the morning and evening meals.  **The starting and initial maintenance dose must be prescribed by the initiating specialist. Treatment should be initiated and monitored only under specialist supervision.** |
| Baseline investigations, initial monitoring, and ongoing monitoring to be undertaken by specialist | Monitoring at baseline and during initiation is the responsibility of the specialist; only once the patient is optimised on the chosen medication with no anticipated further changes expected in the immediate future will prescribing and monitoring be transferred to primary care. Baseline investigations:  * Liver function tests (LFTs) * Urea and electrolytes (U&Es), including potassium, magnesium, and serum creatinine * Electrocardiogram (ECG) * Confirm that women of childbearing potential are not pregnant  Initial monitoring:  * Liver function tests: after 7 days of treatment, after 1 month of treatment, then monthly until prescribing is transferred to primary care * Urea and electrolytes: after 7 days of treatment, and after a further 7 days if any elevation is observed. If serum creatinine continues to rise then consideration should be given to further investigation and discontinuing treatment. * Monitor concurrent medicines as appropriate, e.g. anticoagulants, digoxin.  Ongoing monitoring: At initiation of shared care, communication to primary care should include current and ongoing dose, any relevant test results, and date the next monitoring is required.   * Chest X-ray and pulmonary function tests, if respiratory symptoms or toxicity suspected   After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in [section 6](#six_monitoring) remains appropriate. |

## Ongoing monitoring requirements to be undertaken by primary care

If monitoring results are forwarded to the specialist team, please include clear clinical information on the reason for sending, to inform action to be taken by secondary care.

| **Monitoring** | **Frequency** |
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| Urea and electrolytes (including potassium) and creatinine clearance  Magnesium | Every 6 months |
| Liver function tests | * Monthly for the first 6 months of treatment, and at month 9 and month 12 * Every 6 months thereafter |
| Symptoms of heart failure, e.g. development or worsening of weight gain, dependent oedema, or dyspnoea | Ongoing |
| ECG | At least every six months |

## Pharmaceutical aspects

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| Route of administration: | Oral |
| Formulation: | 400 mg film-coated tablets |
| Administration details: | Tablets should be swallowed whole with a drink of water during a meal. The tablet cannot be divided into equal doses and should not be split.  If a dose is missed, patients should take the next dose at the regular scheduled time and should not double the dose. |
| Other important information: | Grapefruit juice should be avoided during treatment with dronedarone (see [section 7](#nine_interactions)). |

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| Cautions and contraindications | This information does not replace the Summary of Product Characteristics (SPC), and should be read in conjunction with it. Please see [BNF](https://bnf.nice.org.uk/drugs/dronedarone/) & [SPC](https://www.medicines.org.uk/emc/search?q=dronedarone) for comprehensive information.  **Contraindications:**   * Known hypersensitivity to dronedarone or any of the excipients. * Second- or third-degree atrio-ventricular block, complete bundle branch block, distal block, sinus node dysfunction, atrial conduction defects, or sick sinus syndrome (except when used in conjunction with a functioning pacemaker). * Bradycardia less than 50 beats per minute. * Permanent atrial fibrillation (AF) with an AF duration ≥6 months (or duration unknown), and attempts to restore sinus rhythm no longer considered by the physician. * Unstable haemodynamic conditions. * History of or current heart failure, or left ventricular systolic dysfunction. * Patients with liver or lung toxicity related to previous use of amiodarone. * Co-administration with potent cytochrome P450 3A4 (CYP3A4) inhibitors, such as ketoconazole, itraconazole, voriconazole, posaconazole, telithromycin, clarithromycin, nefazodone and ritonavir (see [section 9](#nine_interactions)). * Co-administration with medicinal products inducing torsades de pointes, including phenothiazines, cisapride, bepridil, tricyclic antidepressants, terfenadine and certain oral macrolides (such as erythromycin), class I and III anti-arrhythmics (see [section 9](#nine_interactions)). * Co-administration with dabigatran. * QTc Bazett interval greater than 500 milliseconds. * Severe hepatic or renal impairment (CrCl less than 30 mL/min).   **Cautions:**  Dronedarone can cause serious adverse reactions; clinical monitoring for development of congestive heart failure, left ventricular systolicdysfunction**,** QTc prolongation, liver injury, and respiratory disease are required (see also [section 5](#five_initial_monitoring) & [section 6](#six_monitoring)). |
| Significant drug interactions | The following list is not exhaustive. Please see [BNF](https://bnf.nice.org.uk/drugs/dronedarone/) & [SPC](https://www.medicines.org.uk/emc/search?q=dronedarone) for comprehensive information and recommended management.  **Dronedarone is associated with a large number of interactions, some of which are significant enough to contradict concurrent use, require dose adjustment and/or additional monitoring**.  Dronedarone is contraindicated when co-administered with potent cytochrome P450 3A4 (CYP3A4) inhibitors, medicinal products inducing torsades de pointes, and dabigatran (see [section 8](#eight_cautions_cx)).  Dronedarone is an enzyme inhibitor and can increase exposure to a number of medicines including:   * P-glycoprotein (PgP) substrates (e.g. digoxin, dabigatran, apixaban, rivaroxaban, edoxaban). * CYP3A4 substrates (e.g. ciclosporin, statins, fentanyl, sildenafil, tacrolimus, sirolimus, everolimus, apixaban, rivaroxaban, edoxaban). * CYP2D6 substrates (e.g. metoprolol).   Dronedarone interacts with other medicines that:   * Induce Torsade de Points or prolong QTc (e.g. phenothiazines, cisapride, tricyclic antidepressants, quetiapine, citalopram, escitalopram, certain oral macrolides (such as clarithromycin and erythromycin), terfenadine and Class I and III anti-arrhythmics). Concomitant use is contraindicated. * Lower heart rate (e.g. beta-blockers, calcium channel blockers). * Induce hypokalaemia (e.g. diuretics, stimulant laxatives). * Induce hypomagnesaemia (e.g. diuretics).   Other interactions include:   * CYP3A4 inhibitors – may increase exposure to dronedarone (e.g. ketoconazole, itraconazole, voriconazole, posaconazole, ritonavir, clarithromycin, grapefruit juice). Concomitant use is contraindicated. * Potent CYP3A4 inducers – may reduce exposure to dronedarone and are not recommended (e.g. rifampicin, phenobarbital, carbamazepine, phenytoin, St John’s Wort). * Anticoagulants – vitamin K antagonist and direct oral anticoagulant (DOAC) exposure may be increased by dronedarone (e.g. warfarin, rivaroxaban, edoxaban). |

## Adverse effects and management

As well as responding to absolute values in laboratory tests, a rapid change or a consistent trend in any value should prompt caution and extra vigilance**.** For information on incidence of ADRs see relevant SPCs.

**Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit** [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard).

Advice based on shared care guidelines published by NHS England, and checked against current guidance.

| **Adverse effect** | **Management** |
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| **Renal function:**  Electrolyte deficiency: hypokalaemia / hypomagnesaemia | Continue dronedarone. Correct deficiency as per local or SPS guidelines - [Treating acute hypokalaemia in adults](https://www.sps.nhs.uk/articles/hypokalaemia/) or [Treating acute hypomagnesaemia in adults](https://www.sps.nhs.uk/articles/treating-acute-hypomagnesaemia-in-adults/). |
| Creatinine elevated from baseline | **Stop** **dronedarone** for any elevations of serum creatinine which occur after transfer to primary care. Discuss urgently with specialist |
| Creatinine clearance less than 30 mL/minute/ 1.73m2 | **Stop dronedarone** and refer urgently to the specialist. |
| **Cardiovascular:**  Bradycardia:  Heart rate 50 - 60bpm without symptoms | Continue dronedarone. Repeat monitoring. No action required if heart rate remains >50 without symptoms. |
| Heart rate ≤ 50bpm or ≤ 60bpm with symptoms  NB: dronedarone is contraindicated if HR less than 50bpm (see [section 8](#eight_cautions_cx)). | Discuss with specialist team; dose reduction may be required. |
| Worsening of arrhythmia, new arrhythmia, or heart block | **Stop dronedarone.** Urgent referral to specialist team. |
| Recurrence of atrial fibrillation | Refer to specialist team; discontinuation should be considered.  Discontinue dronedarone if patient develops permanent AF with a duration of six months or more. |
| Signs or symptoms of congestive heart failure, e.g. weight gain, dependent oedema, or increased dyspnoea. | **Stop dronedarone** if congestive heart failure is suspected and refer urgently to specialist team. |
| **Hepatotoxicity**:  Serum transaminases greater than 5xULN or any symptoms of hepatic injury | **Stop dronedarone**. Urgent referral to initiating specialist and hepatologist. |
| ALT elevated greater than 3xULN but no symptoms of hepatic injury | Continue dronedarone and repeat LFTs in 48-72 hours. If still elevated **stop dronedarone** and discuss with specialist urgently. |
| Symptoms of hepatic injury (e.g. hepatomegaly, weakness, ascites, jaundice) | Check LFTs urgently; proceed as above. |
| **Pulmonary toxicity**:  new/worsening cough, shortness of breath or deterioration in general health (e.g. fatigue, weight loss, fever) | Continue dronedarone**.** Urgent referral to initiating specialist and respiratory specialist.  Discontinuation may be warranted if symptoms confirmed. |
| **Gastrointestinal disturbance**: diarrhoea, nausea, vomiting, abdominal pain, dyspepsia | Continue dronedarone. May require dose reduction; discuss with specialist if persistent. |
| **General disorders**: fatigue, asthenia | Continue dronedarone. May require dose reduction; discuss with specialist. |
| **Dermatological disorders**: rashes, pruritus, photosensitivity | Continue dronedarone. Reinforce appropriate self-care, including sun avoidance and purchasing of a broad-spectrum sunscreen (at least SPF30) if photosensitivity occurs.  May require dose reduction; discuss with specialist. |

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| Advice to patients and carers The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual drugs. | The patient should be advised to report any of the following signs or symptoms to their primary care prescriber without delay:   * Signs or symptoms of pulmonary toxicity, e.g. breathlessness, non-productive cough or deterioration in general health (e.g. fatigue, weight loss, fever). * Signs or symptoms of liver injury, e.g. abdominal pain, loss of appetite, nausea, vomiting, fever, malaise, fatigue, itching, dark urine, or yellowing of skin or eyes. * Signs or symptoms of heart failure, e.g. development or worsening of weight gain, dependent oedema, or dyspnoea. * Signs or symptoms of bradycardia, e.g. dizziness, fatigue, fainting, shortness of breath, chest pain or palpitations, confusion or trouble concentrating.   The patient should be advised:   * Avoid grapefruit and grapefruit juice while taking dronedarone. * If taking a statin and dronedarone, to report any signs of unexplained muscle pain, tenderness, weakness or dark coloured urine. * Photosensitivity is an uncommon side effect of dronedarone (less than 1 in 100 people). If it occurs, patients should be advised on appropriate self-care: e.g. sun avoidance, protective clothing, avoiding tanning (including tanning beds) and to purchase and use of a broad spectrum sunscreen (at least SPF30). These measures should be continued for the duration of therapy.   Patient information: [British Heart Foundation – Anti-arrhythmics](https://www.bhf.org.uk/informationsupport/heart-matters-magazine/medical/drug-cabinet/anti-arrhythmics) |
| Pregnancy, paternal exposure and breastfeeding | It is the responsibility of the specialist to provide advice on the need for contraception to male and female patients on initiation and at each review, but the ongoing responsibility for providing this advice rests with both the primary care prescriber and the specialist.  Pregnancy:  There are limited data on the use of dronedarone in pregnant women. Studies in animals have shown reproductive toxicity. Use is not recommended during pregnancy and in women of childbearing potential not using contraception. Women of childbearing potential should use effective methods of contraception during treatment with dronedarone and for 7 days after the final dose.  Breastfeeding:  Low levels of dronedarone are anticipated in breast milk. Use is cautioned while breast feeding; infants should be monitored for adverse events such as diarrhoea, vomiting, weakness, bradycardia.  Information for healthcare professionals: [UK Drugs in Lactation Advisory Service](https://www.sps.nhs.uk/medicines/dronedarone/) |
| Specialist contact information and arrangements for referral | Details for contacting specialist must be included on the clinic letter. |
| Additional information | Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed. Ensure that the specialist is informed in writing of any changes to the patient’s GP or their contact details. |
| References | 1. British National Formulary accessed via <https://bnf.nice.org.uk/> on 26/10/2023. 2. Dronedarone hydrochloride 400 mg film-coated tablets (Multaq®). Sanofi. Date of revision of the text: 01/01/21. Accessed via <https://www.medicines.org.uk/emc/product/497/> on 26/10/23. 3. Dronedarone hydrochloride 400 mg film-coated tablets (Dronedarone Aristo). Aristo Pharma. Date of revision of the text: 14/10/2020. Accessed via <https://www.medicines.org.uk/emc/product/10924/smpc> on 26/10/23. 4. Dronedarone 400 mg film-coated tablets. Aurobindo Pharma – Milpharm Ltd. Date of revision of the text: 08/03/2022. Accessed via <https://www.medicines.org.uk/emc/product/14895/smpc> on 11/10/23. 5. NHS England. Items which should not routinely be prescribed in primary care: policy guidance. August 2023. Last updated October 2023. Accessed via <https://www.england.nhs.uk/long-read/items-which-should-not-routinely-be-prescribed-in-primary-care-policy-guidance/> on 26/10/23. 6. MHRA. Drug Safety Update volume 5 issue 3: A1. October 2011. Dronedarone (Multaq▼): cardiovascular, hepatic and pulmonary adverse events – new restrictions and monitoring requirements. Accessed via <https://www.gov.uk/drug-safety-update/dronedarone-multaq-cardiovascular-hepatic-and-pulmonary-adverse-events-new-restrictions-and-monitoring-requirements> on 26/10/2023. 7. NICE. TA197: Dronedarone for the treatment of non-permanent atrial fibrillation. Last updated December 2012. Accessed via <https://www.nice.org.uk/guidance/ta197> on 26/10/2023. 8. NICE. NG196: Atrial fibrillation: diagnosis and management. Last updated June 2021. Accessed via <https://www.nice.org.uk/guidance/ng196> on 26/10/2023. 9. Specialist Pharmacy Service. Medicines Monitoring. Dronedarone. Published July 2021 Accessed via <https://www.sps.nhs.uk/monitorings/dronedarone-monitoring/> on 26/10/2023. 10. Specialist Pharmacy Service. Lactation Safety Information: dronedarone. Last reviewed 05/08/20. Accessed via <https://www.sps.nhs.uk/medicines/dronedarone/> on 26/10/2023. 11. LiverTox. Dronedarone. Last updated 05/01/2018. Accessed via <https://www.ncbi.nlm.nih.gov/books/NBK548208/> 26/10/2023. 12. CredibleMeds. QTDrugs List. Clarithromycin. Last updated June 26 2023. Accessed via <https://crediblemeds.org/> on 26/10/2023. |
| To be read in conjunction with the following documents | * Shared Care for Medicines Guidance – A Standard Approach (RMOC). Available from <https://www.medicinesresources.nhs.uk/shared-care-for-medicines-guidance-a-standard-approach-rmoc.html> * NHSE guidance – Responsibility for prescribing between primary & secondary/tertiary care. Available from <https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/> * General Medical Council. Good practice in prescribing and managing medicines and devices. Shared care. Available from <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care> * NICE NG197: Shared decision making. Last updated June 2021. <https://www.nice.org.uk/guidance/ng197/>. |