BNSSG Shared Care Guidance
Please complete all sections

Section 1: Heading

Drug	Sodium valproate and valproic acid (semi-sodium valproate) In this document, 'valproate' will be used to describe both drugs.
Amber ***three months***	
Indication	***New regulatory measures for valproate, January 2024:*** A. *Valproate must not be started in new patients (male or female) younger than 55 years, unless two specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply.* B. *At their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgement Form, which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation changes.* *Risk Acknowledgement Forms:* • Annual Risk Acknowledgement Form: For female patients starting valproate and at annual review (where clinically appropriate – see section on woman not at risk of pregnancy on p10). • Risk Acknowledgement Form for male patients starting valproate ***Do not stop prescribing unless recommended by the specialist team.*** These measures are **required** for people under the age of 55 because this is the age group most likely to be affected by the reproductive risks of valproate. These risks should also be **considered** for men and women over the age of 55 years planning to have children. Valproate is highly teratogenic (known risk of birth defects and neurodevelopmental disorders following use of valproate in pregnancy) and should only be prescribed for women and girls of childbearing potential* in exceptional circumstances. If valproate is used in women of childbearing potential* then the conditions of the **Pregnancy Prevention Programme (PPP)** need to be followed. *Childbearing potential is used to describe a female child or any woman who is capable of becoming pregnant even if the patient's circumstances mean this is unlikely. For comprehensive information on whether PPP applies to an individual patient, also see section 5.

	ADULT indications: **All forms of epilepsy** **Bipolar disorder and mania/hypomania:** - Mania and hypomania associated with bipolar disorder - Continuation after manic/hypomanic episode where acute mania has responded to valproate. **Migraine prophylaxis** N.B. Do not use valproate for migraine prophylaxis for new patients. This is non-formulary, off-label and no longer recommended. Adults currently prescribed valproate for migraine may continue without change until they and their NHS clinician consider it appropriate to stop. Clinicians must review use of valproate at the next routine review to explore alternative treatment options. **Neuropathic pain** N.B. Do not use valproate for neuropathic pain for new patients. This is non-formulary, off-label and no longer recommended. Adults currently prescribed valproate for neuropathic pain may continue without change until they and their NHS clinician consider it appropriate to stop. Clinicians must review use of valproate at the next routine review to explore alternative treatment options. ***PAEDIATRIC indication*** **Epilepsy**

Section 2: Treatment Schedule

Usual dose and frequency of administration *(Please indicate if this is licensed or unlicensed and any relevant dosing information)*	**ADULTS:** ***Sodium Valproate*** **All forms of epilepsy** Adult: By mouth; initially 600 mg daily in 1–2 divided doses, then increased in steps of 150–300 mg every 3 days; maintenance 1–2 g daily, alternatively maintenance 20–30 mg/kg daily; maximum 2.5 g per day. **For mania and bipolar (unlicensed indication)** Adults: The starting dose is usually approx. 500mg/day increasing according to tolerability; maintenance dose is 20-30mg/kg per day. Both IR and MR products are available (from Maudsley prescribing guidelines). ***Valproic Acid*** **For Manic episodes in bipolar where lithium is contraindicated or not tolerated (licensed indication) or for continuation of treatment after manic episode in those who have responded to Depakote (licensed) and maintenance treatment for bipolar (unlicensed indication)** Adult: The daily dosage should be established and controlled individually by the treating physician. The initial recommended daily dose is 750 mg daily in 2-3 divided doses. The dose should be

	increased as rapidly as possible to achieve the lowest therapeutic dose which produces the desired clinical effect. The daily dose should be adapted to the clinical response to establish the lowest effective dose for the individual patient. The mean daily dose usually ranges between 1-2g valproate. Patients receiving daily doses higher than 45 mg/kg/day body weight should be carefully monitored (see summary of product characteristics). **PAEDIATRICS:** ***Sodium Valproate*** **All forms of epilepsy** • Neonate: By mouth; Initially 20 mg/kg once daily; maintenance 10 mg/kg twice daily. • Child 1 month–11 years: By mouth; Initially 10–15 mg/kg daily in 1–2 divided doses (max. per dose 600 mg); maintenance 25–30 mg/kg daily in 2 divided doses, doses up to 60 mg/kg daily in 2 divided doses may be used in infantile spasms; monitor clinical chemistry and haematological parameters if dose exceeds 40mg/kg daily. • Child 12–17 years: By mouth; Initially 600 mg daily in 1–2 divided doses, increased in steps of 150–300 mg every 3 days; maintenance 1–2 g daily in 2 divided doses; maximum 2.5 g per day. **Dose equivalence and brand prescribing** Semi-sodium valproate and sodium valproate are not bioequivalent and display different characteristics. A 10% dose increase is recommended when switching from valproate semi-sodium valproate to sodium valproate. Depakote® (semi-sodium valproate) and Episenta® / Epival® (sodium valproate m/r) are licensed for treatment of mania. In practice however, generic sodium valproate is commonly used off-label to treat bipolar disorder. Sodium valproate should be used first line before semi-sodium valproate for treatment for bipolar disorder in BNSSG. Valproate is classified as a category 2 drug. Hence, for epilepsy only, clinical judgement is required when switching between branded original and generic products.
Route and formulation	Oral (tablet, gastro-resistant tablets, modified release tablet, modified release capsule, modified release granules, oral solution). Except in exceptional circumstances, valproate must be dispensed in the manufacturer's original full pack. Please see MHRA guidance for further information including exceptional circumstances and BNSSG Original pack dispensing of valproate exceptions risk assessment.
Duration of treatment	Life-long or until specialist discontinues. Avoid abrupt withdrawal; if treatment with valproate is stopped, reduce the dose gradually over at least 4 weeks – refer to specialist for advice.

Section 3: Monitoring

Please give details of any tests that are required before or during treatment, including frequency, responsibilities (please state whether they will be undertaken in primary or secondary care), cause for adjustment and when it is required to refer back to the specialist.

Baseline tests - where appropriate

To be done by specialist:

- Weight / BMI, FBC and LFTs, U+E and renal function
- Serum pregnancy test in women and girls of childbearing potential* before the first prescription is issued.

Subsequent tests - where appropriate *(Please indicate who takes responsibility for taking bloods and interpreting results)*

Test	Frequency	Who by	Action/management
LFTs	During first 6 months of treatment, especially in patients most at risk. Clinical vigilance is most important. Severe reported complications have occurred early in treatment and usually in children in treatment for epilepsy.	Adults – primary care Paediatrics – secondary care	Raised liver enzymes are usually transient. Raised liver enzymes in isolation are not always a good measure. Patients should be assessed clinically and FBC (including platelets) and liver function (including prothrombin time and coagulation tests) monitored until return to normal. Discontinue if abnormal liver function (do not stop if liver enzymes raised in isolation).
FBC and clotting screen (including bleeding time and coagulation tests)	Before surgery or following spontaneous bleeding or bruising.	Before surgery – secondary care Spontaneous bleeding or bruising – discuss most appropriate route with specialist team.	If FBCs and clotting abnormal, discuss with specialist team.
Pregnancy test for women and girls of childbearing potential*	In line with PPP if not on continuous highly effective contraception method or any reason to suggest lack of compliance or effectiveness of contraception.	Primary care	Prescribe folic acid 5mg daily immediately, and refer back to specialist and maternity/obstetrics service urgently (same day) in case of unplanned pregnancy. Remind the patient not to stop taking valproate medicine in the interim.
For patients with bipolar disorder only (adults only): Weight or BMI, diet, nutritional status and level of physical activity. Cardiovascular status, including	Annually	Primary care	Part of physical health check recommended in NICE CG185 Bipolar disorder: assessment and management

pulse and blood pressure. Metabolic status, including fasting blood glucose or glycosylated haemoglobin (HbA1c), and blood lipid profile. Liver function.			

Section 4: Side Effects

Please list only the most pertinent side effects and management. Please provide guidance on when the GP should refer back to the specialist. For everything else, please see BNF or SPC.

Side effects and management

Side effect	Frequency/severity	Action/management
Hepatic dysfunction	Common	Withdraw treatment immediately if persistent vomiting and abdominal pain, anorexia, jaundice, oedema, malaise, drowsiness, or loss of seizure control and refer back to specialist.
GI effects - Abdominal Pain, diarrhoea, vomiting	Common	Refer back to specialist if becomes unmanageable.
Abnormal behaviour, impaired concentration, hallucination, headache, tremor	Common	Refer back to specialist if becomes unmanageable.
Pancreatitis	Uncommon	Discontinue treatment if symptoms develop and refer back to specialist. Refer for urgent hospital admission if the person has suspected acute pancreatitis, for further management. Do not delay admission by taking blood samples or ordering imaging in primary care.

	<table><tr><td>Agranulocytosis</td><td>Rare</td><td>Discontinue treatment if symptoms develop and refer back to specialist.</td></tr><tr><td>Skin reactions such as Severe Cutaneous Adverse Reactions (SCARs), Systemic Lupus Erythematosus (SLE)</td><td>Rare</td><td>Discontinue treatment if symptoms develop and refer back to specialist.</td></tr><tr><td>Psychiatric disorders Suicidal ideation or behaviour</td><td>Not known</td><td>Refer for urgent psychiatric assessment via local pathways e.g. crisis or specialist teams, if appropriate. Notify specialist team. Do not stop valproate medicine.</td></tr></table>
Referral back to specialist	• When used for bipolar disorder and mania / hypomania - any change in mood or development of suicidal thoughts likely to indicate a significant deterioration in the patient's condition. • Advise people taking valproate, and their carers, how to recognise the signs and symptoms of blood and liver disorders and to seek immediate medical help if any of these develop. Manage in line with advice above. • Discontinuation should normally only be done under the supervision of a specialist in a gradual manner. This is due to the possibility of sudden alterations in plasma concentrations with associated risk of acute withdrawal syndromes or rapid relapse. If the patient stops the medication without medical advice please refer to specialist team. • See information about Pregnancy Prevention Program (PPP) including information about referral back to specialist if the patient is planning a family, or becomes pregnant.

Section 5: Other Issues

(e.g. Drug Interactions, Contra-indications, Cautions, Special Recommendations)

Please list only the most pertinent action for GP to take (For full list please see BNF or SPC)

Issues	**Drug Interactions** See BNF or SPC for drug interactions with valproate. **Contra-indications** Acute porphyrias; mitochondrial disorders (higher rate of acute liver failure and liver-related deaths); personal or family history of severe hepatic dysfunction; urea cycle disorders, women and girls of

childbearing potential* unless the conditions of the pregnancy prevention programme are fulfilled.

Pregnancy
Use of valproate in pregnancy is contraindicated for migraine prophylaxis and bipolar disorder. It must only be considered for epilepsy if there is no suitable alternative treatment; in such cases, access to counselling about the risks should be provided and a Risk Acknowledgement Form signed by both specialist and patient.

Cautions

- Systemic lupus erythematosus
- Consider vitamin D supplementation in patients that are immobilised for long periods or who have inadequate sun exposure or dietary intake of calcium.
- Liver dysfunction (including fatal hepatic failure) has occurred in association with valproate usually in first 6 months and usually involving multiple antiepileptic therapy. Raised liver enzymes during valproate treatment are usually transient but patients should be reassessed clinically, and liver function (including prothrombin time) monitored until return to normal - discontinue if abnormally prolonged prothrombin time (particularly in association with other relevant abnormalities).

Special Recommendations

Pregnancy Prevention Programme (Prevent) (PPP)

Background
Valproate is highly teratogenic and evidence supports that use in pregnancy leads to neurodevelopmental disorders (approx. 30–40% risk) and congenital malformations (approx. 10% risk).

Valproate should only be used in exceptional circumstances in women and girls of childbearing potential* – it is not for routine use.
Valproate must not be used in women and girls of childbearing potential* unless the conditions of the **Pregnancy Prevention Programme** (PPP) are met and only if other treatments are ineffective or not tolerated, as judged by an experienced specialist.

Prescribers must ensure that all female patients* are informed of and understand:

- the risks associated with valproate during pregnancy;
- the need to use highly effective contraception***;
- the need for regular review of treatment;
- the need to rapidly consult if she is planning a pregnancy or becomes pregnant

***Transgender men and non-binary (assigned female) people**
The guidance around use of valproate in female patients of childbearing potential also applies to transgender men (assigned female at birth) and non-binary (assigned female at birth) people who have **not** undergone hysterectomy (i.e. who still have a uterus) or bilateral oophorectomy.
N.B. treatment with testosterone and gonadotrophin releasing hormone analogues cannot be relied on for contraceptive protection. Please also refer to information for women not at risk of pregnancy below.

Specialist Responsibilities**

- Discuss the risks with the patient (or parent/caregiver/responsible person as appropriate)
- Exclude pregnancy in women and girls of childbearing potential (by serum pregnancy test) before the first valproate prescription is issued
- Arrange for highly effective contraception*** for women and girls of childbearing potential before the first prescription is issued
- Complete relevant risk acknowledgement forms with patient (or parent/caregiver/ responsible person); give them a copy and send a copy to GP
    - Annual Risk Acknowledgment Form for female patients starting valproate and at annual review
    - Risk Acknowledgement Form for male patients starting valproate
- See the patient urgently without delay (within 2 working days) if referred back in case of unplanned pregnancy or within one month if she wants to plan a pregnancy
- Provide a copy of the Patient Guide to the patient (or parent/caregiver/ responsible person)
- Book in review appointments at least **annually** with women and girls under the Pregnancy Prevention Programme and re-evaluate treatment as necessary
- Continue to see the patient annually for review of the Annual Risk Acknowledgment Form. Copies must be sent to the patient / carer and their GP on an annual basis in a timely manner to enable valproate prescribing to continue in primary care.

****Epilepsy Specialist Nurses** are in an excellent position to support girls and women of childbearing potential with epilepsy taking valproate. For the purposes of this SCP, they are regarded as 'specialists'.

Epilepsy Specialist Nurses will be able to see women and girls of childbearing potential taking valproate, advise on an appropriate alternative drug, or on appropriate contraception in line with the Pregnancy Prevention Programme (PPP), and complete the Annual Risk Acknowledgement Form.

Valproate should be initiated and continued in line with current MHRA and CHM guidance. This decision should be taken as part of a multidisciplinary team, involving a consultant neurologist.

General Practitioners' Responsibilities

- Ensure continuous use of highly effective contraception*** in all women of childbearing potential. Any contraceptive changes should be communicated promptly to the specialist.
- Supply of contraception should be provided in a timely manner.
- Consider the need for pregnancy testing if not on a highly effective method or any reason to suggest lack of compliance or effectiveness of contraception.
- For any patients on valproate not under the care of secondary care, refer to her specialist (unless she has seen one in the last year and is on **Prevent/PPP**)
- After specialist review, check she is on **Prevent/PPP**, i.e. ensure that:
    - she has the Patient Guide and has a copy of the Annual Risk Acknowledgment Form signed by the specialist;

	○ a copy of the signed Annual Risk Acknowledgment Form is filed in her medical records; ○ she is using highly effective contraception and understands the need to comply with contraception. ▪ Check that all patients have an up to date, signed, Annual Acknowledgment of Risk Form each time a repeat prescription is issued unless there is clear documentation to say that the potential for not becoming pregnant is permanent - see below. In the case of an absence of this, contact specialist. ▪ Prescribe folic acid 5mg daily immediately, and refer back to specialist and maternity/obstetrics service urgently (same day) in case of unplanned pregnancy or where a patient wants to plan a pregnancy. Remind the patient not to stop taking valproate medicine in the interim. ▪ Remind her that she will need to see her specialist at least every year while taking valproate medicines and arrange for referral as necessary. ▪ Refer back to specialist if she does not engage in Prevent (PPP). ***Highly effective contraception is considered for regulatory purposes to be those user independent methods such as the long acting reversible contraceptives (LARC), copper intrauterine device (Cu-IUD), levonorgestrel intrauterine system (LNG-IUS) and progestogen only implant (IMP) and female sterilisation, all of which have a failure rate of less than 1% with typical use. Progestogen-only injections have a typical-use failure rate of 6%, but this may be due to repeat injections being administered late. Progestogen-only injections may be considered as highly effective if repeat injections are documented as having been administered on schedule by a healthcare professional.[12] User dependent methods such as the condom, cap, diaphragm, combined oral contraceptive pill (COC) or progestogen-only contraceptive pill (POP) and fertility awareness based methods are not considered highly effective since the typical use incorporates user failure risks.[12] COC or POP methods have a typical failure rate of around 9% – they must be used together with a barrier method of contraception and frequent pregnancy testing should be carried out. Pregnancy tests may not detect an early pregnancy that has occurred after unprotected sex in the preceding 3 weeks. Therefore, women should have a repeat pregnancy test 3 weeks after starting a new contraceptive method if there was any risk of pregnancy at the start of the contraceptive method, even if the first test was negative. For children or for patients without the capacity to make an informed decision, provide the information and advice on highly effective methods of contraception and on the use of valproate during pregnancy to their parents/caregiver/responsible person and make sure they clearly understand the content. **At least one highly effective method of contraception (preferably a user independent form such as an intrauterine device or implant) or two complementary forms of contraception including a barrier method should be used.**

Individual circumstances should be evaluated in each case when choosing the contraception method, involving the patient in the discussion to guarantee her engagement and compliance with the chosen measures. Even if she has amenorrhoea she must follow all the advice on highly effective contraception.

Further information to be found in the MHRA Guide for Healthcare Professionals Information on the risks of Valproate use in girls (of any age) and women of childbearing potential (Epilim, Depakote, Convulex, Episenta, Epival, Kentlim, Orlept, Sodium Valproate, Syonell, Valpal, Belvo & Dyzantil)[12], the Pan College Guidance Document on Valproate Use in Women and Girls of Childbearing Years[4] and the FSRH CEU Statement: Contraceptive Choices and Sexual Health for Transgender and Non-binary People[10].

For Women Not At Risk of Pregnancy
Women of childbearing potential (from menarche to menopause) who are taking valproate should fulfil all the requirements of Prevent /PPP. The only exception is when the specialist prescriber considers that there are reasons to indicate that there is no risk of pregnancy:

- The **absence of risk of pregnancy is permanent/there is a permanent reason the reproductive risks do not apply** (e.g., post-menopausal patients or those after hysterectomy).
  For these patients, valproate can continue to be prescribed in accordance with standard clinical practice by a single prescriber (second specialist review is **not** required). The ARAF should be used to document the clinical decision. The ARAF does **not** need to be completed annually.

- The **absence of risk may change** (e.g., the patient is pre-menarche). Although Prevent/PPP does not apply to this cohort of patients, **their treatment with valproate must be reviewed regularly and at least annually by the specialist**.

An individualised risk-based decision needs to be undertaken by the specialist for women who are not at risk of pregnancy for health-related, physical or personal reasons such as women who have had a hysterectomy or tubal ligation, a woman in a long term monogamous relationship with a vasectomised male partner, women in same sex relationships not planning pregnancy or a transgender woman who does not have a uterus.

The reason for no contraception being needed in such cases can be documented on the Annual Risk Acknowledgement Form and wherever appropriate reviewed annually. This information must be documented in the patient records and relevant clinical correspondence.

If the reason for not being at risk of pregnancy is permanent, annual specialist review from the perspective of the regulations per se should not be necessary, but may be indicated for the underlying condition. There may be other compelling reasons that will need to be considered on an individual basis, such as religious convictions.

If the reason for not being at risk of pregnancy is not considered permanent, the woman needs to be fully aware of the high likelihood of serious harm to the child if she should conceive, and attend for annual

	specialist review and completion of the Annual Risk Acknowledgement Form, in line with the Pregnancy Prevention Programme. **Men** Male patients on valproate who are planning a family in the next year should talk to their healthcare professional about their treatment. **Breastfeeding** Present in milk—risk of haematological disorders in breast-fed newborns and infants – seek specialist advice. The MHRA have published three infographics to clarify in which situations review by two specialists may be required: • for female patients under 55 years old • for male patients under 55 years old • for male and female patients 55 years and older
Reminder to ask patient about specific problems	As above

Section 6: Advice to the patient

Advice for prescribing clinician to inform patient

1. To be aware of potential teratogenic effects of valproate and to understand that taking the highly effective contraception or two complementary forms of contraception including a barrier method is a condition of treatment with valproate. Provide a patient card to female* patients*. Additional useful leaflets include:
    a. Decision support tool: is valproate the right epilepsy treatment for me?
    b. Decision support tool: bipolar disorder – is valproate the right treatment for me?
    c. AWP patient information leaflets on valproate which include very easy read leaflets and the leaflet in a range of languages.(AWP staff only)
    d. NHS information leaflet to support person-centred, informed discussions about taking valproate as safely as possible. Translated into 30 languages. (Available to all)
2. Female patients* to attend **annual reviews** with the specialist for a review, complete the **Annual Risk Acknowledgment Form** and retain a copy.
3. Female patients must contact the GP urgently in the case of becoming pregnant or if thinking of becoming pregnant.
4. Male patients on valproate who are planning a family in the next year should talk to their healthcare professional about their treatment.
5. To contact the GP urgently if their contraceptive method changes or has failed, or if they have plans to change their contraceptive method.
6. To be aware of the signs and symptoms of blood or liver disorder or pancreatitis and seek immediate medical attention if symptoms develop.
7. All patients should be advised to seek medical advice should signs of suicidal ideation or behaviour emerge.
8. For bipolar and mania:
    a. Patients must inform the DVLA in the event of a manic episode and they are then advised to cease driving. They should also inform the DVLA about regular medication. It's a duty of the prescriber to ensure the patient is aware of this obligation. A patient whose mental state is stable may however drive safely (with the agreement of the DVLA) on valproate if they are not unduly sedated.
    b. Gradual discontinuation is generally recommended to avoid the risk of acute withdrawal syndromes or rapid relapse. Contact GP or specialist if contemplating discontinuing.

Section 7: Generic principles of shared care for SECONDARY CARE

Please do not amend.

Core responsibilities

1. Initiating treatment and prescribing for the length of time specified in **section 1.**
2. Undertaking the clinical assessment and monitoring for the length of time specified in **section 1** and thereafter undertaking any ongoing monitoring as detailed in **section 3.**
3. Communicate details of the above in 1 and 2 to GP within the first month of treatment. This information should be transferred in a timely manner.
4. Refer patients to GP and provide information of further action where appropriate e.g. if blood test is due.
5. Send a signed copy of the Annual Risk Acknowledgement Form (ARAF) to the GP practice at least **annually**.
6. To provide advice to primary care when appropriate.
7. Review concurrent medications for potential interaction prior to initiation of drug specified in **section 1.**
8. Stopping treatment where appropriate or providing advice on when to stop.
9. Reporting adverse events to the MHRA via Yellow Card Scheme.
10. Reminder to ask patients about other issues see **section 5.**

Section 8: Generic principles of shared care for PRIMARY CARE

Please do not amend.

Core responsibilities

1. Responsible for taking over prescribing after the length of time specified in **section 1.**
2. Responsible for any clinical assessment and monitoring if detailed in **section 3** after the length of time specified in **section 1.**
3. Review of any new concurrent medications for potential interactions.
4. Reporting adverse events to the MHRA via Yellow Card Scheme.
5. Refer for advice to specialist where appropriate.
6. Reminder to ask patients about other issues see **section 5.**

Section 9: Contact Details

Name	Organisation	Telephone Number	E mail address
Mental health – contact named responsible clinician or Recovery Team for the individual patient.	AWP	Team contact numbers can be found here - Community services :: Avon and Wiltshire Mental Health Partnership NHS Trust (awp.nhs.uk) Alternatively ring the AWP switchboard on 01225 325680.	Click here to enter details

NBT neurology consultants	NBT	Via switchboard 0117 9505050	NMSKNeurologyConsultants@nbt.nhs.uk
NBT neurosciences specialist pharmacist(s)	NBT	Via switchboard 0117 9505050	Click here to enter details
UHBW Paediatric neurology consultants	UHBW	Via switchboard 0117 923 0000	Click here to enter details
UHBW Paediatric neurology registrar	UHBW	Via switchboard 0117 923 0000 bleep 6734	

Section 10: Document Details

Date prepared	20/12/2023
Prepared by	Helen Allcutt, ICB Interface Pharmacist based on previous valproate SCPs.
Date approved by JFG	Minor update May 2024 Minor update July 2025
Date of review	May 2028
Document Identification: Version	V1.3

Section 11: Collaboration

All shared care protocols should be BNSSG wide where possible. Specialists in any one discipline are encouraged to collaborate across the health community in preparing shared care guidance. Please give details

1. Lisa Rees, Principal Medicines Optimisation Pharmacist, BNSSG ICB
2. Kate Ryan, Senior Medicines Optimisation Pharmacist, BNSSG ICB
3. Dr Howard Faulker, Consultant Neurologist and Epileptologist, NBT
4. Dr Monica Mohan, Consultant Neuropsychiatrist, NBT
5. Dr Dane Rayment, Consultant Neuropsychiatrist, NBT
6. Sarah Belcher, Clinical Lead Pharmacist, AWP
7. AWP Valproate Working Group – Valerie McElhinney (Chief Pharmacist), Dr Jacek Kolsut, Dr Jochen Binder-Dietrich, Dr Narendra Singh, Dr Geoff Williams and Dr Vivek Tandon
8. BNSSG Valproate Safety Working Group

Section 12: References

Please list references

1. BNF Online https://bnf.nice.org.uk/ Accessed December 2023
2. Summary of Product Characteristics for Sodium Valproate and Valproic Acid Online https://www.medicines.org.uk/emc#gref Accessed December 2023
3. SPS Medicines Monitoring Tool https://www.sps.nhs.uk/home/tools/drug-monitoring/ Accessed December 2023
4. Pan College Guidance Document on Valproate Use in Women and Girls of Childbearing Years, Judy Shakespeare FRCGP, Sanjay M Sisodiya FRCP, on behalf of the Royal College of General

Practitioners and Association of British Neurologists and Royal College of Physicians; Version 1, 29th March 2019. Available from: https://www.rcog.org.uk/guidance/browse-all-guidance/other-guidelines-and-reports/valproate-use-in-women-and-girls-of-childbearing-years/ Accessed December 2023
5. Annual Risk Acknowledgement Form for Female Patients. Available from: https://mhra-gov.filecamp.com/s/i/6iqrRqc0zoFgeEo7 Accessed January 2024
6. MHRA Drug Safety Update April 2017 Accessed December 2023
7. MHRA guidance – Valproate use by women and girls Accessed December 2023
8. NHSE Decision support tool: is valproate the right epilepsy treatment for me? Accessed December 2023
9. AWP Patient information leaflets on valproate Accessed December 2023
10. FSRH CEU Statement: Contraceptive Choices and Sexual Health for Transgender and Non-binary People Accessed December 2023
11. SPS Specific medicine switches for solid dose and liquid formulations Online https://www.sps.nhs.uk/articles/specific-medicine-switches-for-solid-dose-and-liquid-formulations/ Accessed December 2023
12. MHRA Guide for Healthcare Professionals Information on the risks of Valproate use in girls (of any age) and women of childbearing potential (Epilim, Depakote, Convulex, Episenta, Epival, Kentlim, Orlept, Sodium Valproate, Syonell, Valpal, Belvo & Dyzantil) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/950802/107995_Valproate_HCP_Booklet_DR15_v07_DS_07-01-2021.pdf Accessed December 2023
13. BNFC online https://bnfc.nice.org.uk/ Accessed December 2023
14. MHRA. Valproate: review of saety data and expert advice on management of risks. Online https://assets.publishing.service.gov.uk/media/65660310312f400013e5d508/Valproate-report-review-and-expert-advice.pdf Accessed December 2023
15. Risk Acknowledgement Form for male patients starting valproate. Available from: https://mhra-gov.filecamp.com/s/i/bEnPD49yZtHsXp3M Accessed January 2024.
16. MHRA. Collection Valproate safety measures. Available from: https://www.gov.uk/government/collections/valproate-safety-measures?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=1831cba2-cc84-4d38-b2d6-cd505f869ec8&utm_content=immediately Accessed January 2024/

Section 13: Resources and additional information

A collection of information and guidance for patients and healthcare professionals on the reproductive risks of valproate and new safety measures introduced to reduce these risks is available from the MHRA.

This includes:

- Annual Risk Acknowledgement Form: For female patients starting valproate and at annual review
- Risk Acknowledgement Form for male patients starting valproate

More information about use of valproate can also be found online at www.medicines.org.uk by entering “valproate” in the search box and then clicking on “Risk Materials” next to any of the medicines that appear.