South East London Integrated Medicines Optimisation Committee
Formulary recommendation

Reference	**157**
Intervention:	**Melatonin immediate release tablets (Adaflex®) for managing insomnia in children and adolescents (aged 6 years to 17 years) with attention deficit hyperactivity disorder (ADHD)** (Melatonin is a hormone released by the pineal gland in the brain that regulates the sleep–wake cycle)
Date of Decision:	**Decision pending pathway update: March 2023** **Revised in September 2024 following a request to reconsider the category for all melatonin products in paediatric sleep disorders**
Date of Issue:	**March 2025 – time lag from initial application discussion in March 2023 to issuing the decision as the pathway update was progressed.**
Recommendation:	**Amber 2 – initiation and supply by specialist paediatric teams for a minimum of 1 month. The usual timeframe for dose stabilisation is between 1 to 3 months and during this time the specialist would continue to prescribe and review the patient.**
Further Information:	• Melatonin 1mg, 2mg, 3mg, 4mg and 5mg immediate release tablets (Adaflex®) are accepted for use in SEL as a **first line option** for the management of insomnia in children and adolescents in line with the licensed indication as follows: *The treatment of insomnia in children and adolescents aged 6 -17 years **with attention deficit hyperactivity disorder (ADHD)** where sleep hygiene measures have been insufficient.* • This formulary recommendation only covers the maximum licensed dose for Adaflex®, which is up to 5mg daily. The lowest effective dose should be sought. Further information can be found in the Summary of Product Characteristics for the different product strengths. • Treatment initiation, continuation and ongoing review will follow the SEL paediatric melatonin prescribing pathway, which describes the place in therapy of different melatonin products. • In line with the local melatonin pathway, behavioural interventions will have been trialled for at least 3 months before treatment with a melatonin product is considered. • Switching between melatonin products, where appropriate, can be undertaken by primary care clinicians in line with the local melatonin pathway guidance. • To simplify product choice and the prescribing process, preferred melatonin products within SEL should be prescribed by **brand** where specified, in line with the local melatonin pathway. • There are limited data on the long-term use of melatonin generally and in view of this, patients will undergo initial review by the specialist and should then have regular review (at least 6-monthly) following discharge to primary care*. Treatment breaks should be considered in line with the local melatonin pathway. • Behavioural measures will form part of the ongoing treatment plan for paediatric and adolescent patients with insomnia. • Melatonin products for sleep disorders in paediatrics will be initiated and prescribed by the specialist paediatric team for at least the first month before prescribing can be transferred to the GP. The usual timeframe for dose stabilisation is between 1 to 3 months and during this time the specialist would continue to prescribe and review the patient **More complex patients (as determined by the specialist), will remain under the care of the specialist as clinically indicated.*
Shared Care/ Transfer of care required:	N/A – individual management plan and clear communication to the GP

Cost Impact for agreed patient group	• Based on costings prepared in March 2025, it is estimated that a total of 510 children and adolescents in SEL may be suitable for treatment with Adaflex® for the management of insomnia in ADHD. The Adaflex® brand has a higher acquisition cost than melatonin MR 2mg tablets; the cost of Adaflex (all strengths 1mg – 5mg) is £132.59 per patient per year whereas the cost for melatonin MR 2mg tablets is £16.38 to £81.88 per patient per year depending on dose (1mg – 5mg) • If 10% of patients use 1 mg, 40% use 2 mg, 20% use 3 mg, 20% use 4 mg and 10% use 5 mg this equates to approximately £67,621 per annum for Adaflex®, compared to £23,400 for melatonin MR 2mg tablets. The overall cost for implementing Adaflex® in SEL is approximately £44,000 per annum (~£2,200 per 100,000 per year) • The estimated cost for implementing Adaflex® is likely to be lower as some patients with ADHD and insomnia may be treated with melatonin 2mg MR tablets, which may be more suitable instead of Adaflex® due to the modified release formulation being a preferred release profile in comparison to the immediate release profile with Adaflex®.
Usage Monitoring & Impact Assessment	**Acute and mental health Trusts:** • Monitor use and submit usage data and audit reports (against this recommendation and the pathway) upon request to the SEL IMOC.
	SEL Borough Medicines Teams: • Monitor EPACT 2 data • Exception reports from GPs if inappropriate prescribing requests are made to primary care.
Evidence reviewed:	**References (from evidence evaluation, March 2023)** 1. Hvolby A. Associations of sleep disturbance with ADHD: implications for treatment. ADHD Atten Def Hyp Disord (2015) 7:1–18. 2. Hobson S, Davie M, Farquhar M. Fifteen-minute consultation: Managing sleep problems in children and young people with ADHD. Arch Dis Child Educ Pract Ed 2019 (104) p292–297. 3. Wilson S, Anderson K, Baldwin D et al. British Association for Psychopharmacology consensus statement on evidence-based treatment of insomnia, parasomnias and circadian rhythm disorders: An update. Journal of Psychopharmacology 2019, Vol. 33(8) 923–947. 4. Adaflex (melatonin) immediate release tablets. Summary of Product Characterisitics. Available online at: https://www.medicines.org.uk/emc/product/13628/smpc (accessed 28/11/2022). 5. NICE CG87: Attention deficit hyperactivity disorder: diagnosis and management (Updated September 2019). 6. 2021 exceptional surveillance of attention deficit hyperactivity disorder: Diagnosis and management (NICE guideline NG87). NICE December 2021. Available online at: https://www.nice.org.uk/guidance/ng87/resources/2021-exceptional-surveillance-of-attention-deficit-hyperactivity-disorder-diagnosis-and-management-nice-guideline-ng87-10892592253/chapter/Surveillance-decision?tab=evidence (accessed 28/11/2022). 7. Van der Heijden K, Smits M, Van Someren E et al. Effect of Melatonin on Sleep, Behavior, and Cognition in ADHD and Chronic Sleep-Onset Insomnia. J. Am. Acad. Child Adolesc. Psychiatry, February 2007, 46:2, p233-241. 8. Hoebert M, van der Heijden K, van Geijlswijk I et al. Long-term follow-up of melatonin treatment in children with ADHD and chronic sleep onset insomnia. J. Pineal Res. 2009; 47 p1–7. 9. Weiss M, Wasdell M, Bomben M et al. Sleep Hygiene and Melatonin Treatment for Children and Adolescents With ADHD and Initial Insomnia. J. Am. Acad. Child Adolesc. Psychiatry 200 10. 6, 45:5, p512-519.Mohammadi M, Mostafavi S, Keshavarz S et al. Melatonin Effects in Methylphenidate Treated Children with Attention Deficit Hyperactivity Disorder: A Randomized Double Blind Clinical Trial. Iran J Psychiatry 2012; 7 p87-92.

NOTES:

a) SEL IMOC recommendations and minutes are available publicly via the website.

b) This SEL IMOC recommendation has been made on the cost effectiveness, patient outcome and safety data available at the time. The recommendation will be subject to review if new data becomes available, costs are higher than expected or new NICE guidelines or technology appraisals are issued.

c) Not to be used for commercial or marketing purposes. Strictly for use within the NHS