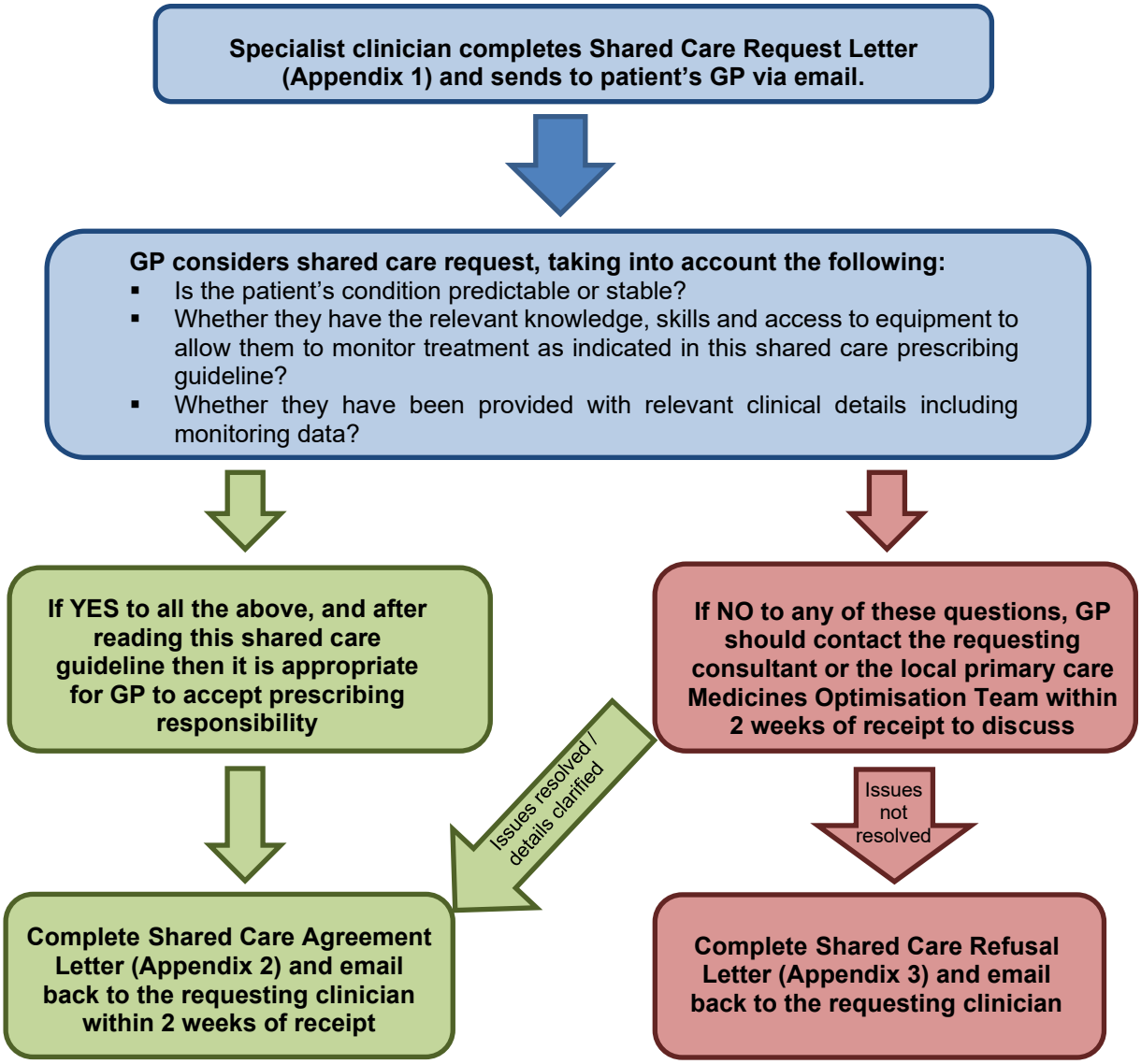
SHARED CARE PRESCRIBING GUIDELINE

Methylphenidate, atomoxetine, dexamfetamine and lisdexamfetamine for the treatment of COMPLEX Attention Deficit Hyperactivity Disorder in ADULTS

SHARED CARE PROCESS FLOWCHART



NOTES

There may be implications for the patient where invitation to share care is declined. For example, the patient may need to be changed to an alternative treatment regimen. It would not normally be expected that shared care prescribing would be declined on the basis of cost.

Sharing of care assumes communication between the specialist, GP and patient. The intention to share care should be explained to the patient by the doctor initiating treatment. **It is important that patients are consulted about treatment and are in agreement with it**.

Prescribing should follow requirements in the South East London Interface Prescribing Policy.
The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use. The patient's best interests are always paramount.

If the GP is not confident to undertake these roles, then he or she is under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. If a specialist asks the GP to prescribe this drug, the GP should reply to this request as soon as practicable (within 2 weeks).

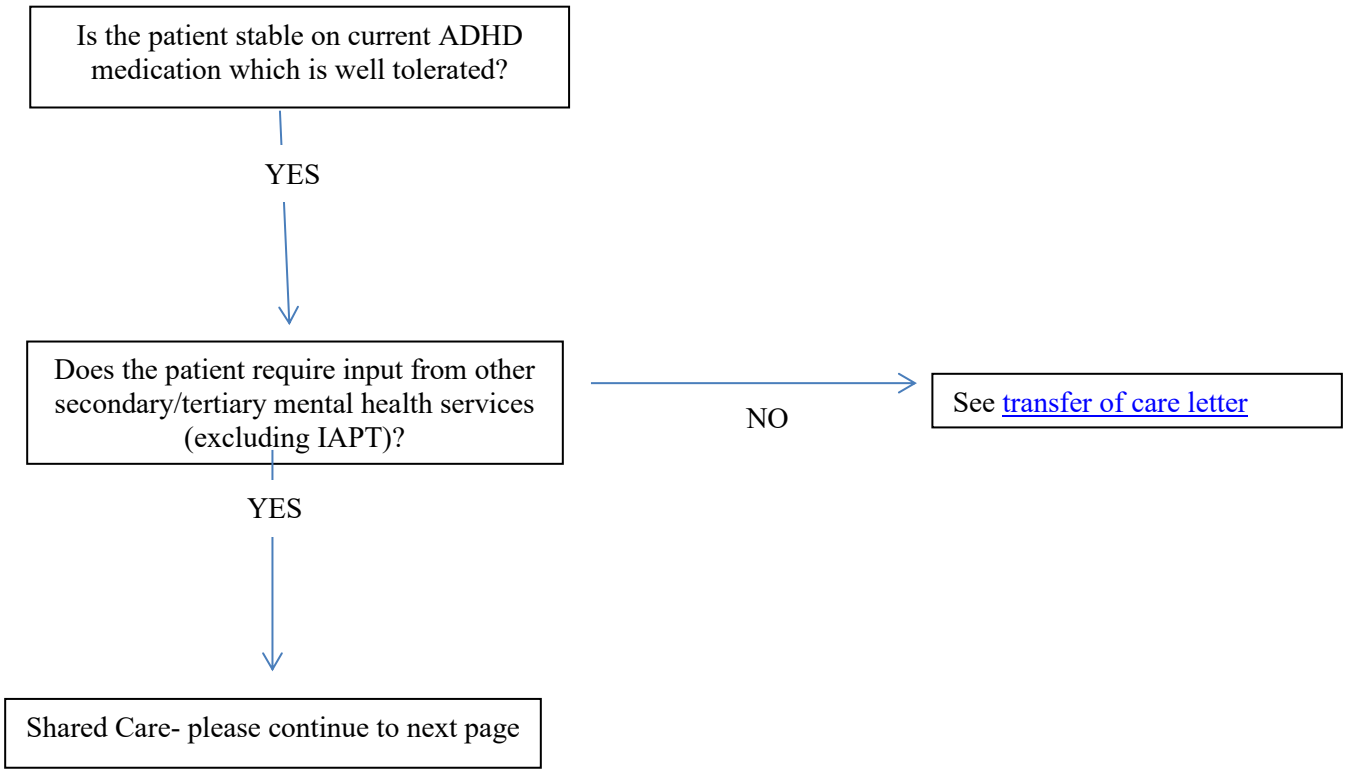
SHARED CARE PRESCRIBING GUIDELINE Methylphenidate, atomoxetine, dexamfetamine and lisdexamfetamine for the treatment of COMPLEX Attention Deficit Hyperactivity Disorder in Adults

Some patients may be suitable for *transfer of care* rather than shared care. Complex patients should remain as shared care and remain under a specialist. Complex patients may include safeguarding patients and patients with mental health issues. However, it is recognised that some less complex patients may be suitable for transfer of care and could be managed by their GP.

Is your patient suitable for shared care or transfer of care?

Some patients may be suitable for transfer of care where they are discharged from mental health services and fully managed by their GP

Please follow flow chart below to determine if shared care or transfer of care would be most appropriate for a particular patient



1. AREAS OF RESPONSIBILITY

It is the responsibility of the specialist team to work with the Primary Care Lead to support GPs with drug monitoring, including consideration of patient recall systems where appropriate, and to advise on long-term stock issues where these become apparent.

Consultant / Specialist team responsibilities

- Establish or confirm current ADHD diagnosis, devise a management plan, and assess patient suitability for pharmacological treatment, and share this information with the patient and GP in written form.
- Conduct a careful history taking to assess any history/presence of cardiac disease and risk of substance misuse/diversion.
- Conduct baseline monitoring of BP/pulse and weight - **these should be shared with the GP following a request to** take up shared care
- Consider whether further physical testing/monitoring (such as blood tests, ECG, etc.) or a cardiologist opinion is required prior to commencing on medication. See NICE guidance for further details.
- Establish and document any allergies and previous hypersensitivity to medications
- Discuss pharmacological treatment with patients or carers, ensuring and documenting that they have a clear understanding of potential benefits, side effects, frequency of administration and monitoring requirements
- Email a signed shared care guideline with patient details completed to GP for consideration of shared care request once need for pharmacological treatment is confirmed.
- Check drug interactions with medications currently prescribed to patient
- Initiate treatment and titrate the dose against symptoms and side effects (usually over 4-6 weeks) until dose optimisation is achieved or alternative medication is initiated. BP/pulse to be repeated after any dose increase or medication changes. (NB - At the time of initiating any new ADHD medication, inform GP in writing as to which of the 4 drugs included in this shared care guideline has been prescribed by sending a new shared care document).
- Once titration has been completed, and the patient's condition is stable or predictable, prescribing can be handed over to GP where this has been agreed.
- Information provided to the GP at handover should include:
- - A copy of the shared care guidelines and **complete the Shared Care Request letter (Specialist to Primary Care Prescriber) – see Appendix 1**
  - That prescriptions for the first 3 months supply have been given, and date and details of final prescription and the maintenance dose.
  - Information on when the patient will next be reviewed and by whom (NB minimum of annual specialist review initially).
- - It is usually best practice to prescribe generically, however, for **modified-release methylphenidate preparations,** the medication should be prescribed by brand name due to brands having different bi-phasic release of immediate release and modified release components. This has also been recommended by an MHRA Drug Safety Update (Sep 2022) and the Specialist Pharmacy Service. Numerous branded generic modified-release tablets and capsules are available, and prescribers should follow SEL formulary guidance and initiate patients on the recommended cost-effective brand – see Appendix 5
  - details of BP/pulse/weight at handover, and recommendations for future monitoring. .
- Inform GP of abnormal monitoring results and any changes in therapy
- Evaluate adverse events reported by GP or patient
- Carry out on-going monitoring and follow up accordingly to shared care guidelines including evaluating symptom control, side-effects, BP/pulse/weight, and continued need for therapy. Review at least annually once on a maintenance dose.
- Advise GP when ADHD treatment should be discontinued and provide necessary supervision and support during the discontinuation phase.
- To communicate promptly with the GP if treatment is changed. To report any suspected adverse effects to the MHRA: http://www.yellowcard.gov.uk

General Practitioner responsibilities

- Consider shared care proposal within 2 weeks of receipt and complete and return to specialist either the Shared Care Agreement Letter (Primary Care Prescriber to Specialist) or Shared Care Refusal Letter (Primary Care Prescriber to Specialist) (see Appendix 2 or 3)
- State in the patient's records that the medicine is being prescribed under a Shared Care agreement

After agreement to shared care

- Prescribe maintenance dose as recommended once the patient's condition is stable or predictable as directed by the specialist.
- Continue prescriptions after stabilisation in line with the points below.
- Monitor general health of patient and check adverse effects as appropriate
- Monitor weight, blood pressure and pulse as advised by specialist (NICE advice - BP/pulse and weight to be monitored every 6 months once on a maintenance dose).
- If patients develop symptoms suggestive of cardiac disease during treatment, including sustained resting tachycardia (more than 120 beats per minute) arrhythmia, or clinically significant increase in systolic blood pressure measured over two occasions, then reduce ADHD medication dosage, and refer for prompt specialist cardiac evaluation. See NICE guidance on hypertension.
- Stop treatment on advice of specialist or immediately if urgent need arises
- Check for drug interactions when prescribing new or stopping existing medication
- Discuss any suspected adverse events or abnormal results with specialist and agree any action required (this could be a telephone discussion).
- Only ask specialist to take back prescribing should the patients clinical condition deteriorate. Allow an adequate notice period of 10 working days. Consider a telephone discussion with the specialist if appropriate.
- Check that the patient is attending specialist appointments at least annually
- To advise the specialist if non-compliance is suspected
- To refer back to specialist if the patient's condition deteriorates.
- To report any suspected adverse effects to the MHRA via the Yellow Card scheme: http://www.yellowcard.gov.uk

Patient's / Carer's responsibilities

- To contact the specialist or GP if he or she does not have a clear understanding of any aspect of the treatment.
- To inform prescribing specialist, GP and other healthcare professionals of any other medication being taken, including over the counter products, alternative therapies or recreational drugs.
- To inform community pharmacists that they are using ADHD Treatments before purchasing medication over-the-counter
- To attend all hospital and GP appointments
- To take medicines as agreed and take steps to ensure that no doses are missed and not to share medicines with others
- To read the patient information leaflet included with the medication.
- To report any adverse effects or warning symptoms to GP or hospital specialist
- To report to GP if pregnant or breastfeeding.
- To inform GP and hospital of any changes in addresses or telephone contact numbers.
- To request the need for repeat prescriptions in a timely manner to allow appropriate processing of the script. **N.B**. If patient is prescribed methylphenidate, dexamfetamine or lisdexamfetamine these prescriptions will be issued as paper prescriptions and be picked up from the GP and taken to local pharmacy for dispensing

2. CLINICAL INFORMATION

NOTE: The information here is not exhaustive. Please also consult the current Summary of Product Characteristics (SPC) prior to prescribing for up to date prescribing information, including detailed information on adverse effects, drug interactions, cautions and contraindications (available via www.medicines.org.uk)

Background	The information in the shared care guideline has been developed in consultation with South East London ICB and it has been **agreed** that it is suitable for shared care. This document should provide sufficient information to enable the prescriber to make an informed decision regarding the clinical and legal responsibility for prescribing either methylphenidate, atomoxetine, dexamfetamine or lisdexamfetamine for the treatment of ADHD. The questions below will help you confirm this: Is the patient's condition predictable or stable? Do you have the relevant knowledge, skills and access to equipment to allow you to monitor treatment as indicated in this shared care prescribing guideline? Have you been provided with relevant clinical details including monitoring data? If you can answer YES to all these questions (after reading this shared care guideline), then it is appropriate for you to accept prescribing responsibility. If the answer is NO to any of these questions you should contact the requesting consultant/ specialist team or your local Borough Medicines Management Team. There may be implications for the patient where the invitation to share care is declined. For example, the patient may need to be changed to an alternative treatment regimen. It would not normally be expected that shared care prescribing would be declined on the basis of cost. Sharing of care assumes communication between the specialist, GP and patient. The intention to share care should be explained to the patient by the doctor initiating treatment. It is important that patients are consulted about treatment and are in agreement with it. Prescribing should follow requirements in the South East London Interface Prescribing Policy. The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use. The patient's best interests are always paramount.
Indications	Attention Deficit Hyperactivity Disorder (ADHD) See Appendix 4 for licensing information
Place in Therapy	See Appendix 4
Locally agreed off-label use Including supporting information	See Appendix 4
Initiation and ongoing dose regime	**Initial stabilisation:** **(The loading period must be prescribed by the initiating specialist)** On initiation of treatment the consultant/specialist will provide prescriptions for a **minimum** of 12 weeks (if CD schedule 2 drug supply either as 3x28 or 3x30 day prescriptions depending on pack size) **Maintenance dose (following initial stabilisation):** **(The initial maintenance dose must be prescribed by the initiating specialist)**

<table>
<tr><td></td><td colspan="3">See Appendix 4

<u>Conditions requiring dose adjustment</u>

See Appendix 4

<u>Duration of treatment</u>
Long-term treatment may need to continue. Patients who take treatment for extended periods (i.e. >1 year) should have their treatment reviewed at least once a year by a specialist to determine whether continuation is needed

If improvement of symptoms is not observed after the appropriate dosage adjustment over one month, it should be discontinued.

The drug may be discontinued periodically (e.g. by stopping the drug for up to two weeks each year) to assess the patient's condition as advised by the consultant/specialist. Need for continued treatment should be routinely reviewed at least yearly</td></tr>
<tr><td rowspan="4">Pharmaceutical aspects</td><td>Route of administration</td><td colspan="2">Oral</td></tr>
<tr><td>Formulation</td><td colspan="2">tablet / capsule</td></tr>
<tr><td>Administration details</td><td colspan="2">See Appendix 4</td></tr>
<tr><td>Other important information</td><td colspan="2">See Appendix 4</td></tr>
<tr><td>Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist</td><td colspan="3"><u>Baseline investigations and initial monitoring</u>
• 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 the GP.</td></tr>
<tr><td>Ongoing monitoring requirements to be undertaken by primary care</td><td>Monitoring

Weight (methylphenidate, atomoxetine, dexamfetamine, lisdexamfetamine):

Record weight at least every 6 months. Consider monitoring BMI if there is significant weight change associated with treatment. If problematic weight loss is associated with drug treatment please contact the service to consider changing or stopping treatment.
Cardiac function and blood pressure (methylphenidate, atomoxetine, dexamfetamine, lisdexamfetamine)
Monitor heart rate and blood pressure before and after each dose change, and at least every 6 months.
Clinically significant sustained or increased resting tachycardia, arrhythmia or systolic blood pressure measured on two occasions should prompt dose reduction and referral to a specialist physician (cardiology).

Atomoxetine
Monitor for dysmenorrhoea, erectile dysfunction and ejaculatory dysfunction.
Monitor for agitation, irritability, suicidal thinking and self-harming behaviour, and unusual changes in behaviour, particularly during the initial months of treatment, or after a dose change.
Patients should be warned about the potential for: increased agitation, anxiety, suicidal thinking and self-harming behaviour especially during the first few weeks of treatment and liver damage in rare cases (usually presenting as abdominal pain, unexplained nausea, malaise, darkening of the urine or jaundice).</td><td>Frequency

every 6 months</td></tr>
</table>

	Seizures (methylphenidate, atomoxetine, dexamfetamine, lisdexamfetamine) If exacerbated in a patient with epilepsy or de novo seizures emerge, discontinue the drug immediately. For de novo seizure, refer to a neurologist. For worsening of pre-existing seizure, once ADHD medication is stopped, refer back to ADHD specialist. **Psychotic symptoms, mania (methylphenidate, atomoxetine, dexamfetamine, lisdexamfetamine)** If psychotic or severe affective symptoms emerge discontinue the drug immediately and refer to a psychiatrist for an assessment	
Adverse effects and management Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme www.mhra.gov.uk/yellowcard	**Result** See Appendix 6	**Action for GP** See Appendix 6
Advice to patients and carers	**The patient should be advised to report any of the following signs or symptoms to their GP without delay:** • See Appendix 6 • 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 medicines. •	
Criteria for stopping treatment	• If improvement of symptoms is not observed. GP should contact specialist services for advice in such circumstances. • If there are adverse effects that necessitate stopping the medication • If ADHD symptoms are judged to have resolved following specialist review The drug may be discontinued periodically (e.g. by stopping the drug for up to two weeks) to assess the patient's underlying ADHD symptoms as advised by the consultant/specialist team, but there is no stipulation in NICE guidance to do this on a regular basis, and it should be decided on a case by case basis.	
Follow up arrangements e.g. frequency of specialist clinic attendance	**Consultant/specialist team:** • To arrange follow-up reviews during the titration period, and at least annually following handing over to GP prescribing. **GP:** • To act upon recommendations communicated by the consultant/specialist team • To monitor prescribing rate of medications for individual patients, usually monthly prescribing for controlled medications. • Check that the patient is attending specialist appointments at least annually To review the appropriateness of prescribing for patients who have not been seen by a specialist for over one year	
Pregnancy, paternal exposure and breast feeding	**Pregnancy:** Refer patient back to Specialist team **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 GP and the specialist.	Refer patient back to Specialist team
Additional information	**Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed.** A pharmaceutical company patient information leaflet (PIL) will be provided to the patient with each supply. A review letter will be sent after initial assessment and following each further appointment. It is assumed that the GP agrees to the shared care arrangements **Methylphenidate modified release preparations to be prescribed by brand name**
Evidence base for treatment and key references Include hyperlinks to original sources and access dates	**References** 1. NICE guideline [NG87] Attention deficit hyperactivity disorder: diagnosis and management . March 2018. https://www.nice.org.uk/guidance/NG87 2. British National Formulary Jan 2020 https://bnf.nice.org.uk/ (last Accessed October 2025) **Summary of Product Characteristics** – access via www.medicines.org.uk 4. Ritalin® - (Last accessed October 2025) 5. Equasym XL® - (Last accessed October 2025) 6. Medikinet® - (Last accessed October 2025) 7. Medikinet XL® - (Last accessed October 2025) 8. Concerta XL® - (Last accessed October 2025) 9. Strattera® - (Last accessed October 2025) 10. Elvanse Adult ® - (Last accessed October 2025)
To be read in conjunction with the following documents	**Information on prescribing Controlled Drugs** Methylphenidate, lisdexamfetamine and dexamfetamine are schedule 2 Controlled drugs - the following applies: • Prescribers can now issue computer-generated prescriptions for all CDs including Schedule 2 and 3 CDs; all details except the signature can be computer-generated • Prescriptions for Schedule 2 CDs are only valid for 28 days. • Schedule 2 CDs cannot be prescribed on repeat dispensing prescriptions • There is a good practice requirement that the quantity of Schedule 2 CDs be limited to a quantity for up to 30 days treatment. In cases where the prescriber believes that a prescription should be issued for a longer period they may do so but will need to be able to justify that there is a clinical need and that it would not cause an unacceptable risk to patient safety • The prescription for CDs must contain the dose, form, strength (where appropriate) and a total quantity of the preparation in both words and figures
Local arrangements for referral Define the referral procedure from hospital to primary care prescriber & route of return should the patient's condition change.	Clinic letter/email request to GP for shared care consideration. Practice letter/email from GP to secondary care

3. COMMUNICATION AND SUPPORT

South London and Maudsley (SLAM): switchboard 020 3228 6000	
Consultant/specialist team Adult ADHD and ASD Outpatient Clinics, South London and Maudsley NHS Foundation Trust	Email: adhdasdadmin@slam.nhs.uk
Medication – Prescribing advice, interactions, availability of medicines The Maudsley Psychiatric Medicines Advice Service	Tel: 020 3228 2317.
Oxleas NHS Trust switchboard (01322) 625 700	
Consultant/specialist team	Email: oxl-tr.adultasdassessment@nhs.net Tel: 020 8659 2151
Medication – Prescribing advice, interactions, availability of medicines Oxleas Medicines Line	Email: oxl-tr.medicinesinfo@nhs.net Tel: 01322 625002

Appendix 1: Shared Care Request letter (Specialist to Primary Care Prescriber)

Dear *[insert Primary Care Prescriber's name]*

Patient name: *[insert patient's name]*
Date of birth: *[insert date of birth]*
NHS Number*:* *[insert NHS Number]*
Diagnosis: *[insert diagnosis]*

As per the agreed South East London shared care prescribing guideline for *[insert medicine name]* for the treatment of *[insert indication].* Treatment was started on *[insert date started]* and the current dose is *[insert dose and frequency]*. This patient is now suitable for prescribing to move to primary care.

The patient fulfils criteria for shared care and I am therefore requesting your agreement to participate in shared care. Where baseline investigations are set out in the shared care protocol, I have carried these out.

I can confirm that the following has happened with regard to this treatment:

[Shared care can only be considered if the following requirements have been met. Please complete all parts of the right hand column to confirm this]	**Specialist to complete:**
The patient has been initiated on this therapy and has been on an optimised dose for the following period of time:	..... *weeks/months*
Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory	*Yes* ☐
The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care	*Yes* ☐
The risks and benefits of treatment have been explained to the patient	*Yes* ☐
[If applicable to SCA, otherwise delete] A contraceptive check for this patient has been completed within the last ..... months/week	*Yes, Dated:.....* ☐ *N/A* ☐
The roles of the specialist/specialist team/ Primary Care Prescriber / Patient and pharmacist have been explained and agreed	*Yes* ☐
The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments	*Yes* ☐
I have enclosed a copy of the shared care protocol which covers this treatment/the SCP can be found here (insert electronic/ web link)	*Yes* ☐
I have included with the letter copies of the information the patient has received	*Yes* ☐
I have provided the patient with sufficient medication to last until:	.....
I have arranged a follow up with this patient in the following timeframe e.g. within 3 months / 6 months (please specify)	.....

If you are in agreement, please undertake monitoring and treatment from *[insert date]* NB: date must be at least 1 month from initiation of treatment.

The next blood monitoring is due on *[insert date]* and should be continued in line with the shared care guideline.

Please could you reply to this request for shared care and initiation of the suggested medication to either accept or decline within 14 days.

Appendix 2: Shared Care Agreement Letter (Primary Care Prescriber to Specialist)

Primary Care Prescriber Response

Dear *[insert Doctor's name]*

Patient *[insert Patient's name]*

NHS Number *[insert NHS Number]*

Identifier *[insert patient's date of birth and/oraddress]*

Thank you for your request for me to accept prescribing responsibility for this patient under a shared care agreement and to provide the following treatment

Medicine	Route	Dose & frequency

I can confirm that I am willing to take on this responsibility from *[insert date]* and will complete the monitoring as set out in the shared care protocol for this medicine/condition.

Primary Care Prescriber signature: _____ Date: _____

Primary Care Prescriber address/practice stamp:

Appendix 3: Shared Care Refusal Letter (Primary Care Prescriber to Specialist)

Re*:*

Patient *[insert Patient's name]*

NHS Number *[insert NHS Number]*

Identifier *[insert patient's date of birth and/oraddress]*

Thank you for your request for me to accept prescribing responsibility for this patient.

In the interest of patient safety, NHS South East London ICS**,** in conjunction with local acute trusts have classified *[insert medicine name]*as a Shared Care drug, and requires a number of conditions to be met before transfer can be made to primary care.

I regret to inform you that in this instance I am unable to take on responsibility due to the following:

		Tick which apply
1.	**The prescriber does not feel clinically confident in managing this individual patient's condition, and there is a sound clinical basis for refusing to accept shared care** As the patients primary care prescriber I do not feel clinically confident to manage this patient's condition because *[insert reason]*. I have consulted with other primary care prescribers in my practice who support my decision. This is not an issue which would be resolved through adequate and appropriate training of prescribers within my practice. **I have discussed my decision with the patient and request that prescribing for this individual remain with you as the specialist, due to the sound clinical basis given above.**	
2.	**The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement** As the medicine requested to be prescribed is not included on the national list of shared care drugs as identified by RMOC (Regional Medicines Optimisation Committees) or is not a locally agreed shared care medicine I am unable to accept clinical responsibility for prescribing this medication at this time. **Until this medicine is identified either nationally or locally as requiring shared care the responsibility for providing this patient with their medication remains with you**	
3.	**A minimum duration of supply by the initiating clinician** As the patient has not had the minimum supply of medication to be provided by the initiating specialist, I am unable to take clinical responsibility for prescribing this medication at this time. Therefore, can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. ***Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.***	
4.	**Initiation and optimisation by the initiating specialist** As the patient has not been optimised on this medication I am unable to take clinical responsibility for prescribing this medication at this time. Therefore can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.	

	Until the patient is optimised on this medication the responsibility for providing the patient with their medication remains with you.	
5.	**Shared Care Protocol not received** As legal responsibility for clinical care lies with the clinician who signs the prescription, I need to ensure that I am in possession of sufficient clinical information for me to be confident to prescribe this treatment for my patient and it is clear where each of our responsibilities lie to ensure the patient is safely managed***.*** For this reason I am unable to take clinical responsibility for prescribing this medication at this time, therefore would you please contact the patient as soon as possible in order to provide them with the medication that you have recommended. ***Until I receive the appropriate SCP, responsibility for providing the patient with their medication remains with you.***	
6.	**Other (Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted. NB: Capacity issues to be discussed with local primary care Medicines Optimisation Team prior to returning this form)**	

I would be willing to consider prescribing for this patient once the above criteria have been met for this treatment.

NHS England 'Responsibility for prescribing between Primary & Secondary/Tertiary care' guidance (2018) states that "when decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. It is therefore essential that a transfer involving medicines with which GPs would not normally be familiar should not take place without full local agreement, and the dissemination of sufficient, up-to-date information to individual GPs." In this case we would also see the term GP being interchangeable with the term Primary Care Prescriber.

Please do not hesitate to contact me if you wish to discuss any aspect of my letter in more detail and I hope to receive more information regarding this shared care agreement as soon as possible

Yours sincerely

Primary Care Prescriber signature: _____ Date: _____

Primary Care Prescriber address/practice stamp

APPENDIX 4

Indication for use, place in therapy, dose and further information. ***NOTE:*** *The Information here is* ***not*** *exhaustive.* ***Please consult the current Summary of Product Characteristics (SPC) for up-to-date prescribing information including detailed information on adverse effects, drug interactions, cautions and contraindications (available via www.medicines.org.uk)***

Drug	Indication	Place in Therapy	Dose and route of administration		Notes
			Preparation	**Dose (BNF)**	
Methylphenidate hydrochloride **MODIFIED RELEASE PREPARATIONS MUST BE PRESCRIBED BY BRAND**	See SPC's Medikinet XL ® licensed for initiation and continuation in adults; Concerta XL®, Delmosart ®, Xenidate XL® licensed for continuation; Equasym XL® used off-label	To be considered **first line** for adults or if 6 week trial lisdexamfetamine has not been successful	**Immediate-release tablets** Available in the following strengths: **5mg, 10mg, 20mg**	Initially 5mg 2-3 times daily, increasing weekly in 5mg dosage increments as necessary depending on treatment response and side-effects. Maximum total dosage - 100mg per day	Patients started on immediate release (IR) medication may switch to extended release preparations if once daily dosing is preferable. In some cases rebound hyperactivity disorder may occur if the effect of the drug wears off in the evening. An additional dose later in the day may eliminate this difficulty, but may disturb sleep.
			Modified-Release tablets Available in the following strengths **18mg, 27mg, 36mg, 54mg** ***The prescriber must specify the brand*** *– see Appendix 5* (N.B. dosage released as 22% immediate release, 78% sustained release)	Initially 18mg once daily in the morning increasing weekly in 18mg dosage increments as necessary depending on treatment response and side-effects, up to a maximum total dosage of 108mg once per day in the morning.	Total daily dose of 15mg IR medication equivalent to Concerta XL®/ Delmosart ®/ Xenidate XL® 18mg once daily. May need additional IR methylphenidate medication in the late afternoon if duration of action is too short – combined Delmosart ®/ Xenidate XL® (or other methylphenidate MR tablets) dosage in IR equivalent and IR dosage not to exceed 108mg. Tablet to be swallowed whole – may pass through GI tract unchanged. Not suitable in dysphagia or if GI lumen is restricted.
			Modified-Release capsules Available in the following strengths **5mg, 10mg, 20mg, 30mg, 40mg, 50mg,60mg** ***The prescriber must specify the brand*** *– see Appendix 5* Medikinet XL ® capsules (dosage released as 50% immediate release, 50% sustained release) Equasym XL ® capsules(N.B. dosage released as 30% immediate release, 70% sustained release) **N.B. Equasym ® XL is not interchangeable with any other brand – seek specialist advice before switching**	Initially 10mg once daily in the morning increasing weekly in 10mg dosage increments as necessary depending on treatment response and side-effects, up to a maximum total dosage of 100mg per day	In some instances, twice daily dosing or the addition of IR methylphenidate may be required if duration of action is too short. Note there is a 5mg capsule where lower starting dose is required. Contents of capsule can be sprinkled on a tablespoon of apple sauce or yoghurt then swallowed immediately without chewing.

Drug	Indication	Place in Therapy	Dose and route of administration		Notes
			Preparation	Dose (BNF)	
Atomoxetine hydrochloride	Treatment of ADHD, licensed for adult initiation	To be considered if cannot tolerate lisdexamfetamine or methylphenidate or their symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate, having considered alternative preparations and adequate doses.	Atomoxetine hydrochloride capsules & liquid	Body weight over 70kg – 40mg daily for 7 days, increasing to 80mg daily thereafter if tolerated. Can be increased to max 120mg daily (unlicensed) under the direction of a specialist. Body weight under 70kg – 500micrograms/kg daily for 7 days, increased according to response. Usual maintenance dose 1.2mg/ kg, but may be increased to 1.8mg/kg (max 120mg daily) under the direction of a specialist.	Total daily dose may be given either as a single dose in the morning or as 2 divided doses with last dose no later than early evening. Patients to be informed of the specific cautions with regard emergent hepatic disorder and suicidal ideation – see SPC/BNF for full details. For patients with a known poor metaboliser genotype, or who don't tolerate the usual 40mg starting dose, a lower starting dose and slower up titration of the dose may be considered.
Dexamfetamine sulfate	Treatment of ADHD, prescribed 'off label' in adults	To be considered for adults whose ADHD symptoms are responding to lisdexamfetamine but who cannot tolerate the longer effect profile	Dexamfetamine tablets & oral solution	Initially 5 mg twice daily, dose is increased at weekly intervals according to response, maintenance dose to be given in 2–4 divided doses; maximum 60 mg per day.	SEL IMOC Formulary recommendation can be accessed here
Lisdexamfetamine dimesylate	Treatment of ADHD, licensed for adult initiation	To be considered **first line** for adults or if 6 week trial methylphenidate has not been successful	Elvanse Adult ® capsules 30/50/70mg licensed in adults 20/40/60mg off label in adults	Initially 30mg once daily in the morning increasing weekly in 20mg dosage increments as necessary depending on treatment response and side-effects, up to a maximum total dosage of 70mg per day in the morning.	Swallow capsule whole or mix contents of capsule in yoghurt or a glass of water or orange juice; contents should be dispersed completely and consumed immediately. SEL IMOC Formulary recommendation can be accessed here

Appendix 5 - Summary of licensed brands available

Please note this list is exhaustive, however products may be subject to change. Healthcare professionals should continue to refer to the BNF before prescribing.
For information on current supply shortages, please check Specialist Pharmacy Services Medicines supply tool (registration required)

Drug Name	Licensed Indication	Preparations
METHYLPHENIDATE *(CD Schedule 2)* Prescriptions for modified-release tablets or capsules should specify the brand	Medikinet XL ® licensed for initiation and continuation in adults; Concerta XL®, Delmosart ®, Xenidate XL® licensed for continuation; Equasym XL® used off-label	***Immediate-release tablets*** • *Prescribe generically* • Available in the following strengths: **5mg, 10mg, 20mg**
		Modified-Release TABLETS • *Prescribe by **brand** name* • Available in the following strengths: **18mg, 27mg, 36mg, 54mg** • **Equivalent brands include* Affenid XL, Atenza XL Delmosart, Matoride XL Xaggitin XL Xenidate XL • Concerta XL is not recommended for initiation • Any equivalent strengths of modified-release tablet can be prescribed but patients should ideally remain on the same brand that they are initiated on. Frequent switching between brands is not recommended • *For full prescribing guidance see* SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
		Modified-Release CAPSULES: • *Prescribe by **brand** name* • Available in the following strengths: **5mg, 10mg, 20mg, 30mg, 40mg, 50mg, 60mg** • *Equivalent brands include* Medikinet® XL Meflynate® XL Focusim XL Metyrol XL • Any equivalent strengths of modified-release capsule can be prescribed but patients should ideally remain on the same brand that they are initiated on. Frequent switching between brands is not recommended • ***Equasym® XL*** - No other preparation is bioequivalent to Equasym XL capsule and these should **not** be switched or prescribed generically; refer back to specialist for advice if there is a national supply issue • *For full prescribing guidance see* SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
ATOMOXETINE	Treatment of ADHD, licensed for adult initiation	**Strattera® capsules 10mg, 18mg, 25mg, 40mg, 60mg, 80mg, 100mg** **Oral solution 4mg/ml**
LISDEXAMFETAMINE (dimesylate) *(CD Schedule 2)*	Treatment of ADHD, licensed for adult initiation	**Elvanse® capsules 20mg, 30mg, 40mg, 50mg,60mg and 70mg**
DEXAMFETAMINE (sulphate) *(CD Schedule 2)*	Treatment of ADHD, prescribed 'off label' in adults	**Amfexa® tablets 5mg, 10mg 20mg** **Oral solution 1mg/ml**

*more bioequivalent brands may become available; check SPS - Specialist Pharmacy Service – The first stop for professional medicines advice for an updated list and with local pharmacy for availability before prescribing

Appendix 6 - Side effects/Interactions: (from SPCs) See also Monitoring Requirements including frequency above

METHYLPHENIDATE			Concerta https://www.medicines.org.uk/emc/medicine/30451 Equasym https://www.medicines.org.uk/emc/medicine/15804 Medikinet https://www.medicines.org.uk/emc/medicine/19664 Medikinet XL https://www.medicines.org.uk/emc/product/313/smpc Ritalin https://www.medicines.org.uk/emc/medicine/1316 Delmosart https://www.medicines.org.uk/emc/product/2340/smpc Xenidate https://www.medicines.org.uk/emc/product/4397/smpc
	Nervousness and insomnia	>10%	Review dose and/or omit afternoon/evening dose if using TDS regime - refer to consultant/specialist team for advice.
	Decreased appetite	1-10%	Usually transient. Try taking medicine with food if it persists. Refer to consultant/specialist team for advice if becomes problematic.
	Headache, drowsiness, dizziness	>10%	Refer to consultant/ specialist team for advice if continues
	Abdominal pain, diarrhoea, nausea & vomiting, dry mouth, dyspepsia	1-10%	Occurs at initiation. May be alleviated by concomitant food intake. Refer to consultant/ specialist team for advice if continues
	Tachycardia, arrhythmia, palpitations, hypertension	1-10%	Monitor. Discontinue if significant & refer back to ADHD consultant/ specialist team & specialist cardiologist if indicated.
	Tics, aggression, anxiety, irritability	1-10%	Discontinue if tics develop. Refer back to consultant/ specialist team.
	Drug induced psychosis (e.g. hallucinations, restlessness) depression, mood swings	1-10%	Discontinue. Refer back to consultant/ specialist team.
DEXAMFETAMINE			Tablets https://www.medicines.org.uk/emc/product/5004/smpc
	Aggressive behaviour, anxiety, confusion, delirium, depression, euphoria, insomnia, irritability, tics, night tremors	Not stated	Reduce dose & ensure not given too near bedtime. Discontinue if tics develop. Refer back to consultant/ specialist team.
	Paranoia, psychosis	Not stated	Discontinue. Refer back to consultant/ specialist team.
	Palpitations, tachycardia, change in blood pressure, cardiomyopathy, chest pain.	Not stated	Monitor. Check pulse after every dose change. ECG if necessary. Discontinue if significant & refer back to ADHD consultant/ specialist team & specialist cardiologist if indicated.

LISDEXAMFETAMINE ▼		(adults)	Lisdexamfetamine Capsules https://www.medicines.org.uk/emc/product/6828/smpc
	Insomnia	>10%	Review dose - ensure taken in morning – refer to consultant/ specialist team for advise
	Decreased appetite (weight decreased)	>10% (1-10%)	Try taking medicine with food if it persists. Refer to consultant/ specialist team for advice if becomes problematic
	Headache, dry mouth	>10%	Refer to consultant/ specialist team for advice if continues
	Anorexia, diarrhoea, upper abdominal pain, nausea	1-10%	May be alleviated by concomitant food intake. Refer to consultant/ specialist team for advice if continues
	Anxiety, agitation, libido decreased, erectile dysfunction, dizziness, restlessness, tremor, irritability, fatigue, feeling jittery, hyperhidrosis	1-10%	Refer back to consultant/ specialist team.
	Tachycardia, palpitations, blood pressure increased,	1-10%	Monitor. Discontinue if significant & refer back to ADHD consultant/ specialist team & specialist cardiologist if indicated.
	Depression, tics, affect lability, dysphoria, euphoria, mania,	0.1-1%	Discontinue if tics develop. Refer back to consultant/ specialist team.
	Blurred vision, vomiting, urticaria, rash, pyrexia	0.1-1%	Discontinue. Refer back to consultant/ specialist team.
	Psychotic episodes, hallucinations, aggression, seizure	Not known	Discontinue. Refer back to consultant/ specialist team
ATOMOXETINE			Capsules https://www.medicines.org.uk/emc/medicine/14482 Liquid https://www.medicines.org.uk/emc/medicine/30371
	Appetite decreased, dry mouth, nausea	>10%	Usually settles after 1st month of treatment. Refer to consultant/ specialist team for advice if continues
	Headache, somnolence, insomnia	>10%	Usually settles after 1st month of treatment. Refer to consultant/ specialist team for advice if continues
	Increased BP and heart rate	>10%	Monitor. Discontinue if clinically indicated. Refer back to ADHD consultant/ specialist team and cardiologist if indicated.
	Abdominal pain, constipation, dyspepsia, flatulence, vomiting	1-10%	Usually settles after 1st month of treatment. Refer to consultant/ specialist team for advice if continues
	Weight decrease	1-10%	Usually settles after initial weight loss. Refer to consultant/ specialist team for advice if becomes problematic
	Palpitations, tachycardia	1-10%	Monitor. Discontinue if clinically indicated. Refer back to ADHD consultant/ specialist team and cardiologist if indicated.
	Libido decreased, sleep disorder, dizziness, sinus headache, tremor, fatigue, lethargy, agitation	1-10%	Refer back to consultant/ specialist team
	Dysuria, urinary hesitation, urinary retention	1-10%	Refer back to consultant/ specialist team

	Dysmenorrhoea, irregular menstruation, ejaculation disorder, erectile dysfunction, male genital pain	1-10%	Refer back to consultant/ specialist team
	Suicide-related events, aggression, hostility and emotional lability,	0.1-1%	Discontinue drug. Refer back to consultant/ specialist team
	QT interval prolongation,	0.1-1%	Discontinue if significant & refer back to ADHD consultant/ specialist team & specialist cardiologist.
	Liver toxicity, abnormal liver function tests, jaundice, hepatitis,	0.01-0.1%	Discontinue drug. Refer back to consultant/ specialist team
	seizure, psychosis (including hallucinations),	0.01-0.1%	Discontinue drug. Refer back to consultant/ specialist team