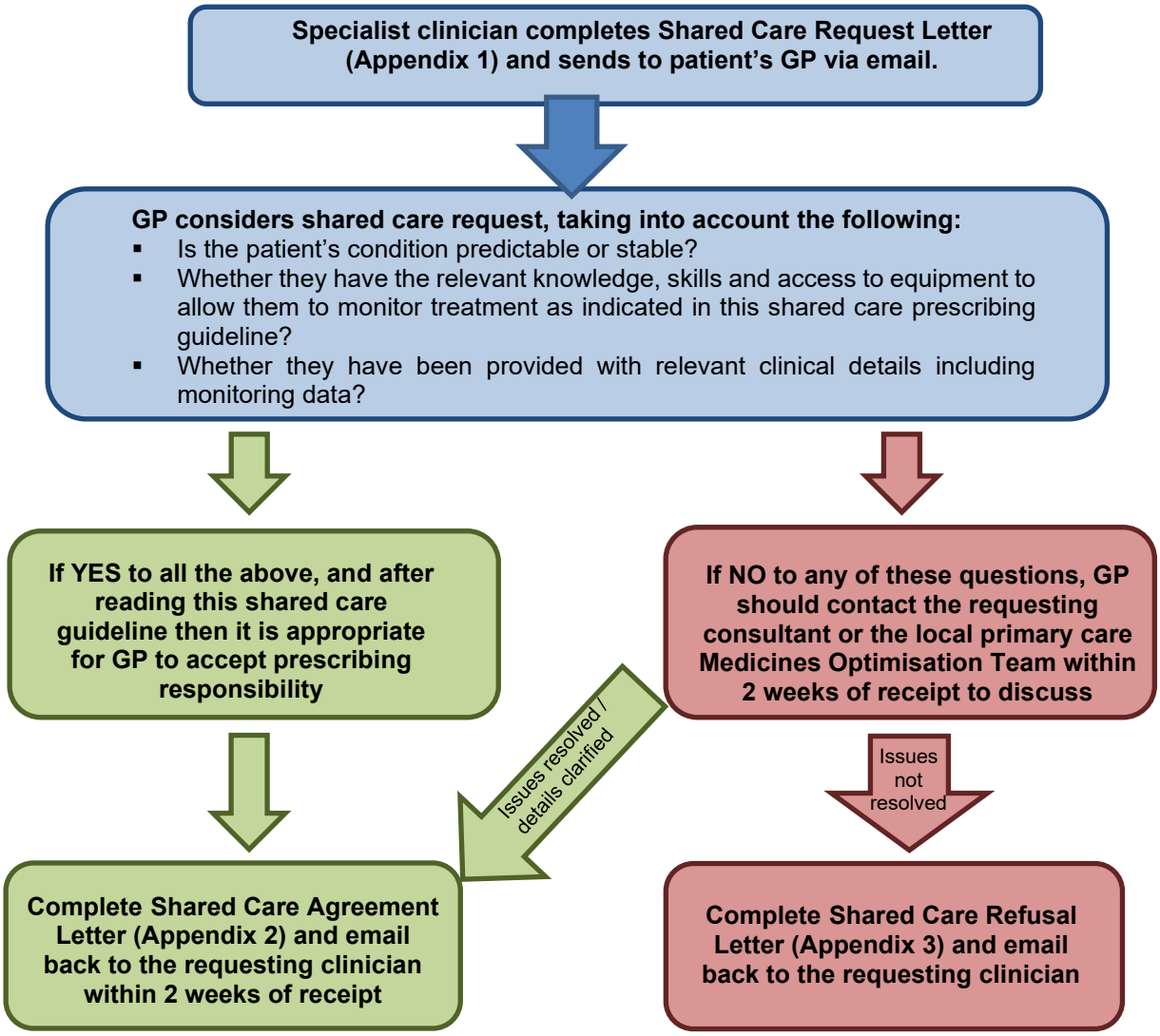
SHARED CARE PRESCRIBING GUIDELINE
Methylphenidate, atomoxetine, lisdexamfetamine, dexamfetamine and guanfacine for the treatment of Attention Deficit Hyperactivity Disorder in PAEDIATRICS

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).

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

Before requesting agreement for shared care

- Establish or confirm diagnosis and assess patient suitability for treatment
- Conduct a careful history and physical examination to assess any presence of cardiac disease
- Establish and document any allergies and previous hypersensitivity

Baseline monitoring - **These should be shared with the GP following a request to take up shared care**

- Height and weight – add to a growth chart
- Cardiovascular status, including blood pressure and heart rate before prescribing and obtain specialist cardiac advice if appropriate
- Discuss treatment with patients or carers, ensuring and documenting that they have a clear understanding of 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
- Before treatment is initiated check for any potential drug interactions if patient is currently on other medications
- Initiate treatment and titrate the dose against symptoms and side effects over 4-6 weeks until dose optimisation is achieved.
- Prescribe and monitor treatment according to local and national guidance until patient's condition is stable or predictable
- At the time of initiating, inform GP in writing which of the 5 drugs included in this shared care guideline has been prescribed and **complete the Shared Care Request letter (Specialist to Primary Care Prescriber) – see Appendix 1**
- It is usually best practice to prescribe generically, however, for **modified-release methylphenidate preparations,** the medication should be prescribed by brand name as recommended by 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
- The GP should be invited to share care once the patient is stable. Information provided to the GP should include:
    - A copy of the shared care guidelines with the relevant amendments made on the Shared Care Request letter detailing the drug which will involve shared care.
    - That prescriptions for a minimum of 12 weeks supply has or will be given
    - Information on when the patient will next be reviewed and by whom.
    - A request that the GP continue prescribing after 12 weeks.
- Advise GP on the appropriateness of any necessary periodic drug holidays

After agreement to shared care

- Inform GP when patient is stable see above – dose titration should occur before transfer.
- Inform GP of abnormal monitoring results and any changes in therapy
- Evaluate adverse events reported by GP or patient
- Carry out ongoing monitoring and follow up according to shared care guidelines including continued need for therapy.
- If a dose change is needed, a prescription is issued from the specialist clinic and GP provided with a letter of the dose change and information regarding any further monitoring that may be required. Consultant/Specialist should review the patient within 3-6 months following any dose change. 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

Before agreement to shared care

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

After agreement to shared care

- Prescribe dose as recommended once the patient's condition is stable or predictable.
- Add 'shared care' read code to patient's medical record.
- Continue prescriptions after stabilisation in line with the points below.
- Monitor general health of patient and check adverse effects as appropriate
- Monitor height, weight, (check against https://www.rcpch.ac.uk/resources/growth-charts) blood pressure* and pulse after the first 3 months of treatment, as well as after each dose adjustment as directed by the specialist, and then every 6 months. Any significant changes from baseline in BP/weight/pulse should be discussed with the specialist. If the patient develops symptoms suggestive of cardiac disease during treatment, they should be referred for prompt specialist cardiac evaluation and the consultant/specialist team informed
- 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 abnormal results with specialist and agree any action required (this could be a telephone discussion).
- Only ask specialist to take back prescribing should the patient's 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 report any suspected adverse effects to the MHRA via the Yellow Card scheme: http://www.yellowcard.gov.uk

*GP's can order small cuffs to enable them to monitor blood pressure, where they are unable to carry out this monitoring they should inform the specialist to arrange how blood pressure can be monitored.

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	Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental condition characterised by symptoms of inattention, hyperactivity, and impulsivity, which can significantly affect a child's educational, social, and emotional development. ADHD affects approximately 3–5% of school-aged children and frequently persists into adolescence and adulthood. In South East London, assessment and initiation of treatment for children and young people with ADHD are undertaken by specialist services, including community paediatrics and Child and Adolescent Mental Health Services (CAMHS). This approach follows **NICE Guideline NG87: Attention Deficit Hyperactivity Disorder (2018)** 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, lisdexamfetamine, dexamfetamine or guanfacine for the treatment of ADHD in Children and Adolescents aged 6-18 years*** ***N.B** *NICE recommends that the treatment of ADHD can start from the age of 5 years – however all medicines that are used to treat ADHD are only licensed for children from 6 years of age.*
Indications Note if indication is unlicensed or not	Attention Deficit Hyperactivity Disorder (ADHD)
Place in Therapy Indicate what drugs should have been tried before this drug is considered	see Appendix 4
Locally agreed off-label use Including supporting information	N/A (Children aged under 6 years to be managed by the specialist)
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)** See Appendix 4 **Conditions requiring dose adjustment** See Appendix 4 **Duration of treatment**

<table>
<tr><td></td><td colspan="2">Long-term treatment may continue into adulthood. 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 child's condition as advised by the consultant/specialist. Need for continued treatment should be routinely reviewed throughout treatment and beyond the age of 18 years</td></tr>
<tr><td rowspan="4">Pharmaceutical aspects</td><td>Route of administration</td><td>Oral</td></tr>
<tr><td>Formulation</td><td>tablet / capsule / oral solution</td></tr>
<tr><td>Administration details</td><td>See Appendix 4</td></tr>
<tr><td>Other important information</td><td>See Appendix 4</td></tr>
<tr><td>Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist</td><td colspan="2"><u>Baseline investigations:</u>
• To assess baseline cardiovascular status, including blood pressure and heart rate before prescribing and obtain specialist cardiac advice if appropriate.
• To review the patient and monitor the following on an annual basis for the duration that the patient is on the medicine and communicate these results to the GP:
• For children under 10 years monitor height, weight and appetite, recorded on a growth chart (check against https://www.rcpch.ac.uk/resources/growth-charts)
• Blood pressure and pulse, recorded on a centile chart (also following dose adjustments).
• To refer patients who develop symptoms such as palpitations, exertional chest pain, unexplained syncope, dyspnoea, or other symptoms suggestive of heart disease for prompt specialist cardiac evaluation.
• The development of new or worsening of pre-existing, psychiatric symptoms (also following dose adjustments and at every visit).
• Monitoring of motor / verbal tics should be carried out at every dose adjustment and at least annually.
• Blood testing should be carried out periodically at the discretion of the supervising clinicians and when clinically indicated (e.g. if recurrent nose bleeds, bruising or infections occur).

Methylphenidate, dexamfetamine and lisdexamfetamine are classed as controlled drugs (see Appendix 4 for prescribing information), Atomoxetine and Guanfacine are Prescription Only Medicines. In order to monitor the effects of treatment the specialist or parents should inform the school concerning any medication for these indications. In order to assess the effects of the drug on the child's emotional, physical or behavioral states the specialist should request further information from the school about the child's behaviour.

<u>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.

<u>Ongoing monitoring:</u>

See below</td></tr>
</table>

<table>
<tr><td>Ongoing monitoring requirements to be undertaken by primary care</td><td>Monitoring

• To monitor, pulse, blood pressure*, and height and weight (for children under 10 years old - check against https://www.rcpch.ac.uk/resources/growth-charts) every three months
• To contact specialist if deterioration in behaviour.
• To report adverse drug reactions to specialist.
• To refer patients who develop symptoms such as palpitations, exertional chest pain, unexplained syncope, dyspnoea, or other symptoms suggestive of heart disease for prompt specialist cardiac evaluation.
• To refer patients with recurrent nose bleeds, bruising or infection.

Blood pressure and pulse rate checks should ideally be done in the more relaxed environment of a GP surgery rather than in hospital. But in reality, the BP and pulse should be checked by whoever sees the patient first after a dose increase (usually within 2 weeks of the change)

*GP's can order small cuffs to enable them to monitor blood pressure, where they are unable to carry out this monitoring they should inform the specialist to arrange how blood pressure can be monitored</td><td>Frequency

• Every 3-6 months</td></tr>
<tr><td>Adverse effects and management

Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme www.mhra.gov.uk/yellowcard</td><td>Result

See above – under Ongoing Monitoring</td><td>Action for GP</td></tr>
<tr><td>Advice to patients and carers</td><td colspan="2">• 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 and when to refer back to either the GP or Specialist with regards to adverse signs or symptoms</td></tr>
<tr><td>Criteria for stopping treatment
e.g. poor response, adverse effects requiring cessation</td><td colspan="2">• If improvement of symptoms is not observed after the appropriate dosage adjustment over one month, medication should be discontinued.

• Patient request

• See Appendix 4</td></tr>
<tr><td>Follow up arrangements
e.g. frequency of specialist clinic attendance</td><td colspan="2">Consultant/Specialist:
• To arrange for follow up at least annually and following each dose adjustment
• Arrangement of a clinic review when the patient is between 17 to 18 years should be considered to assess continued treatment into adult services and to plan for the transfer of care if needed
GP:
• To act upon results communicated by specialist.
• To review the appropriateness of prescribing for patients who have not been seen by a specialist for over one year</td></tr>
</table>

	• Communicate with the consultant/specialist if the patient does not attend appointments
Pregnancy, paternal exposure and breast feeding 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.	**Pregnancy:** Refer the patient back to the Specialist to review patient **Breastfeeding:** Refer the patient back to the Specialist to review patient
Additional information	**Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed.** Some patients may have more individualised parameters set out by their secondary care specialist which fall outside the normal range; these should be communicated to primary care in writing. See Appendix 4
Evidence base for treatment and key references Include hyperlinks to original sources and access dates	1. NICE. Clinical Guideline 87: Attention deficit hyperactivity disorder: Diagnosis and Management (March 2018). Accessed via: https://www.nice.org.uk/guidance/ng87 2. British National Formulary for Children – accessed via BNFC (British National Formulary for Children) | NICE **Summary of Product Characteristics** – accessed via www.medicines.org.uk 3. Ritalin® (Last accessed October 2025) 4. Equasym XL® (Last accessed October 2025) 5. Medikinet® (Last accessed October 2025) 6. Medikinet XL® (Last accessed October 2025) 7. Concerta XL® (Last accessed October 2025) 8. Strattera® (Last accessed October 2025) 9. Elvanse® (Last accessed October 2025) 10. Xenidate® XL (Last accessed October 2025) 11. Amfexa ® (Last accessed October 2025) 12. Intuniv® (Last accessed October 2025) 13. Delmosart® (Last accessed October 2025) 14. Meflynate ® (Last accessed October 2025) 15. Affenid ® (Last accessed October 2025) 16. Xenidate ® (Last accessed October 2025) 17. Xaggitin ® (Last accessed October 2025) 18. Focusim XL ® (Last accessed October 2025) 19. Matoride XL (Last accessed October 2025) 20. Atenza XL ® (Last accessed October 2025) 21. Metryol XL (Last accessed October 2025) 22. Atomoxetine Treatment in Children and Adolescents with Attention-Deficit/Hyperactivity Disorder and Comorbid Oppositional Defiant Disorder. Newcorn J H et al. Journal of the American Academy of Child and Adolescent Psychiatry. 1 March 2005 (vol 44 issue 3 pages 240-8) 23. NICE ESNM19: Attention deficit hyperactivity disorder in children and young people: lisdexamfetamine dimesylate (May 2013). 24. Scottish Medicines Consortium. Lisdexamfetamine dimesylate (May 2013). 25. Coghill D, Banaschewski T et al. European, randomized, phase 3 study of lisdexamfetamine dimesylate in children and adolescents with attention-deficit/hyperactivity disorder. European Neuropsychopharmacology 2013; doi:10.1016/j.euroneuro.2012.11.012 26. Dittmann RW, Cardo E et al. Efficacy and safety of lisdexamfetamine dimesylate and atomoxetine in the treatment of Attention-Deficit/Hyperactivity Disorder: a head-to-head, randomised, double blind, Phase IIIb study. CNS Drugs 2013 DOI 10.1007/s40263-013-0104-8
To be read in conjunction with the following documents	A pharmaceutical company patient information leaflet (PIL) will be provided to the patient with each supply. Medicines for children have also produced PIL which can be accessed via the online website http://www.medicinesforchildren.org.uk/search-for-a-leaflet/ NICE has produced an information leaflet for parents:

	http://www.nice.org.uk/nicemedia/pdf/CG72UNG.pdf 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. **Information which can be provided to the schools -** Managing Medicines in Schools and Early Years Settings https://www.education.gov.uk/publications/standard/publicationdetail/page1/DFES-1448-2005 **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 (see Appendix 1) Practice letter/email from GP to secondary care (see Appendix 2 or Appendix 3)

3. COMMUNICATION AND SUPPORT

Evelina London Children's Hospital switchboard: 0207 188 7188	
Consultant/specialist team Newcomen Neurodevelopment Team	Email: gstt.elchpaedneurodevelopmentalsecretaries@nhs.net Alternative contact: clinical nurse specialist gstt.paedsneurodevnurses@nhs.net
Medication – Prescribing advice, interactions, availability of medicines Sarah-Jane Smyth - Paediatric Neurosciences Pharmacist GSTT Pharmacy Medicines Helpline	Email: gstt.mymedicines@nhs.net Tel: 0207 188 8748
South London and Maudsley (SLAM): switchboard	
Medication – Prescribing advice, interactions, availability of medicines Maudsley Medicines Information Service Petrina Douglas-Hall – Associate Director of Pharmacy – Medicines Advice	Tel: 020 3228 231

Oxleas NHS Trust switchboard	
Consultant/specialist team Integrated Neurodevelopmental Team - ADHD Service	 Tel :020 8836 8621 Email: oxl-tr.childrenstherapies@nhs.net
Medication – Prescribing advice, interactions, availability of medicines Oxleas Medicines Information	 Tel: 013 2262 500

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

NOTE: *The Information here is* ***not*** *exhaustive.* ***Please consult the current Summary of Product Characteristics (SPC) for the treatment 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)***

Drug	Indication	Place in therapy	Dose and Route of Administration		
			Preparation	**Dose**	**Notes**
Methylphenidate	Treatment of ADHD	First line for ADHD	**Immediate-release tablets** Available in the following strengths: **5mg, 10mg, 20mg**	Initially 5 mg 1–2 times a day, increased in steps of 5–10 mg daily if required, at weekly intervals, increased if necessary up to 2.1 mg/kg daily in 2–3 divided doses, max. licensed dose is 60 mg daily in 2–3 doses, (maximum of 90 mg daily under the direction of a specialist) discontinue if no response after 6 weeks	In some children rebound hyperactivity 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*	Initially 18 mg once daily in the morning, increased in steps of 18 mg daily at weekly intervals, increased if necessary up to 2.1 mg/kg daily, max. licensed dose is 54 mg daily, (maximum of 108 mg daily under the direction of a specialist) discontinue if no response after 6 weeks	Total daily dose of 15mg of immediate-release tablet is considered equivalent to 18mg once daily of modified-release tablets. 60mg of Ritalin is the maximum licensed dose. The equivalent dose of Concerta® XL is 72mg, which is above the maximum licensed dose.
			Modified-Release capsules Available in the following strengths **5mg, 10mg, 20mg, 30mg, 40mg, 50mg,60mg** ***The prescriber must specify the brand –*** *see Appendix 5* **N.B. Equasym® XL is not interchangeable with any other brand – seek specialist advice before switching.**	Initially 10mg once daily (in the morning before breakfast), increasing if necessary, in weekly increments of 10mg to a max. licensed dose of 60 mg daily, (maximum of 90 mg daily under the direction of a specialist) discontinue if no response after 6 weeks	40mg XL strength not available in Equasym® XL brand Meflynate XL® may be taken independent of food intake; Equasym XL® should be taken before food; Medikinet XL® should be taken with or after food.
Lisdexamfetamine	Licensed for ADHD for children over 6 years of age.	To be considered if methylphenidate has not been successful or tolerated	**Elvanse® 20mg. 30mg, 40mg, 50mg 60mg and 70mg Capsules**	Starting dose 30mg taken once in the morning (with or without food) The dose may be increased by10-20mg increments at approximately weekly intervals. Maximum recommended dose = 70mg/day	Lower starting dose of 20mg once daily may be needed in some patients Lisdexamfetamine may be swallowed whole, or the capsules opened and the entire contents emptied and mixed with a soft food such as yogurt or in a glass of water or orange juice
Dexamfetamine	Licensed for ADHD for children over 6 years of age.	To be considered if methylphenidate not successful or tolerated and have responded to lisdexamfetamine but	**Amfexa® tablets 5mg, 10mg 20mg** **Oral solution is 1mg/ml**	Initially 2.5 mg 2–3 times a day, increased in steps of 5 mg once weekly if required, increased if necessary up to 1 mg/kg daily, maintenance dose	

		cannot tolerate the longer effect profile		to be given in 2–4 divided doses, up to 20 mg daily (40 mg daily has been required in some children).	
Drug	**Indication**	**Place in therapy**	**Dose and Route of Administration**		
			Preparation	**Dose**	**Notes**
Atomoxetine	Licensed for ADHD for children over 6 years of age.	To be considered if methylphenidate or lisdexamfetamine has not been successful or tolerated	**Strattera® Capsules 10mg, 18mg, 25mg, 40mg, 60mg, oral solution 4mg/ml** **Child over 6 years (body-weight <70kg)**	Initially 500 micrograms/kg daily for 7 days, increased according to response; usual maintenance dose 1.2mg/kg daily, but may be increased to 1.8mg/kg daily (max. 120mg daily) under the direction of a specialist	The SPC dosing states that: *"No additional benefit has been demonstrated for doses higher than 1.2mg/kg/day. The safety of single doses over 1.8mg/kg/day and total daily doses above 1.8mg/kg has not been systematically evaluated."* [4] The 1.2mg/kg/day dose is based on 2001 data on uncomplicated 'pure' attention deficit hyperactivity disorder. The consultant-led clinic is full of complex patients with co-morbidities, and since 2005 a 1.8mg/kg/day dose is known to be more effective in this group[4].
			Child over 6 years (body-weight >70kg)	Initially 40mg daily for 7 days, increased according to response; usual maintenance dose 80mg daily, but may be increased to 120mg daily under the direction of a specialist.	
Guanfacine	Licensed for ADHD for children over 6 years of age	To be considered if methylphenidate or lisdexamfetamine has not been successful or tolerated	**Intuniv ® tablets 1mg, 2mg, 3mg, 4mg** **Child 6-17years (body-weight 25kg – 41.4kg)**	Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 4mg once daily	
			Child 13 - 17years (body-weight 41.5kg – 49.4kg)	Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 5mg once daily	
			Child 13 - 17years (body-weight 49.5kg – 58.4.kg)	Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 6mg once daily	
			Child 13 - 17years (body-weight >58.4.kg)	Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 7mg once daily	Dose can be titrated to a 7 mg/day dose after the subject has completed a minimum of 1 week of therapy on a 6 mg/day dose and the physician has performed a thorough review of the subject's tolerability and efficacy.

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	Licensed for ADHD for children over 6 years of age. **First line for ADHD**	***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
		Modified-Release CAPSULES: • *Prescribe by brand name* • Available in the following strengths: **5mg, 10mg, 20mg, 30mg, 40mg, 50mg, 60mg** • *Equivalent b*rands 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 • ***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 guidance on prescribing and switching between modified-release methylphenidate preparations, please see:* SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
ATOMOXETINE	Licensed for ADHD for children over 6 years of age.	**Strattera® capsules 10mg, 18mg, 25mg, 40mg, 60mg, 80mg, 100mg** **Oral solution 4mg/ml**
LISDEXAMFETAMINE (dimesylate) *(CD Schedule 2)*	Licensed for ADHD for children over 6 years of age.	**Elvanse® capsules 20mg, 30mg, 40mg, 50mg,60mg and 70mg**
DEXAMFETAMINE (sulphate) *(CD Schedule 2)*	Licensed for ADHD for children over 6 years of age.	**Amfexa® tablets 5mg, 10mg 20mg** **Oral solution 1mg/ml**
GUANFACINE	Licensed for ADHD for children 6-17 years old	**Intuniv® tablets 1mg, 2mg, 3mg 4mg**

*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