Humber Area Prescribing Committee

SHARED CARE FRAMEWORK for Atomoxetine

HUMBER AREA PRESCRIBING COMMITTEE

DATE APPROVED BY APC: 4TH SEPTEMBER 2024

PATIENT NAME	*NHS NUMBER*	*DATE OF BIRTH*
ADDRESS		
GP'S NAME		

We agree to treat this patient within this Prescribing Framework

Specialist Prescriber's Name…… Date:……

Specialist Prescriber's Signature……

Professional register name and registration number ……..

Consultant's name (if working under direction of Consultant) ……

Speciality/Department:……..

Primary care prescriber name: …… Date:……

Primary care prescriber Signature ……..... …….

Professional register name and registration number:……

If the General Practitioner is unable to accept prescribing responsibility for the above patient the consultant should be informed within two weeks of receipt of this framework and consultant's / nurse specialist's letter. In such cases the GP are requested to update the consultant, by letter, of any relevant changes in the patient's medication / medical condition.

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Hull	East Riding of Yorkshire	North Lincolnshire	North East Lincolnshire
√	√	X – see separate	X – see separate

Specialist responsibilities

- Assess the patient and provide diagnosis. Ensure the diagnosis is within scope of this shared care protocol (section 2) and communicated to primary care.
- Use a shared decision making approach; discuss the benefits and risks of the treatment with the patient and/or their carer and provide the appropriate counselling (see section 11), to enable the patient to reach an informed decision. Obtain and document consent. Provide an appropriate patient information leaflet.
- Ensure the patient and/or their carer understands that treatment may be stopped if they do not attend for monitoring and treatment review
- Assess for contraindications and cautions (see section 4) and interactions (see section 7).
- Conduct required baseline investigations and initial monitoring (see section 8).
- Initiate and optimise treatment as outlined in section 5. Prescribe the maintenance treatment for at least 4 weeks and until optimised.
- Once treatment is optimised, complete the shared care documentation and send to patient's GP detailing the diagnosis, current and ongoing dose, any relevant test results, and when the next monitoring is required. Include contact information (section 13).
- Prescribe sufficient medication to enable transfer to primary care, including where there are unforeseen delays to transfer of care.
- Conduct the scheduled reviews and monitoring in section 8 and communicate the results to primary care. This monitoring, and other responsibilities below, may be carried out by a healthcare professional in primary or secondary care with expertise and training in ADHD, depending on local arrangements.
- Determine the duration of treatment and frequency of review. After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in section 9 remains appropriate. Trial discontinuations should be managed by the specialist.
- Reassume prescribing responsibilities if a woman becomes or wishes to become pregnant.
- Provide advice to primary care on the management of adverse effects if required.

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Primary care responsibilities

- Respond to the request from the specialist for shared care in writing. It is asked that this be undertaken within 14 days of the request being made, where possible.
- If shared care is accepted, prescribe ongoing treatment as detailed in the specialists request and as per section 5, taking into any account potential drug interactions in section 7.
- Adjust the dose of atomoxetine prescribed as advised by the specialist.
- Conduct the required monitoring as outlined in section 9. Communicate any abnormal results to the specialist.
- Manage adverse effects as detailed in section 10 and discuss with specialist team when required.
- Stop atomoxetine and make an urgent referral for appropriate care if cerebral ischaemia or new or worsening seizures occur.
- Refer the management back to the specialist if the patient becomes or plans to become pregnant.
- Stop treatment as advised by the specialist. Trial discontinuations should be managed by the specialist.

Patient and/or carer responsibilities

- Take atomoxetine as prescribed and avoid abrupt withdrawal unless advised by their prescriber.
- Attend regularly for monitoring and review appointments with primary care and specialist, and keep contact details up to date with both prescribers. Be aware that medicines may be stopped if they do not attend.
- Report adverse effects to their primary care prescriber and consider recording adverse effects by using checklist. Seek immediate medical attention if they develop any symptoms as detailed in section 11.
- Report the use of any over the counter (OTC) medications to their prescriber and be aware they should discuss the use of atomoxetine with their pharmacist before purchasing any OTC medicines.
- Not to drive or operate heavy machinery if atomoxetine affects their ability to do so safely, and inform the DVLA if their ability to drive safely is affected (see section 11).

Patients of childbearing potential should take a pregnancy test if they think they could be pregnant, and inform the specialist or GP immediately if they become pregnant or wish to become pregnant

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Medication Choices

	Medication choice – children aged 5 years and over and young people	Medication choice – adults
Atomoxetine	**FOURTH LINE** • For patients intolerant of methylphenidate or lisdexamfetamine **OR** • After inadequate response to **separate** 6-week trials of lisdexamfetamine* **AND** methylphenidate*	**FOURTH LINE** • For patients intolerant of methylphenidate or lisdexamfetamine **OR** • After inadequate response to **separate** 6-week trials of lisdexamfetamine* **AND** methylphenidate*
Dexamfetamine	**THIRD LINE** • For patients responding to but intolerant of lisdexamfetamine	**THIRD LINE** • For patients responding to but intolerant of lisdexamfetamine
Guanfacine	**FOURTH LINE** • For patients intolerant of methylphenidate or lisdexamfetamine **OR** • After inadequate response to separate 6-week trials of lisdexamfetamine* **AND** methylphenidate*	**ONLY ON ADVICE OF TERTIARY SERVICES**
Lisdexamfetamine	**SECOND LINE** • After inadequate response to 6-week trial of methylphenidate*	**FIRST LINE** **OR** **SECOND LINE** • After inadequate response to trial of methylphenidate*
Methylphenidate	**FIRST LINE**	**FIRST LINE** **OR** **SECOND LINE** • After inadequate response to trial of lisdexamfetamine*
* AT ADEQUATE DOSE		

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Shared Care Framework for *Atomoxetine for ADHD in children over 6 years and adults.*

1. Introduction:	Atomoxetine is a sympathomimetic drug indicated for the treatment of attention deficit hyperactivity disorder (ADHD). It is an alternative treatment option in patients who cannot tolerate lisdexamfetamine or methylphenidate, or whose symptoms have not responded to separate 6-week trials of lisdexamfetamine or methylphenidate (see NICE Guidance NG87 Attention deficit hyperactivity disorder: diagnosis and management). NICE recommends that people with ADHD have a comprehensive, holistic shared treatment plan that addresses psychological, behavioural and occupational or educational needs. Atomoxetine is licensed for use in adults with ADHD of at least moderate severity. Adults should have ADHD symptoms pre-existing from childhood, which should ideally be confirmed by a third party. Atomoxetine should be used as part of a comprehensive treatment programme, typically including psychological, educational, and social measures. Where a person with ADHD is treated by a Child and Adolescent Mental Health Service (CAMHS) or paediatric service but is approaching their 18th birthday, it is expected that CAMHS/paediatrics will refer to the appropriate adult service if a need for ongoing treatment is anticipated. NICE Guidance NG43 Transition from children's to adults' services for young people using health or social care services should be followed. During the transition to adult services, a formal meeting involving CAMHS and/or paediatrics and adult psychiatric services should be considered, and full information provided to the young person about adult services. For young people aged 16 years and older, the care programme approach (CPA) should be used as an aid to transfer between services. The young person, and when appropriate the parent or carer, should be involved in the planning. Long-term usefulness of atomoxetine for extended periods (over 12 months) should be periodically re-evaluated for the individual patient. Consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate.	
2. Indication:	Licensed indication: attention deficit hyperactivity disorder (ADHD)	
3. Licensing Information	In children doses above 100mg daily are not licensed In adults doses above 120mg are not licensed (Both doses maximum doses are as per BNF maximum dose).	
	Route	Oral

4. Pharmaceutical Information	Formulation	Atomoxetine hydrochloride hard capsules: 10 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg, 100 mg Atomoxetine hydrochloride 4 mg/mL oral solution
	Administration details	Atomoxetine can be taken with or without food. Capsules should not be opened for administration: risk of irritation. Oral solution should not be mixed with food or water; it can prevent the full dose being administered and can negatively affect the taste. If a dose is missed then take it as soon as possible, but no later than the early evening. Do not take more than the usual total daily dose in any 24 hour period. A double dose should not be taken to make up for a missed dose.
	Additional information	The initiating specialist will decide the formulation on an individual basis as this will depend on the needs and preferences of the patient.
5. Supporting evidence	Overview | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE	
6. Initiation on ongoing dosage regimen	**Initial stabilisation:** • CHILD 6-17 years (Body-weight up to 70kg): Initially 500micrograms/kg daily for at least 7 days, • CHILD 6–17 years (Body-weight 70kg and above): Initially 40mg daily for at least 7 days, • Adults weighing 70 kg or above: 40 mg daily for at least 7 days, • Adults weighing up to 70 kg: 500 micrograms/kilogram daily for at least 7 days Then titrated according to clinical response and tolerability. Total daily dose may be given as a single dose in the morning or in two equally divided doses, with the last dose no later than the early evening. **The initial stabilisation period must be prescribed by the initiating specialist.** **Maintenance dose (following initial stabilisation):** • CHILD 6-17 years (Body-weight up to 70kg): increased according to response; usual maintenance dose is 1.2mg/kg daily but may be increased to 1.8mg/kg daily (max 120mg daily) [unlicensed]. Total	

daily dose may be given either as a single dose in the morning or in 2 divided doses with the last dose no later than early evening.

- CHILD 6–17 years (Body-weight 70kg and above): increased according to response; usual maintenance 80mg daily, but may be increased to max. 120mg daily [unlicensed] under the direction of a specialist; Total daily dose may be given either as a single
- Adults weighing 70 kg or above: 80 mg to 100 mg daily in a single dose, or in two equally divided doses, as above. Usual maximum total daily dose is 100 mg. Higher doses, up to a maximum of 120 mg, are off-label and must be given under the direction of a specialist.
- Adults weighing up to 70 kg: up to 1.2 mg/kg daily in a single dose, or in two equally divided doses, as above. Usual maximum total daily dose is 1.8 mg/kg daily. Higher doses, up to a maximum of 120 mg, are off-label and must be given under the direction of a specialist.

The initial maintenance dose must be prescribed by the initiating specialist.

The patient should have received at least one month's treatment from the psychiatrist/paediatrician, been shown to respond and the dosage stabilised before prescribing is transferred to the GP. Once the patient has been stabilised a further 4-week supply will be prescribed by the psychiatrist/paediatrician to allow adequate time for information to be passed to their General Practitioner.

Conditions requiring dose adjustment:

Hepatic insufficiency:

- moderate hepatic insufficiency (Child-Pugh Class B) reduce starting and target doses to 50% of usual (reduce dose by half, i.e. starting dose should be 20mg daily, and total daily dose should not exceed 50mg daily)
- severe hepatic insufficiency (Child-Pugh Class C) reduce starting and target doses to 25% of usual (reduce dose by three quarters, i.e. starting dose should be 10mg daily, and total daily dose should not exceed 25mg daily)

Renal insufficiency:

	No adjustment is necessary, but be aware that atomoxetine may exacerbate hypertension in patients with end stage renal disease. <u>Known CYP2D6 poor metaboliser genotype</u>: • Due to several-fold increase in atomoxetine exposure, consider a lower starting dose and slower up-titration.
7. Contraindications and Warnings:	Contraindications: • Hypersensitivity to the active substance or to any of the excipients • During treatment with monoamine oxidase inhibitors (MAOI), or within 14 days of discontinuing those drugs, due to the risk of hypertensive crisis • Narrow angle glaucoma • Severe cardiovascular or cerebrovascular disorders, including severe hypertension, heart failure, arterial occlusive disease, angina, haemodynamically significant congenital heart disease, cardiomyopathies, myocardial infarction, potentially life-threatening arrhythmias, disorders caused by the dysfunction of ion channels, cerebral aneurysm, or stroke • History of phaeochromocytoma Cautions: • Psychiatric and neuropsychiatric symptoms or disorders, including psychotic symptoms, aggressive or hostile behaviour, emotional lability, suicide-related behaviour (suicide attempts or suicidal ideation), motor or verbal tics, anxiety, depressive symptoms, and mania • Known serious structural cardiac abnormalities; consultation with a cardiac specialist required before treatment • Underlying medical conditions which could be worsened by increases in blood pressure and heart rate, including hypertension, tachycardia, or cardiovascular or cerebrovascular disease • Prolonged QT interval (congenital or acquired, e.g. drug-induced) or family history of QT prolongation • Any condition that may predispose patients to hypotension or conditions associated with abrupt heart rate or blood pressure changes (risk of orthostatic hypotension) • Concomitant medications that elevate blood pressure: assess for neurological signs and symptoms at every monitoring visit • Other conditions that may precipitate or otherwise induce cerebrovascular conditions: assess for neurological signs and symptoms at every monitoring visit • Hepatic insufficiency; dose adjustments required, see section 5. • History of seizures • Susceptibility to angle-closure glaucoma • Age over 65 years; safety and efficacy has not been systematically evaluated

	• Known CYP2D6 poor metaboliser genotype. Dose reduction required, see section 5.
8. Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist	**Baseline investigations:** • A full assessment, as recommended by NICE guidance for ADHD. This should include a medical history and cardiovascular assessment, taking into account conditions that may be contraindications for atomoxetine, and to ensure the patient meets the criteria for ADHD and that pharmacological treatment is required • Risk assessment for substance misuse and drug diversion • Height, weight, and body mass index (BMI) – measured and recorded against the normal range for age, height and sex • Appetite • Blood pressure (BP) and heart rate - measured with an appropriately sized cuff and compared with the normal range for age • Electrocardiogram (ECG) and cardiology opinion are recommended if the patient has any of the following: o history of congenital heart disease or previous cardiac surgery o sudden death in a first-degree relative under 40 years suggesting a cardiac disease o shortness of breath on exertion compared with peers o fainting on exertion or in response to fright or noise o palpitations o chest pain suggestive of cardiac origin o signs of heart failure, heart murmur or hypertension o current treatment with a medicine that may increase cardiac risk **Initial monitoring:** • Before every change of dose: assess heart rate, blood pressure, and weight. • After every change of dose: assess heart rate and blood pressure, and any new or worsening psychiatric symptoms. The specialist should determine the appropriate timing for this monitoring. • including development or worsening of tic and movement disorders • Assessment of symptom improvement. Discontinue if no improvement is observed after 4-8 weeks. **Ongoing monitoring:** Ensure the patient receives a review at least annually with a healthcare professional with training and expertise in managing ADHD. This may be

	in primary or secondary care, depending on local arrangements, and should include a review of ADHD medication, including patient preferences, benefits, adverse effects, and ongoing clinical need. Consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate. If continuing medication, document the reasons why. Review outcomes should be communicated to the primary care prescriber in writing, with any urgent changes also communicated by telephone. After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in section 9 remains appropriate.	
9. Ongoing monitoring requirements to be undertaken by primary care	Monitoring	Frequency
	• Blood pressure and heart rate, and assessment for cardiovascular signs or symptoms	At least every 6 months • Monitor heart rate and blood pressure and compare with the normal range for age before and after each dose change and every 6 months. • If a person taking ADHD medication has sustained resting tachycardia (more than 120 beats per minute), arrhythmia or systolic blood pressure greater than the 95th percentile (or a clinically significant increase) measured on 2 occasions, reduce their dose and refer them to a paediatric hypertension specialist or adult physician
	• Weight and height	• Measure height every 6 months in children and young people • Measure weight every 3 months in children 10 years and under • Measure weight at 3 and 6 months after starting treatment in children over 10 years and young people, and every 6 months thereafter, or more often if concerns arise • Measure weight every 6 months in adults • Plot height and weight of children and young people on a growth chart and ensure review by the healthcare professional responsible for treatment
	• Appetite	At least every 6 months

	• Assessment for new or worsening psychiatric and neurological signs or symptoms	At least every 6 months
	• Assessment of adherence, and for any indication of atomoxetine abuse, misuse, or diversion	As required, based on the patient's needs and individual circumstances
	• Review to ensure patient has been offered and attended an annual review with a healthcare professional with expertise in ADHD	Annually
	(If relevant) If monitoring results are forwarded to the specialist team, please include clear clinical information on the reason for sending, to inform action to be taken by secondary care.	
10. Interactions	The following drugs are known or suspected interactions and the GP may wish to discuss with the initiating specialist before commencing:	
	Interacting Drug	Advice
	MAOIs	Avoid atomoxetine use whilst using MAOIs and for a minimum of 14 days after stopping MAOIs. Increased risk of adverse effects.
	CYP2D6 inhibitors	Increased atomoxetine exposure. E.g. selective serotonin reuptake inhibitors (SSRIs), quinidine, terbinafine, bupropion, cinacalcet, dacomitinib, and panobinostat. Slower dose titration and lower final dose may be necessary. Clinical response and tolerability should be re-evaluated if a CYP2D6 inhibitor is started or stopped.
	Potent inhibitors of other cytochrome P450 isoforms	In patients who are poor CYP2D6 metabolisers. It is not clear whether there is a clinically significant increase in atomoxetine exposure in this patient group.
	Beta-2 agonists, including salbutamol	High dose beta-2 agonists, such as salbutamol, may potentiate cardiovascular effects.
	Drugs which prolong the QT interval	Risk of QT interval prolongation. E.g. antipsychotics, class IA and III anti arrhythmics, some antibiotics such as

		ciprofloxacin or erythromycin, methadone, mefloquine, tricyclic, antidepressants, lithium, and some selective serotonin reuptake inhibitors (SSRIs) such as citalopram.
	Drugs which cause electrolyte imbalance	Risk of QT interval prolongation. E.g. thiazide diuretics.
	Drugs which lower the seizure threshold	Risk of seizures. E.g. tricyclic antidepressants, SSRIs, antipsychotics, phenothiazines, mefloquine, chloroquine, bupropion, and tramadol. Use caution when stopping medications that may induce seizures on withdrawal, such as benzodiazepines.
	Anti-hypertensive drugs	Effectiveness of anti-hypertensives may be decreased, monitoring is required.
	Drugs that increase blood pressure	Possible additive effects, monitoring is required.
	Drugs that affect noradrenaline:	Possible additive or synergistic pharmacological effects. E.g. dexamfetamine, lisdexamfetamine, imipramine, venlafaxine, mirtazapine, pseudoephedrine, phenylephrine.
	Other interacting agents: *No further interacting agent* **For full list see SPC at www.medicines.org.uk/emc and BNF**	
11. Adverse effects and management	Adverse effects	Action for GP
	As well as responding to absolute values in laboratory tests, a rapid change or a consistent trend in any value should prompt caution and extra vigilance.	
	Cardiovascular	Resting HR greater than 120bpm, arrhythmia/palpitations, clinically significant increase in systolic BP
	Hypertension	Manage as per local pathways, taking into account risk of clinically significant interactions with several types of antihypertensive medication (see section 7).

		If blood pressure is significantly raised (see guidance box immediately above), reduce dose of atomoxetine by half and discuss with specialist for further advice.
	Gastrointestinal disorders Including abdominal pain, vomiting, nausea, constipation, dyspepsia	Review and provide advice on dosing; patients may benefit from taking atomoxetine in two equally divided doses (once in the morning, and once in the late afternoon or early evening). Generally resolves.
	Weight or BMI outside healthy range, including anorexia or weight loss	Recommend small, frequent meals and/or snacks, and high calorie foods of good nutritional value. Recommend taking atomoxetine with or after meals, and not before. Obtain dietary advice if required. Discuss with specialist if difficulty persists; dose reduction, treatment break, or change of medicine may be required.
	Psychiatric disorders New or worsening psychiatric symptoms, e.g. suicide related behaviour, psychosis, mania, aggressive or hostile behaviour, suicidal ideation or behaviour, motor or verbal tics (including Tourette's syndrome), anxiety, agitation or tension, bipolar disorder, or depression	Contact specialist team and refer for psychiatric assessment if appropriate. Refer for urgent psychiatric assessment if suicide related behaviour or ideation occurs. Discuss ongoing benefit of treatment with specialist team.
	Hepatic effects Signs or symptoms of liver injury, e.g. abdominal pain, unexplained nausea, malaise, jaundice, or darkening of urine	Perform liver function tests (LFTs), including serum bilirubin, and discuss with specialist team. Discontinue atomoxetine permanently in patients who develop jaundice or for whom there is laboratory evidence of liver injury (if unclear if injury or transient derangement, discuss urgently with specialist).
	Nervous system disorders Somnolence or sedation	Review and provide advice on dosing; patients may benefit from taking atomoxetine in two equally divided doses (once in the morning, and once

		in late afternoon or early evening). Generally resolves.
	New onset of seizures, or increased seizure frequency	Discuss with specialist team. Discontinuation of atomoxetine should be considered.
12. Advice to patients and carers The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.	**The patient should be advised to report any of the following signs or symptoms to their primary care prescriber without delay:** • Abnormally sustained or frequent and painful erections. **If an erection persists for more than 2 hours go to A&E**; this is an emergency. • Sudden acute, painful eye(s), impaired vision, red eye(s), and/or semi-dilated and fixed pupil; risk of **angle closure glaucoma**, seek immediate medical attention, ideally from an eye casualty unit or A&E. • Symptoms suggestive of cardiac disease (e.g. palpitations, exertional chest pain, unexplained syncope, or dyspnoea). • New or worsening psychiatric symptoms (e.g. psychotic symptoms, aggressive or hostile behaviour, emotional lability, suicide-related behaviour (suicide attempts or suicidal ideation), motor or verbal tics, anxiety, depressive symptoms, or mania). • Report **suicidal thoughts or behaviour**, and development or worsening of irritability, agitation, and depression. • New or worsening neurological symptoms (e.g. severe headache, numbness, weakness, paralysis, seizures, or impairment of coordination, vision, speech, language, or memory). • Risk of **hepatic injury**: report unexplained nausea, malaise, jaundice, or darkening of urine, and new onset severe or persistent abdominal pain. • Symptoms of allergic or anaphylactic reactions (e.g. rash, angioedema, or urticaria). • If they suspect they may be pregnant or are planning a pregnancy. **The patient should be advised:**	

	• Not to drive or operate machines if atomoxetine affects their ability to do so safely, e.g. by causing dizziness, drowsiness, or fatigue, and to inform the DVLA if their ability to drive safely is affected. See https://www.gov.uk/adhd-and-driving. • Not to stop taking atomoxetine without talking to their doctor and not to share their medicines with anyone else. Patient information: • Royal College of Psychiatrists – ADHD in adults. https://www.rcpsych.ac.uk/mental-health/problems-disorders/adhd-in-adults • NHS – Attention deficit hyperactivity disorder. https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/ • Patient information leaflets are also available from https://www.medicines.org.uk/emc/search?q=atomoxetine
13. Preconception, 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.	**Preconception** No specific advice **Pregnancy:** Atomoxetine is not recommended for use during pregnancy unless a clinical decision is made that the potential benefit outweighs the risk to the fetus. Evidence on exposure to atomoxetine during pregnancy is too limited to draw firm conclusions on adverse outcomes. Clinicians should be aware that patients may have other risk factors which independently alter the risks, and additional monitoring should be considered on a case-by-case basis. Patients who become pregnant while taking atomoxetine, or who plan a pregnancy, should be referred to the specialist team for review. **Breastfeeding:** There is no published evidence on the safety of atomoxetine in breastfeeding. Decisions to use atomoxetine while breastfeeding should be made on a case-by-case basis, taking into account the risks to the infant and the benefits of therapy. Long half-life in slow metabolisers increases risk of accumulation in some breastfed infants. Infants should be monitored for symptoms of CNS stimulation (e.g. decreased appetite or slow weight gain, sleep disturbances, gastrointestinal symptoms), although these may be difficult to detect.

	Information for healthcare professionals: https://www.sps.nhs.uk/medicines/atomoxetine/ **Paternal Exposure** No evidence regarding adverse outcomes following paternal exposure was identified.
14. Specialist contact information	Name: *Consultant as per clinic letter* Role and specialty: *as per clinic letter* Daytime telephone number: *as per clinic letter* Email address: *as per clinic letter* Alternative contact during Office hours: • hnf-tr.adhdinterventionduty@nhs.net • CAMHS contact: 01482 692929 - Option 2 • HNF-TR.MedicinesInformation@nhs.net • or contact specialist as per clinic letter
15. Local arrangements for referral Define the referral procedure from hospital to primary care prescriber & route of return should the patient's condition change.	Contact as above.
16. To be read in conjunction with the following documents	• Shared Care for Medicines Guidance – A Standard Approach (RMOC). Available from https://www.sps.nhs.uk/articles/rmoc-shared-care-guidance/ • NHSE guidance – Responsibility for prescribing between primary & secondary/tertiary care. Available from https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/ • General Medical Council. Good practice in prescribing and managing medicines and devices. Shared care. Available from https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care NICE NG197: Shared decision making. Last updated June 2021. https://www.nice.org.uk/guidance/ng197/.

Document and version control	**This information is not inclusive of all prescribing information and potential adverse effects. Please refer to the SPC (data sheet) or BNF for further prescribing information.**	
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	Date approved by APC:	4th September 2024
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Humber Area Prescribing Committee

Version number	Author	Job title	Revision description:
1	Jane Morgan	Principal Pharmacist HUTH	New document adapted from RMOC version with paediatrics added in from previous version