Humber Area Prescribing Committee

SHARED CARE FRAMEWORK for Dexamphetamine

HUMBER AREA PRESCRIBING COMMITTEE

DATE APPROVED BY APC: 4TH SEPTEMBER 2024

REVIEW DATE: SEPTEMBER 2025

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 12), 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 7) and interactions (see section 10).
- Conduct required baseline investigations and initial monitoring (see section 8).
- Initiate and optimise treatment as outlined in section 6. Prescribe the maintenance treatment for at least 4 weeks and until optimised.
- Prescribe in line with controlled drug prescription requirements (section 4).
- Once treatment is optimised, complete the shared care documentation and send to patient's GP practice detailing the diagnosis, brand to be prescribed, current and ongoing dose, any relevant test results and when the next monitoring is required. Include contact information (section 14).
- Prescribe sufficient medication to enable transfer to primary care, including where there are unforeseen delays to transfer of care.
- Conduct the required 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.

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 specialist's request and as per section 4, taking into account any potential drug interactions in section 10.
- Prescribe in line with controlled drug prescription requirements (section 4).
- Adjust the dose of methylphenidate prescribed as advised by the specialist.
- Conduct the required monitoring as outlined in section 9. Communicate any abnormal results to the specialist.
- Assess for possible interactions with methylphenidate when starting new medicines (see section 10).
- Manage any adverse effects as detailed in section 11 and discuss with specialist team when required.
- Stop methylphenidate and make an urgent referral for appropriate care if cerebral ischaemia, new or worsening seizures, or serotonin syndrome are suspected.
- 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 methylphenidate 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. Seek immediate medical attention if they develop any symptoms as detailed in section 12.
- Report the use of any over the counter medications (OTC) to their primary care prescriber and be aware they should discuss the use of methylphenidate with their pharmacist before purchasing any OTC medicines.
- Not to drive or operate heavy machinery if methylphenidate affects their ability to do so safely, and inform the DVLA if their ability to drive safely is affected (see section 12).
- Avoid alcohol during treatment, as it may make some side effects worse. Avoid recreational drugs.
- Methylphenidate is a schedule 2 controlled drug. Patients may be required to prove their identity when collecting prescriptions, and should store methylphenidate safely and securely. It must not be shared with anyone else.

- 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.

Shared Care Framework for *Dexamphetamine for ADHD (children and adults) and Narcolepsy (adults)*

1. Introduction:	Dexamfetamine sulfate is a sympathomimetic amine with central stimulant and anorectic activity indicated for the treatment of attention deficit hyperactivity disorder (ADHD). It may be offered as an alternative treatment in patients who have been appropriately diagnosed and whose symptoms are responding to lisdexamfetamine but are unable to tolerate the drug's longer effect profile (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. Dexamfetamine is not licensed for all the indications listed in section 2. However, its use for the indications below are established and supported by various sources and bodies including the BNF and NICE. Dexamfetamine is a schedule 2 controlled substance; all legal requirements for prescribing controlled drugs should be followed. See NICE Guidance NG46 Controlled drugs: safe use and management. Where a person with ADHD is treated by a Child and Adolescent Mental Health Service (CAMHS) but is approaching their 18th birthday, it is expected that CAMHS will refer to the appropriate adult service if need for ongoing treatment is anticipated. Long-term usefulness of dexamfetamine for extended periods (over 12 months) should be periodically re-evaluated by a healthcare professional with expertise in ADHD for the individual patient with trial periods off medication to assess the patient's functioning without pharmacotherapy. It is recommended a trial discontinuation at least once yearly to assess the patient's condition. Improvement may be sustained when the medicinal product is either temporarily or permanently discontinued.

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2. Indication:	• *Attention deficit hyperactivity disorder (ADHD) in adults and children* • *Narcolepsy with or without cataplexy*	
3. Licensing Information	*Dexamphetamine is not licensed for adults for ADHD*	
4. Pharmaceutical Information	Route	Oral
	Formulation	Dexamfetamine sulfate 5mg immediate release tablets Dexamfetamine sulfate 5mg/5mL sugar-free oral solution ▼ Please note licensed indications vary by manufacturer. See SPCs for full details
	Administration details	Tablets can be halved Dexamfetamine should not be taken too late after lunch time to avoid disturbances of sleep If a dose is missed then the next scheduled dose should be taken as usual; a double dose should not be taken to make up for a missed dose.
	Additional information	Dexamfetamine is a schedule 2 controlled drug and is subject to legal prescription requirements. It has the potential for misuse and diversion. Patients should be advised to avoid alcohol which may exacerbate the central nervous system (CNS) side-effects of dexamfetamine. Dexamfetamine is subject to additional monitoring by the Medicines and Healthcare products Regulatory Agency (MHRA) and healthcare professionals are encouraged to report any suspected adverse reactions Amfetamines can cause a significant elevation in plasma corticosteroid levels. This increase is greatest in the evening. Amfetamines may interfere with urinary steroid determinations
5. Supporting evidence	Overview | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE	
6. Initiation on ongoing dosage regimen	• Transfer of monitoring and prescribing to primary care is normally after at least 12 weeks, and when the patient's dose has been optimised and with satisfactory investigation results for at least 4 weeks. • The duration of treatment & frequency of review will be determined by the specialist, based on clinical response and tolerability.	

	• All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care clinician. • Termination of treatment will be the responsibility of the specialist. **<u>Initial stabilisation:</u>** **ADHD** **CHILDREN AND YOUNG PEOPLE:** CHILD 6–18 years 2.5mg 2–3 times daily, increased if necessary at weekly intervals by 5mg daily, usual max. 1mg/kg (up to 20mg) daily in 2 to 4 divided doses (40mg daily has been required in some children) • Note any children under 6 years requiring treatment will be prescribed by specialist. **ADULTS**: Initially 5 mg twice daily, dose should be increased according to response at intervals no shorter than 1 week. **Narcolepsy:** Initially 10 mg daily in divided doses, increased in steps of up to 10 mg weekly. **Dexamfetamine must be prescribed by the initiating specialist during initiation and dose stabilisation.** **<u>Maintenance dose (following initial stabilisation):</u>** ADHD and Narcolepsy: maximum 60 mg per day to be given in 2–4 divided doses; **The initial maintenance dose must be prescribed by the initiating specialist**. **<u>Conditions requiring dose adjustment:</u>** • 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. This should be undertaken and supervised by the specialist who will advise the patient and primary care prescriber of the outcome.
7. Contraindications and Warnings:	**Contraindications:** • Known hypersensitivity to the active substance, any of the excipients, or sympathomimetic amines • Glaucoma • Phaeochromocytoma

	• Certain pre-existing cardiovascular disorders constitute contraindications unless specialist cardiac advice is obtained and documented. These include; structural cardiac abnormalities and/or moderate or severe hypertension, heart failure, arterial occlusive disease, angina, haemodynamically significant congenital heart disease, cardiomyopathies, myocardial infarction, potentially life-threatening arrhythmias and channelopathies (disorders caused by the dysfunction of ion channels) • Advanced arteriosclerosis • Concomitant use of monoamine oxidase inhibitors (MAOI) or within 14 days of MAOI treatment • Hyperthyroidism or thyrotoxicosis. • Severe depression, anorexia nervosa/anorexic disorders, suicidal ideation, hyperexcitability, psychotic symptoms, severe and episodic (Type I) Bipolar (affective) Disorder (that is not well-controlled), schizophrenia, psychopathic/borderline personality disorder • Gilles de la Tourette syndrome or similar dystonias • Cerebrovascular disorders (cerebral aneurysm, vascular abnormalities including vasculitis or stroke) • Porphyria • History of drug abuse or alcohol abuse • Pregnancy (see section 12) **Cautions:** • History of epilepsy (discontinue if seizures occur) • Mild hypertension, history of cardiovascular disease, or concomitant medications that elevate blood pressure • susceptibility to angle-closure glaucoma • Psychiatric and neuropsychiatric symptoms or disorders, including manic or psychotic symptoms, aggressive or hostile behaviour, tics, anxiety/agitation, or bipolar disorder

	• Depressive symptoms; patients should be screened for risk of bipolar disorder, including psychiatric and family histories. • Renal and hepatic insufficiency (due to lack of data). • Family history of sudden cardiac or unexplained death or malignant arrhythmia • Breast-feeding (see section 12) Potential for abuse, misuse, or diversion.

8. Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist	**Baseline investigations:**
	• A medical history and cardiovascular assessment, taking into account conditions that may be contraindications, risk of pregnancy (where applicable), and to ensure the patient meets the criteria for ADHD and that pharmacological treatment is required
	• A risk assessment for substance misuse and drug diversion
	• Blood pressure (BP) and heart rate (measured with an appropriately sized cuff and compared with the normal range for age).
	  ○ Refer to a paediatric hypertension specialist before starting medication for ADHD if blood pressure is consistently above the 95th centile for age and height for children and young people
	• Height, weight and body mass index (BMI). Measured and recorded against the normal range for age, height and sex.
	• Arrange for electrocardiogram (ECG), only if the patient has any of the following:
	  ○ History of congenital heart disease or previous cardiac surgery
	  ○ Sudden death in a first-degree relative under 40 years suggesting a cardiac disease
	  ○ Shortness of breath on exertion compared with peers
	  ○ Fainting on exertion or in response to fright or noise
	  ○ Palpitations
	  ○ Chest pain suggestive of cardiac origin
	  ○ Signs of heart failure, heart murmur or hypertension
	  ○ Current treatment with a medicine that may increase cardiac risk

<table>
<tr><td></td><td colspan="2">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
• Assessment of symptom improvement. Discontinue if no improvement is observed after one month.

Ongoing monitoring (ADHD):
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.</td></tr>
<tr><td rowspan="4">9. Ongoing monitoring requirements to be undertaken by primary care</td><td>Monitoring</td><td>Frequency</td></tr>
<tr><td>Measure height</td><td>Children and young people only
• Every 6 months</td></tr>
<tr><td>Weight and check appetite</td><td>Age 10 years and under:
Every 3 months, and after any change of dose recommended by specialist team.
Age over 10 years and young people:
At 3 months and 6 months after starting treatment and every 6 months thereafter, and after any change of dose recommended by specialist team.
Adults:
Every 6 months, and after any change of dose recommended by specialist team</td></tr>
<tr><td>Growth chart</td><td>Plot height and weight of children and young people on a growth chart and ensure review by the</td></tr>
</table>

		healthcare professional responsible for treatment
	Blood pressure and heart rate, and assessment for cardiovascular signs or symptoms	Every 6 months, and after any change of dose recommended by specialist team. Compare with the normal range for age.
	Assessment for new or worsening psychiatric and neurological signs or symptoms (e.g. tics, anxiety, symptoms of bipolar disorder)	Every 6 months, and after any change of dose recommended by specialist team.
	Explore whether patient is experiencing any difficulties with sleep	Every 6 months, and after any change of dose recommended by specialist team.
	Assessment of adherence, and for any indication of dexamfetamine 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:	
	The following medicines must not be prescribed without consultation with the specialist: • **Mono-amine oxidase inhibitors (MAOIs) and other sympathomimetics** (e.g. rasagiline, selegiline, safinamide) – additive hypertensive effect • **Clonidine** – increased duration of action of dexamfetamine, reduced antihypertensive action of clonidine **Other clinically significant interactions** • **Coumarin anticoagulants, anticonvulsants, selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs)**:	

	metabolism may be inhibited by dexamfetamine. Dose adjustment may be required when starting or stopping dexamfetamine. • **SSRIs (e.g. fluoxetine, paroxetine)**: may increase exposure to dexamfetamine. Risk of serotonin syndrome. • **Serotonergic drugs, bupropion, tapentadol, tramadol:** Risk of serotonin syndrome • **TCAs and nabilone**: may increase risk of cardiovascular adverse events. • **Anticonvulsants (e.g. phenobarbital, phenytoin, primidone)**: Metabolism may be inhibited and absorption may be delayed by dexamfetamine. Dose adjustment may be required when stopping or starting dexamfetamine. • **Antacids** (e.g. sodium bicarbonate) **and urinary alkalinizing agents** (e.g. acetazolamide, some thiazides): may increase exposure to dexamfetamine • **Gastrointestinal acidifying agents** (e.g. ascorbic acid, fruit juices) and **urinary acidifying agents** (e.g. ammonium chloride, sodium acid phosphate): may reduce exposure to dexamfetamine • **Antihistamines:** sedative effect may be counteracted • **Antihypertensives, including guanethidine**: effects may be reduced by dexamfetamine • **Beta-blockers (e.g. propranolol)**: risk of severe hypertonia. May reduce effects of dexamfetamine • **Lithium, phenothiazines, haloperidol**: may reduce the effects of dexamfetamine • **Disulfiram**: may inhibit metabolism and excretion of dexamfetamine • **Opioids**: analgesic effects may be increased and the depressant effects (e.g. respiratory depression) may be decreased by dexamfetamine • **Halogenated anaesthetics:** risk of sudden blood pressure increase during surgery. Avoid dexamfetamine on the day of planned surgery.

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- **Cytochrome P450 (CYP450) substrates, inducers or inhibitors**: use with caution; role of CYP450 in dexamfetamine metabolism is not known
- **Alcohol:** may exacerbate adverse CNS effects of dexamfetamine
- **Apraclonidine:** effects decreased by dexamfetamine
- **Ritonavir, tipranavir:** may increase exposure to dexamfetamine

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<tr><td></td><td colspan="2">Other interacting agents:
If immunosuppressant include vaccines info here
For full list see SPC at www.medicines.org.uk/emc and BNF</td></tr>
<tr><td rowspan="5">11. Adverse effects and management</td><td>Adverse effects</td><td>Action for GP</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Resting HR greater than 120bpm, arrhythmia/palpitations, clinically significant increase in systolic BP</td><td>

- In context of recent dose increase, revert to previous dose and discuss with specialist for ongoing management
- In absence of recent dose changes, reduce dose by half and discuss with specialist or cardiology for further advice.

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<tr><td>New or worsening seizures</td><td>Stop dexamfetamine and discuss with specialist. Discontinuation may be indicated.</td></tr>
<tr><td>Anorexia or weight loss, weight or BMI outside healthy range</td><td>Exclude other reasons for weight loss. Exclude other reasons for weight loss. Give advice as per NICE NG87:

- take medication with or after food, not before
- additional meals or snacks early in the morning or late in the evening when stimulant effects have worn off
- obtaining dietary advice

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</table>

		• consuming high-calorie foods of good nutritional value Discuss with specialist if difficulty persists; dose reduction, treatment break, or change of medication may be required.
	Insomnia, sleep disturbance/nightmares, sedation, sexual dysfunction	Review timing of doses and continue treatment unless severe, Give advice on sleep hygiene. Discuss with specialist if required
	Nausea, diarrhoea, abdominal cramps, constipation, dry mouth, headache, dizziness, enuresis, increased daytime urination, tics	Continue treatment unless severe. Some symptoms may be alleviated by concomitant food intake. Discuss with specialist if required
	New or worsening psychiatric or neuropsychiatric symptoms, e.g. mania, depression, paranoia, anxiety and agitation. NB: psychosis may occur following consumption of very high doses.	Discuss with specialist. Stop treatment and consider referral to acute mental health team if suicidal thoughts, mania, or psychosis are present
	Symptoms of serotonin syndrome, e.g. agitation, hallucinations, coma, tachycardia, labile blood pressure, hyperthermia, hyperreflexia, incoordination, rigidity, nausea, vomiting, diarrhoea	Discontinue dexamfetamine as soon as possible. Management depends on severity; use clinical judgement and seek advice if necessary. Discuss with specialist team to determine whether dexamfetamine can be re-started.
	Suspicion of abuse, misuse, or diversion	Discuss with specialist team
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/carer should be advised to report any of the following signs or symptoms to their primary care prescriber without delay:** • Any mood changes, such as depression, paranoia, anxiety or agitation, psychosis, mania, and suicidal ideation • Palpitations, chest pain or syncope • Cerebrovascular symptoms, such as severe headache, numbness, weakness, paralysis, and impairment of coordination, vision, speech, language, or memory • Abdominal pain, malaise, jaundice or darkening of urine • Skin rashes, or bruising easily • If they suspect they may be pregnant, or are planning a pregnancy. Patients of childbearing potential should use appropriate	

	contraception, and take a pregnancy test if they think there is a possibility they could be pregnant. **The patient/carer should be advised:** • Attend regularly for monitoring and review appointments with primary care and specialist, and keep contact details up to date with both prescribers. It may not be safe to continue prescribing without regular review, and patients should be aware that their medicines could be stopped if they do not attend appointments. • Dexamfetamine can affect impair cognitive function and is subject to drug driving laws, therefore patients must ensure their ability to drive is not impaired before driving. For information on 2015 legislation regarding driving whilst taking certain controlled drugs, including amfetamines, see drugs and driving: the law. People who drive must inform the DVLA if their ADHD, narcolepsy or medicines affect their ability to drive safely. See https://www.gov.uk/adhd-and-driving or https://www.gov.uk/narcolepsy-and-driving. • Avoid alcohol while taking dexamfetamine, as it may make some side effects worse. Avoid recreational drugs. Due to the risks of severe depression, over-activity, extreme fatigue as well as changes in the EEG during sleep, abrupt withdrawal after a prolonged period of intake of high doses of dexamfetamine should be avoided. Patients wishing to reduce their dose or stop dexamfetamine treatment should discuss with their specialist before doing so. • Dexamfetamine is a schedule 2 controlled drug. Patients may be required to prove their identity when collecting prescriptions, and should store dexamfetamine safely and securely. It must not be shared with anyone else. There are restrictions on travelling with controlled drugs: see https://www.gov.uk/guidance/controlled-drugs-personal-licences. **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/ • Narcolepsy UK – dexamfetamine. https://www.narcolepsy.org.uk/resources/dexamfetamine • NHS – Narcolepsy - https://www.nhs.uk/conditions/narcolepsy/
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 information available **Pregnancy:** Dexamfetamine is not recommended for use during pregnancy The limited data available shows a risk of premature birth and reduced birth weight. Infants may also develop withdrawal symptoms such as dysphoria, hyperexcitability and pronounced exhaustion. If a patient becomes pregnant or is planning a pregnancy during treatment they should discuss treatment options with their specialist. The specialist will reassume prescribing responsibility, ending the shared care agreement. Healthcare professional information available from: https://www.medicinesinpregnancy.org/bumps/monographs/USE-OF-AMFETAMINES-IN-PREGNANCY/ **Breastfeeding:** Dexamfetamine is excreted in human milk, therefore a risk to infants cannot be excluded. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from dexamfetamine, taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman. High doses may interfere with lactation, although this is not confirmed in practice. If breastfeeding does take place, infants should be monitored for symptoms of CNS stimulation (e.g. decreased appetite/weight gain, sleep disturbances, irritability), although these may be difficult to detect. Healthcare professional information available from: https://www.sps.nhs.uk/articles/safety-in-lactation-drugs-for-adhd/ **Paternal Exposure** No evidence regarding adverse outcomes following paternal exposure was identified.
14. Specialist contact information	**Humber Teaching Foundation NHS Trust** 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 **Humber Neurology Service (for narcolepsy)** Name: *Consultant Neurologists (as per clinic letter – normally Dr Alec Ming)* Role and specialty: *Consultant Neurologist* Daytime telephone number: *as per clinic letter* Email address: *as per clinic letter* Alternative contact: *Neurology Specialist Pharmacist – Priscilla.Kanyoka1@nhs.net or Interface Pharmacist – Jane.morgan14@nhs.net* Out of hours contact details: *Neurologist Oncall – via HUTH Switchboard (01482875875)*
15. Local arrangements for referral Define the referral procedure from hospital to primary care prescriber & route of return should the patient's condition change.	**Humber Teaching Foundation NHS Trust** As per details above **Humber Neurology Service:** The Humber Neurology Service can be contact via advice and guidance on ERS.
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/.

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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.**		
	Date approved by Guidelines and SCF Group:		21st August 2024
	Date approved by APC:		4th September 2024
	Review date:		September 2025
Version number	Author	Job title	Revision description:
1	Jane Morgan	Principal Pharmacist HUTH	Adaption from RMOC approved SCF with addition of paediatric dose and local appendices

Appendix 1: Medication choice for ADHD

	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		