Humber Area Prescribing Committee

SHARED CARE FRAMEWORK for methyphenidate

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.

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- 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 *Methylphenidate for ADHD in adults and children and Narcolepsy in adults*

1. Introduction:	Methylphenidate is a central nervous system stimulant licensed as part of a comprehensive treatment programme for attention deficit hyperactivity disorder (ADHD). It may be offered as a first line pharmacological treatment option for adults with ADHD who have been appropriately diagnosed (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. Methylphenidate is available as immediate-release tablets, and modified-release tablets and capsules. The modified-release preparations contain both immediate-release and prolonged-release methylphenidate, and different brands have different proportions of each. Brands may therefore vary in their release characteristics and clinical effect. Modified-released preparations should therefore be prescribed by brand name. Methylphenidate 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. Risk of misuse can be reduced by using modified-release preparations. 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. 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. After transition to adult services, adult healthcare professionals should carry out a comprehensive assessment of the person with ADHD that includes personal, educational, occupational and social functioning, and assessment of any coexisting conditions, especially drug misuse, personality disorders, emotional problems and learning difficulties. The safety and efficacy of long-term use of methylphenidate has not been systematically evaluated in controlled trials. Patients should be reviewed for ongoing need at least annually, and the manufacturers recommend a trial discontinuation at least once yearly to assess the patient's condition. Methylphenidate is not licensed for all the indications it is used to treat below. However, its use for the indications below are established and supported by various sources and bodies including the BNF and NICE.	
2. Indication:	• Attention deficit hyperactivity disorder (ADHD) in adults and children • Narcolepsy‡ ‡ Off-label indication.	
3. Licensing Information	*Methylphenidate is not licensed for narcolepsy* *Not all brands of methylphenidate are licensed for ADHD in adults (see further details in section 4*	
4. Pharmaceutical Information	Route	Oral
	Formulation	Methylphenidate hydrochloride. **<u>Standard release tablets:</u>** Medikinet®: 5mg, 10mg, 20mg Methylphenidate hydrochloride (generic): 5mg, 10mg, 20mg Ritalin®: 10mg Tranquilyn®: 5mg, 10mg, 20mg **NB: Methylphenidate standard release tablets are not licensed for use in adults. Use is considered off-label.** Brand name prescribing is not necessary for standard release tablets. **<u>Prolonged-release tablets</u>:** NB: Modified-released preparations vary in their release characteristics and <u>must be prescribed by brand name</u>. The specialist must specify the brand to be prescribed. Concerta XL®: 18mg, 27mg, 36mg, 54mg Delmosart®: 18mg, 27mg, 36mg, 54mg Matoride XL®: 18mg, 36mg, 54mg

		Xaggitin XL®: 18mg, 27mg, 36mg, 54mg Xenidate XL®: 18mg, 27mg, 36mg, 54mg **NB: Methylphenidate prolonged-release tablets are licensed for continuation in adults who have shown clear benefit from treatment in childhood and/or adolescence. They are not licensed for intiation in adults. Use in this way is considered off-label.** **Modified-release capsules:** NB: Modified-released preparations vary in their release characteristics and must be prescribed by brand name. The specialist must specify the brand to be prescribed. Equasym XL®: 10mg, 20mg, 30mg Medikinet XL® ▼: 5mg, 10mg, 20mg, 30mg, 40mg, 50mg, 60mg Ritalin XL®: 10mg, 20mg, 30mg, 40mg, 60mg **NB: Ritalin XL and Medikinet XL modified-release capsules are licensed for initiation and continuation in adults. Equasym XL is not licensed for use in adults** **Please consult the relevant SPC for brand-specific licensing information.**
	Administration details	Methylphenidate can be taken with or without food, but patients should standardise which method is chosen. Administration requirements vary by formulation and brand. Methylphenidate capsules can be opened and sprinkled on a small amount of soft food for administration. Please consult the relevant SPC for brand-specific information. 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	Methylphenidate is a schedule 2 controlled drug and is subject to legal prescription requirements. It has the potential for misuse and diversion. The choice of formulation will be decided by the treating specialist on an individual basis, and depends on the intended duration of effect. Risk of misuse can be reduced by using modified-release preparations. Alcohol may exacerbate CNS adverse effects of methylphenidate and should be avoided during use. Methylphenidate may cause false positive laboratory test results for amphetamines. Information on the release characteristics of each brand is available at handychartadhduk.pdf (choiceandmedication.org).

5. Supporting evidence	• NICE NG87: Attention deficit hyperactivity disorder: diagnosis and management. https://www.nice.org.uk/guidance/ng87/ • MHRA Drug Safety update September 2022: Methylphenidate long-acting (modified-release) preparations: caution if switching between products due to differences in formulations
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. **Initial stabilisation:** **Recommended starting dose in ADHD in Children and Young People (6-18 years):** Immediate release tablets: 5mg once or twice daily and increase at weekly intervals by 5–10mg daily; usual max. 60mg daily in divided doses but may be increased to 2.1mg/kg daily (max. 90mg daily) by the specialist. If improvement is not observed after appropriate dosage adjustment the drug will be discontinued. In some patients, rebound hyperactivity may occur as the effect of the drug wears off in the evening. Dividing the doses to include an additional dose at bedtime may eliminate this difficulty. However, bedtime doses may cause sleep disturbance. Modified release tablets: Treatment may also be commenced using modified-release preparations – please see product literature for the recommended dosing schedule for the brand required. Modified release capsules: Treatment may also be commenced using modified-release preparations – please see product literature for the recommended dosing schedule for the brand required. **Recommended starting dose in ADHD in over 18s (unlicensed use)**: • Immediate release tablets: 5 mg, given 2-3 times daily • Modified release tablets: 18 mg daily, given in the morning • Modified release capsules: 10-20 mg daily Adults with ADHD who have shown clear benefit from methylphenidate in childhood or adolescence may continue treatment into adulthood at

	the same daily dose. Consult SPC for the prescribed brand for more information. **Recommended starting dose in narcolepsy (off-label)**: • Immediate release tablets: 10 mg daily in divided doses, to be taken before meals **During initiation Methylphenidate must be prescribed by the initiating specialist during initiation and dose stabilisation.** **Maintenance dose (following initial stabilisation):** The dose of methylphenidate should be titrated to response, usually at weekly intervals. Patients can be converted from standard methylphenidate preparations as described in the relevant Summary of Product Characteristics. **Maximum dose in ADHD:** • Immediate release tablets: up to 100 mg daily in 2-3 divided doses • Modified release tablets: up to 108 mg once daily, given in the morning • Modified release capsules: up to 100 mg daily. May be given as a single dose in the morning or in divided doses in the morning and at midday, depending on brand. The maximum licensed daily dose varies with formulation and brand; consult BNF and SPC. **Usual dose in narcolepsy (off-label)**: • Immediate release tablets: 20-30 mg daily in divided doses, taken before meals. Maximum dose 60 mg daily **The initial maintenance dose must be prescribed by the initiating specialist.** **Conditions requiring dose adjustment:** • 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: • Hypersensitivity to methylphenidate or to any of the excipients • Glaucoma

	• Phaeochromocytoma • During treatment with non-selective, irreversible monoamine oxidase (MAO) inhibitors, or within a minimum of 14 days of discontinuing those drugs, due to the risk of hypertensive crisis • Hyperthyroidism or thyrotoxicosis • Diagnosis or history of severe depression, anorexia nervosa/anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, psychopathic/borderline personality disorder. • Diagnosis or history of severe and episodic (Type I) bipolar (affective) disorder (that is not well-controlled). • Certain pre-existing cardiovascular disorders constitute contraindications unless specialist cardiac advice is obtained and documented. These include 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, and structural cardiac abnormalities. • Pre-existing cerebrovascular disorders cerebral aneurysm, vascular abnormalities including vasculitis or stroke. • Medikinet XL only: history of pronounced anacidity of the stomach with a pH value above 5.5, or during therapy with H2 receptor blockers, proton pump inhibitors or antacids. **Cautions:** • Family history of sudden cardiac or unexplained death, malignant arrhythmia. • Cardiovascular status should be carefully monitored (see section 8 & section 9) • Underlying conditions which might be compromised by increases in blood pressure or heart rate. • Known drug or alcohol dependency or misuse of central nervous system (CNS) stimulants: potential for abuse, misuse or diversion. • Alcohol consumption (not recommended during treatment) • Epilepsy: may lower seizure threshold

	• Psychiatric and neuropsychiatric symptoms or disorders, including manic or psychotic symptoms, aggressive or hostile behaviour, motor or verbal tics (including Tourette's syndrome), anxiety, agitation or tension, depressive symptoms, bipolar disorder. • Renal or hepatic insufficiency (due to lack of data) • Leukopenia, thrombocytopenia, anaemia, or other haematological abnormalities. • Prolonged-release tablets only: severe narrowing of the gastrointestinal tract or dysphagia; risk of obstruction • Safety and efficacy has not been established in patients older than 60 years of age. • Susceptibility to open-angle glaucoma. • Pregnancy or breast-feeding (see section 13) • 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
	• Risk assessment for substance misuse and drug diversion
	• Height, weight, and body mass index (BMI)
	• Blood pressure (BP) and heart rate
	• 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
	Initial monitoring:

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- 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.
- 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.
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<tr><td rowspan="4">9. Ongoing monitoring requirements to be undertaken by primary care</td><td>Monitoring</td><td>Frequency</td></tr>
<tr><td>

- Blood pressure and heart rate, and assessment for cardiovascular signs or symptoms
- Weight and appetite
- Assessment for new or worsening psychiatric and neurological signs or symptoms (e.g. tics, anxiety, symptoms of bipolar disorder)
- Explore whether patient is experiencing any difficulties with sleep
</td><td>Every 6 months, and after any change of dose recommended by specialist team.</td></tr>
<tr><td>Assessment of adherence, and for any indication of methylphenidate abuse, misuse, or diversion</td><td>As required, based on the patient's needs and individual circumstances</td></tr>
<tr><td>Review to ensure patient has been offered and attended an annual</td><td>Annually</td></tr>
</table>

	review with a healthcare professional with expertise in ADHD	
	(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:	
	• **Monoamine oxidase inhibitors (MAOIs):** risk of hypertensive crisis. The combination should be avoided, and use of methylphenidate and MAOIs should be separated by at least 14 days • **Coumarin anticoagulants, anticonvulsants (e.g. phenobarbital, phenytoin, primidone), selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants**: metabolism may be inhibited by methylphenidate.Dose adjustment may be required when starting or stopping methylphenidate. • **Anti-hypertensive drugs**: effectiveness may be reduced by methylphenidate • **Other drugs which elevate blood pressure:** risk of additive effects (e.g. linezolid) • **Alcohol:** may exacerbate adverse CNS effects of methylphenidate • **Serotonergic drugs**, including SSRIs and MAOIs**:** increased risk of central nervous system (CNS) adverse effects, risk of serotonin syndrome • **Halogenated anaesthetics:** risk of sudden blood pressure increase during surgery. Avoid methylphenidate on the day of planned surgery. • **Dopaminergic drugs**, **including antipsychotics**: increased risk of pharmacodynamic interactions including dyskinesias or hypertensive crisis (e.g. risperidone, paliperidone, selegiline, rasagiline) • **Apraclonidine:** effects decreased by methylphenidate. • **Carbamazepine:** may decrease methylphenidate levels • **Ozanimod:** may increase risk of hypertensive crisis	
	Other interacting agents: nil **For full list see SPC at www.medicines.org.uk/emc and BNF**	
	Adverse effects	Action for GP

11. Adverse effects and management	**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	• 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.
	Weight or BMI outside healthy range, anorexia or 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 • 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.
	Haematological disorders Including leukopenia, thrombocytopenia, anaemia or other alterations NB: no haematological monitoring is recommended. Haematological disorders would be a chance finding/due to patient reporting adverse drug reactions.	Contact specialist team. Discontinuation should be considered. Referral to haematology may be warranted; use clinical discretion.
	Psychiatric disorders New or worsening psychiatric symptoms, e.g. psychosis, mania,	Discuss with specialist. Stop treatment and consider referral to

	aggressive or hostile behaviour, suicidal ideation or behaviour, motor or verbal tics (including Tourette's syndrome), anxiety, agitation or tension, bipolar disorder, depression	acute mental health team if suicidal thoughts, mania, or psychosis are present Methylphenidate should not be continued unless the benefits outweigh the risks.
	Nervous system disorders Symptoms of cerebral ischaemia, e.g. severe headache, numbness, weakness, paralysis, and impairment of coordination, vision, speech, language or memory	Discontinue methylphenidate, refer urgently for neurological assessment
	New or worsening seizures	Discontinue methylphenidate. Discuss with specialist team.
	Symptoms of serotonin syndrome, e.g. agitation, hallucinations, coma, tachycardia, labile blood pressure, hyperthermia, hyperreflexia, incoordination, rigidity, nausea, vomiting, diarrhoea	Discontinue methylphenidate as soon as possible. Management depends on severity; use clinical judgement and seek advice if necessary. Discuss with specialist team to determine whether methylphenidate can be re-started.
	Insomnia or other sleep disturbance	Review timing of methylphenidate dose and advise as appropriate. Give advice on sleep hygiene. Discuss with specialist if difficulty persists; dose reduction may be required.
	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 should be advised to report any of the following signs or symptoms to their GP without delay:** • Abnormally sustained or frequent and painful erections: seek immediate medical attention. • Signs or symptoms of serotonin syndrome (e.g. agitation, hallucinations, coma, tachycardia, labile blood pressure, hyperthermia, hyperreflexia, incoordination, rigidity, nausea, vomiting, diarrhoea) • Any mood changes, for example. psychosis, mania, aggressive or hostile behaviour, suicidal ideation or behaviour, motor or verbal	

	tics (including Tourette's syndrome), anxiety, agitation or tension, anxiety, depression • New or worsening neurological symptoms (e.g. 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 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. • Not to drive or operate machines if methylphenidate affects their ability to do so safely, e.g. by causing dizziness, drowsiness, or visual disturbances. • 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 methylphenidate, as it may make side effects worse. Avoid recreational drugs. • Not to stop taking methylphenidate without talking to their doctor. Medical supervision of withdrawal is required, since this may unmask depression or chronic over-activity. • 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. 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 – methylphenidate. https://www.narcolepsy.org.uk/resources/methylphenidate • 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 inforamtion **Pregnancy:** Methylphenidate is not recommended for use during pregnancy unless a clinical decision is made that postponing treatment may pose a greater risk to the pregnancy. Evidence on exposure to methylphenidate 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. Patients who become pregnant while taking methylphenidate, or who plan a pregnancy, should be referred to the specialist team for review. The specialist will reassume prescribing responsibility, ending the shared care agreement. Healthcare professional information available from: https://www.medicinesinpregnancy.org/bumps/monographs/USE-OF-METHYLPHENIDATE-IN-PREGNANCY/ Patient information available from: https://www.medicinesinpregnancy.org/Medicine--pregnancy/Methylphenidate/ **Breastfeeding:** Methylphenidate has been found in breast milk in small amounts. Evidence for safety in breastfeeding is limited. Decisions to use while breastfeeding should be made on a case-by-case basis, taking into account the risks to the infant and benefits of therapy. 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. High doses may interfere with lactation, although this is not confirmed in practice. 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. Further information for patients: bumps - best use of medicine in pregnancy (medicinesinpregnancy.org)
14. Specialist contact information	**Humber Teaching Foundation NHS Trust** Name: *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** Contact as per details above **Humber Neurology Service (for Narcolepsy)** Humber Neurology Service can be contacted via Advice and Guidance.
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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- Methylphenidate hydrochloride 5 mg tablets (Tranquilyn®). Date of revision of the text 21/09/20. Accessed via https://products.mhra.gov.uk/
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- Methylphenidate hydrochloride 18 mg prolonged-release tablets (Concerta XL®). Date of revision of the text 07/10/20. Accessed via https://www.medicines.org.uk/emc/product/6872/smpc
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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

Humber Area Prescribing Committee

Version number	Author	Job title	Revision description:
1	Jane Morgan	Interface Pharmacist	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		

Appendix 2: The differences in the most common brands of modified-release methylphenidate

Brand	Immediate release component	Modified-release component	Duration of Action (hours)
Type 1			
Concerta XL	22%	78%	12
Matoride XL			
Xenidate XL			
The above three product all have similar release characteristics but are made using different techniques which may lead to different clinical response.			
Xaggitin XL	25%	75%	12
Delmosart XL			
Type 2			
Equasym XL	30%	70%	8
Ritalin XL	50%	50%	8
Exattent XL			8
Addepta XL			8
Type 3			
Medikinet XL	50%	50%	8
Metyrol XL			
Meflynate XL			

Note: none of the products claim equivalence. Switching products can lead to different clinical response and should not be done without consultation and agreement with the patient.