## DRUGS USED IN THE MANAGEMENT OF ADHD IN CHILDREN OVER 5 YEARS AND ADULTS

### 1. REFERRAL CRITERIA
- Shared Care is only appropriate if it provides the optimum solution for the patient.
- Prescribing responsibility will only be transferred when it is agreed by the consultant and the patient’s GP that the patient’s condition is reasonably predictable and the treatment regime has been specified.
- Patients will only be referred to the GP once the GP has agreed in each individual case, subject to receiving the relevant clinical information.
- The patient will be given a supply of the relevant drug sufficient for 4 weeks maintenance therapy.

### 2. AREAS OF RESPONSIBILITY

<table>
<thead>
<tr>
<th>GP responsibilities</th>
<th>Consultant/Specialist Service’s responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial referral to specialist raising possibility of ADHD</td>
<td>Inform patient about unlicensed status (adults)</td>
</tr>
<tr>
<td>Provide information re medical history and perform physical examination if requested.</td>
<td>Discuss the benefits and side effects of treatment with the patient/carer and the importance of adherence. In particular ensure awareness of: how to recognise symptoms of hepatic disorder (stomach pain, nausea, dark urine, jaundice); need to report promptly suicidal thoughts &amp; self-harming behaviour; possible teratogenicity in pregnancy (as appropriate).</td>
</tr>
<tr>
<td>Reply to the request for shared care as soon as practicable.</td>
<td>Risk assess for diversion and misuse.</td>
</tr>
<tr>
<td>Prescribe by brand name for MR preparations</td>
<td>Assess full medical history including history of cardiac disease, convulsive disorders, thyroid disorders, mental health problems and current medication.</td>
</tr>
<tr>
<td>Adjust the dose as advised by the specialist.</td>
<td>Initiate treatment taking into account contra-indications, cautions, side-effects, compliance/diversion issues and cost.</td>
</tr>
<tr>
<td>Once dose has been stabilised, prescribe repeat prescriptions – maximum of 30 days recommended (NB.CD requirements for all except atomoxetine)</td>
<td>Initiate prescriptions, titrating the dose against symptoms and side effects until dose optimisation is achieved. Titrate cautiously where indicated e.g. in neurodevelopmental disorders, mental health conditions and physical health conditions such as epilepsy or cardiac disease.</td>
</tr>
<tr>
<td>Confirm adherence to treatment and support as appropriate. Monitor for signs of diversion and misuse (e.g. by checking prescribing intervals of prescriptions)</td>
<td>Prescribe by brand name for MR preparations</td>
</tr>
<tr>
<td>Report to and seek advice from the specialist on any aspect of patient care that is of concern and may affect treatment.</td>
<td>Ask the GP whether he or she is willing to participate in shared care once the dose is stable (informing of unlicensed status where applicable). Do not continue to prescribe once responsibility is transferred without communicating with the GP (risks of misuse-communicate to GP if a CD prescription has been issued to patient from secondary care).</td>
</tr>
<tr>
<td>Refer patient to the specialist if his or her condition deteriorates.</td>
<td>Communicate promptly with the GP when treatment is changed or the patient defaults attending clinic.</td>
</tr>
<tr>
<td>Stop treatment on the advice of the specialist or immediately if an urgent need to stop treatment arises.</td>
<td>Review patient regularly, with an annual review of medications. Communicate the results of the review to the GP and provide advice on stopping treatment as appropriate.</td>
</tr>
<tr>
<td>If informed by the consultant or specialist clinic that the patient has defaulted from attending clinic do not continue prescription unsupervised</td>
<td>Agree monitoring schedule with GP for adults every 6 months and ensure sharing of these results.</td>
</tr>
<tr>
<td>Report any adverse events to the referring specialist and MHRA yellow card scheme.</td>
<td>Have a mechanism in place to receive rapid referral of a patient from the GP in the event of deteriorating clinical condition.</td>
</tr>
</tbody>
</table>

**Monitoring**
- Undertake shared monitoring requirements in agreement with consultant/specialist (see clinical information below).
- Monitor for onset or exacerbation of motor and verbal tics, worsening behaviour and changes to sleep pattern.
- Monitor for the development or worsening of psychiatric disorders.

**Adults**
- Monitor HR and BP. Liaise with specialist and reduce the dose if:
  - sustained tachycardia, arrhythmia or
  - a clinically significant increase in

**Monitoring & treatment adjustment**

**Baseline**
- Height (under 18 only), weight, pulse and BP
- Examination of cardiovascular system.
- Refer for specialist cardiac evaluation if there is:
  - a history of congenital heart disease or cardiac surgery
  - history of sudden death in a first degree relative under 40 years
  - undue breathlessness
  - fainting on exertion or in response to fright or noise
systolic BP measured on two occasions.

**Atomoxetine**
- Monitor for sexual dysfunction with Atomoxetine and refer back to specialist if a problem.

**Guanfacine**
- If a person taking guanfacine has sustained orthostatic hypotension or fainting episodes reduce the dose and refer back to the specialist for review.

**Switching brands of methylphenidate**
Switching between brands is supported if bioequivalent and recommended by Derbyshire medicines management team. Patients may be changed in primary care to the preferred recommended brand by their GP for ongoing prescribing, providing they have been appropriately informed before the switch takes place.

Currently the recommended brands are Delmosart SR and Xaggitin XL, which are both bioequivalent to the brand Concerta XL.

- \[ \text{o palpitations that are rapid, regular and start and stop suddenly} \]
- \[ \text{o chest pain suggesting cardiac origin} \]
- \[ \text{o signs of heart failure} \]
- \[ \text{o a murmur heard during cardiac exam} \]
- \[ \text{o high blood pressure (adults only).} \]
- \[ \text{An ECG is not needed before starting stimulants, atomoxetine or guanfacine if cardiovascular history and examination are normal and the person is not on medicine that poses an increased cardiovascular risk'} \]
- \[ \text{Base line evaluation to identify patients at risk of sedation and somnolence before starting guanfacine.} \]

**Ongoing**
- Monitor for onset or exacerbation of motor and verbal tics, worsening behaviour and changes to sleep pattern.
- Monitor for the development or worsening of psychiatric disorders.
- Reduce the dose and refer to an adult physician or paediatrician if there is sustained resting tachycardia, arrhythmia or systolic blood pressure greater than the 95th percentile or a clinically significant increase on two occasions
- If a person develops new or worsening seizures review ADHD medication and stop any that may be contributing; after investigation cautiously reintroduce if found to be unlikely cause.

**Children and young people**
- Monitor BP/ HR/ weight and Height
- Refer to paediatric hypertension specialist if BP is consistently above 95th centile for age and height in children and young people.

**Atomoxetine**
- Monitor for sexual dysfunction with Atomoxetine

**Guanfacine**
- If a person taking guanfacine has sustained orthostatic hypotension or fainting episodes reduce the dose or switch to another medication

**Patient/ carer responsibilities:**
- Report any adverse effects
- Maintain handheld records
- Complete any monitoring forms requested by the specialist
- Order repeat prescriptions and supplies and store safely
- Attend all medical / other appointments as necessary

### 3. COMMUNICATION AND SUPPORT

**i. Contacts**
If necessary contact the consultant who is supervising care – refer to assessment letter for details.

**Pharmacy departments:**
- Derbyshire Healthcare NHS Foundation Trust: 01332 623700 ext 33268
- Royal Derby Hospital: 01332 340131 Pharmacy via switchboard
- Chesterfield Royal Hospital: 01246 512157

**ii. Out of hours:**
- On call psychiatrist/paediatrician/CAMHS via CRH switchboard 01246 277271
- On call psychiatrist/paediatrician/CAMHS via DHCFT switchboard 01332 623700
- On call paediatrician RDH via switchboard 01332 340131

**iii. Specialist support/resources available to GP including patient information**
Information on treatment for ADHD is available at [http://www.choiceandmedication.org/derbyshcft/](http://www.choiceandmedication.org/derbyshcft/)
The local Parent Support Group contact is: FLARE, Derbyshire ADHD Support Service.
Telephone: 01246 569012    E-mail: flareadhd@aol.com
4. CLINICAL INFORMATION

See Summary table below

Cautions and contraindications in cardiac disorder, cerebrovascular disorder, glaucoma, phaeochromocytoma and hyperthyroidism.

Caution in patients whose underlying medical condition might be compromised by increases in blood pressure or heart rate. Caution in epilepsy or history of seizures.

Methylphenidate is contraindicated in patients with a diagnosis or history of severe depression, anorexia nervosa/anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, and personality disorder.

For full prescribing information please see the relevant Summary of Product Characteristics.

Information Sources Used:

- SPCs accessed July 2018 at www.emc.medicines.org.uk
  - Ritalin, Equasym XL, Delmosart SR, Xaggitin SR and Medikinet XL
  - Strattera
  - Elvanse
  - Intuniv
- MHRA Drug Safety Update Volume 5 Issue 6 January 2012 Atomoxetine (Strattera▼): increases in blood pressure and heart rate—new contraindications, warnings, and advice for monitoring
- BNF accessed on-line July 2018
- BNF for Children accessed on-line July 2018
- Stockley's Drug Interactions accessed July 2018 at www.new.medicinescomplete.com

Further information:


Clinical Knowledge Summaries. Attention deficit hyperactivity disorder. (https://cks.nice.org.uk/attention-deficit-hyperactivity-disorder)

Acknowledgement

Shared care ADHD guideline for children:

<table>
<thead>
<tr>
<th>Reviewed and Reformatted by:</th>
<th>Beverley Thompson Deputy Chief Pharmacist Derbyshire Healthcare NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lisa Taylor Senior Pharmacist Derby Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td></td>
<td>Dr Morton Consultant Paediatrician Derby Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td></td>
<td>Dr J Thomas, Chesterfield hospital</td>
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<tr>
<td></td>
<td>Dr S Banta, Derbyshire Healthcare NHS Foundation Trust</td>
</tr>
<tr>
<td></td>
<td>Dr S Taylor, Derbyshire Healthcare NHS Foundation Trust</td>
</tr>
<tr>
<td>In consultation with:</td>
<td>The Shared Care Guidelines Group Derby Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td></td>
<td>Child and Adolescent Mental Health Services (CAMHS) Derbyshire</td>
</tr>
</tbody>
</table>

Shared care ADHD guideline for adults:

<table>
<thead>
<tr>
<th>Written by:</th>
<th>Simon Taylor, Consultant Psychiatrist, Derbyshire Mental Health Services NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beverley Thompson, Pharmacist, Derbyshire Mental Health Services NHS Trust</td>
</tr>
<tr>
<td>Updated by:</td>
<td>Sally Jordan, Pharmacist, Derbyshire Healthcare Foundation Trust May 2012</td>
</tr>
</tbody>
</table>

Shared Care ADHD guideline for adults & children:

<table>
<thead>
<tr>
<th>Amalgamated and reviewed by:</th>
<th>Beverley Thompson, Pharmacist, Derbyshire Healthcare Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>In consultation with:</td>
<td>Dr Walters, Chesterfield Royal Hospital</td>
</tr>
<tr>
<td></td>
<td>Dr McIntyre, Derby Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td></td>
<td>Drs Banta &amp; Taylor, Derbyshire Healthcare Foundation Trust</td>
</tr>
</tbody>
</table>

This does not replace the SPC, which should be read in conjunction with it.

Reviewed: September 2018
Next Review Date: August 2021
<table>
<thead>
<tr>
<th>Place in Therapy</th>
<th>Indication</th>
<th>Drug Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>First line</td>
<td>As part of a comprehensive treatment programme for ADHD in children aged 6 and over. Treatment of ADHD in adults is <strong>unlicensed</strong>. NICE: Offer medication for ADHD only if symptoms are still causing a persistent significant impairment in at least one domain after environmental modifications have been implemented and reviewed.</td>
<td>Warfarin; Phenytoin; Valproate; Carbamazepine; MAOIs; Tricyclic antidepressants; SSRIs; Clonidine; Risperidone</td>
</tr>
</tbody>
</table>

### Methylphenidate

<table>
<thead>
<tr>
<th>Brand name</th>
<th>Prescribe generically (brands include Ritalin, Medikinet)</th>
<th>Delmosart SR Xaggitin XL (Previously Matoride XL and Concerta XL were the preferred brands)</th>
<th>Equasym XL</th>
<th>Medikinet XL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength</td>
<td>5mg, 10mg, 20mg tablets</td>
<td>18mg, 27mg, 36mg, 54mg tablets</td>
<td>10mg, 20mg, 30mg capsules</td>
<td>5mg, 10mg, 20mg, 30mg, 40mg, 50mg, 60mg capsules</td>
</tr>
</tbody>
</table>

### Place in Therapy

<table>
<thead>
<tr>
<th>Controlled Drug</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
</table>

### Dose in children 6 years and over

- **5mg** once or twice a day. Titrate by weekly increments of 5-10mg/day against symptoms and side effects. **Max:** 60mg/day in divided doses.
- **4-5 years (unlicensed):**
  - 2.5mg twice a day, increased by 2.5mg at weekly intervals. **Max:** 1.4mg/kg in 2-3 doses.

### Unlicensed dose in children

- Can be increased to 2.1mg/kg daily in divided doses up to a maximum of 90mg under specialist supervision. Discontinue after 1 month if no response
- Can be increased to 2.1mg/kg daily in divided doses up to a maximum of 108mg under specialist supervision. Discontinue after 1 month if no response (Note BNFc only includes this under Concerta XL, not Delmosart or Xaggitin)

### Dose in adults (unlicensed)

- **5mg** 2 or 3 times a day. Titrate against symptoms and side effects at weekly intervals. **Max:** 100mg/day in up to 4 divided doses.
- **As per plain tablets, using an equivalent dose.**
- **If initiating treatment use 18mg daily, adjusted at weekly intervals.**
- **Usually given once daily, but not more than twice daily.**

### Adult physical Monitoring by GP

- **Agree monitoring schedule with GP and consultant/specialist**
- **Pulse & BP before and after dose changes and then every 6 months; Weight every 6 months.**
- **Reduce the dose and liaise with specialist if: sustained tachycardia, arrhythmia or a clinically significant increase in systolic BP measured on two occasions.**

### Monitoring in children by specialist

- **Monitor BP/HR**
- **Monitor Weight:** every 3 months in children aged 10 years and under; at 3 months & 6 months in young people and children over 10 years and every 6 months thereafter
- **Monitor Height every 6 months for children and adolescents and recorded on growth chart**

### Drug Interactions

- Warfarin; Phenytoin; Valproate; Carbamazepine; MAOIs; Tricyclic antidepressants; SSRIs; Clonidine; Risperidone

### Side effects (common or significant)

- **At the beginning of treatment:** Nervousness, insomnia, decreased appetite
  - **CNS** – headache, drowsiness, dizziness, dyskinesia, psychomotor hyperactivity
  - **GI** – abdominal pain, nausea/vomiting, dry mouth, weight loss, diarrhoea
  - **CVS** – tachycardia, palpitations, arrhythmias, changes in heart rate and BP (usually increase). **Heart disease: Symptoms require prompt specialist cardiac evaluation.**
- **Psychiatric disorders:** associated with causing or worsening e.g. depression, suicidal thoughts, hostility, anxiety, agitation, psychosis and mania.
- **Motor and verbal tics:** associated with exacerbation or onset.
- **In children:** moderately reduced weight gain and growth retardation

<table>
<thead>
<tr>
<th>Side effects</th>
<th>Common or significant</th>
<th>Skin – rash, pruritus, urticaria, arthralgia, hair loss.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td><strong>Blood</strong> – very rarely leucopenia, anaemia, thrombocytopenia</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Other</strong> – fever, cough.</td>
</tr>
<tr>
<td>Brand name</td>
<td>Dose in children 6 years and over</td>
<td>Dose in adults</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>Lisdexamfetamine</td>
<td>30mg once daily in the morning or 20mg if appropriate. Titrate according to response/ tolerability. May be increased at weekly intervals by 10-20mg increments. Max: 70mg once a day</td>
<td>30mg once daily in the morning. Titrate according to response/ tolerability. May be increased at weekly intervals by 20mg increments. Max: 70mg daily</td>
</tr>
<tr>
<td>Dexamfetamine</td>
<td>2.5mg 2 or 3 times a day, increasing if necessary by 5mg daily at weekly intervals up to 1mg/kg in 2-4 divided doses up to 20mg daily (40mg or more in some children).</td>
<td>-</td>
</tr>
<tr>
<td>Atomoxetine</td>
<td>&lt;70kg: initially 0.5mg/kg/day minimum of 7 days, then titrate according to response and tolerability. Recommended maintenance dose is approx. 1.2mg/kg/day. <strong>Unlicensed:</strong> 1.8mg/kg/day (up to 120mg.) &gt;70kg: initially 40mg/day minimum of 7 days titrated according to response and tolerability. Recommended maintenance dose is 80mg. Max dose 100mg <strong>Unlicensed max:</strong> 120mg. Once a day in the morning or 2 evenly divided doses (morning &amp; late afternoon/ early evening) if not tolerated/inadequate response</td>
<td>-</td>
</tr>
<tr>
<td>Guanfacine</td>
<td>1mg once a day, adjusted in increments of not more than 1mg per week then titrated according to response and tolerability. Recommended maintenance dose range is 0.05-0.12 mg/kg/day.</td>
<td>-</td>
</tr>
<tr>
<td>Brand name</td>
<td>Dose in children 6 years and over</td>
<td>Dose in adults</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>Dexamfetamine</td>
<td>5mg, 10mg, 20mg tablets</td>
<td>-</td>
</tr>
<tr>
<td>Atomoxetine</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lisdexamfetamine</td>
<td>-</td>
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</tr>
</tbody>
</table>

**Brand name**
- Elvanse
- Amfexa

**Controlled Drug**
- Yes
- No

**Strength**
- 20mg, 30mg, 40mg, 50mg, 60mg, 70mg caps. Adult: 30mg, 50mg, 70mg caps
- 5mg, 10mg, 20mg tablets
- 10mg, 18mg, 25mg, 40mg, 60mg caps and 4mg/ml oral solution
- 1mg, 2mg, 3mg, 4mg prolonged release tablets

**Indication**
- As part of a comprehensive treatment programme for ADHD in children aged 6 and over, when response to previous methylphenidate is considered clinically inadequate. Treatment of ADHD in adults. **Unlicensed max:** 120mg.
- As part of a comprehensive treatment programme for ADHD in children aged 6 and older, in adolescents and in adults.

**Place in Therapy**
- Second line
- Third line
- Third line for children aged 5 years and over and young adults

**Dose in children 6 years and over**
- 30mg once daily in the morning or 20mg if appropriate.
- 2.5mg 2 or 3 times a day, increasing if necessary by 5mg daily at weekly intervals up to 1mg/kg in 2-4 divided doses up to 20mg daily (40mg or more in some children).
- <70kg: initially 0.5mg/kg/day minimum of 7 days, then titrate according to response and tolerability. Recommended maintenance dose is approx. 1.2mg/kg/day. **Unlicensed:** 1.8mg/kg/day (up to 120mg.)

**Dose in adults**
- 30mg once daily in the morning. Titrate against symptoms and side effects, increasing at weekly intervals as required. **Unlicensed**
- Max: 70mg daily
- Max: 60mg/day in 2 - 4 divided doses
- 40mg/day minimum of 7 days, then titrate as required. BNF: start at 0.5mg/Kg if <70kg Usual maintenance dose 80-100mg/day. **Unlicensed max** dose 120mg.
- Once a day in the morning or 2 evenly divided doses (morning & late afternoon/ early evening). If not tolerated/inadequate response

**Adult Physical Monitoring by GP**
- Agree monitoring schedule with GP and consultant/specialist Pulse & BP before and after dose changes and then every 6 months; Weight every 6 months.
- Reduce the dose and liaise with specialist if: sustained tachycardia, arrhythmia or a clinically significant increase in systolic BP measured on two occasions.

**Monitoring in children by specialist**
- Monitor BP/ HR
- Monitor Weight: every 3 months in children aged 10 years and under; at 3 months and 6 months in young people and children over 10 years and every 6 months thereafter
- Monitor Height every 6 months for children and adolescents and recorded on growth chart
- **Guanfacine:** weekly monitoring (for somnolence, sedation, hypotension and bradycardia) during dose titration; 3 monthly monitoring during first year of treatment

**Other monitoring**
- Monitor for sexual dysfunction with and refer back to specialist if a problem.
- If orthostatic hypotension or fainting episodes reduce the dose and refer
<table>
<thead>
<tr>
<th></th>
<th>Lisdexamfetamine &amp; dexamfetamine</th>
<th>Atomoxetine</th>
<th>Guanfacine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug Interactions</strong></td>
<td>MAOIs &amp; Moclobemide</td>
<td>CYP2D6 inhibitors eg Fluoxetine &amp; Paroxetine</td>
<td>CYP3A4/5 inhibitors or inducers</td>
</tr>
<tr>
<td></td>
<td>Tricyclic antidepressants</td>
<td>Drugs that increase the QT interval.</td>
<td>Drugs that increase the QT interval</td>
</tr>
<tr>
<td></td>
<td>SSRIs</td>
<td>Drugs that lower the convulsive threshold. Drugs that cause electrolyte imbalance MAOIs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SNRIs</td>
<td>Methadone, Tramadol</td>
<td>Methadone, Tramadol</td>
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<tr>
<td></td>
<td>Lithium</td>
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<td></td>
<td>Haloperidol</td>
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<td></td>
<td>HIV protease inhibitors</td>
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<tr>
<td></td>
<td>Opioids</td>
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<td></td>
</tr>
</tbody>
</table>

| **Side effects (common or significant)** |                         | CNS – headache, somnolence, dizziness, insomnia. | CNS – headache, somnolence, dizziness, insomnia. |
|                                        | GI - abdominal pain, nausea, vomiting, diarrhoea, weight loss. | GI - abdominal pain, nausea, vomiting, constipation, dyspepsia, dry mouth, weight loss. | GI - abdominal pain/discomfort, nausea, vomiting, constipation, diarrhoea, dry mouth, decreased appetite |
|                                        | CVS - increased BP and pulse rates, QT prolongation, orthostatic hypotension | CVS - increased BP and pulse rates, QT prolongation, orthostatic hypotension | CVS - bradycardia, hypotension |
|                                        | Skin                               | Skin                               | Skin                               |
|                                        | CNS                               | CNS                               | CNS                               |
|                                        | GI                                | GI                                | GI                                |
|                                        | CVS                               | CVS                               | CVS                               |
Summary of NICE NG87 recommended on medication choice

Medication choice - children aged 5 years and over and young people
Recommendations 1.7.7 to 1.7.10

- Offer
  - Methylphenidate

- Switch
  - Lisdexamfetamine
    - If after 6-week trial of methylphenidate at an adequate dose not derived enough benefit in terms of reduced ADHD symptoms and associated impairment

- Consider
  - Dexamfetamine
    - If ADHD symptoms are responding to lisdexamfetamine but cannot tolerate the longer effect profile

- Offer
  - Atomoxetine or guanfacine
    - if they cannot tolerate methylphenidate or lisdexamfetamine or
    - their symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate

Medication choice - adults
Recommendations 1.7.11 to 1.7.15

- Offer
  - Lisdexamfetamine or methylphenidate

- Switch
  - Lisdexamfetamine or methylphenidate
    - If after 6-week trial of initial treatment at an adequate dose not derived enough benefit in terms of reduced ADHD symptoms and associated impairment

- Consider
  - Dexamfetamine
    - If ADHD symptoms are responding to lisdexamfetamine but cannot tolerate the longer effect profile

- Offer
  - Atomoxetine
    - if they cannot tolerate methylphenidate or lisdexamfetamine or
    - their symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate
DERBYSHIRE JAPC SHARED CARE AGREEMENT LETTER

Dear «GP_TITLE» «GP_SURNAME» «FORENAME_1» «SURNAME» «DATE_OF_BIRTH»
«CURRENT_ADDRESS_1» «CURRENT_ADDRESS_2» «CURRENT_ADDRESS_3» «CURRENT_ADDRESS_4» «CURRENT_POSTCODE»

Your patient was seen on {Insert date} with a diagnosis of {Insert diagnosis}. Following out discussion of (date) and your agreement to continue the prescribing when we discharge him/her, I have initiated the following medication {Insert drug name} and am writing to ask you to participate in the shared care for this patient.

This medication has been accepted as suitable for shared care by the Derbyshire Joint Area Prescribing Committee (JAPC). I agree to the secondary care responsibilities set out in the shared care agreement for this medication (available from www.derbyshiremedicinesmanagement.nhs.uk/clinical_guidelines/shared_care_guidelines). I am therefore requesting your agreement to share the care of this patient. Where preliminary tests are set out in the agreement I have carried these out and results are below.

<table>
<thead>
<tr>
<th>Dose Regimen</th>
<th>Date {Insert medicine name} started</th>
<th>Date for GP to start prescribing {Insert medicine name} from</th>
</tr>
</thead>
</table>

The baseline test results are (if applicable): See overlleaf for initiation criteria.

I confirm I have explained to the patient: the risks and benefits of treatment and have given them the relevant patient information leaflet. The relevant baseline tests have been conducted and the need for monitoring, how monitoring will be arranged, and the roles of the consultant / nurse specialist, GP and the patient in shared care have been explained. I confirm the patient has understood and is satisfied with this shared care arrangement at this time.

If you do NOT wish to participate in shared care for this patient, usually under clinical grounds, please complete the attached form.

I will write to you prior to the discharge in 3 months with regards to continued prescribing.

Yours sincerely

{Consultant name}
GP RESPONSE TO SHARED CARE (only complete & send if NOT participating in shared care)

Shared care is produced by GPs and specialists knowledgeable in the field of that drug usage. The shared care has been approved by the JAPC. This allows a more convenient service to the patient and cost effective use of NHS resources.

<table>
<thead>
<tr>
<th>Patient:</th>
<th>NHS No:</th>
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</table>

<table>
<thead>
<tr>
<th>Consultant:</th>
<th>Medicine requested for shared care:</th>
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</tbody>
</table>

I will NOT be undertaking the GP responsibilities as described in the agreed shared care guideline. My clinical reasons for declining shared care for this patient are listed in the box below:

Yours sincerely

{GP name}
{Surgery}

Please send a copy of this response to:

1. The specialist/consultant requesting shared care
2. **AN ANONYMISED COPY OF THIS FORM ONLY** to the Medicines Management and Clinical Policies and Decisions Team, 1st Floor East Point, Cardinal Square, 10 Nottingham Road, Derby, DE1 3QT or E-MAIL: ddcg.medicinesmanagement@nhs.net

(Sending a copy of this form to the Medicines Management and Clinical Policies and Decisions Team will help to identify any inappropriate requests for shared care e.g. indication not covered, hospital monitoring requirements not fulfilled. It will also help to inform the CCG prescribing group of the reasons shared care is not being undertaken allowing for changes to be made in future updates to improve patient care).