

Shared Care Guidelines for the Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in Working Age Adults
Methylphenidate (Ritalin[®], Equasym XL[®], Medikinet[®], Medikinet XL[®], Concerta XL[®]), Dexamfetamine, Atomoxetine (Strattera[®]) and Lisdexamfetamine (Elvanse[®])

DOCUMENT TO BE SCANNED INTO ELECTRONIC RECORDS AS AND FILED IN NOTES

Patient Name :

Date of Birth:

NHS No:

Name of Referring Consultant:

Contact number:

INTRODUCTION – Indication and Licensing

1. Drug treatment is considered to be the first-line treatment for all working age adults with ADHD. It should be considered for those with symptoms and impairment. methylphenidate is the most widely recommended drug treatment in Europe owing to the wide availability of several preparations offering different dosages and longer acting treatments.
2. Before starting drug treatment, working-age adults should have a full pre-treatment assessment, which should include:
 - a. full psychiatric assessment to assess for symptoms of ADHD but also to look for comorbidities
 - b. physical health assessment and relevant physical examination, including:
 - i. Assessment of history of exercise syncope, undue breathlessness and other cardiovascular symptoms
 - ii. Heart rate and blood pressure
 - iii. Body mass index (BMI)
 - iv. Family history of cardiac disease
 - v. ECG and determination of the QTc interval
 - vi. Risk assessment for substance misuse and drug diversion (where the drug is passed on to others for non-prescription use).
3. Estimates of the prevalence of ADHD vary widely within and between countries. It is estimated that around 2.5% of working age meet the DSM-IV diagnostic criteria for ADHD in the UK. Of those diagnosed in childhood 15% continue to have symptoms at age 25.
4. First line drug treatment for adult ADHD is with methylphenidate or sometimes dexamfetamine. Where this is contraindicated atomoxetine may be considered; lisdexamfetamine is an alternative in adults who do not respond to these drugs. Pulse, blood pressure, psychiatric symptoms, appetite, weight and height should be recorded at the initiation of therapy, and monitored regularly during the duration of treatment and not less than annually
5. **The cheapest agent should be used in situations where equivalent effectiveness can be demonstrated.**
6. Successful treatment reduces the risk of development of secondary complications such as difficulties in adult education, occupational underachievement, problems with the criminal justice system and relationship problems. The medication should be discontinued if review shows it to be no longer needed. Periodic drug holidays should be considered. Methylphenidate, dexamfetamine and lisdexamfetamine should be withdrawn carefully in those who have been taking it regularly long term. atomoxetine **can** be discontinued without tapering the dose.

7. Rarely, under specialist supervision, methylphenidate and atomoxetine may be combined. If this occurs then prescribing will remain wholly within secondary care.
8. In those working age adults where ADHD is unresponsive to methylphenidate, atomoxetine and dexamfetamine, and lisdexamphetamine, further treatment may include the use of medication such as Bupropion, Clonidine, Modafinil, Imipramine, Venlafaxine or combination treatments (such treatments often require referral to a specialist centre)
9. A specialist should initiate medication for the treatment of ADHD after appropriate assessment. This will be a Consultant psychiatrist or a non-consultant psychiatrist under the supervision of a Consultant
10. If treatment is adopted and the patient is stabilised, then consideration will be given to shared care arrangements. Usual practice is for the specialist to write to the GP requesting that they continue prescribing in line with this protocol. It is the responsibility of the GP to contact the specialist if they do not agree or there is a problem. Two written and one verbal agreement should be sought and evidence kept to that effect.
11. The shared care arrangements should be agreed by the patients and supported by GP and patient information leaflets.

Licensed indications

Prescribing for working age adults is often “off-label”. In children methylphenidate atomoxetine and dexamfetamine are all licensed for ADHD treatment. Atomoxetine, and methylphenidate (concerta XL) are both licensed for use in working age adults when the condition was diagnosed and treatment commenced before the age of 18. There is however a growing body of evidence that these drugs are safe and effective for the treatment of ADHD in adults, and their use is sanctioned by NICE and the British Association of Psychopharmacology

NICE recommends the use of methylphenidate as first line for the management of ADHD diagnosed in adults except where there is a risk of abuse or diversion when Atomoxetine (non-stimulant) is to be preferred. Where there is no improvement with methylphenidate after a trial period of six weeks, or where there are intolerable side effects then treatment with either atomoxetine or dexamfetamine should be considered. NICE makes no recommendation for third line treatment whilst the UK Adult ADHD Network (UKAAN) recommends Bupropion in this instance

Where medications are prescribed for ADHD, patients should ideally also receive psychological, behavioural, occupational and educational support – dedicated services such as this for adults with ADHD remain in short supply in the UK and are not commissioned from NELFT

ORAL DOSE AND ADMINISTRATION

Methylphenidate (Oral Administration)

Methylphenidate is contraindicated for use in patients in the presence of hyperthyroidism, cardiovascular disease, severe angina pectoris, cardiac arrhythmia, glaucoma, thyrotoxicosis and hyperexcitability states.

- a. Dosing as per BNF: initially 5 mg 2–3 times daily, increased if necessary at weekly intervals. The maximum recommended dose for methylphenidate is 100mg daily and this is rarely exceeded in clinical practice.
- b. Concerta® XL dosing as per BNF: initially 18 mg once daily (in the morning), increased if necessary at weekly intervals according to response; BNF recommended maximum dose is 108 mg daily under the

direction of a specialist. Concerta® XL tablets consist of an immediate-release component (22% of the dose) and a modified-release component (78% of the dose).

- c. Medikinet XL® capsules consist of an immediate-release component (50% of the dose) and a modified-release component (50% of the dose).
- d. Equasym XL® capsules consist of an immediate-release component (30% of the dose) and a modified-release component (70% of the dose).
- e. Doses after 5pm are more likely to worsen sleep but occasionally may help settling if given less than three hours before bedtime.
- f. Whilst some adults are managed with doses only on working days, or situations in which focus and attention is paramount or omitted during holidays, it is generally acknowledged that many need continuous medication.

Atomoxetine (Oral Administration)

Patients should be monitored for signs of depression, suicidal thoughts or suicidal behaviour, particularly at the start of treatment.

Patients should be informed of this risk and advised to watch for any clinical worsening, irritability or agitation, suicidal thoughts or behaviour or other unusual changes in behaviour.

Atomoxetine is contraindicated for use in patients with narrow angle glaucoma and should be used with caution in patients with cardiovascular disease including hypertension and tachycardia; structural cardiac abnormalities; QT-interval prolongation (avoid concomitant use of drugs that prolong QT interval); psychosis or mania; history of seizures; aggressive behaviour, hostility, or emotional lability.

The BNF reports rare instances of hepatic disorders and patients should be made aware that they should seek medical advice in cases of abdominal pain, nausea, malaise, darkening of the urine or jaundice whilst taking this drug

For adults over 70kg, start with 40mg, the initial dose should be maintained for a minimum of seven days prior to upward titration according to response and tolerability. The recommended maximum dose is 80-100mg daily but can be increased to 120mg by a specialist

- a. No additional benefit has been demonstrated for doses above 100mg but doses of up to 120 mg daily may be used if thought to be appropriate by a specialist.
- b. **For adults weighing under 70kg** the initial dose should be 500 micrograms/Kg, maintained for a minimum of seven days before increasing according to response and tolerability. The recommended maintenance dose is 1.2mg/Kg . No additional benefit has been demonstrated for doses above this but the maximum recommended daily dose is 1.8mg/Kg daily under the direction of a specialist.
- c. Can be taken with or after food.
- d. Full benefit of Atomoxetine may not be seen until after 4 weeks of continued treatment. It needs to be given every day of the week. Total dose may be given *either* as a single dose in the morning *or* in 2 evenly divided doses with the last dose no later than early evening, if efficacy or tolerability needs to be improved.
- e. It can be prescribed where a child has developed significant side effects on methylphenidate or other medication for ADHD and is unable to continue with it.

If switching from methylphenidate or Dexamfetamine to Atomoxetine it is wise to continue the stimulant medication until the therapeutic effect of Atomoxetine is established.

Dexamfetamine (Oral Administration)

Dexamfetamine is contraindicated for use in patients in the presence of hyperthyroidism, cardiovascular disease, severe angina pectoris, cardiac arrhythmia, glaucoma, thyrotoxicosis and hyperexcitability states. Caution is required in the prescribing of dexamfetamine for adults with epilepsy, psychotic disorders or a history of drug or alcohol dependence.

- a. Treatment should not continue beyond four weeks if benefit has not been established.
- b. Dosing as per BNF 5mg twice daily increased if necessary at weekly intervals; usual max. 60mg daily

- c. Doses after 5pm are more likely to worsen sleep but occasionally may help settling if given less than three hours before bedtime.
- d. Whilst some adults are managed with doses only when at work/study, or omitted during holidays. It is generally acknowledged that many need continuous medication.

Lisdexamphetamine (oral administration)

The starting dose for all patients – 30mg taken once in the morning (with or without food). The dose may be increased by 20mg increments at approximately weekly intervals and the maximum recommended dose is 70mg daily. If improvement of symptoms is not observed after the appropriate dosage adjustment over one month, it should be discontinued. Common (frequency estimate 1% to 10%) side effects include

- Abdominal pain, nausea, dry mouth, appetite suppression (usually transient), weight loss
- Headache, drowsiness, dizziness, dyskinesia
- Tachycardia, palpitations, arrhythmias, changes in BP and heart rate
- Rash, pruritis, urticaria, fever,
- Nervousness and insomnia common at start of treatment, usually controlled by dose adjustment

CAUTIONS- see Statement of Product Characteristics for details

Caution should be used when treating patients whose underlying medical conditions that might be compromised by increased blood pressure or heart rate.

Lisdexamphetamine may be swallowed whole, or the capsules opened and the entire contents dissolved in a glass of water

Careful supervision is required during drug withdrawal since this may unmask depression as well as chronic overactivity

CONTRA-INDICATIONS- see Statement of Product Characteristics for details

- Unless specialist cardiac advice has been obtained: in pre-existing cardiovascular disorders, including severe hypertension, heart failure, arterial occlusive disease, angina, haemodynamically significant.
- Hypersensitivity to sympathomimetic amines
- Concomitant use of MAOIs or within 14 days of stopping MAOIs.
- Hyperthyroidism or thyrotoxicosis
- Agitated states
- Advanced arteriosclerosis
- Glaucoma

Therapeutic use

Methylphenidate and Dexamfetamine

Methylphenidate and Dexamfetamine formulations are controlled drugs and therefore subject to the requirements of the Misuse of Drugs Regulations 1985. Both drugs have a resale value as drugs of abuse. Amphetamine-like drugs are effective in increasing attention and concentration and reducing impulsive and restless behaviours. Secondary effects include improved work/study performance, improved relationships, reduced aggression and fewer negative comments colleagues, employers friends and family. Aggression often remains a problem, requiring anger management. Response rates are good and are generally seen within the first four weeks of treatment.

- a. Generally well tolerated
- b. Appetite suppression may be an issue so these drugs should preferably be taken after meals if the patient has a low BMI
- c. Failure to gain weight – may be a problem or advantageous in some
- d. Sleep may be improved or worsened. The evening dosing is more problematical hence the need for caution in giving late afternoon or evening doses.
- e. Stomach pains and headaches on initiation usually settle within a few days.
- f. Rash, unexplained/easy bruising or recurrent infections may be due to rare blood dyscrasias – no reported fatalities.
- g. Blood pressure may be affected.

- h. Methylphenidate may exacerbate tics, habits or mannerisms. The management of those with a combination of Tourette's and ADHD can be particularly problematic. In a small subgroup tics appear for the first time following administration of the drug. Side effects such as these should usually lead to withdrawal of treatment. There are reports of new-onset tics persisting after withdrawal.
- i. No reports of addiction to methylphenidate or increased rates of addiction to other substances.
- j. Abrupt withdrawal should be avoided in cases of continuous administration to prevent depression or renewed hyperactivity**
- k. Overdose effects are similar to those seen with Amphetamine.

Atomoxetine

This is a non-stimulant drug, which is effective in increasing attention and concentration and reducing impulsive and restless behaviours. It may also improve sleep and have an effect on early morning behaviours. It provides continuous 24 hour control of ADHD symptoms.

For full prescribing details, please consult the latest SPC

- a. Many patients taking Atomoxetine experience a modest increase in pulse (mean <10bpm) and/or changes in blood pressure (mean < 5mmHg). For most people these changes are not clinically important.
- b. The Medicines and Healthcare Regulatory Agency (MHRA) yellow card scheme has issued advice about the risk of rare, but sometimes severe, cases of hepatic disorder. The risk is estimated at below 1 in 50,000 patients treated but it is important patients and their families are warned of the risk and told of the possible symptoms. Routine monitoring of liver function is not recommended, but all suspected hepatic reactions should be investigated. Atomoxetine should be discontinued in patients with jaundice or laboratory evidence of hepatic injury, and should not be restarted.
- c. Atomoxetine causes clinically important increases in blood pressure or heart rate, or both, in a small proportion of patients. Atomoxetine should not be used in patients with severe cardiovascular or cerebrovascular disorders. Thorough pretreatment screening and regular monitoring of cardiovascular status is recommended. Specialist cardiac evaluation and advice should be sought if pretreatment findings suggest cardiac disease or history, or if symptoms suggesting cardiac disease are found during treatment**
- d. Abdominal pain and decreased appetite were the most commonly reported side effects in clinical trials. In practice, indigestion, nausea, vomiting and drowsiness can be problematic. The tablets have a very bitter taste.
- e. All serious suspected reactions should be reported to the MHRA - has black triangle status even if the adverse event is well recognised or if a causal link is uncertain. See BNF for details.

Drug Interactions

For further advice on drug interactions, contact the Pharmacy Department at Goodmayes Hospital or the local specialist clinics.

Methylphenidate

Methylphenidate undergoes rapid first-pass metabolism, only 30% of the dose is available systemically with a low plasma protein-binding rate. Peak plasma concentrations are achieved 2 hours after administration, but these show considerable inter-patient variability:

- a. Inhibition of tricyclic metabolism resulting in accumulation and raising blood levels. Concurrent administration should be avoided as there is often an increase in cardiac arrhythmias

- b. Increased plasma concentration of phenytoin, phenobarbital and primidone. Concurrent use should be approached with caution, particularly if high doses of phenytoin are prescribed
- c. Antagonism of antihypertensive effect of adrenergic neurone blockers
- d. Hypertensive crisis with MAOI's and sympathomimetics such as ephedrine / phenylephrine (which may be found in cough medicines) or within 14 days of stopping treatment

Dexamfetamine

- a. Severe hypertension with concurrent use of Dexamfetamine and beta-blockers
- b. Hypertensive crisis with MAOI's and sympathomimetics such as ephedrine / phenylephrine (which may be found in cough medicines) or within 14 days of stopping treatment
- c. Acute dystonia may result if Dexamfetamine is given with haloperidol due to a potentiating of dopamine release
- d. Effects of alcohol unpredictable.

Atomoxetine

- a. **Atomoxetine causes clinically important increases in blood pressure or heart rate, or both, in a small proportion of patients. Atomoxetine should not be used in patients with severe cardiovascular or cerebrovascular disorders. Thorough pretreatment screening and regular monitoring of cardiovascular status is recommended. Specialist cardiac evaluation and advice should be sought if pretreatment findings suggest cardiac disease or history, or if symptoms suggesting cardiac disease are found during treatment.**
- b. Atomoxetine should not be used in conjunction with MAOI's due to similarities in their mode of action. There must be a minimum of a two-week gap in between taking the medications.
- c. Slower titration of Atomoxetine may be necessary in people taking CYP2D6 inhibitor medicines e.g. Fluoxetine, Paroxetine.
- d. Atomoxetine should be administered with caution to people receiving high dose nebulised or systemically administered Salbutamol as the action of Salbutamol on the cardiac system may be potentiated.
- e. Medicines that affect norepinephrine should be used cautiously with Atomoxetine because of the potential for additive pharmacological effect. Examples include antidepressants e.g. Venlafaxine, Mirtazapine, Imipramine and decongestants such as Pseudoephedrine or Phenylephrine (which may be found in cough medicines).

Lisdexamphetamine

- a. Lisdexamphetamine is a schedule 2 Controlled Drug subject to the requirements of the Misuse of Drugs Regulations 1985. It has a resale value as a drug of abuse.
- b. This is a black triangle drug. The black triangle symbol (▼) identifies newly licensed medicines that require additional monitoring by the European Medicines Agency. Prescribers and patients are encouraged to report any adverse drug reactions from taking this product to the MHRA.
- c. Antagonises hypotensive effect of adrenergic neurone blockers
- d. Risk of hypertensive crisis when given with MAOIs and moclobemide
- e. Chlorpromazine and Haloperidol may inhibit the effects of lisdexamphetamine
- f. Possibly inhibits metabolism of SSRIs and tricyclics
- g. Alcohol may exacerbate adverse CNS effects therefore it is advisable to abstain from alcohol during treatment

MONITORING STANDARDS FOR MEDICATION AT NELFT

Monitoring

Methylphenidate, Dexamphetamine & Lisdexamfetamine

Parameter	Frequency of Monitoring	Notes	By Whom
Weight	Annually	Weight loss is more important in those with a low initial BMI	Specialist
Full Blood Count	Only if rash/infection develops		Specialist/GP as agreed
Appearance of suicidal behaviour, self-harm or hostility.	Ongoing basis at appointments	More likely with Atomoxetine and at the commencement of treatment.	Specialist/GP as agreed
Pulse	Annually 6-monthly for Atomoxetine	Monitor whilst taking medication.	Specialist
Blood Pressure	Annually 6 monthly for Atomoxetine	Monitor whilst taking medication	Specialist

KEY ADVERSE EFFECTS & ACTIONS

Refer to pages 2-6. Please refer to the current British National Formulary and Summary of Product Characteristics.

Detail any important cautions

PREGNANCY AND BREAST FEEDING

If it is recommended that the patient should not become pregnant whilst on the drug, women will be counselled about contraception and what to do if pregnancy occurs. The counselling should be documented in the patient notes.

For comprehensive information please refer to the current British National Formulary and Summary of Product Characteristics.

SHARED CARE

Shared care guideline: is a document which provides information allowing patients to be managed safely by primary care, secondary care and across the interface. It assumes a partnership and an agreement between a hospital specialist, GP and the patient and also sets out responsibilities for each party. The intention to shared care should be explained to the patient and accepted by them. Patients are under regular follow-up and this provides an opportunity to discuss drug therapy. Intrinsic in the shared care agreement is that the prescribing doctor should be appropriately supported by a system of communication and cooperation in the management of patients. The doctor who prescribes the medicine has the clinical responsibility for the drug and the consequence of its use.

Consultant

1. To identify those patients who will benefit from treatment with medication and to discuss potential benefits and side effects of treatment with the patient/carer to identify whether they have a clear picture of these
2. Assess for psychiatric comorbidities and develop an appropriate treatment/management plan
3. Undertake pre-treatment monitoring (BMI, blood pressure, ECG) and advise the GP of any abnormal results.
4. Assess Atomoxetine patients on an ongoing basis for appearance of suicidal behaviour, self-harm or hostility.
5. Check drug-drug and drug-disease interactions e.g. establish any history of cardiac or epileptic conditions and any concurrent medicines
6. Initially prescribe and stabilise the patient on the chosen medication. Monitor BMI and blood pressure at least annually and undertake ECG check on QTc interval annually
7. When appropriate, ask GP if they are willing to participate in shared care.
8. Advise GP of information provided to the patient/carer about the treatment and/or about the proposed shared care arrangement e.g. what and to whom the patient should report potential side effects.
9. Continue to prescribe for the patient after initiation of treatment until such time as the patient's GP agrees to accept prescribing responsibility and provide prescriptions for the patient under an agreed shared care arrangement.
10. Communicate promptly with the GP about any changes in treatment when the GP is the prescriber
11. Monitor the efficacy of the treatment at least annually, considering whether continuation is necessary.
12. Agree how the outcome of monitoring will be communicated between specialist, GP and patient.
13. Ensure clear arrangements are in place for back up, advice and support e.g. out of hours and/or when the consultant initiating therapy is not available.
14. Evaluate any adverse effects reported by the GP (Any adverse effects which are suspected to relate to the drug should be reported to the MHRA).

General Practitioner

1. To reinforce patients understanding of their treatment regime and any monitoring and follow up that is required on an ongoing basis.
2. Confirm that proposed therapy is not contra-indicated because of concurrent therapy for other conditions the patient may be suffering from e.g. check drug-drug and drug-disease interactions.
3. Prescribe medication at the dose recommended by the Specialist once the patient is stabilised on treatment and side effects have been excluded as far as possible by the specialist team.
4. To discuss with the specialist if suicidal behaviour, self-harm or hostility develop.
5. Monitor parameters as agreed with specialist. Confirm with specialist which changes in these or other parameters, including loss of efficacy or worsening of condition related symptoms, should trigger urgent referral back to the specialist.
6. Arrange appropriate investigation if the patient shows signs of liver problems and discontinue the medication if the person has jaundice or has laboratory evidence of hepatic injury. Contact the specialist team immediately.
7. Report any suspected adverse drug reactions to Specialist who initiated therapy under the shared care agreement. Report adverse events to the CMS; If the drug has black triangle status or is unlicensed, all adverse events should be reported even if causal relationship is not known or if the adverse event is already known about.
8. Monitor compliance through rates of prescription.

CCG

1. To provide feedback to trusts via the relevant Trust Medicines Committee.
2. To support GPs to make the decision whether or not to accept clinical responsibility for prescribing.
3. To support trusts in resolving issues that may arise as a result of shared care.

Patient/ Carer

1. Discuss potential benefits and side effects of treatment with the specialist and GP, to identify whether they have a clear picture of these from the specialist and to raise any outstanding queries
2. Share any concerns they have in relation to treatment with their drug(s)
3. Report any adverse effects to their specialist or GP whilst taking drug(s)
4. Report to the specialist or GP if they do not have a clear understanding of their treatment
5. Participate in the monitoring of therapy and the assessment of outcomes, to assist health professionals to provide safe,

Costs

Drug Product	Cost in primary care
<p><i>Methylphenidate</i> 10mg od to 20mg tds Ritalin® 10mg scored tablets. net price 30-tab pack = £5.57</p>	<p>Ritalin® 10mg tabs= £16.71 to 33.42/mth</p>
<p>Medikinet® (Methylphenidate hydrochloride) 5 mg, net price 30-tab pack = £3.03; 10 mg, 30-tab pack =£5.49 ; 20 mg, 30-tab pack = £10.92</p>	<p>Based on 5mg od to bd: Medikinet® 5mg caps = £3.03 to £6.06/mth Based on 20mg tds: Medikinet® 20mg tabs= £32.76/mth</p>
<p>Equasym XL® 10 mg (white/green), net price 30-cap pack = £25.00; 20 mg (white/blue), 30-cap pack = £30.00; 30 mg (white/brown), 30-cap pack = £35.00.</p>	<p>Based on Equasym® 10mg XL od: Equasym® 10mg XL caps = £ 25.00/mth Based on Equasym® 30mg to 60mg XL od: Equasym® 30mg XL caps = £35.00 to £70.00/mth</p>
<p>Medikinet XL® (Flynn) Capsules, m/r, methylphenidate hydrochloride 5 mg (white), net price 30-cap pack = £24.04; 10 mg (lilac/white), 30-cap pack = £24.04; 20 mg (lilac), 30-cap pack = £28.86; 30 mg (purple/light grey), 30-cap pack = £33.66; 40 mg (purple/grey), 30-cap pack = £57.72.</p>	<p>Based on Medikinet® XL 10mg od: Medikinet® 10mg XL caps = £24.04/mth Based on Medikinet® XL 60mg od: Medikinet® 20mg & 40mg XL caps = £86.58/mth</p>
<p>Concerta XL® 18mg and 36mg tablets Concerta XL® 18 mg (yellow), net price 30-tab pack = £31.19; 27 mg (grey), 30-tab pack = £36.81; 36 mg (white), 30-tab pack = £42.45</p>	<p>Based on Concerta® XL 18mg od: Concerta® XL 18mg caps = £31.19 Concerta® XL 54mg od: Concerta® XL 18mg caps = £93.37</p>
<p>Elvanse® capsules, lisdexamfetamine mesilate 30mg (white/pink), net price 28-cap pack = £58.24, 50mg (white/blue), 28-cap pack = £68.60, 70mg (blue/pink), 28-cap pack = £83.16</p>	<p>Based on Elvanse® 30mg od to 70mg od: £58.24 to £83.15/mth</p>
<p>Dexamfetamine 7.5mg daily to 20mg daily (40mg has been required in some children) Dexamfetamine 5mg scored tablet. Net price 28-tab pack = £22.58.</p>	<p>Based on dexamfetamine 2.5mg bd to 20mg od using 5mg scored tabs = £22.58/mth to</p>

Atomoxetine 10mg od to 100mg od, BNF prices Strattera (Atomoxetine)(as hydrochloride) 10 mg (white), net price 7-cap pack = £15.62, 28-cap pack = £62.46; 18 mg (gold/white), 7-cap pack = £15.62, 28-cap pack = £62.46; 25 mg (blue/white), 7-cap pack = £15.62, 28-cap pack = £62.46; 40 mg (blue), 7-cap pack = £15.62, 28-cap pack = £62.46; 60 mg (blue/gold), 28-cap pack = £62.46; 80 mg (brown/white), 28-cap pack = £83.28. 100mg (brown), 28 cap pack = £ 83.28	£112.90/mth Based on atomoxetine 40mg od using 40mg caps = £62.46/mth Based on atomoxetine 80mg od using 80mg caps = £83.28/mth
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Based on British National Formulary for Children July 2014 - July 2015, last accessed 28/10/14 via:
<https://www.medicinescomplete.com/mc/bnfc/current/PHP12233-cns-stimulants-and-other-drugs-for-attention-deficit-hyperactivity-disorder.htm>

RESOURCES AVAILABLE

This Shared Care Agreement should be read in conjunction with:

Current Summary of Product Characteristics (SPC, datasheet). Current revisions available at: <https://www.medicines.org.uk/emc/>.

British National Formulary for Children July 2014 - July 2015

NICE. Clinical Guideline 72: Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults (2008). Review date: September 2014. Accessed via: <http://publications.nice.org.uk/attention-deficit-hyperactivity-disorder-cg72>

NELFT - For Back-up Advice and Support

If you would like information about medicines used in mental health services, please click on the link below. This will take you to the NELFT section of a website called Choice and Medication.

Go to the Choice and medication website.

The information on this website can help you to make informed decisions about medication. Use this site on your own or use it together with your family or someone you care for or your doctor, nurse or pharmacist. Medications website's full link:

<http://www.choiceandmedication.org.uk/nelft/>

Chief Pharmacist or the local Consultants can be contacted for advice.

Ms.Heather Walker	Chief Pharmacist	03005551200
Dr Richard Duffett	Redbridge	03005551200 ext 7975
Dr Vaughan Williams	Waltham Forest	03005551200 ext 8953
Dr Asif Bachlani	Barking and Dagenham	03005551200 ext 5828
Dr Darlington Daniel	Havering	03005551200 ext 5717

References

This is a new Guideline for Adults with ADHD based on the shared Care guideline of 2014 authored by Dr Manas Sarkar CAMHS Consultant

References used

British National Formulary 2014-2015. Accessed via: <https://www.medicinescomplete.com/mc/bnfc/current/>

NICE. Clinical Guideline 72: Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults (2008). Review date: September 2014. Accessed via: <http://publications.nice.org.uk/attention-deficit-hyperactivity-disorder-cg72>

Handbook for ADHD in Adults – UK Adult ADHD Network – Springer Healthcare 2013

Refer to the relevant CCG website to obtain the latest version of this guideline

NELFT

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Dexamfetamine, Atomoxetine (Strattera®) and Lisdexamfetamine (Elvanse®)**

SHARED CARE AGREEMENT LETTER

Name of GP Address
.....
.....
.....

Dear GP

Re: Patient's Name.....

Date of Birth.....

NHS Number.....

Indication for ADHD

Route Oral

Drug Dose.....mg daily

Enclosed is a copy of the shared care guidelines for ADHD to be retained in the patient's notes. Should you agree to shared care, we will send a letter containing the details of the patient's treatment plan, the dose to be prescribed and all relevant blood results.

Please sign below and return this letter to the Hospital Specialist if you agree to the shared care arrangements for this patient.

Many thanks

Hospital Specialist GP
Signature..... Signature.....
Name Name
Date..... Date.....

If you are not taking on shared care for this patient please state the reason why and return this letter to the Hospital Specialist.

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