NELFT NHS
NHS Foundation Trust
Best care by the best people

# BHR CCGS and NELFT Shared Care Guidelines

## Shared Care Guidelines for the Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in children and adolescents (under 18 years of age)
## Methylphenidate, Dexamfetamine ,Atomoxetine, Lisdexamfetamine and Guanfacine

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

| | |
|---|---|
| Shared care guidelines for treatment of ADHD in children and adolescents under 18 years of age. | Version 1: November 2018 |
| Scope | |
| Authors/originators | |
| Authorised by | |
| Date of issue | |
| Review date | |

| | | |
|---|---|---|
| **Patient Name:** | **Date of Birth:** | **NHS No:** |
| **Name of Referring Consultant:** | **Contact number:** | |

### AIMS/Scope of guidelines:

These shared care guidelines is aimed at providing information and guidance to GPs, consultants and CCGs on the safe, effective and appropriate administration of methylphenidate, dexamphetamine, atomoxetine, lisdexamfetamine and guanfacine when used for treatment of ADHD in children under the age of 18.

### Introduction

1. ADHD (as defined in DSM-IV-TR) is a common disorder. In the UK, it is estimated that amongst children between the ages of 5 and 15 years, 3.62% of boys and 0.85% of girls had ADHD, though not all of these children and adolescents would require treatment .Approximately 1% of the school aged children and adolescents would meet the diagnostic criteria for hyperkinetic disorder.
2. For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:
    a) meet the diagnostic criteria in DSM-IV-TR or ICD-10 (hyperkinetic disorder) and
    b) be associated with at least moderate psychological, social and/or educational or occupational impairment based on interview and/or direct observation in multiple settings, and
    c) be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings.
3. As part of the diagnostic process, include an assessment of the person's needs, coexisting conditions, social, familial and educational or occupational circumstances and physical health. For children and young people, there should also be an assessment of their parents' or carers' mental health
4. Children and adolescents referred for assessment for ADHD should receive a specialist clinical assessment by a psychiatrist or paediatrician, with the aim of ruling out undiagnosed disorders with symptoms that in rare instances may mimic or cause some aspects of ADHD, such as hearing impairment, epilepsy, thyroid disorder and iron deficiency anaemia.

**Indications, licensing, prescribing advice, doses and routes of administration of medication in guidelines**

5. Drug treatment is not indicated as the first-line treatment for all school-age children and young people with ADHD. It should be reserved for those with severe symptoms and impairment or for those with moderate levels of impairment who have refused non-drug interventions, or whose symptoms have not responded sufficiently to parent-training/education programmes or group psychological treatment.
6. All children with ADHD will benefit from behavioural, educational and psychological input. Information about ADHD and additional support should be offered to parents and carers of all children aged 5 years and over and young people with ADHD. The support should be ADHD focused, can be group based and as few as 1 or 2 sessions.
7. Medications should only be initiated by an appropriately qualified healthcare professional with expertise in ADHD after a comprehensive assessment. Medication should be offered to children and young people only if their ADHD symptoms are still causing a persistent significant impairment in at least one domain after environmental modifications have been I, mplemented and reviewed, they and their parents and carers have discussed information about ADHD, and a baseline assessment has been carried out (see point 8 below).
8. Before starting drug treatment, children and young people with ADHD should have a full pre-treatment assessment, which should include:
    a) full mental health and social assessment
    b) full history and physical examination, including:
        i. assessment of history of exercise syncope, undue breathlessness and other cardiovascular symptoms
        ii. heart rate and blood pressure (plotted on a centile chart)
        iii. height and weight (plotted on a growth chart)
        iv. family history of cardiac disease and examination of the cardiovascular system
        v. an electrocardiogram (ECG) if there is past medical or family history of serious cardiac disease, a history of sudden death in young family members or abnormal findings on cardiac examination
        vi. risk assessment for substance misuse and drug diversion (where the drug is passed on to others for non-prescription use).
9. NICE guidelines (2018) makes the following recommendations for pharmacological intervention in children and young people diagnosed with ADHD:
    a) Offer methylphenidate (either short or long acting) as the first line pharmacological treatment for children aged 5 years and over and young people with ADHD
    b) Consider switching to Lisdexamfetamine for children aged 5 years and over and young people who have had a 6-week trial of methylphenidate at an adequate dose and not derived enough benefit in terms of reduced ADHD symptoms and associated impairment
    c) Consider dexamfetamine for children aged 5 years and over and young people whose ADHD symptoms are responding to Lisdexamfetamine but who cannot tolerate the longer effect profile
    d) Offer atomoxetine or Guanfacine to children aged 5 years and over and young people if:
        i) They cannot tolerate methylphenidate or Lisdexamfetamine or
        ii) Their symptoms have not responded to separate 6-week trials of Lisdexamfetamine, methylphenidate, having considered alternative preparations and adequate doses

10. **The cheapest agent should be used in situations where equivalent effectiveness can be demonstrated (see appendix 2)**
11. Successful treatment reduces the risk of development of secondary complications such as conduct disorder or academic failure. The medication should be discontinued if review shows it to be unneeded. Methylphenidate, Dexamfetamine and Lisdexamphetamine should be withdrawn carefully in those who have been taking it regularly long term. Atomoxetine **can** be discontinued without tapering the dose.

12. Rarely, under specialist supervision, Methylphenidate and Atomoxetine may be combined. If this occurs then prescribing will remain wholly within secondary care.
13. In children and young people whose ADHD is unresponsive to Methylphenidate, Atomoxetine, Dexamfetamine,Lisdexamphetamine and guanfacine (specialist prescribing only), further treatment may include the use of medication unlicensed for the treatment of ADHD (such as Bupropion, Clonidine, Modafinil and Imipramine) or combination treatments (including psychological treatments for the parent or carer and the child or young person).
14. NICE Guidelines recommend that a cardiovascular examination and ECG should be carried out before starting treatment with Clonidine in children or young people with ADHD.
15. A specialist should initiate medication for the treatment of ADHD after appropriate assessment. This may be a Consultant in Child and Adolescent Psychiatry, a Consultant paediatrician with a specialist interest in ADHD or a GP with a special interest, in conjunction with the advice from the local Child and adolescent psychiatric team.
16. If treatment is adopted and the patient is stabilised, then consideration can be given to shared care arrangements. The specialist should 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.
17. The shared care arrangements should be agreed by the patients (if appropriate) and their parents and supported with patient information leaflets and their GP.
18. A number of children continue to require treatment into adulthood. Decisions to continue or initiate treatment in adults should be considered by adult psychiatrists after an assessment of symptoms and as part of a wider programme of care.

*Table 1: Indications, place in therapy, doses and routes of administration of medication included in shared care guidance*

| Drug | Indication | Place in therap | Dose and Route of Administration | | |
|---|---|---|---|---|---|
| | | | **Preparation** | **Dose** | **Notes** |
| Methylphenidate | Treatment of ADHD | First line for ADHD | **<u>Plain tablets*</u>**<br>Available in the following strengths: **5mg, 10mg, 20mg**<br>Ritalin® Medikinet® | Initially 5 mg 1–2 times a day, increased in steps of 5–10 mg daily if required, at weekly intervals, increased if necessary up to 2.1 mg/kg daily in 2–3 divided doses, max. licensed dose is 60 mg daily in 2–3 doses, (maximum of 90 mg daily under the direction of a specialist) discontinue if no response after 6 weeks | In some children rebound hyperactivity may occur if the effect of the drug wears off in the evening. An additional dose later in the day may eliminate this difficulty but may disturb sleep. |
| | | | **<u>Sustained release tablets</u>**<br>Available in the following strengths **18mg, 27mg, 36mg, 54mg**<br>Concerta® XL, Matoride, Xenidate, Delmosart, Xaggitin<br>***The prescriber must specify the brand*** | Initially 18 mg once daily in the morning, increased in steps of 18 mg daily at weekly intervals, increased if necessary up to 2.1 mg/kg daily, max. licensed dose is 54 mg daily, (maximum of 108 mg daily under the direction of a specialist) discontinue if no response after 6 weeks. ConcertaXL® tablets consist of an immediate release component (22%) of the dose and a modified release component (78% of the dose). | Total daily dose of 15mg of standard release tablet is considered equivalent to 18mg once daily of sustained release tablets. 60mg of Ritalin is the maximum licensed dose. The equivalent dose of Concerta® XL is 72mg, which is above the maximum licensed dose. |
| | | | **<u>Sustained release capsules</u>**<br>Available in the following strengths **5mg, 10mg, 20mg, 30mg, 40mg, 50mg,60mg**<br>Equasym® XL Medikinet® XL ***The prescriber must specify the brand*** | Initially 10mg once daily (in the morning before breakfast), increasing if necessary, by weekly increments of 10mg to a max. licensed dose of 60 mg daily, (maximum of 90 mg daily under the direction of a specialist) discontinue if no response after 6 weeks.<br>Medikinet XL® capsules consist of an immediate release component (50% of the dose) and a modified release component (50% of the dose).<br>Equasym XL® capsules consist of immediate release component (30% of the dose) and a modified release component (70% of the dose). | 40mg XL strength not available in Equasym® XL brand |
| Lisdexamfetamine | Licensed for ADHD for children over 6 years of age. | To be considered if methylphenidate has not been successful or tolerated | **Elvanse® 20mg. 30mg, 40mg, 50mg 60mg and 70mg Capsules** | Starting dose 30mg taken once in the morning (with or without food)<br>The dose may be increased by10-20mg increments at approximately weekly intervals.<br>Maximum recommended dose = 70mg/day | Lower starting dose of 20mg once daily may be needed in some patients<br>Lisdexamfetamine may be swallowed whole, or the capsules opened and the entire contents emptied and mixed with a soft food such as yogurt or in a glass of water or orange juice |

| Drug | Indication | Place in therapy | Dose and Route of Administration | | |
|---|---|---|---|---|---|
| | | | Preparation | Dose | Notes |
| Dexamfetamine | Licensed for ADHD for children over 6 years of age. | To be considered if methylphenidate not successful or tolerated and have responded to lisdexamfetamine but cannot tolerate | **Amfexa® tablets 5mg, 10mg 20mg**<br>Oral solution is 1mg/ml | Initially 2.5 mg 2–3 times a day, increased in steps of 5 mg once weekly if required, increased if necessary up to 1 mg/kg daily, maintenance dose to be given in 2–4 divided doses, up to 20 mg daily (40 mg daily has been required in some children). | Doses after 5pm are more likely to worsen sleep but occasionally may help settling if given less than three hours before bedtime. |
| Atomoxetine | Licensed for ADHD for children over 6 years of age. | To be considered if methylphenidate or lisdexamfetamine has not been successful or tolerated | **Strattera® Capsules 10mg, 18mg, 25mg, 40mg, 60mg, oral solution 4mg/ml**<br>**Child over 6 years (body-weight <70kg)** | Initially 500 micrograms/kg daily for 7 days, increased according to response; usual maintenance dose 1.2mg/kg daily, but may be increased to 1.8mg/kg daily (max. 120mg daily) under the direction of a specialist | The SPC dosing states that:<br>*"No additional benefit has been demonstrated for doses higher than 1.2mg/kg/day. The safety of single doses over 1.8mg/kg/day and total daily doses above 1.8mg/kg has not been systematically evaluated."*<br><br>The 1.2mg/kg/day dose is based on 2001 data on uncomplicated 'pure' attention deficit hyperactivity disorder. The consultant-led clinic is full of complex patients with co-morbidities, and since 2005 a 1.8mg/kg/day dose is known to be more effective in this group |
| | | | **Child over 6 years (body-weight >70kg)** | Initially 40mg daily for 7 days, increased according to response; usual maintenance dose 80mg daily, but may be increased to 120mg daily under the direction of a specialist. | |
| Guanfacine | Licensed for ADHD for children over 6 years of age | To be considered if methylphenidate or lisdexamfetamine has not been successful or tolerated | **Intuniv ® tablets 1mg, 2mg, 3mg, 4mg**<br><br>**Child 6-17years (body-weight 25kg – 41.4kg)** | Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 4mg once daily | |
| | | | **Child 13 - 17years (body-weight 41.5kg – 49.4kg)** | Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 5mg once daily | |
| | | | **Child 13 - 17years (body-weight 49.5kg – 58.4.kg)** | Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 6mg once daily | |
| | | | **Child 13 - 17years (body-weight >58.4.kg)** | Initially 1mg once daily increasing in weekly increments of 1mg up to a maximum of 7mg once daily | Dose can be titrated to a 7 mg/day dose after the subject has completed a minimum of 1 week of therapy on a 6 mg/day dose and the physician has performed a thorough review of the subject's tolerability and efficacy. |

***Table 1 (cont'd): Indications, place in therapy, doses and routes of administration of medication included in shared care guidance***

**NOTE: The Information in the table is not exhaustive**. **For comprehensive information on cautions, contra-indications and interactions please refer to the current British National Formulary and Summary of Product Characteristics (www.medicines.org.uk)**

## MONITORING STANDARDS FOR MEDICATION AT NELFT

**Monitoring by Specialist or GP in conjunction with CAMHS**

### a) Methylphenidate, Dexamphetamine, Lisdexamfetamine , Atomoxetine and Guanfacine

For people taking methylphenidate, lisdexamfetamine, dexamfetamine and atomoxetine, routine blood tests and ECGs are not recommended unless there is a clinical indication.
Prior to prescribing, it is necessary to conduct a baseline evaluation of a patient's cardiovascular status including blood pressure and heart rate
Liver damage is a rare and idiosyncratic adverse effect of atomoxetine but routine liver function tests are not recommended

***Table 2: Monitoring for methylphenidate, dexamphetamine, lisdexamfetamine and atomoxetine***

| Parameter | Frequency of Monitoring | Action | By Whom |
|---|---|---|---|
| Weight and height | 3 and/or 6 monthly depending on age:<br>-every 3 months in children ≤10 years<br>- at 3 and 6 months in children over >10 years and every 6 months after | Failure to gain weight appropriately (Many children lose a small amount of weight (about a kg) at the beginning of treatment.<br>-Weight and height should be plotted on published Growth Charts<br>-If weight loss continues or if child's weight trajectory crosses more than one centile line or if this translates into the height trajectory being similarly affected:<br>•Provide supporting information to help parents promote good diet – see Appendix 1.<br>•Reduce dose or encourage breaks from treatment at weekends/in school holidays.<br>•Withdraw treatment | Specialist |
| Appearance of suicidal behaviour, self-harm or hostility. | Ongoing basis at appointments | Patients/parents should be advised of this risk and made<br>aware of possible signs/symptoms to report back to the<br>Specialist immediately if noticed. | Specialist/GP as agreed |
| Blood pressure and pulse Auscultation (heart rate and regularity) | 6 monthly | -Monitor whilst taking medication to ensure within published range e.g. for age of child. If raised repeat the measurement. The dose may need to be reduced, or arrangements may need to be made for 24hour blood pressure readings. The Specialist will be able to advice.<br>-Before and after a dose change. | Specialist |

***Table 3: Monitoring for guanfacine***

| Parameter | Frequency of monitoring | Action | By whom |
|---|---|---|---|
| Gaunfacine<br>**Special note* | Treatment initiation | ***Monitoring during titration***<br>During dose titration, weekly monitoring for signs and symptoms of somnolence and sedation, hypotension and bradycardia should be performed.<br>***Ongoing monitoring***<br>During the first year of treatment, the patient should be assessed at least every 3 months for:<br>Signs and symptoms of:<br>•somnolence and sedation<br>•hypotension<br>•bradycardia<br>•weight increase /risk of obesity<br>It is recommended clinical judgement be exercised during this period. 6 monthly monitoring should follow thereafter, with | Specialist |

| | | | |
|---|---|---|---|
| | | more frequent monitoring following any dose adjustments | |
| Appearance of suicidal behavior, self-harm or hostility | Ongoing basis at appointments | Patients/parents should be advised of this risk and made aware of possible signs and symptoms to report back to the specialist immediately if noticed. | Specialist |
| Blood pressure and pulse Auscultation (heart rate and regularity) | 6 monthly | Monitor whilst taking medication to ensure within published range e.g. for age of child – see appendix 1. | Specialist |
| Growth (weight and height) | 6 monthly | Many children lose a small amount of weight (about a kg) at the beginning of treatment. Weight and height should be plotted on published Growth Charts – see appendix 1. If weight loss continues or if child's weight trajectory crosses more than one centile line or if this translates into the height trajectory being similarly affected:<br>• Provide supporting information to help parents promote good diet – see Appendix 1.<br>• Reduce dose or encourage breaks from treatment at weekends/in school holidays.<br>• Withdraw treatment<br>• Change medication | Specialist |

## PREGNANCY AND BREAST FEEDING

If is recommended that the patient should not become pregnant whilst on the drug and 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**

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|---|
| 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. Undertake pre-treatment monitoring (for example height, weight, blood pressure) and advise the GP of any abnormal results. |
| 3. Assess Atomoxetine patients on an ongoing basis for appearance of suicidal behaviour, self-harm or hostility. |
| 4. Check drug-drug and drug-disease interactions e.g. establish any history of cardiac or epileptic conditions and any concurrent medicines |
| 5. Initially prescribe and stabilise the patient on the chosen medication. Monitor height weight and blood pressure every 6 months or until it is taken over by primary care (according to local arrangements). |
| 6. When appropriate, ask GP if they are willing to participate in shared care. |
| 7. 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. |
| 8. Continue to prescribe for the patient after initiation of treatment until such time as the patient's GP agrees shared care arrangement. |
| 9. Communicate promptly with the GP about any changes in treatment. |
| 10. Monitor the efficacy of the treatment at least 6 monthly, considering whether continuation is necessary. |
| 11. Agree how the outcome of monitoring will be communicated between specialist, GP and patient. |
| 12. 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. |
| 13. Educate the family about the drug therapy to maximise compliance and be aware of when to seek medical advice. |
| 14. Liaise with the school if necessary. |
| 15. Evaluate any adverse effects reported by the GP (Any adverse effects which are suspected to relate to the drug should be reported to the CSM). |
| 16. Refer for additional behavioural therapy (social skills, anger management or parents group/parenting skills) if appropriate. |
| 17. The Specialist will specify the brand of medication in their communication to GP. |

**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 any new therapy initiated by GP 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 Methylphenidate/ Dexamfetamine/ Atomoxetine/Lisdexamfetamine at the dose recommended by the Specialist once the patient is stabilised for a minimum of four weeks on treatment and side effects have been excluded as far as possible by the specialist team. Continuation of ADHD medicines without specialist review is not recommended. |
| 4. | To discuss with the specialist if suicidal behaviour, self-harm or hostility develop. |
| 5. | Monitor parameters as agreed with specialist. If patient reports changes in these or other parameters, including loss of efficacy or worsening of condition related symptoms, urgent referral back to the specialist should be considered. |
| 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. |
| 8. | Report adverse events to the CSM; 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. |
| 9. | Only ask the Specialist to take back the prescribing should unmanageable problems arise and/or patient not engaging with GP. |

**CCG**

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| 1. To provide feedback to trusts via 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**

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|---|---|
| 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. | Check that where possible the specialists have provided a patient-held record or information sheet for monitoring and/or to alert other clinical staff to the treatment they are receiving |
| 3. | Share any concerns they have in relation to treatment with their drug(s) |
| 4. | Report any adverse effects to their specialist or GP whilst taking drug(s) |
| 5. | Report to the specialist or GP if they do not have a clear understanding of their treatment |
| 6. | Participate in the monitoring of therapy and the assessment of outcomes, to assist health professionals to provide safe, appropriate treatment |

## Costs

Based on current prices in the BNF online

Give the cost of a 1 month course of treatment for each drug listed (**see comparative list in Appendix 2**)

## *RESOURCES AVAILABLE*

This Shared Care Agreement should be read in conjunction with the current Summary of Product Characteristics (SPC) with up to date revisions available at: https://www.medicines.org.uk/emc/
Other resources include:

- Most recent editions British National Formulary and British National Formulary for Children [online], available at https://www.medicinescomplete.com/#/
- NICE. Clinical Guideline 87: Attention deficit hyperactivity disorder: diagnosis and management (2018) Available at https://www.nice.org.uk/guidance/ng87

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 available at:
http://www.choiceandmedication.org.uk/nelft/

## NELFT - For Back-up Advice and Support

For any queries, back-up advice or support with regards to the shared care guidance, please contact any of the following:

| Name | Title | Phone number |
|---|---|---|
| Dr. Leon Wehncke | Consultant child & adolescent Psychiatrist (Brookside Adolescent Unit and Young Person's Home Treatment Team) | 03005551155 |
| Dr Liam Young | Consultant child &adolescent Psychiatrist (Brookside Adolescent Unit and Young Person's Home Treatment Team) | 03005551155 |
| Dr Alice Mallucci | Consultant child & adolescent Psychiatrist (CAMHS, Barking and Dagenham) | 03005551035 |
| Dr.Skirma Povilenaite | Consultant child & adolescent Psychiatrist (CAMHS, Barking and Dagenham) | 03005551035 |
| Dr Colin Welch | Consultant child & adolescent Psychiatrist (CAMHS, Waltham Forest) | 03005551247 |
| Dr.Manas Sarkar | Consultant child & adolescent Psychiatrist (CAMHS, Havering) | 03005551124 |
| Dr. Hena Vijayan | Consultant child & adolescent Psychiatrist (CAMHS, Havering) | 03005551124 |
| Mr Rahul Singal | Chief Pharmacist | 03005551200 |

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Scottish Medicines Consortium: Lisdexamfetamine dimesylate, 30mg, 50mg & 70mg capsules (Elvanse®) SMC No. (863/13) Accessed via https://www.scottishmedicines.org.uk/files/advice/lisdexamfetamine_dimesylate__Elvanse__FINAL_April_2013_Amended_26.04.13_for_website.pdf (last accessed 08/11/2018)

Summary of Product Characteristics [online] Available at https://www.medicines.org.uk/emc/ (last accessed 08/11/18)

**Appendix 1**

Address:

Tel: 0300 555 1200

**SHARED CARE AGREEMENT LETTER**

Dear GP,

**RE: NAME: DOB: Hospital Number:**

**Indication: Medicine name: Dose:**

The above patient is under our care in the …… Service and has been commenced on ……

The patient has shown benefit and has been stabilised on the medication for …… month(s). We would be most grateful if you would facilitate the continuing care as per the ATTACHED shared care guideline, which details the GP and the Consultant's responsibilities. Please note that in NELFT there is no expectation to proactively contact the family in advance of prescribing the medication as they have already been fully counselled.

We have advised the family of the potential side effects and of the need to review continued use at least every 6-12months.

Shared Care Agreement would mean that the case will remain open to NELFT who will continue to hold responsibility for reviewing the patient regularly for the monitoring of the response to the medication/s and the side effects and monitoring the appropriate physical observations. We will keep you informed of these reviews by letter and inform you of any changes or adjustments made to medication or if it is to be stopped.

If you are in agreement with the shared care arrangement, please sign the form at the bottom of the page and fax a copy to …… or send it back to the above address.

Shared care guidelines are also available on the GP Portal on the CCG website and NELFT website

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Many Thanks

Hospital Specialist Signature: .....Name: …… Date……..……

GP Signature: ..... Practice: …… Date……..

GP Name: …….

Contact No: ……

If you have any objections in prescribing medication for the aforementioned child; please kindly state your reasons for this below:

# Appendix 2

## Methylphenidate hcl modified release tablets

*Methylphenidate hydrochloride XL 18 mg* (*30 tablets)*
Concerta XL 18mg tablets (Janssen-Cilag Ltd) =£31.19
Delmosart 18mg modified-release tablets (Actavis UK Ltd) =£15.59
Matoride XL 18mg tablets (Sandoz Ltd) =£24.95
Xaggitin XL 18mg tablets (Ethypharm UK Ltd) = £15.58
Xenidate XL 18mg tablets (Mylan Ltd) = £20.27

*Methylphenidate XL hydrochloride 27 mg (30 tablets)*
Concerta XL 27mg tablets (Janssen-Cilag Ltd) = £36.81
Delmosart 27mg modified-release tablets (Actavis UK Ltd) = £18.41
Xaggitin XL 27mg tablets (Ethypharm UK Ltd)
Xenidate XL 27mg tablets (Mylan Ltd) = £23.93

*Methylphenidate XL hydrochloride 36 mg (30 tablets)*
Concerta XL 36mg tablets (Janssen-Cilag Ltd) = £42.45
Delmosart 36mg modified-release tablets (Actavis UK Ltd) = £21.23
Matoride XL 36mg tablets (Sandoz Ltd) = £33.96
Xaggitin XL 36mg tablets (Ethypharm UK Ltd) = £21.22
Xenidate XL 36mg tablets (Mylan Ltd) = £27.59

*Methylphenidate XL hydrochloride 54 mg (30 tablets)*
Concerta XL 54mg tablets (Janssen-Cilag Ltd) = £73.62
Delmosart 54mg modified-release tablets (Actavis UK Ltd) = £36.81
Matoride XL 54mg tablets (Sandoz Ltd) = £60.48
Xaggitin XL 54mg tablets (Ethypharm UK Ltd)
Methylphenidate hydrochloride 54 mg= £36.80
Xenidate XL 54mg tablets (Mylan Ltd) = £47.85

## Methylphenidate hydrochloride tablets (30)

Methylphenidate 5mg tablets = £3.03
Methylphenidate 10mg tablets= £5.49
Methylphenidate 20mg tablets= £10.92

## Methylphenidate Modified-release capsule (30)

Medikinet XL 5mg capsules (Flynn Pharma Ltd) = £24.04
Equasym XL 10mg capsules (Shire Pharmaceuticals Ltd) = £25.00
Medikinet XL 10mg capsules (Flynn Pharma Ltd) = £24.04
Equasym XL 20mg capsules (Shire Pharmaceuticals Ltd) = £30.00
Medikinet XL 20mg capsules (Flynn Pharma Ltd) = £28.86
Equasym XL 30mg capsules (Shire Pharmaceuticals Ltd) = £35.00
Medikinet XL 30mg capsules (Flynn Pharma Ltd) = £33.66
Medikinet XL 40mg capsules (Flynn Pharma Ltd) = £57.72
Medikinet XL 50mg capsules (Flynn Pharma Ltd) = £62.52
Medikinet XL 60mg capsules (Flynn Pharma Ltd= £67.32

## Dexamphetamine tablets: (30)

Dexamfetamine 5mg tablets (A A H Pharmaceuticals Ltd) = £18.99
Amfexa 5mg tablets (Flynn Pharma Ltd) = £19.89
Dexamfetamine 5mg tablets (Alliance Healthcare (Distribution) Ltd= £22.45
Dexamfetamine 5mg tablets (Teva UK Ltd) = £24.75
Amfexa 10mg tablets (Flynn Pharma Ltd) = £39.78
Amfexa 20mg tablets (Flynn Pharma Ltd= £79.56

## Lisdexamfetamine Dimesylate (28)

Elvanse 20mg capsules (Shire Pharmaceuticals Ltd) ▼= £54.62
Elvanse 30mg capsules (Shire Pharmaceuticals Ltd) ▼= £58.24
Elvanse 40mg capsules (Shire Pharmaceuticals Ltd) ▼ = £62.82
Elvanse 50mg capsules (Shire Pharmaceuticals Ltd) ▼= £68.60
Elvanse 60mg capsules (Shire Pharmaceuticals Ltd) ▼= £75.18
Elvanse 70mg capsules (Shire Pharmaceuticals Ltd) ▼= £83.16

## Atomoxetine hydrochloride

*Capsules (28)*
Strattera 10mg capsules (Eli Lilly and Company Ltd= £53.09
Strattera 18mg capsules (Eli Lilly and Company Ltd) = £53.09
Strattera 25mg capsules (Eli Lilly and Company Ltd) = £53.09
Strattera 40mg capsules (Eli Lilly and Company Ltd = £53.09
Strattera 60mg capsules (Eli Lilly and Company Ltd) = £53.09
Strattera 80mg capsules (Eli Lilly and Company Ltd) = £70.79
Strattera 100mg capsules (Eli Lilly and Company Ltd) = £70.79

*Solution (300ml)*
Strattera 4mg/1ml oral solution (Eli Lilly and Company Ltd) = £85.00

## Guanfacine

*Tablets (28)*
Intuniv 1mg modified-release tablets (Shire Pharmaceuticals Ltd) ▼= £56

Intuniv 2mg modified-release tablets (Shire Pharmaceuticals Ltd) ▼=£58.52
Intuniv 3mg modified-release tablets (Shire Pharmaceuticals Ltd) ▼=£65.52
Intuniv 4mg modified-release tablets (Shire Pharmaceuticals Ltd) ▼=£76.16