

**Dexamfetamine Shared Care Guideline: Prescribing Agreement for Attention Deficit** **Hyperactivity Disorder in Children & Young People (6-18 years)**

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| **Section A: To be completed by the hospital specialist initiating the treatment** |
| **GP Practice Details:*****(IT add full GP address, practice code etc)*** | **Patient Details: (IT add patient fields)** |
| **Specialist prescriber name:** ……………………………...... **Clinic name:**………………………………….**Contact details**: Address:........................................................................................................................Tel no: …………………………………… E-mail: …………………………… |
| **Diagnosis: (IT add latest diagnosis)** | **Medication name, dose and frequency to be prescribed by GP:** ………………………………………………. |
| **Next hospital appointment:**  |
| Dear Dr. …………………….,Your patient was reviewed on *;* they started (insert medication name and dose) on  for the above diagnosis and in my view, their condition is now stable. I am requesting your agreement to sharing the care of this patient from  in accordance with the attached Shared Care Prescribing Guideline (approval date ). Please take particular note of the responsibilities for the specialist, GP and patient for this shared care arrangement are detailed. Patient information has been given outlining potential aims and side effects of this treatment. The patient has given me consent to treatment possibly under a shared care prescribing agreement (with your agreement) and has agreed to comply with instructions and follow up requirements.Report all adverse effect of atomoxetine to the MHRA via the yellow card system..The most recent investigations have been performed on  and are acceptable for shared care. Please monitor:Blood pressure, pulse, and weight every 6 monthsFor children 10 years and underweight every 3 months.For children over 10 years weight at 3 and 6 months after starting treatment and every 6 months thereafter. For signs of liver toxicity with atomoxetine.Please re-refer the patient or seek specialist advice from the psychiatrist or paediatrician if there is deterioration in ADHD symptomatology, behaviour, evidence of suicidal ideation or adverse effects of medication.

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| **Test** | **Baseline** | **Date** | **Current** | **Date** |
| Blood pressure |  |  |  |  |
| Pulse |  |  |  |  |
| Weight (including centiles) |  |  |  |  |
| Height (including centiles) |  |  |  |  |

Other relevant information: ……………………………………………………………………………………..Specialist Signature: ………………………………………………Date:  |

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**Dexamfetamine Shared Care Guideline: Prescribing Agreement for Attention Deficit Hyperactivity Disorder in Children & Young People (6-18 years)**

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| **NOTES to the GP** The expectation is that these guidelines should provide sufficient information to enable GPs to be confident to take clinical and legal responsibility for prescribing this medicine.  The questions below will help you confirm this: * Is the patient’s condition predictable or stable?
* Do you have the relevant knowledge, skills, and access to equipment to allow you to monitor treatment as indicated in this shared care prescribing guideline?
* Have you been provided with relevant clinical details including monitoring data?

 If you can answer YES to all these questions (after reading this shared care guideline), then it is appropriate for you to accept prescribing responsibility. Prescribe a maximum of 30 days at a time with a review date of every 6 months. Quantities should be supplied in line with pack size and local waste reduction program.  If the answer is NO to any of these questions, you should not accept prescribing responsibility. You should write to the specialist prescriber within 14 days, outlining your reasons for NOT prescribing. If you do not have the confidence to prescribe, we suggest you discuss this with your local Trust/specialist service, who will be willing to provide training and support. If you still lack the confidence to accept clinical responsibility, you still have the right to decline. Your CCG pharmacist will assist you in making decisions about shared care.  It would not normally be expected that a GP would decline to share prescribing on the basis of cost. **The patient’s best interests are always paramount**  |

Approved by: Integrated medicines committee (IMOC)

Approval date: 27th November 2024

Review Date: November 2026

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| **Dexamfetamine for attention deficit hyperactivity disorder (ADHD) in in Children & Young People (6-18 years)**  |
| **Specialist prescriber responsibilities** * Assess the patient and provide diagnosis; ensure that this diagnosis is within scope of this shared care protocol (section 2) and communicated to primary care.
* Use a shared decision-making approach; discuss the benefits and risks of the treatment with the patient and/or their carer and provide the appropriate counselling (see section 11), to enable the patient to reach an informed decision. Obtain and document patient consent. Provide an appropriate patient information leaflet. <https://www.choiceandmedication.org/swlstg-tr/printable-leaflets/patient-information-leaflets/41/ALL/>
* Ensure the patient and/or their carer understands that treatment may be stopped if they do not attend for monitoring and treatment review.
* Assess for contraindications and cautions (see section 4) and interactions (see section 7).
* Conduct required baseline investigations and initial monitoring (see section 8).
* Initiate and optimise treatment as outlined in section 5. Prescribe the maintenance treatment for at least 4 weeks and until optimised.
* Once treatment is optimised, complete the shared care documentation and send to patient’s GP practice detailing the diagnosis, current and ongoing dose, any relevant test results and when the next monitoring is required. Include contact information (section 13).
* Prescribe sufficient medication to enable transfer to primary care, including where there are unforeseen delays to transfer of care. Prescribe in line with controlled drug prescription requirements (section 6).
* Conduct the scheduled reviews and monitoring in section 8 and communicate the results to primary care. After a review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in section 9 remains appropriate.
* Ensure the patient and/or their carer understands that treatment may be stopped if they do not attend for monitoring and treatment review.
* Determine the duration of treatment and frequency of review. After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in section 9 remains appropriate. Trial discontinuations should be managed by the specialist.
* Reassume prescribing responsibilities if a woman becomes or wishes to become pregnant.
* Provide advice to primary care on the management of adverse effects if required.

**Primary care responsibilities** * Respond to the request from the specialist for shared care in writing. It is asked that this be undertaken within 14 days of the request being made, where possible.
* If accepted, prescribe ongoing treatment as detailed in the specialist’s request and as per section 5 taking into account any potential drug interactions in section 7.
* Prescribe in line with controlled drug prescription requirements (section 6).
* Adjust the dose of dexamfetamine prescribed as advised by the specialist.
* Conduct the required monitoring as outlined in section 9. Communicate any abnormal results to the specialist. • Assess for possible interactions with dexamfetamine when starting new medicines (see section 7)
* Manage adverse effects as detailed in section 10 and discuss with specialist team when required.
* Stop dexamfetamine and make an urgent referral for appropriate care if cerebral ischaemia, new or worsening seizures, or serotonin syndrome are suspected.
* Refer the management back to the specialist if the patient becomes or plans to become pregnant.
* Stop treatment as advised by the specialist. Trial discontinuations should be managed by the specialist.

**Patient and/or carer responsibilities** * Attend regularly for monitoring and review appointments with primary care and specialist and keep contact details up to date with both prescribers. Be aware that medicines may be stopped if they do not attend.
* Report adverse effects to their primary care prescriber. Seek immediate medical attention if they develop any symptoms as detailed in section 11.
* Report the use of any over the counter (OTC) medications to their primary care prescriber and be aware they should discuss the use of dexamfetamine with their pharmacist before purchasing any OTC medicines.
* Dexamfetamine is subject to drug driving laws. Not to drive, cycle or operate machines if dexamfetamine affects their ability to do so safely, e.g. by causing dizziness, drowsiness and visual disturbances and to inform the DVLA if their ability to drive safely is affected. See <https://www.gov.uk/adhd-and-driving>and section 11.
* Avoid alcohol while during treatment, as it may make some side effects worse. Avoid recreational drugs.
* Dexamfetamine is a schedule 2 controlled drug. Patients may be required to prove their identity when collecting prescriptions and should store dexamfetamine safely and securely. It must not be shared with anyone else.
* Patients of childbearing potential should take a pregnancy test if they think they could be pregnant and inform the specialist or GP immediately if they become pregnant or wish to become pregnant.

**ADHD resources for children and young people, parents/carers and primary care professionals** Working with the ADHD Foundation, we have launched new set of booklets for children, teenagers and their parents and carers. There are three separate booklets, each of which has a different focus: * The children’s booklet is an interactive guide with 20 fun activities for children to help them focus, manage their emotions, and succeed
* The teenager’s booklet is a guide and workbook with information and activities to support teenagers living with ADHD
* The parents/carers booklet is an information and resource guide for parents and carers of children and young people with ADHD and may also be useful for health professionals including those working in primary care.

All three booklets are available to share and download on our website: <https://www.transformationpartnersinhealthandcare.nhs.uk/cyp-adhd-resources>   |

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|  **1. Background** Back to top  |
| Dexamfetamine sulphate is a sympathomimetic amine with central stimulant and anorectic activity indicated for the treatment of attention deficit hyperactivity disorder (ADHD). It may be offered as an alternative treatment in patients who have been appropriately diagnosed and whose symptoms are responding to Lisdexamfetamine but are unable to tolerate the medicine’s longer effect profile (see NICE Guidance NG87 Attention deficit hyperactivity disorder: diagnosis and management). NICE recommends that people with ADHD have a comprehensive, holistic shared treatment plan that addresses psychological, behavioural, and occupational or educational needs.  Dexamfetamine is a schedule 2 controlled substance; all legal requirements for prescribing controlled drugs should be followed. See NICE Guidance NG46 Controlled drugs: safe use and management. Where a person with ADHD is treated by a Child and Adolescent Mental Health Service (CAMHS) but is approaching their 18th birthday, it is expected that CAMHS will refer to the appropriate adult service if need for ongoing treatment is anticipated. Long-term usefulness of dexamfetamine for extended periods (over 12 months) should be periodically re-evaluated by a healthcare professional with expertise in ADHD for the individual patient with trial periods off medication to assess the patient's functioning without pharmacotherapy. It is recommended a trial discontinuation at least once yearly to assess the patient’s condition. Improvement may be sustained when the medicinal product is either temporarily or permanently discontinued.  |
|  **2. Indications** Back to top |

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| Dexamfetamine is indicated for attention-deficit/hyperactivity disorder (ADHD) in children and adolescents aged 6 to 17 years when response to previous methylphenidate treatment is considered clinically inadequate as part of a comprehensive treatment programme A comprehensive treatment programme typically includes psychological, educational, and social measures. To be considered if methylphenidate is not successful or tolerated and have responded to Lisdexamfetamine but cannot tolerate the longer effect profile  |
|  **3. Locally agreed off-label use** Back to top  |
| Not applicable  |
|  **4. Contraindications and cautions** Back to topThis information does not replace the Summary of Product Characteristics (SPC) and should be read in conjunction with it. Please see [BNF](https://bnf.nice.org.uk/drug/ciclosporin.html) & [SPC](https://www.medicines.org.uk/emc/search?q=ciclosporin) for comprehensive information.  |
| **Contraindications:** * Known hypersensitivity to the active substance, any of the excipients, or sympathomimetic amines.
* Glaucoma
* Phaeochromocytoma
* Certain pre-existing cardiovascular disorders constitute contraindications unless specialist cardiac advice is obtained and documented. These include structural cardiac abnormalities and/or moderate or severe hypertension, heart failure, arterial occlusive disease, angina, haemodynamically significant congenital heart disease, cardiomyopathies, myocardial infarction, potentially life-threatening arrhythmias and channelopathies (disorders caused by the dysfunction of ion channels)
* Advanced arteriosclerosis
* Concomitant use of monoamine oxidase inhibitors (MAOI) or within 14 days of MAOI treatment
* Hyperthyroidism or thyrotoxicosis.
* Severe depression, anorexia nervosa/anorexic disorders, suicidal ideation, hyperexcitability, psychotic symptoms, severe and episodic (Type I) Bipolar (affective) Disorder (that is not well-controlled), schizophrenia, psychopathic/borderline personality disorder.
* Gilles de la Tourette syndrome or similar dystonia
* Cerebrovascular disorders (cerebral aneurysm, vascular abnormalities including vasculitis or stroke) • Porphyria
* History of drug abuse or alcohol abuse
* Pregnancy (see section 12)

 **Cautions:** * History of epilepsy (discontinue if seizures occur)
* Mild hypertension, history of cardiovascular disease, or concomitant medications that elevate blood pressure.
* susceptibility to angle-closure glaucoma
* Psychiatric and neuropsychiatric symptoms or disorders, including manic or psychotic symptoms, aggressive or hostile behaviour, tics, anxiety/agitation, or bipolar disorder.
* Depressive symptoms: patients should be screened for risk of bipolar disorder, including psychiatric and family histories.
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| * Renal and hepatic insufficiency (due to lack of data).
* Family history of sudden cardiac or unexplained death or malignant arrhythmia
* Breast-feeding (see section 12)
* Potential for abuse, misuse, or diversion.

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|  **5. Initiation and ongoing dose regime** Back to top |
| * Transfer of monitoring and prescribing to primary care is after at least **12 weeks**, and when the patient’s dose has been optimised and with satisfactory investigation results for at least 4 weeks.
* The duration of treatment & frequency of review will be determined by the specialist, based on clinical response and tolerability.
* All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care clinician.

Termination of treatment will bethe responsibility of the specialist. **Initial stabilisation:** **ADHD**: 5 mg once or twice daily (e.g., at breakfast and lunch). Can be started at 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. Dexamfetamine must be prescribed by the initiating specialist during initiation and dose stabilisation.  **The loading period** **must be prescribed by the initiating specialist.** **Maintenance dose (following initial stabilisation):** Increased, if necessary, by weekly increments of 5 mg in the daily dose according to tolerability and degree of efficacy observed. Maintenance dose to be given in 2–4 divided doses.  The maximum daily dose in children and adolescents is usually 20 mg, although doses of 40 mg may in rare cases be necessary. **The initial maintenance dose must be prescribed by the initiating specialist.** **Conditions requiring dose adjustment:** Consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate. This should be undertaken and supervised by the specialist who will advise the patient and primary care prescriber of the outcome. Treatment must be stopped if the symptoms do not improve after appropriate dosage adjustment over a one-month period. If paradoxical aggravation of symptoms or other serious adverse events occur, the dosage should be reduced or discontinued. |
|  **6. Pharmaceutical aspects** Back to top  |
| Route of administration: | Oral  |
| Formulation: | Dexamfetamine sulfate 5mg, 10mg and 20mg immediate release tablets (Amfexa®▼) Dexamfetamine sulfate 5mg immediate release tablets Please note licensed indications vary by manufacturer. See [SPCs](https://www.medicines.org.uk/emc/search?q=dexamfetamine) for full details |

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| Administration details: | Tablets can be halved. Dexamfetamine should not be taken too late after lunch time to avoid disturbances of sleep. If a dose is missed, then the next scheduled dose should be taken as usual; a double dose should not be taken to make up for a missed dose. |
| Other important information: | Dexamfetamine is a schedule 2 controlled drug and is subject to [legal prescription requirements.](https://bnf.nice.org.uk/guidance/controlled-drugs-and-drug-dependence.html) It has the potential for misuse and diversion. Patients should be advised to avoid alcohol which may exacerbate the central nervous system (CNS) side-effects of dexamfetamine. Dexamfetamine is subject to additional monitoring by the Medicines and Healthcare products Regulatory Agency (MHRA) and healthcare professionals are encouraged to report any suspected adverse reactions. Amphetamines can cause a significant elevation in plasma corticosteroid levels. This increase is greatest in the evening. Amphetamines may interfere with urinary steroid determinations.  |
|  **7. Significant medicine interactions** Back to topThe following list is not exhaustive. Please see [BNF](https://bnf.nice.org.uk/drug/ciclosporin.html) or [SPC](https://www.medicines.org.uk/emc/search?q=ciclosporin) for comprehensive information and recommended management.  |
| * **Mono-amine oxidase inhibitors (MAOIs) and other sympathomimetics** (e.g., rasagiline, selegiline, safinamide) – additive hypertensive effect
* **Clonidine** – increased duration of action of dexamfetamine, reduced antihypertensive action of clonidine.

**Other clinically significant interactions** * **Coumarin anticoagulants, anticonvulsants, selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs)**:metabolism may be inhibited by dexamfetamine. Dose adjustment may be required when starting or stopping dexamfetamine.
* **SSRIs (e.g., fluoxetine, paroxetine)**: may increase exposure to dexamfetamine. Risk of serotonin syndrome. • **Serotonergic drugs, bupropion, tapentadol, tramadol:** Risk of serotonin syndrome
* **TCAs and nabilone**: may increase risk of cardiovascular adverse events.
* **Anticonvulsants (e.g., phenobarbital, phenytoin, primidone)**: Metabolism may be inhibited, and absorption may be delayed by dexamfetamine. Dose adjustment may be required when stopping or starting dexamfetamine.
* **Antacids** (e.g., sodium bicarbonate) **and urinary alkalinizing agents** (e.g. acetazolamide, some thiazides): may increase exposure to dexamfetamine
* **Gastrointestinal acidifying agents** (e.g., ascorbic acid, fruit juices) and **urinary acidifying agents** (e.g., ammonium chloride, sodium acid phosphate): may reduce exposure to dexamfetamine
* **Antihistamines:** sedative effect may be counteracted
* **Antihypertensives, including guanethidine**: effects may be reduced by dexamfetamine.
* **Beta-blockers (e.g., propranolol)**: risk of severe hypertonia. May reduce effects of dexamfetamine.
* **Lithium, phenothiazines, haloperidol**: may reduce the effects of dexamfetamine.
* **Disulfiram**: may inhibit metabolism and excretion of dexamfetamine
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| * **Opioids**: analgesic effects may be increased and the depressant effects (e.g. respiratory depression) may be decreased by dexamfetamine
* **Halogenated anaesthetics:** risk of sudden blood pressure increase during surgery. Avoid dexamfetamine on the day of planned surgery.
* **Cytochrome P450 (CYP450) substrates, inducers, or inhibitors**: use with caution; role of CYP450 in dexamfetamine metabolism is not known.
* **Alcohol:** may exacerbate adverse CNS effects of dexamfetamine
* **Apraclonidine:** effects decreased by dexamfetamine.
* **Ritonavir, tipranavir:** may increase exposure to dexamfetamine.

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| **8. Baseline investigations, initial monitoring, and ongoing monitoring to be undertaken by specialist** Monitoring at baseline and during initiation is the responsibility of the specialist; only once the patient is optimised on the chosen medication with no anticipated further changes expected in immediate future will prescribing and  monitoring be transferred to primary care. Back to top |
| **Baseline investigations:** * **A** medical history and cardiovascular assessment, taking into account conditions that may be contraindications, risk of pregnancy (where applicable), and to ensure the patient meets the criteria for ADHD and that pharmacological treatment is required.
* A risk assessment for substance misuse and drug diversion
* Blood pressure (BP) and heart rate
* Height, weight and body mass index (BMI)
* Arrange for electrocardiogram (ECG), only if the patient has any of the following: o History of congenital heart disease or previous cardiac surgery o Sudden death in a first-degree relative under 40 years suggesting a cardiac disease.
	+ Shortness of breath on exertion compared with peers. o Fainting on exertion or in response to fright or noise o Palpitations
	+ Chest pain suggestive of cardiac origin o Signs of heart failure, heart murmur or hypertension o Current treatment with a medicine that may increase cardiac risk.

**Initial monitoring:** * Before every change of dose: assess heart rate, blood pressure, and weight.
* After every change of dose: assess heart rate and blood pressure, and any new or worsening psychiatric symptoms.
* Assessment of symptom improvement. Discontinue if no improvement is observed after one month.

**Ongoing monitoring:** Ensure the patient receives a review at least annually with a healthcare professional with training and expertise in managing ADHD. This may be in primary or secondary care, depending on local arrangements, and should include a review of ADHD medication, including patient preferences, benefits, adverse effects, and ongoing clinical need.  |

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| Consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate. If continuing medication, document the reasons why. Review outcomes should be communicated to the primary care prescriber in writing, with any urgent changes also communicated by telephone. When a patient is reviewed, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in section 9 remains appropriate.  |
| **9. Ongoing monitoring (ADHD)*** Ensure the patient receives a review at least annually with a healthcare professional with training and expertise in managing ADHD. This in southwest London will be carried out by secondary care specialists, and should include a review of ADHD medication, including patient preferences, benefits, adverse effects, and ongoing clinical need. Consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate. If continuing medication, document the reasons why.
* Review outcomes should be communicated to the primary care prescriber in writing with any changes.

Back to topSee section 10 for further guidance on management of adverse effects/responding to monitoring results. |
| **Monitoring**  | **Frequency**  |
| * Blood pressure and heart rate, and assessment for cardiovascular signs or symptoms
* Weight and appetite
* Assessment for new or worsening psychiatric and neurological signs or symptoms (e.g., tics, anxiety, symptoms of bipolar disorder)

Explore whether patient is experiencing any difficulties with sleep | Every 6 months, and after any change of dose recommended by specialist team. |
| Assessment of adherence, and for any indication of dexamfetamine abuse, misuse, or diversion | As required, based on the patient’s needs and individual circumstances |
| Review to ensure patient has been offered and attended an annual review with a healthcare professional with expertise in ADHD  | Annually  |
|  **10. Adverse effects and other management** Back to top**Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit** [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard) For information on incidence of ADRs see relevant summaries of product characteristics <https://www.medicines.org.uk/emc> |
| **Result**  | **Action for primary care**  |
| **As well as responding to absolute values in laboratory tests, a rapid change or a consistent trend in any value should prompt caution and extra vigilance**  |
| Resting HR greater than 120bpm, arrhythmia/palpitations, clinically significant increase in systolic BP | • In context of recent dose increase, revert to previous dose and discuss with specialist for ongoing management.In absence of recent dose changes, reduce dose by half and discuss with specialist or cardiology for further advice. |
| New or worsening seizures | Stop dexamfetamine and discuss with specialist. Discontinuation may be indicated. |

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| Anorexia or weight loss, weight, or BMI outside healthy range | Exclude other reasons for weight loss. Give advice as per [NICE NG87:](https://www.nice.org.uk/guidance/ng87/) * take medication with or after food, not before.
* additional meals or snacks early in the morning or late in the evening when stimulant effects have worn off.
* obtaining dietary advice
* consuming high-calorie foods of good nutritional value

Discuss with specialist if difficulty persists; dose reduction, treatment break, or change of medication may be required. |
| Insomnia, sleep disturbance/nightmares, sedation, sexual dysfunction | Review timing of doses and continue treatment unless severe, Give advice on sleep hygiene. Discuss with specialist if required |
| Nausea, diarrhoea, abdominal cramps, constipation, dry mouth, headache, dizziness, enuresis, increased daytime urination, tics | Continue treatment unless severe. Some symptoms may be alleviated by concomitant food intake. Discuss with specialist if required |
| New or worsening psychiatric or neuropsychiatric symptoms, e.g. mania, depression, paranoia, anxiety and agitation. NB: psychosis may occur following consumption of very high doses.  | Discuss with specialist. Stop treatment and consider referral to acute mental health team if suicidal thoughts, mania, or psychosis are present |
| Symptoms of serotonin syndrome, e.g., agitation, hallucinations, coma, tachycardia, labile blood pressure, hyperthermia, hyperreflexia, incoordination, rigidity, nausea, vomiting, diarrhoea | Discontinue dexamfetamine as soon as possible. Management depends on severity; use clinical judgement and seek advice if necessary. Discuss with specialist team to determine whether dexamfetamine can be re-started. |
| Suspicion of abuse, misuse, or diversion | Discuss with specialist team |
|  **11. Advice to patients and carers** Back to topThe specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.  |
| **The patient should be advised to report any of the following signs or symptoms to their primary care prescriber without delay:** * Any mood changes, such as depression, paranoia, anxiety or agitation, psychosis, mania, and suicidal ideation • Palpitations, chest pain or syncope
* Cerebrovascular symptoms, such as severe headache, numbness, weakness, paralysis, and impairment of coordination, vision, speech, language, or memory • Abdominal pain, malaise, jaundice or darkening of urine.
* Skin rashes or bruising easily.
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| * If they suspect, they may be pregnant or are planning a pregnancy. Patients of childbearing potential should use appropriate contraception and take a pregnancy test if they think there is a possibility, they could be pregnant.

**The patient/carer should be advised:** * Normally the first increasing dose is given in the morning. Dexamfetamine should not be taken too late after lunch time to avoid disturbances of sleep.
* Attend regularly for monitoring and review appointments with primary care and specialist and keep contact details up to date with both prescribers. It may not be safe to continue prescribing without regular review, and patients should be aware that their medicines could be stopped if they do not attend appointments.
* Dexamfetamine is subject to drug driving laws. Not to drive, cycle or operate machines if dexamfetamine affects their ability to do so safely, e.g., by causing dizziness, drowsiness, and visual disturbances and to inform the DVLA if their ability to drive safely is affected. See <https://www.gov.uk/adhd-and-driving>and section 11.
* Avoid alcohol while taking dexamfetamine, as it may make some side effects worse. Avoid recreational drugs. Due to the risks of severe depression, over-activity, extreme fatigue as well as changes in the EEG during sleep, abrupt withdrawal after a prolonged period of intake of high doses of dexamfetamine should be avoided. Patients wishing to reduce their dose or stop dexamfetamine treatment should discuss with their specialist before doing so.
* Dexamfetamine is a schedule 2 controlled drug. Patients may be required to prove their identity when collecting prescriptions and should store dexamfetamine safely and securely. It must not be shared with anyone else. There are restrictions on travelling with controlled drugs: see [https://www.gov.uk/guidance/controlled-drugs-personallicences](https://www.gov.uk/guidance/controlled-drugs-personal-licences)

 **Patient and carer information:** * [» Attention Deficit Hyperactivity Disorder (choiceandmedication.org)](https://www.choiceandmedication.org/swlstg-tr/condition/attention-deficit-hyperactivity-disorder/)
* [ADHD and Mental Health | Signs and Symptoms of ADHD | YoungMinds](https://www.youngminds.org.uk/young-person/mental-health-conditions/adhd-and-mental-health/)
* NHS – attention deficit hyperactivity disorder. [https://www.nhs.uk/conditions/attention-deficit-hyperactivitydisorder-adhd](https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd)
* ADHD support groups [Support Groups | The UK ADHD Partnership](https://www.ukadhd.com/support-groups.htm)
* [Patient leaflets | BMJ Best Practice](https://bestpractice.bmj.com/patient-leaflets)
* [ADHD and hyperkinetic disorder for parents | Royal College of Psychiatrists (rcpsych.ac.uk)](https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/ADHD-and-hyperkinetic-disorder-information-for-parents)

**ADHD resources for children and young people, parents/carers and primary care professionals** Working with the ADHD Foundation, we have launched new set of booklets for children, teenagers and their parents and carers. There are three separate booklets, each of which has a different focus:* The children’s booklet is an interactive guide with 20 fun activities for children to help them focus, manage their emotions, and succeed
* The teenager’s booklet is a guide and workbook with information and activities to support teenagers living with ADHD
* The parents/carers booklet is an information and resource guide for parents and carers of children and young people with ADHD and may also be useful for health professionals including those working in primary care.

All three booklets are available to share and download on the website: <https://www.transformationpartnersinhealthandcare.nhs.uk/cyp-adhd-resources> |

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|  **12. Pregnancy, paternal exposure and breast feeding** Back to top  |
| It is the responsibility of the specialist to provide advice on the need for contraception to male and female patients on initiation and at each review, but the ongoing responsibility for providing this advice rests with both the primary care prescriber and the specialist.**Pregnancy:** Dexamfetamine is not recommended for use during pregnancy. The limited data available shows a risk of premature birth and reduced birth weight. Infants may also develop withdrawal symptoms such as dysphoria, hyperexcitability and pronounced exhaustion. If a patient becomes pregnant or is planning a pregnancy during treatment, they should discuss treatment options with their specialist. The specialist will reassume prescribing responsibility, ending the shared care agreement. Healthcare professional information available from: [https://www.medicinesinpregnancy.org/bumps/monographs/USEOF-AMFETAMINES-IN-PREGNANCY/](https://www.medicinesinpregnancy.org/bumps/monographs/USE-OF-AMFETAMINES-IN-PREGNANCY/)  **Breastfeeding:** Dexamfetamine is excreted in human milk, therefore a risk to infants cannot be excluded. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from dexamfetamine, taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman. High doses may interfere with lactation, although this is not confirmed in practice. If breastfeeding does take place, infants should be monitored for symptoms of CNS stimulation (e.g. decreased appetite/weight gain, sleep disturbances, irritability), although these may be difficult to detect. Healthcare professional information available from: [https://www.sps.nhs.uk/articles/safety-in-lactation-drugs-foradhd/](https://www.sps.nhs.uk/articles/safety-in-lactation-drugs-for-adhd/)  **Paternal exposure**: No evidence regarding adverse outcomes following paternal exposure was identified.  |
|  **13. Specialist prescriber contact information** Back to top  |
| Name: *[insert name]* Role and specialty: *[insert role and specialty]* Daytime telephone number: *[insert daytime telephone number]* Email address: *[insert email address]* Alternative contact: *[insert contact information, e.g. for clinic or specialist nurse]* Out of hours contact details: *[insert contact information, e.g. for duty doctor]*  |
|  **14. Additional information** Back to top |
| Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed. Ensure that the specialist is informed in writing of any changes to the patient’s GP or their contact details.  |
|  **15. References** Back to top  |
|  • eBNFc Dexamfetamine Accessed via [Dexamfetamine sulfate | Drugs | BNFC | NICE](https://bnfc.nice.org.uk/drugs/dexamfetamine-sulfate/) accessed 22/11/22.  |

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| * Dexamfetamine sulfate 20 mg tablets Date of last update 02/05/22. Accessed via [Dexamfetamine Sulfate 5 mg Tablets - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)2](https://www.medicines.org.uk/emc/product/11004/smpc)1/11/2022.
* NICE NG87: Attention deficit hyperactivity disorder: diagnosis and management. Last updated September 2019. Accessed via <https://www.nice.org.uk/guidance/ng87/>on 21/11/2022.
* NICE NG43: Transition from children to adults’ services for young people using health or social care services. Last updated February 2016. Accessed via <https://www.nice.org.uk/guidance/ng43/>on 21/11/2022.
* Specialist Pharmacy Service. Safety in Lactation: Drugs for ADHD. Last updated October 2020. Accessed via <https://www.sps.nhs.uk/articles/safety-in-lactation-drugs-for-adhd/>on 21/11/2022.
* NICE. NG46: Controlled drugs: safe use and management. April 2016. Accessed via [Overview | Controlled drugs: safe use and management | Guidance | NICE](https://www.nice.org.uk/guidance/ng46) on 22/11/2022
* NICE Clinical Knowledge Summaries. Attention deficit hyperactivity disorder: Amphetamines. Last revised October 2022. Accessed via [Amphetamines | Prescribing information | Attention deficit hyperactivity disorder | CKS | NICE](https://cks.nice.org.uk/topics/attention-deficit-hyperactivity-disorder/prescribing-information/amfetamines/) on 22/11/2022
* Gov.uk. Drugs and driving: the law. Accessed via <https://www.gov.uk/drug-driving-law>on 22/11/22.
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| **16. Other relevant national guidance** Back to top  |
| * Shared Care for Medicines Guidance – A Standard Approach (RMOC). Available from <https://www.sps.nhs.uk/articles/rmoc-shared-care-guidance/>
* NHSE policy – Responsibility for prescribing between primary & secondary/tertiary care. Available from [https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiarycare/](https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/)
* General Medical Council. Good practice in prescribing and managing medicines and devices. Shared care. Available from [https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-andmanaging-medicines-and-devices/shared-care](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care)
* NICE NG197: Shared decision making. Last updated June 2021. [https://www.nice.org.uk/guidance/ng197/.](https://www.nice.org.uk/guidance/ng197/)
 |
|  **17. Local arrangements for referral** Back to topDefine the referral procedure from hospital to primary care prescriber & route of return should the patient’s condition change.  |
| Define the referral procedure from hospital to primary care prescriber & route of return should the patient’s condition change. Shared care from hospital to primary care Primary care to hospital – Urgent referrals mental health crisis line or A&E out of hours. For routine/non-urgent referrals contact local CAMHs team.    |
| **18. Communication** Please note that the clinical letter received from the specialist prescriber/ team should have the relevant contact details. If this is not provided you may find the following contact details useful. **Medicines Information Services** * South West London and St Georges Mental Health Hospital: Tel. 020 3513 6829
* South London and Maudsley (SLAM): Tel. 020 3228 2317
* Georges Hospital medicines helpline: Tel. 020 872 51033
* Kingston Hospital medicines helpline: Tel. 020 85467711 ext.2092
* Epsom and St Helier Trust medicines helpline: Tel.020 872 51033
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