NORFOLK AND WAVENEY STP THERAPEUTICS ADVISORY GROUP (TAG)

SHARED CARE AGREEMENT

Shared care guidelines for treatments used in adults with ADHD
Amber Level 2 – Prescribe drug and perform more intense level of monitoring e.g. 3-monthly review

Generic and Proprietary/Brand Name	
Methylphenidate plain:	Generic, Ritalin®, Medikinet®
Methylphenidate modified-release:	
Concerta XL®, Delmosart®, Matoride XL®, Xaggitin XL®, Xenidate XL®	
See appendix 1 for comparative costs of these once-daily methylphenidate products	
Equasym XL®, Medikinet XL®	
Dexamfetamine:	Generic
Lisdexamfetamine:	Elvanse®, Elvanse Adult®
Atomoxetine:	Strattera®

Indications for shared care

In line with NICE NG 87 (March 2018) stimulants and atomoxetine are indicated for the treatment of Attention Deficit/Hyperactivity Disorder (ADHD) as part of a treatment package where remedial measures alone prove insufficient.

For newly diagnosed cases in adulthood:

Specialist Initiation, with the GP taking over prescribing responsibility in line with this Shared Care Agreement

1. Drug treatment is the first-line treatment for adults with ADHD with either moderate or severe levels of impairment.
2. Methylphenidate or lisdexamfetamine should normally be tried first in newly diagnosed cases in adults.
3. Consider switching to the other first-line option for adults who have had a 6-week trial of the initial drug at an adequate dose but have not derived enough benefit in terms of reduced ADHD symptoms and associated impairment.
4. Consider dexamfetamine for adults whose ADHD symptoms are responding to lisdexamfetamine but who cannot tolerate the longer effect profile.
5. Exercise caution if prescribing dexamfetamine to people at risk of stimulant misuse or diversion.
6. Offer atomoxetine if methylphenidate or lisdexamfetamine are not tolerated or ADHD symptoms do not respond after an adequate trial (usually about 6 weeks), having considered alternative preparations and adequate doses.
7. Atomoxetine is licensed for new treatment in adults with ADHD symptoms that can be confirmed from childhood and may be considered as a first-line treatment if there are concerns about drug misuse and diversion (for example, in prison).

For adults who have been previously been treated in childhood / adolescence:

GP may continue prescribing for adults whose ADHD symptoms have persisted beyond adolescence, supported by the locally commissioned Adult ADHD specialist service

1. Methylphenidate can be continued into adulthood if the person had been taking it as an adolescent.
2. Lisdexamfetamine can be continued into adulthood if the person had been taking it as an adolescent.
3. Dexamfetamine can be continued for refractory attention deficit hyperactivity disorder in adults over 17 years [unlicensed use]
4. Atomoxetine is licensed for new treatment in adults with ADHD symptoms that can be confirmed from childhood.

Specialist Prescribing and Monitoring Responsibilities – summary. Full details in main body of document	GP / Community Team - Primary Care Prescribing and Monitoring Responsibilities – summary. Full details in main body of document
Prescribing: • Specialist prescription for the initial titration is provided by either a Consultant Psychiatrist, delegated doctor, or non-medical prescriber. • Initial follow up is provided, either by telephone call or face-to-face by an ADHD specialist, until titration is complete • Regular follow-up by the specialist service will be provided via annual reviews by an ADHD specialist. **Monitoring:** • Annual face-to-face reviews will be provided by an ADHD specialist in the local specialist clinic. • The specialist clinic will monitor BP, Pulse and weight as required at appointment. • If potential cardiovascular issues are identified the Norfolk & Waveney Adult ADHD Team may request the GP complete an ECG or referral to cardiology before treatment can continue. • Side effects during initiation and dose titration	**Prescribing:** Continuation of treatment, with specialist support. **Monitoring:** • BP and pulse • Weight

Patient Information
Patients will be provided with relevant patient information leaflets.

Specialist Contact Details
Norfolk & Waveney: Dr Jacobus Hamelijnck, Consultant Psychiatrist, Norfolk & Waveney Adult ADHD Service, 80 St Stephen's Road, Norwich NR1 3RE Tel: 01603 201486 **NSFT Pharmacy Medication Helpline:** Tel: 01603 421212 (12 noon to 4.00pm)

GENERAL PRINCIPLES FOR SHARED CARE PRESCRIBING

- Shared Care is only appropriate if it provides the optimum solution for the patient.
- GPs are **invited** to participate. If GPs are not confident to undertake these roles, they are under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist.
- **If a specialist asks the GP to prescribe this drug, the GP should reply to this request as soon as practicable if they are unwilling to do so.**
- Prescribing responsibility will only be transferred when it is agreed by the consultant and the patient's GP and when the patient's condition is stable or predictable.
- Safe prescribing must be accompanied by effective monitoring.
- **The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.**

Background to Treatment

Methylphenidate, dexamfetamine and lisdexamfetamine (a pro-drug for dexamfetamine) are centrally-acting sympathomimetics. Their mechanism of action is mainly through inhibition of noradrenaline and dopamine transporters. Methylphenidate and lisdexamfetamine are the NICE treatments of first choice.

Atomoxetine is a noradrenaline reuptake inhibitor which indirectly boosts dopamine.

Licensed use and agreed local off-label use

Drug prescribing in adults is usually off-label. Exceptions are atomoxetine, which is licensed for new treatment in adults with ADHD symptoms that can be confirmed from childhood, and lisdexamfetamine (as ***Elvanse Adult***®) and Medikinet XL which is indicated as part of a comprehensive treatment programme for attention deficit/hyperactivity disorder (ADHD) in adults.

Clinicians are supported in prescribing for adults with ADHD by the NICE NG 87, BAP (British Association of Psychopharmacology) guidelines.

Criteria for Patient Selection

People who appear to fulfil standard DSM-V or ICD-10 criteria for ADHD can be referred to the Trust Adult ADHD Service for a single diagnostic assessment with NSFT

- External referral eg GP made to either **SPOC** (26 years and under) or **AAT** in GY&W & **SPOA** in Central & West (26 years and over) then follow process below
- If addressed to Adult ADHD; Send to Adult ADHD Norfolk & Waveney for triage by ADHD team
- If addressed to generic mental health team; AAT/SPOC/SPOA will screen referral and if there is uncertainty about the referral being ADHD, AAT/SPOC/SPOA contacts ADHD for advice. If it is appropriate for ADHD then AAT/SPOC/SPOA sends to ADHD for triage by ADHD

The Adult ADHD team does not offer Care Co-ordination/Case Management or Psychosocial Interventions. We offer assessment and drug therapy for Adults with ADHD with a view to discharge back to primary care following titration.

Adult ADHD may present as:

- Continuation of symptoms from adolescence
- Adults who have had a treatment gap from a childhood diagnosis with continuation of symptoms
- First diagnosis, never diagnosed as children but with a history of symptoms.

Stimulant medication is considered the benchmark standard pharmacological treatment for ADHD. Atomoxetine is also available. NICE NG 87 recommends that specialists diagnose and that

prescribing in adult ADHD should be ***under the guidance*** of a psychiatrist, nurse prescriber specialising in ADHD or other clinical prescriber with training in ADHD diagnosis and management.

Form and strength of preparation

Three *types* of methylphenidate multiphasic XL preparations are available:

- ***Concerta XL®, Matoride XL®, Xenidate XL® , Delmosart® or Xaggitin XL®*** tablets (22% Immediate Release [IR], 78% extended release [XL])

  (*See* **Appendix 1** *for comparative costs of these once-daily methylphenidate products*)

- ***Equasym XL®*** capsules (30% IR, 70% XL)
- ***Medikinet XL®*** capsules (50% IR, 50% XL)

These different types of products are **not interchangeable** and the BNF recommends prescribing by brand name to avoid the risk of destabilisation from different release characteristics of the XL products dispensed generically.

Strengths of Methylphenidate modified-release products:

(22% Immediate Release [IR], 78% extended release [XL])

***Concerta XL®*:** capsule-shaped tablets with internal hard membrane, 18mg (equivalent to 15mg of plain tablets), 27mg, 36mg or 54mg in packs of 28, or 30

***Matoride XL®*:** cylindrical tablets with internal hard membrane, 18mg (equivalent to 15mg of plain tablets), 36mg or 54mg in packs of 28, 30, 60 or 90

***Xenidate XL®*:** round, biconvex tablets, 18mg (equivalent to 15mg of plain tablets), 27mg, 36mg or 54mg in packs of 28, 30 or 100

***Delmosart®*:** capsule-shaped, biconvex tablets, 18mg (equivalent to 15mg of plain tablets), 27mg, 36mg or 54mg in packs of 28, 30 or 90

***Xaggitin XL®*:** capsule-shaped, biconvex tablets, 18mg (equivalent to 15mg of plain tablets), 27mg, 36mg or 54mg in packs of 28, 30 or 90

(*See* **Appendix 1** *for comparative costs of these methylphenidate products*)

***Equasym XL®*:** (30% IR, 70% XL) capsules with small globules inside, 10mg, 20mg, 30mg in packs of 30

***Medikinet XL®*:** (50% IR, 50% XL) capsules with wax beads inside, 5mg, 10mg, 20mg, 30mg, 40mg, 50mg & 60mg in packs of 28

Dexamfetamine sulphate (non-proprietary): 5mg scored tablets

Lisdexamfetamine (*Elvanse®*, *Elvanse Adult®*): 20mg, 30mg, 40mg, 50mg, 60mg and 70mg capsules in packs of 28 or 30

Atomoxetine (*Strattera®*): capsules with wax beads inside, 10mg, 18mg, 25mg, 40mg and 60mg, 80mg – 100mg in packs of 7 or 28.

Side Effects and Management

BNF – Methylphenidate Dexamfetamine Lisdexamfetamine Atomoxetine

SPC - Methylphenidate Dexamfetamine Lisdexamfetamine Atomoxetine

Stimulants:

Nervousness and Insomnia (>10%) - Review dose and consider switching to different preparation
Headache, drowsiness, dizziness (1-10%)

Appetite loss (1-10%) - usually transient, try taking with or after food

Abdominal pain, vomiting, nausea, dry mouth (1-10%) – Occurs at Initiation. May be alleviated by concomitant food intake.

Tachycardia, palpitations – NICE recommends monitoring every 6 months. Local agreement has compromised on at least 6 to 12 monthly unless otherwise agreed by specialist clinic. If resting pulse rate is raised over 100bpm with symptoms of palpitations, consider discontinuation of ADHD treatment and primary care to manage and treat prior to referral to ADHD to review ADHD medications. **Increased blood pressure (1-10%)** - NICE recommends monitoring 6-monthly but as a compromise at least 12 monthly unless otherwise agreed by specialist clinic. If BP >140/90 mmHg follow NICE Hypertension Guidelines, consider discontinuation of ADHD treatment and primary care to manage and treat prior to referral to ADHD to review ADHD medications.

Tic, aggression, anxiety, irritability (1-10%) – Refer back to ADHD service

Drug-induced psychosis e.g. hallucinations (<1%) – Discontinue treatment and refer secondary mental health services

Atomoxetine:

Very common adverse effects: decreased appetite (usually settles after four weeks of treatment), insomnia, dry mouth, nausea

Common adverse effects: weight decrease (usually settles after initial weight loss), early morning awakening, libido decreased, sleep disorder, dizziness, middle insomnia, sinus headache, palpitations, tachycardia, hot flushes, abdominal pain, constipation, dyspepsia, flatulence, dermatitis, sweating, increased difficulty in micturition, urinary hesitation, urinary retention, dysmenorrhoea, ejaculation disorder, ejaculation failure, erectile disturbance, impotence, menstruation irregular, orgasm abnormal, prostatitis, fatigue, lethargy, rigors.

Increase in blood pressure and heart rate – Very common ≥1/10

In January 2012 the MHRA published the following safety guidance regarding BP:
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.

Full MHRA advice is available at: ***Link***

Drug Interactions

BNF – Methylphenidate Dexamfetamine Lisdexamfetamine Atomoxetine

SPC - Methylphenidate Dexamfetamine Lisdexamfetamine Atomoxetine

Cautions and Contraindications

BNF – Methylphenidate Dexamfetamine Lisdexamfetamine Atomoxetine

SPC - Methylphenidate Dexamfetamine Lisdexamfetamine Atomoxetine

Methylphenidate:

People with hypertension, tachycardia, and cardiovascular, cerebrovascular disease or structural cardiac abnormality.

History of drug or alcohol abuse: consider alternative non-stimulant treatments.

Care needed in hyperthyroidism, glaucoma, pregnancy, breastfeeding.

Epilepsy: normally not a major problem but care should be taken as there is the possibility of further lowering the seizure threshold.

Dexamfetamine:

Cardiovascular disease including moderate to severe hypertension, structural cardiac abnormalities, advanced arteriosclerosis, hyper-excitability or agitated states, hyperthyroidism, history of drug or alcohol abuse.

Lisdexamfetamine:

Symptomatic cardiovascular disease including moderate to severe hypertension and advanced arteriosclerosis, hyperexcitability or agitated states, hyperthyroidism.

Atomoxetine:

People with severe cardiovascular or cerebrovascular disorders; people with narrow angle glaucoma; people with pheochromocytoma or a history of pheochromocytoma

In January 2012, the MHRA warned of severe cardiovascular or cerebrovascular disorders in which clinical deterioration would be expected, with increases in blood pressure or resting heart rate that could be clinically important (e.g. by 15–20 mmHg in blood pressure, or 20 beats per minute in heart rate).

Initiation of therapy and ongoing dose regimen

For new diagnosis:

- Specialist prescription for the initial titration is provided by either a Consultant Psychiatrist, delegated doctor, or non-medical prescriber. Initial follow up is provided, either by telephone call or face-to-face by an ADHD specialist, until titration is complete
- Regular follow-up by the specialist service will be provided via annual reviews by an ADHD specialist.
- GPs can refer back or telephone for advice if necessary.

For continuation of care from childhood:

- The Norfolk & Waveney Adult ADHD Team will offer a transition assessment 12 months following the last appointment with childhood services providing the patient is 18 years of age or above.
- Regular follow-up by the specialist service will be provided via annual reviews by an ADHD specialist.

GPs can refer back or telephone for advice if necessary.

Initial dose and administration

Methylphenidate:

Modified-release preparations should be used due to the lower risk of diversion.

In adult ADHD, 'robust' dosing (mean 1mg/kg/day) may be highly effective (response 76% vs 19% placebo) compared to more traditional dosing. The Concerta XL® formulation daily dose may be up to 1.3mg/kg/day but it is recommended to monitor pulse and BP at these doses.

***22% Immediate Release [IR], 78% extended release [XL] products*:** initially 18 mg once daily in the morning, increased at weekly intervals according to response, max. 108 mg daily *(for offlabel use in adults)*.

***Equasym XL*® (30% IR, 70% XL):** initially 10 mg once daily in the morning before breakfast, increased gradually at weekly intervals according to response, max. 100 mg daily *(for off-label use in adults)*.

***Medikinet XL*® (50% IR, 50% XL):** initially 10 mg once daily in the morning with breakfast, increased at weekly intervals according to response, max. 100mg daily

Lisdexamfetamine:

Start at 20 - 30mg/day in the morning. The dose may be increased by 10 - 20 mg increments, at approximately weekly intervals, according to response, up to a maximum dose of 70mg/day.

Dexamfetamine:

Initially 5mg twice daily, increased at weekly intervals according to response; max 60mg daily *(for off-label use in adults)*.

Atomoxetine:

Atomoxetine should be initiated at a total daily dose of 40 mg. The initial dose should be maintained for a minimum of 7 days prior to upward dose titration according to clinical response and tolerability. The recommended maintenance daily dose is 80 mg to 100 mg. The maximum recommended total daily dose is 100 mg. The safety of single doses over 120 mg and total daily doses above 150 mg have not been systematically evaluated.

Duration of therapy / How the treatment will be reviewed and if appropriate, stopped

Review of effectiveness as stated above under **Initiation of therapy and follow-up** by the Consultant Psychiatrist or delegated doctor/ADHD specialist.

Annual reviews by an ADHD specialist will be provided by the local specialist service. When tolerated and effective, likely use is several years.

Other information about prescribing

Methylphenidate, dexamfetamine and lisdexamfetamine are **Controlled Drugs** (Atomoxetine is *not* a Controlled Drug).

The prescription for these treatments *must*:

- Be indelible (or as otherwise allowed via the Electronic Prescribing service (EPS))
- State the name and address of the patient
- State the form (tablets or capsules) and where appropriate the strength of the preparation
- Include either the total quantity (in words and figures) of the preparation to be supplied *or* include the total number of dosage units (in both words and figures) to be supplied
- The dose and frequency to be taken
- Be dated
- State the prescriber's address.
- Be signed in the prescriber's own handwriting (or as otherwise allowed via the Electronic Prescribing service (EPS))

GP prescribing responsibilities

Continuation of treatment, with specialist support.

Specialist monitoring responsibilities

- Annual face-to-face reviews will be provided by an ADHD specialist in the local specialist clinic.
- The specialist clinic will monitor BP, Pulse and weight as required at appointment.
- If potential cardiovascular issues are identified the Norfolk & Waveney Adult ADHD Team may request the GP complete an ECG or referral to cardiology before treatment can continue.
- Side effects during initiation and dose titration.

GP / Community Team or other Primary Care monitoring responsibilities

BP and pulse rate:

NICE NG 87 1.8.9 (March 2018) recommends 6 monthly monitoring of heart rate and BP, and the specialist service will offer an annual review.

If BP >140/90 mmHg follow NICE Hypertension Guidelines, and consider discontinuation and referral back to psychiatrist.

Weight:

NICE NG 87 1.8.5 (March 2018) recommends 6 monthly monitoring of weight, patients can be asked to self-monitor and report any concerns. The specialist service will provide annual monitoring.

If significant weight loss that is of concern to the patient occurs as a result of medication, consider the following strategies to reduce weight loss:

- Taking medication with or after food, rather than before meals.
- Eating additional meals or snacks early morning or late evening when medication effects have worn off.
- Obtaining dietary advice and eating high calorie foods of good nutritional value.

Consider referral back to specialist service for further advice to consider switching or discontinuation of medication.

Indications for referral back to Specialist

Uncommon, severe or unexpected side effects or emerging lack of efficacy.

If there are concerns or queries, telephone consultation will usually be available at short notice.

Otherwise re-refer via usual route to locality if mental health deterioration.

Further information and supporting documents

BAP Guidelines Reference: https://www.bap.org.uk/pdfs/BAP_Guidelines-AdultADHD.pdf

Evidence-based guidelines for the pharmacological management of attention deficit hyperactivity disorder: *Update on recommendations from the British Association for Psychopharmacology*

Blanca Bolea-Alamañac, David J Nutt, Marios Adamou, Phillip Asherson, Stephen Bazire, David

Coghill, David Heal, Ulrich Müller, John Nash, Paramalah Santosh, Kapil Sayal, Edmund Sonuga-Barke and Susan J Young for the Consensus Group (2014) *Journal of Psychopharmacology 1–25 (2014)* sagepub.co.uk/journalsPermissions.nav DOI: 10.1177/ 0269881113519509 jop.sagepub.com

Refer to the manufacturers' SPCs for individual products via:
http://www.medicines.org.uk/emc/

Author(s) and Organisation	Dr Jacobus Hamelijnck, Consultant Psychiatrist and Esther Johnston, Chief Pharmacist, the Norfolk and Suffolk NHS Foundation Trust, in consultation with the Therapeutics Advisory Group (TAG) and the Integrated Mental Health and Learning Disabilities Commissioning Team for Norfolk CCGs/ICB
Date of Approval	Transferred to new template – April 2024
Reviewed by	Therapeutics Advisory Group
Last review date	April 2023
Date of next review	April 2025

Appendix 1 - **Price comparison of Methylphenidate 22% Immediate Release [IR], 78% extended release [XL] products:** Refn: BNF – accessed 2/4/2024

Strength ↓	*Concerta XL*	*Matoride XL*	*Xenidate XL*	*Delmosart*	*Xaggitin XL*
	Price (30)	**Price (30)**	**Price (30)**	**Price (30)**	**Price (30)**
18mg	£31.19	**£15.58**	**£15.57**	**£15.57**	**£15.58**
27mg	£36.81	X	**£18.39**	**£18.39**	**£18.40**
36mg	£42.45	**£21.22**	**£21.21**	**£21.21**	**£21.22**
54mg	£73.62	**£36.80**	**£36.79**	**£36.79**	**£36.80**

Document history:

Version	Date	Author / Editor	Status	Comment
1.1	24th June 2014	Professor Stephen Bazire, on behalf of the Norfolk and Suffolk NHS Foundation Trust / FM, TAG Lead Pharmacist, NEL CSU Anglia	Draft	Draft proposal for consideration by the TAG on 3rd July 2014. Dexamfetamine missing from several sections within the document that discuss different treatment options. Queries regarding the need for clarification on responsibility for prescribing and monitoring for adverse effects caused by treatment, but also regarding the need for follow-up regarding the effectiveness of treatment highlighted in *red italics*. Returned to the author for clarification and amendment.
1.2	8th Sept 2014	Professor Stephen Bazire, on behalf of the Norfolk and Suffolk NHS	Draft	Dexamfetamine info added. Other queries not resolved prior to the TAG meeting.

		Foundation Trust / FM, TAG Lead Pharmacist, NEL CSU Anglia		Draft proposal for further consideration by the TAG on 4th September 2014. Several queries unresolved at the Sept 2014 TAG meeting. Document to be updated by NSFT specialists in consultation with GP TAG members and returned to the TAG and commissioners as soon as possible.
1.3	17th Sept 2014	Esther Johnston, Pharmacy NSFT, Dr Uju Ugochukwu, Consultant Psychiatrist, NSFT / FM, TAG Lead Pharmacist, NEL CSU Anglia	Draft	**Changes proposed by Dr Uju Ugochukwu and** **Esther Johnston in consultation with Dr Rebecca Horne, and Dr Jaap Hamelijnck:** Details added regarding follow-up of patients; additional information on self-assessment rating scales and dosage requirements; strategies added for dealing with adverse effects; details added on the recommended frequency and proposed responsibility for monitoring the tolerability and effectiveness of treatment; CD writing requirements revised; specialist contacts updated.
1.4	12th Dec 2014	Esther Johnston, Pharmacy NSFT, Dr Uju Ugochukwu, Consultant Psychiatrist, NSFT / FM, TAG Lead Pharmacist, NEL CSU Anglia	Draft	**Amendments made by FM in line with feedback received from Drs Ian Tolley, Tesh Patel and Paul Williams (GP TAG members), and after confirmation of service specification being finalised (Nov 2014).** Where previous proposals for change to the made by the NSFT have been not commented on or have broadly accepted by the TAG GPs, these have been incorporate within the text. Any outstanding queries remain in coloured text as per the colour key. For final consideration and support by the authors and for check by the contract manager against the service specification.
1.5	6th January	Esther	Draft	**Amendments made by FM in line with feedback received**

	2015	Johnston, Pharmacy NSFT, Dr Uju Ugochukwu, Consultant Psychiatrist, NSFT / FM, TAG Lead Pharmacist, NEL CSU Anglia		**from Dr Uju Ugochukwu (NSFT):** **Side-effects:** Threshold for "raised resting pulse rate changed from (+100bpm)" to "by >10bpm)" **Initiation of therapy and follow-up:** Transfer of
1.6	26th January 2015	Esther Johnston, Pharmacy NSFT, Dr Uju Ugochukwu, Consultant Psychiatrist, NSFT / FM, TAG Lead Pharmacist, NEL CSU Anglia	Draft	The TAG recommended more emphasis on MHRA warnings regarding adverse effects of using atomoxetine in patients with underlying CV problems. Further clarification regarding thresholds for raised BP and heart rate. The CCGs and LMC GPs recommended that annual face to face review by a nurse specialist should be provided in response to concerns regarding the potential for long term use of these agents without appropriate specialist review.
1.7	27th January 2015	Esther Johnston, Pharmacy NSFT, Dr Uju Ugochukwu, Consultant Psychiatrist, NSFT / FM, TAG Lead Pharmacist, NEL CSU Anglia	Superseded	Further clarification of the text in the "Initiation of treatment" section. Addition of Matoride XL®, branded generic with bioequivalence to Concerta XL®. Version supported by TAG/CCG GPs. Signed off by Dr Ian Tolley, TAG Chair, to facilitate the startup of the new specialist service for adults with ADHD. **28th January 2015** - Checked against agreed to be in line with service specification by Derek Holesworth, Integrated Mental Health and Learning Disabilities Commissioning Manager.

1.8	2nd February 2015	Esther Johnston, Pharmacy NSFT, Dr Uju Ugochukwu, Consultant Psychiatrist, NSFT / FM, TAG Lead Pharmacist, NEL CSU Anglia	Superseded	Insertion of NSFT specialist details for West Norfolk. Amendments on NSFT Pharmacy Helpline info. Clarification that the NSFT Specialist Service for Adults with ADHD is currently commissioned by the Central and the West Norfolk CCGs and hence the Shared Care Agreement relates only to GPs in these areas. Reflected in the title of the document. Specialist contact details for the Great Yarmouth & Waveney area removed until it is confirmed that the specialist service has been commissioned for GY&W also.
1.9	2nd July 2015	As per 1.8	Final	The TAG was advised that to date the contract for the NSFT Adult ADHD service has not been finalised with the Central and West Norfolk CCGs. V1.8 of this document must therefore be withdrawn from Knowledge Anglia. However it was confirmed that GY&W have finalised commissioning a service from NSFT and that v1.9 should reflect use in this local CCG only for the time being. Specialist contact details for Central and west removed; GY&W service details added and revised NSFT Medicines Info service times added.
2.0	27th August 2015	As per 1.8	Draft	The TAG is asked to consider the changes to the sections on *'Indication for Shared Care'* and *'Licensed Use'* which are highlighted in red font proposed by Dr Uju Ugochukwu (NSFT) due to her having received a queries from people who have found the document confusing.
2.1	Sept 2015	As per 1.8	Draft	TAG Sept 2015: The TAG considered the proposed text and recommended that any changes to the wording under "*Indication for Shared Care*" clarified the use of drug treatments in adults previously

				diagnosed and treated as children and in those newly diagnosed in adulthood. The proposed text under "*Licensed use*" was accepted apart from the last reference to the shared care document itself providing clinicians with support for prescribing ADHD drugs offlicence. Xenidate XL added to the products options. Hyperlink to BAP Guideline and reference added. NSFT Pharmacy Helpline times updated. Info on **Types of methylphenidate multiphasic** **XL preparations** moved from "**Pharmacology**" to "**Forms and strengths of preparations**" **Appendix 1** with comparative costs of methylphenidate XL products added
2.2	Sept 2015	As per 1.8	Final	Final amendments following advice from Dr Uju Ugochukwu (NSFT) regarding the licensed status of available treatments.
2.2.1	Oct 2015	As per 1.8	Current - for WN CCG use only	29th October 2015: Notification received from WN CCG that NSFT specialist service for adults with ADHD has now been commissioned. Version of document for use by West Norfolk GPs published on the Norfolk section of Knowledge Anglia. **Appendix 1** also updated with current prices.
3.0	February 2016	As per 1.8	Draft – for cross-N&W use	January 7th to February 4th 2016 – issues raised by the Trust and commissioners regarding handover of prescribing responsibility under "Initiation of therapy and follow-up" which was understood to be 4 weeks but could be read as up to 12 months. Wording under this section and related text throughout the

				document reviewed by the TAG Chair, Dr Ian Tolley in consultation with the NSFT to clarify that the Trusts would provide the first 4 weeks' of treatment only for new cases.
3.1	April 2016	As per 1.8	Superseded	No concerns about version 3.0 received to date from the NSFT lead specialist, Dr Uju Ugochukwu. Notification received from Clive Rennie (NN CCG) that the NSFT service for the central Norfolk CCGs has been running since January 2016. All 5 CCGs now have a commissioned specialist service to support adults with ADHD. Version 3.1 including all specialist contacts and published on Knowledge Anglia as a cross-N&W version
3.2	May 2016	As per 1.8	Final – cross N&W use	Advice from Dr Uju Ugochukwu that lisdexamfetamine capsules are now available in more strengths (20mg, 40mg & 60mg) and that as Elvanse Adult (30mg, 50mg and 70mg) is licensed for adults with ADHD. New strength and price for Xenidate XL 27mg also added.
4.0	April 2019	TBC	Draft for review	Updated with reference to NICE NG 87. Delmosart® and Xaggitin XL® added
5.0	April 2019	FM, TAG Lead Pharmacist, AGEM CSU Anglia	Draft for review	Checked against SPCs. Hyperlinks and references checked and updated. Prices and pack sizes checked and updated. Reference to the Electronic Prescribing service (EPS) regarding CDs added. Sent to NSFT (Esther Johnston and Dr Jacobus Hamelijnck) for consultation For consideration by the TAG September 2019

5.1	November 2019	JC, TAG Lead Technician, AGEM CSU Anglia	Final	Amendments made in line with comments received from Mark Randall, Clinical Team Leader, NSFT. TAG September 2019 – There were no concerns expressed that the comments changed the guidance in any significant form. The group were happy to accept the shared care agreement.
6.0	February 2021	JC, TAG Lead Technician, AGEM CSU Anglia	Draft	Addendum regarding Norfolk and Waveney CCG commissioned service to support a catch-up programme in conjunction with private provider
6.1	July 2021	JC, TAG Lead Technician, AGEM CSU Anglia	FINAL	Addendum reviewed and updated by Specialist Clinicians. Supported by TAG and D+TC
6.2	April 2022	JC, TAG Lead Technician, AGEM CSU Anglia	FINAL	Addendum regarding catch-up service removed.
7.0	April 2024	JC, TAG Lead Technician, NWICB	FINAL	Transferred to new template for publishing on KNoW