Nottinghamshire Area Prescribing Committee

National shared care protocol adult for local use:

Dexamfetamine for patients within adult services

As well as these protocols, please ensure that summaries of product characteristics (SPCs), British national formulary (BNF) or the Medicines and Healthcare products Regulatory Agency (MHRA) or NICE websites are reviewed for up-to-date information on any medicine.

Specialist responsibilities

- Assess the patient and provide diagnosis. Ensure the 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.
- 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.
- Prescribe in line with controlled drug prescription requirements (section 6).
- Once treatment is optimised, write to the patient's GP practice and request shared care, detailing the diagnosis, current and ongoing dose, any relevant test results and when the next monitoring is required. Include the specialist service contact information (section 13). Prescribe sufficient medication to enable transfer to primary care, including where there are unforeseen delays to transfer of care.

- Conduct the required monitoring in section 8 and communicate the results to primary care. This monitoring, and other responsibilities below, may be carried out by a healthcare professional in primary or secondary care with expertise and training in ADHD, depending on local arrangements.
- 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

- If shared care is not accepted, inform the specialist of the decision in writing within 14 days with reasons as to why shared care cannot be entered into.
- If accepted, prescribe ongoing treatment as detailed in the specialists 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. See section 10
- 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.
- Ensure the patient is given the appropriate appointments for monitoring. If a patient fails to attend, contact the patient in a timely manner and arrange an alternative appointment.

Patient and/or carer responsibilities

- Take dexamfetamine as prescribed and avoid abrupt withdrawal unless advised by primary care prescriber or specialist.

- 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 medications to their primary care prescriber and be aware they should discuss the use of dexamfetamine with their pharmacist before purchasing any OTC medicines.
- Be aware that dexamfetamine can affect cognitive function and is subject to drug driving laws, therefore patients must ensure their ability to drive is not impaired before driving (see 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.

1. Background

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Dexamfetamine sulfate 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 drug'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 not licensed for all the indications listed in section 2. However, its use for the indications below are established and supported by various sources and bodies including the BNF and NICE.

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) or Community Paediatrics team but is approaching their 18th birthday, it is expected that CAMHS or Community Paediatrics team will refer to the appropriate adult service if need for ongoing treatment is anticipated. See the Nottinghamshire Area Prescribing Committee shared care protocols and medication information leaflets for children and young people with ADHD at:

https://www.nottsapc.nhs.uk/shared-care/.

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

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- Attention deficit hyperactivity disorder (ADHD) in adults ‡

‡ Off-label indications. (Please note licensed indications vary by manufacturer. See SPCs for full details).

3. Locally agreed off-label use

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As above

4. Contraindications and cautions

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This information does not replace the Summary of Product Characteristics (SPC) and should be read in conjunction with it. Please see BNF & SPC for comprehensive information.

Contraindications:

- Known hypersensitivity to the active substance (dexamfetamine), 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 (consult specialist), 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 dystonias
- 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 Stimulants may lower the convulsive threshold in patients with prior history of seizure. In the presence of new onset or worsening seizures (discontinue if seizures occur)
- Mild hypertension, history of cardiovascular disease, or concomitant medications that elevate blood pressure
- Sudden deaths, stroke, and myocardial infarction have been reported in adults taking stimulant drugs at usual doses for ADHD. Although the role of stimulants in these adult cases is also unknown, adults have a greater likelihood than children of having serious structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, coronary artery disease, or other serious cardiac problems. Adults with such abnormalities should also generally not be treated with stimulant drugs. 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 Stimulants may exacerbate symptoms of behaviour disturbance and thought disorder in patients with pre-existing psychotic disorders

- Depressive symptoms: patients should be screened for risk of bipolar disorder, including psychiatric and family histories. Particular care should be taken in treating ADHD patients with comorbid bipolar disorder because of concern for possible induction of mixed/manic episodes in such patients.
- Treatment emergent pyschotic or manic symptoms can be caused by stimulants at usual doses. If these occur, consider the potential role of the stimulant, and discontinuation of treatment may be appropriate.
- Stimulants have been associated with a slowing of weight gain and a reduction in appetite
- 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.

5. Initiation and ongoing dose regimen

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- Following treatment initiation, transfer of monitoring and prescribing to primary care is normally after at least 12 weeks, and when the patient's dose has been optimised and with satisfactory investigation results for at least 4 weeks.
- For patients already under shared care, when a specialist adjusts the dose or formulation, transfer of monitoring and prescribing to primary care is normally after a minimum of four weeks, provided the patient has demonstrated tolerance or stability with the new dose or formulation.
- 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 be the responsibility of the specialist. unless in the case of managing adverse effects as detailed in section 10

Initial stabilisation:

ADHD: Initially 5 mg twice daily, dose should be increased according to response at intervals no shorter than 1 week.

Dexamfetamine must be prescribed by the initiating specialist during initiation and dose stabilisation.

Maintenance dose (following initial stabilisation):

ADHD: maximum 60 mg per day to be given in 2–4 divided doses;

The initial maintenance dose must be prescribed by the initiating specialist. **Specialist will inform GP on any subsequent doses. GPs should not alter any doses without discussing with specialist unless stopping due to side effects. See** section 10.

Where a patient has been switched between medications (i.e. lisdexamfetamine to dexamfetamine) further monitoring may be required, as per specialist instruction.

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.

6. Pharmaceutical aspects

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Route of administration:	Oral
Formulation:	Dexamfetamine sulfate 5mg, 10mg and 20mg immediate release tablets (Amfexa®▼) Dexamfetamine sulfate 5mg immediate release tablets Dexamfetamine sulfate 5mg/5mL sugar-free oral solution▼ (non formulary) Please note licensed indications vary by manufacturer. See SPCs for full details In the event of drug shortages, please consult the APC ADHD Shortages page or the Nottinghamshire Joint Formulary for up-to-date local guidance and support tools
Administration details:	Tablets have score lines and can be divided into four parts. The score lines on the tablets are only to facilitate breaking for ease of swallowing and not to divide into equal doses.

	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. 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 Amfetamines can cause a significant elevation in plasma corticosteroid levels. This increase is greatest in the evening. Amfetamines may interfere with urinary steroid determinations

7. Significant medicine interactions

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The following list is not exhaustive. Please see BNF or SPC for comprehensive information and recommended management.

The following medicines must not be prescribed without consultation with the specialist:

- **Mono-amine oxidase inhibitors (MAOIs) and other sympathomimetics** (e.g. rasagiline, selegiline, safinamide, isocarboxazid, moclobemide, phenelzine and tranylcypromine - dexamfetamine should not be used in combination with MAOIs or within 2 weeks of stopping a MAOI due to risk of hypertensive crisis) – 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.
- Coumarins: dexamfetamine may enhance the anticoagulant effect of warfarin. May require an increased frequency of INR monitoring.
- **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 thus increasing plasma levels of phenytoin and possibly primidone and phenobarbital.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
- **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
- Amfetamines can cause a significant elevation in plasma corticosteroid levels. This increase is greatest in the evening. Amfetamines may interfere with urinary steroid determinations.

8. Baseline investigations, initial monitoring and ongoing monitoring to be undertaken by specialist

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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.

Baseline investigations:

- A full assessment, as recommended by NICE guidance for ADHD. This should include 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
- Pre-treatment assessment to be performed will include diagnostic interview, behavioural rating scales (e.g., SDQ, Conners', CAARS self and observer report) and descriptive reports from partner or carer
- A risk assessment for substance misuse and drug diversion
- Baseline blood pressure (BP) and heart rate
- Height, weight, appetite and body mass index (BMI)
- A cardiovascular assessment.
  An electrocardiogram (ECG) is not needed before starting, dexamfetamine unless the person has any features below or a co- existing condition being treated with a medicine that may pose an increased cardiac risk.
- Arrange for electrocardiogram (ECG), /echocardiogram /refer for cardiology opinion before starting medication only if the patient has any of the following:
  - History of congenital heart disease or previous cardiac surgery
  - History of sudden death in a first-degree relative under 40 years suggesting a cardiac disease
  - Shortness of breath on exertion compared with peers
  - Fainting on exertion or in response to fright or noise
  - Palpitations that are rapid, regular and start and stop suddenly (fleeting occasional bumps are usually ectopic and do not need investigation)
  - Chest pain suggestive of cardiac origin
  - Signs of heart failure or heart murmur
  - Current treatment with a medicine that may increase cardiac risk
  - Blood pressure that is classified as hypertensive. Refer to NICE guidelines for hypertension in adults

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. The specialist should determine the appropriate timing for this monitoring as no standard is given in literature
- Assessment of symptom improvement. Discontinue if no improvement is observed after one month.

Ongoing monitoring (ADHD):

Ensure the patient receives a review at least annually with a healthcare professional with training and expertise in managing ADHD. This 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 urgent changes also communicated by telephone or electronic records such as System1 where available.

If the patient fails to attend for physical monitoring, despite attempts to re-appoint, do not issue any further prescriptions, contact the patient/carer and inform the specialist. The patient should be informed of this policy when treatment begins.

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9. Ongoing monitoring requirements to be undertaken by primary care

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See 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	Every 6 months, before and after any change of dose recommended by specialist team.

• Explore whether patient is experiencing any difficulties with sleep	
• Assessment for new or worsening psychiatric and neurological signs or symptoms (e.g. suicidal thoughts tics, anxiety, symptoms of bipolar disorder)	Every 6 months, before and after any change of dose, at every visit
• Medication related side-effects*	At each visit
• ECG, LFTs, FBC	Not recommended unless there is a clinical indication.
• 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

*Consider using standard symptom and side effect rating scales during treatment as an adjunct to clinical assessment.

** The specialist should determine the appropriate timing for this monitoring as no standard is given in literature

If monitoring results are forwarded to the specialist team, please include clear clinical information on the reason for sending, to inform action to be taken by secondary care.

10. Adverse effects and other management

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Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit www.mhra.gov.uk/yellowcard

For information on incidence of ADRs see relevant summaries of product characteristics

European guidelines on managing adverse effects of medication for ADHD were published in 2011. These provide additional guidance for clinicians.

IF YOU ARE IN ANY DOUBT ABOUT ANY POTENTIAL ADVERSE REACTION, PLEASE CONTACT THE SPECIALIST TEAM.

If the patient in front of you is acutely unwell, please contact oncall medical team

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 team or oncall team immediately.
Symptoms of cerebral ischaemia, e.g. severe headache, numbness, weakness, paralysis, and impairment of coordination, vision, speech, language or memory	Discontinue dexamfetamine, refer urgently for neurological assessment
Anorexia or weight loss, weight or BMI outside healthy range	Exclude other reasons for weight loss. Exclude other reasons for weight loss. Give advice as per NICE 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
Haematological disorders Including leukopenia, thrombocytopenia, anaemia related symptoms (e.g. paleness, lethargy) or other alterations Abnormal bruising / bleeding / severe sore throat / skin lesions or severe infection NB: no haematological monitoring is recommended. Haematological disorders would be a chance finding/due to patient reporting adverse drug reactions.	Seek immediate medical attention, not known to be related to dexamfetamine.
New or worsening psychiatric or neuropsychiatric symptoms, e.g. mania, depression, psychosis, mania, aggressive or hostile behaviour, suicidal ideation or behaviour, motor or verbal tics (including Tourette's syndrome), anxiety, agitation or tension, bipolar disorder, 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 and discuss with specialist team or oncall team immidiately.
Suspicion of abuse, misuse, or diversion	Discuss with specialist team
Failure to attend for physical monitoring checks	Do not issue further prescriptions, discuss as soon as possible with specialist.

11. Advice to patients and carers

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The 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/carer 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
- 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:

- 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 can affect impair cognitive function and is subject to drug driving laws, therefore patients must ensure their ability to drive is not impaired before driving. For information on 2015 legislation regarding driving whilst taking certain controlled drugs, including amfetamines, see drugs and driving: the law. People who drive must inform the DVLA if their ADHDor medicines affect their ability to drive safely. See https://www.gov.uk/adhd-and-driving.

- 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-personal-licences.

Patient information:

- Royal College of Psychiatrists – ADHD in adults. https://www.rcpsych.ac.uk/mental-health/problems-disorders/adhd-in-adults

- NHS – Attention deficit hyperactivity disorder. https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/

12. Pregnancy, paternal exposure and breast feeding

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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/USE-OF-AMFETAMINES-IN-PREGNANCY/

Patient information is available from

bumps - best use of medicine in pregnancy (medicinesinpregnancy.org)

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.

Paternal exposure:

No evidence regarding adverse outcomes following paternal exposure was identified.

13. Specialist contact information

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Neurodevelopmental Specialist Service: Adult ADHD service
Daytime telephone number: 01159 560893
Email address: NeSS@nottshc.nhs.uk
Out of hours telephone: Contact on-call Community Health Services Psychiatrist via Nottinghamshire Healthcare NHS Foundation Trust 0118440500

Oncall medical teams
Sherwood Forest Hospitals NHS Foundation Trust Switchboard 01623 622 515
Nottingham University Hospital QMC Switchboard 0115-8831181

Other local NHS specialists may request shared care including local mental health teams and intellectual disability teams. The contact details for these teams will be detailed on the shared care request letter.

14. Additional information

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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

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- NICE NG87: Attention deficit hyperactivity disorder: diagnosis and management. Last updated September 2019. Accessed via https://www.nice.org.uk/guidance/ng87/ on 18/02/25
- eBNF. Dexamfetamine, last updated 26th February 2025. Accessed via https://bnf.nice.org.uk/ on 1803/2025
- Dexamfetamine sulfate 20 mg tablets (Amfexa®). Date of revision of the text: 30/03/23. Accessed via https://www.medicines.org.uk/emc/product/7404/smpc on 18/02/25
- Dexamfetamine sulfate 5mg tablets (Amfexa®). Date of revision of the text: 17/09/24. Accessed via https://www.medicines.org.uk/emc/product/5004/smpc on 18/02/25
- NICE. NG46: Controlled drugs: safe use and management. April 2016. Accessed via https://www.nice.org.uk/guidance/ng46/ on 18/02/2025
- NICE Clinical Knowledge Summaries. Attention deficit hyperactivity disorder: Amfetamines. Last revised February 2025. Accessed via https://cks.nice.org.uk/topics/attention-deficit-hyperactivity-disorder/prescribing-information/amfetamines/ on 18/02/2025
- Gov.uk. Drugs and driving: the law. Accessed via Drugs and driving: the law - GOV.UK on 18/03/25.

- Graham J et al. European guidelines on managing adverse effects of medication for ADHD. Eur Child Adolesc Psychiatry (2011),20:17-37. On-line at http://www.springerlink.com/content/y667034856017253/fulltext.pdf

16. Other relevant national guidance

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- NHSE guidance – Responsibility for prescribing between primary & secondary/tertiary care. Available from 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-and-managing-medicines-and-devices/shared-care
- NICE NG197: Shared decision making. Last updated June 2021. https://www.nice.org.uk/guidance/ng197/.

17. Local arrangements for referral

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Define the referral procedure from hospital to primary care prescriber & route of return should the patient's condition change.

- Prescribing and monitoring responsibility will only be transferred when the patient's condition and medication are stable.
- The specialist will request shared care with the GP in writing.
- If the GP doesn't agree to shared care, they should inform the specialist of their decision in writing within 14 days.
- In cases where shared care arrangements are not in place or where problems have arisen within the agreement and patient care may be affected, the responsibility for the patients' management including prescribing reverts back to the specialist.
- Should the patient's condition change, the GP should contact the relevant specialist using the details provided with the shared care request letter.