

ADHD Medication Supply Disruption and Advice

Advice and guidance to support healthcare professionals to respond to individual patient cases – Version 51

A [National Patient Safety Alert](#) has been issued warning of an impending shortage of specific medicines for Attention Deficit and Hyperactivity Disorders (ADHD). The affected medicines include:

[Methylphenidate:](#)

[Lisdexamfetamine:](#)

[Guanfacine](#)

[Atomoxetine](#)

Resources to support patients can be found [here](#)

The supply disruption of these products is attributed to the combined effect of manufacturing issues and increased global demand. Other ADHD products remain available but at insufficient quantities necessary to meet the insurmountable increases in demand. Current expectations are that supply disruptions may resolve at various dates. The Specialist Pharmacy Service (SPS) has a Medicines Supply Tool that provides the latest information on supply issues, recommended actions, alternative options, and expected resolution dates. The content in this tool is provided by the Department of Health and Social Care (DHSC) and the Commercial Medicines Unit (CMU). You can access the tool [here](#). Please note that registration is required to use this tool.

This document serves to provide information and clinical recommendations about how to manage these shortages. A quick reference guide for **adults** can be found [here](#) and for **children** can be found [here](#).



Immediate Action

Prescribers should:

1. not initiate new patients on products affected by this shortage until the supply issues resolve.

Healthcare professionals in primary care (and secondary care if appropriate) should:

2. identify all patients currently prescribed these products, particularly those prescribed guanfacine and lisdexamfetamine and
3. make early contact with patients to establish how much supply they have remaining. Recheck monthly

Where patients have insufficient supplies to last until the re-supply date:

4. Ask the patient to try to obtain a supply (locally) but to contact the practice again if not possible
5. Contact the patient's specialist team for advice on management options if the product cannot be sourced.

Specialist teams should:

6. support primary care teams seeking advice for patients currently prescribed the affected products,
7. provide individualised management plans, where required; and
8. recommend alternatives in line with NICE guidance, where appropriate.

Refer to the information below for more detailed recommendations

Recommendations

A quick reference guide for **adults** can be found [here](#) and for **children** can be found [here](#).

Below is some centralised information on medicine availability, potential resupply dates and clinical recommendations to help guide decisions around individual patient management. Please refer to the Specialist Pharmacy Service ([SPS](#)) Medicines Supply Tool for the latest information on supply issues and expected resolution dates. Please note that registration is required to use this tool. Additionally, SPS is a national resource and may not account for local variations.

The advice is to prescribe 12-hour Prolonged Release Methylphenidate tablets and Lisdexamfetamine capsules **generically**, whenever possible during this period of ADHD medication supply disruption. This allows community pharmacy to dispense any brand they have in stock. TABLETS must be specified on the prescription for to12-hour Prolonged Release Methylphenidate tablets . The advice to prescribe generically only applies to12-hour Prolonged Release Methylphenidate tablets and Lisdexamfetamine capsules. 8 hour Modified Release Methylphenidate **capsules** must be prescribed by **brand**.



METHYLPHENIDATE AMBER 1 Shared Care

Once daily dosing (12 hour PR tablets)

Examples of brands include : Affenid XL® , Atenza XL® Concerta XL® , Delmosart ®, Matoride XL®, Xaggitin XL® , Xenidate XL®

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Recommendations: Can be managed in primary care

- Discussions should be had with each patient around a treatment break / drug holiday.
- Low doses of methylphenidate (up to 36mg daily) can be stopped suddenly with minimal risks of withdrawal symptoms.
- Suddenly stopping higher doses may cause withdrawal effects and so a gradual reduction in dose may be more appropriate, where possible, ideally reducing down to the next tablet size weekly.
- Where ADHD medication is deemed essential consider swapping brands (as they are equivalent) depending on current supplies. Prescribing **GENERICALLY** allows community pharmacy to dispense any brand they have in stock. **TABLETS** must be specified on the prescription. [See Patient leaflet](#)

Monitoring:

Patients/carers should be asked to monitor for signs of withdrawal such as extreme tiredness, increased activity, being irritable, poor sleep, increased appetite, and depression and for the return of ADHD symptoms. These signs may only need to be reported where symptoms are severe or unmanageable.



Once daily dosing - Equasym XL® capsules (30:70 release ~8-hour duration)

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Recommendations: *Advice from a specialist is required for switching to alternative medications*

- Discussions should be had with each patient around a treatment break / drug holiday.
- Low doses of Equasym XL® (up to 20mg daily) can be stopped suddenly with minimal risks of withdrawal symptoms.
- Higher doses should be gradually tapered down by 10mg weekly to minimize the risk of withdrawal symptoms, where possible.

Advice from specialist required for switching to alternative medications:

- Where ADHD medication is deemed essential consider swapping to Focusim XL®, Medikinet XL®, Meflynate XL®, Metyrol XL®, Ritalin XL® (50:50 8 hour duration) as these are the most similar medication. **Prescribe by brand**
- Change to an immediate release form of methylphenidate and give 2 or 3 times a day at 5mg or 10mg depending on the dose used of Equasym XL®.

Monitoring:

Patients/carers should be asked to monitor for signs of withdrawal such as extreme tiredness, increased activity, being irritable, poor sleep, increased appetite, and depression and for the return of ADHD symptoms. These signs may only need to be reported where symptoms are severe or unmanageable.



LISDEXAMFETAMINE AMBER 1 Shared Care

Please refer to the Specialist Pharmacy Service ([SPS](#)) Medicines Supply Tool for the latest information on supply issues and expected resolution dates. Registration is required to use this tool. Please note, the SPS Medicines Supply Tool is a national resource and may not account for local variations.

Recommendations: Can be managed in primary care

- Discussions should be had with each patient around a treatment break / drug holiday.
- Lisdexamfetamine can be stopped abruptly if the dose is low (up to 30mg daily)
- Suddenly stopping higher doses may cause withdrawal effects and so a gradual reduction in dose may be more appropriate, where possible. Ideally reduce dose by 20mg per week.
- Prescribe **GENERALLY** to allow community pharmacy to dispense any brand they have in stock.

Advice from specialist required for switching to alternative medications:

- Dexamphetamine 5mg could be used as an alternative up to 3 times a day. It can however cause rebound overactivity as it wears off.
- Methylphenidate preparations may be used depending on supplies and whether the patient can tolerate this based on any previous trials. Would need to gradually reduce Elvanse ® and then start prolonged release methylphenidate 18mg OD and then gradually increase weekly.

Monitoring:

Patients/carers should be asked to monitor for signs of withdrawal such as extreme tiredness, increased activity, being irritable, poor sleep, increased appetite, and depression and for the return of ADHD symptoms. These signs may only need to be reported where symptoms are severe or unmanageable.

ATOMOXETINE AMBER 1 Shared Care



Please refer to the Specialist Pharmacy Service ([SPS](#)) Medicines Supply Tool for the latest information on supply issues and expected resolution dates. Registration is required to use this tool. Please note, the SPS Medicines Supply Tool is a national resource and may not account for local variations.

Recommendations: **Can be managed in primary care**

- Discussions should be had with each patient around a treatment break / drug holiday.
- Atomoxetine is not associated with withdrawal symptoms if it is stopped suddenly. It can therefore be discontinued temporarily without the need for dose tapering if supplies are unavailable, however tapering the dose slowly is the preferred method for stopping. Reductions of 10mg weekly (or adjust down to next tablet size), on a case-by-case basis.

Advice from specialist required for switching to alternative medicines:

- There are no alternative atomoxetine preparations. If continued pharmacological treatment is required, a different treatment will need to be sought, based on the patient's ADHD medication history and medical history.
- Once it is possible to restart atomoxetine, depending on the gap in treatment, achieving a therapeutic response again may take several weeks.

Monitoring:

Advise patient or carer to monitor for the return of ADHD symptoms. Note that though symptoms may return, evidence is that symptoms do not return to pre-treatment levels and this may only need to be reported where symptoms are severe or unmanageable.



GUANFACINE RED, Specialist management only

Please refer to the Specialist Pharmacy Service ([SPS](#)) Medicines Supply Tool for the latest information on supply issues and expected resolution dates. Registration is required to use this tool. Please note, the SPS Medicines Supply Tool is a national resource and may not account for local variations.

Recommendations: Specialist management only

- If continued pharmacological treatment is required, a different treatment will need to be sought, based on the patient's ADHD medication history and medical history. Clonidine (another alpha-2-agonist) may be an alternative, especially in those with a tic disorder and 100micrograms of clonidine is equivalent to 1mg Intuniv. Patients on 1-2mg Intuniv could be prescribed 50micrograms clonidine once or twice a day. For patients on 3mg or more trial 100 micrograms of clonidine at night and then increase in increments of 25-50micrograms every 5 to 7 days. Clonidine can be used up to 3 times a day and usual maximum dose is 250 to 300 micrograms in 24 hours. This alternative should only be prescribed as directed by a specialist. Higher doses of clonidine may cause sedation, bradycardia and postural hypotension. Hence, slow titration (every 5-7 days) of clonidine in 25-50 microgram increments is recommended. Use of clonidine in this manner is unlicensed. Prescribers must ensure that this is explained to the patient/carer, providing them with enough information about the medicine in order for them to make an informed decision about the proposed treatment.
- Do not initiate any new patients on guanfacine until supply issues have been rectified.
- Avoid suddenly stopping guanfacine due to the increased risk of rebound hypertension and tachycardia. Rebound hypertension is more likely on higher doses (i.e. 3mg and above). Hypertensive encephalopathy has been very rarely reported on abrupt cessation of treatment.
- Identify all patients currently prescribed guanfacine to establish if they have sufficient supplies to last until the shortage resolves.
- For patients with insufficient supplies, offer guidance / advice on how to reduce their dose gradually if their stock of medication at home allows. If not, prescribe a gradual dose reduction.
- Ideal tapering is to reduce in decrements of 1mg every 3 – 7 days. For example, for a patient prescribed 4mg Intuniv® tablets, with a stock of 3mg and 1mg tablets at home: reduce the dose to 3mg, then 2mg, then 1mg. Intuniv® tablets cannot be split. Ensure BP and HR are monitored to identify possible withdrawal effects.
- If it is not possible to reduce slowly, for patients on an established dose of 3mg and above, monitor BP and HR on stopping. Rebound hypertension may occur and has been reported to persist in some cases. The rebound hypertensive effect of abruptly stopping guanfacine is typically apparent 24-48 hours after the last dose and may take about 2 – 4 days to resolve. This is usually asymptomatic and clinically



insignificant. Monitor BP and HR at day 2 (24-48 hours after last dose), and again at day 4. If blood pressure is raised at day 4, measure again at weekly intervals until normal.

If there are signs of clinically significant rebound hypertension, seek medical advice.

For advice on blood pressure and heart rate monitoring in children see:

https://www.nottsapc.nhs.uk/media/vv2jpti/bp_and_hr_monitoring_for_children.pdf

Monitoring:

Blood pressure and HR monitoring is required following abrupt discontinuation of doses of 3mg and above. See information above in 'recommendations' for specific information. Advise patient or carer to monitor for the return of ADHD symptoms. Note that though symptoms may return, evidence is that symptoms do not return to pre-treatment levels and this may only need to be reported where symptoms are severe or unmanageable.

VERSION CONTROL

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Version 50

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