## Atomoxetine for patients within children and adult services

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| Version: | RDTC v1.0 | Replaces version: | NHSE v1.0 |
| Clinical content last reviewed: | March 2024 | Next review date: | March 2026 |

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| **Version** | **Date published** | **Changes since previous version** |
| RDTC v1.0 | 15/05/2024 | Clarified maximum dosing for adults weighing up to 70kg, included caution with oral solution for patients with hereditary fructose intolerance, added missing information on management of CV effects, included additional information regarding clinically significant BP raises, minor addition to safety in lactation section. Hyperlinks and references updated to current versions. |
| HNYv1.1 | 28/04/2025 | The RDTC version has been adjusted to include children as well as adults within the same document.  Section 1: Include reference to children as well.  Section 2: Added in children over 6 years as well.  Section 3: For Attention Deficit Hyperactivity Disorder in children aged 6 to 17 years and adults.  Section 4: Transfer of care should occur after at least 12 weeks following stabilisation of dose and monitoring,  Section4: initial stabilisation –   * Children and adults weighing up to 70 kg: 500 micrograms/kg daily for at least 7 days * Children and adults weighing 70 kg or above: 40mg daily for at least 7 days   Section 4: maintenance Dose  Dosing of paediatric population up to 70 kg Body Weight:  Atomoxetine should be initiated at a total daily dose of approximately 0.5 mg/kg. 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 dose is approximately 1.2 mg/kg/day (depending on the patient's weight and available dosage strengths of atomoxetine).  Dosing of paediatric population over 70 kg Body Weight:  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 dose is 80 mg. No additional benefit has been demonstrated for doses higher than 80 mg. The maximum recommended total daily dose is 100 mg  Adults:  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. For those patients up to 70kg, doses up to 1.2 mg/kg daily in a single dose, or in two equally divided doses, as above. Higher doses exceeding 100mg daily, up to a maximum of 1.8 mg/kg daily (maximum 120mg daily), are off-label and must be given under the direction of a specialist.  • Dose to be reviewed and amended in line with changing weight (particularly children).  • Usual maximum total daily dose is 100mg. Higher doses, up to a maximum of 120mg daily, are off-label and must be given under the direction of a specialist  Section 5; Baseline investigations   * Height, weight, and body mass index (BMI) – **recorded on centile chart (not applicable in patients > 18 years).** * Blood pressure (BP) and heart rate– **recorded on centile chart (not applicable in patients > 18 years)**   Initial monitoring  Prior to there being a shared care agreement in place:  Height:   * Children aged 6 to 17 years of age – 6-monthly   Weight:   * Children aged 6 to 10 years of age – 3-monthly * Children aged 11 years of age – at 3 months, 6 months, then 6-monthly thereafter * Adults: 6-monthly   On going monitoring:  If still on treatment at school-leaving age, determine if treatment needs to be continued and, if it does, arrange for transition to adult services by 18 years of age.  Section 6; Monitoring section  To include with dose changes as well.  In children and young people, record BP and HR on centile charts to detect clinically important changes.  Weight and appetite:  Children aged 6 to 10 years of age - every 3 months – record weight on a growth chart  Children aged 11 – 17: at 3 months, 6 months then every 6 months – record on growth chart  Formulation  Oral solution: only approved for patients with more complex needs e.g. younger patients and those with swallowing difficulties.  Section 11: Added in link to BNFC PIL  <https://www.medicinesforchildren.org.uk/medicines/atomoxetine-for-adhd/>  Section 13: Details for contacting specialist must be included on clinic letter. |

**Local review and adoption**

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| **Local approval** | **Date** |
| Local content added |  |
| Approved for use by HNY ICB |  |
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Clinical content has been reviewed and updated by the RDTC on the date indicated above. Every effort is made to keep the content up to date. These templates are provided to the North West and North East and Yorkshire ICBs for localisation and approval through standard ICB processes. The most recent version is available on the RDTC website at <https://rdtc.nhs.uk/prescribing-support-document/shared-care-protocol-atomoxetine-in-adults/>.

Information requiring local completion is highlighted.

This document is intended for use by NHS healthcare professionals and cannot be used for commercial or marketing purposes.

**Shared Care Protocol**

## Atomoxetine for patients within children and adult services

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| Background | Atomoxetine is a sympathomimetic drug indicated for the treatment of attention deficit hyperactivity disorder (ADHD). It is licensed for this indication in children 6 years and over and adults. It is an alternative treatment option in patients who cannot tolerate lisdexamfetamine or methylphenidate, or whose symptoms have not responded to separate 6-week trials of lisdexamfetamine or methylphenidate (see NICE Guidance [NG87](https://www.nice.org.uk/guidance/ng87) ADHD: 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.  Atomoxetine is licensed for use in adults and children 6 years and over with ADHD of at least moderate severity. Adults should have ADHD symptoms pre-existing from childhood, which should ideally be confirmed by a third party.  Atomoxetine should be used as part of a comprehensive treatment programme, typically including psychological, educational, and social measures.  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 a need for ongoing treatment is anticipated. NICE Guidance [NG43](https://www.nice.org.uk/guidance/ng43) Transition from children to adult services for young people using health or social care services, should be followed.  Long-term usefulness of atomoxetine for extended periods (over 12 months) should be periodically re-evaluated for the individual patient. 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. |
| Licensed and agreed off-label indications | Attention deficit hyperactivity disorder  This shared care protocol applies to children aged 6 to 17 years and adults. |
| Locally agreed indications | For Attention Deficit Hyperactivity Disorder in children aged 6 to 17 years and adults. |
| Initiation and ongoing dose regime | 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 12 weeks.  The duration of treatment and 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 specialist unless directions have been discussed and agreed with the primary care clinician.  Termination of treatment will be the responsibility of the specialist.  **Initial stabilisation:**   * Children and adults weighing up to 70 kg: 500 micrograms/kg daily for at least 7 days * Children and adults weighing 70 kg or above: 40mg daily for at least 7 days   Then titrated according to clinical response and tolerability. Total daily dose may be given as a single dose in the morning or in two equally divided doses, with the last dose no later than the early evening.  **The loading period must be prescribed by the initiating specialist.**  **Maintenance dose for adults and children aged 6 and over (following initial stabilisation):**  **Dosing of paediatric population up to 70 kg Body Weight:**  Atomoxetine should be initiated at a total daily dose of approximately 0.5 mg/kg. 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 dose is approximately 1.2 mg/kg/day (depending on the patient's weight and available dosage strengths of atomoxetine).  **Dosing of paediatric population over 70 kg Body Weight:**  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 dose is 80 mg. No additional benefit has been demonstrated for doses higher than 80 mg. The maximum recommended total daily dose is 100 mg  **Adults:**  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. For those patients up to 70kg, doses up to 1.2 mg/kg daily in a single dose, or in two equally divided doses, as above. Higher doses exceeding 100mg daily, up to a maximum of 1.8 mg/kg daily (maximum 120mg daily), are off-label and must be given under the direction of a specialist.   * Dose to be reviewed and amended in line with changing weight (particularly children). * Usual maximum total daily dose is 100mg. Higher doses, up to a maximum of 120mg daily, are off-label and must be given under the direction of a specialist.   **The initial maintenance dose must be prescribed by the initiating specialist.**  **Conditions requiring dose adjustment:**  Hepatic insufficiency:   * Moderate hepatic insufficiency ([Child-Pugh](https://www.sps.nhs.uk/articles/what-is-the-child-pugh-score/) Class B): reduce starting and target doses to 50% of usual. * Severe hepatic insufficiency ([Child-Pugh](https://www.sps.nhs.uk/articles/what-is-the-child-pugh-score/) Class C): reduce starting and target doses to 25% of usual.   Renal insufficiency:  No adjustment is necessary but be aware that atomoxetine may exacerbate hypertension in patients with end stage renal disease.  Known CYP2D6 poor metaboliser genotype:  Due to several-fold increase in atomoxetine exposure, consider a lower starting dose and slower up-titration. |
| 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 the immediate future will prescribing and monitoring be transferred to primary care.  **Baseline investigations:**   * A full assessment, as recommended by [NICE guidance for ADHD](https://www.nice.org.uk/guidance/ng87/chapter/Recommendations#medication). This should ensure that the patient meets the criteria for ADHD and that pharmacological treatment is required. The assessment should also include a medical history and cardiovascular assessment, considering conditions that may be contraindications for atomoxetine. * Risk assessment for substance misuse and drug diversion * Height, weight, and body mass index (BMI) – recorded on centile chart (not applicable in patients > 18 years). * Appetite * Blood pressure (BP) and heart rate– recorded on centile chart (not applicable in patients > 18 years) * Electrocardiogram (ECG) and cardiology opinion are recommended if the patient has any of the following:   + history of congenital heart disease or previous cardiac surgery   + 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   + chest pain suggestive of cardiac origin   + signs of heart failure, heart murmur or hypertension * ECG is recommended if the patient has a co-existing condition treated with a medicine that may increase cardiac risk.   **Initial monitoring:**  Before every change of dose: assess heart rate, blood pressure, and weight.  Prior to there being a shared care agreement in place:Height:   * Children aged 6 to 17 years of age – 6-monthly   Weight:   * Children aged 6 to 10 years of age – 3-monthly * Children aged 11 years of age – at 3 months, 6 months, then 6-monthly thereafter * Adults: 6-monthly * After every change of dose: assess heart rate and blood pressure, and any new or worsening psychiatric symptoms, including development or worsening of tics. The specialist should determine the appropriate timing for this monitoring. * Assessment of symptom improvement. Discontinue if no improvement is observed after 4-8 weeks.   **Ongoing monitoring:**   * Monitoring before and after dose adjustments, as above.   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. 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. If still on treatment at school-leaving age, determine if treatment needs to be continued and, if it does, arrange for transition to adult services by 18 years of age.  Review outcomes should be communicated to the primary care prescriber in writing, with any urgent changes also communicated by telephone. After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in [section 6](#_Ongoing_monitoring_requirements) remains appropriate. |

## Ongoing monitoring requirements to be undertaken by primary care

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.

| **Monitoring** | **Frequency** |
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| * Blood pressure and heart rate, and assessment for cardiovascular signs or symptoms | At least every 6 months and after any change of dose.  In children and young people, record BP and HR on centile charts to detect clinically important changes. |
| * Height (children and young people only) | At least every 6 months |
| * Weight and appetite | Children aged 6 to 10 years of age - every 3 months – record weight on a growth chart  Children aged 11 – 17: at 3 months, 6 months then every 6 months – record on growth chart  Adults: very 6 months |
| * Assessment for new or worsening psychiatric and neurological signs or symptoms | At least every 6 months |
| * Assessment of adherence, and for any indication of atomoxetine abuse, misuse, or diversion. * Monitor young people and adults for sexual dysfunction (erectile and ejaculatory dysfunction) as potential adverse effects of atomoxetine. | 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 |

## Pharmaceutical aspects

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| Route of administration: | Oral |
| Formulation: | Atomoxetine hydrochloride hard capsules: 10mg, 18mg, 25mg, 40mg, 60mg, 80mg, 100mg  Atomoxetine hydrochloride 4 mg/mL oral solution - only approved for patients with more complex needs e.g. younger patients and those with swallowing difficulties. |
| Administration details: | Atomoxetine can be taken with or without food.  Capsules should not be opened for administration: risk of ocular irritation.  Atomoxetine oral solution contains sorbitol. Patients with hereditary fructose intolerance (HFI) should not take this product. The oral solution should not be mixed with food or water; it can prevent the full dose being administered and can negatively affect the taste.  If a dose is missed then take it as soon as possible, but no later than the early evening. Do not take more than the usual total daily dose in any 24-hour period. A double dose should not be taken to make up for a missed dose. |
| Other important information: | The initiating specialist will decide the formulation on an individual basis as this will depend on the needs and preferences of the patient. |

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| Cautions and contraindications | This 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/) & [SPC](https://www.medicines.org.uk/emc/search?q=atomoxetine) for comprehensive information.  **Contraindications:**   * Hypersensitivity to atomoxetine or to any of the excipients * During treatment with monoamine oxidase inhibitors (MAOI), or within 14 days of discontinuing these drugs, due to the increased risk of adverse effects e.g. hypertensive crisis, serotonin syndrome. * Narrow angle glaucoma * Severe cardiovascular or cerebrovascular disorders, including severe hypertension, heart failure, arterial occlusive disease, angina, haemodynamically significant congenital heart disease, cardiomyopathies, myocardial infarction, potentially life-threatening arrhythmias, disorders caused by the dysfunction of ion channels, cerebral aneurysm, or stroke. * History of phaeochromocytoma   **Cautions:**   * Psychiatric and neuropsychiatric symptoms or disorders, including psychotic symptoms, aggressive or hostile behaviour, emotional lability, suicide-related behaviour (suicide attempts or suicidal ideation), motor or verbal tics, anxiety, depressive symptoms, and mania. * Known serious structural cardiac abnormalities; consultation with a cardiac specialist required before treatment * Underlying medical conditions which could be worsened by increases in blood pressure and heart rate, including hypertension, tachycardia, or cardiovascular or cerebrovascular disease * Prolonged QT interval (congenital or acquired, e.g. drug-induced) or family history of QT prolongation * Any condition that may predispose patients to hypotension or conditions associated with abrupt heart rate or blood pressure changes (risk of orthostatic hypotension) * Concomitant medications that elevate blood pressure: assess for neurological signs and symptoms at every monitoring visit * Other conditions that may precipitate or otherwise induce cerebrovascular conditions: assess for neurological signs and symptoms at every monitoring visit * Hepatic insufficiency: dose adjustments required, see [section 4](#_Initiation_and_ongoing). * History of seizures * Susceptibility to angle-closure glaucoma * Age over 65 years; safety and efficacy has not been systematically evaluated * Known CYP2D6 poor metaboliser genotype. Dose reduction required, see [section 4](#_Initiation_and_ongoing). |
| Significant drug interactions | The following list is not exhaustive. Please see [BNF](https://bnf.nice.org.uk/) & [SPC](https://www.medicines.org.uk/emc/search?q=atomoxetine) for comprehensive information and recommended management.   * **MAOIs**: avoid atomoxetine use whilst using MAOIs and for a minimum of 14 days after stopping MAOIs. Increased risk of adverse effects. * **CYP2D6 inhibitors** (e.g.selective serotonin reuptake inhibitors (SSRIs), quinidine, terbinafine, bupropion, cinacalcet, dacomitinib, and panobinostat): increased atomoxetine exposure. Slower dose titration and lower final dose may be necessary in patients already taking these drugs. Clinical response and tolerability should be re-evaluated if a CYP2D6 inhibitor is started or stopped. * **Potent inhibitors of other cytochrome P450 isoforms** in patients who are poor CYP2D6 metabolisers. It is not clear whether there is a clinically significant increase in atomoxetine exposure in this patient group. * **Beta-2 agonists, including salbutamol**: high dose beta-2 agonists, such as salbutamol, may potentiate cardiovascular effects. * **Drugs which prolong the QT interval** (e.g.antipsychotics, class IA and III anti-arrhythmics, ciprofloxacin, erythromycin, methadone, mefloquine, tricyclic antidepressants (TCAs), lithium, and some SSRIs e.g. citalopram): risk of QT interval prolongation. * **Drugs which cause electrolyte imbalance** (e.g. thiazide diuretics):risk of QT interval prolongation. * **Drugs which lower the seizure threshold** (e.g. TCAs, SSRIs, antipsychotics, phenothiazines, mefloquine, chloroquine, bupropion, and tramadol)**:** risk of seizures. Use caution when stopping medications that may induce seizures on withdrawal, such as benzodiazepines. * **Anti-hypertensive drugs:** effectiveness of anti-hypertensives may be decreased, monitoring is required. * **Drugs that increase blood pressure:** possible additive effects, monitoring is required. * **Drugs that affect noradrenaline** (e.g.dexamfetamine, lisdexamfetamine, imipramine, venlafaxine, mirtazapine, pseudoephedrine, phenylephrine)**:** possible additive or synergistic pharmacological effects. |

## Adverse effects and management

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**.** For information on incidence of ADRs see relevant [SPCs](https://www.medicines.org.uk/emc/search?q=atomoxetine).

**Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit** <https://yellowcard.mhra.gov.uk>.

Advice based on shared care guidelines published by NHS England and checked against current guidance.

| **Adverse effect** | **Management** |
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| **Cardiovascular**  Resting HR greater than 120 bpm, arrhythmia/palpitations, clinically significant increase in systolic BP (≥15–20 mmHg or systolic BP greater than the 95th centile) | * 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. |
| Hypertension | Manage hypertension as per local pathways, considering the risk of clinically significant interactions with some antihypertensive medication (see [section 9](#_Significant_drug_interactions)).  If blood pressure is significantly raised (≥15–20 mmHg), follow the advice in the management box immediately above. |
| **Gastrointestinal disorders**  Including abdominal pain, vomiting, nausea, constipation, dyspepsia | Review and provide advice on dosing; patients may benefit from taking atomoxetine in two equally divided doses (once in the morning, and once in the late afternoon or early evening). Generally, this resolves. |
| **Weight or BMI outside healthy range**, including anorexia or weight loss | Recommend small, frequent meals and/or snacks, and high calorie foods of good nutritional value. Recommend taking atomoxetine with or after meals, and not before. Obtain dietary advice if required.  Discuss with specialist if difficulty persists; dose reduction, treatment break, or change of medicine may be required. |
| **Psychiatric disorders**  New or worsening psychiatric symptoms, e.g. suicide related behaviour, psychosis, mania, aggressive or hostile behaviour, suicidal ideation or behaviour, motor or verbal tics (including Tourette’s syndrome), anxiety, agitation or tension, bipolar disorder, or depression | Contact specialist team and refer for psychiatric assessment if appropriate. Refer for urgent psychiatric assessment if suicide related behaviour or ideation occurs.  Discuss ongoing benefit of treatment with specialist team. |
| **Hepatic effects**  Signs or symptoms of liver injury, e.g. abdominal pain, unexplained nausea, malaise, jaundice, or darkening of urine | Perform liver function tests (LFTs), including serum bilirubin, and discuss with specialist team.  Discontinue atomoxetine permanently in patients who develop jaundice or for whom there is laboratory evidence of liver injury (if unclear if injury or transient derangement, discuss urgently with specialist). |
| **Nervous system disorders**  Somnolence or sedation | Review and provide advice on dosing; patients may benefit from taking atomoxetine in two equally divided doses (once in the morning, and once in late afternoon or early evening). Generally, this resolves. |
| New onset of seizures, or increased seizure frequency | Discuss with specialist team. Discontinuation of atomoxetine should be considered. |

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| Advice to patients and carers The specialist will counsel the patient about the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual drugs. | **The patient should be advised to report any of the following signs or symptoms to their primary care prescriber without delay:**   * Abnormally sustained or frequent and painful erections. **If an erection persists for more than 2 hours go to A&E**; this is an emergency. * Sudden acute, painful eye(s), impaired vision, red eye(s), and/or semi-dilated and fixed pupil; risk of **angle closure glaucoma**, seek immediate medical attention, ideally from an eye casualty unit or A&E. * Symptoms suggestive of cardiac disease (e.g. palpitations, exertional chest pain, unexplained syncope, or dyspnoea). * New or worsening psychiatric symptoms (e.g. psychotic symptoms, aggressive or hostile behaviour, emotional lability, suicide-related behaviour (suicide attempts or suicidal ideation), motor or verbal tics, anxiety, depressive symptoms, or mania). * Report **suicidal thoughts or behaviour**, and development or worsening of irritability, agitation, and depression. * New or worsening neurological symptoms (e.g. severe headache, numbness, weakness, paralysis, seizures, or impairment of coordination, vision, speech, language, or memory). * Risk of **hepatic injury**: report unexplained nausea, malaise, jaundice, or darkening of urine, and new onset severe or persistentabdominal pain. * Symptoms of allergic or anaphylactic reactions (e.g. rash, angioedema, or urticaria). * If they suspect they may be pregnant or are planning a pregnancy.   **The patient should be advised:**   * Not to drive, cycle, or operate machines if atomoxetine affects their ability to do so safely, e.g. by causing dizziness, drowsiness, or fatigue, and to inform the DVLA if their ability to drive safely is affected. See <https://www.gov.uk/adhd-and-driving>. * Not to stop taking atomoxetine without talking to their doctor and not to share their medicines with anyone else.     **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/>  Patient information leaflets are also available from <https://www.medicines.org.uk/emc/search?q=atomoxetine>  <https://www.medicinesforchildren.org.uk/medicines/atomoxetine-for-adhd/> |
| Pregnancy, paternal exposure and breastfeeding | 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:**  Atomoxetine is not recommended for use during pregnancy unless a clinical decision is made that the potential benefit outweighs the risk to the fetus.  Evidence on exposure to atomoxetine during pregnancy is too limited to draw firm conclusions on adverse outcomes. Clinicians should be aware that patients may have other risk factors which independently alter the risks, and additional monitoring should be considered on a case-by-case basis.  Patients who become pregnant while taking atomoxetine, or who plan a pregnancy, should be referred to the specialist team for review.  Information for healthcare professionals: [UK Teratology Information Service](https://uktis.org/monographs/use-of-atomoxetine-in-pregnancy/)  Information for patients: [Best Use of Medicines in Pregnancy](https://www.medicinesinpregnancy.org/leaflets-a-z/atomoxetine/)  **Breastfeeding:**  There is no published evidence on the safety of atomoxetine in breastfeeding. It is not known if atomoxetine is excreted in human milk. Decisions to use atomoxetine while breastfeeding should be made on a case-by-case basis, considering the risks to the infant and the benefits of therapy. Long half-life in poor metabolisers of atomoxetine increases the risk of accumulation in some breastfed infants. Infants should be monitored for symptoms such as decreased appetite or slow weight gain, somnolence, nausea, and vomiting, although these may be difficult to detect. For further support, contact the [UK Drugs in Lactation Advisory Service](https://www.sps.nhs.uk/home/about-sps/get-in-touch/medicines-information-services-contact-details/breastfeeding-medicines-advice-service/).  **Paternal exposure**:  No evidence regarding paternal exposure was identified. |
| Specialist contact information and arrangements for referral | Details for contacting specialist must be included on clinic letter. |
| Additional information | 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. |
| References | 1. eBNF. Atomoxetine. Accessed via <https://bnf.nice.org.uk/drug/atomoxetine.html> on 14/03/2024. 2. Atomoxetine 10mg capsules, hard (ATOMAID®) SPC. Dr. Reddy’s Laboratories (UK) Ltd. Date of revision of the text: 19/02/2020. Accessed via <https://www.medicines.org.uk/emc/product/12645/smpc> on 14/03/2024. 3. NICE NG87: Attention deficit hyperactivity disorder: diagnosis and management. Last updated September 2019. Accessed via <https://www.nice.org.uk/guidance/ng87/> on 14/03/2024. 4. NICE NG43: Transition from children’s 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 14/03/2024. 5. UKTIS. Use of atomoxetine in pregnancy. Last updated March 2023. Accessed via <https://uktis.org/monographs/use-of-atomoxetine-in-pregnancy/> on 14/03/2024. 6. Drugs and Lactation Database (LactMed®). Atomoxetine. Last updated February 2023. Accessed via <https://www.ncbi.nlm.nih.gov/books/NBK501732/> on 14/03/2024. 7. NICE Clinical Knowledge Summaries. Attention deficit hyperactivity disorder: Atomoxetine. Last updated August 2023. Accessed via <https://cks.nice.org.uk/topics/attention-deficit-hyperactivity-disorder/prescribing-information/atomoxetine/> on 14/03/2024. 8. MHRA. Drug Safety Update: Atomoxetine (Strattera▼): increases in blood pressure and heart rate. January 2012. Accessed via <https://www.gov.uk/drug-safety-update/atomoxetine-strattera-increases-in-blood-pressure-and-heart-rate> on 14/03/2024. 9. MHRA. Drug Safety Update. Atomoxetine: risk of psychotic or manic symptoms in children and adolescents. March 2009. Accessed via <https://www.gov.uk/drug-safety-update/atomoxetine-risk-of-psychotic-or-manic-symptoms-in-children-and-adolescents> on 14/03/2024. 10. Regional Medicines Optimisation Committee (RMOC). February 2021. Shared Care for Medicines Guidance – A Standard Approach. Available via [FutureNHS](https://future.nhs.uk/connect.ti/PrescribingMedicinesOptimisation/view?objectId=44553232) (log in required). |
| To be read in conjunction with the following documents | * 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/>. |