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## Lisdexamfetamine for patients within children and adult services

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

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| **Version** | **Date published** | **Changes since previous version** |
| RDTC v1.0 | 29th May 2024 | Additional dosing information from SPC, updated advice on use in pregnancy in line with UKTIS, hyperlinks and references updated to current versions, minor content clarifications, and alignment of content with dexamfetamine, and other ADHD SCPs. |
| HNY v1.1 | 28th April 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 for the ADHD indication.  Section 3: For the treatment of ADHD in patients from the age of 6 years  Section 4: State that prescribing and monitoring should be transferred after at least 12 weeks  Initial stabilisation  For all patients, whether starting treatment for ADHD or switching from another medication, the starting dose is  Section 5: baseline investigations   * Blood pressure (BP) and heart rate – recorded on centile chart (not applicable in patients > 18 years)Height –recorded on centile chart (not applicable in patients > 18 years) * Weight and body mass index (BMI) – recorded on centile chart (not applicable in patients > 18 years)   Initial monitoring   * Before every change of dose: assess heart rate, blood pressure, appetite 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 aggressive or hostile behaviour and tics. The specialist should determine the appropriate timing for this monitoring. For under 18s, record BP, height and weight on centile charts to detect clinically important changes.   Ongoing monitoring  Ensure the patient receives a review at least annually with a healthcare professional with training and expertise in managing ADHD. This may be in primary or secondary care, depending on local arrangements, and should include a review of ADHD medication, including patient preferences, benefits, adverse effects, and ongoing clinical need. 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 (preferably during school holidays, for those still in education). 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.  Section 6  BP/ HR: For under 18s, record BP, height and weight on centile charts to detect clinically important changes.  Weight/ 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  Section 7  Take in the morning  (this does not affect the duration of action of each dose). The contents should be stirred until completely dispersed. The patient must consume the whole portion of food or drink immediately; it should not be stored. The active ingredient dissolves completely once dispersed; however, a film containing the inactive ingredients may remain in the glass or container once the mixture is consumed  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-lisdexamfetamine-in-adults/](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care).

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**

## Lisdexamfetamine for patients within children and adult services

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| Background | Lisdexamfetamine dimesylate is metabolised following administration to dexamfetamine and therefore has the same sympathomimetic mechanism of action with central stimulant and anorectic activity. It may be offered as part of a comprehensive treatment programme as a first line pharmacological treatment option for children and adults with attention deficit hyperactivity disorder (ADHD) who have been appropriately diagnosed, or as an alternative treatment when the response to a 6-week trial of methylphenidate is considered clinically inadequate (see NICE Guidance [NG87](https://www.gov.uk/drug-driving-law) 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.  Lisdexamfetamine is a schedule 2 controlled substance; all legal requirements for prescribing controlled drugs should be followed. See NICE Guidance [NG46](https://www.nice.org.uk/guidance/ng197/) Controlled drugs: safe use and management.  Where a person with ADHD is treated by a Child and Adolescent Mental Health Service (CAMHS) but is approaching their 18th birthday, it is expected that CAMHS will refer to the appropriate adult service if need for ongoing treatment is anticipated. NICE Guidance [NG43](https://www.nice.org.uk/guidance/ng43) Transition from children’s to adults’ services for young people using health or social care services should be followed.  Pharmacological treatment of ADHD may be needed for extended periods. When lisdexamfetamine is used for extended periods (over 12 months) its usefulness should be re-evaluated at least yearly by a healthcare professional with expertise in ADHD, and consideration given to trial periods off medication to assess the patient's functioning without pharmacotherapy. |
| Licensed and agreed off-label indications | Attention deficit hyperactivity disorder (ADHD) in children and adults. Lisdexamfetamine is licensed in children aged 6 and over.  This shared care protocol applies to adults and children aged 6 years and over. |
| Locally agreed indications | For the treatment of ADHD in patients from the age of 6 years |
| 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:**  For all patients, whether starting treatment for ADHD or switching from another medication, the starting dose is 30mg taken once daily in the morning, increased in increments of 10mg to 20mg at intervals no shorter than 1 week. A lower starting dose of 20mg once daily in the morning may be used if deemed clinically appropriate.  **The loading period must be prescribed by the initiating specialist.**  **Maintenance dose (following initial stabilisation):**  Maximum 70mg per day.  **The initial maintenance dose must be prescribed by the initiating specialist.**  **Conditions requiring dose adjustment:**  In severe renal impairment (GFR 15-30mL/min/1.73m2 or CrCl less than 30mL/min), the recommended maximum dose is 50mg per day. Further dose reduction should be considered in patients undergoing dialysis.  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 GP of the outcome. |
| 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://rdtc.nhs.uk/prescribing-support-document/shared-care-protocol-lisdexamfetamine-in-adults/#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 lisdexamfetamine, and risk of pregnancy (where applicable). * A risk assessment for substance misuse and drug diversion * Blood pressure (BP) and heart rate – recorded on centile chart (not applicable in patients > 18 years)Height –recorded on centile chart (not applicable in patients > 18 years) * Weight and body mass index (BMI) – recorded on centile chart (not applicable in patients > 18 years) * Appetite * 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, appetite 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 aggressive or hostile behaviour and tics. The specialist should determine the appropriate timing for this monitoring. For under 18s, record BP, height and weight on centile charts to detect clinically important changes. * Assessment of symptom improvement. Discontinue if no improvement is observed after one month.   **Ongoing monitoring (ADHD):**   * 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 (preferably during school holidays, for those still in education). 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. |

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## Ongoing monitoring requirements to be undertaken by primary care unless completed at review by specialist team

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 * Weight and appetite * Assessment for new or worsening psychiatric and neurological signs or symptoms (e.g. tics, anxiety, depression, symptoms of bipolar disorder, aggressive or hostile behaviour) * Explore whether patient is experiencing any difficulties with sleep | Every 6 months, and after any change of dose recommended by, and agreed with the specialist team.  For under 18s, record BP, height and weight on centile charts to detect clinically important changes.  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  At least every 6 months |
| Assessment of adherence, and for any indication of lisdexamfetamine 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 |

## Pharmaceutical aspects

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| Route of administration: | Oral |
| Formulation: | Lisdexamfetamine dimesylate 20mg, 30mg, 50mg, 60mg and 70mg hard capsules (Elvanse Adult®)  Lisdexamfetamine dimesylate 20mg, 30mg, 40mg, 50mg, 60mg and 70mg hard capsules (Elvanse®) – use in adults may be considered off-label. See [SPCs](https://www.nice.org.uk/guidance/ng87/chapter/Recommendations?q=lisdexamfetamine) for full details. |
| Administration details: | The dose should be taken in the morning, with or without food  Lisdexamfetamine capsules may be swallowed whole, or the capsule opened, and the entire contents emptied and mixed with a soft food such as yogurt or in a glass of water or orange juice (this does not affect the duration of action of each dose). The contents should be stirred until completely dispersed. The patient must consume the whole portion of food or drink immediately; it should not be stored. The active ingredient dissolves completely once dispersed; however, a film containing the inactive ingredients may remain in the glass or container once the mixture is consumed. See [SPC](https://www.medicines.org.uk/emc/search?q=lisdexamfetamine) for further information  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. Afternoon doses should be avoided because of the potential for insomnia. |
| Other important information: | Lisdexamfetamine is a schedule 2 controlled drug and is subject to [legal prescription requirements](https://bnf.nice.org.uk/guidance/controlled-drugs-and-drug-dependence.html). It has the potential for misuse and diversion, it is good practice to limit prescription quantities to a 28-30 day supply.Patients should be advised to avoid alcohol which may exacerbate the central nervous system (CNS) side-effects of lisdexamfetamine.  Amfetamines can cause a significant elevation in plasma corticosteroid levels. This increase is greatest in the evening. Amfetamines may interfere with urinary steroid determinations. |

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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://future.nhs.uk/connect.ti/PrescribingMedicinesOptimisation/view) & [SPC](https://www.medicines.org.uk/emc/search?q=lisdexamfetamine) for comprehensive information.  **Contraindications:**   * Known hypersensitivity to lisdexamfetamine, any of the excipients, or sympathomimetic amines. * Glaucoma. * Symptomatic cardiovascular disease. * Moderate or severe hypertension. * Advanced arteriosclerosis. * Concomitant use of monoamine oxidase inhibitors (MAOI) or within 14 days of MAOI treatment (see [section 9](#_Significant_drug_interactions)). * Hyperthyroidism or thyrotoxicosis. * Agitated states.   **Cautions:**   * History of substance or alcohol abuse. * Cardiovascular disorders such as structural cardiac abnormalities, cardiomyopathy, arrhythmias, coronary artery disease, mild hypertension, recent myocardial infarction, or heart failure. * Family history of sudden cardiac or unexplained death or ventricular arrhythmia. * Underlying medical conditions or concomitant drugs which can increase the QT-interval or heart rate, or elevate blood pressure (e.g. cardiac disease, electrolyte disturbance). * History of seizure disorders (discontinue if seizures occur). * Susceptibility to angle-closure glaucoma. * Psychiatric and neuropsychiatric symptoms or disorders, including manic or psychotic symptoms, aggressive or hostile behaviour), tics, Tourette’s syndrome, anxiety, or bipolar disorder. * Depressive symptoms: patients should be screened for risk of bipolar disorder, including detailed psychiatric and family history of suicide, bipolar disorder and depression. * Severe renal impairment; GFR 15-30mL/min/1.73m2 or CrCl less than 30mL/min. Dose reduction is required, see [section 4](#_Initiation_and_ongoing). * Hepatic insufficiency (due to lack of data). * Pregnancy or breast-feeding (see [section 12](#_Pregnancy,_paternal_exposure)). * Potential for abuse, misuse, or diversion. * Avoid abrupt withdrawal. |
| Significant drug interactions | The following list is not exhaustive. Please see [BNF](https://www.nice.org.uk/guidance/ng87/chapter/Recommendations) & [SPC](https://www.nice.org.uk/guidance/ng43/?q=lisdexamfetamine) for comprehensive information and recommended management.  **The following medicines must not be prescribed without consultation with the specialist:**   * **MAOIs and other sympathomimetics** (e.g. rasagiline, selegiline, safinamide): risk of hypertensive crisis and serotonin syndrome. Concomitant use is contraindicated (see [section 8](#_Cautions_and_contraindications)).   **Other clinically significant interactions**   * **Fluoxetine, paroxetine**: may increase exposure to lisdexamfetamine, increased risk of serotonin syndrome * **Serotonergic drugs e.g. bupropion, tapentadol, tramadol, triptans, lithium, selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs):** increased risk of serotonin syndrome * **Tricyclic antidepressants (TCAs) and nabilone**: may increase risk of cardiovascular adverse events. * **Ascorbic acid and other agents and conditions (thiazide diuretics, diets high in animal protein, diabetes, respiratory acidosis)** that acidify urine: may reduce exposure to lisdexamfetamine * **Sodium bicarbonate and other agents and conditions (diets high in fruits and vegetables, urinary tract infections and vomiting)** that alkalinise urine: may increase exposure to lisdexamfetamine * **Antihypertensives, including guanethidine**: effects may be reduced by lisdexamfetamine * **Lithium, phenothiazines, haloperidol**: may reduce the effects of lisdexamfetamine * **Opioids** (including tapentadol and tramadol): analgesic effects may be increased and the depressant effects (e.g. sedation, respiratory depression) may be decreased by lisdexamfetamine * **Alcohol:** Limited data is available; therefore, caution is advised as alcohol may exacerbate the CNS side effects of lisdexamfetamine; avoid. * **Apraclonidine, brimonidine:** effects potentially decreased by lisdexamfetamine * **Ritonavir, nirmatrelvir boosted with ritonavir, tipranavir:** may increase exposure to lisdexamfetamine * **Atomoxetine**: increased risk of adverse effects * **Drugs that increase blood pressure:** possible additive 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=lisdexamfetamine).

**Any serious adverse reactions should be reported to the MHRA via the Yellow Card scheme. Visit** [https://yellowcard.mhra.gov.uk/](https://www.medicines.org.uk/emc/search).

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 120bpm, arrhythmia/palpitations, clinically significant increase in systolic BP (≥15–20 mmHg or systolic BP > 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. |
| **Weight or BMI outside healthy range**, anorexia, or weight loss | Exclude other reasons for weight loss. Give advice as per [NICE NG87](https://www.nice.org.uk/guidance/ng87/):   * take medication with or after food, not before * additional meals or snacks early in the morning or late in the evening when stimulant effects have worn off * obtaining dietary advice * consuming high-calorie foods of good nutritional value   Discuss with specialist if difficulty persists; dose reduction, treatment break, or change of medication may be required. |
| **Gastrointestinal disorders**  Nausea, vomiting, diarrhoea, abdominal pain, constipation, dry mouth | Usually occur at the beginning of treatment and may be alleviated by concomitant food intake. Discuss with specialist team if difficulty persists. |
| **Psychiatric disorders**  New or worsening psychiatric or neuropsychiatric symptoms, e.g. psychosis, suicidal ideation or behaviour, mania, bipolar disorder, depression, paranoia, anxiety, agitation, aggressive or hostile behaviour, motor or verbal tics (including Tourette’s syndrome) | Discuss with specialist team. Stop treatment and consider referral to acute mental health team if suicidal ideation or behaviour, mania, or psychosis are present. Lisdexamfetamine should not be continued unless the benefits outweigh the risks. |
| **Insomnia or other sleep disturbances** | Review timing of lisdexamfetamine dose and advise as appropriate. Give advice on sleep hygiene. Discuss with specialist team if difficulty persists; dose reduction may be required. |
| **Haematological disorders**  Including leukopenia, thrombocytopenia, anaemia, or other alterations  NB: no haematological monitoring is recommended. Haematological disorders would be a chance finding/due to patient reporting adverse drug reactions. | Contact specialist team. Discontinuation should be considered. Referral to haematology may be warranted; use clinical discretion. |
| **Nervous system disorders**  Symptoms of cerebral ischaemia, e.g. severe headache, numbness, weakness, paralysis, and impairment of coordination, vision, speech, language, or memory | Discontinue lisdexamfetamine, refer urgently for neurological assessment. |
| New or worsening seizures | Stop lisdexamfetamine and discuss with specialist team. Discontinuation may be indicated. |
| Headache, dizziness | Continue treatment unless severe. Discuss with specialist team if difficulty persists. |
| Symptoms of serotonin syndrome, e.g. agitation, hallucinations, coma, tachycardia, labile blood pressure, hyperthermia, hyperreflexia, incoordination, rigidity, nausea, vomiting, diarrhoea | Discontinue lisdexamfetamine as soon as possible. Management depends on severity; use clinical judgement and seek advice if necessary.  Discuss with specialist team to determine whether lisdexamfetamine can be re-started. |
| Suspicion of abuse, misuse, or diversion | Discuss with specialist team. |

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| Advice to patients and carers 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 drugs. | **The patient/carer should be advised to report any of the following signs or symptoms to their primary care prescriber without delay:**   * New or worsening psychiatric symptoms (e.g. paranoia, anxiety, depressive symptoms, agitation, psychotic or manic symptoms, aggressive or hostile behaviour, suicide-related behaviour (suicide attempts or suicidal ideation), motor or verbal tics. * Symptoms suggestive of cardiac disease (e.g. palpitations, exertional chest pain, unexplained syncope, or dyspnoea). * New or worsening neurological symptoms (e.g. severe headache, numbness, weakness, paralysis, or impairment of coordination, vision, speech, language, or memory). * Symptoms suggestive of hepatic injury (e.g. new onset severe or persistent abdominal pain, unexplained nausea, malaise, jaundice or darkening of urine). * Skin rashes or bruising easily. * Any visual changes such as difficulty with accommodation or blurring of vision. * 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 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. * Not to drive, cycle, or operate machines if lisdexamfetamine affects their ability to do so safely e.g. by causing dizziness, drowsiness, or visual disturbances. For information on 2015 legislation regarding driving whilst taking certain controlled drugs, including amfetamines, see [drugs and driving: the law](https://bnf.nice.org.uk/). People who drive must inform the DVLA if their ADHD or medicines affect their ability to drive safely. See [https://www.gov.uk/adhd-and-driving](https://www.medicines.org.uk/emc/search). * Avoid alcohol while taking lisdexamfetamine as it may make some side effects worse. Avoid recreational drugs. Due to the risks of depression, and fatigue, abrupt withdrawal after a prolonged period of intake of high doses of lisdexamfetamine should be avoided. Patients wishing to reduce their dose or stop lisdexamfetamine treatment should discuss with their specialist before doing so. * Lisdexamfetamine is a schedule 2 controlled drug. Patients may be required to prove their identity when collecting prescriptions and should store lisdexamfetamine 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](https://www.gov.uk/drug-driving-law) * NHS – Attention deficit hyperactivity disorder. [https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/](https://www.nice.org.uk/guidance/ng46/chapter/Recommendations)   **Patient information leaflets are also available from:**  <https://www.medicines.org.uk/emc/search?q=dexamfetamine> |
| 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**:  The active metabolite of lisdexamfetamine, dexamfetamine, crosses the placenta. Limited safety data suggest that use of therapeutic amfetamines in early pregnancy is not associated with an increased risk of malformations, however their impact on fetal growth later in pregnancy is unknown. There is evidence suggesting a possible small increased risk of preterm delivery, which may be further increased with use in later pregnancy. Other possible associations such as placental abruption, preeclampsia, low Apgar scores and the requirement for neonatal resuscitation and admission have also been noted. Given the CNS stimulant properties of amfetamines, there is also a possibility of neonatal withdrawal and associated complications.  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. The manufacturer recommends that lisdexamfetamine should only be used during pregnancy if the potential benefit outweighs the risks.  Information for healthcare professionals: [UK Teratology Information Service](https://yellowcard.mhra.gov.uk/)  Information for patients: [Best Use of Medicines in Pregnancy](https://www.medicinesinpregnancy.org/leaflets-a-z/therapeutic-amfetamines/)  **Breastfeeding**:  The active metabolite of lisdexamfetamine, dexamfetamine, is excreted in human milk, therefore a risk to infants cannot be excluded. The manufacturer of lisdexamfetamine recommends against use during breastfeeding. An individual risk assessment must be made, taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman. High levels of dexamfetamine 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, slow weight gain, sleep disturbances, irritability), although these may be difficult to detect. For further support, contact the [UK Drugs in Lactation Advisory Service](https://www.rcpsych.ac.uk/mental-health/problems-disorders/adhd-in-adults).  **Paternal exposure**:  No data regarding outcomes following 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.  Notify specialist immediately (within 2 weeks) if transfer of prescribing and monitoring responsibility is not accepted so that alternative arrangements can be put in place  Contact specialist if communication of prescribing & monitoring requirements is unclear. |
| References | 1. NICE NG87: Attention deficit hyperactivity disorder: diagnosis and management. Last updated September 2019. Accessed via [https://www.nice.org.uk/guidance/ng87/](https://www.gov.uk/adhd-and-driving) on 08/05/24. 2. eBNF. Lisdexamfetamine. Accessed via <https://bnf.nice.org.uk/> on 08/05/24. 3. Lisdexamfetamine dimesylate 20mg hard capsules (Elvanse®) SPC. Takeda UK Ltd. Date of revision of the text: 16/01/24. Accessed via [https://www.medicines.org.uk/emc/product/14091/smpc](https://uktis.org/monographs/use-of-therapeutic-amfetamines-in-pregnancy/) on 08/05/24. 4. Lisdexamfetamine dimesylate 30mg hard capsules (Elvanse® Adult) SPC. Takeda UK Ltd. Date of revision of the text: 20/03/24. Accessed via <https://www.medicines.org.uk/emc/product/6828/smpc> on 08/05/24. 5. NICE NG46: Controlled drugs: safe use and management. April 2016. Accessed via <https://www.nice.org.uk/guidance/ng46/> on 08/05/24. 6. 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/](https://bnf.nice.org.uk/) on 08/05/24. 7. UKTIS. Use of therapeutic amfetamines in pregnancy. Last updated May 2023. Accessed via <https://uktis.org/monographs/use-of-therapeutic-amfetamines-in-pregnancy/> on 08/05/2024. 8. Drugs and Lactation Database (LactMed®). Lisdexamfetamine. Last updated August 2023. Accessed via [https://www.ncbi.nlm.nih.gov/books/NBK501741/](https://www.sps.nhs.uk/home/about-sps/get-in-touch/medicines-information-services-contact-details/breastfeeding-medicines-advice-service/) on 08/05/24. 9. Gov.uk: Drugs and driving: the law. Accessed via [https://www.gov.uk/drug-driving-law](https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/) on 08/05/24. 10. NICE Clinical Knowledge Summaries. Attention deficit hyperactivity disorder: last revised April 2024. Accessed via <https://cks.nice.org.uk/topics/attention-deficit-hyperactivity-disorder/prescribing-information/amfetamines/> on 08/05/24 11. Regional Medicines Optimisation Committee (RMOC). February 2021. Shared Care for Medicines Guidance – A Standard Approach. Available via [FutureNHS](https://www.medicines.org.uk/emc/product/14091/smpc?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](https://www.ncbi.nlm.nih.gov/books/NBK501741/). * NICE NG197: Shared decision making. Last updated June 2021. [https://www.nice.org.uk/guidance/ng197/](https://www.nice.org.uk/guidance/ng87/). |