## Dexamfetamine 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 | 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 | 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.  It is licensed for the treatment of ADHD which is refractory to methylphenidate in children aged 6-17 years  Section 2: Added in children for the ADHD indication  Section 3: Attention deficit hyperactivity disorder (ADHD) in children aged 6 – 17 years  Section 4: State that prescribing and monitoring should be transferred after at least 12 weeks  Initial stabilisation:  **ADHD Child 6 – 17 years:** 2.5mg 2 -3 times per day increased in steps of 5 mg once weekly if required  Section 5:   * Blood pressure (BP) and heart rate – recorded on centile chart (not applicable in patients > 18 years) * Height, 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 to 17 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  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  Blood pressure and heart rate, and assessment for cardiovascular signs or symptoms:   * Every 6 months and at each dose change, and at each face-to-face review if >6 months since last check by team or GP – record on centile charts to detect clinically important changes   Weight:   * Children aged 6 to 10 years of age – 3-monthly * Children aged 11 to 17 years of age – at 3 months, 6 months, then 6-monthly thereafter * Adults: 6-monthly * Monitor more often if there are concerns around weight loss * Record weight on weight chart for patients <18 years of age   Height (children and adolescents only)  Every 6 months – record on growth chart  Section 7: Pharmaceutical aspects  In the treatment of hyperkinetic disorders / ADHD, the times at which the doses of dexamfetamine are administered should be selected to provide the best effect when it is most needed to combat school and social behavioural difficulties. Normally the first increasing dose is given in the morning.  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-dexamfetamine-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**

## Dexamfetamine for patients within children and adult services

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| Background | Dexamfetamine sulfate is a sympathomimetic amine with central stimulant and anorectic activity indicated for the treatment of attention deficit hyperactivity disorder (ADHD).  It is licensed for the treatment of ADHD which is refractory to methylphenidate in children aged 6-17 years; use in adults for this indication is unlicensed, but 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](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.  Dexamfetamine is not licensed for all the indications listed in [section 2](#_Licensed_and_agreed). 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](https://www.nice.org.uk/guidance/ng46) 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.  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 to conduct 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. |
| Licensed and agreed off-label indications | * Attention deficit hyperactivity disorder (ADHD) in children aged 6 – 17 years * Attention deficit hyperactivity disorder (ADHD) in adults ǂ * Narcolepsy with or without cataplexy   ǂ Off-label indication; see [section 1](#_Background) for circumstances where NICE recommends use in adults. (Please note licensed indications vary by manufacturer. See [SPCs](https://www.medicines.org.uk/emc/search?q=dexamfetamine) for full details). |
| Locally agreed indications | Attention deficit hyperactivity disorder (ADHD) in children aged 6 – 17 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:**  **ADHD Child 6 – 17 years:** 2.5mg 2 -3 times per day increased in steps of 5 mg once weekly if required  **ADHD Adult (> 18 years)**: Initially 5mg twice daily (e.g. breakfast and lunch), dose should be increased according to response at intervals no shorter than 1 week.  **Narcolepsy:** Initially 10mg daily in divided doses, increased in steps of up to 10mg each week. In elderly patients, initially 5mg daily, increased in steps of 5mg each week.  **The loading period must be prescribed by the initiating specialist.**  **Maintenance dose (following initial stabilisation):**  The maximum daily dose in children & adolescents is usually 20 mg; 40 mg may be necessary in rare cases for ADHD  The maximum daily dose in adults is 60 mg per day to be given in 2-4 divided dose for ADHD and Narcolepsy.  **The initial maintenance dose must be prescribed by the initiating specialist.**  **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. |
| 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 dexamfetamine, 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, 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 to 17 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 (preferably during school holidays if in education) or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate. 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.  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. 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 | * Every 6 months and at each dose change, and at each face-to-face review if >6 months since last check by team or GP – record on centile charts to detect clinically important changes |
| * Appetite | * Every 6 months |
| * Weight | * Children aged 6 to 10 years of age – 3-monthly * Children aged 11 to 17 years of age – at 3 months, 6 months, then 6-monthly thereafter * Adults: 6-monthly * Monitor more often if there are concerns around weight loss * Record weight on weight chart for patients <18 years of age |
| * Height (children and adolescents only) | Every 6 months – record on growth chart |
| * 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. |
| Assessment of adherence, and for any indication of dexamfetamine abuse, misuse, or diversion | As required, based on the patient’s needs and individual circumstances |
| ADHD patients: 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: | Dexamfetamine sulfate 5mg, 10mg and 20mg immediate release tablets (Amfexa®)  Dexamfetamine sulfate 5mg immediate release tablets  Dexamfetamine sulfate 5mg/5mL sugar-free oral solution▼  Please note licensed indications vary by manufacturer. See [SPCs](https://www.medicines.org.uk/emc/search?q=dexamfetamine) for full details |
| Administration details: | Amfexa® tablets can be halved for ease of swallowing, and not to divide into equal doses. Some generic tablets can be divided into equal doses. Consult individual [SPCs](https://www.medicines.org.uk/emc/search?q=dexamfetamine).  In the treatment of hyperkinetic disorders / ADHD, the times at which the doses of dexamfetamine are administered should be selected to provide the best effect when it is most needed to combat school and social behavioural difficulties. Normally the first increasing dose is given in the morning.  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](https://bnf.nice.org.uk/guidance/controlled-drugs-and-drug-dependence.html). Limit prescriptions to 28 to 30 days supply in line with good practice relating to CDs. 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.  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://bnf.nice.org.uk/) & [SPC](https://www.medicines.org.uk/emc/search?q=dexamfetamine) for comprehensive information.  **Contraindications:**   * Known hypersensitivity to 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 (see [section 9](#_Significant_drug_interactions)) * Hyperthyroidism or thyrotoxicosis * Severe depression, anorexia nervosa/anorexic disorders, suicidal ideation, 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](#_Pregnancy,_paternal_exposure))   **Cautions:**   * History of epilepsy (discontinue if seizures occur) * Mild hypertension, history of cardiovascular disease, or concomitant medications that elevate blood pressure * 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 * Depressive symptoms: patients should be screened for risk of bipolar disorder, including detailed psychiatric and family history of suicide, bipolar disorder and depression. * 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](#_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://bnf.nice.org.uk/) & [SPC](https://www.medicines.org.uk/emc/search?q=dexamfetamine) 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)). * **Clonidine**: concomitant use may increase duration of action of dexamfetamine and reduce 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. * **Fluoxetine, paroxetine**: may increase exposure to dexamfetamine; increased risk of serotonin syndrome. * **Serotonergic drugs e.g. bupropion, tapentadol, tramadol, triptans, lithium, SSRIs, serotonin and norepinephrine reuptake inhibitors (SNRIs):** increased 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. 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 effect may be increased and the depressant effects (e.g. sedation, 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; avoid. * **Apraclonidine, brimonidine:** effects potentially decreased by dexamfetamine * **Ritonavir, nirmatrelvir boosted with ritonavir, tipranavir:** may increase exposure to dexamfetamine * **Drugs that increase blood pressure:** possible additive effects. * **Atomoxetine:** increased risk of adverse 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=dexamfetamine).

**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 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 team for ongoing management. * In absence of recent dose changes, reduce dose by half and discuss with specialist team 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 team if difficulty persists; dose reduction, treatment break, or change of medication may be required. |
| **Gastrointestinal disorders**  Nausea, vomiting, diarrhoea, abdominal cramps, 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. Dexamfetamine should not be continued unless the benefits outweigh the risks. |
| Insomnia or other sleep disturbances | Review timing of dexamfetamine 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 dexamfetamine, refer urgently for neurological assessment. |
| New or worsening seizures | Stop dexamfetamine 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 dexamfetamine as soon as possible. Management depends on severity; use clinical judgement and seek advice if necessary.  Discuss with specialist team to determine whether dexamfetamine 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 regarding 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 dexamfetamine 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://www.gov.uk/drug-driving-law). People who drive must inform the DVLA if their ADHD, narcolepsy or medicines affect their ability to drive safely. See <https://www.gov.uk/adhd-and-driving> or <https://www.gov.uk/narcolepsy-and-driving>. * Avoid alcohol while taking dexamfetamine, as it may make some side effects worse. Avoid recreational drugs. Due to the risks of 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/> * Narcolepsy UK – <https://www.narcolepsy.org.uk/> * NHS – Narcolepsy - <https://www.nhs.uk/conditions/narcolepsy/>   **Patient information leaflets (ADHD) are also available from:**  <https://www.medicines.org.uk/emc/product/7404/rmms#about-medicine>  <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**:  Manufacturers of dexamfetamine recommend against use during pregnancy. 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.  Information for healthcare professionals: [UK Teratology Information Service](https://uktis.org/monographs/use-of-therapeutic-amfetamines-in-pregnancy/)  Information for patients: [Best Use of Medicines in Pregnancy](https://www.medicinesinpregnancy.org/leaflets-a-z/therapeutic-amfetamines/)  **Breastfeeding**:  Dexamfetamine is excreted in human milk, therefore a risk to infants cannot be excluded. The manufacturer recommends that a decision must be made whether to discontinue breastfeeding or to discontinue dexamfetamine, considering the benefit of breastfeeding for the child and the benefit of therapy for the woman. High doses 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.sps.nhs.uk/home/about-sps/get-in-touch/medicines-information-services-contact-details/breastfeeding-medicines-advice-service/).  **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/> on 02/05/24. 2. eBNF. Dexamfetamine. Accessed via <https://bnf.nice.org.uk/> on 02/05/24 3. Dexamfetamine sulfate 20mg tablets (Amfexa®). Medice UK LTD. Date of revision of the text: 10/02/22. Accessed via <https://www.medicines.org.uk/emc/product/7404/smpc> on 02/05/24. 4. Dexamfetamine sulfate 5mg tablets (Amfexa®). Medice UK LTD. Date of revision of the text: 10/02/22. Accessed via <https://www.medicines.org.uk/emc/product/5004/smpc> on 02/05/24. 5. Dexamfetamine sulfate (Amfexa®) risk minimisation materials. Accessed via <https://www.medicines.org.uk/emc/product/7403/rmms#about-medicine> on 07/05/24. 6. Dexamfetamine sulfate 5mg tablets. Brown & Burk UK Ltd. Date of revision of the text: 26/07/22. Accessed via <https://www.medicines.org.uk/emc/product/11004/smpc> on 07/05/24. 7. NICE. NG46: Controlled drugs: safe use and management. April 2016. Accessed via <https://www.nice.org.uk/guidance/ng46/> on 02/05/24. 8. 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 02/05/24. 9. UKTIS. Use of therapeutic amfetamines in pregnancy. Last updated May 2023. Accessed via <https://uktis.org/monographs/use-of-therapeutic-amfetamines-in-pregnancy/> on 02/05/2024. 10. Drugs and Lactation Database (LactMed®). Dextroamphetamine. Last updated August 2023. Accessed via <https://www.ncbi.nlm.nih.gov/books/NBK501740/> on 02/05/24. 11. NICE Clinical Knowledge Summaries. Attention deficit hyperactivity disorder: Amfetamines. Last revised April 2024. Accessed via <https://cks.nice.org.uk/topics/attention-deficit-hyperactivity-disorder/prescribing-information/amfetamines/> on 02/05/24. 12. Gov.uk. Drugs and driving: the law. Accessed via <https://www.gov.uk/drug-driving-law> on 02/05/24. 13. 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/>. |