Shared Care Agreement: Methylphenidate in adult services

This Shared Care Protocol sets out details for the sharing of care for patients prescribed Methylphenidate in adult services. This protocol is for use within the indications listed on section 2.

It should be read in conjunction with the latest Summary of Product Characteristics (SPC) available at www.medicines.org.uk/emc/.

As outlined in NHS England Guidance 2018 "Responsibility for Prescribing between Primary & Secondary/Tertiary Care. When a specialist considers a patient's condition to be stable or predictable, they may seek the agreement of the GP concerned (and the patient) to share their care.

This document provides information on drug treatment for the shared commitment between the consultant and GP concerned. GPs are invited to participate. If the GP is not confident to undertake these roles, then they are under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. The doctor who prescribes the medication has the clinical responsibility for the drug and the consequences of its use. N.B. If the GP decides not to participate in shared care for a particular patient, they must inform the relevant specialist in writing, within 10 working days of receipt of a request to share care unless exceptional circumstances apply.

Introduction

This shared care guideline sets out details to support the transfer of responsibility for prescribing Methylphenidate for any of the indications listed on page 5, from specialist to primary care. For further information please click on the links below: British National Formulary and http://www.medicines.org.uk/emc/.

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Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

Table of contents

The content of this shared care protocol was correct as of May 2025. As well these protocols, please ensure that summaries of product characteristics (SPCs), British national formulary (BNF) or the Medicines and Healthcare products Regulatory Agency (MHRA) or NICE websites are reviewed for up-to-date information on any medicine.

Specialist responsibilities

For ADHD:

- Assess the patient and provide diagnosis. Ensure the diagnosis is within scope of this shared care protocol (section 2) and communicated to primary care.
- Use a shared decision making approach; discuss the benefits and risks of the treatment with the patient and/or their carer and provide the appropriate counselling (see section 11), to enable the patient to reach an informed decision. Obtain and document consent. Provide an appropriate patient information leaflet.
- Ensure the patient and/or their carer understands that treatment may be stopped if they do not attend for monitoring and treatment review
- Assess for contraindications and cautions (see section 4) and interactions (see section 7).
- Conduct required baseline investigations and initial monitoring (see section 8).
- Initiate and optimise treatment as outlined in section 5. Prescribe the maintenance treatment for 4 weeks.
- Prescribe in line with controlled drug prescription requirements (section 6).
- Once treatment is optimised, complete the shared care documentation and send to patient's GP practice detailing the diagnosis, brand to be prescribed, current and ongoing dose, any relevant test results and when the next monitoring is required. Include contact information (section 13).
- Prescribe sufficient medication for 4 weeks to enable transfer to primary care, including where there are unforeseen delays to transfer of care.
- Conduct the required monitoring in section 8 and communicate the results to primary care. This monitoring, and other responsibilities below, may be carried out by a healthcare professional in primary or secondary care with expertise and training in ADHD, depending on local arrangements.
- Determine the duration of treatment and frequency of review. After each review, advise primary care whether treatment should be continued, confirm the ongoing dose, and whether the ongoing monitoring outlined in section 9 remains appropriate. Trial discontinuations should be managed by the specialist.
- Reassume prescribing responsibilities if a woman becomes or wishes to become pregnant.
- Provide advice to primary care on the management of adverse effects if required.

For Narcolepsy:

The patient will be assessed by a consultant in the tertiary referral centre. If the patient is in agreement with the treatment plan, then the hospital will undertake to:

- Send a letter to the primary care clinician requesting shared care for the patient including details of baseline monitoring undertaken.
- Evaluate patients for a history of drug abuse and account for any additional risks in these patients.
- Provide information to the patient regarding the medicine.
- Provide an initial one-month supply of methylphenidate tablets.
- Recommend an initial dose and how this may be titrated according to the response to treatment.
- Inform the primary care clinician after each clinic attendance if there is any change to treatment or monitoring.
- Inform primary care clinician of patients who do not attend clinic appointments and discuss patient's on-going treatment plan.
- Review the patient's progress on treatment. If the patient has failed to respond adequately to treatment after a reasonable period then methylphenidate therapy will be discontinued and other treatment options considered.
- Be available for advice to the primary care clinician.
- Answer patient/carer enquiries on any aspect of this therapy.

Primary care responsibilities

For ADHD:

- If shared care is accepted, prescribe ongoing treatment as detailed in the specialist's request and as per section 5, taking into account any potential drug interactions in section 7.
- Refuse the request from the specialist for shared care in writing. It is asked that this be undertaken within 14 days of the request being made, where possible.
- Prescribe in line with controlled drug prescription requirements (section 6).
- Adjust the dose of methylphenidate prescribed as advised by the specialist.
- Conduct the required monitoring as outlined in section 9. Communicate any abnormal results to the specialist.
- Assess for possible interactions with methylphenidate when starting new medicines (see section 7).
- Manage any adverse effects as detailed in section 10 and discuss with specialist team when required.
- Stop methylphenidate and make an urgent referral for appropriate care if cerebral ischaemia, new or worsening seizures, or serotonin syndrome are suspected.
- Refer the management back to the specialist if the patient becomes or plans to become pregnant.

- Stop treatment as advised by the specialist. Trial discontinuations should be managed by the specialist.

For Narcolepsy:

- Agree to shared care guideline (No response required).
- Continue to prescribe methylphenidate once this has been initiated by the RSSC consultant specialist.
- Report any adverse events to the hospital specialist, where appropriate.
- Request advice from the hospital specialist when necessary.
- Monitor blood pressure and pulse at each dose adjustment and at least every 6 months. The same approach to managing hypertension should be taken as for the general population (NICE Guideline 136). Please contact the Specialist via Advice and Guidance to inform them of the steps being taken to manage hypertension.
- Monitor weight and appetite at each dose adjustment and at least 6 monthly. If the patients weight drops by >10% from baseline, or they become clinically underweight (BMI<18.5) please contact specialist via the Advice and Guidance service.

Patient and/or carer responsibilities

For ADHD:

- Take methylphenidate as prescribed, and avoid abrupt withdrawal unless advised by their prescriber.
- Attend regularly for monitoring and review appointments with primary care and specialist, and keep contact details up to date with both prescribers. Be aware that medicines may be stopped if they do not attend.
- Report adverse effects to their primary care prescriber. Seek immediate medical attention if they develop any symptoms as detailed in section 11.
- Report the use of any over the counter medications (OTC) to their primary care prescriber and be aware they should discuss the use of methylphenidate with their pharmacist before purchasing any OTC medicines.
- Not to drive or operate heavy machinery if methylphenidate affects their ability to do so safely, and inform the DVLA if their ability to drive safely is affected (see section 11).
- Avoid alcohol during treatment, as it may make some side effects worse. Avoid recreational drugs.
- Methylphenidate is a schedule 2 controlled drug. Patients may be required to prove their identity when collecting prescriptions, and should store methylphenidate safely and securely. It must not be shared with anyone else.
- Patients of childbearing potential should take a pregnancy test if they think they could be pregnant, and inform the specialist or GP immediately if they become pregnant or wish to become pregnant.

For Narcolepsy:

- Report to the hospital specialist or primary care clinician, if they do not have a clear understanding of their treatment.
- Patients must not exceed the recommended dose.
- Patients must attend their scheduled clinic and blood test appointments (where relevant).
- Must inform other clinical staff that they are receiving treatment. Report any adverse effects to the hospital specialist or primary care clinician.
- Share any concerns they have in relation to their treatment.

1. Background

Back to top

ADHD:

Methylphenidate is a central nervous system stimulant licensed as part of a comprehensive treatment programme for attention deficit hyperactivity disorder (ADHD). It may be offered as a first line pharmacological treatment option for adults with ADHD who have been appropriately diagnosed (see NICE Guidance NG87 Attention deficit hyperactivity disorder: diagnosis and management). NICE recommends that people with ADHD have a comprehensive, holistic shared treatment plan that addresses psychological, behavioural and occupational or educational needs.

Methylphenidate is available as immediate-release tablets, and modified-release tablets and capsules. The modified-release preparations contain both immediate-release and prolonged-release methylphenidate, and different brands have different proportions of each. Brands may therefore vary in their release characteristics and clinical effect. Modified-released preparations should therefore be prescribed by brand name. Unless alternative instructions are provided in stock shortages.

Methylphenidate is a schedule 2 controlled substance; all legal requirements for prescribing controlled drugs should be followed. See NICE Guidance NG46 Controlled drugs: safe use and management. Risk of misuse can be reduced by using modified-release preparations.

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.

The safety and efficacy of long-term use of methylphenidate has not been systematically evaluated in controlled trials. Patients should be reviewed for ongoing need at least annually, and the manufacturers recommend a trial discontinuation at least once yearly to assess the patient's condition.

Methylphenidate is not licensed for all the indications it is used to treat below. However, its use for the indications below are established and supported by various sources and bodies including the BNF and NICE.

Narcolepsy:
Narcolepsy occurs in 1 in 2500 subjects and is a chronic, debilitating, life-long neurological disease characterised by excessive daytime sleepiness with peak incidence during the second and third decades of life.
Narcolepsy may progress to include cataplexy (sudden loss of muscle tone), sleep paralysis, hypnagogic hallucinations and fragmented nocturnal sleep. Excessive, uncontrollable daytime sleepiness is experienced by all patients with narcolepsy, and is usually treated with stimulants such as methylphenidate during the day to help keep patients awake.
Methylphenidate hydrochloride is used (unlicensed indication) for the treatment of narcolepsy in adult patients. At Royal Papworth Hospital, Tertiary referral centre for sleep disorders, methylphenidate is used to manage symptoms of narcolepsy, particularly excessive daytime sleepiness. The recommendation to start treatment will be made by a specialist Consultant or their supervised delegate who will initiate methylphenidate treatment.
Methylphenidate should only be used in patients who have had a complete evaluation of their excessive sleepiness and in whom a diagnosis of narcolepsy has been made in accordance with diagnostic criteria. Such an evaluation usually consists of, in addition to the patient's history, sleep measurement testing in a laboratory setting and exclusion of other possible causes of the excessive sleepiness.

2. Indications

Back to top

- Attention deficit hyperactivity disorder (ADHD) in adults
- Narcolepsy‡ (Royal Papworth Hospital only)

‡ Off-label indication. Please note licensed indications vary by manufacturer; see SPC for full details. Some brands are not licensed in adults (see section 6)

3. Locally agreed off-label use

Back to top

See above.

4. Contraindications and cautions

Back to top

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

Contraindications:

- Hypersensitivity to methylphenidate or to any of the excipients
- Glaucoma
- Phaeochromocytoma

- During treatment with non-selective, irreversible monoamine oxidase (MAO) inhibitors, or within a minimum of 14 days of discontinuing those drugs, due to the risk of hypertensive crisis
- Hyperthyroidism or thyrotoxicosis
- Diagnosis or history of severe depression, anorexia nervosa/anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, psychopathic/borderline personality disorder.
- Diagnosis or history of severe and episodic (Type I) bipolar (affective) disorder (that is not well-controlled).
- Certain pre-existing cardiovascular disorders constitute contraindications unless specialist cardiac advice is obtained and documented. These include 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, and structural cardiac abnormalities.
- Pre-existing cerebrovascular disorders cerebral aneurysm, vascular abnormalities including vasculitis or stroke.
- **Medikinet XL** only: history of pronounced anacidity of the stomach with a pH value above 5.5, or during therapy with H2 receptor blockers, proton pump inhibitors or antacids.

Cautions:

- Family history of sudden cardiac or unexplained death, malignant arrhythmia.
- Cardiovascular status should be carefully monitored (see section 9 & section 10)
- Underlying conditions which might be compromised by increases in blood pressure or heart rate.
- Known drug or alcohol dependency or misuse of central nervous system (CNS) stimulants: potential for abuse, misuse or diversion.
- Alcohol consumption (not recommended during treatment)
- Epilepsy: may lower seizure threshold
- Psychiatric and neuropsychiatric symptoms or disorders, including manic or psychotic symptoms, aggressive or hostile behaviour, motor or verbal tics (including Tourette's syndrome), anxiety, agitation or tension, depressive symptoms, bipolar disorder.
- Renal or hepatic insufficiency (due to lack of data)
- Leukopenia, thrombocytopenia, anaemia, or other haematological abnormalities.
- Prolonged-release tablets only: severe narrowing of the gastrointestinal tract or dysphagia; risk of obstruction
- Safety and efficacy has not been established in patients older than 60 years of age.
- Susceptibility to open-angle glaucoma.
- Pregnancy or breast-feeding (see section 12)
- Potential for abuse, misuse, or diversion.

5. Initiation and ongoing dose regimen

Back to top

- Transfer of monitoring and prescribing to primary care is normally when the patient's dose has been optimised and with satisfactory investigation results for 4 weeks.
- The duration of treatment & frequency of review will be determined by the specialist, based on clinical response and tolerability.
- All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care clinician.
- Termination of treatment will be the responsibility of the specialist.

Initial stabilisation:

Recommended starting dose in ADHD:

- *Immediate release tablets*: 5 mg, given 2-3 times daily
- *Modified release tablets*: 18 mg daily, given in the morning
- *Modified release capsules*: 10-20 mg daily

Adults with ADHD who have shown clear benefit from methylphenidate in childhood or adolescence may continue treatment into adulthood at the same daily dose. Consult SPC for the prescribed brand for more information.

Modified release formulations may be more suitable for most patients, due to patients needing to take them at a lower frequency and therefore less likely to miss doses.

Recommended starting dose in narcolepsy (off-label):

Methylphenidate is provided as 5,10 and 20 mg tablets.

- The initial dose is usually 5 to 10 mg daily, either as a single morning dose or from 10 mg it might be split to twice daily, with the first dose on rising and the second dose at lunchtime.
- The dose is then typically escalated by adding 5 to 10 mg per week until symptoms are controlled or 60 mg daily in divided doses is reached

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

Maintenance dose (following initial stabilisation):

The dose of methylphenidate should be titrated to response, usually at weekly intervals.

***Maximum* dose in ADHD:**

- *Immediate release tablets*: up to 100 mg daily in 2-3 divided doses
- *Modified release tablets*: up to 108 mg once daily, given in the morning
- *Modified release capsules*: up to 100 mg daily. May be given as a single dose in the morning or in divided doses in the morning and at midday, depending on brand.

The maximum licensed daily dose varies with formulation and brand; consult BNF and SPC.

***Maximum* dose in narcolepsy (off-label)**:

- *Immediate release tablets*: up to 60 mg daily in divided doses.

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.

Patients can choose to try stopping the medication every 1-5 years, with the guidance of the specialist clinic if desired.

6. Pharmaceutical aspects

Back to top

Route of administration:	Oral
Formulation:	Methylphenidate hydrochloride. ***Standard release tablets:*** Medikinet®: 5mg, 10mg, 20mg Methylphenidate hydrochloride (generic): 5mg, 10mg, 20mg Ritalin®: 10mg Tranquilyn®: 5mg, 10mg, 20mg **NB: Methylphenidate standard release tablets are not licensed for use in adults. Use is considered off-label.** Brand name prescribing is not necessary for standard release tablets. ***Prolonged-release tablets:*** NB: Modified-released preparations vary in their release characteristics and *must be prescribed by brand name*. The specialist must specify the brand to be prescribed unless otherwise instructed due to stock shortages. Concerta XL®: 18mg, 27mg, 36mg, 54mg Delmosart®: 18mg, 27mg, 36mg, 54mg Matoride XL®: 18mg, 36mg, 54mg Xaggitin XL®: 18mg, 27mg, 36mg, 54mg

	Xenidate XL®: 18mg, 27mg, 36mg, 54mg **NB: Methylphenidate prolonged-release tablets are licensed for continuation in adults who have shown clear benefit from treatment in childhood and/or adolescence. They are not licensed for intiation in adults. Use in this way is considered off-label.** ***Modified-release capsules*:** NB: Modified-released preparations vary in their release characteristics and *must be prescribed by brand name*. The specialist must specify the brand to be prescribed unless otherwise instructed due to stock shortages. Equasym XL®: 10mg, 20mg, 30mg Medikinet XL®▼: 5mg, 10mg, 20mg, 30mg, 40mg, 50mg, 60mg Ritalin XL®: 10mg, 20mg, 30mg, 40mg, 60mg **NB: Ritalin XL and Medikinet XL modified-release capsules are licensed for initiation and continuation in adults. Equasym XL is not licensed for use in adults** **Please consult the relevant SPC for brand-specific licensing information.**
Administration details:	Methylphenidate can be taken with or without food, but patients should standardise which method is chosen. The effect of food on the absorption of methylphenidate tablets has not been studied. Therefore, a possible effect of food on absorption cannot be excluded. Hence, it is recommended that methylphenidate tablets should be taken in a standardised manner in relation to the timing of meals, i.e. that doses should be given at the same times, relative to the time of meals, on each day, preferably with or immediately after meals. The tablets should be swallowed whole or divided into halves with the aid of liquids. Administration requirements vary by formulation and brand. Methylphenidate capsules can be opened and sprinkled on a small amount of soft food for administration. Please consult the relevant SPC for brand-specific 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*.
Other important information:	Methylphenidate is a schedule 2 controlled drug and is subject to legal prescription requirements. It has the potential for misuse and diversion.

	The choice of formulation will be decided by the treating specialist on an individual basis, and depends on the intended duration of effect. Risk of misuse can be reduced by using modified-release preparations. Alcohol may exacerbate CNS adverse effects of methylphenidate and should be avoided during use. Methylphenidate may cause false positive laboratory test results for amphetamines.

7. Significant medicine interactions

Back to top

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

- **Monoamine oxidase inhibitors (MAOIs):** risk of hypertensive crisis. The combination should be avoided, and use of methylphenidate and MAOIs should be separated by at least 14 days
- **Coumarin anticoagulants, anticonvulsants (e.g. phenobarbital, phenytoin, primidone), selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants**: metabolism may be inhibited by methylphenidate. Dose adjustment may be required when starting or stopping methylphenidate.
- **Anti-hypertensive drugs**: effectiveness may be reduced by methylphenidate
- **Other drugs which elevate blood pressure:** risk of additive effects (e.g. linezolid)
- **Alcohol:** may exacerbate adverse CNS effects of methylphenidate
- **Serotonergic drugs**, including SSRIs and MAOIs**:** increased risk of central nervous system (CNS) adverse effects, risk of serotonin syndrome
- **Halogenated anaesthetics:** risk of sudden blood pressure increase during surgery. Avoid methylphenidate on the day of planned surgery.
- **Dopaminergic drugs**, **including antipsychotics**: increased risk of pharmacodynamic interactions including dyskinesias or hypertensive crisis (e.g. risperidone, paliperidone, selegiline, rasagiline)
- **Apraclonidine:** effects decreased by methylphenidate.
- **Carbamazepine:** may decrease methylphenidate levels
- **Ozanimod:** may increase risk of hypertensive crisis

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

Back to top

Monitoring at baseline and during initiation is the responsibility of the specialist; only once the patient is optimised on the chosen medication with no anticipated further changes expected in immediate future will prescribing and monitoring be transferred to primary care.

Baseline investigations:

ADHD:

- A medical history and cardiovascular assessment, taking into account conditions that may be contraindications, risk of pregnancy (where applicable), and to ensure the patient meets the criteria for ADHD and that pharmacological treatment is required.
- Risk assessment for substance misuse and drug diversion
- Height, weight, and body mass index (BMI)
- Blood pressure (BP) and heart rate
- Arrange for electrocardiogram (ECG), only 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
  - Chest pain suggestive of cardiac origin
  - Signs of heart failure, heart murmur or hypertension
  - Current treatment with a medicine that may increase cardiac risk

Narcolepsy:

- Prior to prescribing, it is necessary to conduct a baseline evaluation of the patient's cardiovascular status including blood pressure and heart rate. A comprehensive history should document concomitant medications, past and present co-morbid medical and psychiatric disorders or symptoms, family history of sudden cardiac/unexplained death and accurate recording of pre-treatment height and weight.
- Cardiovascular status:
  - Patients who are being considered for treatment with stimulant medications should have a careful history (including assessment for a family history of sudden cardiac or unexplained death or malignant arrhythmia) and physical exam to assess for the presence of cardiac disease and should receive further specialist cardiac evaluation if initial findings suggest such history or disease. Patients who develop symptoms such as palpitations, exceptional chest pain, unexplained syncope, dyspnoea, or other symptoms suggestive of cardiac disease during methylphenidate treatment should undergo a prompt specialist cardiac evaluation.
  - Tachycardia and hypertension are potential adverse effects. Methylphenidate should not be prescribed if the diastolic blood pressure is 100 mmHg or greater before treatment. The blood pressure should be monitored at appropriate intervals in all patients especially those with hypertension.
  - Treatment with stimulants in general may lead to a minor increase in blood pressure (approx. 2- 4 mmHg) as well as an increase in heart rate (approx. 3-6 beats/minute). In a few patients, these values may be higher.

- Caution is indicated in treating patients whose underlying medical conditions might be compromised by increases in blood pressure or heart rate.
- Pre-existing structural cardiac abnormalities: Sudden death has been reported in association with the use of stimulants of the central nervous system at usual doses in children with structural cardiac abnormalities. Although some structural cardiac abnormalities alone may carry an increased risk of sudden death, stimulant products are not recommended in children, adolescents, or adults with known structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, or other serious cardiac problems that may place them at increased vulnerability to the sympathomimetic effects of a stimulant medicine.

Initial monitoring:

ADHD and Narcolepsy:

- Before every change of dose: assess heart rate, blood pressure, and weight.
- After every change of dose: assess heart rate and blood pressure, weight and any new or worsening psychiatric symptoms. The specialist should determine the appropriate timing for this monitoring.
- Assessment of symptom improvement. Discontinue if no improvement is observed after one month despite dose increases.

Narcolepsy:

- Monitor development or worsening of pre-existing, psychiatric symptoms at every dose adjustment and then at least every 6 months, and at every visit - methylphenidate could cause or worsen some psychiatric disorders such as depression, suicidal thoughts, hostility, anxiety, agitation, psychosis, and mania.
- Appetite should be recorded after every dose adjustment, and at least every 6 months.

Ongoing monitoring (ADHD):

Ensure the patient receives a review at least annually with a healthcare professional with competency 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. Review outcomes should be communicated to the primary care prescriber in writing, with any urgent changes also communicated by telephone.

Ongoing monitoring (Narcolepsy):

To be added

9. Ongoing monitoring requirements to be undertaken by primary care

Back to top

See section 10 for further guidance on management of adverse effects/responding to monitoring results.

Monitoring	Frequency
ADHD and Narcolepsy: • 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, symptoms of bipolar disorder) • Explore whether patient is experiencing any difficulties with sleep	Every 6 months, and after any change of dose recommended by specialist team.
• Assessment of adherence, and for any indication of methylphenidate 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

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

10. Adverse effects and other management

Back to top

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

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

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.

Result	Action for primary care
Cardiovascular Resting HR greater than 120bpm, arrhythmia/palpitations, clinically significant increase in systolic BP	• In context of recent dose increase, revert to previous dose and discuss with specialist for ongoing management • In absence of recent dose changes, reduce dose by half and discuss with specialist or cardiology for further advice.
Weight or BMI outside healthy range, anorexia or weight loss	Exclude other reasons for weight loss. Give advice as per NICE NG87: • take medication with or after food, not before • additional meals or snacks early in the morning or late in the evening when stimulant effects have worn off • obtaining dietary advice • consuming high-calorie foods of good nutritional value Discuss with specialist if difficulty persists; dose reduction, treatment break, or change of medication may be required.
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.
Psychiatric disorders New or worsening psychiatric symptoms, e.g. psychosis, mania, aggressive or hostile behaviour, suicidal ideation or behaviour, motor or verbal tics (including Tourette's syndrome), anxiety, agitation or tension, bipolar disorder, depression	Discuss with specialist. Stop treatment and consider referral to acute mental health team if suicidal thoughts, mania, or psychosis are present Methylphenidate should not be continued unless the benefits outweigh the risks.
Nervous system disorders Symptoms of cerebral ischaemia, e.g. severe headache, numbness, weakness, paralysis, and impairment of coordination, vision, speech, language or memory	Discontinue methylphenidate, refer urgently for neurological assessment

New or worsening seizures	Discontinue methylphenidate. Discuss with specialist team.
Symptoms of serotonin syndrome, e.g. agitation, hallucinations, coma, tachycardia, labile blood pressure, hyperthermia, hyperreflexia, incoordination, rigidity, nausea, vomiting, diarrhoea	Discontinue methylphenidate as soon as possible. Management depends on severity; use clinical judgement and seek advice if necessary. Discuss with specialist team to determine whether methylphenidate can be re-started.
Insomnia or other sleep disturbance	Review timing of methylphenidate dose and advise as appropriate. Give advice on sleep hygiene. Discuss with specialist if difficulty persists; dose reduction may be required.
Suspicion of abuse, misuse, or diversion	Discuss with specialist team

11. Advice to patients and carers

Back to top

The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.

The patient 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: seek immediate medical attention.
- Signs or symptoms of serotonin syndrome (e.g. agitation, hallucinations, coma, tachycardia, labile blood pressure, hyperthermia, hyperreflexia, incoordination, rigidity, nausea, vomiting, diarrhoea)
- Any mood changes, for example. psychosis, mania, aggressive or hostile behaviour, suicidal ideation or behaviour, motor or verbal tics (including Tourette's syndrome), anxiety, agitation or tension, anxiety, depression
- New or worsening neurological symptoms (e.g. severe headache, numbness, weakness, paralysis, and impairment of coordination, vision, speech, language or memory)
- Abdominal pain, malaise, jaundice or darkening of urine
- Skin rashes, or bruising easily
- If they suspect they may be pregnant, or are planning a pregnancy. Patients of childbearing potential should use appropriate contraception, and take a pregnancy test if they think there is a possibility they could be pregnant.

The patient 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 or operate machines if methylphenidate affects their ability to do so safely, e.g. by causing dizziness, drowsiness, or visual disturbances.
- 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 methylphenidate, as it may make side effects worse. Avoid recreational drugs.
- Not to stop taking methylphenidate without talking to their doctor. Medical supervision of withdrawal is required, since this may unmask depression or chronic over-activity.
- Methylphenidate is a schedule 2 controlled drug. Patients may be required to prove their identity when collecting prescriptions, and should store methylphenidate 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 – methylphenidate. https://www.narcolepsy.org.uk/resources/methylphenidate
- NHS – Narcolepsy. https://www.nhs.uk/conditions/narcolepsy/

12. Pregnancy, paternal exposure and breast feeding

Back to top

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*:**

Methylphenidate is not recommended for use during pregnancy unless a clinical decision is made that postponing treatment may pose a greater risk to the pregnancy.

Evidence on exposure to methylphenidate 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.

Patients who become pregnant while taking methylphenidate, or who plan a pregnancy, should be referred to the specialist team for review. The specialist will reassume prescribing responsibility, ending the shared care agreement.

Healthcare professional information available from: https://www.medicinesinpregnancy.org/bumps/monographs/USE-OF-METHYLPHENIDATE-IN-PREGNANCY/
Patient information available from: https://www.medicinesinpregnancy.org/Medicine--pregnancy/Methylphenidate/

***Breastfeeding*:**
Methylphenidate has been found in breast milk in small amounts. Evidence for safety in breastfeeding is limited. Decisions to use while breastfeeding should be made on a case-by-case basis, taking into account the risks to the infant and benefits of therapy. Infants should be monitored for symptoms of CNS stimulation (e.g. decreased appetite/weight gain, sleep disturbances, irritability), although these may be difficult to detect. High doses may interfere with lactation, although this is not confirmed in practice.
Healthcare professional information available from: https://www.sps.nhs.uk/articles/safety-in-lactation-drugs-for-adhd/

***Paternal exposure*:**
No evidence regarding adverse outcomes following paternal exposure was identified.
Further information for patients: bumps - best use of medicine in pregnancy (medicinesinpregnancy.org)

13. Specialist contact information

Back to top

Cambridgeshire and Peterborough NHS Foundation trust

Royal Papworth Hospital NHS Foundation Trust (Narcolepsy indication)
Respiratory support and sleep centre – Tertiary referral centre:

Specialist	Post	Telephone
Dr Ian Smith	Medical Director of Royal Papworth Hospital and Consultant Sleep Physician	01223 639715
Dr Tim Quinnell	Director RSSC, Consultant Sleep Physician	01223 639718
Dr Mike Davies	Consultant Sleep Physician	01223 638571
Dr Nick Oscroft	Consultant Sleep Physician	01223 639803
Dr Martina Mason	Consultant Sleep Physician	01223 638401
Dr Dariusz Wozniak	Consultant Sleep Physician	01223 639619
Mr Duncan Grady	RSSC Directorate Pharmacist	01223 638700

Pharmacy Medicines Information Service	Non-Urgent Medicines Information for Clinicians engaging in methylphenidate via shared Care	01223 638179
Pharmacy Medicines Helpline	Non-urgent Medicines Information for Patients receiving methylphenidate via a shared care agreement	01223 638777 (answerphone)

*For ADHD Ind***ication**

Name: Cambridgeshire and Peterborough NHS Foundation Trust Adult Attention Deficit Hyperactivity Disorder (ADHD) clinic
Daytime telephone number: 01223 219674
Email address: *CPFTAdultADHDService@cpft.nhs.uk*

Name: CARE ADHD (Centre for ADHD Research & Excellence Ltd.)
Daytime telephone number: 020 4525 0709
Email address: *nhsreferrals@careadhd.co.uk*

Name: Harley Street Mental Health
Daytime telephone number: 0203 488 3655
Email address: *contact@hsmh.co.uk*

Name: Harrow Health ADHD Service
Daytime telephone number: 0203 989 6766
Email address: *harhl.adhdforms@nhs.net*

Name: Modality LLP
Daytime telephone number: 0300 0201 800
Email address: *m85178.modality.adhd@nhs.net*

Name: Skylight Psychiatry
Daytime telephone number: 0333 577 1996
Email address: *skylightpsych.adhdreferrals@nhs.net*

Name: The Owl Centre
Daytime telephone number: 01242 571883
Email address: *owl.rtc@nhs.net*

Name: Eton Psychiatrists
Daytime telephone number: 020 7929 2520

Email address: *Info@etonpsychiatrists.co.uk*

14. Additional information

Back to top

Where patient care is transferred from one specialist service or GP practice to another, a new shared care agreement must be completed. Ensure that the specialist is informed in writing of any changes to the patient's GP or their contact details.

15. References

Back to top

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16. Other relevant national guidance

Back to top

- Shared Care for Medicines Guidance – A Standard Approach (RMOC). Available from https://www.sps.nhs.uk/articles/rmoc-shared-care-guidance/
- NHSE guidance – Responsibility for prescribing between primary & secondary/tertiary care. Available from https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/
- General Medical Council. Good practice in prescribing and managing medicines and devices. Shared care. Available from https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/shared-care
- NICE NG197: Shared decision making. Last updated June 2021. https://www.nice.org.uk/guidance/ng197/.

17. Local arrangements for referral

Back to top

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

See Specialist Contact Information.

Appendix 1: Shared Care Request letter (Specialist to Primary Care Prescriber)

Dear: *[insert Primary Care Prescriber's name]*

Patient name: *[insert patient's name]*
Date of birth: *[insert date of birth]*
NHS Number*: [insert NHS Number]*
Diagnosis:*[insert diagnosis]*

As per the agreed *[insert APC name]*shared care protocol for *[insert medicine name]* for the treatment of *[insert indication],* this patient is now suitable for prescribing to move to primary care.

The patient fulfils criteria for shared care and I am therefore requesting your agreement to participate in shared care. Where baseline investigations are set out in the shared care protocol, I have carried these out.

I can confirm that the following has happened with regard to this treatment:

	Specialist to complete
The patient has been initiated on this therapy and has been on an optimised dose for the following period of time:	
Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory	*Yes / No*
The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care	*Yes / No*
The risks and benefits of treatment have been explained to the patient	*Yes / No*
The roles of the specialist/specialist team/ Primary Care Prescriber / Patient and pharmacist have been explained and agreed	*Yes / No*
The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments	*Yes / No*
I have enclosed a copy of the shared care protocol which covers this treatment/the SCP can be found here (insert electronic/ web link)	*Yes / No*
I have included with the letter copies of the information the patient has received	*Yes / No*
I have provided the patient with sufficient medication to last until	
I have arranged a follow up with this patient in the following timescale	

Treatment was started on *[insert date started]* and the current dose is *[insert dose and frequency]*.

If you are in agreement, please undertake monitoring and treatment from *[insert date]*
NB: date must be at least 1 month from initiation of treatment.

The next blood monitoring is due on *[insert date]* and should be continued in line with the shared care guideline.

Please respond to this request for shared care, in writing, within 14 days of the request being made where possible.