NORFOLK AND WAVENEY STP THERAPEUTICS ADVISORY GROUP (TAG)

SHARED CARE AGREEMENT (SCA) FRAMEWORK

Shared care guidelines - Melatonin for Sleep Disorders in Children	
Monitoring level	**Level Amber 0 – prescribe the drug and perform basic monitoring, such as annual review.**

Generic and Proprietary/Brand Name

The following formulations of melatonin are covered by this shared care agreement:

1. Melatonin standard release tablets - Adaflex®[1] (**Prescribe by brand**)

Adaflex® is licensed for the treatment of insomnia in children and adolescents aged **6-17 years with ADHD**, where sleep hygiene measures have been insufficient. Use outside of this licensing would be off-label prescribing.

2. Melatonin 3mg tablets – Ceyesto®[2] (**Prescribe by brand**)

Ceyesto® is licensed for the treatment of insomnia in children and adolescents aged **6-17 years with ADHD**, where sleep hygiene measures have been insufficient. Use outside of this licensing would be off-label prescribing.

3. Melatonin film coated tablets - Syncrodin®[3] (**Prescribe by brand**)

Syncrodin® does not have a UK marketing authorisation for the indication covered by this shared care, the use of Syncrodin® is therefore **off-label**.

4. Melatonin 2mg modified release tablets (generic)

Off-label use for this indication.

5. Melatonin prolonged-release tablets - Circadin®[4]

Circadin® does not have a UK marketing authorisation for the indication covered by this shared care, the use of Circadin® is therefore **off-label**.

The Medicines and Healthcare products Regulatory Agency (MHRA) advice is to prescribe licensed products in preference to off-label and unlicensed preparations.

Patients already established on Circadin® or Syncrodin® can continue without the need to try Adaflex®.

Liquid formulations of melatonin are not covered by this SCA - TAG Double Red reserved for patients with fine bore enteral feeding tubes.

See Appendix 1 for Summary Table of melatonin formulations, and Appendix 2 for Pathway.

Indication for shared care

1. Autistic spectrum conditions with severe sleep problems not amenable to behaviour management strategies.[6,7]
2. Insomnia in children with ADHD, which is not responsive to sleep hygiene intervention.[8, 14, 15]
3. Insomnia in children with neurodevelopmental disabilities not responsive to sleep hygiene intervention.[9]

For all other specialist requests please email the medicines optimisation team at nwicb.medsqueries@nhs.net for further guidance.

Melatonin is indicated for the treatment of sleep onset disorders in patients under 18 years where no physical cause is identified and it has not responded to behavioural advice, including sleep hygiene which should be offered initially.

Patients **under 18 years of age with sleep disorders** do not need to remain under regular specialist follow-up, however specialists will be available to discuss drug therapy.
The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.

Melatonin should not be initiated in patients 18 years and above; however, treatment can be continued in patients aged 18 years and over if initiated when the patient was a child. This is providing the continued need for treatment is reviewed regularly and 6 monthly drug holidays introduced.

Specialist Prescribing and Monitoring Responsibilities	GP / Community Team - Primary Care Prescribing and Monitoring Responsibilities
1. Assess suitability of patient for treatment. 2. Discuss treatment options with the patient, the parent(s) and carer(s). Obtain appropriate consent to treatment and to share care with the GP. 3. Initiate treatment, ensuring that the patient is stabilised on the dose before the patient is transferred back to the care of the GP. 4. Send a letter to the GP suggesting that initial shared care is agreed for this patient. 5. Prescribe melatonin, please see the summary table and pathway in Appendix 1 & 2. Only the formulations named can be prescribed under this shared care agreement. 6. Review the patient regularly and monitor their response to treatment; a drug holiday is recommended after the initial three months of treatment, and then every six months thereafter. This involves a trial withdrawal of treatment for two weeks to test ongoing need (See Duration of Therapy section below for more information on melatonin drug holidays). Most patients will be under more regular secondary care review for underlying neurodevelopmental condition. 7. Report adverse events and suspected adverse drug reactions to the MHRA through the Yellow Card reporting scheme. 8. Ensure clear arrangements for GP back up advice and support. 9. If no adverse effects and clear benefit to child and no other medical issues requiring ongoing specialist review (i.e. ADHD medication) patient can be discharged to primary care. 10. Once discharged if primary care need advice this can be offered. Regularly monitor height, weight, pubertal maturation progress and seizure frequency in epileptic patients in first year of use. If well tolerated and no adverse side effects continued need for treatment can be assessed in primary care, every 12 months.	1. Prescribe melatonin after communication with specialist about the need for treatment. 2. GP to take on prescribing following written confirmation from the specialist within 3 months. 3. Ask patient/carer about side effects and general well-being and report back to the Specialist. 4. Ask carer about effectiveness. 5. Report to and seek advice from the specialist on any aspect of patient care that is of concern to the GP and may affect treatment. 6. Report adverse events and suspected adverse drug reactions to the MHRA through the Yellow Card reporting scheme. 7. Stop treatment if patient no longer needs it or has unacceptable side effects. 8. Stop or adjust treatment if necessary (e.g. side effects) on discussion child and if necessary can discuss with the Specialist.

Patient Information
Families will be provided with relevant patient information leaflets.
Specialist Contact Details
Jenny Lind Clinic, NNUH, Colney Lane, Norwich NR4 7UY 01603 286343 The Child Development Unit, Norwich 01603 505581 CAMHS, 80 St Stephens Road, Norwich NR1 3RE 01603 201400 CAMSH, Mary Chapman House St James, Extons Road, King's Lynn, Norfolk PE30 5NU 01553 668500

GENERAL PRINCIPLES FOR SHARED CARE PRESCRIBING

- Shared Care is only appropriate if it provides the optimum solution for the patient.
- GPs are **invited** to participate. If GPs are not confident to undertake these roles, 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.
- **If a specialist asks the GP to prescribe this drug, the GP should reply to this request as soon as practicable if they are unwilling to do so.**
- Prescribing responsibility will only be transferred when it is agreed by the consultant and the patient's GP and when the patient's condition is stable or predictable.
- Safe prescribing must be accompanied by effective monitoring.
- **The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.**

Background to Treatment

Children with neurodevelopmental disabilities which include Autistic Spectrum Disorder, learning disabilities and ADHD, are at increased risk of having a sleep disorder. These tend to be longstanding, resistant to treatment and adversely affect development and health. Co-morbid sleep problems exacerbate the burden of neurodevelopmental disability on care-givers.[5]

Melatonin is a hormone produced by the pineal gland in a circadian manner, in response to darkness. The link with circadian rhythms has led to its use in the treatment of sleep disorders underpinned by learning disability, Autistic Spectrum Disorders and ADHD. Melatonin is classified as a medicine in the UK and is only available on prescription. In contrast, it is readily available to purchase in some countries, e.g., USA.

In practice, the use of melatonin for the treatment of paediatric sleep-wake cycle disorders is widespread. There are a number of published trials [6, 7, 8, 9,10,11] although these are often small and of short duration, they have come to similar conclusions. Children with ADHD treated with melatonin have been shown to fall asleep earlier and sleep for longer when compared to controls.[8] Generally no significant change in behaviour or attention has been demonstrated. It would appear that there is wide variability in response. Melatonin may be most effective in those children whose sleep patterns indicate that their circadian rhythm is disrupted, and in whom sleep hygiene methods have been ineffective.

Melatonin is recommended for use in these disorders in the BNFC.

Licensed Use

Adaflex® is an immediate release tablet licensed for the treatment of insomnia in children and adolescents aged **6-17 years with ADHD**, where sleep hygiene measures have been insufficient.[1]

The recommended starting dose of Adaflex® is 1-2 mg 30-60 minutes before bedtime. The dose of Adaflex® can be increased by 1 mg every week until effect up to a **maximum 5 mg per day**, independent of age. The lowest effective dose should be sought.

Ceyesto® is an immediate release tablet licensed for the treatment of insomnia in children and adolescents aged **6-17 years with ADHD**, where sleep hygiene measures have been insufficient[2]. Ceyesto is only suitable when the lowest effective dose has been established to be 3mg[2]. Maximum licensed dose is 3mg[2].

Syncrodin® is an immediate release tablet that is licensed in the UK for the treatment of short-term treatment of jet-lag in adults.[3]

Melatonin 2mg modified release tablets (generic) are licensed for the short-term treatment of primary insomnia characterised by poor quality of sleep in patients who are aged 55 or over.

Circadin® is a sustained release tablet formulation of melatonin that is licensed in the UK for the treatment of primary insomnia in adults aged 55 years and over.[4]

Slenyto® is another melatonin formulation that is licensed for use in children. Slenyto® is indicated for the treatment of insomnia in children and adolescents aged 2-18 with Autism Spectrum Disorder (ASD) and / or Smith-Magenis syndrome, where sleep hygiene measures have been insufficient.[12] Slenyto® is not recommended for prescribing by the East of England Prescribing area committee. This is because the case for cost effectiveness has not been proven[13].

Criteria for Patient Selection

1. Autistic spectrum conditions with severe sleep problems not amenable to behaviour management strategies.[6,7]
2. Insomnia in children with ADHD, which is not responsive to sleep hygiene intervention.[8, 14, 15]
3. Insomnia in children with neurodevelopmental disabilities not responsive to sleep hygiene intervention.[9]

For all other specialist requests please email the medicines optimisation team at nwicb.medsqueries@nhs.net for further guidance.

Form and strength of preparation

PRODUCT	MANUFACTURER	STRENGTH	PACK SIZE	PRICE[A]	
Adaflex®	AGB-Pharma AB	1mg tablet	30	£13.30	
		2mg tablet	30	£15.30	
		3mg tablet	30	£19.81	
		4mg tablet	30	£20.23	
		5mg tablet	30	£23.27	
Ceyesto®	Alturix Limited	3mg tablet	30	£10.99[B]	
Syncrodin®	Pharma Nord Medical	3mg film-coated tablet	30	£14.95[B]	
Melatonin	Generic	2mg modified release tablet	30	£8.25	
Circadin®	Flynn Pharma Ltd	2mg prolonged release tablet	30	£15.39	

[A] Price based on Drug Tariff, April 2023
[B] Price from BNF for Children, April 2023

Side Effects – Please refer to BNFC and SPCs

1. Melatonin is generally well tolerated with only mild adverse effects similar to placebo such as: headaches, drowsiness, gastrointestinal disturbances, drowsiness, arthralgia, sleep disorders and pain. [9,16]
2. Delay in sexual maturity and alterations in hormone levels have been reported in animal studies. The effect of melatonin on onset of puberty in children is uncertain.[14]
3. Vivid dreaming has been reported which may be dose related and diminishes with time.
4. Adverse events, interactions and precautions for the different formulations can be found in the SPC. Circadin® is only licensed for (and has only been adequately tested in) adults aged 55 years and above with primary insomnia; similarly, Syncrodin® is only licensed for short-term treatment of jet lag in adults. Therefore, the information presented in the SPC cannot be presumed to apply to paediatric patients.
5. **Other:** Itching, tachycardia, dizziness see BNFC for further information
6. **Children with epilepsy:** Melatonin has some anti-convulsant properties, but some reports have shown that children may have more seizures. Melatonin should be used with caution, see below.

Drug Interactions - Please refer to BNFC and SPCs

Possible interactions with other medicinal products have not been fully characterised. Interaction of melatonin with selective serotonin re-uptake inhibitors has been observed. Melatonin may potentiate the effectiveness of warfarin or other oral anticoagulants and may increase the effectiveness of other monoamine oxidase inhibitors. Melatonin may reduce the effectiveness of nifedipine and other calcium channel blockers.[17]
Sodium valproate and GABAergic antiepileptics reported to suppress nocturnal levels of melatonin.[18]

Cautions and Contraindications - Please refer to BNFC and SPCs

Ensure that obstructive sleep apnoea is ruled out.
Caution in autoimmune disease. BNFC states to avoid use to limited information available for patients with autoimmune disease; exacerbation reported occasionally.
Melatonin studies have shown possible adverse immunomodulatory effects on rheumatoid arthritis and asthma. However, some studies have shown that patients with asthma showed that their sleep difficulties improved with melatonin without side effects.[18]

Caution susceptibility to seizures; BNFC states risk of increased seizure frequency. Increased seizure activity has been reported in patients with epilepsy, but there is also anecdotal evidence that seizure activity improves as a result of improved sleep. Much of the clinical trial data with melatonin does not report an increase in seizure frequency, but data must be treated cautiously due to the short-term nature, size, and heterogeneous nature of the populations studied. Until more is known, prescribers need to approach melatonin use in children with epilepsy cautiously and be alert for alterations in seizure activity.

Hepatic impairment: BNFC states to avoid modified-release tablets as risk of decreased clearance, limited information available. For immediate-release formulations the BNFC states to avoid in moderate or severe hepatic impairment as risk of decreased clearance, limited information available.

Renal impairment: BNFC states caution with use in renal impairment. To avoid immediate release formulations in severe renal impairment.

Initiation of therapy

1. Paediatric consultant or paediatric registrar under supervision of consultant.
2. Consultant child psychiatrist or child psychiatry registrar under supervision of the consultant.

Initial dose and method of administration and supply

For standard release tablets (Adaflex®):[1]

Child aged 6 – 17 years: Recommended starting dose of Adaflex tablet: 1 - 2 mg 30-60 minutes before bedtime. The dose of Adaflex® can be increased by 1 mg every week until effect up to a maximum 5 mg per day, independent of age**.**

Use outside of this licensing would be off-label prescribing.

Adaflex® tablets are licensed to be **crushed and mixed with water** directly before the administration.

Food can enhance the increase in plasma melatonin concentration. Intake of melatonin with carbohydrate-rich meals may impair blood glucose control for several hours. It is recommended that **food is not consumed 2 hours before and 2 hours after** Adaflex tablets[1].

For Ceyesto® 3mg tablets:[2]

For the treatment of insomnia in children and adolescents aged 6-17 years with ADHD the dose is 3mg to be taken 30-60 minutes before bedtime. Ceyesto® is suitable only when the lowest effective dose has been established to be 3mg. Maximum licensed dose is 3mg. Use outside of this licensing would be off-label prescribing.

For immediate release film-coated tablets (Syncrodin®):[3]
The standard licensed dose for the short-term treatment of jet-lag in adults is 3mg daily for a maximum of 5 days. The SPC states the dose can be increased to 6mg daily if the standard dose does not alleviate symptoms.

Use of Syncrodin® in children is off-label prescribing.

Whilst not licensed to be dissolved in water the manufacturer Pharma Nord Medical confirms that from UK clinical practice (post-marketing) they have received feedback from various clinical settings that Syncrodin® 3mg Film-Coated Tablets **disintegrate very quickly when in contact with even few ml of water** (e.g. on a 2.5ml measuring spoon, or in saliva within the mouth). Croscarmellose sodium (an excipient of Syncrodin® 3mg Film-Coated Tablets) plays an important role in dissolving the tablet quickly. However please note Syncrodin® 3mg Film-Coated Tablets are NOT designed as soluble tablets.

For melatonin 2mg modified release tablets (generic): Tablets to be swallowed whole; there is no information available on crushing or dispersing tablets in water. Modified-release tablets should be taken with or after food.

Use of melatonin 2mg modified release tablets (generic) in children is off-label prescribing.

For Circadin® prolonged release tablets:[4]

Child more than 1 year of age: An initial dose of 2mg (given 30 – 60 minutes before bedtime) has been used; in the absence of improvement after 1 – 2 weeks, the dose can be increased to 4 – 6mg at night. If there is no improvement by 4 weeks, then discontinue medication. Maximum dose of 10mg per day as per BNFC. Please note use of Circadin® in children is off-label. Circadin® tablets may be **crushed** if required for easier swallowing

and mixed in water. [19] When crushed Circadin® will act as immediate-release melatonin. Circadin® tablets are not licensed for crushing.

Maintenance Dose and Administration

See above.
Consultant responsible for prescribing until stable dose achieved. This would usually be within 1 month. Once stable dose achieved consultant to request GP to take on prescribing. GP to take on prescribing following written confirmation from the specialist within 3 months. It is important to continue to review the need for ongoing treatment. A drug holiday is recommended after the initial three months of treatment, and then six monthly thereafter. This involves a trial withdrawal of treatment for 2 weeks to test ongoing need (See Duration of Therapy section below for more information on melatonin drug holidays).

Duration of therapy / How the treatment will be reviewed and if appropriate, stopped

Treatment should be stopped when there is evidence of lack of effect from a sleep diary or patient/parent perception.

Treatment may need to be long term. Patients should be instructed to withdraw melatonin for a period known as a 'drug holiday' to assess on-going need.
Ideally a drug free holiday will take place 3 months after the commencement of treatment and 6 monthly thereafter. The patients should undergo a drug free holiday for 2 weeks. Patients and their carers can choose a suitable time to undertake a drug free holiday and do not have to inform their GP or specialist. An opportunity to undertake the drug free holiday could be two to four weeks before the specialist's annual review; recording the outcomes on and off treatment in a sleep diary. Alternatively, patients could try having a drug free holiday during the school holidays to avoid adverse effects on school days and their sleep diary reviewed at their next specialist review. If the break from melatonin has resulted in no deterioration in sleep cycle, the young person can remain off melatonin. The specialist and GP should be informed if the drug withdrawal trial has been successful, and that melatonin is no longer required.
If withdrawal of medication has impacted the young person's sleep cycle they should restart treatment, at the same dose they were stable on prior to the drug holiday.
If there is a consistent correlation of sleep deterioration during a drug holiday, patients should be advised to continue without a break unless they are suspected to be a poor metaboliser of melatonin (in which case regular washout with ongoing drug holidays when the benefit wanes is recommended).

If requiring further advice relating to drug holidays the GP should contact the patient's specialist

Initial monitoring / baseline assessment – by Specialist

Monitor effectiveness for the first 4 weeks with a sleep diary or patient/parent perception.

Specialist monitoring responsibilities

Regularly monitor height, weight, pubertal maturation progress and seizure frequency in epileptic patients in first year of use. If well tolerated and no adverse side effects continued need for treatment can be assessed in primary care, every 12 months.

GP / Community Team or other Primary Care monitoring responsibilities

Ask patient/carer about side effects and general well-being and report back to the specialist.

Consultant / Specialist prescribing responsibilities

1. Assess suitability of patient for treatment.
2. Discuss treatment options with the patient, the parent(s) and carer(s). Obtain appropriate consent to treatment and to share care with the GP.
3. Initiate treatment, ensuring that the patient is stabilised on the dose before the patient is transferred back to the care of the GP.
4. Send a letter to the GP suggesting that initial shared care is agreed for this patient.
5. Prescribe melatonin, please see the summary table and pathway in Appendix 1 & 2. Only the formulations named can be prescribed under this shared care agreement.
6. Review the patient at least annually to monitor response to treatment, with trial withdrawal of treatment for 2 weeks to test ongoing need. Most patients will be under more regular secondary care review for underlying neurodevelopmental condition.
7. Report adverse events to the MHRA (Yellow Card reporting scheme).
8. Ensure clear arrangements for GP back up advice and support.
9. If no adverse effects and clear benefit to child and no other medical issues requiring ongoing specialist review (ie ADHD medication) can be discharged to primary care.
10. Once discharged if primary care need advice this can be offered.

GP prescribing responsibilities

1. Prescribe melatonin after communication with specialist about the need for treatment.
2. GP to take on prescribing following written confirmation from the specialist within 3 months.
3. Ask patient/carer about side effects and general wellbeing and report back to the Specialist.
4. Ask carer about effectiveness.
5. Report to and seek advice from the specialist on any aspect of patient care that is of concern to the GP and may affect treatment.
6. Report adverse events to the MHRA via the Yellow Card reporting scheme.
7. Stop treatment if patient no longer needs it or has unacceptable side effects.
8. Stop or adjust treatment if necessary (e.g. side effects) on discussion child and if necessary can discuss with the Specialist.

Indications for referral back to Specialist

Uncommon, severe, or unexpected side effects. Lack of efficacy. If there are concerns or queries, telephone consultation will usually be available at short notice.

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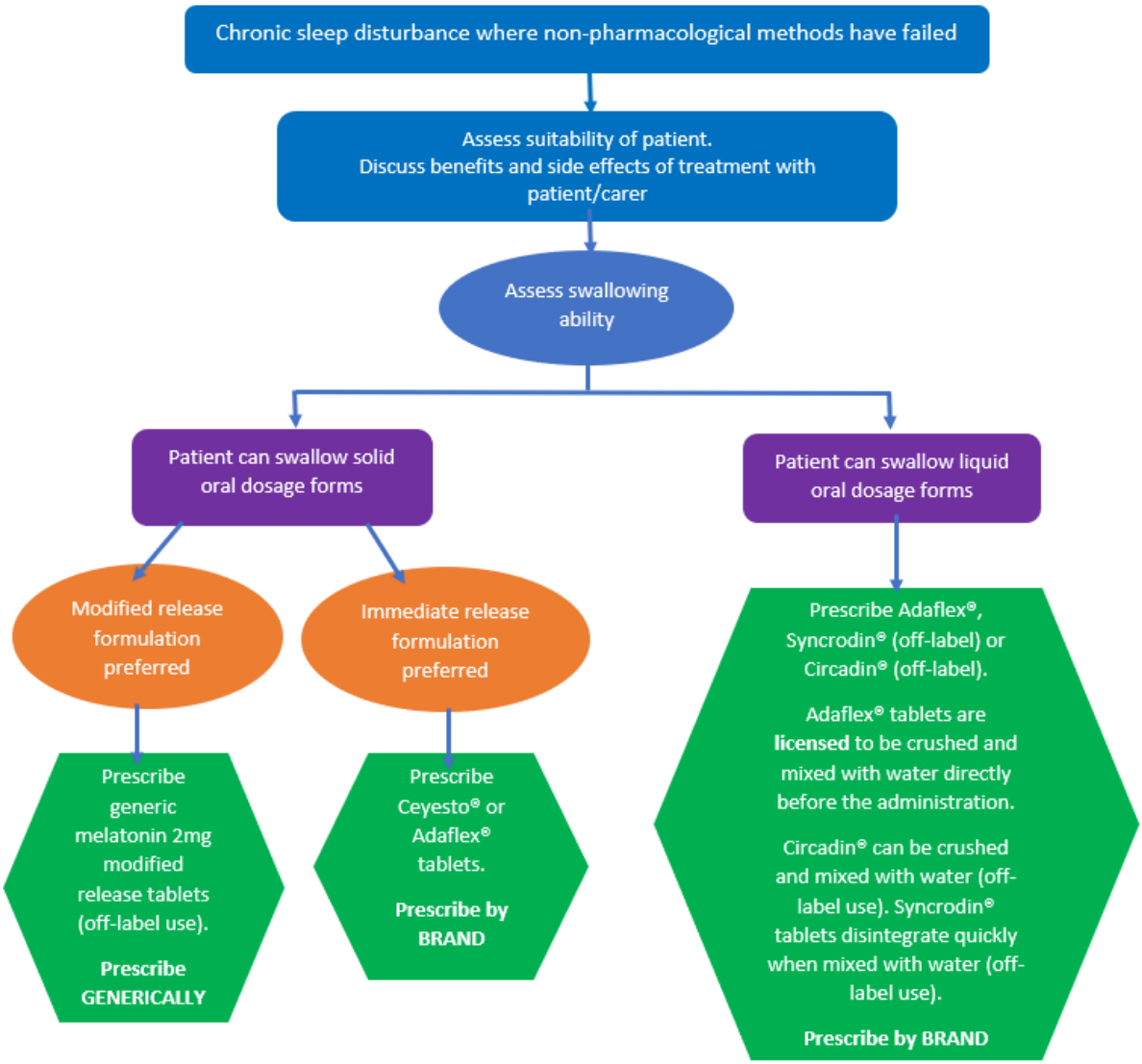
Last review date	November 2023
Date of next review	January 2026

Appendix 1: Formulations of Melatonin Summary Table

Immediate release					
Name of formulation	**Strength**	**Licensing**	**Price per Pack (30)**[A]	**How to Prescribe**	**Administration**
Adaflex®	1mg tablet 2mg tablet 3mg tablet 4mg tablet 5mg tablet	**For the treatment of insomnia in children and adolescents aged 6-17 years with ADHD**. Use outside of this licensing would be off-label prescribing.	£13.30 £15.30 £19.81 £20.23 £23.27	Prescribe by **brand**	Adaflex® tablets are **licensed** to be **crushed and mixed with water** directly before the administration.
Ceyesto®	3mg tablet	For the treatment of insomnia in children and adolescents aged **6-17 years with ADHD**. Use outside of this licensing would be off-label prescribing.	£10.99[B]	Prescribe by **brand**	**Tablets to be swallowed whole.**
Syncrodin®	3mg film-coated tablet	Syncrodin® does **not** have a UK marketing authorisation for the indication covered by this shared care, the use of Syncrodin® is therefore **off-label**.	£14.95[B]	Prescribe by **brand**	Tablets disintegrate very quickly when in contact with even few ml of water (e.g. on a 2.5ml measuring spoon, or in saliva within the mouth). This is an **off-label** use.
Modified release					
Name of formulation	**Strength**	**Licensing**	**Price per Pack (30)**[A]	**How to Prescribe**	**Administration**
Melatonin 2mg modified release tablets (Generic)	2mg modified release tablet	**Off-label** use for this indication.	£8.25	Prescribe **generically**	**Tablets to be swallowed whole.**
Circadin®	2mg prolonged release tablet	Circadin® does **not** have a UK marketing authorisation for the indication covered by this shared care, the use of Circadin® is therefore **off-label**.	£15.39	If crushing to facilitate administration prescribe by **brand.** This will ensure the intended product is dispensed.	Circadin® tablets may be crushed if required for easier swallowing and mixed in water (off-label). [19] When crushed Circadin® will act as immediate-release melatonin. This is an **off-label** use.
[A] Price based on Drug Tariff, April 2023 [B] Price from BNF for Children, April 2023					

Appendix 2: Pathway



Document history:

Version	Date	Author/Editor	Status	Comment
1.	Mar11	Dr R Adiga, Dr Z Iqbal, Dr R Hoogkamer, Dr S Steel. Edited by F Marshall	Superseded	Therapeutics Advisory Group (TAG) approved
2.	Feb12	Dr R Hoogkamer Edited by F Marshall	Superseded	Updated manufacturer, pack size and price following transfer of product licence / marketing authorisation
3.	Sept 13	Dr R Adiga (NCH&C), Dr Z Iqbal (NSFT), Dr R Hoogkamer (NSFT), Dr S Steel (NCH&C) / Edited by F Marshall, TAG Lead Pharmacist (CSU)	Superseded	Use of current version extended to March 2014 pending results of audit of prescribing and monitoring by local providers, NCH&C and NSFT. January 2014 – Contact details for Drs Hoogkamer and Iqbal updated.
4.	July 14	Edited by F Marshall, TAG Lead Pharmacist (NEL CSU Anglia) on behalf of the TAG.	Superseded	Shared Care Agreement reviewed and approved by the TAG following presentation of a report of audit results from NCH&C.
5.0	Feb – March 17	Dr R Hoogkamer (NSFT) and Dr S Steel (NCH&C) / F Marshall, TAG Lead Pharmacist (CSU).	Superseded	Reviewed by authors. Sleep disorders in depression and anxiety, and delayed sleep phase disorder added under criteria for use – considered and supported by the TAG.
6.	Nov 20	Dr S Steel	Superseded	Reviewed by authors. Request that after 1 year no longer needs specialist review as safety of medication is good

6.1	March 2021	Jen Carroll, TAG Lead Technician	Superseded	Supported by TAG and D+TC. Ratified by CCG Governing Body
6.2	March 2022	Jen Carroll, TAG Lead Technician	Superseeded	Added Syncrodin as immediate release option. Supported by TAG and D+TC. Ratified by CCG Governing Body May 2022. Also amended title
6.3	September 2022	Natalie Cunningham Medicines Optimisation Pharmacist	Superseded	Addition of Adaflex as first line treatment option. Addition of information relating to the dissolution of Syncrodin® by manufacturer. Request that treatment can be continued in patients aged over 18 years, if initiated as a child, and reviews have been conducted.
7	April 2023	Natalie Cunningham Medicines Optimisation Pharmacist	Superseded	Addition of Ceyesto® and generic 2mg modified release melatonin tablets. Liquid melatonin changed to Double Red from Black to reflect change in status. Addition of Appendix 1, Summary Table, and Appendix 2 Pathway.
7.1	July 2023	Natalie Cunningham Medicines Optimisation Pharmacist	Superseded	Recommendation for 6 monthly drug holidays.
7.2	October 2023	Natalie Cunningham Medicines Optimisation Pharmacist	Superseded	Amendment to Specialist Prescribing and Monitoring Responsibilities section, now refer to pathway in Appendix 2 rather than specify here the brands/formulations that are covered by shared care.

7.3	January 2024	Natalie Cunningham Medicines Optimisation Pharmacist	Superseded	Title changed from '*Shared care guidelines for Melatonin for Sleep Disorders*' to '*Shared care guidelines - Melatonin for Sleep Disorders in Children*'. Indications for shared care section expanded; to make it clearer which indications melatonin is commissioned for in primary care. In criteria for patient selection wording changed from '*Autistic spectrum conditions **and** severe sleep problems not amenable to behaviour management strategies*' to '*Autistic spectrum conditions **with** severe sleep problems not amenable to behaviour management strategies.*' Caution in autoimmune disease added to cautions and contraindications section. Links to the BNFC and SPC also added to the following sections – side effects, drug interactions and cautions/contraindications section. Hepatic and renal impairment also added to the cautions and contraindications section as per BNFC.
7.4	January 2024	Natalie Cunningham Medicines Optimisation Pharmacist	Current	Indications for shared care reviewed. The following indications for shared care have been removed: i) Sleep disorders in depression and anxiety (Not provided by NCHC), and ii) Delayed sleep phase syndrome when appropriate behavioural sleep interventions fail (NCHC are not commissioned to provide this service unless child has

				neurodevelopmental disorder). Removed to reflect current service provisions; unclear if these services are still commissioned. Note added to Indication for Shared Care and Criteria for patient selection sections which states, '*For all other specialist requests please email the medicines optimisation team at nwicb.medsqueries@nhs.net for further guidance*.' Note also added to Adaflex and Ceyesto to say '*Use outside of this licensing would be off-label prescribing*'. In the Initial dose and method of administration and supply section a note has been added to state that '*Use of Syncrodin® in children is off-label prescribing*'. For melatonin 2mg modified release tablets (generic) a note was also added to state '*Use of melatonin 2mg modified release tablets (generic) in children is off-label prescribing*'.