**AREA PRESCRIBING COMMITTEE – Birmingham, Sandwell, Solihull and environs**

**Decision Making Support Tool**

The following document supports the committee to consider formulary applications against defined criteria.

| Formulary application reference: | | APCBSSE/0035 |
|---|---|---|
| Drug name and formulations: | | Guanfacine prolonged release (Intuniv®) |
| **Criteria** | ***Example*** | **Committee Consensus** |
| Patient Safety | *Potential for abuse, toxicity, significant drug interactions* | Lower potential for abuse. Adverse effects such as orthostatic hypotension, bradycardia, hypno-sedation, fatigue and headaches are very common and could limit tolerability. Rebound hypertension and tachycardia may also occur after discontinuation of guanfacine, particularly if abrupt. |
| Clinical effectiveness | *Established licensed product* | No head to head analysis. Network meta-analysis indicated that guanfacine resulted in a higher response rate versus atomoxetine (55.9% vs. 49.7% respectively), but the results were not statistically significant. No evidence of improved efficacy over atomoxetine |
| Strength of evidence | | No head to head comparison. Evidence not robust. |
| Cost effectiveness or resource impact | *£* | This would represent a substantial investment. Extrapolating the figures for Solihull stated in the application it equates to 600 patients across Birmingham and Solihull who would be eligible for non-stimulant treatment. Current price difference between atomoxetine and guanfacine is approx. £500 per year. The number of patients who will require guanfacine instead of atomoxetine is not clear from the application. Therefore the potential absolute increase in costs could be up to £250,000 per year if guanfacine is prescribed instead of atomoxetine. |
| Place of therapy relative to available treatments | *1/2nd tier* | Second tier (stimulants contraindicated or not effective or tolerated). |

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| National guidance and priorities | *NICE, MTRAC* | SMC have approved (February 2016). All Wales Medicines Strategy Group have not approved (June 2016); case for cost-effectiveness not proven. NICE guidance on ADHD revision expected in 2018. |
| Local health priorities | *CCG views* | Cost could be prohibitive in current financial climate. Would only support use as last line resort (after everything else has not worked). |
| Equity of access | *Equality assessment* | N/A |
| Stakeholder views | *Define wider groups to be engaged* | N/A |
| Implementation requirements | *Requires, RICAD ESCA etc.* | Specialist prescribing only initially because of monitoring requirements. Currently no shared care agreements in place for ADHD drugs, except in Solihull. |
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**Decision Summary**

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| Resubmission is recommended to complete the information to enable a decision: | |
| Not approved and rationale: | |
| Formulary status (RAG) and rationale | RED Initiation and maintenance of prescribing by Specialists only.<br>Rationale: Monitoring requirements and concerns with side-effect profile. |
| Implementation requirements: | |
| Implementation monitoring: | |