MINISTRY for HEALTH
15, PALAZZO CASTELLANIA, MERCHANTS STREET, VALLETTA, MALTA

DH CIRCULAR No. 183/2016
DH 1467/2014

6th May 2016

Attention All: Consultants
Medical Officers
Pharmacists
Pharmacy Technicians
Nurses

Re: New Atomoxetine Request Form

It is being brought to your attention that the protocol for entitlement to Atomoxetine Capsules (Protocol 4, Annex 1 attached) has been amended and prescribing consultants are now being requested to also fill in the Atomoxetine Request Form (attached as Annex 2), together with the Schedule V Application for new cases requiring atomoxetine. (This does not apply to renewals which should be treated as per usual procedure.)

The Schedule V Application Form and the Atomoxetine Request Form are also available on the POYC website via the following link: https://health.gov.mt/en/poyc/Pages/One-Stop-Shop/Medicines-Approval/Application-Forms.aspx

The co-operation of prescribing consultants is kindly being requested for the appropriate application forms to be used. Requests for atomoxetine for new cases without the affixed Atomoxetine Request Form will only be accepted until the end of May. As of 1st June 2016, such requests without all the necessary documentation will not be processed.

Thanks in advance for your co-operation.

Dr. Denis Vella Baldacchino
Chief Medical Officer

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Atomoxetine 18mg, 25mg and 40mg Capsules

Prescriber Criteria: Consultant Paediatrician (Community Paediatrics)
Consultant Paediatrician (Paediatric Neurology and Neurodisability)
Consultant Psychiatrist

Out-patient and In-patient use:

1. Chronic Psychiatric Disorders Starting in Childhood

Reserved for patients with ADHD:

- in whom methylphenidate is ineffective at the maximum tolerated dose* or
- who are intolerant to low or moderate doses of methylphenidate* or
- when stimulant medication is contraindicated

* Copy of *Control Card for Narcotic/Psychotropic Drugs* confirming methylphenidate preparation initial trial MUST be attached to request.

Duration of Approval:
1 year

Note: Consultant should fill the 'Atomoxetine Request Form' to apply for this treatment for new patients.

POYC
Pharmacy of Your Choice
Medicines Approval Section

Pharmacy Of Your Choice Unit
St. Luke's Square, G'Mangia
Email: scheduleV.poyc@gov.mt
Tel. No. 21 232424 / 22481800

ATOMOXETINE REQUEST FORM

PATIENT DETAILS

Patient's Name and Surname: _____

Date of Birth: _____ **I.D. Card No:** _____

Address: _____

Age: _____ **Tel/Mob No:** _____ **Date of application:** _____

SECTION A

Schedule V Condition:

☐ Chronic Psychiatric Disorders Starting in Childhood

SECTION B

Patients with ADHD with one of the following *(tick where appropriate)*:

☐	Methylphenidate is ineffective at the maximum tolerated dose*
☐	Intolerant to low or moderate doses of methylphenidate*
☐	Stimulant medication is contraindicated *(please tick the applicable contraindication/s below)* ☐ Diagnosis or history of severe and episodic (Type 1) Bipolar (affective) disorder (that is not well controlled) ☐ Diagnosis or history of severe depression, anorexia nervosa/anorexic disorders, suicidal tendencies, psychotic symptoms, severe mood disorders, mania, schizophrenia, psychopathic/borderline personality disorder. ☐ During treatment with non-selective, irreversible monoamine oxidase (MAO) inhibitors, or within a minimum of 14 days of discontinuing those drugs, due to risk of hypertensive crisis ☐ Glaucoma ☐ Hyperthyroidism or thyrotoxicosis ☐ Known sensitivity to methylphenidate or to any of the excipients present ☐ Phaechromocytoma ☐ Pre-existing cardiovascular disorders including 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) ☐ Pre-existing cerebrovascular disorders cerebral aneurysm, vascular abnormalities including vasculitis or stroke or known risk factors for cerebrovascular disorders ☐ Other. Kindly specify: _____

*** A copy of the Control Card for Narcotic/Psychotropic Drugs confirming methylphenidate preparation initial trials MUST be attached to the request.**

_____ _____

Signature of Consultant | Name in Block Letters and Medical Council Reg. Number

Date _____

For office use only:

Copy of Control card attached ☐

Approved ☐

Not Approved ☐

_____ _____ _____

Pharmacist's Signature | Name in Block Letters | Date

Kindly fill ALL required sections

Data Protection Statement

All personal data is required to provide you with health care services as necessary, and is processed in accordance with the Data Protection Act, and as permitted by law. Further information about your data can be obtained on request.