



Changes to psychostimulant medicines prescribing: what this means for primary care

Prescribing restrictions and funding criteria have been amended to improve access to psychostimulant treatment for people with ADHD. Vocationally registered general practitioners and nurse practitioners working within their area of practice can now initiate these medicines for adults with ADHD. It is expected that this change will be of most interest to clinicians who have experience in managing patients with ADHD or who intend to undertake training in this area.



This article is intended as a brief overview of the prescribing and regulatory changes for psychostimulant medicines for ADHD; a more comprehensive resource on managing patients taking these medicines will be available shortly.

Psychostimulant medicines for ADHD: prescribing changes

From 1st February, 2026, a wider range of healthcare professionals can initiate treatment with psychostimulant medicines, i.e. methylphenidate, lisdexamfetamine and dexamfetamine, for adults with attention-deficit/hyperactivity disorder (ADHD) without the written recommendation of a psychiatrist or paediatrician (Table 1).¹ These changes to the Pharmaceutical Schedule and prescribing rules have occurred after consultation from Pharmac and Medsafe with the sector.

From 1st February, 2026:¹

- Vocationally registered general practitioners and nurse

practitioners working in their area of practice can initiate psychostimulant medicines for patients aged 18 years and over with ADHD

- Nurse practitioners working within their area of practice of paediatric services or child and adolescent mental health services can initiate psychostimulant medicines for patients aged 17 years and under with ADHD
- Vocationally registered psychiatrists and paediatricians will continue to be able to initiate psychostimulant medicines for any patient
- Medical practitioners and nurse practitioners can continue psychostimulant medicines for any patient with ADHD if they have written approval from one of the authorised prescribers (mentioned above)

The written recommendation for the treatment of ADHD allows methylphenidate, lisdexamfetamine and dexamfetamine to be prescribed interchangeably, where clinically appropriate, e.g. if there is a supply issue affecting the psychostimulant medicine the patient was initially prescribed, as long as the recommendation does not include any restrictions.¹

These changes will take time to implement in primary care

The decision for primary care prescribers to initiate psychostimulant medicines for patients aged 18 years and over with ADHD in the community is voluntary. It is not a regulatory requirement to have specific training in ADHD diagnosis and management before prescribing psychostimulant medicines. However, it is expected that primary care clinicians who choose to prescribe these medicines will have a special interest in ADHD and have competence and confidence in ADHD care. Training courses in ADHD management are available; however, clinicians will typically need to self-fund their attendance.

It is likely that many practices will not currently have the resources or expertise to offer ADHD diagnosis and management for patients, but this may be introduced over time. Practices will need to develop strategies and protocols for structuring and costing appointments for this.

Prescribing psychostimulant medicines in primary care* will typically occur in the following scenarios:

- Initiating psychostimulant medicines after making a diagnosis of ADHD in an adult patient
- Initiating psychostimulant medicines in an adult patient who has received a diagnosis of ADHD from another

- health professional, e.g. a psychologist, psychiatrist, another general practitioner or nurse practitioner
- Restarting psychostimulant medicines in an adult patient with a historical diagnosis of ADHD, who has previously trialled psychostimulant medicines
 - Continuing a prescription for a patient with ADHD who has been initiated on a psychostimulant medicine by another prescriber

* See Table 1 for guidance on the authorised prescribers of psychostimulant medicines

Psychostimulant treatment of ADHD in primary care


Methylphenidate, lisdexamfetamine* or dexamfetamine (unapproved indication) are all recommended as first-line treatment options for adults with ADHD who have symptoms that significantly impact their daily lives, e.g. family life, education, employment.³ Several formulations of these medicines are available (Table 2) and funded with Special Authority approval (see: “Special Authorities for psychostimulant medicines”). They have different release mechanisms and pharmacokinetic profiles, and are not all considered interchangeable (see: “Switching regimens if a preferred medicine is not available”).⁴ There is also substantial inter-person variability in treatment response and adverse effects.⁴ Understanding of these factors is critical for safe and effective prescribing.

* [Special Authority criteria for lisdexamfetamine](#) require the patient to have previously trialled atomoxetine, methylphenidate or dexamfetamine, be unable to access other psychostimulant medicine due to supply issues or the prescriber has concerns regarding diversion or abuse of immediate-release medicines

Table 1. Authorised prescribers of psychostimulant medicines from 1st February, 2026.^{1,2}

	Children and adolescents aged 17 years and under	Adults aged 18 years and over
Initiating* a psychostimulant medicine	Medical practitioners with a vocational scope of practice of paediatrics or psychiatry	Medical practitioners with a vocational scope of practice of paediatrics, psychiatry or general practice
	Nurse practitioners working within their area of practice of paediatric services or child and adolescent mental health services	Nurse practitioners working within their area of practice
Continuing a psychostimulant medicine	Any medical practitioner or nurse practitioner (when acting on the written recommendation of one of the practitioners who initiated prescribing)	

* Initiation of prescribing means to diagnose a patient, either personally or in collaboration with a multi-disciplinary team, as having a specified condition and to personally prescribe or provide a written recommendation to another prescriber to prescribe, methylphenidate, dexamfetamine or lisdexamfetamine for the treatment of that condition

 For further information on the prescribing rules for psychostimulant medicines, see: [Restriction on the Supply of Dexamfetamine, Lisdexamfetamine, and Methylphenidate—Approval to Prescribe, Supply and Administer](#)

Prescribers should refer to the [New Zealand Formulary](#), local HealthPathways, [New Zealand Clinical Principles Framework for Attention Deficit Hyperactivity Disorder](#) and international clinical guidelines for information on the pharmacological management of adults patients with ADHD:

- [Australian Evidence-Based Clinical Practice Guideline for ADHD](#) (2022). These guidelines have been endorsed by the Royal Australian and New Zealand College of Psychiatrists, and the Royal Australasian College of Physicians.
- [NICE guidelines](#) (2018; updated 2019)
- [Canadian ADHD Practice Guidelines](#) (2020)



Discussion with a psychiatrist is recommended if there are any queries or concerns prior to initiation of psychostimulant medicines. Primary care clinicians should have a low threshold for consulting with a psychiatrist if initiating psychostimulant medicines in patients with concomitant mental health conditions, e.g. schizophrenia or bipolar disorder, personality disorders, eating disorders, post-traumatic stress disorder, or substance misuse. Patients with complex needs or high-risk clinical features should not be managed in primary care; referral to psychiatric services is recommended.⁵

Switching regimens if a preferred medicine is not available

Due to differences in pharmacokinetics between formulations of methylphenidate, along with inter-person variability in response, clinicians are generally advised to specify the brand of methylphenidate when prescribing to avoid patients experiencing insufficient treatment response or adverse effects due to unnecessary brand changes. However, recent global supply issues have meant that switching between brands is often necessary; therefore, the advice has been updated to consider prescribing immediate-release methylphenidate generically to make this process easier.⁸ Modified-release methylphenidate preparations must still be prescribed by brand.⁸



For further information on bioequivalence and switching brands, see: [A reminder: generic medicines, bioequivalence and switchability](#) (Medsafe)

General principles for switching psychostimulant formulations

Caution is recommended when switching patients to a different brand of medicine in any clinical situation.¹⁸ Advice for switching between psychostimulant medicine formulations in patients with ADHD is largely based on expert clinical opinion.

Special Authorities for psychostimulant medicines

Psychostimulant medicines require Special Authority approval for funding in New Zealand. There are four separate Special Authorities.

For methylphenidate:

- [SA2590](#) applies to first-line or lower-cost brands: Ritalin, Rubifen SR, Methylphenidate ER – Teva, Methylphenidate Sandoz XR (Rubifen LA is proposed to be listed on this Special Authority from 1st July, 2026)
- [SA2591](#) applies to second-line or higher-cost brands: Ritalin LA, Concerta

For amfetamines:

- [SA2587](#) applies to dexamfetamine sulfate
- [SA2588](#) applies to lisdexamfetamine dimesilate

Any relevant prescriber can apply for Special Authority approval. If the patient's usual brand is out of stock and the appropriate alternative brand is not covered by their current Special Authority, the prescriber may need to apply for another Special Authority number for the person to receive the funded medicine. As a result of ongoing stock shortages affecting methylphenidate worldwide, most people already prescribed methylphenidate for treatment of ADHD now have both SA2590 and SA2591 approval.

Since 1st December, 2024, there has no longer been a requirement to renew Special Authority approvals for psychostimulant medicines; once issued they remain valid indefinitely.⁷

Table 2. Overview of funded psychostimulant medicines for managing ADHD in adults and children aged six years and over as of 1st February, 2026.^{8–16} N.B. This table is based on information contained within New Zealand medicine data sheets for these products and is intended as a guide; onset and duration of action for specific medicines may differ due to inter-person variability and other factors.

Medicine	Methylphenidate				Dexamfetamine (unapproved indication in adults)	Lisdexamfetamine
Formulation/release type:	Immediate-release	Slow-release	Long-acting	Extended-release	Immediate-release	Extended duration of action (prodrug)
Brands (Special Authority application form)	<i>Innovator</i> Ritalin (SA2590) <i>Generic</i> Rubifen (SA2590)	<i>Generic</i> Rubifen SR (SA2590)	<i>Innovator</i> Ritalin LA (SA2591) <i>Generic</i> Rubifen LA (<i>proposed to be funded from 1st July, 2026 – proposal currently out for consultation</i>)	<i>Innovator</i> Concerta (SA2591) <i>Generic</i> Methylphenidate ER – Teva (SA2590) Methylphenidate Sandoz XR (SA2590)	Dexamfetamine (Noumed) (SA2587)	Vyvanse (SA2588)
Onset of action	20 minutes – 1 hour	1 – 2 hours	1 – 2 hours	1 – 2 hours	20 minutes – 1 hour	60 – 90 minutes
Duration of action	3 – 5 hours	Up to 8 hours	6 – 8 hours	Up to 12 hours	4 – 6 hours	8 – 14 hours
Comments	Can be taken with or without food	Fewer fluctuations in plasma concentrations compared to multiple doses of immediate-release methylphenidate Take with food	Intended to mimic two doses of immediate-release methylphenidate taken four hours apart, but with less variation in peak-to-trough levels Can be taken with or without food Capsules can be opened, and beads can be sprinkled on cold food if required for administration	Can be taken with or without food	Can be taken with or without food	Can be taken with or without food Capsules can be opened and contents dissolved in water or juice, or mixed through food if required for administration

Key considerations include:

- **Establish a baseline** for symptoms and daily functioning to guide dose titration for the new formulation.¹⁹ Validated symptom questionnaires (diagnostic/screening tools) can be used to assess symptoms and measure improvement and treatment response, e.g. [Adult ADHD Self-Report Scale](#).²⁰ Re-evaluation for substance misuse or diversion may also be appropriate.
- **Check the patient's medical history** to see if they have previously trialled other brands of methylphenidate or amfetamines, and if so, how they responded. Brands (or medicines) that previously resulted in a good treatment response and were well tolerated should be the first choice when switching.
- **Ideally, select another brand that is most similar to the current medicine**, (e.g. if prescribed the extended-release methylphenidate, Concerta, choose another extended-release brand, i.e. Methylphenidate Sandoz XR or Methylphenidate ER – Teva see Table 2). However, be aware that some patients may not respond/experience the same effect even with a similar brand; close monitoring and regular follow-up is required.
- **Theoretically, all brands of methylphenidate have daily dose equivalence**, i.e. 20 mg of immediate-release methylphenidate taken in divided doses is equivalent to 20 mg of sustained release methylphenidate. However, a new brand is often started at a reduced dose, to evaluate treatment response before titrating back up. If switching from an immediate-release to a longer-acting formulation, calculate the total daily dose and delivery over a similar duration, e.g. a patient prescribed 10 mg immediate-release methylphenidate to be taken in the morning and early afternoon could be switched to a once daily 20 mg dose of a modified-release formulation, e.g. Rubifen SR or Ritalin LA.
 - If switching from a modified-release (or prodrug) formulation to divided doses of an immediate-release formulation, warn patients that they may experience variations in symptom control because of peaks and troughs in plasma levels caused by repeated dosing
- **Close monitoring is required whenever a patient is switched to a different psychostimulant medicine (brand or formulation type).**⁴ Evaluate treatment response and adverse effects, e.g. appetite suppression, mood swings and sleep disturbance, one to two weeks after any change in formulation or dose.
- **Consider dosing adjustments before switching again.** Confirm that any new adverse effects are not related to the duration of action, e.g. the patient is experiencing insomnia because the duration of action is too long (or

Dispensing considerations in relation to supply shortages


Pharmacists must navigate ongoing supply issues, as well as controlled drug regulations and funding rules when dispensing psychostimulant medicines. [Regulation 42 \(4\)](#) of the [Medicines Regulations 1984](#) permits brand substitution for psychostimulant medicines providing that the active ingredient, dose form and strength remain the same, and there is no clinical reason that the new brand should not be dispensed.

Key considerations if the prescribed brand of psychostimulant is not available:²¹

- ✓ Dispensing a different brand of immediate-release methylphenidate is permitted without a new prescription as long as the total dose for each individual dose remains unchanged, e.g. substituting Rubifen 10 mg where Ritalin 10 mg is not available
- ✓ Dispensing different strengths of the same formulation of psychostimulant is permitted without a new prescription as long as the total dose for each individual dose remains unchanged, e.g. dispensing two Ritalin LA 20 mg capsules per dose when Ritalin LA 40 mg capsules are prescribed but unavailable
- ✗ Dispensing a different brand of modified-release methylphenidate is not permitted and prescriber involvement is required for consideration of switching to a different modified-release formulation. A new prescription is required in these situations.
- 🔍 Where a permitted change is made to a prescription, pharmacists must annotate the change on the prescription, e.g. brand supplied, date of change, signature of pharmacist authorising the change.²¹

too short, i.e. the patient cannot “shut off” their brain before bed), or low mood and irritability due to a rapid reduction in plasma level (rebound effect). Adjust the dosing schedule if required.

- **Trial a second alternative within the same class before switching to a different medicine** if the patient does not respond/tolerate the first formulation, e.g. trial two brands of methylphenidate before switching to an amphetamine, or trial both types of amphetamine before switching to a methylphenidate formulation.

 **Best Practice Tip:** Contact the patient’s preferred pharmacy before prescribing a different brand, formulation type or medicine to confirm what stock is currently available, and work with your local pharmacies to establish the best way of staying informed about their stock levels. Latest information on supply issues is also available on the [Pharmac website](#).

Clinician resources

- Local HealthPathways
- [New Zealand Clinical Principles Framework for Attention Deficit Hyperactivity Disorder](#) (2025)
- [Adult ADHD GP Masterclass](#) (2025). This series of six webinar is presented by Dr Sidhesh Phaldessai, a senior psychiatrist with a special interest in adult ADHD, in conjunction with the Royal New Zealand College of General Practitioners. The first webinar is free to access for all GPs. The rest of the webinar series is free for College registrars enrolled from February, 2022. There is a cost of \$60 + GST for the remainder of the series for everyone else.
- [Goodfellow Unit](#). Webinars and E-learning resources. Both free and paid resources are available.
- [Safe, comprehensive, and equitable ADHD care](#) (2025). The Royal Australian and New Zealand College of Psychiatrists Position Statement on ADHD care.
- [Australian Evidence-Based Clinical Practice Guideline for ADHD](#) (2022). These guidelines have been endorsed by the Royal Australian and New Zealand College of Psychiatrists, and the Royal Australasian College of Physicians.
- [NICE guidelines](#) (2018; updated 2019)
- [Canadian ADHD Practice Guidelines](#) (2020)
- [Adult ADHD Assessment Quality Assurance Standard](#) (UK; 2024)
- [Skirrow, P. Practice Standards for the Assessment of ADHD: A Synthesis of Recommendations From Eight International Guidelines. JNZCCP 2025; 35: 96– 116](#). This article summarises current international guidelines on ADHD diagnosis with the goal of establishing the minimum safe practice standards for diagnostic assessments.

Patient and family/whānau resources

- [Changes to the Rules for Prescribing Medicines for ADHD – Information sheet](#) (2025). A patient information handout produced by the Ministry of Health, Manatū Hauora, Pharmac and Medsafe that covers frequently asked questions about the regulatory and medicines funding criteria changes.
- Healthify has patient information for ADHD in [adults](#) and [children](#). Patient information on [medicines used to treat ADHD](#) is also available.
- [ADHD New Zealand](#) is national advocacy group that provides practical information and support for people living with ADHD and their families/whānau. This includes New Zealand-specific resources, information relating to managing medicine supply shortages and a directory of ADHD healthcare professionals.
- [Children and Adults with Attention-Deficit/Hyperactivity Disorder](#) (CHADD) is a American website providing evidence-based information and support for people living with ADHD and their families

N.B. Ask the patient what their preferred medium for receiving health information is. Conventional patient handouts and information leaflets may not be the best method to provide information to patients living with ADHD. Consider referring them to websites, podcasts or books that may be helpful.

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Coming soon: Pharmacological management of ADHD in adults and children: a new frontier for primary care. A comprehensive article about prescribing psychostimulant medicines for patients with ADHD is currently in development by bpac^{nz} and will include information about pharmacokinetics, pre-treatment considerations and investigations, initiation and dose titration, monitoring, switching between formulation types and treatment cessation. N.B. This article will not cover the diagnosis of ADHD or the use of psychostimulant medicines for other indications such as narcolepsy.

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