THE MEDICAL CANNABIS CLINICIANS SOCIETY

GOOD PRACTICE GUIDE

FOR PRESCRIBERS OF CBMPS

MAY 2026 | V5

Medical Cannabis Clinicians Society

References to healthcare regulators and registration requirements
This guidance is designed as a clinician-focused resource, intended to sit alongside existing professional standards and regulatory frameworks. It does not replace guidance from professional bodies such as the General Medical Council (GMC), or regulation from the relevant healthcare regulator, inspectorate or registration authority in the jurisdiction where care is delivered.
In this guide, references to the Care Quality Commission (CQC) in England and equivalent bodies in Scotland, Wales, Northern Ireland and the Crown Dependencies should be understood to include, where relevant: Healthcare Improvement Scotland (HIS), Healthcare Inspectorate Wales (HIW), the Regulation and Quality Improvement Authority (RQIA) in Northern Ireland, the Jersey Care Commission, and the relevant health and care regulatory arrangements in the Bailiwick of Guernsey.

Document Reference: MCCS_EXT_GOOD_PRACTICE_25
Date of Release: June 2024
Updated Dates: July 2025, November 2025, April 2026, May 2026
Next Review Date: October 2026
Reviewed by: Executive Committee

CONTENTS

ABOUT THE GOOD PRACTICE GUIDE

Cannabis-based medicinal products (CBMPs) have been legal to prescribe in the UK since November 2018. Since then, an estimated 95,000 patients have received prescriptions, supported by approximately 160 prescribers across around 40 private clinics. Despite this growth, NHS prescribing remains extremely limited, and the absence of mandatory training and consistently applied clinical standards has led to variation in practice across the sector. In response, the Medical Cannabis Clinicians Society (MCCS) has developed this updated edition of the Good Practice Guide for Prescribers of CBMPs.

The Society's position is that CBMPs can be prescribed safely where there is appropriate clinical assessment, oversight and follow-up. Drawing on the experience of clinicians actively prescribing in real-world settings, the guidance aims to support clinicians, particularly those newer to prescribing, to understand what safe and responsible prescribing looks like in practice.

Position within existing regulation
This guidance is designed as a clinician-focused resource, intended to sit alongside existing professional standards and regulatory frameworks. It does not replace guidance from bodies such as the General Medical Council (GMC), or regulation from bodies such as the Care Quality Commission (CQC) in England and equivalent bodies in Scotland, Wales, Northern Ireland and the Crown Dependencies, but supports clinicians in applying relevant standards in the context of cannabis-based prescribing. We welcome more formal engagement with regulators to support alignment, share clinical expertise, and contribute to the development of proportionate, effective oversight.

The primary focus of this guide is the individual clinician and their professional responsibilities. While many prescribers work within clinics or structured services, safe prescribing ultimately depends on the clinical judgement, decision-making and accountability of the prescriber. The role of the Society is to support clinicians in this process, though clinics are encouraged to adopt and align with these guidelines.

Scope and practical application
Prescribing CBMPs requires careful clinical judgement, an understanding of the current evidence base, and clarity around professional responsibility. This guide provides a structured framework to support clinicians in areas including consultation, prescribing decisions, peer review, documentation and follow-up. The standards outlined are applicable across all clinical settings and relevant to any professional involved in prescribing or supporting CBMP care.

This framework is not intended to limit clinical decision-making, but to ensure that where clinicians depart from standard approaches, risks are recognised, documented and appropriately managed. Cannabis medicine is an evolving field, and clinicians must apply their professional judgement in the context of individual patient need. Prescribers remain responsible for their own clinical decisions and must ensure that prescribing is based on an individual assessment, aligns with GMC standards and regulatory requirements, and is in the patient's best interests.

By setting out practical expectations for assessment, prescribing, monitoring and communication, the guidance seeks to support safe, consistent, high-quality practice across the sector, strengthen clinical confidence, and improve patient outcomes.

Professor Mike Barnes MD FRCP
Chair, Medical Cannabis Clinicians Society

> ***"Prescribing cannabis-based medicinal products requires careful clinical judgement, a clear understanding of the evidence, and a strong awareness of professional responsibilities. This guide provides the structure clinicians need to practise safely, lawfully and in the best interests of patients."***

1. PRESCRIBING RESPONSIBILITIES

1.1 CLINICAL AND PRESCRIBING RESPONSIBILITIES

All prescribers must ensure they are practising within their area of competence, in line with General Medical Council (GMC) guidance,[1] and are familiar with relevant prescribing standards and controlled drug regulations. Where a patient presents outside the prescriber's usual scope of practice, additional specialist input or MDT oversight must be sought.

As most CBMPs are unlicensed "specials", prescribing carries additional clinical responsibility in accordance with The Medicines and Healthcare products Regulatory Agency (MHRA) guidance[2]. This includes ensuring appropriate documentation, monitoring, and communication, particularly within shared care arrangements.

Where prescribing falls outside typical parameters, the same regulatory principles apply as for any other medicine[3]. Prescribers must be able to demonstrate that their decision is:

- Based on a clear clinical rationale
- Supported, where possible, by available evidence or clinical experience
- In the best interests of the patient

In such cases, clinicians should clearly document their reasoning, reference any relevant evidence or guidance, and demonstrate that risks have been considered and appropriately managed.

1.2 INITIATING PRESCRIBER ROLE & RESPONSIBILITIES

The law change in November 2018 allows medical practitioners on the GMC Specialist Register to initiate prescription of cannabis-based medicinal products. The specialist must determine that prescribing is in the patient's best interests and is responsible for issuing the initial prescription.

The initiating specialist prescriber is responsible for:

- Initiating treatment and providing ongoing monitoring, either long-term or until the patient can be safely transferred to a follow-up prescriber under a shared care arrangement
- Providing appropriate guidance to the patient and/or carers regarding treatment
- Defining clear parameters within a written treatment plan or policy, allowing follow-up prescribers (doctors not on the specialist register, independent prescribers (pharmacists[4]), or nurses[5]) to adjust dose and formulation in response to the patient's clinical progress
- Reviewing the patient where clinically indicated, including through peer review or MDT processes where appropriate
- Reporting adverse drug reactions via the Yellow Card scheme

The frequency of review should be determined by clinical judgement, informed by the patient's condition, response to treatment, and input from the wider prescribing team.

1.3 FOLLOW-UP PRESCRIBING AND SHARED CARE

Following initiation by a specialist, ongoing prescribing may be undertaken by other appropriately qualified prescribers, including General Practitioners, resident doctors, and non-medical independent prescribers (e.g. pharmacists or nurses)[6]. Once treatment is established and stable, prescribing may continue under a shared care arrangement.

---

1 https://www.gmc-uk.org/professional-standards/the-professional-standards/cosmetic-interventions/knowledge-skills-and-performance
2 https://www.gov.uk/government/publications/supply-unlicensed-medicinal-products-specials
3 https://www.gmc-uk.org/professional-standards/the-professional-standards/good-practice-in-prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines
4 https://www.pharmacyregulation.org/students-and-trainees/pharmacist-education-and-training/independent-prescriber-education-and-training
5 https://www.rcn.org.uk/Get-Help/RCN-advice/non-medical-prescribers
6 https://www.england.nhs.uk/long-read/cannabis-based-products-for-medicinal-use-cbpms/#guidance-and-advice-for-prescribing-decisions

NHS England states that non-specialist prescribers may begin prescribing:
"once patients are established on a particular treatment with no problems. It is expected that patients receiving these products remain under the direct care of a specialist doctor (i.e. initiation and continued prescribing and monitoring) in the first instance."[7]

In practice, shared care means:

- The initiating specialist retains overall responsibility for the treatment plan, clinical strategy, and any significant changes to therapy
- The patient remains under ongoing specialist oversight, even where prescribing is delegated
- A non-specialist prescriber may continue prescribing where the treatment is stable and within their competence.

A specialist consultant should, at a minimum, be involved in the patient's first follow-up appointment before care is fully transitioned to a shared care arrangement. The initiating prescriber should:

- Review the patient periodically, ensuring prescribing is not open-ended
- Be available for advice where concerns arise
- Define clear parameters for when they should be re-consulted, ideally within a written clinic policy

1.4 RESPONSIBILITIES OF THE FOLLOW-UP PRESCRIBER

The follow-up prescriber is responsible for:

- Continuing prescriptions for stable treatment regimens
- Reviewing the patient at clinically appropriate intervals
- Monitoring effectiveness, side effects, and adherence, including signs of misuse
- Checking for drug interactions and ongoing safety
- Providing guidance on dose adjustment, weaning, or discontinuation where appropriate
- Reporting adverse drug reactions via the Yellow Card scheme

They should:

- Liaise with the initiating specialist if concerns arise regarding efficacy, safety, or compliance
- Refer back to the specialist where:
    - The patient's condition becomes unstable
    - Significant dose or product changes are being considered
    - Further specialist input is required

7 https://www.england.nhs.uk/long-read/cannabis-based-products-for-medicinal-use-cbpms/

2. PRINCIPLES OF CBMP PRESCRIBING

2.1 USE OF UNLICENSED TREATMENTS

The MHRA, in its role in the regulation of medicines, issued specific guidance on CBMPs[8]. This guidance indicates that the prescription of an unlicensed medication is allowable *"to fulfil the special needs of that patient that cannot be met by existing licensed medicines"* and that *"This product should not be supplied where a licensed medicinal product can meet the special needs of the patient."*

In practice, this means that initiating prescribers should be satisfied that there are no licensed medicines available that can adequately meet the patient's clinical need. The use of non-pharmacological approaches does not remove or replace this responsibility.

GMC guidance[9] states that:
"Unlicensed medicines may be appropriate where, on the basis of an assessment of the individual patient, you conclude, for medical reasons, that it is necessary to do so to meet the specific needs of the patient," *where "There is no suitably licensed medicine that will meet the patient's need."*
It also states that:
"If making a decision to prescribe, the prescriber must be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy, and take responsibility for overseeing the patient's care, including informed consent about its unlicensed status and documenting reasons for prescribing an unlicensed medicine."

NHS England guidance states that, as the majority of CBMPs are unlicensed, they should not be considered first-line treatments[10]. Prescribers should first consider medicines that are licensed for the condition being treated.[11]

The MCCS recognises that this ultimately requires clinical judgement. However, as a general principle, prescribers should be able to demonstrate that conventional, evidence-based treatments have been appropriately explored.

In most cases, this will mean:

- The patient has tried at least two recognised, evidence-based treatment options for the condition
- These treatments have been given sufficient time and dose to assess effectiveness
- There is clear evidence of lack of efficacy, intolerance, or unacceptable side effects

This threshold is not a strict legal requirement. It, rather, represents a patient focused clinical approach that takes into account their preferences to avoid pharmaceutical treatments and to opt for non-pharmaceutical ones. Nevertheless, the final decision of prescribing CBPM lies with the consultant and they must consider their patient's preference alongside the severity of their condition and the risk attached. The process should end with the patient's informed consent.

It is reasonable to first consider:

- Licensed medicines used within their marketing authorisation
- Licensed medicines used off label, where supported by evidence[12] and accepted clinical practice

There must be a clear unmet clinical need, and that prescribing a CBMP is in the best interests of the patient.

8 https://assets.publishing.service.gov.uk/media/645e19f5ad8a03000c38b3bc/The_supply_of_unlicensed_medicinal_products__special_GN14.pdf
9 https://www.gmc-uk.org/professional-standards/the-professional-standards/good-practice-in-prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines
10 https://www.england.nhs.uk/long-read/cannabis-based-products-for-medicinal-use-cbpms
11 https://www.gov.uk/drug-safety-update/off-label-or-unlicensed-use-of-medicines-prescribers-responsibilities
12 https://www.gmc-uk.org/professional-standards/the-professional-standards/good-practice-in-prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines

2.2 ALTERNATIVE AND NON-PHARMACOLOGICAL TREATMENTS

Questions often arise where patients have tried alternative approaches but not necessarily licensed medicines.

Common examples include:

- Over-the-counter analgesics or non-pharmacological approaches such as physiotherapy or acupuncture for pain
- Psychological or behavioural interventions such as CBT or relaxation techniques for anxiety

These interventions may form an important part of the patient's treatment history. However, prescribers should consider whether standard pharmacological options have been adequately explored, unless there is a clear clinical reason why they are not appropriate.

2.3 CLINICAL JUDGEMENT AND DOCUMENTATION

There will be cases where deviation from this approach is appropriate. For example:

- Where licensed treatments are contraindicated
- Where previous treatments are poorly tolerated or carry significant risk
- Where patient-specific factors make standard pathways unsuitable

In these situations, it is essential that the rationale is clearly documented, clinically justified and aligned with the patient's overall risk profile and treatment goals.

3. MAIN INDICATIONS FOR CBMP TREATMENT

In the UK, there are no legally defined indications for prescribing CBMPs[13]. Prescribing is based on individual clinical judgement and must always be in the best interests of the patient, taking into account clinical need, available evidence, and risk profile.

In practice, prescribing often occurs in patients who have complex, multi-system conditions, are experiencing multiple symptoms (e.g. pain, sleep disturbance, anxiety) and have been treated with multiple conventional therapies that have been ineffective, poorly tolerated, or associated with unacceptable side effects.

CBMPs may therefore be used to address a primary indication, or a cluster of symptoms impacting overall function and quality of life.

3.1 COMMON INDICATIONS

The most frequently prescribed indications, and those with the strongest or most established evidence base, include:[14]

- **Chronic pain**
  Including neuropathic pain, nociplastic pain and pain associated with long-term conditions
- **Anxiety and related disorders**
  Including generalised anxiety disorder, PTSD and other trauma-related conditions
- **Epilepsy**
  Particularly treatment-resistant epilepsy
- **Neurological conditions**
  Including multiple sclerosis, Parkinson's disease, dystonia, Tourette's syndrome, and conditions associated with significant spasticity
- **Sleep disorders**
  Particularly where associated with chronic pain or anxiety
- **Inflammatory conditions**
  Including inflammatory bowel disease
- **Cancer-related indications**
  Primarily for symptom management and quality of life, including pain, nausea and appetite

3.2 EVIDENCE BASE AND CLINICAL JUDGEMENT

The evidence base for medical cannabis continues to evolve and varies between indications.

Prescribers should be familiar with the current evidence base relevant to their area of practice, understand the strength and limitations of available evidence and apply this alongside clinical judgement and patient-specific factors.

While some indications have a stronger evidence base (e.g. chronic pain, epilepsy, spasticity), others rely more heavily on emerging evidence, real-world data and clinical experience.

The MCCS provides access to a growing body of educational and evidence-based resources for members, detailed in Appendix 2.

13 https://www.england.nhs.uk/long-read/cannabis-based-products-for-medicinal-use-cbpms/
14 https://www.drugscience.org.uk/t21

4. INITIAL CONSULTATION STANDARDS

4.1 ACCESS TO MEDICAL RECORDS

The Summary of Care Record (or equivalent medical records) must be obtained prior to prescribing or be available at the time of the initial consultation. The medical records should show evidence of two failed treatments with licensed medications, unless a clinical rationale is documented supporting the consultant's decision to initiate CBPM (in the best interest of the patient) with one only failed treatment with licensed medicines. (See section 2.1)

The guidance makes this clear - GMC Good Medical Practice states:[15]
"If you don't have access to relevant information from the patient's medical records you must not prescribe controlled drugs or medicines that are liable to abuse, overuse or misuse or when there is a risk of addiction and monitoring is important. Exceptions to this are when no other person with access to that information is available to prescribe without unsafe delay and it is necessary to:
a. avoid serious deterioration in health or avoid serious harm
b. ensure continuity of treatment where a patient is unexpectedly without access to medication for a limited period"

4.2 THE INITIAL CONSULTATION

The initial consultation must be comprehensive, structured and clinically robust. It forms the foundation for safe prescribing, particularly given that most CBMPs are unlicensed medicines.

The initial consultation should typically take at least 30 minutes to ensure adequate assessment. This is appropriate where:

- There is sufficient access to medical records
- A full assessment can be conducted safely
- Risks are appropriately identified and managed

However, for more complex or higher-risk patients, a longer consultation may be more appropriate, such as when:

- There is significant psychiatric history
- There are concerns around capacity, safeguarding or substance use
- The clinical picture is unclear

There may be a requirement for greater cooperation and coordination between NHS and private clinicians.

The initial consultation can be by telemedicine but if the prescriber considers a physical examination or more detailed mental health assessment is required then a face-to-face appointment should be organised either through a new appointment at that clinic or, if face-to-face is not offered, then through another clinic that does offer that service.

Preliminary assessment by non-prescribers does not negate the responsibility of prescribers to make their own independent assessment of suitability of CBMPs in the patient's best interests.

15 https://www.gmc-uk.org/professional-standards/the-professional-standards/good-practice-in-prescribing-and-managing-medicines-and-devices/controlled-drugs-and-other-medicines-where-additional-safeguards-are-needed

4.3 CONSULTATION GUIDELINES: CORE ASSESSMENT AREAS

The MCCS Consultation Guideline sets out the minimum standard expected for assessment prior to initiating treatment. The initial consultation should include:

Presenting complaint and diagnosis
- Current symptoms and functional impact
- Underlying diagnosis and indication for treatment

Medication and treatment history
- Previous treatments trialed, including duration and dose
- Evidence of treatment failure, intolerance, or side effects
- Current medications and potential interactions

Past medical history
- Including cardiovascular, hepatic and renal disease
- Any relevant neurological or respiratory conditions

Mental health history
- Current and past psychiatric diagnoses
- History of psychosis, schizophrenia, bipolar disorder or mania
- Severity and stability of mental health conditions
- Current psychiatric treatment and level of support
- Suicide risk assessment

Family history
- Including mental health history, particularly psychotic disorders

Substance use and dependency risk
- Current and past substance use, including alcohol and illicit drugs
- History of cannabis use disorder or dependency
- Assessment of "at risk" behaviours

Social history
- Employment (particularly safety-critical roles such as driving or operating machinery)
- Family responsibilities, including safeguarding considerations
- Living situation and social support
- Falls risk in older patients

Physical examination and investigations
- As clinically indicated

Contraindications and risk factors
- Consideration of any contraindications (see relevant section)

4.5 ASSESSING COMPLEX PRESENTATIONS

Prescribers should not rely solely on Summary Care Records where there is clinical complexity. Reasonable steps should be taken to obtain up-to-date and comprehensive information, including confirmation of involvement of other specialists. Where information is incomplete, prescribing should be approached with caution and clearly documented.

See also section 9.3 Prescribing for High-Risk Patients.

4.5.1 PSYCHIATRIC RISK ASSESSMENT

Where mental health is a key clinical consideration, a structured psychiatric risk assessment should be undertaken prior to prescribing. This should include:
- Personal history of psychosis, mania, bipolar disorder
- Family history of psychotic illness
- Current psychiatric diagnosis and level of stability
- Current treatment and involvement of mental health services
- Assessment of suicide risk

Clinicians should also undertake a detailed review of the Summary Care Record and available medical records, including:

- Previous mental health diagnoses
- Prior pharmacological treatments and response
- History of crisis presentations
- Any history of inpatient psychiatric admission or intensive community support

Where there is a complex mental health history or any uncertainty regarding risk, clinicians should:

- Make appropriate contact with other professionals involved in the patient's care, such as the GP, psychiatrist, or mental health team
- Seek collateral information where needed to clarify diagnosis, stability, and current risk

Where significant risk factors are identified, prescribing should be approached with caution and may require:

- Further specialist input
- MDT discussion
- Additional monitoring or alternative treatment pathways

4.5.2 ASSESSMENT OF SUBSTANCE USE AND CANNABIS EXPOSURE

Clinicians should take a structured, non-judgmental approach to substance use. These conversations should be open and supportive, with the aim of enabling patients to disclose use honestly and understand the implications for treatment.

This assessment should include:

- Use of appropriate screening tools where indicated
- Assessment of problematic use patterns or dependency
- Distinguishing between therapeutic use and misuse

Where patients are using illicit cannabis, this should be explored clearly and sensitively. These discussions provide an opportunity to support transition into a regulated, prescribed treatment pathway.
Clinicians should explain that illicit cannabis presents specific risks, including:

- Unknown cannabinoid composition (e.g. THC/CBD ratios)
- Variable potency and dosing
- Potential contamination (e.g. pesticides, heavy metals, mould)
- Unregulated cultivation and storage conditions

These factors make it difficult to assess safety, response to treatment, and appropriate dosing.
Patients should be advised that:

- Treatment requires a controlled and consistent prescribing environment
- Concurrent use of prescribed CBMPs and illicit cannabis is not appropriate, as it prevents accurate assessment of efficacy, side effects, and titration

Where a patient indicates they are likely to continue using illicit cannabis, clinicians should not initiate prescribing, as safe and responsible prescribing cannot be assured. Clear counselling should be provided and documented, with supporting written information where available.

Where prescribing is considered in the context of cannabis dependency, clinicians must explicitly determine whether treatment is likely to reduce harm or reinforce problematic use. Clinicians should consider whether prescribing is clinically appropriate, whether specialist addiction input is required, and whether treatment may reinforce dependency.

Prescribing should form part of a structured plan with a clear rationale for how it contributes to risk management and harm reduction where appropriate.

5. CONTRAINDICATIONS TO PRESCRIBING

Prescribing CBMPs requires careful consideration of contraindications and patient-specific risk factors. These should be understood as indicators of increased risk rather than absolute exclusions, informing clinical judgement, monitoring and documentation rather than preventing access to treatment in all cases.

This guidance does not adopt rigid exclusion criteria, recognising that clinicians frequently encounter patients with mixed or evolving diagnoses, incomplete or historical diagnostic labels, and complex treatment histories across multiple settings. The emphasis is therefore on individualised risk assessment, clear documentation, appropriate communication, and proportionate clinical decision-making.

5.1 PRIMARY MEDICAL CONTRAINDICATIONS

Caution or avoidance is advised in patients with:

- Severe or unstable cardiovascular disease
- Recent myocardial infarction or stroke
- Cardiac dysrhythmias, particularly where tachycardia may pose risk
- Severe liver disease
- Severe renal impairment
- Significant respiratory disease (where inhaled routes are being considered)
- Fertility treatment, planned or unplanned pregnancy, breastfeeding
- Hypersensitivity to cannabis products (rare)
- Younger patients (under 21 years)
- Not a contraindication, but requires caution with THC exposure, dosing and monitoring

5.2 PRIMARY PSYCHIATRIC CONSIDERATIONS

The most significant contraindication to THC-containing CBMPs is a history of psychosis or schizophrenia, particularly where this is current, recent, or unstable. However, this should not be considered an absolute or lifelong prohibition as diagnostic labels may not fully reflect current risk.
In selected cases:

- Careful re-evaluation over time may identify patients where prescribing is appropriate
- CBD-dominant products may be considered, given their non-intoxicating and potentially antipsychotic profile

Prescribing in this group requires additional caution:

- A clear and structured risk assessment
- Evidence of stability over time
- Consideration of specialist psychiatric input
- Two-way communication between other prescribers working with the patient
- Enhanced monitoring and follow-up

See section 9.3, Prescribing for High-Risk Patients for more detail.

5.3 OTHER MENTAL HEALTH CONSIDERATIONS

Caution is also required in patients with:

- Bipolar disorder or history of mania
- Severe anxiety disorders
- Depression with suicide risk
- Complex psychiatric comorbidity

Where risk is present, but prescribing may still be appropriate, clinicians should:

- Clearly document clinical reasoning and justification
- Consider lower THC or balanced THC:CBD formulations
- Use slower titration and closer follow-up
- Involve MDT discussion and/or mental health services where appropriate

5.4 SUBSTANCE USE AND DEPENDENCY

- History of cannabis use disorder or dependency
- Evidence of problematic or escalating use without a management plan

These are not absolute contraindications, but require:

- Careful assessment of risk versus benefit
- A structured plan to stabilise and reduce harm
- Clear boundaries around prescribing and monitoring

5.5 PRESCRIBING FOR CHILDREN

The Royal College of Paediatrics and Child Health states:[16]
The use of unlicensed medicines or licensed medicines for unlicensed applications is necessary in paediatric practice when there is no suitable alternative. Such uses are usually informed and guided by a respectable and responsible body of professional opinion.

Prescribing to children (under 18 years) can only be done through an an appropriately registered, regulated clinical service, operating in accordance with the requirements of the relevant healthcare regulator, inspectorate or registration authority in the jurisdiction where care is delivered, such as a CQC registered clinic with a paediatric prescribing licence.

Prescriptions to this group are largely for drug-resistant epilepsy but occasional prescription may be appropriate for autism or ADHD symptoms or rarely for “adult” symptoms occurring in children, like chronic pain or other neurological conditions. The initiating consultant prescriber must have an appropriate professional background and shared care may well not be appropriate for this group.

Two-way communication with the paediatric teams in the NHS (or other private sector teams if involved) is essential. Close follow-up is required. See also section 10.4.

16 https://www.rcpch.ac.uk/resources/use-unlicensed-medicines-or-licensed-medicines-unlicensed-applications-paediatric#:~:text=an%20unlicensed%20preparation.-,The%20use%20of%20unlicensed%20medicines%20or%20licensed%20medicines%20for%20unlicensed,exemptions%20which%20enable%20prescribers%20to:

6. DRUG INTERACTIONS

Most medicines do not have clinically significant interactions with CBMPs. However, caution is required in certain situations, particularly in patients with complex comorbidity and polypharmacy.
Cannabinoids are metabolised via the cytochrome P450 enzyme system, particularly:

- THC: primarily via CYP2C9 and CYP3A4
- CBD: primarily via CYP2C19 and CYP3A4

CBD is also a potent inhibitor of CYP450 enzymes, which may increase levels of co-administered medicines.
Particular attention should be paid to:

- Medicines with a narrow therapeutic index
- Drugs metabolised via CYP450 pathways (particularly CYP3A4, CYP2C19 and CYP2C9)

See section 8.2 Oil prescribing which references an MCCS publication detailing drug interactions in more detail.

6.1 CLINICALLY RELEVANT INTERACTION RISKS

Sedative medicines

- Increased sedation when combined with opioids, benzodiazepines, gabapentinoids or Z-drugs
- Buprenorphine: increased levels and sedation
- Clobazam: increased sedation due to elevated active metabolite

CNS-active medicines

- Additive cognitive or psychomotor impairment with antidepressants, antipsychotics and mood stabilisers
- Potential pharmacokinetic interactions with SSRIs and TCAs
- Chlorpromazine: may require dose adjustment

Anticoagulants

- CBD may increase warfarin levels
- INR should be closely monitored, particularly when initiating or adjusting treatment

Antiepileptic medicines

- CBD may increase clobazam levels
- Sodium valproate: increased risk of adverse effects, including hepatic effects

Immunosuppressants

- Tacrolimus: increased drug levels, monitor closely

Smoking-related effects

- Smoking cannabis may reduce levels of some drugs (e.g. theophylline) due to enzyme induction

Additive physiological effects

- Sedatives: increased drowsiness and impairment
- Stimulants: potential increase in heart rate and blood pressure

6.2 PSYCHIATRIC AND ANXIETY PRESCRIBING CONSIDERATIONS

- Additive CNS depression with benzodiazepines, Z-drugs and other sedatives
- CBD may alter metabolism of some antidepressants, antipsychotics and anticonvulsants via CYP3A4 and CYP2C19
- Care is required where patients are already on multiple CNS-active agents

6.3 POLYPHARMACY AND DOSE ADJUSTMENT

Cannabis prescribing often occurs in patients with complex, treatment-resistant conditions, many of whom are already taking multiple medications, including:

- Antidepressants
- Mood stabilisers
- Sedatives or sleep medications

In these patients, there is increased risk of additive side effects and drug interactions and greater caution is required in older adults and those on multiple CNS-active medicines.

At the same time, some patients may reduce or discontinue other medicines (e.g. opioids, benzodiazepines, sleep medication) as symptoms improve. This should be anticipated, monitored and managed in a structured and documented way.

7. PRODUCTS AVAILABLE FOR PRESCRIPTION

The law defines what constitutes a cannabis-based medicinal product, with full details available via GOV.UK[17]. In practice, prescribers can be reassured that products listed on a clinic formulary or supplied through a specialist pharmacy will meet these legal requirements.

Products imported into the UK must meet Good Manufacturing Practice (GMP) standards. The MHRA ensures that products have been manufactured to appropriate quality and safety standards prior to the issuing of an import licence by the Home Office. Similarly, UK-based producers are subject to strict regulatory inspection and quality assurance processes.

7.1 PRODUCT QUALITY AND COMPOSITION

Prescribers should understand the composition of the products they prescribe. Each product should be accompanied by a Certificate of Analysis (CoA), which provides information on:

- Cannabinoid content (e.g. THC and CBD and minor cannabinoid levels)
- Terpene profile (where available - not always available but should be, to allow informed prescribing)
- Confirmation of absence of contaminants (e.g. pesticides, heavy metals, microbial contamination)

Reviewing the CoA is both a clinical safety check and a valuable opportunity to develop familiarity with product variation. It is important to recognise that the final chemical composition (chemovar) of a product is what determines its clinical effects. The cultivar or “strain name” should not be relied upon to predict this.

While genetics provide a guide, the final cannabinoid and terpene profile is influenced by:

- Cultivation methods
- Environmental conditions
- Timing of harvest
- Processing and storage

7.2 TERMINOLOGY AND CLINICAL COMMUNICATION

The MCCS recommends avoiding terminology derived from recreational cannabis markets. Names such as “Girl Scout Cookies” or “Gorilla Glue” have very limited clinical meaning, do not support professional communication and may undermine acceptance of CBMPs as legitimate medicines.

Clinical discussion should instead focus on cannabinoid profile (THC/CBD ratio), terpene composition where relevant and dose and formulation - the chemovar. It is good to see a reduction in this practice over the last 12 months across many parts of the sector.

The traditional distinction between “Sativa” and “Indica” is not a reliable clinical framework. While commonly used to describe “Sativa” as more stimulating or daytime use and “Indica” as more sedating or night-time use, this distinction is inconsistent and not evidence-based and not sufficient to guide prescribing decisions

However, these terms may still have some practical value in patient communication, particularly for individuals with prior cannabis experience. In these cases, they may help describe perceived effects, but should not replace a pharmacologically informed approach.

17 https://www.england.nhs.uk/long-read/cannabis-based-products-for-medicinal-use-cbpms/#product-information

8. PRESCRIBING GUIDELINES

8.1 GENERAL PRESCRIBING PRINCIPLES

Cannabis medicine is highly personalised, and dosing requirements vary significantly between individuals. It is not appropriate to apply rigid dosing rules. However, clear principles can guide safe and effective prescribing.

The overarching approach should be: "start low and go slow." This reduces the risk of adverse effects and allows for careful titration based on individual response. We recommend initiating treatment with a CBD-dominant, full-spectrum oil, particularly in cannabis-naïve individuals, or a balanced full spectrum oil commenced at a low dose where clinically appropriate. Clinicians should note that cannabis-experienced patients may titrate more quickly and require higher starting doses.

Clinicians prescribing CBMPs should ensure they have appropriate training in dosing and titration. The MCCS provides education and CPD-accredited training to support safe and consistent prescribing practice.

8.2 OIL PRESCRIBING

Cannabis oils are typically used for baseline symptom control. A common approach is:

- Start with CBD-dominant oil (e.g. 10 mg CBD daily)
- Increase gradually in increments (e.g. 10 mg every 5 days)
- Assess response and tolerability at each stage

If symptoms remain insufficiently controlled:

- Introduce or transition to a higher THC:CBD ratio oil
- Increase THC cautiously (e.g. 1 mg increments every 5 days)

Many patients, particularly with anxiety-related conditions, may stabilise at approximately:

- ~100 mg CBD daily
- ~10 mg THC daily

However, there is wide inter-individual variation, and dosing should always be guided by clinical response.

The MCCS has developed a detailed, evidence-based dosing guide for cannabis oils, *Medical Cannabis Oils Dosing and Guidance for Safe and Effective Treatment in Adults and Children*. It covers:

- Initiation and titration strategies
- Condition-specific dosing approaches
- Monitoring and adverse effect management
- Harm reduction principles

This resource includes structured dosing tables across multiple conditions, including chronic pain, anxiety, epilepsy, sleep disorders and neurological conditions. It is available to purchase here.

8.3 FLOWER AND INHALED PRESCRIBING

Inhaled cannabis (flower or cartridges) is typically used for breakthrough symptoms and acute episodes (e.g. trigeminal neuralgia, cluster headache, panic episodes, migraine aura, panic attack). A few experienced patients state that their symptoms are better controlled on a vaped flower.

Typical dosing:

- Most patients: ~1g per day
- Around 10%: up to 2g per day
- A small minority may require higher doses, particularly in severe pain

We feel it is reasonable that prescriptions exceeding:

- 2g per day, or
- 25% THC content

These prescriptions should be:

- Subject to peer review prior to prescribing
- Built up gradually rather than initiated at high levels
- Supported by clear documentation of clinical need and response

8.4 PRODUCT SELECTION AND THC CONSIDERATIONS

There is increasing patient demand for high-THC products. While this may be appropriate in some cases, very high THC products may contain lower levels of other cannabinoids and terpenes and this may reduce potential therapeutic benefit. Emerging data suggests that higher THC does not necessarily correlate with improved outcomes, particularly in pain.

Clinicians should:

- Balance efficacy, tolerability, and overall product composition
- Avoid default escalation to high-THC products without clear rationale
- Seek MDT approval initially for THC prescriptions over 25% THC

8.5 WHEN TO STOP TREATMENT

Treatment should be reconsidered or discontinued where there is no meaningful clinical benefit despite appropriate titration and duration of treatment, side effects are unacceptable or outweigh the clinical benefit, there are concerns regarding safety, misuse, or adherence or the patient is unable to follow the treatment plan safely or consistently.

When stopping treatment:

- Undertake a structured discussion with the patient, explaining the rationale for discontinuation
- Ensure decisions are clearly documented, including:
- Treatment goals set at initiation
- Outcome measures used
- Evidence of insufficient response or adverse effects
- Consider gradual dose reduction, particularly where THC-containing products are used:
- Taper THC where appropriate to minimise withdrawal or rebound symptoms
- Monitor for symptoms such as sleep disturbance, anxiety, irritability or return of baseline symptoms
- Provide guidance on managing withdrawal or symptom recurrence, including:
- Supportive measures
- Adjustment of other medications where appropriate
- Consider and discuss alternative treatment options, including:
- Other pharmacological therapies
- Non-pharmacological approaches

Where treatment is discontinued, this should be recorded as a treatment failure or intolerance, with clear justification. Documentation should include:

- Reason for discontinuation
- Duration of treatment and doses reached
- Observed benefits and adverse effects
- Plan for ongoing care

8.6 INTERMITTENT TREATMENT BREAKS AND OPTIMISATION

In some patients, particularly those using THC-containing products, planned intermittent treatment breaks may be beneficial. These may help to:

- Reduce tolerance and maintain therapeutic effect
- Reassess ongoing clinical need and response
- Minimise dose escalation over time

Where appropriate:

- Consider short, structured breaks from THC-containing products
- Plan these in advance with the patient to ensure safety and continuity of care
- Optimise the use of non-THC treatments during this period, including:
- CBD-dominant products
- Other prescribed pharmacological therapies
- Non-pharmacological strategies

Patients should be counselled on:

- Possible temporary changes in symptoms during the break
- How and when to restart treatment
- When to seek clinical advice

Any treatment break should be individualised, clinically justified, and clearly documented, including rationale and follow-up plan.

9. MULTI-DISCIPLINARY TEAM OVERSIGHT

9.1 MDT PRINCIPLES

The Chief Medical Officers expect prescribing decisions for CBMPs, in both NHS and private practice, to be informed by multidisciplinary team (MDT) discussion[18]. In practice, most services implement this through a structured peer review process, often involving regular meetings (e.g. weekly in-person or virtual) or, in some cases, asynchronous processes such as documented case discussions or digital approval systems to review proposed prescriptions before initiation. Regardless of format, the process must be structured, consistent, and clearly documented.

However, reliance on single-clinician review or purely asynchronous, 'tick-box' approval processes is not sufficient to meet the intent of MDT working. Clinics should ensure that MDT input reflects genuine multidisciplinary engagement, rather than administrative sign-off.

Peer review is a core component of safe prescribing practice and is intended to:

- Support clinicians in complex decision-making
- Provide shared clinical accountability
- Strengthen overall prescribing safety and governance
- Enable ongoing learning, reflection, and peer development

The MDT should:

- Include multiple clinicians (more than two), ensuring a genuinely multidisciplinary approach
- Meet regularly to review cases, not only for initiation but also for ongoing management
- Include clinicians with experience in CBMP prescribing
- Where possible, include at least one clinician from the same specialty as the prescriber
- Provide appropriate scrutiny, particularly for new or complex cases

Healthcare regulators and inspectorates are likely to expect services to demonstrate clear clinical governance, including appropriate peer review of higher-risk or unlicensed prescribing decisions. In England, the CQC has specifically emphasised the importance of peer review for initial prescribing decisions. This ensures appropriate oversight at the point of treatment initiation.

9.2 WHEN PEER REVIEW IS REQUIRED IN CBMP CARE

Peer review is indicated for:

- All new CBMP prescriptions
- Where there are clinically significant changes, including:
- Dose escalation outside usual ranges
- Change in product or formulation
- Emergence of concerning or difficult side effects
- Prescribing outside usual clinical boundaries, including:
- High-dose prescribing
- Atypical or less well-supported indications
- Complex comorbidity or polypharmacy scenarios
- The MCCS recommends peer review for first prescriptions over 2g flower/day and 25% and above THC levels

18 https://www.england.nhs.uk/long-read/cannabis-based-products-for-medicinal-use-cbpms

In higher-risk cases, including complex psychiatric presentations or substance use disorders, MDT review should provide enhanced scrutiny, with explicit discussion of risks, alternative options, and justification for prescribing.
For patients who are clinically stable, routine follow-up prescriptions do not require repeated MDT review.

9.3 PRESCRIBING FOR HIGH-RISK PATIENTS

Some patients present with increased clinical complexity or risk. This may include those with significant psychiatric history, substance use disorder, complex comorbidity, unreliable history, or limited access to supporting clinical information.

In these cases, prescribing decisions require a more structured and cautious approach, including review of full medical records where possible, enhanced MDT scrutiny, more intensive monitoring, and ongoing communication with relevant care providers.

Some clinics have established enhanced monitoring pathways for patients with complex psychiatric history, substance use disorder, or significant social instability.

10. CONSIDERATIONS FOR SAFE PRESCRIBING AND ADHERENCE

10.1 INFORMED CONSENT AND THE ROLE OF THE PATIENT

Prescribing should be a shared clinical discussion, taking into account patient experience and preferences, clinical indication and evidence and the safety and risk profile. However, the clinician retains ultimate responsibility for the prescription.
It is not appropriate for patients to dictate specific products or doses without clinical agreement.

Obtaining informed consent is a fundamental part of safe prescribing[19]. Patients should be provided with clear, balanced information to support an informed decision about treatment.

Clinicians should ensure that consent discussions cover:

- Potential benefits and risks
- Likely therapeutic effects based on the indication
- Common and clinically significant side effects
- Limitations of the evidence base
- Recognition that long-term evidence is limited for some indications
- Use of CBMPs as part of an evolving area of clinical practice
- Psychoactive effects of THC
- Potential for cognitive impairment, sedation or anxiety
- Variability in individual response
- Impact on driving and employment
- Legal responsibilities around driving, including impairment
- Potential implications for safety-critical roles or workplace policies
- Expected timelines for benefit
- Gradual onset of effect, particularly with oral preparations
- Need for titration before assessing efficacy
- Trial of treatment
- Agreement that initial prescribing represents a time-limited trial
- Use of outcome measures to assess response
- When treatment may be stopped
- Lack of meaningful benefit
- Intolerable side effects
- Safety concerns or inability to adhere to treatment

Clinicians should consider the reliability of the patient's history and ability to engage with treatment, and their role in supporting safe and effective care.

Patients should be made aware that they are expected to:

- Attend scheduled reviews and engage with follow-up care
- Use the medication strictly as prescribed and not share it with others
- Report any side effects or concerns promptly
- Adhere to legal requirements and ensure appropriate storage of CBMPs
- Inform the clinical team of any changes to their health or other medications

Clear discussion of these responsibilities should form part of the consultation and be reinforced throughout treatment.

19 https://www.ncbi.nlm.nih.gov/books/NBK430827/

10.1.1 PATIENTS WHO LACK CAPACITY AND BEST INTERESTS DECISIONS

Where a patient lacks capacity to make decisions about treatment, prescribing must follow the principles of the Mental Capacity Act 2005. Clinicians must assess and document capacity in relation to the specific decision at the time it is required.

If a patient is assessed as lacking capacity, any decision to prescribe CBMPs must be made in the patient's best interests. This should include:

- Consideration of the patient's past and present wishes, feelings, beliefs and values
- Involvement of those close to the patient, such as family members, carers or legally appointed representatives
- Consultation with other professionals involved in the patient's care where appropriate
- Careful consideration of the balance of potential benefits, risks and burdens of treatment

Where there is a Lasting Power of Attorney (LPA) for health and welfare, or a court-appointed deputy, their role in decision-making must be recognised in line with legal requirements.

Given the complexity and limited evidence base for CBMPs, prescribing in this context requires a higher threshold of justification, clear documentation, and, where appropriate, multidisciplinary input.

10.2 DEFINING TREATMENT SUCCESS & ESTABLISHING OUTCOME MEASURES

Treatment success should be clearly defined and agreed with the patient. This may include:

- Clinically meaningful symptom reduction (e.g. ≥30% improvement in pain)
- Improved function or quality of life
- Reduction in reliance on other medications
- Acceptable balance between benefit and side effects

Clinicians should define clear treatment goals at the outset and agree how progress will be monitored over time. The use of outcome measures supports objective assessment, improves documentation, and provides a basis for ongoing prescribing decisions.

Outcome measures do not need to be complex, but they should be relevant to the patient's primary symptoms, consistent over time and simple to use in routine practice. Depending on the clinical indication, appropriate measures may include:

- **Pain** - Visual Analogue Scale (VAS), Numerical Rating Scale (NRS), Functional impact (e.g. mobility, daily activity levels)
- **Sleep** - Sleep quality scores, Sleep duration, Night-time awakenings
- **Neurological conditions** - Seizure frequency and severity, Spasticity scales, Tremor or movement assessments
- **Mental health and anxiety** - Standardised scales (e.g. GAD-7, PHQ-9 where appropriate), patient-reported anxiety levels and functional improvement (e.g. return to work, social engagement
- **General** - Patient-reported outcome measures (PROMs), Quality of life assessments, Reduction in use of other medications (e.g. opioids, sedatives)

10.3 FINANCIAL FEASIBILITY AND PRACTICAL ACCESS TO PRESCRIBED TREATMENT

Clinicians should assess whether a proposed treatment plan is realistic and sustainable for the patient. This is essential in allowing for adherence with treatment plans. This should include:

- Whether the patient can afford the prescribed products on an ongoing basis
- Whether cost constraints may influence product selection or adherence
- Awareness of any clinic access schemes or discounted pricing options

Cost-related decisions can have direct clinical implications and risk. For example, patients may prioritise a single product based on affordability, which may result in use of higher THC products without balancing CBD, suboptimal dosing or inconsistent use and an increased risk of side effects or poorer outcomes.

Prescribers should address affordability as part of the treatment plan and consider whether a more balanced or simplified prescribing strategy would be safer or more appropriate. This may include a discussion of alternative formulations or dosing approaches that improve affordability while maintaining safety.

10.3.1 ACCESS TO DEVICES AND ADMINISTRATION

Where inhaled or device-dependent products are prescribed, clinicians should also confirm that the patient can access and use the required equipment.

This includes the ability to obtain a medical-grade vaporiser for flower, access to a compatible device where vape cartridges are prescribed and an understanding of how to use the device safely and effectively. If a patient cannot access appropriate equipment, this should be considered when selecting the formulation.

10.4 PRESCRIBING TO PATIENTS UNDER 18

Prescribing CBMPs to patients under 18 requires additional caution, oversight and documentation. While age alone is not a contraindication, younger patients may be more vulnerable to adverse effects, particularly in relation to neurodevelopment, mental health, and psychoactive exposure.

Clinicians should take a more cautious approach to:

- THC exposure, including lower starting doses and slower titration
- Potential impact on cognition, mood and neurodevelopment
- Increased sensitivity to psychoactive effects

CBD-dominant products may be preferred, particularly in younger or cannabis-naïve patients.

10.4.1 APPROPRIATE CIRCUMSTANCES FOR PRESCRIBING TO UNDER 18S

Prescribing may be appropriate where:

- There is a clear and significant unmet clinical need
- Conventional treatments have been ineffective, not tolerated, or inappropriate
- There is a reasonable evidence base or clinical rationale for use

Common scenarios may include:

- Treatment-resistant epilepsy
- Severe neurological conditions
- Complex chronic pain or spasticity
- Other specialist-led indications

10.4.2 SPECIALIST OVERSIGHT

Prescribing in this group should be specialist-led, particularly within paediatric or relevant specialty settings. Multidisciplinary input should be considered in more complex cases, and there must be clear arrangements for ongoing monitoring and review. Shared care arrangements should be approached cautiously and may well not be appropriate for this group.

10.4.3 SAFEGUARDING AND FAMILY INVOLVEMENT

Safeguarding is a key consideration when prescribing to patients under 18. Clinicians should assess capacity and consent, including the involvement of parents or guardians where appropriate. Consideration should be given to the home environment, including supervision and safe storage of medication. Treatment decisions must be made in the best interests of the young person.

11. COMMUNICATION & DOCUMENTATION

11.1 COMMUNICATION WITH THE WIDER CARE TEAM

Episodes of care must be clearly communicated with the patient's GP and, where relevant, other healthcare providers involved in their care, including secondary and tertiary services.

Care delivered across multiple providers introduces increased risk, particularly in relation to medication safety, duplication of prescribing and incomplete clinical information. Effective communication is therefore a core component of safe prescribing practice and is a two-way process.

The approach to communication will vary depending on the clinical context, patient circumstances, and the services involved. Clinicians should apply proportionate clinical judgement, adapting their approach while maintaining a clear standard of reasonable effort, documentation, and patient safety.

Clinicians should ensure appropriate communication with the patient's wider care team, including:

- Informing the patient's GP of:
- Diagnosis and indication for treatment
- Prescribed products, dosing and titration plan
- Monitoring arrangements and review intervals
- Contacting relevant specialists, where appropriate, for example:
- Treating psychiatrists in patients with mental health conditions
- Other specialists involved in complex or shared care
- Communicating treatment plans clearly, including:
- Clinical rationale for prescribing
- Expected outcomes and monitoring approach
- Any identified risks and mitigation strategies
- Invite response or feedback from other treating clinicians

Where a patient is under the care of a psychiatrist, community mental health teams, or other specialist mental health service, prescribers should make reasonable attempts to establish direct communication prior to initiation. In higher-risk cases, prescribing should not proceed without appropriate collaboration. Generally, CBMP prescribing should complement, not replace, existing medical or psychiatric care.

Clinicians should encourage patients to remain engaged with appropriate services and, by communicating effectively with other care teams, reduce the risk that CBPM prescribing does not inadvertently disrupt established treatment pathways.

11.1.1 TWO-WAY COMMUNICATION

Communication should be understood as a two-way process. Prescribing clinicians should make reasonable efforts to engage with NHS and other care providers and remain open to receiving relevant clinical information that may influence prescribing decisions.

In practice, responses from NHS or other services may be delayed, unavailable, or declined. The approach to communication should therefore be proportionate and adapted to the clinical context.

Where direct engagement is not possible, clinicians should:

- Take all reasonable steps to inform relevant providers of the treatment plan
- Encourage patients to share information with their wider care team

Absence of response should not be interpreted as agreement. Equally, a lack of engagement does not in itself prevent clinically justified prescribing, provided the clinician is satisfied that treatment is clinically appropriate and safe based on the available information.

Where clinical information is incomplete or collaboration cannot be established, this should be clearly documented, along with the rationale for proceeding or deferring treatment. In such cases, clinicians should exercise additional caution and ensure that informed consent reflects any uncertainties.

11.2 TRANSFER OF CARE BETWEEN CLINICS

Patients may change clinics for a variety of reasons. This is not uncommon and is often appropriate.

However, the new provider should request records from the previous clinic before initiating new treatment. This helps to ensure continuity of care and confirm the rationale for previous prescribing.

11.3 REVIEW INTERVALS AND MONITORING

Patients should be reviewed at appropriate intervals to assess response and safety. Typical approach:

- Early review during titration phase (e.g. every 2–4 weeks)
- Longer intervals once stable (e.g. every 3 months)

Reviews should include:

- Assessment of outcome measures
- Evaluation of side effects
- Review of adherence and dosing
- Consideration of any changes in medical or social context
- Adequate time must be allotted to a follow-up consultation to allow appropriate discussion. Very short appointment intervals (less than 5 minutes) are rarely justified.

.

12. PRESCRIBING INDEPENDENCE, STOCK AND PHARMACY CHOICE

Prescriptions for CBMPs in the private sector must comply with the requirements for Schedule 2 controlled drugs. Prescriptions must:

- Be written on an FP10PCD ("pink pad")
- Follow the legally required format, including:
- Drug name (including brand name) and form
- Dose and total quantity
- Quantity written in both words and figures

Pharmacies cannot dispense without receipt of the original (top copy) prescription, signed in wet ink[20].

12.1 PRESCRIBING INDEPENDENCE

The GMC and relevant healthcare regulator or inspectorat require clinicians to retain full clinical independence in prescribing decisions. This includes the ability to prescribe any appropriate and available product, freedom from restriction to a single pharmacy formulary and selection of products based only on clinical need.

12.2 PRACTICAL PRESCRIBING AND STOCK AVAILABILITY

Cannabis products are frequently subject to supply variability and stock shortages. To reduce delays and improve patient experience, it is good practice to:

- Check availability with the dispensing pharmacy prior to issuing the prescription
- Send a copy of the prescription electronically in advance, where appropriate, so stock can be reserved
- Ensure timely delivery of the original prescription to enable dispensing

12.3 PATIENT CHOICE AND PHARMACY ACCESS

Once a prescription has been issued, the patient has the right to take that prescription to any pharmacy able to dispense CBMPs. While many clinics work with linked or partner pharmacies, this must not be mandated or limit access to alternative pharmacies.

'Prescription direction', where prescriptions (NHS and private) are directed to a specific pharmacy for non-clinical reasons[21], is unethical and may represent a breach of professional standards. These approaches undermine patient choice, create potential conflicts of interest, and may compromise safe and equitable access to treatment.
Any concerns regarding such practices should be reported to the General Pharmaceutical Council (GPhC), GMC and CQC or relevant healthcare regulator or inspectorate.

12.4 CLINICAL INFORMATION SHARING AND SCR ACCESS

Many dispensing pharmacies specialising in CBMPs do not hold NHS contracts and therefore do not have access to the NHS Summary Care Record system. As a result, pharmacists may be reliant on the information provided within the prescription and accompanying clinical documentation when performing their final clinical check.

20 https://pharmacysafety.org/wp-content/uploads/2020/12/psg-guidance-signature-requirements-for-private-prescriptions.pdf
21 https://www.bma.org.uk/advice-and-support/gp-practices/prescribing/prescription-direction-to-certain-pharmacies

Where possible, prescribers are strongly encouraged to share relevant clinical information with the dispensing pharmacy. This may include a copy of the SCR, clinic letter, or a structured medication and medical history summary to support safe dispensing.

Pharmacists have a corresponding professional responsibility to ensure appropriate clinical checks are undertaken prior to supply. Regulatory expectations are increasing in this area, and the GPhC[22] has made clear that pharmacies must be able to demonstrate that adequate clinical information has been reviewed to support safe dispensing of higher-risk or unlicensed medicines.

22 https://assets.pharmacyregulation.org/files/document/guidance_for_registered_pharmacies_preparing_unlicensed_medicines_august_2018_0.pdf

13. TRAINING & CONTINUING PROFESSIONAL DEVELOPMENT

Safe practice in this area requires active peer engagement. Prescribers should participate in a peer group, either within their clinic or externally, to support clinical discussion, shared learning, and reflective practice. This may include formal MDT meetings, structured peer review processes, or regular professional forums.

Early prescribing should be supported by mentorship and peer input, particularly in the initial stages of practice.

Prescribers should also undertake a recognised training programme, with appropriate certification, before initiating prescribing.

The Medical Cannabis Clinicians Society provides a comprehensive curriculum of CPD-accredited training to support clinicians at all stages of their prescribing journey. This includes:

- Structured live training sessions delivered online (e.g. Zoom), including the Society's regular 3-hour training programme
- On-demand online learning modules for flexible, self-directed study
- Access to practical prescribing guidance and case-based learning

Clinicians also benefit from a wider programme of ongoing professional support, including:

- Regular briefing notes on key clinical and regulatory topics
- Webinars and educational events covering emerging evidence and clinical practice
- Monthly member meetups, providing an informal forum for discussion, shared learning, and peer support

13.1 ONGOING LEARNING AND PROFESSIONAL DEVELOPMENT

Prescribers should maintain up-to-date knowledge in this evolving field. This includes:

- Keeping abreast of emerging evidence and clinical guidance
- Engaging in continued professional development activities
- Participating in peer discussion and reflective practice

APPENDIX 1: PUBLISHED GUIDELINES

Prescribers should familiarise themselves with the following published guidelines, regardless of the stance of the document on medicinal cannabis.

Recommendations and Guidance on Medical Cannabis under Prescription with the All-Party Parliamentary Group for Medical Cannabis under Prescription
The Medical Cannabis Clinicians Society, 2020 | Link

Cannabis-based medicinal products guideline [NG144], updated October 2021
NICE, 2019 | Link

Recommendations on cannabis-based products for medicinal use
Royal College of Physicians, 2018 | Link

Guidance on the use of cannabis-based products for medicinal use in children and young people with epilepsy
British Paediatric Neurology Association, 2018 | Link

Commentary and critique on the BPNA publication: Guidance on the use of cannabis-based products for medicinal use in children and young people with epilepsy
Medical Cannabis Clinicians Society, 2021 | Link

The supply of unlicensed medicinal products 'specials', guidance note 14
Medicines and Healthcare products Regulatory Agency, 2014 with recent updates | Link

Cannabis-based medicinal products PS05/19
The Royal College of Psychiatrists, 2019 | Link

Guidance for pharmacists dispensing CBPMs
Medical Cannabis Clinicians Society, 2025 | Available to members

Medical Cannabis Oils - Dosing & Guidance for Safe & Effective Treatment in Adults & Children
Medical Cannabis Clinicians Society. | Link

Guidance from other countries is also useful:

- Guidance for the use of medicinal cannabis in Australia: Overview
- Therapeutic Goods Administration (TGA) Canada's lower-risk cannabis use guidelines

APPENDIX 2: THE EVIDENCE BASE FOR MEDICAL CANNABIS

The evidence base for cannabis-based medicinal products (CBPMs) is developing rapidly but remains heterogeneous in both quality and scope. Clinicians should understand that this is not a single, unified body of evidence, but a combination of:

- Randomised controlled trials (limited in number for many indications)
- Observational studies and real-world data
- Systematic reviews and meta-analyses
- Patient-reported outcomes and registry data
- Longstanding clinical experience in some therapeutic areas

As with other unlicensed medicines, prescribing decisions should be based on a combination of available evidence, clinical judgement, and individual patient need.

Clinicians are expected to be familiar with the evolving evidence base and to remain up to date as new data emerges

THE MCCS EVIDENCE DATABASE

Members of the Medical Cannabis Clinicians Society have access to a dedicated, fully searchable evidence database via the Member's Hub.

This resource:

- Is updated monthly with newly published studies
- Includes both clinical and pre-clinical research
- Covers a wide range of indications, including pain, neurology and psychiatry
- Provides a centralised, practical tool for clinicians to review the current literature

The purpose of this database is not to provide prescriptive answers, but to support informed clinical decision-making in an area where evidence continues to evolve.

The Society also encourages active discussion and peer exchange of evidence within the Member's Hub, recognising the importance of shared clinical experience alongside published data.

MCCS EVIDENCE PUBLICATIONS

The Society has developed a series of structured evidence summaries to support clinicians.

Introduction to Medical Cannabis: The Evidence Base
December 2025 | eBook

This publication provides a clear and accessible overview of:

- The pharmacological basis of cannabis-based medicines
- Mechanisms of action and the endocannabinoid system
- Current clinical evidence across key indications
- Limitations of the existing evidence base

It is intended as a foundation resource for clinicians seeking to understand the scientific and clinical context of prescribing.

Medical Cannabis and Epilepsy: The Evidence Base
December 2025 | eBook

This publication provides a more detailed, indication-specific review, including:

- Clinical trial data in epilepsy
- Licensed product evidence (e.g. CBD-based treatments)
- Real-world outcomes
- Safety and tolerability considerations

Epilepsy remains one of the areas with the strongest supporting evidence for cannabis-based medicines, although this is largely confined to specific syndromes and formulations.

Evidence in Development
Further structured evidence reviews are currently in development, including:

- Pain
- Psychiatry

These areas represent a significant proportion of current prescribing activity but are also where the evidence base is more variable and, in some cases, contested.

The Society's approach is to:

- Present the available evidence transparently
- Acknowledge uncertainty where it exists
- Support clinicians to make balanced, patient-centred decisions

The evidence base for medical cannabis will continue to evolve.

THE MEDICAL CANNABIS CLINICIANS SOCIETY

- The Medical Cannabis Clinicians Society is an independent community of medical cannabis pioneers - the leading prescribers of this treatment in across the world.
- We believe that every patient who could benefit from medical cannabis should have access to it.
- We provide the medical and scientific community interested in supporting patients with medical cannabis with high-quality training and expert support.
- Membership is open to those with a professional interest in medical cannabis, including clinicians, nurses, GPs, allied health professionals (AHPs), medical students, healthcare scientists, pharmacists and those working across acute, prmary and community healthcare.

- As part of the leading group of medical cannabis experts, members have access to information to inform treatment decisions and support to ensure clinicians can become as confident in prescribing medical cannabis as they are with first line treatments.
- With the most respected medical cannabis clinicians across the world providing support, members are better able to help their patients.
- Our work is made possible by unrestricted educational grant funding from supporters.

www.ukmccs.org

FIND OUT MORE