THE MEDICAL CANNABIS CLINICIANS SOCIETY

GOOD PRACTICE GUIDE

FOR PRESCRIBERS OF CBMPS

JULY 2025 | V2

Medical Cannabis Clinicians Society

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ABOUT THE GOOD PRACTICE GUIDE

PROF MIKE BARNES

SOCIETY CHAIR

Cannabis-based medicinal products (CBMPs) have been legal to prescribe in the UK since November 2018.

Since then, around 75,000 patients have received prescriptions, supported by approximately 160 prescribers across 40 private clinics. Despite this, uptake within the NHS remains extremely limited, and the absence of mandatory training or consistent clinical standards has led to significant variation in practice.

In response, the Medical Cannabis Clinicians Society (MCCS) has produced this second edition of the Good Practice Guide for Prescribers of CBMPs. Drawing on the experience of clinicians prescribing CBMPs daily, this guide sets out practical, evidence-informed principles to support safe, lawful and effective prescribing.

It offers a clear framework for best practice in consultations, prescribing decisions, peer review, documentation and follow-up care.

While it is written with specialist cannabis clinics in mind, the standards outlined here are applicable across all clinical settings and relevant to any prescriber - whether a doctor, pharmacist, nurse or clinic manager - working in this evolving field.

Our aim is to raise standards across the sector, ensure consistency and confidence in prescribing, and ultimately improve outcomes for patients.

We hope this guide proves useful to all clinicians committed to delivering safe and supportive care.

Professor Mike Barnes
Chair, Medical Cannabis Clinicians Society
July 2025

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

1. WHO CAN PRESCRIBE?

The law change in November 2018 allowed medical practitioners on the specialist register of the General Medical Council to prescribe CBMPs for any condition.

It is up to the specialist to decide whether prescribing is in the Best Interest of the patient.

However, the law does allow other prescribers to continue prescribing once the initial prescription has been made by the specialist.

The 'follow-up' prescribers can be General Practitioners, junior doctors working under the specialist or non-medical independent prescribers (pharmacists or nurses).

This is the wording from NHS England:

Non-specialist prescribers may start 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."*[1]

Prescribers need to be aware of the GMC guidance on prescribing[2] and, in particular, note that they should only prescribe within their own area of competence.

Prescribers should also be aware of the MHRA guidance on prescribing unlicensed medication.[3]

1 - NHS England - Cannabis-based products for medicinal use (CBPMs)
2 - GMC - Keeping up to date and prescribing safely - professional standards
3 - GOV.UK - Off-label or unlicensed use of medicines: prescribers' responsibilities

2. PEER APPROVAL PROCESS

The Chief Medical Officers expect both NHS and non-NHS prescribers to have their decisions on prescription to be based on a multidisciplinary team discussion.[4]

The composition of such a team is not stipulated but most clinics require their prescribers to meet, say, weekly or more often to discuss the prescribing suggestions prior to issue of the prescription.

It is sensible for that team to consist of fellow clinicians with experience in prescribing CBMPs and preferably at least one from the same discipline. This latter point has been emphasised in the circular issued by the Welsh government.[5]

We consider this process is essential for all new prescriptions and must be properly documented.

Follow-up prescriptions for patients who are stable and do not need clinically significant dose or product changes do not necessarily need face-to-face review but any clinically significant changes with regard to dose or product (as determined by the prescriber but preferably in accord with a defined protocol), or emergence of troublesome side-effects, would need a further documented team review.

These reviews can be in person (likely on-line) or asynchronous, as long as properly documented.

3. REQUIREMENT FOR TWO LICENSED MEDICINES

The regulations do not stipulate that two licensed medications must have been tried before prescribing a CBMP.

Nevertheless, the MCCS consider that the principle of trying licensed medicines, or licensed medicines 'off-label', before a CBMP, is reasonable.

Generally, CBMPs are not first-line medicines. Questions arise when the patient has tried alternative therapies but not necessarily a licensed medicine.

Common examples are:

- over-the-counter analgesics or valid alternatives such as acupuncture or physiotherapy for **pain**
- CBT or relaxation techniques for **anxiety**.

The MCCS feel that prescribers must make a judgement themselves on this issue but nevertheless we feel that completion (and consequent failure) of two accepted, evidenced-based treatments for the condition is a minimum requirement.

4 - NHS England - Cannabis-based products for medicinal use (CBPMs)
5 - GOV.Wales - The rescheduling of Cannabis for medicinal purposes

4. INITIAL CONSULTATION

The initial consultation must be thorough.

The below is a useful checklist based on the Guidance for the use of medicinal cannabis in Australia.[6]

- **Presenting symptoms and underlying diagnosis.**
- **Past medical history**
  - In particular, cardiovascular disease, liver disease and renal disease.
- **Medication review**
  - Treatments that have been tried and have failed; as well as the length of time the treatments were trialled and the reasons for ceasing.
- **Mental health history**
  - History of mental illness, particularly psychosis/schizophrenia.
- **Family health history**
  - Including mental health, particularly a family history of psychosis/schizophrenia.
- **'At risk' behaviours associated with drug dependence and substance abuse disorder.**
  - While previous cannabis use may not be a contraindication, care should be taken to manage the risk of dependence.
- **Social history**
  - Social and family support for the use of a medicinal cannabis product.
  - Consideration should be given to family responsibilities such as caring for young children, child safety, employment (especially where it involves driving or operating machinery), 'at risk' living conditions and the risk of falls in older patients
- **Physical examinations/investigations as appropriate.**
- **Consideration of any contraindications (see contraindication section)**

We consider that an initial consultation of this depth should take at least 30 minutes.

The consultation must be properly documented.

6. TGA - Guidance for the use of medicinal cannabis in Australia: Overview

5. PUBLISHED GUIDELINES

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

1. 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
The Guidance, revised in 2021, includes information about who can prescribe medical cannabis, prescribing and prescriptions, conditions, funding and more.

2. Cannabis-based medicinal products – guideline [NG144], updated October 2021
NICE, 2019
Link
This guideline covers prescribing of cannabis-based medicinal products for people with intractable nausea and vomiting, chronic pain, spasticity and severe treatment-resistant epilepsy. The update guidance is important with regard to the loosening of recommendations about paediatric epilepsy prescribing. Overall, the guidelines are not supportive, mainly because of their focus on double-blind placebo-controlled trials and ignoring real-world evidence and foreign language publications.

3. Recommendations on cannabis-based products for medicinal use
Royal College of Physicians, 2018
Link
The RCP jointly produced recommendations with the Royal College of Radiologists (RCR) and in liaison with the Faculty of Pain Medicine of the Royal College of Anaesthetists. The guidelines are unhelpful and do not recommend prescribing for pain, contrary to overwhelming evidence to the contrary.

4. Guidance on the use of cannabis-based products for medicinal use in children and young people with epilepsy
British Paediatric Neurology Association, 2018
Link
The BPNA highlights the key questions specialist clinicians should address before considering prescribing and also provide guidance on appropriate dosage and treatment regimes. However, these guidelines are extraordinary in their bias against medicinal cannabis and are deeply unhelpful. See the MCCS Commentary & Critique.

5. The supply of unlicensed medicinal products 'specials', guidance note 14
Medicines and Healthcare products Regulatory Agency, 2014 with recent updates
Link
Guidance on manufacturing, importing, distributing and supplying specially manufactured or ordered products, including cannabis-based products for medicinal use in humans (CBPMs), known as 'specials'.

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

7. 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

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

9. Medical Cannabis Oils – Dosing & Guidance for Safe & Effective Treatment in Adults & Children
Medical Cannabis Clinicians Society
Awaiting publication.

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 - Canada.ca
- And others, especially in individual US States

6. CONTRAINDICATIONS TO PRESCRIBING

The main contraindication to a THC-containing CBMP prescription is a history of psychosis/ schizophrenia, especially a current or recent history.

The MCCS does not consider that such diagnosis should lead to a life-long contraindication but caution will always need to be exercised in such individuals. Careful and cautious re-evaluation at a future time could make such an individual a candidate for therapy.

We note that CBD is anti-psychotic and is likely to be safe to prescribe to such individuals.

Other contraindications and risks to be considered are:

- **A history of hypersensitivity to cannabis products (albeit rare)**
- **Severe or unstable cardiopulmonary disease or recent history of myocardial infarction or stroke**
- **Cardiac dysrhythmia, especially if it may be adversely affected by tachycardia**
- **Hepatitis C**
- **Previous or current mental health condition, other than psychosis, such as mania**
- **Pregnancy or breastfeeding**
- **Younger patients, less than 21 years**
    - This is not a contraindication but caution is required with, for example, THC strength and dosing.
- **Severe liver disease**
- **Severe renal disease**
- **Individuals with concomitant medication with known interactions with cannabis.**
    - Most medications do not have an adverse interaction with cannabis but caution needs to be exercised with some medications including, but not limited to:
        - warfarin
        - theophylline
        - chlorpromazine
        - tacrolimus
        - buprenorphine
        - clobazam
        - sodium valproate
- **History of cannabis dependency syndrome**

7. MAIN INDICATIONS

In the UK there are no indications that are illegal but prescription must always be in the Best Interest of the individual. The most prescribed indications and those with the most evidence base are:

- **Chronic pain**
- **Anxiety and related conditions, such as PTSD**
- **Epilepsy**
- **Other longer term neurological conditions**
  - **Tourette's, dystonia, Parkinson's disease, multiple sclerosis and conditions with marked spasticity**
- **Inflammatory bowel disease**
- **Life-threatening cancer (as quality-of-life treatment)**
- **Sleep disorders**

A prescriber should keep up-to-date with the latest literature on the evidence base for cannabis. The MCCS has an evidence base available to members as well as a growing library of evidence publications, including:

- An Introduction to Medical Cannabis
- Medical Cannabis and Epilepsy

A further publication on the evidence for pain indications will be published in Autumn 2025 and others will follow. These publications will be available on the MCCS website from Autumn 2025.

8. WHAT CAN BE PRESCRIBED

The law defines a CBMP and the requirements can be explored on gov.uk.[7]

Essentially, the prescriber can be reassured that products on a clinic formulary or available through an independent pharmacy specialising in cannabis will meet the defined requirements.

The MHRA will have checked that the product has been produced under euGMP regulations and meets the necessary safety and purity criteria, prior to the issue of an import license by the Home Office.

UK growers are likewise inspected against stringent criteria.

We do recommend that prescribers look at and understand the Certificate of Analysis that should accompany the product so that they can see the cannabinoid and, preferably, terpene composition and be reassured on lack of impurities.

It is also a valuable learning exercise. The product “strain name” or cultivar should not be relied upon to predict the final composition as, whilst the genetics are a guide, the final cannabinoid and terpene profile will depend on the grow conditions, induction of flowering, time of harvest, etc.

APPROPRIATE TERMINOLOGY

The MCCS recommend that producers should not use “recreational” names (such Girl Scout Cookie, Gorilla Glue, etc) as they mean little in clinical terms and do not assist in the acceptance by clinicians and many patients of the medical value of the plant. It is the final chemovar that is important and not the name of the cultivar.

We also recommend that clinicians move away from reliance on the terms “sativa” and “indica”. In general terms, sativa types are non-sedating and “energising” and useful for daytime use whilst indica types are sedating and useful for the evening / night-time.

The distinction is only a general guide and not a clinical distinction to be relied upon.

However, it may be useful as a means of communication for experienced patients to inform their clinician regarding the kind of medication that has worked for them in the past, but generally should be abandoned.[8]

7 - GOV.UK - Rescheduling of cannabis-based products for medicinal use in humans
8 NIH.GOV - The Cannabis sativa Versus Cannabis indica Debate: An Interview with Ethan Russo, MD

9. OVERALL PRESCRIBING PLAN

Cannabis medicine is highly personalised and dosage very variable. It is not appropriate to dictate strict guidelines.

However, some basic principles can be applied. The mantra should always be 'start low and go slow'. This will avoid, as far as possible, unwanted side effects and recognise the highly variable dosing requirements.

Many authorities suggest starting with a high CBD / low THC full spectrum oil product, especially in cannabis-naïve individuals.

A starting dose of say just 10mgs CBD with a gradual increase with increments of 10mgs CBD every 5 days or so, would be reasonable.

Once a dose of around 60mgs CBD daily is achieved, and further improvements are still needed, then adding in (or substituting) a higher THC oil and then escalating that dose at just, say, 1mgs THC daily every 5 days or so would also be reasonable.

Many individuals, especially with anxiety, will be ideally treated at around 100mgs CBD and 10 mgs THC, albeit with considerable variation.

The same basic principles could be applied to cannabis-experienced individuals but the escalation period could be quicker and / or the dosage increments larger.

Once stability is obtained on oil then a flower (or cartridge) for vaping could be added to assist with breakthrough pain or for sudden pain attacks, such as trigeminal neuralgia, cluster headaches or aura of migraine to prevent an attack.

The MCCS is aware that some patients, especially experienced patients, feel that a flower is preferable to oil and many clinicians start with a flower prescription. This is an entirely acceptable practice but we recommend careful documentation of the reason.

OUTCOME MEASURES

We recommend that the clinician sets out the aims of treatment and the methods to monitor progress towards that aim.

Outcome measures can be simple, such as a visual analogue scale for pain or simple counting of seizures, but nevertheless it is good practice to include an outcome measure.

10. PRESCRIBING GUIDELINES

OIL PRESCRIBING GUIDELINES

The MCCS is about to publish thorough and evidence-based guidelines on oil dosing.

This will be available on the MCCS website from early Autumn 2025.

FLOWER PRESCRIBING GUIDELINES

Flower is mainly used for breakthrough pain or acute pain episodes, such as trigeminal neuralgia or even an acute panic attack.

However, some, particularly experienced, patients prefer the effect of flower vaped several times each day to the longer-term effect of oil. This may be reasonable although the reasons should be carefully documented.

Most individuals are suited to around 1g flower per day but about 10% need up to 2g flower daily, as indicated by T21 project data to be published in autumn 2025. A small minority need more than that, especially for severe pain.

A cannabis prescription should always be a discussion between the patient and clinician but in the end the clinician takes responsibility for the prescription and must feel comfortable and justified with the product and dosage prescribed.

It is not appropriate for a patient to demand a specific product. There always needs to be a discussion between the patient and the prescriber.

We recommend that a prescription of over 2g daily, which may be entirely reasonable, should always be subject to approval by a peer panel.

There is also a tendency for some patients to ask for a flower with a high THC content, even up to 30%. For some patients, particularly with severe pain, this is entirely reasonable.

However, very high THC flowers will by definition have less minor cannabinoids and terpenes and therefore probably less medical value.

Studies on this area are admittedly lacking, although Drug Science T21 project data on this topic will be available in Autumn 2025.

We recommend that a prescription over 25% THC by weight should have peer approval prior to prescription and such doses should not normally be prescribed initially but built up to slowly, with careful documentation of the effects.

11. PRESCRIPTIONS

Prescriptions in the private sector for controlled drugs need to written on the 'pink pad' or FP10PCD.

The proscribed format for controlled prescriptions (with, for example, numbers written in figures and words) must be followed.[9]

Pharmacies cannot dispense without a top copy.

As cannabis products are not infrequently out of stock then it is good practice to check with the pharmacy that a product prescribed is in stock and the prescription sent electronically so that the stock can be reserved awaiting dispensing once the top copy arrives.

Soon, the MCCS will have access to live pharmacy stock information, available to members on-line.

12. SCRIPT DIRECTION

Once a prescription is written, the patient has a right to take that prescription to any pharmacy.

Many clinics have linked pharmacies and, whilst it may be convenient for the prescription to be sent to that linked pharmacy, this must not be mandated.

Clinicians also must not be restricted to prescribing from a formulary of a linked pharmacy.

The clinician must be able to prescribe whatever product is available and suitable for the patient from whatever pharmacy stocks that product. Script direction is unethical and should be reported to the General Pharmaceutical Council.

Pharmacies with a particular product seeking to charge other pharmacies a premium for providing that product is also unethical practice and should be reported.

13. TRAINING

Cannabis medicine is rather different from other medical disciplines and prescribers should have undergone a recognised training programme, with due certification, before starting to prescribe.

The MCCS runs a monthly 3-hour training programme.

Mentoring in the first months of prescribing is also essential, although such mentoring is likely to come in any case from the multi-disciplinary prescription review process.

9 - BNF | NICE - Controlled drugs and drug dependence | Medicines guidance

14. FOLLOW-UP CONSULTATIONS & SHARED CARE

Follow-up consultations, after initial prescription by the specialist, can be conducted by other medical practitioners and pharmacy and nursing prescribers with appropriate qualifications.

The initiating specialist prescriber continues to have overall responsibility and should be consulted if there any concerns at follow-up, especially with regard to major dose adjustments, product changes or concerning side-effects. A written policy on when the initiating consultant needs to be consulted again is wise for all clinics.

The initiating specialist prescriber has responsibilities to:

- initiate treatment and monitor, either long-term or until the patient, in the opinion of the specialist, can be safely passed to a "follow-up" prescriber under a shared care arrangement.
- offer guidance on CBPMs to patient and / or carers.
- allow 'follow-up' prescribers (GP/pharmacist/nurse) to make adjustments to dose and formulation in accordance with patient's response to treatment and within parameters defined in a written policy.
- review patient if clinically indicated with the peer review team to monitor response to treatment.
    - The frequency of review is a clinical judgment, with advice from the prescribing team.

The 'follow-up' prescriber also has responsibilities to:

- review patient at clinically appropriate intervals.
- monitor effectiveness and side effects at regular intervals and check for any signs of misuse.
- offer guidance on weaning / discontinuation if needed.
- report adverse drug reactions via the Yellow Card system.
- liaise with the specialist if concerns arise regarding efficacy, safety or compliance.
- refer back to the specialist for discussion if the patient's medication requirements are unstable or if further guidance on dose titration is required.

The patient also has responsibilities to:

- attend scheduled clinic reviews.
- use the medicine as prescribed and not share it with others.
- report any side effects to their healthcare provider.
- adhere to legal and storage guidelines for CBPM.
- inform the clinical team of any changes to health or other medications.

The Registered Clinic Manager has responsibilities to ensure all procedures and protocols are followed and that the CQC is properly informed of any Statutory Notifications. The Registered Manager also has a duty to ensure the clinical staff follow guidelines (preferably, these guidelines) and any safeguarding issues are dealt with in a timely manner and any complaint raised follows clinic protocols. Overall, the Registered Manager is responsible for the safe running of the service.

Non-clinical management should not interfere with any clinical aspect of the service, as this is solely the prerogative of the clinical team and the Registered Manager.

The MCCS has provided a template for shared care documentation which is available to members.

THE MEDICAL CANNABIS CLINICIANS SOCIETY

- The Medical Cannabis Clinicians Society is an independent community of medical cannabis pioneers – the first prescribers of this treatment in the UK.
- 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 UK's 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 in the country 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