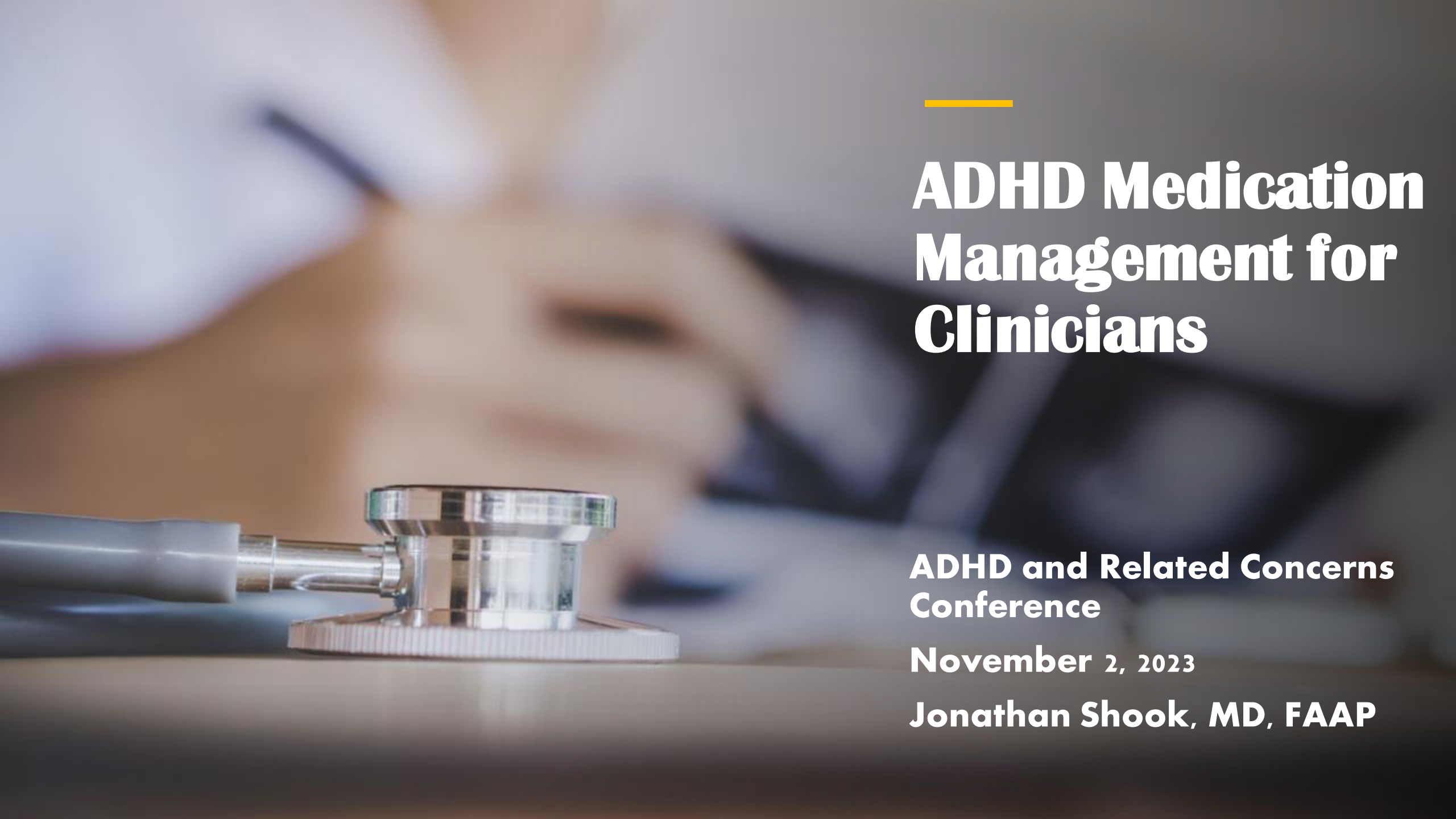

ADHD Medication Management for Clinicians

ADHD and Related Concerns Conference

November 2, 2023

Jonathan Shook, MD, FAAP

Disclosures

- I have no relevant financial relationships with manufacturers of any commercial products and/or providers of commercial services discussed in this CME activity.

- Generic medication names used when possible, but brand names are often needed to clearly identify some formulations of ADHD medications

Objectives

- As a result of participation in this activity, the learner should be able to do the following:
  - More confidently choose among ADHD medications and troubleshoot common side effects or concerns related to ADHD medications.
  - Improve quality of care and patient satisfaction by having more treatment options for patients with ADHD.
  - Overcome certain barriers to care for patients with ADHD by navigating insurance formularies, manufacturer rebates/coupons, and other tools that can reduce drug costs for patients.

Volume 144, Issue 4
October 2019

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Article Contents

FROM THE AMERICAN ACADEMY OF PEDIATRICS | CLINICAL PRACTICE GUIDELINE | OCTOBER 01 2019

Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

Mark L. Wolraich, MD, FAAP; Joseph F. Hagan, Jr, MD, FAAP; Carla Allan, PhD; Eugenia Chan, MD, MPH, FAAP; Dale Davison, MSpEd, PCC; Marian Earls, MD, MTS, FAAP; Steven W. Evans, PhD; Susan K. Flinn, MA; Tanya Froehlich, MD, MS, FAAP; Jennifer Frost, MD, FAAFP; Joseph R. Holbrook, PhD, MPH; Christoph Ulrich Lehmann, MD, FAAP; Herschel Robert Lessin, MD, FAAP; Kymika Okechukwu, MPA; Karen L. Pierce, MD, DFAACAP; Jonathan D. Winner, MD, FAAP; William Zurhellen, MD, FAAP; SUBCOMMITTEE ON CHILDREN AND ADOLESCENTS WITH ATTENTION-DEFICIT/HYPERACTIVE DISORDER

Address correspondence to Mark L. Wolraich, MD, FAAP. Email: mark-wolraich@ouhsc.edu

POTENTIAL CONFLICT OF INTEREST: All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the American Academy of Pediatrics board of directors. Dr Allan reports a relationship with ADDitude Magazine; Dr Chan reports relationships with TriVox Health and Wolters Kluwer; Dr Lehmann reports relationships with International Medical Informatics Association, Springer Publishing, and Thieme Publishing Group; Dr Wolraich reports a Continuing Medical Education trainings relationship with the Resource for Advancing Children's Health Institute; the other authors have indicated they have no potential conflicts of interest to disclose.

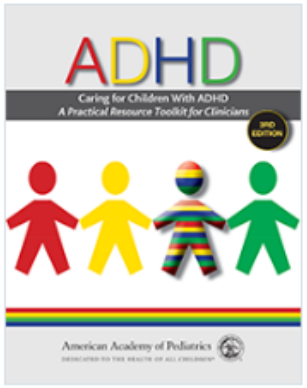
FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

Pediatrics (2019) 144 (4): e20192528.
https://doi.org/10.1542/peds.2019-2528

Connected Content

This is a revision to: ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

This is a revision to: Clinical Practice Guideline: Diagnosis and Evaluation of the Child With Attention-



‹ Prev Next ›

ADHD – Caring for Children With ADHD: A Practical Resource Toolkit for Clinicians (3rd Edition)

By
William Zurhellen, MD, FAAP;
Herschel R. Lessin, MD, FAAP;
Eugenia Chan, MD, MPH, FAAP;
Carla Counts Allan, MS, PhD;
Mark Wolraich, MD, FAAP;

TOOLKIT CHAPTER

Systemic Barriers to the Care of Children and Adolescents with ADHD

DOI: https://doi.org/10.1542/9781610023627-1_05_Barriers
Published: 2019

Introduction

With its 2019 Clinical Practice Guideline, the American Academy of Pediatrics published a supplemental paper addressing, from a clinical and policy standpoint, barriers to high-quality care for children and adolescents who are being evaluated and/or treated for ADHD, and offering strategies for improvement. These barriers and strategies are summarized below.

Barrier: Limited Access to Care Because of Inadequate Developmental-Behavioral and Mental Health Care Training During Pediatric Residency and Other Clinical Training Programs and Shortages of Consultant Specialists and Referral Resources

There is an overall lack of adequate pediatric residency and other training programs for pediatric clinicians on developmental-behavioral and mental health conditions, including ADHD.

Key Action Statement 4

- ADHD is a chronic condition; therefore, the PCC should manage children and adolescents with ADHD in the same manner that they would children and youth with special health care needs, following the principles of the chronic care model and the medical home.
    - No significant change from 2011

CONNECTIONS HATTIESBURG CLINIC

ADHD Long Term Prognosis

- Chronic course
  - 50-60% of children continue with ADHD in adulthood
  - 75% of adolescents continue with ADHD into adulthood

- Acknowledge positive traits/strengths
  - Curiosity (inattention)
  - Energetic (hyperactivity)
  - Creative/spontaneous (impulsive)

ADHD Long Term Prognosis

- More likely to have motor vehicle crashes and lose driving license
  - Stimulant meds improve driving performance
- Poorer academic outcomes
  - Less schooling completion, lower achievement scores, more course failures
- More likely to be unemployed or have poor job performance

Why treat ADHD?

- More likely to have lower self esteem
  - More anxiety and depression
- May have increased risk for substance abuse
  - Some studies show stimulants are protective

CONNECTIONS HATTIESBURG CLINIC

Why treat ADHD?

Friction between the child and parents, teachers and peers

- Difficulty making and keeping friends
- Tension between parents – marital problems for parents
- Losing shoes, coats, etc.

Greater risk for intentional and unintentional injury

- Stimulant meds may be preventive

CONNECTIONS HATTIESBURG CLINIC

Why treat ADHD?

- Quantifying the Protective Effects of Stimulants on Functional Outcomes in Attention-Deficit/Hyperactivity Disorder: A Focus on Number Needed to Treat Statistic and Sex Effects
- Joseph Biederman, M.D. Maura DiSalvo, M.P.H.Ronna Fried, Ed.D.K. Yvonne WoodworthItai Biederman, M.B.A.Stephen V. Faraone, Ph.D.
- Published:July 23, 2019DOI:https://doi.org/10.1016/j.jadohealth.2019.05.015

- "Our study documents that early treatment with stimulant medication has very strong protective effects against the development of serious, ADHD-associated functional complications like mood and anxiety disorders, conduct and oppositional defiant disorder, addictions, driving impairments and academic failure," says Joseph Biederman, MD, chief of the Pediatric Psychopharmacology and Adult ADHD Program at MGH and MassGeneral Hospital for Children.

CONNECTIONS HATTIESBURG CLINIC

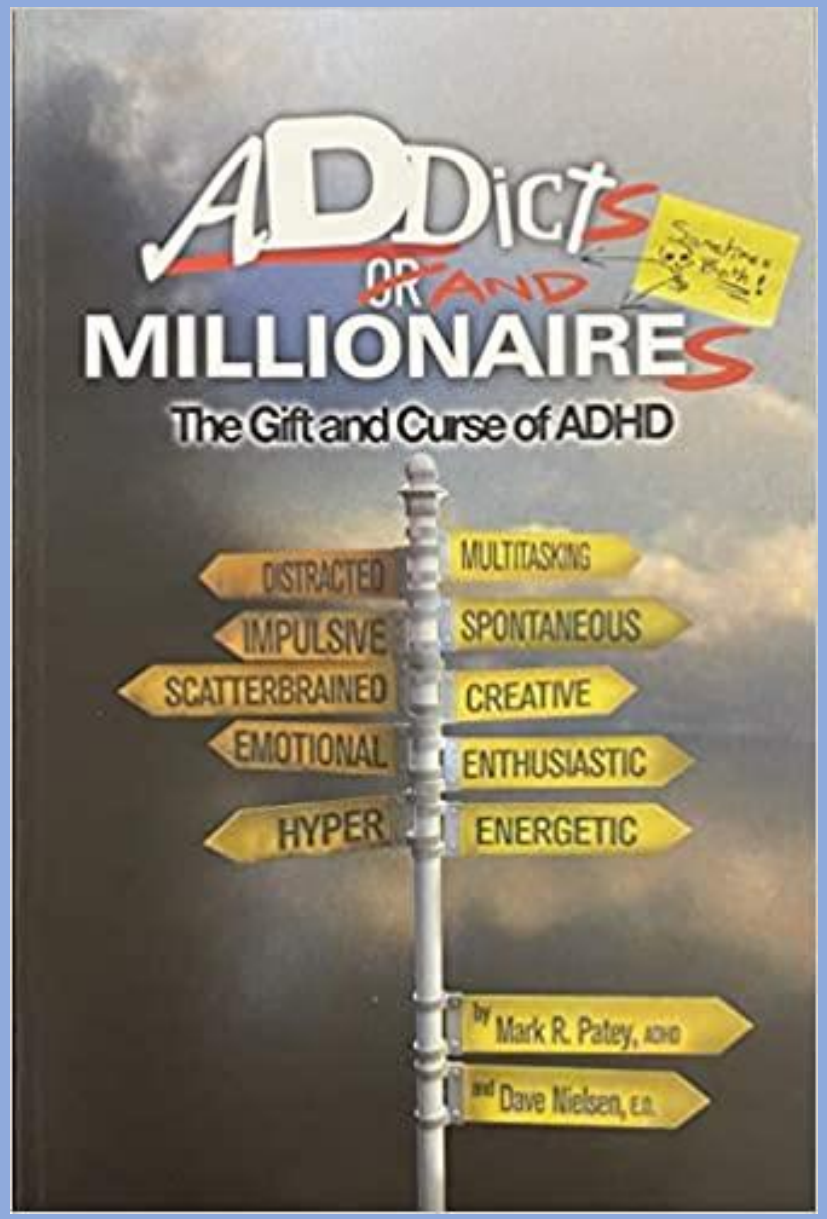
Why treat ADHD?

- Study (continued from previous slide) calculated protective effects of stimulant medication for children/teens:

- 3 participants with ADHD needed to be treated to prevent 1 from repeating a grade or developing conduct disorder, anxiety disorders or oppositional-defiant disorder.
- 4 participants with ADHD needed to be treated to prevent 1 from developing major depression or experiencing an accident during the driving simulation.
- 5 participants with ADHD needed to be treated to prevent 1 from developing bipolar disorder, 6 to prevent 1 from smoking cigarettes, and 10 to prevent 1 from developing a substance use disorder.

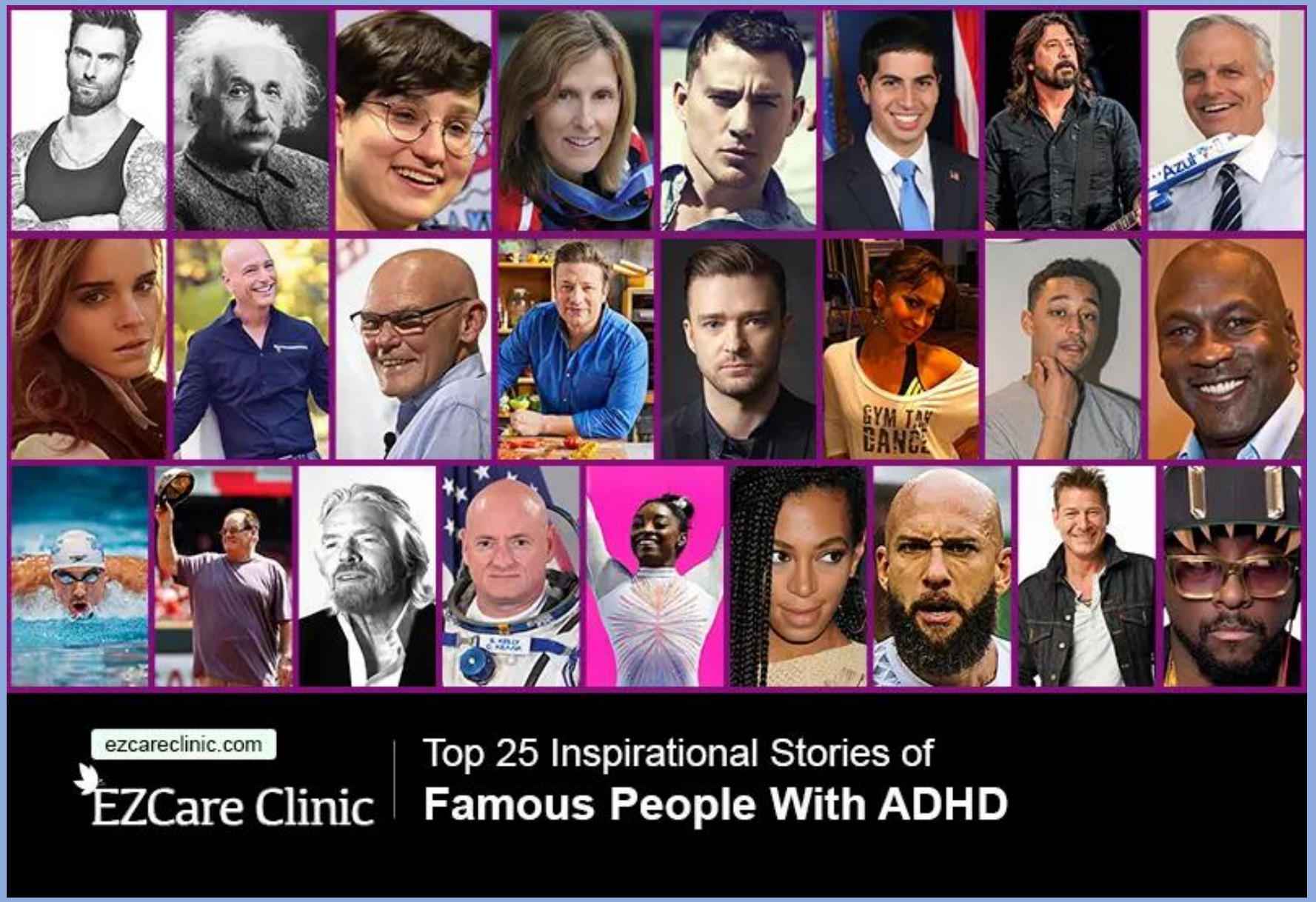
CONNECTIONS
HATTIESBURG CLINIC

ADHD Long Term Prognosis



CONNECTIONS
HATTIESBURG CLINIC

ADHD Long Term Prognosis



Key Action Statement 5: ADHD Treatment

- Age 4 - 5:
  - Parent training in behavior management (PTBM) first line Tx
  - Consider Methylphenidate (MPH) if needed
- Age 6 - 11:
  - FDA approved med first line (preferably stimulant)
  - Med plus PTBM and/or behavioral classroom interventions (preferably both)
- Age 12 – 18:
  - FDA approved med first line **with teen's assent**
  - Behavioral and/or training interventions if available

Key Action Statement 5

- No significant change from 2011

KAS 5a: For preschool-aged children (age 4 years to the sixth birthday) with ADHD, the PCC should prescribe evidence-based PTBM and/or behavioral classroom interventions as the first line of treatment, if available.

Methylphenidate may be considered if these behavioral interventions do not provide significant improvement and there is moderate-to-severe continued disturbance in the 4- through 5-year-old child's functioning. In areas in which evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication before the age of 6 years against the harm of delaying treatment.

KAS 5b. For elementary and middle school-aged children (age 6 years to the 12th birthday) with ADHD, the PCC should prescribe FDA-approved medications for ADHD, along with PTBM and/or behavioral classroom intervention (preferably both PTBM and behavioral classroom interventions). Educational interventions and individualized instructional supports, including school environment, class placement, instructional placement, and behavioral supports, are a necessary part of any treatment plan and often include an IEP or a rehabilitation plan (504 plan).

KAS 5c. For adolescents (age 12 years to the 18th birthday) with ADHD, the PCC should prescribe FDA-approved medications for ADHD with the adolescent's assent. The PCC is encouraged to prescribe evidence-based training interventions and/or behavioral interventions as treatment of ADHD, if available. Educational interventions and individualized instructional supports, including school environment, class placement, instructional placement, and behavioral supports, are a necessary part of any treatment plan and often include an IEP or a rehabilitation plan (504 plan).

ADHD Treatments

- Non-pharmacologic treatments
  - Behavior therapy
    - **Parent training in behavior management (PTBM) recommended by American Academy of Pediatrics (AAP) as first-line for preschoolers**
  - Education and training
    - Home/family routines
    - Extra help at school
    - Organizational skills training for older kids/teens
  - Lifestyle optimization
    - Sleep, nutrition, exercise, etc.

ADHD Treatments

- FDA Approved Medications:
  - **Stimulants: recommended by AAP as first line for school-age children 6 years old and up** (with or without behavior therapy).
    - Immediate release (shorter duration)
    - Extended release (longer duration)
  - Non-stimulants
    - Work differently; can take weeks to see optimal effects
    - Can be taken along with stimulants

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Benefits of ADHD Medications

- Sustained and improved focus
- Less impulsivity
- Improved mood
- Greater attention to detail
- Better memory

Stimulant medications

- Methylphenidate and amphetamine formulations
  - Used to treat ADHD since the 1960s.
- Primary target neurotransmitter is dopamine
  - key role in attention and motivation.
  - helps in controlling emotional responses.
- Effective in reducing symptoms in 70-80% of those with ADHD
- Optimal dose not determined by age, weight, or severity of symptoms
  - Efficacy and tolerability

Non-stimulant medications

- Designed for 24 hour duration
- Gradual onset of action
- Side effects usually mild and transient
  - e.g. somnolence, nausea, fatigue, dizziness, etc.
- Good option when stimulants not tolerated
- Often used + stimulant

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Non-stimulant Medications

- Different mechanism of action and side effects than stimulants.
  - Atomoxetine (SNRI)
  - Viloxazine (SNRI)
  - guanfacine (Alpha-2 agonist)
  - clonidine (Alpha-2 agonist)
- Primarily Increase brain activity of or mimic effects of norepinephrine.
  - neurotransmitter linked to attention and mood
  - Effectiveness < stimulants
  - may take 2-6 weeks to show effectiveness

CONNECTIONS HATTIESBURG CLINIC

Guanfacine

- Extended release (Intuniv) FDA approved for ADHD ages 6-17
  - Generic available: 1,2,3,4 mg tabs- must be swallowed
  - Once daily dose
- Immediate release (Tenex) FDA approved for HTN in adults
  - Studied and used successfully off label for ADHD and Tics in children
  - Generic available: 1,2 mg tabs- can be halved, chewed/crushed
  - Recommended bid-tid dosing

- *Strange BC. Once-daily treatment of ADHD with guanfacine: patient implications. Neuropsychiatr Dis Treat. 2008 Jun;4(3):499-506. doi: 10.2147/ndt.s1711. PMID: 18830439; PMCID: PMC2526381.*

Guanfacine Immediate Release (Tenex)

- Off label Tx option for younger children with ADHD
- Consider for younger kids with significant hyperactivity/impulsiveness
  - +/- stimulant Tx
- Does not usually affect appetite
- May also help tics and sleep onset
  - May increase sleepwalking, dreams, bedwetting, etc.
- Main side effect is sedation- often improves with time
  - Dose can be reduced/spaced if needed
  - Monitor HR/BP
- Titrate upward as follows with 1 mg tab:
  - 1/2 tab q evening x 3 nights; 1/2 tab bid x 1 week; 1/2 tab q a.m. + 1 tab q p.m. x 1 week;1 tab bid.
  - hold dose at optimal benefits/side effects; can continue up to 2 mg bid if needed

Criteria for initiation of pharmacotherapy in children with ADHD

Diagnostic assessment is complete and confirms diagnosis of ADHD
Child is age 4 years or older*
Caregivers accept medication as a contribution to management
School will cooperate in administration and monitoring¶
No previous sensitivity to the chosen medication
Child has normal heart rate and blood pressure
Child has no known cardiac risk factors
Child does not have a significant comorbid condition such as seizures, tics, depression, or anxiety△
Substance abuse and stimulant misuse/diversion among household members are not a concern (for children who will be treated with immediate-release stimulants)◇

* Primary care clinicians may wish to consult a specialist for medication management of children age 4 to 5 years.

¶ It is not safe to permit the child or adolescent to take their own medication to school.

Δ Primary care clinicians may wish to consult with a specialist for management of children with ADHD complicated by comorbid conditions.

◇ Nonstimulants, osmotic release methylphenidate, the methylphenidate patch, and prodrug stimulant formulations are alternatives to immediate-release or more easily abusable stimulant preparations for children who live in households where substance abuse, diversion, and misuse are a concern.

Adapted from: Hill T, Taylor E. An auditable protocol for treating attention deficit/hyperactivity disorder. Arch Dis Child 2001; 84:404.

Updated with information from:

1. *Wolraich ML, Hagan JF Jr, Allan C, et al. Clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. Pediatrics 2019; 144: e20192528.*

CONNECTIONS HATTIESBURG CLINIC

ADHD Medication Prerequisites

- Document baseline height, weight, blood pressure, & heart rate
- Pretreatment baseline for common ADHD med side effects
  - appetite, sleep pattern, headaches, abdominal pain, tics
  - h/o sleep problems does not predict stimulant-related sleep problems and may actually improve with stimulant Tx
- Adolescent patients should be assessed for substance use or abuse
  - should undergo evaluation and treatment for addiction before treatment for ADHD (if possible)

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Pretreatment Education Visit

- Acceptance of med by child/teen improves long term adherence
- Discuss potential benefits/goals of successful ADHD medication
  - Daily symptom/functional improvements and long term progress/goals
- Discuss potential risks/side effects
  - Appetite/weight, sleep, tics, mood, etc.
- Explain process of med dose titration and frequency of f/u
  - In person vs. telehealth visits, communication via phone calls/messages
  - f/u questionnaires for teachers, forms for school, etc.

ADHD Meds: Choice of Agent

- Duration of desired coverage
  - homework or driving may require coverage into evening
- Time of day when the target symptoms occur
- Preference of the child/adolescent and their caregiver or guardian
- Expense/insurance coverage/availability
- Ability of the child to swallow pills or capsules
- Desire to avoid administration at school

ADHD Meds: Choice of Agent

- Potential adverse effects
- H/o substance abuse in pt. or household
  - avoid stimulants or use stimulants with less potential for abuse
- Coexisting emotional or behavioral condition
  - Consider alpha-2 agonist if over-aroused, easily frustrated, highly active, or aggressive
- Coexisting tic disorder
  - Consider alpha-2 agonist

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Stimulants vs. Non-stimulants

- Stimulants have larger treatment effect size and have long record of safety and efficacy
  - Positive response rate for children/teens to a given stimulant is ~ 70%
  - ~ 80% will have positive response if stimulants tried systematically
- Stimulants have shown significant improvement in multiple domains:
  - ADHD core symptoms
  - caregiver-child interactions
  - aggressive behavior
  - academic productivity and accuracy
- Stimulant benefits limited to duration of action during the day
  - Non-stimulant benefits available 24 hr.

Methylphenidate (MPH) vs. Amphetamine (AMP)

- MPH more tolerable than AMP in children/teens
  - AAP guidelines make no preference
  - England's National Institute for Health and Care Excellence (NICE) ADHD guidelines recommend MPH first line for children/teens
- AMP slightly more efficacious than MPH in children/teens
  - Consider AMP if MPH not effective/tolerated
  - Consider if h/o positive response to AMP in close family member

Stimulant Duration of Action

- Long acting stimulant in a.m. best for most students
  - Most help for 8-12 hr.
  - Usually avoids med dosing during school day
  - Improves medication consistency/adherence
  - Less risk for diversion
- Short acting stimulant often used in after school hours to help with homework or other activities
  - Duration 3-5 hr.

ADHD Medication Guide*

Revised: September 1, 2023

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Methylphenidate Formulations – Long Acting, Oral** (Capsules and tablets in this section are shown at actual size)

Concerta®†	6-12 Yrs: 18-54mg; SD: 18mg 13-17 Yrs: 18-72mg; SD: 18mg ≥18 Yrs: 18-72mg; SD: 18mg or 36mg	G 18mg	G 27mg	G 36mg	G 54mg	Methylphenidate ER (bioequivalent to corresponding Concerta dosing)	G 45mg	G 63mg	G 72mg
Focalin® XR‡ (dexmethylphenidate)	6-17 Yrs: 5–30mg; SD: 5mg 18 Yrs-Adult: 5–30mg; SD: 5mg (biphasic – 50/50)	G 5mg		G 10mg	G 15mg	G 20mg; G 25mg	G 30mg	G 35mg	G 40mg
Cotempla XR-ODT®¶ (grape flavor)	6-17 Yrs: 8.6–51.8mg; SD: 17.3mg	8.6mg		17.3mg	25.9mg	34.6mg	51.8mg		
Aptensio® XR‡	6 Yrs–Adult: 10–60mg; SD: 10mg (biphasic – 40/60)	G 10mg	G 15mg	G 20mg	G 30mg	G 40mg; G 50mg	G 60mg		
Quillivant XR® 25mg/5mL (5mg/mL) (banana flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg	10mg 2mL; 1 Bottle: 300mg 60mL		20mg 4mL; 1 Bottle: 600mg 120mL	30mg 6mL; 1 Bottle: 900mg 180mL	40mg 8mL; 2 Bottles: 600mg 120mL	50mg 10mL; 2 Bottles: 750mg 150mL	60mg 12mL; 2 Bottles: 900mg 180mL	
QuilliChew ER®§ (cherry flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg (biphasic – 30/70)			20mg	30mg	40mg			
Ritalin® LA‡	6-12 Yrs: 10–60mg; SD: 20mg (biphasic – 50/50)	G 10mg		G 20mg	G 30mg	G 40mg		G♦ 60mg	
Metadate® CD‡	6-17 Yrs: 10–60mg; SD: 20mg (biphasic – 30/70)	G 10mg		G 20mg	G 30mg	G♦ 40mg	G 50mg	G♦ 60mg	
Metadate® ER†	6 Yrs-Adult: 20–60mg; SD: 20mg	G♦ 10mg		G 20mg					

Methylphenidate Pro-Drug Formulations - Long Acting, Oral** (Medications in this section are shown at actual size)

Azstarys®? (dexmethylphenidate + serdexmethylphenidate)	6-12 Yrs: 26.1/5.2 – 52.3/10.4; SD: 39.2/7.8 mg; 13 Yrs – Adult: 39.2/7.8 – 52.3/10.4; SD: 39.2/7.8mg	26.1mg SDX / 5.2mg d-MPH	39.2mg SDX/ 7.8mg d-MPH	52.3mg SDX/ 10.4mg d-MPH	

Methylphenidate Formulations – Long Acting/Delayed Onset, Oral** (Medications in this section are shown at actual size)

Jornay PM®‡	6 Yrs–Adults: 20–100mg (dosed in the evening); SD: 20mg	20mg	40mg	60mg	80mg	100mg

Methylphenidate Formulations – Short Acting, Oral** (Medications in this section are shown at actual size)

Focalin® (dexmethylphenidate)	6–17 Yrs: Daily: 5–20mg, divided BID; SD: 2.5mg BID		G 2.5mg	G 5mg	G 10mg	
Ritalin®	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID		G 5mg	G 10mg	G♦ 20mg	
Methylphenidate Chewable§ (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID	G♦ 2.5mg	G♦ 5mg	G♦ 10mg		
Methylin® Solution (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID		G 5mg/5mL	G 10mg/5mL		

Methylphenidate Formulations - Long Acting, Transdermal

Daytrana®
6-17 Yrs: 10–30mg; SD: 10mg
(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)

30mg / 9 hrs ~ 1.5"x 3.9"
20mg / 9 hrs ~ 1.5"x 2.6"
15mg / 9 hrs ~ 1.5"x 1.9"
10mg / 9 hrs ~ 1.4"x 1.4"

Administration Key:

¶ Orally disintegrating tablet
† Must be swallowed whole
§ Chewable
¥ Can be mixed with yogurt, orange juice, or water
‡ Can open capsule and sprinkle medication on apple sauce
⁋ Can open capsule and sprinkle medication into water or onto apple sauce
⁝ Can open capsule and mix with apple sauce or yogurt

G Indicates a generic formulation is also available; generic products are not shown
G Indicates a generic (but NOT a branded) formulation is available

• View the latest version of the ADHD Medication Guide at www.ADHDMedicationGuide.com

♦**Discontinued ADHD Medications:** The following FDA-approved proprietary formulations are no longer available (though, in some cases, branded or generic equivalents are still available): Adhansia XR; Ritalin LA capsule (60mg); Metadate CD capsules (40mg, 60mg); Metadate ER tablet (10mg); Ritalin SR tablets (20mg); Methylin Chewable tablets (2.5mg, 5mg, 10mg); Dexedrine Spansules (5mg, 10mg); Dexedrine tablets (5mg, 10mg); DextroStat tablets (5mg, 10mg); LiquADD solution (5mg/5mL), and Cylert (pemoline).

Important Information: The age-specific dosing information listed for each medication reflects the FDA-approved prescribing information. "SD" refers to the FDA-recommended starting dose, which sometimes varies by age. Practitioners should refer to the full prescribing information for each medication. **Please note:** medications have been arranged on the ADHD Medication Guide for ease of display and visual comparison; dosing comparability cannot be assumed.

- Updated versions of the ADHD Medication Guide can be viewed at: www.ADHDMedicationGuide.com
- Laminated copies of the ADHD Medication Guide can be ordered on-line from the ADD Warehouse
- Contact Dr. Andrew Adesman with any comments or suggestions: ADHDMedGuide@Northwell.edu

Cohen Children's Medical Center
Northwell Health

http://www.adhdmedicationguide.com/

ADHD Medication Guide*

Revised: September 1, 2023

CONNECTIONS HATTIESBURG CLINIC

Amphetamine Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

Dyanavel® XR (d- & l-amphetamine sulfate)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg		5mg		10mg		15mg		20mg	
Dyanavel® XR (d- & l-amphetamine sulfate) 2.5mg/mL (bubblegum flavor)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg	2.5mg 1mL	5mg 2mL	7.5mg 3mL	10mg 4mL	12.5mg 5mL	15mg 6mL	17.5mg 7mL	20mg 8mL	
Mydayis®‡ (mixed amphetamine salts)	13–17 Yrs: 12.5–25mg; SD: 12.5mg Adults: 12.5-50mg; SD: 12.5mg	12.5mg		25mg		37.5mg		50mg		
Adzenys XR-ODT®¶ (d- & l-amphetamine) (orange flavor)	6–12 Yrs: 3.1–18.8mg; SD: 6.3mg 13–17 Yrs: 3.1–12.5mg; SD: 6.3mg Adults: 12.5mg		3.1mg	6.3mg	9.4mg	12.5mg	15.7mg	18.8mg		
Adzenys ER® (d- & l-amphetamine) 1.25mg/mL (orange flavor)	6–12 Yrs: 6.3–18.8mg; SD: 6.3mg 13–17 Yrs: 6.3–12.5mg; SD: 6.3mg Adults: 12.5mg		3.1mg 2.5mL	6.3mg 5mL	9.4mg 7.5mL	12.5mg 10mL	15.7mg 12.5mL	18.8mg 15mL		
Adderall XR®‡ (mixed amphetamine salts)	6–17 Yrs: 5–30mg; SD: 10mg Adults: 5-30mg; SD: 20mg (biphasic – 50/50)		G 5mg	G 10mg	G 15mg	G 20mg	G 25mg	G 30mg		
Dexedrine Spansule® (d-amphetamine sulfate)	6-17 Yrs: 10–60mg; SD: 5mg 1-2x/day		G◆ 5mg	G◆ 10mg	G 15mg					

Amphetamine Pro-Drug Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

Vyvanse®¥ (capsules) (lisdexamfetamine)	6 Yrs–Adults: 10–70mg; SD: 30mg	G 10mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg	G 70mg		
Vyvanse®§ (chewables) (lisdexamfetamine) (strawberry flavor)	6 Yrs–Adults: 10–70mg; SD: 30mg	G 10mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg			

Amphetamine Formulations - Long Acting, Transdermal

Xelstrym™ (d-amphetamine)
6-17 Yrs: 4.5–18mg; SD: 4.5mg
Adults: 9-18mg; SD: 9mg

(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)

Amphetamine Formulations – Short Acting, Oral** (Medications in this section are shown at actual size)

Evekeo® (d- & l- amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		5mg		10mg					
Evekeo® ODT (d- & l- amphetamine sulfate)	6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	5mg		10mg		15mg	20mg		
Zenzedi® (d-amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–16 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	G 5mg	7.5mg	G 10mg		G 15mg	G 20mg	G 30mg	
Adderall® (mixed amphetamine salts)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg	G 7.5mg	G 10mg	G 12.5mg	G 15mg	G 20mg	G 30mg	
ProCentra® (d-amphetamine sulfate) (bubblegum flavor)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg/5mL							

Non-Stimulants** (Medications in this section are shown at actual size)

Intuniv®† (guanfacine, extended release)	6–12 Yrs: 1-4mg; SD: 1mg 13–17 Yrs: 1-7mg; SD: 1mg Weight-based dosing: SD: 0.05-0.08 mg/kg/day; may increase to 0.12 mg/kg/day	G 1mg	G 2mg	G 3mg	G 4mg					
Kapvay®† (clonidine, extended release)	6–17 Yrs: 0.1-0.2mg BID; SD: 0.1mg qHS	G 0.1mg	(only in dose pack) 0.2mg							
Strattera®† (atomoxetine)	≤70kg: 0.5mg/kg x ≥3days, then 1.2mg/kg (max:1.4mg/kg, not to exceed 100mg) >70 kg: 40mg x ≥3days, then 80mg (max:100mg)	G 10mg	G 18mg	G 25mg	G 40mg	G 60mg	G 80mg	G 100mg		
Qelbree®‡ (viloxazine)	6–11 Yrs: 100-400mg; SD: 100mg 12–17 Yrs: 200-400mg; SD: 200mg Adults: 200-600mg; SD: 200mg	100mg	200mg	300mg +		400mg +				

http://www.adhdmedicationguide.com/

Key Action Statement 6

- 2019: The PCC should titrate doses of medication for ADHD to achieve maximum benefit with tolerable side effects.
    - No significant change from 2011

ADHD Medical Management

- “High bar" of expectations with ADHD medicine
  - •Goal is a "win-win“ with noticeable improvement and no significant side effects
  - •change plans when needed
- Start med at low dose and increase as needed
  - every 7-10 days for children
  - Every 3-5 days for older teens/adults

ADHD Medical Management

- Follow up soon after starting or changing medicine
  - Usually 2 - 3 weeks
- Regular visits to monitor weight, height and vital signs
  - feedback from the individual with ADHD
  - feedback from parents, teachers and others
- Follow up appointments spaced to every 3 months after medicine dosage optimized.
  - Telemedicine = improved communication/convenience

Treatment Failure on Stimulant

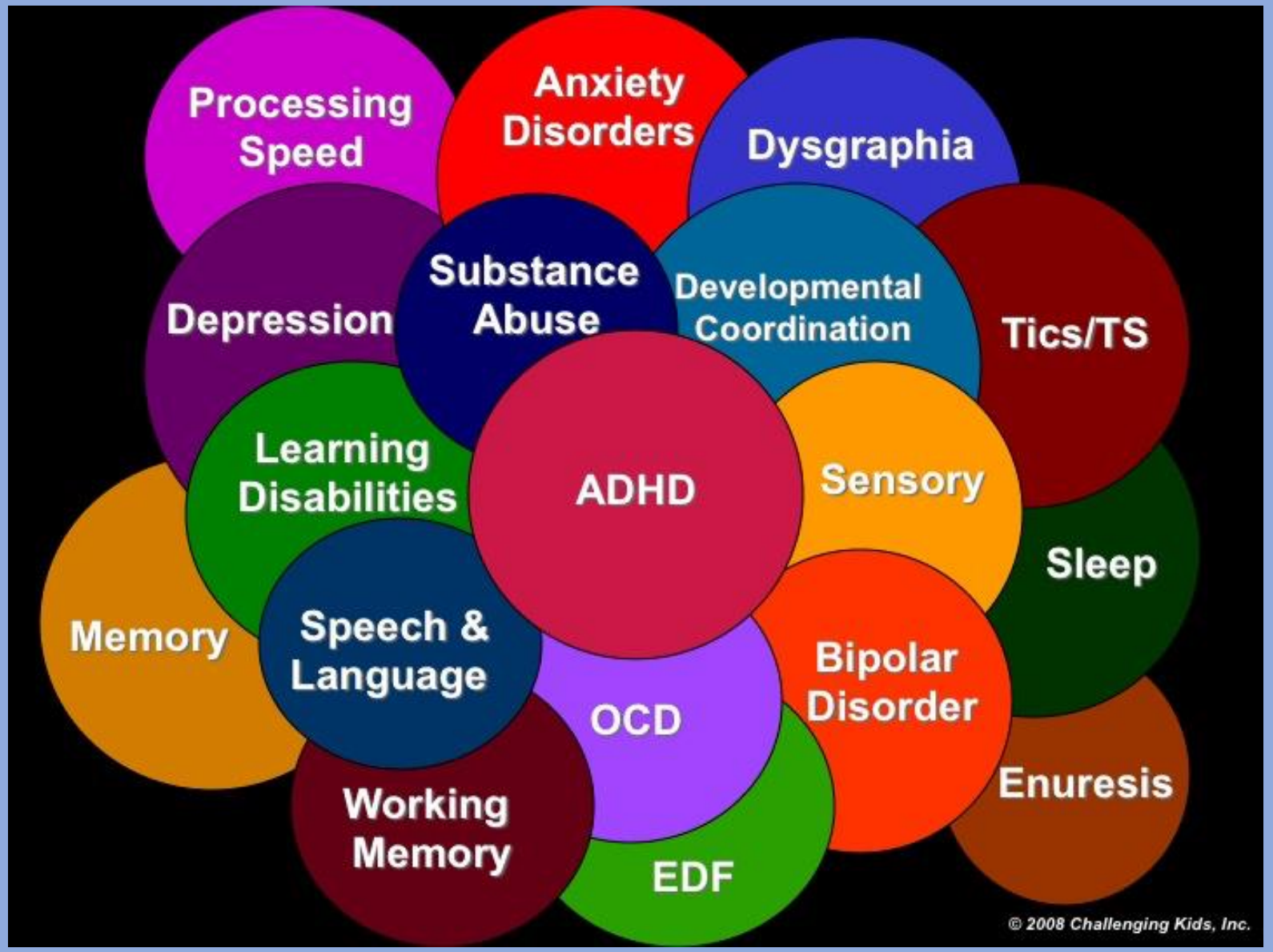
- Is dosage high enough?
- Adherence?
  - Check PDMP and growth chart
- Try different stimulant
- Consider adding or changing to non-stimulant

Key Action Statement 7 (NEW!)

- 2019: The PCC, if trained or experienced in diagnosing comorbid conditions, may initiate treatment of such conditions or make a referral to an appropriate subspecialist for treatment. After detecting possible comorbid conditions, if the PCC is not trained or experienced in making the diagnosis or initiating treatment, the patient should be referred to an appropriate subspecialist to make the diagnosis and initiate treatment.

ADHD Co-existing Conditions

CONNECTIONS
HATTIESBURG CLINIC



ADHD Stimulant Medication Shortage

- Increased demand since pandemic
  - Increased stresses on those previously not treated for ADHD
  - Increased access to care with relaxed restrictions
  - Over-diagnosing?
- Supply of ingredients limited by DEA?
- Manufacturing problems?

ADHD Stimulant Medication Shortage

- Duration?

- Affecting:
  - Adderall (mixed amphetamine salts) IR and XR generics
  - Ritalin (methylphenidate) brand and generics
  - Focalin (dexmethylphenidate) IR and XR generics
  - Concerta (methylphenidate HCl extended-release) generics
  - Metadate ER & CD (methylphenidate HCl extended-release) generics
  - possibly others

ADHD Stimulant Medication Shortage

- Brand Concerta and Adderall XR supply is available for now
  - Some pharmacies may not order/keep it
  - Insurance coverage can be obstacle

- MS DOM, MSCAN, CHIP programs say they will now cover brand name Concerta and Adderall XR due to shortages.

MISSISSIPPI DIVISION OF MEDICAID

MISSISSIPPI DIVISION OF MEDICAID
UNIVERSAL PREFERRED DRUG LIST

(For All Medicaid, MSCAN and CHIP Beneficiaries)

EFFECTIVE 10/01/2023
Version 2023
Updated:09/29/2023

CONNECTIONS HATTIESBURG CLINIC

Gainwell Technologies' DUR+ process is a proprietary electronic prior authorization system used for Medicaid fee for service claims. MSCAN plans may/may not -have electronic PA functionality. However, they must adhere to Medicaid's PA criteria.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			• 1 claim for a 30-day supply with the requested agent in the past 105 days Documented diagnosis of narcolepsy – ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI
	LONG-ACTING		
	ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER CONCERTA (methylphenidate) dexmethylphenidate ER dextroamphetamine ER DYANAVEL XR SUSPENSION(amphetamine) lisdexamfetamine (generic Vyvanse) lisdexamfetamine (generic Vyvanse Chewable) methylphenidate CD (generic Metadate CD) methylphenidate ER (generic Concerta) methylphenidate ER Tabs (generic Ritalin SR) methylphenidate ER/LA Caps (generic Ritalin LA) QUILLICHEW (methylphenidate) QUILLIVANT XR (methylphenidate)	ADHANSIA XR (methylphenidate) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSPENSION (amphetamine) amphetamine susp 24 hr (generic ADZENYS ER) APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphen/dexmethylphen) COTEMPLA XR-ODT (methylphenidate) DAYTRANA (methylphenidate) DEXEDRINE (dextroamphetamine) DYANAVEL XR tablet(amphetamine) FOCALIN XR (dexmethylphenidate) JORNAY PM (methylphenidate) methylphenidate ER caps (generic Aptensio XR) methylphenidate ER (generic Relexxi) methylphenidate patch (generic Daytrana) MYDAYIS (amphetamine salt combination) RELEXXI (methylphenidate)	**Minimum Age Limit** • **6 years –** Adderall XR, Adhansia XR, Adzenys ER Suspension, Adzenys XR ODT, Aptensio XR, Azstarys, Concerta, Cotempla XR ODT, Daytrana, Dexedrine, Dyanavel XR Focalin XR, Jornay PM, Metadate, CD, methylphenidate ER 72mg, Quillichew, Quillivant XR, Relexxii, Ritalin LA, Vyvanse, Xelstrym • **13 years –** Mydayis • **16 years –** Provigil • **18 years –** Nuvigil, Sunosi **Maximum Age Limit** • **18 years –** Cotempla XR ODT, Daytrana

Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

PREFERRED BRANDS will not count toward the two brand monthly Rx limit.

Drugs highlighted in yellow denote a change in PDL status.

An * denotes existing users will be grandfathered; grandfathering is defined as approving a Non-Preferred agent for an existing user; all other changes will not qualify for grandfathering.

A # denotes existing users will NOT be grandfathered.

To search the PDL, press CTRL + F

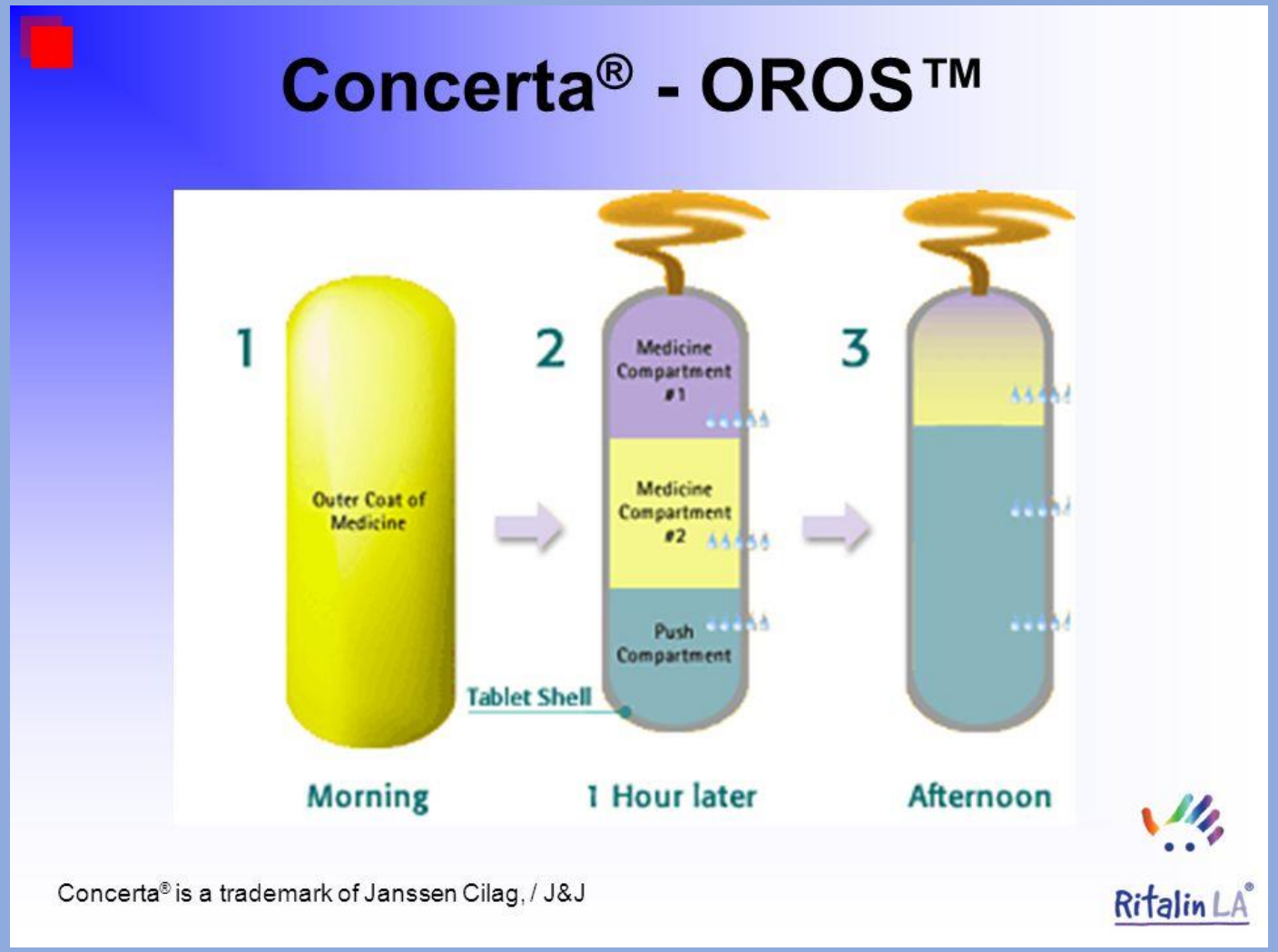
www.medicaid.ms.gov/preferred-drug-list/

Vyvanse (lisdexamfetamine) Update

CONNECTIONS HATTIESBURG CLINIC

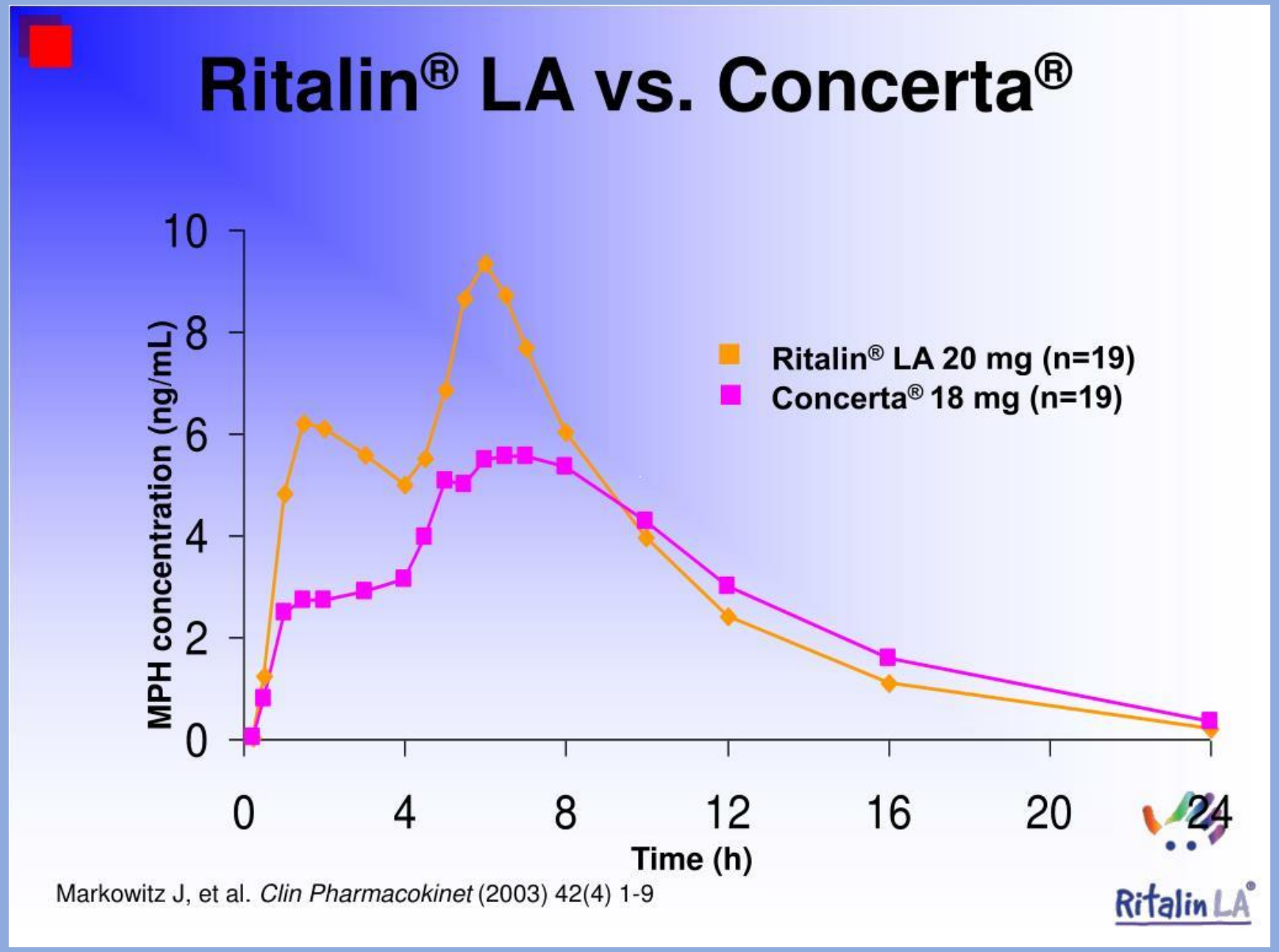
- 14 companies may now manufacture and sell generic versions of Vyvanse capsules and chewable tablets, according to the FDA.

ADHD Stimulant Medication Shortage



CONNECTIONS
HATTIESBURG CLINIC

ADHD Stimulant Medication Shortage

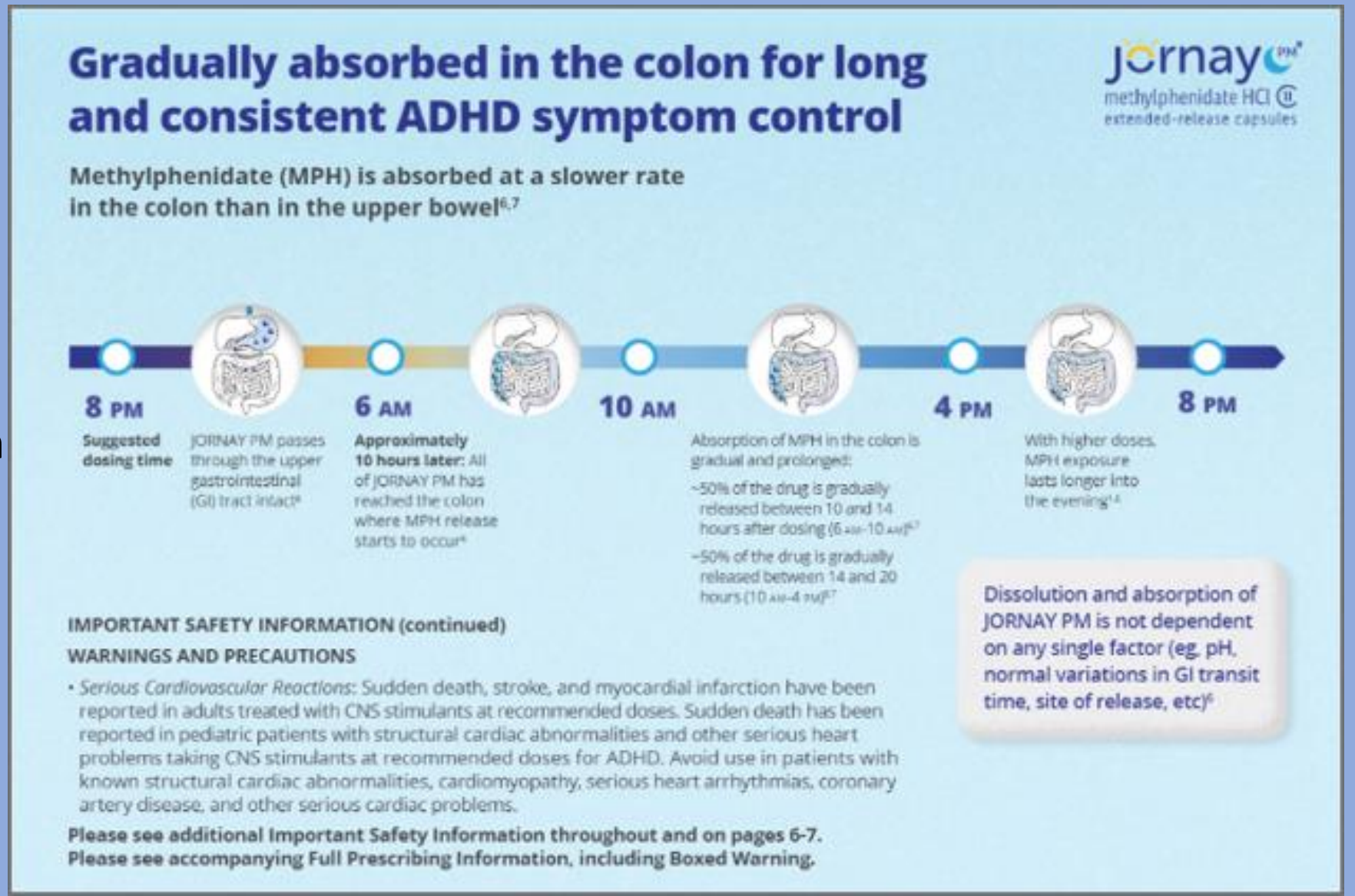


Newest stimulant medications

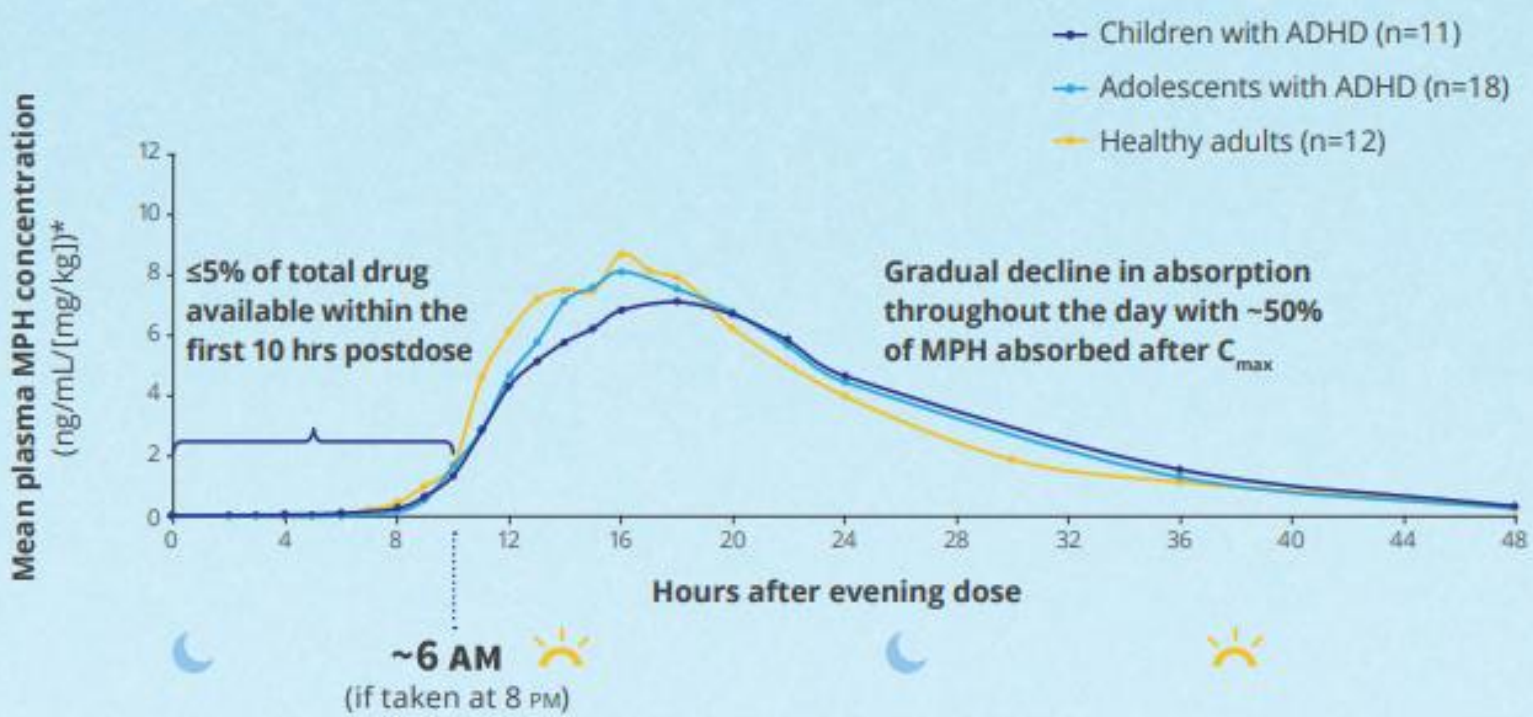
- **Jornay PM**:

  (Delayed release, extended-release Methylphenidate)

  - **Taken in the evening.**
  - Effective by time of awakening and through the rest of the day.



Jornay PM
(Delayed release, extended-release Methylphenidate)



Based on multiple-dose simulations, accumulation of JORNAY PM was predicted to be negligible[8]

*Concentrations are dose–weight-normalized in healthy adults, adolescents with ADHD, and children with ADHD. Results based on a 54-mg oral dose of JORNAY PM administered in the evening at 9 PM. Dose–weight-normalized exposure was similar among all age groups.[6]

C_{max} occurs between noon and 2 PM (16–18 hours postdose).[6]

C_{max}, peak plasma concentration; PK, pharmacokinetic.

IMPORTANT SAFETY INFORMATION (continued)

Jornay PM
(Delayed release, extended-release Methylphenidate)

Optimizing dose and time of dosing

Your child's healthcare provider will likely start with 20 mg and may increase their dose to achieve continued efficacy through the evening. In clinical studies, most patients aged 6-12 had optimal efficacy at 60 mg or 80 mg.

JORNAY PM has a bioavailability of about 75%. This means that it cannot be substituted milligram-for-milligram with other methylphenidate products.[5]

Study 1 post hoc analysis—estimated ratio of JORNAY PM optimized dose and prior stable stimulant dose[6]

Prior ADHD Therapy[a]			Sample Size	Mean Prior Stimulant Dose (mg/day)	Mean Optimized JORNAY PM Dose (mg/day)	Mean Dose Ratio[b]
MPH	ER	OROS MPH	26	38	69	2.0
		d-MPH ER	10	18	62	4.3
		MPH CD	15	37	59	1.8
		MEROS	11	34	66	2.2
		MPH HCl ER	5	18	48	3.5
		ER MPH	2	15	40	3.0
AMP	ER	Lisdexamfetamine dimesylate	14	45	60	1.9
		MAS ER	3	20	80	4.0

[a]Included branded and generic formulations: **ADHD**, attention-deficit/hyperactivity disorder; **AMP**, amphetamine; **d-MPH ER**, dexmethylphenidate (Focalin XR®); **ER**, extended release; **MAS ER**, mixed amphetamine salts extended release (Adderall XR®); **MEROS**, methylphenidate extended-release oral suspension (Quillivant XR®); **MPH**, methylphenidate; **MPH CD**, methylphenidate controlled-release delivery (Metadate CD®); **MPH HCl ER**, methylphenidate hydrochloride extended release (Ritalin LA®); **OROS MPH**, osmotic release oral system methylphenidate (Concerta®).

[b]The mean dose ratio for each prior therapy was the average of individual dose ratios.

Post hoc analysis of a pivotal study (Pivotal Study 1) of JORNAY PM in ADHD patients aged 6-12 years (N=98) to compare prior ADHD medication dose and mean optimized dose of JORNAY PM at the end of the 6-week, open-label dose-optimization phase.[6]

Reassure your patients that they will likely optimize to a higher dose of JORNAY PM than their previous methylphenidate due to its unique qualities[5]

CONNECTIONS
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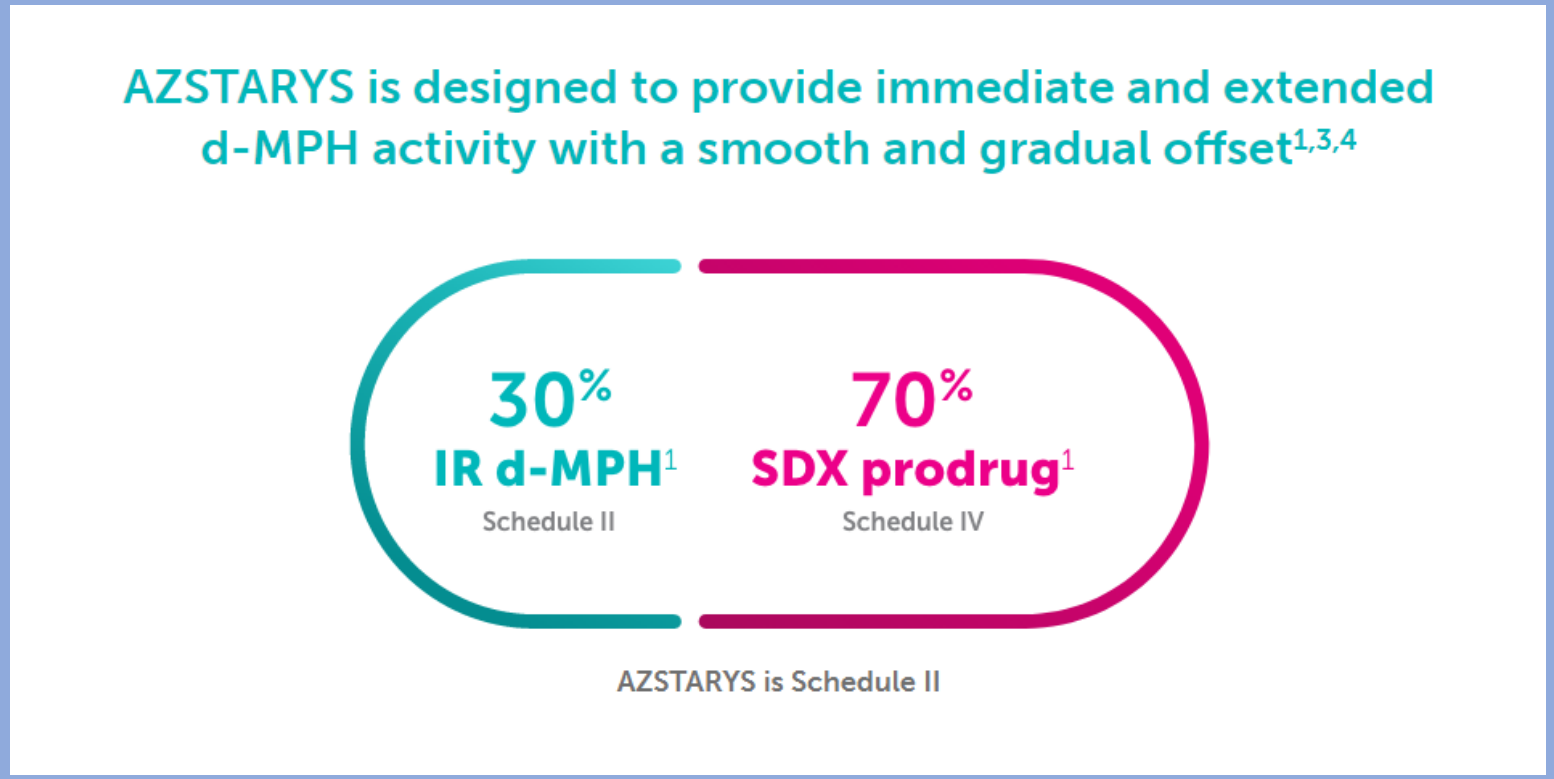
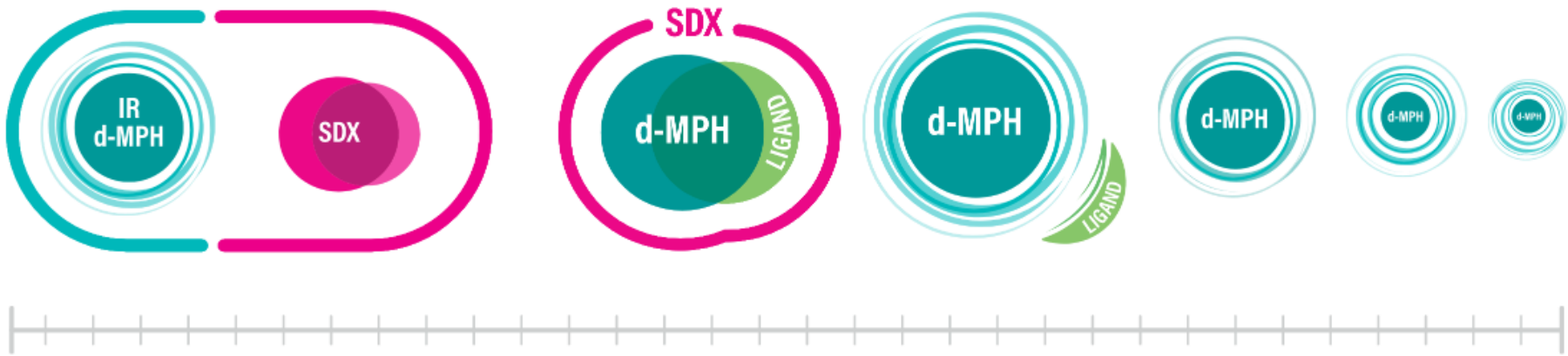
Newest stimulant medications

CONNECTIONS HATTIESBURG CLINIC

- **Azstarys**
  - 30% dexmethylphenidate/ 70% serdexmethylphenidate



Azstarys
(30% dexmethylphenidate/ 70% serdexmethylphenidate)



Rapid

d-MPH is immediately released.[1,4]

Bioactivation

SDX travels to the lower GI tract, where it is bioactivated.[1,5,6]

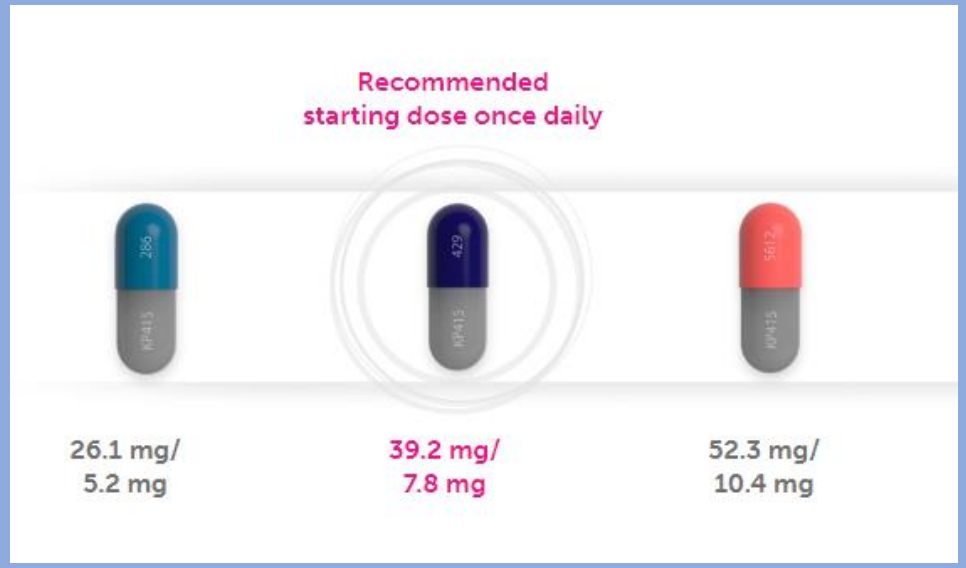
Using proprietary Ligand Activated Therapy® technology, SDX is converted to d-MPH.[4,5]

Continuous

The continuous conversion of d-MPH provides active drug throughout the day with a smooth and gradual offset.[1,3,4]

Azstarys

(30% dexmethylphenidate/ 70% serdexmethylphenidate)



Total d-MPH HCl from the IR d-MPH and SDX prodrug

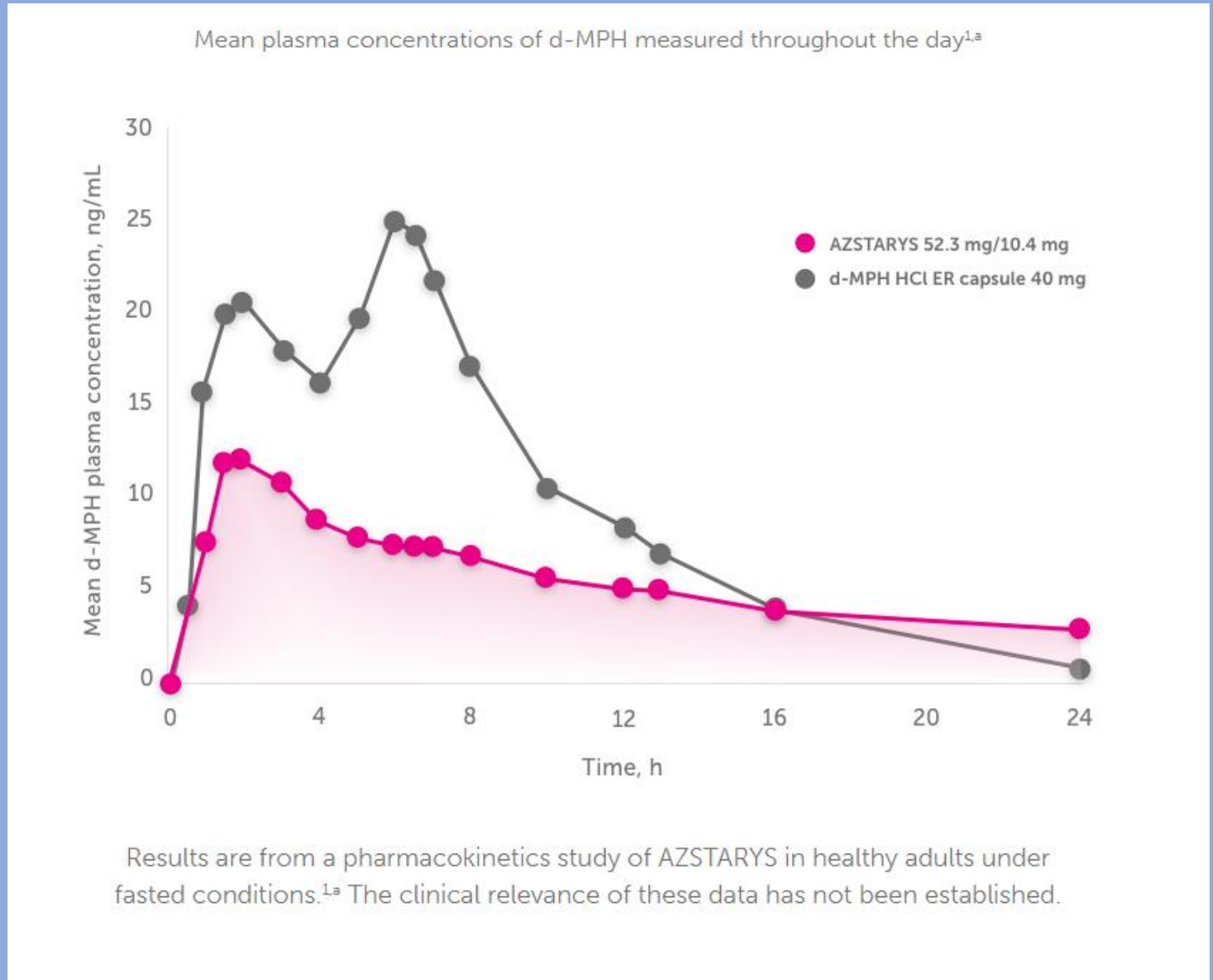
Recommended starting dose once daily

39.2 mg SDX | 7.8 mg IR d-MPH

AZSTARYS (SDX/d-MPH)	Total d-MPH HCl per dose: Combined molar dose over the day (d-MPH HCl)
26.1 mg/5.2 mg	20 mg
39.2 mg/7.8 mg	30 mg
52.3 mg/10.4 mg	40 mg

Azstarys

(30% dexmethylphenidate/ 70% serdexmethylphenidate)

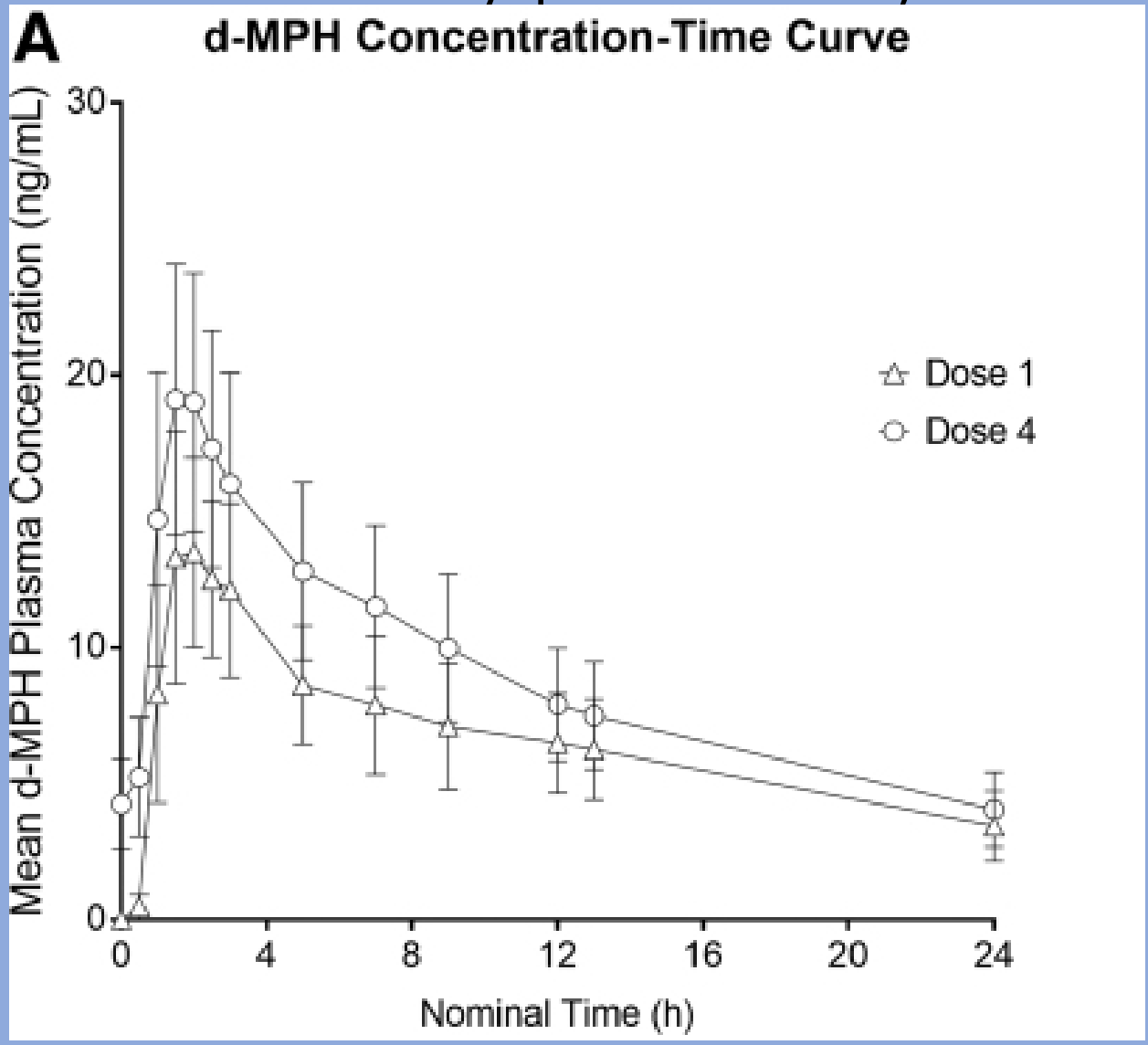


Azstarys

(30% dexmethylphenidate/70% serdexmethylphenidate)

- Plasma concentration–time curve (mean ± standard deviation) for **(A)** d-MPH and **(B)** SDX after 1 and 4 doses of Treatment D: 52.3/10.4 mg SDX/d-MPH, 40 mg total equivalent d-MPH HCl. *n* = 23. d-MPH, dexmethylphenidate; SDX, serdexmethylphenidate.

- Braeckman R, Guenther S, Mickle TC, Barrett AC, Smith A, Oh C. Dose Proportionality and Steady-State Pharmacokinetics of Serdexmethylphenidate/Dexmethylphenidate, a Novel Prodrug Combination to Treat Attention-Deficit/Hyperactivity Disorder. J Child Adolesc Psychopharmacol. 2022 Jun;32(5):288-295. doi: 10.1089/cap.2022.0015. Epub 2022 Jun 3. PMID: 35666231; PMCID: PMC9245728.



Newest non-stimulant medication

- Qelbree (viloxazine)

- Selective norepinephrine reuptake inhibitor (NRI)
- Approved to treat ADHD in adults and children 6 and older
- Extended release capsules (100, 150, 200 mg)
    - Can be opened and sprinkled into food
- 24 hr. Duration taken once daily

CONNECTIONS HATTIESBURG CLINIC

Qelbree (viloxazine)

- Immediate release form was approved in Europe from the 1974 until 2002 for treatment of depression
  - Recent research has shown effects on serotonin and dopamine systems which could explain improvements seen in depression and possibly anxiety.

IMPORTANT SAFETY INFORMATION

WARNING: SUICIDAL THOUGHTS AND BEHAVIORS

In clinical studies, higher rates of suicidal thoughts and behaviors were reported in patients with ADHD treated with Qelbree than in patients treated with placebo. Closely monitor all Qelbree-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors.

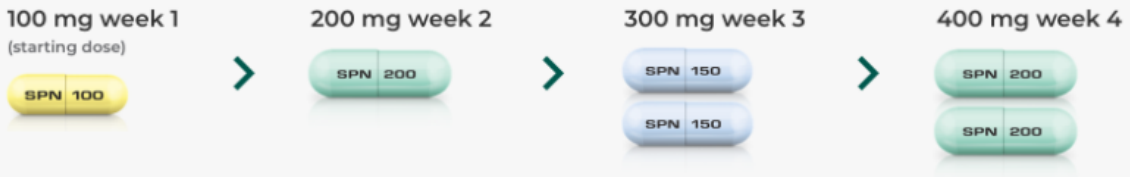
CONNECTIONS HATTIESBURG CLINIC

Qelbree (viloxazine)

Titrate weekly as needed to optimize ADHD symptom control[1,2]

Children 6 to 11[1]

100 mg week 1 (starting dose) → 200 mg week 2 → 300 mg week 3 → 400 mg week 4



Titrate Qelbree 100 mg/week over 1 to 3 weeks to reach effective dose.[1]

Adolescents 12 to 17[1]

200 mg week 1 (starting dose) → 400 mg week 2

Titrate Qelbree 200 mg/week over 1 week as needed to reach effective dose.[1]

Maximum dose for children and adolescents is 400 mg daily

Adults 18 and older[2]

200 mg week 1 (starting dose) → 400 mg week 2 → 600 mg week 3

Titrate Qelbree 200mg/week over 1-2 weeks as needed to reach an effective dose; maximum dose for adults is 600 mg daily.[1]

Maximum dose for adults is 600 mg daily

Helpful App for Insurance Coverage of Medications

App Store Preview

Open the Mac App Store to buy and download apps.

Coverage Search 4+

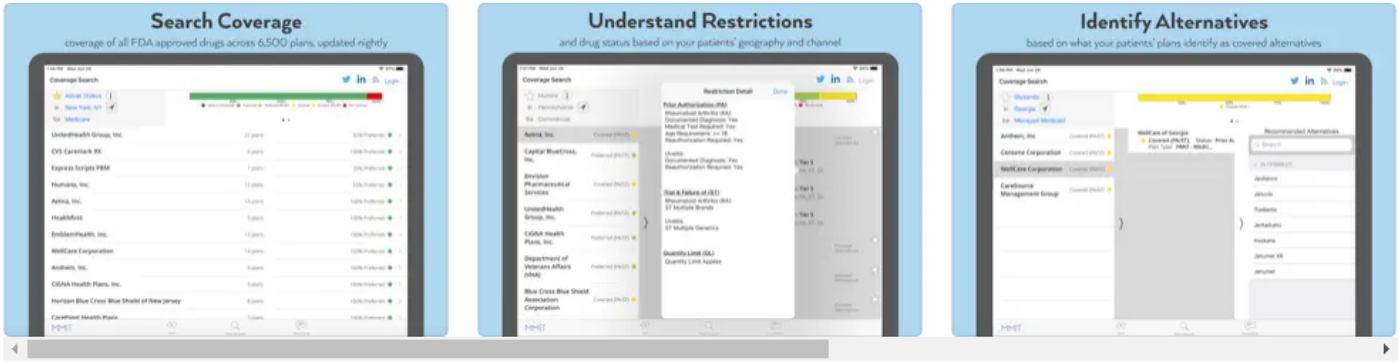
MMIT

Designed for iPad

★★★★★ 4.2 • 438 Ratings

Free

Screenshots iPad iPhone



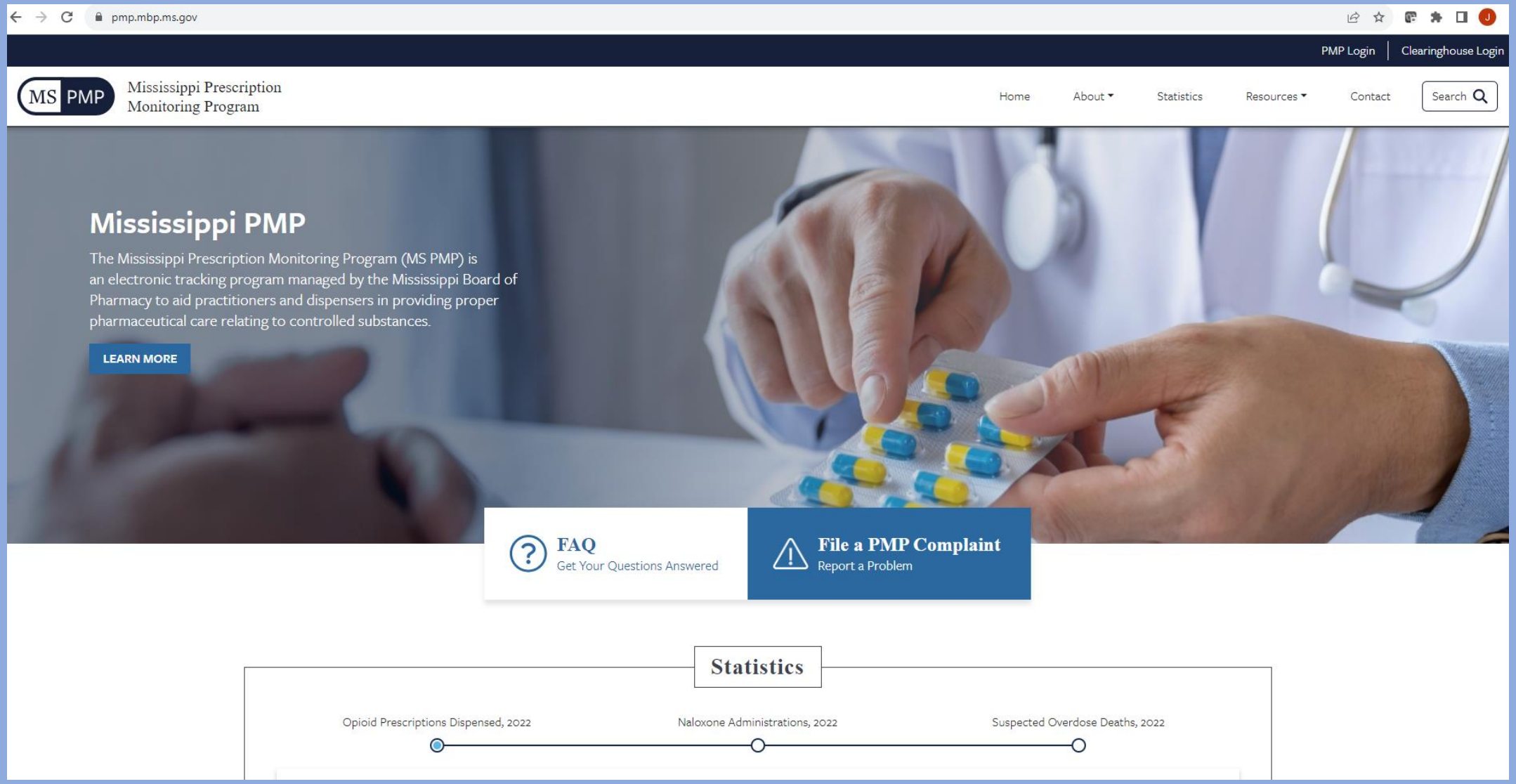
Your single source of reliable and current drug coverage and restriction information. "Need to know if that drug is covered? Are you a prescribing doc and want to select a preferred drug for your patient?" MMIT's drug status information is updated nightly, ensuring you have the data points needed to guide prescribing decisions for your patients. Quickly understand how every health plan and PBM covers all FDA approved medications in your geography. more

CONNECTIONS HATTIESBURG CLINIC

MS Prescription Monitoring Program (MS PMP)

CONNECTIONS HATTIESBURG CLINIC

www.pmp.mbp.ms.gov



CONNECTIONS HATTIESBURG CLINIC

MS Prescription Monitoring Program (MS PMP)

- Electronic tracking program managed by the MS Board of Pharmacy
- Online service available 24/7 that provides patient's controlled substance drug profile as well as prescriber and dispenser information.
- Tool for regulatory agencies and authorized law enforcement to identify potential inappropriate use of controlled substance prescription medication

CONNECTIONS HATTIESBURG CLINIC

MS Prescription Monitoring Program (MS PMP)

- Aids practitioners and dispensers in providing proper care relating to controlled substances.
- Helpful to monitor med adherence
- Useful to ensure correct dosage and formulation
  - Possible to integrate into EHR

ADHD medcalc™

taking your patients to peak performance

ADHD Medication Calculator/Converter

For Healthcare Professionals Only

CONNECTIONS HATTIESBURG CLINIC

	Current Medication	New Medication
Name:	Concerta (methylphenidate)	Focalin XR (dexmethylphenidate)
Dose:	36 mg	10mg
Duration Of Action:	8-12h, dosed qd	8-12h, dosed qd
Time to Peak Effect:	45-90 min	15-30 min
Recommended Starting Dose:	>6yo: 18mg , >18yo: 18-36mg	>6yo: 5mg, adults: 10mg
Titration Recommendation:	Increase weekly 18mg/day	>6yo: increase 5mg/day weekly, adult; increase 10mg weekly.
Maximum Recommended Dose:	6-13yo: 2mg/kg/day up to 54mg >13yo: 72mg	30mg child, 40mg adult
Off Label Maximum Dose:	< 40kg: 72mg , adolescent: 90mg , adult: 108mg	50mg
Dosage forms available:	18,27,36, 54	5,10, 15, 20,25, 30, 35, 40

How To Use

1. Read the Terms of Use
2. Choose your patient's existing medication (e.g. Adderall) in the left column
3. Enter your patient's current dosage
4. Choose your patient's new medication (e.g. Vyvanse) in the right column

Available on the iPhone App Store

ANDROID APP ON Google play

ADHD Medication Coupons/Discount Programs

- Cotempla XR-ODT (methylphenidate) and Adzenys XR-ODT (d,l-amphetamine)
  - https://aytubio.com/products/#ADHD
  - Patients with commercial insurance pay no more than $75 at any pharmacy, $50 at partner pharmacies

ADHD Medication Coupons/Discount Programs

- Quillivant XR (methylphenidate), Quillichew (methylphenidate) ER, Dyanavel XR (d,l-amphetamine sulfate)
  - https://coupon.trisadhd.com/
  - Commercially insured patients may pay as little $25.
  - Discount is capped; cost can be higher depending on insurance plan

ADHD Medication Coupons/Discount Programs

- Jornay PM (Delayed, extended release methylphenidate)
  - https://www.jornaypm-pro.com/#savings-and-support
  - Commercially insured patients pay $0 for first Rx
  - $25 or less for further Rx if insurance covers Jornay PM
  - $75 or less if insurance does not cover Jornay PM

ADHD Medication Coupons/Discount Programs

- Azstarys (30% dexmethylphenidate/ 70% serdexmethylphenidate)
  - https://www.azstarys.com/savings-and-support
  - Commercially insured patients pay $0 for first Rx
  - $25 or less for further Rx if insurance covers Azstarys
  - $50 or less if insurance does not cover Azstarys

ADHD Pharmacogenetics

- Genes have been identified that can affect how one responds to certain medications.
  - Primarily genes involving how drugs are metabolized

- Several companies offer genetic testing to help with selecting mental health medications.

ADHD Pharmacogenetics

- Goal is to decrease the need for trial and error when prescribing mental health medications.
  - Not uncommon try several doses and types of ADHD medication to find the right fit.

- Not enough evidence that genetic testing will help find “the right” ADHD medication
  - Majority of population are “normal” metabolizers; tests more helpful for the less common “outliers”

CONNECTIONS HATTIESBURG CLINIC

ADHD Pharmacogenetics

- Genetic tests are very expensive and often not covered by insurance
  - Other factors affect how medications work
  - age, sex, diet, lifestyle routines, other health conditions, other medications

- Not recommended for use in ADHD treatment guidelines by American Academy of Pediatrics (AAP) or other organizations.
  - Possible in the future depending on research findings
  - May be an option for some who have tried and failed multiple medications

Stimulants: Rare side effects

CONNECTIONS HATTIESBURG CLINIC

- weight loss
- increased anxiety
- social blunting/withdrawal
- slight delay in the rate of growth, but final height likely not affected
- heart problems in children with pre-existing heart defects

Stimulants: Common side effects

CONNECTIONS HATTIESBURG CLINIC

- Loss of appetite
- Sleep problems
- Body complaints – headache, stomachache, heart racing, dizziness, dry mouth, chest pain
- Moodiness – sadness or madness
- Tics

Managing Poor Appetite with Stimulants

- Take med at or after a meal
- Breakfast very important
  - protein and complex carbohydrates
- Calorie dense foods at meals and snacks
- Adjust eating schedule
  - Understand about lunch; go with times most hungry
- Possible medication
  - Cyproheptadine most common

Sleep problems on Stimulants

CONNECTIONS HATTIESBURG CLINIC

- No screen for one hour before bedtime – good reading time
- Good bedtime routine
- Possible white noise or soft music
- Limit sugar and caffeine after 4 PM
- Possible medication
- Consider decreasing duration of stimulant med

Moodiness on Stimulants

CONNECTIONS HATTIESBURG CLINIC

- Improve sleep, nutrition, exercise
- If throughout duration with no symptom improvement, increase dose
- If at peak time, lower dose or try longer acting med
- If in afternoon, add IR medication or increase dose
- Change medication type or mode of release
- Additional diagnosis?

Body Complaints on Stimulants

CONNECTIONS HATTIESBURG CLINIC

- Headaches or Dizziness
  - better nutrition, better sleep, more fluids
- Chest pain
  - take medication with food (not sugary)
  - GERD medication

Tics on Stimulants

- Patience
- Lower dose or different release mode
- Change medication type
- Add medication
  - e.g. guanfacine or clonidine

Common Concerns about Stimulants

- Long term side effects?
  - Growth
  - Cardiovascular
- Risk of addiction?
- Are generic medications OK?
- Can ADHD meds be taken during pregnancy?

Common Concerns about Stimulants

- Drug holidays?
  - Weekends/holidays/summers
- Can one develop tolerance to ADHD meds?
- Can I take other medications or drink alcohol?

Goals of treatment

- Appropriate academic performance
- Good self-esteem
- Improved Relationships
- Happy, healthy, productive adult

Helpful ADHD Resources

- AAP ADHD Guidelines
- www.uptodate.com/ADHD in children and adolescents: Treatment with medications
- www.adhdmedicationguide.com/
- www.chadd.org
- www.additudemag.com
- www.apsard.org

The REACH Institute

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The REsource for Advancing Children's Mental Health

REACH is a 501c3 non-profit organization dedicated to ensuring that the most effective, scientifically proven mental health care reaches all children and families. REACH provides thousands of primary care providers, therapists, and health care institutions with training in the best evidence-based therapies in order to better diagnose, treat and manage child and adult mental health issues.

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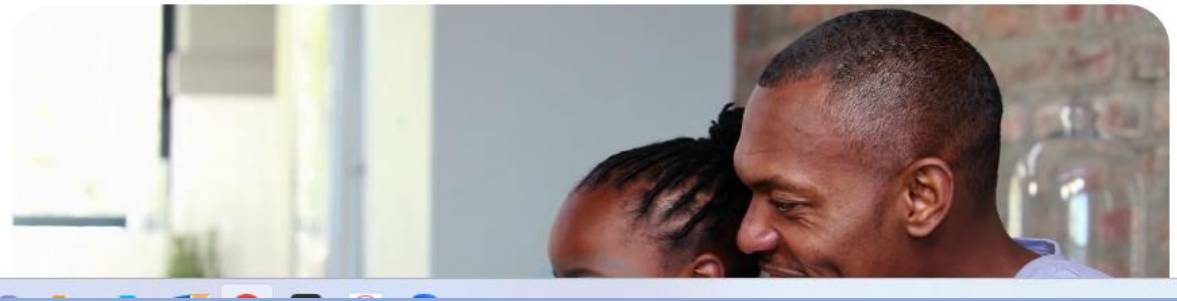
Expanding Access To Mental Health Care

The US has a pediatric mental health crisis. At least 6 million children and teens were suffering from mental illness before COVID-19. Most did not have access to mental health services even then. During the pandemic, pediatric mental illness has skyrocketed, while services have stayed flat. By providing mental health training for doctors, therapists, educators, and parents, REACH increases the nation's capacity to help children with mental health disorders.



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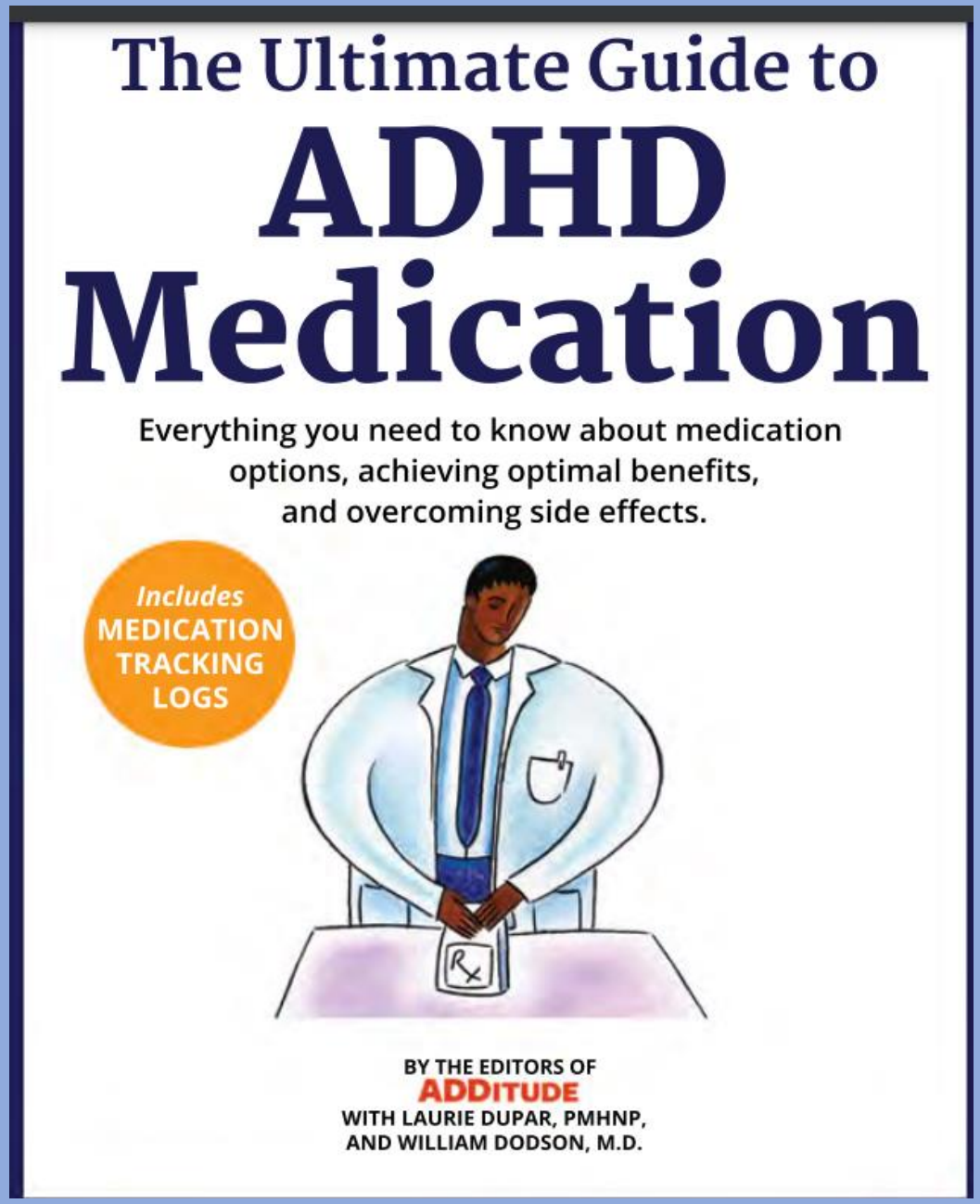

- https://www.additudemag.com/download/ultimate-guide-adhd-medications/

Comments/Questions?

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