# Attention-Deficit/Hyperactivity Disorder (ADHD) Pharmacological Treatment Recommendations

## Treatment Recommendations for a Patient with a Confirmed Diagnosis of ADHD AND Level of Impairment to Warrant Pharmacological Management

| Preschool-aged children<br>4 years to 6th birthday | School-aged children<br>6 years to 12th birthday | Adolescents<br>12 years to 18th birthday | Adults<br>18 years and older |
|---|---|---|---|
| **First-line treatment:** Evidence-based behavioral interventions and classroom behavioral interventions<br>**Second-line:** May prescribe methylphenidate if no significant improvement and moderate-to-severe continued disturbance | Treat with pharmacologic therapy AND *evidence-based behavioral interventions and/or classroom behavioral interventions | Treat with pharmacologic therapy and may consider *evidence-based behavioral interventions and/or classroom behavioral interventions | Treat with pharmacologic therapy and cognitive behavioral therapy/ psychosocial treatment |

*For further information regarding evidence-based behavioral interventions please see Appendix 2.2 “Nonpharmacologic Treatments”

### Guidance for Initial Pharmacological Management of ADHD

Stimulant therapy is usually considered first-line in patients 6 years of age and older, unless the patient is not a suitable candidate. Methylphenidate and amphetamine options tend to have similar effectiveness, but amphetamines may be associated with more side effects. Patient-specific factors should be evaluated to determine if the patient is a candidate for use of a stimulant medication.

#### Contraindications

- Known sensitivity
- Serious cardiac conditions
- Hyperthyroidism
- Glaucoma
- Patients who have used an MAOI, linezolid, or methylene blue within the last 14 days
- History of substance misuse
- Agitated state (use caution in patients with bipolar disorder/mania, as stimulants have the potential to induce mania)

#### Precautions

- Patients with suicidal ideation or major depression
- Mild hypertension or tachycardia
- Significant hepatic or renal impairment
- History of seizure disorders
- Eating disorders
- Cerebrovascular disease
- Pregnancy/ breastfeeding
- Geriatric patients

Caregiver/patient/family preference regarding use of a stimulant versus a non-stimulant medication should be discussed and considered. When starting adolescents and adults on stimulant medications clinicians should obtain the patient’s consent to treat and assess for symptoms of substance use and monitor prescription refill requests for signs of misuse or diversion. Consider the patient’s insurance coverage and formulary requirements when selecting an agent. Starting a stimulant:

- Long-acting formulations are recommended
- Children and adolescents starting stimulants should be initiated at the starting dose and then gradually titrated weekly to the dose that optimally controls symptoms with minimal adverse effects
- Adults starting stimulants should start at the lowest possible dose and titrate slowly. Before switching to another agent, titrate to the maximum dose if no side effects are present.

If the patient is **not** a candidate for stimulant therapy and/or caregiver/patient/family preference is to avoid stimulant therapy, common non-stimulant treatment includes atomoxetine, viloxazine, guanfacine and clonidine. Consider and educate the patient on the duration of time to maximum response of the chosen agent. The time for maximum response tends to be within a few weeks for stimulants whereas clonidine and guanfacine can take about 2 to 4 weeks and viloxazine and atomoxetine may take up to 6 to 8 weeks. Once pharmacological and/or non-pharmacological treatment is initiated continue to closely monitor all patients receiving pharmacological therapy.

See “ADHD Monitoring and Follow Up” for specific recommendations.