Use of an ADHD Non-Stimulant at Higher Than Recommended Dose For 45 or More Days (Under 18 Years)

CLINICAL ISSUE	CLINICAL CONSIDERATIONS	REFERENCES
▪ Increased risk of side effects. ▪ May contribute to poor adherence. ▪ May indicate non-responsiveness to this class. ▪ May indicate diagnostic uncertainty.	▪ Reconsider original diagnosis and revise treatment to reflect current clinical formulation including comorbid mental health disorders. ▪ If current stimulant is ineffective, consider stimulants and/or non-stimulant treatments. ▪ Consider down titrating dose to determine if the higher than recommended dose is needed. ▪ Consider psychosocial interventions and/or consider referral for consultation by a child and adolescent psychiatrist. ▪ Consider reviewing medication use and adherence with patient and/or family.	▪ Rappley MD. Clinical practice. Attention deficit-hyperactivity disorder. *N Engl J Med.* 2005;352(2):165-173. ▪ Michelson D, Allen AJ, Busner J, et al. Once-daily atomoxetine treatment for children and adolescents with attention deficit hyperactivity disorder: a randomized, placebo-controlled study. *Am J Psychiatry.* 2002;159(11):1896-1901. ▪ Michelson D, Faires D, Wernicke J, et al. Atomoxetine in the treatment of children and adolescents with attention-deficit/hyperactivity disorder: a randomized, placebo-controlled, dose-response study. *Pediatrics.* 2001:108(5):E83. ▪ Newcorn JH, Spencer TJ, Biederman J, et al. Atomoxetine treatment in children and adolescents with attention-deficit/hyperactivity disorder and comorbid oppositional defiant disorder. *J Am Acad Child Adolesc Psychiatry.* 2005;44(3):240-248.

Use of Clonidine at Higher Than Recommended Dose For 45 or More Days (Under 18 Years)

CLINICAL ISSUE	CLINICAL CONSIDERATIONS	REFERENCES
▪ Increased risk of side effects such as hypotension, somnolence, bradycardia, irritability and weakness at high doses. ▪ May contribute to poor adherence. ▪ May indicate non-responsiveness to this class, which when prescribed for youth is typically for ADHD and/or tic disorders. ▪ May indicate diagnostic uncertainty.	▪ Consider reviewing medication use and adherence with patient and/or family. ▪ Consider whether stimulant dosing may contribute to sleep difficulties. ▪ If used for sleep, consider whether mid-sleep awakening is contributing to dose escalation. ▪ Consider down titrating dose to determine if the higher than recommended dose is needed. ▪ Reconsider original diagnosis and revise treatment to reflect current clinical formulation including comorbidity. ▪ Consider psychosocial interventions and/or consider referral for consultation by a child and adolescent psychiatrist.	▪ Rappley MD. Clinical practice. Attention deficit-hyperactivity disorder. *N Engl J Med.* 2005;352(2):165-173. ▪ Connor DF, Barkley RA, Davis HT. A pilot study of methylphenidate, clonidine, or the combination in ADHD comorbid with aggressive oppositional defiant or conduct disorder. *Clin Pediatr(Phila).* 2000;39(1):15-25. ▪ Hazell PL, Stuart JE. A randomized controlled trial of clonidine added to psychostimulant medication for hyperactive and aggressive children. *J Am Acad Child Adolesc Psychiatry.* 2003;42(8):886-994. ▪ Pliszka SR, Greenhill LL, Crismon ML, et al. The Texas Children's Medication Algorithm Project: Report of the Texas Consensus Conference Panel on Medication Treatment of Childhood Attention-Deficit/Hyperactivity Disorder. Part II: Tactics. Attention-Deficit/Hyperativity Disorder. *J Am Acad Child Adolesc Psychiatry.* 2000;39(7):920-927.

Use of Guanfacine at Higher Than Recommended Dose For 45 or More Days (Under 18 Years)

CLINICAL ISSUE	CLINICAL CONSIDERATIONS	REFERENCES
▪ Increased risk of side effects such as mid-sleep awakening at high doses. ▪ May contribute to poor adherence. ▪ May indicate non-responsiveness to this class which when prescribed for youth is typically for ADHD and/or tic disorders. ▪ May indicate diagnostic uncertainty.	▪ Consider reviewing medication use and adherence with patient and/or family. ▪ Consider whether stimulant dosing may contribute to sleep difficulties. ▪ Consider down titrating dose to determine if the higher than recommended dose is needed. ▪ Reconsider original diagnosis and revise treatment to reflect current clinical formulation including comorbidity. ▪ Consider psychosocial interventions and/or consider referral for consultation by a child and adolescent psychiatrist.	▪ Rappley MD. Clinical practice. Attention deficit-hyperactivity disorder. *N Engl J Med.* 2005;352(2):165-173. ▪ Scahill L, Chappell PB, Kim YS, et al. A placebo-controlled study of guanfacine in the treatment of children with tic disorders and attention deficit hyperactivity disorder. *Am J Psychiatry.* 2001;158(7):1067-1074. ▪ Pliszka SR, Greenhill LL, Crismon ML, et al. The Texas Children's Medication Algorithm Project: Report of the Texas Consensus Conference Panel on Medication Treatment of Childhood Attention-Deficit/Hyperactivity Disorder. Part II: Tactics. Attention-Deficit/Hyperativity Disorder. *J Am Acad Child Adolesc Psychiatry.* 2000;39(7):920-927.

Use of Bupropion at Higher Than Recommended Dose For 45 or More Days (Under 18 Years)

CLINICAL ISSUE	CLINICAL CONSIDERATIONS	REFERENCES
▪ Increased risk of side effects such as nausea, vomiting, rash and possible seizures at high doses. ▪ May contribute to poor adherence. ▪ May indicate non-responsiveness to this class which when prescribed for youth is typically for ADHD and/or tic disorders. ▪ May indicate diagnostic uncertainty.	▪ Consider reviewing medication use at high dose and adherence with patient and/or family. ▪ Consider down titrating dose to determine if the higher than recommended dose is needed. ▪ Reconsider original diagnosis and revise treatment to reflect current clinical formulation including comorbidity. ▪ Consider psychosocial interventions and/or consider referral for consultation by a child and adolescent psychiatrist.	▪ Rappley MD. Clinical practice. Attention deficit-hyperactivity disorder. *N Engl J Med.* 2005;352(2):165-173. ▪ Waxmonsky J. Assessment and treatment of attention deficit hyperactivity disorder in children with comorbid psychiatric illness. *Curr Opin Pediatr.* 2003;15(5):476-482. ▪ Pliszka SR, Greenhill LL, Crismon ML, et al. The Texas Children's Medication Algorithm Project: Report of the Texas Consensus Conference Panel on Medication Treatment of Childhood Attention-Deficit/Hyperactivity Disorder. Part II: Tactics. Attention-Deficit/Hyperativity Disorder. *J Am Acad Child Adolesc Psychiatry.* 2000;39(7):920-927.