Community Behavioral Health

Clinical Guidelines for the Pharmacologic Treatment of Attention Deficit and Hyperactivity Disorder (ADHD) in Children and Adolescents

August 4, 2020

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1. PREFACE

Community Behavioral Health (CBH) is committed to working with our provider partners to continuously improve the quality of behavioral health care for our shared population. Whenever possible, this is best accomplished through the implementation of evidence-based practices, as well as those informed by nationally recognized treatment guidelines, while respecting the need for individualized treatment.

The following are medication prescribing standards, adapted for the CBH Network from national treatment guidelines. They are intended to guide providers in aligning their practices with the best available scientific evidence to help members with ADHD access state-of-the-art care.

To assess quality of care, CBH will be collecting several standardized metrics. These metrics come either from the Healthcare Effectiveness Data and Information Set (HEDIS), a set of measures used by many major health care organizations for quality improvement, or are measures of clear clinical priority in our network. While CBH will be collecting specific data related only to guidelines that have been issued to the network thus far, the use of empirical guidelines and practice parameters is encouraged in all prescribing.

CBH expects providers to follow these guidelines in addition to all other relevant CBH, state, and federal regulations and standards, including CBH prescribing Bulletins (e.g. Provider Bulletin 07-07: Screening for and Treatment of the Components of Metabolic Syndrome[1]), the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Practice Guidelines for Resiliency and Recovery-oriented Treatment,[2] and the Network Inclusion Criteria Standards of Excellence.[3]

Note further that the following are guidelines for the *pharmacologic* treatment of ADHD. CBH and DBHIDS encourage a biopsychosocial and recovery- and resiliency-based approach to treatment; in each case these guidelines for medication treatment should be but one part of a robust, multidisciplinary treatment approach that involves high-quality psychosocial treatment, collaboration with physical health providers, and inclusion of families and other supports.

2. INTRODUCTION

CBH has updated its guidelines for the treatment of ADHD in children and adolescents to reflect the most recently published evidence-based practice parameters available: those of the

[1] Community Behavioral Health (CBH), *Provider Bulletin 07-07: Screening for and Treatment of the Components of Metabolic Syndrome*.
[2] Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), *Philadelphia Behavioral Health Practice Guidelines*, 2013, or latest version.
[3] Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), *Network Inclusion Criteria Standards of Excellence*, February 2019, or latest version.

American Academy of Pediatrics (AAP), issued in 2019.[4] The current guidelines include references to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, published since the last iteration of the guidelines in 2011. The update includes the addition of a key action statement regarding the treatment of comorbid conditions. Also notable is the addition of a supplemental article on systemic barriers to the care of children and adolescents with ADHD. The AAP subcommittee included representatives from the American Academy of Child and Adolescent Psychiatry (AACAP). AACAP Clinical Practice Guidelines for ADHD are pending and will replace the AACAP Practice Parameters for ADHD.[5] CBH encourages its network providers to remain current with the state of evidence-based practice parameters and to incorporate these into the clinical care offered. These guidelines reflect the best scientific evidence available to guide treatment delivery and should be considered the standard of care in the CBH Network.

Resources including further details on behavioral treatments related to these guidelines for providers may be accessed here.

3. GUIDELINES (ADAPTED FROM THE AAP GUIDELINES)

1. Any child four through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity should receive an evaluation for ADHD. To make a diagnosis of ADHD, the prescribing physician should confirm and document that DSM-5 criteria have been met (including documentation of impairment in more than one major setting). This diagnosis should be informed primarily by reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. Parent and teacher behavior rating scales (e.g. the ADHD Rating Scale-IV, the Child Behavior Checklist, the Vanderbilt ADHD diagnostic scales, and the Conners rating scales) may be helpful in clarifying the diagnosis.

2. In the evaluation of a child for ADHD, assessment should be completed for comorbid conditions, including emotional or behavioral (e.g. anxiety, depressive, oppositional defiant, conduct, or trauma-related disorders, substance use), developmental (e.g. learning and language disorder, autism spectrum disorders), and physical (e.g. tics, sleep apnea) conditions. These evaluations must be done by appropriately trained and licensed personnel. The presence of a comorbid condition may alter the treatment of ADHD in some cases.

[4] Wolraich ML, Hagan JF, Allan C, et al. AAP SUBCOMMITTEE ON CHILDREN AND ADOLESCENTS WITH ATTENTION-DEFICIT/HYPERACTIVE DISORDER. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*. 2019;144(4):e20192528.
[5] AACAP Parameters, Updates, and Guidelines.

3. Recent evidence suggests that African American and Latinx children are less likely to have ADHD diagnosed and are less likely to be treated for ADHD. Special attention should be given to these populations when assessing comorbidities related to ADHD and during ADHD treatment.

4. Recommendations for treatment of children and adolescents with ADHD vary by age:

    a. For preschool-aged children (defined by the AAP as children 4–5 years of age), the AAP recommends implementing evidence-based parent- and/or teacher-administered behavior therapy (e.g. Parent Child Interaction Therapy) as the first line of treatment. The AAP recommends methylphenidate as the first line medication if behavioral interventions do not provide significant improvement and there is moderate to severe functional impairment. The AAP notes that methylphenidate is not FDA-approved for the treatment of ADHD in preschool-aged children but has the most robust evidence to support its use in this population. Short-acting amphetamine/dextroamphetamine and dextroamphetamine are FDA-approved to treat ADHD in children as young as three years of age. The AAP does not recommend amphetamines as first line medication for ADHD in this population as they report that the criteria for FDA approval at the time does not meet current standards for approval. The AAP does not recommend diagnosing or treating children younger than four years of age with ADHD based on insufficient data, with the exception of parent training in behavior management for ADHD-like symptoms with significant impairment.

        In areas where evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment.

    b. For elementary school-aged children (6–11 years of age), the clinician should prescribe FDA-approved medications for ADHD (see Table 1 in Section 5.) and/or evidence-based parent and/or teacher-administered behavior therapy as treatment for ADHD, preferably both.

        The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order).

        The school environment, placement, and supports should be a part of a comprehensive treatment plan and often includes an Individualized Education Program (IEP) or Section 504 plan.

    c. For adolescents (12–18 years of age), clinicians should prescribe FDA-approved medications for ADHD (see Table 1) with the assent of the adolescent and may prescribe behavior therapy as treatment for ADHD, preferably both. Stimulant

medications are highly effective in reducing core ADHD symptoms in adolescents.

The school environment, program, or placement should be a part of a comprehensive treatment plan and often includes an IEP) or Section 504 plan.

5. The prescriber should initiate and titrate the doses of medication for ADHD to achieve the maximum benefit with minimum adverse effects.

6. Prescribers are encouraged to monitor heart rate (HR) and blood pressure (BP) in youth taking stimulant medication. Non-stimulant ADHD medications may also impact HR and BP. Clinicians are advised to obtain the youth's and family's cardiac history prior to initiation of ADHD medications. The AAP recommends further cardiac evaluation prior to initiation of treatment if risk factors are present. Prescribing guidelines for stimulants and atomoxetine include monitoring height and weight at baseline and periodically during treatment.

7. Prescribing of medications for ADHD that are not FDA-approved for this indication is generally discouraged and must proceed according to Bulletin 10-03 on the use of "off-label" medications in children and adolescents.[6]

8. To ensure appropriate titration to optimize symptom control, for appropriate re-evaluation of symptoms and functional impact, and to monitor for the emergence of adverse effects, these follow-up intervals are required after the initiation of an ADHD medication:

    a. One medication management follow-up visit no more than 30 days after the prescription is initiated

    b. At least two more such visits after the initial 30-day period of medication

4. CBH IMPLEMENTATION REVIEW

CBH encourages its providers to maintain robust internal quality management programs to ensure treatment of CBH members adheres to these and other applicable guidelines. In addition to "as needed" reviews of medical records when quality issues arise, CBH will be tracking and sharing the following performance metrics with providers:

[6] Community Behavioral Health (CBH), *Provider Bulletin 10-03: Use of Psychotropic Medications in Children and Adolescents (FDA-Approved and Off-Label)*.

- Appropriate medication follow-up (initial and continuation/maintenance phase) appointments for children and adolescents prescribed medications for ADHD (which will be tracked via the National Committee for Quality Assurance (NCQA) HEDIS measure[7])

- Appropriate use of medication for children and adolescents diagnosed with ADHD (will be tracked via claims data to generate percentages of members with ADHD prescribed FDA-approved medications, other medications, and no medication)

In addition, providers should maintain documentation of all evaluations and interventions described in these guidelines, whether delivered by the provider or an outside practitioner. CBH and the DBHIDS Network Improvement and Accountability Collaborative (NIAC) will continue to monitor treatment provided to assure that care is consistent with the DBHIDS Network Inclusion Criteria (NIC) Standards of Excellence.[8]

[7] National Committee for Quality Assurance (NCQA), *Follow-Up Care for Children Prescribed ADHD Medication (ADD)*.
[8] Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), *Network Inclusion Criteria Standards of Excellence*, February 2019, or latest version.

5. APPROVED MEDICATIONS FOR ADHD

Table 1. Approved Medications for ADHD[9]		
Class	**Trade Name**	**Generic Name**
Stimulants		
Amphetamines	Adderall	mixed amphetamine salts
	Adderall XR	extended release mixed amphetamine salts
	Dexedrine	dextroamphetamine
	Dexedrine Spansule	dextroamphetamine
	Vyvanse	Lisdexamfetamine (extended release)
Methylphenidate	Concerta	Methylphenidate (extended release)
	Daytrana	methylphenidate (patch)
	Focalin	dexmethylphenidate
	Focalin XR	extended release dexmethylphenidate
	Metadate ER	extended release methylphenidate
	Metadate CD	extended release methylphenidate
	Methylin	methylphenidate hydrochloride (liquid and chewable tablets)
	Quillivant XR	extended release methylphenidate (liquid)
	Ritalin	methylphenidate
	Ritalin LA	extended release methylphenidate
	Ritalin SR	extended release methylphenidate
Non-stimulants		
(Norepinephrine Uptake Inhibitor)	Strattera	Atomoxetine
(Alpha Adrenergic Agents)	Intuniv	extended release guanfacine
	Kapvay	extended release clonidine

[9] ADHD: Parents Medication Guide. Prepared by the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association, Revised 2013.

6. ADDITIONAL RESOURCES

- FDA Medication Guides
- ADHD Medication Guide (recommended by the AAP)
- CMS Pediatric Stimulant and Related Medication Factsheet
- CMS Pediatric Dosing Chart