DCFS Psychotropic Medication List

GENERIC NAME	TRADE NAME	RECOMMENDED DOSES/ BLOOD LEVELS**	MEDICATION MANAGEMENT	BLACK BOX WARNING	NOTES	FDA INDICATION FOR CHILDREN
α-agonist						
Clonidine	Catapres, Catapres TTS	3 - 5 µg/kg in 3-4 divided doses Start: 0.05 mg PO qd then increase by 0.05 mg/day q7 days [<12 y.o.] Dose 0.45 mg/d [13 – 17 y.o.] Dose: 0.6 mg/d	Baseline cardiac history, medication history, family history and screening, BP, P Recommend baseline EKG, though not mandated (AHA statement: Cardiovascular Monitoring of Children and Adolescents Receiving Psychotropic Drugs) Follow-up BP, P	None	More beneficial for hyperactivity and impulsivity, less for attention span.	None
Guanfacine	Tenex	15-43 µg/kg in 1-2 divided doses [< 12 y.o.] Dose: 4 mg/day [13 - 17 y.o.] Dose: 6 mg/day	Same as clonidine	None	Same as clonidine	The FDA has given Shire an approvable letter for Intuniv ER, an extended release formulation of guanfacine for the treatment of ADHD.
Antidepressants						
Tricyclic Antidepressants						
Amitriptyline*	Elavil	1 – 3 mg/kg/d div TID Max: 5 mg/kg up to 200 mg/d	Baseline and follow-up EKGs, BP, and P	Increased risk of suicidal thinking and behavior		None

		Therapeutic blood levels (AMI + NOR): 100 - 250 ng/mL	Monitor plasma amitriptyline, nortriptyline levels Monitor for worsening of depression and increasing suicidality			
Clomipramine HCl	Anafranil	3 mg/kg/day Maximum dosage: 200 mg daily Therapeutic levels: 150 – 300 ng/ml	Baseline and follow-up EKGs, BP, and P Monitor plasma clomipramine levels Monitor for worsening of depression and increasing suicidality	Increased risk of suicidal thinking and behavior		Psychiatric - OCD
Desipramine HCl	Norpramin	2.5 – 5 mg/kg/d Therapeutic levels: 125 – 300 ng/ml	Baseline and follow-up EKGs, BP, and P Monitor plasma desipramine levels Monitor for worsening of depression and increasing suicidality	Increased risk of suicidal thinking and behavior		None
Doxepin HCl*	Sinequan	25 – 300 mg/d Therapeutic blood levels: 100 - 250 ng/mL	Baseline and follow-up EKGs, BP, and P Monitor plasma doxepin levels Monitor for worsening of depression and increasing suicidality	Increased risk of suicidal thinking and behavior	Powerful antihistaminic agent, very sedating.	None
Imipramine HCl	Tofranil	Enuresis: 10 – 75 mg/d Depression: 1.5 – 5 mg/kg/d Max: 5 mg/kg/d	Baseline and follow-up EKGs, BP, and P Monitor plasma imipramine and	Increased risk of suicidal thinking and behavior		Psychiatric: nocturnal enuresis

		Therapeutic plasma levels (IMI + DMI): 150 – 300 ng/ml	desipramine levels Monitor for worsening of depression and increasing suicidality			
Nortriptyline HCl	Pamelor, Aventyl	Enuresis: 10 – 35 mg qHS Depression: 2 – 3 mg/kg/d Max: 150 mg/d Therapeutic plasma levels: 50 – 150 ng/ml	Baseline and follow-up EKGs, BP, and P Monitor plasma nortriptyline levels Monitor for worsening of depression and increasing suicidality	Increased risk of suicidal thinking and behavior		None
Protriptyline*	Vivactyl	10 – 60 mg/d Therapeutic plasma levels: 75 - 200 ng/ml	Baseline and follow-up EKGs, BP, and P Monitor plasma protriptyline levels Monitor for worsening of depression and increasing suicidality	Increased risk of suicidal thinking and behavior	Highly activating tricyclic antidepressant, do not give at bedtime. Not commonly used.	None
Trimipramine*	Surmontil	50 – 200 mg/d Therapeutic blood levels: unknown	Baseline and follow-up EKGs, BP, and P	Increased risk of suicidal thinking and behavior	No advantage over other tricyclic antidepressants.	None
Selective Serotonin Reuptake Inhibitors (SSRIs)						
Citalopram hydrobromide	Celexa	10 – 40 mg/d 0.25 – 0.70 mg/kg/d		Increased risk of suicidal thinking and behavior	Racemic mixture of the citalopram molecule	None
Escitalopram oxalate	Lexapro	5 – 20 mg/d		Increased risk of suicidal thinking and behavior	S – enantiomer of the citalopram molecule	None
Fluoxetine HCl	Prozac, Prozac Weekly, Serafem	OCD: 20 – 60 mg/d		Increased risk of suicidal thinking and behavior	Fluoxetine is recommended as the first drug of	Psychiatric: depression, OCD

		MDD: 10 – 40 mg/d			choice in the treatment of depression in children and adolescents. Mann et al.; “ACNP Task Force Report on SSRIs and Suicidal Behavior in Youth” (Neuropsychopharmacology, 31:473-492, 2006), concludes that only fluoxetine has strong statistical evidence supporting its efficacy in treating depression in youth in RCTs and recommends additional study of potential antidepressants in children and adolescents by RCTs using fluoxetine as the reference compound. Fluoxetine’s efficacy was replicated by two separate meta-analyses reported in the Journal of Child and Adolescent Psychopharmacology 16 (1/2), 2006 (Kratchovil et al and Wallace et al). Furthermore, according to the FDA meta-analysis (Hammad, 2004)	

					and data published by Olfson and colleagues (Antidepressant drug therapy and suicide in severely depressed children and adults. A case-control study. Arch Gen Psychiatry 63:865-872, 2006), fluoxetine has a better safety profile with less likelihood of inducing suicidal ideation, agitation and behavioral activation than other SSRIs. Finally, fluoxetine is FDA approved and available as a generic.	
Fluvoxamine maleate	Luvox - Brand name preparation removed from market.	Obsessive-compulsive disorder [8-11 y.o.] Dose: 50-200 mg PO qd [12–18 y.o.] Dose: 50-200 mg PO qd Max: 300 mg/day		Increased risk of suicidal thinking and behavior		Psychiatric: OCD
Paroxetine HCl*	Paxil, Paxil CR, Pexeva	10 - 60 mg/d	Highly unfavorable risk-benefit ratio	Increased risk of suicidal thinking and behavior	Will not approve new requests unless patient has responded to previous trial of paroxetine or a member of the patient's immediate family has responded to paroxetine.	None
Sertraline HCl	Zoloft	Obsessive-compulsive		Increased risk of		Psychiatric: OCD

		disorder [6-12 yo] Dose: 25 mg - 200 mg/day [13-17 yo] Dose: 50 mg - 200 mg qd Max: 200 mg/day		suicidal thinking and behavior		
Monoamine oxidase inhibitors					Very rarely used in children and adolescents.	
Phenelzine*	Nardil	45-60 mg/day Max: 90 mg/day	Requires tyramine free diet.	Increased risk of suicidal thinking and behavior	May cause malignant hypertension with tyramine containing foods and adrenergic agonists, may cause serotonin syndrome. Do not use in combination with meperidine.	None
Selegeline*	EMSAM	6 mg/24h patch qd, incr. by 3 mg/24h q2wk Max: 12 mg/24h		None	Tyramine reaction noted only at high dosages.	None
Tranylcypromine*	Parnate	Start: 10 mg PO bid, incr. 10 mg/day q1-3wk Max: 60 mg/day	Requires tyramine free diet.	Increased risk of suicidal thinking and behavior	May cause malignant hypertension with tyramine containing foods and adrenergic agonists, may cause serotonin syndrome. Do not use in combination with meperidine, SSRIs, pseudophedrine.	None

Other						
Amoxapine*	Asendin	Start: 50 mg PO bid - tid Max: 400 mg/day	Marketed as an antidepressant but has efficacy as an atypical antipsychotic.	Increased risk of suicidal thinking and behavior		None
Bupropion	Wellbutrin, Wellbutrin SR, Wellbutrin XL, Zyban	1.4 - 6 mg/kg/d Max: 450 mg/d		Increased risk of suicidal thinking and behavior	Can cause seizures at doses greater than 6 mg/kg. Contraindicated in bulimia.	None
Desvenlafaxine*	Pristiq	50 mg/d		Increased risk of suicidal thinking and behavior	Desvenlafaxine, the active metabolite of venlafaxine, is a dual serotonin-norepinephrine reuptake inhibitor. Desvenlafaxine has two advantages over venlafaxine. First, patients can immediately start taking the medication at the therapeutic dose of 50 mg/d rather than gradually increasing the dose. Second, desvenlafaxine is not metabolized by the liver and is therefore less likely to interact with other medications that are metabolized by the liver. There are no data to support use in children and adolescents.	None

Duloxetine*	Cymbalta	40 - 60 mg/d, with increases at intervals of no less than 1 wk Max: 60 mg/d	Monitor blood pressure at base and periodically	Increased risk of suicidal thinking and behavior	Dual serotonin-norepinephrine reuptake inhibitor. In a meta-analysis of the literature in adults, venlafaxine was found to be superior to duloxetine in the treatment of depression. There is no data to support use in children and adolescents.	None
Maprotiline*	Ludiomil	Start: 25-75 mg PO div bid-tid; incr. 25 mg/day q2wk; Max: 150 mg/day		Increased risk of suicidal thinking and behavior		None
Mirtazapine	Remeron, RemeronSolTab	7.5 – 45 mg qHS		Increased risk of suicidal thinking and behavior	Antihistimine effects predominate over $\square_2$ receptor antagonist effects at 7.5 mg, very sedating at lower doses	None
Nefazodone HCl*	Serzone - Brand name preparation removed from market.	50 – 300 mg/d Max: 300 mg BID	Monitor LFTs	Increased risk of suicidal thinking and behavior Hepatic failure	Associated with rare instances of liver failure resulting in death or transplantation.	None
Trazodone HCl	Desyrel	For depression [6-12 yo] 1.5-6 mg/kg/day PO div tid Max: 6 mg/kg/day [12-18 yo] Max: 6 mg/kg/day or 400 mg/day For acute management of		Increased risk of suicidal thinking and behavior	Associated with priapism	None

		sleep difficulties 25 – 100 mg qHS				
Venlafaxine HCl	Effexor, Effexor ER	Start: 37.5 mg PO bid, incr. dose q4 days Max: 375 mg/day	Take with food	Increased risk of suicidal thinking and behavior	Dual serotonin-norepinephrine reuptake inhibitor. Abrupt discontinuation of venlafaxine has been associated with the appearance of agitation, anorexia, anxiety, confusion, coordination impaired, diarrhea, dizziness, dry mouth, dysphoric mood, fasciculation, fatigue, headaches, hypomania, insomnia, nausea, nervousness, nightmares, sensory disturbances (including shock-like electrical sensations), somnolence, sweating, tremor, vertigo, and vomiting.	None
Antienuretics						
Desmopressin	DDAVP (tabs), DDAVP (nasal spray)	Children aged 6+ Dosage (tablet): start at 0.2 mg PO qhs Max: 0.6 mg/day Dosage (nasal): Dose: start at 20 mcg NAS qhs Max: 40 mcg/day	Baseline and periodic sodium levels	None	Children treated with intranasal DDAVP for nocturnal enuresis are susceptible to severe hyponatremia and seizures, therefore, intranasal DDAVP will no longer be	Psychiatric: nocturnal enuresis (tablet form only) Medical: central diabetes insipidus

		Give 1/2 dose each nostril			approved for the treatment of enuresis. DDAVP should not be used in hyponatremic patients or patients with a history of hyponatremia. Treatment with DDAVP should be interrupted during acute illnesses that may lead to fluid and/or electrolyte imbalance and used cautiously in patients at risk for water intoxication with hyponatremia.	
Oxybutynin	Ditropan, Ditropan XL	[>6 yo] Dose: 0.2 mg/kg PO BID – QID Max: 15 mg/day		None		Psychiatric: overactive bladder associated with neurological problems
Antihistamines						
Diphenhydramine HCl	Benadryl	25 – 50 mg PO qHS		None		Psychiatric: dystonic reactions, short-term treatment of insomnia Medical: allergies, anaphylaxis, anti-tussive, motion sickness
Hydroxyzine pamoate	Vistaril	[<6 yo] 50 mg/d in divided dosages [>6 yo] 50 – 100 mg/d in divided dosages		None		None

Antiparkinsonian agents						
Benztropine	Cogentin	[> 3 years old] 0.02-0.05 mg/kg PO/IM/IV qD - BID Max: 4 mg/d		None		Psychiatric: extrapyramidal reaction
Trihexyphenidyl HCl	Artane	5 - 15 mg PO div TID - QID Max: 15 mg/day		None		None
Antipsychotics						
First Generation (neuroleptics)						
Chlopromazine HCl	Thorazine	Children > 12 yrs: 200-800 mg/day PO div tid-qid Max: 1 g/day		None		Psychiatric: severe behavior disorders Medical: pre-operative sedation, nausea/vomiting, intraoperative nausea/vomiting, tetanus (adjunct treatment)
Fluphenazine decanoate	Prolixin decanoate	Start: 1.25x PO qd dose or 12.5-25 mg IM q3-6wk; incr. by 12.5-25 mg q3-6wk Max: 100 mg/dose		None		None
Fluphenazine HCl	Prolixin	Children age 12+:0.25 – 0.5 mg BID Max: 10 mg/d		None		None
Haloperidol	Haldol	[3 – 12 yrs] 0.05-0.15 mg/kg/day PO div bid-tid Max: 0.15 mg/kg/day		None	Significant EPS	Psychiatric: severe behavior disturbance, psychosis, agitation, Tourette's

		[> 12 yrs] 0.5-5 mg PO bid-tid Max: 100 mg/day for severe, refractory cases				syndrome
Haloperidol decanoate	Haldol decanoate	Start at 10 – 20 times oral dose. 50 – 100 mg/d. Max: 450 mg/mo		None		None
Loxapine succinate*	Loxitane	[> 16 years] 10 – 100 mg/d Max: 250 mg/d		None		None
Molindone HCl	Moban	[> 12 years] 5 – 50 mg TID – QID Max: 225 mg/d		None		Psychiatric: schizophrenia (> age 12)
Perphenazine	Trilafon	8-16 mg PO bid-qid Max: 64 mg/day		None		Psychiatric: schizophrenia (> age 12)
Pimozide*	Orap	[> 12 years] 0.2 mg/kg/d Max: 10 mg/d	Baseline and follow-up EKG		May cause QTc prolongation Avoid abrupt withdrawal	Psychiatric: Tourette's syndrome
Thioridazine HCl*	Mellaril	[2- 12 years] 0.5 mg- 3 mg/kg/d. [>13 years] 50 – 100 mg TID Max:: 800 mg/d	Baseline and follow-up EKG, K+	Proarrhythmia effects	May cause prolonged QTc interval and torsades de pointes and sudden death. Use restricted to schizophrenia resistant to standard treatments	Psychiatric: refractory schizophrenia
Thiothixene HCl	Navane	[> 12 years] 2 – 5 mg BID or TID Max: 60 mg/d		None		Psychiatric: schizophrenia (> age 12)
Trifluoperazine HCl	Stelazine	[6-12 years] 1 mg q.i.d. or b.i.d.		None		None

		[> 12 years] 1 -5 mg b.i.d. Max: 40 mg/d				
Second Generation (atypical)			The American Diabetic Association recommends that patients on atypical antipsychotic medications be monitored for the development of the metabolic syndrome with baseline and follow-up weight, waist circumferen ce, blood pressure, fasting blood sugar, and fasting lipid profile.			
Aripiprazole	Abilify	[6 – 12 years] 2.5 – 5 mg/d Max: 15 mg/d [12 – 18 years] 10 – 15 mg/D Max: 30 mg/d. Dosages greater than 10 mg have not been shown to be more effective.	Baseline and follow-up fasting blood sugar, blood pressure, blood cholesterol/triglyceri de levels	Dementia related psychosis	Unique pharmacological profile for antipsychotic medications with mixed dopamine agonist/antagonist activity.	Psychiatric: schizophrenia (13-17 y.o.)
Clozapine	Clozaril	[< 12 years] 3 -6 mg/kg/d [> 12 years] 12.5 mg qD – BID, increase dosage 25 – 50 mg q3 – 7 days Max: 900 mg/d	Monitor WBC, ANC qwk x 6 mo, q2wk x 6 mo, then qmo until D/C. Baseline and follow-up fasting blood sugar, blood pressure, blood cholesterol/triglyceri de levels. Also, Mg++, K+, and EKG	Agranulocytosis, seizures, myocarditis, orthostatic hypotension w or w/o syncope, dementia related psychosis		None

			at baseline and follow-up. Check qwk x4wk after D/C			
Olanzepine	Zyprexa, Zyprexa Zydis	0.12 -0.20 mg/kg qD Max: 20 mg/d	Baseline and follow-up fasting blood sugar, blood pressure, blood cholesterol/triglyceride levels	Dementia related psychosis		None
Paliperidone*	Invega	[12 – 18 years] 6 mg/d	Baseline and follow-up fasting blood sugar, blood pressure, blood cholesterol/triglyceride levels Follow-up prolactin levels, if symptomatic	Dementia related psychosis	Paliperidone requires special consultation for approval and will primarily be considered in patients with liver failure. Paliperidone is not a preferred medication because: 1) paliperidone (9-hydroxy-risperidone) is the principal active metabolite of risperidone and offers no advantage over risperidone, 2) the 9-hydroxy metabolite of risperidone is responsible for the hyperprolactinemia seen with risperidone pharmacotherapy, and 3) there is no experience with this drug in the pediatric population.	None
Quetiapine fumarate	Seroquel	[< 12 years] 50 – 400 mg/d	Baseline and follow-up fasting blood	Increased risk of suicidal thinking		None

		[12 – 18 years] 100 – 800 mg Max: 800 mg/d	sugar, blood pressure, blood cholesterol/triglyceride levels. Also, Mg++, K+, and EKG at baseline and follow-up.	and behavior Dementia related psychosis		
Risperidone	Risperdal, Risperdal Consta, Risperdal M-Tab	[< 12 years] 0.25 – 3 mg/d [12 – 18 years] 0.5 – 6 mg/d	Baseline and follow-up fasting blood sugar, blood pressure, blood cholesterol/triglyceride levels Follow-up prolactin levels, if symptomatic	Dementia related psychosis		Psychiatric: irritability due to autistic disorder bipolar disorder, acute mania, 10-17 y.o. schizophrenia, 13-17 y.o.
Ziprasidone HCl	Geodon	Initiation - 20 mg b.i.d Max: 80 mg b.i.d	Baseline and follow-up fasting blood sugar, blood pressure, blood cholesterol/triglyceride levels Baseline and follow-up EKG, K+, and Mg++	Dementia related psychosis		None
Benzodiazepines/ Anxiolytics					Benzodiazepines will be approved for acute management of aggression. Use for insomnia is discouraged and consent will be time limited. SSRIs are the drugs of choice in the treatment of anxiety. Special consultation is required for consent requests for	

					benzodiazepines that exceed 10 days.	
Alprazolam	Xanax	0.5 – 6 mg/d				None
Buspirone HCl	Buspar	2.5 mg t.i.d increase to 20 mg t.i.d Max: 60 mg/d			Less useful to those who have used BZDs	None
Chlordiazepoxide HCl*	Librium	5-10 mg PO tid-qid				Psychiatric: preoperative apprehension and anxiety (> age 6)
Clonazepam	Klonopin	1 – 6 mg/d				Medical: seizure disorder
Diazepam	Valium	5 – 100 mg/ d				Medical: seizure disorder, muscle relaxation
Lorazepam, lorazepam injectable	Ativan	1 – 6 mg/d				None
Oxazepam*	Serax	[> age 6] 5 – 60 mg/d				Psychiatric: anxiety Medical: procedural sedation, status epilepticus, nausea/vomiting,
Hypnotics						
Chloral hydrate		Sedation, 30 – 60 minutes pre-EEG: 25-50 mg/kg PO x1 Max: 100mg/kg				Medical: sedation (EEG)
Eszopiclone	Lunesta	5 – 10 mg PO qHS				None
Melatonin (OTC)		1 – 6 mg PO qHS			May have an antigonadal effect	N/A
Ramelteon	Rozerem	8 mg PO qHS			Melatonin MT1 and MT2 agonist	None

					Associated with decreased testosterone levels and increased prolactin levels.	
Zaleplon	Sonata	5 – 10 mg Max: 20 mg PO qHS				None
Zolpidem tartrate*	Ambien, Ambien CR	5-10 mg PO qhs Max: 10 mg PO qd	Baseline liver, kidney and COPD disease history		This medication will not be approved for use in wards. No more effective than placebo in treating children (aged 6-17 years) with insomnia associated with attention-deficit/hyperactivity disorder (up to 10 mg/day). Zolpidem did not significantly decrease latency to persistent sleep as measured by polysomnography after 4 weeks of treatment. Hallucinations seen in 7.4% of patients.	None
ß-blockers						
Propranolol	Inderal, Inderal LA	1 – 5 mg/kg/d BID – QID Max: 8 mg/kg/d or 320 mg/d, whichever is less	Baseline cardiac history, medication history, family history and screening, BP, P		Can exacerbate asthma Must not be discontinued abruptly Combination therapy with phenothiazines is contraindicated	None

Mood Stabilizers/ Anticonvulsants						
Carbamazepine	Tegretol, Carbetrol ER, Equetro	< 25 kg: 20 – 30 mg/kg/d; 400 mg 25 to 40 kg: 400 - 800 mg > 40 kg: 800 - 1200 mg plasma level 4 – 12 □g/ml	CBC with differential and platelet count at baseline and follow-up	Aplastic anemia/ agranulocytosis	Severe, even fatal skin reactions such as Stevens Johnson syndrome and toxic epidermal necrolysis, that can be caused by carbamazepine therapy, are significantly more common in patients with the human leukocyte antigen (HLA) allele, HLA-B*1502. This allele occurs almost exclusively in patients with ancestry across broad areas of Asia, including South Asian Indians. Patients with ancestry from areas in which HLA-B*1502 is present should be screened for the HLA-B*1502 allele before starting treatment with carbamazepine.	Medical: epilepsy
Divalproex sodium	Depakote, Depakote ER	15 – 60 mg/kg/d plasma level 50 – 125 □g/ml	CBCs, LFTs at baseline and 3 and 6 months, then q 6 months	Hepatotoxicity with risk of fatal hepatotoxicity in youngsters less than 2 years old Teratongenicity – implicated in neural tube defects	Implicated in polycystic ovary disease	Medical: seizure disorder

				Pancreatitis		
Gabapentin*	Neurontin	[3 – 4 years] 40 mg/kg/d Max: 50 mg/kg/d [5 – 12 years] 25 – 35 mg/kg/d Max: 50 mg/kg/d [> 12 years] 300 – 600 mg TID Max: 3,600 mg/d	Creatinine clearance at baseline in patients with impaired renal functioning	None		Medical: add on therapy for epilepsy
Lamotrigine	Lamictal	[2 – 12 years] 5 – 15 mg/kg/d Max: 200 mg/d [> 12 years] Max: 400 mg/d (200 mg/d divalproex sodium adjunct)	Baseline and follow-up CBC with differential, liver function tests	Serious rash – Stevens-Johnson syndrome, toxic epidermal necrolysis	Rate of Stevens-Johnson Syndrome is approximately 2.4/10,000 It is recommended that lamotrigine be discontinued if a rash develops. No data supports the use of lamotrigine to treat acute mania and its use will not be approved for the treatment of acute mania.	Medical: Lennox-Gastaut seizures, partial seizures
Lithium carbonate	Eskalith, Eskalith CR, LithoBID	< 25 kg: 600 mg 25 to 40 kg: 900 mg > 40 kg: 1200 mg serum lithium level 0.6 – 1.2 meq/l	CBC with diff, RFT, TFT, UA at baseline Lithium levels q 1 – 2 wks till stable then q 1 – 2 months TFTs, UA q 3 – 6 months for F/U			None
Lithium citrate	Cibalith-S	serum lithium level 0.6 –	CBC with diff, RFT,			None

		1.2 meq/l	TFT, UA at baseline Lithium levels q 1 – 2 wks till stable then q 1 – 2 months TFTs, UA q 3 – 6 months for F/U			
Oxcarbazepine	Trileptal	4 – 16 yrs: Start: 8-10 mg/kg/day 20-24kg Max: 300-450 mg PO bid 25-34 kg Max: 600 mg PO bid 35-44kg Max: 450-750 mg PO bid 45-49kg Max: 600-750 mg PO bid 50-59kg Max: 600-900 mg PO bid 60-69kg Max: 600-1050 mg PO bid > 70kg Max: 750-1050 mg PO bid > 16 yrs: Max: 2400 mg/day	CBC, electrolytes, serum creatinine, LFT	None	Causes hyponatremia in 2.5% of patients treated. Use of this medication as a first or second line medication for the treatment of bipolar disorder is discouraged unless the patient has had a positive response to a previous trial or if a first degree relative has had a response. Dineen-Wagner et. (Am J Psychiatry:163:1179-86) compared oxcarbazepine and placebo in 116 patients aged 7 – 18 years and found no difference. In addition, oxcarbazepine was associated with serious psychiatric side effects requiring hospitalization.	Medical: partial seizures
Topiramate	Topamax	[2 – 16 years] 5 – 9 mg/kg/d Max: 400 mg/d	Baseline and follow-up serum bicarbonate	None	Can cause clinically relevant hyperchloremic, non-anion gap	Medical: Lennox-Gastaut seizures, partial seizures, general tonic-

					metabolic acidosis in 3-11% of patients on topiramate Significant adverse effect on cognitive functioning at dosages > 400 mg/d	clonic seizures
Valproate sodium	Depakene	15 – 20 mg/kg/d plasma level 50 – 125 □g/ml	Baseline and follow-up CBC, LFT, pancreatic enzymes			Medical: seizure disorder
Psychostimulants					The American Heart Association recommends that children with ADHD should be evaluated before starting a stimulant. Specifically, they recommend a cardiac evaluation with an EKG before starting a stimulant and for patients who are already on a stimulant but who have not had a previous cardiac evaluation. View the scientific statement here.	
Amphetamine combination	Adderall, Adderall XR	2.5 - 30mg/d Max: 30 mg/d		High abuse potential. Risk for sudden death and serious adverse cardiac events.		Psychiatric: ADHD Medical: narcolepsy
Lisdexamfetamine dimesylate*	Vyvanse	[6-12 years] Start at 30 mg qAM. Increase dose by 20 mg/day in weekly intervals.		High abuse potential. Risk for sudden death and serious adverse cardiac events.	Lisdexamfetamine dimesylate requires special consultation for approval and will be considered	Psychiatric: ADHD

		Max: 70 mg/day			mainly for use in patients with a documented history of nasal or IV abuse of amphetamines. Lisdexamfetamine dimesylate is a pro-drug of d-amphetamine. After administration it is absorbed from the GI tract and converted to d-amphetamine. Its main advantages are that it is inactive as a prodrug and cannot be abused by snorting or IV injection and its extended release of d-amphetamine into the blood resulting in claims of better evening coverage of ADHD symptoms. This may increase the rate of treatment induced insomnia, often requiring pharmacological treatment. Doses of lisdexamfetamine dimesylateup to 100 mg do not produce a significantly greater drug liking effect than placebo; 150 mg produces drug liking effects similar to 40 mg of oral immediate-release	

					d-amphetamine.	
Methylphenidate transdermal system*	Daytrana	12.5 cm^2: 10 mg/9 hours 18.75 cm^2: 16 mg/9 hours 25 cm^2: 20 mg/9 hours 37.5 cm^2: 27 mg/9 hours	Baseline ECG, CBC, metabolic panel	None	Daytrana will only be approved for patients who cannot swallow pills. The FDA's Psychopharmacologic Drugs Advisory Committee noted the potential for future allergic reactions to other oral methylphenidate products if a user experiences an allergic skin reaction to the patch and recommended that oral forms of the stimulants be considered prior to selecting Daytrana. Furthermore, the oral preparation of Concerta has a more favorable pharmacokinetic profile with more rapid achievement of therapeutic plasma levels of d-MPH.	Psychiatric: ADHD
Dexmethylphenidate HCl	Focalin, Focalin XR	2.5 mg/d given b.i.d., at least 4hrs. apart to a maximum of 20 mg/day (10 mg twice)	Baseline ECG	None		Psychiatric: ADHD
Dextroamphetamine	Dexedrine spansules, Dextrostat	0.15 mg/kg 1.5mg/kg/d maximum dosage	Baseline ECG	High abuse potential. Risk for sudden death and serious adverse cardiac events.		Psychiatric: ADHD Medical: narcolepsy
Methylphenidate	Metadate ER,	0.3 mg/ kg	Baseline ECG, CBC,			Psychiatric:

	Metadate CD, Methylin, Methylin ER, Ritalin, Ritalin LA, Ritalin SR, Concerta	Max: 2 mg/kg/d or 60 mg/d (72 mg/d in adolescents for Concerta)	metabolic panel			ADHD
Other						
Miscellaneous CNS Agents						
Amantadine*	Symmetrel	[≤ 8 years] 75 mg b.i.d. [> 9 years] 100 mg b.i.d.			May improve behavior and cognitive functioning in children with recent traumatic brain injury. Used as antiparkinsonian and for ADHD. Can cause psychosis.	Medical: influenza A treatment and prophylaxis
Modafanil*	Provigil	Start: 100 mg PO qam Max: 400 mg/day	Monitor closely for skin rash		Received a nonapproval letter for the treatment of ADHD due to Stevens-Johnson syndrome.	Medical: narcolepsy
Opiate antagonist						
Naltrexone HCl*	Revia	50 mg PO qD	Baseline and follow-up LFT			None
Selective norepinephrine reuptake inhibitors						
Atomoxetine	Strattera	< 70 kg: 1.2 mg/kg/d - 1.4 mg/kg/d 70 kg: 80 mg/d Max: 100 mg/d				Psychiatric: ADHD

Combination medications						
Fluoxetine/olanzepine*	Symbyax	Start: 25 mg/6 mg PO qpm Max: 75 mg/18 mg/24h		Suicidality – increased risk of suicide Dementia related psychosis	Symbyax will not be approved. If combination therapy with olanzepine and fluoxetine is indicated requests should be submitted for each drug individually.	None

* - these medications are non-preferred. Requests for these medications will be closely scrutinized and may require an MD-to-MD consultation.

** - initial consent requests for doses higher than recommended will be modified and approved only to the highest recommended dosage. Higher dosages than those recommended in the table may be appropriate in some instances and would be considered for approval if the patient has had only a partial response after an adequate trial at the recommended dose.